



Republic of Moldova

Accelerating progress towards MDG 6 in the Republic of Moldova:

an application of the MDG
Acceleration Framework





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United Nations

MOLDOVA

Opinions expressed in this publication do not necessarily reflect the official views of the United Nations.

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ABBREVIATIONS

AIHA	– American International Health Alliance	NGO	– Non-governmental organization
ART	– Antiretroviral Therapy	NHIC	– National Health Insurance Company
CC	– Community Centres	NPHC	– National Public Health Centre
CSW	– Commercial Sex Workers	NRS	– National Reference System
DOTS	– Directly Observed Treatment, Short-course	NTP	– National Tuberculosis Programme
EU	– European Union	OST	– opioid substitution therapy
GF	– Global Fund	PITC	– provider-initiated testing and counselling
HDCD	– Hospital of Dermatology and Communicable Diseases	PLH	– people living with HIV
HIV	– Human immunodeficiency virus	QALY	– quality-adjusted life years
HR	– harm reduction	SIME HIV	– HIV Monitoring and Evaluation Information System
HVB	– Viral Hepatitis B	SIME TB	– TB Monitoring and Evaluation Information System
HVC	– Viral Hepatitis C	STI	– Sexually transmitted infections
IDU	– Injectable drug user(s)	TB	– Tuberculosis
IOM	– International Organization for Migration	TWG	– technical working groups
LPA	– Local Public Administration	UCIMP	– „Unitatea de Coordonare, Implementare și Monitorizare a Proiectului de Restructurare a Sistemului Sănătății” <i>(Health System Restructuring Project Coordination, Implementation and Monitoring Unit)</i>
LSC	– commercial sex workers	UNAIDS	– Joint United Nations Programme on HIV/AIDS
MDG	– Millennium Development Goal (referred throughout the report to MDG 6)	UNDP	– United Nations Development Programme
MDL	– Moldovan Leu (national currency of the Republic of Moldova)	UNGASS	– Special Session of the United Nations General Assembly
MDR TB	– multi drug-resistant tuberculosis	UNICEF	– United Nations International Children’s Emergency Fund
MIA	– Ministry of Internal Affairs	UNODC	– United Nations Office on Drugs and Crime
MJ	– Ministry of Justice	VCT	– voluntary counselling and testing services
MLSPF	– Ministry of Labour, Social Protection and Family	WHO	– World Health Organization
MOH	– Ministry of Health		
MSM	– men who have sex with men		
MTEF	– Medium Term Expenditure Framework		
NAP	– National AIDS Programme		
NCC	– National Coordination Council		
NCC	– National AIDS Council/Committee/Commission		

FOREWORD

The Republic of Moldova, together with 191 countries, is committed to achieving the Millennium Development Goals (MDGs) by 2015. While countries share the same overarching goals, they often choose different paths to achieving them and vary in terms of progress made. Moldova first established national targets for achieving the MDGs in 2004. Three years later, based on analyses made on progress and consultations with stakeholders, most targets were revised, including those under Goal Six, which relate to HIV, malaria and other diseases such as tuberculosis (TB). The revised targets were included in the Government's National Development Strategy (NDS) for 2008-2011 and the development vision until 2020.

The Government is committed to maintaining good public health services and combatting socially-conditioned diseases, such as HIV/AIDS while tuberculosis, remains a priority. Despite the Government's commitments and efforts that have been made in collaboration with development partners, the incidence of HIV has risen. The TB situation is also challenging. Multi-drug resistant tuberculosis (MDR TB) is increasing, especially among socially vulnerable groups, which have been made even more vulnerable due to the economic crisis. The general population is not immune to this risk.

In 2011, in order to accelerate sustainable progress on HIV/AIDS and TB, the Government and relevant stakeholders decided to apply the Millennium Development Goals Acceleration Framework (MAF), the methodology endorsed by the United Nations

Development Group. With support from UNDP, WHO and other UN agencies, the application of MAF has helped investigate the social and medical determinants of health and identify potential barriers within and outside the health system – bottlenecks at socio-economic and institutional levels. It has also focused on the needs of those socially vulnerable groups that bear the brunt of HIV and TB epidemics. Economic and social marginalization, stigma and the discrimination that they face are some of the underlying reasons why they are vulnerable to these diseases.

The Action Plan developed through the MAF exercise identified priority bottlenecks that impede key populations from accessing proper social support and health care and proposed solutions for better and more cost effective models for integrated HIV, tuberculosis and HIV-tuberculosis care. The Action Plan is a set of priority, evidence-based strategies that, if effectively and sustainably implemented, should accelerate progress on HIV and TB. Implementation of the Action Plan requires the sustained and coordinated commitment of government agencies and partners, including donors and civil society. By coalescing around this plan, the national response will be strengthened and the tide might finally be turned on these two epidemics that are present in Moldova.



Andrei Usatii,
Minister of Health

FOREWORD

The Republic of Moldova has been coping with constantly high level of HIV/AIDS and tuberculosis incidence and prevalence over recent years, mostly affecting specific populations and vulnerable groups. Notwithstanding the many measures that have been put into place with international support and national efforts, the progress towards MDG 6 has been modest, resulting in high morbidity and risk of mortality due to HIV, tuberculosis, and co-infection.

In 2010, based on worldwide best practice, the United Nations launched an MDG Acceleration Framework (MAF) to assess the bottlenecks impeding existing interventions, and provide hands-on solutions based on evidence of best practice and cost-efficiency. The Government of the Republic of Moldova, through the Ministry of Health, led the application of the MAF to MDG 6, in close relation to national programmes ongoing in both disease areas and adapting to the health system in the country. This report presents the results of the diagnostic exercise as well as the resulting action plan.

The Action Plan highlights critical issues and solutions, and proposes a partner-

ship “compact” that can be put into action through existing national HIV and tuberculosis programmes. Impressive stakeholder involvement and cross-sectoral collaboration between the Ministry of Health, Justice, Labor, Social Protection and Family, Economy, civil society and health experts led to the identification of integrated and innovative solutions that go beyond the health sector. Our Government partners acknowledge that these priority actions will help strengthen the joint national response in the short- and medium-term, especially in light of anticipated erosion of funding sources.

The UN Country Team was privileged to provide support in application of the MAF through the joint efforts of UNDP and WHO, in partnership with UNAIDS, UNODC, OHCHR and other agencies. This collaborative effort is timely, as the country faces challenges related to the financial and economic crises affecting Europe, while striving at the same time to reform the health system to expand quality health and social services to vulnerable groups. The United Nations is committed to support the Government in its implementation of the MAF Action Plan.



Nicola Harrington-Buhay,
UN Resident Coordinator



Jarno Habicht,
WHO Representative

EXECUTIVE SUMMARY

This report provides a comprehensive analysis of the HIV and TB situation in the Republic of Moldova, and proposes the Millennium Development Goals (MDG) Acceleration Action Plan that identifies the priority short- and medium-term solutions to key bottlenecks. The MDG Acceleration Framework endorsed by the United Nations Development Group has been applied as the main methodology to the currently off-track MDG 6 targets in Moldova.

HIV

Overall, the incidence of HIV has increased significantly since 2000 in Moldova (see Figure 1). To date, the epidemic has mostly affected injecting drug users, sex workers, men who have sex with men and their partners. The most affected regions include the city of Balti and the Transnistria region. Despite a slight decrease in new infections over the past three years, national targets on HIV are not likely to be met without a redoubling of efforts. These targets are: reduction of HIV incidence from 10 cases per 100,000 in 2006 to 8 per 100,000 people by 2015. In the 15-24 age group, the national target is a reduction from 13.3 cases per 100,000 in 2006 to 11 per 100,000 by 2015.

Tuberculosis

Tuberculosis, like HIV, represents a significant public health challenge in Moldova. Overall, TB incidence has increased over the past decade, from 97.3 (per 100,000 people) in 2002 to 114.3 in 2011 (see Figure 1). About 26% of new cases are multi-drug resistant TB (MDR TB), a worrisome trend that points to ineffective or incomplete treatment. Even though the mortality rates fell for the first time in 2008 down to 17.4 cases per 100,000, it still remains high at 16.1 per 100,000 in 2011. On average, about two patients a day died from TB in Moldova.

The national target to reduce the rate of mortality associated with tuberculosis from 15.9 per 100,000 people in 2002 down to 10 per 100,000 by 2015 is unlikely to be met without concerted efforts.

The most affected are vulnerable groups, such as transient or homeless individuals, adults, people living with HIV, children from poor households, prisoners, orphans and injecting drug users. Many of these groups are also most affected by HIV.

Overall, reversing the spread of these two infections in the short run is unlikely, without sustained efforts in the medium-to-long term.

Recently, the Government has undertaken a number of actions towards improving the above situation, including the amendment of the normative framework (Law on HIV, Law on control and prevention of tuberculosis, National HIV Programme, National TB Programme), and increased political commitment by creating a participative National Coordination Council for HIV and TB with a Secretariat and 11 Technical Working Groups. Positive practical achievements can be also mentioned in the service provision for HIV and TB - a comprehensive package of services for key populations, including, but not limited to, harm reduction programs, opiate substitu-

tion therapy with methadone, voluntary counseling and testing, Youth Friendly Health Centres, protocols for antiretroviral therapy, community centres for TB, directly observed treatment (DOT) strategy, DOTS-Plus for multidrug resistant TB and other activities.

Despite a rather pessimistic overview in short-term, the Government and key development partners, civil society organizations and local administrations foresee certain opportunities to accelerate progress. By applying the standard MAF methodology, relevant stakeholders were able to prioritize key current interventions, identify bottlenecks to these, and most impactful and feasible solutions that would allow for acceleration.

Actions to be taken

The proposed interventions in both HIV and TB sectors were prioritized a thorough analysis of the epidemic situation and all available studies and reports, national and international recommendations. These interventions can help improve access and acceptability of risk populations to specific patient-tailored services, effectively decreasing transmission of the infections and safeguarding the human rights of people living with HIV and people with TB. In addition, these interventions were identified as the most feasible and impactful. Such prioritization is very important in the current situation, when recent financial and economic crises have adversely impacted the availability of national resources while at the same time external support from key global partners, such as the Global

Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), is diminishing. Together, these raise significant concerns over sustainability of the HIV and TB responses. Besides these challenges, the solutions also address other systemic issues that impede progress on both HIV and TB, such as those around governance - decentralization and coordination among different levels of authorities, health and social services.

Regarding the HIV segment, the MAF report suggests the need to focus attention on the following priority interventions: (a) scaling up harm reduction programmes to focus on HIV prevention in key populations; (b) strengthening the case-management system and ensuring a better adherence to ARV treatment and (c) ensuring early detection of HIV infection by promoting and offering voluntary counselling and testing services in vulnerable populations.

Specific acceleration solutions include: (a) expanding the integrated suite of services for risk groups and people living with HIV and their partners to include, in addition to the traditional harm reduction services, also the prevention and treatment of sexually transmitted infections and TB, as well as the vaccination and treatment of viral hepatitis; (b) geographically extending harm reduction programmes to cover also the southern districts of the republic, which have high rates of injecting drug use and other risk behaviours but currently have insufficient service coverage; (c) developing health services delivery mechanisms, including through NGOs, with national financial support under the compulsory medical insurance scheme; (d) preventing of the

transmission from risk to general population by including sexual partners and clients in harm reduction programmes; (e) ensuring the functionality of the electronic HIV Monitoring and Evaluation Information System which is already prepared and ready to be practically implemented; (f) involving the community centres that provide support services to risk groups to refer to ARV treatment and improve ARV treatment adherence; (g) advocating for and overtaking of the ARV treatment costs by the funds of the national compulsory insurance system, alternative funding identification; (h) developing a comprehensive referral mechanism to the voluntary counselling and testing services; (i) building the capacity and supportive supervision of the VCT service (j) scaling up HIV counselling and testing, including using mobile VCT.

In the TB segment, the MAF exercise revealed the importance of focusing on 3 particular areas of intervention: (a) increasing the access of socially vulnerable groups to medical services, including TB services;

(b) ensuring the adherence to anti-tuberculosis treatment of the people with active TB and (c) strengthening the infection control in the specialized facilities.

This could be achieved through the following prioritized solutions: (a) examining people in placement centres and other places by preventive examination and building capacity of the staff in these places; (b) appointing a person in charge of TB in primary health facilities, whose job is to conduct and report on the activities related to TB screening of the population within socially-vulnerable groups; (c) ensuring conditions for continued treatment tailored to needs of vulnerable people; (d) allocating sufficient resources and creating other incentives to support patients' in follow-up care; (e) defining the incentives mechanism for the employees involved in TB control activities, among others. Identification and allocation of domestic and other sources of funding for front-line services providers is another important solution proposed in the Action Plan.

ACKNOWLEDGEMENTS

Throughout its preparation process this Report has benefited greatly from the generous support and valuable contributions received from the many individuals and organizations, some of which are mentioned below. A number of others contributed to the Report either directly, through feedback on drafts, discussions, or indirectly through their research. We are particularly grateful to UNDP's HQ colleagues, Tuya Altangerel, Policy Specialist on MDGs, Poverty Practice and Brian Lutz, Policy Specialist, HIV, Health and Development Practice, and to WHO Country Office in the Republic of Moldova colleague, Silviu Ciobanu, for their professional support for the development of this Report.

The team owes special thanks to Nicola Harrington-Buhay, UN Resident Coordinator and UNDP Resident Representative in Moldova, and Narine Sahakyan, UNDP Deputy Resident Representative, for their intellectual advice and professional guidance. Special thanks to Alex Oprunenco, UNDP Policy Specialist, and Dumitru Vasilescu, UNDP Project Manager for effective project management and policy guidance. Special tribute is to be paid to Kaarina Immonen, former UN Resident Coordinator/UNDP Resident Representative in Moldova, and Matilda Dimovska, former UNDP Deputy Resident Representative for their important contribution to the conceptualization of the current report. We would like to thank all those directly or indirectly involved in guiding the development of this Report, while retaining sole responsibility for any remaining errors.

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Arcadie Astrahan, UNDP Moldova consultant, Alexandrina Iovita, UNAIDS monitoring and evaluation advisor

Consultative process

The Report has passed through several rounds of consultations. Worthy of particular mention are three national MAF workshops organized jointly by the UNDP, WHO and the Moldovan Ministry of Health several focus groups in both HIV and TB segments were organized with UNDP support. In-depth interviews with key LPAs were also undertaken to better understand the potential involvement of LPAs in the MAF implementation.



CHAPTER 1.

INTRODUCTION

Implementation of the national MDG agenda has been a key development challenge for Moldova. Since the signature of the Millennium Declaration in 2000, the country has made significant progress in certain areas of human development – economy, governance and management of ecosystems— while in other areas, more sustained effort is needed to achieve the national targets by 2015. The progress may become harder to attain under the current conditions of economic uncertainty and financial austerity. Despite the fact that Moldova has weathered the consequences of the global economic crisis fairly well, the progress on the achievement of the national targets remains uneven. The main areas of concern are MDG 2 and MDG 6, whose targets Moldova is likely to miss. Furthermore, downside risks are looming, stemming from the limited sustainability and inclusiveness of economic growth. As the latter slows down, the Government, supported by its development partners, should take steps to ensure that new growth opportunities are identified and its benefits are distributed in a more inclusive and equitable manner. Overall, measuring progress along the national MDGs, designing and implementing feasible and sustainable acceleration solutions requires consolidated efforts by all relevant stakeholders, including central and local authorities, civil society organizations, development partners, private sector and individual citizens.

Moldova is committed to achieving MDG 6, which is to combat HIV/AIDS, tuberculosis and other diseases". Combatting socially-conditioned diseases, such as HIV/AIDS and

tuberculosis, is a priority for Moldova in the context of maintaining good public health, and goes beyond the commitments taken on in connection with the MDGs. The incidence of HIV/AIDS is on the rise despite consistent efforts made by the Government and the support of the country's development partners. The mortality rate from tuberculosis, which fell for the first time in recent years in 2008, continues to pose a threat to the population of Moldova, especially in the context of the economic crisis, as the disease mainly affects socially vulnerable groups.

Moldova has the necessary components to provide a well-coordinated national response to HIV and TB. The normative framework, including the recent amendments to the special Laws – the Law on HIV prevention and the Law on TB prevention, National Programmes on HIV and TB, provide for the necessary normative background to priorities and implement activities oriented towards effective HIV and TB prevention, voluntary testing and counselling, treatment and care. A joint National Coordination Council (NCC) is set, comprising main stakeholders, including multilateral specialists, PLHIV and civil society organizations, different government agencies and ministries with the NCC Secretariat headed by the Government Counselor on Social Issues. The multilateral orientation of the national response for both HIV and TB is ensured also by the formed permanent working groups on epidemiological surveillance, education and youth, vulnerable groups, treatment and care for people living with HIV, communication and prevention, voluntary counseling and

testing, monitoring and evaluation and the group on social protection in HIV and TB.

Although a series of measures were taken to combat HIV/AIDS and tuberculosis, the Republic of Moldova did not meet the intermediate targets, set forth in the MDG 6, to reduce HIV/AIDS incidence and TB-associated mortality by 2006. Moreover, the spread of these diseases developed at such a pace that the accomplishment of the targets set for 2010 and 2015 has become impossible. This has made it necessary to review the targets and set more achievable values in this area. At the same time, with the revision of the MDG in 2007, the name of this goal was changed to exclude malaria as a disease for which Moldova is to set medium-term and long-term goals. That change was not reflected in the initial MDG Report, as the measures carried out in recent years to prevent and combat malaria have led to the disappearance of local cases of this disease.

Despite efforts, Moldova has not been able to achieve the revised goal for both HIV and one TB targets – 1) in 2011 the HIV incidence was 17.58 per 100 000 population (target 1. - 9.6 cases by 2010 and 8 by 2015); 2) the HIV/AIDS incidence in the 15-24-year age group in 2011 is 14,99 (target 2. - 11.2 cases by 2010 and 11 cases by 2015); 3) the rate of mortality associated with tuberculosis in 2011 is 16 (15.0 in 2010 and 10.0 in 2015). An important part of the incidence, especially for HIV, is composed by a significantly higher rate of cases on the left bank of Nistru. Although the TB mortality rate seems to be stabilized (still far from

the target value yet), the rate of multidrug resistant form of TB is worrisome

Compared to other diseases, the HIV situation has been carefully studied in a number of quantitative and qualitative studies. In the field of TB, the available data are weaker and the recent qualitative surveys were prioritized for TB in six focus groups, including pulmonologists (medical lung specialists) from municipalities and district centres, specialized hospitals, family doctors and health care assistants.

A common element and task for the government in both the fields of HIV and TB is to identify and provide for funding possibilities that would progressively rely on national sources, the NHIC, after it was announced that the Global Fund would no longer finance most national programmes. It was also decided in the process of application to the next round of the GFATM, to prioritize and respectively amend the policy documents, including the National Strategic Programmes in order to focus and address key populations at risk and to make more specific and explicit prioritization and resource allocation, outlined in a recent Joint Assessment Report prepared by a team of international recognized independent experts¹. A critical issue was identified being the lack of use of available monitoring and evaluation (M&E) data to drive and shape the national HIV response to match the epidemic pattern. The main results to be achieved by the programme need to be identified and prioritized, and used for planning purposes. Progress towards these results should be tracked².

¹ *Joint Assessment Report and Annexes - MOLDOVA NATIONAL PROGRAMME FOR HIV/AIDS AND STIS CONTROL AND PREVENTION FOR 2011-2015*; <http://aids.md/aids/index.php?cmd=item&id=1142>

² *ibid*

In these circumstances, the application of the MDG Acceleration Framework (MAF) methodology looks as the most appropriate way to identify actions that need to be prioritized to effectively address the situation.

The MAF helps to accelerate progress at the country level on those MDGs which currently seem to unlikely to be reached by 2015. It can be adapted to different country circumstances and complements existing government planning processes, while also improving the mobilization coordination of efforts and resources contributed by various partners. Countries can use this approach as one way to respond to the shared call to accelerate progress that was made at the MDG Summit in September 2010. The MAF provides national stakeholders with a systematic approach to identify and analyze bottlenecks that are causing MDGs to veer off-track or to move ahead too slowly. It then aims to generate shared diagnostics and to recommend comprehensive, collaborative and focused actions, based on prioritized 'acceleration' solutions. It also helps governments to focus on disparities and inequalities, two of the major causes of uneven progress, by particularly responding to the needs of the vulnerable. The pilot experience has shown

that when governments take the lead and have effective assistance from all partners, progress is possible.

During the analyses in both the fields of HIV and TB, it was clarified that some of the priority solutions identified to the bottlenecks are systemic and address the common problems in response to both TB and HIV. The actions for these solutions are common and raise their feasibility and impact to address both target groups.

This report presents the extensive analytical work of the experts in a concise manner, applying the MAF methodology for MDG 6 in the Republic of Moldova, which contains detailed analyses with all references and description of the available relevant data. This summary report consists of the following chapters with interventions specific for HIV and TB: Chapter 1. Prioritization for acceleration in HIV and Chapter 2. Prioritization for acceleration in TB with relevant sub-chapters on: A. Priority interventions; B. Priority bottlenecks; C. Priority Solutions; D. Action Plan for HIV/TB; E. Conclusions for the HIV/TB segment. The report also provides an overview and analyses common features for both areas as well as specific interventions in HIV and TB fields.



CHAPTER 2.

**MAF: ACCELERATING
PROGRESS IN COMBATING
HIV**

1A. EPIDEMIC SITUATION AND OVERVIEW ON MDG PROGRESS³

MDG 6 TARGET 1. Stabilize the spread of HIV/AIDS infection by 2015. Reduce HIV/AIDS incidence from 10 cases per 100,000 of the population in 2006 to 9.6 cases by 2010 and 8 by 2015.

The incidence of HIV/AIDS rose from 4 cases per 100,000 of the population in 2000 to 19.4 cases per 100,000 population in 2008, and declined marginally to 17.2 cases per 100,000 population in 2009 and 17.6 in 2011. As HIV/AIDS has steadily risen, it is difficult to ascertain if the slight decline in incidence in the last 3 years represents a turning point in the evolution of the epidemic or just a pause in a longer-term increase. A particularly alarming situation is the increase of HIV in Transnistria, the separatist region in eastern Moldova.

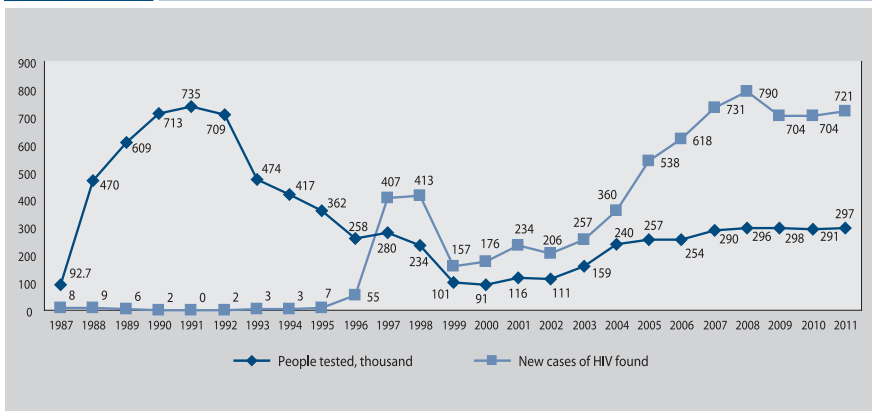
In 2007, following an analysis of progress made towards the first preliminary set of targets for 2006, the target relating to the reduction of HIV/AIDS incidence per 100,000 of the population was revised down by more than half. In 2006, HIV/AIDS incidence stood at 14.7 cases, as opposed to the initial intermediary target of 4 cases per 100,000 of the population.

721 new cases of HIV infection were discovered in 2011, including 227 in the eastern territories (704 cases in 2012, of which 247 in the eastern territories) (Fig.1).

In 2011 the incidence of HIV per 100,000 population amounted to a total of 17.58 for the Republic of Moldova (18.37 for the right bank and 42.10 for the territories on the left bank of the Nistru River).

At the end of 2011, the HIV prevalence amounted to 129.04 per 100,000 popula-

Figure 1. The dynamic of new HIV cases and the volume of tests for HIV Markers in the Republic of Moldova for the 1987 – 2011 period (abs.).



Source: Ministry of Health.

³ Based on the Informative bulletin: The situation of HIV/AIDS 2011 period of reference. The National Public Health Centre and on The Second Millennium Development Goals Report

tion, including 98.18 on the right bank and 292.86 in the eastern territories.

By January 1, 2012, 7,125 new HIV cases were registered on both banks of the Nistru River. In the past 3 years, the number of new HIV cases has remained stable.

There is significant geographic variation in HIV incidence and prevalence, with significantly higher prevalence in several municipalities – prevalence in Balti, in the north of Moldova is the highest, amounting to 723.97; several cities on the left bank of Nistru – Ribnita (453.57), Tiraspol (219.06) and Bender (207.09), while there are districts with rates lower than the national average, including the capital Chisinau.

MDG 6 TARGET 2. Reduce HIV/AIDS incidence in the 15-24-year age group from 13.3 cases per 100,000 population in 2006 to 11.2 cases by 2010 and 11 cases by 2015.

HIV/AIDS mainly affects persons of reproductive age, including those in the 15-24 age group. As with the previous indicator, the intermediate target for 2006 with respect to HIV incidence in the 15-24 age group was not accomplished, registering a result almost three times worse than the desired value. That was also a reason for revising targets in 2007, from 4 to 4.2 cases per 100,000 population by 2010 and from 11.2 to 11 cases by 2015.

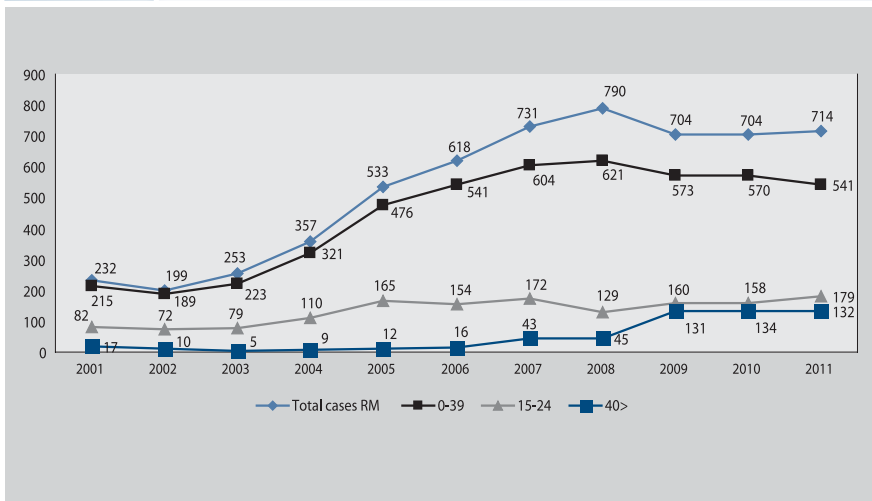
However, unlike the combined HIV/AIDS incidence, the incidence of this disease

in the 15-24 age group fell in 2008. It was 16.1 cases per 100,000 population, as compared to 21.2 cases in 2007 and 18.7 cases in 2006 (see chart). But in 2009 a new spike in the age specific epidemic for the 15-24 age group was recorded: 19.59 cases per 100,000 inhabitants. As in the case of combined HIV/AIDS incidence, the incidence for this age group was higher on the eastern side of the Nistru (39.5 cases per 100,000 inhabitants).

By 2011, a decrease in the identification of HIV infection cases can be noticed in the 15-39 age segment, amounting to 72,81% of the total number of cases found.

In 2011 in the age segment 15-19 it is 2.91%, age 15 - 24- 18.3 %, in age segment 0 - 39 it amounts to 75.17% while in age segment 40 and over it registers an increase, respectively amounting to 27.82%.

From the debut of the epidemic, 1,597 people were diagnosed with AIDS, which is 22.7% of the number of HIV infected persons. In 2011, 420 persons have been diagnosed with AIDS (290 in 2010). The most frequent AIDS indicator diseases are: pulmonary infection with Mycobacterium tuberculosis– 49.19%, esophagus candidosis– 20% and the HIV fatigue syndrome– 6.66%. There are annual data reports on the HIV/AIDS epidemiological surveillance to the European Centre for Disease Prevention and Control. There is a quarterly analysis of indicators accompanied by the information of The Global Fund to Fight AIDS, Tuberculosis and Malaria.

Figure 2.**Distribution of HIV cases registered by age at the moment of identification in the Republic of Moldova, 2001-2011 period (abs.)**

Source: Ministry of Health.

Treatment, care and support

For ensuring universal access to treatment for all those who needed it, the National Programme has one of the main objectives to ensure access to ARV treatment of at least all 80% of the estimated number of PLHIV in need of ART. This objective was achieved for 2010 and is maintained in 2012 for those officially registered with treatment centres, mostly because the treatment is totally free of charge thanks to support from the GFATM, regardless of the statute of compulsory health insurance. The real constraint in achieving the genuine 100% coverage is the fact that there is an estimated significant gap between the number of those registered and the real number of those who are HIV infected. The real need for ART is estimated at 5,683 persons (4,380 on the right bank and 1,303 on

the left bank of the Nistru River). The necessity for mother to child transmission prevention treatment for 2011 was estimated at 205 HIV positive pregnant women (163 on the right bank and 42 on the left bank of the Nistru River).

The most important achievements relate to ensuring access to HIV treatment, which in fact is 100% available to those who need and want it; to achievements in the decentralization of treatment services and HIV care throughout the country; updating treatment protocols with the WHO financial support; initiating the creation of infrastructure for testing viral resistance to ARV preparations; improving accessibility and quality of prophylactic ART for HIV pregnant women; opening a pediatric ward within the ARV treatment institution.

Since 2011, the decentralization of ARV treatment has begun and is available in the northern part of the country in the Balti municipality, the southern region – Cahul and in Chisinau. On the left bank of the Nistru River, the ARV treatment is provided by the AIDS Centre in Tiraspol and in Ribnita for citizens from the northern part of Transnistria.

The regulation on the organization of palliative care services for people with HIV/AIDS was developed. An HIV case management protocol is missing. Support and care services are assessed as inadequate on the grounds that palliative care is not institutionalized and is provided almost exclusively by the NGO sector; human capacities are underdeveloped; the concept of vulnerability is not sufficiently developed and social assistance based on the concept is in the process of being operationalized. Data show that coverage of children with ARV

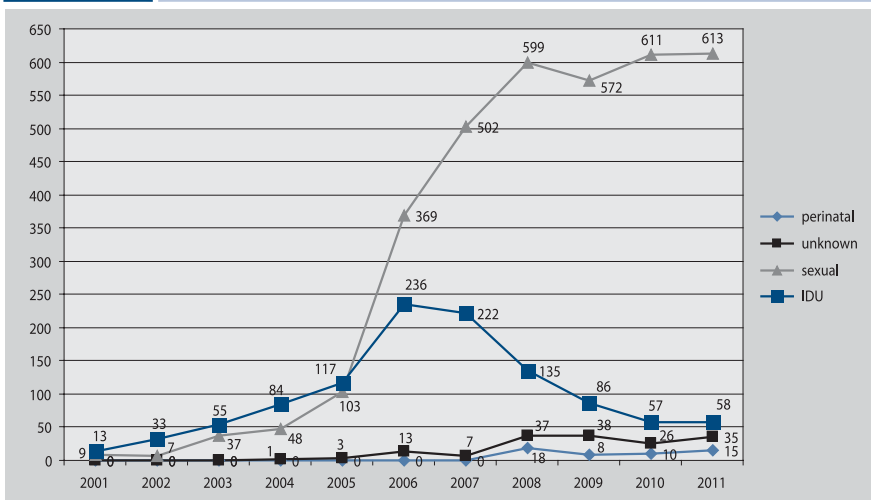
treatment is lower than for adults. Insufficient training, laboratory diagnostics and situation monitoring in the field of HIV/AIDS on the left bank of the Nistru River represent gaps that need special consideration.

Routes of transmission and risk groups

In the last five years, sexual transmission is the main probable route reported by newly registered HIV cases in the Republic of Moldova (out of 704 new HIV cases reported in 2010, 86.79% identified the sexual route as the main probable route of HIV transmission; out of 721 new HIV cases reported in 2011, 85.02% identified the sexual route as the main probable route of HIV transmission). Out of the number of newly registered HIV cases, where the probable route of transmission was the sexual one, men and women have almost equal shares (52.9% of men in 2011). This

Figure 3.

Distribution of HIV infection cases registered, by route at the moment of identification in the Republic of Moldova, period between 2001-2011 (abs.)



Source: Ministry of Health.

represents a significant shift in the epidemic, such that sexual transmission far outweighs injecting drug use as the direct cause of HIV transmission.

The change in the structure of newly reported HIV cases in terms of probable route of transmission increases the vulnerability of women, constituting 47.71% of new HIV cases registered in 2011. HIV/AIDS is mainly registered among young people of reproductive and economically-active age, aged 15-39 – 72.81% of new HIV cases registered in 2011, in age segments of 20 - 24 years old – 15.39% and 25-29 years old – 18.56%.

Starting in 2007, more than 99% of pregnant women were tested for HIV which allows for HIV prevalence to be calculated in this group. For the past 6 years, the prevalence of new HIV cases is relatively stable.

The estimation of the real size of groups at risk has an important role in programme planning. In 2011 the Republic of Moldova carried out a rigorous activity to estimate the size of key populations at risk to replace previous rounds of estimations that had limitations due to scarcity of available data and methodology used (largely, experts' opinion). The estimation was made for big cities (Chisinau, Balti, Tiraspol) for both the right and the left banks of the

TABLE 1. AN ESTIMATION OF MOST-AT-RISK POPULATION GROUPS, REPUBLIC OF MOLDOVA, 2011.

Group	Region	Group Size
Intravenous drug users (IDU)	Right bank	21061
	Left bank	10501
	Total	31562
Commercial sex workers (CSW)	Right bank	12359
	Left bank	2409
	Total	14768
Men having sex with men (MSM)	Right bank	19670
	Left bank	2615
	Total	22285

Source: Ministry of Health.

Nistru river. The geographical disaggregation of these figures is important also due to significant discrepancy in the incidence and prevalence between the two banks of Nistru, requiring different approach and volume of intervention.

Counselling and testing for HIV

The access to voluntary counselling and testing is provided in 67 Voluntary Counselling and Testing sites, including 54 in public medical institutions located on the right bank of the Nistru, 5 in penitentiary institutions and 8 in the eastern territories. The share of Voluntary Counselling and Testing sites per 100,000 population has increased from 0.16 in 2007 to 1.63 in 2011. In 2011, 81,521 persons were tested in the voluntary counselling and testing sites, which amounts to 38.36% of the total number of people tested for HIV from the medical workers initiative and from the clients initiative, 142,021 pre- and post test counselling sessions for HIV infection markers having been carried out. The comeback coefficient for post-test counselling of the people who were counselled pre-test and tested for HIV is 74.21% .

Despite these figures, the HIV testing practice, reported also by a recent WHO assessment⁴, disproportionately fails to cover populations at higher risk for HIV. For example in 2010, out of 290,856 HIV screening tests performed, only 3,410 (0.01%) were IDU, of whom 35 (1%) were positive; only 2,458 (0.8%) were CSW, of whom 89 (3.6%) were positive. However, populations which are at low risk for HIV were tested in significantly higher numbers

with a much lower rate of detection. For example 24,786 (8%) of all those who were tested were young people in the category of those who are take the recommended pre-marital HIV testing. Out of those, 37 (0.1%) were positive. It is also not clear and difficult to evaluate those who find themselves in the "others" category – a number of 115,664 (40% of all those tested in 2010) of whom only 0.02% were positive.

In the majority of cases, visits to VCT are referred by medical workers amounting to 90.38% (89.03% in 2010) of the people counseled, while requesting testing by personal initiative or NGO referral is low, some 9.61% (10.97 % in 2010), raising concern about how the service was promoted and how effective or attractive the promotion was.

It seems that as the official national voluntary counseling and testing network is located in the public primary health institutions, it remains unattractive to people from risk populations. On the other hand, organizations that have outreach and peer-support activities are not allowed to provide counseling and testing and the referral to the official network from these organizations does not seem to be particularly effective.

Legal and policy context

Normative acts have been adjusted according to the recommendations of the World Health Organization, UNAIDS and European Union, in accordance with the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS. A human rights-based approach has been

⁴ Evaluation of the HIV testing component of National HIV programme in Moldova; Eramova, Ciobanu, March 2011

applied aiming to promote basic principles of non-discrimination of people living with HIV, to minimize the consequences of the epidemic and to ensure Universal Access with the implementation of comprehensive and multidisciplinary interventions. In an effort to bring existing regulatory frameworks in line with these basic human rights principles an MoH Order on "Abolishment of some Acts regulating Prevention and Control of HIV/AIDS" has been approved and normative acts containing stigmatizing provisions have been abolished. The amendment of Law 23 of February 16, 2007, referring to the prevention of HIV/AIDS, has been approved. Civil society was consulted over the amendments. The approval of the modifications to the Law nr 23 fully guarantees the right to privacy and confidentiality of personal information and also significantly strengthens safeguards for disclosing HIV status, the right to non-discrimination and equality of people living with HIV/AIDS and the right of people living with HIV/AIDS to freedom of movement. This amendment also excluded all kind of mandatory HIV testing and recognized the vulnerability of women to HIV.

In June 2011 the National Programme on Prevention and Control of HIV/AIDS and STI underwent an external evaluation performed by a team of national and interna-

tional experts. As a result of the evaluation, a series of recommendations have been developed and programme objectives have been reformulated: such as the prevention of transmission of HIV, Hepatitis and STI, especially among key-populations; reducing the negative impact of the epidemic, mainly by offering treatment, care and support to people living with HIV/AIDS and members of key-populations; promoting synergies with other components of the health system; developing an efficient system of programme management. The amended National Programme takes into account these recommendations and will have improved focused objectives (to be adopted).

Within the region, Moldova is recognized as an example of good practice due to the way it successfully implemented Harm Reduction Programmes in key populations at risk in the civilian sector (IDUs, CSWs, MSM) and in penitentiary institutions (IDUs). There are now information/education/outreach, and needle exchange activities, as well as referrals to medical and social services. Methadone Substitution treatment is provided both in the civilian sector and in penitentiary institutions (on right bank of Nistru river only). During the reporting period, services were extended to 3 more localities, including some on the left bank of the Nistru river (IDU).

1B. PRIORITY INTERVENTIONS

The first step in applying the MAF to HIV is to identify the priority interventions. In order to determine the priority interventions, existing data, literature and relevant legal and regulatory frameworks were reviewed and analyzed.

Numerous studies carried out in Moldova on HIV/AIDS reflect the situation from several perspectives. The results of these studies were used both for the prioritization of the necessary interventions and for the identification of bottlenecks and possible solutions.

The following step was a qualitative sociological survey. In order to create a broader overview of the epidemiologic situation related to control of tuberculosis and HIV/AIDS and to supplement the available knowledge with qualitative data and allow the analysis of gaps and to prioritize activities, a qualitative sociological study was carried out. The qualitative sociological study comprised of 4 focus groups. The group discussions aimed at providing information support under MAF project for the acceleration of MDG 6 – Fighting HIV/AIDS and Tuberculosis. The categories participating in the study, as main implementation actors, were recommended by the team of national consultants, taking into account issues that had been approached less by other studies on the same topic. Therefore, the higher priority was assigned to the subject of Tuberculosis, since there are more recent studies on HIV/AIDS that can be used. To find out problems related to control of HIV/AIDS a focus group with

family physicians was organized. Group discussions were focused on underlying the main problems in the field, the difficulties of intervention, the poor reference and testing, the adherence to treatment but also identifying solutions to address these issues.

Having analyzed the literature and conducted the desk review of the legal and normative framework in force in Moldova and taking into account the results of the focus group discussions with family physicians, eight interventions for the acceleration of progress towards MDG 6 were suggested:

1. strengthening the capacity to prevent HIV in the key populations (IDU, CSW, MSM) by increasing the access to harm reduction programmes and covering at least 60% of the estimated number of people in this category, as well as preventing the transmission of infection from these populations to the general population;
2. increasing adherence to ARV treatment of persons with HIV/AIDS;
3. increasing the access of the population to voluntary counselling and testing services;
4. promoting synergies with other health and education programmes related to prevention, building a safe and harm-free behaviour as integral parts of implementation of HIV/AIDS strategies;
5. family planning for women living with HIV, treatment and care for HIV for pregnant and women with children;

6. blood safety, safety of injections and universal precaution interventions;
7. influence of community leaders, civil society and religious groups to improve the epidemiological situation of HIV/AIDS;
8. Reducing stigma and discrimination of people living with HIV/AIDS and the members of their families.

All identified interventions were analyzed in terms of impact that will allow the acceleration towards MDG 6, based on the following criteria: quality input of the intervention in terms of the outcome, beneficiaries (affected population) and speed of impact. Also, the feasibility of these interventions was assessed by the criteria of governance, capacity, and availability of financing, as well as other factors.

In accordance with the priorities set forth in the National Programme and recommendations of international experts who assessed it between June 27 and July 7, 2011, three of the initially eight interventions have been prioritized. As a result of focus group discussions with family physicians, in-depth interviews with representatives of NGOs working on HIV / AIDS, discussions with representatives of local authorities, and national consultations with key stakeholders, the interventions have been prioritized largely due to the updated National AIDS Programme (to be adopted), followed by the Joint Assessment of the National Strategies (JANS) in June - July 2011⁵. The rationale for each priority intervention is presented below.

I. SCALE UP HARM REDUCTION PROGRAMMES TO FOCUS ON HIV PREVENTION IN KEY POPULATIONS

The HIV epidemic in Moldova is concentrated, mainly in certain sub-populations, such as injectable drug users (hereinafter - IDU). This is confirmed by the Epidemiologic Surveillance Studies (2010), which showed very high rates of HIV prevalence among IDU.

Despite the fact that in the previous National Programme the role of injecting drug users and their sexual partners in the epidemic was less prominent, available evidence points to them currently being the primary driving force of the epidemic. This fact was highlighted during the current Joint Assessment Report which recommended a re-evaluation of the situational analyses and programming and furthermore, strategic planning.

This priority was also stressed at the national stakeholders' roundtable and in the qualitative interviews in the focus group.

Therefore, given the current epidemic situation, prevention activities for key populations must be prioritized, in order to reduce HIV transmission overall and to prevent HIV from gaining a foothold in populations that are currently largely unaffected. Since most IDU, CSW, MSM and their clients and partners are young, the updated national programme for the prevention and control of HIV/AIDS and sexually transmitted infections for 2011-2015 will emphasize the delivery of basic services to some of the most vulnerable and marginalized young people in the country.

⁵ <http://aids.md/aids/index.php?cmd=item&id=120>

The impact of the intervention was assessed to be high due to the number of beneficiaries, focus on the most at risk populations and available data on cost effectiveness of these activities⁶. By 2015 at least 60% of IDUs, CSWs and 40% of MSM of the estimated number of population groups at high risk for HIV infection, should benefit from increased access to HIV prevention programmes. These measures also allow for bridge populations to be tackled. Partial impact is possible within 3 months and full impact within 4 years (by 2015), according to the National AIDS Programme (NAP) 2011-2015. Given the good experience of the national actors in implementing the harm reduction programmes, the current capacities, the intervention is also estimated to be feasible, although efforts will have to be made to identify financial resources for sustainability and scale-up activities, which given the cost-effectiveness should not be excessively problematic. Normative changes will also be needed to regulate the requirements for service providers, including NGOs for harm reduction and other services.

II. STRENGTHEN THE CASE MANAGEMENT SYSTEM FOR ENSURING BETTER ADHERENCE FOR ART

Antiretroviral treatment (ART) is one of the most important advancements in medicine recorded in the last decades. With the establishment of ARV treatment we can estimate that the life expectancy of an HIV infected patient under ART medication is very long, appreciated by some studies as being nearly equal to that of a person who

does not have HIV. Also, the ARV treatment results in improved life quality of PLHIV.

One of the specific targets of the „National Programme on Prevention and Control of HIV/AIDS and STI for 2011 – 2015“ is providing ARV treatment to 80% of the estimated number of people living with HIV and people with AIDS who require treatment. This objective mainly aims at improving the quality of life of PLHIV by ensuring: the necessary ARV treatment, the treatment of opportunistic infections and infections associated with AIDS, home caretaker, social protection, including for the orphaned children. The establishment of an empowered environment would allow an increased adherence to ARV treatment and ensure a more efficient case management.

Under certain conditions, ARV treatment for PLHIV can act as an effective HIV prevention strategy, as it significantly reduces the risk of spreading the HIV infection. It remains to be seen whether such a strategy can be implemented on a large scale and whether it applies in concentrated epidemics, like in the Moldovan context, where the most affected groups face barriers to early, regular access to HIV testing, treatment and care.

At the impact level, this intervention can potentially cover a significant proportion of MDG gap by 2015 (better survival of PLHIV and those receiving ARV treatment through better adherence to therapy and better access to ARV services) and better quality of life, capacity to work and be useful to the society etc. Besides PLHIV that receive treatment, indirectly their partners

⁶ UNAIDS regional office cost-efficiency study and “Ensuring the Sustainability of Harm Reduction Programmes by looking up funding in the national budgets”, 2010, SOROS Foundation Moldova

and the general population may also be able to benefit, due to preventive effect of the treatment. The current capacities of the service providers and the involved governmental actors allow us to estimate that intervention would be feasible in the short and mid-term (speed of impact). As for most HIV and TB activities, given the fact that the majority of activities are relying on GFATM resources, the funding will have to be reevaluated and additional resources identified. Due to the fact that the procured ART medications are procured under the national HIV programme and not through the regular, national medication procurement scheme, regulatory changes will have to be operated to register and authorize the ARV medications on the same basis as the rest of the medications.

III. ENSURE EARLY DETECTION OF HIV BY PROMOTING THE VCT SERVICE IN VULNERABLE POPULATIONS

Voluntary counseling and testing is a very cost effective means of preventing HIV. It provides for educating the population, including people with risky behavior about healthy lifestyles by changing their behaviour in order to reduce the transmission of HIV, early access to health care, antiretroviral therapy of HIV-positive people and the possibility to prevent mother-to-child transmission of HIV.

Ensuring that the population has access to voluntary counseling and testing helps raise public awareness, about HIV, promotes a healthy lifestyle, encourages safe behaviour, reduces discrimination and

stigmatization of people infected or affected by HIV and increases the accessibility of health services and socio-psychological assistance to HIV-positive people.

The measures aimed at increasing the access to counselling and testing services include the implementation of provider-initiated testing and counselling for patients with signs and symptoms of HIV infection or treated for diseases with similar transmission patterns. The expanded and improved access to counselling and testing services is particularly important for populations who are the most vulnerable and at risk of HIV infection, including IDUs, MSM, CSW, and other people who practice risky behaviour. The current testing and counseling system is not geared towards key populations, as only 0.24% test positive overall and, only 0.01% of tests in IDUs. NGOs with access to risk populations can provide efficient large scale use in VCT of rapid, simple-to-use tests, including through mobile services. Information campaigns promoted during the extended outreach will increase awareness levels about available testing and counselling services and the importance of knowledge about the HIV status. HIV prevention through public information and transition from risky to safe behaviours through counselling services; early detection and early initiation of ARV treatment, and use of other relevant psychosocial support services can potentially cover a significant proportion of MDG gap by 2015. While VCT are covered by the National Health Insurance Company, resources for scaling up funding still need to be confirmed. Available capacities make intervention feasible, although the poor quality of VCT, access to

VCT in communities, low uptake because of perceived stigma and discrimination and low use of rapid HIV tests due to high costs still need to be properly tackled.

HIV Interventions scorecard

The priority areas of interventions in the HIV sector can be summarized in the following overall scorecard:

and feasibility; i.e. the potential feasible solutions to accelerate progress and which organizations and resources are responsible for such interventions.

Apart from specific HIV and TB bottlenecks, some general systemic issues were identified during the parallel analyses.

For Intervention 1, Scale up harm reduction programmes to focus on HIV prevention in

Interventions	Impact	Feasibility	Rank	Intervention chosen?
Scale up harm reduction programmes to focus on HIV prevention in key populations	Green	Amber green	1	Yes
Strengthen the system of medical follow-up and monitoring of people diagnosed with HIV infection	Green	Amber green	2	Yes
Ensure early detection of HIV infection by promoting voluntary counselling and testing services	Green	Amber green	3	Yes

1C. PRIORITY BOTTLENECKS

Based on available evidence and in close consultation with the key national stakeholders, a team of experts identified and analyzed each of the prioritized interventions, all possible obstacles that could prevent the expected outcome being achieved. Each obstacle or bottleneck has been analyzed for its impact; i.e. the impact of removing the obstacle on direct and indirect beneficiaries

key populations, the below key prioritized bottlenecks have been analyzed:

1a. Limited choice (medications, legal and psychological services), poor quality of some consumables (condoms)

Recent consultative studies with beneficiaries of HR programmes and also close consultations with service providers reveal that the poor quality of some products and

limited HR service package is a major disincentive for key sectors of the population at risk to use them. Considering the number of the beneficiaries and the crosscutting effect, the impact is very important. Although there are financial resource constraints in the feasibility studies, addressing this bottleneck will greatly contribute to the success of the priority intervention. Furthermore, it is very important to address the key populations and ensure that HR programmes are well monitored and evaluated, given the well-established indicators that allow for the relevant actions to be significantly adjusted and corrected.

The bottleneck impacts a large number of risk populations – among IDU - 19000, CSW - 9000, MSM – 9000. It also impacts the bridge populations (their partners) which are significant in numbers - 60% of the population group: IDU partners – 12,700 people, CSW clients – 26,000 people, partners of CSW clients – 17,000 people and the female partners of MSM – 7,300 people⁷. The challenge for removing the bottleneck in the short term is conditioned by tight budgets and the lack of state funding sources earmarked for HR related activities, the gradual withdrawal of the GF from Moldova and the fact that there are no mechanisms in place to use public funds for the contracting of NGOs, or limited accreditation of NGOs.

It is estimated that the provision of high-quality products and services will increase the attractiveness of such services, and shall further curb the spread of HIV. Making the services more attractive will increase and fuel the demand for for more and better

services, something that has been demonstrated by quality studies with recent beneficiaries of HR programmes. Ultimately, everyone can benefit from innovative and more comprehensive services.

Ib. Zero funding by 2015 from the Global Fund

This is a major bottleneck which has a significant impact identified also as a common systemic issue which is also relevant for the TB sector (described here).

The main reason for selecting this bottleneck to be addressed is the stringent need to solve the problem of the planned withdrawal of the GF from funding the HR programmes. It is directly linked to the success of the HR programmes and greatly impacts the key populations, which are the main focus under the revised National Programme, but also is equally relevant to the next intervention on ARV treatment and treatment adherence. Although addressing it is less than feasible by identifying alternative financial resources from the state budget and other international donors, the issue is inevitable to be addressed and there is a clear commitment of the government to do so. At the National Conference on HIV/AIDS in December 2011, the Prime Minister's office declared that tHIV treatment will be a priority and that solutions to the gap in financial coverage will be found. Governmental working groups involving the Ministry of Finance and NHIC are created to propose mechanisms for treatment, harm reduction and other important components from the governmental resources. The protection of the human rights of PL-HIV was also identified as important and

⁷ Source – Study, *Modes of transmission*, UNAIDS, November 2010

resulted in the HIV law amendment to exclude any kind of discrimination of PLHIV, adopted by the parliament in April 2012. Given the major number of directly benefiting population, the crosscutting impact, but also availability of concrete specific means of monitoring and evaluation, addressing this bottleneck is estimated to be one of the most important in the national HIV response.

The affected groups and number are similar with the previous bottleneck described above. The cross-cutting impact of the bottleneck is relevant to all segments particularly the 15 to 24 age group.. Additionally this also has an effect on other components of the national HIV response related to availability of the treatment and care.

The availability of short term solution is challenging due to tight budgets for the following years (including for the national programmes, budgets of LPAs, MoF and NHIC), the absence of provisions for financial allocations for the treatment and HR under the new Medium Term Expenditure Framework (MTEF). Besides internal government funding, there is the possibility of identifying new international donors, including those from the European Union.

1c. Insufficient decentralization of some services (ART, methadone, legal counselling, psycho-social assistance)

There is clear evidence of a link between results obtained in prevention, the treatment of HIV and the availability and accessibility of services in the regions. Addressing the

issue means tackling both supply and demand. Removing the bottleneck will allow for improved access, acceptability and equity for people in risk groups, PLHIV and those who are affected. Scaling up services (not only HR, but also treatment and legal and psycho-social assistance) already started with the expansion of treatment and social centres for PLHIV. However, this should also go hand in hand with the promotion of these services through available means such as peer-to-peer networks, quality and content improvements, etc. The geographic expenditure of available services has also proved highly cost-efficient and also directly impacts the quality of life of PLWA and reduces transmission.

Decentralization has been on the Government's agenda for a while, yet so far, progress has been modest. The pilot phase has been successful (legal services, methadone services, psycho-social assistance, peer to peer etc.). While there are limitations in short-term achievement due to financial resources that need to be invested, overall there will be a significant direct and cross-cutting impact for the priority intervention if the bottleneck is to be removed.

A serious commitment by the Government and local authorities is needed to address this issue. Several structural and normative changes have already been implemented.

For Intervention II, Strengthen the system of medical follow-up and monitoring of people diagnosed with HIV infection the below key prioritized bottlenecks have been analyzed:

Ila. SIME-HIV Information System not applied

The SIME-HIV informational monitoring and evaluation system is an efficient tool for coordinating efforts between medical chains in response to HIV. It allows the medical and epidemiologic surveillance to increase considerably. Its efficiency is proven in the TB and STI field, where it has been fully functional in Moldova for several years. A major advantage is that the system is technically ready and to address this bottleneck; no significant financial resources are required. However, the impact from removing this bottleneck is significant and it is specific and targeted. Removing the bottleneck will ensure access to health supervision and the early beginning of ART and will provide ART planning and procurement opportunities. Besides PLHIV the bottleneck has cross-cutting impact on people living with HIV, who have not yet started ART. SIME HIV has been developed, but it is currently not operational as there are administrative obstacles and the capacity of the new institution in charge of operating SIME HIV remains underdeveloped.

Ilb. Lack of coordination between infection specialists at local level and the treatment centre

The current system of coordination between the diagnosis and treatment follow-up is performed by different medical professionals, who do not belong to the same management structure, resulting in poor quality and limited treatment results. This is reported by the specialists of the HIV treatment centres and other actors. By

eliminating this barrier, the quality of treatment and timely inducement in treatment will be significantly improved. Additionally there is a commitment from the government (MoH) to operate structural changes to provide a unique structure uniting the management for the different levels of the HIV medical response. The impact for the accomplishment of the priority intervention to strengthen the treatment quality is significant. The benefit will consist of improved health results for MDG 6 (HIV), due to permanent health supervision and an early induction into ART, as well as increased adherence for PLHIV and particularly for those on ARV treatment. The feasibility of this bottleneck removal is partially related to the implementation of the SIME-HIV (see previous bottleneck) but also might have constraints due to stigma and discrimination of PLHIV from the medical staff which was reported in several studies⁸.

Ilc. Lack of Community Centres (CC) regulation and poor use of CC

The few community centres that exist for various kinds of support for people in risk groups are run by NGOs under GFATM funding, and serve as efficient chains in prevention and non-medical follow up. Psycho-social assistance provided in these centres, peer support are effective means also for treatment adherence and access to risk and bridge populations. Currently there are no official requirements for standards of service provision by the community centres for PLHIV. According to the National Programme, 10% of the PLHIV who will be supervised, will benefit from the

⁸ Report on PLH socio-economic status survey, 2011 (preliminary report); The study Stigma Index 2011 (preliminary report);

psycho-social assistance in Community Centres. The approval of CC regulations and the functionality of these centres are mutually dependent and can be regarded as an overall bottleneck. The psycho-social support is currently available from the funds Round VIII of GFATM. Recent developments show a good practice for the sustainability of the 4 regional social centres which will be overtaken to be funded by the local public authorities.

For Intervention III, ensure early detection of HIV infection by promoting voluntary counseling and testing services, the below key prioritized bottlenecks have been analyzed:

IIIa. Lack of a comprehensive referral mechanism to VCT

The rate of VCT for people referred from different places, including PITC is extremely low. This is especially significant for specialists providing services to representatives of key populations (narcologists, STI specialist, etc.)⁹. It is internationally recommended and stressed by the VCT specialists that for some categories of patients with the same transmission patterns the HIV testing should be recommended. The lack of guidelines for referring to VCT for medical and non-medical professionals is also contributing to this situation. Removing this bottleneck will increase the access and demand of VCT of the target population. The advantage is also that no significant barriers to remove this bottleneck are foreseen, so the result can be achieved quickly and the availability of VCT improved. The bottleneck impacts y all risk populations

directly and indirectly people with clinical signs of sexually transmitted infections and IDU and their sex partners and clients (around 1,500 persons).

IIIb. Lack of mobile counselling in key population

Moldova lacks a concept of mobile VCT. The VCT offices are placed in medical institutions, most frequently within family doctors centres, the NGOs do not provide counselling. In this way the counselling of key populations is not provided. According to recent studies, including BSS, accessing VCT and evaluating VCT studies reports that the demand of counselling between key populations is high but the coverage by official VCT is extremely low (0.01% and 0.8% for IDU and FSW respectively). Removing this bottleneck will have significant impact and the advantage is that work on the concept has already started. It has also been suggested that the mobile counselling would work well in the regions where harm reduction programmes are in place. Based on such programe sites to enhance sustainability and cost efficiency.

The impact of this bottleneck is significant to tested and counselled people - 4,000 (6%of the estimated number of the key populations (IDU, CSW, MSM).

The elaboration of this concept has already started but regulatory provisions will have to be adjusted to provide specific requirements for the service.

⁹ Evaluation of the HIV testing component of National HIV Programme in Moldova (WHO 2011)

IIIc. No provision of VCT by the organizations who have access to key populations at risk

While mobile VCT services are meant to improve HIV testing and counselling by reaching out to key populations, the NGOs will have a greater role in providing VCT services to key populations. The VCT available in the primary medical care institutions do not properly cover the key population, mostly offering services to general population, couples before marriage. The VCT rooms in clinics are not attractive to IDU, FSW and MSM. On the other hand, the NGOs who have outreach activities and access to key populations cannot be contracted by the public authorities under the existing normative arrangements for providing VCT or other similar services to MARP. The reference to the official (public

VCT network from the side of organizations working with risk populations is also shown not effective. The international experience and good practices show that VCTs can effectively address the existing demand at the local level.

Removing the bottleneck will increase the number of tested people which will have a great impact on the risk groups, their partners and clients. The availability of short-term solution is related only to the lack of normative provisions and does not require financial investments, yet still the impact is significant.

Summary scorecard

Overall, all identified and analyzed bottlenecks under the prioritized areas of intervention are summarized in the below scorecard:

HIV BOTTLENECKS' SCORECARD

Intervention	Bottleneck	Direct impact	Cross-cutting impact	General Impact	Availability of short-term solution	Rank
Scale up harm reduction programmes to focus on HIV prevention in key populations	limited choice (medicines, legal and psychological services), poor quality of some consumables (condoms)	60 percent of the estimated key population, IDU – 19,000, CSW - 9000 and 40 percent MSM - 9000	60% of the population group: UDI partners – 12700 people, clients of the CSW – 26,000 people, partners of CSW clients – 17,000 people and female partners of MSM – 7,300 people,	Green	Amber green	1

Intervention	Bottleneck	Direct impact	Cross-cutting impact	General Impact	Availability of short-term solution	Rank
	Zero funding by 2015 from the Global Fund	60 percent of the estimated key population, IDU – 19,000, CSW - 9000 and 40 percent MSM - 9000	60% of the population group; IDU partners – 12,700 people, IDU clients – 2,600 people, partners of CSW clients – 17,000 people, female partners of MSM – 7,300 people : 60% of the population group; IDU partners – 12,700 people, IDU clients – 2,600 people, partners of CSW clients – 17,000 people, female partners of MSM – 7,300 people,	Green	Amber green	2
	Insufficient decentralization of some services (ART, methadone, legal counselling, psycho-social assistance)	60 percent of the estimated key population, IDU – 19,000, CSW - 9000 and 40 percent MSM - 9000	60% of the population group; IDU partners – 12,700 people, IDU clients – 2,600 people, partners of CSW clients – 17,000 people, female partners of MSM – 7,300 people,	Amber green	Amber green	3

Intervention	Bottleneck	Direct impact	Cross-cutting impact	General Impact	Availability of short-term solution	Rank
Strengthen the health supervision and monitoring system for people diagnosed with HIV by strengthening the multidisciplinary teams based on regional / health care rooms.	Monitoring system SIME-HIV not applied	Number of PLH who will be under medical supervision 6 000	Number of PLH who will be under medical supervision who are not in ART 4 000	Green	Amber green	1
	Lack of coordination between infection specialists at local level and the treatment center	Number of PLH who will be under medical supervision 6 000	Number of PLH who will be under medical supervision who are not in ART 4 000	Green	Amber green	2
	Lack of Community Centres (CC) regulation and failure to use CC effectively	600	600	Amber green	Amber green	3
Assure early detection of HIV by promoting the VCT service	Lack of a clear referral mechanism to VCT by Primary Health Care, hospital care and connected medico-social services (community centers, etc)	Average number of beneficiaries of the testing and counselling service during the recent 3 years - 100 000	Average number of beneficiaries of the testing and counselling service during the recent 3 years - 100 000	Amber green	Green	1
	Lack of mobile counselling in key population	6 percent of the estimated key population number 4 000	6 percent of the estimated key population number 4 000	Amber green	Amber green	2

Intervention	Bottleneck	Direct impact	Cross-cutting impact	General Impact	Availability of short-term solution	Rank
Assure early detection of HIV by promoting the VCT service	No provision of VCT by the organizations who have access to key populations at risk	Average number of beneficiaries of the testing and counselling service during the recent 3 years - all tested and counselled people	Average number of beneficiaries of the testing and counselling service during the recent 3 years - 100 000	Amber green	Green	3

Systemic bottlenecks common to HIV and TB.

During the MAF exercise, a team of national experts and specialists identified common systemic problems which are similar in both HIV and TB. This is partly due to the fact that the TB and HIV control mechanisms share the same country coordination mechanism (NCC) which are financed by the Global Fund resources (more than 90%) but also due to common social aspects of the diseases. The following bottlenecks have been identified from available studies and statistical data in both TB and HIV. They are partly addressed in the review of each (please refer further to each bottleneck and solution) and their removal serves for identifying areas of priority interventions in both fields. Although additional resources should be identified for addressing some

of the issues, the commitment of the Government and the necessity in addressing them- but also considering the combined scaled up impact for MDG targets achievement- make them a priority for rapidly identifying solutions. Many of these health system issues have been identified or will be identified either in the past or during upcoming programme reviews (JANS for HIV, July 2011 and mid-term review for the National TB programme scheduled for February 2013). The following common bottlenecks are relevant for the most important areas of intervention which have been identified separately for each field.

Common priority bottlenecks are:

Lack of government funding for national programme activities (please refer to the bottlenecks description in the separate fields)

Gradual withdrawal of the GF from Moldova, along with many other national programmes (e.g., immunization programme following GAVI graduation) because there is one common budget line for all national programmes, makes this a priority. For the HIV National Programme, the non-covered costs will increase for 2014 and 2015 to 19.2 and 38.2 mln MDL and for the TB Programme to 9.4 and 32.9 mln of MDL respectively. This means that less than 15% of the total needs for both TB and HIV will be covered by the National Programmes¹⁰.

Poor coordination and implication at central and local levels

Although the country coordination mechanism (in Moldova – the National Coordination Council) is common for both TB and HIV, represented by different ministries from the Government and the official secretariat, the coordination between government focal points is weak, and the Ministry of Health and its agencies and the NGOs active in the field do most of the implementation. Several studies and stakeholder consultations also report that a major issue is partnerships at a local level, the lack of coordination with local public authorities and the inability of LPAs to develop adequate HIV and TB local intervention plans.

Poor inter-sectorial coordination, particularly at LPA level for a coordinated medico-social individual support.

Relevant studies show that there is very little or no coordination between medical and social services to provide a multilateral

coordinated individualized support system to ensure early detection and adherence to treatment in both HIV and TB. Despite the fact that there a special working group was created under the Country Coordination Mechanism – the technical working group on social protection in HIV and TB (national regulation on social aid on general vulnerability grounds is also available), in practice vulnerable groups or people living with HIV or TB do not benefit from social assistance except for packages provided under the GF. There is also a lack of skilled multidisciplinary teams which can individually assess and assist people in communities.

As far as impact goes, it has been widely reported that a significant part of poor addressability and initiation of treatment and adherence is caused by social and economic factors^(11,12,13). There are also constraints on obtaining reliable data on the number of people with HIV or TB who benefit from social support due to confidential data protection.

The detailed field-specific bottlenecks and appropriate solutions are proposed in detail described in the specific chapters for HIV and TB.

PRIORITY INTERVENTION FOR SYSTEMIC BOTTLENECKS

Lack of government funding for national programme activities

The detailed solutions applicable to the HIV or TB sectors are proposed at the appropriate section (specifically in HIV II.3 and TB).

¹⁰ Estimations for 2015 – both programs – 10.017 mln MDL covered and 71.034 mln not covered.

¹¹ Estimations for 2015 – both programs – 10.017 mln MDL covered and 71.034 mln not covered.

¹² Assessment of risk factors associated with adherence to treatment of patients with multi-drug resistant tuberculosis (MDR TB) enrolled in the DOTS Plus treatment.

¹³ Moldovan Migrants' Health - Impact of the Socio-Economic Welfare.

At a systemic national level, addressing this bottleneck requires the involvement of multiple stakeholders and an administrative and political will. Some regulatory amendments are also required. Addressing the issue itself does not require financial investment – the main activities are related to the analysis of existing budgets and mechanisms in different sectors, thorough consultations and collaboration between the main stakeholders at a national level with the Ministry of Finance, the National Health Insurance Company, the Ministry of Health, the Ministry of Social Protection and the Ministry of Justice. The main solutions are:

- To create inter-ministerial working groups for identification of the financial resources specific for activities covered currently from GFATM
- Approve mechanisms of health services funding through both main modalities:
 - General service provision reimbursement scheme by NHIC from the health insurance funds
 - Funding by national programmes from the government budget for activities specific to the sector (special arrangements for medication procurement, rapid and other diagnostic tests procurement, etc)
- Approve mechanism for procurement of other mixed or non-medical services (psycho-social support, social allowances and incentives, legal services, etc)

Poor coordination and implication at central and local levels

The detailed solutions for sectors are proposed in the relevant sections in the part

referring to coordination with local authorities. The quality of collaboration between central and local authorities is an ongoing issue in various spheres in Moldova. The Government approved the National Decentralization Strategy and the National Plan 2012-2015¹⁴. The activities in the strategy are aimed at enhancing coordination and applying national policy documents at local levels, including by developing local action plans. This instrument is to be used to coordinate a joint response for HIV and TB. As a separate matter, the capacity of the CCM should also be addressed.

The main solutions include:

- Capacity building of the CCM for a coordinated programming and monitoring
 - Revision of the CCM terms of reference
 - Revision of technical working groups terms of reference
 - Training for the CCM
- Capacity building of local authorities to elaborate and implement local action plans for the response to HIV and TB in line with the national programmes

Poor inter-sectorial coordination, particularly at LPA level for a coordinated medico-social individual support.

The detailed solutions for sectors are proposed in the relevant sections (HIV all activities in intervention II and TB I.2., I.3., II.1., III.3.). At a regulatory level the multi-disciplinary teams and competent case management are areas to intervene for addressing the issue.

¹⁴ <http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=344005>.

Feasible solutions are:

- Scaling up the good practices with community centres (regional social support centres for HIV and community centres for TB)
- Elaborate and approve the national regulation and quality standards for case management in HIV and TB
- Normative changes to regulate the medico-social services
- Capacity building/trainings of multidisciplinary teams and case managers.

1D. PRIORITY SOLUTIONS HIV

Following the prioritization of bottlenecks and interventions, the potential short-and medium-term solutions for each bottleneck were identified and assessed, to speed up achieving the priority MDG targets. The identification of possible solutions was based on evidence-based solutions and case studies, expert interviews, focus groups, as well as government documents and international assessments. For each solution, a profile reflecting the impact and the feasibility of the solution were developed (e.g. magnitude, sustainability and speed of the impact, availability of funds). This information served as the basis for the prioritization of solutions.

The key acceleration solutions identified and prioritized for the three areas of intervention are:

Intervention I - Scale up harm reduction programmes to focus on HIV prevention in key populations

I.1. Expand the suite of integrated services based on the UNODC/WHO/UNAIDS recommendations, developing and implementing services for bridge populations

Profile of the solution I.1

Will address the bottlenecks of the lack of innovative and attractive services (service package) and will increase the demand for HR services by key populations. The currently available services are:

1. Needle and syringe programmes (NSPs)
2. Opioid substitution therapy (OST) and other drug dependence treatment
3. HIV testing and counselling (T&C)
4. Antiretroviral therapy (ART)
5. Condom programmes for IDUs and their sexual partners
6. Targeted information, education and communication (IEC) for IDUs and their sexual partners

Services to be extended:

1. Prevention and treatment of sexually transmitted infections (STIs)
2. Vaccination, diagnosis and treatment of viral hepatitis
3. Prevention, diagnosis and treatment of tuberculosis (TB).

The direct impact will be on the risk groups and cross-cutting on their partners and clients and those affected.

Although implementation needs additional financial resources, its cost effectiveness is evident. An advantage is the good experience that implementing the basic package of HR services in the republic has had.

1.2. Extend harm reduction programmes to 5 more districts.

Profile of the solution 1.2 primarily refers to the obstacle "Insufficient decentralization of some services" and would ensure scale up and extension of geographical coverage for HR programmes. This solution will provide better geographic coverage with HR programmes. HIV prevention services will be closer to the clients thus making such services more geographically accessible and equitable.

The direct beneficiaries will be risk populations from the regions but also the bridge population. The final exact regions have to be decided following a thorough analysis. Natural criteria for selection would be districts with a higher incidence (for e.g. Basarabasca, Ceadir-Lunga, Comrat, Riscani, Ribnita, Slobozia which are higher than average as well as the geographical proximity to the nearest available HR centre. Again, the good experience of implementing the basic package of HR programmes in most regions of Moldova is an advantage and the extension should be only technical. Trainings for the new staff is required and additional financial resources will be needed which will be cost effective and will save money for treatment for cheaper preventive measures.

1.3. Develop health services delivery mechanism with financial support from the NHIC

Profile of the solution 1.3 is addressing the bottleneck 1a. . A Lack of any innovative interventions (non-attractive services) and limited choices (medicines, legal and psychological services) and the poor quality

of some consumables (condoms). It also provides for the scale up of the HR services with sustainable NHIC company funds. It will also provide for the involvement of civil society in the service provision for HR, including in parallel peer to peer services and other services that proved efficient in comparison to public service providers. Mostly this solution will require activities of regulatory amendments to the existing service procurement scheme.

It will also provide for greater participation of organization of PLHIV and social inclusion.

1.4. Use risk reduction programs to focus on preventing HIV transmission from key populations to their sexual partners and their clients

This solution addresses the problem of containing the spread of the infection among the general population. The impact of the bridge population on the spread of the infection towards the general population is not well researched, but data collected during focus groups interviews and service providers' reports suggest that this is an important step. This solution can close a large portion of the MDG gap by 2015 - by 2015 population groups which are at high risk of HIV infection (IDUs, CSWs, MSM). They will have 60 % more access to prevention programmes that will reduce the risk of transmitting HIV/AIDS among these groups and their interaction with the general population. Practically, no additional institutional efforts will be needed due to the already established HR programmes that will be used also for the risk group partners and their clients, thus extending

the number of beneficiaries. The capacities already exist and the financial resources for the additional exchange materials (syringes and condoms) will be cost efficient. The statements are supported by the findings of the UNAIDS cost-efficiency study.

Intervention II - Strengthen the case-management system and ensuring a better adherence to ARV treatment

II.1. The 4 regional treatment centres (Chisinau, Balti, Cahul and Tiraspol) effectively use data management system 'SIME HIV'.

Speeding up the resolution of technical and administrative problems for the launch of SIME HIV, computer based data management system

Profile of the solution II.1 provides for proper implementation of the data base management system SIME HIV, outlined in bottleneck IIa. In line with the recent re-organization of the HIV prevention, treatment and support system, the data management system can feasibly be launched shortly as the delay is only administrative and technical. The effective activity of the SIME HIV will ensure the quality of medical follow-up and will generate reliable national level data for strategic planning, systemic needs assessment and data for the medical and epidemic surveillance individually and at public health level.

II.2. Empower and build capacity of Community Centres for active reference to treatment and for improving the treatment adherence.

Profile of the solution II. 2 tackles bottlenecks on poor collaboration between medical and social sectors (bottlenecks IIb, IIc and IIIa) by providing better coordination in the multi-sectorial effort to timely start an ensure treatment adherence. The Community Centres ensure the provision of psycho-social support to PLHIV. Additionally capacities for referring more people to other services, including ART will increase the treatment adherence. Range of care provided will be more comprehensive and inclusive of patient's other needs (e.g., social etc.). The necessary capacity is available. There are some bottlenecks in provision of staff and ensuring of sustainability starting with 2015 (Lack of funding from GF). Recently, during the last month 3 out of 4 planned centres have been opened and are already operational. Clear-cut lines of authorities, referral protocols and effective communication channels are needed between health and social care services to improve coordination and provide better services.

II.3. Develop short-term advocacy plan in order to secure funds for the ART from the state budget and other alternative sources

Profile of the solution II. 3 addresses the retirement of the Global Funds from financing the national programme (IIb).The implementation of the solution would have a significant impact, since without the Government's involvement it will be impossible to carry out funding plans and programmes to cover treatment costs for PLHIV. It does not require funding in the short run to advocate for it, however, it will

require huge funds down the road (to take over the purchasing of ARV drugs and relevant lab supplies for the clinical monitoring of patients). The success of most other solutions is determined by this crucial measure. In the same time the re-allocation of financial resources from the state budget and the budget of the NHIC will require analytical work on prioritization and financial analyses, including specialists from key actors such as the Ministry of Health, ministry of Finance and other stakeholders.

Estimated time for planning/development - 3 months

Estimated time for implementation 2014 (testing), in rest 2015 implementation

Estimated time before the field results become visible - By the end of 2015 some significant results may be visible.

Intervention III - Ensure early detection of HIV by promoting the VCT service in vulnerable populations

III.1. Develop a comprehensive Referral Mechanism for the Voluntary Counseling and Testing services

Profile of the solution III. 1: the solution will improve the number of counselling and testing initiatives by physicians and health care and in parallel by NGOs that have access to risk groups, providing for VCT to key populations and vulnerable people. The proposed activity, developing a referral manual will allow an increasing number of people to benefit from pre- and post-testing counselling. The direct output is the provision of HIV prevention services

through counselling services, increased awareness, behavioural change, referral to other prevention services, including for people at high risk who are seeking follow-up services.

III.2. Develop capacity and supportive oversight of the VCT service

Profile of the solution III.2 addresses the issue of the quality of counselling and testing in the existing and extended VCT rooms after allowing NGOs as providers of VCT to vulnerable populations (most at risk and bridge population – their partners and clients), including the outreach mobile counselling and testing (see previous solutions).

The report on the comprehensive assessment of the VCT performed by WHO shows that the impact of the current VCT network is poor due to several factors – including orientation towards testing general population with low positive rates; the location and working hours of the public primary health institutions and no attraction for the risk populations such as IDUs and FSWs.

Increasing the quality of VCT through staff training session including NGOs will improve the access of key populations to VCT services. The indirect impact – the growing number of key populations tested and counselled; the decrease on the number of people who did not follow up; the equity/segment of the impacted population.

A new regulatory framework is needed to provide for minimum quality standards and accreditation from the Government for organizations providing VCT, to secure good quality of the service provision.

III.3. Scale up VCT services in all sectors, including NGOs and the development of the mobile counselling concept

Profile of the solution III. 3 refers to the bottleneck of poor supervision and supply for the VCT. This will ensure counselling and testing for vulnerable and at risk populations, including through permission to provide VCT and contracting NGOs that have access to risk populations, the creation of the mobile counselling concept. The scale

up after the VCT was reformed will ensure equitable access geographically and among different populations. The result will be a national network of VCT rooms. The impact and feasibility is similar to the previous solution.

Solutions Summary Scorecard HIV

This table provides the summary of prioritized solutions based on impact and feasibility:

Interventions	Solutions	Impact	Feasibility	Priority ranking
Scale up harm reduction programmes to focus on HIV prevention in key populations Corresponding bottleneck: Ia and Ic, partly Ib (through solution I.3.)	Expand the suite of integrated services based on the UNODC/WHO/UNAIDS recommendations, developing and implementing services for bridge populations	Green	Green	1
	Extend harm reduction programmes to 5 more districts (possibly Basarabeasca, Ceadir-Lunga, Comrat, Riscani, Ribnita, Slobozia).	Green	Amber Green	2
	Develop service delivery mechanism with financial support from the NHIC	Amber Green	Amber Green	3
	Use risk reduction programmes to focus on preventing HIV transmission from key populations to their sexual partners and their customers.	Green	Amber Green	3

Interventions	Solutions	Impact	Feasibility	Priority ranking
Strengthen the case-management system and ensuring a better adherence to ARV treatment Corresponding bottleneck: IIa, IIb, IIc, systemic common bottleneck I and III	The 4 regional treatment centres ensure functionality of SIME HIV.	Green	Amber Green	1
	Use CC to refer to ART and increase the adherence to treatment.	Amber Green	Green	2
	Develop the short-term advocacy plan before the Government with the view of allocating funds for the ART from the state budget and other alternative sources	Amber Green	Amber Green	3
Ensure early detection of HIV by promoting the VCT service in vulnerable populations Corresponding bottlenecks: IIIa-IIIc	Develop of a comprehensive Referral Mechanism to VCT	Green	Amber Green	1
	Build supportive oversight of the VCT service	Amber Green	Green	2
	Scale up VCT services in all sectors, including NGOs and the development of the mobile counselling concept	Amber Green	Amber Green	3
Systemic solutions		Green	Green	1

Action Plan for systemic solutions

Systemic bottlenecks will be tackled through wider and longer-term efforts undertaken jointly by all partners and the MOH in general, and shall draw on the results of ongoing health system reforms

(e.g., hospital reform master plan, primary health care reform, health financing, National Health Insurance Company strategy) and shall be tackled separately, including through planned programme reviews (The National TB Programme review is to be conducted by WHO in February 2013).

	Bottleneck category	Solution Description	Perceived needs	Costing (estimates, USD)	Potential/ proposed partners
Systemic intervention					
Corresponding to systemic solutions					
1.	Lack of government funding for national programme activities	<p>Create inter-ministerial working groups for identification of the financial resources specific for activities covered currently from GFATM</p> <p>Approve mechanisms of health services funding through main modalities:</p> <ul style="list-style-type: none"> ■ General service provision reimbursement scheme by NHIC from the health insurance funds ■ Funding by national programmes from the government budget for activities specific to the sector (special arrangements for medication procurement, rapid and other diagnostic tests procurement, etc) 	The solution activity can be achieved within the regular inter-ministerial collaboration methodology	No additional financial input required	MoH, MoF, MLSPF, NHIC, state chancellery

	Bottleneck category	Solution Description	Perceived needs	Costing (estimates, USD)	Potential/proposed partners
		Approve mechanism for procurement of other mixed or non-medical services (psycho-social support, social allowances and incentives, legal services, etc)	The solution activity can be achieved within the regular inter-ministerial collaboration methodology	No additional financial input required	MoH, MoF, MLSPF, NHIC, state chancellery
2.	Poor coordination and implication at central and local levels	<p>Build capacity of the CCM for a coordinated programming and monitoring</p> <ul style="list-style-type: none"> ▪ Revision of the CCM terms of reference ▪ Revision of technical working groups terms of reference ▪ Training for the CCM <p>Build capacity of local authorities to elaborate and implement local action plans on HIV and TB response according to the national programmes – main regional districts (Chisinau, Tiraspol, Balti, Cahul)</p>	<p>Coordination and meetings of stakeholders from the CCM</p> <p>Training materials and trainers – the trainings in the main districts</p>	<p>No additional financial input required</p> <p>10 000</p>	<p>All actors from the CCM</p> <p>LPA, CCM secretariat and experts</p>

	Bottleneck category	Solution Description	Perceived needs	Costing (estimates, USD)	Potential/proposed partners
3	Poor inter-sectorial coordination, particularly at LPA level for a coordinated medico-social individual support.	<ul style="list-style-type: none"> • Scale up the good practices with community centers (regional social support centers for HIV and community centers for TB) • Elaborate and approve the national regulation and quality standards for case management in HIV and TB • Normative changes to regulate the medico-social services • Capacity building/ trainings of multidisciplinary teams and case managers. 	<p>See solutions II</p> <p>Drafting working groups</p> <p>The activity shall be organized within regular trainings of MDT and national referral system</p>	<p>Costs from solution II.1.2.</p> <p>No financial inputs required</p> <p>No financial inputs required</p>	LPA, NRS, MoH, MLSPF, CCM

1E. ACTION PLAN FOR HIV

The action plan was developed after the interventions, bottlenecks and solutions were identified and prioritized, which could enable quicker progress towards MDG 6 in the short- and medium- terms. Firstly, the activities required for the implementation of solutions were identified. Then the roles

and responsible key partners who were involved were assessed. Lastly, an evaluation of the required capacity and identification of the corresponding budget was conducted. This activity was followed by the development of the monitoring and evaluation plan for the implementation of the Action Plan, to support the government's coordination efforts.

	Solutions category	Solution Description	Perceived needs	Costing (estimates, USD)	Potential/proposed partners
I. Scale up harm reduction programmes to focus on HIV prevention in key populations					
Corresponding solutions I.1. – I.4.					
1.	Expand the suite of integrated services based on the UNODC/WHO/UNAIDS recommendations, developing and implementing services for bridge populations	Ensure the access of IDU, broken down by age and gender specific needs, to comprehensive HIV prevention services, including in the prison system	There will be HIV prevention services embedded in the comprehensive package of IDU services, for about 60 per cent of estimated IDU population, including prevention of overdose, rehabilitation services, and appropriate supplies.	650 000	Republican Narcological Dispensary
		Scale up the opioid substitution therapy (OST)	IDUs will be covered with OST within the framework of harm reduction projects.	50 000	Soros Foundation Moldova
		Strengthen HIV prevention activities among MSM and their sexual partners. Design and implement specific prevention activities targeting MSM selling sex.	The outreach will cover 40 per cent of the estimated number of MSM through NGOs.	80 000	Soros Foundation Moldova

	Solutions category	Solution Description	Perceived needs	Costing (estimates, USD)	Potential/proposed partners
		Strengthen HIV prevention among FSW and their permanent sexual partners. Grant programme	The outreach will cover 60 per cent of the estimated number of FSW through NGOs	100 000	Soros Foundation Moldova
		<p>Ensure access to Hepatitis B Virus (HBV) immunization (IDU, MSM, FSW), provide testing and treatment for those co-infected</p> <p>The procurement of additional consumables will increase the attractiveness of prevention measures</p> <p>(syringes, condoms) for the beneficiaries. The demand for the services will increase.</p> <p>For the IDU, procurement of disinfectants, ointments, gauze, vitamins and other pharmaceutical products.</p> <p>For CSW, procurement of absorbents and female condoms</p>	In order to avoid getting co-infected with HBV, there will be vaccination with three doses of HBV vaccine for those eligible (not infected with HBV)	150 000	Ministry of Health

	Solutions category	Solution Description	Perceived needs	Costing (estimates, USD)	Potential/ proposed partners
		<p>For MSM, procurement of water-based lubricants and enhanced condoms.</p> <p>Carry out behavioural Change outreach activities, including counselling for sexual partners and customers of the key populations</p>	<p>Procurement of consumables</p> <p>packages and their monthly distribution, the amounts estimated for one year:</p> <p>for the IDU – 14 000,</p> <p>for the CSW – 2 000,</p> <p>for MSM – 1,000.</p> <p>Purchase of various consumables (phone cards, razors, personal hygiene items) to motivate people in risk groups, to increase the attractiveness and the enrollment in HR programmes</p> <p>Operational research needs to be conducted to identify best ways to cover such groups, and a Behavioural Change Plan</p>	<p>840, 000</p> <p>120 000</p> <p>60 000</p> <p>40 000</p> <p>60 000</p> <p>800 000</p>	

	Solutions category	Solution Description	Perceived needs	Costing (estimates, USD)	Potential/proposed partners
2.	Geographically extend harm reduction programmes to 5 more districts	<p>Scale up HIV prevention activities among IDUs</p> <p>Scale up HIV prevention activities among SW</p> <p>Scale up HIV prevention activities among MSM</p>	Beginning in 2013 the HIV prevention activities for IDUs, SW and MSM are to be scaled up to include up to 5 more districts (South and Transnistria, possibly the districts Basarabeasca, Ceadir-Lunga, Comrat, Riscani, Ribnita, Slobozia) through small grant programs	175 000	Soros Foundation Moldova
3.	Expand of alternative service delivery mechanisms, including through NGOs, with financial support from the National Health Insurance Company (NHIC)	Active involvement of the NHIC will support the implementation of current and planned Harm Reduction programs, including development of the mechanisms for contracting of NGOs, for front-line service delivery to key populations.	Dialogue between the MoH and the NHIC.	6 000	MOH / NHIC / UN
			Development of the mechanism of NGOs contracting by the NHIC for the delivery of health care services	4 000	

	Solutions category	Solution Description	Perceived needs	Costing (estimates, USD)	Potential/proposed partners
			Training of front-line service providers (NGOs implementing Harm Reduction projects)	20 000	
4.	Use risk reduction programmes to prevent sexual transmission of HIV from key populations to their sexual partners and their customers.	Activities and needs similar to the previous solutions for harm reduction services to (MARF)	Change in the regulation and standards of HR services Use the same centers and programmes as for the risk groups	To be assessed only for additional exchange materials	same

II. Strengthen the case-management system and ensuring a better adherence to ART treatment

Corresponding solutions II.1. – II.3.

1.	The 4 regional treatment centres (Chisinau, Balti, Cahul and Tiraspol) effectively use Data Management System SIME HIV.	The launch of the database will improve the quality of medical follow-up and monitoring of the people living with HIV. the retroactive entering of the ambulatory monitoring data will allow better forecasting the ARV medications needs, provision of health care and planning of laboratory investigations to determine the efficiency of the ARV treatment.	Making SIME-HIV operational in all administrative regions of the country	3 400	- National Health Management Centre, - The Republic-an AIDS and Dermato-Venereo-logy Centr
			Retroactive entering of epidemiological and clinical follow-up data since 2003 onwards,	11 000	
			Ongoing entering of epidemiological and clinical follow-up data for the new cases.	1 400	

	Solutions category	Solution Description	Perceived needs	Costing (estimates, USD)	Potential/ proposed partners
2.	Build capacity of Community Centres to effectively participate in referring to ART and improve ART adherence	<p>The use of Community Centres will ensure an entry point in the service delivery system, in addition to providing psycho-social support for the PLHIV, including treatment services. This will improve their treatment adherence and quality of life.</p> <p>Institutionalize the training and capacity building of health workers, non-health and social workers in the area of HIV case management</p>	<p>Strengthen referral mechanisms at regional level, with CC as one of the service delivery entry point</p> <p>Provide for the training of staff</p> <p>Training of staff working in residential facilities under the aegis of the MOLSPF and LPAs to provide the PLHIV and HIV affected people with services and fight stigma and discrimination; Building the capacity of multidisciplinary teams in providing case management support to the people infected with and affected by HIV through the NRS</p>	30 000	<p>City halls: Chişinău, Bălţi, Comrat, Tiraspol</p> <p>MOLSPF and LPAs</p>

	Solutions category	Solution Description	Perceived needs	Costing (estimates, USD)	Potential/ proposed partners
3.	Develop the short-term advocacy and action plan to help secure funding for ART from the state budget and identify alternative sources of funding	<p>The state's engagement in the planned and programmed financing for the coverage of the costs of ARV treatment for PLH</p> <p>A working group should meet regularly to support MoH in the dialogue with the Ministry of Finance (?)</p>	Development of MTEF financing plan for the allocation of financial resources from the state budget, targeting ART.	0	MoH and the Ministry of Finance

III. Ensure early detection of HIV infection by promoting voluntary counseling and testing (VCT) services among key populations and their partners

Corresponding solutions III.1. – III.3.

1.	Develop a comprehensive Referral Mechanism to VCT	The delivery of HIV prevention services through counseling can help improve awareness, prompt behavioural change and facilitate referral to other social services	Consultative Development of the Referral Mechanism	2 000	Medicine and Pharmacy State University / National AIDS and Dermatovenereology Center
			Consultations and capacity building of public and NGO service providers to ensure implementation of the Referral Mechanism	6 000	

	Solutions category	Solution Description	Perceived needs	Costing (estimates, USD)	Potential/proposed partners
2.	Capacity building and supportive supervision of the VCT service	<p>Strengthen quality assurance mechanism, including through patient-centred oversight of the quality of VCT sessions, and on-the-job training</p> <p>Use existent VCT counsellors as trainers and ensure the training schedule as continuous education</p>	<p>Elements of quality control exist but ought to be reviewed and institutionalized, with clear assessment form and feedback channels between the institution exercising oversight and central level, and public and NGO service providers at local level. Refresher training of counsellors and training of new counsellors ought to be provided upon need</p>	to be calculated	<p>Hospital of Dermato-venereology and Communicable Diseases</p> <p>International NGOs</p>
3.	Scale up VCT services through all available providers including NGOs and the development of the mobile counselling schemes	<p>Draft criteria for the accreditation of NGOs to deliver VCT services</p>	Develop and endorse criteria	500	NGO / NHIC
		<p>Training of NGO counsellors in pre- and post-test counselling</p>			<p>Hospital of Dermato-venereology and Communicable Diseases</p>
		<p>Provide NGOs with relevant VCT equipment</p> <p>Promote VCT among Most At Risk Populations</p>	<p>Planning and carrying out a training</p>	2 500	

Solutions category	Solution Description	Perceived needs	Costing (estimates, USD)	Potential/proposed partners
	The development of a mobile counselling scheme will help improve confidential access to non-medical facilities and will generate demand among key populations	Purchase of equipment	20 000	
		Carrying out VCT promotion activities among key populations	2 000	
		2 authors working in HIV control area will develop the concept.	1 000	
		Creation of 2 mobile teams, that will ensure the counselling among the key population	20 000	
		Purchase of 2 vehicles for VCT mobile teams	80 000	

1F. CONCLUSIONS FOR THE HIV SEGMENT

Despite efforts in HIV surveillance and control of HIV in recent years, there is still a high incidence of this infection in Moldova. At the end of 2011, a total of 7,125 people with HIV were recorded in Moldova, the prevalence of HIV amounting to 0.17%, with significantly higher prevalence in various marginalized groups. The incidence of this infection has remained at the same level in the past three years. So,

in 2009 the incidence of HIV was 17.12; in 2010 – 17.12, and in 2011 – 17.58.

In the context of the epidemiological situation and the annual incidence of HIV/AIDS in Moldova, there is a significant risk that the targets proposed under MDG 6 will not be attained by 2015. This is also confirmed by the results of several studies. According to the second generation epidemiological data among the population at high risk of infection (2009-2010), HIV prevalence in Chisinau, the country's capital amounts

to 16.4% among IDU, among CSW - 6.8%, MSM - 0.7%. These results confirm that the epidemiological situation concerning HIV in Moldova belongs to the category of epidemic concentrated in the population at high risk of infection (according to WHO classification).

Based on MAF methodology, 3 priority interventions for the surveillance and control of HIV/AIDS in Moldova are needed and have been identified to make faster progress towards MDG 6 targets.

These interventions were defined taking into consideration the current epidemiological situation in the country, the legal framework that is in force, namely the National Programme on Prevention and Control of HIV/AIDS and STI for 2011 to 2015. They were also based on the studies conducted on HIV/AIDS, the results of the qualitative research (focus groups with PLH, family physicians and in-depth interviews with the representatives of NGOs and LPA), round table discussions held on February 9-10, 2012, attended by all stakeholders - representatives of the National Public Health Centre, Republican Narcological Dispensary, National Centre for Health Management, Ministry of Justice, Ministry of Finance, Ministry of Labour and Social Protection, UNDP, UNAIDS, WHO and NGOs.

The interventions focused on the increased access to prevention, treatment, care and support services for the people at high risk of infection (IDU, MSM, CSW) and members of the PLH community were considered as more important. Each of these interventions will help accelerate

the progress towards achieving the MDG 6 targets and subsequently improve the epidemiological and human rights situation in the country.

Intervention II "Strengthen the case-management system and ensuring a better adherence to ARV treatment" will increase the adherence to treatment of PLH and will help improve their quality of life, as well as will reduce the risk of HIV transmission to other people, since the ARV treatment is also considered a method of HIV prevention.

Intervention III "Ensure the early detection of HIV by promoting the VCT service in key populations at risk" will help ensure the early detection of infected persons, particularly those at high risk of infection and ultimately the early enrollment in ARV treatment.

A common need for all interventions is improving the coordination of various activities and different sectors, which will also lead to improving the case management in HIV and a continuity of care provided to people living with HIV.

For each intervention, lists of bottlenecks and solutions were developed and later based on the MAF methodology to identify the most important solutions for an efficient and quick implementation of the interventions. Most bottlenecks that were identified are related to budget and funding, as well as accessibility and acceptability of existing services, especially among marginalized groups most at risk. As a result, a plan of action at the country level was developed, the implementation of which will

allow acceleration towards achieving the MDG 6 targets. This plan of action does not intend to replace the existing strategies and action plans, but it comes as their continuation and completion.

Achieving the MDG 6 targets by 2015 is possible if the proposed action plan is supported and implemented through a strong political commitment and adequate funding. Implementation of the monitoring and evaluation is also important to allow for an up-to-date assessment of the progress

The following lessons have been learned as a result of this exercise:

Active participation of all relevant stakeholders, including ministries, civil society institutions and development partners is critical for the effective response to HIV epidemic.

A constructive partnership between all relevant stakeholders, with clear distribution of roles and responsibilities, particularly between government and non-government organizations is necessary for implementation.

To implement the action plan, additional funds should be committed from stakeholders already involved in HIV response, while streamlining the current expenditure patterns.

At the same time there are solutions with high impact at low cost.

The technical and financial assistance provided by international organizations (UNAIDS, WHO etc.) as well as new partners in this area (such as Soros Foundation and EU) is essential for the successful implementation of the national programme.



CHAPTER 3.

**MAF: ACCELERATING
PROGRESS IN COMBATING
TB**

2A. EPIDEMIC SITUATION AND OVERVIEW ON MDG PROGRESS

MDG 6 TARGET 3. Halt and begin to reverse the spread of tuberculosis by 2015. Reduce the rate of mortality associated with tuberculosis from 15.9 (per 100,000 population) in 2002 down to 15.0 in 2010 and 10.0 in 2015.

Tuberculosis remains a significant public health problem of great concern in Moldova. Controlling TB is a priority for the Moldovan government.

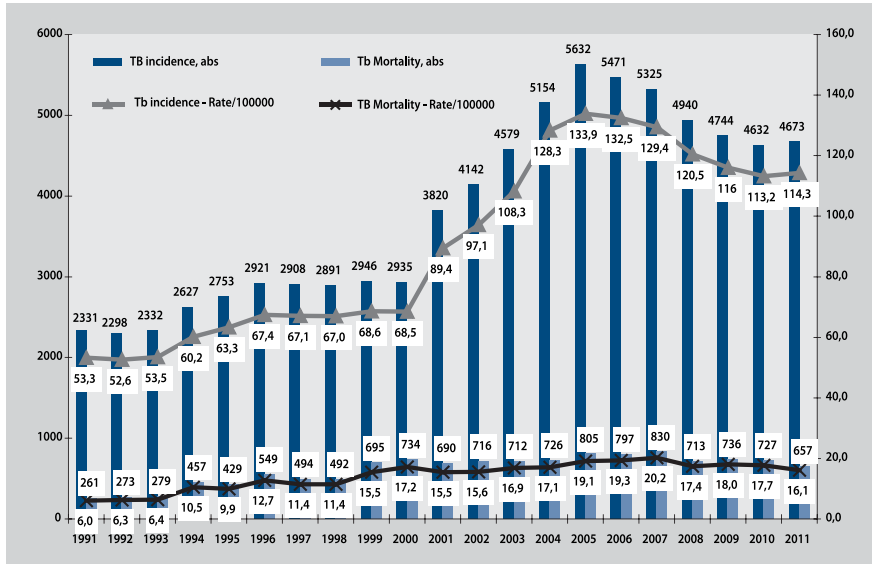
As with targets on HIV, the slow progress made in lowering the mortality rates associated with tuberculosis was a key reason for revising the MDG targets for 2010 and 2015. However, unlike the HIV incidence, mortality from tuberculosis fell in 2008 for the first time in the last decade. In 2008 it

was 17.4 cases per 100,000 population and in 2011 it was 16.1, compared to 20.2 cases in 2007 and 19.3 cases in 2006. But the progress achieved is less than steady. The national target to reduce the rate of mortality associated with tuberculosis from 15.9 per 100,000 people in 2002 down to 10 by 2015 is not likely to be met without major efforts in the remaining period.

Overall, TB incidence has increased over the past decade, from 97.3 (per 100,000 people) in 2002 to 114.3 in 2011. The number of new cases recorded in 2011 was 3,833 or 93.8 per 100,000 people. The number of new cases from 2011 showed a slight increase of 2.3% from the previous year, but also 7.9% reduction compared to 2007. The number of recorded relapses was 839 in 2011 or 20.5 to 100,000 people, down by only 8% compared to 2010.

Figure 4.

TB Incidence and TB Mortality, Republic of Moldova, 1991-2011.



Source: <http://monitoring.mednet.md:8090/db/tb>

The rate of new cases of pulmonary tuberculosis was 83.4 per 100,000 people for 2011, an increase of 2.2% compared to 2010. It is of concern that out of the total number of new pulmonary cases recorded for 2011 about 38% were destructive TB (a severe form of the disease), and 3.4% were sputum positive TB, which is considered the most contagious form of tuberculosis and may imply a late diagnosis of tuberculosis.

The most affected age groups: In 2011, predominantly people aged between 35 and 54 in their the most productive period of life were affected. The most affected age group among adults is 25-34 year olds, and 5-14 year olds among children. In 2011, there were 225 new cases in children, or 26.4 per 100,000 people. Data analysis noted an increase of 11.1 % compared to 2010, but also a decrease by 18.2% compared to 2007. About two-thirds of new cases of tuberculosis recorded in 2011 were in children from rural areas, In conclusion, children from rural areas were twice as likely to contract tuberculosis.

At the same time the number of newly diagnosed cases rose among immigrants in recent years, most of whom, due to frequent changes of address, do not undergo tuberculosis treatment. Owing to the low adherence to treatment and the high mobility of people, some of whom do not hold mandatory health insurance policies, the in-

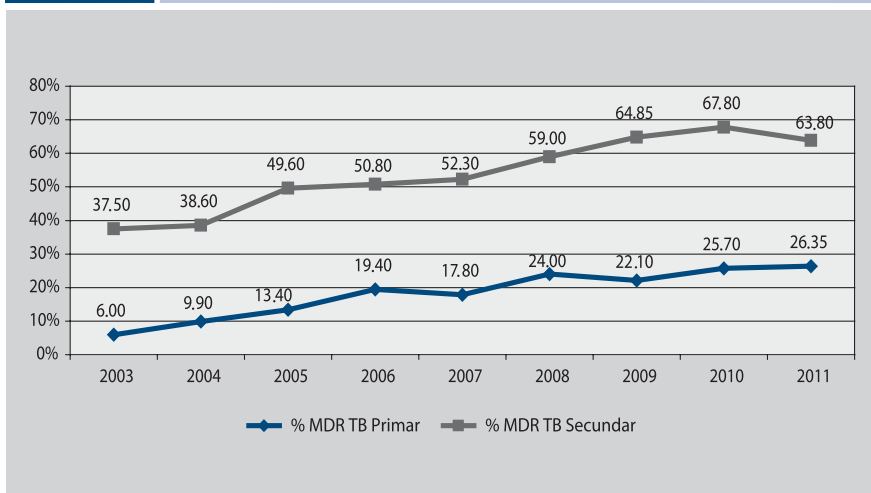
cidence of multi-drug resistant tuberculosis is rising among this population group.

An alarming fact is that in 2011 the number of people with tuberculosis increased among people infected with HIV. Out of 4,631 TB patients with new and/or relapsed cases in 2011, 254 or 5.1% also had HIV.

Treatment success and TB resistance

In 2011, treatment results among patients with tuberculosis did not demonstrate make any significant progress. Only 57.3% of patients diagnosed for the first time with pulmonary tuberculosis with positive sputum in the previous year successfully completed the treatment. Therefore, the success rate was a deviation of (-20,7%) compared to the expected result of the National Programme for Tuberculosis Control (NPTC) for 2011-2015 (78%). This indicator was also influenced by the high rate of default--in 2010, 12.0% of TB patients abandoned the treatment.

Also, the success rate is also influenced by the increasing number of tuberculosis forms resistant to treatment. The Multi Drug Resistant (MDR) TB rate among new cases with positive smear in 2011 was 26.3% (which is double the average in the European Region). Out of these, only 63.8% reached re-treatment

Figure 5.**MDR TB, new cases and retreatment, Republic of Moldova 2003- 2011.**

Source: <http://monitoring.mednet.md:8090/db/tb>

The assessment of DOTS Plus treatment outcome in the patients enrolled in the treatment in 2008 was as follows: successful treatment among patients with MDR TB was achieved only in 48.7% cases; 26.1% of patients receiving DOTS Plus treatment abandoned it, 9.7% died, and 15.3 % failed the treatment. Therefore, the success rate represented a deviation of - 11.3% compared to the expected outcome of the NPTBC 2011-2015.

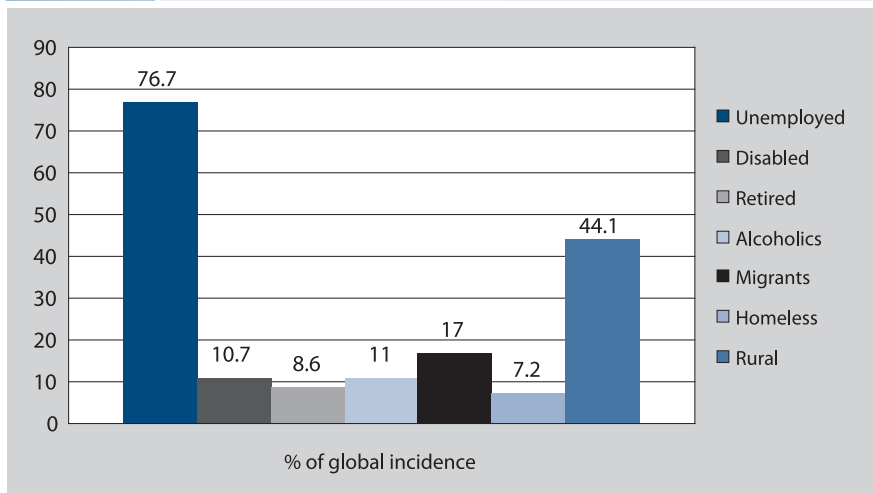
The success of the TB treatment depends on several clinical, economic factors, but also on the issues related to the providers of services such as patient management, quality and continuity of treatment, patients' knowledge about tuberculosis and treatment.

Social context

TB infection in Moldova is strongly linked to social factors. An expansion of the tuberculosis infection pool is currently observed primarily among risk groups, especially in socially vulnerable people. Along with former prisoners, which are "traditional" risk group, the number of alcohol abusers, unskilled hard workers, the number of persons of other socially vulnerable categories has increased considerably in recent years. These include the unemployed, the homeless, migrants, refugees, drug addicts and people living below the average living standard.

The social structure of TB patients is as follows: unemployed (76.7%), rural people living below the poverty line - 44, 1%, migrants (17%), people abusing alcohol (11%) and people with disabilities (10.7%).

Figure 6. Status of TB patients, 2010.



Source: <http://monitoring.mednet.md:8090/db/tb>

Studies show that the patient's economic situation influences the success of the treatment, as the loss of a job or security can negatively influence the patients' adherence to treatment. There is a major risk of patients abandoning treatment, estimated at $\approx 20\%$ for respondents with a low monthly income, representing, on average, half of the respondents ($\approx 51\%$). Every second respondent ($\approx 47\%$) lost their job or some additional income because they contracted tuberculosis. For this category of respondents a major risk of non-adherence was estimated of up to 20%.

The poor coordination between medical and social and other support services is also reported as a big concern determining an adequate response and stimulation of the persons to stick to the treatment. This is valid at a local community level, but also

at the regional and national levels. There are no specific regulations to recognize and support vulnerable people affected by TB who need to enter treatment but may lose income because of it.

Poor conditions in hospitals and intra-hospital transmission of the infection also poses challenges for people to adhere to the prescribed treatment inpatient conditions, as there are limited options for outpatient alternatives, and a general lack of patient-centred approach.

The National Programme on Tuberculosis Control for 2011-2015

The National Tuberculosis Control Programme for 2011-2015 was developed in accordance with the special TB legislation, the National Development Strategy for 2008-2011, the National Health Policy and WHO

standards in TB control. The purpose of the National Tuberculosis Control Programme for 2011-2015 is to improve the health of the population by reducing the burden of tuberculosis in Moldova, in accordance with the MDGs and objectives of the "Stop TB" Partnership.

The Programme sets the following main objectives:

- ensure qualitative diagnosis and achieve the detection rate of over 70% for cases of pulmonary tuberculosis with positive sputum smear by 2015 ;
- achieve and thereafter sustain the universal access to treatment of all forms of tuberculosis and to reach by 2015, a treatment success rate of 78% for new cases of pulmonary tuberculosis with positive sputum smear and a treatment success rate of not less than 60% for multi-drug-resistant tuberculosis cases;
- ensure the social support for at least 90% of TB patients from socially vulnerable categories by 2015;
- ensure by 2015, the efficient control of TB/HIV co-infection and to reduce the rate of TB/HIV co-infection below 3% among TB patients;
- increase the level of population knowledge about tuberculosis up to at least 80% and maintaining BCG vaccination rate at birth of at least 98% by 2015;
- develop and apply scientific and operational research results in the domain of tuberculosis control, implementation of at least 7 investigations by 2014;
- consolidate by 2015 of an effective system of management, coordination, mo-

onitoring and evaluation of the Programme.

As in the HIV sector the great majority of the national plan is covered financially by the resources from the GFATM. The 11th round was replaced by the Transitional Funding Mechanism and Moldova was not eligible. This planned significant reduction of the resources poses a great challenge that could hinder the proper diagnostics and treatment measures for the next two years. The estimated deficit for the Programme is around 35% and at the current moment the estimation for the coverage deficit for diagnostics and treatment for 2015 is more than 95% and 80% respectively.

During the elaboration of the new National Programme, some issues and recommendations from the assessment of the previous plan were considered. The assessment of the previous plan was performed with the support of WHO office in Moldova.¹⁵

A number of studies that provide comprehensive analyses of the TB situation in Moldova are available, such as:

- Assessment of risk factors associated with adherence to treatment of patients with multi-drug resistant tuberculosis (MDR TB) enrolled in the DOTS Plus treatment.
- Risk factors associated with the abandonment and failure of the strictly supervised treatment of tuberculosis in the Republic of Moldova
- A qualitative study for the assessment of DOTS implementation with medical workers

¹⁵ <http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=344005>.

- Tuberculosis in Moldova: Knowledge, Attitude and Practice in Population Behaviour.
- Tuberculosis: Knowledge, Attitudes and Practices.
- The report „Anti-tuberculosis drug resistance surveillance. Republic of Moldova – 2006. National Study“.
- Assessment of infection control interventions in drug resistant tuberculosis in Moldova (Report of the Mission for Infection Control in Tuberculosis, Moldova, November 22 – 28, 2009).

2B. PRIORITY INTERVENTIONS

During the MAF exercise experts reviewed and analyzed all the existing data and current literature on tuberculosis control in the country, including a review of the legal and regulatory framework. This stage was also supplemented by focus group discussions: I focus group – with the TB patients, II - with phthisiopulmonologists responsible for specific TB treatment and the III - with family doctors. Also, at this stage in-depth interviews were conducted with representatives of NGOs working on TB and representatives of local governments. This stage helped to obtain a qualitative overview of the problems in controlling tuberculosis in the country from different perspectives and different experiences. As a next step the national consultation with key stakeholders was held at the round table on February 9 - 10, 2012. This step allowed for the necessary interventions to be prioritized and bottlenecks and possible solutions to be identified.

Having reviewed the current epidemiological situation with regard to tuberculosis in the Republic of Moldova, the stakeholders identified a number of interventions from existing plans and programmes that can potentially lead to reaching MDG 6 goal quicker. These include, increasing the access of socially vulnerable groups to TB services; reducing stigma and discrimination, strengthening partnerships with local public authorities (LPA) in controlling TB, strengthening laboratory diagnosis; building the capacity for achieving effective control of TB/HIV co-infection, strengthening the infection control in specialized facilities; increasing the adherence to anti-tuberculosis treatment of persons who have active TB.

All identified interventions were analyzed and prioritized in terms of impact and feasibility that would allow MDG 6 to be reached sooner. They were based on the following criteria: contribution of the intervention to the overall outcome, impact on direct and indirect beneficiaries (affected populations) and the speed of impact. Also, the feasibility of these interventions was assessed by the criteria of governance, capacity, and availability of financing, as well as other factors.

The interventions were prioritized based on the evidence gathered from the strategies of the National Tuberculosis Control Programme, the current epidemiological situation, the results of recent TB studies, the results of focus groups and in-depth interviews with representatives of NGOs, working in the field and LPA representa-

tives. This followed the round table discussions of February 9-10 which were attended by representatives of the specialized TB hospitals, the Pneumophthisiology Department of the Medical University, National Health Management Center, the Ministry of Health, the Ministry of Justice, the Ministry of Labour, Social Protection and Family, NGOs and other relevant partners

Following these assessments, three priority interventions were identified: 1) Increase the access of persons in the socially vulnerable groups to TB services; 2) increase adherence to TB treatment of people with active TB and 3) strengthen infection control in TB specialized facilities. The rationale for these interventions is explained below.

I. INCREASE ACCESS OF THE SOCIALLY VULNERABLE GROUPS TO TB SERVICES

All available data confirm that the majority of TB infection occurs among the vulnerable groups. Due to this epidemiological situation, one of the most important lines of action within the National TB Control Programme for 2011-2015 is the active detection of tuberculosis particularly among the affected populations. These are homeless people, people in isolated communities, people which have a low social-economic level, homeless children and youth, migrants, prisoners and former detainees. This will help ensure the quality of the diagnosis, and improve the rate of detection of cases of pulmonary tuberculosis with positive sputum by more than 70% by 2015, as well as support patients in vulnerable groups for further treatment.

Currently, an expansion in those who have been infected is observed primarily among socially vulnerable patients. Along with people from other risk groups, such as former prisoners, people abusing alcohol, people engaged in unskilled manual labour, the number of people in other categories has increased significantly. These include unemployed people, the homeless, migrants, refugees, drug addicts, people living below the poverty line. Among these groups destructive forms (which are an advanced form of lung TB) which are resistant to anti-tuberculosis medications, including MDR TB have been detected.

One of the main reasons for the low rate of success in treatment is the late detection of TB cases, as the share of destructive forms and other complication amount to 38% of new cases of pulmonary tuberculosis registered in 2011.

The analysis of the current data in TB data management system reveals that one of the reasons for late detection is the unsatisfactory work performed with groups at high risk of TB. In this way, the share of destructive forms among these people has increased compared to the average value of this indicator in the country. This index is particularly serious among people who are abusing alcohol (59.4%), those without permanent residence (57.8%), the disabled (51.8%), migrants (48.6%) and other risk groups.

This idea is confirmed by the very low percentage of actively detected cases (by prophylactic control) in different risk groups of tuberculosis. Of all TB patients or at risk groups registered in 2010, only 23.3% were diagnosed by prophylactic control. Among

patients with post-tuberculosis consequences the share of actively detected cases is only at 8.9%.

II. INCREASE ADHERENCE TO TB TREATMENT OF PERSONS WITH ACTIVE TB

The prioritization of this intervention was further justified by the objectives of the Action Plan on implementing the National Tuberculosis Control Programme for 2011-2015: to develop and preserve the universal access to effective treatment of all forms of tuberculosis by 2015 and to achieve a success rate of treatment of new cases of pulmonary tuberculosis with positive sputum by at least 78%. Other objectives of this programme include a treatment success rate of a multidrug-resistant tuberculosis which is at least 100% by 2015 and providing social support for at least 90% of tuberculosis patients in the socially-vulnerable category. Treatment results among patients with tuberculosis did not record any great progress in 2011. Only 57.3% of patients diagnosed with pulmonary tuberculosis with positive sputum for the first time successfully completed the treatment. Therefore, the success rate was a deviation of (-20.7%) compared to the expected result of NPTBC 2011-2015. This indicator was also influenced by the level of treatment abandonment, or default rate, which remains high and amounted to 12.0% in 2010. The success rate is also influenced by the increasing number of cases of resistant tuberculosis. Some 276 persons or 23.2% of the 1,188 new cases of tuberculosis in 2011 were multi-drug resistant tuberculosis.

One of the most urgent and persistent problems of tuberculosis control is the patients' failure to comply with the treatment, something which is expressed by the irregular taking of anti-tuberculosis medications or giving up treatment.

The default rate among socially vulnerable populations is the following: for homeless people - 14.5%, people abusing alcohol - 13.4%, migrants - 10.1%, followed by ex-prisoners - 9.2% and the unemployed - 8.8%.

The assessment of DOTS Plus treatment outcomes in the patients enrolled in the treatment in 2008 was as follows: successful treatment among patients with MDR TB was achieved only in 48.7% cases and 26.1% of patients receiving DOTS Plus treatment abandoned it, 9.7% died, and 15.3 % failed the treatment. Therefore, the success rate represented a deviation of - 11.3% compared to the expected outcome of the NPTBC 2011-2015.

The success of the TB treatment depends on several clinical, social and economic factors, but also on the issues related to the providers of services such as patient management, quality and continuity of treatment, patients' knowledge about tuberculosis and treatment.

III. STRENGTHEN THE TB INFECTION CONTROL IN SPECIALIZED FACILITIES

Ensuring infection control in health care facilities is one of the directions provided for in the national TB control programme for 2011-2015. This would allow for universal access to effective treatment of all forms

of tuberculosis to be achieved and maintained. If this was achieved, there would be a success rate of 78 % of treatment of new cases of pulmonary tuberculosis with positive sputum and a success rate of the treatment of multi-drug resistant tuberculosis of at least 60% by 2015. In its Stop TB Strategy and its recent tuberculosis control policies, the World Health Organization (WHO) clearly underlines the importance of implementing effective infection control measures in specialized hospitals and clinics.

The recent identification of multidrug-resistant (MDR-TB) and extensive drug resistant TB (XDR-TB) in the context of HIV pandemic has focused attention and concern about infection control and general safety in the specialized TB facilities, both in terms of the

safety of patients and of health workers. One of infection control compliance indicators for the hospitals is the number of the health care staff infected with tuberculosis, which according to 2010 institutional statistics for 2010 was eight people.

Given the design and the extensive use of the existing medical infrastructure in hospitals and the lack of attention on infection control from managers and health staff, there is a high risk of intra-hospital transmission of TB in specialized facilities. The survey conducted in Moldova confirmed the nosocomial transmission of MDR TB and XDR TB in specialized facilities¹⁶. This problem must be addressed promptly by the health system and health workers.

TB INTERVENTIONS SCORECARD

Interventions	Impact	Feasibility	Ranking
I. Increase adherence to TB treatment of persons with active TB	Green	Amber green	1
II. Increase the access of the socially vulnerable groups (migrants, people from asylums, homeless people, drug users, people abusing of alcohol, prisoners and persons released from prisons, street children and youth, etc.) to TB services	Green	Amber green	2
III. Strengthen the TB infection control in specialized facilities	Green	Amber green	3

¹⁶ Poor infection control increase risk of reinfection with MDR or XDR-TB strains. Valeriu Crudu, Sabine Ruch-Gerdes, Stefan Niemann, Nicolae Moraru, Larisa Carchilan, Victor Lesan, Galina Blagodeteleva, Ecaterina Stratan.

Several sub-interventions were identified for each intervention. For intervention II **Increase the access of persons in the socially vulnerable groups to TB services** these sub-interventions included:

- active detection of tuberculosis,
- increasing advocacy and education activities aimed at prevention of social diseases and promoting healthy lifestyles,
- improving adherence to treatment (transport provision, providing incentives for treatment, outreach workers remuneration for performing DOT,
- providing accommodation during the continuation treatment stage, providing psychological and legal support,
- strengthening partnership with local governments in TB control,
- reviewing alternative ways of DOT for patients in vulnerable groups);
- identifying the people who have abandoned treatment and re-enrolling them;
- providing incentives for increased engagement of local NGOs for TB control by implementing small grant programmes and trainings;
- supporting continuous treatment among patients in detentions and those released from prisons.

For intervention I **Increase the adherence to anti-tuberculosis treatment of the people with active TB** the following sub-interventions were identified:

- ensuring the uninterrupted supply of anti-tuberculosis or drugs;

- strengthening the capacity of the human resources involved in TB control;
- developing and implementing incentive mechanisms for the staff involved in TB control activities;
- providing support aimed at increasing compliance with the treatment (education and information materials for TB patients;
- providing incentives for adherence to treatment: hygiene and food packages for the patients; reimbursing travel costs; additional expenditure for the patients;
- involving social services to support adherence to treatment (employment support, housing, provision of clothes etc. for the poor),
- strengthening partnership with LG in TB control;
- managing side effects, including improving access to the treatment of side effects;
- identifying some alternatives to the current treatment protocols, through behaviour research aimed at increasing adherence to treatment, encouraging and supporting research for the development and validation of forecast instruments aimed at identifying the patient related, social and cultural factors related to low adherence to treatment, especially for drug-resistant TB;
- reducing stigma and discrimination.

The following sub-interventions were identified for the intervention III **Strengthen TB infection control in specialized facilities**:

- strengthening infection control at the administrative level in specialized facilities;
- strengthening infection control at the engineering level in specialized facilities;
- strengthening infection control, including personnel protection level in specialized facilities.

2C. PRIORITY BOTTLENECKS

Following the identification of priority interventions and sub-interventions required for the acceleration of progress towards MDG 6, bottlenecks to these interventions have been identified. For each sub-intervention, sector-specific bottlenecks were identified, that affect directly the sector performance and which can be approached by a minister, as well as the cross-cutting bottlenecks, which affect several sectors and require an integrated response between ministries/agencies. The sector specific bottlenecks belong to one of the four categories: policy and planning; budget and funding; service delivery and service use (demand).

The bottlenecks have been identified based on the evidence of recent studies of tuberculosis in the Republic of Moldova, focus groups with TB patients, phtisio-pneumologists and family doctors, in-depth interviews with the representatives of NGOs and LPA, opinions of tuberculosis experts, and round-table discussions held on February 9-10, 2012.

Profiles for each bottleneck have been developed, including the direct and cross-

cutting impact of overcoming the bottleneck (the number of people who would reach the MDG 6 target, the affected population, as well as the availability of potential solutions). As a result, profiles for each bottleneck have been developed, assessing the impact of removing/reducing the bottleneck. A number of bottlenecks for each sub-intervention have also been identified.

Selective profiles for the prioritized bottlenecks are presented below:

For Intervention I, the below key prioritized bottlenecks have been analyzed:

1a. The multidisciplinary team working in the regions has insufficient training for providing high quality services

Although the multidisciplinary approach which will create teams at a community level has been introduced in Moldova, the capacity of these teams remains low and their coverage is insufficient

The efficiency of the multidisciplinary teams at a community level for early detection has been proven, ensuring adequate adherence to treatment and control measures in TB. Good experiences exist in the region, in Russia and Baltic States. While the impact from removing this bottleneck is significant, the implementation does not require major inputs and expenses. The direct impact will be primarily for the patients with active TB and members of their family but also the cross-cutting impact will be an increased responsibility for timely detection and treatment of TB such as a decreased rate of TB transmission in soci-

ety, particularly among family members of people who are infected with TB.

Ib. Improper incentive scheme for medical staff involved in TB control activities

Studies show that adequate incentives for medical staff at a primary level influence the quality of TB control measures. Focus group discussions and recent surveys determined that the remuneration of family physicians for newly detected cases in 2007 was perceived as more effective compared to the payment for successfully completed treatment (bonus for performance indicator) applied in 2012. Addressing this bottleneck may result in a significant improvement in the TB detection rate, and may positively influence the adherence to treatment. The increased adherence to treatment of TB patients will also decrease TB and MDR incidence.

The current incentive scheme is also cumbersome: in order to receive the bonus for successful completion of treatment (bonus for performance indicator), medics are confronted by bureaucracy involving the assessment of shared responsibilities and remuneration of family doctors and pulmonologists in the process.

Ic. Lack of measures aimed at strengthening the partnership with Local Public Authorities (on TB and HIV control)

As in the case with HIV, the TB control measures require multi-stakeholder involvement at a community level. Available data in Moldova reveal problems in coopera-

tion and partnership with local authorities to provide a coordinated local TB response. This is also significant for prioritizing the TB problem for the local governments responsible for specific TB and HIV service providers (TB hospitals, phthysiopneumologists and infection disease specialists at primary care level, etc).

The strengthened partnership with the LPA on TB control will result in better acceptance of and support to the person with TB by the community, thus increasing the adherence to treatment and decreasing the incidence of TB and MDR TB. A more efficient cooperation between different stakeholders to prevent and control TB is also expected from medical staff.¹⁷

As this is a systemic issue and is also valid and problematic for the prevention of other diseases such as HIV, the removal of this barrier will have an important impact on the community and regional level on people affected or at risk of TB, HIV and other diseases which have a social impact.

For Intervention II, the following key prioritized bottlenecks have been analyzed:

Ila. Lack of screening for TB in placement centres and other places where socially vulnerable persons gather.

In Moldova, there are permanent social care institutions and temporary social care centres (social centres) that provide services for vulnerable people like homeless, people with disabilities, triage centres for minor delinquents, etc. Currently, there is no adequate TB screening for the beneficiaries of these centres. Removal of this

¹⁷ Focus group with family physicians, 2012.

bottleneck is relatively simple, cost effective and feasible, and the impact on the target population is significant.

Intensive TB detection among the most vulnerable groups, in places where they usually congregate, has proven to be a practical and efficient solution so far¹⁸. The number of people who would reach the MDG target when this bottleneck is removed is high- 30% of Moldova's population who are in the socially vulnerable category. The cross-cutting impact will be an increased rate of TB detection and subsequent decrease in the incidence of TB incidence and the number of infection sources among the vulnerable group and decrease in the number of contamination cases. There is a short-term solution available by training the staff of front line service providers in the places where the vulnerable groups are concentrated.

IIb. Limited responsibility of the primary health facilities in TB control in the regions.

An important task in early detection of TB is attributed to the primary health sector which according to the available data lacks the capacity and accountability for detecting and following up on TB cases. Appointing a medical professional such as a doctor or a specialized nurse who is responsible for coordinating TB related-care at the primary healthcare level, especially in those areas with a high concentration of TB could be a simple yet effective solution. Addressing this bottleneck will lead to an improved rate of TB detection in target communities and at regional levels. The

lack of a person in charge of tuberculosis in primary healthcare, diminishes the responsibility of the primary health care and public health authorities in the regions and undermines the importance of TB activities. Indicators to measure a primary health care's involvement in TB detection are poorly developed. The family doctors acknowledge they dedicate little time to this disease as they are overloaded with various activities and categories of patients¹⁹.

A reasonable solution to the bottleneck is to appoint a specific person in charge of TB who will conduct and report activities related to TB screening of the socially vulnerable groups. This short term solution does not require significant investments.

IIc. Insufficient information on the available services leads to a low demand.

The limited access of the socio-vulnerable people to health and social services result in late TB detection. Low awareness about the risks of infection and safe behaviour and a lack of information on available free medical services for TB has proven to result in a low demand for medical services, low detection and treatment success for TB. This was identified as an important bottleneck for increasing the detection rate for vulnerable groups. While the profile of people at risk makes the task quite difficult, provision of the relevant information by involving NGOs and other front line agents working with vulnerable populations, using accessible language, could result in the removal of this barrier. The regional good practice should also to be used in the so-

¹⁸ (C. Didelescu. *Intensive TB detection among institutionalized people. REVISTA MEDICALA ROMANA – VOL. LV, NR. 1, AN 2008*).

¹⁹ *Focus group – Family physicians, 2012.*

lution of this bottleneck. Information campaigns for beneficiaries in an accessible language and interventions into groups at risk are also envisaged as a short-term solution for this bottleneck.

For Intervention III, the below key prioritized bottlenecks have been analyzed:

IIIa. The treatment lacks outpatient alternatives and a patient-centered approach

Several reports conducted by international experts recommend taking steps to address the problem of intra-hospital transmission of M/XDR TB. The first problem in this regard is the lack of out-patient alternative for treatment, and the poor conditions in hospitals. Around 5,000 people receive hospital care per year in specialized TB institutions.²⁰

Removing this bottleneck will have an impact on the intra-hospital spread and the quality of services provided. It will also raise the attractiveness and acceptance of the treatment. A proposed solution is through optimization of the hospital care through patient centered approach with emphasis on outpatient treatment and community involvement. This will help, decrease in treatment abandonment rates in early stages, and will help improve the overall treatment outcomes.

IIIb. Lack of modern infrastructure in TB specialized clinics

The lack of up-to-date technical means to prevent the transmission of TB inside medical institutions and also the proper maintenance of these means is repeatedly reported as one of the most important causes of intra-hospital transmission. Adequate ventilation in health-care facilities is essential for preventing transmission of airborne infections, and is strongly recommended for controlling the spread of TB. Priority should be given to achieving adequate ACH using ventilation systems. However, in some settings it is not possible to achieve adequate ventilation. In such cases, a complementary option is to use upper room or shielded ultraviolet germicidal irradiation (UVGI) devices. This environmental control does not provide fresh air or directional airflow (WHO policy on TB infection control in health-care facilities, congregate settings and households, WHO, 2009)

Addressing this bottleneck will ensure adequate safeguarding to all patients who receive in-patient treatment and also to the medical staff from these institutions. A solution would be to assess the situation in each region and meeting of minimum needs, including by making necessary amendments to the budget.

²⁰ National Health Insurance Data.

IIIc. Staff trained insufficiently on respiratory protection

Although training on the protection measures for the medical staff is done continuously, it usually involves only senior medical specialists such as doctors, and not nurses and technical staff. The training should be extended to routinely include all staff of medical specialized TB institutions. The impact will include both all the patients in the specialized inpatient institu-

tions but also all staff of these institutions. The removal of the bottleneck is easy to achieve and is therefore prioritized.

The cross-cutting impact will be a decreased number of contacts and nosocomial transmission of TB, including of the drug-resistant TB; a decreased number of therapeutic failure because of nosocomial MDR TB; an increased rate of success and an increased number of hospitalizations in TB treatment facilities.

Bottlenecks' scorecard							
Intervention	Subintervention	Bottleneck	Direct impact	Cross-cutting impact	General impact	Availability of short-term solution	Ranking
Ensure adherence to anti-tuberculosis treatment of people with active TB	Ensure uninterrupted supply of anti-tuberculosis medicines	Lack of state guaranteed funding, resulting in the risk of interruption in the supply of medicines and increase in number of untreated cases	4,802 (4,344 adults +458 children)	All population, particularly children and work-aged persons (and vulnerable groups)	Green	Amber green	1
	Build the capacity of the human resources involved in TB control	The multidisciplinary teams working in the regions is trained insufficiently/are not coordinated for provision of high quality services	4,802 (4,344 adults +458 children)	All population, particularly children and work-aged persons	Green	Green	1

Bottlenecks' scorecard							
Intervention	Subintervention	Bottleneck	Direct impact	Cross-cutting impact	General impact	Availability of short-term solution	Ranking
Ensure adherence to anti-tuberculosis treatment of people with active TB	Build the capacity of the human resources involved in TB control	Insufficient human resources involved in TB control to meet the current needs and shortage of professionals in the regions	4,802 (4,344 +458 children)	All population, particularly children and work-aged persons	Green	Amber green	2
	Develop and implement incentive mechanisms for the staff involved in TB control activities	The financial rewards/ resources are too dispersed among team members, resulting in insufficient incentives	4,802 (4,344 +458 children)	All population, particularly children and work-aged persons	Green	Green	1
		Lack of certain incentive mechanisms for the staff involved in TB control activities	4,802 (4,344 +458 children)	All population, particularly children and work-aged persons	Green	Amber green	2
	Ensure support for treatment compliance, strengthening the partnership with LPAs in TB control	Insufficient capacity and resources to cover all patients and ensure adherence to treatment.	4,802 (4,344 +458 children)	All population, particularly children and work-aged persons	Green	Amber red	3
		Insufficient information for patients and their family members on transmission channels and behaviour.	4,802 (4,344 +458 children)	All population, particularly children and work-aged persons	Amber green	Green	1

Bottlenecks' scorecard							
Intervention	Subintervention	Bottleneck	Direct impact	Cross-cutting impact	General impact	Availability of short-term solution	Ranking
		Lack of measures aimed at strengthening the partnership with LPAs on TB control	4,802 (4,344 +458 children)	All population, particularly children and work-aged persons	Green	Amber green	2
Ensure adherence to anti-tuberculosis treatment of people with active TB	Side effects' management, access to treatment of side effects	The health care providers are insufficiently trained on side effects' management and "low" awareness of service users in recognition and declaring of side effects	4,802 (4,344 +458 children)	All population, particularly children and work-aged persons	Green	Green	1
	Identify of alternatives to current treatment protocols through behavioral research to increase adherence to treatment, and encourage and support of studies for development and validation of predicting tools to identify patient-related and development of drug-resistant TB	Lack of funding for development of protocols and studies on behaviour research	4,802 (4,344 +458 children)	All population, particularly children and work-aged persons	Green	Amber red	1

Bottlenecks' scorecard							
Intervention	Subintervention	Bottleneck	Direct impact	Cross-cutting impact	General impact	Availability of short-term solution	Ranking
	Reduce of stigma and discrimination	A low awareness of society about TB, which is currently considered a "condemnation"	4,802 (4,344 +458 children)	All population, particularly children and work-aged persons	Green	Green	1
		Lack of psychological, social and other support for patients with active TB undergoing treatment	4,802 (4,344 +458 children)	All population, particularly children and work-aged persons	Green	Amber green	2
Increase the access of persons in the socially vulnerable groups to TB services	Active detection of tuberculosis	Low accountability of primary health facilities in TB control in the regions. The insufficient training of the primary health care staff results in low detection among socially vulnerable groups.	30 percent of the population (all people and households below the poverty threshold)	90 percent of the socially vulnerable persons	Green	Green	1
		Lack of screening for TB in placement centres and other places where socially vulnerable people gather,	30 percent of the population	90 percent of the socially vulnerable persons	Green	Green	2

Bottlenecks' scorecard							
Intervention	Subintervention	Bottleneck	Direct impact	Cross-cutting impact	General impact	Availability of short-term solution	Ranking
Increase the access of persons in the socially vulnerable groups to TB services	Active detection of tuberculosis	Insufficient informing of the socially vulnerable people on the available services. The limited seeking of health services by socially vulnerable persons results in inadequate TB detection.	30 percent of the population	90 percent of the socially vulnerable persons	Green	Green	3
	Intensify advocacy and education activities, aimed at preventing social diseases and promoting a healthy life style	Shortage of health care workers involved in tuberculosis control activities	30 percent of the population	90 percent of the socially vulnerable persons	Green	Amber red	3
		Insufficient responsibility and capacity of the LPA in development and implementation of programs at the local level.	30 percent of the population	90 percent of the socially vulnerable persons	Amber green	Amber green	1

Bottlenecks' scorecard							
Intervention	Subintervention	Bottleneck	Direct impact	Cross-cutting impact	General impact	Availability of short-term solution	Ranking
Increase the access of persons in the socially vulnerable groups to TB services	Intensify advocacy and education activities, aimed at preventing social diseases and promoting a healthy life style	Stigma and discrimination lead to an increased degree of vulnerability of people with tuberculosis and jeopardize the successful implementation of prevention, treatment, care and support activities.	30 percent of the population	90 percent of the socially vulnerable persons	Green	Amber red	2
	Improve adherence to treatment through integrated support services (providing transport, providing incentives for treatment, outreach workers remuneration for performing DOT, accommodation during the continuation phase of treatment, providing psychological and legal support,	Weak intersectoral policy. Lack of an intersectoral plan and a mechanism for its implementation	65 percent of people with TB included in treatment	50 percent of patients with TB from socially vulnerable groups	Green	Amber green	1

Bottlenecks' scorecard							
Intervention	Subintervention	Bottleneck	Direct impact	Cross-cutting impact	General impact	Availability of short-term solution	Ranking
Increase the access of persons in the socially vulnerable groups to TB services	Strengthen partnership with LPA in controlling TB, reviewing DOT alternatives for patients in vulnerable groups)	Lack of multidisciplinary (intersectoral) teams for prompt response in case of treatment interruption and provision of complex social services. Deficiencies in intersectoral logistics, which do not provide for other types of DOT services, not necessarily in conditions of ambulatory.	65 percent of people with TB included in treatment	50 percent of patients with TB from socially vulnerable groups	Green	Amber green	2
		Weak training of human resources on TB activities. Deficiencies in monitoring and reporting of different TB related activities	65 percent of people with TB included in treatment	50 percent of patients with TB from socially vulnerable groups	Amber green	Amber green	3
		Low participation of non-governmental organizations in TB related activities, leading to low provision of services acceptable and accessible by populations and overloading of health care providers	65 percent of people with TB included in treatment	50 percent of patients with TB from socially vulnerable groups	Amber green	Amber green	4

Bottlenecks' scorecard							
Intervention	Subintervention	Bottleneck	Direct impact	Cross-cutting impact	General impact	Availability of short-term solution	Ranking
Increase the access of persons in the socially vulnerable groups to TB services	Identify people who abandoned the treatment and their re-enrollment into treatment	Re-enrollment services are not provided, which leaves persons who have abandoned the treatment outside of the health system	12 percent of the population	12 percent of the socially vulnerable persons	Green	Amber green	1
		Insufficient integration of social and primary health services to motivate re-enrollment	12 percent of the population	12 percent of the socially vulnerable persons	Green	Amber red	3
		Insufficient support and advocacy about the consequences of abandonment, which would allow maintaining all patients in treatment. Low involvement of the society and community support towards persons who are at most risk	12 percent of the population	12 percent of the socially vulnerable persons	Amber green	Green	2
	Stimulate local NGOs TB initiatives, by implementing small grant programmes and trainings	Lack of a legal framework regulating and supporting NGOs activity in TB control	65 percent of people with TB included in treatment	50 percent of patients with TB from socially vulnerable groups	Green	Amber green	1

Bottlenecks' scorecard							
Intervention	Subintervention	Bottleneck	Direct impact	Cross-cutting impact	General impact	Availability of short-term solution	Ranking
Increase the access of persons in the socially vulnerable groups to TB services	Support for anti-tuberculosis treatment of patients with TB among people in detention or people released from prison	Dependence on funding from external sources, limited budget contribution, preserving the risk of losing the obtained results in TB control among people in detention	17,500 persons in prison	300 persons annually	Green	Amber green	2
		Insufficient training of health care providers, including the "team work" with other prison services and the civil health system leads to uncoordinated activities	17,500	300 persons annually	Green	Amber green	3
		Lack of integrated social services and insufficient informing of detainees during the period of detention and after release, lead to treatment abandonment	400 persons annually	300 persons annually	Green	Amber green	1

Bottlenecks' scorecard							
Intervention	Subintervention	Bottleneck	Direct impact	Cross-cutting impact	General impact	Availability of short-term solution	Ranking
	Strengthen infection control at the administrative level in TB specialized facilities	Absence of a TB control plan at the national and regional level	4,802 (4,344 +458 children)	3,746 (78%)	Green	Amber green	4
		The lack of a TB control plan at the regional level affects implementation of quick win activities					
		The staff trained insufficiently on measures of infection control and do not know sufficiently how to proceed in case of identification of a TB symptomatic person and measures of (engineering control) and respiratory protection.	4,802 (4,344 +458 children)	3,746 (78%)	Green	Green	2
		Poorly informed patient about public behaviour and respiratory protection, which contributes to the spread of infection in the society	4,802 (4,344 +458 children)	3,746 (78%)	Green	Green	3

Bottlenecks' scorecard							
Intervention	Subintervention	Bottleneck	Direct impact	Cross-cutting impact	General impact	Availability of short-term solution	Ranking
	Strengthen infection control at the level of personal protection in TB specialized facilities	Rationalization of hospital care through the patient-centred approach with emphasis on outpatient treatment and community involvement	4,802 (4,344 +458 children)	3,746 (78%)	Green	Green	1
		There is no complex assessment of premises, existing ventilation systems and their functionality, it does not allow adequate assessment of infrastructure and conformity with modern infection control requirements	4,802 (4,344 +458 children)	3,746 (78%)	Amber green	Green	3
		Lack of space for symptomatic persons' triage and location of medical offices, leading to placement in the same location of somatic and suspected TB patients, the triage is superficial and leads to transmission of the infection	4,802 (4,344 +458 children)	3,746 (78%)	Green	Amber green	2

Bottlenecks' scorecard							
Intervention	Subintervention	Bottleneck	Direct impact	Cross-cutting impact	General impact	Availability of short-term solution	Ranking
	Strengthen infection control at the level of personal protection in TB specialized facilities	Lack of modern infrastructure in TB specialized clinics (insufficient ventilation systems and bactericidal lamps, which also increases the risk of exposing patients and staff to infection)	4,802 (4,344 +458 children)	3,746 (78%)	Green	Amber green	1
		Staff trained insufficiently about respiratory protection	4,802 (4,344 +458 children)	3,746 (78%)	Green	Green	1
		The patient informed poorly about respiratory protection	4,802 (4,344 +458 children)	3,746 (78%)	Amber green	Green	3
		There is no focal point in specialized medical facilities responsible for personal protection and regular training, or systematic monitoring of hygienic and sanitary requirements	4,802 (4,344 +458 children)	3,746 (78%)	Green	Amber green	2

2D. PRIORITY SOLUTIONS

The identified solutions were prioritized and arranged in sequential order in order to maximize the magnitude and the speed of impact in terms of priority MDG interventions for TB.

Following the prioritization of bottlenecks and interventions, the potential short-term solutions for each bottleneck have been identified and assessed, to allow a quick acceleration towards the priority MDG targets. The identification of possible solutions was based on evidence-based solutions and case studies, as well as government documents and assessments. For each solution a profile reflecting the impact and the feasibility of the solution have been developed (for example, the magnitude, sustainability and speed of the impact and the availability of funds). This information served as the basis for the prioritization of solutions.

The key acceleration solutions identified and prioritized for the three areas of intervention are:

Intervention I - Increase adherence to TB treatment of persons with active TB

1.1. Sufficient allocation of resources for supporting patients during treatment

The proposed solution is oriented to the real needs of the patients and also responds to adherence of the treatment. The continuous patient tailored support can also contribute to the efficiency of the treatment and decrease the source of infection. This might need a multi-sectoral approach including welfare allowances and incentives, including the reimbursement of expenses

for transportation, additional medication and food.

1.2. Clear definition of the mechanism for incentives for employees who are involved in TB control activities

Budget allocations (NHIC) do not meet the needs. Some 4,802 people will be positively impacted by removing this bottleneck (according to data from the NCHM Form 30). Inpatient care will be improved, and this may lead to an increased adherence to treatment of TB patients.

The adequate motivation of the staff involved in TB control activities will result in increased responsibility for service delivery, thus increasing the adherence to treatment of people with TB and helping to reduce the incidence of TB and MDR TB. The remuneration of family physicians for newly detected cases in 2007 was perceived as a stimulating procedure compared to paying physicians for successfully terminated treatment (bonus for performance indicator) which was applied in 2012.

The health care staff motivation scheme does not work efficiently: in order to receive money for the successful completion of treatment (bonus for performance indicator) this entails a bureaucratic process, which also creates divergences between family physicians and pulmonologists. The motivation for "successful completion of treatment (bonus for performance indicator)" is not successful either, since many health workers report that they did not receive the money while others said they were paid, but only up to 200 lei, because the money was shared out between several health workers²¹.

²¹ "Risk factors associated with cases of abandonment and failure of strictly supervised treatment of tuberculosis in Moldova", 2009.

1.3. Creation and training multidisciplinary teams in the regions

Active multi-disciplinary involvement in tuberculosis control activities will help the timely detection, conducting of DOT, which in turn will increase the adherence to treatment and reduce the rate of abandonment. This is also very important in terms of education, information and promotion of healthy lifestyles. The multidisciplinary teams also provide psycho-social support, the involvement of other medical specialists (narcologist, psychologists, etc). Early assessment of the existing teams show the efficiency for the treatment adherence and respect for a person's needs and rights. The multi-disciplinary teams are very efficient in tuberculosis control activities for the socio-vulnerable groups (e.g. – organization of tuberculosis control in Tomsk region, Russia, Latvia). A professional referral system is essential for coordinated efforts and to ensure successful treatment.

Intervention II - Increase access of persons from the socially vulnerable groups to TB services

II1. Examination of people in the placement centres and other places where they meet through radiological control for adults and IDR Mantoux 2UT for children.

As mentioned earlier, people such as migrants, the homeless, unemployed people are the main risk groups for TB. There is evidence that many of these people do not have access to primary health care and preventive TB screening. This leads to late diagnosis, non-diagnosis and a continuous source of infection. While the solution might need a re-distribution of screening

means and additional financial resources, the cost effectiveness due to the significant impact can be demonstrated.

TB screening programme in vulnerable groups will reduce transmission of TB through early detection and appropriate treatment of active TB cases (priority in TB control activities). Active diagnosis of tuberculosis with mandatory screening of individuals among vulnerable social groups will decrease the rate of transmission of tuberculosis not only in this population, but also in society as a whole. In the case that TB is detected, all those contacts will be identified and examined allowing for the infection to be traced and stop its spreading. Establishing the TB screening programme will reduce the incidence of tuberculosis. Timely detection of the tuberculosis treatment significantly reduces costs and decreases the mortality rate.

II2. Appoint a person (a nurse within the PHC), responsible for TB screening in socially-vulnerable groups

Appointing a person to be in charge of TB at the level of primary health facilities, who will conduct and report the activities related to TB screening of the socially-vulnerable groups will raise the accountability and responsibility of the primary care for the specific measures in TB prevention and follow-up.

This person can be a nurse within the primary health care system, especially in localities where there is an outbreak of TB. In Moldova the PHC (primary health care assistant) is responsible for examining the group at risk of tuberculosis and for detecting people with tuberculosis among those who show symptoms of TB. A good option

would be for a person within the PHC to be named responsible for detecting tuberculosis within the socially-vulnerable groups.

The rationale behind this: TB detection on people impacted by the disease people should be carried out in locations which are closest to the patient and training should focus on detecting TB in vulnerable groups. Training PH staff about early detection on the screening methods applicable to vulnerable groups is also needed.

III.3. Ensure alternative conditions for the stage of continuing inpatient

Vulnerable, marginalized and homeless people frequently lack constant support and monitoring by the community which leads to an increase in the default rate and an increase in cases of drug resistant strains of TB. Reviewing hospitalization criteria, providing accommodation and health services aimed at increasing the adherence to treatment will result in a decreased abandonment rate and increased success rate of anti-TB treatment. Technical difficulties in design and implementation might be needed and also the involvement of the NHIC.

Intervention III. Strengthen infection control in TB specialized facilities

III.1. Modernization of infrastructure in TB specialized clinics

The proper functioning of bactericidal lamps and the ventilation system, will help reduce the nosocomial transmission of infection among health care staff and patients undergoing inpatient treatment and reduce the number of therapeutic fail-

ure because of intra-hospital MDR TB. Adequate ventilation in health-care facilities is essential for preventing transmission of airborne infections, and is strongly recommended for controlling spread of TB. Priority should be given to achieving adequate ACH using ventilation systems. However, in some settings it is not possible to achieve adequate ventilation. In such cases, a complementary option is to use upper room or shielded ultraviolet germicidal irradiation (UVGI) devices.

III.2. Provision of incentives, compensations for the patient

Provision of the alternative for the patient in choosing the treatment conditions and financial coverage of these alternatives. Some patients do not feel safe in hospitals, due to bad hygiene conditions and an unfriendly environment (former prisoners, homeless people). Alcohol, disorder, conflicts, physical abuse are major problems in hospitals, which the health workers cannot always settle. On the other hand, the hospital conditions are considered beneficial for some patients (single persons, people from vulnerable families, the homeless, etc.), but less favorable for other categories of citizens who refuse hospitalization or who are formally admitted (Focus group with TB patients, 2012). Many patients would prefer to be treated at home, or at an out-patient facility. This can lead to the impact on costs of a treated case, due to a reduction of the inpatient cost, and will also reduce the intra-hospital transmission of MDR TB, which is already demonstrated by the available studies.

III.3. Training about infection control measures, respiratory protection

The implementation of the solution would have a significant impact, as trained staff will correctly apply the operational procedures of the Infection Control Plan. The procedure establishes the roles and responsibilities for specialists involved in the implementation of the infection control plan.

As results, we have developed a scorecard with the rankings of short-term solutions in order to accelerate the progress towards MDG 6 targets. Only solutions which were ranked 1-3 were chosen to be included in the MAF Action Plan, based on their impact and feasibility assessments. To present a fuller picture, the rest of the solutions are also presented in the table below.

SOLUTIONS SUMMARY SCORECARD TB

Interventions/Bottleneck	Solutions	Impact	Feasibility	Priority Ranking
Ensure the adherence to anti-tuberculosis treatment of people with active TB Corresponding bottlenecks: 1. Lack of psychological, social and other support for patients with active TB undergoing treatment 2. Insufficient capacity and resources to cover all patients and ensure adherence to treatment. 3. Improper incentive scheme for medical staff involved in TB control activities 4. The multidisciplinary team working in the regions is trained insufficiently for provision of high quality services 5. Lack of measures aimed at strengthening the partnership with Local Public Authorities on TB control	Sufficient allocation of resources for patients' support during treatment	Green	Amber green	1
	Clear definition of incentives' mechanism for the employees involved in TB control activities	Green	Amber green	2
	Creation and training of multidisciplinary teams in the regions to support adherence to treatment	Amber green	Amber green	3
	Definition of mechanisms to strengthen the partnership with LPAs and communities on TB control	Amber green	Amber green	4

Interventions/Bottleneck	Solutions	Impact	Feasibility	Priority Ranking
<p>Increase the access of social vulnerable patients to TB services</p> <p>Corresponding bottlenecks:</p> <ol style="list-style-type: none"> 1. Lack of screening for TB in placement centres and other places where socially vulnerable people meet. Availability of the primary health facilities in TB control in the regions. 2. Insufficient training of the primary health staff leads to the insufficient detection in the group at social risk.. 3. Lack of multidisciplinary (intersectoral) teams for prompt response in case of treatment interruption and provision of complex social services. Deficiencies in intersectoral logistics, which do not provide for other types of DOT services, not necessarily in conditions of ambulatory. 4. Insufficient information on the available services leads to a low demand. The limited access of the socio-vulnerable people to health and social services result in late TB detection. 	<p>Examination of people in placement centres and other places they meet X-ray control in adults and IDR Mantoux 2UT for children. Training of the placement centres' staff on early detection, on the screening methods applicable among vulnerable groups.</p>	Green	Amber green	1
	<p>Appoint a person in charge of TB at the level of primary health facilities, who will conduct and report the activities related to TB screening of the population within the socially-vulnerable groups</p>	Green	Amber green	2
	<p>Ensure alternative conditions for the treatment continuation in hospitals, specialized facilities, particularly for the homeless people, the people in vulnerable families</p>	Green	Amber green	3

Interventions/Bottleneck	Solutions	Impact	Feasibility	Priority Ranking
	Conduct information campaigns by bringing services closer to beneficiaries, Publishing of information materials, video and audio spots about TB.	Amber green	Amber green	4
Strengthen infection control in the specialized facilities	Modernization of infrastructure in facilities specialized in TB	Green	Amber green	1
Corresponding bottlenecks:				
1.Lack of modern infrastructure in TB specialized clinics (insufficient ventilation systems and bactericidal lamps, which also increases the risk of exposing patients and staff to infection)	Provision of the alternative for the patient in choosing the treatment conditions and financial assurance of these alternatives by providing incentives, compensations for the patient	Green	Amber green	2
2. Rationalization of hospital care through the patient-centred approach with emphasis on outpatient treatment and community involvement	Train the public health, PH, social service staff and patients on infection control measures, respiratory protection.	Amber green	Amber green	3
3. Staff trained insufficiently about respiratory protection				

2E. ACTION PLAN FOR TB

Following the identification and prioritization of solutions to the bottlenecks the action plan was developed, to enable acceleration towards MDG 6 target on TB in the short-to-medium terms. Firstly, the activities required for the implementation

of solutions were identified. Then partners and estimated financing needs were identified based on consultations with key stakeholders. Lastly, a monitoring and evaluation plan was drafted to enable the government and partners to implement these solutions in a timely manner.

	Solutions category	Solution Description	Perceived needs	Solution financing (estimated, USD)	Potential partners
<p>Intervention 1. Ensure the adherence to anti-tuberculosis treatment of the people with active TB.</p> <p>Corresponding Bottleneck:</p> <p>1. Lack of psychological, social and other support for patients with active TB undergoing treatment.</p> <p>2. Insufficient capacity and resources to cover all patients and ensure adherence to treatment.</p> <p>3. Improper incentive scheme for medical staff involved in TB control activities.</p> <p>4. The multidisciplinary team working in the regions is trained insufficiently for provision of high quality services.</p> <p>5. Lack of measures aimed at strengthening the partnership with Local Public Authorities on TB control.</p>					
1.	Sufficient allocation of resources for continued patient support and follow up after treatment completion	Provide incentives to increase adherence to treatment, providing the supplement in the form of a check/ voucher (\$3) upon receiving every dose	Supplement provision mechanism	at least 9 936 000	MoH, NTCP, NHIC, FG, LPA Ministry of Labour, Social Protection and Family, local authorities
		Provide reimbursement for patients' travel costs to the treatment centre, a sum of 2\$		at least 2 592 000	
		Ensure the support aimed at increasing adherence to treatment, covering the additional costs incurred by the patients (documents, certificates)		at least 1 900 000	

	Solutions category	Solution Description	Perceived needs	Solution financing (estimated, USD)	Potential partners
2.	Develop a performance based incentives' mechanism for the medical employees involved in TB control	Develop an incentive mechanism for the PHC staff involved in TB control activities	Incentive mechanisms for the PHC staff involved in TB control activities		MoH, NHIC, NTCP
		Implement the system of performance-based bonus system for family physicians for the early detection of TB in the amount of 40 USD		920 000	
		Implement the system of performance-based bonus system for family physicians for the completion of the TB patient's treatment, the sum, of 50 USD		1 472 000	
3.	Create and train the multidisciplinary teams in regions	<p>Develop the operating regulations for the multidisciplinary team under the local public administration in cooperation with specialized NGOs</p> <p>Develop job descriptions for the team members. Train the multidisciplinary teams</p>	<p>Operate regulations for the multidisciplinary team</p> <p>Job descriptions for the members of the team</p> <p>Training sessions</p> <p>Development of manuals, referral materials for the trainings</p> <p>Printed materials</p>	40 000	MoH, NTCP, MLSP, local authorities

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	Solutions category	Solution Description	Perceived needs	Solution financing (estimated, USD)	Potential partners
<p>Intervention 2. Increase access of social vulnerable patients to TB services Corresponding Bottleneck: 1. Lack of screening for TB in placement centres and other places where socially vulnerable people meet. Availability of the primary health facilities in TB control in the regions. 2. Insufficient training of the primary health staff leads to the insufficient detection in the group at social risk. 3. Lack of multidisciplinary (intersectoral) teams for prompt response in case of treatment interruption and provision of complex social services. Deficiencies in intersectoral logistics, which do not provide for other types of DOT services, not necessarily in conditions of ambulatory. 4. Insufficient information on the available services leads to a low demand. The limited access of the socio-vulnerable people to health and social services result in late TB detection.</p>					
1	Examine people in placement centres and other public settings by applying X-ray control in adults and IDR Mantoux 2UT for children. Train the placement centres' staff on early detection, on the screening methods applicable among vulnerable groups.	Train the placement centres' (shelters) staff on early detection	Training sessions for the placement centres' staff Development of manuals, referral materials for the trainings Printed materials	40 000	MoH, NTCP, NHIC, FG, SUMP (NGO?) SUMP „Nicolae Testemițanu” Ministry of Labour, Social Protection and Family

⋮

	Solutions category	Solution Description	Perceived needs	Solution financing (estimated, USD)	Potential partners
		<p>Ensure the differentiated diagnosis of the people with clinical symptoms of the tuberculosis, using modern clinical-radiology methods</p> <p>Ensure the radiology examination of symptomatic persons</p> <p>Ensure advanced services for the symptomatic persons (TC, RMN examinations)</p> <p>Procure mobile digital radiology equipment</p>	<p>Purchase of mobile radiologic equipment (regional use)</p>	<p>8 368 923</p> <p>375 000 for stationary X-ray equipment - 2 187 500 are required, for mobile X-ray equipment - at least 2</p>	
			<p>Purchase of radiologic film for the mobile digital radiologic equipment</p>		
		<p>Ensure the creation of an electronic data basis for the persons examined using the mobile digital equipment</p>	<p>Development of a centralized electronic data basis for the persons examined using the mobile digital equipment</p> <p>Computer equipment</p> <p>Website development</p>	<p>Estimated cost per soft 60 000 and annual maintenance 6 000</p>	

	Solutions category	Solution Description	Perceived needs	Solution financing (estimated, USD)	Potential partners
		<p>Active detection of tuberculosis (ensuring radiologic examinations) within the vulnerable groups of the population – using including mobile screening teams</p> <p>Active detection of tuberculosis – X-ray for adults and IDR Mantoux 2UT for children in the vulnerable groups</p> <p>Develop and implement incentive mechanisms for the staff of the placement centres, NGOs, volunteers in the TB screening activities within vulnerable groups</p>	<p>Remuneration of the staff operating the mobile digital radiologic equipment</p> <p>Procurement of radiologic film for the active detection of the tuberculosis in the vulnerable groups</p> <p>Procuring Tuberculin and tuberculin syringes for the active detection of the tuberculosis in children from vulnerable groups</p>	10 089 090	
2	Appoint a person in charge of TB at the primary health care level, responsible for conducting TB screening among socially-vulnerable groups	Develop and implement incentive mechanisms for the primary health care staff involved in TB control activities implemented within the vulnerable groups	Development of job descriptions and mechanism for the remuneration of the PHC staff who will be implementing and reporting on the TB control activity among the socially-vulnerable groups		MoH, NTCP, NHIC, FG, SUMP „Nicolae Testemițanu”

	Solutions category	Solution Description	Perceived needs	Solution financing (estimated, USD)	Potential partners
		Ensure the remuneration of the primary health care staff, who will be implementing and reporting the TB control activities among the socially-vulnerable groups		91 640	
		Train the primary health care network staff (PHC)	Training sessions for the PHC staff Development of manuals, referral materials for the trainings Printed materials	40 000	
3	Ensure alternative conditions for the treatment continuation in hospitals, specialized facilities, particularly for the homeless people, and people from vulnerable families	Develop and implement a new payment mechanism for inpatient treatment from the NHIC (government), in the specialized facilities, particularly for the homeless persons, persons in vulnerable families Carry out education activities among TB patients during their stay in the hospital Develop peer-to-peer support groups involving former TB patients	Payment mechanism for inpatient treatment, in specialized facilities, particularly for the homeless persons, persons in vulnerable families Flyers, posters for the TB patients staying in hospitals Creation of "peer-to-peer" support groups	72 000	MoH, NTCP, NHIC, FG, Ministry of Labour, Social Protection and Family, local authorities

	Solutions category	Solution Description	Perceived needs	Solution financing (estimated, USD)	Potential partners
		<p>Train the health care staff in the specialized facilities on TB patients education activities for the period they remain in hospital</p> <p>Create counselling groups to increase the treatment compliance of the TB patients:</p>	<p>Training sessions for the medium health care staff in the specialized facilities</p> <p>Development of manuals, referral materials for the trainings</p> <p>Printed materials</p>		

Intervention 3. Strengthen the infection control in the specialized facilities

Corresponding bottleneck:

- 1. Lack of modern infrastructure in TB specialized clinics (insufficient ventilation systems and bactericidal lamps, which also increases the risk of exposing patients and staff to infection).**
- 2. Rationalization of hospital care through the patient-centred approach with emphasis on outpatient treatment and community involvement.**
- 3. Staff trained insufficiently about respiratory protection**

1	Modernize of infrastructure in facilities specialized in TB	<p>Modernize the infrastructure in facilities specialized in TB treatment I: purchasing HEPA filter devices for air cleaning in the hospital rooms, purchasing UV lamps, respirators</p> <p>Permanent maintenance of the ventilation systems in the specialized phtisio-pneumologic and LR facilities</p> <p>Ensure individual infection control devices for the staff of the specialized phtisio-pneumologic and LR facilities</p>	<p>HEPA filter devices</p> <p>Display UV lamps</p> <p>Equipment for the measuring of the air flow speed</p> <p>Equipment for the measuring of the ray intensity</p> <p>Individual infection control means (respirators)</p> <p>Device for the respirators' pressurization test.</p>	<p>460 800</p> <p>276 610</p> <p>1 075 821</p>	<p>MoH,</p> <p>NTCP,</p> <p>FG,</p> <p>WHO</p>
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	Solutions category	Solution Description	Perceived needs	Solution financing (estimated, USD)	Potential partners
2	Provide the option for the patient to choose the treatment conditions and financial assurance by providing incentives, compensations for the patient and specialist supervision	Develop and implement the TB patient stimulation mechanisms aimed at increasing the compliance with treatment	Supplement provision mechanism	at least 9 936 000	MoH, NTCP, FG, NHIC
		Ensure adherence to treatment: food and hygienic product packages (checks) for the patients upon receiving each dose		at least 2 592 000	
		Ensure the compliance with the treatment: travel costs for patients for traveling to the treatment centre		at least 1 900 000	
		Ensure adherence to treatment, by covering the additional costs incurred by the patients			
		Ensuring adherence to treatment: education and information materials for the patients			

	Solutions category	Solution Description	Perceived needs	Solution financing (estimated, USD)	Potential partners
3	Train the public health, social service staff and patients on infection control measures, respiratory protection.	Initial and refreshment training of the staff	Training sessions Development of manuals, referral materials for the trainings Printed materials	40 000	MoH, FG, NTCP, SUMP „Nicolae Testemitanu“

2F. CONCLUSIONS FOR THE TB SEGMENT

Considering the current epidemiological situation in Moldova, there is a significant risk that MDG 6 target in TB will not be achieved by 2015. Despite all efforts made in recent years in TB control, Moldova is still among the top 15 countries with a high incidence of MDR-TB in Europe.

The analyses and evidence reveal that DOT alone did not prove effective in recent years in TB control programmes. The broad, multidisciplinary approach, inclusion of the community and local government support and involvement of various stakeholders will lead to a better quality of medical and social support services. This approach can also foster a patient centred approach that observes the rights of TB patients and improves the outcomes of TB control measures in the country. The solutions described above underscore the importance of following the epidemic and providing flexible, yet quality services for critical population groups. Coordination

among primary health care professionals, TB doctors and specialized facilities as well as social services is key. Measures to finance and support frontline service providers working with target groups have also been highlighted as a top priority solution. Moldovan civil society should continue to be involved in tuberculosis control, and measures need to be taken to support NGOs and frontline services providers that have direct access to and work with vulnerable populations.

The interventions focused on improving the access of socially vulnerable groups to TB services, ensuring adherence to anti-tuberculosis treatment of people with active TB and strengthening infection control in TB specialized facilities. All of these were considered as the most important things to be done in the short- and medium-terms and each of these interventions will help improve the epidemiological situation in the country thereby allowing for faster progress towards achieving the MDG 6 targets.

Intervention I “Increase the access of socially vulnerable groups (migrants, people from asylums, homeless people, drug users, people abusing alcohol, prisoners and former detainees, street children and youth, etc.) to TB services” and Intervention II “Increase adherence to TB treatment of persons with active TB” will help achieve a treatment success rate of 78% for new cases of pulmonary tuberculosis with positive sputum smear and a treatment success rate of not less than 60% for multi-drug-resistant tuberculosis cases by 2015. An important solution highlighted here is to allow more outpatient treatment of TB for eligible patients by reviewing the TB hospitalization criteria.

The implementation of intervention III “Strengthen the infection control in TB specialized facilities” will help reduce the global tuberculosis incidence and bring it under the level of 90.0 registered cases per 100,000 people and reduce the prevalence of MDR TB.

Since the country is currently unable to cover all costs related to the implementation of this plan of actions, it is very impor-

tant to attract different donors and partners, based on this action plan which has prioritized the most important activities for the next 2-5 years. The plan of actions can be successfully implemented in Moldova if it is supported by all stakeholders - not only the Ministry of Health, but also other ministries, civil society and development partners. The monitoring plan included can help governments and partners assess the milestones and the general progress in implementing the solutions. The MAF Action Plan highlights the importance of effectively utilizing existing resources (for example, through the National Health Insurance scheme) while seeking additional resources through major partners such as the European Union and others. The effective allocation of the transitional funding mechanism from the Global Fund to Fight HIV, Malaria and Tuberculosis to priority activities described in this report is also crucial. The United Nations Country Team (UNCT), particularly through WHO, UNAIDs, UNDP and other organizations, will continue to support the country’s efforts to accelerate progress in combating the TB epidemic.



CHAPTER 4.

ANNEXES

1. IMPLEMENTATION AND MONITORING PLAN HIV

MDG	Key solutions	Sub activities	Proposed implementation period (2012 - 2015)					Monitoring indicators (2012 - 2015)				Responsible partners
			2012	2013	2014	2015	2012	2013	2014	2015		
I. Scale up harm reduction programs to focus on HIV prevention in key populations												
MDG6	Extending the range of services from 6 to 9 based on the UNODC/WHO/UNAIDS recommendations, developing and implementing services for bridge populations	There will be HIV prevention services embedded in the comprehensive package of IDU services provided to at least 60 per cent of IDU,		X	X	X	Number of generic categories of services (aim – 9, WHO/UNAIDS/ UNODC)	Share of IDU covered out of estimated	Share of IDU covered out of estimated	Share of IDU covered out of estimated	Share of IDU covered out of estimated	MoH, SFM
		IDUs are to be covered with OST with methadone within the framework of harm reduction projects	X	X	X		No. of OST sites Share of IDU covered out of estimated	Share of IDU covered out of estimated	Share of IDU covered out of estimated	Share of IDU covered out of estimated		
		Covering 40 per cent of estimated MSM, including through NGOs		X	X		Share of MSM covered out of estimated Share of MSM selling sex covered, out of estimated	Share of MSM covered out of estimated Share of MSM selling sex covered, out of estimated	Share of MSM covered out of estimated Share of MSM selling sex covered, out of estimated	Share of MSM covered out of estimated Share of MSM selling sex covered, out of estimated		

MDG	Key solutions	Sub activities	Proposed implementation period (2012 - 2015)					Monitoring indicators (2012 - 2015)					Responsible partners
			2012	2013	2014	2015	2012	2013	2014	2015			
							Share of FSW covered out of estimated	Share of FSW covered out of estimated	Share of FSW covered out of estimated	Share of FSW covered out of estimated			
		Covering 60 per cent of estimated FSW, including NGOs through NGOs			X	X	Share of FSW covered out of estimated	Share of FSW covered out of estimated	Share of FSW covered out of estimated	Share of FSW covered out of estimated	Share of FSW covered out of estimated	Share of FSW covered out of estimated	
		Vaccination with three doses of HBV vaccine			X	X	Share of eligible key population vaccinated	Share of eligible key population vaccinated	Share of eligible key population vaccinated	Share of eligible key population vaccinated	Share of eligible key population vaccinated	Share of eligible key population vaccinated	
		Purchase and distribution of consumables		X	X	X	No. of distributed packages per estimated number of key populations at risk per annum	No. of distributed packages per estimated number of key populations at risk per annum	No. of distributed packages per estimated number of key populations at risk per annum	No. of distributed packages per estimated number of key populations at risk per annum	No. of distributed packages per estimated number of key populations at risk per annum	No. of distributed packages per estimated number of key populations at risk per annum	
		Ensuring the diagnosis and the treatment of viral hepatitis			X	X	Share of key populations tested for HBV / HCV	Share of key populations tested for HBV / HCV	Share of key populations tested for HBV / HCV	Share of key populations tested for HBV / HCV	Share of key populations tested for HBV / HCV	Share of key populations tested for HBV/HCV	

MDG	Key solutions	Sub activities	Proposed implementation period (2012 - 2015)					Monitoring indicators (2012 - 2015)				Responsible partners
			2012	2013	2014	2015	2012	2013	2014	2015		
			Share of people covered out of estimated				Share of people covered out of estimated					
		BCC activities with the partners and the customers of the key populations	X	X	X	X	Share of people covered out of estimated	Share of people covered out of estimated	Share of people covered out of estimated	Share of people covered out of estimated		
	Development of service delivery mechanism with financial support from the NHIC	Buying various consumables (phone cards, razors, personal hygiene items) to motivate people in risk groups, to increase the attractiveness and the enrollment in HR programs	X	X	X	X	No. of consumables distributed per estimated number of key populations at risk per annum	No. of consumables distributed per estimated number of key populations at risk per annum	No. of consumables distributed per estimated number of key populations at risk per annum	No. of consumables distributed per estimated number of key populations at risk per annum	No. of consumables distributed per estimated number of key populations at risk per annum	- MOH, - National Drug Agency - Association of Pharmacists
		Developing a mechanism for NGO contracting by the NHIC for health service delivery	X				Mechanism developed and institutionalized					

MDG	Key solutions	Sub activities	Proposed implementation period (2012 - 2015)					Monitoring indicators (2012 - 2015)					Responsible partners		
			2012	2013	2014	2015	2012	2013	2014	2015					
	Using risk reduction programs to focus on preventing HIV transmission from key populations to their sexual partners and their customers.	Training of on-site beneficiaries (NGOs implementing HR projects) Operational research conducted to identify interventions for bridge populations	X						No of trained staff	No of findings incorporated in an action plan for service delivery					
	BCC activities with the partners and the customers of the key populations		X	X	X				Share of people covered out of estimated	Share of people covered out of estimated	Share of people covered out of estimated	Share of people covered out of estimated			
	Extending HR programs to 5 additional districts	Beginning in 2013 the HIV prevention activities for IDUs, SW and MSM are to be scaled up to include 5 more regions (South and Transnistria) through small grant programmes							No. Of projects ongoing, disaggregated per key population at risk	No. of beneficiaries per annum	No. Of projects ongoing, disaggregated per key population at risk	No. Of projects ongoing, disaggregated per key population at risk	No. Of beneficiaries per annum	No. Of projects ongoing, disaggregated per key population at risk	RND, SFM

MDG	Key solutions	Sub activities	Proposed implementation period (2012 - 2015)					Monitoring indicators (2012 - 2015)				Responsible partners	
			2012	2013	2014	2015	2012	2013	2014	2015			
II. Strengthening the case-management system and ensuring a better adherence to ARV treatment													
	4 regional treatment centers ensure functionality of SIME HIV	Implementation of a real-time database (DB) in all administrative regions of the country	X	X			No. of districts / regions where the DB is used						- National Center for Health Management National AIDS and Dermato-Venereology Center
		Retroactive entering of epidemiological and clinical follow-up data since 2003 onwards	X	X			% of PLHIV entered retroactively to SIME-HIV out of total cases registered	% of PLHIV entered retroactively to SIME-HIV out of total cases registered					
	Ensuring the use of Community Centers	Ongoing entering of epidemiological and clinical follow-up data on new cases	X	X	X		No. of new cases entered to SIME-HIV	No. of new cases entered to SIME-HIV	No. of new cases entered to SIME-HIV	No. of new cases entered to SIME-HIV	No. of new cases entered to SIME-HIV	No. of new cases entered to SIME-HIV	City halls: Chişinău, Balti, Comrat, Tiraspol
		referral mechanisms at regional level, with CC as one of the service delivery entry point	X				No. of established CC	No. of established CC	No. of established CC	No. of established CC	No. of established CC	No. of established CC	No. of cases referred to treatment centers No. of cases referred to treatment centers

MDG	Key solutions	Sub activities	Proposed implementation period (2012 - 2015)					Monitoring indicators (2012 - 2015)					Responsible partners		
			2012	2013	2014	2015	2012	2013	2014	2015					
							No. of CC having worked without interruptions during one year	No. of CC having worked without interruptions during one year	No. of CC having worked without interruptions during one year	No. of CC having worked without interruptions during one year					
		Ensuring the work of the 4 CC (Chişinău, Comrat, Tiraspol, Balti)	X	X	X	X	No. of CC having worked without interruptions during one year	No. of CC having worked without interruptions during one year	No. of CC having worked without interruptions during one year	No. of CC having worked without interruptions during one year	No. of people trained	No. of people referred through the NRS system	No. of people referred through the NRS system	No. of people referred through the NRS system	MOH, MOLSPF, GFATM
		Training of staff from residential facilities of MOLSPF and LPAs to provide PLHIV with services / fight stigma and discrimination					No. of beneficiaries served	No. of beneficiaries served	No. of beneficiaries served	No. of beneficiaries served	No. of people trained	No. of people referred through the NRS system	No. of people referred through the NRS system	No. of people referred through the NRS system	MOH, MOLSPF, GFATM
	Development of the short-term advocacy plan before the Government with the view of allocating the funds for the ART from the state budget and other alternative sources	Building the capacity of multidisciplinary teams in providing case management support to PLHIV through NRS (SNR)	X				No. of teams trained	No. of people referred through the NRS system	No. of people referred through the NRS system	No. of people referred through the NRS system	No. of people referred through the NRS system	No. of people referred through the NRS system	No. of people referred through the NRS system	MOH, National AIDS and DV Center Government	
		Development of an advocacy plan for the government for financing based on the MTEF and earmarking of state budget funds for ART	X				Plan developed								

MDG	Key solutions	Sub activities	Proposed implementation period (2012 - 2015)					Monitoring indicators (2012 - 2015)				Responsible partners
			2012	2013	2014	2015	2012	2013	2014	2015		
		Allocation of state budget funds for ART			X	X				% of financial coverage of the needs	% of financial coverage of the needs	
III. Ensuring early detection of HIV by promoting voluntary counseling and testing (VCT) services in key populations												
	Development of a comprehensive Referral Mechanism to VCT	Consultative Development of the Referral Mechanism	X					Mechanism developed				Medicine and Pharmacy State University
		Consultations and capacity building of public and NGO service providers to ensure implementation of the Referral Mechanism (4 seminars for about 120 people)	X						- No of seminars organized - No of trained staff, disaggregated by type of service provider			
	Capacity building and supportive oversight of the VCT service	A team of HIV-experienced authors to develop the concept	X					Concept developed				
		Strengthen quality assurance mechanism, including through supportive oversight of quality of VCT session, and on-the-job training	X		X							

MDG	Key solutions	Sub activities	Proposed implementation period (2012 - 2015)					Monitoring indicators (2012 - 2015)					Responsible partners
			2012	2013	2014	2015	2012	2013	2014	2015			
							Share of new VCT counselors trained	Share of new VCT counselors trained	Share of new VCT counselors trained	Share of new VCT counselors trained			
		Use existent VCT counsellors as trainers and ensure the training schedule as continuous education					Share of VCT counselors covered with refresher training	Share of VCT counselors covered with refresher training	Share of VCT counselors covered with refresher training	Share of VCT counselors covered with refresher training	Share of VCT counselors covered with refresher training	Share of VCT counselors covered with refresher training	MoH
		2 authors working in HIV control area will develop the concept.	X				Concept in place, developed participatorily and endorsed by MoH						
		Setting up 2 mobile teams to ensure VCT among key populations	X	X	X		No. of visits undertaken by team of beneficiaries from key populations at risk served	No. of visits undertaken by team of beneficiaries from key populations at risk served	No. of visits undertaken by team of beneficiaries from key populations at risk served	No. of visits undertaken by team of beneficiaries from key populations at risk served	No. of visits undertaken by team of beneficiaries from key populations at risk served	No. of visits undertaken by team of beneficiaries from key populations at risk served	

MDG	Key solutions	Sub activities	Proposed implementation period (2012 - 2015)					Monitoring indicators (2012 - 2015)					Responsible partners	
			2012	2013	2014	2015	2012	2013	2014	2015				
							No. of vehicles purchased							
		Purchase of 2 vehicles for VCT mobile teams	X											
	Scale up VCT services in all sectors, including NGOs and the development of the mobile counseling concept	Develop accreditation criteria for NGOs to deliver VCT services		X						Criteria developed				
		Training for public sector and NGO service providers		X						people trained				
		Providing NGOs with relevant VCT equipment		X						No. of VCT rooms equipped				
		Promoting VCT among MARP		X	X	X	X	X	X	No of beneficiaries	No of beneficiaries	No of beneficiaries	No of beneficiaries	

2. IMPLEMENTATION AND MONITORING PLAN TB

MDG	Main interventions	Indicative interventions	Implementation period (2012 - 2015)				Monitoring indicator (2012 - 2015)				Responsible partners	
			2012	2013	2014	2015	2012	2013	2014	2015		
Ensuring adherence to anti-tuberculosis treatment of people with active TB												
	Sufficient allocation of resources for patients' support until full recovery.	Ensuring the support aimed at increasing the adherence to treatment, providing the supplement in the form of a check for 50 lei upon receiving the first dose					The number of assisted TB patients					MoH, NTCP, NHIC, FG, LPA, Ministry of Labour, Social Protection and Family
		Providing reimbursement for the patients' costs for travel to the treatment centre, in the amount of 20 lei					The number of assisted TB patients					MoH, NTCP, NHIC, FG, LPA
	Certain/clear definition of incentive mechanisms for the staff involved in TB control activities	Ensuring the support aimed at increasing the adherence to treatment, covering the additional costs incurred by the patients (documents, certificates)					The number of assisted TB patients					MoH, NTCP, NHIC, FG, LPA

MDG	Main interventions	Indicative interventions	Implementation period (2012 - 2015)				Monitoring indicator (2012 - 2015)				Responsible partners	
			2012	2013	2014	2015	2012	2013	2014	2015		
		Developing an incentive mechanism for the PHC staff involved in TB control activities					The mechanism developed;					MoH, NTCP, NHIC, FG
		Implementing the system of performance-based bonus system for family physicians for the early detection of TB in the amount of 500 lei					The number of motivated persons					MoH, NTCP, NHIC, FG
	Creation and training of multi-disciplinary teams working in the regions.	Implementing the system of performance-based bonus system for family physicians for the completion of the TB patient's treatment in the amount of 800 lei					The number of motivated persons					MoH, NTCP, NHIC, FG
		Developing the operating regulations for the multidisciplinary team					The regulation developed					MoH, NTCP, MLSP
		Developing job descriptions for the members of the team					The job descriptions developed					MoH, NTCP, MLSP

MDG	Main interventions	Indicative interventions	Implementation period (2012 - 2015)				Monitoring indicator (2012 - 2015)				Responsible partners
			2012	2013	2014	2015	2012	2013	2014	2015	
Training the multidisciplinary teams											MoH, NTCP, MLSP
Increasing the access of persons in the socially vulnerable groups to TB services											
MDG 6	Examination of people in the placement centers and other crowded places through radiologic control for adults and IDR Mantoux 2UT for children.	Continuous training of the placement centers' staff on early detection								The number of trained placement centers' staff	MoH, NTCP, NHIC, FG, SUMP „Nicolae Testemițanu” Ministry of Labor, Social Protection and Family
		Ensuring the differentiated diagnosis, using modern clinical-radiologic methods, of the people with clinical symptoms of the tuberculosis								The share of the patients diagnosed with tuberculosis of the total number of patients with suspect tuberculosis symptoms	MoH, NTCP, NHIC, FG
		Ensuring the radiologic examination of symptomatic persons								The number of conducted radiologic investigations	MoH, NTCP, NHIC, FG

MDG	Main interventions	Indicative interventions	Implementation period (2012 - 2015)				Monitoring indicator (2012 - 2015)				Res-possible partners	
			2012	2013	2014	2015	2012	2013	2014	2015		
		Ensuring advanced services for the symptomatic persons (TC, RMN examinations)					The number of symptomatic persons with conducted high-quality investigations					MoH, NTCP, NHIC, FG
		Procurement of the mobile radiologic digital equipment					Number of procured stationary digital radiologic equipment					MoH, NTCP, NHIC, FG, local authorities
		Development of the computerized data basis for the persons examined using the mobile digital equipment					The data basis functional					NTCP HMC
		Procurement of radiologic film for the mobile digital radiologic equipment					The number of the people in the special groups examined for TB using the radiologic method					MoH, NTCP, NHIC, FG
		Remuneration for the staff operating the mobile digital radiologic equipment					Number of remunerated people					MoH, NTCP, NHIC, FG

MDG	Main interventions	Indicative interventions	Implementation period (2012 - 2015)				Monitoring indicator (2012 - 2015)				Res-possible partners	
			2012	2013	2014	2015	2012	2013	2014	2015		
		Active detection of tuberculosis (ensuring radiologic examinations) within the vulnerable groups of the population					The number of the people in the special groups examined for TB using the radiologic method					MoH, PHC, NTCP
		Active detection of tuberculosis (IDR Mantoux 2UT for children) in the vulnerable groups					The number of the people in the special groups examined for TB using the IDR Mantoux 2UT method					MoH, PHC, NTCP
		Procuring the radiologic film for the active detection of the tuberculosis in the vulnerable groups					The number of purchased films					MoH, NTCP, NHIC, FG
		Procuring Tuberculin and tuberculin syringes for the active detection of the tuberculosis in children in vulnerable groups					The amount of purchased tuberculin, syringes					MoH, NTCP, NHIC, FG

MDG	Main interventions	Indicative interventions	Implementation period (2012 - 2015)				Monitoring indicator (2012 - 2015)				Responsible partners
			2012	2013	2014	2015	2012	2013	2014	2015	
	Appointing a person in charge of TB at the level of PHC, who will perform and report activities related to TB screening of the socially-vulnerable population.	Development and implementation of incentive mechanisms for the staff of the placement centres, NGOs, volunteers in the TB screening activities within vulnerable groups					The mechanism developed; The mechanism implemented				MoH, NTCP, WHO
		Development and implementation of incentive mechanisms for the primary health care staff involved in TB control activities implemented within the vulnerable primary health care (PHC)					The mechanism developed; The mechanism implemented				MoH, NTCP, WHO
		Ensuring the remuneration of the primary health care staff, who will be implementing and reporting the TB control activities in the socially-vulnerable groups					The number of nurses within the PHC involved in TB control activities remunerated				MoH, NTCP, NHIC, FG
	Provision of alternative conditions for the continuation of inpatient treatment in specialized facilities, particularly for homeless people, those coming from vulnerable families.	Training the primary health care network staff (PHC)					The number of the PHC network staff trained on TB control				MoH, NTCP, SUMP „Nicolae Testemițanu”

MDG	Main interventions	Indicative interventions	Implementation period (2012 - 2015)				Monitoring indicator (2012 - 2015)				Responsible partners	
			2012	2013	2014	2015	2012	2013	2014	2015		
		Developing and implementing payment mechanism for the inpatient treatment, in the specialized facilities, particularly for the homeless persons, persons in vulnerable families					The mechanism developed; The mechanism implemented					MoH, NTCP, NHIC, FG Ministry of Labour, Social Protection and Family, local authorities
		Performing TB patients' education activities					The number of conducted activities					MoH, NTCP, PAS Center Soros Ministry of Labor, Social Protection and Family, local authorities
		Developing and supporting peer-to-peer support groups					The number of meetings held in the specialized facilities					MoH, NTCP, PAS Centre Soros Ministry of Labor, Social Protection and Family, local authorities

MDG	Main interventions	Indicative interventions	Implementation period (2012 - 2015)				Monitoring indicator (2012 - 2015)				Res-possible partners	
			2012	2013	2014	2015	2012	2013	2014	2015		
		Training of mid-level health care staff in the specialized facilities on TB patients education activities for the period of staying in the hospital					The number of mid-level health care staff in the specialized facilities trained on TB patients education activities					Moh, NTCP, SUMP „Nicolae Testemi- țanu”
		Ensuring support to increase the treatment compliance of the TB patients: creating counselling groups					The number of trained counsellors.					Moh, NTCP, PAS Center Soros Ministry of Labor, Social Protection and Family, local authorities

MDG	Main interventions	Indicative interventions	Implementation period (2012 - 2015)					Monitoring indicator (2012 - 2015)					Res-possible partners	
			2012	2013	2014	2015	2012	2013	2014	2015				
Strengthening infection control in specialized facilities														
	Modernization of the infrastructure in the facilities specialized in TB	Modernization of the infrastructure in facilities specialized in TB treatment by strengthening the infection control at the engineering level: purchasing HEPA filter devices for air cleaning in the hospital rooms, purchasing display UV lamps												MoH, NTCP, WHO
		Permanent maintenance of the mechanic ventilation systems in the specialized phthisio-pneumologic and LR facilities												MoH, NTCP, WHO
		Ensuring individual infection control devices for the staff of the specialized phthisio-pneumologic and LR facilities												MoH, NTCP, WHO
		Ensuring infection control measures in the LR, purchasing HEPA filters												MoH, NTCP, WHO

MDG	Main interventions	Indicative interventions	Implementation period (2012 - 2015)				Monitoring indicator (2012 - 2015)				Res-possible partners	
			2012	2013	2014	2015	2012	2013	2014	2015		
		Purchasing the equipment for the air-flow speed and UV-rays intensity measuring					The number of purchased equipment for the air-flow speed and UV-rays intensity measuring					MoH, NTCP, WHO
	Provision of an alternative for the patient to select the treatment method and provision of financial support for these methods by providing incentives, reimbursements for the patient.	Purchasing the device for the respirators' pressurization test.					The number of purchased devices for the respirators' pressurization test.					MoH, NTCP, WHO
		Development and implementation of the TB patient stimulation mechanisms aimed at increasing the compliance with treatment					The mechanism developed; The mechanism implemented					MoH, NTCP, MLSP, FG, LPA, WHO
		Ensuring the support aimed at increasing the adherence to treatment: food and hygienic product packages (checks) for the patients upon receiving each dose					The number of assisted TB patients					MoH, NTCP, MLSP, FG, LPA, WHO

MDG	Main interventions	Indicative interventions	Implementation period (2012 - 2015)				Monitoring indicator (2012 - 2015)				Responsible partners	
			2012	2013	2014	2015	2012	2013	2014	2015		
		Ensuring the support aimed at increasing the compliance with the treatment: travel costs for the patients for travelling to the treatment centre					The number of assisted TB patients					MoH, NTCP, MLSP, FG, LPA, WHO
		Ensuring the support aimed at increasing the adherence to treatment, covering the additional costs incurred by the patients					The number of assisted TB patients					MoH, NTCP, MLSP, FG, LPA, WHO
		Ensuring the support aimed at increasing the adherence to treatment: education and information materials for the patients					The number of assisted TB patients					MoH, NTCP, MLSP, FG, LPA, WHO
	Training of public health, phthisio-pneumologic, PHC and social services in infection control measures	Initial and refreshment training of the staff					Number of trained people					MoH, FG, NTCP, SUMP "Nicolae Testemițanu"

BIBLIOGRAPHY

HIV

1. Bivol S., Scutelnicuic O., Parkhomenko J., "Evaluation of services of Prevention of HIV Mother to Child Transmission in the Republic of Moldova". Report 2009. Chisinau 2010. In print.
2. Center PAS. Progress reports for the project Social Support to PLWH and Strengthenin ARV Treatment Adherence. Unpublished work.
3. European AIDS Treatment Group et al. Access to ARV drugs in seven Former Soviet Union countries in year 2007.
4. GenderDoc-M. Progress Report on the Project "Social Integration of the LGBT community in Moldova". Submitted to Cordaid Foundation February, 2006. Unpublished work.
5. Gutu Luminita, „Epidemiological and social aspects of the HIV/AIDS in the Republic of Moldova” thesis of doctor in medicine, Chisinau, 2009.
6. IDIS Viitorul. "Youth in Moldova 2008. Assessment of the situation of Youth in the Republic of Moldova". Chisinau 2009. In print.
7. Ministry of Health of the Republic of Moldova. Order no. 344 from 05.09.2007 „Regarding the development of Voluntary Counseling and testing Service”.
8. Moldovan National League of People Living with HIV in Moldova. Report on the situation in the Republic of Moldova as of April 2006. Unpublished work.
9. Mortimore G., "A review of the current National HIV/AIDS delivery infrastructure including the development of a new organizational model for the coordination of HIV/AIDS prevention, treatment and care services in the Republic of Moldova." December 2009. Unpublished work.
10. National Blood Transfusion Center. "Blood Safety in the Health System of the Republic of Moldova in years 2008-2009 and Future Perspectives." Report presented for UNGASS progress report 2010. Unpublished work.
11. National Blood Transfusion Center. Annual activity report 2008. Unpublished work.
12. National Center of Health Management. National Report Republic of Moldova. "Monitoring the Declaration of Commitment on HIV/AIDS." January 2006 – December 2007. Chisinau 2008.
13. National Center of Health Management. "National monitoring data of the activity of VCT centers in years 2008 and 2009." Data extracted from national VCT data base.
14. National Center for Preventive Medicine. National HIV Database 2008.
15. National Coordination Council for HIV/AIDS & TB of the Republic of Moldova. Assessment Report: HIV/AIDS M & E System. Chisinau, 2009. Unpublished work.
16. National Coordination Council for HIV and TB. National HIV/AIDS Monitoring and Evaluation Plan 2006 – 2010. Updated and amended after MTR 2008. Unpublished work.

17. National Coordination Council, UNAIDS Moldova. "Midterm Review of the National Programme on Prevention and Control of HIV/AIDS/STIs 2006-2010." March 2009. Accessed on January 15, 2010: <http://www.aids.md/information/library/d31118/>.
18. Project Coordination, Implementation and Monitoring Unit of the Ministry of Health of the Republic of Moldova. MOL-607-G03-H. "Scaling-up Access to Prevention, Treatment and Care under the National Program for Prevention and Control of HIV/AIDS/STIs 2006-2010". Grant Performance Report. External Print Version, 17 December 2009. Unpublished work.
19. Scutelnicuic O., Bivol S., "Behavioral and Sentinel HIV Surveillance Moldova 2007". Chisinau, 2010.
20. Scutelnicuic O., Iliinschi E., "Surveillance of Risk Behavior associated to HIV. Assessment of Risks to HIV infection among young Injecting Drug Users, Men having Sex with Men, Commercial Sex Workers and Juveniles in Detention." Chisinau 2010.
21. Scutelnicuic O., Condrat I., Gutu L., "Youth's Knowledge, Attitudes and Practices regarding HIV/AIDS." 2008, Chisinau. Rolsi Media SRL, 2008. ISBN 978-9975-9526-3-7.
22. Scutelnicuic O., Bivol S., Osoianu L., "Families and Children Affected by HIV and AIDS Situation Analysis 2008." Survey Report
23. Scutelnicuic et al. 5-year evaluation. Republic of Moldova. Health Impact Evaluation Study Area 3. HIV/AIDS Report. Chisinau 2008
24. Smolskaya T., Yakovleva A., Kasumov V., Gheorgitsa S., "HIV Sentinel Surveillance in highrisk groups in Azerbaidjan, Republic of Moldova and in the Russian Federation."
25. Soltan V., Damian E, Bivol S. HIV Prevalence among New TB registered Cases in the Republic of Moldova. Operational study. Final report. Chisinau 2008
26. Steffan E., Sokolowski S., "The Health Risks of Migration: The Link between Health and Migration with Particular Consideration of Knowledge and Attitudes towards HIV/STIs and the Sexual Practices of Moldovan Migrants." Final report. Unpublished work.
27. Subata E., "Final Report on the Evaluation of Methadone Maintenance Therapy in the Republic of Moldova 2007". Unpublished work.
28. Subata E., "Final Report on the Evaluation of Opioida Substitution Therapy in the Republic of Moldova 2009". Unpublished work.
29. Technical Working Group on HIV Care and Treatment. Activity report for mid-term evaluation, 2009. Unpublished work.
30. USAID Project on HIV/AIDS and Hepatitis B and C Prevention. "Medical personnel's knowledge, attitudes, and practices with regard to nosocomial infections supervision and control (based on the results of sociological research)." Study report. Unpublished work.

TB

1. Assessment of risk factors associated with adherence to treatment of patients with multi-drug resistant tuberculosis (MDR TB) enrolled in the DOTS Plus treatment. Chisinau 2010
2. Risk factors associated with the abandonment and failure of the strictly supervised treatment of tuberculosis in the Republic of Moldova. Chisinau 2009
3. Tuberculosis in Moldova: Knowledge, Attitude and Practice in Population Behaviour. Chisinau 2004
4. Tuberculosis: Knowledge, Attitudes and Practices. Chisinau 2008
5. The report „Anti-tuberculosis drug resistance surveillance. Republic of Moldova– 2006. National Study”
6. NATIONAL PROGRAMME on tuberculosis control for 2011-2015
7. WHO policy on TB infection control in health-care facilities, congregate settings and households, WHO, 2009
8. Report of the Mission for Infection Control in Tuberculosis, Moldova, November 22 – 28, 2009
9. Health systems and M/XDR TB mission report to Moldova. Bert Schreuder, 1 iulie 2011
10. GLT monitoring mission to the Republic of Moldova october 2011, temporary advisor Dr. Soren Thybo
11. Worldwide: Incentives for Tuberculosis Diagnosis and Treatment, 2008, Center for Global Development | www.cgdev.org
12. Ciurea D (2007). Studiu de fezabilitate privind necesitatile din Asistenta Medicala Primara [Feasibility study: development of a master plan and assessment of primary health care]. Chisinau, World Bank (<http://www.ms.md/public/international/proiects/AsistentaSociala/>)
13. Mobile targeted digital chest radiography in the control of tuberculosis among hard to reach groups. Health Protection Agency Centre for Infections for Department of Health – November 2007
14. C. Didelescu. Depistarea intensivă a TB la persoanele instituționalizate. REVISTA MEDICALĂ ROMÂNĂ – VOL. LV, NR. 1, AN 2008



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