IDOM
INSTITUTUL PENTRU
DREPTURILE OMULUI

MOLDOVAN INSTITUTE FOR HUMAN RIGHTS

STRENGTHENING THE INVOLVEMENT OF THE TB AND HIV COMMUNITIES IN THE CONTEXT OF THE APPLICATION OF THE REPUBLIC OF MOLDOVA TO THE GLOBAL FUND 2024-2026

Chișinău Republic of Moldova, May 2023

Content

Executive summary

Civil society involvement in the response to tuberculosis (TB) and Human Immunodeficiency Virus (HIV) infection in the Republic of Moldova (RM) is guided by global TB and HIV/AIDS elimination strategies, which emphasize the role of civil society organizations (CSOs). The National Programmes (NP) in response to TB[1] and HIV/AIDS[2] 2022-2025 provide the active involvement of CSOs and people living with HIV, people affected by TB, and those groups and communities at higher risk of HIV infection and TB. Recognizing the importance of ensuring the meaningful role of civil society and communities in the processes associated with the development of country application to the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GF), on behalf of the TB Platform and the Key Affected Populations (KAP) Committee, technical assistance was requested to ensure a participatory process of dialogue and inclusion of identified and recommended priorities and interventions from CSOs and key populations in the application to GF 2024-2026.

Acknowledgments

Technical assistance on strengthening TB and HIV related community engagement in the context of Moldova's funding request to the GF for the years 2024-2026 would not have been possible without full collaboration with partners such as the GF; Eurasian Harm Reduction Association (EHRA), Institute for Human Rights (IDOM); Secretariat of the National Coordinating Council of National HIV/AIDS, Sexually Transmitted Infections (STI) and TB Prevention and Control Programmes (CCM TB/AIDS); *KAP* Committee*;* CSO TB Platform; Coordinators of National HIV/AIDS and STI Prevention and Control Programmes (NP HIV/AIDS) and TB Response Programmes (NTP); GF Principal Recipient: *Unit for Coordination, Implementation and Monitoring of Health Projects* and the sub-recipient: *Centre for Health Policy and Analysis* (PAS Centre) and CSOs: *Society of Moldova Against Tuberculosis (SMIT); AFI Public Association; Union for Equity in Health; Positive Initiative; Speranta Terrei; Casa Sperantelor; Medico-Social Programs; League of People Living with HIV; GENDERDOC-M* and other relevant community organizations/groups and people affected by these diseases.

Team of consultants

Sveltana Doltu	Master of Public Health, President, Public Association AFI
Oxana Buzovici	Master of Social Work, Project Coordinator, The Union for Equity and Health
Ludmila Marandici	Master of Public Health, Project Coordinator, NGO Positive Initiative
Ana Ciobanu	Master of Public Health, Independent Consultant, Republic of Moldova
Veaceslav Mulear	Health Program Coordinator, NGO Information Centre “GENDERDOC-M”
Alexandru Rucșineanu	Master of Political Sciences, Moldovan National Association of TB Patients “SMIT”
Ala Iatco	Master of Public Health, President, The Union for Equity and Health
Oxana Rucșineanu	Master of Public Health, Director, Moldovan National Association of TB Patients “SMIT”

[1] Government Decision no.107 of 23 February 2022 https://simetb.ifp.md/Download/oficial_docs/hotarire_gov_2022_02_23_nr107_pn_tb.pdf
[2] Government Decision No 134 of 02-03-2022, https://www.legis.md/cautare/getResults?doc_id=130469&lang=ro

Abbreviations

ACSM	Advocacy Communication and Social Mobilization
AFI	Act for Involvement
PHC	Primary Health Care
SAMC	Specialised Ambulatory Medical Care
NPA	National Prison Administration
LPA	Local Public Authority
MSM	Men having sex with men
CAD	computer-aided design
CCPPH	Centre for Centralised Public Procurement in Health
CD4	Differentiation group/cluster 4 (glycoprotein)
NLAC	National Legal Aid Council
NHIC	National Health Insurance Company
NSIC	National Social Insurance Company
CCM	Country Coordination Mechanism (National Coordinating Council for National HIV/AIDS, STI and TB Control and Prevention Programmes (CCM TB/AIDS)
CLM	Community Led Monitoring - Community Led/Based Monitoring
CLR	Community Led Research
COVID-19	Coronavirus Disease 2019
TPCF	Temporary Placement Centre for Foreigners
CRG	Community, Rights and Gender
CSS	Community Systems Strengthening
RDN	Republican Dispensary of Narcology
DOT	directly observed treatment
TWG	Technical Working Group; GTL-TB - GTL-HIV
EHRA	Eurasian Harm Reduction Association
GF	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
HRG	High risk group (for infection)
HIV	Human Immunodeficiency Virus
HUB	Community HUB - National key expert team composed by CSO members
IBBS	Integrated biological and behavioural assessment
IDOM	Institute for Human Rights
TDI	Temporary detention isolators (Ministry of Interior Affairs)
GPI	General Police Inspectorate
IFP	"Chiril Draganiuc" Institute of Phthysiopneumology
GIBP	General Inspectorate of the Border Police (Ministry of Interior Affairs)
STIs	Sexually transmitted infections
PDI	Pre-trial detention isolators (Ministry of Justice)
KAP	Key Affected Populations
SW	Sex worker
MIA	Ministry of Interior Affairs
M&E	Monitoring and Evaluation
MLSP	Ministry of Labour and Social Protection
MoH	Ministry of Health
MTB	Mycobacterium tuberculosis
WHO	World Health Organization
CSO	Civil Society Organisations. In this report CSOs include both NGOs and community representatives.
PAAR	Prioritized Above Allocation Request (PAAR)
HA	Homeless adults
PAS	Centre for Health Policy and Analysis
PUD/PID	People using drugs/ people injecting drugs

NCP	National Clinical Protocol
PEP	HIV post-exposure prophylaxis
NP HIV/AIDS	National programme for the prevention and control of HIV AIDS and sexually transmitted infections
TB platform	Platform of Civil Society Organisations active in the field of Tuberculosis
NTP	National Tuberculosis Response Programme. The report also uses the abbreviation PN TB
PrEP	HIV pre-exposure prophylaxis
HRP	Harm Reduction Programmes
RIF	Rifampicin
PLWH	People living with HIV (PTH in Romanian)
OASP	Opioid antagonist support program
REACT	A JavaScript library for building user interfaces
RM	Republic of Moldova
RSSH	Resilient and sustainable systems for health
DCDH	Dermatology and Communicable Diseases Hospital
SIME TB	Tuberculosis Monitoring and Evaluation Information System
SMIT	Society Against Tuberculosis
ART	Antiretroviral Treatment
TG	Transgender people
TB	Tuberculosis
TPT	Preventive Treatment of Tuberculosis
MDR TB	Multidrug-resistant tuberculosis
TB RR	Rifampicin-resistant tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
VST	Video supported (assisted) treatment
DCDH	Dermatology and Communicable Diseases Hospital

Introduction and context

The TB burden faced by Moldova places the country among the 30 countries in the world with a high burden of multidrug-resistant (MDR) TB[3] and remains among the 18 countries in the World Health Organization (WHO) European Region with a high TB priority[4] .

The spread of HIV infection in the RM is one of the priority public health issues, with the disease being concentrated in key-affected and hard-to-reach groups and conditioned by (1) further spread among injecting drug users (IDUs) and their sexual partners and (2) spread among men who have sex with men (MSM), which is a major contributor to the increase in infections among men.

The primary responsibility for TB and HIV control is on the Ministry of Health (MoH), which exercises this role through the programme coordinating units (Chiril Draganiuc Institute of Physiopneumology (IFP) and the Dermatology and Communicable Diseases Hospital (DCDH) in collaboration with other government entities, development partners and civil society organisations (CSOs).

CSOs providing prevention, treatment and care services in the context of TB and HIV advocate for the removal of punitive laws and policies that impede the response to TB and HIV and provide data to influence health policy through community monitoring of health services and systems.

In recent years, the country has made critical interventions to respond to the COVID-19 pandemic and its impact in the context of a series of social and economic crises, and has made significant progress in prevention, diagnosis, treatment and care of people affected by TB and HIV. Significant steps have been taken to strengthen the role of civil society and TB and HIV affected communities in the national response to public health emergencies by preparing the regulatory framework and implementing CSO contracting from national budget resources. CSOs play a significant role in keeping HIV and TB issues on the political agenda, empowering decision-makers to ensure that human rights are respected, protected and fulfilled.

Aim and objectives

The purpose of the GF's Community, Rights and Gender (CRG) technical assistance, delivered through IDOM, is to support the involvement of civil society, community groups, including key affected populations, in identifying priorities and interventions and to assess the extent to which these are reflected in the funding request to the GF for 2024-2026.

The technical assistance provided through IDOM had the following objectives:

1. Identify key challenges and gaps in the national response to HIV/AIDS and TB;
2. Shape the role of communities and CSOs in the national response to HIV/AIDS and TB;
3. Formulate recommendations to address the challenges identified from a CSO engagement perspective;
4. Consult the interventions planned in the Financing Request to GF 2024-2026;
5. Formulate specific CSO interventions to supplement the Financing Request to GF 2024-2026 in line with the activities of the NP HIV/AIDS and NTP 2022-2025;
6. Quantification of specific CSO interventions linked to the activities planned in the Financing Request to the GF 2024-2026 and the NP HIV/AIDS and TB 2022-2025.

The technical assistance provided through the EHRA had the following objectives:

[3] https://www.who.int/tb/publications/global_report/high_tb_burdencountrylists2016-2020.pdf
[4] http://www.euro.who.int/en/health-topics/communicable-diseases/tuberculosis/tuberculosis-read-more

1. Maintain liaison with the CRG team and the GF application writing team (external and national experts, and technical working groups: TWG-TB and TWG-HIV) to ensure that identified interventions are used in the development of the grant application;
2. Conduct and facilitate a validation meeting after the WHO consultations and present the document containing the identified interventions to key stakeholders;
3. Support in the development of the monitoring and evaluation (M&E) framework for the communities' component;
4. Monitor the costs and budgets of CSO priorities and interventions throughout the application development process;
5. Communicate on progress to CSOs during the development process.

Table 1. Technical assistance outputs and results

Main deliverable	Objectives / results	Support
Desk review	Review relevant documents to identify challenges	IDOM
Methodology	Development of the methodological concept of the consultations	IDOM
Consultation	Facilitate online consultations to collect input from TB and HIV related CSO representatives	IDOM
Interim report	Writing the report based on the challenges identified with recommendations for interventions and quantification to address them. Report adjustment based on consultations	IDOM/EHRA
Final report	Final report including the draft budget consulted and agreed with KAP for CSOs to be considered for the country application to the GF and the draft M&E module for CSOs	IDOM/EHRA

Methodology

Stage I. Document review: At this stage, available documents relevant to the areas were reviewed, challenges were identified, CSO involvement in HIV and TB response activities was assessed, overlap with international recommendations, guidelines and best practices involving CSOs was performed.

Stage II. Conducting interventions:

i. Discussions in TWG-TB, TWG-HIV, CSO TB Platform, KAP Committee.
ii. Data collection through questionnaires. Two types of questionnaires (on HIV and TB) were developed. Data collection was conducted online via Google Forms application from 15-30 March 2023. 32 participants took part in the questionnaires on TB Component and 60 CSO representatives on HIV Component. Ethical issues such as confidentiality and voluntary participation were taken into account.

Stage III. Synthesis and interim report. Compilation and synthesis of recommendations with reference to CSO involvement in the implementation of HIV and TB response activities related to national TB and HIV/AIDS programmes for 2022-2025, including for components to be included in the application to GF 2024-2026.

Stage IV. Presentation and finalisation of the report. Presentation and discussion of the interim report in meetings with the KAP Committee, the TB Platform and other CSO representatives; agreement on conclusions and recommendations; adjustment of the report following suggestions received; finalisation of the report.

Stage V. Sharing key findings and recommendations, including through distribution of the report to members of the TB TWG and HIV TWG, the CCM TB/AIDS and stakeholders.

TB component

Recommendations

- In the current social and economic crisis, the competing health and social priorities, the post-covid situation and the war in Ukraine, there are risks of a worsening epidemiological situation by TB. Therefore, strong support, fortified by commitments to TB-related CSOs must be continued in order to maintain the progress achieved in TB care and to continue strengthening health system interaction and collaboration between government and non-government services at both national and local levels.
- CSOs have undergone training to engage in monitoring with community efforts "Community Led Monitoring" (CLM). The data collected is planned to be used for informed decision-making. Annual indicators and consolidated data obtained, including through measuring the impact of CLM on TB response should be included in the national health system.
- Good working relationships have been built and maintained with NTP, CCM HIV/AIDS, KAP Committee through frequent interaction. Increased value of CSOs due to active involvement and impact of activities carried out in recent years. However, domestic funds allocated to CSOs are not sufficient to cover needs after withdrawal of support from foreign partners. In this context, a focus on clear measures on the transition of CSO activities currently funded from external resources to ensure their sustainability is critical.
- CSOs are represented on national, municipal and local TB and HIV coordination platforms, including, more recently, by joining the TWG on procurement of medicines and health commodities. More integration between TB and HIV CSOs should be considered to explore and expand integrated approaches and services for TB and HIV/AIDS NP beneficiaries, including by channelling the flow of financial resources through a single resource. In addition to boosting performance-based results (PBR), it is recommended to contract for, and reporting against results achieved and distinct validation indicators.
- Training for CSOs in the provision of paralegal assistance has been initiated. However, regular trainings, formalization of services and institutionalization of CSO workers who undergo such training should be available in line with the National Legal Aid Council (NLAC) national standards to ensure quality assistance for people seeking such support, including through integration with HIV paralegal services.
- TB screening among key populations has further demonstrated the value of CSO interventions. However, the use of ultra-portable X-ray and CAD (computer-aided design) has not been initiated. Current regulations do not allow CSOs to use CAD systems and mobile X-ray equipment without having a qualified specialist and mechanisms to allow operation of the systems by CSOs. Therefore, advocacy and technical assistance should be available to CSOs to ensure access to TB screening among vulnerable populations with the use of innovative systems that would facilitate TB screening.
- In the eastern part of the country, a region not controlled by Moldova, there is no compulsory health insurance similar to the one on the right bank of the Dniester River, it is not possible to refer people from groups at risk for TB screening. Local legislation on personal data prohibits the data controller (i.e. the therapist in the outpatient network) from transferring information on persons registered in the outpatient clinic or dispensary without their consent. The local legislation also does not provide for special support mechanisms for people with TB. In this context, additional facilities and provisions for screening and support interventions carried out in this region are encouraged.
- Treatment adherence support interventions are offered to people affected by TB. There is a need to develop and implement a more systemic approach with clear algorithms for working with different vulnerable populations and good coordination between TB stakeholders at all levels of care, as well as more active referral to access existing social support resources provided by the authorities.

- The standardised package of community support services, developed at regional level, has been translated and adapted, but has yet to be approved by the MoH. It is not clear when this will be approved and what the plan will be for taking over the coverage of the services included in the package from national budget funds. Given the good experiences of working with and contracting from the National Health Insurance Company (NHIC) of the active screening service, systemic steps should be taken to expand the range of services, including adherence support, which could be contracted from NHIC funds in addition to the incentives offered to people with TB on treatment.
- CSOs need to be actively involved in TB legislation review processes by proposing and formulating relevant changes to the legislative and regulatory framework to overcome barriers to access TB services, but also with more focus on integration with other relevant areas, including social policy.
- Studies were conducted to assess stigma, community, gender rights and challenges, working with LPAs and social services. However, CSO leadership at the community level should be encouraged through mechanisms for interaction with community actors and, additionally, adequate training should be provided to conduct community-led and community-based research/evaluation.
- Multiple opportunities were provided for capacity building and TB awareness for both civil society and TB affected communities at national and local levels. In order to further build capacity, prevent burnout among CSOs and engage volunteers/ new people in TB, it is recommended to foster competitiveness, provide spaces for trainings, meetings, exchange of experiences locally but also internationally for capacity building, mental health counselling and team building.
- Innovative methods of treatment surveillance (video supported treatment - VST) have been implemented, including based on partnership between CSOs and healthcare institutions, which became a practical solution during the COVID-19 pandemic. Efforts are needed to ensure full government uptake of this modality of treatment delivery as an alternative to directly observed treatment (DOT), and to explore other opportunities.
- A considerable part of the services provided by CSOs are financially supported from GF grant sources (prevention - over 90%, psychosocial support - 100%). Diversification of funding sources for TB screening and support services within the national budget and local health and social budgets alike needs to be ensured in view of the importance of securing sustainability of services.

Priority directions, CSO TB, 2024-2026

1. Advocacy and involvement in building coordination among TB stakeholders at all levels, including strengthening local HIV/AIDS and TB control programmes and implementation units with provision of M&E tools, access to programmatic and financial data and participation in cross-sectoral platforms.
2. Conduct monitoring with community efforts and continuously strengthen the dialogue platform with the authorities to discuss and resolve identified issues.
3. Carrying out social integration activities, including legal advice, paralegal assistance, supported employment for people from vulnerable groups.
4. Advocacy for the expansion of CSO support models, access and adequate funding, including from national and local budgets.
5. Conduct community-led research on a range of topics to inform data-driven decision making and engage in research and innovation by working with academia/researchers;
6. Strengthening CSO capacities in service delivery and participation in decision-making in the context of national programme implementation.
7. Implement interventions for early and active TB detection, including the use of portable X-ray systems in key and vulnerable populations, to contribute to the timely identification of TB cases.

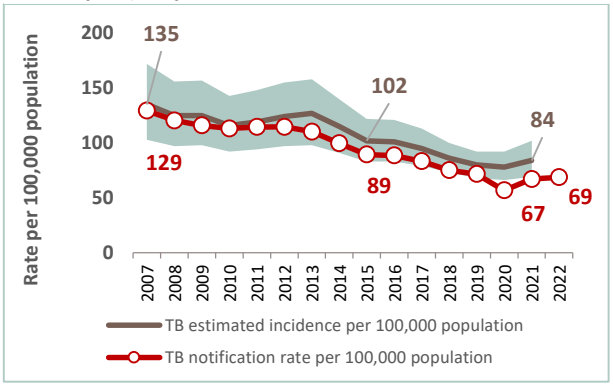
8. Providing psychosocial support and adherence programmes, including community-led preventive treatment (TPT) in groups at risk.
9. Conduct outreach, education and communication activities to raise awareness of TB, increase addressability of services and eliminate stigma, discrimination and other barriers to access TB services through targeted interventions.
10. Advocacy and support for the revision of the legal framework to ensure a human rights and gender equality approach to TB.

TB burden in the Republic of Moldova

TB has remained a priority public health problem in Moldova for more than two decades.

Incidence of new cases and relapses through TB. According to WHO estimates, in 2021, the Republic of Moldova was expected to diagnose 84 TB cases per 100 000 population (range: 69-102), while in reality, 67 cases per 100 000 population (Figure 1), data that placed the country second (after Kyrgyzstan - 70 per 100 thousand population) in the incidence of new cases and relapses among the 18 countries of the WHO European Region with priority for TB. Since 2007, the TB notified incidence is decreasing at an annual average of (-3.8%), registering a 37% reduction compared to 2015 (END TB target[5] - 50% reduction by 2025 compared to 2015). At the same time, it should be noted that TB case notification in relation to estimated cases is at the lower end of the established range, indicating a detection rate of new cases and relapses of 74% and 80% for the years 2020 and 2021, respectively.

Figure 1. Estimated and notified TB incidence (new cases and relapses), Republic of Moldova, 2007-2022



TB mortality. The WHO has estimated a TB mortality rate (excluding HIV cases) of 5.7 [range: 4.9-6.6] per 100 000 population for the year 2021 for the Republic of Moldova, with 4.9 cases per 100 000 population in the country (Figure 2). Between 2007 and 2022, there was a reduction in mortality of (-8.0%) per year, and compared to 2015, TB mortality was reduced by 35% (END TB target[6] - 75% reduction by 2025 compared to 2015).

Figure 2. Estimated and reported TB (excl. TB/HIV) mortality, Republic of Moldova, 2007-2022

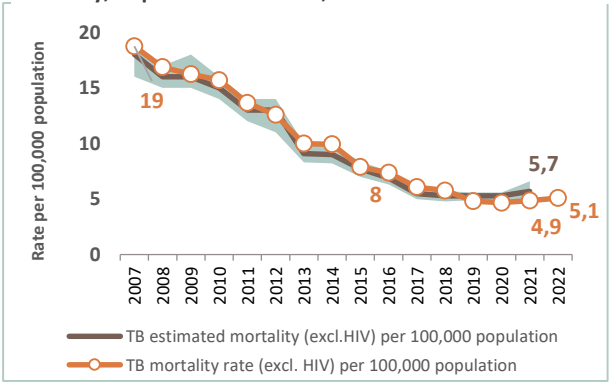
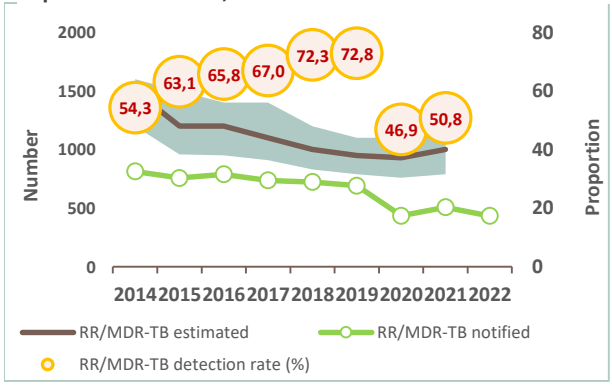


Figure 3. Estimated and notified RR/MDR tuberculosis, Republic of Moldova, 2014-2022



Source: WHO Reports 2007-2022, SIME TB

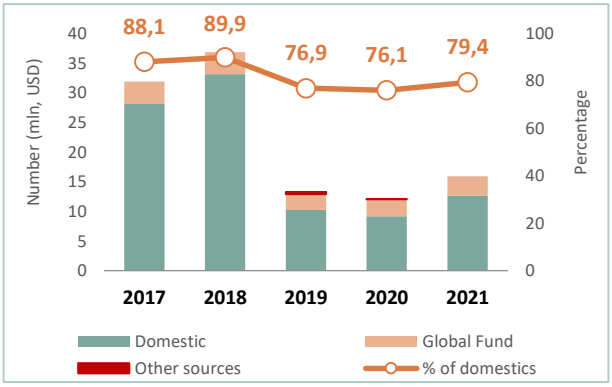
[5] https://www.who.int/publications/i/item/WHO-HTM-TB-2015.19
[6] https://www.who.int/publications/i/item/WHO-HTM-TB-2015.19

Drug Resistant TB. One of the biggest challenges in the fight against the TB epidemic is TB with resistance to basic drugs, namely Rifampicin (RR), but also in combination with resistance to Isoniazid (MDR). The detection rate of RR/MDR TB has taken an improving trajectory over the period 2013-2019, and by the years 2020 and 2021 has been reduced to 47% and 51%, respectively (Figure 3).

Programme factors on the TB epidemiological situation

Internal and external financing of the NTP. The NTP is financed from internal sources (state budget, including NHIC sources), but also from external sources (GF). NTP funding from internal sources has been reduced and constituted 76-79% of the "de facto" needs of the NTP (Figure 4). RTP remains dependent on external sources.

Figure 4. NTP funding, 2017-2021

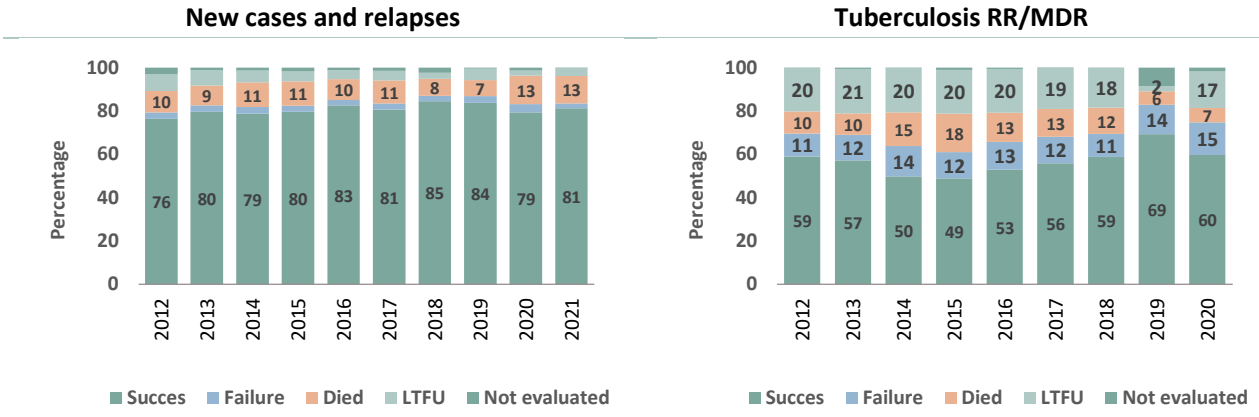


Preventive treatment of TB.

- The proportion of people with HIV on TPT in 2021 was 33% [7]
- The proportion of children up to 5 years of age from contact with bacteriologically confirmed TB who received TPT in 2021 was 47% [range: 43-51].[8]

Access to diagnosis. The proportion of new cases and relapses tested by rapid methods (Xpert MTB/RIF) in 2021 was 93% (94% in 2020).

Figure 5. Treatment outcomes of susceptible and resistant tuberculosis, Republic of Moldova, cohort 2012-2021



Access to treatment for TB. TB treatment coverage = 80% [range: 66-98%].[9]

TB treatment outcomes. In the RM, 81% of new and relapsed cases (2021 cohort) and 60% of RR/MDR TB cases were successfully treated.

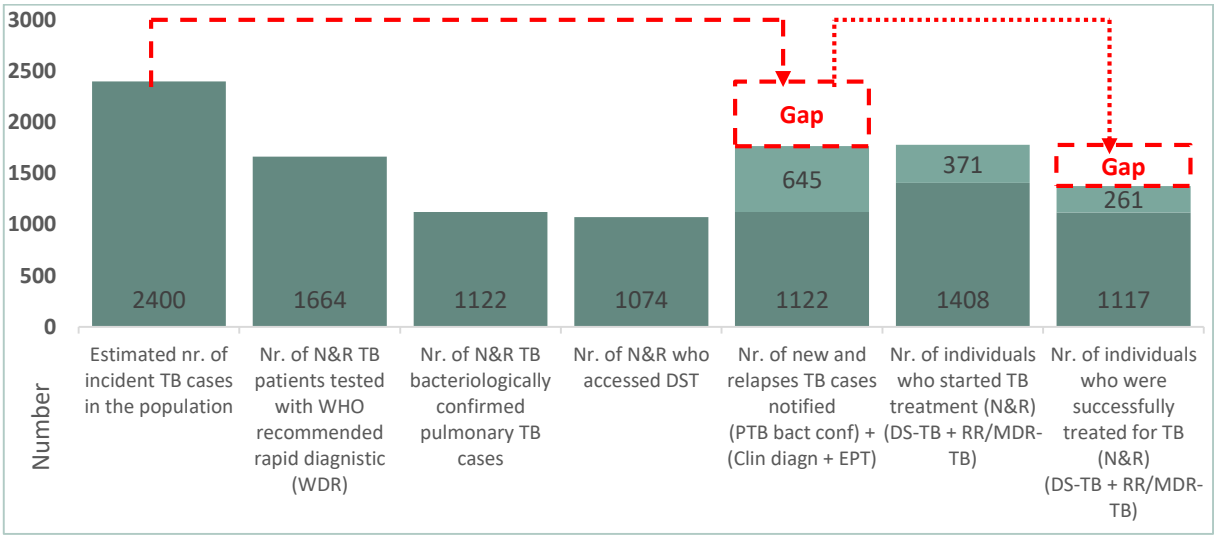
Treatment failure is mainly driven by deaths (13%) among patients with susceptible TB and loss to surveillance (17%) among those with RR/MDR TB (Figure 5)

[7] 33% = 263 new HIV cases on preventive TB treatment / 804 total new HIV cases*100%
[8] 47% = 109 children up to 5 years of age from contact with bacteriologically confirmed TB contacts who received preventive TB treatment / estimated no. of family contacts up to 5 years of age (232; range: 214-253)
[9] 80% = (reported incidence/estimated incidence) = 2067*100/[2600 (2100-3100)].

The cascade of TB services

The cascade of services, shown in Figure 6, demonstrates the gaps in achieving TB response activities by 2020. The most obvious are the gaps in diagnosis and successful treatment of TB patients. Over a quarter (26%) of people with TB have not been diagnosed, and over a fifth (22%) of people diagnosed with TB (new or relapsed case) have not been successfully treated (Figure 6).

Figure 6. Cascade of TB services, Republic of Moldova, year 2020



Source: WHO Reports 2012-2021; EMIS TB

External factors that may influence the TB epidemiological situation

- According to World Bank data, Moldova is an upper-middle-income country[10]
- Out-of-pocket payments for healthcare were 36% in 2019[11] (higher than the acceptable level of 25%)[12]
- HIV infection:
    - Estimated number of people (adults and children) with HIV = 15 000 [13 000 - 19 000] by 2021[13]
    - Estimated HIV prevalence (adults aged 15+) = 0.8 [0.7 - 1.0] by 2021[14]
    - Anti-retroviral treatment coverage (ART), all ages = 48% [40-58%] by 2021[15]
- High tobacco use - 29% (men - 52%; women - 6%; year 2020)
- High alcohol consumption. Total alcohol consumption per capita (litres of pure alcohol, estimated data, 15 years and over) was 11.4 litres in 2018[16]
- Estimated increasing prevalence of diabetes (5.6% for 2021; 6.4% for 2030)[17]
- Incarceration rate - slight reduction (191 per 100 thousand population in 2020 compared to 215 in 2018)[18]

[10] https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-group
[11] https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=MD
[12] WHO indices
[13] https://www.unaids.org/en/regionscountries/countries/republicofmoldova
[14] https://www.unaids.org/en/regionscountries/countries/republicofmoldova
[15] https://www.unaids.org/en/regionscountries/countries/republicofmoldova
[16] https://data.worldbank.org/indicator/SH.ALC.PCAP.LI?locations=MD&name_desc=false
[17] https://diabetesatlas.org/
[18] https://www.prisonstudies.org/country/moldova-republic

Module Susceptible and resistant TB: diagnosis, care and treatment

TB screening

CSO involvement in TB diagnostic activities

CSO TB screening activities have focused on screening, contact tracing and sporadically, sputum collection and transport to microscopy centres. In the period 2020-2021, 10 and 12 CSOs respectively were involved in screening activities; 6 and 8 CSOs respectively in contact tracing activities and 2 and 1 out of 13 active CSOs respectively in sputum collection activities[19] .

Over the period 2017-2021, the number of TB outpatient specialised healthcare facilities (OSHCs) working with CSOs to screen for TB increased from 8 (2017) to 35 (2018) and included all 59 OSHCs (2020-2022)[20]. The passive TB screening method, is prevalent in the country (67% in the average 2019-2022). Respectively about one third of the cases diagnosed with TB are screened by the active method. Note the contribution of CSOs in their involvement in TB screening: 41% (2021) and 19% (2022) of TB cases screened by the active method were referred for diagnosis by CSOs (Figure 7).

Figure 7. Number (proportion) of TB cases detected by passive and active methods by the health system and CSOs, 2019-2022

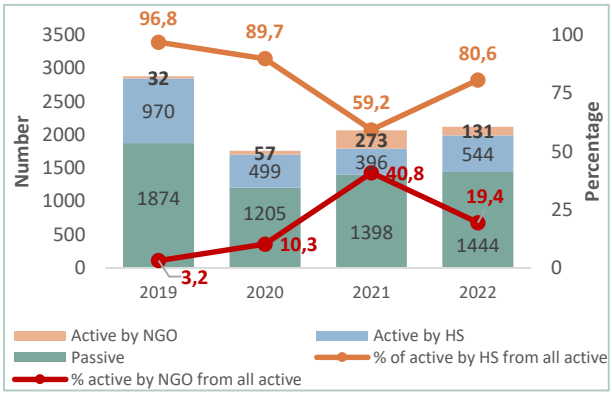
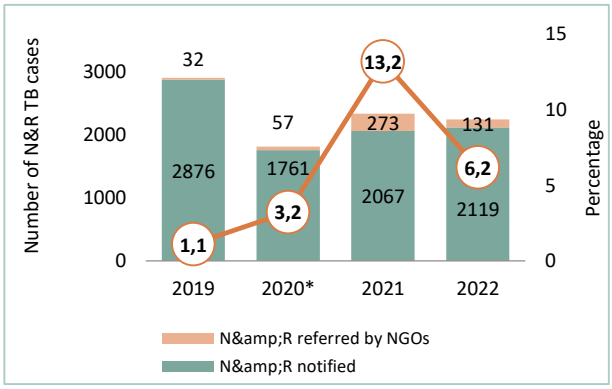


Figure 8. Number of new and relapsed TB cases notified and referred (proportion) by CSOs to TB diagnostic testing facilities, 2017-2021



HS=health System: N&R = new and relapse; *year 2020 includes only 4 months of CSO activity; Source.[21]

Between 2021-2022, CSOs contributed to TB counselling and screening of 41,513 people at risk of TB nationwide, contributing to the detection and treatment enrolment of 273 (13%) and 131 (6%) people with TB respectively out of the total notified cases (Figure 8). Note that the variation between 2021 and 2022 is due to the lower volume of investigations performed with CSO support in 2022 compared to 2021.

Screening activities were carried out from GF and NHIC sources, and the cost for radiological examination was covered from Primary Health Care (PHC) budgets or through mobile screening equipment (MoH/NHIC). Furthermore, one third of all persons screened for TB were diagnosed with other lung (including cancer) and cardiovascular pathologies and referred for further diagnosis and care as needed.

Screening activities, with the involvement of CSOs, have been carried out among groups at risk for TB and especially among those most difficult to reach by the health service, such as: homeless adults (HA), people who

[19] Retrospective study conducted to analyse the involvement of civil society organisations active in the field of tuberculosis in the Republic of Moldova, http://pas.md/ro/PAS/Studies/Details/389
[20] WHO Report 2017-2022
[21] Retrospective study conducted to analyse the involvement of civil society organisations active in the field of tuberculosis in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/389

inject drugs (PID), people with alcohol dependence, unemployed, day labourers, low-income people, people living with HIV (PLWH), migrants. According to 2021 data, among the examined homeless 4.4% (33/743) of TB, 1.2% (43/3466) of IDUs and people dependent on alcohol, 0.7% (121/17284) of unemployed, day labourers and low-income people, 6.6% (5/76) of PLWH and 1.3% (16/1255) of migrants[22] were detected with TB. However, taking into account the estimated number of the population of the RM that is attributed to one of the TB groups at risk and in need of TB screening, the need for continued efforts and even geographical expansion is emerging, particularly in territories that are facing human resource shortages at PHC level.

CSO views based on involvement in TB diagnostic (screening) activities

Following the implementation of TB support and detection activities (screening activities), community representatives encountered difficulties in identifying beneficiaries in accordance with their affiliation to the TB groups at risk, which was mentioned by 71% of CSO-TB respondents. It was also mentioned that in most cases, information on groups at risk is missing or insufficient in the PHC registers (71%). In addition, problems were mentioned in paying for radiological examinations for persons in the TB group at risk from the medical institution (50%); difficulties in mobilising and organising the selected persons for various reasons, including drunkenness (79%), but also overlapping and/or competing with examinations carried out using mobile screening equipment (37%) in the absence of prior coordination.

It should be noted that in the course of CSO screening activities, issues that could influence in one way or another the accessibility of TB diagnostic services were also noted. Although, performance investigations in TB diagnosis is not a routine examination, in some cases (medical indications, differentiated diagnosis, etc.) they are indicated to patients, but are not carried out due to the excessive cost of investigations, also taking into account that most of the people with TB are uninsured. The request for performance investigations (additional costly diagnostic examinations such as CT scan, etc.) was indicated in 35% by the CSOs. In this regard, covering the cost of expensive investigations, necessary in some cases for TB diagnosis, would be welcome for people with signs suggestive of TB in accessing TB diagnostic services, mentioned in 88% cases by the CSO-TB.

The contribution of the community in the detection of TB on the background of cases diagnosed and notified with TB at national level is hardly visible, and not recognized as an indicator, due to the de facto lack of such an indicator - *the number of people identified with TB with CSO support in the electronic register (SIMETB),* this was mentioned by 44% of CSO-TB.

Also, often, the case with signs suggestive of TB referred by the CSO for confirmation or refutation of the TB diagnosis can take on average more than 30 days (minimum 10 days, maximum 100 days). Another aspect mentioned by respondents is the duration of the inclusion of information on the confirmed TB case in the national electronic register (Information System for Monitoring and Evaluation of TB cases - SIME TB), which can vary between 7 and 100 days (on average 30 days)[23] , which sometimes leads to errors in the reporting of indicators, but also to delays in the validation process of the case referred by the CSO.

Challenges and Opportunities

- The detection rate of TB cases in relation to the estimated number is about 80% (Figure 1), which indicates that 20% of TB cases at national level remain undiagnosed by the health system; cases that remain in the community and can transmit TB infection. It should also be noted that passive detection (67%) of TB cases is predominant, which also indicates late detection of the disease. In this context, active screening needs

[22] Retrospective study conducted to analyse the involvement of civil society organisations active in the field of tuberculosis in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/389

[23] Current legislation requires reporting of confirmed TB case within 72 hours

to be more widely implemented. The value of CSOs in active TB screening is also clearly evident (38% of actively screened cases referred by CSOs).

- TB screening activities among key and vulnerable populations remain a challenge for TB control in the country, namely in the area of early TB detection, and CSO support and involvement in TB screening activities adds value to TB screening among hard-to-reach populations with limited access to health services.
- CSO involvement in TB screening activities is requested in the more hard-to-reach contingents of the health system and at higher risk of TB than the general population, such as:
    - people who use drugs (PUD) (27 times higher risk of TB)
    - people with alcohol abuse (risk of TB is 27 times higher); on average 10% of TB cases notified annually are people with alcohol abuse
    - Homeless people (the risk of TB is 16 times higher); on average 9% of cases diagnosed with TB are people without a stable place to live (mainly concentrated in Chisinau municipality)
    - External migrants - on average 12% of TB cases notified are migrants
    - uninsured and/or low-income and/or socially vulnerable (proportion of TB patients without medical insurance police - 59%; unemployed and/or without income - 61%; living in unsatisfactory living conditions - 48% of total number of people notified with TB annually)[24]
    - people with reduced access to health services. PHC coverage in districts ranges from 98% to 61%. On average 30% of people notified with TB also suffer from other diseases, such as non-communicable diseases[25] . Respectively, the involvement of CSOs in screening activities in districts with low coverage of PHC services at community (village) level could bring added value in screening activities, including through the integration of testing services for TB, HIV, Hepatitis C, and non-communicable diseases.
    - people living with HIV (risk of TB is 20 times higher). More than 10% of people diagnosed with TB are HIV-infected.
- Expanding TB groups at risk for CSO accessibility in screening activities would lead to an expansion in access to TB diagnostic services for people at risk for TB. This was mentioned by 71% of TB CSOs.
- Developing mechanisms on how to access people in some key groups and how to facilitate TB screening by CSOs would avoid the procrastination of the person's TB investigation. This was mentioned by 63% of TB CSOs.
- It is recommended to conduct a study on the examination of contacts and TB risk group at PHC level in order to identify barriers and ways to improve activities in these groups.
- There is a need to estimate the number of people per risk group, to develop distinct performance indicators and how to calculate them.

Adherence to TB treatment

In terms of adherence to TB treatment, the CRG study[26], highlights the limited consultation and discussion with patients at the PHC and/or OSMC level on TB progress, treatment outcomes, infection control, etc., but also the shortcomings at the territorial level on the implementation of the motivational support mechanism (incentives), including at the private PHC level; but also the insufficiency of social support services to ensure treatment completion.

[24] Statistical data, SIME TB
[25] Statistical data, SIME TB
[26] Assessment of barriers related to community involvement, human rights, gender issues and level of stigma associated with TB in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/395

The same study[27] indicates that daily visits to the health centre by the person with TB could contribute to disclosure of the TB diagnosis, which fosters stigma and treatment discontinuation; and that non-compliance with DOT out of good intentions (doctors trust some patients and release their pills for a long period of time to spare patients from daily visits) could lead to non-compliance with the regimen and treatment interruptions - all of which are arguing for maintaining and expanding the opportunity for DOT activity at home.

With reference to homeless people, the CRG study[28] points out the following: 1) in most cases, homeless are discharged early from inpatient care for regimen violations, often due to internal conflicts and stigmatisation from other patients; 2) there are no placement centres for Homeless with TB where they could receive treatment on an outpatient basis; 3) in most cases, Homeless people are not welcome at the doctor's office in medical institutions, being a highly stigmatised group, also due to the lack of a permanent place to live, which makes it difficult to supervise the person.

CSO involvement in TB adherence activities

Activities carried out by the CSOs for TB treatment adherence included: DOT support, VST, adherence counselling and psychological support[29] (Figure 9).

Figure 9. Number of CSOs involved in TB treatment adherence activities, 2014-2021

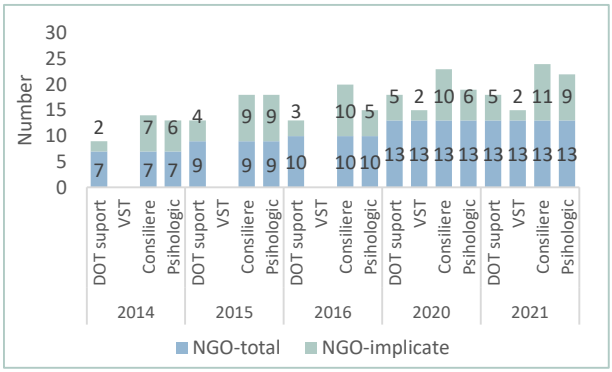
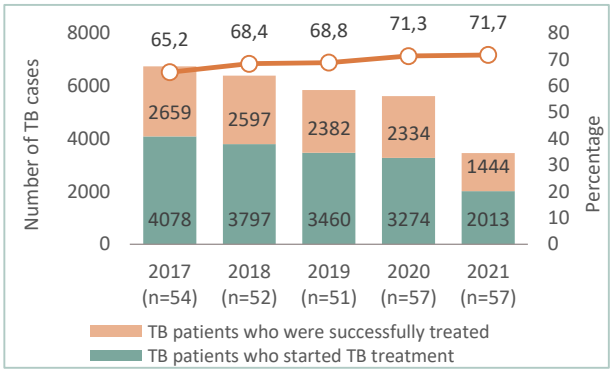


Figure 10. Number and proportion of TB patients receiving adherence support, 2017-2021



Source: WHO Reports 2017-2021

During 2021, 4515 TB patients (all forms) were on treatment, of which 402 (9%) received information and/or counselling from CSOs to improve adherence to TB treatment. During 2021, 17% of TB patients on treatment (all forms) received treatment adherence support from the CSO (including psychosocial support).

With reference to the provision of social support to patients for adherence to treatment, the number of TB institutions through which support was provided varied from 51 (2019) to 57 (2021) out of the 59 medical institutions involved in TB care[30] . Treatment success among patients receiving social support increased from 65% in 2017 to 72% in 2021 (Figure 10).

According to the KAP survey[31] , the majority of respondents felt that not treating TB to completion was determined by *hospitalization for at least 2 months, going to the doctor daily for treatment* (76%) and *long*

[27] Assessment of barriers related to community involvement, human rights, gender issues and level of stigma associated with TB in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/395
[28] Assessment of barriers related to community involvement, human rights, gender issues and level of stigma associated with TB in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/395
[29] Retrospective study conducted to analyse the involvement of civil society organisations active in the field of tuberculosis in the Republic of Moldova, http://pas.md/ro/PAS/Studies/Details/389
[30] WHO Annual Report, 2019-2021
[31] Tuberculosis in Moldova: knowledge, attitudes and practices of the general population, 2021; https://pas.md/ro/PAS/Studies/Details/361

duration of treatment (76%). The same survey[32] , points out that in the majority of cases respondents agreed to morally support and follow up on the administration of medication by a former TB patient (74%), indicating the need to maintain peer support.

The CRG study[33] also emphasises the existing eligibility criteria for VST which limit the availability of VST for all potential patients, including minors.

CSO views based on involvement in TB treatment adherence activities

CSO-TB mentioned about the availability of services related to treatment adherence in the locality (district/municipality) where they work: DOT (79%); VST (92%); screening services for adverse reactions to TB medication (42%); outpatient treatment of adverse reactions (29%), motivational kits (67%), reimbursement of transport costs (75%).

From CSO-TB's work experience, the most welcome types of services for adherence to treatment among medical ones would be: DOT at home (83%), VST (83%), availability of treatment for adverse reactions at outpatient level (87%); of the support services: social support (100%), nutritional support (100%), child care support (in the community-79%; in foster care -58%), peer support (67%), motivational kits (non-food, hygiene packs) - 83%.

In accessing TB treatment services, patients often face associated costs. The opinion of the CSO-TB, based on the implementation of the support activities in the field is: covering related costs such as reimbursement of transport costs to take their treatment at the DOT point (family doctor's office/centre) - 75% and reimbursement of transport costs to go to the TB clinic (92%). These are or would be most beneficial for the person with TB to maintain adherence to treatment.

Following the implementation of support activities by CSO-TB in the field, they were outlined with some difficulties such as: lack of cost of the support service (intervention), including information (67%); current low expected cost of implementing DOT at home (71%); current unattractive cost of the support interventions (71%). More than a third of CSO-TBs (38%) reported complaints from beneficiaries about the motivational packages offered from NHIC sources, and 33% of CSO-TBs noted insufficient technical skills of medical staff for VST operation, which most likely determines the low inclusion of people in VST. In order to remedy the situation, CSO-TBs stress on the need to ensure continuity of treatment for people at high risk of discontinuation and loss of supervision (100%), the need in quantifying the package of support services offered by CSOs (83%), but also increasing the attractiveness of the package of services for adherence to treatment (88%).

Challenges and Opportunities

- The treatment adherence rate among people with TB who received support increased from 65% (2017) to 72% (2021).
- Ensure support for treatment adherence through CSO involvement by:
    - Maintaining 'peer-to-peer' councillors.
    - Promote the use of VST, through the model of providing logistical support services from CSOs and coordination activities through the M&E Department (NTP coordination unit). It is recommended to reassess the eligibility criteria for VST.

[32] Tuberculosis in Moldova: knowledge, attitudes and practices of the general population, 2021; https://pas.md/ro/PAS/Studies/Details/361
33 Assessment of barriers related to community involvement, human rights, gender issues and level of stigma associated with TB in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/395

- Maintain home-based DOT through CSOs, including expanding the package of home-based DOT services to cover more people willing to benefit from such support within available resources, but also in the context of clear criteria for enrolment in such support.
- Ensuring continuity of homeless TB treatment through CSO involvement. Develop TB case management at homeless people, including application of social management.
- Review the way motivational support for adherence to treatment is provided from NHIC sources.

- Conducting the operational study on the assessment of risk factors for non-adherence to treatment (susceptible TB and resistant TB) at different stages of treatment.

Prevention Module

In 2020, 550 contacts from bacteriologically positive outbreaks in the Republic of Moldova have initiated TPT, of which 441 (80%) have completed it. It is worth mentioning the availability in the country from 2021 of the short preventive treatment regimen with *Rifapentine* and the initiation of such treatment among 335 persons (including PLWH)[34].

Involvement of CSOs in carrying out prevention activities

As of 2020, 13 CSOs carry out awareness raising and information activities on TB prevention (10 CSOs in 2016 and 7 CSOs in 2014)[35].

CSO views on TB prevention

More than half (58%) of CSO-TBs mentioned about the availability of TPT for eligible people in their locality. In 67% of cases, CSO-TBs consider TPT for eligible people to be one of the most welcome types of health services.

Priority TB prevention interventions from a CSO-TB perspective for an effective national response to TB challenges were considered: Advocacy Communication and Social Mobilization (ACSM, 54%), information and education (92%); promotion of TB vaccination as a prevention method (63%), as well as organizing TB vaccination promotion campaigns (71%), promotion of TPT (88%).

Challenges and Opportunities

- The low share of knowledge about the availability of TPT for eligible persons is an indication of insufficient information of the population about the existence and opportunities of TPT for eligible persons.
- Conduct TB vaccination promotion campaigns. Involve CSOs in TB vaccination outreach interventions among key and vulnerable populations.
- Running campaigns to promote TPT and increase demand for it.
- Community-based TPT (involving CSOs) in TPT adherence information interventions, but also the possibility of actual treatment delivery, consultation and supervision.

Key and vulnerable populations module

According to the latest updates, there are 18 groups identified in the country that are systematically screened for TB, such as: contacts persons from TB outbreaks (intra-domiciliary contact), persons deprived of liberty, PLWH, with untreated lung changes detected during chest X-ray, with non-specific chronic lung disease, with diabetes mellitus, starting therapy with TNF (formate/nitrite transporter) inhibitors, treated by dialysis, preparing for organ or bone marrow transplantation, suffering from silicosis, homeless, PUD, who abuse

[34] WHO Annual Report, 2022

[35] Retrospective study conducted to analyse the involvement of civil society organisations active in the field of tuberculosis in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/389

alcohol, mental health disorders, active smokers, migrants (outpatients), as well as staff in healthcare institutions and staff employed in places of deprivation of liberty (both at increased risk of infection)[36] .

Involvement of CSOs in carrying out TB response activities in key and vulnerable groups

The CSO conducted TB screening activities among PLWH, PIDs, people with alcohol dependence, unemployed, day labourers, low-income people and migrants (see TB screening, p.12).

CSO views on key and vulnerable TB populations

The majority of CSO-TB (79%) respondents mentioned the need to implement integrated case management, including social case management in vulnerable groups, but also the need to develop the Intervention guide for external migrants (75%).

Challenges and Opportunities

- Involvement of CSOs in carrying out screening activities in key and vulnerable groups (see sub-module TB screening, p. 12)
- Involvement of CSOs in conducting treatment adherence activities, including homeless (see TB adherence sub-module, p. 14)
- Involvement of CSOs in carrying out treatment adherence activities in detention and referral/accompaniment for continuity of treatment of people with TB released from prison (see Module 4, p.35)
- Implementation of integrated case management, including social case management in vulnerable groups, in particular homeless (see module Integrated person-centred services, p.43)
- Development of the Regulation on interventions for external migrants and refugees.

[36] (Национальное руководство по организации и проведению систематического скрининга и профилактического лечения при туберкулезе, 2022 at MS level for approval)

HIV component

Recommendations

- CSOs active in the field of HIV prevention, harm reduction and support contribute to the achievement of the objectives of the National HIV/AIDS Programme, an effort that needs to be further supported by the Ministry of Health, the National Health Insurance Company, the Ministry of Labour and Social Protection (MLSP) through the development and implementation of policies, methodological norms and funding mechanisms, as well as by taking into account the voice of civil society in the processes and decisions taken in the field of HIV/AIDS (within the CCM TB/AIDS) and related ones.
- Intersectoral cooperation in the implementation of the National HIV/AIDS Programme (relations with the coordinating department, principal recipient, sub-recipient) is considered by CSOs as constructive and the national dialogue in the context of the development of the GF 2024-2026 implementation as inclusive. At the same time, there have been reported uncertainties regarding the management architecture of the new grant activities and services at the Principal Recipient/Sub-recipient level and informing the CSO on the dynamics of the negotiation processes and decisions.
- The synergy between the efforts of the National HIV/AIDS Programme and the National Tuberculosis Response Programme, at the level of cooperation, services and activities implemented is evolving, however there is no a common management plan and joint actions at the level of the coordinating departments of the programmes, including on issues of collaboration among CSOs in the two sectors. It is recommended to coordinate efforts at both policy and activity level by integrating CSO services (screening, testing, diagnosis, support, HIV/TB adherence) and the KAP Committee with CSOs active in TB - members of the TB Platform, including the Community HUB expert team.
- CSOs provide a wide range of services, from prevention to support in the context of ensuring treatment effectiveness. Organisations vary in their level of development and their efforts can be enhanced by strengthening their capacities through the establishment and maintenance of a system of continuous training and provision of cross-cutting and multidisciplinary training. Ensuring sufficient funding for CSO efforts is a priority in maintaining their active involvement in the implementation of the National HIV/AIDS Programme.
- CSOs are providing services based on the Standard for the Organisation and Operation of HIV Prevention Services in the setting of key populations, including young people in these groups[37] which involves addressing the complex needs of beneficiaries in the context of HIV, TB, substance dependence, sexual and reproductive health (SRH), mental health, etc. However, there is a lack of integrated services at the level of CSOs and medico-social services, highlighting the need for resources and mechanisms. It is proposed to create two community-based integrated medico-social care centres with piloting from GF sources.
- In its efforts the CSO documents a number of legislative barriers to accessing health and social services faced by people in the group at high risk of infection and PLWH (disclosure of personal and medical data, denial of services, criminalisation of drug use and sexual service activity, etc.). Humanisation and decriminalisation of the RM legislation in the context of HIV, drug use and sex for remuneration, and other issues associated with access to social and health services, including violation of the rights of people in HRG and PLWH are critical.

[37] Order MSMPS No.278 of 18.03.2020 On the approval of the Standard of organization and operation of HIV prevention services in key populations, including young people in these groups, http://uorn.md/wp-content/uploads/2020/05/Standardul-de-organizare-si-functionare-a-serviciului-de-prevenire-HIV.pdf

- Inadequate coverage of prevention and support services for key afected populations and PLWH calls for coordinated efforts by CSOs and HIV/AIDS NP authorities to implement comprehensive, quality and attractive services through the provision of basic and extended packages of services, in line with the Standards, but also with sufficient quantification and funding. Financing of extended packages of services for 30% of the beneficiaries of the basic package needs to be ensured following the identification of national funding sources, with the current allocation of resources from the GF and the qualification of a high priority (avoiding inclusion in the PAAR - Prioritized Above Allocation Request).
- A considerable part of the services provided by CSOs are financially supported from GF sources (prevention - 90%, psychosocial support for high risk groups and opioid agonist support programmes (OASPs) clients - 100%, psychosocial support for PLWH - 100%). In order to ensure sustainability of services, it is recommended to diversify funding sources for HIV and TB prevention, harm reduction and support services within the national and local public budgets (health and social), and to involve MLSP more actively in financing social support for key affected populations and PLWH .
- Strengthen OASP and support the capacity of the coordination unit at the level of the Republican Dispensary of Narcology (RDN) to ensure geographical expansion, quality and accessibility of OASP services and other treatments in the context of drug dependence, implement effective M&E based on WHO recommendations to ensure increased OASP coverage from 5% to at least 20% of people using and dependent on opiates. Implementation of VST in OASP.
- In order to reduce inequalities in access to services, increase the involvement of women in prevention services and men in ART and ensure their adherence, as well as coverage of MSM and transgender people, it is necessary to reform HIV and TB prevention, harm reduction and support services taking into account the gender, age and place of residence (rural, urban) of the beneficiaries.
- The political support provided to CSOs by the Local Public Authorities (LPA) is considerable, with the exception of direct funding of services for high risk groups and PLWH and ensuring effective management of local HIV/AIDS prevention and control programmes, thus it is recommended to strengthen local HIV/AIDS and TB programmes and implementation and coordination units, with the provision of M&E tools, access to programmatic and financial data, as well as LPA participation in the CCM TB/AIDS platform.
- The high level of stigma and discrimination is maintained by the medical and social system in relation to HRG and PLWH, it is recommended to support practices and tools created by CSOs to overcome legal barriers in accessing services and advocacy, protection of human rights and legal empowerment of people in HRG and PLWH to claim their rights (network of paralegals, REACT[38] , Implementation of strategic litigation, advocacy campaigns etc.).
- The need to increase HIV testing rates and inclusion in ART, ensure adherence and undetectable viral load, increase geographical coverage with prevention and support services in the context of accessibility (including during COVID-19) has conditioned the development and application by CSOs of innovative methods through digitization of interventions (development of web-outreach and telemedicine approaches) that need to be maintained and expanded, including at the public service level. In this context it is recommended to implement index testing through CSOs.
- The political and economic environment in the eastern part of the country is not supportive of implementing innovations and ensuring the sustainability of CSOs. Efforts are needed to ensure sustainability and identify at least one mechanism to support HIV and TB related CSOs from local resources. It is recommended to continue support activities for high risk groups and OASP implementation with the support of international organisations.

[38] A JavaScript library for building user interfaces

- The M&E system of the HIV/AIDS National Program is provided with coordination and implementation tools (including the online service register), but without including the work of the regional social centres in the current reporting and monitoring system. It is recommended to consider and implement the CLM and to integrate the CLM into the national M&E mechanism of the HIV/AIDS NP. The M&E vertical at local level needs to be strengthened and coordinated.
- In order to strengthen prevention and harm reduction services, it is recommended to initiate a dialogue on the opportunity to create safe consumption rooms. It is recommended to develop a normative basis and pilot two safe consumption areas.
- Underage children do not have access to harm reduction services, including those with substance use problems to prevention, screening and treatment programmes (HIV testing, needle exchange, condoms, OASP), including the use of new psychoactive substances, alcohol and tobacco, which is a national problem. Age limits should be revised in line with international recommendations to exclude barriers to accessing harm reduction services for minors.
- The National Administration of Penitentiaries (NAP) implements HIV prevention services among PID, and is an international model of best practice. At the same time, support activities are carried out exclusively by CSOs and funded mainly from GF sources. In order to ensure the sustainability of interventions, there is a need to develop mechanisms for contracting CSOs to provide psychosocial support services to prisoners and to involve prison staff (psychologists, social workers) in providing psychosocial support for people in high risk groups, including cognitive behavioural change programmes and support for adherence to OASP, ARV and TB treatment.
- Criminalising drug use in places of detention, conditions limited access to harm reduction programmes (HRS), including OASP and requires legislative changes. Stigma and discrimination against people in OASP, amplified by the influence of the criminal subculture on initiation and adherence, particularly in pre-trial detention, requires the development and implementation of a comprehensive strategy to reduce stigma and discrimination against high risk groups in detention.
- The war in Ukraine, which followed the COVID-19 pandemic and influenced the activities of the TB and National HIV/AIDS Programme, including CSO interventions. HIV and TB prevention activities among refugees and external migrants need to be strengthened, based on their impact in short, medium and long term (distinct and integrated TB and HIV interventions in these groups, based on clear accompaniment and referral mechanisms).

Priority directions, CSO HIV, 2024-2026

1. Ensuring universal access to prevention, support and health care services by implementing comprehensive and quality services for people in high risk groups, PLWH, those affected by TB and HIV and addicted to psychoactive substances in line with international recommendations, but also reforming services taking into account the gender, age and place of living (rural, urban) characteristics and particularities of the beneficiaries.
2. Create enabling conditions for the implementation of community-based pre-exposure prophylaxis (PrEP) through de-personalisation of data as well as 'demedicalization' of community-based post-exposure prophylaxis (PEP) and include these provisions in the National Clinical Protocol (NCP) on PrEP.
3. Humanization and decriminalization of the Moldovan legislation in the context of HIV transmission, drug use and sex work and other issues related to access to social and medical services and violation of the rights of people in HRG and PLWH.

4. Support practices and tools created by CSOs to overcome barriers, including legal barriers in accessing services and advocacy, protecting human rights and legally empowering people in HRG and people living with or affected by HIV and TB to protect their rights (network of paralegals, REACT, etc.).
5. Diversify funding sources for HIV and TB prevention, harm reduction and support services from national and local health and social budgets alike.
6. Strengthen CSO capacities in service delivery and participation in decision-making in the context of the implementation of the National HIV/AIDS Programme through equipping, training, involvement, including CSO and community involvement in conducting operational research in the areas of HIV, TB and related areas.
7. Strengthen the OASP and support the capacity of the coordination unit at RDN level to ensure geographical expansion, quality and accessibility of OASP services and other treatments in the context of drug dependence, implement effective M&E and based on WHO recommendations, implement communication tools with the patient community and involve them in the processes of organising OASP work.
8. Strengthen local HIV and TB response programmes and implementation units in both the civil and prison sectors on both sides of the Dniester River by providing M&E tools, access to programmatic and financial data, participation in the CCM TB/AIDS platform.
9. Implementation of the CLM, including the application of the separate methodology, exclusion of conflicts of interest and respect of ethics. Consider CLM as part of the M&E tools of the National HIV/AIDS Programme and provide financial support for the development and implementation of CLM by communities.
10. Supporting innovation, including through digitisation and telemedicine, applied to policy, management, M&E, service delivery, capacity building, in both government and associations.

HIV burden in the Republic of Moldova

HIV/AIDS is a public health priority in Moldova. Cumulatively, from the beginning of the epidemic to the end of 2022, 16,106 HIV positive cases have been registered compared to 15,249 estimated cases (SPECTRUM)[39] .

HIV case notification. In 2022, 929 new HIV positive cases were registered. The share of detected HIV cases out of the number of cases expected to be detected was 87% in 2021 (Figure 11).

The majority of people tested for HIV are young people of reproductive age who are sexually active. The number of primary HIV cases reported by gender shows different trends. The number of HIV cases among women remains stable - 380 (18 cases per 100 thousand population), the number of HIV cases among men shows an increasing trend from 341 (17.4 per 100 thousand population) to 538 (28.3 per 100 thousand population in 2010 - 2022. Among the new cases registered in 2022 - 59.4% are men.
The HIV epidemic is thought to be concentrated in HRG, particularly among MSM and IDUs.

- PID - 11.4% -
- Sex workers (SW) - 2.7%
- MSM - 11.4%

HIV prevalence in the SW setting is lower compared to the MSM and PID group, with a slight downward trend from 3.9% (2017) to 2.7% (2020). In Balti municipality, the prevalence is twice as high as in Chisinau municipality (4.4% and 2.1%, respectively).

The HIV prevalence in the PID environment shows a stable decreasing trend during the last years from 13.9% (2017) to 11.4% (2022). Tiraspol municipality (eastern region) shows the highest prevalence (23.5%) compared

[39] https://sdmc.md/wp-content/uploads/2022/08/MD_Raport_anual_HIV_RO_2021.pdf

to Balti (14.9%) and Chisinau (8.1%). The majority of PIDs are concentrated in large localities of the country, given the concentration of the population, although they are also identified in small districts[40].

AIDS mortality. During 2022, 271 deaths were recorded, down 16.9% from 2021 (Figure 12).

Figure 11. Estimated and notified new HIV cases, Republic of Moldova, 2012-2022

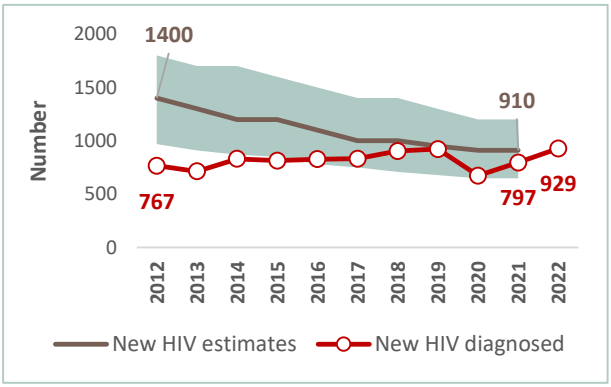
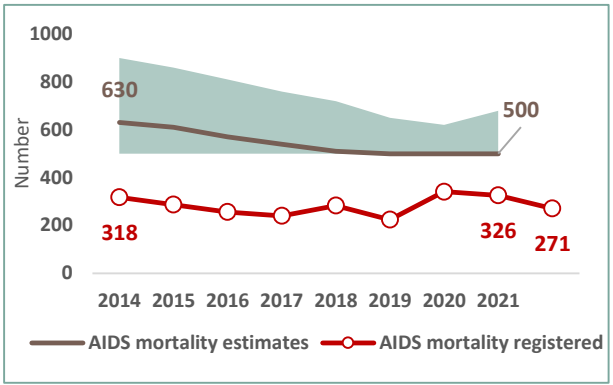


Figure 12. AIDS mortality, estimated number vs. number of registered deaths, 2014-2021



Source: UNAIDS, DCDH

Estimates and forecasts

- Forecasts 2021-2025, SPECTRUM
    - HIV prevalence will increase - from 0.51% to 0.56%
    - Incidence of new HIV positive cases will decrease from 0.03% to 0.02%
    - Mortality due to AIDS is projected to decrease steadily from 16.01 per 100 thousand population (2021) to 4.55 per 100 thousand population (2025).
- Estimates of people in HRG, year 2020
    - PID - 27 500 people (HIV prevalence - 10.3% right bank; 20% - left bank)
    - SW - 15 800 people (HIV prevalence - 2.7% right bank)
    - MSM - 14 600 people (HIV prevalence - 11.4% right bank)
- To reduce the number of transmissions and prevalence of infection, especially in HRG: MSM - no more than 12%, PID - 10%, SW - 2.5% and to minimise HIV-related mortality.

Programmatic factors on the HIV epidemiological situation

HIV prevention programmes, year 2022:

- PID covered with prevention services - 61.7% (NP target HIV/AIDS - 75.9%)
- SW covered with prevention services - 49.1% (NP HIV/AIDS target - 61.0%)
- MSM covered with prevention services - 33.8% (NP HIV/AIDS target - 41%)

HIV testing. The contribution of CSOs to HIV testing is evident and adds value. Over 10.5% of HIV tests performed were in CSO settings, demonstrating the accessibility of CSOs in hard-to-reach groups (Figure 13). Of the number of HIV cases detected, more than 10% are detected in CSO settings (Figure 14).

The proportion of **late diagnosis** remains very high (57.3% in 2021).

Mother-to-child transmission rate of HIV was 1.03% in 2022[41] (6.42% in 2021; 7.4% in 2019) (NP HIV/AIDS target - 2.0%)

[40] dates of harm reduction programmes, 2023
[41] Preliminary dates, 2022

Figure 13. Number of HIV tests performed in health facilities and CSOs (including proportion), 2019-2022

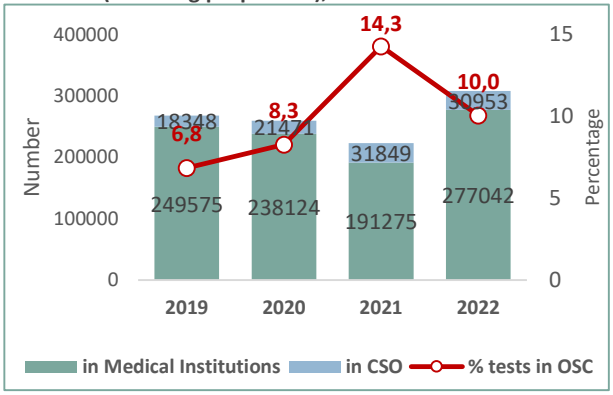
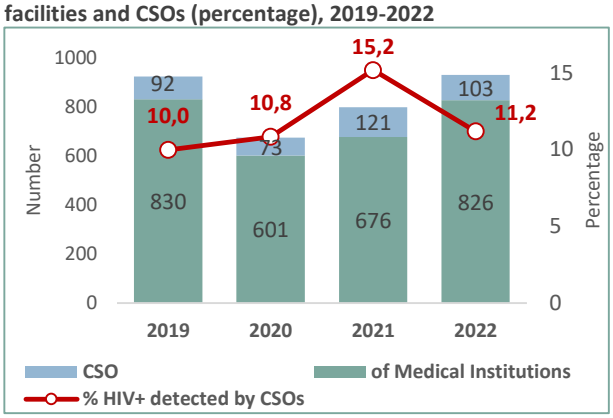


Figure 14. Number of HIV-positive cases detected by health facilities and CSOs (percentage), 2019-2022



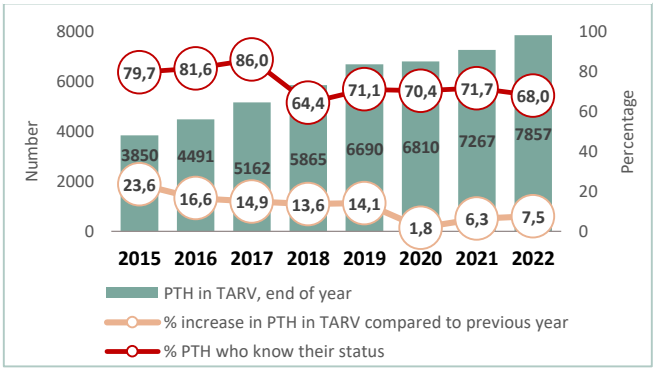
Source: SDMC

The proportion of **late diagnosis** remains very high (57.3% in 2021).

Mother-to-child transmission rate of HIV was 1.03% in 2022[42] (6.42% in 2021; 7.4% in 2019) (NP HIV/AIDS target - 2.0%)

ART coverage.[43] According to the HIV NCP[44,45] , all patients with HIV, regardless of disease stage and CD4 level[46] are taken on ART. The number of HIV-infected people on ART is increasing (**Ошибка! Источник ссылки не найден.**).

Figure 15. ART coverage, 2015-2022



In 2022, 921 people were placed on ART, 330 people were re-initiated, 378 people were abandoned and 166 people died. At the end of 2022 were administering ART - 7,857 persons.

In order to increase **adherence to treatment** in 2022, 77.5% PLWH received support services. By the end of 2022 after 12 months from the start of treatment, adherence was 82% (85% in 2021), after 24 months - 74% (81% in 2021) and after 60 months - 69% (74% in 2021).

HIV cascade

Cascade 95-95-95 (year 2022): the first 95% reached 68% (66% -2021), the second - 70% (72%- 2021), and the third - 89% (89% - 2021) (Figure 16). Note that the figures reported for the HIV cascade 95-95-95 require increased interventions.

Cascade 95-95-95 (year 2022) in territorial disaggregation, after the left and right bank of the Dniester River is presented:

- Right bank - the first 95% reached 67%, the second - 73% and the third - 88%.
- Left bank - the first 95% reached 79%, the second - 72% and the third - 92%.

Cascade 95-95-95 (year 2021) in disaggregation by sex is shown:

[42] Preliminary dates, 2022
[43] https://sdmc.md/wp-content/uploads/2022/08/MD_Raport_anual_HIV_RO_2021.pdf
[44] Order No 538 of 7 June 2022 "On the approval of the National Clinical Protocol "HIV infection in adults and adolescents"
[45] Order No 540 of 7 June 2022 "On the approval of the National HIV Clinical Protocol for children aged 0 to 10 years"
[46] Differentiation group/cluster 4 (glycoprotein)

- Men - the first 95% reached 87%, the second - 69% and the third - 56%.
- Women - the first 95% reached 91%, the second - 75%, and the third - 84%.

Figure 16. Cascade 95-95-95, 2019-2022

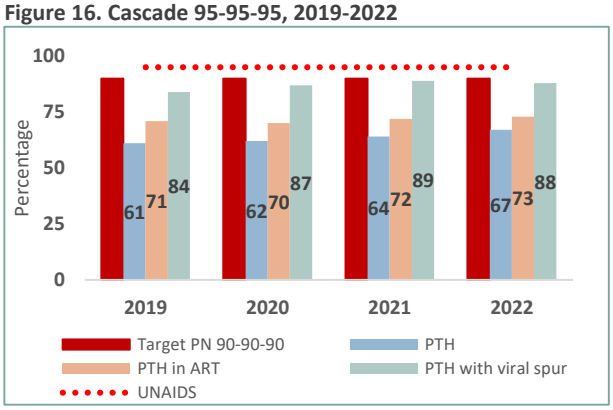
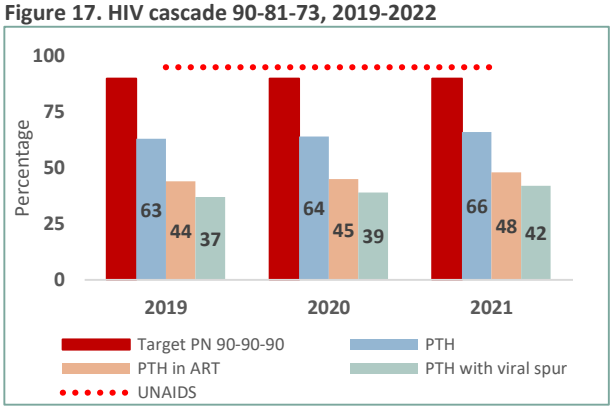


Figure 17. HIV cascade 90-81-73, 2019-2022



ART - antiviral treatment, PTH - people living with HIV

Therefore, if in the case of people on ART who have undetectable viral load, the difference between women and men is not evident (6%), then for those who know their status, the difference is significant - 28%, which highlights that men are not sufficiently covered by treatment and support services.

Analysis of the 90/81/73 waterfall shows that all three targets remain untouched (Figure 17).

Module: HIV/AIDS Prevention and Control Programme Management

Through the coordination unit (located at the DCDH), the management of the HIV/AIDS NP is in a continuous process of streamlining on issues related to M&E of programme activities, intersectoral collaboration, including with CSO service providers, support to national funding and synergy of funding mechanisms from different sources (GF, NHIC), representation at political level of the interests of the HIV/AIDS NP.

The leadership of the coordination unit of the HIV/AIDS NP is undisputed at TWG level, by supporting and placing on the agenda the topics related to the work of the HIV/AIDS NP, contributing to their analysis and resolution. From the perspective of intersectionality, however, the coordination unit does not fully succeed in coordinating and synergising its activities with the NTP coordination unit, as well as facilitating collaboration with other related programmes, such as the SRH Programme[47] (2018-2022) and the National Anti-Drug Strategy[48] (2011-2017). On M&E aspects although successful implementation of viable and sustainable tools (Single Electronic Reporting Register) is achieved, the NP HIV/AIDS does not have a comprehensive M&E manual with inclusion of all tools including community implementation tools (CLM - Community Led Monitoring, CLR - Community Led Research) and satisfaction assessment tools. Coordination and M&E at the local management level of the HIV/AIDS NP activities is weak, including the lack of communication and interaction with some local coordinating entities (LPA health services, Public Health Centres), a situation that undermines the intention to increase the financial contribution from LPA resources for the implementation of the HIV/AIDS NP.

There is no plan to ensure the sustainability of activities financed from external resources (transition plan), but there is also no risk management plan, although in the context of the war in the neighbourhood and the large influx of refugees on the territory of the Republic of Moldova, assistance and access to prevention and treatment services for people from Ukraine has been provided in a timely manner.

[47] https://www.legis.md/cautare/getResults?lang=ro&doc_id=108813
[48] https://www.legis.md/cautare/downloadpdf/121214

Key groups: MSM, transgender people

CSO involvement in PrEP implementation

PrEP implementation, started in health facilities in 2018, with 2-6 people enrolled in 2018-2019, which following CSO efforts by piloting community PrEP expanded to 416 people (of which 321 or 80% of them are MSM) by the end of 2022. The specific task is to increase the number of MSM in PrEP, but also to increase the involvement of other groups such as PID and SW. However, the number of people enrolled in PrEP remains small (including community) compared to the NP HIV/AIDS targets.

The prevention programme for transgender (TG) persons was launched in 2021 (GF sources). 69 TG persons (115%) were covered by such services in 2022.

Challenges and Opportunities

- Coverage with prevention services among MSM and TG persons is low.
- MSM and TG persons have been prioritised and included as major groups, but the funding does not cover the needs of the beneficiaries and the package of services (e.g. in 2022, 550 BSB received services from national sources (NHIC), which is 40% of the estimated total expected to be funded).
- PrEP scale-up is limited and conditional on the requirement to provide passport data, which reduces the acceptability of PrEP services among key populations, especially in regions and small towns (districts).
- Monitoring of PrEP enrolees requires additional tools and analysis, with new HIV cases (10 cases) reported among PrEP users for reasons such as being in the window period and for reasons of non-compliance with PrEP administration.
- Expand quantitative and geographical coverage with HIV/STI prevention services, improve the package of services, including by increasing the attractiveness and quality and sufficient funding of services in MSM and TG settings.
- Develop web outreach, cover expenses for profile accounts on mobile apps and social media, outreach (advertising, outreach), HIV education among MSM and TG via online platforms.
- Ensuring delivery of the basic, expanded and modular HIV/STI prevention package among the MSM, TG and LGBT+ community[49] . Note the need to quantify the package of services for TG people according to the needs of the group (specialist consultations: endocrinologist, psychiatrist, gynaecologist, proctologist, urologist, hormone therapy, etc.).
- Create favourable conditions for PrEP implementation through depersonalisation of data (application of e-cards), implementation of community PEP (through CSOs) and inclusion of these provisions in the NCP, quantification of services, information campaigns to promote MSM, TG, LGBT+.
- Ensuring access to integrated community medical and social services.

Key groups: Sex workers

Penalising of paid sex creates considerable barriers to accessing health and social services for SW, maintains high levels of stigma and discrimination, as well as group isolation and anonymity. Despite efforts to activate and mobilise this group, SW remains the most 'silent' group, with insignificant results in addressing specific issues.

[49] Abbreviated LGBT+ (sometimes LGBT, LGBTIA+, LGBT+ LGBTQ, queer, gay or other acronyms) is an acronym referring to the lesbian, gay, bisexual, transgender, transsexual, queer, and other non-sexual minority communities

Data from the study *Assessing the level of training of sex workers in Chisinau in Community Mobilization, including involvement in HIV control measures* [50] , presents information on the consistent use of contraceptive methods by SW; on alcohol and drug use before and after service provision, but also in case of physical and/or sexual abuse by partner/client. The study also reflects on the reservations in integrating SW into the community, but on the non-involvement of SW in community mobilisation. The analysis of the degree of access to medical services by SW highlighted that in most cases medical tests (pregnancy test and HIV test) were provided by CSOs. The majority of SW (75%) are not registered with their family doctor and only 7% have a health insurance policy.

CSO involvement

HIV prevention services for SW are provided through 13 CSOs (9 - right bank, 4 - left bank) in 36 localities.

Challenges and Opportunities

- Expanding coverage including geographic coverage with HIV prevention services, including improving the attractiveness and quality through sufficient funding of services in SW settings.
- Ensure provision of basic, expanded, modular HIV/STI prevention packages in the SW setting.
- Developing online prevention services in the SW environment.
- Sufficient quantification of services in relation to the needs of the SW group (specialist consultations: gynaecologist, therapist, psychologist, social worker, paediatrician, hygiene packs, etc.).
- Increase awareness of community PrEP and implementation in SW settings.
- Creating and ensuring SW access to integrated community-based health and social services, including crisis foster care, SRH, mental health, gender-based violence, vocational integration guidance and support.
- Social mobilisation of the SW community (including within the KAP committee and the CCM TB/AIDS).
- Implementation of primary legal aid services, paralegal services, strategic litigation.
- Capacity building of existing hotline operators and extension of skills in the context of specific SW information assistance.
- Advocacy for decriminalisation of sexual activity, information campaigns to raise visibility and change the SW situation, etc.
- Conduct operational research on availability, access and proximity of prevention and support services for SW.

Key groups: People who use drugs

Achievements, including through CSO involvement

The estimated number of PID in 2020 was 27,500, most of them concentrated in large towns, although small communities are also identified in small districts[51]. HIV prevalence in PID settings shows a stable decreasing trend over the last years (13.9% - in 2017 and 11.9% in 2020)[52]. Tiraspol shows the highest prevalence (23.5%) compared to Balti and Chisinau municipalities (14.9% and 8.1%, respectively).

HRS services are provided through the NAP and 10 organisations (6 right bank and 4 left bank) covering 34 localities. Within the prison system, HIV prophylaxis activities for PID in detention are carried out in 15 prisons.

[50] Study "Assessment of the level of training of sex workers in Chisinau in Community Mobilization, including involvement in HIV control measures", AFI with financial and technical support from UNAIDS Moldova, 2021 http://afi.md/eng/news/assessment-of-the-level-of-training-of-sex-workers-in-chisinau-capital-of-the-repu-141

[51] PRR data, 2023

[52] IBBS, 2020

It should be noted that by the end of 2022, non-injectable PUD were not included in the list of beneficiary groups within the framework of the prevention interventions of the HIV/AIDS NP, financed from the GF and NHIC sources. Although the work of pilot interventions carried out with UNODC support in this group identified imminent behavioural risks of HIV and STI infection in consumption and sexual practices[53]. The "Standard for the organisation and operation of HIV prevention services among at-risk groups, including at-risk young people"[54], covers, in addition to the interventions recommended by the WHO, expanded services such as psychological, social and legal support; SRH protection, prevention and support services in the context of violence, including on a gender basis; gender-sensitive services, as well as shelter services, provided both at the level of provider organisations and by referral. However, these services are not funded from either source.

Other achievements

- Satisfactory geographical coverage with HRS for PID - 34 localities and 15 prisons.
- The KAP Committee is an active platform for dialogue between civil society and the CCM TB/AIDS, consulted in the decision-making processes.
- Initiating the integration of the PID into the environment of people consuming stimulants and new substances with psychoactive properties, including the approval of the Protocol on assistance to persons using stimulants and new substances with psychoactive properties[55] .
- Initiating PrEP inclusion of PUD, although to date, the number of PUD covered by pre-exposure prophylaxis is low and stands at around 5% of all people included in PrEP.
- Creation in 2021, with the support of UNODC, of three crisis rooms for women in the PUD environment in the cities of Chisinau, Balti and Rabnita.
- Creation of a distance learning platform for HRS staff and staff of organisations providing HIV support services www.formare.md.[56]
- Organize and maintain the activity of the network of paralegals/specialized legal aid, with the technical support of the NLAC active in providing primary legal aid services and overcoming legal and social barriers in accessing services. Documentation of human rights violations through REACT.
- Update the costs of HR services financed from GF resources at the end of 2022 taking into account inflation (34%).

OASP context - achievements, CSO involvement

OASP s have been implemented since 2004 in the civilian sector and since 2005 in the prison sector. OASP is a key part of the National HIV/AIDS Programme and the National Drug Strategy[57]. As of 2019, OASP is funded from national sources through the NHIC and is currently available in 10 locations in the civil sector and 13 prisons. HIV/AIDS NP within its specific objectives aims by 2025 to increase the geographical coverage with 18 new OASP implementation sites. Buprenorphine has been introduced in the OASP since 2018, although there is previous experience in administering this preparation. Both methadone and buprenorphine are included in the list of essential medicines and procured through the Centre for Centralised Public Procurement in Health

[53] http://uorn.md/wp-content/uploads/2021/01/Moldova-NPS-Research_RUS.pdf
[54] Order MSMPS No.278 of 18.03.2020 On the approval of the Standard of organization and operation of HIV prevention services in key populations, including young people in these groups, http://uorn.md/wp-content/uploads/2020/05/Standardul-de-organizare-si-functionare-a-serviciului-de-prevenire-HIV.pd
[55] Order of the Ministry of Health of the Republic of Moldova No 314 of 31.03.2022 on the approval of the National Clinical Protocol "Disorders related to the use of new substances with psychoactive and stimulant properties in adults and adolescents", https://ms.gov.md/wp-content/uploads/2022/10/Protocol-Clinic-399-RO-final.pdf
[56] 2021, UNAIDS & Unwomen).
[57] National Anti-Drug Strategy 2020-2027 https://cancelaria.gov.md/sites/default/files/document/attachments/proiectul_640.pdf

(CCPPH), but are not in the catalogue of registered products in the RM. The average doses of the preparations are 60-70 mg for methadone and 12-14 mg for buprenorphine, and the treatment itself is long-term oriented. The policy and regulatory framework is supportive and collaboration and technical assistance from multilateral partners[58] ensures alignment with international recommendations. The NCP for OASP is updated regularly, on average every two years. Home-based treatment was widely introduced during the COVID-19 pandemic period, being implemented at a reasonable scale - 35-70% depending on location, with review of the approach by moving to daily administration from the second part of 2022, in relation to payment per visit conditional on NHIC and some behavioural patterns of major overdose risk recorded in patient settings. During 2022, innovative solutions have been proposed and initiated within the OASP such as: integration into the common electronic patient record register and VST that will ensure validation of remote intervention on par with face-to-face visit. Continuity of treatment of people released from prison is ensured, if OASP is available in the patient's locality of reference. The existence of dialogue at the level of the parliamentary committee on the subject is aimed at strengthening the narcological care system, the quality, accessibility and availability of OASP services.

Challenges

- Inadequate coverage of prevention services in the context of UNAIDS 95-95-95 targets.
- Low level of HIV testing among PUD as part of the HRS (5.4% in 2017 and 21.5% in 2019).
- Minimal interventions in small and rural areas, including through CSOs and the public health system (50% of cases identified in rural areas).
- Concentration of services in the PID setting and lack of a clear vision for identifying and covering non-injectable PUD with HR interventions.
- Conditioning inclusion in the OASP with compulsory medical supervision (Single Register).
- Insufficient integration of TB, HIV, Viral Hepatitis services at CSO level to provide services to key populations, insufficient exploration of resources for related programmes (TB, viral hepatitis, mental health, SRH).
- Lack of a national electronic OASP record-keeping system, which creates problems for recording, referral, estimating needs and assessing stocks of medicines.
- The volume and modality of funding in relation to the coverage indicator incentivises the achievement of quantitative outcomes, reducing the quality of services in terms of the needs and expectations of service beneficiaries.
- Extremely low OASP coverage - <5% (611 patients out of an estimated 12,900 with opioid dependence) and modest targets set under the HIV/AIDS NP - 14.9% by 2025.
- Lack of OASP on the left bank of the Dniester River and prospects for implementation.
- Medical supervision under the OASP narcotic register - a condition that is a major barrier affecting demand for this care.
- Lack of referral mechanisms for the provision of complex care (PHC, psychiatric, etc).
- Funding *per visit* (NHIC) decreases the motivation for doctors to administer treatment at home.
- Provision of OASP services only through the narcotic care system - need to extend to PHCs, private medical institutions and pharmacies.
- The quality of OASP services is not monitored and there is no viable M&E system.

[58] UNAIDS, UNODC, WHO

- The psycho-social component is not mandatory and the sustainability of its funding is not ensured (the only source of funding being the GF).
- Concentration of the OASP in the narcology service, lack of narcology doctors and the existence of the practice of decentralisation of treatment in the PHC and the prison system.
- Presence of negative perceptions of some doctors about OASP, refusal to implement them, and lack of administrative tools to redress the situation.
- Stigma and discrimination against OASP patients in medical and social institutions.

Opportunities

- Documentation of risks and implementation of HR interventions tailored to the PUD group, with increased focus on the youth group, increased gender, age and human rights sensitivity, starting from the definition of outreach strategies, expansion of the package of interventions based on the complexity of needs, including specific consumables, as well as their quantification and integration into funding mechanisms from GF and NHIC sources.
- Analysis of geographical coverage in terms of the need to reach the PUD in small and rural localities not covered by HR interventions, where new cases of infection are documented (50% of all new cases), ensuring gender and age sensitivity.
- Adjust funding mechanisms and volumes to ensure continuity and quality of interventions, based on indicators achieved, boosting performance.
- Ensure the planning and implementation of specific actions to integrate TB and HIV, viral hepatitis, mental health, SRH services to ensure safe, quality and comprehensive services for key and vulnerable gender and age sensitive populations.
- Evaluate and strengthen the narcology care system, review the current narcology medical supervision mechanism based on the register of records.
- Train and educate narcologists on evidence-based treatment and care.
- Extend OASP, including based on implementation of alternative service delivery models and adaptation of appropriate regulations through PHCs, private healthcare providers, pharmacies, mobile units.
- Implementation of the video assisted OASP treatment (VST).
- Develop connections between narcology services, PRR and mental health centres.
- Develop and introduce mechanisms to monitor the quality of OASP, including tools for communication and interaction with patients. Ensure the application of CLM in the context of OASP.
- Ensure coordination and management of national anti-drug policies as set out in the National Anti-Drug Strategy, based on specific quantifiable targets, costs and funding.
- Ensure the effectiveness of the OASP coordination entity (RND) by strengthening its administration.
- Develop and implement tools to involve the PUD and patient community in the organisation, evaluation and promotion of the OASP, both at national and local level.
- National implementation of an electronic OASP and medicines record system.

Differentiated HIV testing services module

The "Test and Treat" strategy is being implemented: rapid testing and rapid initiation of ART (same day or within 7 days of diagnosis in most cases).

CSO results, year 2022:

⇒ PID - 19,274 HIV tests, number of people tested - 12,121, of which 23 were confirmed positive (19 - right bank and 4 - left bank).

⇒ SW - 8,141 HIV tests, of which 7 were confirmed positive (2 - right bank and 5 - left bank).

⇒ MSM - 5,683 HIV tests, number of people tested - 4,143, of which 17 were confirmed positive (16 - right bank and 1 - left bank).

⇒ Testing of partners of the above mentioned groups carried out without consistency and periodicity, being a voluntary work within the framework of the NP HIV/AIDS activities.

Challenges and opportunities

- Despite the wide range of testing approaches (self-testing, HIV testing promoted through social media, community-based testing, testing in health facilities, etc.), the proportion of late diagnosis remains high (57.3% in 2021).
- There are missed opportunities in HIV testing of HRG or facing inequities, both in PHCs and in the work of CSOs active in TB and HIV, which requires targeted efforts, including by expanding testing to small and rural settlements.
- Self-testing is poorly promoted and the reporting algorithm is not developed.
- Implement Index testing, notification and partner-assisted testing and facilitate linkage to treatment and support services in case of confirmed infection.
- Increase awareness and knowledge among PHC and OSMC medical staff about clinical indications for HIV testing.

Treatment, care and support module

Achievements, including through CSO involvement

Access to ART is provided in 15 territorial-administrative medical facilities (including the Eastern Region and the prison system on both sides) regardless of the availability of the health insurance policy.

The number of people on ART is steadily increasing. By the end of 2022, the UNAIDS targets (95-95-95) have been reached 67-73-89, while the UNAIDS targets (90-90-90) have not been reached.

The health care system is fragmented. The lack of integrated centres for the provision of patient-oriented HRG services is a constant obstacle to providing a comprehensive package of services in the context of the person's needs, related to issues such as drug addiction, TB, hepatitis, HIV, mental health, treatment of non-communicable diseases, etc[59] .

CSO views on treatment, care and support

The majority (87%) of CSOs-HIV believe that several types of treatment support such as motivational food, non-food, health (ointments, vitamins, etc.) and hygiene kits, financial and peer support would be welcome. CSO-HIV also mentions on the difficulties in managing the transport costs of PLWH for ART pick-up as well as their accessibility.

[59] Республика Молдова: Оценка устойчивости ответа на ВИЧ среди ключевых групп населения в контексте перехода от поддержки Глобального фонда на государственное финансирование https://harmreductioneurasia.org/wp-content/uploads/2022/01/TMT-Report-Moldova-EHRA-2021-RUS.pdf

Following the CSO-HIV opinions it is revealed that doctors in the territorial offices perceive their workload as enormous. At the same time, the CSO-HIV specifies the lack of funding from national sources for psychosocial support provided by CSOs.

In the context of implementing interventions for treatment, care and support, the CSO outlines including some challenges that directly or indirectly influence the delivery of interventions, such as the reluctant approval of the Standards for Support and Care (6 months after their completion) and the lack of quantification of them[60].

Challenges and opportunities

- Continue decentralisation of ART and introduce psychosocial support interventions as part of the integrated approach to service provision in line with person-centred needs.
- Develop integrated services (including psychosocial support in all treatment centres).
- Institutionalize the possibility of issuing ART using courier services with the support of CSO workers, but at the same time ensure oversight of the effectiveness of ART.
- With a view to including PLHIV in ART, there is a need to promote and develop mechanisms for adherence support for ART and OASP from NHIC sources (similar to the existing TB adherence support model).

Mixed component

Mixed module: human rights, gender equality and non-discrimination in accessing HIV and TB services

The main barriers to accessing HIV and TB prevention, treatment and support services remain: lack of trust in the health system, perceived high levels of stigma and discrimination by health workers towards people living with HIV and TB, lack of respect for confidentiality of personal data, even in the presence of protection mechanisms, especially in districts and rural areas (studies 2018[61] CRG[62]). Even if not enforced, provisions of the law still criminalize and penalize HIV exposure and transmission, drug use, including in places of detention, sexual activity creating additional barriers to ensuring safe behavioral practices and access to services. All of these increase vulnerability and amplify risks to TB and HIV or even reduce access to prevention, diagnosis, treatment and care services. As a result, these inequalities influence people's ability to realise their right to health, resulting in limited access to TB and HIV services despite their availability.

According to the KAP operational survey[63], one in ten (9%) respondents said they had seen and heard of cases where a person with TB was stigmatised because of the disease. The CRG study[64] indicates that people generally do not know their rights, are stigmatised by family members, children are institutionalised and there is insufficient support at community level. Despite the fact that people with TB are perceived as a source of infection and their social rejection and isolation affects the long-term psychological well-being of the individual, there is extremely low[65] addressability to the Equality Council compared to the scale of the phenomenon, also

[60] Standard of organization and functioning of the psychosocial support service for PTH, approved by MS order no.273 of 31.03.2023
[61] http://uorn.md/otchet-po-rezultatam-issledovaniya-dostup-k-uslugam-snizheniya-vreda-dlya-zhenshhin-upotreblyayushhih-inektsionnye-narkotiki-gorod-belts-respublika-moldova/
[62] Assessment of barriers related to community involvement, human rights, gender issues and level of stigma associated with TB in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/395
[63] Tuberculosis in Moldova: knowledge, attitudes and practices of the general population, 2021; https://pas.md/ro/PAS/Studies/Details/361
[64] Assessment of barriers related to community involvement, human rights, gender issues and level of stigma associated with TB in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/395
[65] In the entire history of the Equality Council 2011-2023, only one case of stigma or discrimination in the context of TB (compared to COVID-19, HIV AIDS, other diseases) has been reported,

due to insufficient knowledge of recognition of discriminatory situations[66,67]. The level of stigma perceived by health workers towards people with TB is 61%. Presence of stigma in health care institutions (mentioned by 22% of respondents), which could hinder access to TB services[68] .

Achievements, including through CSO involvement

Networks of specialised paralegals have been developed (developed procedures, with the support of the NLAC, but also collaboration of CSOs with the territorial offices of the NLAC, public defenders and human rights organisations - IDOM, Promo-LEX, People's Advocate).

Several important amendments have been made to the Law on Ensuring Equality, with reference to both non-discrimination and equality[69] .

On the other hand, there is less involvement of TB-related CSOs in respecting human rights, reducing stigma and discrimination against people with TB, which underlines the need to integrate approaches to the topic along the lines of HIV-related CSOs[70].

CSO views in the context of human rights

In the survey about 10% of CSOs-HIV said they did not know what human rights are, which is alarming considering that some of them are either service providers or service recipients. Three of the most frequently violated rights are: the right to privacy (88%), the right to physical and mental health (64%) and the right to social protection. According to the CSO-TB, three of the most frequently violated human rights in accessing TB services are: the right to privacy (75%), the right to social protection (46%) and equally - the right to innovation, freedom and information (33%).

In this context, CSOs indicated about the availability of services in their locality (district/municipality): lawyer's advisory services (21% CSO-TB), paralegal assistance (29% CSO-TB and 94% CSO-HIV), support in the preparation of documents (38% CSO-TB and HIV), specialized legal services (94% CSO-HIV).

In the process of conducting treatment adherence support activities, all (100%) CSO-TB mentioned about the lack of resources for motivating or addressing some pressing needs of the person not adherent to TB treatment such as completion of paperwork, etc.

With reference to the most welcome types of support services for people affected by TB and HIV mentioned by CSOs would be legal support (67% CSO-TB and 80% CSO-HIV), specialised paralegal and legal assistance (71% CSO-TB and 81% CSO-HIV), conflict mitigation and referral to specialised assistance (56% CSO-TB and 78% CSO-HIV).

In terms of social inclusion and non-discrimination services, the most welcome would be: supported employment during the period of illness for eligible persons (67%), supported employment during the post-treatment period (96%), stigma reduction interventions (97%), the implementation of campaigns to promote human rights and stigma reduction (83%), and the need to implement social management of children affected by TB, mentioned in 71% of cases by CSO-TB. CSO-HIV consider supported employment and stigma reduction interventions as the most important social inclusion and non-discrimination services.

[66] Assessment of barriers related to community involvement, human rights, gender issues and level of stigma associated with TB in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/395
[67] http://egalitate.md/news-and-information/marcarea-zilei-mondiale-de-combatere-tuberculozei/
[68] Assessment of barriers related to community involvement, human rights, gender issues and level of stigma associated with TB in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/395
[69] https://www.legis.md/cautare/getResults?doc_id=135489&lang=ro
[70] Assessment of barriers related to community involvement, human rights, gender issues and level of stigma associated with TB in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/395

Challenges and Opportunities

- The existence of legal provisions that criminalise and penalise certain key populations in the context of HIV and TB. The involvement of the work of the Parliamentary Committee on Health and Social Protection in addressing human rights issues and the provision of health and social services, including the need to review legislation on various issues, is an opportunity.
- Review of legislation providing for unjustified transmission of medical data to third parties. Review the mechanism of data transmission and clearly define the circle of health employees for whom this information is needed.
- Review and adjust legal framework in line with international recommendations on decriminalisation of drug use for non-medical purposes, including exclusion of compulsory (forced) treatment, humanisation of HIV legislation, decriminalisation of sex work; adjust national legislation by gender recognition, gender identity (gender recognition) in identity documents (Public Services Agency), which is a legal barrier in accessing medical-social services for TG persons. Align the RM with WHO recommendations on demedicalization of programmes for TG persons.
- Harmonisation of the legal framework related to TB control and prophylaxis with specific issues to remove barriers related to community involvement, respect for human rights (inequity, support during treatment, medical and social rehabilitation after treatment), gender and stigma issues and linkage with other legislative initiatives and integration of common monitoring and evaluation indicators.
- The monitoring and evaluation system of the HIV/AIDS NP does not include gender and age specificity (formulation of indicators, reporting and analysis procedures, use of gender-neutral formulations)
- Strengthen the network of specialised paralegals in all programmes including public programmes, targeting PLWH, HRG and people affected by TB (including through digital solutions) and expand the implementation of CLM through the network of paralegals and strengthen their work in removing legal barriers in accessing prevention and support services.
- Low but consistent level of violation of the rights of people living with HIV and HRG representatives in the health system.
- Existing and distributed supplies for HRG do not reflect the gender and age dimension and are 'gender neutral', often being reduced to SW-specific hygiene packs and specialised advice only in some implementation units.
- Ongoing information to HRG, people affected by TB and service providers about fundamental human rights, and availability of legal support in case of their violation, in a gender and age specific context.
- Develop and implement a comprehensive strategy to reduce stigma and discrimination against people from HRG in detention.
- Conduct TB and HIV human rights information and literacy campaigns to eliminate stigma, discrimination and other barriers to accessing TB and HIV related health services (supported in 83% CSO-HIV and TB), decriminalisation, reduction of stigma towards HRG. The need for these was mentioned by 75% of CSOs.
- The need to implement social management of children affected by TB, mentioned by 71% of CSOs-TB.
- Over time CRG and stigma assessments to document progress, mentioned in 60% of CSOs- HIV and TB.

Mixed mode: People in detention

The prevalence of TB, HIV and drug addiction is higher in places of detention compared to the community. The comprehensive package of 15 HIV prevention, treatment and care interventions[71], is essential for scaling up HIV prevention, treatment and care (including in the context of TB, viral hepatitis, STIs, SRH) in prisons and other places of detention. The Committee for the Prevention of Torture has visited the RM in recent years (2022[72] and 2020[73]) with a focus on access to TB and HIV services for people in detention in police and prison custody. Given the importance of respecting the pathway of people from vulnerable groups, it is essential to ensure access to support services from the moment of detention (for 72 hours) and throughout the time in the prison system. Another challenge is the Foreigners' Placement Centre, managed by the Migration and Asylum Bureau of the Ministry of Interior Affairs (MIA), which in addition to activities related to illegal migrants requires support to align its approaches in providing TB and HIV services, as well as cross-border transfer of information in case of extradition.

Tuberculosis in prisons (right bank)

- Proportion of TB cases constitutes 3.1% of the number of new cases and relapses registered (4.6% in 2021)
- Incidence of new cases and relapses reduced from 1204.9 (year 2018) to 891.2 per 100,000 population (year 2022)
- Proportion of TB cases diagnosed with TB on entry to prison - 40% (year 2022)
- Share of TB/HIV among new cases and relapses - 19% (year 2022)
- TB treatment success rate (new cases and relapses) - 88.7% (2021 cohort)
- TB treatment success rate (RR/MDR-TB) - 50% (2020 cohort)

Tuberculosis in prisons (left bank)

- Proportion of TB cases constitutes 6.9% of the number of new cases and relapses registered (6.4% in 2021)
- Incidence of new cases and relapses reduced from 68.0 (year 2018) to 109.5 per 100 thousand population (year 2022)
- Proportion of TB cases diagnosed with TB on entry to prison - 91% (year 2022)
- Share of TB/HIV among new cases and relapses - 17% (year 2022)
- TB treatment success rate (new cases and relapses) - 45% (2021 cohort)
- TB treatment success rate (RR/MDR-TB) - 53% (2020 cohort)

HIV in prisons (right bank)[74]

- HIV tested - 5586 in 2022 (4496 in 2021 and 2473 in 2019)
- New HIV cases among prisoners - 26 in 2022 (20 in 2021 and 29 in 2019)
- Number of HIV infected prisoners - 196 in 2022 (178 in 2021 and 149 in 149)
- ART - 185 inmates, including - 26 new and 7 returning ART patients (year 2022)

Estimated data (right bank)[75]

- PID - 1940 detainees annually or about 15% of people in detention

[71] recommended by WHO, UNODC, IOM, UNAIDS (2013, updated 2020) https://www.unodc.org/unodc/en/hiv-aids/new/prison_settings_HIV.html
[72] https://www.coe.int/ru/web/cpt/republic-of-moldova
[73] https://rm.coe.int/16809f8fa8
[74] REPORT on the work of the penitentiary system for the year 2022
https://drive.google.com/file/d/1lwPQj2QaMNceE2_xb4LNq1H8qf9CbKH8/view
[75] https://www.unodc.org/unodc/en/hiv-aids/new/prison_settings_HIV.html

OASP in prisons (end 2022). 101 PIDs (32 - new beneficiaries) benefited from **OASP**; 29 beneficiaries discontinued methadone treatment; 20 convicts benefited from continuity of methadone therapy through case transfer from MoH and 33 beneficiaries were released from detention. Buprenorphine treatment was given to 22 prisoners. Detainees convicted for circulation of narcotic substances[76] constitute 9.0% of the total number of detainees on the right bank of the Dniester River[77]. **OASP** in prisons in the eastern region is not available.

Health care in the area of TB and HIV response in the prison system is provided in accordance with the provisions of the NP HIV/AIDS and TB. The CRG study[78] notes the unsatisfactory conditions of detention and inadequate food, as well as insufficient medical staff in prisons.

In the 15 temporary detention isolators (TDIs) in the custody of the General Police Inspectorate (GPI), about 5,000 people are held every year, about half of whom are transferred after 72 hours to the custody of the NAP. The high proportion of TB and HIV cases detected on entry into the penitentiary system points to a need for interventions in this segment and high probability of reaching hard-to-reach groups for both NPs. Role of CSO in ensuring communication between government actors (GPI, NAP, NP) in case of transfer of person, ensuring continuity of TB, HIV, OASP treatments, ensuring access to confidential screening services through CSO and with gradual involvement of TDIs medical staff. There are good practices of working with police officers and carrying out joint activities in the field of TB and HIV, trainings[79] and provided search kits, referral schemes to the Temporary Placement Centre for Foreigners (TPCF), Migration and Asylum Office and Border Police GI Medical Service, MIA. The TPCF has a capacity of about 60 places, with up to 100 people being placed during a year. Medical assistance is provided through the medical service of the General Inspectorate of the Border Police (GIBP)[80]. There are a number of inadequacies in accessing TB and HIV services, such as lack of confidentiality, involuntary testing, interrupted treatment while in the RM and after extradition. Changing the composition of TB risk groups as well as the refugee crisis in Ukraine requires several aspects of intersectoral collaboration and mechanisms to be established and implemented, including human resource capacity building.

Involvement of CSOs in delivering HIV and TB interventions

OASP is running in 13 prisons, including 4 pre-trial izolators (PTI), with a cumulative number of 697 beneficiaries *(since the project's inception - 2005).* The psychosocial support component, including OASP, is implemented by CSOs in 11 prisons (mostly remand prisoners are not covered). Continuity of treatment of persons released from detention and availability of OASP in the locality of reference is ensured, but separate programmes implemented by CSOs for PLWH and persons in OASP are not available. With CSO support has developed the[81] training programme for HIV peer counsellors (in the process of approval by the National Agency for Quality Assurance in Education and Research).

In 2022, 22 prisoners with TB completed treatment, receiving adherence support through CSOs, and 1 prisoner with TB was released from detention and accompanied to the civilian medical system to continue treatment in outpatient settings. Annually, about 100 prisoners benefit from adherence support, but about 50 prisoners are

[76] Art. 217- 219 (Art. 225 of the Criminal Code) https://www.legis.md/cautare/getResults?doc_id=121991&lang=ro, date 01.01.2023
[77] https://www.unodc.org/unodc/en/hiv-aids/new/prison_settings_HIV.html
[78] Assessment of barriers related to community involvement, human rights, gender issues and level of stigma associated with TB in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/395
[79] with the support of external partners UNODC, UNAIDS, FG
[80] http://ombudsman.md/wp-content/uploads/2022/11/Raport-privind-vizita-de-monitorizare-efectuat%C4%83-la-Centrul-de-plasament-temporara-al-str%C4%83nilor-din-cadrul-Biroului-Migra%C8%9Bie-%C8%99i-Azil-al-MAI-la-17-august-2022.pdf
[81] https://formare.md/course/view.php?id=25

released. Support programmes in prisons in the eastern region are not available, and TB inmates released from the 4 prisons are admitted to the TB hospital in Bender.

CSO opinions

With reference to working with the prison system, CSOs mentioned improving referral mechanisms for continuity of treatment of prisoners with TB (71%), the need to ensure continuity of treatment of prisoners with TB (63%) and the need to review the TB Case Management Regulation in the prison system (33%).

It was also noted that there is a need to work with the police to establish referral schemes for treatment and support schemes for HRG[82], including involvement in campaigns to promote non-discrimination, HIV testing, etc. In a regional initiative, there was good collaboration at municipality level resulting in the signing of Zero HIV cities declarations[83]. The same good collaboration with the police was also mentioned by CSOs from the Eastern region. There is a need to support and expand these collaborative activities.

Challenges and opportunities

In the CSO's view there are several challenges, including systemic ones, which become obstacles in the implementation of the interventions foreseen in the NP on HIV/AIDS and TB, including those implemented with CSO support such as:

- Psychosocial support in the prison system is provided through full-time psychologists but is not focused on working with key affected groups. The service is also available through CSOs and funded by the Ministry of Justice (therapeutic community) but the funding does not fully cover the costs, the service is co-financed from GF sources. PTIs experience the highest OASP discontinuation rate but are not covered by psychosocial support services.
- There are reservations in the multidisciplinary approach to case management in the context of HIV and TB (predominantly from GF sources through CSOs). Psychologists and social workers employed by the prison system do not possess sufficient skills to provide support to people in HRG in line with the provisions of the service package. The need is highlighted in the development of treatment adherence training for prison support staff (psychologist, social worker) and involvement in OASP, ARV, TB treatment adherence support activities to ensure sustainability of interventions.
- There are discontinuations of ARV, OASP and other treatments after release and lack of support programmes. Interventions are needed to ensure continuity of treatment on entry and after release from detention (referral and follow-up system; similar to TB practices), including through CSOs.
    - Development of prison treatment adherence programmes (psychologist) and multidisciplinary teams, including training of prison staff
    - Continue to provide psychological counselling and adherence support to ART, OASP, TB for prisoners through CSO involvement in 11 prisons, including through NAP contracting mechanisms
    - Review and adapt existing referral mechanisms for TB treatment continuity after release (mechanisms, standard operating procedures developed) for ART and OASP
- Implementation of peer counselling programmes (among prisoners). One opportunity could be to involve peer counsellors from among prisoners (trained on the curriculum) with the subsequent possibility of their employment and integration with HRS volunteers.
- Conduct training of multidisciplinary prison teams (medical and non-medical staff) and CSOs on TB and HIV, including working with community actors to ensure uninterrupted provision of TB services. Develop a

[82] https://www.leahn.org/ru/archives/4135
[83] https://aph.org.ua/en/our-works/eastern-europe-and-central-asia/resservices/

separate programme to ensure continuity of OASP in PTI, including through the exclusion of the influence of the criminal subculture.

- Accreditation of the prison hospital and alignment with the standards laid down in the Health Regulations (TB clinical and microbiology laboratory) is necessary to provide access to quality services for prisoners with TB and HIV.
- The revision of the Regulation on TB case management in prisons and adaptation to current WHO recommendations, including the inclusion of collaborative aspects with CSOs, is a priority for sustainability and adjustment of the regulatory framework with the possibility of further contracting.
- Given the fact that underage children in detention do not have access to sex education and life skills, including HRS and treatment of addictions, HIV, STIs and TB - there is a need to develop and implement training curricula on TB, HIV and STIs for children.
- The lack of specific SRH programmes for men highlights the need to develop and implement training curricula for men and women in detention.
- The development and implementation of the telemedicine system (interdepartmental relations: prison hospital interconnected with IFP, DCDH and RND) is a sustainable and cost-effective solution that will improve prisoners' access to quality services.
- Develop and implement M&E mechanisms with the support of the TB and HIV community in the NAP, including the involvement of prisoners and ex-prisoners.
- The development of a stigma strategy for HRG and in particular towards people in OASP is a necessity in order to increase the addressability for treatment, followed by information campaigns and training for inmates, prison staff, and mixed.
- Ensure access to MSM support services, including PrEP.
- National statistics and reports provide little disaggregated data with reference to prisoners, and little operational research and studies conducted, outdated data (IBBS - Integrated biological and behavioral assessment and estimation of the number of PID, conducted in 2016). Conducting operational research in the prison system in partnership with CSOs is a necessity for evidence-based decision making. In OSC's view the following are needed:
    - conducting the IBBS study with the inclusion of TB aspects
    - estimation of the number of PUDs in prisons (including non-injectable)
    - Assessing community mobilisation preparedness of prisoners and ex-prisoners affected by TB, HIV
    - assessing gender issues in TB and HIV in prisoners
- Expanding access to HIV prevention and treatment services for people in other places of detention (police, placement centres for foreigners), including with CSO involvement.
- Improved collaboration with the Migration and Asylum Office, Border Police to establish mechanisms for working with CSOs in response to TB and HIV (external migrants, refugees).
- Conduct operational research on the accessibility and quality of TB and HIV services in places of detention, following the person pathway.

Mixed module: Refugees

An additional challenge for the health system in Moldova is the war in Ukraine. From the very first days of the war, the country has faced a large influx of refugees including people from HRG, PLWH and people with TB. Taking into consideration the public health priorities, i.e. uninterrupted access to prevention, screening, diagnosis, treatment and care services for communicable diseases, including HIV, OASP and TB, a decision was taken at the central level to provide prevention, medical, psychosocial and support assistance to all refugees

and to include people from HRG in the existing prevention, treatment and support programmes on both HIV and TB. Thus, during 2022:

⇒ were covered with services by CSOs (HIV field) - 4022 refugees
⇒ received harm reduction services - 1220 refugees
⇒ benefited from OASP - 87 refugees
⇒ were readmitted for further ART - 204 refugees
⇒ 748 refugees were tested for HIV in the CSO setting - 11 of whom tested HIV positive
⇒ received treatment for TB - 12 refugees.

Challenges and opportunities

- Working activities with external migrants (development of the database of external partners: medical and CSO)
- Ensuring access to diagnosis and treatment (TB and HIV) in the country of residence of foreign migrants, or access to treatment in the RM and mechanisms for cross-border transfer of patient information.
- The need to develop a Regulation on interventions for external migrants and refugees was supported by 75% of CSOs-TB and HIV.
- The need to involve the Border Police in the work in order to identify joint interventions and establish referral mechanisms to TB and HIV services through public providers and CSOs.

Mixed module: TB/HIV co-infection

TB/HIV burden

TB/HIV prevalence. According to WHO data, in 2021, the RM is expected to have 11% [range: 9.3-12] HIV cases among new and relapsed TB cases (Figure 18). 215 TB/HIV cases were registered in the country, which accounted for 10.4% of new TB cases and relapses reported during this period.

Figure 18. Estimated and reported TB/HIV prevalence, Republic of Moldova, 2007-2022

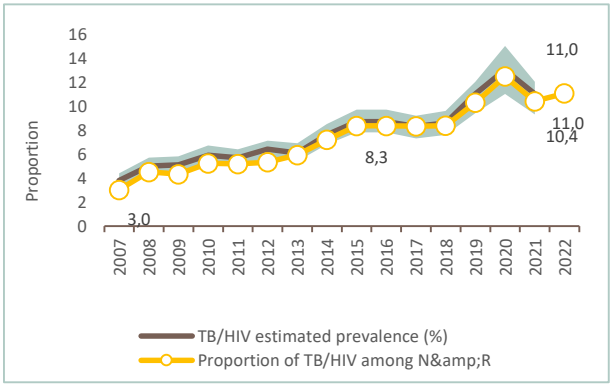
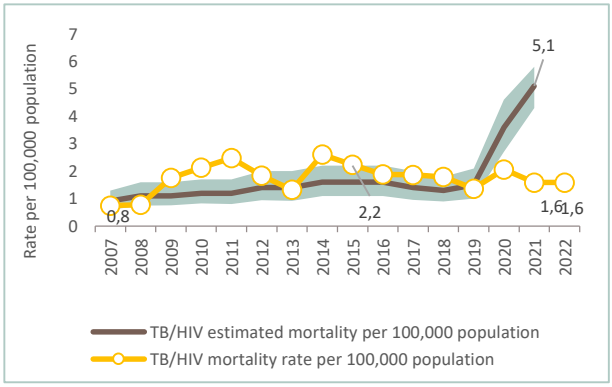


Figure 19. Estimated and reported TB/HIV mortality, Republic of Moldova, 2007-2022



Source: WHO reports 2007-2022

Over the years 2007-2022 there is an average annual increase (+10%) in HIV prevalence among TB cases while the M&E framework for tracking the WHO European Region TB Action Plan, 2023 - 2030[84] predicts annual decreases as the TB/HIV situation in the region improves.

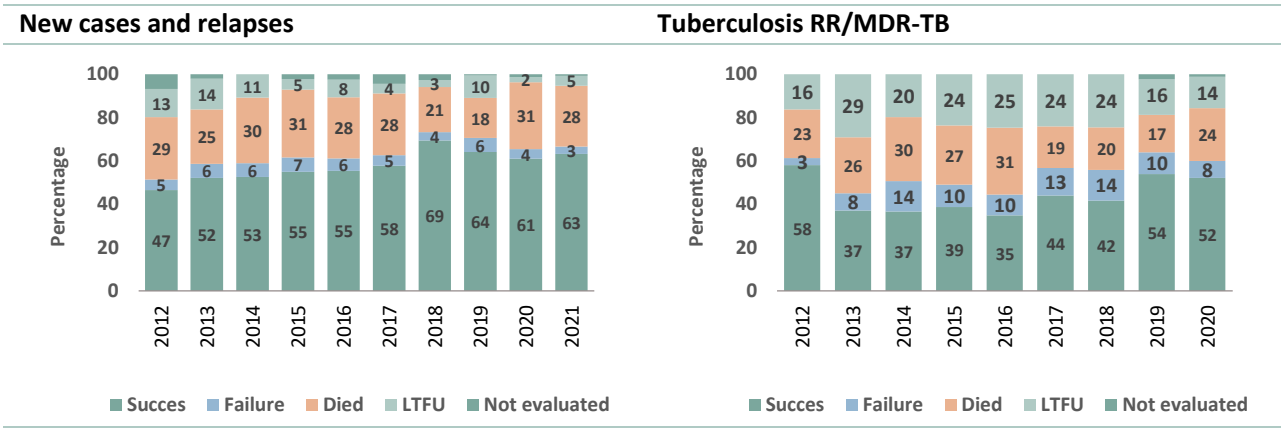
[84]https://apps.who.int/iris/bitstream/handle/10665/361921/72bg06e-AP-TB.pdf?sequence=1&isAllowed=y

TB/HIV mortality. WHO calculations forecast a TB/HIV mortality of 5.1 per 100 thousand population in 2021. In fact, 49 TB/HIV deaths or 1.6 per 100 thousand population were recorded (Figure 19).

Successful treatment was achieved in 63% of new cases and relapses with TB/HIV co-infection (2021 cohort) and 52% of those with HIV infection and RR/MDR TB. Treatment failure among PLWH with TB was mostly due to deaths (28% of new cases and relapses and 24% of cases with RR/MDR TB (Figure 20).

ART in TB/HIV co-infection. The proportion of registered people with TB/HIV included in ART does not exceed 80% (79%; 169/214 in 2021 and 78%; 170/219 in 2020).[85]

Figure 20. Treatment outcomes TB/HIV cohort, Republic of Moldova, cohort 2012-2021



HIV and TB testing. Even though the proportion of TB patients who know their HIV status is high (97%), the proportion of PLWHs who are screened for TB annually is low and at variance with the provisions of the TB and HIV NCP, including for the application of TPT. The administration of TPT for PLWH is performed by the infectious disease physician in collaboration with the phthiopneumologist and involves considerable effort to inform, educate and train PLWH for this additional medication. Even though the incidence of TB in the PLWH setting is high and TB is the main cause of PLWH deaths today, only a small number of PLWHs administer TPT (33%)[86].

Both National Programs have separate chapters dedicated to addressing TB/HIV co-infection, including strategic objectives for applying person-centred models, providing care and treatment according to the needs of the person, decentralisation, ensuring quality and continuity of services and integration with other NPs.

TB screening in key HIV groups and HIV screening in TB groups at risk

PLWH and PUD are part of the at-risk groups requiring TB monitoring[87]. These provisions, should and can be achieved, including through drug-related HRS and support activities for PMTCT which although they involve, according to the quality standard of prevention services, screening and follow-up for TB examination, de facto do not reach the set targets.

In the context of these programmes TB screening, by radiological examination, for PLWH and PUD, should be carried out at least once a year, with the application of the referral and follow-up mechanism for specialist advice, diagnosis and initiation of treatment in the phthiopneumology service, support in the treatment process, and appropriate quantification of the service. Currently, only a few CSOs providing HRG services perform TB screening, including accompaniment to radiological investigations and consultations with the

[85] https://aidsreportingtool.unaids.org/, WHO Report 2020-2021, SIME TB.
[86] https://aidsreportingtool.unaids.org/, WHO Report 2020-2021, SIME TB.
[87] MS provision no. 107 of 27.02.23https://simetb.ifp.md/Download/oficial_docs/disp_ms_2023_02_27_nr_107d.pdf

phthiopneumologist. Conversely, CSOs active in TB are not empowered and do not actively screen for HIV infection through available rapid testing. It is worth noting that large groups of people at district and village level (where nearly 50% of new HIV cases are currently identified) are investigated through TB-related CSOs, but HIV testing is omitted from this chain of interventions, although TB-related CSOs have been trained in HIV testing in 2022.

CSO views on TB/HIV co-infection

- Need for integration of HIV and TB screening activities (71% CSO-TB)
- Development of algorithms for integrated person-centred TB and HIV services for screening services (79% CSO-TB) and support services (67% CSO-TB)
- Quantification of TB and HIV screening and adherence intervention packages (79% and 67% CSO-TB and HIV)
- Promotion of community-based TPT (TB and HIV) (71% and 47% CSO-TB and HIV)

Challenges and opportunities

Following the implementation of TB and HIV response interventions in the context of TB/HIV co-infection, the CSO highlights several issues such as:

- Despite the fact that both NPs have separate chapters on TB/HIV co-infection, there are no written action plans or roadmap on practical implementation, synergy and interaction between NPs. Therefore, there is a need to develop such a document (plan, roadmap, etc.), but also algorithms for integrated TB and HIV screening services and algorithms for person-centred integrated TB and HIV community services (specified in 65% of cases by the CSOs interviewed).
- In this context, there is a need for large-scale screening for early detection of TB among PLWH and PUD - beneficiaries of the HIV NP.
- Not all HIV- and TB-related CSOs are aware of each other, and the interaction and limited input in managing the burden of TB/HIV co-infections is evident. No joint planning and cooperation dialogue has been organised during the current GF grant (2021-2022), although three of the CSOs providing TB services are also involved in HIV services.
- The need for community-based TPT promotion information campaigns is emerging.
- It is proposed to carry out TB/HIV related operational research such as:
    - TB infection prevalence study among PLWH.
    - Study of TB/HIV co-infection management in clinical and social behaviour aspects.

Mixed mode: Collaboration with other service providers and sectors

The CSO in its activities on the national TB and HIV response, as a component part in the implementation of the TB NP and the HIV/AIDS NP works jointly with:

⇒ MoH, which is the primary institution responsible for TB and HIV control, exercising its functions through the TB and HIV Coordination Units located within IFP (TB) and DCDH (HIV)

⇒ Coordination units (IFP and DCDH) - in coordination activities of interventions carried out through TB and HIV related CSOs

⇒ Municipal Health Directorates (Chisinau, Balti), responsible for TB/HIV control in the municipality - through the development of municipal HIV and TB control plans, information, screening and treatment adherence support activities (psychological, counselling, DOT, VST) in the framework of CSO TB and HIV related activities

⇒ OSMA (phtysiopneumology clinics) - in information, screening and support activities for treatment adherence (psychological, counselling, DOT, VST)

⇒ PHC - in TB screening activities and TB treatment adherence support (motivational interviewing, DOT, VST) in TB-related CSO activities (TB and HIV services at PHC level, p. 44)

⇒ National Public Health Agency (NPHA) and District Public Health Centres - in outreach activities, in the framework of CSO TB and HIV related activities

⇒ LPAs - in information, screening and adherence support activities (social assistance, material support) in the framework of CSO TB-related activities

⇒ NAP - in information and support activities for adherence to treatment (psychological, counselling, accompaniment) in the framework of the activities carried out by the CSO TB and HIV (Mixed module People in detention, p. 35)

⇒ RND - in outreach activities, HIV and TB screening, support for adherence to AOSP, implementation of TPT for PUD (including HIV positive)

⇒ MIA - in activities of referral to CSOs of people from HRG to be included in HRP and psycho-social services.

⇒ Other institutions and/or services such as: psychologist, psychosocial, paralegal, legal, mental health, youth centres, etc. in CSO TB and HIV related activities

CSOs and service providers (health, social, etc.)

Working with LPAs - successful examples of LPAs working with TB-related CSOs in 2020-2022:

- Development and implementation of local TB control programmes and HIV (Chisinau, Floresti, Balti)
- CSO representatives local and district councillors - direct information to district councils in planning separate public resources for TB control activities (Cahul, Comrat, Leova, Cantemir).
- Collaboration agreements between LPAs and CSOs with funding (Chisinau, Balti, Cahul)
- Targeted TB screening programmes in groups at risk and increased vigilance (CSOs, LPAs, PHCs)
- Placement of children affected by TB in families/parental care (Causeni)
- Creation of Health corner (placement of information materials on TB, including on the rights of people affected by TB, stigma and discrimination) in 32 district libraries
- TB awareness activities at local cultural events, including World TB Day (24 March), Health Day (7 April), Human Rights Day (10 December);
- Organisation of DOT by involving LPAs (in some special cases, Anenii Noi).

The CRG study[88] cites as barriers the low involvement and lack of separate budgets for support for people with TB at LPA level, accessible only on the basis of vulnerability, and the presence of communication, integration and implementation practice gaps in mechanisms for working together between health and social services.

In this context, cross-sectoral involvement, including from the first level LPAs, which currently have a number of tasks, is determined by the presence of budgets. Given that local autonomy is conditional on the existence of financial autonomy, there can be no real local autonomy, as the financial resources made available at local level by LPAs for involvement in public health issues are insufficient in most cases.

TB-related CSOs provided **referral** services **to medical/non-medical service providers**, namely: liaison with TB institutions (10), support in facilitating transport (9), accompaniment (10), legal assistance and administrative support (7 out of 13 active TB CSOs)[89] .

[88] Assessment of barriers related to community involvement, human rights, gender issues and level of stigma associated with TB in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/395

[89] Retrospective study conducted to analyse the involvement of civil society organisations active in the field of tuberculosis in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/389

Working with NPHA. Currently, cooperation with NPHA is mainly limited to information activities. At the same time, the involvement of CSOs in integrated screening activities, including for non-communicable diseases, in collaboration with NPHA would contribute to facilitating access to people in TB risk groups (including people at medical risk, such as people with diabetes, chronic lung disease, with TB sequelae, as well as active smokers), especially in districts with less access to health services to complex prevention and prophylaxis services by organising caravans using mobile teams equipped with screening kits, including tests for HIV, viral hepatitis, syphilis, blood glucose, etc.

Challenges and Opportunities

- Involvement in building coordination between TB and HIV stakeholders at all levels
- Multi-disciplinary approach, pro-active and integrated involvement in TB and HIV, including in places of detention
- Development of algorithms and referral systems for collaboration between actors, integration and collaboration with social services, including child protection, mental health, labour offices, paralegals, etc.
- Develop mechanism for contracting CSOs by NAP, PHC for TB and HIV services.

Mixed component: resilient and sustainable health system

Module 1. Integrated person-centred services

The CRG study[90] points to weak person-centred approaches, with needs often not taken into account.

CSO views on integrated services per person

The community opinion survey outlined the need to address integrated and person-centred services, such as TB and other disease screening, but also community support services (75% CSO-TB) and complex services that address HRG in more depth, including at PHC and OSMA level (100% CSO-HIV).

The person-centred aspect of interventions itself encompasses medical and non-medical activities. The communities have been asked about the availability of services in their locality (district/municipality). Thus, PRR (92%), HIV/syphilis testing (98%), psychological counselling (92%), information and support services in the context of TB (90%), APSP services (66%), rehabilitation services (62%), motivational kits (62%), access to other health products (62%), social worker (79%) and psychologist (79%) counselling services are found.

In terms of services that are welcomed and needed (mentioned by 87% of CSOs-HIV), the necessary areas of assistance extend to medical services (specialist consultations: proctologist, urologist, dermatovenerologist, endocrinologist, gynaecologist, infectious diseases specialist, narcologist-psychiatrist, phthyziopneumologist, family doctor/therapist, neurologist, dentist), palliative care services, complex psychosocial services such as rehabilitation services, psychological and social counselling, social support, psychological support. CSO-TB considers that palliative care services (58%), narcologist consultation (5%) psychological support (96%) would be the most welcome types of medical and support services for people with TB and their families. On the other hand, CSO-TB encountered reluctance and difficulties regarding referral for support by doctors exclusively to people with TB with multiple social problems (54%), and the existing levers and possibilities to respond to patients' needs and expectations being de facto insufficient or even totally absent.

[90] Assessment of barriers related to community involvement, human rights, gender issues and level of stigma associated with TB in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/395

HIV and TB services at primary health care level

Youth-friendly health centres are set up within the PHC ring and number 41 units in total. Their objectives include the promotion of healthy lifestyles and care for young people, and they are also involved in HIV prevention activities for young people (10-24 years). It should be noted that currently neither the normative acts nor the work of these centres show efforts to respond to TB in the environment of this population segment.

Community mental health centres, which are also the PHC's link and which by their objectives provide assistance to population groups marked by addiction, thus potentially also HRG with HIV and TB, are in no way involved in HIV and TB prevention and control efforts.

SRH is still a context with shortcomings implemented at the PHC level, which - although it has a Regulation for the provision of contraceptives to vulnerable groups and through which some of the needs of people from groups at risk of HIV and TB, PLWH, people affected by TB could be covered - does not implement specific collaborative actions with the voluntary sector, whose beneficiaries are a large part of the groups mentioned.

PHC is involved in testing people for HIV and has rapid tests. When new HIV cases are identified, the worker who initiated the testing receives a financial remuneration, which has led to an increase in the number of people detected with HIV by the PHC, although efforts are insufficient in the context of the epidemiological picture. On the other hand, the performance indicator for PHCs in the context of TB interventions was cancelled in 2020, which conditioned PHC involvement and low interest in TB at the primary level. Thus, in the aspect of working with the PHC service and the phthysiopneumology offices, reluctance in carrying out TB screening activities among groups at risk was observed, such as difficult working with the PHC in the formation of screening lists (83% CSO-TB), lack of leadership and motivation of the phthysiopneumology office in organizing screening activities (50% CSO-TB), difficulties in selecting transport services for transporting persons suggestive of TB for radiological examinations (33% CSO-TB). In addition, the CRG study[91] highlights the limited interventions on informing people at risk about the signs of TB by the PHC, but also the insufficient collaboration with the public health service, the lack of effective and sustainable psychosocial support programmes for long periods of treatment.

Challenges and opportunities

The CSO vision from the perspective of implementing person-centred interventions highlights the following:

- Lack of vision on integration of TB, HIV, viral hepatitis services at CSO level to provide services to key populations, insufficient exploration of resources for related programs (TB, SRH, Hepatitis, mental health) at PHC level.
- There is a need to evaluate the package of medical, social and motivational support for adherence to treatment by developing an integrated, attractive and person-centred mechanism (mentioned in 88% of CSO-TB) and integrating screening services (TB, HIV, viral hepatitis, non-communicable diseases) through intersectoral collaboration, including the organisation of testing caravans.
- It becomes essential to ensure the planning and implementation of specific actions to integrate TB, HIV, viral hepatitis, mental health, SRH services in order to provide safe, quality and comprehensive services to key and vulnerable, gender- and age-sensitive populations, including on a community basis, which outlines the need to strengthen social centres and CSOs by providing community-based health and social services.

[91] Assessment of barriers related to community involvement, human rights, gender issues and level of stigma associated with TB in the Republic of Moldova; http://pas.md/ro/PAS/Studies/Details/395

- Lack of referral mechanisms for the provision of complex care, especially for the uninsured. On the need to develop algorithms for integrated person-centred community support services 65% of CSOs-TB and HIV specified.
- Strengthening of health facility-based treatment units (in the field of HIV, TB and OASP) by integrating psychosocial support (based on the experience of DCDH and RDN).
- The current way of providing AOS services only through the narcotic care system outlines the need to extend it to PHCs, private medical institutions and pharmacies.
- The need to develop and implement integrated case management, including social case management in vulnerable groups was mentioned in 60% of CSOs and HIV.
- The issue of palliative care for TB and HIV patients remains a priority system issue that outlines the need in quantifying palliative care services, mentioned in 63% of cases by TB and HIV CSOs. This highlights the need to develop a mechanism to involve CSOs in TB and HIV palliative care services.
- Conduct information campaigns to address integrated and person-centred TB and HIV services.
- Conducting operational research such as:
    - Assessment of satisfaction with TB and HIV services;
    - Mapping TB and/or HIV patient needs in accessing direct and related services.

Module 2. Strengthening Community Systems

The GF supports community systems strengthening (CSS) as an essential part of resilient and sustainable systems for health (RSSH) and as a vital element of the response to HIV and TB.

In the GF 2023-2028 strategy and 2023-2025 allocation period, the GF prioritizes funding for four CSS interventions: (1) community-led monitoring, (2) community-led research and advocacy, (3) capacity building and leadership development, and (4) community engagement in referral and coordination systems.

In mobilising the community, it is essential that people in the community are directly involved in shaping an effective response to the HIV and TB epidemics. This means that community members take responsibility for the national response to HIV and TB. The TB and HIV/AIDS NP in its objectives provide for interventions involving CSOs at different levels. In this context, CSOs in TB and HIV communities:

- Carries out project planning, implementation and M&E activities through the TB and HIV/AIDS NP.
- Carry out activities by coordinating communication between the TB and HIV/AIDS NP Coordination Units, CSOs and other stakeholders through established partnerships.
- They are members of the TWG on HIV and TB. Recently, CSO representatives have become part of the working groups within CCPPH and NHIC, but attendance is sometimes formal as CSO group members do not always possess the necessary skills to participate actively and qualitatively in the related processes. There is an emerging need for capacity building of CSOs by area.
- Response mechanisms were mobilised and ensured for continuity of treatment and access to TB screening services, HIV testing and support for people affected by TB and HIV nationally, including refugees, in the context of the COVID-19 pandemic and the war in Ukraine.
- It should be noted that even if CSOs are represented and included in multi-sectoral decision-making mechanisms and participate in programme planning processes, in some cases the voice and arguments of community members are not valued by decision-makers.
- There is a Platform of CSOs active in TB (TB Platform) aimed at cooperation and information exchange between CSOs, including with voting representation in the CCM TB/AIDS. The KAP Committee is another platform for dialogue between affected communities and CSOs in the context of TB and HIV. Both

platforms aim to ensure that key groups affected by TB and HIV are provided with integrated, accessible, quality and affordable health services, centred on the needs of the individual, and that their interests are defended and promoted in decision-making processes. Recently, the work of the Community HUB, which is a team of community experts who come together to advocate and promote the interests of TB and HIV communities, has also crystallised.

Community-led research and advocacy. Increased understanding of different experiences at global and national levels has highlighted the need to involve participants and communities as partners rather than subjects or users of medical advances resulting from studies. Also highlighted are the benefits to trials and participants of a programme of community involvement in research and development that continues through to dissemination of results and beyond. In addition, securing funding for sustained, early community involvement in study design, building acceptance by researchers (academia) of the importance of working with the community on issues of innovation[92] . In addition to the challenges revealed with reference to researchers' lack of understanding of its role, the results show that building cooperation between researchers and the community with approaches based on country-specific needs is useful. Incentivising communities for R&D performance increases transparency, ownership and autonomy, along with long-term sustainability. The STREAM II[93] ZeNix[94] studies were two international, multi-centre, randomised, controlled trials among people with resistant TB that applied the Good Participatory Practice (GPP) approach and established community engagement interventions at research sites to improve, sustain in-country engagement and culture-specific settings and ultimately disseminate results[95].

CSO views on strengthening EU systems

CSOs self-assessed the progress of their work in the areas of TB and HIV, marking the grid from 1 (lowest) to 10 (highest). Thus, CSOs rated their activities as having progressed between 8 and 10 from 64% of CSO-HIV respondents and 79% of CSO-TB respondents.

For consistency and effectiveness, CSOs in the areas of HIV and TB have mentioned that they are needed:

- CSO management capacity in fundraising and other leadership skills (63% each, CSO HIV and TB CSOs)
- Employee empowerment and team building, prevention of burnout (82% and 83%, CSO HIV and TB)
- Promoting volunteering and competitiveness among outreach workers (57% and 75%, CSO HIV and TB)
- Participation in national and international events (80% and 71%, CSO HIV and TB)
- Accreditation of CSOs for health and social services (59% and 42%, CSO HIV and TB)
- Hiring of legal and human resources consultancies for CSOs (67% and 79%, CSO-HIV and TB)

In the process of carrying out activities, TB-related CSOs mentioned that they faced difficulties such as:

- Professional burn-out of CSO management (46%); professional burn-out of field workers (79%)
- Financial instability of CSOs (interruptions in project implementation), mentioned in 67% of cases
- Lack of alternative donors for TB (63%)
- Limited number of team building activities (50%)
- Lack of mental health counselling sessions (63%)

HIV-related CSOs have specified on the lack of resources in addressing pressing needs of beneficiaries, as well as on the professional burn-out of teams, but also on the lack of supervision and team building activities. In

[92] https://smitmd.wordpress.com/2021/06/16/community-engagement-lessons-learned-a-community-perspective/
[93] Evaluation of two short standardised regimens for the treatment of rifampicin-resistant tuberculosis (STREAM stage 2): an open-label, multicentre, randomised, non-inferiority trial, DOI:https://doi.org/10.1016/S0140-6736(22)02078-5
[94] N Engl J Med 2022; 387:810-823, DOI: 10.1056/NEJMoa2119430
[95] https://smitmd.wordpress.com/2021/06/16/community-engagement-lessons-learned-a-community-perspective/

the same vein, the need to quantify in line with the real cost of direct and indirect staffing needs, maintain premises and improve working conditions for the provision of quality services was addressed.

With reference to strengthening community systems, CSO-TB and HIV, considers the following interventions necessary:

- Community-based monitoring (75% and 74%, CSO-TB and HIV)
- Conducting community-based research (63% and 76%, CSO-TB and HIV)
- Integration of the TB Platform with the KAP Committee, strengthening the Community HUB (63% and 59% CSO-TB and HIV)
- Targeted advocacy campaigns (79% and 73%, CSO-TB and HIV)
- Conducting information and community mobilisation campaigns (79% CSO-TB)

Challenges and Opportunities

- The level of development of HIV and TB-related CSOs is very different, and mutual use of resources through partnerships is not common. There is no system of continuous training of CSO staff. This has a direct influence on the quality of services provided. There is a need for training and social inclusion, mentioned in 87% of CSO-HIV cases.
- In this context, capacity building of CSOs is required through the development of training modules, maintenance and strengthening of existing training platforms, including online, with the development and integration of modules in the context of TB, HIV and cross-cutting (mental health, SRH, human rights), community mobilisation, fundraising, involvement in research and development, prevention of burnout, M&E, etc.
- The existing dialogue platforms for TB and HIV-related CSOs (KAP Committee and TB Platform) do not have common objectives and do not synergise efforts on co-infections and integrated services. An opportunity would be to integrate them by building a vision on effective collaboration and interaction, training CSO representatives on different directions, to ensure a qualitative and participatory process of members in different processes (procurement, CLM, etc.), including team-building activities, trainings, exchange of experiences at national and international level. In addition, it is necessary to strengthen communities by including new people, developing activism, volunteering, etc.
- Lack of integrated services at CSO level of medico-social services creates barriers in accessing health services for HRG, PLWH and people affected by TB. In this context, there is a need to synergise interventions through the development of integrated and referral and coordination systems for the implementation of integrated and person-centred medico-social services.
- Strengthen community-based monitoring based on a distinct methodology respecting ethics and excluding conflict of interest.
- Conducting community-based research on various issues, involving CSO representatives in the research. Community involvement in research and development by working with CSOs and academia, including the development of a plan for community involvement in research and innovation with a dedicated budget (mentioned by 63% CSO-TB).
- Conduct targeted advocacy, information and community mobilization campaigns, including promotion of volunteerism and competitiveness among workers, community actors involved in the local TB and HIV response.
- Conduct TB information campaigns, education and communication activities to increase TB awareness and generate demand for TB services.

Module 3. Systems of financing and management of health sectors

As of 2018, funding for services in the context of HIV and TB from GF sources is decreasing and the country is currently in transition from external to domestic funding. The government is committed to gradually taking over the financing of HIV and TB response activities funded from GF sources[96] .

Prevention programmes. Since 2017 and 2020 respectively, HIV prevention programmes in HRG and TB screening programmes have started to be funded from national sources from the NHIC[97]. Despite this, the mechanism is used with difficulty, is unstable and does not contribute to the sustainability of these programmes[98] . Ensuring the continuity of funding for prevention projects is associated with procrastination in setting priorities, allocating funds, organising the competition for projects that do not have clear deadlines set to ensure the predictability of the process. The financial resources allocated are increasing but do not cover existing and planned needs under the HIV/AIDS and TB NP, and the process of allocating funds is often delayed (signing of contracts with delays, late allocations; timeframe for closing contracts June-November).

Thus, for HIV prevention in 2017 733,792[99] were allocated; in 2018 - 1,235,233; in 2019 - 1,083,812; in 2020-2021 was allocated 827,231 and 2,000,000; in 2022 - 2,471,208 MDL[100].

The number of PID assumed for coverage with prevention programmes in 2022 was 16,024 people, de facto covering 16,563 people (103%). From national sources NHIC have beneficiaries of services - 400 people (2022), which is only 10% of the total estimated beneficiaries expected to be covered from NHIC under the NP HIV/AIDS. In 2022, 61.7% of the estimated number of PID were covered with HRS services, the basic package, with a target of 78.3%. As of the fourth quarter of 2022, the adjusted cost of the package per beneficiary was 853.13 MDL (first 3 quarters 2022 - 681.72 lei), from NHIC sources - 1061.63 MDL (with consumables for distribution

Financing of TB prevention services started in 2020 and amounted to 88,400; in 2021 - 1,616, 342; and in 2022 amounted to 1,800,129 MDL.

Synergies between NPs providing for HIV/AIDS, TB, Hepatitis, SRH, mental health control are minimal and do not ensure sharing of funding on the basis of activities for related beneficiary groups.

Funding from local budget resources for separate HIV and TB activities, including those carried out by CSOs, is minimal due to lack of prioritisation at local level and lack of involvement of local programme coordination units in promoting these priorities.

In this context, several challenges regarding the financing of the HIV/AIDS and TB NP are emerging, such as:

- The mechanism for allocating NHIC funds is used with difficulty and without predictability for CSOs.
- Different costs of service packages for key populations depending on the funder (NHIC vs GF).
- CSO funding from GF sources is by indicator, but reporting by process, with detailed financial reporting by budget line, with financial resources returned even if the contracted indicator has been achieved.
- Services provided by HIV-related CSOs are funded through the Principal Recipient and those provided by TB-related CSOs through the Sub-Recipient. This has led to different approaches in monitoring and reporting arrangements, resulting in dispersed programmes, disruption of service delivery and divergence in issues of synergy and integrated treatments.

[96] NCC decision of 10 June 2021., the need to respect the co-financing commitments made by the country under the Global Fund grant 2021-2023: http://ccm.md/sites/default/files/2021-06/Hotarirea%20CNC%2010.06.2021.pdf.
[97] National Health Insurance Company: http://www.cnam.md/?&pg=63&news=683&page
[98] http://uorn.md/raport-evaluare-mecanism-de-finantare-fmp-cnam-proiecte-in-dom-hiv/
[99] National Health Insurance Company: http://www.cnam.md/?&pg=55&news=760&page.
[100] http://www.cnam.md/?page=235&

- Lack of funding mechanisms from national sources for psycho-social support services provided by CSOs for PLWH, PUD, SW and people affected by TB.
- Lack of financial support from local budgets for the implementation of the NP HIV/AIDS and TB activities, including those carried out by CSOs.
- Lack of state funding mechanisms in the presence of quality standards and accreditation mechanisms for HIV-related CSO services.

CSO views on funding and management systems

With reference to priority interventions to strengthen community funding systems, CSO-TBs mentioned the need to finalize and unify the cost of services provided by CSOs funded from NHIC and GF sources (60%), advocacy for increased allocations from national sources such as NHIC (58%), advocacy for other funding sources (such as MoH, LPAs, etc.) (58%).

CSO-HIV representatives mentioned outdated quantification of services (100%) and insufficient financial motivation of outreach workers (100%). 87% of CSOs pointed to the need to increase the cost of basic, extended, attractive and palliative packages.

The CSO-TB considers that in order to exclude the delay in the investigation of the person with signs suggestive of TB and to avoid duplication in the examination, an opportunity would be to include the costs of radiological examinations (for certain categories of persons in the TB groups at risk) at the time of contracting the CSO for screening services similar to the way the NHIC contracts mobile screening equipment. This was mentioned by 54% of TB CSOs. Also delimiting the weight of the budget dedicated to radiological examination at the level of MPA budgets in the context of TB could eliminate the procrastination of the investigation of the person for TB, mentioned in 63% of cases by CSO-TB.

Challenges and opportunities

Following the implementation of TB and HIV activities implemented with CSO support, several challenges related to financial aspects and sustainability in the continuity of services are emerging, such as:

- The need to allocate financial resources for prophylaxis and HR services, from national sources, mainly the NHIC in accordance with the provisions of the National TB and HIV/AIDS Plans and to diversify funding sources, especially in terms of psycho-social support activities for beneficiaries.
- Lack of continued funding of HRS provided from NHIC sources and the small number of beneficiaries proposed for coverage from NHIC sources.
- Ensuring the sustainability of prophylaxis, HRS and psychosocial support services, by ensuring sustainable and predictable funding, including from the resources of the National Social Insurance Company, but also at the level of local programmes.
- Adjust funding mechanisms and funding volume to ensure continuity and quality of interventions, based on indicators achieved through the use of service contracts and performance incentives.
- Review and approval of quantification per service, support in obtaining accreditation of services, application of funding per outcome, targeting of financial sources for TB and HIV related CSOs from a single source, including contracting of CSOs for the period of implementation of the GF 2024-2026 grant (3 consecutive years), with annual annexes to the basic contracts concluded with implementing CSOs, including clear modalities for their termination if necessary.
- In context, it is necessary:
    - Review and adjust HRS costs financed from GF sources and national budget. Quantification of HRS services needs to be updated not only in relation to inflation but also in relation to real costs (2017 quantification is not acceptable and realistic).

- Review mechanisms and identify additional sources of funding, including from social and local budgets to ensure funding for complex psychosocial support.
- Reviewing the cost of basic, extended, attractive and palliative packages and applying them across all funding sources.
- Adjustment of the cost of the package per beneficiary (MSM, TG), including quantification of interventions specific to the needs of men, women, including youth and young women, non-binary people, older people; quantification of harm reduction interventions and integration into the financing mechanisms of the GF grant and the NHIC Prophylaxis Fund
- Quantification of the cost of TB and HIV screening and adherence intervention packages (mentioned in 79% and 71%, CSO-TB and HIV respectively)
- Quantification, including delineation of the share of the budget dedicated to radiological examination in PHC budgets in the context of TB, and consideration of opportunities for contracting TB-related CSOs by PHCs to carry out TB prophylaxis and social activities by NSSC.
- Review the AOSP funding system per case treated, including the development of an incentive system to encourage Medical institutions to implement and expand AOSPs. Per-visit financing by the NHIC for AOSP decreases the motivation for doctors to administer treatment at home.

- Given the fact that some of the support activities have been carried out by CSOs over the years, the lack of cost estimation, but also the potential differentiated costs depending on some specific needs, the need for clarity on the cost estimation for the following services has emerged:
  - inpatient and outpatient support services for TB patients
  - Inpatient social care for the TB patient
  - quantification of the hygiene package, including gender specific (TB and HIV)
  - supported employment, integration support (TB and HIV)
  - education and counselling by telephone and other methods/applications/technologies (TB and HIV)
  - costs for re-emission identity documents (recovery or initial documentation) (TB and HIV)

Module 4. Management of TB and HIV programmes, including M&E systems

CSOs carry out their activities in collaboration with the TB and HIV/AIDS NP Coordination Units. In the context of collaboration, CSOs fully implement project activities, but encounter difficulties, which are often indirectly caused by systemic issues.

Challenges and opportunities

- The coordination at national level of the HIV/AIDS and TB NPs, the prospects for increasing their effectiveness through integration is marked by a fragmented dialogue, at least as perceived by CSOs, who have participated several times in dialogues on the collaborative management of the HIV/AIDS and TB NPs, the need for their integration, including at the level of coordination departments, but without finality. The vision of the model for joint management and improved coordination of integrated HIV, STI, TB and viral hepatitis (planned for 2021) has not been shaped so far.
- Strengthening the capacities of local HIV and TB Programme Coordination Units, including from the perspective of integration, sustainability and financing, and the need to involve them in national dialogues, including the CCM TB/AIDS platform. The dialogue within the development of the Application to the GF (2024-2026) should emphasize the importance of the topic and provide sustainable solutions on the integration and smooth functioning of both the HIV/AIDS and TB NPs with the extension of coordination with local programmes, i.e. LPAs.

- Optimal configuration, based on an extensive and transparent dialogue, of the coordination of the HIV/AIDS and TB NP with key components (prevention, diagnosis, treatment, M&E, financing) ideally in a single structure, ensuring a rapid increase of its capacity using the experience gained and human resources consolidated in previous programmes.
- National efforts seem to be ongoing, but without consistency and results at the policy and service delivery levels, in public and private institutions alike. Examples speak for themselves: lack of integration of HIV testing services into TB-related CSO work, and fragmentation of TB screening efforts in HIV prevention programmes in HRG, lack of a considerable uptake of TPT in the setting of PLWH and PUD, single (primary) HIV testing at the time of TB diagnosis without further testing.
- Local coordination of TB and HIV/AIDS programmes and the effort to integrate them is minimal, partly due to a lack of human resources in local programme coordination units and partly due to a lack of information and M&E tools similar to those available at national level.
- Gaps in funding from local budgets for HIV/AIDS and TB programme activities, condition the lack of interest and involvement of LPAs. The fact that LPAs are not connected to the CCM TB/AIDS dialogue and decision making platform, maintains the passive approach and lack of contributions both at funding and coordination level. Local Public Health Authorities have limited involvement and lack capacity to mobilise and synergise efforts at local (municipal and district) level.
- M&E of the HIV/AIDS NP does not include and monitor the activities of regional social centres in the current reporting and monitoring system. The integration of CLM and Social Centres' work into the national M&E system needs to be done in the narrowest possible terms.
- The quality of AOSP services is not monitored and there is no viable system for coordination and M&E of these programmes.
- Reservations on the analysis of progress achieved at management level. Reports contain dry epidemiological data and often become public late, despite an existing and lucrative electronic TB system. This was mentioned by 58% of TB CSOs.
- The conduct of joint M&E visits (NTP/NHIC/CSO/Principal Recipient), specified in 60% of the CSO-TBs surveyed, needs to be implemented.
- Statistical data on cases referred by TB-related CSO workers are currently collected manually. In order to optimise the calculation of this indicator (but also the possibility to disaggregate by other parameters such as environment, gender, age, type of TB, etc.) it is proposed to adjust the paper TB case report form (F089/1-e) and the electronic one (SIME TB) by adding on p.12 "Referred to TB office doctor" and the response variant "referred by CSO". In this context, it is also recommended to define separate ways of calculating the indicators achieved (indicator passport), as different calculation methodologies are currently applied depending on the provider (CSO vs. PHC).

CONCLUSIONS

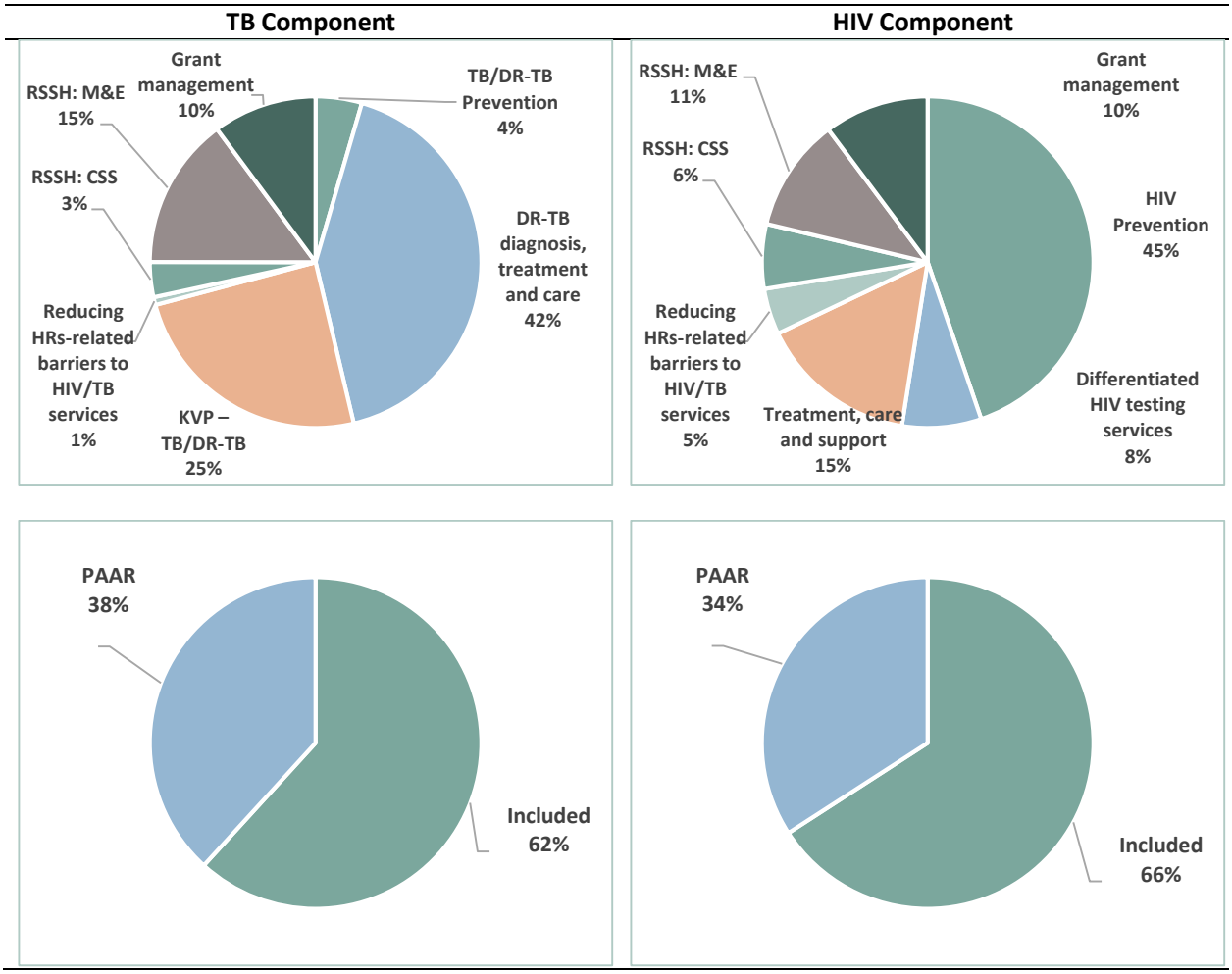
1. Early detection of TB, HIV testing, initiation of effective treatment including prevention will improve the epidemiological situation in the country by reducing morbidity and mortality rates. Special attention should be paid to key groups through information and education campaigns, various motivational measures to increase demand for access to available TB and HIV services. In addition, early detection measures can contribute to the timely diagnosis of TB and HIV and to stopping the spread of TB and HIV infections in the community, especially among people with low access to health services.
2. Comprehensive, people-oriented social support approaches will also influence the epidemiological situation through TB and HIV. As all people affected by TB and HIV will benefit from coordinated medical and social care, with appropriate monitoring by communities with advocacy measures, this will not only help to identify the needs of the person, but also to meet them in the implemented project activities. Therefore, patients will be able to follow and adhere to a qualitative course of treatment, receive the social support they need, acquire the skills to protect their rights, which will lead to an improvement in the overall quality of life. Also, increased engagement and coordination between PHCs, LPAs, OSHCs and CSOs will contribute to the quality of TB and HIV care provided, as well as bring a positive image for service providers due to multidisciplinary interventions and the achievement of desired outcomes. Improving the regulatory and legal framework, preventing and overcoming stigma and discrimination are important issues to be addressed further.
3. The dimensions of gender, age, place of living (rural/urban), as well as the consideration of social determinants remain essential components to be considered in the process of organising and delivering services and interventions in both the public and private systems, capable of increasing sensitivity to the particularities and specific needs of the target groups. The implementation of human rights, as an inherent principle of all actions at policy and service level, will ensure that barriers are removed and will enhance progress towards achieving the objectives of the HIV/AIDS and TB NP.
4. The effectiveness of the management of the HIV/AIDS and TB NP, including extrapolation of experiences and good practices to the local level, focus on sustainability, accessibility, acceptability and quality of interventions, recognition and valorisation of CSO contribution require increased attention and high prioritisation in the new grant formulated for GF implementation for the years 2024-2026.

Strengthening the involvement of CSOs TB and HIV in the implementation of national programmes

The team of consultants appreciates the openness of the TWG, National Program Managers, Principal Recipient and the sub-Recipient in the process of discussing the activities proposed in the CRG TA consultancy. Thus, the vast majority of interventions on both components were partially or totally accepted and included in the application to GF. PAAR includes interventions that are commonly agreed upon and accepted as important, being prioritized by consensus. The ongoing dialogue has resulted in the unification and integration of existing CSO practices in the field of TB and HIV, contributing to a person-centred approach.

Status of interventions in relation to their inclusion in the Country Application for GF for 2024-2026 is shown in Figure 21. The proportion attributed to CSOs for TB Component is 29% (Reducing human rights-related barriers to HIV/TB services – 1%; Community Systems Strengthening – 3%; Key Vulnerable Population TB/DR-TB-25%) and for HIV Component is 59% (HIV Prevention-45%; Reducing human rights-related barriers to HIV/TB services – 5%; Community Systems Strengthening – 6%; Differentiated HIV testing services-3%).

Figure 21. Status of activities in relation to their inclusion in the Country Application for GF for 2024-2026



HRs – human rights; TB-Tuberculosis; DR-drog-resistant; HIV- Human Immunodeficiency Virus; RSSH- Resilient and sustainable systems for health; M&E-monitoring and evaluation; CSS- Community Systems Strengthening; KVP-Key Vulnerable Population; PAAR- Prioritized Above Allocation Request

Annex

Table 2. Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria

Description of recommended intervention and expected impact or outcome	Activity included in the final funding request submitted to the GF	Activity included in the final PAAR submitted to the GF	Additional comments
TB component			
1. Advocacy and engagement in building coordination among TB stakeholders at all levels, including with local TB programs and respective implementation through the provision of M&E tools, facilitation to programmatic and financial data, and engagement in multisectoral platforms.	☒ Yes 1.1. 117,715.55 – small grants to strengthen coordination among stakeholders for 2024-2026		Budget secured for 36 months
2. Conduct community led monitoring (CLM) and ensure a platform for continuous dialogue with the authorities to discuss and solve the identified issues.	☒ Partially 2.1. 100,919.90 - CLM via app. for 2024	☒ Yes 2.2. 121,791.72 for 2025	Budget secured for 2024 (12 months) Budget for 2025-2025 included in PAAR
3. Provide social integration activities including legal, paralegal advice, assisted employment for KVP, legal literacy.	☒ Partially 3.1. 48,775.00 - Paralegal assistance; ☒ Yes 3.2. 6,565.99 - Know your rights among TB people	☒ Yes 3.2. 23,972.00 - Paralegal assistance	Budget secured for 2024-2025 (24 months) Budget for 2026 included in PAAR
4. Conduct community led (CLR) research on various topics to inform data-driven decision-making and engagement in research and innovation by working with academia/researchers.	☒ Yes 4.1. 23,413.20 - CLR: Mapping the needs of TB people	☒ Yes 4.2. 19,089.22 - CLR: Satisfaction level with TB services; 4.3. 16,105.03 - CLR:CRG Assessment; 4.4. 21,278.86 - CLR: Stigma Assessment; 4.5. 20,758.37 - CLR:level of SM among detainees	Budget for 1 CLR secured only Budget for the other 4 CLRs included in PAAR
5. Strengthen the capacities of CSOs in the provision of services and participation in decision-making in the context of the implementation of national programs, including advocacy for the expansion of CSO support models, access and adequate funding, including from national and local budgets.	☒ Yes 5.1. 84,340.82 - TB CSOs Platform for 2024-2026; ☒ Yes 5.2. 23,438.08 – Capacity building via formare.md ☒ Yes 5.3. 1,220.73 – TA for the Elaboration of NGO sustainability transition plan, M&E methodology, plan and progress reports		Budget secured for 2024-2026 (36 months)

	(funding diversification, organizational support, accreditation, standards)		
6. Conduct early and active TB detection interventions, including the use of portable X-ray systems in key and vulnerable populations to contribute to timely TB case finding.	☒ Partially 6.1. 1,603,662.32 - ACF for 2024-2025; 38,575.17 ☒ Partially 6.2. TOP-up for 2024-2025	☒ Yes 6.3. 801,831.16 - ACF for 2024-2025; 6.4. 19,287.59 - TOP-up for 2026	Budget secured for 2024-2025 (24 months) Budget for 2026 included in PAAR
7. Provide treatment psychosocial support/adherence programs, including TB treatment (DOT), community-led TPT (CL TPT) to KVP, motivational packages.	☒ Partially 7.1. 250,488.36 - Adherence and social support for 2024-2025; ☒ Yes 7.2. 12,481.93 - Hygiene packages for 2024-2026; ☒ Yes 7.3. 81,004.79 - Strengthen TB control in prisons, by accompanying and offering support to former detainees, to ensure treatment continuity, incl. with the involvement of CSOs for 2024-2026	☒ Yes 7.4. 117,491.97 - Adherence and social support for 2026; 7.5. 49,660.63 - CL TPT; 7.6. 2,441.47 – TA; 7.7. 3,662.20 – TA; 7.8. 247,423.63 - CL DOT	Budget for adherence secured for 2024-2025 (24 months) Budget for 2026 included in PAAR
8. Conduct information, education and communication activities to raise TB awareness, increase demand generation and remove stigma, discrimination and other barriers to accessing TB services through targeted interventions, including advocacy and support (TA) for the revision of the legal framework to ensure a human rights and gender equality based approach to TB.	☒ Partially 8.1. 5,850.41 - TB and HR campaigns for 2025	☒ Yes 8.2. 5,850.41 - TB and HR campaigns for 2026; 8.3. 1,220.73 - TA for TB volunteer concept; 8.4. 12,204.83 - Community mobilization and engagement of the local public authorities in TB response at the community level with the slogan "My community without TB!"	Budget for campaigns secured for 2025 (12 months) Budget for 2024 and 2026 included in PAAR
HIV Component			
9. Ensuring universal access to prevention, support and health care services by implementing comprehensive and quality services for people in high risk groups (HRG),	☒ Partially 4 709 191 USD – prevention programs for HRG, including left bank and penitentiary sector	☒ Partially Additional and extended packages of prevention for HRG	Lack of activities addressing gender, age dimension and place of living

in line with international recommendations, but also reforming services taking into account the gender, age and place of living (rural, urban) characteristics and particularities of the beneficiaries.		20 000 – size estimation of Trans people 734 707 – 2 pilot projects for implementing community based integrated health and social services	characteristics (rural, urban)
10. Ensuring universal access to treatment by implementing comprehensive and quality services for PLWH, taking into account the gender, age and place of living (rural, urban) characteristics and particularities of the beneficiaries.	☒ Partially 1 595 376 USD – treatment, care and support,	☒ Yes 343 762 - Additional package of support for PLWH on ART (motivational) 788272 – support for the regional social centres for PLWH in implementing medico-social services 1 181 210 – additional medico-social services for PLWH Support services and activities for young PLWH and families	Lack of activities addressing gender, age dimension and place of living characteristics (rural, urban)
11. Create enabling conditions for the implementation of community-based pre-exposure prophylaxis (PrEP) through de-personalization of data as well as 'demedicalization' of community-based post-exposure prophylaxis (PEP) and include these provisions in the National Clinical Protocol (NCP) on PrEP.	☒ Yes 145 124 – service package, national protocol adjustment, round table	☒ Yes 5 000 – public discussions, social awareness campaigns	
12. Humanization and decriminalization of the Moldovan legislation in the context of HIV transmission, drug use and sex work and other issues related to access to social and medical services and violation of the rights of people in HRG and PLWH.	☒ Yes 153 410 – advocacy campaign 21 400 – IEC materials 46 205 – improving laws and policies	☒ No	No activities related to humanization and decriminalization of the Moldovan legislation in the context of drug use and sex work
13. Support practices and tools created by CSOs to overcome barriers, including legal barriers in accessing services and advocacy, protecting human rights and legally empowering people in HRG and people living with or affected by HIV	☒ Partially 217 086 – paralegals activity	☒ Yes 107 765 - budget for 2026 included in PAAR (paralegals, REACT)	The paralegal activity for Left bank of Dniester need to be the developed and adapted, due to specific legal environment

and TB to protect their rights (network of paralegals, REACT, etc.).			
14. Diversify funding sources for HIV and TB prevention, harm reduction and support services from national and local health and social budgets alike.	☒ No	☒ No	No activities, included in the final funding request or PAAR, related to diversification of funding sources for HIV and TB prevention, harm reduction and support services from national and local health and social budgets alike
15. Strengthen CSO capacities in service delivery and participation in decision-making in the context of the implementation of the National HIV/AIDS Program through equipping, training, involvement, including CSO and community involvement in conducting operational research in the areas of HIV, TB and related areas.	☒ Partially 240 271 – civil society capacity building 77 933 – e-learning platform 75 597 – action at community level	☒ Yes 10700 - IEC info materials for key populations 10 324 - E-learning platform budget for 2026 included in PAAR	
16. Strengthen the OASP and support the capacity of the coordination unit at Republican Dispensary of Narcology (RDN) level to ensure geographical expansion, quality and accessibility of OASP services and other treatments in the context of drug dependence, implement effective M&E and based on WHO recommendations, implement communication tools with the patient community and involve them in the processes of organizing OASP work.	☒ No No activities for strengthening the OASP and support the capacity of the coordination unit at RDN level	☒ Partially 46854 – procurement and maintenance of a mobile unit for OASP expansion, quality and accessibility of OASP	91 444 – advocacy, equipping, procurement of buprenorphine for left side of Dniester river, psychosocial support – included in the final funding request, but not related to support the coordination capacity of RDN
17. Strengthen local HIV and TB response programs and implementation units in both the civil and prison sectors on both sides of the Dniester River by providing M&E tools, access to programmatic and financial data, participation in the CCM TB/AIDS platform.	☒ Partially 81 004 - the support for penitentiary sector included	☒ No	Local entities for HIV and TB response must be strengthen in implementing M&E tools, use of programmatic and financial

			data, participating in the CCM TB/AIDS platform.
18. Implementation of the CLM, including the application of the separate methodology, exclusion of conflicts of interest and respect of ethics. Consider CLM as part of the M&E tools of the National HIV/AIDS Program and provide financial support for the development and implementation of CLM by communities.	☒ Yes 257 617 – CLM activities	☒ No	A M&E guidelines for National HIV/AIDS program, included CLM, need to be elaborate and implemented
19. Supporting innovation, including through digitization and telemedicine, applied to policy, management, M&E, service delivery, capacity building, in both government and associations.	☒ Partially 195 123 – web outreach for HRG 265 511 – vending machines.	☒ Yes 420 422 - new vending machines, including penitentiary sector 2 Community medico-social integrative centres 86 096 Gamification (rewarding for patients regarding HIV prevention and treatment) 153 100 – risk indicator e-system 299 200 – Safer drug consumption room	