ROMANIA

Country Progress Report on AIDS

Reporting period January 2010 – December 2011

Bucharest, 2012

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Abbreviations

ARAS	Romanian Association against AIDS, NGO
ARV	Antiretroviral Treatment
BSS	Behavioural Surveillance Survey
CDC	Center for Diseases Control
CRIS	Country Response Information System
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HBV/HCV	Hepatitis B/C
IDUs	Injecting Drug Users
IEC	Information Education Communication
ILO	International Labour Organization
KAP	Knowledge, Attitude and Practices
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MSM	Men having sex with men
NAD	(National Anti Drug Agency), GOV
NGO	Non-governmental Organization
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PR	Principal Recipient
PSI	Population Services International, NGO
RAA	Romanian Angel Appeal, NGO
TB	Tuberculosis
SCR	Save the Children Romania

STI	Sexually Transmitted Diseases
SWs	Sex Workers
UN	United Nations
UNICEF	United Nations Children's Fund
UNGASS	United Nations General Assembly on HIV/AIDS
UNODC	United Nations Office for Drug and Crime
UNOPA	National Union of PLHIV Association
VCT	Voluntary Counselling and Testing

I. Status at a glance

a) Inclusiveness of stakeholders in the report-writing process

The national report was developed through a transparent and inclusive process, in February-March 2012. The process was facilitated by National Institute for Infectious Diseases "Prof. Dr. Matei Bals" through the Compartment for Monitoring and Evaluation of HIV Data in Romania, Romanian HIV Center and UNICEF Romania, represented by the HIV Focal Point on international collaboration.

All stakeholders, both institutional and nongovernmental, active in the HIV/AIDS field in Romania, represented in the Country Coordination Mechanism – were invited to ensure input to the present report and most of them provided valuable data for it.

More in-depth input, review and suggestions were requested from the M&E group working Group on HIV/AIDS (group that includes representatives of Government, NGOs, UN Agencies, Academia and the PR of the GFTAM project currently implemented in Romania). The M&E working Group is facilitated by UNICEF office, which ensure UNAIDS presence in the country and includes relevant stakeholders with attributions and capacity of data collection in the area of HIV/AIDS. The group was developed as a technical working group in support of the M&E activities of the National HIV/AIDS Coordinating structure – the CCM. Members of the M&E group had 2 consecutive meetings in the period March 2012 dedicated to review the reporting format, the available data and solutions for collecting the data needed for reporting.

Also, in March, the Global AIDS tools were sent to all the relevant institutions (government, NGOs, international agencies) involved in the implementation and data collection for the National HIV/AIDS Programme (over 25 institutions).

The HIV Center team collected the information and prepared the first draft of the report, with the consistent support of M&E group members, UN agencies, experienced experts. This report was consolidated with all the comments and suggestions coming from the 11 institutions involved in the reporting process.

b) The status of the epidemic

The HIV/AIDS situation in Romania remains stable with no major changes neither in incidence in adults, or in children. The number of HIV cases among vulnerable groups have increased in 2011, especially IDUs (18% in 2011 *vs.* 3% in 2010) while the number of infections among the MSM group doubled, compared with 2009, namely from 8% to 14% in 2011.

The largest age group of people living with HIV/AIDS is formed of young people (20-24), over 7,000, who are in fact the children infected in the period 1987 – 1991, long term

survivors. Since the beginning of the Romanian epidemic, Government committed to ensure treatment and care for PLHIV. Over the past 2 years, treatment and care for PLHIV has continued to be ensured through the public health care settings for infectious diseases.

The infection monitoring and treatment recommendations, as well psycho-social services are organized in 9 regional centres. The ARV treatment has been constantly provided free of charge and is available for PLHIV, as well as the social support. The programs addressing social vulnerabilities of PLHIV implemented exclusively by NGOs (UNOPA) with funding from GFATM (June 2010) and European Structural Funds (2011) and focusing on the social integration, access to education and jobs of the young people living with HIV, are currently under funded. Efforts to reduce stigma and discrimination are still necessary, as PLHIV still face discrimination in accessing some medical services (especially specialized health care – eg. Gynecology and stomatology).

c) The policy and programmatic response

In 2011, Romania reiterated its commitment to ensure universal access to prevention, treatment and care for PLHIV and vulnerable groups by signing the Political Declaration on HIV 2011. In this respect. Romania's HIV/AIDS Strategy 2012-2016 is in process of approval. The document targets among others, priority areas for treatment and effective interventions, which are essential for a proper coordination of programmes for vulnerable groups and MARPS.

The antiretroviral therapy (ART) is one of the most important factors which contribute to the maintenance of a good health state of PLHIV. Moreover, the universal access to treatment is one of the objectives considered as reached in Romania, starting from the premises that any person needing treatment will get it. The evaluation performed by the World Health Organization and UNAIDS, which also considers the number of undiagnosed seropositive people, still suggests a coverage ratio of 81% in 2009 (WHO, 2010), which is considered to be a very high level compared to other countries from the same region (Petrescu, 2010).

During 2009 and especially during 2010, many nongovernmental organizations signalled interruptions in the antiretroviral therapy in various counties from the country (Press Releases UNOPA2 and ADV3). The data presented by the Compartment for Monitoring and Evaluation of HIV/AIDS Data within the Institute of Infectious Diseases "PhD. Matei Balş", also include cases of individuals who had interrupted their treatment. A research carried by Bucharest University and UNOPA, with support from UNICEF recorded that 65.2% of the participants in the research stated that there were such situations while only 34.8% claimed to have received their regular treatment. There were not any significant differences in concerning the access to treatment on demographic criteria (age, sex, ethnicity, education or occupation).

The same research report showed concerns in the area of treatment adherence, more than 40% of PLHIV from long term survivors' cohort interrupting treatment for a period of time. MoH response to treatment adherence problems will concretize at the end of 2011 in the revision of the treatment guidelines for PLHIV, revision which will lead to a better monitoring and evaluation of the resources allocated for national HIV programme.

Access to harm reduction programmes for groups vulnerable to HIV infection diminished, in 2011 more than half of the service providers closed their operations due to lack of funds and no future prospects for reopening the following period of time. Despite consistent advocacy efforts to MoH, no funds were allocated for prevention programmes for vulnerable groups, in the context of HIV increase among IDUs and MSMs.

In order to engage additional funds for continuity of the harm reduction interventions, NGOs active in the area of HIV advocated towards MoH and Bucharest municipality, but without concrete results so far. A new opportunity, that is already used to cover the financial gap in prevention and social support, is the existence of the EU Structural Funds for Romania that are approved for the period 2007 – 2013. Despite the fact that funds do not have an explicit public health component, their social focus has been used to address the social-health issues faced mostly by vulnerable populations and PLWHA.

The coordination and partnership of all national and international partners involved in the national response worked well, based on the *coordination mechanism* for the projects funded by the Global Fund (the role of the former National Multisectorial AIDS Commission was transferred to the CCM). In 2010, a new draft of National AIDS Strategy was developed in a large consultative process and submitted for approval to MoH and other resort ministries, but remained unapproved till the moment of the current report.

d) Indicator data in an overview table

Target 1 - Reduce sexual transmission of HIV by 50% by 2015	Indicator value	Resource
Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**	47.26% in 2011	Baseline Youth for Youth
Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months	No data available for 2010 No data available for 2011	
Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	No data available for 2010 No data available for 2011	
Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	No data available for 2010 No data available for 2011	
Percentage of young people aged 15-24 who are living with HIV **		

Percentage of sex-workers reached with HIV prevention programmes	No data available for 2010 No data available for 2011	
Percentage of female and male sex workers reporting the use of a condom with their most recent client	88.96% in 2010 No data available for 2011	BSS RAA 2010
Percentage of sex workers who received an HIV test in the last 12 months and who know their results	No data available for 2010 No data available for 2011	
Percentage of sex workers who are living with HIV	1% No data available for 2011	BSS RAA 2010
Percentage of men who have sex with men reached with HIV prevention programmes		
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	42.01% in 2010 No data available for 2011	EMIS, PSI 2010
Percentage of MSM who received an HIV test in the last 12 months and who know their results	41.57% in 2010 No data available for 2011	EMIS, PSI 2010

Percentage of men who have sex with men (MSM) who are living with HIV	5% in 2010 No data available for 2011	EMIS, PSI 2010
Percentage of health facilities that provide HIV testing and counselling services	0.48 in 2010 No data available for 2011	National Statistical Institute
Sexually Transmitted Infections (STIs)	No data available for 2010 No data available for 2011	
Percentage of sex workers with active syphilis	No data available for 2010 No data available for 2011	
Percentage of men who have sex with men (MSM) with active syphilis	No data available for 2010 No data available for 2011	
Percentage of migrants from countries with generalized HIV epidemics who had sex with more than one partner in the past 12 months who used a condom during their last sexual intercourse	Topic not relevant	
Percentage of migrants from countries with generalized HIV epidemics who received an HIV	Topic not relevant	

test in the last 12 months and who know their results		
Percentage of migrants who are HIV-infected	Topic not relevant	
Percentage of prisoners who are HIV-infected	0.16% in 2010 No data available for 2011	BSS UNODC 2011
Target 2 - Reduce transmission of HIV among people who inject drugs by 50% by 2015		
Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	48.87 in 2011	Estimations from Romanian Associations Against AIDS 2012
Percentage of people who use drugs who report the use of a condom at last time sexual intercourse	56.37 in 2010 No data available for 2011	UNODC BSS 2011
Percentage of people who use drugs who reported using sterile injecting equipment the last time they injected	15.58% in 2010	UNODC BSS 2011
Percentage of people who inject drugs who have received an HIV test in the last 12 months and know their results	100% in 2010 No data available for 2011	UNODC BSS 2011 (testing for HIV, HCV and HVB was part of the BSS routine)
Percentage of injecting drug users (IDUs) who are HIV-infected	1.04 in 2010	UNODC BSS

		2011
Percentage of opioid-dependent people on opioid substitution therapy (OST)	2163 in 2010 No data available for 2011	National Antidrug Agency report 2011
Number of needle and syringe programme (NSP) and opioid substitution therapy (OST) sites	7 NSP in 2010 2 NSP in 2011 7 OST in 2010 10 OST in 2011	UNODC evaluation report 2011 M&E group
Target 3 - Eliminate mother to child transmission of HIV by 2015		
Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission	87.91% in 2011	National AIDS Commission
Percentage of infants born to HIV-infected women receiving a virological test for HIV within 2 months of birth		
Mother-to-child transmission of HIV (modeled)		
Percentage of pregnant women who were tested for HIV and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status		
Percentage of infants born to HIV-infected women (HIV-exposed infants) receiving antiretroviral prophylaxis to reduce the risk for mother-to-child transmission		
Distribution of feeding practices (exclusive breastfeeding, replacement feeding, mixed	No data available	

feeding/other) for infants born to HIV-infected women at DPT3 visit		
Pregnant women who inject drugs	No data available	
Percentage of HIV positive pregnant women who were injecting drug users (IDUs)		
Percentage of HIV positive pregnant IDU women who received OST during pregnancy		
Percentage of HIV positive pregnant IDU women who received ARVs to reduce the risk of mother-to-child transmission during pregnancy		
Target 4 - 80% of people eligible for treatment will be receiving it, including 100% of diagnosed people living with HIV with CD4 counts <350 per mm3		
Percentage of eligible adults and children currently receiving antiretroviral therapy *(ART coverage of all PLHIV eligible for ART (CD4 count <350 per mm3)*	99.54% in 2011	National AIDS Commission
ART coverage of diagnosed cases eligible for ART (CD4 count <350 per mm3)		
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	No data available	
Percentage of injecting drug users with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	No data available	
Percentage of adults and children with HIV known to be on treatment 60 months after initiation of antiretroviral therapy	No data available	
Percentage of injecting drug users with HIV known to be on treatment 60 months after initiation of antiretroviral therapy	No data available	
Percentage of health facilities dispensing ARVs which have experienced a stock-out of at least one required ARV in the last 12 months		

Percentage of people with HIV infection who already need antiretroviral therapy at the time of diagnosis		
Target 5 - Reduce tuberculosis deaths in people living with HIV by 50% by 2015		
Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV		
Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	26.22% in 2011	National AIDS Commission
Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit		
Target 6 - Domestic HIV funding will be enhanced and oriented towards cost-effective priority interventions		
National AIDS spending (NASA)		
Target 7 - Critical enablers and synergies with development sectors		
National Commitments and Policy Instrument (NCPI)		
ECDC additional NCPI		
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	No data available	
Number of adults and children with HIV enrolled in HIV care	9428 cases in 2011	National AIDS Commission
Percentage of adults and children enrolled in HIV care who were screened for hepatitis C		

II. Overview of the AIDS epidemic

Romania is one of the few countries in Central and South-Eastern Europe with a significant number of people affected by HIV/AIDS. According to the National Report of the HIV/AIDS Monitoring and Evaluation Department in Romania, at the end of 2011, a cumulative total of 17.435 cases of HIV and AIDS infection had been recorded, while 10,903 persons were living with HIV/AIDS at the end of 2011.

The majority of the cases were diagnosed at the age when they were children (<14). At the present moment, the majority of people living with HIV in Romania are adults (the 20-24 years being the most prominent group) and a relatively low number of children are affected .

The incidence of HIV/AIDS (the number of cases discovered annually in relation to the population) has been stable from 2004.

Year	2009	2011
No. of new cases of HIV /AIDS diagnosed	428	619

For HIV/AIDS prevalence/incidence trends please see the table bellow1:

	2010	2011
AIDS prevalence (per 100.000)	56.03	58.39
AIDS incidence among children (per 100.000)	0.23	0.30
AIDS incidence among adults (per 100.000)	1.05	1.35
HIV prevalence (per 100.000)	21.49	23.26
HIV incidence among adults (per 100.000)	1.24	1.93

[1] Data provided by the M&E department of the National AIDS Commission

Almost 30% of the newly discovered HIV/AIDS cases discovered in 2011 are among persons aged 15 to 24 and > 35% are “late presenters”. Among adults, sexual transmission is prevalent, more than 60% of the newly discovered HIV/AIDS cases. The transmission associated with drugs consumption of the newly identified HIV cases increased from 0.8% in 2007 to 18.4% in 2011 and the number of HIV cases among MSMs population doubled from 7.5% in 2008 to 14% in 2011. Among children, the vertical transmission is responsible for 16 new cases of HIV/AIDS in 2011[2].

In conclusion, the sexual transmission of HIV continues to lead the epidemic among adults, followed by HIV transmission among injecting drug users and men having sex with men.

III. National response to the AIDS epidemic

Since 2002, Romania has a special law (Law no. 584/2002) regarding the HIV/AIDS prevention and main protection measures for PLHIV. Other legal provisions guarantee access to health care, education, workplace, but the existing legal provision still lacks institutionalised enforcement, situation which still allows for discrimination which affects mostly, people living with HIV and other vulnerable people.

In the reporting period, the National Response to HIV/AIDS consisted in coordinated:

a) program of treatment and care for the people living with HIV ensured by the public health sector, under the leading authority of National AIDS Commission of the Ministry of Health, and funded by the national Health Insurance House,

b) prevention programs targeting population segments including pregnant women, young people, populations at risk and

c) social support and integration program for PLWA.

The HIV/AIDS evaluation is assured by 41 Infectious Diseases Hospitals from 41 counties, day clinics, University Clinics within the nine centers of surveillance, the National Institute for Infectious Diseases “Matei Bals” from Bucharest. ARV treatment costs are covered from the National Program funds, being provided free of charge.

a) Program of treatment and care for the people living with HIV

A programme providing universal access to HIV/AIDS treatment and care was introduced in Romania in 2001. The programme was considered a model in the region and was based on

[2] Data provided by the M&E Department of the National AIDS Commission

the political commitment and partnership between public authorities, pharmaceutical companies, patients and other International Agencies. The number of patients benefiting from top quality antiretroviral treatment increased from 3500 in 2001 to almost 7536 at the end of 2011. This was made possible by increasing the budgetary allocations on one hand and on the other hand through negotiated partnerships with pharmaceutical companies, which committed to providing significant price reductions and donations.

The ARV treatment programme in Romania deploys based on norms approved by Ministry of Health, under the technical coordination of National Institute for Infectious Diseases 'Prof. Dr. Matei Bals" in Bucharest. Currently, Romania holds the largest number of long term survivors, in the age group 20-24 years, who belong to the 1987-1990 cohort. The average survival period for this segment grew progressively, from 3 months at the beginning of the 1990s to 82 months at the end of 2010.

This achievement was reached by a sustained effort to introduce specific ART, in conformity with International Guidelines, but tailored to the epidemiological particularity of the country. The latest ART Guideline has been recently launched for 2011-2012 period. This document targets newly diagnosed patients, eligible for treatment in European context and, especially, therapeutic schemes designed for a big number of multi experienced patients in treatment for over 10 years.

Specific ARV treatment was introduced in 1996-1997, which led to a long survival period for patients but also to an accumulation of a large number of therapeutic schemes, determined by viral resistance to ART. Thus, 34% of patients in treatment received at least 4 ARV plans (4-16 schemes), that resulted in a progressive increase of costs.

The treatment programme worked well while it was procured through centralized means as it allowed for effective price control and distribution, as well as proper patient monitoring. The first issues occurred in early 2008, just before the economic crisis, when the Ministry of Health decided to decentralize antiretroviral drug (ARV) procurement to county level. The rather hasty decision was taken despite strong opposition of experts, patient associations and UN specialized agencies. The decentralization of procurement led to a 20% increase in treatment programme costs in 2008, compared with 2007, and subsequently led to significant distribution problems.

In 2009, UNAIDS facilitated a meeting of all the partners involved with, the newly established government in order to decide on measures to avoid a further deepening of the crisis in the treatment programme. Following the meeting, the Ministry of Health agreed that the HIV/AIDS treatment programme would remain a priority and that it would resume centralized procurement as means to reduce costs.

At the initiative of UNICEF and with support from UNOPA and Faculty of Sociology and Social Assistance, treatment interruptions and causes for this unprecedented situation were documented. According to a quantitative research, representative at national level in 2010, more than 65% of PLHIV interrupted treatment due to deficiency in ensuring the flow of medicines at hospital level. Same research indicated problems in the area of treatment adherence for PLHIV from long term survivors' cohort, indicating that more than 40% of PLHIV interrupted treatment due to the fatigue in administrating the therapy.

In response to ART shortages in some counties, the Ministry of Health took emergency measures to redistribute available funding to those suffering severe shortages. Official reports claimed that existing funding would cover this need only until the end of the year 2009. Similarly, it is expected that a budgetary reallocation will supplement funding which would prevent counties with insufficient funding further sending patients to medical units where drugs are available.

Pharmaceutical companies are contributing by donating stocks. The national centralized procurement process was supposed to start again from 2010 onwards and contracts were expected to be signed by the end of 2009 and to be valid until 2012. Unfortunately, the centralized procurement process was delayed and other issues arose as a consequence of the financial crisis.

A preliminary analysis found[3] that the main reasons for the current situation are: the economic recession and the poor planning and disinvestment in the drug procurement process. The system of decentralization, where each hospital procures their own ARVs using funds advanced by the Ministry of Health, seems to play a role in this. Several hospitals did not have enough financial resources allocated nor did they have a well-developed tender process, which led to shortages of ARVs.

Starting with 2001, Romania developed **a Plan for Universal access to Treatment and Care.** As a result the number of PLHIV receiving ARV treatment grew each year, universal free access continuing to be ensured through national budget fund allocation **(56.115.171 USD/2010 and 66.462.500 USD/2011).**

Year	2010	2011
No of PLHIV receiving ARV treatment	7,276	7,536

Research[4] shows that 40% long term patients enrolled in ARV treatment gave it up, for various reasons (burn out, unbearable secondary effects or because they feel healthy). In 2011, 605 of the people in treatment with ARV gave it up (and others were enrolled, among newly diagnosed who needed it).

b) Prevention programs targeting population segments including pregnant women, young people, and populations at risk

[3] UNICEF 2011 Report on access to HIV/AIDS treatment including recommendations for strengthening the national HIV/AIDS treatment programme

[4] UNICEF report; Access to treatment, care and prevention, 2011

Even though the government did not endorse the National HIV Strategy, the active actors in the area of HIV, mainly HIV/AIDS National Commission and NGOs were guided by it.

The main objective of this strategy was to maintain the HIV incidence for 2015 at the level registered in 2010 while ensuring the universal access to treatment, care and social services for infected and affected people.

The target groups stipulated in this document are: young people, IDUs, female SWs, MSM, inmates, children living on the street/in institutions, pregnant women, PLHIV and Roma communities. The strategy was developed in consultation with all the stakeholders (GOV, NGOs, private companies, bilateral and multilateral development partners).

The National Multisectoral HIV/AIDS Commission over viewing the implementation of the National HIV/AIDS strategy was transferred during 2007 from the Government Secretariat to the MoH, due to government restructuring and had its roles further transferred to the CCM , which is not a legally organised entity, but is fully structured and organised, its secretariat being ensured by the Romanian HIV Center. The CCM is chaired by the representative of the Ministry of Health and co-chaired by the representative of the large Network of People Living with HIV – UNOPA. It includes all governmental authorities with specific roles in the implementation of the strategy (among which Ministry of Health, Ministry of Education, Ministry of Labour, Ministry of Interior), as well as civil society, representatives of the people affected by HIV and TB, academic field, UN agencies, pharmaceutical firms .

Funding prevention interventions for vulnerable populations is not ensured after the closure of GFATM projects in mid-2010. Government at national and local level, despite repeated commitments has not yet identified the resources and the adequate mechanisms to ensure sustainable adequate funding. NGOs despite their proven capacity and results are still not benefiting of subcontracts from public funds for public health interventions.

Prevention programs such as prevention of transmission among young people, PMTCT, uniformed services and prisoners developed or extended in the framework of the GFATM Round 2 programme (2004-2008), which significant scaled up and became national, restrained dramatically, after the end of the projects, in December 2008. The concern about the sustainability of these programs which were supposed to be overtaken by the different ministries, turned into a reality: adequate funding, and continuous training of personnel were diminished.

Other interventions, like prevention among vulnerable groups and rroma population developed in the framework of the GFATM Round 6 program (2007-2010) and of UNODC 5 year program, diminished in 2010 and especially 2011 due to lack of funding. For instance, the programme concerning prevention of HIV infection among Roma young people, ran by Save the Children Romania, during the first 8 months in 2010 covered more than 4400 persons in 3 counties of Romania, but the need is much higher. At the end of 2011, less than 30 % of the population of drug users in Bucharest had access to needle exchange services (including needle and syringe exchange) and less than 10% to substitution treatment. Services for drug users are limited and hardly accessible; even if another new substitution centre (an NGO) opened a OST center in 2011.

Even if HR services are mentioned as components of the draft *National AIDS Strategy 2012-2016* (and in the previous National AIDS Strategy 2004-2007), described as services for

IDUs in a Governmental Decision initiated by NAD and recommended by a sociological Report drawn by a Presidential Commission (presented in September 2009), HR services remained acutely debated and disputed in the political as in the mass media. Despite advocacy efforts, neither MOH nor any of the municipalities of Bucharest did undertake any support for the needle exchange projects. Needle exchange programmes sustained through GFATM and other UN agencies (UNICEF and UNODC) diminished in 2011 at the level of 2 NGOs from 7 in 2010.

HIV prevention is part of the Health Education curricula taught in the Romanian schools for all classes/grades. It is promoted as optional course at all levels of the mandatory education (starting with primary school and ending with high school – 12 grades), specific training programmes being developed for teachers. Currently, no data are available regarding the coverage of HIV prevention programmes in schools. In fact, some of them are only formal and generally not implemented in schools.

HIV prevention programs targeting young people remained almost entirely focused on schools. Campaigns targeting young people outside school settings or the general population in 2010 and 2011 were mostly at regional scale (e.g. events organised around WAD – December the 1st). Yet, a 2 years HIV education project targeting young people in school and outside school settings, developed by a consortium consisting of NGOs, a health specialised publicity firm and a public Institution (YfY, ARAS, ARPS, UNOPA, ADV Romania and CNCD) reached 13000 young people through a structured program. The project was a peer based intervention, but targeted also teachers (840) with a training program. The project focused on HIV prevention, as well as on but also stigma and discrimination prevention. (Funding: EEA Grants.) At their turn, volunteers of Save the Children developed programmes of education for health, including prevention of HIV infection, in schools in 12 counties and Bucharest, reaching thousands children and adolescents.

Following the 1987-1991 nosocomial transmission, blood safety is a priority for the health system. The data provided by the National Transfusion Haematology Institute indicates that all blood donors (398,993 in 2011) were screened for HIV both through standard internal screening procedures and external quality schemes (BioDev).

PMTCT - HIV testing is included at national level in the antenatal health services package (free of charge, recommended by general practitioners. A network of 18 centers which were organised by RAA foundation in the framework of GFATM projects funded in round II were included in the District Health Authorities structures at the end of 2006. At the end of 2009, 4 of them (two in the country and two in the capital city Bucharest) were closed and other problems were revealed by monitoring and evaluation activities: delays of procurement of Elisa testing kits, the decrease of outreach activities for VCT and PMTCT in the counties, the loss of trained human resource (counsellor and nurses), given lack of perspectives. It is not clear the statute of these VCT centres in the context of health care reform.

About 120.804 HIV tests were performed to pregnant women, out of which 95 tests were HIV positive.

VCT services are available in each district of Romania (MoH centers in each district capital city). The national program for communicable diseases covers for the substances used for VCT and PMTCT programs.

MoH registers only the number of HIV tests performed and the population based surveys did not include questions regarding HIV testing as it (last ones conducted in 2004/2006) resulted in lack of data.

The total number of HIV tests performed in the general population ("by request", at the VCT centers) were: in 2010 – 117345 (out of which 918 were positive) and in 2011 - 118243 HIV tests (out of which 1190 were positive).

No investigation was made regarding higher risk sex and condom use during higher-risk sex among general population. These indicators was supposed be included in the Reproductive Health survey 2009, which, unfortunately was not implemented.

HIV prevention services provided during reporting period to female sex workers were implemented mainly by a civil society organization – ARAS, with funding from European Structural Funds and included STI/HIV transmission prevention, IEC and counselling, primary medical care assistance, referrals to social and medical services. In Bucharest, where about 1/3 of the SWs also inject drugs, needle exchange was provided as a component of the service package. Rapid testing for HIV, HBV and HCV was available in outreach services, as well as two medical-social centers opened for persons at risk and disadvantaged (capital city Bucharest). The testing methodology is based on UNAIDS, WHO, CDC Atlanta. Programme monitoring data indicates that 2540 SWs were targeted in 2010 and 2400 in 2011.

The coverage of OST is still low both in community (9%) and in prison settings (difficult to measure since no data is available on the number of IDU in prison settings.). As for the NSPs, the coverage in the community is up to 50% but this means that also half of the target group is still not reached. Bucharest's city belt, Ilfov County, is not reached at all by either OST or NSP and other HIV prevention services, and given that in this area many IDUs live, steps have to be taken to reach this group.

New trends of injecting legal highs may change or even increase risk behaviour among (new) injecting populations. The recently conducted 2nd BSS shows that due to the current trend of injecting legal highs, the number of people that shares needles has grown. This needle sharing practice, also among IDU not in services, may be the result of continuous lack of access to NSPs (limited in number) and an acute lack of urgency to use clean needles since HIV-infections among this group is still low.

Finally, as for prisons, the coverage of both OST and NSP are still very low but this is not due to lack of capacity, but is linked to a general fear among inmates to make use of these services.

Needle exchange services for IDUs were provided in outreach (by 7 civil society organizations in 2010 and 2, in 2011) and drop-in centers (from 4 centers in 2009 to 2 centers in 2011, Bucharest) (information, sterile syringes and health materials, testing for HBV/HCV and HIV, medical and psychological assistance on site and referral to specialized services). Programme monitoring data indicates that approximately 5667 IDUs were targeted in 2010 with needle exchange and 4832 in 2011. Secondary exchange conducts to even bigger cover sample. Secondary exchange conducts to even bigger cover sample. The

number of syringes distributed varies from 946,820 in 2010 to 900 000 syringes in 2011 (National Antidrug Agency report). 38% of drug users access substitution treatment services in 2010[5]. The HR services are not covering the needs of the IDUs population in Bucharest, in the context in which clean injecting equipment is seldom accessible through pharmacies.

In 2008, the national Administration of the Penitentiaries initiated a pilot substitution center for drug users inmates at Rahova hospital – penitentiary, as well as needle exchange projects at Jilava and Rahova Penitentiaries. The projects were developed with technical and financial support from UNODC.

Prevention activities targeting MSM were developed by civil society organisations through outreach activities in 10 cities and special campaigns and events in MSM clubs and bars. With the support of international funding agencies (GFATM, in round II and VI), the activities included information, education, communication on STIs and risky behaviours, condom free distribution, counselling, medical referrals and psychological assistance. Also, internet/virtual outreach, a network of peer educators trained and a special MSM helpline info service offered a larger coverage of the need for information, counselling and referrals among MSM.

IDU's[6]

IDU population are mainly from Bucharest and Ilfov county, 62% aged 18 to 29. ¾ of IDUs are men. For most of IDUs, 77% of used drugs in the last 30 days were heroin and psychoactive substances. 15% initiated drug use when they were aged 8 to 14 years; 46% at 15 to 19 years old. 65% of the sample size has HIV, HCV and HVB risk behaviours since they shared syringes at the last injection.

In respect to HIV infection, 1% of the sample size was positive to HIV, while a large percentage of IDUs (88%) was positive to HCV and only 3% tested positive for HVB.

Although there aren't significant changes compared with 2009, in respect to gender and age aspect, the 2010 study is showing changes in types of drugs used and in patterns of HIV risk behaviours. In 2009 the main drug used was heroin, while in 2010, 77% declared multiuse of heroin and amphetamines which determined changes in injecting patterns and increasing with 45% the number of injections.

Female sex workers

No data are available regarding the number of female sex workers in Romania. Available data (2009[7]) suggest that the FSW population's average age is 27.5 The percentage of FSW who respond correctly to the UNGASS indicator for comprehensive information about HIV/AIDS is of only 11%. In regard to the use of the condom, FSW have had different

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[5] UNODC, HIV and hepatitis C and B prevalence among IDUs in Bucharest and Ilfov, 2010

[6] UNODC, HIV and hepatitis C and B prevalence among IDUs in Bucharest and Ilfov, 2010

[7] Romanian Angel Appeal Foundation (2009). The prevalence of HIV, HBV and HCV and risk behaviour in their transmission among female sex workers in Bucharest and Ilfov. [From Romanian:Prevalenţa virusurilor HIV, VHB şi VHC şi a comportamentelor cu risc de transmitere a acestora în rândul femeilor care practică sexul comercial în Bucureşti şi în judeţul Ilfov.] Unpublished report.

behaviours, according to the partner and the type of sexual intercourse. Almost all FSW (99%) declared to having used the condom with the last client they had; the percentage dropped to 34% when discussing about occasional partners or even to 15% in the case of steady partners. Overall, 50% of FSW used a condom during the last sexual intercourse, regardless of the partner. The probability of a FSW to have used the condom for the last 10 oral sexual intercourses is relatively smaller than in the cases of other types of sexual intercourse (vaginal or anal). Over 60% of all FSW who have a steady partner have never used condoms for the last 10 sexual intercourses with the above mentioned (regardless of the type of sexual intercourse). 38% of FSW in Bucharest can be included in the category of constant injection drug users; the use of injecting drugs is more spread among women who have been institutionalised at a certain moment in their past. Risky injecting practices have been reported by approximately 60% of FSW who use injection drugs. The access to services for the prevention of HIV (providing free condoms, sterile injecting equipment, HIV tests) is possible for a large number of FSW but it does not guarantee that these women have interrupted any risk practices in the HIV transmission. Thus, the rates showing the proportions in which a condom is used have to be collated with the percentage of FSW who have access to free condoms, which is of 89% as stated by the female individuals interviewed. A similar inconsistency between access an actual use can be met in the case of sterile injecting equipment: 63% of FSW who received sterile syringes or needles used at least one component of the medical equipment together with another person, while the common use is of only 32% in the case of women who declared never having had access to free medical equipment. As far as the HIV testing is concerned, half of respondents declared to have never been tested. The following prevalence of HIV, HBV and HCV has been recorded among the FSW population in Bucharest: 1% HIV, 4% HBV and 31% HCV (the association between the HCV infection and the use of injecting drugs being significant).

c) Care and social support for PLHIV

The social support for the people living with HIV is provided by the Ministry of Labour and Social Solidarity - through its local entities, as well as through local institutions responsible for social assistance and child protection (county level).

Over the last 2 years Romanian authorities maintained the focus and commitment to provide universal access to treatment, care and social support for people living with HIV/AIDS. The country provides treatment to all the people living with HIV who need it, according to the National HIV Treatment Protocol. Yet, in 2010 and 2011, some procurement problems determined stock out situations.

Social support for PLWHA is foreseen by both Law 584/2002 and Law 448/2006 (regarding the protection of disabled persons). While the nutritional allowance stipulated by law 584 is provided to every PLHIV who requests it, the other social support forms are linked with the recognition of HIV/AIDS as a disability that entitles the person having a disability certificate, to benefit of economic subsidies (double subsidy for HIV+ children, allowance for the people who never worked, a salary for a personal assistant, as well as other facilities as tax exemption, free transportation for a limited number of trips, etc). The access to rights is an

area which has lately recorded significant progress. Thus, more than half of subjects have a personal care attendant or they have chosen the disability allowance instead of the social worker, which means they have a certificate of advanced degree of disability. Other accessed rights may also include: meal allowance, disability allowance, free travel tickets, complementary budget, housing or income tax exemption.[8]

The fear of stigma and discrimination, as well as the lack of information are limited as far the number of PLHIV that accessed such benefits to about xxx of the eligible ones.

The access of PLHIV to all forms of education is guaranteed by law and the discrimination in schools is an exceptional situation. The perception of HIV/AIDS infected individuals towards access to education or a job reveals that most subjects (62.3%) have a positive perception regarding the education and employment opportunities[9].

The professional integration and vocational training/education of YPLHIV aiming to increase PLHIV social integration and autonomy were, in 2010 and 2011 the focus of NGOs interventions funded by the European Structural funds, which ended in 2011 and without coverage starting with end of 2011. According to UNICEF 2011 study, 58.9% of PLHIV are unemployed, while only 9.3% have a job and 25.1% are pupils or university students. Respondents' lack of working place is probably influenced by the disability degree certificate.

Psycho-social support services are available at national level, public and private providers still having different quality standards. The network of the 18 Day Care Clinics managed currently by the MoH remains the most important service provider beside the social assistance departments of the city halls. 79% of PLHIV believe that their access to psychological and social services was almost unlimited or little limited[10]. At the same time, there is a record of positive answers linked to the access to the support group or the chance to discuss with other seropositive individuals (over 80%).

Confidentiality is stipulated in all cases and any infringement may be punished, but cases of complaint are very few.

The National Council for Combating Discrimination, the Ombudsmen as well as different NGOs may provide legal advice for PLHIV who want to defend their rights.

IV. Best practices

The Romanian medical monitoring and treatment for the people living with HIV system including treatment protocols is a well-known model of practice in the region. The outreach

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[8] UNICEF research, Access to treatment, 2011

[9] UNICEF research, Access to treatment, 2011

[10] UNICEF research, Access to treatment, 2011

interventions among vulnerable people are also recognized as best practice models, recommended by GFATM to various country teams implementing GF projects.

There is also a valuable know-how in providing training in risk reduction training, psycho-social support for PLHIV, monitoring and evaluation.

The establishment of the Romanian HIV/AIDS Centre as a technical facility for improving and strengthening the national response represents an entry point for all the UN assistance and will expand to be a technical facility for the benefit of other countries in SE Europe.

V. Major challenges and remedial actions

The key challenges are the maintenance, if not better, the strengthening of the national coordination mechanisms, the mobilization of national public funds for interventions targeting IDUs and MSMs and strengthening the political commitment for HIV/AIDS which diminished due to the remission of other major social and health issues during the economic crisis.

This is a major obstacle in developing and implementing large scale sustainable prevention and access to services programmes.

It is also essential to develop and implement a monitoring and evaluation system to measure the national AIDS strategy implementation, a system which would be mostly effective if it would be assumed by national institutions. The national effort to develop a well-based strategic document to cover the period 2012 – 2016 accompanied by annual work plans , budgets and future implemented activities is a key priority.

Mobilization of national public funds for prevention programmes, including interventions targeting IDUs and MSMs remains a key target for the following period of time.

Research and interventions for vulnerable groups and for the large group of adolescents and young people living with HIV/AIDS have to continue. Young adults living with HIV/AIDS need special programmes and special tailored support for increasing treatment adherence, adequate social integration that will guarantee that they will not be the origin of a new epidemic wave.

The issue of stigma and discrimination continues to be a high priority. The successful partnership established during the national HIV/AIDS Anti-discrimination campaign also needs to be maintained.

Mainstream youth should be constantly addressed regarding STIs and HIV/AIDS prevention, especially in the context of broader reproductive health and developing life skills and abilities. Thus, lobby to sensitize the decision makers to develop and apply effective and structured national strategies, is to be strategically planned and implemented.

VI. Support from the country's development partners

UN technical and financial support in the field of HIV diminished and concentrated around:

- Leveraging of funds from other donors, as the European Union, succeeded in 2011 to offer technical assistance for an NGO developing interventions in the area of harm reduction interventions and ensured continuity of HIV response in this area.
- Advocacy for mobilization of resources for HR interventions at the level of MoH;

V. Monitoring and evaluation environment

The main official M&E tool in the country is the Compartment for Monitoring and Evaluation of HIV/AIDS data in Romania (MOH), which is confined to National Institute for Infectious Diseases "Prof. Dr. Matei Bals" in Bucharest, Coordinator of the National HIV Programme. The national reporting system has as nexus this department which receives epidemiological and social HIV/AIDS data from the nine Regional Centres in the country (2 in Bucharest INBI Matei Bals and V. Babes Hospital and the other 7 in: Brasov, Cluj, Constanta, Craiova, Iasi, Targu Mures, Timisoara) and which further introduces the information and maintains the National HIV/AIDS Data Base.

NIID "Matei Bals" in Bucharest institute is also responsible with the coordination of the HIV/AIDS Commission of Experts and Romanian HIV Centre. The latter was established as a partnership between UN agencies (UNAIDS, UNDP), Ministry of Health and the institute, and is currently under the management of Matei Bals Institute. The centre is a link between various actors in the HIV/AIDS field, from Ministries with relevant activity and contribution to HIV to NGOs and has served as the Secretariat of the Romanian Country Coordination Mechanism for the HIV/AIDS and Tuberculosis Programs funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria throughout Round 6.

Next period challenges are related to the development of the estimations for the most at risk groups (CSWs, IDUs and MSM) at national level, as well as introducing sero - prevalence surveillance among these groups in the context of insufficient funds for HIV national programme.

The GFATM programme and the UNODC technical support increased M&E capacity of both governmental and non-governmental implementers and this advantage should be leveraged by providing M&E training to all interested stakeholders in order to set the base for a coherent data collection system and allow disaggregation of indicators on age groups.

Data collection methodology still needs to be harmonized in order to ensure cross-project/programs/providers comparison, while other programmatic choices such as definition of a minimum package of services are to be made in the next period of time.

M&E technical assistance needs are linked to the development of BSS methodologies and seroprevalence surveys and most vulnerable populations' estimation, as well as for NASA implementation.

Capacity building interventions for the following period should focus on increasing M&E capacity at the level of a large number of implementers, development of specific guidelines for national indicators and dissemination of such guidelines. Data collection and data quality control systems at all levels (national and sub-national) should also be elaborated.

Lists of institutions participating at Global AIDS Reporting:

1. National Institute for Infectious Diseases Dr. Matei Bals
2. Romanian HIV Center
3. National Antidrug Agency
4. National Administration of Penitentiaries
5. Population Services International
6. Romanian Association Against AIDS
7. Close to you Foundation
8. National Union of PLHIV Association
9. Romanian Harm Reduction Network
10. Save the Children Romania
11. Romanian Angel Appeal
12. UNICEF Romania