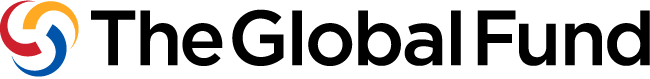
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| |  | | --- | | Funding Request Form  Allocation Period 2020-2022 |   Tailored for Focused Portfolios |

*Refer to the “Tailored for Focused Portfolios” Instructions to complete this form.*

Summary Information

|  |  |
| --- | --- |
| **Country(s)** | Moldova |
| **Component(s)** | TB, HIV |
| **Planned grant(s) start date(s)** | January 1, 2021 |
| **Planned grant(s) end date(s)** | December 31, 2023 |
| **Principal Recipient(s)** | PI CIMU HSP |
| **Currency** | Euro |
| **Allocation Funding Request Amount** | 18,061,192 |
| **Prioritized Above Allocation Request (PAAR) Amount[[1]](#footnote-2)** | 4,231,590 |
| **Matching Funds Request Amount[[2]](#footnote-3)**  (if applicable) | N/A |



# **Section 1: Funding Request and Prioritization**

## Overall Context and Funding Priorities

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Overall context**  Republic of Moldova is a country in eastern Europe, surface area of 33.9 thousand sq. km, bordering Romania (member of the European Union) and Ukraine. Its history of independence dates 1991 following dissolution of the Soviet Union. Moldova is ranked by the World Bank as a lower-middle income country (LMIC); Gross National Income (GNI) per capita in 2018 (Atlas method) was estimated at USD 3,900 per capita[[3]](#footnote-4). Administratively it is divided in 32 districts, 5 municipalities (Chisinau, the capital city, Balti, Comrat, Tighina, Tiraspol) and 2 regions with special status: Autonomous Territorial Unit Gagauzia, and territorial administrative units from the left part of Nistru river, generically known as Transnistria or Left Bank. The so-called Moldovan Republic of Transnistria has self-proclaimed its independence in 1990 but has not been recognized by any state. It is not controlled by the government, de facto authorities govern the region comprising 5 districts and two municipalities (Tiraspol- the capital and Tighina).[[4]](#footnote-5)  In 1991, Moldova started transition to democracy and has experienced sweeping political, economic and social changes. Adoption of [market economy](https://en.wikipedia.org/wiki/Market_economy) in 1992 resulted in large [inflation](https://en.wikipedia.org/wiki/Inflation) and economic plunge, causing socio-economic distress, abrupt impoverishment, increasing inequalities and massive outmigration. This led to health system funding shortages, reductions in service provision and human resources for health, increased out-of-pocket (OOP) payments for users. Social distress led to increased vulnerabilities and risk behaviors, i.e. increased alcohol use and a new pattern of injecting drug use pre-cursor to an HIV explosive epidemic among people who injected drugs. TB also re-emerged as a public health issue. Economy rebounded since 2001, with positive annual growth until now. A large-scale banking fraud in 2014 has generated political instability lasting since. According to the latest Human Development Report 2019, there is persistent inequality and stagnating human development. While absolute poverty is nearly inexistent since 2007, over half of population lives in precariat (USD 1.9-5.5/day) and 15% are relatively poor (USD 1.9-5.5/day) and middle class stagnated since financial crisis in 2008[[5]](#footnote-6). [Remittances](https://en.wikipedia.org/wiki/Remittance) from Moldovans abroad account for a quarter of Moldova's [GDP](https://en.wikipedia.org/wiki/GDP).  Moldova has the third fastest shrinking population in the world. In 2020 its present population is 2.8 mln (National Bureau of Statistics NBS 2020[[6]](#footnote-7)), and a population of 475,665[[7]](#footnote-8) in Transnistria, adding up to a total of 3.3 mln, compared to 4.2 mln in 1991. Following reanalysis of Census 2014 data, NBS will update population breakdown by districts later in 2020. UN projections show a total 4.0 mln population,[[8]](#footnote-9) this discrepancy in population leading to overestimations in targets based on estimated indicators. In parallel to outmigration, Moldova experiences a negative population growth, 1.2 children being born to the average woman, a birth rate less than the worldwide average population is expected to decline to 1 mln by 2050.   |  |  | | --- | --- | |  | D:\Documents\average-real-gdp-per-capita-across-countries-and-regions(1).png | | Sources: GDP per capita evolution - Madisson Project database 2018, multiple year benchmaks: <https://ourworldindata.org/>  Population pyramid: <https://worldpopulationreview.com/countries/moldova-population/> | |   Moldova faces a tight macro-economic environment in 2020. Even before the COVID-19 crisis, the economy growth declined sharply to 0.2 percent in the last quarter of 2019, as agriculture and electricity production plunged, with a slowdown in exports and investments. A World Bank analysis shows that the COVID epidemic has set off an economic crisis. The unfolding economic crisis will lead to a contraction of Moldova's economy in 2020 and the real GDP growth for 2020 is set at -3.1% as baseline and -5.2% as downside. Economic lockdown, travel restrictions and a fall in remittances will lead to a sharp deterioration in activity, and a severe drop in disposable income will further depress private consumption.[[9]](#footnote-10)  Poverty and related migration of large segments of the population are central development issues in Moldova. Labor migration affects access to health services, including doctors and nurses leaving Moldova to work in other countries. Covid-19 epidemic puts a particularly high burden on health workforce, as approximately 25% of all cases have been diagnosed among health workers. Moldova has a double epidemiological burden as both rates of communicable diseases, like HIV and TB have increased since independence. Heart disease and stroke, cancers and digestive diseases (mostly liver-related) predominate as the main causes of mortality in the Republic of Moldova for both men and women. NCDs are the main cause of premature mortality and have been linked to social distress and increased risk factors. Poverty, high level of alcohol and tobacco use (45% of men smoke, a high alcohol per capita) are the key health determinants for most Moldovans and mortality and morbidity from these factors account for a sizeable burden on society. Life expectancy in 2018 was 72 (women 76, men 68). Higher mortality rates for the top causes registered and increasing in rural compared to urban areas and a difference in life expectancy almost 4 years higher in urban versus rural areas.  **TB context**  Moldova is among the WHO European Region’s 18 high-priority countries for tuberculosis (TB) control and among the world’s 27 high multidrug-resistant (MDR) TB burden countries (WHO, 2007; 2011a) and TB a top public health priority in the country. Estimated TB incidence and mortality in 2017 were 95 (the second in the region) and 6.1 per 100 000 population respectively,[[10]](#footnote-11) both on a decreasing trend since mid-2000s. According to the national reporting system (electronic system SIME TB), 2,879 new and relapse cases were registered, a global incidence of 71.7 per 100,000, a 5% reduction compared to 2018, and a 20% reduction compared to 2015. MDR-TB resistance was 27% in newly diagnosed and 56% in previously treated TB patients in 2019. There is geographic variation, incidence reaching 105.5 on the Left Bank compared to 67.2 on the Right Bank. There is also significant variation by districts. In the absence of updated population distribution by district data (expected to be released by NBS later in 2020), rates and estimated indicators will be updated later in 2020.   |  |  | | --- | --- | | **New cases notified (all forms), absolute number and density map (per 100,000), by district 2019** | **MDR-TB Prevalence, in absolute numbers and density map (per 100,000), by district, 2019** | | C:\Users\Stela Bivol\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\837HB3RO\TBR TB Incidenta RM_2-01.png | C:\Users\Stela Bivol\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\837HB3RO\TBR TB Prevalenta RM_2-01.png |   Source: National TB Program Coordination Unit. Statistics data for 2019 extracted from SIME TB  Moldova’s TB epidemic is characterized with most notifications from people aged 18-64 years with specific risk groups including prisoners, migrants and TB-HIV co-infected persons. While most infections within the general population are being identified as drug sensitive TB cases, MDR-TB has been steadily increasing from 2005 to 2012, where it appears to have stabilized; except for within prison populations. Despite a steadily improving epidemiologic situation, Moldova remains among the world’s 30 high MDR-TB burden countries Data suggests that cases of latent TB may have decreased over time amongst the general population, but are high amongst prisoners, migrants and PLHIV. (Annex 7 Optima TB 2018)  As elsewhere, in Moldova TB affects mostly men, 74% men and 26% women in 2019. The number of new TB cases notified in children (0-18 years) in 2019 was 136, 4.7% out of total number. Incidence of new cases for 2019 was 17 per 100,000, a 13% reduction compared to 2015. (Annex NSP 2016-2020)  **Proportion of incident TB cases by age group and sex (absolute numbers), 2019**   |  | | --- | |  |   Source: National TB Program Coordination Unit. Statistics data for 2019  Over the last fifteen years, both TB incidence and mortality have significantly decreased.  **Annual number of notified TB cases in Moldova and mortality rate (1990-2019)**  Source: National TB Program Coordination Unit. Annual report  TB case notifications provide good proxy indication of TB incidence, however like in many other countries, in Moldova adjustments are made by a standard factor to account for under-reporting/-diagnosis. Also the estimated general population size used by WHO (4.1 million in 2014-2018) much higher than the current figure by the National Bureau of Statistics (2.7 million in 2019),[[11]](#footnote-12) i.e., application of a standard factor to significantly smaller population may result in lower incidence estimates/targets. Given the country's increased active case-finding strategies and universal coverage with Xpert, it is likely that UNHLM targets are an overestimation and may need to be revised. The annual notified cases are on decline, and bacteriologic confirmation increased form 58% in 2014 to 67% in 2018. Reasons behind low bacteriologic confirmation are administrative and related to informational system (no automatic import and no automatic validation between the informational modules)[[12]](#footnote-13)  **Annual number of notified TB cases by category, 2015-2019**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | 2015 | 2016 | 2017 | 2018 | | New cases total | **2860** | **2844** | **2686** | **2456** | | New pulmonary bacteriologically confirmed | 1620 | 1596 | 1492 | 1417 | | New pulmonary clinically diagnosed | 929 | 942 | 888 | 770 | | New extrapulmonary | 306 | 306 | 306 | 266 | | Previously treated cases total | **1330** | **1258** | **1146** | **984** | | Relapses pulmonary bacteriologically confirmed | 477 | 428 | 386 | 378 | | Relapses pulmonary clinically diagnosed | 274 | 269 | 246 | 167 | | Relapses extrapulmonary | 29 | 29 | 36 | 21 | | Other previously treated | 550 | 532 | 478 | 418 | | Other cases | **33** | **30** | **22** | **26** | | All TB cases | **4637** | **4132** | **3854** | **3463** |   Source: GLC mission report 2019  **MDR TB:** The European Region has the highest rates of drug-resistant TB (DR-TB) in the world. Moldova has the same pattern, 27% of new TB cases and 56% of previously treated cases had rifampicin-resistant TB (RR-TB) in 201 (national reporting), compared to global figures of 4.1% and 19%. Resistance to anti-TB drugs is the largest challenge and the main obstacle to effectively addressing the TB epidemic in Moldova. In 2019, 631 drug resistant TB patients (RR-TB an MDR-TB), bacteriologically confirmed, were notified, compared to the target 1,023 estimated cases.  **Percent of MDR among total TB cases notified (new and retreatment)**  Source: National TB Program Coordination Unit. Annual report  **Key and/or vulnerable populations for TB**  Currently, key and vulnerable populations in Moldova are prioritized according to the National Clinical TB Protocol in three categories. The protocol defines population groups at risk for TB eligible for active case finding (ACF). However, except for contacts and certain KPs targeted by the NGOs, data on ACF are not reported per key population and groups at risk. The yield of ACF is not known in the various risk groups, which does not allow assessment of the ACF effectiveness and decision making on its contribution to TB control.  **Key and priority groups for TB systematic screening (as per National Clinical TB Protocol 2020)**   |  |  | | --- | --- | |  |  | | High risk populations  (annual screening CXR) | Close and household contacts (adults and children)  People who had TB in past 5 years and those with sequelae  PLHIV  People with immune suppression  People with diabetes  People in mental institutions and other closed settings  People in detention and prison personnel  Migrants (internal external)  Homeless people  Staff of emergency ambulance service  Staff of pneumo-phtysiology facilities | | Groups for increased focus  (annual symptom screening, referral of presumptives to digital X-ray) | **People from socially vulnerable groups**: jobless, informal workers, low-income  **Exposed to medical and biologic risks**: people with chronic lung disease, smokers, those with alcohol and drug use, patients with renal failure, gastrectomy or bypass, pregnant women with TB symptoms, postpartum with TB symptoms  **People in closed settings**: nursing homes, palliative care, temporary placement long residential institutions  **Students and residents**’ medical universities and colleges  **Medical personnel**  **Social assistants** | | Mandated groups  (annual screening CXR) | Health personnel from newborn and pediatric hospitals and  Personnel from child care facilities: kindergarten, preschool and primary schools, sanatoriums |   Source: National Clinical Protocol TB in adults 2020  Since 2011 previous and current GF TB grants and a TB Reach Wave 2 grant targeted active case fining in homeless, people in detention and people who inject drugs. This led to 4-5% contribution to cases notified. (Annex 5 TB Evaluation report 2020, p.8-9) Due to decreased funding level of CSO-led work, the operational scale has decreased in 2018-2020.  Given implementation experience, populations that are considered at higher risk are the following:   * People living with HIV * Homeless people * People in detention * People with alcohol dependency * People who inject drugs * Migrants * People with other co-morbidities, including diabetes * People with Mental Disabilities * Children of people with TB * Roma population   **People in detention**: on average, the prison population is around 6,500 people and is one of the key populations for TB and HIV response due to higher incidence compared to general population. Global incidence has reduced from 1,353 per 100,000 (99 cases) in 2015 to 1,100/100,000 (84 cases) in 2019. In 2019 percent of new TB cases detected through CXR at the time of prison entry was 48% (58 cases) or Xpert in presumptive cases. People in detention receive TB treatment in Pruncul, the only prison hospital with TB beds on the Right Bank. In 2019, some 98 people have received treatment while in prison.  **PLHIV**: TB is the most prevalent co-infection among PLHIV, including among those who start ART and the main cause of mortality among HIV patients, with proportion ranging from 40% to 62%.[[13]](#footnote-14) The main reason is late HIV detection in advanced AIDS stages simultaneously with TB, as over 29% of men and 26% of women who were diagnosed with HIV in 2019 had CD4<200. HIV and TB co-infection rate and doubled over last decade to reported 10.2% of HIV infections among incident new and relapses TB cases in 2019 compared to 5% in 2011[[14]](#footnote-15). TB/HIV co-infection rate among new and relapse MDR TB cases in 2019 was 13.2%. There are large geographical variations, with co-infection rates in the country as high as 25% on the Left Bank and 18% in the municipality of Balti[[15]](#footnote-16).  **Migrants:** several aspects related to migration are important in the context of Moldova. Russia is a destination country where Moldovans work as unregistered migrants. There are specific legal barriers and deportation practices of migrants identified with TB following the intensive treatment phase and no information exchange between the countries. However, there is very scarce data on size of the problem and statistics. Second, an important part of loss to follow up of MDR TB patients is due to people interrupting TB treatment and leaving the country. The loss to follow up in the DS-TB cases decreased to 2.9% in 2019 compared to 7% in 2013, and of those, 39% was due to migration, Migration accounted for 20% as the reason for loss to follow for MDR TB 2017 cohort. According to Optima TB[[16]](#footnote-17) (Annex 7), migrants are the only population forecasted to increase in number of active TB cases and scaling up testing and treatment for migrants is indicated for reducing the number of active TB infections, however these increases will not reverse the trend on their own.  **Trends in loss to follow up including the role of leaving the country for labor migration (2013-2018)**   |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | 2013 | | 2014 | | 2015 | | 2016 | | 2017 | | 2018 | | | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | | LTFU, new and relapse | 276 | 7.1 | 189 | 5.5 | 137 | 4.6 | 123 | 4.0 | 123 | 4.5 | 66 | 2.9 | | of LTFU, outmigration | 66 | 23.9 | 50 | 26.5 | 43 | 31.4 | 39 | 31.7 | 27 | 22.0 | 24 | 38.7 | | LTFU MDR, total | 194 | 20.6 | 188 | 20.5 | 202 | 20.3 | 198 | 20.2 | 197 | 20.2 | NA | NA | | of LTFU, outmigration | 50 | 25.8 | 38 | 20.2 | 31 | 15.4 | 37 | 18.7 | 39 | 19.8 | NA | NA |   Source: NTCP data extracted from SIME TB  **TB Response: progress, challenges and opportunities**  The Ministry of Health, Labor and Social Protection has the primary responsibility of TB response in the country and multidrug resistant-TB (MDR-TB) is clearly recognized as a public health emergency. Implementation of the National TB control programme (NTCP) is coordinated by the NTCP Coordination unit which is the structural unit under the Institute of Phthisio-Pulmonology “Chiril Draganiuc” (IFP). The Coordinator of the NTCP is also appointed as the deputy director of the Institute. The national TB response is based on the National Tuberculosis Control Plan for 2016-2020. The current National TB Control Plan 2016-2020 builds on the progress achieved of implementation of the national TB control programs since 2001. It is aligned to the WHO End-TB Strategy and focused on strategic interventions to reduce the burden of TB, with emphasis on patient centered approaches and specific activities structured around the following objectives:   * Ensure universal access to early diagnosis of all forms of TB, detecting at least 85% of the total estimated number of MDR-TB cases by 2020; * Ensure universal access to patient-centered treatment, reaching a treatment success rate for bacteriologically-confirmed pulmonary TB of at least 85% for new cases and at least 75% for MDR-TB cases by 2020; * Ensure synergies with other national health programs and cutting the burden of TB/HIV down to 5%; * Ensure TB prevention measures and BCG coverage rate at birth of at least 95%; * Ensure health system strengthening for effective TB control; * Develop and use new tools and innovative interventions for TB control; and * Ensure stronger community and civil society involvement in patient-centered TB control.   **TB health service organization**: TB services are well-defined and effectively organized. Since 2005, starting with health finance reform and introduction of national health insurance system, TB services have been integrated in primary and secondary care general health services network. Primary care level is organized by levels: municipal, district level, rural, with a recommended ratio of 1 family physician plus a team of nurses to 1,500 population. However, given shortages in rural areas, family physicians service much larger populations, some reaching to 4-5,000. Secondary level outpatient TB care is provided in each of the districts of the country, in the specialist outpatient departments located in district hospitals. Phthisio-pneumology outpatient department manage presumptive and confirmed TB patients and include adequate TB screening and diagnostic Xpert MTB/RIF technology, and smear microscopy. X-ray diagnostics is available in the same facility at district or municipal level. Presumptive patients and those who are to be screened on annual basis are identified and referred to secondary level by PHC/family doctors. There are 7 inpatient health facilities with TB beds in civilian sector of the Right Bank and Left Bank (865 beds) and 5 in prison sector with a total capacity of 330 beds.[[17]](#footnote-18)  The current approaches to TB response have been shaped by an evolving understanding of needed actions and overcoming recurrent bottlenecks since 1st National TB Program in 2001. The focus of the national TB response has shifted from focused emergency support to revamp the TB core functions (diagnostic and treatment, lab establishment, M&E) to a more health systems strengthening response to support the shift from a vertical approach to one more integrated in the health system, i.e. engaging primary care in case detection and treatment monitoring (since 2004), and support to people-centered approaches (starting 2011) and sustainability building.  **Figure: Evolution of TB response in time**  **C:\Users\Stela Bivol\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\837HB3RO\Moldova Evolution TB-01 (00000002).jpg** Source: Case Study Country case on advancing people-centered TB care in Moldova [[18]](#footnote-19) **People-centered model of care**: The NSP 2016-2020 was built around the main axis of transitioning from a hospital-centric model of care to a decentralized outpatient care in communities and people centered model of care. A national road map to transition to people-centered model of TB care was adopted in 2017. In the past decade, with support of donors, mainly Global Fund (national and TB-REP regional grants), Stop TB Partnership and WHO, a redesign of the model led to strengthening the role of primary care and specialist outpatient level, in developing stronger patient support systems, strengthening the role of communities and civil society engagement in both TB service delivery, advocacy and mobilization and representing patients interest in decision-making processes, as well as strengthening the core functions of the TB program (coordination, M&E, lab, modern DST testing and molecular diagnostics and quality drug regimens).  **Figure: Evolution of TB model of care**  C:\Users\Stela Bivol\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\837HB3RO\Model TB Moldova-01.jpg Source: TB REP: Case Study Country case on advancing people-centered TB care in Moldova In parallel to GF support to stronger patient support systems, the Government of Moldova has gradually increased its domestic contributions reduced excess bed capacity and has increased support to patient incentives (takeover from GF), translating in absolute terms to a 13% reduction in funding allocated to hospital care, a 24% increase in contribution to patient incentives and a 70% increase in PHC P4P payments in 2019 compared to 2016. However, hospitalization rates are still high, despite significant reduction in length of stay for MDR TB. Several missions recommended to reduce hospitalization in favor of outpatient provision, provided technical solutions, the country had made high level commitments and the level of Parliament and Government. However, progress is slow and reasons relate to slow change in contracting mechanisms that would not incentivize hospital stays (change per diem payment to mixed payment stimulating reduced hospital stays)[[19]](#footnote-20).  **Hospital admission rate 2015-2018, Percent hospital admissions, and average length of stays (days)**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | **2015** | **2016** | **2017** | **2018** | | **Percentage of new TB cases hospitalized** | 70.2 | 69.5 | 67.4 | 68.5 | | **Average length of hospital stay, new TB cases, days** | 67.3 | 66 | 64.8 | 56.8 | | **Percentage of MDR-TB patients hospitalized** | 87.8 | 86.1 | 86.3 | 80.4 | | **Average length of hospital stay, MDR-TB cases, days** | 188.7 | 172.3 | 147.2 | 102 |   Source: NTCP annual reports  There is a need of a strong political commitment to the roadmap implementation, particularly related to changes in payment mechanism and strategic purchasing function. In the next phase the country will prioritize aligning needs to resources available for levels of care and of medical and supportive service packages as the basis to exercise strategic purchasing function according to the principle “money follows the patient”.   |  |  | | --- | --- | | **Number of TB beds (total and MDR) 2014-2019** | **Expenditures for PHC bonus payments and patient incentives 2014-2019** | |  |  |   Source: NTCP annual reporting  **Early detection:** Based on the number of WHO estimated TB incident cases as well as TB cases notified through national TB surveillance system, around 500 TB patients were missing in 2018 (WHO global TB database 2018). However, these estimates should be interpreted with some caution given the overestimated general population size as mentioned above and a possible revision of correctional factor assumptions. During the recent years, the TB notification rate for all TB cases decreased steadily from 103.5/100 000 (4,211) in 2015 to 82.5/100 000 (,3313) in 2019, according to NTP data. Case detection is conducted in accordance with the National clinical protocol (the latest version was approved in 2020).  TB patients are mainly detected through passive case-finding, i.e., by examining people who seek medical care at health facilities for symptoms. PHC/family doctors at the primary care level in both rural and urban settings identify and refer patients with presumptive TB for further diagnosis at the secondary level facilities, in accordance with the PCMC,[[20]](#footnote-21) as well as the screening/ diagnostic algorithms (i.e., GeneXpert testing, microscopy, CXR) defined in the TB national clinical protocols for adults and children.[[21]](#footnote-22) Xpert MTB/RIF test is first diagnostic test for all (new) people with TB symptoms, with 95% of new and relapse cases tested with it at the time of diagnosis in 2018.[[22]](#footnote-23)  **Facility-based ACF**: the responsibility for ACF lies with family doctors who conduct screening of three categories high risk groups. priority groups, and mandated groups.[[23]](#footnote-24) Reliable data on the coverage with TB screening among KP as the size of KP groups is not available, limits analysis of coverage and targeting. There are certain challenges in this case finding modality, including shortage of family doctors, challenges to reach certain KP groups and get them examined, improper reimbursement mechanisms for the cost of screening examinations, insufficient incentives to screen all KP. Additional factors that impacted ACF coverage are financial barriers among KP related both to transport costs, but also charge on CXR for people not covered by health insurance. Therefore, additional support to those outside reach of GP is needed and the key role in paradigm shift role of CSO-led responses is obvious.  **TB contact investigation (CI)** is conducted at district level jointly by phthisio-pneumologist and epidemiologist among household contacts, including children, referred from the PHC level. The CI cascade data for 2015 -2019 among household/close contacts shows persistent high coverage (>90%) of TB screening among contacts. At the same time, the yield of TB cases among household contacts has been low (1.2% in 2017 and 2018; 1.1.% in 2019).[[24]](#footnote-25) More granular cascade data needs to be available, particularly among different types of contacts as well through different operational modalities/settings.  **Mobile CXR**: Since 2018, the NTP started an ACF with CXR screening by using mobile van to reach people at high risk for TB in remote rural communities and prisons. In 2019, 34,172 people were screened through mobile outreach, with 166 patients diagnosed with TB (486 cases per 100,000).  **TB case-finding in communities:** NGOs conduct ACF in key populations, including homeless, PLHIV, PWID and prisoners since 2011 with the Global Fund support and Stop TB Partnership TB REACH Initiative and have demonstrated their value in TB care among hard to reach KP and vulnerable groups. Within the NGO-implemented programs, the rates of TB cases per 100,000 people screened were 1,365 for homeless, 614 for PLHIV, and 1,416 for prisoners, compared to 1,676 for contacts in ACF undertaken by the health system.[[25]](#footnote-26)  **TB case-finding in communities**   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | NGO activities – homeless in Chisinau | | | PLHIV screened for TB | NGO in Balti | | KP/activity | | | | 2017 | 2018 | 2019 | 2019 | 2018 | 2019 | 2018 contacts | 2018 prisoners | 2019 mobile van | | People screened | 1,452 | 1,532 | 1,538 | 2,443 | 264 | 1,021 | 17,958 | 6,991 | 34,172 | | Tested for TB (% of screened) | 449 (31%) | 378 (25%) | 362 (24%) | 465 (19%) | - | - | 628 (3%) | Not available | 5,888 (17%) | | TB diagnosed (% of tested) | 18 (4%) | 15 (4%) | 21 (6%) | 342 (74%) | 2 | 11 | 580 (92%) | 5997 (86%) | Not available | | TB per 100,000 screened | 1,240 | 979 | 1,365 | 15 (4%) | 758 | 1,077 | 301 (52%) | 99 (2%) | 166 |   Source: APMG TB Evaluation Report 2020, data from NTCP and PAS Center reporting  As revealed by a costing study (*Annex 8 CIF 2019, Costing of TB transition components*), the funding gap for 2020 for community and civil society is the largest in proportional terms. The TB Evaluation report 2020 highlighted that funding limitations, subsequently, affected case finding: in 2016 and 2017, 11 NGOs were involved in ACF (in KPs and other groups) resulting in screening of 3,108 people and detection of 115 TB patients, a rate of 3,700 per 100,000. The same numbers for the 2018 and 2019 period were: 10 NGOs, 953 people screened and 23 TB patients diagnosed, a rate of 2,413 per 100,000. Given that it is unlikely the governmental health services will be able to take over ACF in hard-to-reach groups addressed by NGOs, insufficient involvement of the latest may severely affect case finding in KP.  In addition to designated key populations where higher incidence is notes, a number of priority and vulnerable populations were also screened in previous efforts but data was not disaggregated by groups, i.e. migrants, Roma, low-income, but support stopped because of insufficient funding. Currently, there are no activities focused on Roma people. There have been some practices in this area, during 2010-2012. Roma, being a closed community with own traditions and culture (some of them prohibiting accessing health services) needs specific tailoring of interventions that are culturally sensitive and requires involvement of community mediators.  **Diagnosis:** The laboratory network covers the whole country and includes 59 microscopy centers located at TB outpatient facilities at the district level, out of which 57 are equipped with Xpert; three regional reference laboratories that perform culture tests and DST; and national reference laboratory. The diagnostic algorithm has both smear microscopy and Xpert as the first line test for people with TB symptoms. Xpert MTB/RIF was introduced in the Republic of Moldova in 2012 with support of STP TB REACH and then rolled out with GF support towards almost universal coverage, including penitentiary system and HIV services. The widespread use of Xpert MTB/RIF has improved diagnostic testing and shortened the time to MDR-TB detection and treatment. In 2018, 95% of notified new and relapse TB patients were tested using Xpert MTB/RIF. In line with the transition from GF to domestic funding, the government covers all consumables for smear microscopy, as well as a large part of the GeneXpert cartridges (in 2019, 40% of the needs for the Right Bank). Given the existing co-morbidity profile, the country also plans to use Xpert as multi-disease integrated platforms, namely TB/HIV/HCV/COVID-19.  **High DST coverage**: 97% of bacteriologically confirmed new TB cases, and 80% of bacteriologically confirmed previously treated cases, were tested for RR, respectively; 83% of RR-/MDR-TB cases were tested for resistance to second-line drugs. The coverage of FLD DST for susceptible pulmonary TB increased from 68% in 2014 to 76% in 2018, and also for extra-pulmonary TB, from 10% in 2014 to 21% in 2018. The coverage of SLD DST for MDR-TB patients increased from 58% in 2014 to 71% in 2018 for pulmonary TB and from 17% to 70% for extra-pulmonary TB. Eighty-two percent of XDR-TB patients had SLD-DST in 2018.  **TB laboratory network**: TB lab network in line with international standards was established in 2004 with support from USAID and Global Fund. The well-developed laboratory network includes National Reference Lab (NRL) in Chisinau and three regional reference labs (RRLs) in Balti, Vorniceni, and Transnistria as well as 57 Xpert MTB/RIF technology/microscopy centers attached to TB outpatient health facilities at district level. The NRL and RRLs have an adequate diagnostic capacity for culture/DST for both first-line and second-line drugs. Annual external quality assessment (EQA) is carried out in all NRL/RRLs by the Supranational Reference Laboratory (SRL) in Borstel, Germany, achieving 100% coincidence in results starting from 2017. The NRL also participates in the EQA performed by the INSTAND (Society for Promoting Quality Assurance in Medical Laboratories), Germany, for TB microscopy, culture/DST, and molecular methods. In March 2020, the NRL received from the INSTAND (Society for Promoting Quality Assurance in Medical Laboratories), Germany, certificates of successful completion of an EQA for TB microscopy, culture/DST, and molecular methods. The NRL carries out EQA for the same methods for all three RRLs, and RRLs carry out external quality control of the lower level laboratories focusing on TB microscopy and Xpert MTB/RIF testing, with the results of these efforts used for continuous technical support and performance improvement. The GF TB grant supports the implementation of TB sample transportation network for transporting samples from peripheral Xpert MTB/RIF centers including the penitentiary system to NRL and RRLs for culture/DST.  **Prevention:** INH –basedTB preventive treatment (TPT) was included in previous national protocol and available for contacts of TB patients and PLHIV. The uptake was low. Overall, of the contacts eligible, 11% in 2017 and 14% 2018 received TPT. The TPT completion rates were quite reasonable: 80% and 78% respectively. TPT for PLHIV was launched on the right bank in 2017 and on the left bank in 2018. There has been a limited data available on TPT among PLHIV: 76 PLHIV in 2017, 812 in 2018, and 163 in 2019 started TPT. The HIV program does not have data on eligibility or completion. Better progress has been registered in TPT in children, in 2019 1,080 children who were contacts were administered TPT. The updated clinical protocol 2020, in addition to INH-based 6-9 month TPT, now includes 3 months combined Rifampentine-INH regimen for contact children and adults. This creates premises for better acceptability and compliance to TPT.  **Treatment:** For drug-susceptible TB cases, the treatment success rates are relatively high: for 2018, 85% of new and relapse cases were successfully treated. At the same time, the outcomes of DR-TB treatment are still poor and progress slowly. For the 2017 cohort (the latest annual MDR-TB cohort evaluated for final treatment results), only 55% of MDR-TB cases and were successfully treated, among new cases success reaching 72% rate, while in retreatment cases success rate was 41%. Given the high and increasing burden of resistance to second-line drugs, this is a key concern for the NTPs to take prompt actions to ensure administration of newer drug regimens, as well as to implement evidence-based interventions for intensive support and follow-up of DR-TB patients on treatment. TSR was 58% in 2017 cohort of TB/HIV cases; in 2018, enrolment into treatment for laboratory confirmed RR-/MDR-TB was 100%, and for XDR-TB was 56%.  **Table. Treatment outcomes, RR/MDR-TB cases, 2013–2017 cohorts**   |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | 2013 | | 2014 | | 2015 | | 2016 | | 2017 | | | **N** | **%** | **N** | **%** | **N** | **%** | **N** | **%** | **N** | **%** | | RR/MDR-TB cohort size | 943 | - | 919 | - | 996 | - | 979 | - | 975 |  | | Treatment success | 538 | 57 | 457 | 49.7 | 487 | 48.9 | 518 | 53.9 | 537 | 55.1 | | Treatment failure | 93 | 9.9 | 142 | 15.5 | 177 | 17.8 | 132 | 13.5 | 124 | 12.7 | | Death | 112 | 11.9 | 129 | 14 | 120 | 12 | 125 | 12.8 | 117 | 12 | | LTFU | 194 | 20.6 | 188 | 20.5 | 202 | 20.3 | 198 | 20.2 | 197 | 20.2 | | Not evaluated | 6 | 0.6 | 3 | 0.3 | 10 | 1 | 6 | 0.6 | 0 | 0 |   Source: NTCP MDR TB cohort reporting  Since 2011, the Government has been procuring first-line anti-TB drugs (FLDs); since 2014 - a part of the county’s second-line anti-TB drugs (SLDs). Currently, the Government covers full needs for FLDs; the proportion of SLDs procured by the Government has been gradually increasing during 2018-2020 from 46% to 50% and 63%. In June 2020 the NTCP has revised the treatment protocol to include the most recent WHO recommendations (WHO 2019). Introduction of modified treatment guideline allows patients to receive shorter and all oral regimens, which is expected to contribute to better treatment outcomes. The country participates in Operational Research which includes administration of “Short, all-Oral Regimens for Rifampicin-resistant Tuberculosis” (started in 2019 by WHO EURO with partial support form TB REP 2.0). The new drugs and new regimens require strong systems for patient monitoring, drug management and pharmacovigilance for preventing severe adverse events and development of resistance to new drugs - related aspects are presented under the RSSH component.  **People-centered support:** adaptation of the people-centered model of TB care is supported by a range of innovative treatment service delivery interventions: provider incentives in PHC (P4P for early detection and treatment success), patient incentives, patient support community centers, CSO-led peer-to-peer support and community interventions, and digital adherence technologies.  **An incentive program for TB patients** to improve adherence to treatment at outpatient level is in place since 2011, initially covered by the Gf and gradually got to the phase of being primarily funded by the NHIC for the Right Bank, with cost-sharing from GF for the Left Bank. The Government, through National Health Insurance Fund, fully covers the incentive payments for susceptible TB patients and 75% of MDR-TB patients. Approximately the same in the size, incentives covered by GF and NHIC differ in terms of the application approach. Patients covered by the GF funding receive cash incentives, the patients covered by NHIF receive food vouchers and travel reimbursement.  **CSO-led peer-to-peer patient support:** this includes support to increase TB treatment adherence and strengthen the capacity of TB affected people by informing about TB, educate TB patients on the importance of continuing treatment in ambulatory phase and community services available in territories, during 2013-2017 were conducted by CSO through following services: (1) information/counseling about treatment adherence, (2) support group meetings, (3) peer to peer counseling and education of family members on TB, to increase treatment adherence support, (4) awareness-raising activities to reduce stigma and discrimination in the community towards TB patients, based on collected information from people with TB about stigma and discrimination cases, (5) advocacy for improved availability of resources, services and drugs, based on collected information from people with TB about quality of medical services, disruptions in incentives provision, drug stock-outs and out of pocket expenses . These activities will be continued and improved through using the community monitoring app to collect data on barriers people with TB are facing during the treatment, respond immediately to the person need helping to solve the individual case and generate data for advocacy to change identified systemic gaps.  **TB Support Centers**: to address the psycho-social needs and vulnerabilities during MDR-TB treatment, the country established community centers functionally attached to the outpatient TB unit at the district level. The first 10 community centers were established in 2011, as part of the previous GFATM grant. The psychosocial support package provided by the community centers include DOT support, information and counselling to TB patients and their families, non-compliance risk assessment and individual plan for support, referrals to the existing social services, referrals to legal counselling. As a result, the treatment success rate was higher (72% versus 62%) and the rate of lost to follow-up was significantly lower (5% versus 21%) for cases assisted by the community centers. In 2017, community centers were scaled up to all districts with gradual transition, in the following years, to the domestic funding. The Government takeover of these centers occurred as integration with TB services by adding respective staff units (psychologist, social worker and DOT supporter) to the outpatient TB unit. Currently ongoing activities on developing the package of the support services and related purchasing mechanisms will be essential to enable strengthening the patient adherence support component of the people-centered model of TB care. In the next phase, solutions to optimize the impact of the patient adherence support will focus on improving case-management through multidisciplinary approach, including needs assessment and case management for each person affected by TB and their families.  **Digital adherence tools**: another important element of the recently introduced people-centered approaches is introduction of digital adherence treatment (DAT) modality through Video Observed Treatment (VOT). In 2016-2017 a consortium of partners has conducted and trial for DAT approach in Moldova. The results showed significantly higher adherence rates, higher acceptance, and lower time and treatment-related costs for patients on VOT compared to those in DOT. Building on this successful intervention trial, with support of TB-REACH Initiative of the Stop TB Partnership, the country currently is implementing a rollout of a digital tool *I Like VOT* to make digital adherence supported VOT a more feasible option in a few sites. National scale up of VOT and home-based care is prioritized for GF support the next period to support health system transformation for better TB outcomes.  **TB program in prison and pre-trial detention**: TB screening includes CXR for all people in prisons upon admission and then twice a year. TB screening and diagnosis is made in line with the national protocols, including Xpert MTB/Rif as first line test as well as c/DST (through contracts with labs in the civil sector). Currently CSOs implement pre-release interventions and case-management to ensure continuity of care between prison and community care. In 2019, 14 DS-TB people and 9 patients with MDR-TB have been released and linked to care. SLD are covered through GF, FLD are procured by Ministry of Justice (MoJ) tender by the Agency for Public Procurement of Medicines through separate bids, with plans to have one pooled procurement for the country starting 2021. TB/HIV bidirectional activities in prions TB and HIV screening and ART and TB treatment enrolment[[26]](#footnote-27).  **TB/HIV collaborative activities:** in Moldova**,** TB is by far the greater killer of people living with HIV (PLHIV) while HIV co-infection affects 10% of TB patients and does not impact the overall TB epidemic. Optima TB suggests that improving link between ART and TB treatment will lead to reaching 90-90-90 would result in reduced active TB prevalence of 30% and TB-related deaths by 50% among PLHIV. An external assessment highlighted that the public health approach to the HIV epidemic is in a younger phase compared to that against TB. HIV services decentralization is still in the initial phase, while TB services are strong and effectively organized at all levels and made a series of recommendation in improving screening, early diagnosis and care for patients particularly ART timely initiation.[[27]](#footnote-28) The audit of TB/HIV cases performed by PAS Center in 2016 (2012 – 2014 cohort) provided insight on key challenges and bottlenecks of clinical management of TB/HIV in Moldova delays along cascade.[[28]](#footnote-29) Since 2017 coordination between the two programs and joint management of co-infection has significantly improved. HIV testing rate among TB patients stays high at 97% and 88% patients enrolled on ART in 2019. Moving forward collaborative approach at national and local levels and integration with other health and social services are a key priority.  **Key TB/HIV indicators (2015-2019)**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | 2015 | 2016 | 2017 | 2018 | 2019 | | Total of new and relapse cases and cases with unknown previous TB treatment history | 3,608 | 3,571 | 3,358 | 3,022 | 2,879 | | Number of new and relapse TB patients tested for HIV at the time of TB diagnosis or with known HIV status at the time of TB diagnosis | 3,439 | 3,366 | 3,188 | 2,893 | 2,792 | | | New and relapse TB patients tested for HIV at the time of TB diagnosis or with known HIV status at the time of TB diagnosis (percent) | 95.3% | 94.3% | 95.1% | 95.7% | 97.0% | | | Number of new and relapse TB patients recorded as HIV-positive | 300 | 293 | 277 | 248 | 294 | | | HIV-positive new and relapse TB patients started or continued on antiretroviral therapy | 197 | 193 | 190 | 168 | 260 | | | Registered HIV-positive new and relapse TB patients started or continued on antiretroviral therapy (percent) | 65.7% | 65.9% | 68.6% | 67.7% | 88.4% | | | People living with HIV newly enrolled in HIV care who started treatment for latent TB infection | 0 | 0 | 76 | 812 | 163 | | | Total number of adults and children newly enrolled in HIV care who are diagnosed as having active TB disease during the reporting period | N/A | N/A | N/A | 123 | 132 | | | Treatment success rate for HIV-positive TB cases (percent) new case and relapse | 58.6% | 62.0% | 61.3% | 69.5% | N/A | |   Source: NTCP and NAP routine statistics data  **TB M&E system:** the M&E unit of the national TB control program operates at the Institute of Phthisio-Pulmonology "Chiril Draganiuc", it does not have specific budget and depends on the donor funding. The list of activities includes coordination of program, development and implementation of strategies in the phthisio-pulmonology service; generalization, processing and analysis of information from the phthisio-pulmonology service. The TB surveillance system consists of paper-based and an electronic case-based register called SIME TB, which is a real-time web-based application with nationwide coverage including the penitentiary system. The routine surveillance data are available on the NTP website and widely used for peer-reviewed publications The TB register is designed to capture a minimum set of variables for all reported TB cases, which includes age, gender, bacteriological results etc. In addition, detailed information on socioeconomic status and underlying risk factors is collected. It includes area of residence (urban vs rural), occupation, living conditions, history of incarceration, number of household contacts and comorbidities, as well as HIV status and ART treatment. The data flow between clinicians and the laboratory is smooth, however, the laboratory and patient modules of SIME TB are not integrated (i.e., manual data entry of the laboratory data is required into the patient module of SIME TB). Data quality assessment procedures are in place, both automatic upon data entry as well as supervisory visits. The program is also inter-operable with the information system of surveillance of communicable diseases hosted by the National Centre for Public Health. Although SIME TB functions well, it is not possible to add new variables or make substantial changes, which is due to the programming language used that has reached the end of its life and is in need for an update.  Below is a summary of major areas where progress needs to be made in the next allocation period.  **Table: Major Gaps and priorities in TB response**   |  |  | | --- | --- | | Major gaps and barriers | Key priorities | | Late case detection and case finding of insufficient scale among key and most vulnerable populations | * Ensure ACF cascade reporting and analysis; * Strengthen ACF strategies at facility level * Screen all high risk groups (PLHIV, inmates, PWID, homeless) * Roll out of innovations in case finding involving communities allowing for more tailored approaches for different KPs * Improve PHC reimbursement mechanisms and financial incentives for ACF; * Improve mobile CXR performance and introduce artificial intelligence; expand NGO involvement in ACF. * Maintain high quality TB diagnostic network using rapid molecular technology and new diagnostics, consistent with WHO guidelines * Access to rapid drug susceptibility testing, especially for ruling out fluoroquinolone resistance | | Slow pace of improvement of treatment outcomes for MDR TB: phased uptake of new treatment regimens | * Scale up use of new DR-TB regimens consistent with WHO guidelines * Adequate patient support and case-management for improved treatment outcomes * Rapid scale-up of VOT * Accelerate decentralized and outpatient based treatment, strengthen ambulatory care * Integration of TB/HIV Hepatitis, diabetes, drug and alcohol services | | Slow implementation of people centered model of care | * Develop and advocate for TB medical and non-medical service packages for all levels of care as basis for strategic purchasing * Further reduction in unnecessary hospital stays | | Suboptimal scale-up of TB prevention measures | * Update and implement TPT guidelines, ensure sustainable access to TPT, IGRA. * Scale-up TB preventive treatment among household contacts (children and adult) and PLHIV | | Low availability of routine and survey data for adaptation of response | * Strengthen surveillance systems, improve use of data, measure social and economic impact of TB, enhance digital technologies in support of TB treatment delivery adherence, TPT and case finding. | | Existing barriers to access and on key populations | * Conduct CRG analysis to prioritize key populations, establish size estimations * Reduce stigma and discrimination from family members and community * Ensure choice of treatment modalities and right to movement * Promote a rights’ based approach * Community-based monitoring to reduce barriers | | Community systems in TB need strengthening and funding predictability | * Social contracting of NGOs for TB service delivery * Collaborative learning, capacity building organizational development[[29]](#footnote-30) |   **HIV context**  Moldova experiences a concentrated HIV epidemic since mid-1990s. According to SPECTRUM, the estimated HIV prevalence in the adult general population is 0.6% [0.3 in women and 0.6 in men], new infections occur mostly in adult population over 24: the estimated incidence of 0.45 in 15-49, 0.08 in 50+, 0.29 in 15-24 and 0.04 0-14. The latest estimated number of people living with HIV (PLHIV) in Moldova is 14,589, lower compared to previously estimated 17,000 until 2018, decrease due to National Bureau of Statistics revising population size based on Census conducted in 2014. (Annex 10. SPECTRUM 2020) According to national statistics, since 1987 to date, a total of 13,656 people with HIV of 4,437 AIDS cases and 3,879 deaths were cumulatively registered on both banks of the Nistru River. The readjusted prevalence based on new population is 310 per 100,000. (National Agency for Public Health 2020). In 2019, 922 new HIV cases were registered (31% more compared to 2010) and 206 AIDS-related deaths, of them 58% men, 42% women and 21% young people 15-24 years. Incidence was 20 per 100,000 inhabitants on the Right Bank of Nistru and 47 per 100,000 inhabitants in the Transnistria (Left Bank).  **Figure. HIV incidence (new cases per 100,000), years 2000-2019**  Source: National Agency of Public Health surveillance data  According to the latest Global Aids Monitoring Report 2019, the HIV epidemic continues to be concentrated among key affected populations, mostly PWID, with an increasing contribution of SWs and MSMs. Data suggest that the epidemic has transitioned from a PWID driven epidemic to one in which transmissions to sexual partners and other key populations has become a source of new infections. (Annex 11 GAM 2019)   |  |  | | --- | --- | | **Progress in estimated HIV transmission** | **Progress in AIDS-related deaths** | |  |  |   Source: <http://aidsinfo.unaids.org/>  The geographic distribution shows concentration in urban areas, the most affected sites are municipalities of Balti, Tiraspol and a town in Transnistrian region Rybnitsa. (National Agency for Public Health. Annual Epidemic Update 2020)   |  |  | | --- | --- | | **Cumulative number of HIV cases registered (absolute number) and cumulative incidence (per 100,000), by district 2019** | **New HIV cases registered (absolute number) and incidence (per 100,000), 2019** | | C:\Users\Stela Bivol\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\837HB3RO\Prevalenta RM _2-01.png | C:\Users\Stela Bivol\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\837HB3RO\Incidenta RM _2-01.png | | Source: National Agency of Public Health surveillance data.  Note: exact values of incidence and cumulative incidence per 100,000 will be adjusted when new population size per district is released by NBS. Cumulative incidence includes all number of cases registered since 1987 until 2019. | |   A trend analysis shows an overall changing epidemic, from predominantly transmission through drug injection towards transmission to sexual partners of key populations and an increasing trend among MSM and SWs. Following the first outbreak among people who injected drugs in 1996-1999, the harm reduction / needle and syringe programs set up in hot spots in 2000 significantly decreased transmission through injecting drugs. In 2019, among 922 newly diagnosed PLHIV, 69% reported a heterosexual transmission route, 1.3% through same sex, 4% through injecting drugs and 2% PMTCT (rest 22% unknown). Mother to child transmission has been at less than 2% in the past decade, contributing 1-2% and in absolute terms between 10-20 newborns are diagnosed with HIV every year.  A shift in trends by gender and age has also occurred. Newly diagnosed cases are registered in adult populations, highest in 25-39-year group (54%), age groups over 26 years accounting for 84% of HIV diagnosed cases. Since 2010, the share of 15-24-year age group has decreased from 22% in 2010 to 8% in 2019. Gender distribution of HIV diagnoses evolved over time: initially an increase in proportion of women from 27% in 2001 to 52% in year 2010, probably mostly as sexual partners of PWID and among female PWID and SWs, followed by a decrease to 41% in 2019. In absolute terms, number of new cases is stable among women (<380 cases per year) and increasing in men from 341 cases in 2010 to 544 cases in 2019. Heterosexual transmission route prevails but as a share has decreased from 86% in 2010 to 69% in 2019. Case reporting among men having sex with men increased from 6 in 2010 to 27 in 2019. These trends are an indication of increase of HIV transmission among men having sex with men.   |  |  | | --- | --- | | **Relative distribution ratio of new HIV cases, years 2010-2019** | **Distribution by age groups, cumulative 2010-2019** | |  | |  |  |  | | --- | --- | --- | | Age, years | # | % | | 0-5 | 107 | 1% | | 6-14 | 32 | 0% | | 15 -19 | 237 | 3% | | 20-24 | 886 | 11% | | 25-39 | 4,320 | 54% | | 40-49 | 1,463 | 18% | | 50-59 | 723 | 9% | | 60> | 263 | 3% | | Cumulative total | **8,031** | **100%** | |   Source: National Agency of Public Health surveillance data  **Key populations affected by HIV**  The HIV epidemic is concentrated in the following key populations prioritized by national HIV programs: people who inject drugs (PWID), men who have sex with men (MSM), sex workers (SWs) and people in detention. Four rounds of Integrated Bio Behavioral Survey (IBBS) support these trends. Since 2010 IBBS has been conducted through respondent-driven sampling in all surveyed key populations in main cities. Based on preliminary data of IBBS 2020 (still I progress), the HIV epidemic continues to be concentrated in key populations, with prevalence of 12.5% among people who inject drugs (PWID), 12.3% among men who have sex with men (MSM), 3% among sex workers (SW).  However, there are differentiated trends observed, site by site and by key population:   * In Chisinau a continuing increase in MSM, stable in PWID, and decrease in SWs. * In Balti HIV prevalence is a decreasing in PWID due to normative use of single use of syringes and needles, stable trend in SWs and decrease in MSM. * In Tiraspol the HIV prevalence has been increasing in PWID, the only population surveyed. * Among people in detention, the trend has been stable.   Since 2010, size estimates in these populations are conducted. The current size estimates are 36,900 PWID, 21,300 SWs, and 17,100 MSM. The latest size estimation exercise is now in progress and results will be available later in 2020.   |  |  | | --- | --- | | **HIV prevalence and size estimates in key populations** | | | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Key populations | Site | HIV prevalence | | | | | **2010** | **2013** | **2016** | **2020** | | PWID | Chisinau | 16 | 9 | 14 | 13 | | Balti | 40 | 42 | 17 | 15 | | Tiraspol | 12 | 24 | 29 | N/A | | SWs | Chisinau | 6 | 12 | 4 | 3 | | Balti | 23 | 22 | 22 | N/A | | MSM | Chisinau | 2 | 5 | 9 | 12 | | Balti | 0.2 | 8 | 4 | N/A | | People in detention | Right Bank | 3 | 2 | 4 | N/A | | |  |  |  |  | | --- | --- | --- | --- | |  | Size estimates | | | | **2010** | **2013** | **2016** | | PWID | 31,600 | 30,200 | 36,900 | | SW | 14,800 | 12,000 | 21,300 | | MSM | 22,300 | 13,500 | 17,100 | |   Source: HIV - IBBS data. Note: IBBS 2020 is now in progress. Data collection is finalized during funding request submission. Data is preliminary. Size estimates 2020 are currently in process to be analyzed  **HIV Response: progress, challenges and opportunities**  The overall implementation of National HIV program is coordinated by the National HIV/AIDS Program Coordination Unit which located and in subordination to the Hospital of Dermatology and Communicable Diseases (SDMC), the National Program Coordinator being head of a department. The national HIV response is based on a robust, well prioritized, costed National Control and Prophylaxis HIV/AIDS Program for 2016-2020 (NAP). The GF grant supports the achievement of NAP targets. The current National Plan for HIV and STI control for 2016-2020 is the 5th since 1995 and is in its final year of implementation. It is focused on key drivers of the epidemic and aligned to global 90-90-90 strategies, anchored in the following objectives:   1. Prevention of HIV and STIs among PWID, SW MSM and people in detention through providing access to HIV prevention services and testing to at least 60% of the estimated number of SWs and 40% for MSM by 2020 2. Universal access to treatment care and support to PLHIV covering 60% from estimated PLHIV with ART (tripled form 17% baseline) 3. National AIDS Program (NAP) management focused on efficiency, management, coordination, resilient and sustainable systems for health, human rights, financial sustainability, evidence generation and M&RE systems.   **Progress in KP prevention:** NGO-delivered HIV combination prevention programs for key populations are mature programs set up since 2000. Coverage with prevention services is high in PWID, moderate for SWs and low in MSM. Basic services are provided through sites, outreach, and pharmacies (prevention commodities: syringes, condoms, alcohol napkins, information materials). Three mobile clinics offer extended services for all KPs. 10 NGOs and Department of Penitentiary Institutions (Ministry of Justice) service PWID covering 40 sites and 18 prisons; 11 NGOs provide services to SWs in covering 30 localities); 6 NGOs provide prevention services to MSM in 17 sites and prisons on the Left Bank. In 2017 and 2018 as part of sustainability and transition, the National Health Insurance Company allocated equivalent of 100,000 and 77,000 euros to contract two HIV prevention grants per year, with a cumulative coverage of 1,148 PWID, 263 SW and 425 MSM.[[30]](#footnote-31) Service standards were updated based on last international recommendations for all key populations [[31]](#footnote-32)and divided in basic service package and comprehensive service package (included KP tailored, gender and age-sensitive, client navigation and additional support services); people who use non-injecting drugs and transgender people have been introduced as new key population groups (approved by Ministry of Health, Labor and Social Protection in March 2020). Integration of sexual and reproductive services translates into access of state funded contraception and cervical screening programs.  Coverage dynamics show that in absolute terms the number of beneficiaries increases annually. Size estimations of key populations in 2017 were higher compared to previous round, therefore in relative terms coverage lower compared to 2015-2016. In 2019 decline in coverage was due to a change in the validation criteria[[32]](#footnote-33) of the client covered by the services. Since 2019, a real-time electronic card-based registration database system has been introduced, it allows NGOs working with KPs electronic data entry using mobile technologies. Data is centralized, simplifies monitoring system and removes double-counting. Another factor influencing stagnating number in PWID is an emerging pattern of transition to non-injecting use among young KPs, as a response to changes in the drug market, the massive emergence of new psychoactive substances used by other methods than injection. (Annex 14. New Psychoactive substance use in Moldova and Belarus).  **Coverage of key populations with prevention services (2016 -2019)**   |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | 2015 | | 2016 | | 2017 | | 2018 | | 2019 | | Target 2020 | | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **%** | | PWID | 13,069 | **43** | 14,806 | **49** | 15,431 | **41** | 20,801 | **56** | 15,627 | **42** | **60%** | | SW | 4,858 | **40** | 4,717 | **39** | 5,620 | **26** | 8,373 | **40** | 7,332 | **34** | **60%** | | MSM | 2,805 | **20** | 3,013 | **22** | 3,636 | **21** | 4,630 | **27** | 4,376 | **26** | **40%** |   Source: annual program reports of GF implementers. Note in 2016 new size estimate exercise was conducted.  **OST program:** Opioid substitution therapy with methadone was established in Moldova in 2004 (following a pilot with buprenorphine in 2001-2003) and in prisons in 2005 (Right Bank only). Starting in 2015, service has expanded geographically and increased coverage. From 2018 Buprenorphine based OST is available. OST is provided through 8 sites and in 13 prisons and pretrial detention centers. This program has been functioning in the penitentiary institutions as well. By February 2020, a total of 522 people were in OST, including 72 in prisons, 33 on buprenorphine. Starting with 2019, OST fully transitioned to public funding, state budget covering cost of medicines (2019), National Health Insurance service package service (2018). Non-governmental organizations provide psychosocial support (GF grant).  **PrEP:** starting in 2019 a community-based PrEP program has been introduced intending to cover all key populations. 1st phase included a PrEP protocol and preparatory work. NGO staff training on community-based PrEP. So far 125 persons were enrolled, of them 78% MSM and 22% other KPs.  **Progress towards eMTCT**: Sustained efforts in PMTCT across all four prongs are supported by public funding and the PMTCT is fully integrated with RMNCH services. Moldova adopted B+ as part of its national protocol since 2014. Medical staff involved in measures to prevent HIV transmission from mother to child were trained at all levels (level 1 maternities, level 2 maternities, reproductive health clinics, primary care, district level infectious diseases physicians and from ART centers). All medical institutions are equipped with HIV tests, maternity hospitals are equipped with rapid tests and ARV drugs, all newborns of mothers with HIV are provided with milk formulas. HIV testing in pregnant women reached 99.8% in 2019 (identifying 54 new HIV cases in ANC, overall 208 women) and ART coverage in pregnant women was 95.7%. Early infant diagnosis is implemented in first 48 hours and 6 weeks, with 97% coverage. The rate of mother-to-child transmission of HIV (MTCT) rate varies due to small numbers: 5.2% in 2015, 2.5% in 2016, 1.4% in 2017 and 2.6% in 2018 2018. In 2019 MTCT was 4.8%, causes are related to social vulnerabilities of mothers and inefficient engagement of PHC, leading to postpartum ART interruption and challenges in tracking of most vulnerable mother-baby pair. Last mile efforts are needed to achieve EMTCT. Moldova has received syphilis elimination status and maintained it. In order to validate the elimination of mother-to-child transmission of HIV, in 2018 the national clinical protocol was updated in accordance with WHO recommendations. To progress in reducing the number of new HIV infection cases among children, an analysis of all cases of mother-to-child transmission of HIV registered during 2016-2018 lead to recommendations, the need in staff capacity building, and work directed in ensuring postpartum mother-infant tracking and follow up. A national evaluation report Elimination of Mother to Child Transmission of HIV. (Annex 13. EMTCT revalidation report 2020)  **Progress towards achieving 90-90-90 goals**: the HIV testing and treatment cascade for Moldova demonstrates progress towards attainment of global and regional 90-90-90 targets in this funding cycle, reaching 64-71-84 in 2019 compared to a much lower baseline of 52-53-69 in 2015. By January 2020, there were 9,407 people living with HIV who knew their status, 8,234 were enrolled in care, 6,690 were on ART at the end of reporting period and 5,602 had viral suppression. As of January 2020, 81 children under 10 years were on ART mostly on LPV/r-based schemes (84%,) a few on EFV-based regimens (16%) are on EFV treatment schemes.  **90-90-90 cascade evolution 2015-2019**  C:\Users\Stela Bivol\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\837HB3RO\graphHiv 2-01.jpg  Source: National Coordination Unit, National Program on Prevention and Control of HIV/AIDS and STI data  Results vary by region, with lower coverage on the Left Bank, higher levels among women compared to men and higher coverage in children compared to adults.  **90-90-90 cascade in 2019, by region, age and sex**  **C:\Users\Stela Bivol\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\837HB3RO\graphHiv 2_-02.jpg**  Source: National Coordination Unit, National Programme on Prevention and Control of HIV/AIDS and STI data.  **90% of people who know their HIV status**: Based on the latest estimate in 2019, out of 14,588 people estimated to live with HIV in Moldova, some 5,181 are yet to be reached and diagnosed with HIV. (SPECTRUM 2020) This is the largest bottleneck in the cascade.  **HIV testing in key populations**, NAP 2016-2020 set the testing targets at 60% for PWID and SWs, and 40% of MSM who are covered with HIV prevention package. In 2018 and 2019 these targets were met for SWs and MSM and not met for PWID. Strategies that led to this increase included rollout of new testing strategy based on rapid diagnostic tests, (RDT), a pay for performance to outreach workers scale-up of HIV testing in key populations, outreach-assisted oral fluid-based tests for self-testing for KAPs, HIV self-test (HST) kits through pharmacies.  **Progress in achieving testing targets in key populations, NSP 2016-2020 targets**   |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | 2015 | | 2016 | | 2017 | | 2018 | | 2019 | | Target 2020 | | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **%** | | PWID | **1,036** | **8** | **2,415** | **16** | **2,443** | **16** | **10,175** | **49** | **7,922** | **51** | **60%** | | SW | **288** | **6** | **314** | **7** | **807** | **14** | **5,431** | **65** | **4,980** | **68** | **60%** | | MSM | **185** | **7** | **232** | **8** | **454** | **12** | **2,848** | **62** | **2,411** | **55** | **40%** |   Source: Annual program reports of GF implementers. Percent tested is calculated out of those covered with HIV prevention services.  Adoption of new approaches included adopting WHO-recommended testing strategy based on RDTs for both providers initiated testing and counseling (PITC) and community-based testing (CBT) and some decentralization to PHC. Self-testing is available since 2016, through NGOs and youth clinics. Adoption of new testing algorithm decreased time to results to 1-2 days as opposed to month.  Test yield overall has not changed, at 0.3% in both 2016 and 2019, showing high number of untargeted testing. Total number of tests increased from 267K (170k gen pop, 80k blood donors,18k KPs) to 347K in 2019 (250K gen pop, 80K blood donors and 18K in KPs), this lead to increase in cases diagnosed from 835 in 2017 to 922 in 2019. Comparative analysis shows that by type of testing, coverage with testing has increased in all categories, (except blood donors and pregnant women, a rather stable number and >99% coverage). Similarly, coverage with testing among key populations have significantly increased but has not brought significantly more positives, number of new cases among KPs in 2019 close to the one in 2016 (98 versus 86). This shows that current testing strategies have yet to significantly refocus on case finding for both either PITC or CBT. The table below shows a similar yield in PITC and CBT. On PITC, the highest yield was found in sexual partners of PLHIV, at 13%, which stresses the importance of partner testing, including to index testing, sexual network partner testing. Other groups of PITC with yield >1% are: sexual partners of PLHIV (13%), TB patients (2%), AIDS-indicator symptoms (1.8%), STI symptoms (1%).  **Testing positivity rate, depending on group and treatment modality, 2016 compared to 2019**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Key populations | 2016 | | | 2019 | | | | |  | **# tests** | **HIV+** | **%** | **# tests** | **HIV+** | **%** | | Testing in KPs (community and PITC) | **4,061** | **86** | **2.1%** | **20,235** | **98** | **2.8%** | | PITC, groups yield >1% | **19,635** | **389** | **2.0%** | **21,504** | **491** | **2.3%** | | PITC, other groups yield <1% | **27,732** | **140** | **0.5%** | **54,784** | **179** | **0.3%** | | Blood donors and recipients, pregnant women | **198,351** | **188** | **0.7%** | **152,631** | **133** | **0.5%** |   Source: National Coordination Unit, National Program on Prevention and Control of HIV/AIDS and STI data  **90% of PLHIV are on ART - HIV diagnosis and linkage to care**: The number of PLHIV both diagnosed and linked to care has been increasing in past few years. During 2019 alone, 922 PLHIV learned their HIV status and 1,074 people started ART. Despite implementation of the new testing strategy, late diagnosis is still unchanged at 29% have low CD4 < 200 at time of diagnosis. Data from NCU-NAP (2019) indicates that late diagnosis is associated with certain demographic characteristics: higher among men (33%) compared to women (25%) in 2019 and this trend is stable over time. Among those diagnosed with CD4<200, the age group 25-39 years has been decreasing, with 40.9% in 2019 compared with 48.4% in 2015. Similarly, the levels of late diagnosis among those who reported heterosexual transmission are also higher with 78%.  **Late presentation for HIV diagnosis: age breakdown of those with CD4 count<200 (2015-2019)**  Source: National Coordination Unit, National Program on Prevention and Control of HIV/AIDS and STI data  **ART provision**: “test and treat” approach led to no waiting time for treatment enrolment, all newly diagnosed are put on treatment. Treatment services are covered by national program regardless of health insurance status for all diagnosed people. Currently there are 8 treatment sites in the country. New clinical protocols are in place since 2018 include DTG-based regimens as 1st line, with 250 patients enrolled in 2018 and 850 in 2019, and treatment regimen optimization reduced from 28 in 2016 to 17 in 2019. As a result, ART costs have significantly decreased. Differentiated approach allows multi-month scripting for stable adherent patients. During COVID-19 outbreak CSOs have home delivered ART to 798 patients who were not able to travel to pick up the ARV medicines from facility. However, the treatment coverage remains suboptimal, some reasons being high centralization of ART service, insufficient staff in existing ART centers, insufficient s funding for services not allowing quality service provision.  **90% of PLHIV are virally suppressed:** Treatment retention was 85% at 12 months, 81% at 24 months and 74% at 60 months, achieving current NAP targets set at 80% at 12 months, 75% at 24 months and 70% at 60 months at the end of 2019. Treatment monitoring includes Xpert viral load testing and toxicity monitoring. Key bottlenecks in improving treatment coverage is finding people lost to follow up and bringing them back into care. Most of this work is done by medical staff and there is no strategy allowing other PLWH to find those lost to follow up. Other barriers to improve adherence are centralization of ART, high workload for infectious disease specialists in ART sites, insufficient supportive services, and migration. The treatment continuity between prisons, health facilities and NGOs is still weak and fragmented. Lack of an operational electronic system decreases timely information exchange between all these actors.  **TB/HIV**: TB/HIV co-infection is part of general objective of current NAP 2016-2020. “By 2020, 80% of people living with HIV in need of treatment for opportunistic infections receive appropriate treatment and antiretroviral therapy” and includes specific indicator for TB. TB/HIV coinfection is part of the protocols and includes algorithm of patient care, drugs interaction, prophylactics of Isoniazid and co-trimoxazole. The clinical protocol also includes the indicators related to death of HIV patients due to TB and treatment of both infections. During 2016-2019, significant improvements were registered in screening PLHIV for TB (85% in 2019), starting TPT in 2017, and enrolling 90% of TB/HIV patients on ART. TB/HIV clinical audits and link to auditing national mortality data showed areas of improvement and removing bottlenecks. Employment of an ID specialist on staff at IFP and TB physician at SDMC improved clinical management. However, despite improvement, mortality due to TB is still high, TPT enrolment is low and earlier HIV case finding and linkage to care is needed to ensure sufficient time for appropriate TB/HIV interventions for next period.  **Trends in TB/HIV key indicators, 2015-2019**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | 2015 | 2016 | 2017 | 2018 | 2019 | | PLHIV screened for TB | 83% | 68% | 78% | 78% | 85% | | Number of PLHIV on TPT | 0 | 0 | 75 | 812 | 163 | | %PLHIV and TB who are on ART | 48.3% | 69.4% | 68.1% | 68.8% | 90% | | TB as cause of death in PLHIV due to | 54.3% | 52.9% | 54.2% | 40.6% | 35.7% |   Source: National Coordination Unit, National Program on Prevention and Control of HIV/AIDS and STI data  **Management of comorbidities: progress, Integrated approach to management of co-morbidities:** 3,000 PLHIV received Hepatitis C treatment. Main barriers include lack of: (1) capacity to refer between specialists, as the current referral mechanism is through primary physician primary care and disclosing HIV status is to primary care is still a large barrier and (2) lack on information exchange. Main barriers include lack of: (1) capacity to refer between specialists, as the current referral mechanism is through primary physician primary care and disclosing HIV status is to primary care is still a large barrier, (2) lack on information exchange, (3) lack of medical insurance, (4) lack of experience in the treatment of HCV in people with HIV in the country and reluctance of infection doctors, (5) lack of a clinical protocol for the treatment of HCV in people with HIV, (6) poor information of people with HIV and their fear of side effects.  **HIV laboratory network:** at the national level, SDMC’s lab centralizes the national capacity to conduct HIV testing, diagnosis, and follow-up for patients in ARV treatment, additionally, the SDMC lab performs PCR tests for the detection of the HLA B\*5701 Real-TM as a screening test for the prevention of abacavir hypersensitivity reactions. Currently, the lab received the tests for the detection of HIV Avidity (HIV recency). Six labs are able to conduct HIV diagnosis. For HIV VL testing and early infant diagnosis via PCR (Xpert HIV-1 Qual), the Republic of Moldova uses the Gene Xpert platforms, which are located in 6 sites (4 on the right bank (one in the penitentiary system) and 2 in the Left Bank). CD4 count machines are located in 5 sites, 3 machines on the Right Bank and 2 on the Left Bank and are used according to updated protocols. Moldova comprises a network of more than 300 laboratories primary health care setting and in all hospitals that are able to conduct HIV testing and. Additional labs in testing are located in blood transfusion (ECLIA).   The national clinical protocol sets standards for lab monitoring for HIV aligned to WHO 2016 guidelines.  External validation of immune assays, viral load and EID testing is done by German institution INSTAND. The SDMC lab has started EQA for HIV since 2019. Major gaps include lack of LIS connecting HIV confirmatory labs and HIV screening sites (reports are excel-based), lack of unique identifier does not allow counting people tested, only tests used, and lack of reference system to linkage to care.  **HIV M&E system:** The M&E unit of the National HIV/AIDS Program Coordination unit (hosted in the Hospital of Dermatology and Communicable Diseases (HDCD)) is responsible for the overall monitoring and evaluation of prevention, diagnosis, treatment of PLHA, care and support. It does not have specific budget and depends on the donor funding HIV routine and and sentinel surveillance responsibilities are with National Agency for Public Health who reports to joint WHO/ECDC database (the European Surveillance System -TESSy) is provided by the. Although relevant strategic information has been regularly provided to inform the decision‐making process in the national response to HIV and to international data collections, and over the years, this system passed through a series of reforms and modifications, but it is yet premature to state that the system is fully functional and satisfies all the key information needs. The HIV monitoring systems are different modules with no linkages between them that have been developed over time through a piecemeal approach:   * SIME-HIV – collects ARV treatment data, which is only partially updated and non-operational at present. Data is currently recorded in a parallel system - Excel databases updated by all institutions providing ARV treatment to PLHIV; * Database for clients of social support. * Voluntary counselling and testing (VCT) – used for registration of beneficiaries who received HIV testing and counselling (HTC) services; * HIV/Ident – for registration of beneficiaries of services provided in the sphere of care and support; * IDU/Ident and MSM&CSW/Ident - two separate information systems targeted at separate risk groups to capture services provided for key populations.   **HIV care and treatment Cascade**   |  |  | | --- | --- | | Major gaps and barriers | Key priorities | | * Transmission in MSM is highest, but low coverage. Optima shows SW 2nd group. * Innovative combination approaches at low scale * Reaching saturation in PWID coverage, due to changing drug scene to non-injectable drugs * Basic prevention service package unattractive, decreased options for outreach and navigation * OST: low uptake due to changing drug scene, compulsory medical registration and registration as a drug user, low level of psychosocial support for OST patients * Drugs use continues to lead to imprisonment | * Prioritize prevention among MSM, tailored services to TG needs) and SWs (tailoring to age groups and include MSWs) * Scale-up PrEP * Document risks of young KPs and users of recreational drugs, start small scale interventions; Innovative interventions for emerging KPs and PWUD * Improve quality of prevention service package: basic package, extended package, mobile clinics, more outreach * Remove barriers to extend on Right bank, introduce OST to Left Bank * Alternatives to imprisonment for PWID | | 1st 90   * High number of tests, low case finding in testing in KPs and PITC   2nd 90   * Late diagnosis and treatment enrolment Treatment coverage suboptimal: model of care still centralized, undefined service package for testing, care and treatment for health * Low capacity to find those lost to follow up in the past between HIV testing and treatment initiation * CSOs lack formalized case-management and client navigation roles.   3rd 90   * Suboptimal adherence * Treatment continuity between prisons, health facilities and NGOs is still weak and fragmented and poor information exchange | **1st 90**:   * Develop a quality approach to differentiated testing strategies for each key populations using a strategic mix of tailored strategies of PITC and CBT platforms, including index testing, network testing, lay provider testing. * Incentives to CSOs and primary care staff for case finding * Improve quality of HTS delivery and quality assurance.   **2nd 90**:   * Design differentiated service delivery model for HIV care and treatment in health systems and community settings, * Define and cost HIV service packages across conitnuum * Decentralize and differentiate service delivery models, * Decentralized ART prescription at infectious disease specialist level in 10 new ART sites, * Improve positive case tracking and re improving treatment coverage is finding people lost to follow up and bringing them back into care.   **3rd 90**:   * Improve strategy for ensuring treatment adherence and stronger psychosocial support * Improve continuity of care and linkages (cross referrals, case holding and case management) * Integrate services at district level (TB, HIV, Hepatitis, OST) * Improve quality of care * Operationalize HIV HMIS and EMR to ensure interoperability with other systems and timely information exchange between all these actors. |   **Health system context:**  The health care system of the Republic of Moldova is organized in line with the principles of universal health coverage universal access to basic health services and equity in accordance with the 1994 Constitution ensuring the right to health for all citizens as well as solidarity in financing of health care, either by the state subsidy or each person through compulsory health insurance,[[33]](#footnote-34) in line with National Healthcare Development Strategy the National Public Health Strategy 2014-2020,[[34]](#footnote-35) as well as the draft the National Development Strategy “Moldova 2030”.[[35]](#footnote-36)  **Service organization**: Moldova’s health system has significantly evolved from the model inherited from the Soviet Union, which in 1990s has become unaffordable and inefficient in during severe economic downturn faced by the country. The years 2000 have brought economy recovery, creating conditions for rebuilding the health system. There were notable improvements in the health system’s performance over the recent years and major structural included introduction of primary care based on family medicine in early 1997, nationwide mandatory national health insurance became operational in 2005, and investments in priority health programs, such as reproductive, mother and child and adolescent health, non-communicable diseases, TB, HIV and Hepatitis. Tuberculosis and HIV/AIDS are priority for public health as reflected in the National Public Health Strategy 2014-2020. One of the objectives is to reduce the burden of communicable diseases by reducing the risk factors and ensuring equitable access of population to primary, secondary, and tertiary prevention services; to improve the cross-sector collaboration mechanisms with clear definition of responsibilities among the health sector and other sectors in implementing the essential public health operations.  After almost three decades of ongoing transition from Semashko model of heath care, the health system is still struggling to overcome vertical, fragmented design. Out roughly 80 hospitals in the country, around 40 are in Chisinau, the capital city. Stakeholders acknowledge it perpetuates inefficient use of limited resources, fragmentation poor coordination and continuity of care and a medicalized approach. Purchasing mechanisms predominantly cover hospital services and underfund outpatient services. There is a curative focus and investments into procurement of equipment, medicines and technologies and health-facility based investments over more challenging transformation of processes, quality, coordination, integration and continuity of services. The public health reform was conceptualized and reorganization has taken place a number of times, and intent is to bring coordination of national programs under one umbrella, but process has been stalling. The very much needed transformation of service delivery to people centered models to and hospital modernization process is hampered by political instability (since 2015 there were seven ministers of health and four directors of National Health Insurance Company (NHIC) related to frequent change in governments).  **Health finance**: Moldova spends 12.9 percent of total public expenditures and at 5 percent of GDP on health (2018)[[36]](#footnote-37) being on higher end in the region. In absolute terms though total health expenditure is at PPP$ 514 per capita (2014), much lower compared to countries in the European Union, and twice less than neighboring Romania PPP$ 1079 per capita (2014)[[37]](#footnote-38),[[38]](#footnote-39) Some 15% of the population remains uninsured, and these are more likely to be rural residents working in agriculture and informal sector and labor migrants. NHIC provides access to an essential package of emergency, primary, and inpatient services without charge. However, out-of-pocket expenditures are the largest barrier to universal health coverage.[[39]](#footnote-40) Pharmaceutical expenditures being heavily reliant on patient out-of-pocket payments for outpatient medicines. The government spending for health has significantly increased over the past decade, yet it only accounts for less than half of total health expenditure. This limits the possibilities to cover all needs of both national TB and HIV programs from state and national health insurance budgets. The shortage is particularly acute in regard to the community involvement of NGOs in TB and HIV community-based efforts.  **Procurement and supply:** until this decade, GF was the only provider of ART and TB drugs in the country. Since 2011, all FLDs have been procured from the national budget by the MOLHSP and the Ministry of Justice for the civilian and penitentiary sectors, respectively. Since 2014, the government started purchasing SLDs, with 50% of SLDs currently purchased from domestic sources (the other 50% is purchased from GF budget). Similarly, Government procures ARV procurements 100% of 1st line ART needs and increasing proportion of 2nd line, ART, all consumables for HIV tests, CD4 and VL tests. From 2016 to 2018, UNDP procured medicines and other health products for treatment and diagnosis of diseases included in the national and special health programs, including HIV and TB medicines. Since 2019, procurement is managed by the MOLHSP Centre for Centralized Public Procurement in Health. The Centre must adhere to the national procurement law, which lacks effective regulations and continues to suffer from opaque tender processes.[[40]](#footnote-41) Deficiencies in legislation also impede procurement on international platforms, e.g., the Centre is not able to make advance payments and therefore cannot purchase directly from GDF. Despite these challenges, in 2019 the Centre procured around 60% of M-/XDR-TB medicines as well as most TB reagents for culture, Hain and Bactec – all products of good quality standards (WHO-prequalified or approved by an SRA, the EMA or FDA), with good remaining shelf life (>80%), in two annual deliveries, based on DDP INCO conditions (supplier is responsible and covers the costs until delivery to the NTP warehouse), and at competitive prices.[[41]](#footnote-42)  **Human resources**: Despite a high production rate of health workforce through both State Medical and Pharmaceutical University and Medical Colleges, new graduates prefer to leave the country for better employment prospects in neighboring Romania (with which Moldova shares the same language due to common history and a large proportion of Moldovan population have dual citizenship) or other EU countries. As a result, the health workforce experiences shortages in both primary care doctors and specialists and particularly of nurses, particularly outside urban areas and district centers, and ageing phenomenon, more than half of the workforce are over 50 years old or already retired. This significantly affects the options for decentralization of care and there are challenges with staff motivation and retention. In these circumstances a human resources strategy is needed and an external assessment provided a series of recommendations for TB human resource planning.[[42]](#footnote-43)  **Community systems:** As in other former Soviet Union countries, the health and social service delivery in Moldova were state-centered and community groups had little role to play. Starting early 1990s, community systems and community-based organizations have started to develop in Moldova, with international donor support, initially of Open Society Foundations, then of many more donors. In response to the outbreak of HIV epidemic, a large group of population started to be increasingly affected by drug use and HIV and NGO service organizations emerged. In years 2000, the Soros Foundation Moldova initiated harm reduction projects in communities and prisons with participation PWID as outreach workers and volunteers in providing peer-to-peer support, increasing coverage with services and providing non-medical care. With Global Fund support the prevention work expanded to NGOs active in other key populations, MSM and SWs. Currently, there are several organizations nationally representing the interests of most-at-risk populations and PLHIV: the Union for HIV/AIDS Prevention and Harm Reduction in Moldova (UORN) and Initiative group Puls represents interests of PWID, Gender-Doc represents interests of the LGBT community and several community-based organizations represent PLHIV constituency: National League of PLHIV, Positive Initiative.  For TB Initially one organization Carlux (now renamed as Act For Involvement AFI) was active in addressing TB in prisons in 2000s. More TB community organizations emerged starting with 2010 as service providers of community-based delivery and in advocacy and mobilization efforts starting with GF Round 9 TB grant and NFM 1. With Global Fund support, 10 NGOs have been engaged in community-based delivery for patient adherence and peer support. In 2013, the National Platform of Civil Society Organizations was created in order to strengthen joint efforts in the fight against tuberculosis in Moldova. 11 NGOs working in the field of tuberculosis control and prevention are part of this platform and have 3 voting seats in the CCM (1 representing the Platform, 2 representing TB affected people from both banks of Nistru). SMIT and Platform of NGOs active in TB represent the KAP and NGOs interests, with voting seats on the CCM. All communities are represented in Key Affected Populations Platform.  Community systems are critical to reaching most vulnerable as part of last mile efforts. The weaknesses of the community systems are: (1) lack of sustainable funding, as the majority of community organizations thus far have relied exclusively on international donor funding with earmarked funds for service activities for target groups; (2) organizational management, as given the narrow scope and short-term funding, the newly developed community based-organizations did not have enough resources to allocate to organizational strengthening; and (3) lack of sustainable contracting by the state.  For HIV, although NGOs are the main providers of HIV prevention in KAP, there is insufficient coordination with the public sector, and a lack of mechanism to contract out HIV prevention services to NGOs by the government that needs costing of services, certification and accreditation of NGOs. Despite the acknowledged role in service provision of NGOs in HIV prevention and HIV prevention projects for key populations run by NGOs financed by National Health Insurance Fund, Prophylaxis Fund starting 2018, the practice lacks predictability, the volume of resources is not aligned to commitments of the National Program for HIV/AIDS/STI control and Prophylaxis Program 2016-2020and the sustainability and transition (STC) plan which covers the same period. The first harm reduction projects financed from national resources represent an icebreaker and has recognized as a good practice by WHO in 2018[[43]](#footnote-44). The Covid social and economic impact may further weaken the financing efforts.  Several lessons learnt from HIV prevention experience have to be further taken into consideration: 1) need for continued policy dialogue with health and finance authorities to ensure the prioritization of HIV and TB services; 2) civil society involvement in health budget planning; 3) differentiated and diversified sources of financing, state budget; municipal resources etc.  Compared to HIV, there were fewer community strengthening interventions for TB NGOs. Although CSOs active in TB control have demonstrated their value in providing support services for TB patients, active case finding activities, current funding is fragmented and short-term, with a considerable risk of losing the capacity accumulated by NGOs over the years, as well as the relationship with the key populations. The results of the NGO activities have been quite impressive in terms of finding TB patients in certain groups, including key affected populations. Some progress has been made in funding the NGOs active in TB control by the state. National consultants, under the NTP guidance are at the last stage of developing service standards that would allow contracting the TB NGOs by the state.  **Human rights, gender and age-related barriers and inequities in access to services**  **TB**  Although, in Moldova health is recognized as a human right, human rights, stigma and gender barriers occur in the country. A comprehensive human rights, gender and legal assessment was not carried out yet to assess comprehensively the HRG related barriers, however several assessments conducted in country are reporting human rights, gender and age-related barriers and inequities in access to services:   1. **Stigma** **and discrimination** from family members and colleagues is still a real issue as reflect the findings of the KAP study (2017); 2. **Community stigma, including stigma from health-care workers and other support services** is revealed in the “Moldova tuberculosis evaluation” (2020), based on focus-group discussions; 3. **Confidentiality issues,** on behalf of health-care and social services providers, bear patients, especially in rural areas, from attending such facilities, thus limiting their access to treatment and support. 4. **Right to movement** it is not fully ensured for TB as patients have to receive treatment where they are registered for residence, which is not necessarily the place where they actually reside; 5. **Isolation of children from their parents/ care giver**s by transporting them to “recovery centers” because of the socioeconomic situation and/or TB infection at home; 6. **Isolation of mothers from their children** if the child is under TB treatment in stationary facility; 7. **Restrictive state policies and practices regarding sex work** delay addressing of health services from sex workers living with HIV and / or suffering from TB; 8. **Existing guarantees for job security** are often not respected in practice by employers, while the person with TB is on medical leave for the entire period of treatment;   TB Knowledge Attitudes and Behavior (KAP) study conducted in 2017[[44]](#footnote-45) surveyed general population and key populations, namely migrants, PLHIV, PWUD, homeless people and people in prisons showed much better knowledge about TB in KAPs, and 24% considered TB a stigmatized disease, 50% would avoid disclosing having TB. The KAP study (2017) showed that although the majority of people, including KP, know about TB as an infectious disease, its transmission and symptoms, misperceptions about the transmission exist and diagnosis of TB is associated with poverty, being of a risk group such as prisoners, homeless or PWUD. Perceptions of TB that the disease is shameful, and people having it would try to hide the diagnosis from others as well, will delay the addressing to health care in many of cases. More activities of awareness raising are needed to improve people knowledge about TB, as well the scale-up of video observed treatment, as a more people-centered approach for TB treatment which also ensure a higher level of confidentiality that daily visits to health facility. KP have often limited access to TB diagnosis, treatment and care services, those being ensured only through the CSOs and community representatives. Ensuring the sustainability of CSO interventions, including from the public budget, is vital to ensure continuity of access to services for key population groups.  **HIV**  Existing legal, administrative and criminalization of drug possession and sex work and HIV transmission continue to be barriers to accessing prevention and care programs which leads to late presentation and increased HIV mortality.   1. **Stigma** **and discrimination:** despite progress over year the years, it is still high. HIV Stigma Index (2018), revealed that four out of ten PLWH experienced discriminatory treatments in the previous 12 months; four out of ten people said that their status was disclosed to the third parties, most often it happened in the health system, family or close community. Almost all respondents self-stigmatized, experiencing feelings of shame, and underestimation, 6.6% recognized suicidal tendencies[[45]](#footnote-46). Discrimination of PLHIV manifests in health settings in poor attitudes, status disclosure to third parties, refusing medical services. 2. **High levels of intolerance towards KPs.** Social Cohesion and Reconciliation (SCORE) 2018 measured social tolerance of general population towards people left behind, including people living with HIV, sex workers, people who use drugs and LGBTQI community. The study reveals that approximately 88% would not accept living in the same community with SW, PWUD, LGBTQI, while about 66% - PLHIV, pointing to a discriminatory and homophobic society, which influences negatively access the health services[[46]](#footnote-47). Human rights perception study 2018, guided by UNDP&OHCHR on human rights revealed that right to health is not fully fulfilled and PLHIV and LGBT communities remain the most stigmatized and left behind people.[[47]](#footnote-48) 3. **Gender–related barriers**: an assessment on women LWH economic, human rights, SRH needs revealed many barriers for the women LWH to be empowered and to realize fully their fundamental rights. Report on Costing Domestic Violence and Violence Against Women in Moldova[[48]](#footnote-49) recommendations informed advocacy for a new comprehensive strategic document on fighting violence against women and domestic violence in Moldova approved by Government in 2018. Moldova has a National Strategy on prevention and combating violence against women and domestic violence for 2018-2023 and national efforts to make tangible progress in reducing violence against women and children is ongoing with multiple donor support. Donors support a number of efforts to address gender inequality, and human rights violations towards women, girls and transgender, i.e. gender academy. 4. **Human rights:** HIV Legal Environment Assessment (LEA) developed under UN leadership provided over 70 recommendations for potential legislative changes and will serve as guidance for national authorities in undertaking sector-wide reforms, compliant with international standards and best practices. LEA informs about HIV transmission, sex work and use of drugs criminalization, as well as legal aspect related to confidentiality, and norms that would impede the full range of health, education, work rights. (Annex 17) 5. **Criminalization of drug possession**: While drug use per se was decriminalized, drug possession irrespective of amount of drugs is subject to criminal law. |

b) Summarize the **approach used for the prioritization** of modules and interventions (or in the case of Payment for Results, the performance indicators and/or milestones).

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| **Country dialogue**: the country dialogue started following receipt of the Allocation Letter on December 16, 2019 and the Portfolio Analysis communicating the funding envelope and requesting a joint TB/HIV funding request. On January 24, 2020 the CCM set the timeline for submission for Window 2 and decided to initiate the funding request development after the TB and HIV national working groups develop the first drafts of TB National Programs and HIV National Program for the years 2021-2025, using the opportunity to fully align the funding request to the national programs. The country dialogue coincided in time with the onset of COVID-19 epidemic in the country and the national emergency response to it. The 1st case of COVID-19 was registered on March 7th and the national lockdown was instituted since March 15, 2020 and partial movement restrictions in force until the submission. Despite COVID-19 related challenges, Moldova has ensured an all-inclusive approach to development of both the TB and HIV NSPs and the funding request, through wide remote consultations with key populations and communities affected by the epidemics, civil society actors, national authorities and public agencies.  **Prioritization process:** the funding priorities included in the funding request are by design and process fully aligned to the ambitions and interventions included in both the National HIV Program and National TB Program for the years 2021-2025. The prioritization process was shaped by GF strategic directions provided in the Allocation Letter and the Portfolio Analysis and GF technical briefs and guidance. The strategic choice of interventions is fully aligned to key recommendations made by Optima HIV Resource Optimization to Maximize HIV response in Moldova[[49]](#footnote-50) and Optima TB: Optimizing investments in Moldova’s tuberculosis response[[50]](#footnote-51), as well as the findings and recommendations of Focused Country Evaluations: Moldova HIV Evaluation and TB Moldova Evaluation conducted in February 2020. (Annexes 4,5,6,7) The national technical working groups have also made self-assessments and reviewed evidence and independent evaluations, as well as a range of technical reports (Annexes 11, GAM, Annex 12 GDF).  Based on the first stage, the national working groups used the following approach to critically assess the status of the national response and make decisions about national program priorities:   |  |  | | --- | --- | | Strategic dimensions | Key principles | | Reaching targets | Where are we now in long-term response to end the epidemic | | Continued scale-up and improved operations | What we are doing well and what needs to continue | | Lessons learned inform new directions | What we are not doing well and should be doing differently | | Improve quality and efficiency | What new approaches and innovations we should adopt to ensure quality while streamlining and optimizing |   After the full expression of demand was included in the work plan and budget of each of the TB and HIV National Strategic Programs, the national NSP development teams have used a negotiation process to decide on the final list of activities included within allocation. For those activities that were not included within the allocation, the technical working group for funding request development has applied a consistent approach by reviewing each proposed activity through the following criteria to decide the priority for GF funding request PAAR.   |  |  |  | | --- | --- | --- | | # | Criteria | Value | | 1 | **Potential for Impact** | High/medium/low | | 2 | **Sustaining the gains**: essential or add-on approach? | Essential/Add-on | | 3 | **Innovation:** new solution to a recurrent issue | Yes/No | | 4 | **Aiming to remove bottlenecks**: improves process, quality/removes barriers? | Yes/No | | 5 | **Potential for sustainability:** shift from health system support to resilient and sustainable system? | Yes/no |   For TB, funding priorities are aligned to STP’s Investment package for EECA setting[[51]](#footnote-52), all interventions are prioritized in the funding request (1) maintain universal coverage with RMD as first test for DS and DR TB at all levels of care: (2) Increase coverage of rapid culture and DST testing in referral labs; (3) Universal access to quality DR TB with special emphasis on children and adolescents; (4) Ensure appropriate support including the use of digital tools; (5) Strengthen monitoring of people on treatment and management of comorbidities, adverse events and pharmacovigilance; (6) Upgrade TB information system; (7) Ensure effective TB control; (8) Effective and efficient health finance and allocation to people-centered TB delivery; (9)Address special needs of populations with an emphasis on prisoners and migrants; (10) Scale up coverage and quality of contact investigation, with a focus on close contracts, TPT.  For HIV, funding priorities are aligned with the need to improve the cascade of care and reach the 90-90-90 by using a strategic mix of testing, improving the cascade per se and removing the bottlenecks, prioritize MSM and SWs in prevention activities, revamp combination prevention approaches and improve quality of KP prevention service package, scaling up PrEP.  Overall the funding request includes a number of RSSH and CSS interventions to strengthen more sustainable mechanisms for public finance of HIV and TB services in the context of decentralization and integration, in order to accelerate adoption of people-centered approaches and to ensure access to quality and affordable commodities as Moldova increasingly takes over these costs and uses national procurement mechanisms.   |  |  |  | | --- | --- | --- | | **Component 1: TB** | **EUR** | **% of Total** | | TB care and prevention |  |  | | MDR-TB |  |  | | **Component 2: HIV** |  |  | | Prevention |  |  | | Differentiated HIV Testing Services |  |  | | PMTCT |  |  | | Treatment, care and support |  |  | | Program management |  |  | | **Component 3: RSSH** |  |  | | RSSH: Health sector governance and planning |  |  | | RSSH: Integrated service delivery and quality improvement |  |  | | RSSH: Human resources for health, including community health workers |  |  | | RSSH: Health management information systems and M&E |  |  | | RSSH: Laboratory systems |  |  | | RSSH: Health products management systems |  |  | | **Component 4: CSS and HRG** |  |  | | RSSH: Community systems strengthening |  |  | | Reducing human rights-related barriers to HIV/TB services |  |  | | **Component 5: Program management** |  |  | | Grant Management |  |  |   The following tables summarize the alignment of prioritized interventions and activities structured by Modular Framework to WHO the End TB Strategy and UNAIDS Fast-Track Ending the AIDS epidemic by 2030 key priorities. |

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| End TB Pillars and Components | Modules and Interventions | Activities |
| 1 Integrated People Centered Care and Prevention | | |
| Early Diagnosis including universal DST and screening of contacts and high risk groups | **MDR-TB: Key Populations other**  **MDR-TB: Detection and diagnosis** | Active case finding in key populations (homeless PLHIV, PWID, hard to-reach), mobile X-ray with AI.  Rapid molecular testing. Phenotypic and genotyping testing maintenance of Xpert and other equipment  Procurement of Xpert for XDR 4 RRLs.  *PAAR:*  *Procurement of genomic sequencer* |
| Treatment of all people with TB including patient support | **MDR-TB: Treatment**  **MDR TB: Key populations Prisoners**  **MDR TB: Key populations Migrants**  **MDR TB:**  **Collaborative activities with other programs and sectors** | Provision of all-oral DR-TB treatment regimens (including pediatric)  Adherence support (multidisciplinary approach and case-management, peer-to-peer),  VOT nationwide scale-up. Community-based DOT  Ensuring treatment adherence and pre and post-release case-management  Develop standard operating procedure for TB case-management for those requesting political asylum and trans-border transfer  *PAAR: Reintegration and rehabilitation of TB patients with CSO support* |
| Collaborative TB/HIV and co-morbidities | **RSSH - Integrated service delivery and quality improvement** | Integrated platform for managing co-morbidities of TB/HIV, Hepatitis OST;  Collaborative to improve TB with co-infections: TB/HIV, mental disease, diabetes, including key populations |
| Preventive treatment of persons at high risk | **TB care and prevention-prevention**  **TB care and prevention - community care delivery** | Develop TPT guide in line with new normative guidance; LTBI testing using IGRA.  Advocacy, communication and social mobilization activities (national and community level), informational materials for key populations. |
| 2 Bold Policies and Supportive Systems | | |
| A Political commitment with adequate resources | **RSSH - Health sector governance and planning** | Hospital optimization and strengthened outpatient care  Costed TB service package and contracting mechanisms: PHC, specialist, hospital, CSO.  Actual health expenditure reporting for TB |
| B. Engagement of communities CSOs and public providers | **RSSH: CSS / Social mobilization, building community linkage and coordination**  **RSSH: CSS / Community-based monitoring**  **Reducing human rights-related barriers to HIV/TB services:**  **RSSH: CSS / Institutional capacity building, planning and leadership development**  **RSSH: CSS /** **Community-led advocacy and research** | Develop and implement social contracting mechanisms for TB supportive services active case finding and case-management  Document structural and access barriers to TB (gender, human rights, financial, stigma); involve NGOs in removing barriers and increase access and linkage to care for key populations; human rights literacy; community-based monitoring for TB; community and CSO audit  TB stigma index, legal aid, paralegal network, legal aid and strategic litigation  *PAAR: organization capacity, leadership and sustainability, strategic planning, fund raising*  *PAAR: Sociological analysis - NGOs involvement in TB response* |
| C Universal Health coverage policy and regulatory frameworks | **RSSH - Health sector governance and planning**  **RSSH - Integrated service delivery and quality improvement**:  **RSSH - Health Management Information Systems and M&E:**  **RSSH: Human resources for health, including community health workers**:  **RSSH: Health products management systems:**  **RSSH - Laboratory systems** | MAF: multi-sectorial coordination mechanism for TB  Response at national level; collaborative partnerships at community level; develop integrated service delivery regulation  Redesign electronic informational system SIME TB (add lab and CF modules, ensure interoperability),  Ensure core M&E visits with CSO engagement  Human resource planning (needs-based medium term), capacity building national TB program unit staff, integration in-service training into continuous medical education using digital platforms, integrating in-service training of non-medical staff on digital platforms.  Ensuring access to medicines for preventing adverse reactions during TB treatment, pharmacovigilance,  TB lab strengthening (quality management, external quality assessment, biosecurity standards) |
| D social protection and action on determinants |  | (*UHC and incentives fully covered through public funding)*  *Ensuring collaborative, CSO, LPG and Social Service etc.* |
| 3 Intensified research and innovation | | |
| Discovery development and rapid uptake of tools | **RSSH - Health Management Information Systems and M&E** | AI X-ray operational research |
| Research to optimize implementation and impact | **RSSH - Health Management Information Systems and M&E** | Catastrophic TB costs survey, KAP TB, TB/HIV clinical audit |

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| Fast-Track Targets | Modules and Interventions | Activities |
| 1 Prevent new cases of HIV | | |
| Scale up prevention in KPs | MSM / Behavior change interventions  Transgender people / Behavior change interventions  PWID and their partners: Needle and syringe programs drug dependence treatment  Sex workers and their clients/ Behavior change interventions  People in prisons and other closed settings / Behavior change interventions | Basic prevention package for MSM  *PAAR Extended package MSM*  *PAAR: attractive services new beneficiaries*  Project in TG  Basic prevention package for PWID  OD Naloxone (Left Bank)  OST scale-up (penitentiary, Left Bank)  Gender-sensitive package PWID  *PAAR Extended package PWID*  Basic prevention package for SWs  *PAAR Extended package* SWs  *PAAR: attractive services new beneficiaries*  NSP prisons  Basic prevention package for prisons  Training for staff in prisons |
| Scale up combination prevention in all KPs- PrEP and innovative approaches | MSM/Behavior change interventions PrEP  Other populations  Interventions for young key populations  Addressing stigma, discrimination and violence | PrEP scale up  Incentives for friendly physicians  Mobile clinics  Advocacy for safe injection - 1 project  Developing regulatory basis for PrEP in health facility  Costing of PrEP service  Informational campaigns PrEP  Staff training  *PAAR: Young KPs non-injecting PWUD package*  *PAAR: Sets for personal protection against infection with HIV for General Police Inspectorate staff* |
| Eliminate MTCT transmission | PMTCT / Preventing vertical HIV transmission Prong 4 | Xpert cartridges for EID |
| 2 90-90-90 | | |
| 1st 90 find the positives | Differentiated HIV Testing Services: MSM TG, SWs, PWID, Prisons / Community-based testing / Self-testing / Facility based testing | Procurement of RDTs for differentiated testing: index, PITC, network-based, KP-led  Self-testing in general population  Incentives for CSOs and PHC for each detected case  Assessment and revision of National Testing Guide |
| Improve the cascade Reduce leakage  2nd 90 sustainable systems for early treatment initiation | Treatment, care and support/ all people living with HIV: Differentiated ART service delivery and HIV care | TA to develop differentiated model and regulations  Develop and cost packages of services across continuum for all levels of health care  Support to ART decentralization: coordination, equipping, training, MDT approach  *PAAR: Improve quality of services, clinical audit of ART, develop standards*  Linkage to care: regulation on referral for a co-infected HIV, syphilis, Hepatitis services |
| 3rd 90 improve treatment retention and viral suppression | Treatment, care and support: Counseling and psycho-social support  Treatment, care and support: Treatment monitoring  Prevention and management of co-infections and co-morbidities | Psychosocial support package  Re-profiling Social Centers in medical and social centers (renovation, change in status)  Procurement additional diagnostic equipment, CD4 machine, tests for CD4, follow up tests  Cardio-vascular screening tool  *PAAR: drug resistance subtypes*  LAM determination  Tests for the determination of Cryptococcal Ag  HLA\*B 5701 determination  *PAAR: PCR tests STIs* |
| 3 Zero Discrimination | | |
| Reduce stigma | Reducing human rights-related barriers to HIV services | Information campaign for different audiences, printed IEC  Modular program on overcoming self-stigma |
| Remove barriers human rights and gender barriers | Reducing human rights-related barriers to HIV services | Remove legal barriers (70 recommendations from LEA)  Discrimination data collection via Soft RID  Paralegals and PromoLex training |
| 4. Enabling environment | | |
| Increase health system capacity to sustain the response | **RSSH: Health sector:** governance and planning  **RSSH: Integrated service delivery and quality improvement**: service organization and facility management  **RSSH: HMIS and M&E** Routine reporting  **RSSH: HMIS and M&E**: Surveys  **RSSH: HMIS and M&E**: Analysis, evaluations, reviews and transparency  **RSSH Lab** Quality management systems and accreditation  **RSSH Lab** Quality  Infrastructure and equipment management systems  **RSSH: Laboratory systems**: Information systems and integrated specimen transport networks    **RSSH: Human resources for health** policy and governance  RSSH: **Human resources for health** in-service training  **Health products management systems:** Regulatory/quality assurance support | Develop vision for new governance and coordination structure for national programs HIV, TB, Hepatitis +all the rest (NCDs, MCH etc)  Support to new governance structure by 2023  Integration concept for services at all levels HIV/TB/STIs/Hep/OST (regulations, model of integrated services at specialist level, integrated in CSOs platforms  MDT capacity building  EMCT elimination TA for external assessment, reporting mechanism for HIV+ pregnant  EMTCT capacity building family doctors and maternity staff and PMTCT protocol revision  SIME HIV design, interoperability and implementation  HIV core M&E: salaries, visits  CCM website – repository and dissemination  HIV Surveillance: capacity building on case-based surveillance and patient monitoring; annual training;  *PAAR: Core M&E assessment and functional redesign, M&E training, lobby for takeover of M&E staff costs*  *PAAR: HIV Surveillance: update of HIV surveillance regulations, printing*  Size estimation on number of people who use non-injecting drugs  *PAAR: Survey in migrants and mobile populations*  *PAAR: Youth KAP*  Assess the capacity of HIV/STI/HIV testing in Moldova  Analysis of genotypes and resistance (collaboration with Romania)  Recency incidence operational research  HIV mortality audit  Audit of psychosocial support services  Operational research to document service integration process, effectiveness, outcomes.  Analysis of cascade leakages to improve cascade strengthening  Operational research to assess surveillance with participation of National Surveillance System and NAPH in HIV response and control  *PAAR*: *Mid-term HIV NSP review*  *PAAR*: *Development and publication of annual HIV epi report*  *PAAR*: *Preparing epi data to Euro WHO and ECDC*  Implementation and maintaining QMS ISO 15189 in National Reference lab  EQA participation  Periodic auditing of Testing Center (QA)  Develop and implement national QC program for NRL and RRL and Testing Centers for HIV/STI  Establish and strengthen National HIV/STI Lab  *PAAR*: *Renovation and equipping NRL*  Establish and strengthen Regional Reference HIV/STI Labs  Lab equipment maintenance (NRL and RRLs)  LIS implementation and maintenance NRL level  LIS HIV testing Centers level  Develop and revise regulations for HR planning and retention  Develop and update job description and requirements for CSOs  Integrate non-medical CSO positions in roster professions  Integrate curriculums into CME  *PAAR: digital learning platform*  Local and international trainings for NRL and RRL staff  Training for staff included in HIV service provision  Pharmacovigilance: training on active reporting side effects  *PAAR: Improve PV regulation for HIV*  *PAAR: Regulations on ARV registration (WHO Collaborative Registration Procedure)* |
| Increase community system capacity to sustain the response | **CSS:** Social mobilization, building community linkage and coordination  **CSS:** Community-based monitoring / Community-led advocacy and research | Improve institution and organizational potential for CSOs working with KPs (including KAP platform)  Support to public leadership (Memorial Days)  Engagement working groups, committees  Monitoring takeover by country  Budget advocacy  Capacity building for communities to implement national program  TA to HIV service orgs  Communication and visibility |

1. **one table for each disease component, TB, HIV, RSSH, CSS/HRG**.

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| Component | **Tuberculosis: increase early TB detection, diagnose and successfully treat people with DR-TB, including children and prevent new transmission** |
| Module/interventions | The National TB Program 2021-2025 goal is to reduce TB Burden, reduce mortality by 75% and incidence by 50% and reduce catastrophic costs of patients with TB. It sets ambitious targets:  (1) ensure 90% of contacts and key populations screened for TB,  (2) early TB diagnosis 90% of estimated cases,  (3) ensure treatment success for 90% of DS TB and 80% of DR TB, including children, based on a people-centered model of care;  (4) universal coverage to manage co-morbidities, case management, collaboration with HIV, Hepatitis, Drug, Alcohol, Diabetes, Mental Health national programs, penitentiary sector and civil society  (5) reduce TB infection through prevention measure and >95% immunization rate in newborns;  (6) adopt policies to reduce TB burden, reducing social determinants, service costing and improving payment mechanisms, with involvement of CSOs and key affected populations;  (7) accelerate response through adoption of innovations and improved data for decision making  The funding request prioritized Integrated People Centered Care and Prevention Pillar related activities as part of three objectives in TB component, while Pillar 2 Bold Policies and Supportive Systems and Intensified Research and Innovation are included in the RSSH and HRG component. The main focus of TB component is further strengthening screening of high-risk groups, accelerate progress in provision of people-centered health services, continue to scale-up the use of new regimens with particular focus on efforts in Transnistria. It aligns to the recommendations of TB Evaluation Report to strengthen active case finding for key populations, reduce hospitalization and improve outpatient treatment provision, provide NGOs more stable financing, develop new electronic HMIS using a modular approach, conduct a costing TB exercise and consider procurement through GDF or Wambo (Annex 7).  **Universal access to timely and quality TB detection and diagnosis of TB**  The funding request will support the key objective of universal and timely access to and targeted case finding to achieve the ambitious target of reaching >90%TB and DR-TB cases. Compared to current allocation, this component prioritizes particular focus on: (a) TB screening and intensified case finding including outreach and community-based approaches and (b) Rapid and more sensitive diagnostics, with innovative technologies. Interventions will scale up active TB case finding among key population groups and those hard to reach by primary care case finding efforts, will maintain high coverage of rapid molecular diagnostics at the peripheral services delivery level and effective and efficient specimen transportation system; ensure high quality of implementation of WHO-recommended diagnostics at the reference laboratories. Activities have appropriate focus on KPs.  **TB screening and active case finding in key populations** (homeless, people in detention, PLHIV, PWID and other subpopulations that are hard-to-reach for primary care) through civil society engagement. Several NGOs received funding for ACF in KP such as homeless and prisoners. Data analysis shows that TB patients diagnosed through contact investigation (done by primary care providers) was responsible for 8-9% of all TB notifications in the years 2016-2018; and prisoners, homeless and PWUD combined for 4-5% of TB notifications in the same period. Further scale-up of screening in key populations via CSO is essential in closing the gaps in early detection. This will be a CSO-provided activity to ensure outreach and client navigation. Expected coverage is: 20,000 PWID, 11,800 homeless, 2,000 Roma, 7,000 migrants and 1,000 people with disabilities.  **Mobile X-ray using artificial intelligence (AI) technology:** the current 7 mobile units servicing both Right and Left banks and the prison sector will be connected to AI, as well as staff capacity building and developing needed regulation to implement AI in Moldova. A current bottleneck a time lag needed to process X-ray results: X-Ray images need to be downloaded and interpreted, delivering results back can take two weeks. AI technology will increase throughput and timeliness of results. The costs of mobile van operations (staff and operations) are fully covered by the national resources.  **Maintain universal access to rapid molecular testing.** Moldova has achieved universal access to rapid molecular testing using Xpert technology. The funding request includes support for 100% of needs of Xpert for Left Bank and 55-50-45% needs for the Right Bank in Xpert cartridges (standard and Ultra), including warranties, calibration cartridges, ensure maintenance, Xpert replacement of modules and coverage of other necessary servicing and maintenance costs. Given the existing comorbidity profile as well as current COVID-19 crisis, special focus will be made on multi-disease integrated GeneXpert platforms, namely, TB/HIV/HCV/COVID-19 integration will be planned based on the need and GeneXpert utilization data.  **Ensure access to phenotypic DST 1st line and 2nd line**. Rapid and full DST to SLDs including that for new drugs is key to scale-up new treatment regimens for DR-TB including modified all-oral shorter regimens, directly impacting potential for treatment success. New types of DST testing to fluoroquinolones require more tests needed beyond financial means of the NTP. The funding request includes support for 100% of needs for Left Bank and at 80-60-50% of needs for the Right Bank in DST testing needs. Specimen transportation system has been well organized and improves effective at timely sample processing. The funding request include gasoline costs and car maintenance for 90-50-20% and drivers for 100%.  **Procurement of Xpert for fluoroquinolone resistance** (assay for fluoroquinolones and isoniazid resistance): 4 machines of Xpert assay for fluoroquinolones, second-line injectables and isoniazid resistance technology (under premarketing stage) will be introduced NRLs to immediately expand rapid testing for all TB-positive Rif-resistant samples. Validation of the latter novel cartridge by WHO is expected later in 2020). Moldova is one of the three sites who have been included in research of the assay. The NRL has been implementing the Xpert MTB/XDR assay (Cepheid, USA, FIND project). The preliminary results from diagnostic accuracy study for detecting resistance to INH, ETH, FQs, and second-line injectables suggests that Xpert MTB/XDR is highly accurate for detecting resistance in relevant clinical settings. It is a significant advantage that the country already has the experience of the new Xpert MTB/XDR system proposed by Cepheid, which will be put to the best use in the future. Expected coverage: 5,535 per year.  ***PAAR: Introduce innovative whole genome sequencing (WGS) technology in Moldova****:* ***procurement of genomic sequencer***: *while innovations such as shorter drug regimens, better treatment MDR TB and vaccines help progressing towards ending TB, these alone are not enough. Recent RCTs and community wide case finding showed disappointing results of untargeted interventions. Similarly, while Xpert technology increases people-centered approaches, it will not have an impact on TB control, particularly in high-incidence MDR sites. A spatial analyses study conducted on 2007-2010 data in Moldova revealed striking geographic heterogeneity of MDR-TB.[[52]](#footnote-53) Methods to identify locations of high MDR-TB risk and burden should allow for better resource allocation and more appropriate targeting of studies to understand local mechanisms driving resistance.**Moreover, Moldova was involved in small molecular epidemiological study using WGS which found that ~50% of initially drug-susceptible TB patients who developed MDR-TB while in the hospital had a new strain at follow-up[[53]](#footnote-54). This suggests that either re-infection is occurring during treatment (potentially nosocomial transmission during the 2-month hospitalization period) and/or patients are infected with multiple strains at baseline.*  *C:\Users\SB\Dropbox\Screenshots\Screenshot 2019-10-27 14.29.44.png***Figure: Spatial heterogeneity of MRT TB transmission in Moldova**[[54]](#footnote-55)  *Genomic sequencing for TB has become routine for high-income countries and is increasingly becoming an affordable technology after one-time investment and highly relevant to determine strains and adjust targeted and optimized treatment based on transmission chains. The national TB lab infrastructure in Moldova is well developed with high quality standards in the National Reference lab and quality assurance of tests. The sophisticated NRL TB lab capacity in Moldova can allow use to fully characterize the role of acquired and transmitted resistance with detailed hotspot mapping and combination with special analysis for better targeting of case finding interventions.*  **Improve treatment outcomes of DR-TB patients**  As highlighted in gap analysis, DR treatment outcomes are suboptimal and people-centered efforts put into to improving the outcomes start showing improvements, i.e. TB treatment success rate is 76% in the 2017 cohort of new DR TB cases. To further improve interventions, the funding request includes a multifaceted strategy building on current lessons learned:  (1) focus on uptake on new treatment regimens, with specific focus on pediatric TB;  (2) strengthen patient support systems;  (3) diversify treatment administration options  (4) address specific areas for continuity of care for people in prisons and migrants. Social determinants and further adaptation  The funding request will support the key objective of universal and timely access to and targeted case finding to achieve the ambitious target of reaching >90%TB and DR-TB cases. Of note is that interventions related to health system elements of institutionalizing the people-centered of care is included in RSSH component.  **Provision of all oral MDR TB treatment regimens (including pediatric) with gradual takeover:** The country starts full rollout of short and all oral treatment regimens from June 2020, having all necessary medicines. The new TB national clinical protocol developed in May 2020 is aligned to latest WHO guidance and the country will participate in Operational Research (OR) which includes administration of “Short, all-Oral Regimens for Rifampicin-resistant Tuberculosis”. The main activities included for support by TGF grant include support to OR team, patient incentives, lab tests (HVB, HVC, TSH) and supplies.  The funding request includes support for 100% of needs of pediatric regimens, 100% adults for Left Bank and 45-35-25% needs for the Right Bank in DST testing needs. The Government of Moldova and de facto authorities in Transnistria will cover 100% on DS-TB drug procurement and other operational costs of treatment including staff and facility costs.  **Nationwide scale-up of digital adherence**. Currently, with support from STP TB REACH Wave 6 grant, Moldova is in the process of expanding treatment administration via digital adherence technology I-LIKE-VOT app. The app combines feature of VOT (including adverse reaction reporting) and One Impact technologies, (community based monitoring. Given Covid mobility restrictions and health system overload, the country expanded the enrolment in VOT in Chisinau, and is in the process to enroll in more sites, including Balti, Transnistria and districts. The funding request will support expansion of I-LIKE-VOT at national level and its routine offering to ensure acceleration of outpatient decentralized model. The funding request includes equipment and operational costs, informational materials to ensure full implementation.  **Case-management and adherence support through multidisciplinary approach**: The current and previous grants have provided support to a multidisciplinary approach to providing non-medical support to patients on ambulatory TB case. Staff at the TB Treatment Support Center at district level is an addition to pneumo-phtisiology department and include a coordinator, a psychologist, a social worker and a DOT worker. A case management approach is used to ensure patients stay on treatment and their non-medical needs are addressed. Such approach demonstrated success, in 2018 and 2019 prevented 16% of patients being lost-to-follow-up; 13% on the right bank and 26% in Transnistria. The sustainability and transition plan includes full takeover of this model for the Right Bank by end of 2020. At the end of December 2019, the Ministry of Health integrated these positions in TB pneumo-phtisiology service on the Right Bank. However, no additional funding was allocated in 2020 to support staff. It is expected that as a result of TB service costing exercise currently ongoing in 2020, the TB service will be able to receive additional funding to cover these positions starting with 2021. There is no takeover plan in Transnistria. Therefore, the funding request include 100% support to current centers in Transnistria and operational support to ensure supervision, capacity building activities for Right Bank.  **Peer-to-peer support and CSO-led adherence support (small grants):** this is CSO-led support. It will place special emphasis on supporting patients from vulnerable groups and communities during ambulatory TB and DR-TB treatment. This will be addressed through intensified psychological support, involving families and community actors, information / education, following up on referrals and mitigating the risks of defaulting, peer-to-peer counseling of patients at the time of treatment initiation and throughout treatment, home visits and individual and group counseling. The activities will include information and education work through peer support, motivating the beneficiaries to stay on treatment, psychological support and facilitating links between TB and HIV services, and addressing legal barriers to care and discrimination. As part of funding request CSOs will provide such support to 10-15-20% of patients with DS-TB and 10-15-20% of MDR-TB patients.  **Adherence support and case management for prisoners:** a small grant will ensure all necessary accompaniment to provide supportive services, case-management and prerelease work to 100% of people in detention who have TB. Expected coverage 550 in the years.  **Continuity of care for migrants:** activities related to migrants’ contribution will receive IOM support from International Organization for Migration. The funding request includes technical assistance develop standard operating procedure for TB case-management for those requesting political asylum and trans-border transfer  **Reduce TB transmission**  **Scale-up TPT:** the intervention will support scale-up of new approaches to TPT and targets scale-up of TPT in children and adult contacts, PLHIV. Shorter, Rifapentine-containing preventive treatment regimens (3-month regimen) of needs covered from th e GF 80%-40%-60%, of all preventive treatments will be introduced. Based on accumulated experience, national procurements of Rifapentine will gradually pick up the cost. The funding request include support to co-developing a TPT guide in line with new normative guidance and scale up; LTBI testing using IGRA for 1,000 people per year and gradual take over through national procurement.  **TB care and prevention - community care delivery: as part of primary prevention efforts and community mobilization, the funding request will provide support** the project will support a number of activities aimed at increasing knowledge and awareness of TB patients, their families and communities regarding TB disease and the need to support the patients to complete treatment. At the same time, activities will target decision makers at different levels for ensuing appropriate response to the epidemic. The key approach to ACSM activities is to promote supporting attitudes to TB patients, which will facilitate provision of patient-centered care with participation, along with medical professionals, of other public service and non-state actors at community level. public TB communication and social mobilization campaigns, informational materials.) will be developed and distributed among target audiences. The project will also support production and broadcasting of TV and radio spots on local and national stations. |
| Priority populations | * Key populations: homeless people, prisoners and ex-prisoners, PLHIV, PWID people who are outside reach of primary care * People with presumptive TB and active TB, patients with drug-resistant TB and their families; * Children with presumptive TB and active TB, patients with drug-resistant TB and their families. |
| Barriers and inequities | * Active TB case finding activities among will address the key barriers to and inequities in accessing essential TB services faced by key populations, due to stigma and discrimination by health care staff and other providers and lack of motivation to seek and complete screening and diagnosis * Ensuring universal access to Xpert technology at the peripheral TB service delivery level will allow to eliminate the key barrier in access to rapid and reliable diagnosis of TB and DR-TB for all people with presumptive TB. * Ensuring universal coverage of quality DST will provide for timely administration of treatment based on the resistance profile, including effective implementation of modified shorter treatment regimens for DR-TB based on DST to second-line drugs and new drugs (Bdq, Dlm). * Expanding the use of new anti-TB drugs and treatment regimens will allow to eliminate the key barrier in access to modern and effective treatment of DR-TB including for patients with advanced drug resistance. * Provision of people- and patient-centered support and follow-up during TB treatment aims to address the key barriers to and inequities in accessing essential TB services faced by key populations, due to complex and lengthy treatment and service setup requiring substantial time and additional expenditures by patients and households; Substantial limitations in receiving appropriate care, stigma and discrimination, and other barriers for the most neglected and marginalized groups such as the homeless and people with alcohol dependence. |
| Rationale | **Choice of strategic priorities:** Despite progress made in reducing TB incidence and deaths, Moldova’s TB response continues to face challenges, particularly in relation to increases in drug resistant TB and relatively late diagnosis of active TB. Modelling demonstrated that a shift towards more active case finding could lead to earlier diagnoses. To achieve an optimized use of current TB resources, specific reallocations are required in relation to how TB programs are delivered. Transitioning from hospital care to ambulatory care could reduce treatment cost by 24% and free up approximately US$2.8 million for reallocation to higher impact interventions or reinvestment to increase coverage. Resources freed up by changing treatment modalities would need to be invested in selected higher-impact interventions and delivery solutions. These include provision of incentives for providers of ambulatory TB care, procurement of new, more efficacious drug regimens for MDR-TB and XDR-TB, scale up of rapid molecular diagnostics, enhanced active case finding among high-risk populations and enhanced contact tracing. Despite these improvements in optimized allocation, current domestic TB resources would be insufficient to achieve global TB targets set for 2035 and new technologies as well as strategies to address latent TB would be required to achieve 2035 targets. (Annex 7 Optima TB)  **Access to rapid molecular and DST testing**: Another modeling exercise showed that In Moldova, a combined measures scenario yields reductions of 27% (95% CrI 17–41) in cumulative incidence and 52% (35–63) in mortality, between 2018 and 2045, highlighting the importance of early drug sensitivity testing for settings with high MDR-tuberculosis burden, with similar effects attributable to levels of drug sensitivity testing in new and previously treated cases.[[55]](#footnote-56)  The current TB screening in high and priority risk groups is integrated in primary care service provision, as well as contact investigation. However, a number of groups fall behind in reaching screening every year, i.e. those with alcohol use, those who are not on PHC list etc. There is no good quality data on key populations and an exercise to do size estimation and prioritization is planned under TB HRG module. In addition to ACF conducted by the TB services through Government and National Health Insurance Company NHIC funding. Contact investigation. Family doctors do contact investigation and they receive lists of contacts through the phtisio-pneumonologist. Funding is based on per capita of the population in the area where they work through the NHIC. Results of involvement of CSOs in screening high risk population shows higher yield compared to routine screening through PHC and thus is a cost-effective intervention. At the same time, reduced investment form GF allocation in current cycle to CSO-led case finding activities had a negative impact on results. According to the evaluation reduced funding for ACF in KP in 2018-2019 has substantially affected additional cases found: 2016-2017, community-based screening of 3,108 people detection 115 TB patients, a rate of 3,700 per 100,000. 2018-2019 out of 953 people screened, 23 TB patients diagnosed, a rate of 2,413 per 100,000. These data show there is clearly a need for ACF activities in KP, and investigating less people will result in less TB patients detected with potentially continued transmission in communities.  **Transition to new regimens**: The country anticipates full rollout of short and all oral treatment regimens from June 2020, when Moldova expect to receive all necessary medicines and clinical protocols will be endorsed by MoHLSP. A new protocol is approved in June 2020. The country anticipates full rollout of short and all oral treatment regimens from June 2020, when Moldova expect to receive all necessary medicines and clinical protocols will be endorsed by MoHLSP.  **Models of patient support and treatment administration modalities**: Taking into account as a result of the prioritization process, the proposal includes a comprehensive set of activities aimed at strengthening and diversifying approaches of people-centered approaches in TB care with a special emphasis on key population groups that face limitations in access to quality services. The approach is phasing out payment for patient incentives for the Right Bank (fully absorbed by the country), and multidisciplinary approach (keeping a capacity building and oversight and support component) for Right Bank, with a stronger and more differentiated approach to CSO-led support. On the Left Bank, given much poorer outcomes. |
| Expected Outcome | **Number of people reached within active TB case finding activities**  **among key populations and hard to reach**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | KP group | 2021 | 2022 | 2023 | Total | | Homeless | 3,900 | 3,900 | 4000 | **11800** | | People who inject drugs (PWID) | 5400 | 6800 | 7800 | **20000** | | Roma |  | 1000 | 1000 | **2000** | | Migrants |  | 3500 | 3500 | **7000** | | People with disabilities |  | 500 | 500 | **11000** |   **Estimated number of people with TB on MDR-TB, 2021-2023**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | 2021 | 2022 | 2023 | Total | | DR-TB: Individualized longer treatment regimens (iLTRs)  (Right Bank) | 420 | 403 | 391 | **1214** | | DR-TB: Individualized longer treatment regimens (iLTRs)  (Left Bank) | 206 | 206 | 209 | **213** | | DR-TB: modified al-oral shorter treatment regimens (mSTRs) (for FQ-sensitive cases) | 170 | 166 | 160 | **496** | | DR-TB: modified al-oral shorter treatment regimens (mSTRs) (for FQ-sensitive cases) | 76 | 76 | 76 | **228** | | Total DR TB cases | 872 | 851 | 836 | **2151** | |
| Expected investment | EUR 7,582,725  PAAR |

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| Component | **HIV: Reduce new HIV transmissions, close the gap in achieving 90-90-90 targets through increased early HIV detection, link to rapid ART initiation and increased treatment retention** |
| Module/interventions | The current national program ends in 2020. The targets were set at 60%: expansion of HIV testing: PWID 60%; SW 60%; MSM 40%; antiretroviral treatment coverage of people living with HIV: 60%, coverage of prevention services: PWUD 60%; SW 60%; MSM 40%. Despite an acceleration in recent years, Moldova is behind the 90/90/90 goals due to low starting point. According to HIV Optima 2019, to reach 95-95-95, a 230% increase in the budget is needed, which is unrealistic.  Therefore, the national program 2021-2025 sets highly ambitious targets for the country context. For NAP 2021-2025 the national stakeholders adopted targets set at 90-90-90 by 2025 and next NAP will adopt 95-95-95 targets for 2030.    **Strategic Goal**: Reduce negative consequences of HIV and STIs through decreasing the number of infections and transmission in key populations <10% in MSM, <20% in PWID and <6% in SWs and reduce AIDS mortality to minimum.  Three strategic priorities of the national program are to:   1. **Reduce number of new HIV cases**: 2. **Increase access to health services and improve health status of people living with HIV** 3. **Ensure effective coordination of NAP through strengthening health system**   To reach reduction in HIV transmission, 90/90/90 and zero discrimination, the funding request focuses on several strategic axes and technical approaches:   * reprioritize focus on MSM as the group with highest increase HIV transmission, sustain the gains of current KP prevention programs (PWID, SWs and people in detention) and innovate mature programs to expand reach and achieve higher coverage * design a people-centered model of HIV care based on a health system approach and strong focus on care cascade to decrease leakages * optimize testing strategies to incentivize finding the positives and early linkage to care, improve strategies to bring back to care those lost between pillars and achieve higher treatment retention * focus on integration, starting from service integration, including of CSO-led programs, and evolve the governance model for national programs for communicable diseases (RSSH component) * strong focus on health systems strengthening to advance sustainability of HIV response, focus on better quality and stronger data collection tools, towards integrated HMIS, prevention, treatment, epidemiological, laboratory and procurement components (RSSH component) * maintain a vibrant community voice able to monitor the response and reduce human rights barriers (in HRG component).   **Reduce new HIV transmission**  High risk key populations MSMs, SWs, PWID and their sexual partners and people in detention will be the focus of key interventions and activities. The funding request will support further improvements to KPs programs: (1) scale-up and redesign interventions that have been supported by the Global Fund, such as needle and syringe exchange, opioid substitution therapy, preventive programs for SW and MSM; (2) innovative approaches: support PrEP scale-up. treatment as prevention, condoms and other interventions will help reduce new HIV infections.  **New service packages for all key populations**: In NFM1 the KP service packages were costed at 42-48 EUR/covered person different for PWID, SWs and MSM, de facto NFM1 covered for 44/PWID, 24/SW and 37/MSM. In NFM 2 the service package reduced to 25 EUR (8 EUR for consumables procured separately), then added to 38 EUR during implementation. The recommendations of the 2020 HIV evaluation concluded that 25 EUR was inadequate for effective prevention and testing and not aligned to global good practice to cost all KP servicers at the same level as the range of services needed by SW and PWID for example are different and are likely to cost different amounts.  The service packages for KPs have been revised and adjusted based on new standards approved in March 2020. Standards take into account the last international recommendations for all groups at high risk of HIV infection; age-specific services for young people from these groups; people who use non-injectable drugs (PWUD) are included as a separate group, as well, transgender people. The costing exercise conducted in 2020 separates service packages in basic and extended, with higher cost per person covered compared to previous costing exercises. The basic service package has been costed at 52 EUR/per person and includes for the first time symptom TB screening for all key populations and testing for HIV, Hepatitis B, C and syphilis.  **Evolution of service package for key populations**   |  |  |  |  | | --- | --- | --- | --- | |  | 2015-2017 | 2018-2020 | 2021-2023 | | MSM | Condom and lubricant; IEC, HTS (+client navigation), social support, medical consultations, legal aid, psychosocial support  (costed 48 EUR, de facto 37 EUR) | Condom and lubricant; IEC, HTS  (38 EUR) | Condom and lubricant; IEC, Testing HIV, Syphilis, Hep B and C, TB screening  (53 EUR) | | SW | Condom (female, male, condom marketing) and lubricant; C, HTS (+client navigation), feminine hygiene package, pregnancy tests, gender-sensitive services, including GBV, social support, medical consultations, legal aid, psychosocial support  (costed 48 EUR, de facto 24 EUR) | Condom (female, male, condom marketing) and lubricant; IEC, HTS (+client navigation), feminine hygiene package, pregnancy tests.  (38 EUR) | Condom and lubricant; IEC, Testing HIV, Syphilis, Hep B and C, TB screening  (55 EUR) | | PWID | Syringes, disinfectants,  Naloxone, Condom; IEC, HTS (+client navigation), social support, peer support, medical consultations, legal aid, psychosocial support  (costed 48 EUR, de facto 44 EUR) | Syringes, disinfectants,  Condom; IEC, HTS (+client navigation), social support, peer support, medical consultations, legal aid, psychosocial support  (38 EUR) | Syringes, disinfectants,  Condom; IEC, Testing HIV, Testing HIV, Syphilis, Hep B and C, TB screening  (52 EUR) |   The extended service packages include add-on tailored to KP needs, gender-sensitive services to ensure linkage to care, client navigation, case-management.  **Services in extended packages for key populations**   |  |  |  | | --- | --- | --- | |  | Services | Cost | | MSM | * Health products, disinfectants, IEC * Male sexual health services, including GBV and trafficking prevention * Client navigation, psychosocial support, peer support, medical consultations, legal aid * Motivational services: STI testing | 38 EUR | | SW | * Female health products, disinfectants, * Gender-sensitive services, sexual and reproductive health services, including GBV and trafficking prevention * Motivational services | 39 EUR | | PWID | * Counseling for OST initiation and adherence * Overdose prevention and Naloxone * Health products and disinfectants, IEC, * Client navigation, psychosocial support, peer support, medical consultations, legal aid. | 42 EUR |   The planned coverage is to reach 70% of MSM, 70 transgender people, 75% of PWID, 70% of SWs. All extended service packages were set at 30% of expected coverage (most in need) and are included in the PAAR.  **In prisons** the service package includes NSP for all people estimated to be injecting drugs in all prisons in both Right and Left Banks (around 2,780 on a yearly basis) and a service package for all prisoners. It includes condoms, HIV and syphilis and IEC for targeted 30%, 35% and 40% by the end of 2023, with co-financing from the MoJ budget.  **OST scale-up:** Since 2018 the OST provision on the Right Bank has been fully taken over by the government, both in prisons and civilian sector. NHIC covers cost of services and procurement of methadone. Buprenorphine will be added as an option fully procured by the Government. The funding request includes scaling up OST in 8 new sites, including 2 on the Left Bank (set up costs). A new activity is starting OST program in Transnistria. In Year 1 advocacy activities will prepare the opening on the Left Bank. It is planned that in year 2 the 1st OST will open in in Transnistria and start enrolment in treatment 2022-2023, planned coverage 335 people in 2022 and 469 in 2023. OST psycho-social support is included for both Right and Left Bank clients on OST based on service package costed in 2017.  **Provision of comprehensive package of HIV prevention services to transgender people:** for the first time, transgender people are separated from MSM. The intervention aims to tailor services to the specific needs of transgender people, with focus on HIV and STI prevention. The service package includes HIV/STI testing and sexual health. The extended package includes legal support formal process of correct marker of gender identity in ID, mental health. The service package for TG includes basic and extended package tailored to the needs (EUR 91). Annual targets are 50, 60 and 70 by 2023.  **Community-based PrEP**: In Moldova PrEP was introduced through an initial project for all key groups 2018, 77% of enrolled were MSM in 2019. The ongoing project shows that PrEP is a suitable and acceptable intervention to a segment of high risk MSM. The intervention aims to reduce the risk of HIV infection among key populations, with focus on MSM and will be implemented by NGOs. A 50% target increase of the latest year reach is aiming at bringing Moldova to 750 persons in 2025 from the 90 persons enrolled in 2019 (the baseline). Community-based PrEP in all key populations introduced in Moldova starting the end of 2019, which brought about 125 persons in 9 months of 2019-2020, compared to 2 persons in 2018. Community-based PrEP is a person-centered approach. It includes PrEP prescription and follow up supervision in community organizations/NGOs, ensuring a friendly doctor consulting the beneficiaries, where most convenient for the beneficiary. The NGO accompanies the person for the HIV/STI testing and additional requested investigations (ex. creatinine), counsels the person on the treatment regime and follows up the correctness of the prophylactic treatment in-take, being supported by focused and targeted education and communication (PrEP package). The quality of the service is to be ensured through continuous capacity building, results-based staff motivation and M&E.  **Mobile clinics:** ensure geographical reach of the prevention programs and provision of integrated services. Currently there are three mobile clinics (2 Right Bank 1 Left Bank) allow reaching new clients or those having difficulties to reach NSP sites, conduct testing and clinical management and link to care the most vulnerable segments of key populations. The costs include staff and operational costs (van maintenance, gasoline etc).  **Pharmacy based prevention services**: are an innovative approach where clients go to pharmacy to get prevention commodities. It has been first introduced in NFM 1, then in Chisinau and districts through social contracting by NHIC on the Right Bank and NFM2 scaled up to 26 districts on the Right Bank and 4 on the Left Bank. The funding request includes scale-up of pharmacy-based outreach to the Left Bank.  **PMTCT**: the costs of full PMTCT program are fully covered by government, except for costs of Xpert cartridges for early infant diagnosis (EID). The EMTCT validation component along with improved information system, protocol revision and training is included in RSSH component as per modular framework guidance  ***PAAR: Innovative approach: Young KPs non-injecting PWUD intervention***  *Most existing programs targeting key populations serve mature adults and do not attract younger segments of KPs. There is limited information available on the role of younger groups in epidemic dynamics and risks are not documented, At the same time, there is evidence from other countries in the region that recreational drugs, known as chemsex, Currently UNODC conducts risk and needs assessment at regional level and Moldova is part. The proposed approach in funding request includes conducting a size estimation starting demonstration project to assess needs, document practices, train providers, establish outreach approach, adjusting the service package to these needs (i.e. safer smoking kits, overdose prevention from NSPs etc and outreach modalities via online outreach. associated with higher likelihood or unsafe sexual practices including low condom use and multiple sexual partners.*  ***PAAR: Harm reduction services based on the safety drug consumptions facilities****.*  *Drug consumptions rooms (DCR) and supervised injecting facilities (SIF)) are an innovative way to maintain people linked to services. Safe Use Rooms are professionally supervised facilities where people can use drugs in a safe environment, evidence shows this leads to less risks associated with HIV infection, a reduction in the frequency of overdose. The funding request proposes one project in Balti and one in Chisinau.*  ***PAAR:*** *Extended and attractive packages for all KPs*  ***PAAR:*** *Developing regulatory basis for PrEP in health facility*  ***PAAR:*** *Costing of PrEP service*  ***PAAR:*** *Informational campaigns PrEP*  ***PAAR:*** *Staff training*  ***PAAR:*** *Training for staff in prisons*  **Improve testing strategies** **to find the positives**  A strategic mix of tailored HIV testing modalities and linkage to continuum of care lays the foundation of a much stronger strategic focus testing in this funding request. Differentiated testing for KPs: PWID, MSM, SWs, TG, people in detention, and their sexual partners will ensure testing scale-up and provider-initiated testing and counseling (PITC) will focus on priority populations to increase case identification. Dual HIV/syphilis tests will be used for all testing strategies. To overcome the over reliance of facility-based testing, more emphasis will be on outreach-based testing improved access to HIV testing service to those in need:  mainly improve outreach, mobile testing and through pharmacies.  **For key populations:**  Community-based approaches will be predominant, but facility-based is also possible.   * Community Based Screening - provider initiated by CSO provider * Index testing will be introduced with focus on protection of confidentiality and after informed consent (incentive to CSO provider EUR 50/case HIV new diagnosed and EUR 10 for Syphilis new diagnosed) * Network-based testing for MSM * Self-testing: all key populations using oral tests through improved outreach, mobile and pharmacies   **For other groups:**   * Index testing with focus on protection of confidentiality and after informed consent through incentives to health staff (EUR 50/case HIV diagnosed and EUR 10 for Syphilis case detected) * Implementing the model of multidisciplinary teams with community nurses to increase access to testing ( * Provider initiated testing (facility-based) based on AIDS indicating diseases and key groups where yield is >1% * Self-testing through pharmacies   The funding request will focus on early case finding and HIV testing quality assurance. Government covers the costs of RDT test procurement for general population and key populations for the Right Bank. The service package for key populations includes the testing service described above. The funding request includes in this intervention:   * Situation assessment and revision of National Testing Guidelines: international and national TA to develop the differentiated testing strategy * Procurement of RDTs for differentiated testing for key populations * Implementation and uptake of HIV self-testing in general population * Index testing and PHC involvement: incentives to PHC staff (EUR 50/case HIV diagnosed)   ***PAAR: international TA to assess and assist in designing testing strategy and cascade improvement approaches*** *to provide an independent view review the HIV testing approaches and testing yields and cost-effectiveness to help support further prioritization of testing strategy towards highest impact.*  **Improve treatment cascade and increase treatment coverage**  Moldova has made progress in ART scale-up, adopted test and treat and intensified efforts to enroll people on treatment and achieve higher results for viral suppression. The Government provides ensures universal health coverage for health services (inpatient and outpatient) to PLHIV. In line with commitments made as part of sustainability and transition plan, Moldova will fully take over the costs of ARV procurement in the next national strategic program, including for Left Bank. Differentiated service delivery models (DSDM) will be enhanced to deliver quality services, enhance retention and viral suppression will be the main focus.  Prioritized Interventions include the following activities and approaches:  **Improve the cascade reduce leakage and develop sustainable systems for early treatment initiation:** the funding request prioritizes improvement of treatment cascade and therefore the funding request proposes a number of strategies to support:   1. A well-defined differentiated model of care that decreases leakages and ensure sustainability: (international and national TA) 2. Defined and costed medical and support services along the care continuum and payment mechanisms to stimulate more decentralized care, and inclusion of psycho-social support (national TA)   **ART decentralization**: to increase access to ART, the funding request includes plan to decentralize ART to infectious diseases specialists at district level as part of the specialist outpatient department of the district hospital who currently do not provide HIV care. The scale-up is phased to follow after the costing services can allow the money (contracted by NHIC) to follow the patient to district level and contract the new ART service package to the infectious disease specialist. Therefore, the plan is to set up 6 new ART sites in Year 1 and 6 additional sites in Year 3. The approach will also allow for service integration (*integration and multidisciplinary team approach included in RSSH component).* The request includes support to a decentralization coordinator, as well as costs for equipping, training, TA to develop regulation of district ART sites.  **Continuity of care**: This set of activities aim at improving coordination of care, to ensure linkages and coordination of care with TB service, drug addiction, other social services, between penitentiary and civilian sectors and developing a regulation on referral for a co-infected HIV, syphilis, Hep service  *PAAR Quality of care Improve quality of services, clinical audit of ART program, develop standards.*  **Improve treatment retention and ensure viral suppression**  Prioritized Interventions include:  **Psychosocial support** provided to ensure adherence to all who start treatment or after treatment interruption to pregnant women, children and those with TB/HIV co-infection (costed at 100 EUR/patient based on historic costs, and adjusted after service costing in year 1) and travel reimbursement for out-of-town PLHIV.  **Re-profiling Social Centers as medico-social:** with options to offer ART, TB other health services from visiting specialists (TA, minor renovation and equipment in year 1, support to offer comprehensive package in year 2 and 3 and international TA to assess the model)  **Treatment monitoring and co-infection management**: includes cost of monitoring tests (for Left Bank); Procurement additional diagnostic equipment, CD4 machine, tests for CD4, follow up tests, LAM determination, Tests for the determination of LAM, Cryptococcal Ag. A new activity is developing and implementing protocol for cardio-vascular diseases (integration of NCDs.) |
| Priority populations | MSM, TG, SW (including male SWs and TG sex workers, PWID, prisoners  Sexual partners and networks  Young people who use recreational drugs  Other priority populations for testing are groups where testing shows yiled higher than the general population  PLHIV |
| Barriers and inequities | * KPs are not sufficiently covered under the current program and further expansion is required.   Stigma & discrimination by health-care workers hamper access to health care in general and to HIV services and ART in particular, for all KPs as well as PLHIV: most often PLHIV in Moldova face some discrimination from health workers.  Criminalization of drug use and sex work: as a result, police harassment hampers access for PWID and SWs to HIV prevention services  There are no HIV services tailored to the specific needs of transgender people: despite the distinct risk behaviours and vulnerabilities of TG people, they were not specifically targeted.  No efficient referral system and unified HIV and integrated TB database, therefore patients released from prisons or referred to other doctors often are lost to follow up.  Lack of access to HIV prevention services for users of newly psychoactive substances (NPS). NPS use has doubled in recent years and is used as pills, inhaled, as well as injected. However, there is insufficient knowledge about NPS and effective services are not available for mostly young NPS users, leaving them vulnerable to HIV infection through needle sharing and unprotected sex.   * Limited PrEP availability * Lack of attractiveness of current basic package of services * Lack of access to OST on the Left Bank * Lack of availability of KP- friendly services, i.e. transgender services, no specific targeting for young KPs using recreational drugs, * No capacity of district health facilities to provide comprehensive and quality HIV care * No budget support for adherence and psychosocial service package. |
| Rationale | High impact prevention strategies targeting high-risk key populations are needed to sustain the gains of a stable epidemic among PWID and reduce HIV transmission in MSM and SWs. Because these KP program are mature, innovations are needed to maintain interest of people to access these services. A number of innovations would catalyze further scale up and reach to achieve more ambitions target.  Current testing strategies have not shown significant increase in the number of cases found, despite scale-up in key populations. Most cases come from PITC, which can be further made more strategic and targeted. There is also a need to incentivize expansion for the recommended decentralized rapid diagnosis algorithm and CSO providers to focus not only on testing levels but also on finding new cases. Therefore, along with a new testing guidance, the approach suggests introducing incentives to index case finding for both CSO and primary care, increasing access to self-testing and develop new more effective testing strategies.  Based on current epidemiological data, there are gaps in the HIV cascade in ensuring that clients are enrolled and retained on treatment. As Moldova advances in increasing prevention coverage to reduce new infections, retention to treatment and viral suppression of PLHIVs is critical in stopping transmission of HIV to key and vulnerable populations. To reach this goal, cascade performance lags behind and approaches to service organization need to be revamped in order to remove leakages and allow achieving the 90/90/90 goals. |
| Expected Outcome | Reduction in the high risk behavior and stabilization of HIV epidemic levels.  Increase in targets for coverage with prevention, OST, testing and PLHIV on treatment and virally suppressed.  *See Annex: Coverage targets HIV spread sheet.* |
| Expected investment | EUR 6,380,155  PAAR: |

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| Component | **RSSH** |
| Module/interventions | **RSSH - Health sector governance and planning:**   * Develop vision for new governance and coordination structure for national programs HIV, TB, Hepatitis +all the rest (NCDs, MCH etc) * Support to new governance structure by 2023 * MAF: multisectorial coordination mechanism for TB * Hospital optimization and strengthened outpatient care * Costed TB service package and contracting mechanisms: PHC, specialist, hospital, CSO. * Actual health expenditure reporting for TB   **RSSH: Integrated service delivery and quality improvement**: service organization and facility management   * Integration concept for services at all levels HIV/TB/STIs/Hep/OST (regulations, model of integrated services at specialist level, integrated in CSOs platforms * Response at national level; collaborative partnerships at community level; develop integrated service delivery regulation * *PAAR: MDT capacity building* * EMCT elimination TA for external assessment, reporting mechanism for HIV+ pregnant * *PAAR: EMTCT capacity building family doctors and maternity staff and PMTCT protocol revision*   **RSSH: Human resources for health, including community health workers**:   * Human resource planning, capacity building national TB program unit staff, integration in-service training into continuous medical education using digital platforms, integrating in-service training of non-medical staff on digital platforms * Develop and revise regulations for HR planning and retention * Develop and update job description and requirements for CSOs * Integrate non-medical CSO positions in roster professions * Integrate curriculums into CME and digital learning platform * Local and international trainings for HIV NRL and RRL staff * Training for staff included in HIV service provision   **RSSH - Health Management Information Systems and M&E:**   * Redesign electronic informational system SIME TB (add lab and CF modules, ensure interoperability), ensure core M&E visits * Redesign electronic informational system SIME HIV, interoperability and implementation * HIV core M&E: salaries, visits * HIV Surveillance: capacity building on case-based surveillance and patient monitoring; annual training * CCM website – data repository and dissemination * *PAAR: HIV core M&E assessment and functional redesign, M&E training, lobby for takeover of M&E staff costs* * *PAAR: HIV Surveillance: update of HIV surveillance regulations, printing*   **RSSH: HMIS and M&E**: Surveys   * Catastrophic TB costs survey, KAP TB, clinical audit TB/HIV * AI CXR operational research * *PAAR: Size estimation on number of people who use non-injecting drugs* * *PAAR: Size estimation on transgender and qualitative component to assess needs* * *PAAR: IBBS + Size estimates KPs (reduce frequency, plan for 2024 to inform new NSP)* * *PAAR: Survey in migrants and mobile populations* * *PAAR: Youth KAP*   **RSSH: HMIS and M&E**: Analysis, evaluations, reviews and transparency   * Assess the capacity of HIV/STI/HIV testing in Moldova * Analysis of genotypes and resistance (collaboration with Romania) * Recency incidence operational research * HIV clinical and mortality audit * Audit of psychosocial support services * Operational research to document service integration process, effectiveness, outcomes. * *PAAR*: *Analysis of cascade leakages to improve cascade strengthening* * *PAAR*: *Operational research to assess surveillance with participation of State surveillance of NAPH in response and control* * *PAAR*: *Mid-term HIV NSP review* * *PAAR*: *Final HIV NSP review* * *PAAR*: *Development and publication of annual HIV epi report* * *PAAR*: *Preparing epi data to Euro WHO and ECDC*   **RSSH Laboratory systems**: **Quality management systems and accreditation**   * TB lab strengthening (quality management, external quality assessment, biosecurity standards) * Implementation and maintaining QMS ISO 15189 in HIV National Reference lab * HIV EQA participation * Periodic auditing of HIV Testing Center (QA) * Develop and implement national QC program for HIV NRL and RRL and Testing Centers for HIV/STI   **RSSH Laboratory systems**: **Quality Infrastructure and equipment management systems**   * Establish and strengthen National HIV/STI Lab * *PAAR*: *Renovation and equipping NRL* * Establish and strengthen Regional Reference HIV/STI Lab * Lab equipment maintenance (NRL and RRLs)   **RSSH: Laboratory systems**: Information systems and integrated specimen transport networks   * LIS implementation and maintenance NRL level * LIS HIV testing Centers level   **RSSH: Health products management systems**   * Ensuring access to medicines for preventing adverse reactions during TB treatment, pharmacovigilance * *PAAR: Pharmacovigilance: training on active reporting HIV treatment side effects* * *PAAR: Improve PV regulation for HIV* |
| Priority populations | Key populations: MSM, SW, PWID, people in prisons, homeless, migrants, Roma |
| Barriers and inequities | * Rural residents have lower access and need to travel to access specialized services * Excessive hospitalization creates a number of barriers in families affected by TB * People-centered models of care are implemented at slow pace * Despite universal coverage by Government some additional costs occur and to many key populations can be catastrophic. Better services closer to home that include comprehensive package cand reduce the financial burden |
| Rationale | The priorities related to RSSH for HIV emerge from those listed the NAP 2016-2020:   * Build capacity and improve management, coordination, and administration systems for the effective management of HIV/TB/Hepatitis programs; * Provide timely, quality information for strategic decision making; * Strengthen the capacity of the HIV/STI Testing and Diagnostic Service by providing quality results in at least 95% of HIV/STI testing and diagnostic units; * Ensure the effectiveness of program implementation by investing in the knowledge and skills necessary to provide services; * Eliminate barriers to the introduction of technology (diagnostics, laboratory), medication, and strengthen the supply system (PSM strengthening).   Similarly, the National TB program includes priority areas related to RSSH:   * Capacity building for the NTCP efficient management * Strengthening the health systems through well-aligned funding mechanisms for TB * Capacity building of human resources involved in TB control * Strengthening collaborative actions in TB control with other national programs * Development of regulatory acts for surveillance based on individual data, improving the quality of registration of civil status documents, the quality and rational use of medicines and pharmacovigilance * Social protection, poverty reduction and action on other TB determinants, including among migrants and detainees * Carrying out operational studies   **Integration at governance level and coordination of collaborative activities: responses:** the National TB, HIV Aids and STIs Program management governance model has been a recurrent discussion in the past decade. The National Public Health Strategy 2014-2020 included integration of the vertical programs for monitoring of TB, HIV/AIDS and STDs in the wider health system of communicable diseases as one of the priority interventions. Due to an unstable political environment since 2015, it has not been implemented so far. The current model where National Programs for both communicable and non-communicable diseases are located as part of tertiary hospitals creates some disadvantages in terms of ensuring best and multi-sectoral coordination, missing potential synergies and optimization. Two external independent evaluations[[56]](#footnote-57),[[57]](#footnote-58) provided views on possible options moving forward, including setting a new entity to manage national programs, house all national programs under the MoHLSP and maintain status quo.  Coordination and overall supervision of national TB and HIV programs is carried out through the National Coordinating Council, i.e., an interagency and intersectoral decision-making structure, with dedicated thematic working groups for TB and HIV as well as a separate group for TB/HIV. The integrated TB/HIV service model is based on the local healthcare system context, i.e., the linkage and referral between two vertical TB and HIV programs. Developing and implementing the models for integrated service delivery, including relevant policy, regulations, and guidelines considering the service organization specificity at all levels as well as exiting priorities and needs in terms of coinfections/comorbidities.  **MAF:** Necessary commitments needed for reaching these targets are specified in the current TB NSP 2021-2025 and the related operational plan (Annex I), also in relevant cross-Ministerial/Multisectoral policies, plans and strategies. However, all these actions are fragmented, and there is need in an effective national multisectoral mechanism which must be established/strengthened and tasked with providing oversight, coordination, and periodic review functions. Currently CCM is assuming some of the roles and responsibilities of the MAF-TB, with major focus on GF supported TB and HIV programs. CCM is mostly operates with GF support, considering the anticipated GF withdrawal, the country will start planning for transition or these roles and responsibilities vis-a-vis the establishment of MAF-TB, which will be accomplished in line with WHO standards.[[58]](#footnote-59) As an initial step, MAF-TB baseline assessment will be conducted, to be followed by the development of MAF-TB, including the following four key elements: (a) formalizing commitments, targets and roles via laws, decrees, NSPs and budgets; (b) multisectoral engagement – prioritized list of ministries for engagement; (c) civil Society engagement & and other stakeholder roles across all components of accountability framework; (d) national TB Reports, advocacy and associated documents; and (e) high-level review and coordination mechanisms: design, operation, indicators, etc.  **Integration of services and programs** are the key to improving case detection as well as treatment outcomes for both TB and HIV, as well as managing patients with co-morbidities. Interventions witll support screening/diagnostic assessment and monitoring by different setting and patient groups taking into account most prevalent comorbidities including HIV, HCV, DM, MCH, mental health disorders, alcohol and drug use, etc. Similarly, the efforts will be made on redesigning/adjusting patient care pathways with relevant focus on integrated service delivery and most prevalent comorbidities (e.g., problematic alcohol use, DM, HCV coinfection, etc.) including developing/ revising and implementing appropriate technical documents and guidelines. Collecting additional epidemiological, people-centered, and health system data with relevant focus on coinfection/ comorbidities is planned under the national TB research agenda/priorities    **People-centered model for TB: hospital optimization and scaling up outpatient treatment:** In line with WHO EURO policy and the TB NSP 2016-2020, [[59]](#footnote-60),[[60]](#footnote-61) the country has developed the national TB hospital optimization plan to improve TB/MDR-TB treatment outcomes and achieve cost-efficiency of interventions.[[61]](#footnote-62) However, this plan has not been implemented as planned; TB hospital care is still financed through a blend of per bed day and global budget, which incentivize long hospital stays and high rates of admission.[[62]](#footnote-63) It is recognized that the key to solving this problem is a broader (TB) hospital financing reform, which may also require the reorganization of TB facility network in the country. To support this process, the NTP has developed the initiative aiming at reorganization of the specialized TB hospital service. In the meantime, the NTP will update the optimization plan for the bed capacity. There is a need in improving the quality of care across TB care cascade, particularly for ambulatory patients receiving the respective treatment under supervision of phthisiopneumologist and with direct involvement of PHC/family doctors (at village health facilities) and regularize involvement of CSO and case-management and psychosocial support as part of routine offering. The national leading institutions in TB prevention and care, i.e., with technical support from the Centre for Health Policies and Studies (PAS), through TB REP grant has developed a national guide to a people-centered model of care (PCMC) for TB.[[63]](#footnote-64)  The expansion of ambulatory treatment will be optimized through improving service packages at peripheral level and updating the current health payment mechanisms at primary and secondary levels of care, as well as develop a service package for supportive services as the basis financing strategies. If money follows the patient, this will create premises to maintain adequate staff and adjust human resource development, integration of services, etc., which should be designed and implemented in light of overarching UHC concept. The recently introduced people-centered approaches implemented through community centers as well as by NGOs/CSOs will provide patient adherence support for ambulatory treatment through LTFU risk assessment/ management, homebased care as well as psychological and social support. Furthermore, the national regulatory and legislative framework should allow for full and early integration of patients on effective treatment into daily social life (e.g., the attendance of work, school, or pre-school institutions. This should be also supported with broader collective efforts to reduce TB-related stigma in local communities (described under the respective sections of Pillar 2 below).  **Human resource development**: Integrated care approach, as a foundation for predominantly ambulatory model of TB care delivery requires new approaches for HRD and planning, distribution and professional development. A critical task during transition from outdated model of hospital-driven care to people-centered outpatient model will be to ensure shifting of TB-related tasks to general service providers (based on the defined and agreed packages of services), and to retain optimal number of TB specialists. This task will be accomplished through: (1) Developing/updating the HRD policies and plans (including numbers, deployment, retention, operations, workload and working conditions) considering the new requirements of integrated TB service delivery at all levels, based on the respective HRD assessments and operations research. (2) Setting competencies, tasks, and standards of care for the health workforce at different levels considering the updated patient care pathway, task shifting, etc. (3) Updating pre- and in-service education and training curricula (considering the updated patient care pathway, integrated service delivery, task shifting, social protection, etc.), and continuous training of relevant healthcare workers involved in TB prevention and care at various levels, including through digital platforms and distance learning programs.  **Procurement and supply chain management**: From 2005 to 2011, GF was the only provider of anti-TB drugs in the country. Since 2011, all FLDs have been procured from the national budget by the MOLHSP and the Ministry of Justice for the civilian and penitentiary sectors, respectively. Since 2014, the government started purchasing SLDs, with 50% of SLDs currently purchased from domestic sources (the other 50% is purchased from GF budget). From 2016 to 2018, UNDP procured medicines and other health products for treatment and diagnosis of diseases included in the national and special health programs, including HIV and TB medicines. Since 2019, procurement is done by the MOLHSP Centre for Centralized Public Procurement in Health. Procuring TB medicines in Transnistria from quality-assured sources; Updating the National Essential Medicines List (last updated in 2011), by including newer medicines such as bedaquiline, delamanid, clofazimine and child-friendly formulations; Technical assistance to Moldova’s Medicines and Medical Devices Agency to assess the current policies and practices for registration and import of health products and medicines, pharmacovigilance systems and quality assurance/quality control standards as well as planning and implementing the actions for improvement  **SIME TB:** Although SIME TB functions well, it is not possible to add new variables or make substantial changes, which is due to the programming language used that has reached the end of its life. The database is able to generate standardized reports, but ad-hoc analyses are rather time consuming because easy variable selection is not possible. This hinders a more granular analysis. Additional modules are also needed for lab and case finding.  **HIV M&E system:** The HIV monitoring systems are different modules with no linkages between them that have been developed over time and it is not possible to ensure continuity of data flow. SIME-HIV – collects ARV treatment data, which is only partially updated and non-operational at present. There are additional excel databases updated by all institutions providing ARV treatment to PLHIV. In light of decentralization there is a stringent need for a new HMIS and EMR system. The current digital health strategy in Moldova envisions setting interoperability of various emerging HMIS systems and does nt plan for a single integrated HMIS.  **HIV laboratory network:** at the national level, SDMC’s lab centralizes the national capacity to conduct HIV testing, diagnosis, and follow-up for patients in ARV treatment. Major gaps include lack of LIS connecting HIV confirmatory labs and HIV screening sites (reports are excel-based), lack of unique identifier does not allow counting people tested, only tests used, and lack of reference system to linkage to care. With decentralization of testing capacity, more focus on quality management systems is needed. |
| Expected Outcome | * Stronger capacity of health system to support TB and HIV response * Improved governance structure for coordination of national programs * Improved provision of integrated and decentralized services leads to better TB and HIV outcomes * Service packages for TB and HIV in decentralized models are costed, approved and used to channel appropriate funding at outpatient level of care * Reduction in hospitalization rated for TB and better care and more comprehensive available in ambulatory setting * Better information systems able to provide granular data for decision-making and response adjustment and ensure continuity of care |
| Expected Investment | EUR 1,836,404  PAAR |

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| Component | **CSS and HRG** |
| Module/interventions | **RSSH: CSS / Social mobilization, building community linkage and coordination**   * Improve institution and organizational potential for CSOs working with KPs (including KAP platform) * **HIV:** Support to public leadership (Memorial Days) * **HIV:** Engagement working groups, committees * **TB:** Develop and implement social contracting mechanisms for TB supportive services active case finding and case-management * **RSSH: CSS / Community-based monitoring** * **HIV:** Monitoring takeover by country * **HIV:** Budget advocacy * **HIV:** Capacity building for communities to implement national program * **HIV:** TA to HIV service orgs * **HIV:** Communication and visibility   **Reducing human rights-related barriers to TB services:**   * Document structural and access barriers to TB (gender, human rights, financial, stigma); * Involve NGOs in removing barriers and increase access and linkage to care for key populations; * human rights literacy; * community-based monitoring for TB; * TB stigma index, legal aid, * paralegal network, * legal aid and strategic litigation   **Reducing human rights-related barriers to HIV services:**   * **Reduce stigma related to HIV and KP**: Information campaign for different audience, printed IEC, Modular program on overcoming self-stigma * Barriers: Remove legal barriers (70% recommendations from HIV LEA), * Discrimination data collection via Soft RID * Paralegals and PromoLex training |
| Priority populations | * People living with HIV * Homeless people * Prisoners and people in detention * People with Alcohol Dependency * People who inject drugs * Migrants * People with other co-morbidities, including diabetes * People with Mental Disabilities * Children of people with TB * Roma population |
| Barriers and inequities | **For TB**   * Stigma and discrimination from family members and community * Community stigma, including stigma from health-care workers and other support services * Confidentiality issues, * Right to movement * Existing guarantees for job security are often not respected * Restrictive state policies and practices regarding sex work   **For HIV**   * Stigma and discrimination * High levels of intolerance towards KPs. * Human rights * Criminalization of drug possession, sex work and HIV transmission |
| Rationale | * In the Republic of Moldova prevention programs in key populations (1st priority of the National AIDS Program 2016-2020), representing about 30% of the budget, are being implemented by nongovernmental organizations representing the community of those people. All their activities are regulated by standards and guidelines approved by the Ministry of Health, Labor and Social Protection. Starting with 2017 harm reduction projects have partially been funded from domestic funds, namely from the Prophylaxis Fund of the National Health Insurance Company. In 2019 2 such projects have been contracted to NGOs, amounting at circa 1.5 million MDL to cover about 2000 persons. This is a relevant achievement towards ensuring the sustainability of harm reduction programs, after over five years of advocacy; those efforts should be further continued and strengthened. The activities related to HIV care and support include as well community-lead interventions to ensure the PLWH quality of life, as well as ART adherence, which influences the third 90 of the ART cascade. * Human rights and stigma and discrimination researches realized recently reflect on the societal attitudes that inform: right to health is considered the most actual and important right that requires enhanced attention from Moldovan society[[64]](#footnote-65), including by people infected and affected by TB and HIV, while about 90% of population would not accept living in the same society with the members of key populations or PLWH[[65]](#footnote-66). LEA (Legal Environment Assessment) performed under the guidance of UNDP Moldova in 2018 informs about a multitude of normative acts that have to be adjusted to ensure a protective environment for the respect of full range of rights for those most affected by TB and HIV. LEA informs about serious barriers legal and normative acts perpetuate and contribute to reduce the access of people and addressability to health services. * Interventions in the funding request will address about 70 recommendations of LEA research related to reducing stigma and discrimination in general population through communication campaigns, in working settings with the focus on health system with capacity building on rights’ awareness and alphabetization and at the individual level, to fight self-stigma. Interventions to adjust and align the normative framework to international and human-rights based standards are also envisaged. In order for those legal norms to be approved, it is proposed to have advocacy related measures, as well as follow up community monitoring. * Community monitoring is aimed at closely looking at the results produced by programmatic interventions, use of resources, including in procurement, human rights and the implementation of national HIV and TB operational plans and policies. It will be ensured through the e-community monitoring platform and capacity strengthening of civil society and communitarian organizations, organizational development and empowerment of both individuals and organizations to ensure the voices are heard. * One of the key recommendation in the “Moldova tuberculosis evaluation” (2020) is to identify and address the rights, legal, and gender barriers to health outcomes for individuals and key affected populations, this aspect being evaluated as very poor in TB control in Moldova. In this regard, is proposed to conduct a CRG assessment in further involve the CSOs in interventions to remove barriers and increase access and linkage to care for key populations. * Data show there is clearly a need for active case finding activities in KP, and investigating less people will result in less TB patients detected with potentially continued transmission in communities. Activities to ensure sustainable financing of CSOs working with KP are proposed to increase the access of KP to TB care. * TB NGOs mainly received service provision grants, but little funding for CSS or HRG work. In order to document the barriers by involving those most affected, a community based monitoring digital tool should be rolled-out at the country level. Also more focus on organizational development is needed. * The referral system for legal support to people with TB is deficient. Stigma and discrimination is notes throughout the treatment period, but also in the period after the end of the treatment and re-employment in society and / or in the field of work. Barriers documented through the data generated by the community monitoring application will be handled by a network of legal support specialists that will help the people with TB to overcome the human rights related barriers (stigma, discrimination, confidentiality, guarantees for job security). * Isolation of children from their parents or care givers by transporting them to “recovery centers” because of the socioeconomic situation and/or TB infection at home is still practiced in Moldova. The practice of institutionalization of children is outdated and there is a range of issues with it, starting from unnecessary isolation, violation of human rights and unwise use of public money. An assessment of the quality of care provided and the living conditions of children in these centres should be carried out with the involvement of CSOs. The role of the CSOs is crucial in ensuring the rights of the children. |
| Expected Outcome | * Removal of the identified barriers in the CRG assessment and through the data generated by the community monitoring app, for increased access to care for key populations; * Guaranteed right of choosing the modality of treatment for people with TB by scaling-up the video-observe treatment at country level. * Reduced stigma and discrimination level through improving people knowledge about TB during awareness campaigns and through promotion of the community based monitoring app use among KP, where the module with information on TB is included. * Increased treatment success rate among KP (including Roma population), due to early TB detected cases and support for treatment adherence provided by CSOs and also due to increased level of knowledge on TB by using the community based monitoring digital solution. * Improved case management of children affected by TB through deinstitutionalization and involvement of the community / social services / LPA in their support. * Improved literacy of TB affected population on human rights |
| Expected Investment | EUR 479,159  PAAR |

1. Does any aspect of this funding request use a **Payment for Results** modality?

Yes  No

If **yes**, in the table below, indicate the relevant performance indicators and rationale for the choice of performance indicators and/or milestones.

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| **Performance indicator or milestone** | **Target** | | | | **Rationale for the indicator/milestone selection for Global Fund funding** | |
| **Baseline** | **Y1** | **Y2** | **Y3** |
| **HIV case detection CSO provider** |  |  |  |  |  | |
| **HIV case detection health staff** |  |  |  |  |  | |
| Add rows if necessary |  |  |  |  |  | |
| **Total amount requested from the Global Fund** | | | | | |  |

Specify how the accuracy and reliability of the reported results will be ensured.

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| During the 2018-2020 grant, the PR has been applying a reliable mechanism, i.e. a nation-wide Monitoring Software, which helps the National HIV Control Program to track down all services and beneficiaries supported through GF and NHIC funding in HIV control. Thus, the results reported by implementers, are verified by the NAP against potential duplications, number of services provided, location of service provision, and consumables distributed, and are validated in accordance with agreed validation criteria. Consecutively, the quarter or semiannual disbursements of funding to service providers are carried out by the PR, based on the NAP validated data.  This mechanism has proved to be very effective in counteracting duplications, misuse of distribution materials for beneficiaries, as well as tracking in real time delivery of services and their location.  The PR and the coordinating teams of the national programs shall further apply and sustain this approach during the 2021-2023 grant. |

1. **Opportunities for integration:** Explain how the proposed investments take into consideration:

* Needs across the three diseases and other related health programs;
* Links with the broader health systems to improve disease outcomes, efficiency and program sustainability.

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| The CCM has prioritized the opportunity of a joint TB/HIV request to make a strong emphasis on integration at all levels: governance and management, strategic purchasing of services, service delivery, and along the health system building blocks. Acknowledging the intertwined nature of the TB HIV STIs and Hepatitis and epidemics in Moldova, the funding request creates premises for a progressive integration across TB, HIV and other related health programs through a series of approaches at different levels.  **Health sector governance and planning:** Currently, the TB and HIV programs coexist as two vertical disease-oriented programs with separate coordination units managed by different entities at the level of tertiary health care institutions for TB and HIV services respectively. A lot of progress has been made to improve collaboration and coordination between the two coordination units. However, the nature of two silo-ed structures housed by tertiary hospitals affects integration at the operational level. However, there is a strong determination of the public health authorities to establish a single structure that will coordinate implementation of TB, HIV, and viral hepatitis programs and possibly consider a single entity for all national programs management. During implementation plan a concept for an integrated national program management unit and a feasibility assessment will set the ground to move towards this goal. The funding request will support development and implementation of this model with all supportive regulatory framework. Similar coordination at the local level will be ensured through development of the collaborative partnerships by involving CSOs and LPAs.  **Health system-based service delivery models:** Coordination of TB and HIV services through multidisciplinary approach has been streamlined under this funding request. Decentralization of HIV services to ID specialist at the rayon level creates premises for integrated service delivery. A case-management approach will be used to address both medical and non-medical needs of the patients with TB and HIV through multidisciplinary teams at district specialist level. TB treatment support centers operating at this level will serve as a starting point for integration and establishing multidisciplinary approaches.  **Community-based service delivery models:** Community system strengthening will promote “one stop” approach to allow integration of TB and HIV services at the community level. Based on service package development and costing, starting with year two there will be an option to integrate services for the same key populations. Social centers designed to channel resources for social support to PLHIV will be re-profiled, expanding the scope of the support services and beneficiaries’ eligibility to KPs and patients with both HIV and TB. Implementation of such integrated approach will be enabled by activities to define and cost the package of services for KPs currently ongoing.  **Health Finance:** addressing costing for services package for both TB and HIV creates opportunities for greater TB/HIV integration at the provider level, but also between prevention and care continuum. The same principles to underpin design of the payment schemes and cost estimates for services for both TB and HIV will be applied.    **Structural and health systems barriers:** The proposed investments of this funding request not only take into consideration the needs across TB and HIV, but also links with the broader health system. A number of activities that will address the gaps under the different health system blocks have the potential to improve enabling context for better TB/HIV integration.  **Health Management Information Systems:** SIME HIV and SIME TB will be developed/upgraded ensuring compatible design, standard data collection and reporting tools, and procedures. Interoperability between the systems that allows to integrate data sources for TB and HIV will provide the information for policy planning and implementation of the collaborative TB/HIV activities addressing the needs of those most vulnerable. In addition to compatible design between these two HMIS, interoperability is needs with HMIS at primary care level and the HMIS now under scale-up for secondary care level.  **Health products management systems**: procurement of the TB and HIV medicines and other commodities is already operated by a single national entity, the Center for Centralized Procurements in Health**.** Further work on strengthening pharmaceutical regulatory systems and improving procurement mechanisms, identified as structural barriers in the context of transition to domestic procurement, will strengthen overall the drug supply chain and improve outcomes across all diseases.  **Laboratory systems:** Sharing resources developed as part of the single disease program and respond to the needs in other collaborative programs will expand access to timely testing across different conditions. There are 57 Xpert machines available in the country in all districts, including in the prisons sector, Aids Laboratory and Transnistria. These can be used as multi-disease diagnostic platforms to ensure early diagnosis of TB, early infant diagnosis and viral load in HIV. In times of Covid, the country has already requested buying Xpert cartridges for Covid from savings of the current grant which will allow for test availability throughout the country compared to highly centralized lab capacity now available in just a few public and private labs. Another point of consolidation that will generate efficiencies is integration of the TB sample transportation system into the general national laboratory system.    **Links with the broader health systems:** The funding request has a major focus on strengthening sustainability, and in this context includes many interventions to strengthen community systems as well as health systems beyond the specific area of HIV and TB. These include:   1. Removing human rights-related barriers to services for KPs – such as interventions to ***reduce stigma and discrimination*** of KPs and PLHIV or providing legal support to KPs, PLHIV and undocumented migrants – will also benefit their access to TB and overall health-care services, as well as social services and support systems; 2. ***Strengthening social contracting*** will also benefit NGO service delivery to KPs in other areas, including TB, HCV, sexual and reproductive health, and harm reduction programs; 3. The overall strong focus on strengthening ***community-based interventions*** will benefit health and social programs for key and vulnerable populations beyond HIV, TB and broader health issues. This includes also social support for outreach work among KPs that are currently under-served; interventions aimed to forge community linkages between NGOs and State institutions beyond the mere field of HIV and TB; and strengthening the institutional capacity of NGOs. All these interventions have a knock-on effect on broader health and community systems beyond HIV and TB, as they strengthen KPs’ and PLHIV’s access to health and social services, as well as sustainable financing for these services |

1. Summarize how the funding request complies with the **application focus requirements** specified in the allocation letter.

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| The Funding request is fully in line with the requirements specified in the allocation letter.  TB and HIV service interventions are evidence-based programs for key and vulnerable populations, as per WHO, Stop TB Partnership and UNAIDS guidance and aligned to the highest impact interventions as outlined in Optima TB and Optima HIV studies.  The funding request includes effort to further strengthen screening of high-risk groups including through outreach and community bases approaches and using digital x-rays and rapid diagnostics with particular focus on Transnistria. The funding request focuses on acceleration of transition to rapid all-oral treatment regimens and universal to these will need further decentralized models of care and more patient support for most vulnerable patients in communities where they live. Therefore, the funding request includes stronger focus on CSO-led activities that will provide support to patients in communities through more comprehensive approaches compared to current grant, including case-management, community-based DOT, home-based DOT and digital adherence strategies. All patients with DR-TB will be provided with comprehensive package of supportive services to improve treatment adherence and best clinical outcomes for patients. To sustain focus on key populations in Transnistria, the patient support package will also include patient incentives, because of ongoing challenges for these to be taken over by the de facto authorities.  The HIV component is primarily focused on prevention and testing services and improving cascade of care for key populations. The Government takes over fully the cost of ART, so that the funding allocation can focus on service provision to key populations and removing service delivery bottlenecks and support the health system capacity to improve the 90-90-90 cascade for key populations.  The RRSH request is primarily focused on improving the overall program outcomes for key and vulnerable populations and support scale-up efficiency and alignment of interventions. A strong focus on models of people-centered care, decentralization, service packages, quality of care and integration and capacity building of both health and CSO providers will lead to better services for key populations.  Finally, community systems advocacy, social mobilization and community-based monitoring and work around stigma will be fully implemented by non-government actors to remove the remaining barriers and inequities in access. |

1. Explain how this funding request reflects **value for money**, including examples of improvement in value for money compared to the current allocation period. To respond, refer to the Instructions for the aspects of value for money that should be considered.

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| The funding request integrates Global Fund supported services into the national health systems, provide synergies with investments from domestic government, and fills resource gaps critical to ending HIV and TB epidemics in Moldova. It balances the use of Global Fund investments to advance disease control and meet global targets while also building the capacity of national disease programs and health systems to sustain achievements in the future  **Economy:** The funding request only includes a portion of MDR-TB drugs and confirmatory testing for HIV and TB (Xpert and DST), a portion of procurement of methadone (for Transnistria) and prevention commodities (syringes, condoms, and RDT for KPs). The major part of medicines is planned to be procured through national budget, including 100% of ART needs and 60% of MDR TB medicines needs. The selection of health products us fully aligned with current WHO guidelines on rapid expansion of new MDR TB treatment regimens and technical guidance for HIV. Procurement plans and supply chain capacity is consistent with the programmatic targets set. PSM capacity has been assessed as high by both TB and HIV evaluation reports and GDF mission (Annex 12 GDF Mission 2019), as no stock outs were reported for any commodities, and procurement practices considers bids only form WHO-prequalified suppliers key quality health products procured, transported, distributed and managed efficiently, reducing stock-outs and wastage has been highly rated by GDF mission for TB. Salaries are paid in line with national human resources procedures and salary scales. Costing of service packages will allow alignment between different areas and simplification of approach for the NHIC to be able to contract them in a simplified approach that will be simpler in administration.    The technical group has made a decision to invest in innovative technologies of GeneXpert for fluoroquinolone rapid resistance profile to be placed in NRLs and AI for mobile CRX, to allow for higher CXR capacity and remove the delay in result interpretation related to need to do it centrally. At the same time and even more advance whole genome sequencing capacity was placed in the PAAR because of the choice between the two approaches to more advanced early diagnosis. Moldova undertook significant measures to rationalize ART procurement, leading to much larger orders for some medications and thus to lower prices than had previously been paid through government purchasing. Similarly, for TB services are delivered in ways that reflect good use of existing infrastructure and health system capacity  **Allocative efficiency:** Available resources are strategically allocated across interventions, geographies and population groups to maximize impact of respective disease programs. The architecture of both national disease specific plans and GF grant was designed based on allocative efficiency modeling. In line with 2018 Optima TB findings the technical working group has prioritized increased focus on case-finding in key populations and stronger contact investigation with higher TPT uptake, rapid diagnostics, new treatment all-oral regimens with better clinical outcomes, decentralized care and people-centered approaches with diversified treatment administration modalities. Aligned with 2020 Optima HIV findings the funding request prioritizes removing barriers to scale-up ART to high levels, scale up investment in HIV testing and prevention of MSM and SWs. The funding request has prioritized investment in strengthening both health and community systems to address shared bottlenecks for the delivery of health services    **Technical efficiency:** the funding request plans for service delivery optimized through choice of appropriate strategies to provide quality services including task-shifting (HIV testing in primary care, HIV decentralization ART to district level), reducing unnecessary hospitalization for TB , and providing integrated service delivery through primary health care (PHC) facilities, community health workers, as well as community-led and based organizations by integrating TB and HIV services with hepatitis, OST in and case-management sand supportive services in integration demonstration sites.    **Improve the efficiency of the health system by integrating parallel and duplicative disease specific management systems**: taking advantage of the first TB/HIV joint funding request, it plans efforts to integrate TB and HIV disease programs at all levels: governance and national coordination under one umbrella, TB and HIV service delivery at community, primary and start phased scale-up of integration and of TB and HIV services and case-management at specialist outpatient levels, procurement through national public procurement agency  Implementation arrangements are designed to minimize program management costs and respond to programmatic risks and bottlenecks. In response to GF request in allocation letter to submit a joint TB/HIV funding request with one PR, the CCM has nominated one Government PR PI CIMU HSP and one non-government SR PAS Center. Compared to current implementation arrangement with two local government and non-government organizations PRs (dual track finance), two separate TB/HIV and TB grants and three sub-recipients, this is a new slim implementation format. Civil society and community-based organizations will have roles of both service providers and CSS/HRG implementers.  **Equity:** an analysis on populations with the highest disease burden and areas where newest infections occur for HIV to best of granularity (based on IBBS, Optima HIV modeling) and based on age, gender and geography at district level. For TB the teams have sufficient epidemic understanding by age, gender, and geography, as well as some research and modelling data but insufficient granularity by key populations in terms of size estimations and disease burden, except for program data from current implementer. incidence and prevalence. Data for key populations for TB, human rights and gender barriers tools and designing a TB “find-treat-retain” cascade design is planned for year 1 and will inform better targeting and programming in years 2 and 3. Similarly for HIV, a key focus is understanding better the geographic distribution of both new transmissions and actively finding the existing HIV cases is a priority. In PAAR international technical assistance is included for designing cascade improvement strategy, to infuse fresh thinking into a mature program.  Global Fund investment focuses solely of services for most at-risk populations delivered by both CSOs and public health system and in programs to remove human rights and gender-related barriers they face A series of existing financial, human rights and gender-related barriers in service access, uptake and retention are highlighted in the context section and HRG component. Stigma remains an important barrier for both people affected by TB and HIV, especially in rural areas and a factor to be addressed as part of decentralization efforts. Human rights barriers are well documented for HIV and planned activities target their removal. For TB a CRG assessment will systematically document these barriers and CSO efforts will focus on addressing them in years 2 and 3. Resources have been planned to build and sustain community responses to promote service access, update and retention |

## Matching Funds (if applicable)

This question should only be answered by applicants with designated matching funds, as indicated in the allocation letter.

Describe how the **programmatic and financial conditions**, as outlined in the allocation letter, have been met.

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| N/A |

# **Section 2: Operationalization and Implementation Arrangements**

To respond to the questions below, refer to the *Instructions* and an updated **Implementation Arrangement Map**[[66]](#footnote-67).

1. Describe how the proposed **implementation arrangements** will ensure efficient program delivery.

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| In its Allocation Letter on December 16, 2019, the GF Secretariat informed the Country Coordination Mechanism of the National Tuberculosis and National HIV/AIDS/STI Control program (CCM Moldova) that the total envelope approved by the GF Board to support the National TB and HIV response in Moldova in 2021-2023 period totals EUR 18,061,192 for HIV, TB and building resilient and sustainable systems for health, with a recommended funding split of EUR 8,662,849 for HIV disease component and EUR 9,398,343 for TB disease component. For implementation arrangement specifically, the Global Fund requested that Moldova submits a joint funding request for one grant to be implement by one Principal Recipient.  Consistent with the GF Allocation Letter, the CCM decision on February 6, 2020, the CCM has approved the implementation arrangement of the joint TB/HIV grant for 2021-2023 by nominating the Public Institution “Coordination, Implementation and Monitoring Unit of the Health System Projects” further, PI CIMU HSP, as Principal Recipient (PR) from governmental sector and PAS Center as sub-recipient (SR) from non-government sector. Both PR and SR are experienced local organizations, PI CIMU HSP has been a government PR of GF HIV and TB grants since starting with Round 1 2003. PAS Center has been a sub-recipient in Round 6 and since 2009, a non-government PR for HIV grants (Round 8 - NFM 1) and TB grants (Round 9 – NFM 2) under dual track finance policy. PAS Center is a PR for EECA TB regional grant TB REP (2016-2018) and multi-country EECA TB REP 2.0 grant (2019-2021). The PCIMU - PAS grant implementation responsibilities shall be formally regulated, based on a three-year PR-SR contract/Memorandum of understanding/ cosigned by the two parts.  The CCM TB/HIV and its National Expert Commission (oversight body) both include voting members from communities and KAPs, will guarantee the program oversight role throughout the entire grant life. It will ensure the overall grant implementation and coordination between different sectors as well as different programs implemented by other external partners. The CCM will closely monitor the project progress through its National Expert Commission and ensure implementation is aligned to the work-plan and on track in achieving programmatic targets. National Technical Workings will be convening for inclusive multi-stakeholder decision-making. On the community side, Key Affected Population (KAP) Platform will ensue community based monitoring of the grant. the LFA shall act within the Terms of Reference agreed upon with the Global Fund, undertaking, among other, on-site project performance verifications (OSV). External audits evaluating grants’ programmatic and financial performance are an integral part of the proposed management arrangements.  The direct beneficiaries of the TB/HIV consolidated grant will be:   * key populations affected by the TB and HIV diseases * National TB and HIV Control Programs managed by the MoHLSP and operated under the auspices of the IFP (Institute of Phtizioppneumology/IPP “Ch. Draganiuc”) and SDMC (Dermatology and Communicable Diseases Hospital/DCDH)   The PR will be responsible for all overall the project implementation, procurement of equipment, commodities and reagents, medical drugs and services, financial management, project-related monitoring and evaluation and reporting to the Global Fund, will develop work plans for project implementation and will present project performance reports to the CCM. Financial and activity progress reports will be forwarded to the CCM members for review. The CCM through its oversight committee will continue to assess the effectiveness of activities implemented by the PR.  In programmatic terms, the overall grant management and implementation responsibilities shall be assumed by the PR CIMU, while the (modular) interventions shall be duly taken on following the arrangements described below:   |  |  | | --- | --- | | **Principal Recipient**  **PI CIMU HSP** | Program management  HIV Prevention MSM, PWID, TG, SW People in Prisons  Differentiated HIV Testing Services  Differentiated ART service delivery and HIV care  Counseling and psycho-social support  Treatment monitoring  Prevention and management of co-infections and co-morbidities  MDR-TB: Detection and diagnosis  MDR-TB: Treatment  TB care and prevention  RSSH health sector governance and planning  RSSH Integrated service delivery and quality improvement  RSSH Human resources for health, including community health workers  RSSH Health Management Information Systems and M&E  CSS / Community-based monitoring, Social mobilization, building community linkage and coordination  Reducing human rights-related barriers to HIV services | | **Sub-recipient**  **PAS Center** | MDR-TB: Key Populations  MDR-TB: Treatment  TB care and prevention  PMTCT  Differentiated ART service delivery and HIV care  RSSH health sector governance and planning  RSSH Integrated service delivery and quality improvement  RSSH Human resources for health, including community health workers  RSSH Health Management Information Systems and M&E  RSSH PSM  RSSH CSS / TB Community-based monitoring, Social mobilization, building community linkage and coordination  Reducing human rights-related barriers to TB services |   For a comprehensive outline of all beneficiaries, implementers and monitoring or overseeing stakeholders with assigned roles or responsibilities, see the attached Annex “Implementation Arrangements Map”. |

1. Describe the role that **community-based organizations** will play under the implementation arrangements.

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| The role of civil society organisation (CSOs) and particularly community-based organizations (CBOs) of key populations and PLHIV and people affected by TB is essential to support the national response to TB and HIV in Moldova. The active involvement of community-based organizations in the development process of both National TB/HIV Programs and the GF Funding Request has ensured that the needs and key services for communities and KPs are properly addressed and sustained within the course of the next three years. CSOs from both sides of the River Nistru represent over 40% of CCM membership. KAPs (PWIDs, MSM, SWs, inmates and homeless people) and Communities of people living with HIV/TB and comorbidities play an important role in designing, implementing and monitoring interventions to be supported through the 2021-2023 GF allocation.  The 2021-2023 grant activities are aligned with the prioritized country needs and based on the drafts of the National Plans for TB and HIV Control 2021-2025 and are aiming to partially or fully support important interventions needed by the KAPs and health systems, which cannot be yet fully taken over by the state budget. Moreover, one of the key axes of the newly drafted NAP is to support a vibrant community voice able to monitor the response and reduce human rights barriers.  CBOs will play multiple roles in grant implementation: (1) implementers (2) watchdog and advocates to ensure access to services and remove barriers, and (3) beneficiaries of capacity strengthening efforts.  HIV and TB community-based organizations will be key implementers of activities targeting key populations for HIV prevention and ARV/OST/TB treatment adherence services for PLWH/TB, PWID, SWs, MSM, prisoners, and vulnerable populations such as TGs, people who use non-injecting drugs, mobile-populations, community-based testing and self-testing to HIV in KAPs; behavior change interventions in PLWH/TB, PWID, SWs, MSM&TG, and inmates; treatment adherence and support for patients on ARV, OST and TB medical care. Building on the NAP intend to sustain and scale-up current services for KAPs and introduce innovative approaches, Moldova will use the 2021-2023 allocation to support services better tailored to KAPs needs: decentralized and closer to patients ART and TB treatment and care, as well as integrated HIV/TB/OST services; introducing innovative approaches to ART adherence in different populations; implementation of differentiated HIV testing services, including self-testing; scaling-up communitarian PrEP; initiated OST services on the left bank of the Nistru River; as well diversifying HRP through pharmacies and vending machines.  In TB component the funding request will support increased involvement of CSOs and CBOs in the following areas: active case finding and reaching key and vulnerable groups, in supporting patients complete their treatment and address their psychosocial and emotional needs, VOT scale-up activities, CSO engagement in NTP-led activities, social mobilization, building community linkage and coordination community-based monitoring and documenting and removing barriers.  As watchdog and advocates, CBOs have planned and included activities aiming at removing barriers, reducing stigma, monitoring rights-based approaches to aces to services, advocacy to increase sustainability of CSO-led program (social contracting and budget advocacy)  In all the above-mentioned interventions, KAPs and communities of people living with HIV, TB and other comorbidities/associated diseases will be both primary beneficiaries of community strengthening activities.  These implementing arrangements would help the country to sustain the gains from the current and previous allocations and improve the quality and deliveries of services targeting key populations and communities of people affected by communicable diseases. |

1. Is the Principal Recipient an **international institution** (for example, international NGO or UN agency)?

Yes  No

If **yes**, describe how the Principal Recipient’s responsibilities pertaining to the national disease response will eventually be **transferred to national entities**. Also, (i) outline the timeframe for transitioning these responsibilities, and (ii) explain how national capacities will be strengthened to lead the national disease response.

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| N/A |

1. Describe the **top three anticipated implementation risks** that might negatively affect: (i) the delivery of the program objectives supported by the Global Fund; and/or (ii) the broader health system. Then, describe the mitigation measures that address these risks.

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| **Key Implementation Risks** | **Corresponding Mitigation Measures** |
| Political instability, lack of political will to inclusively endorse the National TB&HIV Programs for 2021-2025, and another time-taking phase of central health reforms. | MoHLSP shall ensure that normative framework put in practice to regulate and guide attaining of objectives of the National Public Health Strategy, as well as provision of key services to KPs and maintaining the gains of GF funding, are sustained.  MoHLSP, will commit and ensure that any further/potential reform in the health sector will not negatively or largely affect the 2021-2023 implementation arrangements.  The MoHLSP, National TB and HIV Programs, and the PR will inform the GF Secretariat about the potential/if any process of reforms, associated effects, and interventions planned to mitigate negative affects/if any |
| Socio-economic instability, that might challenge committed funding for the implementation of National TB&HIV Programs for 2021-2025, as well as the co-funding commitments under the country allocation. | Based on the active Privileges and Immunities Agreement for the GF, ratified by the Parliament of the R. of Moldova, the MoHLSP will sign, under the 2021-2023 allocation, a binding Agreement with the GF on specific co-funding commitments, which shall be part of the Grant Agreement for country allocation. The binding agreement will be cosigned by the Ministry of Finance of Moldova.  MoHLSP and central authorities shall commit to make the prevention fund of the NHIC more predictable and engage with local public authorities to plan and implement TB/HIV response funding needed at the local level. |
| COVID-19 like emergencies that might put additional burden on TB/HIV response and hinder service provision in accordance with tree-year action plan | Strategically use the C19RM funding for Moldova to deliver the requested equipment and commodities requested by the National and regional/Transnistrian TB and HIV Programs, including needs of communities, KPs and CSOs to respond to the COVID-19 challenge over a period of 10 months.  MoHLSP will engage with bilateral partners and other donors to update and adjust the National COVID-19 Emergency Response Plan based on emerged challenges or realities |

1. Does the funding request envisage a **joint investment platform** with other institutions?

Yes  No

If **yes**, describe specific arrangements and modalities.

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| N/A |

# **Section 3: Co-Financing, Sustainability and Transition**

To respond to the questions below, refer to the *Instructions*, the domestic financing section of the allocation letter, the [Sustainability, Transition and Co-Financing Guidance Note](https://www.theglobalfund.org/media/5648/core_sustainabilityandtransition_guidancenote_en.pdf), **Funding Landscape Table(s)**, **Programmatic Gap Table(s)**, **Transition Workplan** and **Transition Readiness Assessment** (if available)[[67]](#footnote-68).

**3.1 Co-Financing**

1. Have **co-financing commitments** for the **current** allocation period been realized?

Yes  No

If **yes**, attach supporting documentation demonstrating the extent to which co-financing commitments have been met.

If **no**, explain why and outline the impact of this situation on the program.

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| For the current allocation, the 2018 co-financing commitments were met by the Republic of Moldova and the CCM has accordingly reported to the GF on that in October 2019. In accordance with the reporting deadlines, the 2019 country Report is to be submitted to the GF Secretariat in October 2020. (See attached the Annex 8 Country Report for 2018).  Thanks to joint efforts with the GF, Moldova succeeded to:  1) mobilize more national resources – from the Ministry of Justice and local authorities, including the de-facto structures in Tiraspol, channeled for the TB/HIV treatment/control which reached 100% of coverage of first line ARV treatment regimens in 2020;  2) update and implement national and regional HIV treatment protocols with transition to optimized and DTG-containing treatment regimens and adopt latest WHO recommended to accelerate transition to all-oral new DR TB treatment regimens;  3) introduce rapid HIV testing at the community level and maintain a high level of rapid molecular testing for all presumptive cases of TB at district level, in penitentiaries and ART Centers;  4) provide treatment support to all patients with MDR-TB through community centers, CSO-led community support to key populations 5) integrate the positions of social worker, psychologist and DOT supporter in phthysiopulmonogy service at district level 6) allocate resources and contract HIV prevention and services from the NHIC funds,  5) continue and scale-up innovative HIV prevention services (through pharmacies) and mobile clinics;  6) develop and rollout an electronic system, which monitors all HIV prevention and treatment adherence services funded by the GF and the NHIC.  National investments in health overall, and HIV and TB programs response specifically, have increased on a yearly basis, as planned. Moreover, measuring the actual investments in 2018-2019 of EUR 27.56 million against the co-funding commitment of EUR 26.46 million committed by the Government of Moldova under the 2018-2020 allocation. Thus, the Government of Moldova has honored its previous commitments and is on track to honor it for the 2020, despite challenging context related to Covid-19 pandemic.   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Program | Government co-financing overview (million EUR) | | | | | | | **Estimated** | | | **Actual** | | | |  | **2018** | **2019** | **2020** | **2018** | **2019** | **2020** | | HIV | 3.29 | 4.05 | 4.75 | 3.53 | 4.58 | 4.82 | | Tuberculosis | 10.02 | 10.2 | 10.34 | 9.37 | 8.98 | 10.19 | | Total | **13.31** | **14.25** | **15.09** | **12.9** | **13.56** | **15.02** |   Note: the budget for 2020 is the approved amount. In 2021 the actual will be reported  Our investments in the two diseases in the period 2018-2020 have been focused on:   * Procurement of all first-line antiretroviral drugs and first-line anti-TB drugs; * Purchase of second-line medicines and lab tests for monitoring ARV treatment (2018 - 50%; 2019 - 60%; 2020 – 70%); * Purchase pf the first-line ARV medicines for the Eastern region, of 30% in 2018, 60% in 2019, and 100% in 2020. * Purchase of second-line anti-TB medication is also increasing (2018 – 46%; 2019 - 50%; 2020 - 63%). * Social contracting for Provision of HIV preventive services In 2017 and 2018 as part of sustainability and transition, the National Health Insurance Company allocated equivalent of 100,000 and 77,000 euros to contract two HIV prevention grants per year, with a cumulative coverage of 1,148 PWID, 263 SW and 425 MSM (ref [[68]](#footnote-69)).   Like in previous allocations, Moldova and the GF can make use of several instruments to report and monitor the country co-financing commitments. In this respect, we are providing the Global Fund the following reports that are already public or are scheduled to be duly shared with the donor. They provide verifiable and reliable documentation and evidence on disbursement of domestic funds and or implementation of agreed upon activities:   * The 2018 Country Report on Co-funding Commitments, assumed by the MoHLSP and submitted to the GF by the CCM in October 2019. * The 2019 and 2020 Country Reports on Co-funding Commitments shall be submitted for GF consideration in October 2020 and, respectively, in October 2021. * The Moldova GAM Report for 2018, 2019. * For the TB response, the 2021-2023 Funding Request incorporates the development of an operational tool to track public expenditures in TB. |

1. Do **co-financing commitments** for the **next** allocation period meet minimum requirements to fully access the co-financing incentive?

Yes  No

If details on commitments are available, attach supporting documentation demonstrating the extent to which co-financing commitments have been made.

If co-financing commitments do not meet minimum requirements, explain why.

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| With due consideration of GF recommendations on co-funding commitments stated in the Allocation Letter, and based on steadily increasing trend of domestic investments in TB and HIV response during the current grant, Moldova can confirm the country qualifying to fully access the co-financing incentive.  (See the attached Annex 1 Co-funding commitments Form) |

1. Summarize the **programmatic areas** to be supported by domestic co-financing in the next allocation period. In particular:

i. The financing of key program costs of national disease plans and/or health systems;

ii. The planned uptake of interventions currently funded by the Global Fund.

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| The main system of health financing and coverage in Moldova is based on national compulsory health insurance, introduced in January 2004. The funding channeled through the national insurance scheme currently comprises 90% of the total public health spending and covers all health care institutions and interventions at central and local level. The central health budget, administered by the Ministry of Health, accounts for about 10% of public health spending and is used for funding of public health services (formerly sanitary-epidemiology services), several national programs and administration at central level. The contributions to health from local (rayon level) authorities, other than MOH central state bodies as well as that of private sources are not significant. While the HIV funding needs include Transnistria, the information on funding from Transnistria de facto authorities is not available and therefore was not included.  Under all NFM grants, the Republic of Moldova has committed and accordingly met the co-funding requirements agreed with the GF. The domestic funding has been gradually increased to support and ensure provision of key services to people affected by TB/HIV, including part of prevention services  Government’s investments for the next Global Fund allocation period (2020-2022) will be in line with the domestic financing requirements as per the FG allocation letter from December 16, 2019. More specifically, the country authorities commit to invest the available domestic resources in interventions targeting:   * up-taking all costs for ARV/syphilis treatment and TB drug sensitive treatment for people diagnosed, (including Transnistria), including PMTCT, baby nutrition for children born to HIV+ mothers aged 0-12 months and treatment and monitoring costs for patients initiating PrEP; * Provider initiated HIV testing * diagnostics, prevention and treatment of opportunistic/coinfections for during TB and HIV treatment; * Support to multidisciplinary teams as part of TB service at district level on the Right Bank   At the same time, authorities commit to:   * increase efforts and resources for HIV prevention in KPs; * increase funding for Harm Reduction and HIV&TB prevention programs in KPs, including inmates, and support treatment adherence to TB patients; * support “finding the positives” approaches on earlier testing * implement alternative prevention services for KPs, like HRP through pharmacies * partly cover SLD and diagnostics for TB patients. * consolidate program coordination through capacity building in program management * build capacity and improve joint management and coordination of HIV/TB/Hepatitis Programs * support capacity consolidation of (TB and) HIV reference laboratories * develop resilient systems contributing to earlier enrollment in ARV/TB treatment   **Co-Finance Commitment Letter is attached as Annex 1** |

**3.2 Sustainability and Transition**

1. Based on the analysis in the **Funding Landscape Table(s),** describe the funding need and anticipated funding, highlighting gaps for major program areas in the next allocation period.

Also, describe how (i)national authorities will work to secure additional funding or new sources of funding, and/or (ii)pursue efficiencies to ensure sufficient support for key interventions, particularly those currently funded by the Global Fund.

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| The two NSPs for the TB and HIV control in 2021-2025 and the integration service approach are budgeted to accordingly plan available funding from domestic resources, to estimate the gap of uncovered interventions, to coordinate and mobilize additional funding – all that needed to support and sustain key services for KPs while ensuring targeted and efficient implementation of funding.  The Funding Landscape Table provides a detailed breakdown of estimated funding planned locally and needed to be secured from alternative/additional sources, including the GF allocation for 2021-2023.  In accordance with the next 5-year NTP and the MDR-TB- Treatment targets, the state budget will cover the MDR-TB treatment on the Right bank of Moldova for adults by: 314 in 2021 including 11 in penitentiary sector (55% of the need), 357 - in 2022, including 13 in penitentiary sector (65% of the need), and 399 in 2023 including 14 in penitentiary sector (75% of the need).  TGF funding shall be used to contribute to adherence support services for key populations and problematic patients. The targets for which TGF partially contributes have been tied to the domestic resources.  The total number of MDR-TB patients to get treatment with TGF support:  - for children (right and left banks) - 24 in 2021, 23 in 2022 and 22 in 2023 (100% of needs)  - on the left bank (adults in civil sector and penitentiaries): 334 in 2021, 328 in 2022 and 324 in 2023 (100% of the need).  TGF also fully supports adherence support services for for key populations and problematic patients with TB (homeless, PAFA, others) and TB patients from left bank.  For the Programmatic Gap Table, the targets for which TGF partially contributes have been tied to the domestic resources.  For the HIV control, the targets set-up for prevention programs in key populations, including differentiated HIV testing services, shall be financially covered as follows:   * *Based on the estimated population of 17 100 MSM* (including 4100 from in Transnistria region), provision of preventive services for MSM in Moldova will be covered by state budget for 975 (25% of target) people in 2021, 1365 (30% of target) - in 2022 and 1820 (35% of target) in 2023 on the right bank of Nistru river. The total number of MSM to be fully covered with preventive services with TGF support include: 4,155 in 2021, 4,620 in 2022 and 5,020 in 2023. TGF shall contribute to preventive services with tests (for HIV, Hepatitis, STI, etc.) for 3,694 MSM in 2021, 4309 beneficiaries in 2022 covering all needs, and 1570 people in 2023 when TGF will cover only the need for Transnistria region (30% of all need). * Given the estimated population size of 36,9000 IDUs (including 10,800 - in Transnistria region), provision of preventive services for PWID in Moldova will be covered by state budget for 3020 (25%) people in civilian sector in 2021, 4540, including 554 PWID from prisons (30%) - in 2022 and 5906, including 832 PWID from prisons (35%) in 2023 on the right bank of Nistru river. The total number of PWID to be fully covered with preventive services with TGF support include: 16,816 (75% of national targets for right bank, 100% for Transnistria region and penitentiaries) in 2021; 17,002 (70% of national targets for right bank, 100% for Transnistria region and 80% of targets for penitentiaries) in 2022 and 17,343 (65% of national targets for right bank, 100% for Transnistria region and 70%of targets for penitentiaries) in 2023. TGF contributes to preventive services with tests (for HIV, Hepatitis, STI, etc.) for 10921 PWID in 2021, 12013 beneficiaries in 2022 covering all needs, and 4,177 people in 2023 when TGF will cover only the need for Transnistria region (30% of all need). * *From the total estimated population size of 21,300 CWs* (including 3500 in Transnistria region), provision of preventive services for SWs in Moldova will be covered by state budget for 1780 (25%) people in 2021, 2403 (30%) - in 2022 and 3115 (35%) in 2023 on the right bank of Nistru river. The total number of SW to be fully covered with preventive services with TGF support include: 6,740 (75% of national targets for right bank and 100% for Transnistria region) in 2021, 7,182 (70% of national targets for right bank and 100% for Transnistria region) in 2022 and 7,535 (65% of national targets for right bank and 100% for Transnistria region) in 2023. TGF contributes to preventive services with tests (for HIV, Hepatitis, STI, etc.). TGF will contribute to preventive services with tests (for HIV, Hepatitis, STI, etc.) for 5453 SWs in 2021, 6134 beneficiaries in 2022 covering all needs, and 2172 people in 2023 when TGF will cover only the need for Transnistria region (30% of all need)   In an effort to minimize the impact of the funding gap, the national authorities are strategically working to mobilize resources from regional budgets, while also planning some interventions under the PAAR mechanism.  TO UPDATE BASED ON FINAL BUDGETS OF NSP TB AND HIV |

1. Highlight **challenges** related to sustainability (see indicative list in the *Instructions*). Explain how these challenges will be addressed either through this funding request or other sources. If already described in the national strategy, sustainability and/or transition plan, and/or other documentation submitted with the funding request, refer to relevant sections of those documents.

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| [Applicant response]  WORK IN PROGRESS |

1. If you have developed and implemented a transition workplan in the current allocation cycle, provide a status **update** as to what has been achieved.

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| The National HIV and TB Programs for the years 2016-2020 were approved with a considerable, cca 45% deficit estimated for the implementation of programed objectives and interventions. Part of that funding shortage is covered from external sources, especially from FG grants.  In order to respond to regulatory and financial constraints, as well as resource deficits, coordination, and programmatic challenges, the TB and HIV stakeholders developed in a nation-wide and inclusive country dialogue and the CCM endorsed, on March 15, 2017, a Sustainability Plan per each five-year NSP. The Sustainability Plans include those activities, which at the time of elaboration were financed from external sources. Both plans were developed taking into account the conclusions and recommendations of the Transition Readiness Assessment conducted in 2016.  The TB and HIV Sustainability Plans objectives are aligned to the NSPs 2016-2020 and target the following key pillars:   1. Strengthen policies, practices and capacities to ensure effective control of tuberculosis for sustainable implementation. 2. Ensuring the sustainability of universal access to quality prevention, diagnosis and treatment services and the application of patient-centered strategic interventions. 3. Improving policies, practices, capacities to ensure the sustainability of each NAP objective. 4. Budget arrangements to ensure transition of HIV/STIs services from external to national sources for each program objective.   In accordance with the defined objectives, the government and non-state implementers of the sustainability plans succeeded in carrying an important number of key activities aiming to mitigate the funding shortages of the TB and HIV NSPs.  In 2019, in an effort to better monitor the implementation of the two Sustainability plans, the Soros Foundation Moldova funded an assessment of the two plans.  The assessment reports highlight specific conclusions and recommendations per each program objective. Thus, the Assessment Report on implementation of the TB Sustainability Plan concludes that interventions under the two objectives were implemented in proportion of cca 25%, worth noting here that a bulk of activities are under implemented in 2020. On the other hand, the interventions planned under the HIV Plan are implemented as following: the 1st objective- in proportion of 75%; objective 2 – 50%; objective 3 – 37%.  The two Assessment Reports recommend among others:   * Revision of two sustainability plans based on current situation and update the program priorities; * revision of costs for activities included in the Sustainability Plan in accordance with national legislation; * approval of sustainability plan for internal financing and its endorsement by the Government of the Republic of Moldova; * establishment of a system for monitoring for the implementation of the sustainability plan; * development of a national health account for the "Tuberculosis" component; * implementation of a mechanism for redirecting the funds released as a result of optimizing the number of tuberculosis beds to the development of outpatient treatment; * review of the social contracting regulations and development of a mechanism for the financial accountability of the NHIC on contracting NGO services, as well as identification of alternative funding pools for contracting prevention and treatment support services; * allocation of adequate budgetary funds to support the activity of the PNCT Coordination Department and the continuation of M&E; * development of national guidelines for the introduction of a person-centered TB care model; * development and implementation of the integrated services approach (HIV/TB/OST).   In line with sustainability ends, the Republic of Moldova has been piloting and further institutionalizing best practices aiming at sustaining quality and beneficiary-centered TB and HIV services. One of such examples is contracting from NHIC funds HIV Prevention and TB/HIV/OST treatment adherence services provided by CSOs. Within the 2018-2020 period, the NHIC has been funding HIV preventive services to a total of 4704 beneficiaries from KAPs and TB treatment support for 9655 patients. That practice, despite not being yet fully predictable or systematic on a long-term basis, is considered an icebreaker and is recognized at WHO European region as a good practice that has to be strengthened and continued. <https://www.euro.who.int/en/publications/abstracts/compendium-of-good-practices-in-the-health-sector-response-to-hiv-in-the-who-european-region>.  Another important example is represented by the endeavor and the success of local authorities in up-taking full costs for first line TB drugs, and first line ARV drugs. This case is even more weighty if to mention that the central authorities of Moldova succeeded in adopting and making operational a funding mechanism, which sustains procurement of ARV drugs from local funds for the entire territory of Moldova. Thus, in accordance with the Decision of the Government of Moldova, HG869[[69]](#footnote-70) from 05.09.18, the Hospital for Dermatology and Communicable Diseases is allowed to provide the AIDS Center in Tiraspol with antiretroviral drugs and diagnostic devices for screening and diagnosis of HIV/AIDS and STIs and monitoring the effectiveness of antiretroviral treatment, against the full payment of costs for the purchased goods, as well as the payment of the overheads in volume of 5% of the cost of the goods, regardless of their origin.  The findings and recommendations of the Sustainability Plan Reports as well as the best practices are being considered by the field stakeholders in the process of development and implementation of the NSPs for 2021-2025, which will integrate the sustainability plan objectives and drives. |

# **Annex 1: Documents Checklist**

Use the list below to verify the completeness of your application package:

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|  | Funding Request Form |
|  | Programmatic Gap Table(s) |
|  | Funding Landscape Table(s) |
|  | Performance Framework |
|  | Budget |
|  | Prioritized above allocation request (PAAR) |
|  | Implementation Arrangement Map(s)[[70]](#footnote-71) |
|  | Essential Data Tables (updated) |
|  | CCM Endorsement of Funding Request (Template is available on the website.) |
|  | CCM Statement of Compliance Template is available on the website. |
|  | Supporting documentation to confirm meeting co-financing requirements for the current allocation period |
|  | Supporting documentation for co-financing commitments for the next allocation period |
|  | Transition Workplan (if available) |
|  | Transition Readiness Assessment (if available) |
|  | National Strategic Plans (Health Sector and Disease specific) |
| ☐ | All supporting documentation referenced in the funding request |
|  | Health Product Management Template (if applicable) |
|  | List of Abbreviations and Annexes |

1. PAARs can only be submitted with the Funding Request. To complete a PAAR, fill-in the Excel template that you will receive from the Global Fund Secretariat. [↑](#footnote-ref-2)
2. This is only relevant for applicants with designated matching funds as indicated in the allocation letter. [↑](#footnote-ref-3)
3. The World Bank, [http://data.worldbank.org/country/](http://data.worldbank.org/country/kazakhstan)moldova; Atlas method, in current US dollars. [↑](#footnote-ref-4)
4. Republic of Moldova official site. <https://moldova.md/en/content/administrative-territorial-organization-moldova> [↑](#footnote-ref-5)
5. UNDP.Human Development Report Moldova 2019. Preliminary data. [↑](#footnote-ref-6)
6. National Bureau of Statistics database: <https://statbank.statistica.md/pxweb/pxweb/ro/20%20Populatia%20si%20procesele%20demografice/20%20Populatia%20si%20procesele%20demografice__POPrec__POP010/POP010100rcl.px/table/tableViewLayout1/?rxid=b2ff27d7-0b96-43c9-934b-42e1a2a9a774> [↑](#footnote-ref-7)
7. 2015 Census in Transnistria. [↑](#footnote-ref-8)
8. [↑](#footnote-ref-9)
9. World Bank. Moldova economic update Spring 2020. <https://www.worldbank.org/en/country/moldova/brief/moldova-economic-update> [↑](#footnote-ref-10)
10. Tuberculosis surveillance and monitoring in Europe, 2019 (2017 data), Joint ECDC and WHO Report, 2019 [↑](#footnote-ref-11)
11. <https://statistica.gov.md/category.php?l=en&idc=103&> [↑](#footnote-ref-12)
12. GLC mission report 2019. [↑](#footnote-ref-13)
13. Presentation: Barbuć R. Aspects of Collaboration in Tuberculosis Control in Bălţi municipality, Clinic Hospital Balti,

    03/22/2019 [↑](#footnote-ref-14)
14. NTCP data. [↑](#footnote-ref-15)
15. Rucşineanu O. et al. Advocacy strategy for the transition to outpatient treatment of tuberculosis: Republic of Moldova 2016-2018. Bălţi : S. n., 2018 [↑](#footnote-ref-16)
16. Burnet Institute et al (2018) Optimizing Investment in Moldova’s TB Response. <http://optimamodel.com/pubs/Moldova%202018.pdf> [↑](#footnote-ref-17)
17. NTCP data 2020. [↑](#footnote-ref-18)
18. ## TB REP: Country case on advancinf people-centred care in Moldova <http://pas.md/en/PAS/Studies/Details/114>

    [↑](#footnote-ref-19)
19. Technical assistance for development of sustainable financing models for TB control, allocation mechanism, and provider payment mechanisms for TB care in different care settings in the Republic of Moldova.<http://pas.md/en/PAS/Studies/Details/172?fbclid=IwAR1kOhSXdOnX1q4LJLS3UOBuAs436Km-6ddI2CPjdxRGakPSAtROgjwu65s> [↑](#footnote-ref-20)
20. NTCP. People-Centered Model of TB Care draft. [↑](#footnote-ref-21)
21. National clinical protocol for TB in Adults and Children <http://simetb.ifp.md/Download/oficial_docs/Ordin_MS_2020_05_05_nr_440_441-aprobare-protocoale.pdf>

    <http://simetb.ifp.md/Download/oficial_docs/PCN-55-2020-Tuberculoza_la_copil.pdf>

    <http://simetb.ifp.md/Download/oficial_docs/PCN-123-2020-Tuberculoza_la_adult.pdf> [↑](#footnote-ref-22)
22. WHO global TB database 2018 [↑](#footnote-ref-23)
23. <http://old2.ms.gov.md/sites/default/files/legislatie/ordin_nr._1080_din_13.10.2014_cu_privire_la_masurile_de_eficientizare_a_depistarii_tuberculozei.pdf>; [http://old2.ms.gov.md/sites/default/files/legislatie/ord.\_411\_din\_31.05.2017\_modificarea 1080 depistarea\_tbc.pdf](http://old2.ms.gov.md/sites/default/files/legislatie/ord._411_din_31.05.2017_modificarea%201080%20depistarea_tbc.pdf) [↑](#footnote-ref-24)
24. The NTP 2019 data [↑](#footnote-ref-25)
25. WHO (2019). Compendium of good practices in the implementation of the TB Action Plan for the European Region 2016-2020. Republic of Moldova. Joint effort of state and civil society actors in the early detection of active TB among contacts and high-risk groups (p.9) <https://apps.who.int/iris/bitstream/handle/10665/311065/9789289053983-eng.pdf?sequence=1&isAllowed=y> [↑](#footnote-ref-26)
26. Ministry of Justice Department of Penitentiary Instiutions, annual reporting data 2019. [↑](#footnote-ref-27)
27. Matteelli A (2018) Technical Assistance for Strengthening the framework of TB/HIV collaborative activities in Moldova. <http://pas.md/en/PAS/Studies/Details/173?fbclid=IwAR08GRlq3BcWIDZalwj8JWuEGYtocqsr_nNaHYcPgw1RRUaVcLI95alJ39U> [↑](#footnote-ref-28)
28. Chart audit of cased with TB/HIV coinfection 2014<http://pas.md/en/PAS/Studies/Details/27> [↑](#footnote-ref-29)
29. Recommendations of the 2017 Evaluation Report of NGO grants for TB services in Moldova (Annex 9 p. 5) [↑](#footnote-ref-30)
30. WHO (2018). Compendium of Good Practices in the health sector response to HIV in the European Region ( p.95) <https://www.euro.who.int/en/publications/abstracts/compendium-of-good-practices-in-the-health-sector-response-to-hiv-in-the-who-european-region> [↑](#footnote-ref-31)
31. Assessment of capacity building needs of NGOs working with key populations and healthcare providers in the Republic of Moldova <http://www.pas.md/en/PAS/Studies/Details/121> [↑](#footnote-ref-32)
32. Until 2019 a client was validated by a single visit / contact during the year with the provision of three main services per year. Starting 2019, the criteria expanded to include at least 6 visits per year with the provision of a basic package of services (exchange of syringes + alcohol wipe, condom, information material). [↑](#footnote-ref-33)
33. HIT Moldova 2012: <https://www.euro.who.int/__data/assets/pdf_file/0006/178053/HiT-Moldova.pdf?ua=1> [↑](#footnote-ref-34)
34. National Public Health Strategy 2014-2020, the Government Decision No. 1032, December 20, 2013, <https://ansp.md/wp-content/uploads/2014/07/strategia-HG1032RUS.pdf> [↑](#footnote-ref-35)
35. National Development Strategy “Moldova 2030”, submitted to the Government and Parliament of the Republic of Moldova for approval, <https://gov.md/sites/default/files/document/attachments/intr40_12_0.pdf> [↑](#footnote-ref-36)
36. National Bureau of Statistics. [↑](#footnote-ref-37)
37. WHO Health for all databse:  <https://gateway.euro.who.int/ru/indicators/hfa_569-6720-total-health-expenditure-ppp-per-capita-who-estimates/visualizations/#id=19664&tab=table> [↑](#footnote-ref-38)
38. WHO, PAS Center (2015). Barriers and facilitating factors in access to health services in the Republic of Moldova. <https://www.euro.who.int/__data/assets/pdf_file/0018/183510/e96775-final.pdf> [↑](#footnote-ref-39)
39. Vian et al (2015) Barriers to universal health coverage in Republic of Moldova: a policy analysis of forma and informal out-of-pocket payments. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4531477/> [↑](#footnote-ref-40)
40. Moldova: Overview of corruption and anti-corruption, a focus on the healthcare and procurement sectors, 2017 [↑](#footnote-ref-41)
41. Focused Country Evaluations, Moldova TB Evaluation, APMG, 2020 (Annex 4) [↑](#footnote-ref-42)
42. Leimane I (2017). Health Workforce for Tuberculosis treatment and support in the Republic of Moldova. <http://pas.md/en/PAS/Studies/Details/171> [↑](#footnote-ref-43)
43. WHO (2018) Compendium of good practices in the health sector response to HIV in the European region. <https://www.euro.who.int/en/publications/abstracts/compendium-of-good-practices-in-the-health-sector-response-to-hiv-in-the-who-european-region> [↑](#footnote-ref-44)
44. Cioban A an Birnat A (2017). Tuberculosis in Moldova: knowledge attitudes and practices in general population and key affected populations. <http://www.pas.md/en/PAS/Studies/Details/79> [↑](#footnote-ref-45)
45. UN Moldova (2018) The People Living with HIV Stigma Index <https://www.stigmaindex.org/country-report/moldova/> [↑](#footnote-ref-46)
46. Moldova Social Cohesion and Reconciliaion Index. <https://www.scoreforpeace.org/en/moldova/2018-General%20population-0> [↑](#footnote-ref-47)
47. <http://md.one.un.org/content/unct/moldova/en/home/publications/joint-publications/perceptions-of-human-rights-in-the-republic-of-moldova/> [↑](#footnote-ref-48)
48. <https://moldova.unwomen.org/en/biblioteca-digitala/publicatii/2016/01/report-on-costing-of-domestic-violence-and-violence-against-women-in-moldova> [↑](#footnote-ref-49)
49. <http://optimamodel.com/pubs/Moldova_2020.pdf> [↑](#footnote-ref-50)
50. <http://optimamodel.com/pubs/Moldova%202018.pdf> [↑](#footnote-ref-51)
51. STP’s Paradigm Shift: Global Plan to End TB 2018-2022 (page 57) <http://www.stoptb.org/assets/documents/global/plan/GPR_2018-2022_Digital.pdf> [↑](#footnote-ref-52)
52. Jenkins etc al (2013) Assessing spatial heterogeneity of MDR-TB in a high burden country. [Eur Respir J. 2013 Nov; 42(5):](https://www.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&retmode=ref&cmd=prlinks&id=23100496)  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3800490/ [↑](#footnote-ref-53)
53. Research in progress, no publication yet. [↑](#footnote-ref-54)
54. Jenkins etc al (2013) [↑](#footnote-ref-55)
55. [Vesga](https://www.ncbi.nlm.nih.gov/pubmed/?term=Vesga%20JF%5bAuthor%5d&cauthor=true&cauthor_uid=30904521) et al. M **Assessing tuberculosis control priorities in high-burden settings: a modelling approach.** [Lancet Glob Health.](https://www.ncbi.nlm.nih.gov/pubmed/30904521) 2019

    Reid, MJA et al (2019). Building a tuberculosis-free world: The *Lancet* Commission on tuberculosis [↑](#footnote-ref-56)
56. WHO (2019). Assessment of collaborations between TB HIV and viral hepatitis services of Republic of Moldova. Country mission report. Draft. [↑](#footnote-ref-57)
57. Godwin (2015) TB/HIV&AIDS Consultancy Report. Assessment of the National TB and HIV/AIDS&STIs Programme’s management and scenarios aimed at improving overall NPs management, governance and control in Moldova. [↑](#footnote-ref-58)
58. Multisectoral accountability framework to accelerate progress to end tuberculosis by 2030 [↑](#footnote-ref-59)
59. A people-centered Model of TB Care, Blueprint for EECA countries, first edition, 2017 [↑](#footnote-ref-60)
60. TB NSP 2016-2020 [↑](#footnote-ref-61)
61. Roadmap for the modernization of the phthisiopneumology service, The MOHSP order No. 305 of 04/14/2011 [↑](#footnote-ref-62)
62. TB REP Moldova 2018 [↑](#footnote-ref-63)
63. A National Guide to a People-Centered Model of TB Care [↑](#footnote-ref-64)
64. Study “Perception of human rights in the Republic of Moldova”, People’s Advocate Office and the Office of the United Nations High Commissioner for Human Rights (OHCHR), in consultation with the United Nations Development Program (UNDP) Moldova, Chisinau, 2016 <https://tbinternet.ohchr.org/Treaties/CRC/Shared%20Documents/MDA/INT_CRC_IFS_MDA_26438_E.pdf> [↑](#footnote-ref-65)
65. SCORE – Social Cohesion and Reconciliation Study, UN Moldova, 2018, <https://www.scoreforpeace.org/en/moldova/2018-General%20population-0> [↑](#footnote-ref-66)
66. An updated implementation arrangement map is mandatory if the program is continuing with the same PR(s). In cases where the PR is changing, the implementation arrangement map may be submitted at the grant-making stage. [↑](#footnote-ref-67)
67. Note that information derived from the supporting documentation provided in response to the questions below, including information on funding landscape or domestic commitments, may be made publicly available by the Global Fund. [↑](#footnote-ref-68)
68. WHO (2018). Compendium of Good Practices in the health sector response to HIV in the European Region ( p.95) <https://www.euro.who.int/en/publications/abstracts/compendium-of-good-practices-in-the-health-sector-response-to-hiv-in-the-who-european-region> [↑](#footnote-ref-69)
69. <https://www.legis.md/cautare/getResults?doc_id=111740&lang=ro> [↑](#footnote-ref-70)
70. An updated implementation arrangement map is mandatory if the program is continuing with the same PR(s). In cases where the PR is changing, the implementation arrangement map may be submitted at the grant-making stage. [↑](#footnote-ref-71)