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**This action is funded by the European Union**

Annex V

to the Commission Implementing Decision on the Annual action plan in favour of North Macedonia for 2024

Action Document EU for Health

**Annual Action plan**

This document constitutes the annual work programme in the sense of Article 110(2) of the Financial Regulation, and annual and multiannual action plans and measures in the sense of Article 9 of IPA III Regulation and Article 23(2) of NDICI - Global Europe Regulation.

# SYNOPSIS

# Action Summary Table

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Title** | EU for Health  Annual Action plan in favour of North Macedonia for 2024 | | | | |
| **OPSYS** | [/OPSYS business reference][[1]](#footnote-2): <reference> | | | | |
| **ABAC** | ABAC Commitment level 1 number: <reference> | | | | |
| **Basic Act** | Financed under the Instrument for Pre-accession Assistance (IPA III) | | | | |
| **Economic and Investment Plan (EIP)** | Yes  Health Resilience – 100%[[2]](#footnote-3) | | | | |
| **EIP Flagship** | Yes  Flagship: VIII Digital Infrastructure” – 67% | | | | |
| **Team Europe** | No | | | | |
| **Beneficiar(y)/(ies) of the action** | The Action shall be carried out in the Republic of North Macedonia | | | | |
| **Programming document** | IPA III Programming Framework | | | | |
| **PRIORITY AREAS AND SECTOR INFORMATION** | | | | | |
| **Window and thematic priority[[3]](#footnote-4)** | Window 4: Competitiveness and inclusive growth  Thematic Priority 1: Education, employment, social protection and inclusion policies, and health (100 %) | | | | |
| **Sustainable Development Goals (SDGs)** | Main SDG 3: Ensure healthy lives and promote well-being for all at all ages.  Other significant SDGs (up to 9) and, where appropriate, targets:  SDG 1: End poverty in all its forms everywhere  SDG 5: Achieve gender equality and empower all women and girls | | | | |
| **DAC code(s)**[[4]](#footnote-5) | 12110 Health policy and administrative management | | | | |
| **Main Delivery Channel** | 12000-Recipient Government | | | | |
| **Targets** | Climate  Gender  Biodiversity | | | | |
| **Markers[[5]](#footnote-6)**  **(from DAC form)** | **General policy objective** | **Not targeted** | **Significant objective** | | **Principal objective** |
| Participation development/good governance |  |  | |  |
| Aid to environment |  |  | |  |
| Gender equality and women’s and girl’s empowerment |  |  | |  |
| Reproductive, maternal, new-born and child health |  |  | |  |
| Disaster Risk Reduction |  |  | |  |
| |  | | --- | | Inclusion of persons with  Disabilities | |  |  | |  |
| Nutrition[[6]](#footnote-7) |  |  | |  |
| **RIO Convention markers** | **Not targeted** | **Significant objective** | | **Principal objective** |
| Biological diversity |  |  | |  |
| Combat desertification |  |  | |  |
| Climate change mitigation |  |  | |  |
| Climate change adaptation |  |  | |  |
| **Internal markers[[7]](#footnote-8) and Tags** | **Policy objectives** | **Not targeted** | **Significant objective** | | **Principal objective** |
| EIP |  |  | |  |
| EIP Flagship | YES | | NO  ☐ | |
| Tags[[8]](#footnote-9): | YES | | NO | |
| Transport |  | |  | |
| Energy |  | |  | |
| Environment and climate resilience |  | |  | |
| Digital |  | |  | |
| Economic development (incl. private sector, trade and macroeconomic support) |  | |  | |
| Human Development (incl. human capital and youth) |  | |  | |
| Health resilience |  | |  | |
| Migration and mobility |  | |  | |
| Agriculture, food security and rural development |  | |  | |
| Rule of law, governance and Public Administration reform |  | |  | |
| Other |  | |  | |
| Digitalisation[[9]](#footnote-10) [@](http://www.cc.cec/wikis/display/crisknowledgebase/DAC+-+Chapter+3#DAC-Chapter3-3.6.5.1Digitalisation) |  |  | |  |
| Tags[[10]](#footnote-11)  digital connectivity  digital governance  digital entrepreneurship  digital skills/literacy  digital services | YES | | NO | |
| Connectivity [@](https://eeas.europa.eu/sites/default/files/eu-asian_connectivity_factsheet_september_2019.pdf_final.pdf) |  |  | |  |
| Tags  digital connectivity  energy  transport  health  education and research | YES | | NO | |
| Migration[[11]](#footnote-12) [@](https://myintracomm.ec.europa.eu/DG/INTPA/devco-management/programming/Pages/index.aspx#thematic-guidance) |  |  | |  |
| Reduction of Inequalities [@](https://webgate.ec.europa.eu/fpfis/wikis/display/PCM/Guidelines+for+mainstreaming+the+reduction+of+inequality+in+interventions) |  |  | |  |
| COVID-19 |  |  | |  |
| **BUDGET INFORMATION** | | | | | |
| **Amounts concerned** | Budget line: : 15.020201  Total estimated cost: EUR 14 160 000  Total amount of EU budget contribution: EUR 12 000 000 | | | | |
| **MANAGEMENT AND IMPLEMENTATION** | | | | | |
| **Implementation modalities (management mode and delivery methods)** | **Direct management** through:  - Procurement of services and supplies | | | | |
| **Final Date for conclusion of Financing Agreement** | At the latest by 31 December 2025 | | | | |
| **Final date for concluding contribution / delegation agreements, procurement and grant contracts** | 3 years following the date of conclusion of the financing agreement, with the exception of cases listed under Article 114(2) of the Financial Regulation | | | | |
| **Indicative operational implementation period** | 72 months[[12]](#footnote-13) following the conclusion of the Financing Agreement | | | | |
| **Final date for implementing the Financing Agreement** | 12 years following the conclusion of the Financing Agreement | | | | |

# Summary of the Action

The Action aims at improving the health and well-being of Macedonian citizens by optimising the country's health care service. It will support the modernisation and digitalisation of the healthcare system by strengthening the tele-radiology services, integrating the mobile primary healthcare services (such as EMS, patronage, duty service, home treatment, vaccination, and rural doctor services) in the e-health system, upgrading the information technology of the Emergency Medical Service and enhancing the health cloud infrastructure. The EU assistance will allow North Macedonia to significantly improve the health data collection and use for prevention, diagnostics, treatment, and management purposes. In medium term perspective this will enable the country to become a valuable contributor to the EU tele-radiology and e-health platforms. The action will also support the prevention of non-communicable diseases by extending the coverage of screening programs with lung and colorectal cancer screening. The modernisation of the ambulance fleet will strengthen the pre-hospital and hospital response to medical, surgical and trauma emergencies in line with the international and European standards.

## Beneficiar(y)/(ies) of the Action

The action shall be carried out in North Macedonia.

# RATIONALE

# Context

# North Macedonia has a comprehensive legal framework for regulating public health, with fundamental laws covering healthcare, health insurance, public health, health records, and patient rights. The country has implemented significant reforms, including establishing a *Health Network* for strategic healthcare resource planning, deploying a health information system called *Moj Termin*, and changing the *Health Insurance Law*, providing public insurance coverage to more than 90% of the population. In February 2019, the Ministry of Health launched a national reform to introduce a new integrated and patient-centred care model to improve health coverage in the primary healthcare system.

From a strategic perspective, North Macedonia has developed the *National Health Strategy* 2021-2030 with significant public participation in its elaboration. The strategy sets out a direction and pathway for the modernisation and development of the country's health system to improve the population's health status and the healthcare experience of all citizens.

Health expenditure is relatively low compared to EU and South-Eastern European countries, per capita and as a percentage of gross domestic product (GDP). Spending on health as a percentage of GDP decreased from 8,9% in 2000 to 7,3% in 2019[[13]](#footnote-14). Although more than half of health spending comes from public sources (57%), public expenditure per capita is meagre. In 2019, North Macedonia spent 775 US$ PPP (purchasing power parity) on health, the second lowest in South Eastern Europe after Albania (377US$ PPP). The share of public spending on health as a share of GDP decreased from 5% in 2033 to 4,3% in 2019[[14]](#footnote-15).

The Public Health Sector in the country includes the National Institute for Public Health and ten regional Public Health Centres, which are responsible for promoting health and preventing diseases. There is a network of primary care providers at the municipal level, although these were privatised between 2004-2007, leading to a diversified provider market. The Health Network was created in 2012 to establish a well-distributed network of certified public and private healthcare providers contracted by the Health Insurance Fund (HIF) to provide services under the health insurance system.

Despite the Health Network's vision to establish a new primary healthcare model with multidisciplinary and integrated teams, there must be more coordination between primary care providers. The network of secondary and tertiary care providers is well-developed, but there is significant variation in capacity utilisation across similarly classified hospitals. In 2017, hospital beds per capita decreased, and North Macedonia now has a lower hospital-bed ratio than the EU. Despite the decrease in beds, hospitals operate far below total capacity, and bed occupancy rates are among the lowest in Europe, with an unequal distribution of hospital beds, with more than half of all hospitals in Skopje.

The health sector in North Macedonia requires more physicians, nurses, and midwives, especially specialists, to meet the growing demand for healthcare services. Although salaries have increased as a retention policy, medical staff either move to the private sector or work abroad. In 2019, the total health system workforce was estimated to be 33,544, an increase of over 6,500 from 2010. The number of physicians has increased, approaching the EU average, but the ratio of nurses to the population is less than half the average. Therefore, efforts should be made to retain medical staff and attract qualified professionals from other countries.

North Macedonia has made technological investments in medical equipment in the last ten years but still lags behind the EU average in modern diagnostic imaging technologies. As of 2018, there were only 3.9 MRI units per million population compared to the EU average of 17.4, while there were 8.7 CT units per million inhabitants, representing 39% of the EU average. In 2018, there were 26 mammography units (1.25 units per 100,000 population). However, the country has significantly boosted its medical infrastructure by donating modern equipment by the EU to eight regional medical centres, with MRI and computed tomography devices distributed to various hospitals nationwide.

North Macedonia has an ageing population trend, which could impact its health system. The fertility rate is below the EU average and well below the replacement level, [[15]](#footnote-16) while life expectancy is lower than the EU average[[16]](#footnote-17). In 2019, the infant mortality rate was higher than the EU average, and regional variations exist in premature mortality. Although premature mortality is decreasing with the increase in life expectancy, there is still a significant difference between the best- and worst-performing regions.

Non-communicable disease (NCD) accounts for an estimated 95% of all deaths: cardiovascular diseases (61%) and cancer (21%), in particular, lung cancer, colorectal, pancreatic, and prostate, are the main contributors with diabetes and chronic respiratory disease making up most of the balance[[17]](#footnote-18).

High-risk factors such as tobacco, alcohol, psychoactive drug abuse, high blood pressure, lack of physical exercise, and unhealthy diet contribute to premature mortality, morbidity, and disability. Overweight and obesity rates and smoking prevalence are increasing among people aged 15-64 in North Macedonia, which is a cause for concern, especially for vulnerable populations. Particulate air pollution is a significant public health issue in urban centres, particularly in Skopje, and is a risk factor for ill health. The government has adopted a plan to consistently implement laws on smoking protection, including strengthening smoking control in public places.

North Macedonia has implemented a nationwide cloud-based e-health system called "Moj Termin" initially designed to manage appointments in the hospital sector. It has since been expanded to cover various services across public and private institutions, with several modules that can integrate with other healthcare applications. These modules include a digital scheduling system, an electronic health record, e-referrals, laboratory and imaging services ordering, and e-prescriptions. The system has reduced waiting times for diagnostic imaging and clinical appointments, highlighting the importance of strategic planning for e-health.

Emergency services in North Macedonia are provided by primary care providers and emergency care units in Health Centres and hospital emergency wards. However, the demand for emergency care has proliferated in the past decade, resulting in increased pressure on services, department overcrowding, and long waiting times. The Macedonian EMS system has improved its medical response capabilities across all situations in recent years, with EMS vehicles primarily run by non-specialist-trained physicians. The country uses a standard emergency call number (112) adopted throughout Europe, and 86 ambulance vehicles were added to the system in 2013 to improve efficiency. However, in rural areas with poor road conditions can take over an hour to reach the nearest emergency care unit.

The proposed Action aims to support candidate countries in achieving equal opportunities, access to the labour market, fair working conditions, social protection, inclusion, and a high level of human health protection, in line with the **IPA III Programming Framework**. It explicitly addresses **Objective 1.4 in Window 4**, **Thematic Priority 1**, by improving healthcare infrastructure and equipment, addressing unmet medical needs, implementing an electronic health system, and improving standards of care for communicable and non-communicable diseases. The Action also aligns with the **United Nations' 2030 Agenda for Sustainable Development** by contributing to Goal 3 (Good Health and Well-being) and target 3.4 (Reduce premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being).

# Problem Analysis

Short problem analysis

*Healthcare system digitalisation*

In 2011, North Macedonia established the National System for e-Health - "Moj Termin" - with only basic functionalities. The system has been updated several times, including in the last two years, to reflect COVID-19 related diagnostic and vaccination indicators. Currently, around 19,000 professional users, including over 10,000 doctors (4,800 from primary, 3,700 from secondary, and 900 from tertiary health care levels), use "Moj Termin." Despite its successes, legal and operational barriers hinder further system uptake, such as integrating diagnostic images and providing access to specific healthcare providers. By the end of 2023, patients will become direct system users, and it is expected to generate over 1.8 million active patient files. Patients can schedule visits to family doctors or vaccination appointments online.

To ensure security and business continuity, the system must be upgraded[[18]](#footnote-19). Full system availability should be guaranteed for the entire working day - 99.95% of the time - while the lowest degree of unavailability should be less than 4.38 hours annually. Additionally, a critical challenge is the mobility of some health services that do not occur on health institution premises but are conducted in the field. While supporting such services in the interest of patients, data security, connection, and synchronisation with the centralised working environment must be ensured. Finally, this Action complements the IPA III 2022 Action *Document "EU for Health, Social Protection, and Gender Equality,"* which will define Enterprise Resource Planning (ERP) and electronic laboratory operation (LOINC) standards for public health institutions and laboratories and consolidate the Ministry of Health and Health Insurance Fund IT systems.

*Mortality due to cancer*

North Macedonia faces a challenge with the decreasing number of radiologists and inadequate medical diagnostic and treatment services in rural and peripheral areas. Cancer is the country's second most common cause of death, with lung cancer being the leading cause, accounting for 12.9% of all cancer cases. The mortality rate for bronchus and lung cancer has been increasing, particularly among men, from 64.8 in 2010 to 66.9 in 2014 and 67.6 per 100,000 men in 2020. Colorectal cancer represents 5.8% of all cancer cases, and only 14% are detected early. North Macedonia lacks a systematic screening program for colorectal cancer across the country. A screening program based on the Faecal Occult Blood Test (FOBT) has only been implemented in Skopje, but its accuracy is facing some critical challenges.

This Action aims to strengthen radiology services and improve the early diagnosis of non-communicable diseases, particularly colorectal cancer. This initiative complements the IPA 2022 Action *"EU for Health, Social Protection, and Gender Equality,"* which focuses on strengthening screening programmes and methodology for oncological diseases, enhancing medical skills, and upgrading equipment and technologies related to breast and cervical cancers. The IPA 2024 Action will extend the screening programme's coverage to include lung cancer, expand activities to prevent colorectal cancer, and increase the use of tele-radiology. Furthermore, this Action aims to improve the national tele-radiology system to allow remote access to radiological data and establish a national database of medical imaging recordings from various diagnostic equipment.

*Emergency Medical Service*

North Macedonia provides healthcare to its citizens through a tiered system, and emergency care is free for everyone. Early steps have been taken to create a more modern version of an effective EMS system. Further progress should be made in developing an integrated emergency medical services network through reconfiguring facilities to create modern integrated receiving hospital departments with appropriate technologies and capacities, e.g., integral diagnostic imaging, minor operating and treatment rooms, 24-hour observation beds, etc. All elements require investment in human resource development education and training to create the skills and capacities necessary for a modern system.

The Emergency Medical Services (EMS) network is based on thirty-three (33) primary level Health centres covering the entire country territory. Each EMS provides diagnostic and therapeutic services for life-threatening and urgent intervention cases and is on the front line in crises and emergencies. The EMS undertakes on-the-spot resuscitation and intensive care measures and ensures transport to the nearest healthcare institution for the necessary treatment, rehabilitation, and reintegration. Currently, the EMSs have a fleet of 160 vehicles, of which 90% have been in use for more than ten years, and 50% have for more than 15 years. Most vehicles must be equipped up to the EU standards (CEN standard 1789:2020), are high-energy intensive and in poor technical status, and their use and maintenance could be more efficient and effective. Moreover, North Macedonia needs an adequate system to manage and monitor the entire fleet of ambulance vehicles nationwide.

The Action aims to improve the pre-hospital and hospital response to emergency medical, surgical and trauma situations in line with international and European standards. This will be achieved by renewing part of the ambulance fleet and upgrading the EMS ICT technologies. The Action has chosen ambulances with EURO 6 standards over electric ambulances, hybrid vehicles, or those with solar panels due to their lower cost for procurement and maintenance, longer range, and not requiring any additional infrastructure. While electric ambulances, hybrid vehicles, and solar panels have environmental benefits, ambulances with EURO 6 standards may be more practical due to cost, range, reliability, speed and infrastructure.

Main stakeholders

* The **Ministry of Health (MoH)** is responsible for setting the health system's strategic direction, developing legislation and policies, monitoring performance, planning funding models, and ensuring guidelines are met. It is also responsible for occupational medicine activities and grants authorisations to healthcare institutions to practice occupational therapy based on evaluations of their minimum criteria, keeping a register of such institutions.
* The **Health Insurance Fund (HIF) purchases** public health services through performance-based contracts with public and private health providers.
* The **Institute of Public Health (IPH)** performs healthcare-related activities per the Law on Health Protection. This includes monitoring the population's health status, studying risk factors, planning prevention and early disease detection measures, and promoting health and the environment. The IPH also monitors the work of public health centres and keeps health statistics for North Macedonia.
* The **e-Health Directorate** is a state administration body within the Ministry of Health with the capacity of a legal entity that performs professional work relevant to developing and promoting the integrated health information system. It is responsible for upgrading, optimisation, execution, regulation, maintenance, control, education of the health staff and analysis of all processes and functionalities related to the integrated health information system that health institutions use within the health network, the Ministry of Health, the Health Insurance Fund, the Drug Agency or other entities in the field of health.
* **The university clinic for pulmonology** and allergology and the **University clinic for gastroenterohepatology** are public health institutions providing tertiary health care and can perform screening programs for lung and colorectal cancer.

# Lessons Learned

Before COVID19, the EU assistance for the sector of health was limited to the context of the migration crisis 2015/2016. The pandemic has revealed the vulnerability of the health systems, and pushed for a more ambitious response to the pandemic and other health challenges. While the EU assistance of EUR 20 million is still under implementation, the following lessons have crystallised:

* The reforms in the health sector are resource-intensive and require strong political commitment and national consensus in a medium to long-term perspective. The sector policy dialogue must be intense and inclusive to channel various inputs, visions, and concerns effectively. The sector working group on health needs therefore to be significantly strengthened and the inclusion of patients’ organisations must be ensured.
* The significant investments needed in the health care sector must be closely linked to the sector reforms to improve the effectiveness of the investments. Research shows that lung cancer incidents are linked to high pollution, smoking and unhealthy life style. Prevention and early detection of lung cancer requires, along with investments in the health care, enhancement of the national anti-tobacco policy and significant measures to decrease urban pollution due to outdated transport and heating systems. To address this finding, the Action encompasses also a policy advisory contract, which will guide the authorities in taking the right policy measures.
* The administrative capacity of the Ministry of Health to work with the EU assistance and EU counterparts is very low as the experience is limited and primarily accumulated in COVID19 context. The Ministry needs to establish a well-staffed and prepared project management unit to channel and coordinate the external assistance for the sector reforms. With this purpose, a policy advisory contract is planned within the scope of this action.

# DESCRIPTION OF THE ACTION

# Intervention Logic

The Overall Objective(s)/(Impact(s)) of this Action is:

*To improve the health and well-being of North Macedonia’s citizens.*

The Specific Objective (Outcome) of this Action is:

*To enhance the digitalisation and modernisation of the Healthcare System.*

This Outcome will be achieved through the delivery of the following Outputs:

**Output 1.** Improved National Tele-radiology System to allow remote use of radiology data

**Output 2.** Improved prevention and control of non-communicable diseases

**Output 3.** Improved health cloud infrastructure

**Output 4.** Improved mobile primary healthcare service

**Output 5.** Modernised Emergency Medical Service (EMS)

# Indicative Activities

The Action will be implemented through the following main activities:

**Output 1: Improved National Tele-radiology System to allow remote use of radiologic data**

This output will be attained through the following activities:

* Establishing a national database of medical image recordings from various diagnostics (tomography, magnetic resonance imaging and mammography) reliable for scientific and professional analysis. In addition to the definition of the requirements and the scope of medical imaging recordings, and putting the database in place, the Action will also establish governance system to ensure that the data is collected, managed, and used responsibly and ethically. The data security and privacy will be addressed - access will be provided to authorised users, such as healthcare professionals, researchers, and policymakers, while measures to protect the data from unauthorised access, use, or disclosure will be put in place in line with the data protection laws and regulations.
* Simplifying the implementing procedures for quality control of the operation of radio diagnostic cabinets nationwide and comprehensive training to the technicians who operate the radio diagnostic cabinets to apply the standardise procedures, conduct regular maintenance of the radio diagnostic and ensure the proper use of the equipment and its optimal performance. The new protocols will allow automatisation of the data collection which will simplify the monitoring process, reduce the risk of errors and streamline the reporting procedures.
* Purchase and installation of the ICT hardware and software solutions connecting and integrating the radiological equipment with the National e-Health System. The process will involve software upgrades, configurations, custom solutions and/or standardised protocols such as DICOM (Digital Imaging and Communications in Medicine) for setting secure connections and interfaces between the radiological equipment and the e-health system to ensure that data is exchanged seamlessly, accurately and securely. Appropriate security measures must be implemented to protect the data and ensure it is only accessible to authorised personnel.

**Output 2: Improved prevention and control of non-communicable diseases**

This output will be achieved through the following activities:

* Policy advice and support for the implementation of the national far-reaching horizontal cancer prevention measures such as aligning the anti-tobacco policy with the EU standards for free-of-smoke public areas, analysing the exposure of youth, girls and women to higher pollution, raising the awareness of the citizens on the causes of lung cancer, particularly smoking and air pollution and promotion of healthy life style. The awareness campaigns should be focused on the following aspects:
* Smoking is the leading cause of lung cancer: It is essential to highlight the link between smoking and lung cancer. Cigarette smoke contains numerous chemicals that can damage the cells in the lungs and lead to cancer. It's important to emphasise that smoking harms the smoker and those around them through second-hand smoke.
* Air pollution can also cause lung cancer: Air pollution is a significant risk factor. In North Macedonia, sources of air pollution include industrial emissions, vehicle exhaust, and burning solid fuels for heating and cooking. It's essential to educate the public about the steps they can take to reduce their exposure to air pollution.
* Early detection is crucial: Early detection of lung cancer can significantly improve the chances of successful treatment. Encouraging people to get screened for lung cancer, especially those at high risk due to smoking or exposure to air pollution, can help identify cancer earlier.
* Prevention is key: The best way to prevent lung cancer is to avoid smoking and reduce exposure to air pollution. The campaign could provide information on smoking cessation resources, such as counselling and nicotine replacement therapy, as well as tips for reducing exposure to air pollution, such as using public transportation, walking or biking instead of driving, and supporting policies that reduce pollution.
* Support for those affected: The campaign could also provide information on support resources for those affected by lung cancer, such as support groups and counselling services.
* Put in place a lung cancer screening programme which will define the criteria for enrolment in the screening programmes, the qualification and responsibility of the personnel involved, modules for lung cancer screening, quality standards, and technical requirements for imaging. More specifically, this lung cancer screening programme involves several steps, including:
* Establish a multidisciplinary team to plan and implement the screening programme. This team should include radiologists, pulmonologists, thoracic surgeons, oncologists, and epidemiologists.
* Define the target population for the screening programme. This population includes current or former smokers who meet certain criteria, such as age and smoking history.
* Develop enrolment criteria for the screening programme. This may include age, smoking history, and other risk factors for lung cancer.
* Define the screening protocol, which includes the imaging modality (e.g. low-dose CT) and the frequency of screening.
* Define the qualifications and responsibilities of the personnel involved in the screening programme, including radiologists, technologists, and support staff.
* Establish quality standards, including quality assurance and quality control measures.
* Develop technical requirements for imaging, including equipment specifications and image interpretation guidelines.
* Develop a referral and follow-up process for individuals with suspicious lesions on imaging.
* Develop a data management plan to ensure that data collected during the screening programme is securely stored and managed appropriately.
* Evaluate the programme to determine its effectiveness in reducing lung cancer mortality and improving patient outcomes. This evaluation should include ongoing programme performance and outcomes monitoring and periodic programme reviews and updates as needed.
* Put in place an operational screening programme for colorectal cancer[[19]](#footnote-20) encompassing modernised colonoscopy equipment, and an integrated IT solution to link all actors in diagnosing and treating colorectal cancer (primary health care doctors, specialists, university clinics, pathology labs, etc.). The improved screening programme will be piloted in Skopje and will cover 5,000 women and men per year aged 50-74.

**Output 3: Improved health cloud infrastructure**

This output will be achieved through the following activities:

* Providing a cloud infrastructure to support the e-Health system security, business continuity, and numerous potential points of the outage. This will bring the following benefits related to security, business continuity, and outage management:
* Enhance the security of e-Health systems by providing advanced security features such as data encryption, access control, and threat detection. These features can help protect sensitive patient information and prevent unauthorised access, data breaches, and cyber-attacks.
* Ensure business continuity by offering reliable and scalable computing resources that can support the continuous operation of the e-Health system. In case of hardware or software failures, the cloud can automatically redirect traffic and computing resources to alternative servers or data centres, minimising downtime and preventing service disruptions.
* Provide a robust outage management system with real-time monitoring, automated alerting, and rapid recovery mechanisms. In an outage or service disruption, the cloud can quickly identify the root cause, notify the relevant stakeholders, and activate the recovery procedures.
* Setting up an integrated modular security solution that includes Endpoint, Network and Data Centre security, which involves:
* Identifying Security Requirements on the grounds of assessing the potential vulnerabilities and threats to the organisation’s network, endpoints, and data centre infrastructure.
* Select the appropriate security technologies that can address those requirements. This can include firewalls, intrusion detection and prevention systems, endpoint protection software, data encryption, access control technologies, and other security tools.
* Design the integrated modular security solution.
* Deploy and configure the security technologies. This can involve installing hardware and software components, configuring network devices, and creating security policies and rules.
* Testing and validation to ensure the security solution is effective in detecting and preventing security threats.
* Ongoing management and maintenance to ensure it remains effective over time. This involves monitoring security events, updating security policies and rules, and conducting regular security assessments to identify new threats and vulnerabilities.
* Elaborating a model for business continuity with a level of unavailability lower than 43 seconds per day.
* Establishing a solution without a Single Point of Failure, which will create a system that is resilient and able to continue functioning even if one part of it fails. This approach would help to prevent critical breakdowns in the healthcare system and improve overall patient care.
* Providing the component of the health could infrastructure (hardware components, system hosting and internet connections, database system licenses, migration of the “Moj Termin” system to the new infrastructure).

**Output 4: Improved mobile primary health care services**

This output will connect the emergency services, patronage, medical duty service, home treatment, vaccination, and rural doctor to the e-Health system. It will be achieved through:

* Providing hardware and network infrastructure for virtualisation of operations (servers, storage, networking) installed at the central location.
* Providing local units with equipment and work devices -static and mobile.
* Providing an integrated IT solution based on “Moj Termin” as a separate module for mobility services and telemedicine.

**Output 5: Modernised Emergency Medical Service (EMS)**

This output will be achieved through the following activities:

* Replacing 50 technologically old and far from the standard emergency health care vehicles to strengthen the emergency response at the site of events/accidents and in transit, which at the same time will enable low emission of gases in line with gas emission standard EURO 6. The vehicles will be distributed throughout the established network of emergency health care. The expected results are decreased time of response, better utilisation of the existing teams for emergency health care, and increasing the number of emergency teams in place. This will significantly improve the patients’ care outreach.
* Upgrading the EMS ICT technologies **-** Establishing fully-functional dispatch centres connecting them with a new ITC system for managing the EMS. The new system will allow the EMS to collect, track and dispatch emergency and accident-related information and crew report data. Interoperability and data traceability will be achieved with the 112 Emergency Centre, hospital emergency departments and the digital health system. The expected results include:
* Improved response times – the new system will allow the emergency medical service to respond quicker to emergencies. The system will allow collecting, tracking, and dispatching information in real-time, significantly reducing response times and improving patient care outcome.
* Improved patients’ care - The new system will allow emergency crews to quickly access critical information about a patient’s medical conditions and history and transfer information on the patient status to the hospital receiving the patient. This information can help inform treatment decisions, leading to better patient outcomes.
* Enhanced coordination: interoperability and data traceability will facilitate the communication and coordination between emergency response teams, which will lead to a more seamless response to emergencies.
* More efficient use of resources: the new system will allow emergency crews to collect and record data more efficiently, which can help reduce the burden on the healthcare system and improve the quality of care.
* Improved data management: The system will provide better management of data related to emergency incidents, which can help improve the overall quality of care and inform policy decisions.

# Mainstreaming

**Environmental Protection, Climate Change and Biodiversity**

As part of a broader obligation to sustainable development, the EU is committed to address environmental concerns in its assistance programmes. This Action does not pursue specific environmental and climate change objectives. Still, its implementation will contribute to addressing some environmental challenges, particularly related to pollution and energy efficiency. The promotion of tobacco-free public space and healthier life style will support the change in the mind set and gradual shift to a more conscientious behaviour towards the environment. This will be paired with investment in digitalisation and purchase of ambulances, materials and equipment compliant with the EU environmental standards (i.e. EURO 6 for the ambulances).

**Gender equality and empowerment of women and girls**

As per OECD Gender DAC codes identified in section 1.1, this action is labelled as G1. This implies that the Action is gender-sensitive. The recently conducted WHO/Europe assessment of North Macedonia has identified important gender equity gaps in the health system[[20]](#footnote-21), starting from the lack of systemic approach to collecting sex disaggregated data, through health-care coverage and reach, to clearly discriminative practices. Gender-based violence, unintended pregnancies, early and forced marriage, harmful gender norms make girls and women more frequent users of the health care system or push them to take health risks and not seek help or health care in time, aggravating their health status. Improving the health care system is therefore first of all for the benefit of the women of North Macedonia, who would benefit most of an equitable effective health care system. In addition, the Action invests also in the health sector reforms by strengthening the policy making and the monitoring on the health reforms (including disaggregated data in the e-health system), and improving the employment conditions and efficiency of the health workers, the majority of which are women.

**Human Rights**

North Macedonia is committed to being a reliable partner in the implementation of the EU Action Plan on Human Rights and Democracy 2020-2024, which sets out the priorities of the EU and its Member States on human rights in relations with third countries, and the 2030 Agenda for Sustainable Development and Universal Health Coverage. The Action will support the government to reinforce the right to health care for all, paying particular attention to the needs of those at risk of poverty, which represent 40% of the country’s population[[21]](#footnote-22). These are people who face financial insecurity, poor living conditions, gender inequality, and insecure employment. The majority are located in rural and remote areas. The intended improvements in the emergency medical services and the enhanced digitalisation will support these citizens and families, as well as people with acute or chronic conditions obtain adequate medical care and escape health inequities.

**Disability**

As per OECD Disability DAC codes identified in section 1.1, this action is labelled as D2. This implies that this Action will improve the health and living standards and the medical services for the citizens of North Macedonia, particularly for the most disadvantaged people, notable people with disabilities, vulnerable people, and other disadvantaged groups, who are the primary users of social and health services. Moreover, investing in health care will add to the prevention of disabilities in the country.

**Civil Society**

This Action has been developed in an inclusive process involving civil society as a part of the established sector policy dialogue. This approach will also apply in the next stage, as civil society organisations are part of the Sector Working Groups (SWG), channelling the policy dialogue on sector priorities, IPA programming and reporting. Moreover, the participation of civil society is important for promoting a new health culture and life style, compliant with the EU environmental norms.

# Risks and Assumptions

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Category** | **Risks** | **Likelihood**  **(High/**  **Medium/**  **Low)** | **Impact**  **(High/**  **Medium/**  **Low)** | **Mitigating measures** |
| People and the organisation | Lack of political will to continue the demanding reforms in the health sector. | M | H | Engage in continuous policy dialogue with national authorities through the Sector Working Group on Health engaging authorities, donors and international partners and civil society organisation. |
| Planning, process and system | Weak administrative capacity and experience with EU assistance | H | M | The ongoing Public Administration Reform (PAR) is expected to address the high staff turnover in all institutions by proposing a viable retention and merit-based policy and modern human resource management. As intermediate mitigation approach, technical assistance and capacity building measures, including by this action, will be put in place. |

**External Assumptions**

The following assumptions should hold true to guarantee the success of the intervention:

* There is a political commitment to continue the reforms in the health sector continue, improve the funding model for health care, and channel investments to health care institutions.
* The population becomes more aware of the health risks created by certain behaviours and adjusts it accordingly.
* There is an improvement in public awareness on need and benefits of early screening and health prevention.

# Indicative Logical Framework Matrix

| **Results** | **Results chain:**  **Main expected results** | **Indicators** | **Baselines**  **(values and years)** | **Targets**  **(values and years)** | **Sources of data** | **Assumptions** |
| --- | --- | --- | --- | --- | --- | --- |
| **Impact** | To improve the health and well-being of the population of North Macedonia through the optimisation of its health care service | Life expectancy at birth (years) *[[22]](#footnote-23)* | Total: 76.34  Male: 74.39  Female: 78.29 (2017-2019) | Total: ≥ 77,70  Male: ≥ 76,00  Female: ≥ 79,30 (2027) | SSO | *Not applicable* |
| Healthy life expectancy at birth (years)*[[23]](#footnote-24)* | 66.14 (2019) | ≥ 67.70 (2027) | WHO |
| Percentage of new lung cancer cases by sex[[24]](#footnote-25) | 21% (males)  7,2% (females)  (2020) | ≤ 17% (males)  ≤ 5.9% (females)  (2027) | The Global Cancer Observatory (WHO) |
| Colon cancer mortality rate (per 100 000 inhabitants) by sex | 6% (2020) | ≤ 3% (2027) | Cancer registry IPH |
| **Outcome 1** | Enhanced digitalisation and modernisation of the Healthcare System | Percentage of the population with access to its health records | 0% (2022) | 20% (2027) | E-health monitoring system | Government continues investing in the health protection  Population becomes more aware of the health risks created by certain behaviours and adjusts it accordingly |
| Proportion of early detected CRC | 14% (2021) | ≥ 50% (2027) | Programme reports |
| Rate of ambulances available (100 000 inhabitants) | 160/1,836,000x100,000 = 8.7 (2022) | 210/1,836,0000x100,000 = 11,4 (2027) | MoH |
| Number of emergency teams in effective operation | 176 (2022) | ≥ 308 (2027) | MoH |
| **Output 1** | Improved National Tele-radiology System to allow remote use of radiologic data | Number of radiologists using tele-radiology system | 0 (2022) | ≥ 140 (2026) | MoH | There are sufficient resources, including financial and human resources, to implement and sustain the proposed interventions.  Improved public awareness on early screening and health prevention.  Reforms in the health sector continue, and the funding model for health care is improved.  Collaboration and partnerships between Government agencies, civil society organisations, health professionals, and communities will be fostered to ensure the success of the proposed interventions. |
| % of results of CT, MRI, Mammography, PET CT read 2 day plus the exam is done | 25% (2021) | ≤ 5% (2026) | MoH |
| **Output 2** | Improved prevention and control of lung and colorectal cancers | Number of people annually dying of lung cancer | 984 (2022) | < 645 (2026) | MoH |
| Number of people per year encompassed with the CRC (Colorectal Cancer) screening | 0 (2022) | ≥5000 (2026) | MoH |
| **Output 3** | Improved health cloud infrastructure | Level of information security (scale 7-10) | 7 (2022) | 10 (2026) | MoH |
| Average response time (API) | 145ms (2021) | ≤50ms (2026) | MoH |
| **Output 4** | Improved mobile primary health care service | Number of local mobile units’ equipment and work devices delivered | 0 (2022) | ≥30 (2026) | MoH |
| **Output 5** | Modernised Emergency Medical Service (EMS) system | Number of newly equipped and operational ambulances | 0 (2022) | ≥ 50 (2026) | MoH |
| Number of fully functional dispatch centres connected with ICT system for managing the EMS | 0 (2022) | ≥ 30 (2026) | MoH |
| Number of software prepared for integrating dispatch information and communication with hospital emergency departments | 0 (2022) | 1 (2026) | MoH |
| Number of software prepared for management and monitoring of vehicles for EMS | 0 (2022) | 1 (2026) | MoH |

# IMPLEMENTATION ARRANGEMENTS[[25]](#footnote-26)

# Financing Agreement

In order to implement this Action, it is envisaged to conclude a financing agreement with the North Macedonia.

# Indicative Implementation Period

The indicative operational implementation period of this Action, during which the activities described in section 3 will be carried out and the corresponding contracts and agreements implemented, is 72 months from the date of conclusion of the financing agreement.

Extensions of the implementation period may be agreed by the Commission’s responsible authorising officer by amending this Financing Decision and the relevant contracts and agreements.

# Implementation Modalities

The Commission will ensure that the EU appropriate rules and procedures for providing financing to third parties are respected, including review procedures, where appropriate, and compliance of the action with EU restrictive measures[[26]](#footnote-27).

# Direct Management (Procurement)

# Procurement will be used to achieve all outputs.

# Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents shall apply, subject to the following provisions.

The Commission’s authorising officer responsible may extend the geographical eligibility on the basis of urgency or of unavailability of services in the markets of the countries or territories concerned, or in other duly substantiated cases where application of the eligibility rules would make the realisation of this action impossible or exceedingly difficult (Article 28(10) NDICI-Global Europe Regulation).

# Indicative Budget

|  |  |  |
| --- | --- | --- |
| **Indicative Budget components** | **EU contribution**  **(amount in EUR)** | **Indicative third-party contribution, in currency identified** |
| **Methods of implementation –** cf. section 4.3 |  | |
| **Outcome 1: Enhanced digitalisation and modernisation of the Healthcare System** composed of | 12 000 000 | 2 160 000 |
| Procurement (direct management) – cf. section 4.3.1 | 12 000 000 | 2 160 000 |
|  |  |  |
| **Evaluation** – cf. section 5.2 | Will be covered by another Decision [[27]](#footnote-28) | N.A. |
| **Audit/Expenditure verification** – cf. section 5.3 | Will be covered by another Decision |  |
| **Communication and visibility** – cf. section 6 | N.A | N.A. |
| **Contingencies**[[28]](#footnote-29) | 0 | 0 |
| **Totals** | **12 000 000** | **2 160 000** |

# Organisational Set-up and Responsibilities

# The Delegation of the European Union (EUD) to North Macedonia is in charge of implementing the Action. It will collaborate with the Ministry of Health and the NIPAC office within Secretariat for European Affairs (SEA), and all stakeholders and implementing partners.

# At policy level, the implementing partners will be accountable to the SWG Health and the IPA Monitoring Committee.

# At contract level, the implementation arrangements will be discussed through the project Steering Committee having advisory functions and composed of EUD, the relevant national authorities and all relevant implementing partners.

# As part of its prerogative of budget implementation and to safeguard the financial interests of the Union, the Commission may participate in any governance structures set up for governing the sector reforms and for the implementation of the EU assistance.

# PERFORMANCE MEASUREMENT

# Monitoring and Reporting

The day-to-day technical and financial monitoring of the implementation of this action will be a continuous process, and part of the implementing partner’s responsibilities. To this aim, the implementing partner shall establish a permanent internal, technical and financial monitoring system for the action and elaborate regular progress reports (not less than annual) and final reports. Every report shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its Outputs and contribution to the achievement of its Outcomes, and if possible at the time of reporting, contribution to the achievement of its Impacts, as measured by corresponding indicators, using as reference the logframe matrix (for project modality) and the partner’s strategy, policy or reform action plan list (for budget support). The Commission may undertake additional project monitoring visits both through its own staff and through independent consultants recruited directly by the Commission for independent monitoring reviews (or recruited by the responsible agent contracted by the Commission for implementing such reviews).

Arrangements for monitoring and reporting, including roles and responsibilities for data collection, analysis and monitoring: the implementation of the Action will be monitored at the sector level through the established 2020 Performance Assessment Framework (PAF), which includes outcome and impact indicators, targets and baseline data. PAF has been established as a web-based application (backed up by a government decision on responsibilities and deadlines), allowing regular electronic data input, processing, and analytics. The PAF data will be used in the Sector Working Group on Health, which is also the inclusive platform for all stakeholders to monitor the implementation of the sector priorities.

At the output level, data about each project and contract implementation will be collected in OPSYS. They will be based on official reports, acceptance certificates or equivalent documents. The competent actors are expected to produce timely and meaningful data to monitor the results and impact of the Action.

# Evaluation

Having regard to the importance of the Action, a final evaluation will be carried out for this Action or its components via independent consultants. It will be carried out for accountability and learning purposes at various levels (including for policy revision).

The Commission shall form a Reference Group (RG) composed by representatives from the main stakeholders at both EU and national (representatives from the government, from civil society organisations (private sector, NGOs, etc.), etc.) levels. If deemed necessary, other donors will be invited to join. The Commission shall inform the implementing partner at least 2 months in advance of the dates envisaged for the evaluation exercise and missions. The implementing partner shall collaborate efficiently and effectively with the evaluation experts, and inter alia provide them with all necessary information and documentation, as well as access to the project premises and activities.

The evaluation reports shall be shared with the partner country and other key stakeholders following the best practice of evaluation dissemination[[29]](#footnote-30). The implementing partner and the Commission shall analyse the conclusions and recommendations of the evaluations and, where appropriate, in agreement with the partner country, jointly decide on the follow-up actions to be taken and any adjustments necessary, including, if indicated, the reorientation of the project.

# Audit and Verifications

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audit or verification assignments for one or several contracts or agreements.

# STRATEGIC COMMUNICATION AND PUBLIC DIPLOMACY

All entities implementing EU-funded external actions have the contractual obligation to inform the relevant audiences of the Union’s support for their work by displaying the EU emblem and a short funding statement as appropriate on all communication materials related to the actions concerned. To that end they must comply with the instructions given in the 2022 guidance document [*Communicating and raising EU visibility: Guidance for external actions*](https://international-partnerships.ec.europa.eu/knowledge-hub/communicating-and-raising-eu-visibility-guidance-external-actions_en) (or any successor document).

This obligation will apply equally, regardless of whether the actions concerned are implemented by the Commission, the partner country, service providers, grant beneficiaries or entrusted or delegated entities such as UN agencies, international financial institutions and agencies of EU Member States. In each case, a reference to the relevant contractual obligations must be included in the respective financing agreement, procurement and grant contracts, and contribution agreements.

# SUSTAINABILITY

The sustainability potential of the Action is high at institutional, regulatory, financial and cultural levels. It is defined by the cross-pollination of capacity building, upgrade of procedures, investments in technological infrastructures and emergency vehicles, data management, and raising awareness measures.

The body of knowledge will be improved along with the regulative environment. The new regulations and practices are expected to become an integral part of the everyday activities of institutions, health care practitioners and health system managers, and this will support sustaining of the achieved results in medium-term perspective. The Action is also expected to trigger changes in the behaviour of individuals and support healthier life style patterns among young people.

Radiology and early diagnosis of cancer along with the modernised emergency services and the more efficient mobile health teams will have an immediate impact on the patient's health, quality of life and longevity, while also strengthening the link between patients and health system and creating a new dynamic in the health reforms. Thus, the action will continue to generate benefits also at policy level. The intended upgrade of the e-Health system is not only extending the services to the population, nut will substantially improve the efficiency and effectiveness of the health system management, providing richer disaggregated data for policy-making purposes.

Another vector of sustainability is provided by the inclusive policy dialogue, which is expected (1) to support the implementation of the coherent sector policies underlying this Action by keeping a strong focus on the sector priorities, and (2) to translate the political commitment into sufficient funding and modern human resource management to ensure that the policy gains are sustained.

**Appendix 1: IDENTIFICATION OF THE PRIMARY INTERVENTION LEVEL FOR REPORTING IN OPSYS**

A Primary intervention[[30]](#footnote-31) (project/programme) is a coherent set of results structured in a logical framework aiming at delivering development change or progress. Identifying the level of the primary intervention will allow for:

* Differentiating these Actions or Contracts from those that do not produce direct reportable development results, defined as support entities (i.e. audits, evaluations);
* Articulating Actions and/or Contracts according to an expected common chain of results and therefore allowing them to ensure a more efficient and aggregated monitoring and reporting of performance;
* Having a complete and exhaustive mapping of all results-bearing Actions and Contracts.

The present Action identifies as

|  |  |  |
| --- | --- | --- |
| **Action level** (i.e. Budget support, Blending) | | |
|  | Single action | Present action: all contracts in the present action |
| **Group of actions level** (i.e: i) top-up cases, ii) second, third, etc. phases of a programme) | | |
|  | Group of actions | Actions reference (CRIS#/OPSYS#): |
| **Contract level** (i.e. Grants, Contribution Agreements, any case in which foreseen individual legal commitments identified in the budget will have different log frames, even if part of the same Action Document) | | |
|  | Single Contract 1 | N/A |
| **Group of contracts level** (i.e: i) series of programme estimates, ii) cases in which an Action Document foresees many foreseen individual legal commitments (for instance four contracts and one of them being a Technical Assistance) and two of them, a technical assistance contract and a contribution agreement, aim at the same objectives and complement each other, iii) follow up contracts that share the same log frame of the original contract) | | |
|  | Group of contracts | N/A |

1. Depending on the availability of OPSYS at the time of encoding, a provisional CRIS number may need to be provided. [↑](#footnote-ref-2)
2. The share of the priority areas should be linked to the NEAR EIP sub-tags: Transport, Energy, Environment and climate resilience, Digital, Economic development (incl. private sector, trade, and macroeconomic support), Human Development (incl. human capital and youth), Health resilience, Migration and mobility, Agriculture, food security and rural development, Rule of law, governance and public administration reform, Other. [↑](#footnote-ref-3)
3. Indicate the lead window and thematic priority as identified in the relevant programming document. Please indicate for each thematic priority the approximate share (%) of the window budget it represents. [↑](#footnote-ref-4)
4. Development Assistance Committee (DAC) sectors (codes and descriptions) are indicated in the first and fourth columns of the tab ‘purpose codes’ in the following document: [DAC and CRS code lists - OECD](https://www.oecd.org/development/financing-sustainable-development/development-finance-standards/dacandcrscodelists.htm) [↑](#footnote-ref-5)
5. For guidance, see [Development finance standards - OECD](https://www.oecd.org/development/financing-sustainable-development/development-finance-standards/) (Go to “Data collection and resources for reporters”, select Addendum 2, annexes 18 (policy) and 19 (Rio) of the reporting directive. If an action is marked in the DAC form as contributing to one of the general policy objectives or to RIO principles as a principal objective or a significant objective, then this should be reflected in the logframe matrix (in the results chain and indicators). [↑](#footnote-ref-6)
6. Please check the [Handbook on the OECD-DAC Nutrition Policy Marker](https://scalingupnutrition.org/wp-content/uploads/2020/12/OECD_PolicyMarkerNutrition.pdf). [↑](#footnote-ref-7)
7. These markers have a different scope/rationale than the DAC codes. They are drawn from the level of budget allocation and emphasise the action in terms of main objective(s) selected. The definition of objectives and outputs in the description of the action should be in line with this section. [↑](#footnote-ref-8)
8. When a marker is Significant or Principal Objective, please indicate the relevant tags by selecting “YES” or “NO”. [↑](#footnote-ref-9)
9. Please address the digitalisation marker in line with the note ARES(2019)7611708, which provides internal guidelines on the criteria to be used to assess the degree of relevance of the marker for the action (not targeted, significant or main objective). [↑](#footnote-ref-10)
10. When a marker is “Significant Objective“ or “Principal Objective”, please indicate the relevant tags by selecting “YES” or “NO”. [↑](#footnote-ref-11)
11. Please address the migration marker in line with the note Ares(2021)6077013. [↑](#footnote-ref-12)
12. Number of months should not exceed 72 months. [↑](#footnote-ref-13)
13. Global Health Expenditure Database (WHO 2022a). [↑](#footnote-ref-14)
14. Global Health Expenditure Data Base (WHO 2022a). [↑](#footnote-ref-15)
15. https://ec.europa.eu/eurostat/databrowser/view/tps00199/default/table?lang=en [↑](#footnote-ref-16)
16. https://ec.europa.eu/eurostat/databrowser/view/sdg\_03\_10/default/table?lang=en [↑](#footnote-ref-17)
17. Institute of Health Metrics and Evaluation, https://www.healthdata.org/macedonia. [↑](#footnote-ref-18)
18. Where General hospital and health centers are merged [↑](#footnote-ref-19)
19. This activity will build upon the IPA 2022 Action “EU for Improved Health, Social Protection and Gender Equality”, which will provide funding for the development of a national cancer control plan/Strategy and a plan for implementation and quality control for the national population-based screening programmes for breast, cervical and colorectal cancer. [↑](#footnote-ref-20)
20. <https://www.who.int/europe/news/item/04-11-2022-who-europe-accelerates-efforts-to-advance-health-equity-in-north-macedonia-with-data-and-research> [↑](#footnote-ref-21)
21. <https://www.who.int/europe/news/item/04-11-2022-who-europe-accelerates-efforts-to-advance-health-equity-in-north-macedonia-with-data-and-research> [↑](#footnote-ref-22)
22. [http://www.stat.gov.mk/Publikacii/SG2019/03-Naselenie-Population.pdf](http://www.stat.gov.mk/Publikacii/SG2019/03-Naselenie-Population.pdf%20) (Population; T.03.02.1.; page 79.) [↑](#footnote-ref-23)
23. https://www.who.int/data/gho/data/themes/topics/indicator-groups/indicator-group-details/GHO/life-expectancy-and-healthy-life-expectancy [↑](#footnote-ref-24)
24. <https://gco.iarc.fr/today/data/factsheets/populations/807-north-macedonia-fact-sheets.pdf> [↑](#footnote-ref-25)
25. This section is to be completed by the EU Office/Delegation. [↑](#footnote-ref-26)
26. [EU Sanctions Map](https://www.sanctionsmap.eu/#/main). Please note that the sanctions map is an IT tool for identifying the sanctions regimes. The source of the sanctions stems from legal acts published in the Official Journal (OJ). In case of discrepancy between the published legal acts and the updates on the website it is the OJ version that prevails. [↑](#footnote-ref-27)
27. Where the action is not covered by a financing agreement (see section 4.1), put ‘will be covered by another decision’ as it is unlikely that evaluation and audit contracts on this action would be concluded within N+1. These contracts have to be authorised by another Financing Decision. [↑](#footnote-ref-28)
28. Consider that contracts where no financing agreement is concluded, contingencies have to be covered by individual and legal commitments by 31 December of N+1. [↑](#footnote-ref-29)
29. See best [practice of evaluation dissemination](https://europa.eu/capacity4dev/evaluation_guidelines/wiki/disseminating-evaluations) [↑](#footnote-ref-30)
30. For the purpose of consistency between terms in OPSYS, DG INTPA, DG NEAR and FPI have harmonised 5 key terms, including ‘Action’ and ‘Intervention’ where an ‘Action’ is the content (or part of the content) of a Commission financing Decision and ‘Intervention’ is a coherent set of activities and results which constitutes an effective level for the operational follow-up by the EC of its operations on the ground. See more on the [concept of intervention](https://webgate.ec.europa.eu/fpfis/wikis/display/PCM/Concept+of+intervention) *[to access the link an EU Login is needed]*. [↑](#footnote-ref-31)