SUMMARY REPORT INCLUDING 'CONCEPT NOTE' TEMPLATE
Inequalities tool assessment

1 INEQUALITIES ASSESSMENT

1.1 Summary

In the period December 2022 - March 2023, Republic of Moldova (RM) piloted the HIV inequality assessment tool developed by UNAIDS. Moldova inequalities assessment report was developed using the recommended pre-set four-step methodology provided by the tool.

The analysis of inequalities allowed the Republic of Moldova to explore more deeply the multitude of available demographic, epidemiological, reports and research data, which allowed to highlight the groups of people left behind in the HIV response. The exercise is built around understanding the root causes of inequalities and making the connection between HIV impact and outcome results with the ones produced by HIV processes and interventions (outputs/inputs).

Two kinds of analyses were performed: 1) the situational analyses and 2) the contextual analyses. The situational analysis of the inequalities associated with HIV looked at epidemiological data and impact indicators, as well as digging deeper around root causes of inequalities. While the contextual analysis of the interventions included the analysis of the legal framework associated with HIV and the barriers related to structural architecture of the response, resulted from mapping HIV testing, prevention, treatment and care services. The analyses pointed out on 8 groups of people facing inequalities to access HIV services:

1. Men
2. Men who have sex with men
3. Migrants
4. Persons with mental disabilities
5. Female sex workers
6. Female drug users
7. Teenagers 15-24 years old
8. The rural population

These population groups are strongly left behind and unevenly access services and record different results along the entire cascade ***prevention - diagnosis - treatment - undetectability of the viral load***, which in turn influences the targets of the National HIV Control and Prophylaxis Program (PN HIV) , but also those set by the Global AIDS Strategy and the specific HIV indicators with the 2030 Global Agenda and the Sustainable Development Goals (SDG).

This exercise coincided with the mid-term evaluation of the national program for the HIV/AIDS and STI infections prevention and control for the years 2021/2022 – 2025 conducted by a group of WHO experts who covered (treatment, monitoring and evaluation, epidemiology, prevention, financed and procurement, HIV response governance) under UBRAF resources. The mid-term preliminary results of the evaluation support the results produced within the inequalities assessment.

The identification of the populations facing inequalities in accessing HIV services was followed by the prioritization of the populations with the greatest impact for the HIV epidemic in the Republic of Moldova. The priority groups were analyzed through the prism of the difficulties and challenges they face, and the lessons learned, followed by the development of priority interventions to reduce inequalities among identified population groups. These

interventions will inform the improvement of the national HIV strategy and the development of the GFTAM application for the years 2024-2026.

Likewise, based on the analysis carried out, a working plan was developed to allow a better understanding of the current situation and to contribute to minimize the effects of inequalities of HIV/AIDS response. Therefore, this tool has proven to be effective, and it is recommended for periodic use aimed at evaluating the effectiveness of the planned interventions on one hand and continuously adjusting those to ensure that no one is left behind (LNOB).

1.2 Background to Assessment

Inequalities in access to HIV prevention, treatment, care and support limit the realization of human rights, particularly for vulnerable groups, including the right to health, the right to non-discrimination and equality before the law, the right to an adequate standard of living and social security, the right to participate in political and cultural life, as well as the right to enjoy the benefits of scientific progress and innovations.

It is largely recognized that the inequalities defined in the Global AIDS Strategy as ***"an imbalance or lack of equity"*** represent one of the central factors that affect the achievement of the SDGs and 2030 Development Agenda results set at the global level, but also the ones set at the national level, namely within the National Program on HIV/AIDS/STI Control and Prevention for the years 2021/2022-2025. A comprehensive HIV situational and contextual analysis and review were requested to allow the inequalities' understanding and identification. It was followed by the development of a mitigation response and reduction measures aimed at reducing inequalities. The analysis through the lens of inequalities allowed the identification of groups of people who are still left behind, whose coverage with services remains very low and, respectively, the people's quality of life is negatively affected at the individual level, and so are the public health outcomes at the national level.

The Republic of Moldova joined the exercise of inequalities assessment pilot for at least 3 major (three) reasons.

The first would be that Moldova has access to the advanced scientific medical progress in relation to HIV prevention, treatment, care and support and it owns several good practices in these areas. These progresses were most recently appreciated within the 2023 mid-term evaluation of the National HIV programme 2021/2022 – 2025, carried out by WHO with the financial support of UNAIDS. At the same time, several impact indicators, including the rate of mother to child transmission, which exceeds 2%, the low achievement of 95-95-95 targets, the high rate of late detection of HIV cases, etc. inform about some severe gaps, including the fact that some groups of people do not have access or have poor access to the services available in Moldova. Moldova wanted, thus, to understand the causes of the discrepancy between the availability of services and their limited access, which ultimately hinders the achievement of the expected results.

The second reason has to do with a large availability of HIV data, namely epidemiological, programmatic, data produced through operational research and/or various evaluations, and yet it still remains difficult to understand the links between the data, their granularity and the cause of the modest outcome results the country achieves. It was expected that the inequalities tool facilitates a deeper data analysis and the understanding of the root causes of the issues, as well as guides towards the identification of the most fitted solutions for the envisaged groups of population that are left behind.

The third consideration relates to the synergy of this exercise with several others which takes place at the same time in Moldova, namely: GAM (Global AIDS Monitoring) reporting, mid-term evaluation of the national HIV/AIDS/STI control and prevention program 2021/2022 – 2025 (which allows for comparison/ data triangulation) and the development of funding

request towards GFATM 2024-2026 (which enables the use of the results of Inequalities assessment).

The Republic of Moldova followed the methodology set in inequalities assessment tool, as described below:

1) Situational analysis carried out mostly through:
   - Literature review and analysis of documents, analyses, operational research, etc.;
   - Carrying out several focus-group discussions with medical workers and identifying aspects related to migrants/people with disabilities.
   - Carrying out a focus group discussion with members of communities and non-governmental organizations.
2) Contextual analysis of inequalities, which included:
   - Mapping available efforts and services.
   - Mapping the actors involved in the HIV response.
3) Prioritizing actions to address the identified inequalities.
   - Organization of several consultative meetings at national level and validation of the results.
4) Development of the concept note that includes a plan out of priority interventions.

Different guides and annexes provided by the inequality tool were used to successfully manage the inequalities assessment and further development of the concept note.

The exercise was preceded by a presentation of the tool, its purpose and the expected results in a meeting of the technical working group of the CCM (country coordination mechanism); the preliminary results were consulted in several meetings, including with the WHO evaluation team, and the final results of the exercise were presented during the mixt CCM technical working group on TB/HIV.

The list of revised documents is presented in Annex 2 and the resource persons for the exercise in Annex 1.

- Key documents reviewed (details in Annex 2)
- Key Informants (details in Annex 1)

1.3 Situational and Contextual / Response Analysis (4 pages)

A disaggregated analysis of the outcome indicators using different data sources highlights **major discrepancies between women and men**, the latter attesting worse results when it comes to the incidence/registration of new cases, burden of the disease, which seems to be informed by reduced and limited access to HIV testing, diagnostic and treatment services.

At the end of 2021, Moldova reported 15,178 cumulative HIV cases since 1987 according to the surveillance data. Of these cases, about 58% are men and 42% - women; the share of men among new HIV positive cases registered in the last 7 years (2014 - 2021) is increasing (from 54.15% in 2014 to 58% in 2021).

In 2021, 797 new HIV positive cases were registered in the Republic of Moldova; the majority - 58% are men, and the greater share being in rural areas - 53%.

The same trends, by which the vulnerability of men is attested, in relation to HIV new cases estimations is informed by the estimates of Spectrum 2022. Thus the share of new cases among men is estimated at 69% and it is maintained until 2025 (Table 1) .

Table 1 Forecasts of the HIV epidemic in the Republic of Moldova (Spectrum 2022)

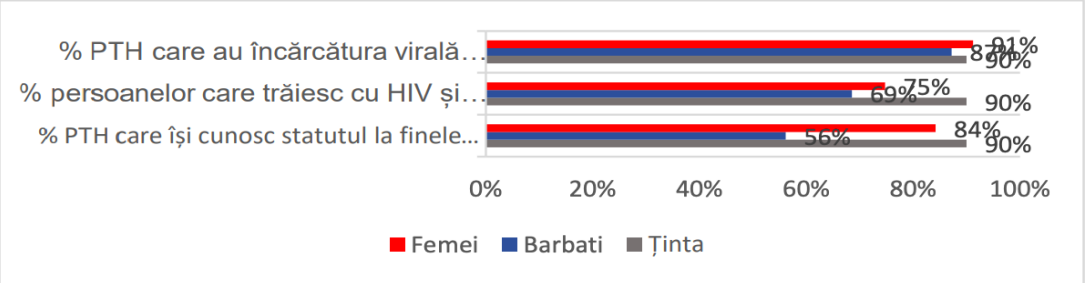
		2021	2022	2023	2024	2025
HIV Population	Total	15,249	15,455	15,574	15,714	15,842
	Men	9,715	9,813	9,869	9,951	10,032

	Women	5,534	5,642	5,705	5,762	5,810
	Men	64%	63%	63%	63%	63%
	Women	36%	37%	37%	37%	37%
New HIV infections	Total	911	852	653	615	561
	Men	629	589	452	426	388
	Women	281	262	201	190	173
	Men	69%	69%	69%	69%	69%
	Women	31%	31%	31%	31%	31%

On 01.01.2022, there were 10,139 people living with an established HIV positive status in the country, out of the 15,249 cases estimated in SPECTRUM 2022. The gender distribution of the alive PLH (people living with HIV) estimation shows that most HIV cases are among men 64% and this trend continues until 2025.

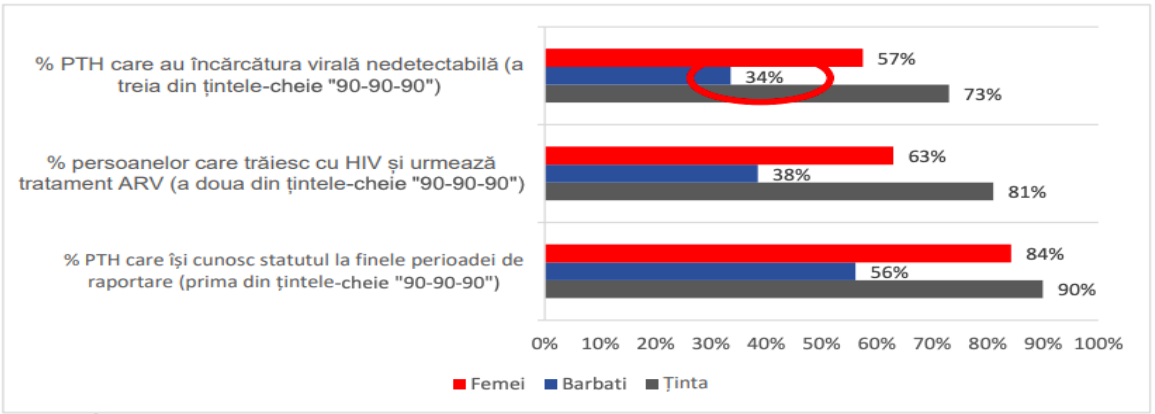
The analysis of the 90/90/90 cascade for the year 2021, allows us to find that the percentage (%) of people who know their status is disproportionate based on gender. If this difference is not obvious in people who are in treatment and have an undetectable viral load, (6% difference between men and women), in the case of people who know their status at the end of 2021, the difference is significant (28%) which determines that men are not sufficiently covered by testing and diagnostic services (Figure 1).

Figure 1 HIV Cascade 90-90-90 (01/01/2022)



The analysis of the 90/81/73 cascade shows that only one third (34%) of HIV-infected men have an undetectable viral load, which means that they do not transmit HIV infection to other people, meanwhile this indicator among women is practically double.

Figure 2 HIV Cascade 90-81-73(01/01/2022)



Consequently, based on the analyzed data, it is confirmed that **men are** the group that is under-covered with HIV services (testing and treatment). The low percentage of men with confirmed HIV infection out of the estimated number of men living with HIV can be explained by the lower HIV testing coverage (48%) of men compared to women (52%), a trend that has

been maintained for the past 3 years. In general, HIV testing in the Republic of Moldova is concentrated in the network of medical institutions (85%), while the rest of tests being carried out by NGOs (non-commercial organizations) active in the field of HIV.

Moreover, it is confirmed that the average number of HIV tests performed annually during the last 3 years was about 250,000 tests, of which about 48% among men and 52% among women. And even with fewer tests among men, the number of new cases is higher among them.

The distribution of testing by sex shows differences in the indications for HIV testing, for women most testing is done during pregnancy (35%), blood and organ donors (18%), followed by the category of testing according to clinical indications and TB (15%) and testing for administrative purposes[1](14%). For men the distribution is different, with donors having the highest share of HIV testing (44%), followed by testing for administrative purposes (17%), clinically indicated and TB (17%) and self-referral (10%).

Following the analysis of the programs that detect new cases of HIV infection, it is confirmed that the number of new HIV cases detected is higher in the case of men (58%), not to mention the fact that the number of tests is lower. The main programs that detected new cases among men are clinically indicated testing and TB (43%), index testing or performing testing of partners (14%), self-referral (12%) and testing for administrative purposes (9%).

Data analysis of reasons for testing and results of testing reveals that approximately 50% of men tested for HIV are tested for blood and organ donation. At the same time, new cases detected in this category represent only 3%. It allows to presume that HIV infection is not concentrated among men in the general population. While the distribution of testing among LGBT and new detected cases in that group attests a higher share of new case detection in that particular group of men. This confirms that the **HIV epidemic among men in the Republic of Moldova is significant among men who have sex with men from key populations (MSM).**

Several research show us that the HIV epidemic in the Republic of Moldova is concentrated among key populations, namely integrated bio-behavioral IBBS (all research rounds starting with 2009 and Optima (Allocative efficiency) performed in 2018 and 2022). They confirm the stage of the advanced concentrated epidemic and show a high level of HIV prevalence in different target groups. In the period 2009-2020 a reduction of HIV prevalence among people who inject drugs (PID) and sex workers (SW) is attested. At the same time there is a trend of increasing prevalence among men who have sex with men (MSM). ,

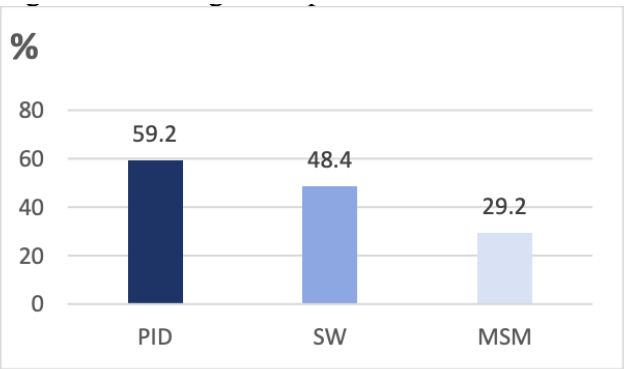
Table 2 HIV prevalence in the population at increased risk of HIV infection 2009 – 2020

	Chișinău	Bălți	Tiraspol	Chișinău	Bălți	Chișinău	Bălți
	PCID			**LS**		**BSB**	
2009	16,4	39,8	23,9	11,6	21,5	1,7	0,2
2013	8,5	41,8	12,1	6,1	23,4	5,4	8,2
2016	13,9	17,1	23,1	3,9	22,3	9,0	4,1
2020	8,1	14,9	23,5	2,1	4,4	11,6	8,6

Very limited data is available to inform on the coverage with treatment, care, and support services of all key populations' groups. While those data that monitor the coverage with HIV prevention services inform about a low coverage and the lowest remains in the MSM group. Trends in recent years have not seen a significant difference in coverage growth.

1 Testing for administrative (bureaucratic) purposes requires the presence of the HIV result for completion of documents (e.g. travel documents, etc.).

Figure 4. Coverage with prevention services in KP, RM, %, 2021.



Data on the high detection of new cases by administrative programs suggest that another category of men may increase the number of HIV positive people. This category can be assigned to **migrant people** who apply for HIV testing. According to NBS data, the majority of the proportion of the migrant population is due to men aged 25-49, which coincides with the typical profile of the HIV positive person in the Republic of Moldova according to SPECTRUM forecasts. During the focus group discussions with health workers, responsible for enrolling and managing ART, they inform about high migration phenomena among people living with HIV. Unfortunately, neither the routine surveillance data nor the estimated or research-produced data provide sufficient evidence to better understand the coverage within the HIV prevention-testing-treatment-care and support cascade coverage results or health outcomes.

The following groups of women in key populations were identified as being left behind, **namely women drug users and sex workers**. According to the recent data of the I*ntegrated Biological and Behavioral Surveillance Study among sex workers, injection drug users and men who have sex with men in the Republic of Moldova (2020),* **women drug users and sex workers** are a distinct risk group facing inequalities in accessing health services and being characterized by a high degree of vulnerability to HIV and other STIs. The aggregated and weighted HIV prevalence for both localities where the study was conducted (Chisinau and Balti) is 2.7%, although not all respondents were aware of their HIV status at the time of testing. Similarly, 18.1% of SW cannot always negotiate condom use with their partner. Condom use with casual partners is inconsistent for 30% among SW from Balti and 36% among SW from Chisinau. Not all SW know where they can get a confidential HIV test. More formative research is needed to more accurately determine the injecting and sexual behaviors of women who inject drugs.[2]

The bio-behavioral and surveillance study and the estimation of the size of the population of drug users in the Republic of Moldova (2022), emphasizes that 74.8% of female drug users and their permanent sexual partner use drugs (compared to the permanent partners of men who use injecting drugs of only 32.9%). The average condom use among the respondents of this research is only 34.8% in all localities. Distinctive characteristics of the person who consumes drugs and is infected with HIV are considered to be female, resident of the city over 25 years of age, with incomplete education, practices of not using condoms and having more than 2 sexual partners (including one permanent or occasional drug user).

Focus groups with health workers who provide health services to PLH suggest a new category of people at increased risk of HIV infection that requires increased attention and suggest the need to study the phenomenon in the Republic of Moldova. This group is **people**

2 https://sdmc.md/wp-content/uploads/2021/03/IBBS_REPORT_MD_2020_RO_Final-martie.pdf

with mental disabilities, including institutionalized persons. Unprotected sexual behavior that increases the risk of HIV infection is the main risk factor for HIV transmission among that group. Unfortunately, these conclusions are advanced only by health workers and there is lack of data and evidence to support that hypothesis.

Young people between the ages of 15 and 24 still do not receive adequate HIV education and face barriers to accessing information. Many young people do not receive adequate sexuality education, and those who do are often misinformed about HIV prevention and transmission. Young people also face barriers to accessing HIV services, including sexual and reproductive health services, HIV treatment and harm reduction. These barriers include stigma, discrimination, restrictive laws and policies. The main legal barrier is related to the parental/tutor consent to access health services established for the age of 18 by the legal norms.

Thus, the incidence of sexually transmitted infections among adolescents aged 15-19 in the Republic of Moldova is 50% higher than in the general population, suicide mortality among adolescents aged 15-19 is three times higher than in the general population, and about 70% of the cases of early mortality in adults, according to the estimates of the World Health Organization, is determined by the risk behaviors initiated during adolescence.[3]

Analysis of the root causes of inequalities

Stigma and discrimination remain the main barriers to access HIV-related services in Moldova. Because of initial fears and people's reluctance to seek medical help, the disease is detected at late stages in more than 50% of PLH. These fears are also fueled by the fact that HIV disease is associated with discrimination, marginalization, social exclusion, high risks of being subject to criminal liability, even for endangering the transmission of HIV.

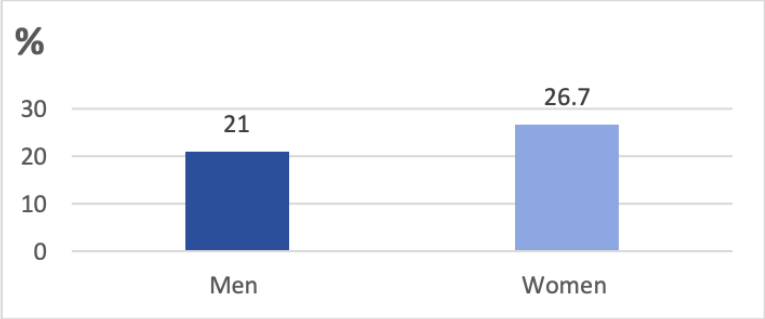
Among the fundamental causes underlying the inequalities mentioned above, certain gender patterns/gender-based social norms are also highlighted; high stigma and discrimination of key groups by the general population and high social distance from them; high stigma and discrimination in medical institutions, but also certain policies/legal and normative aspects that criminalizes certain behaviors.

Thus, a study carried out by the National Bureau of Statistics of Moldova in households in the Republic of Moldova ([4]), indicates about the low addressability of men to medical services, due to certain patterns related to gender, and the patriarchal norms existing in the Republic of Moldova, or the proportion of women, who addressed for medical services was higher (26.7%), compared to the share of men (21%), advancing them by 5.7 percentage points (Figure 5).

Figure 5 Share of people who sought medical services in the last 4 weeks, by sex

3 "Moldova 2030" National Development Strategy Project, https://cancelaria.gov.md/sites/default/files/cu_privire_la_aprobarea_proiectului_de_lege_pentru_aprobarea_strategiei_nationale_de_dezvoltare_moldova_2030.pdf

4 The population's access to health services, the results of the 2022 household study, https://msmps.gov.md/wp-content/uploads/2022/06/Acces_servicii_sanatate_2022.pdf



The high level of stigma and discrimination and many stereotypes is shared by citizens towards marginalized groups. This is attested in the Study on perceptions and attitudes towards equality in the Republic of Moldova, (2015[5], 2018[6], 2021[7]), which also calculates the social distance from the respective groups, based on the Bogardus scale.[8] If the level of acceptance is higher than 2, then the person would not accept to be a neighbor with the representative of the minority group. Thus, the level of acceptance of LGBT people is 4.5 (2021) and 5.2 (2015), still being the most unaccepted group in the community; the level of acceptance of people living with HIV is 3.5 (2021) and 4.3 (2015), being dynamically a group with a large social distance. Respectively, these prejudices lead to reduced involvement in addressing and solving the problems of these people at the community level, social isolation, and the lack of support necessary to access HIV services.

According to UNAIDS, people living with and affected by HIV in Moldova face serious legal and human rights issues, stigma and discrimination, and out-of-sync/outdated legislation, which remain significant barriers to accessing essential services and fully enjoying life.[9]According to the a survey conducted by UNAIDS in 2017[10], approximately one in five people living with HIV reported being denied medical care (including dental care, family planning services or sexual and reproductive health services). The same study indicates that 50% of people living with HIV in the Republic of Moldova reported that medical personnel had ever disclosed their HIV status without their consent.

5 *Study on perceptions and attitudes towards equality in the Republic of Moldova, 2015,* http://egalitate.md/wpcontent/uploads/2016/04/RO_Studiu-Perceptii-2015_FINAL_2016-Febr-25_Imprimat.pdf

6 *Study on perceptions and attitudes towards equality in the Republic of Moldova, 2018,* http://egalitate.md/wpcontent/uploads/2016/04/Studiu-privind-percep--iile.pdf

7 *Study on perceptions and attitudes towards equality in the Republic of Moldova, 2021,* https://rm.coe.int/studiu-privindperceptiile-si-atitudinile-fata-de-egalitate-study-on-p/1680a655e7

8 The Bogardus Social Distance Scale empirically measures people's willingness to participate in social contacts of varying levels of intimacy with members of different social groups. The scale asks people about the extent to which they would accept members of a group to (i) be related by marriage to a family member (score 0), (ii) be a friend (score 1), (iii) be a neighbor (score 2), (iv) be a work colleague (score 3), (v) be a citizen of my country (score 4), (vi) be a visitor to my country (score 5), (vii) would exclude/deport from the country (score 6). The index of social distance (IDS) is the average of the points assigned to each position depending on the level of "rejection" (acceptance as a family member is assigned 0 points - the lowest social distance, the desire to expel a person from the country - 6 points). Therefore, index equal to 0 means acceptance at all positions, while index equal to 6 means no acceptance at all positions.

9 https://www.sparkblue.org/content/how-legal-environment-assessment-opened-our-eyes-systemic-changemoldova

10 UNAIDS, *Confronting discrimination: Overcoming HIV-related stigma and discrimination in healthcare settings and beyond, 2017*, http://www.unaids.org/sites/default/files/media_asset/confronting-discrimination_en.pdf

According to the **HIV Stigma Index data 2021-2022**[11], discrimination against women, including discriminatory remarks from family members, was reported more often compared to men (18.0% vs. 16.6% for men) and compared to discrimination from others persons (18.1% versus 15.2% for men), verbal abuse and blackmail, which confirms and reflects on the vulnerability of women in cases of stigmatization and discrimination.

Stigma and discrimination against people affected by HIV, especially in medical facilities, is a barrier to testing and treatment.

Social Cohesion and Reconciliation (SCORE) 2018-measured social tolerance of general population towards people left behind, including people living with HIV, sex workers, people who use drugs and LGBTQI community. The study reveals that approximately 88% of population would not accept living in the same community with SW, PWUD, LGBTQI, while about 66% - PLH, pointing to a discriminatory and homophobic society, which negatively influences access to health services.

Sex workers and women who use drugs are a marginalized and invisible community in the Republic of Moldova, being extremely vulnerable to HIV/AIDS, human trafficking, harassment and violence due to multiple factors, including discrimination, stigmatization and social exclusion, and criminalization. Despite their particular vulnerability, their specific needs are continuously ignored by the state and this group of women systematically faces barriers in realizing their fundamental rights, including the right to the highest attainable standard of health, reproductive and sexual rights, the right to a decent treatment, without humiliation and violence, and the right to justice.[12]

Criminalization of sex work creates barriers to access to HIV prevention and treatment services. Sex workers are also vulnerable to violence, which also increases their risk of contracting HIV. The majority of sex workers face threats and violence from clients, managers and intimate partners that prevent them from using condoms. Research carried out in the Republic of Moldova among SW identified that 60% of the respondents were positive about the legalization of sex work due to the presence of violence, stigma and the sense of the need for protection.[13] SW involved in the study reported that they face violence practically constantly. They have mostly been subjected to physical and sexual violence since childhood, starting the age of 15, but also violence from the partner/client in the last 12 months.

The CEDAW 2020 report finds that women from Transnistria and Gagauzia, undocumented and stateless women and Romani women are particularly vulnerable to trafficking for the purposes of sexual exploitation and forced labour. Observations include: (1) lack of information on rehabilitation services that address the specialized needs of women and girls who are victims of trafficking for sexual exploitation, including medical services (2) Lack of protection for victims of trafficking in the phase of police investigation (3) Criminalization of women who provide sex services and the absence of drop-out programs for sex workers.[14]

Stigma, discrimination and marginalization of people living with HIV, criminalization of HIV transmission and penalization of drug use and sex work remain some of the main legal barriers for accessing HIV prevention, treatment and care services.

And for young people, one of the biggest impediments in accessing prevention, treatment, care and support services remains the consent of the parent or guardian for accessing them until the age of 18.

Men from rural areas

11 https://www.stigmaindex.org/country-reports/#/m/MD

12 https://docs.google.com/viewerng/viewer?url=http://uorn.md/wpcontent/uploads/2021/07/INT_CEDAW_CSS_MDA_41065_E.pdf&hl=en

13 http://afi.md/pic/uploaded/AFI%20-%20Raport_FSW.pdf

14 https://digitallibrary.un.org/record/3856669?ln=ru

Privacy and lack of anonymity – Because rural communities are small and tend to have close-knit social networks, it can be difficult for individuals to privately seek HIV/AIDS services. Community members may see individuals accessing these services or may work at an organization where HIV testing or treatment services are provided. Combined with social stigma, the inability to privately access services may deter people from getting tested for HIV or seeking care for HIV/AIDS. Personal data protection of people living with HIV is not fully ensured and respected.

There is insufficient data on the prevalence of HIV in rural communities. Because the HIV epidemic has historically been most intense in urban areas, there may be a lack of awareness that HIV/AIDS is a problem in rural communities. In addition, prevalence of HIV/AIDS in rural areas may be underestimated, as individuals who are tested in urban areas may move back to rural areas for family support after a diagnosis, or individuals from rural areas may provide testing facilities a false address out of fear that others will learn about their HIV status.

Rural communities may not be able to sustain important services, such as public transportation, due to sparse populations. Lack of basic transportation services can make it difficult for individuals in rural areas to access HIV/AIDS services. In addition, lack of services can make it challenging for HIV-positive individuals with low resources to engage in regular HIV care or adhere to an HIV treatment regimen. Rural residents may need to travel long distances to find a provider, which impacts retention in HIV treatment.

The interaction between community stigma, consequences of isolation, lack of financial resources, and other barriers demonstrate that these factors must all be addressed together, in order to reduce their collective impact and improve HIV/AIDS prevention and treatment in rural areas.

1.4 Context analysis

The National Program for the Prevention and Control of HIV/AIDS and STI infection (NP HIV) 2021/2022 – 2025 is the fundamental policy that sets national objectives, outcomes, interventions, budget and M&E framework in the field of HIV and sexually transmitted infections. It sets the priorities for action to prevent the spread of HIV and sexually transmitted infections and reduce their impact.

NP HIV 2021/2022-2025 is focused on three basic strategies:

- Maintaining the prevalence of HIV in groups at increased risk of infection (GRSI) as follows: at most 12% in MSM, 10% in PWID, 2.5% in SW by 2025 by implementing HIV/STI comprehensive prevention infections;
- Increasing access to cascade services (testing, treatment, viral suppression) from 66/72/89 in 2022 to 90/90/90 by 2025 by ensuring universal access to treatment, care and support for people living with HIV;
- Improving PN management by strengthening the health system, including providing timely and high-quality strategic information by 2025 by ensuring effective management of the National Program.

The National Program for the prevention and control of HIV/AIDS and STIs 2021/2022 – 2025 considered the outcomes and priorities ser with the Global AIDS Strategy 2021-2026, WHO recommendations, as well as the commitments of the Republic of Moldova towards Global Fund to fight HIV/AIDS and Tuberculosis.

According to the preliminary conclusions of the mid-term evaluation of the National HIV Program, carried out in 2023, it is found that the current NP HIV has a correct strategic focus to respond to the current epidemiological trends. It also has the potential to achieve the desired impact. At the same time, the Program must be more data and evidence driven, when

certain adjustments of interventions and technical approaches are made; it must involve new groups that are left behind and adjust the geographic focus.

If we are to analyze the capacities of the health system in covering the population with health services, it should be noted that there is a large availability of prevention, treatment, care and support services. These are decentralized, but at the same time the geographical coverage is conditioned mostly by the availability of human resources. Insufficient human resources are attested both in medical institutions and NGOs. The system remains highly verticalized, and the integration of services is weak, which leaves the person/patient who needs services in difficult situations to access services.

HIV prevention services among key groups are offered by a network of 13 NGOs, 8 of them on the territory of the Republic of Moldova (called also right bank), including one in the penitentiary system and 4 NGOs that cover de facto Transnistria region (the frozen conflict region of Moldova), called also the left bank. Some of these NGOs (6 on the rights bank and 4 from Transnistrian region) offer also psycho-social support services for PLH and legal support upon request. NGOs are accredited to provide TB and HIV/syphilis screening and testing services. Also, starting 2019, NGOs are enabled to provide community pre-exposure prophylaxis (PreP) services. One single NGO is working with MSM, the one that advances the rights of LGBTQI community. The NGOs is based in Chisinau, the capital of Moldova. This fact informs about a week infrastructure to cover MSM from other regions of the country with HIV prevention services. For the coverage of services for MSM in other localities, the NGOs in the respective localities hire peer-to-peer workers from Chisinau organization to meet the needs of this group.

At the end of 2022, there were 16 ARV treatment facilities in the Republic of Moldova offering ARV, PMTCT, PEP and PrEP. Their number doubled in 2022, compared to 2020, when 8 ART clinics were active in the country. The decision to decentralize the treatment service is largely due to the growing need to bring treatment services closer to the person. At the same time, the human resources in the health system remain insufficient and poorly prepared/capacitated. The lack of a digitalized monitoring and evaluation system makes decentralization difficult to implement. High stigma and discrimination are a serios barrier for many of the patients to accept closer services to the localities where they live.

The Republic of Moldova decentralized, the HIV testing service and included rapid HIV tests in the testing algorithm. The testing thus, is implemented in all family medicine institutions, specialized medicine, and NGOs. Self-testing is available for free in pharmacies from the end of 2022.

Starting from 2014, the psycho-social support service of PLH (people living with HIV) was implemented through four psycho-social centers. These centers are distributed territorially to provide national coverage at the regional level, namely: center, north and south (RM) and east (Transnistrian region).

At the level of sustainability, it is important to mention that the Republic of Moldova is ahead of the maturity curve of its national institutions and their ability to ensure the programmatic takeover of services and purchases supported by donors, according to the preliminary results of the Mid-term evaluation, 2023. Thus in 2021, apr. 60% of the national response expenses were covered from domestic resources, and these fully cover ARV treatment, testing and diagnostics and to a lesser extent, HIV prevention services provided by NGOs. A small amount of HIV prevention services is covered from domestic resources, namely from the National Health Insurance Company, the Prophylaxis Fund.

1.5 Conclusions

Following the analysis, the following categories of people who face inequalities in accessing HIV prevention, testing and treatment and care services were determined:

1. Men
2. Men who have sex with men
3. Migrants
4. People with mental disabilities
5. Female sex workers
6. Female drug users
7. Teenagers 15-24 years
8. Rural population

1. The analysis emphasizes that the insufficient coverage with HIV testing and diagnostics, as well as with HIV treatment and care services of men in the Republic of Moldova has led to an increase in the cases of mortality associated with HIV/AIDS among men, a higher prevalence and detection of new HIV cases among them. This is associated with the fact that men have a lower tendency to seek medical services in the Republic of Moldova due to gender norms. In general, 51% of men in the Republic of Moldova consider their health to be good or very good and do not consider it necessary to seek medical services. The culture of health in the Republic of Moldova is considered very low, especially for men.
2. Men who have sex with men face discriminatory and homophobic practices, including from medical staff. This leads to lower addressability and referral for HIV prevention, testing, treatment and care services. According to the 2020 IBBS study, this group of people has the highest HIV prevalence, while also having the lowest coverage with prevention and medical/treatment services. Punitive approaches to homosexuality fuel stigma and hatred against this population, with the highest level of non-acceptance in the population.
3. Migration to the Republic of Moldova is associated with people of working and sexually reproductive age, the majority of whom are men who leave the Republic of Moldova for economic purposes (employment in the labor field). This group of people, while being highly mobile, has low access to public health services, including HIV testing. They do not have mandatory medical insurance and mainly turn to private medical services where HIV testing is not promoted, and HIV testing services are mainly paid (they are not attractive for migrants). It is recognized it is difficult to cover migrants with HIV prevention and testing services. At the same time, PLH faces reduced access to HIV-related services in the countries they migrate to.
4. People with mental disabilities were targeted as a population for the first time. This group was identified as a result of the focus groups held with medical staff. There is insufficient evidence to identify this group as being at increased risk of HIV transmission, however medical personnel indicate that there is a high number of HIV positive newly registered people identified during pregnancy, or based on clinical indications or other HIV-related testing interventions that have mental disabilities.
5. Data analysis identified that sex workers remain a category of women at high risk associated with HIV and STI transmission, often associated with gender-based violence, and with reduced access to medical services, including HIV-related ones due to factors such as low education, lack of medical insurance policy, not being registered with a family doctor, criminalization of the provision of sexual services and a high level of stigma and discrimination.
6. In addition to female sex workers, a separate category of women with reduced access to services who face similar inequalities are female drug users (injecting and non-injecting). This category is largely a subgroup of female sex workers but with specific needs. Mainly the consumption of psychoactive substances (often polyconsumption), including alcohol,

leads to behaviors with a high risk of HIV infection. These women are blamed and stigmatized by the society, and by medical personnel.

7. The reduced access to HIV prevention and testing services for adolescents aged 15-24 years is conditioned by the imperfect regulatory framework, which restricts the access of HIV prevention and testing services for people under 18 years of age.
8. Unequal access to health services is common for the rural population. The rural population has also low access to HIV-related services. This fact requires thorough research and the development of the intervention strategy for the rural population.

1.6 Recommendations for planning

According to the conclusions, priority interventions for the identified groups need to be built around each specified group and need to aim to widen access to HIV prevention, testing, treatment and care services. At the same time, it is necessary to specify that ensuring availability does not always reflect the widened access and acceptance of services by specific groups.

Color codes were used to prioritize groups based on the data and evidence availability, and thus estimating the groups' impact on HIV. Red color informs on first priority groups to be further addressed by the national policies and GFATM, orange are the second priority groups which have to be distinctly covered with interventions and HIV resources, while for social, structural and other barriers, synergies with other programs have to be applied. Additional data to further identify inequalities and their link to health and HIV outcomes have to be collected. The groups colored green are to be further monitored, better granular data collected and synergies with other programs ensured.

Table 2. Groups prioritization

Groups	Focused HIV interventions (both programmatic and structural)	Granular data and evidence	Synergies with other available programs
Men	X	X	
Men who have sex with men	X	X	
Migrants		X	X
People with mental disabilities		X	X
Female sex workers	X	X	X
Female drug users	X	X	X
Teenagers 15-24		X	X
Rural population		X	X

To reduce the inequalities associated with HIV, complex interventions are needed that include not only increasing geographic access, the spectrum of services, but also to perform interventions looking for the improvement of the normative framework. In most cases, additional research and studies are needed to determine the existing gaps. The inequalities assessment exercise has proven to be useful in determining and identifying existing gaps and strategizing activities and policy actions needed to reduce inequalities between different population groups.

1) The following priority interventions targeting under-coverage with HIV testing, treatment and care services among **men** were identified within this exercise:

- Implementation of the Index-testing strategy among partners with elements of the "snowball" strategy. It envisages covering the chain of partners with HIV testing services with subsequent remuneration of positive results.
- Elaboration of the normative base and implementation of testing of pregnant women's partners. This is aimed at expanding the access to HIV testing services to men of reproductive age.
- Improve the implementation of the key performance indicators-based strategy to provide incentives and motivate the medical and non-medical staff to test and detect new HIV cases.
- Promotion of HIV self-testing available for free in pharmacies through communication campaigns.

2) A separate category of men for whom specific interventions are being developed are **men who have sex with men**:

- Increase geographical access to HIV prevention services among MSM through the use of electronic online (WEB) information services and consumables and supplies provision (including PrEP), self-testing for HIV, anonymously through the use of courier services (e.g. NovaPoshta, CourierRapid, etc.)
- Web informational campaigns related to the access to HIV prevention, testing, treatment and care services through specialized social networks focused on the target population (eg Viber, FB, Telegram groups, etc.).
- Boost PrEP services through the personalization and "demedicalization" of the service.
- Capacitation of medical personnel on the reduction of stigma and discrimination of this group by developing their abilities to use a human rights based approach and efficient interpersonal communication.
- Deeper research of high-risk practices among MSM (eg chemsex).

3) **Migrants** as a separate, hard-to-reach group require special interventions:

- Carry out a study to determine the prevalence of HIV among migrants, estimate the number of PLH among them, determine the needs in HIV prevention, testing and treatment as well as interventions focused (tailored) on this population group.
- Develop an information resource register and realize the mapping regarding the availability of HIV prevention, testing, treatment and care services in the Republic of Moldova as well as in the countries of emigration of the population.
- Expand HIV prevention and testing services at the border crossing points of the Republic of Moldova.
- Ensure synergies and integration of HIV services with existing TB services for migrants, that are developed and implemented in Moldova in collaboration with IOM (International Organization for Migration).

4) It is recommended to use a specific approach towards **people with mental disabilities, including the** integration of HIV services with mental health services:

- Carry out a study to determine the prevalence of HIV among people with mental disabilities, estimate the number of PLH among them, determine the needs in HIV prevention, testing and treatment as well as interventions focused (tailored) for this population group.
- Ensure synergies and integration of prevention services, HIV testing and ARV treatment within mental health centers, including through the implementation of Index-Testing strategies.

5) **Female sex workers, including those who use drugs (injectable and non-injectable)**, being a category of women with a much higher risk of HIV infection compared to other women, require the development of specific services:
   - In order to increase the attractiveness of HIV prevention services for these population groups, it is necessary to review the package of services for HIV prevention, by including legal support activities, social re-inclusion and integration with sexual reproductive health services, including through services provided by mobile clinics.
   - Boost the comprehensive HIV prevention services advanced in the National HIV Programme.
   - Tailor the HIV prevention, testing and treatment services to the needs of women, ensuring their gender-responsiveness
   - Ensure synergy of the HIV programme with the ones available to respond to gender based-violence.
   - Decriminalise the sex work and drug use practices.

6) The reduced access to HIV testing and prevention services for adolescents aged 15-24 requires interventions in the normative framework of the Republic of Moldova:
   - Review of the normative-legislative framework regarding the accessibility of HIV prevention and testing services for persons who have not reached the age of 18 without the consent of their parents or guardian.
   - Review the package of HIV prevention services with an emphasis on this population group and the provision of these services in the places where they are addressed (e.g. youth centers, youth health centers, clubs, etc.)
   - Carry out an HIV KAP study (knowledge, attitudes and practices) among adolescents aged 15-24 years.

7) **The rural population** in the Republic of Moldova, has a lower rate of addressability to medical services compared to the population in the urban environment. At the same time, more data and evidence is needed to understand the HIV related tendencies in that specific group of population.
   - Ensure disaggregation and granularity in relation to the residence and place of living in the existing data collection information systems.
   - Carry out an in-depth study on access to HIV services for the rural population and its risk behaviour.

2 ANNEXES

2.6 Key Informants

INTERESTED PARTY	ATTITUDE of the interested party towards subject	IMPORTANCE of the problem to the interested party	INFLUENCE of the interested party on the problem
MINISTRY OF HEALTH	++	I	A

NP HIV COORDINATION UNIT	++	I	L
CCM (INCL. UN AGENCIES AND DONORS)	++	I	A
MINISTRY OF JUSTICE	0	L	L
THE NATIONAL ADMINISTRATION OF PENITENTIARIES	0	L	L
MEDICAL UNIT OF THE NATIONAL PENITENTIARY ADMINISTRATION	++	I	L
KEY AFFECTED COMMUNITIES/KAP COMMITTEE	++	I	L
NON-GOVERNMENTAL ORGANIZATIONS	++	I	L
NATIONAL PUBLIC HEALTH AGENCY	+	A	A
OFFICE OF THE PEOPLE'S ADVOCATE/OMBUDSMAN	+	A	I
EQUALITY COUNCIL	+	L	A
THE PARLIAMENT OF THE REPUBLIC OF MOLDOVA	0	L	I
THE GOVERNMENT OF THE REPUBLIC OF MOLDOVA	0	L	A
MINISTRY OF INTERIOR	0	L	L
BMA	0	L	A
LOCAL PUBLIC AUTHORITIES	0	L	A
MINISTRY OF EDUCATION	+	A	A
MINISTRY OF LABOR AND SOCIAL PROTECTION	+	L	A

NATIONAL SOCIAL ASSISTANCE AGENCY	+	A	A
NATIONAL HEALTH INSURANCE FUND	+	I	A

ATTITUDE	IMPORTANCE	INFLUENCE
++ = absolutely pro **+ = pro** **o = neutral** **- = contra / against** **-- = absolutely contra / against**	**L** = low **A** = average **I** = increased	**L** = low **A** = average **I** = increased

2.7 **Documents Reviewed**

Scientific Evidence	Year	Name of Report	Link
	2016	Accessing methadone within Moldovan prisons: Prejudice and myths amplified by peers	https://www.sciencedirect.com/science/article/abs/pii/S0955395915003692
administrative statistics	2017	Country progress report - Republic of Moldova Global AIDS Monitoring 2017	http://sdmc.md/wp-content/uploads/2018/07/GAM-2017_MDA.pdf
administrative statistics	2018	Country progress report - Republic of Moldova Global AIDS Monitoring 2018	http://sdmc.md/wp-content/uploads/2019/04/GAM_Country_Progress_Report_RM_2018.pdf
administrative statistics	2019	Monitoring and control HIV infection in the Republic Moldova, year 2019	https://sdmc.md/wp-content/uploads/2021/02/MD_Raport_anual_HIV_RO_2019_FINAL_DB-modificat.pdf
administrative statistics	2020	Monitoring and control HIV infection in the Republic Moldova, year 2020	https://sdmc.md/wp-content/uploads/2021/08/SPITALUL.pdf
administrative statistics	2021	Monitoring and control HIV infection in the Republic Moldova, year 2021	https://sdmc.md/wp-content/uploads/2022/08/MD_Raport_anual_HIV_RO_2021.pdf
administrative statistics	2021	Country progress report - Republic of Moldova Global AIDS Monitoring 2021	https://www.unaids.org/ru/regionscountries/countries/republicofmoldova
Assessments & Studies			
Gender Assessment	2019	Data dynamics 2014-2018. Moldova in an international context	https://neovita.md/studii-si-cercetari/hbsc-moldova-dinamica-datelor-2014-2018-moldova-context-national/?fbclid=IwAR0Pc6A3tMSAz

			KPFnKXAGMFn57QtGeGcedF1TulG_ZHWJbFuEVrcW6dn56g
Legal Environment Assessment	2021	Equality Perceptions and Attitudes Survey	http://egalitate.md/wp-content/uploads/2016/04/studiu-privind-perceptiile-si-atitudinile-fata-de-egalitate_study-on-perceptions-and-attitudes-towards-equality.pdf
Human rights barriers assessment	2017	FROM WORDS TO DEEDS Combating discrimination and inequality in Moldova	http://egalitate.md/wp-content/uploads/2017/01/ro_doc_1468582624_39949422.pdf
CLM reports	2018	Youth Well-being Policy Review of Moldova	https://www.oecd.org/countries/moldova/Youth_Well-being_Policy_Review_Moldova.pdf
Youth score cards	2020	Legal Environment Assessment on HIV in Moldova	https://www.ohchr.org/sites/default/files/Documents/Issues/MentalHealth/HIVConsultation/Submissions/UNDP_Moldova.docx
	2020	Concluding observations on the 6th periodic report of the Republic of Moldova : Committee on the Elimination of Discrimination against Women	https://digitallibrary.un.org/record/3856669?ln=ru
CAP	2012	CAP among the young people	http://www.ucimp.md/images/pdf/RAPORT%202012%20final%207_08_2012.pdf
IBBS	2016	Integrated biological-behavioral surveillance survey among key populations in the RM 2020	http://pas.md/ro/PAS/Studies/Details/72
IBBS	2020	Integrated biological-behavioral surveillance survey among key populations in the RM 2020	https://sdmc.md/wp-content/uploads/2020/12/IBBS_REPORT_MD_2020_FINAL_eng.pdf
key population estimate	2020	Estimating the sizes of key population in the RM 2017	http://pas.md/ro/PAS/Studies/Details/70
key population estimate	2020	Estimating the sizes of key population in the RM 2020	https://sdmc.md/wp-content/uploads/2021/01/National_size_estimation_RM_report_22_01_2021-ENGL.pdf
access to ART	2017	Assessment of barriers to access to HIV continuum of care	http://www.ucimp.md/images/pdf/technicalassistanceremovalofbarrierstoaccesstohivcontinuumofcare.pdf

access to ART	2017	Evaluation of psychosocial services addressed to PLH in the Republic of Moldova	http://www.ucimp.md/images/pdf/raportevaluarecsr20sept2017.pdf
access to ART	2021	Audit of ART abandon cases	https://sdmc.md/wp-content/uploads/2022/05/Raport_studiu_abandon_21.01.2021_Final.pdf
access to ART	2021	Audit of HIV confirmed cases who did not reach the services.	https://sdmc.md/wp-content/uploads/2022/05/Raport_studiu-neadresare_21.01.2021.pdf
access to ART	2021	Late address for ART	https://sdmc.md/wp-content/uploads/2022/05/Raport_studiu_adresare_tardiva_21.01.2021.pdf
Other			
Politics documents	2022	National Program for Prevention and control HIV/AIDS and sexually transmitted infection for 2022-2025	https://www.legis.md/cautare/getResults?doc_id=130469&lang=ro

2.8 **Other**

HIV-Related Inequalities	Available interventions to respond	Opportunities (including various factors above)	Challenges (including various factors above)	Lessons Learned	Priority Interventions
Insufficient coverage with prevention in men, including MSM (men who hav sex with men)	✓ Activities in PN HIV ✓ PCN ✓ Medical and community PreP ✓ GFAM resources ✓ NGO servicies (condoms, weboutreach)	✓ GFATM Application 2024-2026 ✓ In-depth research into causes, including chem sex ✓ Adjusted legal and regulatory basis	✓ Discriminatory and homophobic practices ✓ Geographical coverage and limited infrastructure ✓ Stigma and discrimination by doctors ✓ Requirement to provide passport data in order to receive PrEP reduces the acceptability of PrEP services	✓ Availability does not mean access and acceptance of services until you address homophobia and discriminatory practices from the root	✓ Carrying out the study among men, including chemsex ✓ Extension of services, including web, ✓ Training of medical personnel ✓ Campaigns to reduce homophobia ✓ Depersonalization and "demedicalization" of PreP

			among key populations ✓ Low coverage with PrEP, esp. in regions. ✓ PrEP services delivery is still partially medicalized /institutionalized, which creates additional barriers in stigmatized environment		
Insufficient HIV testing coverage of men, including MSM	✓ Various testing options: medical sector, NGOs, self-testing ✓ There is the Instruction on police involvement in HIV prevention and working with GRSI	✓ Information campaigns targeted at the men's group, including MSM / including online ✓ Performance indicators for testing men ✓ Expanding HIV testing through NGOs in IDP Temporary Detention Centers (15 locations)	✓ Stigma and discrimination ✓ Gender norms ✓ Health culture is very low in this group ✓ Labor migration	✓ Administrative aspects (conditionality of HIV testing for migration) influence addressability ✓ Data granularity (by sex) is very important and identification, planning of focused interventions (use of data)	✓ Testing partners of pregnant women ✓ Testing contacts of people diagnosed with HIV (INDEX-testing) ✓ Expanding MSM's HIV testing and prevention service coverage ✓ Organization of informational campaigns aimed at men's health ✓ Adjustment of the normative and implementation framework with the inclusion of specific performance indicators

Inadequate HIV treatment coverage of men, including MSM	✓ Establishing indicators for family medicine and NGOs for inclusion in treatment ✓ Patient incentives for ART initiation and ART adherence/retention	✓ Global Fund Application ✓ Integrated services for addiction, TB, HIV, hepatitis			✓ Development of integrated models of medical services, including non-communicable diseases ✓ Referral of PLH, diagnosed with HIV from PHCs and NGOs to specialized services for ART initiation
The insufficiency of HIV prevention, testing, treatment, care and support services for migrants	✓ Services for migrants focused on TB ✓ There is the Instruction on police involvement in HIV prevention and working with GRSI ✓ The Aliens Placement Center (BMA) is served by the	✓ Global Fund Application ✓ Focused services in TB and the fact that we have common TB/HIV strategies in both national programs represent an opportunity	✓ Very hard-to-reach group - mobile (screening and testing); ✓ Insufficient data and policies unfriendly to personal data ✓ Criminalization of HIV in recipient countries (Russia) ✓ ARV interruptions related to migration (work) ✓ Missing data	There is a continuing need to look at data from a different angle and adapt evidence-based/analysis-based interventions – applying the Inequity tool and identifying this group confirms that	✓ Carrying out studies to estimate the prevalence of HIV among migrants ✓ Expanding coverage of HIV testing services at border crossings Expanding HIV prevention services among migrants ✓ Combining TB screening activities with HIV testing among migrants ✓ Mapping (mapping) the distribution of PLH living outside the Republic of

	medical service of the Border Police				Moldova and their estimation (study in ART clinics) ✓ Development of an information resource on access to testing, prevention and treatment services in different countries (regions) ✓ Elaboration of mechanisms and SOPs regarding the provision of ARV drugs on demand for people who are outside the Republic of Moldova
Insufficient data on HIV status among people with intellectual disabilities	✓ The network of community mental health centers and NGOs active in the field that can be involved ✓ The network of temporary placement centers where	✓ Adapting the IBBS methodology for this population category ✓ Training of medical personnel in Centers in HIV testing ✓ Expanding population groups for NGO services	✓ Lack of interventions/tools adapted to the understanding of this population group ✓ Unadapted regulatory framework (informed consent, privacy, services) ✓ Lack of disaggregated data on HIV in this group	Disaggregated data is important to highlight distinct population groups that require changes to routine data collection systems	✓ The study to determine the prevalence of HIV among people with mental deficiencies through Mental Health Centers ✓ Development of HIV prevention and testing services based on Mental Health Centers ✓ Integrating ART services of PLH with mental impairment in mental health/fostering facilities

	people are institutionalized				
Insufficient HIV service coverage of women Sex workers (SW)	✓ Services available in NGOs ✓ Mobile clinics ✓ Weboutreach ✓ Vending machines ✓ Service delivery standards	✓ FG and CNAM application ✓ Diversification and increasing the attractiveness of the service package for LS	✓ Stigma and discrimination of this group ✓ Criminalization of the activity ✓ Frequent victims of violence ✓ Low addressability for medical services ✓ Lack of insurance policies and family doctor ✓ Low education and unsafe sexual practices (no condom, multiple partners)	✓ The provision of sexual services is accompanied by several risks, not only of contracting HIV or other STIs, but also of physical and sexual violence that requires an integrated approach	✓ Revision of the service package for SW (incl. legal support activities, social re-inclusion, non-communicable diseases, treatments) ✓ Development of medico-social services for SW
Insufficient HIV service coverage of women who use drugs	✓ Services available in NGOs ✓ Mobile clinics ✓ Weboutreach ✓ Vending machines ✓ Service delivery standards ✓ Studies available -IBBS	✓ FG and CNAM application ✓ Development of services for women users of synthetic drugs ✓ Providing the complex service package	✓ Stigma and discrimination against women who use drugs ✓ Insufficient gender sensitive services at the level of medical institutions ✓ Low education and unsafe sexual practices	✓ The polyconsumption of substances and the need to address several addictions (including alcohol) of varying degrees is particularly sensitive in the case of women,	✓ Review of performance indicators of medical institutions and NGOs including gender transformation and sensitivity ✓ Revision of the package of services for women drug users (incl. legal support activities, social re-inclusion,

	2020, 2022 ✓ National protocols 2020, 2022		(no condom, multiple partners)	who are blamed and stigmatized by society, including in the case of accessing medical and social services	non-communicable diseases, treatments)
Reduced access to HIV services for adolescents aged 15-24	✓ Fragmented sexual reproductive health services ✓ The school curriculum includes optional life skills ✓ Optional vocational schools ✓ CPT ✓ PrEp of youth ✓ Researches	✓ More synergies with other programs: sexual-reproductive health ✓ Compulsory inclusion of the subject of life skills in school curricula ✓ Modification of the normative framework	✓ The regulatory framework provides for HIV testing from the age of 18 ✓ Standard in HIV prevention is a common one with adults ✓ There is not enough disaggregated data ✓ No access to risk reduction services (syringes, opioid drug treatment)	✓ Children and young people up to the age of 18 are in the sexually active period and are tempted to engage in risky behaviors, and the conditioning of the testing with the consent of the parents or guardian is essential	✓ Review of the normative/legislative framework regarding access to HIV testing services for adolescents under the age of 18, in the absence of parental and guardian consent. ✓ Carrying out a KAP HIV study among adolescents ✓ Developing the standard of risk reduction services for people up to 18 years old
Uneven access to HIV services for the Urban/Rural population	✓ Routine data is collected disaggregated by medical institutions and NGOs	✓ GFATM Application	✓ the existing collection system does not contribute to capacity building in data analysis and interpretation ✓ the lack of a functional	The Republic of Moldova being a geographically small country, requires an individualized approach for different localities (cities, district centers and villages) to	✓ Ensuring the functionality of the information system for data collection and analysis ✓ Carrying out an in-depth study on access to HIV services for the Urban/Rural population

			data collection information system generates difficulties in data collection and analysis	ensure equitable access to services	

2.9 **Implementation plan**

Item	Task	Start	End	Dec	Jan	Feb	Mar
1.0	**Inception and planning**						
	Conduct Desk Review	10.12.2022	21.12.2022				
	Produce Stakeholder Mapping	10.12.2022	21.12.2022				
	Develop Final Inception Report	10.12.2022	21.12.2022				
2.0	**Inequality Analysis**						
	Perform Situational Analysis	22.12.2022	23.02.2023				
	perform Contextual Analysis	22.12.2022	23.02.2023				
	Identify and validate Prioritizing Actions	22.12.2022	23.02.2023				
	Regular chech-ins with national consultants /biweekly in December/January and weekly/February 2023/or at need	22.12.2022	23.02.2023				
	Check in with global consultant and UNAIDS management for feedback	22.12.2022	23.02.2023				
	Develop the Plan ?	22.12.2022	23.02.2023				
3.0	**Concept Note**						
	Development of the Concept Note / Report on analysis outcome	24.02.2023	24.03.2023				
4.0	**Documenting, Reporting and Feedback (throughout)**						
	UCDs						
	Global Consultant						
	UNAIDS HQ						