UNGASS COUNTRY PROGRESS REPORT

Romania

Reporting period: January 2006–December 2007

Submission date: 31 January 2008

Table of Contents

	Abbreviations	page 2
I.	Status at a glance	page 3
II.	Overview of the AIDS epidemic	page 5
III.	National response to the AIDS epidemic	page 6
IV.	Best practices	page 15
V.	Major challenges and remedial actions	page 15
VI.	Support from the country's development partners	page 16
VII.	Monitoring and evaluation environment	page 17

Abbreviations

ARAS	–Romanian Association against AIDS, NGO
ARV	– Anti Retroviral Treatment
BSS	– Behavioural Surveillance Survey
CDC	– Center for Diseases Control
CRIS	– Country Response Information System
GFATM	– Global Fund Fighting AIDS, Tuberculosis and Malaria
HIV	– Human Immunodeficiency Virus
HBV/HCV	– Hepatitis B/C
IDUs	– Injecting Drug Users
IEC	– Information Education Communication
ILO	– International Labour Organization
KAP	– Knowledge, Attitude and Practices
M&E	– Monitoring and Evaluation
MoH	– Ministry of Health
MSM	– Men having sex with men
NAD	– (National Anti Drug Agency), GOV
NGO	– Non-governmental Organization
PLHIV	– People Living with HIV
PMTCT	– Prevention of Mother-to-Child Transmission
PR	– Principal Recipient
PSI	– Population Services International, NGO
RAA	– Romanian Angel Appeal, NGO
TB	–Tuberculosis
STI	– Sexually Transmitted Diseases
SWs	–Sex Workers
UN	– United Nations
UNICEF	– United Nations Children's Fund
UNGASS	– United Nations General Assembly on HIV/AIDS
UNODC	–United Nations Office for Drug and Crime
UNOPA	– National Union of PLHIV Association
VCT	– Voluntary Counselling and Testing

I. Status at a glance

The national report was developed through a highly transparent process, equal access being granted to governmental institutions, NGOs and other stakeholders. First consultations were initiated in September 2007 within the M&E Working Group on HIV/AIDS (group that includes representatives of Government, NGOs, UN Agencies, Academia and PRs of the 2 GFTAM projects currently implemented in Romania totaling 15 institutions represented). The M&E working Group is facilitated by UNAIDS Office and includes all the relevant stakeholders with attributions and capacity of data collection in the area of HIV/AIDS. The group was developed as a technical working group in support of the M&E activities of the National HIV/AIDS Commission. Members of the M&E group had 3 consecutive meetings in the period September – December 2007 dedicated to review the new reporting format, the available data and solutions for collecting together all the data needed for reporting. Also in September 2007 the UNGASS reporting format was sent to all the relevant institutions (government, NGOs, international agencies) involved in the implementation and data collection for the National HIV/AIDS Programme (over 25 institutions). The M&E working group mandated a smaller group to collect all the information and prepare the first draft of the report. This first draft was presented in the consensus meeting organized in 28 January 2008 and was consolidated with all the comments and suggestions coming from the 35 institutions invited to this meeting.

The HIV/AIDS situation in Romania remains stable with no major changes in incidence. Level of epidemic is low and there is no sign of concentration among vulnerable groups despite high-risk behavior identified among them. Romania has a large group of adolescents living with HIV/AIDS, over 7,000, which are in fact the children infected in the period 1987 – 1991. They are long time survivors. Although their treatment and care is ensured, programs have still to be developed to ensure their social integration, access to education and jobs and to reduce stigma and discrimination they are facing.
Romania has committed in its strategies to provide universal access to prevention, treatment and care. While the access to treatment and social support can be considered universal the access to prevention especially for vulnerable groups is still limited.
The coordination and partnership of all national and international partners involved in the national response works well, based on the current national strategy and facilitated by National Multi-sectoral HIV/AIDS Commission and Country Coordination Mechanism established for GFTAM projects.

UNGASS 08 - Summary Report - Romania

Code	Indicator	Status
Government HIV and AIDS Policies		

1	AIDS Spending	Completed	213047568.0000
National Programme Indicators			
3	Blood Safety	Completed	100.00%
4	HIV Treatment: Antiretroviral Therapy - 2006	Completed	100.00%
4	HIV Treatment: Antiretroviral Therapy - 2007	Completed	100.00%
5	Prevention of Mother-to-Child Transmission - 2006	Completed	97.40%
5	Prevention of Mother-to-Child Transmission - 2007	Completed	97.14%
6	Co-Management of Tuberculosis and HIV Treatment	Completed	No data available
7	HIV Testing in the General Population	Completed	No data available
8	HIV Testing in Most-at-Risk Populations - Sex Workers	Completed	35.44%
8	HIV Testing in Most-at-Risk Populations - Men Who have Sex with Men	Completed	46.88%
8	HIV Testing in Most-at-Risk Populations - Injecting Drug Users	Completed	15.94%
9	Most-at-risk Populations: Prevention Programmes - Sex Workers	Completed	No data available
9	Most-at-risk Populations: Prevention Programmes - Men Who have Sex with Men	Completed	58.59%
9	Most-at-risk Populations: Prevention Programmes - Injecting Drug Users	Completed	No data available
10	Support for Children Affected by HIV and AIDS	Completed	Not relevant
11	Life Skills-based HIV Education in Schools	Completed	63.66%
11	Life Skills-based HIV Education in Schools	Completed	Missing
Knowledge and Behaviour Indicators			
12	Orphans: School Attendance	Completed	Not relevant
13	Young People: Knowledge about HIV Prevention	Completed	Missing
14	Most-at-risk Populations: Knowledge about HIV Prevention - Sex Workers	Completed	13.92%
14	Most-at-risk Populations: Knowledge about HIV Prevention - Men Who have Sex with Men	Completed	45.31%
14	Most-at-risk Populations: Knowledge about HIV Prevention - Injecting Drug Users	Completed	29.80%
15	Sex Before the Age of 15	Completed	10.30%
16	Higher-risk Sex	Completed	No data available
17	Condom Use During Higher-risk Sex	Completed	No data available
18	Sex Workers: Condom Use	Completed	85.06%
19	Men Who Have Sex with Men: Condom Use	Completed	72.66%
20	Injecting Drug Users: Condom Use	Completed	Missing
21	Injecting Drug Users: Safe Injecting Practices	Completed	27.60%
Impact Indicators			
22	Reduction in HIV Prevalence	Completed	No data available
23	Most-at-risk Populations: Reducation in HIV Prevalence - Sex Workers	Completed	No data available
23	Most-at-risk Populations: Reducation in HIV Prevalence - Men Who have Sex with Men	Completed	No data available
23	Most-at-risk Populations: Reducation in HIV Prevalence - Injecting Drug Users	Completed	No data available
24	HIV Treatment: Survival After 12 Months on Antiretroviral Therapy	Completed	No data available

II. Overview of the AIDS epidemic

Romania is one of the few countries in Central and South-Eastern Europe with a significant number of people affected by HIV/AIDS. According to the National Report of the HIV/AIDS Monitoring and Evaluation Department in Romania, by the end of 2006, a cumulative total of 16,877 cases of HIV infection had been recorded. Of these, 10,264 people were registered with AIDS.
The incidence of HIV/AIDS (the number of cases discovered annually in relation to the population) reduced in Romania starting from 2004. At the level of year 2006, the situation of HIV/AIDS in Romania did not suffer significant changes as concerns the incidence.

Year	2005	2006	2007 (first 6 months)
No of new cases of HIV diagnosed	490	391	141

For HIV/AIDS prevalence/incidence trends please see the table bellow[1]:

	2004	2005	2006
AIDS prevalence (per 100.000)	42.7	45.4	47.5
AIDS incidence among children (per 100.000)	1.91	0.64	0.35
AIDS incidence among adults (per 100.000)	1.57	1.62	1.14
HIV prevalence (per 100.000)	28.65	29.7	30.6
HIV incidence among adults (per 100.000)	1.51	1.12	0.94

From MoH HIV/AIDS Commission data results that over 50% of the newly discovered HIV cases in 2006 are among young persons aged 15 to 29. Sexual transmission is prevalent (over 78% of the newly discovered HIV cases), followed by vertical transmission, increasing in 2005 and 2006 and exceeding 5%, while transmission associated with drugs consumption stays under 2%. The increase in the vertical transmission determined the need to scale up counselling and testing services for pregnant women in the 2004-2006.

The sexual transmission of HIV continues to lead the epidemic among adults, this data being confirmed by corroboration with the annually high incidence rates for syphilis. Injecting drug use comes also as a major risk factor especially for the capital city Bucharest were it is estimated that 1% of the population is injecting heroin. In Bucharest, 73% of the heroin injectors used non-sterile injecting equipment during the last injection and over 90% injected with used needle within the last month according to the 2004 BSS Study on drug use in Romania.

[1] Data provided by the HIV/AIDS Evaluation Dept of the Ministry of Health.

III. National response to the AIDS epidemic

The Romanian Parliament adopted in 2002 a special law (Law no. 584/2002) regarding the HIV/AIDS prevention and main protection measures for PLHIV.
In the reporting period the National Response to HIV/AIDS was governed by the National HIV/AIDS Strategy covering the period 2004-2007. The main objective of this strategy was to maintain the HIV incidence for 2007 at the level registered in 2002 while ensuring the universal access to treatment, care and social services for infected and affected people.
The main target groups foreseen by the National HIV/AIDS Strategy are young people, IDUs, female SWs, MSM, prisoners, children living on the street/in institutions, pregnant women, PLHIV. The strategy had an M&E framework including targets and foresaw an interim evaluation (conducted in 2006), without having a detailed budget of programmatic costs. The strategy was developed and monitored in consultation with all the stakeholders (GOV, NGOs, private companies, bilateral and multilateral development partners).
The National Multisectoral HIV/AIDS Commission over viewing the implementation of the National HIV/AIDS strategy was transferred during 2007 from the Government Secretariat to the MoH, due to government restructuring. It includes all governmental authorities with specific roles in the implementation of the strategy (among which Ministry of Health, Ministry of Education, Ministry of Labour, Ministry of Interior, Ministry of Defence, Ministry of Justice, Ministry of Finance), as well as civil society and PLHIV representatives.
During 2007 different consultations and specific working groups were organized for the preparation of the new HIV/AIDS strategy that will cover the 2008-2013 period.

Prevention efforts were diversified and significantly scaled up in the last 2 years, mainly with international financial support provided by GFATM and UN Agencies. Some of the areas like prevention of transmission among young people, PMTCT, uniformed services and prisoners developed or extended in the framework of the GFATM Round 2 programme[2] (2004-2008) have reached significant scale and became national. Concern is related to the sustainability of these programs that are now overtaken by the different ministries that should provide adequate funding, continuous training of personnel and expand them further. Further advocacy and capacity building initiatives are needed in order to maintain and integrated the HIV prevention services in the national health and social services infrastructure.
Other interventions like prevention among vulnerable groups and rroma population have expanded but not reached significant scale. An important contribution to the scaling–up and increased sustainability of programs will be provided by the interventions foreseen in the framework of the GFATM Round 6 program (2007-2009)[3] and of UNODC 5 year program aiming to reach 35% coverage of HIV prevention program among IDUs and prisoners by 2010[4]. Thus at the end of 2007, less than 25% of the population of drug users in Bucharest had access to drug services (including needle and syringe exchange and substitution treatment). When it comes to drug treatment, services are even more limited and sometimes inaccessible, but important steps have been made in 2007 by the development of four new substitution centers as public –private partnerships (involving Prof Matei Bals Infectious

[2] Total funds disbursed as far US$ 25,519,696.

[3] Approved funding for the first phase US$ 9,400,906.

[4] Total budget US$ 3,000,000.

Diseases Institute, National AntiDrug Agency and NGOs) and the introduction of buprenorphine beside methadone. All interventions were developed with technical and financial support of UNODC. In the same year (2007) needle exchange programs (NSPs) were expanded to new locations, beside capital city Bucharest.
A very important step forward was the signature in December 2007 of a memorandum of understanding between the National Administration of Penitentiaries (Ministry of Justice) and UNODC that will allow the implementation of pilot methadone and needles exchange programmes in prisons (condom distribution and HIV prevention, IEC peer programs already in place).
Programs targeting most at risk population have a very important outreach component, a 3 year UNICEF program addressing most at risk adolescents.
STI prevention is part of the Health Education curricula taught in the Romanian schools (see above) for teens classes/grades.
Moreover, NGOs implementing the GFATM financed HIV Program, developed during last 3 years in and out-school IEC activities aiming to disseminate knowledge on STI prevention. Apart civilians, such IEC sessions did reach as well military young students from National Defence and Ministry of Interior units.
Very little was made regarding HIV workplace programs, such interventions being foreseen for the next years (especially as the strategy will promote PLHIV professional integration). ILO's best practice code regarding HIV/AIDS and workplace was translated in Romanian and disseminated in 2007.
Government commitment in prevention programmes, especially those addressing most at risks groups is still low and should increase, as well as local authorities funding for programs specifically addressing community needs. Special working groups at local level are foreseen to be developed 10 districts in order to support needs analysis, planning and community mobilization.

Following the 1988-1991 nosocomial transmission, blood safety became a priority for the health system. The data provided by the National Transfusion Hematology Institute indicates that all blood donated units (327.050 in 2006 and 343.159 in 2007) were screened for HIV both through standard internal screening procedures and external quality schemes (BioDev).

Starting 2001 Romania developed a Plan for Universal access to Treatment and Care. As a result the number of PLHIV receiving ARV treatment grew each year, universal free access continuing to be ensured through national budget fund allocation (46,134,263 US$ in 2006).

Year	**2003**	**2004**	**2005**	**2006**	**2007 (30/09/2007)**
No of PLHIV receiving ARV treatment	5547	6116	6400	6846	6521

Even if the treatment program registered good results (see the long survival period of the patients) the present structure of the database including epidemiological data on more than 16,000 people ever diagnosed with HIV/AIDS in Romania does not allow the calculation of the *survival after 12 months on antiretroviral therapy*. Currently this database is under reconstruction, the process being foreseen to end this year (2008).

Currently PMTCT interventions cover 18 of the 41 districts of Romania, while HIV testing is included at national level in the antenatal health services package (free of charge, recommended by general practitioners). About 97% of the pregnant women diagnosed with HIV received ARV treatment in the framework of PMTCT services.

PMTCT site	Pregnant women 15-24 yo tested for HIV in 2006*	Diagnosed as HIV+ in 2006 *	Pregnant women 15-24 yo tested for HIV in 2007*	Diagnosed as HIV+ in 2007*
Bacau	916	-	526	2
Brasov	1,283	1	1,084	-
Cluj	420	-	336	-
Constanta	854	3	855	1
Dambovita	992	-	873	1
Dolj	862	-	1,306	1
Galati	1,179	-	598	-
Suceava	754	-	562	-
Timis	647	-	40	-
Braila	553	-	473	-
Deva	387	-	314	-
Olt	1,169	1	1,302	3
Resita	456	-	443	2
Sibiu	1,202	3	661	-
Bihor	499	-	504	-
Prahova	650	2	784	-
Bucuresti (Cantacuzino)	577	1	503	-
Total	8,418	11	11,164	10

*PMTCT Programme monitoring data (Romanian Angel Appeal)

Although Romania is a country with a high incidence of TB, the number of co-infection cases is still low (please see table containing data provided by the Epidemiological surveillance Unit of the National TB Control Program). Starting 1998, HIV testing is routinely performed (with patient consent) for all people diagnosed with TB (MoH order), 8,411 tests being done in 2006 (30 of which resulted positive)[5].

Year	Total TB cases*	PLHIV receiving TB treatment	
		Males	Females
2006**	28,117	44	16
2007***	24,532	101	74

** including new cases, relapses and TB chronic cases*
***monitoring operative data*
**** preliminary data*

VCT services are available in each district of Romania (MoH centers in each district capital city), 18 of the 41 districts having VCT centers with service quality control procedures. The fact that MoH registers only the number of HIV tests performed and the fact that population based surveys did not included questions regarding HIV testing as far (last ones conducted in 2004/2006) resulted in lack of data.
The total number of HIV tests performed in the general population ("on demand", at the VCT centers) in 2006 was of 81.099 HIV tests, of which positive 945. For 2007, the total number of HIV tests performed in the general population (on demand, at the VCT centers) was of 73.155 HIV tests, of which positive test 859. No disagregation on age or sex is reported even if these data are registered at VCT sites.

No investigation was made as far regarding higher risk sex and condom use during higher-risk sex among general population. These indicators will be included in the next Reproductive Health survey that should take place in 2009.

The HIV prevention is included in the health education curricula (32 hours/year) promoted as optional course at all levels of the mandatory education (starting with primary school and ending with high school – 12 grades), specific training programmes being developed for teachers. The program covers currently 4,979 (63.66%) of the 7,821 schools at national level.

[5] Data provided by the Epidemiology Dept of the National Programme for TB Control.

No.	District	National Program „Health Education in the Romanian School” 2006		
		schools	Children targeted by curricular activities	Children targeted by extra-curricular activities
1	**ALBA**	112	4604	16310
2	**ARAD**	105	6444	12540
3	**ARGEŞ**	81	6100	15990
4	**BACĂU**	200	9021	87000
5	**BIHOR**	210	15351	28437
6	**BISTRIȚA-NĂSĂUD**	85	6249	84213
7	**BOTOŞANI**	101	10324	82578
8	**BRAŞOV**	89	8578	19600
9	**BRĂILA**	78	6143	48200
10	**BUZĂU**	74	5527	22700
11	**CARAŞ-SEVERIN**	98	5970	19090
12	**CĂLĂRAŞI**	54	4921	7500
13	**CLUJ**	107	8967	49400
14	**CONSTANȚA**	138	9156	22000
15	**COVASNA**	46	4622	8000
16	**DÂMBOVIȚA**	76	7194	10500
17	**DOLJ**	97	7727	15640
18	**GALAȚI**	99	7982	6500
19	**GIURGIU**	68	4531	15200
20	**GORJ**	170	6483	8750
21	**HARGHITA**	51	3323	15990
22	**HUNEDOARA**	92	8254	22500
23	**IALOMIȚA**	64	8682	8941
24	**IAŞI**	78	8602	106000
25	**ILFOV**	45	4105	9600
26	**MARAMUREŞ**	121	9538	12000
27	**MEHEDINȚI**	148	9653	38500
28	**MUREŞ**	289	8120	22000
29	**NEAMȚ**	46	3544	3450
30	**OLT**	146	14001	17500
31	**PRAHOVA**	198	10237	12700
32	**SATU-MARE**	162	16200	16100
33	**SĂLAJ**	178	10759	12900
34	**SIBIU**	115	8749	48000
35	**SUCEAVA**	220	11356	88000
36	**TELEORMAN**	170	18782	60000
37	**TIMIŞ**	178	9834	27900
38	**TULCEA**	96	11647	11200
39	**VASLUI**	121	10208	17300
40	**VÂLCEA**	122	18893	21170
41	**VRANCEA**	90	12708	13400
42	**BUCUREŞTI**	161	19893	156000
	TOTAL	***4979***	***382,982***	***1,321,299***

Even if almost 100% of young people (both males and females) heard about HIV/AIDS, and recognize the condom as HIV prevention method (82.5%), the very low percentage of respondents who value faithfulness as HIV prevention method results (9.7%) in low scores in UNGASS knowledge indicators. This may be also a result of the fact that programs were concentrated so far on condom promotion.
The risky behaviors of young people (15-24 yo) were investigated in 2006 through a national representative KAP study conducted by the National Institute for Health Research and Development. It revealed that:

- About 10.30% started their sexual life before the age of 15 (17.30% of the men and 3.30 of the women);
- 1 out of 6 people among the targeted group had at least 2 sex partners during the last 3 months;
- 66,2% of the men who are sexually active and 61,4% of the women declared to have used the condom during the first intercourse - an increased in the use of the condom for the first intercourse (2004 data - 58,9% of the men and 52,9% of the women);
- 22,6% of the respondents who have been sexually active during the last 12 months declared to have had casual sex (with partners they just met or commercial sex workers). Out of this percentage of 22,6%, less than a half (46,3%) always used a condom, more than a third (35,8%) used a condom almost every time and 6,8% never used a condom;
- Regarding UNGASS knowledge indicator, 9.2% of the respondents (12.5% of women and 5.8% of the male respondents) know two methods to prevent the HIV infection and 34.7% of the respondents (39.8% women and 29.4% men) correctly reject the three misconceptions. As the study did not make the intersection between the responses to the two prevention methods and the three misconceptions, this is not available in this report.

Most at risk populations
No accurate estimations of most at risk groups are available as far (except total estimated number of injecting drug users in capital city that was of 24,000 in 2006).

Services provided during reporting period to female sex workers were safer sex promotion and STI/HIV transmission prevention, IEC and counseling, primary medical care assistance, referrals to social and medical services. As many SWs and pimps use drugs, they benefited also of the needle exchange programs. At the end of 2006 HIV, HBV and HCV rapid testing among CSW and IDUs was introduced, the testing methodology being based on UNAIDS, WHO, CDC Atlanta. Outreach interventions covered Bucharest, surrounding Ilfov county and other 9 locations (Brasov, Timisoara, Arad, Cluj, Craiova, Iasi, Piatra Neamt, Bacau and Constanta). Programme monitoring data indicates that 2.667 female SWs and clients were targeted in 2006 and 3.016 in the first 3 quarters of 2007.

Services for IDUs were provided in outreach and drop-in centers (information, sterile syringes and health materials, testing for HBV/HCV and HIV, medical and psychological assistance on site and referral to specialized services). Programme monitoring data indicates that 1.254 IDUs were targeted in 2006 and 4.434 in 2007. Secondary exchange conducts to even bigger coverage. GFATM Rd 2 annual report for 2006 registered 460.779 syringes distributed and while 451.091 syringes during the first 3 quarters of 2007.

Outreach activities were developed to target MSM. Those included information, education, communication on STIs and risky behaviors, condom free distribution, counseling, medical referrals and psychological assistance.

Surveys among female SWs indicate high risks related to unprotected sexual practices with paying and non-paying partners, as well as existing interrelation between sex work and injecting drug use. According to the national survey focused on sex work and risk behaviours performed in 2005 by ARAS, National Commission to fight HIV/AIDS (Ministry of Health) and UNAIDS Romania,[6] 36% of female SWs interviewed reported condom use during their last sexual intercourse and only 20% reported regular condom use in 2005. Out of 395 female SWs interviewed, more than 11% injected drugs in 2004 and 2005 and of these almost half (40%) shared injection equipment. Only 35.44% the female SWs from the sample had an HIV test in 2004 and were aware of the results, a slightly higher percentage being register among older ones (41.33% for SWs above 25 yo). The HIV knowledge indicator registered very good scores for the condom (93.92%) and lowest for the mosquito one (30.89%), resulting in an over all score of 13.92% better than the one registered in the general population. Usually better responses are given by older SWs (about 10% differences on all questions). The lack of updated data is motivated by the fact that BSS surveys foreseen to take place among female SWs and IDUs in 2007 were postponed for 2008. These studies will include a sero-prevalence component that will provide for the first time information regarding HIV prevalence among vulnerable groups (the study targeting MSM is foreseen for 2009).

IDUs data are extracted from a special BSS survey conducted by NAD Agency in 2007 (among 333 IDUs clients of prevention and treatment programmes) and a 2004 study conducted among 500 IDUs, also programme clients. The HIV knowledge indicator extracted from the 2007 study registered good scores for the condom (84.28%), even if less if compared to other groups and lowest for the mosquito one (57.28%), resulting in an over all score of 29.8%. Only 27.6% of the 500 IDUs who responded in 2004had used sterile injecting equipment the last time they injected, with females having significantly lower scores (17.43% versus 30.18% for males).

Starting November 2007 a BSS study was developed among MSM[7]. Preliminary data indicate that 46.88% of the respondents made an HIV test in the last 12 months and know the result, against 59.4% in 2005[8]; moreover, 58.59% of the respondents reported to have participated in HIV prevention programs, against 3.1% reported in 2005. The HIV knowledge indicator registered very good scores for the condom (90.63%) and lowest for meal sharing misconception (69.53%), resulting in an over all score of 45.31%, the highest in all at risk groups. Significant differences among age groups is registered in the faithfulness question (80.52% respond correctly among those under 25 and only 68.63% among older MSM). Condom use at last anal sex is of 72.66%, with older MSM (<25 yo) having increased risky behaviour (68.63%) if compared to younger ones (75.32%).The small number of respondents may have introduced some biases.

---

[6] Commercial Sex Work – A public health and social perspective, ARAS, National Commission to fight HIV/AIDS and UNAIDS, 2005

[7] PSI Respondent Driven Survey

[8] Data referred to respondents who took an HIV test in the last 2 years.

The population sub-group of children affected by HIV/AIDS is no longer relevant for Romania, as the compact group of about 7,000 people living with HIV are now in the 15-19 age group, the existing needs being focused on professional integration and social support (4,294 people benefited of social subsidies at 30 September 2007[9]).

Over the last 2 years Romanian authorities maintained the focus and commitment to provide universal access to treatment, care and social support for people living with HIV/AIDS. The country provides treatment to all who is in need, in line with National HIV Treatment Protocol. Within 2006, 8,666 of the PLWHA have accessed a specialized medical service at least once; from them, 79% (6,846) were on antiretroviral (ARV) treatment. Opportunistic infections treatment is ensured as well. Difficulties have been registered in 2006/2007 in treatment monitoring (lack of specific tests).

The social support for PLWHA is foreseen by both Law 584/2002 and Law 448/2006 (regarding the protection of disabled persons). It is mainly linked with the recognition of HIV/AIDS as a disability that entitles the person having a disability certificate to benefit of economic subsidies (nutritional allowance, double subsidy for HIV+ children, as well as other facilities as tax exemption, free transportation for a limited number of trips, etc).

The access of PLHIV to all forms of education is guaranteed by law and tolerance in schools have increased significantly, but past discrimination episodes as well as family over protection resulted in a significant number of drop-outs from school[10]. A study conducted at national level in 2006[11] among 534 YPLHIV (15-19 yo) showed that 24.3% of them only graduated primary school and 48.9% secondary school, while 9% never went to school. About 220 YPLHIV (41,2% of the sample) had already abandoned school.

The professional integration and vocational training/education of YPLHIV aiming to increase PLHIV social integration and autonomy are the objective of present intervention included also in the GFATM Round 6 Programme. Both NGOs and public authorities (district level occupation agencies) are providing counseling, orientation, vocational training and tutoring services, but on a still incipient level. Little is known about the barriers and limitations faced by PLHIV entering on the job market, as well as about best ways to support them. Specific studies will be conducted with this aim in 2008.

The fear of stigma and discrimination, as well as the lack of information limited as far the number of PLHIV that accessed such benefits to about 40% of the eligible ones.

Psycho-social support services are available at national level, public and private providers still having different quality standards. The network of the 18 Day Care Clinics managed currently by the MoH remains the most important service provider (4,007 PLHIV in 2007), beside the social assistance departments of the city halls.

The existing non-discriminatory provisions included in the Constitution and in the Law 48/2002 regarding the prevention and punishment of all discrimination forms, as well as all provision included in other sectoral legislation protect the rights of PLHIV.

Confidentiality is stipulated in all cases and any infringement should be punished.

---

[9] National Authority for Disabled People, Ministry of Labor.

[10] Records of Romanian Angel Appeal Foundation indicated in 2007 that about 30% of their beneficiaries of schooling age were drop-outs or never attended school.

[11] Buzducea, D., 2007, *Riscuri la tineri. Studiu de caz:adolescentii cu HIV/SIDA din Romania*, Editura Universitatii din Bucuresti, Bucuresti. The same study showed that 39.5% of the sample had already started their sexual life with very similar percentages for males (39.3%) and females (39.7%). Only 21.2% of the sample had sexual intercourse in the last 2 months, 12.5% reporting consistent condom use.

The National Council for Combating Discrimination, the Ombudsmen as well as different NGOs may provide legal advice for PLHIV who want to defend their rights.
The National Union of the Association of People affected by HIV/AIDS (UNOPA) releases quarterly monitoring reports on PLHIV rights infringements.
2006 and 2007 were signed by a large mass media campaign targeting the general population developed under the title "Open your heart", which intended to promote anti-discrimination messages and solidarity. The campaign was supported by local activities targeting communities developed by a large number of NGOs both in rural and urban areas.

IV. Best practices

One of the major programmatic gaps identified in the early 2006 evaluation of the implementation of the national HIV/AIDS strategy was the coverage and the funding of the interventions targeting vulnerable groups. Based on this evaluation and with UN technical and financial support, Romania mobilized over US $16 million from GFTAM, UNODC and UNICEF for the period 2007 – 2010. The funds will cover in a great extent the gap in HIV prevention for vulnerable groups. As PR for GFATM Rd 6 programme, RAA established in late 2007 an advocacy group aiming to fight (1) for the sustainability of the HIV programs recently scaled up with international funding and (2) for the integration of the HIV prevention programs in existing governmental infrastructure.

A major step forward in 2007 was, based on the agreement reached with the national partners, the establishment of the Romanian HIV/AIDS Center as a technical facility for improving and strengthening the national response. This Center will also be the entry point of all the UN assistance and will expand to be a technical facility for the benefit of other countries in SE Europe.

V. Major challenges and remedial actions

A key challenge is the strengthening the national coordination mechanisms, as well as the functions of monitoring and evaluation and modernize the public administration programmes in line with the EU standards and requirements. All these mechanisms need to be taken over fully by national institutions. The national effort to develop a well-based strategic document to cover the period 2008 – 2013 accompanied by annual work plans and budgets is a key priority for the future. Research and interventions for vulnerable groups and for the large group of adolescents and young people living with HIV/AIDS have to continue and to be expanded. Young adults living with HIV/AIDS need special programmes and special tailored support for adequate social integration that will guarantee that they will not be the origin of a new epidemic wave. Period 2008 - 2009 is also important for the implementation of the health reform started by the Government in 2006. The issue of stigma and discrimination continues to be a high priority. The successful partnership established in 2005 and 2006 for the national HIV/AIDS Anti-discrimination campaign needs to continue and expand further more.
Also, mainstream youth should be addressed regarding STIs and HIV/AIDS prevention, especially in the context of broader reproductive health and developing life skills and abilities. Thus, lobby to sensitize the decision makers to develop and apply effective and structured national strategies, is to be strategically planned and implemented.

A major policy gap is the one referring to commercial sex and its increasing relation in Romania with trafficking of human beings and drug use. For the moment prostitution is illegal and very closely linked with organized crime. This is a major obstacle in developing and implementing large scale sustainable prevention and access to services programmes.

VI. Support from the country's development partners

In the reporting period Romania witnessed the withdrawal of all the bilateral donors as a consequence of the EU integration. UN presence on HIV/AIDS continued and even expanded in financial terms and started to be focused more and more on prevention among vulnerable groups and on provision of quality technical assistance while building the capacity of the national partners to strengthen and expand in a sustainable manner the response to HIV/AIDS.

VII. Monitoring and evaluation environment

Last National HIV/AIDS Strategy (2004 – 2007) had as one of the operational objectives the establishment of a Joint M&E office to serve the implementation. Due to various reasons, including lack of funding, poor operational capacity at the level of national Multisectoral HIV/AIDS Commission and lack of appropriate intersectoral M&E culture this office was never established.

Special attention was paid to the "**The Three Ones**" objective (**One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners, **One** National AIDS Coordinating Authority, with a broad-based multisectoral mandate, **One** agreed country-level Monitoring and Evaluation System).

Partners took an alternate solution deciding to establish a virtual M&E office and an M&E working group. This office based at the moment within the UNAIDS office provides assistance to the NAC and to all the national partners in the efforts to harmonize and coordinate the M&E activities. All the data and capacity of this virtual office is now in the process to be transferred to the newly established (August 2007) Romanian AIDS Centre. The virtual office centralized with the support of stakeholders all the data available resulted during the implementation of the national strategy, while M&E working group provided technical assistance to different research and advocacy efforts, including research on sex workers, IDUs, prisoners, MSM, young people.

The office facilitated an evaluation of the M&E framework of the National HIV/AIDS Strategy at the following levels:

- indicators definitions,
- targets accomplishment,
- linkage between strategy – activities – indicators,
- Research strategy (typology, schedule, methodology).

The M&E working group on HIV/AIDS mandate is to:

- ensure coordination of data collection, analyses and dissemination of strategic information in the area of HIV/AIDS;
- develop a set of national indicators, harmonized with the international ones and ensure the usage in all the national relevant documents and processes;
- assist the NAC in the process of developing the new National HIV/AIDS Strategy (2008 – 2013);
- assist the capacity building initiatives in the area of M&E;
- maintain the national data base with the HIV/AIDS indicators.

The group includes national partners in all HIV/AIDS program areas, PRs of the 2 Global Fund Projects, experts, and donors.

The Romanian AIDS Centre that is currently taking over the virtual M&E office is established as a partnership between UN, Ministry of Health and NGOs, being hosted by the Institute for Infectious Diseases Matei Bals in Bucharest, the institute that is also hosting the HIV surveillance office of MOH and is coordinating the HIV/AIDS Commission of experts established by MOH. The institute is providing office space and part of the staff for Romanian AIDS Centre. All the M&E information and regular reports will be available on the AIDS Centre web-page, which will also work as a HIV/AIDS resource center.

Next period challenges are related to the development of the estimations for the most at risk groups (CSWs, IDUs and MSM) at national level, as well as introducing seroprevalence surveillance among these groups. By the other hand after having benefited of a NASA

training in December 2007 we are more convinced now that in the view of increasing governmental funding for HIV prevention programmes and in order to ensure accountability, better HIV/AIDS cost estimates should be developed in the next two years.
The GFATM programme definitely increased M&E capacity of both governmental and non-governmental implementers and this advantage should be levered by providing M&E training to all interested stakeholders in order to set the base for a coherent data collection system and allow disagregation of indicators on age groups.
Data collection methodology still needs to be harmonized in order to ensure cross-project/programs/providers comparison, while other programmatic choices such as definition of a minimum package of services are to be made in the next period of time.
M&E technical assistance needs are linked to the development of BSS methodologies and seroprevalence surveys and most vulnerable populations' estimation, as well as for NASA implementation.
Capacity building interventions for the following period should focus on increasing M&E capacity at the level of a large number of implementers, development of specific guidelines for national indicators and dissemination of such guidelines. Data collection and data quality control systems at all levels (national and sub-national) should also be elaborated.