Review of the National Programme on Prevention and Control of HIV/AIDS and STIs for 2001-2005.

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August 2004

Glossary of Terms

HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
STI	Sexually Transmitted Infections
TB	Tuberculosis
MSM	Men who have Sex with Men
CSW	Commercial Sex Worker
IDU	Injecting Drug User
IEC	Information Education and Communication
MTCT	Mother to Child Transmission of HIV
M&E	Monitoring and Evaluation.
PLHA	Persons Living with HIV or AIDS
GFATM	Global Fund for AIDS, TB and Malaria
WB	World Bank
ARV	Anti-Retrovirals
HAART	Highly active anti-retroviral treatment

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Acknowledgement

The author wants to express his gratitude to Gabriela Ionashcu, UNAIDS Country Programme advisor for all her support, the excellent administrative arrangements and for her vital advice and comments. I also wish to thank everyone involved (Annex A) who gave generously of their time and whose comments and suggestions form a major part of this report. Thanks also to Eugen for his useful translation services.

Structure of the Report

This report is based on the results of a desk review of a number of key reports and studies prepared over the period of the programme and on the information obtained from a number of structured key informant interviews. Whenever possible the information obtained from the interviews was matched with the content of the reports and the information provided by other key informants.

Executive Summary

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Much has been achieved but much more needs to be done.
Note three ones policy

Introduction

The national programme was launched in 2001 with the following objectives:

- Reduce the rate of increase of HIV/AIDS infection, of Sexually Transmitted Infections (STIs) incidence and improve the epidemiological situation in the republic of Moldova;
- Minimise the consequences of HIV/AIDS infection at individual, community and social levels;
- Increase the state's activities on prevention, providing medical, social, psychological and legal and rehabilitation assistance and involvement more NGOs in the implementation of these activities.

At the time when this programme was being devised it was believed that the new cases of HIV were going to continue to increase at a very sharp rate if no action was taken. Moldova had the third highest incidence rate in the CIS. Also the prevalence of the notified cases of syphilis was amongst the highest in the region with the officially registered infections reaching over 250 per 100000 per year. Funds were very limited and many of the HIV/AIDS prevention activities were small projects funded by donors which on their own would probably not have significantly affected the course of the epidemic, particularly in the IDU community.

The government responded with adapting the UNAIDS modules[1] to prepare a National Strategic Plan. A comprehensive Situation Analyses was carried out. This was followed by an Analysis of the Response by the Government of the Republic of Moldova and the other partners, donors and NGOs. Important gaps and deficiencies as well as local strengths were identified. With this unbiased information at hand a multidisciplinary team could focus on planning for the more critical activities that needed to be done to alter the course of the epidemic. This scientific evidenced-based approach to planning is probably an example of best practice for the rest of the region. Once the strategic plan was converted into a National Programme, the financial and human resources were detailed and found to be quite considerable. The government still went ahead and approved this ambitious programme, using it to lobby for funds by the international donors with the help and support of the local UN Theme Group on AIDS. The result was that an unprecedented amount of project funding and grants were obtained to support the implementation of the activities in the Programme.

This 2001-2005 National Programme is divided into eight strategic areas:

1. Development of a national policy for the prevention of HIV/AIDS and Sexually Transmitted Infections.
2. Prevention of transmission of HIV/AIDS infection among injecting drug users (IDUs).
3. Prevention of HIV/AIDS and STIs infection among youth.
4. Assurance of blood safety, safe medical interventions and services.
5. Prevention of transmission of HIV and STIs through sexual transmission.
6. Prevention of transmission of HIV/AIDS and STIs from mother to child (MTCT).
7. Provision of medical assistance and social support to people living with HIV or AIDS (PLHA) and their families.
8. Epidemiological surveillance and state monitoring of HIV/AIDS and STIs.

The National Programme also aimed to expand the response beyond the health sector, striving for the greater involvement and cooperation between other ministries, departments, NGOs and international organizations in one partnership under the coordination of an Interdepartmental Multisectoral Committee.

The lobbying also was very successful. A Global Fund to Fight AIDS, TB and Malaria (GFATM) grant based on the needs of this programme and the results of the strategic planning exercise was accepted and a separate large World Bank (WB) grant was approved. A joint implementation office, the TB/AIDS Program in Moldova (GFATM/WB) Project Coordination Unit (PCU) was established to support their implementation. Sub-recipients were appointed: SOROS Foundation to coordinate all NGO and other activities related to vulnerable populations, Ministry of Education is the sub recipient for the schools education project, while all the other activities are directly contracted by the PCU. This GFATM grant will be evaluated in May 2005 and following this there will be some reorganisation of the activity funding for the next 36 months. A rapid review of the HIV/AIDS donor funds in the country in 2003 showed that almost 10 million US dollars had been mobilised and were available for AIDS activities[2].

[1] Guide to the strategic planning process for a national response to HIV/AIDS. UNAIDS. 1998

[2] Annex to the 2003 Resident Coordinator Annual Report –HIV/AIDS EXPENDITURES

Next year also the government National Programme will come to a close and another Programme for 2006-2010 will need to be finalised. It is hoped that this report will be of use for both the GFATM reorganisation process as well as the formulation of a new National Programme.

Observations on the Epidemiology of HIV and STIs in Moldova

Moldova has a population of 4.3 million and a relatively high population density of 125.1 persons per kilometre – with about 46% living in the towns and cities. Until recently there has been a negative population growth of about 14000 per year (although there are some signs that this may be lessening) and large scale labour migration – estimated at 600000 in 2002. Both these factors forecast serious problems with the dependency ratios (able-bodied people caring for the elderly) in the near future. An AIDS epidemic is predicted to further decimate this ratio as 93.5% of the known PLHA are aged 15-39 years old, with a rapidly increasing proportion of women (traditional carers) being seen.

Taking into consideration the official statistics, the HIV epidemic in Moldova appears to have passed through three phases. The first phase runs from the mid-1980s to roughly the beginning of 1996. This was a quiet phase interrupted by small isolated outbreaks (also known as a Stage 1 epidemic), such as the one affecting African students in 1995, or sporadic infections in persons believed to have been infected abroad. During this time most policy makers believed that this was a disease restricted to the West or Africa and adopted the Soviet general policy of focussing the main government efforts to mass screening and strict border controls in an effort to keep out the infection. The structures and legislation established under the Soviet years, common to many countries of the CIS, were maintained and AIDS was not really considered a major priority in the light of all the other competing problems. During this time there were serious warnings that problems may be emerging as the official syphilis and gonorrhoea incidence rates exploded into a major national epidemic, following the trends seen in Moldova's neighbouring countries.

A second phase of this epidemic appears to emerge between roughly 1996 and about 1999 when a series of rapid outbreaks were detected among the IDU brought forward for testing – also mirroring a similar picture seen in neighbouring Belarus, Ukraine and Russia. The increases in official figure was dramatic, from 7 HIV registered in 1995 to 408 registered PLHA (about 9 per 100000 population) in 1997. More than 80% of these were known to be young IDU and about 18% were believed to have been infected through sexual transmission. By far Balti and Chisinau were the worst affected, but by the end of 1999 all administrative territories could boast of having local infection with HIV. By 1998 everyone in Moldova had to accept that we were no longer looking at a disease affecting foreigners, but that this had now become a Moldovan problem. During this same period the STIs, in particular notified syphilis, reached some of the highest incidence rates recorded in recent decades, implying that the needle sharing by the IDUs was not the only problem and that sexual transmission could also explode in the medium term. Unfortunately the beginning of this so called Concentrated Phase (or Stage II) of the epidemic was accompanied by a decline in the economy and government resources available for Health. In fact the United Nations Human Development Index ranked Moldova as 75th out of 174 countries in 1994, but this dropped to 113th place in 1998. The severe resources situation meant that even basic materials such as test kits for HIV were in very short supply or out of stock for long periods. This led many to believe that the official incidence of HIV as 157 in 1999 (down from 413 PLHA in 1998) or of 175 in 2000 as being unreliable or incomplete data. The shortages even affected prescribing adequate treatment for STIs, and frequently many people either had to purchase limited amounts of antibiotics or resort to unconventional or not very effective alternative treatments.

At the same time the severe economic times was accompanied by growing unemployment, deteriorating living standards, high migration of people of reproductive age in search of jobs (unfortunately mainly to Russia which was experiencing the fastest growing epidemic of HIV and had a massive STI epidemic) and a fast growing illicit drug trade. This expanding illegal drugs market in a newly impoverished society is usually associated with rising crime, which brings about such high risk activities as commercial sex (CSW) or illicit human trafficking. All these social stresses are known to be major determinants which facilitate the spread of HIV and STI. This was the situation which spurred the government to give higher priority to AIDS and started the strategic planning process which led to the National Programme described in the previous chapter.

The Moldovan HIV epidemic now appears to be entering a new third phase. Now that funding for essentials such as ELISA test kits for HIV has more or less returned them to full supply, some sentinel surveillance and broad screening and testing programmes have been resumed. The overall crude incidence of reported HIV

appears to be relatively stable at about 200 to 250 PLHA each year (132 in the first eight months of 2004) – still mainly concentrated in the more vulnerable populations. However without major changes in the testing patterns, the proportion of those believed to have been infected through heterosexual transmission appears to have risen from 20% (of all PLHA from 1987 to 2003) to 43.5% in 2003. Similarly the proportion of women infected has risen from 28.4% (of all PLHA from 1987 to 2003) to 37.9% in 2003. Two sentinel surveys carried out at the end of 2003 on CSW and MSM found 4.4% and 1.69% positive – a much higher prevalence than was expected from the reported official figures. As the sentinel surveys are not from representative population samples, these results cannot be extrapolated to the general population, but it would be interesting to follow future survey results to see if these rates are maintained. Although these changes may be suggesting that Moldova could be at the beginning of a more generalised epidemic, through the infection of the so called bridge groups, there are many possible explanations for the changing proportions, not least is sampling bias. More in-depth studies are necessary to estimate the element of bias or completeness of these figures. This should be one of the new government's Monitoring and Evaluation (M&E) Unit's priority actions for the next programme, as confirming this shift in the epidemic would imply the need to carry out major shifts in the funding priorities.

One very interesting point that emerged recently is that sentinel surveillance carried out by the AIDS Centre on the IDU attending the NGO managed Harm Reduction projects, has clearly demonstrated the effectiveness of this approach as the incidence of HIV cases among these IDUI decreased from 29% in November 2001 to 22% in December 2003. This is a clear acknowledgment that the policy to work through NGOs adopted by the government should yield the desired results, provided the NGOs are given sufficient resources and political support to complete the task.

Rapid Evaluation of the Programme

The programme had set 27 indicators (mainly input and process type) to monitor the progress of implementing the eight strategies of the National Program on Prevention and Control of HIV/AIDS and STIs. Many of these required specific data or studies to be carried out in order to correctly evaluate their performance. Whenever this specific data was not available, the author obtained an impression of the likelihood of the indicator having being achieved either through the reports available or by speaking to key stakeholders and experts in that area.

The result of this rapid review is encouraging: 11 indicators appear to have been fully achieved (40.7%) and a further 9 indicators appear to be mainly achieved or partially achieved (33.3%), assuming that all indicators are given the same weighting. In the case of two indicators of Strategy 5 (Prevention of STI), the official reduction in syphilis incidence is believed by some to be influenced by an increasing degree of under-reporting as people seek informal or private treatment (the extent of this bias is currently being researched by the M&E Unit).

Six indictors of Strategy 2 (Prevention among IDU) and one indicator from Strategy 5 (Prevention of STI) and were not achieved, giving an overall failure rate of 25.9%. In the case of the Strategy 2 indicators, two of these probably had unrealistic targets, as some progress in the right direction was registered but not enough to reach to actual target. A further two Strategy 2 indicators required a series of special studies to be carried out in order to obtain the information required. These were never properly done, most likely because it was unclear who was responsible for doing these studies. It is hoped that now everyone recognises that the new M&E Unit is finally responsible for collecting the data on all current and any future indicators. It is therefore expected to take measures to ensure that they will not allow any future programme's indicators to remain incomplete. A rapid review shows the following results:

Strategy 1: DEVELOPING AND ESTABLISHING A NATIONAL POLICY FOR THE PREVENTION OF HIV/AIDS AND STIs

1.1. Activity: Developing and Establishment of a National Policy on HIV/AIDS and STIs

Indicator	Target	Evaluation	Result
Establishment of National Inter-Departmental Multisectoral Committee on Prevention of HIV/AIDS/ and STIs, assuring intersectoral participation	Second quarter of 2001	Established formally 1 October 2001	Achieved
Approve the National Programme on Prevention and Control of HIV/AIDS and STIs	Second quarter of 2001	Approved 18 June 2001	Achieved

1.2. Activity: Protection of human rights as a state priority

Indicator	Target	Evaluation	Result
Amendments to improve existing legislation on CSW, MSM and Drug Misuse	2001-2002	Laws amended[3]	Achieved

1.3. Activity: Multisectoral and interdepartmental implementation of planned activities

Indicator	Target	Evaluation	Result
Ministries, Departments and Public Administrations will have developed and implemented activities under the National Programme on Prevention and Control of HIV/AIDS/STIs.	2001	See Table 1.3A below	Mainly Achieved

1.3A. Summary of multisectoral/interdepartmental implementation, resulting from the rapid review[4].

Main Partners who have developed and implemented at least some activities under this programme	Main Partners who do not appear to have developed and implemented activities under this programme
Ministry of Health	Ministry of Finance
Ministry of Education	Ministry of External Affairs
Ministry of Internal Affairs	Ministry of Labour and Social Protection
Ministry of Justice	State Company «Teleradio Moldova»
Department of Youth and Sports	NGO: AntiSIDA
Several local public administrations like Balti, Orhei, Jedinet and others	NGO: Mileniul III
Various mass – media organisations	
NGO: Tineri pentru dreptul la viata, Chisinau, Balti	
NGO: InfoSIDA, Singerei,	
NGO: Adolescentul, Orhei	
NGO: AntiHIV	
NGO: CASTITAS	
NGO: Centrul de Dezvoltare a Tineretului	
NGO: Centrul de Sănătate pentru Tineri „Neovita”, Chișinău	
NGO: CIVIS	
NGO: Consiliul Național al Tineretului din Moldova	
NGO: Credința, Chișinău	
NGO: Dependența de drog și alcool, Soroca	
NGO: Familie Sănătoasă, Ștefan Vodă	
NGO: Gender Doc-M	
NGO: International Relief Friendship Foundation Moldova, Chișinău	
NGO: Lume fără Droguri, Chișinău	

[3] may require further amendments

[4] Note: this list may be incomplete as it is based on the information available during the one week review.

1.3A. Summary of multisectoral/interdepartmental implementation, continued…

Main Partners who have developed and implemented at least some activities under this programme	Main Partners who do not appear to have developed and implemented activities under this programme
NGO: Proiecte Inovative în Instituții Penitenciare	
NGO: Reabilitarea Socială a Persoanelor care trăiesc cu HIV/SIDA (PLHA)	
NGO: REMEDAL	
NGO: Rural 21, Sud	
NGO: Sănătatea	
NGO: Să salvăm împreună viitorul, Fălești	
NGO: Tinerii pentru Dreptul la Viată, Chișinău	
NGO: Tinerii pentru Dreptul la Viață, Bălți	
NGO: Tineri și Liberi, Chișinău	
NGO: Viață Nouă	
NGO: Vis Vitalis, Ungheni	
NGO: Asociația Tinerilor Talente din Republica Moldova	
NGO: "VIMIS"	
NGO: Centrul de Promovare a sanatatii si educatie pentru sanatate "Sanatatea", Edinet	
NGO "Lariola" , Balti	
NGO "Midas", Ungheni	
NGO: Corabia Salvarii, Balti	

Strategy 2: PREVENTION OF TRANSMISSION OF HIV/AIDS INFECTION AMONG INJECTING DRUG USERS (IDUs).

2.1. Activity: Involvement of IDUs in Harm Reduction programmes

Indicator	Target	Evaluation	Result
Implementation of Harm Reduction programmes in Chisinau, Faleshti, Balti, Orhei.	2001-2002	Projects launched	Achieved

2.2. Activity: Effective Treatment provided to IDUs

Indicator	Target	Evaluation	Result
10% of registered IDUs undergo effective treatment (including substitution therapy/detoxification) within the state system.	2001	Buprenorphine introduced but on a very limited scale	Not Achieved
25% of registered IDUs undergoing effective treatment (including substitution therapy/detoxification) within the state system.	2002	Buprenorphine introduced but on a very limited scale	Not Achieved

2.3. Activity: Number of IDUs covered by Harm Reduction

Indicator	Target	Evaluation	Result
At least 95% of the total officially registered IDUs (7564[5] in 2002) covered by Harm Reduction	2001-2002	3105[6] attended in 2002 = 41%	Not Achieved
At least 50% of the total estimated number (40000[7] in 2004) of IDUs attend Harm Reduction	2003-2005	4940[8] attended in 2004 = 12.4%	Not Achieved

[5] Moldova Country Report on Drug Information System. Bumad UNDP Project. October 2003.
[6] Soros Foundation Records. 2004. – this figure excludes IDUs in prisons.
[7] Ministry of Interior official estimates. 2004

2.4. Activity: Primary Prevention of Drug Misuse

Indicator	Target	Evaluation	Result
Up to 25% of teenagers and young persons from vulnerable groups will change their risk behaviour	2001-2002	No baseline or interim study done on vulnerable populations	Not assessed – unlikely to have been achieved.
Up to 35% of teenagers and young persons from vulnerable groups will have their behaviour changed	2003-2005	No baseline or interim study done	Not assessed – unlikely to have been achieved.

Strategy 3: PREVENTION OF HIV/AIDS AND STIs INFECTION AMONG YOUTH.

3.1. Activity: Prevention of HIV/AIDS and STIs infection among Youth

Indicator	Target	Evaluation	Result
Introducing of the training program "Sexuality, HIV/AIDS/STIs and drug misuse prevention"[9] in schools, colleges and university curricula.	2001-2005	Programme prepared, will be piloted in 2004 and launched in 2005	Expected to be achieved

Strategy 4: ASSURING BLOOD SAFETY AND SAFE MEDICAL INTERVENTIONS AND SERVICES

4.1. Activity: Assuring Safety of Blood Transfusions, Medical Interventions and Medical Services

Indicator	Target	Evaluation	Result
Mandatory testing for HIV, hepatitis and syphilis of each blood donation and blood product	2001-2005	Done, with assistance from the Global Fund Project	Achieved
Supplying medical institutions with a minimum of necessary equipment, instruments, bleach and detergents	2001-2005	Universal Precautions principle never adopted officially	Believed to be only partially achieved
Supplying medical staff with the necessary means of individual protection	2001-2005	No detailed assessment ever done – only evaluated based on impression	Believed to be only partially achieved

[8] Soros Foundation Records. 2004.
[9] Now title changed to Lifeskills Education

Strategy 5: PREVENTION OF TRANSMISSION OF HIV AND STIs THROUGH SEXUAL TRANSMISSION.

5.1. Activity: Efficiency of the Educational Programmes

Indicator	Target	Evaluation	Result
Stabilization of the syphilis incidence rate	2001-2002	Official statistics[10] show that this was achieved	Achieved
Reducing the syphilis incidence rate by 5-10%	2003-2005	Official statistics show that this was achieved	Achieved

5.2. Activity: Increase Accessibility of the Population to STI Services

Indicator	Target	Evaluation	Result
Increase by 30% the number of persons presenting themselves to medical institutions with clinical signs of gonorrhoea and non-specific urethritis.	2001 to 2005	In 2001: gonorrhoea: 41.1; Chlamydia: 50.6. In 2003: gonorrhoea: 47.7; Chlamydia: 23.5 (all figures are per 100000)	Not achieved yet and will probably not be achieved.
Treatment of patients with STIs in non-specialized medical institutions up by 10%	2001	No evaluation done	Probably achieved but not registered.
Treatment of patients with STIs in non-specialized medical institutions up by 20%.	2002-2005	No evaluation done	Probably achieved but not registered.

5.3. Activity: Access to Condoms

Indicator	Target	Evaluation	Result
Widespread availability for sale of condoms through the network of drugs stores, in hotels, restaurants, commercial units, stations etc.	2001-2005	Good expansion of the market volume, but with no quality control	Achieved

Strategy 6: PREVENTION OF TRANSMISSION OF HIV/AIDS AND STIs FROM MOTHER TO CHILD

6.1. Activity: Providing Counselling Services to HIV positive mothers

Indicator	Target	Evaluation	Result
Providing of counselling services regarding the risk of transmission of HIV from mother to child during pregnancy, delivery and breastfeeding to HIV positive mothers to 100%.	2001-2005	Unclear if all HIV + mothers are attending antenatal services in time.	Believed to be mainly achieved for positive mothers but VCT for the remainder is not really available.

[10] A rapid survey carried out in 2003 by the Monitoring and Evaluation Unit suggests that up to 30% of STIs are being treated privately and are not being officially registered.

6.2. Activity: Assisting early diagnosis of HIV in pregnant women

Indicator	Target	Evaluation	Result
100% of HIV positive mothers undergo an ultrasound investigation of pregnant women to determine the age and condition of pregnancy.	2001-2005	No assessment done	Believed to be mainly achieved

6.3. Activity: Providing Condoms to HIV Positive Women

Indicator	Target	Evaluation	Result
Distribution of condoms to HIV positive women through family planning institutions.	2001-2005	So far this is being done mainly by an NGO	Achieved

Strategy 7: PROVISION OF MEDICAL ASSISTANCE AND SOCIAL SUPPORT TO PEOPLE LIVING WITH HIV OR AIDS (PLHA) AND THEIR FAMILIES

7.1. Activity: Provision of Medical Assistance to PLHA and to AIDS patients

Indicator	Target	Evaluation	Result
Hospitalization of PLHA and ensuring access to antiretroviral therapy.	2001-2005	New Unit set up, ARV purchased and available.	Achieved

Strategy 8: EPIDEMIOLOGICAL SURVEILLANCE AND STATE MONITORING OF HIV/AIDS AND STIs

8.1. Activity: Epidemiological Surveillance and State Monitoring of HIV/AIDS and STIs

Indicator	Target	Evaluation	Result
Epidemiological surveillance of HIV/AIDS and STIs in the country.	2001-2005	There is a national surveillance system in place	Achieved
Sentinel surveillance in the following groups: - IDUs – 5000 - STI patients – 2000 - Pregnant women – 5000 - Detainees of penitentiaries – 2000 - FSW – 500 - Persons travelling abroad – 2000 - Institutionalized children (orphans) – 200	2001-2005	Annual sentinel surveillance is carried out on: IDUs: 500; STI patients: 1000; Pregnant women: mass screened not really sentinel surveillance; Detainees of penitentiaries: 500 + 300 CSW: 150 Persons travelling abroad: 500 Institutionalized children (orphans): not done but various other groups screened instead	Nearly Achieved

Detailed analysis of the National Programme Achievements

STRATEGY 1: Developing and establishing a national policy for the prevention of HIV/AIDS and STIs

These activities were planned to confer the appropriate priority and commitment to dealing with HIV/AIDS/STIs by all the stakeholders in the Republic, including the various government departments. Among the activities planned were: the establishment and strengthening of a National Inter-Departmental Multisectoral Committee on prevention of HIV/AIDS/ and STIs, promoting and facilitating the greater involvement of NGOs and donors, integrating HIV/AIDS/STIs and drug use into one national health policy, promoting the development of local strategic plans and proposing amendments to the legislation to deal more humanely with sex workers, homosexuals, drug users and other groups at high risk of infection.

A National Interdepartmental Committee was formed in October 2001 and still meets, although irregularly (met three times in 2003 and once up to August 2004). Its aims include coordinating the activities of the various Ministries, Departments and NGOs and evaluating these activities (but no practical plan how to carry out the evaluation was ever produced). Training for committee members, local administrators and NGOs working at a policy level was carried out to show how AIDS was not just a medical problem – this appears to have had some good outcomes. Working with local policy makers and administrators in Balti and Chisinau helped them to develop local HIV/AIDS/STI programmes, but this was not successful elsewhere. Training is being extended to the new Rayons level of Administrators. The Committee's implementation capacity is severely restricted as there are little funds or resources to directly support it's activities – similarly the local administrators have every little funds for any such activity.

After this programme was introduced the Global Fund to Fight AIDS, TB and Malaria (GFATM) approved a grant which required that a policy making Country Coordinating Mechanism (CCM) be established in 2002. This was set up in parallel to the National Committee (due to the inclusion of the TB element), even though many members sit on both committees. The CCM is considered to be a higher level committee, with broader representation of the key stakeholders and the more serious problems and issues appear to be first referred for discussion at the CCM level. The CCM was established to apply for the grant, but also became the local Project Steering Committee for the World Bank's IDA-financed Moldova TB/AIDS Project. The CCM is believed by many not to be fully functional – not meeting regularly and not serving as a proper forum for discussion but rather as a decision making tool. In addition, the division of responsibilities between the CCM and the older National AIDS Committee has remained unclear. Although financing between the IDA grant and that GFATM has been consolidated into one implementation office (a PCU), program coordination can be even stronger if the funding from several other sources are also consolidated within the CCM mechanism. This would also better reflect the generally accepted 'Three Ones' principle promoted by the United Nations as Moldova would have moved closer to One National Framework and One Country Coordination Mechanism. The general review of the GFATM grant coming up in May 2005 should be considered an opportunity to review the CCM terms of reference. In particular this should have the inclusion of the organization of regular meetings, more encouragement of discussion during the meetings, a better clarification of the membership and role of the technical committees that have been assisting the implementation of the HIV/AIDS and TB programs and the relationship with the older Interdepartmental Committee. One suggestion is that the Interdepartmental Committee becomes a technical sub-committee to the CCM focussing on coordinating the government's part of the programme.

The government has shown that it is giving more priority to the HIV/AIDS and STIs problem. A national health policy was produced: "To a Healthy Future – National Health Policy 2002" and this devoted the whole of Chapter 5 to recognizing the importance of HIV/AIDS and STIs.

A detailed review of the existing legislation was carried out early on in the programme, and following broad discussions, the relevant laws were amended especially where it related negatively to vulnerable populations and the rights of PLHA. Among these changes were that consensual sexual acts between adults of the same gender is no longer criminalized, the actual act of selling sex is no longer an offence, drug users may now carry on them small amounts of drug for personal use without it being held as evidence against them and voluntary substitution treatment is now legally possible. All these changes are important steps to help reduce barriers for vulnerable populations to come forward for assistance and to help better protect themselves and other s against HIV/STI. A recent external review of the legislation identified that there are still a small number of points and ambiguities in the legislation which may be improved further (especially regarding the

administrative laws on CSWs, the issue of the criminal vs victim status of the 'simple' drug user and still some uncertainty regarding the status of methadone as a drug). The suggested changes in this review should be considered to continue to improve the social environment for prevention of HIV and STI transmission.

Perhaps the greatest success of the whole programme has been the gradual transformation from a relatively closed, rather medicalised programme into one which demonstrates a greater recognition of the role of the NGOs and other non-health sectors. They are more actively involved in the programme, and participate at the CCM and National Committee levels. Despite the obvious advantages of this recognition and even clear evidence of their effectiveness beginning to emerge, there still appears to be restrictions on the state directly funding or otherwise supporting NGOs. It is clear that some government elements within the national programme still regard NGOs with suspicion and some even appear to feel threatened by them, even today that NGOs have shown the effectiveness of the harm reduction policies they implement. Certain policy makers still do not have a clear perception of the bigger picture and may only see these activities as supporting drug use with needles and methadone. Advocacy needs to be maintained with all the policy makers to ensure that the work of NGOs receives the appropriate amount of appreciation and that they are perceived as vital partners and not as rivals for funds.

So far mass information and communication for behaviour change has been mostly missing – with only small initiatives being carried out. Also despite all previous efforts, these is still some stigma surrounding HIV/AIDS, even among medical staff, many of whom believe that all PLHA are drug addicts and treat them with less respect. It is important to prepare a medium term communication strategy to support the new national programme which will be introduced and to focus on promoting the correct attitude to the HIV/AIDS problem. It is understood that several donors are interested in supporting this valid initiative.

Finally there is a lack of technical capacity at the central level of the government – with little analysis of the data on the current situation for informed policy making to be done. It is hoped that the new M&E Unit will take over this role and provide the necessary leadership in this matter..

Recommendations

1. The relationship between the CCM and the national Inter-Departmental Multisectoral Committee on prevention of HIV/AIDS/ and STIs needs to be sorted out. One suggestion is that the Inter-Departmental Multisectoral Committee becomes a technical subcommittee of the CCM, and focus it's energies on coordinating purely the government response, leaving other issues like working through NGOs to the CCM.

2. A stronger institutional framework is needed for better programme coordination in the face of expanding projects and activities funded by varied sources.

3. The legislation related to vulnerable populations (particularly affecting CSW, IDU and legislation regulating drug users treatment) may be further improved to enhance the prevention of HIV and STIs.

4. NGOs have proven their value in delivering often difficult prevention activities, the government should set up mechanisms for financing and supporting the more important NGOs to ensure their long term sustainability. A full time liaison office to facilitate and support the work of NGOs should be set up within the central government to implement this support.

5. An appropriate communication strategy needs to be planned and launched to maintain public support for the national programme activities.

STRATEGY 2: Prevention of transmission of HIV/AIDS infection among injecting drug users (IDUs).

This strategy underlined the importance of dealing appropriately with the most vulnerable population causing concern at the time the programme was finalized – the injecting drug users. The preferred strategy combined primary and secondary prevention while expanding harm reduction through NGOs and working with various other sectors. The importance of safer sexual behaviour among drug users and their sexual partners, in an attempt the limit infection in these so called 'bridge' populations, was also highlighted. More specifically

these activities planned for behavioural studies of IDUs linked to sentinel surveillance of HIV, information, education and communication (IEC) activities targeted at IDUs, peer education, condoms, bleach, needles and syringes provided to IDUs, facilitating access to services like early diagnosis and effective treatment of STIs based on the syndromic approach, facilitating voluntary HIV counselling and testing, psychological support to IDUs, providing substitution therapy. This strategy also included a strong training element for specialists and the development of standard methods and educational materials for the primary and secondary prevention of drug misuse. The activities included working with the military, police and in penitentiaries – the main sectors outside of Health which meet with IDU.

Although a recent survey of young drug users[11] mostly aged between 20-35 showed some encouraging results. They claimed to have high percentages reporting that they never shared needles and found needles readily available, high condom use and good general knowledge of AIDS but quite a high proportion reported 'indirect' needle sharing practices. For example 60% reported filling their syringes from a common jar, some 24% used front or backloading (drawing in the drug directly from another syringe), 24% used pre-loaded syringes (and therefore cannot be certain that they were unused). There are various other aspects of IDU personal behaviour which have not been clarified - this sort of research needs to be conducted regularly (at least biannually) to be most useful for policy making. An example of the behavioural determinants needing further research is condom use by the drug user or drug using sex worker with their regular partners.

The efforts to promote earlier identification and rehabilitation of IDU have been partially successful. Two relatively small methadone projects has started up – one operated by the narcology services and one in a female prison (Rusuca). This falls very short of the number of methadone or other substitution therapy points which are needed nationwide. Besides the proven direct effect of substitution therapy, like methadone, that reduces the IDU's dependence on injecting the opiate (and therefore reduces the chances of risky needle exchange), reduces the normally chaotic lifestyle of the IDU that regularly leads them to crime and imprisonment and reduces the chances of accidental overdose, methadone is also proven to have a tendency to bring the IDU closer to the treatment services as it increases their confidence in the narcologists, psychologists and doctors. Many times methadone is the route for IDUs to end up coming forward to undergo a full detoxification and rehabilitation programme. Training of specialists on these issues has been completed and most now have a better appreciation of the need of such a diversified programme for the IDU.

Similarly detoxification of the IDU on its own is usually a relatively ineffectual approach to the problem because as soon as the 'cured' IDU returns to their home and social environment they will tend to meet up with the same 'friends' and social circle which led them to start taking drugs in the first place. Without strong social and personal skills, improved self esteem and long term psychological support, the detoxified drug user will easily relapse to taking drugs again. For this purpose the programme included plans for expanding long term rehabilitation services for the IDU. Apart from one NGO's effort in rehabilitation in Chisinau (using a 'working habits' approach) and one other NGO in Balti starting up a small rehabilitation centre there has been very little investment in true rehabilitation services by the government. This area will need greater emphasis in the next programme. Also the focus of the present programme has been on improving accessibility to treatment and rehabilitation of drug users but there has been no specific social protection developed to help IDU.

In the harm reduction activities intended to prevent HIV transmission among drug users the programme has been much more successful. Most of the best work has been through the 22 harm reduction projects managed through the Soros Foundation serving about 5000 IDUs. These projects provide HIV testing, targeted IEC, clean needles, condoms, counselling and referral to specialists if the drug user agrees. This good work needs to continue to expand to serve more drug users to prevent future sporadic outbreaks of HIV and hepatitis.

Similarly all the 19 prisons in the country have harm reduction activities offering most of these services, including condoms and disinfection supplies, however in only three 'pilot' prisons is needle exchange available. This should be extended to all these institutions which may host IDU.

Primary prevention activities have included: integration of the education on drugs, HIV and STIs in the schools curriculum, NGO projects for youth summer schools where they educate youth on the prevention of HIV and carry out prevention through peer education, preparation of some information, education and communication (IEC) materials were prepared, condoms have been distributed and a project to improve journalists awareness (encouraging them to write more about HIV/AIDS) is planned. More needs to be done

[11] HIV/AIDS Behavioural Surveillance Survey. Moldova. 2004. CIVIS/SOROS

and the communication strategy referred to above should include a major element of primary prevention of drugs and HIV transmission through unsafe drug use. At the policy level, there was the preparation of the Charter "Youth in XXI century – spiritually healthy and drugs free». This national strategy has been published and adopted.

It is felt that the development and production of the next generation of IEC materials needs to be done more professionally starting with focus group discussions, 'market' research among youth; testing of the messages and text, revision according to the results of the tests, and re-testing of revised messages with sample audiences; and then imaginative layout and artwork added. These steps all have a cost and this need to be included in the next programme. Also a greater emphasis should be made on the recruitment of peer educators, possibly from former drug users to educate and inform youth.

As the harm reduction projects are expected to expand in numbers the next programme needs to plan for a suitable system of disposal of contaminated needles. This includes provision of suitable sharps containers, transport, biohazard disposal and (usually) incineration or microwave treatment.

Finally there have been several prevention and educational activities among the military, border control personnel, police and with staff in penitentiaries. Coverage has been good and these activities need to be sustained in the longer term to maintain a high level of awareness and correct knowledge in these vital partners. Projects to expand the subjects to lifestyle behaviour and to expand VCT services in the army are also planned.

Recommendations

1. Future targeted education activities need to continue to emphasizes safe injecting practices as the basis of the Harm Reduction approach and also include education about 'indirect' needle sharing. The IEC materials need to be carefully prepared, using drug users' inputs, to ensure they remain relevant and effective among the youth.

2. There is the need to carry out behavioural research surveys on a more regular basis to develop into true behavioural surveillance.

3. The next programme must plan to expand greatly the number of Harm Reduction projects, methadone sites and long term drug rehabilitation (not merely detoxification) services. In order to do this the government should see how it can facilitate the growth of the NGO community.

4. Once harm reduction becomes more visible there will be the need to continue to advocate for the policy makers support. This should help institutionalise the harm reduction strategy for the long term.

5. The prisons programme needs to extend methadone and needles exchange to all prisons and remand facilities.

6. The next programme needs to plan for a suitable system of disposal of contaminated needles.

STRATEGY 3: Prevention of HIV/AIDS and STIs infection among youth.

The country's youth is rightly given a very high priority in this programme. The activities under this strategy were designed to expand the educational programmes focussing on sexuality, the prevention of HIV/AIDS/STIs and drug misuse, all integrated in the concept of a healthy lifestyle approach. So the activities included the production of school based educational materials and messages, training of teacher trainers and teachers, the development of educational programmes for the general population and for out-of-school youth, condom promotion programmes targeted at youth, increasing accessibility of condoms for youth and performing studies on knowledge attitudes and behaviour of youth.

In the prevention in schools activities, the work has been carried out in close collaboration with the Ministry of Education. Sufficient funds were made available through the Global Fund Grant to ensure that the educational programmes will be available on a national scale. The teaching program «Sexuality, HIV/AIDS/STIs and drug misuse prevention" was not introduced in school and university curricula because an improved version focussing on Lifeskills (including sexuality, HIV/AIDS/STI and drugs) was been developed and will be piloted in 40 schools in 2004 prior to being adapted nationally. This decision to pilot has been criticised by quite a few who were involved in this project as the lifeskills curricula that has been adopted is similar to curricula adopted in many other countries and therefore piloting it may be a useless or redundant exercise. The mandatory lifeskills curriculum will cover all 7 to 19 year olds (approx 560 000 students). The curriculum was well developed and covers the delicate subjects in an appropriate fashion. Training of the school heads and teachers has been carried out and training of the teachers will start in September 2004, as part of the piloting. Further training needs to be planned for the school based psychologists which are found in most of the schools, in order to improve their HIV/STI counselling skills to meet the expected demands for support which the lifeskills curriculum will no doubt generate in the pupils.

The next educational programme will need the development of a new and separate curriculum for the 160 000 students at university (approximately) as this has not yet been planned or funded. Meanwhile there has been as small project targeting the development of an interactive CD and web site directed at the prevention of HIV/STI mainly targeting the older youth and university students.

One activity where this strategy has not been very successful is prevention among the young people who are out of school and not regularly employed. These represent a high-risk category as they are more likely than other youth to engage in risky behaviour. This group is insufficiently covered by the general education, information, communication activities or even other targeted prevention activities. The reason for this is possibly is that no single agency was selected by the programme to take the lead and develop activities with this particular vulnerable population. One possible solution suggested by the Ministry of Education is working on the rayons and districts long established youth centres. A victim of the severe economic decline and competing priorities, these centres have fallen into neglect and are poorly attended. It is believed that a project to review their role, modernised their approach and physically invest in refurbishment and re-equipment could possibly restore the popularity that these youth centres used to enjoy in the past – possibly creating the 'safer spaces' for these out of school unemployed youth – and finally resulting in some prevention of HIV/STI and drug use. Otherwise so far there have only been some small scale peer education activities and a planned 'street theatre' project for out of school youth. There is the need to develop training and funding for appropriate telephone 'hotline' services for youth. At present there are some information telephone lines, but they are not truly operating as effective counselling and educating hotlines due to lack of funds and appropriate training.

There have been some other HIV/STI educational activities. These have included changes in various educational curriculums including of medical institutions, undergraduate and post graduate curricula, various seminars held in high schools, production of brochures and working with NGOs in the rayons to organise local seminars.

There has been much work to establish more youth friendly clinics for STI and HIV – three have been established and another 10-12 are planned. These are especially important as the traditional voluntary testing and counselling (VCT) services are relatively inaccessible and not very amenable for youth.

There has also been an acceptable amount of condom promotion especially through NGOs and medical clinics, although on a sporadic level. Over 748 000 condoms for example were distributed on or about the 28 May 2004 on a national wide level (mainly through health centres, clinics, etc) in one promotional activity – but more needs to be done to ensure a sustained programme of condom promotion among youth.

Several behavioural studies have been carried out on youth and the results mainly show that although there is relatively good awareness and information about HIV/AIDS/STI, there remains some inappropriate attitudes and behaviour modification that needs to be tackled by their educational programmes.

Recommendations

1. The greater awareness that will result from the new lifeskills education will create a demand for more personal clarification and education regarding these delicate matters. Specific training for the school based psychologists which are found in most of the schools, needs to be planned to improve their HIV/STI counselling and information skills.

2. The next programme needs to plan for the development of a separate curriculum for the university students.

3. One agency/body needs to be made responsible for coordinating activities to deal with young people who are out of school and not regularly employed. This should include a project to review the role of the local youth centres, modernise their approach and physically invest in refurbishment and re-equipment to create 'safe spaces' and thereby assist in the prevention of HIV/STI and drug use.

4. The telephone hotline services for youth need to be further developed and promoted to ensure that they receive the right information and appropriate referral to youth friendly clinics if necessary.

5. Condom promotion among youth needs to remain high on the agenda of priority activities.

STRATEGY 4: Assuring blood safety and safe medical interventions and services

This strategy focused on improving the organised health services. Most of the activities were to prevent transmission of HIV through blood donation and the remainder were aimed to reduce the risk of nosocomial transmission of infection. The blood safety measures included strengthening the blood donors selection/exclusion system, introducing new testing policies and standards, development of a National Program on Blood Transfusion, establishment of a blood bank (including autologous transfusions), training of specialists, new equipment (including PCR) and diagnostic kits and providing sufficient blood substitutes to the medical institutions.

The activities related to the prevention of nosocomial transmission included a variety of activities such as regulations for accreditation of medical institutions, the strict monitoring of sterility and disinfecting standards for surgical procedures and other medical assistance, the provision of the basic equipment, medical kits, disinfectants and detergents, disposables and suitable protective equipment to the staff, expanding medical education about HIV/AIDS/STIs and even including preventive measures in the conditions of license of beauty saloons, barbers saloons, manicure and pedicure saloons.

In the first few years of this programme there was some decline in the standards of blood safety due to the economic limitations. Test kits were in short supply and equipment frequently broke down due to infrequent maintenance. Two cases of transmission of HIV following a blood transfusion were recorded as late as in 1997 and 1999. With the assistance of international donors and the Global Fund grant this decline has been reversed. The improvement is also reflected in the impressively increasing numbers of blood donors, from 35000 in 2001 to 54000 donors in 2003. These increases are also probably a result of greater decentralisation of the services with the opening of several district sites (there are now 25 locations outside of the two main Blood Transfusion Centres) - making it more convenient for donors. Another reason for this increase could also be the result of less donors being sent away because of shortages of test kits on the day they attend. Procedures have been streamlined and whereas the whole process of donation used to take a full day (which may have put some people off), it now takes much less time. As a priority area blood safety still remains a cause for concern as in 2003, 11,4% of all blood taken for donation was found to have markers of various infections like Hepatitis B, Hepatitis C, or syphilis - with 0.006% found positive for HIV.

In general the quality of the blood supply has improved with 100% of donations now being tested for HIV. However to date all the HIV test kits used are funded by the international community. This is probably not a sustainable arrangement in the longer term and the next national programme should include a plan for the gradual transfer of an increasing proportion of the funding of these essential test kits by the state budget over the next few years.

Most of the activities under this strategy have been achieved. A National Program on Blood Transfusion was prepared and approved in 2001 and has been in effect since then. Similarly a national standard for blood transfusion has been prepared. The next programme should include a general review of this National Program on Blood Transfusion and the standards to see whether any aspects require an update or revision.

Training of specialists has been carried out in seminars and workshops held both locally and abroad. A number of small initiatives have been held to promote voluntary blood donation but there was never a structured communications strategy to improve the donor recruitment. Despite this the numbers of voluntary donation has increased dramatically so this may not be such a high priority activity for the next programme.

The potential donor selection process has been strengthened with the introduction of a self assessed questionnaire to restrict those with risk behaviour. The potential donor is then interviewed by a doctor who further assesses the risks of the individual. This system rejects about 40% of potential donors and appears to be working well.

On the equipment level there has been some investment (such as the PCR line in Balti), but there still is a great need for more essential 'hard' equipment for testing, storage, processing, transport and separation of blood and blood products, apart from 'soft' equipment like automated beds for donors. These should be included for funding in both the second part of the GFATM grant as well as in the new Programme.

Regarding the prevention of nosocomial transmission, although there has been a great deal of improvement most agree that there is still some way to go before this is considered satisfactory. Shortages of suitable disposables and personal prevention equipment like disposable masks, gowns and gloves are still evident. A policy promoting the internationally accepted principle of universal precautions (where medical staff take precautions with every patient they see as they would if they were infected with HIV or Hepatitis B) was prepared but this was never officially adopted, possibly due to fears of being unable to supply all the disposable equipment this would require. This universal precautions policy should be made official and adopted in the next programme to further reduce the chance of nosocomial transmission. Also since 2001 a national standard was adopted on the post-exposure prophylaxis for medical personnel. This standard includes the use of anti-retrovirals for those who may have become accidentally exposed to HIV. It is uncertain how well this policy is being implemented throughout the country but to date there has been no case of such an infection recorded.

Finally it is claimed that all the beauty parlours, salons, etc are regularly inspected to ensure that they have suitable sterility conditions and disposables, however this could not be verified in this review. It is unclear what is the legal status and actual numbers of tattooists and acupuncturists (two practices which are becoming more popular and fashionable) and whether they are also regularly inspected – these are high risk professions which need specific attention in the next programme.

Recommendations

1. The next national programme should include a plan for the gradual take over of funding of test kits by the state budget over the next few years.

2. The next programme should include a general review of this National Program on Blood Transfusion and the current standards to see whether any aspects require an update or revision.

3. The blood transfusion services still require a variety of equipment like ELISAs (fully automated lines) and training in their use, centrifuges (6 to 15 L), power generators, 600L fridges, deep freeze fridges (-80^{o}C), air extractors/conditioners for rooms with fridges and other furnishings to encourage donors like automated beds.

4. The policy promoting the internationally accepted principle of universal precautions needs to be agreed and adopted.

STRATEGY 5: Prevention of transmission of HIV and STIs through sexual transmission

This strategy included various activities to raise awareness on the modes of transmission of HIV/AIDS/STIs and to improve the education about these matters on a broad scale.

The main planned activity was the introduction in school and university educational programs of the mandatory subject: «Sexuality and prevention of HIV/AIDS and STI including drug misuse», already mentioned above. It also included various other educational activities like training of local and central administrators, policy makers and ministry officials on such matters as promotion of a healthy lifestyle and prevention of HIV/AIDS/STI and drug misuse, a public information campaign on STIs, education and promotion of safer sex, with the involvement of NGOs, communities and mass-media, preparation of various educational materials and the activities for World AIDS Day.

The second group of activities focussed on improving the effectiveness and acceptability of the dermatovenerological services, both for the general population but especially for the more vulnerable populations. The strategy planned to improve public accessibility to these services, provide free and wherever necessary anonymous services and improve the supply of diagnostics and efficient treatment for STI, some education and training activities (including training of peer educators and outreach among vulnerable populations) on the prevention of HIV/AIDS and STI, the promotion of condom use and improve condom accessibility for the population possibly through social marketing and planning behavioural studies among the vulnerable populations. Also included were STI prevention activities among the military, police and in penitentiaries.

The schools educational programme was discussed under Strategy 3. The other specific educational activities on STIs planned for the various sectors appear to have been predominantly carried out successfully. On the other hand there were few mass media activities promoting safer sex and healthy lifestyle. These efforts to educate on a broad scale do not appear to have been very structured or targeted and were certainly not good enough to be really effective. A future strong mass information and communication strategy should be considered for the next programme. There have been some activities planned to improve the general support for media education and advocacy by working through journalists.

The dermatovenerologial services have improved both in range as well as in scope. There is a greater availability of tests, more treatment available, more specialists are aware of the importance of HIV, there are more dermatovenerologists promoting condoms and there have been some projects to create more 'friendly' clinics to improve the accessibility of these services. The syndromic approach is an accepted strategy, where required, and testing and treatment of STIs are free at point of use although there is some lack of awareness by the general population on the availability of this free of charge treatment in rural area.

Most of the activities to improve the STI prevention among vulnerable populations have mainly been carried out by NGOs. The WB estimates that Moldova has about 65,000-70,000 highly vulnerable people (40,000 to 50,000 IDUs, 10,000 prisoners, 5,000 CSWs and 3,000 out of school, unemployed youth). All the prison population is covered by education and other prevention activities by the penitentiary staff working in collaboration with NGOs. About 11,000 of the remainder are covered by 28 NGO subprojects managed by the Soros Foundation, most of these working with IDU. Although the number of vulnerable populations covered has increased, this needs to continue to expand to a great extent. One of the main impediments is that although there have been some improvement, the social environment in Moldova is still not conducive to working with NGOs.

The next programme should take into account other at-risk populations. 17.6% of the sexually active population in Moldova are temporary migrant workers[12]. Most (57.7%) go to CIS (mainly Russia) and Italy. There is some evidence to suggest that when on this extended absence they are more vulnerable to the risk of infection with HIV/STI and then go on to expose their partners to this risk when they return. Also in many cases these migrants leave children behind for long periods, sometimes not with appropriate guardians, raising new problems with increasing risk behaviour of these children. It has been suggested that there should be specific laws to deal with the responsibilities of guardians of children of migrant workers. Other at risk populations to be focused on next programme includes trafficked women and children, out of school youth, institutionalised children/orphans and long distance truck drivers.

[12] Labour Migration and Remittances in the Republic of Moldova. Ghencea B., Gudumac I. Soros Foundation Moldova. 2004

The issue of improving the NGO sector to enable it to expand and to become more effective should also be addressed in the next programme. The suggestion to establish a national network to represent all NGO interests is a good one and should be supported. This network can serve to build capacity building among NGOs including basic training in such essential management skills as accounting and human resource management.

In the past those NGOs working with drug users used to have frequent problems with the local police. This has improved with the introduction of the routine practice that before an NGO starts to commence operations, a memorandum of understanding with the local authorities (including the local police) is signed – there should be no more stories of harassment of these vital prevention workers. Newly established NGOs often lack office space and basic equipment. Those who have some premises reluctantly offered to them by local administrations usually find them inadequate or impossible to use. Both central and local government still do not recognise or appreciate that working with NGOs is a vital part of their daily operation and they do not have budget lines to support NGOs, neither do they have the administrative possibility to do so. At the same time everyone accepts that we will need to contract a larger number of NGOs in the near future to expand the prevention activities among the vulnerable populations. As a solution it is suggested that an office of a full time NGO coordinator be set up within the Ministry of Health at the policy-making level, to enable the government to support the actions of the NGOs, help the network grow and develop, improve communication with NGOs and find ways to ensure that their activities are sustained in the longer term. Changes to the administrative laws must be made to enable the government to contract and fund NGOs to do specific work.

In contrast to the good prevention work being carried out with IDU, the prevention among MSM and CSW has so far been limited to only a few small projects run by NGOs. What evidence is available does not support the theory that this is because there are few of these vulnerable populations, but rather this is a symptom of the lack of government policy, will and commitment to be seen to work with these heavily stigmatised groups. This needs advocacy with the policy makers to alter their perception of these members of Moldovan society.

The condom promotion and accessibility activities have not been consistent. Again there is no one office or organisation which was made responsible for this important subject and this is reflected in the few activities in this area. Most of the condom promotion has been through certain STI clinics or NGO-run projects with the vulnerable populations apart from 'one off' condom promotion activities. The next programme needs to consider contracting one agency or institution to run a long term programme of social marketing on a wider scale to improve the general population's (especially among youth) condom utilisation rates. Also from the supply point of view it appears that condoms are not reaching the village bar level but are available only at the rayon level – there seems to be a persistent supply and distribution block which needs to be looked into for the next programme. There are also some quality concerns about some of the condoms on the market as there are no National Standards or Quality Control Laboratories in the country.

International best practices show that behavioural studies carried out among the vulnerable populations are best conducted on a routine basis – repeating the study once or twice a year among samples of people taken from a similar population (example: a sample of MSM living in major towns, a sample of CSWs working on the streets, a sample of IDU attending needle exchange, a different sample of IDU not attending needle exchange points). The results of these regular surveys, known as behavioural surveillance, should then be linked to the results of biological surveillance (testing) on samples taken from the same type of population (second generation surveillance). Despite some effort in this direction (see Strategy 8), and some surveys among youth, this system does not appear to have been adapted for the risk groups on a routine basis. In the next programme the M&E unit should be given the support to ensure that this is implemented as a routine.

Recommendations

1. A strong mass information and communication programme needs to be planned for the next programme.

2. Moldova needs more NGOs working in this area. The government needs to study how best to improve the social environment to help the NGO community get stronger. A national network to represent NGO interests is a good idea and also appointing a senior level government administrator as a full time NGO coordinator within the Ministry of Health to support the actions of the NGOs should help. There should also be changes

made to the administrative laws to enable the government to contract NGOs to do specific work so that the NGO work becomes more sustainable..

3. The next programme should expand the work with at risk populations to migrants, children of migrants, trafficked women and children, out of school youth, institutionalised children/orphans and long distance truck drivers.

4. There needs to be more support to help more NGOs work with MSM and CSW.

5. Condom promotion is still underdeveloped. The next programme needs to consider contracting one agency to run a long term programme of social marketing to improve the condom use rates and improve the supply of good quality condoms even in the villages.

6. Although there has been some behavioural studies on the main vulnerable populations this needs to be organised in a more systematic fashion to convert it into behavioural surveillance.

STRATEGY 6: Prevention of transmission of HIV/AIDS and STIs from mother to child (MTCT)

This strategy aimed to reduce the risk of transmission of HIV from positive mothers to newborns during or after childbirth. One of the main concerns at the time was that the expanding epidemic in IDU meant that an increasing number of mainly young men, and then a short while later their young female partners, will be infected with HIV.

The specific activities included developing national principles/guidelines on prevention of mother to child transmission of HIV/AIDS, some training, expanding confidential voluntary testing and counselling (VCT) for women, providing specific antiretroviral treatment for all those who need it and some education and general support activities (including condom distribution and promotion) for families with a positive mother.

This strategy has been well funded and organised with most of the activities carried out successfully. 22 PLHA and 23 children have so far benefited from the anti-retroviral drugs and milk substitute provided in two specialised units in Chisinau and Balti. An expert committee developed good national principles/guidelines on prevention of mother to child transmission of HIV/AIDS. These may need to be reviewed every two years to keep in touch with the latest treatment regimes, medical advances and recommendations. One aspect which may require revision is that also pregnant women are sometimes tested 2 -3 times for HIV during the antenatal period. This is probably unnecessary and wasteful.

A manual for training health professionals was developed. In February, the NGO "V.I.S." (Chisinau) was contracted to run training courses on prevention of HIV/AIDS transmission from mother to child, with participation of trainers from the State Medical and Pharmaceutical University "N. Testemitanu". Despite this training it appears that the doctors seem to have placed greater emphasises on the clinical and treatment aspects and there are some doubts as to how much they appreciated the importance of the pre- and post-test counselling for these women. Various sources report that although they may have improved slightly, there is very little real VCT done on a routine basis, apart from some counselling available in Balti, Chisinau and Tiraspol. The impression is that the clinical guidelines on counselling have not reached the periphery. One suggestion was that routine counselling should be included in these specialists' official job descriptions.

Also although the testing is free and usually done confidentially, there have been doubts raised as to how well the confidentiality is maintained once a person is found to be HIV positive, especially in the longer term, even though this is required by law. The next programme should develop more regulations to enforce the confidentiality of PLHA to encourage them to come forward for this highly effective preventive treatment.

The prevention of mother to child transmission programme needs to develop better links between those attending the Harm Reduction programmes and the MTC services. This is because the IDUs have a natural suspicion of the medical services, much of it as a result of the general tendency of the health workers to discriminate against them. As most of the HIV positive pregnant women are these IDUs or their partners, there should be a system of referral to 'safe' clinics – or clinics where the staff is trained to welcome and deal with IDU. This is to ensure that these women do attend the MTC services early enough to be receive the

appropriate treatment to prevent infection. The author heard stories that known PLHA who are IDU were afraid to attend the antenatal services because of the lack of confidentiality and discrimination issue – especially those coming from the rural areas - as they feared their status will become known back home. Finally there are stories of women who are afraid to take the anti-retroviral drugs (ARV) and prefer to take a chance that the virus will not be transmitted in their case, as a result of lack of adequate information.

Pregnant mothers are asked to attend four antenatal classes – which includes education on family planning and condom use among others. These classes may need some support to improve attendance and also to develop some suitable IEC materials to improve their impact. Most of the specific education and general support of HIV positive mothers is currently being done by an NGO "CREDENTIA" manned by PLHA although there has also been some similar activities organised by the AIDS Centres. They carry out education of men and women of reproductive age on issues of family planning and condoms (believed to have distributed about 150000 so far).

Recommendations

1. The National principles/guidelines on prevention of mother to child transmission of HIV/AIDS need regular review.

2. The VCT in the antenatal services needs to be improved all round.

3. The next programme should develop means to improve the confidentiality of the status of PLHA to give them confidence and not be reluctant to come forward for this highly cost-effective preventive treatment.

4. The prevention of mother to child transmission needs to create better links between those attending the Harm Reduction programmes and the MTC services to provide 'safe' referral of IDU and their partners.

STRATEGY 7: Provision of medical assistance and social support to people living with HIV or AIDS (PLHA) and their families

This strategy focussed on the specific needs of the PLHA and their families. It included activities to improve the social support and assistance for PLHA and their families, setting up a suitable treatment ward with improved diagnostic facilities and the development of national standards on treatment of PLHA, supporting home care and palliative care for PLHA, and establishing a public information and psychological support 'trust phone' or hot-line to help promote healthy lifestyles for PLHA and drug users.

It is estimated that Moldova currently has about 5,000 PLHA, of which about 2,000 have been identified. At present there is enough ARV treatment in stores to treat 130 PLHA – they are currently treating 68 (includes 7 in prisons) with these are expected to increase to 70 by the end of the year. This ARV treatment has been purchased by the Ministry of Health at an average price of $1,100 per person per year. Today there are various international initiatives and foundations which have been set up to facilitate negotiations to reduce the average price of good quality generic highly active anti-retroviral treatment (HAART) drugs. This may result in significant savings, liberate funds either to treat more patients or to buy more diagnostic or other medical equipment or disposables which may be required. The government should make every effort to become involved in these negotiations to reduce the cost of HAART. So far HAART is only available in Chisinau – eventually there will need to be some roll out to make it available in other parts of the country – with the more stable patients treated in the rayons.

A newly refurbished AIDS ward of 35 beds (including 5 paediatric beds) was opened in the Republican Dermatovenerological Hospital instead of the "Toma Ciorba" Hospital. Besides there being more space (and the author was informed that 'it has a separate entrance') and improved diagnostic services, the Republican Dermatovenerological Hospital is more isolated than the "Toma Ciorba" Hospital. Therefore it is less likely to see demonstrations by less informed members of the public against the AIDS patients as is reported to have happened not too long ago. It is not just the general public which still shows some discrimination against PLHA. There are few dentists or surgeons ready to treat PLHA outside Chisinau – more need to be identified. Also the author heard an unverified story how certain clinicians, in this case chest physicians,

were reluctant to treat PLHA who developed TB, either because they felt that this was a waste of time or because they were seen to be taking up valuable treatment resources from 'normal' patients. The story goes that a PLHA developed TB and was referred to the chest physician. They took a chest X-Ray and claimed that as there were no typical TB changes seen, they did not see any reason for investigating further (an excuse?). The PLHA went on to die of TB. This is quite a serous allegation as experience in other countries has shown that not treating TB within any PLHA aggressively may lead to larger general TB epidemic and even the emergence of multidrug resistant TB with serious consequences for the nation. In 2003 there were 111.2 new cases registered of TB per 100000 (4016 new infections detected), slightly less than in 2002 – still a very high incidence.

The next programme should look into these allegations and if found to exist, see that this sort of attitude among the clinicians is stamped out. Those involved in AIDS, TB and STI management need to work closer together for the benefit of all. One practical suggestion to help move this along is to set up a small TB laboratory in the Dermatology Hospital and assign a TB specialist to carry out regular clinical sessions at this hospital.

Medications for most opportunistic infections are readily available in the new location, as are the majority of the treatment and diagnostics needed for any concomitant STIs. The negative aspect of the decision to place this AIDS Ward in the Republican Dermatovenerological Hospital is that this Hospital does not have the permits for all the medication that may be required – for example strong opiates like morphine (which is so necessary in the terminal care of these patients) are not available or permitted. Neither do they have resuscitation, rehabilitation or high dependency support equipment for these AIDS patients – as these all these require to be managed by separately accredited specialists who do not attend this hospital. A review of the specific needs of AIDS in-patients should be carried out and the necessary permits or supplies obtained. A minor complaint voiced by the PLHA was that there was only one main clinician running the AIDS ward and he has so many demands on his time for training and education, that sometimes this does not leave him enough time for treating PLHA. Another issue which requires some consideration is that having just one ward for AIDS frequently results in active drug users mixing with children for example – with the staff uncertain how to cope with the possible ill-effects this may cause.

Contracts for procurement of equipment and reagents for CD4 and CD8 for the National Reference Laboratory of Chisinau and Balti have been signed. Although the AIDS Centre has proposed that a second PCR is procured for its use in Chisinau (as have the Blood Transfusion Services), the existing PCR that was procured for the Dermatological and Venereal Diseases Dispensary is underutilised. This despite the availability of tests systems and of fully trained staff trained to operate PCR. The requests for a second or third PCR in Chisinau should not be entertained in the short to medium term but a second one they may become necessary in the longer term. An administrative arraignment for the existing PCR in Chisinau to start carrying out tests for the AIDS Centre or the Blood Transfusion Services should be introduced.

Good national standards on the treatment of HIV/AIDS have been developed as has a National Protocol on palliative care for AIDS patients. In the case of the latter however, there seems to be some confusion about what is the difference between palliative care and the concept of home care. Home care of PLHA is planned to be done through the Family Doctors but it is unclear how palliative care will be carried out as the Family Doctors do not yet have the skills or knowledge to take over this function. Neither have there been any hospices established to take on this important aspect of care. Despite the much improved effectiveness of the ARV, hospices will be needed in future and the ideal situation would be to base the offices of an NGO operating the services with the same building.

There have been some advances in the social support for PLHA. These now get a minimum of social assistance and since 2003, PLHA are entitled to get an invalidity pension. With the reforms in the health sector rules regarding who is entitled to automatic health insurance, this is related to the employment status of the individual. For many PLHA this does not apply very well because although some will have employment, most are likely to have to give up employment due to extended periods of ill-health which may result from either complications of treatment or due to the AIDS itself. The government should consider passing a regulation which would allow PLHA to get an automatic health insurance policy even if not employed as they are experiencing difficulties getting treatment for various complications and related medical problems besides AIDS. Another suggestion is the possibility of providing some further social assistance for the carers/families who will be caring for sick AIDS patients. These should be given the possibility of having extended work breaks without loosing their jobs to care for their PLHA at home. Finally there has been a suggestion that

some of the poorer PLHA, especially the IDU, should be provided with a nutrition allowance or food package which they would need to build up their strength and to help the medication work more effectively.

Recommendations

1. The government should take advantage of the various possibilities to reduce the average cost of HAAR Treatment.

2. So far HAART is only available in Chisinau. This will eventually need to be extended to other parts of the country in the interests of equity.

3. At present there are few dentists or surgeons ready to treat PLHA outside Chisinau – more need to be identified and trained to take on this task.

4. A review of the specific needs of AIDS in-patients should be carried out and the necessary permits, equipment or specific supplies (such as morphine or high dependency equipment) obtained. This may include setting up a small TB laboratory in the Dermatology Hospital and assign a TB specialist to carry out regular clinical sessions at this hospital or a small resuscitation section.

5. An administrative arraignment for the existing PCR in Chisinau to carry out tests for the AIDS Centre or the Blood Transfusion Services should be introduced.

6. Greater efforts need to be made to ensure that any remaining discrimination against PLHA among the medical profession does not continue.

7. There needs to be more work to sort out how palliative care and home care of PLHA will be provided.

8. There needs to be hospices run by NGOs set up and supported.

9. The government should consider how best to ensure that PLHA are covered by health insurance (for their other health needs besides ARV) even if they are not employed. .

10. The next programme should introduce further social assistance for the carers/families who will be caring for sick AIDS patients in the home.

STRATEGY 8: Epidemiological surveillance and state monitoring of HIV/AIDS and STIs

This last strategy focussed on strengthening the process of monitoring the HIV/AIDS and STIs epidemiological situation with a view to better inform the policy makers and enable them to respond adequately to these infections. Most of the activities were associated with improving the effectiveness of some of the older AIDS institutions. These first organizations were initially developed in the 1980s to organise mass testing and screening so as to identify as many HIV positive persons as possible with a view to impose preventive measures on the individual. They later broadened their range of activities when the knowledge about HIV/AIDS became more sophisticated.

This strategy therefore planned for supplying test kits, organising sentinel surveillance surveys, introducing second generation surveillance at a national and district level of groups at high risk and to introduce specific sentinel surveillance of TB among PLHA. There were also plans to try to evaluate the effectiveness of the 'anti-epidemic measures' in the worst affected parts of the country. The strategy included improving general access to testing while providing anonymous pre- and post-test counselling wherever required, and to further support the efforts to prevent nosocomial transmission in the state medical institutions and private medical institutions, as well as in beauty saloons, manicure and pedicure saloons and other similar establishments at higher risk of transmitting the infection.

For many years the AIDS Centres were the foundation of the government response to the epidemic. As their experience of the AIDS problem increased, they became the first government body to recognise that AIDS is

more than just a health problem and that only by pulling together a broad multisectoral response can there be any progress. The AIDS Centre also took on much of the early educational demands of a variety of audiences. They were the first government institution to actively seek to collaborate with NGOs and representatives of the vulnerable populations. Apart from being involved in a wide variety of activities, the main role of the AIDS centre has been to organise the national surveillance programme. The full testing and screening programmes have been re-established in 9 laboratories throughout the country and they have resumed some sentinel surveillance surveys on various vulnerable populations[13] – mainly among those participating in various projects run by NGOs.

One of the most established sentinel surveillance programme is in the prisons system. Every 10th convict is counselled and then asked for a blood sample. This surveillance showed that two prisons, in Tighina and Soroca there were prevalence rates greater than 10% and that most of these were in prisoners involved in drug related crime.

Three surveys (in 2000, 2003, 2004) of roughly 500 IDUs attending the harm reduction projects, showed HIV positive rates of 25.7%, 29.2% and 22.13% of respectively. A survey of Roma (September 2003) of 115 persons found no HIV, but 12.8% had Hepatitis C and 10.6% had syphilis, indicating that this group is still at risk. 118 MSM attending projects were also surveyed (September 2003) and were found to have 1.69% with HIV, 11.4 % had Hepatitis C and 12.12% were found to have syphilis. Similarly 151 CSW attending projects were surveyed (September 2003) and 4.4% were found with HIV, 10.98% with Hepatitis C and 12.12% with syphilis[14].

Usually every effort should be made to ensure that surveys of this type are as representative as possible of the sub-population as a whole. Frequently, however, for reasons of ethics or feasibility, non-random sampling techniques are inevitable, but still it should be possible in future for the sentinel surveillance samples to be extended to risk groups beyond those persons who are attending for the projects. At present these results might give a false sense of achievement as the prevalence rates of the Harm Reduction participants for example, should tend to continue to improve in time, while the real situation in those drug users not attending these projects (at present these are probably eight times as many) may be deteriorating. Examples of new sentinel sites for IDU may include surveying a sample (with their informed consent) of those admitted to hospital due to an overdose of drugs (but excluding any who regularly attend the Harm Reduction projects to eliminate overlap) or sampling newly arrested injecting drug users, or obtaining saliva samples from drug users attending bars, clubs or from certain streets). This may be referred to as expanding the index subpopulation to other exposed populations.

Secondly for this sort of surveillance to be of greater value, the surveys need to be repeated on a more regular basis as the sample in sentinel surveys is not big enough to be truly representative of that particular vulnerable population[15]. Data from sentinel surveys is best used to follow the trends in the population (and not to give a snapshot picture) so testing once a year, at this stage of the epidemic in Moldova, is probably too long to allow between surveys. The surveys need to be repeated at least every four to six months now that the test kits and systems are available. Also in order to facilitate recruitment to these regular surveys, testing may be done on the non-invasive saliva or urine. Although the accuracy of these latter tests systems is slightly less than of the blood tests, this is still acceptable as the samples will not be used in a screening programme (so to diagnose individuals) but for a sentinel survey (to identify the proportion with HIV to give only an indication of the situation). The results of these tests could still provide a valid trend if repeated regularly.

There have been few behavioural surveys among the vulnerable population and these were certainly not done on a regular enough basis to be termed behavioural surveillance. Behavioural surveillance implies repeated cross-sectional surveys of behaviour in a well defined representative population, with the survey questions designed to enable the researcher to track changes in risk behaviour over time. Besides the lack of expertise in organising and conducting these surveys properly, the serum surveys (so-called biological surveillance) are mainly organised by the AIDS Centre, while the behavioural surveys were mainly done by NGOs or by projects funded by donors. To be most effective biological and behavioural data should be linked and used to validate one another. Two sets of data pointing in the same direction make a more convincing case than just

[13] Sentinel Surveillance Programme. Republican AIDS Centre.
[14] Sentinel Surveillance Programme. Republican AIDS Centre.
[15] Guidelines for effective use of data from HIV surveillance systems. WHO/UNAIDS/FHI/EC (2004)

behavioural data or HIV prevalence alone[16]. At present these datasets are kept in separate locations, even though the populations studied were probably similar (it is usually recommended that behavioural and serological data are drawn from different individuals but broadly representative of the same index population). The new M&E unit needs to work to combine these datasets and produce a joint report – thereby moving closer to true Second Generation Surveillance. This merging of the data should be planned carefully. The next series of surveys need to first have a detailed mapping exercise before deciding whether to retain the present sampling techniques and recruitment methods or whether different methods (and sampling sites) are required. It is the time to take the existing, relatively good surveillance system to a more sophisticated level and produce true 2nd generation surveillance reports to improve the quality of the next national programme. New protocols for this sort of second generation surveillance have been prepared but the author recommends that these be reviewed in the light of these comments. Further training of technical personnel in sentinel and behavioural surveillance, interpretation and reporting is also recommended.

The good work carried out in renewing surveillance has not been matched by the activities in expanding the voluntary testing and counselling services. The author heard several sources complain that there was a great deal of suspicion among the general public as to how truly *anonymous* (meaning that the result has no personal identifier at all either for the laboratory or for the clinician) verses being *confidential* (which means that the individual's details are kept secret or are coded but they can eventually be traced by the laboratory) are some of the testing practices and even these serosurveys. The author was informed that any person may ask for an anonymous test and is given the result. If they are found positive, they will be asked to repeat the test (apparently to confirm the result), but this time the individual must provide the full personal details to the laboratory and these are then passed on to the AIDS Centre. The reason given for this is that unless the person is notified, with fu details registered, than that patient cannot be given ARV treatment.

Also there were some doubts about how much those organising these serosurveys obtained informed consent from the participants before going ahead with these tests. The official system of recording notified cases of HIV is another potential source of information leaking out on who is positive. Once the laboratories or clinicians send the full details (as required by law) to be entered into the AIDS Centre HIV register, these personal details are then for some obscure reason sent out to a long list of official bodies such as the local police, the family doctor, the Centre for Preventive Medicine, sometimes to the institution where the blood sample came from, etc. Somewhere along the line, the confidentiality surrounding this sensitive information wanes to the detriment of the PLHA, even though the actual registers are actually kept under very high security in the AIDS Centre. Many negative comments were passed about the confidentiality of the HIV status of PLHA once the test result is known. These concerns are compounded in those facilities outside of the main towns which offering the HIV test. Here attendance for the test seems to be low partly because of their fears that information about their status will be disclosed by the medical staff. Lack of confidence in the system may actually serve to drive away those people who may be most at risk of infection, as many of them will not want their status to be made know to their families, work colleagues and social circles. This system of passing on full personal details taken out of the register should be reviewed. In most cases the other institutions only need only to know the 'blind' aggregated data – that there is x number of HIV in their district this month. Even the clinicians treating the person could have their patients details coded in such a way that only they will understand the identity of the PLHA.

Most of the key stakeholders agreed that the system of VCT was the poorest element this National HIV/AIDS Programme. Although on paper this is available throughout the country, in practice true pre- and post-test counselling with suitable referral systems are provided in few sites. More training in counselling skills and on emphasising the importance of counselling is needed for staff working with STIs and HIV/AIDS. This training should be extended to every clinician who may be involved with a PLHA – for example the VCT is understood to be especially poor in the antenatal clinics outside of Chisinau and Balti.

In the other activities there has been some good progress registered, for example, in adopting the more practical policy of voluntary partner notification over the old mandatory contact tracing of PLHA. As part of the post-test counselling, usually at the AIDS Centre, the PLHA is now offered advice and any assistance they may request with voluntary partner notification, as is practiced in most countries.

[16] Initiating second generation HIV surveillance systems: practical guidelines. WHO/UNAIDS (2002). and Guidelines for Second Generation HIV Surveillance. UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance. (2000)

As mentioned previously under Strategy 4, there were some concerns about the possibility of nosocomial transmission of virus in beauty parlours, hair-dressing salons, etc. when the programme was written. The claims that there was obligatory training in hygiene and that they are being inspected regularly could not be verified, but again it is suggested that the next programme gives priority to tattooists and acupuncturists over the other lesser risk professions. Apparently there was a recent order published (in 2004) that all hairdressers must be mandatory tested for HIV. This is probably wasteful of resources, of uncertain benefit and may lead to persons at higher risk avoiding testing to avoid any measures being imposed on them. Better would be to use these funds to promote and teach safe practices and then to maintain the knowledge with annual reinforcement.

Recommendations

1. In future sentinel surveillance needs to be extended to risk groups beyond those persons who are attending for the projects as this might give a false sense of achievement. Also consideration of introducing testing using non-invasive saliva or urine should be given.

2. Further training of technical personnel in sentinel and behavioural surveillance, interpretation and reporting is recommended and the behavioural surveys need to be carried more regularly and be better planned with the serum surveys.

3. Confidentiality appears to be a major problem which needs to be looked into to improve public confidence. Current practices of sending details of newly registered PLHA to a mailing list should stop.

4. Voluntary Testing and Counselling needs to be given particular importance in the next programme as there are many grounds for improvement.

OTHER CROSS CUTTING INITIATIVES:

1. Monitoring and Evaluation

A specialized M&E unit was created within the National Centre of Public Health Management (CPM) in response to the greater demands for better quality evaluation. It is still too early in the life of this unit to evaluate their work but there are very high expectations for the future and clearly a great amount of work ahead for this team. It is certainly the case that the present technical team needs to be strengthened and more investment in suitable human resources is needed. The type of skills they will require include staff knowledgeable in qualitative and quantitative study design and interpretation, designing and implementing knowledge, attitude and behaviour studies, needs assessments, cost effectiveness studies, epidemiology and interferential statistics and strong coordination skills. The problems with recruiting staff of sufficient technical quality will remain for some time and training will therefore continue to be a major activity. The most difficult skill remains learning how to take decisions based on the evaluation of the data.

They have developed 150 national TB/AIDS indicators to assist in their evaluation work. Many of these indicators require baseline studies or rapid assessments to establish their initial values and the unit is currently developing protocols for these studies which should be completed by next year. The M&E unit will be establishing a scientific research unit to perform the big studies themselves, but they will also have the facility to contract NGOs or involve part time specialists from university academics to do other specific studies. Also a strong IT system is being developed – purchasing equipment and establishing a network linking all hospitals reference labs, AIDS Centres, etc –this should make the routine data more readily available. The M&E unit should also plan to include data routinely collected from the other Ministries, especially the Ministry of Education, Ministry of Justice (including prisons), Ministry of Internal Affairs, Ministry of Social Protection and Labour (for orphans and homeless), etc. It is important that a proportion of the work of the M&E unit involves focussing on the validity of the data – identifying errors, bias and sources of bias and eliminating any false data.

Another of the main tasks will be to improve the appreciation of M&E among the health personnel and the decision makers. On suggestion is to include the subject in undergraduate curricula or organise workshops to show the relevance of good programme evaluation.

Finally the crude epidemiology picture suggests that Moldova may be at the beginning of a shift to a more generalised epidemic through the infection of so called bridge groups, specific studies are needed to estimate if this is the case or not. This should be one of the new M&E Unit's priority actions for the next programme as the results of these studies could mean a profound shift in the funding priorities.

Recommendations

1. The present technical team needs to be strengthened urgently with more investment in suitable human resources needed.

2. Besides the usual sources of data, the M&E unit should also plan to collect data routinely collected from the other Ministries, departments and institutions outside the health sector.

3. It is important that a good proportion of the work of the M&E Unit involves focussing on the validity of the data collected.

4. The M&E Unit needs to study and focus particularly on the bridge populations to stay one step ahead of the epidemic

2. Working through NGOs

As mentioned above NGOs have been active in the development and implementation of educational programs, providing assistance, care and support to PLHA and implementing the more difficult targeted prevention activities among vulnerable groups or groups at high risk like IDU, sex workers, MSM and the Roma.

Despite the proven effectiveness of this approach, the expansion of the non-government organisation community has been hindered by a persistent distrust from certain sectors of the government. Decision and policy makers need to formally accept that NGOs play a vital role in the broad response to the epidemics. They need to work to eliminate administrative restraints which do not enable government departments and entities to directly support the work of NGOs within a balanced plan devised for the next programme. It is generally accepted that the NGO community needs to expand to increase the prevention activities among the vulnerable populations, also throughout the country as at present there is an uneven geographic distribution.

As mentioned under Strategy 5 the government needs to study how it can best support and improve the NGO sector to enable it to expand and become more effective. They should be seen as complementary to and not in competition with the government structures. Changes to the administrative laws must be made to enable the government to contract and fund NGOs to do specific work.

Recommendations

1. The government needs to explore new ways of supporting the expansion and effectiveness of the NGOs working on targeted prevention activities among vulnerable groups. This may involve changing administrative laws and regulations to allow direct support to NGOs.

3. Information and Communication

With the very real possibility that HIV will gradually extend into the broader population in the next few years, the general public needs to be made to feel that HIV is a real threat to everyone and is not just a problem of the more vulnerable populations. This will require the development and broadcasting of specialized TV, radio and press programmes to raise awareness of the population on the importance of prevention of HIV/AIDS and STIs. A structured campaign should first be carefully planned so that the messages chosen are the most effective possible, are repeated often enough to have an effect and are understood correctly. At the

same time the messages on prevention need to be combined with messages to promote a more caring approach to PLHA aiming to reduce any discrimination and stigma of PLHA. .

There has already been some work on planning such a National Communication Strategy but this will need to develop further during the next programme. Some work has also been carried out on working with journalists as important partners in such a campaign and this work should be broadened in the coming years.

Recommendations

1. The next programme needs to give a higher priority to developing a National Communication Strategy and the government's capacity to implement and monitor such a Strategy needs to be improved.

Annex A

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