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REPUBLIC OF MOLDOVA

PROGRESS REPORT ON HIV/AIDS

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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

An efficient and successful AIDS response has to be measured by the achievement of concrete and time-bound targets. This report is designed to measure national achievements versus global targets, to which Moldova aligned to, as well as to identify challenges and constraints, and recommend actions to accelerate achievement of the targets.

The Republic of Moldova consistently reported starting with the 2001 Declaration of Commitment on HIV/AIDS, followed by the one from 2006. The 2011 UN Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS (General Assembly resolution 65/277), adopted at the United Nations General Assembly High-Level Meeting on AIDS in June of that year invited countries to report on commitments related to that Declaration.

This reporting round is imperatively important due to the fact that the 2016 Global AIDS Response Progress Reporting is a transition reporting round for AIDS-related targets in the Millennium Development Goals and the Sustainable Development Goals providing the baseline for targets to be set at the High-Level Meeting (HLM) on AIDS in 2016 and it is also the last reporting round for 2011 UN Political Declaration on HIV and AIDS.

The Monitoring and Evaluation (M&E) Unit is part of the management unit of the National Programme on Prevention and Control of HIV/AIDS and STI in the Republic of Moldova, under the Hospital of Dermatology and Communicable Diseases. An M&E system was developed and made functional starting with 2005 within the Centre of National Health management. Over the years, this system passed through a series of system changes and reforms. However, relevant strategic information has been obtained and made 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 a national workshop at the beginning of April 2016. Also, it is part of the Dublin Declaration and of the WHO Global Strategy and UNICEF reporting on Health sector.

The HIV epidemic in the Republic of Moldova is a concentrated one in key populations. Impact and outcome assessments through sentinel surveys show a mixed picture in the three largest cities. For people who inject drugs, comparative results of 2012-2013 and 2009-2010 data show a decrease in HIV prevalence in Chisinau (from 16.4% to 8.5%), a small increase in Balti (from 39.0% to 41.8%) and a significant increase in Tiraspol (from 12.6% to 23.9%). In 2012/2013, Integrated Biological and Behavioural Survey (IBBS) Ribnita (in Transnistria) was included for the first time and the HIV prevalence in people who inject drugs was the highest in the country, at 43.7%. The HIV prevalence in sex workers shows a worsening situation in Chisinau (from 6.1% to 11.6%) and a stable prevalence in Balti (23.4% and 21.5%). Finally, the HIV prevalence in men having sex with men was much higher in 2012/2013 in both sites Chisinau (increase from 1.7% to 5.4%) and Balti (from 0.2% to 8.2%)¹ compared to data from 2009-2010.

¹ Ulrich Laukamm-Josten, Report "Support to perform the HIV epidemiological situation analyses", December, 2014, Chisinau, the Republic of Moldova

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 (NAP). As the programme for 2014-2015 ended last year, a new Programme was developed for the period 2016-2020. The programme was built on thorough and extensive situational analyses, which included epidemiological review. The epidemiological review, supported by external assistance (WHO/UNAIDS) was based on the data coming from routine statistics, operational researches and programmatic data. NAP has also, at the basis several researches as Allocative Efficiency/Investment case realised with the support of UNAIDS/World Bank/UNDP and South Wales University (2015); NSP/OST/ARV cost-effectiveness (UNAIDS and French National Institute of Health and Medical Research (2015) providing clear recommendations on the investments to be allocated so that to produce maximum of health impact and efficiency. It also aligns to the latest UNAIDS strategies as Fast Track and WHO recommendations related to treatment, care and support. The draft NAP for 2016-2020 is recognised by national partners and development agencies as a robust, evidence-based and comprehensive one.

The programme has been consensually agreed upon by the CCM members and it is now in the phase of approval by the Government.

The process of Programme development included several phases and approaches as follows:

- 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 2014-2015 period;
- Active involvement of the members of the National Coordination Council on TB/AIDS (NCC on TB/AIDS) and Technical Working Groups (TWG) of the NCC;
- Consultations based on a consensus among main participants in the field, including the Government, international organisations, non-governmental organisations and PLWHA.

The draft of the National AIDS Programme for was endorsed by NCC members is focused around 2 main strategic programmatic directions:

- The continuity and scale up of the implementation of activities on prevention of transmission of HIV and STIs among people at increased risk of infection (injecting drug users, commercial sex workers, men doing sex with men, prisoners) by providing access to and coverage with harm reduction programs for these groups in proportion of at least 60% of the estimated number, as well as on the prevention of the infection transmission from these populations to general population;
- Ensuring universal access to treatment, care and support of the people infected with HIV and sexually transmitted infections;

The third objective does not envisage the programmatic area, but the managerial one, reflecting on M&E system strengthening, the organization and implementation arrangements of the Programme, stakeholders' coordinator and involvement, communities' involvement and strengthening, ensuring synergies with the health system and with other national programmes etc.

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). Thereby, there are information/education/outreach, condoms provision 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 4 other localities, including the left bank of the Nistru River (IDU).

The Investment case exercise (2015) and the strategy on scaling up harm reduction, ensured doubling the budget on prevention programmes from Global Fund New Funding Model Grant for the period 2015-2017, as well as projecting ambitious targets on prevention in the new NAP 2016-2020.

The practices in prisons were recognised by UNAIDS PCB, as one of the best practices in addressing HIV in prisons. "In the Republic of Moldova, the prison system has gradually expanded a comprehensive harm reduction programme started in 1999 that includes needle, syringe and condom distribution as well as opioid substitution therapy. Coverage of antiretroviral therapy among prisoners living with HIV increased from 2% in 2005 to 62% in 2013" as per the new report entitled "Do no harm: health, human rights and people who use drugs" released by UNAIDS ahead of the United Nations General Assembly Special Session on the World Drug Problem.

Moreover, during the national consultations on UNAIDS approach of public health and human rights in world drug control policy, Moldova finalised with formally committing and sustaining it informing the President of General Assembly, UNAIDS Executive Director and UNODC Executive Director on that position.

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 2012-2015 years. By getting involved in the "Peer-to-Peer" network the young people had the possibility to participate in actions of prevention of HIV/AIDS, STI, drug addiction and alcoholism.

The voluntary Counselling 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. 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 of those most vulnerable and affected to 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 Law has been adopted by the parliament in 2012, which ensures the rights of people and tolerance towards the most vulnerable and stigmatised.

HIV EPIDEMIC IN THE REPUBLIC OF MOLDOVA

Moldova continues to experience a concentrated HIV epidemic among people who inject drugs (PWID), men who have sex with men (MSM), female sex workers (FSW) and their clients, as well as their sexual partners in the general population. The HIV epidemic is more severe on the left bank of Nistru River – Transnistrian region, which counts for the third part of the total number of registered cases and where coverage of prevention programs is lower. Estimations of HIV data in the general population have been made since 2010, including 2016 using the estimations and projections tool called Spectrum. The data are used for monitoring the progress, understand the trends, sustain policy projections and decision-taking processes.

By the 1st of January 2016 there have been registered 10213 new HIV cases on both banks of the Nistru River. Around 58% of them are males and 42% are female. The share of young people aged 15-24 are 24%. They are less on the left bank of Nistru river (22.4%) than on the right bank (25%).

During 2015 - 165.4 thousand people were tested, 50317 of whom - pregnant women. Around 30.4% of HIV testing is among pregnant women and 17.8% among donors, while prevention program covered only 10,3% of testing.

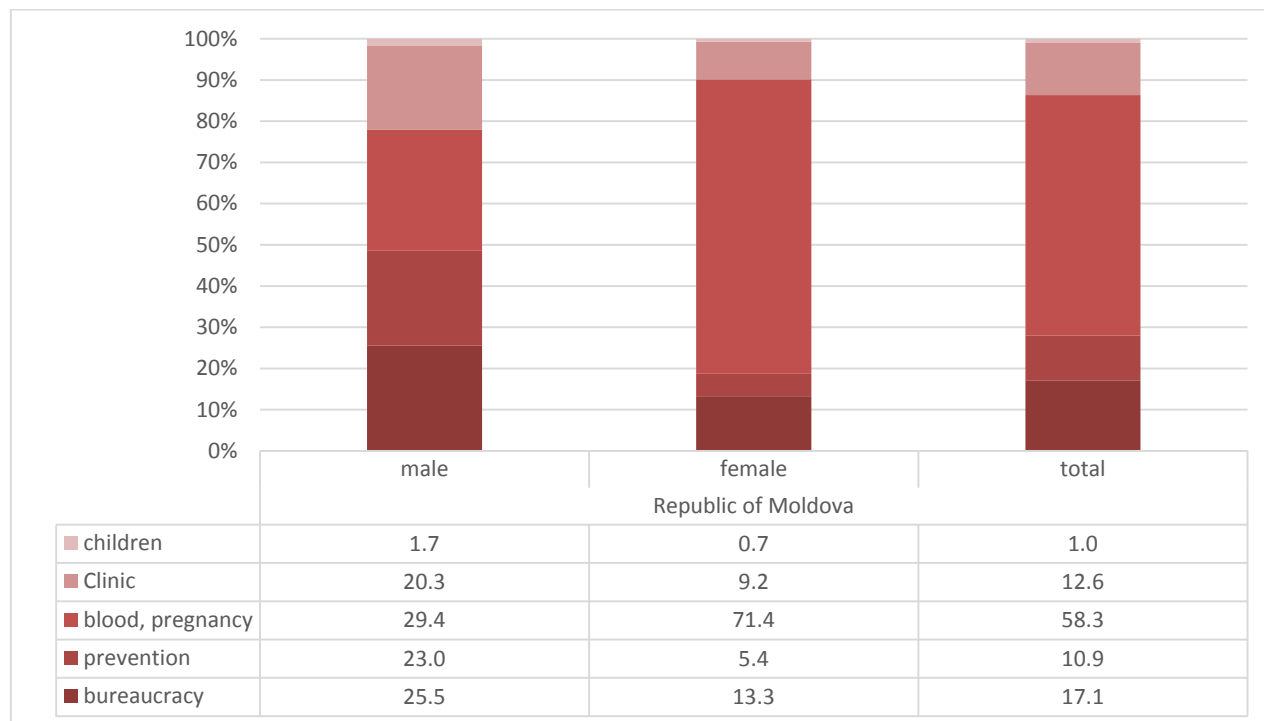


Figure 1. Share of programs of HIV testing in 2015, Republic of Moldova, %

From the confirmed test data, it becomes apparent that the share of cases found in the prevention programs has declined over time to a low of about 25% of all cases in the last 5 years. This means that the majority of newly found cases are presenting in the hospitals with symptoms, as pregnant women or as tests of blood in hospitals. This implies that most cases are in fact cases infected sometime in the past. However, the greater number of new cases is registered by prevention programs and by clinical cases. This means that the testing efforts must be directed to prevention programs.

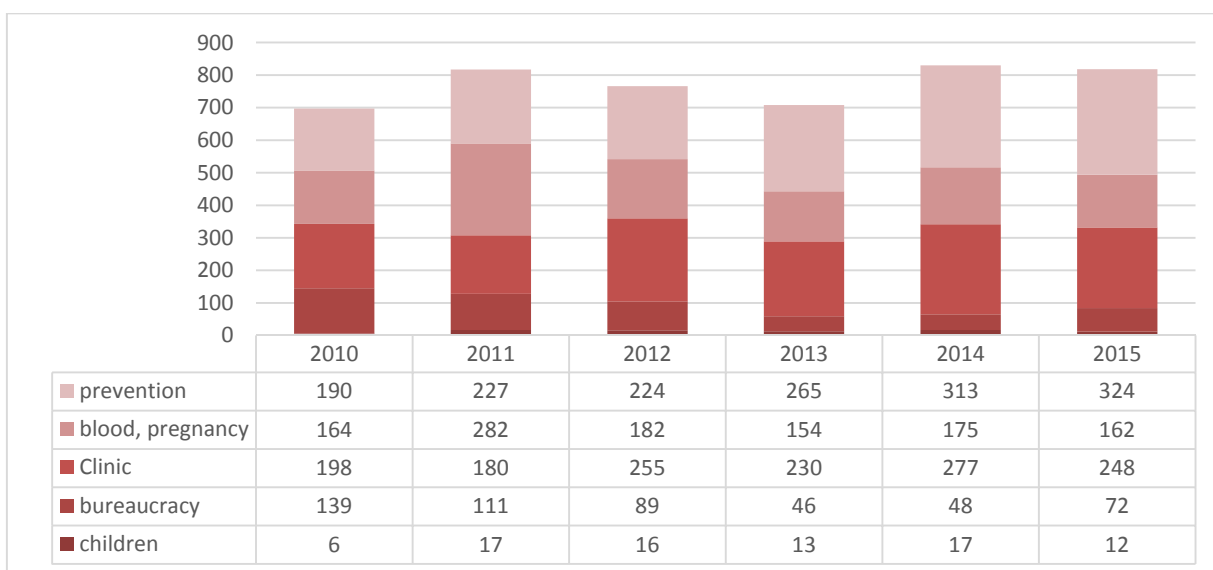


Figure 1 Share of programs that register new cases, 2010 - 2015, Republic of Moldova

New HIV cases are mainly registered among young people and persons of reproductive and economically-active age 15-49 years – 86.4% and 15 - 24 years old – 12.6%(2015). Compared to the data from 2014, no changes can be noted - out of all newly registered HIV cases, 86.4% were registered in 15-49 age group, 12.5% - 15 - 24 years old.

Starting with 2007 coverage with HIV Testing of pregnant women exceeds 99, 0%, which allows calculating HIV prevalence among them and which remains relatively stable in the last years.

The modes of transmission have changed over time as would be expected in a concentrated epidemic, driven by PWIDs: IDU has become the minor mode while sexual transmission has become the predominant mode. Out of 830 new cases reported in 2014, 86,6% mentioned about the sexual route as the main probable route of HIV transmission; out of 818 new HIV cases reported in 2015, 87.5% mentioned about it. 85.4% of new cases detected in 2015 mentioned the heterosexual rout of transmission, 2.1% mentioned the homosexual rout, injecting drug use is the mode of transmission for 6.7% of new cases and mother to child transmission is for 0.7%. The mode of transmission can't be determined in 14.9% of cases.

During 2015, 284 new cases of AIDS were reported. Cumulatively there are 3073 cases of AIDS among registered people who live with HIV, which represent 30% of HIV cases.

In the reporting period, 280 deaths were registered among HIV + people, the mean age at time of death being of about 40.7 years.

At the end of 2015 there were 7331 people living with HIV registered in Republic of Moldova (4952 people on the right bank and 2379 on the left bank of Nistru river). Males represent 53.4% of PLH and 46.6% are females.

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 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. The same methodology was used in the 2012-2013 of the IBBS, making the data comparable. The RDS methodology 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, 2007 surveys.

Results of HIV prevalence, among IDUs, CSWs, MSM and prisoners as per the latest IBBS 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 prevalence among CSW, Republic of Moldova, 2013

Location of Data Collection	Sample	HIV,%
Chisinau	364	11.6
Balti	362	21.5

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

The next Integrated Bio-Behavioural study on Knowledge, Attitudes and Practices among most at risk populations will be carried out in the 2016 and the new results will be available in 2017.

NATIONAL RESPONSE TO HIV/AIDS EPIDEMIC

Government HIV and AIDS policies

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 2016–2020 (NAP), to be approved by the Government of the Republic of Moldova by mid of 2016.

The overall coordination and oversight of the NAP is realised through 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).

In line with the Ministry of Health road map on health system reform and based on the Joint assessment (JA) 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 control at the national level.

In the health sector, the following three institutions have national level responsibilities in HIV/AIDS control:

1. Hospital of Dermatology and Communicable Diseases (HDCD)– responsible for the overall coordination of prevention, diagnosis, treatment of PLHA, care and support. In an integrative manner, the hospital, thereby, coordinates VCT (voluntary counselling and testing), the laboratory service, treatment, treatment monitoring, palliative care and STI clinic. The M&E unit, which used to have 4 positions and to be with the national Centre for Health Management, was transferred to the hospital, meaning the M&E informational data base, M&E responsibilities and the M&E coordinator (one person only). The reform is considered not finished and needs further strengthening. The main issues are related to the lack of staff for the management unit of the programme and the resources to cover those positions.

2. National Centre for Public Health – 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. It owns now minor functions related to HIV M&E.

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 new 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 (2012), Law on AIDS Prevention and Control (2007 modified in December, 2012), Law on Combating Domestic Violence (2008), Law on Social Assistance (2008), Law on donors and blood transfusions (2009).

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).

During 2014-2015, the National HIV Treatment Clinical Protocol was reviewed and approved, having at basis the WHO recommendations bringing the threshold of CD4 at new requests; Regulations on sharing personal health information related to the HIV, Standards on HIV counselling and testing using rapid tests amongst vulnerable groups, provided by non-governmental organizations were developed and approved.

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 law 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 in the process of the development of the new NAP 2016-2020. 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.

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 strongest 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 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.

Prevention

There is progress attested in HIV prevention activities among MARPs that experienced the fastest scale up. Among all areas of HIV prevention, HIV Prevention among IDUs has seen the most progress and included an early adoption of harm reduction and NSP as the national strategy of HIV Prevention in IDUs (since year 2000), initial implementation of 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. In 2016, UNAIDS released the report: "Do no harm: health, human rights and people who use drugs", popularizing Moldova's experience alongside with other countries that own good practices and encourage countries to adopt human-health-rights centered approaches towards drug control. 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 28 geographic sites that include stationary NSP points and outreach to apartments. NSPs are also provided in penitentiary institutions on both banks of Nistru river, which are counted as 2 sites: one for Moldova penitentiaries (providing NSP services in 13 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. During 2015 the prevention package for IDUs was completed with other activities as testing via rapid saliva tests, the prevention of overdoses, gender-specific activities for female IDUs. To improve the coverage with harm reduction programs, the peer driven interventions were implemented in the most affected and biggest cities during 6 months of 2015 year.

HIV prevention interventions for FSWs include the following services: condom distribution, IEC distribution, HIV testing via rapid saliva tests 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 three main cities (Chisinau, Balti and Tiraspol). 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 and testing services, and developing referral system to medical specialists, referral to facility-based VCT. During 2015 they started providing the informational sessions for inmates in penitentiary institutions.

In 2015 the opioid substitution treatment was extended to other 5 sites, which offer the possibility to increase the coverage with this service in the country. Also the OST services were extend in two additional penitentiary institutions. By 2015, with the Global Fund support, Moldova established four sites which enrolled and maintained PWID in OST, as Chisinau, Balti, Cahul, and penitentiary system. The program continues to provide support to 4 community-based OST support sites, aimed at increasing access to OST, facilitating the enrolment and OST adherence. The community-based sites established their services as 'one stop shopping', thereby, providing additional services outreach work, HIV testing and counseling, harm reduction, linking with other services (including TB/HIV collaborative), peer-to-peer consultation, psychological and legal consultations, self-support and social support. 'One stop shopping' approach ensured the improvement of cost-efficiency, quality of services and coverage. The revision of the National Clinical Protocol on Methadone for Opioid substitution was performed; which regulates the mechanism of taking methadone for several days at home conditions for the stable patients.

Among other achievements, it is worth mentioning that in 2015, the initiative to provide HIV counselling and testing services through NGOs was 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 implemented the needle exchange and condom provision programs. In 2013, DPI approved the Regulation on protection of personal health data of inmates.

Among the most stringent constraints, which were 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.

Treatment, care and support:

The National HIV Programme for 2016-2020 is built on treatment cascade philosophy, promoted by WHO&UNAIDS, which recommends to start with good testing and diagnosis strategies, continuing with enrolment in treatment, offering qualitative treatment and care so that to finalise with a viral load close to zero. The treatment cascade is part, also of 90-90-90 strategy which encourages countries to diagnose 90% of those estimated living with AIDS, to enrol in treatment 90% of those who need it and to ensure the viral load of 90% of those being in treatment is undetectable.

As Moldova is a concentrated epidemic, all those aspects are focused on those most at risk to get HIV infected: PWID, SW, MSM.

The ART package of service envisages several elements as TARV, TARV as prevention, including prevention from mother to child and post-contact prophylaxis, treatment of co-infections. Care and support programme includes 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 address the health service; decentralizing treatment services and HIV care throughout the country, as well as providing PMTCT services; 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. Since 2013, the Government started covering the treatment of about 500 new patients from domestic resources, covering in 2015 the entire first line for the patients on the right bank, as well as about 50% of the second line. There is a gradual plan of taking over the entire expenditures for treatment by 2017.

In terms of care and support, 4 regional social centres for psychosocial support for PLWH (social, psychological, legal, etc. support); provision of home based palliative care are functional since 2014. In 2016, the costs of the centers were taken by the Government.

The government authorities ensure that PLWH qualify for the status of people with disabilities and can benefit of financial support. It means that they are entitled to have the same benefits, as non HIV people with disabilities. More specifically, People living with HIV can receive social benefits paid both of State fund of social support as well as state budget - 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. These social policies are only addressing HIV people from the right bank.

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 significant treatment, care and support services are provided 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 capacity building and training for health staff, weak quality of laboratory diagnostic, including the one related to the monitoring of HIV patients on both banks of the Nistru River are still among major challenges that has to be addressed by HIV stakeholders and partners.

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. 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 is 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 not only for PLWH but for MARs also. 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. In addition, a national program to promote gender equality has been developed for the years 2014-2015, a new draft for 4 more years has been developed. 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 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.

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, 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 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 6.1 HIV/AIDS spending

In order to ensure reporting according to the provisions of the indicator for 2015, data have been collected from various sources in accordance with the recommendations of the guide *“Domestic and international AIDS spending by categories and financing sources”*. Hence, there have been selected organizations from national and local levels that implemented and disbursed funds as per the HIV spending categories indicated in the template on reporting on HIV expenditures. 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 2015, data on annual expenditures with special destination for HIV/AIDS 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 and STI, and for implementation of the National Program for Prevention and Control of HIV/AIDS and STI 2014-2015;
- 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;
- 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) and NGO (New Life, Initiative Positive, League of People living with HIV, Union for HIV prevention and Harm Reduction) . 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, 2013, 2014 and 2015 are presented in the Matrix for 2011, Matrix for 2012, Matrix for 2013, Matrix for 2014 and for 2015 respectively.

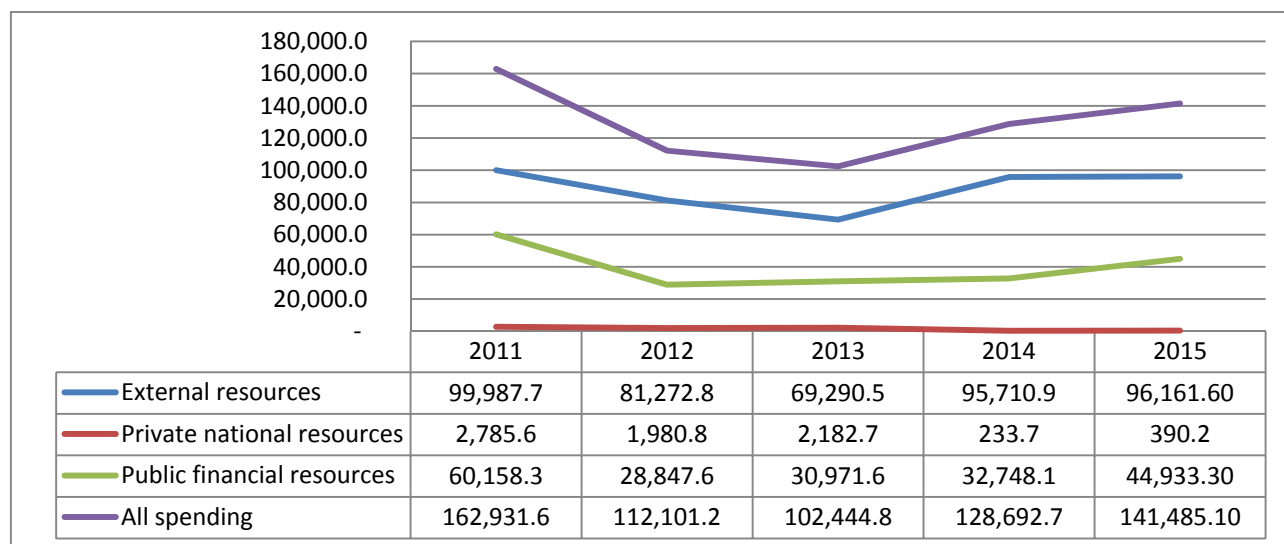


Figure 4 Structure of expenditures for the national HIV response by sources of financing, Republic of Moldova, 2011, 2012, 2013, 2014, 2015

The expenditures for the HIV response in 2015 increased with about 12.8 mln. MDL (+9.9%) compared to the volume of expenditures from 2014 and reached the total amount of about 141.5 mln. MDL or USD 7,517,809. From those expenditures, the public financial resources constituted 44.9 mln. MDL or USD 2,387,532 (31.8%). International resources for this year constituted 96.2 mln MDL or USD 5,109,544 (68%) and the private national resources reached 0.4 mln. MDL or USD 20,733 (0,2%). **(Error! Reference source not found.** Figure 5 and Figure 6).

Simultaneously it is necessary to note that increased spending for the national response to HIV in 2015 is due to increased public financial resources, which are up about 37.2%, from 32.7 mln. MDL in 2014 to 44.9 mln. MDL 2015.

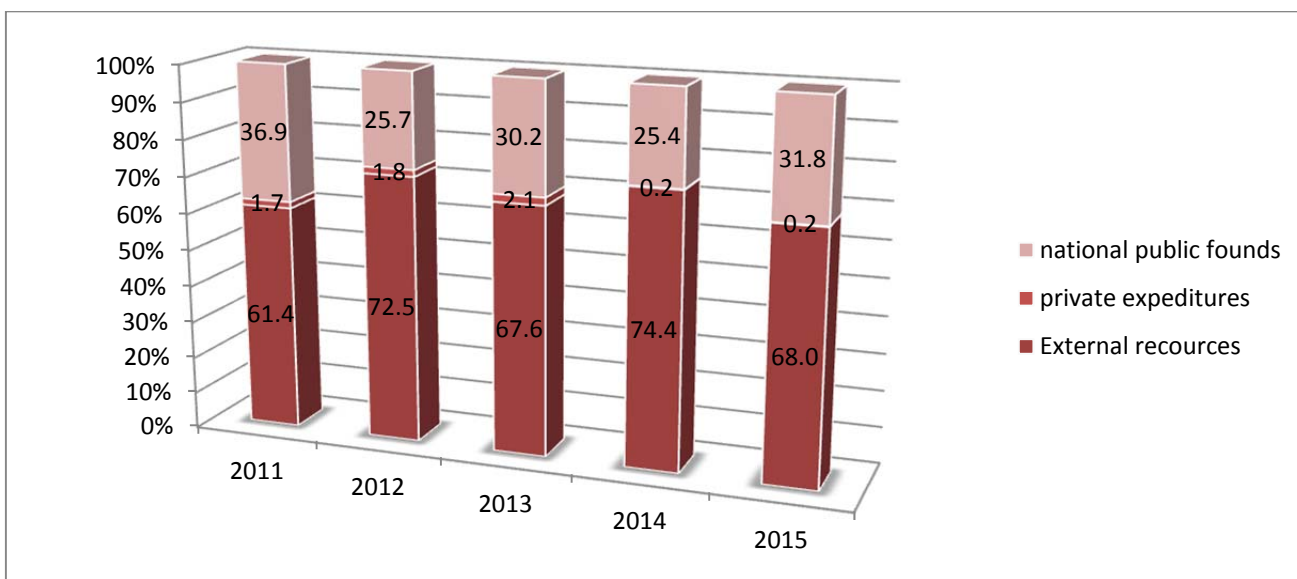


Figure 5 Structure of expenditures for the national HIV response by sources of financing, %, Republic of Moldova, 2011, 2012, 2013, 2014, 2015

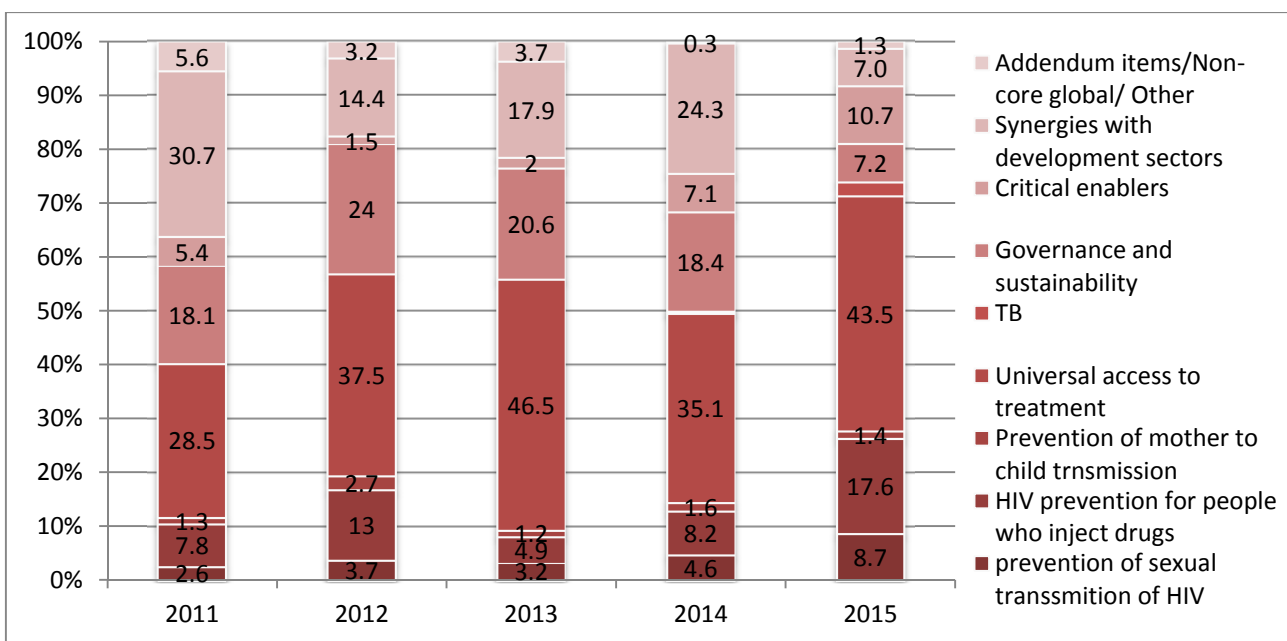


Figure 6 Structure of expenditures for the national HIV response, by spending category, Republic of Moldova, 2011, 2012, 2013, 2014 and 2015

Classified by spending category of expenditures for the national response to HIV in the framework of the national response to HIV in 2015, 43.5 % went to **Treatment and Care**. For the spending category **HIV Prevention for people who inject drugs** financial resources of about 17.6% have been allocated, Critical enablers – 10.7% allocated, Prevention of sexual transmission of HIV 8.7% allocated, Prevention of mother to child transmission – 1.4%, **Governance and sustainability -7.2%, Synergies with development sectors-7.0%, TB – 2.6%, Others – 1.3%.**

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 the integral budget and cannot be disaggregated.
- Some international institutions are reported the data without the desired desegregations.

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 4.1 Percentage of adults and children receiving ARV treatment

ARV treatment became available in the Republic of Moldova since 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 7 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 <500. 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 2015, 19 children and 935 adults have been enrolled in treatment.

Table 6. New enrolments into ARV treatment, Republic of Moldova, 2003-2015

		2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
New enrolments into ARV treatment	Males	49	66	62	109	150	210	211	275	285	305	412	494
	Females	32	41	52	88	113	152	156	255	310	264	487	460
	Total	81	107	114	197	263	362	367	530	595	569	899	954

During 2015 the Government procured ARV drugs of 1st line for the patients from the right bank of Nistru. The remaining ARV drugs for left bank of Nistru 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 were validated. The Spectrum outputs are in course of validation to UNAIDS team and UNAIDS will introduce the data in the on line tool. Only data for the numerator were introduced in the on-line AIDS Reporting tool for 2015 .

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 must represent the sum of both estimates.

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

Table 7 Number of adults and children receiving ARV treatment, Republic of Moldova, 2015

	All	Males	Females	< 15 years	< 1 year	1-4 years	5-9 years	10-14 years	15-19 years	20-24 years	25-49 years	50+ years and older	15 + years and older
Numerator	3850	1916	1934	106	3	27	39	37	42	170	3106	426	3744
Persons newly initiating ARV therapy during the last reporting year	954	494	460	19	3	4	7	5	2	95	736	82	535

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.

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 2015, out of the number of women that gave birth during 2015, 99.3% have been tested for HIV at least once. Since 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 counsel persons before testing and give the result to patients.

During 2015, 92 new cases of HIV infection were identified among pregnant women and 114 HIV positive women became pregnant and decided to go on with the pregnancy. In correspondence with the clinical protocol on ARV treatment, HIV infected pregnant women start ARV treatment as

prophylaxis too 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, 2014 and 2015

	2014	2015
Numerator	152	175
Denominator	170	187
Indicator value	89.4%	93.5%

Among the HIV positive pregnant women receiving ARV treatment to reduce mother to child transmission of HIV/AIDS in 2014, 140 HIV positive pregnant women received a complete course of antiretroviral drugs to reduce mother-to-child transmission (79 of them newly initiated ARV treatment during current pregnancy, 42 pregnant women already on ART before the current pregnancy and 19 women received ARV prophylaxis), and 9 HIV positive pregnant women received an incomplete course of ARV prophylaxis (8 of them initiated ART treatment), 3 HIV positive pregnant women received ARV prophylaxis only during delivery and 18 HIV positive pregnant women don't receive ARV prophylaxis and 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 2015, 159 HIV positive pregnant women received a complete course of antiretroviral drugs to reduce mother-to-child transmission (107 of them newly initiated ARV treatment during current pregnancy, 52 pregnant women already on ART before the current pregnancy) and 14 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 12 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 starting with 2014, all HIV positive pregnant women start ARV treatment that will continue for life immediately after they are taken the specific tests.

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 95,4% in 2014 and 94,7% in 2015 (for both banks of the Dniester River). The prevalence registered in 2014 and 2015 is about 7,2% and 8,1%.

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. Since 2013 all medical providers can counsel persons before testing and give the result to patients.

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

1. If CD4<500, the patient initiates anti TB treatment ; Arv treatment will follow 3-4 weeks later.
2. If CD4 >500, patient initiates anti-TB treatment. Patient is supervised regarding initiation of ARV treatment

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, 2014 and 2015

	2014					2015				
	Total	Males	Females	< 15	15 + years	Total	Males	Females	< 15	15 + years
Indicator value	48.3	42.9	59.8	75	47.9	69.6	68.8	71.1	100	69.5
Numerator	140	85	55	3	137	197	128	69	1	196
Denominator (registered number of HIV/TB cases)	290	198	92	4	286	283	186	97	1	282

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

The last data available for the 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” are for 2012 and they have been reported in the progress report on combating HIV/AIDS in the Republic of Moldova in 2014. According to the national surveillance plan, the behavioural surveys in general population are carried out once in 3-5 years.

The last data available for the indicators:

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

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

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

are for 2012/2013 and they have been reported in the progress report on combating HIV/AIDS in the Republic of Moldova in 2014. 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 2016, and data will be available for the future reporting periods.

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 28 geographical localities that include prevention centres within Needle Exchange Programme (NEP) and outreach activities in the field. The services have been extended to 4 new sites in 2015. 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 13 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 2016, a number of 13069 IDUs have been covered with NEP services during 2015, constituting coverage of 43.3% 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 PWIDs is the NEP (59.1%) and for 35.4% of PWIDs in Balti the pharmacy is the main source of syringes.

In order to increase the coverage and make these measures more effective, in 2015 the activities were centered on service provision of the comprehensive package that still are not covered fully by NAP (needle exchange, condom programming, IEC, VCT, Hepatitis, STI, ARV, OST) and put additional emphasis on gender and age-specific programming, peer-driven interventions, overdose prevention, legal aid, activities in prisons, and an important component of technical assistance and training to improve quality of care and institutionalize new services. The intervention includes also all activities implemented in penitentiary sector, which is a well-known best practice model in the region and beyond. Also, to increase the coverage of PWID with harm reduction services, the project was introduced a new approach in boosting access of key affected populations through peer-driven interventions in three main cities of Moldova (Chisinau, Balti and Tiraspol). 689 new UDIs were reached by prevention programs through the PDI interventions.

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.² 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. This protocol was updated in 2014. 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.³ Currently, both infected and non-infected patients can benefit from services within civilian sector clinics, and penitentiary institutions. During year 2015 OST services have been extended to five additional sites and two additional penitentiary institutions. The number of 468 permanent Injecting Drug Users are receiving Methadone Substitution treatment at the end of the reporting period.

HIV prevention interventions for SWs include the following services: condom distribution, distribution of informational material, specialist consultation (psychologist, social assistant, medical), STI management, peer to peer counselling, VCT, distribution of syringes and distribution of disinfectants, etc., through 5 projects implemented by 5 NGOs. The services have been extended to 4 new sites in 2015. Primary method of services provision is outreach in apartments and on the street. Presently, there are 9 centres within the programme offering outreach services for SWs. Based on activity reports, during the reporting period (2015 year), 4,858 (age: <25 -1,754, 25+ 3,104) female CSWs have been covered with HIV prevention services, constituting coverage of 40.5% of the estimated number of 12000 SWs from both banks of the Republic of Moldova. 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 To increase the coverage of SWs with preventive services, in 2015 was

² 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

³ Subata E. Final Report on the Evaluation of Opioid Substitution Therapy in the Republic of Moldova 2009. Unpublished work

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

introduced a new approach in boosting access of key affected populations through peer-driven interventions (PDI) in two main cities of Moldova (Chisinau and Balti). 539 new beneficiaries among SW were identified through PDI interventions.

HIV Prevention actions targeting MSM are accomplished by various civil society organisations (Gender-Doc and ATIS Centre) in the 3 main cities of the country (Chisinau, Balti and Tiraspol). 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, HIV testing by rapid tests and accompaniment to the health facilities for confirmation and enrolment in the health care. 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 2015, HIV prevention services cover a number of 2805 MSM. Based on the integrated bio-behavioral survey in 2013 around 24% of MSM in Chisinau and 88% in Balti received condoms and/or lubricants free of charge. To increase the coverage of MSM with preventive services, in 2015 was introduced a new approach in boosting access of key affected populations through peer-driven interventions (PDI) in two main cities of Moldova (Chisinau and Balti). 500 new beneficiaries among MSM were identified through PDI interventions.

Indicator 1.7 Percentage of sex workers reached with HIV prevention programmes and **indicator 1.11** Percentage of men having sex with men that are reached by HIV prevention programmes

The last data available for these indicators are for 2012/2013 and they have been reported in the progress report on combating HIV/AIDS in the Republic of Moldova in 2014. 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 2016, and data will be available for the future reporting periods.

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 2015, **2352097** 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 **78 syringes** per IDU per year.

Indicator value for the right bank of the Dniester River is 114 syringes per user per year, while for the left bank it represents 13 syringes per user per year, the coverage being significantly lower on the left bank compared to the right bank of the Dniester River.

43.3% of estimated number of IDUs was covered by prophylactic programs during 2015. If it divides the number of syringes by the number of beneficiaries, we obtain 180 syringes distributed per person who inject drugs (beneficiaries) per year.

Knowledge and Behaviour

The last data available for the indicators:

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

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 surveys in general population are carried out once in 3-5 years. When the new data will be available they will be reported.

Risky behaviour

The last data available for the 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” are for 2012 and they have been reported in the progress report on combating HIV/AIDS in the republic of Moldova in 2014. According to the national second generation surveillance plan, the behavioural surveys in general population are carried out once in 3-5 years.

The last data available for the indicators:

- 1.8 Percentage of sex workers that used a condom during the last sexual intercourse with the last commercial sexual partner
- 1.12 Percentage of men having sex with men that used a condom during the last homosexual anal contact
- 2.2 Percentage of injecting drug users that reported the use of condom during the last sexual intercourse
- 2.3 Percentage of injecting drug users that reported the use of condom during the last sexual intercourse

are for 2012/2013 and they have been reported in the progress report on combating HIV/AIDS in the Republic of Moldova in 2014. 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 2016, and data will be available for the future reporting periods.

Impact indicators

The last data available for the indicators:

- 1.10 Percentage of commercial sex workers living with HIV/AIDS
- 1.14 Percentage of men having sex with men that are HIV infected

2.5 Percentage of injecting drug users that are HIV infected

are for 2012/2013 and they have been reported in the progress report on combating HIV/AIDS in the Republic of Moldova in 2014. 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 2016, and data will be available for the future reporting periods.

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 10 Percentage of persons enrolled in ARV treatment that reached 12 months of ARV treatment, Republic of Moldova, cohort of 2014, measured at the beginning of 2016.

	Total	Males	Females	<15 years	15+ years
Indicator value	84%	82%	85.6%	100%	83.6%
Numerator	755	338	417	22	733
Denominator	899	412	487	22	877
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	93				
Died	51				

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 11 Percentage of persons who initiated ARV treatment and are known to be on treatment for more than 12 months, Republic of Moldova, years 2007-2015

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015
Enrolment in ARV treatment for more than 12 months	86,7%	76%	88,3%	87,5%	80,67%	81.89%	81.2%	78.9%	84%

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 2014 and mother to child transmission of HIV at their children.

Numerator: Number of new HIV cases among children born by HIV positive mothers in 2014.

Denominator: Number of HIV positive pregnant women given birth during 2014.

Table 12 Rate of mother-to-child transmission of HIV in the Republic of Moldova for 2014 cohort analysis

	2014
Rate of mother-to-child transmission of HIV	3.5%
Number of new HIV cases among children born by HIV positive mothers	6
Number of children born by HIV positive pregnant women given birth during 2014, HIV status was determined	171

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 2014 is 3.5% (6 HIV infected infants at 171 children born by HIV positive pregnant women, whom HIV status was determined) at the end of 2015. For the cohort of 2015, it must be taken into account the fact that all infants born to HIV positive mothers during 2014 will be under medical supervision until the age of 19 months of life. At the end of 2015 there is 3 children born in 2015 confirmed with HIV out of 191 children life born by HIV positive mothers. 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 2015, 185 infants have been tested for HIV in the first 2 months of life. Out of this number, 178 infants received a negative result for the test, 6 received a positive result for the test and 1 tests are indeterminate because the blood was collected but there are no results yet. 187 HIV positive women gave birth during the reporting period but was born 191 life children and 1 stillborn. They are 5 twins.

Indicator value is **96.86%**.

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 –52

Denominator: Number of HIV positive pregnant women that gave birth during the reporting period – 187. There are 191 children born by HIV positive women, they were five twins and one stillbirth.

Indicator value – **27.2%**

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 needle exchange, condom distribution, specialist consultation (psychologist, social assistant, medical), distribution of informational material, peer to peer counselling, VCT, etc. 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). The prevention program has been extended during 2015 to 4 sites for IDUs, in other 4 sites for SWs. Methadone Substitution treatment has been extended also in 5 sites in the civilian sector and in other 2 penitentiary institutions. During 2015 were implemented a new interventions as gender specific for female IDUs, informational sessions about and overdoses and use of Naloxon, that will be distributed to beneficiaries at the beginning of 2016.

Moldovan authorities have demonstrated leadership, and pragmatism, in adopting evidence-based HIV prevention programs. 15 years later, Moldova remains one of only a few countries in the world where comprehensive harm reduction services are available in prisons.

Currently, the prison system is implementing 12 out of 15 interventions recommended within the comprehensive package of harm reduction services. Main stages of implementing the Comprehensive package of services in prisons:

1. 1999 - starting needle exchange and distribution of condoms programs;
2. 2001 - Implementation of DOTS in tuberculosis;
3. 2004 - Implementing antiretroviral therapy and development of the first DIP ordinance for HIV/AIDS control;
4. 2005 - Implementation of pharmacotherapy with methadone also in 2005 implementation of DOTS (plus) treatment resistant tuberculosis;
5. 2007 - excluding the mandatory HIV testing of inmates when entering the prison;
6. 2008 – the opening of HIV Voluntary Testing Counselling services and the methodological recommendations on HIV –TB co-infection management in prisons;
7. 2012 (GeneXpert) the method for rapid diagnosis of tuberculosis is implemented;
8. 2013 – VTC through NGO on saliva available for inmates

The needle and syringe exchange program in the Republic of Moldova initially was piloted in one prison and gradually it was extended to 13 prisons in 2015. The average number of syringes distributed annually is about 80,000 syringes per 13 prisons. During 2015 was possible to make the estimation of IDUs beneficiaries of harm reduction in prisons. As per beneficiaries of the program there are two groups: inmates who continue to use drugs while being in prisons and prison staff as the implementation of the program is reducing significantly the risk of accidental puncture with used needles therefore serving as a security at work place response. The syringe exchange programme is unrolled within prisons 24/24 and 7/7days, confidentiality is fully respected. At the NS sites are also distributed alcohol swabs, antiseptic and anti-inflammatory items and IEC materials.

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