2012

Republic of Moldova
South-East European Region
National Coordination Council

Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS

REPUBLIC OF MOLDOVA
PROGRESS REPORT ON HIV/AIDS

January 2010 – December 2011

Chisinau 2012

Consiliul national de coordonare al programelor naţionale de profilaxie şi control al infecţiei HIV/SIDA, infecţiilor cu transmitere sexuală şi de control al tuberculozei

Country coordination Mechanism of the National Tuberculosis and National HIV/AIDS/STI Control Programs

Nr. 12/06 **Chişinău** 31/03/2012

Dear Sir/Madame,

We are pleased to introduce the fifth AIDS Progress Report that the Government of Moldova has produced.

With this report you will find evidence of better use of data to guide national planning processes, and greater focus on reflecting the contribution of all stakeholders in the national response to AIDS. This reporting cycle has reiterated the willingness of the government not only to honor the commitment to the Political Declaration on HIV/AIDS of Commitment, endorsed in 2011, but also to ensure that the interventions set out to reach the commitments are successful, constructive and accountable. The Political Declaration of Commitment on HIV/AIDS and the reporting process have established a framework for strengthened collaboration and partnerships across organizations, regions and sectors going beyond health.

The common objectives, such as reaching Universal Access to Prevention, Care and Treatment, reinforced the message that HIV is one of the world's challenges that is too intersectorial and complex for any sector to proceed alone. Common objectives – such as to save people's lives, to ensure social inclusion of People Living with HIV/AIDS and to mitigate the impact AIDS has on community and household levels have finally paved the way for enhanced collaboration between the government, civil society, and People Living with HIV/AIDS. An example of such cooperation has occurred in producing the reporting hereto – the AIDS Progress Reporting and the Monitoring of Dublin Declaration – through broad consultations with key stakeholders involved.

We are strong in our intention to support further AIDS Progress reporting, and to ensure its quality improves along with the increased quality of strategic planning, coordination and transparency of decision making and with improved monitoring and evaluation.

Minister of Health,
Chair of the National
Coordination Council **Andrei USATII**

mun. Chişinău, str. Cozmescu 3, Republica Moldova
Consiliul naţional de coordonare TB/SIDA
Tel/fax:280-590, e-mail: ccm_secretariat@mednet.md

Acknowledgements

The following institutions have contributed to developing the report hereto:

- Ministry of Health
- Ministry of Labour, Social Protection and Family
- Department of Penitentiary Institutions, Ministry of Justice
- Ministry of Education
- Ministry of Youth
- National Center of Health Management
- National Scientific and Practical Center of Preventive Medicine, National AIDS Center
- National Blood Transfusion Center
- Dermato-Venerial Dispensary
- Infectious Deseases Hospital „Toma Ciorba”
- Republican Narcology Dispensary
- AIDS Center, Tiraspol, Transdniestrian region
- League of PLWH
- Soros Foundation-Moldova
- National Bureau of Statistics
- UNAIDS Moldova
- WHO Moldova
- UNICEF Moldova
- UNFPA Moldova

CONTENTS

List of acronyms

AIDS - Acquired Immunodeficiency Syndrome
ARV - Antiretroviral
CSW - Commercial Sex Worker
HIV - Human Immunodeficiency Virus
IDU - Injecting Drug User
ILO - International labor Organization
GFATM - Global Fund to Fight AIDS, Tuberculosis and Malaria
LGBT - Lesbian Gay Bisexual Transsexual
MARP - Most at risk population
MDG - Milenium Development Goal
MDL - Moldovan Leu
MSM - Men having sex with Men
M&E - Monitoring and Evaluation
NGO - Non-governmental organization
RDSAT - Respondents Drivern Sampling Analysis Tool
PLHIV - People Living with HIV
PMTCT - Prevention of mother-to-child transmission
STI - Sexually Transmitted Infenction
TB - Tuberculosis
UNAIDS - United Nations Joint Programme on HIV/AIDS
UNICEF - United Nations Children's Fund
UNGASS - United Nations General Assembly Special Session
UNIFEM - United Nations Development Fund for Women
UNFPA - United Nations Population Fund
UNDP - United Nations Development Porgramme
USD - United States Dollar
USAID - United States Agency for Inetrnational Development
VCT - Voluntary Counseling and Testing
WHO - World Health Organization

EXECUTIVE SUMMARY

Reliable information is one of the most important determinants in the process of development and implementation of efficient and effective strategies. Information represents the evidence base for establishing the framework, soundly based on the status quo, for efficient interventions to prevent the spread of HIV.

Together with other countries, the Republic of Moldova participated at the UN General Assembly in 2011 where the Political Declaration of Commitment to eliminate HIV/AIDS was signed. Also, it is part of the Dublin Declaration and of the WHO Global Strategy on Health sector.

The joint Monitoring and Evaluation system of the National Programme on Prevention and Control of HIV/AIDS and STI in the Republic of Moldova has been implemented starting with 2005. Over the years, this system passed through a series of system strengthening stages, but it is yet premature to state that the system is fully functional and satisfies all the key information needs. However, relevant strategic information has been obtained and made and accessible to inform the decision-making process in the national response to HIV.

The given report is the result of collaboration among institutions, ministries, and public organisations, non-governmental and international organisations. Due to the fact that several sectors are involved in the National AIDS Response, each of them with specific interventions, the data are generated by numerous governmental and non-governmental institutions, their quality being also different. Representatives of governmental institutions and nongovernmental organizations which are part of the national HIV response have been involved in the process of collection, analysis and interpretation of data for the current AIDS Progress Reporting. The values of the indicators reported have been discussed and agreed upon in the framework of meetings aimed at development of the National Programme for the Prevention and Control of HIV/AIDS and STI for the years 2010-2015. A detailed description of the process can be found in Appendix 7. The development of the report has been coordinated by the Unit for Audit of Data Quality, established in 2011 based on the Monitoring and Evaluation Unit within the National Centre for Health Management of the Ministry of Health.

The HIV epidemic in the Republic of Moldova is a concentrated one in the IDUs population. The results of the last HIV seroprevalence survey among IDUs carried out in 2009 have shown an HIV prevalence of 16.4% in the capital of the country. The HIV seroprevalence registered in 2009 among IDUs attests a stable trend in IDUs from the capital city and from other two locations where the study was carried out (16,4% in 2009, 17,5% in 2007 and 14,4% in 2003/2004). In the last 3 years, the number of newly registered HIV cases among the tested IDUs is decreasing. The number of newly registered HIV cases reported among blood donors registers a slight decrease in the last 2 years (in 2010 there have been registered 39,6 new HIV cases at 100 000 blood samples and in 2011 there have been registered 33,1 new HIV cases at 100 000 blood samples).

At the national level, the state policy framework guiding the HIV response in the Republic of Moldova is implemented through the National Programme on Prevention and Control of HIV/AIDS and STI for 2011-2015, which determines the priority national strategies: prevention, epidemiological surveillance, treatment and care. The Programme is an integral and multi-sectoral plan. The process of Programme development includes:

- Correlation with the process of development and implementation of grant proposals of the RM to the Global Fund on AIDS/Tuberculosis and Malaria;
- Situation assessment, analysis of the national response and results of the implementation of the National Programme for the Prevention and Control of HIV/AIDS and STI for 2006-2010;

- Active involvement of the members of the National Coordination Council for coordination of the implementation of the National Programme on Prevention and Control of HIV/AIDS and TB Control and Technical Working Groups of the NCC;
- Consultations based on a consensus among main participants in the field, including the Government, international organisations, non-governmental organisations and PLHA.
- The National AIDS Programme was endorsed through the Government Decision of 24 December, 2010 and has the following objectives:
    - HIV incidence will not exceed 20, 0 cases per 100000 population within the age group 0-39 years.
    - Mortality of people living with HIV/AIDS of the total number of persons estimated will be reduced by 10% by 2015.

In June 2011 the National Programme on Prevention and Control of HIV/AIDS and STI underwent an external evaluation performed by a team of national and international experts. As a result of the evaluation, a series of recommendations have been developed and programme objectives have been reformulated:

- Prevention of transmission of HIV, Hepatitis and STI, especially among key-populations;
- Reducing the negative impact of the epidemic, mainly by offering treatment, care and support to people living with HIV/AIDS and members of key-populations;
- Promoting synergies with other components of the health system;
- Development of an efficient system of programme management.

The Programme (to be approved) is focused on:

- Prevention of HIV transmission in the Republic of Moldova, especially HIV transmission among key-populations, such as IDUs, CSWs, MSM, and prisoners, as well as prevention of HIV transmission from these groups to the general population.
- Reducing the impact of the epidemic, mainly by providing treatment, care and support to people living with HIV and members of key-populations, by covering PLHA with ARV therapy, treatment of co-infections and other STI, and use of ARV therapy for prevention purposes, such as prevention of mother to child transmission and post-contact prophylaxis. Care and support includes a large chain of services, including palliative care.
- Promotion of synergies with other components of the health system, such as activities on hepatitis, blood safety and STI. In cases of hepatitis and blood safety, these components have their own National Programmes. There is no separate Programme on STI, but STI management is an integral part of the given programme.
- Effective and efficient management of the programme by coordinating a large series of partners and stakeholders interested in implementation, including state institutions, civil society organisations and people living with HIV. Also, the aim is to ensure some adequate levels of funding for the Programme from both internal resources and donors. Another envisaged result is development and management of strategic information through data collection and an efficient monitoring and evaluation systems.

The Republic of Moldova is recognised in the region as an example of good practices due to its successful implementation of Harm Reduction Programmes in key populations at risk in the civilian sector (IDUs, CSWs, MSM) and in penitentiary institutions (IDUs). Thus, there are information/education/outreach, and needle exchange activities, as well as referrals to medical and social services. Methadone Substitution treatment is provided both in the civilian sector and in penitentiary institutions (on right bank of Dniester

river only). During the reporting period, services extended in 3 other localities, including the left bank of the Nistru River (IDU).

During the reporting period, activities were carried out in the general population in order to promote a healthy lifestyle and safe behaviours, by excluding the risk of HIV infection and to promote condom use, especially among young people. By getting involved in the "Peer-to-Peer" network and in the international project for HIV prevention among youth "Dance 4 Life", the young people had the possibility to participate in actions of prevention of HIV/AIDS, STI, drug addiction and alcoholism. During 2011 there were 2 national campaigns entitled „Zero Tendency: Zero New HIV Cases, Zero Discrimination, Zero Deaths caused by AIDS".

The voluntary Counseling and testing service established in 2007 has been extended and reached nation al coverage, being present in all administrative territories.

Normative acts have been adjusted according to the recommendations of the World Health Organisation, UNAIDS and European Union, in accordance with the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS. Human rights-based approach has been applied, aiming to promote basic principles of non-discrimination of people living with HIV, to minimize the consequences of the epidemic and to ensure Universal Access with the implementation of comprehensive and multidisciplinary interventions. In an effort to bring existing regulatory framework in line with these basic human rights principles,, the Order on "Abolishment of some Laws regulating Prevention and Control of HIV/AIDS" has been approved and normative acts containing stigmatizing provisions have been abolished. A draft on modification and completion of Law nr 23 of 16 February 2007 on prevention of HIV/AIDS has been developed. The draft amendments have been consulted with the civil society, examined by the Government and submitted to the Parliament for approval. The approval of proposed modifications to the Law nr 23 will fully guarantee the right to privacy the right to non-discrimination and equality of people living with HIV/AIDS and the right of people living with HIV/AIDS to freedom of movement.

To ensure standardisation of services, a National Guideline has been developed on quality management of HIV/AIDS laboratory investigations and the following draft are in the process of endorsement and approval:

- Operational Manual of the National Plan for Monitoring and Evaluation of HIV/AIDS, 2011-2015;
- National Protocol and Operational Manual on HIV/AIDS second generation epidemiological surveillance;
- National Communication Strategy on HIV/AIDS;

A distance learning programme on HIV/AIDS has been developed in collaboration with the School on Public Health Management of the State University of Medicine and Pharmacy "Nicolae Testemitanu". This curriculum contains the following modules: *General Overview on HIV/AIDS, Epidemiology and Control of HIV/AIDS, Care and Support of people living with HIV/AIDS, Surveillance and care of HIV infected patients, Voluntary Counseling and Testing, Coverage of Most at Risk Populations, Human Rights in the context of HIV/AIDS, Monitoring and Evaluation in the context of HIV/AIDS.* During 2011 there have been trained 160 persons (family doctors, managers of medical facilities, epidemiologists) to use distance learning.

The Republic of Moldova is classified as a concentrated/low prevalence country with a concentrated HIV epidemic in IDUs population. There is evidence of spread of the infection in the general population. Estimations of HIV prevalence in the general population have been made in 2010 and repeated in 2011 and early 2012 using the estimations and projections tool called Spectrum. According to the estimations made in 2012 there are 1882 new estimated HIV cases (1283 cases on the right bank and 599 cases on the left bank of the Nistru River). Also, the estimated HIV prevalence for the right bank of the Nistru River is 0,44% and 1,31% for the left bank. The population infected with HIV in 2012 was estimated at 14528(10517 on the right bank and 4011 on the left bank). The need for ARV treatment is estimated at 5683 persons (4380 on the right bank and1303 on the left bank of the Nistru River). The necessity for prophylactic treatment for 2011 was estimated at 205 HIV positive pregnant women (163 on the right bank and 42 on the left bank of the Nistru River).

By the 1st of January 2012 there have been registered 7125 new HIV cases on both banks of the Nistru River. During the last 3 years, the number of new HIV cases is stable.

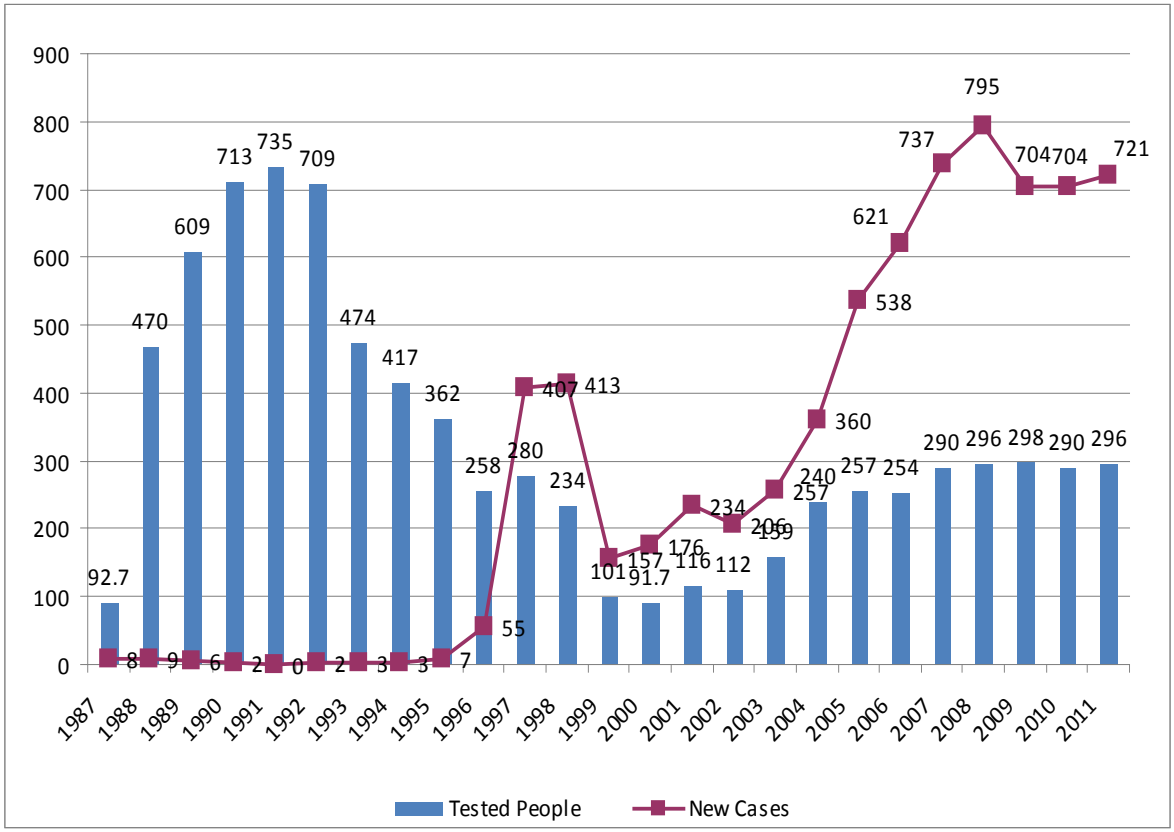

Figure 1 HIV testing and the number of newly registered HIV cases, Republic of Moldova, 1987-2011

In the last 5 years, sexual transmission is the main probable route reported by newly registered HIV cases in the Republic of Moldova (out of 704 new HIV cases reported in 2010, 86,79% mentioned about the sexual route as the main probable route of HIV transmission; out of 721 new HIV cases reported in 2011, 85,02% mentioned about the sexual route as the main probable route of HIV transmission). Out of the number of newly registered HIV cases, where the probable route of transmission was the sexual one, men and women have almost equal shares (52, 9% of men in 2011).

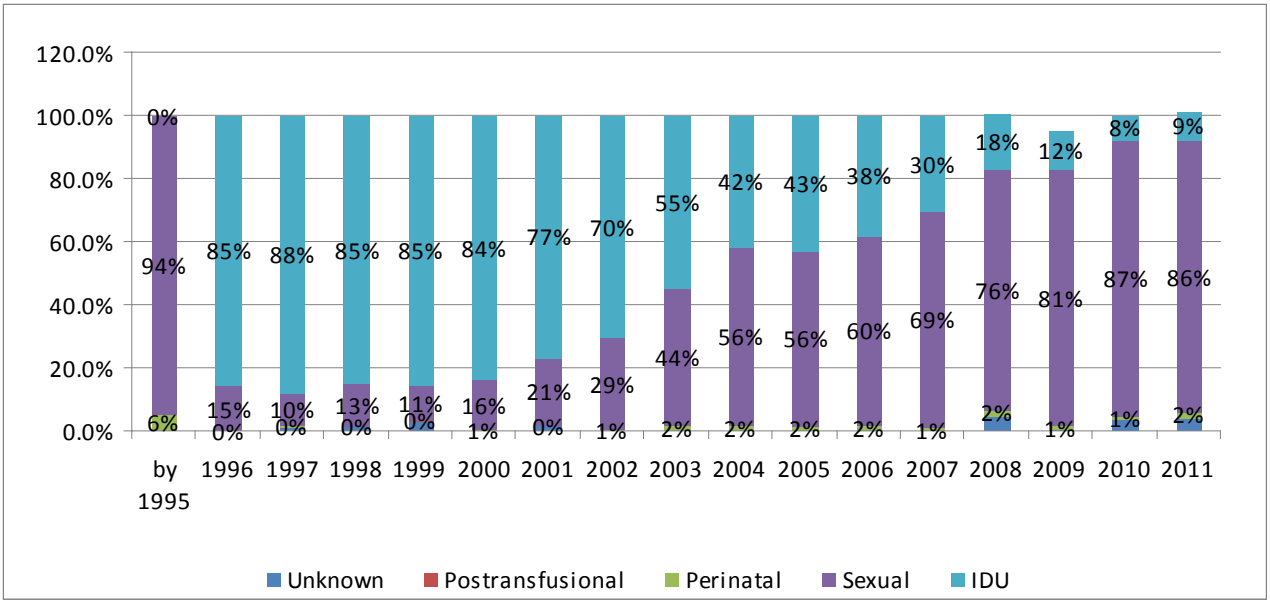

Figure 2 Distribution of new HIV cases by probable route of transmission in the Republic of Moldova, 1995-2011

The change in the structure of newly reported HIV cases in terms of probable route of transmission increases the vulnerability of women, constituting 47.71% of new HIV cases registered in 2011 (in 2010 out of the newly reported HIV cases, women represented 51,57%). HIV/AIDS is mainly registered among young people of reproductive and economically-active age, aged 15-39 – 72,81% of new HIV cases registered in 2011, in age segments of 20 - 24 years old – 15,39% and 25-29 years old – 18,56% (in 2010, out of the newly registered HIV cases in age groups of 15-39 years old constituted 79,5%, 20 - 24 years old – 17,47% and 25-29 years old – 22,3%).

Starting with 2007 coverage of pregnant women with HIV Testing exceeds 99, 0%, which allows calculation of HIV prevalence among them. For the last 6 years, the prevalence of new HIV cases is relatively stable.

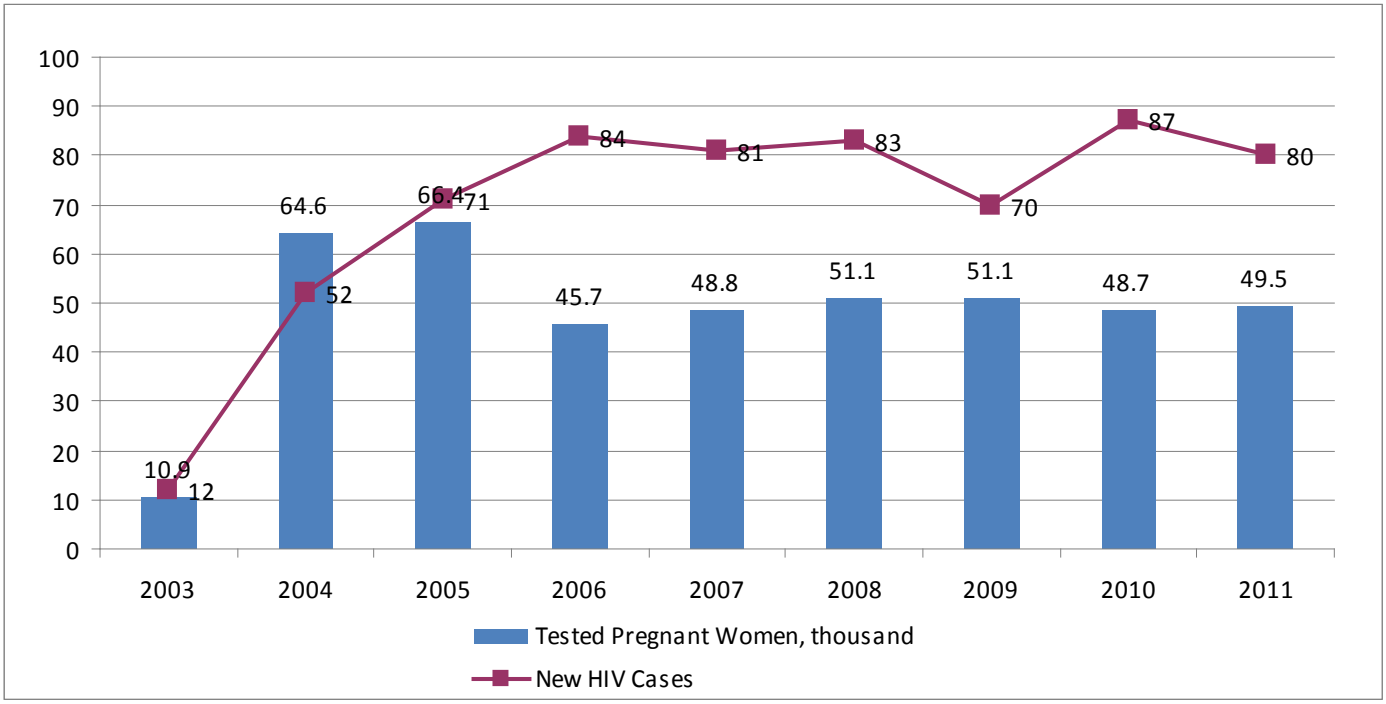

Figure 3 HIV testing and the number of newly registered HIV acses among pregnant women, Republic of Moldova, 2003-2011

Out of the total number of pregnant women registered during 2011, 75,89% have undergone Voluntary Counseling and Testing and benefitted from pre-test Counseling. The VCT service is being implemented and it covers the whole territory of the country, being accessible for the entire population, including most at risk populations. Throughout 2011 there have been tested 296707 persons, out of which IDU 3208 (in 2010 there have been tested 290856 persons, out of which 3410 were injecting drug users).

According to the Survey on Knowledge, Attitudes and Practices regarding HIV/AIDS carried out in the in the general population aged 15-64 on the right bank of the Nistru river in 2010, 56,2% know about the possibility to take an HIV test in the locality where they live. Out of the respondents tested during the last year, 62,6 % received pre-test Counseling, and 46,8% benefitted from post-test Counseling. Within the survey on Vulnerability of Women to HIV infection carried out in the general population aged 15-64 on the left bank of the Nistru river in 2011, 63,9% of the respondents know about the possibility of taking an HIV test in the locality where they live, the indicator having a significant lower value for the rural area (17,8%). Out of the respondents tested during the last year, 46,1% benefitted from pre-test Counseling and 20,1% received post test Counseling.

The data of the survey on Knowledge, Attitudes and Practices about HIV infection carried out among young people aged 15-24 in 2010, show that 48,9 % know about the possibility to take an HIV test in the locality where they live. Out of the respondents tested during the last year, 60,6 % benefitted from pre-test Counseling and 40,8% received post test Counseling.

The Integrated Bio-Behavioural study on Knowledge, Attitudes and Practices among most at risk populations was carried out in the Republic of Moldova during 2009-2010, using the Respondent Driven Sampling methodology for the first time. This fact enabled the recruitment of respondents other than just beneficiaries of harm reduction programmes (as done in past survey rounds, when convenience sampling has been used), although it made results not comparable to 2003, 2004,

2007surveys. Results of HIV prevalence among IDUs, CSWs, MSM and prisoners are presented in the table below.

Table 1 HIV prevalence among IDU, Republic of Moldova, 2009

Location of Data Collection	Sample	HIV,%
Chisinau	301	16,4
Balti	362	39,0
Tiraspol	281	12,6

Table 2 HIV prevalenceamong CSW, Republic of Moldova, 2010

Location of Data Collection	Sample	HIV,%
Chisinau	300	6,1
Balti	359	23,5

Table 3 HIV prevalence among MSM, Republic of Moldova, 2010

Location of Data Collection	Sample	HIV,%
Chisinau	188	1,7
Balti	209	0,2

Table 4 Prevalence among prisoners, Republic of Moldova, 2010

Location of Data Collection	Sample	HIV,%
Prisons from the right bank of the Nistru river	530	3,4

A Modes of Transmission study has been carried out in Moldova in late 2010. Data triangulation was carried out in the Republic of Moldova in 2011. The investigation questions were:

1. What is the trend of HIV in the Republic of Moldova (with particular analysis of migrationand mobile populations, determinants of the epidemic in rural area, young people and most at risk populations)?
2. What is the impact of prevention and behaviour change interventions in most at risk populations?

In order to respond to these questions, data from the following sources have been used:

- HIV Testing
- Epidemiological forms for all new HIV+ cases
- IBBS
- Reported HIV cases with sexual transmission
- KAP studies in the general population and among young people.

Analysis of these data revealed that although the epidemic remains concentrated among males from urban areas, the trends of new cases show an increase among females in the rural areas. Among new cases, there is an increase in the rate of people infected through heterosexual and homosexual route. The high percentage of cases with undetermined route of transmission, especially on the left bank of the Nistru River, is a great obstacle in the development of prevention measures.

The number of new cases of HIV infection among IDUs increases among males compared to females and prevails in the age group over 30 years.

Migration history of self and/or partner is self-reported as a risk factor for HIV infection and drug use, especially on the left bank.

In 2011 the Republic of Moldova carried out a rigorous activity to estimate the size of key populations at risk to replace previous rounds of estimations that had limitations due to scarcity of available data and methodology used (largely, experts' opinion). The estimation was made for big cities (Chisinau, Balti, Tiraspol) for both the right and the left banks of the Nistru river. Multiplier and network scale-up methods have been used.

Table 5 Results for the estimation of sizes of most at risk populations, Republic of Moldova, 2011

Group	Region	Group Size
IDU	Right bank	21061
	Left bank	10501
	Total	**31562**
CSW	Right bank	12359
	Left bank	2409
	Total	**14768**
MSM	Right bank	19670
	Left bank	2615
	Total	22285

NATIONAL RESPONSE TO HIV/AIDS EPIDEMIC

INDICATOR 6.1 HIV/AIDS spending

In order to ensure reporting according to the provisions of the indicator for 2010 and 2011, data have been collected from various sources in accordance with the recommendations of the *Global AIDS Response Progress Reporting 2012 Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS (UNAIDS 2011).* Hence, there have been selected organisations from national and local levels that implemented and disbursed funds for Prevention and Treatment of HIV/AIDS, and for activities of coordination, monitoring and evaluation in the field. Organizations were asked to provide information on financial allocations spent and destination of disbursement according to the NASA matrix.

Thus, for calculation of expenses in the field of HIV/AIDS for 2010 and 2011, data on annual expenditures with special destination for HIV/AIDS Prevention have been taken into consideration from the following institutions within the health system:

- Ministry of Health, for state budget allocations and funds for Mandatory Health Insurance, for "Public Health Services" Programme, for Prevention of HIV/AIDS an STI, and for implementation of the National Programme for Prevention and Control of HIV/AIDS and STI 2006-2010 and the National Programme for Prevention and Control of HIV/AIDS and STI 2011-2015;
- National Public Health Centre responsible for HIV/AIDS epidemiological surveillance, laboratory diagnostic, prevention activities, representing the superior hierarchic structure of the AIDS Centre and of the AIDS regional laboratories;
- National Blood Transfusion centre responsible for Blood Safety;

- National Dermatovenereal Dispensary for the Infectious Diseases Section responsible for pre ART surveillance, ARV treatment management and ARV treatment provision;
- "Toma Ciorba" infectious disease hospital, responsibly for pre-treatment surveillance and ARV treatment;
- National Narcology Dispensary for the activities on Harm Reduction in IDUs, including the methadone substitution programme;
- National Institute of Research in the field of Mothers' and Children's health, for PMTCT;
- National Centre of Health Management for the activities of Monitoring and Evaluation of the National Programme on Prevention and Control of HIV/AIDS/STI for 2006 - 2010;
- National Coordination Council for coordination of the implementation of the National Programme on Prevention and Control of HIV/AIDS/STI for 2006-2010;
- Educational institutions, subordinated to the Ministry of Health, for expenditures in training, refresher training and specialisation for medical workers.

Information on financial flows was requested from municipal and district councils, line Ministries (Ministry of Justice; Ministry of Defence; Ministry of Youth and Sports; Ministry of Education; Ministry of Labour, Social Protection and Family) and international organizations implementing their activities in the Republic of Moldova (UNAIDS, World Health Organisation, World Bank, the main recipients of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), UNICEF, UNFPA, UNODC, SOROS, Word AIDS Campaign). Public Health Institutions have made separate reports for each of the years (2010 and 2011) according to budget lines, specifying the spending category and the source of financing. Bilateral or multilateral international organizations were classified according to the criteria of source of financing, but also as financial agents.

The content of the received questionnaires was verified in order to exclude the double counting of resources. In order to exclude possible overlapping of resources, the expenditures for each year separately have been cumulated in accordance with the disaggregation by cost categories.

Expenditures for the national HIV response in the Republic of Moldova (in national currency) [1] for 2009, 2010 and 2011 are presented in the Matrix for 2009, Matrix for 2010 and for 2011 respectively *(see data introduced in CRIS3)*.

[1] Average exchange rate of the National Bank: 1 US Dollars = 11,11 MDL in 2009, 1 US Dollars = 12,37 MDL in 2010 and 11,74 MDL = 1 US Dollarsin 2011

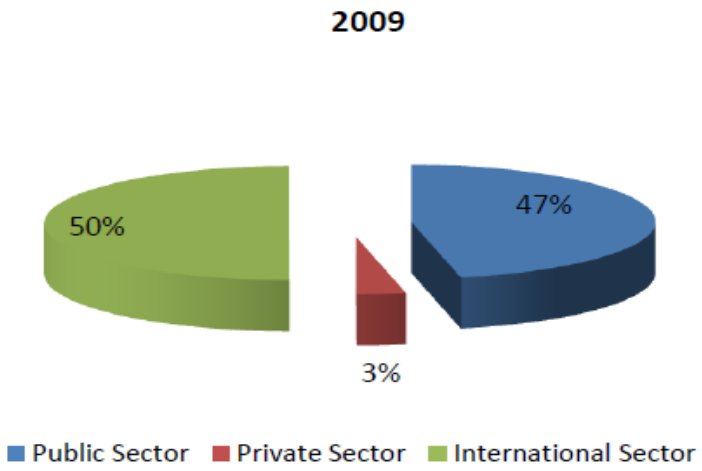

Figure 4 Structure of expenditures for the national HIV response by sources of financing, Republic of Moldova, 2009

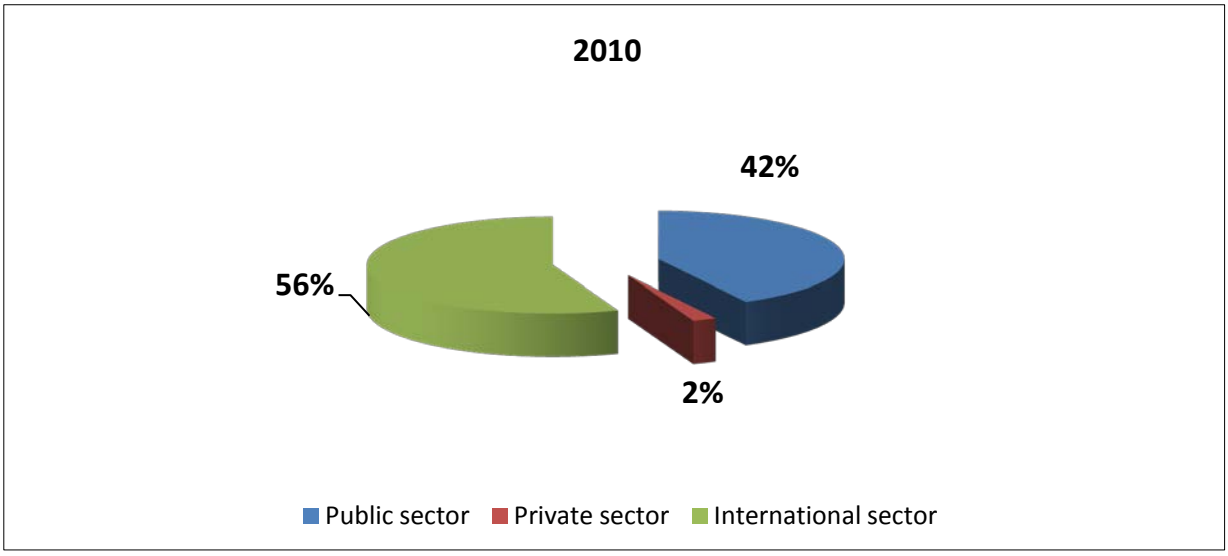

Figure 5 Structure of expenditures for the national HIV response by sources of financing, Republic of Moldova, 2010

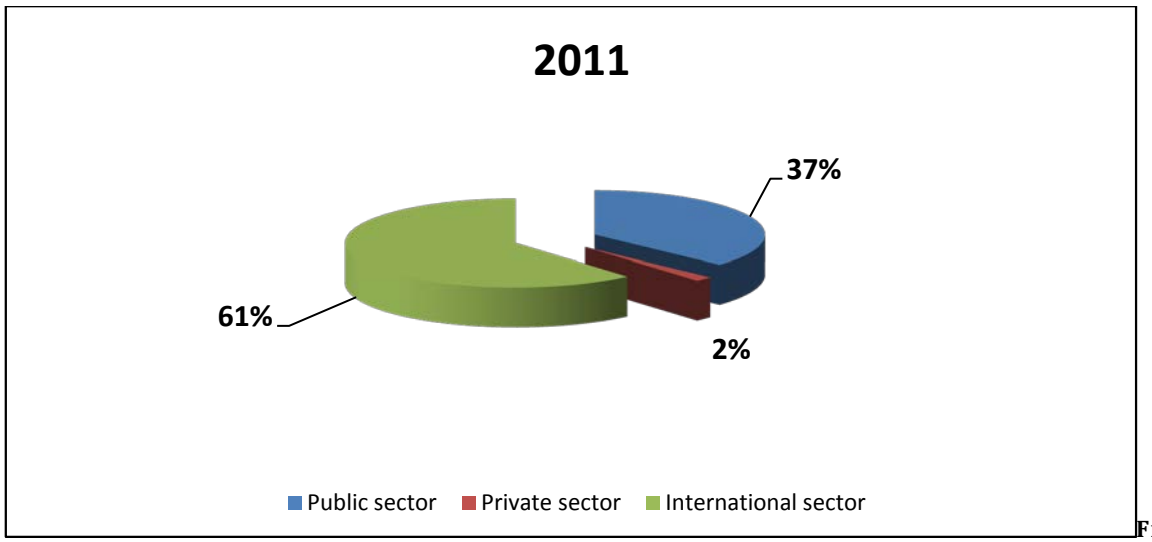

Figure 6 Structure of expenditures for the national HIV response by sources of financing, Republic of Moldova, 2011

Thus, in the year 2010, expenditures for the national HIV response have increased with around 15,4 mln. MDL (+12,9%) compared with those in 2009 and reached 135,4 mln MDL or 10 948 537 US dollars, out of which, public financial resources constituted 57,1 mln MDL or 4 617 719 US dollars (42%). International resources for this period reached 75,5 mln MDL or 6 103 216 US dollars (56%) and national private resources constituted 2,8 mln MDL or 227 602 US dollars (2%). For 2011, expenditures for the national AIDS response registered an increase with around 27,5 mln MDL (+20,3%) compared with 2010 and reached the value of 162,9 mln. MDL or 13 881 886 US dollars, out of which, public financial resources constituted 60,1 mln MDL or 5 125 535 USD (37%). International resources for this period reached 100,0 mln MDL or 8 519 016 US dollars (61%) and national private resources constituted 2,8 mln MDL or 237 335 US dollars (2%) (2).

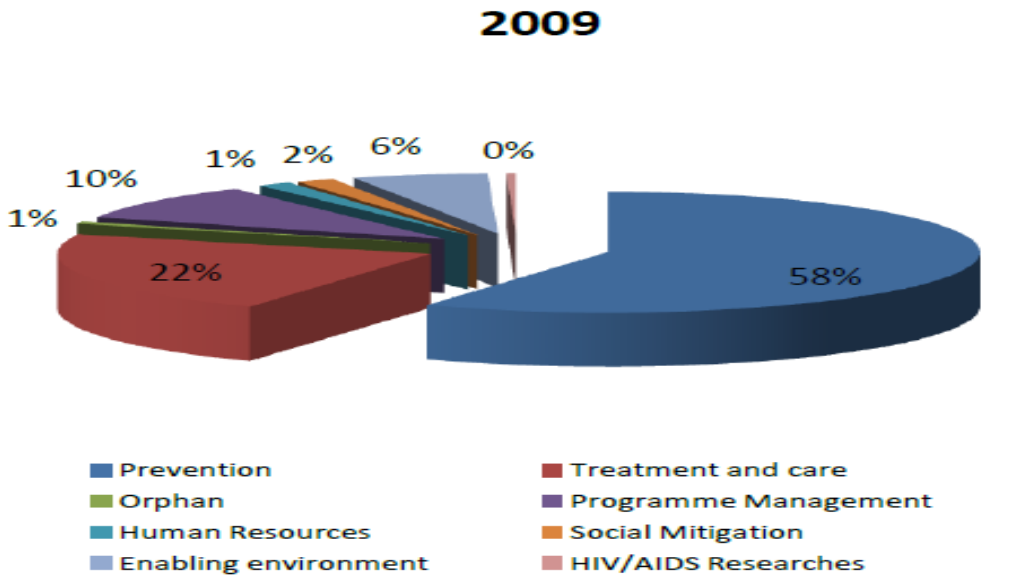

Figure 7 Structure of expenditures for the national HIV response, by spending category, Republic of Moldova, 2009

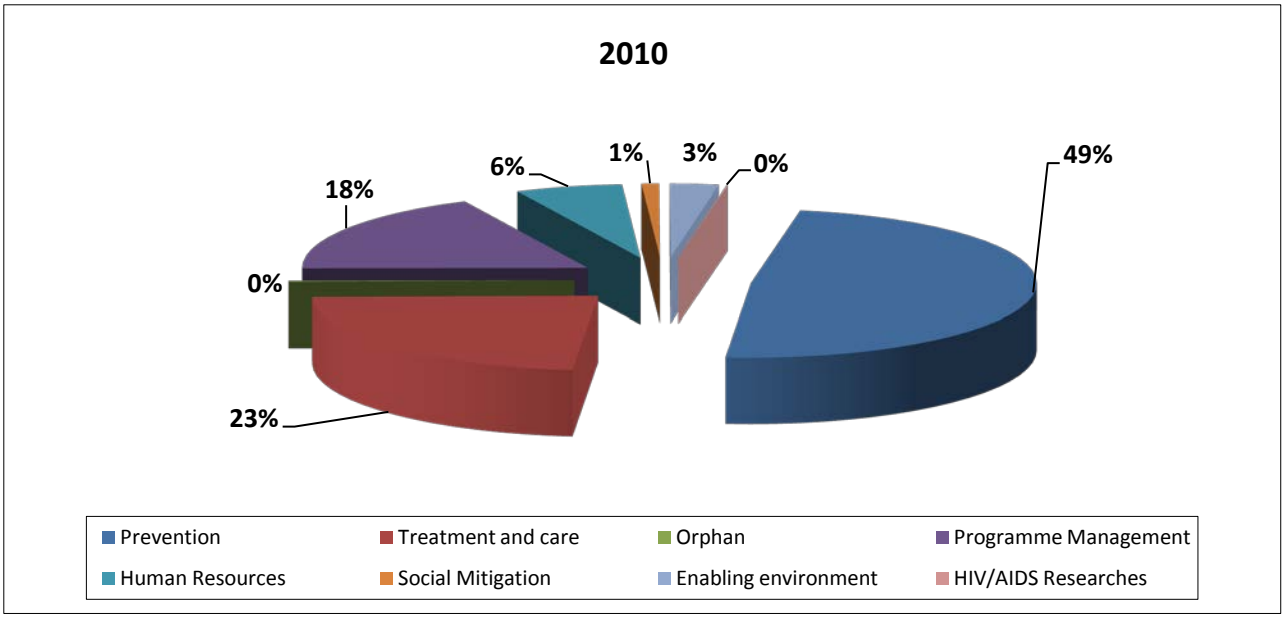

Figure 8 Structure of expenditures for the national HIV response, by spending category, Republic of Moldova, 2010

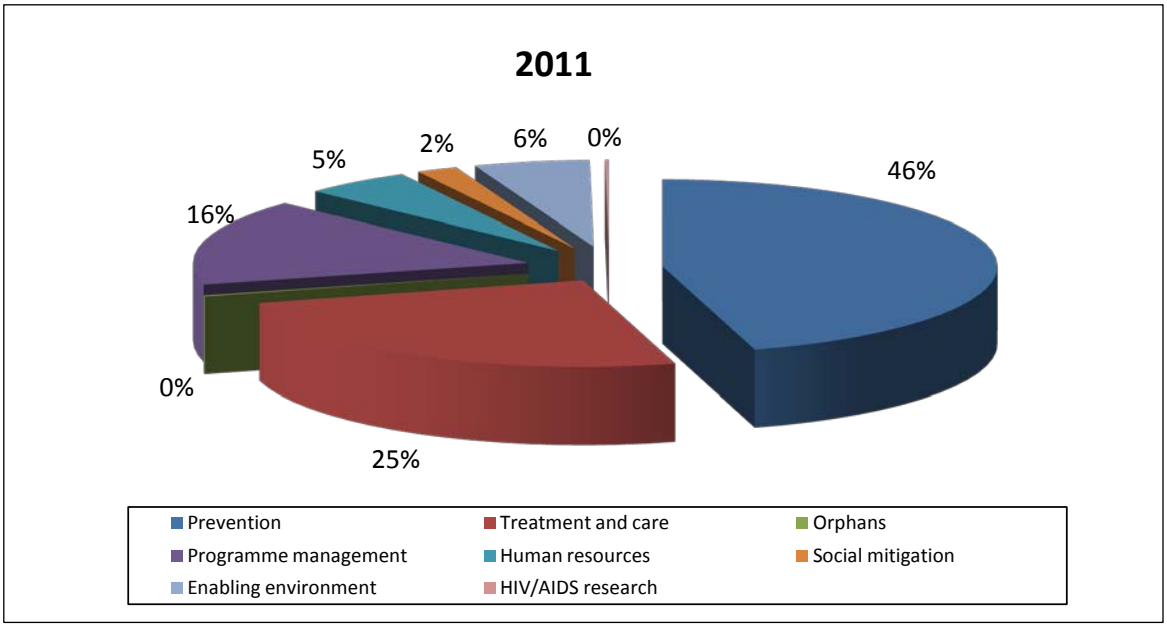

Figure 9 Structure of expenditures for the national HIV response, by spending category, Republic of Moldova, 2011

Classified by spending category of expenditures for the national response to HIV in the framework of the national response to HIV in 2010, 49% went to ***Prevention***. 23% - to ***Treatment and Care***, 18% - to ***Programme Management***, 6% - to ***Human Resources***, *3%* - ***Enabling Environment*** and *1% to* ***Social Mitigation,*** while the other categories represented 0%. In 2011, the biggest share went to ***Prevention*** (46%), followed by ***Treatment and Care*** (25%), ***Programme Management*** (16%), ***Enabling Environment*** (6%), ***Human Resources*** (5%), and ***Social Mitigation*** (2%), while the other categories represented 0%.

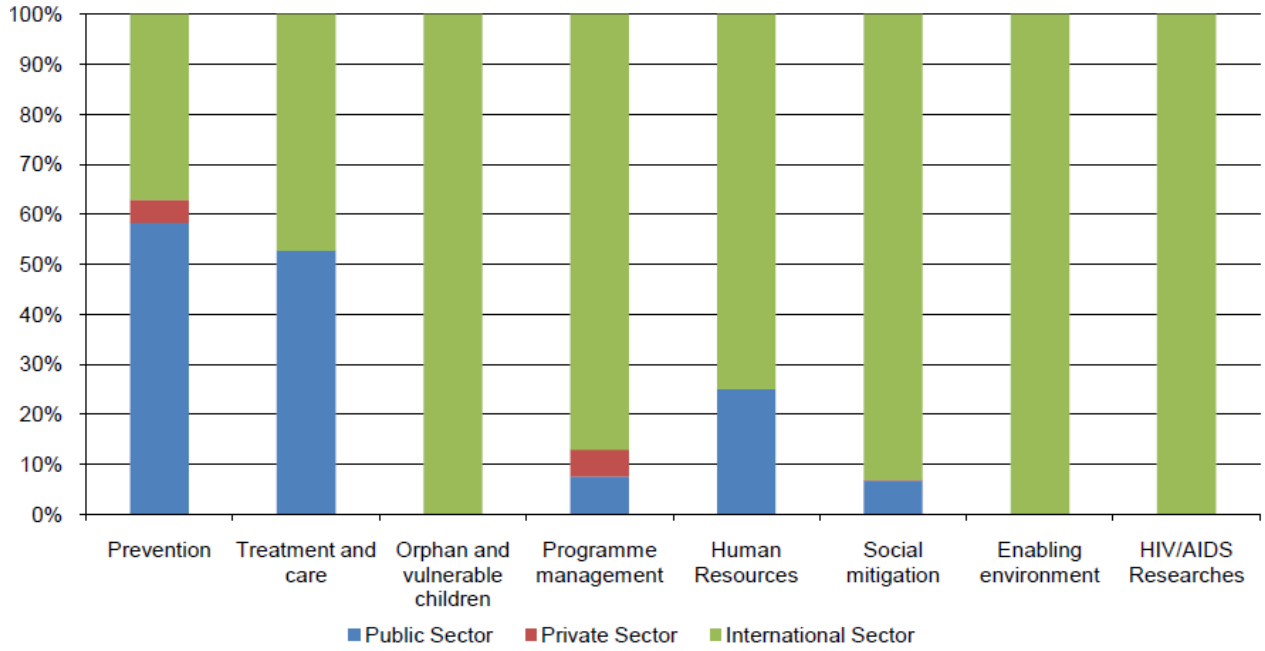

Figure 10 Structure of HIV/AIDS expenditures by financing categories, year 2009

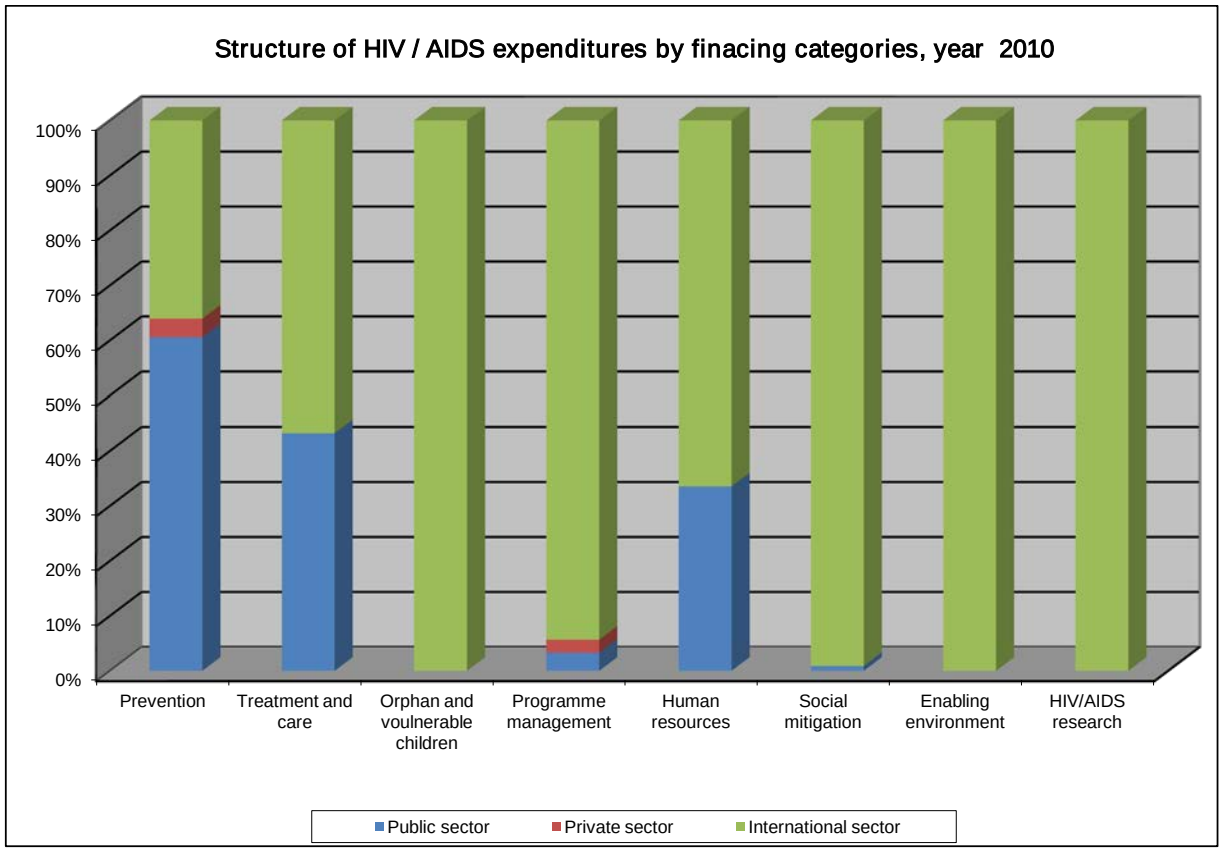

Figure 11 Structure of HIV/AIDS expenditures by financing categories, year 2010

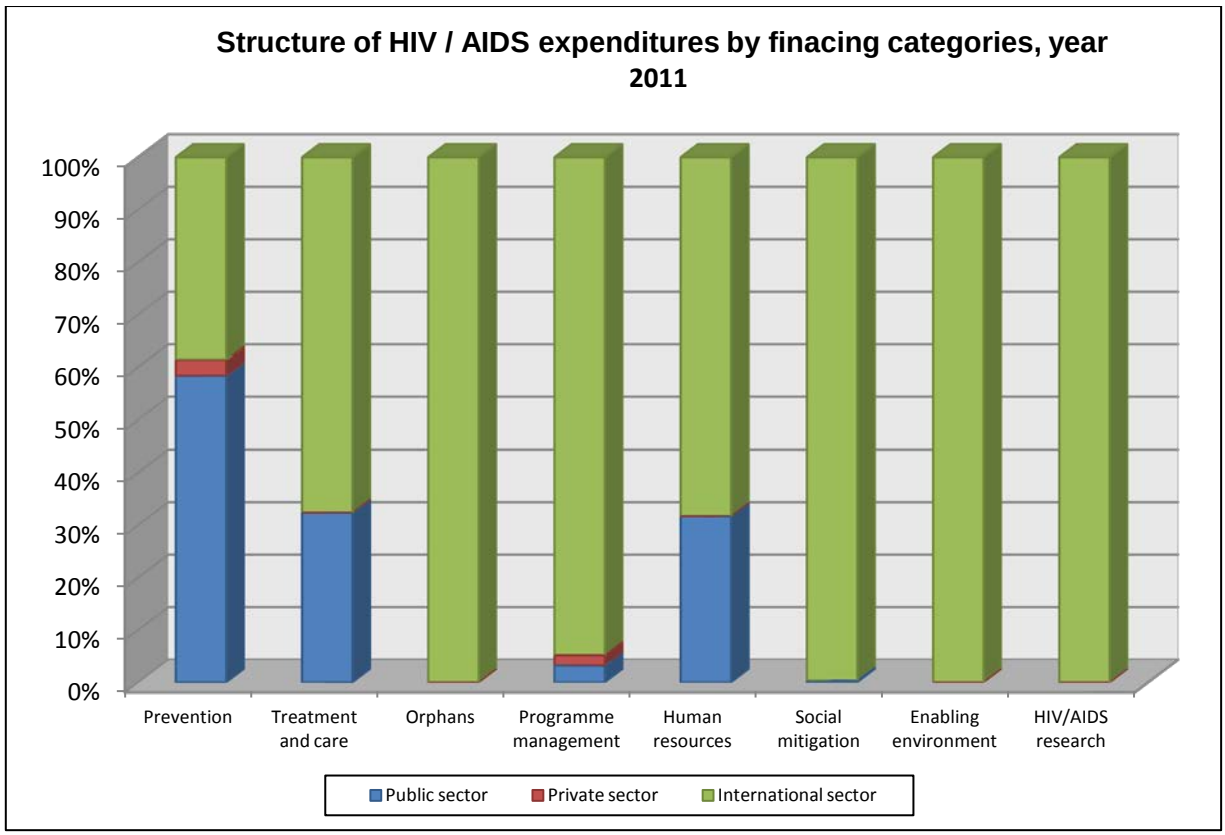

Figure 12 Structure of HIV/AIDS expenditures by financing categories, year 2011

The limitations of the method applied for the generation of this indicator are as follows, some of them being valid for the previous reporting periods as well:

- Though significant progress has been registered in data collection from the greatest majority of organizations and institutions, involved in various aspects of the national HIV response, including coordination, monitoring and evaluation, there are still entities with budgets committed and spent for HIV/AIDS that do not report their expenditures and are not reflected in the matrix, due to the fact that activities are not targeting general population, or PLHIV, or MARPs as such and are more tangential to the response, hence not fitting comfortably in the pre-set spending categories.
- In the case of public institutions funded by the State budget, tracking all indirect costs of the subdivisions, specifically the maintenance and utilities costs associated to activities in the framework of the national HIV response, has not been possible as the maintenance costs per institution form an the integral budget and cannot be disaggregated.
- Not all international and national organizations and institutions have reported disaggregated data.

In conclusion, the data collected for the Indicator I for the Republic of Moldova allow the comparative analyses of trends over time in costs of activities in HIV/AIDS, based on budget categories covered.

INDICATOR 7.1 Government HIV and AIDS policies

National AIDS Programme: at the national level, the state policy in the area of HIV/AIDS in Moldova is implemented through the National Programme on Prevention and Control of HIV/AIDS and STI for 2011–2015 (National AIDS Programme – NAP), just approved by the Government of the Republic of Moldova on December 16, 2010. The current NAP follows the previous three programs implemented in years 1996-2000, 2001-2005 and 2006-2010. The last NAP has been primarily funded by international donor assistance, with the Moldovan government contributing about 20% overall.

The NAP has the following main expected outcomes by 2015:

1. HIV incidence will not be more than 20 cases per 100,000 population of age 0-39 years.
2. Mortality of PLWH will be reduced by 10%

It has also prioritized HIV control strategies in the following 10 objectives to be achieved by 2015:

1. Ensuring access of at least 10% of general population to HIV/STI prevention services
2. Ensuring access of 60% of the estimated size of MARPs (IDUs, SWs, MSMs) to prevention services
3. Ensuring access of 10% of general population to condoms
4. Ensuring access to STI treatment of 80% of diagnosed STI cases
5. Ensuring access of 95% of pregnant women to PMTCT services
6. Ensuring 100% blood safety
7. Ensuring access of 100% persons exposed to HIV transmission risk to post-contact prophylaxis
8. Ensuring access to ARV treatment of 80% of the estimated number of PLWH in need of ART
9. Ensuring access to care and support services of 10% of the estimated number of PLWH
10. Development of an effective program management system.

In the health sector, there are three main institutions with responsibilities in HIV/AIDS at central level:

1. ***National AIDS Centre*** – a Department of the Centre of Public Health within the Ministry of Health, with the main responsibility of diagnosis of HIV. A unit for coordination of the NAP has been established in 2011, constituting of coordinators for prevention, VCT, treatment, capacity building and M&E.
2. ***Infectious Diseases Hospital*** – responsible for the treatment of PLHA. The Hospital is subordinated to the Ministry of Health. As of 2012, the Ministry of Health intends to bring the 2 institutions under one common administration, together with the national STI clinic.
3. ***National Centre for Health Management (NCHM)*** is a public institution under the auspices of the Ministry of Health of the Republic of Moldova, which works in accordance with the provisions of legislation in place, normative acts of the Government, the Ministry of Health, other normative acts, international treaties the Republic of Moldova has signed. The activity of NCHM focuses on implementation of the health management state policy, medical statistics and data basis of the national health system, medical equipment and building of the Integrated Medical Information System.

Implementation of the NAP is coordinated by the National Coordination Council for HIV and TB, an interministerial and intersectorial decision-making body that has under its auspices 7 functional working groups which enhance coordination and capitalize upon the value added of joint efforts of all key stakeholders from different sectors, and a permanent Secretariat. The NCC and its TWGs have been involved all throughout the design of NAP and NTP (www.ccm.md).

International and national principles applicable to public health programs underpinned the design of the state programme, as follows:

Principle 1 NAP is developed based on evidence NAP 2011-2015 is designed based on the evidence generated by the mid-term review (MTR) of NAP 2006 – 2010 and the analysis of the national response at the beginning of 2010.

Principle 2 NAP is developed through a human rights based approach NAP 2011-2015 is designed through human rights lenses, while identifying the right holders and duty bearers and the rights of the most marginalized populations. NAP is developed by following the non-discrimination, equity and social inclusion principles and is promoting transparency and accountability of all stakeholders.

Principle 3 NAP is designed to be gender sensitive The gender dimension takes into account the responsibilities and opportunities of men and women from a social, cultural and political standpoint. Various monitoring, evaluation and surveillance tools have been developed to provide data disaggregated by sex and to identify gender sensitive interventions.

Principle 4 NAP is designed to ensure UA to HIV prevention, treatment, care and support The key principle for UA provides for the services' fairness, geographic accessibility, affordability, comprehensiveness and sustainability. Ensuring UA is based on setting and tracking national targets, aligned to international standards, outlining the target values to be reached by the end of NAP.

Principle 5 Involvement of PLHIV and communities living with HIV in NAP design, implementation and evaluation NAP was designed by abiding by this principle ensuring PLHIV's rights and opportunities. Civil society involvement, including PLHIV and high-risk group representatives, strengthened the quality and efficiency of national response to HIV.

Aiming at having an efficient AIDS-response, the Republic of Moldova has committed to the Declaration of Commitment and has embarked on building and strengthening the 3 Ones. The National Programme on Prevention and Control of HIV/AIDS/STI for 2006-2010 was aligned to national strategic frameworks and to international commitments Moldova has embraced. The NAP had clear linkages to the MDG-centred National Development Strategy 2008 – 2011, which represents a tool for the integration of the strategic frameworks under implementation, as well as a device for alignment between the budgeting process and the policy framework, and absorption of external technical and financial assistance. The new NAP document has also been profoundly anchored in national development policies and plans.

The National Development Strategy (NDS) for 2008-2011 foresees accomplishment of MDG 6 Fight HIV/AIDS and Tuberculosis; other relevant sectorial policies include the National Health Policy approved in 2007, National Strategy for Health System Development for 2008-2017, which foresees consolidation of actions in area to stop the increase in HIV incidence. Moldova's development Strategy to 2020 focuses on several key very specific objectives, including improving infrastructure for enhanced access to ehalth services. The legislative tools include a set of laws which have been adopted to ensure sustainability of actions: Law on Health Protection (1995), Law on Reproductive Health and Family Planning (2001), Law on Migration (2003), Law on Equal Opportunities (2006), Law on AIDS Prevention and Control (2007), Law on Combating Domestic Violence (2008), Law on Social Assistance (2008), Law on donors and blood transfusions (2009).

With the support and advocacy of specialized NGOs (namely, NGO "IDOM") and in accordance with the Ministry of Health Order Nr. 347 dated 26.05.2010, the Ministry of Health initiated a working group to revise a series of Laws, including the Law on Prophylaxis of HIV/AIDS, the Law on Migration, the Law on the Legal Regime of foreigners, etc., as well as subordinated normative documents (i.e. Instruction on HIV Testing of Young People before Registration of Marriage, Instruction on HIV Testing of Pregnant Women etc.). In accordance with the Ministry of Health Order Nr. 36 dated 17.01.2011, a series of amendments removing discriminatory elements were operated to the aforementioned legal documents. Amendments to most of the regulatory acts have been approved by the Government, still, the amendments to the Laws which require the endorsement of other line ministries, are still under examinations by the related line

ministries and awaiting approval. The amendments to the HIV Prevention Law (2007) are currently awaiting approval in the Parliament.

Significant efforts were invested to develop harmonized national standards and instructions related to the prevention and prophylaxis of HIV/AIDS. These include a series of national standards and guidelines related to HIV services (VCT, PMTCT, HIV surveillance, Infection Control, HIV Care and Treatment etc). However, in practice, the enforcement of these normative documents is still not perfect and there are discriminatory episodes in provision of medical treatment and services.

The exposure to or transmission of HIV is still prosecuted under the Criminal Code (approved by Law Nr. 985-XV dated 18.04.2002) with specific provisions under articles 211 and 212. HIV transmission has been criminalized in an attempt by the government to respond to the rising numbers of HIV infections and prevent the deliberate contamination with HIV; yet, human rights campaigners and other NGOs have expressed concerns that these laws lead to a violation of the rights of people living with HIV, exacerbating their marginalization. Hepatitis and TB are also considered to be diseases of a same level of threat for public health, still, their transmission is not prosecuted. However, it is worthwhile mentioning that Moldovan legal framework does not contain an offence for a man to have sex with another man (MSM). Moldova has one the most progressive legal environments around harm reduction and decriminalising drug possession. Since 2004 there has been a marked shift in drug enforcement strategy towards prioritising the prosecution of drug dealers alongside the detection of drug trafficking networks and drug producers, rather than criminalisation of drug use In addition, in 2008, personal drug use was decriminalised. Major amendments to the Penal Code and Administrative Offences Code reformed criminal punishment, including by promoting alternative punishments to imprisonment, and by excluding the application of arrest for personal drug use, now constituted an administrative rather than criminal offence. The illegal purchase or possession of narcotic drugs or psychotropic substances in small quantities without the intention to distribute them, as well as their consumption without a medical prescription, is sanctioned by a fine or community service. Selling sex is an administrative misdemeanour; pimping is a criminal offence.

During the period 27 June to 8 July in Moldova the Joint Assessment (JA) of the National Program for HIV/AIDS and STI Control and Prevention for 2011-2015 (NSP) was conducted. It was the first Joint Assessment conducted under the GFATM Second Wave of the National Strategy Application (NSA) modality.

The Joint Assessment was based upon the JANS tool; it responded to the areas of expertise identified by the Joint Assessment Organizing Body (JAOB) as key for Moldova: Strategic Planning (as an overarching, cross-cutting issue), HIV Disease (to manage the Situation Analysis category of the JANS tool), Multi-stakeholder Involvement (to manage the Process category), Finance and Audit (for that section of the tool), Programme Management and Health Systems (for the Implementation and Management category), Procurement and Supply Management (to handle specifically attribute 15), and M&E (for the Results, Monitoring and Evaluation category).

Moldova's M&E Plan was developed jointly by Government and civil society representatives during a MOH-led workshop, with foreign assistance and support, and NCC TWG on HIV/TB M&E. However, the use of M&E data for decision-making remains weak, despite some recent trends and national evaluations conducted in the context of JANS and NSA updates.

The representatives from the governmental sector are satisfied with the degree of participation in the process of development, validation and evaluation both of the National Programme, and of other strategic documents on HIV/AIDS/STI.

Representatives from the governmental structures affirm that the international agencies are characterized by consistency and they apply complex, multi-aspectual approaches; they ensure financial support, and quality in the coordination process of the National Response to HIV/AIDS.

Among the most strong points of the strategies developed and implemented by the international actors, the representatives of the governmental sector enumerated the following:

- The programmes are innovative and of high quality due to the fact that they represent best practices in the field of HIV/AIDS at the international level;
- They always have technical and financial support, which make them stable;
- Actors representing international agencies have new suggestions and tools, and they ensure a continuity from objectives to results in their strategies;

Due to some political and administrative limitations, this report does not contain a thorough analysis of the legal framework on HIV/AIDS present in the Transnistrian region. However, it is worthwhile mentioning that, de jure, the so-called Transnistrian authorities put in place the legal framework on HIV/AIDS which, in principle, can be considered developed in accordance with the basic international standards. HIV prevention and combating is regulated by the so-called Law Nr. 32-3 on HIV Prevention in Trasnistria dated 7.02.1997, Law Nr. 29-3 on Fundamentals on Public Health, so-called Criminal Code (art. 119 and art. 134) and other subordinated normative documents. While Transnistrian Law on HIV Prevention and other related legal documents contain non-discriminatory provisions (i.e. HIV testing is not compulsory for young people who want to register their marriage), de facto, there are many inconsistencies between these laws and the subordinated normative documents and mechanism of their implementations is ineffective. In the region, there are frequent incidents of discrimination and infringements of the rights of the people living with HIV/AIDS, including HIV testing of migrants.

On national level, the importance of approving amendments to the 2007 HIV Law cannot be overstated. Relevant regulatory and normative documents should also be subjected to revision to ensure consistency with human rights and non-discrimination.

Prevention: there is progress attested in HIV prevention activities among MARPs that experienced the fastest scale up, but a more temperate evolution. The temperate evolution is due to uneven coverage and low quality of services.

Among all areas of HIV prevention, HIV Prevention among IDUs has seen the most progress and included early on adoption of harm reduction and NSP as the national strategy of HIV Prevention in IDUs (since year 2000), initial NSP in the most affected areas (Balti and Chisinau and other 4 most affected rayons) in years 2000-2002 and rapid program scale-up under Global Fund Round 1 (years 2003-2006). Due to early start and rapid scale-up of Harm Reduction Programmes among MARPs, both in the civil sector (IDUs, SWs, MSM) and in penitentiaries (IDUs), the Republic of Moldova is known as being an example of best practice. Global Fund Round 6-8-supported NSP is provided by both public and community-based points of care and they provide sterile needles, syringes, alcohol swabs, informational brochures, and condoms and offer collection and safe disposal of injection equipment. The distribution is made through a network of 12 geographic sites that include stationary NSP points and outreach to apartments. In addition, social and outreach workers provide referrals to other HIV prevention services, VCT, gynecological consultations, STI diagnosis. NSPs also provide a point of entry to substitution therapy. There is uneven geographic distribution of needle-syringe programs and other harm reduction activities, with still low coverage rates in the most affected cities, especially Chisinau.

HIV prevention interventions for FSWs includes the following services: condom distribution, IEC distribution and referral to facility-based STI and VCT services. The primary method of service delivery is via outreach to apartment- and street- based venues. There are currently five program sites that provide outreach services to SWs. Overall, HIV prevention programs targeted to FSWs focus on condom distribution and referral to facility-based VCT and STI management; not all elements within a state of the art package of HIV prevention services targeted to FSWs are provided.

HIV prevention interventions targeted to MSM are provided primarily by community-based organizations (Gender-Doc and Center ATIS) in the two main cities (Chisinau and Balti). GenderDoc-M has started outreach activities within the Health Program in 2005. Services include condom and lubricant distribution, distribution of information leaflets, organization of seminars, safer sex promotion parties for the LGBT community, providing individual counseling services, and developing referral system to medical specialists, referral to facility-based VCT.

Communication campaigns to change behavior among the various segments of the general population have a systematic character and meet quality standards. HIV VCT Services were extended throughout the country, including in penitentiaries. Rapid tests were introduced, with particular emphasis on the use of rapid tests in maternities for pregnant women coming to give birth without prior antenatal care and HIV test. Meanwhile, with ILO support and with the financial support of GTZ, there were implemented the first consolidated efforts in HIV in the workplace prevention. There have been quality control standards for blood safety and participation of all blood transfusion centers and wards in an external quality assurance scheme of the National AIDS Reference Laboratory. There have been challenges attested related to limited financial possibilities of the state for prevention; fragmented coordination; reduced sustainability of interventions in both prevention among MARPs and the general population; limited financial possibilities to establish regional multisectorial strategies for prevention and communication for the behavior change of MARPs.

Treatment, care and support: the most important achievements relate to ensuring access to HIV treatment, which in fact is 100% available to those who need and want it; to achievements in the decentralization of treatment services and HIV care throughout the country, as well as providing MST services; updating treatment protocols with WHO financial support; initiating the creation of infrastructure for testing viral resistance to ARV preparations; improving accessibility and quality of prophylactic ART for HIV pregnant women; opening a pediatric ward within the ARV treatment institution.

Starting with 2011, the decentralisation of ARV treatment has started, being available for the northern region of the country in Balti municipality, the southern region – Cahul, and the centre of the country – Chisinau municipality. On the left bank of the Nistru River, the ARV treatment is provided by the AIDS Centre in Tiraspol and in Ribnita for citizens from the northern part of Transnistria.

The regulation on the organization of palliative care services for people with HIV/AIDS was developed. The HIV case management protocol is being developed.

An HIV case management protocol is missing. Support and care services are assessed as inadequate on the grounds that palliative care is not institutionalized and is provided almost exclusively by the NGO sector; human capacities are underdeveloped;, the concept of vulnerability is not sufficiently developed and social assistance based on the concept is in the process of being operationalized . Data show that coverage of children with ARV treatment is lower than for adults. Insufficient training, laboratory diagnostic and

situation monitoring in the field of HIV/AIDS on the left bank of the Nistru River represent gaps that need special consideration.

United Nations Development Assistance Framework

The UN System plays a high-profile role in advocacy and the provision of technical support for the national response. While the volume of resources contributed by the UN agencies is considerably smaller than other donors such as the Global Fund, the UN has also played an essential role in mobilizing additional financial resources, including its role in coordinating the successful Global Fund grant proposals.

International agencies operating in Moldova (UNAIDS, UNFPA, WHO, IOM, UNICEF, UNHCR, UNDP, etc.) are actively involved in providing technical assistance to establish empirical evidence on the trends of the HIV epidemic and its determinants. Specifically, the 2010 study among migrant workers was sponsored by the International Organization for Migration (IOM), WHO and UNAIDS while UNAIDS provided experts for estimating sizes of vulnerable groups such as injecting drug users and sex workers. UNAIDS has also funded in 2011 the first data collection through a general population survey in the Transnistria region.

The country adopted the WHO protocols for ARV treatment, as well as guidelines for prevention of mother to child HIV transmission, has developed the plan for second generation surveillance, has implemented harm reduction projects, etc.

The new UN Programme Framework has been developed with national counterparts in 2011, to replace UNDAF 2007-2012.

Millennium Development Goals

Ten years after committing itself to achieve the Millennium Development Goals (MDGs) at the Millennium Summit in New York, in September 2000, the Republic of Moldova issues its Second Millennium Development Goals Report. The report prepared by the Government, with the support of the United Nations in Moldova, identifies the progress made by Moldova in meeting those eight goals. It also outlines the steps that will be taken in the next five years which will be decisive for the fate of those commitments.

Five years before 2015 - the deadline set by the world leaders for achieving the Millennium Development Goals, the Second Millennium Development Goals Report of the Republic of Moldova notes that today, the MDGs are included in the Government's medium-term agenda, which are set out in the National Development Strategy (NDS) for 2008-2011.

The National Development Strategy 2008 - 2011 comes to strengthen the commitment to achieve MDGs based on the amended national targets, including those for Objective 6. The Millennium Development Goals are transposing into concrete and tangible tasks the most vital and compelling issues related to development of a country. For Goal 6, the national targets are: stabilization of HIV/AIDS prevalence by 2015, reducing the incidence of HIV/AIDS per 100,000 population from 10 in 2006 down to 9.6 by 2010 and 8 by 2015; reducing the incidence of HIV/AIDS per 100,000 people between the ages of 15-24 years from 13.3 in 2006 down to 11.2 by 2010 and 11 by 2015; halting the spread and incidence of tuberculosis by 2015, reducing the mortality rate associated with tuberculosis (per 100,000 population) from 16.0 in 2002 to 15 in 2010 and up to 10 in 2015).

The National Report notes that the main achievements of the country related to the eight Millennium Development Goals are aimed at eradicating poverty, reducing infant and maternal mortality, extending the areas protected by the state and the increasing role of information technology in the context of creating partnerships for development. Less successful were developments in the area of education, combating

HIV/AIDS and tuberculosis and ensuring people had access to an adequate health infrastructure. The United Nations will continue to support the people and the Government of Moldova in achieving prosperity and progress in the country.

Intersectorial Aspects

Migration

Migrants represent a group with an increased risk of HIV and STI by means of sexual contact, with a twice bigger number of persons having occasional sexual partners than the general population. In this regard UNAIDS jointly with IOM, the Ministry of Health of the Republic of Moldova conducted a study on the health implications of the socio-economic welfare of Moldovan migrants. The research was carried out within the framework of the IOM project "Managing the Impact of Migration on the Healthcare System of Moldova" and benefited of methodological and financial support from UNAIDS and the World Health Organization.

Russia continues to be the main country of destination for Moldovan migrants: 71.0% of those who have been away in the past were years were in Russia and 66.7% of spouses away in the past six months were in Russia. Ukraine is a destination country for 8.7% of migrants and 5.7% of their spouses. Given the high HIV prevalence in Ukraine and Russia, these two destinations are the most important from the point of view of risk of acquiring HIV.

One of the basic determinants of migrants' vulnerability relates to more frequent engagement in risk behaviour associated with migration. Allegations of this kind are based on the reasoning that migrants' mobility, break of couples for long periods, or unmarried young people getting beyond their parents' control would lead to frequent involvement of migrants into casual sexual activity.

The integrated index of knowledge about HIV/AIDS shows a satisfactory level of awareness about HIV and AIDS, but with a large number of migrants having misconceptions about HIV transmission

Almost every tenth migrant (9.3%) in the last 12 months (2010) had at least one occasional sexual partner (non-commercial), which is more than double compared with the non-migrant population - 4% in the case of families receiving remittances, and 3.3% in the case of families not receiving remittances.

The incidence of sexual contacts with commercial partners is very small, making a deeper analysis impossible. Commercial sexual activity was reported by 0.6% of migrants and members of families receiving remittances, with no recorded cases of commercial sexual contacts among members of families not receiving remittances.

On the other hand, migrants reveal a higher frequency of condoms use, even as couples, where condoms use is very rare. Thus, 12.6% of migrants used a condom during the last sexual intercourse with a permanent partner living in the same household, as compared to 7.6% in the case of families receiving remittances, and 4.9% in the case of families not receiving remittances. In non-couple sexual relations (besides sex partners the respondent lives with) the frequency of condoms use is much higher, even with permanent sexual partners (with whom the respondent does not live under one roof). Every second migrant (55.3%) used a condom during the last intercourse with a permanent partner outside the family couple, and 67.8% used a condom during the last intercourse with an occasional partner (non-commercial).

Here we conclude about the vulnerability of migrants, who are much more often engaged in sexual activity with occasional partners without using a condom at least in one third of cases.

Human rights

The draft anti-discrimination law awaits approval of the Parliament since February 2011. Moldova has constitutional provisions banning discrimination, there is 2006 Gender Equality Law in force but ineffective There are few cases in courts identifying discrimination, with the notable exception of a Supreme Court decision in late 2011, banning discrimination based on HIV status in issuing residence permits for HIV+ foreign nationals.

The human rights protection machinery currently in place centres around the Ombudsman institute. There are also hotlines maintained by line Ministries and some NGO to empower actors to react to cases of discrimination. There Is low legal knowledge among the population and a limited culture of seeking redress for human rights violations.

Even with the few laws that protect the rights of key populations, patients etc., and the enforcement of those is weak. The draft comprehensive anti-discrimination Law envisions the establishment of an enforcement body.

Gender

In the Republic of Moldova the legislation and the policies in the area of gender equality are quite well developed. The gender equality is a founding principle set by the supreme law, the Constitution, and there is a specific law on gender equality. The Republic of Moldova has adhered to the Millennium Development Goals (MDG) where the third priority is promoting gender equality and has included this objective in its Strategy for National Development. In addition, a national program to promote gender equality has been developed for the years 2010-2015. The Republic of Moldova has adhered early on to international conventions addressing gender inequality: it has ratified Committee on the Elimination of Discrimination against Women Convention (CEDAW) in year 1994.

The Constitution of the Republic of Moldova establishes that men and women are equal in front of law and local pubic authorities. A law that promotes equal opportunities for women and men was adopted by the Parliament on 9 February 2006. Its main goal is to ensure exercise of equal rights of women and men in the political, economic, social and cultural aspects of life, which are guaranteed rights by the Constitution of the Republic of Moldova, in order to prevent and eliminate all forms of gender-based discrimination. In reality, some experts consider that the gender equality legislation is mainly declarative, including because of patriarchal traditions and the traditional perceptions regarding women's role in the society.

A report on monitoring the implementation of the new law has shown that its implementation is difficult because of insufficient legal enactment mechanisms and poor familiarity of the population and employers with the content of the law.

The Strategy for National Development for years 2008-2011: includes the MDG no. 3 to promote gender equality and women empowerment and sets as objectives increasing the level of political representation of women (in local councils from 26.5% in 2007 to 40% in 2015, number of women mayors from 18% in 2007 to 25% in 2015 and deputies in Parliament to 30% in 2015) and decreasing the difference in salaries by at least 10% by 2015 (in 2006 the average salary in women being 68.1% of that of men).

National Program for Promoting Gender Equality for years 2010-2015 and Action Plan for years 2010-2012: The national program outlines the major gender-related problems in the Republic of Moldova. Although women have better education (58.9% of university and over 60% of postgraduate students are women), they are employed in lower proportions than men (occupation rate was 41.0% in urban and 39.5% rural women compared to 48.6% in urban men and 42.7% in rural men). In addition, they are usually

employed in lower-paid occupations and positions. The most important priority in this area is decreasing the discrepancy between the salaries of women compared to men. Another problem is the out-migration, although affecting more men (women constituted 35% in year 2008), there are many instances when both mothers and fathers leave their children behind. Women are traditionally regarded as unpaid care providers for family members, receive lower pensions due to lower income and three priority problems have been identified in this area: double burden for women in professional and family lives, women being the main care-giver due to traditional roles and the discrepancies in average retirement pension

In health, the national program has identified several areas as problematic: limited access of rural women to reproductive health services, use of abortion as a family planning method, increased maternal mortality rates in rural areas, increasing rates of alcoholism both in women and men and high injury rates in men. No HIV gender-specific problems have been identified in the National Program.

In the area of gender-based violence and human trafficking the following four problems have been outlined:

- Family based violence against women and girls
- Violence against girls and boys in educational settings
- Sexual harassment of women at workplace
- Women and girl trafficking

The National Program sets the following priorities for the years 2010-2015:

1. Labour and migration: decreasing the discrepancies between salaries of men and women, elimination of all forms of gender based discrimination on the labour market, economic empowerment of rural women, integration of gender dimension in migration policies
2. Gender-sensitive budgeting (GSB): development and promotion of GSB concept
3. Women participation in the decision-making process: increasing women representation in political and public areas
4. Family and social protection: improving the participation of men in distribution of family responsibilities, e.g. child care leave, formalizing the care-giving role of women, decreasing disparities between the amount of pensions
5. Health care: inclusion of gender dimension in health sector policies, reducing discrepancy between men and women, improving the socio-economic factors conducive to maternal mortality rate in rural women
6. Education: inclusion of gender dimension in education policies, reduction of feminization of the educational system.
7. Violence and human trafficking: eradicating family-based violence and human trafficking, decreasing violence against girls and boys in the educational facilities and improving services for victims of gender-based violence and human trafficking.
8. Increasing gender awareness: promoting positive images of women and men and the role distributions in private life, combating use of sexist images in marketing and advertisement industries.
9. National mechanism: improving gender responsibilities.

The gender equality is the mandate of several structures at the governmental level. A Governmental Commission on Equal Opportunities for Women and Men is established. The Ministry of Labour, Social Protection and Family has a Department of Equal Opportunities and Family Policies. Since year 1999 all ministries have established gender focal points and there are local commissions on women issues at the level of local public authorities.

INDICATOR 4.1 Percentage of adults and children receiving ARV treatment

ARV treatment became available in the Republic of Moldova beginning with 2002. Beginning with 2003, medication for ARV treatment was bought with the financial support of the World Bank and GFATM grants (Round 1 and Round 6). In the Republic of Moldova there are 8 institutions providing ARV treatment: on right bank the HIV/AIDS and Dermato-Venerial Republican Centre (provides services to patients from the central region of the country, right bank of the Nistru river and persons from other regions at their request, provides inpatient treatment for all patients in the country); municipal hospital from Balti (provides services to patients from the northern region of the country); district hospital from Cahul (provides services to patients from the southern region of the country); the Penitenciary Institutions Department for inmates on the right bank of the Nistru River; and on the left bank, the AIDS Centre in Tiraspol (provides services for patients and inmates on the left bank of the Nistru River), district hospital from Ribnita (provides treatment to patients from the northern part of Transnistria), Phthisiopneumology Dispensary from Bender (provides services for patients with TB/HIV co-infection), the Penitentiary Institutions Department for inmates on the left bank of the Nistru River.

According to the National Protocol followed in all medical institutions that initiate ARV treatment, undertake clinical monitoring and dispense ARV drugs, the immunologic criteria for enrolment in treatment in the reporting period have been CD4 <350 and RNA HIV>100000. The clinical monitoring provides for quarterly CD4 and viral RNA testing for those that were initiated on treatment and for twice per year CD4 and viral RNA testing for those not yet on ARV treatment.

The demand for ARV increases annually. During 2011, 11 children and 519 adults have been enrolled in treatment.

Table 6. New enrolments into ARV treatment, Republic of Moldova, 2003-2011

		2003	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
New enrolments into ARV treatment, adults	Males	14	49	66	62	109	150	210	211	275
	Females	13	32	41	52	88	113	152	156	255
	Total	**27**	**81**	**107**	**114**	**197**	**263**	**362**	**367**	**530**

Presently, all ARV drugs are procured from Global Fund sources, Round 6.

According to the recommendations, for calculation of ARV treatment coverage, the estimated number of persons that need treatment generated by SPECTRUM is the denominator. In the framework of workshops with participation of technical level representatives and decision makers from relevant institutions, entry data and Spectrum outputs were validated. Thus, at the end of 2011, in the Republic of Moldova the standard indicator value of coverage with treatment reached 29,31% for both banks of the Nistru River. For 2010 this indicator represents 25%. Data introduced in the on-line AIDS Reporting tool are for 2011.

Method of Calculation and Indicator Value

Numerator: Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocols at the end of the reporting period.

Denominator: Estimated number of adults and children with advanced HIV infection that require ARV treatment for the reporting period.

Since the Republic of Moldova estimates were made separately for right and left bank of the Nistru River, denominator data represents the sum of both estimates.

Source: Registries of patients in ARV treatment from institutions providing ARV treatment.

Table 7 Percentage of adults and children receiving ARV treatmen, Republic of Moldova, 2011

	All	Males	Females	< 15 years	15 + years and older	MSM	Injecting Drug Users	Former Injecting Drug Users	NON Injecting Drug Users	Patients receiving OST	Patients that Do Not receive OST	Prisoners
Indicator Value	29.31 %	23.52 %	38.23 %	48.15 %	28.95 %							
Numerator	1666	866	765	52	1614	15	494	NA	1172	34	460	135
Denominator	5683	3682	2001	108	5575							
Number of children and adults requiring ARV treatment at the end of the reporting period (out of patients on record)	2030	1061	932	53	1977	15	201	NA	1829	NA	NA	158

Enrolment of children in ARV treatment represents 98,1% of the evaluated needs, because one mother refused to accept the HIV diagnostic of her child. Enrolment of adults is stable for the last years.

Stock-outs and waiting lists have not been registered during the reporting period. Thus, all patients, who accessed relevant medical institutions (directly or by reference) and needed ARV treatment, were offered to enrol in treatment, and those who accepted initiated ARV treatment. In framework of Global Fund Round 8 grant, interventions were implemented that had as main objectives the increase of adherence and enrolment in treatment, and increase of geographic access to ARV treatment (decentralisation of ARV treatment) that is intended to scale up demand for treatment. Talking into account the increased demand for treatment, once the financial support from the Global Fund Round 6 is completed, the Government of the Republic of Moldova will apply for funding to external donors to ensure continuity of ARV treatment after 2012 in accordance with the demand and needs.

INDICATOR 3.1 Percentage of HIV positive pregnant women who received ARV drugs to reduce the risk of mother-to-child transmission

According to the administrative statistics for 2011, out of the number of women that gave birth during 2011, 99,2% have been tested for HIV at least once. By 2011 Voluntary Counseling and Testing service for HIV and viral hepatitis B and C covers the whole territory of the Republic of Moldova, including the left bank of the Dniester River. Out of the total number of pregnant women registered during 2011, 66,7% benefitted from Counseling, which reveals that reference of pregnant women to

the VCT service for HIV, and viral hepatitis B and C is still low. The rate of pregnant women that have been tested and know their result during 2011 is higher (56,8%) compared with 2010 (43,6%).

The study on vulnerability of women to HIV carried out on the left bank of the Nistru river in 2011 showed that 95,3% of women who have ever given birth received antenatal care.

During 2010, 87 new cases of HIV infection were identified among pregnant women and 54 HIV positive women became pregnant and decided to go on with the pregnancy. In 2011, 80 cases of HIV infection among pregnant women were identified and 85 HIV positive women became pregnant and decided to go on with their pregnancy.

In correspondence with the clinical protocol on ARV treatment, HIV infected pregnant women who do not need ARV treatment for own health according to clinical or immunological criteria are administered ARV prophylaxis treatment starting with the 24th week of pregnancy, while infants receive ARV prophylaxis treatment for 7 days.

Data source:

Register of new cases of HIV infection, register of patients in pre-treatment and ARV treatment, register of HIV positive pregnant women receiving ARV prophylaxis treatment.

Method of Calculation:

Numerator*:* Number of HIV positive pregnant women that received ARV prophylaxis treatment for reduction of mother to child transmission.

Denominator*:* In the case of the Republic of Moldova, because of almost universal coverage with HIV testing, the number of HIV positive pregnant women registered during the reporting period was taken into account.

Table 8 Percentage of HIV positive women receiving ARV prophylaxis treatment to reduce HIV transmission from mother to child in the Republic of Moldova, 2010 and 2011

	2010	**2011**
Numerator	123	123
Denominator	141	165
Indicator value	**87,2%**	**74,5%**

Among the HIV positive pregnant women receiving ARV treatment to reduce mother to child transmission of HIV/AIDS in 2012, 25 women received ARV, being eligible for treatment according to clinical and immunological criteria, 89 women received ARV prophylaxis treatment to reduce vertical transmission of HIV and 9 women received emergency ARV prophylaxis treatment during delivery. In all cases, children received prophylaxis treatment during the first 7 days of life.

Among the HIV positive pregnant women receiving ARV treatment to reduce mother to child transmission of HIV/AIDS in 2011, 36 women received ARV, being eligible for treatment according to clinical and immunological criteria, 87 women received ARV prophylaxis treatment to reduce vertical transmission of HIV and children received prophylaxis treatment during the first 7 days of life.

The difference in the percentage of women that received ARV prophylaxis treatment compared to the previous years is caused by the large number of HIV positive women that became pregnant knowing their HIV positive status. At the same time, the numerator is calculated among women that gave birth, to assess if they received complete ARV prophylaxis treatment during pregnancy (more

than 4 weeks), incomplete ARV prophylaxis treatment during pregnancy (less than 4 weeks) or emergency ARV prophylaxis treatment during delivery. According to the national guideline for HIV positive women that are not eligible for ARV treatment for own health, ARV prophylaxis treatment is prescribed starting with the 24th week of pregnancy. Hence, out of 165 HIV positive pregnant women registered during 2011 there are:

- Women that started ARV prophylaxis treatment, but didn't give birth and were not counted as HIV positive women that received ARV prophylaxis treatment,
- Women that have not reached the pregnancy stage for initiation of ARV treatment (10 new cases among pregnant women have been identified during first ANC visit in the IV quarter of 2011, and these have not reached yet 24 weeks of pregnancy to be enrolled in PMTCT by the end of 2011).

INDICATOR 5.1 Percentage of new HIV positive incident TB cases that received treatment for TB and HIV

According to national recommendations, HIV testing is recommended to TB patients. According to the national statistics, coverage with HIV testing of the new and relaps cases of TB was 90,9% in 2010 and 93,2% in 2011 (for both banks of the Dnieser River). The prevalence registered in 2010 and 2011 is about 5,5% and 5,2%.

The Counseling and testing service for HIV and Hepatitis B and C is also available based on institutions constituting the phtysiopneumology service. Thus, at the end of 2011, 4 VCT units were open in the medical institutions offering in-patient treatment services for TB cases.

According to the national protocols, the algorithm in case of a TB patient with HIV positive status, is as follows:

1. If CD4<200, the patient initiates anti-TB treatment; ARV treatment will follow 3-4 weeks later.
2. If CD4 = 200 - 350, patient initiates anti-TB treatment; 2 months later the CD4 test is repeated. If CD4 number does not increase, ARV treatment is initiated.
3. If CD4 >350, patient initiates anti-TB treatment. Patient is supervised regarding initiation of ARV treatment.
4. If patient is already in ARV treatment, anti-TB treatment is initiated.

Data source: SIME TB database, register of patients in pre ART and in ARV treatment.

Method of calculation and indicator value:

Numerator: Number of people with advanced HIV infection who have received antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (new TB cases) (in accordance with national TB programme guidelines) within the reporting year.

Denominator: Number new and relapse cases of TB that are HIV positive, according to the SIME TB database (The source of data for the WHO database).

Coverage with ARV and anti-TB treatment for cases of co-infection is presented in Table 9.

Table 9 Percentage of new TB cases among PLHIV that have initiated anti-TB treatment in the Republic of Moldova, 2010 and 2011

	2010					2011				
	Total	**Males**	**Females**	**< 15**	**15 + years**	**Total**	**Males**	**Females**	**< 15**	**15 + years**

Indicator value	**40,4%**	44,5%	33,3%	0	40,4%	**51.06%**	49.71%	54.55%	100%	50.64%
Numerator	97	68	29	0	97	121	85	36	2	119
Denominator (estimated by WHO is 380 average for 2011)	240	153	87	2	238	237	171	66	2	235

There is an increase in the rate of TB patients among people living with HIV/AIDS enrolled in treatment compared with the previous years.

HIV testing

INDICATOR 1.5 Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results

Data source:

The data for this indicator have been collected within the framework of the household survey carried out in the general population in 2010 *(reference); (see Appendix 2, Survey on „Knowledge, Attitudes and Practices in the general population aged 15-64 related to HIV/AIDS" 2010)*.

For the purpose of the present report, the sub-sample of 15-49 year old respondents was extracted from the database of the study and was analyzed according to the recommendations of the *Global AIDS Response Progress Reporting 2012, Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS (UNAIDS 2011)*.

Method of Calculation:

In the data collection tool the questions have been formulated as follows:

1. "When did you have your last HIV test?" one of the possible answers being "in the last 12 months"
2. "I don't want to know the result, but do you know the result of your last HIV test?"

Numerator: Number of respondents aged 15–49 who have been tested for HIV during the last 12 months and who know the result of the last test.

Denominator: Number of all respondents aged 15–49.

Results: The demographic structure of sub-samples is presented in the Table 10:

Table 10 Distribution by gender and age group of the respondents 15 – 49 years old that have undertaken an HIV test during the last 12 months and know the result of the last test, Republic of Moldova, (right bank of Dniester River), 2010

		Males		Females		Total	
		num	**%**	**num**	**%**	**num**	**%**
15-19 years old	**Numerator**	52	9,2	75	13,6	127	12,3
	Denominator	511		524		1035	

20-24 years old	**Numerator**	72	16,3	82	17,6	154	17,3
	Denominator	414		477		891	
25-49 years old	**Numerator**	67	11,1	81	14,2	148	12,8
	Denominator	563		596		1159	
Total	**Numerator**	191	11,9	238	15,0	429	**13,9**
	Denominator	1488		1597		3087	

It has been attested that respondents aged 20-24 more frequently are covered with testing and know their results (both males and females). Female respondents more frequently are covered with testing and know their results (15,0%) than male respondents (11,9%).

The value of this indicator for 2007 has been 8,5%, while in 2008 among respondents of a general population survey coverage with testing in the last 12 months has been 10,3%. The value of this indicator in the framework of the survey on **Gender-associated Vulnerability to HIV** carried out in 2009 is 13,2%. Thus, there were no great variations registered in the coverage with HIV testing and level of knowledge of test results.

Within the framework or the study on "Vulnerability of women to HIV in Transnistria" the percentage of males and females aged 15-49 who received an HIV test during the last 12 months and know the results was calculated for the left bank of the Dniester River. Data are presented in the table 11:

Table 11 Distribution by gender and age group of the respondents 15 – 49 years old that have undertaken an HIV test during the last 12 months and know the result of the last test, Republic of Moldova, (left bank of Dniester River), 2011

		Males		**Females**		**Total**	
		num	%	num	%	num	%
15-19 years old	Numerator	3	10.7%	0	0.0%	3	4.7%
	Denominator	28		36		64	
20-24 years old	Numerator	3	13.0%	6	14.6%	9	14.1%
	Denominator	23		41		64	
25-49 years old	Numerator	6	9.8%	30	21.0%	36	17.6%
	Denominator	61		143		204	
Total	Numerator	12	**10,7%**	36	**16,4%**	48	**14,5%**
	Denominator	112		220		332	

It is attested that coverage with HIV Testing and knowledge of results is better in the age group of 25-49 years, especially among women. Among males, HIV Testing and knowledge of results is better in the age group of 20-24 years. Similar to the situation on the right bank of the Nistru River, female respondents (16,4%) are better covered with HIV Testing and know their results compared to male respondents (10,7%).

Data for the right bank of the Dniester River are introduced in the online tool.

Limitations of the study:

1. No national estimates exist. Data are available separately for the right and left banks of the Dniester River.

INDICATOR 1.9 Percentage of sex workers that received an HIV test in the last 12 months and know their results

The last data available for this indicator are for 2009/2010 and they have been reported in the progress report on combating HIV/AIDS in the republic of Moldova in 2010. According to the national second generation surveillance plan, the behavioural and HIV seroprevalence surveys are carried out once in 2-3 years. The following survey will be in 2012, and data will be available for the next reporting period.

INDICATOR 1.13 Percentage of men having sex with men that received an HIV test in the last 12 months and know the result

Data source:

Data for this indicator have been collected within the Behavioural and HIV Seroprevalence survey that was carried out in 2010 among Men Having Sex with Men in Chisinau and Balti *(see Appendix 4).* Data introduced in the electronic tool are those for the capital of the country, Chisinau municipality.

Method of Calculation:

The set of questions and the respective answers that served as basis for the calculation of this indicator have been the following:

1. "When have you last had an HIV test?" with an option of answer stating "in the last 12 months".
2. "I don't want to know the result, but do you know the result of your last HIV test?"

Thus, the set of questions and answers have been adjusted according to the recommendations of the *Global AIDS Response Progress Reporting 2012 Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS (UNAIDS 2011)*.

***Numerator**:* The number of respondents stating that they received an HIV test in the last 12 months and know the result.

***Denominator**:* the number of survey respondents.

Results: Distribution by age of respondents that received an HIV test in the last 12 months and know the result is presented in the table12:

Table 12 Disaggregation by age of men having sex with men that received an HIV test in the last 12 months and know the result in Chisinau, Republic of Moldova, 2010

Total			
		Number	**%**
<25 years	Numerator	16	6,6
	Denominator	101	
25 + years	Numerator	18	20,4
	Denominator	86	
Total	Numerator	34	**12,1**
	Denominator	187	

In the case of older respondents, coverage with HIV Testing and the level of knowledge related to HIV is significantly higher compared to the respondents of younger age. One respondent has never heard of for HIV and was not included in the denominator.

In Balti, those tested for HIV in the last 12 months that know their results represent 2,8%, with a lower value for the age group up to 25 years (2,2%) compared to the respondents from the age group over 25 years (4,3%).

Limitations of the Survey:

1. Data have been self-reported which indicates that recall and social desirability biases are possible.
2. Data are representative only for the locality where the survey was carried out and cannot be extrapolated over the whole country.

INDICATOR 2.4 Percentage of IDUs that received an HIV test in the last 12 months and know the result

The last data available for this indicator are for 2009/2010 and they have been reported in the Progress Report on Combating HIV/AIDS in the Republic of Moldova from 2010. According to the National Second Generation Surveillance Plan, HIV Seroprevalence and Behavioural Studies are carried out once in 2-3 years. The following survey will take place in 2012; respectively data will be available for the next reporting period.

Interventions in Key Populations at Risk

Within HIV prevention programmes carried out in the country, HIV prevention among IDUs registered the greatest progress, As of 2000, Harm Reduction Programmes and Needle Exchange Programmes have been included in the National Strategy for Prevention of HIV among IDUs (previously called National Prevention Strategy for the most affected regions - Balti, Chisinau and other 4 most affected districts),. The Harm Reduction Programme has been scaled up rapidly with the support of Global Fund Round 1 (years 2003-2006).

Due to the establishment and scale up of the Harm Reduction Programmes among key populations at risk, both in the civilian sector (IDUs, SWs, MSM) and in penitentiaries (IDUs), the example of Republic of Moldova can be considered a best practice. Distribution is made through a network of sites in 23 geographical localities that include prevention centres within Needle Exchange Programme (NEP) and outreach activities in the field. In addition, social and outreach workers make referrals to other HIV Prevention services, VCT, gynaecologic consultations, diagnostic of STI. The Needle Exchange Programme (NEP) provides an entry point for access to substitution therapy.

The Needle Exchange Programme covers 9 penitentiary institutions and detention centres. Starting with October 2010, 3 prisons on the left bank of the Nistru River started implementing NEP.

According to data from January 2012, a cumulative number of 14815 IDUs have been covered with NEP services, constituting coverage of 47% (however, double counting of beneficiaries is possible and may over-inflate coverage estimates) of the estimated number of 31562 IDUs from both banks of the Republic of Moldova[2]. Starting with 2011, when the unique identifier programme and client registration are introduced, it will be possible to obtain more veridical coverage data. The Integrated Bio- Behavioural Survey carried out in 2009 showed limited coverage with 3 main interventions (awareness regarding HIV/ Test, receipt of condoms and syringes free of charge) among IDUs in Chisinau (7,4 %) and Balti (29,2 %). At the same times, free of charge syringes do not represent an attractive service for many IDUs, given the fact that 99, 4 % of

[2] GFATM Round 6-8 Progress Report for trimester IV, 2011

respondents from Chisinau and 98, 9 % respondents from Balti mentioned that they can easily get syringes when needed. Given the fact that syringes are very cheap, and do not require doctor's prescription, the main source for urban IDUs is the pharmacy (88, 6 % for IDUs in Chisinau and 59, 3 % in Balti) and only 31, 4 % in Balti and 8, 5 % in Chisinau receive syringes free of charge from NEP.

In 2005 the Government adopted the Strategy on OST as a national strategy for prevention of HIV. Simultaneously, an enabling environment of support and development of OST was developed. The Law on HIV stipulates about Methadone Substitution Therapy as an HIV Prevention Strategy.[3] Moldova is one of the first countries in the region that introduced MST in prisons at the beginning of 2005. In 2008 the Ministry of Health approved a protocol on OST that adjusted national principles to WHO principles, thus revising selection criteria, building capacities of enrolment in OST of patients on outpatient basis, without hospitalisation. With the implementation of outpatient OST services, continuity of OST care services from the civilian sector and prisons improved, and currently there is close cooperation between the 2 sectors.[4] Currently, both infected and non-infected patients can benefit from services within civilian sector clinics, and penitentiary institutions. From 2004 until 2011, 986 Injecting Drug Users benefitted from Methadone Substitution treatment.

HIV prevention interventions for SWs include the following services: distribution of condoms, distribution of Information, Education and Communication materials, and references to STI and VCT services. Primary method of services provision is outreach in apartments and on the street. Presently, there are 5 centres within the programme offering outreach services for SWs. Based on activity reports, by the end of 2011, 1,465 female CSWs have been cumulatively covered with HIV prevention services.[5] Based on the integrated bio-behavioural survey in 2010, around 30.9% of SWs in Chisinau and 17.3% in Balti received condoms free of charge, while the vast majority buys them from drugstores (58.8% in Chisinau and 45.8% in Balti).[6]

HIV Prevention actions targeting MSM are accomplished by various civil society organisations (Gender-Doc and ATIS Centre) in the 2 main cities of the country (Chisinau and Balti). Services include distribution of condoms and lubricants, informative leaflets, organisation of workshops, promotion of safe sex, provision of individual consultation services and development of referral system to medical specialists, and referral to VCT services. Programmes cover MSM through outreach activities and through places attended by MSM, such as bars, touristic zones, and support groups established in community centres. At the end of 2011, HIV prevention services cover a cumulative number of 1001 MSM.

INDICATOR 1.7 Percentage of sex workers reached with HIV prevention programmes

The last data available for this indicator are for 2009/2010 and they have been reported in the Progress Report on Combating HIV/AIDS in the Republic of Moldova in 2010. According to the National Second Generation Surveillance Plan, the Behavioural and HIV Seroprevalence surveys are carried out

[3] Parliament of the Republic of Moldova. Law no. 23 from 16 February 2007 Regarding HIV/AIDS Prevention. Chapter III, article 7, point 4. Official Gazette no. 54-56, from 20.04.2007, art. 250

[4] Subata E. Final Report on the Evaluation of Opioid Substitution Therapy in the Republic of Moldova 2009. Unpublished work

[5] SOROS Foundation Moldova; Activity Report, 2010; Unpublished work

[6] National Center for Health Management; Integrated Bio-behavioural survey 2010; unpublished work, 2011

once in 2-3 years. The following survey will be in 2012, and data will be available for the next reporting period.

INDICATOR 1.11 Percentage of men having sex with men that are reached by HIV prevention programmes

Data Source:

Data presented for this indicator have been collected within the Behavioural HIV Seroprevalence survey carried out in 2010 among Men Having Sex with Men in Chisinau and Balti *(see Appendix 4).* Data introduced in the electronic tool are for the capital of the country, Chisinau municipality.

Method of Calculation:

The set of questions and the respective answers that served as basis for the calculation of this indicator have been the following:

1. "Do you know where you can get an HIV test?"
2. "In the last 12 months, did you receive free condoms?" (e.g. through an outreach service, NGO, youth friendly services or any other source?)

In this way, the set of questions and answers is adjusted to the recommendations of the *Global AIDS Response Progress Reporting 2012, Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS (UNAIDS 2011)*.

***Numerator**:* The number of respondents that stated that they know where to undertake an HIV test and received condoms free of charge during the last 12 months.
***Denominator**:* The number of survey respondents.
Results: Data of this indicator desegregated by age are presented in the table13:

Table 13 Distribution by age of men having sex with men that know where to undertake an HIV test and received condoms free of charge in Chisinau municipality, Republic of Moldova, 2010

		Total		<25 years		25 years and more	
"Do you know where you can get an HIV test?"	Numerator	115	56,9%	60	52,9%	55	68,2%
	Denominator	188		101		87	
"In the last 12 months, did you receive free condoms?" (e.g. through an outreach service, NGO, youth friendly services or any other source?)	Numerator	94	37,5%	42	37,8%	52	57,7
	Denominator	188		101		87	
Integrated Indicator	Numerator	69	**25,7%**	32	21,1%	37	44,9%
	Denominator	188		101		87	

Coverage with HIV prevention services is bigger among respondents over 25 years old. In Balti municipality, 7,2% of the respondents received condoms free of charge in the last 12 months and 38,5% of the respondents know where to receive an HIV test.

Limitations of the survey:

1. Data have been self-reported which indicates that recall and social desirability biases are possible.
2. Data are representative only for the locality where the survey took place and cannot be extrapolated for the whole country.

INDICATOR 2.1 Number of syringes distributed annually per injecting drug user through harm reduction programmes

Data Source:

Data for this indicator have been collected from the registers of syringes distributed within Harm Reduction Programmes and results of size estimations of injecting drug users produced in 2011.

Method of Calculation:

Numerator*:* Number of syringes distributed within Harm Reduction Programmes

Denominator*:* Number of estimated Injecting Drug Users in the country

Results: Throughout 2011, **1827859** have been distributed within Harm Reduction Programmes through needle exchange sites. The estimated number of Injecting Drug Users in the country represents 31562 persons, 21061 on the right bank and 10501 on the left bank of the Dniester River.

Indicator value is **58 syringes** per IDU per year.

Indicator value for the right bank of the Dniester River is 81 syringes per user per year, while for the left bank it represents 12 syringes per user per year, the coverage being significantly lower on the left bank compared to the right bank of the Dniester River.

Knowledge and Behaviour

INDICATOR 1.1 Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission

Data Source:

The data for this indicator have been collected within the framework of a behavioural study targeting young people aged 15-24 survey in households with national coverage performed in 2010 see Annexe 3 Evaluation Study on "Knowledge, Attitudes and Practices of young people aged 15-24 related to HIV/AIDS").

Method of Calculation:

The basis for the development of the compartment on Knowledge, Attitudes and Practices related to HIV/AIDS was the guideline on Study of Behaviour specificities (Family Health International, 2004). The questionnaire for interviewing the adult population aged 15-49 has been selected from this guideline. The argument for this selection was the facts that a significant share of young people aged 15-24 are married or are cohabiting (11.6% of the respondents within the survey carried out in 2008). Separate analysis for young people that have never been married and that did not have cohabitating

sexual partners during the last year has been made by extracting from the database the respondents corresponding to the criteria of inclusion in the sub-sample.

There were 4 questions formulated in the data collection tool out of the 5 questions recommended in the guideline entitled G*lobal AIDS Response Progress Reporting 2012Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS (UNAIDS 2011)* (reference). The question measuring misconceptions was missing in the questionnaire - „ Can a person get HIV by mosquito bite?" which was not replaced by any other question relevant for the regional context.

The set of the questions that has been used for the calculation of the integrated indicator of knowledge on HIV transmission in the questionnaire included the following questions:

1. Can the risk of getting HIV be reduced by using a condom every time they have sex?
2. Can the risk of getting HIV be reduced by having sex with only one uninfected partner who has no other partners?
3. Can a healthy-looking person be HIV infected?
4. Can a person get HIV by sharing dishes with someone who is infected?

***Numerator**:* Number of respondents aged 15-24 years who gave the correct answer to all four questions.

***Denominator**:* Number of all respondents of the study aged 15–24 years old. The respondents that never heard of HIV and of AIDS have been included in the denominator.

Results:

The integrated indicator of the knowledge of youth on HIV transmission reaches the value of 38,2%. The respondents in the age group 20 – 24 are overall better informed than the younger age group. The results on the level of knowledge show a decrease of the integrated indicator score on HIV/AIDS knowledge in 2010 (38,2%) compared with results in 2008 (40,8%), but it is better compared with the result received in 2006 (26,3%). The distribution by sex and age of the respondents with correct answers to all four questions and the values of the integrated indicator are shown in the Table below:

Table 14 Correct answers to questions related to HIV/AIDS among respondents aged 15-24, figures and %, Republic of Moldova (right bank of the Nistru River), 2010

Questions		Total	Males			Females		
			15-19 years old	20-24 years old	total	15-19 years old	20-24 years old	total
Integrated Indicator	%	**38.2**	**32,1**	**39,6**	**35,0**	**38,2**	**45,3**	**41**
	Numerator	438	106	83	189	134	113	247
	Denominator	1209	344	219	563	377	266	643
Can the risk of getting HIV be reduced by using a condom every time they have sex?	%	**75,9**	**76,9**	**79,9**	**78,1**	**69,7**	**80,5**	**74,0**
	Numerator	927	271	176	447	264	214	478
	Denominator	1209	344	219	563	377	266	643
Can the risk of getting HIV be reduced by having sex with only	%	**81,0**	**79,0**	**87,5**	**82,3**	**78,0**	**82,4**	**79,7**
	Numerator	967	269	187	456	286	222	508

one uninfected partner who has no other partners?	Denominator	1209	344	219	563	377	266	643
Can a healthy-looking person be HIV infected?	%	**75,8**	**69,8**	**77,0**	**72,6**	**75,7**	**83,4**	**78,8**
	Numerator	875	231	164	395	267	211	478
	Denominator	1209	344	219	563	377	266	643
Can a person get HIV by sharing dishes with someone who is infected?	%	**60,3**	**58,5**	**57,6**	**58,1**	**62,0**	**62,6**	**62,2**
	Numerator	747	203	131	334	239	172	411
	Denominator	1209	344	219	563	377	266	643

Source: Survey on „Knowledge, Attitudes and Practices among Youth related to HIV/AIDS", 2010

Limitations of the indicator:

1. The results are representative only for the right bank of the Dniester River.

INDICATOR 1.2 Percentage of young women and men aged 15 – 24 who have had sexual intercourse before the age of 15

Data source:

The data for this indicator have been collected within Knowledge, Attitudes and Practices survey targeting youth aged 15-24 — a household survey with national representation carried out in 2010 (Reference) (*see Appendix 3 "Youth knowledge, attitudes and practices regarding HIV/AIDS" survey*).

Method of Calculation:

The data collection tool has been developed based on the guideline on Behaviour Surveillance Surveys[7]. The questionnaire for interviewing the adult population aged 15-49 has been selected from this guideline.

The question that has been used for the calculation of the indicator has been formulated as follows in the data collection tool:

1. "How old were you when you had your first sexual intercourse?"

***Numerator**:* The number of respondents aged 15-24 who related that they had their first sexual intercourse before the age of 15.

***Denominator**:* The number of respondents within the age of 15-24.

Results: The distribution by sex and age of the respondents reported the first sexual intercourse before the age of 15 is presented in Table 15.

Table 15 Distribution by gender and age of 15 – 24 years old respondents who stated that they had their first sex before age of 15, absolute figures and %, Republic of Moldova (right bank of the Nistru River), 2010

	Absolute number	Percent

[7]Family Health International, Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV. Family Health International, 2004

Males	15-19 years old	Numerator	36	**11,8**
		Denominator	344	
	20-24 years old	Numerator	21	**9,5**
		Denominator	219	
	total	Numerator	57	**10,6**
		Denominator	563	
Females	15-19 years old	Numerator	6	**1,5**
		Denominator	377	
	20-24 years old	Numerator	2	**0,6**
		Denominator	266	
	total	Numerator	8	**1,1**
		Denominator	643	
Total		Numerator	65	**5,6**
		Denominator	1209	

Source: „Knowledge, attitudes and practices among youth related to HIV/AIDS", survey, 2010

Out of all the respondents of the survey, 5.6% related that they had their first sexual intercourse before the age of 15. The dependence of this indicator value on the gender of the respondent is evident.

Limitations of the Indicator:

a. The small number of respondents reporting early sexual initiation (65), constitutes a limitation in disaggregation by age and gender.
b. Recall and social desirability biases are possible.
c. Results are representative only for the right bank of the Dniester River.

INDICATOR 1.3 Percentage of women and men aged 15 – 49 who have had sexual intercourse with more than one partner in the last 12 months

Data source:

The data for this indicator have been collected within the framework of the household survey carried out in the general population in 2010 (reference), (see Appendix 2, evaluation survey on „Knowledge, Attitudes and Practices in the general population aged 15-64 on HIV/AIDS" 2010).

For the purpose of the present report, the sub-sample of 15-49 year old respondents was extracted from the database of the study and was analyzed according to the recommendations of the *Global AIDS Response Progress Reporting 2012Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS* (UNAIDS 2011).

Method of Calculation:

In the data collection tool the question has been formulated as follows:

1. "How many sexual partners have you had in the last 12 months?"

Numerator: The number of respondents aged 15-49 who have had more than one partner in the past 12 months.

Denominator: The number of respondents aged 15-49.

Results: Distribution by sex and age group of the respondents who have had more than one sexual partner in the last 12 months (calculated as a numerator) in absolute and relative figures (%) is presented in Table 16.

Table 16 Distribution by gender and age of 15 – 49 years old respondents who stated that they had more than one partner during the last 12 months, absolute figures and %, Republic of Moldova (right bank of the Nistru River), 2010

	Total	Males				Females			
		15-19 years old	20-24 years old	25-49 years old	total	15-19 years old	20-24 years old	25-49 years old	total
Percent %	**9,0**	**25,0**	**15,5**	**9,1**	**16,4**	**3,4**	**2,1**	**1,1**	**2,2**
Numerator	274	126	67	50	243	16	8	7	31
Denominator	3087	511	414	563	1448	524	477	596	1597

Out of the survey respondents aged 15-49 years old, 9,0% have reported having more than one sexual partner throughout the last year. There may be underreporting among females due to socially-accepted desirability bias.

Indicator values reported in 2007 represent 8,3%, in 2008 – 10,8%, in 2009 – 9,8%. Thus, no change is attested in the behaviour of the general population related to multiple sexual partners.

This indicator was calculated for the left bank of the Nistru River within the survey on "Vulnerability of Women to HIV in Transnistria" carried out on the territory of the left bank of the Nistru River among the general population aged 15-64 in 2011. The sub-sample aged 15-49 was extracted for the analysis. Data for the left bank are presented in the table 17:

Table 17 Distribution by gender and age of 15 – 49 years old respondents who stated that they had more than one partner during the last 12 months, absolute figures and %, Republic of Moldova (left bank of the Nistru River), 2011

	Total	Males				Females			
		15-19 years	20-24 years	25-49 years	total	15-19 years	20-24 years	25-49 years	total
Percentage, %	13.3	50.0	47.8	18.0	32.1	0.0	12.2	2.1	3.6
Numerator	44	14	11	11	36	0	5	3	8
Denominator	332	28	23	61	112	36	41	143	220

13,3% of the respondents aged 15-49 from the left bank of the Nistru River stated that they had more than one sexual partner during the last 12 months.

Male respondents from the left bank (32,1%) report multiple partners more frequently in the last 12 months than male respondents from the right bank (16,4%), the difference being identified in all age groups.

Data for the right bank of the Dniester River have been introduced in the online tool.

Risky behaviour

INDICATOR 1.4 Percentage of women and men aged 15-49 who had more than one partner in the last 12 months and used a condom during their last sexual intercourse

Data source: The data for this indicator have been collected within the framework of the household survey carried out in the general population in 2010 *(reference), (see* Appendix 2 *survey on "Knowledge, Attitudes and Practices of the general population aged 15-64 related to HIV/AIDS" 2010)*.

For the purpose of the present report, the sub-sample of 15-49 year old respondents was extracted from the database of the study and was analyzed according to the recommendations of the *Global AIDS Response Progress Reporting 2012 Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS (UNAIDS 2011).*

Method of Calculation:

In the data collection tool, the questions have been formulated as follows:

1. How many sexual partners have you had in the last 12 months?" with numerical answers.
2. "Did you use a condom during the last sexual intercourse?"

Numerator: The number of respondents aged 15-49 who have had more than one sexual partner in the last 12 months and used a condom during the last sexual intercourse.

Denominator: The number of respondents aged 15-49 who have had more than one partner in the last 12 months.

Results: Distribution by sex and age group of the respondents who have had more than one sexual partner in the last 12 months and who used a condom during the last sexual intercourse is presented in Table 18.

Table 18 Distribution by gender and age of 15 – 49 years old respondents who stated that they had more than one sexual partner during the last 12 months and used condom during the last sexual intercourse, Republic of Moldova (right bank of Nistru River), 2010

	Total	Males				Females			
		15-19 years old	20-24 years old	25-49 years old	total	15-19 years old	20-24 years old	25-49 years old	total
Percent, %	**47,6**	**60,6**	**45,7**	**28,3**	**49,9**	**19,8**	**49,6**	**37,2**	**31,8**
Numerator	134	79	31	14	124	4	4	2	10
Denominator	274	126	67	50	243	16	8	7	31

Out of the respondents reporting more than one sexual partner in the last 12 months, 47,6% stated the use of condoms at last sexual intercourse. The highest condoms use is registered for males aged 15 – 19, and for females aged 20-24 years old. Overall, there are significant gender-associated differences in the indicator value.

The value of the indicator reported in 2007 has been 49,3%, while the value registered in a general population survey in 2008 is 46,1%. The value of the indicator represents 50,8% within the framework of the survey on Vulnerability of Women to HIV carried out in 2009 in the Republic of Moldova. Thus, no essential behavioural changes have been attested in the general population aged 15-49.

This indicator was calculated for the left bank of the Nistru River within the survey on "Vulnerability of Women to HIV in Transnistria" carried out on the territory of the left bank of the Nistru River among the general population aged 15-64 in 2011. Data for the left bank are presented in the table 19:

Table 19 Distribution by gender and age of 15 – 49 years old respondents who stated that they had more than one sexual partner during the last 12 months and used condom during the last sexual intercourse, Republic of Moldova (left bank of Nistru River), 2011

	Total	Males				Females			
		15-19 years	20-24 years	25-49 years	total	15-19 years	20-24 years	25-49 years	total
Percent, %	**50.0**	64.3	63.6	27.3	52.8	0.0	20.0	66.7	37.5
Numerator	22	9	7	3	19	0	1	2	3
Denominator	44	14	11	11	36	0	5	3	8

Out of the respondents that had sexual contact with more than one partner during the last 12 months, 50,0% used a condom at the last sexual contact, the rate of condom use being higher in males aged 15-19 and in females aged 25-49. Overall, there are significta gender-associated differences in the indicator value.

The rate of condom use at the lat sexual contact among respondents who had more than one partner during the last 12 months on the left bank is higher than one the right bank nearly in all age groups.

Data for the right bank of the Dniester River have been introduced in the online tool.

Limitations of the indicator:

a. The sub-sample reporting multiple partners throughout the last 12 months is too small for proper analysis and disaggregation by sex and age groups
b. Recall and desirability biases are possible.
c. There are no nationally-representative estimates. Results are available for the right and the left banks of the Dniester River separately.

INDICATOR 1.8 Percentage of sex workers that used a condom during the last sexual intercourse with the last commercial sexual partner

The last data available for this indicator are for 2009/2010 and they have been reported in the progress report on combating HIV/AIDS in the republic of Moldova in 2010. According to the national second generation surveillance plan, the behavioural and HIV seroprevalence surveys are carried out once in 2-3 years. The following survey will be in 2012, and data will be available for the next reporting period.

INDICATOR 1.12 Percentage of men having sex with men that used a condom during the last homosexual anal contact

Data source:

Data for this indicator have been collected within the Behavioural and HIV Seroprevalence survey that took place in 2010 among Men Having Sex with Men in Chisinau and Balti *(see Appendix 4).* Data introduced in the electronic tool are those for the capital of the country, Chisinau municipality.

Method of Calculation:

The set of questions and the respective answers that served as basis for the calculation of this indicator have been the following:

1. „Did you have anal sex with men during the last 6 months?" with affirmative answer
2. „Did you use a condom during the last anal sexual contact?" with affirmative answer.

Thus, the set of questions and answers is adjusted to the recommendations of the *Global AIDS Response Progress Reporting 2012 Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS* (UNAIDS 2011).

***Numerator**:* The number of respondents who stated that they had anal sexual intercourse with a man in the last 6 months and used a condom during the last anal sexual contact with a man.

***Denominator**:* The number of survey respondents stating that they had anal sexual contact with a man in the last 6 months.

Results: Data on the given indicator disaggregated by age is given in the table 20:

Table 20 Disaggregation by age of men who have sex with men who had used a condom at last anal sexual contact during the last 6 months in Chisinau, Republic of Moldova, 2010

	Total	<25 years	25+ years
Percentage (%) of MSM that used a condom during the last anal homosexual contact	**55,7%**	60,2%	51,5%
The number of respondents that used a condom during the last anal homosexual contact	81	44	37
The number of respondents that anal sexual contact with a man in the last 6 months	140	72	68

The percentage of men having sex with men that used a condom during the last anal sexual contact with a man represents 55,7%, being higher in respondents younger than 25 years old compared to those older than 25 years.

In Balti, the value of this indicator represents 76,4%, with a rate of condom use during the last anal homosexual contact higher among younger respondents (78,5%) compared to older ones (68,4%).

Limitations of the Survey:

1. Data have been self-reported which indicates that recall and social desirability biases are possible.
2. Data are representative only for the locality where the survey was carried out and can not be extrapolated over the whole country.

INDICATOR 2.2 Percentage of injecting drug users that reported the use of condom during the last sexual intercourse

The last data available for this indicator are for 2009/2010 and they have been reported in the progress report on combating HIV/AIDS in the republic of Moldova in 2010. According to the national second generation surveillance plan, the behavioural and HIV seroprevalence surveys are carried out once in 2-3 years. The following survey will be in 2012, and data will be available for the next reporting period.

INDICATOR 2.3 Percentage of injecting drug users that reported the use of sterile equipment the last time they injected

The last data available for this indicator are for 2009/2010 and they have been reported in the progress report on combating HIV/AIDS in the republic of Moldova in 2010. According to the national second generation surveillance plan, the behavioural and HIV seroprevalence surveys are carried out once in 2-3 years. The following survey will be in 2012, and data will be available for the next reporting period.

Impact indicators

INDICATOR 1.10 Percentage of commercial sex workers living with HIV/AIDS

The last data available for this indicator are for 2009/2010 and they have been reported in the progress report on combating HIV/AIDS in the republic of Moldova in 2010. According to the national second generation surveillance plan, the behavioural and HIV seroprevalence surveys are carried out once in 2-3 years. The following survey will be in 2012, and data will be available for the next reporting period.

INDICATOR 1.14 Percentage of men having sex with men that are HIV infected

Data source:

Data for this indicator have been collected within the Behavioural and HIV Seroprevalence survey that was carried out in 2010 among Men Having Sex with Men in Chisinau and Balti *(see Appendix 4).* Data introduced in the electronic tool are those for the capital of the country, Chisinau municipality.

Method of Calculation:

Numerator*:* The number of blood samples tested positive as a result of HIV testing (ELISA)

Denominator*:* The number of tested blood samples.

Results: Distribution of the respondents by age group is presented in the table 21:

Table 21 Distribution by age group of blood samples tested as HIV-positive as a result of ELISA testing, % and absolute figures and percentage, MSM, Chisinau municipality, Republic of Moldova, 2010

Total			
		Number	**%**
<25 years	Numerator	1	0,2
	Denominator	95	
25 + years	Numerator	4	4,8
	Denominator	87	
Total	Numerator	5	**1,7**
	Denominator	182	

In Balti municipality, HIV prevalence among Men having Sex with Men represents 0,2% (1 respondent out of 209).

Limitations of the survey:

1. Respondents have been recruited within the geographic limits of the localities where the data collection has taken place. Hence, these results cannot be extrapolated to the whole MSM population of the country. The MSM profile may vary among regions.

INDICATOR 2.5 Percentage of injecting drug users that are HIV infected

The last data available for this indicator are for 2009/2010 and they have been reported in the progress report on combating HIV/AIDS in the republic of Moldova in 2010. According to the national second generation surveillance plan, the behavioural and HIV seroprevalence surveys are carried out once in 2-3 years. The following survey will be in 2012, and data will be available for the next reporting period.

INDICATOR 1.21 Percentage of prisoners who are HIV infected

Data source:

Data presented for this indicator have been collected within the Behavioural and HIV Seroprevalence survey carried out in 2010 among prisoners in the Republic of Moldova, right bank of the Dniester River *(see Appendix 8).*

Method of Calculation:

Numerator: The number of blood samples tested positive as a result of HIV testing (ELISA)

Denominator: The number of tested blood samples

Results:

Distribution by gender and age group of the respondents is presented in the table 22:

Table 22 Distribution by gender and age group of HIV-infected prisoners in the Republic of Moldova, right bank of the Dniester River, 2010

	Total	Males	Females	<25 years	25+ years
Number of blood samples tested for HIV with positive results	18	15	3	4	14
Number of tested blood samples	523	481	42	114	407
Percentage of prisoners who are HIV-infected	**3,4%**	3,1%	7,1%	3,5%	3,4%

HIV prevalence among female respondents in penitentiaries is twice higher than among male respondents. No difference is attested among various age groups.

According to the Behavioural and HIV Seroprevalence survey carried out among prisoners in 2007, HIV prevalence was 4,2%.

INDICATOR 4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Method of Calculation:

***Numerator**:* Number of adults and children who are alive enrolled in ARV treatment 12 months after its initiation

Denominator: Number of adults and children that initiated ARV treatment in the cohort reporting (2010)

Source: Register of patients in ARV treatment from institutions providing the given service

Table 23 Percentage of persons enrolled in ARV treatment that reached 12 months of ARV treatment, Republic of Moldova, cohort of 2010, measured at the beginning of 2012.

	Total	**Males**	**Females**	**<15 years**	**15+ years**
Indicator value	**80.66%**	83.18%	77.36%	100%	80.28%
Numerator	296	173	123	7	289
Denominator	367	208	159	7	360
Disaggregation of persons who initiated ARV treatment and have not reached 12 months of treatment by cause of treatment interruption					
Number of persons recorded as lost to follow up from the surveillance system	1				
Stopped ARV treatment	34				
Died	36				

Compared with previous years, the percentage of persons enrolled in ARV treatment that continue the treatment for more than 12 months is decreasing. When calculating this indicator separately for the right and the left banks of the Dniester River, it is attested that adherence to ARV treatment for more than 12 months on the right bank is identical with this indicator value for the previous years (88,3%). This indicator shows a considerably lower value for the left bank (68,7%). High migration rates, particularly emigration form the left bank, may be accountable for some of the drop outs from treatment.

Table 24 Percentage of persons who initiated ARV treatment and are known to be on treatment for more than 12 months, Republic of Moldova, years 2006-2011

Year	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Enrolment in ARV treatment for more than 12 months	80,7%	86,7%	76%	88,3%	87,5%	80,67%

INDICATOR 3.3 Mother-to-child transmission of HIV

The National Programme on Prevention and Control of HIV/AIDS stipulates maintenance of vertical HIV transmission rate under 2%.

Calculation Method:

Numerator: Estimated number of new HIV cases generated by Spectrum.

Denominator: Estimated number of HIV positive pregnant women generated by Spectrum

Table 25 Rate of mother-to-child transmission of HIV in the Republic of Moldova for 2010-2011 generated by Spectrum

	2010	2011
Estimated number of new HIV cases generated by Spectrum	19	24
Estimated number of HIV positive pregnant women generated by Spectrum	177	205
Rate of mother-to-child transmission of HIV	10,7%	11,7%

According to the recommendations, both the numerator and the denominator are generated by Spectrum. Entry data and Spectrum outputs have been validated within organised workshops with the participation of key decision makers and staff at technical level from relevant institutions.

According to the national guidelines, infants born to HIV positive mothers are tested for HIV at 6 weeks of life, at 12 and 18 months, subsequently being released from medical surveillance as being healthy or taken under medical supervision as HIV positive patient. According to the registered statistics data, the rate of mother-to-child transmission of HIV in 2010 is 2,8% (4 HIV infected infants at 141 HIV positive pregnant women registered) and 0,6% (1 HIV positive infant at 165 HIV positive pregnant women registered) at the end of 2011, taking into account the fact that all infants born to HIV positive mothers during 2011 will be under medical supervision until the age of 19 months of life. Cases of mother-to-child transmission have occurred among women that have not received ARV prophylaxis treatment during pregnancy and delivery.

Additional indicators

INDICATOR 4.4 Percentage of health facilities dispensing ARVs that experienced one or more stock-outs of at least one required ARV drug in the last 12 months

Numerator: Number of medical institutions dispensing ARVs that experienced one or more stock-outs during the last 12 months

Denominator: Number of medical institutions dispensing ARVs

Indicator value is **0%.** There were no stock-outs registered during the reporting period.

INDICATOR 3.2 Percentage of children born to hiv positive mothers that have been tested for hiv in the first 2 months of life

Data source: register of infants born to HIV positive mothers, register of HIV positive mothers that gave birth

Method of Calculation:

Numerator: Number of infants born to HIV positive mothers that have been tested for HIV in the first 2 months of life.

Denominator: Number of HIV positive pregnant women that gave birth during the reporting period.

Results: Throughout 2011, 109 infants have been tested for HIV in the first 2 months of life. Out of this number, 106 infants received a negative result for the test, 3 received a positive result for the test. 131 HIV positive women gave birth during the reporting period.

Indicator value is **83,2%.**

INDICATOR 3.9 Percentage of children born to HIV positive mothers initiated on Cotrimoxazol prophylaxis in the first 2 months of life

Numerator: Number of children who received Cotrimoxazol – 35

Denominator: Number of HIV positive pregnant women that gave birth during the reporting period – 131

Indicator value – **26,7%**

INDICATOR 7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months.

During the period of July-November 2010 the study on "Domestic Violence against Women" (*Apendix 6)* was carried out covering women aged 15-64. The study measured violence from the male intimate partner: physical, sexual, psychological and economic, as well as non-partners. Data collection tool was based on pilot module developed by the Economic Commission for Europe of United Nations (UNECE) that was revised and adjusted to the national context. The study comprised both qualitative and quantitative parts.

59,4% of the interviewed women reported psychological violence in their life, while 25,7% endured violence in the last 12 months. 37,9% of the interviewed women reported psychological violence from their husband or intimate partner during their lifetime, and 8,9% - during the last 12 months. The prevalence of sexual violence from the husband or intimate partner within the sample of 15-64 years old during their lifetime is 18,6%, and during the last 12 months is 4,1%.

For the present report, the sub-sample of 15-49 years was extracted from the survey database and was analysed according to the recommendations of the *Global AIDS Response Progress Reporting 2012 Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS (UNAIDS 2011)*

Method of Calculation:

*Numerator***:** Number of married female respondents aged 15-49 that have a permanent sexual partner and have endured physical or sexual violence from their partner within the last 12 months.

Denominator: Number of women aged 15-49 that are married or have one permanent sexual partner.

Data obtained within the survey have been extrapolated for the whole female population aged 15-49 from the right bank of the Dniester River.

Indicator value with disaggregation by age group is presented in the table 26:

Table 26 Disaggregation by age group of women aged 15-49 that are married or have one permanent sexual partner and endured physical or sexual violence from their partner within the last 12 months, Republic of Moldova, right bank of the Nistru River, 2010

	Total females	15-19 years	20-24 years	25-49 years
Numerator	93118	0	15564	77554
Denominator	695869	8264	67608	619997
Indicator value	**13,4%**	0	23,0%	12,5%

Rate of physical and sexual violence from the partner is higher in the age group of 20-24 years.

Within the survey on Women Vulnerability to HIV *(Apendix 5)* in Transnistria carried out on the left bank of the Dniester River in 2011, the female subsample aged 15-49, 18,4 reported physical violence throughout their life, and 7,3% during the last 12 months. 60,2% of the respondents endured psychological violence throughout their lifetime, and 33,8% - in the last 12 months. 5,7% respondents reported sexual violence from their partner throughout their lifetime and 3,0% - within the last 12 months.

EXAMPLES OF GOOD PRACTICES

By adopting the „Three ones" principle and with the beginning of the implementation Global Fund grant in 2003, the National Coordination Council became the main mechanism of Coordination and Implementation of the National Programmes on Prevention and Control of HIV/AIDS/STI and Tuberculosis. Members of this Coordination mechanism are representatives of central public administration, representatives of donors and nongovernmental sector working in the field. In the Republic of Moldova, this mechanism proved to be a functional one for consolidating national and international efforts to achieve the objectives of National Programmes. The number of civil society representative increased reaching 40% of the members. Also, the private sector is represented. To achieve the "Three Ones' objective, and a better case management, the Ministry of Health performed an assessment of the system of coordination of activities in the field of HIV/AIDS and identified problems, obstacles that reduce the efficiency of the system. Hence, based on the recommendations suggested, the Ministry of Health undertook a series of measures to restructure service delivery infrastructure focused on PLHA, by creating coordination institutions.

The legal framework in the field of social protection was revised to reduce stigma and discrimination of PLHA and social protection activities started being implemented.

The Republic of Moldova is recognised in the region as an example of good practices due to its successful implementation of Harm Reduction Programmes in key populations at risk in the civilian sector (IDUs, CSWs, MSM) and in penitentiary institutions (IDUs). Thus, there are information/education/outreach, and needle exchange activities, as well as referrals to medical and social services. Methadone Substitution treatment is provided both in the civilian sector and in penitentiary institutions (on right bank of Dniester river only). During the reporting period, services extended in 3 other localities, including the left bank of the Dniester River (IDU).

Implementation and strengthening of one Monitoring and Evaluation system is another example of good practice. By creating an M&E Unit within a public structure in charge of health information and capacity building, the centralisation of data collection and their standardisation was possible. Improvement

of data quality is one of the results of efforts made by national and international organisations. Within the framework of Round VI of the Global fund to Fight AIDS, TB and Malaria, the M&E unit was designated as the main data collector and provider for the given grant, having the role of validation of data. Hence, GFATM reporting has been aligned to national reporting processes. Due to GFATM monitoring processes, reporting from Transnistria has been established, representing one of the few data exchanges between the 2 banks. In 2011, a first ever general population survey has been conducted on the left bank, closing some of the data gaps; an estimation of sizes of MARPs using network scale up has also been possible. The National HIV/AIDS/STIs Programme has the National M&E Plan incorporated as an annex and integral part; an Operational Manual elaborating on relevant stipulations of the M&E Plan have been developed.

SUPPORT REQUESTED FROM DEVELOPMENT PARTNERS

Within the implementation of Global Fund grant Round 8, there were activities on increasing adherence and enrolment in treatment, scale up of geographical access to ARV (opening of 3 other institutions, establishment and development of multidisciplinary teams) that would result in an increase of demand for treatment. Taking into account the increase of demand for treatment, once the support from the Global Fund grant Round 6 is completed, the Government of the republic of Moldova will apply for funding to external donors to ensure continuity of ARV treatment after 2012 according to the demand and needs.

As it was mentioned above, the Republic of Moldova is recognised in the region as an example of good practices due to its successful implementation of Harm Reduction Programmes in most at risk populations of the civil sector (IDUs, CSWs, MSM) and in penitentiary institutions (IDUs). Presently, the Programme has a budgetary deficit, which does not allow expansion and provision of a full package of quality services. As a result of reduced funding starting in 2008 (due to the decrease in purchasing power of U.S. dollar which is the currency of the GFATM grant, Round 6), regionalization of implementation led to the decrease of administrative costs and allowed for maintaining services provided. But the status quo does not provide for services comprehensive enough to lead to an impact. International support in this area is urgently needed. Technical support from development partners is of great importance. Due to such technical support, it has been possible to estimate costs of the new programme per unit and per service, thus improving budgeting processes and building capacities in strategic planning, monitoring and evaluation of activities.

Another important aspect of the National AIDS Programme is the greater involvement of NGOs in implementation. In this context, it is necessary to build the capacities of the nongovernmental sector, and provide support to establishing NGO subcontracting mechanisms from state budget resources.

MONITORING AND EVALUATION

Starting with 2005, the Ministry of Health in Moldova, together with its partners, including the Global Fund, World Bank and UNAIDS, created the concept of one joint Monitoring and Evaluation system for the National programme on Prevention and Control of HIV/AIDS/STI. The M&E unit on national health programmes was established as a department of the National Centre for Health Management of the Ministry of Health. It is in charge of M&E of the NP on HIV/AIDS/STIs, on TB and of the Drugs Observatory. In 2011, the M&E Unit strove for building capacities of line institutions as the National AIDS Center to undertake routine programme monitoring, and has been reformed to act as a Unit for Audit of Data Quality. The M&E unit monitors a set of indicators that was developed and agreed with all key actors to support the monitoring and evaluation of the National Programme on HIV/AIDS and ensures regular UNGASS reporting and Universal Access with all necessary consultations and data collections. Up to date, the M&E unit

developed 3 UNGASS reports with all consultations and data collections for 2004-2005, 2006-2007 and 2008-2009 and the report on Universal access for 2008, 2010. Other products include building upon the one joint functional M&E system, according to the stipulations of the M&E National Plan, and a joint national indicators set. The M&E unit implemented the following types of surveys to measure results of interventions: IBBS 2007 and IBBS 2009/2010, KAP surveys for youth and general population 2006, 2008, 2010, qualitative and quantitative surveys among most at risk adolescents (young IDUs, CSWs, and MSM), situation analysis of children and families affected by HIV/AIDS, evaluation of PMTCT services in the Republic of Moldova.

The National Coordination Council acts as a decision-making forum and coordinates the national M&E system; there is a permanent M&E Technical Working Group under the auspices of the NCC. Routine administrative statistics in health include case registration of HIV and STI, registration of the number of HIV infected people in medical surveillance, number of HIV tests and registration of screening results of blood donors.

In April 2011, the functionality of the M&E system has been thoroughly self-assessed by a large team of national stakeholders. The methodology was based on the Organisational Framework of functional M&E systems, endorsed by MERG, and included filling in the 12 components Tool during a multi-stakeholder assessment workshop with participation of important actors, representing various institutions and levels of M&E systems. As a result of the evaluation, key challenges and priorities have been outlined for future actions. The National Monitoring and Evaluation Operational Manual was developed based on these challenges and key priorities for strengthening the 12 components of the national M&E system, based on the general principles and M&E infrastructure outlines in the National M&E Plan. A costed and time-bound national M&E Work Plan has been developed for 2011-2012.

Challenges

- Lack of institutionalized routine inter-sectorial reporting mechanisms;
- Limited allocations to the M&E system from the state budget and over-reliance on international financial support, which curtails sustainability;
- Gaps in national technical expertise;
- Given political constraints affecting full collaboration with Transdniestrian region, full coverage with comprehensive M&E of the region is difficult;
- Operational research, scientific research and programme evaluation are not carried out in a consistent and comprehensive manner;
- Existing gaps in ensuring the confidentiality of data, and the confidentiality of data debacle that renders the developed information system software ineffective.

Priorities

- Comprehensive national M&E system for health is needed to avoid redundancies and parallel reporting
- Inter-sectoral collaboration between stakeholders involved in the national HIV/AIDS response ensures the quality of data, accessibility of information and the implementation of findings into the policy process
- One body responsible for M&E, with clear framework for data collection, analysis, dissemination and use, and sufficient allocations from the state budget are ingredients of a successful M&E system

- In-depth, comprehensive assessments of the components of M&E system are imperative for identifying weaknesses and strengthening the system
- A costed and time-bound M&E Plan is a precondition for effective development of the M&E system and an asset to the quick estimation of funding gaps.
- A national research, operational research & evaluation agenda is needed to avoid overlap and strengthen the strategic information base consistently.
- Capacity building in M&E for all players, at all levels is critical to the enhancement of data quality and its implementation into policy
- Developing and institutionalizing data quality assurance mechanisms is imperative for enhancing the focus of the national response
- Confidentiality of data issues need to be properly addressed
- A comprehensive national database needs to be developed to strengthen data use
- Consistent and consequential data dissemination activities need to be undertaken to enhance
- Evidence-based planning and implementation in the framework of the national response.

Appendix 1 „Routes method”

Considering the vast migration (both internal and external) of the population of the Republic of Moldova, the State Population Register cannot be used as sampling frame for the probabilistic studies within the general population (risk for substitution rate increase which can affect study representativeness).

“Routes method” is used as a solution for sampling within the general population and is considered as a randomized and quasi-probabilistic method. As a result of stratification procedures (regions, localities) and randomized selection of localities within the strata, a number of necessary routes is pre-established in each selected locality depending on the number of questionnaires distributed per locality. The households where the interview is going to take place are selected by randomized route technique based on the statistical step. The interviewer from the selected household is the one that belongs to the target group. If there are more than necessary, then the person whose next birthday is closer to the interview date is invited. One of the limitations of this sampling is the exclusion of students’ hostels from the calculation of the statistical step.

In case of quasi-probabilistic studies, the calculation of maximal statistical error is an estimated one.

Appendix 2 Survey on „Knowledge, attitudes and practices of the general population (15-64 years) regarding HIV/AIDS"

Source: Scutelniciuc, Cantarji. Survey on „ knowledge, attitudes and practices of the general population (15-64 years) regarding HIV/AIDS", NHMC, UCIMP 2010

Type of research: quantitative household surveys.

Target group: general population aged 15 - 64 that live permanently on the territory of the Republic of Moldova (right bank of the Nistru River[8]).

Final sample size: 4060 respondents.

Sampling method: stratified, multistage, quasiprobabilistic, "Routes Method"

Data collection period: 8 September – 7 November 2010**.**

Data collection instrument: Structured questionnaire. The surveys were filled using the "face to face" procedure in the respondent's household.

Representativeness: sample considered nationally representative for the general population of the Republic of Moldova in a 15-64 age group, permanent Republic of Moldova inhabitants (right bank of the Nistru River). The maximum estimated sampling error is ±1,6%. Results were weighted according to official statistics distribution by gender and adjusted to the distribution by gender of people that are temporarily abroad. The difference between weighted and unweighted data reaches the maximum of 0,9%.

Demographic Structure of the Final Sample:

Table 1 Distribution of respondents by age group

Age Group	Share in the final Sample
15 – 24 years	25,7
25 –34 years	22,0
35 – 49 years	28,7
50-64 years	23,6
15-49 years	76,4

Table 2 Distribution of respondents by area of residence

	Share in the final Sample
Urban	43,8
Rural	56,2

Table 3 Distribution of respondents by sex

	Share in the final Sample
Males	46,9
Females	53,0

Main Limitations of the Survey:

1. Representative only for the right bank of the Nistru River.
2. Application of „routes method" - quasiprobabilistic method for selection of respondents *(see Appendix 1 Routes Method)*

[8] Following the frozen political conflict on the Nistru River, the territories on the left bank of the Nistru are not fully controlled by the Chisinau government. Social research agencies activating on the right bank of the Nistru are not collecting data from the left bank of the Nistru.

Appendix 3 Survey on „knowledge, attitudes and practices of youth (15-24 years) regarding HIV/AIDS"

Source: Scutelniciuc, Cantarji. Survey on „ knowledge, attitudes and practices of young people (15-24 years) regarding HIV/AIDS", NHMC, UCIMP 2010

Type of research: quantitative survey in households

Target group: youth aged 15 – 24, permanent residents on Republic of Moldova territory (right bank of the Nistru[9]).

Final size of sample: 1209 respondents.

Sampling method: stratified, multistage, quasiprobabilistic („route method").

Data collection period: 26 September – 7 November 2010**.**

Data collection instrument: Structured questionnaire. Surveys were carried on using the "face to face" method in the respondents' household.

Representativeness: sample considered representative nationally representative for people aged 15–24, living permanently in the Republic of Moldova, on the right bank of the Nistru River. Maximum estimated sampling error is ±1,6%. Results have been weighted depending on distribution by sex according to the official statistics data and adjusted to the distribution per sex of people who are temporarily abroad. The difference between weighted and unweighted data reaches the maximum of 0,9%.

Demographic Structure of the Final Sample:

Table 4 Distribution of respondents by age group

Age Group	Share in the final Sample
15 – 19 years	60,6
20 –24 years	39,4

Table 4 Distribution of respondents by area of residence

	Share in the final Sample
Big urban area	24,1
Small urban area	19,3
Rural	56,6

Table 5 Distribution of respondents by sex

	Share in the final Sample
Males	47,9
Females	51,8
Transgender	0,3

Limitations:

1. Representative only for youth living on the right bank of the Nistru River.

2. Using the "Routes Method" – quasiprobabilistic method of respondent selection which excludes student hostels from the survey *(see Appendix 1 „Routes Method").*

[9] Following the frozen political conflict on the Dniesteru River, the territories on the left bank of the Nistru are not fully controlled by the Chisinau government. Social research agencies activating on the right bank of the Nistru are not collecting data from the left bank of the Nistru.

Appendix 4 HIV seroprevalence and behaviour study among men having sex with men

Type of research: repeated, multicentric (2 centres), cross-sectional, based on a questionnaire combined with qualitative testing for antibodies to HIV, HVC, HVB and syphilis.
Target group: Men having Sex with Men who are permanent inhabitants on the territory of Chisinau or Balti municipalities.
Final size of sample: 209 respondents recruited in the municipality of Balti, 188 respondents recruited in the municipality of Chisinau.

Sampling method: Respondent Driven Sampling

Data collection period: April - August 2010

Data collection instrument: Structured questionnaire. Surveys were carried on using the "face to face" method
Representativeness: sample considered as representative for MSM living in the geographical limits of localities where data collection was carried on.

Table 27 Demographical structure of sample by age groups:

	Chisinau		**Balti**	
	#	**%**	**#**	**%**
16 - 19 years	34	27.8	115	73.2
20 - 24 years	67	46.8	34	13.0
25 - 29 years	28	10.6	27	6.3
30 - 34 years	10	2.1	19	4.2
35 - 39 years	13	2.6	9	2.0
40 years and more	36	10.1	5	1.3
Total	**188**		**209**	

Limitations:

- This sampling method was applied to recruit MSM benefiting from risk reduction programs as well as those not covered by such programmes[10]. Seventh wave was reached in all implementation locations.
- All collected data are based on self-reporting, which does not exclude social desirability bias. Recall bias could occur in the answers of those who had a less often occurrence of the events mentioned by the questionnaire (last injection, last sexual contact, etc.) during the last year or the last moth previous to the interview.
- Because of the impossibility to get objective screening, there is a probability that there are persons recruited in the survey that do not belong to the target group.
- Respondents have been recruited within the geographic limits of the locations where the data collection has taken place. Hence, these results cannot be extrapolated to the whole MSM population of the country. The MSM profile may vary among regions.

[10] Studies previously carried on in the Republic of Moldova have used convenience sampling among risk reduction programme benefic Studies previously carried on in the Republic of Moldova have used convenience sampling among risk reduction programme beneficiaries iaries.

Appendix 5 Survey on „Vulnerability of women to HIV infection in Transnistria"

Source: Cantarji. Preliminary data, survey on „Vulnerability of Women to HIV infection in Transnistria", UNAIDS, 2011

Type of research: quantitative survey in households.

Target group: general population aged 15 - 64 who are permanent inhabitants on the left bank of the Nistru River.

Final size of sample: 540 respondents

Sampling method: stratified, multistage, quasiprobabilistic „route method" (see Appendix 1 "Routes Method").

Data collection period: 2011.

Data collection instrument: Structured questionnaire. Surveys were carried on using the "face to face" method in the respondents' household.

Representativeness: sample considered representative for the general population in Transnistria from the age segment of 15 - 64 that are permanent inhabitants on the left bank of the Dniester River. The maximum sampling error is ±4,2%. Results have been weighted depending on distribution per sex according to official statistics data.

Table 28 Demographic structure of the sample, 15 – 64 years, %, Transnistria (left bank of the Dniester River), 2011

	% in final sample
15-19 years	9,4%
20-24 years	14,3%
25-49 years	37,8%
50-64 years	38,5%
Total	100%

Table 29 Distribution of respondents by sex

	% in final sample
Females	67,4%
Males	32,6%

Table 30 Distribution of respondents by residential area

	% in final sample
Urban	39,56
Rural	60,4

Limitations:

1. Representative only for the left bank of the Nistru River.
2. Application of „routes method" - quasiprobabilistic method for selection of respondents (see appenix 1 „ routes method").

Appendix 6 Survey on „Domestic violence against women in the Republic of Moldova"

Source: Bivol, Scutelniciuc, Vladicescu. Survey on „Vulnerability of Women to HIV infection in the Republic of Moldova", NHMC, UNAIDS 2009

Type of research: quantitative study in households.

Target group: general population aged 15 - 64 years permanent inhabitants of the Republic of Moldova (right bank of the Dniester River).

Final size of sample: 1969 respondents

Sampling method: stratified, multistage, quasiprobabilistic, "Routes Method" *(Appendix 1 „Routes Method").*

Data collection period: 14 August – 14 September 2009.

Data collection instrument: Structured questionnaire. The surveys were filled using the "face to face" procedure in the respondent's household.

Representativeness: sample considered nationally representative for the general population of the Republic of Moldova in a 15-64 age, permanent inhabitants of the Republic of Moldova (right bank of the Dniester river). The maximum estimated sampling error is ±2.5%. Results were weighted according to official statistics distribution by gender.

Table 31 Demographical structure of the final sample, 15 – 64 years old, Republic of Moldova (right bank of the Dniester River), 2009

	Males		Females		Total	
	Num	%	Num	%	Num	%
15-19 years	125	13,0	149	14,7	274	13,9
20-24 years	138	14,3	107	10,6	245	12,4
25-49 years	477	49,6	498	49,4	975	49,5
50-64 years	221	23,0	254	25,2	475	24,1
Total	961	48,8	1008	51,2	1969	-

Table 32 Distribution of respondents by residential area

	% in final sample
Urban	39,56
Rural	60,4

Main limitations of the survey:

1. Representative only for the right bank of the Dniester River.
2. Application of „routes method" - quasiprobabilistic method for selection of respondents (see appendix 1 „ routes method").

Apendix 8 HIV seroprevalence and behaviour study among inmats

Type of research: repeated, multicentric, cross-sectional, based on a questionnaire combined with qualitative testing for antibodies to HIV, HVC, HVB and syphilis.
Target group: The target group of the study comprised persons who at the time of the study were in pre-trial detention or serving sentences in penitentiary institutions of the Ministry of Justice of the Republic of Moldova (right bank of Dniester River).

Final size of sample: 530 respondents.

Sampling method: A probability sample and a two-stage cluster sampling design were applied

Data collection period: 20 May – 15 July 2010

Data collection instrument: Structured questionnaire. Surveys were carried on using the "face to face" method
Representativeness: sample considered as representative for right bank of Republic of Moldova

Table 33 Socio-demographic structure of the sample, prisoners, Republic of Moldova (right bank of the Dniester River), 2010

	Total		Males		Females	
	#	%	#	%	#	%
16 - 19 years	20	3.8	19	3.9	1	2.4
20 - 24 years	95	18.0	94	19.3	1	2.4
25 - 29 years	117	22.2	102	21.0	15	35.7
30 - 34 years	93	17.6	89	18.3	4	9.5
35 - 39 years	60	11.4	56	11.5	4	9.5
40 - 49 years	90	17.0	81	16.7	9	21.4
50 years and older	53	10.0	45	9.3	8	19.0
Subtotal	**528**		**486**		**42**	
Missing age	2	0.4	2	0.4	0	0.0
Total	**530**		**488**		**42**	
Mean age, years	33.6		33.3		37.2	
SD, years	10.9		10.8		12.2	
Median age, years	31		31		34	

Limitation:

1. The assurance of interview privacy was not possible in all penitentiary institutions and these circumstances influenced the answers, especially in the case of questions about legal and illegal drug use, homosexual intercourse and interaction with penitentiary institutions employees.
2. All data was collected on self reporting basis, which is biased by socially desirable answers.
3. Recall bias might have occurred in answers of respondents with less frequent applicable experience (last sexual intercourse, etc.) that the questionnaire referred to during the last year and last month before the survey was carried out.

List of Tables

List of figures

Reference

1. Guvernul Republicii Moldova. Hotarire Nr. 410 din 04.04.2003 cu privire la aprobarea Strategiei nationale "Educatie pentru toti".
   http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=301786 .
   Ref Type: Electronic Citation2009, *Midterm review (MTR) of the National Programme on Prevention and Control of HIV/AIDS/STIs 2006-2010*.
2. Guvernul Republicii Moldova. Hotarire Nr. 1143 din 16.12.2010 cu privire la aprobarea Programului national de control si profilaxie a tuberculozei pentru anii 2011-2015.
   http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=337100. 2010a.
   Ref Type: Electronic Citation
3. Guvernul Republicii Moldova. Hotarire Nr. 825 din 03.08.2005 cu privire la instituirea Consiliului national de coordonare a programelor nationale de profilaxie si control al infectiei HIV/SIDA, infectiilor cu transmitere sexuala si de control al tuberculozei.
   http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=295363 . 2005b.
   Ref Type: Electronic Citation
4. Guvernul Republicii Moldova. Hotarire Nr. 913 din 26.08.2005 cu privire la aprobarea Strategiei Nationale a sanatatii reproducerii.
   http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=305468 . 2005c. 88
   Ref Type: Electronic Citation
5. Guvernul Republicii Moldova. Hotarire Nr. 948 din 05.09.2005 cu privire la masurile de profilaxie si control al infectiei HIV/SIDA si infectiilor cu transmitere sexuala.
   http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=295510 . 2005d.
   Ref Type: Electronic Citation
6. Guvernul Republicii Moldova. Hotarire Nr. 1362 din 29.11.2006 cu privire la aprobarea Regulamentului-cadru de organizare si functionare a centrelor de asistenta si protectie a victimelor traficului de fiinte umane.
   http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=318737 . 2006.
   Ref Type: Electronic Citation
7. Guvernul Republicii Moldova. Hotarire Nr. 1143 din 19.10.2007 cu privire la Programul National de combatere a hepatitelor virale B, C si D pentru anii 2007-2011.
   http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=325682 . 2007a.
   Ref Type: Electronic Citation
8. Guvernul Republicii Moldova. Hotarire Nr. 1471 din 24.12.2007 cu privire la aprobarea Strategiei de dezvoltare a sistemului de sanatate in perioada 2008-2017.
   http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=326615 . 2007b.
   Ref Type: Electronic Citation
9. Guvernul Republicii Moldova. Hotarire Nr. 637 din 07.06.2007 cu privire la aprobarea Programului national "Securitatea transfuzionala si autoasigurarea tarii cu produse sangvine pentru anii 2007-2011".
   http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=324478 . 2007c.
   Ref Type: Electronic Citation
10. Guvernul Republicii Moldova. Hotarire Nr. 658 din 12.06.2007 cu privire la Programul national de promovare a modului sanatos de viata pentru anii 2007-2015.
    http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=324620 . 2007d.
    Ref Type: Electronic Citation
11. Guvernul Republicii Moldova. Hotarire Nr. 886 din 06.08.2007 cu privire la aprobarea Politicii Nationale de Sanatate.
    http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=324940 . 17-8-2007e. Monitorul Oficial Nr. 127-130 art 931. 20-3-2009e.
    Ref Type: Electronic Citation

12. Guvernul Republicii Moldova. Hotarire Nr. 847 din 11.07.2008 cu privire la crearea Centrului de asistenta si protectie a victimelor si potentialelor victime ale traficului de fiinte umane. http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=328567 . 2008a. Ref Type: Electronic Citation
13. Guvernul Republicii Moldova. Hotarire Nr. 948 din 07.08.2008 pentru aprobarea Regulamentului privind procedura de repatriere a copiilor si adultilor - victime ale traficului de fiinte umane, traficului ilegal de migranti, precum si a copiilor neinsotiti. http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=328840 . 2008b.
Ref Type: Electronic Citation
14. Guvernul Republicii Moldova. Hotarire Nr. 544 din 09.09.2009 cu privire la aprobarea Conceptului Sistemului informational automatizat „Registrul de stat al cazurilor de violenta on familie". http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=332288 . 2009a. Ref Type: Electronic Citation
15. Guvernul Republicii Moldova. Hotarire Nr. 933 din 31.12.2009 cu privire la aprobarea Programului national de asigurare a egalitatii de gen pe anii 2010-2015. http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=333441 . 2009b.
Ref Type: Electronic Citation
16. Parlamentul Republicii Moldova. Lege Nr. 411 din 28.03.1995 ocrotirii sanatatii. http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=312823 . 1995.
Ref Type: Electronic Citation
17. Parlamentul Republicii Moldova. Lege Nr. 241 din 20.10.2005 privind prevenirea si combaterea traficului de fiinte umane. http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=313051 . 2005a.
Ref Type: Electronic Citation
18. Parlamentul Republicii Moldova. Lege Nr. 263 din 27.10.2005 cu privire la drepturile si responsabilitatile pacientului. http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=313060 . 2005b.
Ref Type: Electronic Citation
19. Parlamentul Republicii Moldova. Lege Nr. 264 din 27.10.2005 cu privire la exercitarea profesiunii de medic. http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=313062 . 2005c.
Ref Type: Electronic Citation
20. Parlamentul Republicii Moldova. Lege Nr. 5 din 09.02.2006 cu privire la asigurarea egalitatii de sanse intre femei si barbati. http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=315674 . 2006.
Ref Type: Electronic Citation
21. Parlamentul Republicii Moldova. Lege Nr. 295 din 21.12.2007 pentru aprobarea Strategiei nationale de dezvoltare pe anii 2008-2011. http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=326734 . 2007a.
Ref Type: Electronic Citation
22. Parlamentul Republicii Moldova. Lege Nr.23-XVI din 16.02.2007 cu privire la profilaxia infectiei HIV/SIDA. http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=323271 . 2007b.
Ref Type: Electronic Citation
23. Parlamentul Republicii Moldova. Hotarire Nr. 257 din 05.12.2008 privind aprobarea Strategiei Sistemului national de referire pentru protectia si asistenta victimelor si potentialelor victime ale traficului de fiinte umane si a Planului de actiuni privind implementarea Strategiei Sistemului national de referire pentru protectia si asistenta victimelor si potentialelor victime ale traficului de fiinte umane pe anii 2009-2011. http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=330608 . 2008a.
Ref Type: Electronic Citation
24. Parlamentul Republicii Moldova. Lege Nr. 241 din 20.11.2008 privind donarea de singe si transfuzia sanguina. http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=330306 . 2008b.
Ref Type: Electronic Citation

25. Parlamentul Republicii Moldova. Lege Nr. 45 din 01.03.2007 cu privire la prevenirea si combaterea violentei in familie . http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=327246 . 2008c.
Ref Type: Electronic Citation
26. Parlamentul Republicii Moldova. Lege Nr. 25 din 03.02.2009 privind aprobarea Strategiei nationale pentru tineret pe anii 2009–2013. http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=331208 . 2009.
Ref Type: Electronic Citation
27. National Coordination Council for HIV/AIDS & TB of the Republic of Moldova. Assessment Report: HIV/AIDS M & E System. 2011. Chisinau.
Ref Type: Unpublished Work
28. Bivol, Scutelniciuc&Vladicescu. Evaluation of HIV Prevention Programmes in the Republic of Moldova 2010 http://aids.md/aids/files/1145/Moldova%20HIV%20Prevention%20Evaluation_draft_April_8_for%20translation.doc 2010
Ref Type: Electronic Citation
29. Bivol, Scutelniciuc, & Vladicescu. Gender-associated vulnerabilities to HIV. 2009. CNMS, UNAIDS 2009 .
Ref Type: Generic
30. Bivol S. 2009, *National HIV/AIDS Response Analysis Republic of Moldova 2009* Chisinau. Bivol S. & Parkhomenko Zh. 2009, *Evaluation of Prevention of HIV Mother to Child Transmission Services in the Republic of Moldova*.
31. BSS. Behavoiral and Sentinel Surveillance among MSM. 2010a.
Ref Type: Unpublished Work
32. BSS. Behavoiral and Sentinel Surveillance among prisoners. 2010b.
Ref Type: Unpublished Work
33. CBS AXA. Public Opinion OMNIBUS Survey 01.03.2010 - 15.03.2010. 2010.
Ref Type: Generic
34. Family Health International 2004, *Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV*.
35. National Coordination Council for HIV/AIDS & TB of the Republic of Moldova. Joint Assessment Report and Annexes - Moldova national Programme for HIV/AIDS and stis control and prevention for 2011-2015 , 2011 http://aids.md/aids/files/1142/JOINT%20ASSESSMENT%20REPORT%20-%20MOLDOVA%20-%20FinalEngl.doc Ref Type: Electronic Citation
36. Hoover J. & Jurgens R. Harm Reduction in Prison: The Moldova Model. http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/moldova_20 090720/moldovaeng_20090720.pdf . 2009. Open Society Institute. 7-12-2009.
Ref Type: Online Source
37. Ministerul Sanatatii al Republicii Moldova. Ordin Nr. 20 din 19.01.07 cu privire la standardul "Supravegherea epedemiologica a infectiei HIV/SIDA". http://ms.gov.md/_files/2566-2007.19.01%2520%2520ord.20.pdf . 2007a. Ref Type: Electronic Citation
38. Ministerul Sanatatii al Republicii Moldova. Ordinul Nr. 314 din 31.07.2007 Cu privire la Regulile de examinare si supraveghhere medicala pentru depistarea contaminarii cu virusul imunodeficientei umane (Maladia SIDA). 2007b. Ref Type: Generic
39. Ministerul Sanatatii al Republicii Moldova. Ordinul Nr. 344 din 05.09.2005 Cu privire la crearea Serviciului de Consiliere si Testare Voluntara. http://ms.gov.md/_files/1643-Ordin%2520nr.%2520344%2520din%252015.09.2007%2520cu%2520privire%2520la%2520crearea%2520Serviciului%2520de%2520Consiliere%2520si%2520Testare%2520Voluntara.pdf 2007c. Ref Type: Electronic Citation
40. Ministerul Sanatatii al Republicii Moldova. Ordinul Nr. 283 din 18.07.2008 cu privire la aprobarea Protocolului clinic national „Tulburari mentale si de comportament legate de consumul de

opiacee". http://www.ms.gov.md/_files/2339-Tulburari%2520mentale.pdf . 18-7- 2008. 7-12-2009. Ref Type: Online Source
41. Ministerul Sanatatii al Republicii Moldova. Ordinul Nr. 266 cu privire la aprobarea standardelor de reducere a riscurilor asociate consumului de droguri injectabile si de asistenta psihosociala consumatorilor de droguri. http://www.ms.gov.md/_files/4596-Microsoft%2520Word%2520-%2520Ordin%2520nr.266%2520din%252003.08.pdf . 3-8-2009a. Chisinau. 7-12-2009a. Ref Type: Online Source
42. Ministerul Sanatatii al Republicii Moldova. Ordinul Nr. 523 din 24.12.2009 Cu privire la aprobarea Ghidului national de tratament si ongrijiri in infectia HIV si SIDA. http://ms.md/_files/5192Ordin%2520nr.523%2520din%252024.12.09%2520Ghid%2520national%2520HIV%2520si%2520SIDA.pdf . 2009b. Ref Type: Electronic Citation
43. Scutelniciuc, Cantarji *HIV/AIDS related knowledge, attitudes and practices of general population* (15-64) Survey report, 2010, http://www.ucimp.md/images/pdf/POPULATIE_GENERALA_15_64_LAST_2011.pdf Type: Online Source
44. Scutelniciuc, Cantarji *HIV/AIDS related knowledge, attitudes and practices of of youth aged 15-24* Survey report, 2010 http://www.ucimp.md/images/pdf/TINERI_15-24_LAST_2011.pdf Type: Online Source
45. BNS, UNDP *Violenta fata de femei in familie in Republica Moldova, 2011,* http://www.statistica.md/public/files/publicatii_electronice/Violenta/Raport_violenta_fam.pdf Type: Online Source
46. Cantarji. *Vulnerabilitatea femeilor din Transnistria la infectia HIV.* UNAIDS, 2011 Type: Unpublished report.
47. PHH Project 2007, *Knowledge, Attitudes and Practices of the population on Viral Hepatitis V and C and Voluntary Counselling and Testing on HIV and Viral Hepatitis* Chisinau. Scutelniciuc O. 5-year evaluation. Republic of Moldova. Health Impact Evaluation Study Area 3. HIV/AIDS Report. 2008. Ref Type: Generic
48. Scutelniciuc O., Condrat I., & Gutu L. 2008, *Youth's Knowledge, Attitudes and Practices regarding HIV/AIDS 2008* Chisinau.
49. Scutelniciuc O., Gutu L., & Lesco G. 2006, *Youth's Knowledge, Attitudes and Practices regarding HIV/AIDS 2006* Chisinau.
50. Soltan V., Damian E., & Bivol S. 2008, *HIV Prevalence among New TB registered Cases in the Republic of Moldova*.
51. Soros Foundation - Moldova. Harm Reduction Program, Activity report. HIV/AIDS prevention among vulnerable groups. HIV/AIDS control and prevention program financed by GOVMD/GFATM/WB. 2011. Ref Type: Unpublished Work
52. UNAIDS. Global AIDS Response Progress Reporting. Guidelines on construction of core indicators for monitoring the 2011 political Declaration on HIV/IADS. 2012 Reporting . 2011a. Ref Type: Generic
53. UNAIDS. National AIDS Spending Assessment. http://data.unaids.org/pub/Manual/2009/20090916_NASA_Classifications_edition_en.pdf . 2011b. Ref Type: Electronic Citation
54. UNAIDS & MERG. Organizing Framework for a Functional National HIV Monitoring and Evaluation System. http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798113269545908/GROrganizingFrameworkforHIVMESystem.pdf . 2008. Ref Type: Online Source
55. WHO. Norms reffering to the collection, treatment and quality control of blood, its components and plasma derivatives." WHO Technical Report Nr. 840. 1994. Ref Type: Generic
56. WHO. HIV/AIDS Treatment and Care Clinical protocols for the WHO European Region. http://www.euro.who.int/Document/E90840.pdf . 2007. Ref Type: Online Source

ANNEX 1 Consultation/preparation process for the Country Progress Report on monitoring the 2011 Political Declaration on HIV/AIDS

Minutes of the meeting on Global AIDS Reporting Data collection and validation,
UNAIDS Office, 67, Bucharest Str.
Date: March 30th , 2012, 13:00 – 15.00
Location: UNAIDS Representative Office, 67, Bucharest Str.

Participants:
Ministry of Health: Liliana Gantea
Ministry of Health: Vitalie Slobozeanu
WHO: Silviu Ciobanu
CCN TB/AIDS Secretariate: Violeta Teutu
UNAIDS:Iuliana Stratan
UNAIDS: Alexandrina Iovita
UNODC: Elena Jidobin
UNICEF: Angela Capcelea
AIDS Centre: Stefan Gheorghita
AIDS Centre: Iurie Osoianu
AIDS Centre: Regina Povar
AIDS Centre: Svetlana Popovici
AIDS Centre: Ecaterina Busuioc
AIDS Centre: Silvia Stratulat
AIDS Centre Tiraspol: Alexandru Goncear
Soros Foundation: Liliana Gherman
Soros Foundation: Veronica Zorila
Soros Foundation: Ina Tcaci
IDH "Toma Ciorba": Angela Nagit
Public Institution UCIMP: Svetlana Plamadeala
Centre PAS: Liliana Caraulan
National Centre for Health Management: Valeriu Plesca
National Centre for Health Management: Lilia Todiracu
National Centre for Health Management: Tatiana Costin
National Centre for Health Management: Tatiana Cotelnic-Harea
League of People Living with HIV of Republic of Moldova: Igor Chilcevschi
NGO "Credinta": Ludmila Untura
NGO "Copilarie pentru toti": Tatiana Scaruba
NGO "Initiativa pzitiva": Alexander Kurasov

Agenda:
1. Spectrum data presentation and validation;
2. Data presentation and validation of NCPI, "Government HIV and AIDS policies Part A, administrated by government officials";
3. Data presentation and validation of NCPI, "Government HIV and AIDS policies" Part B, administrated by civil society organizations, bilateral agencies, and UN organizations";
4. Data presentation on National AIDS Spending;
5. Presentation of National response to HIV /AIDS indicators;
6. Other.

AGENDA ITEM 1. Spectrum data presentation and validation, Facilitator Tatiana Cotelnic-Harea, National Centre for Health Management

The meeting was opened by **Ms.Tatiana Cotelnic-Harea** who thanked the members for their participation and presented the agenda of the meeting and its participants.

Ms. Cotelnic-Harea started the presentation in front of audience of the "Spectrum data presentation and validation". **Mr. Plesca** mentioned that the Spectrum data of this year are more realistic comparatively to the previous one, according to the opinion of other specialists. **Ms.Iovita** pointed out that a great achievement was obtained this year by including data of the both banks of the river Nistru. The formulas used according to the South Eastern Europe region (not as in the previous variants of Spectrum).

Ms. Cotelnic-Harea presented first the data for the right bank of river Nistru, and secondly – the left one. Then, Ms. Cotelnic-Harea spoke about the Results (overall results, incidence, prevalence, mortality, need of treatment, new cases etc.)

At the end oh her presentation Ms. Cotelnic-Harea called the participant for comments until the last day before submitting the Report.

AGENDA ITEM 2. Data presentation and validation of NCPI, "Government HIV and AIDS policies", Part A, administrated by government officials, Facilitator Violetei Teutu, CCN TB/AIDS Secretariat.

Ms. Violeta Teutu started her presentation with listing the national stakeholders involved or being related to the governmental policies. She reported to have being assisted by Ms. Plamadeala Svetlana in filling in the governmental part of the questionnaire. **Ms. Plamadeala** stressed the differences between the answers of non-governmental partners and the governmental ones. That is why, as Ms. Plamadeala explained; only answers of governmental stakeholders have been taken under consideration. Within this context, **Ms. Teutu** said that the positions of the stakeholders have been analyzed, which are going to be revised and accepted in their final variant at the present meeting.

Further, Ms. Teutu spoke about each area covered by Part A. When talking about governmental policies, **Mr. Gheroghita** recommended to edit the phrase "The New HIV/AIDS Program 2011-2015" with the phrase "The HIV/AIDS Program 2011-2015" due to the fact that that it is not a modified Program, just an improved and prolonged version of the old one. The group had agreed over this change.

Next, the group had discussions over the issue of most at risk populations and the relevancy of the fact that some population groups may require explicit attention and if the government made any prioritizing. **Ms. Iovita Alexandrina** pointed out that no specific prioritization of the Most at risk populations have been done. **Ms. Plamadeala**, as well as **Mr. Gheorghita** stated that the NAP 2006-2010 budget have covered the MARPs. In this order of ideas, everybody agreed to include in the category "Other" the STI patients, the general population (according to the financial analysis).

When analyzing the answers to the question of ART availability for "Undocumented migrants" category, **Ms. Iovita** suggested indicating in comments that there are signs of danger of the migrants with a risk behavior, according to the data of the triangulation process of the last year.

AGENDA ITEM 3. Data presentation and validation of NCPI, "Government HIV and AIDS policies" Part B, administrated by civil society organizations, bilateral agencies, and UN organizations", Facilitator Iuliana Stratan, UNAIDS;

Ms. Stratan started her power point presentation by listing the respondents. The group took the decision to consider the answers of "Zdorovoe Budushcee" NGO as of the League of People living with HIV/AIDS, due to the fact that the given NGO have participated at the special meeting of League of People living with HIV/AIDS, a meeting designed for discussions around the Global Funding Report questionnaire, a fact confirmed by **Ms.Untra Ludmila**, present at the meeting.

Ms. Stratan continued her presentation of the civil society organizations, bilateral agencies, and UN organizations attitudes over the Government HIV and AIDS policies, analyzing each area comprised in the instrument. She also presented the excel version of the questionnaires, filled in by the respondents in order to explain to the audience the methodology.

AGENDA ITEM 4. Data presentation on National AIDS Spending, Facilitator Lilia Gantea, Ministry of Health

Ms. Gantea started her presentation with the sources of data collection, which include ministries, governmental authorities, local and international NGOs and international organizations. She also mentioned the areas of spenditures (prevention, treatment, social protection, orphans, HIV/AIDS studies, social development etc.)

During her presentation **Ms. Gantea** explained the methodology for tracking of HIV and AIDS financial flows at national level. Ms. Gantea reported the financial sources, beneficiaries, costs and providers with regard to the records of financial flows. She also presented the financial flows separately for years 2010 and 2011.

AGENDA ITEM 5. Presentation of "National response to HIV /AIDS indicators", Facilitator Tatiana Cotelnic Harea

Ms. Cotelnic Harea presented each indicator, with its corresponding data, sources of data collection and comments. The "pregnant women" category, indicator 3.1 provoked discussions, especially around the source of data collection. Ms. Cotelnic Harea mentioned that there are differences between the data in the questionnaires received from maternities and those of Family Medical Centers.

6. Other. An extra Agenda item was brout by **Ms. Teutu** with regard to the request of permission from ECDC for using data of EMIS research in the Dublin Declaration report 2012. She explained that there are differences between the data of UNGASS and those of EMIS. At the proposal of **Mr. Gheorghita**, the both reports were compared and the differences were identified, due to the different methods used in data collection. The Working Group decided to allow to ECDC to use the EMIS data, with the condition to include in comments the sources and some explanations related to methodology of work.

<u>Conclusions:</u>

1. The data of NCPI and National response to HIV /AIDS indicators have been validated
2. To allow ESDC to use data of EMIS research in the Dublin Declaration report 2012 with the condition to include in comments the sources and some explanations related to methodology of work

Moldova Report NCPI

NCPI Header

COUNTRY

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:
Violeta Teutu
Postal address:
3, Cozmescu street, Chisinau city MD_2009 Republic of Moldova
Telephone:
+ (373) 22 727359
Fax:
+ (373) 22 723000
E-mail:
ccm_secretariat@mednet.md

Describe the process used for NCPI data gathering and validation:
Data collection and validation processes for the NCPI were carried out as part of the UNGASS 2012 reporting exercise. After national consultants for the NCPI were identified for both the Government sector and the civil society sector, the process of data collection and validation had several major milestones: - Desk review: consultants have analyzed the most recent documents, survey reports, as well as policies and strategies in the field. - Initial brainstorming and discussion at a consultation meeting with broad representation of stakeholders from all sectors and at all levels. - Interviewing key people most knowledgeable about the topic. - Discussing the draft with the president of the League of People Living with HIV, and the president of NGOs working in Harm Reduction. - The preliminary version of the questionnaire and of the narrative report has been circulated by e-mail for additional comments. - Presenting the draft NCPI at a technical working group and gaining further insights, as well as building consensus in a stakeholder meeting taking place on March 22, 2012. - Validation of the NCPI, associated with the UNGASS report validation process in both a technical level on March 28 and a consensus-building meeting with high level decision makers on March 30, 2012.
Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:
The NCPI development process has been participatory and has aimed at building consensus among stakeholders. Throughout the formal and informal discussions, ratings and comments have been discussed, debated, and ultimately agreed upon. Perhaps the most important consensus building mechanism has been the continuity of participatory processes and the involvement of stakeholders all throughout programme implementation, strategic planning and M&E, which has constituted a major conflict resolution and partnership strategy for this cycle of UNGASS reporting
Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):
The questionnaire is well known among stakeholders thus no concerns were raised relating to data quality or potential misinterpretation. Among limitations that can be attested are various mandate-driven priorities for the national stakeholders that may affect the objectivity of interview outputs.

NCPI - PART A [to be administered to government officials]

Organization	Names/Positions	A.I	A.II	A.III	A.IV	A.V	A.VI
Organization: Ministry of Health	Names/Positions: Vitalie Slobozian/Chief of Department	A.I: Yes	A.II: Yes	A.III: No	A.IV: No	A.V: No	A.VI: No
Organization: Ministry of Health	Names/Positions: Liliana Gantea/Chief of Departement	A.I: Yes	A.II: Yes	A.III: No	A.IV: No	A.V: No	A.VI: No
Organization: AIDS Department	Names/Positions: Stefan Gheorghita/ Director	A.I: Yes	A.II: Yes	A.III: Yes	A.IV: Yes	A.V: Yes	A.VI: Yes
Organization: AIDS Department	Names/Positions: Iurie Osoianu/ Chief of department	A.I: Yes	A.II: Yes	A.III: Yes	A.IV: Yes	A.V: No	A.VI: No
Organization: AIDS Department	Names/Positions: Svetlana Popovici/ Chief of unit	A.I: No	A.II: No	A.III: Yes	A.IV: No	A.V: Yes	A.VI: Yes
Organization: National Centre of Health Management	Names/Positions: Oleg Barba/ Director	A.I: Yes	A.II: Yes	A.III: Yes	A.IV: Yes	A.V: Yes	A.VI: Yes
Organization:	Names/Positions: Tatiana Cotelnic	A.I:	A.II:	A.III:	A.IV:	A.V:	A.VI:

National Center of Health Management	Tatiana Coteinic-Harea/M&E Unit	No	Yes	Yes	Yes	Yes	Yes
Organization: Department of Penitentiary Institutions	Names/Positions: Svetlana Doltu/Senior specialist	A.I: No	A.II: No	A.III: Yes	A.IV: Yes	A.V: No	A.VI: No
Organization: Public Institution "Coordination, Implementation and Monitoring Unit of Health System Restructuring Project"	Names/Positions: Svetlana Plamadeala/Coordinator	A.I: Yes	A.II: Yes	A.III: No	A.IV: No	A.V: No	A.VI: No
Organization: Center for Health Policies and Studies	Names/Positions: Liliana Caraulan/Program Coordinator	A.I: No	A.II: Yes	A.III: Yes	A.IV: Yes	A.V: No	A.VI: No
Organization: -	Names/Positions: -	A.I: No	A.II: No	A.III: No	A.IV: No	A.V: No	A.VI: No
Organization: -	Names/Positions: -	A.I: No	A.II: No	A.III: No	A.IV: No	A.V: No	A.VI: No
Organization: -	Names/Positions: -	A.I: No	A.II: No	A.III: No	A.IV: No	A.V: No	A.VI: No

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

Organization	Names/Positions	B.I	B.II	B.III	B.IV	B.V
Organization: UNAIDS	Names/Positions: Gabriela Ionascu, Country Coordinator	B.I: Yes	B.II: Yes	B.III: Yes	B.IV: Yes	B.V: Yes
Organization: WHO	Names/Positions: Silviu Ciobanu, Programme coordinator, Communicable diseases	B.I: Yes	B.II: Yes	B.III: Yes	B.IV: Yes	B.V: Yes
Organization: UNICEF	Names/Positions: Angela Capcelea, Child and Adolescent Health Officer	B.I: Yes	B.II: Yes	B.III: Yes	B.IV: Yes	B.V: Yes
Organization: UNDP	Names/Positions: Claude Cahn, UN Human Rights Adviser	B.I: Yes	B.II: Yes	B.III: Yes	B.IV: Yes	B.V: Yes
Organization: UNDP	Names/Positions: Arcadie Astrahan, Human Rights and Health Consultant	B.I: Yes	B.II: Yes	B.III: Yes	B.IV: Yes	B.V: Yes
Organization: UNODC	Names/Positions: Elena Jidobin, Project Coordinator	B.I: Yes	B.II: Yes	B.III: Yes	B.IV: Yes	B.V: Yes
Organization: UNFPA	Names/Positions: Viorel Gorceag, Medical Consultant	B.I: Yes	B.II: Yes	B.III: Yes	B.IV: Yes	B.V: Yes
Organization: League of PLWHA	Names/Positions: Igor Chilcevschii, NGO Presindent	B.I: Yes	B.II: Yes	B.III: Yes	B.IV: Yes	B.V: Yes
Organization: Viata Noua (New Life)	Names/Positions: Poverga Ruslan, Coordinator	B.I: Yes	B.II: Yes	B.III: Yes	B.IV: Yes	B.V: Yes
Organization: Credinta (Faith)	Names/Positions: Untura Ludmila, Coordinator	B.I: Yes	B.II: Yes	B.III: Yes	B.IV: Yes	B.V: Yes
Organization: Copilarie pentru toți (Childhood for all)	Names/Positions: Tatiana Scaruba, Coordinator	B.I: Yes	B.II: Yes	B.III: Yes	B.IV: Yes	B.V: Yes
Organization: GenderDoc -M	Names/Positions: Veaceslav Mulear, Coordinator	B.I: Yes	B.II: Yes	B.III: Yes	B.IV: Yes	B.V: Yes
Organization: Zdorovoe Buduşcee (Happy Future)	Names/Positions: Xenia Postolachi, Coordinator	B.I: Yes	B.II: Yes	B.III: Yes	B.IV: Yes	B.V: Yes
Organization: Regional Centre for Community Policies	Names/Positions: Ivtodi Rodica, Coordinator	B.I: Yes	B.II: Yes	B.III: Yes	B.IV: Yes	B.V: Yes
Organization: Mothers for life	Names/Positions: Belevtova Irina, Coordinator	B.I: Yes	B.II: Yes	B.III: Yes	B.IV: Yes	B.V: Yes
Organization: Positive Initiative	Names/Positions: Curaşov Alexandr, Coordinator	B.I: Yes	B.II: Yes	B.III: Yes	B.IV: Yes	B.V: Yes
Organization: -	Names/Positions: -	B.I: No	B.II: No	B.III: No	B.IV: No	B.V: No

A - I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?
(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2):

Yes
IF YES, what was the period covered:
2011-2015
IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. IF NO or NOT APPLICABLE, briefly explain why.:
The National Programme on Prevention and Control of HIV/AIDS/STIs for 2006-2010 was aligned to national strategic frameworks and to international commitments Moldova has embraced. The NAP had clear linkages to the MDG-centred National Development Strategy 2008 – 2011, which represents a tool for the integration of the strategic frameworks under implementation, as well as a device for alignment between the budgeting process and the policy framework, and absorption of external technical and financial assistance. The NAP (2011-2015) has also been profoundly anchored in the national development policies and plansThe National Programme on Prevention and Control of HIV/AIDS/STIs for 2006-2010 was aligned to national strategic frameworks and to international commitments Moldova has embraced. The NAP had clear linkages to the MDG-centred National Development Strategy 2008 – 2011, which represents a tool for the integration of the strategic frameworks under implementation, as well as a device for alignment between the budgeting process and the policy framework, and absorption of external technical and financial assistance. The NAP (2011-2015) has also been profoundly anchored in the national development policies and plans

1.1 Which government ministries or agencies

Name of government ministries or agencies [write in]:
Ministry of Health

1.2. Which sectors are included in the multisectoral strategy with a specifc HIV budget for their activities?

SECTORS

Included in Strategy Earmarked Budget

Included in Strategy:	Earmarked Budget:
Yes	Yes
Included in Strategy:	Earmarked Budget:
Yes	Yes
Included in Strategy:	Earmarked Budget:
Yes	No
Included in Strategy:	Earmarked Budget:
Yes	Yes
Included in Strategy:	Earmarked Budget:
No	No
Included in Strategy:	Earmarked Budget:
Yes	Yes
Included in Strategy:	Earmarked Budget:
Yes	Yes

Other [write in]:
Justis (inmates), social protection
IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specifc activities?:
-

1.3. Does the multisectoral strategy address the following key populations, settings and cross-cutting issues?

Men who have sex with men:
Yes
Migrants/mobile populations:
Yes
Orphans and other vulnerable children:
Yes
People with disabilities:
No
People who inject drugs:
Yes
Sex workers:
Yes
Transgendered people:
Yes
Women and girls:
Yes
Young women/young men:
Yes
Other specific vulnerable subpopulations:
-
Prisons:
Yes

Schools:
No
Workplace:
Yes
Addressing stigma and discrimination:
Yes
Gender empowerment and/or gender equality:
Yes
HIV and poverty:
Yes
Human rights protection:
Yes
Involvement of people living with HIV:
Yes

IF NO, explain how key populations were identifed?:
-
1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country [write in]?:
The following target groups have been identified by the National Programme of prevention and control of HIV/AIDS/STI 2011-2015: vulnerable populations, pregnant women, people in uniforms, orphan and other voulnerable children, women, youth, including rural youth, people living with/affected by HIV/AIDS, medical workers, parents, inmates, migrant population, patients with TB and STI, religious sector.
1.5. Does the multisectoral strategy include an operational plan?:
Yes

1.6. Does the multisectoral strategy or operational plan include

a) Formal programme goals?:
Yes
b) Clear targets or milestones?:
Yes
c) Detailed costs for each programmatic area?:
Yes
d) An indication of funding sources to support programme implementation?:
Yes
e) A monitoring and evaluation framework?:
Yes

1.7

1.7. Has the country ensured “full involvement and participation” of civil society in the development of the multisectoral strategy?:
Active involvement
IF ACTIVE INVOLVEMENT, briefly explain how this was organised:
Implementation of the NAP is coordinated by the National Coordination Council for HIV and TB - an interministerial and intersectorial decision-making body that has under its auspices 7 functional working groups which enhance coordination and capitalize upon the value added of joint efforts of all key stakeholders from different sectors, and a permanent Secretariat. The NCC and its TWGs have been involved all throughout the design of NAP and NTPCivil society is actively involved in HIV/AIDS prevention and control activities. NGOs are part of one or more networks, leagues or unions in the field: Union of NGOs active in harm reduction, the League of People living with HIV/AIDS, the AIDS Network. Members of NGOs or NGO associations represent them in the NCC and/or its technical work groups. Implementation of the NAP is coordinated by the National Coordination Council for HIV and TB, an interministerial and intersectorial decision-making body that has under its auspices 7 functional working groups which enhance coordination and capitalize upon the value added of joint efforts of all key stakeholders from different sectors, and a permanent Secretariat. All throughout the process, from planning till final conclusions and recommendations, civil society representatives have been actively involved.

1.8. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?:
Yes

1.9

1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?:
Yes, all partners

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?:
Yes

2.1. IF YES, is support for HIV integrated in the following specifc development plans?

Common Country Assessment/UN Development Assistance Framework:
Yes
National Development Plan:
Yes

Poverty Reduction Strategy:
Yes
Sector-wide approach:
Yes
Other [write in]:
National Plan “Education for all 2004-2015”, National Programme to promote healthy lifestyles 2007-2015”, National Health Policy, National Strategy of reproductive health, National Strategy for the development of the health system 2008-2017, National Program to control and prevent Tuberculosis for the 2011-2015 period; Law No 25-XVI of 03.02.2009 for the approval of the National Youth Strategy 2009 – 2013, National Programme for control of Hepatitis B, C, D 2007-2011, Government Decision 1143 of 19.10.2007

2.2. IF YES, are the following specifc HIV-related areas included in one or more of the development plans?

HIV impact alleviation:
Yes
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support:
Yes
Reduction of income inequalities as they relate to HIV prevention/treatment, care and/or support:
Yes
Reduction of stigma and discrimination:
Yes
Treatment, care, and support (including social security or other schemes):
Yes
Women’s economic empowerment (e.g. access to credit, access to land, training):
Yes
Other[write in below]:
prevention for vulnerable populations, mother to child transmission prevention, development/strengthening of primary healthcare, STI

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?:
Yes
3.1. IF YES, on a scale of 0 to 5 (where 0 is “Low” and 5 is “High”), to what extent has the evaluation informed resource allocation decisions?:
4
4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?:
Yes
5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS?:
Yes
5.1. Have the national strategy and national HIV budget been revised accordingly?:
Yes
5.2. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?:
Estimates of Current and Future Needs
5.3. Is HIV programme coverage being monitored?:
Yes

5.3

(a) IF YES, is coverage monitored by sex (male, female)?:
Yes
(b) IF YES, is coverage monitored by population groups?:
Yes
IF YES, for which population groups?:
MSM, CSWs, IDUs, inmates, migrants.
Briefly explain how this information is used:
Information is used for planning interventions for each group, and planning of epidemiological surveillance of these groups
(c) Is coverage monitored by geographical area:
Yes
IF YES, at which geographical levels (provincial, district, other)?:
district, regions (left an right bank of Dniestr River)
Briefly explain how this information is used:
The annual reports monitoring the implementation of the National HIV/AIDS/STI Programme uses epidemiological indicators of incidence and prevalence disaggregated by district and regions

5.4. Has the country developed a plan to strengthen health systems?:
Yes
Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:
-
6. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate strategy planning efforts in the HIV programmes in 2011?:

8
Since 2009, what have been key achievements in this area:
During the period 27 June to 8 July, 2011 in Moldova the Joint Assessment (JA) of the National Program for HIV/AIDS and STIs Control and Prevention for 2011-2015 (NSP) was conducted. It was the first Joint Assessment conducted under the GFATM Second Wave of the National Strategy Application (NSA) modality. The Joint Assessment was based upon the JANS tool; it responded to the areas of expertise identified by the Joint Assessment Organizing Body (JAOB) as key for Moldova: Strategic Planning (as an overarching, cross-cutting issue), HIV Disease (to manage the Situation Analysis category of the JANS tool), Multistakeholder Involvement (to manage the Process category), Finance and Audit (for that section of the tool), Programme Management and Health Systems (for the Implementation and Management category), Procurement and Supply Management (to handle specifically attribute 15), and M&E (for the Results, Monitoring and Evaluation category). Among the most strong points of the strategies developed and implemented by the international actors, the representatives of the governmental sector enumerated the following: • The programmes are innovative and of high quality due to the fact that they represent best practices in the field of HIV/AIDS at the international level; • They always have technical and financial support, which make them stable; • Actors representing international agencies have new suggestions and tools, and they ensure a continuity from objectives to results in their strategies.
What challenges remain in this area:
In view of the Government decision to introduce results-based planning and management (RBM), the NSP needs to reformulate its goals, aims and objectives to become results-based, coherent and logic. This will bring strategic coherence to the programme; allow for evidence-based correction and adjustment and ensure attributable reporting towards

A - II. POLITICAL SUPPORT AND LEADERSHIP

1. Do the following high offcials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year

A. Government ministers:
Yes
B. Other high offcials at sub-national level:
Yes

1.1

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.):
Yes

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:
National AIDS Conference 2011, World AIDS Day 2010-2011, International AIDS Candlelight Memorial Day. The speech of the Prime Minister during the National AIDS Conference, 5-7 December 2011 (http://aids.md/aids/index.php?cmd=item&id=1112)
2. Does the country have an offcially recognized national multisectoral HIV coordination body (i.e., a National HIV Council or equivalent)?:
Yes

2.1. IF YES, does the national multisectoral HIV coordination body

Have terms of reference?:
Yes
Have active government leadership and participation?:
Yes
Have an official chair person?:
Yes
IF YES, what is his/her name and position title?:
Andrei Usatii/ Minister of Health
Have a defined membership?:
Yes
IF YES, how many members?:
33
Include civil society representatives?:
Yes
IF YES, how many?:
12
Include people living with HIV?:
Yes
IF YES, how many?:
2
Include the private sector?:
No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?:
Yes

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private

sector for implementing HIV strategies/programmes?:
Yes
IF YES, briefly describe the main achievements:
-
What challenges remain in this area:
The National Programme needs to strengthen the technical base for programme management, results-based planning and management, costing, etc. Capacity building programmes for all stakeholders should be made more explicit.
4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?:
14%

5.

Capacity-building:
Yes
Coordination with other implementing partners:
Yes
Information on priority needs:
Yes
Procurement and distribution of medications or other supplies:
No
Technical guidance:
Yes
Other [write in below]:
-

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?:
Yes
6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?:
Yes
IF YES, name and describe how the policies / laws were amended:
With the support and advocacy of specialized NGOs (namely, NGO “IDOM”) and in accordance with the Ministry of Health Order Nr. 347 dated 26.05.2010, the Ministry of Health initiated a working group to revise a series of Laws, including the Law on Prophylaxis of HIV/AIDS, the Law on Migration, the Law on the Legal Regime of foreigners, etc., as well as subordinated normative documents (i.e. Instruction on HIV Testing of Young People before Registration of Marriage, Instruction on HIV Testing of Pregnant Women etc.). In accordance with the Ministry of Health Order Nr. 36 dated 17.01.2011, a series of amendments removing discriminatory elements were operated to the aforementioned legal documents. Amendments to most of the regulatory acts have been approved by the Government, still, the amendments to the Laws which require the endorsement of other line ministries, are still under examination of the related line ministries and are awaiting approval. The amendments to the HIV Prevention Law (2007) are currently awaiting approval in the Parliament. Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies: The exposure to or transmission of HIV is still prosecuted under the Criminal Code (approved by Law Nr. 985-XV dated 18.04.2002) with specific provisions under articles 211 and 212. HIV transmission has been criminalized in an attempt by the government to respond to the rising numbers of HIV infections and prevent the deliberate contamination with HIV; yet, human rights campaigners and other NGOs have expressed concerns that these laws lead to a violation of the rights of people living with HIV, exacerbating their marginalization
Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:
The exposure to or transmission of HIV is still prosecuted under the Criminal Code (approved by Law Nr. 985-XV dated 18.04.2002) with specific provisions under articles 211 and 212. HIV transmission has been criminalized in an attempt by the government to respond to the rising numbers of HIV infections and prevent the deliberate contamination with HIV; yet, human rights campaigners and other NGOs have expressed concerns that these laws lead to a violation of the rights of people living with HIV, exacer-bating their marginalization
7. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the political support for the HIV programme in 2011?:
8
Since 2009, what have been key achievements in this area:
Although there is room for improvement, the Government has been collaborating with PLHIV and key population subgroups through the country’s formal mechanisms in place – NCC, TWG. The Ministry of Labor, Social Protection and Family, and the Ministry of Health involved these groups in setting up community-based social care centers, consisting of multidisciplinary teams providing comprehensive care. Various new financing mechanisms has been considered, including through the National Health Insurance Company, to cover some additional costs (e.g., outpatient care for ART and medical follow-up)
What challenges remain in this area:
Relatively weak political commitments; Scanty funds earmarked for this; Poor formal cooperation / contracting between government and civil society; Donor (finance) driven activities; Not always focused and priority-based.

A - III. HUMAN RIGHTS

1.1

People living with HIV:
Yes
Men who have sex with men:

No
Migrants/mobile populations:
No
Orphans and other vulnerable children:
Yes
People with disabilities:
Yes
People who inject drugs:
No
Prison inmates:
Yes
Sex workers:
No
Transgendered people:
No
Women and girls:
Yes
Young women/young men:
Yes
Other specific vulnerable subpopulations [write in]:
-

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:
No
IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:
Moldova has constitutional provisions banning discrimination. The Government approved a draft anti-discrimination bill in February 2011. The bill is waiting for Parliament adoption, appended to a plan to strengthen anti-discrimination policy and enforcement machinery on an ambitious timeframe. The draft bill agreed upon by the Government constitutes a good basis for work. However, the draft will also need to be improved somewhat, if it is to finally bring Moldovans an effective legal mechanism against discrimination. There is no single case of any court or other body identifying discrimination.
Briefly explain what mechanisms are in place to ensure these laws are implemented:
Even with the few laws that protect the rights of key populations, patients etc., the enforcement of those is weak. The draft comprehensive anti-discrimination Law envisions the establishment of an enforcement body.
Briefly comment on the degree to which they are currently implemented:
The Government approved a draft anti-discrimination bill in February 2011. The bill now goes to Parliament for adoption, appended to a plan to strengthen anti-discrimination policy and enforcement machinery on an ambitious timeframe. The draft bill agreed upon by the Government constitutes a good basis for work. However, the draft will also need to be improved somewhat, if it is to finally bring Moldovans an effective legal mechanism against discrimination. There is one single case of any court or other body identifying discrimination.
2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:
Yes

IF YES, for which subpopulations?

People living with HIV:
No
Men who have sex with men:
No
Migrants/mobile populations:
No
Orphans and other vulnerable children:
No
People with disabilities:
No
People who inject drugs :
No
Prison inmates:
No
Sex workers:
No
Transgendered people:
No
Women and girls:
No
Young women/young men:
No
Other specific vulnerable subpopulations [write in below]:

Briefly describe the content of these laws, regulations or policies:
The exposure to or transmission of HIV is still prosecuted under the Criminal Code (approved by Law Nr. 985-XV dated

18.04.2002) with specific provisions under articles 211 and 212.
Briefly comment on how they pose barriers:
HIV transmission has been criminalized in an attempt by the government to respond to the rising numbers of HIV infections and prevent the deliberate contamination with HIV; yet, human rights campaigners and other NGOs have expressed concerns that these laws lead to a violation of the rights of people living with HIV, exacer¬bating their marginalization

A - IV. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?:
Yes

IF YES, what key messages are explicitly promoted?

Abstain from injecting drugs:
Yes
Avoid commercial sex:
Yes
Avoid inter-generational sex:
No
Be faithful:
Yes
Be sexually abstinent:
Yes
Delay sexual debut:
Yes
Engage in safe(r) sex:
Yes
Fight against violence against women:
Yes
Greater acceptance and involvement of people living with HIV:
Yes
Greater involvement of men in reproductive health programmes:
Yes
Know your HIV status:
Yes
Males to get circumcised under medical supervision:
No
Prevent mother-to-child transmission of HIV:
Yes
Promote greater equality between men and women:
Yes
Reduce the number of sexual partners:
Yes
Use clean needles and syringes:
Yes
Use condoms consistently:
Yes
Other [write in below]:
-

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?:
No
2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?:
Yes

2.1. Is HIV education part of the curriculum in

Primary schools?:
No
Secondary schools?:
Yes
Teacher training?:
Yes

2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?:
Yes
2.3. Does the country have an HIV education strategy for out-of-school young people?:
Yes
3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations?:
Yes

Briefly describe the content of this policy or strategy:
Check which specific populations and elements are included in the policy/strategy

3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address?

IDU	MSM	Sex workers	Customers of Sex Workers	Prison inmates	Other populations
IDU: Yes	MSM: Yes	Sex workers: Yes	Customers of Sex Workers: Yes	Prison inmates: Yes	Other populations: -
IDU: Yes	MSM: No	Sex workers: No	Customers of Sex Workers: No	Prison inmates: Yes	Other populations: -
IDU: Yes	MSM: Yes	Sex workers: Yes	Customers of Sex Workers: Yes	Prison inmates: Yes	Other populations: -
IDU: Yes	MSM: No	Sex workers: No	Customers of Sex Workers: No	Prison inmates: Yes	Other populations: -
IDU: Yes	MSM: Yes	Sex workers: Yes	Customers of Sex Workers: Yes	Prison inmates: Yes	Other populations: -
IDU: Yes	MSM: Yes	Sex workers: Yes	Customers of Sex Workers: Yes	Prison inmates: Yes	Other populations: -
IDU: Yes	MSM: Yes	Sex workers: Yes	Customers of Sex Workers: Yes	Prison inmates: Yes	Other populations: -
IDU: No	MSM: No	Sex workers: No	Customers of Sex Workers: No	Prison inmates: No	Other populations: -

3.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate policy efforts in support of HIV prevention in 2011?:
8
Since 2009, what have been key achievements in this area:
Scale up of VCT rooms countrywide and contracting by the NHIC; PMTCT; Harm Reduction programs, and OST with methadone; Awareness campaigns; Strategies focused on prevention in key populations
What challenges remain in this area:
Migrants are broadly overlooked and/or understudied.
4. Has the country identified specifc needs for HIV prevention programmes?:
Yes
IF YES, how were these specific needs determined?:
In 2010 an Evaluation of HIV Prevention Programmes in the Republic of Moldova has been performed. The main objectives of the study were to determine the effectiveness of an HIV prevention project in changing the risk behaviour among IDUs in the NAP implementation period 2006 – 2010, on the right bank of Nistru; Determine the key factors contributing to or impeding project results. The findings of the evaluation will be used to inform government and NGO partners of the viability of scaling up the harm reduction programme to rural areas; Assess the effectiveness of HIV prevention interventions focusing on behavior change in the general population, with a particular focus on young people, in the NAP implementation period 2006 – 2010, on the right bank of Nistru; Determine the key factors contributing to or impeding results. The findings of the evaluation will be used to inform government and NGO partners in planning Behavior Change Communication in the framework of the NAP 2011 – 2015.

4.1. To what extent has HIV prevention been implemented?

Blood safety:
Strongly Agree
Condom promotion:
Agree
Harm reduction for people who inject drugs:
Agree
HIV prevention for out-of-school young people:
Strongly Agree
HIV prevention in the workplace:
Agree
HIV testing and counseling:
Agree
IEC on risk reduction:
Agree
IEC on stigma and discrimination reduction:
Disagree
Prevention of mother-to-child transmission of HIV:
Strongly Agree
Prevention for people living with HIV:
Strongly Agree
Reproductive health services including sexually transmitted infections prevention and treatment:
Agree
Risk reduction for intimate partners of key populations:
Agree
Risk reduction for men who have sex with men:

Disagree
Risk reduction for sex workers:
Agree
School-based HIV education for young people:
Disagree
Universal precautions in health care settings:
Strongly Agree
Other[write in]:
-

5. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in implementation of HIV prevention programmes in 2011?:
8

A - V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?:
Yes
If YES, Briefly identify the elements and what has been prioritized:
Medical follow-up, including lab tests (PCR, CD4); Management of key opportunistic infections; ARV treatment, care and support; Incentives and enablers; Community-based support and peer-to-peer care; Free quality drug supply; Integration with other health care services (e.g., TB)
Briefly identify how HIV treatment, care and support services are being scaled-up?:
-

1.1. To what extent have the following HIV treatment, care and support services been implemented?
Antiretroviral therapy:
Strongly Agree
ART for TB patients:
Strongly Agree
Cotrimoxazole prophylaxis in people living with HIV:
Strongly Agree
Early infant diagnosis:
Agree
HIV care and support in the workplace (including alternative working arrangements):
Neutral
HIV testing and counselling for people with TB:
Strongly Agree
HIV treatment services in the workplace or treatment referral systems through the workplace:
Disagree
Nutritional care:
Neutral
Paediatric AIDS treatment:
Agree
Post-delivery ART provision to women:
Agree
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):
Strongly Agree
Post-exposure prophylaxis for occupational exposures to HIV:
Strongly Agree
Psychosocial support for people living with HIV and their families:
Agree
Sexually transmitted infection management:
Strongly Agree
TB infection control in HIV treatment and care facilities:
Strongly Agree
TB preventive therapy for people living with HIV:
Strongly Agree
TB screening for people living with HIV:
Agree
Treatment of common HIV-related infections:
Agree
Other [write in]:
-

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?:
Yes
Please clarify which social and economic support is provided:

According to the Law on prevention and control of HIV/AIDS nr. 23-XVI of 16.02.2007 PLTHIV shall benefit of equal rights as their peers, benefiting of access to educational and HIV/AIDS prevention programmes, social assistance and legal protection, as well as care and treatment, which they require as a result of their status. The NAP 2011-2015 aims at improving the quality of life of the PLHIV by ensuring: required ARV therapy, treatment of opportunistic infections and HIV/AIDS associated conditions, home care, social protection, and care.
3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?:
Yes
4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications?:
Yes
IF YES, for which commodities?:
The country has access to regional procurement and supply mechanisms for the following medical products: ARV medication, condoms, methadone, TB medicine, Opportunistic Infection medicine, STI medicine, HIV diagnostic tests and CD4.
5. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2011?:
8
Since 2009, what have been key achievements in this area:
The most important achievements relate to ensuring access to HIV treatment, which in fact is 100% available to those who need and want it; achievements in the decentralization of treatment services and HIV care throughout the country, as well as providing MST services; updating treatment protocols with WHO financial support; initiating the creation of infrastructure for testing viral resistance to ARV preparations; improving accessibility and quality of prophylactic ART for HIV pregnant women; opening a pediatric ward within the ARV treatment institution. Decentralisation of ARV treatment has started in 2011, being available for the northern region of the country in Balti municipality, the southern region – Cahul, and the centre of the country – Chisinau municipality. On the left bank of the Dniestr River, the ARV treatment is provided by the AIDS Centre in Tiraspol and in Ribnita for citizens from the northern part of Transnistria. The regulation on the organization of palliative care services for people with HIV/AIDS was developed.
What challenges remain in this area:
An HIV case management protocol is missing. Support and care services are assessed as inadequate on the grounds that palliative care is not institutionalized and is provided almost exclusively by the NGO sector; human capacities are underdeveloped; the concept of vulnerability is not sufficiently developed and social assistance based on the concept is in the process of being operationalized . Data show that coverage of children with ARV treatment is lower than for adults. Insufficient training, laboratory diagnostic and situation monitoring in the field of HIV/AIDS on the left bank of the Dniestr River represent gaps that need special consideration.
6. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?:
Yes
IF YES, is there an operational definition for orphans and vulnerable children in the country?:
Yes
IF YES, does the country have a national action plan specifically for orphans and vulnerable children?:
Yes
IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?:
No
IF YES, what percentage of orphans and vulnerable children is being reached? :
-
7. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?:
7
Since 2009, what have been key achievements in this area:
The most important achievements relate to ensuring access to HIV treatment, which in fact is 100% available to those who need and want it; to achievements in the decentralization of treatment services and HIV care throughout the country, as well as providing MST services; updating treatment protocols with WHO financial support; initiating the creation of infrastructure for testing viral resistance to ARV preparations; improving accessibility and quality of prophylactic ART for HIV pregnant women; opening a pediatric ward within the ARV treatment institution. Starting with 2011, the decentralization of ARV treatment has started, being available for the northern region of the country in Balti municipality, the southern region – Cahul, and the centre of the country – Chisinau municipality. On the left bank of the Dniestr River, the ARV treatment is provided by the AIDS Centre in Tiraspol and in Ribnita for citizens from the northern part of Transnistria. The regulation on the organization of palliative care services for people with HIV/AIDS was developed. The HIV case management protocol is being developed. Several play grounds were opened by NGOs, based on the territorial coverage principle, with the purpose of integrating these children in the society and providing them care and support - The baseline assessment of children affected by HIV has been carried out, representing a planning tool for inetrventions covering these children
What challenges remain in this area:
-MARA have limited access to prevention, care and support services because of stigma and discrimination - Capacities of service providers in service provision for MARA and support to OVC are underdeveloped

A - VI. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?:

Yes
Briefly describe any challenges in development or implementation:
Some important progress has been registered, particularly in regard to development of a National M&E Plan as part of the NSP and of a M&E workplan, which has enabled more integrative approaches to M&E capacity building, clearer scope of responsibilities for the M&E TWG, and more priorities-based approach to studies, surveillance, evaluations and research. The coordination of M&E system and its effectiveness has been enhanced by the NAC newly-established Coordination Unit that acts as an additional layer ensuring implementation oversight, hence permitting the more independent data audit and evaluation roles of the M&E Unit that serve as data validation mechanisms.
1.1 IF YES, years covered:
2011-2015
1.2 IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?:
Yes, some partners
Briefly describe what the issues are:
• Due to national legislative/normative technique requirements, the National M&E Plan is very ascetic, and there are missing blocks of the 12 components in the M & E Plan • limited participation in the development of the M & E Plan on behalf of LPA; for certain entities, participation has been less substantial due to capacity limitations • indicators to monitor progress & performance of the M&E system are limited in number and scope

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy:
Yes
Behavioural surveys:
Yes
Evaluation / research studies:
Yes
HIV Drug resistance surveillance:
No
HIV surveillance:
Yes
Routine programme monitoring:
Yes
A data analysis strategy:
No
A data dissemination and use strategy:
Yes
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate):
Yes
Guidelines on tools for data collection:
Yes

3. Is there a budget for implementation of the M&E plan?:
Yes
3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities? :
10%
4. Is there a functional national M&E Unit?:
Yes
Briefly describe any obstacles:
N/A

4.1. Where is the national M&E Unit based?

In the Ministry of Health?:
Yes
In the National HIV Commission (or equivalent)?:
-
Elsewhere [write in]?:
National Center of Health Management

Permanent Staff [Add as many as needed]

POSITION [write in position titles in spaces below]	Fulltime	Part time	Since when?
POSITION [write in position titles in spaces below]: Head department	Fulltime: fulltime	Part time: -	Since when?: 2004
POSITION [write in position titles in spaces below]: IT specialist	Fulltime: fulltime	Part time: -	Since when?: 2004
POSITION [write in position titles in spaces below]: Surveys coordinator	Fulltime: fulltime	Part time: -	Since when?: 2007
POSITION [write in position titles in spaces below]: VCT M&E	Fulltime: fulltime	Part time: -	Since when?: 2008

Temporary Staff [Add as many as needed]

POSITION [write in position titles in spaces below]	Fulltime	Part time	Since when?
IT personel	-	Part time	2005

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?:
Yes
Briefly describe the data-sharing mechanisms:
The ammended M&E Plan sopecifies data flows and periodicity of reporting to the National M&E Unit, laos, subsequent to the streamlining of the GFATM M&E to the national M&E system, the M&E Unit has viable mechanisms to influence timely reporting.
What are the major challenges in this area:
Intersectorial reporting, particular on the horizontal level, remains challenging
5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?:
Yes
6. Is there a central national database with HIV- related data?:
No
6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?:
-

6.2. Is there a functional Health Information System?

At national level:
Yes
At subnational level:
Yes
IF YES, at what level(s)?:
district level

7. Does the country publish an M&E report on HIV , including HIV surveillance data at least once a year?:
Yes

8. How are M&E data used?

For programme improvement?:
Yes
In developing / revising the national HIV response?:
Yes
For resource allocation?:
Yes
Other [write in]:
-

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:
Data from the second generation surveillance researches/studies are used for the strategic planning especially in the process of scaling up HIV/AIDS control and prevention activities and services. All prevention campaigns are based on Knowledge, Attitudes, Practices and behaviors studies, as well as impact studies realized post campaigns. However, data should be used in a more systematic manner to guide policy development and sharpen the focus of programme implementation.

9. In the last year, was training in M&E conducted

At national level?:
Yes
IF YES, what was the number trained:
37
At subnational level?:
Yes
IF YES, what was the number trained:
173
At service delivery level including civil society?:
Yes
IF YES, how many?:
50

9.1. Were other M&E capacity-building activities conducted` other than training?:
Yes
IF YES, describe what types of activities:
M&E visits
10. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?:
8
Since 2009, what have been key achievements in this area:
The biggest achievement is the M&E system assessment through the functionality review for each of its 12 components. The assessment has determined the strengths and weaknesses for each component and the strategy for actions. The final report is

attached. - The National M&E Plan 2011 - 2015 has been amended based on quality criteria. The development process has been participatory and transparent and has been based on the findings of the M&E system assessment. - Was institutionalized the curriculum based on the Medical University. There is i included in distance learning curriculum for doctors.
What challenges remain in this area:
Strengthen capacities of the National AIDS Center to coordinate NSP monitoring, and to institute internal data quality assurance mechanisms Limited allocations to the M&E system from the state budget and over-reliance on international financial support, which curtails sustainability; Lack of institutionalized routine intersectorial reporting mechanisms;

B - I. CIVIL SOCIETY INVOLVEMENT

1. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?:
4
Comments and examples:
In 2011, civil society was involved in the national strategy/ policy formulation through the: 1) National Coordination Council (NCC) 2) NCC technical Working Group (TWG) 3) UNCT and UNJT on HIV/AIDS 4) UNDAF 5) MDG Acceleration Framework (MAF) 6) Joint Assessment of National HIV Program (JANS) 7) National HIV Conference 8) HIV/AIDS related events (Candle Light Memorial, WAD) etc. The weak part still remained building up the political commitment of top leaders.
2. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?:
3
Comments and examples:
In 2011, civil society was involved in the HIV strategy planning and budgeting process through the: National Coordination Council (NCC) 2) NCC technical Working Group (TWG) 3) UNCT and UNJT on HIV/AIDS 4) UNDAF 5) Joint Assessment of National HIV Program (JANS) 6) National HIV Strstegy Update (both programmatic and budgeted) 7) Draft NSA applications

3.

a. The national HIV strategy?:
4
b. The national HIV budget?:
3
c. The national HIV reports?:
4
Comments and examples:
By and large, all relevant evidence-based activities performed by civil siciety are accounted for in the National HIV Program (NAP). However, most of the funding for it comes from donors and aids organizations, leaving it vulnerable to foreign investiments and over -reliance on donor funding. Civil society activities have budget lines under the NAP, yet no budget funds are earmarked for those.

4.

a. Developing the national M&E plan?:
3
b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?:
4
c. Participate in using data for decision-making?:
3
Comments and examples:
Moldova’s M&E Plan was developed jointly by Government and civil society representatives during a MOH-led workshop, with foreign assistance and support, and NCC TWG on HIV/TB M&E. However, the use of M&E data for decision-making remains weak, despite some recent trends and national evaluations conducted in the context of JANS and NSA updates.

5. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, and faith-based organizations)?:
5
Comments and examples:
Extremely diverse (including, but not limited to, HIV service organizations, including harm reduction and needle/syringe exchange, UN agencies/programs, League of PLHIV, key population representatives – MSM, IDU, FSW), confessions etc.

6. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society able to access

a. Adequate financial support to implement its HIV activities?:
3
b. Adequate technical support to implement its HIV activities?:
4
Comments and examples:
There is access to financial support, however it has been limited to those areas that were included in the NAP and the NAP budget lines (mostly funded by donors – therefore, contingent on submitting project proposals; e.g., small grants projects intermediated through the Soros Foundation Moldova). Limited government funding available to civil society due to scarce budgets, lack of a financial cooperation mechanism and/or subcontracting mechanism for civil society organizations and

government funds.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

People living with HIV:
51-75%
Men who have sex with men:
>75%
People who inject drugs:
51-75%
Sex workers:
>75%
Transgendered people:
>75%
Testing and Counselling:
<25%
Reduction of Stigma and Discrimination:
51-75%
Clinical services (ART/OI)*:
<25%
Home-based care:
<25%
Programmes for OVC**:
25-50%

8. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to increase civil society participation in 2011?:
7
Since 2009, what have been key achievements in this area:
NAP 2006-2010 evaluated NAP 2011-2015 drafted, assessed (JANS) and updated (NSA-related) NCC expanded, with more civil society representatives included TWG diversified, with more civil society representatives included Capacity building in strategic planning, forecasting and estimates; Legal and regulatory framework improved (draft law pending adoption, discriminatory regulations abrogated)
What challenges remain in this area:
Relatively weak political commitments Scanty funds earmarked for this Poor formal cooperation / contracting between government and civil society Donor (finance) driven activities Not always focused and priority-based

B - II. POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?:
Yes
IF YES, describe some examples of when and how this has happened:
Although there is room for improvement, the Government has been collaborating with PLHIV and key population subgroups through the country’s formal mechanisms in place – NCC, TWG. The Ministry of Labor, Social Protection and Family, and the Ministry of Health involved these groups in setting up community-based social care centers, consisting of multidisciplinary teams providing comprehensive care. Various new financing mechanisms has been considered, including through the National Health Insurance Company, to cover some additional costs (e.g., outpatient care for ART and medical follow-up)

B - III. HUMAN RIGHTS

1.1.

People living with HIV:
Yes
Men who have sex with men:
No
Migrants/mobile populations:
No
Orphans and other vulnerable children:
Yes
People with disabilities:
Yes
People who inject drugs:
No
Prison inmates:
Yes
Sex workers:
No
Transgendered people:

No
Women and girls:
Yes
Young women/young men:
Yes
Other specific vulnerable subpopulations [write in]:
No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:
No
If YES to Question 1.1 or 1.2, briefly describe the contents of these laws:
As a first matter, the draft bill includes a ban on discrimination on grounds of disability. A second issue concerns the enforcement body. Although the current draft would provide it with the power to issue contravention sanctions, victims of discrimination would have to seek remedy before a court. As to the most electrifying, and potentially polarizing issue – protecting LGBT minorities from discrimination – here the Government and Parliament have a remarkable opportunity to provide leadership. Moldova has constitutional provisions banning discrimination, there is 2006 Gender Equality Law in force but ineffective, a draft comprehensive anti-discrimination Law is pending adoption and will likely be adopted in 2012.
Briefly explain what mechanisms are in place to ensure that these laws are implemented:
Even with the few laws that protect the rights of key populations, patients etc., the enforcement of those is weak. The draft comprehensive anti-discrimination Law envisions the establishment of an enforcement body.
Briefly comment on the degree to which they are currently implemented:
The Government approved a draft anti-discrimination bill in February 2011. The bill now goes to Parliament for adoption, appended to a plan to strengthen anti-discrimination policy and enforcement machinery on an ambitious timeframe. The draft bill agreed upon by the Government constitutes a good basis for work. However, the draft will also need to be improved somewhat, if it is to finally bring Moldovans an effective legal mechanism against discrimination. There is one single case of any court or other body identifying discrimination.
2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:
Yes

2.1. IF YES, for which sub-populations?
People living with HIV:
Yes
Men who have sex with men:
Yes
Migrants/mobile populations:
No
Orphans and other vulnerable children:
No
People with disabilities:
No
People who inject drugs:
No
Prison inmates:
No
Sex workers:
Yes
Transgendered people:
Yes
Women and girls:
No
Young women/young men:
No
Other specific vulnerable subpopulations [write in]:
No

Briefly describe the content of these laws, regulations or policies:
The exposure to or transmission of HIV is still prosecuted under the Criminal Code (approved by Law Nr. 985-XV dated 18.04.2002) with specific provisions under articles 211 and 212.
Briefly comment on how they pose barriers:
HIV transmission has been criminalized in an attempt by the government to respond to the rising numbers of HIV infections and prevent the deliberate contamination with HIV; yet, human rights campaigners and other NGOs have expressed concerns that these laws lead to a violation of the rights of people living with HIV, exacer¬bating their marginalization.
3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?:
Yes
Briefly describe the content of the policy, law or regulation and the populations included:
Law on Preventing and Combating Family Violence, Law Number 45-XVI of 1 March 2007. This law establishes the legal and organizational framework for preventing and combating family violence, the authorities and institutions responsible for preventing and combating family violence, and the mechanism for identifying and solving cases of violence. This law applies to: the

aggressor and the victim citizens of the Republic of Moldova and to foreign citizens and stateless persons who live in the Republic of Moldova.
4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?:
Yes
IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:
The regulatory framework, which prohibits discrimination against persons infected with / affected by HIV / AIDS or vulnerable to infection, has been developed and adapted in accordance with international standards, taking into account the principle of respect for human rights and dignity is the basis for the implementation of complex cross-sectoral activities of the National Programme. National Program for Prevention and Control of HIV / AIDS and sexually transmitted infections through the years of 2011-2015 is based on the principles of human rights. The program emphasizes the aspects of human rights and legal framework, which prohibits discrimination against people living with HIV
5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and/or other vulnerable sub-populations?:
Yes
IF YES, briefly describe this mechanism:
The Institute for Human Rights (IDOM) and their lawyers upheld the rights of PLHIV in court; MOH hot line; League of PLHIV inner mechanisms

6. Does the country have a policy or strategy of free services for the following?

Provided free-of-charge to all people in the country	Provided free-of-charge to some people in the country	Provided, but only at a cost
Provided free-of-charge to all people in the country: Yes	Provided free-of-charge to some people in the country: -	Provided, but only at a cost: -
Provided free-of-charge to all people in the country: -	Provided free-of-charge to some people in the country: Yes	Provided, but only at a cost: -
Provided free-of-charge to all people in the country: -	Provided free-of-charge to some people in the country: Yes	Provided, but only at a cost: -

If applicable, which populations have been identified as priority, and for which services?:
Key populations (MSM, IDU, FSW, inmates), more recently – migrants IDU – harm reduction, NSP, methadone VCT rooms (pervasive, with focus on pregnant women, risk groups) Blood safety – pervasive ART – pervasive (according to medical indications)
7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?:
Yes
7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?:
Yes
8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?:
Yes
IF YES, Briefly describe the content of this policy/strategy and the populations included:
The country is pursuing universal access to HIV treatment, care and support, including VCT, ART, OST etc., making allowance for the various needs of different groups and genders; However, with UNIFEM support, the development of a first national Law (Strategy) on Gender Equality and Enhancement of Women's Rights and Opportunities

8.1

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?:
Yes
IF YES, briefly explain the different types of approaches to ensure equal access for different populations:
The country developed a national multisectoral strategies to combat HIV Different approaches include innovative principles for the provision of services for different population groups (women and girls, young women / young men, IDUs, MSM, sex workers, orphans and other vulnerable children, HIV infected pregnant women in the prison system). Defined by the organization providing services and strategies are the roles and responsibilities of service providers and the resources they need. National Program for HIV Prevention and Control / AIDS, Law on HIV / AIDS, etc. ensure equitable access for different groups (IDUs, CSWs, MSM).

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?:
No

10. Does the country have the following human rights monitoring and enforcement mechanisms?

a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work:
Yes

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts:
No
IF YES on any of the above questions, describe some examples:
HR Institute (IDOM) Ombudsmen - the center for Human Rights UN Human Rights Adviser

11. In the last 2 years, have there been the following training and/or capacity-building activities

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?:
Yes
b. Programmes for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work?:
Yes

12. Are the following legal support services available in the country?

a. Legal aid systems for HIV casework:
Yes
b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV:
Yes

13. Are there programmes in place to reduce HIV-related stigma and discrimination?:
Yes

IF YES, what types of programmes?

Programmes for health care workers:
Yes
Programmes for the media:
Yes
Programmes in the work place:
Yes
Other [write in]:
for the employees of the school and preschool education, police, armed forces

14. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?:
6
Since 2009, what have been key achievements in this area:
Removal of a long-term stay in MDA for the PLHIV foreigners Mainstreaming HR in the new NAP Universal access to HIV prevention, treatment, care and support; Removal of obligatory HIV testing before marriage
What challenges remain in this area:
Law enforcement Discrimination and stigma Populations with special needs Social support
15. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?:
6
Since 2009, what have been key achievements in this area:
Fragmentary one-time / limited-scope efforts
What challenges remain in this area:
Poor mechanisms to enforce laws in general

B - IV. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?:
Yes
IF YES, how were these specific needs determined?:
Specific needs within HIV prevention programs identified through the program "Spectrum" and taken into account when developing strategies and programs for prevention.

1.1 To what extent has HIV prevention been implemented?

Blood safety:
Strongly Agree
Condom promotion:
Agree
Harm reduction for people who inject drugs:
Agree
HIV prevention for out-of-school young people:
Disagree
HIV prevention in the workplace:
Disagree
HIV testing and counseling:
Agree

IEC on risk reduction:
Agree
IEC on stigma and discrimination reduction:
Disagree
Prevention of mother-to-child transmission of HIV:
Strongly Agree
Prevention for people living with HIV:
Strongly Agree
Reproductive health services including sexually transmitted infections prevention and treatment:
Strongly Agree
Risk reduction for intimate partners of key populations:
Disagree
Risk reduction for men who have sex with men:
Disagree
Risk reduction for sex workers:
Agree
School-based HIV education for young people:
Agree
Universal precautions in health care settings:
Agree
Other [write in]:
treatment - strongly agree

2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?:
8
Since 2009, what have been key achievements in this area:
Scale up of VCT rooms countrywide and contracting by the NHIC; PMTCT; Harm Reduction programs, and OST with methadone; Awareness campaigns; Strategies focused on prevention in key populations
What challenges remain in this area:
Migrants are broadly overlooked and/or understudied

B - V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV and AIDS treatment, care and support services?:
Yes
IF YES, Briefly identify the elements and what has been prioritized:
-
Briefly identify how HIV treatment, care and support services are being scaled-up?:
Medical follow-up, including lab tests (PCR, CD4); Management of key opportunistic infections; ARV treatment, care and support; Incentives and enablers; Community-based support and peer-to-peer care; Free quality drug supply; Integration with other health care services (e.g., TB)

1.1. To what extent have the following HIV treatment, care and support services been implemented?

Antiretroviral therapy:
Strongly Agree
ART for TB patients:
Strongly Agree
Cotrimoxazole prophylaxis in people living with HIV:
Strongly Agree
Early infant diagnosis:
Agree
HIV care and support in the workplace (including alternative working arrangements):
Disagree
HIV testing and counselling for people with TB:
Strongly Agree
HIV treatment services in the workplace or treatment referral systems through the workplace:
Disagree
Nutritional care:
Agree
Paediatric AIDS treatment:
Agree
Post-delivery ART provision to women:
Agree
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):
Strongly Agree
Post-exposure prophylaxis for occupational exposures to HIV:
Strongly Agree

Psychosocial support for people living with HIV and their families:
Agree
Sexually transmitted infection management:
Strongly Agree
TB infection control in HIV treatment and care facilities:
Agree
TB preventive therapy for people living with HIV:
Disagree
TB screening for people living with HIV:
Agree
Treatment of common HIV-related infections:
Strongly Agree
Other [write in]:
Palliativ care - Agree

1.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?:
8
Since 2009, what have been key achievements in this area:
The most important achievements relate to ensuring access to HIV treatment, which in fact is 100% available to those who need and want it; to achievements in the decentralization of treatment services and HIV care throughout the country, as well as providing MST services; updating treatment protocols with WHO financial support; initiating the creation of infrastructure for testing viral resistance to ARV preparations; improving accessibility and quality of prophylactic ART for HIV pregnant women; opening a pediatric ward within the ARV treatment institution.
What challenges remain in this area:
Insufficient training, laboratory diagnostic and situation monitoring in the field of HIV/AIDS on the left bank of the Dniester River represent gaps that need special consideration.
2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?:
No
3. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?”:
-
Since 2009, what have been key achievements in this area:
None
What challenges remain in this area:
None
