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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

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 2014-2015.

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 2014-2015, 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 and for 1010-2015;
- 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.

- 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.The National AIDS Programme was endorsed through the Government Decision of 6 October, 2014 and has the following objectives:
    - 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 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 2012,2013 and 2014 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 nation al 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 2014 there have been trained 217 persons (family doctors, managers of medical facilities, epidemiologists, ONG workers, nurses) to use distance learning. They obtained 700 certifications.

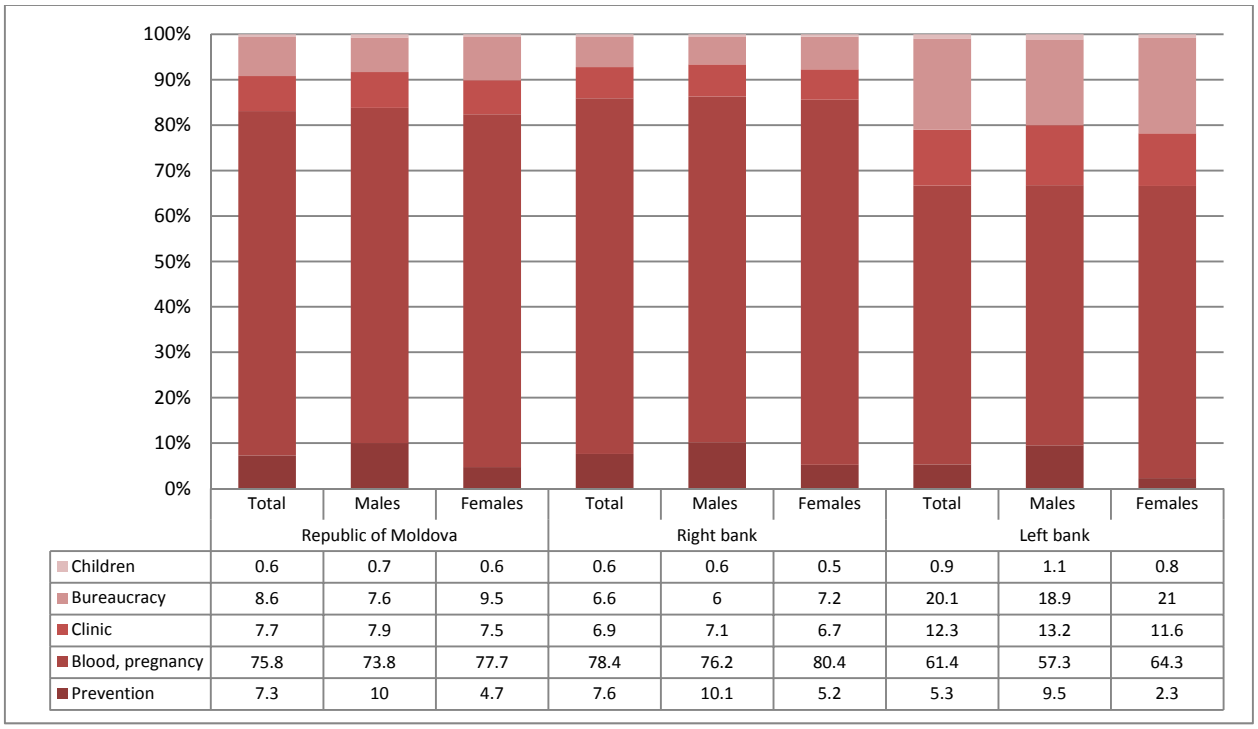
HIV EPIDEMIC IN THE REPUBLIC OF MOLDOVA

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, where coverage of prevention programs is lower. 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, 2014 and early 2015 using the estimations and projections tool called Spectrum. According to the estimations made in 2015 there is 1544 new estimated HIV cases (884cases on the right bank and 660 cases on the left bank of the Nistru River). Also, the estimated HIV prevalence for the right bank of the Nistru River is 0.0,30% and 1.32% for the left bank. The population infected with HIV in 2014 was estimated at 17541(11249 on the right bank and 6292 on the left bank). The need for ARV treatment is estimated at 11628 persons (8974 on the right bank and 2654 on the left bank of the Nistru River). The necessity for prophylactic treatment

for 2014 was estimated at 195 HIV positive pregnant women (129 on the right bank and 66 on the left bank of the Nistru River).

By the 1st of January 2015 there have been registered 9398 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 25.2%, They are less on the left bank of Nistru river (23.0%) than on the right bank (26.2%).

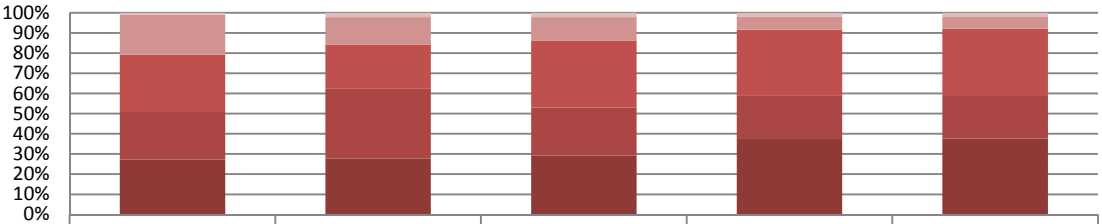
During 2014 were tested 233 thousand people, 46359 being pregnant women. Around 76% of HIV testing is among pregnant women and donors, while prevention program covered only 7% of testing.



	Republic of Moldova			Right bank			Left bank		
	Total	Males	Females	Total	Males	Females	Total	Males	Females
Children	0.6	0.7	0.6	0.6	0.6	0.5	0.9	1.1	0.8
Bureaucracy	8.6	7.6	9.5	6.6	6	7.2	20.1	18.9	21
Clinic	7.7	7.9	7.5	6.9	7.1	6.7	12.3	13.2	11.6
Blood, pregnancy	75.8	73.8	77.7	78.4	76.2	80.4	61.4	57.3	64.3
Prevention	7.3	10	4.7	7.6	10.1	5.2	5.3	9.5	2.3

Figure 1. Share of programs of hiv testing in 2014, Republic of Moldova, %

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.



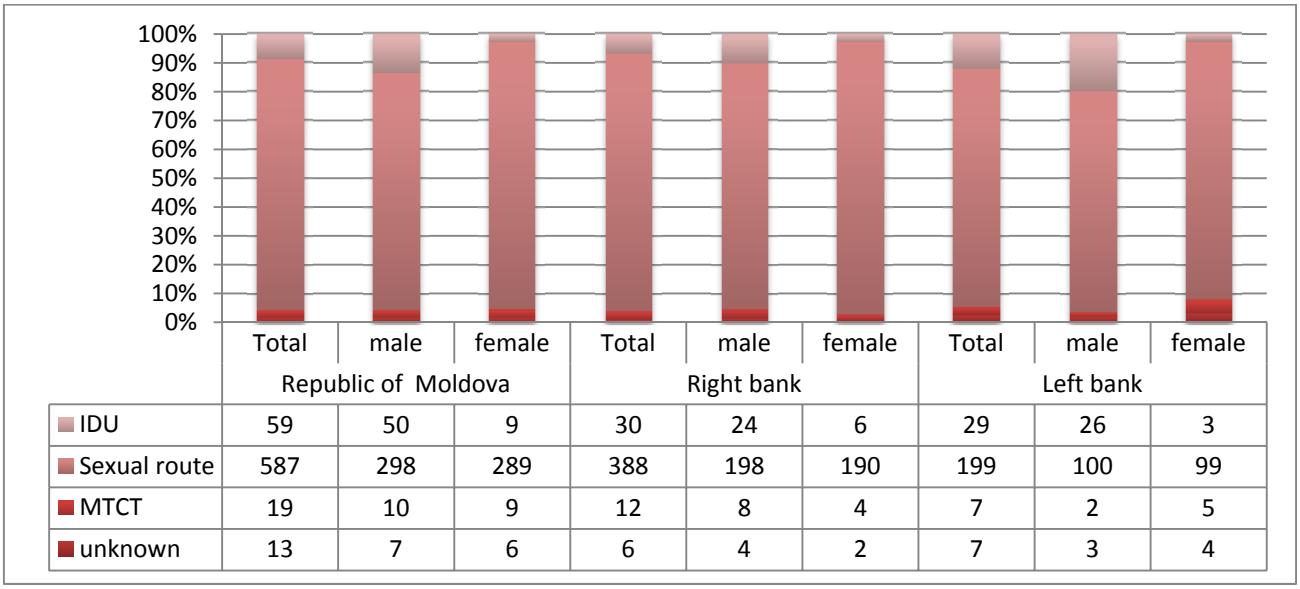
	2010	2011	2012	2013	2014
Children	6	17	16	13	17
Bureaucracy	139	111	89	46	48
Clinic	198	180	255	230	277
Blood, pregnancy	164	282	182	154	175
Prevention	190	227	224	265	313

Figure 1 Share of programs that register new cases, 2010 – 2014, 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

HIV/AIDS is mainly registered among young people of reproductive and economically-active age, aged 15-49 – 86.4% of new HIV cases registered in 2014, in age segments of 15 - 24 years old – 12.8% (in 2013, out of the newly registered HIV cases in age groups of 15-49 years old constituted 87.4%, 15 - 24 years old – 17.8%). 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.

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 706 new HIV cases reported in 2013, 91,9% mentioned about the sexual route as the main probable route of HIV transmission; out of 830 new cases reported in 2014, 86,6% mentioned about the sexual roué as the main probable route of HIV transmission).



	Republic of Moldova			Right bank			Left bank		
	Total	male	female	Total	male	female	Total	male	female
IDU	59	50	9	30	24	6	29	26	3
Sexual route	587	298	289	388	198	190	199	100	99
MTCT	19	10	9	12	8	4	7	2	5
unknown	13	7	6	6	4	2	7	3	4

Figure 3 The likely routes of new cases of HIV infection by regions, Republic of Moldova, 2014

During 2014 were reported 234 new cases of AIDS. Cumulatively there are 2789 cases of AIDS among registered people who live with HIV, which is 29, 7% of HIV cases.

During 2014 there were 302 deaths among HIV + people, with a mean age at time of death of about 39.5 years.

At the end of 2014 there are 6891 people living with HIV registered in Republic of Moldova (4640 people on the right bank and 2251 on the left bank of Nistru river). Males represent 54% of PLH and 46% 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 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

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**

INDICATOR 6.1 HIV/AIDS spending

In order to ensure reporting according to the provisions of the indicator for 2014, 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 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 2014, 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:

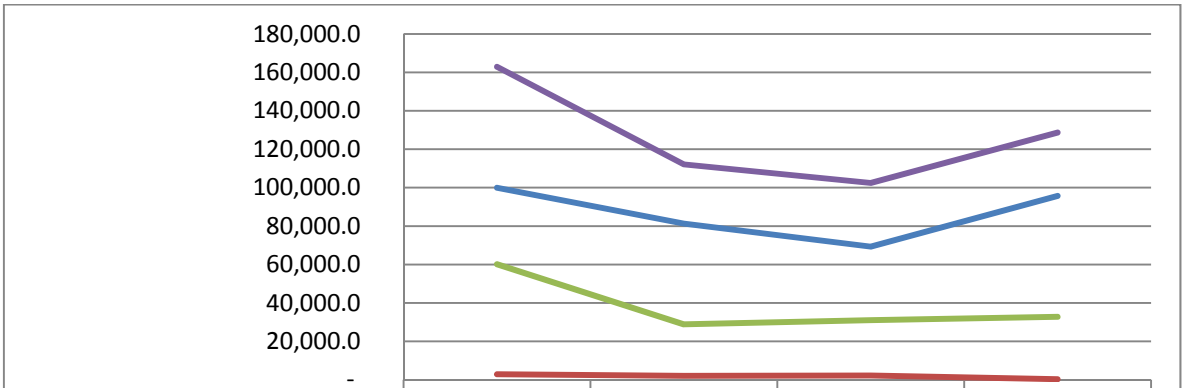
- Ministry of Health, for state budget allocations and funds for Mandatory Health Insurance, for "Public Health Services" Program, for Prevention of HIV/AIDS an STI, and for implementation of the National Program for Prevention and Control of HIV/AIDS and STI 2014-2015;
- Medical –Sanitary Public Institution 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 and 2014 are presented in the Matrix for 2011, Matrix for 2012, Matrix for 2013 and for 2014 respectively.

Need to mentioned that the data about the spending for national response of HIV epidemic in Republic of Moldova for the 2014 was collected using the new Matrix model. The data about spending for national response of HIV epidemic in Republic of Moldova for years 2011, 2012, 2013 were transferred in the new model of Matrix using transferring tables.



	2011	2012	2013	2014
External resources	99,987.7	81,272.8	69,290.5	95,710.9
Private national resources	2,785.6	1,980.8	2,182.7	233.7
Public financial resources	60,158.3	28,847.6	30,971.6	32,748.1
All spending	162,931.6	112,101.2	102,444.8	128,692.7

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

The expenditures for the HIV response in 2014 increased as follows (about 26,2 mln. MDL (+25,6%%) compared to the volume of expenditures from 2013 and reached the total amount of about 128,7 mln. MDL or USD 9166929. From those expenditures, the public financial resources constituted 32,8 mln. MDL or USD 2 332 684 (25,4%). International resources for this year constituted 95,7 mln MDL or USD 6817600 (74,4%) and the private national resources reached 0,2 mln. MDL or USD 16 645(0,2%). (**Error! Reference source not found.** and Figure 5).

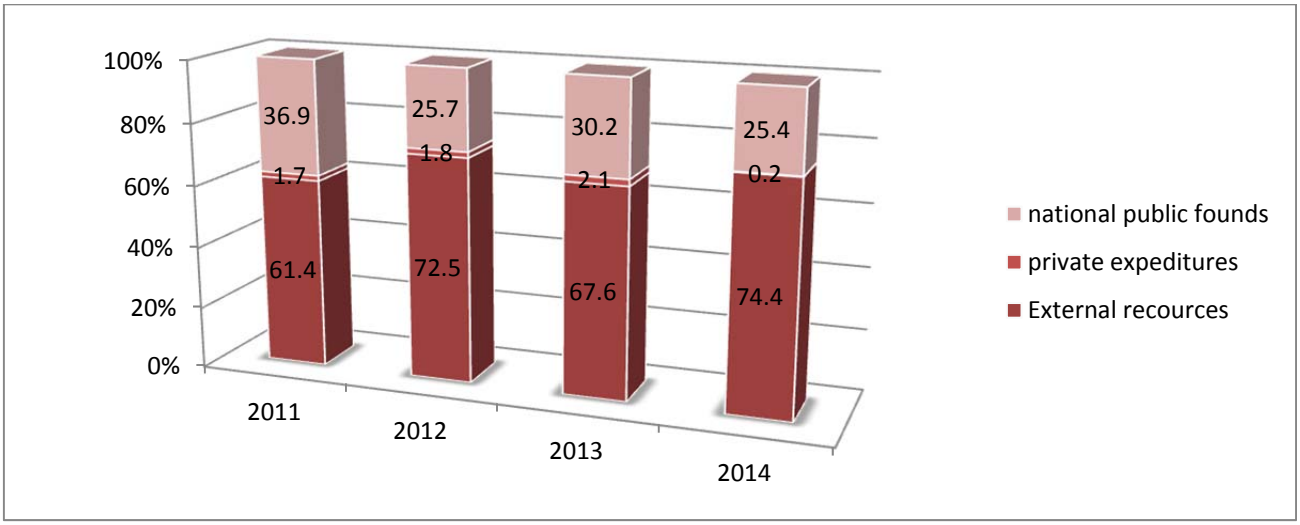


Figure 5 Structure of expenditures for the national HIV response by sources of financing, %, Republic of Moldova, 2011, 2012, 2013, 2014

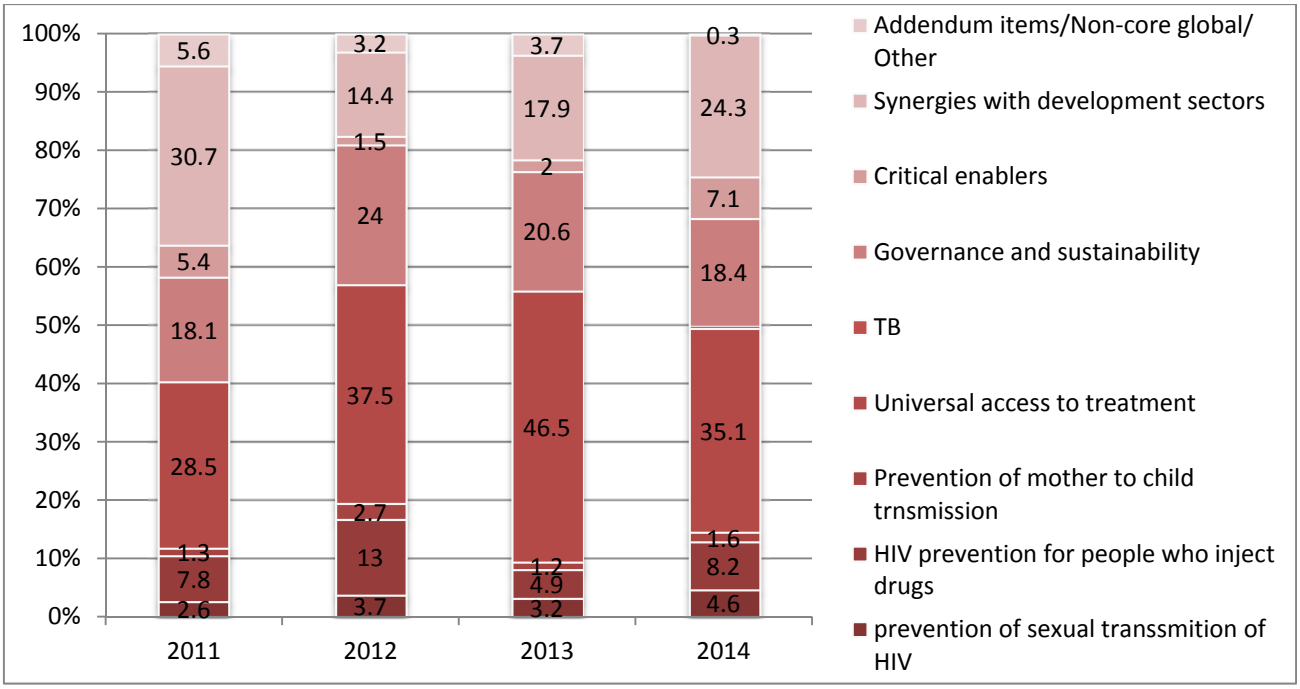


Figure 5 Structure of expenditures for the national HIV response, by spending category, Republic of Moldova, 2011, 2012, 2013and 2014

Classified by spending category of expenditures for the national response to HIV in the framework of the national response to HIV in 2014, 35.1 % went to ***Treatment and Care.*** For the spending category HIV ***Prevention for people who inject drugs*** financial resources of about 8,2%% have been allocated, Prevention of sexual transmission of HIV 4,6% allocated, Prevention of mother to child transmission – 1,6%, ***Governance and sustainability -18,4%***, ***Synergies with development sectors-*** 24,3%, *TB – 0,4%, Others – 0,3%.*

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 an the integral budget and cannot be disaggregated.

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 2014–2015 (National AIDS Programme – NAP), approved by the Government of the Republic of Moldova on October 6, 2014. This is the revised NAP for 2011-2015 approved on December, 16, 2010. The current NAP follows the previous three programs implemented in years 1996-2000, 2001-2005 and 2006-2010.

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 2014, 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 (2007modified in December, 2012), Law on Combating Domestic Violence (2008), Law on Social Assistance (2008), Law on donors and blood transfusions (2009).

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).

During 2014 was approved the review of the National Treatment Clinical Protocol 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.

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 form 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 Trasnistria 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 in13 PI – penitentiary institutions) and one for Transnistran 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 multidisplinary 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 (Transnsitria, 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 2014-2015 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, was opened 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 2014-2015. 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 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 2014, 22 children and 877 adults have been enrolled in treatment.

Table 6. New enrolments into ARV treatment, Republic of Moldova, 2003-2014

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

During 2014 the Government first time procured a part of ARV drugs of 1st line. The remaining 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 2014, in the Republic of Moldova the standard indicator value of coverage with treatment reached for both banks of the Nistru River. For 2013 this indicator represents 16.8% (following the same principle of calculation). Data introduced in the on-line AIDS Reporting tool are for 2014.

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, 2014

	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	**17,8%**	**15,4%**	**20,8%**										
Numerator	3116	1529	1587	98	3	22	50	23	17	134	2694	324	3018
Denominator	17541	9921	7620										
Number of children and adults requiring ARV treatment at the end of the reporting	4233	2095	2055	102					-	-	-	-	4131

period (out of patients on record)													
Persons newly initiating ARV therapy during the last reporting year	**899**	**412**	**487**	**21**	**3**	**10**	**3**	**5**	**4**	**94**	**792**	**86**	**878**

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. 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 2014, the Government started procuring drugs from public/domestic resources for about 400 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 2014, out of the number of women that gave birth during 2014, 99.5% 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 2014, 87 new cases of HIV infection were identified among pregnant women and 113 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, 2013 and 2014

	2013	2014

Numerator	146	152
Denominator	153	170
Indicator value	**95.4%**	**89.4%**

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.

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.

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. Hence, out of 197 HIV positive pregnant women registered during 2014, 193 initiated or continued ARV treatment. The remaining 4 was tested and initiated ARV prophylaxis in January 2015.All pregnant women with HIV will receive ARV treatment.

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 94.98% in 2013 and 96.3% in 2014 (for both banks of the Dniester River) . The prevalence registered in 2013 and 2014 is about 5.9% and 7.3%.

The counselling and testing service for HIV and Hepatitis B and C is also available based on institutions constituting the phtysiopneumology 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, 2013 and 2014

	2013					2014				
	Total	**Males**	**Females**	**< 15**	**15 + years**	**Total**	**Males**	**Females**	**< 15**	**15 + years**
Indicator value	53.2	53.1	53.5			48.3	42.9	59.8	75	47.9
Numerator	165	119	46	2	163	**140**	**85**	**55**	**3**	**137**
Denominator (estimated by WHO is average for 2014)	310	224	86			290	198	92	4	286

There is a decrease 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

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 2014. According to the national surveillance plan, the behavioural surveys in general population are carried out once in 3-5 years.

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

The last data available for this indicator 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 1.13 Percentage of men having sex with men that received an HIV test in the last 12 months and know the result

The last data available for this indicator 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 2.4 Percentage of IDUs that received an HIV test in the last 12 months and know the result

The last data available for this indicator 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 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 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 2015, a number of 9310 IDUs have been covered with NEP services during 2014, constituting coverage of 30.8% 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 order to increase the coverage and make these measures more effective, the project activities for the next years (2015-2017) are 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 will introduce a new approach in boosting access of key affected populations through peer-driven interventions in three main cities of Moldova (Chisinau, Balti and Tiraspol)

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. 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.[2] Currently, both infected and non-infected patients can benefit from services within civilian sector clinics, and penitentiary institutions. The number of 392permanent Injecting Drug Users are receiving Methadone Substitution treatment at the end of 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. It plans to further scale-up OST by geographic extension in additional five locations in the Southern, Central and Northern regions of the country.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 (2014 year), 2952 female CSWs have been covered with HIV prevention services, constituting coverage of 24.6% of the estimated number of 12000 SWs from both banks of the Republic of Moldova, or 29,5% of the number of 10000SWs from the right bank of the Republic of Moldova, because the HIV prevention interventions for SWs are only on the right bank[3] Based on the integrated bio-behavioural survey in 2013, around 55.0% of

[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

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, the future project will introduce a new approach in boosting access of key affected populations through peer-driven interventions (PDI) in two main cities of Moldova (Chisinau and Balti).

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 2014, HIV prevention services cover a number of 1978 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, the future project will introduce a new approach in boosting access of key affected populations through peer-driven interventions in Chisinau city.

INDICATOR 1.7 Percentage of sex workers reached with HIV prevention programmes

The last data available for this indicator 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 1.11 Percentage of men having sex with men that are reached by HIV prevention programmes

The last data available for this indicator 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

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

Results: Throughout 2014, **2039750** 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 **67.5 syringes** per IDU per year.

Indicator value for the right bank of the Dniester River is 97 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.

30.8% of estimated number of IDUs was covered by prophylactic programs during 2014. If it divides the number of syringes by the number of beneficiaries, we obtain 219 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 surveys in general population are carried out once in 3-5 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 surveys in general population are carried out once in 3-5 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

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 2014. According to the national second generation surveillance plan, the behavioural surveys in general population are carried out once in 3-5 years.

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

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 2014. According to the national second generation surveillance plan, the behavioural surveys in general population are carried out once in 3-5 years.

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

The last data available for this indicator 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 1.12 Percentage of men having sex with men that used a condom during the last homosexual anal contact

The last data available for this indicator 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 2.2 Percentage of injecting drug users that reported the use of condom during the last sexual intercourse

The last data available for this indicator 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 2.3 Percentage of injecting drug users that reported the use of sterile equipment the last time they injected

The last data available for this indicator 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

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

The last data available for this indicator 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 1.14 Percentage of men having sex with men that are HIV infected

The last data available for this indicator 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 2.5 Percentage of injecting drug users that are HIV infected

The last data available for this indicator 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 2013, measured at the beginning of 2015.

	Total	**Males**	**Females**	**<15 years**	**15+ years**
Indicator value	**78.9%**	75.7%	82.6%	100%	78.1%
Numerator	449	231	218	21	428
Denominator	569	305	264	21	548
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	4				
Stopped ARV treatment	74				
Died	42				

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 2006-2014

Year	2006	2007	2008	2009	2010	2011	2012	2013	2014
Enrolment in ARV treatment for more than 12 months	80,7%	86,7%	76%	88,3%	87,5%	80,67%	81.89%	81.2%	78.9%

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 2013 and mother to child transmission of HIV at their children.

*Numerator: N*umber of new HIV cases among children born by HIV positive mothers in 2013.

Denominator: Number of HIV positive pregnant women given birth during 2013.

Table 12 Rate of mother-to-child transmission of HIV in the Republic of Moldova for 2013 cohort analysis

	2013
Rate of mother-to-child transmission of HIV	**6.9%**
Number of new HIV cases among children born by HIV positive mothers	11
Number of HIV positive pregnant women given birth during 2012	159

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 2013 is 6.9% (11 HIV infected infants at 159 HIV positive pregnant women) at the end of 2014. For the cohort of 2014, 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 2014 there is 3 children born in 2014 confirmed with HIV out of 171 children 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 2014, 159 infants have been tested for HIV in the first 2 months of life. Out of this number, 146 infants received a negative result for the test, 8received a positive result for the test and 5 tests are indeterminate because the blood was collected but there is no results yet. 170 HIV positive women gave birth during the reporting period.

Indicator value is **93.5%.**

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 –28

Denominator: Number of HIV positive pregnant women that gave birth during the reporting period – 170. There are 171 children born by HIV positive women, it was one twins.

Indicator value – **16.4%**

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 Transdniestrian 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.

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