ASSESSMENT REPORT:

HIV/AIDS M & E SYSTEM

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

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CONTENTS

EXECUTIVE SUMMARY

The Republic of Moldova has an immature National HIV M&E system in the process of establishment since 2004.

A mid-term review (MTR) of the National HIV/AIDS Programme (NSP) 2006 – 2010 is ongoing, the National HIV M&E system assessment being envisaged as part of the Review. 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 also 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 National HIV M&E system has never been assessed in a comprehensive participatory manner applying a standardized tool.

The methodology of the assessment hereto 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.

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 is aligned to national strategic frameworks and to international commitments which Moldova has embraced. The NAP has clear linkages to the MDG-centered National Development Strategy for 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 is composed of 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 Working Groups functioning under the NCC 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 NAP is primarily funded by international donor assistance and the Moldovan government which contributes approximately 20 % of the total. 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 approved a new Law on the prevention of HIV/AIDS which had been developed based on international recommendations for the observance of human rights and the ensurance of universal access.

There is one coordinating entity in Moldova for the control of TB/HIV : the National Coordination Council, which includes government stakeholders, representatives of people living with HIV, NGOs and the international community. The NCC (NAC) is a decision-making body having 7 functional technical 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 government also endorses 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 M&E Unit monitors the set of indicators which was developed and agreed upon by all stakeholders to support monitoring and evaluation and to ensure regular UNGASS reporting with all of the proper consultations and data collection. The first outputs of the M&E Unit were the participatory development of the UNGASS reports for 2003-2005 and 2005-2007. Two important outcomes have been the unified methodology on M&E, as stipulated in the National M & E Plan, and the unified national indicator set. Under the auspices of the NCC, a multi-stakeholder technical working group (TWG) on M & E works towards improved data quality and better information flows in the routine statistics, as well as improved national capacities in operational research.

The routine health data collection system includes HIV case registration, data on geographic and gender distribution, socio-economic status and way of transmission. A 2nd generation surveillance system is under development, which will provide for the biannual collection of behavior and prevalence data from 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 still some inherent weaknesses:

- Lack of some institutionalized routine reporting mechanisms for inter-sector reporting
- Limited allocations from the state budget and overreliance on international financial support which curtails sustainability
- Gaps in national technical expertise
- Lack of size estimations of vulnerable population groups
- Barriers to full coverage and comprehensive M & E of the region, due to political constraints around the separatist region of Transnistria
- Non-implementaion of operational research for the evaluation of activities
- Gaps in the 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 the framework of developing proposals to GFATM where resources had 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 Round 1 and Round 6 of the GFATM projects. The monitoring of the Global Fund grant performance has been streamlined into the general practice of the M&E Department in an effort to reduce overlap and double reporting.

The purpose of the 2008 mid-term review of the NAP, was to evaluate the NAP implementation, to identify gaps, 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 had been planned and implemented according to the Organisational Framework for 12 components of a functional M & E system, which was part of a piloting exercise of the assessment tool developed by MERG. The piloting of the assessment was extremely timely, as in light of the alignment of NAP 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.

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 which each applied a comprehensive tool, preceded by a comprehensive desk review.

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 the technical level, the Ministry of Health chairs the NCC and maintains the NCC Secretariat, thus leading a large role in implementation of the NAP.

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

1. National AIDS Centre – a Department of the Centre of Preventive Medicine within the Ministry of Health, who is primarily responsibile for the diagnosis of HIV.
2. Republican Dermato-Venerological Dispensary – a subordinate of the Ministry of Health who is responsible for the treatment of PLHA.
3. 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 Decision No. 387 (25.4.1997) of the Government of the Republic of Moldova, "On the foundation of the Scientific and Practical Centre of Public Health and Health Management." It was transformed into the National centre of Health Management, by the Decision of the Government of Republic of Moldova No. 1247 (16.11.2007), “On the National Centre of Health Management". The M & E Unit was established in 2004 and is responsible for the 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 after the adoption of the Law Nr.1513-XII (16.06.93) on the sanitary-epidemiological safety for the population.

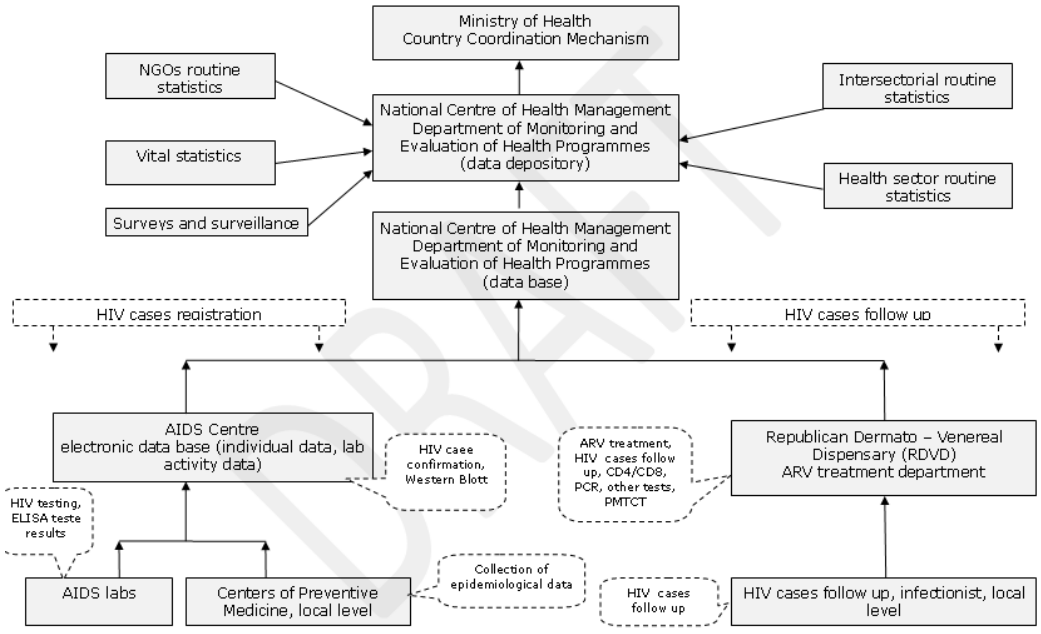
The in-patient treatment facility for AIDS patients is based on the Republican Dermato-Venerological Dispensary. A palliative care unit is expected to be established in 2010 based on the RDVD.

At the local level, patient monitoring and case management is entrusted to infectious diseases specialists at a primary healthcare level. The Ministry of Health intends to institutionalize an HIV/AIDS Department, 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 on April 25th, 2004), regarding the necessity to implement "The Three Ones" Principle, the Ministry of Health of Moldova, together with its partners, 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 statistic data and public health related data to the National Statistics Bureau, which is 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 being institutionalized. The involvement of the private sector is yet to be reflected by the system, because currently no HIV services are provided at that level.



In an effort to improve routine statistic data, a new software was developed, with the support of the World Bank, the GFTAM and UNAIDS, for HIV case reporting and follow-up treatment., A separate module was developed for STI case reporting. According to the design of the SIME AIDS system, the information should be centralized and electronically stored in the M&E Department. However, the patient's data ought to be aggregated and any personal identification removed to observe confidentiality requirements according to the Law on HIV/AIDS was adopted in 2007. Within the framework of the GFATM 5 Year Evaluation, data on registered HIV cases have been entered retrospectively in the data base at the national level (about 4000 cases) and located in AIDS centre, the only institution mandated to store nominal data at the national level. The informational flow is to be adjusted based on confidentiality principles and different access rights at different levels regarding individual's HIV-related information. The use of new software will reduce the burden of errors occurring from manually processing data. The issue of connectivity between different levels and institutions involved in the collection of data is critical for the design and implementation. It is based on existing connectivity to assure the sustainability of the service. The equipment has been procured to ensure connectivity within the system.

Creation of a data depository that will store validated data from all available sources is part of an M&E data use and dissemination strategy that is under development.

ROUTINE STATISTICS

The diagnosis is established when the person undergoes 2 positive screening test type ELISA and is 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 local level preventive medicine doctors are responsible for the data collection of the newly registered HIV. Demographics, probable route of transmission, family members' data, employment, pregnancy data, and risk factors are the most important data that needs to be collected. The paper based filled forms are sent to the AIDS Centre, 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, timeliness and accuracy. When a person who 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 the confirmation test – Western Blot. The confirmation test is performed only at national level, by the AIDS Centre, which is why there is no variation in the number of newly registered cases. Due to the fact that the date of the Western Blot confirmation is counted as the 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 a previous validation study and electronic system. Iinconsistencies, particularly those related to cases from the left bank of the Dniester River (Transnistria region), are explained by delays in confirmation due to one

single reference laboratory which confirms the HIV cases, located on the right bank of the Dniester River (capital city of Chisinau), and reduced number of ELISA positive samples referred for confirmation from the left bank of the Dniester River. These two phenomena are due to political tension surrounding the frozen conflict in the region[1].

The follow up of HIV cases is conducted by the infectionist at the local level and by the ARV department in the Republican Dermato – Venereal Dispensary (RDVD). The data collected at this level are related mainly to the pre ART follow up and ART monitoring. After confidentiality issues about the SIME AIDS data base have been addressed, the RDVD can start the retrospective data entry of HIV cases that have ever been under follow up.

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 of 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 a 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 a 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 was conducted prior to 2008. At the national level, 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 of syphilis testing is part of the RDVD reporting system. The system is a vertical one in terms of distribution of tests and reporting. Due to centralized TPHA tests release and the involvement of a single institution, the probability of significant bias is low. Data are available only for the right bank of the Dniester River.

The blood safety system has its own information system to store the data of donors. The probability of duplication/losing of cases is low. Data are available only for the right bank of Dniester River.

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 from an M&E officer from the Soros Foundation – the umbrella organization for NGOs working in the field of Harm Reduction.

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

[1] As a result of a secessionist conflict that evolved into 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. Thus, 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.

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, and is expected to act as a data validation mechanism.

SURVEYS AND SURVEILLANCE

Studies on Knowledge: Attitudes and Practices related to HIV/AIDS among the general population.

Quantitative research, in the form of 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, multistaged and quasi-probabilistic. The surveys are considered representative of 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 ±3% for both surveys. The data collection tool has been adjusted to international reporting standard for core indicators that makes the results comparable at a 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).

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

Quantitative research conducted in 2006 (1190 respondents) (Scutelniciuc, 2006) and repeated in 2008 (1182 respondents) (Scutelniciuc, 2008), was comprised of 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 methods were stratified, multistaged and quasi-probabilistic. The surveys are considered representative of 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 ±3% in both cases. Both surveys used the same data collection tool and the same sampling methodology which makes them comparable. The data collection tool has been adjusted to international reporting standard for core indicators which make the results comparable at a global level.

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

The fisrt Behavioural and Sentinel Surveillance Survey (BSS) for IDUs was conducted in 2001 (200 respondents) (CIVIS, 2001), repeated in 2003/2004 (507 respondents) (Bivol, 2004) and 2007 (630 respondents) (Scutelniciuc & Bivol, 2008). All surveys targeted exclusively the beneficiaries of Harm Reduction Programmes services. The first two surveys used the time location cluster sampling, multicentric, cross-sectional, questionnaire-based and were not combined with qualitative testing for

the presence of antibodies in 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 multicentric, cross-sectional and two-stage cluster sampling design-based questionnaire that was 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 a global level. Overtime the international recommendations for construction of core indicators have changed, the comparability between data points have been reduced. The fact that the target of these surveys were exclusively IDUs - beneficiaries of Harm Reduction Programmes - reduces the survey's quality of representation. Consequently, results could not be extrapolated for the entire IDU population. The staff and volunteers of the Harm Reduction Programmes were recruited as interviewers because they could inspire the respondents to participate in the survey thus reflecting the prevention aspects of the projects.

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

The fisrt Behavioural and Sentinel Surveillance Survey (further BSS) for Commercial Sex Workers (CSWs) was conducted in 2003 (150 respondents) (Wolrd Health Organization Regional Office for Europe, 2004), repeated in 2004 (149 respondents) (Scientific and Practical Centre of Public Health and Sanitary Management, 2006) and again in 2007 (496 respondents) (Scutelniciuc & Bivol, 2008). All surveys targeted exclusively the beneficiaries of Harm Reduction Programmes services. In all three surveys 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 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.

Data collection tools have been adjusted to international reporting standard for core indicators thus making the results comparable at a global level. Overtime the international recommendations for construction of core indicators have changed, the comparability between data points has been reduced. The fact that the target of these surveys were exclusevly the CSWs - beneficiaries of Harm Reduction Programmes – reduce the representativity of the surveys and results could not be extrapolated for the entire population of CSWs. The staff and volunteers of the Harm Reduction Programmes were recruited as interviewers because they could inspire the respondents to participate in the survey thus reflecting the prevention aspects of the projects.

Behavioural and Sentinel Surveillance Surveys related to HIV/AIDS among the MSM population.

The fisrt BSS within the Men who have Sex with Men (MSM) was conducted in 2003 (118 respondents) (Wolrd Health Organization Regional Office for Europe, 2004), repeated in 2004 (121 respondents) (Scientific and Practical Centre of Public Health and Sanitary Management, 2006) and again in 2007 (94 respondents) (Scutelniciuc & Bivol, 2008). All surveys targeted exclusively the beneficiaries of Harm Reduction Programmes 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 of a poor quality due to its smaller sample size and broken rules in its data collection process (Scutelniciuc & Bivol, 2008).

The data collection tools have been adjusted to international reporting standard for core indicators which makes the results comparable at a 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 Programmes - reduce the representativity of the survey and results could not be extrapolated for the entire MSM population. The staff and volunteers of the Harm Reduction Programmes were recruited as interviewers because they could inspire the respondents to participate in the survey thus reflecting the prevention aspects of the projects.

ASSESSMENT RESULTS

1. Organizational Structures with HIV M&E Functions.

Component Description

The National Coordination Council acts as a decision-making and coordination forum for the national M & E system; there is a permanent Technical Work Group that focuses on M & E under the NCC. The mandate for M & E is in the NCC's TOR.

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

- 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 Centre 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 outlined in their job descriptions. National Health

Accounts are in the incipient stage of development, hence monitoring of expenditures in relation to programme results is complicated.

At the *central level*, other Ministries lack a mandate in HIV M & E. Due to its leading role in 2008 in revitalizing the social services TWG, the Ministry of Social Protection, Family and Child has assumed M & E functions under NAP. The HIV focal point of the MoSPFC, which 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, recommendations have been to institute focal points within respective Ministries. The Center for Blood Transfusions and the Republican Drug Dispensary have M & E units within their organizational structure, also mandated with HIV M & E.

At the *sub-national level*, there are rayon (district) multidisciplinary commissions for HIV/AIDS with varying degrees of functionality (ex. The Falesti commission meets twice a year, however there are other rayons in which the commission has never met). The commission acts as coordinating body for district-level implementation of the NAP; membership is unremunerated and in addition 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 and 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/declarative: capacities are limited.

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

Across levels, access to external technical assistance has been assessed from average to good; however, the need for technical assistance has been indicated as not fully nor timely assessed.

<u>Identified Weaknesses</u>

- 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
- Insufficient current human resources in the context of increasing complexity and the multi-sector nature of the HIV M & E system

<u>Recommendations for Future Action</u>

- Explicit mandate for HIV M & E across all sectors and levels
- Framework for continuous data flows – based on an improved coordination framework between all sectors and levels; mechanisms to

include reporting of data from Transnistria need to be designed and implemented
- 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

2. Human Capacity for Multi-Sector HIV M&E.

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, the lack of a central database of events (with the notable exception of www.aids.md that has a dynamic events platform), excessive reliance on external technical assistance and capacity building that curtails sustainability. An inventory of the existing capacity, however limited it might be, as well as avenues for capacity building, are missing. Capacity assessments, somewhat tangential, have been carried out in the process of GFATM Round 8 proposal formulation and MTR 2008 of the NAP.

The standard University education curricula is lacking modules on M&E. Another missing link, is the capacity building plan that would be built on identified capacity needs and gaps; it would include 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 M & E unit staff, as well as other key staff responsible for supervising the data collection, aggregation process and levels, need to be augmented. The 5 Year Evaluation of GFATM has highlighted the need to extend the data coverage, to increase the data quality and to strengthen the existent M & E system.

Among capacity gaps, participants have identified projections, modelling and estimation skills and capacities as being critical.

In human resources, a barrier identified was 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 there is little motivation to pursue an education.

Identified Weaknesses

- Missing inventory of existing capacity and avenues for capacity building
- No higher education in M & E. The School of public health provides a Masters programme only for Medical University graduates
- No database/common pool of experts
- No database of M & E ongoing capacity building events
- Lack of a capacity building plan

- Non-implementation of assessments regarding needs and gaps, regular assessments and milestones: the ability to measure implementation of capacity building plan

Recommendations for Future Action

- The development of a curriculum in M & E (with different modules, including HIV-specific) and the subsequent incorporation of it into the curricula of the School of Public Health, professional in-training/refresher courses for medical specialists, University-level programmes (bachelors and Masters), education classes for social assistants and refresher training programmes for social assistants and social workers
- Inventory of capacity gaps, needs, and ways to enhance capacity
- Database of training events in M & E maintained by the TWG on M & E (could be decentralized to a umbrella organization to avoid overwhelming the TWG capacity)
- Amending the public service inventory to include the position of specialist in M & E, to ensure formal recognition and the space for professional growth
- Introducing M & E capacity assessments into the framework of accreditation and job performance evaluations

3. Partnerships to Plan, Coordinate and Manage the Multi-Sector HIV M&E System.

Component Description

Under the National Coordination Council, there is a joint TWG for M & E for HIV, STIs and TB, as well as a TWG for Surveillance. 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 and to represent the technical level rather than the decision-making level because the current composition curtails the efficiency of the TWG. Currently the TWG acts 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, which overwhelms 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 the central level.

According to the TOR of NCC, TWGs meetings are to be held on a quarterly basis; however, in reality, 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 also disseminated through the NCC Bulletin. However, there is no formal mechanism to follow up on the decisions of the TWG.

Identified Weaknesses

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

Recommendations for Future Action

- Review membership; in the meantime – invite non-members to TWG meetings
- 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
- Build the TWG's capacity in the areas of M & E, 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 expanded to include the NCC

4. **National, Multi-Sector HIV M&E Plan.**

Component Description

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

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 (with its currently limited membership), with only one umbrella organization participation: the Soros Foundation. While it has been circulated broadly for comments, most stakeholders have simply endorsed it without additional input. Amendments to the Plan need to be transparently and consultatively done, perhaps in a workshop that would entail capacity building in M & E, allowing stakeholders to make informed contributions.

The M & E plan is not costed per se; the projected cost of data collection exercises envisaged is provided for in the relevant institutions' budget and in the budget of the Round 6 proposal. The GF contribution is landmark for the operationalization of the national M & E system and the implementation of the M & E Plan, complementing the very limited contribution form the state budget: only 2-4% of the total HIV programme

funding allocated by the government is for the M&E plan. The resources committed to the implementation of the M & E Plan are still not sufficient; the M & E costs are estimated to be around 4% of the NAP costs, which is far below the recommended 10%.

Identified Weaknesses

- Limited participation in the development of the M & E Plan due to process failures and limited capacity
- 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 the NAP

Recommendations for Future Action

- Amending the National M & E Plan, through a consultative process, based on existing best practices
- Developing mechanisms, at national, sub-national and institutional levels, for monitoring the implementation of M&E plans and budgets
- Capacity building for NGO and other service providers in an effort to develop agency-level M & E plans and their subsequent implementation
- Budgeting and the creation of operational M&E work plans which would include clear indication of costs, funding gaps, responsibilities and leading agencies

5. **Costed, National, Multi-sector HIV M&E Work Plan.**

Component Description

The National M & E Plan needs to be made operational by a costed workplan to include priority actions, roles and responsibilities of stakeholders, timeframes and budgets. 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) acted 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.

Identified Weaknesses

- The M & E work plan is missing; the GFATM Round 6 project work plan acts as a substitute work plan
- The GFTAM work plan severely underestimated the M & E budgets; 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 (mostly GFATM, as well as bilateral and multilateral development organizations), hence the possibility of sustainability is severely limited

Recommendations for Future Action

- Costing and operationalizing the M & E Plan by creating time-explicit work plans, with clear indication of costs, funding gaps, responsibilities and leading agencies
- Costs related to the implementation of the M & E work 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

6. Communication, Advocacy and Culture for HIV M&E.

Component description

Communication and advocacy for M & E has received overall more positive ratings due to the communication of the results of M & E activities and disseminating data and the insurance of transparency and communication regarding various aspects of the national response (including M & E system performance and outcomes). However, at the sub-national and service providers' level, there is less inclusion in the reporting mechanisms and thus the data related to their part of the M & E system is less available.

The M & E system is not assessed in a systematic manner, but rather on an ad-hoc basis as needed (need might arise for reports destined for UNGASS, GFATM or any other major donors).

While data produced by the M & E system are available in the public domain on the web (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 of HIV exists, it is more declarative than true buy-in leading to actions. M&E policy and strategies are included in the NAP and other relevant HIV policies and programmes, however they are frequently the reflection of international commitments and the result of pressure from international organization; there are seldom invested, concentrated efforts to ensure their effective, coherent and systematic implementation.

The commitment of decision-makers and managers to M & E within organizations is also declaratory – while data is requested for reporting purposes, there is little effort to allot human or financial resources, to build capacity or motivate staff. The data requested by managers is related more to process indicators than impact indicators.

Identified Weaknesses

- Commitment for HIV M & E if frequently limited to being only formal and declaratory at all levels of the decision-making
- Communication of M & E data is incomplete – the contribution of other sectors and the sub-national and service-provision level is not as well represented
- Gaps in communication may lead to an overlap of planned and implemented activities.

Recommendations Future 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 at all levels
- A strategy advocating for HIV M & E and the use of data in the planning stages needs to be designed, or incorporated into the Framework for HIV/AIDS Communication designed by the TWG for 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

7. Routine HIV Programme Monitoring.

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 the routine monitoring of VCT, treatment and care are quite well designed, and the M & E,and surveillance, and prevention among key populations at-risk has systems in place,, the prevention interventions among the general population and young people, as well as social services and support sector 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, the treatment case management forms, the VCT reporting forms and the instructions for statistic reports produced by the Ministry of Health (for HIV and STI cases). Other programme areas lack guides or instructions. The available national standards and instructions 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 auditing purposes. During oversight field visits undertaken by the National AIDS Center, the quality of data is checked and feedback is offered. Mechanisms for ensuring confidentiality of data need to be further improved. For the use of services, double reporting is technically 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, M & E and surveillance, in other programme areas indicators are yet to be standardized.

Identified Weaknesses

- Prevention interventions (in the general population and among young people), 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 properly account 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 Future 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
- SYME AIDS needs to be operationalized from the data input level to the end users levels
- The unique identifier mechanism needs to be implemented to ensure confidentiality and avoid double reporting

8. Surveys and Surveillance.

Component description

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

The Workplace survey was implemented at national level for the first time in 2008; currently, there is no policy regarding the periodicity of such surveys.

The National Epidemiological Surveillance Standard is developed according to international guidelines. All surveys include the survey protocol and questionnaire. An Ethics Commission approves all surveys.

Identified Weaknesses

- An inventory of surveys is inexistent
- Operational research is underdeveloped
- Over-reliance on external funding for implementation of the surveys

Recommendations for further action

- The national M & E Plan needs to include prospective surveys and timeframes for completion envisaged
- Mechanisms ought to be designed to secure a better degree of involvement on behalf of the local, public authorities, the civil society and the local, public service providers in the implementation of surveys

9. National and Sub-National HIV Databases.

Component Description

A comprehensive national database has yet to be developed. There is the SIME AIDS database, where HIV and STI cases (based on form No 2), data on treatment case management (form No 14) and data on HIV cases in pregnant women (form No 32) are recorded. Other programme intervention areas, as well as the input of other key stakeholders are not represented.

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 values for UNGASS and UA reporting.

IT equipment and supplies are available at the level of central institutions in 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.

Identified Weaknesses

- SIME AIDS is not operational; confidentiality issues need to be addressed and capacity building in the use of SIME AIDS is needed
- Other components of the national database missing
- Mechanisms for regular inter-sectorial reporting, as well as reporting by the civil society, are missing
- The accessibility of data is limited to formal dissemination endeavors

Recommendations for Future Action

- Development of a clear TOR for the national and sub-national database, with provisions for export of data and communication with other databases (like the one maintained by the National Statistics Bureau and the Ministry of Economy and Trade, DevInfo)
- All programme areas need to be properly reflected in the national database; this 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, as well as clear roles and information flows to the public and NGO service providers (at local level), and actors at sub-national level and central level institutions need to be defined
- Data from the database should be made available to the public domain through an up-to-date website ,
- Implementation of mechanisms to validate and insure quality of data

10. Supportive Supervision and Data Auditing.

Component Description

As indicated by the M & E system assessment and the M & E profile for Moldova (drafted by the Global Fund), Moldova is lacking effective mechanisms for data quality assurance. Data originating from different sources may vary. Such inconsistencies affect planning for better programme delivery and Moldova's image and credibility when data are reported through various international reporting mechanisms without the proper comprehensive in-country data reconciliation and validation.

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

National guidelines and tools for supportive supervision on M&E are lacking. The National Health Management Center and the National AIDS Center implement oversight and data auditing.

Identified Weaknesses

- 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 are lacking
- National guidelines and tools for supportive supervision of M&E are lacking

Recommendations for Future 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

11. HIV Evaluation and Research Agenda.

Component Description

While some evaluations are included in the framework of the National programme on HIV/AIDS/STIs (joint multi-stakeholder mid-term and end-programme reviews) and some research is being implemented by the Academy of Sciences, an inventory of the research institutions, research and evaluation initiatives is missing. A concerted approach to the identification and prioritization of research problems and using findings for strategic planning is imperative to enhance the value and quality of this research. The M & E profile drafted by the Global Fund identifies operational research as underdeveloped in Moldova. Commitment and buy-in to the feasibility of research and evaluations differs among different stakeholders (including NCC members).

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

Relevant international and regional HIV research and evaluations results, 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.

Identified Weaknesses

- Certain members of the NCC display reservations regarding the feasibility of mid-term and final programme evaluations
- An inventory of research and evaluations (including those that are in the planning, implementation or completions stages) and of the local research/evaluation capacity, is missing
- operational research as underdeveloped

Recommendations for Future Action

- 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

12. Data Dissemination and Use.

Component Description

While the M & E system assessment has commended the transparency and availability of data, it has also highlighted the somewhat sporadic nature of data provision, identified certain actors missing from the information flows, and identified the need for a clear data dissemination and use plan, which 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 the NAP and international reporting commitments, however the needs of different actors are not properly accounted for. Some data is disseminated without the proper interpretation, or in a complicated and overly technical manner, rendering it virtually incomprehensible to the majority of actors (especially decision-makers who seldom have scientific expertise).

Dissemination of data ought to be more systematic.. 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 data may be forgotten. 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 who have limited internet connectivity.

There is some evidence of the usage 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 implemented 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 implemented.

Identified Weaknesses

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

Recommendations for Future Action

- Assessing stakeholder's information needs to guide further in the planning of M&E
- 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

KEY ACTION POINTS

The following priorities have been established and deemed as feasible[2]:

1. **Strengthening the outer ring of the M & E system** - human resources, partnerships and planning the collection and usage of data.

a. Developing the framework for a functional M & E system - updating the National M & E Plan 2006 – 2010 as the outcome of the MTR and of the M & E system assessment, and developing a costed time-bound work plan for a medium term (2 years)
b. M & E capacity building by assessing current capacity gaps, as well as capacity development needs, and developing a capacity building plan

2. **Investing in the middle ring** - improved mechanisms through which data are collected, verified, and transformed into useful information.

a. Developing and institutionalizing data quality assurance mechanisms
b. Developing the national research & evaluation agenda

3. Contributing to the central purpose of the M & E system – enhanced data use for decision-making - developing a data dissemination and use plan and an Advocacy for M & E and communication strategy

Recommendations

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

[2] PAF funds secured for the activities outlined below