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REPUBLIC OF MOLDOVA

PROGRESS REPORT ON HIV/AIDS

January 2012 – December 2013

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List of acronyms

AIDS - Acquired Immunodeficiency Syndrome
ARV - Antiretroviral
CSW - Commercial Sex Worker
HIV - Human Immunodeficiency Virus
IDU - Injecting Drug User
ILO - International Labour Organization
GFATM - Global Fund to Fight AIDS, Tuberculosis and Malaria
LGBT - Lesbian Gay Bisexual Transsexual
MARP - Most at risk population
MDG - Millennium Development Goal
MDL - Moldovan Leu
MSM - Men having sex with Men
M&E - Monitoring and Evaluation
NGO - Non-governmental organization
RDSAT - Respondents Driven Sampling Analysis Tool
PLHIV - People Living with HIV
PMTCT - Prevention of mother-to-child transmission
STI - Sexually Transmitted Infections
TB - Tuberculosis
UNAIDS - United Nations Joint Programme on HIV/AIDS
UNICEF - United Nations Children's Fund
UNGASS - United Nations General Assembly Special Session
UNIFEM - United Nations Development Fund for Women
UNFPA - United Nations Population Fund
UNDP - United Nations Development Programme
USD - United States Dollar
VCT - Voluntary Counselling and Testing
WHO - World Health Organization

EXECUTIVE SUMMARY

Reliable information is one of the most important determinants in the process of development and implementation of efficient and effective strategies. Information represents the evidence base for establishing the framework, soundly based on the status quo, for efficient interventions to prevent the spread of HIV.

Together with other countries, the Republic of Moldova participated at the UN General Assembly in 2011 where the Political Declaration of Commitment to eliminate HIV/AIDS was signed. Also, it is part of the Dublin Declaration and of the WHO Global Strategy on Health sector.

The joint Monitoring and Evaluation system of the National Programme on Prevention and Control of HIV/AIDS and STI in the Republic of Moldova has been implemented starting with 2005. Over the years, this system passed through a series of system strengthening stages, but it is yet premature to state that the system is fully functional and satisfies all the key information needs. However, relevant strategic information has been obtained and made and accessible to inform the decision-making process in the national response to HIV.

The given report is the result of collaboration among institutions, ministries, and public organisations, non-governmental and international organisations. Due to the fact that several sectors are involved in the National AIDS Response, each of them with specific interventions, the data are generated by numerous governmental and non-governmental institutions, their quality being also different. Representatives of governmental institutions and nongovernmental organizations which are part of the national HIV response have been involved in the process of collection, analysis and interpretation of data for the current AIDS Progress Reporting. The values of the indicators reported have been discussed and agreed upon in the framework of meetings aimed at development of the National Programme for the Prevention and Control of HIV/AIDS and STI for the years 2010-2015. A detailed description of the process can be found in Appendix 7.

The HIV epidemic in the Republic of Moldova is a concentrated one in the IDUs population. The results of the last HIV seroprevalence survey among IDUs carried out in 2012/2013 have shown an HIV prevalence of 8.5% in the capital of the country. The HIV seroprevalence registered in 2012/2013 among IDUs attests a lower value in IDUs from the capital city and from other two locations where the study was carried out (16,4% in 2009, 17,5% in 2007 and 14,4% in 2003/2004). In the last 3 years, the number of newly registered HIV cases among the tested IDUs is decreasing.

At the national level, the state policy framework guiding the HIV response in the Republic of Moldova is implemented through the National Programme on Prevention and Control of HIV/AIDS and STI for 2011-2015, which determines the priority national strategies: prevention, epidemiological surveillance, treatment and care. The Programme is an integral and multi-sectoral plan. The process of Programme development includes:

- Correlation with the process of development and implementation of grant proposals of the RM to the Global Fund on AIDS/Tuberculosis and Malaria;
- Situation assessment, analysis of the national response and results of the implementation of the National Programme for the Prevention and Control of HIV/AIDS and STI for 2006-2010;
- Active involvement of the members of the National Coordination Council for coordination of the implementation of the National Programme on Prevention and Control of HIV/AIDS and TB Control and Technical Working Groups of the NCC;
- Consultations based on a consensus among main participants in the field, including the Government, international organisations, non-governmental organisations and PLHA.

- The National AIDS Programme was endorsed through the Government Decision of 24 December, 2010 and has the following objectives:
 - HIV incidence will not exceed 20, 0 cases per 100000 population within the age group 0-39 years.
 - Mortality of people living with HIV/AIDS of the total number of persons estimated will be reduced by 10% by 2015.

In June 2011 the National Programme on Prevention and Control of HIV/AIDS and STI underwent an external evaluation performed by a team of national and international experts. As a result of the evaluation, a series of recommendations have been developed and programme objectives have been reformulated:

- Prevention of transmission of HIV, Hepatitis and STI, especially among key-populations;
- Reducing the negative impact of the epidemic, mainly by offering treatment, care and support to people living with HIV/AIDS and members of key-populations;
- Promoting synergies with other components of the health system;
- Development of an efficient system of programme management.

The Programme (to be approved) is focused on:

- Prevention of HIV transmission in the Republic of Moldova, especially HIV transmission among key-populations, such as IDUs, CSWs, MSM, and prisoners, as well as prevention of HIV transmission from these groups to the general population.
- Reducing the impact of the epidemic, mainly by providing treatment, care and support to people living with HIV and members of key-populations, by covering PLHA with ARV therapy, treatment of co-infections and other STI, and use of ARV therapy for prevention purposes, such as prevention of mother to child transmission and post-contact prophylaxis. Care and support includes a large chain of services, including palliative care.
- Promotion of synergies with other components of the health system, such as activities on hepatitis, blood safety and STI. In cases of hepatitis and blood safety, these components have their own National Programmes. There is no separate Programme on STI, but STI management is an integral part of the given programme.
- Effective and efficient management of the programme by coordinating a large series of partners and stakeholders interested in implementation, including state institutions, civil society organisations and people living with HIV. Also, the aim is to ensure some adequate levels of funding for the Programme from both internal resources and donors. Another envisaged result is development and management of strategic information through data collection and an efficient monitoring and evaluation systems.

The Republic of Moldova is recognised in the region as an example of good practices due to its successful implementation of Harm Reduction Programmes in key populations at risk in the civilian sector (IDUs, CSWs, MSM) and in penitentiary institutions (IDUs). Thus, there are information/education/outreach, and needle exchange activities, as well as referrals to medical and social services. Methadone Substitution treatment is provided both in the civilian sector and in penitentiary institutions (on right bank of Dniester river only). During the reporting period, services extended in 3 other localities, including the left bank of the Nistru River (IDU).

During the reporting period, activities were carried out in the general population in order to promote a healthy lifestyle and safe behaviours, by excluding the risk of HIV infection and to promote condom use, especially among young people. The on-line life school based education module, within the discipline “Civic Education”, for young people from 5th to 12th forms has been developed and made

functional since 2012, as well for the secondary education the module “decisions for healthy style” has been developed and implemented through 2012 and 2013 years. By getting involved in the “Peer-to-Peer” network a the young people had the possibility to participate in actions of prevention of HIV/AIDS, STI, drug addiction and alcoholism.

The voluntary Counseling and testing service established in 2007 has been extended and reached national coverage, being present in all administrative territories.

Normative acts have been adjusted according to the recommendations of the World Health Organisation, UNAIDS and European Union, in accordance with the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS. Human rights-based approach has been applied, aiming to promote basic principles of non-discrimination of people living with HIV, to minimize the consequences of the epidemic and to ensure Universal Access with the implementation of comprehensive and multidisciplinary interventions. In an effort to bring existing regulatory framework in line with these basic human rights principles,, the Order on “Abolishment of some Laws regulating Prevention and Control of HIV/AIDS” has been approved and normative acts containing stigmatizing provisions have been abolished. A modification and completion of Law nr 23 of 16 February 2007 on prevention of HIV/AIDS has been approved in the mid of 2012. The amendments to the Law nr 23 fully guarantee the right to privacy the right to non-discrimination and equality of people living with HIV/AIDS and the right of people living with HIV/AIDS to freedom of movement. The antidiscrimination called the Law of Equal chances has been adopted by the parliament in 2012, which ensures the rights of people and tolerance towards the most vulnerable and stigmatised.

To ensure standardisation of services, a National Guideline has been developed on quality management of HIV/AIDS laboratory investigations and the following drafts are in the process of endorsement and approval:

- Operational Manual of the National Plan for Monitoring and Evaluation of HIV/AIDS, 2011-2015;
- National Protocol and Operational Manual on HIV/AIDS second generation epidemiological surveillance;

A distance learning programme on HIV/AIDS has been developed in collaboration with the School on Public Health Management of the State University of Medicine and Pharmacy "Nicolae Testemitanu". This curriculum contains the following modules: *General Overview on HIV/AIDS, Epidemiology and Control of HIV/AIDS, Care and Support of people living with HIV/AIDS, Surveillance and care of HIV infected patients, Voluntary Counseling and Testing, Coverage of Most at Risk Populations, Human Rights in the context of HIV/AIDS, Monitoring and Evaluation in the context of HIV/AIDS*. During 2013 there have been trained 760 persons (family doctors, managers of medical facilities, epidemiologists, ONG workers, nurses) to use distance learning.

HIV EPIDEMIC IN THE REPUBLIC OF MOLDOVA

The Republic of Moldova is classified as a concentrated/low prevalence country with a concentrated HIV epidemic in IDUs population. There is evidence of spread of the infection in the general population. Estimations of HIV prevalence in the general population have been made in 2010, repeated in 2011, 2012, 2013 and early 2014 using the estimations and projections tool called Spectrum. According to the estimations made in 2014 there are 1392 new estimated HIV cases (906 cases on the right bank and 486 cases on the left bank of the Nistru River). Also, the estimated HIV prevalence for the right bank of the Nistru River is 0.45% and 1.84% for the left bank. The population infected with HIV in 2014 was estimated at 14801(9762 on the right bank and 5039 on the left bank).

The need for ARV treatment is estimated at 6591 persons (4398 on the right bank and 2193 on the left bank of the Nistru River). The necessity for prophylactic treatment for 2013 was estimated at 180 HIV positive pregnant women (120 on the right bank and 60 on the left bank of the Nistru River).

By the 1st of January 2014 there have been registered 8557 new HIV cases on both banks of the Nistru River. During the last 5 years, the number of new HIV cases is more or less stable.

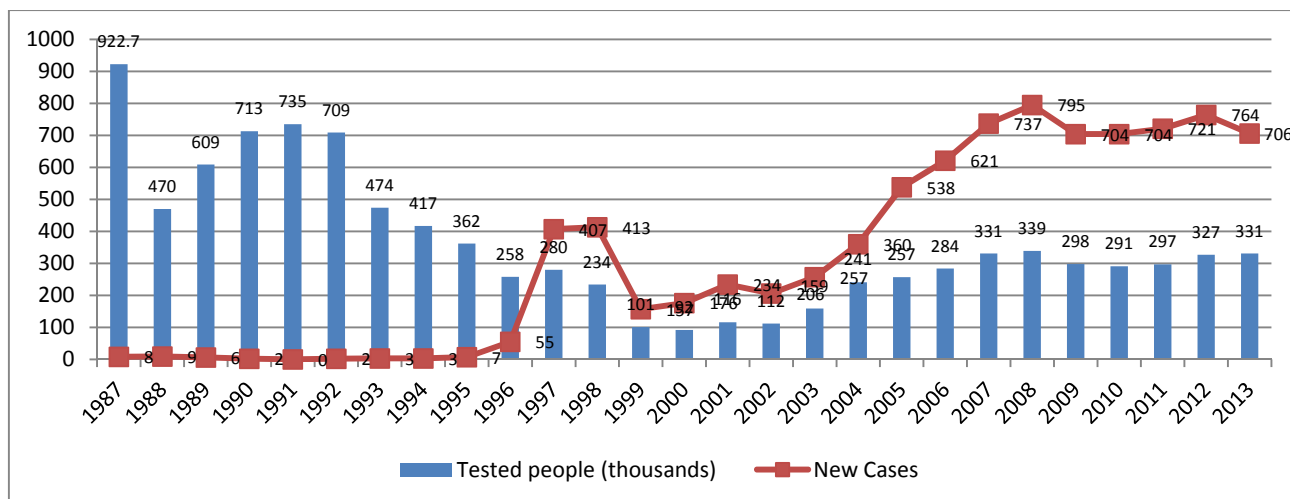


Figure 1 HIV testing and the number of newly registered HIV cases, Republic of Moldova, 1987-2013

In the last 5 years, sexual transmission is the main probable route reported by newly registered HIV cases in the Republic of Moldova (out of 764 new HIV cases reported in 2012, 86,8% mentioned about the sexual route as the main probable route of HIV transmission; out of 706 new HIV cases reported in 2013, 91,9% mentioned about the sexual route as the main probable route of HIV transmission).

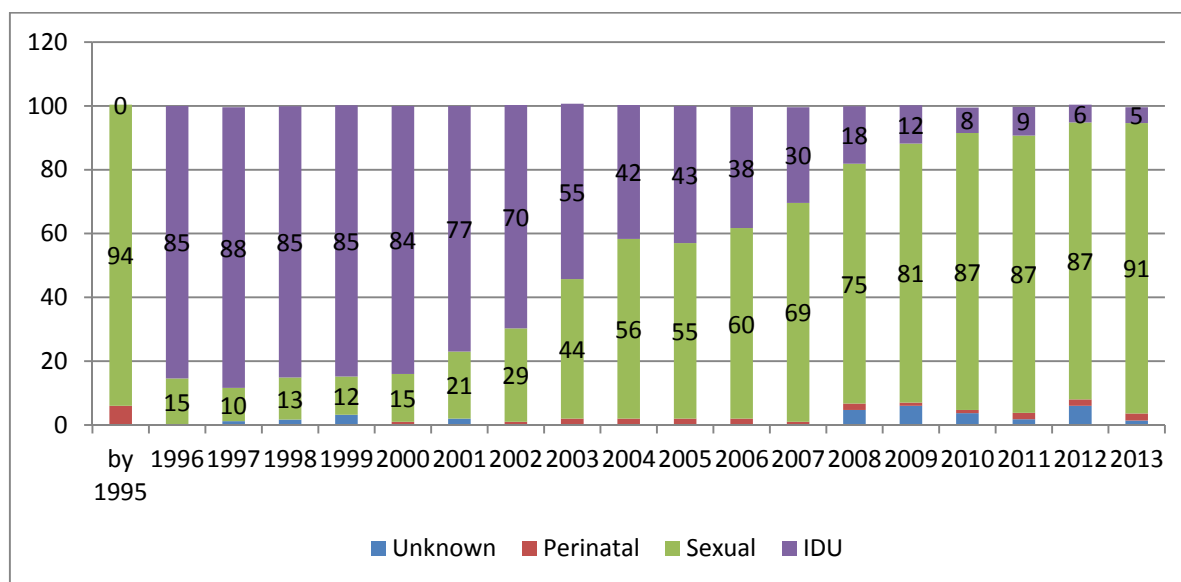


Figure 2 Distribution of new HIV cases by probable route of transmission in the Republic of Moldova, 1995-2013

The change in the structure of newly reported HIV cases in terms of probable route of transmission increases the vulnerability of women, constituting 46.31% of new HIV cases registered in 2013 (in 2012 out of the newly reported HIV cases, women represented 51,2%). HIV/AIDS is mainly registered among young people of reproductive and economically-active age, aged 15-39 – 71,1% of new HIV cases registered in 2013, in age segments of 20 - 24 years old – 13,46% and 25-29 years old – 18,8% (in 2012, out of the newly registered HIV cases in age groups of 15-39 years old constituted 74,3%, 20 - 24 years old – 14,4% and 25-29 years old – 20,9%). Starting with 2007 coverage of pregnant women with HIV Testing exceeds 99, 0%, which allows calculation of HIV prevalence among them. For the last years, the prevalence of new HIV cases is relatively stable.

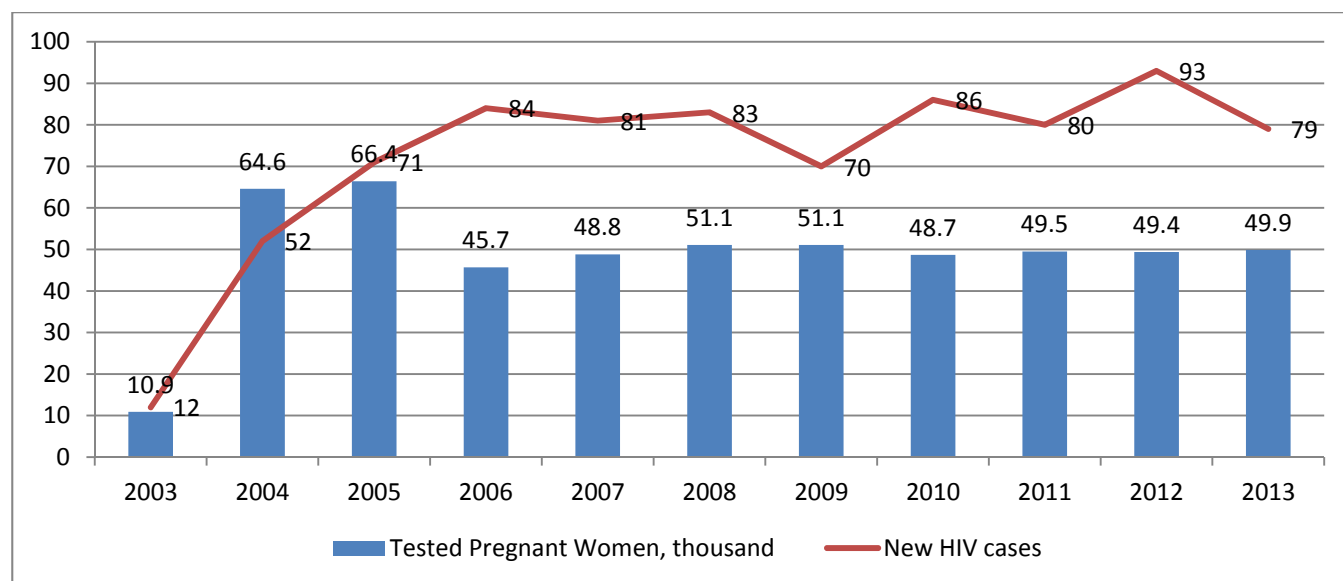


Figure 3 HIV testing and the number of newly registered HIV cases among pregnant women, Republic of Moldova, 2003-2013

According to the Multiple Indicator Cluster Survey carried out in the in the general population on the right bank of the Nistru river in 2012, 78.5% of female respondents and 64,6% of male respondents know about the possibility to take an HIV test in the locality where they live.

The Integrated Bio-Behavioural study on Knowledge, Attitudes and Practices among most at risk populations was carried out in the Republic of Moldova during 2009-2010, using the Respondent Driven Sampling methodology for the first time and repeated in 2012-2013 using the same methodology. This fact enabled the recruitment of respondents other than just beneficiaries of harm reduction programmes (as done in past survey rounds, when convenience sampling has been used), although it made results not comparable to 2003, 2004, 2007surveys. Results of HIV prevalence among IDUs, CSWs, MSM and prisoners are presented in the table below.

Table 1 HIV prevalence among IDU, Republic of Moldova, 2012

Location of Data Collection	Sample	HIV,%
Chisinau	365	8.5
Balti	363	41.8
Tiraspol	300	23.9

Table 2 HIV prevalenceamong CSW, Republic of Moldova, 2013

Location of Data Collection	Sample	HIV,%
Chisinau	364	11.6

Balti	362	21.5
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Table 3 HIV prevalence among MSM, Republic of Moldova, 2013

Location of Data Collection	Sample	HIV,%
Chisinau	250	5.4
Balti	200	8.2

Table 4 Prevalence among prisoners, Republic of Moldova, 2012

Location of Data Collection	Sample	HIV,%
Prisons from the right bank of the Nistru river	528	1,9

Table 5 Results for the estimation of sizes of most at risk populations, Republic of Moldova, 2014

Group	Region	Group Size
IDU	Right bank	19400
	Left bank	10800
	Total	30200
CSW	Right bank	10000
	Left bank	2000
	Total	12000
MSM	Right bank	9700
	Left bank	3800
	Total	13500

NATIONAL RESPONSE TO HIV/AIDS EPIDEMIC

INDICATOR 6.1 HIV/AIDS spending

In order to ensure reporting according to the provisions of the indicator for 2013, data have been collected from various sources in accordance with the recommendations of the *Global AIDS Response Progress Reporting 2014 Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS*. Hence, there have been selected organizations from national and local levels that implemented and disbursed funds for Prevention and Treatment of HIV/AIDS, and for activities of coordination, monitoring and evaluation in the field. Organizations were asked to provide information on financial allocations spent and destination of disbursement according to the NASA matrix.

Thus, for calculation of expenses in the field of HIV/AIDS for 2013, data on annual expenditures with special destination for HIV/AIDS treatment and prevention have been taken into consideration from the following institutions within the health system:

- Ministry of Health, for state budget allocations and funds for Mandatory Health Insurance, for “Public Health Services” Program, for Prevention of HIV/AIDS an STI, and for implementation of the National Program for Prevention and Control of HIV/AIDS and STI 2006-2010 and the National Program for Prevention and Control of HIV/AIDS and STI 2011-2015;
- Medical –Sanitary Public Institution Hospital of Dermatovenerology and communicable diseases, the highest as hierarchy institution responsible for HIV response, specific responsibilities relate to HIV

surveillance, HIV/AIDS diagnosis and laboratory, pre ART surveillance, ARV treatment management and ARV treatment provision, as well as STI case management;

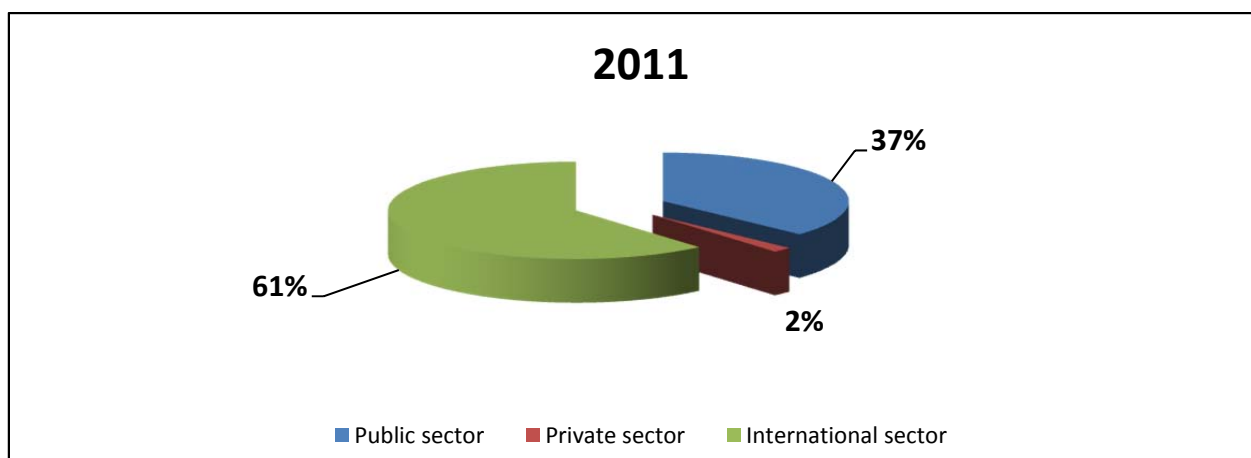
- National Public Health Centre responsible for HIV/AIDS epidemiological surveillance and prophylaxis activities;
- National Blood Transfusion center responsible for Blood Safety;
- National Narcology Dispensary for the activities on Harm Reduction in IDUs, including the methadone substitution program;
- National Institute of Research in the field of Mothers' and Children's health, for PMTCT;
- National Centre of Health Management for the part of the activities of Monitoring and Evaluation of the National Program on Prevention and Control of HIV/AIDS/STI for 2011 - 2015;
- National Coordination Council for coordination of the implementation of the National Programme on Prevention and Control of HIV/AIDS/STI for 2011-2015;
- Educational institutions, subordinated to the Ministry of Health, for expenditures in training, refresher training and specialization for pedagogical workers.

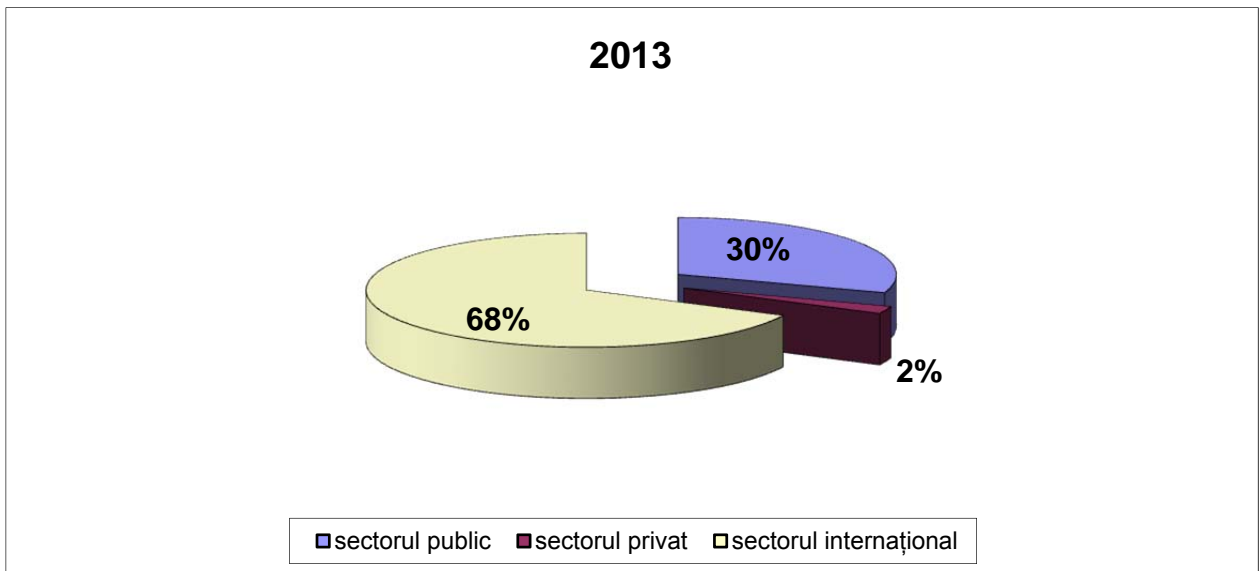
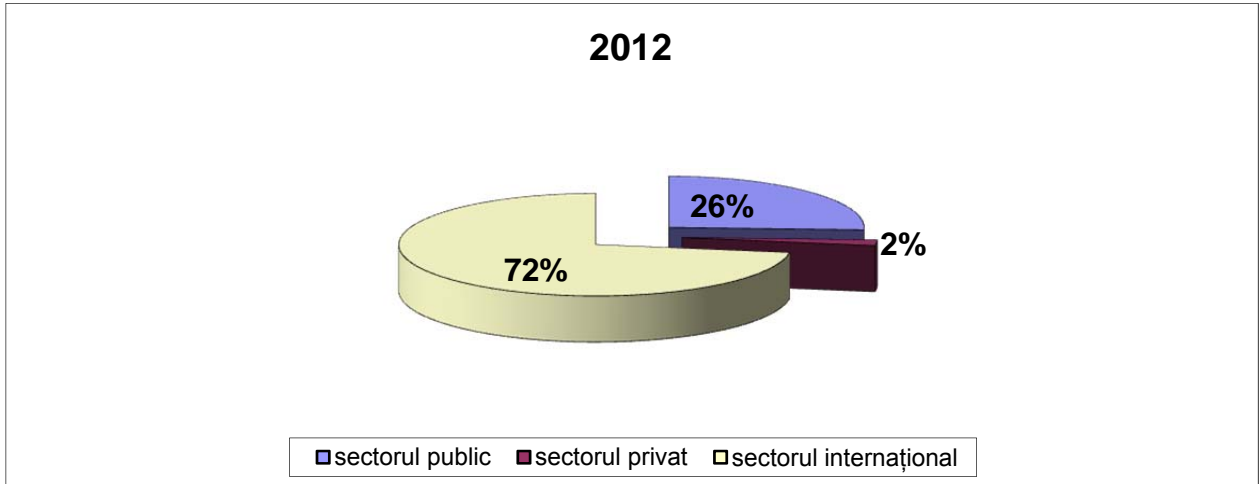
Information on financial flows was requested from municipal and district councils, line Ministries (Ministry of Justice; Ministry of Defense; Ministry of Youth and Sports; Ministry of Education; Ministry of Labor, Social Protection and Family) and international organizations implementing their activities in the Republic of Moldova (UNAIDS, World Health Organization, the principal recipients of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), UNICEF, UNFPA, UNODC, SOROS). Public Health Institutions reported according to budget lines, specifying the spending category and the source of financing. Bilateral or multilateral international organizations were classified according to the criteria of source of financing, but also as financial agents.

The content of the received questionnaires was verified in order to exclude the double counting of resources. In order to exclude possible overlapping of resources, the expenditures have been cumulated in accordance with the disaggregation by cost categories.

Expenditures for the national HIV response in the Republic of Moldova (in national currency) for 2011, 2012 and 2013 are presented in the Matrix for 2011, Matrix for 2012 and for 2013 respectively.

Figure 4 Structure of expenditures for the national HIV response by sources of financing, Republic of Moldova, 2011, 2012, 2013

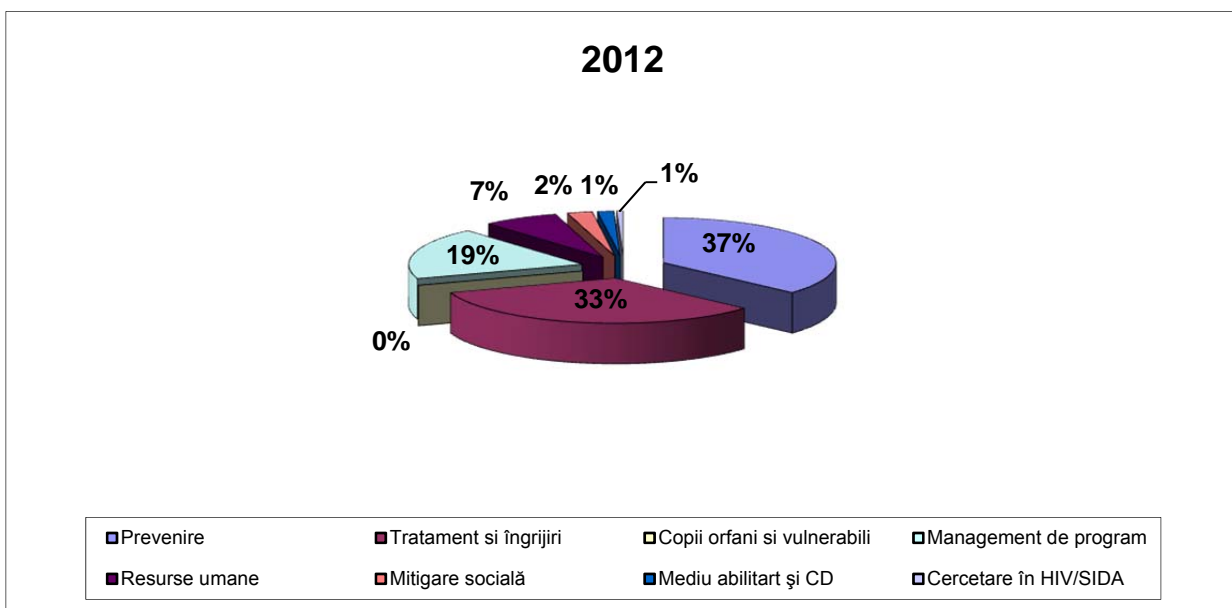
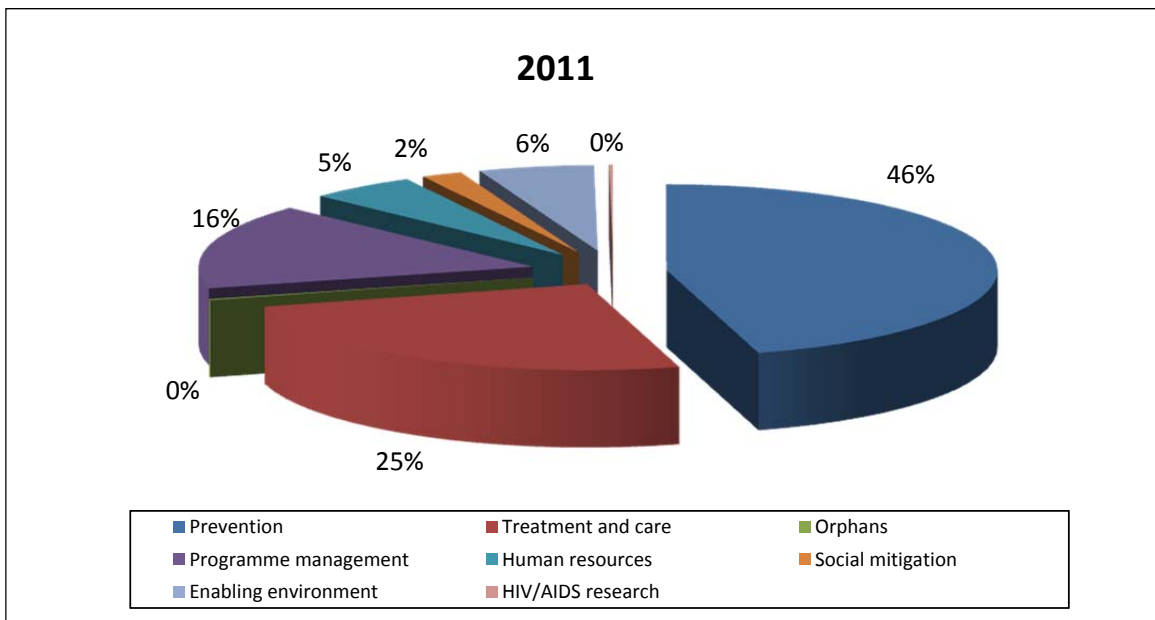


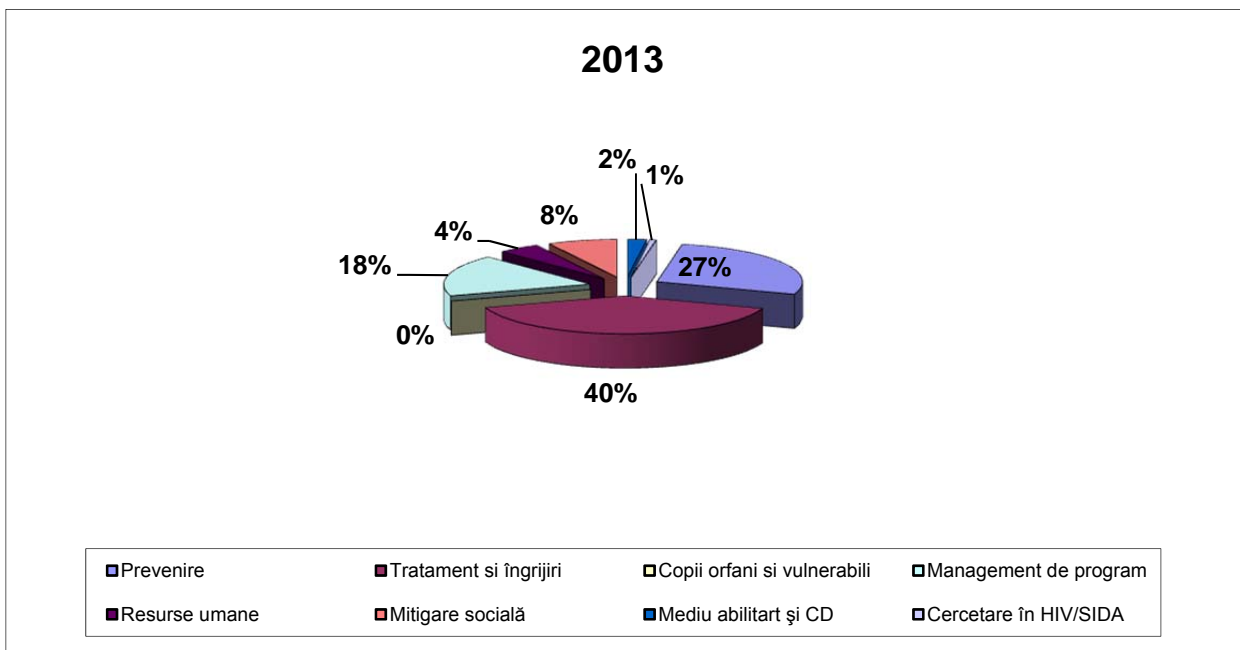


In the conditions of financial constraints and limited resources, the expenditures for the HIV response in 2013 decreased as follows (about 9,6 mln. MDL (-8,6%) compared to the volume of expenditures from 2012 and reached the total amount of about 102,5 mln. MDL or USD 8 136 543. From those expenditures, the public financial resources constituted 31,0 mln. MDL or USD 2 459 879 (30%). International resources for this year constituted 69,3 mln MDL or USD 5 503 307 (68%) and the private national resources reached 2,2 mln. MDL or USD 173 357 (2%). **(Error! Reference source not found.)**.

Reduced total amount of expenditures for HIV response in 2013 is explained by the significant reduction of external or international resources by 14,8%, (from 81,3 mln. MDL or USD 6 709 992 in 2012 to 69,3 mln. MDL or USD 5 503 307 in 2013). It is worth mentioning that the public financial resources are increasing by 7,6%, (from 28,8 mln MDL or USD 2 381 695 in 2012 to 31,0 mln. MDL or USD 2 459 879 in 2013).

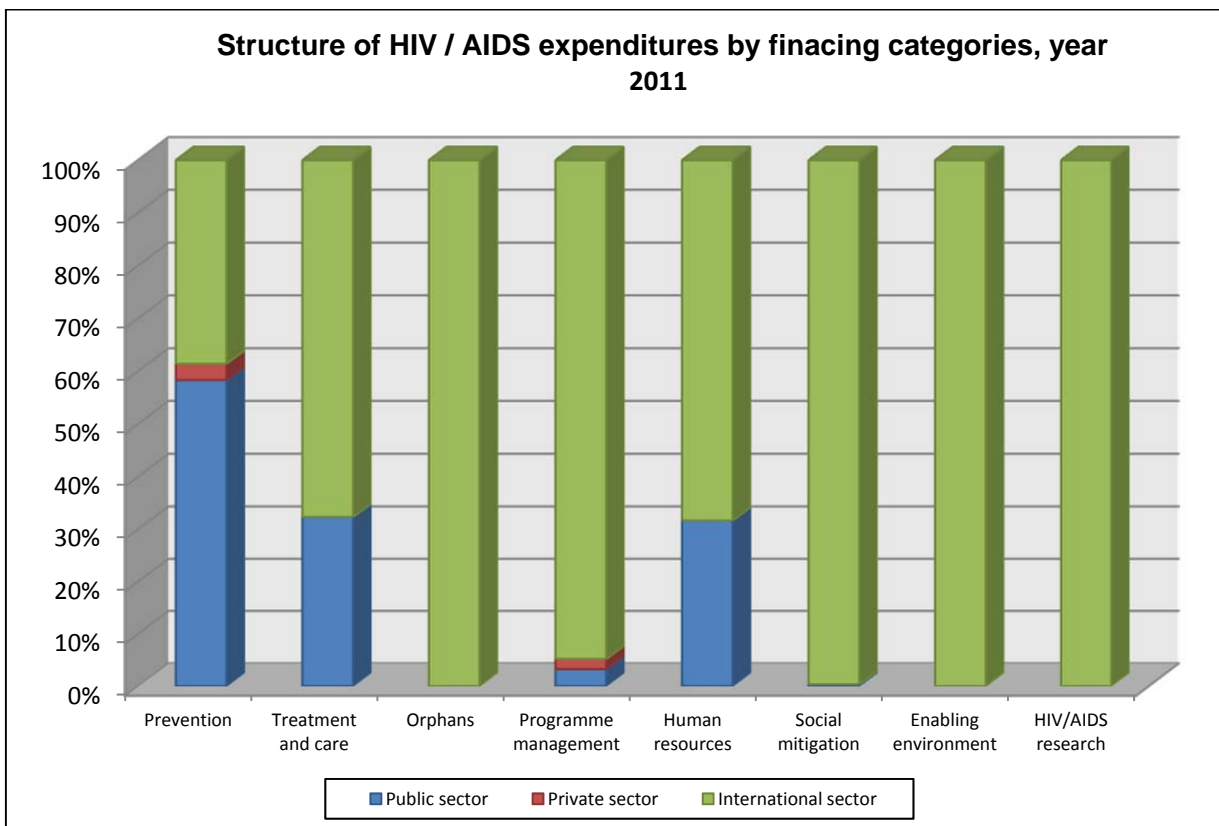
Figure 5 Structure of expenditures for the national HIV response, by spending category, Republic of Moldova, 2011, 2012, and 2013

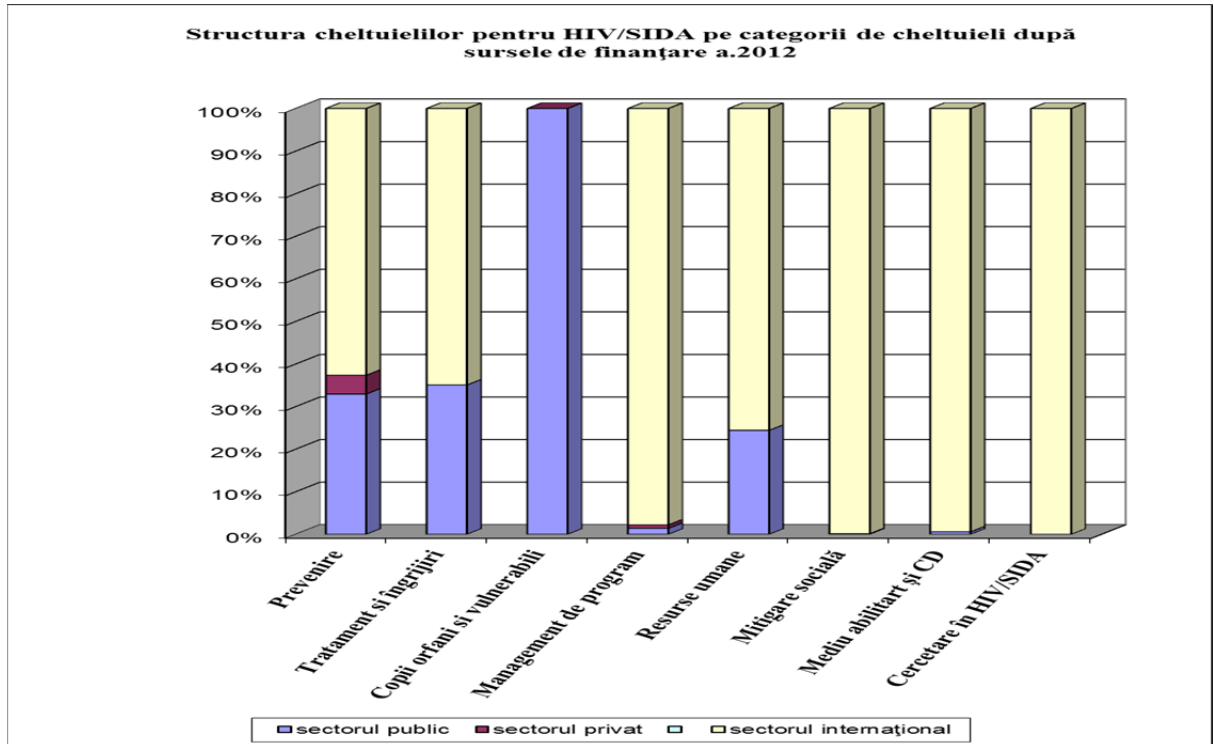




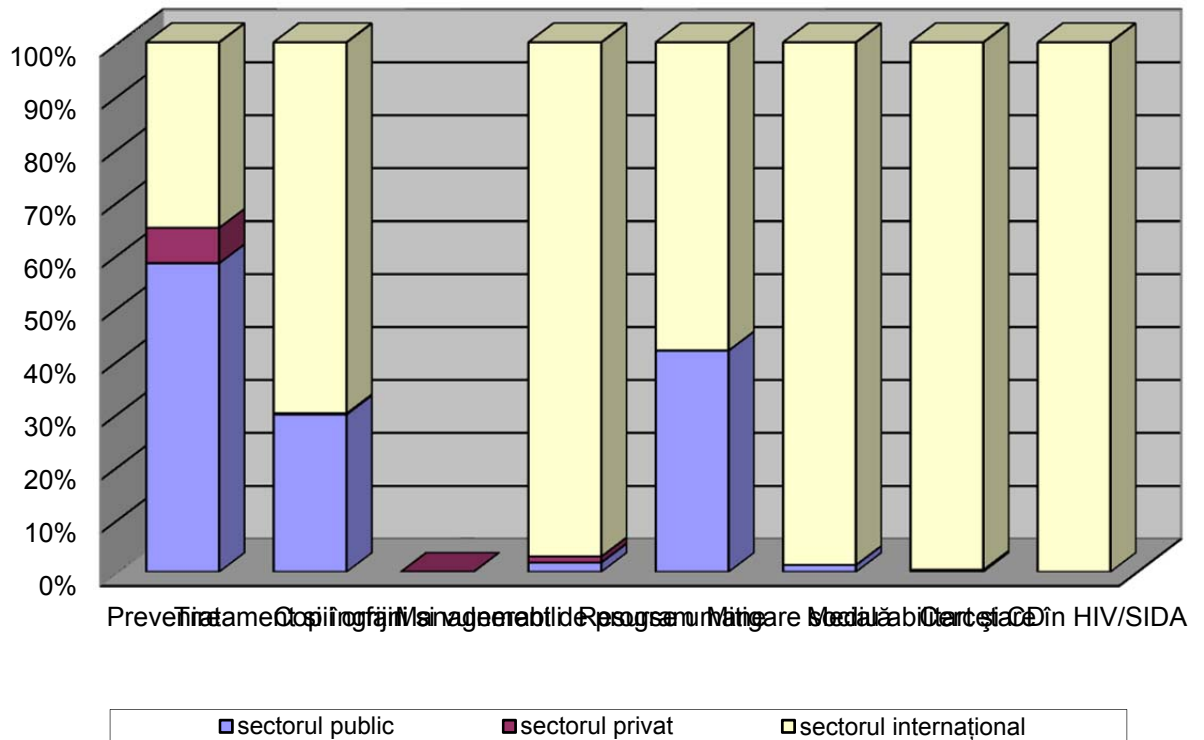
Classified by spending category of expenditures for the national response to HIV in the framework of the national response to HIV in 2013, 40 % went to **Treatment and Care**. For the spending category **Prevention** financial resources of about 27% have been allocated, **Programme Management -18%**, **Social Mitigation- 8%**, **Human Resources -4%**, **Enabling Environment- 2%** and **research in HIV/AIDS -1%**.

Figure 6 Structure of expenditures by spending categories according to sources of finances for 2011, 2012, 2013.





Structure of the expenditures for HIV response by spending according to the financial sources y. 2013



The limitations of the method applied for the generation of this indicator are as follows, some of them being valid for the previous reporting periods as well:

- Though significant progress has been registered in data collection from the greatest majority of organizations and institutions, involved in various aspects of the national HIV response, including coordination, monitoring and evaluation, there are still entities with budgets committed and spent for HIV/AIDS that do not report their expenditures and are not reflected in the matrix, due to the fact that activities are not targeting general population, or PLHIV, or MARPs as such and are more tangential to the response, hence not fitting comfortably in the pre-set spending categories.
- In the case of public institutions funded by the State budget, tracking all indirect costs of the subdivisions, specifically the maintenance and utilities costs associated to activities in the framework of the national HIV response, has not been possible as the maintenance costs per institution form an the integral budget and cannot be disaggregated.
- Not all international and national organizations and institutions have reported disaggregated data.

In conclusion, the data collected for the Indicator I for the Republic of Moldova allow the comparative analyses of trends over time in costs of activities in HIV/AIDS, based on budget categories covered.

INDICATOR 7.1 Government HIV and AIDS policies

National AIDS Programme: at the national level, the state policy in the area of HIV/AIDS in Moldova is implemented through the National Programme on Prevention and Control of HIV/AIDS and STI for 2011–2015 (National AIDS Programme – NAP), approved by the Government of the Republic of Moldova on December 16, 2010. The current NAP follows the previous three programs implemented in years 1996-2000, 2001-2005 and 2006-2010.

The NAP has the following main expected outcomes by 2015:

1. HIV incidence will not be more than 20 cases per 100,000 population of age 0-39 years.
2. Mortality of PLWH will be reduced by 10%

It has also prioritized HIV control strategies in the following 10 objectives to be achieved by 2015:

1. Ensuring access of at least 10% of general population to HIV/STI prevention services
2. Ensuring access of 60% of the estimated size of MARPs (IDUs, SWs, MSMs) to prevention services
3. Ensuring access of 10% of general population to condoms
4. Ensuring access to STI treatment of 80% of diagnosed STI cases
5. Ensuring access of 95% of pregnant women to PMTCT services
6. Ensuring 100% blood safety
7. Ensuring access of 100% persons exposed to HIV transmission risk to post-contact prophylaxis
8. Ensuring access to ARV treatment of 80% of the estimated number of PLWH in need of ART
9. Ensuring access to care and support services of 10% of the estimated number of PLWH
10. Development of an effective program management system.

In June 2011, the current Program was holistically assessed by a joint team of local and international experts, with the active involvement of various stakeholders from the governmental and non-governmental sectors.

It was the first Joint Assessment (JA) conducted under the GFATM Second Wave of the National Strategy Application (NSA) modality. The Joint Assessment was based upon the JANS tool; it responded to the areas of expertise identified by the Joint Assessment Organizing Body (JAOB) as key for Moldova: Strategic Planning (as an overarching, cross-cutting issue), HIV Disease (to manage the Situation Analysis category of the JANS tool), Multi-stakeholder Involvement (to manage the Process category), Finance and Audit (for that section of the tool), Programme Management and Health Systems (for the Implementation and Management category), Procurement and Supply Management (to handle specifically attribute 15), and M&E (for the Results, Monitoring and Evaluation category).

As a result, a better prioritization of the national HIV programme and its objectives was proposed in order to focus and address key populations at risk of infection and resources needed to provide efficient and targeted services. Though the reviewed Program was adopted and fully supported by the CCM and civil society, it has not yet been approved by the Government. The actual reviewed programme represents the basis for the Global Fund application for the period 2012-2014 and it will be at the basis for the New Funding Model application to cover the period 2015-2017.

Actually even there is an approved Programme, the country follows and uses de facto the one which was reviewed after the JA process. MOH still does efforts to approve the reviewed version through a Government Decision.

The revised programme has the following main strategies to be followed by 2015:

1. Prevention of HIV and STI transmission with the focus on key populations;
2. Reduce the negative impact of the epidemic, especially through treatment, care and support to people who live with HIV and to members of their families;
3. Promotion of common/synergies in HIV prevention with other programmes;
4. Creation of an efficient system of the management of the Programme

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

1. **Principle 1** NAP is developed based on evidence NAP 2011-2015 is designed based on the evidence generated by the mid-term review (MTR) of NAP 2006 – 2010 and the analysis of the national response at the beginning of 2010.
2. **Principle 2** NAP is developed through a human rights based approach NAP 2011-2015 is designed through human rights lenses, while identifying the right holders and duty bearers and the rights of the most marginalized populations. NAP is developed by following the non-discrimination, equity and social inclusion principles and is promoting transparency and accountability of all stakeholders.
3. **Principle 3** NAP is designed to be gender sensitive The gender dimension takes into account the responsibilities and opportunities of men and women from a social, cultural and political standpoint. Various monitoring, evaluation and surveillance tools have been developed to provide data disaggregated by sex and to identify gender sensitive interventions.
4. **Principle 4.** NAP is designed to ensure UA to HIV prevention, treatment, care and support The key principle for UA provides for the services' fairness, geographic accessibility, affordability, comprehensiveness and sustainability. Ensuring UA is based on setting and tracking national targets, aligned to international standards, outlining the target values to be reached by the end of NAP.
5. **Principle 5.** Involvement of PLHIV and communities living with HIV in NAP design, implementation and evaluation NAP was designed by abiding by this principle ensuring PLHIV's rights and opportunities. Civil society involvement, including PLHIV and high-risk group representatives, strengthened the quality and efficiency of national response to HIV.

In line with the Ministry of Health road map on reformation of the health system and Based on the JA assessment recommendations to review the management of the programme, due to fragmented services, vertical subordination and unclear share of responsibilities, the HIV service reform has been initiated at the mid of 2012, which reshaped the responsibilities on HIV/AIDS at the central level with the following institutions:

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

1. **Hospital of Dermatology and Communicable Diseases (HDCD)**– responsible for the overall coordination of prevention, treatment of PLHA, care and support. The reform resulted in bringing to the hospital the VCT, the laboratory service, treatment, palliative care and STI clinic. The M&E unit, especially for the M&E informational data base was also brought to the hospital and the only one M&E person is under the HDCD. The reform is considered not finished and needs further strengthening, especially in terms of staff for management goals, better M&E structure and allocated resources for those purposes.
2. **National AIDS Centre** – responsible mainly for the prevention, including among key populations and HIV surveillance.
3. **National Centre for Health Management (NCHM)** is a public institution under the auspices of the Ministry of Health of the Republic of Moldova, which works in accordance with the provisions of legislation in place, normative acts of the Government, the Ministry of Health, other normative acts, international treaties the Republic of Moldova has signed. The activity of NCHM focuses on implementation of the health management state policy, medical statistics and data basis of the national health system, medical equipment and building of the Integrated Medical Information System.

Implementation of the NAP is coordinated by the National Coordination Council for HIV and TB, an interministerial and intersectorial decision-making body that has under its auspices 7 functional working groups which enhance coordination and capitalize upon the value added of joint efforts of all key stakeholders from different sectors, and a permanent Secretariat. The NCC and its TWGs have been involved all throughout the design of NAP and NTP (www.ccm.md).

At the end of 2013, the CCM went through revision of its working groups and actually approved to have 3 HIV specific groups: HIV prevention, HIV treatment, care and support, HIV surveillance and 2 mixt HIV/TB groups: on M&E and social assistance.

Aiming at having an efficient AIDS-response, the Republic of Moldova has committed to the Declaration of Commitment and has embarked on building and strengthening the 3 Ones.

The NAP document has also been profoundly anchored in national development policies and plans: relevant sectorial policies include the National Health Policy approved in 2007, National Strategy for Health System Development for 2008-2017, which foresees consolidation of actions in area to stop the increase in HIV incidence. Moldova's development Strategy to 2020 focuses on several key very specific objectives, including improving infrastructure for enhanced access to health services.

The legislative tools include a set of laws which have been adopted to ensure sustainability of actions: Law on Health Protection (1995), Law on Reproductive Health and Family Planning (2001), Law on Migration (2003), Law on Equal Opportunities (2006), Law on AIDS Prevention and Control (2007), Law on Combating Domestic Violence (2008), Law on Social Assistance (2008), Law on donors and blood transfusions (2009). 7).

One of the most important achievements is the amendment of the HIV Law nr. 23 in April 2012. It provides for non-discrimination and privacy and confidentiality safeguards, and **removes travel and immigration barriers for HIV/AIDS persons**. It contains specific clauses on Women, HIV and Gender. Art. 22 of the Law clearly stipulate that it is forbidden any kind of discrimination based on HIV status at the working place. All labour rights should be equally ensured to PLWH. Art. 15 of the above mentioned Law stipulates the prohibition of obligatory testing at HIV as a precondition to be hired, or to access health services, to access education or to marry. All the hidden forms of testing are prohibited.

2012 is the year for Moldova to adopt the antidiscrimination law called the Law of equal chances. Thus, Law on equality no. 121 from 25.05.2012 adopted by Parliament, aiming at preventing and fighting

discrimination, as well as ensuring equal chances to all people of Moldova in political, economic, social, cultural and other spheres, irrespective of race, colour, nationality, ethnical origin, language, religion or beliefs, sex, age, disability, opinion, political beliefs. The Law # 298 from 21/12/2012 approved the Regulation of the Council on Preventing and Eliminating Discrimination and Ensuring Equality (“Equality Council”) which serves as one of the mechanisms to ensure the law implementation. The Council acts as a collegial body, impartial and independent, with the status of a public legal entity, established to ensure protection against discrimination to all persons who consider themselves victims of discrimination.

Significant efforts were invested to develop harmonized national standards and instructions related to the prevention and prophylaxis of HIV/AIDS. These include a series of national standards and guidelines related to HIV services (VCT, PMTCT, HIV surveillance, Infection Control, HIV Care and Treatment etc).

The period 2012-2013 is characterised by the review of the National Treatment Clinical Protocol and its further approval in 2014 in accordance with WHO recommendations bringing the threshold of CD4 at new requests; development and approval of Regulations on sharing personal health information related to the HIV status; development and approval of the Standard on HIV counselling and testing using rapid tests amongst vulnerable groups, provided by non-governmental organizations which is recognised as a major success in 2013.

However, in practice, the enforcement of these normative documents is still not perfect and there are discriminatory episodes in provision of medical treatment and services.

The exposure to or transmission of HIV is still prosecuted under the Criminal Code (approved by Law Nr. 985-XV dated 18.04.2002) with specific provisions under articles 211 and 212. HIV transmission has been criminalized in an attempt by the government to respond to the rising numbers of HIV infections and prevent the deliberate contamination with HIV; yet, human rights campaigners and other NGOs have expressed concerns that these laws lead to a violation of the rights of people living with HIV, exacerbating their marginalization. Hepatitis and TB are also considered to be diseases of a same level of threat for public health, still, their transmission is not prosecuted. However, it is worthwhile mentioning that Moldovan legal framework does not contain an offence for a man to have sex with another man (MSM). Moldova has one of the most progressive legal environments around harm reduction and decriminalising drug possession. Since 2004 there has been a marked shift in drug enforcement strategy towards prioritising the prosecution of drug dealers alongside the detection of drug trafficking networks and drug producers, rather than criminalisation of drug use. In addition, in 2008, personal drug use was decriminalised. Major amendments to the Penal Code and Administrative Offences Code reformed criminal punishment, including by promoting alternative punishments to imprisonment, and by excluding the application of arrest for personal drug use, now constituted an administrative rather than criminal offence. The illegal purchase or possession of narcotic drugs or psychotropic substances in small quantities without the intention to distribute them, as well as their consumption without a medical prescription, is sanctioned by a fine or community service. Selling sex is an administrative misdemeanour; pimping is a criminal offence.

Moldova’s M&E Plan was developed jointly by Government and civil society representatives during a MOH-led workshop, with foreign assistance and support, and NCC TWG on HIV/TB M&E. However, the use of M&E data for decision-making remains weak. After the reform at mid 2012, which intended to have a unique management system, bringing together all the services, including the M&E one, both governmental and civil society representatives recognised the M&E system was seriously affected. After reformation and disbanding local UNAIDS office the work on M&E system in terms of coordination and development is recognised as being weakened.

The representatives from the governmental sector, as those from civil society are satisfied with the degree of participation in the process of development, validation and evaluation both of the National Programme, and of other strategic documents on HIV/AIDS/STI. Representatives from the governmental structures affirm that the international agencies are characterized by consistency and they apply complex, multi-aspectual approaches; they ensure financial support, and quality in the coordination process of the National Response to HIV/AIDS.

Among the most strong points of the strategies developed and implemented by the international actors, the representatives of the governmental sector enumerated the following:

- The programmes are innovative and of high quality due to the fact that they represent best practices in the field of HIV/AIDS at the international level;
- They always have technical and financial support, which make them stable;
- Actors representing international agencies have new suggestions and tools, and they ensure a continuity from objectives to results in their strategies;

Due to some political and administrative limitations, this report does not contain a thorough analysis of the legal framework on HIV/AIDS present in the Transnistrian region. However, it is worthwhile mentioning that, de jure, the so-called Transnistrian authorities put in place the legal framework on HIV/AIDS which, in principle, can be considered developed in accordance with the basic international standards. HIV prevention and combating is regulated by the so-called Law Nr. 32-3 on HIV Prevention in Transnistria dated 7.02.1997, Law Nr. 29-3 on Fundamentals on Public Health, so-called Criminal Code (art. 119 and art. 134) and other subordinated normative documents. While Transnistrian Law on HIV Prevention and other related legal documents contain non-discriminatory provisions (i.e. HIV testing is not compulsory for young people who want to register their marriage), de facto, there are many inconsistencies between these laws and the subordinated normative documents and mechanism of their implementations is ineffective. In the region, there are frequent incidents of discrimination and infringements of the rights of the people living with HIV/AIDS, including HIV testing of migrants. In Transnistria, the existing laws do not specify protection for MSM, migrants, IDUs, prison inmates, CSWs, transgender people. The region does not have a general law on discrimination.

On national level, the importance of approving amendments to the 2007 HIV Law cannot be overstated. Relevant regulatory and normative documents should also be subjected to revision to ensure consistency with human rights and non-discrimination.

Prevention: there is progress attested in HIV prevention activities among MARPs that experienced the fastest scale up, but a more temperate evolution. The temperate evolution is due to uneven coverage and low quality of services.

Among all areas of HIV prevention, HIV Prevention among IDUs has seen the most progress and included early on adoption of harm reduction and NSP as the national strategy of HIV Prevention in IDUs (since year 2000), initial NSP in the most affected areas (Balti and Chisinau and other 4 most affected rayons) in years 2000-2002 and rapid program scale-up under Global Fund Round 1 (years 2003-2006). Due to early start and rapid scale-up of Harm Reduction Programmes among MARPs, both in the civil sector (IDUs, SWs, MSM) and in penitentiaries (IDUs), the Republic of Moldova is known as being an example of best practice. Global Fund Round 6-8-supported NSP is provided by both public and community-based points of care and they provide sterile needles, syringes, alcohol swabs, informational brochures, and condoms and offer collection and safe disposal of injection equipment. The distribution is made through a network of 26 geographic sites that include stationary NSP points and outreach to apartments and penitentiary institutions on both banks of

Nistru river counted as 2 sites: one for Moldova penitentiaries (providing NSP services in 9 PI – penitentiary institutions) and one for Transnistrian part (providing NSP to 3 PI). In addition, social and outreach workers provide referrals to other HIV prevention services, VCT, gynecological consultations, STI diagnosis. NSPs also provide a point of entry to substitution therapy. There is uneven geographic distribution of needle-syringe programs and other harm reduction activities, with still low coverage rates in the most affected cities, especially Chisinau.

HIV prevention interventions for FSWs include the following services: condom distribution, IEC distribution and referral to facility-based STI and VCT services. The primary method of service delivery is via outreach to apartment- and street- based venues. There are currently five program sites that provide outreach services to SWs. Overall, HIV prevention programs targeted to FSWs focus on condom distribution and referral to facility-based VCT and STI management; not all elements within a state of the art package of HIV prevention services targeted to FSWs are provided.

HIV prevention interventions targeted to MSM are provided primarily by community-based organizations (Gender-Doc and Center ATIS) in the two main cities (Chisinau and Balti). GenderDoc-M has started outreach activities within the Health Program in 2005. Services include condom and lubricant distribution, distribution of information leaflets, organization of seminars, safer sex promotion parties for the LGBT community, providing individual counselling services, and developing referral system to medical specialists, referral to facility-based VCT.

Following the 2011 Joint Assessment of the NHP, prevention of HIV transmission among most at risk populations (IDUs, CSWs, MSM) became a priority of the amended program. The prophylaxis/prevention needs are established based on the HIV epidemiological evidence and tendencies. They are also based on the results of the bio-behavioural researches conducted with a periodicity of 3 years, the most recent being conducted within the period 2012-2013. Those needs are reflected into the National Programmes as interventions, budget and M&E framework. The management of those is also described, including the description of the accountability of specific institutions.

In 2012 the opioid substitution treatment underwent an evaluation and in 2013 a comprehensive national evaluation of the Harm Reduction projects was realised.

The evaluation of the harm reduction services highlighted mainly the low coverage of HR and low quality of provided services. Specifically, the conclusions regard the low coverage of most hidden risk groups and a reduced focus on sexual behaviour change. The sustainability of the programmes which are actually financed only from Global Fund resources is reiterated by the evaluation, but also by the respondents to the NCPI questionnaires, both part A and B. Gender analyses realised within the research showed an insufficient coverage of IDUs women and also of the young persons under 18. A small rate of HIV IDUs on methadone is on HIV treatment which was pointed also as a weak point. The weak collaboration between the services provided by health institutions, as ARV treatment facilities, Narcological service, TB one etc... and with the services provided by nongovernmental organizations was highlighted.

The OST service evaluation mainly showed the low coverage (less than 1 % of those who need it) and low quality of the service. Specifically referring to the quality the evaluation pointed out the causes due to physicians very high work-load of OST patients and other regular duties of narcologist , no multidisciplinary approach, doses below recommended, small duration of treatment, OST medical staff (both in civil sector and penitentiary) had conflicting attitudes towards dependence and OST treatment. The system of referral of OST patients to other outpatient and inpatient treatments (such as HIV infection, TB) and from HIV and TB treatment to narcological service was not established NGO staff had conflicting attitudes or gaps in

information on OST goals and basic principles. In penitentiary system in spite of the shortage of medical specialists, professionalism of OST staff has increased. Currently, external funding was the major source for OST in Moldova and sustainability of the service is of question.

The recommendations of the evaluations resulted in clear following up actions. Thus the evaluation of harm reduction resulted into a harm reduction strategy for 2014-2016 period, and the OST service evaluation resulted into an action plan endorsed by the CCM Chair.

Among other achievements, it is worth mentioning that in 2013, the initiative to provide HIV counselling and testing services through NGOs started being implemented (rapid saliva tests procured, instructions to provide those services elaborated and approved, service providers trained). The Department of Penitentiary Institutions (DPI) succeeded to take over from NGOs and successfully implement the needle exchange and condom provision programs. In 2013, DPI approved the Regulation on protection of personal health data of inmates.

Among the other constraints, which were provided additionally to the ones pointed out in the harm reduction and OST evaluations, the respondents of the NCPI and Dublin declarations listed that the Eastern region of the country (Transnistria, the conflict one) does not have any OST service, approaching injecting drug users only from coercive treatment approach. Stigma and discrimination, which is spread out to the entire country is yet a problem.

Providing information on prevention, especially for students' not attending school youth, adolescents from immigrant families requires strengthening. The opportunity of applying to the New Funding Model, which is to be realised by 15th of May 2014 was stated by numerous stakeholders, highlighting the need to ensure sustainability and real accountability for investments and for results.

Treatment, care and support:

The National HIV Programme for 2011-2015 stipulates the following elements of the package of services: TARV, TARV as prevention, including prevention from mother to child and post-contact prophylaxis, treatment of co-infections. Care and support include: nutritional, legal and psychosocial support, including palliative care, services for HIV + children and orphans (social and psycho-social services). The package also includes: active medical surveillance of all persons diagnosed with HIV in specialized institutions, with specific investigations; palliative care for AIDS patients who need it.

The most important achievements relate to ensuring access to HIV treatment, which in fact is 100% available to those who need and want it; to achievements in the decentralization of treatment services and HIV care throughout the country, as well as providing MST services; initiating the creation of infrastructure for testing viral resistance to ARV preparations; improving accessibility and quality of prophylactic ART for HIV pregnant women; opening a paediatric ward within the ARV treatment institution. The regulation on the organization of palliative care services for people with HIV/AIDS was developed. The HIV case management protocol was developed.

Among the important achievements it is worth mentioning that the criteria for initiating TARV were reviewed, thus changing the CD4 cells level to initiate TARV in asymptomatic patients from 350 to 500; new criteria have been introduced for the treatment- pregnancy, viral hepatitis, age more than 50 years, HIV+ partner in discordant pairs, oncological diseases, etc. It is worth mentioning than from 2013, the Government started covering the treatment of about 500 new patients from domestic resources, intending to scale up the process in the upcoming years.

In terms of care and support, the stakeholders stated the opening of Social centres for psychosocial support for PLWH (social, psychological, legal, etc.); provision of home based palliative care, by NGOs contracted by the National Health Insurance Company.

The government authorities ensure that PLWH qualify for the status of people with disabilities and can benefit of financial support. Otherwise they are entitled to same benefits provided for people with no HIV infection. More specifically, People living with HIV can receive social benefits paid both of BASS as well as BS - disability pensions, benefits, allowances, compensations, social and material aid. In accordance with current legislation, people infected / affected by HIV/AIDS do not have a special status based on the HIV infection, but could be among the beneficiaries of social benefits, based on the eligibility criteria set out in legislation. HIV+ children qualify for the degree of disability until the age of 18 years and are offered a specific benefit in this regard. In Transnistria, there is no such policy.

Among the biggest challenges country faces the following have been listed: low TARV adherence; late and low enrolment in TARV. Sustainability of the programmes has to be addressed in the coming years, as all the treatment, care and support services are provided mostly from the donor resources. The quality of the services has to be increased. In Transnistria, there are no possibilities to ensure palliative care services for children and adults with AIDS.

Insufficient training, laboratory diagnostic and situation monitoring in the field of HIV/AIDS on both banks of the Nistru River represent gaps that need special consideration.

Intersectorial Aspects

Human rights

The anti-discrimination law has been approved by the Parliament in 2012. A complementary Law to ensure equality, i.e. Regulation of the Council on Preventing and Eliminating Discrimination and Ensuring Equality ("Equality Council") has been adopted. In 2013 the Parliament abrogated provisions of the Contravention Code setting penalties for advocacy of homosexuality in children. Civil society advocated with the Ministries of Health and Labor, Social Protection and Family, for reforms related to rights of persons with disabilities to live and participate fully in the community (new disability evaluation methodology includes HIV specific provisions). Moldova has constitutional provisions banning discrimination, there is 2006 Gender Equality Law in force but ineffective. There are few cases in courts identifying discrimination, with the notable exception of a Supreme Court decision in late 2011, banning discrimination based on HIV status in issuing residence permits for HIV+ foreign nationals.

The human rights protection machinery currently in place centres around the Ombudsman institute. There are also hotlines maintained by line Ministries and some NGO to empower actors to react to cases of discrimination. There is low legal knowledge among the population and a limited culture of seeking redress for human rights violations.

Gender

In the Republic of Moldova the legislation and the policies in the area of gender equality are quite well developed. The gender equality is a founding principle set by the supreme law, the Constitution, and there is a specific law on gender equality. The Republic of Moldova has adhered to the Millennium Development Goals (MDG) where the third priority is promoting gender equality and has included this objective in its Strategy for National Development. In addition, a national program to promote gender equality has been developed for the years 2010-2015. The Republic of Moldova has adhered early on to international

conventions addressing gender inequality: it has ratified Committee on the Elimination of Discrimination against Women Convention (CEDAW) in year 1994.

The Constitution of the Republic of Moldova establishes that men and women are equal in front of law and local public authorities. A law that promotes equal opportunities for women and men was adopted by the Parliament on 9 February 2006. Its main goal is to ensure exercise of equal rights of women and men in the political, economic, social and cultural aspects of life, which are guaranteed rights by the Constitution of the Republic of Moldova, in order to prevent and eliminate all forms of gender-based discrimination. In reality, some experts consider that the gender equality legislation is mainly declarative, including because of patriarchal traditions and the traditional perceptions regarding women's role in the society.

A report on monitoring the implementation of the new law has shown that its implementation is difficult because of insufficient legal enactment mechanisms and poor familiarity of the population and employers with the content of the law.

The Strategy for National Development for years 2008-2011: includes the MDG no. 3 to promote gender equality and women empowerment and sets as objectives increasing the level of political representation of women (in local councils from 26.5% in 2007 to 40% in 2015, number of women mayors from 18% in 2007 to 25% in 2015 and deputies in Parliament to 30% in 2015) and decreasing the difference in salaries by at least 10% by 2015 (in 2006 the average salary in women being 68.1% of that of men).

National Program for Promoting Gender Equality for years 2010-2015 and Action Plan for years 2010-2016: The national program outlines the major gender-related problems in the Republic of Moldova. Although women have better education (58.9% of university and over 60% of postgraduate students are women), they are employed in lower proportions than men (occupation rate was 41.0% in urban and 39.5% rural women compared to 48.6% in urban men and 42.7% in rural men). In addition, they are usually employed in lower-paid occupations and positions. The most important priority in this area is decreasing the discrepancy between the salaries of women compared to men. Another problem is the out-migration, although affecting more men (women constituted 35% in year 2008), there are many instances when both mothers and fathers leave their children behind. Women are traditionally regarded as unpaid care providers for family members, receive lower pensions due to lower income and three priority problems have been identified in this area: double burden for women in professional and family lives, women being the main care-giver due to traditional roles and the discrepancies in average retirement pension

In health, the national program has identified several areas as problematic: limited access of rural women to reproductive health services, use of abortion as a family planning method, increased maternal mortality rates in rural areas, increasing rates of alcoholism both in women and men and high injury rates in men. No HIV gender-specific problems have been identified in the National Program.

In the area of gender-based violence and human trafficking the following four problems have been outlined:

- Family based violence against women and girls
- Violence against girls and boys in educational settings
- Sexual harassment of women at workplace
- Women and girl trafficking

The National Program sets the following priorities for the years 2010-2015:

1. Labour and migration: decreasing the discrepancies between salaries of men and women, elimination of all forms of gender based discrimination on the labour market, economic empowerment of rural women, integration of gender dimension in migration policies
2. Gender-sensitive budgeting (GSB): development and promotion of GSB concept
3. Women participation in the decision-making process: increasing women representation in political and public areas
4. Family and social protection: improving the participation of men in distribution of family responsibilities, e.g. child care leave, formalizing the care-giving role of women, decreasing disparities between the amount of pensions
5. Health care: inclusion of gender dimension in health sector policies, reducing discrepancy between men and women, improving the socio-economic factors conducive to maternal mortality rate in rural women
6. Education: inclusion of gender dimension in education policies, reduction of feminization of the educational system.
7. Violence and human trafficking: eradicating family-based violence and human trafficking, decreasing violence against girls and boys in the educational facilities and improving services for victims of gender-based violence and human trafficking.
8. Increasing gender awareness: promoting positive images of women and men and the role distributions in private life, combating use of sexist images in marketing and advertisement industries.
9. National mechanism: improving gender responsibilities.

The gender equality is the mandate of several structures at the governmental level. A Governmental Commission on Equal Opportunities for Women and Men is established. The Ministry of Labour, Social Protection and Family has a Department of Equal Opportunities and Family Policies. Since year 1999 all ministries have established gender focal points and there are local commissions on women issues at the level of local public authorities.

INDICATOR 4.1 Percentage of adults and children receiving ARV treatment

ARV treatment became available in the Republic of Moldova beginning with 2002. Beginning with 2003, medication for ARV treatment was bought with the financial support of the World Bank and GFATM grants (Round 1 and Round 6). In the Republic of Moldova there are 8 institutions providing ARV treatment: on right bank the Dermatology and Communicable Disease Hospital (provides services to patients from the central region of the country, right bank of the Nistru river and persons from other regions at their request, provides inpatient treatment for all patients in the country); municipal hospital from Balti (provides services to patients from the northern region of the country); district hospital from Cahul (provides services to patients from the southern region of the country); the Penitentiary Institutions Department for inmates on the right bank of the Nistru River; and on the left bank, the AIDS Centre in Tiraspol (provides services for patients and inmates on the left bank of the Nistru River), district hospital from Ribnita (provides treatment to patients from the northern part of Transnistria), Phthisiopneumology Dispensary from Bender (provides services for patients with TB/HIV co-infection), the Penitentiary Institutions Department for inmates on the left bank of the Nistru River.

According to the National Protocol followed in all medical institutions that initiate ARV treatment, undertake clinical monitoring and dispense ARV drugs, the immunologic criteria for enrolment in treatment in the reporting period have been CD4 <350 and RNA HIV>100000. The clinical monitoring provides for quarterly CD4 and viral RNA testing for those that were initiated on treatment and for twice per year CD4 and viral RNA testing for those not yet on ARV treatment.

The demand for ARV increases annually. During 2013, 21 children and 548 adults have been enrolled in treatment.

Table 6. New enrolments into ARV treatment, Republic of Moldova, 2003-2013

		2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
New enrolments into ARV treatment	Males	14	49	66	62	109	150	210	211	275	285	305
	Females	13	32	41	52	88	113	152	156	255	310	264
	Total	27	81	107	114	197	263	362	367	530	595	569

Presently, all ARV drugs are procured from Global Fund sources.

According to the recommendations, for calculation of ARV treatment coverage, the estimated number of persons with HIV generated by SPECTRUM is the denominator. In the framework of workshops with participation of technical level representatives and decision makers from relevant institutions, entry data and Spectrum outputs were validated. Thus, at the end of 2013, in the Republic of Moldova the standard indicator value of coverage with treatment reached 16.8 % for both banks of the Nistru River. For 2012 this indicator represents 14.4% (following the same principle of calculation). Data introduced in the on-line AIDS Reporting tool are for 2013.

Method of Calculation and Indicator Value

Numerator: Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocols at the end of the reporting period.

Denominator: Estimated number of adults and children living with HIV.

Since the Republic of Moldova estimates were made separately for right and left bank of the Nistru River, denominator data represents the sum of both estimates.

Source: Registries of patients in ARV treatment from institutions providing ARV treatment.

Table 7 Percentage of adults and children receiving ARV treatment, Republic of Moldova, 2013

	All	Males	Females	< 15 years	< 1 year	1-4 years	5-9 years	10-14 years	15-19 years	20-24 years	15-49 years	50+ years and older	15+ years and older
Indicator Value	16,8	13.4	23.4	67.2	20	52.8	100	68.4	1.8	3.7	16.6	14.6	16.4
Numerator	2493	1303	1190	82	3	19	34	26	11	74	2170	241	2411
Denominator	14812	9735	5077	122	15	36	33	38	600	1997	13036	1655	14691
Number of children and adults requiring ARV treatment at the end of the reporting period (out of	2827	1566	1261	82	3	19	34	26	-	-	-	-	2745

patients on record)													
Persons newly initiating ARV therapy during the last reporting year	569	305	264	21	3	6	9	3	9	32	495	53	548

Enrolment of adults is stable for the last years.

Stock-outs and waiting lists have not been registered during the reporting period. Thus, all patients, who accessed relevant medical institutions (directly or by reference) and needed ARV treatment, were offered to enrol in treatment, and those who accepted initiated ARV treatment. In framework of Global Fund consolidated grant (rounds 6 and 8) grant, interventions were implemented that had as main objectives the increase of adherence and enrolment in treatment, and increase of geographic access to ARV treatment (decentralisation of ARV treatment) that is intended to scale up demand for treatment. Talking into account the increased demand for treatment, once the financial support from the Global Fund consolidated grant is completed, the Government of the Republic of Moldova will apply for the new funding model from Global Fund to ensure continuity of ARV treatment since 2014 in accordance with the demand and needs. It is worth mentioning that from 2013, the Government started procuring drugs from public/domestic resources for about 500 new patients, with the intention to scale up the process in the upcoming years.

INDICATOR 3.1 Percentage of HIV positive pregnant women who received ARV drugs to reduce the risk of mother-to-child transmission

According to the administrative statistics for 2013, out of the number of women that gave birth during 2013, 99.3% have been tested for HIV at least once. By 2011 Voluntary Counselling and Testing service for HIV and viral hepatitis B and C covers the whole territory of the Republic of Moldova, including the left bank of the Dniester River. Since 2013 all medical providers can counselling persons before testing and give the result to patients.

During 2012, 85 new cases of HIV infection were identified among pregnant women and 90 HIV positive women became pregnant and decided to go on with the pregnancy. In 2013, 79 cases of HIV infection among pregnant women were identified and 90 HIV positive women became pregnant and decided to go on with their pregnancy.

In correspondence with the clinical protocol on ARV treatment, HIV infected pregnant women who do not need ARV treatment for own health according to clinical or immunological criteria are administered ARV prophylaxis treatment starting with the 24th week of pregnancy, while infants receive ARV prophylaxis treatment for 7 days.

Data source:

Register of new cases of HIV infection, register of patients in pre-treatment and ARV treatment, register of HIV positive pregnant women receiving ARV prophylaxis treatment.

Method of Calculation:

Numerator: Number of HIV positive pregnant women that received ARV prophylaxis treatment for reduction of mother to child transmission. In the numerator we have included HIV positive pregnant women covered with PMTCT out of those that have given birth in the last 12 months (in order to include those having the chance for a full course of PMTCT).

Denominator: In the case of the Republic of Moldova, because estimated data from Spectrum for PMTCT indicators are not significant, was used the number of women given birth during the reporting period.

Table 8 Percentage of HIV positive women receiving ARV prophylaxis treatment to reduce HIV transmission from mother to child in the Republic of Moldova, 20102 and 2013

	2012	2013
Numerator	141	146
Denominator	152	153
Indicator value	92.8%	95.4%

Among the HIV positive pregnant women receiving ARV treatment to reduce mother to child transmission of HIV/AIDS in 2012, 127 HIV positive pregnant women received a complete course of antiretroviral drugs to reduce mother-to-child transmission, and 12 HIV positive pregnant women received an incomplete course of ARV prophylaxis (less than 4 weeks), 2 HIV positive pregnant women received ARV prophylaxis only during delivery. In all cases, children received prophylaxis treatment during the first 7 days of life.

Among the HIV positive pregnant women receiving ARV treatment to reduce mother to child transmission of HIV/AIDS in 2013, 135 HIV positive pregnant women received a complete course of antiretroviral drugs to reduce mother-to-child transmission (71 of them received ARV, being eligible for treatment according to clinical and immunological criteria and 64 women received ARV prophylaxis), and 9 HIV positive pregnant women received an incomplete course of ARV prophylaxis (less than 4 weeks), 2 HIV positive pregnant women received ARV prophylaxis only during delivery and 8 HIV positive pregnant women don't receive ARV prophylaxis and children received prophylaxis treatment during the first 7 days of life.

The numerator is calculated among women that gave birth, to assess if they received complete ARV prophylaxis treatment during pregnancy (more than 4 weeks), incomplete ARV prophylaxis treatment during pregnancy (less than 4 weeks) or emergency ARV prophylaxis treatment during delivery. According to the national guideline for HIV positive women that are not eligible for ARV treatment for own health, ARV prophylaxis treatment is prescribed starting with the 24th week of pregnancy. Hence, out of 169 HIV positive pregnant women registered during 2013 there are:

- Women that started ARV prophylaxis treatment, but didn't give birth.
- Women that have not reached the pregnancy stage for initiation of ARV treatment.

Starting with 2014 all pregnant women with HIV will receive ARV treatment that will continue for life.

INDICATOR 5.1 Percentage of new HIV positive incident TB cases that received treatment for TB and HIV

According to national recommendations, HIV testing is recommended to TB patients. According to the national statistics, coverage with HIV testing of the new and relapse cases of TB was 94.1% in 2012 and 94.98% in 2013 (for both banks of the Dniester River). The prevalence registered in 2012 and 2013 is about 5.1% and 5.9%.

The counselling and testing service for HIV and Hepatitis B and C is also available based on institutions constituting the phthysiopneumology service. Thus, at the end of 2011, 4 VCT units were open in the medical institutions offering in-patient treatment services for TB cases.

According to the national protocols, the algorithm in case of a TB patient with HIV positive status, is as follows:

1. If CD4<200, the patient initiates anti-TB treatment; ARV treatment will follow 3-4 weeks later.
2. If CD4 = 200 - 350, patient initiates anti-TB treatment; 2 months later the CD4 test is repeated. If CD4 number does not increase, ARV treatment is initiated.
3. If CD4 >350, patient initiates anti-TB treatment. Patient is supervised regarding initiation of ARV treatment.
4. If patient is already in ARV treatment, anti-TB treatment is initiated.

Data source: SIME TB database, register of patients in pre ART and in ARV treatment.

Method of calculation and indicator value:

Numerator: Number of people with advanced HIV infection who have received antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (new TB cases) (in accordance with national TB programme guidelines) within the reporting year.

Denominator: Number new and relapse cases of TB that are HIV positive, according to the SIME TB database (The source of data for the WHO database).

Coverage with ARV and anti-TB treatment for cases of co-infection is presented in Table 9.

Table 9 Percentage of new TB cases among PLHIV that have initiated anti-TB treatment in the Republic of Moldova, 2012 and 2013

	2012					2013				
	Total	Males	Females	< 15	15 + years	Total	Males	Females	< 15	15 + years
Indicator value	41.53					53.2	53.1	53.5		
Numerator	103	61	42	2	101	165	119	46	2	163
Denominator (estimated by WHO is 303 average for 2013)	248					310	224	86		

There is an increase in the rate of TB patients among people living with HIV/AIDS enrolled in treatment compared with the previous years.

HIV testing

INDICATOR 1.5 Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results

Data source:

The data for this indicator have been collected within the framework of the Multiple Indicator Cluster Survey in 2012 (*reference*); (*see Appendix 2, Survey on „Multiple Indicator Cluster Survey” 2012*).

For the purpose of the present report, the sub-sample of 15-49 year old respondents was extracted from the database of the study and was analysed according to the recommendations of the *Global AIDS Response Progress Reporting 2014, Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS (UNAIDS 2014)*.

Method of Calculation:

In the data collection tool the questions have been formulated as follows:

1. “When did you have your last HIV test?” one of the possible answers being “in the last 12 months”
2. “I don’t want to know the result, but do you know the result of your last HIV test?”

Numerator: Number of respondents aged 15–49 who have been tested for HIV during the last 12 months and who know the result of the last test.

Denominator: Number of all respondents aged 15–49.

Results: The demographic structure of sub-samples is presented in the Table 10:

Table 10 Distribution by gender and age group of the respondents 15 - 49 years old that have undertaken an HIV test during the last 12 months and know the result of the last test, Republic of Moldova, (right bank of Dniester River), 2012

		Males		Females		Total	
		num	%	num	%	num	%
15-19 years old	Numerator	17	6.4	91	9.9		
	Denominator	259		920			
20-24 years old	Numerator	26	10.9	213	24.1		
	Denominator	234		884			
25-49 years old	Numerator	100	9.5	790	18.8		
	Denominator	1049		4196			
Total	Numerator	142	9.2	1094	18.2	1041	13.8
	Denominator	1545		6000		7545	

It has been attested that respondents aged 20-24 more frequently are covered with testing and know their results (both males and females). Female respondents more frequently are covered with testing and know their results (18.2%) than male respondents (9.2%).

The value of this indicator for 2007 has been 8,5%, while in 2008 among respondents of a general population survey coverage with testing in the last 12 months has been 10,3%. The value of this indicator in the framework of the survey on **Gender-associated Vulnerability to HIV** carried out in 2009 is 13,2%. For 2010 the value of this indicator has been 13.9%. Thus, there were no great variations registered in the coverage with HIV testing and level of knowledge of test results.

Limitations of the study:

1. No national estimates exist. Data are available only for the right banks of the Dniester River.

INDICATOR 1.9 Percentage of sex workers that received an HIV test in the last 12 months and know their results

Data source:

Data for this indicator have been collected within the Behavioural and HIV Seroprevalence survey that was carried out in 2013 among Sex Workers in Chisinau and Balti (*see Appendix 4*). Data introduced in the electronic tool are those for the capital of the country, Chisinau municipality.

Method of Calculation:

The set of questions and the respective answers that served as basis for the calculation of this indicator have been the following:

1. "When have you last had an HIV test?" with an option of answer stating "in the last 12 months".
2. "I don't want to know the result, but do you know the result of your last HIV test?"

Thus, the set of questions and answers have been adjusted according to the recommendations of the *Global AIDS Response Progress Reporting 2014 Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS (UNAIDS 2011)*.

Numerator: The number of respondents stating that they received an HIV test in the last 12 months and know the result.

Denominator: the number of survey respondents.

Results: Distribution by age of respondents that received an HIV test in the last 12 months and know the result is presented in the table12:

Table 11 Disaggregation by age sex workers that received an HIV test in the last 12 months and know the result in Chisinau, Republic of Moldova, 2013

Total			
		Number	%
<25 years	Numerator	13	19.5
	Denominator	88	
25 + years	Numerator	77	24.4
	Denominator	276	
Total	Numerator	90	22.0
	Denominator	364	

In the case of older respondents, coverage with HIV Testing and the level of knowledge related to HIV is higher compared to the respondents of younger age.

In Balti, those tested for HIV in the last 12 months that know their results represent 29.5%, with a lower value for the age group up to 25 years (13.1%) compared to the respondents from the age group over 25 years (35.9%).

Limitations of the Survey:

1. Data have been self-reported which indicates that recall and social desirability biases are possible.
2. Data are representative only for the locality where the survey was carried out and cannot be extrapolated over the whole country.

INDICATOR 1.13 Percentage of men having sex with men that received an HIV test in the last 12 months and know the result

Data source:

Data for this indicator have been collected within the Behavioural and HIV Seroprevalence survey that was carried out in 2013 among Men Having Sex with Men in Chisinau and Balti (see Appendix 4). Data introduced in the electronic tool are those for the capital of the country, Chisinau municipality.

Method of Calculation:

The set of questions and the respective answers that served as basis for the calculation of this indicator have been the following:

3. "When have you last had an HIV test?" with an option of answer stating "in the last 12 months".
4. "I don't want to know the result, but do you know the result of your last HIV test?"

Thus, the set of questions and answers have been adjusted according to the recommendations of the *Global AIDS Response Progress Reporting 2014 Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS (UNAIDS 2011)*.

Numerator: The number of respondents stating that they received an HIV test in the last 12 months and know the result.

Denominator: the number of survey respondents.

Results: Distribution by age of respondents that received an HIV test in the last 12 months and know the result is presented in the table12:

Table 12 Disaggregation by age of men having sex with men that received an HIV test in the last 12 months and know the result in Chisinau, Republic of Moldova, 2013

Total		Number	%
<25 years	Numerator	19	21.5
	Denominator	59	
25 + years	Numerator	63	23.8
	Denominator	191	
Total	Numerator	82	24.4
	Denominator	250	

In the case of older respondents, coverage with HIV Testing and the level of knowledge related to HIV is not significantly different compared to the respondents of younger age.

In Balti, those tested for HIV in the last 12 months that know their results represent 1.1%, with a lower value for the age group up to 25 years (0%) compared to the respondents from the age group over 25 years (1.6%).

Limitations of the Survey:

1. Data have been self-reported which indicates that recall and social desirability biases are possible.
2. Data are representative only for the locality where the survey was carried out and cannot be extrapolated over the whole country.

INDICATOR 2.4 Percentage of IDUs that received an HIV test in the last 12 months and know the result

Data source:

Data for this indicator have been collected within the Behavioural and HIV Seroprevalence survey that was carried out in 2012/2013 among injecting drug users in Chisinau and Balti on the right bank of Nistru River and in Tiraspol and Ribnita on the left bank of Nistru River (see *Appendix 4*). Data introduced in the electronic tool are those for the capital of the country, Chisinau municipality.

Method of Calculation:

The set of questions and the respective answers that served as basis for the calculation of this indicator have been the following:

5. “When have you last had an HIV test?” with an option of answer stating “in the last 12 months”.
6. “I don’t want to know the result, but do you know the result of your last HIV test?”

Thus, the set of questions and answers have been adjusted according to the recommendations of the *Global AIDS Response Progress Reporting 2014 Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS (UNAIDS 2011)*.

Numerator: The number of respondents stating that they received an HIV test in the last 12 months and know the result.

Denominator: the number of survey respondents.

Results: Distribution by age and gender of respondents that received an HIV test in the last 12 months and know the result is presented in the table 12:

Table 13 Disaggregation by age and gender of injecting drug users that received an HIV test in the last 12 months and know the result in Chisinau, Republic of Moldova, 2013

	Total	Males	Females	<25 years	25 + years
%	47.3	47.1	49.8	35.6	48.6
Numerator	182	153	29	17	165
Denominator	365	315	50	38	327

In the case of older respondents, the values for the coverage with HIV Testing and the level of knowledge related to HIV are higher compared to the values attested for the respondents of younger age. There is not significantly difference between female respondents and male respondents.

In Balti, those tested for HIV in the last 12 months that know their results represent 43.4%, with a lower value for the age group over 25 years (43.2%) compared to the respondents from the age group

up to 25 years (48.6%). Female respondents reported to be more frequently covered with testing and knowing their results (49.0%) than male respondents (42.1%).

In Tiraspol, those tested for HIV in the last 12 months that know their results represent 28.9%, with a lower value for the age group up to 25 years (6.1%) compared to the respondents from the age group over 25 years (35.6%). Female respondents reported to be more frequently covered with testing and knowing their results (36.0%) than male respondents (26.6%).

Limitations of the Survey:

1. Data have been self-reported which indicates that recall and social desirability biases are possible.
2. Data are representative only for the locality where the survey was carried out and cannot be extrapolated over the whole country.

Interventions in Key Populations at Risk

Within HIV prevention programmes carried out in the country, HIV prevention among IDUs registered the greatest progress. As of 2000, Harm Reduction Programmes and Needle Exchange Programmes have been included in the National Strategy for Prevention of HIV among IDUs (previously called National Prevention Strategy for the most affected regions - Balti, Chisinau and other 4 most affected districts). The Harm Reduction Programme has been scaled up rapidly with the support of Global Fund Round 1 (years 2003-2006).

Due to the establishment and scale up of the Harm Reduction Programmes among key populations at risk, both in the civilian sector (IDUs, SWs, MSM) and in penitentiaries (IDUs), the example of Republic of Moldova can be considered a best practice. Distribution is made through a network of sites in 24 geographical localities that include prevention centres within Needle Exchange Programme (NEP) and outreach activities in the field. In addition, social and outreach workers make referrals to other HIV Prevention services, VCT, gynaecologic consultations, diagnostic of STI. The Needle Exchange Programme (NEP) provides an entry point for access to substitution therapy.

The Needle Exchange Programme covers 2 counted points in penitentiary institutions – one on the right bank (actually covering 9 penitentiary institutions and detention centres) and 1 in Transnistrian region (3 of prisons providing NEP services), starting with October 2010. ,

According to data from January 2014, a number of 8712 IDUs have been covered with NEP services during 2013, constituting coverage of 28.8% of the estimated number of 30200 IDUs from both banks of the Republic of Moldova. Starting with 2011, when the unique identifier programme and client registration are introduced, it was possible to obtain more veridical coverage data. The Integrated Bio- Behavioural Survey carried out in 2012 showed limited coverage with 3 main interventions (awareness regarding HIV/ Test, receipt of condoms and syringes free of charge) among IDUs in Chisinau (16.5 %) and Balti (51.4 %). At the same times, free of charge syringes do not represent an attractive service for many IDUs, given the fact that 99.8 % of respondents from Chisinau and 98.7 % respondents from Balti mentioned that they can easily get syringes when needed. Given the fact that syringes are very cheap, and do not require doctor's prescription, the main source for IDUs in Chisinau is the pharmacy (85.1%) and only 22.9% receive syringes free of charge from NEP. In Balti the main source of syringes for IDUs is the NEP (59.1%) and for 35.4% of IDUS in Balti the pharmacy is the main source of syringes.

In 2005 the Government adopted the Strategy on OST as a national strategy for prevention of HIV. Simultaneously, an enabling environment of support and development of OST was developed. The Law on HIV stipulates about Methadone Substitution Therapy as an HIV Prevention Strategy.¹ Moldova is one of the first countries in the region that introduced MST in prisons at the beginning of 2005. In 2008 the Ministry of Health approved a protocol on OST that adjusted national principles to WHO principles, thus revising selection criteria, building capacities of enrolment in OST of patients on outpatient basis, without hospitalisation. With the implementation of outpatient OST services, continuity of OST care services from the civilian sector and prisons improved, and currently there is close cooperation between the 2 sectors.² Currently, both infected and non-infected patients can benefit from services within civilian sector clinics, and penitentiary institutions. The number of 337 permanent Injecting Drug Users benefitted from Methadone Substitution treatment during the reporting period.

Both harm reduction services and MST have been evaluated in 2013 and 2012 accordingly, showing mostly a low coverage with services and low quality of the services provided. The recommendations of the evaluations resulted into a harm reduction strategy for the period 2014-2016 and into a working plan to ensure the OST recommendations are in place.

HIV prevention interventions for SWs include the following services: distribution of condoms, distribution of Information, Education and Communication materials, and references to STI and VCT services. Primary method of services provision is outreach in apartments and on the street. Presently, there are 5 centres within the programme offering outreach services for SWs. Based on activity reports, during the reporting period (2013 year), 2704 female CSWs have been covered with HIV prevention services.³ Based on the integrated bio-behavioural survey in 2013, around 55.0% of SWs in Chisinau and 22.0% in Balti received condoms free of charge, while the vast majority buys them from drugstores (69.8% in Chisinau and 36.0% in Balti).⁴

HIV Prevention actions targeting MSM are accomplished by various civil society organisations (Gender-Doc and ATIS Centre) in the 2 main cities of the country (Chisinau and Balti). Services include distribution of condoms and lubricants, informative leaflets, organisation of workshops, promotion of safe sex, provision of individual consultation services and development of referral system to medical specialists, and referral to VCT services. Programmes cover MSM through outreach activities and through places attended by MSM, such as bars, touristic zones, and support groups established in community centres. During the 2011, HIV prevention services cover a number of 1685 MSM.

INDICATOR 1.7 Percentage of sex workers reached with HIV prevention programmes

Data Source:

Data presented for this indicator have been collected within the Behavioural HIV Seroprevalence survey carried out in 2013 among sex workers in Chisinau and Balti (*see Appendix 4*). Data introduced in the electronic tool are for the capital of the country, Chisinau municipality.

¹ Parliament of the Republic of Moldova. Law no. 23 from 16 February 2007 Regarding HIV/AIDS Prevention. Chapter III, article 7, point 4. Official Gazette no. 54-56, from 20.04.2007, art. 250

² Subata E. Final Report on the Evaluation of Opioid Substitution Therapy in the Republic of Moldova 2009. Unpublished work

³ SOROS Foundation Moldova; Activity Report, 2013; Unpublished work

⁴ National Center for Health Management; Integrated Bio-behavioural survey 2013; unpublished work,

Method of Calculation:

The set of questions and the respective answers that served as basis for the calculation of this indicator have been the following:

1. "Do you know where you can get an HIV test?"
2. "In the last 12 months, did you receive free condoms?" (e.g. through an outreach service, NGO, youth friendly services or any other source?)

In this way, the set of questions and answers is adjusted to the recommendations of the *Global AIDS Response Progress Reporting 2014, Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS (UNAIDS 2011)*.

Numerator: The number of respondents that stated that they know where to undertake an HIV test and received condoms free of charge during the last 12 months.

Denominator: The number of survey respondents.

Results: Data of this indicator desegregated by age are presented in the table13:

Table 14 Distribution by age of sex workers that know where to undertake an HIV test and received condoms free of charge in Chisinau municipality, Republic of Moldova, 2013

		Total		<25 years		25 years and more	
"Do you know where you can get an HIV test?"	Numerator	308	85.9	72	84.2	236	86.7
	Denominator	364		88		276	
"In the last 12 months, did you receive free condoms?" (e.g. through an outreach service, NGO, youth friendly services or any other source?)	Numerator	227	54.6	46	41.8	181	58.8
	Denominator	364		88		276	
Integrated Indicator	Numerator	205	49.4	39	37.1	166	53.7
	Denominator	364		88		276	

The value of the coverage with HIV prevention services is higher among respondents over 25 years old. In Balti municipality, 21.4% of the respondents reported that received condoms free of charge in the last 12 months and 63.3% of the respondents reported to know where to receive an HIV test.

Limitations of the survey:

1. Data have been self-reported which indicates that recall and social desirability biases are possible.
2. Data are representative only for the locality where the survey took place and cannot be extrapolated for the whole country.

INDICATOR 1.11 Percentage of men having sex with men that are reached by HIV prevention programmes

Data Source:

Data presented for this indicator have been collected within the Behavioural HIV Seroprevalence survey carried out in 2013 among Men Having Sex with Men in Chisinau and Balti (see Appendix 4). Data introduced in the electronic tool are for the capital of the country, Chisinau municipality.

Method of Calculation:

The set of questions and the respective answers that served as basis for the calculation of this indicator have been the following:

3. "Do you know where you can get an HIV test?"
4. "In the last 12 months, did you receive free condoms?" (e.g. through an outreach service, NGO, youth friendly services or any other source?)

In this way, the set of questions and answers is adjusted to the recommendations of the *Global AIDS Response Progress Reporting 2014, Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS (UNAIDS 2011)*.

Numerator: The number of respondents that stated that they know where to undertake an HIV test and received condoms free of charge during the last 12 months.

Denominator: The number of survey respondents.

Results: Data of this indicator desegregated by age are presented in the table13:

Table 15 Distribution by age of men having sex with men that know where to undertake an HIV test and received condoms free of charge in Chisinau municipality, Republic of Moldova, 2013

		Total		<25 years		25 years and more	
"Do you know where you can get an HIV test?"	Numerator	219	78.9	48	69.1	171	82.4
	Denominator	250		59		191	
"In the last 12 months, did you receive free condoms?" (e.g. through an outreach service, NGO, youth friendly services or any other source?)	Numerator	132	28.8	33	34.4	99	29.6
	Denominator	250		59		191	
Integrated Indicator	Numerator	125	24.0	32	28.6	93	24.1
	Denominator	250		59		101	

The value for the coverage with HIV prevention services is higher among respondents up to 25 years old. In Balti municipality, 88.6% of the respondents reported to receive condoms free of charge in the last 12 months and 93.0% of the respondents reported that know where to receive an HIV test.

Limitations of the survey:

1. Data have been self-reported which indicates that recall and social desirability biases are possible.
2. Data are representative only for the locality where the survey took place and cannot be extrapolated for the whole country.

INDICATOR 2.1 Number of syringes distributed annually per injecting drug user through harm reduction programmes

Data Source:

Data for this indicator have been collected from the registers of syringes distributed within Harm Reduction Programmes and results of size estimations of injecting drug users produced in 2014.

Method of Calculation:

Numerator: Number of syringes distributed within Harm Reduction Programmes

Denominator: Number of estimated Injecting Drug Users in the country

Results: Throughout 2013, **1963500** have been distributed within Harm Reduction Programmes through needle exchange sites. The estimated number of Injecting Drug Users in the country represents 30200 persons, 21061 on the right bank and 10501 on the left bank of the Dniester River.

Indicator value is **65 syringes** per IDU per year.

Indicator value for the right bank of the Dniester River is 94 syringes per user per year, while for the left bank it represents 14 syringes per user per year, the coverage being significantly lower on the left bank compared to the right bank of the Dniester River.

28% of estimated number of IDUs were covered by prophylactic programs during 2013. If it divides the number of syringes by the number of beneficiaries, we obtain 225 syringes distributed per person who inject drugs (beneficiaries) per year.

Knowledge and Behaviour

INDICATOR 1.1 Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission

The last data available for this indicator are for 2012 and they have been reported in the progress report on combating HIV/AIDS in the republic of Moldova in 2013. According to the national second generation surveillance plan, the behavioural and HIV seroprevalence surveys are carried out once in 2-3 years. The following survey will be in 2015, and data will be available for the next reporting period.

INDICATOR 1.2 Percentage of young women and men aged 15 – 24 who have had sexual intercourse before the age of 15

The last data available for this indicator are for 2012 and they have been reported in the progress report on combating HIV/AIDS in the republic of Moldova in 2013. According to the national second generation surveillance plan, the behavioural and HIV seroprevalence surveys are carried out once in 2-3 years. The following survey will be in 2015, and data will be available for the next reporting period.

INDICATOR 1.3 Percentage of women and men aged 15 – 49 who have had sexual intercourse with more than one partner in the last 12 months

Data source:

The data for this indicator have been collected within the framework of the Multiple Indicator Cluster Survey in 2012 (reference), (see Appendix 2, evaluation survey on Multiple Indicator Cluster Survey " 2012).

For the purpose of the present report, the sub-sample of 15-49 year old respondents was extracted from the database of the study and was analysed according to the recommendations of the *Global AIDS Response Progress Reporting 2014, Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS* (UNAIDS 2011).

Method of Calculation:

In the data collection tool the question has been formulated as follows:

1. "How many sexual partners have you had in the last 12 months?"

Numerator: The number of respondents aged 15-49 who have had more than one partner in the past 12 months.

Denominator: The number of respondents aged 15-49.

Results: Distribution by gender and age group of the respondents who have had more than one sexual partner in the last 12 months (calculated as a numerator) in absolute and relative figures (%) is presented in Table 16.

Table 16 Distribution by gender and age of 15 – 49 years old respondents who stated that they had more than one partner during the last 12 months, absolute figures and %, Republic of Moldova (right bank of the Nistru River), 2012

	Total	Males				Females			
		15-19 years old	20-24 years old	25-49 years old	total	15-19 years old	20-24 years old	25-49 years old	total
Percent %	7.6	8.1	32,8	10.5	13.5	2.7	4.2	1.6	2.0
Numerator	577	21	78	110	209	11	37	69	117
Denominator	7545	259	238	1049	1545	920	884	4196	6000

Out of the survey respondents aged 15-49 years old, 7.6% have reported having more than one sexual partner throughout the last year. There may be underreporting among females due to socially-accepted desirability bias.

Indicator values reported in 2007 represent 8,3%, in 2008 – 10,8%, in 2009 – 9,8%, in 2010 – 9.0%. Thus, no change is attested in the behaviour of the general population related to multiple sexual partners.

Risky behaviour

INDICATOR 1.4 Percentage of women and men aged 15-49 who had more than one partner in the last 12 months and used a condom during their last sexual intercourse

Data source: The data for this indicator have been collected within the framework of the Multiple Indicator Cluster Survey in 2012 (reference), (see Appendix 2, evaluation survey on Multiple Indicator Cluster Survey” 2012).

For the purpose of the present report, the sub-sample of 15-49 year old respondents was extracted from the database of the study and was analysed according to the recommendations of the *Global AIDS Response Progress Reporting 2014, Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS* (UNAIDS 2011).

Method of Calculation:

In the data collection tool, the questions have been formulated as follows:

1. How many sexual partners have you had in the last 12 months?” with numerical answers.
2. “Did you use a condom during the last sexual intercourse?”

Numerator: The number of respondents aged 15-49 who have had more than one sexual partner in the last 12 months and used a condom during the last sexual intercourse.

Denominator: The number of respondents aged 15-49 who have had more than one partner in the last 12 months.

Results: Distribution by gender and age group of the respondents who have had more than one sexual partner in the last 12 months and who used a condom during the last sexual intercourse is presented in Table 18.

Table 17 Distribution by gender and age of 15 – 49 years old respondents who stated that they had more than one sexual partner during the last 12 months and used condom during the last sexual intercourse, Republic of Moldova (right bank of Nistru River), 2012

	Total	Males				Females			
		15-19 years old	20-24 years old	25-49 years old	total	15-19 years old	20-24 years old	25-49 years old	total
Percent, %	47.7	87.2	63.4	33.0	49.5	-	(9.6)	28.8	34.5
Numerator	275	18	49	36	104	4	19	17	40
Denominator	577	21	78	109	209	11	37	59	117

Out of the respondents reporting more than one sexual partner in the last 12 months, 47,7% stated the use of condoms at last sexual intercourse. The highest condoms use is registered for males aged 15 – 19, and for females aged 20-24 years old. Overall, there are significant gender-associated differences in the indicator value.

The value of the indicator reported in 2007 has been 49.3%, while the value registered in a general population survey in 2008 is 46.1%. The value of the indicator represents 50.8% within the framework of the survey on Vulnerability of Women to HIV carried out in 2009 in the Republic of Moldova and 47.6% in 2010. Thus, no essential behavioural changes have been attested in the general population aged 15-49.

Limitations of the indicator:

- a. Recall and desirability biases are possible.
- b. There are no nationally-representative estimates. Results are available only for the right banks of the Dniester River.

INDICATOR 1.8 Percentage of sex workers that used a condom during the last sexual intercourse with the last commercial sexual partner

Data source:

Data for this indicator have been collected within the Behavioural and HIV Seroprevalence survey that took place in 2013 among Sex Workers in Chisinau and Balti (*see Appendix 4*). Data introduced in the electronic tool are those for the capital of the country, Chisinau municipality.

Method of Calculation:

Respondents are asked the following question:

“Did you use a condom with your most recent client?”

Thus, the set of questions and answers is adjusted to the recommendations of the *Global AIDS Response Progress Reporting 2014 Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS* (UNAIDS 2011).

Numerator: The number of respondents who stated that they had commercial sexual intercourse in the last 12 months and used a condom during the last sexual contact with the most recent client.

Denominator: The number of survey respondents stating that they had commercial sexual contact in the last 12 months.

Results: Data on the given indicator disaggregated by age is given in the table 20:

Table 18 Disaggregation by age of sex workers who had used a condom with the most recent client in Chisinau, Republic of Moldova, 2013

	Total	<25 years	25+ years
Percentage (%) of SWs that used a condom during the last sexual intercourse with the last commercial sexual partner	87.5	88.4	87.3
The number of respondents that used a condom during the last sexual intercourse with the last commercial sexual partner	330	79	251
The number of survey respondents stating that they had commercial sexual contact in the last 12 months.	364	88	276

The percentage of sex workers that reported that used a condom during the last sexual intercourse with the last commercial sexual partner represents 87.5%, the value being higher in the respondents younger than 25 years old compared to those older than 25 years.

In Balti municipality, 79.4% of the respondents reported that used a condom during the last sexual intercourse with the last commercial sexual partner, the value in respondents younger than 25 years old (81.5%) is higher compared to those older than 25 years (78.9%).

Limitations of the Survey:

1. Data have been self-reported which indicates that recall and social desirability biases are possible.

2. Data are representative only for the locality where the survey was carried out and cannot be extrapolated over the whole country.

INDICATOR 1.12 Percentage of men having sex with men that used a condom during the last homosexual anal contact

Data source:

Data for this indicator have been collected within the Behavioural and HIV Seroprevalence survey that took place in 2013 among Men Having Sex with Men in Chisinau and Balti (see Appendix 4). Data introduced in the electronic tool are those for the capital of the country, Chisinau municipality.

Method of Calculation:

The set of questions and the respective answers that served as basis for the calculation of this indicator have been the following:

1. „Did you have anal sex with men during the last 6 months?” with affirmative answer
2. „Did you use a condom during the last anal sexual contact?” with affirmative answer.

Thus, the set of questions and answers is adjusted to the recommendations of the *Global AIDS Response Progress Reporting 2014 Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS* (UNAIDS 2011).

Numerator: The number of respondents who stated that they had anal sexual intercourse with a man in the last 6 months and used a condom during the last anal sexual contact with a man.

Denominator: The number of survey respondents stating that they had anal sexual contact with a man in the last 6 months.

Results: Data on the given indicator disaggregated by age is given in the table 20:

Table 19 Disaggregation by age of men who have sex with men who had used a condom at last anal sexual contact during the last 6 months in Chisinau, Republic of Moldova, 2013

	Total	<25 years	25+ years
Percentage (%) of MSM that used a condom during the last anal homosexual contact	49.2	56.1	46.6
The number of respondents that used a condom during the last anal homosexual contact	101	26	75
The number of respondents that anal sexual contact with a man in the last 6 months	188	43	145

The percentage of men having sex with men who reported that used a condom during the last anal sexual contact with a man represents 49.2%, the value in respondents younger than 25 years old (46,6%) being lower compared to those older than 25 years (56,1%).

Limitations of the Survey:

3. Data have been self-reported which indicates that recall and social desirability biases are possible.
4. Data are representative only for the locality where the survey was carried out and cannot be extrapolated over the whole country.

INDICATOR 2.2 Percentage of injecting drug users that reported the use of condom during the last sexual intercourse

Data source:

Data for this indicator have been collected within the Behavioural and HIV Seroprevalence survey that was carried out in 2012/2013 among injecting drug users in Chisinau and Balti on the right bank of Nistru River and in Tiraspol and Ribnita on the left bank of Nistru River (see Appendix 4). Data introduced in the electronic tool are those for the capital of the country, Chisinau municipality.

Method of Calculation:

The set of questions and the respective answers that served as basis for the calculation of this indicator have been the following:

1. Have you injected drugs at any time in the last month?
2. If yes: Have you had sexual intercourse in the last month?
2. If yes in answer to both 1 and 2: Did you use a condom when you last had sexual intercourse?

Thus, the set of questions and answers have been adjusted according to the recommendations of the *Global AIDS Response Progress Reporting 2014 Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS (UNAIDS 2011)*.

Numerator: The number of respondents stating that they injected drugs in the last month and has sexual intercourse in the last month and use a condom at last sexual intercourse. .

Denominator: The number of respondents stating that they injected drugs in the last month and has sexual intercourse in the last month.

Results: Distribution by age and gender of respondents that reported the use of condom during last sexual intercourse is presented in the table12:

Table 20 Disaggregation by age and gender of injecting drug users that reported the use of condom during last sexual intercourse in Chisinau, Republic of Moldova, 2013

	Total	Males	Females	<25 years	25 + years
%	25.9	26.9	5.3	26.4	25.8
Numerator	64	58	6	6	58
Denominator	246	216	30	28	218

In the case of male respondents (26.9%), that reported the use of condom during last sexual intercourse is higher compared to the female respondents (5.3%). In Balti, those that reported the use of condom during last sexual intercourse represent 22.7%, with a higher value for the age group over 25 years (24.2%) compared to the respondents from the age group up to 25 years (0% - 2 respondents). Female respondents more frequently reported that used the condom during last sexual intercourse (37.6%) than male respondents (20.5%).

In Tiraspol, those that reported the use of condom during last sexual intercourse represent 13.4%, with a lower value for the age group over 25 years (13.8%) compared to the respondents from the age group up to 25 years (20.7%). Female respondents reported to more frequently use the condom during last sexual intercourse (46.8%) than male respondents (13.3%).

Limitations of the Survey:

1. Data have been self-reported which indicates that recall and social desirability biases are possible.
2. Data are representative only for the locality where the survey was carried out and cannot be extrapolated over the whole country.

INDICATOR 2.3 Percentage of injecting drug users that reported the use of sterile equipment the last time they injected

Data source:

Data for this indicator have been collected within the Behavioural and HIV Seroprevalence survey that was carried out in 2012/2013 among injecting drug users in Chisinau and Balti on the right bank of Nistru River and in Tiraspol and Ribnita on the left bank of Nistru River (see Appendix 4). Data introduced in the electronic tool are those for the capital of the country, Chisinau municipality.

Method of Calculation:

The set of questions and the respective answers that served as basis for the calculation of this indicator have been the following:

1. "Have you injected drugs at any time in the last month?"
2. If yes: "The last time you injected drugs, did you use a sterile needle and syringe?"

Thus, the set of questions and answers have been adjusted according to the recommendations of the *Global AIDS Response Progress Reporting 2014 Guidelines Constructor of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS (UNAIDS 2011)*.

Numerator: The number of respondents stating that they used the sterile equipment the last time they injected.

Denominator: the number of respondents who reported injecting drugs in the last month.

Results: Distribution by age and gender of respondents used sterile equipment the last time they injected is presented in the table12:

Table 21 Disaggregation by age and gender of injecting drug users used sterile equipment the last time they injected in Chisinau, Republic of Moldova, 2013

	Total	Males	Females	<25 years	25 + years
%	99.4	99.2	100	100	99.2
Numerator	243	213	30	28	215
Denominator	246	216	30	28	218

There is not attested a difference between the values obtained for female respondents and male respondents and for the values obtained for younger and older respondents.

In Balti, the percent of respondents stating that they used the sterile equipment the last time they injected is 96.7%, no difference of values by age groups and bay gender.

In Tiraspol, the percent of respondents stating that they used the sterile equipment the last time they injected is 83.4%, with a lower value for the age group up to 25 years (65.5%) compared to the respondents from the age group over 25 years (94.3%). Male respondents reported that more frequently used sterile equipment at the last time they injected (86.1%) than female respondents (43.0%).

Limitations of the Survey:

1. Data have been self-reported which indicates that recall and social desirability biases are possible.
2. Data are representative only for the locality where the survey was carried out and cannot be extrapolated over the whole country.

Impact indicators

INDICATOR 1.10 Percentage of commercial sex workers living with HIV/AIDS

Data source:

Data for this indicator have been collected within the Behavioural and HIV Seroprevalence survey that was carried out in 2013 among Sex Workers in Chisinau and Balti (*see Appendix 4*). Data introduced in the electronic tool are those for the capital of the country, Chisinau municipality.

Method of Calculation:

Numerator: The number of blood samples tested positive as a result of HIV testing (ELISA)

Denominator: The number of tested blood samples.

Results: Distribution of the respondents by age group is presented in the table 21:

Table 22 Distribution by age group of blood samples tested as HIV-positive as a result of ELISA testing, % and absolute figures and percentage, SWs, Chisinau municipality, Republic of Moldova, 2013

Total			
		Number	%
<25 years	Numerator	6	6.7
	Denominator	88	
25 + years	Numerator	40	13.5
	Denominator	271	
Total	Numerator	46	11.6
	Denominator	359	

In Balti municipality, HIV prevalence among Sex workers represents 21.5%.

Limitations of the survey:

1. Respondents have been recruited within the geographic limits of the localities where the data collection has taken place. Hence, these results cannot be extrapolated to the whole SWs population of the country.

INDICATOR 1.14 Percentage of men having sex with men that are HIV infected

Data source:

Data for this indicator have been collected within the Behavioural and HIV Seroprevalence survey that was carried out in 2013 among Men Having Sex with Men in Chisinau and Balti (*see Appendix 4*). Data introduced in the electronic tool are those for the capital of the country, Chisinau municipality.

Method of Calculation:

Numerator: The number of blood samples tested positive as a result of HIV testing (ELISA)

Denominator: The number of tested blood samples.

Results: Distribution of the respondents by age group is presented in the table 21:

Table 23 Distribution by age group of blood samples tested as HIV-positive as a result of ELISA testing, % and absolute figures and percentage, MSM, Chisinau municipality, Republic of Moldova, 2013

Total			
		Number	%
<25 years	Numerator	1	1.9
	Denominator	59	
25 + years	Numerator	17	8.4
	Denominator	191	
Total	Numerator	18	5.7
	Denominator	250	

In Balti municipality, HIV prevalence among Men having Sex with Men represents 8.2%.

Limitations of the survey:

2. Respondents have been recruited within the geographic limits of the localities where the data collection has taken place. Hence, these results cannot be extrapolated to the whole MSM population of the country. The MSM profile may vary among regions.

INDICATOR 2.5 Percentage of injecting drug users that are HIV infected

Data source:

Data for this indicator have been collected within the Behavioural and HIV Seroprevalence survey that was carried out in 2013 among Injecting Drug Users in Chisinau and Balti on the right bank of Nistru River and in Tiraspol and Ribnita on the left bank of Nistru River (*see Appendix 4*). Data introduced in the electronic tool are those for the capital of the country, Chisinau municipality.

Method of Calculation:

Numerator: The number of blood samples tested positive as a result of HIV testing (ELISA)

Denominator: The number of tested blood samples.

Results: Distribution of the respondents by gender and age group is presented in the table 24:

Table 24 Distribution by gender and age group of blood samples tested as HIV-positive as a result of ELISA testing, % and absolute figures and percentage, IDUs, Chisinau municipality, Republic of Moldova, 2013

	Total	Males	Females	<25 years	25+ years
Percentage of IDUs who are HIV-infected	8.5	8.7	6.9	1.4	9.1
Number of blood samples tested for HIV with positive results	41	36	5	2	39
Number of tested blood samples	339	297	42	37	302

In Balti municipality, HIV prevalence among Injecting Drug Users represents 41.2%.

In Tiraspol municipality, HIV prevalence among Injecting Drug Users represents 23.9%.

Limitations of the survey:

3. Respondents have been recruited within the geographic limits of the localities where the data collection has taken place. Hence, these results cannot be extrapolated to the whole IDUs population of the country. The IDUs profile may vary among regions and different banks of Nistru River.

INDICATOR 4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Method of Calculation:

Numerator: Number of adults and children who are alive enrolled in ARV treatment 12 months after its initiation

Denominator: Number of adults and children that initiated ARV treatment in the cohort reporting (2012)

Source: Register of patients in ARV treatment from institutions providing the given service

Table 25 Percentage of persons enrolled in ARV treatment that reached 12 months of ARV treatment, Republic of Moldova, cohort of 2012, measured at the beginning of 2013.

	Total	Males	Females	<15 years	15+ years
Indicator value	81.2%	76.1%	85.8%	100%	80.7%
Numerator	483	217	266	16	467
Denominator	595	285	310	16	579
Disaggregation of persons who initiated ARV treatment and have not reached 12 months of treatment by cause of treatment interruption					
Number of persons recorded as lost to follow up from the surveillance system	0				
Stopped ARV treatment	68				
Died	44				

Comparable values of the percentage of persons enrolled in ARV treatment that continues the treatment for more than 12 months is presented in the table 26.

Table 26 Percentage of persons who initiated ARV treatment and are known to be on treatment for more than 12 months, Republic of Moldova, years 2006-2013

Year	2006	2007	2008	2009	2010	2011	2012	2013
Enrolment in ARV treatment for more than 12 months	80,7%	86,7%	76%	88,3%	87,5%	80,67%	81.89%	81.2%

INDICATOR 3.3 Mother-to-child transmission of HIV

The National Programme on Prevention and Control of HIV/AIDS stipulates maintenance of vertical HIV transmission rate under 2%.

Calculation Method: Spectrum is not sensible to the small figures of Republic of Moldova. For this reason was used the cohort analysis of pregnant women with HIV delivered in 2012 and mother to child transmission of HIV at their children.

Numerator: Number of new HIV cases among children born by HIV positive mothers in 2012.

Denominator: Number of HIV positive pregnant women given birth during 2012.

Table 27 Rate of mother-to-child transmission of HIV in the Republic of Moldova for 2013 cohort analysis

	2012
Rate of mother-to-child transmission of HIV	3.3%
Number of new HIV cases among children born by HIV positive mothers	6
Number of HIV positive pregnant women given birth during 2012	182

According to the national guidelines, infants born to HIV positive mothers are tested for HIV at 6 weeks of life, at 12 and 18 months, subsequently being released from medical surveillance as being healthy or taken under medical supervision as HIV positive patient. According to the registered statistics data, the rate of mother-to-child transmission of HIV in 2012 is 3.3% (6 HIV infected infants at 182 HIV positive pregnant women) at the end of 2013. For the cohort of 2013, it must be taken into account the fact that all infants born to HIV positive mothers during 2013 will be under medical supervision until the age of 19 months of life. Cases of mother-to-child transmission have occurred among women that have not received ARV prophylaxis treatment during pregnancy and delivery.

Additional indicators

INDICATOR 4.4 Percentage of health facilities dispensing ARVs that experienced one or more stock-outs of at least one required ARV drug in the last 12 months

Numerator: Number of medical institutions dispensing ARVs that experienced one or more stock-outs during the last 12 months

Denominator: Number of medical institutions dispensing ARVs

Indicator value is **0%**. There were no stock-outs registered during the reporting period.

INDICATOR 3.2 Percentage of children born to HIV positive mothers that have been tested for HIV in the first 2 months of life

Data source: register of infants born to HIV positive mothers, register of HIV positive mothers that gave birth

Method of Calculation:

Numerator: Number of infants born to HIV positive mothers that have been tested for HIV in the first 2 months of life.

Denominator: Number of HIV positive pregnant women that gave birth during the reporting period.

Results: Throughout 2013, 138 infants have been tested for HIV in the first 2 months of life. Out of this number, 132 infants received a negative result for the test, 5 received a positive result for the test and one test is indeterminate. 153 HIV positive women gave birth during the reporting period.

Indicator value is **90.2%**.

INDICATOR 3.9 Percentage of children born to HIV positive mothers initiated on Cotrimoxazol prophylaxis in the first 2 months of life

Numerator: Number of children who received Cotrimoxazol –78

Denominator: Number of HIV positive pregnant women that gave birth during the reporting period – 153

Indicator value – **50.98%**

INDICATOR 7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months.

The last data available for this indicator are for 2010 and they have been reported in the Progress Report on Combating HIV/AIDS in the Republic of Moldova from 2012. According to the National Surveillance Plan of Studies are carried out once in 3-5 years.

EXAMPLES OF GOOD PRACTICES

By adopting the „Three ones” principle and with the beginning of the implementation Global Fund grant in 2003, the National Coordination Council became the main mechanism of Coordination and Implementation of the National Programmes on Prevention and Control of HIV/AIDS/STI and Tuberculosis. Members of this Coordination mechanism are representatives of central public administration, representatives of donors and nongovernmental sector working in the field. In the Republic of Moldova, this mechanism proved to be a functional one for consolidating national and international efforts to achieve the objectives of National Programmes. The number of civil society representative increased reaching 40% of

the members. Also, the private sector is represented. To achieve the “Three Ones’ objective, and a better case management, the Ministry of Health performed an assessment of the system of coordination of activities in the field of HIV/AIDS and identified problems, obstacles that reduce the efficiency of the system. Hence, based on the recommendations suggested, the Ministry of Health undertook a series of measures to restructure service delivery infrastructure focused on PLHA, by creating coordination institutions.

The legal framework in the field of social protection was revised to reduce stigma and discrimination of PLHA and social protection activities started being implemented.

The Republic of Moldova is recognised in the region as an example of good practices due to its successful implementation of Harm Reduction Programmes in key populations at risk in the civilian sector (IDUs, CSWs, MSM) and in penitentiary institutions (IDUs). Thus, there are information/education/outreach, and needle exchange activities, as well as referrals to medical and social services. Methadone Substitution treatment is provided both in the civilian sector and in penitentiary institutions (on right bank of Dniester river only). During the reporting period, services extended in 3 other localities, including the left bank of the Dniester River (IDU).

MONITORING AND EVALUATION

Starting with 2005, the Ministry of Health in Moldova, together with its partners, including the Global Fund, World Bank and UNAIDS, created the concept of one joint Monitoring and Evaluation system for the National programme on Prevention and Control of HIV/AIDS/STI. The M&E unit on national health programmes was established as a department of the National Centre for Health Management of the Ministry of Health. It used to be in charge of M&E of the NP on HIV/AIDS/STIs, on TB and of the Drugs Observatory. In 2011, the M&E Unit strove for building capacities of line institutions as the National AIDS Center to undertake routine programme monitoring, and has been reformed to act as a Unit for Audit of Data Quality. The M&E unit monitored a set of indicators that was developed and agreed with all key actors to support the monitoring and evaluation of the National Programme on HIV/AIDS and ensures regular UNGASS reporting and Universal Access with all necessary consultations and data collections. The M&E unit developed 4 UNGASS reports with all consultations and data collections for 2004-2005, 2006-2007 2008-2009, 2010-2011, 2 GARPR reports for 2013, and 2014 and the report on Universal access for 2008, 2010. Other products include building upon the one joint functional M&E system, according to the stipulations of the M&E National Plan, and a joint national indicators set. The M&E unit implemented the following types of surveys to measure results of interventions: IBBS 2007, IBBS 2009/2010, IBBS 2012-2013, KAP surveys for youth and general population 2006, 2008, 2010, qualitative and quantitative surveys among most at risk adolescents (young IDUs, CSWs, and MSM), situation analysis of children and families affected by HIV/AIDS, evaluation of PMTCT services in the Republic of Moldova.

From the mid of 2012, due to the HIV reform service, the M&E was fragmented. Some of the collecting national data remains with the M&E unit, the data base, and one person staff was transferred to the new coordination institution – the Hospital of Dermatology and Communicable Diseases, the roles and responsibilities among public actors being not well defined, shared and implemented.

The National Coordination Council acts as a decision-making forum and coordinates the national M&E system; there is a permanent M&E Technical Working Group under the auspices of the NCC. Routine administrative statistics in health include case registration of HIV and STI, registration of the number of HIV

infected people in medical surveillance, number of HIV tests and registration of screening results of blood donors.

In April 2011, the functionality of the M&E system has been thoroughly self-assessed by a large team of national stakeholders. The methodology was based on the Organisational Framework of functional M&E systems, endorsed by MERG, and included filling in the 12 components Tool during a multi-stakeholder assessment workshop with participation of important actors, representing various institutions and levels of M&E systems. As a result of the evaluation, key challenges and priorities have been outlined for future actions. The National Monitoring and Evaluation Operational Manual was developed based on these challenges and key priorities for strengthening the 12 components of the national M&E system, based on the general principles and M&E infrastructure outlines in the National M&E Plan. A costed and time-bound national M&E Work Plan has been developed for 2011-2015.

Challenges

- The consolidation of the HIV service reform to include specific developments on M&E aspect;
- Lack of human resources and capacities to undertake fully the M&E system and platform after the HIV reform;
- Lack of institutionalized routine inter-sectorial reporting mechanisms;
- Limited allocations to the M&E system from the state budget and over-reliance on international financial support, which curtails sustainability;
- Gaps in national technical expertise;
- Given political constraints affecting full collaboration with Transdnestrian region, full coverage with comprehensive M&E of the region is difficult;
- Operational research, scientific research and programme evaluation are not carried out in a consistent and comprehensive manner;

Priorities

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

- Confidentiality of data issues need to be properly addressed
- A comprehensive national database needs to be developed to strengthen data use
- Consistent and consequential data dissemination activities need to be undertaken to enhance
- Evidence-based planning and implementation in the framework of the national response.

DATA COLLECTION SOURCES

APPENDIX 1 Multiple indicator cluster survey

Type of research: quantitative household surveys.

Target group: women and men aged 15 - 49 that live permanently on the territory of the Republic of Moldova (right bank of the Nistru River⁵).

Final sample size: 12,528 households.

Sampling method: stratified, multistage, quasiprobabilistic.

Data collection period: between April 17 and June 30, 2012.

Data collection instrument: Structured questionnaire. Household Questionnaires; Questionnaires for Individual Women (age 15-49); Questionnaires for Individual Men (age 15-49); Questionnaires for Children under Five

Representativeness: sample considered nationally representative separately for the women and for the men of the Republic of Moldova in a 15-49 age group, permanent Republic of Moldova inhabitants (right bank of the Nistru River).

Demographic Structure of the Final Sample:

	<i>Number completed</i>	<i>Response rate</i>
Household Questionnaires	11,354	97.4
Questionnaires for Individual Women (age 15-49)	6,000	89.3
Questionnaires for Individual Men (age 15-49)	1,545	77.0
Questionnaires for Children Under Five	1,869	96.3

Main Limitations of the Survey:

1. Representative only for the right bank of the Nistru River.

⁵ Following the frozen political conflict on the Nistru River, the territories on the left bank of the Nistru are not fully controlled by the Chisinau government. Social research agencies activating on the right bank of the Nistru are not collecting data from the left bank of the Nistru.

APPENDIX 2 Integrated bio-behavioural surveys in injecting drug users

Source: (BSS 2012/2013)

Type of research: repeated, multicentre (34 centres), cross-sectional, based on a questionnaire combined with qualitative testing for antibodies to HIV, HVC, HVB and syphilis.

Target group: UDIs living in the municipality of Chisinau, Balti, Tiraspol and Ribnita.

Final size of sample: 362 respondents recruited in the municipality of Balti, 365 respondents recruited in the municipality of Chisinau and 300 respondents recruited in Tiraspol and 115 respondents recruited in Ribnita (left bank of Dniester River).

Sampling method: Respondent Driven Sampling.

Data collection period: October, 9 2012 – March, 27 2013.

Data collection instrument: Structured questionnaire. Surveys were carried on using the “face to face” method.

Representativeness: sample considered as representative for UDIs living in the geographical limits of localities where data collection was carried on.

Table 29 Demographic structure of final sample, IDUs, Municipality of Chisinau, capital city of the Republic of Moldova, 2012/2013

	Total		Males		Females	
	#	%	#	%	#	%
Up to 25 years	38	8,2[5,2-11,8]	30	7,1[4,3-10,8]	8	17,6[6,2-33,7]
25 + years	327	91,7 [88,1 - 94,8]	285	92,9 [89,2-95,7]	42	81,9 [65,5-93,5]
Total	365		315	87,98 [82,54 - 92,31]	50	12,12 [7,79 - 17,65]

Table 30 Demographic structure of final sample, IDUs, Municipality of Balti, 2012/2013

	Total		Males		Females	
	#	%	#	%	#	%
Up to 25 years	23	7,4 [4,1 – 12,0]	16	7,0 [3,4 – 12,7]	7	7,5 [2,3 – 13,5]
25 + years	339	92,6 [88,1 - 95,9]	260	93,0 [87,3 – 96,6]	79	92,5 [86,5 – 97,7]
Total	362		276	80,0 [74,5 - 84,7]	86	20,0 [15,3 - 25,5]

Limitations

- This sampling method was applied to recruit UDIs benefitting from risk reduction programs and UDIs who do not. Ninth wave was reached in all implementation locations.
- All collected data are based on self-reporting, which doesn't exclude the offering of socially desirable answers. Recall bias could occur in the answers of those who had a less often occurrence of the events mentioned by the questionnaire (last injection, last sexual contact, etc.).
- Respondents have been recruited within the geographic limits of the locations where the data collection has taken place. Hence, these results cannot be extrapolated to the whole IDUs population of the country. The IDUs profile may vary among regions.

APPENDIX 3 Integrated bio-behavioural survey in female commercial sex workers

Source: (BSS 2013)

Type of research: repeated, multicentre (2 centre), cross-sectional, based on a questionnaire combined with qualitative testing for antibodies to HIV, HVC, HVB and syphilis.

Target group: Female Commercial Sex Workers (CSWs) living in the municipality of Chisinau and municipality of Balti.

Final size of sample: 362 respondents recruited in the municipality of Balti and 364 respondents recruited in the municipality of Chisinau

Sampling method: Respondent Driven Sampling.

Data collection period: February, 15 2013 - June, 7 2013.

Data collection instrument: Structured questionnaire. Surveys were carried on using the “face to face” method.

Representativeness: sample considered as representative for CSWs living in the geographical limits of localities where data collection was carried on.

Limitations:

- This sampling method was applied to recruit CSWs benefitting from Harm Reduction Programme and CSWs who do not. Ninth wave was reached in all implementation locations.
- Respondents have been recruited within the geographic limits of the locations where the data collection has taken place. Hence, these results cannot be extrapolated to the whole SWs population of the country. The SWs profile may vary among regions.
- All collected data are based on self-reporting, which doesn't exclude the offering of socially desirable answers. Reminder errors could occur in the answers of those who had a less often occurrence of the events mentioned by the questionnaire (latest injection, latest sexual contact, ETC.) In the year or month before the in the survey.

Appendix 4 HIV seroprevalence and behaviour study among men having sex with men

Type of research: repeated, multicentric (2 centres), cross-sectional, based on a questionnaire combined with qualitative testing for antibodies to HIV, HVC, HVB and syphilis.

Target group: Men having Sex with Men who are permanent inhabitants on the territory of Chisinau or Balti municipalities.

Final size of sample: 200 respondents recruited in the municipality of Balti, 250 respondents recruited in the municipality of Chisinau.

Sampling method: Respondent Driven Sampling

Data collection period: 15 February – 09 April 2013 in Chisinau and 18 March – 11 June 2013 in Balti

Data collection instrument: Structured questionnaire. Surveys were carried on using the “face to face” method

Representativeness: sample considered as representative for MSM living in the geographical limits of localities where data collection was carried on.

Table 28 Demographical structure of sample by age groups in Chisinau, capital city:

	Chisinau	
	Number	%
16 - 19 years	19	16,2 [8,8 - 27,9]
20 - 24 years	39	16,3 [10,3 - 24,4]
25 - 29 years	46	22,7 [14,5 - 33,2]
30 - 34 years	40	11,7 [6,5 - 17,7]
35 - 39 years	23	5,6 [2,5 - 7,6]
40-44 years	17	3,7 [1,3 - 5,9]
45-49 years	17	7,1 [2,5 - 11,6]
50-54 years	18	7,7 [2,8 - 13,3]
55 years and more	31	9,0 [3,7 - 14,1]
Total	250	

Limitations:

- This sampling method was applied to recruit MSM benefiting from risk reduction programs as well as those not covered by such programmes⁶. Ninth wave in Chisinau and eighth wave in Balti was reached.
- All collected data are based on self-reporting, which does not exclude social desirability bias. Recall bias could occur in the answers of those who had a less often occurrence of the events mentioned by the questionnaire (last injection, last sexual contact, etc.) during the last year or the last month previous to the interview.

⁶ Studies previously carried on in the Republic of Moldova have used convenience sampling among risk reduction programme beneficiaries. Studies previously carried on in the Republic of Moldova have used convenience sampling among risk reduction programme beneficiaries.

- Respondents have been recruited within the geographic limits of the locations where the data collection has taken place. Hence, these results cannot be extrapolated to the whole MSM population of the country. The MSM profile may vary among regions.

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