CURATIO INTERNATIONAL FOUNDATION

EVALUATION OF THE HIV MONITORING AND EVALUATION SYSTEM IN REPUBLIC OF MOLDOVA

FINAL REPORT

RFP: CQS_MDA_H/CS/12_2017

CONFIDENTIAL

November, 2017

PREPARED BY: TAMAR GOTSADZE, MD., PHD

ABBRIVIATIONS

CSW	Commercial Sex Workers
CNAM	National Health Insurance Company
CSO	Civil Society Organizations
DHS	Demographic and Health Survey
DIP	Department of Penitentiary Institutions
DQA	Data Quality Assurance
ET	Evaluation Team
GAM	Global Aids Monitoring
GF	The Global Fund to fight Aids, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IDU	Intravenous Drug Users
KAP	Knowledge, Attitude and Practice Survey
KP	Key Population
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
MoLHSA	Ministry of Labor, Health and Social Affairs
MSM	Men who have sex with men
NAP	National AIDS Program
NASA	National AIDS Spending Assessment
NCC	National Coordination Council
NCHM	National Centre of Health Management
NCU	National Coordination Unit
NGO	Non-Governmental Organization
NGO	Non-governmental Organization
NHA	National Health Accounts
NPHA	National Public Health Agency
NPHC	National Public Health Center
PLWH	People Living with HIV
PR	Principle Recipient
PWID	People Who Inject Drugs
RB	Right Bank of Dniester River
RND	Republican Narcology Dispensary
SDMC	Dermatological and Communicable Diseases Hospital
SR	Sub-Recipient
STI	Sexually Transmitted Infections
TB	Tuberculosis

TOR	Terms of Reference
TWG	Technical working group
UCIMP	Coordination, Implementation and Monitoring Unit of the Health System Projects
UNAIDS	Joint United Nations Program on HIV/AIDS
UNGASS	UN General Assembly Special Session
VCT	Voluntary Testing and Counselling

TABLE OF CONTENT

LIST OF TABLES

LIST OF FIGURES

1. INTRODUCTION

1.1. COUNTRY CONTEXT

The Republic of Moldova is a landlocked country in south-eastern Europe, bordered by Ukraine and Romania on the east and west respectively. Its largest part lies between two rivers, the Dniester and the Prut. It is one of the most densely populated countries of the former Soviet Union (106 inhabitants/km2), and has a population of approximately 4.2 million (last census in 1994), 790 000 of whom live in the capital city of Chisinau. About 53% of the population lives in rural areas. An estimated 500 000 people live in the Transnistria region[1] (the figure could be lower because of migration patterns).

1.2. BACKGROUND

Reliable information is one of the most important determinants in the process of development and implementation of efficient and effective strategies. Information represents the evidence base for establishing the framework, soundly based on the status quo, for efficient interventions to prevent the spread of HIV. Together with other countries, the Republic of Moldova participated at the UN General Assembly in 2016 where the Political Declaration On the Fast-Track to End AIDS in the age of Sustainable Development was signed. Also, it is part of the Dublin Declaration and of the WHO Global Strategy on Health sector. The joint Monitoring and Evaluation system of the National Programme on Prevention and Control of HIV/AIDS and STI in the Republic of Moldova has been implemented since 2005. Over the years, this system passed through a series of system strengthening stages, but it is yet premature to state that the system is fully functional and satisfies all the key information needs. However, relevant strategic information has been obtained and made and accessible to inform the decision-making process in the national response to HIV.

1.3. NATIONAL RESPONSE TO HIV/AIDS AND SEXUALLY TRANSMITTED DISEASES EPIDEMIC

The National AIDS Program (NAP) for years 2016-2020 was approved by the Government Decision of 22 October 2016. This program is a continuation of the previous one. However, unlike previous program, it emphasis the expansion of testing with a view to early detection and service integration. The overall goal of the NAP is to minimize the consequences of HIV and STIs epidemic by reducing transmission, as well as the mortality associated with HIV particularly among key-population (KP). The program has ambitious targets to be reached by 2020. Namely it aims at achieving the coverage of risk groups with prevention services 60% of IDUs and CSW and 40% of MSM by 2020. The People Living with HIV (PLWH) coverage with HIV antiretroviral treatment by 2020 - at least 60% of the estimated PLWH.

The NAP has three main objectives detailed below:

Objective 1. To prevent HIV and STIs transmission, particularly among key-populations.
Achievement of the given objective will be measured by prevalence of HIV among KPs:

1. PWID not higher than 20%;
2. CSWs – not higher than 11%;
3. MSM – not higher than 5%;
4. prisoners – not higher than 3.5%;
5. general population not higher than 0.44%.

Objective 2. To ensure universal access to treatment, care and support of all people infected with STIs
The impact targets for the given objective has been defined as:

1. HIV-related death rate per 100 000 people < 3;

[1] Right Bank (RB) of Dniesetr River

2. % of adults and children with HIV still alive and known to be on treatment after initiation of antiretroviral therapy:
    a. after 12 months - not lower than 80%
    b. after 24 months – not lower than 75%,
    c. after 60 months – not lower than 70%;
3. Percentage of infants born to HIV-infected mothers – not higher than 2%.

Objective 3. To ensure an efficient Programme management

Impact and outcomes within this objective will be measured using the UNGASS National Composite Policy Index and through mid-term and end-of-project evaluations. The success of this objective will be measured by the extent to which objectives 1 and 2 of the program are achieved.

A set of indicators has been developed and agreed by all stakeholders to support monitoring and evaluation, and the technical groups have developed a log-frame to support the implementation of the National Programme.

The HIV M&E system in Moldova is immature and there are yet some inherent weaknesses:

- Lack of some institutionalized routine reporting mechanisms for inter-sector reporting;
- Limited allocations to the M&E system from the state budget; overreliance on international financial support that curtails sustainability
- Gaps in national technical expertise in data collection, analysis and presentation
- Due to political constraints around the region of Transnistria, full coverage with comprehensive M&E of the region is complicated
- Operational research for evaluation of activities is fragmented and not systematic
- Data Confidentiality issues
- Partially functioning electronic based register of HIV patients, partially functioning unique identifiers software and drug management systems
- Lack of relationship between surveillance and M&E System, Treatment System, etc.

Aiming at ensuring programmes sustainability, the service optimization and efficiency, as well as in view of the upcoming development of the GFATM funding continuation request for 2018-2020 in an informed and evidence-based manner it is the country's intention to perform assessment of M&E System (on the right border). The evaluation is expected to comprehensively assess the M&E system aimed at – standardizing the reporting forms, build the national information flow within HIV related organizations, developing the national M&E System and Plan. The evaluation has to provide recommendations for improvement of M&E System, enhance its quality and comprehensiveness, including coordination and sustainability of the system.

The evaluation assesses the M&E system in Republic of Moldova. Type of indicators and data flows are assessed from the first service contact level up to the national level; between different sectors and with emphasis on Transnistia region.

Primary intended users of the evaluation results are the Ministry of Health (MoH) and other sectorial ministries under the leadership of the National Coordination Council. The Program Management structure, regional health authorities, health and other service providers will largely benefit from enhanced and comprehensive M&E system, for which the evaluation will formulate recommendations.

1.4. EVALUATION METHODOLOGY

To achieve overarching objective of the assignment the phased approach was used. The assignment was implemented in three phases: In the first Inception phase, the Evaluation Team (ET) carefully examined all

documents collected and identified information gaps. The desk review informed necessary adjustments of the M&E system Assessment tool recommended by the UNAIDS[2]. At the end of this phase the inception report was prepared and shared with the Contracting Agency, Program and M&E Coordinators for their comments and suggestions. Comments and suggestion solicited were considered during the filed data collection phase. In the second, Data Collection phase, a one week mission to the country was undertaken to collect data (qualitative as well as quantitative). At the end of the evaluation mission, preliminary findings and recommendations were presented to M&E Technical Working Group (TWG) of the National Coordination Council to validate preliminary findings and recommendations and collect initial comments. Comments solicited were addressed during the report writing phase (Phase 3). Furthermore, the draft report was subject to a formal internal review process and quality assurance. Furthermore, the draft report was presented to the key stakeholders in the country to validate findings and solicit stakeholder comments/suggestions. The final report incorporates recommendations and comments by the country based reviewers and stakeholders. The Results of the final report will be presented on a round table organized by the Contracting Agency.

The evaluation was largely guided by the UNAIDS HIV M&E System Assessment framework which contains 12 components. The evaluation used a mix methodologies:

- **Desk reviews** of available documents: to thoroughly appreciate the background, context and progress so far in order to ensure the review is founded on documented evidence (Annex 1: List of Documents Reviewed).
- **Meetings and interviews with relevant stakeholders** (policy-makers, health care providers, NGOs working with beneficiaries and key affected populations): to inform the review with the insights, experience and perspectives of those who know the programmes best (Annex 3: List of People Met);
- **Visits to selected healthcare facilities/units in Balti and Transnistria**: both to gather information and understanding from field-level staff, and to ensure a reality check for all perspectives;
- **A round-table discussion** with interested stakeholders to explain the analysis, explicate challenges, and explore possible solutions;
- **A Report** setting out the analysis, findings and recommendations;
- **A consensus meeting** on findings with the interested stakeholders to ensure that proposals are owned by stakeholders.

[2] 12 Components Monitoring and Evaluation System Strengthening Tool , UNAIDS
http://www.unaids.org/sites/default/files/sub_landing/files/2_MERG_Strengthening_Tool_12_Components_ME_System.pdf

2. EVALUATION RESULTS

This chapter of the report is forward looking and assesses 12 components of the HIV M&E system, which will be in place at the beginning of the reviewed NAP starting from January 2018.

2.1. ORGANIZATIONAL STRUCTURES WITH HIV M&E FUNCTIONS

The National Monitoring and Evaluation System is Government-based and Government-led. The National M&E system has important functions at national, territorial and service provision levels. At National level, there are number of organizations been involved in M&E.

Dermatological and Communicable Diseases Hospital (SDMC): SDMC, national institution providing HIV/AIDS treatment services at national level to people living with HIV and AIDS patients, has been assigned as a National Institution responsible for the coordination and M&E of the National AIDS Program 2018-2020. At the SDMC a National Coordination Unit (NCU) was established in 2016 by the MoH Decree[3] with clear functions, staffing, roles and responsibilities. NCU represents the gatekeeper to the one national monitoring and evaluation mechanism at the country level and implements the system by monitoring the set of indicators, which has been developed and agreed by all stakeholders to support monitoring and evaluation of the NAP, The Global Fund to fight Aids, Tuberculosis and Malaria (GF) reports and ensures regular international reporting with all proper consultations and data collection analyses, interpretation and validation.

The range of management tasks performed by this unit includes strategy development and planning, forecasting and management of drugs and consumables, coordination with implementing agencies/organizations, supervision and M&E of the NAP. NCU has staffed M&E position (full position), apart from staff responsible for monitoring prevention, treatment and laboratory services. NCU staff is largely financed from the hospital budget except for M&E specialist, being funded through the GF grant. The latter consequently raises concerns of sustainability when GF funding ends.

Apart from SDMC, responsibility for monitoring the NAP implementation have other national level bodies described below.

National Coordination Council: In the Republic of Moldova, there is a single National Coordination entity, the National Coordination Council (NCC) in the area of TB and HIV, an inter-ministerial decision-making body which includes government stakeholders, representatives of people living with HIV, NGOs as well as international community. The NCC is a decision-making body, placed under the MoH[4,5]. The Minister of Health[6] chairs the NCC and maintains the NCC Secretariat, having also a leading role in implementation of the NAP. The coordination is considered good and efficient within the Health Sector, while according to the stakeholders creates challenges for inter-sectoral coordination.

NCC M&E TWG: The NCC has 14 functional technical working groups (TWG) including M&E TWG, aiming towards improved data quality and better information flows in the routine statistics, as well as improved national capacities in operational research. M&E TWG has wide representation of all key stakeholders from public and civil society organizations (CSO), meets regularly on a quarterly basis and more frequently when required. Meetings have clear agenda and decisions made are spelled out in the meeting minutes. The TWG practices annual planning of work, albeit last available plan is dated by 2016. The M&E TWG does not have specific Terms of Reference (TOR), as all TWGs, formed under the NCC, have one generic TOR, which possibly limits effectiveness of the TWG work.

[3]

[4] After the recent merger of the Ministry of Health and Ministry of Labor and Social Affairs, the Ministry's name changed to Ministry of Labor, Health and Social Affairs (MOLHSA), but for this report the abbreviation MoH is used.

[5] Chair Minister of Health, co-chair Minister of Education, chief of League of PLWH

[6] NCC membership has not been yet updated since the merger of two ministries

MoLHSA: The Department of State Programs of the ministry has the overall responsibility to supervise the implementation of the national programs. Albeit department's function is limited to planning and reporting only.

The National Centre of Health Management (NCHM)[7], a public institution, subordinated to the Ministry of Health, responsible for the data quality control and external audit, also acting as a technical hub supporting M&E processes of all National Programmes. NCHM collects and reports vital statistics data and public health related data to the National Statistics Bureau, the main data collection and analysis institution at central level. To monitor all NPs in 2004 the M&E Unit has been established in the NCHM, albeit later the unit was dissolved. In line with ongoing administrative reforms, the NCHM is planned to be merged under the new, National Public Health Agency (NPHA). Albeit de jure the merger has been approved, de facto the role, organizational place, staffing and division of responsibilities among staff of NCHM within NPHA, is yet to be defined.

National Public Health Center (NPHC): The National Public Health Center is a public institution subordinated to the MoH and founded following the adoption of the Law Nr.1513-XII from 16.06.93 on the sanitary-epidemiological safety for population. The NPHC focuses on health promotion and disease prevention by overseeing activities in preventive field medicine and sanitation, public health surveillance, capacity building and policy development. The NPHC is actively involved in behavior change monitoring through various research and 2nd generation studies, but due to the funding flows from external donors, full execution of functions, such as behavior change, monitoring is limited. Similar to NCHM, the NPHC de jure became a sub-structure of the NPHA, but the role, organizational place, staffing and division of responsibilities among staff of NPHC within NPHA, is yet to be defined.

At the national level, **other Ministries** lack a specific mandate in HIV M&E and staff/units with primary responsibilities in HIV M&E are difficult to justify in the context of a concentrated epidemic like Moldova. There are Divisions for Analysis and M&E of Policies within all Ministries, that have broad M&E functions and a standard TOR across all Ministries. If appropriately trained, these divisions could institute/act as HIV M&E focal points within respective Ministries. As to the profile of such M&E staff, database administrators and/or epidemiologists are lacking within other Ministries.

UCIMP: Coordination, Implementation and Monitoring Unit of the Health System Projects (UCIMP), a public agency subordinated to MoLHSA, has been one of the Principle Recipients (PR) of the Global Fund funding. Starting from 2018, UCIMP will become the only public PR of GF grant for the next three years. The organization functionally responsible for implementation of the GF grant activities, including contracting of services from NGO sector and goods and respectively contributing towards NAP M&E Framework. In order to ensure its M&E responsibilities, it has one full time staffed M&E position.

National Health Insurance Company (CNAM): Starting from October 2017, CNAM will be contracting NGOs providing harm reduction services to Injection Drug Users (IDU)s from its prevention fund. At the time of evaluation contracting of the NGOs was in the process, contracts under the development but reporting requirements along with performance indicators not yet defined. At present experience of CNAM in contracting NGOs and monitor harm reduction services is limited. Whilst CNAM has well established and experienced M&E unit in monitoring the quality of provided services at the medical facilities, methodology, tools, knowledge and skills to monitor the quality of harm reduction services is lacking.
The **Republican Narcology Dispensary (RND)** is equipped with one unit whose functions include data aggregation and control, while the **National Blood Transfusions Center** also has positions with similar functions. The respective M&E units are also mandated with HIV M&E.

[7] Founded by the Decision of the Government of Republic of Moldova No. 387 from 25.04.97 "On the foundation of the Scientific and Practical Centre of Public Health and Health Management" and reorganized in National center of Health Management by the Decision of the Government of Republic of Moldova No. 1247 from 16.11.2007 „ On the National Centre of Health Management"

Department of Penitentiary Institutions (DIP): DIP, subordinated to the Ministry of Justice, is responsible for the provision of the HIV services to risk group detainees through its medical facilities. DIP has fully staffed M&E position, maintains database for registration of cases and formulation of regular reports to respective institutions and agencies.

AIDS Center in Transnistria region: AIDS center in Transnistria region, is responsible for the data collection and analysis of the epidemiological situation, maintenance of official statistics, planning of activities and confirmation and reference tests for HIV/AIDS. The Center has a full time staffed M&E position and collaborates well with SDMC as well as other partners involved in implementation of NAP. In line with NAP, Transnistria region develops state HIV/AIDS/STI program and indicators for measurement of the program performance is in line with NAP indicators. According to key informants further enhancement of M&E capacities and capabilities are required.

Service providers: At service provision level, there are certain HIV and HIV M&E responsibilities attributed to different persons/units within medical facilities at primary healthcare level – the infectionist, the family doctor, the statistics division. In addition to public entities, domestic NGOs working in the field of HV/AIDS in Moldova make an invaluable contribution to the national response, particularly in the areas of service provision and prevention. NGOs also manage and implement the majority of activities supported from the GF grants and other international donors. NGO service providers often do not have specifically-appointed M&E personnel. Due to shortage of human resources and time, these responsibilities are frequently formal in nature and capacities are limited.

The diversity of actors, and the participatory strategic planning, implementation, monitoring and evaluation processes of the NAP imperatively request a clear vision of the levels of the multi-sectoral comprehensive M&E system, of the roles stakeholders play within the system hereto and the data flows. Clear implementation benchmarks and reporting are imperative components of M&E system strengthening interventions.

The strength and weakness of all "Organizations with the mandate of M&E" component is summarized in the Table 1 below.

Table 1: Organizational Structures with M&E Functions: Strength and Weaknesses

STRUCTURE	STRENGTH	WEAKNESSES
M&E TWG	- M&E TWG meets regularly on a quarterly basis with clear meeting agenda - Meeting minutes available and spell decisions made by the TWG - M&E TWG annual action planning practiced	- M&E TWG TOR too general not guiding roles and responsibilities of the TWG. - Delegation of roles and responsibilities within the M&E TWG is decided spontaneously. - TWG meetings became rare in 2017 and there is no TWG action plan available since 2016
Department of State Programs	- Has functional responsibility for National Program oversight - Has responsibility for program planning and reporting to the MoLHSA and Government	- Does not have M&E function and is principle recipient of the M&E results for formulation of required reports
National Coordination Unit at SDMC	- CU is established according to the MoH Decree - Has clearly defined functions, structure and responsibilities - Has staffed separate M&E position - Staff of CU is mostly financed through hospital budget	- M&E position at CU is fully funded by external resources that raises concerns of sustainability when external funding ends

National Centre of Health Management	- Technical hub supporting M&E processes of all National Programmes - Collects medical statistics data - Responsible for data quality control and external audit - Responsible for National Health Accounts	- Is under the process of reorganization - Future functions and structural divisions not yet clear - Staffing norms limits execution of functions at full range - National Health Accounts lacks HIV module to track HIV/AIDS expenditures
National Public Health Center	- Functionally responsible for health promotion and disease prevention, epidemiological surveillance and behavior change monitoring	- Is under the process of reorganization - Future functions, structural divisions, division of roles and responsibilities not yet clear - Due to the funding flows from external donors, execution of functions such as behavior change monitoring is limited.
UCIMP	- Institution responsible for administration of GF funded grant – the only Principle Recipient (PR) of the GF grant starting from 2018. - Has a separate staffed M&E position, fully funded by the GF grant - Responsible for monitoring and reporting of inputs and processes/outputs of the GF grant - Has one full time M&E position	- Reporting requirements and forms to be updated in view of expanded service provision - M&E position at CU is fully funded by external resources that raises concerns of sustainability
CNAM	- Reach experience of contracting and monitoring health service provider organizations (health facilities)	- Lack of experience in contracting harm reduction and preventive services, especially from non-health service providers; - Absence of reporting forms, methodology and tools for monitoring harm reduction services provided by NGOs - Staff of M&E unit are clinicians, but does not necessarily have sufficient knowledge about HIV services
Transnistria region AIDS Center	- Participates in the development of the state HIV/AIDS/STI program; - AIDS Center has staffed separate M&E position; - Facilitates regular data collection	- Further enhancement of M&E capacities and capabilities are required
Service providers	- M&E positions available in few service providers (public and NGOs)	- Majority service providers do not have M&E positions - Where M&E positions are available, there is absence of the clear Terms of Reference for staff

2.2. HUMAN CAPACITY FOR MULTI-SECTOR HIV M&E

The current organizational systems for managing M&E are complex and, as a result, human resources are needed in many different places. There are three levels where capacity is required to ensure overall performance of the HIV M&E system: system, organizational and individual. This section below details evaluation results at each level.

System Level: The evaluation has identified a shortage of qualified human resources at all levels of the national M&E system, ad-hoc approaches to capacity building versus institutionalized M&E capacity building. M&E capacity building events excessively rely on external technical assistance and funding that curtails sustainability. The country lacks national M&E curriculum and M&E related trainings are not well integrated into undergraduate and postgraduate education programs. A distance learning programme on HIV/AIDS has been developed in collaboration with the School on Public Health Management of the State University of Medicine and Pharmacy "Nicolae Testemitanu" in 2013/2014. This curriculum contains the following modules: General Overview on HIV/AIDS, Epidemiology and Control of HIV/AIDS, Care and Support of people living with HIV/AIDS, Surveillance and care of HIV infected patients, Voluntary Counseling and Testing, Coverage of Most at Risk Populations, Human Rights in the context of HIV/AIDS, Monitoring and Evaluation in the context of HIV/AIDS. The given distance learning program is not free of charge; thus, NGOs find difficult to allot payment from their resources. Alternatively, there is no mechanism for the development of the NGO human resources.

A barrier identified in human resources strengthening is the limited motivation and professional growth of M&E staff. For example, the public service inventory does not include the position of specialist in M&E in the list of professions, hence the motivation to pursue an education in M&E is limited. However, an opportunity encouraging capacity building in M&E for staff in the health sector is the requirement of 400 hours of in-training/refresher training within a 5-year period in order to be accredited/receive qualification. Low pay scale in public health sector and absence of carrier path development, demotivates knowledgeable people to apply to M&E positions in the public sector. In support of accreditation/qualification system, a national database of resources trained is maintained at the NCHM, with the aim to avoid duplication and assure complementarity. Country lacks system(s) in support of M&E capacity development in civil sector.

Organization Level: Majority of public organizations and NGOs, involved in coordination and/or implementation of NAP, do not have M&E positions, thus M&E function is assigned to staff who has other regular functions to complete within the organization. In most NGOs/CSOs, there is a full-time position of registrator. Few exceptions, where a separate staff position is allotted for M&E, are SDMC, Republican Narcology Dispenser, AIDS Center in Transnistria region, UCIMP, PID and couple of CSOs, where at least one full staff position is assigned to M&E. Most of M&E staff deployed in these organizations/institutions lack a clear TORs.

Individual Level: Staff responsible for M&E function in both, public institutions and NGO sector, have received trainings in M&E few years ago. Since than no formal "of the job" trainings have been organized, rather staff responsible for M&E in NGO sector receive on-the-job trainings from PR/SRs (Soros Foundation, Positive Initiative and PAS Center) during regular supervision/monitoring visits. On-the-job trainings are less reported in the public health institutions. Provided, that majority of staff responsible for M&E, perform other regular duties, little time is left to perform effective M&E functions. Low salaries and lack of carrier development is additional factor negatively affecting M&E function on public institutions.

The strength and weakness of "Human Resource Capacity" component is summarized in the Table 1 below.

Table 2: Human Resources: Strength and Weaknesses

LEVEL	STRENGTH	WEAKNESSES
System	- A distance learning programme on HIV/AIDS, including M&E - Accreditation/qualification system that motivates staff training - National database on human resources trained	- Shortage of qualified human resources at all levels of the national M&E system - Ad-hoc approaches to capacity building versus institutionalized M&E capacity building; - Lacks national M&E curriculum; - Limited motivation and professional growth of M&E staff;

		- High Staff turnover due to labor migration; - Absence of mechanisms for training NGO personnel
Organization	- SDMC, Republican Narcology Dispenser, AIDS Center in Tiraspol, UCIMP, PID and couple of CSOs have full time staffed M&E positions - M&E specialist at NCU has clearly formulated TOR	- Absence of M&E positions in majority of organizations/institutions; - M&E functions are assigned to staff with other regular functionalities; - Where M&E positions are available, TORs for M& specialists are lacking
Individual	- On-the-job trainings are provided to NGO staff during supervision visits -	- On-the-job trainings are less reported in the public health institutions - Majority of staff responsible for M&E, perform other regular duties, little time is left to perform effective M&E functions - Low salaries and lack of carrier development is additional factor negatively affecting M&E function on public institutions

2.3. PARTNERSHIPS TO PLAN, COORDINATE AND MANAGE THE MULTI-SECTOR HIV M&E SYSTEM

There is a joint TWG on M&E for HIV and TB, and a TWG on Surveillance under the auspices of the NCC. As noted above formal TORs are generic for all TWGs. The National M&E Plan (2011-2015) outlines ambitious expectations of the M&E TWG as the coordination entity for M&E Plan/Workplan implementation, hence the TOR of the M&E TWG need to dully reflect such responsibilities.

The membership of the TWG on M&E is intersectoral with wide participation of key public stakeholders, NGOs and representatives of sub-national stakeholders (Transnistria region) as formal members with voting rights. International development partners actively participate in the National M&E TWG, both as members and invitees. However, membership currently being more on decision-making rather than technical level, it may represent a barrier in fulfilling the very technical functions vested by the National M&E Plan on the respective TWG.

Ordinary meetings are held on a quarterly basis. Meetings are also convened on an ad-hoc basis when the need arise. Minutes of the TWG meetings are taken and placed on the NCC website (www.ccm.md). Information pertaining to the TWG work is disseminated also through the NCC Bulletin. As of yet there is no formal mechanism to follow up on the decisions of the TWG. The TWG plan for upcoming years has yet to be developed and approved.

The strength and weakness of the given component is summarized in the Table 1 below.

Table 3: Partnerships to plan, coordinate and manage the multi-sector HIV M&E system: Strength and Weaknesses

STRENGTH	WEAKNESSES
- M&E TWG well represented and ensures wide participation of key public and NGO stakeholders - TWG meets regularly and communicates decisions through various channels	- Specific M&E TWG ToR has yet to be developed; - The membership is at decision-making level, making it difficult to have in place a truly technical mechanism actually performing the tasks of a TWG - The joint HIV/TB scope also limits the capacity of the TWG to operationalize its tasks and responsibilities - There are no formal mechanisms as of yet to ensure follow-up on the TWG decisions

2.4. NATIONAL MULTI-SECTOR HIV M&E PLAN

The national M&E plan for the new NAP (2018-2020) has yet to be developed, however as the NAP is a continuation of the previous program, the evaluation examined the national M&E plan of the previous NAP. It is believed that findings, summarized below, will inform the M&E Plan design for the period 2018-2020.

The national M&E plan (2015-2017) contains clearly-described indicators at a number of levels including impact, outcome, output and process. These are baseline and multi-year targets. Sources of information are clearly-described and flows of information are well-presented and understood. Methods of data collection and management are well-presented and well-understood.

There was a detailed assessment of the M&E system, using a 12-step process developed by the UNAIDS Monitoring and Evaluation Reference Group (MERG). Although it gives a very detailed assessment, The M&E Plan does not address all identified weaknesses. Out of 12 components, the plan fully cover 5 components (components 4,5,7,10, and 12), partially cover 5 components (components 1,2,3,9 and 11), whereas components 6 and 8 are fully ignored. Many important details have been only sketched or left out of the National M&E Plan. The Table 4 below summarizes results of the M&E plan assessment.

Table 4: M&E National Plan (2011-2015): Assessment of 12 M&E system components

#	Component	Addressed in M&E Plan 2011-2015	Comments
1	Organizational Structures	Partially	Separate sections of the M&E Plan give provisions to the organizational structure responsible to report and organizational structures responsible to receive reports. While this is commendable, it is recommended that the plan clearly describes organizational structure of the M&E system as a whole, unified system and defines roles and responsibilities of each structure with M&E functions.
2	Human Resources	Partially	The plan speaks about a need of capacity building of individuals tasked with M&E function at all levels, albeit the mechanisms for capacity building are not spelled out and the budget is not defined.
3	Partnership	Partially	The role and mechanisms for engagement of Transnistria region not clearly defined
4	National M&E Plan	Yes	
5	Costed National M&E Plan	Yes	
6	Communication & Advocacy	No	Communication and advocacy strategy missing
7	Routine HIV Program Monitoring	Yes	
8	Surveys and Surveillance Systems	No	Absence of the separate section describing surveys and surveillance system
9	National and Sub-National Databases	Partially	Fragmentation and non-functional databases have not been adequately addressed, with the exception of SEMI/HIV. Development/strengthening of data bases at right bank is not addressed
10	Supportive Supervision and DQA	Yes	
11	HIV Evaluation and Research	Partially	Detailed plan and responsibles for evaluation and other researches absent
12	Data dissemination and use	Yes	

In general, the approach of stakeholders in Moldova is determined strongly on trying to get additional financial resources for the HIV response. There has been little focus to date on using M&E data to determine which approaches are most needed and/or most effective and/or which interventions represent best value for money. There is little appreciation of the opportunity costs of current approaches to decision-making which appear to give equal focus to different elements of a response to HIV without clear prioritization. Furthermore, absence of sectorial, territorial and institutional level plans has been acknowledged by the evaluation.

The strength and weakness of national multisectoral M&E plan is summarized in the Table 5 below.

Table 5: National Multi-sectoral HIV M&E Plan: Strength and Weaknesses

STRENGTH	WEAKNESSES
- National M&E Plan is developed based on the NAP - Covers majority of M&E system components; - Contains clearly-described indicators (impact, outcome, output and process); - Each indicator has baseline and multiyear targets, responsible institutions, data verification means and implementation time period.	- National multisectoral M&E Plan for the NAP 2018-2020 yet to be developed along with M&E Operational manual; - In the old Plan, not all recommendations of the M&E system assessment are addressed in the plan; - Lack of sectorial, territorial and institutional-level M&E plans.

2.5. COSTED NATIONAL MULTI-SECTOR HIV M&E PLAN

The National M&E Plan (2015–2017) has been operationalized by a costed workplan that includes priority actions, roles and responsibilities of stakeholders, timeframes and budgets. The costs of the M&E work plan were not included in the Medium-Term Expenditure Framework (MTEF) for the reporting period. The new MTEF make explicit earmarking of funds for the NAP, including M&E costs; however, it reflects only costs and contributions of MoH, other Ministries being notoriously left out. Resources are only partly available to meet agency-specific M&E work plan requirements, and the absolute majority of such resources are from donors.

The strength and weakness of costed national multisectoral M&E plan is summarized in the Table 6 below.

Table 6: Costed National Multi-sectoral HIV M&E Plan: Strength and Weaknesses

STRENGTH	WEAKNESSES
- National M&E Plan for 2015-2017 is costed, provides annual financial allocations and identifies sources of funding	- Limited allocations to the M&E system from the state budget and over-reliance on international financial support, which curtails sustainability - The costs of the M&E work plan not included in the Medium-Term Expenditure Framework

2.6. COMMUNICATION, ADVOCACY AND CULTURE FOR HIV M&E

Data produced by the M&E system are available on the web in the public domain (for example on www.aids.md, www.ccm.md; www.cnms.md; www.cnsp.md;), their use in policy development, particularly by other entities than those in the health sector, is limited. The performance of the M&E system is communicated/reported frequently though NCC and TWG meetings, as well as national strategic planning processes and thematic workshops, but not adequately addressed in the M&E plan.

HIV/AIDS Monitoring and Evaluation Advocacy Plan, available to evaluation, has been developed by M&E TWG for 2011-2012, albeit the plan remained as draft and not implemented. There are people who strongly advocate for and support M&E in some of the entities – members of the NCC, while others, as the FBO and private sector, need further capacity building and efforts should be invested to enhance their involvement in national M&E processes. Within most of the line Ministries, there are promoters of HIV M&E but concerted technical support is needed to identify best ways to mainstream HIV M&E in existing sectoral M&E mechanisms and reporting flows.

The commitment of decision-makers and managers for M&E within some organizations is declaratory, while data is requested for reporting purposes, there is little engagement for allotting human or financial resources or for capacity building and motivation of staff. Informants noted, that most of organizations involved in implementation of NAP, lack analytical capacity to monitor achievements and use evidence for further planning. While HIV related information is requested before and/or during HIV review, planning and costing processes, data requested by managers is more related to process indicators than impact indicators.

> We are requested to regularly report on the number of beneficiaries and number of services provided, but rarely receive any feedback on the outcomes of our work…
>
> **Quote: from Key Informant**

The strength and weakness of communication and advocacy component is summarized in the Table 7 below.

Table 7: Communication and Advocacy: Strength and Weaknesses

STRENGTH	WEAKNESSES
- Communication channels well established - Members of the NCC strongly advocate for and support M&E in some entities	- M&E data requested by managers in most of the organizations are only for reporting purposes - Lack of HIV M&E mainstreaming in line ministries' M&E systems - Weak analytical capacity at organizations engaged in NAP implementation

2.7. ROUTINE HIV PROGRAM MONITORING

The program monitoring indicators have operational definitions that meet international standards. The government has developed and approved national guides and standard forms such as the National Epidemiological Surveillance Standard, the HIV case reporting forms, treatment case management forms, VCT reporting forms, instructions for statistics reports produced by the Ministry of Health (for HIV and STI cases). Most of the reporting is performed in electronic format, whereas at the lower level, yet the information is collected on paper and respectively entered into the electronic database. The national standards and instructions available reflect data collection mechanisms from public service providers. A separate set of standards and instructions are developed by Program Managers (PRs/SRs) for the GF funded preventive services. All source documents are available at the service provision level for audit purposes in both, public and NGO sectors.

Albeit unique identifier is institutionalized for preventive service recipients, technically double reporting on the use of services is possible due to non-functional/underdeveloped separate electronic databases (Ident) developed for different risk groups and services in the country. The latter limits to track beneficiaries road map and prevention, care and support services received from different providers. To mitigate this problem, Program Managers (PR and SRs) closely analyzed various databases to estimate clear demand for services.

As already mentioned started from 2018, preventive services, solely provided by NGO sector, will be procured by CNAM (harm reduction) and UCIMP (preventive services). This calls for an urgent need of development/revision of standards and instructions for data collection, recording and reporting by respective agencies.

The strength and weakness of routine HIV program monitoring component is summarized in the Table 8 below.

Table 8: Routine HIV Program Monitoring: Strength and Weaknesses

STRENGTH	WEAKNESSES
- National guides and standard forms available - National instructions available for public service providers - Instructions for preventive services provided by NGOs and funded through GF available - Most of reporting in electronic format - All source documents available at service provision level - Program	- Fragmented and underdeveloped electronic databases for different risk groups and services creates potential for duplications; - A need for revision of preventive service standards and instructions for data collection, recording and reporting

2.8. SURVEYS AND SURVEILLANCE SYSTEM

Routine Surveillance: The routine health data collection system is established and includes: HIV case registration, data on geographic, gender and age distribution, HIV patient surveillance, enrolment in treatment, partially ways of transmission. There is a National Epidemiological Surveillance Standard developed according to international guidelines strictly followed by all actors.

Second Generation Surveillance System: The 2nd generation surveillance research is performed every 3 years with collection of behavior and prevalence data for various groups (IDUs, CSWs, MSM, and Prisoners) as well as population size estimates (PSE). Moldova is implementing the IBBS on solid and scrupulous methodology since 2003. It is an important research to measure the prevalence, as well as risky behaviors in most at risk populations. Since 2009, IBBS studies use respondent driven sampling methodology and data analyses are performed using the RDSAT software version 5.6.0[8]. The methodology is fully described in the reports of the researches, available online. It is prioritized in the national plan as intervention, but never financed by the government. All surveys include the survey protocol and questionnaire and ethical clearance obtained from Ethics Commission.

IBBS research is carried out by different actors since its commencement. Preparation for the IBBS is carried out in a participatory manner by involvement of key public and NGO stakeholders. Survey methodology is reviewed/updated as necessary before each IBBS round and data collectors are trained. The data entry is performed by the NCHM, where the databases for at least surveys are stored.

The evaluation found number of weaknesses in the second-generation surveillance system that has to be addressed in coming years. Namely:

Time period required for research - As per key informants, on average each IBBS wave takes around 24 months. This served as justification for planning IBBS rounds once every three years, whereas all other countries implement the survey once every 2 years. Available IBBS literature[9] reveals that in most countries, data collection is completed within a relatively short period of time ranging from less than a month to more than half a year, depending on the survey (see Table 9). This relatively compact timeline does not include the time needed for survey preparation activities. For studies of this size the planning process can be expected to require at least several months and often much longer. If multiple rounds of IBBS data are collected, subsequent rounds may be planned even years in advance. Overall, the IBBS research takes not more than 12 months.

[8] IBBS 2012-2013, key results (http://aids.md/aids/index.php?cmd=item&id=1432), ucimp.md, cnms.md, IBBS 2009 http://aids.md/aids/index.php?cmd=item&id=1205, BSS 2007 http://aids.md/aids/files/1193/IBBS_2007_last_version_ROM_ENG.pdf)

[9] Elke Johanna de Buhr, Assessment of Integrated Biological and Behavioral Surveys (IBBS) for Key Populations, 2013, http://aidsmerg.org/wp-content/uploads/2015/12/IBBS-DeBuhr-Report.pdf

Table 9: IBBS Data Collection Timeline

IBBS	Study design/planning	Data collection	Release Final Report
Cambodia	02.2010	03.2010 – 10.2010	2010
Ghana	na	5 weeks in 2006	2006
India	na	Two rounds of data collection in 2005-07 and 2009-10	2010
Indonesia	na	01.2011 – 03.2011	2011
Kenya	01.2010 -03.2010	04.2010 – 06.2010	2010
Nepal	na	01.2011 – 03.2011	2011
Pakistan	na	06.2011 – 09.2011	2011
Vietnam	na	06.2009 – 02.2010	2011

Using this benchmark, the M&E TWG is advised to assess reasons for lengthy implementation of research and elaborate recommendations for optimization of the research duration.

Cost of the IBBS: IBBS funding in Moldova is predominantly external and likely not sustainable at this level. Responsibilities for IBBS is spread among different agencies. Dejure the National Public Health Center is responsible for implementation of behavioral and biological studies, but de facto National Health Management Center performs the data entry and holds the databases (except the last round, which is yet ongoing). Data collection is performed by different organizations across different rounds.

Most recently databases have been transferred to the SDMC NCU. Albeit legally SDMC is appointed as a coordinator for the NAP, it is not clear: i) what is the mechanism for ensuring participatory approach in planning and implementation; ii) which agency will receive GF funding for future IBBS rounds; iii) which organization will be responsible for organization of work, filed data collection and analysis.

Apart from fragmentation of functions and absence of the "parent" for IBBS, according to key informants, it is too expensive (around 120,000 US$) to be carried out biannually. Cost of the research is particularly valid advocacy argument to obtain government's buy in and leveraging public funding to ensure sustainability of this research when the donor funding ends.

> "On average, the cost was approximately 75 USD to 100 USD per respondent for an IBBS. Economies of scale for large-scale IBBSs resulted in a cost on the lower side of the range. The average sample size has been between 3,000 and 3,500, covering six to eight sampling domains. In hilly/remote areas, the unit cost was on the higher side of the range".
>
> **Source:** Elke Johanna de Buhr, Assessment of Integrated Biological and Behavioral Surveys (IBBS) for Key Populations, 2013.

For this purpose, the evaluation team looked for available evidence to examine whether the cost of the research in Moldova is higher compared to other countries. The assessment of IBBS in number of countries states that the cost varies from approximately 75 USD to 100 USD per respondent, depending on the scale of IBBS. Economies of scale for large-scale IBBSs resulted in a cost on the lower side of the range. The average sample size has been between 3,000 and 3,500, covering six to eight sampling domains. In remote areas, the unit cost was on the higher side of the range[10].

The analysis of the total cost of IBBS research (IDUs, MSM and CSW) conducted in 2012, average unit cost (approximately 52 USD) is within the range of comparator countries. In research, trade-offs between data quality and costs are very common. This might mean that IBBS research has to concentrate on collecting 'good enough' data that achieves a balance between data quality and costs and serves the advocacy purpose for advancement of public funding. Diversifying funding sources, including local sources of

[10] Ibid 8

funding, would make data collection not only more sustainable but might also benefit participation, ownership and use of the research findings.

Access and use of IBBS results: The costs associated with IBBS data collection are only justified if IBBS data are accessible and widely used. World-wide, IBBS data and research findings are being used for many different purposes and by a variety of stakeholder groups. In Moldova, IBBS practical application is limited to provision of critical data for NAP outcome and/or impact evaluation and global reporting requirements and is less utilized as a tool for program planning.

In order to promote data use, territorial governments, including government agencies implementing programs, have to be directly involved in research design, data collection and analysis, which are ideally carried out by a **responsible government institution**. The development of a detailed data use strategy in preparation of each round of IBBS research would also be beneficial, especially if combined with assistance to implement this strategy following survey data collection (including assistance with data analysis, if needed). Given the growing experience with IBBS research worldwide, there is a potential for synergies if country teams share their experiences and learn from each other's best practices.

In addition, public release datasets should be shared for analysis by a broader group of researchers. User groups not directly involved in data collection would also benefit from a responsive contact charged with providing assistance and answering questions on the available data and research findings.

Other surveys: Population-based surveys are also carried out – Reproductive Health Survey (RHS), Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), Knowledge, Attitude and Practice survey (KAP), etc. At the time of evaluation, Moldova lacks a formal inventory of surveys and there is absence of a single depositary where all survey databases and reports are stored.

The strength and weakness of surveys and surveillance component is summarized in the Table 10 below.

Table 10: Surveillance System: Strength and Weaknesses

STRENGTH	WEAKNESSES
- Routine health data collection system established; - 2nd generation surveillance carried out regularly and uses robust methodology; - Cost of IBBS research is comparable with other countries; - Population-based surveys are also carried out	- Lengthy implementation of IBBS research; - IBBS studies predominantly externally funded; - Institution solely responsible for IBBS planning, implementation and reporting not identified; - The role of SDMC in surveys and 2nd generation surveillance not specified; - Sporadic use of IBBS data; - absence of a single depositary where all survey reports are stored

2.9. NATIONAL AND SUB-NATIONAL HIV DATABASES

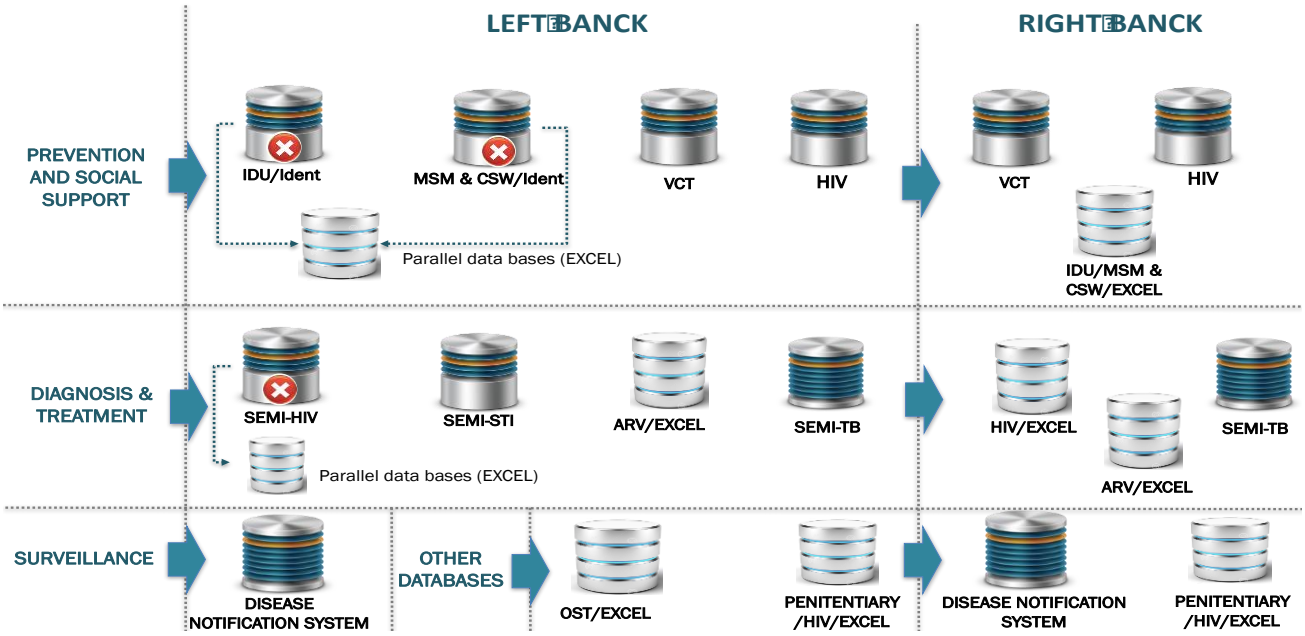
The Republic of Moldova lacks a single legal instrument on health information (collection, processing, analysis, dissemination and utilization)[11], but the country has certain legal acts in force regarding the health information framework. Having regard to the violation of the legislation in force and the lacks in legislation, the opinion of a great part of the individuals involved in the working groups and of experts is the need of a single legal act that would regulate all the aspects related to the health information framework (appointment of the main actors, stipulation of the collaboration mechanisms and undertaking of responsibilities). At present, the country does not have a HIS that would cover all components, in

[11] The evaluation of the Health Information System in the Republic of Moldova, Health Matrix Network, 2007

accordance with Health Metrix Network Assessment (HMN) Framework. The existing HIS is mainly inherited from the soviet time, though with certain adjustments to the requirements of the international agencies. Within the health system, no written policy exists regarding the promotion of the information utilization culture, as a component of the strategic plan related to Health Information System.

Following a need to have an evidence-based process of planning and decision making in combating HIV/AIDS epidemic, different governmental and non-governmental organizations, UN agencies and donors implementing activities in the field of HIV/AIDS, Moldova established and used various information systems (IS) (Figure 1).

Figure 1: National and territorial HIV data bases

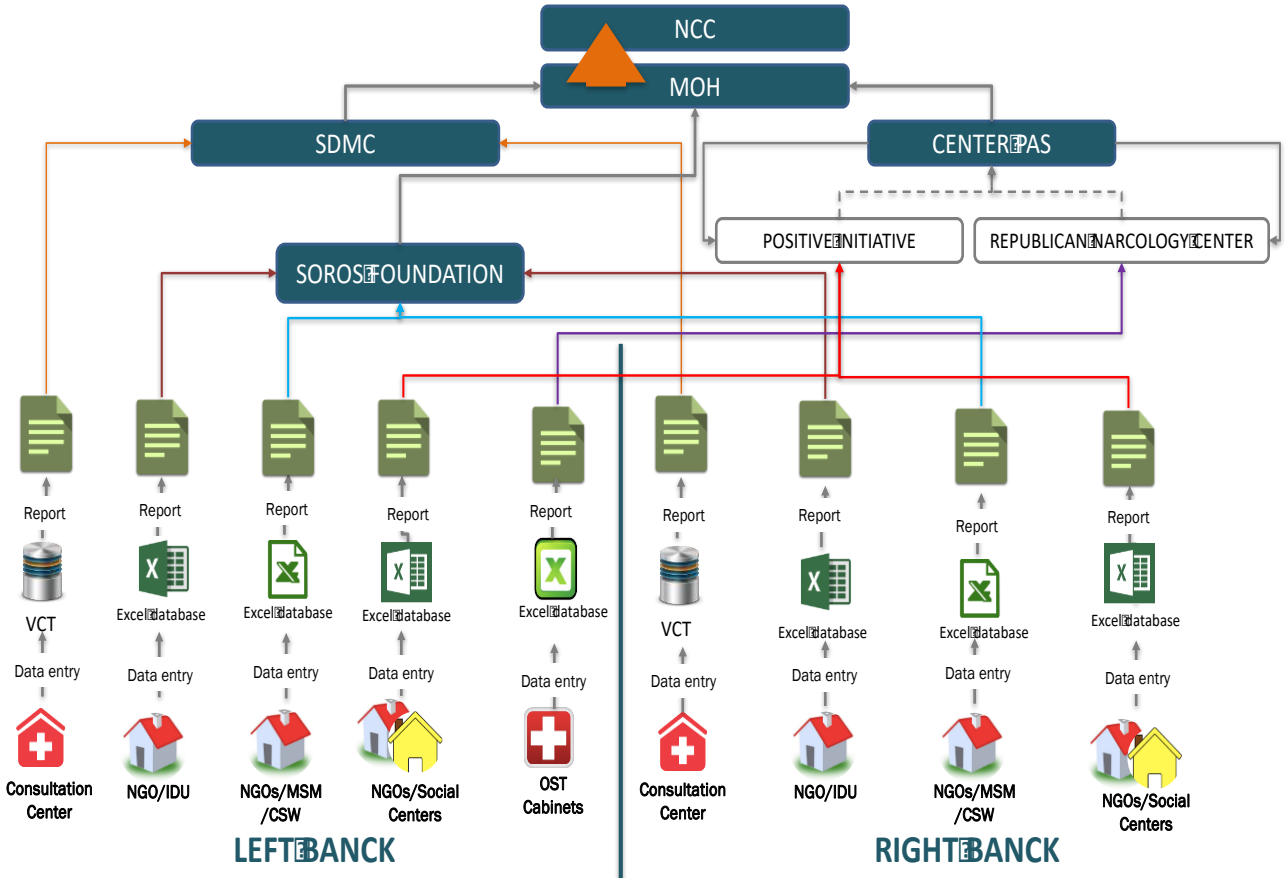


In the field of HIV prevention and care & support, there are number of information systems developed with the support of GF and other donors, such as: i) VCT – used for registration of beneficiaries who received VCT services; ii) HIV/Ident – for registration of beneficiaries and services provided in the sphere of care and support; and iii) two separate information systems, IDU/Ident and MSM&CSW/Ident targeted at separate risk groups. At the time of evaluation only two information systems, VCT and HIV/Ident, were fully operational in both territories (left and right bank of river Nistru) allowing data entry, processing and generation of reports, whereas remaining information systems (IDU/Ident and MSM&CSW/Ident) were not fully functional. Service provider NGOs are mandated to continue entry of the data into respective information systems by program managers (PR/SRs), even though the systems either are underdeveloped to produce required reports or are not maintained to generate data useful to the end user. Furthermore, albeit all these systems are built on the same platform, systems do not interact to share and exchange information and track services a unique beneficiary has received in a given reporting period. IS is outdated and limits registration of cases for the use of rapid tests and mobile clinics.

To comply with regular reporting requirements, NGOs operating in both territories, were forced to establish parallel systems in the form of Excel databases. Excel databases are standardized within the service line (all service providers use same database for particular services), but differ among service lines (Figure 2). Existence of dual information recording requirements stretches already scarce M&E resources and limits M&E activities to pure data entry and superficial data validation. Inefficient use of resources is also noted at the Program Managers' level (PR/SRs) when all databases are reviewed manually by M&E specialists to avoid double counting of beneficiaries. The quality of data recording in the given databases

is suboptimal limiting use of Excel automated analysis functions. The latter points to the lack of staff knowledge of Excel programme.

Figure 2: Information flows and reporting for prevention, OST and care and support



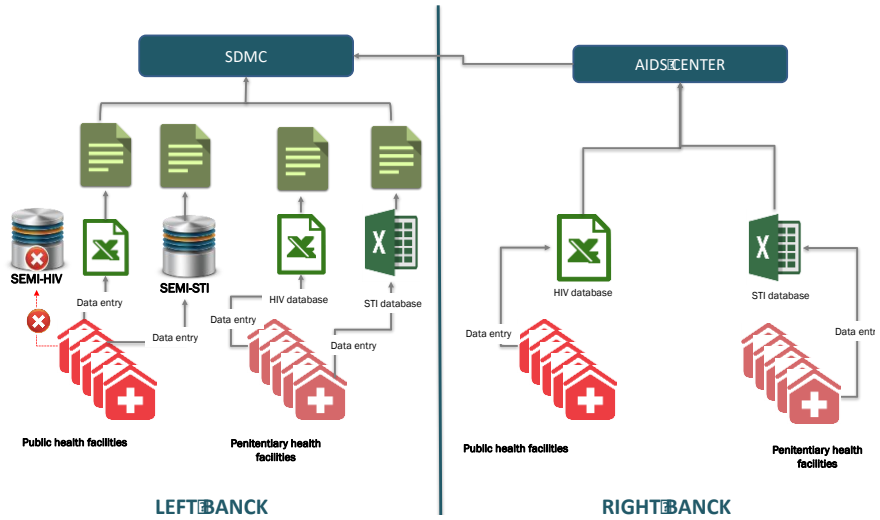
Similar challenges are observed for maintaining information related to HIV treatment. SEMI/HIV, the information system developed by partners, is not operation at present, therefore data is recorded in a parallel system - Excel database by all institutions providing ARV treatment to People Living with HIV (PLHIV) in both territories. At the time of evaluation, SDMC has upgraded SEMI/HIV IS and initiated data entry from the primary data sources. It is estimated that by end of 2018 all data for both territories will be retrospectively entered (using source documents) into the renewed IS.

There is a separate SEMI/STI system for recording data related to Sexually Transmitted Infections and SEMI/TB recording data about TB treatment as well as HIV/TB co-infection. The evaluation was not able to assess the interoperability of all these three systems due to non-functional SEMI/HIV system, but all key informants and users of the given systems noted inability of these systems to exchange data. In Transnistria region, STI data is processes through Excel based database.

In addition, a separate Excel based database is maintained for ARV treatment at penitentiary department (

Figure 3).

Figure 3: Information flows and reporting for treatment and ARVs



A separate Excel based database is used for Opioid Substitution Therapy (OST). The structure and the format of the database is standardized for all OST service providers in the left bank of river Dniester and in both, penitentiary and civil sectors.

Another challenge observed in M&E system is diverse reporting lines for different services to different institutions/organizations (Table 11), which apparently needs to be refined provided change in Principle Recipient and channeling public funding through CNAM for the procurement of HIV testing, treatment and harm reduction services.

Table 11: Current information flows and reporting lines

Territory	IS used	Responsible for:						
		Data processing	Reporting	Accounting level 1	Accounting level 2	Accounting level 3	Reporting to GF	Reporting to MoH/SDMC
Prevention Services to IDUs, MSMs, CSWs								
Left bank	Excel DB	Service NGO	Service NGO	SOROS/POSITIVE INITIATIVE (SR)s	Center PAS (PR)	na	Center PAS (PR)	Center PAS (PR)
Right bank								
VCT services								
Left bank	VCT IS	Consultation Centers	Consultation Centers	SDMC (SR)	UCIMP (PR)	na	UCIMP (PR)	UCIMP (PR)
Right bank				AIDS Center	SDMC (SR)	UCIMP (PR)		
Care and Support services								
Left bank	HIV/Ident	Service providers	Service providers	SOROS/POSITIVE INITIATIVE (SR)s	Center PAS (PR)	na	Center PAS (PR)	Center PAS (PR)
Right bank								
OST services								
Left bank	Excel DB	Narcology clinics	Narcology clinics	RND	RND	UCIMP (PR)	UCIMP (PR)	UCIMP (PR)
PID		Penitentiary Health Clinics	Penitentiary Health Clinics	PID				
ART services								
Left bank	Excel DB	Service providers	Service providers	SDMC (SR)	SDMC (SR)	UCIMP (PR)	UCIMP (PR)	SDMC
Right bank				AIDS Center				

Since SDMC became a Coordinator of the NAP, the M&E Unit operational at NCHM has been dissolved and alternative capacity at SDMC not established. Information Systems[12] remained at NCHM without adequate maintenance and support.

[12] IDU/Ident, MSM/CSW/Ident

Overall, the process of data collection, analysis and interpretation needs improvement and restructuring as, according to the observations during the in-country visit and respondents' opinions, country still faces the challenge of creating one consolidated M&E System which would satisfy all key information needs. The multi-unit approach towards collection and analysis of data makes it necessary for further verification/validation of data. It is also not always clear if these data duplicate themselves, as in several instances discrepancies were noticed in the same data but produced by the different institutions mentioned above in their reports or documents.

The strength and weakness of National and sub-national databases component is summarized in the Table 12 below.

Table 12: National and Sub-National Databases: Strength and Weaknesses

STRENGTH	WEAKNESSES
- Certain information systems operational and used by service providers - SEMI/HIV IS upgraded and retrospective data entry initiated	- Fragmentation of databases; - Difficulties in operationalizing the national database and some informational systems (IS) for the routine NAP monitoring; - Absence of IS maintenance and support services; - Information systems do not interact to share and exchange information; - Information systems outdated; - Parallel Excel databases formed and used, but differ per service type - Dual information recording requirements stretches already scarce M&E resources and limits M&E activities to pure data entry and superficial data validation; - Inefficient use of resources at the Program Managers' level (PR/SRs) when all databases are reviewed manually by M&E specialists to avoid double counting of beneficiaries;

2.10. SUPPORTIVE SUPERVISION AND DATA QUALITY AUDITING

Effective mechanisms for data quality assurance are underdeveloped in Moldova. Data originating from different sources may vary, such inconsistencies affecting planning for better programme delivery. Data errors may begin at the entry level of service providers, both caused by technical inconsistencies, interpretation errors and lack of capacities, and affect further collation and aggregation. Some data validation controls are implemented. National comprehensive reconciliation and validation in-country processes exist however, these elements are sporadic, data quality assurance lacking comprehensiveness and permanence.

Oversight and data validation field visits were mostly reported by NGOs. Center PAS (PR) and Soros (SR) regularly, once a quarter visit NGOs with the purpose of the data validation. Data quality audits are not systematically carried out by public institutions and feedback mechanisms along with monitoring implementation of recommendations are lacking. The National Center for Health Management has been tasked to develop Data Quality Assurance (DQA) Guidelines for the health sector and to undertake the role of external data quality audits, whilst National Public Health Center has been tasked with internal data quality management and audits. Nevertheless, at the time of evaluation, such guidelines were absent and clear framework and correlation among internal and external data quality assurance mechanisms not specified.

Supportive supervision refers to overseeing and directing the performance of others and transferring the knowledge, attitudes, and skills that are essential for successful M&E of HIV activities. It offers an opportunity to take stock of the work that has been done; critically reflect on it; provide feed-back to local staff; and where appropriate, provide specific guidance to make improvements. Supportive supervision should be conducted with a sample of HIV service delivery organizations (i.e., not all providers), and can also be used as a mechanism to strengthen local M&E capacity. National guidelines and tools for supportive supervision on M&E are lacking. In Moldova, the Government system for planning, management and implementation is still based on a hierarchical system of oversight and reporting. Despite significant improvements in Government requirements for the development and implementation of results-based programs, in practice accountability on results is weak. Particularly in the health sector, reports to the supervising institutions tend to represent lists of inputs and activities, providing little information on achievements and results.

The strength and weakness of Supportive supervision and data quality auditing component is summarized in the Table 13 below.

Table 13: Supportive Supervision and Data Quality Auditing: Strength and Weaknesses

STRENGTH	WEAKNESSES
- National comprehensive data reconciliation and validation in-country processes exist; - NCHM tasked with external DQA and NPHC with internal DQA audits - Oversight and data validation field visits mostly practiced by NGOs targeted at TGF indicators only	- Effective mechanisms for data quality assurance are underdeveloped - National comprehensive reconciliation and validation in-country processes exist; however, these elements are sporadic - DQA guidelines for the health sector, specific for HIV/AIDS/STI not yet developed - National guidelines and tools for supportive supervision on M&E are lacking - Mechanisms for monitoring recommendation implementation lacking.

2.11. HIV EVALUATION AND RESEARCH AGENDA

The TWG on M&E is in charge for coordination and implementation of research and evaluations. The research/studies planned under NAP 2018-2020 are outlines in the NAP Implementation plan. Evaluations occur in the framework of the National programme on HIV/AIDS/STIs, including joint multi-stakeholder midterm and end programme reviews.

Country regularly monitors AIDS expenditure. The Economic Department of MOLHSA was producing National AIDS Spending Assessment (NASA) report every 2 years and there is only one specialist who is knowledgeable of the methodology and has analytical capacity to produce NASA report. Nevertheless, due to the budgetary constraints, the decision has been made to replace NASA with collecting expenditure data on an annual basis for Global Aids Monitoring (GAM, former GARP) purposes and the NCHM is tasked with this function. There is no separate National Health Accounts (NHA) module on HIV and TB yet developed at NCHM, which can produce spending data more accurately and on a regular basis.

In practice, planning of evaluations and research is usually contingent of financial coverage availability and the mandate of the funding agency, and less so determined by the national research priorities. Operational research is underdeveloped in Moldova. While planned in the NAP and M&E workplan, extensive capacity building is needed for proper research design and implementation of such operational research. The country lacks a formal inventory of research/surveys and there is absence of a single depositary where all survey reports are stored.
The priority research topics have been prioritized based on input from key HIV and research stakeholders. However, academics have been consulted only sporadically. Efficient and permanent communication

channels need to be established between decision makers and technical operational level of NAP implementers, and academia, to institute an applied and practical scientific approach. Priorities need to be reviewed periodically, at the stage of the MTR and final review of the NAP.

Relevant international and regional HIV research and evaluations findings, as well as the experience of comparable countries and epidemics, are being used in policy formulation, planning and implementation. Financial resources are almost exclusively international.

The strength and weakness of HIV Evaluation and Research Agenda component is summarized in the Table 12 below.

Table 14: HIV Evaluation and Research Agenda: Strength and Weaknesses

STRENGTH	WEAKNESSES
- Research and Studies planned and included in the NAP Implementation plan; - Evaluations of the National programme on HIV/AIDS/STIs is carried out regularly; - AIDS spending data regularly collected;	- Priority research topics are dictated by available funding and donor mandate; - Operational research is weak; - Engagement of academic research institutions in research/study design not practiced - A formal inventory of surveys not maintained and there is absence of a single depositary where all survey reports are stored; - Financial resources are almost exclusively international

2.12. DATA DISSEMINATION AND USE

Dissemination is the release of information obtained from routine statistics, surveillance, research and studies to users using different channels. The objectives of data dissemination and related communications activities to maximize the use of data for decision making and planning by responding to user needs when developing and disseminating information; increasing access to information by disseminating directly and through other organizations and providing maximum access to information of broad interest by sustaining an appropriate delivery infrastructure.

Research/studies and M&E results are presented and discussed to NCC and M&E TWG. In some cases, round table meetings, sessions and workshops are organized. Reports and/or presentations of different research/studies and evaluations are placed on selected websites by responsible or funding agencies. As already mentioned, the country lacks a single depositary, where all data is stored and is accessible to interested parties. Planning dissemination strategy for research/data is not a regular practice. Target audience and key messages are not defined for effective communication. Data use and dissemination is omitted in the M&E plan for 2012-2015.

There is some evidence of use of M&E data for strategic planning. Data from the second-generation surveillance researches/studies are used for the strategic planning especially in the process of scaling up HIV/AIDS control and prevention activities and services. However, data should be used in a more systematic manner to guide policy development and sharpen the focus of program implementation.

The strength and weakness of “Data Dissemination and Use” component is summarized in the Table 12 below.

Table 15: Data dissemination and use: Strength and Weaknesses

STRENGTH	WEAKNESSES
- Research/studies and M&E results are presented and discussed at NCC and M&E TWG meetings - Results presented on round tables, workshops, seminars - Reports posted on web sites - M&E data is used for strategic planning	- The country lacks a single depositary, where all data is stored and is accessible to interested parties; - Planning dissemination strategy for research/data is not a regular practice; - Target audience and key messages are not defined for effective communication; - Data use and dissemination is omitted in the M&E plan; - More systematic use of data is required to guide policy development and improve program implementation.

3. RECOMMENDATIONS

This section of the report provides recommendations based on the evaluation findings. Recommendations and suggestions are grouped by M&E system components as well as by key institutions engaged.

3.1. RECOMMENDATIONS BY M&E SYSTEM COMPONENTS

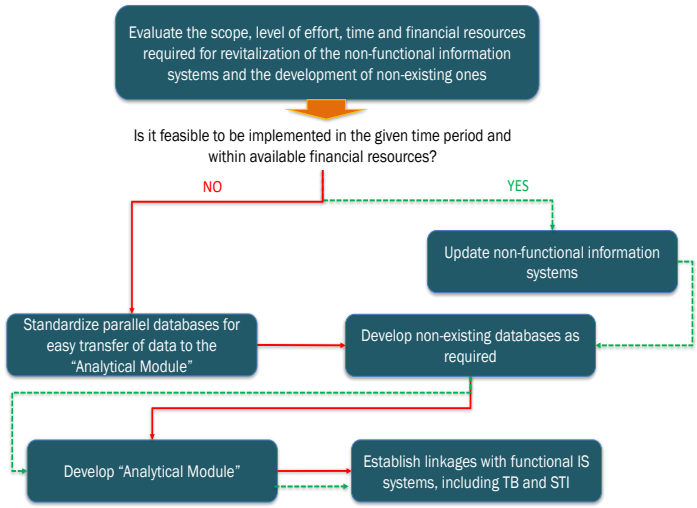
RECOMMENDATION 1: Develop "Analytical Module "of the information system (component 9)

Provided challenges identified in each component of HIV M&E system, ideally it is recommended to develop a new information system that is based on the patient / beneficiary and meets NAP requirements. However, attaining this objectives by end of the new NAP seems unrealistic due to the following contextual factors:

- **Time limitations:** Provided that there is only three years for the implementation of the new NAP and SDMC (NCU) has an obligation for overall coordination, M&E of NAP implementation and reporting to the Government and International Agencies, development of the new unified M&E system in a given time period is not realistic.
- **Administration Reforms:** The ongoing central administration reforms, including merger of the Ministry of Health and Ministry of Labor and Social Affairs, followed by modification of ministry's organizational structure, roles and responsibilities of departments and institutions subordinated to MOLHSA may slow down decision making process as well as active participation of respective departments/institutions in the design and implementation of the new unified M&E system. Importantly, merger of the National Public Health Center and National Health Management Center, an important player in HIV M&E system, under the National Public Health Agency, will delay the process of defining and functioning effective system of information flows.
- **Funding prospects:** As already stated, lion share of the M&E system funding comes from external sources. The only funds available to support the development of the new, unified M&E system, is available through TGF. Financial resources allotted in the GF grant are far below required funding and has limited utilization time-frame (3 years).

Provided contextual factors that may hinder development of the new information system, it is obvious that the country needs a system "Analytical Module" that can extract data from currently available ISs and/or parallel databases and generate reports as required.

Figure 4: Decision Tree



But before development of the "Analytical Module", the main sources of data (ISs and/or parallel systems) have to be defined. For this purpose, the following decision pathway, schematically presented on the Figure 4, is suggested. The first important step is to perform feasibility study by carefully examining scope, level of effort and time requirements as well as financial resources needed for the upgrade of existing non-functional information systems and for the development of the non-existing needed ISs. Depending on the

feasibility assessment results two strategic options are proposed:

- **Option 1:** If it's feasible to upgrade existing non-functional information systems, develop non-existing ISs and make "Analytical Module" operational for reporting purposes within the given time-frame and financial resources, it is highly recommended to embark on this option.
- **Option 2:** If the upgrade of existing non-functional information systems is not feasible, the only remaining option is to standardize Excel data bases to enable data extraction by the "Analytical Module" and establish linkages with functional information systems (HIV/Ident, SEMI/STI and SEMI/TB).

RECOMMENDATION 2: Identify Organization/Institution responsible for system operation and maintenance (component 1 & 9)

Operation of monitoring and information system functionality coordinated by one unit that it is in charge of this information flows has long been proven the most effective solution. Therefore, to ensure well-functioning M&E system, there is a need to identify institution responsible to house the system and ensure its effective functioning and maintenance. In order to define most appropriate institution to be tasked with this function, the evaluation identified two main institutions: i) National Public Health Agency and ii) SDMC. The assessment of strength and weaknesses of both institutions, provided in the Table 16 below concludes, that most feasible institution that can house the given system during the transition period is SDMC NCU endowed with relevant powers and enhanced capacity.

Table 16: Strength and Weaknesses of selected institutions

NATIONAL PUBLIC HEALTH AGENCY[13]		SDMC	
STRENGTH	WEAKNESSES	STRENGTH	WEAKNESSES
- In line with Agency's functional responsibilities; - Possibility to generate revenues from different sources	- At present under the structural reorganization. Process of NPHC and NCHM merger in process; - Unclear staffing norms and potential human resource capacity; - Absence of staff motivation mechanisms and practice	- Functionally responsible for NAP coordination and M&E; - Operational National Coordination Unit; - Adequate staff capabilities; Large portion of funding for the NCU operations (staff salaries) born by the Hospital; - Ability to leverage resources from different sources; - Ability of staff motivation.	- Weak powers to collect statistical data; Risks of transferring NAP Coordination function to another institution/sub-structure of the ministry as a result of administrative reforms.

RECOMMENDATION 3: Define roles and responsibilities of key organizational structures in M&E (component 1)

SDMC/NCU as a national coordinator for the NAP implementation has responsibility to monitor program performance, operate the M&E system and produce various reports for the government and other international organizations, realistic expectations have to be set considering NCU's size and capacity. This calls for strategic planning of the M&E, where roles and responsibilities of various organizations/institutions in both territories have to be clearly defined. Effective M&E system will require redistribution of tasks between organizations/institutions for data processing, internal and external data

[13] Entity where NPHC and NCHM are merged

quality auditing, data validation and reporting as one small unit cannot be tasked with all these functions. Proposed redistribution of tasks and responsibilities are outlines in Annex 2. Coordination between partners can be ensured by a present and functioning effective system of information flows, with constant two-way mutual exchange and communication. Thus, it is suggested for each organization to define its specific authority and responsibility with respect to M&E and the processes for shared decision-making among organizations.

RECOMMENDATION 4: Enhance M&E Human Resource Capacity (component 2)

When planning for M&E performance improvement, human resource capacity building should be done at all three levels. In fact, improving capacity at one level may require concurrent interventions at another level. Recommended interventions to enhance M&E human resource capacity are listed in the table below

Table 17: Recommended Activities for enhancement of M&E human resource capacity

LEVEL	ACTIVITIES
System level	- Development of HIV capacity building Strategy based on a formal assessment of capacity gaps and needs among stakeholders at different levels and with different competencies; - Complementing the Capacity Building Strategy with a log frame with time-bound targets, and developing a Plan of Actions for its implementation; allotting financial resources and establishing responsibilities for the implementation of the Plan of Actions; - Promote building capacities across sectors (within education, defense, penitentiary sectors) – the good practice of applied sector specific training - Development of a national curriculum in M&E (with different modules, including HIV specific) and institutionalization in the curriculum of the undergraduate and postgraduate levels; - Ensure availability of HIV related M&E training modules and professional in-training/refresher courses for medical specialists; - Ensure availability of HIV related M&E in the curriculum of the University-level (bachelors and Masters programmes) education for social assistants, as well as refresher training programmes for social assistants and social workers - Ensure availability of HIV related M&E training for NGO representatives - Maintain inventory of capacity gaps, needs, and capacity building avenues - Operationalizing the unique HIV training information system, with the option to filter people trained, facilitators and technical support capacities, and trainings under the M&E heading
Organization level	- To the extent possible ensure establishment of separate M&E positions and leverage required funding for it, allowing staff deployed on this position to have sufficient time, knowledge and skills to perform pure M&E functions; - Revisit Job descriptions for M&E positions; - To reinforce M&E technical training at the individual level, it is important to institutionalize regular performance assessments linked to job incentives at the organizational level; - Regularly applying post-training and post-workshop questionnaires/feedback forms, as an assessment of capacity needs and gaps; centralized analysis of such forms before developing subsequent training plans; - Institutionalization of staff motivation systems.
Individual level	- Staff performance evaluation to be carried out in a transparent way to allow an individual self-assess as well as receive feedback from supervisor on the gaps in competencies, knowledge and skills; - Set annual targets for professional development

RECOMMENDATION 4: Enhance partnerships to plan, coordinate and manage the multi-sector HIV M&E system (component 3)

The evaluation revealed enhancement of the role of M&E TWG in improved partnerships for planning, coordination and management of M&E system. To address identified weaknesses, it the Government of Republic of Moldova is advised to:

- Establishing an HIV M&E operational sub-committee as part of the joint HIV/TB M&E TWG; clearly determining the TOR for both, the sub-committee and the TWG.
- Ensure periodical participatory revision of the TOR (once every 2 years), in line with the M&E National Plan and Operational Manual, and the NCC Operational Manual
- Ensuring functionality of all coordination roles, tasks and responsibilities provided for in the National M&E Plan
- Instituting mechanisms for monitoring TWG members' participation (based on physical presence at the meetings, number of issues raised/presented, share of consultative processes in which the respective member has been involved)
- Enhance cooperation and partnerships among M&E staff within different entities, including NGO and territorial authorities
- The TWG shall develop multiannual TWG Action Plan, indicating interventions, estimated costs, implementation periods, entities responsible, as well as implementing partners. This Actions Plan shall represent the main instrument for the monitoring of M&E system consolidation actions and shall allow for the identification of financial resources needs. This Actions Plan is correlated with (a) the analysis of the progress of implementation of the National Plan for years 2018-2020 in December of each year, and with (b) the annual process of activities and budget planning.
- The TWG should maintain a registry of the decisions made and executed.

RECOMMENDATION 5: Develop costed national multi-sector HIV M&E plan (components 4&5)

M&E planning should be scheduled as soon as possible after this evaluation to ensure timely implementation of recommended actions. An assessment/evaluation that is not followed by appropriate M&E planning and implementation serves little or no purpose. The objectives of the national multi-sectoral HIV M&E plan should be explicitly linked to the NAP to ensure that relevant data are collected to measure the progress in the country's HIV response. Because the national M&E plan is the basis for the implementation of a functional national HIV M&E system, it should describe how all 12 components of the M&E system would be implemented over time. The national M&E plan should:

(1) Describe implementation strategy for years 2018-2020;
(2) In order for the National M&E Plan to become operational, clear implementation mechanisms ought to be described in the M&E operational Manual, which has to be developed based on the findings of the given evaluation. An additional step in implementation of M&E system strengthening as well as entities' roles and responsibilities in M&E of NAP ought to be represented by territorial/sectoral/institutional level M&E plans.
(3) To make the national HIV M&E plan operational, an annual costed national M&E work plan needs to be developed that describes the priority M&E activities for the year with defined responsibilities for implementation, the costs for each activity, identified funding, funding sources and a clear timeline for delivery of outputs. This work plan enables the NCC and/or M&E TWG to ensure that financial and human resources are mobilized and allows for monitoring progress towards implementation of one national HIV M&E system. The costed national M&E work plan should reflect agreement on who will implement and finance each activity; specifically, it should be a joint work plan that integrates the HIV M&E activities of all relevant stakeholders.
(4) Outline a strategy for resource mobilization;

In addition:

- Ensure that annual M&E work planning cycle is closely linked to the overall budgeting cycle for HIV to ensure that funding can be secured for implementation of the plan.
- Promote early involvement of Policies, Economic, Analysis and M&E Divisions of other Ministries in the M&E work planning process, securing their buy-in for further lobbying for inclusion of M&E related costs under their respective portions of the MTEF.
- Advocate for allocations for M&E from the state budget to enhance sustainability
- The national M&E plan should be reviewed and updated regularly to adjust in data collection needs and to strengthen M&E system performance based on periodic M&E assessments.
- Each actor of the M&E system shall, in its turn, develop plans at the agency/institution level, based on the National M&E Actions Plan.

RECOMMENDATION 6: Revise/develop communication and advocacy strategy and plan (component 6)

Factors contributing to success at country level include effective communication within and outside of the country keeping international, national, territorial or district government and civil society partners informed about plans and activities. Thus, key recommendations are to:

- Develop an advocacy and communication strategy for HIV/AIDS/STI M&E that outlines activities and provides resources to encourage national investment in the M&E system and evidence-based decision-making;
- Develop advocacy materials addressing the utility of M&E and specific actions points;
- Establish and maintain a communications infrastructure for M&E-related information, including a dedicated communications team or unit with responsibility for the timely production and distribution of useful M&E information targeted at key audiences.

RECOMMENDATION 7: Institutionalize Supportive Supervision and Data Quality Assurance Systems (component 10)

To strengthen existing M&E systems it is recommended to:

- Develop national guidelines and tools for data quality assurance, and instruments for supportive supervision, for the broader health sector;
- Establish national standards and procedures for HIV data quality assurance in accordance with international standards. Agree on data quality standards with relevant sectors and organizations, including consensus on standardized protocols and tools for data audits and assessments.
- Training in DQA and support responsible staff and/or data auditing unit(s) for oversight of auditing and audit reports.
- Organize regular meetings between external data auditors and internal staff responsible for data quality.

RECOMMENDATION 8: Enhance planning and monitoring of research, evaluations, studies (component 8 & 11)

NCC& M&E TWG are advised:

- To organize a national workshop with relevant individuals and organizations to agree on priority evaluation and research (including operational research) as part of a national agenda-setting process;
- Establish procedures for implementation of the national evaluation and research agenda;
- Establish a mechanism for ensuring adherence with ethical procedures for evaluation and research;
- Maintain a regularly updated national inventory of evaluation and research studies;
- Establish a mechanism for sharing evaluation and research findings, including the synthesis and interpretation of programmatic implications of the findings.

RECOMMENDATION 9: Data dissemination and Use (component 12)

It is suggested that specific attention is paid to data dissemination and use. Specifically, it is highly recommended to:

- Develop and implement guidelines on data confidentiality and data release with explicit decision-making processes and authorities;
- Develop a decision calendar to identify key points in the year when critical decisions are made and data are needed;
- Develop and implement a communication strategy and plan for M&E products tailored to different audiences
- Conduct an analysis of barriers to data use and elaboration of strategy for the advancement of data use in policy decision making, planning and implementation.

RECOMMENDATION 10: Enhance capacities for 2nd generation surveys (component 8)

The M&E TWG is advised to:

- Assess reasons for lengthy implementation of research and elaborate recommendations for optimization of the research duration;
- Ensure that NAPH becomes the institutions solely responsible for coordination, planning, implementation and reporting of IBBS research and maintains databases of respective studies;
- Advocate to leverage public funding for 2nd generation surveillance and mechanisms for ellocation of public funding for this purpose.
- Accelerate IBBS practical application for program planning, along with monitoring of critical data for NAP outcome and/or impact evaluation and global reporting.

3.2. ORGANIZATION SPECIFIC RECOMMENDATIONS

This section of the report focuses on organization specific recommendations provided in Table 18.

Table 18: Organization specific recommendations

Organization	Recommendations
SDMC/NCU	- Develop an analytical module for unified M&E of NAP implementation; - Serve as a depository of all IS, databases of research and studies and ensure effective maintenance of IS systems; - Develop M&E Plan for 2018-2020 that addresses all 12 components of M&E system; - Develop M&E Plan for 2018-2020 Operational Manual to ensure standard approaches for data collection, processing, analysis at each level of M&E system (see sample outline in annex 4); - Collect from partners all existing M&E methodologies and guidelines; - Develop DQA methodology, define roles and responsibilities of all involved organizations/institutions in internal and external data quality assurance; - Facilitate the development of a methodological guide for supportive supervision; - Train M&E staff of all involved organizations in the implementation of NAP in M&E, Supportive supervision and DQA; - Advocate for the development of national M&E training curricula and its integration of the undergraduate, postgraduate and continuous professional development education programs; - Carry out DQA visits to service providers, provide feedback on DQA findings, maintain recommendation log and monitor their realization.
NCC/M&E TWG	- Develop specific TOR for M&E TWG; - Approve the M&E Plan 2018-2020; - Develop detailed annual M&E action plans, which will guide M&E TWG operation;

	- Regularly monitor implementation of NAP M&E Plan and update annually; - Advocate to leverage funding for M&E Plan implementation
UCIMP	NGO Contracting - Obtain standard NGO contract template from Soros Foundation and use for NGO contracting; - Review and adapt reporting forms giving priority to the quality of services provided - Organize meeting with contracted NGOs about reporting forms and reporting indicators; Enhance M&E function - Develop M&E annual Plans - Design a IS that would capture all data for inputs; - Regularly carry out DQA as defined in the M&E Plan 2018-2020 - Train M&E staff of contracted NGOs in DQA methodology
CNAM	NGO Contracting and Reporting - Develop a list of indicators and reporting forms in accordance with the NAP indicators in close cooperation with the SDMC/NCU - Develop a methodological guide providing indicators' definition, measurement, source data, reporting forms, the frequency of reports. - Provide regular reports to SDMC/NCU for data reconciliation. Enhance M&E function - Develop M&E annual Plans; - Develop a M&E methodological guide with emphasis on supportive supervision; - Develop CNAM specific DQA methodological guide - Train respective M&E staff Financing of service providers - Ensure provision of advance payments to NGOs with consequent reconciliation according to performed services; - Develop financial reporting forms and train respective NGO staff
AIDS Center Tiraspol	- Develop M&E annual Plans; - Regularly carry out DQA according to approved DQA methodological guide; - Enahance M&E staff capacity at service provision level; - Provide regular reports to SDMC/NCU for data reconciliation. - Advocate to levarge funding for operational reserach

ANNEXES:

ANNEX 1: LIST OF DOCUMENTS REVIEWED

1	Assessment report HIV/AIDS M&E system, 2011 , National Coordination Council for HIV/AIDS & TBof the Republic of Moldova
2	Data Synthesis on Tendencies of the HIV epidemic and Impact of HIV prevention interventions in the Republic of Moldova 2011
3	Epidemiological Overview: Report on most recent epidemiological trends , National Public Health Center National AIDS Center, 2011
4	Evaluation of HIV Prevention Programmes in the Republic of Moldova 2010
5	Government Decree #825on the estabishment of the National Coordination Council for HIV/AIDS, T and Malaria", 2005
6	Health Statistical Yearbook, 2016
7	Helth Systems in Transition, Republic of Moldova: Health system Review, 2012, WHO, European Observatory on Health Systems and Policies
8	HIV/AIDS Monitoring and Evaluation Advocacy Plan for 2011-2012
9	Integrated Bio-Behavioural Study in key populations at higher risk: key indicators,
10	Jörg Radeke, Anne Mdinaradze, Impact assessment of Moldova's participation in the extended WTO Information Technology Agreement (ITA), German Economic Team Moldova, 2017
11	Jörg Radeke, Realising the Potential of Moldova's Information Technology Sector , German Economic Team Moldova, 2013
12	LAW on prevention and control of HIV/AIDS nr. 23-XVI of 16.02.2007
13	M & E system assessment report 2008, Republic of Moldova, 2009, National Coordination Council for HIV/AIDS & TBof the Republic of Moldova
14	M & E system assessment report, Republic of Moldova, 2010
15	Moldova National Programme For HIV/AIDS And STIs Control And Prevention For 2011-2015, Joit Assessment, 2011
16	Moldova National Programme For HIV/AIDS AND STIS Control And Prevention For 2016-2020
17	Multiple Indicator Cluster Survey Republic of Moldova*, 2012
18	National HIV/AIDS Response Analysis, Republic of Moldova 2010
19	National HIV/AIDS Response Analysis, Republic of Moldova 2010
20	National M&E workplan 2011 - 2012 and M&E Calendar 2011-2015
21	National Protocol and Operational Manual in HIV/AIDS second generationa surveillance Republic of Moldova, 2011
22	National Strategy For Information Society Development "Digital Moldova 2020", 2013
23	Needs Assessment Study: Prevention of Mother to Child Transmission Programme in the Republic of Moldova, 2009
24	Prevention of Mother to Child Transmission Programme in the Republic of Moldova, Needs Assessment Study, 2009
25	Programme for Results: Health Transformation Project Moldova, Environmental and Social Systems Assessment
26	The evaluation of the Health Information Systemin the Republic of Moldova, Health Metrics Network, 2007
27	Ulrich Laukamm-Josten, SUPPORT TO PERFORM THE HIV EPIDEMIOLOGICAL SITUATION, UNADIS, 2015

ANNEX 2: ROLES AND RESPONSIBILITIES OF DIFFERENT INSTITUTIONS IN MONITORING NAP

Indicator		Source of Information	Responsible for Data generation	Responsible for Internal Data Quality Audit	Responsible for external Data Quality Audit	Responsible for Data reconciliation	Responsible for Reporting
IMPACT							
Percentage of people who inject drugs who are living with HIV		IBBS	NAPH	NAPH	NAPH	na	SDMC/NCU
Percentage of men who have sex with men who are living with HIV							
Percentage of sex workers who are living with HIV							
HIV prevalence among general population		Routine Statistics	NAPH	NAPH	SDMC	SDMC	
AIDS related mortality per 100,000 population		Vital and disease-specific registry	NAPH	NAPH	SDMC	SDMC	
OUTCOME							
Percentage of injecting drug users who used sterile equipment during the last injection		IBBS	NAPH	NAPH	NAPH	na	SDMC/NCU
Percentage of injecting drug users using a condom during their last sexual intercourse							
Percentage of female sex workers using a condom during the last commercial sex act							
Percentage of men who have sex with men using a condom during the last homosexual anal contact							
PROSESS/OUTPUT							
Percentage of injecting drug users covered by preventive services under risk reduction programs	LB	IDU/Ident or Excel DB?	Service Provider	CNAM	NAPH	CNAM	CNAM
	RB				AIDS Center		
Percentage of female sex workers covered by preventive services under risk reduction programs	LB	IDU/Ident or Excel DB?	Service Provider	CNAM	NAPH		
	RB				AIDS Center		
Percentage of men who have sex with men covered by preventive services as part of risk reduction programs	LB	IDU/Ident or Excel DB?	Service Provider	CNAM	NAPH		
	RB				AIDS Center		
Number of syringes distributed per injecting drug user per year	LB	IDU/Ident or Excel DB?	Service Provider	Service Provider	CNAM		
	RB						
Percentage of injecting drug users who have been tested for HIV	LB	VCT	Service Provider	SDMC	SDMC	SDMC	SDMC
	RB			AIDS Center	SDMC		
Percentage of female sex workers who have been tested for HIV	LB	VCT	Service Provider	SDMC	SDMC	SDMC	SDMC
	RB			AIDS Center	SDMC		
	LB	VCT		SDMC	SDMC	SDMC	SDMC

Percentage of men who have sex with men who have been tested for HIV	RB		Service Provider	AIDS Center	SDMC		
Percentage of injecting drug users who have been tested for HIV in the last 12 months and who know the result of the analysis	LB RB	IBBS	NAPH	NAPH			SDMC
Percentage of female sex workers who have been tested for HIV in the last 12 months and who know the result of the analysis	LB RB	IBBS	NAPH	NAPH			SDMC
Percentage of MSM who have been tested for HIV in the last 12 months and who know the result of the analysis	LB RB	IBBS	NAPH	NAPH			SDMC
Percentage of injecting drug users receiving opioid substitution therapy for at least 6 months	LB PID	OST	Service Provider	RND PID	NAPH RND	RND	RND
Number of injecting drug users, new patients in substitution therapy	LB PID	OST	Service Provider	RND PID	NAPH RND	RND	RND
Number of injecting drug users permanently on substitution therapy	LB PID	OST	Service Provider	RND PID	NAPH RND	RND	RND
The number of territories from the civilian sector where substitution therapy is provided	LB	?	NRD	NRD	NAPH	NRD	NRD
Number of penitentiaries where substitution therapy is provided	LB	?	PID	NRD	NRD	NRD	NRD
Number of penitentiaries covered by HIV prevention programs and sexually transmitted infections	LB RB	? ?	PID PID	PID PID	NAPH ?	NAPH	NAPH
Percentage of people living with HIV who have been diagnosed with HIV	LB RB	Routine Statistics Spectrum	SDMC	SDMC		SDMC	SDMC
The mortality rate associated with HIV per 100 000 population	LB RB	Routine Statistics Routine Statistics	Service Provider	NAPH AIDS Center	NAPH AIDS Center	NAPH	NAPH
The mortality rate associated with TB/ HIV	LB RB	Routine Statistics Spectrum	SDMC	SDMC		SDMC	SDMC
Percentage of adults and children living with HIV receiving antiretroviral therapy at 12 months after initiation of treatment	LB RB	SEMI/HIV or Excel DB	Service Provider	SDMC AIDS Center	NAPH UCIMP	SDMC	SDMC
Percentage of adults and children living with HIV receiving antiretroviral therapy within 24 months after initiation of treatment	LB RB	SEMI/HIV or Excel DB	Service Provider	SDMC AIDS Center	NAPH UCIMP	SDMC	SDMC
Percentage of adults and children living with HIV receiving antiretroviral therapy within 60 months after initiation of treatment	LB RB	SEMI/HIV or Excel DB	Service Provider	SDMC AIDS Center	NAPH UCIMP	SDMC	SDMC
Percentage of people living with HIV who started antiretroviral therapy at CD4 <200 cells / mm^3	LB RB	SEMI/HIV or Excel DB	Service Provider	SDMC AIDS Center	NAPH UCIMP	SDMC	SDMC
Percentage of people living with HIV receiving antiretroviral therapy with undetectable viral load after 12 months of treatment	LB RB	SEMI/HIV or Excel DB	Service Provider	SDMC AIDS Center	NAPH UCIMP	SDMC	SDMC
The level of vertical HIV transmission	LB	SEMI/HIV or Excel DB	Service Provider	SDMC	NAPH	SDMC	SDMC

	RB	SEMI/HIV or Excel DB		AIDS Center	UCIMP		
The percentage of patients who were first diagnosed with HIV and the CD4 viral load at the time of diagnosis did not exceed 350 / mm3	LB	SEMI/HIV or Excel DB	Service Provider	SDMC	NAPH	SDMC	SDMC
	RB			AIDS Center	UCIMP		
Percentage of people living with and receiving antiretroviral therapy from the estimated number of people in need of treatment	LB	SEMI/HIV or Excel DB/spectrum	Service Provider	SDMC	NAPH	SDMC	SDMC
	RB			AIDS Center	UCIMP		
The percentage of people living with HIV who had at least one CD4 test in the past year	LB		Service Provider	SDMC	NAPH	SDMC	SDMC
	RB			AIDS Center	UCIMP		
Percentage of people infected with HIV who were diagnosed with tuberculosis during the reporting period, receiving anti-tuberculosis treatment and antiretroviral therapy	LB	SEMI/HIV or Excel DB	Service Provider	SDMC	NAPH	SDMC	SDMC
	RB			AIDS Center	UCIMP		
Percentage of people diagnosed with tuberculosis within a year and who registered the result of the HIV test at the time of diagnosis of tuberculosis	LB	SEMI/TB	Service Provider	TB Institute	NAPH	SDMC	SDMC
	RB			TB Hospital	UCIMP		
Percentage of HIV-positive pregnant women who received antiretroviral therapy to reduce the likelihood of mother-to-child transmission of HIV	LB	SEMI/HIV or Excel DB	Service Provider	SDMC	NAPH	SDMC	SDMC
	RB			AIDS Center	UCIMP		
Percentage of children born to HIV-positive mothers who were tested for the determination of ribonucleic acid HIV in the first 2 months of life	LB	SEMI/HIV or Excel DB	Service Provider	SDMC	NAPH	SDMC	SDMC
	RB			AIDS Center	UCIMP		
Percentage of people who find themselves in a situation of risk for HIV infection who received post-exposure prophylactic treatment	LB	SEMI/HIV or Excel DB	Service Provider	SDMC	NAPH	SDMC	SDMC
	RB			AIDS Center	UCIMP		
The prevalence of viral hepatitis B among injecting drug users	LB	SEMI/HIV or Excel DB	Service Provider	SDMC	NAPH	SDMC	SDMC
	RB			AIDS Center	UCIMP		
The prevalence of viral hepatitis B among sex workers	LB	SEMI/HIV or Excel DB	Service Provider	SDMC	NAPH	SDMC	SDMC
	RB			AIDS Center	UCIMP		
The prevalence of viral hepatitis B among MSM	LB	SEMI/HIV or Excel DB	Service Provider	SDMC	NAPH	SDMC	SDMC
	RB			AIDS Center	UCIMP		
The prevalence of viral hepatitis C among injecting drug users	LB	SEMI/HIV or Excel DB	Service Provider	SDMC	NAPH	SDMC	SDMC
	RB			AIDS Center	UCIMP		
The prevalence of viral hepatitis C among sex workers	LB	SEMI/HIV or Excel DB	Service Provider	SDMC	NAPH	SDMC	SDMC
	RB			AIDS Center	UCIMP		
The prevalence of viral hepatitis C among MSM	LB	SEMI/HIV or Excel DB	Service Provider	SDMC	NAPH	SDMC	SDMC
	RB			AIDS Center	UCIMP		
Percentage of blood tests tested for HIV and syphilis according to national protocols	LB	Excel DB	Service Provider	Service Provider	NAPH	SDMC	
	RB						

ANNEX 3: LIST OF PEOPLE MET

#	NAME	ORGANIZATION	POSITION
1	Daniela Demișcan	MOLHSA	Deputy Head of Public Health Department
2	Iurie Climașevschi	SDMC	National Coordinator, National Programme on Prevention and Control of HIV/AIDS and STI
3	Igor Condrat	SDMC	M&E Coordinator, National Programme on Prevention and Control of HIV/AIDS and STI
4	Svetlana Popovici	SDMC	ARVT Coordinator, National Programme on Prevention and Control of HIV/AIDS and STI
5	Ecaterina Noroc	SDMC	Laboratory Coordinator, National Programme on Prevention and Control of HIV/AIDS and STI
6	Maia Rîbacova	SDMC	Prevention Coordinator , National Programme on Prevention and Control of HIV/AIDS and STI
7	Svetlana Plămădeală	UNAIDS	UNAIDS Country Manager
8	Irina Barbiroș	MOJ	Ministry of Justice / Department of Penitentiary Institutions (M&E TWG/NCC)
9	Vasilisa Covalschi	RND	Republican Narcology Dispensary (M&E TWG/NCC)
10	Doina Banari	National Center for Blood TransfTusion	M&E TWG/NCC
11	Vileta Teutu	UCIMP	PI "CIMU HSP" (M&E TWG/NCC)
12	Ludmila Untură	NGO	League of People Living with HIV (M&E TWG/NCC)
13	Cristina Gaberi	UNICEF	UNICEF, Moldova (M&E TWG/NCC)
14	Veaceslav Mulear	NGO	Union for HIV prevention and harm reduction (M&E TWG/NCC)
15	Nicolai Jelamschi	UCIMP	Executive Director
16	Victor Volovei	UCIMP	Deputy Director
17	Angela Alexeiciuc	UCIMP	M&E specialist, HIV Project
18	Angela Carp	UCIMP	Procurement Specialist, HIV Project
19	Svetlana Maciuca	UCIMP	M&E specialist, TB Project
20	Vileta Teutu	UCIMP	HIV Project Coordinator
21	Daniel Stici	CNAM	General Deputy Director
22	Maria Lifciu	CNAM	Head of International Relations Service

23	Doina-Maria Rotaru	CNAM	Chief adjunct contracting and supplier relations
24	Ala Ulianovschi	CNAM	Chief general quality, evaluation and control
25	Liliana Caraulan	CENTER PAS	Program Coordinator
26	Tatiana Cotelnic-Harea	CENTER PAS	Program officer
27	Veaceslav Mulear	"GENDERDOC-M" Information Center	"LGBT Health" Program Coordinator
28	Andrei Verbonco	"GENDERDOC-M" Information Center	Administrator IT
29	Alexei Leorda	Public Association ”Reforme Medicale”	Director
30	Tatiana Fomina	Public Association “Positive initiative”	M&E specialist
31	Feodora Rodiucova	City Hall, Balti	Chief Health Service
32	Sergiu Rotaru	Public Medical Sanitary Institution, Municipal Clinical Hospital Balti	Chief medic, Head of Municipal Clinical Hospital Balti
33	Valentina Stepanenco	Public Medical Sanitary Institution, Municipal Clinical Hospital Balti	Infectious physician
34	Lilia Crețu	Public Medical Sanitary Institution, Municipal Clinical Hospital Balti	Infectious physician
35	Eduard Nenescu	Public Medical Sanitary Institution, Municipal Clinical Hospital Balti	Narcologist, Methadone Substitution treatment Service
36	Viorica Sevciuc	Public Medical Sanitary Institution, Municipal Clinical Hospital Balti	Voluntary Counseling and Testing Service
37	Ala Iatco	Association “Tinerii pentru dreptul la viață” (TDV), Bălți	Director
38	Oxana Buzovici	Association “Tinerii pentru dreptul la viață” (TDV), Bălți	Program Coordinator
39	Aliona Babina	Association “Tinerii pentru dreptul la viață” (TDV), Bălți	M&E specialist
40	Tatiana Spînu	Association “Tinerii pentru dreptul la viață” (TDV), Bălți	Resource Center Administrator of HRP
41	Arina Vetreniuc	Association “Tinerii pentru dreptul la viață” (TDV), Bălți	Psychologist
42	Aliona Ciobanu	Association “Tinerii pentru dreptul la viață” (TDV), Bălți	Program Coordinator
43	Corina Popa	Association “Tinerii pentru dreptul la viață” (TDV), Bălți	Advocacy and community mobilization specialist
44	Russu Ecaterina	Public Institution, Social Center „Viață cu speranță”	Director

45	Rodica Slivciuc	Public Institution, Social Center „Viață cu speranță”	M&E specialist
46	Aurelia Ghinju	Public Institution, Social Center „Viață cu speranță”	M&E specialist
47	Irina Baicalova	Public Institution, Social Center „Viață cu speranță”	Director of Community Center for Elderly People "Respiratia a doua"
48	Svetlana Nichita	National Health Management Center	Deputy Director, Department of Human Resource Analysis and Planning in Health
49	Diana Simașco	National Health Management Center	Deputy Head, National Health Programs Department
50	Lilia Todirașcu	National Health Management Center	Head of Section, Behavioral Studies and Health Surveys
51	Silvia Stratulat	National Public Health Center	Head of Section, Surveillance and control of HIV / AIDS and viral hepatitis
52	Vitalie Slobozian	SOROS FOUNDATION	Program Coordinator, Harm Reduction Program
53	Veronica Zorilă	SOROS FOUNDATION	M&E specialist, Harm Reduction Program
54	Mihai Oprea	RND	Director
55	Ghenadie Zaporojan	RND	Deputy Director
56	Anatolie Moraru	RND	Psychiatrist
57	Vasilisa Covalschi	RND	Psychologist, M&E specialist
58	Svetlana Timuș	RND	Head of Internment Section, narcologist in Methadone Substitution treatment Service
59	Lilia Feodorova	RND	Psychiatrist-narcologist
60	Aureliu Suhan	PID	Deputy Director
61	Irina Barbiroș	PID	Head of Section preventive medicine
62	Nelea Caras	PID	Principal specialist
63	Alexandr Goncear	AIDS Center Tiraspol	Chief Doctor, Head of AIDS Center Tiraspol
64	Tatiana Alexeenco	AIDS Center Tiraspol	Deputy Chief Doctor
65	Roman Sandu	Information Center ”Здоровое будущее”	Chairman

ANNEX 4: SAMPLE OUTLINE OF THE M&E OPERATIONAL MANUAL

TABLE OF CONTENTS