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**Acronyms**

- AIDS: Acquired Immunodeficiency Syndrome
- ARV: Antiretroviral
- BCC: Behavior Change Communication
- BSS: Behavioral Surveillance Survey
- DOTS: Directly Observed Treatment Strategy
- FSW: Female Sex Workers
- GF: the Global Fund
- HAART: Highly Active Antiretroviral Therapy
- HBsAg: Hepatitis Surface Antigen (Australian)
- HIV: Human Immunodeficiency Virus
- HR: Harm Reduction
- IEC: Information, Education and Communication
- IDU: Injecting Drug User
- ILO: International Labor Organization
- KAP: Knowledge, Attitudes and Practice
- LGBT: Lesbian Gay Bisexual Transgender
- MARA: Most-At-Risk Adolescents
- MARP: Most-At-Risk Population
- MDR: Multi-drug resistant
- MoH: Ministry of Health
- MSM: Men Having Sex with Men
- MTR: Mid-Term Evaluation
- M&E: Monitoring and Evaluation
- NAP: National AIDS Programme
- NBTC: National Blood Transfusion Center
- NCHM: National Center of Health Management
- NCC: National Coordination Council
- NGO: Non-governmental Organization
- NHIF: National Health Insurance Fund
- OI: Opportunistic Infections
- OST: Opioid Substitution Therapy
- PEP: Post-Exposure Prophylaxis
- PLWH: People Living with HIV
- PMTCT: Prevention of Mother-to-Child Transmission
- RDVD: Republican Dermato-Venereal Dispensary
- RND: Republican Narcology Dispensary
- SCM: Syndrome Case Management
- SFM: Soros Foundation Moldova
- SIDA: Swedish International Development Agency
- STI: Sexually Transmitted Infections
- TB: Tuberculosis
- TPHA: Treponema Pallidum Hemaglutination Assay
- TWG: Technical Working Group
- UN: United Nations
- UNDP: United Nations Development Programme
- UNFPA: United Nations Population Fund
- UNGASS: United Nations General Assembly Special Session
- WHO: World Health Organization
- USAID: United States Agency for International Development
- VCT: Voluntary Counseling and Testing
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Introduction

The first case of HIV infection in Republic of Moldova was registered in 1987. Since then the country embarked on building its national response to the HIV epidemic. Few cases were attested during the first period until the middle of ‘90s, but in 1995 an HIV outbreak was registered among the injecting drug users (IDUs). Starting with year 2000, the share of heterosexual transmission was gradually increasing, prevailing in 2005 over transmission through injecting drug use. Yet, as of the end of 2008, IDU mode of HIV transmission represented 50% of cumulative cases, sexual transmission–47.3%, mother-to-child–1.3% and undetermined–1.3%. It is still considered the epidemic to be concentrated in most-at-risk populations (IDUs, Female Sex Workers (FSW), men having sex with men (MSMs), prisoners). The rate of HIV infected among these groups is significantly higher than the one of the general population, and according to sero-surveillance studies the HIV prevalence does not show signs of decrease in MARPs.

The national response has passed through several stages. Initially, the main national response was HIV screening for greater numbers of patients and HIV testing, as well as increasing the diagnosis and surveillance capacity. Once the infection among IDUs has increased, the country has started mandatory HIV testing for drug users, as well as Harm Reduction projects implementation, in order to preserve the epidemic in the most affected areas. Two National AIDS Programmes have been implemented so far and the third is undergoing in present. The National Programme on Prevention and Control of HIV/AIDS and STIs for 2006–2010 (National AIDS Programme–NAP) determines national strategies of priority for prevention, epidemiological surveillance and treatment and is currently in its last year of implementation.

The current NAP underwent a mid-term-review (MTR) process. This process represented a huge task involving many players and required a good coordination mechanism. The evaluation process was facilitated and supervised by a coordination team authorized by the Country Coordination Mechanism, and took place from July to December 2008. The acceptance of MTR have determined the future of the programme and brought to a consensus the priorities for the implementation of the NAP and the National Monitoring and Evaluation plan. It provided an opportunity for partners to review jointly the programme evolution, identify the achievements, the constraints and the gaps to be addressed.

In addition to MTR, the country is currently undergoing the processes of situation and response analysis. The national response analysis is focused on the national response to HIV. It relates to the national response in the lights of the areas which determine the HIV spread in the Republic of Moldova, and outlines the priority areas defined by the National AIDS Program.

The goal of this document is to find out whether the national response tackles the roots of the HIV-related situation in its priority areas and to identify the obstacles on the way of its achievement. The response analysis has attempted to take into consideration the response of all various sectors of society, the government-led programmes as well as those generated by community groups and non-governmental organizations, which emphasize the HIV spread priority areas, to identify gaps in the response and analyses why various initiatives are working well and why others are failing.

The response analysis draws on the findings of the MTR report and on many secondary data sources, such as activity and program reports in various priority areas, country progress reports to various international organizations, external and internal evaluation reports, as well as special studies that enhance monitoring of knowledge, behaviors and impact of the HIV response.
1. Prevention among Most-at-Risk Populations

Importance: High
Progress: Moderate

Situation overview

Although there are signs of spread through heterosexual transmission into general population and feminization of the HIV epidemic in Moldova, the HIV epidemic is still concentrated among most-at-risk populations (MARPs), including, most significantly IDUs, sex workers, MSM, and prisoners, and their sexual partner. As of the end of year 2008, IDU mode of HIV transmission accounted for 50% of cumulative cases, heterosexual mode for 47.3%, vertical transmission for 1.3% and undetermined mode for 1.3%. According to the results of the HIV prevalence survey in 2007, an increase of the HIV prevalence was registered among MARPs that are clients of harm reduction and prevention services: the HIV prevalence among IDUs reached 22% in year 2007 compared to 17% in year 2004, among FSWs 11% in year 2007 compared to 8.5% in year 2004 and among MSM of 4.8% in year 2007 compared to 2.5% in year 2004.

The HIV prevalence have shown different dynamics depending on the harm reduction project. Older harm reduction projects (5 sites that started in year 2000) have shown a fluctuating prevalence among their clients of 29.3% in 2001, 22.0% in 2004, and 24.8% in 2007, while newer projects have shown a steady dynamic of 17.9% in 2004 and 17.2% in 2007.

The key behavioral indicators have shown mixed results: in 2007, 97.3% IDUs used a clean syringe at last injection, compared to 91.3% in year 2004. In the same time, condom use with casual sex partners has decreased from 92.7% in year 2004 to 83.7% in year 2007. In FSWs the condom use with commercial sex partners has increased from 86.5% in year 2004 to 94.3% in year 2007. Condom use by MSMs represented 48.1% in year 2007 compared to 59.0% in year 2003.

At the same time, while significant successes in changing injecting sharing behaviors have been registered among adult MARPs, the situation with most-at-risk adolescents (MARA) is very different. In 2008 a baseline study on MARA knowledge and engagement in risky behaviors has been conducted. Only half of the respondents stated always using sterile syringes during the last month. All respondents in the 12 – 14 age group reported an indirect sharing of the injection equipment during the last month before the interview. IDUs aged 12 to 14 years reported extremely poor access to services, which makes them even more vulnerable to HIV. None of the respondents from this age group resorted to Harm Reduction Programmes for sterile syringes during the last 12 months. A very small number of MARA was reached by outreach services. Obviously, there are legal and ethical obstacles in providing syringe exchange to age younger than 18 years old, but at the same time, they are engaging in higher risk behaviors compared to their older peers.

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3. The sampling method of blood samples has changed to drawing blood from the respondent of the behavioral component in BSS 2007 compared to testing blood from used syringes in years 2001 and 2004, therefore comparisons should be done with reservations.
Estimations of the size of MARPs are currently in progress, therefore, it is impossible to estimate the coverage with interventions.

Other key populations at risk include inmates, due to high prevalence of man-to-man sex, including forced sex, but also high rate of drug users among the prisoners. The HIV prevalence in inmates is high, of 4.2% in year 2007\textsuperscript{9} and about the same level compared to 4.7% in year 2004.\textsuperscript{10}

**Response analysis**

**Achievements**

The NAP sets prevention among MARPs as its 4\textsuperscript{th} priority and communication efforts are included in 2\textsuperscript{nd} priority. The activities include prevention based on harm reduction principles and outreach in MARPs, developing Opioid Substitution Treatment (OST) program, Information, Education Communication (IEC) for MARPs and increasing access to condoms.

Among all areas of prevention, HIV prevention among MARPs has experienced the most rapid growth. Since 2003, there has been commendable progress in mobilization of resources and efforts to scale-up the programmes for some MARPs.

On a larger scale, harm reduction programmes for IDUs were legalized in Moldova in 2001, including OST and needle exchange for IDUs both inside and outside of the prisons. There are harm reduction projects in 21 sites targeting IDUs, including 6 in penitentiaries and 3 on the Left Bank, 5 projects working with FSWs, and one project aimed at MSM covering two administrative territories. As of the end of the year 2009, there were some 13,050 IDUs, 1,116 FSWs, 829 members of LGBT community and 5,518 truck drivers ever reached by interventions. Harm reduction projects are considered a best practice for the country with a quite high number of IDUs in harm reduction.\textsuperscript{11}

In 2005 the Government endorsed the OST strategy, registering slow progress until year 2007, when only 16 patients were in OST.\textsuperscript{12} Since then a rapid scale-up occurred and a total of 262 IDUs were on OST at the end of 2009.\textsuperscript{13} The Ministry of Health (MoH) has developed a protocol on OST, the capacity of outpatient services in enrolling OST without hospitalization has been allowed, there is a better cooperation between penitentiary and civil sector.\textsuperscript{14}

Prevention programs in LGBT are implemented by the NGO “Gender-Doc” and include safe sex promotion among LGBT, advocacy against discrimination and promoting respect for human rights.\textsuperscript{15}

**Gaps and opportunities for action**

Although the scale-up of the prevention programs have occurred rapidly, they still did not keep pace with the scale and the intensity of the epidemic. In particular, the geographic scope of programmes has been uneven and the coverage of specific populations remains imbalanced. In large cities the coverage is still incomplete. As seen from the behavioral data, the older projects

fail to contain the epidemic and these projects are located in the cities of Chisinau and Balti, where the highest numbers of IDUs are registered. According to preliminary data of BSS 2009, only about 13% of IDUs from the city of Chisinau, 19.2% from Tiraspol and 34.6% from Balti have received free syringe from syringe exchange points in the past 12 months.\textsuperscript{16}

The equivocal Governmental commitment to provide resources, support and services for IDUs, sex workers and MSM and to address the existing legal, financial and administrative barriers to service access for MARA indicates a lot more needs to be done on the part of the Government of Moldova to address the HIV epidemic in those most vulnerable populations. The Government’s financial contribution to and involvement in prevention efforts among MARPs is barely adequate. Coordination of service delivery by Governmental and non-governmental service providers needs to be strengthened to contribute to the sustainability of the entire prevention programme supported by the Global Fund grants and the viability of overall prevention efforts.

The design and implementation of prevention programmes in this area are largely consistent with needs of the populations they serve, but require some significant revisions and improvements. The majority of current prevention services do not reach those most hidden and vulnerable populations, and are not well-suited to address emerging sub-groups, such as members of the social and sexual network of MARPs. In addition, due to budget limitations, they are not comprehensive, i.e. they fail to provide services beyond syringe exchange and provision of condoms and IEC, such as healthcare services, psychological, social, legal counseling, vocational training, behaviour change communication and skills building or other services that might make harm reduction services more attractive for the end users.

Although there is an extensive network of harm reduction services in the country, the range of services they provide is limited due to shrinking financing in the past years and they have an insufficient coverage of adolescents. Given that HIV transmission in young IDUs is presently linked with high-risk sexual behaviors and indirect sharing, this will likely translate in higher HIV/STI transmission rates in the future.

Remaining issues in OST relate to coverage and quality. The estimated coverage is less than 1% at the moment and geographical availability is still low. OST in health care facilities still lacks full multidisciplinary approach to address multiple social needs. Existing practices of OST still interfere with the social reintegration of IDU due to the requirement of daily attendance of health care facility. The coverage of IDU to OST in penitentiary institutions is still low.\textsuperscript{17}

Rehabilitation services for IDUs are underdeveloped. The few existing services are offered by the National Center for Narcology (Narcological Dispensary, NDR) and a few NGOs (“Your Choice”, “New Life” and others). The number of beneficiaries is limited. During the years 2006 – 2008, NDR and the NGO “Your Choice” have assisted about 200 people, while an additional 100 people were assisted by the NGO “New Life”. There were 280 people enrolled in the “12 Steps” Programme. There are no long-term rehabilitation centers for drug users financed from the national budget or by the National Medical Insurance Company and NDR provides outpatient rehabilitation to insured patients. Therapeutic communities/rehabilitation centers are needed for proper service provision.\textsuperscript{18}

\textsuperscript{16} BSS 2009. Preliminary data extracted from the study database. Interim results.
\textsuperscript{18} National Coordination Council, UNAIDS Moldova. Midterm Review of the National Programme on Prevention and Control of HIV/AIDS/STIs 2006-2010, March 2009
Priorities

- Conduct a detailed inventory of Governmental policies, regulations and practices that undermine or inhibit HIV prevention programmes among MARPs (e.g. legal barriers hindering service provision to MARA), and systematically revise them to eliminate or at least minimize their negative impact.

- Establish a responsible entity for coordinating all components related to HIV prevention among MARPs in the National AIDS Programme within the Government of Moldova.

- Develop a normative framework for the financing of harm reduction programs from national sources (local public authorities, the National Medical Insurance Company, the Ministry of Health, and the Ministry of Social protection, Family, and Child) and ensure that the National AIDS Programme allocates and earmarks proportionate funding for prevention programmes among MARPs.

- Elaborate a minimum package of prevention services for each MARP and MARA and standards of quality for all prevention programmes.

- Introduce national-level standards and clinical protocols regarding the provision of integrated assistance to drug users and national level official definitions for the notions of rehabilitation and social reintegration.

- Develop specific strategies to address safe sexual behaviour of IDUs and programmes to focus on sexual partners of IDUs and on pre-injectors.

- Estimate the sizes of MARPs and assess coverage targets for each of the MARP for inclusion in the National AIDS Programme.

- Expand coverage among all programmes to target IDU, sex workers, and MSM in smaller cities and towns where there is evidence of risk behavior, using mobile outreach, and where appropriate, peer driven interventions (PDI), as well as in large cities where coverage remains insufficient.

- Expand substitution treatment programmes based on low-threshold provision of methadone and client friendly service provision, integrated with other medical and non-medical services for IDUs, ensure continuity of services for MST patients who leave the penitentiary system and expand MST services to cover Transnistria.
2. HIV Prevention Among the General Population

Importance: High
Progress: Moderate

Situation overview
Starting with 2002, the current tendencies of HIV epidemics, point to a prevailing heterosexual transmission mode, the feminization of the epidemic and geographical spread to all the administrative units of the country, including the rural areas. As of January 1, 2009, the HIV prevalence constituted 94.8 on the Right Bank and 285.8 on the Left Bank, with an average total prevalence of 121.6. As of January 1, 2010, a cumulative number of 5,700 HIV cases were registered, including 1,794 in the Transdniestrian region. The absolute number of newly detected HIV cases has increased from 360 cases in year 2004 to 795 new cases in year 2008, therefore the global incidence has increased more than two-fold to 19.3 in year 2008 (including 63.8 for Transdniestrian region) compared to 8.4 in year 2004.

Until year 2000 the main mode of transmission was through injecting drug use, but since year 2004 the heterosexual mode of transmission prevails, it constituted 75.8% in year 2008 compared to 48.2% in year 2004. The feminization of the epidemic brought to an increase of the share of HIV-infected women from 26.7% in year 2001 to 43.7% in year 2008. The HIV incidence in youth aged 15-24 years has decreased in year 2008 to 16.1%, compared to an increasing trend in the past five years, including 21.2% in year 2007 and 18.7% in year 2006.

Several subpopulation groups are thought to be at higher risk of acquiring HIV in the general population: mobile populations (e.g. migrants and truck drivers), young people, sexual partners of people engaging in high-risk sexual encounters (partners of migrants, female partners of clients of FSWs), but few prevalence studies have been conducted thus far to document the actual transmission rates in these subpopulations. At the moment, an estimation survey of HIV prevalence among the migrants is on the way and will be finalized in 2010. The National AIDS Center reports that out of a cumulative number of 194,618 migrants that have done the tests before leaving the country, in the period of 2003-2009, 166 were HIV-positive, the prevalence being of 0.09%.

Detailed research has been conducted to document risk behaviors and HIV knowledge and attitudes of the general populations and these subpopulations. The knowledge about HIV has been assessed among 15-24 year olds in the period of 2006 and 2008. The integrated HIV knowledge indicator has significantly increased from 26.0% in 2006 to 40.8% in 2008, yet younger (38.3% in 15-19 year-olds and 45.6% in 20-24 year-olds) and rural youth (34.9% in rural versus 49.3% in urban respondents) have poorer knowledge. The preliminary findings of the most recent general population survey show an integrated HIV knowledge indicator value of 30.6% in the general population aged 15-49 years in year 2009.

Risk behaviors also do not show signs for optimism. Migrants reported higher risk sexual behaviors: a total of 40.3% reported two or more sexual partners and a consistent condom use with these partners of an average 44%. Some 11.2% of men and 1.1% of women reported to have commercial sex while abroad. The proportion of migrants who always used condom with

19 Preliminary data on year 2009 provided by the National AIDS Center.
non-regular partners was only 12.6%. Among truck drivers 21.1% had non-regular partners and some 72.7% used condom at last sex with them, while another 7.4% admitted to having commercial sexual partners. Youth in Moldova start their sexual life at an average age of 16.6 years, but the sex practices they enter are not always safe. Some 33.7% of boys and 3.4% girls admitted to have multiple sexual partners during the last 12 months, a total of 10% of the sample reported having had commercial sex in the past year and only 53.6% of youth 15-24 years reported condom use at last intercourse (67.1% of boys and 35.8% girls) in year 2008. In the general population, while only 10.6% admitted to have had non-regular partners during the last 12 months, some 68.0% used condom at last sexual intercourse in 2009.

Response analysis

Achievements

HIV/AIDS awareness and HIV prevention activities among the general population have improved in recent years, but key groups still remain only partially in the reach of current programmes. These activities are funded and largely implemented by international organizations and NGOs (UNICEF, AFEW, UNDP, UNFPA, IOM, SFM, etc.). Generally, the specific population groups targeted in this programmatic area are young people, school children, students in universities and vocational schools, out-of-school children, uniformed services personnel and recruits, mobile populations, and the general population. According to the current National AIDS Programme, HIV awareness and prevention among the general population is a key strategy and priority of the national response to HIV/AIDS in Moldova. Elements of prevention in the general population can be found in the Strategies 2, 4, 6, 7, and 8 of the NAP 2006-2010. The National AIDS Law also stipulates information, education, and communication activities among the general population and the youth.

The number of prevention programmes and activities for the general population and young people increased in recent years. Over the period 2005-2007, two nationwide Behavior Change Communication (BCC) campaigns to increase awareness and decrease stigma in the general population and youth were conducted.

Migrant prevention activities include awareness raising and prevention activities by IEC material distribution at customs checkpoints, railway stations and airport. A total of 1,053,542 IEC materials and 269,548 condoms were distributed during the period of 2006-2009. This group becomes a very important one in the context of HIV epidemic and it needs more attention to detailed research, programming and funding is needed for them. Truck drivers also receive IEC and BCC interventions at centers for the instruction of divers and leaflets at customs checkpoints. Prevention activities have also been implemented among the uniformed services, including capacity building for VCT services and HIV awareness-related trainings for both staff and recruits. Workplace interventions included a number of trainings on HIV-awareness in the workplace, engaging a few Moldovan companies, NGOs providing services to HIV-infected/affected people, and government employees.

Other initiatives in the area of prevention among youth included the launch of peer-to-peer activities and the development of a network of 12 Youth Friendly Health Services with a cumulative number of 239,000 beneficiaries of all services. The introduction of Life Skills Based Education (LBSE) in the mandatory school curriculum was also piloted in 2005-2006, but the

initiative was met with hostility and debates, which, eventually limited LBSE to the status of an
elective/optional course for students of 12 years old and above. Some 120,000 have been
reached by peer-to-peer education by the end of year 2009. Another example of peer–to-peer
intervention is the launch of the international initiative for school children Dance4Life, aimed
mostly at increasing youth involvement in HIV prevention.

Activities focusing on engaging the religious community discussions regarding the HIV/AIDS
episode and in HIV/AIDS control activities were also implemented. Several trainings for this
group, with support from the Moldavian Christian Aid (MCA), are considered to have
contributed to a more tolerant and constructive attitude towards the epidemic. In addition, a
number of public events, including concerts, were organized with the purpose of increasing
awareness of HIV/AIDS and reducing stigma with regard to HIV-infected/affected persons.

Gaps and opportunities for action

The major failure of all prevention activities for various subpopulations is represented by debates
and resistance from various social groups, from educational system, parent groups and religious
groups, the promotion of behavior change to safe sex, which was oftentimes concealed in a broad
prevention message that missed its target. For example, one of the most effective strategies of
HIV prevention in youth, that includes HIV and safe sex education in schools, was halted due to
opposition of some interest groups resistance, even though studies have shown that the majority
of parents (65.2%)30 and young people (82%)31 favor the introduction of such topics in schools.
In addition, social acceptance towards use and 24-hour access to cheap or free condoms is very
limited, especially in rural areas for women and youth.

The coverage of prevention activities among the general population and among youth remains
limited, especially in rural areas. The most of HIV education and prevention programmes for
specific population groups, such as young people not enrolled in school, uniformed services,
mobile populations, migrants and refugees have been fragmented and quality assessments for
these activities has not been done. Moreover, there have been very limited prevention efforts
targeting most at-risk children and teenagers. Overall, prevention efforts have focused so far on
increasing HIV knowledge and have focused less on attitude and behavior change of specific
higher-risk subpopulations. The efforts to decrease stigma and discrimination towards PLWH
proved little effectiveness, thus far, According to recent studies conducted on issues of stigma
and discrimination related to HIV/AIDS in Moldova, almost 70% of the population showed a
high degree of intolerance towards PLWH.32

Although the existence of IEC and BCC activities for migrants and truck drivers represent a
progress, they are implemented by a small number of organizations. These activities should be
intensified and made more efficient, with an increased collaboration from customs personnel and
government support. Importantly, there is a lack of reliable information regarding HIV
prevention efforts targeting mobile populations in Transnistria.

The IEC/BCC component in the NAP lacks a certain unity, as some activities pertaining to the
strategy of prevention among the general population are also included in other strategies of the
Programme. This represents an obstacle in the coordination of prevention activities in the
country. For example, activities such as developing a strategic framework to ensure access to and
quality of condoms are included in other components. It is thus necessary to integrate all
activities mentioned in the NAP pertaining to the area of prevention among the general

work.
print.
32 National Coordination Council, UNAIDS Moldova. Midterm Review of the National Programme on Prevention and Control of
population into one comprehensive framework, in order to ensure a better coordination and certain continuity of prevention efforts in the country.

**Priorities**

- To identify the governmental body with authority over coordination and overall management of HIV prevention system in Moldova, and develop accountability lines between the ministries regarding their specific responsibilities both in terms of the specific groups of the general population of interest and programmatic/service provision areas within a unified IEC/BCC strategy.

- Ensure gradual increase of government support and funding for national HIV awareness campaigns, promote legislation for free-of-charge social advertisement and broadcasting of HIV prevention messages.

- All designed IEC/BCC activities have to be targeted based on gender, age and subpopulation, have a clear behavioral focus, need to be evidence based and properly evaluated for further planning and decision making.

- Expand the HIV prevention efforts and BCC activities in migrants, by encouraging safer sexual behaviors and access to VCT services upon return home and by piloting innovative and more effective HIV prevention strategies, e.g., referrals to VCT or mobile VCT units at the points of entry to the country.

- Make continuous efforts to evaluate the school curriculum and identify entry points for safer behaviors education in the area of HIV and STI prevention in school curriculum, as well as in colleges, universities, and vocational schools.

- Expand the network of youth-friendly services and strengthen the referrals and capacity of YFHS and reproductive health cabinets/offices, expand low threshold facilities, for especially vulnerable children and adolescents, based on a one-stop-shop approach.
3. Voluntary Counseling and Testing

**Importance:** High

**Progress:** Moderate

**Situation overview**

On average, some 350 thousand tests are performed annually, including the screening of 70-80 thousand blood donations, 70 thousand representatives of high risk contingents, 40 thousand pregnant women tested twice during pregnancy, anonymous testing of 10 thousand persons, 10 thousand persons with STI symptoms, 10 thousand tests among those with clinical indications, and 20 thousand for biologic sentinel surveillance.\(^\text{33}\)

HIV testing among the general population stands at 4.1\(^\text{34}\). Although HIV testing is undertaken by a low number of people, it has been steadily increasing since 2003, reaching more than 331,300 in 2007. The rate of HIV testing among MARPs is much higher: 34.1% among IDUs, 31.7% among CSWs, and 38.3% among MSM have undertaken a voluntary HIV test and got a result during the last year.\(^\text{35}\) According to official statistics, the testing of pregnant women in the last 5 years varies between 95-98% on the right bank of the Dniester River.

A total of 19,423 people received pre-test counseling from a VCT counselor in 2008 and 56,432 people in 2009, an almost triple increase. The rate of return for post-test counseling was lower than anticipated: only 78.5% in 2008 and 74.9% in 2009 of those who received pre-test have returned to receive post-test counseling. Yet, when broken down by groups, only 0.5% (114 people) in 2008 and 0.7% (396 people) in 2009 were MARPs, which indicates an underutilization of VCT services by at-risk populations and possibly underreporting of at-risk categories because of fear of stigma. Pregnant women counted 30% (16,959 tested women) in 2009, and only 64% (10,901) of them came back for counseling for the second test.\(^\text{36}\)

A recent survey of parturient women showed that most women (93.5%) knew they have been tested for HIV during their last pregnancy. Most of them (65.8%) knew the test was done twice, but only 71.3% mentioned that medical staff has discussed with them about HIV, and in only 25.6% of cases this was a VCT counselor. In addition, only a half of the sample (49.8%) has discussed the test result with their physician and only 16.9% received it in a VCT Center. Almost a third (31.9%) have received the result on paper, without discussing it with anyone and only three quarters (73.2%) felt they have received enough information, about two thirds (63.5%) have discussed about condom use and only every sixth (15.5%) have assessed their behaviors during counseling session.\(^\text{37}\)

**Response analysis**

**Interventions**

The extension of VCT services has been stipulated by the 6\(^{th}\) strategy of the NAP. Currently VCT services were provided nationwide in 56 VCT sites and it is anticipated to increase access to 74 VCT centers (6 of them located on the Left Bank of the Dniestr River) with support from GFTAM Round VI. The national Law on HIV/AIDS adopted specifies that all HIV testing must be done on a voluntary basis, and must be accompanied by pre- and post-test counseling, except

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for mandatory testing of donations of blood, liquids, tissues, and organ samples and when a person is charged with the crime of willful transmission of HIV or rape. Specific policies that regulate VCT services in the country have also been endorsed by the Ministry of Health. There is a coordinated VCT referral system and a designated authority at the local level, the VCT services are reimbursed by the National Health Insurance Fund. Personnel have been identified and a group of 10 national trainers have trained 104 persons in topics relating to VCT. An M&E framework and coordination has been set up. Thus, significant progress has been made in recent years in scaling up access to VCT.

The use of rapid testing has been only recently introduced in Moldova, with particular focus on the use of rapid tests in maternity hospitals for pregnant women presenting for delivery without a previous antenatal HIV test. As many as 5,000 rapid tests (blood based) are purchased annually. National protocols for blood and saliva rapid testing for HIV/AIDS have also been developed.

Gaps and opportunities for action

A number of gaps have been identified by both internal and external evaluators. Most importantly, the current approach to VCT in Moldova is not consistent with the concentrated nature of the HIV epidemic. National VCT targets have not been established for specific subgroups or regions. VCT services usually focus on routine contingents (general population and pregnant women) that are referred by health workers in the medical settings and have failed so far to attract high-risk clients from MARPs and young people, as indicated in the situation analysis. The coverage and frequency of voluntary and counseling among most at-risk populations in general and among those on the left bank of the Dniester River in particular remain seriously inadequate.

The existing VCT centers throughout the country experience human resources shortages (only one person from a VCT center has been trained as a counselor) and are not fully integrated within the medical institutions and public health system in terms of coordinated efforts and effective referrals, factors that considerably limit the quality and reach of these services. YFHS Centers are an important underused resource in this context, incorporating VCT in the package of services offered would mean age-appropriate and youth-friendly counseling, as well as enhanced coverage of adolescents and young people.

The quality of voluntary and counseling remains suboptimal. In the many of clinical institutions, the tests continue to be done without adequate pre- and post-test counseling. In addition, some qualitative surveys have shown that the turn-around time for a test result might take up to 3 weeks.

In the area of rapid testing progress has been very limited, due to some concerns of the Ministry of Health regarding quality assurance for these tests in the country and regarding the decentralization of the epidemiologic surveillance mandate. Progress has been made with the implementation of rapid testing in maternity hospitals in Moldova, but these benefits are limited to expanding testing among a small population of pregnant women who did not receive antenatal care. Recent progress has been made to introduce rapid testing for most at-risk populations. However, the scope of the use of this type of testing remains limited. Serious shortcomings relate to the registration, validation and quality assurance and quality control of rapid tests in Moldova.

The current M&E framework has some limitations as well, e.g., the soft provides data only for the age group 15-44 years and does not generate some indicators required for international reporting.

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38 National AIDS Center. Informative note on the VCT situation at the end of year 2009. Unpublished work
Priorities

- Develop an Action Plan for scaling up availability and quality of VCT to focus on increasing quality and availability of VCT for MARPs and other vulnerable groups (especially IDU, sex workers prisoners, STI and TB patients).

- Promote and strengthen partnerships for NGOs and build their capacity in the area of VCT, in order to increase VCT reach to vulnerable populations; develop capacity to provide mobile VCT services in outreach programmes.

- Develop a national rapid testing strategy, to focus on accessibility and use of rapid tests in point of care and community settings.

- Improve the quality of counseling by ensuring continuous and regular training for VCT counselors on specific topics, expand the human resources capacity of units and ensure mandatory joint professional training programmes for NGO outreach personnel and staff from AIDS labs.

- Improve referral system to VCT services within medical institutions, including improving collaboration and coordination of efforts between VCT centers and YFHCs, reproductive health services and family doctors to increase referral of patients to VCT services.
4. Lab Diagnostics and Patient Monitoring

Importance: High
Progress: Moderate

Situation overview

By the end of 2009, a total of 15 AIDS Laboratories were functioning on the entire territory of the Republic of Moldova (14 on the Right Bank and 1 on the Left Bank), including the National Reference AIDS Laboratory within the AIDS Center. The regional AIDS laboratories perform ELISA type tests only, the confirmation Western Blot test is under the responsibility of National Reference AIDS Laboratory. The ELISA positive or uncertain samples are sent to the National Reference AIDS Laboratory for confirmation from both banks of the Dniester River. The numbers of tests performed show a gradual increase in the total number of tests in year 2007 compared to year 2002. (Table 1).

<table>
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<tr>
<th></th>
<th>2002</th>
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<td>ELISA tests</td>
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<td>MRS tests (Syphilis)</td>
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<td>799,372</td>
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<td>TPHA test (Syphilis)</td>
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<td>773</td>
<td>563</td>
<td>34,895</td>
<td>33,866</td>
<td>41,800</td>
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</tbody>
</table>

Patient Monitoring

Initially all patients are referred to RDVD for initial clinical examination and registration in the get on patient follow-up registry. There are currently to ART sites on the Right Bank (RDVD and in the hospital of the Penitentiary Department) and one on the Left Bank (Tiraspol).

A cumulative number of 2,155 CD4 counts and 2,390 PCR tests were done by the end of year 2007. Taking into account that there were 547 patients on ART that year, clearly most of these tests were done to monitor the existing patients, since each patient receives at least three tests a year. No data is available regarding coverage of PLWH with patient monitoring before they need ART.

An effective system of routine monitoring of treatment outcomes for all patients with HIV/AIDS has yet to be developed and implemented. There exists a lack of critical strategic information on incidence and treatment of opportunistic infections, TB/HIV co-infection, viral hepatitis, drug addiction, co-infection with STIs.

Response analysis

Achievements

The clearly defined structure of HIV testing and diagnostic algorithm and referral of positive samples to the National AIDS Laboratory has greatly improved control of the testing process and the quality of the results. All the personnel from the HIV labs were trained on using the quality testing procedure. The RDVD lab has been equipped with flow-cytometer equipment and PCR equipment. National Blood Transfusion system also used advanced equipment and high

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40 Data provided at UNAIDS Moldova's request by the National Scientific and Practical Centre of Preventive Medicine, AIDS Centre and NCDV, Ministry of Health.
sensitivity tests for HIV testing and pooled-PCR method for complete elimination of any HIV risk.

Within the GFATM first round grant, there were no planned activities for the left bank of the Dniester River. Moreover, no additional AIDS laboratory has been opened during the reporting period on the left bank of the Dniester River. However, out of savings resulted from the implementation of the GFATM first round grant, quality equipment was bought for the AIDS laboratory in Tiraspol. Procurement of equipment has also been carried out under GFATM Round 6.

Gaps and opportunities for interventions

The system for procurement of laboratory kits, reagents and supplies for HIV testing and clinical monitoring is inconsistent and poorly managed at the national and regional level. Procurement is not based on appropriateness to the specific tasks. When most countries now lease expensive laboratory equipment from the manufacturer or supplier, Moldova has purchased expensive laboratory equipment, which locks the pertinent centers into using specific and sometimes outdated equipment and reagents.

Many senior laboratory staff are well trained in general laboratory disciplines, but they have no opportunities for advanced education and training regarding HIV specific testing, especially in essential aspects related to quality assurance, confirmatory testing, flow cytometry and more advanced molecular technologies such as viral load and DNA PCR.

The capacity to reach out to PLWH to monitor their clinical progression after receiving HIV diagnosis and before they have clinical indications for HIV treatment is poor, as the transfer of patients from the National AIDS Center to RDVD is hampered by the current referral patterns. The role of the district ID specialist is uneven in different regions as to their involvement in HIV patient follow-up. As a result, out of the 5,000 patients on AIDS registry, only 2,000 are in RDVD registry.

Patient monitoring for opportunistic infections is limited due to the lack of appropriate access to lab exams.

There is a serious lack of capacity in this area on the Left Bank of the Dniestr River: there is only one lab for HIV testing, which is obviously insufficient, given the more serious HIV situation in the region. These circumstances hinder considerably the possibilities of scaling up clinical monitoring services in Transdnistria.

The scale-up of clinical monitoring services in laboratories in regional centers (flow cytometry) is very important as it enables the scale-up of treatment.

Priorities

- Revise procurement specific to HIV, to ensure the quality of the test kits, additionally to review of specifications.

- Ensure regular professional training opportunities for all HIV/AIDS laboratory personnel.

- Create a single and centralized database regarding the list of HIV-infected persons and the results of their monitoring and treatment.
5. Blood and Injection Safety and Post-exposure Prophylaxis

Situation overview

Blood safety.

The blood transfusion system in Moldova is considered to be safe and comparatively well-protected from the risk of HIV infection, with 100% of donated blood tested for HIV in a quality assured manner. A total of 81,033 blood samples were screened for HIV and all in a quality assured manner in 2009, compared to 62,265 screened samples in year 2004. The recent changes in HIV transmission routes and growing prevalence of HIV in the general population led to a steady increase in the number of newly detected HIV cases among the donated blood samples in Moldova from 39.4 to 100,000 donated blood samples in year 2004 to 58.6 in year 2008. Transmission through blood transfusion has been confirmed in two cases in years 1997 and 1999 and no cases have been registered since then.\(^{41}\)

Universal precautions, injection safety and PEP.

No data on universal precautions and injection safety is available on a national level. A recent PMTCT study documented injection practices among maternity and outpatient health workers from 10 districts, including 2 districts on the Left Bank, and cities of Chisinau and Balti. Only about half of health workers knew that universal precautions meant treating all patients as potentially infected and most thought UP are mostly about proper biological sample disposal practices. The study has shown that, while nearly everyone wears white gowns and washes the hands after each consultation, and wears gloves when disposing biological materials, only 50.5% outpatient and 69.0% maternity health workers always wear gloves during their clinical work and only 42.8% outpatient and 70.7% maternity workers change the gloves after each consultation. At the same time, while most felt they had enough syringes (89.3%) or disinfectants (92.1%), less felt they had enough gloves (75.4% outpatient and 47.2% maternity workers).\(^{42}\)

Less than a quarter of respondents (21.2%) had knowledge about the correct risk of HIV transmission through needle stick, which is 0.3%, and more than half (62.3%) overrated their risk. Yet, almost a third of maternity health workers (29.1%) a quarter (25.2%) outpatient health workers had a needle stick injury during the last 12 months. A striking finding was that 1.7% (and 3.4% on Left Bank) admitted using a syringe more than once. While most health workers are supposed to know what to do after a needle stick injury, less than a half (41.0%) of maternity health workers and only 28.1% outpatient health workers were aware that they could access PEP ARV regimen in their facility in case of a high-risk exposure.\(^{43}\)

In 2007, another KAP on infection control in three pilot institutions has been conducted. The results showed that about 40% of respondents mentioned that they change the gloves after each patient, 23.3% for each procedure, and 20.5% only for invasive procedures. Nearly 90% of the questioned medical personnel do not know the definition of standard precaution. At the same time, two thirds of the questioned medical personnel have benefited from training in the field of nosocomial infections control during past three years.\(^{44}\)

\(^{43}\)Ibid.
\(^{44}\)USAID Project on HIV/AIDS and Hepatitis B and C Prevention. Medical personnel’s knowledge, attitudes, and practices with regard to nosocomial infections supervision and control (based on the results of sociological research). Study report. Unpublished work.
Response analysis

Interventions

Blood safety

Blood safety and infection control activities are stated in the 7th strategy in the NAP. In the last few years, significant progress in this area has been achieved through the adoption of quality control standards for blood safety and the participation of all blood transfusion centers in the external quality assurance scheme, provided by the National HIV Reference Laboratory. The Ministry of Health of Moldova initiated the development of quality standards for blood safety, in order to ensure the quality of the donated blood. Currently, all the blood processed by the NBTC and RBTC is tested for HIV, hepatitis B, hepatitis C, and syphilis. ELISA methodology is used for HIV, hepatitis B, and hepatitis C, while syphilis is screened by using Immutre RPR and confirmed with TPHA. The National Laboratory of Control of Quality of Blood Products in Chisinau conducts the quality control for all prepared products and re-agents following the Guide on Preparation, Use and Quality Control of Blood Components, which is based on the Council of Europe Guide, adapted for Moldova, and approved by the Ministry of Health. By 2007, three out of four existing blood transfusion labs took part in an external quality assurance scheme, provided by the National HIV Reference Laboratory of Moldova.

Injection Safety and Post-Exposure Prophylaxis

For injection safety, there is a wide use of disposable needles and syringes in hospitals, clinics and pediatric immunizations centers. There is also a system of waste management in place with proper disposal of contaminated sharps. Treatment standards addressing appropriate injection use have been approved. There are ongoing training programs for personnel involved in administering injections. In 2008, the Ministry of Health has endorsed a Guide on Surveillance and Control of Nosocomial Infections. PEP is available at the RDVD and is provided on the basis of the evaluation of the risk for those who had occupational or non-occupational risk of HIV infection. There are no documented cases of HIV sero-conversion, indicating that the current PEP programme has been successful in minimizing HIV transmission in cases of occupational exposure.

Gaps and opportunities for action

The shortcomings that must be addressed in the area of blood safety are to increase the quality and the capacity of the lab on the Left Bank of the Dniestr River, by increasing the number of voluntary non-remunerated donors from low-risk groups, and to develop the lab capacity in Cahul.

Although, the most of the health personnel were trained in infection control in the past three years, they still do not use consistently standard/universal precautions. Data on the evaluation of the training process is not available. Often medical workers will forgo the standard use of protective barriers such as gloves, gowns, aprons, masks, or protective eyewear for work with all patients. On the contrary, medical workers often only use precautions in working with patients known or suspected to be infected with HIV. The situation when the observing the UP requirements is not always possible, leads to differential use of protection means towards HIV-infected patients, with most using additional protection measures in case of HIV-infected patients often in excess to standard/ universal precautions. This show a lack of knowledge about sero-negative window when a patient is the most infectious, yet the usual HIV test gives negative result.

The purchase of safe injection equipment is supported by local budgets, so availability of injection supplies varies widely between regions, depending on the availability of funding. Another shortcoming is represented by the weakness of SOPs regarding the disposal medical waste and sharps. In some places, patients are expected to bring their syringes to clinics and
hospitals, a fact that indicates that the health system is not providing injection supplies in adequate quantity. Boxes for disposal of needles are also reported to be in short supply in some rural areas and medical institutions. In clinical practices, injections may sometimes be given in cases where suitable alternative oral therapies exist.

There are also limitations regarding access to PEP. Although available to everyone requesting it, as shown earlier, the awareness about such an option is limited in the medical personnel. The geographic availability and delays in transporting the PEP from central level also decrease the availability of PEP for medical personnel. There are reports that staff have sometimes been required to pay out of pocket for the cost of medication for PEP, as well as reports of discrimination from supervisors or other co-workers, even though there were no documented cases of occupational infection. Currently, PEP is readily available only for health care workers. However, occupational exposure to HIV may also happen in other occupations, including emergency rescue staff, waste-disposal workers, law enforcement personnel and fire-fighters that may be exposed to blood and other potentially infectious body fluids while performing their work duties. It is not clear if PEP is available to people who think they had a high-risk non-occupational exposure.  

**Priorities**

*Blood Safety*

- Promote continuous training of medical staff in blood safety procedures according to international standards, including training and support for the improvement of quality-assurance programs in laboratory testing.

- Enhance the capacity of local territories to increase voluntary non-remunerated blood donations by attracting low-risk regular blood donors.

- Continue to provide capacity building support to the blood transfusion center in Tiraspol.

*Universal Precautions*

- To establish a comprehensive training process that would include reassessment of the infection control curriculum and inclusion of information on actual HIV occupational risks, Universal Precautions, sero-negative window and PEP. The curriculum should mostly be oriented at changing attitudes and developing skills, therefore it should include adequate time for quality exercises and practices and specific skills in trainers to perform these exercises thoroughly. The training process should be a continuous effort, with supervision, evaluation and retraining performed as needed.

- To ensure basic training on infection control and PEP, included in the training programmes and recertification programmes for all medical personnel in Moldova, and, where appropriate, other occupations (emergency rescue staff, waste-disposal workers, law enforcement personnel and fire-fighters, etc.) who may be exposed to blood and other potentially infectious body fluids while performing their work duties.

*Injection Safety*

- Ensure adequate and continuous availability of sterile/disposable injection equipment, even in resource restricted communities by conditioning accreditation to ensure adequate supply of syringes and other infection control consumables.

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• Develop and implement clear medical waste and sharps disposal regulations, including the availability and use of incinerators for medical waste

*Post-Exposure Prophylaxis*

• Ensure at least one clinical centre in each large city in Moldova with adequate trained personnel and resources to PEP management.

• Develop capacity for PEP for non-occupational exposures.

• Sign cooperation with the Ministry of Interior so that a Ministry Decision is issued on informing victims of rape and other physical abuse about the availability of PEP services.

• Ensure regular collection and analysis of data on PEP on an annual basis.
6. Medical Care and Treatment
Importance: High
Progress: Moderate

Situation overview
Since 2006, significant progress has been made in the provision of medical care and treatment for people living with HIV/AIDS in Moldova. Currently, ART is available to all reported and eligible HIV/AIDS patients in Moldova, based on clinical/immunological indications in one location on the Right Bank and two sites on the Left Bank. The UNAIDS have estimated that there were 8,814 adults (15-49 years old) and 51 children (<15 years) living with HIV/AIDS as of December 2007, including 2,582 women (29.3%) and 6,232 men (70.7%). By contrast, for the same period the National AIDS Center reported 4,131 PLWH reported in the Republic of Moldova. Of the total number of HIV-infected persons registered with the NAC, there are about 2,000 PLHIV monitored by the RDVD, where the HAART Unit is located. According to estimations, a number of 856 needed ART, yet 464 people or 54.2% were actually receiving it at the end of year 2007.

As many as 1,232 people (964 RB and 268 LB) have started HAART since 2003, when ART became first available in Moldova. As of December 2009, there were 776 patients still on HAART on the Right Bank and 209 on the Left Bank. There was an uneven access to HAART by gender, with more men being on ARV compared to women (men – 70%, women – 30%). Data on access of vulnerable groups is not available.

At the end of 2009 the rate of people on ARV treatment after 12 months was 95.2% on the Right Bank (160 out of 168 patients) and 62.7% on the Left Bank (62 out of 102), with a total of 82.9%.

At the end of 2009, as many as 4,933 viral load tests and 3,274 CD4/CD8 counts were performed country-wide to monitor the status of PLHIV and ART efficiency. There are no data regarding the number of patients that have been examined CD4 to determine if they need ARV.

Response analysis
Achievements
The NAP 5th priority stipulates care and treatment activities. The vertical centralized system has proved efficiency for the first phase of HAART implementation. It allowed achieving the highest rate of ART coverage in the region. There has been significant progress in adjusting national treatment and care protocols to WHO recommendations and timely revisions were made in year 2008, but they have not been officially approved yet. Improvement in infrastructure on inpatient and outpatient care has been achieved through refurbishment of HIV care adult and children's department. Moderate progress has also been achieved in building the capacity for medical care and treatment services, particularly through certain short-term mechanisms to provide specialized HIV/AIDS training for health workers, enabling them to provide services in a multidisciplinary team. Pharmaceutical procurement mechanisms have been established and allow the Republic of Moldova to get cheap ARV drugs.

49 Data from the Annual Report of the HIV/AIDS Treatment Department, RDVD.
A significant achievement is the provision of HAART in penitentiary system. HIV+ inmates in need of ARV treatment receive it in the Pruncul Pententiary Hospital, that is the second ARV treatment center established in the country. Based on the Order of the Department of Penitentiary Institutions No.54 from 16.04.2004 „On instituting ARV treatment”, the infectious disease doctor was appointed to coordinate the treatment. The Order has also established hospitalization of patients in ART every 6 months in the infectious diseases unit of the Pruncul Hospital; in case of medical indications, the hospitalization occurs more often.

**Gaps and opportunities for action**

The health care system in Moldova provides few effective provisions for proactive follow-up of patients and treatment outcomes. A large number of persons who initially tested HIV positive are never registered under medical observation at the HIV/AIDS treatment facilities/centers. At the moment, there are about 2,700 PLWH monitored by the RDVD, compared to the 5,000 registered by the AIDS Center. There is a general lack of patient orientation of health care services in Moldova. The majority of health services require patients to exercise initiative and face various institutional obstacles in order to access care and treatment.

Although, in 2007, the number of patients included in HAART continued to grow, the increase ART coverage from 48% in 2006 to 54% in 2007 was small, as the number of patients in need of treatment continued to grow faster than the scale-up of treatment. The methods for calculating the ART coverage, while having improved in recent years, are still based on the officially reported number of patients with HIV, which is not consistent with international recommendations.

The decentralization strategy is being implemented with difficulty, given that medical institutions and personnel are not trained in this area, but also because of a high level of discrimination in the general health system compared to specialized services. This leads to the heavy reliance of the regions on HIV specialized services in Chisinau. For example, serious discrimination by medical personnel and other barriers exist for patients with HIV to access diagnostic procedures, such as endoscopies.

The limited capacity of the ART units also represents a serious barrier to treatment for patients from other cities and areas. Thus, many patients, especially those living in the North of the country are still facing quite a few obstacles when enrolling in the ART programme in Chisinau.

Financially, 100% drugs are bought through the Global Fund grant. In addition, the PLWH community has expressed concerns regarding the procurement of some ARV drugs that were not registered in the country and the lack of a mechanism of in-country check of the quality of drugs available to end-users.

No accurate data are available about the incidence of opportunistic infections (OIs), and no studies for effectiveness of OI treatment are available. Overall, treatment for OIs in Moldova is available to all patients needing it, while prophylactic treatment for such infections is also available in outpatient settings. But many conditions are under-diagnosed because of lack of experience and appropriate lab tests and equipment. Moreover, HIV/AIDS treatment units rely on diagnostic facilities in nearby or in other hospitals or departments, which are often difficult to access and available only for paid services.

There are significant limitations in the capacity to manage the two most frequent co-infections: TB and Hepatitis. Widespread shortcomings relate to the diagnosis of tuberculosis. The diagnosis of extra-pulmonary tuberculosis is particularly poor, with reports of surgeons refusing to carry out biopsies on HIV-positive people. Although viral hepatitis is a major cause of
morbidity and mortality among HIV patients, the NAP 2006-2010 does not state the provision of viral hepatitis treatment for PLHIV because of high costs (drugs, tests, laboratory facilities).

The model for the medical care and treatment of HIV/AIDS patients has not yet been systematically described or standardized, neither for existing specialized ARV treatment centers, nor for emerging HIV/AIDS treatment sites in general healthcare settings. In some regions, infectious disease physicians appear to be overburdened. However, much of the work that is done by physicians is administrative, involving the scheduling of visits, completion of documentation, and the provision of adherence counseling. The role of nurses and social workers is severely limited, their work being underappreciated and their potential role in the treatment of patients with HIV/AIDS being underused. The integral role and expertise of laboratory staff is largely underused in the multidisciplinary model. People living with HIV are not yet systematically involved in the provision of care and the provision of adherence counseling.

The enrollment of patients in medical care and treatment, as well as the efficiency of treatment, is seriously hampered by the highly vertical nature of the medical system in Moldova. Patients affected by multiple conditions are forced to visit different specialized health services, and often receive uncoordinated or inappropriate treatment and care.

**Priorities**

- To review the treatment and care targets for the next years, based on the total estimated number of PLWH in Moldova and estimated projections for future growth of the epidemic and to add relevant targets for palliative care, pediatric care, opportunistic infections, drug substitution treatment, HIV/TB co-infection, viral hepatitis, STIs and for specific settings, including the prison system.

- The Government of Moldova must ensure the continuous provision of drugs, particularly ensuring the first line of treatment to 1,300 patients. The Government must consider gradually taking over the costs associated with treatment (1st line drugs) in the medium to longer term, according the commitments assumed over the years.

- Develop national and regional scale-up plans to achieve universal access to treatment and medical care of HIV and associated diseases, with detailed plans to scale-up access and coverage for ART, non-ART medical care (clinical monitoring and OI), palliative care, drug substitution treatment, hepatitis, tuberculosis, STIs.

- Develop a clear and understandable document of the model for delivery of HIV medical care and treatment services that clearly outlines the distribution of roles and responsibilities between institutions, and members of the multidisciplinary team that can be read and understood by medical specialists, governmental personnel, health care providers, and patients living with HIV/AIDS.

- Develop a guide on the principles of clinical management of cases and ensure training of medical personnel in inpatient services and clinical surveillance.

- Improve capacity of services to pro-actively follow-up patients to minimize loss of persons under medical observation and lower the threshold of access to such services, with emphasis on outreach approaches, particularly for IDUs.

- Take urgent measures to increase access to treatment and care for vulnerable populations, including IDU, prisoners, sex workers, MSM, migrants and refugees.

- Ministry of Health to take urgent steps to procure quality-assured essential drugs for OI, especially gancyclovir, and ensure the adequate and continuous supply of these and other
basic medications for the treatment of OIs. To develop capacity for diagnosis and management of all OIs; to update and improve medical and laboratory equipment in order to have accurate diagnosis and adequate treatment of infections such as CMV, herpes, toxoplasmosis, EB virus, etc. and to ensure adequate treatment and care to PLHIV.

- Provision of equipment and resources for viral hepatitis B and C treatment for HIV patients presenting chronic viral hepatitis (antiviral drugs, laboratory equipment), as well as the provision of resources for the procurement of the hepatitis B vaccine to be administered to all HIV-infected persons who are not immune and have not yet been infected with the virus among the vulnerable groups.

- Improve and maintain confidentiality practices, in order to build the patients’ trust in medical institutions and to decrease stigma and discrimination (which can also contribute to an increase in ART adherence).

- Further support the establishment of comprehensive ART teams in selected regions (HAART centers in Chisinau, Balti, Comrat, and Tiraspol and/or Ribnita), thus ensuring follow-up of treatment locally/in the regions after the initiation of treatment in Chisinau.

- Maintain ongoing training of medical personnel involved in HIV service provisions in all the regions of the country and add follow on advanced trainings for in-service personnel.

- Conduct assessments/studies on ARV drug resistance in Moldova.
7. STI Diagnosis and Treatment

Importance: High
Progress: Moderate

Situation Overview

The official STI statistics indicate a trend toward reduction of syphilis morbidity rate (71.4 per 100,000 of population in year 2008 compared to 98.8 in year 2000), as well as a reduction in gonorrhea incidence rate (46.6 in year 2008 compared to 50.1 in year 2000). At the same time, a much higher and slightly increasing level of uro-genital trichomoniasis (376.6 in year 2008) chlamydiosis (104.7 in year 2008) and viral uro-genital infections (53.1 in year 2008) is reported by the national STI statistics. Overall, the global STI incidence is also a slight increasing trend from 618.7 in year 2000 to 652.6 in year 2008. The official STI reporting system might underreport the actual incidence, since it is based on passive reporting of newly diagnosed cases and since STI treatment became widely available outside the STI vertical system, not all new cases enter the public health system.  

No general population surveys have been conducted to estimate STI prevalence, but data from the blood transfusion system can provide some calculations, since the national blood transfusion system screens all blood donors for syphilis antibodies (about 80,000 people a year). Hypothetically, the syphilis prevalence should be lower in blood donors than in the general population, because of the questionnaire screening before blood collection. Yet, in the case of Moldova it can still be used as a proxy for the situation in the general population, since most blood donors are replacement donors that sometimes hide risk factors and very few are low risk voluntary regular donors. According to their data, NBTC has registered an overall increase in the syphilis prevalence from 1.8% in year 2002 to 3.0% in year 2007.  

The BSS 2007 has shown a much higher syphilis prevalence in MARPs: 12.1% of IDUs, 13.2% of FSWs, 6.5% of MSMs and 13.5% inmates have had antibodies to T. pallidum. In terms of knowledge, the level of knowledge was relatively good in FSWs, IDUs and inmates and poor in MSMs: 35.9% could not name at least one STI symptom in men. An interesting finding was that almost twice as many respondents have used STI counseling services compared to the proportions to have admitted having STI symptoms.  

As for young people, the incidence of sexually transmitted infections (STI) in Moldova is very high, compared to other European region countries. According to UNICEF’s Innocenti Center, the STI prevalence was 186.8 to 100,000 in 15-19 year-olds (202.6 in boys and 170.5 in girls) in year 2006. This situates Moldova on the second place in the European region after the Russian Federation.  

Table 2. Knowledge, self-reported STI symptoms and service use in MARPs, BSS 2007

<table>
<thead>
<tr>
<th></th>
<th>IDUs</th>
<th>FSWs</th>
<th>MSMs</th>
<th>Inmates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannot name at least one symptom in women</td>
<td>20.4%</td>
<td>1.4%</td>
<td>59.8%</td>
<td>43.8%</td>
</tr>
<tr>
<td>Cannot name at least one symptom in men</td>
<td>8.4%</td>
<td>4.3%</td>
<td>35.9%</td>
<td>14.7%</td>
</tr>
<tr>
<td>Had any symptoms during the last 12 months</td>
<td>14.8%</td>
<td>19.8%</td>
<td>11.8%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Received STI counseling during the last 12 months</td>
<td>19.0%</td>
<td>40.3%</td>
<td>22.6%</td>
<td>7.2%</td>
</tr>
</tbody>
</table>

As for young people, the incidence of sexually transmitted infections (STI) in Moldova is very high, compared to other European region countries. According to UNICEF’s Innocenti Center, the STI prevalence was 186.8 to 100,000 in 15-19 year-olds (202.6 in boys and 170.5 in girls) in year 2006. This situates Moldova on the second place in the European region after the Russian Federation.  

The KAP survey conducted in 2008 showed that although most adolescents have

heard about STIs, less than half of them (47.8%) could name at least one STI symptom, without any significant change compared to the 2006 KAP survey (48.0%).

**Response analysis**

**Achievements**

The political endorsement of STI control measures is strong. The NAP has integrated STI control measures in all its priorities at the same level as HIV control measures. The M&E system for STI is regulated by a MOH policy act. A Guide on diagnosis and treatment of STI in line with the most recent international recommendations has been developed and integrated in the current curriculum.

The STI system is hierarchical, with RDVD at central level and specialized assistance in the ambulatory departments of rayon hospitals and family medicine centers, which provides a clear structure of coordination of care and referrals geographically.

Institutionalizations of 36 TPHA-fitted laboratories that are uniformly distributed throughout the country are crucial in providing two-steps serological diagnostics in syphilis: microprecipitation test as screening test and TPHA as confirmatory one.

The development and institutionalization of STI diagnostic and treatment standards within National Mandatory Health Insurance Fund with 100% coverage for syphilis, gonorrhea and scabies diagnostic and treatment has been imperative in terms of scaling up coverage and promoting sustainability.

There are established NGOs now working with MARPs in Republic of Moldova who are referring their clients for STI counseling. YFHCs in the cities of Chisinau and Balti and some other YFHCs offer free STI counseling for young people, but the diagnostic and treatment is not free of charge. The access to free diagnosis and treatment is possible for MARPS who hold health insurance. Some of the harm reduction projects offer free STI counseling for FSWs and IDUs.

**Gaps and opportunities for action**

The current system of STI care provision in Republic of Moldova is not oriented towards reaching and ensuring low-threshold programs to MARPs. At present there is no specific public budget allocation of resources to enable existing STI services to provide special services for MARPs. Existing STI services are oriented to screening individuals at lower risk of contracting STIs than MARPs. For example, in accordance with current policies in Republic of Moldova, a number of professional groups are obliged to undergo medical check-ups prior to employment and periodically thereafter. As shown by BSS 2007, less than a quarter of MARPs that have access to harm reduction services are screened for STIs, including only 40.3% of FSWs. This shows that the coverage with currently provided services for STI diagnostic and treatment are not adequate.

In order to respond effectively, it is usually necessary to reconfigure existing STI service provision quite radically in order to meet the sexual health needs of marginalized populations who are likely to find it difficult to access STI care because of cost, inexperience, confidentiality issues and hostile attitudes from service providers and other service users.

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The collaboration between NGOs now working with MARPs and the current STI screening, diagnostic and treatment system is not sufficient. The current practice is to refer clients to the STI specialists who cannot provide anonymous on-site low-cost or free treatment.

In the present, MARPs cannot be offered immediate treatment for STI symptoms due to: (1) the lack of rapid tests practice for STIs in Republic of Moldova, (2) in case of a positive screening test there is a strict requirement of referring to DV specialist for confirmatory testing, (3) interdiction of anonymous treatment for MARPs in the ministerial regulations. At present syndrome case management is not officially practiced in Republic of Moldova. Part of the reason for delay in treatment lies in legal/normative requirements for conventional screening testing and confirmatory testing prior to diagnosis and absence of official approval for utilization of syndromic case management (SCM).

STI-infected persons are not aware that single dose treatment options exist. Despite of introduction of new National STI Guidelines, treatment practices currently focus on multi-dose, sometimes multi-agent regimens specified by outdated guidelines.

In theory, MARPs should be able to obtain care for STIs free of charge. However, in practice this is infrequent. Asking fees for testing, for confirmatory tests, for medication and demands for out-of-pocket payment are a common practice. The opportunities for free of charge tests for care services, (syndrom case management), costs reduction or cheaper treatments (single dose treatment when available) are not currently being taken. Costs of STI treatment to MARPs can be reduced by carrying out less tests and simplified treatment.

Syndrome case management is not being implemented within Republic of Moldova and no projects have introduced periodic presumptive treatment for female sex workers. These are well validated interventions widely used in other countries that can enhance access to STI care by MARPs. Periodic presumptive treatment interventions proved to be able to achieve notable reductions in gonorrhea, Chlamydia and cancroids prevalence among sex workers and their clients. Syndrome case management has been shown capable of increasing attendance by 50% in populations with poor access to STI care. It has also been shown to reduce the spread of HIV when employed in populations where STI prevalence is high and the HIV is still concentrated among high risk persons, as in Republic of Moldova.

**Priorities**

- Develop a national consensus between public institutions and health providers, NGOs and other stakeholders regarding the best model of provision of care model for STIs in MARPs.

- Revise current regulations in order to allow anonymous STI testing, use of rapid tests and syndrome case management for MARPs.

- Pilot several projects on STI service provision to MSMs IDUs and FSWs by including local NGOs (or branches of national NGOs) and local service providers in the provision of STI services to MARPs.

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57 Ministry of Health of the Republic of Moldova. Order nr. 284 from 17.10.2002 „On intensifying epidemiological surveillance through STI”.


• Update national STI surveillance reporting systems to include reporting by syndrome from all centers that offer SCM.

• Increase adherence of DV specialists to single dose treatments for gonorrhea, chlamydia, syphilis and trichomoniasis, as they are officially added as first line options to existing National STI guidelines.

• Develop a financing mechanism to provide free STI treatment for MARPs who do not hold health insurance and identify the financing source.

• Support a pilot project or clinical trial to compare current standard of care with syndrome case management for the care of MARPs and periodic presumptive treatment for female sex workers in Republic of Moldova.

• Expand the mandate of VCT Centers to provide counseling and referral to STI testing.

• Develop a training strategy for health professionals that address stigma and discrimination of MARPs, and stigma and discrimination within the health sector itself.
8. HIV-TB Co-infection

Importance: High
Progress: Inadequate

Situation overview

The national statistics report a TB incidence of 129.5 in year 2008, an HIV prevalence of 0.9% in 2007. According the national standards, every newly detected TB case should be counseled and tested for HIV\(^{61}\), yet only 82% of new cases (3736 out of total 4547 new TB cases) of TB were tested for HIV\(^{62}\). From the national statistics it is not clear if there were significant social and behavioral differences between those who tested for HIV and those not tested. The statistics regarding the coverage with HIV VCT of the TB patients are also not accurate.

A special prospective HIV prevalence study conducted on a cohort of TB patients has estimated an HIV point prevalence of 3.48%. The study concluded that if routine HIV testing is offered to all TB patients, the HIV prevalence in TB patients is much higher than previously reported. The HIV prevalence in new TB patients exceeds the national HIV prevalence in Moldova (except Transnistria) by 42 times. An alarming HIV prevalence of 12.2% was reported in Balti city, which should be a sign of high concern and immediate action with TB/HIV integrated interventions.\(^{63}\)

By the end of year 2009 there have been registered a cumulative number of 318 TB/HIV co-infection cases and among them 12 with MDR-TB. In the period of 1987-2007 in the Republic of Moldova, there were 528 AIDS cases (12.7% of all HIV positive), 255 of them (48.3%) being associated with tuberculosis. Most cases are concentrated in the two main cities: 190 cases in the city of Chisinau and 234 cases in the municipality of Balti.\(^{64}\)

The routine statistics do not provide accurate information on treatment outcomes, including deaths, because the disease classification currently does not allow for accurate recording of TB/HIV joint diagnosis at necropsy. A special cohort study of 92 patients with TB/HIV co-infection showed that two thirds of patients were from vulnerable groups (former prisoners or IDUs). During the first year of research, over two thirds of patients receiving treatment were deceased.\(^{65}\)

Response analysis

Achievements

The HIV/TB collaborative activities are included in the 9\(^{th}\) NAP priority and oriented towards better coordination of care and surveillance, guidelines development and training of personnel. Progress has been made at the level of national program coordination, policy and guidelines development and M&E framework for collaborative TB/HIV interventions. The collaborative prevention of HIV and TB are priorities for both National Programs on HIV and TB, and specific prevention interventions are stipulated in both policies. The CCM is responsible for collaborative HIV/TB actions. The M&E of TB and HIV programs is integrated within one agency, the National Center for Management in Health. There are appointed HIV/TB coordinators in the main TB facilities whose responsibilities include HIV testing in TB patients, prevention and

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\(^{61}\) Ministry of Health of the Republic of Moldova. Order Nr.344 from 05.09.2007 „Regarding the development of Voluntary Counseling and testing Service”.


\(^{65}\) Ibidem.
detection of TB in HIV patients and TB treatment in patients with TB/HIV co-infection, as well as coordination of care with AIDS care specialist for HAART. Relevant clinical guidance has been approved in several policies endorsed by the Ministry of Health that regulate the clinical management of TB/HIV co-infection (HIV Clinical protocols, Order on TB DOTS strategy).

Anti-TB treatment of persons with co-infection is carried out exclusively in medical TB service units. Anti-TB treatment is administered based on standard protocols and is prescribed by TB specialist. ARV treatment is prescribed by the specialized ART department placed in the DDVR. The decision to initiate anti-retroviral treatment or change the line of ARV treatment administered concomitantly with and subsequent to anti-TB treatment is placed with the infectionist and will be made in accordance with National Protocols approved by Ministry of Health (depending on the immune status indicators - the white cells count, CD4, viral load, etc.).

The introduction of HIV and TB prevention and diagnosis, treatment and care for people in prisons on the basis of the NAP represented a first for a state-run initiative in a former country of the Soviet Union.

Gaps and opportunities for action
At the level of leadership and coordination, there is no separate technical working group that would be responsible for interventions TB/HIV co-infection.

While collaborative interventions are part of the policies and clinical guidelines, their implementation on the ground lags behind. For example, although HIV testing is offered to all patients with TB, around 20% remain uncovered by HIV testing. The reasons for these patients to be left out of the testing are not known and should be further investigated. Quite possibly, as special seroprevalence survey has shown, these patients might be at higher risk to have HIV as well. Another problem is that even if TB patients are tested for HIV, not everyone receives pre- and post-test counseling, minimizing the preventive and educational value of the HIV test in those HIV-negative, and proper adherence to treatment in those HIV-positive.

In medical units of the NPCT, co-infected patients should be placed in rooms according to the results of microscopy/culture/sensitivity; in order to minimize risk of re-infection, there should be separate rooms for co-infected patients. In reality, this rule is not always observed, which can lead to re-infection of the people co-infected by TB/HIV and to a worsening of both diseases.

While at the level of republican institutions there is a clear algorithm of coordination of care between TB and HIV specialists, the situation of coordination and provision of care in rayons is not well organized. Given the centralized system, the rayon-level ID specialist is not responsible for providing HIV care and the TB specialist is not responsible for managing a case of TB/HIV co-infection, thus minimizing their participation in the clinical management of such patients.

Priorities
- To create a TWG at the level of NCC specifically responsible for all joint TB/HIV activities in the country.
- To develop a strategic plan of collaboration between the TB and HIV national programs that should regulate the process of guidelines and clinical protocols development and coordination of care. The strategic plan should also promote the development of partnerships with community organizations, emphasize confidentiality and ethics.
- To improve collaboration between the control and prevention of TB programme, harm reduction programmes, OST programme and penitentiary systems in clear and timely cross-referral algorithms.
• To increase the coverage with counseling and testing for both HIV and TB patients, especially for MARPS (IDUs, inmates, CSWs). At district or local level, TB testing in PLWH should be managed by district infectious diseases specialists.

• In order to improve local coordination of care, either infectious disease specialists and TB specialists should be appointed as coordinators of TB/HIV care. Clinical training programs should be conducted, in order to increase their clinical capacity to provide such care.

• In medical units of the NPCT, co-infected patients shall be placed in rooms according to the microscopy/culture/sensitivity in order to minimize risk of re-infection.

• Given the high case-fatality ratio, the NPCT medical units should improve clinical treatment protocols, but also must ensure “hospice”-type rooms for people co-infected TB-HIV/AIDS in the terminal phase.
9. Hepatitis diagnostics and treatment

Situation overview
The Republic of Moldova is one of the high-prevalence countries for Hepatitis B and C. While the number of acute cases of Hepatitis B and C have been decreasing since the early 1990s due to introduction of vaccination of infants and youth, safe injection practices and single use supplies, the national statistics show a significant increase in the incidence and prevalence of chronic viral hepatitis over the last several years, as well as an increase in cirrhosis due to viral hepatitis from 54.4 per 100,000 reported in 2003 up to 96.8 per 100,000 in 2007. It is a known fact that while babies usually produce acute symptomatic cases of Hepatitis B that are treated by physicians, 75% of adults having a new infections will have no symptoms, therefore usually it is diagnosed only by chance at a medical check-up. Therefore, a hidden epidemic of hepatitis B continues to occur in the general population of the Republic of Moldova.

A sentinel seroprevalence survey conducted in 2007 among risk groups showed higher prevalence of HCV versus HIV in IDUs, FSWs and inmates. The HCV prevalence accounted for 42.7%, 24.9%, and 21% respectively, whereas the HIV prevalence was reported to be at least half the figures reported in the very same groups: 21%, 10% and 4.2% respectively. It has been estimated that 9 to 10% of blood donors are HBsAg positive and 4 to 6% of blood donors have HCV antibodies.

An analysis of behavioral and knowledge data has shown that the general knowledge levels about hepatitis B and C in high risk groups (IDUs, CSWs, MSMs and migrants) is higher than in the general population. IDUs, CSWs and MSMs are at higher risk for both Hepatitis B and C. The average number sexual partners in IDUs, CSWs and MSMs were much higher than in the general population and migrants. There was a reported high condom use level at last sex with commercial partners and non-commercial partners, but lower proportions used condoms with their official permanent sexual partners. In addition to high risk sex and drug use, there were large shares of hepatitis B and C risk situations in medical settings, imprisonment, tattoo and piercing, altogether putting at risk for hepatitis the majority of risk groups. The vaccination against Hepatitis B is lower than in the general population every tenth of the high-risk groups have been vaccinated against Hepatitis B, compared to 29% in the general population.

The comparison of self-reported Hepatitis B and C levels with actual sero-prevalence levels of chronic Hepatitis B and C showed that only every 5th IDU, every 10th CSW and every 3rd MSM knew they have Hepatitis C. This clearly indicates that people are not aware about their Hepatitis C status, therefore might not be taking any preventive measures to protect others from getting it or seeking health services to control the disease. These findings are supported also by testing behavior. Only every third or every fourth respondent have ever taken a Hepatitis B and C test.

No seroprevalence survey for Hepatitis B and C has been conducted in the general population, but it is estimated that about 300,000 people in Moldova could be living with chronic hepatitis infection, according to the information received from the senior specialist on infectious diseases. Health care system registered about 70,000 patients with chronic hepatitis B and C, of who about 30-40 per cent (28,000) need treatment. In 2007 NHIIC funds covered with treatment merely 125

70 Ibidem.
patients with chronic hepatitis C. About 1,000-1,800 patients needing immediate treatment are on a waiting list managed by the MoH.\textsuperscript{71}

**Response analysis**

**Achievements**

The NAP does not include any activities towards hepatitis control. In 2007 the Government of Moldova endorsed a National Programme on Hepatitis B, C, and D for 5 years. It includes a plan of actions for the MoH and subordinate health care facilities. Besides supporting routine infant immunization, the programme identifies high-risk population groups for HBV immunization.

The main strengths of Hepatitis B and C prevention efforts are a national immunization programme for Hepatitis B for infants, inclusion of Hepatitis testing availability at VCT centres, 100% screening of donated blood for Hepatitis B and C by ELISA and PCR methods (starting with year 2009), opening of a wide network of 56 VCT centres that provide Hepatitis B and C counselling and testing, adoption of guidelines for infection control of nosocomial infections (including blood-borne pathogens), and public information campaign performed in years 2008-2009. Starting with year 2007 NHIF has started to cover costs of Hepatitis C treatment for a small number of patients, to cover 225-250 patients in year 2008, and a 31% increase was foreseen in 2009.\textsuperscript{72}

Starting with year 2007, Hepatitis B and C serosurveillance and behaviour assessments have been conducted in the MARPs.

**Gaps and opportunities for action**

Routine surveillance system is based on passive case-reporting and is not accurate. There is no unified data at national level on the number of hepatitis screening tests performed or number of people tested, thus providing only a glimpse of the overall picture in terms of viral hepatitis B/C incidence and prevalence data.

The national programme identifies high-risk population groups for free of charge HBV immunization. However, the list is not exhaustive and does not include subpopulations, such as HIV-infected patients, prisoners, men who have sex with men (MSM), and sex workers (SW). The at-risk groups do not know about the free access to vaccines, as usual, they avoid the public health system and as a consequence, the actual numbers of MARPs receiving Hep B vaccination is quite small.

Counselling and testing for viral hepatitis is offered by VCT centers, the cost of test needs to be paid including by vulnerable groups. The tests are free only for pregnant women and those who have been in contact with a newly identified case receive free hepatitis testing.

Laboratory diagnosis is expensive (HCV RNA - $93, genotyping - $176). The previous tests piloted in Moldova indicated that genotype 1b accounted for almost 95-97%, while the treatment rate of success reported for this condition at the Hospital for Infectious Diseases for Adults is around 60-65%. The cost of treatment reaches $24,000. Diagnostics and treatment are provided in 3 hospitals in the country (two in Chisinau – National Clinical Hospital, and the Hospital for Infectious Diseases of Adults, and one – in Balti).\textsuperscript{73}

An MoH ordinance stipulates criteria for patient selection and contraindications, as well as the treatment per se. Though recommended treatment for hepatitis C is in accordance with


\textsuperscript{72} Ibidem.

\textsuperscript{73} Ibidem.
international recommendations, the list of contraindications is rather extensive, and HIV co-infection is among them. So, HIV patients with viral hepatitis have no access to hepatitis treatment, in contrast to WHO recommendations.  

**Priorities**

- The list of people at high risk for hepatitis B should be revised and broadened, as to include groups traditionally at risk for HIV (MSM, SW, IDUs, prisoners etc.) and consider vaccination for hepatitis B for the HBsAg-negative PLHIV, prisoners, IDUs, MSM, SW, as indicated in the WHO EURO Protocols 12 “Immunization of people living with HIV and people at risk of HIV infection”.

- There is a need for promotion of the VCT service for hepatitis among high-risk groups, as well as directly referring them for a test by all the services and organizations that work with MARPs. In addition, informing them about the existence and conditions for Hepatitis B vaccination, as well as referring to vaccination service from their project contacts would be a highly effective intervention.

- Government of Moldova should start negotiations with representatives of the pharmaceutical companies delivering specific medication for the treatment of hepatitis C in Moldova, with focus on price reduction and quality of drugs.

- WHO recommended to use only those specific drugs and treatment regimens that were included in the national treatment protocols, based on the WHO’s regional clinical protocols, and of adequate quality, as per the list of WHO pre-qualified drugs. All other non-specific or lower quality, or locally manufactured drugs, which have not passed the WHO pre-qualification, should be discouraged from use, until their quality is proved through the standard scientific procedures.

- Many of PLHIV who got infected through IDU also suffer from chronic hepatitis C. It is recommended to revise the list of contraindications for the treatment of Hepatitis C to conform to WHO recommendations.

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10. Non-medical Care and Support
Importance: Medium
Progress: Inadequate

**Situation overview**

Many PLWH are socially vulnerable and are affected by poverty in higher proportions than the general population. A study assessing current non-medical needs of PLWH in the country revealed that PLWH are socially vulnerable, having lower socio-economic status, lower employment rates (13.6% reported having no income and 39.0% of economically active PLWH were not employed) compared to general population.75 The families with children are in an even more vulnerable situation than PLWH without children. The capacity to afford nutritious meals and a moderate standard of living is very limited, home heating being within the means of 41.1% respondents and meals with meat or fish every other day are within their means of 33.2% respondents. At the same time, in addition to costs of living, they spend a high share of their limited incomes on health care (including travel to RDVD and non-ARV medicines), and less than half hold health insurance. What PLWH mostly need is non-discriminatory access to social and welfare services and to kindergartens and schools for children coming from families affected by HIV. When asked to identify themselves their needs, most respondents expressed a need for financial aid (89.4%), social services (80.7%), employment support (60.8%), non-HIV health care (75.1%), counseling services (59.4%), and assistance with child care (55.7%).76

The number of people needing end-of-life care is increasing every year. According to the AIDS Center, since year 1987 a cumulative number of 610 people had an AIDS diagnosis, and 170 AIDS-related deaths.77 Yet, the number of HIV-positive people with who have died is higher. The National Centre of Health Management cross-compared the national mortality database with the HIV-case registration database and identified as many as 500 deaths among HIV-positive people (not only AIDS-related).78 Even provision of ARV is not a life-saver for all. As many as 87 PLWH who have started HAART have died in the years 2003-2009.

The study evaluating palliative care needs found that a wide range of palliative care services was needed for PLHA in Moldova, including pain relief, treatment of other symptoms such as nausea, weakness and fatigue, help with nursing, infection control, psychological support, help with preparations for death when needed and support for families and caregivers. In light of the growing need for treatment among PLHA, it is expected that the need for palliative care will also rapidly increase.79

**Response analysis**

**Achievements**

The NAP 2006-2010 stipulates “social assistance and protection of people living with HIV/AIDS, members of their families and children affected by HIV/AIDS”. Strategy V makes reference to the availability of palliative care and psycho-social support services for people

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75 25.7% of the economically active general population living on the right bank of Dniester River was not employed in 2008. In 2008, a General Population Survey was conducted in the Republic of Moldova on the basis of a representative sample of the population aged 15-64 years old living on the right bank of the Dniester River. The rate of unemployment was calculated out of the number of economically active respondents (men younger than 64 old and women younger than 57 years). (Scutelniciuc, et all, 2009).


78 Ibidem.

living with HIV/AIDS in Moldova. Particularly, this strategy provides the “development and expansion of palliative care services and psycho-social support of people living with HIV/AIDS at home with the participation of public medical and sanitary institutions and non-governmental organizations.”

Within social welfare system, by law, some special benefits to temporary inability to work are provided to PLWH: welfare payments are provided for at least one year, compared to the other disability categories that provide payments for six months.

The social assistance and welfare system is currently undergoing a large reform of switching from providing services based on categories to identifying needs based on vulnerability and income. Thus, PLWH, as all other categories, will be eligible to receive assistance based on their vulnerability score.

Regulations regarding the provision of palliative care services have been adopted, though they require continuous revision and updates.

The NGO “Credinta” has been providing various forms of assistance (material, counseling, and referral) and psychosocial support for PLHA under projects funded by the Global Fund and the SFM. They also provide skills-building workshops for PLWH.

With GFATM support, the PAS Center developed a network of six play centers for children that provide psycho-social support services for HIV-affected/infected children across Moldova. They have been established through public institutions, such as social welfare and RDVD in Chisinau, youth department in Balti and an NGO in Tiraspol in years 2008-2009. Summer camps for HIV-positive children and their mothers have been organized in years 2008 and 2009. For adult PLWHs, the only consistent social support is reimbursement of transportation costs to come to RDVD to receive medical follow-up when on ARV treatment. A peer counselor has been established at RDVD in October 2008 and he has consulted so far 358 new patients and provided 3,047 consultations as of the end of 2009.80

Since 2005, the Soros Foundation Moldova (SFM) has been implementing a few subprojects for home and community based support and care for PLHA. As of 2007, there were seven such projects being implemented (six on the right bank of the Dniester River and one on the left bank). The activities involved have focused on: rendering palliative care services to PLHA; distributing informational materials, providing social care services, including distribution of food packages, facilitation of access to antiretroviral therapy, legal counseling, and primary health care; and raising the awareness of socially vulnerable children on HIV/AIDS, increasing access to information, reducing risky behavior and attitudes, including tolerance toward PLHA, and promoting a healthy lifestyle.81

Gaps and opportunities for action

Care and support services are essential in maintaining and improving the quality of life of PLHA. Such services should include among others: treatment preparedness counseling, adherence counseling, legal support, peer education/support groups, daycare centers for children with HIV, social assistance and welfare, and rehabilitation, home care for chronically ill patients, palliative care for terminally ill patients, care and support for prisoners with HIV, and professional skills-building for employment. The progress in most of these areas has been modest.

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80 Center PAS. Progress reports for the project Social Support to PLWH and Strengthening ARV Treatment Adherence. Unpublished work.
Currently, the majority of non-medical services are funded by the Global Fund grants and other donors and implemented almost exclusively by non-governmental organizations. Support services are mostly limited to those provided by NGO with little coverage.

In the public social welfare system, PLWH, along with other socially vulnerable individuals and groups, encounter difficulties in navigating the system of assistance and benefits provisions, as the level of awareness of available social protection measures included in existing legislation is very low. Case-management system does not exist, to help access to various medical and non-medical services to which PLWH are entitled.

Child focused care and support programmes are very limited, as well as interventions aimed at improving household economic capacity, provision of psychological support to affected children and their caregivers, child-care capacities strengthening, and the promotion of community care for children without family support. In addition, there are stigmatizing and discriminatory attitudes towards children affected by HIV in kindergartens, where in contradiction to HIV law, certificates of lack of HIV of the child and his parents are required.

Currently, the existing regulation also encroaches upon the right of HIV-infected children to a caring family environment. Specifically, the current policies prohibit the adoption not only of children with HIV/AIDS or congenital syphilis, but also of children who have one biological parent infected with HIV or syphilis. These formal barriers are evidently discriminatory and affect considerably the social inclusion of HIV infected/affected children. A new law on adoptions is to be adopted by the Parliament of the Republic of Moldova.

The lack of capacity within the health system to provide palliative care and outreach to PLHA represents another essential gap in the delivery of care and support services. There are shortages of staff and resources necessary to provide institutionalized palliative services, home-based services and psychological support to PLHA. The consistent lack of Government funding and support in this area, particular for services implemented by non-governmental organizations, represents a serious barrier to the sustainability of these services as well. At present, however, palliative services, including “hospice”-type, and psychosocial support for people living with HIV/AIDS at home and within public healthcare institutions is not provided, and existing palliative care and psychosocial services are offered by NGOs only.

Priorities

- Most of the expressed needs by PLWH relate to social welfare, therefore should be mostly provided by the social welfare system in the same way as the social welfare is provided to other socially vulnerable families, after vulnerability assessment of each case. Non-discriminatory access to these services and assistance in navigating through the system, with the help of case-managers needs to be ensured.

- Address and revise regulations preventing PLHA from adopting children with HIV/AIDS and regulations prohibiting the adoption of HIV infected/affected children in Moldova.

- Take steps to improve the social protection standards for PLHA (e.g., regulations for nutrition support for children and adults).

- Ensure development of national standards or guidelines for care and support services in collaboration with NGOs and relevant government ministries.

- Develop and implement a model of case-management, develop case management guidelines and protocols and train social workers and peer-counselors.
• Establish a Palliative Care Unit within the NCDV, provide state support and contracting out services for home-based palliative care.

• Ensure that all staff providing care and support services have relevant qualifications and have completed mandatory training programmes to ensure quality of services and prevent stigma and discrimination.

• Enhance monitoring and evaluation systems for care and support to ensure all service providers use the same definition for clients, coverage and frequency, and ensure reporting of coverage data on a quarterly basis.
11. Prevention of Mother-to-Child Transmission and Pediatric Care

Importance: Medium
Progress: Moderate

Situation overview
An evaluation of the PMTCT national data was conducted as part of PMTCT evaluation study in year 2009. The results of the analysis of national statistics in the area of PMTCT shows significant progress in MTCT transmission rate of 1.7% in year 2008, significant coverage with HIV testing during pregnancy (99.7%) and of children born to HIV-positive mothers, ARV prophylaxis of both mothers and children and high proportions of formula feeding. Yet, the national monitoring of PTMCT data is not of a good quality: there are many gaps in the information provided by various agencies, the full list of critical indicators is not collected and the computation of indicators is difficult because of inconsistencies in denominators.

The HIV prevalence among pregnant women has doubled in the past four years. from 0.08% in year 2004 to 0.16% in year 2008. Importantly, the HIV prevalence among pregnant women is estimated at three times higher on the left bank of the Dniester River. A total of 51,122 women undertaken the first HIV test during the pregnancy in year 2008 and 78% of them (an absolute number of 38,180 women) of women received a second test, according to the data provided by the National AIDS Center (both banks of Dniester River). According to the data collected by NCHM from all maternities in the Republic of Moldova (both banks of Dniester River), the numbers are different: some 99.7% of women (a total number of 36,857) who gave birth in year 2008 were tested for HIV at least once during pregnancy and 90.6% were tested twice. No data is collected by any agency regarding the number of rapid HIV tests performed on women at delivery. Of the reported pregnant women none was an active drug user and no data is available regarding pregnant HIV+ women with active TB.

Antenatal care: 60% of women received ARV prophylaxis starting with the weeks 24-28 in year 2007 and 52% in year 2008. Some 7.2% of pregnant women in 2007 and 0.9% in 2008 received ARV prophylaxis during delivery only, according to the RDVD. According to the estimations of the M&E team, some 18.1% of women in 2007 and 6.7% in 2008 did not receive antenatal prophylaxis before hospitalization for delivery.

Intranatal care: according to the NCHM, 18% of women in 2007 and 16.7% in 2008 had a C-section. There were 3 still births in 2007 and 1 in 2008 and 15.5% of women in 2007 and 3.7% in 2008 received ARV prophylaxis only during delivery. According to M&E team estimations, 26 women in 2007 and 12 women in 2008 did not receive any ARV prophylaxis. According to RDVD, some 14 children in 2007 and 2 children in 2008 received ARV prophylaxis after birth (meaning that the mother did not receive any ARV prophylaxis).

Postnatal care of women: according to RDVD, 108 women in 2007 and 111 women in 2008 were examined for indications for ARV treatment. A total of 76.7% in 2007 and 70.0% in 2008 of those who needed ARV treatment got it. Two women who gave births died of AIDS in 2007 and none in 2008.

Children and MTCT transmission rate: A total of 96 children in 2007 and 107 in 2008 were registered at RDVD as been born to HIV-positive mothers. The RDVD has consulted and examined with PCR at 1-2 months and 3-6 months 100% children born to HIV+ mothers. Of them 1 (1.0%) were HIV+ in 2007 and 2 (1.7%) were HIV-positive in 2008 before 12 months.

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According to the estimations of the M&E team, another 17 children with ages between 12+ months and 15 years were registered HIV-positive in 2008 (born in different years).

According to the Ministry of Health data, 14 children were taken in HAART in year 2005. The number of children on HAART increased to 20 in 2007, with 19 children still receiving it at the end of 2007. As of the end of 2009, there were 34 children on HAART. According to the RDVD and the Spectrum-generated data, the ART coverage rate increased from 48% in 2006 to 54% in 2007 for adults, compared to the increase from 45% (or 14 out of 31 children in need of HAART) in 2006 to 49% (or 19 out of 39 children in need of HAART) for children under the age of 15 in year 2007. The UNAIDS estimated that there were a total of 51 children (<15 years) living with HIV/AIDS in Moldova at the end of 2007. The data thus shows that the coverage with treatment among children is lower than the coverage among adults.

**Response analysis**

**Achievements**

Strategy 7 of NAP stipulated PMTCT activities oriented towards primary HIV prevention among women of reproductive health, VCT for pregnant women, prevention of unintended pregnancies, ensuring access to formula feeding for children born to HIV-infected mothers and improving social assistance to children affected by HIV.

Republic of Moldova has achieved excellent results in decreasing mother-to-child transmission rate from 10% in 2004 to 1.7% in 2008. The notable successes were achieved in coverage with services for pregnant women, counseling and testing, provision of ARV prophylaxis to pregnant HIV-positive women and newborns, as well as supply of milk formula and early HIV detection by PCR in infants. Importantly, more pregnant women diagnosed with HIV before pregnancy decided to become pregnant and keep their pregnancy in 2007, indicating more trust in the preventive ART services available in the country. The centralized model of provision of PMTCT services, with four institutions providing specific interventions of ARV prophylaxis and care during delivery proved to be effective while the number of cases was low.

In the period 2005-2008 new National PMTCT guidelines were developed and endorsed, health and medical personnel from the specialized institutions and district hospitals were trained in PMTCT. An ARV care team was trained on pediatric HAART outside the country. An ART pediatric department opened in 2007, providing three wards rooms for treating HIV-infected mothers, children, as well as with a playground for children.

**Gaps and opportunities for action**

As the epidemic is evolving and the number of HIV-positive women that give birth is increasing, the centralized model of service provision in four institutional becomes ineffective and there is a need of decentralization, in order to move services closer to HIV-positive women. In addition, there are still a number of areas for future improvement, such as oversight mechanism, management & coordination, sustainability and continuum of service provision, access and quality of services. The evaluation of PMTCT services has shown worse situation on the Left Bank in all examined areas.

The health system still does not properly reach out to most vulnerable women and their children. As the M&E data showed, no women who inject drugs are reported and there are an increasing number of HIV-positive children who found HIV-positive beyond the age of 12 months, for which the health system did not have any prior records. The current M&E system does not allow

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83 Data provided by RDVD in year 2008.
for collection of quality data, as it is fragmented between three agencies that are partly responsible for a set of indicators, but their coordination and exchange of information is poor and data validation is not possible. The full list of critical indicators is not collected and the computation of indicators is difficult because of inconsistencies in denominators.

The PMTCT evaluation showed that although more than half of health providers have received training in PMTCT, HIV and VCT, their actual knowledge, skills and attitudes are still very low. The areas where health providers score best are antenatal and intranatal care and feeding counseling to HIV-positive women and basic knowledge of HIV transmission and prevention. Health providers have showed widespread intolerant attitudes to PLWH in both social and professional situations and they often break confidentiality in professional settings. At the same time, they lack basic knowledge about actual risks of HIV transmission and about the effectiveness of timely and comprehensive PMTCT measures. In addition, although most have been trained in infection control, they overrate their risk of getting HIV at workplace, not all know or observe universal precautions, showing a lack of knowledge about seronegative window and leading to differential application of infection control and discriminatory isolation practices. Finally, no significant difference was noticed between knowledge and skills of district maternity workers compared to specialized maternity workers, in fact district health workers had better knowledge compared to municipal level, and therefore decentralization should be feasible.

While VCT is a unique opportunity for direct primary prevention of HIV in the population of women of reproductive age, health providers miss to use it at its full potential. Most interviewed pregnant women have been tested twice for HIV during pregnancy, but most did not receive complete or quality counseling from either physician or VCT counselor, showing that the HIV counseling is mostly formal. As a result, their level of basic knowledge of HIV transmission is low and the level of tolerant attitudes towards PLWH is low.

Interviewed HIV-positive women have received adequate care at RDVD level, good antenatal and postnatal care, but the experience of delivering their babies ranged from normal to very bad. Contraception services are provided mostly by RDVD, and when they are provided at other levels, they are sometimes of inadequate quality and incorrect information is provided to them.

In addition, while medical services are provided to HIV-positive women at different levels, the linkages between the medical system and social services or services provided by NGOs are very weak and not institutionalized.

The coverage and quality of diagnosis and treatment of opportunistic infections among pediatric patients is also much lower. Moreover, support services for children are virtually absent. Other shortcomings include inadequate training, lab diagnostics, and monitoring of the situation in these areas on the left bank of the Dniester River.

Priorities

- Revise and further develop national HIV legislation in order to remove several discriminatory provisions and aligning it with the universal human rights approach. Address in relevant regulations the need to remove stigma and discrimination manifestations against children and families affected by HIV in medical and educational institutions (kindergartens and schools), including revisions of adoption procedures for HIV-infected children.

- Improve the regulatory framework, with a particular focus on distinct responsibilities of stakeholders and clearly defined linkages between them, as well as designating a single unit responsible for functioning of effective system of monitoring and information flows.
• To urgently revise M&E system for PMTCT programme, with inclusion of essential, internationally recognized indicators. This process should be also supported by improvement in a mechanism of coordination (clear distribution of roles and responsibilities for collection, analysis and reporting).

• Develop a national plan for the systematic decentralization of PMTCT and pediatric services. Expand an existing system of maternity houses providing services to HIV-positive women and women with unknown HIV status by including secondary level maternity houses, with related provision of ARV drugs for women and newborns, milk formula, elective C-sections as well as ensuring relevant training/education of personnel.

• Create a national, cross-sectoral comprehensive continuum-of-care system for HIV-positive and exposed children, with decentralisation of medical and social care, appropriate development of capacity building interventions and M&E systems. Ensure universal access and higher quality of paediatric care and psychosocial support for HIV-exposed and positive children and their families.

• To establish a comprehensive training process that would include reassessment of the PMTCT curriculum and inclusion of information on HIV-MTCT risks and components of PMTCT, prevention of HIV at workplace, VCT and comprehensive part of decreasing stigma and discrimination. The curriculum should mostly be oriented at changing attitudes and developing skills rather than focusing only on knowledge, therefore it should include adequate time for quality exercises and practices and specific skills in trainers to perform these exercises thoroughly. And lastly, the training process should be a continuous effort, with supervision, evaluation and retraining performed as needed.

• Support integration of family planning component for HIV-positive young women into youth-friendly clinics. Create a system of uninterrupted provision of condoms for HIV-positive women according to determined “needs” at the primary level (according to provisions of the National HIV Law). Ensure access to condoms for HIV-positive and discordant couples at the primary health care level.

• Ensure implementation of effective referral system between medical, social/community workers and NGO staff that provide care and support through capacity building of multidisciplinary team.
12. Monitoring and Evaluation

Importance: High
Progress: Moderate

Description of current M&E framework
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 NCC.

Starting with year 2005, the Ministry of Health 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. 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 NAP, the National TB Programme and the Drug Observatory. 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 HIV/AIDS Programme and ensures regular UNGASS and Universal Access reporting with all proper consultations and data collection.

The M&E Unit has produced two UNGASS reports with all the proper consultations and data collection for the years 2004-2005 and 2006-2007, Universal Access report 2008. 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: BSS 2007 and BSS 2009, youth KAP surveys 2006 and 2008, quantitative and qualitative research in MARA (young IDUs, young CSWs and young MSM), situational analysis of children and families affected by HIV and AIDS, evaluation of PMTCT services in Moldova.

Data sources
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.85

HIV case registration occurs when the person undergoes two positive ELISA tests and one confirmatory Western Blot test. A paper form that includes personal and epidemiologic information is completed by the local epidemiologist. The papers forms are then sent to the National AIDS Center, where after validation, are entered into the unified electronic database SIME-HIV.

HIV clinical monitoring data is under the joint responsibility of the local ID physician and the ARV department at the RDVD. The data collected at this level are related mainly to clinical and treatment monitoring. At this point, the ARV department has a separate EXCEL database for an average 2,700 PLWH and no access to the unified SIME-HIV database due to legal provisions about data confidentiality that prohibits data exchange containing personal identifiers outside the National AIDS Center, except to the tested person itself or the parent/tutor of a minor, the head of the medical facility that has sent the sample for testing, circumscription family medicine center or the judge who has emitted the decision for compulsory HIV testing under certain legal provisions.

HIV testing data is collected in two separate data flows. Data regarding the number of HIV tests performed are registered by the centers of preventive medicine and centralized by the National AIDS Center. Data regarding the people counseled and tested in VCT centers is collected in an electronic database centralized by the NCHM M&E Unit.

Blood donors HIV screening data is registered in a separate electronic database of the National Center of Blood Transfusion. Any positive case is then reported to the National AIDS Center who is responsible for follow-up and HIV case registration.

STI case reporting is part of the RDVD M&E system. The system is a vertical one in terms of distribution of tests and reporting.

Program data is generated by various implementers who provide services to various populations groups. For example, harm reduction routine statistics data are collected by NGOs implementing harm reduction programs and an M&E officer Soros Foundation validates data. There is no national entity responsible for centralization of program indicators collected by various national and international entities.

Given the passive reporting nature of the routine health statistics, all data sources are limited to registering inputs and only those new cases that have accessed the public health system, therefore estimation methods need to be used to evaluate the actual numbers of HIV and STI prevalence in the population or sizes of various MARPs.

Outcome indicators collection system includes 2nd generation sentinel surveillance and population-based surveys. The 2nd generation surveillance system provides biannual collection of behavior and prevalence data from various groups (IDUs, FSWs, MSM, PLHA, MARA, inmates). Since year 2004, three rounds of BSS have been conducted thus far, with the last one currently in the implementation phase. Youth KAP surveys have been conducted in years 2006 and 2008.

Population-based surveys have been also carried out by various entities: RHS (1997), DHS (2005), MICS, Studies 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 Organizational Framework for Functional M&E Systems 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.86

The assessment covered the following 12 core areas:

People, partnerships and planning:
1. Organizational structures with HIV M&E functions;
2. Human capacity for HIV M&E;
3. Partnerships to plan, coordinate, and manage the HIV M&E system;
4. National multi-sectoral HIV M&E plan;
5. Annual national wide HIV M&E work plan;
6. Advocacy, communications, and culture for HIV M&E.

Collecting, verifying, and analyzing data:
7. Routine HIV program monitoring;

8. Surveys and surveillance;
9. National and sub-national HIV databases;
10. Supportive supervision and data auditing;
11. HIV evaluation and research.

**Using data for decision-making:**
12. Data dissemination and use.

Given the in-depth analysis in the M&E assessment report, the current reports will only outline the major challenges and key action points as identified by the assessment and will refer for further details to the following two documents: M&E assessment and M&E plan. ⁸⁷, ⁸⁸

**Challenges**

- Lack of institutionalized routine inter-sector 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 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 SIME-HIV 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;
- An efficient 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, OR & 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;

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⁸⁷ Ibidem;
13. Coordination and Management

Importance: High  
Progress: Moderate

Coordination

The National Coordination Council

The National Coordination Council (NCC) for the National Programmes for the Prevention and Control of HIV/AIDS/STIs and TB was established in 2002. Initially, it was created to oversee and monitor the implementation of projects funded by the World Bank and the Global Fund. Since August 2005 NCC has functioned as a national level intersectoral entity that reflects the Republic of Moldova’s priorities and commitment to control HIV/AIDS/STIs and TB, and its functions have been extended toward overseeing the implementation of the National Programmes on HIV/AIDS and TB. NCC performs the role of the CCM as part of its overall mandate as the ‘one’ body for coordinating the national response to HIV and AIDS in Moldova. Established within the Government and led by the Ministry of Health, NCC has Terms of Reference, a work plan or action plan, and a clear mandate for coordinating responses across all sectors. NCC makes decisions on the allocation of resources for all major HIV/AIDS programmes.

NCC consists of three functional levels. The decisional level is led by the Ministry of Health and comprises 22 members, representing the government sector (Ministry of Health, Ministry of Finance, Ministry of Internal Affairs, Ministry of Justice, Ministry of Education and Youth), the non-governmental sector (the Red Cross Society, the Center for Health Policies and Analyses – the PAS Center, the Resource Center “Young and Free”, the League of PLHA, the Soros Foundation Moldova), and multilateral and bilateral development agencies (UNICEF, UNFPA, UNDP, WHO, UNAIDS, World Bank, USAID, SIDA). The coordination level is represented by the NCC Secretariat, led by the Secretary of the Council. The operational level is represented by the technical working groups (TWGs), which consist of specialists from different fields in the area of HIV/AIDS/STIs and TB. There are 4 groups in the area of TB and 7 groups in the area of HIV/AIDS. The members of the TWGs offer assistance in developing projects/drafts for programmes, strategies, and national plans and identify current and future problems and solutions in the field.

Management

The current NAP is regulated through a series of ordinances, decisions, and instructions of the Ministry of Health and other responsible institutions. Importantly, according to the existing regulations, it is not clear which central institution is responsible for the overall effective implementation of the Programme. Moreover, a detailed analysis of the existing regulatory framework from the service delivery perspective, conducted in the context of MTR evaluation, showed that it includes unclear formulations regarding the role and responsibilities of each medical services provider within the objectives of the NAP. Decision Nr.540 of 28.12.2006 “Regarding the improvement of the management of the prevention and control of HIV/AIDS” speaks to both of these aspects as it distributes partial, overlapping, and somewhat unclear responsibilities in the management of the NAP to a number of institutions:

- The Scientific-Practical Center for Public Health Management – monitoring and evaluation;
- The AIDS Center – epidemiological surveillance, prevention, laboratory screening and diagnostics, communication and information, and VCT;
- The Institute of Scientific Research in the area of Mother and Child Health – PMTCT;

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- The Institute of Phtisio-Pulmonology – specialized medical assistance in HIV-TB co-infection;
- The Republican Dermatovenereology Dispensary – medical care (in-patient), ARV treatment, medical assistance to HIV-infected persons and treatment adherence support;
- The Infectious Diseases Hospital “Toma Ciorba” (jointly with RDVD) – medical care, medical assistance and palliative care for HIV-infected persons;
- The Ministry of Health (through the corresponding department) – ensuring the development, consolidation, and functionality of the medical assistance and palliative care system for HIV-infected persons;
- Regional Preventive Medicine Centers – the implementation of prevention and medical and social assistance activities for HIV-infected persons at the level of regions.

The National Response has ensured a significant degree of participation from civil society and NGOs, national and international. They focused on prevention efforts and has provided good coverage of awareness and services, particularly in urban areas. Civil society is engaged and collaborates with the Ministry of Health, whereas cooperation with the Ministry of Labour and Social Protection has been enhanced starting with 2009[^90]. The collaboration with the Ministry of Education and the Ministry of Youth has been minimal so far.

Non-Governmental Organizations
Almost 40 international and local NGOs working in the field of HV/AIDS and TB in Moldova have made an invaluable contribution to the national response, particularly in the areas of service provision and prevention. NGOs also manage and implement the majority of activities supported from the Global Fund grants and other international donors.

External Donors
As mentioned above, the financing of the national response to HIV/AIDS in Moldova depends in proportion of 70% on external donors. The largest part of external funds comes from the Global Fund grants and has served as de facto basis for guiding the contributions of many external donor contributions. At the same time, given the still weak overall leadership and coordination, reflected in the existing regulatory ambiguities, of the National response to AIDS has resulted in funding for programmes that are driven more by donors than by national strategies, priorities or formal coordination mechanisms.

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

Challenges
One of the challenges of the effective activity in the area of HIV/AIDS programming, in particular at the operational level, pertains to the multitude of actors involved, their different constituencies, and the varying levels of capacity.

With no single institution being responsible for coordinating the programme at the country level, fragmentation of services has occurred with the result that effective case management and planning of health service delivery is divided broadly among the following institutions:

Prevention (including harm reduction): National Centre for Preventive Medicine & International and National NGOs;
Diagnosis: National AIDS Centre;
ART Treatment: Dermato-Venerological Dispenser;
OI Treatment: Infectious Diseases Hospital;
Methadone Maintenance Therapy: Narcological Dispenser;
Care & Support: National and International NGOs and the Ministry of Labour, Social Protection and Family.

Importantly, although the political context limits considerably the collaboration with authorities in Transnistria, steps should be taken to promote collaborative relationships with partners on the left bank of the Dniester River. Thus, far a success was the participation of the Transnistrian AIDS Center to all decision-making and consultative forums and capacity building efforts. The continuous efforts to improve collaboration with authorities in Transnistria will have considerable long-term impact on improving the coverage and the effectiveness of interventions, and thus the national response to HIV/AIDS in Moldova. A step towards including the Left Bank in the overall decision-making process is the suggestion to include the head of the Transnistrian AIDS Center as a member of NCC that needs to be approved by the new Government.

As already mentioned, there is no central institution responsible for the overall implementation of the NAP and roles and responsibilities are divided among a number of institutions. Moreover, there is poor coordination in the context of the NAP between the Ministry of Health, the Ministry of Social Protection, Family, and Child, the Ministry of Education and the Ministry of Youth and Sports, with the latter two often being reluctant to participate in national HIV prevention activities or other related efforts. The NCC lacks the executive powers and the effective mechanisms to ensure implementation of its own decisions, hence not including all the necessary functions to act as One National Authority.

An effort to review the current management and coordination structure has been undertaken in 2009, with external technical assistance. In early 2010 the Ministry of Health has taken a political decision to restructure the current management structure by creating a new stand-alone National AIDS Authority in direct subordination of the Ministry of Health, based on the current National AIDS Center. In order to extend the capacity of the current National AIDS Center to manage the NAP, it will undergo structural changes. The new National AIDS Center will comprise five programme units: Organization, Methodology and Coordination Unit, Diagnostic and Prevention Unit, Epidemiological Surveillance and Research Unit, Clinic and Patient Case Management Unit and Administrative Unit. A total of 16 new staff needs to be hired. The financing source for the restructuring will be offered by MoH with additional support from the GFATM. In addition, the current HIV care clinical department will be subordinated to the National Infectious Diseases Hospital, as opposed to its current subordination to RDVD.

Currently, most of prevention services provided to MARPs are implemented by NGOs, having low threshold programmes and better access to vulnerable groups. In the long run NGOs will still be better suited to provide services to MARPs, but as of now, there is no mechanism of providing public funds to NGOs, quality control mechanisms and coordination on behalf a public authority.

**Priorities**

- Develop very specific terms of reference and mandate for the new NAP coordinating entity, especially related to its authority and position in relationship to all the other institutions involved in HIV/AIDS programming at the national level and clear linkages with/between ministries, other government agencies, and other partners.
• Adjust and update the existing regulatory framework pertaining to the NAP to reflect the new concept of effective coordination and management.

• Based on the new national management structure, adjust the model of service delivery and information flows at the regional and local levels.

• Promote continuous capacity building of the partners involved in HIV/AIDS activities of the, with a particular focus on strengthening of the monitoring and evaluation system of HIV/AIDS/STIs.

• Promote collaborative relationships with partners from other sectors as education, youth, social protection, and those from Transnistria; officially include representatives from Transnistria in the country-level decision-making processes in the area of HIV/AIDS/STIs.

• Develop quality systems for management for HIV/AIDS activities focused on results and performance.

• Develop the national level capacity to adequately assess resource needs and conduct correct and equitable budgeting in the area of HIV/AIDS, and promote increased government contributions.

• Develop mechanisms for public contracting out services to NGOs.
14. Process of prioritization and strategy development

Nationwide, the Republic of Moldova government’s policy in HIV/AIDS over the last 5 years was implemented through the National Programme for prevention and control of HIV/AIDS/STI for 2006-2010 (NAP), providing for the following national priority strategies: prevention, surveillance and treatment. NAP is a comprehensive, multidisciplinary and and multisectorial plan. NAP was developed based on the lessons learnt from the implementation of NAP 2001-2005 through consensus following consultations with key actors from the field, with the involvement of Government, international organizations, NGOs, PLHIV and it was endorsed through the Government Decision of September 2005.

NAP 2006-2010 was drafted along the following lines:

- Continuity and sustainability in planning and carrying out activities and interventions.
- Joining of efforts, involvement, interaction and coordination of the work of Government entities, local public administration authorities, individuals, including PLHIV, NGOs and international organizations as partners in carrying out HIV/AIDS/STI control activities in the Republic of Moldova;
- Drawing and rational use of budget funds, grant proceeds, communication and public awareness raising program projects; undertaking HIV prevention activities among lay population and within target populations, scaling up and ensuring access to health care, treatment, care and support for PLHIV;
- Improving the epidemiical situation, prevention of HIV/AIDS/STI spread, cutting HIV incidence among youth and reducing the negative impact on individuals, communities and society, setting up optimal conditions to improve one’s quality of life, in line with MDG targets;
- Developing a guaranteed social insurance system and ensuring the access of PLHIV to health services;

Since the time the strategic operational framework was developed to date there have been changes, new policy and initiatives, initially not set forth when designing the NAP. Diversity of key actors in terms of technical expertise and geographic coverage was a challenge from a programmatic implementation compliance point of view. To that end, there was consensus among key stakeholders to organize a Mid–Term Review and a final Response Analysis of the NAP 2006-2010 based upon a participative approach. The MTR has been a nationally-led process, owned by the stakeholders of the Moldova response, with foreign facilitation, aiming at reaching the following objectives:

- Conduct an assessment of the progress reached on the HIV/AIDS strategic framework implementation in Moldova based on the technical working group (TWG) reports;
- Share the best practices on HIV/AIDS prevention and control;
- Identify and approve of the key priorities and a set number of benchmarks for 2006-2010;
- Evaluate the goals, objectives and expected outcomes based on the harmonized indicators from the M&E Plan;
- Embed emerging issues in the response to the epidemic.

The evaluation was forward-looking and focused on reaching an agreement on the future priorities of NAP implementation and National M&E Plan. Such evaluation was an opportunity for partners to analyze the progress, quantify achievements, constraints and gaps needed to be worked out.

The Response Analysis / end-of-program evaluation set up the environment for NAP monitoring through partnership mechanisms and reduced the need for costly individual and untimely evaluations, while improving data exchange between the parties involved.
The end-of-program evaluation drew heavily on the papers available as much as possible and made sure that the review and findings regarding NAP were related to the key policies and government processes, including: National Development Strategy, National Health Policy, Health System Reform Strategy, as well as other relevant programs and policies.

**Methodology of Evaluations**

The MTR was a complex multi-sectorial process that required efficient coordination and good organization. For this reason, there was a **coordination team** established, mandated by the National Coordination Council for HIV/AIDS/TB (NCC, also acting as CCM), guiding and supporting the process all throughout and making sure that the key papers and summary reports were developed on time. The coordination team comprised the NCC secretariat, M&E Unit and a team of national consultants under the coordination of an international consultant. Consultants have contributed significantly all throughout the process and have evaluated the whole process in terms of capacity building, continuity and sustainability. The coordination team also involved TWG members. The MTR has resulted in concrete outputs as set of immediate priorities for NAP 2006-2010 implementation, amended M&E Plan, revised ARV Policy, other relevant policy papers and strategies, resource inventory study etc.) The above key papers were shared with TWG members and discussed before the end-of-program evaluation. The coordination team acted as a secretariat to review the MTR and filed a report with CCM and its TWGs.

The Response Analysis drew on the comprehensive process and massive findings of the MTR, and has employed secondary data analysis and analytic desk review of programme monitoring report, surveys and surveillance implemented in the last 2 years of NAP implementation. The RA has also involved an overhaul of the challenges and priorities identified at MTR, and translated into concrete recommendations for interventions under the new NAP. The RA process has been participatory; it involved a national technical coordination team, and successive discussions in broad participatory forums of key findings and recommendations.

The findings of both MTR and RA have been used in the strategic planning process for the development of the new NAP document for 2011 – 2015.

**Organisational Framework for NAP development, implementation, M&E**

The National Coordination Council for NAP and National TB Program (NTP), hereinafter NCC, was established back in 2002. Initially, it was created as a body to supervise and monitor the implementation of the World Bank and Global Fund financed projects.

Since August 2005, NCC is a national interministerial and cross-sectorial entity, being indicative of the priorities and commitments made by the Republic of Moldova in TB and HIV/STI control, subsequently empowered to supervise the implementation of NAP and NTP.

NCC objectives aim at improving the epidemiologic situation and public health by streamlining Government policy in the field of TB and HIV/AIDS/STI control, strengthening intersectorial partnership between public institutions, international development partners and NGOs from Moldova and from abroad operating in the field and ensuring a reciprocal and efficient dialogue.

NCC has three tiers. The decision-making tier is led by the MOH with 22 members, representing Government sector (MOH, Ministry of Finance, Ministry of Interior, Ministry of Justice, Ministry of Education, Ministry of Youth and Sports, Ministry of Labour, Social Protection and Family); civil society (Red Cross society, Health Policy and Analyses Center (PAS Center), Resource Center “Young and Free”, League of PLHIV, Soros Foundation Moldova); multilateral / bilateral

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91 Government Decision no.825 of 3 August 2005;
92 Data reviewed from the Info Note on NCC activities;
development agencies (UNICEF, UNFPA, UNDP, WHO, UNAIDS, World Bank, USAID, SIDA etc).

The coordinating tier is represented by the NCC Secretariat, led by the NCC secretary. There is a policy consultant working at this level, along with a communication / coordination consultant and a communication assistant. The Secretariat has the task of ensuring data exchange between different partners and levels of NCC; of ensuring and monitoring the work of TWGs and calling for and supporting the meetings of NCC for TB and HIV.

The NCC’s operational tier is represented by its TWGs, made of specialists from different sectors of TB and HIV/AIDS/STIs. There are 8 TWGs operating within HIV/AIDS, as follows:

**TWG 1: HIV/AIDS/STI surveillance and sentinel surveillance**

**TWG 2: Education and Youth**

**TWG 3: Vulnerable Groups**

**TWG 4: Treatment and care for PLHIV**

**TWG 5: Communication and prevention**

**TWG 6: VCT for HIV and HCV/HBV infections**

**TWG 7: Social Protection**

**TWG 8: M&E (mixed, both for HIV and TB)**

The NCC has coordinated the strategic planning process for the development and consultations, transparently, openly and through wide involvement of representatives from all sectors, of the draft programme documents, M&E Plans and logframes for both NAP 2006-2010 and NTP 2006-2010. NAP and NTP were both approved by the Government.

The draft AIDS Law has been extensively consulted with the civil society throughout 2006, serving as an opportunity for identifying key priorities for action of partners in implementation of both the Law and NAP, as well as an embodiment of the participation principle of human rights-based approach. In March 2006, the NCC approved the Strategy “Ensuring Universal Access to HIV/AIDS prevention, treatment, care and support”.

The strategy was designed by reviewing NAP activities, by formulating ambitious strategic objectives and activities. Such a document is guiding the work of TWGs. The NAP was further enhanced to ensure coverage of key populations at risk and general population with prevention, treatment and care interventions, as well as actions targeting the establishment of an enabling environment, scaled up to HIV/AIDS prevention programs run among vulnerable groups and lay population alike.

Annually and at programme end, National Programme coordinators have presented during NCC meetings current, intermediary or final reports. Moreover, one could take stock of the ongoing projects implemented in the Republic of Moldova during the period (GFATM, World Bank, UNFPA, AFEW, AIHA/USAID, Caritas Luxembourg etc.)

As a result, most partners in HIV/AIDS and TB control have participated in the joint coordination of activities and budgets, thus avoiding overlapping. International partners have aligned their programs to the NAP/NTP strategic framework, budgets and activities.
In order to ensure communication and a participatory process, the NCC Secretariat has been facilitating the organizing of national consultancy, NCC meetings and TWG meetings. A quarterly info bulletin has been put out (shared with head physicians from all over the country and all members of NCC, TWGs, NGO networks working in the field), touching upon various HIV/AIDS and TB related issues; the web site www.ccm.md is regularly maintained.

**Overview of NAP 2011 – 2015 development process**

The NAP 2011-2015 has been designed in line with the provisions of the national legislative and policy framework in place in the Republic of Moldova and the international guidelines for the development of national programmes, with participation of representatives of the Government (Ministry of Health, Ministry of Labor, Social Protection and Family, Ministry of Education, Ministry of Justice, Ministry of Youth and Sports, Ministry of Interior, and Ministry of Finance) and line public institutions, NGOs, including PLHIV, with technical support of bilateral donors and international organizations (UNDP, UNAIDS, WHO, UNFPA).

The NCC and its TWGs have been involved all throughout the design of NAP and NTP (www.ccm.md).

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

**Principle 1**  **NAP is developed based on evidence**

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

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

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

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

**Principle 6**  **Ex-ante evaluation of NAP impact**
The ex-ante analysis of NAP focused on the modeling and evaluation of possible HIV evolution scenarios and on the analysis of effects and consequences.
When designing the draft NAP, the following components have been duly accounted for:

- Situation analysis (final)
- Analysis of national response
- Estimates and forecasts
- Setting of goals and objectives
- Distribution of tasks within NAP
- Prioritization of key audiences and of interventions per respective groups of rights holders
- Drafting of activities
- Decision on the targets
- Estimates of the sizes of vulnerable groups
- Cost estimates per unit
- Setting indicators
- Human resources strengthening plan
- Technical assistance and funding needs assessments

Overview of goals and objectives:

Keeping the HIV/AIDS epidemic at concentrated values and reducing people’s vulnerability to HIV infection and STIs in Moldova while

Objective 1
Keep HIV incidence among 0-39 year-olds at 20 cases per 100k by 2015

Objective 2
By 2015 reduce by 10% mortality of the total number of estimated PLHIV

Tasks / areas of NAP:

1. Prevention / prophylaxis
2. Treatment and care
3. Orphans and children in need
4. Program management
5. Human resources
6. Mitigation and social protection
7. Enabling environment and community development
8. HIV/AIDS studies and research
M&E framework

This paper provides for the M&E framework for the monitoring and evaluation of HIV/AIDS programs and policies in Moldova and epidemiologic situation in the country. This plan was designed through a participatory process following the recommendations of the evaluation of the M&E system from November 2008, MTR report on NAP from March 2009 and the Analysis of National Response to HIV from March 2010.

The participatory evaluation of the national M&E system from 2008 and the analysis of the national response conducted in March 2010, M&E chapter, revealed the following gaps in the system:

• Cross-sector reporting requires a legal framework, as well as institutionalized mechanisms for routine reporting;
• Scanty funds under the state budgets earmarked for the M&E system; heavy reliance on international financial support, undermining its sustainability;
• Gaps in national technical expertise;
• Because of political constraints related to the breakaway region of Transnistria, full coverage with comprehensive M&E in the region is complicated;
• Operational research to evaluate performance is not conducted;
• Ensuring data confidentiality and data quality assurance require further strengthening.

In order to work out the aforesaid gaps, a number of recommendations were put up for priority interventions, as follows:

1. M&E Plan should be part of the NAP and should have been approved together with NAP thus providing for a legal framework;
2. Empowering key participating institutions from the M&E system through respective regulations; approve of the data flows and associated responsibilities for each level of reporting. Strengthening and improving the national M&E system by providing it with a specific mandate.
3. M&E Plan consists of strategies to protect individual data and assure the quality of data.
4. M&E Plan provides for a strategy to share data to further use it in strategic planning.
5. Build the capacity of specialists with M&E tasks working in the relevant facilities.
6. Ensure the operations of the M&E system by providing for ongoing financing and in the amounts needed to ensure good quality.

The M&E Plan framework was designed following the fundamental principles below:

- Mainstreaming;
- Integration;
- Simplicity;
- Action orientation;
- Transparency and accountability

Drivers underpinning the drafting of M&E Plan:

1. Evaluation of the M&E system as a pre-condition for developing M&E strengthening activities.
2. Need to integrate the structure and components of the M&E system in existing systems and have it approved by stakeholders, to ensure adequate data flows between stakeholders and NCC.
3. Need to establish responsibilities for data collection for specific organizations.
4. Need to ensure M&E system continuity with existing data and making of new data to avoid duplication and avoid gaps in data analysis.
5. Need to add to the M&E Plan an annual operational plan with set deadlines and allocated resources.
6. Provide a base for evidence and data for strategic planning.
Process-wise, the national M&E plan was designed together with the NAP and subsequently reviewed at MTR and end-of-program evaluation. This paper is meant to be a living and flexible operational framework, with all subsequent amendments approved by NCC.

- On 24 February 2010 there was a workshop organized for HIV estimates and forecasts to identify the targets and strategies for the implementation of the new NAP for 2011-2015. A presentation was delivered on the potential outcomes and data flows suggested for institutionalization through the M&E Plan (decision no.75d of 23.02.2010);
- Based on the feedback provided, the M&E Unit from the NCHM, together with UNAIDS, developed the first draft of the M&E Plan for the NAP 2011 – 2015;
- Draft M&E plan for NAP 2011 – 2015 was presented at the TWG M&E on 9 July 2010 (minutes as of 09.07.2010);
- Following that, NCHM team, together with UNAIDS Moldova, reduced the volume of M&E Plan and the paper was circulated via e-mail to all stakeholders for feedback and consultations by 18 July 2010;
- Following the review of it by all stakeholders, their comments were embedded.
- The reviewed draft of the national M&E Plan of the NAP for 2011-2015 was then sent for consultations with all stakeholders participating in the development of this paper by a set deadline of 5 August 2010.
- The national M&E Plan of the NAP for 2011-2015 was validated on 9 August within TWG.
- The national M&E Plan of the NAP for 2011-2015 was forwarded to the team that developed the NAP, following which it was made part of the NAP as Annex no.2.

Through a comprehensive approach, the conceptual framework and key elements of the M&E Plan were discussed at each of the meetings / workshops related to NAP development, making up an integral part of it.

**Budgeting and Performance**


Methodology of prioritizing drew on certain steps underpinning the priority elements of NAP or intervention activities:

Following the examination of evaluation findings, a problem analysis exercise was conducted to identify the most pressing areas of intervention. Through consensus, solutions for each problem have been identified within the limits of resources available. The prioritization process of scientifically rigorous and included several steps:

1. In order to start up the development and approval of the methodology to design a new NAP a workshop was called on in November 2009 (MOH ordinance no.402 of 16.11.2009 ‘on the workshop convention’) with participation of Government entities (MOH, Ministry of Education, Ministry of Youth and Sports, Ministry of Labor, Social Protection, and Family, Ministry of Finance, Department of Prison Facilities under the Ministry of Justice, NCC), NGOs, including League of PLHIV, confessions and international organizations (WHO, UNAIDS, UNICEF, UNDP, UN HR advisor etc).

The following topics were raised during the aforesaid workshop:
- Epidemiologic situation on HIV/AIDS in Moldova;
- Principles for strategic planning and evidence-based planning for the development of NAP. Procedure for NAP validation. Key chapters and quality criteria for validation;
- Methodology of programmatic approach through the human rights lens;
- NAP – key intervention areas, gaps, challenges and lessons learnt during previous NAP implementation (based on the conclusions of MTR);
- Prevention: achievements and challenges. Comprehensive approaches, structural interventions in target groups;
- Treatment: achievements and challenges. Strategies to ensure therapy adherence and funding sustainability;
- Care and support: achievements and challenges. Ways to institutionalize and establish partnerships between sectors and stakeholders;
- Mitigation and enabling environment – coordination of efforts and harmonization of assistance;
- HIV estimates and forecasts – tools and products;
- NAP funding - status quo and prospects;
- NAP development stages – recommendations and suggestions;
- Capacity building M&E needs assessment.

The aforesaid workshop resulted in the approval of an Action Plan for NAP development, and for UNGASS reporting, subsequently submitted to MOH.

2. In order to accomplish the strategy for HIV surveillance within NAP 2006-2010, a second-generation sentinel surveillance study was conducted during May 2009 – July 2010 for MARP (IDUs, FSW, MSM, inmates) (MOH ordinance no.300d of 14 May 2009 and no.74d of 23 February 2010 ‘on the amendments to the MOH ordinance no.300 of 14 May 2009 ‘on second-generation HIV surveillance’)

3. In order to streamline the base for strategic data for the new cycle of NAP 2011-2015 by improving the situation, interpretation and use of data available, as well as by mobilizing new sources of data, building the capacity of national partners in disaggregated data analysis and use, TWG on data triangulation for public health decision-making (MOH ordinance no.373 of 03.06.2010 “on the creation of a TWG for data triangulation for public health decision-making”) running a number of activities:
- Completing the inventory of existing data and consider the options to collect additional data during meetings with specialists from other sectors;
- Collected additional data with technical support of volunteers from the medical colleges and university;
- Performed a provisional analysis of existing and additional data;
- Finished data triangulation process and statement of hypotheses.

TWG for data triangulation for public health decision-making developed a report on data triangulation, outlining its findings.

4. Estimations and projections to determine interventions design and target setting. Based on the conclusions of MTR for the NAP 2006-2010, there were situation analysis and strategic planning organized to design the new NAP. In order to ensure evidence-based strategic planning and cost-efficient interventions, M&E system requested forecasts and epidemic models by making use of validated data sets.

Since 1997 there have been HIV epidemic estimates and forecasts done under the aegis of UNAIDS and WHO for specific states.

Over the last years special programs have been designed, including Workbook and EPP to generate HIV epidemic curves, based on the sentinel surveillance studies. Another application – Spectrum – is using the epidemiologic curve to generate new case prevalence estimates, AIDS associated deaths and number of orphans. Some of the Spectrum products provide the numerators for a number of indicators under the national M&E Plan of the NAP, such as those related to PMTCT, ARV drug needs etc.

In order to do forecasts to guide the development of the new NAP 2011-2015 and sharing of those by set deadlines, as well as in order to build the capacity of people to use EPP and Spectrum applications, validation of data entries, targets and forecasts, pursuant to the Regulation on the way the MOH is organized and operates, approved through the Government Decision no.777 of 27.11.2009 (‘Monitorul Oficial’ no.173 of 01.12.2009, art.855), (as per the MOH ordinance no.28d of 26.01.2010 ‘on the organizing of a workshop for HIV epidemic forecasts’), such a workshop was organized during 28-29 January 2010 to touch upon the following issues:

- Epidemiology in public health programs. Types of data used in public health.
- Types of epidemiologic methods and surveys.
- Spectrum. General overview.
- HIV estimates in adult population and in children.
- Drug needs assessment.
- Social needs assessment.
- GOALS tool. Performance indicators.
- Prevention program needs assessment.
- Financial needs assessment under the NAP.

5. For the purpose of carrying on the development of the draft NAP 2011-2015, evaluation of draft avlues for the UNGASS indicators and pursuant to the provisions of item 8 of the Regulations on the MOH operations, passed through a Government Decision no.777 of 27.11.2009, in line with the MOH ordinance no.72 of 03.02.2010 ‘on workshop convention’, a workshop was organized during 12-13 February 2010 touching upon the following issues:
Analysis of national response.
Provisional results of prioritization (following the workshop from 27-28 November 2009).
NAP components, quality requirements and criteria for NAP development, set forth in the national legal papers in place.
Goal and objectives of NAP 2011-2015.
Priority activities to reach NAP objectives. Estimation of sizes of MARP.
NAP operational plan.
NAP M&E key indicators. Draft M&E Plan.
UNGASS reporting – achievements, next steps, challenges.
Endorsement of UNGASS indicator values.

6. In order to further HIV epidemic forecasting and trends in the Republic of Moldova, as to justify the strategic planning in developing a new NAP for 2011-2015, as well as to evaluate the provisional UNGASS indicators, a workshop was organized during 19-20 March 2010 (as per the MOH ordinance no.163 of 11.03.2010 ‘on the workshop for UNGASS reporting’) a workshop was convened with all partners along the following lines:

- Need to set expected targets. Principles for target-setting. Validation of targets for NAP objectives, benchmarks when running forecasts.
- Sets of data entries required for running forecasts, data sources, and quality issues.
- Estimation of sizes of MARP. Validation of data entries.
- Forecast and estimation tools, EPP and Spectrum models. Features, methodology and how to use.
- EPP: software application for estimates and forecasts. Use of existing data in Moldova to generate epidemic curves for the period ending in 2015 (output: epidemiologic curves by each key group of population validated by participants).
- Spectrum generated forecasts (output: forecasts generated for 2010-2015).
- Presentation of draft UNGASS report 2008-2009: structure, reporting indicators, values and description of achievements and constraints.
- Subsequent international reports – prospects.
- M&E system evaluation: steps taken towards strengthening the functionality of 12 components and objectives of the new M&E plan.
- Building a national database: process. Mapping of data needs for key partners.
- NAP development: next steps. Round of consultations.
- NAP operational plan.

7. Better tools and data analysis skills for evidence-based programming. RDS is widely used in many countries as efficient sampling method of key-population for HIV behavior and biological surveys. However, the monitoring HIV systems of the most of the countries have used sampling method, based on convenience sampling as the main methodology for sampling hidden populations. Although some countries use RDS to recruit members of key population, they didn’t analyze date with software, but did it conventionally, that is not appropriate for RDS data. Many countries use RDS as sampling method for injecting drug users, sex workers and MSM. However, most of these countries have not succeeded to analyze all data due to lack of practice to use this specialized tool (RDSAT) and difficulties to understand the social network and inherent statistical adjustment in the use of this program.

In anticipation of initiation the review of the National AIDS strategy and preparation of new national strategy, starting from the importance of administrative sampling methods...
implementation and proper use of software, for the purpose to obtain precise measurements of critical indicators throughout the data analysis, for training in interpreting the data through RDSAT analysis in the period 3-4 May 2010 the workshop was held (Ministry of Health provision nr. 169d from 22-04-2010 “The organization of the workshop on RDS data analysis and data interpretation”). During workshop have been addressed the following:

- Presentation of survey results within the country;
- RDS methodology and data collection;
- Overview on RDSAT (essential components for RDS analysis, statistical theory of RDS, RDS technical terms for analysis, Hemophilia, network sizes, recruitment models, creating files for RDSAT, work with RDS files in Excel, convert Excel files into text files, encoding files for RDSAT, problem identification);
- Steps of data processing in RDSAT (analysis of separation points, analysis of the parties, Hemophilia, Balance, estimation of prevalence);
- Interpretation of RDSAT results;
- Comparing the proportions of samples with proportions of population;
- Understanding the influence of trends on the proportion of the population;
- Identification of important variables;
- Application of RDSAT using the real data;
- Creating network chains through the NETDRAW;
- Creating a chain of recruitment.

8. For continuously participative process of development of new National Program on prevention and control of HIV/AIDS and STI for the 2011-2015, and for the purpose of consolidation of strategic information database (according with Ministry of Health provision nr. 274d from 14.06.2010 “Regarding organization of workshop “Development of conceptual framework for the national repository on HIV/AIDS M&E system of the Republic of Moldova””) the workshop was held with participation of representatives from governmental sector, non-governmental organizations and persons with HIV. The workshop was held with the international consultant support. During workshop have been addressed following:

- Presentation of quality criteria for national database/international data repository (component 9 of the 12 functional components of the Monitoring and Evaluation system);
- Presentation of existing reporting systems M/E, SIS, SIME-HIV, SIME-TB, CTV, drugs;
- Presentation of sector-wide consultation results regarding national data base design and data flow;
- Conceptual presentation of the comprehensive national data base;
- CRIS 3, working concept, design and possibility to adapt it for national level;
- Capacity building in application of CRIS 3;
- Proposed data base design and design of data repository, levels of access;
- Steps of data base development process;
- Technical assistance from General Quarter

9. For the purpose of ensuring the continuity and efficient implementation of activities, NCC (for its decision-making and operational levels) and for the purpose of getting the commitment of having partners getting actively involved in the management of national response to the two infections (pursuant to ordinance no.668 of 11.10.2010 ‘on the strategic planning within NCC for 2011 and 2012’), a strategic planning workshop was organized during 22-23 October 2010 for NCC, to raise the following issues:

- NCC needs and funding opportunities:
  1. NCC – work results (2005-2010);
  2. CHAT study recommendations,
3. NCC funding step by step – updated GFATM recommendations and rules.
   • Needs assessment for NCC capacity building:
     1. NCC capacity building needs through the lens of decision-making and TWG (cross-sector issues, human rights, gender, cross-sector cooperation, management issues, strategic planning, M&E, costs versus performance, communication etc.)
     2. NCC capacity building needs as seen by the civil society (NGO, private sector, confessions, affected people, regional integration, academia),
     3. NCC capacity building needs through the lens of – GFATM supervision (efficient oversight of PRs, sub-PRs, sub-sub-PRs, reporting, frequency, efficient modalities).
   • Reaching consensus over major conclusions and priorities.
   • Establishing next steps in the planning exercise.
   • Development of a goal.
   • Development of strategy objectives.
   • Development of outcomes by objectives.
   • Development of activities by objectives.
   • Presentation of basic indicators required by GF.
   • Development of indicators and adjusting to those required by GFATM.
   • General overview of the Operational Manual:
     1. Goal and objectives of OM,
     2. Formal mandate of NCC;
     3. Working principles of NCC;
     4. NCC tasks.
   • Principles, ways to operate, TORs at decision-making level.
   • Principles, ways to operate, TORs at coordinating level.
   • Principles, ways to operate, TORs at operational level.

The methodology of the prioritization process for the strategic NAP design:
Problem tree analysis has been performed and a hierarchy of root, underlying and immediate causes have been identified; based on these problems, the results tree has been designed. The Programme elements hierarchy was established based on a certain number of priorities and needs. The planning team reached a consensus on the criteria for prioritization and weight of each criteria before the launch of the process. In prioritizing interventions, those addressing more than one underlying or root cause holistically have been determined as having most value added; lessons learnt through previous evaluations in terms of efficiency and effectiveness have been taken into account. In prioritizing key audiences, Human Rights-Based Approach has been used, emphasis being placed on most affected and most marginalized groups. The key audiences identifies have been classified according to the UNAIDS 2009 Guidelines “Evaluation and classification of beneficiary populations for the national response to HIV/AIDS”. Following this prioritization exercise, there was a set of priority activities established, allowing for getting higher impact at lower cost, and involving risk management mechanisms.

Prioritization criteria included:
   a) Based on the structure of new HIV+ cases, what are the key populations at risk of HIV (most affected populations)?
   b) What are the structural and institutional barriers that lead to marginalizing certain affected groups> How can these be addressed?
   c) How important is the proposed intervention as a solution to identified problem?
   d) Is proposed change feasible?
   e) What is the size of the respective group? What is the weight of the probability of transmission of infection, as augmented by group size?
   f) If interventions are lacking, how probable are adverse consequences (new infections/ deaths/ low QALY and DALY values)?
g) What are the costs of intervention as compared to costs of non-intervention?

h) What are the projections for the evolution of the epidemic?

i) What is the cost-efficiency of the proposed change in terms of financial and human resources needed for its implementation?

j) Is there sufficient absorption capacity?

**Priority interventions and activities or beneficiary services identified**

There was consensus reached between beneficiaries on the activities, interventions and key services. The process was made as participatory as possible. In order to get the inputs of beneficiaries and to make sure that such plan is sensitive to local needs, a number of meetings have been organized and joint planning meetings for beneficiaries to share their prospects and priorities (e.g., NGO and government) or by different levels of Government. Such meetings were programmed together with UCC in Moldova. These meetings provided for a forum whereby different stakeholders learnt and mutually influenced themselves, by providing recommendations for those who developed the program. That was the main method to ensure transparency, as all stakeholders have been participating in the dialogue.

As part of the end-of-the-NAP evaluation there was an evaluation of national partners organized to assess the national response to HIV/AIDS. It was a qualitative study that encompassed about 50 partners. The study was done by making use of a tool developed by UNAIDS - CHAT (Country Alignment and Harmonization Tool). The study results and recommendations were included in a report.

Government sector is happy with the degree of participation in the development, validation and evaluation of NAP, as well as other strategic papers in HIV/AIDS/STIs. About two-thirds of respondents reported a good level of participation. Even if the level of participation in designing the strategic papers was self-reported as high, most respondents stated that public facilities (in particular, other than the MOH) are characterized by occasional participation, on an ad-hoc basis and less quality.

Most respondents from the Government sector are happy with their level of participation in the recent processes of UNGASS development report and end-of-program evaluation of the NAP. As to the relevance and quality of participation of all national partners from the Government sector, only half of them stated that it was good, while another half mentioned insufficient participation. Moreover, likewise with many other national processes, the participation of representatives from the Government sector, mostly – of other ministries – in the M&E system is not enough.

The highest scoring mechanism is that of passing the information around through the NCC Secretariat, which to that end is making use of different channels: emails, web page, info bulletin, involvement in NCC mechanisms: national consultancy, NCC meetings and TWG meetings. Representatives of the Government sector are highly appreciative of the level of information sharing between the organizations and other national partners, and the level of transparency of data sharing through the Secretariat to government partners, and inner communication among national partners.

**Prioritization of intermediary results (IR) was done taking into account the following:**

- Local needs and priorities set by the epidemic situation in the host country recipients;
- Volume (coverage and quality) in which RI are covered by other agencies and organizations;
- Resources and comparative advantages of implementing agencies and partners;

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93 Data from the provisional CHAT study report implemented by UNAIDS.
Opportunities for expanded geographical coverage and access of vulnerable populations and high risk groups;
Accept the objectives for the beneficiary population;
Technical fairness, feasibility and availability to achieve the objectives;
The extent to which the realization of objectives promote the involvement of people living with AIDS, women and youth welfare, community involvement (mobilization and ownership) and proper integration of prevention / assistance/ reducing socio-economic);
The potential for coordination and mobilization of other contributions (public resources, donor and private sector).

**Identification of strategies was possible by determining the following steps:**

- How will be realized this strategic objective;
- What strategies are appropriate and effective for Program objectives;
- How will be ensured adjustment of planning efforts to the local conditions;
- What are the obstacles that have to be avoided in developing new strategies;
- What are the basic opportunities for developing new strategies.

There were identified strategies that helped in achievement of Plan objective. The total number of strategies is reasonable and achievable within period specified in strategic plan. For each priority goal have been identified strategies.

**Strategic planning process was based on ten stages:**

1. Mobilization of the main beneficiaries;
2. Review of evaluation findings;
3. Acceptance of a common vision on the better future;
4. Identifying priority areas of intervention and needs using strategic criteria;
   a) Maximum impact (effectiveness, relevance, effectiveness);
   b) Ethnic standards;
   c) Implementation of organization role, culture and comparative advantage;
   d) Sustainability;
5. Development of goals and objectives;
6. Identification of the approach for each priority objective;
7. Identification of comprehensive activities for each strategy;
8. Budgeting and other resource requirements for this plan;
9. Defining roles of actual and potential implementing partners;
10. Discussions with the main beneficiaries.

Strategies and Program activities are correlated with the Millennium Development Goals, the National Health Policy (2007-2021), and National Strategy for Health System Development (2008-2017).

The program includes the National Monitoring and Evaluation Plan, which was developed in the line with Program and includes indicators on progress, outcome and impact. Result indicators were developed based on obtained and expected data.

Program budget includes the cost of the prevention activities, treatment, care and support. Implementation of the Program will provide benefits for public health, both social areas - reducing costs of antiretroviral treatment and treatment of opportunistic infections, reducing mortality of persons with HIV/AIDS, and economic area – increasing productivity of population, as the result of the good health status.

The Program will be completed according to the Operational Plan where are mentioned who are responsible for implementation, collaborative partners, terms of implementation.

The Program has been consulted with all stakeholders, including people living with HIV/AIDS. The proposals were considered.
For the purpose of ensuring transparency, communication and participatory work continuously are managing the following websites: www.aids.md, www.ms.gov.md and www.ccm.md.
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