

**TECHNICAL ASSISTANCE FOR THE ASSESSMENT OF
BARRIERS AND FOR THE DEVELOPMENT OF A
REPORT ON THE REMOVAL OF BARRIERS TO ACCESS
TO HIV CONTINUUM OF CARE**

FINAL REPORT

This document is presented to the *Global Fund to Fight AIDS, TB and Malaria and Ministry of Labour and Social Protection and Family of Moldova*

DECEMBER 27, 2017





Technical assistance for the assessment of barriers and for the development of a report on the removal of barriers to access to HIV continuum of care- Final Report

This Final Report is the final deliverable under the contract “Technical assistance for the assessment of barriers and for the development of a report on the removal of barriers to access to HIV continuum of care” with the Global Fund to Fight AIDS, TB and Malaria and Ministry of Health, Labour and Social Protection.

Sanigest Internacional © 2017

This document is a formal publication by Sanigest Internacional and all rights are reserved by the firm. This document may be revised, abridged, reproduced, or translated in full or in part, but it may not be sold or used for commercial purposes.

Comments and questions regarding this report:

We welcome all communications regarding this first Report and the Project in general. They may be addressed to the Team Leader (James A. Cercone, jcercone@sanigest.com.)

Acronyms y Abbreviations

AIDS	<i>Acquired Immunodeficiency Syndrome</i>
ART	<i>Antiretroviral Treatment/ Therapy</i>
ARV	<i>Antiretroviral</i>
EHRN	<i>Eurasian Harm Reduction Network</i>
GFATM	<i>Global Fund to Fight AIDS, TB and Malaria</i>
HIV	<i>Human Immunodeficiency Virus</i>
HTC	<i>HIV Testing and Counselling</i>
IBBS	<i>Integrated Bio-Behavioural Study</i>
IEC	<i>Information Education Communication</i>
KPs	<i>Key Populations</i>
LGBT	<i>Lesbian, Gay, Bisexual, and Transgender</i>
M&E	<i>Monitoring and Evaluation</i>
MARP	<i>Most at risk population</i>
MHLSP	<i>Ministry of Health, Labour and Social Protection</i>
MTCT	<i>Mother to Child Transmission</i>
MSM	<i>Men Who Have Sex with Men</i>
NAP	<i>National AIDS Program</i>
NCC	<i>National Coordination Council</i>
NGO	<i>Non-Governmental Organization</i>
NSP	<i>Needle and Syringe Programmes</i>
OST	<i>Opioid Substitution Treatment</i>
PLWH	<i>Person/People Living with HIV</i>
PWID	<i>Person Who Injects Drugs</i>
RSC	<i>Regional Social Centres</i>
STI	<i>Sexually Transmitted Infections</i>
SW	<i>Sex Worker</i>
TB	<i>Tuberculosis</i>
ToR	<i>Terms of Reference</i>
VCT	<i>Volunteer Counselling and Testing</i>
WHO	<i>World Health Organization</i>
WS	<i>Work Stream</i>
UNAIDS	<i>United Nations Joint Programme on HIV/AIDS</i>

Table of Contents

1.	INTRODUCTION	6
1.1.	Description of the Project	8
1.1.1.	Specific Objectives	8
1.1.2.	Scope	9
1.1.3.	Stakeholder Analysis	9
1.1.4.	Limitations	10
1.2.	This Report	10
2.	METHODOLOGY	11
2.1.	Technical Approach.....	11
2.1.1.	The cascade of HIV treatment and care services	11
2.1.2.	The HIV test–treat–retain cascade.....	12
2.1.3.	The HIV care cascade under the WHO 2015 “treat all” policy	13
2.1.4.	Metrics for Monitoring the Cascade of HIV Testing, Care and Treatment Services	14
2.1.5.	How to Implement the Cascade analysis for a country assessment?	15
2.2.	WS 1. Moldovan HIV Cascade Design	15
2.2.1.	Building the HIV Cascade Assessment Framework	16
2.2.2.	Desk Review	16
2.3.	WS 2: Field Visits	21
2.3.1.	Interviews/discussions with key stakeholders	21
2.4.	WS 3. Data Analysis and Final Recommendations.....	22
2.4.1.	Adjusting data	22
2.4.2.	Identifying barriers and recommendations for their elimination	23
3.	SITUATION ANALYSIS	27
3.1.	The National Response to HIV/AIDS and TB	27
3.1.1.	Policies and Legislation.....	27
3.1.2.	NAP expenditures.....	28
3.1.3.	NAP Services.....	29
3.2.	Current HIV Epidemic in Moldova	31
3.2.1.	Means of transmission	31
3.2.2.	Interregional Differences	31
3.2.3.	Prevalence and Testing Among MARP	32
4.	HIV CASCADE ASSESSMENT	33
5.	KEY FINDINGS.....	36
5.1.1.	Barriers in the Cascade of Care for key populations at risk of HIV infection – Republic of Moldova	43
5.1.2.	Conclusions and Recommendations.	50
5.1.3.	Problem Tree and Final Recommendations	52
	REFERENCES	54
	ANNEX 1: TERMS OF REFERENCE.....	55

List of Tables



Table 1: NAP 2016-2020 targets compared to latest data	6
Table 2: Indicators by Cascade Step	17
Table 3: List of stakeholders met during field visit 13-15 Dec. 2017.....	21

List of Figures

Figure 1: Project management framework.....	8
Figure 2: Stakeholder matrix.....	9
Figure 9: The HIV cascades: continuum of care.....	12
Figure 10: A new HIV care cascade after moving to Treatment for All	13
Figure 11: Example of core numerical indicators for periodic cascades	14
Figure 12: Examples of cascade presentation	23
Figure 3: NAP funding by source (2012-2016 in MDL)	29
Figure 4: Main HIV, TB and STI services	29
Figure 5: Continuum of HIV prevention to care (CoPC) cascade	33
Figure 6: CoPC cascade by sex	34
Figure 7: Continuum of care of PLWH	35
Figure 8: MSM continuum of care	35

1. Introduction

After the 2001 Declaration of Commitment on HIV/AIDS, the Republic of Moldova began to consistently report on the national response to HIV/AIDS. The country's commitment was reinforced in 2006 and has increased in importance after the 2011 UN Political Declaration on HIV and AIDS (NCC 2016). This is reflected in the National Programme on Prevention and Control of HIV/AIDS and STI (NAP). The new 2016-2020 program "aims at mitigating the impacts of the epidemic by reducing the spread of HIV and [sexually transmitted diseases] STDs (particularly in the key populations) as well as HIV/AIDS-related deaths" (EHRN 2016). Unlike previous programs, the 2016-2020 NAP focuses on integrating services, expanding testing and has more ambitious targets, as presented in the following table.

Table 1: NAP 2016-2020 targets compared to latest data

	Target 2020
HIV-related death rate	<3% per 100,000
Deaths caused by HIV-associated tuberculosis	Decrease by 35%
Stabilise HIV prevalence in key populations:	
People who inject drugs	< 10% in Chisinau; < 38% in Balti; < 30% Tiraspol
Sex workers	< 9% in Chisinau; < 18% Balti
Men who have sex with men	< 8% in Chisinau; < 12% in Balti
Prisoners	< 2%
Expansion of HIV testing:	
PWID	60%
SW	60%
MSM	40%
Coverage of prevention services	
PWID	60%
SW	60%
MSM	40%
Antiretroviral treatment coverage of people living with HIV	60%

Source: ToR and EHRN (2016)

More specifically, the objectives of the NAP, as detailed in the ToR, are the following:

1. To prevent HIV and sexually transmitted infections transmission, particularly in the key population.
2. To ensure universal access to treatment, care and support for all people infected with STIs.
3. To ensure and efficient Programme management.

These objectives are set in the context of the UNAIDS goals of 90-90-90 which aim to have by 2020, 90% of all people living with HIV will know their HIV status; by 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and by 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

The importance of ensuring each of these goals has led to developing an analytic framework that can be used to diagnose the current situation of HIV programmes around the world and to analyse the barriers at each stage to develop strategies to achieve the 90-90-90 goals. The NAP recognizes that the ultimate goal of HIV treatment is to achieve viral suppression, meaning the amount of HIV in the body is very low or undetectable. This is important for people with HIV to stay healthy, live longer and reduce their chances of passing HIV to others.

In this regard, the HIV care continuum consists of several steps required to achieve viral suppression. Specifically, the cascade, or continuum, tracks:

- Diagnosed
- Linked to care*, meaning they visited a health care provider within: – 1 month (30 days) after learning they were HIV positive
- Received or were retained in care**, meaning they received medical care for HIV infection
- Viral suppression, meaning that their HIV “viral load” – the amount of HIV in the blood – was at a very low level

The NAP is based on the current epidemiological needs and is further aligned with the “latest UNAIDS strategies as Fast Track and WHO recommendations related to treatment, care and support” (NCC 2016), particularly the treatment cascade philosophy.

The Republic of Moldova has seen notable improvement in many of its outcomes, with mixed results when analyzing by city. For example, even though there was a decreased in HIV prevalence in Chisinau from 2013 to 2010, falling from 16.4% to 8.5%, there was an increase during this same period in Tiraspol from 12.6% to almost 24%. Overall, there is a concentrated HIV epidemic on key populations (KPs), notably people who inject drugs (PWID), female sex workers (SW) and their partners, men who have sex with men (MSM) and prisoners. Furthermore, according to the last report by the National Coordination Council (NCC) in 2016, there is greater prevalence in the Transnitrian region.

The implementation and scale up of the Harm Reduction Programmes among the most at risk population (MARP) has yielded positive results in areas of HIV prevention, particularly among PWID. Interventions such as the Needle Replacement Program (NSP) and opioid substitution therapy (OST) have been able to scale up at a rapid rate thanks to the support of the Global Fund to Fight AIDS, TB and Malaria (GFATM). Nevertheless, many of these programs still have low coverage rates and are distributed unevenly between the cities (ToR 2017).

In 2003, GFATM and World Bank grants supported the introduction antiretroviral treatment (ART) in the Republic of Moldova (NCC 2016). The demand for ART increases every year, but ART coverage is still low (ToR 2017). According to the ToR, this is a result of a serious of shortcoming in the HIV control strategies and programmes, where KPs face barriers to access prevention services and testing to know the HIV status. The Ministry of Health, Labour and Social Protection and the GFATM seek to assess the systematic barriers to access the HIV continuum of care for all people living with HIV (PLWH), people living with HIV/TB (PLWH/TB) and KPs (PWID, SW and MSM).

1.1. Description of the Project

The main objective of this project is to implement the cascade assessment and brief key stakeholders on the findings of the HIV test–treat–retain cascade analysis, providing the opportunity to discuss the findings and develop recommendations for urgent action to overcome the obstacles, gaps and missed opportunities identified through this analysis. We understand that the longer-term goals would be visualized on more effective strategies and interventions to accelerate HIV testing and treatment scale-up in Moldova.

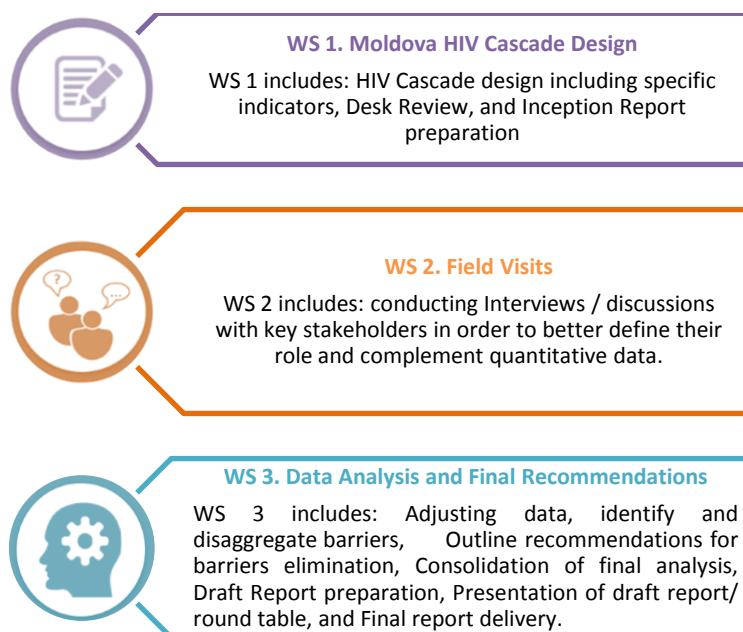
1.1.1. Specific Objectives

The specific objectives identified in the ToR (annex 1) are summarized as follows:

1. Complete a desk review of the latest assessments of the NAP.
2. Identify the role of key stakeholders in order to increase coverage of HIV services and reduce HIV prevalence and incidence
3. Obtain and analyse the data obtained on the continuum of care for the target population groups in order to identify barriers faced by PLWH, PLWH/TB and KPs, taking into account gender and age characteristics
4. Develop a final report on the cascade assessment
5. Develop recommendations regarding the elimination of barriers faced by the target population groups.

In order to carry out the activities required to complete all the objectives of the project, Sanigest has divided the project activities in 3 interrelated Work Streams that will guide the implementation of the consultancy.

Figure 1: Project management framework



Source: Sanigest Internacional

1.1.2. Scope

The project was initially foreseen to take place over an 8-week period and encompass the collection and review of data on the HIV cascade for PLWH, PLWH/TB, PWID, SW and MSM at a national level, however, all deliverables will be produced by December 31st.

1.1.3. Stakeholder Analysis

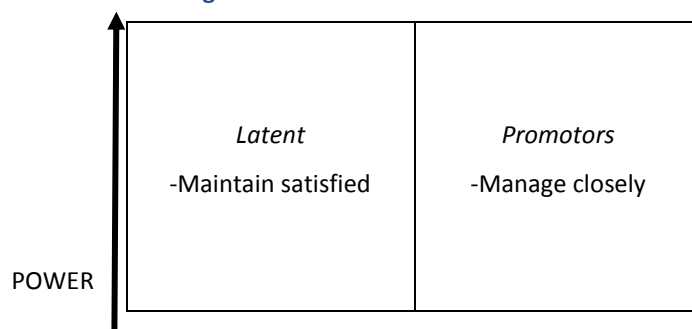
Stakeholders were identified based on the guidelines/toolkit for cascade analysis. Besides the NAP and the National Coordination, Implementation and Monitoring Unit of Health Projects (UCIMP), other stakeholders included key informants from the following:

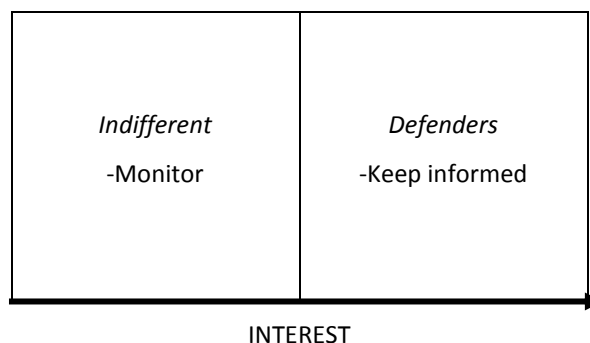
- Regional centers for VCT (HIV, HCV, HBV, STI testing) from Chisinau and Balti
- Clinical hospital providing PMTCT
- Laboratories (national and regional)
- Confirmatory/national testing laboratory
- Social support centers (Chişinău and Bălţi)
- NGOs working with MARPs (such as drug users, sex workers, men having sex with men, prisoners, people with TB or homeless people – Inițiativa Pozitivă, TDV, AFI)
- Outreach workers
- NGOs advocating for the rights of MARPs (Soros Foundation) and for the social inclusion of PLHIV and MARPs (all NGOs contacted).

No meeting was established during the field visit with representatives of MHLSP (established in 2017 by merging the Ministry of Health with Ministry of Labor).

Some stakeholders had greater direct contact with MARPs (e.g. in Balti TDV, in Chişinău Inițiativa Pozitivă and AFI), others had a general overview of the cascade of care (National HIV Program, Soros Foundation), both perspectives creating the possibility for a comprehensive understanding of the care and support services available for MARPs/PLWH. Based on the stakeholders' matrix we consider that all key informants met during the field visits could be included under the *Promotors* category illustrated in Figure 2.

Figure 2: Stakeholder matrix





Source: Sanigest Internacional

1.1.4. **Limitations**

The most important limitation regarding this assignment is the time span assigned for its completions, which is short and coincides with numerous holidays and events that commonly take place during the month of December.

The scope of the work is broad and the analysis requires a significant amount of data, in addition to that found in national reports from previous reporting period (2013-2016), which is not readily available. It is important to note that partial data for the current year (2107) was no available.

1.2. **This Report**

The Final Report outlines the proposed methodology to meet the objectives of the consultancy based on the WHO HIV test-treat-retain cascade analysis, NAP and the Moldovan context. The report is structured as follows:

- Chapter 1 provides an overview of the consultancy.
- Chapter 2 provides a review of the methodology followed.
- Chapter 3 follows with a brief situation analysis based on the desk review.
- Chapter 4 provides the overview of the cascade analysis results
- Chapter 5 outlines the key findings and recommendations

2. Methodology

This section describes the methodology applied to carry out the activities of the Project presented in the ToR and is based on the objectives of the project established by the client and our understanding of the situation. The following sections provide a description of the methodology that will be applied to each WS of the consultancy.

2.1. Technical Approach

The methodology developed is based on our extensive experience in similar consultancy projects and is based on key factors to guarantee the achievement of the project objectives are the following:

- **Comprehensive understanding** of the project and the activities required to achieve the objectives.
- A **highly professional team** of international and local experts with ample field presence and the ability to achieve demonstrable results.
- Establishment of **project management** to ensure timely performance of the tasks and deliverables and to ensure constant communication with the Client and other key stakeholders.
- **Stakeholder buy-in** is one of the most important elements for project implementation, success, and sustainability. For this reason, we have developed our methodology to include regular meetings with key stakeholders and have them involved in each of the three tasks in our methodology.

Our approach is based on the ToR for this technical consultancy and the literature review carried out as part of the desk review. The approach recognizes the fundamental focus of this project is to provide technical assistance on the development of recommendations for urgent action to overcome the obstacles, gaps and missed opportunities identified through conducting a HIV test–treat–retain cascade assessment.

2.1.1. *The cascade of HIV treatment and care services*

HIV cascades are used all over the world, and are referred to by various names, including the HIV/AIDS care continuum; the cascade of HIV care; and recently, the cascade of HIV testing, care and treatment services. The HIV treatment cascade is a tool that has been adapted by HIV programs to evaluate the quality of such activities by measuring the proportion of patients achieving essential steps in the HIV continuum of care that are necessary to maximize individual health and population prevention benefits of ART (Gardner, et al. 2011, McNairy and El-Sdr 2012).

The HIV cascades commonly begin at HIV diagnosis and consist of several bars or steps that illustrate the continuum of care (Figure 1), where the suppressed viral load occurs when antiretroviral drugs reduce the HIV virus to a very low level in the body. Lowering the

amount of virus helps PLHIV live longer, healthier lives and greatly reduces the chances of transmitting HIV to others.

Figure 3: The HIV cascades: continuum of care



According to USAID (2015), this approach ensures stakeholders plan and provide a full range of services to address prevention; care & support; treatment; needs of people- families and communities infected or affected by HIV/AIDS, including strategies to break the cycle of HIV transmission (Aluma 2015). It also helps identifying gaps to improve HIV care using quality improvement methods to support health systems and HIV positive individuals better.

2.1.2. The HIV test–treat–retain cascade

At each step of this continuum of care the health system succeeds in engaging a certain proportion of beneficiaries (PLHIV) and fails to engage or retain others. The losses from one step to another can be visualized in the format of a HIV test–treat–retain cascade.

The cascade shows, in visual form, the number of PLHIV who actually receive the full benefits of HIV testing, care and treatment at each step along the continuum of care for PLHIV (Fig. 2). The main objective of an analysis of the HIV test–treat–retain cascade is to describe and quantify losses and missed opportunities to engage and retain PLHIV along the continuum of care and to explore reasons for these losses.

Analysis of the first step in the continuum, i.e. getting to know one’s HIV status (HIV testing), may reveal low demand for, access to and utilization of HIV testing and counselling services. This situation prevails in the Region and results in the majority of PLHIV being unaware of their HIV status. When diagnosed with HIV infection, many PLHIV are lost before they are linked to care or before they are initiated on ART. Failure to retain PLHIV on life-long treatment after treatment initiation is another reason for loss of PLHIV and for the failure to achieve and sustain viral load (VL) suppression. It is important to bear in mind that the situation at each step of the continuum of care may be different for different population groups and in different countries and may require different solutions.

Identifying losses and missed opportunities for engaging PLHIV along the continuum of care will inform the development of strategies, service delivery approaches and action plans for accelerating access to HIV testing and treatment.

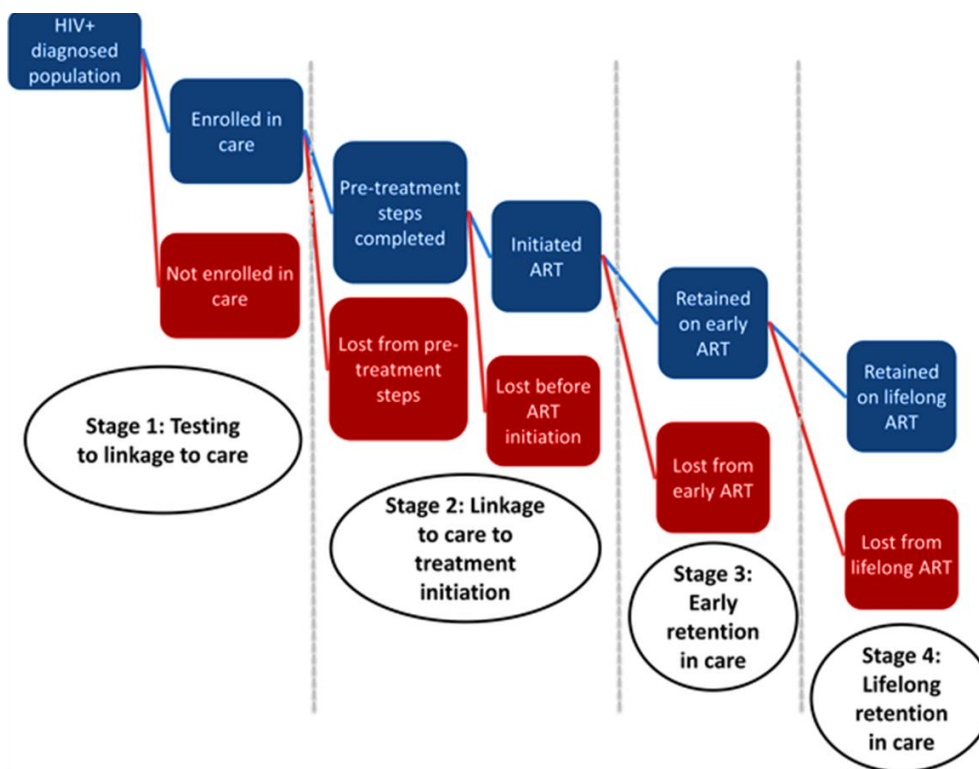
2.1.3. The HIV care cascade under the WHO 2015 “treat all” policy

Before the World Health Organization 2015 “treat all” policy, the HIV treatment cascade did not follow outcomes of patients ineligible for ART, referred to as pre-ART patients. Thus, in many resource-limited settings where the traditional HIV treatment cascade did not provide a comprehensive assessment of all patient outcomes.

Previous studies started to carry out comprehensive HIV care cascade, using a cohort methodology to account for all patients who enroll in HIV programs over time irrespective of ART eligibility and grouping patient outcomes of quality-of-care categories (optimal, suboptimal, and poor). (McNairy, et al. 2015)

In 2015, the WHO recommended ART be offered to all HIV-positive individuals regardless of CD4 count, ushering in the era of “treat all” (WHO 2016). Among the benefits expected by WHO are “significant increases in ART uptake and linkage to care, reduction in the time between HIV diagnosis and ART initiation regardless of baseline CD4 cell count and an increase in the median CD4 value at ART initiation”. One immediate implication of the guideline change is the effective elimination of Stage 2 of pre-ART care, which served as a holding place for patients not yet ART eligible, as shown in the following figure.

Figure 4: A new HIV care cascade after moving to Treatment for All



Source: Fox and Rosen (2017), page 5

The challenge facing health care providers will shift from retaining patients in Stage 2 to improving Stage 1 (getting patients into care after an HIV diagnosis, or “linkage to care”) and Stage 3 (ART initiation). Stages 1 and 3 will remain essential, with the ultimate goal of creating a smooth transition from testing to treatment. This cascade, as in previous

cascades, begins after patients are diagnosed with HIV, and HIV testing could certainly be added as the starting point. The determination of treatment eligibility, is no longer required under a “treat all” policy. In the new cascade, all patients completing Stage 1 immediately enter Stage 2. The challenge for health care providers will be to make this transition as seamless in practice as it appears in the illustration. WHO recommends differentiated care (i.e., care delivered in differing locations, frequency, intensity, etc. for those in different stages of illness, with different levels of adherence to treatment, etc.) as part of the process of ensuring better retention in care across the cascade (Fox and Rosen 2017).

In conclusion, the comprehensive HIV care cascade can serve as a monitoring tool to identify gaps in service models and offer opportunities for specific interventions to improve outcomes. This approach has the potential to enhance quality and enable achievement of the full potential of the global HIV program scale-up.

2.1.4. Metrics for Monitoring the Cascade of HIV Testing, Care and Treatment Services

Key indicators, or metrics, are linked to each bar or step of HIV cascade. These indicators are used to generate a visual representation of HIV service system performance. They help implementers to¹:

- Obtain a snapshot of HIV service system performance
- Present client engagement by gender or key population (as appropriate)
- Identify loss of client engagement – expressed as gaps, leakages or missed opportunities in the continuum of HIV prevention to care
- Prioritize actions to improve HIV service system performance
- Illustrate programmatic progress or improvements over time
- Use human, financial and programmatic resources in strategic ways
- Adopt a public health approach that focuses on population-level impact

The use of consistent unique identifier codes (UIC) in routine monitoring data efforts can improve the validity of outreach data and enable program implementers to graph the progress of individuals through the cascade of services. To ensure that cascades are based on consistent data sources, it is recommended to follow a 1:1 rule. This means that a single, recommended indicator is used to designate each bar of the cascade.

Figure 5: Example of core numerical indicators for periodic cascades



1. *Number of persons in KP groups estimated by the end of the last reporting period.*
2. *Number of KPs reached by community outreach workers during the reporting period*

¹ World Health Organization (WHO) (2014) *Metrics for Monitoring the Cascade of HIV Testing, Care and Treatment Services in Asia and the Pacific*

3. *Number of KPs who received test results and post-test counseling during the reporting period*
4. *Number of KPs who received HIV positive test results and post-test counseling the reporting period or total number of newly diagnosed PLHIV reported during reporting period*
5. *Number of new patients registered at HIV outpatient clinics during the reporting period*
6. *Number of PLHIV with who are newly enrolled reporting period*
7. *Number of PLHIV known to be alive and on treatment 12 months after initiation of ART*

2.1.5. How to Implement the Cascade analysis for a country assessment?

In order to achieve broad ownership of the cascade analysis exercise and the findings and conclusions resulting from it, decision-makers from relevant government bodies and partner agencies, and representatives of service providers, civil society organizations and beneficiaries must be involved. The Sanigest team's scope of activities are divided into 3 WS, which are also subsequently organized into main tasks required to obtain the output associated with each WS. In general teams, the main tasks to be performed are:

- collection of data to draw the HIV test–treat–retain cascade; drawing the cascade and identifying the main gaps along the steps of the cascade;
- determining further needs for quantitative and qualitative data that can explain the causes for the gaps;
- identification and selection of key stakeholders for interviews/discussion and of sites to be visited to fill the information gaps;
- development of tools for collection and compilation of data (an initial outline for this is included in the annex);
- collection of relevant data;
- data analysis: quantification and description of engagement of PLHIV along the HIV test–treat–retain cascade; and interpretation and summary of findings related to the losses/gaps in the treatment cascade;
- presentation and discussion of the main findings to the steering committee; national stakeholders meeting: presentation, discussion and validation of the assessment findings; development of recommendations for urgent action to be taken to accelerate HIV testing and treatment scale-up; and
- development of report summarizing: assessment process and implementation; main findings and discussion; conclusions and recommendations.

The following sections present details on the activities and task to be carried out under each WS.

2.2. WS 1. Moldovan HIV Cascade Design

This WS targets the development of the first deliverable of the consultancy and encompasses the first two objectives detailed under section 1.2., which in turn are related to two main tasks: outlining the proposed methodology, work plan & implementation

schedule under this assignment and conducting a desk review of the latest assessments of the various components of the National Program.

2.2.1. Building the HIV Cascade Assessment Framework

In order to prepare this report and fine-tune methodology of the project, the Team reviewed the six main steps for building a cascade:

1. What? The team chose to use the WHO HIV test-treat-retain cascade analysis Guide and tools as published in 2017, making adjusted to the change in treatment eligibility.
2. Where? National HIV response, with particular focus on the public sector and NGO services provided.
3. Which service area will be emphasized? The focus will be on the whole cascade
4. Who? Target population according to the ToR are PLWH, PLWH/TB, PWID, SW and MSM, disaggregating data by city, age and gender when possible.
5. When? Annual data.
6. How? The final results of the cascade will be illustrated using stacked columns.

All dimensions guided the team in the selection of indicators to include as part of the cascade. The final proposal will be included in the final report.

2.2.2. Desk Review

Under this task, our experts have reviewed the latest assessments of the various components of the National Program to collect any additional *quantitative and qualitative data*. Quantitative data for the HIV cascade came only from official reports and consider the following data collection principals.

1. **Identifying key populations** – It's critical to use size estimation figures that have been officially vetted, either through regional consensus consultations or via national modelling exercises.
2. **Reaching key populations** – Outreach figures should use individuals reached – not contacts – as the designated unit of analysis. Whenever possible, data should be disaggregated by KP sub-category and gender.
3. **Testing key populations** – HIV testing and counseling data of the number of individuals who test or at least the number of tests.
4. **Identifying PLHIV** – Records of the total number of PLHIV reported in districts and provinces within a specified reporting period.
5. **Recording newly diagnosed PLHIV** – The number of newly diagnosed PLHIV within a specified reporting period.
6. **Enrolling PLHIV in care** – Using the facility ART (and pre-ART) registers. If it's a periodic cascade to collect data only for the number of new patients registered at HIV outpatient clinics during the reporting period.

7. **Initiating ART** – For periodic cascades must be distinguished the number of PLHIV who newly initiate ART. Those preparing cross-sectional cascades can also gather cumulative data.
8. **Sustaining ART** – The last bar of the cascade requires implementers to collect data from the previous 12-month period. This figure includes all adult and children patients who are alive and on ART 12 months after initiation of treatment as reported in facility ART registers.

Based on the initial desk review, the following table provides a summary of the selected indicators and available data as it refers to the selected cascade framework, as well as those indicators for which there are data gaps.

Table 2: Indicators by Cascade Step

Cascade Step	Indicator	Value	Source
Identify KP	Estimated number of PLHIV	15,000 (11,000 - 21,000)	UNAIDS, 2016
	Total Population size estimates among key populations: Sex Workers	17,800	Excel file: Estimare_GRSI_raionae_05_10_2017
	Total Population size estimates among key populations: Men who have sex with men	13,000	Excel file: Estimare_GRSI_raionae_05_10_2017
	Total Population size estimates among key populations: PWID	26,100	Excel file: Estimare_GRSI_raionae_05_10_2017
	Total Population size estimates for prisoners	7,762	http://www.prisonstudies.org/country/moldova-republic Data of 2017
Reach KP	Percentage of condoms use among key population: Men who have sex with men	49.2%	UNAIDS, 2016
	Number of condoms distributed among key population: Men who have sex with men	527,074	GARPR, 2016
	Number of IEC materials distributed among key population: Men who have sex with men	3,709	GARPR, 2016
	Number of condoms distributed among prisoners last year	49,669	UNAIDS, 2016
	Number of clean needles distributed among prisoners last year	186,207	UNAIDS, 2016
	Number of prisoners receiving opioid substitution therapy	78	UNAIDS, 2016
	Number of condoms distributed among key population: People who inject drugs.	532 288	Control Monitoring of HIV infection in the Republic of Moldova, 2016
	Number of People who inject drugs receiving information materials	109 644	Control Monitoring of HIV infection in the Republic of Moldova, 2016
	Number of syringes distributed among People who inject drugs.	2 642 705	Control Monitoring of HIV infection in the Republic of Moldova, 2016

Cascade Step	Indicator	Value	Source
	Number of People who inject drugs training in overdose prevention.	1,005	Control Monitoring of HIV infection in the Republic of Moldova, 2016
	Number of People who inject drugs receiving opioid substitution therapy	505	Control Monitoring of HIV infection in the Republic of Moldova, 2016
	Number of condoms distributed among key population: Commercial sex workers	527,395	Control Monitoring of HIV infection in the Republic of Moldova, 2016
	Number of Commercial sex workers receiving information materials	30,969	Control Monitoring of HIV infection in the Republic of Moldova, 2016
Test KP	Number/Percentage of TB patients receiving an HIV test In the past year	2684	Control Monitoring of HIV infection in the Republic of Moldova, 2016
	Number/Percentage of PWID receiving an HIV test In the past year	946	Control Monitoring of HIV infection in the Republic of Moldova, 2016
	Number/Percentage of sexual workers receiving an HIV test In the past year		
	Number/Percentage of man who have sex with men receiving an HIV test in the past year		
	Number/Percentage of prisoners receiving an HIV test In the past year	948	GARPR, 2016
	Number/Percentage of all KP receiving an HIV test in the past year by gender and by age		
Diagnose PLWH	Number of notified HIV cases	11,043	GARPR, 2016
	Number of HIV cases by gender	(M:6,394/F:4649)	GARPR,2016
	Number of HIV cases by age	Age ranges: 0-14/15-49/50+	GARPR, 2016
	Number of people diagnosed HIV positive in the past year	832 M:471/F:361	GARPR, 2016 Control Monitoring of HIV infection in the Republic of Moldova, 2016
	Number of people diagnosed HIV positive in the past year by age		
	Number of MSM diagnosed HIV positive in the past year	2,599	GARPR, 2016
	Number of MSM diagnosed HIV positive in the past year by age		
	Number of SW diagnosed HIV positive in the past year	4,551	GARPR, 2016
	Number of SW diagnosed HIV positive in the past year by age and by gender		
	Number of PWID diagnosed HIV positive in the past year	11,372	GARPR, 2016
	Number of PWID diagnosed HIV positive in the past year by age and by gender		

Cascade Step	Indicator	Value	Source
	Number of prisoners diagnosed HIV positive in the past year	247	GARPR, 2016
	Number of prisoners diagnosed HIV positive in the past year by age and by gender		
	Number of TB patients diagnosed HIV positive in the past year	221	Control Monitoring of HIV infection in the Republic of Moldova, 2016
	Number of TB patients diagnosed HIV positive in the past year by age and by gender		
Enroll in care	Estimated number of PLHIV eligible for ART	5,506 M:2810/F:2696	Control Monitoring of HIV infection in the Republic of Moldova, 2016
	Number/percentage of people enrolled in HIV care within a certain period of time after diagnosis (as per definition agreed in country, e.g. within 1, 3 or 6 months of diagnosis), including age and gender		
	Ratio of number of new PLHIV enrolled in HIV care to number of new people testing positive for HIV	0.58	UNAIDS, 2016
	Number of PLHIV ever enrolled in care	5,881	GARPR, 2016
	Number of PLHIV ever enrolled in care by gender	M:3,066/F:2,815	GARPR, 2016
	Number of PLHIV ever enrolled in care by age		
	Number of PLHIV receiving ART at the end of reporting year	4491 M:2239/F:2252 122 (-15yrs)/3774(15+)	Control Monitoring of HIV infection in the Republic of Moldova, 2016
	Number of PLHIV newly enrolled in HIV care in the last reporting year	924	UNAIDS, 2016
	Number of PLHIV newly enrolled in HIV care in the last reporting year by gender	M:487/F:437	GARPR, 2016
	Number of PLHIV newly enrolled in HIV care in the last reporting year by age		
	Percentage of patients enrolled in HIV care in the last reporting year with CD4 < 350 cell/mm3	49.7%	GARPR, 2016
	Percentage of patients enrolled in HIV care in the last reporting year with CD4 < 350 cell/mm3 by age and by gender		
	Number of PLHIV currently in pre-ART care, also by age and by gender		
	Number of prisoners receiving ART	168	GARPR, 2016
	Number of prisoners receiving ART		

Cascade Step	Indicator	Value	Source
	by gender and by age		
	Number of prisoners newly assigned receiving ART	37	Control Monitoring of HIV infection in the Republic of Moldova, 2016
	Number of prisoner newly assigned receiving ART by age and by gender		
	Number of people with TB newly enrolled on ART	112	GARPR, 2016
	Number of people with TB newly enrolled on ART by age and by gender		
	Number of MSM newly enrolled on ART, also by age		
	Number of SW newly enrolled on ART, also by age and by gender		
	Number of PWID newly enrolled on ART, also by age and by gender		
Initiate ART	ART coverage: Percentage of eligible adults and children currently receiving ART	29% (20-40)	UNAIDS, 2016
	ART coverage: Percentage of eligible adults and children currently receiving ART, by gender		
Sustain ART	Percentage of adults and children still alive and known to be on treatment 12 months after initiating ART	83.54% M:80.97%/86.09%	GARPR, 2016
	Number of adults and children still alive and receiving ART 12 months after initiating treatment in 2015	797 M:400/F:397	GARPR, 2016
	Percentage of health facilities dispensing ARV drugs that experienced a stock-out of at least one required ARV in the last 12 months	0%	GARPR, 2016
Supress viral load	Percentage of patients initiating ART whose VL is <1000 copies/ml after 12 months of ART	74.03% M:69.76%/78.35%	GARPR, 2016
	Percentage of patients initiating ART whose VL is <1000 copies/ml after 12 months of ART by age		
	Number of people living with HIV with supressed viral loads (<1000 copies/ml)	2509 M:1174/F:1335	GARPR, 2016
	Number of people living with HIV with supressed viral loads (<1000 copies/ml) by age		
Outcomes	HIV prevalence among key populations: Sex workers	25.5%	Based on previous table data (Diagnose / Total group population)
	HIV prevalence among key populations: Men who have sex with men	19.9%	Based on previous table data (Diagnose / Total group population)

Cascade Step	Indicator	Value	Source
	HIV prevalence among key populations: PWID	43.5%	Based on previous table data (Diagnose / Total group population)
	HIV prevalence among key populations: Prisoners	3.18%	Based on previous table data (Diagnose / Total group population)

Source: Sanigest Internacional based on data

The table indicates gaps in data available for the detailed cascade assessment. In general, there is no data for the 2017 period for KPs, the number of people of KP tested for HIV and the ART drop-offs for 2015,2016, 2017.

2.3. WS 2: Field Visits

For this second phase, Sanigest conducted a qualitative assessment of a sample of key stakeholders focusing on their characteristics, practices, values, and performance in order to better define their role in the goal of increase the coverage of HIV services and reducing the number of cases in the HIV continuum of care. Since each step of the cascade reflects a combination of processes, understanding the gaps along the cascade of the country will necessitate the collection of additional data in relation to these processes.

2.3.1. Interviews/discussions with key stakeholders

The interviews allowed free discussion by informants, however our interviewers followed a general guide based on the WHO Cascade toolkit to be aware of what questions to ask and topics that should be covered. Our Team has designed a semi-structured interview guideline, which is a key method of enabling dialogue and deep engagement with participants while retaining focus on a particular topic. The interview performed was in strict accordance to the Cascade Strategy framework.

Key informants are people selected for their first-hand knowledge about a topic of interest and these interviews resemble a conversation among acquaintances, allowing a free flow of ideas and information. Interviewers frame questions spontaneously, probe for information and take notes, which are elaborated on later" (USAID 1996).

Reaching out to key informants is particularly useful in cases where the team needs to understand the regulations that might affect the design and implementation of solutions and to gain an understanding of the perspectives, behaviour and motivations stakeholders of an activity or project in order to explain the shortcomings and successes of an activity. This research method will help our Team identify challenges and opportunities to practices and operations.

Based on the initial desk review, the team identified the following stakeholders for the interviews during the field visits:

Table 3: List of stakeholders met during field visit 13-15 Dec. 2017

Stakeholder	Location	Person(s)/Organization
National HIV Team	Chisinau	Iurie Climasevschi – national coord. Maia Râbacov – prophylaxis coord. Ecaterina Noroc – diagn./testing

Stakeholder	Location	Person(s)/Organization
		Valeriu Plesca (?) Igor Condrat – M&E Svetlana Popovici - TARV Iulia Ivtodii - VCT
UCIMP	Chisinau	Victor Volovei
VCT sites 2 public and 1 NGO	Chisinau Balti	VCT center in Chisinau and Balti () Rapid Testing only in NGO
Laboratory	Chisinau Balti	Regional VCT centers
National laboratory / confirmation	Chisinau	National laboratory
Outreach teams	Balti	TDV NGO
NGO working in prisons / TB	Chisinau	AFI (TB+prisons) Initiativa Pozitiva (prisons) - Ruslan Poverga & team
HIV treatment centers – public and non-public	Chisinau Balti	Social Centers (Rotaru Valeriu – Chisinau, Russu Ecaterina - Balti)
Maternity hospital, other hospitals offering PMTCT	Chisinau Balti	Clinical Hospital, no.1 (Dr. Vasile Andreuta)
Groups working on stigma	Chisinau Balti	Initiativa Pozitiva TDV
Groups working with children and adolescents	Chisinau Balti	Social Centers
PLHIV or NGO representing them	Chisinau Balti	In NGOs: Initiativa Pozitiva, TDV Soros Foundation Moldova

Source: Sanigest Internacional

Stakeholders not met include TB staff, NGO delivering treatment (not possible in Moldova), NGO of LGBT (GENDERDOC - M).

2.4. WS 3. Data Analysis and Final Recommendations

Under this final workstream, our Team analysed the collected data in order to determine the barriers faced by PLWH, PLWH/TB and individual key populations (PWID, CSW and MSM), and disaggregating the information taking into account gender and age characteristics in the context of HIV continuum of care in the Republic of Moldova. Our experts will develop recommendations for the elimination of the identified barriers, gaps and leaks by preparing and presenting a Final report.

2.4.1. Adjusting data

For example, in some countries like in Vietnam, HIV testing and counselling data records the number of tests conducted, rather than the number of individuals who test for HIV. This means that the data must be adjusted in order to estimate a true number of KPs who test, with repeat testers – which can constitute, on average, 25% of total tests – subtracted from the totals. Implementers can use the following formula to adjust the data for the number of key populations tested, and for the number of key populations who test HIV positive (which may be included within this column bar):

- Number of KP clients who test for HIV = (Number of reported tests) x (Proportion of clients who tested that are KPs (IDUs, FSWs, MSM)) x (1 - Proportion of clients who retested among clients who are KPs)

- Number of KP clients who test positive for HIV = (Number of reported positive tests) x (Proportion of clients who are KP among clients who are positive for HIV) x (1- Proportion of KP clients who retested among clients who are positive for HIV)

2.4.2. Identifying barriers and recommendations for their elimination

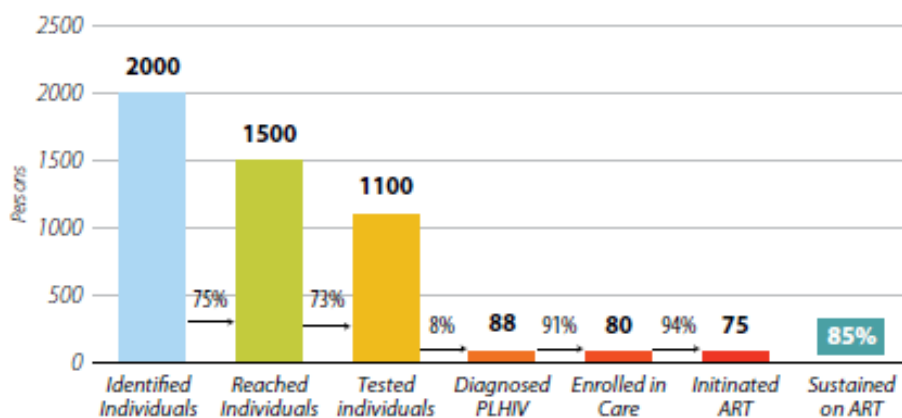
Determining the magnitude of gaps/losses along the HIV test– treat–retain cascade

The assessment starts with the collection of relevant quantitative data on a group of indicators required to draw the cascade of the country. This will provide a first overview of the magnitude of gaps or leaks at each step of the cascade. In addition, since the extent to which different population groups access services is likely to differ, it is useful to explore gaps/losses by subgroup of beneficiaries.

As outlined in our inception report, the approach follows general guidelines to present the cascades include **cascade graphs** that visually display leaks in the HIV service system, where individuals may not be accessing services and receiving the services they need:

1. **Title.** All cascades should have a title that illustrates (a) geographic location or scope; (c) population focus (as applicable); and (d) targeted time period, with month/year if possible.
2. **Vertical axis.** The vertical axis should be displayed as numbers (either hundreds, thousands or higher, as applicable) with the title “persons” or “clients.”
3. **Horizontal axis.** We recommend keeping the cascade bar titles consistent with the ones described in the guide; using different cascade bar terms can be confusing and can make it difficult to compare cascade data over time and place.
4. **Designating cascade column values (top).** Putting numerical values (in numbers) at the top of each relevant column makes it easy for others to interpret the cascade and to use the information for programmatic quality improvement.
5. **Indicating proportions.** Arrows linking cascade bars are labelled with percentages that indicate the proportion of clients moving across relevant steps of the CoPC continuum.
6. **Indicating data source(s).** Whenever possible, cascades should have the relevant data sources listed on the bottom of the graph.

Figure 6: Examples of cascade presentation

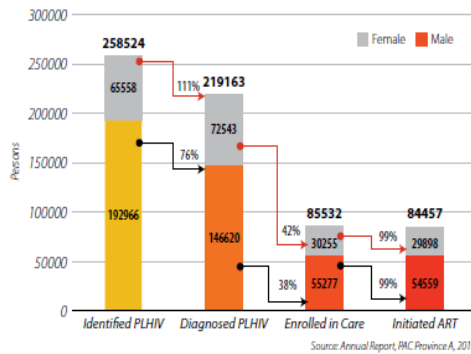


Source: Annual Report, PAC of Province D, 2013

Stacking cascade bars are used to show disaggregated cascade data by:

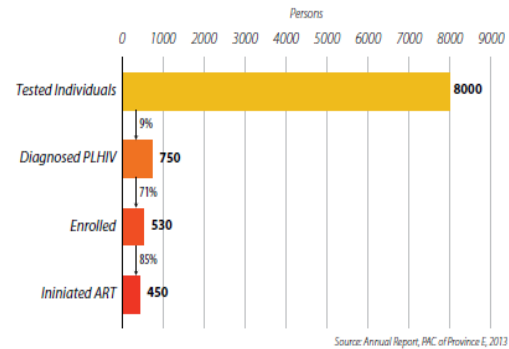
Gender, by showing the differences between men and women as they move through the CoPC

Figure 9 | HIV CoPC Cascade of Province A by Gender, 1-12/2013



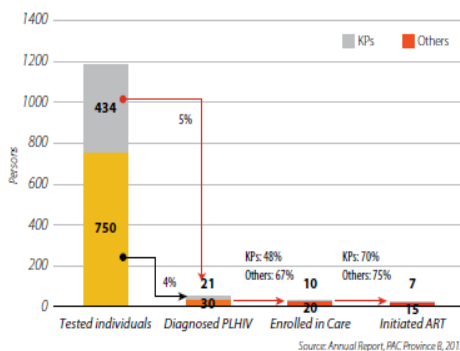
Key population, by distinguishing the proportion of MSM, FSWs or PWID reached and tested for HIV

Figure 10 | HIV CoPC Cascade of People Who Inject Drugs in Province E, 2013



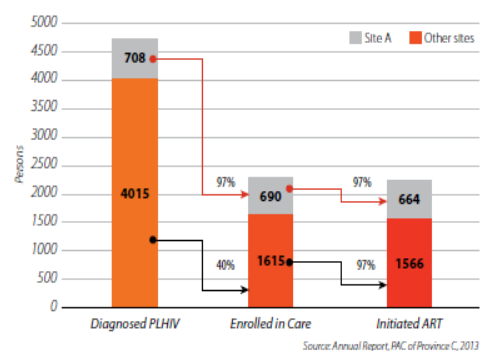
KPs who test positive for HIV, as compared to the total who tested

Figure 11 | HIV CoPC Cascade of PWID and Others in Province B, 2013



Service sites, by showing which sites contribute to cascade bar totals

Figure 12 | HIV Care and Treatment Cascade of Site A compared to other Sites in Province C, 2013



Other forms to present cascade analysis are the **Indicator dashboards**. This data visualization tool can provide an “at a glance” listing of key cascade indicators. Dashboards show recent program performance and actionable information. While dashboards do not track individuals as they progress through the process, they do provide a cross-representational representation of different groups of individuals at different stages of the cascade. And the **Trend graphs** that are particularly useful when implementers assess progress or improvements over time of particular indicators.

Understanding the determinants for the gaps/losses

This will include exploring the reasons and factors related to the National HIV/AIDS and STI Program (policies, strategies, management), to the client/ patient and to the health system. It will be important analyze how far integration (or the lack thereof) of HIV services into the overall health system contributes to the gaps and attrition along the continuum. To analyse and understand the cause-effect relationship between various findings, certain tools can be used, such as the drawing of **problem trees or fishbone diagrams**.

Additionally, some more in-depth analysis for relevant key population groups might be needed to understand the unique challenges for engaging and retaining them in care, for

example, people who inject drugs (PWID). The real value of cascades lies in their use as programmatic assessment and quality improvement tools. When reviewing cascade data, our experts ask the following questions as they begin the process of interpretation and utilization:

- Where are the leaks? While there may be leaks throughout the cascade, some areas may be more pronounced, or more important to address, than others. Often, key leaks in the cascade occur from the reach – test, and from the diagnosis – enrollment phases of the cascade. Deciding where to focus quality improvement efforts is a critical step in interpreting cascade data.
- Who is most affected by the leak(s)? Is the data disaggregated by gender and/or KP subcategory? If so, are there differences between groups and their service access, uptake or retention?
- Why are there leaks? Implementers should examine, in collaboration with service providers, KP clients, and other key stakeholders, the reasons behind cascade leaks. Reasons can include:
 - Client access and uptake barriers. Do clients know and believe in the benefits of the service(s)?
 - Are service locations accessible, affordable, and convenient?
- Structural barriers. Does the legal and policy environment facilitate or impede client access and uptake of services?
- Data quality issues. Do data quality issues compound cascade gaps, or minimize cascade leakages?

Developing recommendations for action

To move from research to real-world solutions, the cascade analysis goes through a process of synthesis and interpretation. This requires a mode of narrowing and culling information and translating insights about the reality of today into a set of opportunities for the future.

Synthesis is understood here as the act of making sense of data collected during the fieldwork by seeing the patterns, linkages, themes, and larger relationships between the information. Our Team will develop a textual analysis through the methodology of Thematic coding, which is the recording or identifying passages of text or images linked by a common theme or idea, allowing the indexation of text into categories. Seeing the patterns and connections between the data will lead our Team quickly toward real- world recommendations.

The results present both quantitative and qualitative analyses of the information obtained, systematized and processed. The quantitative analysis aims to identify and quantify the current situation based on targets and indicators. The qualitative analysis discussing the findings including observations and experiences arising from the interviews and the methodology employed.

Analyzing data in order to summarize and look for patterns is an important part of every assessment. Strategies for the analysis of the data and how the data will be synthesized should be decided at the evaluation design stage. In a general sense, data analysis will seek



to develop a deeper understanding and to translate that understanding into innovations through the recommendations that Sanigest will develop for the final report.

A summary of the most relevant findings, conclusions and suggestions for potential solutions will be developed for validation and discussion at the stakeholder consultation (round-table). One of the important strengths in using the cascade is that it can not only identify where the leak is and who is most affected, it can also lead to tailored interventions that will be most effective in addressing and closing the leaks. Examples of common leaks and relevant solutions include:

Low service coverage of KPs: Solutions may include moving services to locations closer to the KPs, extending opening/closing times, reducing fees, integrating services, training providers to create a more friendly environment for clients being served, etc.

Outdated or no specific policy, may require the updating of policies and standard operating procedures, issuing directives and decrees, etc.

Limited clientele, may require demand creation strategies, performance-based incentives, greater confidentiality, transportation support, etc.

The final report represents a brainstorming on a variety of possible solutions, and we will work in close collaboration with the client to refine the proposed strategies to improve cascade performance.

3. Situation Analysis

The Republic of Moldova is divided into 35 rayons (districts), 3 municipalities at the right of the Nistru River (Chisinau, Balti and Comrat), and the region to the left of the river, Transnistria, is divided into two municipalities as well (Tiraspol and Bender). An additional 8 cities have the status of municipality (Ministry of Health of the Republic of Moldova 2017).

The country is currently facing challenges in the coverage and efficient management of its national HIV response. Even though there has been improvement in the health outcomes of target population groups, there are differences in access and availability of prevention and treatment services by group and location. The following sections provide an overview of the current HIV/AIDS and TB program context and services, the HIV epidemic and an initial assessment of the HIV cascade in the Republic of Moldova.

3.1. The National Response to HIV/AIDS and TB

The Republic of Moldova first signed the Declaration of Commitment to HIV/AIDS in 2001 and since then has reinforced its commitment to increase the efficiency of this HIV response, most recently with the development of the 2016-2020 NAP, which was approved by the Government on October 22nd of 2016.

The new NAP document incorporates the 2013 recommendations and is profoundly anchored in current national development policies and plans. This programme is coordinated by the National Coordination Council for HIV and TB (NCC), which is an inter-ministerial and intersectorial decision-making entity formed by government stakeholders, PLWH representatives, NGOs and international community, forming working groups according to specific functions (ToR, NCC 2017).

3.1.1. Policies and Legislation

According to NAP (MDA Narrative Jan 2016 Report) relevant sectorial policies include the National Health Policy approved in 2007 and the National Strategy for Health System Development for 2008-2017, which foresees consolidation of actions to stop the increase in HIV incidence. Moldova's development Strategy to 2020 focuses on several key very specific objectives, including improving infrastructure for enhanced access to health services.

The legislative tools include a set of laws which have been adopted to ensure sustainability of actions:

- ✓ Law on Health Protection (1995),
- ✓ Law on Reproductive Health and Family Planning (2001),
- ✓ Law on Migration (2003),
- ✓ Law on Equal Opportunities (2012),
- ✓ Law on AIDS Prevention and Control (2007 modified in December, 2012),
- ✓ Law on Combating Domestic Violence (2008),
- ✓ Law on Social Assistance (2008),
- ✓ Law on donors and blood transfusions (2009).

According to NAP reports, significant efforts have been invested to develop harmonized national standards and instructions related to the prevention and prophylaxis of HIV/AIDS. These include a series of national standards and guidelines related to HIV services (VCT, PMTCT, HIV surveillance, Infection Control, HIV Care and Treatment etc.).

During 2014-2015, the National HIV Treatment Clinical Protocol was reviewed and approved based on the WHO recommendations to eliminate the CD4 threshold to qualify for ART. Furthermore, regulations on sharing personal health information related to HIV and standards on HIV counselling and testing using rapid tests amongst vulnerable groups by non-governmental organizations (NGOs) were developed and approved.

It is important to mention that in Moldova the exposure to, or transmission of, HIV is still prosecuted under the Criminal Code (approved by Law No. 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. Nevertheless, human rights campaigners and other NGOs have expressed concerns that these law lead to a violation of the rights of PLWH, exacerbating their marginalization. However, it is worthwhile mentioning that the Moldovan legal framework does not contain an offence for MSM. Moldova has one of the most progressive legal environments around harm reduction and decriminalising drug possession.

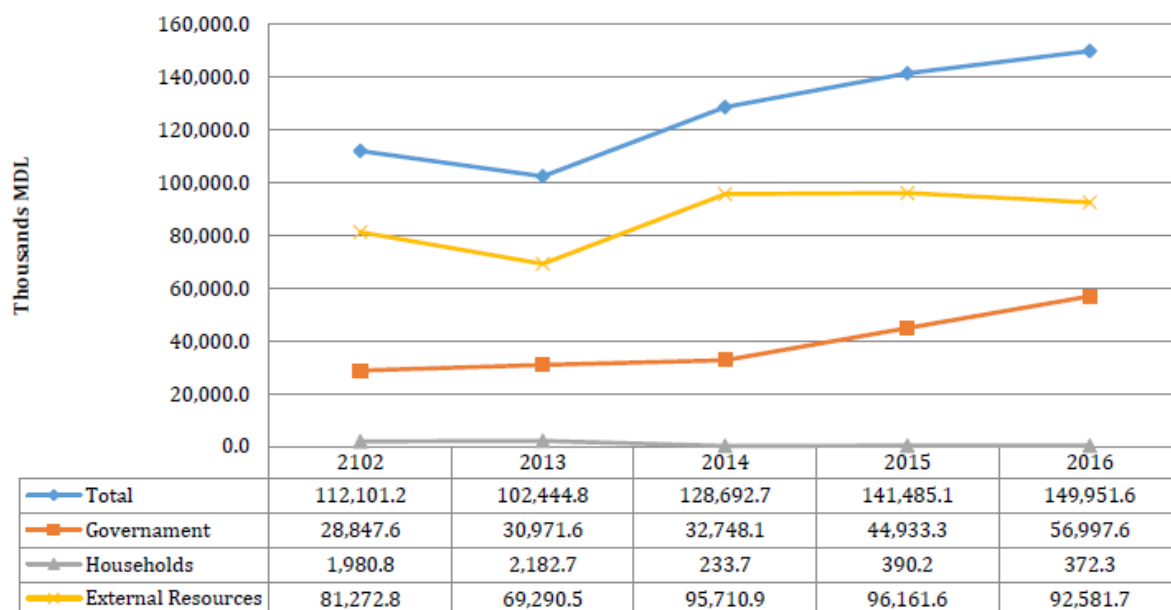
Since 2004 there has been a marked shift in drug enforcement strategy towards prioritising the prosecution of drug dealers alongside the detection of drug trafficking networks and drug producers, rather than criminalisation of drug use. In addition, in 2008, personal drug use was decriminalised.

Major amendments to the Penal Code and Administrative Offences Code reformed criminal punishment, promoting alternative punishments to imprisonment and excluding the application of arrest for personal drug use, now constituted an administrative rather than criminal offence. The illegal purchase or possession of narcotic drugs or psychotropic substances in small quantities without the intention to distribute them, as well as their consumption without a medical prescription, is sanctioned by a fine or community service. Selling sex is an administrative misdemeanour; but pimping is a criminal offence.

3.1.2. NAP expenditures

The national HIV response in Moldova is greatly dependent on external sources, such as fund received from the GFATM, with a steady increase in public resources in the last year, aiming to attain financial sustainability of the programme. The following graph provides an overview of the amount and sources of resources for the national HIV response in Moldova. As can be seen the total expenditures increased from 112 million MDL in 2012 to 150 million MDL in 2016. Of the total amount, government resources increased from almost 26% to 38%.

Figure 7: NAP funding by source (2012-2016 in MDL)

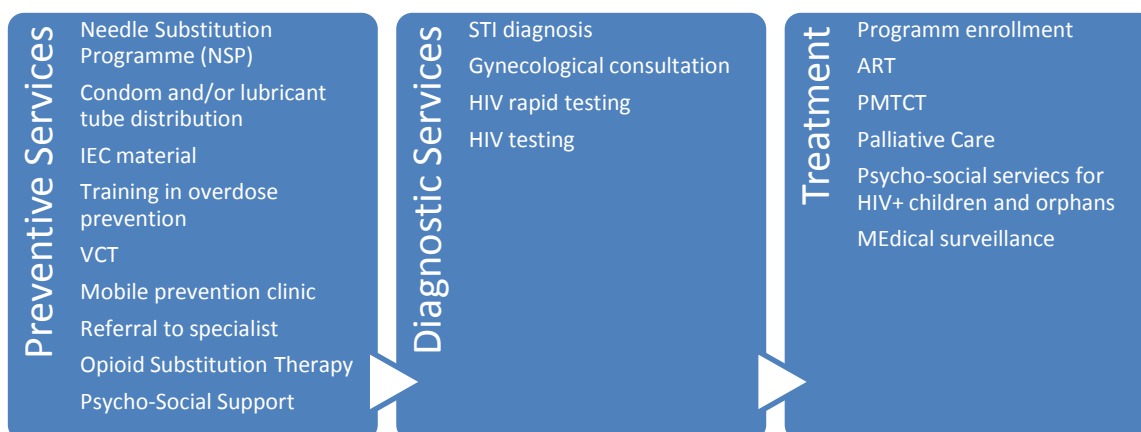


Source: NCC (2017), page 36

3.1.3. NAP Services

The national HIV response consists of several preventive, diagnostic and treatment services, most of which are targeted towards KP considering the concentrated epidemic in the country. The following graph summarizes the services current provided and monitored by the NAP and HIV/TB and STI M&E efforts.

Figure 8: Main HIV, TB and STI services



Source: Based on NCC (2017) and Ministry of Health of the Republic of Moldova (2017)

Prevention:

to HIV prevention activities among the MARP, which have also been the activities who have seen the fastest scale up.

As illustrated in Figure 8, the range of prevention services includes the adoption of several harm reducing strategies and needle substitution programme (NS) as part of the national

strategy for HIV prevention among PWID, which have resulted in the most progress and reduction in the frequency of mode of transmission to less than 9% in year 2016 from more than 80% in year 2009.

Treatment, care and support:

The National HIV Programme for 2016-2020 is built on the 90-90-90 goal and treatment cascade philosophy, promoted by WHO and UNAIDS, which recommends to start with good testing and diagnosis strategies, continuing with enrolment in treatment, offering qualitative treatment and care so that to finalise with a viral load close to zero. The treatment cascade as part of the 90-90-90 strategy encourages countries to diagnose 90% of those estimated living with AIDS, to enrol 90% of those who need treatment 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, and MSM. The ART package of service envisages several elements, such as TARV, TARV as prevention for PMTCT and post-contact prophylaxis, and treatment of co-infections.

Care and support programmes includes nutritional, legal and psychosocial support, including palliative care, services for HIV + children and orphans (social/psycho-social services). The package also includes active medical surveillance of all persons diagnosed with HIV in specialized institutions, with specific investigations.

The most important achievements relate to ensuring access to HIV treatment, which is 100% available to those who access health service, include the:

- Decentralization of treatment services and HIV care throughout the country,
- Provision of PMTCT services,
- Improvement of accessibility and quality of prophylactic ART for HIV pregnant women
- Opening a paediatric ward within the ARV treatment institution.
- Regulation of palliative care services for PLWH
- Development and implementation of HIV case management protocol

Among the important achievements it is worth mentioning that the criteria for initiating ART were reviewed, changing the CD4 cells level to initiate ART in asymptomatic patients from 350 to 500. New criteria have also been introduced for the treatment of pregnancy, viral hepatitis, age more than 50 years, HIV+ partner in discordant pairs, oncological diseases, etc.

Since 2013, the Government started covering the treatment of about 500 new patients from domestic resources, covering in 2015 the entire first line for the patients on the right bank, as well as about 50% of the second line. There was a plan to gradually take over the entire expenditures for treatment by 2017 that has not been completely achieved.

In terms of care and support, the currently are four regional social centres for psychosocial support for PLWH (social, psychological, legal, etc. support). Furthermore, home-base palliative care is available since 2014. The Government covered the cost of the regional social centres the past year.

3.2. Current HIV Epidemic in Moldova

There were 8,557 reported HIV positive cases in the Republic of Moldova between 1987-2013, of which 2,464 (28.8%) developed AIDS and 1,752 (20.5%) died (Pîrîţină et. al. 2014). During 2015, 284 new cases of AIDS were reported. There are 3,073 cumulative cases of AIDS among registered PLWH, which represent 30% of HIV cases. In the 2015 reporting period, 280 deaths were registered among HIV positive people, the mean age at time of death being 40.7 years of age. Approximately 700 to 750 new HIV positive cases are registered per year, where the majority of cases are reported among people between the age of 25 and 39. Moreover, there were about 80-90 registered cases of HIV infection are reported each year among pregnant women, with a mother to child transmission (MTCT) rate of 1.9% in 2013.

3.2.1. Means of transmission

According to the study conducted by Pîrîţină et. al. (2014), the majority of new infections are a result of heterosexual contact, which has increased from 5.7% in 2000 to 91.4% in 2013. The second most common way of transmission is through sharing of needles and injection equipment, particularly among PWID, which decreased from 83.7% to 5% from 2000 to 2013. Also according to Pirtina, et al. (2014), out of 818 new HIV cases reported in 2015, 87.5% mentioned the sexual route as the main probable route of HIV transmission, with 85.4% heterosexual activity, 2.1% mentioned homosexual activity, 6.7% due to injecting drug and MTCT was attributed to 0.7% of new cases. The mode of transmission could not be determined in 14.9% of cases.²

3.2.2. Interregional Differences

The incidence in 2013 was 17.99 per 100,000 population, with a higher rate of 46.91 in the eastern regions (Transnistrian Region). The interregional difference is also reflected in the prevalence rates, with 173.43 per 100,000 population in the general population as of January 1, 2014, but 463.25 in the eastern regions. The large number of new HIV infections in the east territories can be attributed to limited access to the prevention programmes, particularly for the MARP. (Laukamm-Josten 2014, Pirtina, et al. 2014)

An Integrated Bio-Behavioural Study (IBBS) among the MARP was carried out in 2009-2010 and 2012-2013, showing that even when the population size of the MARP was bigger in the right side of the Nistru river, the east side had a higher prevalence, except for the prison population which was not measured and compared. (MDA Narrative Report 2016)

² Lucia Pîrîţină, Angela Nagîţ, Svetlana Popovici, Olga Staicova, Elena Golovco, Irina Cucerova, Iulian Oltu and Viorel Calistru. "Current epidemiological HIV/AIDS situation in Republic of Moldova". BMC Infect Dis. 2014; 14(Suppl 4): O1. Published online 2014 May 29. doi: 10.1186/1471-2334-14-S4-O1; PMID: PMC4072151

3.2.3. Prevalence and Testing Among MARP

The 2012-13 IBBS found that during the past year 47.3% of PWID living in Chişinău that responded had had an HIV test and knew the result. HIV prevalence among this group had decreased to 8.5% from 16.4% in 2009.

A smaller percentage (22.1%) of sex workers (SW) living in Chişinău, had taken an HIV test and knew the result, while HIV prevalence had increased from 6.1% in 2009 to 11.6% in 2013. During 2012, 24.3% of MSM that responded in the study had an HIV test and knew the result, with HIV prevalence also increasing from 1.7% in 2009 to 5.4%.

At that time Moldova was classified as a concentrated/low prevalence country with a concentrated HIV epidemic in key populations such as injecting drug users and their regular sexual partners, commercial sex workers and men who have sex with men and there is an evidence of spread of the infection in the general population.

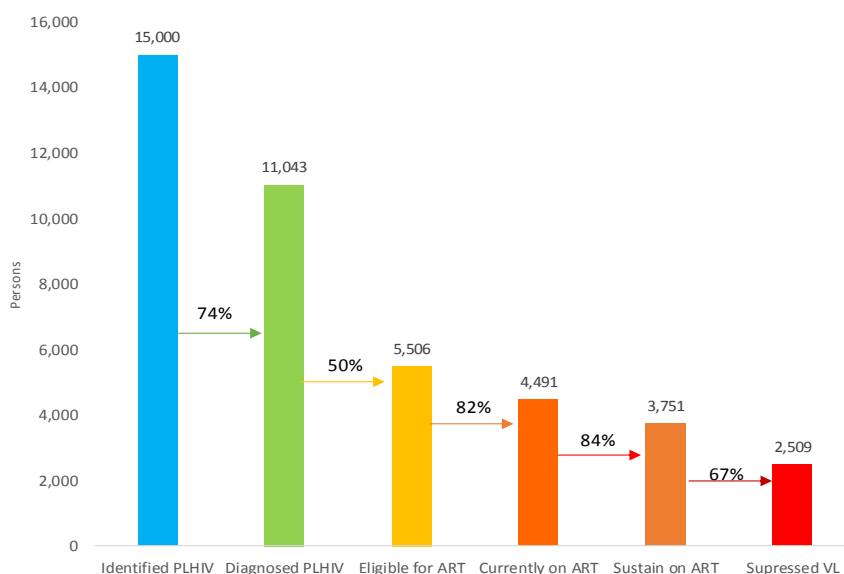
As of 2016, Moldova continues to experience a concentrated HIV epidemic among people who inject drugs (PWID), men who have sex with men (MSM), female sex workers (FSW) and their clients, as well as their sexual partners in the general population. The HIV epidemic is more severe on the left bank of Nistru River – Transnistrian region, which counts for the third part of the total number of registered cases and where coverage of prevention programs is lower.

4. HIV Cascade Assessment

Spectrum, a program used to estimate key HIV indicators for national programs, has been used since 2010 to project key HIV indicators for Moldova’s general population. The resulting data are used for monitoring the progress of the HIV epidemic and response, understanding trends, project possible policies/programs, and inform the overall decision-making processes. The following analysis provides an initial assessment of the current HIV-epidemic within the framework of the continuum of care cascade based on data collected from national reports and Spectrum. The HIV continuum of care cascade considers 6 main steps/stages in the cascade: Identification of PLWH, Diagnosis of PLWH, Eligibility for ART, Currently on ART, Sustained ART, Suppressed viral load (VL).

The following figure provides a summary of the cascade for the general population, showing that only an estimated 17% of the total population has managed to suppress viral loads. The percentage of persons eligible for treatment is currently 50% of the diagnosed population, which is the biggest percentage drop in the continuum of HIV prevention.

Figure 9: Continuum of HIV prevention to care (CoPC) cascade

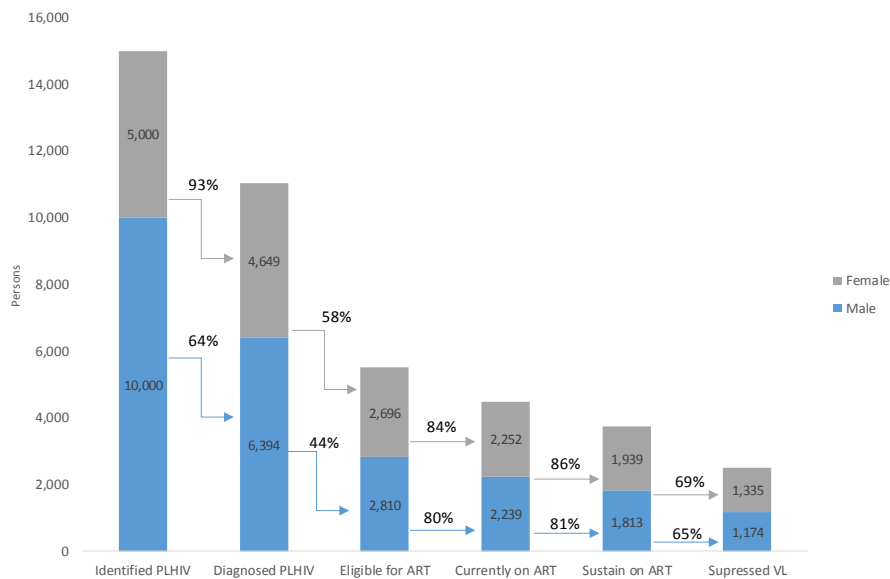


Source: Sanigest Internacional based on data

At the end of 2015 there were 7,331 PLWH registered in Moldova (4,952 people on the right bank and 2,379 on the left bank of Nistru river), 53.4% of which were male and 46.6% female. According to the Multiple Indicator Cluster Survey study carried out by NAP 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 knew about the option to take an HIV test in the locality where they live.

When the cascade assessment is done disaggregating the population by sex, the biggest percentage drop continues to be from the Diagnosed individual to the Eligible for ART population for both population groups, with a bigger drop for male than females (Figure 10).

Figure 10: CoPC cascade by sex



Source: Sanigest Internacional based on data

According to NAP, by January 1st, 2016 there have been 10,213 new HIV cases registered on both banks of the Nistru River. Around 58% of them are males and 42% are female. The share of people aged 15-24 is 24% for the overall population, will a smaller share in the left bank of Nistru river (22.4%) than the right bank (25%).

During 2015, 165.4 thousand people were tested for HIV, 50,317 of whom where pregnant women (30.4%) and 17.8% where donors. Prevention programs only covered 10.3% of all the testing performed that year. According to Laukamm-Josten (2014) and Pirtina, et al. (2014), the share of cases diagnosed in the prevention programs has declined over the last 5 years to about 25% of all cases.

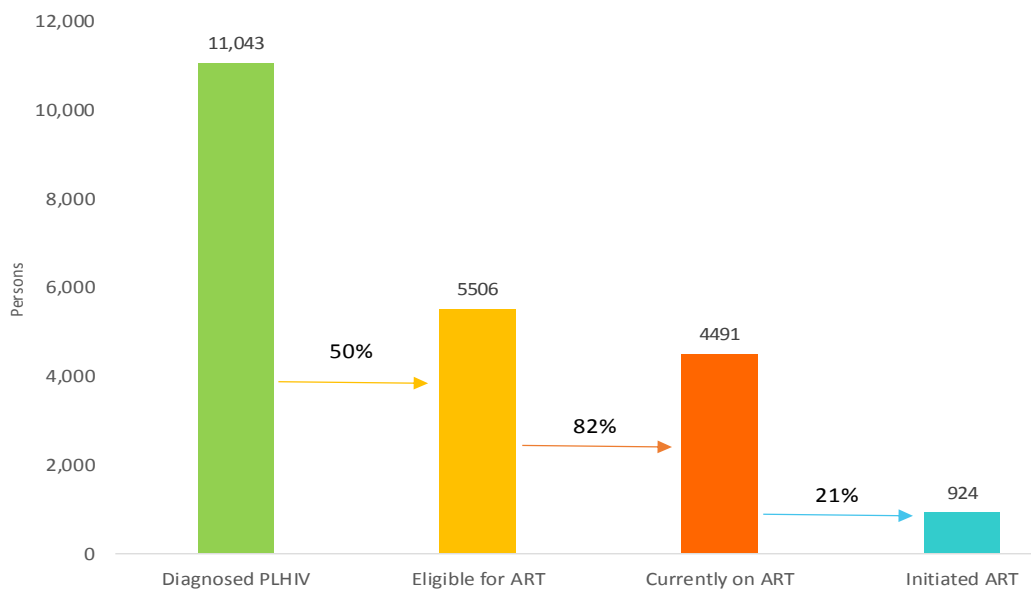
This means that the majority of newly found cases are diagnosed in hospitals when testing for symptoms (e.g. pregnant women) or during other blood tests. This implies that most cases are in fact not new, but transmission took place in the past. However, the greater number of new detected cases are registered by prevention programs and by clinical cases.

New HIV cases in 2015 were mainly registered among young people and persons of reproductive and economically-active age: 15-49 years old (86.4%) and 15-24 years old (12.6%) (NAP MDA Report Jan 2016). Compared to the data from 2014, no changes can be noted. Out of all newly registered HIV cases, 86.4% were registered among the 15-49 age group and 12.5% among the 15-24 years age group.

HIV testing of pregnant women began in 2007, and achieved 99% coverage by 2016, allowing for the estimation of HIV prevalence among that group of the population, which has remained relatively stable in the last years.

The following figure illustrates that after diagnosis, there is a low percentage of new people beginning treatment based on data from the last reporting year (2016).

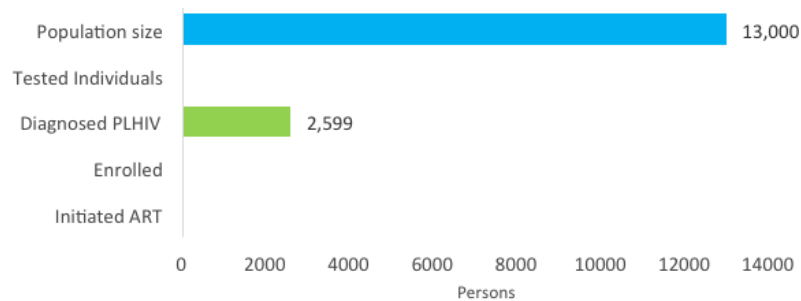
Figure 11: Continuum of care of PLWH



Source: Sanigest Internacional based on data

The same trend is present when restricting the analysis to MSM (Figure 12), where there is a decreasing number of new cases entering ART from the global population size.

Figure 12: MSM continuum of care



Source: Sanigest Internacional based on data

5. Key Findings

HIV testing

- *What proportion of PLHIV know their HIV status?*

Of an estimated 18,226 PLWH, 43% (7,906) were living with the diagnosis in December 2016 (Control Monitoring of HIV infection in the Republic of Moldova- 2016, 2017:39). On the Right Bank of Nistru, the percentage is at 48, whilst on the Left Bank of Nistru is at 37.

- *Why is **Moldova cascade structure/NAP** not able to identify more PLHIV?*

According to Soros Moldova, there seems to be little health education among citizens, so despite HIV/AIDS awareness campaigns people do not test for HIV. Indicators of the late presentation to health facilities are late detection of HIV, (see CD4 count and VL of those newly diagnosed) and the number of survival years for those deceased (approx. 4 years).

Concerning the testing of MARPs outreach workers considered that more staff/outreach workers are needed and could increase (rapid) testing.

When testing pregnant women at local dispensaries/hospitals, it happened that at the first HIV test (in the first quarter of pregnancy) the result was negative and at the second testing (last quarter of pregnancy) it was positive. After further investigation, it was shown that the nurse used the blood sample from one woman/patient recorded for another woman as well, pointing to issues related to the lab testing protocols not being followed. Currently there is only one HIV testing during pregnancy, in the first quarter or testing at birth, if not previously tested.

- *Is **Moldova cascade structure/NAP** using the right strategies/approaches to create demand for HIV testing?*

Generally, yes. There are 4 regional VCT centers (3 on the Right Bank, 1 on the Left Bank of Nistru) and is planned to increase their number. The current VCT centers send the samples for analysis to the national laboratory, in Chisinau (one delivery/week and there is a minimum number of samples required). Also, there are mobile units/outreach teams, collecting rapid saliva tests carried out by NGOs.

It is planned to change the saliva rapid testing used in community-based facilities/outreach programs to blood rapid testing. Increasing rapid blood testing among MARPs is foreseen to (will) increase diagnostic in 2018.

- *Is **Moldova cascade structure/NAP** testing the right people?*

– Do they prioritize the right population groups for HIV testing?

The key populations are correctly identified. However, since the latest data show that sexual transmission is the main route of infection, more is needed to test the sexual partners of key



populations, but also to promote testing among the general population (exposed to heterosexual transmission). Having more men diagnosed with HIV than women, could also suggest that MSM prefer not to disclose the way of infection. There is also, a proportion of newly diagnosed cases whose infection transmission route is unknown, which could suggest stigma concern in disclosing possible route.

– How big is the HIV testing gap among each of the prioritized populations?

Since only approx. 3,000 rapid tests were available for outreach workers (at least in the last 2 years), there is a considerable testing gap in the key populations. Testing of sexual partners of MARPs is a challenge. Testing of sexual partners of MSM was mentioned that was more likely to occur, than for sexual partners of SW and PWID.

Data for 2016 reveal that about 40% of PWID were reached with HIV prevention programs and 5.4% were tested for HIV and knew their result. However, key informants from Soros Foundation consider that the estimated number of PWID in Republic of Moldova (36,900) is too high since in some municipalities it meant that about 10% of the population was using/injecting drugs. The lowest HIV testing appears among MSM and sex workers. No data are available about the testing of sexual partners of MARPs.

HIV testing Coverage among Key Populations, Republic of Moldova, 2016

KP-3d(M): Percentage of people who inject drugs that have received an HIV test during the reporting period and know their results	5.4%
KP-3c(M): Percentage of sex workers that have received an HIV test during the reporting period and know their results	3.9%
KP-3a(M): Percentage of men who have sex with men that have received an HIV test during the reporting period and know their results	2.0%

Source: Moldova Project Proposal to Global Fund, 2017.

- *Is Moldova cascade structure/NAP* succeeding in creating demand for client-initiated HIV testing among the right population groups (populations at higher risk of HIV infection)?

According to outreach workers in Bălți, there are not enough outreach workers and tests available for MARPs. Also, they mentioned that in the Health File, after being tested HIV, some family doctors write the diagnostic (HIV) on the cover of the file, thus leading to increased risk of discrimination when accessing other health services. Testing MSM, SW and PWID is more spread in the big cities and less in rural areas and small municipalities.

- *Are Moldova NAP* approaches to delivering HIV testing services conducive to increasing uptake:

– Is the approach to provider-initiated HIV testing conducive to increasing uptake of HIV testing and counselling in health care facilities?

In the VCT centers, alongside health staff and counsellors, there are also social workers/peer-educators from NGOs, thus potentially increasing accessibility of testing for MARPs. Also, there are mobile testing facilities – of NGOs, for rapid testing only.

Voluntary HIV testing is also available in pharmacies (for home-testing).

- **Is Moldova cascade structure/NAP** using the right approaches to deliver services for client-initiated HIV testing depending on the target population?*

*HIV testing approaches include: community-based (nongovernmental organization), outreach, health facility- based, PITC for clients of health facilities, mobile HCT, etc.

The approaches to HIV testing seem appropriate: community-based, outreach workers, VCT, health-facility based (including in family doctors' facilities), mobile testing facilities. However, testing of MARPs is limited by factors such as: the number of tests available, fear of discrimination/stigma associated with HIV, regional disparities in accessing health facilities, poverty, distance to regional centers/VCT.

Rapid testing kit in NGOs were not available anymore in April 2017 (Soros Foundation). ELISA tests were missing for about 2 months and Western Blot for 2 quarters in 2017. Rapid saliva tests needed sometimes more than 40 minutes to give a result (too much for PWID).

Linkage to HIV care

- **Is Moldova cascade structure/NAP** losing patients between an HIV positive diagnosis and enrolment in HIV care? If so, what are the reasons?

There are patients who have a good health and do not remain in care after the diagnosis, whilst others deny their diagnosis (as a result of wrong information from internet).

Fear of discrimination is another reason for not enrolling into care – not only for MARPs, but also for other people who are afraid of confidentiality breach of their HIV status in the health system. It seems, that the procedures for handling health files are not ensuring full confidentiality and/or there are not strict rules (or are not fully respected) for confidentiality breach. As mentioned above, outreach workers reported that some family doctors (general practitioners) write the HIV + status on the cover of the Health File of the patient.

For the care and support services, there are Regional Social Centers, but these centers are not integrated in the Clinic/health facility, being in another location (in 3 out of 4 is in the same city), which can create difficulties in accessing them especially for vulnerable groups (MARPs) and those with low socio-economic status/poor.

Some outreach workers mentioned also that after referral of MARPs to public VCT, MARPs are lost due to mistrust in health personnel/perceived unfriendly services/facilities.

Migration is another factor for losing patients, especially if they have also Romanian citizenship, which allows them to travel without restrictions in the EU.

For prisoners, a positive HIV and/or TB test leads to discrimination among other prisoners and a lower status in the prison system.

For commercial sex workers (CSW) disclosure of way of infection to VCT is not usual and also not to clients/occasional sexual partners.

PWID can be lost from care if they are active drug users and/or not linked with outreach services/workers. Outreach workers reported that sometimes PWID who are on TB treatment and OST/methadone, due to different locations of treatment facilities and/or side-effects, take treatment in turns (one day ARV, another TB, another methadone). Outreach workers mentioned a research in Bălți revealing that 50% of AIDS related deaths also had TB and 50% of TB deaths had also HIV.

Also, they mentioned harassment from police of MARPs with a criminal record in order to solve other cases/crimes (MARPs with HIV become *usual suspects* and/or are blackmailed to witness).

• **What system is in place to ensure that people who are diagnosed HIV positive are effectively linked and enrolled in HIV care? How effective is this system? What are the specific challenges for infants/children?**

In Regional VCT support services are integrated (counsellor, peer-educator), thus ensuring continuity/linking to care for patients. There is a coding system on referral ensuring confidentiality on the way of infection. The result of HIV test is disclosed by a counsellor during a face-to-face interview. Previously, patients call to find out when/if the result is ready and can come to find it out.

Regional Social Centers and outreach workers have an important role in linking PLHA from MARPs to care services. There is a handbook/guideline of case management for qualified staff from Regional Social Centers. In Bălți the social center is financed by the Local Council, having a daily caseload of 30 cases, but in Chişinău until December 15 2017 the center was not included in the structure/budget of the Local Council. Another challenge is the retention of staff, especially qualified (more in Chişinău), due to low salaries of public employees. After Jan. 2018 no psychologist will be employed in Chişinău Social Center.

The social protection of PLHA in Moldova is comprised of yearly social/special aid (for poor people) and/or enrolment/inclusion into a degree of disability if in an advanced stage of HIV (CD4 under 250, 1st and 2nd degree). There are no specific social protection measures for PLHA.

During interviews there were not any specific challenges for children/infants in linking them to care. However, outreach workers mentioned discrimination in kindergartens for children with HIV and/or of MARPs (usually at least one of the parent is also HIV+).

As a good practice, it can be mentioned that for harm reduction services one NGO (Inițiativa Pozitivă) created in Chişinău a system of accessing harm reduction services for MARPs from pharmacies based on a card, having in about 3 months about 500 persons enrolled and

planning to expand the service. Also, in order to reduce the risk of stigma it is envisaged to advocate to include the use of this card system for other chronic diseases (e.g diabetes).

Outreach workers mentioned that the level of trust of MARPs and PLHA in health personnel is low, suggesting NGO staff (peer-educators, social workers, outreach workers) could be more involved in mediating the relationship doctor-patient and/or referral.

ART and retention in lifelong care

- *What are the reasons for low ART coverage?*

Out of 7,906 PLHA alive in 2016, 6,829 are on active monitoring and 4,491 on ART (69% of those in active monitoring on the Right Bank and 59% on the Left Bank of Nistru). General reasons for low ART coverage mentioned during interviews are: poverty, distance to regional treatment center, migration (mainly external, especially for those with double citizenship), and stigma/(fear of) discrimination from health care staff (especially in the case of MARPs).

Until recently the WHO guidelines for ARV initiation was set lower (e.g. CD4 under 500, VL under 50 copies), thus doctors educated them that they do not need ARVs. Including them into ARV now is likely to be hard to explain/convince – according to the NAP team.

Outreach workers mentioned that if ART delivery would be possible to be carried out by NGO staff, coverage would increase. They also suggested for CSW that an incentive for taking ART would contribute to higher rates of ART coverage.

During interviews, it was mentioned as a good practice from the past the reimbursement of transportation costs for PLHA from KP/poor coming for ART.

- *What are the reasons for deferring ART in those eligible?*

According to NAP team, all those eligible for ART receive it if they want. The centralized procurement and distribution ensures necessary ART supplies. Every 3 months stocks and supply/demand are revised/assessed to ensure all regional centers have enough ART.

It is foreseen to decentralize ART distribution to more regional centers, in order to reduce time/distance/costs to treatment for patients/PLHA.

- *Are key populations accessing HIV treatment? WHY Not – at least 3 reasons*

General factors common to all KP/MARPs:

- Fear of discrimination/stigma
- Low socio-economic status (education, rural, understanding importance of ART)
- Poverty – social protection is limited
- Distance to regional treatment centers
- Delays in confirmatory testing (Western Blot) results (4 weeks in Chişinău, up to 8 weeks if tested in other locations)



For PWID on OST/methadone, specific challenges are linked with the different locations of OST clinics and ART regional centers, thus leading to poor adherence.

MSM face stigma which prevents some of them to access HIV treatment. Also, if living in a small/rural community they become less willing to take ART (fear of disclosure of HIV status).

CSW have as main barrier the fear of losing clients due to confidentiality breach. In Bălți, outreach workers mentioned that 80% of CSW are also PWID, so they face similar challenges with them.

TB patients under directly observed treatment (DOT) have difficulties in accessing both services – for TB and HIV since usually they are located in different hospitals. This is also the case for PWID who are on methadone/OST and on ART and/or have also TB treatment. Outreach workers mentioned that PLHA who are also on TB treatment/DOT and/or OST are less likely to take all treatments – due to side-effects, due to distance between health facilities for each treatment, due to poor nutrition which accentuates/enhances the side-effects.

• How big is attrition and what are main reasons/contributing factors for attrition among patients on ART?

Adherence is measured as those on ART after 12 months. However, those deceased are included in those interrupting ART (about 30% in 2016), which reduces adherence (84% in 2016). In the same time, interruptions are considered if more than 3 months in the last 12 months, which could overestimate adherence.

Special attention

- Why are PWID not accessing treatment?

Besides the barriers already mentioned, another one was suggested by outreach workers: Drug treatment facilities/OST are less friendly with PWID, thus about 500 people are on methadone nationwide.

- **Health System Analysis as related to the Cascade structure based on WHO Concept of Health Systems Building Blocks.**

Health system building block	Key questions
Governance	The results show that there are issues related to the need to decentralize the distribution of some commodities and to improve the integration of the TB and HIV programmes which affect access.
Reasoning /Findings	Collaboration with TB and drug treatment hospitals/programs is not fully developed, leading to low uptake of health services by PLWH who have co-infection and need treatment (with TB), or PWID. As a result of not having the 3 programs integrated patients there are gaps in treating patients. The coding system for each client of the prevention services provided by NGOs created

Health system building block	Key questions
	the premises for a more accurate image of the targeting of the programs.
Financing	There are issues with subsidizing access to treatment for the very poor (transport vouchers for example) that could improve access. Furthermore, there are some aspects related to financing social centers from local authority budgets that should be addressed.
Reasoning/Findings	The centralized procurement of ART allows for a better price of generic treatment, but the financing of Regional Social Centers is not fully covered by Public Local Authorities (e.g. in Chişinău) endangering the provision of support services for KP/MARPs. Establishing a quota of 25EURO/year/client of services is an advantage for bigger NGOs and those with established programs for a variety (if all) of MARPs. Also, harm reduction (HR) services are not covered from public budget, thus after GF funding there is a danger of shortage of HR services, which could lead to increased number of HIV cases in KP.
Human resources	Are human resources for HIV service delivery adequate in number, professional skills and competences? Is the staff of HIV services part of the overall pool of staff of the health service where they work? Are staff/volunteers sufficiently motivated?
Reasoning/Findings	There seem to be a general shortage of qualified staff in health care (due to migration, mainly), especially outside big cities and in public local authorities (due to low salaries/wages) which can negatively affect services. Motivated volunteers and peer-educators from NGOs partially cover these gaps. The staff of HIV services is part of the overall pool of staff in the health service they work.
Procurement/supplies management	Does the way procurement and supplies are managed affect access to and utilization of HIV services?
Reasoning/Findings	The centralized procurement and management of supplies ensures so far full access to HIV services. It is planned to decentralize distribution of ART to more regional treatment centers to reduce distance between PLWH and health providers.
Information systems	Are there challenges with regard to the health information system that impede HIV testing and treatment scale-up?
Reasoning/Findings	Health Information system is not completely integrated and does not provide enough responsive orienting solutions.

5.1.1. Barriers in the Cascade of Care for key populations at risk of HIV infection – Republic of Moldova

People who inject drugs (PWID)					
Cascade step		Identify KP			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale (1= most important, 5= least important)	Responsible Agency & Implementing partners
Coverage of outreach programs	Extend outreach programs	Increase number of outreach workers Create/expand mobile outreach teams for rural/remote areas	2018	1	NAP & NGOs, UCIMP
Cascade step		Reach KP			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Provision of harm reduction services	Expand provision of harm reduction services/NSP through pharmacies	Promote access to harm reduction services with pharmacy card	2018	1	MHLSP, NAP, NGOs, Pharmacies
Unfriendly drug treatment facilities	Train health care staff interacting with drug users	Train personnel interacting with drug users to better understand behavior change during drug use Develop guidelines/protocols for health facilities when having PWID as patients	2019	1	Ministry of Health, Labor and Social Protection (MHLSP), NAP, Addiction/Drug Treatment Hospitals, UCIMP
Discrimination in accessing health services	Raising awareness of health staff on anti-discriminatory practices	Train health staff on anti-discriminatory practices	2019	2	MHLSP, NAP, Addiction/Drug Treatment Hospitals, UCIMP
Cascade step		Test KP			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Access to rapid saliva testing only	Blood-based rapid testing	Procurement of blood-based rapid testing	2018	1	MHLSP, NAP, UCIMP

		toolkits/units			
Limited number of HIV tests available	Increased availability of blood-based rapid tests	Increase number of VCT facilities providing HIV testing Increase number of mobile blood rapid testing facilities	2018	2	MHLSP, NAP
Unfriendly VCT facilities with KP	Reduce time for testing in VCT facilities	Rapid blood-based testing in VCT facilities	2018	3	MHLSP, NAP
Cascade step		Diagnose PLWH			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Delays in confirmatory testing results	Reduce time for HIV confirmatory testing	Procurement of blood-based rapid testing Increase number of confirmation testing facilities	2018	1	MHLSP, NAP, UCIMP
Late diagnostic	Increase HIV testing of KP (PWID)	Increase rapid HIV testing of PWID through mobile units	2019	2	MHLSP, NAP, NGOs
Cascade step		Enrol in care			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Poverty	Increase access to social protection	Provide social support to alleviate poverty Reimbursement of transport cost (means-tested)	2018	1	MHLSP, NAP, NGOs
Reduced access to social services	Increase access to social services	Integrate regional social centers into public local authorities Ensure adequate budget and qualified staff	2018	2	MHLSP, NAP, Local Municipalities
OST treatment perceived as barrier in future social reintegration	Remove legal barriers for social integration of former PWID/on OST	Remove provision forbidding former PWID/OST to have a driving license	2020	3	MHLSP, NAP
Cascade step		Initiate ART			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners

Treating those better off (CD4>500)/not motivated	Promote new guidelines for initiating ART	Support groups on importance of ART in regional social support & treatment centers	2018	1	MHLSP, NAP, Regional Social Support Centers, Regional Treatment Centers
Different locations for OST and ART	Integrate OST and ART facilities for PWID	Provide OST and ART from a single location/facility	2019	2	MHLSP, NAP, Drug Treatment Hospitals
Poor nutrition	Improve nutrition for PLWA	Access/initiate social canteen/food allowance	2020	3	MHLSP, NAP, Local Municipalities
Cascade step		Sustain ART			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Migration	Provide ART for all PLWH	Encourage PLWH to maintain on ART	2018	2	MHLSP, NAP
Co-infections (e.g. TB-HIV, MDRTB-HIV)	Integrate DOT and ART facilities	Provide DOT and ART from a single location/facility	2019	1	MHLSP, NAP, hospitals for TB treatment
Cascade step		Suppress viral load			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Poor adherence for IDU on OST/methadone and ARVs & DOT (directly observed treatment) for TB	Integrate OST, TB-DOT and ART	Provide OST, TB-DOT and ART from a single location/facility	2019	1	MHLSP, NAP, hospitals for TB treatment, hospitals for drug treatment
Regular viral load monitoring	Provide regular VL monitoring to assess suppression	Yearly VL monitoring for all PLWH	2019	2	MHLSP, NAP, Infectious Disease Hospitals

Men having sex with men (MSM)					
Cascade step		Identify KP			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale (1= most important, 5= least)	Responsible Agency & Implementing partners

				important)	
Coverage of outreach programs	Extend outreach programs	Increase number of outreach workers Create/expand mobile outreach teams for rural/remote areas	2018	1	NAP & NGOs, UCIMP
Cascade step		Reach KP			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Provision of harm reduction services	Expand provision of harm reduction services/NSP through pharmacies	Promote access to harm reduction services with pharmacy card	2018	1	MHLSP, NAP, NGOs, Pharmacies
Stigma/Discrimination in accessing health services	Raising awareness of health staff on anti-discriminatory practices	Train health staff on anti-discriminatory practices with MSM	2019	2	MHLSP, NAP, UCIMP
Cascade step		Test KP			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Access to rapid saliva testing only	Blood-based rapid testing	Procurement of blood-based rapid testing toolkits/units	2018	1	MHLSP, NAP, UCIMP
Limited number of HIV tests available	Increased availability of blood-based rapid tests	Increase number of VCT facilities providing HIV testing Increase number of mobile blood rapid testing facilities	2018	2	MHLSP, NAP
Unfriendly VCT facilities with KP	Reduce time for testing in VCT facilities	Rapid blood-based testing in VCT facilities	2018	3	MHLSP, NAP
Cascade step		Diagnose PLWH			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing

					partners
Delays in confirmatory testing results	Reduce time for HIV confirmatory testing	Procurement of blood-based rapid testing Increase number of confirmation testing facilities	2018	1	MHLSP, NAP, UCIMP
Late diagnostic	Increase HIV testing of KP (MSM)	Increase rapid HIV testing of MSM through mobile units	2019	2	MHLSP, NAP, NGOs
Cascade step		Enroll in care			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Poverty	Increase access to social protection	Provide social support to alleviate poverty Reimbursement of transport cost (means-tested)	2018	1	MHLSP, NAP, NGOs
Reduced access to social services	Increase access to social services	Integrate regional social centers into public local authorities Ensure adequate budget and qualified staff	2018	2	MHLSP, NAP, Local Municipalities
Cascade step		Initiate ART			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Treating those better off (CD4>500)/not motivated	Promote new guidelines for initiating ART	Support groups on importance of ART in regional social support & treatment centers	2018	1	MHLSP, NAP, Regional Social Support Centers, Regional Treatment Centers, NGO
Poor nutrition	Improve nutrition for PLWA	Access/initiate social canteen/food allowance	2020	3	MHLSP, NAP, Local Municipalities
Cascade step		Sustain ART			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Migration	Provide ART for all PLWH	Encourage PLWH to maintain on ART	2018	2	MHLSP, NAP

Co-infections (e.g. TB-HIV, MDRTB-HIV)	Integrate DOT and ART facilities	Provide DOT and ART from a single location/facility	2019	1	MHLSP, NAP, hospitals for TB treatment
Cascade step		Suppress viral load			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Regular viral load monitoring	Provide regular VL monitoring to assess suppression	Yearly VL monitoring for all PLWH	2019	2	MHLSP, NAP, Infectious Disease Hospitals

Commercial sex workers (CSW)					
Cascade step		Identify KP			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale (1= most important, 5= least important)	Responsible Agency & Implementing partners
Coverage of outreach programs	Extend outreach programs	Increase number of outreach workers Create/expand mobile outreach teams for rural/remote areas	2018	1	NAP & NGOs, UCIMP
Cascade step		Reach KP			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Provision of harm reduction services	Expand provision of harm reduction services/NSP through pharmacies	Promote access to harm reduction services with pharmacy card	2018	1	MHLSP, NAP, NGOs, Pharmacies
Discrimination in accessing health services	Raising awareness of health staff on anti-discriminatory practices	Train health staff on anti-discriminatory practices	2019	2	MHLSP, NAP, Addiction/Drug Treatment Hospitals, UCIMP
Cascade step		Test KP			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization	Responsible

				scale	Agency & Implementing partners
Access to rapid saliva testing only	Blood-based rapid testing	Procurement of blood-based rapid testing toolkits/units	2018	1	MHLSP, NAP, UCIMP
Limited number of HIV tests available	Increased availability of blood-based rapid tests	Increase number of VCT facilities providing HIV testing Increase number of mobile blood rapid testing facilities	2018	2	MHLSP, NAP
Unfriendly VCT facilities with KP	Reduce time for testing in VCT facilities	Rapid blood-based testing in VCT facilities	2018	3	MHLSP, NAP
Cascade step		Diagnose PLWH			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Delays in confirmatory testing results	Reduce time for HIV confirmatory testing	Procurement of blood-based rapid testing Increase number of confirmation testing facilities	2018	1	MHLSP, NAP, UCIMP
Late diagnostic	Increase HIV testing of KP (CSW)	Increase rapid HIV testing of CSW through mobile units	2019	2	MHLSP, NAP, NGOs
Cascade step		Enroll in care			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Poverty	Increase access to social protection	Provide social support to alleviate poverty Reimbursement of transport cost (means-tested)	2018	1	MHLSP, NAP, NGOs
Reduced access to social services	Increase access to social services	Integrate regional social centers into public local authorities Ensure adequate budget and qualified staff	2018	2	MHLSP, NAP, Public Local Authorities
Cascade step		Initiate ART			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing

					partners
Treating those better off (CD4>500)/not motivated	Promote new guidelines for initiating ART	Support groups on importance of ART in regional social support & treatment centers	2018	1	MHLSP, NAP, Regional Social Support Centers, Regional Treatment Centers
Poor nutrition	Improve nutrition for PLWA	Access/initiate social canteen/food allowance	2020	3	MHLSP, NAP, Public Local Authorities
Cascade step		Sustain ART			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Migration	Provide ART for all PLWH	Encourage PLWH to maintain on ART	2018	2	MHLSP, NAP
Co-infections (e.g. TB-HIV, MDRTB-HIV)	Integrate DOT and ART facilities	Provide DOT and ART from a single location/facility	2019	1	MHLSP, NAP, hospitals for TB treatment
Cascade step		Suppress viral load			
Barrier	Proposed activity	Sub activity	Timelines	Prioritization scale	Responsible Agency & Implementing partners
Poor adherence for CSW-PWID on OST/methadone and ARVs & DOT (directly observed treatment) for TB	Integrate OST, TB-DOT and ART	Provide OST, TB-DOT and ART from a single location/facility	2019	1	MHLSP, NAP, hospitals for TB treatment, hospitals for drug treatment
Regular viral load monitoring	Provide regular VL monitoring to assess suppression	Yearly VL monitoring for all PLWH	2019	2	MHLSP, NAP, Infectious Disease Hospitals

5.1.2. Conclusions and Recommendations.

Based on the intense field work and analysis carried out and extracted from the results obtained from interviews to key informants, is possible to say that there are several challenges for the Cascade of Care in the Republic of Moldova.

1. Social challenges/barriers:

- **Migration** – which influences the number of resident citizens in Moldova, but also the number of patients in care, needing support, thus influencing coverage of HIV prevention programs

- **Stigma of key populations** – which impedes people from vulnerable groups to test, treat/access services and remain in care
- **Poverty** combined with costs to access regional treatment centers for PLWH, but also for KP
- **Limited social protection system** for vulnerable groups – which leads to social insecurity and poor standard of living, especially for those in rural areas/unemployed

2. Individual challenges/barriers

- **Low socio-economic status** of people from KP creates the premises for denial of HIV, misunderstanding of the importance of ART and poor uptake of available services
- **Mistrust in the health care** staff of people from KP
- **Fear of discrimination**

3. Institutional restraining factors

- **integration** of various health services – OST, TB, ART/HIV
- **organization** of regional treatment centers (only a few)

4. The level of development of the national response

- *The enabling environment (legal framework and awareness campaigns),*

The legal framework is generally well structured. However, there are provisions limiting access to some services (e.g driving license) to PWID. No specific provision is for PLWH. Awareness campaigns need to continue and could include: promoting HIV testing, reduce stigma, promote disclosure of HIV status by public figures, documentaries/short movies with/about PLWH and/or from KP/MARPs.

- *The Institutional environment (The commitment to provide answers in terms of resources or specific activities)*

The procurement of most ART is financed from the public budget showing a strong commitment for NAP.

The recent merge of Ministry of Health and Ministry of Health could create the premises for a better coordination between the health and the social protection systems.

- *The human environment (as the way that population understand the risks, and act in consequence).*

Persons from vulnerable groups/KP generally understand the risks if they are in contact with a community-based organization/NGO. NGOs need to use diverse means to promote HIV awareness among KP (including peer-educators or social media).

5.1.3. Problem Tree and Final Recommendations

	Policies/guidelines	Service delivery model	Client/ patient factors
	Use of saliva-based rapid testing for HIV and Syphilis	Limited number of regional centers	Reluctance to access public VCT
	Testing of KP carried out by outreach workers		Fear of discrimination
Problem: low HIV testing of KP	Migration		
	Time of collection of test samples (1/week) in regional centers/VCT	Low number of staff from NGOs able to perform HIV tests	Reduced number of rapid saliva tests in outreach programs
	A minimum number of samples necessary for being sent to regional laboratory	Job retention of qualified staff	Stock out in ELISA and Western Blot tests
	Programme/ service management	Human resources	Supplies

1. The HIV/AIDs epidemic in Moldova follows the concentrated pattern, being the most affected populations those considered most at risk, including MSM, CSW, IDU's. Nevertheless, it is important to mention that the most recent reports show an increasing trend of heterosexual transmission, which introduces a serious risk to other population groups not significantly affected. This includes women of reproductive age and the possibility of HIV infected new-born it is strongly recommended to design and implement a new strategy to increase, and intensify the awareness and the diagnostic (testing) not only to KP's (MARPS) but also to pregnant women, and youth population affected with STD's.

It is also extremely urgent to improve the coordination and integration of the TB diagnostic & Treatment with the Cascade structure in Moldova, this actions have proven efficiency and effectivity in the identification diagnostic and treatment of PLWHIV.

2. The actual structure of the continuum of care for HIV/AIDs in Moldova is consistent with the proposed cascade concept and with the goal of 90-90-90, but certain efforts to cover barriers and gaps -described in the findings chapter- are needed. As a results of the analysis of the data provided by NAP and other reports from the global Fund and WHO, it is evident that the percentage of persons not retained by the system within the ART provision, is high, and also is important to remark the number of persons in ART which are reported as dead (mainly because the causes are not included in the reports). The Sanigest Team recommends to perform a scientific study on the reasons for ART drop-offs and the main causes of death of the enrolled in ART.
3. Main gaps in the continuum of care are the ones related to some territorial aspects marked by important international political issues (Transnistrian Region). The situation currently limits the access to the Identification-Diagnosis-Eligibility-ART initiation process. Regarding the Regional situation it is extremely important to motivate the political sector to search for an humanitarian arrangement for the Most at Risks populations and for the PLWHIV, in order to ensure the access of them to the preventive services and activities as well as to the Cascade structure of the National Health System in Moldova.

4. The Government of Moldova, has made important efforts to contribute with resources to transform the cascade care into a sustainable process in the country, but the provision of financial resources to procure the required set of ARV drugs has not been completely absorbed by the national budget allocations. As the findings chapter shows, the integration of the MoH with the Labour Ministry, is an important issue and the main task recommended here is the permanent advocacy and lobbying activities in order to maintain and increase the allocations for the Cascade related structure of services (including full financing of Antiretroviral as well as correlated drugs.)
5. It is extremely important to identify the reasons or issues causing the low levels of testing, diagnosis as well as the lowering in numbers of the new entrances into ART and the increase of Drop-Offs. The current data does not provide explanation for that situation and further research will be required to verify the actual causes.

References

- Aluma, G. 2015. "Working With A Cascade Approach To Monitor And Evaluate HIV Chronic Care Outcomes." *ISQua's 32nd International Conference*. Doha.
- EHRN. 2016. "News: National program to prevent and control HIV/AIDS approved in Moldova." *Eurasian Harm Reduction Network*. July 29. Accessed December 12, 2017. <http://www.harm-reduction.org/news/national-program-prevent-and-control-hiv-aids-approved-moldova>.
- Fox, MP, and S Rosen. 2017. "A new cascade of HIV for the era of "treat all"." *PloS Med* 14 (4). doi:10.1371/journal.pmed.1002268.
- Gardner, EM, MP McLees, JF Steiner, C Del Rio, and WJ Burman. 2011. "The spectrum of engagement in HIV care and its relevance to test-and-treat strategies for prevention of HIV infection." *Clinical Infect. Dis.* 52 (6): 793-800. doi:10.1093/cid/ciq243.
- Laukamm-Josten, Ulrich. 2014. "Support to perform the HIV epidemiological situation analysis." Chisinau.
- Ministry of Health of the Republic of Moldova. 2017. "Control Monitoring of HIV infection in the Republic of Moldova, 2016." Chisinau, 2017.
- McNairy, M. L., M. R. Lamb, E. J. Abrams, B. Elul, R. Sahabo, M. P. Hawken, and W. M. El-Sadr. 2015. "Use of a Comprehensive HIV Care Cascade for Evaluating HIV Program Performance: Findings From 4 Sub-Saharan African Countries." *Journal of Acquired Immune Deficiency Syndromes* 44-51. <http://doi.org/10.1097/QAI.0000000000000745>.
- McNairy, ML, and WM El-Sdr. 2012. "The HIV care continuum: no partial credit given." *AIDS* 26 (14): 1735-8. doi:10.1097/QAD.0b013e328355d67b.
- NCC. 2016. *Republic of Moldova Progress Report on HIV/AIDS*. Chisinau: National Coordination Council.
- NCC. *Republic of Moldova Progress Report on HIV/AIDS 2016*. Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS, Chisinau: NCC, 2017.
- NAP Reports on HIV/AIDS Cascade; from 2015, 2016 and January-September 2017, Internal documents.
- Pirtina, Lucia, et al. "Current epidemiological HIV/AIDS situation in the Republic of Moldova." *BMI Infect Dis* 14, no. 14 (May 2014).
- The World Bank Group. *Data: Moldova*. 2017. <https://data.worldbank.org/country/moldova> (accessed December 2017).
- United Nations Office of Drugs and Crime. 2017. "Guidelines for Final Reports." In *Handbook of Evaluations*, by UNODC.
- WHO. 2016. *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection Recommendations for a public health approach*. Geneva: WHO.

Annex 1: Terms of Reference

Annex A: Terms of Reference and Scope of Services

For the assessment of barriers and for the development of a report on the removal of barriers to access to HIV continuum of care. The assessment will focus on people living with HIV (PLWH), PLWH affected by tuberculosis (PLWH/TB), and for the following key populations (KPs): people who inject drugs (PWID), sex workers (CSW), men who have sex with men (MSM), taking into account gender and age.

A. GENERAL BACKGROUND

The low ART coverage is the result of an accumulation of failures and weaknesses of current HIV control strategies and programmes. New HIV infections are not prevented because key populations at increased risk of HIV infection do not have access to prevention services responding to their needs. While knowing one's HIV status is a precondition for accessing treatment, the majority of PLHIV in the Region, including Moldova, are unaware of their HIV infection.

Early identification of PLHIV, timely initiation of ART and lifelong care are key elements of the WHO strategy towards achieving universal access to HIV treatment and care and are increasingly recognized as the means to ending the epidemic. Entry into and retention in care are critical to the success of HIV treatment. Retention on ART is essential for individual patient outcome and also has public health consequences.

In order to accelerate HIV testing and treatment scale-up, WHO is launching a regional initiative to end the HIV treatment crisis with the aim of achieving universal coverage of HIV treatment by 2020. With strong ownership, political will and the right policies and strategies in place, this is an achievable goal, as has been demonstrated in other parts of the world. The objective of the initiative is to mobilize urgent actions by governments and nongovernmental partners in order to achieve regional and global treatment targets.

In the Republic of Moldova, The National AIDS Program (NAP) for years 2016-2020 was approved by the Government Decision of 22 October 2016. This program is a continuation of the previous one; however, unlike previous puts the emphasis on the integration of services, expansion of testing with a view to early detection (60% of IDUs and CSWs, and 40% of MSM tested for HIV in 2020). The targets are more ambitious, the coverage of risk groups with prevention services - 60% of IDUs and CSW and 40% of MSM by 2020. The PLWH coverage with HIV antiretroviral treatment by 2020 - at least 60% of the estimated PLWH.

The goal of NP - minimizing the consequences of HIV and STIs epidemic by reducing the transmission, as well as the mortality associated with HIV particularly in the key-population.

Objective 1. To prevent HIV and STIs transmission, particularly in the key-population.

Objective 2. To ensure universal access to treatment, care and support of all people infected with STIs

Objective 3. To ensure an efficient Programme management

Preventing HIV and STIs transmission, particularly in the key-population.

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.

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 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. 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.

Ensuring universal access to treatment, care and support of all people infected with STIs

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 1 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.

The adherence to treatment continues to be around 80% in the last 5 years.

Table 2 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%

ART Treatment drop-outs causes are:

- 30% - Death
- 65% - Stopping treatment

- 5% - lost to follow up

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.

Table 3 People living with HIV who have suppressed viral loads

	Total	Males	Females
Percentage of people living with HIV who have suppressed viral loads at the end of the reporting period	74.03%	69.76%	78.35%
Number of people living with HIV in the reporting period with suppressed viral loads (≤ 1000 copies/mL)	2509	1174	1335
Number of people tested for viral suppression during the last reporting year	3389	1683	1706

Psycho-Social Service for People Leaving with HIV/AIDS in Republic of Moldova

The GFTAM supports activities for intensive patient support and follow-up as a fundamental component for ensuring adherence to HIV treatment. During previous Global Fund support, four regional social centers (RSC) have been established in partnership with Ministry of Labor, Social Protection and Family and Public Local Authorities. The establishment of these services included developing the concept, selection, allocation and refurbishment of these centers, developing regulatory framework and quality standards. They are currently stand-alone legal entities with mixed subordination to local public authorities and Ministry of Labor, Social Protection and Family. Starting with 2016 their administrative costs are covered from the Government resources.

The centers have been established in the same areas where ART has been decentralized and act as referral for each of the 4 regions (North, Center, South and East). The centers serve as locations to centralize and concentrate all services available in both public and NGO sectors.

In parallel, to ensure access of PLHIV community and improve collaboration between the centers and provide low-threshold services to PLHIV and key populations, each of RSC are to work jointly with local NGOs to provide additional support and implement community outreach activities around the four RSCs. In addition, the four RSCs are connected to the wider network of 9 NGOs outside the four sites that are to ensure linking services, including counseling and psycho-social support.

Peer support and community-based self-support programs were to be provided through enhanced wraparound services to PLHIV, other project activities were to work on improving quality of public services and non-discriminatory attitudes. The project was designed to continue to provide support to NGOs and community-based organizations to outreach to PLHIV and their families with a comprehensive support package, including psycho-social support, mentoring, case-management and linking them to other services. A total 9 grants per year were awarded during project implementation, aiming to support capacity building for HIV case management in order to ensure quality of service provision.

Activities covered from GFATM resources are implemented by PAS Center (principal recipient of the Global Fund) and Soros Foundation – Moldova (sub-recipient of PAS Centre).

Ensure an efficient Programme management

There is a single National Coordination entity - the National Coordination Council in the area of TB/HIV, which includes government stakeholders, representatives of people living with HIV, NGOs as well as international community. The NCC (NAC) is a decision-making body having 6

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 National Monitoring and Evaluation System is Government-based and Government-led. The Ministry of Health decided that Dermatological and Communicable Diseases Hospital, has to be in charge of the NAP, including M&E system. The National Coordination Unit of NAP (UNIT) was established within the Dermatological and Communicable Diseases Hospital and represents the gatekeeper to the one national monitoring and evaluation mechanism at the country level.

B. CONSULTANCY OBJECTIVES AND EXPECTED RESULTS

Overall Objective of the assignment

The main objective of the consultation is to brief key stakeholders on the findings of the HIV test-treat-retain cascade analysis and to provide the opportunity to discuss these findings and develop recommendations for urgent action to overcome the obstacles, gaps and missed opportunities identified through the cascade analysis. These recommendations are the basis of planning for effective strategies and interventions to accelerate HIV testing and treatment scale-up.

The cascade approach identifies “leaks” in the system, targeting resources on interventions that diagnose people with HIV, quickly initiate ARV treatment, and sustain PLHIV in care. Using the cascade - in every facility, commune, district and regions – will help Moldova to monitor HIV service system performance and focus its remaining human, financial and programmatic resources on the ultimate aim of the HIV response: viral suppression. Knowing where the drop-offs are most pronounced can assist decision makers and service providers to implement system improvements and service enhancements that make the greatest impact for individuals, communities and Moldova’s society.

Within the framework of this Terms of Reference, it is planned to involve an organization, agency or institution to provide services for the assessment of systemic barriers to access to HIV continuum of care for all PLWH, PLWH/TB and individual key populations (PWID, CSW, and MSM). The assessment should be performed with the consideration of gender and age characteristics, as well as to develop a report on the removal of identified barriers.

Specific Objectives

1. Desk review of the latest assessments of the various components of the National Program (WHO’s mission on HIV testing, substitution therapy in the Republic of Moldova, Psychosocial Support, etc.).
2. Determine and analyze the barriers faced by PLWH, PLWH/TB and individual key populations (PWID, CSW and MSM), taking into account gender and age characteristics in the context of HIV continuum of care in the Republic of Moldova.
3. Identify the role of key stakeholders (civil society, government structures and agencies, local authorities, international organizations and technical partners) in order to increase the coverage of HIV services and reducing the number of cases of PLWH, PLWH/TB and individual key populations (PWID, CSW and MSM) in the process of HIV continuum of care.
4. Analyze the data obtained during the review of the barriers faced by PLWH, PLWH/TB and selected key populations (PWID, CSW and MSM), taking into account gender and age-specific features in the context of HIV continuum of care.
5. Develop and agree on the structure of the report based on the results of the desk review of the systemic barriers in order to access the HIV continuum of care for all PLWH, PLWH/TB and selected key populations (PWID, CSW and MSM), taking into account gender and age, and develop of an action plan to eliminate them.
6. Finalize and disaggregate the identified barriers faced by PLWH, PLWH/TB and selected key populations (PWID, CSW and MSM), taking into account gender and age-specific features in the context of HIV continuum of care in the Republic of Moldova and develop recommendations for their elimination in the form of Draft report.

7. Submit a draft report on the identified barriers faced by PLWH, PLWH/TB and selected key populations (PWID, CSW and MSM), taking into account gender and age-specific features in the context of HIV continuum of care in the Republic of Moldova and develop recommendations for their elimination on National level.
8. To present the draft report to the MHLSP.
9. Receive comments on the draft of the report from national partners.
10. Finalize the Report, taking into account the comments received and present it to the beneficiary.
11. To obtain concrete answer to the specific question:
In witch step of the cascade it was identified the leak, and who is most affected, it can also lead to tailored interventions that will be most effective in addressing and closing the leaks. Examples of common leaks and relevant solutions include:
 - *Low service coverage of KPs*: Solutions may include moving services to locations closer to the KPs, extending opening/closing times, reducing fees, integrating services, training providers to create a more friendly environment for clients being served, etc.
 - *Outdated or no specific policy* may require the updating of policies and standard operating procedures, issuing directives and decrees, etc.
 - *Limited clientele* may require demand creation strategies, performance-based incentives, greater confidentiality, transportation support, etc.
1. **Inception report** outlining the proposed methodology, work plan & implementation schedule under the assignment – within the first week of the assignment;
2. **Draft final report outlining:**
 - 2.1. **Presentation** of draft final report and assessment results in a round table;
 - 2.2. **Final report** – within 4 weeks from the beginning of the assignment.

The language of the reports shall be Romanian or English. All reports are subject to prior approval by the Client. The electronic versions of all deliverables and any other materials relevant to the project shall also be made available to the Client.

C. CONDITIONS FOR CONSULTANCY

The estimated duration of the assignment:
30 full-time working days.

Management of consultancy: The consultants will work under the direct guidance of the National HIV/AIDS and STI Program Coordinator, in cooperation with Principal recipient of the Global Fund to fight AIDS, TB and Malaria. The assignment's results shall be consulted with the MHLSP.

D. PROFILE OF THE CONSULTANT

QUALIFICATION REQUIREMENTS AND BASIS FOR EVALUATION (EVALUATION CRITERIA)

1. **General qualifications**
To participate in the tender are invited **organizations, agencies, companies or health institutes** whose employees have experience in conducting similar work:
 - 1.1. Experience in the collection and analysis of publications and data on public health issues;
 - 1.2. Work experience in the field of HIV infection;
 - 1.3. Experience in conducting qualitative and quantitative research;
 - 1.4. Experience or understanding of the epidemiological situation of HIV/AIDS in the EECA region;
2. **Other qualifications**
 - 2.1. Good knowledge of English language is a pre-requisite; and/or Romanian and/or Russian;