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South-East European Region
National Coordination Council

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REPUBLIC OF MOLDOVA PROGRESS REPORT ON HIV/AIDS

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- Ministry of Health
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- Department of Penitentiary Institutions, Ministry of Justice
- Ministry of Education
- Ministry of Youth and Sports
- National Center of Health Management
- National Center of Public Health
- National Blood Transfusion Center
- Hospital of Dermatovenerology and Communicable Diseases
- Republican Narcology Dispensary
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- National Bureau of Statistics
- UNAIDS Moldova
- WHO Moldova
- UNICEF Moldova
- UNFPA Moldova
- UNODC

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Executive summary

Reliable information is one of the most important determinants in the process of development and implementation of efficient and effective strategies. Information represents the evidence base for establishing the framework, soundly based policies, and at the end ensuring efficient, results-based and beneficiary –centred interventions to prevent the spread of HIV.

Together with other countries, the Republic of Moldova participated at the UN General Assembly in 2011 where the Political Declaration of Commitment to eliminate HIV/AIDS was signed. In addition, it is a part of the Dublin Declaration and of the WHO Global Strategy on Health sector. In 2016, in June, in New York a new bold agenda to end the AIDS epidemic by 2030 was endorsed during the United Nations General Assembly High-Level Meeting on Ending AIDS. The progressive, new and actionable Political Declaration includes a set of specific, time-bound targets and actions that must be achieved by 2020 if the world is to get on the Fast-Track and end the AIDS epidemic by 2030 within the framework of the Sustainable Development Goals, Moldova adhered to it too.

The joint Monitoring and Evaluation framework of the National Programme on Prevention and Control of HIV/AIDS and STI in the Republic of Moldova has been implemented starting with 2005. Over the years, this system passed through a series of system strengthening stages, but it is yet premature to state that the system is fully functional and satisfies all the key information needs. Thus, there is still a need to improve the information system, the informational flow and to adapt the existing reporting forms and software used in the country to the recommendations provided by international experts and to the requests of the civil society. However, relevant strategic information was obtained and made accessible, to inform the decision-making process in the national response to HIV.

The given report is the result of collaboration among institutions, ministries, and public organisations, non-governmental and international organisations. Representatives of governmental institutions and nongovernmental organizations, which are part of the national HIV response, have been involved in the process of collection, analysis and interpretation of data for the current AIDS Progress Reporting. The values of the indicators were presented and validated in the framework of the Country Coordination Mechanism (CCM) technical working meetings with the participation of the community, national and international counterparts.

There are no relevant changes observed in the country's epidemiological context as compared to the previous report. Moldova's HIV epidemic continues to be concentrated among key affected populations (KAP), mostly PWID, with an increasing contribution of SW and MSM. HIV prevalence in general population is 0.20%. Available data suggest the epidemic has transitioned from an early concentrated epidemic in which the highest rates of transmission were among PWID to an advanced concentrated one, in which onward transmission to sexual partners of PWID and other key populations has become a source of new infections.

The results of the last HIV sero-prevalence survey among IDUs carried out in 2016 are not integrated in the present report, because de data collected still needs review and validation, in this perspective the data of 2012/2013 are used for this report. At of April 1st, 2017, the new census data was published, the present report the data on population available before the 31 March 2017 was used. The census data presented in 2017 informs on a significantly lower number of population compared to data used in this report. Taking into account that all estimations were done using the old population data, the new population number will be used for the next round of reporting.

During 2016, the National HIV Program (NAP) has been updated for the period 2016–2020 and endorsed by the Government. The updated NAP remains focused on key epidemic drivers, aligned to global 90-90-90 strategy and international recommendations towards ending the epidemics, taking into account cost efficiency analyses (Cost-effectiveness , Investment case).

Although, strategic directions of the updated NAP are kept the same, much more ambitious targets were setup to ensure the reverse of the epidemic. The updated NAP pays greater attention to synergetic activities with other national programs (TB, HCV, blood security, sexual and reproductive health and drug control), aiming at preventing and treating HIV among people with comorbidities and high-risk groups, by promoting integrated medical, psychological and social services, as well as inter-sectorial linkage of services.

The Republic of Moldova is recognised in the region as an example of good practices:

- Successful implementation of Harm Reduction Programmes in key populations at risk in the civilian sector (IDUs, CSWs, MSM) and in penitentiary institutions (IDUs);
- Methadone Substitution treatment is provided both in the civilian sector and in penitentiary institutions (on right bank of Dniester river only);
- Moldova adopted the so-called 2% Law in 2016, which is an indirect modality the state sustains financially NGOs and represents an alternate source for those;

Moldova continues strengthening PSM for essential medicines and commodities through consolidation of transparent and competitive mechanisms for the best value for money. An agreement between MOH and UNDP has been signed in 2017 on procurement via international mechanisms – covering majority of national programs, including HIV. At the end of 2016 the Law on Public Procurement was amended to allow online trading based procurements.

Epidemiological context

There are no relevant changes observed in the country's epidemiological context as compared to the previous report. Moldova's HIV epidemic continues to be concentrated among key affected populations (KAP), mostly PWID, with an increasing contribution of SW and MSM. HIV prevalence in general population is 0.20% in 2016. Available data suggest the epidemic has transitioned from an early concentrated epidemic in which the highest rates of transmission were among PWID to an advanced concentrated one, in which onward transmission to sexual partners of PWID and other key populations has become a source of new infections.

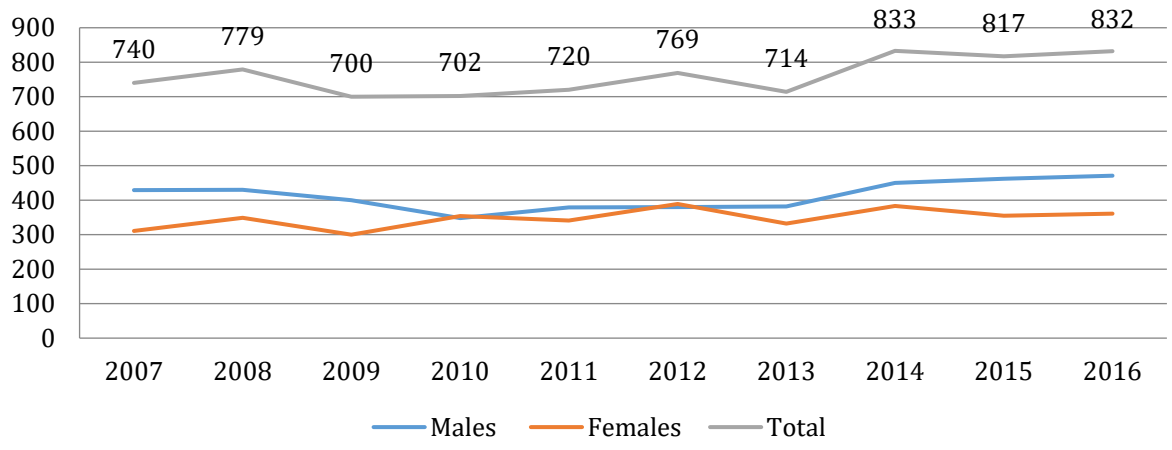
According to latest size estimation there are 30,200 PWID (10,800 - Transnistria), 12,000 SWs (2,000 - Transnistria) and 13,500 MSM (3,800 - Transnistria).

According to national statistics, 11,042 HIV cases (including 3,511 in Transnistria) were cumulatively registered by the end of 2016. HIV prevalence constitutes around 199.86 per 100,000, Transnitria region registering significantly higher rates – 545.2 per 100,000. A stable number of slightly more than 800 new cases (including 230 in Transnistria) was registered yearly in the past 3 years, with no major changes in the gender distribution.

The predominant mode of HIV transmission in 2016 remains heterosexual sex that account for 85.8% from new cases.

Reported cases on both banks, however, are less than a half (40.3%) from 2015 estimated number of PLHIV - 18,226 (Right bank – 44.3%, Left bank – 33.9%). About 50% of new diagnosed cases are at AIDS stage. HIV mortality rate shows a stabilization trend with 4.87 in 2015 and 4.13 in 2016 per 100,000, with significant differences between the right bank (3.52%) and the left one (9.92%). From the total number of deaths, about 67.4 % are HIV related, the main death cause remaining Tuberculosis - 52.9%. In the last 3 years, it is observed a slight decrease in the mortality rate among HIV infected and HIV related deaths.

Figure 1 Number of new HIV+ registered cases, Republic of Moldova, 2007 - 2016



As mentioned, there are limited changes in the trends of incidence, prevalence and diseases transmission rates; the coverage of KAP (Table 1) with prevention is increased

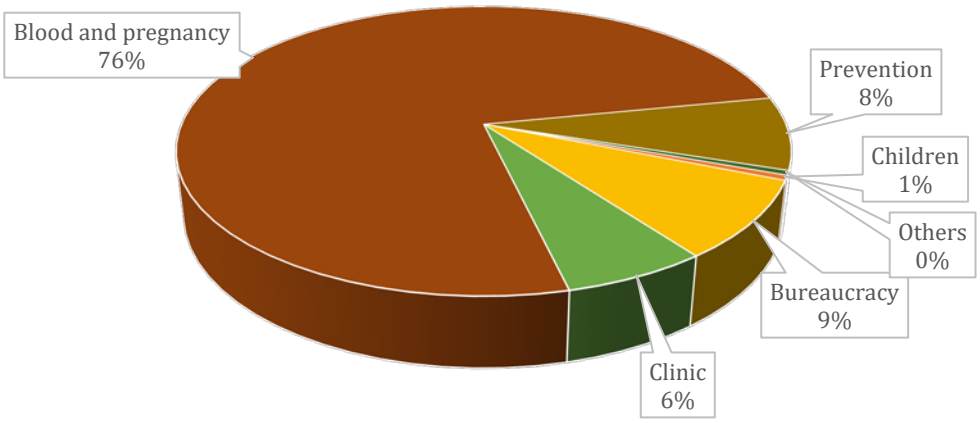
(programmatic data); there are limited geographic shifts in diseases burden. Subsequently, it is considered that these changes can be effectively addressed within the overall on-going grant scope and scale without change in the strategy.

Table 1 Coverage of KAP with prevention services, programmatic data

	2014	2016	Increase
PWID	30.8%	49.0%	18.2%
CSWs	24.6%	39.3%	14.7%
MSM	14.7%	22.3%	7.6%

During 2016 - 251.2 thousand tests were performed, 79,089 of whom - pregnant women. Around 31.1% of HIV testing is among pregnant women and 33.9% among donors, while prevention program covered only 8.2% of testing. From 2014 in the Republic of Moldova the community, based testing was introduced. In 2016, the NGOs performed 3219 tests among key population, 64 persons had positive results, and only 48 persons were newly confirmed with HIV.

Figure 2 Share of programs of HIV testing in 2016, Republic of Moldova, %



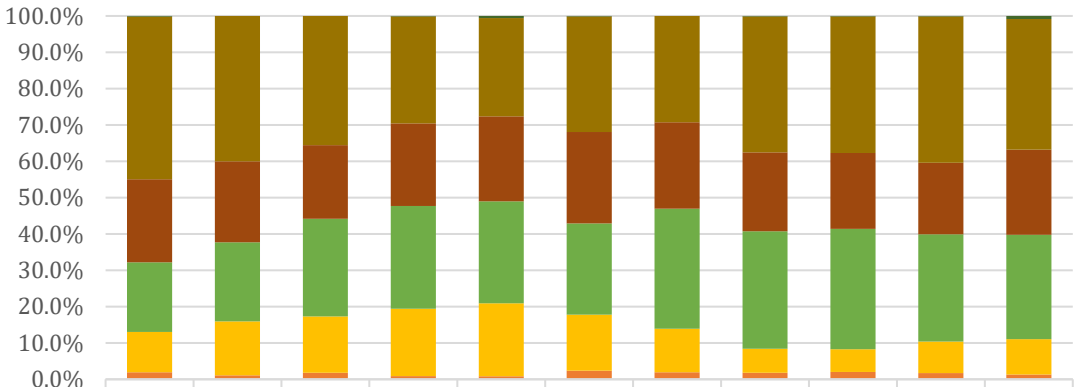
From the confirmed test data, it becomes apparent that the share of cases found in the prevention programs is low and it is about 35.9% of all cases in 2016. This means that the majority of newly found cases are presenting in the hospitals with symptoms, as pregnant women or as tests of blood in hospitals. This implies that most cases are in fact cases infected sometime in the past. However, the greater number of new cases should be registered by prevention programs and not by clinical signs. This means that the testing efforts must be directed to prevention programs.

The rate of HIV+ males from the newly registered cases, found through prevention programmes was 44.8% in 2016, and the rate of HIV+ females was 25.1%. This might be explained by the fact that most prevention programmes are oriented towards PWID, of whom the majority are males.

New HIV cases are mainly registered among young people and persons of reproductive and economically active age 15-49 years – 84.1% and 15-24 years old – 11.2%. Compared to the

data from 2015, no changes can be noted - out of all newly registered HIV cases, 86.4% were registered in 15-49 age group and 12.6% in the 15 - 24 years old. To be noted that in the last 10 years the medium age of new case registration is growing from the age of 31 in 2007 to the age of 36 in 2016.

Figure 3 The share of programs that register new cases, 2010 – 2015, Republic of Moldova



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Other	0.2%	0.0%	0.0%	0.1%	0.6%	0.1%	0.0%	0.1%	0.1%	0.1%	0.8%
Prevention	44.8%	40.0%	35.6%	29.4%	27.1%	31.8%	29.3%	37.4%	37.6%	40.3%	35.9%
Blood and pregnancy	22.9%	22.3%	20.3%	22.7%	23.4%	25.1%	23.8%	21.7%	20.9%	19.7%	23.4%
Clinic	19.2%	21.8%	26.8%	28.3%	28.1%	25.1%	33.0%	32.4%	33.1%	29.5%	28.7%
Bureaucracy	11.1%	14.9%	15.5%	18.6%	20.1%	15.4%	12.0%	6.6%	6.2%	8.7%	9.7%
Children	1.9%	1.1%	1.8%	0.9%	0.9%	2.4%	2.0%	1.8%	2.0%	1.7%	1.3%

Starting with 2007 coverage with HIV Testing of pregnant women exceeds 99, 0%. In 2016 it counted 99.6% what allows calculating HIV prevalence among them and which remains relatively stable in the last years.

The predominant mode of HIV transmission in 2016 remains heterosexual sex, that accounts for 85.8% from new cases, the second largest is homosexual transmission and accounted for 4.95%, injecting drug use mode of transmission – 4.48%, MTC transmission is 0.70 and for 4% of new cases it was not possible to determine the way of infection.

During 2016, 352 new cases of AIDS were reported. Cumulatively there are 3492 cases of AIDS among registered people who live with HIV, which represent 31.6% of HIV cases.

In the reporting period, 246 deaths were registered between HIV+ people, the mean age at time of death being of about 42.3 years.

At the end of 2016 there were 7906 people living with HIV registered in Republic of Moldova (5340 people on the right bank and 2566 on the left bank of Nistru river). Males represent 53.6% of PLH and 46.4% are females.

According to the Multiple Indicator Cluster Survey carried out in the in the general population on the right bank of the Nistru river in 2012, 78.5% of female respondents and 64.6% of male respondents know about the possibility to take an HIV test in the locality where they live.

The Integrated Bio-Behavioural study among most at risk populations was carried out in the Republic of Moldova during 2009-2010, using the Respondent Driven Sampling methodology for the first time. The same methodology was used in the 2012-2013 of the IBBS, making the data comparable. The RDS methodology enabled the recruitment of respondents other than just beneficiaries of harm reduction programmes (as done in past survey rounds, when convenience sampling has been used), although it made results not comparable to 2003, 2004, 2007 surveys.

Results of HIV prevalence, among IDUs, CSWs, MSM and prisoners as per the latest IBBS are presented in the table below.

Table 2 HIV prevalence among IDU, Republic of Moldova, 2012

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

Table 3 HIV prevalence among CSW, Republic of Moldova, 2013

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

Table 4 HIV prevalence among MSM, Republic of Moldova, 2013

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

Table 5 Prevalence among prisoners, Republic of Moldova, 2012

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

Table 6 Results for the estimation of sizes of most at risk populations, Republic of Moldova, 2014

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

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

National response to HIV/AIDS epidemic

Government HIV and AIDS policies

National Programme on Prevention and Control of HIV/AIDS and STI for 2016–2020

At the national level, the state policy in the area of HIV/AIDS in Moldova is implemented through the National Programme on Prevention and Control of HIV/AIDS and STI for 2016–2020 (NAP), approved by the Government Decision on 22 October 2016.

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

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

1) **Hospital of Dermatology and Communicable Diseases (HDCD)** – responsible for the overall coordination of prevention, diagnosis, treatment of PLHA, care and support. In an integrative manner, the hospital, thereby, coordinates VCT (voluntary counselling and testing), the laboratory service, treatment, treatment monitoring, palliative care and STI clinic. The M&E unit, which used to have 4 positions and to be with the national Centre for Health Management, was transferred to the hospital, meaning the M&E informational data base, M&E responsibilities and the M&E coordinator (one person only). In the same time the unit was filled with 3 more specialists: TARV coordinator, Laboratory coordinator and prevention coordinator.
2) **National Centre for Public Health** – responsible mainly for HIV epidemiological surveillance.
3) **National Centre for Health Management (NCHM)** is a public institution under the auspices of the Ministry of Health of the Republic of Moldova, which works in accordance with the provisions of legislation in place, normative acts of the Government, the Ministry of Health, other normative acts, international treaties the Republic of Moldova has signed. Because there is a National Programme department in the NCHM, it owns now minor functions related to HIV M&E.

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

The actual program is a continuation of the previous one, being focused on key epidemic drivers, aligned to global strategies on evidence-based interventions (90-90-90 strategy), international recommendations and cost efficiency analyses (Cost-effectiveness , Investment case) towards ending the epidemics. The NAP is focused on three key strategies:

I. Prevention of HIV and STI, especially in key affected population focused on preventing further transmission of HIV within key population (PWID, SWs, MSM, prisoners) through providing access to harm reduction (HR) programs and testing, which will cover at least 60% of the estimated number of beneficiaries (PWID and LSC, MSM - 40%) by 2020;
II. Universal access to treatment, care and support to PLHIV focused on covering 60% from estimated PLHIV with ART by 2020 (triple from baseline 17%);
III. NAP management focused on efficient management, coordination, resilient and sustainable systems for health and human rights, financial sustainability, evidence generation and M&E systems.

Although, the strategic directions of the new NAP are kept the same, ambitious targets were set up to ensure the reverse of the epidemic (coverage with prophylaxis, including testing programs in all key populations up to 60%, as well as the targets related to continuum of care being tripled and raising to more than 60% compared to the previous programme).

The new Program pays greater attention to synergetic activities with other national programmes (TB, HV, hemotransfusion security, sexual and reproductive health, antidrugs strategy), aiming at preventing and treating HIV among the persons with comorbidities and high-risk groups, by promoting integrated medical, psychological and social services, as well as inter-sectorial reference mechanisms.

Ensuring the continuation of these actions, during the 2018-2020 period, gradually shifting from Donor's funding, as per the provisions of the Sustainability Plan, shall contribute to the realization of a major impact on the evolution of the HIV epidemiological situation.

Legal framework

The legislative tools include a set of laws which have been adopted to ensure sustainability of actions: Law on Health Protection (1995), Law on Reproductive Health and Family Planning (2001), Law on Migration (2003), Law on Equal Opportunities (2012), Law on AIDS Prevention and Control (2007 modified in December, 2012), Law on Combating Domestic Violence (2008), Law on Social Assistance (2008), Law on donors and blood transfusions (2009).

The exposure to or transmission of HIV is still prosecuted under the Criminal Code (approved by Law Nr. 985-XV dated 18.04.2002) with specific provisions under articles 211 and 212. HIV transmission has been criminalized in an attempt by the government to respond to the rising numbers of HIV infections and prevent the deliberate contamination with HIV; yet, human rights campaigners and other NGOs have expressed concerns that these law lead to a violation of the rights of people living with HIV, exacerbating their marginalization. Hepatitis and TB are also considered diseases of a same level of threat for

public health; still, their transmission is not prosecuted. However, it is worthwhile mentioning that Moldovan legal framework does not contain an offence for a man to have sex with another man (MSM).

Moldova has one of the most progressive legal environments around harm reduction and decriminalizing drug possession. Since 2004, there has been a marked shift in drug enforcement strategy towards prioritizing the prosecution of drug dealers alongside the detection of drug trafficking networks and drug producers, rather than criminalization of drug use. In addition, in 2008, personal drug use was decriminalized. Major amendments to the Penal Code and Administrative Offences Code reformed criminal punishment, including by promoting alternative punishments to imprisonment, and by excluding the application of arrest for personal drug use, now constituted an administrative rather than criminal offence. The illegal purchase or possession of narcotic drugs or psychotropic substances in small quantities without the intention to distribute them, as well as their consumption without a medical prescription, is sanctioned by a fine or community service. Selling sex is an administrative misdemeanor; pimping is a criminal offence.

The use of M&E data for decision-making remains weak. After the reform at mid-2012, which intended to have a unique management system, bringing together all the services, including the M&E one, both governmental and civil society representatives recognized that the M&E system was seriously affected.

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

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

Human rights

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

The human rights protection machinery currently is in place centres around the Ombudsman institute. There are also hotlines maintained by line Ministries and some NGO to empower actors to react to cases of discrimination not only for PLWH but for MARs also. There is low legal knowledge among the population and a limited culture of seeking redress for human rights violations.

Gender

Republic of Moldova is aligned to UN standards with regard to right to health for all people as suggested by CESCR - 22 Session of the Committee on Economic, Social and Cultural Rights, the Right to the Highest Attainable Standard of Health (Art. 12) ensuring that services are: accessible, non-discriminatory, physically and economically accessible, informative and qualitative, while providing access to the most vulnerable groups such as marginalized, people with HIV, disabilities, different ethnicity, women and children, etc.

In the Republic of Moldova, the legislation and the policies in the area of gender equality are quite well developed. The gender equality is a founding principle set by the supreme law, the Constitution, and there is a specific law on gender equality.

The Constitution of the Republic of Moldova art. 15, ch. 2 guarantees the right to equal attitude and establishes that men and women are equal in front of law and local public authorities.

Several other organic laws stipulates the right to equal attitude and forbids discrimination: Law No. 411 from 28.03.2005 with regard to the health care ; Law No. 263 from 27.10.2005 with regarding the patients' rights and responsibilities, etc.; Law on gender equality between men and women No.5 XVI from 02.09.2006 ; Law on Social Inclusion of Persons with Disabilities No. 60 - 30.03.2012. The amendment of the Law on HIV/AIDS and the Law on Ensuring Equality strengthen non-discrimination guarantees, equal rights of every person and confidentiality safeguards. National mechanisms, as Ombudsman, Antidiscrimination council are already in place since 2014 to protect the rights of people.

The Law No. 121 from 25.05.2012[1] ensures the equality of chances is aiming at preventing and fighting the discrimination, as well as ensuring the equal chances to all in political, economic, social, cultural and other spheres without making any race, color, nationality, ethnical origin, language, religion or beliefs, sex, age, disability, opinion, political belief or any other similar criteria.

The Law No. 298 from 21.12.2012[2] approves the Regulation of the Council on Preventing and Eliminating Discrimination and Ensuring Equality ("Equality Council") which serves as one of the mechanisms to ensure the law implementation. The HIV Law No. 23 from 16.02.2007 amended and modified in 2012 Art. 25 forbids any kind of discrimination on HIV status.

The NAP 2016-2020 is built upon principles of gender mainstreaming and human rights evidence - based approach (programmatic data and researches) and ensures no one is left behind. The NAP addresses the needs of key affected population PWID, CSW, MSM, prisoners, PLWH, vulnerable youth having those as the center of all the interventions, targeting their needs as per program objectives, budget and M&E framework. In the same time it includes strategic focus on Human Rights, gender sensitive activities for KAPs and community systems strengthening with relevant budget. The NAP M&E framework includes gender-disaggregated data on all those most affected populations, thus ensuring the HR and gender is quantified and measured. Recent Gender assessment of the HIV policies reveals achievements and needs for further improvements.

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

Prevention

There is progress attested in HIV prevention activities among MARPs that experienced the fastest scale up. Impact and outcome under NAP prevention Objective are assessed through IBBS in KAP.

PWID

Due to early start and rapid scale-up of Harm Reduction Programmes among MARPs, both in the civil sector (IDUs, SWs, MSM) and in penitentiaries (IDUs), the Republic of Moldova is known as being an example of best practice.

In 2016, UNAIDS released the report: " Do no harm: health, human rights and people who use drugs", popularizing Moldova's experience alongside with other countries that own good practices and encourage countries to adopt human-health-rights centered approaches towards drug control. Both public and community-based points of care provide NSP and they

[1] http://lex.justice.md/viewdoc.php?action=view&view=doc&id=343361&lang=2

[2] http://lex.justice.md/viewdoc.php?action=view&view=doc&id=346943&lang=2

provide sterile needles, syringes, alcohol swabs, informational brochures, and condoms and offer collection and safe disposal of injection equipment.

The distribution is made through a network of 30 geographic sites that include stationary NSP points and outreach to apartments. 18 NSPs programmes are also provided in penitentiary institutions on both banks of Nistru River, 1565 PWID were covered by prevention services in penitentiary sector. In 2016 – 14806 PWID and their partners (12937 on the right bank and 1869 on the left bank), were covered by comprehensive prevention services, including mandatory needle syringe exchange. In addition, social and outreach workers provide referrals to other HIV prevention services, VCT, gynecological consultations, STI diagnosis. NSPs also provide a point of entry to substitution therapy. These programmes were implemented by 10 NGOs and Department of Penitentiary Institutions.

During 2016, the following results were achieved:

- 2642705 syringes distributed;
- 532288 condoms distributed;
- 109644 IEC materials distributed;
- 1005 PWID trained in overdoses prevention;
- 450 PWID received 946 vials of Naloxone;
- 958 PWID females were trained in gender specific activities.

There is uneven geographic distribution of needle-syringe programs and other harm reduction activities, with still low coverage rates in the most affected cities, especially Chisinau.

During 2016, there were continued prevention activities in the 3 pharmacies, through this service there were covered 201 persons and distributed 7200 needles, 6953 alcohol preps and 825 condoms.

In the same time during 2016 there was established the mobile prevention clinic service, which covers the areas uncovered by stationary prevention programmes. The mobile prevention clinic services provide prevention services such as:

- Needle syringe exchange
- Management of overdoses
- Condoms distribution
- Information Education Communication (IEC) activities for HIV prevention
- VCT for HIV/Viral Hepatitis and Syphilis
- Medical specialists consultation (dermato-venerologist , gynecologist, etc.)
- Referral to medical service
- Etc.

The mobile prevention clinic provides services for all key populations.

OST

In 2016 the opioid substitution treatment was extended to 7 sites in civil sector and in 13 penitentiary institutions, which offer the possibility to increase the coverage with this

service in the country. The program continues to provide support to 4 community-based OST support sites, aimed at increasing access to OST, facilitating the enrolment and OST adherence. The community-based sites established their services as 'one stop shopping', thereby, providing additional services outreach work, HIV testing and counseling, harm reduction, linking with other services (including TB/HIV collaborative), peer-to-peer consultation, psychological and legal consultations, self-support and social support. 'One stop shopping' approach ensured the improvement of cost-efficiency, quality of services and coverage. On 31 December 2016, there were 505 PWID on OST. During 2016 175 new PWID were enrolled in OST, out of them 77% benefited of psycho-social support services. Adherence after 6 month in OST was 64,2%. In 2016 74 persons benefited of OST at home.

The majority of OST service is financed by Global Fund for fighting AIDS, Tuberculosis and Malaria, thus during the reporting period 28 PWID were covered with OST services (7809 consultation) by the National Health Insurance Company.

In 2016 there was conducted OST service evaluation, based on the evaluation report of an action plan to improve the service provision was developed and is being implemented now.

CSW

During 2016, HIV prevention services for CSW were implemented in 9 localities. Prevention programmes for CSW were implemented by 5 NGOs in Republic of Moldova. In the same time 4717 CSWs (4047 on the right bank and 670 on the left bank) were covered by prevention services. HIV prevention services for CSWs include the following services: condom distribution, IEC distribution, HIV testing via rapid saliva tests and referral to facility-based STI and VCT services. The minimum package includes 2 services, the one mandatory is the condom distribution.

The primary method of service delivery is via outreach to apartment- and street- based venues. In the same time, the mobile clinics provide services in the areas not covered by stationary services.

During 2016, the following results were achieved:

- 527395 condoms distributed;
- 30969 IEC materials distributed.

MSM

HIV prevention interventions targeted to MSM are provided primarily by community-based organizations (Gender-Doc and Center ATIS) in the three main cities (Chisinau, Balti and Tiraspol). During the reporting period 3013 MSM were covered by prevention service. Services include condom and lubricant distribution, distribution of information leaflets, organization of seminars, safer sex promotion parties for the LGBT community, providing individual counselling and testing services, and developing referral system to medical specialists, referral to facility-based VCT.

During 2016, the following results were achieved:

- 527074 condoms distributed;

- 31011 lubricants tubes distributed;
- 3709 IEC materials distributed.

VCT

Among other achievements, it is worth mentioning that in 2016, the initiative to provide HIV counselling and testing services through NGOs was continued (rapid saliva tests procured, instructions to provide those services elaborated and approved, service providers trained). In 2016 were done 3219 tests for key population, 64 of them were positive and 48 were newly enrolled in medical service.

Treatment, care and support:

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

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

Treatment

The ART package of service envisages several elements as TARV, TARV as prevention, including prevention from mother to child and post-contact prophylaxis, treatment of co-infections. Care and support programme includes nutritional, legal and psychosocial support, including palliative care, services for HIV+ children and orphans (social and psychosocial services). The package also includes active medical surveillance of all persons diagnosed with HIV in specialized institutions, with specific investigations; palliative care for AIDS patients who need it.

The most important achievements relate to ensuring access to HIV treatment, which in fact is 100% available to those who address the health service; decentralizing treatment services and HIV care throughout the country, as well as providing PMTCT services; improving accessibility and quality of prophylactic ART for HIV pregnant women; opening a pediatric ward within the ARV treatment institution. The regulation on the organization of palliative care services for people with HIV/AIDS was developed.

The ART in provided by seven regional ART Centers (4 on right bank and 3 on the left bank), 2 out of them are providing services in penitentiary institutions.

By the end of 2016 the achievements of ART Centers are:

- 4491 PLWH received ART (3170 on the right bank and 1321 on the left bank);
- 122 children were on treatment (92 on the right bank and 30 on the left bank);
- 168 PLWH received ART in penitentiary sector (85 on the right bank and 83 on the left bank);

- 203 HIV+ mothers delivered 206 newborns, out of them 196 received ART prophylactics;
- 924 new PLWH were enrolled in TARV (687 on the right bank and 237 on the left bank).

Psychosocial support

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

By the end of 2016 the achievements of Social Centers are:

- 2447 PLWH were covered by psychosocial services;
- 21033 consultations were provided to PLWH;
- 1155 group activities with the participation of 1071 persons were done;
- 379 new beneficiaries were enrolled in the psychosocial service.

Palliative care

In terms of palliative care one NGO was active in the field of HIV palliative care, which provided services in 2 biggest cities in Republic of Moldova.

By the end of 2016 the achievements of Social Centers are:

- 200 PLWH were covered by palliative care services;
- 3185 home visits were done to provide palliative care services;
- 1963 visits to the Social Centers were done to provide palliative care services;
- 2593 phone consultations were provided.

Management of NAP

Mentioned result confirms that current NAP mix of evidence-based programmatic interventions are strategically focused, technically sound and on track to achieving results and impact.

In order to strengthen the management of National Program, by the order of Ministry of Health No. 897 of 18.11.2016, the Coordination Unit of the National Program for prevention and control of HIV/AIDS and STI was created. The role of the Unit is:

1) Ensure the efficient management of the program,
2) Provide support for territorial actors,
3) Coordinate with other health sector partners and other sectors, including other ministries, local authorities, development partners and civil society.

Moldova continues to strengthen PSM for essential medicines and commodities through transparent and competitive mechanisms for the best value for money, i.e. Law on Medicines, Public Procurement Law etc. An agreement MoH/UNDP has been signed in 2017 on procurement via international mechanisms. At the end of 2016 amendments were made to the Law on Public Procurement allowing procurement with the possibility of carry out online

trading. Republic of Moldova adopted the so-called 2% Law in 2016, which is an indirect modality the state sustains financially NGOs and represents an alternate source for those.

The country is planning the revision of its testing and treatment guidelines in order to be in line with latest WHO recommendations, including community based and self-testing.

In addition, the Ministry of Health has expressed the political will and consent for validation of the elimination of HIV transmission from mother to child.

The M&E system is sufficient to provide epidemiological and programmatic data, including solid second generation surveillance, qualitative analyses, operational researches, cost-effectiveness studies, etc. available for use and decision-making. Twelve steps based M&E system assessment is planned this year to further fuel system strengthening.

HIV continuum of care is based on collaborative public and community service delivery, well developed, accessible, including in penitentiary system.

NAP 2016-2020 is relying on synergies with other programs as TB, hepatitis, sexual and reproductive health, healthy lifestyle education, blood security etc. for comprehensive response to needs, intersectorial collaboration and integrated service provision.

Acknowledging human resource short falls, the Government approved the health system human resources strategy aimed at ensuring complex health personnel development and retention. Similar strategy is foreseen to address community staff needs.

To enhance the role, build the capacity and improve the representatives of key affected populations and communities, organizations and community networks in the planning, delivery, monitoring and evaluation of services and activities, community members have participated in various trainings and study visits:

- 11 people participated in international events related to the field of HIV / AIDS;
- 54 representatives of organizations working in HIV / AIDS participated in two training related to human resource management and effective consultation;
- There were held 27 working meetings (meetings, workshops, seminars, roundtables).

Indicators

1. Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020

Indicator 1.1 People living with HIV who know their HIV status

HIV epidemics begins in republic of Moldova from 1987, whet first case of HIV was confirmed in the Republic of Moldova. According to administrative statistics, the cumulative number of PLWH is 11,043 persons. In this cumulative number the persons who have two positive ELISA from different blood samples are included and confirmed by Western Blot. For age disaggregation the age of HIV confirmation was taken into account.

Table 7 People living with HIV who know their HIV status

	All	Males (all ages)	Males (0-14)	Males (15-49)	Males (50+)	Females (all ages)	Females (0-14)	Females (15-49)	Females (50+)
A. Cumulative number of people living with HIV diagnosed	11043	6394	91	5889	414	4649	86	4223	340
B. Cumulative number of AIDS-related deaths	3137	2155	10	1930	215	982	5	827	150
Number of people diagnosed with HIV and reported to the surveillance system who are still alive	7906	4239	67	3646	526	3667	64	3227	376

For the calculation of the cumulative number of AIDS related deaths, there were compared to databases: HIV Register and National Mortality Register. In this indicator all cases of HIV positive persons deaths, disregarding the cause of mortality where included: AIDS related or not. The disaggregation of this indicator was done, taking into account the age of death.

The number of people diagnosed with HIV and reported to the surveillance system who are still alive, was taken from the national register of HIV cases without death cases. For the disaggregation was used the age at 31.12.2016.

Indicator 1.2 People living with HIV on antiretroviral therapy

ARV treatment became available in the Republic of Moldova since 2002. Beginning with 2003, medication for ARV treatment was bought with the financial support of the World Bank and GFATM grants (Round 1 and Round 6).

In the Republic of Moldova there are 7 institutions providing ARV treatment: on right bank:

- Dermatology and Communicable Disease Hospital (provides services to patients from the central region of the country, right bank of the Nistru river and persons from other regions at their request, provides inpatient treatment for all patients in the country);
- municipal hospital from Balti (provides services to patients from the northern region of the country);
- district hospital from Cahul (provides services to patients from the southern region of the country);
- the Penitentiary Institutions Department for inmates on the right bank of the Nistru River;
- the Penitentiary Institutions Department for inmates on the left bank of the Nistru River;
- the AIDS Centre in Tiraspol (provides services for patients and inmates on the left bank of the Nistru River);
- district hospital from Ribnita (provides treatment to patients from the northern part of Transnistria).

According to the National Protocol followed by all medical institutions that initiate ARV treatment, undertake clinical monitoring and dispense ARV drugs, the immunologic criteria for enrolment in treatment in the reporting period have been CD4 <500. But in the 2017 it is planned to adjust the protocol to be in line with the "test and treat" strategy.

The demand for ARV increases annually. During 2016, 17 children and 907 adults have been enrolled in treatment.

Table 8 New enrolments into ARV treatment, Republic of Moldova, 2005-2016

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Males	66	62	109	150	210	211	275	285	305	412	494	487
Females	41	52	88	113	152	156	255	310	264	487	460	437
Total	107	114	197	263	362	367	530	595	569	899	954	924

During 2016, the Government procured ARV drugs of 1st line and 50% of the 2nd line for the patients from the right bank of Nistru. The remaining ARV drugs for patients from the left bank of Nistru and Department of penitentiary institutions are procured from Global Fund sources.

According to the recommendations, for calculation of ARV treatment coverage, the estimated number of persons with HIV generated by SPECTRUM is the denominator. In the framework of workshops with participation of technical level representatives and decision makers from relevant institutions, entry data were validated. The Spectrum outputs are in course of

validation to UNAIDS team and UNAIDS will introduce the data in the on line tool. Only data for the numerator were introduced in the on-line AIDS Reporting tool for 2016.

Method of Calculation and Indicator Value:

- **Numerator:** Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocols at the end of the reporting period.
- **Denominator:** Estimated number of adults and children living with HIV.
- *Since the Republic of Moldova estimates were made separately for right and left bank of the Nistru River, denominator data must represent the sum of both estimates.*
- **Source:** Registries of patients in ARV treatment from institutions providing ARV treatment.

Table 9 People living with HIV on antiretroviral therapy

	All	Males	Females	< 15 years	< 1 year	1-4 years	5-9 years	10-14 years	15-19 years	20-24 years	25-49 years	50+ years and older	15 + years and older
Number of people on antiretroviral therapy at the end of the reporting period	4491	2239	2252	122	3	34	37	48	34	184	3579	572	4369
Persons newly initiating ARV therapy during the last reporting year	924	487	437	17	3	9	1	4	13	60	732	102	907
Number of people eligible for treatment according to national criteria (subset of all people living with HIV)	5506	2810	2696	125	3	34	38	50	37	211	4474	659	4281

Indicator 1.3 Retention on antiretroviral therapy at 12 months

Method of Calculation:

- **Numerator**: Number of adults and children who are alive enrolled in ARV treatment 12 months after its initiation
- **Denominator:** Number of adults and children that initiated ARV treatment in the cohort reporting (2012)
- **Source:** Register of patients in ARV treatment from institutions providing the given service

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

	Total	Males	Females	<15 years	15+ years
Percentage of adults and children living with HIV known to be on antiretroviral therapy 12 months after starting	83.54%	80.97%	86.09%	94.74%	83.20%

Number of adults and children who are still alive and receiving antiretroviral therapy 12 months after initiating treatment in 2015	797	400	397	18	779
Total number of adults and children initiating antiretroviral therapy in 2015, within the reporting period, including those who have died since starting antiretroviral	954	494	460	19	935
Disaggregation of persons who initiated ARV treatment and have not reached 12 months of treatment by cause of treatment interruption					
Number of persons recorded as lost to follow up from the surveillance system	3				
Stopped ARV treatment	111				
Died	43				

Comparable values of the percentage of persons enrolled in ARV treatment that continues the treatment for more than 12 months is presented in the Table 11.

Table 11 Percentage of persons who initiated ARV treatment and are known to be on treatment for more than 12 months, Republic of Moldova, years 2007-2016

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
%	86,7%	76%	88,3%	87,5%	80,67%	81.89%	81.2%	78.9%	84%	83.5%

Indicator 1.4 People living with HIV who have suppressed viral loads

Viral suppression among people living with HIV is one of the 10 global indicators in the 2015 WHO consolidated strategic information guidelines for HIV in the health sector. This indicator also helps monitor the third 90 of the UNAIDS 90–90–90 target: that 90% of the people receiving antiretroviral therapy will have suppressed viral loads by 2020.

In Republic of Moldova, the effectiveness of ART is measured with the determination of viral suppression after 1 month from the beginning of ART. And each 3 months if CD4 is less than 500 and each 6 months if CD4 is more than 500. The ART is effective if viral load is not detectable.

Methods of calculation:

- **Numerator:** Number of people living with HIV in the reporting period with suppressed viral loads (≤1000 copies/mL)
- **Denominator**: Estimated number of people living with HIV
- **Additional denominator:** The number of people who had a routine viral load test during the reporting year.

Table 12 People living with HIV who have suppressed viral loads

	Total	Males	Females	Sex unknown
Percentage of people living with HIV who have suppressed viral loads at the end of the reporting period	74.03%	69.76%	78.35%	0

	Total	Males	Females	Sex unknown
Number of people living with HIV in the reporting period with suppressed viral loads (≤1000 copies/mL)	2509	1174	1335	0
Number of people tested for viral suppression during the last reporting year	3389	1683	1706	0
Estimated number of people living with HIV	The data will be filled from the final SPECTRUM estimation.			

Indicator 1.5 Late HIV diagnosis

Proportions of people with a CD4 cell count <200 cells/mm3 and <350 cells/mm3 of those who had an initial CD4 count during the reporting period. As Republic of Moldova scales up HIV services, it is important to monitor whether people are diagnosed at an earlier stage and what percentage of the people are still diagnosed at a late stage. However, the weakness in the republic of Moldova is that people are tested for CD4 at the stage when they are included in the specialized treatment service, and not in the time when they are diagnosed for HIV.

Methods of calculation:

- **Numerator:** Numbers of people living with HIV with an initial CD4 cell count <200 cells/mm3 and <350 cells/mm3 during the reporting period
- **Denominator:** Total number of people living with HIV with an initial CD4 cell count during the reporting period

Table 13 People living with HIV with the initial CD4 cell count <200 cells/mm3

	All	Males	Females	<15	15+
Percentages of people living with HIV with the initial CD4 cell count <200 cells/mm3 during the reporting period	35.66%	32.49%	39.64%	0	36.17%
Numbers of people living with HIV with an initial CD4 cell count <200 cells/mm3 during the reporting period	229	116	113	0	229
Total number of people living with HIV with an initial CD4 cell count during the reporting period	642	357	285	9	633

Table 14 People living with HIV with the initial CD4 cell count <350 cells/mm3

	All	Males	Females	<15	15+
Percentages of people living with HIV with the initial CD4 cell count <350 cells/mm3 during the reporting period	48.13%	51.54%	43.86%	0	48.81%
Numbers of people living with HIV with an initial CD4 cell count <350 cells/mm3 during the reporting period	309	184	125	0	309

	All	Males	Females	<15	15+
Total number of people living with HIV with an initial CD4 cell count during the reporting period	642	357	285	9	633

Indicator 1.6 Antiretroviral medicine stock-outs

Methods of calculation:

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

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

Table 15 Antiretroviral medicine stock-outs

	Total	General clinic	Maternal and child site	TB site
Percentage of treatment sites that had a stock-out of one or more required antiretroviral medicines during a defined period	0%	0%	0%	0%
Number of health facilities dispensing antiretroviral medicines that experienced a stock-out of one or more required antiretroviral medicines during a defined period	7	0	0	0
Total number of health facilities dispensing antiretroviral medicines during the same period	7	0	0	0

Indicator 1.7 AIDS Mortality

For the calculation of the number of AIDS related deaths, there were compared to databases: National HIV Register and National Mortality Register. In this indicator, where included only cases of HIV positive persons deaths related to AIDS (according to WHO Guidelines for HIV Mortality measurement). The disaggregation of this indicator was done, taking into account the age of death.

Methods of calculation:

- **Numerator:** Number of people dying from AIDS-related causes in 2016
- **Denominator:** Total population regardless of HIV status

Table 16 AIDS Mortality

	Total	Males	Females	Sex unknown
Total number of people who have died from AIDS-related causes per 100 000 population	3.9	4.52	3.33	0
Number of people dying from AIDS-related causes in 2015	157	87	70	0
Total population regardless of status	4 023 698	1 922 716	2 100 982	0

In the last 3 years, it is observed a smooth decrease of AIDS related deaths.

2. Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

Indicator 2.1 Early infant diagnosis

Data source: register of infants born to HIV positive mothers from ART Centers, register of HIV positive mothers that gave birth.

Method of Calculation:

- **Numerator:** Number of infants born to HIV positive mothers that have been tested for HIV in the first 2 months of life.
- **Denominator:** Estimated number of HIV positive pregnant women that gave birth during the reporting period (SPECTRUM).

Throughout 2016, 189 infants have been tested for HIV in the first 2 months of life. Out of this number, 183 infants received a negative result for the test, 3 received a positive result for the test and 3 tests are indeterminate because the blood was collected but there are no results yet. 203 HIV positive women gave birth during the reporting period but was born 206 life children. There are 3 twins. According to administrative statistics, the indicator value is 91.74%. However, for reporting the SPECTRUM estimated number would be used.

Table 17 Early infant diagnosis

	Value
Number of infants who received an HIV test within two months of birth during the reporting period. Infants tested are counted once.	189
Positive	3
Negative	183
Indeterminate	3
Rejected for testing	0
Other	0

Indicator 2.2 Mother-to-child transmission of HIV

Estimated percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months.

Methods of calculation:

- **Numerator:** Estimated number of children newly infected with HIV from mother-to-child transmission among children born in the previous 12 months to women living with HIV
- **Denominator:** Estimated number of children delivered by women living with HIV who delivered in the previous 12 months

The indicator values will be taken from the final SPECTRUM file.

Indicator 2.3 Preventing the mother-to-child transmission of HIV

According to the administrative statistics for 2016, out of the number of women that gave birth during 2016, 99.36% have been tested for HIV at least once.

During 2016, 89 new cases of HIV infection were identified among pregnant women and 130 HIV positive women became pregnant and decided to go on with the pregnancy.

In correspondence with the clinical protocol on ARV treatment, HIV infected pregnant women start ARV treatment as prophylaxis immediately after knowing about the pregnancy, disregarding CD4 level, while infants receive ARV prophylaxis treatment for 28 days.

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

Method of Calculation:

- **Numerator:** Number of pregnant women living with HIV who delivered and received antiretroviral medicines during the past 12 months to reduce the risk of the mother-to-child transmission of HIV during pregnancy and delivery.
- **Denominator:** Estimated number of women living with HIV who delivered within the past 12 months. In the case of the Republic of Moldova, the estimated data from Spectrum for PMTCT indicators will be used, thus the administrative statistics number of women given birth during the reporting period will be used in order to have comparable data with previous reports.

Table 18 Percentage of HIV positive women receiving ARV prophylaxis treatment to reduce HIV transmission from mother to child in the Republic of Moldova, 2014, 2015 and 2016.

	2014	2015	2016
Numerator	152	175	196
Denominator	170	187	203
Indicator value	89.4%	93.5%	96.55%

Table 19 Percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV

	Data value
Number of pregnant women living with HIV who delivered and received antiretroviral medicines during the past 12 months to reduce the risk of the mother-to-child transmission of HIV during pregnancy and delivery.	196
1. Newly initiated on antiretroviral therapy during the current pregnancy	126
2. Already receiving antiretroviral therapy before the current pregnancy	70
3. Maternal triple antiretroviral medicine prophylaxis (prophylaxis component of WHO option B)	0
4.Maternal AZT (prophylaxis component during pregnancy and delivery of WHO option A)	0
5. Single dose nevirapine (with or without tail) only	0

	Data value
6. Other (please comment: e.g. specify regimen, uncategorized, etc.)	0

There is observed a smooth increase of PMTCT coverage of pregnant women for the reduction of MTCT risk.

Indicator 2.4 Syphilis among pregnant women

Methods of calculation:

- **Numerator:**
  - Number of women attending antenatal care services who were tested for syphilis
  - Number of women attending antenatal care services who tested positive for syphilis
  - Number of antenatal care attendees with a positive syphilis test who received at least one dose of benzathine penicillin 2.4 mU intramuscularly
- **Denominator:**
  - Number of women attending antenatal care services
  - Number of antenatal care attendees who were tested for syphilis
  - Number of antenatal care attendees who tested positive for syphilis

The data regarding syphilis testing was collected from the National Center of Health Management. Data source being the report of primary health care. The data regarding treatment was obtained from the electronic treatment database "SIME ITS".

Table 20 Coverage of syphilis testing in women attending antenatal care services

At any visit	
	Data value
Percentage of women accessing antenatal care services who were tested for syphilis at any visit	99.1%
Number of women attending antenatal care services and tested for syphilis	44336
Number of women attending antenatal care services	44694
At first prenatal visit (<13 weeks gestation)	
	Data value
Coverage of syphilis testing in women attending antenatal care services at first prenatal visit (<13 weeks gestation)	81.96%
Number of women attending antenatal care services who were tested for syphilis during the first prenatal visit (<13 weeks gestation)	36634
Number of women attending antenatal care services	44694

Table 21 Percentage of pregnant women attending antenatal clinics with a positive (reactive) syphilis serology, data without left bank

	All	15-24	25+
Percentage of pregnant women attending antenatal clinics with a positive (reactive) syphilis serology	0.30	N/A	N/A

	All	15-24	25+
Number of women attending antenatal care services who tested positive for syphilis	110	N/A	N/A
Number of antenatal care attendees who were tested for syphilis	645	N/A	N/A

Table 22 Percentage of antenatal care attendees during a specified period with a positive syphilis serology who were treated adequately

	Total
Percentage of antenatal care attendees during a specified period with a positive syphilis serology who were treated adequately	100
Number of antenatal care attendees with a positive syphilis test who received at least one dose of benzathine penicillin 2.4 mU intramuscularly	125
Number of antenatal care attendees who tested positive for syphilis	125

Indicator 2.5 Congenital syphilis rate - live births

In the Republic of Moldova the case definition for congenital syphilis does not include stillbirths.

Methods of calculation:

- **Numerator:** Number of reported congenital syphilis cases (live births) in the past 12 months
- **Denominator:** Number of live births

Table 23 Congenital syphilis rate (live births)

	Total
Percentage of reported congenital syphilis cases (live births and stillbirth)	0.016%
Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months	7
Number of live births	44 753

3. Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020

Indicator 3.1 HIV incidence

Number of people newly infected with HIV in the reporting period per 1000 uninfected population. In the case of Republic of Moldova there are registered only the cases confirmed thru laboratory system, thus taking in account the late detection of new HIV+ cases, this indicator cannot be fully aligned to the definition of HIV incidence. The HIV incidence based

on the calculated new registered cases of HIV, varies large on the left and right bank, being 0.17 per 1000 on the right bank and 0.49 per 1000 on the left bank.[3]

Methods of calculation:

- **Numerator:** Number of people newly infected during the reporting period
- **Denominator:** Total number of uninfected population (or person-years exposed)
- **Calculation:** Rate: (Numerator x 1000)/denominator

Table 24 HIV incidence, age distribution

	15-49	50+	15-24	0-14	All
Number of people newly infected with HIV in the reporting period per 1000 uninfected population	0.33	0.10	0.17	0.02	0.21
Number of people newly infected during the reporting period x 1000	700 000	122 000	93 000	10 000	832 000
Total number of uninfected population (or person-years exposed)	2 105 945	1 276 454	537 105	633 393	4 015 792

Table 25 HIV incidence, gender/age distribution

	Males (15-49)	Females (15-49)	Males (50+)	Females (50+)	Males (15-24)	Females (15-24)
Number of people newly infected with HIV in the reporting period per 1000 uninfected population	0.38	0.28	0.12	0.07	0.12	0.23
Number of people newly infected during the reporting period	401 000	299 000	65 000	57 000	33 000	60 000
Total number of uninfected population (or person-years exposed)	1 054 859	1 061 086	537 316	739 138	274 132	262 973

Indicators 3.2 – 3.8; 3.11, 3.12; 3.14, 3.15, 3.18 – the last data available for this indicators are available from 2012/2013 IBBS and were reported in 2014 progress report.

In 2016, there were collected the data in the IBBS 2016, but for the moment the data is not validated; in this regard, these indicators will be reported in the next progress report.

[3] The overall number of uninfected population was based on the national statistics data, which were available before 31 march 2017. After 31 March, 2017 there were published the last census data, and the population number is significantly lower. The new population number will be used for the next round of reporting.

Indicator 3.9 Needles and syringes distributed per person who injects drugs

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

Method of Calculation:

- **Numerator:** Number of syringes distributed within Harm Reduction Programmes
- **Denominator:** Number of estimated Injecting Drug Users in the country

Results: Throughout 2016, 2 642 705 syringes were distributed within Harm Reduction Programmes through needle exchange sites. The estimated number of People who inject drugs Users in the country represents 30200 persons, 19 400 on the right bank and 10 800 on the left bank of the Dniester River.

Indicator value is 87.5 per PWID in 2016, compared with 78 syringes per PWID in 2015.

Indicator value for the right bank of the Dniester River is 123 syringes per user per year, while for the left bank it represents 22 syringes per user per year, the coverage being significantly lower on the left bank compared to the right bank of the Dniester River.

Indicator 3.10 Coverage of opioid substitution therapy

Opioid substitution therapy represents a commitment to treat opioid dependence and reduce the frequency of injecting, preferably to zero. It is the most effective, evidence-based public health tool for the reduction of opioid injecting use among the people who inject opioids. Opioid substitution therapy provides crucial support for treating other health conditions, including HIV, tuberculosis and viral hepatitis. Because of political constraints, the OST is available only on the right bank of Nistru River. Taking into account, that there are no disaggregation by gender and age for the estimated number of PWID who use opioids, the data are presented only nationally.

Methods of calculation:

- **Numerator:** Number of people who inject drugs and are receiving opioid substitution therapy at a specified date
- **Denominator:** Number of opioid-dependent people who inject drugs in the country according to the size estimation exercise

Table 26 Coverage of opioid substitution therapy

	All
Percentage of people who inject drugs receiving opioid substitution therapy (OST)	326
Number of people who inject drugs and are on OST at a specified date	505
Number of opioid-dependent people who inject drugs in the country	15500

Indicator 3.13 HIV prevention programmes in prisons

Almost all-penitentiary institution in Republic of Moldova offer prevention services (including OST on the right bank). According to the legislation of the left bank the HIV testing is mandatory for all detainees.

Methods of calculation:

- **Numerator:**
  - Number of clean needles distributed to prisoners
  - Number of prisoners receiving opioid substitution therapy
  - Number of condoms distributed to prisoners
  - Number of prisoners receiving antiretroviral therapy
  - Number of prisoners tested for HIV
  - Number or percentage of people living with HIV among prisoners
  - Number or percentage of prisoners with hepatitis C or co-infected with HIV and hepatitis C virus
  - Number or percentage of prisoners with TB or co-infected with HIV and TB
- **Denominator:** Not applicable

Table 27 Number of prisoners who received HIV prevention and treatment services

	Data value
Number of clean needles distributed to prisoners	186 207
Number of prisoners receiving opioid substitution therapy	78
Number of condoms distributed to prisoners	49 669
Number of prisoners receiving antiretroviral therapy	168
Number of prisoners tested for HIV	2120

Table 28 People living with HIV among prisoners

	Data value
Number of people living with HIV among prisoners	247

Table 29 Prisoners with hepatitis C or co-infected with HIV and hepatitis C virus

	Data value
Number of prisoners with hepatitis C or co-infected with HIV and hepatitis C virus	132

Table 30 Prisoners with TB or co-infected with HIV and TB

	Data value
Number of prisoners with TB or co-infected with HIV and TB	25

4. Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020

The new data for the 4th chapter is not yet available, the survey data regarding stigma and discrimination – Stigma Index was reported in 2010. The new survey is expected to be finalized in 2017 and will be reported in the next progress report. For the indicator No. 4.3 - Prevalence of recent intimate partner violence, last data available for this indicator are for 2010 and they were reported in the Progress Report on Combating HIV/AIDS in the Republic of Moldova from 2012.

5. Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020

The last data available for this indicator are from 2010 Knowledge Attitudes and Practice surveys for the 15-64 age group and they were reported in the Progress Report on Combating HIV/AIDS in the Republic of Moldova from 2012. The latest data regarding Knowledge Attitudes and Practice in the 15-24 age group is from 2012, and was reported in the progress report from 2013.

8. Ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers

Indicator 8.1 Total HIV expenditure (by service/programme category and financing source)

In order to ensure reporting according to the provisions of the indicator for 2016, data have been collected from various sources in accordance with the recommendations of the guide *"Domestic and international AIDS spending by categories and financing sources" (Reference)*.

Hence, there have been selected organizations from national and local levels that implemented and disbursed funds as per the HIV spending categories indicated in the template on reporting on HIV expenditures. Organizations were asked to provide information on financial allocations spent and destination of disbursement according to the NASA matrix.

Thus, for calculation of expenses in the field of HIV/AIDS for 2016, data on annual expenditures with special destination for HIV/AIDS have been taken into consideration from the following institutions within the health system:

- Ministry of Health, for state budget allocations and funds for Mandatory Health Insurance, for "Public Health Services" Program, for Prevention of HIV/AIDS an STI,

and for implementation of the National Program for Prevention and Control of HIV/AIDS and STI 2016-2020;

- Medical–Sanitary Public Institution Hospital of Dermatovenerology and communicable diseases, the highest as hierarchy institution responsible for HIV response, specific responsibilities relate to HIV surveillance, HIV/AIDS diagnosis and laboratory, pre ART surveillance, ARV treatment management and ARV treatment provision, as well as STI case management;
- National Public Health Centre responsible for HIV/AIDS epidemiological surveillance and prophylaxis activities;
- National Blood Transfusion center responsible for Blood Safety;
- National Narcology Dispensary for the activities on Harm Reduction in IDUs, including the methadone substitution program;
- National Institute of Research in the field of Mothers' and Children's health, for PMTCT;
- Educational institutions, subordinated to the Ministry of Health, for expenditures in training, refresher training and specialization for pedagogical workers.

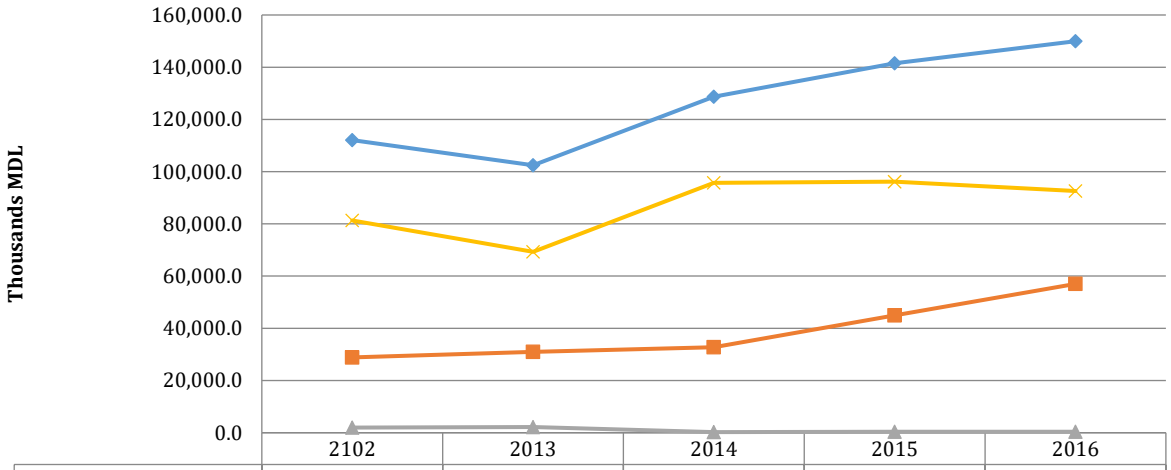
Information on financial flows was requested from municipal and district councils, line Ministries (Ministry of Justice; Ministry of Defense; Ministry of Youth and Sports; Ministry of Education; Ministry of Labor, Social Protection and Family) and international organizations implementing their activities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

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

Expenditures for the national HIV response in the Republic of Moldova (in national currency) for 2011, 2012,2013, 2014, 2015 and 2016 are presented in the Matrix for 2011, Matrix for 2012, Matrix for 2013, Matrix for 2014. Matrix for 2015 and for 2016 respectively.

The expenditures for the HIV response in 2016 increased with about 8.5 mln. MDL (+5.9%) compared to the volume of expenditures from 2015 and reached the total amount of about 150.0 mln. MDL or USD 7,527,690. From those expenditures, the public financial resources constituted 56.9 mln. MDL or USD 2,861,324 (38.0%). International resources for this year constituted 92.6 mln MDL or USD 4,647,675 (61.8%) and the private national resources reached 0.4 mln. MDL or USD 18,691 (0.2%) (Figure 4 and Figure 5).

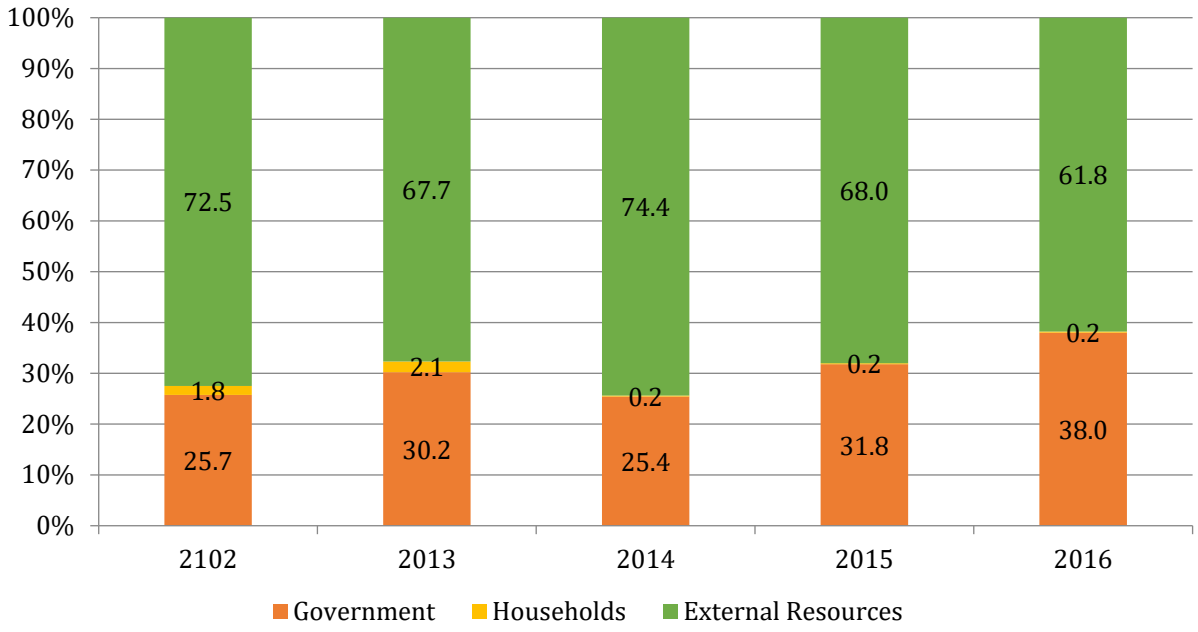
Figure 4 Structure of expenditures for the national HIV response by sources of financing, Republic of Moldova, 2012, 2013, 2014, 2015 and 2016.



	2102	2013	2014	2015	2016
Total	112,101.2	102,444.8	128,692.7	141,485.1	149,951.6
Governament	28,847.6	30,971.6	32,748.1	44,933.3	56,997.6
Households	1,980.8	2,182.7	233.7	390.2	372.3
External Resources	81,272.8	69,290.5	95,710.9	96,161.6	92,581.7

Simultaneously it is necessary to note that increased spending for the national response to HIV in 2016 is due to increased public financial resources, which are up about 26.9%, from 44.9 mln. MDL in 2015 to 57.0 mln. MDL 2016.

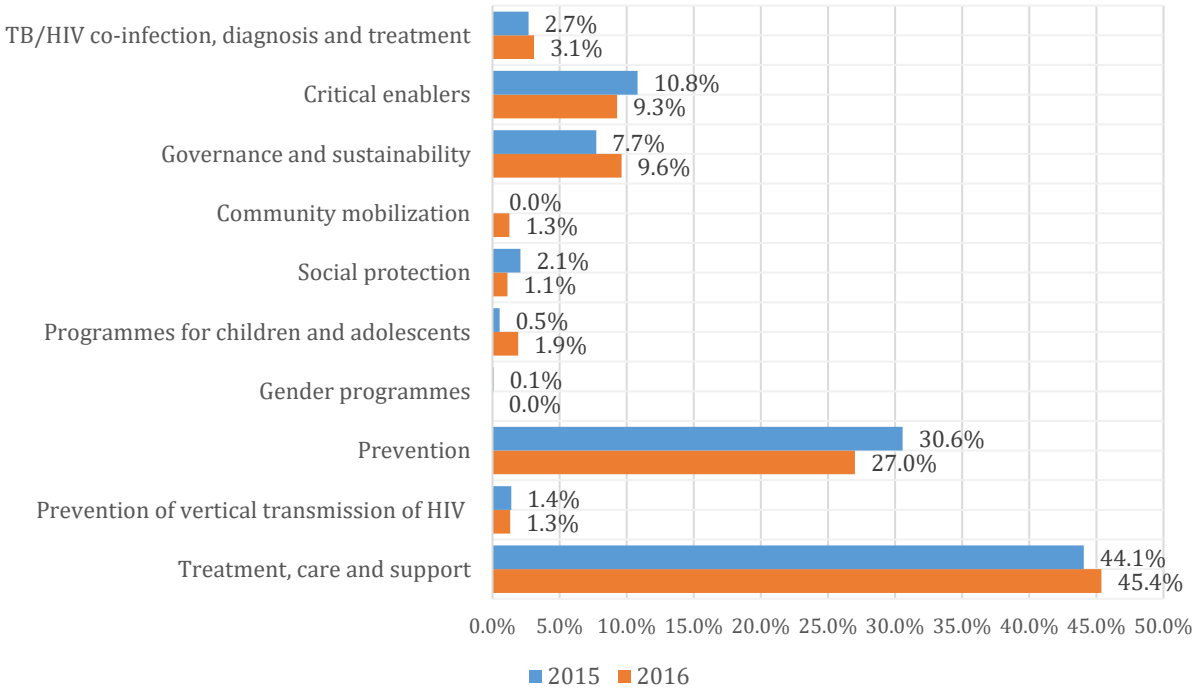
Figure 5 Structure of expenditures for the national HIV response by sources of financing, %, Republic of Moldova, 2012, 2013, 2014, 2015 and 2016



Classified by spending category of expenditures for the national response to HIV (Figure 6) in the framework of the national response to HIV in 2016, 46% went to ***Treatment and Care***. For the spending category ***HIV Prevention*** financial resources of about 27% have been allocated, ***Governance and sustainability*** - 10%, ***Critical enablers*** – 9% allocated, ***TB/HIV co-infection, diagnostic and treatment*** – 3%, category ***Programs for children and***

adolescents – 2% and for the categories ***Prevention of mother to child transmission, Community mobilization*** and ***Social Protection*** – 1% per each of them.

Figure 6 Structure of expenditures for the national HIV response, by spending category, Republic of Moldova, 2015 and 2016



Limitations of the method used to generate this indicator are as follows, some are valid also for prior reporting periods:

- Though significant progress has been registered in data collection from the greatest majority of organizations and institutions, involved in various aspects of the national HIV response, including coordination, monitoring and evaluation, there are still entities with budgets committed and spent for HIV/AIDS that do not report their expenditures and are not reflected in the matrix, due to the fact that activities are not targeting general population, or PLHIV, or MARPs as such and are more tangential to the response, hence not fitting comfortably in the pre-set spending categories.
- In the case of public institutions funded by the State budget, tracking all indirect costs of the subdivisions, specifically the maintenance and utilities costs associated to activities in the framework of the national HIV response, has not been possible as the maintenance costs per institution form the integral budget and cannot be disaggregated.
- Some international institutions are reported the data without the desired desegregations.

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

10. Commit to taking AIDS out of isolation through people-centered systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C

Indicator 10.1 Co-managing TB and HIV treatment

Taking into account that TB is the main cause of HIV related mortality, testing and treatment of TB/HIV co-infection is important prevention measure for averting this deaths.

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

Method of calculation and indicator value:

- **Numerator:** Number of people with advanced HIV infection who have received antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (new TB cases) (in accordance with national TB programme guidelines) within the reporting year.
- **Denominator:** Estimated number of incident TB cases in people living with HIV, WHO calculates annual estimates of the number of incident TB cases in people living with HIV. The 2015 denominator estimates, provided by countries on notification and antiretroviral therapy coverage, become available only in August of the reporting year and do not need to be provided at the time of reporting.

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

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

Table 31 Percentage of new TB cases among PLWH that have initiated anti-TB treatment in the Republic of Moldova, 2014, 2015 and 2016

	2015					2016				
	Total	Males	Females	< 15	15 + years	Total	Males	Females	< 15	15 + years
Indicator value	48.3%	42.9%	59.8%	75%	47.9%	69.4%	68.4%	71.4%	66.7%	69.5%
Numerator	140	85	55	3	137	193	128	65	2	191
Denominator (registered number of HIV/TB cases)	290	198	92	4	286	278	187	91	3	275

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

Indicator 10.2 Proportion of people living with HIV newly enrolled in HIV care with active TB disease

The primary aims of intensified TB case finding in HIV care is early detection of HIV-associated TB and prompt provision of antiretroviral therapy and TB treatment. In the Republic of Moldova all HIV patients are clinic screened for TB and in case of cough all ART Centers have the possibility to perform a sputum microscopy through rapid test with

GeneXpert. All people living with HIV detected with TB disease are referred to phtysiopneumonological service to start anti-TB treatment immediately. But in the same time, there is lack of integrated service provision for the treatment of HIV/TB co-infection.

Methods of calculation:

- **Numerator:** Total number of people who have active TB disease during the reporting period of those newly enrolled in HIV care
- **Denominator:** Total number of people newly enrolled in HIV care during the reporting period (pre–antiretroviral therapy plus antiretroviral therapy)

Table 32 Proportion of people living with HIV newly enrolled in HIV care with active TB disease

	Data value
Total number of people living with HIV having active TB expressed as a percentage of those who are newly enrolled in HIV care (pre-antiretroviral therapy or antiretroviral therapy) during the reporting period	13.51%
Total number of people who have active TB disease during the reporting period of those newly enrolled in HIV care	112
Total number of people newly enrolled in HIV care during the reporting period (pre–antiretroviral therapy plus antiretroviral therapy)	829

Indicator 10.3 Proportion of people living with HIV newly enrolled in HIV care started on TB preventive therapy

In Republic of Moldova, there is a normative indication for TB prevention therapy, but there is not mechanism developed to ensure the TB prevention therapy to PLWH. The result of this indicator is 0%, from the total number of people newly enrolled in HIV care (829 persons) no one received TB prevention therapy.

Indicator 10.5 Gonorrhea among men

Taking into account that gonorrhea treatment services are provided in different settings (including private) the data provided by dermato-venerologycal service is supposed is supposed to be under estimated.

The methods of calculation:

- **Numerator:** Number of men reported with laboratory-diagnosed gonorrhea in the past 12 months
- **Denominator:** Number of men 15 years and older

Table 33 Gonorrhea among 15+ age men

	Total
Rate of laboratory-diagnosed gonorrhea among men in countries with laboratory capacity for diagnosis	0.05%
Number of men reported with laboratory-diagnosed gonorrhea in the past 12 months	737
Number of men 15 years and older	1 596 347

Indicator 10.6 Hepatitis B testing

Methods of calculation:

- **Numerator:** Number of people started on antiretroviral therapy who were tested for hepatitis B during the reporting period using hepatitis B surface antigen tests
- **Denominator:** Number of people starting antiretroviral therapy during the reporting period

Table 34 Proportion of people starting antiretroviral therapy who were tested for hepatitis B

	Total	Males	Females	<15	15+	People who inject drugs
Proportion of people starting antiretroviral therapy who were tested for hepatitis B	68.94%	66.32%	71.85%	64.70%	69.02%	68.18%
Number of people started on antiretroviral therapy who were tested for hepatitis B during the reporting period using hepatitis B surface antigen tests	637	323	314	11	626	60
Number of people starting antiretroviral therapy during the reporting period	924	487	437	17	907	88

Indicator 10.7 Proportion of people co-infected with HIV and HBV receiving combined treatment

Taking into account the large prevalence of HVB in Republic of Moldova, the main scheme of 1st line anti-retroviral treatment contains medicines effective against HVB and HIV infection (i.e. TDF, 3TC, FTC). The co-infection HIV/HVB is an indication for beginning of ART, disregarding of the CD4 cell account. The percentage of the combined HIV/HVB treatment is 0%, thus in the same time the patients receive medicines effective against HVB and HIV infection.

Indicator 10.8 Hepatitis C testing

Methods of calculation:

- **Numerator:** Number of adults and children starting antiretroviral therapy who were tested for hepatitis C during the reporting period using the sequence of anti-HCV antibody tests followed by HCV polymerase chain reaction (PCR) for those who are anti-HCV positive.
- **Denominator:** Number of adults and children starting antiretroviral therapy during the reporting period

Table 35 Proportion of people starting antiretroviral therapy who were tested for hepatitis C virus (HCV)

	Total	Males	Females	<15	15+	PWID
Proportion of people starting antiretroviral therapy who were tested for hepatitis C virus (HCV)	69.37%	67.97%	70.94%	70.59%	69.35%	75.00%
Number of adults and children starting antiretroviral therapy who were tested for hepatitis C during the reporting period using the sequence of anti-HCV antibody tests	641	331	310	12	629	66
Number of adults and children starting antiretroviral therapy during the reporting period	924	487	437	17	907	88

Indicator 10.9 Proportion of people co-infected with HIV and HCV starting HCV treatment

In Republic of Moldova, there was no treatment available for co-infected HIV/HCV during 2016. The result – 0% from the 1688 people diagnosed with HIV and HCV co-infection enrolled in HIV care during a specified time period.

Not applicable indicators for Republic of Moldova

The indicator 3.15, 3.16, 3.17, 10.4 and 10.10 are not applicable to Republic of Moldova settings.

Examples of good practices

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

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

The Republic of Moldova is recognized in the region as an example of good practices due to its successful implementation of Harm Reduction Programmes in key populations at risk in the civilian sector (IDUs, CSWs, MSM) and in penitentiary institutions (IDUs, MSMs). Thus, there are needle exchange, condom distribution, specialist consultation (psychologist, social assistant, medical), distribution of informational material, peer to peer counselling, VCT, etc. as well as referrals to medical and social services.

Methadone Substitution treatment is provided both in the civilian sector and in penitentiary institutions (on right bank of Dniester river only).

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

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

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

8. 2013 – VTC through NGO on saliva available for inmates;

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

Moldova continues strengthening PSM for essential medicines and commodities through consolidation of transparent and competitive mechanisms for the best value for money. An agreement between MOH and UNDP has been signed in 2017 on procurement via international mechanisms – covering majority of national programs, including HIV. At the end of 2016 the Law on Public Procurement was amended to allow online trading based procurements.

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