ASSESSMENT REPORT

HIV/AIDS M & E SYSTEM

National Coordination Council
for HIV/AIDS & TB
of the Republic of Moldova

Chisinau
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CONTENTS

EXECUTIVE SUMMARY

The Republic of Moldova has an immature National HIV M&E system in process of establishment since 2004. A mid-term review (MTR) of the National HIV/AIDS Programme (NSP) 2006 – 2010 has been completed in March 2009, the National HIV M&E system being an integral art of the Review. The main findings have been reviewed and recommendations updated during the Response Analysis that acted as the final evaluation for the 2006-2010 NAP. The M&E system assessment hereto has been reviewed accordingly, and has served as basis for the development of the National M&E Plan as an integral part of the NAP 2011 – 2015, approved by Government Decision in December 2010.

In the light of alignment of National HIV M&E system of the National HIV/AIDS Programme and the M & E of the GFATM grant, there is buy-in at highest level and commitment of stakeholders to assess the existing National HIV M&E system, identify gaps and address them in a concerted and holistic manner. The 2008 assessment has represented a comprehensive participatory process, applying a standardized tool. The 2010 review has represented a desk review, findings being discussed broadly and recommendations formulated through broad consultations.

The methodology of the participatory assessment included a multi-stakeholder assessment workshop with 7 distinct groups of stakeholders representing different institutions and levels of the M & E system, each applying a comprehensive tool for assessing the status of national HIV M&E systems, developed based on the Organisational Framework for Functional M & E Systems endorsed by MERG. The workshop has been preceded by a comprehensive desk review.

This report finds that human resources, partnerships, the planning of collection and utilization of data, as well as data quality assurance are key areas to be enhanced. The

M&E system must methodically plan all aspects of collection, verification, analysis and communication of said data, augment human and monetary capital and build capacity throughout all sectors of the national M & E system. A framework should be created to monitor and evaluate the M&E system itself so that it can continue to improve. To mandate the M&E system properly, such framework ought to be approved by the Government as an integral part of the NAP, hence gaining intersectorial and mandatory characters.

This report concludes that the standardization of all aspects of the system, augmentation of capital and capacity, and monitoring and evaluation of the system itself are necessary steps towards the improvement of the system as a whole. All aspects of the system must have explicitly stated deliverables that include budgets, timeframes and implementing partners, as well as clear actions for implementation.

BACKGROUND

Aiming at having an efficient AIDS-response, the Republic of Moldova has committed to the Declaration of Commitment and has embarked on building and strengthening the 3 Ones. The National Programme on Prevention and Control of HIV/AIDS/STIs for 2006-2010 was aligned to national strategic frameworks and to international commitments Moldova has embraced. The NAP had clear linkages to the MDG-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 new NAP document has also been profoundly anchored in national development policies and plans.

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 Programme. 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 normative framework at national level also includes relevant Laws, strategies and programmes, 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 the Law on Prevention of HIV/AIDS which has been developed largely based on the international recommendations of observance of human rights and ensuring universal access.

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. The NCC (NAC) is a decision-making body having 6 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.

There is 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 National Centre for Public Health and Sanitary Management was identified by the government to be in charge of the 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 gate-keeper to the One national monitoring and evaluation mechanism at the country level; the National AIDSS Center coordinated NAP monitoring and participates jointly with the M&E Unit in system strengthening endeavours as key national implementer. 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.

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.

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 govermental needs for reporting on the health dimensions at national and international levels.

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 behaviour 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-programme 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 aligned into the general practice of the M&E Department 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 Organisational Framework for 12 components of a functional M & E system, as part of a piloting exercise of the assessment tool developed by MERG. The piloting of the assessment has been extremely timely, as in the light of alignment of NSP and GFATM grant M & E, there is also a buy-in at highest level and commitment of stakeholders to assess the existing M & E system, identify gaps and address them in a concerted and comprehensive manner. The National M&E Plan 2006 – 2010 has been revised following the results of the Assessment.

The findings and recommendations of the 2008 M&E system assessment have been reviewed and amended in 2010 as part of the Response Analysis, and have been used for the development of the new National M&E Plan as an integral part of NAP 2011 – 2015.

OVERVIEW OF THE GOVERNANCE STRUCTURES FOR THE HIV RESPONSE

In the Republic of Moldova, the national response is coordinated by 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.

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

1. National AIDS Centre – a Department of the Centre of Preventive Medicine within the Ministry of Health, with the main responsibility of diagnosis of HIV.
2. Infectious Diseases Hospital – responsible for the treatment of PLHA. The Hospital is subordinated to the Ministry of Health.
3. The National Centre of Health Management, an institution within the Ministry of Health, responsible for monitoring and evaluation.

The National Centre of Health Management is a governmental institution founded by the Decision of the Government of Republic of Moldova No. 387 from 25.04.97 "On the foundation of the Scientific and Practical Centre of Public Health and Health Management" and reorganized in National centre of Health Management by the Decision of the Government of Republic of Moldova No. 1247 from 16.11.2007 „ On the National Centre of Health Management". The M & E Unit has been established in 2004 and is tasked with M & E of all health policies; currently M & E of the National Programme on HIV/AIDS, National TB Programme, and the Drug Observatory are operational areas of the Unit.

The National Scientific and Practical Centre of Preventive Medicine, AIDS Centre is a governmental institution founded following the adoption of the Law Nr.1513-XII from 16.06.93 on the sanitary-epidemiological safety for population.

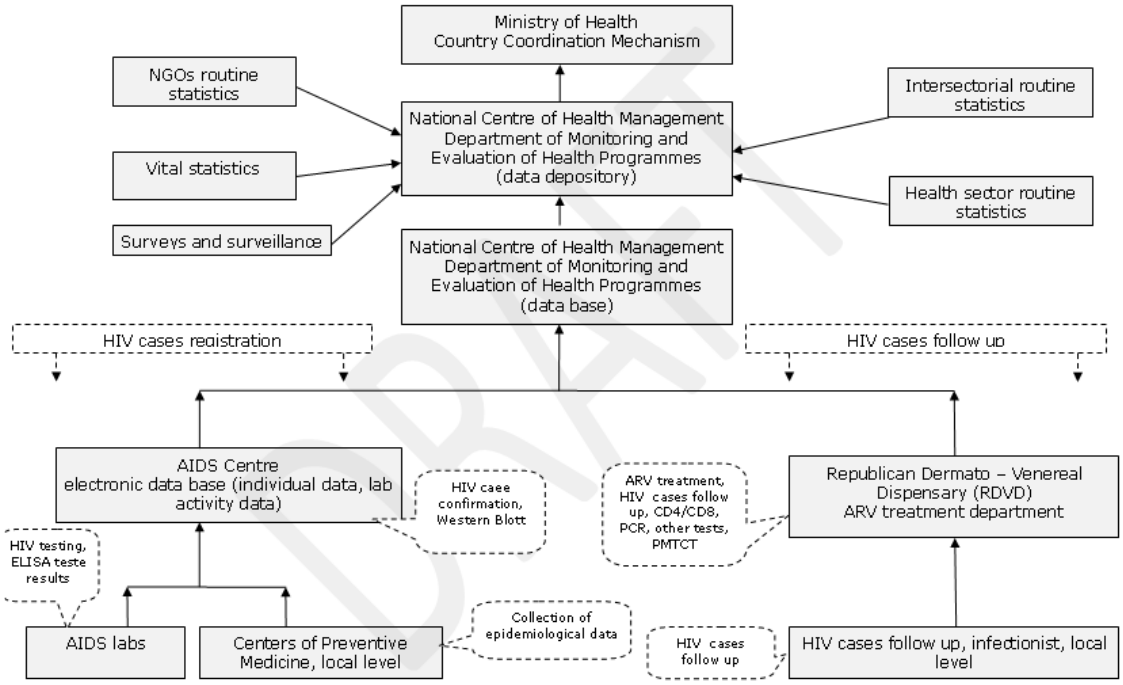
The in-patient treatment facility for AIDS patients is based on the Infectious Diseases Hospital and represents the first AIDS treatment facility in the country. Treatment has now been decentralized to regional treatment centers. A palliative care unit is expected to be established in 2010.

At local level, patient monitoring and case management is entrusted to infectious diseases specialists at primary healthcare level. The Ministry of Health intends to institutionalize an HIV/AIDS Department within the National AIDS Center, unifying the HIV/AIDS sector through unique oversight, decision making and policy development.

DESCRIPTION OF THE NATIONAL HIV M&E SYSTEM

The M & E system in Moldova is an immature system in the process of being established since 2004. Following the approval of the recommendations of the Washington Conference organized by the UNAIDS and the main donors in HIV/AIDS from April 25, 2004, regarding the necessity to implement "The Three Ones" Principle, the Ministry of Health of Moldova, together with its partners, including the Global Fund, the World Bank and UNAIDS created the concept of the national monitoring and evaluation system for the National Program on Prevention and Control of HIV/AIDS/STIs. 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 govermental needs for reporting on the health dimensions at national and international levels. The Department for M&E of National Health Programmes (M & E Unit), as a subdivision of the National Centre 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 Centre 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 data flows within the HIV M&E system, as presented in the graph below, are in the process of institutionalization. The involvement of the private sector is yet to be reflected by the system as for the time-being no HIV services are provided at that level.



Data sources

The routine health data collection system includes HIV and STI case registration and HIV clinical monitoring registration, HIV testing information and blood donors screening registration.[1]

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

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

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

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

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

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

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

[1] Scutelniciuc et al. 5-year evaluation. Republic of Moldova. Health Impact Evaluation Study Area 3. HIV/AIDS Report. Chisinau 2008. In print.

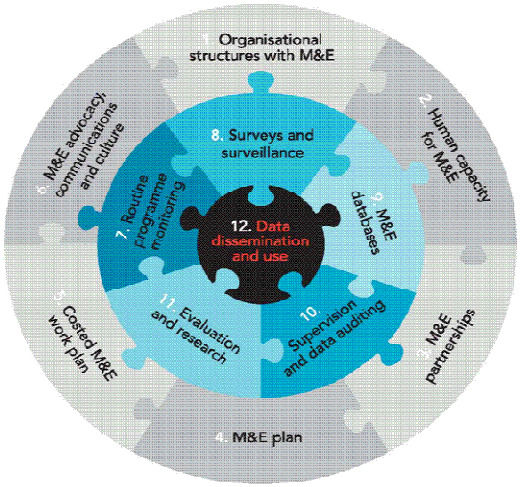
Outcome indicators collection system includes 2nd generation sentinel surveillance and population-based surveys. The 2nd generation surveillance system provides biannual collection of behavior and prevalence data from various groups (IDUs, FSWs, MSM, PLHA, MARA, inmates). Since year 2004, three rounds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

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

ASSESSMENT METHODOLOGY

To avoid duplication of effort and fragmented support, development partners have taken deliberate steps towards a unified M&E approach, culminating with the multi-agency endorsement in 2007 of an organizing framework for a national, multi-sectoral HIV M&E system, based on a common vision for what constitutes a fully functional M&E system and concerted actions to strengthen the system that would capture the data for the national HIV response and measure the achievement of HIV response objectives, hence contributing to programme improvement This framework describes twelve components of an HIV M&E system and some key performance elements against which to judge implementation progress. A single tool to assess the status of national HIV M&E systems, based on the Organisational Framework has been developed by Technical Work Groups under the auspices of MERG, and Moldova has been selected to pilot the assessment tool in November 2008. The methodology included a multi-stakeholder assessment workshop, with 7 distinct groups of stakeholders representing different institutions and levels of the M & E system applying a comprehensive tool, preceded by a comprehensive desk review.



The assessment covered the following 12 core areas:

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

Collecting, verifying, and analyzing data:
7. Routine HIV program monitoring;
8. Surveys and surveillance;
9. National and sub-national HIV databases;
10. Supportive supervision and data auditing;
11. HIV evaluation and research.

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

ASSESSMENT RESULTS:

Component 1. Organizational Structures with HIV M&E Functions. Strengths and weaknesses, steps to be done

Component description

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 HV/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.

Across levels, access to external technical assistance has been assessed from average to good, however the needs for technical assistance have been indicated as not fully/timely assessed.

Gaps and weaknesses identified

- Lack of mandate in HIV M & E across sectors and levels
- M & E responsibilities frequently an afterthought; no capacities or additional motivation for appointed M & E focal points
- Current human resources may be insufficient due to increasing complexity and multisecorality of the HIV M & E system

Recommendations for further action

- Explicit mandate for HIV M & E across sectors and levels
- Framework for continuous data flows – based on an improved coordination framework between sectors and levels; mechanisms to include reporting of data from Transnistria need to be in place
- The role of M & E Unit as national data depository needs to be explicitly mandated
- Continuous capacity building for existing resources
- NCC needs to recommend Ministries to create M & E Units or focal points; further capacity building in HIV/AIDS for these newly established systems

Component 2. Human Capacity for Multi-sector HIV M&E. Strengths and weaknesses, steps to be done,

Component description

The assessment 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 (with the notable exception of www.aids.md that has a dynamic events platform) 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. Capacity assessments, somewhat tangential, have been carried out in the process of GFATM Round 8 proposal formulation and MTR 2008 of the NAP.

Curricula for modules on M & E as part of the standard University education are lacking. Another missing link is 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. In order to be able to build supportive supervision and mentoring in the capacity building plan, the capacity of the staff of the M & E unit, as well as other key staff responsible for supervising the data collection and aggregation process and levels, also needs to be strengthened. The 5 Year Evaluation of GFATM has pointed out the need for capacity building for extending the data coverage, increasing the data quality and strengthening the existent M & E system.

Among critical capacity gaps, participants have listed projections, modelling and estimation skills and capacities.

A barrier identified in human resources strengthening is the limited motivation and professional growth of M & E staff. For example, the public service inventory does not include the position of specialist in M & E in the list of professions, hence the motivation to pursue an education in M & E is limited.

Gaps and weaknesses identified

- Missing inventory of the existing capacity and avenues for capacity building
- No higher education in M & E. The School of public health provides a Masters programme only for graduates of the Medical University
- No database/common pool of experts
- No database of M & E capacity building events ongoing
- Lack of a capacity building plan
- Assessment of needs and gaps not done; regular assessments and milestones – ability to measure implementation of capacity building plan

Recommendations for further action

- 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/refresher courses for medical specialists, as well as in the curriculum of the University-level (bachelors and Masters programmes) education for social assistants, as well as refresher training programmes for social assistants and social workers
- Inventory of capacity gaps, needs, and capacity building avenues
- Database of training events in M & E maintained by the TWG on M & E (could be decentralized to a umbrella organization to avoid overstretching of the TWG capacity)

- Amending the public service inventory to include the position of specialist in M & E, to ensure formal recognition and space for professional growth
- Introducing M & E capacity assessments in the framework of accreditation and job performance evaluations

Component 3. Partnerships to plan, coordinate and manage the multi-sector HIV M&E system. Strengths and weaknesses, steps to be done

Component description

There is a joint TWG on M & E for HIV, STIs and TB, and a TWG on Surveillance under the National Coordination Council. Formal TORs are missing, only main areas of work are outlined in the NCC TOR. There is an unclear relationship between the M & E TWG and the Surveillance TWG, and a fair degree of overlap in membership.

The membership of the TWG on M & E is outdated and limited to representatives of institutions from the health sector. The membership ought to be revised/completed to make the TWH more intersectorial but also to include representation at technical rather than decision-making level as it stands now as current composition makes it difficult to operationalize the TWG. Currently the TWG acts more as a clearance mechanism for surveys and surveillance and other M & E concepts and documents; the technical work is left to the M & E Unit overstretching the limited human resources available in the Unit. The civil society is not represented in the formal membership of the TWG, even though participation in meetings is open. The membership currently is limited to organizations/entities at central level.

According to the TOR of NCC TWGs, meetings are to be held on a quarterly basis, however they happen about twice a year. Meetings can be convened on an ad-hoc basis should the need arise. Minutes of the TWG meetings are taken and placed on the NCC website (www.ccm.md, www.aids.md). Information pertaining to the TWG work is disseminated also through the NCC Bulletin. However, there is no formal mechanism to follow up on the decisions of the TWG.

Gaps and weaknesses identified

- TORs of the TWG are missing; from the description of areas of work that currently exists, the relationship with the Surveillance TWG is unclear
- The membership is at decision-making level, making it difficult to have truly technical mechanism actually performing the tasks of a WG; membership is limited and not intersectorial in nature
- There are no formal mechanisms to ensure consensus-building within the TWG and follow-up of the decisions of the TWG

Recommendations for further action

- review membership; in the meantime – practice of inviting non-members

- include civil society representatives, representatives from other Ministries, local public administration, as members of the TWG
- develop clear TOR and annual work plan for the TWG
- capacity building for the TWG on M & E strengthening capacity but also enhancing coordination and working together
- based on the TWG work plan, implement the practice of joint field visits and other monitoring mechanisms
- develop a conflict resolution policy aiming to develop consensus-based decision-making at TWG level – could later be extrapolated to the NCC

Component 4. National, mulit-sectoral HIV M&E Plan. Strengths and weaknesses, steps to be done

Component description

The National M & E Plan 2006 – 2010 has been developed based on the NAP and is also used as basis for the M & E Plan for the GFATM Round 6 grant; however, it needs further development to meet the key criteria formulated for a functional framework for the M & E system. Important compartments of the Plan are underdeveloped, as a clear organizational framework; other parts are completely missing – as the strategy for assessing quality and accuracy of data, a data dissemination and sue plan, a section on operations research and evaluations.

Among strengths of the M & E Plan, it should be mentioned that indicators are well defined operationally and are documented to assure comparability from various sources. Data sources, measurement methodology, frequency of data collection are specified.

The M & E Plan has been developed with limited meaningful participation of stakeholders – the Plan has been developed by the TWG on M & E in its current limited membership, with the participation of only one umbrella organization – the Soros Foundation. While it has been circulated broadly for comments, most stakeholders have simply endorsed it without further input. Amendments to the Plan need to be operated in a transparent and consultative manner, perhaps in a workshop that would also entail some capacity building in M & E for stakeholders to make informed contributions.

The M & E plan is not costed per se, however the cost of data collection exercises envisaged is provided for in the budget of the relevant institution and in the budget of the Round 6 proposal. The GF contribution is landmark for the full operationalization of the national M & E system and for the implementation of the M & E Plan, as only 2-4% of the total HIV programme funding allocated by the government is earmarked for the M&E plan. The resources committed to the implementation of the M & E Plan are still not sufficient, as the M & E costs can be estimated at around 4% of the NAP costs, far below the recommended 10%.

Gaps and weaknesses identified

- limited participation in the development of the M & E Plan due to failures of the process, but also due to capacity limitations
- missing blocks of the 12 component system in the M & E Plan
- indicators to monitor progress & performance of the M&E system are missing
- discrepancies between the indicators that comprise the national indicator set and the activities envisaged under NAP

Recommendations for further action

- amending the National M & E Plan based on existing best practices, through a consultative process
- developing mechanisms for monitoring the implementation of M&E plans and budgets, at national as well as sub-national and institutional levels
- Capacity building for NGO and other service providers for developing agency-level M & E plans and their implementation
- Costing and operationalizing the M & E Plan with explicit work plans, with clear indication of costs, funding gaps, responsibilities and leading agencies

Component 5. Costed, National, multi-sector HIV M&E Work Plan. Strengths and weaknesses, steps to be done,

Component description

The National M & E Plan needs to be operationalized by a costed workplan to include priority actions, roles and responsibilities of stakeholders, timeframes and budgets, which is currently missing. Participants in the assessment workshop felt that the work plan of the GFATM Round 6 grant, which currently funds almost exclusively the national M & E system, acts as a surrogate costed M & E work plan. However, for sustainability purposes as well as enhanced national ownership and coverage of the M & E work plan, the TWG WG ought to develop a separate document.

Gaps and weaknesses identified

- the M & E work plan is missing; the GFATM Round 6 project work plan acts as a substitute work plan
- M & E budgets provided for the in the GFATM work plan are severely underestimated; there are critical financial gaps.
- Clear time periods and responsibilities in implementation of the M & E work plan are missing
- The M & E system is funded almost exclusively from international sources (GFATM preponderantly, as well as bilateral and mutlitateral development organizations), hence sustainability is severely curtailed

Recommendations for further action

- Costing and operationalizing the M & E Plan with explicit work plans, with clear indication of costs, funding gaps, responsibilities and leading agencies, as well as time periods
- Costs related to the implementation of the M & E wok plan need to be included in the Government mid-term expenditures framework to ensure a greater share of funding from the state budget
- Joint resource mobilization based on the costed work plans

Component 6. Communication, Advocacy and Culture for HIV M&E. Strengths and weaknesses, steps to be done,

Component description

The component on communication and advocacy for M & E has received overall more positive ratings as there are efforts in the field of communicating the results of M & E activities and disseminating data, as well as efforts to ensure transparency and communication regarding various aspects of the national response, including M & E system performance and outcomes. However, the sub-national and service providers level are less included in the reporting mechanisms and hence the data related to their efforts as part of the M & E system are less available.

Assessments of the M & E system are not carried out in a systematic manner, but rather on an ad hoc basis, as needed for example for UNGASS reporting or for reporting to the GFATM or other major donors.

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 programmes, 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.

Gaps and weaknesses identified

- commitment for HIV M & E if frequently formal and declaratory at all levels of decision-makers
- communication of M & E data is incomplete – the contribution of other sectors and the sub-national and service provision level is less reflected

- gaps in communication may lead to overlap of activities planned and carried out

Recommendations for further action

- standardization of HIV M & E information products would enhance quality, comparability and use
- a regular information-sharing mechanism needs to be endorsed by all stakeholders from all sectors and at all levels
- a strategy advocating for HIV M & E and data use in planning needs to be designed, or incorporated in the Framework for HIV/AIDS Communication designed by the TWG on Prevention and Communication
- sub-national and sector level strategies for communication and advocacy for HIV M & E need to be developed based on the national strategy

Component 7. Routine HIV Programme Monitoring. Strengths and weaknesses, steps to be done,

Component description

Seven main programme areas have been selected for assessing routine monitoring systems: prevention among the general population, prevention among youth, prevention among key populations at risk, VCT, treatment and care, social services and support, and M & E and surveillance. The assessment indicated that while systems for routine monitoring of VCT and treatment and care are quite well designed, and the M & E and surveillance, and prevention among key populations in at risk also has systems in place, the prevention interventions in the general population and among young people and social services and support are severely lacking proper routine monitoring mechanisms.

There are national guides and standard forms available: the National Epidemiological Surveillance Standard, the HIV case reporting forms, treatment case management forms, VCT reporting forms, instructions for statistics reports produced by the Ministry of Health (for HIV and STI cases). Other programme areas lack guides or instructions. The national standards and instructions available reflect data collection mechanisms from public service providers; with the exception of the VCT routine monitoring system, there are no guides related to mechanisms for data provision by the civil society.

Most of the reporting is still paper based. All source documents are available at the sub-national (district) level for audit purposes. During oversight field visits undertaken by the National AIDS Center, the quality of data is checked and feedback offered. Mechanisms for ensuring confidentiality of data need to be further strengthened. Technically, double reporting on the use of services is possible – the unique identifier is needed for a clear overview of the true demand for services while maintaining confidentiality.

While program monitoring indicators have operational definitions that meet international standards for interventions related to treatment and care, VCT, prevention

among key populations at risk and M & E and surveillance, in other programme areas indicators are yet to be standardized.

Gaps and weaknesses identified

- prevention interventions in the general population and among young people and social services and support are severely lacking proper routine monitoring mechanisms
- national guides are not available in all programme areas
- the national guides and systems in place do not account properly the contribution of the civil society; data provision of civil society is done on a more ad-hoc basis and lacks proper standardization
- not all indicators have operational definitions that correspond to international standards
- information systems for reporting are underdeveloped
- confidentiality and data quality assurance mechanisms are underdeveloped

Recommendations for further action

- national guidelines, including standardized indicators with operational definitions corresponding to international standards, need to be fully developed for all programme areas
- mechanisms for regular and standardized reporting by the civil society need to be designed
- SIME HIV needs to be operationalized form the data input level and the end users level
- The unique identifier mechanism needs to be implemented to ensure confidentiality and avoid double reporting

Component 8. Surveys and Surveillance. Strengths and weaknesses, steps to be done,

Component description

While a formal inventory of surveys has not been carried out, the GFATM Round 6 project work plan stipulates the majority of surveys designed to monitor the NAP as they are to be funded from the respective grant. The survey results are disseminated widely through the websites form the public domain and the NCC TWG.

The national level Workplace survey has been carried out for the first time in 2008; there are yet no plans as to the periodicity of such surveys.

There is a National Epidemiological Surveillance Standard developed according to international guidelines. All surveys include the survey protocol and questionnaire. There is also an Ethics Commission that clears the surveys.

Gaps and weaknesses identified

- an inventory of surveys has not been developed
- operational research is underdeveloped
- overreliance on external funding for carrying out surveys

Recommendations for further action

- the national M & E Plan needs to include planned surveys and timeframes for their completion
- mechanisms ought to be designed for better involvement of local public authorities, civil society and local public service providers in carrying out surveys

Component 9. National and Sub-national HIV databases. Strengths and weaknesses, steps to be done

Component description

A comprehensive national database is yet to be developed. There is the SIME HIV 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 programme intervention areas are not reflected, as well as the input of other key stakeholders.

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. The national database ought to integrate 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.

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.

IT equipment and supplies are available at the level of central institutions from the health sector, while the sub-national and service provision level, particularly the providers of social services and support, are not covered.

Human resources currently existing are not sufficient to develop, maintain and update the database; capacity building of existing and new human resources is needed.

Gaps and weaknesses identified

- SIME HIV not operational; confidentiality issues need to be addressed and capacity building in the use of SIME HIV needed
- Other components of the national database missing

- Mechanisms for regular intersectorial reporting, as well as reporting by the civil society, missing
- Accessibility of data limited to formal dissemination endeavors

Recommendations for further action

- Clear TOR for the national and sub-national database, and data export and communication with other databases as the one maintained by the National Statistics Bureau and the Ministry of Economy and Trade (DevInfo) need to be developed
- All programme 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
- Availability of the data from the database on an online public domain real time platform
- Mechanisms for data validation and data quality assurance in place

Component 10. Supportive Supervision and Data Auditing. Strengths and weaknesses, steps to be done,

Component description

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 form different sources may vary, such inconsistencies affecting planning for better programme 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. Data quality needs to be enforced in terms of its 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.

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.

A data quality protocol is missing. It ought to be developed in order to verify that appropriate data management systems are in place; verify the quality of reported data for key indicators; and contribute to improvements in M&E through systems strengthening and capacity building

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. National guidelines and tools for supportive supervision on M&E are lacking. 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 National Health Management Center and the National AIDS Center carry out oversight and data auditing. Feedback mechanisms and monitoring implementation of recommendations however are lacking.

Gaps and weaknesses identified

- Protocols for data auditing exist, but they are not specific for the National HIV M & E Plan
- No mechanisms for regular triangulation of data
- Supportive supervision guidelines and tools lacking
- National guidelines and tools for supportive supervision on M&E are lacking

Recommendations for further action

- Data quality assurance/data auditing protocols developed and included in the National M & E Plan
- Mechanism for regular triangulation of data institutionalized
- National guidelines and tools for supportive supervision on M&E developed and included in the National M & E Plan

Component 11. HIV Evaluation and Research Agenda. Strengths and weaknesses, steps to be done,

Component description

While some evaluations occur in the framework of the National programme on HIV/AIDS/STIs, including joint multi-stakeholder mid term and end programme 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.

The TWG on M & E is in charge for coordination and implementation of research and evaluations.

The priority research topics indicated include elucidation of the role of injection drug use in HIV infection among pregnant women, female sex workers and MSM; determining if new HIV cases with so-called heterosexual transmission did not have other risk factors (IDUs or MSM) or were not sexual partners of IDUs; gender associated vulnerabilities to HIV; studying the factors driving adolescents to adopt risky behaviors (particularly 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; 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.

Establishment of a review committee to assess the compliance with ethical standards of studies conducted on human subjects has been deemed as imperative. Current Ethical Commission mostly exst in name, with unclear membership and procedures of review.

Relevant international and regional HIV research and evaluations findings, as well as the experience of comparable countries and epidemics, are being used in policy formulation, planning and implementation.

Financial resources are almost exclusively international.

<u>Gaps and weaknesses identified</u>

- Certain members of the NCC display reservations regarding the feasibility of mid-term and final programme evaluations
- An inventory of research and evaluations planned, in process and/or completed, and of the local research/evaluation capacity, is missing
- operational research as underdeveloped

<u>Recommendations for further action</u>

- Compiling and regularly updating a national inventory (register/database) of HIV research, and evaluation institutions and their activities in the country
- Advocacy for evaluations and research based on the Advocacy for M & E strategy to be developed under component 6, and advocacy for resource allocation
- Developing a prioritized national HIV research and evaluation agenda
- Assessing the feasibility of establishing a national team/committee responsible for coordinating and approving (new) HIV research and evaluations
- Developing procedures for approving (new) HIV research and evaluations
- Developing operational research

Component 12. Data Dissemination and Use. Strengths and weaknesses, steps to be done.

Component description

While the M & E system assessment has commended the transparency and availability of data, it has pointed out the somewhat sporadic nature of data provision, has identified certain actors missing form the information flows, and has identified the need for a clear data dissemination and use plan, that would institutionalize information and data flows and would enhance data use for policy making.

The data needs of various stakeholders have never been assessed. The data collection is guided by NAP and international reporting commitments, while needs of different actors are not properly accounted for. Some data is disseminated without the proper interpretation on in a complicated and overly technical manner, making it virtually unusable by the majority of actors, particularly decision-makers that seldom have the scientific expertise.

Dissemination of data ought to be done in a more systematic manner. Currently it is done in an ad-hoc manner, and some data may be disseminated through a variety of means (websites, e—newsletters, NCC Bulletin), while other may fall through the cracks. Standardization of dissemination channels is needed – currently, most of the dissemination is done through e-mail or by making data available online, which may not be convenient for local level service providers with limited internet connectivity.

There is some evidence of use of M & E data for strategic planning. Data from the second generation surveillance researches/studies are used for the strategic planning especially in the process of scaling up HIV/AIDS control and prevention activities and services. All prevention campaigns are based on Knowledge, Attitudes, practices and behaviors studies, as well as impact studies realized post campaigns. However, data should be used in a more systematic manner to guide policy development and sharpen the focus of programme implementation. Estimations and projections are not being carried out.

Gaps and weaknesses identified

- Stakeholder information needs have not been assessed
- Data interpretation and modeling and estimations epidemiological capacities are underdeveloped
- Dissemination of data performed in an ad-hoc manner
- Some data is disseminated in a complicated and overly technical manner, while decision-makers seldom have the scientific expertise.
- Data disseminated primarily via electronic communication channels, while local level service providers have limited internet connectivity.

Recommendations for further action

- Assessing stakeholder information needs to guide further M & E planning
- Standardization of dissemination channels

- Developing a data dissemination and use strategy, including a component on advocating for enhanced data use
- Dissemination channels need to be standardized and diversified

CHALLENGES AND PRIORITIES FOR ACTION

In conclusion, the 2010 review has indicated that some important progress has been registered since the 2008 review, particularly in regard to participatory assessment of M&E system and development of adjusted M&E Plan that strengthened capacities and commitment of national stakeholders, as well as important initiatives to develop estimations and projections, undertake meta-analysis to estimate modes of transmission and triangulate data sources to assess status of the epidemic and impact of prevention programmes. The coordination of M&E system and its effectiveness has been enhanced by the NAC newly-established Coordination Unit that acts as an additional layer ensuring implementation oversight, hence permitting the more independent data audit and evaluation roles of the M&E Unit that serve as data validation mechanisms.

Challenges

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

Priorities

- Comprehensive national M&E system for health is needed to avoid redundancies and parallel reporting;
- Inter-sectoral collaboration between stakeholders involved in the national HIV/AIDS response ensures the quality of data, accessibility of information and the implementation of findings into the policy process;
- One body responsible for M & E, with clear framework for data collection, analysis, dissemination and use, and sufficient allocations from the state budget are ingredients of a successful M & E system;
- In-depth, comprehensive assessments of the components of M & E system are imperative for identifying weaknesses and strengthening the system;
- An efficient and time-bound M & E Plan is a precondition for effective development of the M & E system and an asset to the quick estimation of funding gaps;
- A national research, OR & evaluation agenda is needed to avoid overlap and strengthen the strategic information base consistently;
- Capacity building in M & E for all players, at all levels is critical to the enhancement of data quality and its implementation into policy;

- Developing and institutionalizing data quality assurance mechanisms is imperative for enhancing the focus of the national response;
- Confidentiality of data issues need to be properly addressed;
- A comprehensive national database needs to be developed to strengthen data use;
- Consistent and consequential data dissemination activities need to be undertaken to enhance evidence-based planning and implementation in the framework of the national response;