



UNGASS Report 2006-2007



Republic of Moldova
South-East European Region
National Centre on
Health Management

REPORT ON PROGRESS

January 2006 – December 2007

Republic of Moldova

Declaration of
Commitment
of the United
Nations General
Assembly Special
Session on HIV/AIDS
(UNGASS)

Chisinau 2008

National Report
Republic of Moldova

Monitoring the Declaration of Commitment on
HIV/AIDS

January 2006 – December 2007

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Chisinau 2008

Dear Sir/Madam,

We are pleased to write on this special occasion an introduction to the third UNGASS report that the Government of Moldova has produced. Compared to the previous reporting period the Republic of Moldova has achieved impressive results, and second, because it is for the first time when the report is being produced under full responsibility and coordination of the newly established Monitoring and Evaluation Department for National Health Programmes.

Not only are we proud of many activities implemented during the years to ensure Universal Access to Care, Treatment and Support in HIV/AIDS but also our success is reflected as the national response is shifting to the quality of services not the quantity.

With this report you will find evidence of raised expectations put into figures and a calling to account of the key players in the national response to AIDS. With this reporting there is a rising demand on our government, not only to honor the commitment to the UNGASS Declaration of Commitment countersigned in 2001 but also to ensure that the interventions set out to reach the commitments are successful, constructive and accountable. The UNGASS Declaration of Commitment and the reporting process for it set a framework for an amplified call for collaboration and partnerships across organizations, countries and non-health sectors.

Common objectives such as reaching Universal Access to Prevention, Care and Treatment and UNGASS helped us to realize that HIV is one of the world's challenges which too interconnected and complex for any sector to proceed alone. Common objectives – such as to save people's lives, to ensure social inclusion of People Living with HIV/AIDS and to mitigate the impact AIDS has on household level have finally paved the way for positive collaboration between government, civil society, and hopefully People Living with HIV/AIDS.

We are strong in our intention to support further UNGASS reporting and ensure its quality increases along with the increased quality of strategic planning, coordination and transparency of decision making and with improved monitoring and evaluation.

Mihai Ciocanu,
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Aknowldgements

Our common goal is to present reliable and valid information in order to generate enough scientific evidence that is the necessary prerequisite for the elaboration of effective strategy that aims to protect the nation.

Improvement of data quality is the priority. We would like to express our gratitude to those involved for their insistence, patience and competence expressed during the process of elaborating this report.

We would like to thank the UNAIDS Moldova for their assistance provided during the report elaboration.

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II Status at a glance

Reliable information is one of the most important determinants in the process of development and implementation of efficient and effective strategies. Information represents the reliable base settling a framework which ensures the sound tackling of reality and the development of efficient interventions to prevent the spread of HIV. In the Republic of Moldova still we can't affirm that there is a consolidated M&E System which would satisfy all key information needs but the progress registered by the country recently show clear signs that in the nearest future all relevant data will become available and the decision making process in the national HIV/AIDS response will be an evidence based one.

Alongside with the application of the multisectoral approach to the National AIDS response and scaling up of the activities to other sectors than the health one the data are to be found in numerous governmental and non-governmental entities which implement specific activities in the field of HIV/AIDS. The quality of data varies from organization to organization and from entity to entity and there is a need for assistance and insistence to apply the international standards recommended for the data collection, analysis and interpretation.

By aligning the country processes to the "Three Ones" principle in 2004¹, the Republic of Moldova has launched the implementation of a one single M&E system for the national HIV/AIDS response. This report is the result of an intersectoral collaboration between public organizations, non - profit organizations, international agencies and donors involved in the national HIV/AIDS response. The development of the report has been coordinated and supervised by the Monitoring and Evaluation Unit of the National Programmes (M&E Unit) established in 2004 within the National Centre of Health Management of the Ministry of Health. Representatives of governmental institutions and non-governmental organizations which are part of the national HIV/AIDS response have been involved in the process of collection, analysis and interpretation of data for the current UNGASS reporting. The current UNGASS report has been discussed and reviewed within the annual planning meeting of the Technical Working Groups of the National Coordination Council - Country Coordination Mechanism² and in the NGO Forum in December 2007.

The Republic of Moldova is classified as a concentrated/low prevalence country with an HIV epidemics concentrated in Injecting Drug Users (IDUs) with signs of spread in the general population. According to the results of the HIV prevalence survey conducted in Most at Risk Populations (MARPs) in 2007³, the HIV prevalence in Injecting Drug Users (IDUs) reached 21%, in Female Sex Workers (FSWs) - 11% and in Men having Sex with Men (MSM) - about 4.8%. Comparing with the previous reporting period data (2003 - 2004) there is a slight increase of the HIV prevalence registered in 2007 in Most at Risk Populations (MARPs) (see *the Overview of the AIDS epidemic*). There is a trend of increase of the number of newly HIV reported cases⁴ in Injecting Drug Users (IDUs), mostly due to the increasing number of

¹ April 25, 2004, Washington DC, USA, Conference organized by the UNAIDS and the main donors in HIV/AIDS

² The Country Coordination Mechanism is responsible for the coordination of the National Programme on Prevention and Control of HIV/AIDS/STIs and National Programme on Prevention and Control of TB.

³ "Behavioral and Sentinel Surveillance Survey among MARPs, Moldova 2007", Unpublished report

⁴ According to the cureent regulation the IDUs under the medical supervision of the Narcological Dispensery are recommended to undertake an HIV once in two years

newly HIV cases reported in IDUs on the left bank of Dniester River⁵. Even if in 2007, the number of IDUs that have been reported as new HIV cases (223) was lower than in 2006 (232), it is still premature to affirm that there is a reduction in the new HIV cases reported in IDUs.

The sexual route is the major route of transmission among newly reported HIV cases – 63.2% in 2007. Among those, the rate of women reached 62.2% in 2007. There is also an increase of the number of newly reported HIV cases among blood donations. Thus, in 2007 the number of newly HIV reported cases per 100 000 blood donations reached 59.4 cases compared to 48.9 cases per 100 000 blood donations registered in 2006. In the last 3 years there is an increase of the HIV prevalence in pregnant women (0.23% in 2007 comparing with 0.1% in 2003). In the context of the high economic external migration this phenomenon can become as a determinant in the future evolution of HIV epidemic in the Republic of Moldova.

Based on the existent evidences, the National Programme on Prevention and Control of HIV/AIDS/STIs for 2006-2010 which currently represents the national strategy in the field has developed specific prevention activities targeting Most at Risk Populations (MARPs) such as IDUs, FSWs, MSM covered by harm reduction activities, alongside, activities aimed at prevention of HIV spread in mobile populations such as truck drivers and migrants have also been developed and implemented. During the reporting period specific activities aimed at general population have been developed and implemented based on information delivery, reducing stigma and discrimination and condom promotion, especially among youth. In 2007, based on the Order of the Ministry of Health Nr. 344 of 05.09.2007 a network of VCT centres has been established which could ensure universal access of the general population to counselling and testing to HIV. To ensure quality of the donated blood the Ministry of Health initiated the development of quality standards for blood safety.

At the beginning of 2007 the Parliament of the Republic of Moldova has approved a new Law on Prevention of HIV/AIDS which has been developed based on the international recommendations of observance of human rights and ensuring universal access.

⁵ As a result of the frozen conflict on the Dniester River (1991 - 1992), the territory of the Republic of Moldova is divided in the territory on the right bank and territory on the left bank (Transnistria) of the Dniester River. The territory on the right bank of Dniester River is controlled by the Chisinau authorities, while that on the left bank is controlled by the self proclaimed, unrecognized authorities from Tiraspol - the main city of this region.

Table 1 Indicators overview table, UNGASS reporting 2008, Republic of Moldova

	<i>Indicator</i>	<i>Value</i>	<i>Measurment unit</i>
	National Commitment and Action Indicators		
1.	Domestic and International AIDS Spending by categories and financing sources	1,025,042,353	MDL
2.	National Composite Policy Index		
	National Programme Indicators		
3.	Percentage of donated blood units screened for HIV in a quality assured manner	73.7	%
4.	HIV treatment: Antiretroviral therapy, 2006	48.3	%
	HIV treatment: Antiretroviral therapy, 2007	54.2	%
5.	Prevention fo mother to child transmission, 2006	82.7	%
	Prevention fo mother to child transmission, 2007	84.9	%
6.	Co-management of Tuberculosis and HIV Treatment	9.96	%
7.	HIV testing in general population	8.5	%
8.	HIV testing in MARPs		
	Injecting Drug Users	34.1	%
	Comercial Sex Workers	31.7	%
	Men having Sex with Men	38.3	%
9.	MARPs covered by prevention programmes		
	Injecting Drug Users	88.7	%
	Comercial Sex Workers	96.4	%
	Men having Sex with Men	86.2	%
10.	Support for Children Affected by HIV	N/A	
11.	Life Skills – based education in school (primary schools)	0	%
	Life Skills – based education in school (primary schools)	92.7	%
	Knowledge and Behaviour Indicators		
12.	Orphanage school attendance	N/A	
13.	Young people: Knowledge about HIV	26.3	%
14.	MARPs: Knowledge about HIV		
	Injecting Drug Users	64.4	%
	Comercial Sex Workers	57.7	%
	Men having Sex with Men	46.8	%
15.	Sex before the Age of 15	3.6	%
16.	Higher risk Sex	8.3	%
17.	Condom Use During Higher Risk Sex	49.3	%
18.	Sex Workers: Condom Use	93.3	%
19.	Men Who Have Sex With Men: Condom Use	48.1	%
20.	Injecting Drug Users: Condom Use	67.9	%
21.	Injecting Drug Users: Seif Injecting Practices	95.9	%
22.	Reduction in HIV Prevalence	N/A	
23.	MARPs: Reduction in HIV Prevalence (capital city)		
	Injecting Drug Users	17.5	%
	Comercial Sex Workers	2.9	%
	Men having Sex with Men	4.8	%
24.	HIV treatment: Survival After 12 Months on ARV therapy	86.8	%

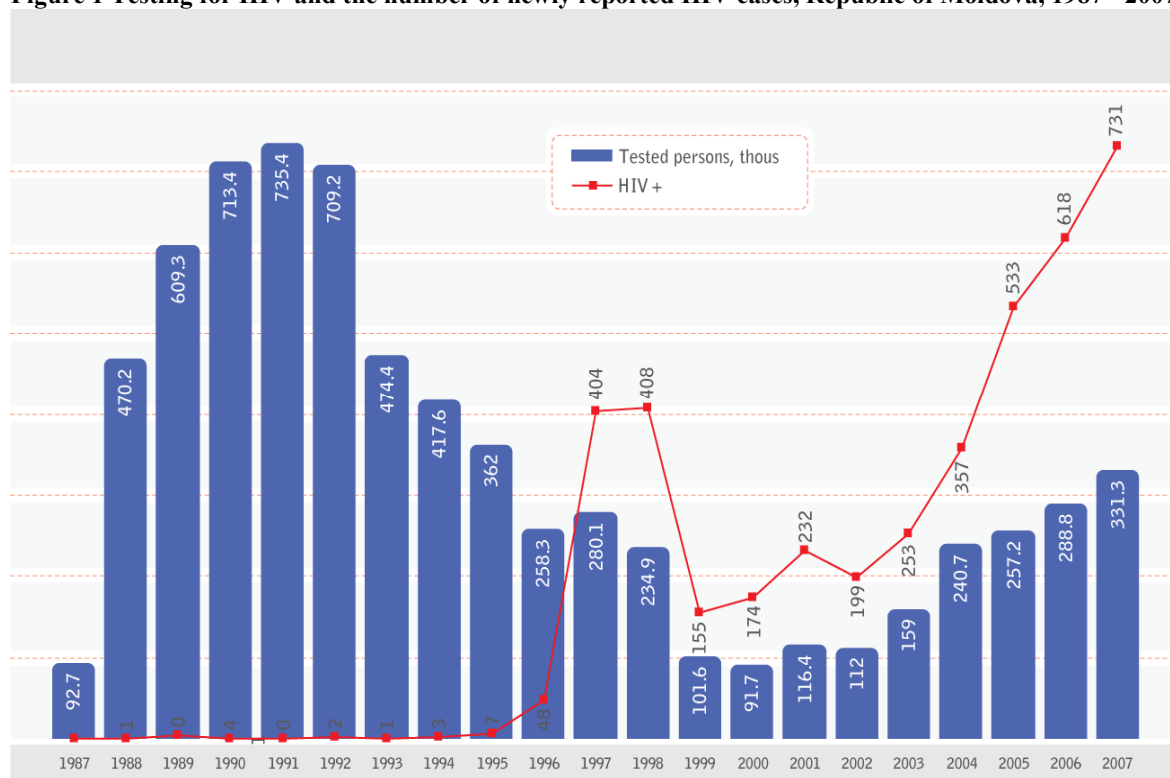
III Overview of the AIDS epidemic

The Republic of Moldova is classified as a concentrated/low prevalence country with an HIV epidemics concentrated in Injecting Drug Users (IDUs). There is evidence of spread of the infection in the general population. At this moment there are no official estimations of the HIV prevalence in the general population available.

General population, routine statistics data

Trend analysis of the HIV epidemic in the general population in the Republic of Moldova based on the annually reported new HIV cases implies limitations depending on the country capacity in HIV testing, the testing regulations applied for Most at Risk Populations (MARPs) which have been subject to changes in time as well as are highly dependent on the political context (where the role of the Transdnestrian conflict plays a major role⁶). According to data from the National Scientific and Practical Centre of Preventive Medicine (NSPCPM) (*unpublished report 2008*) by the end of 2007 cumulatively there have been reported 4131 new HIV cases for both banks of Dniester River, of which about 33% have been registered in 2006-2007. In the last 8 years there is a stable increase in the number of newly reported HIV cases (Figure 1).

Figure 1 Testing for HIV and the number of newly reported HIV cases, Republic of Moldova, 1987 - 2007

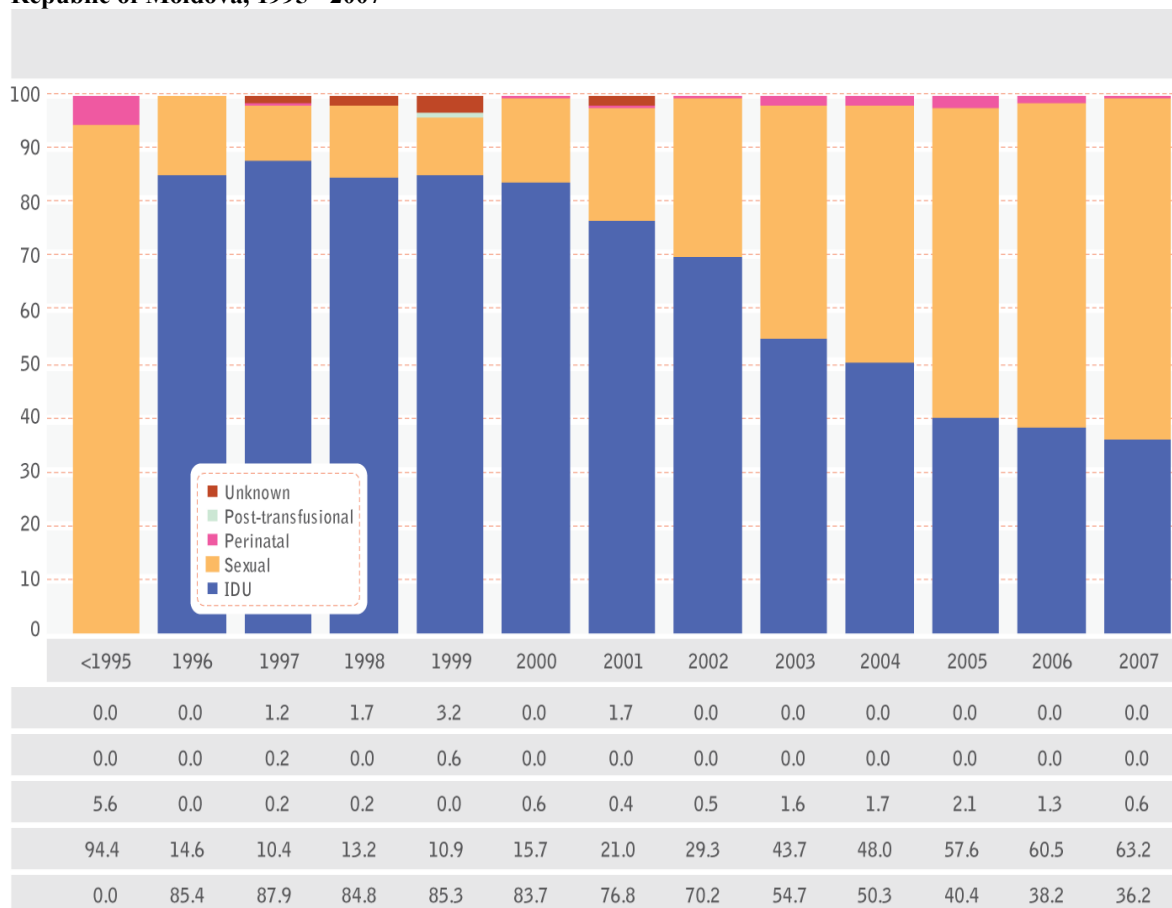


Source: National Scientific and Practical Centre for Preventive Medicine, Ministry of Health

⁶ As a result of the frozen conflict on the Dniester River (1991 - 1992), the territory of the Republic of Moldova is divided into the territory on the right bank and the territory on the left bank (Transnistria) of the Dniester River. The territory on the right bank of the Dniester River is controlled by the Chisinau authorities, while that on the left bank is controlled by the self-proclaimed, unrecognized authorities from Tiraspol - the main city of this region.

Out of 731 newly reported HIV cases in 2007, about 63.2% of cases have had the sexual route of transmission. Since 2005, the sexual route of transmission has got the majority and there is a stable trend on increasing of the rate of this route of transmission among newly reported HIV cases (Figure 2).

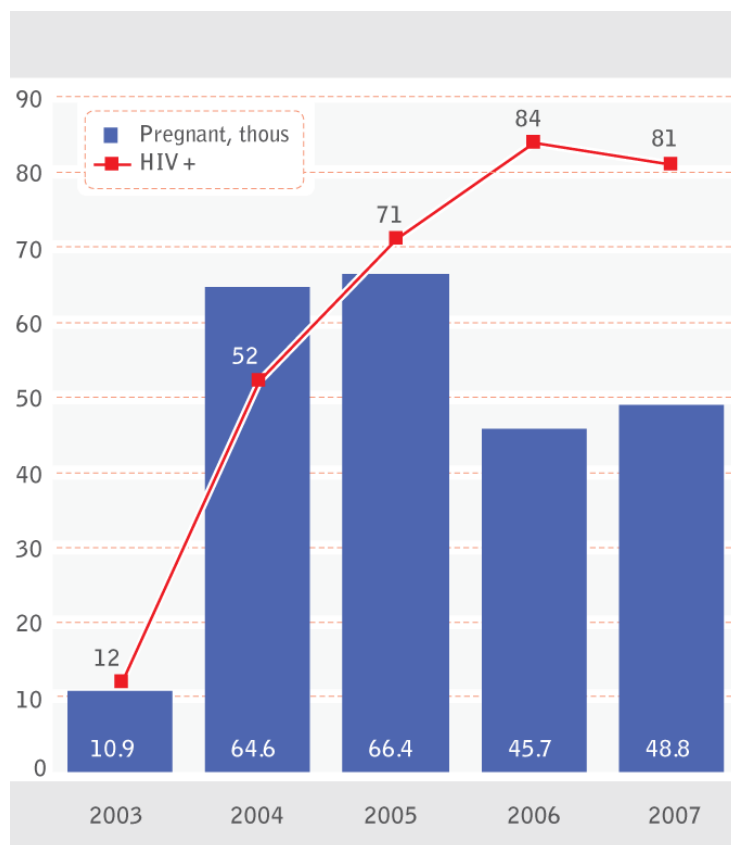
Figure 2 Distribution of newly registered HIV cases in terms of the probable route of transmission, Republic of Moldova, 1995 - 2007



Source: National Scientific and Practical Centre for Preventive Medicine, Ministry of Health

In the context of the high economic migration this phenomenon can become as a determinant in the future evolution of HIV in the Republic of Moldova.

The shift in the structure of newly reported HIV cases according to their route of transmission increases the vulnerability of women. Thus, women are in majority among newly reported HIV cases with sexual route of transmission (2007 – 62.2%, 2006 – 57.2%). The coverage of pregnant women with HIV testing for 2003-2007 varies within 96-99.4% according to data of the National Centre of Health Management (*unpublished report 2008*) which allows the calculation of HIV prevalence among pregnant women based on the routine statistics data. During the reporting period there is an increase in the number of newly reported HIV cases among pregnant women (Figure 3).



Comparing with the previous reporting period, the HIV prevalence among pregnant women reached higher values (2005 – 0.1%). Thus, according to the data of the National Centre of Health Management (*unpublished report 2008*) in 2007, the HIV prevalence among pregnant women reached 0.23%⁷ that is approximately the same as in 2006 (0.21%). Simultaneously with the increase in the number of newly reported HIV cases among pregnant women, there is an increase in the number of HIV positive women who decide to give birth (13 positive women in 2006 and 31 HIV positive women in 2007). In the due time, the new reported HIV cases among blood donations⁸ registers also a slight increase. Thus, in 2007 the number of newly reported HIV cases per

Figure 3 HIV testing and number of newly registered HIV cases among pregnant women, Republic of Moldova, 2003 – 2007

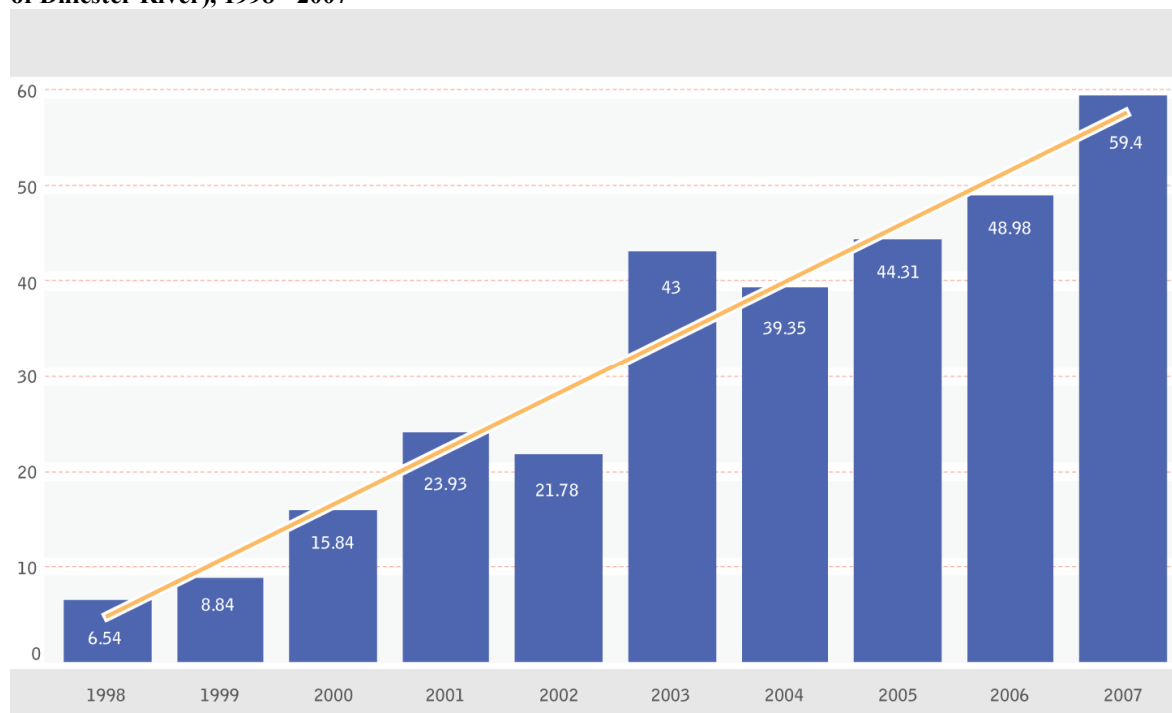
Source: National Scientific and Practical Centre for Preventive Medicine, Ministry of Health

100 000 blood donations reached 59.4 compared to 48.9 cases per 100 000 blood donations registered in 2006 (Figure 4) (*NSPCPM, unpublished report 2008*).

⁷ Number of HIV positive pregnant women reported to the number of officially registered pregnant women. In 2007, 99.2% of birth took place in medical institutions.

⁸ The pre-test screening of potential donors is performed (checkind of the HIV cases data base, behavioural screening).

Figure 4 Number of newly registered HIV cases per 100 000 donations, Republic of Moldova (right bank of Dniester River), 1998 - 2007



Source: National Scientific and Practical Centre for Preventive Medicine, Ministry of Health

The epidemiological situation on the left bank of the Dniester River is alarming. Historically, the number of registered Injecting Drug Users per 100 000 inhabitants, was higher on the left bank of the Dniester River comparing with the one registered on the territory of the right bank of the Dniester River. In the context of the frozen political conflict on the Dniester River, the implementation of HIV prevention and control interventions both in Most at Risk Populations (MARPs) and in the general population started later than on the right bank. In 2007 the HIV prevalence in pregnant women from the left bank of the Dniester River (0.42%) is three times higher than the one from the right bank of Dniester River (0.13%) (*NCHM, unpublished report 2008*). According to data from the National Scientific and Practical Centre of Preventive Medicine (NSPCPM) (*unpublished report 2008*), in 2007, the number of newly reported HIV cases per 100 000 blood donations from the left bank of the Dniester River is almost double (100.3 newly reported HIV cases per 100 000 blood donations) in comparison with the right bank of the Dniester River (55.9 HIV new reported cases per 100 000 blood donations).

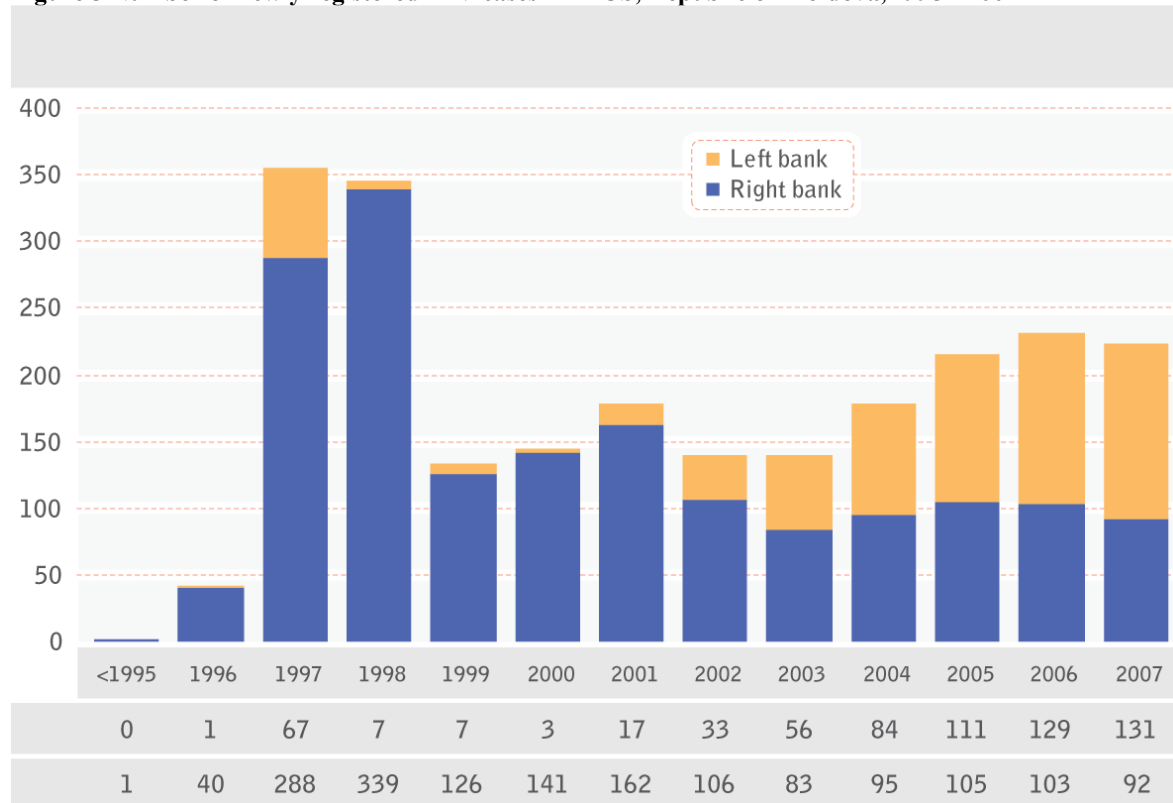
The high level of external migration which is specific for the left bank of the Dniester River as well creates favourable conditions for the rapid spread of HIV infection in the general population.

Most at risk populations, routine statistics data

There is a trend of increase of the number of newly HIV reported cases in Injecting Drug Users (IDUs), mostly due to the increasing number of newly HIV cases in IDUs reported on the left bank of Dniester River⁹ (Figure 5) (*NSPCPM, unpublished report 2008*).

⁹ Confirmation of HIV status in Western Blott is performed only in Chisinau, capital of the Republic of Moldova

Figure 5 Number of newly registered HIV cases in IDUS, Republic of Moldova, 1995 - 2007



Source: National Scientific and Practical Centre for Preventive Medicine, Ministry of Health

Even if in 2007, the number of IDUs that have been reported as new HIV cases (223) was lower than in 2006 (232), it is still premature to affirm that there is a reduction in the new HIV cases reported in IDUs.

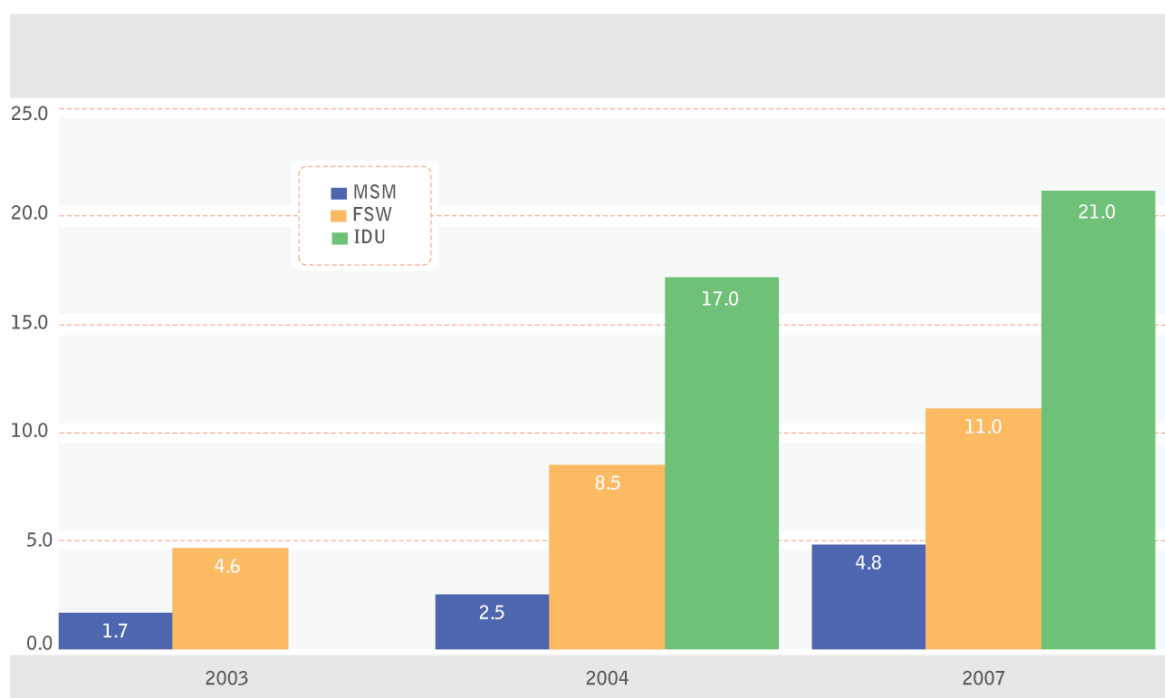
HIV prevalence in Most at Risk Populations (MARPs)

According to the results of the HIV prevalence survey conducted in Most at Risk Populations (MARPs) in 2007¹⁰, the HIV prevalence in Injecting Drug Users (IDUs) reached 21%, in Female Sex Workers (FSWs) - 11% and in Men having Sex with Men (MSM) - about 4.8% (Figure 6).

This research has been conducted among beneficiaries of Harm Reduction Programmes. Taking into account the applied research methods, the results are considered representative for the IDUs which are beneficiaries of the Harm Reduction Programmes (see Annex 4).

¹⁰ "Behavioral and Sentinel Surveillance Survey among MARPs, Moldova 2007", Unpublished report

Figure 6 HIV prevalence among MARPs, Republic of Moldova, 2003 - 2007



The distribution of HIV prevalence in Injecting Drug Users by the geographic location registers a disparity between sentinel sites (Table 2). Municipality of Balti is one of the regions with a higher number of registered Injecting Drug Users comparing with other regions from the right bank of Dniester River. The registered HIV prevalence in IDUs from municipality of Balti, who are beneficiaries of Harm Reduction Programmes, is the highest in the country in 2007 prevalence study as well as in 2004 HIV prevalence study (33%) (*Bivol 2004*).

Table 2 HIV prevalence among Injecting Drug Users, beneficiaries of Harm Reduction Programmes, %, Republic of Moldova, 2007

	Sentinel site	Sample size	HIV Prevalence
1.	Balti	149	44.8%
2.	Causeni	11	27.3%
3.	Donduseni	10	10%
4.	Edinet	20	15%
5.	Falesti	28	10.7%
6.	Chisinau ¹¹	187	17.5%
7.	Rezina	30	16.7%
8.	Soroca	41	0%
9.	Orhei	21	0%
10.	Tiraspol ¹²	70	20.6%
11.	Ungheni	63	6.3%
	Total Republic of Moldova	630	21.0%

Source: “Behaviour and Sentinel Surveillance Survey among MARPs, Moldova 2007”, 2007

¹¹ The capital city of the Republic of Moldova

¹² The left bank of the Dniester River

Table 3 HIV Prevalence among Commercial Sex Workers, beneficiaries of Harm Reduction Programmes, the Republic of Moldova, 2007

	Sentinel Locations	Sample	HIV Prevalence
1.	Balti	122	32.8%
2.	Edinet	34	2.9%
3.	Chisinau ¹³	243	2.9%
4.	Ungheni	20	25%
5.	Orhei	69	0%
Total Republic of Moldova		488	11%

Source: “Behaviour and Sentinel Surveillance Survey among MARPs, Moldova 2007”, 2007

Among FSWs the rate of injecting drug use in the last 12 months reached 15.6% according to the results of the Behaviour and Sentinel Surveillance Survey 2007 (*unpublished report*). This rate is higher in Balti (22%) and Ungheni (20%), a fact which explains the high values of HIV prevalence in these sentinel sites among FSWs (Table 3).

The HIV prevalence in MARPs within the period of 2003-2007 is presented in Figure 6.

An increase of HIV prevalence has been registered in 2007 prevalence study comparing with 2004 HIV prevalence study among IDUs, FSWs and MSM. The significance of this increase among FSWs is limited by the incomparability between these two studies because in 2004 the HIV prevalence studies among FSWs and MSM were conducted in the capital of the country – Chisinau, only. In 2007, the study targeting FSWs was extended to four additional locations, a fact that reduces the comparability in time of the national results. While comparing the results for 2003, 2004 (Figure 6) and 2007 (Table 3) from the capital city of the country only, there is a decreasing trend in the HIV prevalence among FSWs and an increase among MSM. All HIV prevalence surveys among MSM were conducted in the capital city only.

¹³ The capital city of the Republic of Moldova

IV National response to the AIDS epidemic

National Commitment and Action Indicators

Indicator nr 1 AIDS Spending

At the moment of reporting the methodology and the tools proposed for monitoring the financial flows spent on HIV/AIDS as recommended by *National AIDS Spending Assessments (NASA)*, *Aids sub-account of the National Health Accounts (NHA)* and the *Resource Flows (RF) Survey* are not applicable for the Republic of Moldova due to the lack of applicability of any recommended tools and due to the inexistence of the National Health Accounts in Moldova.

In order to ensure a proper reporting of the Indicator on AIDS Spending for 2006 and 2007 the data have been collected from a various range of sources in accordance with the recommendations of the *AIDS Spending Categories by Financing Sources*¹⁴. In accordance with the recommendations for the study there have been selected organizations of the national and local level which have implemented or disbursed funds directly linked to prevention and treatment of HIV/AIDS, as well as financed activities on coordination, monitoring and evaluation in the filed of HIV/AIDS. The organizations from the list have been asked to provide information on the source of financial allocations spent on HIV/AIDS and the destination of disbursement in accordance with the NASA matrix.

As such, for the purpose of the study and for the calculation of the AIDS spending for 2006 and 2007 the data on annual expenditures with a specific destination for HIV/AIDS prevention and treatment of the following institutions from the health system have been taken into account:

- National Scientific and Practical Centre for Preventive Medicine which is the highly hierarchic structure for the National AIDS centre and regional HIV/AIDS testing laboratories
- National Centre for Blood Transfusion which ensures the blood safety by testing the collected blood samples to HIV/AIDS
- National Dermatovenereal Dispensary for the Infectious Diseases Section that provides ARV treatment to patients with HIV and AIDS
- National Narcological Dispensary for the activities on Harm Reduction for IDUs, including the methadone substitution programme
- National Institute of Research in the filed of health of mothers and children for PMTCT
- State budget allocation for the "Public Health Services" programmes for prevention of HIV/AIDS and STIs and for implementation of the National programme on Prevention and Control of HIV/AIDS/STIs 2006-2010
- National Centre for Health Management for the activities of the Monitoring and Evaluation Unit for the National Programmes, HIV/AIDS department
- National Coordination Council for the implementation of coordination activity for the National Programme on Prevention and Control of HIV/AIDS/STIs.

Additionally information on the financial flows has been submitted by the international bilateral and multilateral organizations which implement activities on the territory of the Republic of Moldova.

¹⁴ The flows have been calculated based on the recommendations of the regional workshop „National AIDS Spending Assessments - NASA” organized by UNAIDS in December 2007 in Bucharest, Romania for the countries of Eastern Europe and Central Asia

- USAID – provides financial assistance for the implementation of the project “Prevention of HIV/AIDS and viral hepatitis B and C in the Republic of Moldova” for the implementation of services for voluntary counselling and testing in HIV/AIDS and for communication programmes aimed at behaviour change and enhancing blood transfusion safety,
- UNICEF – for the “Most at Risk Adolescent” project aimed at prevention of HIV among adolescents, especially for the MARPs, as well as PMTCT activities,
- UNAIDS – technical assistance for capacity building of the Three One’s and capacity building of the National League of PLWHA,
- UNFPA – technical assistance for the implementation of Information Education Communication activities aimed at behaviour change for HIV prevention,
- PCU – “TB/AIDS” Programme financed by IDA/World Bank and Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), implemented by the Ministry of Health to ensure reaching the objectives of the Millennium Development Goals and ensuring universal access to prevention, care and treatment as specified in the National Programme on Prevention and Control of HIV/AIDS/STIs 2006-2010.
- AIDS Foundation East – West (AFEW) – for the implementation of the projects financed under Sweden International Development Agency, Sweden grant aimed at implementation of communication campaigns in HIV prevention,
- World Health Organisation – technical assistance in the field of AIDS control and development of Antiretroviral (ARV) treatment protocols,
- United Nations Development Programme – for the project “Prevention of HIV/AIDS/STIs in the armed forces in Moldova”,
- Caritas Luxembourg – for activities aimed at prevention of HIV/AIDS/STIs mainly in the penitentiary sector,
- Red Cross Moldova – for the implementation of activities in youth and Harm Reduction activities among IDUs,
- Soros Foundation Moldova – for policy development and implementation of activities aimed at building the capacity of the NGO sector.

Based on the received questionnaires an analysis of the data has been undertaken in order to reduce overlapping. The public health institutions reported on the data for each year separately (2006-2007), and budget lines specifying the source of financing (national or international). The international bilateral and multilateral organizations which are represented on the territory of the Republic of Moldova have been classified for sources of financing but as financial agents as well.

In order to exclude possible overlapping of resources the expenditures for each year separately have been cumulated in accordance with the disaggregation by cost categories. The evolution in time the HIV/AIDS spending in the Republic of Moldova for 2006 and 2007 is represented in Matrix I and Matrix II and has been expressed in USD at the exchange rate of the National Bank of Moldova¹⁵ which represents 13.1 MDL for \$ 1 USD in 2006 and 12.5 MDL for \$1 USD in 2007.

Thus, for 2006 the disbursements for HIV/AIDS reached 80.9 mln MDL or \$ 6,145, 038 USD at the rate of exchange of which the financial resources from the state budget constituted 27.1 mln MDL or \$ 2, 045, 801 USD (33.5%). The international resources for the same period reached the value of 53.7 mln MDL or \$ 4, 106, 870 USD (66.5%).

The public sources are concentrated at the national level since the funds are part of the public consolidated budget of the health care system which is financed from two sources:

- state budget core resources and state budget resources with special destination and

¹⁵ www.bnm.md

- resources of the National Health Insurance Fund.

Out of the total budget 9.5% come to HIV/AIDS from bilateral agencies and 90.5% - from multilateral agencies. The highest rate coming from multilateral and international resources belong to the World Bank Grant with 48.4%, the second biggest donor is the Global Fund to fight AIDS, Tuberculosis and Malaria with 29.3% followed by United Nations Agencies with a rate of 7.4% and 5.4% are shared by other international agencies.

The analysis of the cost categories for the year 2006 showed that 76.5% out of the total budgets spend on AIDS was registered in *Prevention*. For *Treatment and Prevention* budget category there were spend 14.3%, for *Programme Management and Administration Strengthening* category there were spent 8.2% and for the *Incentives for Human Resources* only 1%.

The comparative analyses for 2007 shows a clear increase in budgets spend on HIV/AIDS by 21.6 mln MDL (\$ 1,720,000 USD) on all budget categories compared to 2006, this is specifically important taking into consideration the difference of the exchange rate for 2007 (decrease of the purchase power of local currency). The increase in budgets spent is mostly due to increased budgets coming from international resources as the state budget allocation did not show a significant increase (27.5 mln MDL in 2007 compared to 27.1 MDL in 2006). For 2007 the total budgets spend on AIDS reached 102.5 mln MDL (\$8,160,000 USD) of which the public resources coming from the state budget scored for 26.8% and the international resources scored for 73.2%.

The analysis of the international resources shows that 26.0% in the total spending belong to bilateral donors and 74% to multilateral agencies. In 2007 the highest rate coming from multilateral and international resources belong to the World Bank Grant with 28.6%, the second biggest donor is still the GFTAM grant with 23.4% followed by UN Agencies with a share of 15% and 7% are shared by other international agencies.

The analyses of the cost categories for the year 2007 showed that 76.7% out of the total budgets spend on AIDS were registered in *Prevention*. For *Treatment and Prevention* budget category there were spend 8.3%, for *Programme Management and Administration Strengthening* category there were spent 14.1% and for the *Incentives for Human Resources* still 1%.

In 2007 for the first time there were registered some progress on budgets spend on AIDS coming from the private sector. The Mobile Phone Provider *ORANGE* has organized a national campaign on fundraising for HIV/AIDS which resulted in an amount of \$14,000 USD that have been allocated for the procurement of medical equipment for the ARV Treatment department.

For the reporting period of 2006-2007 the methodology of completing the NASA Matrix has been used to report on Indicator 1 *AIDS Spending*. Nevertheless, the limitations for this indicator are the same as for the previous periods:

- Though a significant progress has been registered with collecting of data from the greatest majority of organizations and institutions that are running prevention activities in HIV/AIDS, including coordination, monitoring and evaluation still the general understanding is that there are organizations and institutions spending budgets on HIV/AIDS that do not report their budgets into the matrix since their activities are not reported for activities directly targeting general population or PLWHA,
- In the case of state institutions subject to review for the calculation of Indicator 1 the calculation of all costs of the subdivisions, specifically the maintenance costs could not have been reported as the maintenance costs form an the integral budget of the institutions and separation of costs was not possible,

- Not all international and organizations and institutions have reported disaggregated data. Difficulties were identified when reporting on specific activities due to the lack of the *National Health Accounts*, which imposed some limitations for the classification of all budget categories.

In conclusion, the data collected for the Indicator 1 for the Republic of Moldova would allow for comparative analyses of trends in time for the costs in HIV/AIDS based on budget categories covered financially. Still, in 2007 the data are much more comprehensive than the data presented for the last reporting period.

One major progress reported by the subjects to interview when applying the proposed NASA methodology is that implementing of NASA would improve planning capacities and would increase efficiency of spending resources for the activities in HIV/AIDS.

Indicator nr 2 Government HIV and AIDS Policies

According to the Appendix 2

Legal and policy frameworks related to HIV/AIDS in Moldova are generally strong. The overall strategy of the Ministry of Health is based on the National Health Policy (NHP), which was approved by the Parliament in 2007 (*Monitorul Oficial*). The National Health Policy assumes that health and well being of a person are the most important life values and represent the essential condition to ensure the economic and social progress, though public health is of concern, as well as accepted as a permanent priority for state policy. It was clearly understood that the synergic impact on health of the population may be obtained only after organic, complex investments both in health and non-health sectors, such as infrastructure, ecology/environment protection and development, social aspects, education, sports, economy etc. The policy regards a period of 15 years starting with 2007. The main goal of the document consists in creating optimal conditions to achieve maximum health person potential during his life and covering adequate quality standards of population life. NHP is in concordance with the international recommendations as well as national policies, strategies such as:

- National Development plan „Country modernization – population welfare;
- The strategy of economic growth and poverty reduction;
- Action plan Moldova – European Union;
- National plan “Promotion of human gender equality”;
- National strategy “Education for all”;
- National Programme of healthy life style promotion;
- National strategy of health reproduction;
- National concept of young health services;
- National HIV/ADS/STI prophylaxis and control Programme;

NHP developed wide objectives, one of them specifically targeting the control of infectious diseases, which clearly focuses on strictly preventing the transmission of HIV/AIDS/STI infections, enhancing Government commitment related to the disease prevention and ensuring access to medical, social, psychological and juridical services for HIV infected persons. In order to inform population about HIV/AIDS/STI prevention, capacities will be built and the information activities targeted to general population, youth and vulnerable groups will be scaled up. It can be achieved, as the National Communication strategic framework was developed and approved by main stakeholders. Life skills curriculum and continuum training of pedagogic staff will be scaled up to all levels of education. The document ambitiously plans to involve local public authorities and civil sector in the activities related to social rehabilitation and reintegration of the MARPs; injecting drug users will have access to rehabilitation programmes and substitution therapy; the PLWHA will have access to ARV treatment and home based care. Priority will be also the mother to child transmission

and inoffensively of transfusions. This objective is clearly interlinked with all other NHP objectives, specifically with the ones related to healthy life style promotion (focused on general population and specific target groups on creating life skills and transmission prevention activities) and health of young generation (achieved through complex interventions, including by ensuring access to Family planning and reproductive health services to all young people, besides their social status, education, religion, gender etc..)

The exercise undertaken by stakeholders in 2006 in HIV/AIDS within the framework of “Scaling up the Universal Access to Care, Treatment and Prevention” showed high capacity in Moldova for problem identifying and strategic planning. A year before, in 2005, the National Programme on Prevention and Control of HIV/AIDS/STI 2006-2010 was developed and approved by the Government. During scaling up process the national AIDS Programme was reviewed and clear interventions for problems related to programme implementation were identified. The National Programme on Prevention and Control of HIV/AIDS/STI 2006-2010 is the third national program for HIV/AIDS following the first two (NAP 1996-2000, and NAP 2001-2005). Following the final review and of the National Programme on Prevention and Control of HIV/AIDS/STI 2001-2005, the Technical Working Groups under CCM on TB/AIDS were charged with the responsibility of developing the draft of the National Programme on Prevention and Control of HIV/AIDS/STI 2006-2010. The NAP consists of nine key strategic priorities agreed upon by joint government – non-government technical working groups and approved by a decision of the government of the Republic of Moldova:

1. Streamline Coordination and Build Capacity of the Country Coordination Mechanism (CCM) for HIV/AIDS Control;
2. Primary prevention of HIV/AIDS;
3. Vulnerable groups at high risk for getting HIV/AIDS and harm reduction activities;
4. Voluntary and Confidential Counseling and Testing (VCT);
5. HIV/AIDS Treatment and Care;
6. HIV/AIDS-TB co-infection control;
7. Education and communication;
8. HIV/AIDS Monitoring and Evaluation;
9. Prevention of mother-to-child transmission (PMTCT).

The National Programme on Prevention and Control of HIV/AIDS/STI 2006-2010 highlights steps and activities to be undertaken in a period of five years to respond in a more effective and targeted manner to the epidemic. A set of indicators has been developed and agreed by all stakeholders to support monitoring and evaluation, and the technical groups have developed a log-frame to support the implementation of the National Programme on Prevention and Control of HIV/AIDS/STI 2006-2010. Procedures for stakeholder engagement have also been identified.

With support from the United Nations Team Group (UNTG) on HIV/AIDS and in keeping with the “Three Ones”, a single national coordination entity was created in August 2005. Support was provided for the development of its comprehensive Terms of Reference, which also include the operational structure of the Country Coordination Mechanism, and extension of its membership to include PLWHA and NGOs as well as international community and government stakeholders. While the CCM is a decision-making body, there are a number of standing working groups within it (Working Group on Treatment and Care, Working Group on Monitoring and Evaluation, Working Group on Surveillance and Sentinel Surveillance, Working Group on Vulnerable Groups, Working Group on Communication and Education) meeting on a regular basis to bring up outstanding issues relevant for HIV/AIDS control, as well as on an as-needed basis to work out urgent matters.

The last component of the ‘Three Ones’ is a single M&E framework for HIV/AIDS. The Government has endorsed a comprehensive national Monitoring and Evaluation system (M&E) and recognized its advantages and importance and created in 2004 a monitoring and

evaluation department, within the Ministry of Health subordinate structure which at that moment has lacked the financial resources to support its work .

The Government established a multi-stakeholder technical working group (TWG) within the framework of the CCM. The National Center for Health Management was tasked with leading the national M&E system. The first outputs of the M&E Unit was the development of UNGASS report with all the proper consultations and data collection for the period of 2003-2005, as well as 2005-2007. The main important achievement for the period is the unified methodology on M&E, realized in a consultative and participative way.

13 ELISA screening centers were opened with wide geographic reach all over the country, and one Western Blot confirmation center in the capital city of Chisinau. Rapid tests for HIV have been suggested for maternity wards and for surveillance purposes. National protocols for blood and saliva rapid testing for HIV/AIDS are being developed now with WHO support.

Harm reduction programmes for IDUs were legalized in 2001 including opiate substitution treatment (OST) and needle exchange for IDUs both inside and outside of prison.

HAART and preventative ART became available in the country in October 2003 as a result of GFATM/WB support. Teams of physicians, nurses and social workers were trained at the WHO-accredited knowledge hub in Kiev on ART treatment. National Protocols based on WHO recommendations have been developed and approved.

There a number of ongoing public HIV/AIDS awareness campaigns in the country based on the frameworks of the National Communication Strategy in HIV/AIDS, one based on safer sex behavior for the youth aged 15-24 in 2006 and another one for solidarity with people living with HIV/AIDS (anti-stigma and discrimination messages). As a prevention intervention, Life-Skills Based Education (LSBE) is highly promoted in all national strategic documents: National Health Policy, National Programme on Prevention and Control of HIV/AIDS/STI for 2006-2010, National strategy "Education for all", National Strategy on healthy life style. With the support of GFATM/World Bank Project the "Life skills" curriculum was developed, textbooks and guidelines for pedagogic staff were developed, trainings for teachers organized. Still, after the pilot period, when extending it nationally in a mandatory way, the religious sector opposed to it. Actually, the curriculum is an optional one. Ministry of Education appreciates the efforts in the country on involving the religious community in HIV/AIDS control activities. Several trainings for them contributed to a more tolerant and constructive attitude.

Civil society participation in the fight against HIV/AIDS has been institutionalized through the establishment of several coordination mechanisms such as the Harm Reduction Network, a network of NGOs working in the field of HIV/AIDS, a network of PLWHA organizations. The government has expressed its interest in support for mainly advocacy for meaningful involvement of NGOs and international organizations in scaling up the national response to HIV/AIDS. Special attention is paid to the maintenance of a PLWHA network and to the support and development of partnerships between NGOs working in the area of HIV/AIDS through information dissemination and capacity building. An NGO Capacity Building Forum was organized for the organizations working in the area of HIV/AIDS, with 20 NGOs being trained in program management, including planning, budgeting and M&E; legislative framework; resource mobilization; and possible mechanisms for government allocations / contributions to the work of NGOs were brought up. Following that, the development of a draft proposal to facilitate government support to the NGO sector (from allocations to the state budget from individual tax contributions) was initiated. The nongovernmental sector was actively involved in the elaboration of the national strategic documents related to HIV/AIDS control and prophylaxis, prevention. Several national wide range consultancy processes were organized to elaborate the National Programme on Prevention and Control of HIV/AIDS/STI 2006-2010. The representatives of networks NGOs were participating. In April 2005, during the 1st Workshop on monitoring the 1st National NGO Forum decisions,

NGOs representatives presented the final comments to the National Programme on Prevention and Control of HIV/AIDS/STI 2006-2010. The Workshop on monitoring the implementation of the 2nd NGOs Forum held in December 2006 made possible to involve NGO sector in the elaboration of the new HIV/AIDS Law. The network of NGOs being active in Harm Reduction held several meetings during 2006 year to participate at the elaboration of standards on providing Harm Reduction services. In 2007 the League of People living or affected by HIV/AIDS held several meetings to constitute it self and to elaborate the strategic plan. They've also been involved in the process of elaboration of the national protocols on HIV/AIDS treatment and care.

Discussions with representatives of trade unions on the HIV/AIDS workplace strategies were held. The National Programme on Prevention and Control of HIV/AIDS/STI 2006-2010 includes activities aimed at the implementation of workplace policies in the largest Moldovan companies. Stipulations on workplace policies were included in the newly approved Law on HIV/AIDS.

Transnistria Assessments

A series of joint visits by representatives of all United Nations Agencies helped explore possibilities for cooperation and scaling-up of HIV/AIDS-related activities in the Transnistrian part of the country. Representatives of Transnistrian health authorities were involved in a number of joint trainings and workshops aimed at development of the draft National Action Plan, matrix of indicators for monitoring and evaluation etc., and in the drafting of the current National Programme on Prevention and Control of HIV/AIDS/STI 2006-2010. Scaling up of prevention, treatment and care plans have been developed in support of health authorities in Transnistria.

United Nations Development and Assistance Framework

Additionally, the United Nations agencies working in the area of HIV/AIDS (UNAIDS, UNFPA, WHO, IOM, UNICEF, UNHCR, UNDP etc.) have recently developed the United Nations Development Assistance Framework (UNDAF) to help the government cope with the increasing burden of HIV/AIDS/STI and associated problems. The UNDAF for 2007-2011 has three major areas of cooperation with a number of objectives and outputs:

- Governance and Participation;
- Access to Quality Services;
- Regional and Local Development.

The second component is focusing heavily on vulnerable groups enjoying increased equitable and guaranteed access to basic services of good quality provided by the government with the support of civil society (including contraception, VCCT for HIV/AIDS, youth-friendly health services), people of reproductive age adopting safe behaviors and seeking health commodities and information on HIV/AIDS/STIs and Reproductive Health; all people, especially belonging to vulnerable groups, enjoying improved access to essential health care of good quality (including PMTCT and HAART).

Following the conclusion of the '3-by-5' initiative, the country and the entire region alike, should be moving towards universal access to HIV/AIDS treatment and care, while continuing to strengthen prevention activities (both primary and secondary prevention). In this vein, the country adopted the WHO protocols for HAART and care, guidelines for PMTCT, has developed a 2nd generation surveillance plan, implementation of Harm Reduction projects etc.

Millennium Development Goals

The Government's strategy for combating poverty, Economic Growth and Poverty Reduction Strategy Paper for 2004-2006, lays out Moldova's commitment to the United Nations Millennium Development Goals (MDGs) and addresses health care and HIV/AIDS. The strategy calls for increased access to good quality medical services for the poor in support of sustainable development and poverty reduction. This is to be achieved by developing

primary health care (PHC) services, improving the skills of practitioners, and preventing and treating "socially determined diseases" which include HIV/AIDS and TB. These policies are also related to health reform efforts under way, which are reorienting health care towards more accessible PHC services and increasing resources through mandatory health insurance.

Universal Access Initiative

This proposal, and the National Programme on Prevention and Control of HIV/AIDS/STI 2006-2010 on which it is based, was developed with attention to multiple elements supported by WHO/UNAIDS Universal Access to Prevention, Treatment, and Care. Moldova became part of the Universal Access Initiative by approving the Action Plans under the National Programme on Prevention and Control of HIV/AIDS/STI 2006-2010 in line with its recommendations.

Human Trafficking and migrants

Moldova is also working with international development partners to evaluate where HIV/AIDS can be integrated as a logical component into ongoing programs on trafficking and migrants, among others. In the Republic of Moldova, economic hardship and vulnerability have often made women vulnerable to trafficking: NGOs working in trafficking are being encouraged to add HIV/AIDS to their educational and public awareness messages. The IOM representative in Moldova has indicated that IOM will add a tag line regarding HIV/AIDS prevention to future OIM anti-trafficking campaign materials.

More generally, HIV/AIDS efforts also dovetail with efforts to improve access to preventive, therapeutic, support and informational services for migrants, started jointly with UN, IOM and the SFM in the Republic of Moldova.

National Programme Indicators

Indicator nr 3 Percentage of donated blood units screened for HIV in a quality assured manner

Organization of the blood safety system

The Republic of Moldova national blood program is under the authority of the Ministry of Health (MoH). As outlined in the *National Program for Development of Blood Service for 2002-2006*, approved Resolution of the Government of the Republic of Moldova No.1050 on Oct. 04, 2001, the national blood program has a hierarchical structure with four levels:

- Level I: National Blood Transfusion Center (NBTC), located in Chisinau
- Level II: Regional blood transfusion centers (RBTC), located in Balti and Cahul
- Level III: Sections or hospital blood transfusion departments, located in large public hospitals
- Level IV: Offices or hospital blood banks, located in small hospitals.

The National Center for Blood Transfusion (NBTC) is located in Chisinau, the capital city. The NBTC is responsible for the organization and coordination of the overall blood program in Moldova and supervises the other three levels of blood centers. The NBTC is also responsible for the development and implementation of the national policies and research activities. Operationally, the NCBT conducts blood collection and separation into blood components, laboratory testing and investigation, storage, and distribution of blood and blood components throughout the network of blood centers and hospitals. In addition, the NBTC is responsible for quality control of blood and blood components, implementation of autologous blood transfusions, and production of blood derivatives and reagents. The NBTC also serves as the national immunohematology reference laboratory.

There are two RBTC: one located in Balti municipality in the North and one located in Cahul in the South. The Regional BTCs (RBTC) in Balti is fully-operational while the RBTC in Cahul is currently under reorganization. The RBTCs are responsible for the planning and coordination of the blood supply within their geographic area. Operationally, the RBTCs promote blood donation and recruit new donors, collect blood, process blood into components, conduct laboratory testing and investigation, store blood and blood components, and distribute to hospitals within its geographic area. In addition, the RCBT in Balti also produces blood derivatives and reagents and conducts quality control on blood components and reagents.

Moldova was previously awarded a separate Council of Europe Bank \$7 million grant loan to provide blood safety equipment and consumables. There is relative uniformity in equipment used at the NBTC and RBTCs, representing newer technology. In general, both the NBTC and RBTC-Balti had a close approximation of the complement of critical equipment needed to operate a modern blood banking facility.

Testing of blood and quality management

All blood processed by the NBTC and RBTC is currently tested for HIV, hepatitis B, hepatitis C, and syphilis. ELISA methodology is used for HIV, hepatitis B, and hepatitis C, while syphilis is screened using Immutrep RPR and confirmed with TPHA.

The NBTC and RBTC currently prepare packed red blood cells (RBC), frozen plasma (FP), platelet concentrates, and cryoprecipitate. The NBTC and RBTC are also producing blood derivatives including albumin. The National Laboratory of Control of Quality of Blood Products in Chisinau conducts the quality control for these products and reagents following the *Guide on Preparation, Use and Quality Control of Blood Components*, which is based on the Guide from the Council of Europe, adapted for Moldova, and approved by the Ministry of Health.

At the NBTC and RBTC, a logical decision tree or testing algorithm does exist for samples that test initially reactive, based upon WHO testing strategies. Blood and blood components are discarded following an initially-reactive result. Samples testing initially-reactive are further tested in duplicate to make an assessment of the donor's status. Samples testing initially-reactive for HIV are sent to the National HIV Reference Laboratory in Chisinau. The National HIV Reference Laboratory notifies donors of positive test results upon a positive confirmatory test. The centralization of infectious disease testing has greatly improved control of the testing process and quality of results. Same forms and procedures are currently in use at all facilities.

In October 2006, with the technical assistance of USAID Preventing HIV and Hepatitis Project and the technical inputs from American Association of Blood Banks (AABB) consultants, the blood service in Moldova has started a process of implementing a new quality management program. As a first step, training on how to develop standard operating procedures (SOPs) was provided by an AABB consultant. After the initial training conducted in early 2007, the lab personnel have developed SOPs for all labs in the blood service, including for HIV testing procedures. The SOPs on HIV testing procedures were reviewed, validated and approved in 2007 in the NBTC (Table 5). All the personnel from NBTC and RBTS were trained in November on using the new SOPs in transfusion transmissible diseases. The labs from Cahul and Balti RBTCs are going to adjust and approve the SOP on HIV testing in 2008.

At this point all the blood centers take part in an external quality assurance scheme provided by the National HIV Reference Laboratory of Moldova. The procedure of external quality control includes testing one negative sample from each 10th testing plate at the NBTC; each 6th negative sample from all tests performed in regional centers are sent to the National Reference AIDS Laboratory for second testing. At this point the National Reference AIDS Laboratory does not use the known, but undisclosed samples procedures to check the blood service testing quality. The quality of testing is checked during the accreditation procedure that takes place every 5 years. The NBTC passed the accreditation in November 2007. There were no findings regarding the transfusion-transmissible procedures. Participation in an international EQA scheme usually costs a significant amount of money, which a public institution in Moldova cannot afford. The NBTC plans to review the possibilities to enter an international EQA scheme starting with year 2009, after all the equipment has been bought and all the personnel in the blood service has been trained in new operations.

Table 4 Donated blood units screened for HIV in a quality assured manner, Republic of Moldova (right bank of Dnister River), 2006

Name of the blood centre or blood screening laboratory	Quality assurance in HIV screening		Blood units		
	Standard Operating Procedures	External Quality Assurance Scheme	Donated blood	Screened blood	Blood screened in quality – assured manner
Chisinau (NBTC)	No	Yes	54,998	54,998	0 %
Balti (RBTC)	No	Yes	17,192	17,192	0 %
Cahul (RBTC)	No	Yes	2,034	2,034	0 %
Total	No	Yes	74,423	74,423	0 %
					0 %

Source: National Blood Transfusion Centre, Ministry of Health

Table 5 Donated blood units screened for HIV in a quality assured manner, Republic of Moldova (right bank of Dnister River), 2007

Name of the blood centre or blood screening laboratory	Quality assurance in HIV screening		Blood units		
	Standard Operating Procedures	External Quality Assurance Scheme	Donated blood	Screened blood	Blood screened in quality – assured manner
Chisinau (NBTC)	Yes	Yes	54,248	54,248	54,248
Balti (RBTC)	No	Yes	17,615	17,615	0
Cahul (RBTC)	No	Yes	2,150	2,150	0
Total	No	Yes	73,563	73,563	54,248
					73.7%

Source: National Blood Transfusion Centre, Ministry of Health

There is no official collaboration between National Blood Transfusion Centre and respective structure from the left bank of the Dniester River.

Data for the 2007 calendar years were entered into CRIS.

Indicator nr 4 Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

As the HIV pandemic matures, increasing numbers of people are reaching advanced stages of HIV infection. Antiretroviral therapy (ART) has been shown to reduce mortality among those infected and efforts are being made to make it more affordable within low- and middle-income countries. Antiretroviral combination therapy should always be provided in conjunction with broader care and support services including counselling for family caregivers.

According to the Ministry of Health (*unpublished report 2008*), as many as 330 adults and 14 children have been taken in HAART by 2006 year-end, with 248 adults and 14 children still receiving antiretroviral drugs as of December 2006, to reach 527 adults and 20 children taken in HAART by 2007, with 445 adults and 19 children still in it as of 2007 year-end.

As many as 1,167 viral load tests and 1,344 CD4/CD8 counts have been performed to monitor the ART efficiency. Efforts are bent to ensure universal access to HAART for all PLWHA.

The UNAIDS estimated that there were 8,814 adults (15-49 years old) and 51 children (<15 years), tallying up for a total of 8,865 people overall, living with HIV/AIDS as of December 2007, including 2,582 women (29.3%) and 6,232 men (70.7%). According to WHO/EURO, Moldova has a good coverage with HAART in the region (50-75 % of those in need), i.e. there are about 600-1,000 PLWHA requiring HAART in Moldova. The SPECTRUM generated data of some 817 adults in need of HAART, including 384 men and 433 women, and 39 children, as of 2007, compared to 511 adults and 31 children in 2006.

Data source: ART patient registers and databases, HIV surveillance systems

Method of calculation:

Numerator: Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period.

Denominator: Estimated number of adults and children with advanced HIV infection.

Table 6 Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy, Republic of Moldova, 2006

<i>Numerator</i>				
All Adults & Children	Sex		Age	
	Female	Male	<15	15+
248+14	110+6	138+8	14	248
262	116	146	262	
<i>Denominator</i>				
All Adults & Children	Sex		Age	
	Female	Male	<15	15+
511 + 31	269 + 15	242 + 16	31	511
542	284	258	542	
2006 Indicator value				
All Adults & Children	Sex		Age	
	Female	Male	<15	15+
48.34 %	40.84 %	56.59 %	45.16 %	48.53 %

Source: Republican Dermatoveneral Dispensary, Ministry of Health

Table 7 Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy, Republic of Moldova, 2007

<i>Numerator</i>				
All Adults & Children	Sex		Age	
	Female	Male	<15	15+
445+19	195+8	250+11	19	445
464	203	261	464	
<i>Denominator</i>				
All Adults & Children	Sex		Age	
	Female	Male	<15	15+
817 + 39	433 + 19	384 + 20	39	817
856	452	404	856	
2007 Indicator value				
All Adults & Children	Sex		Age	
	Female	Male	<15	15+
54.20 %	44.91 %	64.60 %	48.72 %	54.47 %

Source: Republican Dermatoveneral Dispensary, Ministry of Health

The Tables 6 and 7 represent data for both banks of Dniester River. Data have been entered into CRIS.

Results:

1. In absolute figures, the number of patients taken in HAART is steadily growing year in year out (344 by 2006, and 547 by 2007), as does the number of those remaining in treatment – 262 by 2006 and 464 by 2007. There is a considerable growth in the number of children taken in ART as well (14 by 2006, and 20 by 2007);
2. The proportion of PLWHA in need of HAART was about 48% in 2006 and increased to about 54% by 2007. The same trends are noted by sex and age, showing

improving coverage with HAART despite considerable growth in the absolute number of patients taken in treatment;

3. There is an uneven access to HAART by sex, with men having better access than women both in 2006 (men – 56 per cent, women – 41%) and 2007 (men – 64%, women – 45%). The access improved by roughly 9 per cent for men and merely 4 per cent for women;
4. Similar yet more even growth was reported in the access of adults and children, surging up from 45 to 49 % for children, and from 48 to 54 % for adults, with a higher growth for adults; and
5. Of all the known and confirmed cases of HIV with clinical and/or immunological indications for HAART, as per the WHO-approved national protocols for ART and care, all the PLWHA are getting adequate HAART, i.e. 100 % coverage. Juxtaposed with the above data, it means that more efforts should be bent to identify those in need of HAART yet not registered with an infectionist.

Indicator nr 5 Percentage of HIV positive pregnant women who received antiretroviral drugs to reduce the risk of mother to child transmission

In the absence of any preventative interventions, infants born to and breastfed by HIV-infected women have roughly a one-in-three chance of acquiring infection themselves. This can happen during pregnancy, during labour and delivery or after delivery through breastfeeding. The risk of mother-to-child transmission can be significantly reduced through the complementary approaches of antiretroviral prophylactic regimes for the mother with or without prophylaxis to the infant, implementation of safe delivery practices and use of safe alternatives to breastfeeding. Antiretroviral prophylaxis followed by exclusive breastfeeding may also reduce the risk of vertical transmission when breastfeeding is limited to the first six months.

Data source: ART patient registers and databases, HIV surveillance systems

Method of calculation:

Numerator: Number of HIV positive pregnant women who received antiretroviral drugs to reduce the risk of mother to child transmission (women have been tested HIV-positive during pregnancy plus women have had their HIV diagnosis established before pregnancy)

Denominator: Number of pregnant women who gave birth during the last 12 months multiplied by the HIV prevalence rate reported in pregnant women¹⁶.

As many as 84 women have been tested HIV-positive during pregnancy and 13 have had their HIV diagnosis established before pregnancy, tallying up to 97 HIV-positive pregnant women overall reported as HIV-pregnant women in the last 12 months (in 2006). This number divided by 45,700 pregnant women reported throughout 2006 results in an HIV prevalence rate of about 0.21% among pregnant women in Moldova in 2006. Similarly, for 2007, there have been 81 pregnant women with primarily diagnosed with HIV during pregnancy, adding up to another 31 pregnant women with a diagnosis established before pregnancy in 2007, thus tallying up to 112 women overall, and divided by 48,780 pregnant women tested for HIV in 2007, yielding an HIV prevalence rate of 0.23% among pregnant women in 2007.

¹⁶ The number of pregnant women tested for HIV during pregnancy or in labor accounts for over 97 % of all pregnant women in Moldova, thus the estimated number of HIV infected pregnant women is almost the same as the number of HIV positive pregnant women registered.

There were 35,761 births reported in 2006, and 37,394 births reported in 2007. Hence, the denominator for 2006 is 35,761 times 0.21%, i.e. 75 women for 2006; the denominator for 2007 is 37,394 times 0.23%, i.e. 86 women for 2007.

Table 8 Percentage of HIV positive pregnant women who received antiretroviral drugs to reduce the risk of mother to child transmission, Republic of Moldova, 2006 - 2007

	2006	2007
Numerator	62	73
Denominator	75	86
Indicator value	82.66 %	84.88 %

Source: Republican Dermatovenereal Dispensary, Ministry of Health

Results:

1. The coverage of pregnant women with preventive ART has been relatively high during both 2006 and 2007, also presenting an increase from roughly 82 per cent in 2006 to 85 per cent in 2007, meaning that good efforts have been bent to provide as many pregnant women as possible with preventive ART;
2. In the opinion of national stakeholders, the denominator accounts for terminated pregnancies rather than providing for those pregnancies carried to term. In the same vein, more pregnant women have been diagnosed at earlier terms of pregnancy (before 12 weeks) in 2007, and many decided to terminate their pregnancy through abortion, also counting towards denominator and not to nominator;
3. Another caveat with regards to the denominator is that it also includes pregnant women from the breakaway region of Transnistria (part of the country's overall statistics on the number of HIV-positive pregnant women), however some data in certain instances are incomplete as to the outcome of their pregnancy, thus overstating the denominator, yet some of them also benefiting from preventive ART in Tiraspol. The country should improve its abortion prevention services among HIV-infected pregnant women, as part of a comprehensive PMTCT program;
4. If the denominator would consider only pregnancy resulting in births, all of the HIV-positive pregnant women have been provided with preventive ART, thus raising the coverage with preventive ART services of HIV-positive pregnant women giving birth up to 100 per cent both years (2006 and 2007); and
5. More pregnant women, diagnosed with HIV before the pregnancy, decide to get pregnant and keep their pregnancy, indicating more trust in the preventive ART services available in the country (only 13 in 2006 vs. 31 in 2007, at roughly the same values of primarily diagnosed pregnant women – 84 and 81 reported in 2006 and 2007 respectively).

Indicator nr 6 Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV

Tuberculosis (TB) is one of the commonest causes of morbidity and mortality in people living with HIV, even those on antiretroviral therapy. Intensified TB case-finding and access to quality diagnosis and treatment of TB in accordance with international/national guidelines is essential for improving the quality and quantity of life for people living with HIV. A measure of the percentage of HIV-positive TB cases that access appropriate treatment for their TB and HIV is important.

Data source: ART patient registers and databases, HIV surveillance systems

Method of calculation:

Numerator: Number of adults with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines) within the reporting year

Denominator: Estimated number of incident TB cases in people living with HIV Country-specific annual estimates of the number of incident TB cases in people living with HIV are calculated by WHO and are available at the WHO's: http://www.who.int/tb/country/global_tb_database/en/index.html (updated as of 22 March 2007).

According to WHO/EURO, the incidence of TB among PLWHA accounted for 5.9 per 100,000 people, as of 2005. Considering the results of the latest available censuses, there have been 3,383,332 people reported on the right bank of the Dniester River (2004 census) and 533,548 people reported on the left bank of the Dniester River (Transnistria), tallying up to 3,916,880 people overall in the country. The WHO incidence rate reported results in about an estimated 231 people reported as having both TB and HIV in 2007. The distribution by sex has followed the same trends as indicated in the UNAIDS estimates for the PLWHA in Moldova (as of 2007), i.e. 29.3% women, and 70.7% – men.

Table 9 Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV, Republic of Moldova, 2007

	Male	Female	Total
Numerator	14	9	23
Denominator	163	68	231
Indicator value	8.59 %	13.23 %	9.96 %

Source: Republican Dermatoveneral Dispensary, Ministry of Health

Adequate detection and treatment of TB will prolong the lives of people living with HIV and reduce the community burden of TB. WHO provides annual estimates of the burden of TB among people living with HIV, based on the best available country estimates of HIV prevalence and TB incidence. All incident TB cases among people living with HIV should be started on TB treatment and, depending on country specific eligibility criteria. All or most people living with HIV who have TB should be on antiretroviral therapy, depending on local eligibility criteria. TB treatment should only be started in accordance with national TB programme guidelines.

It is important that those providing HIV care and antiretroviral treatment record TB diagnosis and treatment, as this information have important implications for antiretroviral treatment eligibility and choice of regimen. It is therefore recommended that the date of starting TB treatment is recorded in the antiretroviral treatment register.

Results:

Roughly, a limited number of PLWHA benefited from the management of both HIV and TB infections during 2007 (about 10 per cent). Females have relatively higher access to mixed management of HIV-TB infections than males (about 13% vs. about 9%). Cooperation between the TB and HIV/AIDS services should be strengthened as to timely diagnose TB in HIV/AIDS patients and HIV/AIDS in TB patients.

HIV testing

According to the Law on Prevention of HIV/AIDS nr. 23 – XVI of 16.02.2007 testing for HIV is mandatory only in the following cases:

1. Donations of blood, liquids, tissue and organs;
2. Upon a court order when a person is charged with the crime of willful transmission of HIV or rape, and when the person responsible for this does not give consent for testing after benefiting of thorough counselling.

The “Standard on the Epidemiologic Surveillance of HIV/AIDS Infection” approved by the Order of the Ministry of Health nr. 20 of 19.01.2007 (*Ministry of Health, 2007*) the biologic surveillances foresees screening of the donated blood, screening of some professional groups, and the screening of most at risk and vulnerable populations which in the Republic of Moldova are as follow:

1. Injecting Drug Users,
2. Commercial Sex Workers,
3. Men having Sex with Men,
4. Populations registered by STI Clinics and patients with STIs or patients with clinical signs of STIs,
5. Blood recipients subject to an increased number of blood transfusions as well as patients registered with coagulation problems,
6. Categories of populations with frequent travels, temporary migrants (including Rhoma populations, truck drivers, citizens of the Republic of Moldova who lived outside the country more than 3 months)
7. Detainees of penitentiary institutions-persons with a high risk.

According to the Decision of the Ministry of Health nr. 279d of 17.03.2003 “On Testing of Pregnant Women” (*unpublished report, 2003*) testing of pregnant women to HIV is recommended twice during pregnancy, in cases when the pregnant woman comes to delivery with an unknown HIV status she is advised to undertake a rapid test according to the Order the Ministry of Health nr. 20 of 19.01.2007 (*Ministry of Health, 2007*). According to NCHM (*unpublished report 2008*) in 2007, 99.8% of births out of the total occurred in medical institutions. For the IDUs registered with the Narcological Dispensary HIV testing is recommended once per two years. Promotion of VCT for HIV is part of the Harm Reduction activities implemented in the Republic of Moldova among MARPs.

By the year of 2007 inclusively testing for HIV was of two types: person initiated and health provider initiated where the rate of health provider initiated testing was predominant. Training of the medical staff on pre and post test counselling to HIV was available prior to 2007 but only in 2007 the Republic of Moldova has established a well structured specialized framework for VCT. In the majority of cases the persons subject to testing were pre and post test counselled if at all by the institutions which was taking the blood for testing. The pre and post-test counselling was provided at a greater extent by the non-governmental sector, especially in the case of MARPs. According to the Law on Prevention of HIV/AIDS nr.23 – XVI of 16.02.2007 and the National Programme on Prevention and Control of HIV/AIDS/STIs through the Order of the Ministry of Health Nr. 344 of 05.09.2007 (*Ministry of Health, 2007*) there has been established a network of VCT centres for counselling to HIV and viral hepatitis B and C. The first centres have been piloted in December 2007.

Indicator nr 7 Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results

Data source:

The data for this indicator have been collected within the framework of the operational research in the general population in 2007¹⁷ (PHH 2007) – household survey (see Annex). For the purpose of the present report the database of the study was used where there have been extracted the sub-sample of 15-49 years (908) respondents and analysed based on the recommendations of *Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators. 2008 Reporting (UNAIDS 2007)*. The demographic structure of the sub-sample is represented in Table 10.

Table 10 Demographic structure of the sub-sample of 15-49 years, absolute figures and %, Republic of Moldova, right bank of Dniester River, 2007

	Male		Female		Total	
	Number	%	Number	%	Number	%
15-19 years	89	21.4%	91	18.5%	180	19.8%
20-24 years	72	17.3%	67	13.6%	139	15.3%
25-49 years	255	61.3%	334	67.9%	589	64.9%
25-29 years	46	11.1%	64	13.0%	110	12.1%
30-39 years	95	22.8%	122	24.8%	217	23.9%
40-49 years	114	27.4%	148	30.1%	262	28.9%
Total	416	45.8%	492	54.2%	908	100.0%

Source: „Knowledge, attitudes and practices on Viral Hepatitis B and C and Voluntary Counselling and Testing for HIV and Viral Hepatitis in the general population of Moldova”, 2007

Method of calculation:

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

1. I don't want to know the results, but have you been tested for HIV in the last 12 months?
2. If yes: I don't want to know the results, but did you get the results of that test?

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

Denominator: Number of all respondents aged 15–49.

Results:

The distribution by sex and by age of the respondents (that are part of the numerator and denominator) that have undertaken an HIV test during the last 12 months and know the result of the testing are presented in % and in absolute figures in the Table 11.

¹⁷ The study “ Knowledge, Attitudes and Practices of the Population of the Republic of Moldova on Viral Hepatitis B and C and Voluntarily Counselling and Testing to HIV and Hepatitis” has been developed within the framework of the Project “Prevention of HIV/AIDS and Viral Hepatitis B and C” financed by USAID

Table 11 Distribution by gender and age of the respondents 15 – 49 years old that have undertaken an HIV test during the last 12 months and know the result of the test, % and absolute figures, Republic of Moldova, right bank of Dniester River, 2007

		Males		Females		Total	
		Number	%	Number	%	Number	%
15-19 years	numerator	1	1.1	5	5.5	6	3.3
	denominator	89		91		180	
20-24 years	numerator	8	11.1	6	9.0	14	10.1
	denominator	72		67		139	
25-49 years	numerator	16	6,3	41	12,3	57	9,7
	denominator	255		334		589	
Total	numerator	25	6.0	52	10.6	77	8.5
	denominator	416		492		908	

Source: „Knowledge, attitudes and practices on Viral Hepatitis B and C and Voluntary Counselling and Testing for HIV and Viral Hepatitis in the general population of Moldova”, 2007

Only 8.5% of the total sample of 908 respondents in the age group of 15 - 49 years old have undertaken an HIV test during the last 12 months and know the result of the last test. The rate of females who undertook the HIV testing during the last 12 months is higher (10.6%) than males (6.0%). Based on the age group the biggest rate of respondents who reported on HIV testing during the last 12 months and knowing the results lie in the 30-39 years old age group (13.4%), mainly due to the big rate of female respondents (16.4%). The lowest rate is registered in the 15-19 years age group with a 3.3%.

Limitations:

- The low number of respondents who reported the HIV testing in the last 12 months and knowing the result of that test (77) is considered to be a limitation for the detailed analysis of the results disaggregated by gender and age group.
- There is no data available for the left bank of Dniester River (see Annex 2).

Indicator nr 8 Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results

Injecting Drug Users

Data source:

The data for this indicator have been collected within the framework of the Behaviour and Sentinel Surveillance Survey (BSS) among MARPs, Moldova 2007 (*unpublished report*) conducted in 2007 among IDUs – beneficiaries of the Harm Reduction Programmes (see Annex 4).

Method of calculation:

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

1. I don't want to know the results, but did you receive the results of that test?
2. "Have you been tested for HIV in the last 12 months?" with one option of answer being "during the last 12 months"

Numerator: Number of IDUs respondents who have been tested for HIV during the last 12 months and who know the results.

Denominator: Number of IDUs included in the sample.

Results:

The distribution by gender and by age of the respondents (that are part of the numerator and denominator) that have undertaken an HIV test during the last 12 months and know the result of the testing are showed in % and in absolute figures in Table 12.

Table 12 Distribution by gender and by age of the respondents that have undertaken an HIV test during the last 12 months and know the result of the testing, % and absolute figures, IDUs beneficiaries of the Harm Reduction Programmes, Republic of Moldova, 2007

	All Injecting Drug Users	Males	Females	<25	25+
Indicator Value : Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results (Percent)	34.13%	33.00%	38.35%	28.57%	36.85%
Numerator : Number of most-at-risk population respondents who have been tested for HIV during the last 12 months and who know the results	215	164	51	48	164
Denominator : Number of most-at-risk population included in the sample	630	497	133	168	445

Source: “Behaviour and Sentinel Surveillance Survey among MARPs, Moldova 2007”, 2007

Out of the total sample IDU respondents beneficiaries of the Harm Reduction programmes 34.1% have undertaken the HIV test during the last 12 months and know the result of the test. The rate of women respondents (38.4%) is higher than the rate of men (33.0%). Based on the age group the biggest rate of respondents who reported on undertaking the HIV testing during the last 12 months and knowing the results lie in the 25 + age group (36.9%). In the case of women there have not been registered significant differences between the two age groups subject to analysis.

Limitations:

- The target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes and cannot be extrapolated for the entire population of IDUs.
- The staff and volunteers of the Harm Reduction Programmes have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.

Comercial Sex Workers (Female Sex Workers)

Data source:

The data for this indicator have been collected within the framework of the Behaviour and Sentinel Surveillance Survey (BSS) among MARPs, Moldova 2007 (*unpublished report*) conducted in 2007 among FSWs – beneficiaries of the Harm Reduction Programmes (see Annex 5).

Method of calculation:

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

1. I don't want to know the results, but did you receive the results of that test?
2. "Have you been tested for HIV in the last 12 months?" with one option of answer being "during the last 12 months"

Numerator: Number of most-at-risk population respondents who have been tested for HIV during the last 12 months and who know the results

Denominator: Number of most-at-risk population included in the sample

Results:

The distribution by age of the respondents (that are part of the numerator) that have undertaken an HIV test during the last 12 months and know the result of the testing are showed in % and in absolute figures in Table 13.

Table 13 Distribution by age of the respondents that have undertaken an HIV test during the last 12 months and know the result of the testing, % and absolute figures, FSWs beneficiaries of the Harm Reduction Programmes, Republic of Moldova (right bank of Dnister River), 2007

	All Sex Workers	Males	Females	<25	25+
Indicator Value : Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results (Percent)	31.17%	0.00%	31.17%	28.79%	36.19%
Numerator : Number of most-at-risk population respondents who have been tested for HIV during the last 12 months and who know the results	154	0	154	57	93
Denominator : Number of most-at-risk population included in the sample	494	0	494	198	257

Source: "Behaviour and Sentinel Surveillance Survey among MARPs, Moldova 2007", 2007

Out of the total sample of 494 FSWs respondents beneficiaries of the Harm Reduction programmes 31.2% have undertaken the HIV test during the last 12 months and know the

result of the test. Comparing the both age groups, a higher value has been registered among those who are 25 years old and more (36.2%).

Limitations:

- The target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes and cannot be extrapolated for the entire population of FSWs.
- The staff and volunteers of the Harm Reduction Programmes have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.

Men having Sex with Men

Data source:

The data for this indicator have been collected within the framework of the Behaviour and Sentinel Surveillance Survey (BSS) among MARPs, Moldova 2007 (*unpublished report*) conducted in 2007 among MSM – beneficiaries of the Harm Reduction Programmes (see Annex 6).

Method of calculation:

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

1. I don't want to know the results, but did you receive the results of that test?
2. "Have you been tested for HIV in the last 12 months?" with one option of answer being "during the last 12 months"

Numerator: Number of most-at-risk population respondents who have been tested for HIV during the last 12 months and who know the results

Denominator: Number of most-at-risk population included in the sample

Results:

The distribution by age of the respondents (that are part of the numerator) that have undertaken an HIV test during the last 12 months and know the result of the testing are showed in % and in absolute figures in Table 14.

Table 14 Distribution by age of the respondents that have undertaken an HIV test during the last 12 months and know the result of the testing, % and absolute figures, MSM beneficiaries of the Harm Reduction Programmes, Republic of Moldova (right bank of Dnister River), 2007

	All Men Who Have Sex With Men	<25	25+
Indicator Value : Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results (Percent)	38.30%	35.14%	40.74%
Numerator : Number of most-at-risk population respondents who have been tested for HIV during the last 12 months and who know the results	36	13	22
Denominator : Number of most-at-risk population included in the sample	94	37	54

Source: "Behaviour and Sentinel Surveillance Survey among MARPs, Moldova 2007", 2007

Out of the total sample of 94 MSM respondents beneficiaries of the Harm Reduction programmes 38.3% have undertaken the HIV test during the last 12 months and know the result of the test. Comparing the both age groups, a higher value has been registered among those who are 25 years old and more (40.7%).

Limitations:

- The target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes and cannot be extrapolated for the entire population of MSM.
- The staff and volunteers of the Harm Reduction Programmes have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.
- The low number of respondents who reported the HIV testing in the last 12 months and knowing the result of that test (35) is considered to be a limitation for the detailed analysis of the results disaggregated by age group.

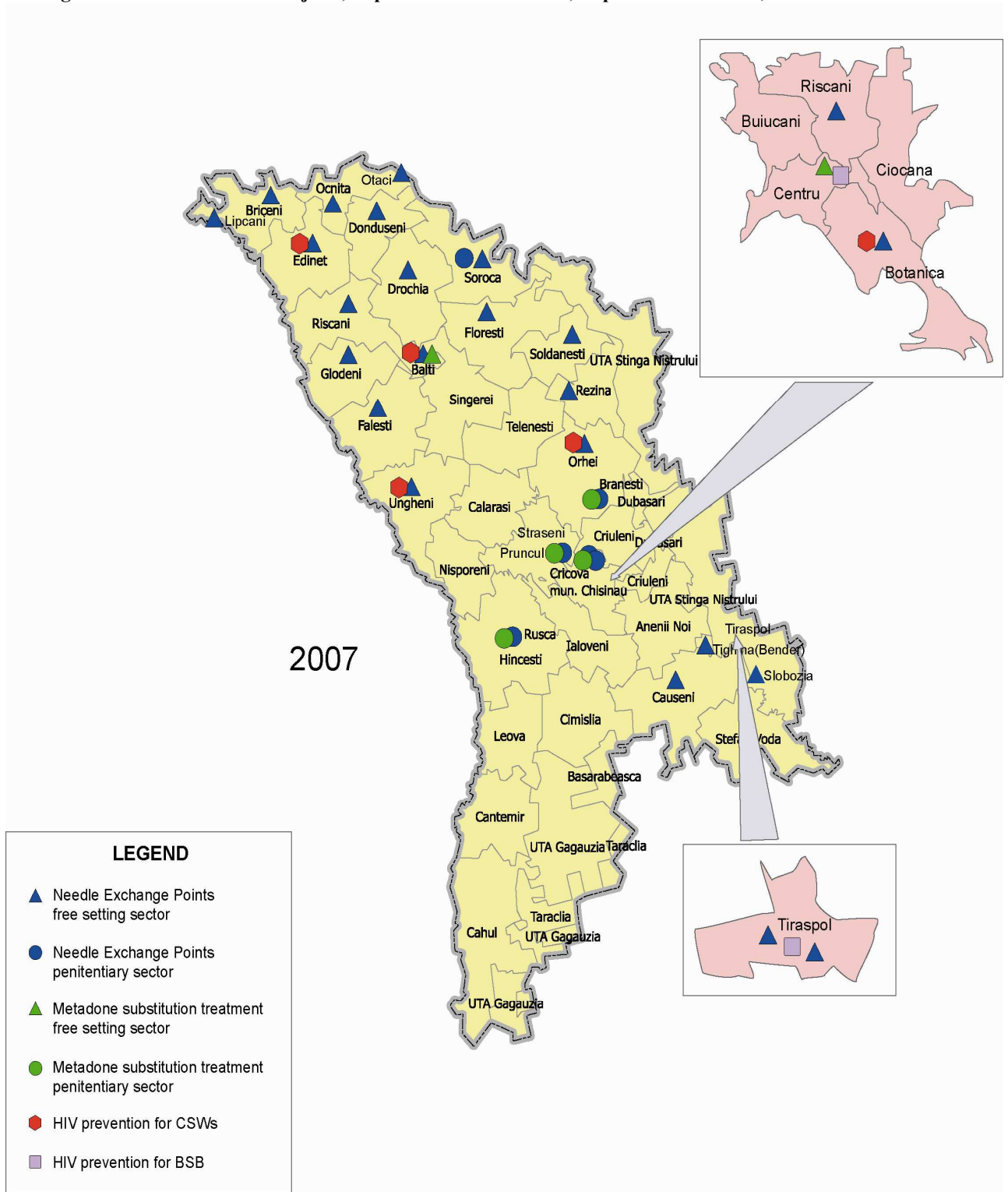
Interventions in MARPs

According to the Law on Prevention of HIV/AIDS nr. 23 – XVI of 16.02.2007 prevention programmes have to be implemented among children, women and families affected by HIV, injecting drugs users, armed forces, in emigrants and in immigrants, refugees and asylum seekers. Strategy VI of the National Programme on Prevention and Control of HIV/AIDS/STIs 2006-2010 foresees additionally activities aimed at prevention activities among commercial sex workers, men having sex with men, youth out –of-school and unemployed youth, children and youth with disabilities.

During 2006-2007 within the framework of implementation of the Harm Reduction Strategy there have been implemented information/education/outreach activities, needle and syringe exchange, referral to health and social protection institutions, as well as institutions dealing with methadone substitution therapy both in the civil sector and in penitentiary institutions.

In 2007 in the Republic of Moldova there were registered under implementation 17 projects based on harm reduction activities in 22 administrative territories aimed at IDUs, 5 projects aimed at CSWs, and one project aimed at MSM covering two administrative territories (Figure7).

Figure 7 Harm Redcution Projects, implementation locations, Republic of Moldova, 2007



During the reporting period there were no registration of important progress as to the geographic scaling up and modifications to the quality standards.

The estimations of coverage by Harm Reduction Programmes is currently impossible due to lack of reliable estimations of the MARPs size such as IDUs, FSWs and MSM. From the moment of launch of harm reduction projects in 1997 to the end of the 2007 cumulatively there have been registered 11938 IDUs covered with services, 854 CSWs, and 751 MSM all from the civil sector. The estimation of the double reporting of services provided to MARPs is currently unavailable due to lack of the unique identifier system assigned to clients of the projects.

In all 19 penitentiary institutions during 2007 there have been made available educational materials and trainings on prevention of HIV/AIDS, in five of all penitentiary institutions there have been made operational needle and syringe exchange outreach points available to detainees 24 hours 7 days per week. The reporting of numbers of detainees who benefit of harm reduction services is difficult as the outreach activity in penitentiaries is based on the volunteers from among detainees who refuse to provide detailed information on the beneficiaries.

For the IDUs/FSWs from the civil sector the basic components of the Harm Reduction Strategy in Moldova are as follows:

- Information/education on HIV/AIDS transmission and prevention in the framework of high risk behaviour and outreach with distribution of information materials, needles and syringes, condoms and trainings
- Referral to medical institutions and social assistance (medical consultations, as a common practice for STIs, consultations for psychological rehabilitation, pre and post-test counselling)
- Needle exchange
- Methadone substitution treatment

The basic components of the Harm Reduction Strategy for the penitentiaries are the following:

- Information/education on HIV/AIDS transmission and prevention in the framework of high risk behaviour and outreach with distribution of information materials, needles and syringes, condoms and trainings
- Referral to medical institutions and social assistance (medical consultations, as a common practice for STIs, consultations for psychological rehabilitation, pre and post-test counselling)
- Needle exchange
- Methadone substitution treatment

Men having Sex with Men in Moldova would benefit of the Harm Reduction Strategy based on the following services:

- Information/education on HIV/AIDS transmission and prevention in the framework of high risk behaviour and outreach with distribution of information materials, needles and syringes, condoms and trainings

Taking into consideration that there are no reliable estimations for any MARPs in Moldova including no estimations of the drug injecting prevalence, it is premature to evaluate the coverage of IDUs with services which slows down the geographic coverage and scaling up of activities under the Harm Reduction Strategy.

Indicator nr 9 Percentage of most-at-risk populations reached with HIV prevention programmes

Injecting Drug Users

Data source:

The data for this indicator have been collected within the framework of the Behaviour and Sentinel Surveillance Survey (BSS) among MARPs, Moldova 2007 (*unpublished report*) conducted in 2007 among IDUs – beneficiaries of the Harm Reduction Programmes (*see Annex 4*).

Method of calculation:

The data collection tool has been developed based on the Guidelines for Repeated Behavior Survey in Population at Risk for HIV¹⁸. The recommendations of the Guide have been used for the development of the questionnaire applied through the interview to injecting drug users. The set of questions and the respective answers that served as basis for the calculation of this indicator have been the following:

1. Do you know where you can go if you wish to receive an HIV test?
2. In the last twelve months, have you been given sterile needles and syringes?
3. In the last twelve months, have you been given condoms? (e.g. through an outreach service, NGO, youth friendly services or any other source?)

Thus the set of the questions can be adjusted to the recommendations of the *Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators. 2008 Reporting (UNAIDS 2007)*.

Numerator: Number of IDUs respondents who stated they know where to receive an HIV test and who received during the last 12 months free of charge needles, syringes and condoms.

Denominator: Number of most-at-risk population included in the sample.

Results:

The distribution by sex and by age of the respondents (that are part of the numerator and denominator) that know where they can go if they want to receive an HIV test, who have been given sterile needles and syringes and condoms in the last twelve months is presented in % and in absolute figures in Table 15.

Table 15 Distribution by sex and by age of the respondents that reported to know where to undertake an HIV test, and during the last 12 months received needles, syringes and condoms, % and absolute figures, IDUs beneficiaries of the Harm Reduction Programmes, Republic of Moldova, 2007

All Injecting Drug Users	Males	Females	<25	25+
88.73%	88.73%	88.72%	90.48%	88.54%
559	441	118	152	394
630	497	133	168	445

Source: “Behaviour and Sentinel Surveillance Survey among MARPs, Moldova 2007”, 2007

The registered high level of coverage is explained by the fact that the target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes.

Limitations:

- The target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes and cannot be extrapolated for the entire population of IDUs.

¹⁸ Family Health International, Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV. Family Health International, 2004

- The staff and volunteers of the Harm Reduction Programmes have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.

Men having Sex with Men

Data source:

The data for this indicator have been collected within the framework of the Behavior and Sentinel Surveillance Survey (BSS) among MARPs, Moldova 2007 (*unpublished report*) conducted in 2007 among MSM – beneficiaries of the Harm Reduction Programmes (see Annex 6).

Method of calculation:

The data collection tool has been developed based on the Guidelines for Repeated Behavior Survey in Population at Risk for HIV¹⁹. The recommendations of the Guide have been used for the development of the questionnaire applied through the interview to injecting drug users. The set of questions and the respective answers that served as basis for the calculation of this indicator have been the following:

1. Do you know where you can go if you wish to receive an HIV test?
2. In the last twelve months, have you been given condoms? (e.g. through an outreach service, NGO, youth friendly services or any other source)

Thus the set of the questions can be adjusted to the recommendations of the *Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators. 2008 Reporting (UNAIDS 2007)*.

Numerator: Number of respondents who said they know where to receive an HIV test and who received during the last 12 months free of charge condoms

Denominator: Number of respondents included in the sample

Results:

The distribution by age of the respondents (that are part of the numerator) that know where they can go if they want to receive an HIV test, who have been given condoms in the last twelve months is presented in % and in absolute figures in Table 16.

Table 16 Distribution by age of the respondents that reported to know where to undertake an HIV test, and during the last 12 months received condoms free of charge, % and absolute figures, MSM beneficiaries of the Harm Reduction Programmes, Republic of Moldova (right bank of the Dnister River), 2007

	All Men Who Have Sex With Men	<25	25+
Indicator Value : Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results (Percent)	38.30%	35.14%	40.74%
Numerator : Number of most-at-risk population respondents who have been tested for HIV during the last 12 months and who know the results	36	13	22
Denominator : Number of most-at-risk population included in the sample	94	37	54

Source: “Behaviour and Sentinel Surveillance Survey among MARPs, Moldova 2007”, 2007

The registered high level of coverage is explained by the fact that the target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes.

Limitations:

- The target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes and cannot be extrapolated for the entire population of MSM.

¹⁹ Family Health International, Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV. Family Health International, 2004

- The staff and volunteers of the Harm Reduction Programmes have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.

Comercial Sex Workers (Female Sex Workers)

Data source:

The data for this indicator have been collected within the framework of the Behaviour and Sentinel Surveillance Survey (BSS) among MARPs, Moldova 2007 (*unpublished report*) conducted in 2007 among FSWs– beneficiaries of the Harm Reduction Programmes (see Annex 5).

Method of calculation:

The data collection tool has been developed based on the Guidelines for Repeated Behavior Survey in Population at Risk for HIV²⁰. The recommendations of the Guide have been used for the development of the questionnaire applied through the interview to injecting drug users. The set of questions and the respective answers that served as basis for the calculation of this indicator have been the following:

1. Do you know where you can go if you wish to receive an HIV test?
2. In the last twelve months, have you been given condoms? (e.g. through an outreach service, NGO, youth friendly services or any other source)

Thus the set of the questions can be adjusted to the recommendations of the *Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators. 2008 Reporting (UNAIDS 2007)*.

Numerator: Number of respondents who said they know where to receive an HIV test and who received during the last 12 months free of charge condoms

Denominator: Number of respondents included in the sample

Results:

The distribution by age of the respondents (that are part of the numerator) that know where they can go if they want to receive an HIV test, who have been given condoms in the last twelve months is presented in % and in absolute figures in Table 17.

Table 17 Distribution by age of the respondents that reported to know where to undertake an HIV test, and during the last 12 months received condoms free of charge, % and absolute figures, FSWs beneficiaries of the Harm Reduction Programmes, Republic of Moldova (right bank of the Dnister River), 2007

	All Sex Workers	Males	Females	<25	25+
Indicator Value : Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results (Percent)	31.17%	0.00%	31.17%	28.79%	36.19%
Numerator : Number of most-at-risk population respondents who have been tested for HIV during the last 12 months and who know the results	154	0	154	57	93
Denominator : Number of most-at-risk population included in the sample	494	0	494	198	257

Source: “Behaviour and Sentinel Surveillance Survey among MARPs, Moldova 2007”, 2007

The registred high level of coverage is explained by the fatc that the target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes.

²⁰ Family Health International, Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV. Family Health International, 2004

Limitations:

- The target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes and cannot be extrapolated for the entire population of FSWs.
- The staff and volunteers of the Harm Reduction Programmes have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.

Indicator nr 10 Support for Children Affected by HIV and AIDS

Not relevant for the country

Indicator nr 11 Percentage of schools that provided life skills – based education in the last academic year

According to the National Legislation on HIV (*Law 23-XVI from February 16, 2007 referring to HIV/AIDS Prophylaxis, Official Gazette nr. 54-56/250 from April 20, 2007, Chapter II, Art.5, Paragraph 1.*) knowledge on HIV/AIDS can be provided in schools beginning with the 5th - 6th level at 12 years old.

The “Life Skills” Concept and curricular were the outcomes of the collaboration between state bodies in the field of education and health care and of non-governmental organizations (UNICEF, the National Youth Resource Centre, the National Scientific and Practical Centre for Preventive Medicine, etc.). According to the Plan of Education approved by Ordinance no. 60 of the 19th of May 2005, “Life Skills” subject started to be taught an hour per week in I-XII grades since the 1st of September 2005.

In the same time, the large-scale implementation of „Life Skills” subject has generated a campaign of hostile declarations that aimed at excluding the subject from the educational system.

Under those circumstances, the Ministry of Education, Youth and Sports held a number of consultative meetings and issued its Ordinances no.473 of 4th of October 2005 and no.790 of 2nd of November 2005 according to which the “Life Skills” subject became an optional subject, while its module “Sexual Education” was excluded from it. Moreover, it was decided that the optional “Life Skills” subject had to be taught based on the Curricular, on the Curricular Implementation Guide and on the Teacher’s Guide, while textbooks were withdrawn from schools.

Data source: Secondary school survey. The national study on HIV/AIDS in schools was accomplished within the period of December 2007–January 2008, the data being representative for the academic year 2006-2007. The target population comprises schools included in the secondary education, which constituted a number of 1406 schools.

The Sample comprised 517 questionnaires, filled in by the school directors from various regions of the Republic of Moldova, except the schools from Transnistria, which were not included in the study. Due to the fact that according to the legislation of the Republic of Moldova, education in schools is permitted starting with the age of 12²¹, only secondary schools were included into the sample – gymnasiums, lyceums, middle schools of general culture. Thus, out of the total number of secondary education institutions – 1443 (excluding primary schools) registered according to the data form the National Bureau of Statistics of the Republic of Moldova in 2006-2007 – 529 schools participated in the Study, of which only 517 have been validated.

Data collection tool: Structured questionnaire, self administrated.

Method of calculation:

Numerator: Number of schools that provided life skills based HIV in last academic year (at least 30 hours of life skills training to each grade)

Denominator: Number of schools surveyed.

²¹ Law 23-XVI from February 16, 2007 referring to HIV/AIDS Prophylaxis, Official Gazette nr. 54-56/250 from April 20, 2007, Chapter II, Art.5, Paragraph 1.

Results:

92.6% of schools which participated in the Survey asserted that specialists from their institutions performed activities of teaching knowledge on HIV/AIDS, 7.4% didn't perform such activities (Table 18).

Table 18 Percentag of schools that provided life skills - based education in the last academic years

	All schools	Primary	Secondary
Numerator	479	0	479
Denominator	517	0	517
Total	92.6%	0	92.6%

Out of the total number of schools from urbane areas (22.4%), 1.4% didn't teach knowledge on HIV/AIDS. Out of the total number of schools from the rural areas (77.6%), 7.4% taught knowledge on HIV/AIDS. Thus, the percentage of schools from rural areas in which knowledge on HIV/AIDS was not taught is greater than that from urbane schools. The total number of pupils who were taught about HIV/AIDS in the academic year 2006-2007 from the questioned schools constituted 98694. Out of 72162 pupils included from the 6th – 9th grade and out of 25527 pupils from lyceum classes (the 10th – 11th grades), 69.4% of pupils listened to courses on HIV/AIDS during the academic year 2006-2007, in the schools included in the sample during the academic year 2006-2007. The quality of education provided may differ by country and over time.

Knowledge and behaviour indicators

Education and information in general population

According to Law on Prevention of HIV/AIDS nr. 23 – XVI of 16.02.2007 information and education activities is stipulated explicitly for the general population and youth. Strategy II of the National Programme on Prevention and control of HIV/AIDS/STIs 2006-2010 provides a clear framework for the development of a Communication Strategy in HIV Prevention and implementation of specific activities aimed at informing school children, young populations and the general population about HIV/AIDS.

During the reporting period there were conducted two nationwide behaviour change communication campaigns for the general population. The first campaign implemented during November 2005-February 2006 had the objective of promoting condom use and aimed youth in the 15-29 years age group. The coverage rate for the target group reached 65%.

In 2005-2006 there has been piloted the "Life Skills Based Education" mandatory curricular for schools. Due to political debates around the curricular it has been recommended for schools as an optional subject and is applied only to school children reaching the age of 12. The results of the researches measuring the level of knowledge on HIV/AIDS during the reporting period did not show major changes (the knowledge integrated indicator in 2006 scored 26.3%) compared to the results of 2005 (the integrated knowledge indicator scored 28.3%).

In order to cover for the lack of life skills based education in 2007 the National programme on Prevention and Control of HIV/AIDS/STIs has launched peer-to-peer activities targeting young people.

Indicator nr 12 Current school attendance among orphans and non orphans aged 10 - 14

No data available for this indicator.

Indicator nr 13 Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Data source: The data for this indicator have been collected within the framework of the household survey conducted in 2006 among youth on the right bank of Dniester River (*Scutelnicu et al. 2006*) (see Annex 3).

Method of calculation:

The data collection tool has been developed based on the Guidelines for Repeated Behavior Survey in Population at Risk for HIV²². The questionnaire for interviewing of adult population in the age group of 15-49 has been selected from the Guide. The questionnaire has been selected based on the argument that 11.5% (*Scutelnicu et al. 2006*) of the population of 15-24 years old are married or live in civil marriages.

The set of questions and the respective answers that served as basis for the calculation of the present indicator have been the following there have been formulated 4 out of the 5 questions recommended by *Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators. 2008 Reporting (UNAIDS 2007)*. The questionnaire missed the questions on misconceptions "Can a person get HIV from mosquito bites?" which has no been replaced by a question pertaining to the regional context?

The set of the questions that have been used for the calculation of the integrated indicator of knowledge on HIV transmission in the questionnaire have been formulated as follows:

1. Can a person reduce the risk of getting HIV by using a condom every time they have sex?
2. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV by sharing food with someone who is infected?

Numerator: Number of respondents aged 15-24 years who gave the correct answer to all four questions.

Denominator: Number of all respondents of the study aged 15–24 years old. The respondents that never heard of HIV and of AIDS have not been included in the denominator.

Results:

The distribution by sex and age of the respondents with correct answers to all four questions and the values of the integrated indicator are shown in Table 12.

The integrated indicator of the knowledge of youth on HIV transmission reaches the value of 26.3%. According to the value of the integrated knowledge indicator the young people of 15-19 years old have better knowledge of the ways of transmission of HIV (23.1%) than the youth in the 20-24 age groups (31.0%) regardless the sex.

The analyses showed that the possibility of reducing the spread of HIV through sexual way of transmission is known to the majority of respondents who agreed that having a single uninfected sexual partner who is faithful (66.1% of respondents) and by using correctly the condom at each sexual contact (65.3% of respondents) can prevent the spread of HIV (Table 19)

The lowest rate of correct answers was registered for the question on the misconception of HIV spread through sharing food with someone who is HIV positive.

Important differences have been registered between respondents from the urban area (34.2%) and rural area (20.4%) where there have been registered the lowest value of the intergrated knowledge indicator on HIV transmission.

Limitations:

- There is no data available for the left bank of Dniester River (*see Annex*).

²² Family Health International, Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV. Family Health International, 200

Table 19 Correct answers to questions on the knowledge on HIV/AIDS transmission among respondents in the 15-24 years age group, absolute figures and %, Republic of Moldova (right bank of Dniester River), 2006

Questions	Male						Female						Total					
	15-19 years		20 – 24 years		total		15-19 years		20 – 24 years		total		15-19 years		20 – 24 years		total	
	number	%	number	%	number	%	number	%	number	%	number	%	number	%	number	%	number	%
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	186	63.3	146	67.3	332	65.0	270	64.4	175	67.3	445	65.5	456	64.0	321	67.3	777	65.3
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	186	63.3	156	71.9	342	67.0	259	61.8	185	71.1	444	65.4	445	62.4	341	71.5	786	66.1
Can a healthy-looking person have HIV?	190	64.6	167	76.9	357	67.0	289	69.0	199	76.5	488	71.9	479	67.2	366	76.7	845	71.0
Can a person get HIV by sharing food with someone who is infected?	156	53.1	145	66.8	301	59.0	222	53.0	163	62.7	385	56.7	378	53.0	308	64.6	686	57.6
Integrated indicator	66	22.4	67	30.9	133	26.0	99	23.6	81	31.1	180	26.5	165	23.1	148	31.0	313	26.3

Source: „Knowledge, attitudes and practices among youth related to HIV/AIDS” , 2006

Education and Information in MARPS

See Intervention sin MARPS

Indicator nr 14 Percentage of MARPs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Injecting Drug Users

Data source: The data for this indicator have been collected within the framework of the Behaviour and Sentinel Surveillance Survey (BSS) among MARPs, Moldova 2007 (*unpublished report*) conducted in 2007 among IDUs– beneficiaries of the Harm Reduction Programmes (*see Annex 4*).

Method of calculation:

The data collection tool has been developed based on the Guidelines for Repeated Behavioral Survey in Population at Risk for HIV²³. The questionnaire for interviewing of IDUs has been selected from the Guide.

The set of questions and the respective answers that served as basis for the calculation of the present indicator have been the following there have been formulated 4 out of the 5 questions recommended by *Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators. 2008 Reporting (UNAIDS 2007)*. The questionnaire missed the questions on misconceptions “Can a person get HIV from mosquito bites?” which has been replaced by a question pertaining to the regional context “Can a person get HIV by using bathroom with someone who is infected?”

The set of the questions that have been used for the calculation of the integrated indicator of knowledge on HIV transmission in the questionnaire have been formulated as follows:

1. Can a person reduce the risk of getting HIV by using a condom every time they have sex?
2. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV by sharing food with someone who is infected?
5. Can a person get HIV by using bathroom with someone who is infected?

Numerator: Number of respondents who gave the correct answer to all 5 questions

Denominator: Number of all respondents of the study. The respondents that never heard of HIV and of AIDS have not been included in the denominator.

Results:

The distribution by sex and age of the respondents with correct answers to all 5 questions and the values of the integrated indicator are shown in Table 20.

The integrated knowledge indicator for youth on the HIV transmission ways scores 64.4%. According to the intergrated knowledge on the HIV transmission indicator calculated for IDUs respondents under the age of 25 have less knowledge (60.7%) on the HIV transmission than IDUs in the age group 25+ (67.9%) regardless the sex. The lowest rate of correct answers has been registered for the question on the use of the common bathroom.

²³ Family Health International, Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV. Family Health International, 200

Table 20 Correct answers to questions on the knowledge on HIV/AIDS transmission among IDUs beneficiaries of Harm Reduction Programmes, absolute figures and %, Republic of Moldova, 2007

	All Injecting Drug Users	Males	Females	<25	25+
Indicator Value : Correct answer to all five questions (Percent)	64.44%	63.98%	66.17%	60.71%	67.87%
Numerator : Number of respondents who gave the correct answers to all questions	406	318	88	102	302
Denominator : Number of respondents who gave answers, including "don't know", to all questions	630	497	133	168	445
	All Injecting Drug Users	Males	Females	<25	25+
Correct answer to question 1, can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? (Percent)	89.84%	89.74%	90.23%	85.71%	91.91%
Numerator : Number of respondents who gave correct answer to question 1	566	446	120	144	409
Denominator : Number of respondents who gave answers, including "don't know", to question 1	630	497	133	168	445
	All Injecting Drug Users	Males	Females	<25	25+
Correct answer to question 2, can a person reduce the risk of getting HIV by using a condom every time they have sex? (Percent)	93.65%	94.37%	90.98%	94.05%	94.61%
Numerator : Number of respondents who gave correct answer to question 2	590	469	121	158	421
Denominator : Number of respondents who gave answers, including "don't know", to question 2	630	497	133	168	445

	All Injecting Drug Users	Males	Females	<25	25+
Correct answer to question 3, can a healthy-looking person have HIV? (Percent)	87.46%	87.53%	87.22%	86.31%	89.66%
Numerator : Number of respondents who gave correct answer to question 3	551	435	116	145	399
Denominator : Number of respondents who gave answers, including "don't know", to question 3	630	497	133	168	445

	All Injecting Drug Users	Males	Females	<25	25+
Correct answer to question 4, can a person get HIV using the same bathroom with someone who is infected?	81.27%	81.29%	81.20%	79.76%	82.92%
Numerator : Number of respondents who gave correct answer to question 4	512	404	108	134	369
Denominator : Number of respondents who gave answers, including "don't know", to question 4	630	497	133	168	445

	All Injecting Drug Users	Males	Females	<25	25+
Correct answer to question 5, can a person get HIV by sharing food with someone who is infected? (or country specific question) (Percent)	85.40%	85.51%	84.96%	83.33%	87.64%
Numerator : Number of respondents who gave correct answer to question 5	538	425	113	140	390
Denominator : Number of respondents who gave answers, including "don't know", to question 5	630	497	133	168	445

Source: "Behavioural and Sentinel Surveillance Survey among MARPs, Moldova 2007", 2007

The registered high level of knowledge is explained by the fact that the target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes.

Limitations:

- The target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes and cannot be extrapolated for the entire population of injecting drugs users.
- The staff and volunteers of the Harm Reduction Programmes have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.

Comercial Sex Workers (Female Sex Workers)

Data source: The data for this indicator have been collected within the framework of the Behavioural and Sentinel Surveillance Survey (BSS) among MARPs, Moldova 2007 (*unpublished report*) conducted in 2007 among FSWs– beneficiaries of the Harm Reduction Programmes (see Annex 5).

Method of calculation:

The data collection tool has been developed based on the Guidelines for Repeated Behavioral Survey in Population at Risk for HIV²⁴. The questionnaire for interviewing of FSWs has been selected from the Guide.

The set of questions and the respective answers that served as basis for the calculation of the present indicator have been the following there have been formulated 4 out of the 5 questions recommended by *Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators. 2008 Reporting (UNAIDS 2007)*. The questionnaire missed the questions on misconceptions “Can a person get HIV from mosquito bites?” which has been replaced by a question pertaining to the regional context “Can a person get HIV by using bathroom with someone who is infected?”

The set of the questions that have been used for the calculation of the integrated indicator of knowledge on HIV transmission in the questionnaire have been formulated as follows:

1. Can a person reduce the risk of getting HIV by using a condom every time they have sex?
2. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV by sharing food with someone who is infected?
5. Can a person get HIV by using bathroom with someone who is infected?

Numerator: Number of respondents who gave the correct answer to all 5 questions

Denominator: Number of all respondents of the study. The respondents that never heard of HIV and of AIDS have not been included in the denominator.

Results:

The distribution by age of the respondents with correct answers to all 5 questions and the values of the integrated indicator are shown in Table 21.

²⁴ Family Health International, Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV. Family Health International, 200

Table 21 Correct answers to questions on the knowledge on HIV/AIDS transmission among FSWs beneficiaries of Harm Reduction Programmes, absolute figures and %, Republic of Moldova (right bank of Dniester River), 2007

	All Sex Workers	Males	Females	<25	25+
Indicator Value : Correct answer to all five questions (Percent)	57.69%	0.00%	57.69%	59.60%	63.42%
Numerator : Number of respondents who gave the correct answers to all questions	285	0	285	118	163
Denominator : Number of respondents who gave answers, including "don't know", to all questions	494	0	494	198	257

	All Sex Workers	Males	Females	<25	25+
Correct answer to question 1, can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? (Percent)	89.47%	0.00%	89.47%	92.93%	90.27%
Numerator : Number of respondents who gave correct answer to question 1	442	0	442	184	232
Denominator : Number of respondents who gave answers, including "don't know", to question 1	494	0	494	198	257

	All Sex Workers	Males	Females	<25	25+
Correct answer to question 2, can a person reduce the risk of getting HIV by using a condom every time they have sex? (Percent)	93.93%	0.00%	93.93%	95.96%	96.50%
Numerator : Number of respondents who gave correct answer to question 2	464	0	464	190	248
Denominator : Number of respondents who gave answers, including "don't know".	494	0	494	198	257

	All Sex Workers	Males	Females	<25	25+
Correct answer to question 3, can a healthy-looking person have HIV? (Percent)	81.98%	0.00%	81.98%	78.79%	87.55%
Numerator : Number of respondents who gave correct answer to question 3	405	0	405	156	225
Denominator : Number of respondents who gave answers, including "don't know", to question 3	494	0	494	198	257
	All Sex Workers	Males	Females	<25	25+
Correct answer to question 4, can a person get HIV using the same bathroom with someone who is infected?	83.60%	0.00%	83.60%	91.92%	86.38%
Numerator : Number of respondents who gave correct answer to question 4	413	0	413	182	222
Denominator : Number of respondents who gave answers, including "don't know", to question 4	494	0	494	198	257
	All Sex Workers	Males	Females	<25	25+
Correct answer to question 5, an a person get HIV by sharing food with someone who is infected? (or country specific question) (Percent)	78.34%	0.00%	78.34%	79.80%	85.21%
Numerator : Number of respondents who gave correct answer to question 5	387	0	387	158	219
Denominator : Number of respondents who gave answers, including "don't know", to question 5	494	0	494	198	257

Source: "Behavioural and Sentinel Surveillance Survey among MARPs, Moldova 2007", 2007

The registered high level of knowledge is explained by the fact that the target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes.

Limitations:

- The target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes and cannot be extrapolated for the entire population of FSWs.
- The staff and volunteers of the Harm Reduction Programmes have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.

Men having Sex with Men

Data source: The data for this indicator have been collected within the framework of the Behavioural and Sentinel Surveillance Survey (BSS) among MARPs, Moldova 2007 (*unpublished report*) conducted in 2007 among MSM – beneficiaries of the Harm Reduction Programmes (see Annex 6).

Method of calculation:

The data collection tool has been developed based on the Guidelines for Repeated Behavioral Survey in Population at Risk for HIV²⁵. The questionnaire for interviewing of MSM has been selected from the Guide.

The set of questions and the respective answers that served as basis for the calculation of the present indicator have been the following there have been formulated 4 out of the 5 questions recommended by *Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators. 2008 Reporting (UNAIDS 2007)*. The questionnaire missed the questions on misconceptions “Can a person get HIV from mosquito bites?” which has been replaced by a question pertaining to the regional context “Can a person get HIV by using bathroom with someone who is infected?”

The set of the questions that have been used for the calculation of the integrated indicator of knowledge on HIV transmission in the questionnaire have been formulated as follows:

1. Can a person reduce the risk of getting HIV by using a condom every time they have sex?
2. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV by sharing food with someone who is infected?
5. Can a person get HIV by using bathroom with someone who is infected?

Numerator: Number of respondents who gave the correct answer to all 5 questions

Denominator: Number of all respondents of the study. The respondents that never heard of HIV and of AIDS have not been included in the denominator.

Results:

The distribution by sex and age of the respondents with correct answers to all 5 questions and the values of the integrated indicator are shown in Table 22.

²⁵ Family Health International, Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV. Family Health International, 200

Table 22 Correct answers to questions on the knowledge on HIV/AIDS transmission among MSM beneficiaries of Harm Reduction Programmes, absolute figures and %, Republic of Moldova (right bank of Dniester River), 2007

	All Men Who have Sex with Men	<25	25+
Indicator Value : Correct answer to all five questions (Percent)	46.81%	45.95%	46.30%
Numerator : Number of respondents who gave the correct answers to all questions	44	17	25
Denominator : Number of respondents who gave answers, including "don't know", to all questions	94	37	54
	All Men Who have Sex with Men	<25	25+
Correct answer to question 1, can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? (Percent)	71.28%	64.86%	74.07%
Numerator : Number of respondents who gave correct answer to question 1	67	24	40
Denominator : Number of respondents who gave answers, including "don't know", to question 1	94	37	54
	All Men Who have Sex with Men	<25	25+
Correct answer to question 2, can a person reduce the risk of getting HIV by using a condom every time they have sex? (Percent)	77.66%	72.97%	79.63%
Numerator : Number of respondents who gave correct answer to question 2	73	27	43
Denominator : Number of respondents who gave answers, including "don't know", to question 2	94	37	54
	All Men Who have Sex with Men	<25	25+
Correct answer to question 3, can a healthy-looking person have HIV? (Percent)	82.98%	78.38%	85.19%
Numerator : Number of respondents who gave correct answer to question 3	78	29	46
Denominator : Number of respondents who gave answers, including "don't know", to question 3	94	37	54

	All Men Who have Sex with Men	<25	25+
Correct answer to question 4, can a person get HIV using the same bathroom with someone who is infected? (Percent)	68.09%	70.27%	64.81%
Numerator : Number of respondents who gave correct answer to question 4	64	26	35
Denominator : Number of respondents who gave answers, including "don't know", to question 4	94	37	54
	All Men Who have Sex with Men	<25	25+
Correct answer to question 5, an a person get HIV by sharing food with someone who is infected? (or country specific question) (Percent)	75.53%	83.78%	70.37%
Numerator : Number of respondents who gave correct answer to question 5	71	31	38
Denominator : Number of respondents who gave answers, including "don't know", to question 5	94	37	54

Source: “Behavioural and Sentinel Surveillance Survey among MARPs, Moldova 2007”, 2007

The registred high level of knowledge is explained by the fact that the target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes.

Limitations:

- The target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes and cannot be extrapolated for the entire population of MSM.
- The staff and volunteers of the Harm Reduction Programmes have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.

Indicator nr 15 Pencetange of young women and men aged 15 – 24 who have had sexual intercourse before the age of 15

Data source: The data for this indicator have been collected within the framework of the household survey conducted in 2006 among youth on the right bank of Dniester River (*Scutelnicuic et al. 2006*) (see Annex 3).

Method of calculation:

The data collection tool has been developed based on the Guidelines for Repeated Behavioral Survey in Population at Risk for HIV²⁶. The questionnaire for interviewing of adult population in the age group of 15-49 has been selected from the Guide. The questionnaire has been selected based on the argument that 11.5% (*Scutelnicuic et al. 2006*) of the population of 15-24 years old are married or live in civil marriages.

The question that has been used for the calculation of the indicator has been formulated as follows:

1. “How old were you when you had your first sexual intercourse?”

Numerator: The number of respondents aged 15-24 who related that they had their sexual debut before the age of 15.

Denominator: The number of respondents within the age of 15-24.

Results:

The distribution by sex and age of the respondents reported the first sexual intercourse before 15th is presented in Table 23.

Table 23 Distribution by gender and age of 15 – 24 years old respondents who stated that they had their first sexual intercourse before age of 15th, Republic of Moldova (right bank of Dniester River), 2006

		Males		Females		Total	
		Number	%	Number	%	Number	%
15-19 years	numerator	22	7.5%	2	0.5%	24	3.4%
	denominator	294		419		713	
20-24 years	numerator	17	7.8%	2	0.8%	19	4.0%
	denominator	217		260		477	
Total	numerator	39	7.6%	4	0.6%	43	3.6%
	denominator	511		679		1190	

Source: „Knowledge, attitudes and practices among youth related to HIV/AIDS”, 2006

Out of all study respondents, 3.6% related that they had the first sexual intercourse before the age of 15th. The value of this indicator is dependent on the sex of the respondent. In this way, male respondents had their sexual debut before the age of 15 more frequently (7.6%) than female respondents (0.6%).

Limitations:

- The small number of these respondents (43) is a limitation of the detailed analysis of results disaggregated by sex and age.
- There is no data available for the left bank of Dniester River (see Annex 3).

Indicator nr 16 Percentage of women and men aged 15 – 49 who have had sexual intercourse with more than one partner in the last 12 months

Data source:

The data for this indicator have been collected within the framework of the operational research in the general population in 2007²⁷ (*PHH 2007*) – household survey (see Annex 2). For the purpose of the present report the database of the study was used where there have been extracted the sub-

²⁶ Family Health International, Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV. Family Health International, 200

²⁷ The study “ Knowledge, Attitudes and Practices of the Population of the Republic of Moldova on Viral Hepatitis B and C and Voluntarily Counselling and Testing to HIV and Hepatitis” has been developed within the framework of the Project “Prevention of HIV/AIDS and Viral Hepatitis B and C” financed by USAID

sample of 15-49 years (908) respondents and analysed based on the recommendations of *Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators. 2008 Reporting (UNAIDS 2007)*. The demographic structure of the sub-sample is represented in Table 4.

Method of calculation:

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

1. “How many sexual partners have you had in the last 12 months?” and one of the answers was “More than one”.

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

Denominator: The number of respondents within the age of 15-49.

Results:

Distribution by sex and age of the respondents who have had more than one sexual partner in the last 12 months (calculated as numerator) in absolute and relative figures (%) is presented in the Tabel 24.

Table 24 Distribution by gender and age of 15 – 49 years old respondents who stated that they had more than one partner during the last 12 months, Republic of Moldova (right bank of Dniester River), 2007

		Male		Female		Total	
		Number	%	Number	%	Number	%
15-19 years	numerator	18	20.2%	2	2.2%	20	11.1%
	denominator	89		91		180	
20-24 years	numerator	23	31.9%	3	4.5%	26	18.7%
	denominator	72		67		139	
25-49 years	numerator	24	9.4%	5	1.5%	29	4.9%
	denominator	255		334		589	
Total	numerator	65	15.6%	10	2.0%	75	8.3%
	denominator	416		492		908	

Source: „Knowledge, attitudes and practices on Viral Hepatitis B and C and Voluntary Counselling and Testing for HIV and Viral Hepatitis in the general population of Moldova”, 2007

Out of 908 respondents aged 15-49, 8.3% have had more than one sexual partner in the last 12 months. Male respondents more frequently have had more than one sexual partner in the last 12 months in all age groups (15.6%) than female respondents (2.0%). Depending on the age group, the greatest number comprised respondents within the age of 20-24 who related that they have had more than one sexual partner (18.7%), both for men (31.9%) and women (4.5%).

Limitations:

- The small number of these respondents (65) is a limitation of the detailed analysis of results disaggregated by sex and age.
- There is no data available for the left bank of Dniester River (see Annex 2).

Indicator nr 17 Percentage of women and men aged 15-49 who had more than one partner in the last 12 months reporting the use of consom during their last intercourse

Data source:

The data for this indicator have been collected within the framework of the operational research in the general population in 2007²⁸ (PHH 2007) – household survey (see Annex 2). For the purpose of the present report the database of the study was used where there have been extracted the sub-sample of 15-49 years (908) respondents and analysed based on the recommendations of *Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core*

²⁸ The study “ Knowledge, Attitudes and Practices of the Population of the Republic of Moldova on Viral Hepatitis B and C and Voluntarily Counselling and Testing to HIV and Hepatitis” has been developed within the framework of the Project “Prevention of HIV/AIDS and Viral Hepatitis B and C” financed by USAID

indicators. 2008 Reporting (UNAIDS 2007). The demographic structure of the sub-sample is represented in Table 4.

Method of calculation:

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

1. How many sexual partners have you had in the last 12 months?" and one of the answers was "More than one".
2. "Did you use a condom during the last sexual intercourse?"

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

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

Results:

Distribution by sex and age of the respondents who have had more than one sexual partner in the last 12 months and who used a condom during the last sexual intercourse (calculated as numerator) in absolute and relative figures (%) is presented in Table 25.

Table 25 Distribution by gender and age of 15 – 49 years old respondents who stated that they had more than one partner during the last 12 months and used condom during the last sexual intercourse, Republic of Moldova (right bank of Dniester River), 2007

		Male		Female		Total	
		Number	%	Number	%	Number	%
15-19 years	numerator	9	50.0	0	0.0	9	45.0
	denominator	18		2		20	
20-24 years	numerator	10	43.5	3	100	13	50.0
	denominator	23		3		26	
25-49 years	numerator	12	50.0	3	60.0	15	51.7
	denominator	24		5		29	
Total	numerator	31	47.7	6	60.0	37	49.3
	denominator	65		10		75	

Source: „Knowledge, attitudes and practices on Viral Hepatitis B and C and Voluntary Counselling and Testing for HIV and Viral Hepatitis in the general population of Moldova”, 2007

Of the respondents who had more than one sexual partner in the last 12 months, 49.3% used a condom during the last sexual intercourse. The small number of respondents who related that they have had more than one sexual partner in the last 12 months (75) and used a condom during their last sexual intercourse (37), constitutes a limitation for the detailed analysis of results in the disaggregation by sex and age.

Limitations:

- The small number of these respondents (31) is a limitation of the detailed analysis of results disaggregated by sex and age.

Indicator nr 18 Percentage of female and male sex workers reporting the use of a condom with their most recent client

Data source: The data for this indicator have been collected within the framework of the Behavioural and Sentinel Surveillance Survey (BSS) among MARPs, Moldova 2007 (*unpublished report*) conducted in 2007 among FSWs – beneficiaries of the Harm Reduction Programmes (see Annex 5).

Method of calculation:

The data collection tool has been developed based on the Guidelines for Repeated Behavioral Survey in Population at Risk for HIV²⁹. The questionnaire for interviewing of FSWs has been selected from the Guide.

In the data collection tool questions were formulated in the following way:

1. "Did the client you had the last sexual intercourse with use a condom?"

²⁹ Family Health International, Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV. Family Health International, 200

Numerator: The number of respondents who used a condom during their last commercial sexual intercourse.

Denominator: The number of respondents who had commercial sex in the last 12 months.

Data are available only for Female Sex Workers.

Results:

Thus, 93.3% of respondents used a condom during their last commercial sexual intercourse.

Distribution by age group of the respondents who had sexual intercourses and who used a condom during their last sexual intercourse with a FSW is presented in Table 26.

Table 26 Distribution by age of the respondents who used a condom during their last sexual intercourse, absolute figures%, FSWs – beneficiaries of Harm Reduction Programmes, the Republic of Moldova, (the right bank of the Dniester River), 2007

	All Sex Workers	Males	Females	<25	25+
Indicator Value : Percentage of female and male sex workers reporting the use of a condom with their most recent client (Percent)	93.32%	0.00%	93.32%	97.47%	96.11%
Numerator : Number of respondents who reported that a condom was used with their last client in the last 12 months	461	0	461	193	247
Denominator : Number of respondents who reported having commercial sex in the last 12 months	494	0	494	198	257

Source: “Behavioural and Sentinel Surveillance Survey among MARPs, Moldova 2007”, 2007

Limitations:

- The target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes and cannot be extrapolated for the entire population of FSWs.
- The staff and volunteers of the Harm Reduction Programmes have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.

Indicator nr 19 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Data source: The data for this indicator have been collected within the framework of the Behavioural and Sentinel Surveillance Survey (BSS) among MARPs, Moldova 2007 (*unpublished report*) conducted in 2007 among MSM – beneficiaries of the Harm Reduction Programmes (see Annex 6).

Method of calculation:

The data collection tool has been developed based on the Guidelines for Repeated Behavioral Survey in Population at Risk for HIV³⁰. The questionnaire for interviewing of MSM has been selected from the Guide.

The final sample was analysed according to the recommendations from *Monitoring the Declaration of Commitment on HIV/AIDS, Guidelines on Construction of Core Indicators. 2008 Reporting (UNAIDS 2007)*

³⁰ Family Health International, Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV. Family Health International, 200

In the data collection tool questions were formulated in the following way:

1. "Did you have anal sex with a man in the last 6 months?"
2. "Did you use a condom the last time you had anal sex with a man?"

Numerator: The number of respondents who had anal sex with during the last 6 months and used a condom during the last anal sexual intercourse with a man.

Denominator: The number of respondents who had anal sex with men during the last 6 months.

Results:

Distribution by age of the respondents who had anal sex during the last 6 months and who used a condom during the last anal sexual intercourse with a man is presented in Table 27.

Table 27 Distribution by age of the respondents who had anal sex with men during the last 6 months and used a condom during the last anal sex a man, absolute figures and %, MSM – beneficiaries of Harm Reduction Programmes, Republic of Moldova (right bank of Dniester River), 2007

	All Men Who Have Sex With Men	<25	25+
Indicator Value : Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (Percent)	48.10%	34.48%	54.17%
Numerator : Number of respondents who reported that a condom was used the last time they had anal sex	38	10	26
Denominator : Number of respondents who reported having had anal sex with a male partner in the last six months	79	29	48

Source: "Behavioural and Sentinel Surveillance Survey among MARPs, Moldova 2007", 2007

Limitations:

- The target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes and cannot be extrapolated for the entire population of MSM.
- The staff and volunteers of the Harm Reduction Programmes have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.

Indicator nr 20 Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse

Data source: The data for this indicator have been collected within the framework of the Behavioural and Sentinel Surveillance Survey (BSS) among MARPs, Moldova 2007 (*unpublished report*) conducted in 2007 among IDUs – beneficiaries of the Harm Reduction Programmes (see Annex 4) .

Method of calculation:

The data collection tool has been developed based on the Guidelines for Repeated Behavioral Survey in Population at Risk for HIV³¹. The questionnaire for interviewing of IDUs has been selected from the Guide.

The set of questions and answers on the basis of which calculations were made for the indicator given in the study questionnaire was presented in the following way:

1. "When was the last time you used injecting drugs?" with the following answers: today/ during the last 7 weeks/ during the last 30 days.
2. "How many times you had sexual intercourses with your partner in the last 30 days?"
 - a. Husband/wife uring the last 30 days" (>0 and <88 (NA)) or
 - b. permanent during the last 30 days" (>0 and <88 (NA)) or
 - c. occasional during the last 30 days" (>0 and <88 (NA)) or

³¹ Family Health International, Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV. Family Health International, 200

d. commercial during the last 30 days” (>0 and <88 (NA))

3. “Did you use a condom during your last sexual intercourse?”

Thus, the set of questions and answers have been adjusted to the recommendations of *Monitoring the Declaration of Commitment on HIV/AIDS, Guidelines on Construction of Core Indicators. 2008 Reporting (UNAIDS 2007)*.

Numerator: The number of respondents, who used injecting drugs during the last month, had sexual intercourses during the last month and used a condom during the last sexual intercourse.

Denominator: The number of respondents who used injecting drugs during the last month and had sexual intercourses during the last month.

Results:

Distribution by sex and age of the respondents is presented in Table 28.

Table 28 Distribution by sex and age of the respondents who used injecting drugs during the last month, had sexual intercourses during the last month and used a condom during their last sexual intercourse, absolute figures and %, IDU – beneficiaries of Harm Reduction, Republic of Moldova, 2007

	All	Males	Females	<25	25+
Indicator Value : Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse (Percent)	67.85%	72.63%	51.82%	75.56%	65.01%
Numerator : Number of respondents who reported that a condom was used the last time they had sex	325	268	57	102	223
Denominator : Number of respondents who report having had sexual intercourse in the last month	479	369	110	135	343

Source: “Behavioural and Sentinel Surveillance Survey among MARPs, Moldova 2007”, 2007

Limitations:

- The target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes and cannot be extrapolated for the entire population of IDUs.
- The staff and volunteers of the Harm Reduction Programmes have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.

Indicator nr 21 Percentage of injecting drug users reporting the use of steril injecting equipment the last time they injected

Data source: The data for this indicator have been collected within the framework of the Behavioural and Sentinel Surveillance Survey (BSS) among MARPs, Moldova 2007 (*unpublished report*) conducted in 2007 among IDUs – beneficiaries of the Harm Reduction Programmes (see Annex 4).

Method of calculation:

The data collection tool has been developed based on the Guidelines for Repeated Behavioral Survey in Population at Risk for HIV³². The questionnaire for interviewing of IDUs has been selected from the Guide.

The set of questions and answers on the basis of which calculations were made for the indicator given in the study questionnaire was presented in the following way:

1. "When was the last time you used injecting drugs?" with the following answers:
today/ during the last 7 weeks/ during the last 30 days.
2. "Did you use sterile equipment the last time you injected?"

Thus, the set of questions and answers has been adjusted to the recommendations of *Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting (UNAIDS 2007)*.

Numerator: The number of respondents, who used injecting drugs during the last month and used sterile equipment the last time they injected.

Denominator: The number of respondents who used injecting drugs during the last month.

Results:

Distribution by sex and age of the respondents is presented in Table 29.

Table 29 Distribution by sex and age of the respondents who used injecting drugs during the last month, and used sterile equipment the last time they injected, absolute figures and %, IDU – beneficiaries of Harm Reduction Programmes, Republic of Moldova, 2007

	All Injecting Drug Users	Males	Females	<25	25+
Indicator Value : Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected (Percent)	95.88%	96.12%	95.00%	94.67%	97.20%
Numerator : Number of respondents who report using sterile injecting equipment the last time they injected drugs	535	421	114	142	382
Denominator : Number of respondents who report injecting drugs in the last month	558	438	120	150	393

Source: "Behavioural and Sentinel Surveillance Survey among MARPs, Moldova 2007", 2007

The registered high level of use of steril injecting equipment is explained by the fact that the target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes.

Limitations:

- The target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes and cannot be extrapolated for the entire population of IDUs.
- The staff and volunteers of the Harm Reduction Programmes have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.

³² Family Health International, Behavior Surveillance Surveys: Guidelines for Repeated Behavioral Survey in Population at Risk for HIV. Family Health International, 200

Impact indicators

Indicator nr 22 Percentage of young people aged 15 – 24 who are HIV infected

Not relevant for the country

Indicator nr 23 Percentage of MARPs who are HIV-infected

Injecting Drug Users

Data source: The data for this indicator have been collected within the framework of the Behavioural and Sentinel Surveillance Survey (BSS) among MARPs, Moldova 2007 (*unpublished report*) conducted in 2007 among IDUs – beneficiaries of the Harm Reduction Programmes (see Annex 4).

Sentinel surveillance among IDUs was performed using the method of anonymous unlinked blood testing. Samples of blood were tested for antibodies to HIV, viral hepatitis B and C and syphilis.

According to the requirements of *Monitoring the Declaration of Commitment on HIV/AIDS, Guidelines on Construction of Core Indicators, 2008 Reporting (UNAIDS 2007)*, reporting is required for the capital city of the country only. Into CRIS only data for the capital city were entered.

Method of calculation:

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

Denominator: The number of tested blood samples.

Results:

Distribution by sex and age of the tested samples is presented in Table 30 for the capital city only.

Table 30 Distribution by sex and age of HIV positive blood samples, absolute figures, IDU – beneficiaries of Harm Reduction Programmes, capital city of the Republic of Moldova, 2007

	All Injecting Drug Users	Males	Females	<25	25+
Indicator Value : Percentage of most-at-risk populations who are HIV-infected (Percent)	17.49%	17.27%	18.18%	6.90%	22.40%
Numerator: Number of members of the most-at-risk population who test positive for HIV.	32	24	8	4	28
Denominator: Number of members of the most-at-risk population tested for HIV.	183	139	44	58	125

Source: “Behavioural and Sentinel Surveillance Survey among MARPs, Moldova 2007”, 2007

Commercial Sex Workers (Female Sex Workers)

Data source: The data for this indicator have been collected within the framework of the Behavioural and Sentinel Surveillance Survey (BSS) among MARPs, Moldova 2007 (*unpublished report*) conducted in 2007 among FSWs – beneficiaries of the Harm Reduction Programmes (see Annex 5).

Sentinel surveillance among IDUs was performed using the method of anonymous unlinked blood testing. Samples of blood were tested for antibodies to HIV, viral hepatitis B and C and syphilis.

According to the requirements of *Monitoring the Declaration of Commitment on HIV/AIDS, Guidelines on Construction of Core Indicators, 2008 Reporting (UNAIDS 2007)*, reporting is

required for the capital city of the country only. Into CRIS only data for the capital city were entered. Only females entered into the sample size.

Method of calculation:

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

Denominator: The number of tested blood samples.

Results:

Distribution by age of the tested samples is presented in Table 31 for the capital city only.

Table 31 Distribution by age of HIV tested blood samples, absolute figures, FSWs – beneficiaries of Harm Reduction Programmes, capital city of the Republic of Moldova, 2007

	All Sex Workers	Males	Females	<25	25+
Indicator Value : Percentage of most-at-risk populations who are HIV-infected (Percent)	2.88%	0.00%	2.88%	2.00%	3.50%
Numerator: Number of members of the most-at-risk population who test positive for HIV.	7	0	7	2	5
Denominator: Number of members of the most-at-risk population tested for HIV.	243	0	243	100	143

Source: “Behavioural and Sentinel Surveillance Survey among MARPs, Moldova 2007”, 2007

Men having Sex with Men

Data source: The data for this indicator have been collected within the framework of the Behavioural and Sentinel Surveillance Survey (BSS) among MARPs, Moldova 2007 (*unpublished report*) conducted in 2007 among FSWs – beneficiaries of the Harm Reduction Programmes (see Annex 6).

Sentinel surveillance among IDUs intended to be performed using the method of anonymous unlinked blood testing. Due to implementation problems, the link between the questionnaire code and the sample code was lost. Thus, there is no possibility for desegregation by age group. Samples of blood were tested for antibodies to HIV, viral hepatitis B and C and syphilis.

According to the requirements of *Monitoring the Declaration of Commitment on HIV/AIDS, Guidelines on Construction of Core Indicators, 2008 Reporting (UNAIDS 2007)*, reporting is required for the capital city of the country only. The survey was conducted in the capital city only.

Method of calculation:

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

Denominator: The number of tested blood samples.

Table 32 Distribution by age of HIV tested blood samples, absolute figures, MSM – beneficiaries of Harm Reduction Programmes, capital city of the Republic of Moldova, 2007

	All	<25	25+
Indicator Value : Percentage of most-at-risk populations who are HIV-infected (Percent)	4.82%	missing%	missing%
Numerator: Number of members of the most-at-risk population who test positive for HIV.	4	missing	missing
Denominator: Number of members of the most-at-risk population tested for HIV.	83	missing	missing

Source: “Behavioural and Sentinel Surveillance Survey among MARPs, Moldova 2007”, 2007

Indicator nr 24 Percentage of adults and children with HIV known to be on treatment after initiation of antiretroviral therapy

Data source: ART patient registers and databases,

At the facility level, the number of adults and children on antiretroviral therapy at 12 months includes patients who have transferred in at any point from initiation of treatment to the end of the 12-month period and excludes patients who have transferred out during this same period to reflect the net current cohort at each facility. In other words, at the facility level, patients who have transferred out will not be counted either in the numerator or the denominator. Similarly, patients who have transferred in will be counted in both the numerator and denominator. The net current cohort (the patients whose outcomes the facility is currently responsible for recording—the number of patients in the start-up group plus any transfers in, minus any transfers out) at 12 months should equal the number in the start-up cohort group 12 months prior.

Method of calculation:

Numerator: Number of adults and children who are still alive and on ART at 12 months after initiating treatment.

Denominator: Total number of adults and children who initiated ART who were expected to achieve 12-month outcomes within the reporting period, including those who have died since starting ART, those who have stopped ART, and those recorded as lost to follow-up at month 12.

Table 33 Percentage of adults and children with HIV known to be on treatment after initiation of antiretroviral therapy, Republic of Moldova, 2007

<i>Numerator</i>				
All	Sex		Age	
	Males	Females	<15	15+
105	54	51	7	98
<i>Denominator</i>				
All	Sex		Age	
	Males	Females	<15	15+
121	66	55	8	113
<i>Indicator value, 2007</i>				
All	Sex		Age	
	Males	Females	<15	15+
86.8%	81.8%	92.7%	87.5%	86.7%

Source: Republican Dermatovenereal Dispensary, Ministry of Health

Results:

- The number of persons who have been benefiting from ART is considerably increasing during the 2006-2007 timeframe. In fact it has almost doubled from 262 HIV/AIDS cases reported by 2006 to 464 people still in HAART by 2007. Only 2 children starting getting HAART in 2006 (drop out 0 per cent), with 5 more children starting HAART in 2007 (drop out around 12 per cent), tallying up to 19 children in HAART by 2007. Overall, the adherence rates are relatively high in all age categories (around 87 per cent) and by sex (82 per cent for men and 93 per cent for women) in 2007; and
- One could notice that the ratio of people still in HAART after a year to those who started the treatment is increasing: 88 still in therapy out of 109 starting HAART in 2006 (80.73 per cent), and 105 to 121 respectively in 2007 (86.7 per cent), thus denoting improving trends in adherence to HAART, due in part to improved access to treatment and care, and better work on adherence at the national level.

Data collection sources, description

Annex 1 Route Method

In the context of migration (both internal and external) of the population in the Republic of Moldova, the State Register of the Population can't be used as basis to constitute the Probabilistic Studies Sample in the general population (the risk of the substitution rate which is increasing and can affect the study representativeness).

The "Routes Method" is used as a solution for study sampling within the general population and is considered a randomized and quasiprobabilistic one. As a result of the stratification procedures (regions, localities) and of the randomized selection within the layers, in each selected locality the necessary number of routes to follow is established depending on the number of questionnaires distributed per locality. Households in which the interview is going to be held are selected by means of the technique called "the aleatory route", on the basis of the statistic step. In the selected households, the person requested to interview is one that belongs to the target group. In case there are many persons, than the person responsible for the interview becomes the one whose birthday is the closest one to the date of the interview. One of the limitations of this type of sampling is the exclusion of the students' hostels from the calculation of the statistic step.

Annex 2 Study on Knowledge, Attitudes and Practices of the population on Viral Hepatitis V and C and Voluntary Counselling and Testing on HIV and Viral Hepatitis

Type of research: quatitative research, household survey.

Target group: General population aged 15-65 who live permanently on the territory of the Republic of Moldova (the right bank of the Dniester River³³).

Sample size: 1300 respondents.

Sampling method: stratified, multistaged, quasiprobabilistic – “the routes method” (see Annex 1).

Data collection period: 6-28 of April, 2007.

Data collection tool: Structured questionnaire. Interviews were held using the “face-to-face” procedure in the respondent’s household.

Representativeness: The sample size is considered as being representative for the general population of the Republic of Moldova comprising the age groups 15-65, that live on the territory of the Republic of Moldova (the right bank of the river Nistru). The estimated sampling error is $\pm 3\%$. Results were weighted according to the officially statistic structure of the population by sex, including the distribution by sex of people who went abroad. The difference between weighted data and those which were not weighted reaches the maximum of 0.9%.

Demogrphic structure of the sample size:

Table 34 Distribution by age group

Age group	Rate in the sample size
15 – 19 years	14%
20 – 24 years	11%
25 – 29 years	8%
30 – 39 years	17%
40 – 49 years	20%
50 – 59 years	21%
60 – 65 years	9%

Table 35 Distribution by residency area

	Rate in the sample size
Urban	41%
Rural	59%

Table 36 Distribution by gender

	Rate in the sample size
Males	46%
Females	54%

³³As a result of the frozen conflict on the Dniester River (1991 - 1992), the territory of the Republic of Moldova is divided in the territory on the right bank and territory on the left bank (Transnistria) of the Dniester River.

Limitations:

- The use of „routes’ method” – a quasiprobabilistic method of respondent selection that excludes from the study the students’ hostels (see “*routes method*”).
- There is no data available for the population living on the left bank of the Dniester River.

Annex 3 Study on Knowledge, attitudes and practices among youth related to HIV/AIDS

Type of research: quantitative research, household survey.

Target group: youth of 15 - 24 years old who live permanently on the territory of the Republic of Moldova (the right bank of the Dniester River³⁴).

Sample size: 1190 respondents.

Sampling method: stratified, multistaged, quasiprobabilistic – “the routes method” (see Annex 1).

Data collection period: 15-31 of July, 2006.

Data collection tool: Structured questionnaire. Interviews were held using the “face-to-face” procedure in the respondent’s household.

Representativeness: The sample size is considered as being representative for the youth population of the Republic of Moldova comprising the age groups 15-24, that live on the territory of the Republic of Moldova (the right bank of the Dniester River). The estimated sampling error is $\pm 3\%$.

Demographic structure of the sample size:

Table 37 Demographic structure of the sample size, 2006

	Males		Females		Total	
	Number	%	Number	%	Number	%
15-19 years	294	57.5%	419	61.7%	713	60%
20-24 years	217	42.5%	260	38.3%	477	40%
Total	511	42.9%	679	57.1%	1190	100,0%

Limitations:

- The use of „routes’ method” – a quasiprobabilistic method of respondent selection that excludes from the study the students’ hostels (see Annex 1).
- There is no data available for the youth living on the left bank of the Dniester River.

³⁴As a result of the frozen conflict on the Dniester River (1991 - 1992), the territory of the Republic of Moldova is divided in the territory on the right bank and territory on the left bank (Transnistria) of the Dniester River.

Annex 4 Behavioural and Sentinel Surveillance Survey among IDUs

Type of research: repeated³⁵, multicentric, cross-sectional, questionnaire based and combined with qualitative testing on the presence of antibodies to HIV, VHC, VHB, and syphilis.

Target group: Injecting Drug Users (IDUs) - beneficiaries of Harm Reduction Programmes living on the territory of the Republic of Moldova.

Sample size: 630 respondents.

Sampling method: probabilistic sampling and a two-stage cluster sampling design. The Primary Sampling Unit (PSU) resulted from grouping IDUs that contact with a programme unit: a syringe exchange point (SEP), an outreach worker, a consultant or a volunteer. The codified list of beneficiaries per each Primary Sampling Unit (PSU) served as a sampling frame. The sampling was systematic and proportional to the cluster size, ensuring the sample selfweighting. A fixed number of respondents per cluster have been attempted.

Data collection period: April – Mai 2007.

Data collection tool: Structured questionnaire. Interviews were held using the “face-to-face” procedure in the projects implementation locations or in medical institutions where the drawing of blood samples took place.

Sentinel surveillance among IDUs was performed using the method of anonymous unlinked blood testing. Samples of blood were tested for antibodies to HIV, viral hepatitis B and C and syphilis.

Representativeness: considered representative for the IDUs beneficiaries of Harm Reduction Programmes. After calculating the sample size, on the basis of the formulas established by Family Health International (FHI) and the reported 2005 UNGASS indicator values, there was a need to involve a sample of at least 600 respondents for level of significance of 95%, a power of study of 90% and a sensitivity to detect a 15% increase.

Demographic structure of the sample size:

Table 38 Demographic structure of the sample size, IDUs beneficiaries of Harm Reduction Programmes, Republic of Moldova, 2007

	Males		Females		Total	
	Number	%	Number	%	Number	%
< 25 years	135	27,2	33	24,8	168	26,7
25 + years	346	69,6	99	74,4	445	70,6
Missing age	16	3.2	1	0.8	17	2.7
Total	497	78.9%	133	21.1%	630	100,0%

Source: “Behavioural and Sentinel Surveillance Survey among MARPs, Moldova 2007”, 2007

Limitations:

- The target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes and cannot be extrapolated for the entire population of IDUs.
- The staff and volunteers of the Harm Reduction Programmes have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.

³⁵ The last survey has been conducted in 2003 – 2004 among IDUs who were beneficiaries fo Harm Reduction Programmes.

Annex 5 Behavioural and Sentinel Surveillance Survey among CSWs

Type of research: repeated³⁶, multicentric (5 centres), crosssectional, questionnaire based and combined with qualitative testing on the presence of antibodies to HIV, VHC, VHB, and syphilis..

Target group: Comercial Sex Workers (CSWs) - beneficiaries of Harm Reduction Programmes living on the territory of the Republic of Moldova.

Sample size: 494 respondents.

Sampling method: The probabilistic sampling was not possible. All target group representatives, who accepted to participate in the study, were included in the study.

Data collection period: Mai – June, 2007.

Data collection tool: Structured questionnaire. Interviews were held using the “face-to-face” procedure in the projects implementation locations or in medical institutions where the drawing of blood samples took place.

Representativeness: After calculating the sample size, on the basis of the formulas established by Family Health International (FHI) and the reported 2005 UNGASS indicator values, there was a need to involve a sample of at least 370 respondents for level of significance of 95%, a power of study of 90% and a sensitivity to detect a 15% increase. Due to the non probabilistic sampling method (“take all”), the sample is not considered representative for the FSWs, beneficiaries of Harm Reduction Programmes.

Demographic structure of the sample size:

Table 39 Demographic structure of the sample size, FSWs beneficiaries of Harm Reduction Programmes, Republic of Moldova, 2007

	Total	
	Number	%
< 25 years	198	40.1
25 + years	257	52.0
Missing age	39	7.9
Total	494	

Source: “Behavioural and Sentinel Surveillance Survey among MARPs, Moldova 2007”, 2007

Limitations:

- The target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes and cannot be extrapolated for the entire population of CSWs.
- The staff and volunteers of the Harm Reduction Programmes have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.

³⁶ Previous survey has been conducted in 2003 – 2004 among FSWs who were beneficiaries fo Harm Reduction Programmes.

Annex 6 Behavioural and Sentinel Surveillance Survey among MSM

Source:

Type of research: repeated³⁷, unicentric (capital city), crosssectional, questionnaire based and combined with qualitative testing on the presence of antibodies to HIV, VHC, VHB, and syphilis..

Target group: Men having Sex with Men (MSM) - beneficiaries of Harm Reduction Programmes living on the territory of the Republic of Moldova.

Sample size: 94 respondents.

Sampling method: The probabilistic sampling was not possible. All target group representatives, who accepted to participate in the study, were included in the study.

Data collection period: July – November, 2007.

Data collection tool: Structured questionnaire. Interviews were held using the “face-to-face” procedure in the projects implementation locations or in medical institutions where the drawing of blood samples took place.

Representativitatea: After calculating the sample size, on the basis of the formulas established by Family Health International (FHI) and the reported 2005 UNGASS indicator values, there was a need to involve a sample of at least 370 respondents for level of significance of 95%, a power of study of 90% and a sensitivity to detect a 15% increase. Due to the non probabilistic sampling method (“take all”) and small sampli size, the sample is not considered representative for the MSM, beneficiaries of Harm Reduction Programmes.

Demographic structure of the sample:

Table 40 Demographic structure of the sample size, MSM beneficiaries of Harm Reduction Programmes, Republic of Moldova, 2007

	Total	
	Num	%
< 25 years	37	39.4
25 + years	54	57.4
Missing age	3	3.2
Total	94	100

Source: “Behavioural and Sentinel Surveillance Survey among MARPs, Moldova 2007”, 2007

Limitations:

- The target group of the research is constituted exclusively from beneficiaries of the Harm Reduction Programmes and cannot be extrapolated for the entire population of MSM.
- The staff and volunteers of the Harm Reduction Programmes have been recruited as interviewers which could have inspired the respondents to provide desired answers to the questions which reflect the prevention activity of the projects.

³⁷ Previous survey has been conducte din 2003 – 2004 among IDUS who were beneficiaries fo Harm Reduction Programmes.

Best practices

By adopting the “Three Ones” Principle and upon the start of the GFATM grant implementation in 2003, the Country Coordination Mechanism became the main mechanism of coordinating the implementation of National Programmes on Prevention and Control of HIV/AIDS/STIs and Tuberculosis. The members of this coordination mechanism are representatives of central public authorities, donor representatives, and representatives from the non-governmental sector that work in this domain. In the Republic of Moldova, this mechanism proved to be functional and allows consolidation of national and international efforts to achieve the objectives of the National Programmes.

The Republic of Moldova is known as being an example of best practice in successful implementation of Harm Reduction Programmes among MARPs both in the public sector (IDUs, CSWs, MSM) and in the penitentiary one (IDUs). Starting from 1997, the implementation of Harm Reduction Programmes had three phases, which resulted in 2007 in the implementation of 17 projects with Harm Reduction Activities in 22 administrative territories which have had as target groups IDUs, 5 projects which have had as target groups CSWs in 5 administrative territories and a project for MSM in 2 administrative territories. The implementation of the Harm Reduction Strategy comprises the activities of information/education/outreach, needle exchange, referral towards medical and social services and methadone substitution therapy both in the public sector and in the penitentiary one. The description for the implementation of Prevention Programmes in MARPs is represented in the compartment for Programme Indicators.

The implementation and strengthening of one national Monitoring and Evaluation System serves as an example of best practices. By creating the Monitoring and Evaluation Unit within the framework of a public structure responsible for health information, providing of capacity building, success was registered in data collection and standardization. Data quality is one of the results following the efforts made by national and international organizations. Within the VI Round Grant of the GFTAM, the Monitoring and Evaluation Unit was designed as responsible for data collection the M&E of the GFTAM grant. The GFTAM is the most important donor in the national HIV/AIDS response and the involvement of the M&E Unit in data collection will facilitate the establishment of national reporting mechanisms which were previously absent and the consolidation of the existent ones. Republic of Moldova has been selected as a secondary data collection country and was granted to implement activities for data quality improvement, thus strengthening the national M&E system (*see Monitoring and Evaluation*).

Major challenges and remedial actions

Legal and policy frameworks related to HIV/AIDS in Moldova are generally strong. During the reporting period, new achievements were registered. The National Health Policy approved by the Parliament in 2007 developed wide objectives, one of them specifically targeting the control of infectious diseases, which clearly focuses on strictly preventing the transmission of HIV/AIDS/STIs, enhancing Government commitment related to the disease prevention and ensuring access to medical, social, psychological and juridical services for HIV infected persons. In order to inform population about HIV/AIDS/STI prevention, capacities will be built and the information activities targeted to general population, youth and vulnerable groups will be scaled up. A new comprehensive Law on HIV/AIDS has been developed and approved in Parliament in 2007, addressing gaps in previous legislation, and strengthening human-rights protections for PLWHA. The National Programme on Prevention and Control of HIV/AIDS/STI 2006-2010 highlights steps and activities to be undertaken in a period of five years to respond in a more effective and targeted manner to the epidemic.

In 2007, the Government of Moldova contributed with 26.8% to the spending on national AIDS response. The National Coordination Council in HIV/AIDS has managed to ensure some financial sustainability of HIV/AIDS interventions by developing a rolling-out from donors' strategy and by introducing such activities as VCT and palliative care under the National Health Insurance Fund. Additionally, with support from donors the Ministry of Health is planning to implement the National Health Accounts, including National AIDS Spending Accounts into the health system for a better monitoring of expenditures against results.

Despite the efforts, the current National Response to AIDS are not adequate to have an impact on the epidemic.

Comparing with the previous reporting there is an increase in the awareness among the driver of the epidemic - IDUs (the integrated indicator is about 66% in 2006 vs 38% in 2004, beneficiaries of Harm Reduction Programmes) and a quite high reported safe injecting practices (about 95.9%, used steril syringes at last injection, beneficiaries of Harm Reduction Programmes). The prevalence among IDUs is high without signs of stability (21% in 2007 versus 17% in 2004). The level of registered awareness among young people is quite low (26.3% in 2006) comparing with the target (95% by 2010) and didn't register any progress in the last 2 years.

A WHO Euro assessment on need for HAART and HIV care made at the request of the Government of Moldova found serious constraints in treatment. The treatment rates are quite high with increasing numbers of PLHA in HAART. However, patients have dropped out of treatment due to poor compliance and low adherence to treatment regimens. Knowledge about ARV is poor amongst PLWHA and in mainstream population alike. Stigma against IDUs and PLWHA adds an additional disincentive. Palliative care for the people living with HIV/AIDS is scarce.

The Transdnistria (left bank of the Dniester River), the separatist region is not part of the majority of prevention activities scheduled by the Moldovan Government under the National AIDS Programme. Activities aimed at IDUs such as methadone substitution treatment, Harm Reduction and ARV treatment are not duly present for the population of Transdnistria (left bank of the Dniester River). During the last year, the collaboration with the Transdnistrian authorities to scale up the HIV prevention on the left bank of Dniester River registered progresses.

Support from the country's development partners

Increased contributions to HIV/AIDS efforts by government is essential, if unlikely in the short term given the realities of Moldova's economic situation. International donors such as the World Bank, GFATM contribute the largest share of funds, and Moldovan NGOs remain "unsustainable", supported almost exclusively by contributions of international donors. Additional funds have been committed by USAID, Swedish SIDA, Soros Foundation. Donors funding remains extremely important for financing the National Programme on Prevention and Control of HIV/AIDS/STIs for the next 5 to 10 years. External money in the National Programme on Prevention and Control of HIV/AIDS/STIs make about 74% of all AIDS spending in 2007. This money are used for prevention activities among vulnerable populations implemented by NGOs, among youth, because existing arrangements are not supported from the state budget, as well as for ARV treatment provided to PLWHA. Following the application to the GFATM round VI, Republic of Moldova was granted for 2008 – 2012 period to increase the universal access to prevention, treatment, care and support as a help to achieve the objectives of the National Programme on Prevention and Control of HIV/AIDS/STIs.

Funds alone will not be enough in dealing with many direct and interrelated challenges. There is a need to strengthen the national National Programme on Prevention and Control of HIV/AIDS/STIs, which in turn will need to help strengthen the administrative capacities of national organizations and foster the partnerships between the government and NGOs. Technical assistance and capacity building is one of the key components in achieving the program's goals, as is advocacy to mobilize political leadership.

Monitoring and Evaluation

Following the approval of the recommendations of the Washington Conference organized by the UNAIDS and the main donors in HIV/AIDS from April 25, 2004, regarding the necessity to implement “The Three Ones” Principle, the M&E Unit as part of the National Centre of Health Management of the Ministry of Health of the Republic of Moldova represents the only monitoring and evaluation mechanism at the country level. The M&E unit is in charge to elaborate the M&E plan for the National Programmes on Prevention and Control of TB and HIV/AIDS/STIs for 2006-2010.

The Government of the Republic of Moldova established a fruitful collaboration with representatives of international organizations (GFATM, the World Bank, and UNAIDS), endorsed the concept of a comprehensive national Monitoring and Evaluation System (M&E) and recognized its advantages and importance over separate systems addressing the monitoring needs of each major initiative. The Government established a multi-stakeholder technical M&E Working Group (TWG) within the framework of the one National Authority, Country Coordination Mechanism for TB and HIV/AIDS/STIs national responses.

Activities of this structure are oriented in two main directions:

1. Improvement of the quality of collected data and of information flows in the routine statistics;
2. Improvement of national capacities and acquisition of experience in implementing operational research.

In order to improve the routine statistics data, with the support of the World Bank, the GFTAM and UNAIDS a new software was developed for HIV cases reporting and treatment follow-up. A separate module was developed STIs cases reporting. Following the selection of the Republic of Moldova for participation at the 5 year Evaluation of the GFTAM, from the Grant offered for strengthening the National M&E System, the retrospective data entry of reported HIV cases started (approximately 4000 cases). As the data entry and validation were not finished for the current indicator reporting, data were actively collected from available registers. Within the framework of the GFTAM Grant, Round VI, starting from January 1, 2008 the M&E Unit is responsible for the M&E of the GFTAM Grant. The application for Round VI was developed in 2006 within the objectives of the National Programmes for HIV/AIDS/STIs Prevention and Control. The set of indicators for the M&E application was developed according to the M&E National Plan. The involvement of this unit in the M&E of the GFTAM Grant, Round VI allows strengthening of data collection mechanism in other activities than those stipulated in the GFTAM grant as well. This fact increases the visibility and functionality of the M&E Unit and creates premises for its durability.

In 2006-2007, the M&E Unit was involved in developing behavioural studies in general population, in young people and in MARPs. In the case of studies in the general population and youth, the M&E Unit standardized the key-questions from the questionnaires to generate the indicators mentioned in the current report. In the case of the Behavioural and HIV Sentinel Surveillance Study (Moldova, 2007), conducted among MARPs (IDU, CSWs, MSM) and vulnerable groups (truck drivers, prisoners), the M&E Unit coordinated its implementation. This study was developed by using the local technical expertise. The data collection was made by representatives of NGOs who develop Harm Reduction activities in the country. The successful interaction between the M&E Unit (public structure) and NGOs within the framework of this study creates favourable premises for a future collaboration in terms of data collection. The M&E Unit tends to perfect the expenses for the components of the M&E System by reducing overlapping of data collection generated by various stakeholders and the involvement of various recourses for covering the areas in which there is deficiency of information. In the process of implementation, extension and strengthening of the national M&E System, four major deficient areas were identified, and their improvement would intensify the comprehensiveness, coherence and durability of this system.

The first area of major deficiency is the inter-sector reporting. The lack of some institutionalized routine reporting mechanisms has a negative impact. The involvement of the M&E Unit in the process of data collection for the GFTAM grant, Round VI from all sub-recipients and grant beneficiaries would bring some improvements. Within this framework the inter-sector reporting mechanisms would be defined and improved. An additional development of software applications

would facilitate the inter-sector reporting would also increase the attractiveness and system comprehensiveness.

The second deficient area is the financial support to the M&E System. The difficulty is that the proper functioning of the national M&E System depends much on the international recourses. In the case of routine statistic data there are institutional mechanisms and a collection system, while in the case of operational research the situation is unstable. Although the operational researches for M&E of the National Programme are approved by the Ministry of Health, unfortunately their implementation is not financed with the help of public sources. This fact encumbers the durability of data collection by means of operational researches which are crucial in measuring the impact.

The third deficient area is the national technical expertise. The gaps existing at the moment in the research design, especially referring to the MARPs and in the interpretation of results is obvious. A solution to overcome these gaps would be the combination of qualitative trainings offered both at the international and local levels, practicing implementation exercises by means of external partnership project development.

The fourth deficient area is the interpretation of the national data results from many sources (triangulation). The best solutions to overcome these gaps would be organizing trainings, implementing external partnership project development, and improving the data dissemination.

Obviously, the present M&E System needs a continuous support in extending the coverage and in consolidating the existent results.

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Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1. Which institutions/entities were responsible for filling out the indicator forms?

- | | |
|----------------------|-----|
| a) NAC or equivalent | Yes |
| b) NAP | Yes |
| c) Others | Yes |

National TB Program, National Centre of Blood Transfusion,
National Centre of Health Management

2. Which inputs from

Ministries:

Education Yes

Health Yes

Labour No

Foreign Affairs No

Others (please specify) Yes

Ministry of Defense, Ministry of Justice

Civil society organizations Yes

People living with HIV Yes

Private sector No

United Nations organizations Yes

Bilaterals Yes

International NGOs Yes

Others (please specify) No

3. Was the report discussed in a large forum? Yes

4. Are the survey results stored centrally? Yes

5. Are data available for public consultation? Yes

6. Who is the person responsible for submission of the report
and for follow-up if there are questions on the Country Progress Report?

Name / title: Otilia Scutelnicuic,
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National Composite Policy Index