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for Drugs and Drug Addiction



National Report

The Former Yugoslav
Republic of Macedonia
2014



European Monitoring Centre
for Drugs and Drug Addiction

National report on narcotic drugs



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Abbreviations

AIDS	acquired immune deficiency syndrome
BZD	benzodiazepines
CBM	community based monitoring
CRC	citizen report cards
DRD	drug-related death
DRID	drug-related infectious disease
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HOPS	Health Options Project Skopje
IDU	injecting drug use, injecting drug user
IMCND	Inter-ministerial Commission for Narcotic Drugs
IPA	Instrument for Pre-Accession Assistance
MKD	Macedonian denars
MMT	methadone maintenance treatment
NFP	national focal point
NGO	non-governmental organisation
NSP	needle and syringe exchange programme
OST	opioid substitution treatment
PDU	problem drug use, problem drug users
PHI	Public Health Institution
Reitox	Réseau Européen d'Information sur les Drogues et les Toxicomanies (European information network on drugs and drug addiction)
TDI	treatment demand indicator
UNODC	United Nations Office on Drugs and Crime
VCCT	Voluntary Confidential Counselling and Testing centre
VCT	voluntary counselling and testing
WHO	World Health Organization

1. DRUG POLICY: legislation and strategies

1.1. Legal framework

Drugs legislation has a high priority in the Former Yugoslav Republic of Macedonia. The legal framework is being continuously updated to harmonise with international standards and conventions, including political directions from the United Nations, the principles of the World Health Organization and European Union directives. In addition to the basic legislation, the legal framework incorporates laws that amend specific areas. The most important laws in the area of drugs include:

- Law for Production and Trade of Narcotic Drugs;
- Law for Precursors;
- Law on Internal Affairs and bylaws;
- Police Act and regulations;
- Law on Border Control and bylaws;
- Law on Offences against Public Order and bylaws;
- Law for Storage and Protection of Flammable Liquids;
- Law for Interception;
- Criminal Code;
- Law on Management of Confiscated Property, Property Benefits and Items Seized in Criminal and Misdemeanour Procedure;
- Law on Protection of Personal Data;
- Law on Misdemeanours;
- Law on Prevention of Corruption;
- Law of Public Prosecution;
- The Criminal Procedure;
- Law on Execution of Sanctions;
- Law on Free Legal Aid;
- Law on Social Protection;
- Customs Law;
- Law on Customs Tariff;
- Law on Customs Administration;
- Law on Intellectual Property Rights;
- Law on Social Protection;
- Law on Health Insurance;
- Healthcare Law;
- Law on National Criminal Intelligence Database.

The Former Yugoslav Republic of Macedonia has ratified the following conventions:

- United Nations (UN) Single Convention on Narcotic Drugs (1961), Protocol Amending the Single Convention on Narcotic Drugs (1972), UN Convention on Psychotropic Substances (1971), UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988);
- Council of Europe Convention on Laundering, Search, Seizure and Confiscation of the Proceeds from Crime (1990) (signed and ratified);
- Criminal Law Convention on Corruption (1998) (entered into force on 1 July 2002);
- Civil Law Convention on Corruption (ratified on 16 February 2002);
- European Convention on Mutual Assistance in Criminal Matters (1957), with Additional Protocol to the Convention of 1958 (ratified 28 July 1999);
- Second Additional Protocol to the European Convention on Mutual Assistance in Criminal Matters (ratified 24 June 2003);
- European Convention on Extradition (1957), with Additional Protocol to the Convention (1957), and Second Additional Protocol to the Convention (1978) (ratified 28 July 1999);
- Convention on the Transfer of Sentenced Persons with Additional Protocol to the Convention (1977) (ratified 28 July 1999 and entered into force 1 June 2000);
- European Convention on the Transfer of Proceedings on Criminal Matters (ratified in 2004);
- European Convention on the Suppression of Terrorism (ratified in 2004);
- UN Convention against Transnational Organized Crime (signed 14 December 2000, in process of ratification);
- European Convention on Cybercrime (ratified in 2004);
- International Convention for the Suppression of the Financing of Terrorism;
- Resolutions and Decisions against narcotic abuse and addiction of the World Health Organization (WHO) and the World Health Assembly.

Drug supply and demand reduction are regulated by relevant international and national instruments, which are being continuously improved to increase the effectiveness of responses in this area. The country's fundamental legal framework for combating drug abuse and illicit trafficking consists of the following basic legal acts: the Criminal Code Articles 215 and 216; the Law for Criminal Procedures; and the Law for Combating Narcotics and Psychotropic Substances.

1.1.1. Criminal Code Articles 215 and 216

The Act covers illicit possession, production, trafficking, acting as a mediator in sale or purchase and any other type of trading in drugs, and also regulates criminal offences committed under the influence of drugs.

Significant changes have been made in recent years to harmonise legislation with European Union (EU) directives. In the area of drugs, important changes were made to the

penalties imposed for the criminal offences listed below. The Law for Criminal Procedure states:

Unauthorised production and sale of narcotic drugs, psychotropic substances and precursors, Article 215

(1) A person who without authorisation manufactures, processes, sells or offers for sale or for buy, holds or transmits or mediates in the sale or purchase or otherwise unauthorised circulates narcotic drugs, psychotropic substances and precursors, shall be punished with imprisonment of three to 10 years.

(2) If the offence under paragraph (1) of this Article relates to smaller amounts of narcotic drugs, psychotropic substances and precursors, this shall be punished with imprisonment of between six months and three years.

(3) If the offence under paragraph (1) is committed by several persons, or the perpetrator of this crime is part of an organised network of resellers or agents, this shall be punished with imprisonment of at least five years.

(4) A person who, without authorisation, purchases, mediates or gives for use equipment, material or substances known to be intended for the production of narcotic drugs, psychotropic substances and precursors shall be punished with imprisonment of one to five years.

(5) The perpetrator of offences under paragraph (2), except the organiser, who discloses the act or contributes to its disclosure, would be exempt from punishment.

(6) If the crime is committed by a legal person they shall be punished by a fine.

(7) Narcotic drugs, psychotropic substances and precursors, as well as movable or immovable objects used for their making, transmission and distribution, will be confiscated.

Facilitating the use of narcotics, Article 216

(1) The use of other narcotic drugs, psychotropic substances or precursors and giving of narcotic drugs and psychotropic substances to any other person for their use, or making available facilities for the use of narcotic drugs, psychotropic substances or otherwise enabling another person to use narcotic drugs shall be punished with imprisonment of one to five years.

(2) If the crime is committed against a minor or against several persons or causes especially grave consequences, it shall be punished with imprisonment of one to 10 years.

(3) If the crime is committed by a legal person it shall be punished by a fine.

(4) Narcotic drugs and movable or immovable property used for their transmission and distribution, or specifically designed or made for use, will be confiscated.

It is important to underline that the Law also allows for alternative measures to be applied (Article 48), as a criminal charge cannot be applied to minor offences when not required by criminal justice and when it is expected that the purpose of punishment can be achieved by giving a warning about the threat of punishment (probation), a caution (judicial admonition) or measures to assist and supervise the conduct of the offender in the community. Alternative measures (Article 48-a) include: probation; probation with supervision; termination of the criminal proceedings; community service; judicial reprimand; and house arrest.

1.1.2 Criminal Procedure Law

The Criminal Procedure Law has undergone significant changes that have increased the powers of the public prosecutor, and the entire investigative process. The law was initially passed in 2010, but was delayed twice while preparations were made to implement its provisions. Article 41 details the leading role of the public prosecutor in pre-trial proceedings, namely that, for the purpose of criminal prosecution, the prosecutor manages the pre-trial proceedings and the Judicial Police.

The public prosecutor can take any action necessary to detect crime and in the prosecution of the perpetrator that is authorised by law authorities. The Criminal Procedure Law permits the establishment of investigation centres. Employees who are selected to work in the investigation centres are available to the public prosecutor. They work under the public prosecutor's supervision and control, observe and carry out his/her orders, and follow his/her directions and instructions. A new development is the establishment of the Judicial Police, which, ex officio or on the order of the public prosecutor, undertake measures and activities to detect criminal offences, prevent further consequences of crimes, capture and arrest perpetrators, provide evidence and carry out other measures and activities to facilitate the smooth conduct of the criminal proceedings.

1.1.3. Law for Combating Narcotics and Psychotropic Substances

In accordance with the Act on Combating Drug Abuse (Article 21), the Minister of Health created the 'List of drugs, psychotropic substances and plants used to produce drugs and substances that can be used in the production of drugs'. The List is regularly updated in line with the relevant international and EU regulations and national risk assessment procedure.

1.1.4. Adoption of amendments to the List of Controlled Substances

A 'new psychoactive substance' is a narcotic or psychotropic drug, in pure form or in preparation, that is not controlled by the 1961 United Nations Single Convention on Narcotic Drugs or the 1971 United Nations Convention on Psychotropic Substances, but which may pose a public health threat comparable to that posed by substances listed in these conventions.

Based on the national risk assessment procedure, and especially the appearance on the drug market of MDPV 3,4-methylenedioxypropylamphetamine, the national List of Controlled Substances was amended (15-1879/1) in March 2014 by the Minister of Health to bring 15 substances under legal control.

Substances under control in the List of Psychotropic Substances (synthetic drugs under national control equivalent to those for the substances in UN71 Schedule I), for which there is also a risk assessment under the Joint Action that has resulted in pan-European controls, are:

- 4-MTA, 4-Methylthioamphetamine;
- PMMA, para-Methoxymethamphetamine;
- 2C-I, 2,5-dimethoxy-4-iodophenethylamine (psychedelic phenethylamine);

- 2C-T-2, 2,5-dimethoxy-4-ethylthiophenethylamine;
- 2C-T-7 2,5-dimethoxy-4-propylthiophenethylamine (psychedelic phenethylamine);
- TMA-2 trimethoxyamphetamines.

The substances that are under control in the List of Narcotic Drugs (under national controls equivalent to those for the substances in UN61 Schedule I) include new substance that give rise to concern. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and Europol have drawn up Joint Reports on these substances ⁽¹⁾:

- mCPP (1-(3-chlorophenyl) piperazine);
- BZP (1-Benzylpiperazine);
- mephedrone (4-methylmethcathinone);
- 4-MA (4-methylamphetamine);
- 5-IT (5-(2-aminopropyl)indole);
- methoxetamine (2-(3-Methoxyphenyl)-2-(ethylamino)cyclohexanone);
- AH-7921 (3,4-dichloro-N-[[1-(dimethylamino)cyclohexyl]methyl]benzamide);
- 25I-NBOMe (4-iodo-2,5-dimethoxy-N-(2-methoxybenzyl)phenethylamine);
- MDPV (3,4-methylenedioxypropylvalerone).

1.2. National Strategy and Action Plan: evaluation and coordination

1.2.1. National Drugs Strategy (2006–12) and Action Plan

In December 2006 the Parliament adopted the first national strategy on drug-related issues. The National Drugs Strategy (2006–12) was based on the relevant international conventions and legal acts on drug control, and set national priorities for dealing with this problem.

The Strategy advocated an integrated, multidisciplinary and balanced approach to tackling the drugs phenomenon. Its structure is illustrated in Figure 1.1.

⁽¹⁾ http://www.emcdda.europa.eu/publications/searchresults?action=list&type=PUBLICATIONS&SERIES_PUB=a105

Figure 1.1. Structure of the National Drugs Strategy (2006–12).



1.2.2. Implementation of the Strategy and Action Plan

The Strategy and its Action Plan were implemented between 2006 and 2012. Implementation was assessed annually on the basis of various (standardised and non-standardised) reports from proficient ministries, institutions and civil society organisations. The Action Plan specified individual measures and actions that were to be taken, the institutions responsible for their implementation, and their deadlines and indicators. Relevant institutions were obliged to report on the progress made in the given period to the Inter-ministerial Commission for Narcotic Drugs. The Department for Controlled Substances in the Ministry of Health analysed progress in implementing strategic documents as well as in general evaluation; its findings were presented to the EU Commission every six months, and to the Mini Dublin Group (accredited foreign diplomats in the country).

The Department for Controlled Substances monitored trends using a variety of indicators, and, when necessary, proposed additional measures or changes to the planned actions in the given period.

At the national level, programmes implemented by civil society organisations were evaluated by external evaluators, since considerable financial resources had been allocated to them from the budget of the Global Fund to Fight AIDS, Tuberculosis and Malaria ('the Global Fund'). Programmes in the fields of drug demand reduction and drugs prevention that were implemented at the local level were often evaluated by local Committees on Combating Drugs Abuse (internally or externally) since they finance such programmes, or by the Agency for Youth and Sports for activities financed by that body.

1.2.3. Evaluation of the Strategy and Action Plan

In May 2012 the Department for Controlled Substances, Ministry of Health carried out a scientific evaluation of the Strategy. Its intention was to align the new strategy for 2014–20 with the specific needs arising from drug-related problems, and to improve the efficiency of the entire system of combating the drugs phenomenon.

1.2.3.1. Survey conducted in cooperation with the Ministry of Health, Ministry of Internal Affairs and Faculty of Security to assess the drugs situation (2)

In 2012 research was carried out using a survey method that included a questionnaire standardised for use in EU countries, adapted to the national circumstances. The sample size of the research was 246 people, in eight regions (20 cities). The research took place in a variety of locations, both public and private, including parks, cafes and clubs.

Results

The average age of respondents was 32.2 ± 7.3 years. The calculated mean values indicate that 50 % of survey respondents were aged over 32.

Table 1.1. Distribution of respondents by gender and location.

City	Male		Female		Total	
	N	%	N	%	N	%
Kumanovo	30	12.20	5	2.03	35	14.23
Ohrid	24	9.76	6	2.44	30	12.20
Skopje	27	10.98	3	1.22	30	12.20
Stip	22	8.94	8	3.25	30	12.20
Strumica	30	12.20	0	0.00	30	12.20
Tetovo	26	10.57	4	1.63	30	12.20
Veles	21	8.54	9	3.66	30	12.20
Bitola	27	10.98	4	1.63	31	12.60
Total	207	84.15	39	15.85	246	100.00

According to Table 1.2, data on age were supplied by 239 (97.15 %) of 246 respondents. The youngest respondent was 17 years old, and the eldest was 55.

Table 1.2. Distribution of respondents by age.

	N	Mean	Median	Mode	Minimum	Maximum	Std Dev.
Age	239	32.2	32.0	32.0	17.0	55.0	7.3

(2) T. Petrushevska, L.J.Todorovski and V.V. Stefanovska (2012), 'Drug abuse among youth in Macedonia', Archives of Public Health of the Former Yugoslav Republic of Macedonia (2), ISSN1857-7148, p. 54.

Table 1.3. Distribution of respondents by gender and age.

Gender	Age								Total
	16-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	
Male	4	32	45	56	35	17	8	4	201
	1.67 %	13.39 %	18.83 %	23.43 %	14.64 %	7.11 %	3.35 %	1.67 %	84.10 %
Female	1	8	13	9	5	1	1	0	38
	0.42 %	3.35 %	5.44 %	3.77 %	2.09 %	0.42 %	0.42 %	0.00 %	15.90 %
Total	5	40	58	65	40	18	9	4	239
	2.09 %	16.74 %	24.27 %	27.20 %	16.74 %	7.53 %	3.77 %	1.67 %	100.00 %

Table 1.4. Distribution of respondents by gender and education.

Education degree	Male	Female	Total
Incomplete	12	3	15
	4.96 %	1.24 %	6.20 %
Primary	66	9	75
	27.27 %	3.72 %	30.99 %
Secondary	123	24	147
	50.83 %	9.92 %	60.74 %
Higher	1	0	1
	0.41 %	0.00 %	0.41 %
Faculty	2	1	3
	0.83 %	0.41 %	1.24 %
Unknown	1	0	1
	0.41 %	0.00 %	0.41 %
Total	205	37	242
	84.71 %	15.29 %	100.00 %

Table 1.5. Distribution of respondents by gender and duration of heroin use.

Use of heroin in years	Male	Female	Total
Up to 1	14	0	14
	5.79 %	0.00 %	5.79 %
1-5	54	10	64
	22.31 %	4.13 %	26.45 %
5-10	60	20	80
	24.79 %	8.26 %	33.06 %
10 and over	75	9	84
	30.99 %	3.72 %	34.71 %
Total	203	39	242
	83.88 %	16.12 %	100.00 %

The Pearson Chi-square: 9.18488, df = 3, p> 0.05 (CI 95 %) showed no statistically significant difference between gender and the duration of heroin use.

Table 1.6. The price of 1 g of heroin.

	N	Mean	Median	Minimum	Maximum	Std Dev.
Price (MKD)	160	1 239.4	1 200.0	300.0	3 000.0	437.6

Data on the price of 1 g of heroin were supplied by 160 (65 %) of the 246 respondents. The minimum price was MKD 300.0 and the maximum was MKD 3 000.0 ⁽³⁾. The average price was MKD 1 239.4 ± 437.6. The calculated mean values indicate that 50 % of respondents had paid over MKD 1 200 for 1 g of heroin.

Table 1.7. The price of 1 g of marijuana.

	N	Mean	Median	Minimum	Maximum	Std Dev.
Price (MKD)	154	166.5	150.0	60.0	600.0	88.7

Data on the price of 1 g of marijuana were supplied by 154 (62.6 %) of 246 respondents. The minimum price was MKD 60.0, and the maximum was MKD 600.0. The average price was MKD 166.5 ± 88.7. The calculated mean values indicate that 50 % of respondents had paid over MKD 150 for 1 g of marijuana.

Table 1.8. The price of 1 g of methadone.

	N	Mean	Median	Minimum	Maximum	Std Dev.
Price (MKD)	53	299.4	120.0	50.0	1 000.0	290.7

Data on the price of 1 g methadone were supplied by 53 (21.5 %) of the 246 respondents. The minimum price was MKD 50.0, and the maximum was MKD 1 000.0. The average price was MKD 299.4 ± 290.7. The calculated mean values indicate that 50 % of respondents had paid over MKD 120.0 for 1 g of methadone.

Table 1.9. The price of one tablet of amphetamine.

	N	Mean	Median	Minimum	Maximum	Std Dev.
Price (MKD)	35	812.9	1 000	250	2 000	477.6

Data on the price of one tablet of amphetamine were supplied by 35 (14.2 %) of the 246 respondents. The minimum price was MKD 250.0, and the maximum was MKD 2 000.0. The average price was MKD 812.9 ± 477.6. The calculated mean values indicate that 50 % of respondents had paid over MKD 1 000.0 for one tablet of amphetamine.

Table 1.10. The price of 1 g of cocaine.

	N	Mean	Median	Minimum	Maximum	Std Dev.
Price (MKD)	28	3 275.0	3 000.0	2 500.0	6 000.0	707.4

Data on the price of 1 g of cocaine were supplied by 35 (14.2 %) of the 246 respondents. The minimum price was MKD 2 500.0, and the maximum was MKD 6 000.0. The average price was MKD 3 275.0 ± 707.4. The calculated mean values indicate that 50 % of respondents had paid over MKD 3 000.0 for 1 g of cocaine.

⁽³⁾ Exchange rate: EUR 1 = MKD 61.

Table 1.11. The price of one ecstasy tablet.

	N	Mean	Median	Minimum	Maximum	Std Dev.
Price (MKD)	51	342.2	300.0	250.0	600.0	73.1

Data on the price of one Ecstasy tablet were supplied by 51 (20.7 %) of the 246 respondents. The minimum price was MKD 250.0, and the maximum was MKD 600.0. The average price was MKD 342.2 ± 73.1. The calculated mean values indicate that 50 % of respondents paid over MKD 300.0 for one Ecstasy tablet.

Table 1.12. The price of LSD (one dose of ca. 80 mg).

	N	Mean	Median	Minimum	Maximum	Std Dev.
Price (MKD)	7	515.0	400.0	300.0	1 200.0	333.3

Data on the price of LSD were supplied by seven (2.8 %) of the 246 respondents. The minimum price was MKD 300.0, and the maximum was MKD 1 200.0. The average price was MKD 515.0 ± 333.3. The calculated mean values indicate that 50 % of respondents paid over MKD 400.00 for LSD.

Table 1.13. Distribution of respondents by gender and frequency of heroin use.

Gender	Frequency of heroin use			Total
	Once or more a month	Once or more a week	Every day	
Male	48 23.65 %	71 34.98 %	49 24.14 %	168 82.76 %
Female	14 6.90 %	11 5.42 %	10 4.93 %	35 17.24 %
Total	62 30.54 %	82 40.39 %	59 29.06 %	203 100.00 %

The Pearson Chi-square: 2.08381, df = 2, p> 0.05 (CI 95 %) showed no statistically significant difference between gender and frequency of heroin use.

Table 1.14. Distribution of respondents by gender and usual way of taking drugs.

Gender	The usual way of consuming drug					Total
	Intravenously	Snuffing	Smoking	Oral	Other	
Male	96 39.02 %	45 18.29 %	64 26.02 %	1 0.41 %	1 0.41 %	207 84.15 %
Female	15 6.10 %	15 6.10 %	9 3.66 %	0 0.00 %	0 0.00 %	39 15.85 %
Total	111 45.12 %	60 24.39 %	73 29.67 %	1 0.41 %	1 0.41 %	246 100.00 %

The Pearson Chi-square: 5.27492, df = 4, p> 0.05 (CI 95 %) showed no statistically significant difference between gender and way of taking drugs.

Figure 1.2. Distribution of respondents injecting drugs, by city.

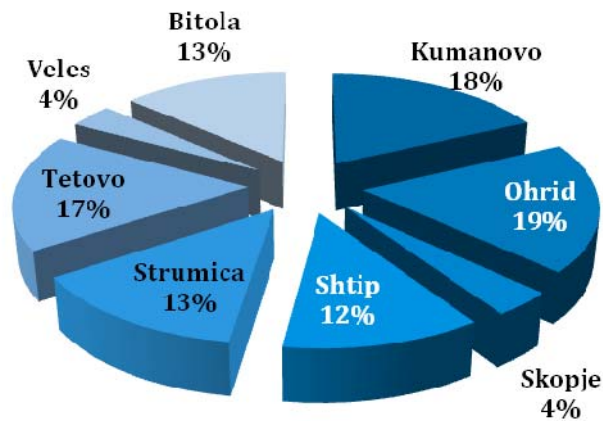


Table 1.15. Distribution of respondents by age and drug supply route.

Age	Route of supply					Total
	Dealer	Friend	Partner	Internet	Smart shop	
16-20	0	3	1	1	0	5
	0.00 %	1.26 %	0.42 %	0.42 %	0.00 %	2.09 %
21-25	17	19	2	1	1	40
	7.11 %	7.95 %	0.84 %	0.42 %	0.42 %	16.74 %
26-30	42	13	2	0	1	58
	17.57 %	5.44 %	0.84 %	0.00 %	0.42 %	24.27 %
31-35	49	12	1	1	2	65
	20.50 %	5.02 %	0.42 %	0.42 %	0.84 %	27.20 %
36-40	31	6	0	0	3	40
	12.97 %	2.51 %	0.00 %	0.00 %	1.26 %	16.74 %
41-45	15	3	0	0	0	18
	6.28 %	1.26 %	0.00 %	0.00 %	0.00 %	7.53 %
46-50	7	1	1	0	0	9
	2.93 %	0.42 %	0.42 %	0.00 %	0.00 %	3.77 %
51-55	3	1	0	0	0	4
	1.26 %	0.42 %	0.00 %	0.00 %	0.00 %	1.67 %
Total	164	58	7	3	7	239
	68.62 %	24.27 %	2.93 %	1.26 %	2.93 %	100.00 %

The Pearson Chi-square: 54.4163, df = 28, p <0.01 (CI 99 %) showed no statistically significant difference between age groups and drug supply route. The analysis showed no statistically significant difference in the drug supply route and gender (3.13254, df = 4, p > 0.05 (CI 95 %)).

Table 1.16. Distribution of respondents by gender and place where drug is purchased.

Gender	Place where drug is purchased					Total
	Home delivery	Open public place	Place closed to public	In dealer's house	Other	
Male	0	3	1	1	0	5
	0.00 %	1.26 %	0.42 %	0.42 %	0.00 %	2.09 %
Female	17	19	2	1	1	40
	7.11 %	7.95 %	0.84 %	0.42 %	0.42 %	16.74 %
Total	42	13	2	0	1	58
	17.57 %	5.44 %	0.84 %	0.00 %	0.42 %	24.27 %

The Pearson Chi-square: 11.3016, df = 5, p <0.05 (CI 95 %) showed no statistically significant difference between gender and the place where the drug was purchased.

Table 1.17. Distribution of respondents by city and ease of access to drugs.

City	Access to drugs					Total
	Fully available	Very easily available	Readily available	Hardly available	Not known	
Kumanovo	8	13	13	1	0	35
	3.25 %	5.28 %	5.28 %	0.41 %	0.00 %	14.23 %
Ohrid	3	1	4	21	1	30
	1.22 %	0.41 %	1.63 %	8.54 %	0.41 %	12.20 %
Skopje	0	3	14	12	1	30
	0.00 %	1.22 %	5.69 %	4.88 %	0.41 %	12.20 %
Shtip	1	1	10	3	15	30
	0.41 %	0.41 %	4.07 %	1.22 %	6.10 %	12.20 %
Strumica	4	4	10	7	5	30
	1.63 %	1.63 %	4.07 %	2.85 %	2.03 %	12.20 %
Tetovo	8	0	5	12	5	30
	3.25 %	0.00 %	2.03 %	4.88 %	2.03 %	12.20 %
Veles	0	3	14	12	1	30
	0.00 %	1.22 %	5.69 %	4.88 %	0.41 %	12.20 %
Bitola	16	1	7	7	0	31
	6.50 %	0.41 %	2.85 %	2.85 %	0.00 %	12.60 %
Total	40	26	77	75	28	246
	16.26 %	10.57 %	31.30 %	30.49 %	11.38 %	100.00 %

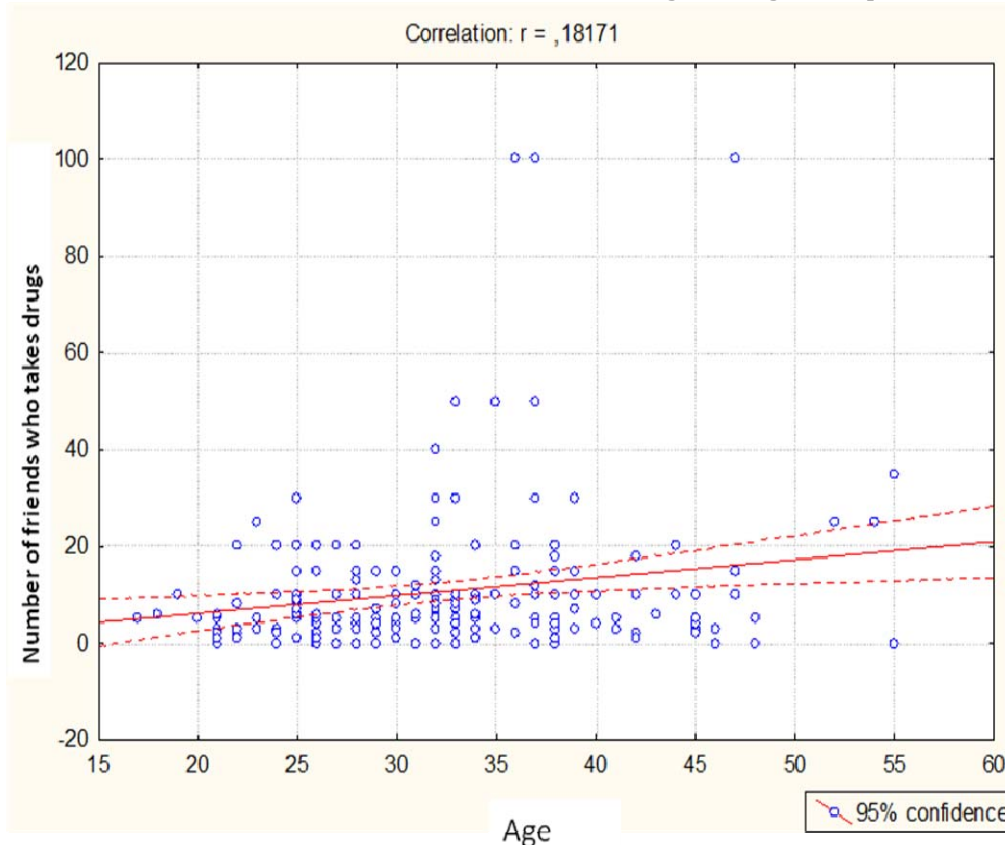
The Pearson Chi-square: 168.196, df = 28 p <0.01 (CI 99 %) showed no statistically significant difference between the city and the availability of drugs. The analysis showed no statistically significant difference between age and availability of drugs (46.2968, df = 28, p > 0.05 (CI 95 %)).

Table 1.18. Distribution of respondents by number of friends who take drugs.

	N	Mean	Median	Mode	Frequency	Min.	Max.	Std Dev.
Number of friends who take drugs	239	10.6	7.0	10.0	43	0.00	100.0	14.6

Data on the number of respondents' friends who take drugs were supplied by 239 (97.15 %) of the 246 respondents. The minimum number was zero, and the maximal was 100. The average number of friends who take drugs was 10.6 ± 14.6 . Over 50 % of respondents had more than seven friends who take drugs. The majority of respondents (over 43) had 10 friends who take drugs.

Figure 1.3. Correlation between number of friends who take drugs, and age of respondent.



There was no statistically significant direct linear relationship ($p < 0.05$) between the age of addicts and the number of friends who take drugs. With the increasing age of addicts, the number of friends who take drugs also increased.

1.2.3.2. Evaluation of the Strategy's implementation

Summary

The purpose of evaluation was to ascertain the current status of drug abuse in the country, to identify whether there were significant changes before and after the Strategy's adoption. The evaluation assessed each of the five fundamental pillars of the strategy: coordination of drug policies; demand reduction; supply reduction; cooperation with international organisations; and research and evaluation. An additional objective was to identify issues

that would need to be addressed by measures and activities in the subsequent drug strategy, for capacity building.

Materials and methods: The research used both qualitative and quantitative methods, and was conducted between January and March 2013. The first part of the study analysed research reports on drug-related problems. Qualitative research was conducted in two parts: a semi-structured questionnaire using three focus groups of 45 people in Skopje, Tetovo and Bitola; and a research survey with a standard questionnaire tailored to the needs, conducted with 76 people who were involved in the implementation of the National Drugs Strategy. Participants in the study were selected according to their willingness to participate.

Results: 64.9 % of respondents said that the Strategy had increased the availability of treatment programmes; 58.4 % said that accessibility had improved; 44.2 % said that the quality of services had improved; 41.6 % said that the diversity of programmes had improved. A total of 75.3 % stated that there was better cooperation and exchange of information and that police activity had reduced the supply of drugs.

Qualitative evaluation

The target group was inspectors from the Department of Internal Affairs, 15 in each regional area (seven from uniformed police, responsible for public order and peace, and eight from the Unit against Drug Trafficking).

Quantitative evaluation

The quantitative evaluation recruited 80 respondents who were involved in implementing the National Drugs Strategy from public and private medical centres (public health centres, Centres for the Treatment and Harm Reduction of Drug Addiction, the Clinic of Toxicology and the Department of Infectious Diseases), non-governmental organisations (NGOs) active in the drugs field, the Red Cross, Government departments (Ministries of Health, Interior, Labour and Social Policy, Education, Customs Administration, Agency for Youth and Sports) and the Public Prosecutor for Organised Crime.

Research instruments: For the first qualitative study, a semi-structured questionnaire was designed specifically for this type of research (focus groups). The issues discussed within the focus groups were:

- In what locations do you find drug users who violate the public order? (For example: In parks, discos, on the street.)
- What are the most common forms of drug use in those locations? (Injecting, smoking using foil, tablets, legally authorised medicines containing controlled substances or synthetic drugs.)
- Do you have information on where drugs are purchased? (Dealers, friend, close family, partner.)

- Do you have experience, as police officers, of a drug addict who has overdosed? If so, how did you handle the situation – do you have a standard operating procedure?
- Are you aware of the cost, quality and purity of drugs that are commonly abused?
- Is there a difference in the types of area that are most commonly used by drug users who violate public order? (Central city area, particular neighbourhoods – which?)
- Is there a particular day of the week on which the number of violations of public order under the influence of drugs reaches a peak?
- Is there a correlation between the time of year and number of violations of public order under the influence of drugs?
- What is your knowledge of new types of psychoactive substances? Are they currently available in the country?
- What experiences do you have of the trend in multiple drug use? (Heroin, cocaine, marijuana, amphetamines, ecstasy.)
- 'Do you know which drugs are used most frequently?
- Do you know about the abuse of methadone by injection?
- Do you have any information about where methadone users purchase the drug? (Pharmacy, treatment centre, the 'black market'.)
- What problems, if any, do you face in carrying out your tasks and activities?
- Do you have any suggestions, proposals, measures or actions that could be implemented to overcome these problems?
- Do you need additional training or information, or more knowledge about drugs?
- Does the Ministry of Internal Affairs provide you with sufficient education, or would it be useful if plans for additional drugs education were included in the new drugs strategy?

Participation in the qualitative research was voluntary. All participants were informed about the confidentiality of information received in relation to their guaranteed anonymity in research. Focus group participants signed informed consent to ensure they were familiar with the goals of the focus group and that participation in the discussions was voluntary.

The findings of the research were as follows:

- Parks are the most common location of drug users who violate the public order.
- The most common forms of drug use are by injection, and smoking heroin on foil.
- Young people often use synthetic drugs in combination with alcohol and legally authorised medicines containing controlled substances (often tramadol and diazepam) at 'techno parties'.
- Drugs are purchased from dealers.
- The number of violations of public order under the influence of drugs reaches a peak at weekends.
- Marijuana is the most commonly used drug, followed by heroin and synthetic drugs.
- In many cases, methadone abusers purchase the drugs from a pharmacy, and from centres that treat dependence.

- Three focus groups highlighted the need for more training for police officers, particularly about new drugs.

The quantitative research was conducted using a standard survey questionnaire used to analyse EU drugs strategy, adapted to the national level. The questionnaire consists of 76 questions covering the five pillars of the Strategy: coordination of drug policies; demand reduction; supply reduction; cooperation with international organisations; and research and evaluation.

A total of 80 respondents were recruited who were involved in the implementation of the National Drugs Strategy. They included men and women with different levels of education, national and ethnic backgrounds and position in their organisation. Respondents were selected according to their willingness to participate, and whether they possessed information of interest to the research.

Figure 1.4. Compatibility of the National Drugs Strategy with EU standards.

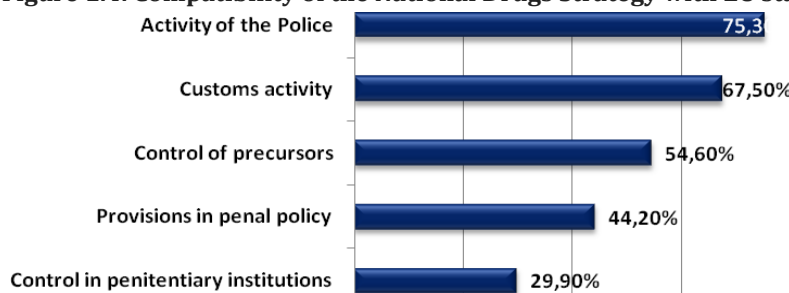


Table 1.19. Opinions on improvement of the National Drugs Strategy.

National Drugs Strategy and Action Plan:	Strongly agree (%)	Agree (%)	Disagree (%)	Strongly disagree (%)	I do not know (%)
Cover all relevant issues	19.48	44.15	5.19	1.30	29.87
Have been prepared in accordance with EU standards	19.48	48.05	2.60	/	29.87
Comply with the Drugs Strategy and Action Plans of the EU	19.48	48.05	1.30	/	31.17

Figure 1.5. Achievements of the National Drugs Strategy in improving access to and the quality of programmes to treat drug addicts.

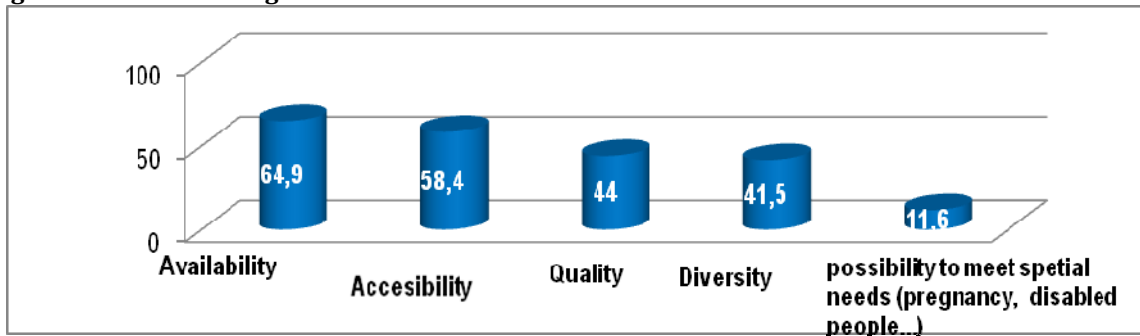


Figure 1.6. Are there barriers that slow down the process of tackling organised criminal groups' involvement in drug production and trafficking?

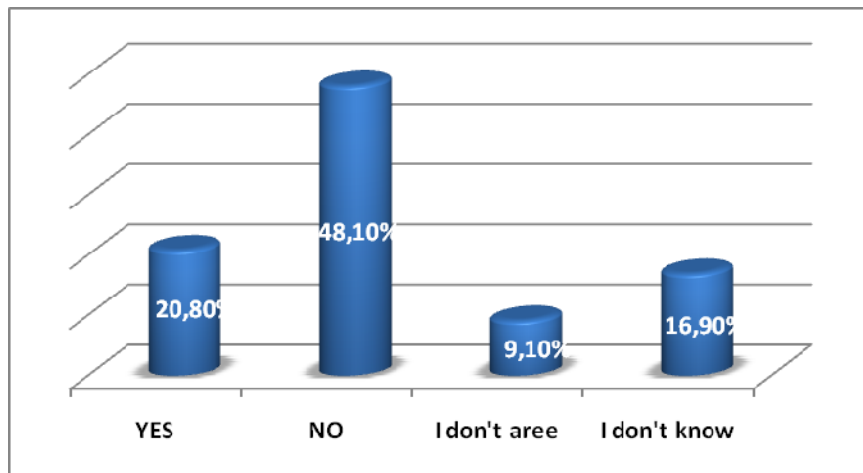


Figure 1.7. 'Does the new National Drugs Strategy need to include additional tools to solve the problem of organised crime's involvement in the illicit production and trafficking of drugs?'

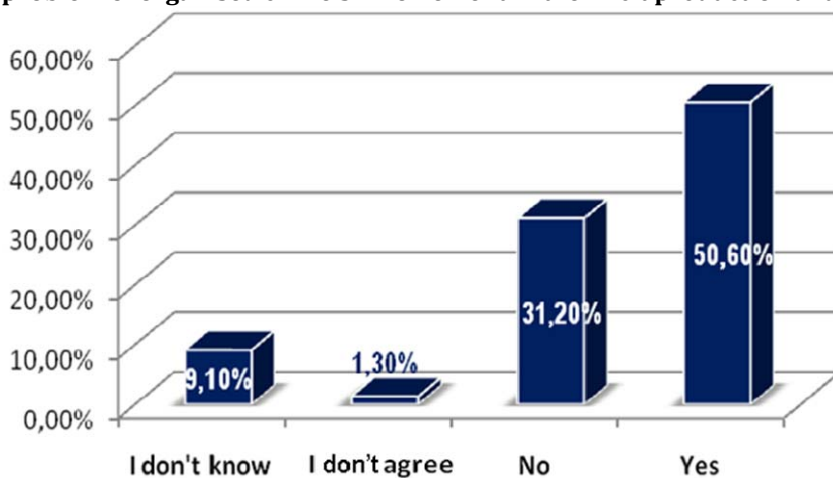


Figure 1.8. Which of these factors have improved following the implementation of the National Drugs Strategy?

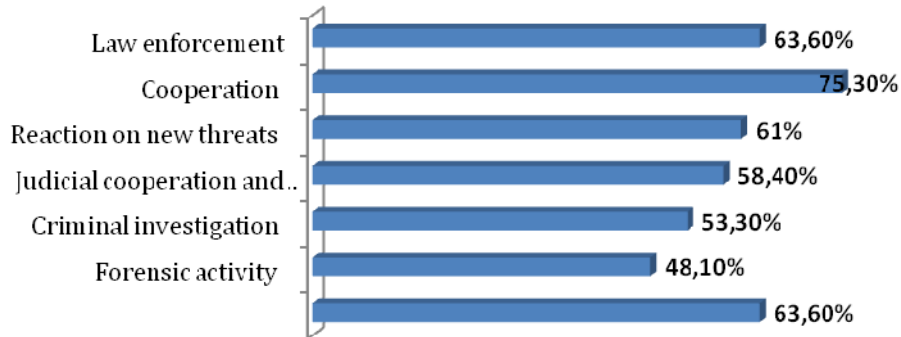
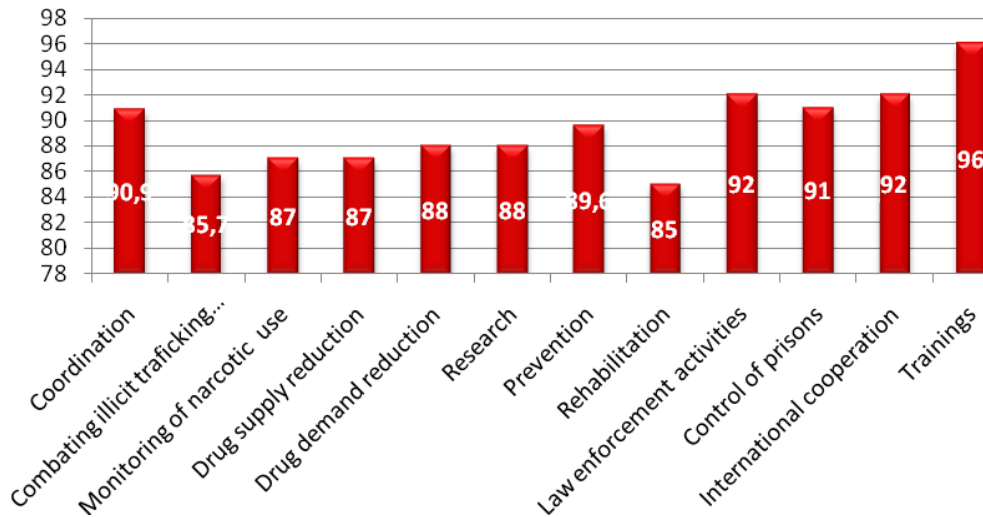
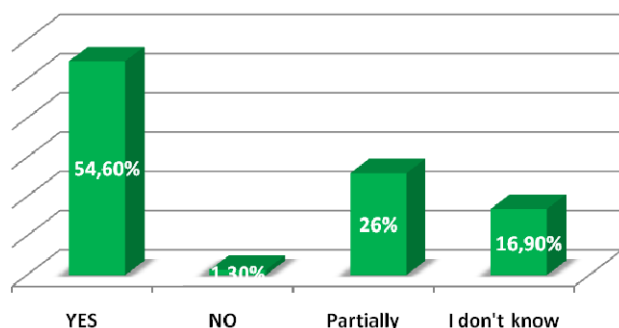


Figure 1.9. What should the priorities be for the new National Drugs Strategy?



Following the adoption of the National Drugs Strategy, the Centre for Monitoring Drugs and Drug Addiction was established within the Department for Controlled Substances, Ministry of Health, as a centre for cooperation with the EMCDDA. The results of the quantitative survey showed an improvement in the collection and processing of data related to drugs issues. The Centre analysed data on drugs from all relevant institutions and organisations in the public, private and non-governmental sectors. With the implementation of three consecutive EU Instrument for Pre-Accession Assistance (IPA) projects designed to build national capacity for collecting and evaluating drug data, the country is ready to collect data relating to the five epidemiological indicators and supply indicators, to process, evaluate and present information about the current drugs situation.

Figure 1.10. Following the adoption of the National Drugs Strategy, has there been an improvement in the collection and analysis of relevant data on drugs?



A significant number of memorandums, protocols and agreements for cooperation were signed within the implementation of the first National Drugs Strategy. This period is characterised by the harmonisation of the country's legislation with EU legislation. There was a significant reduction in drug-related crime and drug demand, and activities were carried out to prevent initiation of drug use, to reduce the adverse health and social consequences and to increase the availability of treatment in 10 cities in the country. Substantial work has been done to prevent the transmission of blood-borne diseases, especially human immunodeficiency virus (HIV) and hepatitis. However, further strengthening is needed of public health and social services, the capacity of forensic laboratories for drug profiling, and education and training.

1.3. Coordination mechanism

Under the Law on the Control of Drugs and Psychotropic Substances the Government established an inter-ministerial State commission to tackle the illegal production, trade and abuse of drugs (the Inter-ministerial Commission for Narcotic Drugs). The Bureau of Medicines in the Ministry of Health conducts the expert and administrative activities related to its work.

1.3.1. The Inter-ministerial Commission for Narcotic Drugs

The Inter-ministerial Commission for Narcotic Drugs (IMCND) consists of representatives of the Ministry of Justice, Ministry of Internal Affairs, Ministry of Health, Ministry of Local Government, Ministry of Environment and Spatial Planning, Ministry of Foreign Affairs, Ministry of Education and Science, Ministry of Labour and Social Policy, Ministry of Agriculture, Forestry and Water Economy, Ministry of Finance, the Customs Office and the Agency for Youth and Sports.

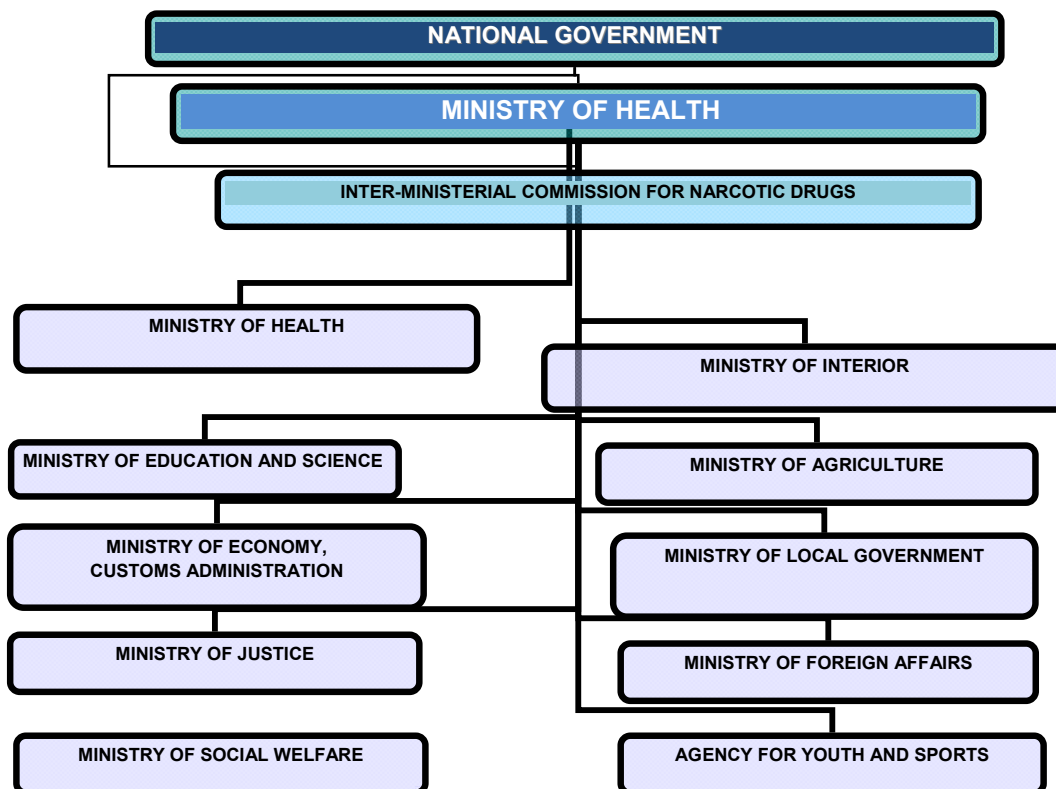
The IMCND is a consultative body to the Government and its area of work, competences and composition are regulated by the Law on the Control of Narcotic Drugs and Psychotropic Substances.

Its main tasks include:

- 1) To analyse the drug situation in the country and provide recommendations and proposals related to the implementation of international conventions for the control of narcotic drugs and other related prescriptions and mechanisms.
- 2) To develop and ensure systematic implementation of the supervision strategy of narcotic drugs, the prevention and suppression of abuse of narcotic drugs.
- 3) To promote preventive actions and public information related to the damage caused by the use of narcotic drugs.
- 4) To implement a system for data collection and data processing related to the nature and widespread emergence of narcotic drug abuse.
- 5) To coordinate and support the activities of local and regional units.
- 6) To review the laws and other prescriptions and mechanisms that are related to the issues of abuse and damage caused by narcotic drug use.
- 7) To propagate the implementation of the international obligations.
- 8) To represent the Government in international bodies and to deliver reports and data in accordance with international conventions for the control of narcotic drugs, and to ensure the maintenance of regular communication with domestic and foreign specialised bodies and departments.
- 9) To submit reports on the current situation and trends on the supply of and demand for narcotic drugs, with recommendations for relevant proposals and actions to be undertaken by state administration bodies.

The IMCND is also responsible for carrying out other tasks delegated by the Government.

Figure 1.11. Organisational structure of the IMCND.



The IMCND sets out tangible goals within three main themes: the rule of law; policy and trend analysis; and prevention, treatment and reintegration:

- Rule of law: The IMCND promotes effective responses to drugs crime by facilitating the implementation of relevant international legal instruments, and by promoting effective, fair criminal justice systems through the use and application of United Nations and EU standards and norms in crime prevention and criminal justice.
- Enhanced knowledge of trends for: effective policy implementation, operational response and impact assessment in drugs and crime; risk analysis; scientific and forensic analysis.
- Effective data analysis: In accordance with the National Drugs Strategy, the IMCND reviews and adopts the reports issued by the national focal point (NFP) at the Department for Controlled Substances, Ministry of Health, and by other departments including the Ministry of Internal Affairs and the Custom Administration. Reports are based on surveys, drug addiction data and trend analysis, seizures, etc. Reports document the activities of governmental bodies, NGOs, experts and intelligence surveillance. This expertise contributes to a powerful knowledge-based policy analysis, coherence of programmes, quality control and knowledge management system.

1.3.2. National focal point (NFP)

The NFP was officially created in May 2007 by the Government Decree on the Establishment of the Centre for Monitoring of Drugs and Drug Addictions (national focal point) (Official Gazette of the Former Yugoslav Republic of Macedonia, 18 May 2007, p. 2, nr. 62). This document describes the NFP's tasks, location, requirements for data collection quality, reporting, basic fields of action, etc. The NFP is led by the head of the Department for Controlled Substances in the framework of the Bureau for Medicines at the Ministry of Health. The NFP is located in the premises of the Ministry of Health.

The National Centre for Monitoring of Drugs and Drug Addictions is required to provide objective, reliable and comparable information on drugs and drug addictions, in line with EU standards. The statistical and technical information and documentation produced by the Centre is intended to provide a global picture of drugs and drugs addictions, which is used as the basis for undertaking measures and planning activities.

The provision of comparable, objective and reliable data will be assured by establishing indicators and common criteria, to increase the uniformity of the data and to establish measurable standards.

The information produced by the Centre must be standardised and meet qualitative and quantitative norms. Providing data with satisfactory quality norms is the basic goal of the Centre, so that a full picture of the drugs situation can be provided. The Centre is required to monitor and evaluate data from three sources:

- the health field, including the five epidemiological health indicators: prevalence of drug use among the general population; problematic drug use; treatment; drug-related deaths; and drug-related infectious diseases;
- police data as indicators for drugs,
- customs data as indicators for drugs.

The Centre also performs special tasks, as required and when authorised by the Ministry of Health or Government, including scientific studies, research and analyses. The Centre cooperates with the EMCDDA and participates in the REITOX network (Réseau Européen d'Information sur les Drogues et les Toxicomanies).

The following bodies provide data to the NFP: Ministry of Internal Affairs, Ministry of Finances, Customs Administration, Ministry of Health, Ministry of Education and Science, Ministry of Labour and Social Policy, Institute for Public Health, Institute of Forensic Medicine, Clinic for Infectious Diseases, Institute for Forensic Medicine and other institutions.

1.4. The process of adoption of the new National Drugs Strategy (2014–20)

The new National Drugs Strategy for the period 2014–20 is in the final stages of adoption by the Government.

The Strategy and Action Plan (2014–17) were prepared by the Sector for control of narcotic drugs, Ministry of Health and submitted for approval to the IMCND.

All 10 members of the IMCND unanimously supported the new National Drugs Strategy and Action Plan.

During the final stages of preparation of the new Strategy and Action Plan, the draft material was presented to and adopted by:

- the Collegiums headed by the Director of the Public Security Bureau, attended by the Assistants Director and most of the Heads of Sectors of the Ministry of Internal Affairs;
- the Collegiums headed by the Assistant Director of Control and Investigation, Customs Administration, Chief of Department of Investigation, the Chief of Department for Risk Management, and the Chief of Department Against Smuggling;
- the Public Prosecutor for Organised Crime.

The draft National Drugs Strategy (2014–20) and Action Plan outline a number of measures and actions to tackle new challenges, including:

- improving the quality, diversification (in terms of sensitivity to cultural differences, gender, age, ethnicity) and availability of centres for opiate substitution/methadone maintenance treatment (MMT);
- re-organising, decentralising and increasing the availability (from tertiary to primary level) of buprenorphine treatment for drug addiction;

- measures and activities for mandatory psychiatric treatment centres and specialised clinics for the treatment of drug addiction, not only pharmacological treatment (issuing opioid substitution treatment (OST));
- ensuring integrated access to healthcare and treatment for psychiatric co-morbidity;
- conducting research and analysis into the reasons for the increasing number of deaths from methadone overdose;
- conducting forensic analysis to estimate the high incidence of deaths from traffic accidents and possible use of psychoactive agents as a risk factor;
- measures to respond to the growing trend for using multiple psychoactive substances at the same time, including prescription drugs that contain psychoactive substances;
- preventing the diversion of chemicals that can be misused as precursors for the production of illegal drugs;
- legal interventions to provide a timely response to emerging trends in new psychoactive substances in EU countries;
- legal interventions to establish an early warning system for new drugs on the market, according to existing EU regulations;
- activities to strengthen the capacity of forensic analysis to determine the purity of and active ingredients in seized drugs;
- establishing a medical body to supervise the implementation of treatment (pharmacological and psychiatric) for people with drug addiction, which will also be responsible for educating medical staff. This body will be under the coordination of the IMCND;
- establishing a specialised body for overseeing the implementation of preventive activities in the area of drugs, under the coordination of the IMCND;
- activities to develop regional coordination bodies (units) in the area of drugs, locally, under the coordination of the IMCND, in accordance with article 9 of the Law on the Control of Narcotic Drugs and Psychotropic Substances.

The National Drugs Strategy is based on the principles of human rights, to ensure equal opportunities for all citizens and equal access to provision that is appropriate to their needs.

The greatest emphasis is given to the prevention of drug addiction and the creation of quality treatment programmes with mandatory psycho-therapeutic treatment and care. The Strategy is expected to: enhance capacity and risk analysis; ensure the maximum use of instruments designed to sharing intelligence; ensure participation in joint international investigation teams; strengthen border controls; and increase active participation in regional and international initiatives and platforms. It has also introduced procedures to prepare for the re-socialisation of prisoners with a drug addiction, and numerous other activities in general.

1.5. Economic issues

It is not possible to provide a comprehensive analysis of the expenditure on implementing the National Drugs Strategy and Action Plan, because particular measure holders (Ministries) have not specified the resources allocated to activities aimed at combating drugs abuse in their budget, but instead fund them through their regular activities.

It is important to note that the following activities, predominantly carried out by NGOs, are funded by the Global Fund: focused interventions, and integrated and community-oriented approaches to ensure sustainability of services and for the implementations of preventive interventions among most-at-risk populations, including injecting drug users (IDUs). The total funding was USD 8 537 039 ⁽⁴⁾ for the period 2012–14.

1.5.1. The Healthcare Programme for People with Addictions

Based on Article 16, paragraph 1, item 5 and paragraph 3 of the Law on Health Protection (Official Gazette of the Former Yugoslav Republic of Macedonia, no. 43/2012 and 145/2012), the Government adopts an annual Healthcare Programme for People with Addictions, and approves the treatment budget. According to the available data sources, there are 20 000 to 30 000 drug users, of which 6 000 to 8 000 are heroin addicts with serious health and social problems who are classed as problem drug users.

In 2012 the University Clinic of Toxicology, Skopje treated 140 people for opioid addiction with the generic product buprenorphine, funded by the Ministry of Health. Approximately 30 people were treated with buprenorphine in private health facilities; these patients were self-funded, and were not part of the State-funded programme of ‘free’ treatment.

The Healthcare Programme is intended for people who use drugs or are dependent on them. It offers widely available, efficient, flexible and individually tailored interventions that will improve drug users’ health and social functioning without stigmatisation. Treatment provided under the Healthcare Programme (including treatment in day hospitals, hospital treatment for 30–90 days, and treatment following a court order) is a combination of pharmacotherapy and psychotherapy, which is carried out following an assessment of the needs of the addict and his or her family. Social skills training to improve social functioning is a feature of the programme.

Ten different care packages (with different prices) are available for outpatient (day hospital) and inpatient (resident in hospital) care. The items in each care package vary, but may include: the psychiatric status of the patient; verbal intervention; history of drug taking and mental health issues (heteroanamnesis); observation (monitoring of patient to determine the correct therapy); preparing and issuing OST; supervision in drinking therapy; measurement of vital signs (pulse and blood pressure); a written report about the patient.

⁽⁴⁾ http://www.aidspace.org/country_grant/MKD-H-MOH

The care packages are delivered by teams made up of doctors, psychiatrists, nurses, psychologists and social workers. The cost of the packages does not include screening tests, medical materials, prescribed therapy, medications and laboratory tests, all of which incur additional charges.

In 2013 the Healthcare Programme provided funds for methadone treatment for 1 200 people and buprenorphine for 210 people. By 2013 the number of people who were provided with buprenorphine had significantly increased.

Any new services for the prevention and treatment of drug abuse that are started during the year will also be included in the Healthcare Programme.

FINANCING: The Healthcare Programme for People with Addictions is allocated an annual budget according to the approved budget of the country of MKD 55 000 000.00 (EUR 901 639.00), of which MKD 33 000 000.00 (EUR 540 983.00) is allocated to the purchase of methadone and buprenorphine by the Ministry of Health and MKD 22 000 000.00 (EUR 360 655.00) to contractual services that will be paid to public health facilities for the services they provide.

The organisations that provide methadone substitution therapy and buprenorphine therapy under the Healthcare Programme are: the University Clinic of Toxicology, Skopje; the Psychiatric Hospitals, Skopje; drug abuse treatment units within the hospitals in Tetovo, Veles, Kumanovo, Strumica, Shtip, Gevgelija, Ohrid, Bitola and Kavadarci; the remand prison 'Skopje'; and Idrizovo Prizon, Skopje.

MONITORING AND EVALUATION: The Ministry of Health carries out regular three-monthly checks on public health facilities that implement the Healthcare Programme. The facilities are evaluated in terms of whether their activities are carried out in accordance with the Programme's requirements, whether the treatment programmes have suitable controls in place, and whether appropriate medical documentation is maintained.

2. DRUG USE IN THE GENERAL POPULATION SURVEY (GPS)

To date, no specific survey has been conducted on drug use among the general population according to EU standards (Global Population Survey), due to a lack of funds.

2.1. Drug use in the school and youth population

2.1.1. The European School Survey Project on Alcohol and Other Drugs

The European School Survey Project on Alcohol and Other Drugs (ESPAD) is conducted with EU school pupils aged 15 to 16 every four years. The first survey was carried out in 1995. ESPAD has been conducted in the country in 1999, 2008, 2011 and 2012 (5).

In the 2011/2012 school year there were 114 schools, of which 11 were private, two were religious and four were special schools.

The 2012 ESPAD survey (6) was only conducted in the city of Skopje (city and rural area) with students in the first and second year (aged 16), so its findings are not representative of the national picture. There were 32 schools in Skopje in 2012, of which 20 were state schools. The survey was conducted in 20 schools, and a total of 2 238 students were surveyed.

The report draws on data from a total of 1 146 students born in 1996 (age 16 years). By comparison in 2012, according to the State Statistical Office, the total number of students aged 16 was 10 368. It will be important to compare the 2012 results with the next ESPAD study in 2016, because in 2012 secondary schools introduced the subject of Life Skills, which contains modules on the prevention of drug abuse.

According to the results of the 2012 survey, 6.6 % of respondents had taken sedatives prescribed by a doctor in the previous three weeks, and 2.5 % had taken them for more than three weeks. In addition, 4.5 % of students reported using sedatives that had not been prescribed by a doctor. Some 15.2 % said that it is very easy to obtain sedatives (if they want them, they are easily available). The 2008 ESPAD survey, conducted across the entire territory of the country, found that 10.1 % of students had taken tranquillizers or sedatives prescribed by the doctor in the previous three weeks.

The 2012 survey shows a decline in the use of marijuana compared with 2008. A total of 8.7 % reported having used marijuana in their lifetime, compared with 10.4 % in 2008. A total of 6.7 % had used marijuana in the last 12 months, while 3.9 % had used it in the last month.

Compared with 2008, in 2012 there has been some reduction in the use of ecstasy in the last year and last month. In 2012 some 3.75 % had used ecstasy in their lifetime, 1.6 % in

(5) S. Oncheva (1999, 2008), *Report ESPAD*, ESPAD (European School Survey Project on Alcohol and Other Drugs), CAN Institute.

(6) S. Oncheva et al. (2012), *ESPAD report, Skopje*, in cooperation with the Institute for Research on Alcohol and Drugs in School Population, Sweden, as reference the European Union Institute for CAN.

the last 12 months, and 0.96 % in the last month (in 2008 the figures were 3.2 %, 2.1 % and 1.6 % respectively).

A total of 2.18 % students in Skopje in 2012 reported having used inhalants in their lifetime, 1.5 % in the last year and 0.96 % in the last month. The reported use of other drugs was below 1 %, similar to the 2008 results. Regarding the results of Skopje 2008, there was a decline in use of amphetamine, LSD, heroin and alcohol taken with tablets.

With regard to how drugs are purchased, most pupils obtained them from an older brother or sister (7.7 %), followed by: an older friend (5.5 %); a friend of the same age or shared amongst a peer group (4.3 %); given to them by a stranger (4.1 %); purchased from a friend (3.3 %); purchased from a stranger (3.2 %).

When asked why they wanted to try drugs, 10.3 % said they wanted to feel high, 5.7 % were curious, 3 % wanted to be seen as belonging to a group, and 2.9 % wanted to forget their problems.

2.1.2. Health Behaviour in School-aged Children

The Health Behaviour in School-aged Children (HBSC) study is supported by the World Health Organization and represents a longitudinal cross-national study. Carried out every four years, the HBSC surveys children aged 11, 13 and 15 about their health, social protection and health behaviour.

HBSC includes 43 countries and regions in Europe and North America, processes more than 60 subjects and includes over 200 000 children and young people. HBSC focuses on understanding the health of young people in their social context — at home, at school, with family and friends — and is the most comprehensive picture of the health and well-being of young people. The HBSC survey has been conducted in the country on four occasions — in 2002, 2006, 2011 and 2013 ⁽⁷⁾.

The national HBSC study, published in 2013 ⁽⁸⁾, aimed to gain new insights and a better understanding of the behaviour of young people, in order to develop more effective policies and practices for improving their situation. The 2013 survey was conducted on a national sample of 3 897 subjects in 120 primary and secondary schools, selected according to the language used to teach the children (90 schools taught in national language, 30 schools taught in Albanian), with the support of municipal departments of education and public health, from all regions of the country. The survey found a low prevalence of cannabis use (4 % male, 2 % female) compared to the average prevalence across Europe and in other HBSC countries (20 % male, 15 % female), ranking these national data lowest among 39 countries.

Boys from non-Albanian classes (2.2 %) were more likely than boys from Albanian classes (1.3 %) to smoke marijuana regularly. However, there were more irregular users and experimenters in Albanian classes (1.7 %) than among the others (1.1 %).

⁽⁷⁾ C. Curri et al. (eds) (2012), *Social determinants of health and well-being among young people. Health Behaviour in School-aged Children (HBSC) study: international report from the 2009/2010 survey* (Health Policy for Children and Adolescents, No. 6), WHO Regional Office for Europe, Copenhagen.

⁽⁸⁾ L. Kostarova Unkovska et al. (2013), *Health as quality of life: social inequalities among young people in the country. Study on health-related behaviours among school-aged children (HBSC): Report 2013 Skopje*, Centre for Psychosocial and Crisis Action, Malinska, ISBN 978 9989 954443.

According to the analysis in the report, adolescents who began experimenting with drugs at a younger age were more likely to remain regular and heavy users. There were large differences in marijuana use between boys and girls, which could be explained by differences in the number and quality of social relations, as well as differences in dealing with problems. In addition, marijuana, tobacco and alcohol were perceived as status symbols by boys but not by girls. The absence of girls from the ethnic Albanian community as users of marijuana may be explained by the norms of traditional Muslim communities, in which young females are under constant supervision and have little involvement in decisions made about their lives and how they spend their free time; this gives them fewer opportunities to experiment with different behaviours. Social isolation and limited time spent away from home and with peers influence the behaviour Albanian girls. The findings that they increasingly smoke, but do not use alcohol and marijuana (unlike their peer group), can be explained by their wish to enjoy themselves despite their lack of opportunity to do so with other social groups.

Although the national prevalence of marijuana use is relatively low compared to other countries, there is some concern about the findings that students are increasingly using marijuana and it is increasingly more prevalent and more easily available in young people's immediate environment, including schools.

Table 2.1. Frequency of marijuana use among 15-year-olds, by gender and language taught in school.

	Pupils who learn in the National language		Pupils who learn in the Albanian language	
	Male (%)	Female (%)	Male (%)	Female (%)
Not a regular user	0.6	0.5	0.7	0.0
Experimenter	0.5	0.4	1.3	0.0
Regular user	2.2	0.7	1.3	0.0
Addict	0.6	0.2	0.0	0.0
Not tried	96.0	98.2	96.6	100

2.1.2.1. Single lifetime use of marijuana, but not in the last 12 months or 30 days

Gender: More boys (4 %) than girls (2 %) had tried marijuana at least once in their lifetime.

Ethnicity (by language): There were no significant ethnic differences in the percentage of boys who said they had tried marijuana at least once in their lifetime.

Family income: There was a significant association between prevalence of use of marijuana and family income. Boys from classes with higher-income families were more likely to use marijuana in comparison with girls, or with poorer children.

2.1.2.2. Marijuana use in the last 30 days: current users and demographic differences

Gender: More boys than girls had used marijuana in the last month (3 % of boys and 1 % of girls).

Ethnicity (by language): An equal proportion of boys in non-Albanian and Albanian classes reporting using marijuana at least once in the last 30 days. There was a difference between girls due to no Albanian speaking girls reporting marijuana use.

Family income: There was a significant association between prevalence of current users of marijuana among boys from non-Albanian classes and their family income, with boys from wealthy families more likely to have used marijuana in the past 30 days

2.1.3. Research conducted on negative childhood experiences: a representative sample of students from high schools and colleges (9)

Research on the impact of negative childhood experiences has been conducted by the Clinic of Psychiatry, Department for Children and Adolescent Psychiatry in Skopje, Ministry of Health and Ministry of Education, in cooperation with the World Health Organization, Regional Office for Europe.

This survey was undertaken with 1 277 students aged over 18 from a representative sample of high schools and universities. The findings show a high reported prevalence of physical abuse (21 %), emotional abuse (10.8 %), sexual abuse (12.7 %), physical neglect (20 %) and emotional neglect (30.6 %). Both genders were affected by sexual abuse, the rate of physical neglect was higher in males and the rate of emotional neglect was higher in females. Household dysfunction was also common: 10 % had witnessed violent treatment of their mother, 3.7 % lived with someone who abused drugs, 10.7 % lived with an alcoholic, 6.9 % had a household member with a mental illness, 5 % had a household member who had been incarcerated, and 3.8 % had experienced parental separation. Adverse childhood experiences were linked to health-risk behaviours. For example, emotional abuse doubled the likelihood of drug abuse, tripled the likelihood of attempting suicide, and increased the likelihood of early pregnancy 3.5 times. Physical abuse increased the likelihood of early pregnancy 8.3 times and doubled the likelihood of attempting suicide. There was a general trend that, as the number of adverse childhood experiences increased, so did health-risk behaviours, implying an association with longer-term poor health outcomes.

The research found that 5.3 % of the 1 277 respondents used one or more illicit drugs.

Table 2.2. Relationship between substance abuse and experience of household dysfunction.

First category of childhood exposure	N	Physical abuse	Emotional abuse	Sexual abuse	Physical neglect	Emotional neglect	Parental divorce	Mental illnesses	Mother treated violently	Imprisonment
Substance abuse	171	60 (35.1 %)	34 (19.9 %)	35 (20.5 %)	54 (31.6 %)	83 (48.5 %)	7 (4.1 %)	33 (19.3 %)	29 (17.0 %)	11 (6.4 %)

(9) M. Raleva (2013) *Survey of adverse childhood experiences among young people in the Former Yugoslav Republic of Macedonia*, World Health Organization, Geneva.

3. PREVENTION

The mid-term analysis of the implementation of the National Drugs Strategy and Action Plan (2006–12) found that addiction prevention programmes had been implemented in an ad hoc way, without systematic evaluation, and that they are still not scientifically based. Therefore the Department for Controlled Substances, Ministry of Health created the National Prevention Programme for Addiction, which was adopted by the IMCND and the Government in 2010. The primary goal of the Programme is to combat and prevent the onset of addiction and at-risk experimenting behaviour in children and young people. More specifically, the Programme analyses the situation and determines the needs for addiction prevention among children and young people, and builds an appropriate prevention system at the national level and as part of the wider prevention strategy. The Programme consists of addiction prevention sub-programmes for pre-school children and school pupils, children and young people within the social care system, and university students. In addition, the Programme pays special attention to the evaluation of prevention programmes, prescribes reporting criteria for prevention programmes at the national and local level, and prescribes criteria for projects and programmes for children and young people.

3.1. Universal prevention

3.1.1. School

3.1.1.1. Introduction of a new class programme in elementary and high school education

Following the adoption of the programme for prevention of drugs, the Bureau for the Development of Education, Ministry of Education and Science, made a systematic step towards the prevention of drug use among young people. A new lecturing programme was introduced as a regular class programme (Life Skills), with the objective of introducing healthy lifestyles in elementary education (for children aged 9 years), safe behaviour in the first years of elementary education, and, for the middle school classes, how to deal with peer pressure to take part in activities and behaviour such as smoking, drinking alcohol, taking some stimulants, etc., that can have a negative effect on their health. It is important to emphasise that the Programme suggests various techniques to inform the students, including life stories, letters from people with addiction, puzzles, quizzes, and class discussions⁽¹⁰⁾. Young people need to be educated about healthy behaviour and attitudes, and encouraged to use prevention measures. This new approach is youth-friendly, and encourages young people to talk to their parents or teachers about health and related issues, such as the prevention of HIV, pregnancy, drugs or other risk behaviours, rather than depending exclusively on information from their peer group and/or older siblings.

⁽¹⁰⁾ 'Life skills for high school students' worksheet, <http://bro.gov.mk>

These new developments in prevention programmes within the school system play a very important role in motivating pupils to choose healthy lifestyles, by organising appropriate leisure activities and developing self-esteem and social skills. They also offer advice to families and teachers about how to identify a possible problem at an early stage, and how to prevent drug use among pupils. Teachers and coordinators of school prevention programmes play an important role in implementing the prevention activities devised by the Bureau for the Development of Education, Ministry of Education and Science.

3.1.1.2. *'Stop the vice among the youth' project*

This prevention project is implemented by the Agency for Youth and Sports in most of the municipalities in the country, with the primary intention of encouraging young people to avoid negative situations, while helping them build healthy habits and good behaviour. The project has several aims: to raise awareness among students about how to protect themselves from and prevent negative behaviour; to educate and inform young people about the negative consequences arise from such behaviour; to improve young people's knowledge, ability and skills in recognising the signs and symptoms of adverse behaviour relating to drugs and alcohol; and to familiarise youngsters with useful and healthy habits and lifestyles. Within the overall project, 47 educational workshops were held.

Figure 3.1. The educational workshops project 'Stop the vice among the youth'.



The project has so far involved approximately 10 000 students in Skopje and other municipalities. The Agency for Youth and Sports has plans to continue to implement the project in other municipalities.

3.1.1.3. Establishing a school-based drug prevention programme in secondary schools, 2008–11

The school-based prevention programme was developed following an assessment of needs in secondary schools. It found that students, teachers and parents needed more information about drugs, and wanted to actively participate in school activities, including prevention programmes and mutual cooperation among them, that dealt with drug problems. The process of establishing a school-based drug prevention programme started in November 2008 as a joint project between the Healthy Options Project, Skopje and the Trimbos Institute, financially supported by the MATRA Programme of the Netherlands Ministry of Foreign Affairs. The main partners were the Ministry of Education and Science, the City of Skopje, the Municipalities of Strumica and Tetovo and three secondary schools.

The intention was for the project to contribute to the development of a school-based drug prevention programme, to reduce the level of risky and problematic drug use among young people and to raise public awareness about the unfavourable position and social exclusion of drug users. The project was implemented in the following way: local teams were established in Skopje, Strumica and Tetovo; a team of experts in school-based drug prevention was established, which provided six-weekly training for local teams; a set of information materials on cannabis and alcohol was developed. The programme was approved by the school councils and the city/municipalities councils as a part of the yearly school programme for 2009/2010 and 2010/2011, in the three pilot schools. As part of the project, a multi-disciplinary expert group was established to support implementation dissemination in other schools. Training in early detection was carried out with representatives from schools and treatment centres. In total, 4 157 students were covered by the training. As a result of the project, school protocols were developed and approved that defined the roles and responsibilities of the members of the school community in relation to alcohol/cannabis use in the pilot schools. In the last phase of the project (finalisation and dissemination), the Ministry of Education and Science and the Bureau for Development of Education recommended that the school-based drug prevention programme (including its materials, trainings etc.) should be integrated into Life Skills education (Dimovska 2014).

3.1.2. Community

Addiction prevention programmes are conducted at the level of municipalities, in which Local Bodies for Combating Drugs Abuse are established, which are based on the work of experts from the fields of education, social welfare, healthcare, NGOs, local administration offices and other relevant institutions that actively participate in combating drug use.

Prevention programmes at the local level are usually oriented towards the general population, but also include intensive work with children and young people who present a risk of addiction due to their social and family conditions. Experience has shown that the most effective prevention programmes are those conducted in cooperation with educational institutions, health and social services, media and the local community.

3.1.2.1. The first counselling centre for the prevention of drug abuse: We Want to Know

The first counselling centre for the prevention of drug abuse among secondary education pupils was opened in the city of Skopje. This youth centre, We Want to Know, aims to make young people who attend feel more secure, comfortable and relaxed. Following the centre's opening, the first aim in terms of primary prevention within the local strategy was 'to strengthen the programmes for the prevention of the abuse of drugs among the youth and to increase the degree of knowledge about drugs among professionals and the parents to work with young people on the prevention of addiction'. The primary aim of the project is to give young people, particularly the high school population, easier access to information and to provide consultations on drug prevention and how to deal with problems arising from drug use. It aims to build the capacity of professional services in schools to work with young people, and provides continuous professional support and resources for the prevention of drug use and early detection. It also supports education in high schools through the creation and implementation of local action plans in the schools, and aims to increase access for young people and their parents to high-security, anonymous consultations with experts. The project uses networking and coordination among high schools and counselling centres, through which they have daily communication with professional services and access to urgent interventions. The opening of the first counselling centre was supported by local governments, young people and their parents on all issues relating to drug use.

The service presents a model of adolescent-friendly provision that fully respects the confidentiality, anonymity and privacy of the client. Young people want access to counselling for personal problem and may have issues and problems with drug abuse, but they do not want to be labelled as 'drug users'. Guaranteeing privacy and anonymity prevents this from occurring.

The We Want to Know counselling centre is open two days per week. The target group includes young people aged 10–24 (both drug users and non-drug users), parents, close family members, and people who work closely with young people and have an impact on their development — such as teaching staff and those providing professional services in high schools (psychologists and counsellors).

The centre hires qualified psychologists and counsellors who are trained to work with young people and who have a non-judgemental attitude, tolerance and respect for differences.

3.2. Selective prevention in at-risk groups and settings

Selective prevention is targeted at a specific sub-population with considerably higher than average future and/or life risks for disorders. This makes it important to identify the risk factors for the onset and development of substance use, especially among young people.

3.2.1. SOS Drugs Helpline

The SOS Drugs Helpline is provided by the Association of Social Workers of Skopje as a permanent service for all citizens. By calling the free number 0800 11 444 citizens can obtain information on different types of drugs, their effects, the consequences of their use, treatment institutions at home and abroad, and information about human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) and sexually transmitted infections, and they can also arrange a free counselling session with a professional.

The primary task of the SOS Drugs Helpline is to develop and promote the prevention of drug use, and to assist individuals, families and friends of those who already have a problem with drug use. The expert team, who have extensive professional experience in the drugs problems, receive ongoing education about tackling drug use and providing telephone assistance. According to statistical analysis of the line's operation, between 2003 and 2014 the SOS Drugs Helpline received calls from 3 278 citizens who asked over 12 093 questions, most of whom were parents seeking advice for their children. An alarming fact to emerge from the Helpline is that the age of juvenile drug abusers has fallen, and many are in trouble with the law. A significant number of calls are from young people seeking information about the consequences of use of various drugs and about treatment institutions. The most frequent requests for information are how to recognise whether a person uses drugs, what treatment institutions are available, information on different types of drugs and information on HIV/AIDS infections. The Helpline receives calls from every city in the country, not just Skopje.

3.3. Indicated prevention

Indicated prevention attempts to identify individuals who have high individual risk factors for drug abuse development in their future life or who already show early signs of substance use.

Programmes for indicated prevention have been substantially scaled up in the past years through the Global Fund. The programmes target IDUs, the most at risk population,

including prisoners. Ten stationary voluntary confidential counselling and testing (VCCT) centres and two outreach VCCT mobile units operate in different regions of the country.

The two outreach mobile units are operated by the NGO HERA, which has successfully established productive and coordinated collaboration between Governmental institutions and the civil society sector. The outreach programme includes all NGOs working with different target populations (men who have sex with men, commercial sex workers, IDUs, Roma, prisoners, students in dormitories, and the general population) and the Institute for Public Health. The outreach activities are tailored to the needs and confidentiality of the specific population by employing 'gatekeeper' representatives from the target group. The aim of this approach is that hard-to-reach populations are more likely to trust the representatives if they have something in common with them.

Following the establishment of one additional outreach VCCT service, which operates throughout the country, there has been an increase in coverage. An additional achievement is the daily collaboration between the different NGOs and health workers, which has practically developed into a partnership network, and can be used as model for future activities.

4. PROBLEM DRUG USE

The EMCDDA defines problem drug use (PDU) as injecting drug use or long-term/regular use of opiates, cocaine and/or amphetamines. This definition specifically includes regular or long-term use of opioids such as methadone, but does not include rare or irregular use, or ecstasy and cannabis use.

In 2010 various methods (expert opinions, inventory, methods of recording and re-recording the condition, as well as methods multipliers) were used to estimate the prevalence of injecting drug use in five cities, including Skopje.

Extrapolation of the results from the IDU population in Skopje (representing approximately 25 % of the total population) to the country as a whole suggested that there were 10 200 intravenous drug users in the country.

The National Monitoring Centre for Drugs and Drug Addiction, Sector for Controlled Substances, has estimated the number of problem drug users, mainly opiate users (multiplier method based on treatment programmes and needle and syringe exchange programmes, contact with police and drug-related deaths). The estimate suggests that there are around 8 000 heroin IDUs. This figure corresponds to a rate of 1.5 users per 1 000 inhabitants aged 15–64 ⁽¹¹⁾.

4.1. Improving the quality of drug dependence treatment programmes in Skopje ⁽¹²⁾

This report is based on two interrelated studies that indicate the need for improving the quality of treatment programmes for drug addiction in Skopje, funded from the national budget. The first study was an analysis of the laws and other legal documents governing the treatment of drug addicts. The second study is actually community-based monitoring by people treated for drug dependence, and it provides insight into the manner in which the legal provisions for the treatment of drug addicts are carried out in practice in Skopje.

This report is the result of an initiative to improve the quality of drug dependence programmes, undertaken by the NGO Health Options Project Skopje (HOPS), and the coalition Sexual and Health Rights of Marginalised Communities.

The fieldwork was carried out using the methodology known as ‘community-based monitoring’. The method used — the inclusion of the community in all the phases of the project’s development — is new. A key element of this methodology is that representation is based on the results of research carried out to identify the position of the wider

⁽¹¹⁾ Calculated according to the method of natural family planning, which used 1 387 796 844 as the number of people aged 15–64 (average population (x 1.000), in 2010 was 2 055, of which 67.8 % were aged 15–64 years) (Central Intelligence Agency, 2011).

⁽¹²⁾ V. Dimitrievski and N. Boskova (2012), *Improving the quality of the programmes for curing drug addiction in Skopje: assessment of the quality of drug dependence treatment programmes with a community based monitoring by persons treated for drug dependence*, HOPS Healthy Options Project, Skopje, Coalition ‘Sexual and health rights of marginalised communities’.

stakeholder community. Community-based monitoring is the assessment of the attitudes of the relevant community regarding some circumstances of importance to that community. The monitoring is performed for a limited time, and the results are then presented to competent organisations/institutions with a request for improvement in the conditions of the community⁽¹³⁾.

The legal documents analysis explored the advantages of and barriers to improving the quality of drug dependence treatment programmes in Skopje. This analysis was done using the results of previously performed fieldwork research (quantitative and qualitative, community-based) carried out by individuals treated for drug dependence in Skopje.

The fieldwork research included the Centre for the Prevention and Treatment of Drug Abuse in Kisela Voda, including the Unit within the Public Health Institution (PHI) University Clinics, Skopje, under the control of this Centre, and the PHI University Clinic for Toxicology, Skopje, because all these programmes are financed by the country's budget and as such it was felt that they should be subject to civil monitoring.

The comparison of the legal documents analysis and the results of the fieldwork research provide a deeper insight into the application of the legislation.

It should be borne in mind that the quality of drug dependence treatments in this document is viewed solely from the perspective of patients of drug dependence treatment programmes, and not from the perspective of programme staff, and that this document was produced with the intention of assisting in negotiations between drug users on one side, and policy creators and implementers on the other, to improve the quality of drug dependence treatment programmes in Skopje. All the programmes that were analysed are financed, fully or partially, with funds from the national budget.

This document demonstrates the need to respect the legal provisions that guarantee equal healthcare to all citizens, and consequently to improve the quality of drug dependence treatment programmes in Skopje, based on the needs of people treated for dependence in the programmes covered by the monitoring.

Community-based monitoring is an essential component of engaging the community as a whole in the assessment and supervision of services being delivered through the Government mechanism. Its objectives are: to raise the awareness level of the community about the available Government health services; to encourage community participation in monitoring Government health services; to ensure accountability among the service providers to provide the stipulated quality service; to identify gaps in the delivery of quality health services.

The community-based monitoring fieldwork was composed of two parts, quantitative and qualitative. The quantitative part was performed via three separate surveys, using citizen report cards (CRC), compliant with community-based monitoring methodology⁽¹⁴⁾.

The monitoring is performed for a limited time, and the results are then presented to competent organisations/institutions with a request for improvement of the conditions of the community⁽¹⁵⁾.

As can be seen in Table 4.1, which shows the research sample per treatment programmes included in the CRCs, a total of 182 interviewees were covered with the CRCs,

⁽¹³⁾ V. Gofman (2010), *Community based monitoring: handbook report no. 21*, August, ISBN 978-9979-9778-4-1.

⁽¹⁴⁾ ADB and PAC, 2007.

⁽¹⁵⁾ Official Gazette of the Former Yugoslav Republic of Macedonia, 8/12, Programme for Healthcare of Persons with Substance Use Disorders in the Former Yugoslav Republic of Macedonia for 2012.

of which 33.52 % (n=61) used CRC1, 34.07 % (n=62) used CRC2, and 32.42 % (n=59) used CRC3.

Table 4.1. Number of interviewees per treatment programme covered by CRCs.

	TOTAL				CRC1				CRC2				CRC3			
	182		100%		61		33,52%		62		34,07%		59		32,42%	
	Male		Female		Male		Female		Male		Female		Male		Female	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Methadone: low threshold	50	27,5%	5	2,7%	20	32,8%	1	1,6%	15	24,2%	2	3,2%	15	25,4%	2	3,4%
Methadone: high threshold	39	21,4%	11	6,0%	11	18,0%	4	6,6%	14	22,6%	4	6,5%	14	23,7%	3	5,1%
Methadone: clinical centre	32	17,6%	12	6,6%	10	16,4%	5	8,2%	12	19,4%	4	6,5%	10	16,9%	3	5,1%
Buprenorphine: Toxicology	27	14,8%	6	3,3%	8	13,1%	2	3,3%	8	12,9%	3	4,8%	11	18,6%	1	1,7%
Total	148	81,3%	34	18,7%	49	80,3%	12	19,7%	49	79,0%	13	21,0%	50	84,7%	9	15,3%

Complementary to the quantitative research, a short qualitative study was carried out that produced a total of 17 research units, of which 12 were in-depth interviews and five were focus group discussions.

Conclusions

- The right to treatment falls within the group of economic, social and cultural human rights, as opposed to political and civil rights⁽¹⁶⁾, but the right to treatment should not be deemed a separate right, because it is closely connected to other rights, which further emphasises the inter-connection and inseparability of human rights⁽¹⁷⁾.
- The right to treatment is a constitutional right, guaranteed with the Constitution⁽¹⁸⁾, and is regulated by the Law on Health Protection, which also guarantees timely and effective treatment and rehabilitation by applying expertise, medical measures, activities and procedures to everyone⁽¹⁹⁾. One of the basic principles of the Law on the Protection of Patients' Rights is the accessibility to health services for all patients equally, without discrimination⁽²⁰⁾.
- The drug dependence treatment programmes in Skopje are intended, above all, to treat opiate/opioid dependent adults. There are no programmes adapted to the treatment of opiate/opioid dependent minors, especially not for individuals below

⁽¹⁶⁾ Kluwer Law International (2011), *Economic, social and cultural rights*, Kluwer Law International, Alphen aan den Rijn.

⁽¹⁷⁾ United Nations (1993) *United Nations World Conference on Human Rights, Vienna Declaration and Programme of Action*, UN doc. A/CONF.157/23, 12 July 1993, Part I, United Nations, Geneva.

⁽¹⁸⁾ Official Gazette of the Former Yugoslav Republic of Macedonia, no. 52/1991, Constitution of the Republic of Macedonia, article 39.

⁽¹⁹⁾ Official Gazette of the Former Yugoslav Republic of Macedonia, no. 38/1991, 46/1993, 55/1995, 10/2004, 84/2005, 111/2005, 65/2006, 5/2007, 77/2008, 67/2009, 88/2010, 44/2011 and 53/2011, Law on Health Protection, articles 2 and 3.

⁽²⁰⁾ Official Gazette of the Former Yugoslav Republic of Macedonia, no. 82/08 и 53/2011, Law on Protection of Patients' Rights, article 3 paragraph 3 line 1.

the age of 16. There are no programmes for the treatment of drug dependent people who do not fall into the group of opiates/opioid drugs funded by the country's budget.

- ❏ Opportunities for access to drug dependence treatment programmes are limited, especially because the programmes' opening hours are often incompatible with the habits and needs of patients, but also because treatment programmes can be a long way away from patients' homes, which creates additional costs for transport. Also, pharmacological therapy is often carried out in locations that do not allow for sufficient confidentiality, which creates the potential for the identity of the patients to be revealed to the wider community.

- ❏ During buprenorphine substitution therapy, the pharmacological therapy is free of charge in the period of induction, which lasts from seven to 10 days, when the patient pays hospital charges. Further into the treatment, from the following month to three months, patients buy buprenorphine with their own funds, with a prescription, and if they do not relapse, after the expiry of this period, the pharmacological therapy becomes free.

- ❏ Patients are not sufficiently familiar with their own rights and obligations when in drug dependence treatment programme, because they do not listen carefully to the compulsory explanations they are provided with at the start of the treatment, but also because they do not receive a copy of the therapy contract that they must sign to enter the programme.

- ❏ Activities for psychosocial support, working therapy and creative expression are insufficient or non-existent, although they would offer opportunities for the re-socialisation of patients, and there is a need for such activities.

- ❏ In the drug dependence treatment programmes in Skopje there is no discrimination on the basis of ethnical, religious, racial or political grounds, but certain patients are privileged because of personal or family acquaintances and contacts with employees of the programmes.

- ❏ There is no special provision for the treatment of dependence among pregnant women and minors, despite the fact that their treatment was proposed in the National Drugs Strategy (2006–12).

5. DRUG-RELATED TREATMENT: DEMAND AND AVAILABILITY

5.1. Introduction: the general concept of collecting treatment data at the European level

According to the EMCDDA's understanding of drug treatment, information on the number of people entering treatment for a drug problem provides insight into general trends and characteristics of problem drug use; it also offers an indirect perspective on the organisation and uptake of treatment facilities.

Routine data collection is already established and implemented in many European countries following an established European protocol (the treatment demand indicator (TDI) protocol). This protocol provides a uniform structure for reporting on the number and characteristics of clients referred to drug treatment facilities and is based on various items concerning the type of treatment provided and the characteristics of clients: socio-demographic data and drugs information.

The objective of the TDI is to increase the comparability of data between countries by harmonising national operational definitions. The collection system classifies clients by primary and secondary drugs used, where the primary drug is the drug reported as the one that causes the client the most problems, while the secondary drugs are those taken in addition to the primary drug (at the same time or at a different time).

The history of drug treatment and treatment monitoring in the Former Yugoslav Republic of Macedonia

The treatment of drug dependent users dates back to the late 1970s and early 1980s, with the introduction of substitution treatment (methadone). Until the first National Drugs Strategy was adopted, this type of treatment was centralised.

In the course of 2006, in the framework of the programme for Building a Coordinative Response to HIV/AIDS Prevention (supported by the Global Fund), the Ministry of Health opened 10 new services for the treatment and harm reduction of drug abuse, including MMT, in nine cities ⁽²¹⁾, and one in the main prison in Skopje.

These services are supported by the Ministry of Health, Ministry of Labour and Social Policy, the Centre for Social Work, the local community and NGOs. This development has created the foundations for improved service coverage, therapeutic services availability and strengthening of institutional capacities. Furthermore, it enabled larger numbers of professionals to be hired, effectively working in multidisciplinary teams at the regional level. In addition, a new model for continuous monitoring and technical support to answer the needs of the target group could be initiated at the same time.

In the framework of the implementation of the National Drugs Strategy (2006–12), further decentralisation and expansion of the network of services for treatment and harm

⁽²¹⁾ Strumica, Kumanovo, Stip, Ohrid, Gevgelija, Bitola, Veles, Kavadarci and Tetovo.

reduction of drug abuse, including MMT, took place with the opening of two additional centres in Skopje, and two more in prison facilities, one in the city of Bitola and another in the remand (pre-trial) prison Skopje, in Skopje.

Treatment options were further expanded with the introduction of buprenorphine in 2009. The only institution currently offering treatment with buprenorphine is the University Clinic of Toxicology, Mother Teresa Clinical Centre, Skopje. Buprenorphine is used for detoxification and substitution treatment.

Methodological framework of data collection

Data on inpatient and outpatient facilities providing treatment for drug users are collected following this general definition of the TDI at the European level. The TDI is widely recognised as an instrument for collecting information on people entering treatment for drug use. Data collection follows the most recent protocol of the TDI (TDI 3.0), which was formally adopted by the EMCDDA in 2012. However, up to now, information has almost exclusively been available on users of opiates (i.e. heroin) in substitution treatment.

Reporting at the national level is based on aggregated information from 20 treatment centres (including substitution centres, private clinics and treatment facilities in prisons). A structure to collect individual data at the national level did exist in the past (embedded into the system of national health statistics). Although, currently, no electronic system exists to continue this detailed data collection, treatment centres are prepared and willing to cooperate in a future system.

In addition to users who start a treatment for their drug use in the reporting year, there is a large group of people who stay in treatment for a long period of time due to the chronic or long-term nature of their addiction ⁽²²⁾.

Aside from the current limitation (the focus on substitution treatment), the monitoring system is set up and able to provide harmonised and comparable data with national coverage. Information is available for all clients in treatment at the beginning of the year and starting treatment during the year. This report covers data from 2012 (12 months) and the first half of 2013 (six months).

Information provided in this report is based on two data sources:

- Estimates for the total number of clients in treatment are based on information collected by the Healthcare Programme for People with Addictions in 2012 and 2013 ⁽²³⁾. This data source only includes information on the total number of clients and their respective diagnoses (and some administrative information).
- Detailed reporting on the characteristics of users is almost exclusively based on (paper-based) TDI questionnaires sent out by the NFP. Between May and July 2013 the NFP contacted every institution providing treatment for drug users.

⁽²²⁾ EMCDDA, www.emcdda.europa.eu

⁽²³⁾ Government of the Former Yugoslav Republic of Macedonia, Programme for Healthcare of Persons with Substance Use Disorders in the Former Yugoslav Republic of Macedonia for 2012 and 2013, Official Gazette of the Former Yugoslav Republic of Macedonia, no. 4/2013.

5.2. Strategy/policy

Even though marijuana is the most abused drug, heroin is of greater concern in the illegal drugs field because of users' high-risk behaviour (i.e. the danger of spreading of a number of blood-borne and sexually transmitted infections, primarily those caused by HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV) in cases of intravenous abuse), and the associated high risk of a fatal outcome.

Notwithstanding this alarming situation, the treatment of these serious and complex socio-medical phenomena was in recent years mostly left to medical institutions, primarily psychiatric ones, and financed by health insurance, yielding modest results in conditions of total absence of support from the other necessary systems.

Within the implementation of the National Drugs Strategy 2006–12, a system of care that includes outpatient treatment, hospital treatment, detoxification and substitution treatment was developed. The therapeutic programmes are an integrated part of the public health model and are continuously monitored and evaluated.

The second National Drugs Strategy (2014–20) is in the process of preparation. It is expected that this strategy will address the need for counselling services and treatment for other types of addictive controlled substances like marijuana, stimulants and new psychoactive substances, and will improve the quality of the treatment system.

National laws connected with the care and treatment of drug addictions are:

- Law on the Control of Narcotic Drugs and Psychotropic Substances ⁽²⁴⁾;
- Law on Protection of Patients' Rights ⁽²⁵⁾;
- Law on Health Protection ⁽²⁶⁾;
- Law on Health Insurance ⁽²⁷⁾.

In 2012 two new guidelines were adopted: the Guidelines on Providing Healthcare when Administering Methadone for Opiate Dependence Treatment; and the Guidelines for Healthcare Related to Children with Neonatal Withdrawal Syndrome.

⁽²⁴⁾ Official Gazette of the Former Yugoslav Republic of Macedonia, no. 103/2008, Law on the Control of Narcotic Drugs and Psychotropic Substances.

⁽²⁵⁾ Official Gazette of the Former Yugoslav Republic of Macedonia, no. 82/08 and 53/2011, Law on Protection of Patients' Rights.

⁽²⁶⁾ Official Gazette of the Former Yugoslav Republic of Macedonia, no. 43 from 29 March 2012, Law on Health Protection.

⁽²⁷⁾ Official Gazette of the Former Yugoslav Republic of Macedonia, no. 19/2011, Law on Health Insurance.

5.2.1. Guidelines on Providing Healthcare when Administering Methadone for Opiate Dependence Treatment ⁽²⁸⁾

These Guidelines, adopted in 2012, include information not only about pharmacological treatment but also the need for psychological and social interventions.

The Guidelines provide a broad overview of the basic principles of OST, which are mainly oriented along the NIDA principles of treatment and WHO guidelines for provision of OST. They also contain a substantial amount of background information on the interaction of methadone with other substances and information about different treatment regimes. The key elements are: concrete suggestions for medical examinations; criteria for inclusion on the methadone programme; therapeutic plan and purpose; and other practical issues, including dosages and treatment schemes of how OST should be carried out.

5.2.2. Guideline on Providing Healthcare when Administering Methadone for Opiate Dependence Treatment ⁽²⁹⁾

Neonatal abstinence syndrome (NAS) is a group of problems that occur in a newborn baby who was exposed to addictive illegal or prescription drugs while in the mother's womb. Babies of mothers who drink during pregnancy may have a similar condition ⁽³⁰⁾.

These guidelines, adopted in 2012, contain all the necessary information and recommendations of how the medical system should deal with children (and their mothers) exposed to substance use during pregnancy.

5.3. The treatment system

As mentioned above, the National Drugs Strategy 2006–12 addressed for the first time the need for a multi-faceted approach to treating drug users, including outpatient treatment, detoxification and OST.

In accordance with the Law for Health Protection, the Centres for the Treatment and Harm Reduction of Drug Addiction should be part of the hospitals, with a minimum staff of one medical doctor (GP), one psychiatrist and one nurse, but these are only available in large hospitals. Drug treatment is available within the framework of the public health national service network, making the public sector the leading actor in drug-related medically assisted treatment. The main funder of drug-related treatment is the Ministry of Health, because this drug treatment is also available for people without social insurance. There are few private psychiatric clinics that treat drug addicts, and the funds for the treatment are partially or entirely provided by the patients. The professionals engaged in

⁽²⁸⁾ Official Gazette of the Former Yugoslav Republic of Macedonia, no. 36/2012, Guideline on Providing Healthcare when Administering Methadone for Opiate Dependence Treatment.

⁽²⁹⁾ Official Gazette of the Republic of Macedonia, no. 36/2012, Guideline on Providing Healthcare when Administering Methadone for Opiate Dependence Treatment.

⁽³⁰⁾ Jansson LM, Velez M. Neonatal abstinence syndrome. *Curr Opin Pediatr.* 2012 Jan 5. [Epub ahead of print]

treatment are psychiatrists, general practitioners (GPs), nurses, pharmacists, social workers and psychologists. There is no specialty in addiction medicine.

The majority of drug users receiving treatment are outpatients, receiving substitution treatment, psychosocial interventions, individual or group counselling and psychosocial therapy. However, it remains unclear to what extent other interventions apart from pharmacological treatment are available.

Treatment is available in three social care centres, 10 centres and three in prison settings for the treatment of drug users (MMT), one therapeutic community, two hospitals and one hospital with capacity for detoxification. Methadone was introduced as a drug substitute in 1992, and it remains the main substance prescribed for substitution treatment. Buprenorphine, introduced in 2009, is used for detoxification and substitution treatment. Nearly 1 250 drug users are involved in programmes for MMT and receive methadone daily or weekly. The Government adopts the programme each year as part of its healthcare provision for people with addiction.

5.3.1. The characteristics of treated clients

5.3.1.1. Patients in MMT in public health facilities in 2013

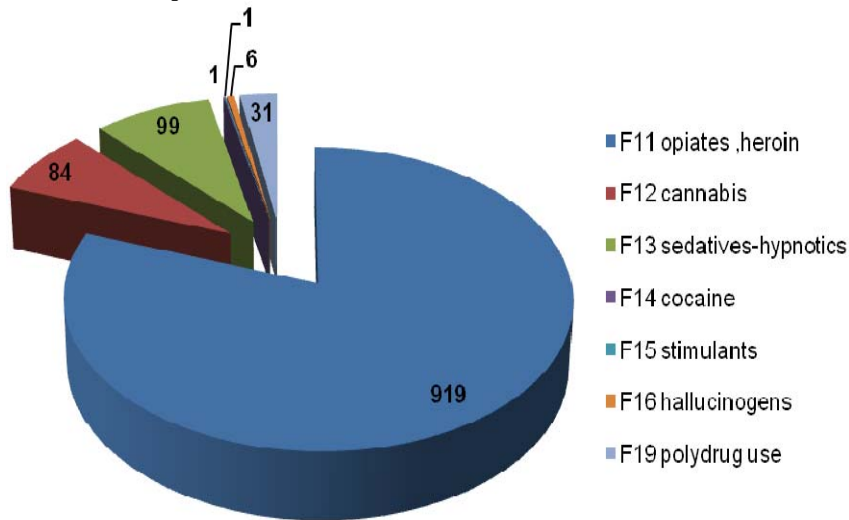
Table 5.1. Number of patients in treatment facilities for F11.2 in 2013.

Drugs category (secondary drug)	2013															TOTAL
	15-19			20-34			35-44			45-54			55-64			
	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	
F11 opiates ,heroin	1		1	542	70	612	248	20	268	35	1	36	2		2	919
F12 cannabis	2		2	49	8	57	25		25							84
F13 sedatives- hypnotics				59	10	69	29		29		1	1				99
F14 cocaine										1		1				1
F15 stimulants				1		1										1
F16 hallucinogens				3		3	2	1	3							6
F19 polydrug use				14	1	15	11	1	12	3		3	1		1	31
Total	3		3	668	89	757	315	22	337	39	2	38	3	0	3	1 141

There were 1 141 patients in treatment facilities under ICD-10 code F11.2 ⁽³¹⁾ in 2013. All were opiate addicts on MMT, but they use cannabis, benzodiazepines, etc. as a secondary drug.

⁽³¹⁾ ICD-10 – International Classification of Diseases, F11.2 – Drug dependence (opiates).

Figure 5.1 Number of patients in treatment facilities for F11.2 in 2013.



Source: Centres for Public Health

5.3.1.2. Pharmacologically assisted treatment: patients on opioid substitution treatment ⁽³²⁾

Another source of information in addition to routine data collection comes from a recent study published by Petrushevska et al. (2014) exploring the characteristics of OST clients. The aim of the quantitative analytical cross-sectional study, which was conducted between September and December 2013, was to analyse national data from OST medical records and to compare it with data from EU countries.

Medical records were analysed for all patients on OST at the national level during 2012. Data for OST patients on MMT were obtained from all 13 public treatment facilities located in 10 cities, three private centres in the capital of Skopje and three prisons. Data for OST patients on buprenorphine were obtained from the Clinic for Toxicology, Mother Teresa Clinical Centre, St Cyril and Methodius University in Skopje.

The data collected in the country was compared with data from 10 EU countries (Austria, Denmark, France, Germany, Greece, Italy, Norway, Portugal, Sweden and the United Kingdom). The survey was based on the items defined in the TDI Protocol 3.0 from the EMCDDA ⁽³³⁾.

National legislation set up inclusion criteria for MMT of 18 year of age and above. In special circumstances, younger people can be included in MMT. In the period analysed, five people were receiving treatment in the age category 15–19, of which one received treatment in a public centre, one in a private centre and three in prisons. This brings the

⁽³²⁾ T, Petrushevska, V.V. Stefanovska (2014), 'Patients on opioid substitution treatment in the Former Yugoslav Republic of Macedonia: what do treatment demand data tell us?' *Macedonian Journal of Medical Science*, manuscript ID MJMS-2014-0575.

⁽³³⁾ EMCDDA (2012), *Treatment demand indicator (TDI) standard protocol 3.0. Guidelines for reporting data on people entering drug treatment in European countries*, EMCDDA, Lisbon, ISBN 978-92-9168-507-3, doi:10.2810/5285.

total number of OST patients to 1 671. Data for the five minors have been excluded from the analyses. The total number of OST patients in all available opioid substitution treatment facilities was 1 857, of which 10 % were on buprenorphine and 90 % were on methadone. Of this total, 1 355 were receiving OST (MMT and buprenorphine) in public centres. Buprenorphine is still exclusively provided in the University Clinic of Toxicology, at the tertiary healthcare level.

The ratio of male to female heroin clients was 11:1, or 162 female clients (9 %). While only 10 % of OST clients were treated with buprenorphine, 90 % were on methadone; 130 (80 %) received MMT in public centres. Of all OST patients, 54 % on MMT and 65 % on buprenorphine were aged 20–34.

Table 5.2. OST patients on MMT.

		20-34			35-40			41-55			Total	%
		M	F	Total	M	F	Total	M	F	Total		
Public centres	N	510	63	573	353	50	403	176	17	193	1 169	70 %
	%	43.6	5.4	49	30	4	34.5	15	1.5	16.5	100 %	
Private centres	N	94	15	109	15	3	18	11	2	13	140	8.4 %
	%	67	11	77	11	2	13	8	1.4	9	100 %	
Prisons	N	207	12	219	116	0	116	22	0	22	357	22 %
	%	57.9	3	61	32	0	32	6	0	6	100 %	
TOTAL	N	811	90	901	484	53	537	209	19	228	1666	100 %
	%	48	5.3	54	29	3	32	12	1	14	100 %	

Source (T.Petrushevska, ID is MJMS-2014-0575.2014)

Table 5.3. Patients receiving OST with buprenorphine maintenance.

		Age									TOTAL
Ethnicity		20-34			35-40			41-55			
		M	F	Total	M	F	Total	M	F	Total	
National	N	71	17	88	34	0	34	14	0	14	136
	%	52	12.5	65	25	0	25	10	0	10	73
Albanian	N	30	0	30	13	0	13	4	0	4	47
	%	64	0	64	28	0	28	8.5	0	8.5	25
Roma	N	2	0	2	1	0	1	0	0	0	3
	%	67	0	67	33	0	33	0	0	0	1.6
TOTAL	N	103	17	120	14	0	48	18	0	18	186
	%	55	9	65	8	0	26	10	0	10	100 %

In 10 of 12 cities, the largest group of OST patients were aged 20–34.

It was evident that very young people were heroin addicts and were already receiving MMT. It was found that patients currently on drug treatment started injecting heroin between the ages of 14–22, and the average age of first heroin use was 18.

Analysis of level of education showed that: 105 patients (9 %) were without basic education; 368 (31 %) were educated to the primary level; 686 (59 %) were educated to the secondary level (high school); and 11 (1 %) had received higher education.

Living status data analysis of 1 314 OST patients (except OST patients from three prisons) showed that: 57 (4.3 %) lived alone; 854 (65 %) lived with family; 326 (24.8 %)

lived with a partner; 13 (1 %) lived with friends; 4 (0.3 %) lived in an institution (not detention); 60 (4.6 %) were in prison. A total of 83 % (1 090) of the patients had a permanent residence.

Patients in public OST who had children: 487 patients (36 %) had children; 337 patients (69 %) were living with their children; 150 patients (31 %) were not living with their children; 868 patients (58.3 %) had no children.

Labour status of patients on OST in public health institutions: 188 (14 %) had a part-time job; 157 (12 %) had permanent employment; 10 (1 %) were students; 860 (63.4 %) were not in employment; 141 (10 %) were receiving social support.

5.3.1.3. Treatment in prisons

The study by Petrushevska et al. also contains information on OST treatment in prisons. They found that all OST patients on MMT in prison were from three prisons: 190 OST patients (65 % of a total number of 290 prisoners) were in the remand (pre-trial) prison 'Skopje'; 139 (11 % of 1 306 prisoners) were in Idrizovo Prison, Skopje; and 38 were in Bitola Prison (56 % of 69 prisoners). There are three MMT centres in prisons: in the pre-trial prison 'Skopje', in the regular Idrizovo Prison, Skopje and in Bitola Prison.

Other prisoners (N=57) were receiving MMT from community treatment centres. The programmes that provided prisoners in prison with OST also arranged their transfer to appropriate community treatment centres following release. The total number of prisoners in OST was 420. In terms of ethnicity, in all treatment facilities with MMT, 66.6 % were nationals, 24 % were Albanian, 6 % were Roma and 3.6 % were classed as 'other'.

Use of benzodiazepines as secondary drugs

All public MMT centres recorded benzodiazepines (BZD) use, except one MMT centre in Skopje, and one that is collecting partial medical data for BZD. Analysis of public MMT facilities refers to 831 patients, of which 608 use BZD (73 %).

Table 5.4. Patients receiving OST with diagnosed benzodiazepines use (ICD-10, F13).

		Age									TOTAL	Total No. OST patients
		20-34			35-40			41-55				
		M	F	Total	M	F	Total	M	F	Total		
PUBLIC OST	N	289	22	311	205	13	218	72	7	79	608	831
	%	47	4	51	34	2	36	12	1	13	100	73
PRIVATE OST	N	76	11	87	13	3	16	7	2	9	113	141
	%	67	10	77	11.5	3	14	6	1.7	8	100	80
TOTAL	N	365	33	398	218	16	234	79	9	88	720	972
	%	51	4.5	55	30	2	32.5	11	1	12	74	

Source (T.Petrushevska, ID is MJMS-2014-0575.2014)

Analysis showed that:

a) There was a difference in BZD use between cities. The percentage of patients using BZD was: 93 % in Ohrid (107 of 115 patients on OST); 91 % in Veles (42 of 46 on OST); 81 % in Skopje (163 of 201 patients on OST for which there are medical records for secondary drug use); 79 % in Strumica (58 of 73 on OST); 69 % in Tetovo (54 of 94 on OST); 64 % in Bitola (59 of 92 on OST); 56 % in Kavadarci (19 of 37 on OST); 56 % in Gevgelija (34 of 61 on OST); and 53 % in Kumanovo.

b) There was a difference in BZD use by age: 41 % (398) of the patients were in the age group 20–34.

c) There was a difference in BZD use by gender: of 662 patients, 92 % were male and 8 % were female.

Comparison of national data with data from 10 EU countries (Austria, Denmark, France, Germany, Greece, Italy, Norway, Portugal, Sweden and the United Kingdom)

In the EU the ratio of male to female heroin treatment clients is 4:1 ⁽³⁴⁾. At national level, the ratio of male to female heroin clients is 11:1.

A study found that females in Israel were more likely to enter MMT at a younger age than males, with twice as many males as females being admitted for treatment in the 18–30 age group ⁽³⁵⁾. The situation is similar in the country, where 1.6 % of female patients are in treatment in the age group 20–34. Male patients make up 89 % of all patients, while an analysis carried out in 10 EU countries using the European Quality Audit of Opioid Treatment (EQUATOR ⁽³⁶⁾), designed to provide an overview of the current state of opioid treatment provision in Europe, found that 74.6 % of patients were male. This distribution was also seen in individual countries, and there were consistently more male patients (range 66–82 %) than female: 79 % of opioid dependent patients observed by the EMCDDA (data from countries ⁽³⁷⁾ taking part in EQUATOR) were male ⁽³⁸⁾; 84 % of OST patients in the PROTEUS study in Spain were male ⁽³⁹⁾; 73 % of OST patients in the DTORS study in the United Kingdom were male ⁽⁴⁰⁾; and 68 % of patients in the German PREMOS study were male ⁽⁴¹⁾.

⁽³⁴⁾ EMCDDA (2013), *Perspectives on drugs: trends in heroin use in Europe — what do treatment demand data tell us?*, EMCDDA, Lisbon.

⁽³⁵⁾ M. Schiff, S. Levit, R.C. Moreno (2007), 'Retention and illicit drug use among methadone patients in Israel: a gender comparison', *Addictive Behaviors* 32, pp. 2108–2119 (<http://www.ncbi.nlm.nih.gov/pubmed/17335982>).

⁽³⁶⁾ G. Fischer and H. Stöver (2012), 'Assessing the current state of opioid-dependence treatment across Europe: methodology of the European Quality Audit of Opioid Treatment (EQUATOR) project' *Heroin Addiction and Related Clinical Problems* 14, pp. 5–70.

⁽³⁷⁾ G. Fischer and H. Stöver (2012), 'Assessing the current state of opioid-dependence treatment across Europe: methodology of the European Quality Audit of Opioid Treatment (EQUATOR) project' *Heroin Addiction and Related Clinical Problems* 14, pp. 5–70.

⁽³⁸⁾ J. Goulão and H. Stöver (2012), 'The profile of patients, out-of-treatment users and treating physicians involved in opioid maintenance treatment in Europe', *Heroin Addiction and Related Clinical Problems* 14(4), pp. 7–22.

⁽³⁹⁾ C. Roncero, on behalf of the PROTEUS Study investigators (2011), 'Therapeutic management and comorbidities in opiate-dependent patients undergoing a replacement therapy programme in Spain: the PROTEUS study', *Heroin Addiction and Related Clinical Problems* 13, pp. 5–16.

⁽⁴⁰⁾ A. Jones et al. (2007), *The Drug Treatment Outcomes Research Study (DTORS): research report 3* (www.dtors.org.uk).

⁽⁴¹⁾ H.U. Wittchen, G. Bühringer and J. Rehm (2011), 'Ergebnisse und Schlussfolgerungen der Premos-Studie' ('Predictors, moderators and outcome of substitution treatment'), *Suchtmedizin in Forschung und Praxis* 13, pp. 199–299.

The average age of patients across Europe was 36.5, ranging from an average of 31.9 in Austria to 43.8 in Denmark⁽⁴²⁾. In the same way, the mean age of patients entering treatment for opioid dependence in the EMCDDA dataset⁽⁴³⁾ was 34.1; the mean age reported in the German COBRA⁽⁴⁴⁾ study was 34.8 and in the PREMOS⁽⁴⁵⁾ study 35; the PROTEUS⁽⁴⁶⁾ study in Spain reported a mean age of 39; in the UK DTORS study⁽⁴⁷⁾, patients on OST were aged between 25 and 44 (45 % were aged 25–34; 27 % were 35–44; 7 % were ≥45). Among OST patient treated in public health facilities in 2012, data for age distribution were similar to the findings of the UK study, with 52 % of patients aged 20–34; 33 % aged 41–55; and 16 % aged 41–55, while there is evidence that very young people are heroin addicts and are already on methadone treatment.

It should be noted that the age at which patients who were receiving treatment in 2012 first took heroin was 14–22. The mean age of first heroin use in the EU is 22 years and, in comparison, among citizens it is 18 years.

With regard to level of education, a comparison between national data and data presented in studies mentioned below showed that the proportion of national patients in OST who had not attended high school (37 %) is similar to data from Sweden (35.5 %) and the United Kingdom (39.5 %), but lower than the EU average (42.3 %). The proportion of patients in OST who were educated to high school level (62 %) is equivalent to the figure from Spain (62.4 %), and higher than the EU average (30.9 %). The proportion of patients in OST who were educated to degree (higher education) level (1 %) is the same as data from the United Kingdom (1.2 %), which is higher than the EU average (0.3 %).

It has been estimated that up to one-third of all heroin addicts pass through a correctional facility each year⁽⁴⁸⁾. The chronic nature of untreated heroin dependence means that imprisonment is usually repeated; studies in the United States and France found that half of heroin users released from prison returned within six months^(49,50).

Polydrug use is predominant among drug users who wish to reduce the unwanted effects of drug taking or to enhance the desired ones^(51,52,53). The substances detected most

(42) J. Goulão and H. Stöver (2012), 'The profile of patients, out-of-treatment users and treating physicians involved in opioid maintenance treatment in Europe', *Heroin Addiction and Related Clinical Problems* 14(4), pp. 7–22.

(43) EMCDDA (www.emcdda.europa.eu).

(44) H.U. Wittchen et al. (2008), 'Feasibility and outcome of substitution treatment of heroin-dependent patients in specialized substitution centres and primary care facilities in Germany: a naturalistic study in 2694 patients', *Drug and Alcohol Dependence* 95, pp. 245–257.

(45) H.U. Wittchen, G. Bühringer and J. Rehm (2011), 'Ergebnisse und Schlussfolgerungen der Premos-Studie' ('Predictors, moderators and outcome of substitution treatment'), *Suchtmedizin in Forschung und Praxis* 13, pp. 199–299.

(46) C. Roncero, on behalf of the PROTEUS Study investigators (2011), 'Therapeutic management and comorbidities in opiate-dependent patients undergoing a replacement therapy programme in Spain: the PROTEUS study', *Heroin Addiction and Related Clinical Problems* 13, pp. 5–16.

(47) A. Jones et al. (2007), *The Drug Treatment Outcomes Research Study (DTORS): research report 3* (www.dtors.org.uk).

(48) A.E. Boutwell et al. (2007), 'Arrested on heroin: a national opportunity', *Journal of Opioid Management* 3, pp. 328–332.

(49) J.N. Marzo et al. (2009), 'Maintenance therapy and 3-year outcome of opioid dependent prisoners: a prospective study in France (2003–2006)', *Addiction* 104, pp. 1233–1240.

(50) G.P. McMillan, S. Lapham and M. Lackey (2008), 'The effect of a jail methadone maintenance therapy (MMT) program on inmate recidivism', *Addiction* 103, pp. 2017–2023.

(51) G. Hunt, K. Evans, M. Moloney and N. Bailey (2009) 'Combining different substances in the dance scene: enhancing pleasure, managing risk and timing effects', *Journal of Drug Issues* 39, pp. 495–522.

(52) S.E. Lankenau and M.C. Clatts (2005), 'Patterns of polydrug use among ketamine injectors in New York City', *Substance Use and Misuse* 40, pp. 1381–1397.

(53) H. Klein, K.W. Elifson and C.E. Sterk (2009), 'Young adult ecstasy users' enhancement of the effects of their ecstasy use', *Journal of Psychoactive Drugs* 41, pp. 113–120.

often were combinations of morphine, benzodiazepine, methadone and stimulants. In terms of polydrug use, the use of benzodiazepines ranged between 11 % and 70 % among substitution treatment clients⁽⁵⁴⁾. Benzodiazepines were widely used by heroin dependent individuals and by patients in OST⁽⁵⁵⁾. This high level of use may be in response to the high incidence of psychiatric co-morbidity in this population⁽⁵⁶⁾.

Benzodiazepine use by MMT patients is associated with a more complex clinical picture and may negatively influence treatment outcomes⁽⁵⁷⁾. Although several studies indicate that rates of non-medical prescription drug use are higher among women than men, particularly for narcotic analgesics and tranquilisers⁽⁵⁸⁾, other studies report equivalent or higher rates among men⁽⁵⁹⁾.

There have been case reports of deaths apparently associated with injections of buprenorphine combined with benzodiazepines⁽⁶⁰⁾, which is the reason why physicians are very cautious about the use of these two drugs in conjunction.

Conclusions

Various treatment options are available for opioid addicts. People in prison receive the same level of healthcare as those in the community. Demographic profiles appeared relatively consistent across the country, with differences in the mean age of patients in treatment; namely, while in the capital city of Skopje the predominant age group was 35–40, in the other towns and cities patients were aged 20–34. It should be noted that in private OST psychiatric clinics, despite the fact that they are all located in Skopje, the age of patients was 20–34. The same situation was found among prison patients, where 62 % were aged 20–34. It is important to strengthen preventive measures, to raise awareness and increase the level of information with younger people about the risks of drug taking. The ratio of male to female patients is higher than the EU average, and the reasons for this warrant further exploration. There is correlation between a low level of education and when heroin abuse started. Benzodiazepine use among MMT patients was common.

This very important and comprehensive analysis of people with drug addictions can lead to successful prevention and treatment responses. Although the treatment network for drug addiction is quite developed, there is a perceived need for further capacity building and an increase the quality of medical care.

⁽⁵⁴⁾ G. Fischer et al. (2011), *The non-medical use of prescription drugs: policy direction issues*, United Nations Office on Drugs and crime, New York.

⁽⁵⁵⁾ N. Lint-eris et al. (2007), 'Pharmacodynamics of diazepam co-administered with methadone or buprenorphine under high dose conditions in opioid dependent patients', *Drug and Alcohol Dependence* 91, pp. 187–194.

⁽⁵⁶⁾ D. Kandel, F.Y. Huang and M. Davies (2001), 'Comorbidity between patterns of substance use dependence and psychiatric syndromes', *Drug and Alcohol Dependence* 64, pp. 233–241.

⁽⁵⁷⁾ B. Brands et al. (2008), 'The impact of benzodiazepine use on methadone maintenance treatment outcomes', *Journal of Addictive Diseases* 27(3), pp. 37–48, doi: 10.1080/10550880802122620.

⁽⁵⁸⁾ L. Simoni-Wastila, G. Ritter and G. Strickler (2004), 'Gender and other factors associated with the nonmedical use of abusable prescription drugs', *Substance Use and Misuse* 39(1), pp. 1–23 (<http://www.ncbi.nlm.nih.gov/pubmed/15002942>).

⁽⁵⁹⁾ C. Blanco et al. (2007), 'Changes in the prevalence of non-medical prescription drug use and drug use disorders in the United States', *Drug and Alcohol Dependence* 90(2–3), pp. 252–260 (<http://www.ncbi.nlm.nih.gov/pubmed/17513069>).

⁽⁶⁰⁾ J.M. Gaulier et al. (2000), 'Fatal intoxication following self-administration of a massive dose of buprenorphine', *Journal of Forensic Sciences* 45(1), pp. 226–228 (<http://www.ncbi.nlm.nih.gov/pubmed/10641946>).

5.3.2. Therapeutic communities

The only therapeutic community in the country is Pokrov, close to the city of Strumica. It is a joint project between the Orthodox Church diocese of Strumica and the NGO Izbor. Most of the funds for the project were donated by the Swiss Agency for Development (SDC), the Municipality of Strumica, the Orthodox Church diocese of Strumica, and other partners from the local business sector. The whole process was led and implemented by the Centre for Institutional Development (CIR).

The duration of the programme is 12 to 18 months, and it consists of the following stages: adaptation; intensive treatment (psychological awareness, personal development, socialisation); re-socialisation; and reintegration (social network therapy).

The community aims to provide high-quality services and complementary and accessible care for addicts. It provides accommodation and food, basic healthcare and mental health observation. The programme includes teaching skills, training in HIV/AIDS prevention and other services crucial for rehabilitation and social reintegration. Its clients also participate in working activities. Courses/lectures and sporting activities are organised for patients. The community employs a range of professional staff (psychologists, social workers, therapists and other professionals).

The therapeutic community model is based on modern methods of withdrawal from alcohol, drugs and gambling, featuring an integrated approach with professional psychotherapy: cognitive behavioural therapy (CBT), eye movement desensitisation and reprocessing (EMDR) (trauma psychotherapy), systemic family psychotherapy, psychodrama and the method of therapeutic community.

5.3.3. Rehabilitation services

There are two rehabilitation services (in Ohrid and in Kumanovo) linked to treatment. They work in close collaboration with the Centres for the Treatment and Harm Reduction of Drug Addiction. Rehabilitation and re-socialisation of drug users and their families is provided through a variety of individual and group activities: counselling, information, social intervention, psychological intervention and testing, motivation interview, group therapy, psycho-educative groups, therapeutic community, creative and occupation therapy and computer skills workshops.

There are no social services programmes that provide drug users with housing, but the Ministry of Labour and Social Policy and the social centres have the competence to initiate social integration of drug users in a number of areas (housing, parental, vocational services, etc.).

6. HEALTH CORRELATES AND CONSEQUENCES

6.1. Report on the current state of play of the 2003 Council Recommendation on the prevention and reduction of health-related harm associated with drug dependence, in the EU and candidate countries, Country Profiles, 2013

A report was produced under the Health Programme (2008–13) in the frame of a contract with the Executive Agency for Health and Consumers acting on behalf of the European Commission. The report is the result of the work of experts from Gesundheit Österreich Forschungs und Planungsgesellschaft mbH (GÖ FP GmbH) and SOGETI, in close collaboration with the Executive Agency for Health and Consumers, the EMCDDA, DG SANCO, and DG JUST.

The report presents an updated overview of the implementation of the Council Recommendation in the EU countries and candidate countries, including country profiles and analyses of regional and EU epidemiological trends. The study also assesses the access to and coverage of harm reduction measures based on the answers to a policy survey.

In order to provide a high level of health protection, the Former Yugoslav Republic of Macedonia identified the prevention of drug dependence and the reduction of related risks as a public health objective, and developed and implemented comprehensive strategies accordingly. Opioid substitution treatment and specialised needle and syringe exchange programmes (NSP) to prevent risk behaviour (e.g. needle sharing) related to drug-related infectious diseases (DRID) (e.g. HIV, hepatitis) have been proven to be effective by a range of high-quality studies. The broad range of benefits from OST (including a reduction in needle-sharing and injecting drug use) has also been observed in prisons.

Within the National Drugs Strategy 2006–12, the following general objectives are stated:

- to maintain a high level of health protection, well-being and social cohesion by preventing and reducing drug use, dependence and drug-related harms;
- to ensure a high level of security for the general public by preventing drug-related crime — including actions against drug production, cross-border trafficking of drugs and diversion of precursors.

All EU Member States, Croatia, Montenegro and the Former Yugoslav Republic of Macedonia have adopted (public health) policy objectives that aim to prevent and reduce the health-related harm caused by drug dependence ⁽⁶¹⁾.

⁽⁶¹⁾ M. Busch, A. Grabenhofer-Eggerth, M. Weigl and C. Wirl (2013), *Report on the current state of play of the 2003 Council Recommendation on the prevention and reduction of health-related harm, associated with drug dependence, in the EU and candidate countries*, Gesundheit Österreich Forschungs- und Planungs GmbH, Vienna, April, on behalf of the European Commission.

Summary of findings in the Country Profile: Information and counselling services for drug users related to harm reduction is widely available, and there has been a significant increase since 2003. Information measures targeted at families and communities related to harm reduction are widely available. Many seminars and working groups were organised by the Inter-ministerial Commission for Narcotic Drugs together with NGOs and supported by the EU and WHO. Outreach work targeted at drug users is widely available, and has been substantially increased. There are four general aims of drugs outreach work: to identify and contact hidden populations; to refer members of these populations to existing care services; to initiate activities aimed at prevention and at demand reduction; and to promote safer sex and safer drug use. These activities are carried out by 13 NGOs for harm reduction, which are financially supported by a Global Fund project that aims to tackle HIV/AIDS and tuberculosis. Peer involvement in outreach work is available to a limited extent only, but there has been an increase since 2003. Networking and cooperation between agencies involved in outreach work is common, and has substantially increased. Drug-related treatment is available nationwide within the framework of the national public health network. Medically assisted treatment is provided mainly by the public sector, either in hospitals or in addiction treatment centres, but also by three private psychiatric services. The treatment system provides outpatient and inpatient treatment, detoxification and OST (as maintenance treatment). Detoxification treatment and psychosocial interventions are provided in both inpatient and outpatient settings, while OST, individual or group counselling and social and psychotherapy are available in outpatient services only.

Methadone, the main substance used for OST, has been available since 1992. Around 1 232 clients receive MMT. Buprenorphine has been available since 2010 for detoxification as well as for OST. Measures to prevent the diversion of substitution substances are in place.

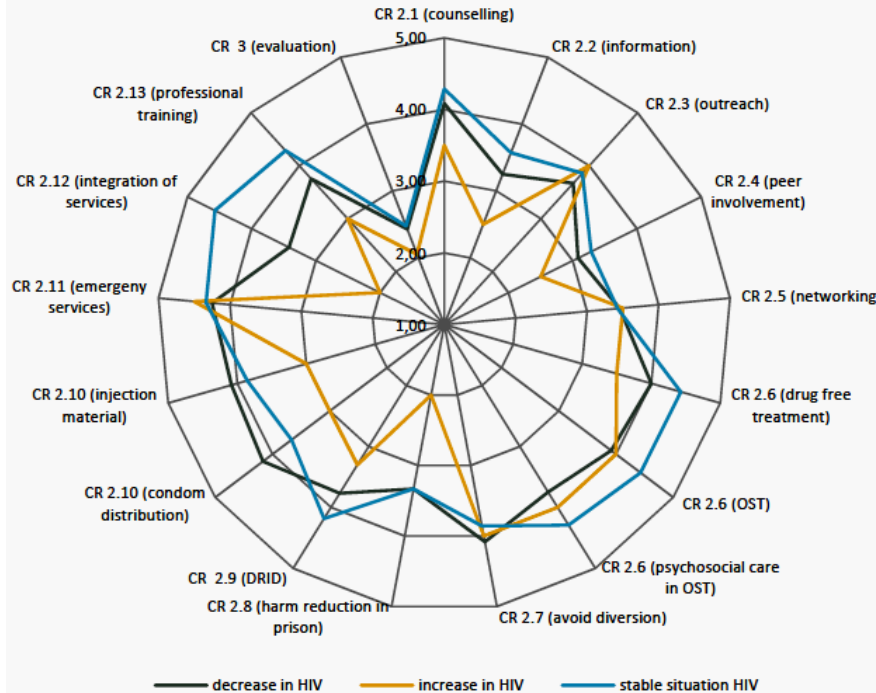
In 2012 MMT programmes were available in all prisons. HBV vaccination and prophylactic measures against HIV, HBV and HCV, tuberculosis and sexually transmitted diseases for injecting drug users, and screening is widely available to injecting drug users and their immediate social networks for HIV, HBV, HCV, tuberculosis and sexually transmitted diseases. Medical treatment of HIV/AIDS for injecting drug users is widely available; medical treatment of HCV, tuberculosis and sexually transmitted diseases is widely available. There has been a substantial increase in these measures since 2003. A major achievement since 2003 is that HBV vaccinations have been integrated into the standard package of immunisation. Fifteen needle and syringe programmes are available and are implemented by local NGOs. In 2008 they were in contact with 1 615 clients. Eleven cities have high coverage, 60 % of all NGOs offer needle and syringe exchange programmes⁽⁶²⁾. Emergency services, which are adequately prepared to deal with drug overdoses, are widely available. There is full integration between health services, social care and specialised risk reduction, with a significant increase since 2003. A major achievement since 2003 is that, in addition to treatment centres for methadone substitution therapy, there are now three centres for the re-socialisation and social integration of drug dependent persons and one therapeutic community.

⁽⁶²⁾ Access and coverage of needle and syringe programmes in Central and Eastern Europe, WHO Regional Office Europe; CEEHRN -Vilnius, Lithuania

Professional training on the reduction of health-related risks associated with drug dependence is extensively available, and there has been a big increase. Scientific evidence is used as the basis for selecting interventions to a large extent, and there has been a substantial increase since 2003. Quality criteria are widely used in evaluations, and there has been a substantial increase. Standardised data collection is routinely used, and there has been a substantial increase since 2003. CARDS (Community assistance for reconstruction, development and stabilisation) and Instrument for Pre-Accession Assistance projects were the main initiators of establishing a NFP for cooperation with the EMCDDA and to set up indicators, a network of institutions and to implement standardised data collection. In 2011 an evaluation was carried out by a working group of 15 individuals, composed of representatives of the Office of the Global Fund for HIV/AIDS in Skopje, UNICEF, the Joint United Nations Programme on HIV/AIDS, NGOs, and representatives of the Ministries of Education, Labour and Social Policy, and Health. The methodology of the survey consisted of interviews with a questionnaire, with the option of selecting more than one answer. All methadone centres are evaluated using questionnaires for staff and methadone users. A total of 276 questionnaires were filled out, of which 224 were completed by methadone users in methadone centres and 52 by staff at methadone centres. In the methadone centre in Idrizovo Prison, 51 inmates who were methadone users and four staff at the centre completed questionnaires.

Professionals have a considerable number of opportunities for exchanging programme results, skills and experience at the European level, and there has been a strong increase since 2003. The EMCDDA and the IPA Project are very important partners of the NFP and all stakeholders. Opportunities for partnership can be increased by study visits and participation in workshops, conferences and forums organised at the EU level for particular areas of interest. Membership of the European Union is the highest strategic interest and priority of the Government. All Council Recommendations and Suggestions are implemented by the relevant institutions. Institutions and professionals have worked hard, showing commitment and adherence to standard practices established in the EU, to strengthen capacities in the system for the treatment and harm reduction of drug addiction. We hope that EU support will continue in the forthcoming period.

Figure 6.1. Coverage of harm reduction measures in EU candidate countries.



Notes:

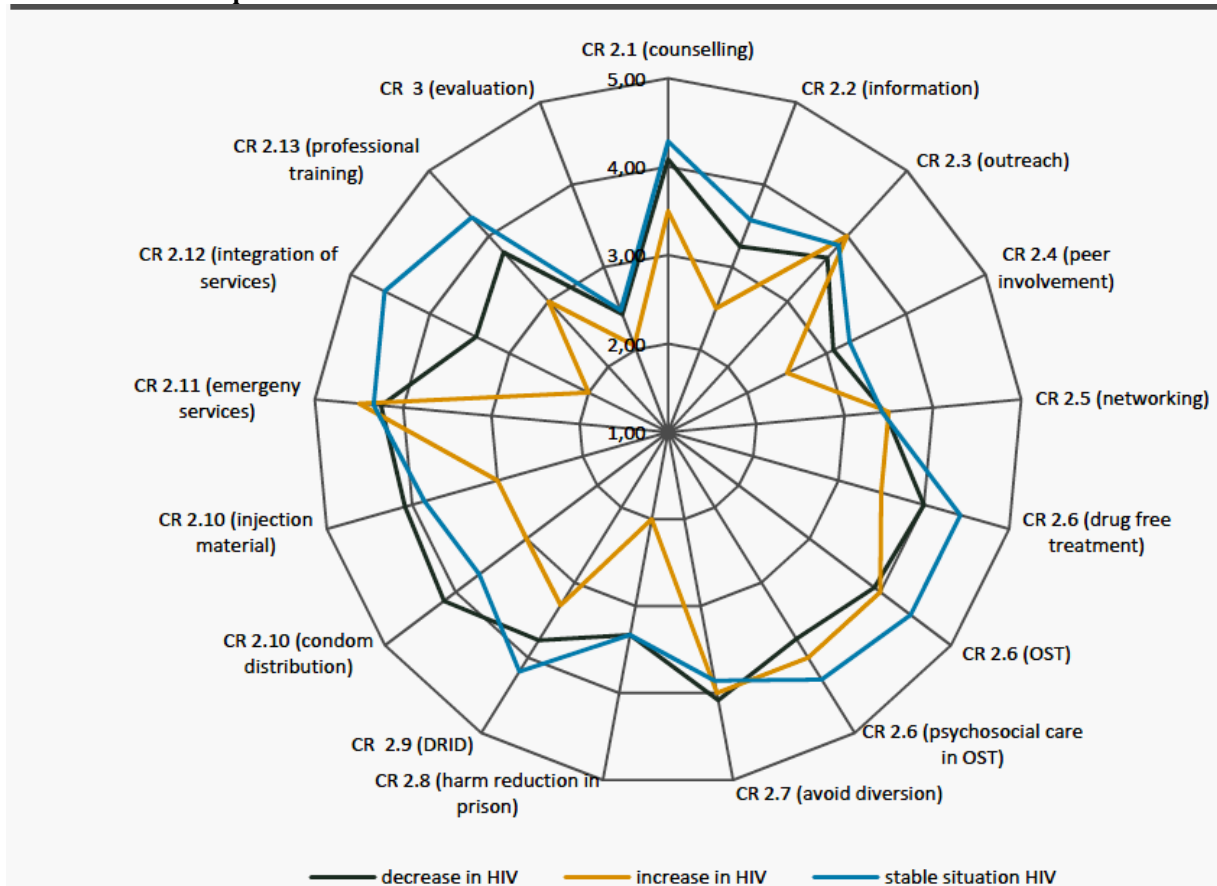
1. DRID = drug-related infectious diseases, OST = opioid substitution treatment.

2. Data refer to: Austria, Belgium, Bulgaria, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, the United Kingdom, Croatia, the Former Yugoslav Republic of Macedonia, Montenegro, Iceland, Turkey.

Coverage: 1 = not available, 2 = rare, 3 = limited, 4 = extensive, 5 = full coverage

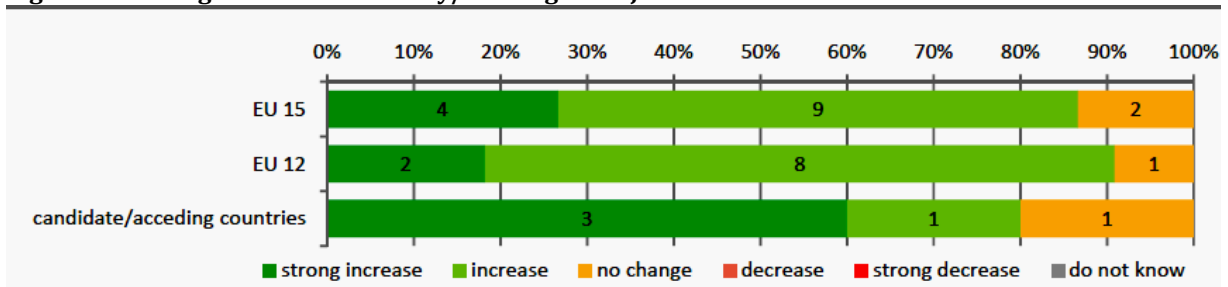
Source: GÖ FP, policy maker survey; graphic representation: GÖ FP, http://ec.europa.eu/justice/anti-drugs/files/report-drug-dependence_en.pdf

Figure 6.2. Coverage of harm reduction measures in countries with increasing, stable or decreasing numbers of HIV acquired via IDU.



Source: http://ec.europa.eu/justice/anti-drugs/files/report-drug-dependence_en.pdf

Figure 6.3. Changes in the availability/coverage of injection materials for IDUs.



Remark: data refer to all 31 countries from the policy maker survey

Figure 6.4. Changes in the coverage of OST, psychosocial care (PSC) and rehabilitation supporting OST and drug-free treatment (DFT) by EU membership status.

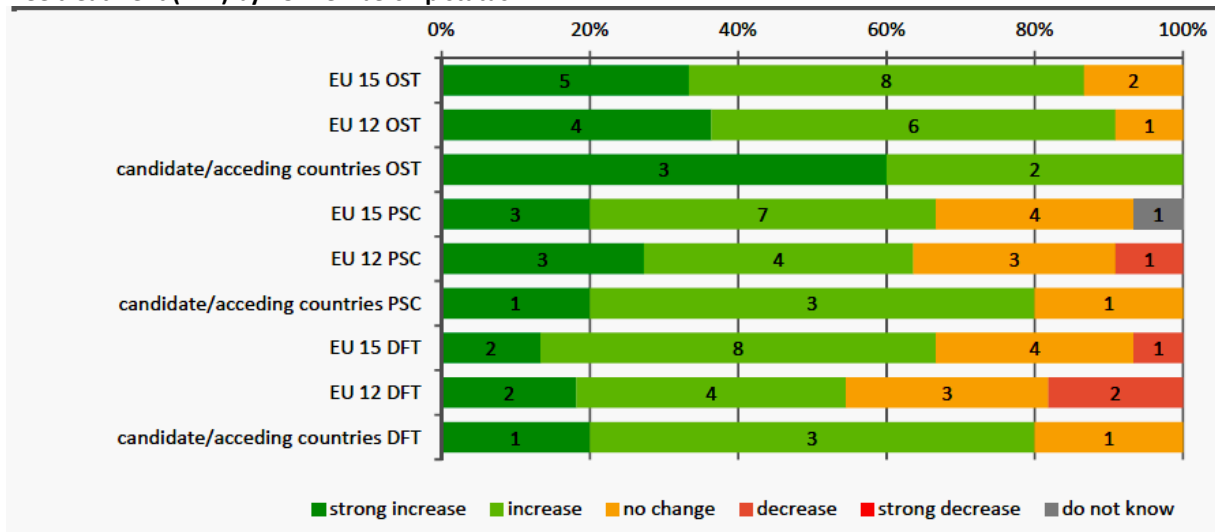
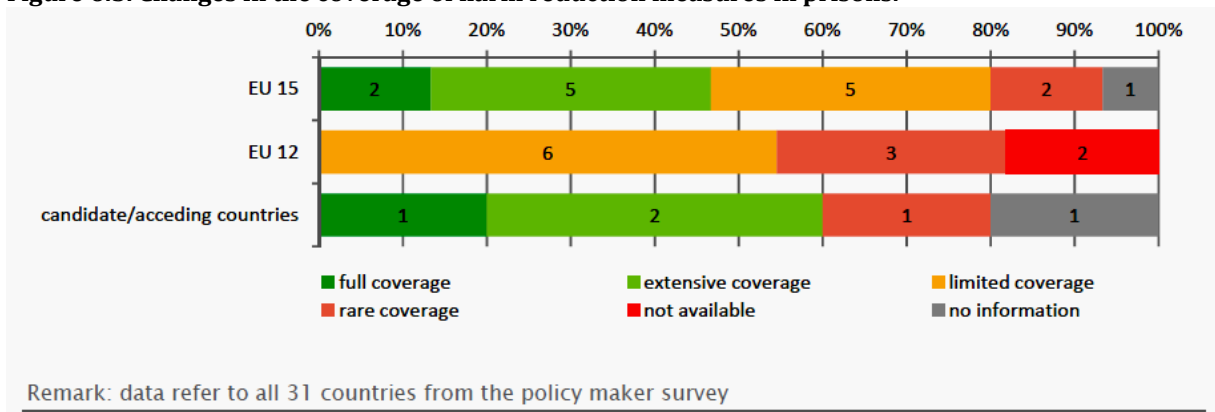


Figure 6.5. Changes in the coverage of harm reduction measures in prisons.



6.2. Policies relating to health correlates and consequences

The risk behaviours of addicts include every kind of behaviour related to drug addiction, which can also lead to additional diseases and complications. These behaviours include sharing needles, syringes and other equipment and risky sexual behaviour (sex without protection). HBV, HCV and HIV are just some of infectious diseases that can be transmitted in these ways, meaning that the addict population is at much greater risk of contracting these diseases than is the general population. It should also be noted that this section refers not only to the prevalence or incidence of diseases, but also to the risk factors for their transmission. Therefore, it is of utmost importance to insist on the implementation of

measures that could reduce the practice of sharing needles and other equipment and to continually raise awareness of their importance.

The Former Yugoslav Republic of Macedonia is a low HIV prevalence country and has reported the lowest number of HIV positive cases so far among the countries in the south-eastern European region. The first HIV infection was registered in the country in 1987 and the first AIDS case in 1989. The first death from AIDS was registered in 1990.

HIV/AIDS testing can be carried out in all public health institutes and clinics for infectious disease, and by NGOs. Free tests for HIV/AIDS are available in 14 centres for public health. Testing is voluntary and anonymous. Pregnant women and nursing mothers are not obliged to be tested for HIV/AIDS.

6.2.1. National Strategy for HIV/AIDS 2012–16 ⁽⁶³⁾

This Strategy elaborates the current situation and evaluates the previous strategy, identifying weak points and accordingly setting strategic priorities, measures and activities. It was adopted and developed by the Ministry of Health.

With regard to the interventions aimed at IDUs, the strategic aim is to maintain the low prevalence of HIV among drug users. Its recommended strategic interventions are:

1. Distribution of sterile accessories for injection, condoms, lubricants and informational materials in day care centres for MMT and in the field; prevention activities against HIV/AIDS, and among drug users who inject narcotics.
2. Providing health, psychosocial, legal and other services to drug users.
3. Improving access to programmes for treatment and rehabilitation with substitution therapy.
4. Creating gender-specific programmes for the treatment and rehabilitation of drug-dependent people who are undergoing substitution therapy.
5. Creating specific programmes for the treatment and rehabilitation of children who inject drugs.
6. Increasing access to voluntary and confidential testing and consultations on HIV/AIDS for people on drugs.
7. Establishing new programmes to reduce drug use harms among females.
8. Establishing new programmes to reduce drug abuse harms among young people, in cooperation with the Centre for Social Affairs.
9. Education and training for health workers and other personnel on IDU treatment and HIV prevention.
10. Improving access to treatment with substitution.
11. Improving the activities of the services for the rehabilitation and re-socialisation of IDUs.

⁽⁶³⁾ www.moh.gov.mk

12. Providing informational and educational workshops on the prevention of HIV/AIDS/STI/drug use for convicted prisoners.

6.2.2. Strategy on the Healthcare of the Prison Population (2012–14) and Action Plan

This strategy addresses the health protection needs of convicted prisoners and minors in the criminal correctional system and educational correctional system. It identifies several areas where change is needed in the material, administrative and organisational aspects of healthcare.

In 2012–13 the Administration for the Execution of Sanctions carried out numerous activities related to healthcare in prisons. Prison reform in the field of health protection, which is the responsibility of the Administration for the Execution of Sanctions, includes specific categories of prisoners, including drug users. The Government adopted the Strategy on the Healthcare of the Prison Population (2012–14) and Action Plan.

The use of narcotics has been highlighted as one of the main problem facing the prison system. There has been a rapid increase in dependency on psychoactive substances, predominantly heroin and tablets, reflecting the situation in society as a whole. Problems relating to drug use are increasing, which underlines the importance of increased awareness.

Drug addiction treatment involves improving the quality of life of the individual, and reducing the risk to the prison community. Treatment is directed towards improving psychophysical health, stimulation and maintenance of good mental health in the individual, reducing damage from drug use and preventing the spread of disease and infections. The specific needs of IDUs particularly highlight the requirement for a standardised and effective educational, health and psychosocial programme within prisons, and the importance of advocating for an effective prison health service that can respond to the challenges it faces.

The situation analyses of the strategy highlighted a lack of standardised procedures and instructions for prison healthcare provision, and a need to improve material, technical, hygienic, organisational and administrative aspects.

The Strategy on the Healthcare of the Prison Population aims to develop a professional and multidisciplinary approach to improving health protection for all those in correctional and educational institutions in accordance with international standards, a respect of human rights and the provision of healthcare.

6.2.3. Interventions to prevent infectious diseases

The Republic Institute for Public Health collects nationwide data on infectious diseases, including HIV and hepatitis. Additional data on drug-related infectious diseases come from the bio-behavioural studies conducted in 2005, 2006, 2007 and 2010 within the project supported by the Global Fund.

Twenty cases of HIV/AIDS were registered in 2012, which is the largest number of newly discovered cases per year since 1987. In total, 166 cases of HIV/AIDS were

registered since 1987, of which 69 died. The trend for transmission of HIV infection is continuing. Heterosexual transmission is the most common route (99 cases), followed by homosexual transmission (42 case). There have only been two cases where IDU was specified as the route of infection transmission in the past eight years.

According to the Institute for Public Health⁽⁶⁴⁾, there were 154 HBV patients in 2011 (98 male and 56 female), and 184 in 2012 (102 male and 82 female). The total number of HCV patients was 76 in 2011 (60 male and 16 female) and 165 in 2012 (117 male and 48 female).

Table 6.1. Analyses performed by the Department of Virology and Molecular Diagnostics, 2012.

Parameter	Negative	Positive	Total
HBs*	987	36	1 023
HCV	690	102	792
HIV	1 057	0	1 057

* Results for markers are not included in this number (anti HBs, anti HBc total, anti HBc IgM, Hbe Ag, anti Hbe) for which 402 analysis were performed.

Source: Institute for Public Health.

During 2012 a total of 48 patients began treatment in the Clinic for Infectious Diseases, Skopje Clinical Centre. Ninety-seven people are currently living with HIV/AIDS. The youngest patient was 4 years of age, while the oldest was 64. Most patients (68 cases) were aged 20–39. There were eight cases aged 0–19.

A 6-year-old child was among those reported, who is the youngest patient suffering from AIDS. The virus was transmitted from the mother while she was pregnant. HIV was diagnosed when the child attended a paediatric clinic for treating inflammation of the brain. Specific symptoms alerted doctors, who carried out a detailed analysis and HIV test. The child was immediately transferred for treatment to the Infectious Diseases Clinic.

6.2.4. Drug-related deaths and emergencies

Deaths related to psychoactive drug use (drug-related deaths) refer to those that are a consequence of acute intoxication with one or more drugs, and deaths caused by illnesses developed due to drug use (e.g. cardiovascular problems in cocaine users), risky addiction behaviour (hepatitis) or drug-related accidents.

The total number of drug-related deaths depends on many factors, such as frequency and route of administering drugs (intravenous, simultaneous use of more drugs), age of the addiction population, concurrent diseases and disorders, and the availability of treatment and emergency services.

According to the EMCDDA definition, drug-related deaths (DRD) refer to deaths that occur shortly after the use of one or more drugs, although very often in such cases alcohol and other medication are also found to be present.

⁽⁶⁴⁾ G. Kuzmanovska (2013), *Internal report for HVB and HVC*, Institute for Public Health, Skopje, January.

The Former Yugoslav Republic of Macedonia adopted this definition, and since 2007 institutes for forensic medicine have reported DRDs to the NFP as the referent centre for cooperation with the EMCDDA.

DRD cases are confirmed following an autopsy. Article 275 of the Law on Health Protection (Official Gazette of the Former Yugoslav Republic of Macedonia, No. 43/12, 10/13) defines a medical autopsy:

When it is obvious or suspected that death is not from natural causes, forensic medical autopsy and forensic medical expertise is performed on the body of the deceased by two physicians, one of which should be a doctor of medicine — forensic specialist.

A forensic medical autopsy is performed in the following cases:

- 1) Homicide or suspected homicide, or suicide or suspected suicide.
- 2) Suspected medical error.
- 3) Technological and environmental disasters.
- 4) When required to protect the health of citizens, or for epidemiological, sanitary and scientific reasons.
- 5) Unexpected death when the cause of death is unknown or unclear or cannot be explained, including sudden infant death and when death has occurred in connection with a diagnostic or therapeutic procedure.
- 6) Death in detention, in jail, after police detention.
- 7) Death suspected to be as a result of torture or inhuman treatment.
- 8) Death associated with police or military activity; unidentified bodies.
- 9) At a request of a close family member of the deceased person.
- 10) The body of a person who died in a mental institution subject to pathological and anatomical autopsy.

An autopsy will be conducted in cases of unnatural death or death by unknown origin, death during diagnostic or therapeutic intervention, death within 24 hours of admittance of the person to a mental institution, death of a person who participated in a clinical trial of a drug or medical device, or in a scientific investigation in a health facility, or in cases of the death of a person whose body parts can be removed for transplantation in accordance with law.

6.2.4.1. Registration of data on DRD

Drug-related deaths are registered by the General Mortality Register of the National Statistical Office and two special registers that provide country-wide documentation: the Police Register of the Ministry of Internal Affairs and the Register of the Institutes for Forensic Medicine. However, the NFP receives the most up-to-date data from four bodies: the Institute of Forensic Medicine, Criminology and Medical Deontology at the Medical Faculty in Skopje, the Institute of Forensic Medicine in Bitola, the Institute of Forensic Medicine in Shtip and the Institute of Forensic Medicine in Tetovo. Data from the General Mortality Register is statistically valuated, with a two to three year delay, and it is difficult

to obtain separate data on DRD without the inclusion of data on other types of poisoning (from toxic chemicals).

In 2012 the Forensic Toxicology Laboratory at the Institute of Forensic Medicine, Criminology and Medical Deontology was equipped with modern and sophisticated equipment, provided by Government. This equipment allows the Forensic Toxicology Laboratory to perform qualitative and quantitative analysis of biological material from cadaver specimen and live patients, including quantitative determination of alcohol in blood and urine by using GC/FID; qualitative and quantitative determination of organic toxic substances in body fluids, organs and hair, food and beverages by using GC/MS and LC/MS. The challenge for the forthcoming period is to increase the Laboratory's skills in the qualitative and quantitative analysis of biological material using the above-mentioned chromatography techniques. The main objective of the Forensic Toxicology Laboratory is to expand to become a regional forensic toxicology laboratory.

6.2.4.2. Coding system

In accordance with EU standards, DRD cases are counted when the death was due to poisoning by accident, suicide, homicide or undetermined intent. Cases are included when the death was due to opiates, amphetamines, cocaine (or crack), cannabis, hallucinogens, solvents or synthetic designer drugs like amphetamine derivatives.

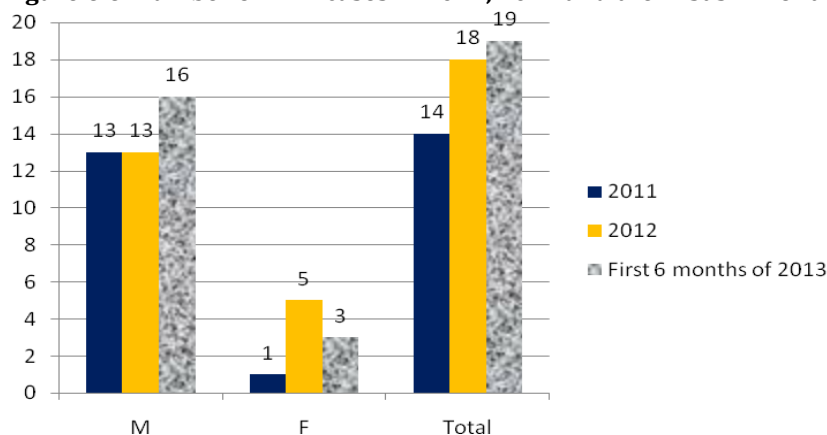
The precise groups of deaths are:

Category of drug-related death	Selected groups
Poisoning by accident, suicide, homicide or undetermined intent	Opiates only (excluding methadone only)
	Methadone only
	Poly-substances including opiates
	Poly-substances excluding opiates
	Unspecified/unknown

The Special Register at the Institute of Forensic Medicine, Criminology and Medical Deontology uses statistics based on the WHO International Classification of Diseases, ICD-10.

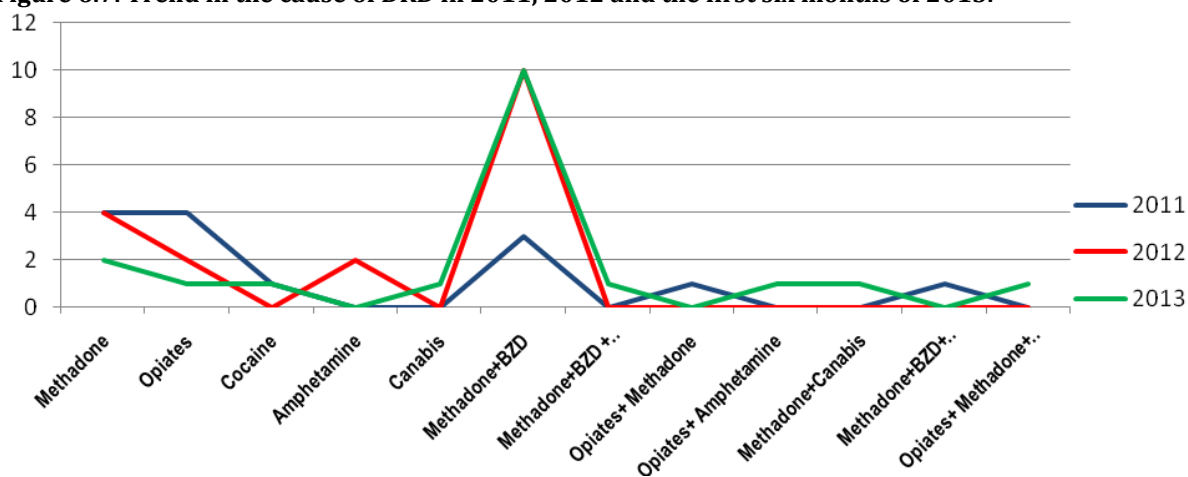
6.2.4.3. Characteristics of the cases

Figure 6.6. Number of DRD cases in 2011, 2012 and the first six months of 2013.



Source: Former Yugoslav Republic of Macedonia NFP.

Figure 6.7. Trend in the cause of DRD in 2011, 2012 and the first six months of 2013.



Source: Former Yugoslav Republic of Macedonia NFP, evaluated reports received from the Institute of Forensic Medicine, Criminology and Medical Deontology at the Medical Faculty in Skopje.

Table 6.2. Characteristics of DRD in 2011, 2012 and the first six months of 2013.

Drug-related deaths	2011	2012	2013 (first 6 months)
Methadone	4	4	2
Opiates	4	2	1
Cocaine	1	0	1
Amphetamine	0	2	0
Cannabis	0	0	1
Methadone + BZD	3	10	10

Methadone + BZD + Cannabis + cocaine	0	0	1
Opiates + methadone	1	0	0
Opiates + amphetamine	0	0	1
Methadone + cannabis	0	0	1
Methadone + BZD + cannabis	1	0	0
Opiates + methadone+ cannabis	0	0	1
Total	14	18	19

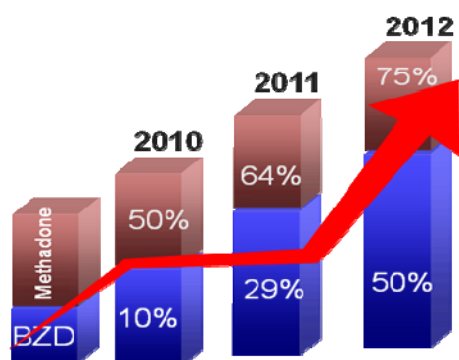
Source: Former Yugoslav Republic of Macedonia NFP, evaluated reports received from the Institute of Forensic Medicine, Criminology and Medical Deontology at the Medical Faculty in Skopje.

Table 6.3. DRD: age breakdown in 2011, 2012 and the first six months of 2013.

	N	Average	Min	Max
2011	14	26	18	40
2012	18	31	21	41
2013 (first 6 months)	19	32	11	50

Source: Former Yugoslav Republic of Macedonia NFP, evaluated reports received from the Institute of Forensic Medicine, Criminology and Medical Deontology at the Medical Faculty in Skopje.

Figure 6.8. Increase in DRD due to methadone, often combined with BZD.



6.2.5. Interventions to prevent and reduce drug-related harm in recreational settings

6.2.5.1. Acute intoxication with psychoactive substances

According to information on acute intoxication from the Toxicological Information Centre PHI, University Clinic of Toxicology, in 2011 there were 11 cases of acute cannabis

intoxication, three of ecstasy, 27 of methadone, 15 of heroin, 6 of cocaine and 12 of narcotic analgesics.

Table 6.4. Acute intoxications, by type of drug and age of victim ⁽⁶⁵⁾.

Type of psychoactive substance	Age					Of the total, detained in hospital	Total intoxication
	1-4	5-14	15-19	20-74	Over 75		
Benzodiazepines	16	14	37	228	3	184	298
Antidepressants	/	1	2	27	/	28	30
Neuroleptics	1	3	2	21	/	22	27
Opioid analgesics	0	3	1	14	/	8	18
Hypnotic	/	/	1	5	/	5	6
Methadone	/	/	1	30	/	11	31
Heroin	/	1	/	15	/	0	16
Cannabis sativa	/	/	4	6	/	0	10
Cocaine	/	/	1	7	/	2	8
Ecstasy	/	/	1	2	/	/	3
Buprenorphine	4	/	/	/	/	4	4
Total	21	22	50	490	3	264	451

Source: Toxicological Information Centre.

Data from the Toxicological Information Centre indicates that 66 % of the 451 cases of acute intoxication with psychoactive substances were due to drugs from the group of benzodiazepines. This situation highlights the need to conduct research in this field to determine the causes.

6.2.6. Quality assurance in harm reduction

In February 2013 the Administration for the Execution of Sanctions (which, according to Article 9 of the Law on the Control of Narcotic Drugs and Psychotropic Substances, is the responsible body for all prisons settings in the country, especially with respect to people with drug addictions in prisons) adopted and began implementing twelve manuals on the healthcare of drug users in prison.

The manuals give instructions on different areas of healthcare in penitentiary and correctional institutions. They covered following areas:

- the duties and ethics of the medical staff of the healthcare sector in the institution;
- control and hygiene, control of serving food and drinking water in the facilities;
- cooperation of the healthcare sector in the institution with the resettlement sector and security sector, cooperation with other criminal correctional institutions and medical facilities outside the institution;
- minimum technical standards (concerning facilities, equipment, staff) for the health units in the institutions;

⁽⁶⁵⁾ P. Zanina (2012), *Annual report of poisoning in the country for 2012*, Toxicological Information Centre, Skopje, 0302-26012.

- medical examination at the release of a detainee;
- prisoners' access to a doctor, distribution of medicines, medical examination outside the institution;
- medical examination and medical supervision during the execution of disciplinary punishment of isolation of three to 15 days, with and without the right to work;
- procedure for a medical examination for use of force against detainees and convicted person;
- procedure for the medical management of prisoners on hunger strike;
- procedure for the separation of remand and convicted prisoners, and juvenile detainees;
- instructions for medical examination at the release of convicted minors from institutions;
- procedure for recognising and recording signs of violence among convicted prisoners in the institution to the and the procedure for registering visible injuries caused by violence against inmates during a jail sentence;
- procedure for medical examination on admission of convicted juveniles in the institution;
- procedure for medical examination of detainees on admission.

In 2013 the Administration for the Execution of Sanctions prepared and adopted three protocols in the field of health protection of convicted persons: the Protocol for the Healthcare of Convicted Persons with Communicable Diseases (HIV/AIDS/tuberculosis/hepatitis/STI); the Protocol for the Distribution of Condoms in Prison; and the Protocol for Replacement Therapy among Convicted Persons who are Drug Users.

In December 2013 two workshops were held (with the support of TAIEX, the Technical Assistance and Information Exchange instrument managed by the Directorate-General Enlargement of the European Commission) to train prison staff on the prevention of violence in prison and the programme for anger management, and on healthcare in prisons.

Idrizovo Prison introduced psychosocial support for convicted prisoners who are drug users.

The manuals, protocols and workshops were defined as goals in the Action Plan of the Strategy on the Healthcare of the Prison Population (2012–14).

6.3. Needle and syringe exchange programmes

Data have indicated that there is a low prevalence of HIV/AIDS, especially among IDUs, but the country has experienced a large increase in HCV cases. Needle and syringe exchange programmes have made a substantial contribution to the low prevalence of HIV/AIDS. The programmes have been financed by the Global Fund for a number of years, and are implemented by NGOs.

Harm reduction activities are defined in the National Strategy for HIV/AIDS. These activities are prohibited under the Criminal Code (elaborated in the section for legislation in this report, 1.1.). Health services wishing to offer these services (within the NGO programmes for exchange of needle and syringes) must meet strict legal parameters (Law for Healthcare), with clearly specified facilities, equipment and staff in medical clinics. Harm reduction programmes are not subject to any health inspection that would supervise and control their health interventions.

In 2011 there were 16 harm reduction programmes, all of which were managed by NGOs with financial support from the Global Fund. The NGO HOPS ran four programmes in Skopje, including a programme for sex workers who inject drugs. Harm reduction programmes had contact with 2 952 unique clients in 2011. Of these, 582 were new clients, in contact with the programmes for the first time. A total of 17.7 % of all new clients were women.

Table 6.5. Number of unique and new clients in harm reduction services, 2011.

City	Unique clients	New clients		Total contacts
		Male	Female	
Skopje	707	137	30	12 426
Strumica	310	75	7	5 810
Kumanovo	121	17	6	2 759
Gostivar	384	31	16	1 100
Kavadarci	40	9	3	1 003
Stip	104	7	1	2 360
Tetovo	89	25	22	760
Ohrid	202	28	2	1 033
Bitola	474	75	6	5 460
Kichevo	120	22	0	830
Prilep	106	19	3	816
Veles	144	18	2	1 041
Gevgelija	151	16	5	3 578
Total	2 952	479	103	38 976

Source: HOPS

Table 6.6. Number of syringes, needles and condoms distributed, by city, 2011.

City	Needles	Syringes	Condoms	Programmes
Skopje	290 625	121 755	14 926	4
Strumica	55 332	24 437	13 300	1
Kumanovo	16 945	12 101	6 856	1
Gostivar	15 248	10 957	8 090	1
Kavadarci	7 489	3 492	1 135	1
Stip	8 632	3 588	1 153	1
Tetovo	11 660	9 773	5 998	1
Ohrid	29 979	14 358	9 939	1
Bitola	159 749	99 156	18 980	1
Kichevo	3 724	1 862	822	1
Prilep	14 657	7 552	7 593	1
Veles	7 295	4 365	1 623	1

Gevgelija	15 575	5 089	4 706	1
Total	636 910	318 485	95 121	14

In 2011 harm reduction programmes delivered 41 986 medical services, most of which were basic medical intervention — intervention/treatment of long-term or not adequate injection, counselling and education on drugs and the consequences of drug use, information on treatment and referrals to treatment.

Social workers delivered 25 788 services, most of which were to obtain identity documents and other personal documents (e.g. birth certificate), assistance with obtaining health insurance and social support, referrals to institutions and legal advisers, and individual psychosocial support.

Table 6.7. Number of medical and social services within harm reduction programmes.

City	Medical services	Social services
Skopje	14 625	5 913
Strumica	1 753	3 001
Kumanovo	2 676	651
Gostivar	1 412	887
Kavadarci	6 890	1 365
Stip	1 562	3 329
Tetovo	983	3 464
Ohrid	1 622	1 484
Bitola	1 535	1 271
Kichevo	5 141	2 685
Prilep	1 393	1 141
Veles	2 394	597
Gevgelija	--	--
Total	41 986	25 788

Source: HOPS

6.4. Voluntary counselling and HIV testing

HIV/AIDS testing is available in all public health institutes, clinics for infectious disease, and via outreach programmes. In order to include as many people as possible from the vulnerable population (people who inject drugs, sex workers, men who have sex with men, young people), Centres for Voluntary Counselling and Testing (VCT) for HIV/AIDS were developed. There are 13 VCT centres, located in the Infectious Clinic, Polyclinic Bit Pazar, the National Institute for Health and 10 Centres for Health Protection.

HIV/AIDS counselling provides a wide range of HIV/AIDS services, including pre- and post-testing confidential and voluntary counselling, provision of HIV/AIDS treatment and counselling, palliative and social care for people living with HIV/AIDS, free condoms, educational materials and other preventive and counselling services within the joint programme, and cooperation with the Clinic for Infectious Diseases and Febrile Conditions.

Twelve NGOs cooperate with the Public Health Institute to implement VCT on outreach, visiting locations such as streets, parks, abandoned properties, etc. that are frequented by drug users.

The NGO Hera operates a free telephone helpline for people to ask questions relating to HIV/AIDS and sexually transmitted infections.

In 2011 a total of 638 VCTs were conducted with drug users; none were found to be HIV positive.

Table 6.8. Number of HIV tests, 2011.

	Male	Female	Total
HIV tests	552	86	638

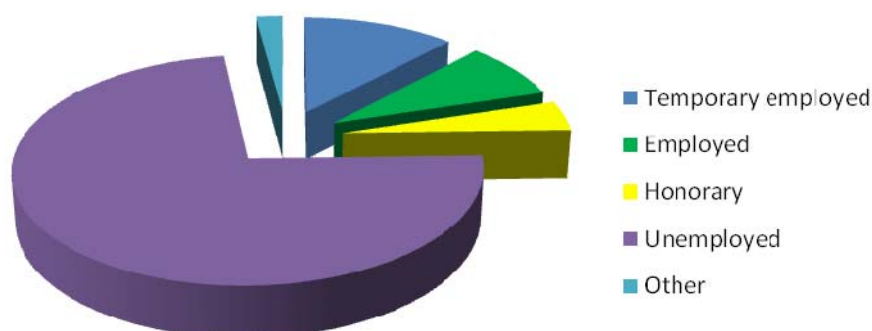
Table 6.9. Employment status of drug users, by city.

City	No of drug users	Employed		Unemployed		Temporary employed		Honorary		Other	
		N	%	N	%	N	%	N	%	N	%
Skopje	167	16	9.58	133	79.64	2	1.20	8	4.79	8	4.79
Strumica	82	9	10.9	59	71.9	7	8.5	7	8.5	0	0
Kumanovo	23	1	4.35	21	91.30	1	4.35	0	0	0	0
Gostivar	47	2	4.25	19	40.4	20	42.5	3	6.38	3	6.38
Kavadarci	12	2	6	6	50	1	12	3	32	0	0
Stip	8	0	0	7	87.5	0	0	1	12.5	0	0
Tetovo	47	6	12.76	32	68.09	9	19.15	0	0	0	0
Ohrid	30	3	10.00	25	83.33	2	6.66	0	0	0	0
Bitola	81	2	3	52	64	26	32	n/a	n/a	1	1
Kichevo	22	0	0	22	100	0	0	0	0	0	0
Prilep	22	4	18.18	15	68.18	0	0	3	13.6	0	0
Veles	20	1	5	19	95	0	0	0	0	0	0
Gevgelija	21	2	9.5	17	80.9	2	9.5	0	0	0	0
Total	582	48	8.3	427	73.4	70	12	25	4.3	12	2

Source: HOPS

The characteristics of clients of needle and syringe exchange programmes were recorded as evidence of personal client data, mostly socio-demographic factors, including data on employment. In addition to its use in analysis, the data can also be use to make possible recommendations for employment, if the client's qualifications and medical condition allow it.

Figure 6.9. Employment status of PDU clients of needle exchange programmes.



Only 30 % of the clients of harm reduction programmes had some form of employment.

Table 6.10. New harm reduction treatment clients with or without health insurance, 2011.

City	No of new clients in 2011	Health insurance		Without insurance		Other	
		N	%	N	%	N	%
Skopje	167	125	74.85	40	23.95	2	1.20
Strumica	82	79	96.3	3	3.65	0	0
Kumanovo	23	20	86.96	3	13.04	0	0
Gostivar	47	38	80.8	9	19.1	0	0
Kavadarci	12	12	100	0	0	0	0
Stip	8	7	87.5	1	12.5	0	0
Tetovo	47	40	85.11	7	14.89	0	0
Ohrid	30	30	100	0	0	0	0
Bitola	81	79	98	2	2	0	0
Kichevo	22	22	100	0	0	0	0
Prilep	22	21	95.45	1	4.54	-	-
Veles	20	20	100	0	0	0	0
Gevgelija	21	19	90.4	2	19.04	0	0
Total	582	512	88	68	11.7	2	0.3

Source: HOPS

Table 6.10 shows that 88 % of PDUs had health insurance, even though only 30 % were employed. This indicates that they were covered by some of the special programmes for vulnerable groups from the government's budget (Programme for Persons with Addiction, Social Care Programme, etc.).

Health insurance allows people to obtain healthcare interventions without payment or by making a small payment, and medicines included in the 'Referent List' which are reimbursed by the State Health Insurance Fund ⁽⁶⁶⁾.

⁽⁶⁶⁾ <http://www.fzo.org.mk/>

6.5. Information on problem drug users from non-treatment sources

PDUs in treatment are discussed in detail in Section 5 of this report.

Following the intervention of the Ombudsman, after a request from 20 NGOs, the Ministry of Internal Affairs is no longer allowed formally to keep records of people who use drugs and were subject to an administrative or criminal sanction. Moreover, this register, which was always up to date and was extremely useful for comparing data from different databases, cannot be used anymore, nor can its data be published, even though it has so far been protected data that did not disclose the identity of drug users.

Data from harm reduction programmes show that 454 (78 %) of 582 drug users were polydrug users; 10.8 % only used heroin.

Table 6.11. Number of new clients, by type of drug used.

City	Polydrug	Heroin	Methadone	Marijuana	Sedative / diazepam	Analeptic	Ecstasy	Amphetamine	LS D	No answer	Total
Skopje	92	32	29	6	2	1	1	1	0	3	167
Strumica	68	6	8								82
Kumanovo	16	4	3								23
Gostivar	42	5									47
Kavadarci	12										12
Tetovo	47										47
Stip	8										8
Ohrid	30										30
Bitola	76	4	1								81
Kichevo	22										22
Prilep	4	12	1	3						2	22
Veles	16	0	2	2	0	0	0	0	0	0	20
Gevgelija	21										21
Total	454	63	44	11	2	1	1	1	0	5	582

Source: HOPS

In 2012 there were 16 active programmes to reduce damage caused by drug use across the country, all run by NGOs with financial support from the Global Fund. The NGO HOPS led four programmes in Skopje, along with a special programme for sex workers who inject drugs.

In terms of how drugs are administered, 454 (77.84 %) of 582 new clients in harm reduction programmes in 2011 injected drugs, a decrease of 3 % compared with 2010. It should be emphasised that harm reduction programmes are intended for people who inject drugs, hence the number of injecting drug users is large.

Table 6.12 Do you inject?

	Yes	No	No answer
Skopje	130	34	3
Strumica	73	6	3
Kumanovo	23	0	0
Gostivar	33	14	0
Kavadarci	12	0	0
Tetovo	33	14	0
Stip	7	1	0
Ohrid	29	1	0
Bitola	81	0	0
Kichevo	12	2	8
Prilep	20	2	0
Veles	13	7	0
Gevgelija	20	1	0
Total	486	82	14

6.6. Harm reduction programmes (sharing needles, OST, counselling centres and support) in Skopje in 2012

A total of 684 unique clients attended the NGO HOPS' harm reduction programmes in Skopje in 2012. Of these, 146 were new clients, making contact for the first time. In terms of gender, 12.3 % of new clients were female.

Table 6.13. Number of unique and new clients attending NGOs in Skopje, 2012.

City	Unique clients	New clients		Total number of contacts
		Male	Female	
Skopje	684	128	18	11 101

Source: HOPS.

Table 6.14 Number of needles, syringes and condoms distributed in Skopje, 2012.

City	Needles	Syringes	Condoms	Programmes
Skopje	291 991	111 542	17 535	4

Source: HOPS.

In 2012 harm reduction programmes delivered 13 001 medical services, most of which were basic medical intervention — intervention/treatment of long-term or not adequate injection, counselling and education on drugs and the consequences of drug use, information on treatment and referrals to treatment.

Social workers delivered 5 351 services, most of which were to obtain ID and other personal documents (e.g. birth certificate), assistance with obtaining health insurance and

social support, referrals to institutions and legal advisers, individual psychosocial support, informative advice, referrals to employment training, or informal conversations.

HOPS co-operates with the Public Health Institute to implement VCT on outreach, and they visit locations (streets, parks, abandoned properties, etc.) that are frequented by drug users.

In 2012 HOPS conducted a total of 69 VCTs with drug users (57 male and 12 female); none were found to be HIV positive.

Table 6.15. Employment status of drug users in Skopje, 2012.

City	Number of drug users	Employed		Unemployed		Temporary employed		Honorary		Other	
		N	%	N	%	N	%	N	%	N	%
Skopje	146	16	10.9	118	80.8	2	1.4	6	4.1	4	2.7

Source: HOPS

Table 6.16. Social and health insurance status of new clients in Skopje, 2012.

City	Number of new clients in 2012	With health insurance		Without health insurance		Other	
		N	%	N	%	N	%
Skopje	146	100	68.5	43	29.5	3	2

Source: HOPS

In 2012, of the 146 new clients in harm reduction programmes, 78 (53.4 %) were polydrug users; 16 (10.9 %) only used heroin; and 55 (29.1 %) were single-drug users.

Table 6.17. Type of drug used by new clients in Skopje, 2012.

City	Polydrug	Heroin	Methadone	Marijuana	Sedative/diazepam	Ecstasy	Amphetamine	LSD	No answer	Total
Skopje	78	56	71	64	31	6	4	1	0	146

Source: HOPS

In terms of how drugs were administered, 92 (63 %) of 146 new clients injected drugs in 2012.

Table 6.18 Number of new clients in Skopje who had injected a narcotic drug, 2012.

	Yes	No	No answer
Skopje	92	48	6

7. SOCIAL CORRELATES AND CONSEQUENCES

7.1. Treatment of drug users in prison

The implementation of guidance for equal care recommended by the World Health Organization means that prisoners have the right to receive healthcare equivalent to that available in the community.

Table 7.1. Overview of drug users receiving treatment in prison settings, 2011.

PRISON	Total number of prisoners in 2011	Number of imprisoned drug users	Prisoners on methadone therapy	Prisoners on buprenorphine therapy	% of drug users
Idrizovo, Skopje	1 316	388	154	5	29.4
Skopje	173	130	116	4	75
Kumanovo		0	0	0	0
Shtip	232	22	18	0	9.4
Strumica	105	21	10	1	20
Gevgelija	68	17	14	2	25
Bitola	85	71	69	2	83
Prilep	65	13	1	0	20
Ohrid	21	17	6	1	80.9
Struga	43	12	9	2	27.9
Tetovo	86	28	16	0	32.5
Tetovo Educational Correctional Institution		13	1	0	
Total		746	414	17	

Source: National Report for 2011 of the Administration for execution of sanctions on the condition and operation of the criminal Correctional and correctional institutions in the Former Yugoslav Republic Macedonia, 2012.

In 2012 and 2013 all prisoners had access to OST. Three centres were active in the three main prison facilities in two cities, Skopje and Bitola. Prisoners at other locations were integrated into community OST programmes, and received substitution therapy and psychosocial support from the nearest community treatment centre. The programmes

ensured a smooth transition between prison and community provision of MMT following imprisonment. The total number of prisoners in OST in 2012 was 420. Further details are provided in Section 5.

8. RESPONSES TO SOCIAL CORRELATES AND CONSEQUENCES

The main causes of poverty and social exclusion are long-term dependence on a low or inadequate income, long-term unemployment, low-paid and/or low-quality jobs, a low level of education and training, children being raised in vulnerable families, the impact of physical and mental disabilities, rural/urban disparities, racism and discrimination, and, to a lesser extent, homelessness and migration. The link between unemployment and social exclusion is particularly significant. Reintegration in its widest sense means every form of social inclusion and involvement through various activities in the fields of sport, culture, work and other social activities. Therefore, the social reintegration of addicts should logically follow psychosocial rehabilitation. However, addicts receiving treatment cannot successfully integrate in society for a number of reasons, including public opinion on drug addiction, which marginalises, stigmatises and excludes the entire population of drug addicts from their work and school settings.

8.1. Social reintegration of drug addicts

Three day centres for social reintegration are operating in the country. They offer patients the opportunity to stabilise and normalise progress they have made with previous health interventions. People with problems due to drug addiction are part of a very sensitive and vulnerable group, and the activities and interventions that are provided require considerable planning, and may need to be provided over a long period of time.

The day centres provide programmes for active participation and for obtaining new skills, work re-training programmes, psychosocial interventions and support in order to speed up the process of re-socialisation, social reintegration and effective inclusion in everyday life.

The model is based on the support of the community as a whole, with the involvement of different professionals. The Ministry of Labour and Social Policy has already established day centres in Ohrid, Kumanovo and Strumica.

In accordance with the policies and activities of the Ministry of Labour and Social Policy, in the frame of the social protection of drug abusers, a day centre is also planned for Skopje, where the needs are greatest.

The reasons for opening the centres can be observed in the goals, tasks and activities outlined in the Skopje centre's working programme:

GOAL:

To strengthen and improve the rehabilitation and reintegration of individuals in the municipality of Skopje with social problems that are the consequences of drug abuse.

TASKS:

- Early and timely interventions with intensive and individual attention to the drug users.
- To provide a place where problems and difficulties can be overcome.

- To strengthen families so that they can successfully face and solve the problems caused by drug abuse.

ACTIVITIES:

- Organised counselling with parents and other members of the family; individual and group work.
- A telephone information line to provide information to those wishing to take part in the activities.
- A classroom with computers.
- Sports activities, art club, a workshop for the preparation of handicrafts from different materials.

Social exclusion among drug users, and drug use among socially excluded groups

Social policy and assistance to people who are socially excluded, especially people with disabilities caused by drug abuse, are in the framework of the activities of the Ministry of Labour and Social Policy.

The Law for Social Protection enables the establishment of day centres for people addicted to drugs, in order to provide services such as information, counselling, education, work training, cultural and recreation activities, etc. for the addicted persons and their families. These day centres are a new form of non-residential specialised addiction treatment service. The centres are organisational units of the social work departments in the municipality in which they are located.

8.2. Responses to social correlates and consequences in the new National Drugs Strategy

It is expected that the following two objectives will be implemented as a result of responses to social correlates and consequences, concerning drug users in prisons:

1. Within the criminal justice system, where appropriate, the capacity for assisting drug addicts who are serving a prison sentence, in terms of education and preparation for resettlement and social reintegration upon completion of sentence, will be increased.
2. Measures will be further developed and made available to reduce the demand for drugs in prison (treatment and rehabilitation), based on a proper assessment of the health status and needs of prisoners, in order to achieve care that is equivalent to that provided in the community and in accordance with the right to healthcare and human dignity registered in the European Convention on Human Rights and the Charter of Fundamental Rights of the European Union. Continuity of care should be ensured at all stages of the criminal justice system, including when the person who has served a prison sentence is released.

9. DRUG MARKETS

9.1. The general situation regarding drug supply activities

In 2012 the quantity of drugs seized on the country's territory increased slightly compared to 2011. Cooperation between the police and Customs Administration on drugs seizures improved and several successful international police operations took place to cut drug trafficking channels. The country is on the main Balkans Route for drug trafficking, and the Customs Administration and the Ministry of Internal Affairs are making continued and sustained efforts to detect and seize narcotics at the borders.

Data exchange with partners including Europol facilitates the fight against the organised crime groups involved in drug trafficking in the region. Europol put into operation an agreement to exchange information from all types of data, including personal, on all levels. The aim of this agreement is to strengthen the operative and strategic cooperation and to reinforce the fight against serious forms of international crime, specifically by exchanging data, information and intelligence. The Former Yugoslav Republic of Macedonia and Croatia are the only countries in the region with such an agreement with Europol. This treaty gives enormous recognition, confirming the country's ability to meet EU standard. Europol sees the Ministry of Internal Affairs as a reliable partner even for the most complex police operations.

Regarding customs cooperation, the Customs Administration took part in a number of international operations and projects to detect the illicit trade in counterfeit goods, drugs, explosives, high-risk chemicals and pharmaceuticals. Cooperation and exchange of intelligence with the customs authorities of neighbouring countries intensified, as did cooperation with the relevant UN agencies. Cooperation with the regional intelligence liaison offices of the World Customs Organization continued.

Joint investigation teams have worked together on the basis of a signed agreement for cooperation with the public prosecutors of Germany, Austria and the Netherlands since 2012. Two successful joint actions in collaboration with the Austrian and German police were completed.

The police have established positive links with national police directorates in neighbouring countries (Albania, Kosovo, Serbia, Bulgaria and Greece); memorandums of understanding were signed with various countries on fighting organised crime and drug trafficking. On a case-by-case basis, the police have been successfully cooperating with national police liaison officers from various EU member states, especially Austria, Germany and Italy. Cooperation also exists via the Interpol and Europol networks. Border control efforts are being strengthened through the development of partnership and effective working relationship with organisations such as Interpol, SELEC, SEPICA, Europol, EUROJUST, DCAF and UNODC.

Cooperation with these above networks is crucial for an effective and coordinated action with the aim of tackling organised crime, and also for an operational approach, due to a highly developed database that allows the identification and targeting of repeat offenders. This type of data makes it possible to identify "hot spots" and linked series of crimes,

supplying information that helps identify preventive measures and evidence linking offenders to crimes.

In the area of **police cooperation and the fight against organised crime**, regional and international law enforcement cooperation through Europol and Interpol continued. Some 225 international arrest warrants were issued in 2013. The SIENA connection for the secure exchange of sensitive and operational data with Europol became operational. A liaison officer has been assigned to Europol.

Amendments to the Law on Internal Affairs introduced a merit-based career system for the police, based on job competencies. A strategy on human resources management and a merit-based recruitment policy were adopted. The Public Security Bureau at the Ministry of Internal Affairs was reorganised to strengthen capacities, improve police performance and implement European standards.

New standard operating procedures and guidelines were issued in order to improve the standard of investigations carried out at regional, local and central level, and to ensure more effective and efficient sharing of information. New procedures for the submission of requests for special investigative measures were issued. In the framework of the new Law on Criminal Procedure, which started being applied from the end of 2013, training of police and public prosecutors has continued. A protocol for cooperation in criminal procedures was signed between the Ministry of Internal Affairs, the Public Prosecutor and Customs Administration.

In 2013 the Department for the Fight against Organised Crime submitted 85 criminal charges against 603 people to the specialised Public Prosecutor's Office for the Fight against Organised Crime and Corruption. Staffing of the department continued to improve. A number of successful operations were carried out against organised crime groups involved in drug smuggling, extortion, smuggling of migrants, facilitating abuse of the visa-free regime, falsification of passports and money laundering. Four operations succeeded in cutting off international marijuana trafficking routes.

There were positive developments in the area of **customs cooperation**. The Customs Administration took part in four international operations and two projects to detect the illicit trade in counterfeit goods, drugs, explosives and high-risk chemicals. Cooperation and exchange of intelligence with the customs authorities of neighbouring countries and the wider region intensified.

9.1.1. The domestic production of drugs

Self-cultivated marijuana — mainly for consumption within the country — remains the major illegal source of drug production.

Licit poppy straw and poppy straw concentrates for medical purposes are continuously produced in the central and Eastern parts of the country in an area of approximately 1 000 hectares, which itself implies an increase of 100 % compared to the formerly cultivated 500 hectares. Twenty-four companies/institutions that deal with the import, export or transit of drugs and/or precursors have been registered in the country.

9.2. Narcotics prices

The data on prices were collected from two sources. Police data is presented in Table 9.1, and data from the survey of drug users is presented in Tables 9.2 to 9.7. Section 1 provides information about the methodology of the data collection from drug users.

Table 9.1. Narcotics prices, 2013.

Heroin		Marijuana					Cocaine	Ecstasy	Buprenorphine	Amphetamine
1 g	0.25 g	100 g	3 g	Joint 1	Joint 2	Couple matches	1 g	1 tbl		1 g
EUR 11-15	MKD 300-500	MKD 4 000	MKD 500	MKD 150	MKD 250	MKD 100-200	EUR 50	MKD 300-500	1 tbl x 2 mg = MKD 200-300 1 tbl x 8 mg = MKD 500	MKD 800-1 000

Source: Ministry of the Interior, Former Yugoslav Republic of Macedonia

Table 9.2. The price of 1 g of heroin, 2012 .

	N	Mean	Median	Minimum	Maximum	Std Dev.
Price (MKD)	160	1 239.4	1 200.0	300.0	3 000.0	437.6

Source: T. Petrushevska et al. (2012)

Table 9.3. The price of 1 g of marijuana, 2012.

	N	Mean	Median	Minimum	Maximum	Std Dev.
Price (MKD)	154	166.5	150.0	60.0	600.0	88.7

Source: T. Petrushevska et al. (2012)

Data on the price of 1 g of marijuana were supplied by 154 (62.6 %) of 246 respondents. The minimum price was MKD 60.0, and the maximum was MKD 600.0. The average price was MKD 166.5 ± 88.7. The calculated mean values indicate that 50 % of respondents had paid over MKD 150 for 1 g of marijuana.

Table 9.4. The price of 1 g of methadone, 2012.

	N	Mean	Median	Minimum	Maximum	Std Dev.
Price (MKD)	53	299.4	120.0	50.0	1 000.0	29.7

Source: T. Petrushevska et al. (2012)

Data on the price of 1 g methadone were supplied by 53 (21.5 %) of the 246 respondents. The minimum price was MKD 50.0, and the maximum was MKD 1 000.0. The average price was MKD 299.4 ± 290.7. The calculated mean values indicate that 50 % of respondents had paid over MKD 120.0 for 1 g of methadone.

Table 9.5. The price of one tablet of amphetamine, 2012.

	N	Mean	Median	Minimum	Maximum	Std Dev.
Price (MKD)	35	812.9	1000	250	2000	477.6

Source: T. Petrushevska et al. (2012)

Data on the price of one tablet of amphetamine were supplied by 35 (14.2 %) of the 246 respondents. The minimum price was MKD 250.0, and the maximum was MKD 2 000.0. The average price was MKD 812.9 ± 477.6. The calculated mean values indicate that 50 % of respondents had paid over MKD 1 000.0 for one tablet of amphetamine.

Table 9.6. The price of 1 g of cocaine, 2012.

	N	Mean	Median	Minimum	Maximum	Std Dev.
Price (MKD)	28	3 275.0	3 000.0	2 500.0	6 000.0	707.4

Source: T. Petrushevska et al. (2012)

Data on the price of 1 g of cocaine were supplied by 35 (14.2 %) of the 246 respondents. The minimum price was MKD 2 500.0, and the maximum was MKD 6 000.0. The average price was MKD 3 275.0 ± 707.4. The calculated mean values indicate that 50 % of respondents had paid over MKD 3 000.0 for 1 g of cocaine.

Table 9.7. The price of one ecstasy tablet, 2012.

	N	Mean	Median	Minimum	Maximum	Std Dev.
Price (MKD)	51	342.2	300.0	250.0	600.0	73.1

Source: T. Petrushevska et al. (2012)

Data on the price of one Ecstasy tablet were supplied by 51 (20.7 %) of the 246 respondents. The minimum price was MKD 250.0, and the maximum was MKD 600.0. The average price was MKD 342.2 ± 73.1. The calculated mean values indicate that 50 % of respondents paid over MKD 300.0 for one Ecstasy tablet.

9.3. Narcotics seizures

Table 9.8. The trend in narcotics seizures, 2011, 2012 and 2013 (to December).

	2011	2012	2013
Marijuana	286 kg 397.8 g	109 kg	923 kg 480 g
Heroin	23 kg 720.04 g	76 kg 124.89 g	13 kg 833 g
Cocaine	1 kg 469.12 g 1.560 ml liquid cocaine	48.93 g	15.35 g and 150 ml liquid cocaine
Hashish	114 kg 115 g	26.5 g	
Amphetamine	10.930 tbl and 1 kg 819 g	3.083 tbl and 4.3 g	54 tbl and 1.5 g
Ecstasy	3.628 tbl	151 tbl	
Methamphetamine	66 tbl and 17.92 g	3.083 tbl and 4.3 g	3 tbl and 7.1 g
Lsd	-	2pcs and 61,7 g	
Cannabis sativa	1.247 plants 1.381 pcs 143.86 g seeds	718 plants 890 pcs 63.49 g seeds	143 plants, 135 pcs 14.37 g seeds
Opium	3.7 g	79.5 aqua solution of opium (with concentr. 2782.5 g opium)	

Ephedrine	1 g	-	
Diazepam	1.005 amp.	115 amp.	59 amp. and 113 tbl
Hallucinogenous mushrooms	0.5 g	128 g	
Mixture tobacco and marijuana	28.55 g	20.21 g	12.93 g
Methadone		600 ml 1 270 tbl	45 ml
Precursor: HCL (Hydrochloric acid)		6.5 l	
Different liquids needed for illicit production of narcotics		28.2 l	
MDMA			72 tbl
Buprenorphine			12 tbl

Source: IMCND 2013

In 2013 the criminal act of illegal drug trafficking was committed by 668 perpetrators, of which 655 national citizens and 13 were foreigners (five Albanian nationals, four Turkish nationals, two Greek nationals, one Croatian national and one Polish national).

National anti-drug trafficking efforts and its commitment to seizing large amounts of drugs at the country's borders in the past years appear to have led to a shift in international drug trafficking routes. With the support of international partners (Interpol, Europol, WCO, UNODC, INCB, EMCDDA, BKA, DEA, and all regional law enforcement authorities), the country increased its capacity by developing integrated border management and tracking the illicit trade through its borders.

9.3.1 Narcotics seizures at border crossing points, 2013

Figure 9.1. Location of customs houses, customs offices and border crossings.



Source: Customs Administration.

Table 9.9. Narcotics seizures by Customs Administration at border crossing points, 2013.

No.	Date	Border crossing point	Import/export	vehicle	Quantity (grams)	Type
1	08.01.2013	Megitlija	Export	Transport motor vehicle	301 454.00	Marijuana
2	12.01.2013	Tabanovce	Export	Passenger motor vehicle (PMV)	14 570.00	Marijuana
3	28.01.2013	Tabanovce	Export	Bus	126 295.00	Marijuana
4	29.01.2013	Tabanovce	Export	Bus	1 945,00	Marijuana
5	06.02.2013	Tabanovce	Export	PMV	1 985.00	Marijuana
6	10.02.2013	Deve Bair	Export	Bus (passenger)	1 030.00	Marijuana
7	15.02.2013	Tabanovce	Export	PMV	14 275.00	Marijuana
8	01.03.2013	Tabanovce	Export	Minibus (passenger)	345.00	Marijuana
9	28.03.2013	Deve Bair	Export	PMV	10 675.00	Marijuana
10	10.04.2013	Tabanovce	Export	PMV	12 960.00	Marijuana
11	18.04.2013	St.Naum	Import	PMV	2 955.00	Marijuana
12	10.05.2013	Kafasan	Import	PMV	10 885.00	Marijuana
13	12.05.2013	Kafasan	Import	PMV	7 060.00	Marijuana
14	16/17.05.2013	Tabanovce	Export	PMV	16 024.00	Marijuana
15	06.04.2013	Delcevo	Export	PMV	6.10	Marijuana
16	14.06.2013	Tabanovce	Export	Bus	98 090.00	Marijuana
17	03.08.2013	Deve Bair	Export	PMV	12 390.00	Marijuana
18	10.09.2013	Tabanovce	Export	PMV	24 747.00	Marijuana
19	09.10.2013	Tabanovce	Export	PMV	5 431.99	Heroin
20	04.10.2013	Delcevo	Import	PMV	0.48	Marijuana
21	01.11.2013	Tabanovce	Export	PMV	13 215.00	Marijuana
22	26.11.2013	Megitlija	Export	PMV	30 000.00	Marijuana
23	26.11.2013	Tabanovce	Export	PMV	6 000.00	Marijuana

Source: Customs Administration.

Table 9.10. Narcotics seizures by Customs Administration at border crossing points, 2012.

	Date	Place	Import/export	Transportation	Quantity	Type
1	31.01.2012	Customs border point Blace	Export	Bus	50 l	Acetone
					8 l	Hydrochloric acid
2	29.03.2012	Customs border point Deve Bair	Import	Passenger motor vehicle (PMV)	1 270 tablets	Methadone
3	09.04.2012	Custom office in Central Post Office	Import	Delivery by post	52 seeds	Cannabis
					70 g	Magic mushroom – psilocin

4	25.06.2012	Customs border point Blato	Import	PMV	3 840 g	Marijuana
5	05.07.2012	Customs border point Tabanovce	Export	Bus	9.89 g	Heroin
6	17.09.2012	Customs border point Tabanovce	Export	PMV	5 670 g	Heroin
7	17.09.2012	Customs border point Tabanovce	Export	PMV	6 835 g	Marijuana
8	11.10.2012	Customs border point Tabanovce	Export	Bus	4.5 g	Hashish
9	21.10.2012	Customs border point Deve Bair	Import	PMV	9 445 g	Heroin
10	24.10.2012	Customs border point Tabanovce	Export	PMV	7.3 g	Marijuana
11	06.11.2012	Customs border point Blace	Import	PMV – taxi	5 385 g	Marijuana
12	11.11.2012	Customs border point Airport	Import	Plane	8 tbl	Methadone

Source: Customs Administration.

Tables 9.9 and 9.10 show the geographical distribution of the seizures in 2012 and 2013. In 2012 seizures were predominantly made at exit border crossing points, mainly Tabanovce, on the border with Serbia, and the main drug seized was marijuana. The law enforcement data indicates that the country of origin was Albania. In one case, in 2013, seizure of a large amount of marijuana was made on the border crossing point Megitlija, which is on the border with Greece. The final destination was intended to be the Netherlands, according to law enforcement data.