

*Draft
Not for quotation*

**NATIONAL HIV/AIDS MONITORING AND
EVALUATION PLAN
2006 - 2010**

(Updated and amended at MTR 2008)

**National Coordination Council for HIV/AIDS &
TB**

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal clinic
ARV	Anti-retroviral treatment
BCC	Behavioral Change Communication
BSS	Behavioral Surveillance Survey
CBO	Community Based Organization
CRIS	Country Response Information System
CSW	Commercial Sex Workers
DHS	Demographic and Health Survey
FBO	Faith-Based Organization
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IAs	Implementing Agencies
IDU	Injecting Drug User
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
M&E TWG	M & E Technical Work Group
MICS	Multiple Indicator Cluster Survey
MoEY	Ministry of Education and Youth
MoH	Ministry of Health
MoIA	Ministry of Internal Affairs
MoSPFC	Ministry of Social Protection, Family and Child
MSM	Men Having Sex with Men
NAC	National AIDS Commission
NAP	National AIDS Program
NCPI	National Composite Policy Index
NGO	Non-governmental Organization
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PLHA	Persons Living With HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
RH	Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
TOR	Terms of Reference
UA	Universal Access
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary Testing and Counselling
WHO	World Health Organization

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EXECUTIVE SUMMARY

This document provides the framework for the monitoring of HIV/AIDS policies and programs in the country. It serves as guidelines for HIV/AIDS monitoring and evaluation for decision makers, key stakeholders in the national HIV/AIDS response and program officers on essential data to be collected, utilized and reported to local and national level authorities. The plan has been amended and updated as a result of the Mid-term Review of the National Program on the Prevention and Control of HIV/AIDS/STI that run from September 2008 to February 2009.

The Plan presents background information on key national frameworks, rationale and process for reviewing and updating the framework for the M&E system. It provides constituents actively involved in the National HIV/AIDS Monitoring and Evaluation (M&E) System with information on core indicators, key data sources, information flows, information products and institutional responsibilities.

The document has several annexes; these include:

- Matrix with indicators and definitions, reference values and expected values
- M&E system evaluation report
- Membership of the TWG on M&E
- TORs for the TWG on M&E
- Communication Plan for the National Plan for the M&E of HIV
- Inventory of studies
- Template of the joint UA reporting form

The Plan has been aligned to existing systems in various sectors and to key national frameworks such as the NDP 2008 – 2011, NAP 2006 – 2010, National Health Policy, and the Health System Reform Strategy.

CHAPTER 1. BACKGROUND

1.1. Socio-demographics and HIV prevalence

According to the National Scientific and Practical Center for Preventive Medicine (NSPCPM) data, there have been 4,996 HIV cases identified throughout 1987-2008, including 1,535 in Transnistria¹. There has been a sharp increase in the number of new cases being diagnosed, with 43 per cent of all cases being reported in the last three years. Based on UNAIDS estimations, there were 8,865 persons (including 51 children) living with HIV/AIDS at the end of 2007 in Moldova.

In the Republic of Moldova, like in other countries from Eastern European region of the former Soviet Union, the early stages of the HIV epidemic in the 1990 were driven by Injecting Drug Users (IDUs) who spread the virus through sharing contaminated needles. Away from few sporadic HIV cases registered prior to 1995 (since 1987, 19 HIV cases were registered cumulatively) with probable route of transmission other than injecting drug use, the onset of the epidemic is considered to be 1996².

After the late 1990s, however, the rate of cases transmitted by injecting drug users began declining while the rate of sexually transmitted cases began increasing. In 2005, for the first time, more newly registered HIV cases were associated to sexual route of transmission than injecting drug use route. Another shift was occurring in infection rates by sex. Out of the 795 new HIV cases reported in 2008, about 75.82% were sexually transmitted. Since 2005, the sexual route of transmission has been prevailing and there are steady trends of up-surfing rates of transmission via the sexual route among the newly reported cases. Considering the high economic migration rates, this phenomenon could become a determinant in the future evolution of HIV in the Republic of Moldova³. The shift in the structure of newly reported HIV cases according to their route of transmission increases the vulnerability of women. In last 3 years, women are in majority among newly reported HIV cases with sexual route of transmission (2007 – 62.2%, 2006 – 57.2%). The share of HIV-infected women increased from 26.72 per cent in 2001 to 43.67 per cent in 2008. In time there is an increase in the number of newly reported HIV cases among pregnant women. There have been 83 pregnant women diagnosed with HIV in 2008 alone. According to the data of the National Center of Health Management in 2007 (National Center of Health Management, 2007), the HIV prevalence among pregnant women reached 0.23% that is approximately the same as in 2006 (0.21%). In the due time, the newly reported HIV cases among blood donations register also a slight increase. Thus, in 2008 the number of newly reported HIV cases per 100 000 blood donations reached 58.6 compared to 48.9 new HIV cases per 100 000 blood donations registered in 2006 (National Scientific and Practical Center of Preventive Medicine, AIDS Center, 2008).

The epidemiological situation on the left bank of the Dniester River is alarming. Historically, the number of registered Injecting Drug Users (further IDUs) per 100 000 inhabitants, was higher on the left bank of the Dniester River comparing with the one registered on the territory of the right bank of the Dniester River. In the context of the frozen political conflict on the Dniester River, the implementation of HIV prevention and control interventions both in Key Populations at Higher Risk (KPARs) and in the general population started later than on the right bank. In 2007 the HIV prevalence in pregnant women from the left bank of the Dniester River (0.42%) is three times higher than the one from the right bank of Dniester River (0.13%) (National Scientific and Practical Center of Preventive Medicine, AIDS Center, 2008). According to this data source from in 2007, the number of newly reported HIV cases per 100 000 blood donations from the left bank of the Dniester River is almost double (100.3 newly reported HIV cases per 100 000 blood donations) in comparison with the right bank of the Dniester River (55.9 HIV newly reported cases per 100 000 blood donations).

Trend analysis of the HIV epidemic in the general population in the Republic of Moldova based on the annually reported new HIV cases implies limitations depending on the country capacity in HIV testing, the testing regulations applied, especially for IDUs which have been subject to changes in time as well

1 Info Bulletin on the Epidemiologic situation in HIV/AIDS, Implementation of the National HIV Program, and Targets for 2009, NCPM, 05.03.09

2 National Drug Observatory, 2006

3 Oxford Analytica 2008

as are highly dependent on the political context (where the role of the conflict on the Dniester River plays a major role⁴). The confirmation HIV test is performed only in Chisinau, the capital city of the Republic of Moldova.

According to the results of the HIV prevalence survey conducted in Key Populations at Higher Risk (KPARs) in 2007, the HIV prevalence in IDUs reached 21%, in Commercial Sex Workers (CSWs) - 11% and in Men having Sex with Men (MSM) - about 4.8% (Scutelnicu & Bivol, 2008). This research has been conducted among beneficiaries of Harm Reduction Programs. An increase of HIV prevalence has been registered in 2007 prevalence study comparing with 2004 HIV prevalence study among IDUs and Men having Sex with Men (MSM). While comparing the results for 2003, 2004 and 2007 from the capital city of the country only, there is a decreasing trend in the HIV prevalence among Commercial Sex Workers (further CSWs) and an increase among Men having Sex with Men (further MSM). All HIV prevalence surveys among MSM were conducted in the capital city only.

The HIV epidemic in the Republic of Moldova is still considered to be concentrated mostly in IDUs population with sign of spreading into the general population. The high level of external migration which is specific for the left bank of the Dniester River as well creates favourable conditions for the rapid spread of HIV infection in the general population. The data presented, i.e. annual rise in HIV incidence, the geographic spread of the epidemic, with new cases of HIV spreading into the general population, including rural population (41.64 per cent of all new cases diagnosed in 2008 was in rural population versus 38.7 per cent reported in 2007), is pointing at the generalization trends of the HIV spread.

Table 1 HIV prevalence in IDUs, Republic of Moldova, 2001- 2007

Data collection site	2001 ⁵		2003 - 2004 ⁶		2007 ⁷	
	Sample	HIV prev	Sample	HIV prev	Sample	HIV prev
Chisinau, capital city	209	15.8 %	306	14.4 %	183	17.5 %
Balti	184	60.3 %	230	36.5 %	145	44.8 %
Causeni	n/a	n/a	10	40.0 %	11	27.3 %
Donduseni	n/a	n/a	n/a	n/a	10	10.0 %
Edinet	n/a	n/a	7	14.3 %	20	15.0 %
Falesti	50	22.0 %	67	11.9 %	28	10.7 %
Orhei	13	23.1 %	44	2.3 %	21	0 %
Rezina	n/a	n/a	43	11.6 %	30	16.7 %
Soroca	87	1.15 %	116	0.0 %	41	0 %
Tiraspol	n/a	n/a	n/a	n/a	68	20.7%
Ungheni	n/a	n/a	47	2.3 %	63	6.3%
Total	543	29.3 %	517	17.0 %	620	21.0%

Table 2 HIV prevalence in CSWs (blood samples, “take all” sampling), Republic of Moldova, 2003 - 2007

Data collection site	2003		2004		2007	
	Sample	HIV prev	Sample	HIV prev	Sample	HIV prev
Chisinau, capital city	150	4.6%	151	8.5%	243	2.9%
Balti	n/a	n/a	n/a	n/a	122	32.8 %
Edinet	n/a	n/a	n/a	n/a	34	2.9 %
Orhei	n/a	n/a	n/a	n/a	69	0 %
Ungheni	n/a	n/a	n/a	n/a	20	25.0 %
Total	150	4.6%	151	8.5%	488	10.9 %

⁴As a result of the frozen conflict on the Dniester River (1991 - 1992), the territory of the Republic of Moldova is divided in the territory on the right bank and territory on the left bank (Transnistria) of the Dniester River. The territory on the right bank of Dniester River is controlled by the Chisinau authorities, while that on the left bank is controlled by the self proclaimed, unrecognized authorities from Tiraspol - the main city of this region.

⁵ Used syringes, “take all” sampling

⁶ Used syringes, time location sampling

⁷ Blood samples, random sampling

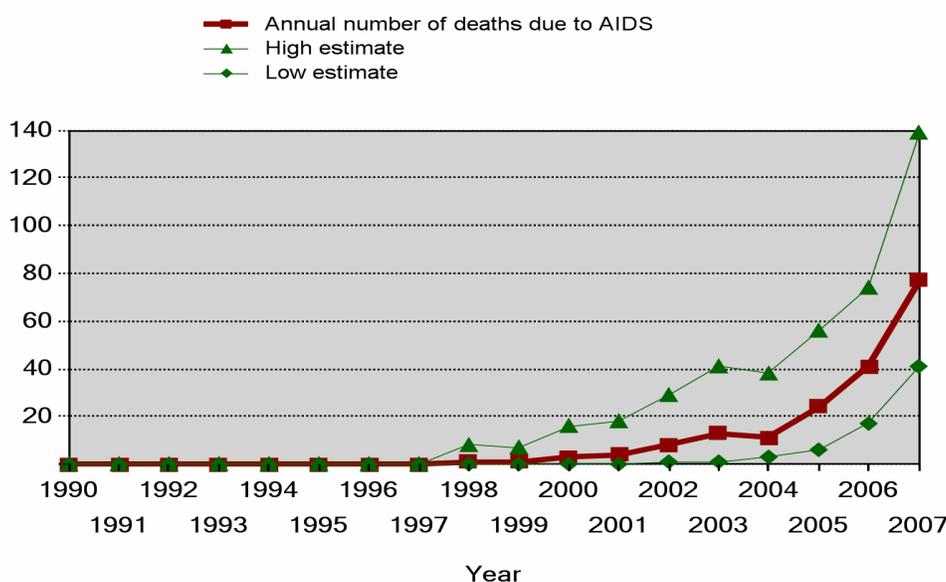
Table 3 HIV prevalence in MSM (blood samples, “take all” sampling), Republic of Moldova, 2003 - 2007

Data collection site	2003		2004		2007	
	Sample	HIV prev	Sample	HIV prev	Sample	HIV prev
Chisinau, capital city	118	1.7 %	121	2.5%	83	4.8 %

Although the first study on risk behaviors in most-at-risk adolescents (MARA) was conducted in 2007-2008, there are no data estimates on the size of this group. The mandatory consent of parents / custodians when doing any medical procedure in underage groups is a major barrier in enrolling MARA in HIV prevalence studies conducted in the most-at-risk populations (MARP).

Recent epidemiological trends in the country indicate high death rates from AIDS. Since the onset of the epidemic, the country has provided for HIV case registration. The National Center of Health Management (unpublished report 2008) cross-compared the national database of vital statistics (deaths) with the HIV-case registration database and identified as many as 500 deaths among HIV-positive people

Estimated number of deaths due to AIDS 1990-2007



1.2. The 3 Ones of the National Response to HIV and AIDS

Aiming at having an efficient AIDS-response, the Republic of Moldova has committed to the Declaration of Commitment and has embarked on building and strengthening the 3 Ones following the approval of the recommendations of the Washington Conference organized by the UNAIDS and the main donors in HIV/AIDS on April 25, 2004.

1.2.1 One strategic framework

1.2.1.1. National Strategic Frameworks

The National Program on Prevention and Control of HIV/AIDS/STIs for 2006-2010 currently under implementation is aligned to national strategic frameworks and to international commitments Moldova has embraced. The NAP has clear linkages to the MDG-centered National Development Strategy 2008 – 2011, which represents a tool for the integration of the strategic frameworks under implementation,

as well as a device for alignment between the budgeting process and the policy framework, and absorption of external technical and financial assistance

The NAP includes nine broad strategies, including prevention activities, consolidation and building of institutional capacity, expanding for voluntary counseling and treatment and prevention of mother to child transmission. A set of indicators has been developed and agreed by all stakeholders to support monitoring and evaluation, and the technical groups have developed a log-frame to support the implementation of the National Program. By approving the actions plans according to NAP, Republic of Moldova became part of WHO/UNAIDS Universal Access to Prevention, Treatment and Care Initiative. The NAP is primarily funded by international donor assistance with the Moldovan government contributing about 20 % overall.

The normative framework at national level also includes relevant Laws, strategies and programs, as well as Ministerial orders and decrees mandating stakeholders in the national response. At the beginning of 2007 the Parliament of the Republic of Moldova has approved a new Law on Prevention of HIV/AIDS which has been developed based on the international recommendations of observance of human rights and ensuring universal access.

The current National Programs on HIV/AIDS and TB were discussed with the wide participation of representatives of all sectors in the respective areas in the context of the NCC activities. .

1.2.1.2 Goal & objectives of the NAP

At the national level, the state policy in the area of HIV/AIDS in Moldova is implemented through the *National Program on Prevention and Control of HIV/AIDS and STIs for 2006–2010* (National AIDS Program – NAP), which determines national strategies of priority for prevention, epidemiological surveillance and treatment. The Program represents an integral, multi-sector plan. The National Program was developed based on lessons learnt from the implementation of the first cycle NAP 2001 – 2005 through consensus-based consultation with key stakeholders in the field, including government, international organizations, non-governmental organizations and people living with HIV and was approved through a Government Decision in September, 2005. The National Program has the following objectives:

- succession and sustainability in planning and implementation of activities and interventions;
- joining efforts, involvement, interaction and coordination of the activities of state institutions, local public authorities, individual persons, including people living with HIV/AIDS, NGOs and international organizations as partners in the comprehensive multidisciplinary response to HIV/AIDS/STIs in the Republic of Moldova;
- attracting and making rational use of budgetary financial resources, from grants, communication projects, raising awareness and behavioral change; prevention work among the general population and target groups, expansion and provision of medical assistance, treatment, care and support for people living with HIV/AIDS;
- improving the epidemiological situation, prevention of HIV/AIDS/STIs, reducing the incidence of HIV among youth and the negative consequences on the individual, community and society, creating favorable conditions for the improvement of the quality of life, according to Objective 6 of the Millennium Development Goals; and
- developing a guaranteed social protection system and provision of access to medical services of people living with HIV.

1.2.2 One Coordination Body to Manage the National Response to HIV and AIDS

There is a single National Coordination entity - the National Coordination Council in the area of TB/HIV which includes government stakeholders, representatives of people living with HIV, NGOs as well as international community.

1.2.2.1. Mandate and organizational structure of the NCC

The National Coordination Council (NCC) for the National Programs 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 (through Government Decision Nr. 825 of August 3, 2005), the 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 Programs on HIV/AIDS and TB. The establishment of the NCC reflected the strategic decision to create a national coordinating body to serve as a partnership forum between the Government, civil society, people living with HIV, and international partners, which was also consistent with the Global Fund's requirements for CCMs. The 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, the NCC has Terms of Reference, a work plan or action plan, and a clear mandate for coordinating responses across all sectors. The NCC makes decisions on the allocation of resources for all major HIV/AIDS programs. The objectives of the NCC pertain to the improvement of the epidemiologic situation and of public health in Moldova by: increasing the effectiveness of government policies in the area of HIV/AIDS/STIs and TB; strengthening intersectoral partnerships between government, non-governmental, and international institutions active in the field in Moldova and abroad; and ensuring an effective dialogue between governmental and non-governmental national and international organizations.

The 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. This level consists of the work performed by a policy consultant, a communication/coordination consultant, and a communication assistant. The role of the Secretariat is to facilitate information exchanges between different partners and levels within the NCC, to facilitate and monitor the activity of the technical working groups, and to ensure the organization of the NCC meetings. The Secretariat assists the NCC in its work and has been assigned a mandate that includes functions such as: overall coordination, resource mobilization and tracking, strategic information management, facilitation of information sharing among various stakeholders and different levels and facilitation and monitoring of the activity of technical working groups as well as support to carrying out NCC meetings.

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 seven HIV/AIDS groups focus on the following aspects: epidemiological and sentinel surveillance; social services; education and social assistance; harm reduction; treatment and care for people living with HIV/SIDA/STIs; communication and prevention; prevention among MARPs; and voluntary counseling and testing. An additional joint group on monitoring and evaluation performs the role of a separate TWG for both HIV & TB.

The NCC (NAC) is a decision-making body having 7 functional working groups which enhance coordination and capitalize upon the value added of joint efforts of all key stakeholders from different sectors, and a permanent Secretariat. the National Coordination Council, an inter-ministerial decision-making body with Deputy Minister-level representation, as well as representation from the civil society and development international organizations (bilateral and multilaterals), instituted based on Government Decree No 825 on 03.08.2005. The NAP mandates different public institutions at national and sub-national levels to act as key stakeholders tasked with its implementation. At technical level, the Ministry of Health chairs the NCC and maintains the NCC Secretariat, having also a leading role in implementation of the NAP.

1.2.2.2. Funding for the National Response to HIV and AIDS

Like many other economies in transition, Moldova is sharing the constraints of mobilizing the necessary revenues for the budget. The socio-economic problems faced by Moldova were further exacerbated by the drought of 2007 and the floods of 2008. As of late 2008, Moldova has started to feel the waves of

the financial crisis, mainly due to the reduction of the flow of remittances and the precarious exports system. Thus, among the main obstacles in the effective implementation of the HIV strategies is the shortage of available financial resources. In this context, while there is government commitment to implement the NAP, the contributions from the state budget register a slow progress – a 1.5% increase in 2007 compared to 2006. Consequently, limited resources allotted to the health system limit the quality and coverage of such services, particularly in rural areas where decreased access to drugs, obsolete equipment, and poor conditions of physical infrastructure can be attested.

The compulsory health insurance system was introduced in Moldova in January 2004 and at present most of the public funding for HIV is provided through this mechanism (complemented by centralized procurement of several goods by the Ministry of Health and limited contributions from the local authorities).

The assessments showed that, for 2006, the disbursements for HIV/AIDS reached 80.9 mln MDL or \$6,145,038 at the rate of exchange, of which the financial resources from the state budget constituted 27.1 mln MDL or \$2,045,801 (33.5%). The international resources for the same period reached the value of 53.7 mln MDL or \$4,106,870 (66.5%). Out of the total budget, 9.5% came from bilateral agencies and 90.5% from multilateral agencies. The World Bank contributed the most covering 48.4% of the total budget, the second biggest donor was the GFATM with 29.3%, followed by UN Agencies - 7.4%, and the remaining 5.4% being shared by other international agencies. The analysis of the cost categories for 2006 showed that 76.5% out of the total budget spent on AIDS was disbursed in the area of Prevention, 14.3% went to the area of Treatment and Prevention, 8.2% was spent for Program Management and Administration Strengthening, only 1% for Incentives for Human Resources.

For 2007, the assessments showed a clear increase in funds spent on HIV/AIDS by 21.6 mln MDL (\$1,720,000) on all budget categories. The increase was mostly due to more funding coming from international resources, as the state budget allocation did not show a significant increase (27.5 mln MDL in 2007 compared to 27.1 MDL in 2006). For 2007 the total expenditures in the area of HIV/AIDS reached 102.5 mln MDL (\$8,160,000), of which the public resources coming from the state budget scored for 26.8% and the international resources scored for 73.2%. Out of the total budget, 26% came from bilateral donors and 74% from multilateral agencies. Again, the World Bank contributed the most covering 28.6% of the total budget, the second biggest donor being the GFATM with 23.4%, followed by UN Agencies - 15%, and the remaining 7% being shared by other international agencies. The analysis of the cost categories for 2007 showed that 76.7% out of the total expenditures on AIDS were registered in the area of Prevention, 8.3% were spent in the Treatment and Prevention budget category, 14.1% were spent for Program Management and Administration Strengthening, and, again, only 1% was spent for Incentives for Human Resources (UNGASS Report 2008).

The NAP budget requires explicit prioritization and delimitation of the NAP objectives and requires that progress be measured and reported in line with the NAP indicators. At the moment, the methodology and the tools proposed by the National AIDS Spending Assessments (NASA) for monitoring the financial flows spent on HIV/AIDS, the Aids sub-account of the National Health Accounts (NHA) and the Resource Flows (RF) Survey, are not applicable to Moldova due to the absence of National Health Accounts. The existing system of evidence of financial flows makes it difficult to conduct and maintain an accurate breakdown of public expenditures for HIV/AIDS by strategies and types of activities within the national response to HIV/AIDS.

1.2.3. One national M & E system

There is also a concept endorsed by the government for building one comprehensive national M&E system. The National Monitoring and Evaluation System is Government-based and Government-led. The Department for M&E of National Health Programs (M & E Unit), as a subdivision of the National Center of Health Management of the Ministry of Health of the Republic of Moldova, represents the only monitoring and evaluation mechanism at the country level. The National Center of Health Management reports vital statistics data and public health related data to the National Statistics Bureau, the main data collection and analysis institution at central level.

The M&E Unit implements the system by monitoring the set of indicators which has been developed and agreed by all stakeholders to support monitoring and evaluation and ensures regular UNGASS and Universal Access reporting with all proper consultations and data collection. The first outputs of the M&E Unit was the development of UNGASS report with all the proper consultations and data collection for the period of 2003-2005, as well as 2005-2007. An important outcome has been the unified

methodology on M&E, as stipulated in the National M & E Plan, as well as a unified national indicator set.

The M&E system is designed to collect information to support the activities and outcomes of the initiatives, taken by the Government of Moldova to fight against this disease (Cercone, 2003). The outputs are intended to serve wider governmental needs for reporting on the health dimensions at national and international levels.

1.3. Status and development milestones for the national M & E system

The National Center of Health Management (NCHM) is a governmental institution founded by Government Decision Nr. 387 from 25.04.1997. The NCHM reports vital statistics and public health related data to the National Statistics Bureau, the main data collection and analysis institution at central level. The M&E Unit was established in 2004 within the NCHM, being tasked with the M&E of all health policies. Currently, the M&E of the National Program on HIV/AIDS, the National TB Program, and the Drug Observatory are the operational areas of the Unit.

The routine health data collection system includes HIV case registration, data on geographic and gender distribution, socio-economic status, ways of transmission. A 2nd generation surveillance system is under development, providing for biannual collection of behavior and prevalence data for various groups (IDUs, FSWs, MSM, PLHA, MARA). Population-based surveys are also carried out – RHS (1997), DHS (2005), MICS, KAP biannual surveys.

The M & E system is immature and there are yet some inherent weaknesses:

- lack of some institutionalized routine reporting mechanisms for inter-sector reporting;
- limited allocations to the M&E system from the state budget; overreliance on international financial support that curtails sustainability
- gaps in national technical expertise
- vulnerable populations size not estimated
- due to political constraints around the separatist region of Transnistria, full coverage with comprehensive M & E of the region is complicated
- Operational research for evaluation of activities not implemented
- Ensuring confidentiality of data

In order to strengthen the national M & E system, assessments have been carried out in the framework of the end-program review of the previous cycle of the NAP, as well as in the framework of developing proposals to GFATM, where resources have been earmarked for ensuring the functionality of the M & E system. Institutional and professional capacity building for the M & E Unit has been provided for under Round 1 and Round 6 GFATM projects. The monitoring of the Global Fund grant performance has been included into the routine work of the M&E Unit to reduce overlap and double reporting

As part of the mid-term review of the NAP, carried out in 2008, with the purpose to evaluate the NAP implementation, to identify gaps and to further develop the NAP to fulfil quality criteria for validation and to serve as a proper framework for the national response, the assessment of the M & E system has been planned and carried out according to the Organizational Framework for 12 components of a functional M & E system, as part of a piloting exercise of the assessment tool developed by MERG. Conclusions and recommendations resulting from system evaluation underpinned the changes to the National M&E Plan.

Moreover, there was a study conducted on partner harmonization and alignment in the national response to HIV (CHAT) within the MTR 2008. This was in line with the provisions of the Paris Declaration on the streamlining of assistance – strengthening the partnership of national and international stakeholders in order to ensure a coordinated response (ownership, alignment, harmonization)⁹.

Respondents stated that despite the National Program having measurable objectives, it has no M&E plan but rather a set of indicators. It is the GFATM project that has a clear-cut M&E plan resulting from the NAP and based upon which the reporting is done in this area. Many respondent organizations, in particular representing other ministries, are at the inception in terms of participating in the ME system

by putting out quarterly and annual reports on a periodic basis, but the system is considered quite immature yet. Only half of respondents were members / participated in the meetings of the technical working group for M&E in HIV/AIDS/STIs and TB, whereas the representatives of facilities that infirmed their membership, such as the DNR, health authorities from Balti and Transnistria, MOSPFC, border guards service, MOEY, showed their interest to be invited to the meetings, or attend at least those meetings during which the common topics or the topics from their respective areas of expertise are being raised. The overall conclusion is that most respondents do understand the importance and need of a national M&E system; however, this is a relatively recent development that needs to further be developed.

Most respondents from the Governmental sector are happy with their level of involvement in the recent events to develop the UNGASS report and the mid-term review of the NAP (90%). As to the relevance and quality of participation of all national governmental partners in this process, in the questionnaires 52% of them selected the answer "much", with the remaining respondents considering their involvement and participation as insufficient. Similarly, as it was the case with other national processes, the participation of Government sector representatives, mainly that of other ministries, in the M&E system is not enough and should be strengthened.

Recommendations drafted by respondents:

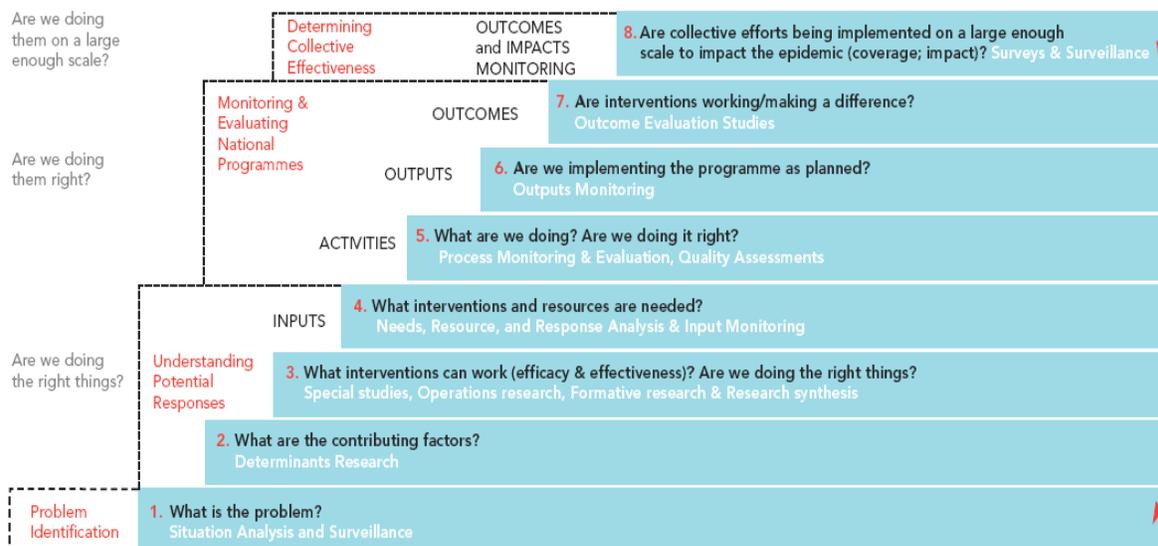
1. Strengthen and improve the national M&E system by providing it with a mandate;
2. At the time a NAP is approved one has to endorse a M&E Plan, whereby each of the stakeholders will identify and get to know their responsibilities and will serve as a data sharing strategy and its subsequent use in planning and programming.
3. Capacity building for the M&E Unit staff, as well as for the relevant national partners involved in this area;
4. Ensure the functionality of the M&E system through steady and adequate financing in this area.

Chapter 2. NATIONAL HIV/AIDS M&E SYSTEM: A CONCEPTUAL OVERVIEW

Internationally, standards and guidelines have been developed for HIV and AIDS monitoring and evaluation systems. These have been documented in a series of M&E manuals: UNAIDS National AIDS Programs: A Guide to Monitoring and Evaluation (UNAIDS 2000); Monitoring the Declaration of Commitment on HIV and AIDS: Guidelines on Construction of Core Indicators (UNAIDS 2002); National AIDS Councils: Monitoring and Evaluation Operations Manual (UNAIDS/World Bank 2002), Organizational Framework for 12 components of a functional M&E system, endorsed in 2007 by development partners and constituting a multi-agency common vision of what constitutes a fully functional M&E system.

The Moldova M & E system shall be strengthened and prioritized for enhanced functionality and cost-efficiency around the public health approach described in Figure 2 below:

Figure 2 . A Public Health Questions Approach to HIV M&E



2.1 Definitions and Concepts

Concepts relating to HIV and AIDS M&E System are defined hereunder:

- **Accountability**—responsibility for the use of resources and the decisions made, as well as the obligation to demonstrate that work has been done in compliance with agreed-upon rules and standards and to report fairly and accurately on performance results vis-a-vis mandated roles and/or plans.
- **Assumptions**—hypotheses about factors or risks which could affect the progress or success of an intervention. Intervention results depend on whether or not the assumptions made, prove to be correct.
- **Attribution**—the ascription of a causal link between observed changes and a specific intervention
- **Baseline**—the status of services and outcome-related measures such as knowledge, attitudes, norms, behaviors, and conditions before an intervention, against which progress can be assessed or comparisons made.
- **Benchmark**—a reference point or standard against which performance or achievements can be assessed.

- **Data Sources:** Data sources are tangible sets of information, usually in the form of reports, survey results, monitoring forms from the field, or official government data sets. Data sources provide the values of the indicators at a specific point in time.
- **Epidemiology**—the study of the magnitude, distribution and determinants of health-related conditions in specific populations, and the application of the results to control health problems.
- **Evaluation** the rigorous, scientifically-based collection of information about program/intervention activities, characteristics, and outcomes that determine the merit or worth of the program/intervention. Evaluation studies provide credible information for use in improving programs/interventions, identifying lessons learned, and informing decisions about future resource allocation. All evaluations are linked to outcomes (impact) as opposed to only immediate results (outputs).
- **Facility survey**—a survey of a representative sample of facilities that generally aims to assess the readiness of all elements required to provide services and other aspects of quality of care (e.g., basic infrastructure, drugs, equipment, test kits, client registers, trained staff). The units of observation are facilities of various types and levels in the same health system. The content of the survey may vary but typically includes a facility inventory and, sometimes, health worker interviews, client exit interviews, and client-provider observations.
- **Generalizability**—the extent to which findings can be assumed to be true for the entire target population, not just the sample of the population under study.
- **Incidence**—the number of new cases of a disease that occur in a specified population during a specified time period.
- **Indicator:** a quantitative or qualitative variable that provides a valid and reliable way to measure achievement, assess performance, or reflect changes connected to an intervention.
- **Information Products:** An information product is a standard report/document that the NERCHA produces at regular intervals after receiving data sources and analysing these data sources. Reporting usually takes place through an information product.
- **Monitoring:** routine tracking and reporting of priority information about a program / project, its inputs and intended outputs, outcomes and impacts. Monitoring is the continuous, routine, daily, and regular assessment of ongoing activities and/or processes. It aims to provide the management and main stakeholders of an ongoing intervention with early indications of progress (or lack thereof) towards the achievement of outputs.
- **M&E results chain:** There are four levels of indicators (inputs, outputs, outcomes and impacts), as described hereunder.
 - **Inputs:** Inputs are the resources that are needed to implement the project and its activities. Inputs can be expressed in terms of the people, equipment, supplies, infrastructure, means of transport, and other resources needed. Inputs can also be expressed in terms of the budget that is needed for a specific project or activity.
 - **Outputs:** Outputs are the immediate results of the activities conducted. They are usually expressed in quantities, either in absolute numbers or as a proportion of a population. Outputs are generally expressed separately for each activity.
 - **Outcomes:** Outcomes are the medium term results of one or several activities. Outcomes are what the immediate outputs of the activities are expected to lead to. Outcomes are therefore mostly expressed for a set of activities. They often require separate surveys to be measured.
 - **Impact:** Impact refers to the highest level of results, to the long-term results expected of the project. Impact therefore generally refers to the overall goal or goals of a project.

These levels form an M&E results chain. This 'chain' illustrates that there is a logical pathway from one level to the next, as illustrated hereunder:

Inputs → Outputs → Outcomes → Impact

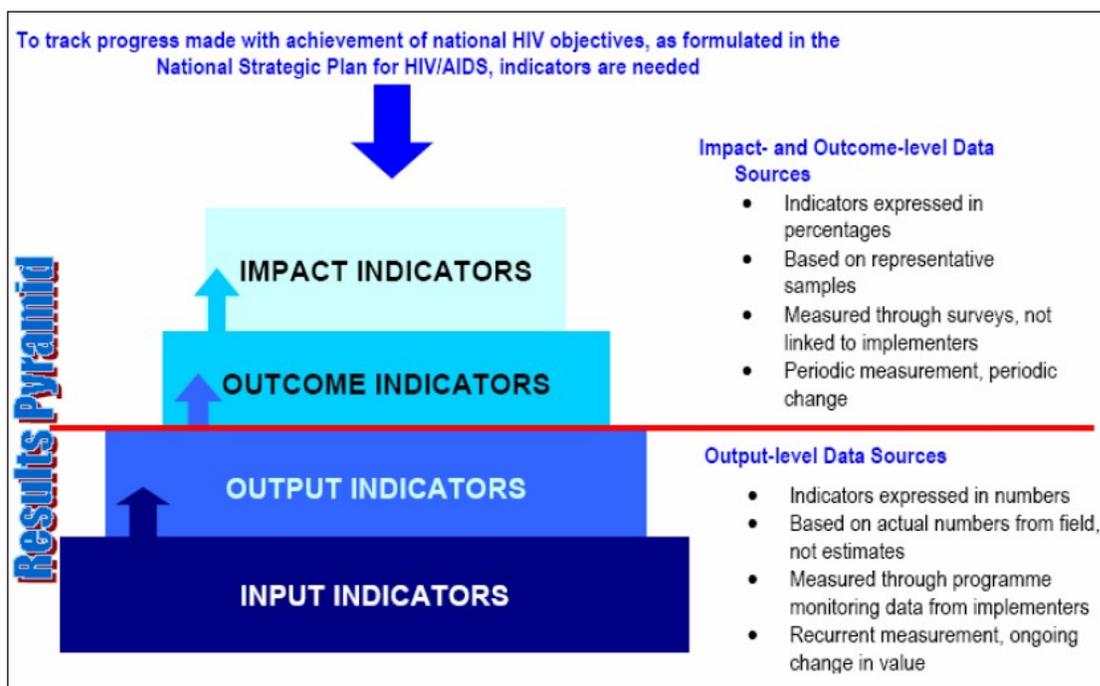
Table 1: Levels of Monitoring and Evaluation of results⁸

	Description	Examples of Tools / Sources
Inputs	Inputs are the people, training, equipment and resources that we put into a program, in order to carry out activities and achieve outputs.	Routine data
Output	Outputs are the specific results of using inputs and carrying out activities, The processes associated with service delivery are very important and involve quality, unit costs, access and coverage.	Routine data HMIS
Outcomes	Through the provision of good-quality, economic, accessible, and widespread services, key outcomes should occur. Outcomes are changes in behavior or skills, especially safer HIV prevention practices and increased ability to cope with AIDS.	Special surveys e.g. DHS, BSS,
Impact	The above-mentioned outcomes are intended to lead to major measurable health impacts, particularly reduced STI and HIV incidence.	Special surveys e.g. DHS, Sentinel Survey

Typically, *inputs* (e.g. money, equipment, resources) are needed to implement activities. Activities that are implemented, lead to activity *outputs* (e.g. persons trained, workshops conducted). In turn, a series of activity outputs, if implemented correctly, should lead to some results or *outcomes* (e.g. reduced sexual risk behavior). In the long term, changes in outcomes should lead to *impact* being achieved (e.g. reduced HIV prevalence). Figure 3 depicts the M&E results chain, and its associated data sources:

⁸ Adapted from UNAIDS, et al. 2002. National AIDS Councils: Monitoring and Evaluation Operations Manual Geneva, Switzerland.

Figure 3: M&E results chain and associated data sources



- **Operational research**—systematic and objective assessment of the availability, accessibility, quality, and/or sustainability of services designed to improve service delivery. It assesses only factors that are under the control of program/project managers, such as improving the quality of services, increasing training and supervision of staff members, and adding new service components.
- **Performance**—the degree to which an intervention or organization operates according to specific criteria/standards/guidelines or achieves results in accordance with stated goals or plans.
- **Population-based survey**—a type of survey which is statistically representative of the target population, such as the AIDS Indicator Survey (AIS), the Demographic and Health Survey (DHS).
- **Prevalence**—the total number of persons living with a specific disease or condition at a given time
- **Qualitative data**—data collected using qualitative methods, such as interviews, focus groups, observation, and key informant interviews. Qualitative data can provide an understanding of social situations and interaction, as well as people’s values, perceptions, motivations, and reactions. Qualitative data are generally expressed in narrative form, pictures or objects (i.e., not numerically). Note: The aim of a qualitative study is to provide a complete, detailed description.
- **Quality assurance**—planned and systematic processes concerned with assessing and improving the merit or worth of an intervention or its compliance with given standards. Note: Examples of quality assurance activities include appraisal, results based management reviews, evaluations.
- **Quantitative data**—data collected using quantitative methods, such as surveys. Quantitative data are measured on a numerical scale, can be analysed using statistical methods, and can be displayed using tables, charts, histograms and graphs. Note: The aim of a quantitative study is to classify features, count them, and construct statistical models in an attempt to explain what is observed.
- **Relevance**—the extent to which the objectives, outputs, or outcomes of an intervention are consistent with beneficiaries’ requirements, organizations’ policies, country needs, and/or global priorities
- **Reliability**—consistency or dependability of data collected through the repeated use of a scientific instrument or a data collection procedure used under the same conditions.
- **Research**—a study which intends to generate or contribute to generalizable knowledge to improve public health practice, i.e., the study intends to generate new information that has relevance beyond the population or program from which data are collected. Research typically attempts to make

statements about how the different variables under study, in controlled circumstances, affect one another at a given point in time.

- **Second-generation surveillance**—HIV surveillance that not only tracks HIV prevalence but also uses additional sources of data to increase the understanding of trends of the epidemic over time. It includes biological surveillance of HIV and other sexually transmitted infections as well as systematic surveillance of the behaviors that spread them.
- **Sentinel surveillance**—ongoing, systematic collection and analysis of data from certain sites (e.g., hospitals, health centers, ante-natal clinics) selected for their geographic location, medical specialty, and populations served, and considered to have the potential to provide an early indication of changes in the level of a disease.
- **Stakeholder**—a person, group, or entity who has a direct or indirect role and interest in the goals or objectives and implementation of a program/intervention and/or its evaluation.
- **Surveillance**—the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health. Surveillance data can help predict future trends and target needed prevention and treatment programs.
- **Target**—the objective a program/intervention is working towards, expressed as a measurable value; the desired value for an indicator at a particular point in time.
- **Triangulation**—the analysis of data from three or more sources obtained by different methods. Findings can be corroborated, and the weakness or bias of any of the methods or data sources can be compensated for by the strengths of another, thereby increasing the validity and reliability of the results
- **Validity**—the extent to which a measurement or test accurately measures what is intended to be measured.

2.2. Goals & objectives

The **goal** of the HIV and AIDS M&E Plan is:

to guide coordinated and efficient collection, analysis, use, and provision of information that will enable the tracking of the progress made in the national response to HIV/AIDS and enhance informed and sound decision making and policy for the HIV and AIDS interventions.

Within the context of this goal, the **objectives** of the M&E Plan are to:

1. Develop clear M&E processes that will enable systematic collection, collation, processing, analysis, and interpretation of data
2. Define a list of core indicators that will enable tracking of progress in the most critical areas of the fight against HIV and AIDS
3. Describe the role that HIV related operational research plays in the overall monitoring and evaluation of the National response to HIV and AIDS
4. Describe the key data sources to be used to gather necessary M&E data.
5. Establish clear data flow channels between the different stakeholders in the fight against HIV and AIDS.
6. Clearly describe the role of each of the stakeholders in the monitoring and evaluation of HIV and AIDS programs.
7. Develop a plan for strengthening the capacity of all partners involved in the monitoring and evaluation of HIV and AIDS programs.
8. Describe the dissemination products and mechanisms for the dissemination of all critical information amongst all stakeholders, implementing agencies, beneficiaries and the general public.

Expected **outputs** on the implementation of the M&E Plan:

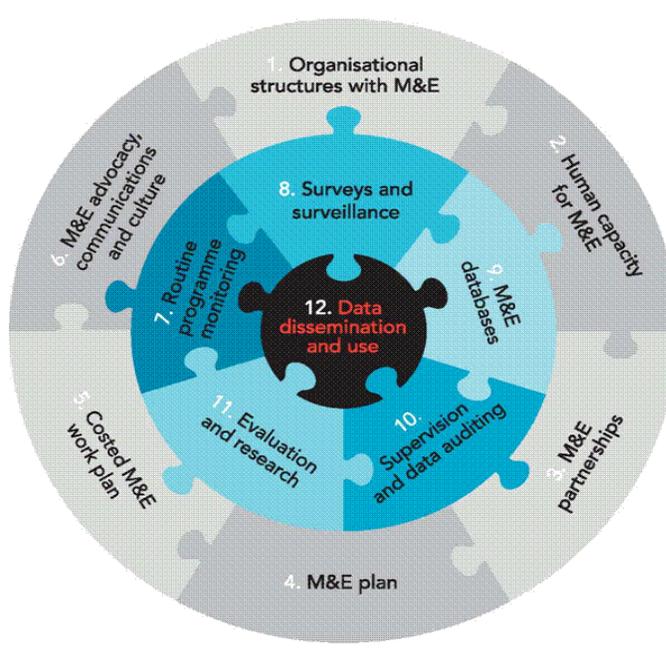
- Quality and timely reporting by all program implementers;

- Strengthening the Monitoring and Evaluation System
- Establishment of a data depository and database
- Establishment of monitoring and evaluation dissemination strategy;
- Structured coordinated flow of routinely collected information among stakeholders at various levels of the M&E system
- Capacity Building Plan
- Research and Evaluation Agendas

2.3 Components of the National HIV and AIDS M&E System

According to the Organizational Framework for 12 components of a functional M&E system, endorsed in 2007 by development partners and constituting a multi-agency common vision of what constitutes a fully functional M&E system, all components need to be present and work to an acceptable standard for the national M&E system to function effectively.

The outer ring represents the human resources, partnerships and planning to support data collection and data use. It includes individuals, organizations, functions/actions, and the organizational culture that are fundamental to improving and sustaining M&E system performance. The middle ring focuses on the mechanisms through which data are collected, verified, and transformed into useful information. The center of the diagram represents the central purpose of the M&E system: using data for decision-making (Figure 4)



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 costed national HIV M&E work plan
6. Advocacy, communications, and culture for HIV M&E

Collecting, verifying, and analysing 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

2.4. Levels of the M & E system

2.4.1. Status Quo

The National M & E system has important functions at central, regional (raion/district) and service provision levels. While functions congregating at central level are better developed, the regional and service provision levels need to be strengthened in a holistic manner.

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 Program. Moreover, a detailed analysis of the existing regulatory framework from the perspective of service delivery show that it contains 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 National Center of 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;
- The Institute of Phtisio-Pulmonology – specialized medical assistance in HIV-TB co-infection;
- The National Center for Dermatovenereology (NCDV) – medical care (in-patient), ART treatment, medical assistance to HIV-infected persons and treatment adherence support;
- The Infectious Diseases Hospital "Toma Ciorba" (jointly with NCDV) – 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.

In addition to public entities, approximately 40 international and domestic NGOs working in the field of HIV/AIDS and TB in Moldova make 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. Bilateral and multilateral donors are also among stakeholders in the national response. The diversity of actors, and the participatory strategic planning, implementation, monitoring and evaluation processes of the NAP imperatively request a clear vision of the levels of the multi-sectoral comprehensive M & E system, of the roles stakeholders play within the system hereto, and of the data flows

Within the *health system*, there are two main entities with the mandate to monitor and evaluate policies and programs:

- The Division for the Policy Analysis, Monitoring and Evaluation within the Ministry of Health, staffed with 4 persons
- The M & E Unit of the National Center of Health Management, the main entity at technical level around which the national M & E system for HIV, TB and drugs control is structured. The M & E Unit is staffed with four permanent employees – 2 M & E specialists and 2 IT specialists.

The National AIDS Center and the Republican Dermato-Venerological Dispensary do not have M & E units; M & E functions are distributed among personnel that have other primary roles and responsibilities according to their job descriptions. National Health Accounts are in the incipient stage of development, hence monitoring of expenditures in relation to program results is complicated.

At the *central level*, other Ministries lack a mandate in HIV M & E. The Ministry of Social Protection, Family and Child, due to its leading role in 2008 in revitalizing the social services TWG, has assumed M & E functions under NAP – the HIV focal point, that also has competencies in M & E, sits in the Equal Opportunities and Violence Prevention Division. Other Ministries have various M & E units/divisions which currently do not have a mandate for HIV M & E; while staff/units with primary responsibilities in HIV M & E are difficult to justify in the context of a concentrated epidemic like Moldova, the recommendation made has been to institute focal points within respective Ministries. The Center for Blood Transfusions and the Republican Drug Dispensary have M & E units in their organigram, also mandated with HIV M & E.

At *sub-national level*, there are rayon (district) multidisciplinary commissions for HIV/AIDS with varying degree of functionality (ex. The Falesti commission meets twice per year, however there are other rayons where the commission has never met). The commission acts as coordinating body for district-level implementation of the NAP; membership is unremunerated and additional to primary job responsibilities. There are poor capacities and limited motivation, as well as no formal mechanisms for fulfilling the M & E mandate.

At *service provision level*, there are certain HIV and HIV M & E responsibilities attributed to different persons/units within medical facilities at primary healthcare level – the infectionist, the family doctor, the statistics division. NGO / service providers often do not have specifically-appointed M & E personnel, M & E responsibilities being part of the work load of service implementers. Due to shortage of human resources and time, these responsibilities are frequently limited/formal in nature. Capacities are limited.

While *umbrella organizations* are involved in routine program monitoring, the mandate for HIV M & E, provided for in the NAP, is not clearly defined at organizational level and there is no formally appointed unit or division and very limited human resources for that purpose (ex. Soros Foundation – 1 M & E officer; no staff with sole or primary M & E responsibilities in other umbrellas).

Under the auspices of the NCC, a multi-stakeholder technical working group (TWG) on M & E is operational, aiming towards improved data quality and better information flows in the routine statistics, as well as improved national capacities in operational research.

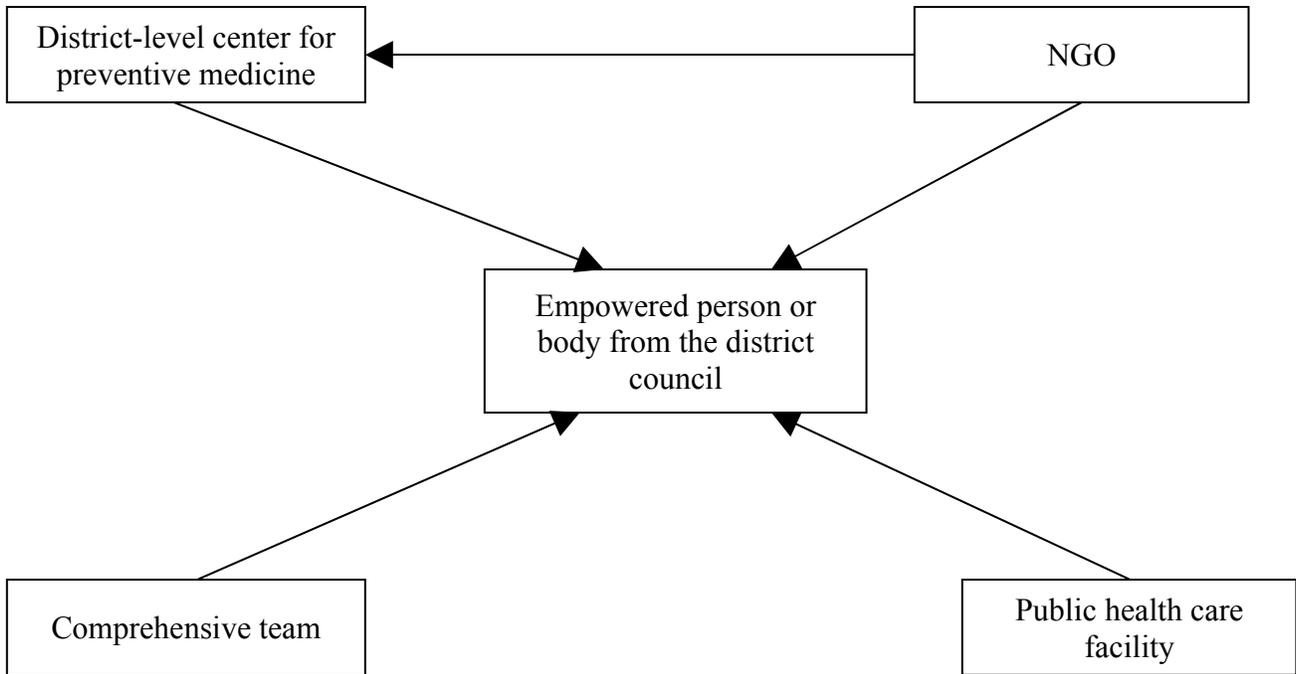
2.4.2. Roles and functions of the M & E system levels:

Table 2 The role of social stakeholders in the M&E system:

Stakeholder	Frequency of reporting	Comments
Prevention		
National Center for Preventive Medicine	Biannually	Data compiled for district level PM centers and NGOs
MEY	Biannually	Data compiled for education facilities and NGOs
Health care facilities (CTV)	Quarterly	Data per VCT case
Health care facilities (STIs)	Monthly	Data per diagnosed case; coded at the level of National Center for Dermatovenereology
SOROS Foundation	Quarterly	Data compiled from NGOs, DNR and DPI
Department of Penitentiary	Quarterly	Aggregated data

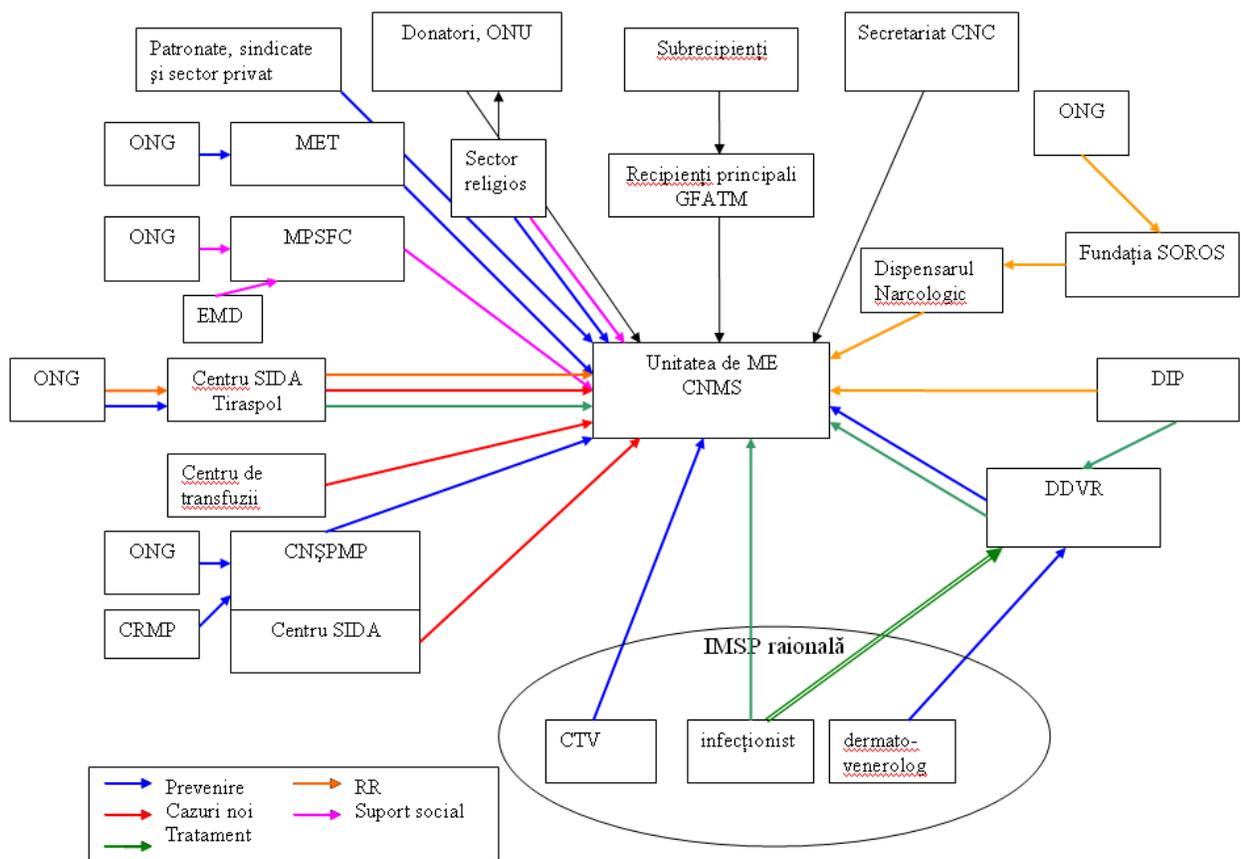
Institutions (DPI) (HR)		
National Center for Drug Addition (DNR)	Quarterly	Aggregated data
National AIDS Center	Quarterly	Codified data
AIDS Center Tiraspol (prevention and HR)	Quarterly	Data compiled for district-level PM centers and NGOs
Transfusion Center	Quarterly	Aggregated data
National Center for Dermatovenereology (NCDV) (STIs)	Quarterly	Aggregated and coded data
Employers associations, trade unions and private sector	Biannually	-
NGOs	Quarterly	Aggregated data
FBOs	Quarterly	Aggregated data
Donors	Biannually	Data by type of assistance and implementers
Treatment and Care		
NCDV (treatment)	Quarterly	Codified data
AIDS Center Tiraspol (treatment)	Quarterly	Data compiled from infectious disease specialists
Health care facilities (infectious disease specialists)	Quarterly	Treatment case; one link is missing – coordination with NCDV
Mitigation		
MOSPFC	Biannually	Data compiled from affiliated facilities and NGOs
FBOs	Quarterly	
Enabling Environment		
CCM Secretariat	Quarterly	
Monitoring and Evaluation Unit	Ongoing	

2.4.3 Stakeholders at district level (Figure 5)



2.5. Data and information flows

The data flows within the HIV M&E system, as presented in the graph below (Figure 6), are in the process of institutionalization.



2.5. Development of the M&E Plan – rationale and process

The National HIV and AIDS Monitoring and Evaluation Plan was created to track progress in implementation of the National Program for Prevention and Control of HIV/AIDS/STI 2006 – 2010. One M&E Plan is one of the tenets of the “Three Ones” principle, endorsed by UNAIDS and its partners in 2004 to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management.

Moldova is a signatory to the 2001 United Nations Declaration of Commitment on HIV and AIDS, also referred to as the UNGASS Declaration. The declaration compels governments to manage, monitor, and evaluate their national HIV and AIDS response. It also commits governments to report to UNAIDS on a biennial basis on country-level indicator values for UNGASS indicators. Moldova has also committed to ensure universal access to prevention, treatment and care and mitigation services, and reports annually on progress towards UA targets. MDG Reports are compiled every 5 years, as part of the development of the new cycle of the National Development Plan based on lessons learnt.

The M & E Plan Framework was developed based on the following **guiding principles**:

Mainstreaming: M&E is mainstreamed / integrated into all HIV/AIDS programs and interventions in the country at each level and by all players. Each intervention will define routine indicators and reporting formats that will guide tracking the progress made.

Integration: National and routine indicators (both clinical and non-clinical) for monitoring the national response will be integrated into the national M & E database.

Simplicity: The ease in which data are collected, analysed, and reported remains crucial. Data collected at facility, household, and community levels should be able to be entered into registers and forms. The data collation and analysis should not stop functioning because of a power failure, a

shortage of printed stationery, or a breakdown of computers. However, data collection should also benefit fully from modern technology to facilitate national data aggregation, analysis, and report generation.

Action Orientation: Data collected must be used for programmatic and technical decision making. There must be a direct link between data collection, analysis, reporting, and decision making at all levels of HIV/AIDS interventions. An M&E system provides information for policy development, program planning, and operational management. It also collects and forwards only the information necessary for decision making, while providing feedback to the periphery.

Transparency and Accountability: M&E of the national response to HIV/AIDS has to be open and participatory for stakeholders and participants at all levels. Those in charge of data collection, analysis, reporting, and policy decisions must take ownership of their actions and be able to professionally defend their reports and/or decisions. All stakeholders and participants have to agree on and abide by this key principle.

The underlying determinants that guided the development of this M&E Plan are as follows:

1. The need for the system to be understood by, be accessible to, and correspond to the needs of all stakeholders involved in the HIV and AIDS response.
2. The need for the structure and components of the M&E system to be integrated into existing systems and be endorsed by stakeholders, to ensure proper data flows from stakeholders to NCC
3. The need to assign responsibilities to specific organizations for data collection.
4. The need for the M&E system to draw on existing data and generate new data to avoid duplication and avoid gaps in data analysis, since data is generated at varying levels and in various forms – either as part of implementation of HIV and AIDS interventions, or in a stand alone manner as part of research or survey activities.
5. The need to underpin the M&E Plan by an annual work plan – to prevent a situation where M&E activities to be implemented are not funded.
6. The need for the M&E Plan to strike a balance between providing a meaningful overview of every program area and providing a national operational framework for the M & E system.

Process-wise, the National M & E Plan shall be developed in parallel to the respective cycle of the National HIV/AIDS Program, and shall be reviewed at MTR and at the final program review. The document intends to be a flexible dynamic operational framework, hence amendments may be operated at annual reviews should the M & E TWG so recommend and the NCC so decide. The data sources for the input, output, outcome and impact indicators, as defined in the logical framework, may be revised if they can be updated with improved (more accurate or more timely) data sources. Should new information products be required, these may be added to the current list of information products, in the same basic format and content.

The M&E work plan and operational budget is to be adjusted when the work plan and budget for the financial year is developed.

CHAPTER 3. NATIONAL HIV INDICATORS BY PROGRAM AREA

This chapter lists the indicators for the monitoring and evaluation of the national response to the HIV and AIDS epidemic. Indicators were selected to be:

- in line with the priority objectives established by the National HIV/AIDS Program;
- In line with the priority objectives and HIV and AIDS related indicators of the Moldova NDP & nationalized MDG;
- in line with internationally recommended core indicators in UNGASS;
- In line with core indicators to achieve 'Universal Access' to HIV and AIDS interventions;
- In line with the HIV and AIDS related indicators in other key national policies and plans (National Health Policy, National RH Program, National YFHS Concept)
- in line with international HIV and AIDS M&E guidelines produced by UNAIDS and its partners⁹, and
- d) realistically measurable at a reasonable cost.

Monitoring equity and access to effective prevention, care and treatment, and impact mitigation interventions is reflected in the definition and disaggregation of the respective indicators. Included in the indicator definitions, is also how these indicators should be disaggregated. The standard categories are: age, sex, location, and region.

This Monitoring and Evaluation Plan has defined a number of indicators to monitor the national HIV response, built around core data sources. Impact and outcome indicators are generally derived from data collected through population based surveys, whereas the program monitoring indicators are derived from routine data systems at program level. Furthermore, impact and outcome results are influenced by a number of programs, whereas program monitoring indicators are more likely to be linked to specific programs, interventions, and activities.

3.1 PREVENTION

1

Because of the complexity of prevention interventions carried out within the NAP, the key stakeholders agreed on a conventional split of activities and decided on a series of results in prevention among vulnerable groups (IDUs, FSW, MSM and prisoners) and general population, including among MARA.

Vulnerable groups

Key activities:

- VCT provided by public health care facilities, including youth-friendly health centers (YFHC)
- Harm reduction programs (BCC/IEC, syringe exchange, condoms, substitution therapy with methadone, consultations services, outreach etc.)
- Diagnosis and treatment of STIs (all recorded and hospitalized IDUs are tested for syphilis; screening for syphilis in general population)
- 'Break the cycle' interventions, aiming at IDUs to prevent the initiation of other people in general and adolescents in particular in injecting drug use.

General population

- Pregnant women
- Youth
- Migrants (including, victims of trafficking)
- Mobile populations – more than 48 hours out of their households
- Population at large

⁹ UNGASS, National Guide To Monitoring And Evaluating Programs For The Prevention Of HIV In Infants And Young Children, National Aids Programs: A Guide To Indicators For Monitoring And Evaluating National HIV/Aids Prevention Programs For Young People, WHO M&E Guidelines For HIV, Malaria And TB; National Aids Programs: A Guide To Indicators For Monitoring And Evaluating National Antiretroviral Programs; Guide To Monitoring And Evaluation Of The National Response For Children Orphaned And Made Vulnerable By HIV/Aids; National Aids Programs: A Guide To Monitoring And Evaluating HIV/Aids Care And Support; PEPFAR indicators; GFATM M&E Toolkit

Key activities

- VCT and HIV testing, PMTCT, HIV testing of blood samples / donors
- BCC/IEC
- STIs – screening, diagnostics and treatment

2

33.1.1 Impact Indicators

Risk groups

Indicator Definition	Numerator	Denominator	International M&E guide	Data Sources	Disaggregated by	Responsible institution	Reporting frequency
Prevalence of HIV; HCV, HBV and syphilis	Number of positive samples	Number of samples tested	UNGASS core indicators guide	Surveillance studies (BSS)	Age, sex, residence	NCHM	Biannually
New HIV cases reported	Newly registered case (confirmed by WB)	-	-	Routine statistics	Age, sex, residence	NAC; NCHM	Quarterly
AIDS associated mortality	Death cases associate to AIDS registered in the data	-	-	Routine statistics	Age, sex, residence	NCDV; NCHM	Annually

General population

Indicator Definition	Numerator	Denominator	International M&E guide	Data Sources	Disaggregated by	Responsible institution	Reporting frequency
HIV prevalence, pregnant women	Number of HIV positive registered pregnant women	Number of registered pregnant women	-	Routine statistics	Age, sex, residence	NAC, NCHM	Annually
Prevalence of syphilis, pregnant women	Number of registered pregnant women with syphilis	Number of registered pregnant women	-	Routine statistics	Age, sex, residence	NCDV, NCHM	Annually
New HIV cases reported	Newly registered case (confirmed by WB)	-	-	Routine statistics	Age, sex, residence	NAC, NCHM	Annually
AIDS associated mortality	Death cases associated to AIDS	-	-	Routine statistics	Age, sex, residence	NCDV, NCHM	Annually

	registered in the mortality data base						
Case notification rate of syphilis	Newly registered cases with siphylis	Number of the population*100000	-	Routine statistics	Age, sex, residence	NCDV, NCHM	Annually

3.1.2 Outcome, Output and Input Indicators

Results

Risk groups

Indicator Definition	Numerator	Denominator	International M&E guide	Data Sources	Disaggregated by	Responsible institution	Reporting frequency
Coverage with services (set of services as per the UNGASS definition)	Number of respondents who know where to get tested to HIV, received syringes for free and condoms for free in the last 12 months	Number of respondents	UNGASS guidelines on core indicators	BSS, UNGASS report	Age, sex, residence	NCHM	Once every 2 years
Level of knowledge	Number of respondents who answered correctly to all 4 key questions	Number of respondents	UNGASS guidelines on core indicators	BSS, UNGASS report	Age, sex, residence	NCHM	Once every 2 years
Behavior (indirect sharing of needles, use of clean needles at last injecting)	Number of respondents who used sterile syringes during the last injection in the last month	Number of respondents who injected in the last month	UNGASS guidelines on core indicators	BSS, UNGASS report	Age, sex, residence	NCHM	Once every 2 years

General population

Indicator Definition	Numerator	Denominator	International M&E guide	Data Sources	Disaggregated by	Responsible institution	Reporting frequency
Level of knowledge	Number of respondents who answered correctly to all 4 key questions	Number of respondents	UNGASS core indicators guide	GPS	Age, sex, residence	NCHM	biannually
Multiple partners	Number of responders who reported at least 2 sexual partners in the last 12 months	Number of responders who reported at least one sexual intercourse in the last 12 months	UNGASS core indicators guide	GPS	Age, sex, residence	NCHM	biannually
Use of condom at higher risk	Number of responders who had at least 2 sexual partners in the last 12 months and used condom last time they had sex	Number of responders who had at least 2 sexual partners in the last 12 months	UNGASS core indicators guide	GPS	Age, sex, residence	NCHM	biannually

Output

Risk groups

Indicator Definition	Data Sources	Disaggregated by	Responsible institution	Reporting frequency
Number of people covered with VCT	Routine monitoring, GF reporting	-	NAC, NCHM	Quarterly
Number of people tested	Routine monitoring, GF reporting	-	NAC	Quarterly

Number of injecting equipment distributed	Routine monitoring, GF reporting	-	Soros Foundation, NCHM	Quarterly
Number of condoms distributed	Routine monitoring, GF reporting	-	Soros Foundation, NCHM	Quarterly
Number of new enrollees in projects	Routine monitoring, GF reporting	-	Soros Foundation, NCHM	Quarterly
Number of permanent beneficiaries (WHO definition: IDUs visiting a NSP site at least once in the last 12 months)	Routine monitoring, GF reporting	-	Soros Foundation, NCHM	Quarterly
Cumulative number of beneficiaries	Routine monitoring, GF reporting	-	Soros Foundation, NCHM	Quarterly
Methadone	Routine monitoring, GF reporting	-	Soros Foundation, NCHM	Quarterly

General population

Indicator Definition	Data Sources	Disaggregated by	Responsible institution	Reporting frequency
Number of people covered with VCT	Routine monitoring	Age, sex, residence	NAC, NCHM	Quarterly
Number of people tested	Routine monitoring	-	NAC	Quarterly
Number of info materials distributed	Routine monitoring, GF reporting	-	Implementers, NCHM	Quarterly
Number of condoms distributed	Routine monitoring, GF reporting	-	Implementers, NCHM	Quarterly
Number of people listening / participating in the events	Routine monitoring, GF reporting	-	Implementers, NCHM	Quarterly
Number of events organized	Routine monitoring, GF reporting	-	Implementers, NCHM	Quarterly

Resources (disaggregated in line with NASA methodology)

- Financial resources
- Material resources

3.2 CARE, SUPPORT AND TREATMENT

Key activities

- ARV Treatment
 - First line
 - Second line
 - Monitoring
- Opportunistic infections (OI)
 - Diagnostics and treatment
- Co-trimoxazole
 - Diagnostics and treatment

Indicator Definition	Numerator	Denominator	International M&E guide	Data Sources	Disaggregated by	Responsible institution	Reporting frequency
% of HIV-infected adults and children still in treatment 12 months after ARV initiation	Number of patients who are on treatment after 12 months from the ARV initiation n	Number of patients initiating treatment during the selected period of time	UNGASS core indicators	Routine monitoring, UA reporting	Age, sex	NCDV, NCHM	Quarterly
% of HIV-infected adults and children still in treatment 24 months after ARV initiation	Number of patients who are on treatment after 24 months from the ARV initiation n	Number of patients initiating treatment during the selected period of time	WHO	Routine monitoring, UA reporting	Age, sex	NCDV, NCHM	Quarterly
% of HIV-infected adults and children still in treatment 36 months after ARV initiation	Number of patients who are on treatment after 36 months from the ARV initiation n	Number of patients initiating treatment during the selected period of time	WHO	Routine monitoring, UA reporting	Age, sex	NCDV, NCHM	Quarterly
% of HIV-infected adults and children still in treatment 48 months after	Number of patients who are on treatment	Number of patients initiating treatment during	WHO	Routine monitoring, UA reporting	Age, sex	NCDV, NCHM	Quarterly

ARV initiation	after 48 months from the ARV initiation	the selected period of time					
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Outputs

Indicator Definition	Data Sources	Disaggregated by	Responsible institution	Reporting frequency
Number of facilities	Routine monitoring, GFATM reporting	Age, sex	NCDV, NCHM	Quarterly
Number of people registered with an infectionist in pre-ART	Routine monitoring, GFATM reporting	Age, sex	NCDV, NCHM	Quarterly
Number of people in ART	Routine monitoring, GFATM reporting	Age, sex	NCDV, NCHM	Quarterly
Number of people newly enrolled in ART	Routine monitoring, GFATM reporting	Age, sex	NCDV, NCHM	Quarterly
Number of investigations /of people investigated (CD4, PCR, HEP-B, HEP-C, syphilis) disaggregated by test results	Routine monitoring, GFATM reporting	-	NCDV, NCHM	Quarterly
Number of PLWHA screened for TB	Routine monitoring, GFATM reporting	-	NCDV, NCHM	Quarterly
ARV patients in methadone program	Routine monitoring, GFATM reporting	Age, sex, residence	NCDV, NCHM	Quarterly

Resources (disaggregated in line with NASA methodology)

- Financial resources
- Material resources

3.3 IMPACT MITIGATION

Key activities

- Care and support for OVC

- Care and support for the patients in ART in the last 3 months
- Home care
- Palliative care
- Psychological support and social integration
- ART adherence
- Outreach / peer to peer

Indicator Definition	Numerator	Denominator	International M&E guide	Data Sources	Disaggregated by	Responsible institution	Reporting frequency
Adherence to treatment				Studies	Age, sex, residence	NCDV, NCHM	Once every 2 years
OVC attending schools				Studies, UNGASS reporting	Age, sex, residence	MSPCF, NCHM	Quarterly

Indicator Definition	Data Sources	Disaggregated by	Responsible institution	Reporting frequency
Number of infants born to HIV-positive mothers who benefited from milk formula	Routine monitoring, GFATM reporting	-	NGOs, NCHM	Quarterly
Number of people benefiting from food package for adults	Routine monitoring, GFATM reporting	-	NGOs, NCHM	Quarterly
Number of organizations delivering services for OVC	Routine monitoring, GFATM reporting	-	NGOs, NCHM	Quarterly
Number of trained staff (health workers)	Routine monitoring, GFATM reporting	-	NGOs, NCHM	Quarterly
Number of trained parents with HIV-infected children	Routine monitoring, GFATM reporting	-	NGOs, NCHM	Quarterly
Number of people the travel costs of which are covered	Routine monitoring, GFATM reporting	-	NCDV, NCHM	Quarterly

Resources (disaggregated in line with NASA methodology)

- Financial resources
- Material resources

3.4 COORDINATING AND IMPLEMENTING THE NATIONAL RESPONSE

3.4.1 Outcome, Output, and Input Indicators

Outcomes

Indicator Definition	Numerator	Denominator	International M&E guide	Data Sources	Disaggregated by	Responsible institution	Reporting frequency
National policy index			UNGASS	Studies using NCPI questionnaire	Public sector, NGO sector	NCHM	Annually
Financial resources earmarked from the state budget, amount and %	Financial resources earmarked from the state budget	Total budget of the Programme	NASA	NASA	NASA categories	NCHM	Annually
Operational ME system (12 components assessed as operational following ME system appraisal)			12 Component Organization Framework	12 components ME system strengthening tool	-	NCHM	Biannually

Outputs

Indicator Definition	Data Sources	Disaggregated by	Responsible institution	Reporting frequency
Number of NGO activities to fight stigma and discrimination	Routine monitoring and GFATM reporting	Age, sex, residence	NGOs, NCHM	Quarterly
Number of NGOs providing the PLHIV with services	Routine monitoring and GFATM reporting	Age, sex, residence	NGOs, NCHM	Quarterly
Number of companies with HIV workplace policy, number of people covered with HIV workplace policy activities	Routine monitoring	Urban/rural, size and profile of companies	ILO, NCHM	Annually
Number of advocacy initiatives	Routine monitoring and GFATM reporting		NGO, NCHM	Quarterly
Number of decision-makers talking about HIV/AIDS	Routine monitoring and GFATM reporting		NGO, NCHM	Quarterly
Number of organizations (public, private) actively involved in the national response to HIV	Routine monitoring and GFATM reporting	Residence	NGO, NCHM	Quarterly

Number of trained CCM / TWG members	Routine monitoring and GFATM reporting	Age, sex, residence	NGO, NCHM	Quarterly
Number of people trained in the workplace	Routine monitoring	Age, sex, residence	NCHM	Quarterly
Number of people trained elsewhere	Routine monitoring	Age, sex, residence	NCHM	Quarterly
Training/retraining programs in HIV	Routine monitoring		NCHM	Quarterly
Service providers submitting data on time	Routine monitoring, ME system review	Residence	NCHM	Quarterly
Number of studies	Routine monitoring, ME system review		NCHM	Quarterly
Number / % of facilities reporting on their steady provision with ...	Routine monitoring and GFATM reporting	Residence	NCHM	Quarterly
Number of facilities covered in operational research	Routine monitoring, ME system review		NCHM	Quarterly
Number of people trained in operational research	Routine monitoring, ME system review		NCHM	Quarterly
Number of operational research studies	Routine monitoring, ME system review		NCHM	Quarterly

CHAPTER 4. DATA SOURCES FOR NATIONAL INDICATORS

Two major data sources can be identified: (a) data sources for indicators that will be measured by surveys (outcome and impact indicators and outcome/impact data sources); and (b) data sources for indicators that will be measured using continuously monitored program outputs (output indicators and output data sources).

Table 3: Major routine and episodic data collection activities

Routine	Health Management Information System
	SIME-AIDS
Periodic	Population-based surveys (DHS, MICS, etc)
	Surveys on specific population groups (e.g. BSS)
	KAP surveys (among youth, general population, in schools, workplace)

4.1. Routine program monitoring

4.1.1. Routine statistics

The NCHM is responsible for collecting the vital statistics, which is further forwarded to the National Bureau of Statistics. To this end, the NCHM is keeping up an information system for health management, which integrates the key morbidity and mortality indicators, with district level data that are aggregated nationwide. At district level, data is entered by the statistical departments of respective health care facilities. The control over data quality is done by the NCHM, which is vested with data validation attributions, to further compile this data and submit it to NBS. The statistics routinely collected by the NBS there is also demographic statistics of the main population changes (birth rate, mortality, fertility, marriages, inbound and outbound migration), as well as the main trends in population growth. In 2008 the NBS developed in cooperation with its relevant government partners, NGOs and donor community a harmonized set of development indicators for gender statistics; the key indicators of the NAP could be found in that framework.

The Ministry of Economy and Trade has customized the database DevInfo to report for the MDGs. The institutional reforms have reduced human potential, thus further endangering the development and implementation of the given database.

The Ministry of Foreign Affairs and European Integration coordinates the reporting on the main international conventions that the Republic of Moldova has committed to, such as the Convention to eliminate all forms of Discrimination against Women, Convention for Child Rights etc., by using the information products of the ME system for HIV/AIDS in reporting on the above indicators.

4.1.2. Routine reporting by public entities

The statistics of public facilities include the following data:

- Number of tests / investigations, new cases diagnosed
- VCT
- Treatment
- Mortality

The diagnosis is established when the person undergoes 2 positive screening test type ELISA and confirmed by the Western Blot test. Upon a new HIV case confirmation, the personal data (name, address, year of birth, gender) are sent to the local level and the data collection on newly registered HIV case is under the responsibility of the local level preventive medicine doctors. Demographics, probable route of transmission, family members' data, employment, pregnancy data, and risk factors are the main data to be collected. The paper based filled forms are sent to the AIDS Center, where the data is incorporated into the national database (retrospectively entered into the SIME AIDS data base, first case registered in 1987). The quality of collected data is checked at national level in terms of

completeness, timeless and accuracy. In the situation when the person that has been registered as a new HIV case is not found to be interviewed by the local level preventive medicine doctors for data collection, the reason for testing is accounted as the probable route of transmission. As of today, there is still no established way to validate data.

The registration date is considered the date of confirmation test – Western Blot. The confirmation test is performed only at national level, by the AIDS Center, and that is why there is no variation in the number of newly registered cases. Due to the fact that the Western Blot confirmation date is counted as registration time, the data based on newly registered cases could delay the epidemic's trends provided by such statistics. There is no data on the average length between the first positive ELISA and the Western Blot confirmation test due to the lack of validation study and electronic system before. Inconsistencies, particularly those related to cases from the left bank of the Dniester River, are explained by delays in timely providing positive ELISA samples to the only reference laboratory confirming the HIV cases, located on the right bank of the Dniester River (capital city of Chisinau), and the worsening of situation by political tensions surrounding the current situation in the region¹⁰. The delay may be reduced by creating another reference laboratory in Transnistria, however this could be resulting in discrepancy and poor quality of data on the new cases diagnosed.

The VCT rooms located within the health care facilities report on the VCT cases to the National AIDS Center and the ME Unit, acting as validation facility. The reporting is standardized by using the form 25-SAN. The reporting is performed pursuant to a database filled in on a quarterly basis.

The follow up of HIV cases is conducted by the infectionist at local level and by the ARV department in the National Center for Dermatovenereology (NCDV). The data collected at this level are related mainly to the pre ART follow up and ART monitoring.

The reporting system on HIV testing is part of the preventive medicine reporting system. The system is a vertical one in terms of distribution of tests and reporting. The reporting on the amount of HIV testing, gender of testees, reasons and results is done by the regional AIDS laboratories based on the paper recordings and sent to the National Reference AIDS Laboratory. The gaps in quality are due to the paper based recording and reporting errors (duplication of data, lost, wrong counted number of tests versus number of tested persons). The reports are sent on monthly basis. The available disaggregation is by gender and district (rayon); disaggregation by age group and residency area is not available. The age is indicated on the request paper, but is not included in the data aggregation process. The sub national data quality is checked at national level in terms of completeness, timeliness and comprehensiveness and during field visits conducted by the National Reference AIDS Laboratory. No data validation operational research has been conducted prior to 2008. At national level the data are disaggregated by territorial units. Due to the administrative - territorial reform in 2004, the comparability of data disaggregated by territorial units is reduced. Number of pregnant women covered by HIV testing is provided by the preventive medicine reporting system, AIDS laboratories. Duplication of data is possible.

The reporting system on syphilis testing is part of the NCDV reporting system, to which territorial health care facilities are reporting. NCDV is responsible for validation and aggregation. The system is a vertical one in terms of distribution of tests and reporting. Due to centralized TPHA tests release and single institution involved, the probability of significant bias is low. Data are available only for the right bank of Dniester River. In May 2009 there will be monthly reports for year 2008, disaggregated by district. Data going back to as early as 1992 was retroactively entered into the information system. Starting in 2009 the reporting will also include Transnistria.

The ART initiation sites (Tiraspol, Balti – yet to be created in 2009) currently are not part of the routine reporting system. Once the SIME-HIV becomes operational, the reports will go to the NCDV, which will

¹⁰ As a result of a secessionist conflict that evolved in a full-fledged armed conflict on the Dniester River (1992), the region of Transnistria is under the control of secessionist authorities and the legitimate Government does not exercise control over it; consequently, the reference to the territory controlled by the Government - the right bank of the Dniester River, and the territory controlled by the self-proclaimed Transnistria authorities – the left bank of the Dniester River.

serve as a validation body. One challenge noticed to that end is the lack of a respective mandate, and reduced capacity and human resources within the NCDV, with only one person responsible for ME within the information and statistics department. There is need for capacity building efforts. The reporting of PLHIV registered with an infectious diseases specialist is done based upon Form 14 and is checked by the experts in the region and by the relevant specialist from the NCDV department.

Cross-sector reporting

The reporting by other ministries on the interventions carried out within the NAP is done on an *ad hoc* basis and is incomplete and inconsistent. A cross-sector reporting system should involve:

- MPSFC – routine reporting on services and social assistance.
- MEY
- DPI, Ministry of Interior
- Ministry of Defense – people in uniforms
- Ministry of Local Public Authorities – operational coordination mechanisms at the LPA level.

There is urgent need to develop the reporting forms as part of the conceptualization of a national database and mechanisms to keep it up, as well as the capacity building of relevant facilities.

4.1.2.1 Reference laboratories (HIV, STIs)

The NAP provides for the work of reference laboratories; for the time being there is no normative act to explicitly set the functions of a reference laboratory. Those should include:

- Quality control
- Data evaluation and validation
- Reference for new cases

There is need to strengthen the capacity of the laboratory network; for instance, testing for other STIs, as currently those provide only syphilis testing. There are basically no tests for HPV and Chlamydia

4.1.2.2. SIME AIDS

In order to improve the routine statistics data, with the support of the World Bank, the GFTAM and UNAIDS, a new software was developed for HIV cases monitoring and reporting. A separate module was developed for STIs cases reporting. According to the design of the SIME AIDS system, the information should be centralized and stored in electronic version in the M&E Department. However, the patients data ought to be aggregated and any personal identification removed to observe confidentiality requirements in place since the Law on HIV/AIDS has been adopted in 2007. Data on registered HIV cases have been entered retrospectively in the data base at national level (about 4000 cases) and located in AIDS center, the only institution mandated to store nominal data at national level. The informational flow is to be adjusted based on confidentiality principles and different access rights at different levels regarding HIV related individual information. The use of the new software will reduce the burden of errors occurring during manual processing of data. The issue of connectivity between the different levels and institutions involved in the collection of data is critical for the design and implementation and is based on the existing connectivity to assure the sustainability of the service. The equipment has been procured to ensure connectivity within the system.

The SIME HIV database is an information system for case management, integrating the follow-up for each PLHIV once a diagnosis is made and the new case is confirmed. Hence, the SIME HIV includes the following chapters: new cases, and case management (patient follow-up, investigations done, treatment provided). Social services and welfare that any given person has benefited from should be reflected in SIME HIV too, with data being entered by the infectious diseases specialist based upon the data provided by the social worker, with those two collaborating within a comprehensive team.

SIME HIV has several levels:

- Primary level, represented by facilities under the purview of which the PLHIV case falls: divided in to 2 major structural components – identification of new HIV cases (NAC) and patient follow-up (infectious diseases physician and maternity wards; TB specialist, collecting the primary information, filling in the paper-based forms and providing those to the next level up.
- Level 2 (treatment centers), where the data enters the system and which is the primary link responsible for case management.

The level of data maintenance, aggregation and coding is done by an operator within the ME Unit of the NCHM.

Data within the SIME HIV is managed by each treatment site, with further breakdown by districts, and further aggregation at national level. The forms used at the data entering level are the patients files filled in by the infectious diseases specialist and the children files for the infants born to HIV-positive mothers filled in maternity wards at birth and further by the infectious diseases specialist. The reports generated by the SIME HIV present data analyses on its main components: access to health and social services, treatment adherence, disease progression, associated conditions, breakdown by districts and communities. For the municipalities of Balti and Chisinau, the information is broken down by city districts.

4.1.2.3. Ensuring Data Confidentiality

SIME HIV implies 3 levels of information security:

- First level access (limited to the data on their respective district, coded) – accessed by infectious disease specialists
- Second level access, to the nominal database, depending on the circumscribing area of the respective treatment site.

Central level facilities, i.e. NAC, management of treatment sites (including, NCDV) and the database operator, all of which have confidentiality clauses in their contracts, have full access by districts to the data on each district.

4.1.3. Routine reporting by NGO

The Harm Reduction routine statistics data are available from quarterly reports provided by the NGOs subcontracted for implementation, based on the signed grant contract. The quality of data in terms of completeness, timeliness, comprehensiveness and accuracy is checked during field visits of the M&E officer from Soros Foundation – the umbrella organization for NGOs working in the field of Harm Reduction. Soros Foundation is centralizing the data on the social services provided by the NGOs supported with GF grants. The given reporting system, created following the need to report on the Global Fund grants, is embedded *ad litteram* within the national ME system's reporting mechanisms, with reporting on the interventions being done irrespective of the funding source (disaggregated by funding source).

Data related to social support and services are available from NGO reports, albeit in a more ad-hoc manner. Donor reports are the main source of data. The National League of People Living with HIV is the umbrella organization for all PLHIV NGO. In the framework of the Mid-term Review of the NAP 200, a multi-stakeholder TWG on social protection has been established under the auspices of the Ministry of Social Protection, Family and Child, expected to act as a data validation mechanism. There will be a single form developed to be used when reporting data to the ME Unit, with MSPFC acting as a data validation body for the information available to MDR teams (aggregated and coded data for the social services only).

The reporting on the services provided by NGOs is done on a quarterly basis.

4.2. Epidemiologic Surveillance

4.2.1. Behavior and Sentinel Surveillance

The “Standard on the Epidemiologic Surveillance of HIV/AIDS Infection” approved by the Order of the Ministry of Health Nr.20 of 19.01.2007 (Ministry of Health 2007) stipulates that biologic surveillance implies screening of the donated blood, screening of some professional groups, and the screening of most at risk and vulnerable populations: IDUs, CSWs, MSM, populations registered by STI Clinics and patients with STIs or patients with clinical signs of STIs, blood recipients subject to an increased number of blood transfusions as well as patients registered with coagulation problems, categories of populations with frequent travels, temporary migrants (including Roma populations, truck drivers,

citizens of the Republic of Moldova who lived outside the country more than 3 months), and detainees of penitentiary institutions-persons with a high risk of HIV infection. The collection of epidemiological data starts at the local level with the Centers for Preventive Medicine.

Importantly, a number of behavior and sentinel surveillance studies have been conducted in Moldova since 2001, focusing on IDUs, FSWs, and MSM. Although these studies are focused exclusively on beneficiaries of harm reduction programs, they do offer a limited picture of behavior and epidemiological trends among these hard to reach vulnerable populations. The data collection tools utilized in the surveys were adjusted to international reporting standards for core indicators, ensured the comparability of the results at the global level. These surveys have provided a wealth of very valuable data that has allowed for more in-depth understanding of the behaviors related to HIV infection and HIV transmission dynamics and networks. Efforts should be made to include the left bank of Dniester in behavior and sentinel surveillance studies in order to depict more accurately trends in behavior and prevalence across the regions.

There is a marked absence of Moldovan academic institutions involved in epidemiology, clinical evaluation of HIV/AIDS patients, treatment program evaluation, interventions, clinical trials, HIV virology and molecular epidemiology. Prospective studies of persons at risk for HIV infection to determine HIV incidence and related factors, allowing for the development of preventive interventions, would be of particular interest. There are many opportunities to take advantage of international funding to explore these areas while both addressing the HIV epidemic and developing scientific capacity and expertise in Moldova. Additional benefits that would arise from the realization of such studies would be the development of a framework for public health and medical ethics and human subjects protection review bodies (institutional review boards and ethical review committees). Data management and analytic capacity would also be enhanced.

The National AIDS Center has performed an exemplary job in the regular compilation and dissemination of HIV/AIDS epidemiological and surveillance data. In particular, the HIV Information Bulletin is being published regularly – once each semester – and contains a large and growing set of reliable and useful data. However, all of the data and each table presented in the bulletin require much more detailed analysis and explanation of limitations, trends, and significance. There is also an extensive research and epidemiologic data that is rarely or never analyzed. The regular and in-depth analysis and use of these data is essential to guiding HIV policies and improving programs.

The development of the capacity for epidemiologic and clinical research will require the establishment of appropriate human subjects review committees and capacity. For example, in the U.S. any research conducted on human subjects supported by government resources requires an ethical review committee assigned to investigate whether the study qualifies to receive a Federal wide Assurance for Protection of Human Subjects, issued by the Office for Human Research Protections, Department of Health and Human Services.

The relatively small number of Moldovan epidemiologists and scientists who are able to work effectively in English limits the ability of Moldova to fully participate in the scientific discourse that is an important part of the international HIV/AIDS effort. It would be very beneficial to have Moldovan epidemiologists and scientists participate in presenting data at international conferences, interact with international epidemiologic networks, develop study proposal and publish findings in international scientific journals. The AIDS Center would benefit from a continuous collaboration with a center of excellence in HIV surveillance and epidemiology to allow for bi-directional exchanges of staff to provide technical assistance in Moldovan and to have Moldovan staff receive training.

Responsibilities

The National Center for Preventive Medicine is the central level authorities empowered to coordinate the epidemiological surveillance. The ME Unit of the NCHM has a data validation role because of its duties to coordinate the national ME system.

Frequency

The data is collected on an ongoing basis and are reported to the ME Unit on a quarterly basis.

Dissemination & use

The NAC generates and disseminates quarterly info bulletins on the epidemiological situation in the Republic of Moldova by sharing it with all the relevant social stakeholders. This data is also put on a websites www.aids.md and www.sanepid.md and on other websites.

4.2.1. Epidemiologic Estimates

Moldova has developed a series of national estimates of the HIV epidemic, based on the best available data and internationally-recommended tools and methods. However, the process of developing these estimates has been largely driven by international partners, with growing, but still inadequate leadership and ownership for these estimates by national experts. These estimates have been generated only for the national HIV epidemic, without the ability to effectively disaggregate estimates at the region level. In order to generate more detailed and robust estimates, Moldova needs adequate data and capacity to generate a new set of HIV estimates at the raion and national level using EPP and Spectrum.

There are complex means of estimating HIV incidence on a national level as conducted in Canada and the United States, and there are methods for estimating HIV incidence in discrete population sub-groups from cross-sectional surveys using a serologic testing algorithm for recent HIV seroconversion (STARHS). The specialized nature of these methods requires adaptation to the specific epidemiologic situation in a country. Currently, there are higher priority issues for the AIDS Center to focus on than embarking on an effort to determine national HIV incidence. However, as methodologies evolve, there should be an ongoing discussion on the appropriate priority and timing of such work in Moldova. In the meantime, the AIDS Center should prioritize low cost tools for estimating incidence, such as the UNAIDS modes of transmission worksheet.

With the support of UNAIDS, in May 2009 there will be an exercise to forecast the epidemic trends based upon a set of validated data (2003 – 2008 timeframe) on the priority groups currently involved in the epidemic. The forecast results shall be validated at country level and shall guide the strategic planning of response interventions. The development of those forecasts will also include capacity transfer and capacity building value-added. Hence, the ME Unit, NCHM; NCDV; NAC and MOH will have specialists trained in how to use forecasts making tools.

Subsequent forecasts and bringing them inline depending on the data newly available will be coordinated by the ME Unit, with direct involvement of the trained staff from the relevant facilities.

4.3. Population-based Surveys

1. Studies on Knowledge, Attitudes and Practices related to HIV/AIDS among general population

Quantitative researches, household surveys that targeted general population aged 15-65 (2007) and 15 – 50 (2005) who live permanently on the territory of the Republic of Moldova (the right bank of the Dniester River) have been conducted in 2005 (1204 respondents, AFEW, 2005) and 2007 (1300 respondents, USAID PHH project, 2007). Sampling was stratified, multistage and quasiprobabilistic. The surveys are considered as being representative for the general population of targeted age groups, that live on the territory of the Republic of Moldova (the right bank of the Dniester River). The estimated sampling error is $\pm 3\%$ for both surveys. The data collection tool has been adjusted to international reporting standard for core indicators that makes the results comparable at global level. The Demographic and Health Survey, conducted in 2005 (30,491 respondents), addressed issues related to HIV/AIDS (National Scientific and Applied Center for Preventive Medicine (NCPM) [Moldova] and ORC Macro, 2006).

2. Studies on Knowledge, Attitudes and Practices related to HIV/AIDS among youth

Quantitative research conducted in 2006 (1190 respondents) (Scutelnicu, 2006) and repeated in 2008 (1182 respondents) (Scutelnicu, 2008), a household survey that targeted youth aged 15 - 24 years old who live permanently on the territory of the Republic of Moldova (the right bank of the Dniester River). Sampling method: stratified, multistage, quasiprobabilistic. The surveys are considered as being representative for the general population of the Republic of Moldova comprising the age groups 15 - 24 years old who live permanently on the territory of the Republic of Moldova (the right bank of the Dniester River). The estimated sampling error was $\pm 3\%$ in both cases. Both surveys used the same data collection tool and the same sampling methodology that make them comparable. The data

collection tool has been adjusted to international reporting standard for core indicators that make the results comparable at global level.

3. Behavioral and Sentinel Surveillance Surveys (BSS) related to HIV/AIDS among IDUs

Description

The Behavioral Surveillance Survey (BSS) is designed to track trends in HIV and AIDS-related knowledge, attitudes, behaviors and prevalence in subpopulations at particular risk of HIV infection, such as female sex workers, migrant populations, and youth. These surveys use a time-location sampling methodology to maximize the inclusion of special population of interest. Based on classic HIV and sexually transmitted infection (STI) serologic surveillance methods, BSS consist of repeated cross-sectional surveys conducted systematically to monitor changes in HIV/STI risk behaviors. Behavioral surveillance surveys may serve many purposes. They may yield evidence of project impact; provide indicators of project success and highlight persistent problem areas; identify appropriate intervention priority populations; identify specific behaviors in need of change; function as a policy and advocacy tool; and supply comparative data concerning behavioral risks.

The first Behavioral and Sentinel Surveillance Survey (BSS) in IDUs was conducted in 2001 (200 respondents) (CIVIS, 2001), repeated in 2003/2004 (507 respondents) (Bivol, 2004) and 2007 (630 respondents) (Scutelnicu & Bivol, 2008). All surveys targeted exclusively the beneficiaries of Harm Reduction Programs services. The first two surveys used the time location cluster sampling, multicentric, cross-sectional, questionnaire based and was not combined with qualitative testing on the presence of antibodies to HIV. The HIV prevalence data were generated based on testing of used syringes collected from sentinel sites. The 2007 BSS used probabilistic sampling and a two-stage cluster sampling design, multicentric, cross-sectional, questionnaire based and combined with qualitative testing on the presence of antibodies to HIV, VHC, VHB, and syphilis.

The data collection tools have been adjusted to international reporting standard for core indicators that make the results comparable at global level. Overtime the international recommendations for construction of core indicators have changed, the comparability between data points being reduced. The fact that the target of these surveys were exclusively the IDUs - beneficiaries of Harm Reduction Programs - reduce the representativity of the survey and results could not be extrapolated to the entire population of IDUs. The staff and volunteers of the Harm Reduction Programs have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.

Data Requirements

- Prevalence of HIV among IDUs
- % of sexually active population who had sex with more than one partner in the last 12 months
- % of sexually active population using condoms at last high-risk sex (sex with non-cohabiting or non-regular partner)

Frequency

The behavioral surveillance is done on a biennial basis.

4. Behavioral and Sentinel Surveillance Surveys (BSS) related to HIV/AIDS among CSWs

Description

The Behavioral Surveillance Survey (BSS) is designed to track trends in HIV and AIDS-related knowledge, attitudes, behaviors and prevalence in subpopulations at particular risk of HIV infection, such as female sex workers, migrant populations, and youth. These surveys use a time-location sampling methodology to maximize the inclusion of special population of interest. Based on classic HIV and sexually transmitted infection (STI) serologic surveillance methods, BSS consist of repeated cross-sectional surveys conducted systematically to monitor changes in HIV/STI risk behaviors. Behavioral surveillance surveys may serve many purposes. They may yield evidence of project impact; provide indicators of project success and highlight persistent problem areas; identify

appropriate intervention priority populations; identify specific behaviors in need of change; function as a policy and advocacy tool; and supply comparative data concerning behavioral risks.

The first Behavioral and Sentinel Surveillance Survey (further BSS) in Commercial Sex Workers (CSWs) was conducted in 2003 (150 respondents) (World Health Organization Regional Office for Europe, 2004), repeated in 2004 (149 respondents) (National Center of Health Management, 2006) and 2007 (496 respondents) (Scutelnicuic & Bivol, 2008). All surveys targeted exclusively the beneficiaries of Harm Reduction Programs services. In all three surveys the probabilistic sampling was not possible. All target group representatives, who accepted to participate in the studies, were included. In 2003 and 2004 the survey was unicentric (capital city only), cross-sectional, questionnaire based and combined with qualitative testing on the presence of antibodies to HIV, VHC, and syphilis. The 2004 BSS involved most of the respondents who participated in 2003 BSS. This fact explains the high values of core indicators registered in 2004. In 2007 the survey was multicentric (extended to four additional locations), cross-sectional, questionnaire based and combined with qualitative testing on the presence of antibodies to HIV, VHC, VHB, and syphilis.

The data collection tools have been adjusted to international reporting standard for core indicators that make the results comparable at global level. Overtime the international recommendations for construction of core indicators have changed, the comparability between data points being reduced. The fact that the target of these surveys were exclusively the CSWs - beneficiaries of Harm Reduction Programs - reduce the representativity of the survey and results could not be extrapolated to the entire population of CSWs. The staff and volunteers of the Harm Reduction Programs have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the HIV prevention activity of the projects.

Data Requirements

- Prevalence of HIV among IDUs
- % of sexually active population who had sex with more than one partner in the last 12 months
- % of sexually active population using condoms at last high-risk sex (sex with non-cohabiting or non-regular partner)

Frequency

The behavioral surveillance is done on a biennial basis.

5. Behavioral and Sentinel Surveillance Surveys related to HIV/AIDS among MSM

Description

The Behavioral Surveillance Survey (BSS) is designed to track trends in HIV and AIDS-related knowledge, attitudes, behaviors and prevalence in subpopulations at particular risk of HIV infection, such as female sex workers, migrant populations, and youth. These surveys use a time-location sampling methodology to maximize the inclusion of special population of interest. Based on classic HIV and sexually transmitted infection (STI) serologic surveillance methods, BSS consist of repeated cross-sectional surveys conducted systematically to monitor changes in HIV/STI risk behaviors. Behavioral surveillance surveys may serve many purposes. They may yield evidence of project impact; provide indicators of project success and highlight persistent problem areas; identify appropriate intervention priority populations; identify specific behaviors in need of change; function as a policy and advocacy tool; and supply comparative data concerning behavioral risks.

The first BSS in Men having Sex with Men (MSM) was conducted in 2003 (118 respondents) (World Health Organization Regional Office for Europe, 2004), repeated in 2004 (121 respondents) (Scientific and Practical Center of Public Health and Sanitary Management, 2006) and 2007 (94 respondents) (Scutelnicuic & Bivol, 2008). All surveys targeted exclusively the beneficiaries of Harm Reduction Programs services. In all three surveys the probabilistic sampling was not possible, being unicentric (capital city only), cross-sectional, questionnaire based and combined with qualitative testing on the presence of antibodies to HIV, VHC and syphilis. All target group representatives, who accepted to participate in the studies, were included. The 2004 BSS involved most of the respondents who participated in 2003 BSS. This fact explains the high values of core indicators registered in 2004. The

2007 BSS in MSM is appreciated as poor quality due to the smaller sample size and broken rules in data collection process (Scutelnicu & Bivol, 2008).

The data collection tools have been adjusted to international reporting standard for core indicators that make the results comparable at global level. Overtime the international recommendations for construction of core indicators have changed, reducing the comparability between data points. The fact that the target of these surveys were exclusively the MSM - beneficiaries of Harm Reduction Programs - reduce the representativity of the survey and results could not be extrapolated to the entire MSM population. The staff and volunteers of the Harm Reduction Programs have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the HIV prevention activity of the projects.

Data Requirements

- Prevalence of HIV among IDUs
- % of sexually active population who had sex with more than one partner in the last 12 months
- % of sexually active population using condoms at last high-risk sex (sex with non-cohabiting or non-regular partner)

Frequency

The behavioral surveillance is done on a biennial basis.

6. Demographic and Health Survey

Description

The DHS is a robust methodology for tracking changes in knowledge and behavior at a national level. In Moldova, this survey is conducted every 4 to 5 years. The methodology has been developed over 30 years of international experience and data are comparable internally over the course of time, and externally with other countries. The core DHS questionnaire emphasizes basic indicators and flexibility. It allows for the addition of special modules so that questionnaires can be tailored to meet host-country data needs. The standard DHS survey consists of a household questionnaire, a women's questionnaire and a men's questionnaire (in every third household). Randomly sampled people aged 15-49 are interviewed. In addition, the data can be disaggregated by age, sex, socio-economic status, educational level, and urban/rural status.

The National Scientific and Applied Center for Preventive Medicine conducted the Demographic and Health Survey in 2005 (on 30,491 respondents), which also addressed issues related to HIV/AIDS.

HIV prevalence information from this data source will be used for triangulations with results from sentinel surveillance and other data sources. Further, this data source will compliment results from sentinel surveillance, especially in terms of disaggregating data by sex, socio-economic and socio-cultural characteristics.

7. Multiple Indicator Cluster Survey

Description

The Multiple indicator Cluster Survey (MICS) is the largest, nationally representative sample survey conducted by the National Statistical Offices. The survey's main objective is to obtain statistically valid estimates at district level on a number of social development indicators related to Moldova Growth and Development Strategy (MGDS), the Millennium Development Goals (MDGS) and the goals of A World Fit for Children (WFFC). The survey is based, in the main on the needs to monitor progress towards goals and targets emanating from the recent international agreements: the Millennium Declaration, adopted by 191 United Nations Member States in September 2000 and A World Fit for Children (WFFC) adopted by 189 Member States at the United Nations Special Session on Children in May 2002.

The MICS would serve as one of the main monitoring tools by providing the necessary data at national, regional and district levels. The information gathered in MICS would serve as a baseline for the new

initiatives and assess the success of the ongoing programs. The MICS provides an opportunity to triangulate its results with DHS results.

Data requirements

- Proportion of children who are orphaned
- Ratio of current school attendance among orphans to that among non-orphans

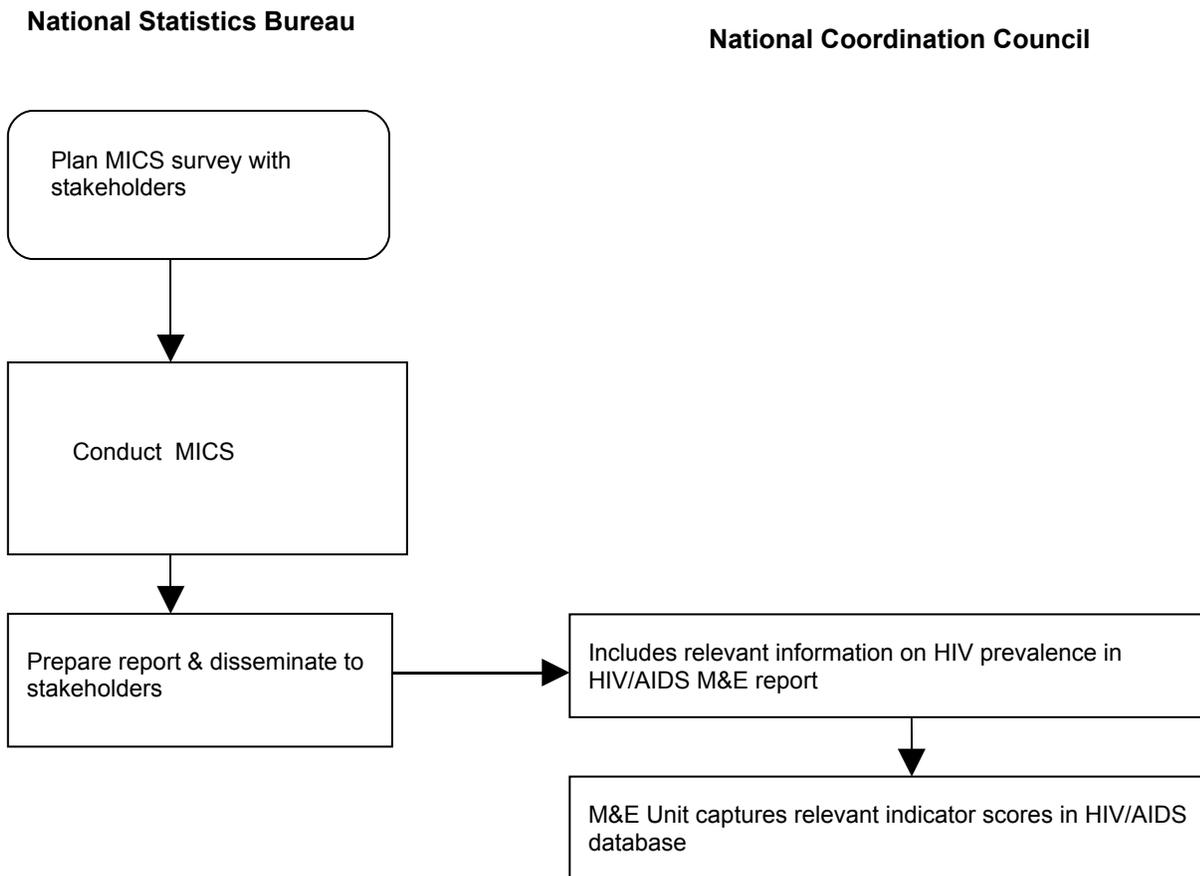
Frequency

A subsequent MICS is planned for 2010 to provide data on trends since the 2005 DHS.

Responsibility

The National Statistics Bureau will be responsible for conducting the MICS.

Data source flow chart



Information Product

The Multiple Indicator Cluster Survey Report

8. Population Census

Description

Population census is the main source of information for the national information resources, focusing on population size, territorial distribution depending on demographic, social and economic, national and language characteristics, education, living conditions of people.

Data requirements

- Life expectancy at birth
- Data on population projections on the natural movement of people

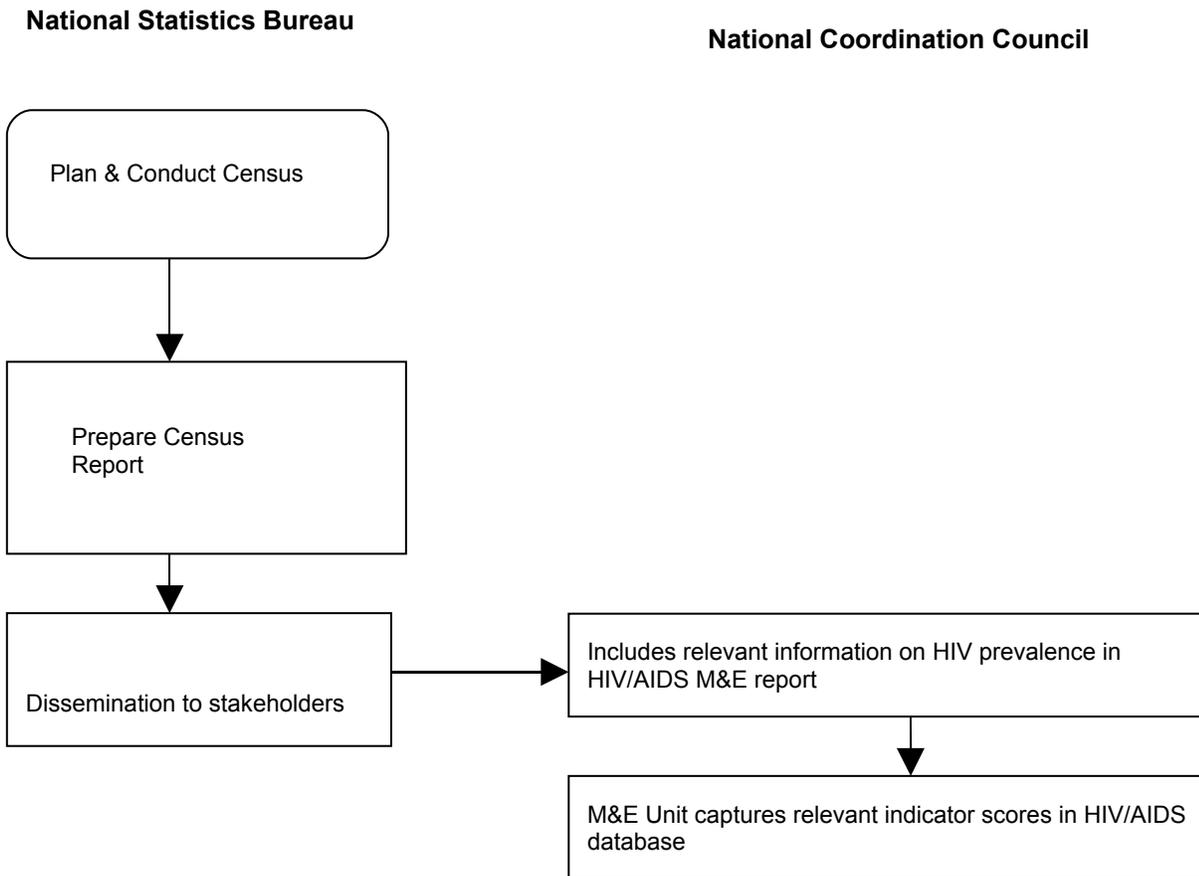
Frequency of data collection

The last census was organized in 2004. the next census is scheduled for 2012.

Responsibility

National Statistics Bureau will be responsible for data collection and analysis

Data source flow chart



Information Product

Behavior studies among most-at-risk adolescents (MARA)

With the financial support of UNICEF, during 2007-2008 the NCHM conducted the first behavior study among MARA. The study focused on four target groups: IDUs, FSW, MSM and adolescent detainees. For the first time the respondent driven sampling (RDS) tool was used to study adolescents IDUs. This allowed for a considerable number of IDUs to be identified, including underage teens, a good share of which were not reported as beneficiaries of HR programs. The study results provide data on the behaviors of adolescents and youth with high risk of getting the infection (injecting practices, unsafe sex), as well as an insight into the access of those to HIV prevention services. The data confirming the adolescents' high vulnerability to HIV owing to limited knowledge they have in the area, risky practices, limited access to HIV prevention services, underpin the need to adjust / develop specific interventions to better reflect the needs of these groups of adolescents. Hence, there is need to conduct, on a regular basis, this type of studies to collect additional information about the risks among MARA, who

are oftentimes overlooked by most interventions, as well as the rationale for decision making when developing HIV prevention programs.

HIV/AIDS Education System Needs Assessment Study

The study was conducted under the aegis of UNESCO in 2007 and aimed at identifying the needs of the education system in HIV/AIDS. The main objectives of the study were to:

- Identify the level of knowledge about HIV/AIDS in schools;
- Learn about the impact of existing methods and identify optimal approaches to promote HIV/AIDS education among key groups in the education system: students, teaching staff, parents;
- Identify priority HIV/AIDS communication agents in schools;
- Assess the attitudes and interests to HIV/AIDS of all target groups within the education system: students, teaching staff, management, parents, public authority representatives;
- Assess the attitudes of religion groups towards HIV/AIDS education.

The methodology of the study included quality and quantity components. The quality study consisted of 15 focus groups with students from grade 12. For each of the focus groups there were about 8-10 students selected. The selection of students was done randomly in line with a preset statistical pace.

Opinion polls have been accomplished in a complex sample, divided in several categories of respondents:

- 1) Students of school year 12, 428 students in total;
- 2) Teaching staff – 362 persons;
- 3) Directors of education facilities – 50 persons;
- 4) Parents with children aged 11–18 years, 600 parents in total.

KAP Survey in the workplace

In order to better tailor the developed programs and projects to the needs of employees and employers alike, the ILO conducted a KAP study in 2008 among people in the workplace about HIV. There was no reference study on HIV/AIDS among employees conducted in the Republic of Moldova before that, providing the rationale for doing it, following uncertainties surrounding the real situation in terms of knowledge, attitudes and behavior practices in the area, as well as in terms of employer attitudes and existing policy within companies towards this disease in general and to PLHIV in particular.

The sample size was 1217 employees aged 17+ years. It was a stratified, probabilistic and two-stage sample. The sample was representative of companies with 300+ employees, with SD around +3%

Migration and Health Study

In order to assess the HIV and STI vulnerability factors and conditions among migrants, the IOM conducted a KAP survey in 2006 to assess the risky sexual behaviors and other HIV/STI vulnerability factors. The migrant definition included Moldovans out of country for at least a month during the last three years, age group 16 – 60 years. The methodology of study included quality and quantity components. The quantity component used the snowball method for recruitment. The sample size included 454 respondents.

4. X Operational Research

There are limited capacities to conduct operational research in Moldova. This is going to be part of the Research and Evaluation Plan, with capacity building efforts under way, subject to NAP priorities.

CHAPTER 5. DATA QUALITY

The M & E Plan hereto establishes principles for monitoring data quality periodically and addressing any obstacles to producing high-quality data that correspond to the criteria below:

- Validity
- Reliability
- Timeliness
- Precision
- Integrity

5.1. Systems for data quality assurance in place

As indicated by the M & E system assessment, as well as by the M & E profile for Moldova drafted by the Global Fund, effective mechanisms for data quality assurance are missing in Moldova. Data originating from different sources may vary, such inconsistencies affecting planning for better program delivery as well as Moldova's image and credibility when data are reported through various international reporting mechanisms without a comprehensive in-country data reconciliation and validation.

Protocols for data auditing exist, though they are not specific for the National HIV M & E Plan. There are also standardized annual report and reporting forms.

While national guidelines and tools for supportive supervision on M&E are lacking, some positive practices occur, as oversight and data auditing carried out by the National Health Management Center and the National AIDS Center.

Due to a capacity shortage, the system of reviewing the quality of data collection and management, which has implications for the much needed data analysis and dissemination, is not adequate. Insufficient attention to data transfers, storage integrity, and back-ups at both the national and sub-national level can result in data losses, or worse, leakage of confidential data. Moreover, gaps in the quality of data due to the paper based recording and reporting errors also create a series of inconsistencies (as a result of duplication of data, loss of data, and incorrectly counted number of tests versus number of tested persons).

Disaggregation of data is done by gender and district (rayon), but it is not available by age group and residency area. Particularly, the age of the testee is indicated on the request paper, but is not included in the data aggregation process. In addition, no data validation operational research has been conducted. At the national level the data are disaggregated by territorial units, but due to the fact that in 2004 the Parliament adopted a new administrative-territorial division of the country, overtime the comparability of data disaggregated by territorial units has been reduced.

5.2. Supportive supervision and oversight

Supportive supervision refers to overseeing and directing the performance of others and transferring the knowledge, attitudes, and skills that are essential for successful M&E of HIV activities. It offers an opportunity to take stock of the work that has been done; critically reflect on it; provide feed-back to local staff; and where appropriate, provide specific guidance to make improvements. Supportive supervision should be conducted with a sample of HIV service delivery organizations (i.e., not all providers), and can also be used as a mechanism to strengthen local M&E capacity.

In Moldova, the Government system for planning, management and implementation is still based on a hierarchical system of oversight and reporting. Despite significant improvements in Government requirements for the development and implementation of results-based programs, in practice accountability on results is weak. Particularly in the health sector, reports to the supervising institutions tend to represent lists of inputs and activities, providing little information on achievements and results.

The M & E TWG shall undertake the task of developing Guidelines for supportive supervision and oversight in M & E that shall aim to:

- incorporate on-the-job training and personal growth at all levels that have M & E functions
- ensure quality of routine data collection at facility and community-based HIV service delivery levels
- ensure consistency and timeliness of reporting
- standardize reporting to avoid overburdening
- develop mechanisms for regular monitoring and supervision and follow-up on feedback

5.3. Data Quality Assurance Protocol

Data quality has been highlighted as a challenge by several reviews of the national response, as regards accuracy, reliability, completeness, timeliness and validity. Measuring the success and improving management of national HIV and AIDS programs is predicated on strong M&E systems that produce quality data.

To address the data quality strengthening, the M & E Plan institutionalizes the general principles that shall constitute the foundation for developing a data quality protocol.

The objectives of this data quality protocol are to:

- Verify that appropriate data management systems are in place
- Verify the quality of reported data for key indicators
- Contribute to improvements in M&E through systems strengthening and capacity building

The protocol intends to provide a common platform and procedures for conducting data verification and data validation for data collected at national and district levels in line with the national M&E Plan. The document sets out generic procedures for conducting data quality assurance assessment, which could be adapted at national and district levels. It describes procedures to be used and when to do data audits.

The responsibility to validate data within sectors lie in the hands of the responsible line ministries. Cross-cutting issues will be handled by the multi-sector M&E Technical Working Group.

Eight functional areas and eleven key components are critical for a data quality assurance system to be well designed and implemented. Such a system is required in order to produce quality data.

Table 4: Data Quality Assurance System

Functional Areas		Components	
I	M&E Capabilities, Roles and Responsibilities	1	Key M&E and data-management staff are identified with clearly assigned responsibilities
II	Training	2	The majority of key M&E and data-management staff have received the required training
III	Data reporting requirements	3	The Program/Project has clearly documented (in writing) what is reported to who, and how and when reporting is required
IV	Indicator definitions	4	There are operational indicator definitions meeting relevant standards and are they systematically followed by all service points
		5	There are standard data-collection and reporting forms that are systematically used
		6	Source documents are kept and made available in accordance with a written policy
VI	Data Management Processes	7	Clear documentation of collection, aggregation and manipulation steps exist
		8	Data quality challenges are identified and mechanisms are in place for addressing them
		9	There are clearly defined and followed procedures to identify and reconcile discrepancies in reports
		10	There are clearly defined and followed procedures to periodically verify source data
VIII	Links with National M & E System data depository	11	The data collection and reporting system of the Program/Project links to the National M & E System data depository

Data auditing is the process of verifying the completeness and accuracy of reported aggregate HIV program data, based on protocols for data quality audits. The data quality audits shall be undertaken along the following stages:

- Phase 1: Self-assessment and Process Assessment
- Phase 2: Verification and Validation
- Internal Audit
- External Audit

Data validation for quality assurance implies mechanisms for internal and external validation. Operational internal validation structures include: the monitoring by the NAC epidemiologist of the territorial CPM with regards to people under epidemiological surveillance; NCPM in its capacity of management structure for the infectious disease case.

The external validation mechanisms already available are: the annual reporting of the NCPM to the European Office for Infectious Diseases; laboratory external control done by another laboratory from abroad once a year.

Based on these sporadic quality control elements, a mechanism for data validation in VCT was created, based upon the external monitoring by the ME Unit – the data validation body – representing one of the successful external validation models. An operational external validation mechanism by an umbrella-organization for the NGOs is the ME mechanism of the Soros Foundation, focused on HR data validation.

Audits shall be undertaken on an annual basis at randomly selected sites and for selected indicators. These audits will be based on a five (5) step process:

1. Description: Describe the connection between the delivery of services/commodities and the completion of the source document that records that service delivery.
2. Documentation Review: Review availability and completeness of all indicator source documents for the selected reporting period.
3. Trace and Verification: Trace and verify reported numbers: (1) Recount the reported numbers from available source documents; (2) Compare the verified numbers to the site reported number; (3) Identify reasons for any differences.
4. Cross-checks (*if feasible*): Perform “cross-checks” of the verified report totals with other data-sources (eg. inventory records, laboratory reports, etc.).
5. Spot checks (*if feasible*): Perform “spot checks” to verify the actual delivery of services or commodities to the target populations.

The data quality assurance protocol shall also include templates (Table 4 - 6¹¹) for assessing data quality threats and for planning steps to address such threats. The data audits shall verify the presence and completeness of such documents, to be completed at the planning stage and to represent a dynamic tool for improving data quality.

Based upon all data quality control mechanisms, the TWG on ME will be responsible for developing a Data Quality Assurance Plan, as per the template below.

Table 5: Data Quality Plan

Indicator	Type of Data Quality Threat (validity, reliability, timeliness, precision, integrity)	Actions Taken or Planned to Address D.Q. Threat

¹¹ Adapted from MEASURE training materials on ensuring data quality, <http://www.cpc.unc.edu/measure/training/mentor/materials>

1. Number of health care providers trained.	The limitations are related to the reliability of the training facilitator to ensure that all participants sign the attendance register every day of the training. Facilitators fail to submit attendance registers on time.	Facilitators should have a checklist of things to do every day of training and top of the list should be signing of attendance register. Cluster manager and M&E person should ensure participant register is attached to each training report
2.		

Once drafted and endorsed by the TWG, this Plan will be an Annex to the Action / Work Plan in ME, and the monitoring of progress accomplished on this will have high priority in the TORs of the TWG on ME.

The quality assurance efforts included in the Plan will be based on risk assessments, as per the template below.

Table 6: Establishing Data Quality Risks

Overall Effect on Data Quality	Probability of Error Occurring			
4) - <i>Catastrophic</i>	16	12	8	4
(3) – <i>Critical</i>	12	9	6	
(2) - <i>Marginal</i>	8	6	4	
(1) - <i>Negligible</i>	4			

Remediation actions will be taken depending on severity of risk and probability of it occurring, as follows:

Table 7: Planning steps to address data quality risks

Risk Score	Risk Type	Remedial Action
9 - 16	High Risk	Establish contingency plan to reduce risk, verify and validate <i>prior to each reporting episode</i> , maintain strict audit trail.
4 - 8	Medium Risk	Establish contingency plan to reduce risk, verify and validate <i>prior to annual return</i> , maintain strict audit trail.
1 - 3	Low Risk	No immediate action required; risk could be managed through normal internal audit processes.

5.4. Triangulation of data

“Triangulation” refers broadly to the process of collecting, arraying together, examining, and interpreting data from multiple sources to improve our understanding of a public health problem and to guide programmatic decision-making to address such problems. Triangulation can be effective when a rigorous, specifically designed research study is not available or when action urgently needs to be taken. Rather than generating new data to answer a specific research hypothesis, triangulation seeks to make the best possible public health decisions based on the available evidence. Triangulation uses inductive reasoning in that it iteratively refines and modifies an explanation of the health problem based on empirical observations. Triangulation also follows the principles of Second Generation HIV Surveillance by focusing on trends over time and by combining data on the prevalence of HIV and STIs, risk behaviors, and program delivery. Triangulation emphasizes the rapid use of data.

The M & E Plan hereto institutionalizes regular triangulation exercises that shall represent a component of various data validation / consensus – building events, as described in Chapter 7: Information products.

CHAPTER 6. DEVELOPING AN EVALUATION AND RESEARCH AGENDA

Evaluation and research are essential but often neglected components of a comprehensive HIV M&E system. Appropriate use of evaluation/research data ensures that the planning of the HIV response is based on the best available evidence and guides ongoing program improvement. Establishing a national process for identifying evaluation/research gaps relevant to the National HIV/AIDS Program and for coordinating evaluation/research partners helps ensure that evaluation/research studies are relevant to the country's needs and provide actionable results; that evaluation/ research efforts are coordinated to avoid duplication of effort; and that study results are shared and available for use in decision-making.

6.1. Process for developing the evaluation and research agenda

While some evaluations occur in the framework of the National program on HIV/AIDS/STIs, including joint multi-stakeholder mid term and end program reviews, and some research is being carried out under the auspices of the Academy of Sciences, an inventory of the research institutions and research and evaluation initiatives is missing, and a concerted approach to setting evaluation and research problems and using findings for strategic planning is imperative for value added. The M & E profile drafted by the Global Fund identifies operational research as underdeveloped in Moldova. The buy-in and commitment of different stakeholders, including NCC members, to the feasibility of research and evaluation, differs.

An Inventory of research and evaluations in the field of HIV/AIDS that has been carried out in Moldova has been completed by the M & E Unit recently. Based on the inventory, and on planned inventory of research capacity and a desk review of relevant international and regional HIV research and evaluations findings, as well as the experience of comparable countries and epidemics, a priority setting workshop shall be organized for stakeholders to endorse the priority research topics recommended by the MTR, to identify any gaps and to prioritize and plan research, operations research and evaluations. An output of the workshop shall be an Evaluation and Research Agenda, which shall be circulated widely for inputs and approved by the NCC once it is finalized.

Currently, financial resources for evaluations and research are almost exclusively international. The Agenda shall form the platform for advocacy for resource allocation from the state contribution to the NAP budget.

6.2. Priority research topics

- elucidation of the role of injection drug use in HIV infection among pregnant women, female sex workers and MSM
- characterization of persons with presumed heterosexually acquired HIV infection – the goal here is to determine if such cases really did not have other risk factors (IDUs or MSM) or were the sexual partners of IDUs (one transmission generation away from an IDU). The results of these studies would allow for a determination of the extent to which there is sustained heterosexual-to-heterosexual transmission and sustained male homosexual transmission unrelated to injection drug use.
- Gender issues
- Studying the factors driving adolescents to adopt risky behaviors (IDU). Study of older IDUs on the start-up of IDU.
- description of linkages to care, the care/treatment experience, and survival after HIV diagnosis
- a descriptive study of HIV-infected pregnant women to define the PMTCT program experience and transmission outcome; and care for women
- epidemiologic topics of interest include: description of the molecular epidemiology of HIV in Moldova, to determine if such studies could shed light on transmission dynamics and networks
- TB and HIV co-infection; management and outcome
- Establish a review committee to assess the compliance with ethical standards of studies conducted on human subjects

6.3. Participatory Reviews & program evaluation

At mid-term and end of the program cycle, joint, participatory reviews and evaluations shall take place to forge of a framework for coherent program implementation, with full involvement of stakeholders in honing strategic interventions proven to work best, through an evidence-based process.

The Mid-term Review objectives are:

- To undertake a review of progress towards delivering the Moldova HIV/AIDS Strategic Framework based on the reports of the thematic technical working groups.
- To exchange opinions on the identification and institutionalization of the best practices for the prevention and control of the HIV/AIDS pandemic.
- To identify and agree on main priorities and a limited number of milestones for the years 2009-2010.
- To review the objectives, targets and expected outcomes based on the harmonized indicators in the Monitoring and Evaluation Plan.
- To incorporate emerging issues in the response to the epidemic.

Final program evaluation will aim at evaluating the results of the Program depending on the expected values for each indicator, as well as on the interventions that make up the national response as per the given program cycle, in order to see if those are:

- Adequate
- Relevant
- Effective
- Efficient

The conclusions of the final evaluation, lessons learnt and positive practices identified lay the foundation for developing a new strategic framework for interventions and for planning priority actions to fulfill strategic objectives.

Component / sector evaluations include participatory exercises, carried out under the coordination of stakeholders that have a vested interest in the respective component (for example, UNICEF and MARA). When planning those, one has to consider the feasibility of sector approaches, substituting for formal and organized multi-sector evaluations wherever possible, such as the mid-term review or end-of-NAP evaluation.

Milestones of the evaluation agenda are aligned to the NDP.

CHAPTER 7. INFORMATION PRODUCTS

The M&E Unit will be responsible for compilation, management and dissemination of all data collected through the HIV and AIDS M&E System at national level. The HIV and AIDS M&E System will produce the following information products:

7.1. Annual HIV and AIDS M&E Report

Purpose of Report

The purpose of this report is to provide a comprehensive overview of Moldova's response to HIV and AIDS. This will be done by reporting on all indicators contained in the national HIV and AIDS M&E plan, and by providing key observations and recommendations for future implementation. This report will be procedurally linked to the NCC annual work planning and budgeting process to ensure that the information is actually used for decision-making.

Data Sources for Report

The data sources for this report are all those mentioned in Chapter 5 of this document. Should new and improved data sources become available, NCC may also wish to supplement this report with additional data sources.

Data Analysis

At national level, data analysis will be the responsibility of the National M&E Unit. All data should focus on the previous financial year, and this will be the *de facto* reporting period for the report.

Report Format

The format of this report will be based on the information needs of the NCC and its stakeholders. The NCC will maintain this standard format to enable trend analyses. The template for the format shall include a brief narrative description of major trends, constraining factors and opportunities, scores for the indicators and an assessment of the implementation of the M & E work plan for the respective period, as well as major plans for the year to follow. This report will include the scores for the entire set of national HIV and AIDS indicators, irrespective of whether the indicator scores have changed for that particular year.

Report Compilation

The National Report will be compiled on an annual basis by the National M & E Unit, and shall be submitted to the M & E TWG for review by December of the reporting year. The M & E TWG shall submit the final version for endorsement to the NCC.

Report Approval

The Annual M & E Report shall be approved at the first session of the NCC in the subsequent year, based on prior circulation of the draft, and on the presentation made by the National Coordinator of the National HIV/AIDS Program.

Report Dissemination

The annual HIV and AIDS M&E Report will be disseminated through various M&E events and workshops held at national and regional level, via newsletters and e-newsletters, and shall be placed on relevant websites in the public domain (www.ccm.md, www.aids.md)

Responsibility and timeframe

The National M & E Unit will be responsible for compiling the Annual HIV and AIDS report on an annual basis.

7.2. Annual and Quarterly Reports to GFATM

7.2.1 Purpose of Report

The goal of the quarterly report is to submit a reporting tool to the donor on the resources used up, activities implemented and products accomplished, as part of a routine monitoring tool system. The

Quarterly report will be supplemented by the annual report providing an overall picture of the outcomes by progress reported against various indicators.

7.2.2 Data Sources for Report

Activity reports submitted by sub-recipients and monitoring reports and data quality control reports generated through the external validation mechanisms are the main sources of data for the report.

7.2.3 Data Analysis

The ME Unit is responsible for data analysis, as per its attributions and responsibilities to monitor the progress on the GFATM grants.

7.2.4 Report Format

The format of the report is set under the Global Fund guidelines.

7.2.5 Report Compilation

The programmatic report and emphasizing of changes to selected indicators are compiled based on the reports submitted by sub-recipients to the ME Unit. Financial recipients are responsible for the financial reporting.

7.2.6 Report Approval

The report that is being produced is then consulted with principal recipients. The ME Unit of the NCHM acts as the final data validator.

7.2.7 Report Dissemination

The reports ought to be put out on the relevant websites on public domain: www.ccm.md, www.aids.md

7.3. Annual UA Reporting

7.3.1 Purpose of Report

As countries scale up their national HIV/AIDS programs towards the goal of universal access to prevention, treatment, care and support ¹², it is increasingly important to strengthen strategic information on the epidemic and national responses to inform policies and programs, improve the effectiveness of interventions and promote accountability. Progress in the health sector is a key measure of progress towards universal access, as well as broader Millennium Development Goals.

WHO, UNICEF and UNAIDS have developed a *joint Reporting Tool* related to WHO's *Framework for Monitoring and Reporting on the health sector response to HIV/AIDS* and the *Report Card on PMTCT and Paediatric HIV Care and Treatment*, that covers the health sector response to HIV/AIDS, with a dedicated module on interventions for women and children. Based on data provided by countries, starting with 2009, a joint report shall be produced on progress in scaling up the *health sector response to HIV/AIDS towards universal access*.

All relevant UA indicators have been included in the National Indicators Framework collected and maintained by the Moldova HIV/AIDS M&E system. This will ensure that the data collection and analysis for the UNGASS indicators form part of the M&E processes within the NCC, and that it is not treated as a report outside the scope of NCC's M&E mandate.

7.3.2 Data Sources for Report

The UA Reporting is streamlined in the national reporting processes, as UA indicators shall be annually reported upon as part of the Annual HIV and AIDS M & E report.

¹² United Nations General Assembly. *Political Declaration on HIV/AIDS*, New York, United Nations, 2006.

7.3.3 Data Analysis

The National M&E Unit shall analyze the data submitted by responsible line institutions, applying data quality checks, and shall submit data for validation by key stakeholders.

7.3.4 Report Format

The European adaptation of the global *joint Reporting Tool* shall constitute the basis for the report hereto.

7.3.5 Report Compilation

A working meeting of the M & E TWG analyzing data requirements and sources of data shall be organized prior to the data collection. Data shall be submitted to the National M & E Unit that shall be in charge for filling in the Reporting Tool. A data validation meeting shall take place prior to submitting the Reporting Tool to WHO/UNICEF/UNAIDS regional offices.

7.3.6 Report Approval

The validation meeting shall be the forum for building consensus on data among the key stakeholders. The NCC shall endorse the report.

7.3.7 Report Dissemination

The Reporting Tool shall be submitted to WHO/UNICEF/UNAIDS regional offices. A short analysis of trends and data for key indicators shall be produced by the M & E Unit and disseminated via newsletters and e-newsletters, and shall be placed on relevant websites in the public domain (www.ccm.md, www.aids.md)

7.3.8 Responsibility and timeframe

The National M & E Unit shall be responsible for overall coordination and compilation of the report. A national roadmap shall be developed, establishing deadlines for each of milestones, in order to ensure submission by the international deadline – **April 1** of each year.

7.4. Biennial UNGASS Report

At the close of the groundbreaking UNGASS on HIV/AIDS in June 2001, 189 Member States adopted the Declaration of Commitment on HIV/AIDS. It reflects global consensus on a comprehensive framework to achieve the Millennium Development Goal of halting and beginning to reverse the HIV epidemic by 2015. Moldova is a signatory to the 2001 Declaration of Commitment on HIV/AIDS at the United Nations Special Session on HIV/AIDS (UNGASS). Part of this Declaration of Commitment includes a set of indicators that the Government of Moldova has agreed to report on to UNAIDS on a periodic basis. All relevant UNGASS indicators have been included in the National Indicators Framework collected and maintained by the Moldova HIV/AIDS M&E system. This will ensure that the data collection and analysis for the UNGASS indicators form part of the M&E processes within the NCC, and that it is not treated as a report outside the scope of NCC's M&E mandate.

7.4.1 Purpose of Report

The purpose of this report is to report to the UNAIDS on a periodic basis in terms of Moldova's progress in the fight against AIDS, by reporting on specific indicators in a manner defined in the *UNAIDS Guidelines for the Construction of Core Indicators*.

7.4.2 Data Sources for Report

The data sources for UNGASS indicators is as per the data sources specific in the *UNAIDS Guidelines for the Construction of Core Indicators*, and can be summarised as follows:

- Expenditures calculated based on NASA methodology
- NCPI questionnaire
- School-based survey and education program review
- Workplace survey
- Health facility survey (MoH Health facilities supervision process data)
- specially-designed surveys and questionnaires, including surveys of specific population groups
- PMTCT and ARV program monitoring and estimates

- nationally representative, population-based sample surveys
- behavioral surveillance surveys
- HIV sentinel surveillance
- records and program reviews

7.4.3 Data Analysis

Data analysis will be carried out as per the *UNAIDS Guidelines for the Construction of Core Indicators*, and the datasheets for each of the UNGASS indicators will be completed, disaggregated as per requirements.

7.4.4 Report Format

The Reports shall be developed based on the structure of the Country Progress Report format, provided for in the *UNAIDS Guidelines for the Construction of Core Indicators*

7.4.5 Report Compilation

The M & E TWG shall represent the technical forum for compilation of the report, under the overall coordination of the M & E Unit. A roadmap shall be developed and approved by the NCC in the year prior to the report submission, outlining the major steps, timeframes and responsibilities. The roadmap shall constitute an Annex to the Plan hereto.

The report development process shall be consultative and include inputs from key stakeholders. The data in the report and the major findings shall be validated prior to submission in a consensus-building meeting

The Country Response Information System (CRIS), developed by UNAIDS as database that facilitates collection, reporting and analysis of program, project and indicator data, shall be used for reporting purposes.

7.4.6 Report Dissemination

The UNGASS report shall be disseminated through various M&E events and workshops held at national and regional level, as well as via newsletters and e-newsletters, and shall be placed on relevant websites in the public domain (www.ccm.md, www.aids.md)

7.4.7 Responsibility and timeframe

The National M & E Unit shall be responsible for overall coordination and compilation of the report. A national roadmap shall be developed, establishing deadlines for each of milestones, in order to ensure submission by the international deadline – March 31, 2010.

7.5. Evaluation Reports

Evaluations will be undertaken selectively by NCC and its stakeholders to answer specific questions to guide decision-making, to establish whether programs are valid, what worked and what did not work and reasons for the outcomes, to determine relevance, efficiency, effectiveness, impact and sustainability of the interventions.

7.5.1 Purpose of evaluation reports

The purpose of the reports will be to provide information on, what works and what does not work and reasons for the outcomes, efficiency, effectiveness and sustainability of interventions.

7.5.2 Data Analysis

Data analysis will be carried out in accordance with the agreed upon terms of reference and by the M & E Unit or by the agreed stakeholders or consultants.

7.5.3 Report Formats

The format of this report will be based on the information needs of NCC and its stakeholders, as individually specified in the TORs for each report.

7.5.4 Report Dissemination

Evaluation reports will be disseminated through various M&E events and workshops held at national and regional level, as well as via newsletters and e-newsletters, and shall be placed on relevant websites in the public domain (www.ccm.md, www.aids.md)

7.6. Contribution to the National MDG Report

Moldova initiated the process of implementing the Millennium Development Goals (MDGs) in 2003. In 2005, the Government approved the first National MDG Report, which provided an analysis of the situation and defined the national MDG indicators and targets. Several MDGs were reformulated to better reflect the country's priorities. The National Development Strategy (NDS), the main strategic planning document for the period 2008-2011, defines policies and activities aimed to achieve long-term objectives, including the MDGs. All revised MDGs and indicators are covered in the NDS

The first Millennium Development Goals Report in the Republic of Moldova, drafted in March 2005 by the Government of Moldova, made a detailed and well-grounded analysis of each of the eight goals. The document also formulated the tasks for the period 2005-2015, identified obstacles and defined medium-term and long-term priority actions, establishing at the same time monitoring tasks and indicators. The second report, developed in 2007 as part of the NDP development process, is entitled the National Report „Millennium Development Goals Report: „New Challenges – New Objectives”. In it, the Government proposed revised targets and indicators, new methodological issues in line with the current situation and progress made. The subsequent Report is expected by 2011, as part of the final review of the current NDP cycle.

The HIV National M & E System shall provide the data needed for reporting on MDG 6; the data shall feed into the general report to be compiled under the coordination of the Policy and External Aid Division, Government Apparatus, the national MDG coordinator.

7.7. Regular Information System Updates (SIME-AIDS)

An operator will maintain the SIME AIDS database at central level within the ME Unit of the NCHM. The reports generated by SIME AIDS will be used by integrating those in the other information products described in this chapter.

7.8. Ad hoc Information Needs

In addition to the specific information products listed above, stakeholders do have specific information needs. Although NCC encourages use of existing information products, the M & E Unit, to the extent of its capacities, will assist if there are any specific and ad hoc information needs that are not covered in one of the above information products. Such information will be provided after analysis of data in databases available. Such requests should be made in writing to the NCC, and will then be considered. The cost implications shall be born by the requesting agency.

Whether or not there are cost implications for the M & E Unit to provide the ad hoc information, the Unit will respond in writing to the request for ad hoc information within 5 working days of receiving such a request. The response will include:

- an acknowledgement that the request has been received
- confirmation of whether the M & E Unit has the data/skills to provide the information that has been requested
- if the M & E Unit is able to provide the information that is requested, the time frame involved for preparing the information
- the name of the contact person at the M & E Unit who will handle this information request and submit the necessary information

Chapter 8: DISSEMINATION TO STAKEHOLDERS FOR ENHANCED DATA USE

The main goal of an operational ME system is to generate quality data to further be used by decision makers to improve the national response. In order to ensure a ME culture that includes implicit use of data products of the ME system, there was an Advocacy and Communication Plan for ME developed, attached hereto.

The national ME system will be based on the following data dissemination strategies for better use of those:

- commitment for and involvement in data generation
- timely and consistent quality data dissemination
- develop different information products for different groups of people
- earmark enough funds for data dissemination
- assistance in data interpretation and use

8.1. Emailing of reports

Reports will be emailed in PDF or MS Word format and will be sent to stakeholders with e-mail access.

8.2. Web-based reports

Once the reports have gone through the consultation and approval process, these reports will be published on the NCC website (www.ccm.md), on www.aids.md and on the website of the M & E Unit.

8.3. Annual HIV and AIDS M&E Dissemination Workshop

On an annual basis, the M&E Unit will organise a national meeting where progress in the national response to HIV and AIDS will be discussed with all stakeholders. The M&E Unit will present the results of the analysed national core indicators and the resource and output tracking. Program Managers of key stakeholders will be invited to make presentations on additional indicators as required. The results of any research relevant to the fight against HIV and AIDS that was conducted during the year will be presented, if the research results warrant such exposure. The annual meeting will form a basis for refining the national response to HIV and AIDS and reviewing strategies and programs. The Workshop shall also serve as the validation forum for the Annual M & E Report.

8.4. Dissemination through the Media

The NCC will ensure that critical information is disseminated to the general public through the media. This includes inviting the media to any relevant meeting, but also disseminating relevant news and results by press releases submitted to radio and television stations and newspapers. The target audience of these advertisements is the general population. The messages will be clear and simple and reserved to news items that are relevant enough for the entire community.

8.5. National data depository / database

A comprehensive national database or data depository is yet to be developed. There is the SIME AIDS database, into which data on HIV and STI cases are fed (based on form No 2), data on treatment case management (form No 14) and data on HIV cases in pregnant women (form No 32). Other program intervention areas are not reflected, as well as the input of other key stakeholders.

The national database and depository will serve as platforms for integrating data from the health information system, data collected at local level and aggregated at district level, values for NAP indicators and for UNGASS and UA reporting.

Clear TOR for the national database and depository, and data export and communication with other information systems, such as that from the health sector, and with databases as the one maintained by the National Statistics Bureau and the Ministry of Economy and Trade (DevInfo), as well as integrating pre-existent elements (SIME HIV, SIME TB, CRIS reporting system) need to be developed. All program areas need to be properly reflected in the national database which would represent a holistic approach to disaggregated data availability and use.

Structures, mechanisms procedures and time frame for transmitting, entering, extracting, merging and transferring data into the national HIV M & E database need to be defined, as well as clear roles and

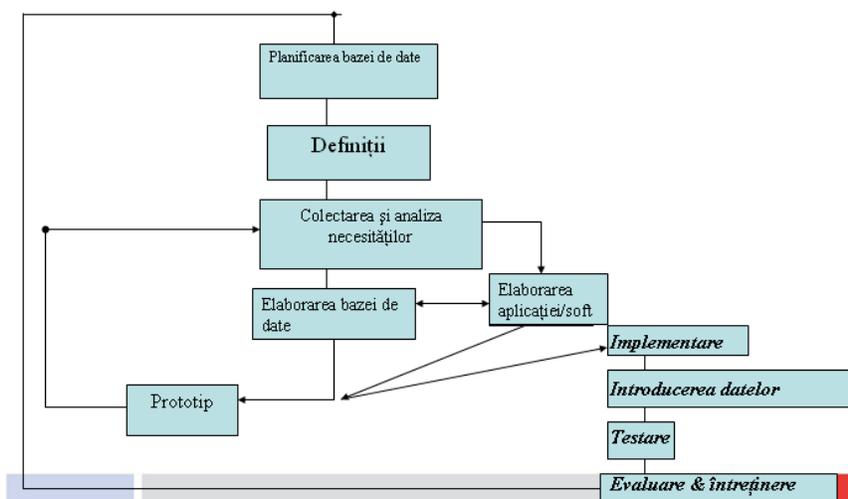
information flows to and from public and NGO service providers at local level, actors at sub-national level and central level institutions. The TWG on ME will request TA to develop the TORs for an operational database and depository and will undertake actions to mobilize funds to develop it along the following quality criteria:

- database conceived in such a way as to meet the information needs in terms of decision-making and reporting of various stakeholders
- link between the relevant databases to ensure data alignment and avoid overlapping
- comprehensive HIV/AIDS database, structured and run adequately, to collect, verify, analyze and submit data for program monitoring at all levels and across all sectors
- information system implies three operational elements: database (software), infrastructure (hardware), and skilled personnel, with strictly defined roles and responsibilities to ensure data flow.

The database will include the following components:

- values of all the national standardized indicators, as set out in the National ME Plan
- values of all indicators to be included in the international reports that Moldova committed to – UA, UNGASS, MDG
- Data from studies and surveillance
- Routine data on the progress in program implementation, at the level of service providers
- Data on the funds available and expenses by areas (NASA)
- Roster of studies and research in HIV/AIDS and research potential
- Data on training activity products / implementation of Capacity Building Plan
- Data on the advocacy and communication actions for ME

The following steps will be followed when developing the database (Figure 7):



The **data depository** will be a web platform, with various levels of access, including for the general public, which will include:

- Values taken from the database
- Information products of the ME system
- Outcomes and findings of studies, evaluations, operational research
- Reports on the progress or HIV program evaluation reports
- Reports on monitoring visits and supervisory works

- Reports of all studies and research done in HIV/AIDS, or adjacent areas, such as reproductive health, carried out in Moldova and in the region.
- Copies of the CCM bulletins, ME electronic bulletins and other information bulletins and relevant publications
- Copies of relevant materials and tools in HIV/AIDS, developed in Moldova, such as didactic materials, training manuals, guidelines etc.
- Context information relevant for HIV/AIDS
- List and contact information of the main stakeholders

The documents listed above shall also be stored in hard copies at the M & E Unit.

CHAPTER 9. MANAGEMENT OF THE NATIONAL HIV AND AIDS M&E SYSTEM

9.1. Roles and Responsibilities of Key Stakeholders

The M&E System defines the STAKEHOLDERS and is designed around the information needs of these stakeholders. Stakeholders are those persons/organizations that are either (i) involved in implementing the national HIV response, (ii) funding aspects of the HIV response, (iii) benefiting directly from the implementation of the national HIV response, or (iv) whose interests are positively or negatively affected by the HIV response.

This M&E Plan has divided its audience into internal and external stakeholders. For the purpose of this plan the internal audience are the primary custodians or program implementers, whilst the external audience perform a support role. The audience therefore includes the following stakeholders:

Table 9: Stakeholders of the M & E System¹³

Stakeholder	Category	Interests	Participation or Role
CCM (NCC)	Financer, decision-maker	To use results for planning purposes; To use ME results to develop new programs, do certain reforms, or develop further strategies etc.	Make decisions based on ME findings
National ME Unit	Implementer	To use results for planning purposes	Provider of data or information
ME focal points, TWG on ME	Implementer	To use results for planning purposes	Provider of data or information
Ministry of Health	Decision-maker	To use ME results to develop new programs, do certain reforms, or develop further strategies etc.	Make decisions based on ME findings
NCHM	Implementer	To use results for planning purposes	Provider of data or information
NAC	Implementer	To use results for planning purposes	Provider of data or information
Other health care facilities	Implementer	To use information for organization support	Make decisions based on ME findings; Be a beneficiary of reform following ME findings
Other ministries and central public administration authorities	Decision-maker	To use ME results to develop new programs, do certain reforms, or	Make decisions based on ME findings; Provider of data or information

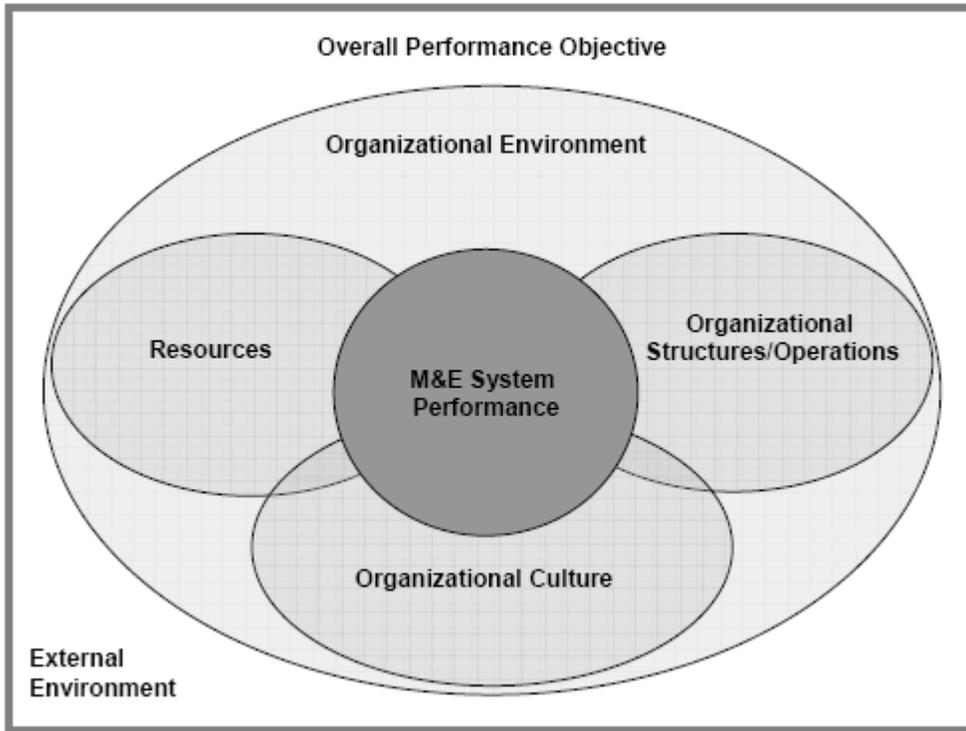
¹³ Adapted from: Enhancing Organizational Performance: A Toolbox For Self-Assessment. Charles Lusthaus, Marie-Hélène Adrien, Gary Anderson, And Fred Carden International Research Development Center, 1999.

		develop further strategies etc.	
Bilateral and multilateral donor organizations	Financer	To use results for planning purposes	Make decisions based on ME findings; Provider of data or information
District level PLA	Decision-maker	To use results for planning purposes	Make decisions based on ME findings; Provider of data or information
District level health care facility	Implementer	To use information for organization support	Be a beneficiary of reform following ME findings; Provider of data or information
Service provider, public sector	Implementer	To use information for organization support	Be a beneficiary of reform following ME findings; Provider of data or information
Service provider, NGO	Implementer	To use information for organization support	Be a beneficiary of reform following ME findings; Provider of data or information
Private sector	Financer	To use information for organization support	Be a beneficiary of reform following ME findings; Provider of data or information

9.2 Capacity Building Strategy

Many elements (resources, steps, abilities, behaviors, attitudes and actions) contribute to HIV/AIDS M&E system performance. **Capacity** is often defined as “the ability to carry out stated objectives”

(Goodman et al, 1998)



The M & E system assessment carried out in November 2008 has identified a critical shortage of qualified human resources at all levels of the national M & E system, ad-hoc approaches to capacity building, potential for overlap of capacity building due to limited communication and lack of a central database of events and excessive reliance on external technical assistance and capacity building that curtails sustainability. An inventory of the existing capacity, however limited it may be, as well as avenues for capacity building, is missing.

The Capacity Building Strategy shall be structured around the capacity needs and gaps of the key stakeholders, and shall include skills, knowledge and capacities needed at the systemic, organizational and technical level, as described below¹⁴:

System Level
<i>Definition</i>
The system level refers to the HIV/AIDS M&E system at the highest level. It reflects collective M&E functions inherent in the national HIV/AIDS program.
<i>Capacity Elements</i>
<ul style="list-style-type: none"> ■ Policymaking systems and approaches ■ Legal/regulatory actions that govern the collection and use of health-related information ■ Systems for management and accountability ■ Resources and process or interrelatedness among institutions within the system

¹⁴ Building National HIV/AIDS Monitoring and Evaluation Capacity, *A Practical Guide for Planning, Implementing, and Assessing Capacity Building of HIV/AIDS Monitoring and Evaluation Systems*, Draft April 2007

Organizational Level
<i>Definition</i>
The organizational level refers to specific organizations situated in or linked to the health system that collect and use data for the national HIV/AIDS program.
<i>Capacity Elements</i>
<ul style="list-style-type: none"> ■ Management processes ■ Communication processes ■ Human resources systems and personnel structures ■ Financial resources and planning ■ Information systems and infrastructure ■ Linkages to in-country universities ■ Organizational motivation

Individual Level
<i>Definition</i>
The individual level refers to the people whose work relates to HIV/AIDS M&E within the national HIV/AIDS program. At the individual level, capacity is focused on human resources and their behavior or actions. Here, capacity building emphasizes enhancing individual job performance (including technical and managerial skills).
<i>Capacity Elements</i>
<ul style="list-style-type: none"> ■ Job requirements ■ Skill levels and needs ■ Training/retraining ■ Individual learning ■ On-the-job training ■ Career progression and accountability ■ Access to information and personal/professional networking ■ Performance reviews ■ Interrelationships and teamwork/interdependencies

The capacity building plan that would be built on identified capacity needs and gaps, with measurable performance objectives; clearly defined outputs, and ways to track progress over time. The capacity building plan shall also aim to strengthen the formal education in M & E, laying the foundation for the development of a curriculum in M & E (with different modules, including HIV-specific) and institutionalization in the curriculum of the School of Public Health and professional in-training/refreshers courses for medical specialists, as well as in the curriculum of the University-level (bachelors and Masters programs) education for social assistants, as well as refresher training programs for social assistants and social workers.

A dynamic database of training events in M & E maintained by the Secretary of the TWG on M & E.

9.3 Technical support for M&E

In its capacity as the body responsible for coordinating the implementation the given Plan and Action / Work Plan, the TWG on ME will identify the gaps in existing capacities and will ask for internal and external TA. The UN Joint Team on HIV/AIDS will act as a broker, facilitating the access to necessary TA and providing it by making use of its either internal or external capacity, depending on the needs and topic.

9.4. Advocacy and Communications for HIV and AIDS M&E in Moldova

While data produced by the M & E system are available on the web in the public domain (for example on www.aids.md and www.sanatate-publica.md), their use in policy development, particularly by other entities than those in the health sector, is limited. While commitment for M & E for HIV exists, it is more formal and declarative than true buy-in leading to actions. M&E policy and strategies are included in the NAP and other relevant HIV policy and programs, however they are frequently the reflection of international commitments and the result of pressure from international organization, there seldom being invested efforts in a concerted manner to ensure their effective, coherent and systematic implementation. The commitment of decision-makers and managers for M & E within organizations is also declaratory – while data is requested for reporting purposes, there is little engagement for allotting human or financial resources or for capacity building and motivation of staff. The data requested by managers is more related to process indicators than impact indicators.

To address the limitations above, Moldova developed a ME Communications and Advocacy Strategy (attached hereto) that will guide advocacy for data reporting and information sharing. Through implementation of this strategy, the NCC will institute viable information sharing at all levels, improve quality of communication products and channels, and engage media in the national response.

To encourage an M&E culture, participatory reviews, best practice and research and M&E dissemination conferences and press briefings will be held on regular basis. Recommendations from M&E results, research studies, and evaluation studies will be repackaged and disseminated to policy makers, decision makers and planners as user-friendly communications products.

The NCC Secretariat and the M&E Unit, as well as the members of the M & E TWG will mainstream advocacy on data reporting and utilization in various forums including progress review workshops, dissemination conferences and management meetings.

9.5 Work plans and Budget Estimates for M&E

In order to enforce the given Plan, the TWG will develop national annual work / action plans, by indicating the interventions, cost estimates, implementation terms and responsible institutions, as well the implementation partners. This work plan will represent the main implementation and monitoring tool for the implementation of ME system strengthening efforts and will allow the identification of needs in terms of financial resources, budget fund resources for any specific intervention and budget deficits, empowering the TWG for ME to undertake resource mobilization efforts for ME.

Each stakeholder of the ME system on the other hand will draft agency / facility level plans pursuant to the National Action / Work Plan for ME.

9.6. Implementation Cycle for National M&E Action / Work Plan

This M&E Monitoring and Evaluation Plan is linked to (a) the progress review of NAP 2006-2010 implementation in December every year, and (b) the annual work planning and budgeting process. This can only be practically achieved if the M&E Information Products are available prior to the work plan being developed, and will ensure that M&E results are used to inform decision making. This can be visualised as follows:

The implementation cycle (See: Figure 7: Implementation Cycle) places a responsibility on the M&E Unit of the NCHM to ensure that the annual HIV/AIDS M&E report is available by December and that the annual HIV/AIDS M&E Dissemination Seminar takes place before work planning commences.

Figure 7: Implementation Cycle

