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2008-2009



Republic of Moldova
South-East European Region



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

National Coordination Council

Republic of Moldova Progress Report

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Consiliul național de coordonare al programelor naționale de profilaxie și control al infecției HIV/SIDA, infecțiilor cu transmitere sexuală și de control al tuberculozei

Country Coordination Mechanism of the National Tuberculosis and National HIV/AIDS/STI Control Programmes

01-9/614 of 31.03.2010

Dear Sir/Madame,

We are pleased to introduce the fourth UNGASS 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 UNGASS Declaration of Commitment, endorsed in 2001, but also to ensure that the interventions set out to reach the commitments are successful, constructive and accountable. The UNGASS Declaration of Commitment and the reporting process has 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 and UNGASS, 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.

We are strong in our intention to support further UNGASS 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**

Vladimir HOTINEANU

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- 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 Diseases Hospital „Toma Ciorba”
- Republican Narcology Dispensary
- AIDS Center, Tiraspol, Transdniestrian region
- League of PLWH
- Soros Foundation-Moldova
- UNAIDS Moldova
- WHO Moldova
- UNICEF Moldova
- UNFPA Moldova

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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
GTZ	German Agency for Technical Cooperation
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
RNA	Ribonucleic acid
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.

Due to multisectoral character of the national HIV response and scaling up of the activities to other sectors than health, data originate from numerous governmental and non-governmental entities. The quality of data varies from organization to organization and there is a need for assistance and insistence to apply methods standardized and adjusted to national and international best practices for the data collection, analysis and interpretation.

By aligning the country processes to the “Three Ones” principle, in 2004, the Republic of Moldova has launched the implementation of a one single M&E system for the national HIV response. This report is the result of an intersectoral collaboration between public organizations, NGOs, international agencies and donors involved in the national HIV response. Saying that the Republic of Moldova has a united consolidated M&E system that satisfies all the key information needs is premature. The registered progress increases expectations that in the near future, relevant strategic information shall be available and accessible and will inform the decision-making process in the national response to HIV.

The development of the report has been coordinated and supervised by the department of Monitoring and Evaluation of National Health Programmes (M&E Unit) established in 2004 within the National Centre of Health Management of the Ministry of Health. Representatives of governmental institutions and non-governmental 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 UNGASS reporting. The values of the indicators detailed below have been discussed and agreed upon in the framework of workshops aimed at development of the National Program for the Prevention and Control of HIV/AIDS and STIs for the years 2011-2015. Consensus has been achieved through a 2 day participatory workshop of counterparts at technical and decision-making levels, and validation of the UNGASS has occurred at a meeting with decision makers from various relevant sectors. A detailed description of the process can be found in the Report development and consultations process.

The HIV epidemic in the Republic of Moldova is a concentrated one. The results of the last HIV seroprevalence survey among IDUs carried out in 2009 have shown an HIV prevalence of 16.4% (RDSAT adjusted). The HIV seroprevalence registered in 2009, when compared to results from previous HIV prevalence surveys in the same locations, attests a stable trend in IDUs from the capital city and from other two locations where the study was carried out in 2009¹. In the last 3 years, the number of newly registered HIV cases among the tested IDUs (Ministerul Sanatatii al Republicii Moldova 2007b) is decreasing. The HIV seroprevalence survey carried out in 2009 in the capital city in CSWs registers a seroprevalence of 6.1% (RDSAT adjusted), variations in HIV prevalence between previous data points being statistically insignificant². The last HIV seroprevalence survey among MSM has been carried out in 2007 and has registered an HIV seroprevalence of 4.8% in the capital city. The seroprevalence survey for 2010 has not been finalized in time for the reporting hereto.

In the last 6 years, the majority of newly registered HIV cases in the Republic of Moldova report heterosexual transmission as probable route (56.3% in 2004 and 81.5% in 2009). The share of males in those infected through heterosexual transmission is increasing (31% in 2004 and 51.2% in 2009). In the last 6 years, the share of rural population in those infected through heterosexual transmission is increasing (33.9% in 2004 and 51.2% in 2009). The number of newly registered HIV cases among blood donors have registered a slight decrease in the last 2 years (60.6 newly registered HIV cases per 100 000 blood donations in 2007 compared to 55.4 new cases of HIV per 100 000 blood donations in 2009). The same trend is seen among

¹ The comparability of data from surveys dated 2003/2004, 2007 and 2009 may be affected due to differences in sampling method and recruitment criteria in the latter one

² The comparability of data from surveys dated 2003, 2004, 2007 and 2009/2010 may be affected due to differences in sampling method and recruitment criteria in the latter

pregnant women (83 newly registered HIV cases in 2008 and 70 newly registered HIV cases in 2009). The shift in the routes of transmission increases the vulnerability of women. The interaction of HIV with the phenomenon of migration, and the impact of the latter, if any, has not yet been sufficiently studied and elucidated. The trends of the HIV epidemic and the potential for generalization ought to be placed on the agenda for further research and analysis.

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 STIs for 2006-2010, which determines the priority national strategies: prevention, epidemiological surveillance and treatment. The program represents an integral, multi-sectorial plan. The National Programme on Prevention and Control of HIV/AIDS and STIs for 2006-2010 was created based on the results of the implementation of previous national programs through a consultative process with the actors in the field, with participants from the governmental sector, international organizations and non-governmental organizations, as well as PLHIV, and was approved by Government Decree in September 2005 (Guvernul Republicii Moldova 2005d).

The National Programme on Prevention and Control of HIV/AIDS and STIs for 2006-2010 has the following objectives:

- Continuance and sustainability in strategic planning and carrying out activities and interventions.
- Joining efforts, involvement, interaction and coordination of the activity of state institutions, local public authorities, and individuals, including people living with HIV, representatives of NGO and international organizations as partners, in implementing interventions to control HIV/AIDS/STI in the Republic of Moldova;
- Mobilizing and rational use of financial resources from the state budget, grants, projects to carry out programmes of communication, awareness and education of the population, carrying out prevention activities among the general population and specific target groups, extension and provision of medical assistance, treatment, and non-medical assistance and support for PLHIV and STIs;
- Improving the epidemiological situation, preventing the spread of HIV and STIs, reducing the HIV incidence among youth and of the impact on the individual, community and society, creating optimal conditions to improve the quality of life according to the Millenium Development Goals;
- Developing a guaranteed social assistance system and ensuring acces of PLHIV to health care services;

Based on the existent data, the National Programme on Prevention and Control of HIV/AIDS and STIs for 2006-2010 which currently represents the One national strategic framework has developed specific prevention harm reduction activities targeting populatiosn at higher risk such as IDUs, CSWs, MSM, alongside activities aiming to prevent HIV in mobile populations such as truck drivers and migrants. During the reporting period, specific activities aimed at the general population have been developed and implemented, aiming to inform and promote safer behaviours, reduce stigma and discrimination and promote condom use, particularly among sexually-active youth. In 2007, based on the Order of the Ministry of Health Nr. 344 of 26.09.2007, a network of VCT centres has been established with the aim to ensure universal access of the general population to counselling and testing of HIV and Hepatitis B and C (Ministerul Sanatatii al Republicii Moldova 2007c). In the reporting period, the VCT service has been extended and reached national coverage. To ensure the quality of donated blood, in 2007, the Ministry of Health initiated the development of quality standards for blood safety. At the beginning of 2007 the Parliament of the Republic of Moldova has approved a new Law (nr. 23 – XVI of 16.02.2007) on Prevention of HIV/AIDS, which has been developed based on the international recommendations of observing human rights and providing universal access (Parlamentul Republicii Moldova 2007b).

Table 1 Indicators overview table, UNGASS reporting 2010, Republic of Moldova

	Indicator	Value	Measurement unit
National Commitment and Action Indicators			
1	Domestic and International AIDS Spending by categories and financing sources	119.9 mln	MDL
2	National Composite Policy Index		
National Programme Indicators			
3	Percentage of donated blood units screened for HIV in a quality assured manner	100.0	%
4	HIV treatment: Antiretroviral therapy, 2008	26.5	%
	HIV treatment: Antiretroviral therapy, 2009	35.4	%
5	Prevention fo mother to child transmission, 2008	94.9	%
	Prevention fo mother to child transmission, 2009	81.9	%
6	Co-management of Tuberculosis and HIV Treatment	38.7	%
7	HIV testing in general population	13.2	%
8	HIV testing in MARPs		
	Injecting Drug Users	48.4	%
	Comercial Sex Workers	28.7	%
	Men having Sex with Men	n/a	
9	MARPs covered by prevention programmes		
	Injecting Drug Users	15.3	%
	Comercial Sex Workers	7.4	%
	Men having Sex with Men	n/a	
10	Support for Children Affected by HIV	n/a	
11	Life Skills – based education in school (primary schools)	0	%
	Life Skills – based education in school (secondary schools)	0	%
Knowledge and Behaviour Indicators			
12	Orphanage school attendance	50.0/96.6	%
13	Young people: Knowledge about HIV	40.8	%
14	MARPs: Knowledge about HIV		
	Injecting Drug Users	64.9	%
	Comercial Sex Workers	28.7	%
	Men having Sex with Men	n/a	%
15	Sex before the Age of 15	6.7	%
16	Higher risk Sex	9.8	%
17	Condom Use During Higher Risk Sex	50.8	%
18	Sex Workers: Condom Use	90.8	%
19	Men Who Have Sex With Men: Condom Use	n/a	
20	Injecting Drug Users: Condom Use	35.6	%
21	Injecting Drug Users: Seif Injecting Practices	99.3	%
22	Reduction in HIV Prevalence	n/a	
23	MARPs: Reduction in HIV Prevalence (capital city)		
	Injecting Drug Users	16.4	%
	Comercial Sex Workers	6.1	%
	Men having Sex with Men	n/a	%
24	HIV treatment: Survival After 12 Months on ARV therapy	88.3	%
25	MTCT rate	2.0	%

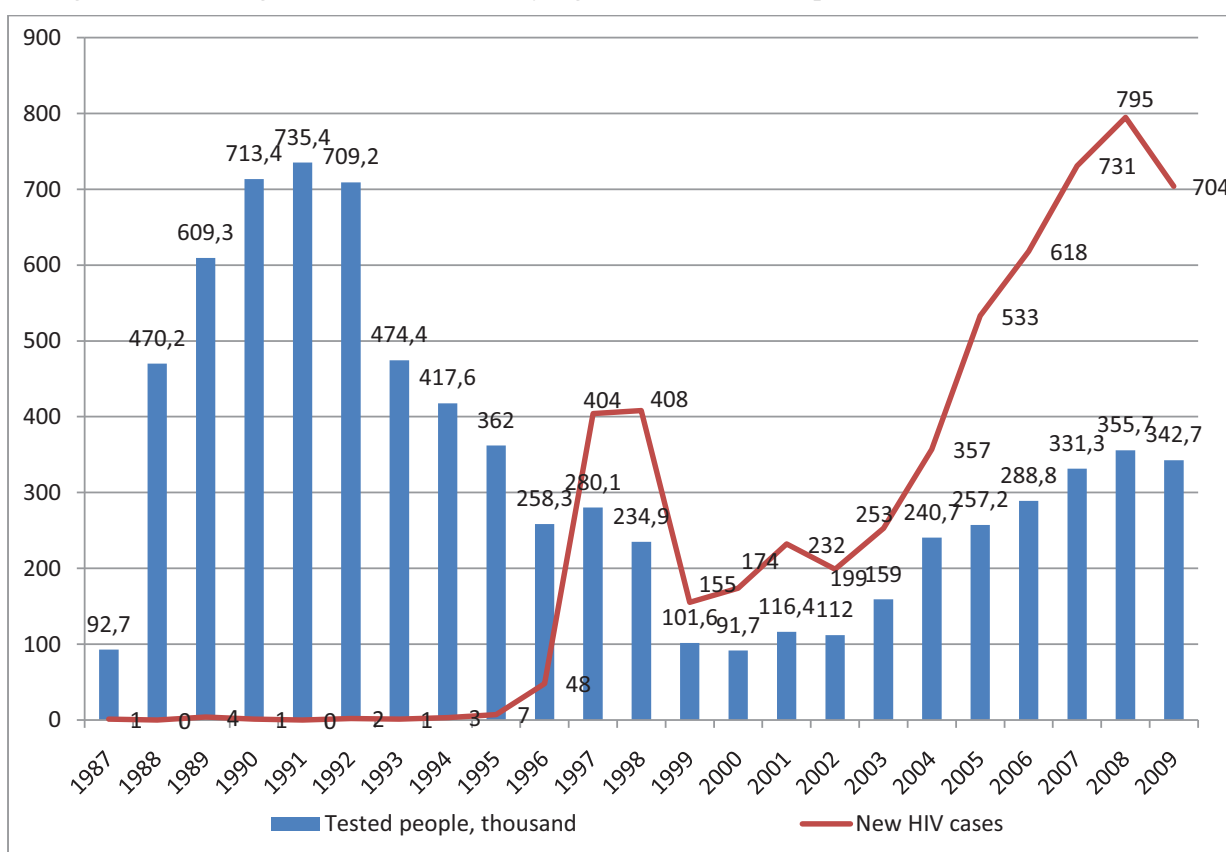
Overview of the AIDS epidemic

The Republic of Moldova is classified as a concentrated/low prevalence country with a concentrated HIV epidemic. There is evidence of spread of the infection in the general population. According to estimations generated by SPECTRUM, the prevalence of HIV among adults (ages 15+) is estimated at 0.42% in 2009, with a projected increase to 0.5% in 2015 (estimations representative for both banks of the Dniester River).

General population, routine statistics data

Trend analysis of the HIV epidemic among the general population of the Republic of Moldova based on annually reported newly registered HIV cases implies limitations depending on the country capacity in HIV testing, testing regulations applied for populations at higher risk which have been subject to changes in time, and on the political context (specifically, difficulties in scaling up programmes to Eastern regions of the country³). Up till 2008, there has been a constant growth in the annual number of newly registered HIV cases. In 2009, there has been a slight decrease in the number of newly registered HIV cases, but any assertions that incidence of registration of HIV cases is decreasing would be premature (Figure 1).

Figure 1 HIV testing and the number of newly registered HIV cases, Republic of Moldova, 1987 – 2009



In the last 6 years, heterosexual transmission is the main probable route reported by newly registered HIV cases. This route got the majority in 2004 and still keeps it throughout the reporting period (Figure 2). In the same period of time, the share of males in newly registered HIV cases who got infected probably through heterosexual intercourse is increasing (31% in 2004 and 51.2% in 2009), as well as the share of rural population in newly registered HIV cases (33.9% in 2004 and 51.2% in 2009).

³ As a result of the frozen political conflict on the Dniester River (1991 - 1992), the territory of the Republic of Moldova is divided in the territory on the right bank and the territory on the left bank (Transnistria) of the Dniester River, the latter also referred to as Eastern region. The territory on the right bank of Dniester River is controlled by the Chisinau authorities, while that on the left bank is controlled by the self proclaimed, unrecognized authorities from Tiraspol - the main city of this region.

Figure 2 Distribution of newly registered HIV cases in terms of the probable route of transmission, Republic of Moldova, 1995 – 2009

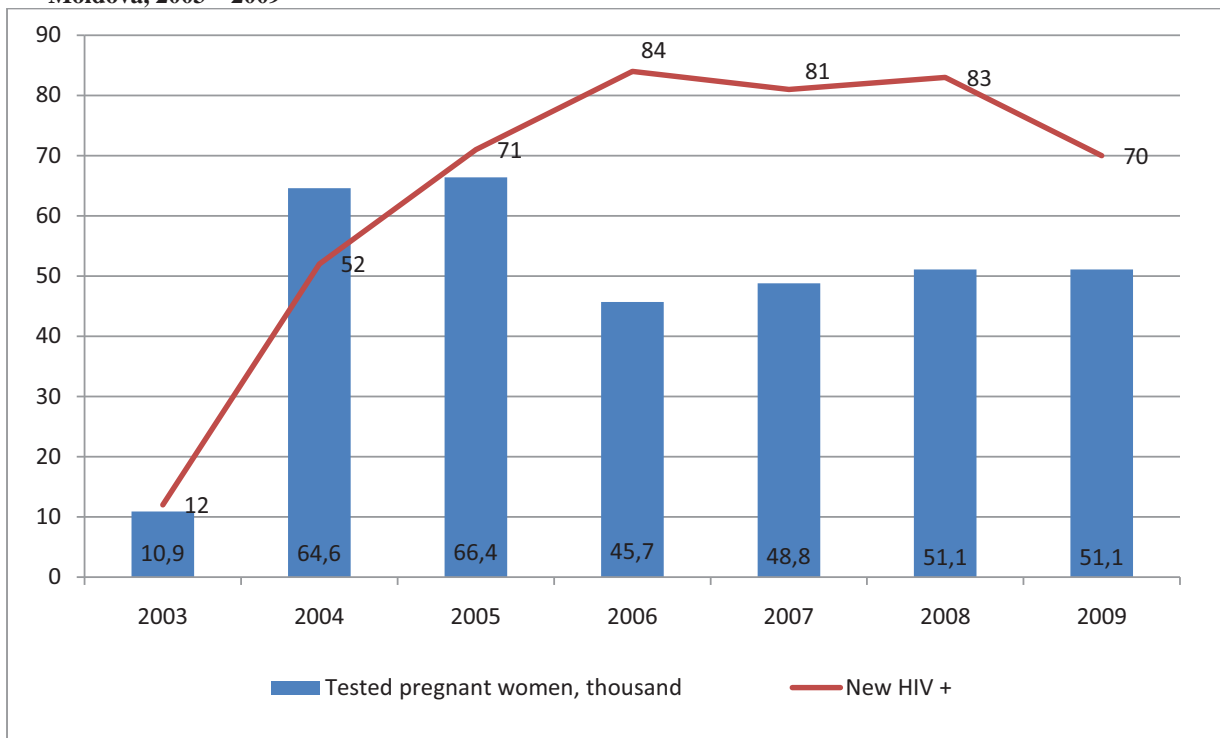


The household survey, carried out in 2009/2010 that applied rapid HIV tests, yielded no positive results among a sample of 692 migrants. The survey's representativeness is reduced by the high non response rate of about 36.5% (the recruited sample has been 1090 migrants). The hypothesis that those that engaged/are engaging in riskier behaviours or those that already know their HIV positive status were more likely to refuse the rapid test intentionally needs to be further verified.

The coverage of pregnant women with HIV testing for the period 2003-2009⁴ (Ministerul Sanatatii al Republicii Moldova 2007c) varies between 95.8-99.4%, which allows measuring HIV prevalence among pregnant women based on routine statistics data. Up till 2008 inclusive, the number of newly registered HIV cases among pregnant women was increasing annually. In 2009, a reduction of newly registered HIV cases among pregnant women is attested, but any assertions that incidence of registration of HIV cases among pregnant women is decreasing would be premature (Figure 3).

⁴ The Order of the Ministry of Health Nr. 314 of 31.07.2007 recommends the testing twice during the pregnancy

Figure 3 HIV testing and the number of newly registered HIV cases among pregnant women, Republic of Moldova, 2003 – 2009



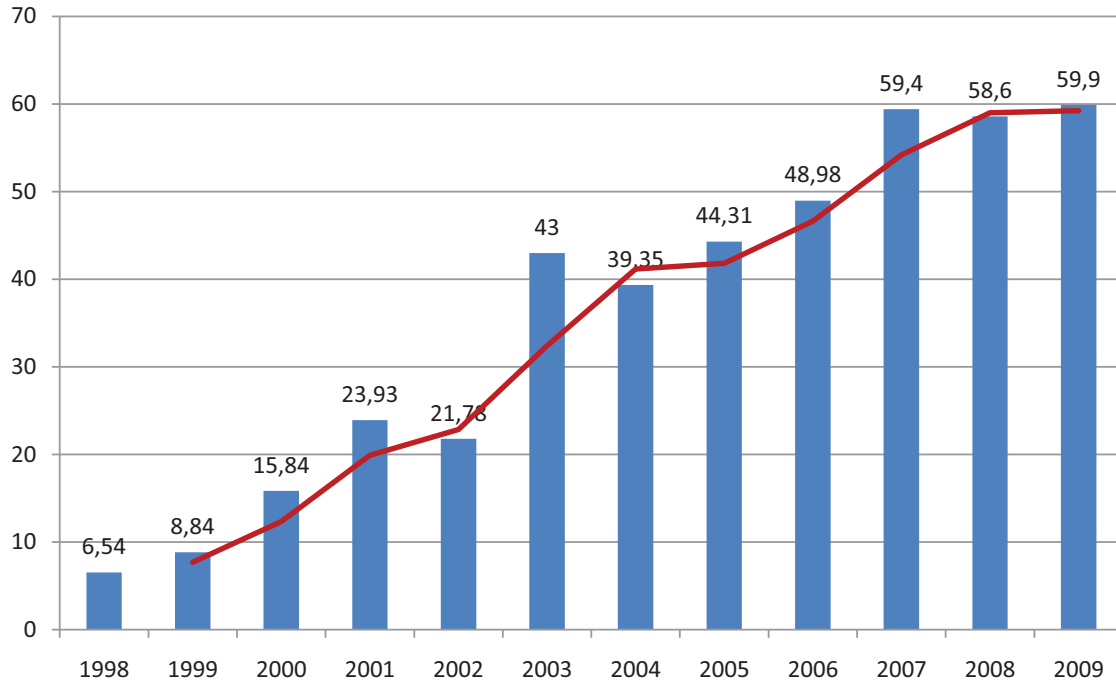
The HIV prevalence among pregnant women is stable. Thus in the year 2009, it has reached the value of 0.29%⁵, being approximately equal to the one in 2007 (0.23%). There is an increase in the number of HIV positive women who decide to give birth, their number being 53 in 2008 and 63 in 2009 (compared to 13 in 2006 and 31 in 2007).

Until 2007, there has been a consistent increase of newly registered HIV cases among blood donors⁶. In the last 2 years, a decrease can be attested, however it is premature to affirm that incidence of registration of newly registered HIV cases among blood donors is decreasing (Figure 4).

⁵ Number of HIV positive pregnant women reported to the number of officially registered pregnant women.

⁶ Potential donors are screened for HIV prior to the test (verification of the reported HIV cases database, behavioural screening).

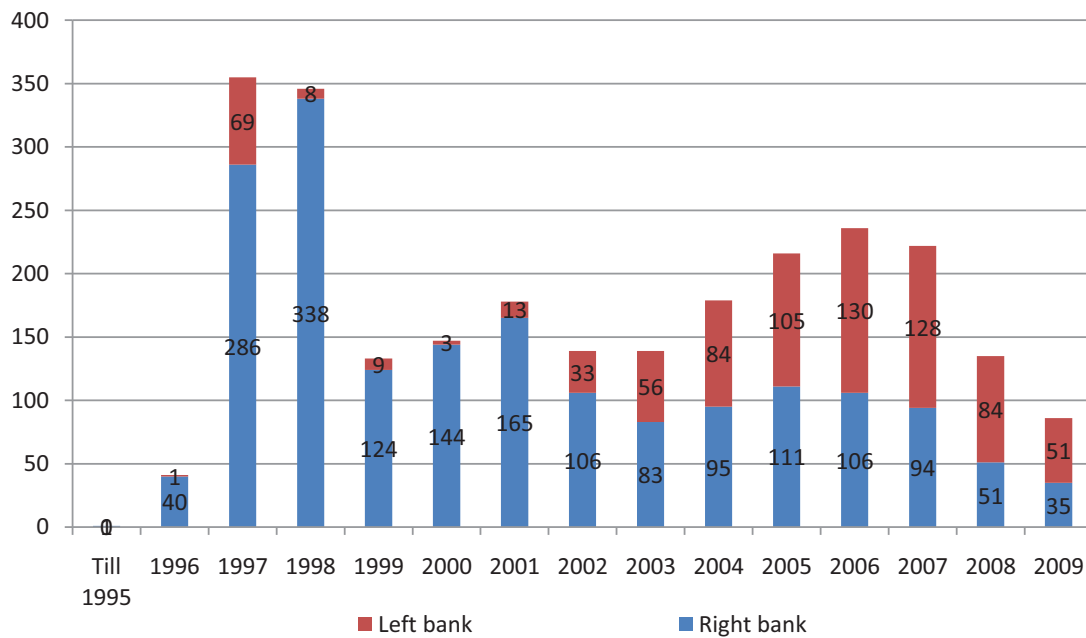
Figure 4 Newly registered HIV cases in blood donors per 100,000 donations, Republic of Moldova, 1992 - 2009



Most at risk populations, routine statistic data

Upon analysis of the number of new HIV cases reported among the IDUs tested for HIV⁷ (Ministerul Sanatatii al Republicii Moldova 2007b) in time, there is a decreasing trend⁸ (Figure 5).

Figure 5 Number of newly registered HIV cases in IDUs, Republic of Moldova, 1995 - 2009



⁷ The Order of the Ministry of Health Nr. 314 of 31.07.2007 recommends the biannual testing of IDUs registered by the Narcology Service

⁸ Laboratory confirmations of the HIV status through the Western Blott test is only performed in Chisinau, capital city of the Republic of Moldova

For other populations at higher risk, routine statistics are unreliable due to high underreporting of risky behaviours and lack of controls associated with decriminalization of sex work, as well as freedom of sexual orientation specified in the normative framework.

HIV prevalence in populations at higher risk

The HIV prevalence registered in 2009 among IDUs shows almost the same values as in previous years for the same population. There comparability between the two Integrated Bio-Behavioural Surveys is affected by the change in the methodology (Table 2).

Table 2 HIV prevalence among Injecting Drug Users, Republic of Moldova, 2001 - 2009

Sentinel site	2001 ⁹		2003 - 2004 ¹⁰		2007 ¹¹		2009 ¹²	
	Sample size	HIV Prevalence %	Sample size	HIV Prevalence %	Sample size	HIV Prevalence %	Sample size	HIV Prevalence %
Chisinau, capital city	209	15.8	306	14.4	183	17.5	301	16,4
Balti	184	60.3	230	36.5	145	44.8	362	39,0
Causeni	n/a	n/a	10	40.0	11	27.3	n/a	n/a
Donduseni	n/a	n/a	n/a	n/a	10	10.0	n/a	n/a
Edinet	n/a	n/a	7	14.3	20	15.0	n/a	n/a
Falesti	50	22.0	67	11.9	28	10.7	n/a	n/a
Orhei	13	23.1	44	2.3	21	0	n/a	n/a
Rezina	n/a	n/a	43	11.6	30	16.7	n/a	n/a
Soroca	87	1.15	116	.0	41	0	n/a	n/a
Tiraspol ¹³	n/a	n/a	n/a	n/a	68	20.7	281	12,6
Ungheni	n/a	n/a	47	2.3	63	6.3	n/a	n/a
Total	543	29.3	517	17.0	620	21.0	n/a	n/a

When comparing results for years 2003, 2004 and 2007 for Chisinau municipality, the limitations in the comparability due to methods applied reduce the ceratinity of registered variations (Table 3 and Table 4).

Table 3 HIV Prevalence among female Commercial Sex Workers, Republic of Moldova, 2003 – 2009

Sentinel site	2003		2004		2007		2009	
	Sample size	HIV %	Sample size	HIV %	Sample size	HIV %	Sample size	HIV %
Chisinau, capital city	150	4.6	151	8.5	243	2.9	300	6.1
Balti	n/a	n/a	n/a	n/a	122	32.8	359	23.5
Edinet	n/a	n/a	n/a	n/a	34	2.9	n/a	n/a
Orhei	n/a	n/a	n/a	n/a	69	0	n/a	n/a
Ungheni	n/a	n/a	n/a	n/a	20	25.0	n/a	n/a
Total	150	4.6	151	8.5	488	10.9	n/a	n/a

⁹ Used syringes used, take-all sampling

¹⁰ Used syringes, time and location sampling

¹¹ Blood samples, random sampling.

¹² Blood samples, respondent driven sampling.

¹³ Left bank of the Dniester River

Table 4 HIV Prevalence among Men having Sex with Men, Republic of Moldova, 2003 – 2007

Sentinel site	2003		2004		2007	
	Sample size	HIV %	Sample size	HIV %	Sample size	HIV %
Chişinău, capital city	118	1.7	121	2.5	83	4.8

The Republic of Moldova has no extensive experience in carrying out HIV seroprevalence studies among most at risk populations. One of the basic limitations of the seroprevalence studies referred to above is that prior to 2009 respondents were exclusively beneficiaries of services of the Harm Reduction Programme. In 2009, Respondent Driven Sampling has been applied, tapping into personal networks of populations at higher risk and going beyond Harm Reduction services' beneficiaries. The interrelations between personal networks of IDUs and CSWs need to be further explored, as high prevalence of HIV and Hepatitis C among CSWs may be explained by the high rate of injecting drug use within the last 12 months.

There are many question marks around the status quo of the HIV epidemic in the Republic of Moldova. In this context, data triangulation has been planned for 2010. The research questions cover the trends among populations at higher risk (IDUs, CSWs, MSM), the impact of Harm Reduction Programme, the arguments of generalization, if any, and the strategic planning implications of these issues.

National Commitment and Action Indicators

Indicator nr 1 AIDS Spending

At the moment of reporting, the methodology and tools proposed for monitoring the financial flows spent on HIV/AIDS, as recommended by the National AIDS Spending Assessments (NASA), and AIDS sub-account of the National Health Accounts (NHA), are not applicable for the Republic of Moldova due to the lack of the system of National Health Accounts (UNAIDS 2009b).

In order to ensure a proper reporting of the Indicator on AIDS Spending for 2008 and 2009, the data have been collected from a various range of sources in accordance with the recommendations of the AIDS Spending Categories by Financing Source. Therefore, there have been selected organizations at the national and local levels, which have implemented or disbursed funds directly linked to prevention, treatment, and/or activities on coordination, monitoring and evaluation in the filed of HIV and AIDS. The organizations have been asked to provide information on the source of financial allocations spent on HIV/AIDS, and the destination of disbursements, in accordance with the NASA matrix.

As such, for the purpose of the study and for the calculation of the AIDS spending for 2008 and 2009, the data on annual expenditures with the specific destination for HIV prevention and treatment of the following institutions from the health care system have been taken into account:

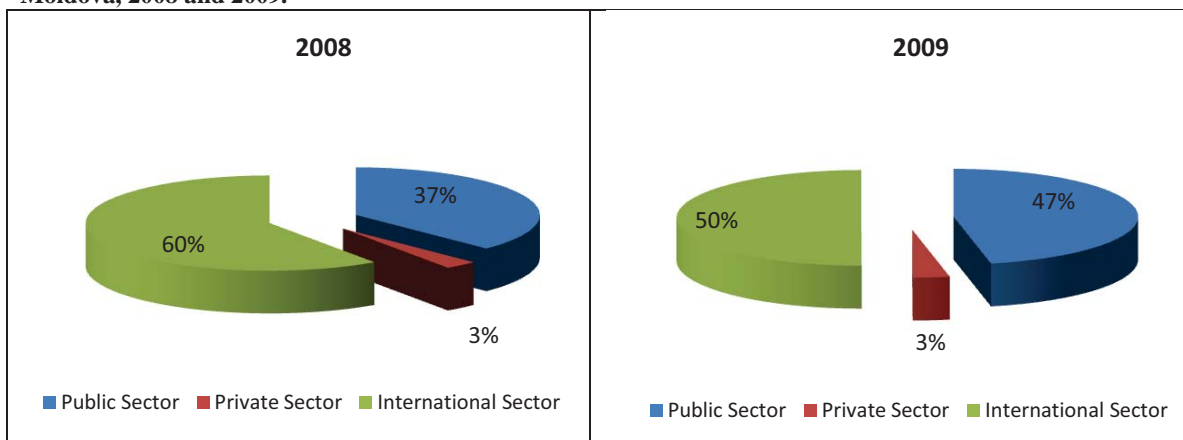
- Ministry of Health, for the state budget allocation to “Public Health Services” programmes for prevention of HIV and STIs, and for the implementation of the National Programme on Prevention and Control of HIV/AIDS and STIs for 2006-2010
- National Scientific and Practical Centre for Preventive Medicine which is primarily responsible for epidemiological surveillance of HIV, laboratory diagnosys and prevention, and is the highest hierarchic structure for the National AIDS Centre and regional AIDS laboratories
- National Centre of Blood Transfusion responsible for blood safety
- National Dermatovenereal Dispensary for the Infectious Diseases Section responsible for pre ART surveillance, ARV treatment management and ARV treatment disposal
- 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/STIs for 2006-2010
- National Coordination Council for coordination of the implementation of the National Programme on Prevention and Control of HIV/AIDS/STIs for 2006-2010
- Educational institutions, subordinated to the Ministry of Health, for expenditure in training, refresher training and specialisation for medical workers
- Transdniestrian Authorities.

Information on financial flows was requested from municipal and district councils, line Ministries (Ministry of Justice; Ministry of Defence; Ministry of Labor, Social Protection and Family) and multilateral donors and international organizations implementing their activities in the Republic of Moldova (UNAIDS, World Health Organisation, World Bank, the main recipient of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), UNICEF, UNFPA, UNDP, ILO/GTZ). Public Health Institutions have made separate reports for each of the years (2008 and 2009) 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)¹⁴ for the years 2008 and 2009 are presented in the Matrix for 2008 and 2009, respectively (*please see CRIS3*).

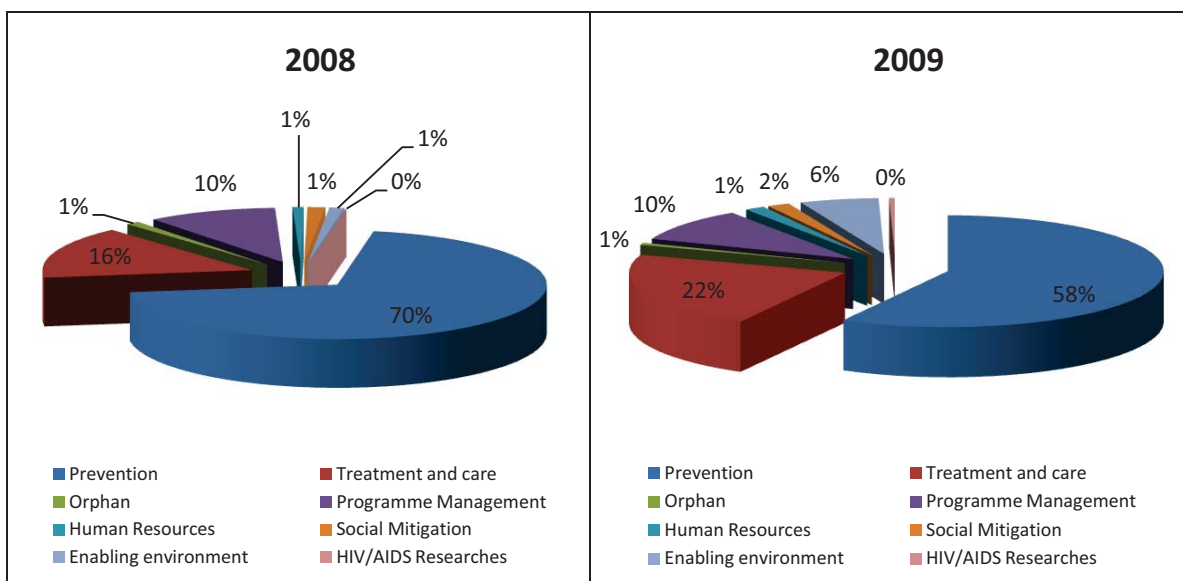
Figure 6 Structure of expenditures for the national HIV response by sources of financing, Republic of Moldova, 2008 and 2009.



Thus, in the year 2008, expenditures for the national HIV response have reached 137.7 mln MDL or 13 254 759 USD, of which the public financial resources represented 52.9 mln MDL or 5 090 879 USD (37%). International resources for this period have reached the value of 82.1 mln. MDL or 7 905 969 USD (60%) and private national resources have constituted 4.0 mln. MDL or 383 343 USD (3%).

In 2009, expenditures for the national HIV response have decreased, reaching 119.9 mln. MDL or 10 792 634 USD, of which the public financial resources represented 56.1 mln. MDL or 5 045 753 USD (47.0%). International resources for the period constituted 60.0 mln. MDL or 5 399 801 USD (50%), while the national private resources spent have been 3.8 mln MDL or 347 080 USD (3%).

Figure 7 Structure of expenditures for the national HIV response, by spending category, Republic of Moldova, 2008 and 2009



Classified by spending category (Figure 7), out of the expenditures registered in 2008 in the framework of the national response to HIV, 70% went to **Prevention**; 16% - to **Treatment and Care**; 10% - to **Programme Management**, while the other categories represented about 1% each.

In 2009, despite the decrease in the total volume of expenditures, the biggest share went to **Prevention** (57%), followed by **Treatment and Care** (22%), **Programme Management** (10%) and **Enabling**

¹⁴ Average exchange rate of the National Bank: 1 US dollar= 10,39 lei in 2008 and 1 US Dollar =11,11 lei in 2009

environment (6%). The Categories **Human Resources** and **Social Mitigation** represented 2% each and for **Orphans** – 1% (Figure 7).

Figure 8 and Figure 9 present the structure of expenditures in the framework of the national HIV response by source per each spending category.

Figure 8 Structure of HIV / AIDS expenditures by financing categories, year 2008

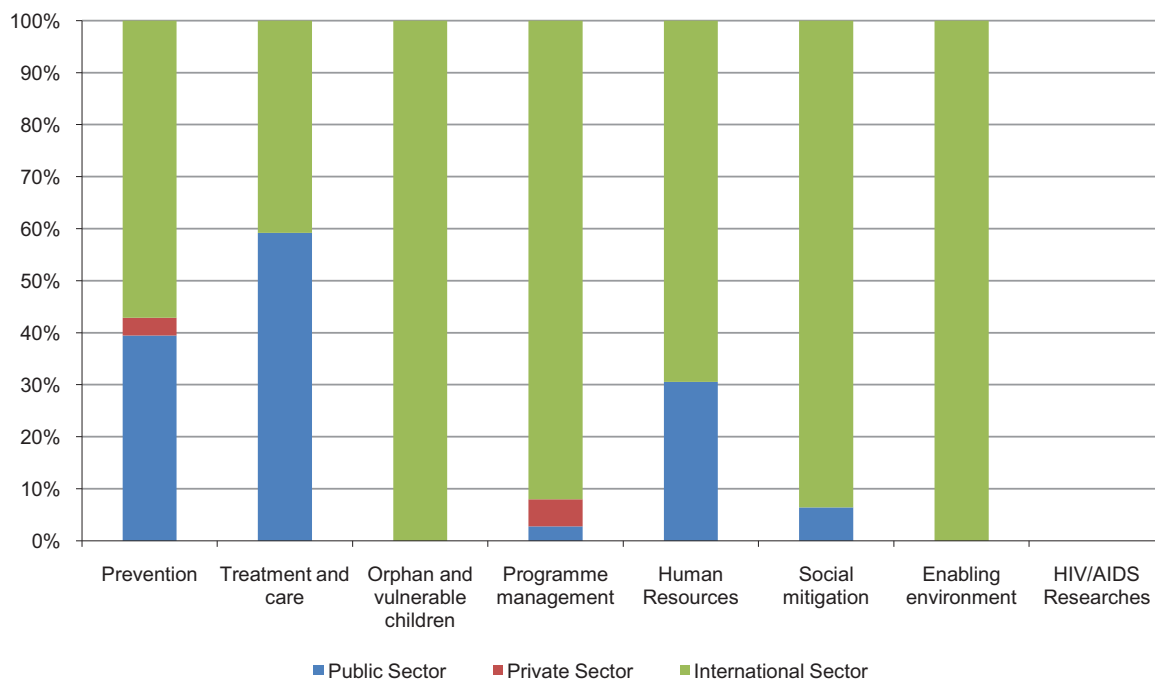
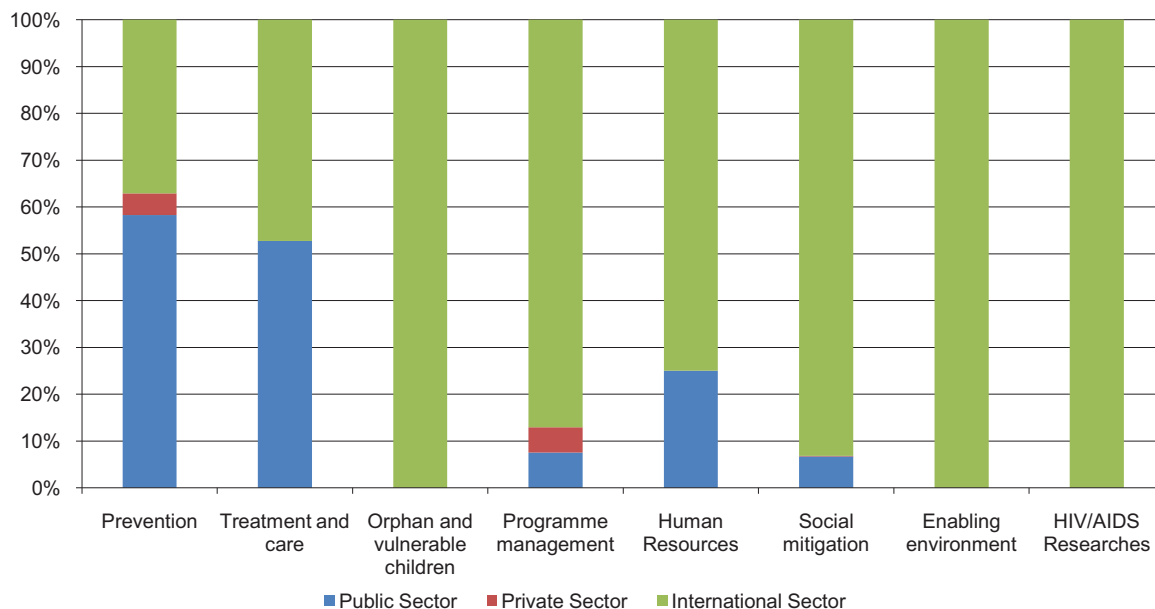


Figure 9 Structure of HIV / AIDS expenditures by financing categories, year 2009



The limitations of the method applied for the generation of this indicator are as follows, some of them being valid for the previous periods of reporting 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, 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 subjected to review for the calculation of Indicator 1, 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.
- Due to the lack of the National Health Accounts, there were limitations attested in classification of existing budget categories.

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 financially. The data collected for 2008 and 2009 are more complex and comprehensive than the data presented for the previous reporting period.

Indicator nr 2 Government HIV and AIDS Policies

During the last two years, the legal framework of the control and prevention of HIV/AIDS has been updated, improved and complemented with many laws that indicate political commitment, prohibit discrimination of people infected and affected by HIV/AIDS or vulnerable to the infection in any way, based on the principle of respect to human rights and human dignity, and represent the legal base for implementing comprehensive, multidisciplinary and intersectorial interventions for minimizing of consequences and reducing the impact of HIV.

Moldova's legislative and normative framework recognizes the primacy of human rights and includes specific provisions forbidding discrimination, intending to ensure equal chances for all. Among the main relevant laws, there are the Constitution of the Republic of Moldova, Law on Healthcare nr.411-XIII of March 28th 1995 (Parlamentul Republicii Moldova 1995), Law on the rights and responsibilities of the patient nr. 263 of October 27th, 2005 (Parlamentul Republicii Moldova 2005b), Law on practicing the doctor profession nr.264 of October 27th, 2005 (Parlamentul Republicii Moldova 2005c), Law on preventing HIV/AIDS nr.23-XVI of February 16th, 2007 (Parlamentul Republicii Moldova 2007b).

The scope and objectives of the **Law nr. 23-XVI on prevention of HIV/AIDS** reverberate on the "legal norms regulating the prevention of HIV/AIDS by reducing new cases of infection, by stopping the exponential growth of the epidemic, and by diminishing its impact through ensured medical, social and psychological assistance to people living with HIV/AIDS and the members of their families, through guarantying respect for their rights, as well as through the consolidation of efforts for prevention" (Parlamentul Republicii Moldova 2007b).

The law aligns to the requirements and principles of universal access to prevention, treatment, care and support, offering a legal regulation framework for a) ***promoting a complex policy*** directed towards joining the efforts of governmental, non-governmental and international structures, people living with HIV, private sector and physical beings, as well as towards enhanced use of the products of the monitoring and evaluation system; b) ***carrying out prevention as a system*** of measures to fight the epidemic, based on activities to ***inform the population (including vulnerable groups)***, aiming to raise the level of knowledge on HIV and AIDS and promote safer behaviours; c) ***excluding discrimination of people living with HIV and AIDS*** by providing for the respect of human rights and human dignity; d) creating and improving ***child protection programs*** by implementing a differentiated education system, promoting a healthy lifestyle, including measures to prevent the use of drugs, by prevention of HIV/AIDS, including through better knowledge of means of transmission and protection, by preventing the status of social orphans following AIDS deaths of one or both parents; e) ***providing access to medical and social assistance of people living with HIV and AIDS, including treatment, care and***

support; f) ensuring universal precautions in providing medical assistance and laboratory diagnostic activities, aimed at preventing nosocomial and professional transmission of HIV (Law Art. 1(2)).

The National Development Strategy 2008 – 2011 (Parlamentul Republicii Moldova 2007a), the **National Health Policy** (Guvernul Republicii Moldova 2007e), other intersectorial and sectorial policies stipulate activities to consolidate and develop prevention, treatment, care and support capacities for HIV/AIDS.

The National Development Strategy for 2008-2011 is a medium term strategic planning document, determining the development objectives of the Republic of Moldova until 2011, reflecting the national commitments undertaken by the Republic of Moldova and establishing measures and actions which are extremely important in reaching these objectives. The NDS starts from the fundamental objective from the Constitution of the Republic of Moldova, i.e. creating proper conditions to improve quality of life. In the same time, improvement of the quality of life is a multilateral phenomenon including a series of interconnected dimensions. On a personal level, the ideal case is the one of a healthy individual, capable of exercising his fundamental rights and freedoms.

The fundamental objective of the **National Development Strategy** is the creation of means to improve living standards of the population by consolidating the basis for a robust, sustainable and inclusive economic growth.

Among the specific objectives of the **National Development Strategy** there are the Millennium Development Goals, nationalized and contextualized:

1. reducing child mortality
2. improving maternal health
3. Fighting HIV/AIDS, TB and other diseases

The National Health Policy recognizes the primordial importance of health and well being in the life of a person as cornerstones to ensure social and economic progress, while public health is seen as one of the concerns and priorities of state policy. The document once again emphasizes that only through synergic efforts related to the overall health of the population can the desired goals be achieved, the efforts being supported by organic and complex investments both in the healthcare system as well as in infrastructure, environment protection and development, social protection, sports, etc. The **National Health Policy** is a strategic long term document covering the 2007-2022 periods (15 years). The main objective of the policy is to create optimum conditions to achieve the highest attainable standard of health of a person in their lifetime, including by ensuring a decent quality of life. The **National Health Policy** is developed based on international strategies and recommendations like the Law nr.5-XVI on insuring equality of chances among men and women of 9.02.2006 (Parlamentul Republicii Moldova 2006); the National Programme to insure gender equality for the 2010-2015 period, Government Decision (GD) nr.933 of December 31st 2009 (Guvernul Republicii Moldova 2009b), the National Strategy “Education for all, 2004-2015 period”, Governmental Decree nr. 410 of 04.04.2003 (Guvernul Republicii Moldova 2003), the National Program “Promoting healthy lifestyles ,2007-2015” Governmental Decree nr. 658 of 12.06.2007” (Guvernul Republicii Moldova 2007d), National Strategy on Reproductive Health, Governmental Decree nr. 913 of 26.08.2005 (Guvernul Republicii Moldova 2005c), the National Strategy for the development of the healthcare system for the 2008-2017 period, Governmental Decree nr 1471 of the 24.12.2007 (Guvernul Republicii Moldova 2007b), the National Program to control and prevent TB for the 2006-2010 period, Governmental Decree 1409 of the 30.12.2005 (Guvernul Republicii Moldova 2005a), the Law nr. 25-XVI of 03.02.2009 on the approval of the National Youth Strategy 2009-2013 (Parlamentul Republicii Moldova 2009), the National Programme to fight Hepatitis B, C, D, for the years 2007-2011, Governmental Decree 1143 of the 19.10.2007 (Guvernul Republicii Moldova 2007a).

On the control of HIV and STI, **the National Health Policy** promotes policies to prevent HIV and provide access to medical, social, psychological and legal services for the population and the people living with HIV/AIDS. Prevention Activities target the **general population** (information, education and communication for the population regarding the prevention of HIV/AIDS and STI); **youth and adolescents** in schools through scaling up the “Life skills” course availability and continuous training for

teachers involved in the educational process; **MARPs** through comprehensive, integrated activities of prevention, treatment, rehabilitation, care and support. Prevention of mother to child transmission and insuring haemotransfusional security are priorities in the field. This objective is connected to other objectives of the **National Health Policy**, especially the ones related to promoting a healthy way of life (targeting the general population and some of the target groups for developing life skills and accomplishing activities to prevent HIV), as well as the health of the youth (through complex intervention, including through the provision of access to family planning and reproductive health for all the young people regardless of social status, education, religion, gender, etc.)

One of the functional mechanisms of implementation of various policies and the actual response strategy to HIV/AIDS and STI is the National Program of Prevention and Control of HIV/AIDS and STI for 2006-2010, approved through Government Decision in September 2005 (Guvernul Republicii Moldova 2005d). The program determines the strategic national priorities: epidemiologic surveillance, prevention, treatment, care and support. This represents a wholistic, multisectorial, strategic plan developed based on lessons learned from the implementation of National Program on Prevention and Control of HIV/AIDS and STIs for the years 2001-2005 through consultations with the key stakeholders, representing the government, international organizations, NGOs, people living with HIV/AIDS.

National Program to Prevent and Control HIV/AIDS and STI for the 2006-2010 period has 9 major strategies:

Major strategies:

- I. Development, consolidation and ensuring the functioning of one national interdepartmental, multi-sectorial system to coordinate activities of state and non-governmental institutions in the control and prevention of HIV/AIDS and STIs (the National Coordination Council).
- II. Capacity building and expanding IEC activities for the general population, youth and vulnerable groups.
- III. Capacity building and development of the second generation epidemiological surveillance system of HIV/AIDS/STI .
- IV. Expansion of HIV/AIDS/STI prevention activities among vulnerable groups through consolidated and state efforts.
- V. Infrastructure development and development of capacities for medical assistance, social and palliative care of people living with HIV/AIDS, members of their families and children affected by HIV/AIDS.
- VI. Extending coverage of the voluntary counseling and testing services in public medical institutions and developing such services in the framework of existing youth-friendly health services.
- VII. Enhancing capacities for the prevention of HIV/AIDS and STI transmission from mother to child.
- VIII. Ensuring blood safety and transfusions security, as well as safety of medical interventions and other activities aimed at the prevention of the nosocomial spread of HIV and syphilis.
- IX. Complementing and expanding activities of prevention, diagnosis, treatment and care for people with HIV/TB co-infection, including in penitentiaries.

The National Program to Prevent and Control HIV/AIDS STI for the 2006-2010 period, establishes measurable objectives, main actions focused on achieving the objectives and a set of indicators to measure the achievement of results at the level of objectives and activities.

The National Program on Prevention and Control of HIV/AIDS and STIs for the years 2006-2010 reiterates the 3 Ones principle. This principle provides for alignment of all partners to one strategic legal framework, corresponding to the current National Program on Prevention and Control of HIV/AIDS and STIs, the functioning of a single coordination mechanism for the implementation of the strategic framework – represented by the National Coordination Council for HIV/AIDS and TB, and of one national system of monitoring and evaluation.

The coordination of activities and the implementation oversight for the National Program to Prevent and Control HIV/AIDS and STI 2006-2010 is the task of the National Coordination Council of National Programmes of Prevention and Control of HIV/AIDS, STI and TB, established through Governmental Decree nr. 825 of August 3rd, 2005 that approves the nominal composition and the operational terms of reference of the National Coordination Council (Guvernul Republicii Moldova 2005b). The Council has three structural levels: decisional – under the overall coordination of the Ministry of Health, coordination - facilitated by a secretariat and operational – Technical Workgroups whose terms of reference include development of draft strategic documents, evaluation of problems and offering solutions and recommendations.

In 2009, following the recommendations of the qualitative study based on the "Country Harmonization and Alignment Tool", the National Coordination Council composition has been extended from 23 to 30 members, 40% of them representing the NGO sector. Thus, the National Coordination Council of the National Programmes for the Control and Prevention of HIV/AIDS, STI and TB was extended by including two representatives of the League of People Living with/ affected by HIV/AIDS, a representative of MARPs (MSM), representatives of the Union of NGOs active in the field of harm reduction (representing IDUs, CSWs, vulnerable youth), of the faith-based organisations, of the private sector, as well as representatives of the Eastern regions of Moldova (Transnistria). Geographically, the composition of the Council has become more representative by including representatives of NGO from the Northern region and the Eastern Region of the country (Transnistria). Compared to the previous reporting period, more active involvement can be attested on behalf of the Ministry of Labor, Social Protection and Family, and Ministry of Youth and Sport, that became new members of the National Coordination Council of National Program on Prevention and Control of HIV/AIDS and STIs and TB. The Ministry of Justice continues to remain an active partner oriented towards scaling up the already institutionalized services in penitentiary institutions, as well as improving their quality: needle exchange, methadone substitution treatment, voluntary counseling and testing, ARV treatment, TB/HIV co-infection case management, post-exposure prophylaxis. Although coordination has seen moderate progress over the last years, there have been deficiencies and challenges attested in the interministerial coordination. At the sectorial level, there has been fragmented coordination in the activities to prevent the spread of HIV among MARPS, as well as youth and the general population. At a HIV case management level, the involvement of more and more health and social institutions is taking place, and the coordination between these actors needs to be enhanced. Representatives of Transnistria are involved in most national consultation processes and procedures, but coordination with the Eastern region authorities remains inadequate.

Referring to high-level **political support** of the national response, it can be noted that in 2008-2009 no essential progress was achieved, mainly due to lack of leadership at the highest level of the previous government as well as due to the fact that 2009 has been an election year. One of the most important achievements for this period is connected to the extension of the National Council of Coordination and Control of the National Programmes on Prevention and Control of HIV/AIDS, STI and TB, including the establishment at the operational level of a new Technical Work Group– for social assistance and support, under the aegis of the Ministry of Labor, Social Protection and Family. During the reporting period, there were activities of support carried out by regional stakeholders, including public administration institutions.

The Ministry of Education was responsible for HIV prevention among adolescents in school; implementation of the "life skills" curriculum as a mandatory subject in schools has not been achieved, currently it being an optional course with sporadic implementation. Presently, the Ministry of

Education, in collaboration with the Ministry of Health and the civil society, have developed and are implementing a pilot LSBE project in 4 vocational schools.

Considering the economic situation in the country, it is acknowledged that state funding for programme activities is limited; however, there has been an impressive increase in coverage from 37% of HIV/AIDS expenses in 2008 to 57% in 2009. Financial coverage for prevention among MARPs from the state budget is minimal. Some MARP groups are not adequately covered by services; the legal framework itself provides no definition of certain MARPs (as CSWs and LGBT) and provides no legal basis for prevention activities to be carried out among them.

The final component of the 3 Ones is the existence of a single Monitoring and Evaluation system/framework for HIV/AIDS. The Government endorsed the concept of establishment of a comprehensive national system of monitoring and evaluation, and recognized its advantages and importance by creating the Department of Monitoring and Evaluation of the National Health Programmes, in 2004, within the National Center for Health Management subordinated to the Ministry of Health.

The Technical Working Group on Monitoring and Evaluation, which includes many stakeholders in the National Programme on Prevention and Control of HIV/AIDS and STIs and TB, was created and operates. The National Center for Health Management was mandated to coordinate the national system of monitoring and evaluation. In November 2008 there was a comprehensive assessment of the M & E system by applying the 12 components tool, which attested that the system is immature and actions out to be taken to address gaps in properly mandating M&E system and human resources, in partnerships, human resources availability and capacities, data collection strategies, validation and use of indicators and data, etc. A report was made based on the exercise and it is available at: <http://www.aids.md/files/me/assessment-report-hiv-m-e-system-2009-en.pdf>

Programme strategies were evaluated and adjusted / updated several times. An initial comprehensive exercise that ensured high intersectorial participation has taken place in the context of target setting for universal access to prevention, treatment, care and support. The target-setting process demonstrated the availability of capacities to identify issues and for strategic planning.

In 2008-2009 the National Programme went through a mid-term evaluation. The evaluation process has primarily taken place in 2008: methodological and logistical support for generating evaluation issues, followed by the work of technical working groups and workshops for the development of major conclusions and recommendations. The Mid-term Review report was released in March 2009. These data will be used to develop the new National Programme for 2011-2015. The draft report is available at: <http://www.aids.md/information/library/d3118>. The main conclusions of the mid-term review refer both to progress, as well as challenges for each strategy, including for the 2008-2009 period, and are summarized below:

Prevention: there is progress attested in HIV prevention activities among MARPs that experienced the fastest scale up, but a more temperate evolution due to uneven coverage and low quality of services. The public reaction to HIV prevention programs has been generally positive, but faced opposition from the religious sector as regards communication campaigns that promoted use of condoms as well as educational programs. 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. There is a need for strengthening the capacity and quality of voluntary counseling and testing, and making VCT more accessible to 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.

The most pressing challenges relate to the fact that access to ARV treatment throughout the country remains limited, primarily because of lack of necessary information for PLHIV and coverage of adherence promotion programs implemented by NGOs, limited to Chisinau.

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. There is lack of support for children. Insufficient training, laboratory diagnosis and CD4 monitoring on the left bank of the Nistru River represent gaps that require action.

United Nations Development Assistance Framework

The United Nations agencies working against HIV/AIDS (UNAIDS, UNFPA, WHO, IOM, UNICEF, UNHCR, UNDP, etc.) are carrying out their programmes based on the Development Assistance Framework (UNDAF). It aims to support the Government in national responses to the spread of HIV. For the years 2007-2011, the UNDAF has 3 key outcomes, with a number of objectives and results:

1. Governance and Participation;
2. Access to quality services;
3. Regional and local development.

The second outcome focuses on vulnerable groups that have guaranteed access to good quality basic services offered by the Government with the support of civil society (including services of contraception, counseling and testing services, healthcare services for the youth); on people of reproductive age that are to practice safe sexual behaviors and that are to possess information on HIV/AIDS, STIs and reproductive health; and on guaranteeing to all people, especially those belonging to vulnerable groups, access to essential medical services of good quality (including PMTCT and ARV treatment).

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.

Millennium Development Goals

Moldova, along with 191 other countries around the world, has committed to achieve the Millennium Development Goals (MDGs) by 2015. However, with virtually the same objectives, the road to their achievement differs from country to country, just like the progress until now. Moldova has set targets for achieving the MDGs based on national context, for the first time in 2004; in 2005 the first progress report has been developed; in 2007, upon analyzing the progress in achieving the Millennium Development Goals and in consultation with the civil society and development partners of the country,

Moldova reviewed most of the targets set. 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).

Intersectorial aspects

Human Rights

In early 2007, the Moldovan Parliament adopted the Law on Prevention and Control of HIV/AIDS, which was developed based on international human rights standards and UA principles. The law prohibits discrimination against people living with HIV and ensures respect for human rights, filling the gaps present in earlier laws. The law stipulates the right to anonymous HIV testing, ARV treatment and care, prevention interventions, both among the general population as well as vulnerable groups such as harm reduction programs for IDUs, as a component of the national response to HIV. The law provides for voluntary and informed consent of the person, expressed in writing, as a prerequisite for testing for HIV, guarantees the right to privacy and prohibits mandatory testing policies as a precondition for employment, travel, access to health services or admission to educational institutions. The law prohibits any discrimination based on HIV status at work, in medical and educational institutions and in access to credit. There are no restrictions or legal barriers to the implementation of programs and services in HIV / AIDS. Subsequent to the approval of the Law on HIV / AIDS - with support and guidance offered by ILO - some major companies have initiated a process of institutionalization of HIV/AIDS policies in the workplace. These actions represent a critical step in reducing stigma and discrimination at work. The availability, although slow, of the private sector to engage in corporate social responsibility initiatives is probably one of the most important recent trends.

Obstacles and challenges

One of the key objectives set out in the Law is prohibiting discrimination against people living with or affected by HIV/AIDS by ensuring respect for human dignity and human rights, with an entire chapter dedicated to this problem. In the same time, some of the stipulations of the Law are inherently discriminatory, such as Article 24 which stipulates HIV testing as a prerequisite for getting the residence permit for foreigners planning to reside in the country for more than 3 months, and the expulsion of seropositive foreigners.

Article 22 (4) requires approval by the Ministry of Health and the Ministry of Labor and Social Protection of the List of jobs and professions where HIV+ individuals are not eligible ; importantly, the list has never been developed, this representing an example when implementation practices are more progressive than the Law in itself.

The 2007 Law and the National Programme stipulate certain responsibilities for the state, in cooperation with the civil society, and provide certain tasks for stakeholders. But some tasks remain unachieved. For example, for children and youth, the law provides the right to education in HIV prevention, issues related to HIV/AIDS being stipulated as part of the mandatory curriculum of secondary, vocational, higher and postgraduate education institutions, the Ministry of Education being invested with the respective responsibility. Following the failures related to the implementation of the Life Skills course as part of the mandatory curriculum, the involvement of the Ministry of Education remains low.

In Moldova, there is a high level of stigma and discrimination associated with HIV/AIDS, including with groups that engage in risky behaviors. The lack of legal norms stipulating a clear definition and set of

actions targeting groups such as sexual minorities and commercial sex workers leads to the lack of an actionable mechanism to redress cases of discrimination. The stigmatizing and social exclusion approaches allow the general population to maintain a false assumption that HIV/AIDS is a "risk group" associated infection and instills a false sense of security conducive to unsafe behaviours. Latest statistics indicate an increase in sexual transmission of HIV among the general population. The widespread stigma and discrimination in the society, combined with the low level of knowledge of those infected / affected by HIV concerning their rights, and the lack of specific services for the protection of human rights of PLHIV, contribute to their reluctance to seek recourse and protection mechanisms for their rights. Service providers such as medical personnel, social workers, law-enforcement personnel and others exhibit a high degree of intolerance to PLHIV and MARPS.

Although the concepts of confidentiality and security of personal data are essential to prevent discrimination and stigma towards the PLWHA, these concepts are not sufficiently developed and their respect does not constitute a general practice within the health system in Moldova. Efforts to measure stigma and discrimination, to assess trends over time and to monitor violations of human rights (fair access to services, confidentiality and anonymity) should be reflected in the national monitoring and evaluation framework.

Gender

The gender equality principle is stipulated in the national legislation: Law 5-XVI from 9.02.2006 regarding provision of equal chances to both men and women (Parlamentul Republicii Moldova 2006); National Programme on Gender Equality for 2010-2015 approved through Government Decision 933 from December 31, 2009 (Guvernul Republicii Moldova 2009b). The National Programme on Gender Equality for 2010-2015 is a strategic document in the field developed by the Ministry of Labour and Social protection, with the support of UNIFEM Moldova, aiming to ensure gender equality in the Republic of Moldova till 2015 and establishing priority actions in the field. The Programme includes the following components: social protection and family, human resources and migration, gender-based budgeting, education, health, violence and human trafficking, political participation, access to information/mass-media. The National Programme on Gender Equality has been developed based on international human rights and equal opportunities standards.

Moldova reports on the implementation of international treaties to relevant Committees. In this respect, the country submitted 3 reports regarding the implementation of the Convention on Elimination of all forms of Discrimination against Women, the latest being submitted at the 36th session of the Committee on Elimination of Discrimination ter Women held on August 7-25, 2006 in New York, USA. Among the final recommendations, the Committee obliges the Government to monitor by quantitative indicators, the impact of laws, policies and action plans and evaluate the progress in achieving gender equality. In order to monitor international commitments, gender sensitive indicators and statistics becomes imperative. An initiative of harmonization has produced harmonized set of gender-sensitive indicators in the framework of the joint UNDP/UNIFEM/UNFPA project on "National Statistics System Strengthening".

A comprehensive collection of gender-sensitive indicators in all social fields is the statistical publication called "Women and Men in the Republic of Moldova". Starting with 2008, the information on main gender sensitive indicators is placed on the website of the National Statistics Office and is available for users. This is one of the main tools enabling decision makers and implementers alike to track male and female social and demographic specificities for development of effective gender-sensitive social policies, as well as for the implementation of equal rights and opportunities principle.

HIV affects the young people and the population of reproductive age fastest, and in recent years a feminization of the epidemic can be attested: if on the onset of the epidemic, most HIV-positive people were male - 84.0% compared to 16.0% women, then in recent years a tendency of increase in the share of women is observed. The turning point occurred in 2004, when on the background of relatively slow growth in the number of men infected, suddenly the number of HIV positive women increased, essentially altering the ratio recorded over the years. A comparative analysis of the number of HIV cases according to mode of transmission, clearly demonstrates the increasing share of women infected over

the last years. Noted is that in the respective years the number of men infected with HIV has doubled, while the number of HIV-positive women increased four times. This greater vulnerability of women is associated with the changing means of transmission to predominantly heterosexual; 48.2% of new cases of HIV with heterosexual probable cause of transmission in 2009 were women.

Currently, data on enrollment in ARV treatment indicate a lower proportion of women, the explanation being that women have entered the epidemic later and hence fewer are meeting the criteria of clinical eligibility at this moment. Data of prevention programs disaggregated by gender indicates that women IDUs face unequal access to harm reduction programs, with the notable exception of injecting CSWs. Determinants of vulnerability, associated with rapid social change and economic transition, contribute to the spread of the epidemic and exacerbates its impact. Gender inequality and stereotype-based patriarchal gender relations are changing the determinant aspects of vulnerability.

The greater vulnerability of women is conditioned biologically, as women are 10 times more likely to get HIV through unprotected penetrative vaginal sex, but it is also determined by the gender roles and norms. The sexuality norms and opinions displayed by the general population indicate an acceptance of infidelity among men, hence exposing women to greater risk, particularly in the context of poor condom negotiation skills. Gender-based violence is endemic, further limiting the ability of women to negotiate condom use with their unfaithful spouses/partners. Rural women are particularly affected. Women in Moldova are less likely to benefit of HIV prevention education and access to condoms. The 2008 Knowledge, Attitudes, Practices(KAP) study among young people, 15-24 years old, indicate lower condom use with a non-permanent partner among young women (35,8%), compared to young men (67,1%). The gender associated vulnerability to HIV survey, carried out in 2009 (Bivol et al. 2009), has indicated that sexuality norms within families put women at greater risk: around 25-50% of the sample displays various degrees of accepting attitudes towards non-marital sex and multiple partners for men.

These trends are alarming in the context of the important role that women play in reproductive health and the reproductive function that they have in the family and community. In the last 5 years, there was a stable HIV prevalence among pregnant women (0.23% in 2007 and 0.29% in 2009). The number of HIV-positive women who decided to give birth increased (53 HIV positive women in 2008 compared with 63 HIV positive women in 2009).

Violence is a widespread problem the study of gender-associated vulnerability to HIV conducted in 2009 showed that 24.2% of all surveyed women aged 15-64 have at least once been victims of physical violence from their permanent sexual partners / spouses, and 10.3% were victims of physical violence in the 12 months preceding the study. In Moldovan legislation, rape in marital relations is not classified as a crime. Violence is a form of manifestation of the vulnerability of women in society in general and in their relations with their sexual partners in particular, enhancing the vulnerability to HIV. Skills to negotiate condom use are also lacking among sex workers. Female SWs are victimized by violence and refusal of partners to use condoms, hence being subjected to higher risk of infection.

Based on CEDAW recommendations for strengthened action against domestic violence, the Law No 45 from 01.03.2007 on Preventing and Reducing Domestic Violence has been adopted and published on 18.03.2008 in the Official Monitor Gazette nr. 55-56, entering into force on 18.09.2008 (Parlamentul Republicii Moldova 2008c). The Law provides for important definitions of domestic violence and its forms, establishes the institutional framework with detailed responsibilities for competent authorities, envisages service provision for victims of violence and an efficient legal mechanism in cases of violence, including through introducing the restraining order for the protection of the victim and isolation of the abuser. Chapter I, article 2 stipulates that "*Sexual violence* represents any type of sexual violence or any type of illegal sexual behavior within the family or in other interpersonal relations such as spousal rape, forbidding of contraception methods, sexual harassment; any unwanted or imposed sexual behavior, unwanted practice of commercial sex; any illicit sexual behaviours targeting a minor. The Ministry has initiated a process of adjusting the national legislation in force to the Law on Preventing and Reducing Domestic Violence.

The concept of the Management Information System entitled “State register of domestic violence cases” was approved through the Government Decision 544 of the 09.09.09 (Guvernul Republicii Moldova 2009a). This system will contribute to the continuous monitoring of the domestic violence cases, while the statistical analyses of indicators extracted from the system will serve as basis for the development of efficient policies to prevent and fight violence. In order to initiate the statistical data collection process, service providers from health, social protection and police at local level shall undertake data entry. In 2008, the MIS has been piloted in Drochia and Cahul, and in 2009 it has been further scaled up.

Another trend which exacerbates the vulnerability of women is migration, especially illegal. Hoping to escape poverty, destruction of infrastructure and social services, and violence, a high proportion of women in Moldova chose emmigration, frequently through illegal channels due to limited freedom of movement. Most migrant women are working in the unofficial sector and don't have employment contracts, hence being at risk of economic and sexual exploitation. Estimates of the La Strada NGO show that between 35 and 50% of victims, assisted by support organizations across Europe, are from Moldova. In the past 7-8 years, over 2227 victims of trafficking were repatriated to Moldova by the International Organization for Migration (IOM). Most victims are women and girls trafficked for sexual exploitation, over 70% of them being victims of domestic violence prior to trafficking. Most of these victims come back with various diseases and afflictions, particularly psychological trauma and STIs, including HIV in some cases. Out of victims of trafficking assisted by the center for assistance and protection of victims and potential victims of human trafficking (established through Government Decision nr.847 of the 11.07.08 (Guvernul Republicii Moldova 2008a) based on the IOM-funded shelter) in 2008 and 2009, approximately 3% had HIV.

Human trafficking is a major concern for South-East European countries, both for Moldova and many other former soviet countries. In Moldova, the following legislative, administrative and organizational measures were taken:

- The Law on “Preventing and Fighting Human Trafficking” nr. 241 –XVI of 20.10.2005 has been developed (Parlamentul Republicii Moldova 2005a);
- The Government Decision nr.948 of 07.08.08 on approving the regulation regarding the procedure to repatriate children and adults—victims of human trafficking, illegal trafficking of migrants and unaccompanied children (Guvernul Republicii Moldova 2008b), was the legal basis of the procedure to identify and repatriate Moldovan citizens.
- standard terms of reference on the organization and functioning of assistance and protection centers for the victims and potential victims of human trafficking have been approved through Government decision nr.1362 of 29.11.2006 (Guvernul Republicii Moldova 2006)
- the Strategy and Action Plan of the National Referral System, approved through Parliament Decision nr.257-XVI of the 05.12.2008 (Parlamentul Republicii Moldova 2008a) have led to intersectorial and multidisciplinary approaches to protection and assistance of victims and potential victims of human trafficking at local level.

The National Referral System in the field of protection and assistance to the victims and potential victims of human trafficking (hereinafter NRS), was launched in 2006 by the Ministry of Social Protection, Family and Child in cooperation with IOM. At the moment, the NRS covers 24 districts (raions), 2 municipalities and one town. The multidisciplinary teams established in the framework of the NRS shall also act as key entry points for PLHIV, referring them to social assistance and services.

CEDAW (Committee on the Elimination of All Forms of Discrimination against Women) recommendations, issued on August 25, 2006, call on Moldova to comprehensively implement measures to redress gender-based violence in families and in the society, also requiring intensified efforts to combat trafficking and sexual exploitation of girls and women by addressing root causes, particularly economic insecurity of women, and to reduce the incidence of HIV and STIs. The gender pay gap was 26.7% in 2008 and 27.6% in 2007. Overall, women are segregated in underpaid jobs, and handle the majority of domestic work thus being subject to a dual burden. Women are the main caretakers of their family members that require care, including the people living with or affected by HIV and AIDS. This largely unpaid care is totally devoid of support systems and is based on the assumption that the caretaker role is "natural" for women, thus contributing to the perpetuation of the burden. This burden

of care can affect both women's health and nutrition, as well as the health and nutrition of the whole family.

In this context, it is clear that the national response must be gender-sensitive in addressing the gender implications of HIV/AIDS, there being some critical factors in the society generally and in the specific context of HIV particularly, contributing to the increased vulnerability of women and girls as a group. In this context, it is imperative to address gender roles and vulnerabilities to achieve a substantial impact in the fight against the spread of the HIV epidemic.

National Programme Indicators

Indicator nr 3 Percentage of donated blood units screened for HIV in a quality assured manner

The activity of the blood service is regulated by the Law regarding blood donations and transfusion Nr.241-XVI of 20.11.2008 (Parlamentul Republicii Moldova 2008b) and the National Program for Transfusional Security and provision of blood products for 2007-2011, approved by government decision nr 637 of 02.07.06 (Guvernul Republicii Moldova 2007c). The Ministry of Health is responsible of establishing the policy in the field of haemotransfusional security and its implementation. The National Blood Transfusion Center is the national level institution that together with the Ministry of Health is implementing the state policy of haemotransfusional security.

The objectives of the blood service are as follows (right bank of Dniester River):

- a) Increasing blood safety and the availability of quality blood components according to international standards;
- b) Involving central and public authorities, NGOs, and the community in the promotion of civil values regarding voluntary and unremunerated blood donations, as a component of transfusional security.
- c) Ensuring a national reserve of blood products for medical assistance, including rare blood groups, according to the clinically argued demand and special circumstances (catastrophies, earthquakes, terrorism, and war).

Currently the national blood service has a hierarchical structure with four levels, organized by the geographic principle (right bank of Dniester River):

- I. The National Blood Transfusion Center, located in Chisinau (production structure supplying 17 blood transfusion wards, and also departmental and private medical institutions)
- II. The regional blood transfusion center, located in Balti, supplying the Northern region of the country, departmental and private medical institutions included
- III. Hospital blood transfusion departments, located in large public hospitals (21 in all, 4 in the north and 17 in the center-south area of the country)
- IV. Offices or hospital blood banks, located in small hospitals (40 in all, of which 31 are public medical-sanitary institutions and 9 are private and departmental).

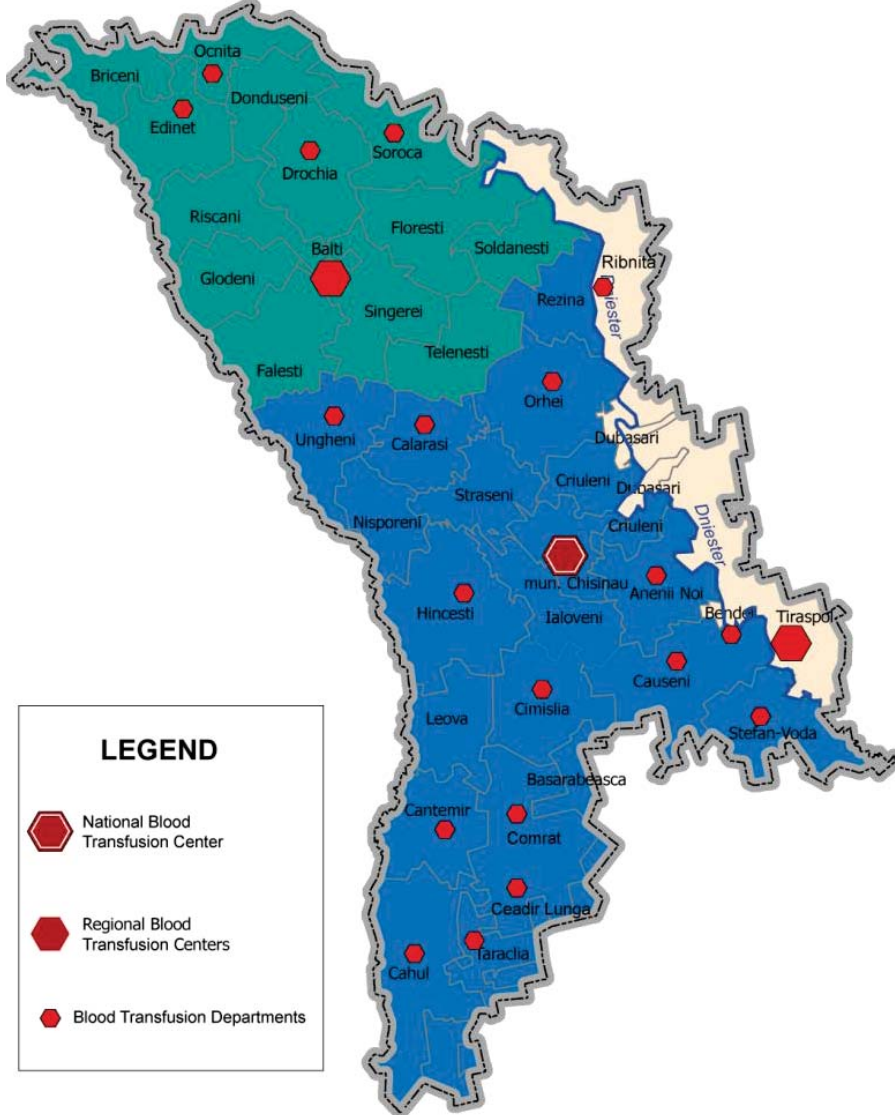
For the time being, the creation of the Regional Blood Transfusion Center in Cahul (Southern area of the country), has not succeeded due to the lack of resources for the general renovation of the building. The Ministry of Health, the National Center for Blood Transfusion, is examining together with the local public authorities opportunities for establishing the Regional Center for Blood Transfusion in Cahul as a production institution for the Southern area of the country. Currently, the Southern area of the country is supplied by the National Blood Transfusion Center located in the capital of the country, Chisinau municipality (Figure 10).

The Blood Transfusion Departments (level III) possess donor blood collection equipment. According to the areas of supply (Figure 10), Blood Transfusion Centres (level I and II institutions) distribute validated

blood products and daily pick up (in specialized transportation) the donor blood collected by the blood transfusion sections/departments. The processing, testing and validating of the blood products is done in a centralized manner only in the Blood Transfusion Centers (level I and II institutions). They have equipment that ensures the safety and security. The National Blood Transfusion Center also serves as the reference immunohematology laboratory for the laboratory exams, and as the quality control mechanism for the blood products produced in the laboratories of the Regional Blood Transfusion Center Balti and, upon request, for the Regional Blood Transfusion Center Tiraspol, located on the northern bank of the Dniester River.

The Blood Transfusion Centres are also tasked with the promotion of voluntary and non-remunerated blood donations, preparing diagnostical and biomedical blood products and providing qualitycontrol.

Figure 10 Geographical distribution of the blood service units, Republic of Moldova (right bank of the Dniester River), 2009



The mandatory testing of all donated blood units is made for HIV, Viral Hepatitis B and C and sifilis is performed through the ELISA method. Blood transfusion centres have testing algorithms for the samples that are initially reactive, elaborated based on WHO recommendations (WHO 1994).

The internal quality control system within laboratories mandated to test blood donations provides for mandatory negative and positive controls for each series of tested blood samples. Samples initially tested as reactive are double tested to evaluate donor status. Samples that test positive in both cases are sent to the National Reference AIDS Laboratory in the Chisinau municipality for confirming the HIV

status of the donor. Beginning with the IV quarter of 2009, the Polymerase Chain Reaction (PCR) method is applied for all the samples that tested negative for markers, using the ELISA test. The centralization of testing at the presence of infectious disease agents in the blood transfusion centres has significantly increased the quality control of the testing process and results.

The external quality control is carried out by the National Reference AIDS Laboratory, through the following checks and controls:

- Confirming the positive test result carried out in the blood service unit's laboratory;
- Remitting one out of 10 consecutive reactive samples to the National AIDS Reference Laboratory
- Through blood samples remitted by the AIDS Center with unknown status to be tested by the blood service laboratory.

The blood products quality control mechanism is applied to blood products that pass through the full production cycle; the processing conditions are also examined for quality benchmarks. The internal quality control is carried out by each Blood Transfusion Center at the blood products processing stage. The external quality control constitutes the responsibility of the National Blood Transfusion Center for blood products produced in other centers or units of the blood service.

At the present stage, a number of similar forms and procedures are used in all institutions, standard procedures being implemented for the process of collecting blood samples: their transportation, preparing them for testing, testing procedure itself.

Unfortunately the international external control could not be performed due to the cancellation of the "Prevention of Hepatitis B and C and HIV/AIDS" Project, carried out with the financial and technical support of USAID – one of the outcomes of which has been performing international external blood quality control.

The quality control management implemented in the laboratories of the Blood Transfusion Centers involved in the diagnosis of markers of the haemotransmissible infections in the 2008 and 2009 period are reflected in Table 5 and Table 6 respectively.

Table 5 Donated blood units screened for HIV in a quality assured manner, Republic of Moldova (right bank of Dniester River), 2008

Name of the Blood Transfusion Centers	Quality assurance in HIV screening		Blood/Plasma units		
	Standard Operating Procedures	External Quality Assurance Scheme	Donated blood	Tested blood	Blood screened in quality – assured manner
Chisinau	Yes	Yes	60464	60464	100%
Balti	Yes	Yes	19173	19173	100%
TOTAL			79637	79637	100%

Source: National Blood Transfusion Centre

Table 6 Donated blood units screened for HIV in a quality assured manner, Republic of Moldova (right bank of Dniester River), 2009

Name of the Blood Transfusion Centers	Quality assurance in HIV screening		Blood/Plasma units		
	Standard Operating Procedures	External Quality Assurance Scheme	Donated blood	Tested blood	Blood screened in quality – assured manner
Chisinau	Yes	Yes	60406	60406	100%
Balti	Yes	Yes	20627	20627	100%
TOTAL			81033	81033	100%

Source: National Blood Transfusion Centre

In the reporting period, significant efforts were made for the consolidation of blood safety in the Republic of Moldova.

On the left bank of Dniester River, there are a Regional Blood Transfusion Center in Tiraspol and blood transfusion wards in district hospitals in Ribnita and Bender. The external quality control for the laboratory of the Regional Blood Transfusion Center from Tiraspol is carried out upon request from the latter and not systematically. In 2009, the Regional Blood Transfusion Center in Tiraspol (left bank of the Dniester River) was equipped with laboratory testing systems. There were no data available from the left bank of the Dniester River for the current reporting.

Indicator nr.4 Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

ARV treatment became available in the Republic of Moldova beginning with 2002, when the first patient received ARV medication bought with Ministry of Health funds. Beginning with 2003, medication for ARV treatment was bought with the financial support of the World Bank (in the framework of the AIDS control project in the Republic of Moldova) and GFATM grants (Round 1 and Round 6). In the Republic of Moldova there are 3 centers providing the initiation of ARV treatment, clinical monitoring and the release of ARV medication: the Dermato-Venerial Dispensary (provides services to patients from the right bank of the Dniester River and to patients from the left bank, enrolled in treatment upon request, prior to 2007), the Penitentiary Institutions Department for inmates on the right bank of the Dniester River and the AIDS Center in Tiraspol (provides services for patients and inmates on the left bank of the Dniester River). In the coming years, a geographical extension of centers for clinical monitoring of the ARV is planned, bringing the total up to 6 centres (2 additional centres on the right bank and 1 additional centre on the left bank of the Dniester River). According to the *National Protocol (Ministerul Sanatatii al Republicii Moldova 2009b)*, 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.

In the reporting period, the demand for ARV increased significantly (Table 7).

Table 7 New enrolments into ARV treatment, adults 2003 - 2009

		2003	2004	2005	2006	2007	2008	2009
New enrolments into ARV treatment, adults	Men	14	49	66	62	109	150	210
	Women	13	32	41	52	88	113	152
	Total	27	81	109	121	253	264	362
	Of them, IDUs	27	50	48	50	128	142	151

Source: Dermato-Venereal Dispensary and AIDS Centre in Tiraspol

Expenditures for in-patient and out-patient treatment of insured HIV patients are covered by the National Health Insurance Fund from the Compulsory Medical Insurance Fund. For uninsured patients, in 2008 and 2009, the costs were covered by the National Health Insurance Fund from Ministry of Health budget sources. Beginning with 2010, the expenses for in-patient and out-patient treatment (regardless of medical insurance status) will be covered solely by the National Health Insurance Fund. The rise in the demand for ARV treatment is also reflected in the increase of total expenditures related to **Treatment** spending category. Total expenses for in-patient and out-patient treatment for the years 2008 and 2009 respectively are presented in Table 8.

Table 8 Total expenditures for in-patient and out-patient treatment of HIV (costs of ARV drugs not included) from the sources of the National Health Insurance Fund, Republic of Moldova (right bank of the Dniester River)

	2008	2009
Inpatient treatment expenditures	1 763 600	1 969 400
Outpatient treatment expenditures	899 700	2 462 900
Total treatment expenditures	2 663 300	4 432 300

Source: Ministry of Health

For the time being, all ARV drugs are bought from external sources, especially round 6 of the GFATM grant. Due to high demands for ARV treatment, the implementation plan for phase II of GFATM grant, Round 6 (for 2010 – 2012 period) was revised with a significant increase of the share of resources allocated for the purchase of ARV medication (Table 9).

Table 9 Expenditures occurred in the 2008-2009 period, planned for the 2010-2011 period, and re-allocated in replanning R6, budget negotiation phase two (years 2010, 2011), Republic of Moldova

Actual expenditures for procurement of ARV drugs for 2008 and 2009 (source GFATM and World Bank), and expenditures planned for 2010 and 2011 (source GFATM)			
Year	Annual disbursement for procurement of ARV drugs (+prophylactic treatment)	Annual disbursement for national HIV response	% of the annual disbursement for procurement of ARV drugs
2008	443975,44	3443517,91	12,89%
2009	435325,21	3423382,4	12,72%
2010	732191,00	2864860,28	25,56%
2011	1042864,00	3164583,66	32,95%
Planned expenditures for the procurement of ARV drugs for 2010 and 2010, rebudgeted in phase II, Round 6 of the GFATM			
2010	1160402,00	3464666,67	33,49%
2011	1335218,00	4001944,74	33,36%

Source: Project Coordination, Implementation and Monitoring Unit, Principal Recipient of the GFATM grant, Round 6

Cost estimates were revised following the increase in demand for treatment in 2009. The same increase has been projected for the following years, i.e. until 2012. Actually the purchase requests are being performed based on enrolment data for the latest available year. Annually, on average, the ARV prophylaxis costs are about 5% of the total amount spent for ARV drugs procurement.

Estimates for 2011 – 2012 will be revised before planning procurement for the respective years. According to the 2010 Guidelines on the construction of core indicators, as denominators for the ARV treatment coverage indicators serve the estimated treatment needs generated by SPECTRUM (UNAIDS 2009a). Entry data for EPP and Spectrum, and estimations and projections generated have been validated by decision makers and technical level representatives of key stakeholders at a national workshop, duly unacknowledging limitations related to data quality and availability. Based on the estimated number of people in need of treatment, coverage at the end of 2009 constituted 35,4% for both banks of the Dniester River, while the value of the respective indicator for 2008 has been 26,8% (Table 10). Indicator values have been entered into CRIS 3.

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 protocol (or WHO/UNAIDS standards) 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.

Source: Registries of patients in ARV treatment, Republican Dermatovenereal Dispensary, AIDS Centre in Tiraspol

Table 10 Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy, Republic of Moldova, 2008

Numerator				
All	Gender		Age	
	Females	Males	<15	15+
682	240	442	29	653
Denominator				
All	Gender		Age	
	Females	Males	<15	15+
2578	836	1742	31	2547
2008 Indicator value				
All	Gender		Age	
	Females	Males	<15	15+
26.45%	28.71%	25.37%	93.55%	25.64%

Source: Dermato-Venereal Dispensary and AIDS Centre in Tiraspol

Table 11 Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy, Republic of Moldova, 2009

Numerator				
All	Gender		Age	
	Females	Males	<15	15+
984	413	571	34	950
Denominator				
All	Gender		Age	
	Females	Males	<15	15+
2780	903	1877	34	2746
2009 Indicator value				
All	Gender		Age	
	Females	Males	<15	15+
35.40%	45.74%	30.42%	100.00%	34.6%

Source: Dermato-Venereal Dispensary and AIDS Centre in Tiraspol

Interpretation:

According to estimations and projections generated by SPECTRUM, around one third of the estimated number of people in need of treatment have been enrolled in ART at the time of the reporting, and the coverage is increasing continuously, being consistent with the targets established in absolute numbers (Table 12). When disaggregating the data by gender, we attest uniformous initiation in treatment for males and females.

Table 12 Projected coverage with ARV treatment, data for denominators were generated by SPECTRUM, %, Republic of Moldova, 2000 - 2015

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Adults													
Females	1,1	4,7	8,2	11,3	20,1	25,4	34,1	40,9	46,7	51,8	56,2	60,0	63,3
Males	1,1	4,7	8,3	11,2	20,0	25,3	34,2	41,0	46,8	51,9	56,2	60,0	63,3
Total	1,1	4,7	8,3	11,2	20,0	25,3	34,2	41,0	46,8	51,8	56,2	60,0	63,3
Children													
Females	10.5	11.1	18.8	43.8	56.3	93.3	106.3	81.8	81.8	90.5	100	100	100
Males	10.5	16.7	25.0	43.8	62.5	100.0	112.5	81.8	86.4	95.2	100	100	100
Total	10.5	13.9	21.9	45.2	61.3	93.5	106.1	81.8	84.1	90.7	100	100	100

Source: National Centre of Health Management

There were no cases of stock outs or waiting lists in the period of reporting. Therefore, all those in need of treatment that were referred or presented themselves to the line institutions responsible of treatment and clinical monitoring, and that expressed their will accordingly, were initiated on ARV treatment. Within round 8 of the GFATM, there are interventions planned aimed at promoting adherence and enrollment in treatment, as well as broadening the geographic coverage through further decentralization and establishment of 2 additional treatment centres. These actions are likely to increase demand for treatment and hence have an impact on coverage. Based on the increasing demand, the Republic of Moldova intends to invest efforts in mobilizing resources from external donors in order to ensure continuity of ARV treatment at the scope necessary.

Indicator nr 5 Percentage of HIV positive pregnant women who received ARV drugs to reduce the risk of mother to child transmission

According to the Order of the Ministry of Health No 314 of 31.07.2007 "Regarding the investigations and clinical monitoring for determining the HIV infection (or AIDS illness) contains detailed stipulations related to epidemiological and clinical indications for HIV testing it is recommended that pregnant women should be tested twice during their pregnancy; when the pregnant woman with unknown HIV status is interned in a health facility to give birth, rapid tests are used (Ministerul Sanatatii al Republicii Moldova 2007a)

In the year 2009, 99.3% of births took place in medical institutions. According to national statistics, HIV test coverage for pregnant women (at least once during pregnancy) is very high for pregnant women on both banks of Dniester River. Thus, out of the women that gave birth in the reporting period, the greatest majority has been tested for HIV (99.4% in 2009 and 95.8% in 2008, respectively) (Provider Initiated Testing).

The Counseling and Testing Service for HIV and Hepatitis B and C was created in 2007, reaching national coverage at the end of 2009, including the left bank of Dniester River. The geographical distribution of the VCT units is presented in Figure 11. Along with scaling up the VCT network, the coverage of women with VCT also improved. Thus, at the end of 2009, 27518 counselling visits for pregnant women were registered, the number being three times bigger than in 2008 (6536 counselling visits). Still referral of pregnant women to the VCT service remains unsatisfactory, testing being sometimes performed without proper pre-test and post-test counseling.

The study of evaluation of the Prevention of mother to child transmission of HIV services, carried out in 2009, has confirmed the high coverage with HIV tests (93,5% of the pregnant women in the post partum period stated that they were tested for HIV at least once during pregnancy). About half of respondents (49.8%) have discussed their results with doctors and only 16.9% received their results from a VCT counsellor (Bivol S. and Parkhomenko Zh. 2009). Coverage of pregnant women with counseling is much lower, which could be partly explained by the fact that the VCT network gained national coverage only at the end of 2009, but, most importantly, the insufficient referral of pregnant women to the VCT service by the family doctors responsible for monitoring physiologic pregnancies.

In 2008 there were 83 newly registered cases of HIV among pregnant women and 53 HIV positive women became pregnant and decided to keep the pregnancy. In 2009, 70 new HIV cases were identified among pregnant women, and 63 HIV positive women have become pregnant and have decided to proceed with the pregnancy. In time an increase in the number of HIV positive women who decide to keep the pregnancy may be observed.

Coverage with prophylactic ARV treatment is presented in Table 13. Indicator values have been entered into CRIS3.

Table 13 Percentage of HIV positive pregnant women who received antiretroviral drugs to reduce the risk of mother to child transmission, Republic of Moldova, 2008 and 2009

	2008	2009
Numerator	129	109
Denominator	136	133
Indicator value	94.9%	82.0%

Source: Dermato-Venereal Dispensary and AIDS Centre in Tiraspol

Method of calculation and indicator value

Data source: Registry of new HIV cases, registry of patients in pre ART monitoring and in ARV treatment, register of HIV positive pregnant women in prophylactic ARV treatment.

Numerator: Number of HIV positive pregnant women who received antiretroviral drugs to reduce the risk of mother to child transmission in the last 12 months.

Denominator: In the case of the Republic of Moldova, because of the high coverage with HIV tests, the number of HIV positive pregnant women was taken into account. The data generated by SPECTRUM and applying the second estimation method gave lower figures for denominator than the official statistics data.

Interpretation

Due to the high level of coverage with HIV tests, the number of HIV positive pregnant women, as specified in the administrative statistics, is considered nationally representative. According to national recommendations (Ministerul Sanatatii al Republicii Moldova 2007b), pregnant women are enrolled in prophylactic treatment beginning with the 24 week of the pregnancy while prophylactic treatment of the baby is recommended in the first seven days of its life. Hence, throughout 2009, out of 109 HIV+ pregnant women that received ARV treatment, 92 received 3 drugs regimen for prophylaxis of mother to child transmission and 17 were receiving ARV treatment for their own health, as specified in the national protocol. By the end of 2009, fewer women reached 24 weeks of pregnancy to receive ARV prophylaxis. Because of that, the coverage in 2009 is lower comparing to 2008.

Indicator nr 6 Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV

According to national recommendations (*Ministerul Sanatatii al Republicii Moldova 2007b*), HIV testing is recommended to TB patients. According to the national statistics, coverage with HIV testing of the new and retreatment cases of TB was 83.7% in 2008 and 90.5% in 2009 (for both banks of the Dniester River). The prevalence registered in 2008 and 2009 is about 5% (5.3% in 2008 and 4.2% in 2009). Between November 2007 – February 2008, the prevalence study among hospitalized new TB cases has registered approximately the same HIV seroprevalence as the national statistics (3.9%). The study sample included only hospitalized new TB cases on the right bank of the Dniester River, this constituting a limitation for the study's results (Soltan V. et al. 2008).

The counseling and testing service for HIV and Hepatitis B and C has also been established within institutions constituting the phthisiopneumology service. Thus, at the end of 2009, 4 VCT units were open in the medical institutions offering in-patient treatment services for TB cases. The geographical distribution of VCT for HIV and Hepatitis B and C is presented in Figure 11.

According to the national protocols (*Ministerul Sanatatii al Republicii Moldova 2009b*), 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.

Method of calculation and indicator value

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

Method of calculation:

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 TB cases 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 14.

Table 14 Percentage of new TB cases among PLHIV that have initiated anti-TB treatment in the Republic of Moldova, 2008 and 2009

	2008				2009			
	Males	Females	<15	15+	Males	Females	<15	15+
Numerator	35	32	0	67	45	18	0	63
Denominator	120	46	0	166	109	54	1	162
Indicator value, %	29.17	69.57	0	40.37	41.28	33.33	0	38.89
Total, %	40.4				38.7			

Source: National Centre of Health Management

There are no significant variations if comparing 2008 and 2009 data.

HIV testing

According to the Law No 23 – XVI of 16.02.2007 on prevention of HIV/AIDS testing for HIV is voluntary and consensual (Parlamentul Republicii Moldova 2007b). Testing is client-initiated or provider-initiated, and is performed based on guides for lab exams and medical monitoring developed and approved by the Ministry of Health. The precondition for testing is the voluntary and informed consent of the individual, expressed in writing. If the client is still a minor, an informed consent shall be obtained from both the minor¹⁵, and the legal guardian of the minor. If the consent of the legal guardian cannot be obtained due to objective reasons, and it is in the best interests of the child to be tested, the written informed consent of the latter shall suffice. The legal framework currently in force guarantees the right to confidentiality of test results and HIV status. Mandatory testing for HIV as a precondition for employment, travel, access to medical services, and admission to an educational institution is prohibited, with the exceptions provided for in the Law. All forms of hidden or implicit testing are prohibited. Testing for HIV is mandatory only in the following cases:

- Donations of blood, liquids, tissue and organs;
- Upon a court order, when a person is charged with the crime of willful transmission of HIV or rape, and when the indicted individual does not give consent for testing after benefiting of thorough counseling.

The “Standard on the Epidemiologic Surveillance of the HIV/AIDS Infection”, approved by the Order of the Ministry of Health No 20 of 19.01.2007 the biologic surveillance foresees screening of the donated blood, screening of some professional groups, and the screening of most at risk and vulnerable populations which in the Republic of Moldova are as follows (Ministerul Sanatatii al Republicii Moldova 2007a):

1. Injecting Drug Users,
2. Commercial Sex Workers,
3. Men having Sex with Men,
4. Clients of STI Clinics, patients with STIs or patients with clinical signs of STIs,

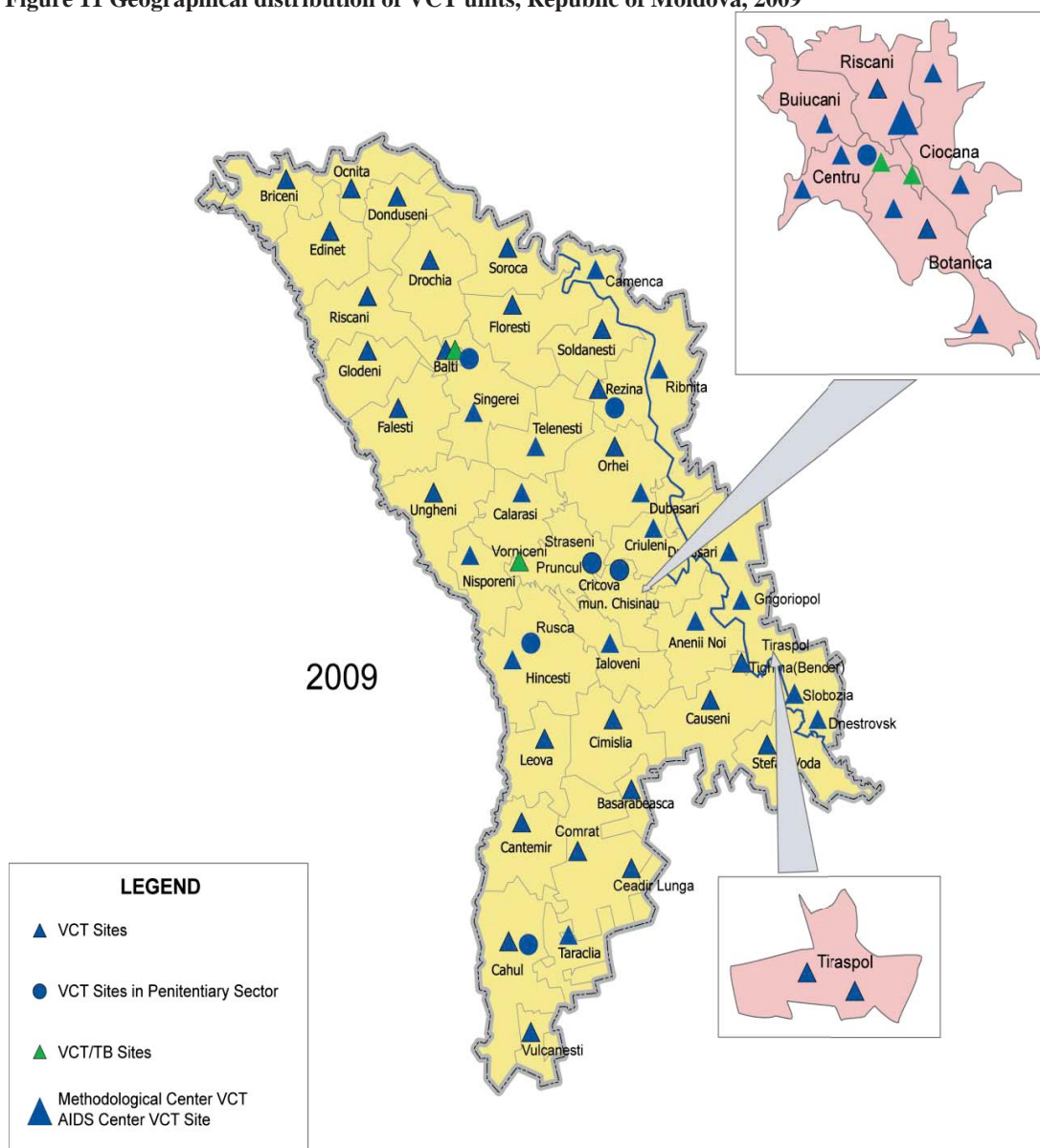
¹⁵ Under 18 years old.

5. Blood recipients subjected to multiple blood transfusions, as well as patients with coagulation disorders,
6. Frequent travelers, temporary migrants (including Roma population, truck drivers, and citizens of the Republic of Moldova who lived outside the country for more than 3 months)
7. Detainees and inmates in penitentiary institutions - persons engaging in higher risk behaviour.

The Order of the Ministry of Health No 314 of 31.07.2007 "Regarding the investigations and clinical monitoring for determining the HIV infection (or AIDS illness) contains detailed stipulations related to epidemiological and clinical indications for HIV testing (Ministerul Sanatatii al Republicii Moldova 2007b)"

In accordance with the Law No 23-XVI of 16.02.2007 On prevention of HIV/AIDS and the National Programme for Prevention and Control of the HIV/AIDS for the 2006-2010, by order 364 of 26.09.2007 "Regarding the creation of Voluntary Counseling and Testing units on the whole territory of the Republic" (Ministerul Sanatatii al Republicii Moldova 2007c), a network of Voluntary Counseling and Testing units for HIV and Hepatitis B and C has been established. The first 6 pilot units were opened beginning with December 1st, 2007. Technical and financial support for these 6 pilot centers was offered by the „Prevention of HIV/AIDS and Hepatitis B and C” project, financed by USAID. In the second phase of implementation, support in opening and consolidation of the VCT network was offered from the Round 6 grant of the GFATM. According to the national implementation plan, national coverage was reached at the end of 2009 (in 2008, the rollout for the right bank of Dniester River has been completed; in 2009, voluntary counselling and testing became available on the left bank of Dniester River as well). Therefore, by the end of 2009, 58 counselling and testing units have been established in the civilian sector in 45 administrative-territorial unit from those 46 planned. In the penitentiary system, with the financial support of the NGO „Carlux” that channeled funds from KNCV, the GFATM and resources cost-shared by the Penitentiary Institutions Department, cabinets for voluntary counselling and testing for HIV and Hepatitis B and C have been established in 7 penitentiaries (Ministerul Justitiei 2008).

Figure 11 Geographical distribution of VCT units, Republic of Moldova, 2009



For more details on the provisions related to the testing of pregnant women, and their testing, see the chapter *Indicator nr 5 Percentage of HIV positive pregnant women who received ARV drugs to reduce the risk of mother to child transmission.*

The VCT for HIV and viral Hepatitis B and C are opened in medical institutions and within the medical service of the respective penitentiary institutions. In 2009, 56806 pre-test counseling visits were made, most of visitors being females (72.5%). This fact may be explained by the more frequent addressability of females to medical institutions, particularly due to pregnancies (68.7% of pretest counselling visits involved pregnant women). There are still underused resources that could increase access to services, especially through better referrals from doctors.

For IDUs registered with the National Narcology Dispensary, biannual HIV testing is recommended according to MoH order (Ministerul Sanatatii al Republicii Moldova 2007b). Other populations at higher risk may access HIV testing, but not report themselves as belonging to these populations or practicing behaviours of higher risk, hence the routine statistics doesn't attribute their tests and results to the relevant codes identifying CSWs and MSM.

According to routine statistical data produced by the VCT units, in 2009, there were 252 counseling pretest visits made by IDU, 1 requested by MSM and 144 requested by CSWs. An evident underreporting

of most-at-risk behaviours during counseling can be attested. Additional trainings are necessary to transfer abilities to communicate with representatives of most at risk groups to counselors. On the other hand, underreporting errors notwithstanding, the extremely small number of visits from representatives of the most at risk populations imposes the stringency of bringing these prevention services closer to the risk groups and making them more accessible.

Indicator nr 7 Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their 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 2009 (see Appendix 2 Survey „ Gender-associated vulnerability to HIV, 2009”)

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 Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators. 2010 Reporting (UNAIDS 2009a).

The demographic structure of the sub-sample is represented in Table 15.

Table 15 Demographic structure of the sub-sample of 15-49 year olds, absolute numbers and %, Republic of Moldova, right bank of Dniester River, 2009

	Males		Females		Total	
	#	%	#	%	#	%
15-19 years	125	16.9	149	19.7	274	18.3
20-24 years	138	18.6	107	14.2	245	16.4
25-49 years	477	64.5	498	66.1	975	65.3
Total	740	49.5	754	50.5	1494	-

Source: Gender-associated vulnerability to HIV, 2009 (Bivol, Scutelnicuic, & Vladicescu 2009)

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 distribution by sex and by age group of the respondents (calculated at the numerator) is detailed in Table 16

Table 16 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, % and absolute figures, Republic of Moldova, (right bank of Dviester River), 2009

		Males		Females		Total	
		#	%	#	%	#	%
15-19 years	Numerator	7	5.4	12	8.2	19	6.9
	Denominator	125		149		274	
20-24 years	Numerator	12	8.9	20	18.8	32	13.2
	Denominator	138		107		245	
25-49 years	Numerator	54	11.3	92	18.4	145	14.9
	Denominator	477		498		975	
Total	Numerator	73	9.8	124	16.4	197	13.2
	Denominator	740		754		1494	

Source: Gender-associated vulnerability to HIV, 2009 (Bivol, Scutelnicuic, & Vladicescu 2009)

It has been attested that female respondents more frequently are covered with testing (16.4%) than male respondents (9.8%). For females, the difference between the coverage of the younger age group and older age groups is significant, fundamenting the assertion that the probability of an HIV test increases in the groups with highest fertility rates and may be associated with pregnancy. The age distribution of those tested among males is more uniform. Overall, the age group 15-19 is less likely to get tested. The parental consent is required until the age of 18 and this may act as a deterrent.

The value of this indicator for 2007 has been 8,5% (PHH Project 2007), while in 2008 among respondents of a general population survey coverage with testing in the last 12 months has been 10,3% (Scutelnicuic O. et al. 2009). The variations attested in the last 3 years are within surveys' margins of error and cannot allow us to affirm that scale up in coverage and knowledge of test results has been attested. Taking into account the fact that the coverage rollout with voluntary counselling and testing for HIV and Hepatitis B and C for the right bank has been achieved only by end of 2008, the impact of the respective services could be measured in several years.

Limitations of the indicator:

- a) The small number of respondents that reported being tested for HIV and knowing their result (197) does not allow for detailed analysis disaggregated by gender and age
- b) Results are representative only for the right bank of Dniester River

Indicator nr 8 Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results

Injecting Drug Users

Data source:

The data for this indicator have been collected within the framework of the Integrated Bio- Behavioral Survey carried out in 2009 among UDIs in the Chisinau and Balti municipalities and in the city of Tiraspol (left bank of the Dneister River) (*please see Appendix 4 Integrated Bio-Behavioural Survey in Injecting Drug Users*). Data from the capital city, the Chisinau municipality, have been entered into CRIS3.

Method of calculation:

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

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

Numerator: Number of IDUs respondents who have been tested for HIV during the last 12 months and who know the results.

Denominator: Total number of respondents.

Results:

The distributions by gender and by age group of the respondents that have received an HIV test during the last 12 months and know their results (and are part of the numerator) are showed in Table 17.

Table 17 Distribution by gender and age group of respondents that were HIV tested for HIV and know their results, % and absolute figures numbers, IDUs, Chisinau municipality, capital of the Republic of Moldova, 2009

		Males		Females		Total	
		#	%*	#	%*	#	%*
< 25 ani	Numerator	29	49.2	1	14.3	30	45.5
	Denominator	59	(57.7)	7	(5.6)	66	(48.2)
25 + ani	Numerator	106	47.1	17	48.6	123	47.3
	Denominator	225	(47.9)	35	(53.8)	260	(48.6)
Total	Numerator	135	47.5	18	42.9	153	46.9
	Denominator	284	(49.4)	42	(41.2)	326	(48.4)

*In () is the value of the indicator adjusted in RDSAT and entered into CRIS3

Source: (BSS 2009b)

In the case of male respondents, there are no significant differences in coverage between age groups. In the case of females, the coverage with HIV test and knowledge of results is higher in the age group of 25 and older than in the younger age group. Overall, coverage of females is lower.

For other 2 data collection localities, the coverage with HIV testing within the last 12 months with known result of the last test is lower comparing to the capital city. Thus, in the municipality of Balti the indicator reached 32.4%, but in Tiraspol – 23.6%. In case of Bati municipality the differences between age groups are significant (12.0% in those who are younger than 25 years and 35.7 in those who are 25 years or older), without difference between males and females.

Limitations of the indicator:

- a) 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 IDU population of the country. The IDU profile may vary among regions.
- b) The small number of recruited females does not allow for proper analysis when disaggregating by age groups.

Commercial Sex Workers

Data source:

The data for this indicator have been collected within the framework of the Integrated Bio- Behavioral Survey among female Commercial Sex Workers (FSWs) in 2009/2010 in Chisinau and Balti municipalities (please see Appendix 5 Integrated Bio-Behavioural Survey in female Commercial Sex Workers). Data from the capital city, the Chisinau municipality, have been entered into CRIS3.

Method of calculation:

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

1. “I don’t want to know the results, but did you receive the result the last test?”
2. “When was your latest HIV test?” one of the possible answers being “in the last 12 months”

Numerator: Number of respondents that have been HIV tested in the last 12 months and know their results.

Denominator: Total number of respondents.

Results: The distribution by age of the respondents that have received an HIV test during the last 12 months and know the results of the last test is showed in the Table 18.

Table 18 Distribution by age group of respondents that were HIV tested in the last 12 months and know the results of the last HIVtest, CSWs, Chisinau municipality, capital of the Republic of Moldova, 2009/2010

		#	%*
< 25 ani	Numerator	26	27.7 (19.2)
	Denominator	94	
25 + ani	Numerator	57	28.8 (26.6)
	Denominator	198	
Total	Numerator	84	28.2 (23.3)
	Denominator	298¹⁶	

*In () is the value of the indicator adjusted in RDSAT and entered into CRIS3

Source: (BSS 2009a)

There is no differences between age groups. This indicator in the other locality where data collection was carried out registered a close value (23.3% in the Balti municipality). In the case of Balti, the same significant difference in terms of age groups can be attested (16,0% in those younger than 25 and 29.5% in those 25 and older).

Limitations of the indicator:

- a) 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 CSWs population of the country. The CSWs profile may vary among regions.

Interventions in MARPs

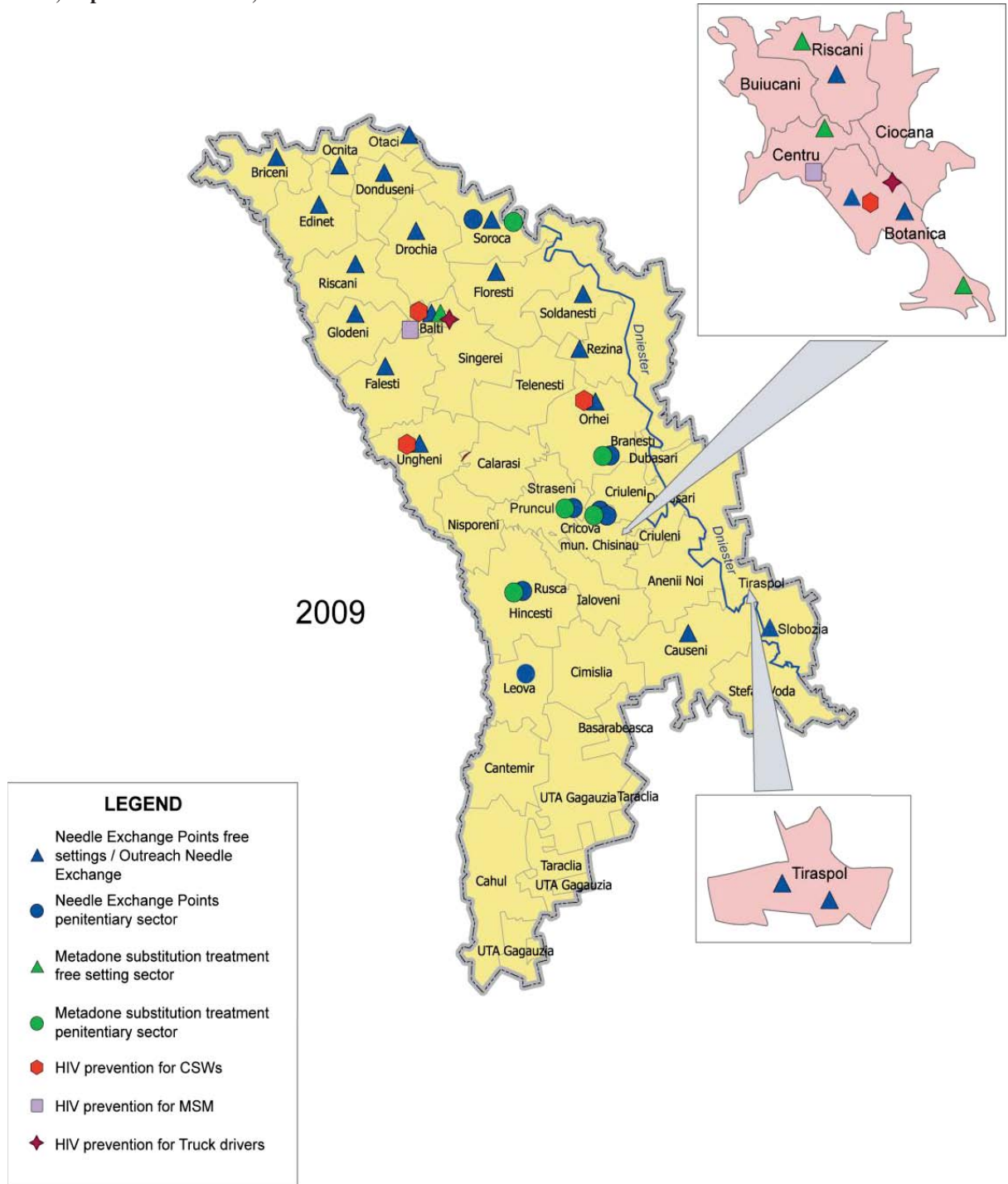
In the Republic of Moldova, the Harm Reduction Programme began in 1997 and is still active. On May 8th 2003, the Ministry of Health of the Republic of Moldova, represented by the PCU¹⁷, and the Soros Foundation-Moldova have signed an agreement based on which, the Soros Foundation Moldova has created a network of NGOs and Public Institutions to implement activities of HIV prevention among MARPs both in the civilian sector and in penitentiary institutions. The Soros Foundation-Moldova manages a grants program that finance harm reduction activities both from Global Fund resources as well as other international funding. Currently, the Government of the Republic of Moldova does not finance the Harm Reduction Programme.

According to the Law No 23 – XVI of 16.02.2007 *On the prevention of HIV/AIDS*, prevention programs are to be developed among children, women and families affected by HIV/AIDS, IDUs, military personnel, detainees, migrants, refugees and asylum seekers (Parlamentul Republicii Moldova 2007b). Strategy IV of the National Programme to Prevent and Control HIV/AIDS /STI for the years 2006 – 2010 stipulates HIV prevention among IDUs, CSW, MSM, out-of-school and unemployed youth and mentally disabled youth (Guvernul Republicii Moldova 2005d).

¹⁶ 6 respondent have missing age.

¹⁷ Project Coordination, Implementation and Monitoring Unit, the principal recipient of the GFATM grant in the Republic of Moldova, rounds 1, 6 and 8.

Figure 12 Geographical distribution of implementation sites, Harm Reduction Programme, IDUs, CSWs, MSM, Republic of Moldova, 2009



Source: Soros Foundation—Moldova, Harm Reduction Programme

Beginning with the launch of the Harm Reduction Programme¹⁸ until the end of 2009, cumulatively 13 050 IDUs (including penitentiary sector), 829 MSM and 1116 CSWs from the civilian sector have

18 The first Harm Reduction Project for IDUs started in 1997 and in 1999 in the penitentiary sector. The first Harm Reduction Project for CSWs started in 2003. The first Harm Reduction Project for MSM started in 2004.

benefitted of assistance. At the moment, it is not possible to estimate the double counting of beneficiaries, hence estimations of coverage based on the estimated size of MARPs groups has inherent limitations that are yet to be evaluated. In 2009 the implementation of the software for the unique identifier system was launched in order to avoid double counting. Implementers of Harm Reduction Programme have initiated the re-registration of beneficiaries, a process planned till the end of 2010.

In April 2008, the Soros Foundation Moldova has announced an open tender for financing projects implemented by NGOs and public institutions in the framework of GFATM Round 6 project. Due to the reductions in funding, cost-shared projects were particularly encouraged. As a result of the tender, in 2008-2009, 6 Harm Reduction projects targeting IDUs were implemented in the civilian sector in 20 territorial-administrative units; 3 projects targeting CSWs in 4 territorial-administrative units, and 2 projects for MSM in 2 territorial-administrative units (Figure 12/Figure 1).

In the 2008-2009 period, in the framework of the Harm Reduction Programme implementation, the following categories of interventions were carried out: information/education/outreach, needle exchange, referral to medical and social services, and methadone substitution therapy both in the civilian sector and in penitentiary institutions.

For MSM, the key components of Harm Reduction Programme in the Republic of Moldova are as follows:

- Information/education/outreach about HIV prevention in the context of higher risk behavior (distribution of informative materials, condoms, educational and informative seminars and events).

For IDUs/CSWs from the civilian sector, the basic components of the Harm Reduction Programme in the Republic of Moldova are as follows:

- Information/education/outreach about HIV prevention in the context of higher risk behavior (distribution of informative materials, condoms, educational and informative seminars and events);
- Referral to medical and social services (medical consultations, particularly for STIs diagnosis, psychological counseling, HIV pre- and post-test counselling);
- Needle exchange for IDUs;
- Methadone substitution treatment.

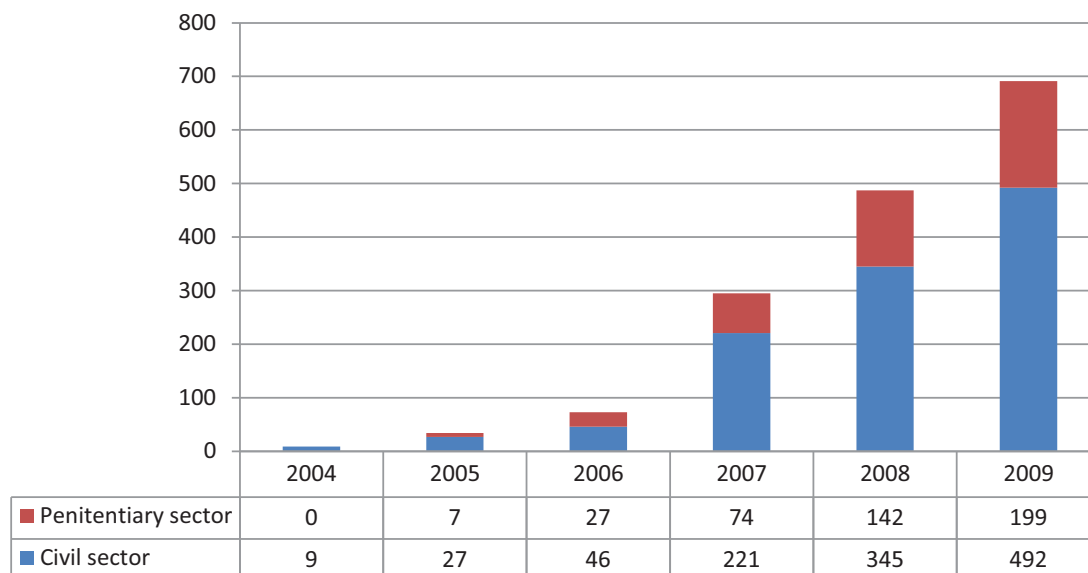
The basic components of the Harm Reduction Programme implemented in penitentiaries are the following:

- Information/education/outreach about HIV prevention in the context of higher risk behavior (distribution of informative materials, condoms, educational and informative seminars and events)
- Needle exchange for IDUs;
- Methadone substitution treatment.

In the 2008-2009 period, 4 methadone substitution treatment units were functioning within the Republican Narcology Dispensary in the municipality of Chisinau (in different regions of the city), 1 unit within the Balti Municipal Hospital and 5 units in penitentiary institutions. Due to the efforts made by specialists involved in programme implementation, starting with 2008 in some criminal investigation isolators in municipality of Chisinau and Balti the detainees could continue the methadone substitution treatment. Until the end of 2009, cumulatively, 691 drug users were enrolled in methadone substitution treatment (492 in the civilian sector and 199 in the penitentiary sector) (Figure 13). On July 18, 2008, by MoH decree No 283, the national clinical protocol „Mental and behavior disorders connected to the use

of opium derived drugs” has been approved (Ministerul Sanatatii al Republicii Moldova 2008). This decree approved the methadone substitution therapy protocol.

Figure 13 Cumulative number of methadone substitution treatment beneficiaries in the civilian and penitentiary sector, Republic of Moldova, (right bank of the Dniester River), 2004-2009



Source: (Soros Foundation - Moldova 2009)

In the reporting period, information materials were distributed and trainings on HIV prevention were carried out in all 18 penitentiary institutions in 8 prisons there were needle exchange units that functioned 24 hours a day, seven days a week (Figure 12). It is not possible to report on the number of IDUs benefiting from the HIV prevention projects in the penitentiary sector due to the unwillingness of detainees to report the use of such services. Due to this reason, starting with 2006, the estimated number of 2337 beneficiaries of HIV prevention is used. The Republic of Moldova model of Harm Reduction Programme in penitentiaries has been published as a best practice in “Harm Reduction in Prison: The Moldova Model” (Hoover J. and Jurgens R. 2009).

The national standard of treatment, assistance and support to drug users, that also includes harm reduction interventions, has been approved through Order of the In 2009 Ministry of Health No 266 on 03.08.2009 of „Regarding the approval of standards for harm reduction in the context of injecting drug use, and of psychosocial assistance to drug users” (Ministerul Sanatatii al Republicii Moldova 2009a). The purpose of these standards is increasing the efficiency of interaction between modern treatment methods of drug addicts and drug use prevention programs, providing for the continuity of assistance for drug users, including their social reintegration, improving HIV prevention.

Indicator nr 9 Percentage of most-at-risk populations reached with HIV prevention programmes

Injecting Drug Users

Data source:

The data for this indicator have been collected within the framework of the Integrated Bio- Behavioral Survey carried out in 2009 among UDIs in the Chisinau and Balti municipalities and in the city of Tiraspol (left bank of the Dneister River) (please see Appendix 4 Integrated Bio-Behavioural Survey in Injecting Drug Users). Data from the capital city, the Chisinau municipality, have been entered into CRIS3.

Method of calculation:

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

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 sterile needles/syringes?"
3. "In the last 12 months, did you receive free condoms?" (e.g. through an outreach service, NGO, youth friendly services or any other source?)

Thus the set of the questions can be adjusted to the recommendations Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators. 2010 Reporting (UNAIDS 2009). (UNAIDS 2009a)

Numerator: Number of IDUs respondents who stated they know where to get an HIV test and who received during the last 12 months free of charge needles/syringes and condoms.

Denominator: Number of respondents.

Results: The distributions by sex and by age group of the respondents are presented in Table 19.

Table 19 Distribution by sex and age group of the respondents that reported to knowing where to get an HIV test, and during the last 12 months received needles/syringes and condoms, IDUs, Chisinau municipality, capital of the Republic of Moldova, 2009

		Males		Females		Total	
		#	%*	#	%*	#	%*
< 25 years	Numerator	4	6.8 (3.2)	0	0.0 (0.0)	4	6.1 (2.6)
	Denominator	59		7		66	
25 + years	Numerator	31	13.7 (8.3)	7	20.0 (10.6)	38	14.5 (8.5)
	Denominator	227		35		262	
Total	Numerator	35	12.2 (7.4)	7	16.7 (7.6)	42	12.8 (7.4)
	Denominator	286		42		328	

*In () is the value of the indicator adjusted in RDSAT and entered into CRIS3

Source: (BSS 2009b)

Females have better coverage than males, and the age group 25 and older is better covered HIV prevention programmes, for both males and females. However, the sample of females that inject drugs is too small to be representative.

In Balti municipality, the indicator value is 29.2%, while in Tiraspol – 16.7%. Females seem to have better access to services in these locations as well. In Tiraspol females reported a 21.1% coverage, while males reported only 15.2%. In Balti, females reported a coverage of 38.3%, while males reported only 26.6%. In all data collection sites, the age group younger than 25 is less covered with HIV prevention services compared to those of 25 and older.

Limitations of the indicator:

- a) 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 IDU population of the country. The IDUs profile may vary among regions.
- b) The sample of females that inject drugs is too small and does not allow for proper analysis of disaggregation by age.

Commercial Sex Workers (Female Sex Workers)

Data source:

The data for this indicator have been collected within the framework of the Integrated Bio- Behavioral Survey among female Commercial Sex Workers (FSWs) in 2009/2010 in Chisinau and Balti municipalities (please see Appendix 5 Integrated Bio-Behavioural Survey in female Commercial Sex Workers). Data from the capital city, the Chisinau municipality, have been entered into CRIS3.

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?)

Thus the set of the questions can be adjusted to the recommendations Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators. 2010 Reporting (UNAIDS 2009). (UNAIDS 2009a)

Numerator: Number of respondents who said they know where to get an HIV test and who received free of charge condoms during the last 12 months

Denominator: Number of respondents included in the sample.

Results: The distribution by age of the respondents that had sexual contact and used is presented in Table 20

Table 20 Distribution by age of the respondents that reported to know where to get an HIV test, and during the last 12 months received condoms free of charge, CSWs, Chisinau municipality, capital of the Republic of Molodva, 2009/2010

		#	%*
< 25 years	Numerator	23	24.2 (15.5)
	Denominator	95	
25 + years	Numerator	47	23.5 (13.9)
	Denominator	200	
Total	Numerator	71	23.6 (15.3)
	Denominator	301¹⁹	

*In () is the value of the indicator adjusted in RDSAT and entered into CRIS3

Source: (BSS 2009a)

No significant differences across age groups have been registered. In the other sites where data have been collected indicates lower coverage with HIV prevention programmes (13.1% in Balti). Also, in Balti there are significant differences between age groups, those of 25 and older being better covered (6.1% in the age group younger than 25 years and 19.0% in those of 25 and older benefitted of HIV prevention interventions).

Limitations of the indicator:

- a) 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 CSWs population of the country. The CSWs profile may vary among regions.

Indicator 10

Not relevant for the country due to concentrated epidemic pattern.

knowledge and Behavior Indicators

Education and information in general population

According to the Law on Prevention of HIV/AIDS No 23 – XVI of 16.02.2007, information and education activities are stipulated explicitly for the general population and youth (Parlamentul Republicii Moldova 2007b). Strategy II of the National Programme on Prevention and control of HIV/AIDS/STIs 2006-2010 provides a clear framework for the development of a Communication Strategy in HIV Prevention and

¹⁹ 6 respondents have missing age, thus were counted for the total sample.

implementation of specific activities aimed at informing school children, youth and the general population about HIV/AIDS (Guvernul Republicii Moldova 2005d).

During the reporting period there was one campaign targeting the general population with the purpose to reduce stigma and discrimination of PLHIV. Starting with the 2005-2006 academic year, the “Life Skills Based Education” course has been implemented in schools. Due to political debates around it, the curriculum has been recommended as an optional course for children in schools and it covers children starting with the age of 12. The implementation of HIV prevention activities through peer to peer education started in 2007.

Indicator nr 11 Percent of schools offering Life Skills Based Education in the last school year

Data presented for this indicator were collected during a survey, representative for schools on the right bank of Dniester River, carried based on Ministry of Education Decision No 119 of 11.03.2010.

Sample size: 200 schools, including 11 primary schools, 91 gymnasiums (grades 1 to 9), 42 middle schools (grades 1 – 11) and 56 lyceums (grades 1 - 12).

Stratification criteria: the sample has been stratified using the following criteria: region, place of residence (big urban, small urban, rural), type of school, size

Sampling method: within pre-established strata, institutions have been extracted based on a random sequence from mathematical tables with random numbers

Results: The main finding of the survey has been that in the Republic of Moldova the value of the indicator related to life-skills based HIV prevention education in the academic year 2008/2009 equals 0. Out of the 200 institutions included in the sample representative for the school education system on the right bank of Dniester River, none had 30 or more hours of HIV prevention taught throughout the previous academic year for each grade .

However, when looking to the disaggregated data, we can attest that the higher the grade, the greater focus on HIV prevention topics (Table 21). The highest average has been registered for schools from small urban areas.

Table 21 Number of HIV prevention hours taught: average values, Republic of Moldova (right bank of Dniester River), academic year 2008/2009

		Big Urban		Small Urban		Rural		Total	
Primary school	Grade 1	0,87	0,92	0,79	1,07	0,65	0,85	0,71	0,89
	Grade 2	0,91		1,34		0,83		0,91	
	Grade 3	0,83		1,09		0,88		0,90	
	Grade 4	1,07		1,06		1,03		1,04	
Gymnasium cycle	Grade 5	1,44	2,27	4,22	5,27	2,35	3,87	2,47	3,85
	Grade 6	1,70		3,86		3,18		3,07	
	Grade 7	2,07		4,50		4,32		4,02	
	Grade 8	2,43		5,51		4,50		4,36	
	Grade 9	3,56		8,02		4,78		5,07	
Lyceum cycle	Grade 10	3,64	3,69	8,14	8,72	5,03	4,83	5,29	5,33
	Grade 11	3,75		8,75		4,29		5,04	
	Grade 12	3,66		9,28		5,14		5,67	

Source: (Ministerul Educatiei 2010)

We can conclude that the academic year 2008/2009 has been a year of maximum optimization of resources, and also a year when the curriculum has been heavily revised. In the respective academic year, the optional course Life Skills has been taught for a limited number of hours, hence the low values of HIV prevention hours reported. However, this was also the year when a new course, Civic Education, has been implemented as a mandatory course; the curriculum of the latter has been developed using modules of Life Skills, and teachers trained in Life Skills are used as resources for the Civic Education course. The survey indicates that pupils express the wish to study LSBE when there is such a didactic opportunity and capacity among teachers and that such a demand increases as age and grade progress.

At the moment of the request, the course is included in the school curriculum becoming a compulsory course for the respective group of students.

Indicator nr 12 School attendance by children

Data source:

Data presented for this indicator were collected during a general population survey, representative for the right bank of Dniester River, targeting 15 – 64 years old adults. Of the survey sample, 217 households have reported children 10 – 14 years old, the total number of children being 235. For household sampling the "Route method was applied" (see Appendix 1 „Routes Method”).

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. „Is the natural mother of this child alive and if yes, does she live in the same household as him?”
2. „Is the natural father of this child alive and if yes, does he live in the same household as him?”
3. „Did this child go to school at least once in the 2009/2010 school year?”

Part A School attendance by orphans aged 10 – 14

Numerator: Number of children who lost both their parents and who attend school.

Denominator: Number of children who lost both their parents.

Part B School attendance by orphans aged 10 – 14

Numerator: Number of children with both or at least one parent alive and who attend school.

Denominator: Number of children with both or at least one parent.

Results: The results are presented in the Table 22. Thus, of those children with both or at least one parent alive attended the school in 96,6% of cases. In case of the second sub-sample, the size is too small to apply any judgement. Data are not available disaggregated by gender.

Table 22 School attendance, children aged 10-14, Republic of Moldova (right bank of the Dniester River), 2010

	#	School attendance rate, %
Part A		
Number of children who lost both their parents and who attend school	1	50,0%
Number of children who lost both their parents.	2	
Part B		
Number of children with both or at least one parent alive and who attend school.	200	96,6
Number of children with both or at least one parent.	207	

Source: (CBS AXA 2010)

Indicator nr 13 Percentage of young women and men 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 Knowledge, Attitudes and Practices survey targeting youth aged 15-24 — a household survey, representative for the right bank of Dniester River, conducted in 2008 (see Appendix 3 “Youth knowledge, attitudes and practices regarding HIV/AIDS” survey).

The data collection instrument was created based on the guide for “Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV” (Family Health International

2004). The questionnaire for interviewing the 15-49 year old adult population was selected from this guide.

Method of Calculation:

The data collection tool included 4 out of the 5 questions recommended by Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators. 2010 Reporting (UNAIDS 2009a). The questionnaire did not include the question on misconceptions “Can a person get HIV from mosquito bites?” which has not been replaced by a regionally-relevant question pertaining to the regional context to ensure comparability with the 2006 survey results.

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. The risk of getting HIV can be reduced by using a condom every time they have sex?
2. The risk of getting HIV can 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 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 23.

The integrated indicator of the knowledge of youth on HIV transmission reaches the value of 40.8%.

The respondents in the age group 20 – 24 are overall better informed than the younger age group. The variations between the value of the indicator for young males and young females are within the survey’s sampling error.

Comparing the trends of the integrated knowledge indicator over time, an increase can be attested in 2008 (40,8%) (Scutelnicuic O. et al. 2008) compared to 2006 (26,3%) (Scutelnicuic O. et al. 2006).

Limitations of the indicators:

- a) The results are representative only for the right bank of Dniester River.

Table 23 Correct answers to questions on the knowledge on HIV transmission in 15-24 years age group, absolute figures and %, Republic of Moldova (right bank of Dniester River), 2008

Questions	Males						Females						Total						
	15-19 years		20 – 24 years		total		15-19 years		20 – 24 years		total		15-19 years		20 – 24 years		total		
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	
The risk of getting HIV can be reduced by using a condom every time they have sex?	Numerator	268		164		432		345		162		507		613		326		939	
	Denominator	331	81,0	195	84,1	526	82,1	432	79,9	204	79,4	636	80,3	763	81,7	399	80,8	1162	
The risk of getting HIV can be reduced by having sex with only one uninfected partner who has no other partners?	Numerator	260		155		415		335		172		507		595		327		922	
	Denominator	330	78,8	195	79,5	525	79,0	433	77,4	206	83,5	639	78,0	763	81,5	401	79,2	1164	
Can a healthy-looking person be HIV infected?	Numerator	252		157		409		352		166		518		604		323		927	
	Denominator	330	76,4	194	80,9	524	78,1	433	81,3	206	80,6	639	79,2	763	80,8	400	79,7	1163	
Can a person get HIV by sharing dishes with someone who is infected?	Numerator	182		138		320		285		135		420		467		273		740	
	Denominator	331	55,0	196	70,4	527	60,7	433	65,8	206	65,5	639	61,1	764	67,9	402	63,5	1166	
Integrated Indicator	Numerator	117	34,8	90	46,4	207	39,1	179	41,0	92	44,9	271	42,2	296	38,3	182	45,6	478	40,8%
	Denominator	336		194		530		437		205		642		773		399		1172	

Source: „Knowledge, attitudes and practices among youth related to HIV/AIDS”, 2008 (Scutelnicu O., Condrat I., & Gutu L. 2008)

Programmes for Education and Information among MARPs

For more details, please see Interventions in .

Indicator nr 14 Percentage of MARPs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Injecting Drug Users

Data source:

The data for this indicator have been collected within the framework of the Integrated Bio- Behavioral Survey carried out in 2009 among UDIs in the Chisinau and Balti municipalities and in the city of Tiraspol (left bank of the Dneister River) (*please see Appendix 4 Integrated Bio-Behavioural Survey in Injecting Drug Users*). Data from the capital city, the Chisinau municipality, have been entered into CRIS3.

Method of calculation:

In the data collection tool there were recommended 5 questions(UNAIDS 2009a).

The questionnaire did not include the question on misconceptions “Can a person get HIV from mosquito bites?” which has been replaced by a regionally-specific question. The set of questions in the data collection tool that have been used for the calculation of the integrated indicator of knowledge on HIV transmission included the following questions:

1. The risk of getting HIV can be reduced by using a condom every time they have sex?
2. The risk of getting HIV can 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?
5. Can a person get HIV by sharing a toilet with someone who is infected?

Numerator: Number of respondents who gave the correct answer to all 5 questions.

Denominator: Number of all respondents. The respondents that never heard of HIV and of AIDS have been included in the denominator.

Results: The distribution by sex and age group of the respondents with correct answers to all 5 questions and the values of the integrated indicator are shown in Table 24.

Table 24 Correct answers to questions on the knowledge on HIV/AIDS among IDUs, Chisinau municipality, capital of the Republic of Moldova, 2009

Questions	Male						Female						Total						
	15-19 years		20-24 years		total		15-19 years		20-24 years		total		15-19 years		20-24 years		total		
	#	%*	#	%*	#	%*	#	%*	#	%*	#	%*	#	%*	#	%*	#	%*	
The risk of getting HIV can be reduced by using a condom every time when having sex?	Numerator	56	94.5 (97.9)	210	92.5 (92.9)	266	93.0 (93.9)	7	100 (96.8)	35	100 (98.7)	42	100 (100)	63	95.5 (97.7)	245	93.5 (93.6)	308	93.9 (94.7)
	Denominator	59		227		286		7		35		42		66		262		328	
The risk of getting HIV can be reduced by having sex with only one uninfected partner who has no other partners?	Numerator	55	93.2 (97.6)	211	93.0 (92.8)	266	93.0 (93.6)	6	85.7 (85.2)	31	88.6 (91.6)	37	88.1 (90.3)	61	92.4 (95.1)	242	92.4 (92.7)	303	92.4 (93.2)
	Denominator	59		227		286		7		35		42		66		262		328	
Can a healthy-looking person be HIV infected?	Numerator	56	94.9 (95.1)	218	96.5 (92.7)	274	96.1 (93.7)	6	85.7 (100.0)	31	88.6 (89.4)	37	88.1 (92.3)	62	93.9 (100)	249	95.4 (92.3)	311	95.1 (93.5)
	Denominator	59		226		285		7		35		42		66		261		327	
Can a person get HIV by sharing dishes with someone who is infected?	Numerator	43	72.9 (83.0)	195	85.9 (85.3)	238	83.2 (84.9)	5	71.4 (72.1)	33	94.3 (93.1)	38	90.5 (92.7)	48	72.7 (80.7)	228	87.0 (86.2)	276	84.1 (85.9)
	Denominator	59		227		286		7		35		42		66		262		328	
Can a person get HIV by sharing a toilet with someone who is infected?	Numerator	41	69.5 (74.9)	193	85.0 (85.0)	234	81.8 (83.1)	5	71.4 (70.9)	27	77.1 (71.5)	32	76.2 (76.7)	46	69.7 (74.0)	220	84.0 (83.4)	266	81.1 (82.3)
	Denominator	59		227		286		7		35		42		66		262		328	
Integrated indicator	Numerator	31	52.5 (68.9)	152	67.3 (64.0)	183	64.2 (64.6)	4	57.1 (57.5)	23	65.7 (65.0)	27	64.3 (66.7)	35	53.0 (66.4)	175	67.0 (64.1)	210	64.2 (64.9)
	Denominator	59		226		285		7		35		42		66		261		327	

*In () is the value of the indicator adjusted in RDSAT and entered into CRIS3

Source (BSS 2009b)

No difference in the level of knowledge has been attested between males and females. For both males and females, the level of knowledge is higher in the older age group.

In Balti, the integrated indicator value constitutes 81.0%, while in Tiraspol – 36.8%²⁰. In Tiraspol, differences can be attested between the level of knowledge of males (38.3%) compared with females (32.4%). In Balti, there are no significant differences between males and females. In all data collection sites, the age group younger than 25 displayed a lower level of knowledge compared to the age group of 25 and older.

Limitations of the indicator:

- a) 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 IDU population of the country. The IDUs profile may vary among regions.

Commercial Sex Workers

Data source:

The data for this indicator have been collected within the framework of the Integrated Bio- Behavioral Survey among female Commercial Sex Workers (FSWs) in 2009/2010 in Chisinau and Balti municipalities (*please see Appendix 5 Integrated Bio-Behavioural Survey in female Commercial Sex Workers*). Data from the capital city, the Chisinau municipality, have been entered into CRIS3.

Method of calculation:

In the data collection tool there were 5 recommended questions (UNAIDS 2009a).

The questionnaire did not include the question on misconceptions “Can a person get HIV from mosquito bites?” which has been replaced by a regionally-specific question.

The set of questions in the data collection tool that have been used for the calculation of the integrated indicator of knowledge on HIV transmission included the following questions::

1. The risk of getting HIV can be reduced by using a condom every time they have sex?
2. The risk of getting HIV can 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?
5. Can a person get HIV by sharing a toilet with someone who is infected?

Numerator: Number of respondents who gave the correct answer to all 5 questions.

Denominator: Number of all respondents. The respondents that never heard of HIV and of AIDS have been included in the denominator.

Results: The distribution by sex and age of the respondents with correct answers to all 5 questions and the values of the integrated indicator are shown in Table 25.

²⁰ In Tiraspol the implementation of Harm Reduction Programme started in 2004, when in Balti in 1999

Table 25 Correct answers for questions referring to knowledge on HIV in CSWs, % and numbers, municipality of Chisinau, capital of the Republic of Moldova, 2009/2010

Questions		Total					
		< 25 years old		25 + years old		total	
		Number	%*	Number	%*	Number	%*
The risk of getting HIV can be reduced by using a condom every time when having sex?	Numerator	83	87.4 (85.1)	170	85.0(81.7)	258	85.7 (83.3)
	Denominator	95		200		301	
The risk of getting HIV can be reduced by having sex with only one uninfected partner who has no other partners?	Numerator	64	67.4 (67.0)	167	83,5 (81.1)	235	78,1 (77.1)
	Denominator	95		200		301	
Can a healthy-looking person be HIV infected?	Numerator	69	72.6 (71.2)	148	74,0 (67.9)	220	73.1 (68.4)
	Denominator	95		200		301	
Can a person get HIV by sharing dishes with someone who is infected?	Numerator	54	56.8 (55.7)	129	64.5 (59.0)	187	62.1 (58.9)
	Denominator	95		200		301	
Can a person get HIV by sharing a toilet with someone who is infected?	Numerator	41	43.2 (40.2)	126	63.0 (55.0)	169	56.1 (50.6)
	Denominator	95		200		301	
Integrated Indicator	Numerator	24	25.3 (28.3)	72	36.0 (29.5)	97	32.2 (28.7)
	Denominator	95		200		301²¹	

*In () is the value of the indicator adjusted in RDSAT and entered into CRIS3

Source (BSS 2009a)

The level of knowledge is higher in the age group of 25 and older. In Balti the integrated knowledge indicator is 53.6%. The age group 25 and older reported a higher level of knowledge compared to those younger than 25 years.

Limitations of the indicator:

- a) 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 CSWs population of the country. The CSW profile may vary among regions.

Indicator nr 15 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, representative for the right bank of Dniester River, conducted in 2008 (see Appendix 3 “Youth knowledge, attitudes and practices regarding HIV/AIDS” survey).

The data collection instrument was created based on the guide for “Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV” (Family Health International

²¹ 6 respondents have missing age.

2004).The questionnaire for interviewing the 15-49 year old adult population was selected from this guide.

Method of calculation:

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 sex 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 26.

Table 26 Distribution by gender and age of 15 – 24 years old respondents who stated that they had their first sex before age of 15th, Republic of Moldova (right bank of Dniester River), 2008

		Males		Females		Total	
		#	%	#	%	#	%
15-19 years	Numerator	50	14,8	5	1,1	55	7,1
	Denominator	338		438		776	
20-24 years	Numerator	22	11,1	2	1,0	24	5,9
	Denominator	199		207		406	
Total	Numerator	72	13,4	7	1,1	79	6,7
	Denominator	537		638		1182	

Source: „Knowledge, attitudes and practices among youth related to HIV/AIDS”, survey, 2008 (Scutelnicu O., Condrat I., & Gutu L. 2008)

Out of all respondents, 6.7% have stated they had their first sexual intercourse before the age of 15. Gender-associated differences for this indicator are obvious. However, underreporting among women is possible due to socially-accepted desirability bias.

In the 2006 survey, the value for this indicator has been 3,6%; the variation is within the limits of the statistical error.

Limitations for the indicator:

- a) The small number of respondents reporting early sexual initiation (72), constitutes a limitation in analysis of age and gender disaggregation.
- b) Recall and disarability biases are possible.
- c) Results are representative only for the right bank of Dniester River.

Indicator nr 16 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 2009 (see Appendix 2 Survey „ Gender-associated vulnerability to HIV, 2009”) 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 (UNAIDS 2009a). The demographic structure of the sub-sample is represented in Table 15.

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 27.

Table 27 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, Republic of Moldova (right bank of Nistru River), 2008

		Males		Females		Total	
		#	%	#	%	#	%
15-19 years	Numerator	22	17,4	4	2,7	26	9,4
	Denominator	125		149		274	
20-24 years	Numerator	40	28,7	6	5,3	45	18,4
	Denominator	138		107		245	
25-49 years	Numerator	71	14,8	4	0,8	75	7,7
	Denominator	477		498		975	
Total	Numerator	132	17,9	14	1,8	146	9,8%
	Denominator	740		754		1494	

Source: Gender-associated vulnerability to HIV, 2009 (Bivol, Scutelnicuic, & Vladicescu 2009)

Out of the survey respondents, 9,8% have reported having more than one sexual partner throughout the last year. The differences between males and females are evident, males reporting more frequently multiple partners. There may be underreporting among females due to socially-accepted desirability bias.

The value of the indicator reported in 2007 has been 8,3% (PHH Project 2007), while the value obtained through a general population survey in 2008 is 10,8% (Scutelnicuic O., Condrat I., & Plamadalea D. 2009). Hence, variations in the last 3 years are within limits of statistical error and do not fundament assertions on the increase or decrease of the share of population engaging in sexual relations with multiple partners.

Limitations of the indicator:

- a) The small sub-sample reporting multiple partners throughout the last 12 months (146) constitutes a limitation for proper analysis and disaggregation by sex and age group
- b) Recall and disarability biases are possible.
- c) Results are representative only for the right bank of Dniester River.

Risk Behavior

Indicator nr 17 Percentage of women and men aged 15-49 who had more than one partner in the last 12 months who 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 2009 (see Appendix 2 Survey „ Gender-associated vulnerability to HIV, 2009”) 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 (UNAIDS 2009a). The demographic structure of the sub-sample is represented in Table 15.

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 (calculated as numerator) is presented in Table 28.

Table 28 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 Dniester River), 2009

		Men		Women		Total	
		Num	%	Num	%	Num	%
15-19 years	Numerator	18	81,3	2	60,0	20	77,9
	Denominator	22		4		26	
20-24 years	Numerator	23	58,6	1	14,3	24	53,1
	Denominator	40		6		45	
25-49 years	Numerator	28	39,5	2	50,0	30	40,1
	Denominator	71		4		75	
Total	Numerator	69	52,1	5	38,4	74	50,8
	Denominator	132		14		146	

Source: Gender-associated vulnerability to HIV, 2009 (Bivol, Scutelnicuic, & Vladicescu 2009)

Out of the sub-sample of respondents reporting more than one sexual partner in the last 12 months, 50,8% stated the use of condoms at last sexual intercourse. The highest condoms use is in the age group 15 – 19, it is decreasing in older age groups.

The value of the indicator reported in 2007 has been 49,3% (PHH Project 2007), while the value registred in a general popualiton survey in 2008 is 46,1% (Scutelnicuic O., Condrat I., & Plamadeala D. 2009). Hence, variations in the last 3 years are within the limits of statistical error and do not fundament assertions on the increase or decrease of the share of those using condoms among the population engaging in sexual relaitons with multiple partners.

Limitations of the indicator:

- d) The sub-sample reporting multiple partners throughout the last 12 months (146) is too small for proper analysis and disaggregation by sex and age groups
- e) Recall and disarability biases are possible.
- f) Results are representative only for the right bank of Dniester River.

Indicator nr 18 Percentage of female sex workers reporting the use of a condom with their most recent client

Data source:

The data for this indicator have been collected within the framework of the Integrated Bio- Behavioral Survey among female Commercial Sex Workers (FSWs) in 2009/2010 in Chisinau and Balti municiplaties (please see Appendix 5 Integrated Bio-Behavioural Survey in female Commercial Sex Workers). Data from the capital city, the Chisinau municipality, have been entered into CRIS3.

Method of calculations:

In the data collection tool questions were formulated in the following way:

1. “Did the client you had the last sexual intercourse with use a condom?”

Numerator: The number of respondents who used a condom during their last commercial sexual intercourse.

Denominator: The number of respondents who reported having commercial sex in the last 12 months.

Results: Distribution by age group of the respondents who had sexual intercourse and who used a condom during their last commercial sexual intercourse is presented in Table 29.

Table 29 Distribution by age of the respondents who used a condom during their last commercial sexual intercourse, CSWs, Chisinau municipality, capital of the Republic of Moldova, 2009/2010

		Total	
		Num	%
< 25 years	numerator	93	97,9 (96,0)
	denominator	95	
25 + years	numerator	174	87,0 (87,0)
	denominator	200	
Total	numerator	272	90,4 (90,8)
	denominator	301	

*In () is the value of the indicator adjusted in RDSAT and entered into CRIS3

Source: (BSS 2009a)

The self-reported condom use is higher in the age group younger than 25 years. In the Balti municipality, the value of the indicator is 91.1%, condom use being higher in those younger than 25 years (92.7%) compared to those of 25 years and older (89.7%).

Limitations of the indicator:

- a) 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 SW population of the country. The SW profile may vary among regions.
- b) Recall and disarability biases are possible.

Indicator nr 20 Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse

Data source:

The data for this indicator have been collected within the framework of the Integrated Bio- Behavioral Survey carried out in 2009 among UDIs in the Chisinau and Balti municipalities and in the city of Tiraspol (left bank of the Dneister River) (please see Appendix 4 Integrated Bio-Behavioural Survey in Injecting Drug Users). Data from the capital city, the Chisinau municipality, have been entered into CRIS3.

Method of calculation:

The set of questions and answers on the basis of which calculations were made for the respective indicator, were presented as follows in the study questionnaire:

1. “When was the last time you used injecting drugs?” with the following answers: today/ during the last 7 weeks/ during the last 30 days.
2. “How many times you had sexual intercourses with
 - a. Your spouse/conhabitating in the last 30 days?” (>0) or
 - b. Permanent partner (non-cohabitating) in the last 30 days? (>0) or
 - c. Occasional partner in the last 30 days? (>0) or
 - d. Commercial Partner in the last 30 days? (>0)
3. „Did you use a condom during your last sexual intercourse?

Thus, the set of questions and answers have been adjusted to the recommendations (UNAIDS 2009a)

Numerator: The number of respondents, who injected drugs during the last month, had sexual intercourse during the last month and used a condom during the last sexual intercourse.

Denominator: The number of respondents, who injected drugs during the last month and had sexual intercourse during the last month.

Results: Distribution by sex and age of the respondents is presented in Table 30.

Table 30 Distribution by sex and age of the respondents who used injecting drugs during the last month, had sexual intercourse during the last month and used a condom during their last sexual intercourse, IDUs, Chisinau municipality, capital of the Republic of Moldova, 2009

		Males		Females		Total	
		#	%*	#	%*	#	%*
< 25 years	numerator	15	41,7 (39,0)	0	0,0 (0,0)	15	38,5 (35,1)
	denominator	36		3		39	
25 + years	numerator	44	33,3 (42,6)	4	20,0 (21,1)	48	31,6 (39,0)
	denominator	132		20		152	
Total	numerator	59	35,1 (40,5)	4	17,4 (12,2)	63	33,0 (35,6)
	denominator	168		23		191	

*In () is the value of the indicator adjusted in RDSAT and entered into CRIS3

Source: (BSS 2009b)

Females are less likely than males to use a condom during the last sexual intercourse.

The value for the respective indicator is 50.0% in Balti municipality and 36.9% in Tiraspol. In those other sites, the same trend persists of males reporting higher condom use than females. In the case of Tiraspol, these differences across gender constitute 34.6% among females and 37.7% among males. For Balti, these differences are almost twofold – 34.1% of females used condoms at last sex compared to 53.2% males. In all data collection sites, males in the age group younger than 25 reported higher condom use compared to males of 25 years and older; for females, the trend is reversed, less females under 25 reporting condom use compared to older age group. A limitation is the small sample of females IDUs participating in the survey.

Limitations of the indicator:

- a) 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 IDUs population of the country. The IDUs profile may vary among regions.
- b) The sub-sample of female IDUs reporting having sex is too small to make conclusive disgregations by age in the data analysis
- c) Recall and social disarability biases are possible.

Indicator nr 21 Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected

Data source:

The data for this indicator have been collected within the framework of the Integrated Bio- Behavioral Survey carried out in 2009 among UDIs in the Chisinau and Balti municipalities and in the city of Tiraspol (left bank of the Dneister River) (please see Appendix 4 Integrated Bio-Behavioural Survey in Injecting Drug Users). Data from the capital city, the Chisinau municipality, have been entered into CRIS3.

Method of calculation:

The set of questions and answers on the basis of which calculations were made for the respective indicator, were presented as follows in the study questionnaire:

- 1. “When was the last time you used injecting drugs?” with the following answers: today/ during the last 7 days/ during the last 30 days.
- 2. “Did you use sterile equipment the last time you injected?”

Thus, the set of questions and answers can be adjusted to the recommendations. (UNAIDS 2009a).

Numerator: The number of respondents, who used injecting drugs during the last month and used sterile equipment the last time they injected.

Denominator: The number of respondents who used injecting drugs during the last month.

Results: Distribution by gender and age group of the respondents is presented in Table 31.

Table 31 Distribution by sex and age of the respondents who used injecting drugs during the last month, and used sterile equipment the last time they injected, IDUs, Chisinau municipality, capital of the Republic of Moldova, 2009

		Males		Females		Total	
		#	%*	#	%*	Num	%*
< 25 years	numerator	46	97,9 (99,5)	5	100 (97,6)	51	98,1 (99,0)
	denominator	47		5		52	
25 + years	numerator	179	99,4 (98,9)	23	100 (98,9)	202	99,5 (98,9)
	denominator	180		23		203	
Total	numerator	225	99,1 (99,1)	28	100 (100)	253	99,2 (99,3)
	denominator	227		28		255	

*In () is the value of the indicator adjusted in RDSAT and entered into CRIS3

Source: (BSS 2009b)

The survey results are supporting conclusively the assertion that the direct sharing of injecting equipment have become a norm of conduct for the IDUs population. In Balti municipality, this indicator value constitutes 97.9%, while in Tiraspol – 91.2%. Compared to previous rounds of surveys, there are no significant variations between use of sterile injecting equipment at last.

Limitations of the indicator:

- a) 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 IDUs population of the country. The IDUs profile may vary among regions.
- b) Recall and social disarability biases are possible.

Impact Indicators

Indicator nr 23 Percentage of MARPs who are HIV-infected

Data source:

The data for this indicator have been collected within the framework of the Integrated Bio- Behavioral Survey carried out in 2009 among UDIs in the Chisinau and Balti municipalities and in the city of Tiraspol (left bank of the Dneister River) (please see Appendix 4 Integrated Bio-Behavioural Survey in Injecting Drug Users). Data from the capital city, the Chisinau municipality, have been entered into CRIS3.

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 sex and age group of respondents is presented in Table 32.

Table 32 Distribution by sex and age group of blood samples tested as HIV-positive as a result of ELISA testing, % and absolute figures, IDUs, Chisinau municipality, capital of the Republic of Moldova, 2009

		Males		Females		Total	
		#	%	#	%	#	%
< 25 years	numerator	0	0, 0 (0,4)	1	14,3 (40,8)	1	1,7 (10,0)
	denominator	38		7		60	
25 + years	numerator	38	18,3 (17,1)	9	27,3 (25,8)	47	19,5 (18,2)
	denominator	208		33		241	
Total	numerator	38	14,6 (14,2)	10	25,0 (29,8)	48	15,9 (16,4)
	denominator	261		40		301	

*In () is the value of the indicator adjusted in RDSAT and entered into CRIS3

Source: (BSS 2009b)

In Balti, the HIV prevalence is 42.0%, while in Tiraspol – 14.2%. When comparing with prevalence obtained through previous rounds of surveys, carried out exclusively among beneficiaries of Harm Reduction Programme, while duly taking into account the reduced comparability due to the change of recruitment methodology, significant variations have not been attested (please see Table 2).

Limitations of the indicator

- 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 IDUs population of the country. The IDUs profile may vary among regions.

Commercial Sex Workers (Female Sex Workers)

Data source:

The data for this indicator have been collected within the framework of the Integrated Bio- Behavioral Survey among female Commercial Sex Workers (FSWs) in 2009/2010 in Chisinau and Balti municipalities (please see Appendix 5 Integrated Bio-Behavioural Survey in female Commercial Sex Workers). Data from the capital city, the Chisinau municipality, have been entered into CRIS3.

Method of calculations:

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

Denominator: The number of tested blood samples.

Results: The distribution by age group of respondents is presented in Table 33.

Table 33 Distribution by age group of blood samples tested for HIV and tested positive, % and absolute numbers, CSWs, Chisinau municipality, capital of the Republic of Moldova, 2009/2010

		Total	
		#	%*
< 25 years	numerator	3	3.2 (1.7)
	denominator	95	
25 + years	numerator	17	8.5 (7.1)
	denominator	199	
Total	numerator	22	7.3 (6.1)
	denominator	300	

*In () is the value of the indicator adjusted in RDSAT and entered into CRIS3

Source: (BSS 2009a)

When comparing with prevalence obtained through previous rounds of surveys, carried out exclusively among beneficiaries of harm reduction, while duly taking into account the reduced comparability due to the change of recruitment methodology, significant variations have not been attested.

Limitations of the indicator:

- a) 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 CSWs population of the country. The CSWs profile may vary among regions.

Indicator 24 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Calculation method

Numerator: Number of adults and children who are still alive and on ARV treatment 12 months after initiating HAART.

Denominator: Number of adults and children who have initiated ART in reporting cohort (2008 cohort)

Source: Registers of patients enrolled in HAART, Republican Dermato-Venerial Dispensary, Tiraspol AIDS Center

Table 34 Percentage of people enrolled in ARV treatment that have reached 12 months of ARV treatment, Republic of Moldova, 2008 cohort assessed in January 2010

<i>Numerator</i>				
All	Sex		Age	
	Male	Female	<15	15+
233	156	77	10	223
<i>Denominator</i>				
All	Sex		Age	
	Male	Female	<15	15+
264	173	91	10	254
<i>Indicator value, 2009</i>				
All	Sex		Age	
	Male	Female	<15	15+
88.26%	90.17%	84.62%	100%	87.8%

Hence, the survival rate after 12 months in treatment constitutes 88,26%. No significant differences have been registered among males and females. Starting with 2007, the Tiraspol AIDS Center has began to dispense ARV treatment, the decentralisation further contributing to enhancing adherence. In the framework of the Round 8 GFATM grant, there are provisions for interventions aimed at scaling up enrolment in treatment and enhancing adherence, as well as scaling up accessibility of ARV treatment through geographic expansion (opening up 3 additional institutions). Clinical management of patients on HAART is to be strengthened via the involvement of multidisciplinary teams at raion (district) level, and the leading proactive role of the Infectious Diseases Doctor, with the key purpose of proper referral, timely initiation on treatment and scaled up adherence.

Indicator 25 Percentage of infants born to HIV-infected mothers who are infected

Efforts invested in prevention of mother to child transmission have resulted in maintaining the transmission rate at below 2% throughout the last years (1,7% according to routine statistics data). An evaluation for assessing gaps and quality in the PMTCT service (according to the 4 WHO strategic interventions) (WHO 2007) has been carried out in 2009 by the Ministry of Health, with the support of UNICEF. The external evaluation has endorsed the achievements of the previous years, but has also reflected the gaps as: insufficient oversight, management and coordination mechanisms; concerns related to the sustainability and continuity of the PMTCT services; access to and quality of services. The knowledge and skills of the medical personnel and the preparedness of medical institutions have also been assessed.

Calculation method

Numerator: Estimated number of new HIV cases in children generated by SPECTRUM

Denominator: *Estimated number of HIV+ pregnant women, generated by SPECTRUM*

Table 35 MTCT transmission rate, Republic of Moldova, 2008 and 2009, based on SPECTRUM generated data

	2008	2009
Estimated number of new HIV cases in children produced by SPECTRUM	1	1
Estimated number of HIV+ pregnant women, produced by SPECTRUM	84	74
Rate of mother to child transmission	2%	2%

Following the recommendations, both the numerator and the denominator represent SPECTRUM outputs. Entry data have been validated, and estimations and projections reviewed and endorsed through a participatory process by representatives of public institutions and NGOs at both decision making and technical levels. Hence, by the end of 2009, the mother to child transmission indicator has a value of 2% for both banks of Dniester River.

Additional Indicators

Additional Indicator 2 Percentage of health facilities that offer ART

Numerator: Number of health facilities that offer ARV treatment

Denominator: Total number of health facilities, excluding specialized facilities where ART services are not/ will never be relevant

Results: There are 3 institutions providing ARV treatment in the Republic of Moldova on both banks of Dniester River. Geographic extension up to 6 institutions is planned.

Indicator value is 50.0 %.

For more details please see *Indicator nr.4 Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.*

Additional Indicator 3 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 health facilities dispensing ARV drugs that experienced one or more stock-outs of at least one required ARV drug in the last 12 months.

Denominator: Total number of health facilities dispensing ARVs

Results: Indicator value is 0%. Stock-outs have not been registered during the reporting period.

For more detail please see *Indicator nr.4 Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.*

Additional Indicator 4 Percentage of health facilities providing ART using CD4 monitoring in line with national guidelines or policies, either on site or through referral

Numerator: Number of health facilities providing ART using CD4 monitoring in line with national guidelines or policies, either on site or through referral

Denominator: Total number of all health facilities providing ART

All 4 institutions currently provide ARV treatment by using CD4 monitoring according to national protocols on site (Dermato-Venereal Dispensary and AIDS Centre from Tiraspol) or through referral (Department of Penitentiary institutions and Slobozia Hospital).

Indicator value is 100%.

For more detail please see *Indicator nr.4 Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.*

Additional Indicator 5 Percentage of sexually active young people aged 15 - 24 who had an HIV test in the last 12 months and who know their results

Data source:

The data for this indicator have been collected within Knowledge, Attitudes and Practices survey targeting youth aged 15-24 — a household survey, representative for the right bank of Dniester River, conducted in 2008 (see Appendix 3 “Youth knowledge, attitudes and practices regarding HIV/AIDS” survey).

The data collection instrument was created based on the guide for “Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV” (Family Health International

2004).The questionnaire for interviewing the 15-49 year old adult population was selected from this guide.

Method of Calculation:

In the data collection tool, questions were formulated as follows:

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?”

Numerator: Number of sexually active young people aged 15 – 24 that have been tested for HIV in the last 12 months and know their results

Denominator: Number of respondents from this age category, including those that had never heard about HIV/AIDS

Results: Disaggregation by gender and age group are presented in Table 36.

Table 36 Distribution by sex and age group of respondents who stated that they have been tested in the last 12 months and know the result of the last HIV test, absolute figures and %, sexually active young people aged 15-24, the Republic of Moldova, 2008

		Males		Females		Total	
		#	%	#	%	#	%
15 - 19 years	numerator	10	7.1	6	8.6	16	7.6
	denominator	140		70		210	
20 – 24 years	numerator	21	14.0	30	21.4	51	17.6
	denominator	150		140		290	
Total	numerator	31	10.7	36	17.1	67	13.4
	denominator	290		210		500	

Source: „Knowledge, attitudes and practices among youth related to HIV/AIDS”, 2008 (Scutelnicuic O., Condrat I., & Gutu L. 2008)

The coverage with HIV testing and the level of awareness of HIV status are significantly higher in female respondents than in male respondents. In the age group of 20 and older, the coverage with HIV testing and the level of awareness of HIV status are significantly higher compared to younger age group. In the case of male respondents, the differences in awareness between the age groups are not significant.

Taking into account the fact that the addressability to medical services is reduced due to age minimum for expressing informed consent and parental consent issues for those below 18, and the fact that national coverage with services of Voluntary Counselling and Testing for HIV and Hepatitis B and C has been reached at the end of 2008 on the right bank, the impact of these services will be measured in several years. Institutionalizing age-sensitive referral mechanisms to services of Voluntary Counselling and Testing for HIV and Hepatitis B and C is a priority.

Limitations of the calculated indicator:

- a) The reduced number of respondents that reported being tested for HIV and being aware of their status (67) does not allow for a detailed analysis, desegregated by gender and age group.
- b) Results are representative only for the right bank of the Dniester River.

Additional indicator 6 Percentage of TB patients who had an HIV test result registered in TB register

For more detail please see Indicator nr 6 Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV

Data sources:

The data presented for this indicator have been generated by the SIME TB database which is a national database for the registration and surveillance of TB cases on both banks of the Dniester River. Thus, results are nationally representative for both banks of the Dniester River. SIME TB is the source for WHO data.

Calculation Method:

Numerator: Number of TB cases having at least one HIV test result registered in SIME TB database

Denominator: Number of TB cases registered in the SIME TB database

Results: In 2009, 81, 6% TB patients were tested for HIV and knew their HIV status (Table 37).

Table 37 Percentage of TB patients who had an HIV test result registered in TB register, Republic of Moldova, 2009

	Males	Females	0 – 4 years	5 – 14 years	15 +	Total
Number of TB cases with known HIV test result	3326	1263	59	78	4452	4589
Number of TB cases	4075	1498	71	97	5405	5573
% TB cases with known HIV test result	81,6	84,3	83,1	80,4	82,4	82,4
Number of TB cases with HIV positive status	180	77	0	1	256	257
% of TB cases with HIV positive status	5,4	6,1	0	1,3	5,2	5,6
Number of TB cases with HIV negative status	3146	1186	59	77	4196	4332
% of TB cases with HIV negative status	94,6	93,9	100	98,7	94,3	94,4

Additional indicator 8 Percentage of infants born to HIV-infected women who received an HIV test within 12 months

Numerator:

Number of children who have been tested to identify the virus during the first 2 months of life

Number of children who have been tested to identify the virus in the first 2-12 months of their life or for the presence of antibodies in the first 9 – 12 months

In 2009 a number of 112 children were tested according to numerator requirements.

Denominator: Estimated number of pregnant women.

Due to the high level of coverage with HIV tests, the number of HIV positive pregnant women, as specified in the administrative statistics, is considered nationally representative. We opted for using the routine statistics data instead of estimations, as the latter are underestimating the number of HIV positive pregnant women,

Thus, in 2009 a number of 133 pregnant women were registered.

$112/133 * 100 = 84, 2\%$

For more details please see the Universal Access Report.

Additional indicator 9 Percentage of children born to HIV positive mothers initiated on cotrimoxazol prophylaxis in the first 12 months of life

According to the National Protocol, criteria are as follows: i. CD4 less than 200 ii. infants born from HIV+ mothers that were tested positive within 2 months after birth (Ministerul Sanatatii al Republicii Moldova 2009b). Due to the fact that all children from the right bank have been tested to viral RNA before 2 months of life, cotrimoxazol has been administered only to children from the left bank, whose HIV status was confirmed later than 2 months of life.

Numerator: Number of children born to HIV positive mothers initiated on cotrimoxazol prophylaxis in the first 2 months of life

In 2009 a number of 33 children have been initiated on cotrimoxazol.

Denominator: Number of HIV positive pregnant women registered.

Thus, 133 pregnant women were registered in 2009.

Indicator value represents **24.8%**.

For more details please see the Universal Access Report.

Additional indicator 11 Percentage of young women and men aged 15-24 who report they could get condoms on their own

Data source:

The data for this indicator have been collected within Knowledge, Attitudes and Practices survey targeting youth aged 15-24 — a household survey, representative for the right bank of Dniester River, conducted in 2008 (see Appendix 3 “Youth knowledge, attitudes and practices regarding HIV/AIDS” survey).

The data collection instrument was created based on the guide for “Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV” (Family Health International 2004).The questionnaire for interviewing the 15-49 year old adult population was selected from this guide.

Method of Calculation:

In the data collection tool, questions were formulated as follows:

1. Do you know where to get a condom in case of need?
2. If yes, where can you find a condom in case of need?

Numerator: Number of young people aged 15 - 24 that have named at least a source where they would find a condom in case of need

Denominator: Number of respondents from this age group

Table 3 Distribution by sex and age group of the respondents who reported that they would find a condom in case of need, absolute figures and %, young people aged 15 - 24, the Republic of Moldova, 2008

		Males		Females		Total	
		#	%	#	%	#	%
15 - 19 years	numerator	297	88.1	334	77.7	631	82.3
	denominator	337		430		767	
20 – 24 years	numerator	180	92.8	183	88,4	363	90.5
	denominator	194		207		401	
Total	numerator	477	89.8	517	81.2	994	85.1
	denominator	531		637		1168	

Source: „Knowledge, attitudes and practices among youth related to HIV/AIDS”, 2008 (Scutelnicuic O., Condrat I., & Gutu L. 2008)

In the age group of 20 years and older, the indicator value is significantly higher than in the younger age group. The difference between age groups in males is not significant.

Limitations of the calculated indicator:

- a) Results are representative only for the right bank of the Dniester River.

Additional indicator 12 Percentage of never married young women and men aged 15-24 who have never had sex

Data source:

The data for this indicator have been collected within Knowledge, Attitudes and Practices survey targeting youth aged 15 – 24 years a household survey, representative for the right bank of Dniester River, conducted in 2008 (see Appendix 3 “Youth knowledge, attitudes and practices regarding HIV/AIDS” survey).

Method of Calculation:

The data collection instrument was created based on the guide for “Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV” (Family Health International 2004).The questionnaire for interviewing the 15-49 year old adult population was selected from this guide.

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

- 1. Have you ever had sexual intercourse?

Numerator: Number of never married young people aged 15 - 24 who had never had sexual intercourse

Denominator: Number of never married respondents aged 15 - 24

Results disaggregated by sex and age group are presented in Table 38.

Table 38 Distribution by gender and age group of respondents that had never been married and never had sexual intercourse, young people aged 15 - 24, the Republic of Moldova, 2008

		Males		Females		Total	
		Num	%	Num	%	Num	%
15 - 19 years	numerator	157	46.4	345	82.1	502	66.2
	denominator	338		420		758	
20 – 24 years	numerator	18	9.9	41	30.4	59	18.6
	denominator	82		135		317	
Total	numerator	175	33.7	386	69.5	561	52.2
	denominator	520		555		1075	

Source: „Knowledge, attitudes and practices among youth related to HIV/AIDS”, 2008 (Scutelnicuic O., Condrat I., & Gutu L. 2008)

In the age group of 20 and older, the indicator value is significantly higher than in the younger age group. Female respondents reported more frequently no prior sexual experience compared to male respondents.

Limitations of the calculated indicator:

- a) Recall and social disarability biases are possible.
- b) Results are representative only for the right bank of the Dniester River.

Additional indicator 13 Percentage of men aged 15-49 reporting sex with a sex worker in the last 12 months who used a condom during last paid 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 2009 (see Appendix 2 Survey „ Gender-associated

vulnerability to HIV, 2009”) 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 (UNAIDS 2009a). The demographic structure of the sub-sample is represented in Table 15.

Method of calculation:

In the data collection tool, questions were formulated as follows:

1. “How many commercial sex partners have you had in the last 12 months?” with the answer > 0.
2. “Did you use a condom during your last sexual contact with a sex worker?”

Numerator: Number of men aged 15 - 49 who report they used a condom at last paid sexual contact with a commercial partner in the last 12 months

Denominator: Number of men aged 15 - 49 having paid sexual contact with commercial partner during the last 12 months

Results disaggregated by sex and age group are presented in Table 39.

Table 39 Distribution by sex and age group of male respondents who reported that they used a condom during their last paid sexual contact, 15-49 years, Republic of Moldova (right bank of the Dniester River), 2009

		Males	
		#	%
15 - 19 years	numerator	1	100.0
	denominator	1	
20 – 24 years	numerator	1	50.0
	denominator	3	
25 – 49 years	numerator	10	74.0
	denominator	13	
Total	numerator	12	72.3
	denominator	17	

Source: Gender-associated vulnerability to HIV, 2009 (Bivol, Scutelnicuic, & Vladicescu 2009)

Out of the sub-sample of males reporting sexual contacts with sex workers in the last 12 months, 72,3% reported using a condom during the last sexual contact with the commercial partner. The value of this indicator is higher in the age group of 25-49 years compared to other age groups. The indicator value within the study carried out in the general population in 2008 is 76.7% (Scutelnicuic O., Condrat I., & Plamadeala D. 2009). Thus, variations registered in the last 2 years are within the limits of the sampling error and do not allow to assert that the condom use at last paid sex among men aged 15-49 who had commercial partners became more or less frequent.

Limitations of the calculated indicator:

- a) The small number of respondents who reported that they had paid sexual partners during the last 12 months (17) does not allow detailed analysis of data disaggregated by gender and age group.
- b) Recall and social disarability biases are possible.
- c) Results are representative only for the right bank of the Dniester River.

Additional indicator 14 Percentage of women and men aged 15-49 expressing accepting attitudes towards people living with HIV

Data source: The data for this indicator have been collected within the framework of the household survey carried out in the general population in 2009 (*see Appendix 2 Survey „ Gender-associated vulnerability to HIV, 2009*”) 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 (UNAIDS 2009a). The demographic structure of the sub-sample is represented in Table 15.

Method of calculation:

In the data collection tool, questions were formulated as follows:

1. If someone of your relatives (male) got infected with HIV (the virus causing AIDS) would you take care of him at home?
2. If someone of your friends got infected with HIV, would you want it to remain a secret?
3. If someone of your relatives (female) got infected with HIV (the virus causing AIDS) would you take care of her at home?
4. If you found out that the owner of the grocery store or the canteen you attend is HIV infected, would you continue buying food from that store?
5. If a teacher/professor were HIV positive, without having AIDS symptoms, can he continue teaching?

Numerator: Number of respondents aged 15 - 49 who answered correctly to all key questions, hence expressing tolerant attitudes towards PLHIV

Denominator: Number of respondents aged 15 - 49 who have heard about HIV/AIDS

Results disaggregated by sex and age group are presented in Table 40.

Table 40 Distribution by sex and age group of respondents expressing a tolerant attitude towards PLHIV, 15-49 years, Republic of Moldova (right bank of the Nistru River, 2009)

	Total	Males	Females
15 – 19 years	1.9%(5/265)	0.8%(1/119)	2.1%(3/146)
20 – 24 years	0.8%(2/239)	0.8%(1/132)	0.9%(1/107)
25 – 49 years	0.8%(7/935)	0.4%(2/454)	1.0%(5/482)
Total	1.0%(14/1439)	0.6%(4/704)	1.2%(9/735)
Non-educated persons	0%(0/1)	-	0%(0/4)
Primary education	0%(0/10)	0%(0/8)	9,1%(1/11)
Secondary and higher education	0.9%(13/1436)	0.6%(4/695)	1.3%(9/719)

Source: Gender-associated vulnerability to HIV, 2009 (Bivol, Scutelnicuic, & Vladicescu 2009)

The presented results indicate a very low level of tolerance. The indicator value within the survey carried out in the general population in 2008 is 2.8% (Scutelnicuic O., Condrat I., & Plamadeala D. 2009). Thus, variations registered in the last 2 years are within the limits of sampling error, and no trends can be identified.

Limitations of the calculated indicator:

- a) Reduced number of respondents reporting tolerant attitudes (14) increases the sampling error when attempting disaggregation by gender, age group, and level of education;
- b) Results are representative only for the right bank of the Dniester River.

Examples of good practices

By adopting the „3 Ones” principle and along with the implementation of the grants from the GFATM since 2003, the National Coordination Council became the main mechanism to coordinate and implement the National Programmes on Prevention and Control of HIV/AIDS/STI and TB. Members of this coordination mechanism are representatives of relevant public authorities, representatives of donors and nongovernmental organizations active in the national response. In the Republic of Moldova, this mechanism proved to be functional and allows for the consolidation of national and international efforts to achieve national response objectives. According to the latest changes in its structure, the number of civil society representatives was extended to 40% of all members; a representative of the private sector has also been granted full membership. To fully achieve the “3 Ones” and for a better case management, the Ministry of Health carried out an independent external evaluation of the system that coordinates activities in HIV/AIDS, and identified problems and barriers that reduced system efficiency. Subsequently, based on the recommendations, the Ministry of Health carried out a series of measures for restructuring the infrastructure of service provision to PLHIV focused services, including by creating a national-level Programme coordination and implementation institution.

In the reporting period there was a more efficient cooperation with the Ministry of Labor, Social Protection and Family that was institutionalised as a technical workgroup in the National Coordination Council. Thus the legal framework in the field of social protection to reduce stigma and discrimination of PLWHA and social protection activities have increased.

Based on a survey carried out in 2008 among PLHIV, the highest level of stigma and discrimination of PLHIV encounter has been attested in the health system. In 2009, in order to minimize stigma and discrimination, the Ministry of Health undertakes a series of trainings for doctors and nurses, and develops a Guide “Reducing stigma and discrimination related to HIV” and a Trainers’ Guide.

The Republic of Moldova is known in the region as an example of good practice through the successful implementation of Harm Reduction Programs for the most at risk groups in free settings (IDUs, CSWs and MSM) and the penitentiary sector (IDUs). Thus, there are information/education/outreach, needle exchange services, referral to medical and social services and methadone substitution treatment both in the civil and penitentiary sectors. Because the Harm Reduction Program is mostly financed from external sources²², along with the dramatic reducing of financing in the GFATM, Round 6, there is a lack of coverage and quality of provided services.

The implementation and consolidation of a unique Monitoring and Evaluation system could serve as another example of good practices. By creating an M&E unit inside a public structure responsible for the information in health and fortifying its capacities in time, the centralization of data collection and their standardization has been succeeded. The increase in the quality of data is one of the results of the efforts made both by national and international organizations. As part of the Round 6 grant of the GFATM, the M&E unit was assigned as the main data collector and supplier for the M&E of the grant, having the role of a validator. GFATM is the most important donor of the national HIV response and in this context, the involvement of the M&E unit in data collection, facilitates the establishment of previously absent national reporting mechanisms and the consolidation of the existent ones. Already two years after the implementation of the grant, the reporting mechanisms and the external validation traditions were created. In this case, the collection of data for the left bank of the Dniester River has been possible, which was not the case previously. It should be mentioned that the interaction with authorities on the left bank has an exclusive tangency with the involvement of external resources but it is a step ahead.

In the reporting period, the Ministry of Health has initiated and later approved and implemented the system to provide services of Voluntary Counselling and Testing financed from the state budget through the National Health Insurance Fund.

²² Except methadone substitution treatment where staff costs are covered from the public budget.

The Republic of Moldova won a grant of the GFTAM, Round 8 which has the creation of social assistance mechanisms for PLHIV, considered be deficient in the present social assistance system as its objectives. In case it succeeds, this might serve as an example of good practices.

Major Challenges and Remedial actions

Legal and policy frameworks related to HIV and AIDS in the Republic of Moldova are generally strong. A MDG-centered National Development Strategy for 2008 - 2011 has been developed through a participatory process, progress towards national targets for each MDG being assessed as part of the strategic planning exercise (Parlamentul Republicii Moldova 2007a). The National Programme on Prevention and Control of HIV/AIDS and STIs has been evaluated at mid-term, and major gaps have been elucidated sharpening the focus of implementation throughout 2009, and guiding the preliminary steps in developing a new programme cycle for 2011 – 2015 (Anon 2009). The Situational Analysis and Response Analysis undertaken in late 2009 as part of the strategic planning process has outlined key gaps and recommended remedial actions (Bivol S. 2009).

While the majority of financial resources congregate to prevention of HIV, an in-depth evaluation of what works and what doesn't has not been carried out. Interventions in the general population and youth are broad and lack the necessary concrete behaviour change plans. Importantly, coordination and sustainability are affected by the lack of a public institution at central level willing to undertake the overall responsibility for HIV prevention and to consolidate efforts of NGOs and public institutions active in the field. Harm Reduction Programme needs to be further scaled up geographically and a more comprehensive package of services ought to be offered to enhance their attractiveness for target population. Services as Voluntary Counselling and Testing and STIs counseling need to be brought closer to populations at higher risk via effective referral mechanisms, counseling and diagnosis via rapid tests dispensed in places where populations at higher risk congregate, and appropriate skills and capacities ought to be developed for tolerant and inclusive service provision.

Arguably, there are signs of generalization of the concentrated epidemic in the Republic of Moldova, and there are allegations that migration may play a certain role in that. Solid strategic information is needed to fundament decision-making at this turning point of the national response, guiding the strategic planning for designing and implementing quick wins as well as sustainable actions for a long term impact. The institutional and human capacity of the M&E system ought to be further strengthened to produce quality data that would guide evidence-based decision making. Enhanced data dissemination mechanisms, and a functional national database and data depository shall constitute affirmative steps in enhanced data use for strategic decision making.

The frozen political conflict on the Dniester River and the somewhat disjointed collaboration in the framework of the national HIV response affects both availability of nationally-representative data as well as focused interventions, sensitive to the greater prevalence trends and the more pure nature of the concentrated epidemic in population at higher risk in the Transnistrian region. Joint implementation of GFATM grants is a powerful advocacy tool, and it ought to be used to ensure that regular reporting mechanisms and data flows are institutionalized.

Most importantly, Republic of Moldova ought to plan for the longer term and design sustainable interventions, increasingly relying on national systems to avoid over-reliance on external funding. National Health Accounts shall represent important planning and expenditure tracking tools once institutionalized.

Support required from development partners

As part of the implementation of GFATM grant, Round 8, there are plans for activities having the increase of adherence end enrollment in treatment, increase of geographic access to ARV treatment (additional opening of 2 extra institutions) which could result in the rise of the requirements for treatment along with the finalization of the demand for treatment, along with the finalization of support from global fund grant round 6, the Government of the Republic of Moldova is about to apply for

financing from external donors in order to insure the continuation of ARV treatment after 2012 according to demands and necessities.

As mentioned earlier, the Republic of Moldova is known in the region as an example of good practice in the successful implementation of Risk Reduction Programs in increased risk groups both in the civil (IDUs, CSWs and MSM) and the penitentiary sector (IDUs). At the moment, the program has a budget deficit, which doesn't allow for the extension and insuring the quality of the services. Following a decrease in financing beginning with 2008 (occurring also because of a decrease in the buying power of the US Dollar which is the currency of the GFATM grant, Round 6), regionalizing of implementation (reducing administrative costs) allowed for the presence of services, which are in far from being sufficiently comprehensive to lead to an impact. International support for this field becomes stringent.

Technical support has a special role in the assistance of development partners. Thus in the following years, keeping in mind that the government is in the course of elaborating a new National Programme, there is an imperative for the estimation of costs per unit and per service for the budgeting of the programme, consolidating the strategic planning capacities and monitoring and evaluation of activities.

Plus, in the context of reporting *Indicator nr 11 Percent of schools offering Life Skills Based Education in the last school year*, there is a necessity for an extra national or regional effort to bring educational systems to insure services for the information and creation of abilities for school children.

Another absolutely necessary dimension in the context of carrying on the new National Programme is the extended involvement of NGOs in the achievement of activities, in this context there being a necessity to consolidate the capacity of the non-governmental sector, as well as support in the implementation of mechanisms to finance NGOs from the state budget.

Human resources availability and their capacity is also quite low particularly in rural areas. The health sector suffers from extremely low salaries which provide little incentive to improve quality and capacities. Counseling and communication skills are particularly weak, which hinders health promotion and disease prevention activities. Limited knowledge about HIV and AIDS, particularly among primary healthcare professionals and local level social assistants, leads to perpetuation of stigma and discrimination that continue to impede counseling, referral services and prevent people from getting tested, disclosing their status and seeking treatment, support and care. Other capacity gaps include limited knowledge of and poor promotion of human rights of PLHIV, by duty bearers at central and local levels but also by claim holders themselves. Another issue is the lack of staff in NGOs which put impediment to scale up of outreach programmes. Turnover of staff is a particular problem as in 2007 80% of staff from penitentiary institutions left the system and thus the 80% of newly hired staff lack knowledge on HIV/AIDS and harm reduction which impedes proper implementation of harm reduction activities for IDUs in prison. The newly recruited staff is in urgent need of training to ensure success of the programme. Another major gap identified is the fact that the available human resources are mainly concentrated in the health sector with very few resources available outside the health sector. There is a severe shortage of human resources in the field of HIV prevention and especially of those who would provide services to populations at higher risk. As a practice delivery of services towards populations at higher risk is available through NGOs that are severely underfinanced.

There are also gaps in available services that impair the efforts of stakeholders to deliver HIV prevention services. Geographic accessibility was recognized as one of the factors of low addressability to VCT services, Harm Reduction, knowledge about HIV and AIDS. Such services are mostly limited to those provided by NGOs with little coverage and consistency. The recently conducted needs assessment of PLHA has identified a series of services aimed at populations at risk that would increase considerably the addressability of populations at risk into existing services, for services of Harm Reduction Programme for example these are the therapeutic communities, for VCT this will be mobile units, for youth friendly services this will be the development of a legal framework etc.

Another issue of concern is strengthening of health system to better respond to the needs of PLHIV and mainstreaming of HIV and AIDS across the health system in terms of service delivery.

Monitoring and Evaluation

Starting with year 2005, the Ministry of Health of the Republic of Moldova, together with its partners, including the Global Fund, the World Bank and UNAIDS created the concept of the national monitoring and evaluation system for National Program on Prevention and Control of HIV/AIDS/STIs and TB. An HIV/TB M&E unit has been created as a department of the National Centre of Health Management of the Ministry of Health. It is responsible for M&E of the National Health Programmes. The M&E Unit monitors a set of indicators which has been developed and agreed by all stakeholders to support monitoring and evaluation of the National Program on Prevention and Control of HIV/AIDS/STIs and ensures regular UNGASS and Universal Access reporting with all proper consultations and data collection.

The M&E Unit has produced three UNGASS reports with all the proper consultations and data collection for the years 2004-2005, 2006-2007 and 2008 - 2009, Universal Access report 2008 and 2009. Other products included the development of the unified M&E framework, as stipulated in the National M&E Plan, as well as unified national indicators set. The M&E unit has also carried out the following surveys to measure outcomes: Integrated Bio-Behavioural Survey in 2007 and 2009 in populations at higher risk (IDUs, CSWs, MSM and prisoners), Knowledges, Attitude and Practices surveys in 2006 and 2008 in youth, quantitative and qualitative research in most at risk adolescents (young IDUs, young CSWs and young MSM), situational analysis of children and families affected by HIV and AIDS, evaluation of prevention of HIV vertical transmission services in the Republic of Moldova. In 2009, the process of the national size estimation of IDUs, CSWs and MSM started and preliminary data are available for the right bank of Dniester River. The methods used are as follows: multiplier, capture-recapture and Network Scale Up for national estimations.

The National Coordination Council acts as a decision-making and coordination forum for the national M&E system; there is a permanent Technical Work Group on M&E under the National Coordination Council.

The routine health data collection system includes HIV and STI case registration and HIV clinical monitoring registration, HIV testing information and blood donors screening registration. (Scutelnicu O. 2008).

Outcome indicators collection system includes 2nd generation surveillance (Integrated Bio-Behavioural Surveys) and population-based surveys (general population and youth household surveys). The 2nd surveillance system provides biannual collection of behavior and seroprevalence data from various groups (IDUs, FSWs, MSM and inmates). Since year 2004, three rounds of Integrated Bio-Behavioural Surveys have been conducted thus far, with the last one currently in the implementation phase. Knowledges, Attitude and Practices surveys have been conducted in years 2006 and 2008 with the last one currently in the implementation phase. Population-based surveys have been also carried out by various entities: RHS (1997), DHS (2005), MICS, Survey on Knowledge, Attitudes and Practices related to HIV/AIDS among general population (AFEW, USAID PHHP).

In 2008 the HIV M&E system has been thoroughly self-assessed by a large team of national stakeholders. The methodology was based on Organisational Framework for Functional M&E Systems using the 12 components tool (UNAIDS and MERG 2008) endorsed by MERG and included a multi-stakeholder assessment workshop with seven distinct groups of stakeholders representing different institutions and levels of the M & E system. (National Coordination Council for HIV/AIDS & TB of the Republic of Moldova 2009)

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, 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

Data sources for indicators

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 „ Gender-associated vulnerability to HIV, 2009”

Source: (Bivol, Scutelnicuic, & Vladicescu 2009)

Type of research: quantitative study in households.

Target group: general population aged 15 – 64, permanent inhabitants of the Republic of Moldova (right bank of the Nistru²³).

Final size of sample: 1969 respondents.

Sampling method: stratified, multistage, quasiprobabilistic, “Routes Method” (Appendix 1 „Routes Method”).

Data collection period: August 14 –September, 14 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 Republic of Moldova inhabitants (right bank of the Nistru). The maximum estimated sampling error is $\pm 2.5\%$. Results were weighted according to official statistics distribution by gender.

Demographical structure of the final sample:

Table 41 Demographical structure of the final sample, 15 – 64 years old, Republic of Moldova (right bank of Dniester River), 2009

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

Table 42 Distribution of respondents by area of residence, 15 – 64 years old, Republic of Moldova (right bank of Dniester River), 2009

	%
Urban	39,56
Rural	60,4

Main limitations of the study:

1. Representative only for the right bank of the Dniester River.
2. Using the “Routes Method” – quasiprobabilistic of respondent selection (see Appendix 1 „Routes Method”).

²³ Following the frozen political conflict on the Dniester 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 “Youth knowledge, attitudes and practices regarding HIV/AIDS” survey

Source: (Scutelnicuic O., Condrat I., & Gutu L. 2008)

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).

Final size of sample: 1182 respondents.

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

Data collection period: March 5 – April, 9 2009.

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 Dniester River. Maximum estimated sampling error is $\pm 3\%$. Results did not require weighting.

Demographical structure of the sample:

Table 43 Demographic structure of the sample, youth aged 15-24, Republic of Moldova (right bank of the Nistru), 2008

	Male		Female		Total	
	Num	%	Num	%	Num	%
15-19 years	338	62.9	438	67.9	776	65.5
20-24 years	199	37.1	207	32.1	406	34.5
Total	537	45.4	645	54.6	1182	-

Limitations

1. Representative only for youth living on the right bank of the Dniester River.
2. Using the “Routes Method” – quasiprobabilistic of respondent selection (see Appendix 1 „Routes Method”).

Appendix 4 Integrated Bio-Behavioural Survey in Injecting Drug Users

Source: (BSS 2009b)

Type of research: repeated²⁴, multicentre (3 centres), cross-sectional, based on a questionnaire combined with qualitative testing for antibodies to HIV, HVC, HVB and syphilis.

Target group: UDIs living in the municipality of Chisinau, Balti and Tiraspol.

Final size of sample: 370 respondents recruited in the municipality of Balti, 328 respondents recruited in the municipality of Chisinau and 281 respondents recruited in Tiraspol (left bank of Dniester River).

Sampling method: Respondent Driven Sampling.

Data collection period: June, 17 – October, 30 2009.

Data collection instrument: Structured questionnaire. Surveys were carried on using the “face to face” method.

Representativeness: sample considered as representative for UDIs living in the geographical limits of localities where data collection was carried on.

Demographical structure of sample:

Table 44 Demographic structure of the final sample, UDIs, municipality of Chisinau, capital city of the Republic of Moldova, 2009

	Males		Females		Total	
		%		%		%
25 years	59	89.4	7	10.6	66	25.2
25 years	227	86.6	35	13.4	262	74.8
Total	286	87.2	42	12.8	328	-

Table 45 Demographic structure of the final sample, UDIs, municipality of Balti, Republic of Moldova, 2009

	Males		Females		Total	
		%		%		%
25 years	42	82.4	9	17.6	51	13.8
25 years	247	77.4	72	22.6	319	86.2
Total	289	78.1	81	21.9	370	-

Table 46 Demographic structure of the final sample, UDIs, Tiraspol city, left bank of Dniester River, Republic of Moldova, 2009

	Males		Females		Total	
		%		%		%
25 years	47	65.3	25	34.7	72	25.6
25 years	163	78.0	46	22.0	209	74.4
Total	210	74.7	71	25.3	281	-

Limitations

- This sampling method was applied to recruit UDIs benefitting from risk reduction programs and UDIs who do not²⁵. Seventh wave was reached in all implementation locations.
- All collected data are based on self-reporting, which doesn't exclude the offering of socially desirable answers. 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.).

²⁴ Previous study was carried on in 2003/2004 and 2007 among IDU beneficiaries of the Risk Reduction Programs.

²⁵ Studies previously carried on in the Republic of Moldova have only targeted risk reduction program beneficiaries.

- 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 IDUs population of the country. The IDUs profile may vary among regions.

Appendix 5 Integrated Bio-Behavioural Survey in female Commercial Sex Workers

Source: (BSS 2009a)

Type of research: repeated²⁶, multicentre (2 centre), cross-sectional, based on a questionnaire combined with qualitative testing for antibodies to HIV, HVC, HVB and syphilis.

Target group: Female Commercial Sex Workers (CSWs) living in the municipality of Chisinau and municipality of Balti.

Final size of sample: 359 respondents recruited in the municipality of Balti and 310 respondents recruited in the municipality of Chisinau

Sampling method: Respondent Driven Sampling.

Data collection period: October, 30 2009 - February, 26 2010.

Data collection instrument: Structured questionnaire. Surveys were carried on using the “face to face” method.

Representativeness: sample considered as representative for CSWs living in the geographical limits of localities where data collection was carried on.

Demographical structure of sample:

Table 47 Demographic structure of the final sample, CSWs, municipality of Chisinau, capital city of the Republic of Moldova, 2009/2010

	Total	
	#	%
< 25 years	95	32.2
25 + years	200	67.8
Missing age	6	-
Total	301	-

Table 48 Demographic structure of the final sample, CSWs, municipality of Balti, Republic of Moldova, 2009/2010

	Total	
	#	%
< 25 years	164	45.7
25 + years	195	54.3
Total	359	-

Limitations:

- This sampling method was applied to recruit CSWs benefitting from Harm Reduction Programme and CSWs who do not²⁷. Seventh wave was reached in all implementation locations.
- The definition of the sampling unit, the sex in exchange of money of drugs in the last 12 months is too broad and creates confusions for screening.
- Due to the absence of objective criteria for screening in case of CSWs, there is a probability that the sample might include people outside of the target group (attractivity of the incentives).
- 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 IDUs population of the country. The IDUs profile may vary among regions.
- All collected data are based on self-reporting, which doesn't exclude the offering of socially desirable answers. Reminder errors could occur in the answers of those who had a less often

²⁶ Previous study was carried on in 2004 and 2007 among CSWs beneficiaries of the Harm Reduction Programme.

²⁷ Studies previously carried on in the Republic of Moldova have only targeted Harm Reduction Programme beneficiaries.

occurrence of the events mentioned by the questionnaire (latest injection, latest sexual contact, etc.) in the year or month before the in the survey.

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Annex 1 Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1. Which institutions/entities were responsible for filling out the indicator forms?

- | | |
|----------------------|-----|
| a) NAC or equivalent | Yes |
| b) NAP | Yes |
| c) Others | Yes |

National Centre of Blood Transfusion, Ministry of Health
National Centre of Health Management

2. Which inputs from

Ministries:

- | | |
|--|-----|
| Education | Yes |
| Health | Yes |
| Labour | Yes |
| Foreign Affairs | No |
| Others (please specify) | Yes |
| Ministry of Defense, Ministry of Justice | |

- | | |
|------------------------------|-----|
| Civil society organizations | Yes |
| People living with HIV | Yes |
| Private sector | No |
| United Nations organizations | Yes |
| Bilaterals | Yes |
| International NGOs | Yes |
| Others (please specify) | No |

3. Was the report discussed in a large forum? Yes

4. Are the survey results stored centrally? Yes

5. Are data available for public consultation? Yes

6. Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name / title: Otilia Scutelnicuic,
Head, Monitoring and Evaluation Unit, National Centre of Health Management

Date: 31.03. 2010

Signature:



Please provide full contact information:

Address: 3, A. Cosmescu str., Chisinau, MD 2009, Republic of Moldova

Email: otilia_sc@yahoo.com

Telephone: + 373 22 73 51 25

The UNGASS report has been developed in a participatory manner, under the overall coordination of the Ministry of Health and the technical responsibility of the M&E Unit, National Center of Health Management, appointed by Ministry of Health as the national coordinator. The UNAIDS Country Office has facilitated consultations and relevant data collection endeavours.

The roadmap for the report development has been drafted according to “Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators. 2010 Reporting” (UNAIDS 2009) (UNAIDS 2009a), tentatively discussed within the M&E Technical Working Group and the United Nations Joint Team on HIV and AIDS, and finalized during a 2-day workshop in November 2009 with key stakeholders, where data sources and additional data collection needed for UNGASS reporting have been discussed and agreed upon, and the core and additional indicators to be reported on discussed and endorsed.

Data collection have occurred well into January, and in early February 2010 a workshop with key decision makers and staff at technical level of public institutions and NGOs part of the national HIV response, has taken place, for the development of the new cycle of National Programme for 2011-2015. UNGASS indicator values have been presented, and data gaps discussed, remedial actions and strategies for further data collection agreed upon. Entry data needs for estimations and projections have also been presented.

The Ministry of Health has subsequently established a Consultative Group for estimations and projections comprised of decision-making representatives of key stakeholders. The Consultative Group has coordinated validation of entry data, and has participated in a 2 day capacity building and consensus building workshop, producing and agreeing upon outputs of EPP & Spectrum, and discussing and validating the UNGASS indicator values. The draft narrative report has also been discussed at the workshop, held March 19-20, 2010, after being previously circulated for comments and amended accordingly.

The final consensus building meeting has taken place on March 29, 2010, where representatives of the public institutions and NGOs involved in the report development have endorsed the narrative report and indicator values for both UNGASS and Universal Access reports.

Response Details

Page 1

- 1) **Country**
Moldova (0)
- 2) **Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:**
Svetlana Plamadeala
- 3) **Postal address:**
3, A.Cosmescu str., Chisinau. MD 2009, Republic of Moldova
- 4) **Telephone:**
Please include country code
+37369328574
- 5) **Fax:**
Please include country code
+37322729011
- 6) **E-mail:**
svetlana.plamadeala@aids.md
- 7) **Date of submission:**
Please enter in DD/MM/YYYY format
31/03/2010

Page 3

8) **Describe the process used for NCPI data gathering and validation:**

Data collection and validation processes for the NCPI (National Composite Policy Index) were carried out as part of the UNGASS 2009 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 participatory workshop 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. (06.02.2010). - 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 workshop and gaining further insights, as well as building consensus in a stakeholder workshop taking place on February 12-13, 2010 - Validation of the NCPI, associated with the UNGASS report validation process in both a technical level workshop on March 19-20 and a consensus-building meeting with high level

decision makers on March 29, 2010.

9) **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 workshops and 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

10)

Highlight concerns -if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):

Among limitations that can be attested are various mandate-driven priorities for the national stakeholders that may affect the objectivity of interview outputs. However, a strategy to address those limitations has been the consultative and participatory process and the many opportunities to discuss issues over and over again until a fair assessment of the status quo has been produced

Page 4

11)

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

	Organization	Names/Positions	Respondents to Part A [Indicate which parts each respondent was queried on]
Respondent 1	Ministry of Health	Aliona Serbulenco / Chief of Department	A.I, A.II, A.III, A.IV, A.V

12)

	Organization	Names/Positions	Respondents to Part A [Indicate which parts each respondent was queried on]
Respondent 2	Ministry of Health	Lilia Gantea / Deputy Chief of Department	A.I, A.II
Respondent 3	National Centre of Health Management	Oleg Barba / Deputy Director	A.I, A.II, A.III, A.IV, A.V
Respondent 4	National Centre of Health Management	Otilia Scutelnicu / Head of M&E Unit	A.I, A.II, A.III, A.IV, A.V
Respondent 5	AIDS Centre	Stefan Gheorghita / Director	A.I, A.II, A.III, A.IV, A.V
Respondent 6	Ministry of Education	Nadejda Velisco / Head of Department	A.III
Respondent 7	Ministry of Education	Galina Gavrilita / consultant	A.III
Respondent 8	Ministry of Labour, Social Protection and Family	Diana Doros / Consultant	A.IV
Respondent 9	Department of Penitentiary Institutions	Ilona Burduja / Chief of unit	A.III, A.IV
Respondent 10	Department of Penitentiary Institutions	Svetlana Doltu / Senior specialist	A.III, A.IV
Respondent 11	National TB Programme	Dumitru Sain / National TB Coordinator	A.IV
Respondent 12	DDVR	Viorel Calistru / Deputy chief	A.IV
Respondent 13	PCU	Victor Burinschi / Coordinator	A.I, A.II
Respondent 14			
Respondent 15			

Respondent
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Respondent
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Respondent
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13)

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

	Organization	Names/Positions	Respondents to Part B [Indicate which parts each respondent was queried on]
Respondent 1	Liga PHS (League of PLWHA)	Chilcevschii Igor	B.I, B.II, B.III, B.IV

14)

	Organization	Names/Positions	Respondents to Part B [Indicate which parts each respondent was queried on]
Respondent 2	Liga PHS (League of PLWHA)	Curasov Alexandru	B.I, B.II, B.III, B.IV
Respondent 3	UORN	Iatco Ala	B.I, B.II, B.III, B.IV
Respondent 4	Tinerii pentru dreptul la Viață, filiala Bălți (Youth for the right to live, Balti branch)	Aliona Ciobanu	B.I, B.II, B.III, B.IV
Respondent 5	Reforme Medicale (Medical Reform)	Leorda Alexei	B.I, B.II, B.III, B.IV
Respondent 6	Pentru Prezent și Viitor (For the present and future)	Nina Tudoreanu	B.I, B.II, B.III, B.IV
Respondent 7	IDOM	Jereghi Vanu	B.I
Respondent 8	IDOM	Mardari Natalia	B.I
Respondent 9	Viata Noua (New Life)	Poverga Ruslan	B.I, B.II, B.III, B.IV
Respondent 10	Credinta (Faith)	Untura Ludmila	B.I, B.II, B.III, B.IV
Respondent 11	Copilarie pentru toți (Childhood for all)	Mardari Natalia	B.I, B.II, B.III, B.IV
Respondent 12	Respiratia a doua pentru oamenii in etate (Second Breath for the elderly)	Baicalova Irina	B.I, B.II, B.III, B.IV
Respondent 13	Zdrovoee Budușcee (Happy Future)	Tacmelova Alina	B.I, B.II, B.III, B.IV
Respondent 14	Proiecte Inovatoare în Penitenciare (Innovative policies in penitentiaries)	Pintilei Larisa	B.I, B.II, B.III, B.IV
Respondent 15	GenderDocM	Bucsanu Olesea	B.I, B.II, B.III, B.IV
Respondent 16	Biserica Ortodoxă din Moldova (The Orthodox Church of Moldova)	Mosin Octavian	B.I, B.II, B.III, B.IV
Respondent			

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Respondent
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Respondent
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Respondent
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Respondent
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Respondent
25

Page 5

15)

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 (0)

Page 7

16) **Period covered:**
2006-2010

17)

1.1 How long has the country had a multisectoral strategy?

Number of Years

10

18)

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

	Included in strategy	Earmarked budget
Health	Yes	Yes
Education	Yes	Yes
Labour	Yes	No
Transportation	No	No
Military/Police	Yes	Yes
Women	Yes	Yes
Young people	Yes	Yes
Other*	Yes	Yes

Page 8

19) **If "Other" sectors are included, please specify:**

Justice (inmates), Defense (border guards and uniformed services), social protection

Page 9

20)

1.3 Does the multisectoral strategy address the following target populations, settings and crosscutting issues?

Target populations	
a. Women and girls	Yes
b. Young women/young men	Yes
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex workers	Yes
f. Orphans and other vulnerable children	Yes
g. Other specific vulnerable subpopulations*	Yes
Settings	
h. Workplace	Yes
i. Schools	No
j. Prisons	Yes
Cross-cutting issues	
k. HIV and poverty	Yes
l. Human rights protection	Yes
m. Involvement of people living with HIV	Yes
n. Addressing stigma and discrimination	Yes
o. Gender empowerment and/or gender equality	Yes

21)

1.4 Were target populations identified through a needs assessment?

Yes (0)

Page 10

22)

IF YES, when was this needs assessment conducted?

Please enter the year in yyyy format

2005

Page 11

23)

1.5 What are the identified target populations for HIV programmes in the country?

The following target groups have been identified by the National Programme of prevention and control of HIV/AIDS/STI 2006-2010: vulnerable populations, pregnant women, people in uniforms, vulnerable and orphan children born to HIV infected mothers, women, youth, including rural youth, people living with/affected by HIV/AIDS, medical workers, parents, inmates, long distance drivers, migrant population, patients with TB and STI, religious sector

24)

1.6 Does the multisectoral strategy include an operational plan?

Yes (0)

25)

1.7 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?	Yes
e. A monitoring and evaluation framework?	Yes

26)

1.8 Has the country ensured “full involvement and participation” of civil society* in the development of the multisectoral strategy?

Active involvement (0)

Page 12

27)

IF active involvement, briefly explain how this was organised:

Around 40 NGOs are actively involved in HIV/AIDS prevention and control. 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, thus ensuring their involvement in the political/decisional management process in the national response to HIV/AIDS/STI. In the framework of developing the National Programme for 2006-2010 period, in 2005, national consultancy processes were organised involving representatives of all NGO networks. Through the workshop for Monitoring the Resolution of the 1st National Forum of NGOs active in the field, they had the chance to offer final proposals and also to approve the Programme framework. The workshop for monitoring the implementation of resolutions of the II National Forum provided an opportunity for NGOs to participate in finalizing the draft law on HIV prevention. The Union of NGOs active in harm reduction has been involved in developing standards for the rendering of services in this specific area. In 2007, organizations of people living with HIV established a League. Currently, the League is one of the major sub-recipients of financial resources under the Round 8 grant. A relevant example of civil society involvement is the mid-term evaluation process for the current cycle of the National Program. Methodologically, the process began with a prioritization workshop where human rights based approaches and evidence-based approaches have been applied to identify gaps, followed by the evaluation per specific thematic areas within technical groups, and a few workshops to elaborate conclusions and recommendations. All throughout the process, from planning till final conclusions and recommendations, civil society representatives have been actively involved. The same approach was used for the M&E system assessment process, performed applying the 12 components tool in November 2008. It should be mentioned that one of the achievements in this field in 2008 was the more active involvement of representatives of religious confesions and tarde unions and employer’s associations. Since 2008, the involvement of NGOs active in the field of Human Rights protection can be attested.

28)

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes (0)

29)

1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners (0)

Page 14

30)

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 (0)

Page 15

31)

2.1 IF YES, in which specific development plan(s) is support for HIV integrated?

- | | |
|--|-----|
| a. National Development Plan | Yes |
| b. Common Country Assessment / UN Development Assistance Framework | Yes |
| c. Poverty Reduction Strategy | Yes |
| d. Sector-wide approach | Yes |
- EU-Moldova Action Plan, Millenium Development Goals, "Promoting gender equality for the 2006-2009 period", 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 2006-2010 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

32)

2.2 IF YES, which specific HIV-related areas are included in one or more of the development plans?

HIV-related area included in development plan(s)

- | | |
|--|-----|
| HIV prevention | Yes |
| Treatment for opportunistic infections | Yes |
| Antiretroviral treatment | Yes |
| Care and support (including social security or other schemes) | Yes |
| 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 |
| Women's economic empowerment (e.g. access to credit, access to land, training) | Yes |
| prevention for vulnerable populations, mother to child transmission prevention, development/strengthening of primary healthcare, STI | |

Page 16

33)

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes (0)

Page 17

34)

3.1 IF YES, to what extent has it informed resource allocation decisions?

4 (4)

35)

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 (0)

Page 18

36)

4.1 IF YES, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

Behavioural change communication	Yes
Condom provision	Yes
HIV testing and counselling	Yes
Sexually transmitted infection services	Yes
Antiretroviral treatment	Yes
Care and support	Yes
post exposure prophylaxis	Yes

Page 19

37)

If HIV testing and counselling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g, indicate if HIV testing is voluntary or mandatory etc):

According to the Law on preventing HIV/AIDS, article 15, and also the National Programme to control and prevent HIV/AIDS/STI for 2006-2010, counseling and testing is voluntary, with the exceptions of donation of blood and tissue, and court decisions in cases of rape and intentional exposure to HIV transmission, if the indicted individual has been counseled properly and still refuses consent for testing. The same principles apply in the case of counseling and testing uniformed personnel. Compulsory testing is prohibited, as well as requesting HIV test results as precondition for employment.

38)

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes (0)

Page 20

39)

5.1 IF YES, for which subpopulations?

a. Women	Yes
b. Young people	Yes
c. Injecting drug users	Yes
d. Men who have sex with men	No
e. Sex Workers	No
f. Prison inmates	Yes
g. Migrants/mobile populations	Yes
Other: Please specify	

40)

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

The following mechanisms exist to ensure the implementation of the Law on prevention of HIV/AIDS: the National Health Policy, the National Programme to prevent and control HIV/AIDS/STI. The Constitution of Moldova stipulates the general principle of non-discrimination and the supremacy of international norms regarding human rights. The HIV/AIDS Law of 2007 expressly forbids discrimination based on real or perceived HIV status. An antidiscrimination draft law has been developed but not approved as it raises doubts due to including explicitly sexual orientation in the range of grounds on which discrimination is prohibited. There are mechanisms to ensure implementation of legal stipulations – through national and

Page 21

41)

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

No (0)

Page 23

42)

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes (0)

Page 24

43)

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes (0)

44)

7.2 Have the estimates of the size of the main target populations been updated?

Yes (0)

Page 25

45)

7.3 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 (0)

46)

7.4 Is HIV programme coverage being monitored?

Yes (0)

Page 26

47)

(a) IF YES, is coverage monitored by sex (male, female)?

Yes (0)

48)

(b) IF YES, is coverage monitored by population groups?

Yes (0)

Page 27

49)

IF YES, for which population groups?

MSM, CSWs, IDUs, inmates, migrants, truck drivers. Youth aged 15-24. Dissagregation based on gender and place of residence (rural/urban) General population. Dissagregation based on gender and place of residence (rural/urban)

Page 28

50)

(c) Is coverage monitored by geographical area?

Yes (0)

Page 29

51)

IF YES, at which geographical levels (provincial, district, other)?

The annual reports monitoring the implementation of the National HIV/AIDS/STI Programme uses epidemiological indicators of incidence and prevalence disaggregated by district

52)

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes (0)

Page 30

53)

Overall, how would you rate strategy planning efforts in the HIV programmes in 2009?

8 (8)

54)

Since 2007, what have been key achievements in this area:

The most important achievement of the National Programme is that it correlates with the commitment undertaken by the country to provide universal access to prevention, treatment, care and support in HIV. The current National Program is generally assessed as being comprehensive, complex and of good quality. As to the strategic planning efforts made in 2009, the Mid-term Evaluation of the National Programme that ended in 2009, and efforts for developing the new NAP cycle 2011-2015 should be mentioned. During the MTR and the situational analysis for the new NAP, the following progresses have been attested: - The field of prevention among - Prevention among the general population, explained through systemic campaigns. Enhanced geographic coverage and programmatic quality are among areas where further efforts are needed - the initiation and interventions in the field of HIV prevention in the workplace; - Implementing a pilot project of preventing HIV in the framework of vocational education, based on a pilot Life Skills Education curricula - in the field of voluntary counselling and testing, explained by the extension of the service nationwide, including in the penitentiary sector; - medical care and treatment, by increasing the coverage, initiating the decentralisation of the service, updating treatment protocols, initiating the creation of infrastructure for the management of ARV treatment resistance, TB/HIV co-infection - coordination and management of the national response; - care and support for people living with HIV; - capacity building of medical professionals and social assistants for prevention of

stigma and discrimination

55)

What are remaining challenges in this area:

- inadequate financing from the Government and cumbersome monitoring of financial flows explained by the lack of national health accounts - in prevention, there is no leading institution and coordination is fragmented for both activities targeting MARPs and the general population - social assistance and support to people living with/affected by HIV provided only by NGO - stigma and high levels of discrimination acting as deterrent and jeopardizing coverage with prevention, care and treatment of MARPs, MARA, and other vulnerable groups; - there is insufficient progress in certain sectors of the national response for one of the most affected areas—the Eastern region (Transnistria) - Gaps in human rights based approaches to programming, and poor gender sensitivity of certain policies in place - Few interventions covering most at risk adolescents

Page 31

56)

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

President/Head of government	No
Other high officials	Yes
Other officials in regions and/or districts	Yes

57)

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?

Yes (0)

Page 32

58)

2.1 IF YES, when was it created?

Please enter the year in yyyy format

2002

59)

2.2 IF YES, who is the Chair?

Name	Vladimir Hotineanu
Position/title	Minister of Health

60)

2.3 IF YES, does the national multisectoral AIDS coordination body:

have terms of reference?	Yes
have active government leadership and participation?	Yes
have a defined membership?	Yes
include civil society representatives?	Yes
include people living with HIV?	Yes
include the private sector?	Yes
have an action plan?	Yes
have a functional Secretariat?	Yes
meet at least quarterly?	Yes

review actions on policy decisions regularly?	Yes
actively promote policy decisions?	Yes
provide opportunity for civil society to influence decision-making?	Yes
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes

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61)

If you answer "yes" to the question "does the National multisectoral AIDS coordination body have a defined membership", how many members?

Please enter an integer greater than or equal to 1

30

62)

If you answer "yes" to the question "does the National multisectoral AIDS coordination body include civil society representatives", how many?

Please enter an integer greater than or equal to 1

12

63)

If you answer "yes" to the question "does the National multisectoral AIDS coordination body include people living with HIV", how many?

Please enter an integer greater than or equal to 1

3

Page 34

64)

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

No (0)

Page 35

65)

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

Please enter the rounded percentage (0-100)

14

66)

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	Yes
Technical guidance	Yes
Procurement and distribution of drugs or other supplies	No
Coordination with other implementing partners	Yes

Capacity-building
Other: Please specify

Yes

67)

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes (0)

Page 36

68)

6.1 IF YES, were policies and laws amended to be consistent with the National AIDS Control policies?

Yes (0)

Page 37

69)

IF YES, name and describe how the policies / laws were amended:

Law on prevention of HIV/AIDS, No 23-XVI of 16.02.2007, published in the Official Monitor Gazette No 54-56/250 of 20.04.2007

70)

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

Deportation of HIV+ migrants; in conflict with Article 10 of the 2007 Law that guarantees equal access to all services of prevention, treatment and care regardless of citizenship, and with the National Programme that does not discriminate based on citizenship when providing for free of charge treatment

Page 38

71)

Overall, how would you rate the political support for the HIV programmes in 2009?

8 (8)

72)

Since 2007, what have been key achievements in this area:

Among key achievements, we consider the extension of the TB/AIDS NCC, representatives of the civil society having reached 40% and including representatives of the religious and private sector, but also more rights-holders from among key populations. The Ministry of Justice continues to be actively involved in the national response, providing commitment and support for prevention programs among inmates, like needle exchange, substitution treatment and initiation of VCT services, ARV treatment, TB/HIV coinfection management, post-exposure prophylaxis, etc. A major player during 2009 was the Ministry of Economy and Trade, responsible for Labour, which has been actively involved in implementing HIV prevention interventions in the workplace. After reforming the government, this chapter has been taken over by the ministry of Labour and Social Protection, the latter being more actively involved in interventions related to support and care for people living with HIV. In 2009, the necessity for a NCC Technical Working Group for assistance and social support of PLHIV and / or TB has translated into establishment of such a TWG. Certain regional leaders have become more involved, as those from Gagauzia autonomy, Balti, Tiraspol.

73)

What are remaining challenges in this area:

Not all local public administration authorities are involved, even though certain regions have more proactive leaders. At the funding level, shortages from public funding can be attested, particularly in the field of prevention. Financial coverage by the government for prevention among MARPs is minimal, even if the country is recognized as having a concentrated epidemic and interventions among MARPs should be a priority.

Page 39

74)

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

Yes (0)

Page 40

75)

1.1 IF YES, what key messages are explicitly promoted?

Check for key message explicitly promoted (multiple options allowed)

- a. Be sexually abstinent (0)
- b. Delay sexual debut (0)
- c. Be faithful (0)
- d. Reduce the number of sexual partners (0)
- e. Use condoms consistently (0)
- f. Engage in safe(r) sex (0)
- g. Avoid commercial sex (0)
- h. Abstain from injecting drugs (0)
- i. Use clean needles and syringes (0)
- j. Fight against violence against women (0)
- k. Greater acceptance and involvement of people living with HIV (0)
- l. Greater involvement of men in reproductive health programmes (0)
- n. Know your HIV status (0)
- o. Prevent mother-to-child transmission of HIV (0)

76)

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes (0)

Page 41

77)

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes (0)

78)

2.1 Is HIV education part of the curriculum in:

primary schools?	No
secondary schools?	Yes
teacher training?	Yes

79)

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes (0)

80)

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes (0)

81)

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk or other vulnerable sub-populations?

Yes (0)

Page 42

82)

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

Check which specific populations and elements are included in the policy/strategy

Targeted information on risk reduction and HIV education	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates, Other populations
Stigma and discrimination reduction	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates, Other populations
Condom promotion	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates, Other populations
HIV testing and counselling	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates, Other populations
Reproductive health, including sexually transmitted infections prevention and treatment	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates, Other populations
Vulnerability reduction (e.g. income generation)	
Drug substitution therapy	Injecting drug user, Prison inmates
Needle & syringe exchange	Injecting drug user, Prison inmates

Page 44

83)

Overall, how would you rate the policy efforts in support of HIV prevention in 2009?

8 (8)

84)

Since 2007, what have been key achievements in this area:

Politically, prevention activities are supported by various national documents such as the Law on HIV / AIDS, the National Programme strategies, the National Health Policy, that explicitly create conditions for implementation of prevention activities among MARPs and the general population.

85)

What are remaining challenges in this area:

Partners have considered political support for these activities as being rather inadequate due to insufficient leadership both in interventions targeting MARPs and Mara, as well as those aiming at the general population.

Page 45

86)

4. Has the country identified specific needs for HIV prevention programmes?

Yes (0)

Page 46

87)

IF YES, how were these specific needs determined?

Needs have been estimated through the second generation seroprevalence survey carried out among IDUs, CSWs, inmates, migrants. In the same time, with the technical support of UNICEF, in a workshop involving all relevant specialists, a needs assessment occurred followed by the development of a prevention strategy.

88)

4.1 To what extent has HIV prevention been implemented?

	The majority of people in need have access
HIV prevention component	
Blood safety	Agree
Universal precautions in health care settings	Agree
Prevention of mother-to-child transmission of HIV	Agree
IEC* on risk reduction	Agree
IEC* on stigma and discrimination reduction	Agree
Condom promotion	Agree
HIV testing and counselling	Agree
Harm reduction for injecting drug users	Agree
Risk reduction for men who have sex with men	Agree
Risk reduction for sex workers	Agree
Reproductive health services including sexually transmitted infections prevention and treatment	Agree
School-based HIV education for young people	Don't agree
HIV prevention for out-of-school young people	Don't agree
HIV prevention in the workplace	Don't agree
Other: please specify	

Page 47

89)

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

7 (7)

90)

Since 2007, what have been key achievements in this area:

- HIV prevention among MARPs registered the fastest growth, yet having a moderate evolution. The moderate evolution is determined by the unequal geographical coverage. - Communication campaigns for behaviour change became systematic and are performed qualitatively; - Extension of VCT services on

the whole territory of the republic, including penitentiaries - Recently rapid tests have been introduced with a special emphasis on using rapid tests in maternity wards on pregnant women coming to give birth without being tested for HIV during pregnancy. - The first consolidated efforts in HIV prevention in the workplace have been carried out; - Quality control standards regarding blood safety and the participation of all blood transfusion centres in external quality assurance scheme of the AIDS National Reference Laboratory

91)

What are remaining challenges in this area:

- Among the most stringent challenges is the insufficiency of public funds from the state budget for prevention - Gaps in coordination of prevention - weak sustainability of interventions, in both among MARPs and among the general population. - Lack of national, regional and multi-sectorial prevention and communication plans for the to change behaviour for increased risk populations; - Limited financing and poor capacities on local level for implementation of intersectorial action plans for behaviour change communication and prevention among MARPs - Limited access of vulnerable populations to prevention programs due to stigma and discrimination

Page 48

92)

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes (0)

Page 49

93)

1.1 IF YES, does it address barriers for women?

Yes (0)

94)

1.2 IF YES, does it address barriers for most-at-risk populations?

Yes (0)

95)

2. Has the country identified the specific needs for HIV treatment, care and support services?

Yes (0)

Page 50

96)

IF YES, how were these determined?

Estimations were made considering the epidemiological situation: both HIV prevalence and the tendencies of HIV to evolve among the people already infected with HIV, the peculiarities of the epidemic. The first estimates were made in 2005 as part of the National Program to Prevent and control HIV/AIDS/STI elaboration. These estimates were reviewed and updated a number of times during the target setting for Universal Access to prevention, treatment, care and support; development of proposals to the Global Fund, (round 6, phase I and II) and the Mid-Term Evaluation of the NAP.

97)

2.1 To what extent have the following HIV treatment, care and support services

been implemented?

The majority of people in need
have access

HIV treatment, care and support service

Antiretroviral therapy	Agree
Nutritional care	Don't agree
Paediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree
Psychosocial support for people living with HIV and their families	Don't agree
Home-based care	Don't agree
Palliative care and treatment of common HIV-related infections	Don't agree
HIV testing and counselling for TB patients	Agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	N/A
TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in HIV-infected people	Don't agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree
HIV treatment services in the workplace or treatment referral systems through the workplace	N/A
HIV care and support in the workplace (including alternative working arrangements)	N/A
Other: please specify	

Page 51

98)

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes (0)

99)

4. Does the country have access to *regional* procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?

Yes (0)

Page 52

100)

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.

Page 53

101)

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

8 (8)

102)

Since 2007, what have been key achievements in this area:

- Moldova had substantial achievements in ARV treatment coverage; 100% of those eligible that request treatment receive ARV drugs free of charge, and there are no waiting lists. However, enrollment in treatment and coverage of those estimated to be in need of treatment are still low - Some achievements occurred in the decentralisation of HIV treatment and care services, and of MST, throughout the territory of the country - Updating treatment protocols; - Initiating the establishment of the infrastructure to test viral resistance to ARV medication - Improving accessibility and quality of preventive ARV treatment for HIV positive pregnant women - Inauguration of the pediatric department in the HIV treatment unit

103)

What are remaining challenges in this area:

- Access to ARV treatment remains quite limited throughout the country, because the necessary information is not available to PLHIV, while the adherence programs implemented by NGOs only cover Chisinau region. - Implementation is only partially adjusted to the scope of current necessities - The protocol for comprehensive HIV case management is missing - Care and support services for people living with / affected by HIV are implemented almost exclusively by NGO - Insufficient training, lab diagnostics and case management on the left bank of Nistru river are other gaps that require interventions

Page 54

104)

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes (0)

Page 55

105)

5.1 IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes (0)

106)

5.2 IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes (0)

107)

5.3 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

No (0)

Page 56

108)

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?

6 (6)

109)

Since 2007, what have been key achievements in this area:

- Several play centres 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 interventions covering these children

110)

What are remaining challenges 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

Page 57

111)

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

Yes (0)

Page 58

112)

**1.1 IF YES, years covered:
Please enter the start year in yyyy format below**

2006

113)

**1.1 IF YES, years covered:
Please enter the end year in yyyy format below**

2010

114)

1.2 IF YES, was the M&E plan endorsed by key partners in M&E?

Yes (0)

115)

1.3 IF YES, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes (0)

116)

1.4 IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, most partners (0)

Page 60

117)

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy

Yes

a well-defined standardised set of indicators	Yes
guidelines on tools for data collection	Yes
a strategy for assessing data quality (i.e., validity, reliability)	No
a data analysis strategy	No
a data dissemination and use strategy	Yes

Page 61

118)

If you check "YES" indicating the national M&E plan include a data collection strategy, then does this data collection strategy address:

routine programme monitoring	Yes
behavioural surveys	Yes
HIV surveillance	Yes
Evaluation / research studies	Yes

119)

3. Is there a budget for implementation of the M&E plan?

Yes (0)

Page 62

120)

3.1 IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

Please enter the rounded percentage (1-100). If the percentage is less than 1, please enter "1".

4

121)

3.2 IF YES, has full funding been secured?

No (0)

122)

3.3 IF YES, are M&E expenditures being monitored?

Yes (0)

Page 63

123)

4. Are M&E priorities determined through a national M&E system assessment?

Yes (0)

Page 64

124)

IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves:

The first M&E system assessment was carried out in 2004, while the comprehensive assessment of the functionality of the 12 components has been carried out in 2008, with the technical support of UNAIDS.

Other system assessments were performed in the context of grants implementation, the Global Fund assessment tool being applied.

125)

5. Is there a functional national M&E Unit?

Yes (0)

Page 65

126)

5.1 IF YES, is the national M&E Unit based

in the National AIDS Commission (or equivalent)?
in the Ministry of Health?
National Center for Health Management of the Ministry of Health Yes

127) Number of permanent staff:

Please enter an integer greater than or equal to 0

4

128) Number of temporary staff:

Please enter an integer greater than or equal to 0

1

Page 66

129)

Please describe the details of all the permanent staff:

	Position	Full time/Part time?	Since when? (please enter the year in yyyy format)
Permanent staff 1	Head Departmnet	Full time	2004
Permanent staff 2	IT specialist	Full time	2004
Permanent staff 3	Surveys coordinator	Full time	2007
Permanent staff 4	VCT M&E	Full time	2008
Permanent staff 5			
Permanent staff 6			
Permanent staff 7			
Permanent staff 8			
Permanent staff 9			
Permanent staff 10			
Permanent staff 11			
Permanent staff 12			
Permanent staff 13			
Permanent staff 14			
Permanent staff 15			

130)

Please describe the details of all the temporary staff:

	Position	Full time/Part time?	Since when? (please enter the year in yyyy format)
Temporary staff 1	IT specialist	Part time	2005
Temporary staff 2			
Temporary staff 3			
Temporary staff 4			

Temporary staff 5
Temporary staff 6
Temporary staff 7
Temporary staff 8
Temporary staff 9
Temporary staff 10
Temporary staff 11
Temporary staff 12
Temporary staff 13
Temporary staff 14
Temporary staff 15

Page 67

131)

5.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes (0)

Page 68

132)

IF 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.

133)

What are the major challenges?

Intersectorial reporting, particular on the horizontal level, remains challenging. AS a remedial action, the M&E Plan for the new NAP cycle is planned to be approved by Government decision, hence strengthening the mandate of the national M&E system

Page 69

134)

6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

Yes, but meets irregularly (0)

135)

6.1 Does it include representation from civil society?

Yes (0)

Page 70

136)

IF YES, briefly describe who the representatives from civil society are and what their role is:

As permanent members of the technical work group, there are both the League of People Living with HIV and the Soros-Moldova Foundation (the program coordinator for harm reduction). They have voting

rights and participate fully in the work of the group, participating in developing drafts of strategic and operational documents, in assessments and evaluations, and in issuing recommendations. Since meetings are open, depending on the topic of the meeting, representatives of all interested NGOs are invited to participate in decision making, coordination and reaching consensus in the field.

137)

7. Is there a central national database with HIV- related data?

No (0)

Page 72

138)

7.3 Is there a functional* Health Information System?

At national level	Yes
At subnational level	Yes

Page 73

139) **For Question 7.3, you have indicated "Yes" to "subnational level", please specify at what level(s)?**

District level treatment facilities

140)

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

Yes (0)

141)

9. To what extent are M&E data used

9.1 in developing / revising the national AIDS strategy?:

4 (4)

142)

Provide a specific example:

An important finding of the M&E system assessment is the use of data produced by the M&E system in the strategic planning processes. For example, the data collected through second generation surveillance studies are used for sharpening the focus of prevention interventions among MARPs. All prevention campaigns are designed based on findings of KAP and other behavioral studies, and are followed by outcome evaluations after completion. The prioritization of interventions to fall under the outcomes of the new cycle of NAP has been carried out through a participatory process, based on the key gaps and priority actions put forth by the Mid-Term Evaluation Report and the final Response Analysis of the 2006 – 2010 NAP

143)

What are the main challenges, if any?

Although the M&E system assessment has highly appreciated the transparency and availability of data, a certain lack of continuity has been attested, with sporadic data provision and some key actors missing from existent information flows. Dissemination of some data is done without being accompanied by an adequate interpretation, or is done in an exaggeratedly technical manner, which jeopardizes data use, particularly by decision makers that frequently lack the respective scientific background. Dissemination of data should be done more systematically. At the moment, dissemination is done in an ad-hoc manner, some data being widely publicized (being posted on websites, in electronic bulletins, NCC

Bulletin), while others being less accessible. Standardisation of dissemination channels is necessary. Currently, most of the data is made available through e-mail or by posting on websites, which curtails the access of local level service providers that lack access to internet.

Page 74

144)

9. To what extent are M&E data used

9.2 for resource allocation?:

3 (3)

145)

Provide a specific example:

The new cycle of the National Programme, including costing of interventions, have been developed based on gaps and priority areas identified through the mid-term evaluation and the final response analysis

Page 75

146)

9. To what extent are M&E data used

9.3 for programme improvement?:

4 (4)

147)

Provide a specific example:

The M&E system assessment and the MTR of the NAP have identified a series of gaps, and have formulated recommendations to guide stakeholders in programme implementation

Page 76

148)

10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?:

Yes, at all levels (0)

Page 77

149)

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

At national level?	Yes
At subnational level?	Yes
At service delivery level including civil society?	Yes

Page 78

150) **Please enter the number of people trained at national level.**

Please enter an integer greater than 0

30

151) **Please enter the number of people trained at subnational level.**

Please enter an integer greater than 0

200

152) **Please enter the number of people trained at service delivery level including civil society.**

Please enter an integer greater than 0

30

Page 79

153)

10.2 Were other M&E capacity-building activities conducted other than training?

Yes (0)

Page 80

154)

IF YES, describe what types of activities:

M&E visits

Page 81

155)

Overall, how would you rate the M&E efforts of the HIV programme in 2009?

8 (8)

156)

Since 2007, 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 2006 - 2010 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. - The M&E capacity building strategy and curriculum for the MA in Public Health Programme has been developed. Advocacy is planned for 2010 for institutionalizing the curriculum based on the Medical University. - The M&E Advocacy Strategy has been developed. - The concept of the national database is in process of being developed, expected to integrate all data flows and serve as a comprehensive platform enhancing data availability and use

157)

What are remaining challenges in this area:

- Lack of institutionalized routine intersectoral 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; - Vulnerable populations sizes have not yet been estimated; - Given political constraints affecting full collaboration with the Transnistria region, full coverage with comprehensive M&E of the region is difficult; - Operational research for the evaluation of activities is not implemented; - Existing gaps in ensuring the confidentiality of data.

Page 82

158)

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions

and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)

Yes (0)

Page 83

159)

1.1 IF YES, specify if HIV is specifically mentioned and how or if this is a general nondiscrimination provision:

1. The Constitution of the Republic of Moldova (forbids all kind of discrimination) 2. National Health Policy, 17. 08. 2007, published in the Official Monitor Gazette nr. 127-130 (general document) 3. Law nr. 23-XVI of the 16. 02. 2007, regarding HIV/AIDS prevention , published in Official Monitor Gazette nr. 54-56/250 of the 20. 04. 2007 4. Law Nr. 263 of the 27. 10. 2005, regarding rights and responsibilities of patients published in Official Monitor Gazette Nr. 176 of 30. 12. 2005 5. Law№. 411 of the 28. 03. 95 regarding healthcare protection published in Official Monitor Gazette Nr. 034 of the 22. 06. 95 (general document) 6. Republic of Moldova Government Decision 948 On the activities to prevent and control HIV/AIDS and STI, National Program for Prevention and Control of HIV/AIDS/STI 2006-2010.

160)

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

Yes (0)

Page 84

161)

2.1 IF YES, for which subpopulations?

a. Women	Yes
b. Young people	Yes
c. Injecting drug users	No
d. Men who have sex with men	No
e. Sex Workers	No
f. prison inmates	No
g. Migrants/mobile populations	Yes
Other: Please specify	

162)

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

The observance of the rights is ensured at two levels, on the level of the responsible institutions which provides a framework for amiable settlement of disputes, and in a court of law within the judicial system Based on the nature of the conflict the cases can be solved at the level of institutions by: 1. competent Ministries where there exist Departments for Petitions and specialized committees 2. National Health Insurance Company 3. Non-government organizations dealing with human rights (such as CREDO www.credo.md etc) 4. Human Rights Centre of the Republic of Moldova (Centre of Ombudsmen / Parliamentary Lawyers www.ombudsman.md) 5. other structures, established and mandated in accordance with the legislation in force 6. If the conflict could not be settled amiably or it could not be settled at the level of institutions mentioned above, the case can be brought in a court of law, without any discrimination.

163)

Briefly describe the content of these laws:

The equality of rights and the free access to justice is stipulated in the Constitution of the Republic of Moldova adopted on July 29, 1994. Article 16. Equality of Rights (2) All citizens of the Republic of Moldova are equal in front of law and public authorities, without any discrimination as to race, nationality, ethnic origin, language, religion, sex, political choice, personal property or social origin. Article 20. Free Access to Justice (1) Every citizen has the right to obtain effective protection from competent courts of law against actions infringing on his/her legitimate rights, freedoms and interests. (2) No law may restrict the access to justice.

164)

Briefly comment on the degree to which they are currently implemented:

Legal provisions are respected as a general legal norm. Lack of coherent mechanisms to monitor their implementation sometimes allow for the discrimination of PLHIV

Page 85

165)

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

No (0)

Page 87

166)

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes (0)

Page 88

167)

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

1. Republic of Moldova Government Decision Nr. 948 On the activities to prevent and control HIV/AIDS and STI, National Program for prevention and Control of HIV/AIDS/STI 2006-2010. 2. Law nr. 23-XVI of the 16. 02. 2007, regarding HIV/AIDS prevention, published in the Official Monitor Gazette nr. 54-56/250 of 20. 04. 2007

168)

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?

Yes (0)

Page 89

169)

IF YES, briefly describe this mechanism:

There are general mechanisms to monitor human rights violations: 1. Non governmental organizations dealing with human rights 2. Parliamentarian Committee on Human Rights 3. Human Rights Centre of the Republic of Moldova (Centre of Ombudsmen/Parliamentarian Lawyers www.ombudsman.md) The

Human Rights Center and Parliamentary commission for human rights have never mentioned cases of discrimination of people living with HIV/AIDS in their reports.

170)

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

Yes (0)

Page 90

171)

IF YES, describe some examples:

People living with HIV/AIDS, injecting drug users, commercial sex workers and some other representatives of the most at risk groups in Moldova have joined non-governmental organizations dealing with the development and implementation of strategies aimed to most at risk populations. Thus, NGOs that are part of the National Coordination Council and its Technical Working Group (www.aids.md) are responsible for the development of sectorial strategies and plans. The number of NGO representatives in the NCC has risen to up to 40% in 2009. The Non-governmental sector actively participated to the creation of the National Program of Prevention and Control of HIV/AIDS 2006-2010, through involvement throughout the situation analysis, response analysis, strategic planning and resource mobilization. For the resource mobilization part, NGOs were involved in developing the project proposals that the Government has submitted to the GFTAM (Rounds 6, 8, 9). Also, the active participation of NGOs was attested in the process of creating the Law on preventing HIV/AIDS, approved in 2007. Throughout 2008-2009, NGOs have developed, in partnership with relevant medical institutions, the national medical standards regarding the complex approach to care, support, treatment and rehabilitation of IDUs. NGO took active part in the Mid-term Review of the HIV/AIDS National Program 2006-2010, that has taken place from September 2008 till March 2009. Representatives of the NGO sector are participating actively in developing the new cycle of the national program (2011-2015).

172)

7. Does the country have a policy of free services for the following:

- | | |
|---|-----|
| a. HIV prevention services | Yes |
| b. Antiretroviral treatment | Yes |
| c. HIV-related care and support interventions | Yes |

Page 91

173)

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

As stipulated by the Law on Prevention of HIV/AIDS nr. 23-XVI of 16.02.2007, published in the Official Monitor Gazette nr.54-56/250 din 20.04.2007 the government is responsible for the activities aimed at reducing the spread of HIV. The activities developed under the National Programmes are usually covered by the state budget and by funds coming from the National Health Insurance Scheme. At present, due to resource constraints the state budget for implementation of the activities under the National programme are quite reduced and cover only screening of blood. The National Health Insurance Company covers VCT and partially Palliative Care. The rest of activities are covered from the sources of international donors, such as World Bank, GFTAM, UN Agencies etc.

174)

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes (0)

Page 92

175)

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes (0)

176)

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes (0)

Page 93

177)

IF YES, briefly describe the content of this policy:

1. Republic of Moldova Government Decision Nr. 948 On the activities to prevent and control HIV/AIDS and STI, National Program for prevention and Control of HIV/AIDS/STI 2006-2010. 2. Law nr. 23-XVI of the 16. 02. 2007, regarding HIV/AIDS prevention, published in the Official Monitor Gazette nr. 54-56/250 of 20. 04. 2007

178)

9.1 IF YES, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

Yes (0)

Page 94

179)

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

Activities regarding IDUs are stipulated in the law on HIV (2007). Activities regarding other vulnerable groups are described in the National HIV/AIDS Programme. In 2009 comprehensive national standards for care, support, treatment and rehabilitation of IDUs were developed. Standards include: harm reduction, methadone substitution therapy, rehabilitation.

180)

10.Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes (0)

181)

11.Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes (0)

Page 95

182)

11.1 IF YES, does the ethical review committee include representatives of civil society including people living with HIV?

No (0)

Page 96

183)

– 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 (0)

184)

– Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

Yes (0)

185)

– Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

No (0)

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186)

IF YES on any of the above questions, describe some examples:

Even if there exist general mechanisms for monitoring human rights violations, their involvement specifically in promotion of human rights in the context of HIV/AIDS is minimal, as we know of no precedents in the field.

Page 98

187)

13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?

No (0)

188)

– Legal aid systems for HIV casework

Yes (0)

189)

– Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes (0)

190)

– Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes (0)

191)

15. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes (0)

Page 99

192)

IF YES, what types of programmes?

Media	Yes
School education	Yes
Personalities regularly speaking out	No
Other: please specify	

Page 100

193)

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

7 (7)

194)

Since 2007, what have been key achievements in this area:

- Scaling up existing interventions carried out by the NGO sector, with the support of GFATM Grant R8 - Increased number of NGOs representatives in the NCC

195)

What are remaining challenges in this area:

- Regulations and bylaws are not always in line with relevant legislation - Mechanisms are not sufficient to achieve the implementation of legal provisions - The existence of negative stigma and discriminatory practices of people with HIV/AIDS - Insufficient education programs on HIV/AIDS, reproductive health and non-discrimination as measures to prevent the spread of HIV/AIDS and reducing stigma and discrimination of PLHIV; those that do exist are limited in scope and/or are implemented by NGOs

Page 101

196)

Overall, how would you rate the efforts to enforce the existing policies, laws and regulations in 2009?

5 (5)

197)

Since 2007, what have been key achievements in this area:

- NGOs are part of the National Coordinating Council and its technical working groups - Number of NGO representatives in the NCC increased to 40% in 2009

198)

What are remaining challenges in this area:

- Ensuring proper implementation of normative acts - Lack of a clear concept of coordination and effective management of the National AIDS Programme, which would include a clear definition of national institutions responsible for overall implementation of activities within the national response and clear links with/between ministries, other government agencies and partners - There are insufficient mechanisms to monitor specifically human rights violations, stigma and discrimination related to HIV.

Page 102

199)

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

4 (4)

200)

Comments and examples:

NGOs are part of the National Coordination Council and its technical working groups, which are responsible for developing plans and sectoral strategies. During 2008-2009, NGOs have developed, in partnership with relevant national medical institutions, national standards regarding complex approach to care, support, treatment and rehabilitation of IDUs. NGOs were actively involved in the mid-term review of the National Programme on HIV/AIDS in 2008. Representatives of the civil society sector are actively involved in developing the National Programme (2011-2015).

Page 103

201)

2. To what extent 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)?

4 (4)

202)

Comments and examples:

NGOs were actively involved in developing project proposals submitted by the Government to GFTAM (Rounds 6, 8, 9)

Page 104

203)

a. the national AIDS strategy?

4 (4)

204)

b. the national AIDS budget?

1 (1)

205)

c. national AIDS reports?

4 (4)

206)

Comments and examples:

National civil sector involvement in HIV/AIDS is broadly provided for in the National Programme for Prevention and Control of HIV/AIDS 2006-2010, particularly in the strategies focusing on prevention and care and support for PLHIV NGOs were actively involved in the Mid-Term Review of the National Programme on HIV/AIDS in 2008. During the reporting period, NGOs have participated in developing reports on Monitoring the Dublin Declaration, UA and UNGASS.

Page 105

207)

a. developing the national M&E plan?

3 (3)

208)

b. participating in the national M&E committee / working group responsible for coordination of M&E activities?

4 (4)

209)

c. M&E efforts at local level?

2 (2)

210)

Comments and examples:

- NGOs are members of the NCC Technical Working Group on M & E - Some NGOs are also members of local committees on HIV/AIDS.

Page 106

211)

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

4 (4)

212)

Comments and examples:

The National League of People Living with HIV/AIDS The National AIDS Network of NGOs working in prevention of HIV/AIDS The National Union of Organizations working in Harm Reduction covering MSM, IDUs, CSWs, migrant populations, inmates from penitentiary institutions NGOs providing AIDS related services Women's associations Youth associations Religious and confessional organizations The National Red Cross Society

Page 107

213)

a. adequate financial support to implement its HIV activities?

3 (3)

214)

b. adequate technical support to implement its HIV activities?

3 (3)

215)

Comments and examples:

On pt.a) – Generally, financing comes exclusively from GFATM resources On pt.b) – UNAIDS, UNICEF, Soros Foundation-Moldova, AFEW, etc.

Page 108

216)

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

Prevention for youth	25-50%
Prevention for most-at-risk-populations	
- Injecting drug users	>75%
- Men who have sex with men	>75%
- Sex workers	>75%
Testing and Counselling	<25%
Reduction of Stigma and Discrimination	>75%
Clinical services (ART/OI)*	<25%
Home-based care	>75%
Programmes for OVC**	51-75%

Page 109

217)

Overall, how would you rate the efforts to increase civil society participation in 2009?

8 (8)

218)

Since 2007, what have been key achievements in this area:

Number of NGO representatives in the NCC increased to 40% in 2009

219)

What are remaining challenges in this area:

- Insufficient involvement of the civil sector in making decisions on budgetary allocations within the National Programme. - Producing and validating methodologically-sound estimations of sizes of all MARPs, including orphans and other vulnerable children.

Page 110

220)

1. Has the country identified the specific needs for HIV prevention programmes?

Yes (0)

Page 111

221)

IF YES, how were these specific needs determined?

Needs are assessed taking into account the results of second generation sentinel seroprevalence and behavior studies (carried out among injecting drug users, commercial sex worker's, detainees, migrants). Upon assessing needs and gap through participatory approaches and meaningful consultations of all interest stakeholders, consensus is ensured

222)

1.1 To what extent has HIV prevention been implemented?

	The majority of people in need have access
HIV prevention component	
Blood safety	Agree
Universal precautions in health care settings	Agree
Prevention of mother-to-child transmission of HIV	Agree
IEC* on risk reduction	Don't agree
IEC* on stigma and discrimination reduction	Don't agree
Condom promotion	Don't agree
HIV testing and counselling	Agree
Harm reduction for injecting drug users	Don't agree
Risk reduction for men who have sex with men	Don't agree
Risk reduction for sex workers	Don't agree
Reproductive health services including sexually transmitted infections prevention and treatment	Agree
School-based HIV education for young people	Don't agree
HIV prevention for out-of-school young people	Don't agree
HIV prevention in the workplace	Don't agree
Other: please specify	

Page 112

223)

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

7 (7)

224)

What are remaining challenges in this area:

- Adequately expanding harm reduction activities to the Eastern region of the country (left bank of Nistru). - Funding for HIV prevention activities is largely coming only from external financial resources - Life Skills Education is just an optional course in schools

Page 113

225)

1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes (0)

Page 114

226) **IF YES, how were these specific needs determined?**

Overall estimates were made taking into account the epidemiological situation: HIV prevalence, trends of HIV spread. In 2005, in the process of drafting the National Programme, the initial estimates have been developed. Other estimates have been made in the process of setting targets for universal access, developing project proposals to the Global Fund, etc.

227)

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

	The majority of people in need have access
HIV treatment, care and support service	
Antiretroviral therapy	Agree
Nutritional care	Agree
Paediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree
Psychosocial support for people living with HIV and their families	Don't agree
Home-based care	Don't agree
Palliative care and treatment of common HIV-related infections	Don't agree
HIV testing and counselling for TB patients	Agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	Agree
TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in HIV-infected people	Agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree
HIV treatment services in the workplace or treatment referral systems through the workplace	N/A
HIV care and support in the workplace (including alternative working arrangements)	N/A
Other: please specify	

Page 115

228)

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

8 (8)

229)

Since 2007, what have been key achievements in this area:

Ensuring adequate ARV treatment in Transnistria, according to the Moldovan national standards and protocol

230)

What are remaining challenges in this area:

Ensuring appropriate support and care for PLHIV An operational system of clinical monitoring and specialized treatment for HIV-positive children

Page 116

231)

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes (0)

Page 117

232)

2.1 IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes (0)

233)

2.2 IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

No (0)

234)

2.3 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

No (0)

Page 118

235)

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?

4 (4)

236)

Since 2007, what have been key achievements in this area:

- Active involvement of the MLSPF in the activities of the National Programme - TWG for Social Assistance established as part of the NCC

237)

What are remaining challenges in this area:

- Estimated number of OVC is missing - Estimating and developing a basic package of services for OVC and of adequate implementation mechanisms.