

# THE IMPACT OF TRANSITION FROM GLOBAL FUND SUPPORT TO GOVERNMENTAL FUNDING ON THE SUSTAINABILITY OF HARM REDUCTION PROGRAMS

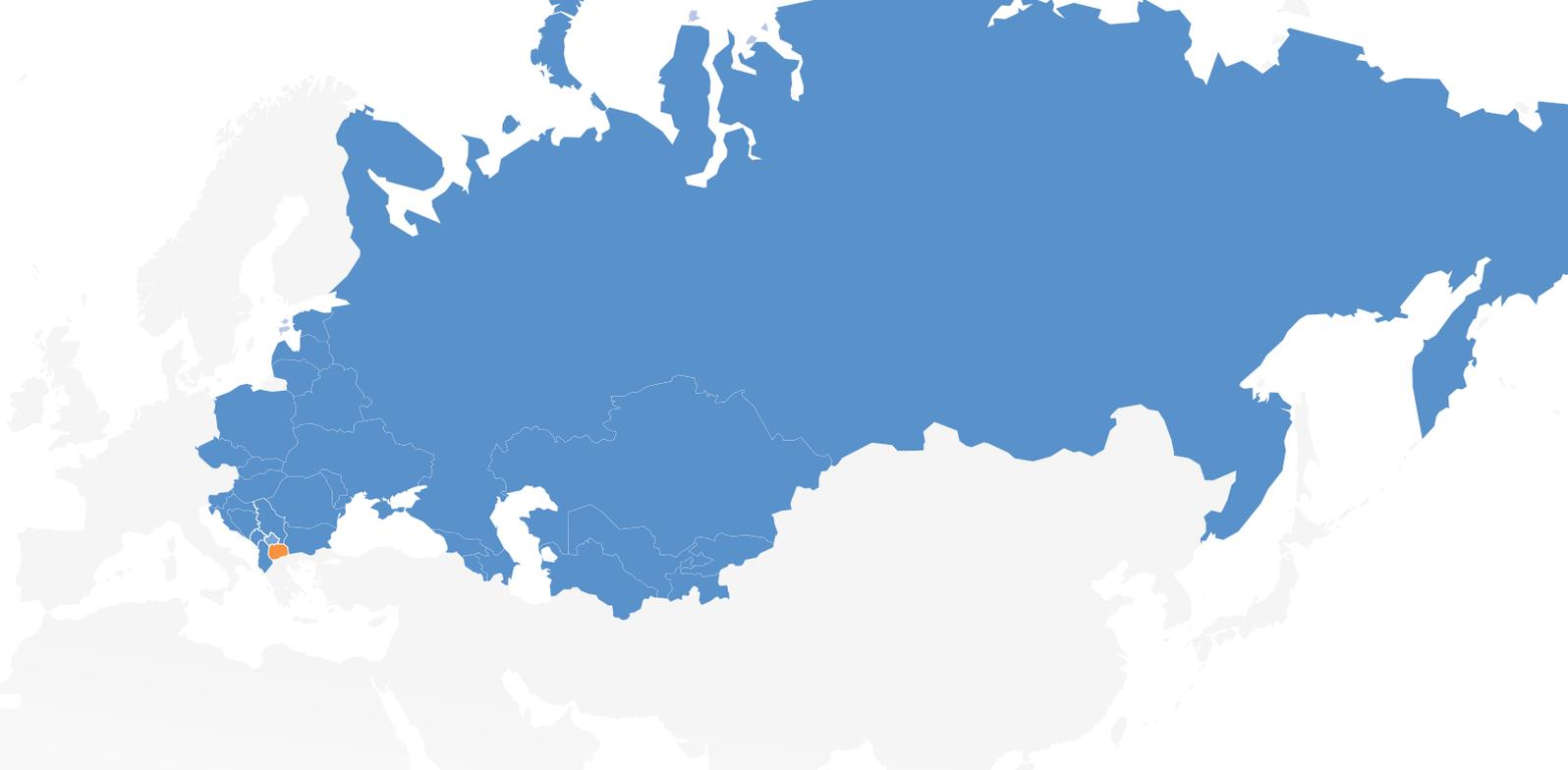
A CASE STUDY FROM MACEDONIA  
EURASIAN HARM REDUCTION NETWORK





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This case study was prepared by Andrej Senih, a civil society activist closely involved in the transition processes in Macedonia and a CCM member, between March and May 2016 and edited by Graham Shaw.

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## Executive Summary

Macedonia, a middle income, low HIV prevalence country in the Balkan region, is one of the countries impacted by the reduction of funding of the Global Fund to fight AIDS, Tuberculosis and Malaria. Macedonia has benefited significantly from Global Fund support for its national HIV strategic plans since 2004. Thanks to these prolonged efforts, Macedonia has maintained its low HIV prevalence, most evident by achieving control of the HIV epidemic among people who inject drugs.



The Global Fund support has helped build a wide network of harm reduction programs, including opioid substitution treatment (OST) and needle and syringe exchange programs (NSP), with Government implementation of OST interventions having already begun by 2009.

As the current and final Global Fund HIV grant is ending on 31 December 2016, Macedonia is now intensively undergoing a transition process to domestic funding primarily for its HIV prevention programs for key affected populations. By using the Transition Readiness Assessment Tool developed by EHRN and APMGlobal (see Attachment 1 for the details), this case study analyzes the readiness and risks in the transition from donor funding to sustainable domestic financing, identifying key barriers and formulating recommendations for all stakeholders involved.

The implementation of the assessment exercise has resulted in a relative readiness score of 47% as of May 2016. Macedonia appears to have fulfilled Stage 1 in nearly all aspects of policy, governance, finance and programs of the national HIV response, and Stage 2 in half of the defined indicators. Macedonia scores relatively high in the areas of finance and policy, whereas it still needs to make significant progress with indicators related to programming and governance.

It is likely that Macedonia can improve its readiness level during 2016 with intense and joint efforts by all stakeholders. Key activities that need to be accomplished in that direction are the strategic planning for the period 2017-2021 and putting into practice the financing mechanism for civil society organizations (CSOs), which has been already worked out to a significant level through a consultative process between civil society and the Ministry of Health.

Unfortunately, in the last and most important year for the transition processes, Macedonia is also facing a very deep political crisis that undoubtedly will impact the pace of the transition process. On the other hand, even if things move forward according to the agreed transition plan and there is enough political will for a responsible transition, it is likely that the country will not be able to fully meet all necessary preconditions to sustain the developed HIV prevention programs, including harm reduction, at an adequate level of coverage in accordance with the WHO recommendations.

All stakeholders can still contribute significantly to a responsible transition in Macedonia. The Global Fund should continue providing political, technical and financial support to the process, while ensuring that key affected populations are central to the process. This can include a no-cost extension for services during 2017, close monitoring of the transition process and support to civil society-based advocacy, as well as making an emergency plan in case there is a threat of interruption to NSP and OST services. The Government should commit to timely implementation of the transition plan, and as soon as possible make decisions about the level of funding to be



committed based on the available evidence and recommendations from a series of analyses performed with the support of the Global Fund, the World Bank and WHO, respectively. In parallel, the Government needs to start testing the new financing mechanism for CSOs through the domestic funding sources of the National HIV Program. Civil society should maintain and intensify participation in the transition processes and continue its advocacy on behalf of the key affected populations.

## Introduction

Rapid economic growth over the last decade in large parts of the Eastern Europe and Central Asia, including the Balkan area, has coincided with important economic and public health shifts that have rendered countries of the region ineligible for development assistance, in particular support from the Global Fund concerning HIV/AIDS. The exponential growth in international aid for health that was previously seen followed by the economic crisis has resulted in a decrease in donor funding available, including for HIV and tuberculosis programs.

In 2014, the Global Fund introduced the New Funding Model (NFM), a new approach to resource allocation that has transformed financing for the three diseases. In upper middle income countries (UMICs), Global Fund invests 100% of its financing to support key and vulnerable populations. According to World Bank classification, there are no longer low income countries in Eastern Europe and Central Asia (EECA), including the countries of the Balkans in Southeast Europe. Although pledges by donors to the Global Fund increased from \$10.08bn. for the period 2011-2013 to \$12.23bn. for 2014-2016<sup>1</sup>, the EECA region saw an overall reduction of 15.1% as a result of the NFM allocation methodology<sup>2</sup>. Furthermore, the recent UN Secretary-General's report includes a table that calls for a significant pullout of international funding from Upper-Middle Income Countries (UMICs) by 2020 that could lead to dramatic consequences in terms of the spread of the HIV epidemic among Key Affected Populations (KAPs) in these countries<sup>3</sup>.

Consequently, there is widespread concern as to how to ensure the successful transition from Global Fund supported HIV and TB programs to national funding and the sustainability of such programs, especially those programs targeted at key affected populations (KAP). As a result, EHRN decided to conduct a number of case studies in 2016 to evaluate the processes and the consequences of the transition from the Global Fund financing of the HIV response among KAP with the sustainability of harm reduction services used as an example in five Balkan countries: Albania, Bosnia, Macedonia, Montenegro and Romania.

## Methodology

A **desk review** of relevant documents (both available in English and in the Macedonian language) was undertaken to analyze the availability of internal and external funding for harm reduction projects in the country, as well as the processes around transitioning from Global Fund to national funding, together with sustainability planning for harm reduction and related services. This has included, for example, an analysis of Global Fund Concept Notes and implementation plans; the National HIV/AIDS Strategy, 2012-2016; the National Strategy on Drugs, 2014-2020; the WHO HIV Program Review in Macedonia, 2015; and, the World Bank allocative efficiency analysis, as well as several civil society analyses and policy documents.

A case study interview guide was developed by EHRN and adapted to the Macedonian situation; key informants were identified and then interviewed primarily face-to-face. Seven in-depth interviews with a total of 11 key informants were conducted, including with 3 high level officials and 2 program officers of the Ministry of Health; the Program



Manager of the Global Fund supported HIV project; the Fund Portfolio Manager for Macedonia; the President of the Inter-Ministerial Commission on Drugs; the CCM Chair; and, 2 leading civil society representatives from the NGOs HOPS and HERA. Additional communications were made with the Finance Manager and the M&E Officer of the HIV Project Implementation Unit. Feedback on the draft case study was provided by the Fund Portfolio Manager for Macedonia.

Information and data obtained through this process was then entered into the **'Transition Readiness Assessment Tool'** developed by EHRN and APMGlobal to analyze the readiness and risks of transition from donor funding to sustainable domestic financing, identifying key barriers that must be addressed before sustainable transition is possible with a particular emphasis on assessing the sustainability of harm reduction services through and beyond the transition period.

## Background

### Country context

A country with a population of roughly 2 million inhabitants in the middle of the Balkan Peninsula, Macedonia has a Gross National Income (GNI) per capita estimated at \$5,150 (2014) and is classified as an upper-middle income country (UMIC)<sup>4</sup>. In 2013, the Government's expenditure on health was 13% and the country's total expenditure on health was 6.4% of GDP, a figure significantly lower than in other countries of South East Europe<sup>5</sup>. The Macedonian health system is primarily financed through a compulsory health insurance, managed by the state Health Insurance Fund, as well as from the national budget and from out-of-pocket co-payments<sup>6</sup>. The system of compulsory health insurance is meant to provide universal coverage<sup>7</sup>.

The majority of HIV strategic interventions in Macedonia are organized into an annual National HIV Program (*Program for the Protection of the Population from HIV/AIDS*) under the Ministry of Health. The Program is partly funded from domestic resources (the national budget or other resources of the Ministry of Health) – covering antiretroviral therapy (ART) and activities of public health institutions primarily targeting the general population – and partly through the Global Fund HIV grant which covers the activities targeting key populations. Although the annual budget of the Republic of Macedonia regards the National HIV Program as a single program with different sources of funding<sup>8</sup>, in practice the Global Fund supported activities are managed separately through a Project Implementation Unit (PIU). The Ministry of Health has been the Principal Recipient for all Global Fund grants in Macedonia.

Thanks to this prolonged investment, a complex national HIV program has been developed in the country; ART was introduced in 2005 for the first time and OST was substantially scaled-up. Comprehensive prevention and support service packages were developed and introduced for key affected populations – people who inject drugs (PWID), men who have sex with men (MSM), and sex workers (SW) – for an optimal response to the HIV epidemic. A number of CSOs have built their capacity and expertise for delivering HIV prevention services and several community based organizations (CBOs) have been established or strengthened within a community systems strengthening approach.

Macedonia has been a candidate country for the European Union (EU) since 2006, but the country hasn't started negotiations yet, which limits its access to structural funds that could be used for its national HIV program. Since February 2015, the country has been going through a major political crisis that has significantly shifted the Government's priorities from other areas to overcoming deep internal political challenges<sup>9</sup>. With a technical (transitional) government appointed in October 2015, the first quarter of 2016 largely focused on preparations to



organize fair and democratic early parliamentary elections in June. However, even this has proven a major challenge and at the moment of finalizing this case study there is great uncertainty around political developments for some time to come<sup>10</sup>.

## *Epidemiological situation with HIV and current trends*

Macedonia has a low level HIV epidemic concentrated among certain key affected populations<sup>11</sup>. The total cumulative number of HIV cases between 1987 and the end of 2015 was 275, whereas the cumulative number of registered AIDS related deaths was 80<sup>12</sup>. In December 2015, 166 people living with HIV (PLHIV) were enrolled in care at the only center for HIV treatment and care in the country, at the University Clinic for Infectious Diseases in Skopje, with 132 PLHIV receiving ART<sup>13</sup>.

Since 2013, there has been an increase in the number of new cases of HIV diagnosed per year, especially among MSM<sup>14</sup>. The highest number was 45 registered cases in 2014. Of those, 33 were MSM, 11 reported heterosexual contact as mode of transmission and one was a person who had used contaminated equipment to inject drugs<sup>15</sup>. With 73% of new diagnoses of HIV in 2014 and 66% in 2015<sup>16</sup>, the epidemic appears to be concentrated among MSM.

In 2010, it was estimated that there were 10,900 PWID in Macedonia<sup>17</sup>. This was the only study on the size of the population undertaken by the Institute of Public Health and it continues to be used as a reference, although civil society representatives and experts have expressed doubts about its accuracy and current relevance, claiming that the actual size of the population could be smaller<sup>18</sup>.

A recently conducted allocative efficiency analysis (Optima) by the World Bank estimated HIV prevalence among PWID at 0.12% in 2014 based on data from a bio-behavioral study (BBS), as well as from NGO testing data – a decline from the estimated 0.42% in 2006<sup>19</sup>. The 2014 BBS also showed a decrease in viral hepatitis C (HCV) prevalence among PWID from an estimated 70.1% in 2009<sup>20</sup> to 64.5% in 2014<sup>21</sup>. These numbers, along with increased rates of using sterile equipment during the last injection and during the last month<sup>22</sup>, suggest that harm reduction programs in Macedonia have had a positive impact. The Optima analysis further concluded that the HIV epidemic among PWID in Macedonia is under control due to significant and prolonged efforts targeting this key group, but warns that there is still a risk of rising HIV infection that may happen as a result of changes in behavior or interactions with HIV-positive PWID in neighboring countries.<sup>23</sup>

## *Global Fund eligibility status*

The Republic of Macedonia has been a recipient of Global Fund support for its HIV and TB programs since 2004. It currently has two active contracts – for HIV and for TB – within Round 10 which will end on 31 December and on 30 September 2016, respectively. In support of its HIV strategic plans between 2004 and 2016, Macedonia has received three grants from the Global Fund and a total commitment of \$23,331,037<sup>24</sup>.

The low burden of HIV in Macedonia, together with it being classified as an upper-middle income country (UMIC) makes it no longer eligible to receive funding from the Global Fund in accordance with the current eligibility criteria<sup>25</sup>. As the last HIV grant will shortly be coming to an end, Macedonia is undergoing extensive transition planning with the involvement of all key stakeholders.



## Overview of harm reduction services in Macedonia

Macedonia has a relatively long history of harm reduction programs, including OST and NSP services<sup>26</sup>, both of which predate the Global Fund grants. Between the 1980's–early 1990's and the first Global Fund grant in 2004, methadone had become available at the Psychiatric Hospital in the capital, Skopje, and at three major penal institutions. Between 2005 and 2011, due to Global Fund support, substitution treatment was scaled-up and several OST centers were opened across the country.<sup>27</sup>

Today **opioid substitution treatment** (OST) is available primarily within the developed national network of public health institutions. The majority of related costs, including the procurement of methadone and buprenorphine, are not covered by the national Health Insurance Fund but through a separate treatment program of the Ministry of Health<sup>28</sup>. Since 2009, OST has been funded exclusively from the state budget and this was one of the first components of the HIV program that transitioned from Global Fund to domestic funding. A total of 16 sites are now delivering OST in 10 cities across the country. Of those, 12 have the official status of *centers for treatment of addictions*, one is the University Clinic of Toxicology and three are located in prisons. In addition to the government program, several private psychiatric clinics are also offering OST<sup>29</sup>.

In 2015, 1,507 clients were receiving methadone<sup>30</sup> and 243 clients were receiving buprenorphine<sup>31</sup> through the national treatment program. In addition, 180 clients paid out-of-pocket for their treatment for either methadone or buprenorphine in private clinics<sup>32</sup>. The total number of clients receiving OST, therefore, amounted to 1,930 in 2015, which equates to a coverage rate of approximately 18% which is far below that recommended by WHO, UNODC and UNAIDS [target setting guide, 2012].

**Needle and syringe programs** (NSP) were first introduced in 1996 by the NGO, Mask, and soon after continued by the NGO, HOPS<sup>33</sup>. Starting from 2004, Global Fund support helped to expand NSP across the country so that there are now 16 NSPs in 13 cities<sup>34</sup>. Unlike OST, these are almost exclusively funded through the Global Fund grant<sup>35</sup>, which raises major concern as to their sustainability after the Global Fund transitions out of Macedonia. The minimum package of services includes one syringe, two needles, a condom and IEC material<sup>36</sup>. However, all programs offer a wider range of services that vary between NGOs, but, as a minimum, include basic medical services and social support, while six NSPs also offer legal support<sup>37</sup>. Voluntary HIV counseling and testing (VCT) has been available through outreach mobile units for all key populations since 2007. In 2015, the Ministry of Health also allowed community-based VCT to be performed in drop-in centers through an NGO-led program with medical professionals engaged on-site only to perform the test<sup>38</sup>. Overdose prevention in Macedonia is not readily available in NGO drop-in centres nor through outreach services. Naloxone can only be accessed through OST centers across the country as well as through the emergency medical service in some cities, and can be applied only by a medical professional. In the last few years, there has been civil society advocacy towards making naloxone accessible more easily to people when needed<sup>39</sup>.

The total number of clients in all NGO-based harm reduction programs has been increasing in recent years (from 3,236 in 2012 to 3,885 in September 2014<sup>40</sup>), as well as the number of clients who use NSP services (the minimum package): 3,217 in 2013, rising to 3,949 clients in 2015<sup>41</sup>. As of 2015, the coverage rate for NSP is 36% of the officially estimated 10,900 PWID<sup>42</sup>, far below the level recommended by WHO, UNODC and UNAIDS.



## Transition processes analysis

### Policy

The transition planning process for HIV prevention programs in Macedonia was formally initiated by the Country Coordination Mechanism (CCM) in March 2014<sup>43</sup>. This followed the Fund Portfolio Manager's notification that the country was expected to prepare a sustainability plan for an easier transition to domestic financing<sup>44</sup>. The Macedonian CCM was, at that time, preparing the application for the second phase of its last Global Fund HIV grant.

The planning process commenced through a multi-stakeholder task force formed by the CCM that later received official recognition by the Minister of Health, an act indicating the early commitment of the Ministry. The task force was given the responsibility to draft the plan after determining and commissioning a series of consultations and analyses. Several key informants for this case study indicate, however, that for a long time there was a lack of coordination and common understanding of the goals, in particular between civil society and the Ministry of Health. As a result, the development of a concrete, costed plan with clear objectives and timeframe did not materialize before the latter half of 2015. Some of the key processes had already started before finalization of the plan, such as a consultative process between the MoH and the civil society sector for designing an appropriate financing mechanism for CSOs. The transition plan was finalized in February-March 2016, leaving less than one year to achieve all of its key objectives.

In support of the transition planning and in the provision of inputs to develop a new post-Global Fund National HIV Strategy (2017-2021), the Global Fund supported the implementation of an allocative efficiency analysis (Optima) performed by an international team and coordinated by the World Bank. In addition, the WHO Office in Macedonia facilitated an HIV Program Review performed by external experts at the end of 2015. Both studies were finalized around the end of 2015 and the first quarter of 2016, respectively. The delay in finalizing the transition plan can partly be attributed to the need to await the findings of both studies.

While the transition plan was developed through an open and consultative process and finalized by the Project Implementation Unit of the Ministry of Health, it hasn't been in any way endorsed by the Government or the Ministry of Finance. Moreover, the plan is costed only with regards to activities that need to occur as part of the process – it does not include, for example, costing of actual programs for the post-Global Fund period. As the HIV strategic planning for 2017-2021 hasn't started yet, the transition plan also lacks specificity around the essential goals and objectives of the future program. Therefore, a developed National HIV Strategy, 2017-2021, with budget and a detailed annual National HIV Program for 2017, endorsed by the Ministry of Finance and the Government, will be a key condition for moving forward from the first stage (out of three) of the transition readiness policy indicator (Indicator 1)<sup>45</sup>.

Concerned about the major delays and the level of government commitment, civil society initiated a process of parliamentary advocacy leading to a public hearing on ensuring sustainability of HIV services for most at-risk populations beyond 2016. The hearing was held by the Parliamentary Commission on Health in December 2015 and reiterated the obligation of the Government and the Ministry of Health 'to implement the national plan for transition from donor to domestic financing from the budget of the Republic of Macedonia and to establish effective legal and policy mechanisms to ensure sustainability of the already established HIV prevention programs before Global Fund support ends'<sup>46</sup>. The Parliamentary Commission on Health committed itself to holding another hearing after six months (June 2016) to assess the progress in the transition processes. Unfortunately, the Parliament is



now dissolved after announcing early elections in June. Moreover, the whole political situation as of April 2016 is extremely unstable, with a climate not conducive to civil society advocacy<sup>47</sup>.

NSPs as a key component in the harm reduction program have been part of three national HIV strategic plans since 2003 and of even earlier Government policy documents<sup>48</sup>. Moreover, harm reduction is recognized in the Law on the control of opioids and psychotropic substances as part of a range of activities including 'exchange of sterile equipment' and 'working with a hidden population'<sup>49</sup>. While there seems to be no legal barriers to its implementation, some services of the expanded package, such as treatment of wounds as well as HIV testing, are considered 'medical services' and CSOs are not recognized in the Law on Health Protection as providers of such services, which poses a potential barrier for the future<sup>50</sup>. In October 2015, civil society engaged in an official consultative process with the Ministry of Health to discuss these issues, as well as the financing mechanism. Representatives of both sides, with the support of the Ministry of Labor and Social Policy, recognized the need for amendments in the laws on health protection and on public health in order to include CSOs as providers of healthcare services and early draft proposals were agreed<sup>51</sup>, but no further steps have since been taken<sup>52</sup>.

However, there are also no legal barriers in Macedonia for government agencies or municipalities to fund NGOs through tender mechanisms<sup>53</sup>. There are modest but functioning examples of such practice at a municipal level (City of Skopje), the Ministry of Labor and Social Policy and other institutions, where NGO projects are funded, or in which organizations are contracted, as partner implementers within particular programs. Moreover, as a result of civil society advocacy, the annual HIV Program for 2015 and 2016 specified NGOs as implementers to receive funding from the government for activities targeting PWID, MSM, SWs and PLHIV. However, unlike with the Ministry of Labor and Social Policy, no procedures or by-laws for this exist at the MoH. The key obstacle for such policies to be endorsed is, again, the lack of recognition of CSOs in the relevant laws as providers of healthcare services or public health interventions. Introducing the legal amendments explained above would enable Macedonia to fully achieve two crucial policy indicators (Indicator 2 and Indicator 3)<sup>54</sup>, now at Stage 2.

## Governance

A multi-stakeholder National HIV Commission under the Macedonian Ministry of Health was re-established in 2011 to coordinate the overall national response to HIV, leaving the CCM responsible more narrowly for matters related to the Global Fund grants. The Commission was appointed by the Minister's Order (Decision) which also specified its key functions: structuring and governance of the national response to HIV; coordinating the implementation of the National HIV Strategy and the annual National HIV Program, including the prevention activities for key populations currently funded by the Global Fund; and, evaluating program activities and ensuring the quality of HIV-related policies<sup>55</sup>. As with the CCM, the Commission includes civil society representatives, some of whom come from key affected groups. Many of the members of the Commission are also members of the CCM, so there seems to be sufficient capacity and experience to perform the functions of the Commission at the level they have been performed by the CCM. It is widely understood by different stakeholders that the Commission will fully replace the CCM after the Global Fund grants have ended. However, it is not clear in practice if this governance body will have the authority to make decisions about funding. Furthermore, the Commission doesn't have the same level of internal procedures, and is not equally effective, as the CCM due to a lack of allocated resources for administrative support<sup>56</sup>. The related governance indicator (Indicator 4) of the transition readiness assessment tool is, therefore, fulfilled only at Stage 2<sup>57</sup>.

The monitoring and oversight functions of the Commission, both in terms of programs and of expenditures, are not very clearly specified in the Minister's act and there are no sub-structures to perform programmatic and financial



monitoring. Ministry officials state that this role of the Commission will be further clarified and specified when the CCM ceases to exist. However, at this moment, the two governance readiness indicators (Indicator 5 and Indicator 6) related to monitoring are only fulfilled at the initial Stage<sup>58</sup>.

## Finance

An allocative efficiency exercise – Optima – which was conducted in the second half of 2015 by the World Bank with the support from UNDP, UNAIDS and the Global Fund, and with the participation of the Ministry of Health, provides an investment case for sustaining overall HIV prevention services targeting key affected groups. Based on the current epidemiological data and mathematical modeling, the exercise recommends a significant increase of funding for prevention among MSM and for scaling-up ART. Yet, it also points out that both OST and NSP should be sustained in order to prevent future risks of HIV outbreaks, as well as for their additional health benefits for PWID, such as preventing HCV.<sup>59</sup>

OST has been fully covered with domestic funding since 2009 (staff costs, medication and psycho-social support) and the allocated budget for 2015 and 2016 was approximately €1.27 million annually<sup>60</sup>. CSOs delivering NSP have performed an analysis of related budgets and a costing exercise that recommended a ‘minimum’ and an ‘optimum’ financial envelope in order to sustain programs in the current format, which is a good evidence base for allocating funds to NSP by the Government. The optimum estimated amount was calculated at €561,078 per year<sup>61</sup>. This indicates a Stage 2 attainment of the first finance indicator (Indicator 7) of readiness<sup>62</sup>. However, further verification of civil society findings and a more detailed analysis and costing is part of the transition plan and is expected to happen within the framework of strategic planning scheduled for the period between April and June 2016.

Following early civil society advocacy, the Ministry of Health took proactive steps towards establishing a financing mechanism for CSOs in 2014. This was reflected in the annual National HIV Program for 2015 which specifies CSOs as implementers of ‘activities for prevention of HIV among MSM, SW and PWID and activities for support of people living with HIV’, included under national funding sources in the Program budget<sup>63</sup>. Allocated amounts were only symbolic and they were meant to set a precedent and provide a framework for establishing and testing the financing mechanism as there is still major funding available from the Global Fund for prevention activities among key affected groups. Unfortunately, these targets were not met in 2015 with only an official consultative process around the financing mechanism having been started during the year. In the National HIV Program for 2016, which received a major increase from the budget of the Ministry of Health, the activities for key populations were included again, along with VCT, with an increased - although still symbolic - budget (approximately €29,000 for all NGO activities compared with the €508,227 from the Global Fund currently allocated for NGOs delivering only NSP). According to meetings held between CSOs and the Ministry, the envisaged social contracting mechanism is meant to include a registry of organizations that qualify to be implementers of the National HIV Program on the basis of their experience and expertise in working on HIV prevention programs and reaching out to key affected populations. Even though appropriate legal changes, as described in this Case Study under *Policy*, have not yet been initiated, a temporary solution has been formulated by the Ministry’s sectors for prevention and for legal matters. However, not having tested the financing mechanism – despite this being scheduled for the first quarter of 2016 in the transition plan – and due to the lack of evidence of an adequate financial commitment, in particular for NSP, it is not yet possible to consider a key finance indicator (Indicator 8) as having been accomplished at the most advanced Stage<sup>64</sup>.

OST and ART have already fully transitioned to government funding and national procurement procedures. In most other cases with using Global Fund support to procure commodities, the national law on public procurement has, in



general, been followed both by the Ministry of Health and by sub-recipient CSOs. In terms of needles and syringes, the regular procurement mechanisms ensure reasonable price standards. Currently, the National HIV Program includes procurement of condoms under the domestic budget but still hasn't taken over the remaining commodities, in particular needles and syringes. An interview with Ministry officers in charge of the Program revealed no obstacle to including procurement of needles and syringes, as well as any other necessary commodities, and indicates that regular procedures in place should ensure reasonable prices<sup>65</sup>. The author of this case study deems that the relevant finance indicator (Indicator 9) related to procurement mechanisms has been fulfilled to a substantial degree (Stage 2)<sup>66</sup> based on the fact that regular national procedures are already in place and functioning<sup>67</sup>.

## Program

Service provision standards for harm reduction programs in Macedonia exist for both OST and NSP. The Ministry of Health has endorsed official treatment protocols for OST<sup>68</sup>, whereas standards for NSP were first developed by service delivery NGOs at the time when needle and syringe exchange was first introduced. These were later revised and improved when the first Global Fund project started in 2004. Although the same NSP standards are still followed by NGOs and have been shared with the Ministry of Health, they have never been officially endorsed. Key informants report that there were only discussions about endorsing NSP standards in the context of developing the most recent National Strategy on Drugs (2014-2020) and suggest this should be part of the process of integrating NSP under domestic funding within the National HIV Program.

However, monitoring of harm reduction service provision against these standards is not defined specifically in any official plan or other national document and does not include civil society representatives outside of the CCM oversight function, indicating a level of accomplishment of Indicator 10 (program)<sup>69</sup> only at Stage 1.

The gaps with regards to the WHO recommended coverage levels for OST and NSP have not been properly assessed. Coverage levels are calculated using the only population size estimation for PWID which was undertaken in 2010, but key informants express doubts as to its current validity. Key NGO experts working in the field believe the actual size of the population is lower than the estimated 10,900 PWID in 2010<sup>70</sup>. If the 2010 size estimation is taken into consideration, then the coverage level of OST in 2015 was 18% of all PWID and 36% for NSP. While the need for scale-up is recognized by experts, as well as the need to improve the quality of the services and the conditions in which OST facilities function, there are no concrete scale-up strategies at this time. It can be concluded that although coverage levels are considered mid-level and appear to be higher than in neighboring countries<sup>71</sup>, an important indicator related to program coverage is not fulfilled even at the most basic stage at this point<sup>72</sup>.

While CSOs have already been explicitly recognized in the National HIV Program since 2015 as implementers of activities specifically targeting key affected groups (MSM, SW, PWID and PLHIV), no contracts have been signed so far as the social contracting mechanism under the Ministry of Health is still not official. However, it is important to note the example of one large NGO (out of 10 that implement needle and syringe programs) that has been receiving some support<sup>73</sup> from the City of Skopje for several years and is explicitly recognized as a partner for harm reduction activities in the City's Program on Social, Child and Health Protection<sup>74</sup>. These circumstances indicate a Stage 1 level of accomplishment of the relevant program indicator in the transition readiness assessment tool<sup>75</sup>.



## Identified challenges and barriers

Discussions about sustainability of HIV prevention programs in Macedonia started relatively early and it is evident that important transition processes are ongoing. Nevertheless, key informants point out that the period for preparing the transition coincided with the last 2 years of the final GF HIV grant and that people engaged in the implementation of the programs have been expected to work in parallel on all necessary planning and preparations for transition. There was no clear guidance from the Global Fund or technical partners. Moreover, a leading activist from the Civil Society Platform points out that 'having an action plan finalized in February 2016 is just one segment in the process: at least 1.5 years is a must for planning, including projections about funds, and an additional 2 to 3 years are needed in order to implement everything in terms of legal changes, service packages, scaling-up of programs, and - very importantly - testing the new model, identifying and overcoming any obstacles. This must include the period immediately after the government has taken over financing of the programs'<sup>76</sup>. Key informants feel that financing of prevention activities is a much greater challenge than financing treatment and that wider political support is missing, largely as a result of stigma towards key affected populations.

A number of specific challenges related to the transition process were identified during the research for this case study and the transition process analysis:

**(1) The transition plan is only endorsed at the level of the MoH.** This is not the level of commitment some key informants would wish for, in the sense that the plan doesn't include a clear and concrete financial commitment by the Government. Even representatives from the Ministry of Health have expressed concerns as to whether the Government will approve the amount of funding at the current level.

**(2) There is a significant delay in the strategic planning process for the first post-Global Fund period, 2017-2021.** Key informants agree that this is a crucial benchmark in Macedonia's transition plan as the National Strategic Plan is adopted by the Government with appropriate fiscal implications. Another related and even more specific indicator is the annual National HIV Program for 2017 which should be derived from the Strategic Plan and include detailed activities and budget that would reflect the level of integration and funding of prevention activities for key populations, including PWID. The timeframe for developing both key documents is extremely short if they are to be endorsed by the Government on time and included in the state budget for 2017.

**(3) The financing mechanism for CSOs is still not established by the Ministry of Health.** Despite the fact that clear political will was shown by the Ministry to find a solution to the funding of prevention activities for key populations conducted by CSOs within the National HIV Program, the drafted criteria and procedures haven't been made official and the mechanism is yet to be tested in practice. Additional challenges still need to be worked out, such as the current practice at the MoH whereby it only reimburses funds from the national budget on a quarterly basis.

**(4) CSOs are not recognized in relevant laws as providers of certain basic medical services.** Provision of rapid HIV testing, treatment of injection site wounds or even sexual and reproductive health services within NGO centers were not only allowed, but also supported, by the Ministry of Health during the period of Global Fund support. However, once there is no external funding, civil society representatives fear this may become an issue. This is also closely related to the establishment of the contracting mechanism through which CSOs would be recognized as partners of the MoH in providing specific public health interventions and delivering services to key populations.



**(5) The Ministry of Health lacks appropriate human resources for management and monitoring of the HIV Program.** The National HIV Program – especially the prevention component for key affected groups – is massive and complex. There is no similar example in the portfolio of the Ministry of Health in both programmatic and financial terms. This in itself poses a challenge to successful transition. Even high level Ministry officials admit that the small department responsible for a number of programs has no capacity to manage such a complex and demanding program<sup>77</sup>. The Project Implementation Unit for the Global Fund-supported prevention activities within the Ministry of Health is not an integral part of this institution and its staff is not employed on a permanent basis. If the Government does not decide to integrate this unit under the Ministry's Prevention Sector, indispensable human resources for managing the prevention programs will be lacking and a wealth of expertise and experience will be lost.

**(6) Program challenges.** With the focus on the mechanisms to sustain services, there seems to be little discussion about the need to scale-up programs and improve their quality. Local experts who were contacted for the purpose of this case study point out that even at the current funding level for OST programs there are a number of challenges in how OST centers deliver services to clients, including understaffing and the lack of appropriate conditions for both clients and healthcare workers. This has also been reflected in the WHO HIV Program review performed in October 2015.

**(7) The National HIV Commission lacks sufficiently developed internal procedures to ensure good governance, in particular in terms of monitoring and oversight, as well as adequate decision-making power.** This national multi-stakeholder body is expected to fully take over all CCM functions beyond Global Fund financing but it needs considerable strengthening of its oversight function in practice. Although civil society representatives are confident that their sector will remain involved in the National Commission and other bodies, they fear civil society positions to influence decision making might be weakened.

**(8) Lack of funds for civil society advocacy.** Civil society in Macedonia started joint advocacy efforts relatively early on and had a clear vision as to what conditions were to be met in order for a responsible transition to happen. However, a number of actions it had planned were delayed or could not happen because the sector had very limited resources for targeted advocacy. CSO representatives believe their actions would have had a major impact on the outcomes of the process if they had had the needed support for advocacy.

**(9) Political crisis and instability.** Unfortunately, the transition period in Macedonia coincides with deep political turmoil that has been ongoing for more than a year at the time of this assessment, including serious terrorist attacks in May 2015, changes in the government and announced – yet uncertain and problematic – early elections scheduled for June 2016. These circumstances, together with an intense migration crisis, may not only cause major delays in the transition process, but they also reveal a climate in which HIV prevention is overshadowed by a number of pressing priorities for decision makers and political actors. This is undoubtedly going to affect the success of the transition process in Macedonia.

## *Lessons learnt*

Macedonia's example of transition processes can offer a number of lessons for national stakeholders as well as for external stakeholders and observers. The following key points emerge from the transition process analysis and include further observations that arose during the interviews with key informants.



### *Factors of progress and civil society advocacy*

While there seemed to be a lack of clear guidance by the Global Fund, stakeholders from different sectors felt responsible to move forward towards sustainability of HIV prevention programs for key populations. Although reportedly there was a lack of coordination and technical support for an appropriate consultative process, transition planning has nevertheless been transparent and open to all stakeholders. Ongoing open interaction between civil society and the Ministry of Health has helped to achieve some level of coordination and a sense of having a common goal to ensure sustainability of HIV programs among stakeholders as well as to gradually mobilize political will. As one representative from the Ministry assures – ‘We have finally established political will and coordination’.

Key informants largely agree that the process has been led by more than one stakeholder, in particular civil society, the CCM and the Project Implementation Unit. Moreover, it is reported that recently the Sector for Prevention at the Ministry of Health took the lead in several important processes with the involvement of high level Ministry officials. In addition to what has been outlined in the analysis, it has emerged from key informants that a strong CCM and a proactive CCM Secretariat was particularly instrumental in moving the process forward in Macedonia. It was the CCM that initiated several consultative processes, mobilized resources and often prepared important documents. Furthermore, in the case of Macedonia, the CCM and its Secretariat have initiated additional activities with a view to building capacity for resource mobilization among CSOs and to initiate a fundraising campaign for additional domestic support to HIV programs from the local business sector.

Civil society has played a key role in the transition process in Macedonia. It started joint advocacy actions in May 2014 by forming a *Platform for Sustainability of HIV Prevention and Support Services* bringing together all 16 Global Fund sub-recipient NGOs in a joint effort to ensure financial sustainability of HIV prevention, care and support services for key affected populations.

The Platform was the first to raise the issue of the need to establish a reliable financing mechanism for CSOs under the Ministry of Health. It was as a result of these demands that the Ministry of Health included prevention activities for key populations – to be implemented by CSOs – under domestic funding sources for 2015 and 2016; furthermore, as a separate activity in the Program, the Ministry of Health specified the establishment of a registry of CSOs that qualify, according to agreed criteria, to be implementers of the National HIV Program. These were key steps in the establishment of a financing mechanism and in the transition process in general.

In 2015 the Platform conducted an assessment of the capacity of CSOs implementing prevention and support programs for key populations, making a case for their public health and human rights importance<sup>78</sup>. On behalf of the whole sector, leading NGOs conducted budget monitoring and analyses<sup>79</sup> and basic optimization exercises for NGO-led harm reduction programs and organized a study visit to Croatia for Ministry of Health officials and Members of Parliament, in order to get them acquainted with the positive experience of transition to national funding for HIV prevention.

The Platform, through one of its leading member organizations, was also instrumental in involving the Parliamentary Commission on Health in the transition process, resulting in a public hearing in December 2015 and clear recommendations to the Government and the Ministry of Health to implement the transition plan and ensure a responsible transition to domestic financing of HIV prevention programs. The involvement of the Parliament as the highest oversight authority has helped bring the issue to a higher level of political attention. The Civil Society Platform is going to remain involved with the Parliamentary Commission on Health in order to ensure oversight of further progress.



By all means, the entire process would have benefited greatly from a specific support for advocacy by civil society, either through the current Global Fund grant or through support from other donors. Unfortunately, as civil society representatives report, it proved impossible to receive this kind of support by using Global Fund assistance through the Ministry of Health as the Principal Recipient.

#### *Transition readiness score and related considerations*

The application of the Transition Readiness Assessment Tool (TRAT) in the particular case of Macedonia has resulted in a readiness score of 47% as of May 2016. Out of 12 indicators defined in the tool, Macedonia has fulfilled the first out of three stages in 11 transition readiness indicators and has achieved the second stage in 6 of them, according to specific benchmarks predefined in the tool. No indicator seems to be fulfilled at stage three at this point. Macedonia scores relatively high in the areas of finance and policy, whereas it still needs to make significant progress in indicators related to programming.

Nevertheless, as all four areas – *policy, governance, finance* and *programs* – are interdependent, Macedonia's readiness percentage is likely to go up in the following months, provided that the transition plan is implemented according to the agreed timelines and objectives. In the view of the author, if Macedonia implements its transition plan, in particular in the area of strategic planning and formalizing and testing the financing mechanism for CSOs, the readiness percentage may well go up to 70% in the following 6 months. Based on what has been prioritized in the national action plan for transition and what was particularly emphasized by key informants, a high level of readiness can be expected in the two most advanced areas – policy and finance – with significant improvement in programming. It seems that the area of governance is least likely to see major improvements by the end of 2016. Additional efforts will be needed, probably beyond 2016, to achieve a strong governance model with CCM functions fully adopted by the National HIV Commission.

It is important to highlight that although processes seem to be moving in the right direction with eight months until the end of the grant, programs for the coming period are still not planned and funding decisions have not yet been made. It is evident that the country would have benefitted from a longer period for the transition. Macedonia's readiness is unlikely to go beyond 70% accomplishment of key indicators in the Transition Readiness Assessment Tool by the end of the final year of the grant. Provided that there is political will even at the higher government levels and funds are allocated, additional time and support will be needed to fully establish a functional system based on national financing.

It is now important to work towards the meeting of objectives set in the plan and to proceed without delay with the strategic planning for HIV for the next 5 years. Careful consideration of scaling-up services according to WHO recommendations, proper costing of activities and possible budget optimization should be integral parts of the process. Even if delayed, it would be important to repeat population size estimation exercises for all key groups, along with new bio-behavioral studies planned for 2016.

In Macedonia's case at this moment, it is crucial to consider the highly unstable and uncertain political situation with political forces focused on priorities far different than that of HIV prevention. At a moment when the European Commission expects radical reforms in several areas, it is difficult to talk about HIV in a low prevalence setting. These circumstances have the potential to determine whether there will be a successful transition in the country.



## Recommendations for key stakeholders

The successful transition in Macedonia will depend on the efforts of all stakeholders. The following recommendations emerge from the study of the Macedonian transition process.

### ***The Global Fund should:***

- Make efforts to mobilize more political support at the highest level, possibly by involving partners such as the World Bank in the process or diplomatic representatives of donor countries in Macedonia;
- Provide on-going support for a fast HIV strategic planning process for the first 5-year period after the current HIV grant ends;
- Ensure that key populations are central to all transition efforts and provide support for appropriate integration of community systems into the next National HIV Strategic Plan;
- Support any request for a no-cost extension of the grant and ensure that activities during the first months of 2017 complement in the best possible way the government funded activities in the first year;
- Work together with the Ministry of Health and the Macedonian Government to ensure that any no-cost extension is planned in a way that best supports a smooth transition of prevention activities for key populations during 2017;
- Discuss the possibility of a no-cost extension with the Ministry of Health and relevant national decision making authorities concerning funding so as to agree on a model that best supports full transition of all prevention activities for key populations during 2017;
- Consider ways to support civil society advocacy and community monitoring of program implementation during the first three years after transition;
- Stay involved by providing technical support until programs can be sustained without Global Fund support;
- Develop and use transition criteria to realistically assess the stage of transition;
- Provide continued support and monitoring of the timely implementation of the developed transition plan; and,
- Establish an emergency plan to help Macedonia and, in particular, the key affected populations in case the political or other factors impact the actual transition of HIV programs for key populations.

### ***The Macedonian Government should:***

- Bring the discussion about appropriate funding of scaled-up HIV programs for key populations to a higher level and make timely decisions;
- Rely on the strong investment case laid out in the report on the allocative efficiency analysis conducted by the World Bank in consultation with UNDP, UNAIDS and the Macedonian Ministry of Health when making the funding decisions for the new National HIV Strategy and the National HIV Program;



- Ensure a swift participatory process of strategic planning for HIV for the period between 2017 and 2021 and endorse the new strategy as soon as possible, but no later than the third quarter of 2016;
- Set new targets for prevention programs with a view to cover gaps and meet WHO recommendations. The strategic planning should also include appropriate costing of strategic interventions and activities and possible optimization of expenditures;
- Plan and approve substantially increased allocation of funds to the annual National HIV Program to cover the financial gap as a result of the Global Fund exit;
- Plan to strengthen and enlarge the Sector for Prevention within the Ministry of Health to ensure sufficient capacity for program and financial management as well as for monitoring and evaluation. This should ensure the integration of experienced PIU staff into the Ministry's Prevention Sector;
- Endorse the financing mechanism for civil society organizations within the Ministry of Health and test it in practice without delay. It should also identify potential practical challenges and take immediate steps to overcome them;
- Ensure that remaining legal barriers for civil society organizations to conduct harm reduction and HIV testing services, as well as most basic medical interventions and sexual and reproductive health services for key populations, are entirely removed by amending relevant laws, in particular the Law on Health Protection and the Law on Public Health;
- Consider demedicalization of community-based HIV testing following the 2015 WHO recommendations;
- Improve the functions of the National HIV Commission and extend its mandate to performing structured monitoring and oversight of program implementation and related expenditures. The capacities built within the CCM, including for oversight of program implementation, should be transferred to the National HIV Commission. The National HIV Commission can adapt some of the procedures of the CCM as a good practice;
- Ensure that by-laws determining the rules and procedures of the National HIV Commission clearly stipulate that there is substantial representation of relevant civil society organizations and of key affected populations in the Commission. These by-laws should also determine that the civil society sector has the right to independently nominate its representatives in the Commission;
- Ensure that there is an adequate and formal participatory process with inclusion of civil society for developing the annual HIV programs on the basis of the National Strategic Plan;
- Continue the well established communication, in good faith, with civil society in the context of HIV programs; and,
- Perform an analysis in order to increase coverage of OST throughout the country including the opening of new OST centers and employing new staff. This should also lead to addressing problems of understaffing and the lack of resources that several OST centers are currently facing. Such an analysis should explore if OST costs can be optimized.



### ***Civil society should:***

- Continue to participate in all transition processes and especially in the strategic planning for 2017-2021 and the planning of the National HIV Program for 2017 and make these a priority for their advocacy actions;
- Advocate for quick endorsement of the financing mechanism for CSOs within the Ministry of Health and putting it into practice. Use the opportunity to prove itself again as a serious actor and partner of the Government in reaching out to key populations and providing important public health services;
- Base their advocacy on emphasizing the already established good practices and demand amendments to relevant laws so that there is appropriate legal regulation of service provision, including basic medical services and consider advocating for demedicalization of HIV testing as recommended by WHO;
- Continue to work with the Parliament to ensure high-level oversight of the government responsibilities in the transition process that were already noted by the Parliamentary Commission on Health in December 2015;
- Make efforts to mobilize more support for advocacy and engage in structured community monitoring of the transition process and of the program implementation beyond Global Fund support;
- Contribute to an active and efficient National HIV Commission that will perform good governance and oversight of HIV program implementation; and,
- Use the Commission to provide input into future HIV programming and other decision making related to the health and rights of key populations.

### ***Technical partners should:***

- Provide support to the Ministry of Health in terms of increasing leadership and coordination, as well as technical support to improve the work of the National HIV Commission;
- Provide capacity building for the Sector for Prevention of the Ministry of Health as the responsible department for management of the National HIV Program;
- Provide technical support needed for a swift and efficient process of strategic planning for HIV for the next 5-year period;
- Provide support to the Ministry of Health in testing and further refining the financing mechanism for civil society organizations; and,
- Take steps to ensure that civil society will continue to be meaningfully included in all national processes related to HIV programs and that the voice of civil society and affected communities is heard.

### ***Other donors should:***

- Consider the clear need to support civil society and government in establishing reliable models for HIV prevention programs beyond external funding;
- Support civil society advocacy initiatives, and especially continued community monitoring of program



implementation and of related expenditures;

- Support the strengthening of governing structures such as the National HIV Commission in terms of performance with regards to their mandate, transparency and good governance;
- Consider stepping in if certain interventions for key affected populations are neglected or missing;
- Support initiatives that will improve HIV programming, scale-up services and improve their quality. This should also include continued capacity building for all actors engaged in HIV programs; and,
- In general (outside of the Macedonian context) consider providing the needed financial and technical assistance to ensure responsible transition processes.



# Attachment 1

## The Transition Readiness Assessment Tool

This case study was guided by a Transition Readiness Assessment Tool (TRAT) which provides a quantitative framework for measuring a country's progress towards readiness for sustainable transition of harm reduction services from external donor funding to domestic resources.

The TRAT is based on **four thematic areas** of transition as previously defined by the Global Fund Secretariat and the Eurasian Harm Reduction Network<sup>1</sup>: policy, governance, finance and program. The TRAT was designed with the underlying assumption that in order for a country to be prepared for a sustainable transition, it must make progress on specific indicators in each of these thematic areas. Under each thematic area, three indicators help to measure this progress.

Thematic Area	Indicators		
POLICY	<b>Indicator 1. Transition Plan:</b> A fully-resourced Transition Plan including harm reduction is proactively guiding transition.	<b>Indicator 2. Legal and Policy Environment:</b> There are no legal or policy barriers to the implementation of harm reduction programs.	<b>Indicator 3. NGO Contracting Mechanisms:</b> Policy or legislation is in place for state and/or municipal governments to contract or grant NGOs for the delivery of harm reduction and other HIV prevention services.
GOVERNANCE	<b>Indicator 4. Sustainable Governance Body:</b> A multi-stakeholder national governance body, including at least government, civil society, and technical partners, is institutionalized to steer the transition process and to continue program planning and oversight after the end of donor funding.	<b>Indicator 5. Program Oversight:</b> The multi-stakeholder national governance body has an oversight function to monitor implementation of the National HIV Program and harm reduction/PWID outcomes are measured as a distinct program area.	<b>Indicator 6. Financial Oversight:</b> The new governance body has an oversight function to monitor expenditure against the planned budget and harm reduction/PWID expenditure is measured as a distinct track of expenditure
FINANCE	<b>Indicator 7. Optimised Budget:</b> Funds for harm reduction are allocated according to an optimized budget scenario.	<b>Indicator 8. Financing for NGOs:</b> Core harm reduction services are funded by the government and delivered by NGOs via grants or contracting mechanisms.	<b>Indicator 9. Procurement Systems:</b> Donor procurement systems are integrated into national systems and assuring reasonable price controls.
PROGRAM	<b>Indicator 10. Standardised Monitoring:</b> Provision of core harm reduction services is monitored according to defined standards.	<b>Indicator 11. Services Coverage:</b> Core harm reduction services are available at levels of coverage recommended by the World Health Organization.	<b>Indicator 12. Partnership with NGOs:</b> NGOs are critical partners in the delivery of harm reduction and other HIV prevention services financed by domestic resources.

1 Eurasian Harm Reduction Network. *Transition and Sustainability of HIV and TB Responses in Eastern Europe and Central Asia: A Regional Consultation Report and Draft Transition Framework*. (2015)  
<http://www.harm-reduction.org/library/transition-and-sustainability-hiv-and-tb-responses-eastern-europe-and-central-asia>



For the purpose of standardizing the measurement of progress against each indicator, the TRAT also assumes that there are three stages of readiness for countries actively preparing for transition:

- Stage I indicates that a country has made some progress towards preparing for a sustainable transition but significant barriers remain;
- Stage II indicates that a country is actively in the process of making positive changes but some time is still needed before systems will be prepared for a sustainable transition to domestic financing; and,
- Stage III indicates a country that is imminently ready to transition with all core mechanisms in place to sustain programming after external donor funding ceases.

Each indicator has three benchmarks corresponding to the stages so as to aid assessors in judging progress against the indicator. In order to quantify this progress, each benchmark achieved under each indicator is valued at one point, leading to a maximum possible score of 36 points.

$$\left[ \begin{array}{c} 4 \\ \text{Thematic} \\ \text{Areas} \end{array} \right] \times \left[ \begin{array}{c} 3 \\ \text{Indicators} \end{array} \right] \times \left[ \begin{array}{c} 3 \\ \text{Stages of} \\ \text{Readiness} \end{array} \right] = \left[ \begin{array}{c} \text{Max. 36} \\ \text{Readiness} \\ \text{Points} \end{array} \right]$$

Ultimately, the TRAT assembles a readiness profile for each country that reflects both a raw quantitative readiness score and a visual depiction of readiness in each thematic area by indicator. This allows the reader to visualize not only the overall degree of readiness but also the distribution of readiness across the thematic areas – highlighting strengths and weaknesses and pointing to major gaps that need intensified effort in order to support a well-balanced effort towards a sustainable transition to domestic financing.

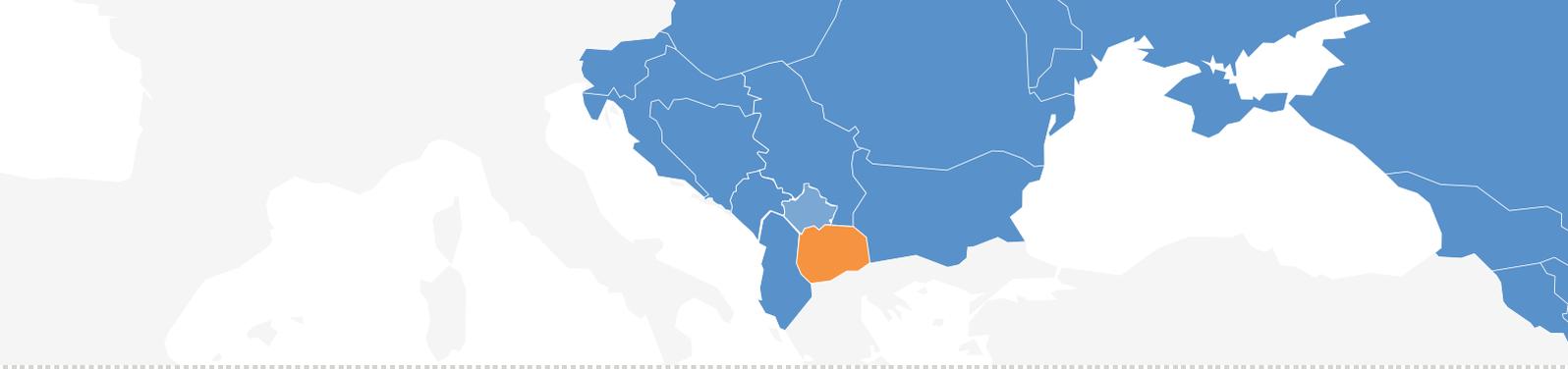
## Macedonia's Transition Readiness Profile

Out of the maximum possible 36 readiness points, Macedonia achieved 17, giving it a raw readiness score of 47%. Macedonia shows moderate preparedness in the areas of policy and finance but is significantly lacking in readiness of governance and programs to transition sustainably. There is a costed transition plan in place, developed through a multi-stakeholder consultative process, but it is not solidly linked with future programming plans. The role of civil society in delivering services is tenuous; both legislative changes and field-testing are needed to assure CSOs will be able to provide a full range of services under domestic funding. In terms of governance, Macedonia has a National HIV Commission in place which shows promise but needs strengthening of internal procedures as well as activation of oversight functions.

*The figure below depicts Macedonia's readiness by indicator in each of the four thematic areas. The lighter, innermost, ring represents achievement of Stage I benchmarks for each indicator; the middle-level ring indicates achievement of Stage II benchmarks; and the darkest, outermost, ring represents achievement of Stage III benchmarks.*

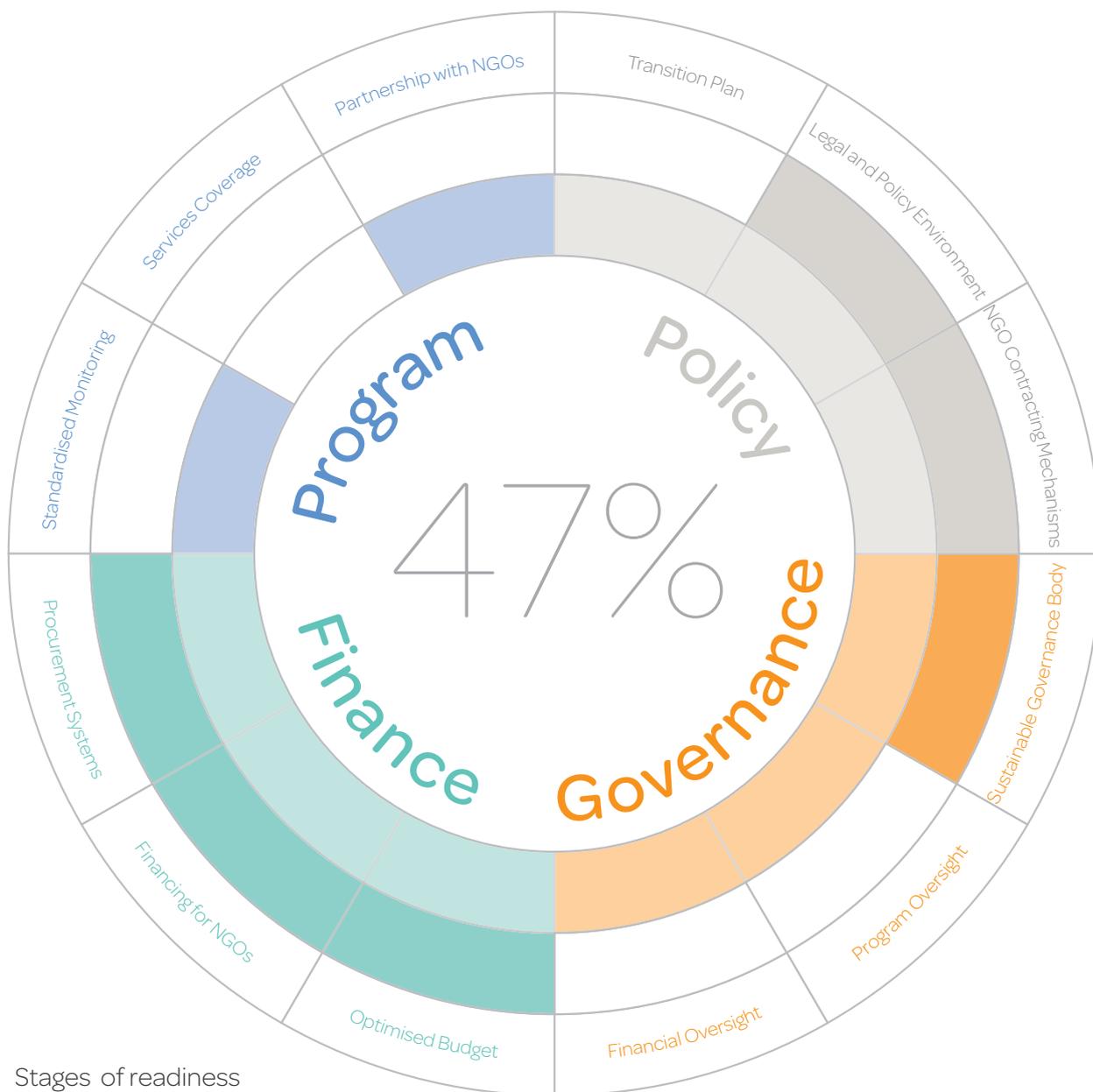
## Transition Readiness Profile – Macedonia

Financial preparedness is Macedonia's relative strong point with the government already funding OST and ART and with an apparent intention for domestic take-over of a full range of harm reduction services, including the procurement of needles and syringes and NGO-led outreach. However, program implementation remains lacking:

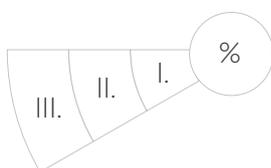


coverage levels of OST and NSP remains insufficient and with only a single, large, NGO currently receiving government funding.

It is likely that Macedonia can improve its readiness level during 2016 with intense and joint efforts by all stakeholders. These efforts must prioritize strategic planning for the period 2017-2021 and activating and utilizing the available financing mechanism for CSOs.



Stages of readiness



**Macedonia**  
47% readiness to sustain  
harm reduction interventions

## Attachment 2

# Budgetary and epidemiological characteristics of harm reduction programs in Macedonia

Budget Details (€)		2013	2014	2015	2016	Source(s)	Notes
Budget designated for harm reduction per national strategies, plans, etc.	NSP	441,015	465,090	479,180	528,288	Estimation/corrected budgeted HIV strategy 2015/2016 (PIU)	
	OST	1,072,974	1,127,073	1,182,675	1,304,399	Estimation/corrected budgeted HIV strategy 2015/2016 (PIU)	
	Other (HCV)	820,000	864,727	894,545	969,091	Estimation/corrected budgeted HIV strategy 2015/2016 (PIU)	
Actual budget realized for harm reduction	NSP	441,017	Not available	Not available	Not available	National AIDS Expenditures for 2013	
	OST	1,229,195	Not available	Not available	Not available		
	Other	708,865 (HCV) + 18,207 (HR programs)	Not available	Not available	Not available		€18,207 used by the NGO HOPS for NSP services from the Budget of the City of Skopje
Amount from domestic funding	NSP	0				National AIDS Expenditures for 2013	
	OST	1,210,055					
	Other	136,575 (HCV) + 18,207 (HR)					€18,207 used by the NGO HOPS for NSP services from the Budget of the City of Skopje



Budget Details (€)		2013	2014	2015	2016	Source(s)	Notes
Amount from GF	NSP	441,017	516,462	503,303	508,227	National AIDS Expenditures for 2013, 2014-2016 Global Fund HIV budget	
	OST	19,140	20,774	23,874	22,374		
	Other (HCV treatment)	572,290	655,688	337,194	337,194		
Amount from other external/donor funding	NSP	0	0	0	0		
	OST	0	0	0	0		
	Other (please specify)	0	0	0	0		
Calculated need for harm reduction							no calculation exists
Gap between need and funds available							no calculation exists

NSP related data	2013	2014	2015	Source	Notes
Number of government-based needle/syringe exchanges	0	0	0		
Number of NGO-based needle/syringe exchanges	16 616,900 needles 303,773 syringes	16 681,020 needles 360,950 syringes	16 608,000 needles, 352,000 syringes	Reported by PIU M&E Officer based on the official reporting database at the MoH (PIU) for the Global Fund supported activities	NSPs are located in a total of 13 cities/towns. Source: Dekov V. The Future of the Harm Reduction Programs in Macedonia. Analysis of the Activities and Budgets of Harm Reduction Programs. HOPS – Healthy Options Project Skopje. Skopje, 2015
Number of drug users enrolled in NSP	3,724	3,885	Not yet available	Dekov V. The Future of the Harm Reduction Program in Macedonia. Analysis of the activities and budgets of harm reduction programs. HOPS – Healthy Options Project Skopje. Skopje, 2015.	Data for 2015 not yet available



NSP related data	2013	2014	2015	Source	Notes
Number of clients receiving minimum package of services	3,217	3,235	3,949	Official reporting database at the MoH (PIU) for the Global Fund supported activities	The minimum package of services includes one syringe, two needles, a condom and IEC material
Number of clients receiving expanded or comprehensive package of services					Not monitored in terms of a fixed expanded package
Coverage of NSP among drug users nationwide (Numerator: the number of drug users enrolled in NSP; Denominator: the estimated population size of drug users) 10,900	34%	36%	36%		Number of clients receiving the minimum package of services used as the numerator for 2015

OST related data	2013	2014	2015	Source	Notes
Number of OST clinics nationwide	12+4	12+4	12+4	Dr. L Kiteva-Ignjatova, President of the Inter-Ministerial Commission on Drugs	There are 12 clinics, officially registered as <i>Centers for Wtreatment of addictions</i> , that offer OST. There are 4 additional official OST service delivery points that do not have the status of a 'Center'. In addition there are several private clinics that offer OST.
Number of clients on methadone	1,428 + 150	1,345 + 150	1,507 + 150	PIU M&E Officer; Program for the Health Care of People with Diseases of Addiction for 2016	150 in private clinics per year
Number of clients on other substitutions therapies	230 + 30	230 + 30	243 + 30	Program for the Health Care of People with Diseases of Addiction for 2014, 2015 and 2016	30 in private clinics per year
Coverage of OST among drug users nationwide (Numerator: the number of drug users enrolled in OST; Denominator: the estimated population size of drug users)	16.8%	16.1%	17.7%		



PWID	2013	2014	2015	Source	Notes
Tested for HIV (by year)	382	815	1083	PIU M&E Officer	
Newly diagnosed with HIV (by year)	0	0	0	Annual HIV/AIDS Report by the Institute of Public Health (unpublished) for 2013, 2014 and 2015	No HIV cases among PWID who are not on OST
On ART (cumulative)	0	0	0	University Clinic for Infectious Diseases and Febrile Conditions	No currently registered cases of PWID that are living with HIV
Living with HIV but not on ART (cumulative)	0	0	0	University Clinic for Infectious Diseases and Febrile Conditions	No currently registered cases of PWID that are living with HIV
Screened for TB (by year)					no data available
Diagnosed with active TB (by year)					no data available
Treated for TB (by year)					no data available

OST clients	2013	2014	2015	Source	Notes
Tested for HIV (by year)	130	167	268	PIU M&E Officer	
Diagnosed with HIV (by year)	0	1	0	University Clinic for Infectious Diseases and Febrile Conditions	
On ART (cumulative)	2	2	2		
Living with HIV but not on ART (cumulative)	0	0	0		
Screened for TB (by year)					no data available
Diagnosed with active TB (by year)					no data available
Treated for TB (by year)	6	3	6	Dr. Maja Zakoska, Insitute for Lung Diseases	



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Eurasian Harm Reduction Network (EHRN) is a regional network of harm reduction programs and their allies from across 29 countries in the region of Central and Eastern Europe and Central Asia (CEECA). Together, we work to advocate for the universal human rights of people who use drugs, and to protect their lives and health.

The Network unites over 600 institutional and individual members, tapping into a wealth of regional best practices, expertise and resources in harm reduction, drug policy reform, HIV/AIDS, TB, HCV, and overdose prevention. As a regional network, EHRN plays a key role as a liaison between local, national and international organizations. EHRN ensures that regional needs receive appropriate representation in international and regional forums, and helps build capacity for service provision and advocacy at the national level. EHRN draws on international good practice models and on its knowledge about local realities to produce technical support tailored to regional experiences and needs. Finally, EHRN builds consensus among national organizations and drug user community groups, helping them to amplify their voices, exchange skills and join forces in advocacy campaigns.

**BECOME AN EHRN MEMBER:**

EHRN invites organizations and individuals to become part of the Network. Membership applications may be completed online at:

[www.harm-reduction.org/become-a-member](http://www.harm-reduction.org/become-a-member)