Ministerul Sănătății, Muncii și Protecției Sociale al Republicii Moldova

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Assessment of capacity building needs of NGOs working with Key Populations and healthcare providers in the Republic of Moldova

ASSESSMENT REPORT

Assessment of capacity building needs of NGOs working with Key Populations and healthcare providers in the Republic of Moldova

Assessment Report

Prepared by
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The assessment was conducted in the framework
of Joint UN Plan on AIDS

2018

The assessment of capacity building needs of NGOs working with key populations and healthcare providers in Moldova was conducted under the coordination of the Ministry of Health, Labor and Social Protection, in the framework of Joint UN Plan on AIDS, based on the UBRAF Funds, in the framework of the partnership between UNAIDS, UNFPA and UNFPA Implementing Partner, Center for Health Policies and Studies (PAS Center).

This document does not necessarily represent the view of UNFPA, the United Nations Population Fund, the UNAIDS, Joint United Nations Programme on HIV/AIDS, or any other affiliated organization.

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Acronyms and Abbreviations

AIDS	Acquired immunodeficiency syndrome
ARV	Anti retroviral treatment
CNAM	National Health Insurance Company
CSO	Civil Society Organizations
FSW	Female sex workers
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HTC	HIV Testing and Counseling
IBBS	Integrated bio-behavioural surveillance
KP	Key Population
M & E	Monitoring and evaluation
MoHLSP	Ministry of Health Labor and Social Protection
MSM	Men who have sex with men
NAP	National AIDS Program
NCC	National Coordination Council
NCU	National Coordination Unit
NGO	Non-Governmental Organization
OST	Opioid substitution treatment
PAS	Center for Health Policies and Studies
PLHA	People Living with HIV/AIDS
PWUD	People Who Use Drugs
PR	Principle Recipient
SDMC	Dermatological and Communicable Diseases Hospital
STI	Sexually Transmitted Infections
TG	Transgender people
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary counseling and testing

Contents:

Introduction

Assessment of capacity building needs of NGOs working with Key Populations and relevant healthcare providers was conducted by an external consultant commissioned by UNFPA Moldova and aimed at identifying major barriers for attracting key populations to the NGO and relevant healthcare providers in Moldova. The assessment was conducted in the framework of the Joint UN Plan on AIDS (UBRAF 2018 – 2019).

Main objectives of the assessment were:

- Assess factors that influence key populations' access and referral to HIV prevention services;
- Assess organizations' working approaches with key populations on HIV prevention;
- Elaborate recommendations for increasing program coverage

Methodology

Assessment methodology included utilization of various methods during visits to the non-governmental and state/municipal structures working on HIV prevention with the Key Populations:

- Individual interviews and focus-group discussions with key informants (program and administrative staff, beneficiaries);
- Desk review of policy and regulatory documents;
- Revision of existing reports and secondary data

Consultant's approach intended to guarantee high level of participation from all major stakeholders, therefore some ethical issues, such as confidentiality and voluntary participation were taken into consideration.

Qualitative research was conducted among the following KP groups:

Type of interview	Number of interviewees
Focus groups: Representatives of FSWs	9
Focus groups: Representatives of PWUD	14
Focus groups: Representatives of MSM	8

During the assessment the following organizations were visited and interviews were taken with their following representatives:

- Ministry of Health, Labor and Social Protection: Tatiana Zatic, Head of Department of Primary, Emergency and Community Health Care

Policies; Daniela Demiscan, Head of Public Health Policies Department;

- Youth Friendly Health Center, CMF No.2, Botanica Territorial Medical Association: Georgeta Gavrilita, Deputy Director Botanica TUA, Veronica Cumpana director of Youth Friendly Health Center, and staff of the YFHC;
- Coordination, Implementation and Monitoring Unit for Health Projects (UCIMP) (principal recipient of GF for HIV program): Victor Volovei, Consolidated Grant Manager; Angela Alexeiciuc, HIV M&E specialist;
- ATIS, Youth-Friendly Health Center: Lina Osoianu, Director of Center, psychologist, volunteer, beneficiaies;
- NGO Youth for the Right to Live (work with PWUD and SW): Corina Popa, program coordinator, Aliona Ciobanu, program coordinator and outreach workers, beneficiaries;
- IC GenderdocM (work with MSM): Veaceslav Mulear, Health Program Coordinator; Natalia Esmanciuc, Health Program Assistant;
- NGO PPV (For Present and Future) (work with PWUD): Nina Tudoreanu, Director; Ecaterina Iovu, outreach coordinator, Lilia Todirascu, psychologist;
- NGO AFI (Act For Involvment) (work with SW): Liliana Severin, Director; Sergiu Cugut, Program Coordinator;
- Center for Reproductive Health and Medical Genetics, Mother and Child Institute: Dr. Victoria Ciubotaru, gynecologist, scientific researcher and Dr. Mihail Stratila, Head of Center for Reproductive Health and Medical Genetics and deputy director of Mother and Child Institute;
- Municipal Hospital of Tiraspol, AIDS Center: Alexandru Goncear, Director of AIDS Center, Tatiana Alexeenco, Infectious Disease Doctor;
- NGO Zdorovoe Buduschee: Sandu Roman, director;
- NGO Trinity: Irina Galacenco, director;
- Coordination Unit of the National HIV / AIDS / STI Prevention and Control Program, Hospital of Dermatology and Communicable Diseases: Iurie Climasevschi, Program Coordinator, Maia Ribacova, Prevention coordinator;
- Buiucani Territorial Medical Association: Golovaci Marina, Deputy Director responsible for Mother and Child Assistance and other specialists from Primary Health Center as gynecologists, reproductive health specialist, family doctors;
- NGO Initiativa Pozitiva (work with PWUD, PLHIV, SW, MSM, prisoners), Ruslan Poverga, director;
- UNAIDS, Svetlana Plamadeala, Country manager, UNAIDS Moldova;
- UNFPA, Eugenia Berzan, Program Analyst on sexual and reproductive health;
- PAS Center: Lucia Pirtina, Program Coordinator, Sabina Taralunga, M&E specialist.

Interviews made by Skype call:

- Vitali Rabinciuc, Community Centre of Psychological Support for Drug Users "PULS";
- Vitalie Slobozian, Harm Reduction Program Coordinator at Soros Foundation- Moldova.

Interviews included the following thematic topics:

Basic principles of efficiency:

- Relevance of the programs to the needs and interests of the community; Involvement of the community.
- Relevance and correspondence of the services to the local epidemiological situation and other specifics of the context.
- Existence of effective mechanisms for reaching the target audience (outreach etc).
- Case management: comprehensiveness and continuity in managing the client and ensuring access to services (comprehensive approach to responding to client needs).
- Case management: integration of services (e.g. mechanisms of leading the client to HIV treatment) and effective mechanisms of referral.
    - Building partnership with other service providers;
    - Promotion of the program (advocacy) and cooperation with other stakeholders;
- Segmentation of the target group and adjusting services offered to each of the subgroups considering their specific needs and other characteristics. Correspondence of strategies and offered services to specifics and needs of the main epidemiologically important segments (subgroups) of the target community.
- Needs assessment and forming the demand/services' marketing, including segmentation of the target group and elaboration of the appropriate strategies and services combinations for each important segment (as applied to each component of the necessary services' package).

Services:

- The package of basic services and their appropriateness to the basic needs of beneficiaries;
- Additional services, aimed at attracting and maintaining clients, covering additional need.

Main qualitative indicators:

- Existence of national and internal (institutional) guidelines, protocols, instructions, their correspondence with the international approaches and their use in practice;

- System of services' quality monitoring (in the organization);
- System of data generation and analysis (in the organization);
- Partnership and building relationship with different organizations;
- Qualification of the personnel.

External factors:

- Legislation and policy. Legal barriers and contributing factors.
- Stigmatization and discrimination. Barriers and contributing factors.
- Empowerment of the local communities. Barriers and contributing factors.
- Violence. Barriers and contributing factors.

The following program and administrative staff of NGOs and state/municipal organizations took part in the interviews and group discussions: directors and financial personnel of the organizations, project managers, consultants, social workers, outreach workers, medical doctors, and psychologists. During the outreach and at the offices of service providers several interviews with the project beneficiaries (MSM, FSWs, PWUD) were conducted. Important information was collected from health policy makers and program coordination structures (Ministry of Health Labor and Social Protection, Principal Recipient of the Global Fund program, Coordination Unit of the National HIV / AIDS / STI Prevention and Control Program).

Two types of instruments were used during the assessment: a) Non-governmental organizations were offered to fill out a structured questionnaire (see Annex 1). Data collected through this instrument helped to identify major barriers for attracting beneficiaries to the NGO and specific medical services. b) Semi-structured questionnaire was used during interviews and focus group discussions.

All interviews and focus group discussions were conducted in Russian language. The participant organizations selected personnel for the interviews and focus groups on their own, based on personnel's involvement in the prevention projects. Identification of the participants is not possible due to confidentiality reasons. During interviews and discussions, the consultant took verbal informed consent from the respondents in order to guarantee their voluntary participation. The assessment was conducted in the period of 24 May - 12 June, 2018. Major findings and recommendations of the assessment are based on the analysis of received information and collected data.

Background

Country Information

Republic of Moldova is a country located in the South-East Europe, bordering with Ukraine and Romania. Since August 27, 1991 it is an independent parliamentary republic. As a result of a conflict which took place in the 90s, the left bank of the river Dniester is not under factual control of the country. According to National Statistics Bureau, Moldova is one of the post-soviet countries with the highest population density (117 people/km2), population size (including left bank) is 4,2 mln; the biggest cities are Chisinau (population 820,500) and Balti (population 151,200). Moldova is divided administratively into 35 territorial units and 3 municipalities, and includes also region of the left bank (2 municipalities: Tiraspol and Bender)[1].

HIV in Moldova

Spread of HIV infection in Moldova represents one of the priority healthcare issues. Epidemic is concentrated among Key Populations, especially among People Who Inject Drugs. In 2016, along with other countries, Moldova took part in UN General Assembly, where the Political Declaration of Commitment to eliminate HIV/AIDS was signed. Moldova has joined new political declaration with ambitious goals, time-bound targets and actions that must be achieved by 2020 if the world is to get on the Fast-Track and end the AIDS epidemic by 2030, within the framework of the Sustainable Development Goals.

Statistical registration of HIV infection cases in Moldova started from 1987. The first national program of HIV and STI prevention was elaborated in 1995. Currently a national program for 2016-2020 is being implemented.

From 2003 the country starts receiving funding of The Global Fund to fights AIDS, Tuberculosis and Malaria, as well as funding of The World Bank. This helps to improve planning and implementation of the programs and gives Moldova possibility to roll out accessible services throughout the whole country. Due to this program the country response was activated, laboratory systems were strengthened, timely diagnostics and more accessible antiretroviral therapy were introduced.

In 2005 a coordination council for national prevention programs on HIV/AIDS,

1 http://www.statistica.md/index.php?l=en

STIs and Tuberculosis was created (National Coordination Council). This contributed to effectiveness of the national programs through management, monitoring and coordination of the grants provided by international organizations, and was in line with the targets formulated in the Millennium Development Goals.

UN Joint Team on HIV (Joint team) had played an important role in fighting HIV in Moldova. This team provided technical support to HIV program, contributed to inclusion of human rights and gender issues into the national measures against HIV and helped to create synergy between this and other programs.

Current (the last) national program (for 2016-2020) was approved in October 2016 and includes three main strategic directions[2]:

- Reduce transmission of HIV and STIs, especially among key populations;
- Ensure universal access to treatment, care and support related to HIV and STIs;
- Ensure effective management of the national program.

Compared to the previous program target of program indicators are higher and stem from the research conducted among the key populations (PWUDs, FSWs, MSM). Program planning is based on cost effectiveness analysis for optimization of the financial flows.

Main targets of the national program(2016-2020)[3]:

HIV-related death rate	<3% per 100,000
Deaths caused by HIV-associated tuberculosis	Decrease by 35%
Stabilize HIV prevalence in key populations	
People who inject drugs	< 10% in Chisinau; < 38% in Balti; < 30% Tiraspol
Sex workers	< 9% in Chisinau; < 18% Balti
Men who have sex with men	< 8% in Chisinau; < 12% in Balti
Prisoners	< 2%
Expansion of HIV testing:	
PWUD	60%
SW	60%
MSM	40%

2 http://aids.md/aids/index.php?cmd=item&id=1575

3 http://aids.md/aids/index.php?cmd=item&id=1575

Coverage of prevention services	
PWUD	60%
SW	60%
MSM	40%
Antiretroviral treatment coverage of people living with HIV	60%

These objectives are set in the context of the UNAIDS goals of 90-90-90 which aim by 2020 that 90% of all people living with HIV will know their HIV status; by 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and by 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

HIV Coordination structures

The Ministry of Health, Labor and Social Protectio – the main responsible structure for coordination of healthcare policy, implementation and coordination of country response to HIV. However, some functions in management and coordination of HIV program are attributed to other structures. This creates a functional unified system. There are structures on the national level which coordinate and monitor implementation of the HIV program in the country. These structures are responsible for program and cost-effectiveness of the existing program. These structures are as follows:

National Coordination Council (NCC): This council, as mentioned above, coordinates TB and HIV programs in the country. It is an inter-agency structure, which includes representatives of the state, non-governmental and international organizations. NCC is a decision-making body, presided by the Minister of Health, Labor and Social Protection. This structure provides important platform, which gives possibility to the affected and community organizations, as well as organizations that work with the key populations, to voice their concerns and participate in the planning and coordination of the programs on the highest leve.

Dermatological and Communicable Diseases Hospital (SDMC): This is a national institution, which provides medical services of HIV/AIDS treatment. SDMC is one of the stakeholders of HIV program implementation. On its basis, as a result of an order of the Ministry of Health, Labor and Social Protection, a **National Coordination Unit** (NCU) was formed, which is responsible for managing, coordinating and implementing the national HIV and STI response and conducts monitoring and evaluation of the national

program. Representatives of the NCU periodically conduct consultations for assessing the progress of the national program and elaborating of the response plans. Non-governmental organizations are also involved in this processs.

UCIMP: A Coordination, Implementation and Monitoring Unit for Health Projects under the Ministry of Health, Labor and Social Protection is a state agency. Since 2018 this structure is the only primary recipient of The Global Fund funding for HIV. The organization's main function is realization of The Global Fund supported activities in the country, purchasing services from NGOs, procurement of medicines and medical supplies, elaboration of the action plans and monitoring schemes of the program etc.

National Medical Insurance Company (CNAM): An autonomous legal entity, which conducts non-commercial activities of mandatory medical insurance. Main goals of the company are to organize and manage processes of the mandatory medical insurance, centralized pooling of founds and mechanisms for covering costs of universal medical insurance program, also, to control quality of the medical services and introduce regulatory basis in the field of medical insurance. This company purchases the health care services for people from health facilities for people. Considering gradual decrease of international funding for HIV Programs in Moldova, the company has to mobilize more resources and elaborate mechanisms for cost-effectiveness in order to maintain and improve the balance of the ongoing programs.

International organizations and local civil society non-governmental organizations have an important role in provision of technical support. These organizations oversee the ongoing processes and offer their expertise for achieving the best results (UNAIDS, UNFPA, UNDP, UNICEF, WHO, UNODC, Soros Foundation - Moldova, Center for Health Policies and Studies, Union of Harm Reduction Organizations, Positive Initiative, League of People Living with HIV in RM, etc.).

The existing legislative framework together with state structures and country policy serves the basic premise of sustainability of health systems and determines the overall well-being.

Legislative framework

Legislative framework is defined by normative regulatory package, which creates conditions for more efficient implementation of HIV programs, so that all interventions are effective and relevant services are accessible for wide range of population groups. Moldova shares and supports international legal approaches towards highest standards of human rights protection. The

following main laws and regulations are effective in the country[4]:

- Law on Health Protection (1995),
- Law on Reproductive Health (2012),
- Law on Migration (2003),
- Law on Combating Domestic Violence (2008),
- Law on Social Assistance (2008),
- Law on donors and blood transfusions (2009),
- Law on Equal Opportunities (2012),
- Law on AIDS Prevention and Control (2012).

It should be mentioned that HIV transmission is punishable by Moldova Criminal Code, which is a preventive measure for intentional transmission considering increased numbers of HIV in the country. However, such norms violate human rights of People Living with HIV and contributes to their marginalization.

According to current legislation, drug use is decriminalized in the country, still it represents administrative offense. This partially influences active involvement of drug users in harm reduction and other services.

Prostitution is also an administrative offense. However, pimping or providing territory to prostitution are criminal offenses.

Voluntary homosexual contacts are not punishable by the law.

Along with the legal normative documents, legislative framework includes also those regulatory documents, which regulate activities of fight with HIV and ensure their quality and unification.

Moldova has elaborated national standards and guidelines in the field of HIV/AIDS. These include various national standards and recommendations related to HIV services, such as standards of VCT, guidelines of HIV surveillance, guidelines for HIV treatment, care and support, national quality standards on HIV prevention services for key populations, etc. These documents represent the basis for work conducted by non-governmental, state health care facilities and public health centers, and provide possibility for monitoring and evaluation of the services.

Epidemiological situation

HIV prevalence in general population is 0.20%. Available data suggest the epidemic has transitioned from an early concentrated epidemic in which the highest rates of transmission were among PWUD to an advanced concentrated

4 http://www.law-moldova.com/eng/legislation_republic_moldova.html

one, in which onward transmission to sexual partners of PWUD and other key populations has become a source of new infections.

As of December 2017, there were 11887 persons diagnosed with HIV in the country. In 2017, 835 new HIV cases were registered. Out of these, 55.9% were males, 49.5% - urban population, 11.9% - young people (15-24 years of age). Estimated number of People Living with HIV is 15,000 (11,000 - 21,000).

Newly registered HIV cases in 2013-2017 (by years)[5]

Newly registered HIV cases (by years)					Total (starting from 1987)
2013	2014	2015	2016	2017	
714	833	817	832	835	11887

Average age of People Living with HIV is increasing gradually – in 2007 it was 31 and in 2017 – 36.5.

Proportion of cases by urban and rural population also changes with the time. In the cities, it begins to decrease: it was 69.2% in 2007 and in 2017 – 49.5%.

Despite the increasing trend of diagnosed HIV cases in 2012-2015 (from 29.3% to 44.6%), in 2017 this indicator has decreased and is 34.8%.

According to epidemiological data, the main route of transmission is heterosexual contact, which makes up to 81.09% of all new cases from 2017 year. In 5.69% of cases transmission happened through injecting drug use, in 5.01% - through homosexual contacts, in 1.59% - from mother to child, and in 6.61% the transmission route is unknown.

In 2017, 278 persons were diagnosed with AIDS (overall number of AIDS diagnosis is 3770, which makes up to 31.7% of all registered HIV cases in the country). Average period from HIV detection until AIDS diagnosis is 3 years.

Despite the indicator of enrollment in treatment has increased during the recent years, treatment adherence indicator has not increased. In 2017, adherence indicator was 83%, lower than in the previous year (84%). The highest indicator for adherence was achieved in 2010 (88%).

Proportion of persons in need of ARV therapy based on immunological, viral and clinical criteria has increased during the four years from 74.1% to 82.3%. Proportion of persons on ARV treatment is increasing (average 86,0%).

In 2017 62.3% of HIV infected persons was tested on viral suppression. Undetectable viral load was identified in 74.3% of the tested individuals.

5 Monitorizarea controlului infecției HIV în Republica Moldova, anul 2017

During the recent years the value of the incidence and prevalence indicators related to HIV have increased and in 2017 reached: incidence 20.7/100000 and prevalence 211/100000. However, in different regions of the country these indicators vary.

Spectrum-calculated prognosis of the epidemic

The prognosis with Spectrum was conducted in March-April of 2017, in order to provide analytical information for decision-making. Assessment and prognosis was done for the period of 2017-2022.

According to this analysis, in 2017-2022 HIV prevalence in the country will increase from 0.36% to 0.45%. Number of the new cases will go down to lower than 0.03%. Also, the indicator of mortality will decrease (from 19.1 to 10.2).

Prognosis of the epidemic (2017-2022)[6]

	2017	2018	2019	2020	2021	2022
HIV+ population	15133	15835	16422	17007	17581	18159
Prevalence %	0,36	0,38	0,40	0,42	0,44	0,45
New cases of HIV	1326	1339	1177	1164	1171	1171
Incidence %	0,03	0,03	0,03	0,03	0,03	0,03
Mortality among HIV+	576	498	450	454	460	458
AIDS mortality	490	406	350	346	343	333
AIDS mortality (%)	85,1	81,5	77,8	76,2	74,6	72,7

HIV program funding

It is estimated that costs for national measures against HIV epidemic in 2017 had increased with about 6.8 mln Moldovan lei compared to 2016, and has reached up to 156.8 mln lei, out of which state funding is 61 mln lei. International resources in 2017 were 95.8 mln lei (61.1%)[7] . Starting from 2018 international funding has decreased significantly and the state has gradually increased funding. This process meaningfully concerned the issue of working with the key populations. Funding of HIV prevention programs from the Global Fund to fight AIDS, TB and Malaria has decreased and quite big proportion of the financial gap was covered by the state funding. Still, the overall needed budget has not been maintained, which laid the ground for elaboration of the new mechanisms of more structured management of

6 Monitorizarea controlului infecției HIV în Republica Moldova, anul 2017.

7 Monitorizarea controlului infecției HIV în Republica Moldova, anul 2017

the program and effective control of the spending. As a result, the financing mechanism selected was funding per capita, which was based on the existing costing of the services and after calculating average amount was defined as 33 Euros (25 Euros on provided service in total and 8 Euros on procured materials). Under this new mechanism, project budgets of the organizations working with the key populations became totally dependent on their promises of reaching coverage indicators. The organization receives 25 Euros for services it will provide to one beneficiary. Since this approach was applied, the organizations started claiming high coverage and reaching other groups which were not their target groups before. During the interviews it was revealed that from 2018 several organizations started working with the groups that they did not have experience of working with before. At the same time, it shall be taken into consideration that key populations have different needs and services packages – basic, recommended and even more so expanded – are very differen.

System of mandatory medical insurance

In Moldova there is a law on mandatory medical insurance, which represents an autonomous system for financial protection of the population health, guaranteed by the state. This system is formed on the basis of solidarity principle, through insurance contributions. Mandatory medical insurance system provides all citizens of Moldova with equal possibilities for up-to-date and quality medical assistance.

The status of insured person in the mandatory health insurance system is obtained by categorizing one of the three categories[8]:

- Employees. The premium of mandatory health insurance per employee is calculated based on the percentage contribution from salary and other rewards. The active period of medical insurance is equivalent to the term of employment.
- Persons insured by the Government. There are 16 categories of persons insured by the state.
- Persons who purchase their own cover health insurance (self-employed people, such as agricultural workers, but not only). They pay in fixed amount. The medical policy is valid until 31 December of the year for which the mandatory health insurance premium was paid.

The insured person benefits from the full amount of healthcare provided in the Unique Program of Mandatory Health Insurance.

However, emergency medical services and services provided at the level of the

8 http://lex.justice.md/viewdoc.php?action=view&view=doc&id=311622&lang=2

family doctor are provided to all persons whether or not they have the status of the insured person. While specialized and high-performance medical services are available free of charge to people with insured status and if the service is included in the Unique Program of mandatory Health Insurance.

The state in total pays medical insurance of 16 groups, including persons who have a right to social assistance (according to the law on social assistance) and unemployed, which are registered in the citizens' employment territorial agencies, pregnant women. These provisions are important for representatives of the key populations.

Medical assistance, provided within the mandatory health insurance, is as follows:

- Emergency
- Primary
- Specialized outpatient
- Inpatient
- Highly specialized
- Home care.

HIV infection, AIDS, Tuberculosis, urogenital infections, etc. are included in the list of diseases, for which it is possible to directly refer to a particular medical specialist and receive specialized medical care. This is an important issue since it provides access to specific services for wide groups of population and decreases stigmatized, stereotypical attitudes towards infections such as HIV, Tuberculosis etc. It also contributes to identification of the new cases. Within the national program, medical personnel of the facilities have the right and are entitled to conduct VCT, including for the key populations' representatives. This became a prerequisite for cooperation between non-governmental organizations and medical services provider structures.

At the end of 2017, for the first time ever, based on the advocacy efforts and the financial mechanism developed with the support of NGO, UNAIDS and NAP, the first 2 harm reduction projects run by NGOs covering the most affected cities of Moldova – Chisinau and Balti were contracted by the National Health Insurance Company from Prophylaxis Fund. The total amount provided by NHIC is of 2 mln MDL to cover services for PWUD, SW and MSM. It is one of the most important steps towards the sustainability of HIV prevention and government accountability towards it.

Key populations

According to the Monitoring and Evaluation Plan of the national program the country has conducted integrated bio-behavioral surveillance surveys among

key populations. The main goal of these surveys was to assess behavioral and biological tendencies among key populations, behavior of which could affect development of the HIV epidemic. Prevention interventions among these populations were also assessed. The surveys were conducted using RDS methodology and the respondents were tested on HIV, hepatitis B and C and syphilis. The surveys geographical coverage was as follows: for PWUDs – Chisinau, Balti, Tiraspol and Ribnita; for sex workers and MSM – Chisinau and Balti.

According to the integrated bio-behavioral surveillance surveys (2016)[9]:

a) **HIV prevalence among PWUDs was estimated by IBBS 2016 as 13.9% in Chisinau and 17% in Balti (one of the biggest cities in Moldova). While IBBS 2013 shows lower HIV prevalence among PWUDs in Chisinau (8.5% in 2013) and much higher prevalence in Balti (41.8% in 2013);**

b) In 2016, HIV prevalence among sex workers in Chisinau is 3,9% which is lower than it was in 2013 (11.6%); In Balti – 2016 data on HIV prevalence among SWs is higher (22.3%) compared to 2013 (21.5%);

c) IBBS of 2016 shows higher HIV prevalence among MSM in Chisinau (9%) compared to 2013 IBBS results (5.4%). The same survey shows the lower HIV prevalence among MSM in Balti in 2016 (4.1%) compared to 2013 results (8.2%).

HIV prevalence among key populations, based on behavioral surveillance surveys

		2016	2013 (2012)
PWUDs	Chisinau	13,9%	8.5%
	Balti	17%	41,8%
	Tiraspol	29,1%	23,9%
	Ribnita	22,2%	-
Sex Workers	Chisinau	3,9%	11,6%
	Balti	22,3%	21,5%
MSM	Chisinau	9%	5,4%
	Balti	4,1%	8,2%

9 http://pas.md/ro/PAS/Studies/Details/72.

As for prevalence of hepatitis C, the survey result shows higher prevalence among PWUDs in 2016 compared to 2013 in Tiraspol (62.1% in 2016; 35.6% in 2013); Compared to 2013, higher prevalence of HCV is observed among SWs in Chisinau and Balti (28.7% and 36.4%, respectively, 2016) and lower prevalence of HCV - among MSM (4.0% in Chisinau and 6.1% in Balti, 2016).

Hepatitis C prevalence among key populations, based on behavioral surveillance surveys

		2016	2013 (2012)
PWUDs	Chisinau	60,4%	65,4%
	Balti	41,8%	38,5%
	Tiraspol	62,1%	35,6%
	Ribnita	32,7%	-
Sex Workers	Chisinau	28,7%	17,2%
	Balti	36,4%	15,0%
MSM	Chisinau	4,0%	4,8%
	Balti	6,1%	6,8%

According to IBBS 2016, the prevalence of hepatitis B is higher among sex workers in Chisinau and Balti (10,2% and 11,9%, respectively, 2016) and among MSM in Balti (7,2% in 2016), compared to 2013 IBBS results.

Hepatitis B prevalence among key populations, based on behavioral surveillance surveys

		2016	2013 (2012)
PWUDs	Chisinau	4,9%	6,6%
	Balti	5,4%	12,4%
	Tiraspol	4,0%	4,1%
	Ribnita	1,0%	-
Sex Workers	Chisinau	10,2%	4,2%
	Balti	11,9%	3,6%
MSM	Chisinau	2,4%	4,8%
	Balti	7,2%	1,6%

It should also have mentioned that indicators of active syphilis among sex workers is higher (in Balti) in 2016, compared to 2013.

Active syphilis prevalence among key populations, based on behavioral surveillance surveys

		2016	2013 (2012)
PWUDs	Chisinau	7,4%	12,7%
	Balti	4,0%	0,7%
	Tiraspol	1,6%	8,5%
	Ribnitsa	1,8%	-
Sex Workers	Chisinau	20,0%	20,5%
	Balti	12,7%	2,4%
MSM	Chisinau	13,3%	14,6%
	Balti	4,9%	5,4%

Population Size Estimation

In conjunction with the above mentioned research population size estimations were conducted, as it was done several times previously as well. In 2017 a size estimation analysis was conducted using broad range of experts, during which previous experience was taken into consideration, a lot of data was collected and analyzed, international experience was used and consequent conclusions were drawn.

Population Size Estimation among Key Populations (2017)[10]

	PWUDs	Sex Workers	MSM
Chisinau	7 200	4 200	5 200
Balti	5 000	2 700	1 200
Tiraspol	2 500	-	1 100
Other territories of Moldova	22 200	14 400	9 600
Moldova total	36 900	21 300	17 100

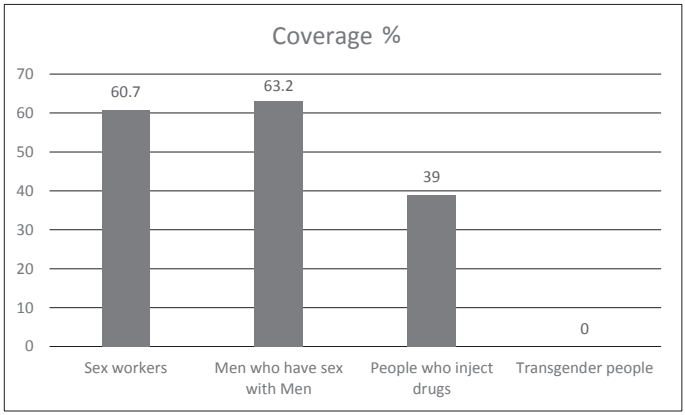
Prevention programs targeting Key Populations

According to the current programs, the following are considered as the key populations: female sex workers, MSM, PWUDs and prisoners. Targeted work is conducted with youth as well as with the sexual partners of PWUDs, female sex workers and MSM.

Indicator of key populations coverage by prevention programs in 2017 is not high, still, this indicator has shown increase compared to the previous years.

10 http://pas.md/ro/PAS/Studies/Details/70.

Coverage of the key populations by prevention programs (2017)[11]



It shall be highlighted that working with the key populations practically does not include specific interventions for transgender. The organizations try to cover this group, however, the specific needs of transgender are not envisaged in the national program and there are no surveys to inform program planning.

PWUDs

According to 2017 annual report, prevention services targeting PWUDs and their sexual partners were implemented in up to 30 geographical locations and in 18 penitentiary institutions. These projects were carried out by 9 non-governmental organizations and Penitentiary Department. 15431 PWUDs have received prevention services[12].

Comprehensive package of prevention services includes:

- Needles and syringes exchange;
- Distribution of condoms, disinfection materials, ointments, bandages etc.;
- Distribution of informational materials;
- Informational-educational work;
- Peer counseling;
- Psychological, legal and social support;
- Outreach, including outreach with the mobile ambulatories;
- Referrals and social accompany to VCT on HIV, hepatitis testing and other medical services;
- Substitution therapy.

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It shall be mentioned that in 2017 comprehensive prevention package was enriched by 2 new services: gender-specific services and overdose management.

Opioid substitution therapy

Opioid substitution therapy with methadone was established in Moldova in 2004. Since 2005 this program has been functioning in the penitentiary institutions as well. During the years this service has expanded geographically and increased coverage. Non-governmental organizations actively cooperate with the program in terms of informing beneficiaries and providing psychosocial support. Despite program expansion, service providers report low referrals of the services, one of the possible reasons for this being fear of being listed in the narcological registry and increase of non-opiate drugs in the country. Also, it should be mentioned that opioid substitution therapy is not functioning on the left bank of Dniester, which affects effectiveness of the PWUD targeted programs in this region.

In 2017 opioid substitution therapy was decentralized in 9 locations and 13 penitentiary institutions. 131 new persons enrolled in the program during the year.

Currently several non-governmental organizations work with the PWUD population. Their work covers both right and left banks of the Dniester. It shall be mentioned that the work is mainly conducted in the big cities and smaller regional settlements are not covered. Organization's resources and development is different and not identical, however, through cooperation they get technical support, share experience, strengthen each other and try to make their work coordinated. According to the information collected from the organizations, work with the beneficiaries is based on various documents, such as: quality standards for HIV prevention services among key populations (national), harm reduction programs regulations (national), consolidated guideline for HIV prevention, diagnostic, treatment and care for key populations (WHO), territorial program on HIV/AIDS (municipal), as well as internal organizational mechanisms. The organizations are involved in the country networks, regional and international partnerships and based their work on both international and regional best practices. However, they report that due to financial constraints (costing of service package per one beneficiary in the current program) they are not able to increase motivation for attracting more beneficiaries.

The organizations try to offer beneficiaries various services, including information and counseling on HIV, STIs, viral hepatitis, harm reduction issues, opioid substitution therapy, mental health, human rights and violence. Over the past 5 years, UNFPA provided support to strengthen NGOs working with PLWHIV and key populations in their capacities to provide sexual and reproductive health services, information, education, counseling and referring. In spite of

this, interviews conducted with the NGO representatives revealed that quite a few NGOs working with key populations still pay insufficient attention to issues related to sexual reproductive health and rights. As for other services, needles and syringes, as well as other materials that are available at the moment (alcohol pads, medications containing heparin, different ointments) are distributed. Beneficiaries reported that at some organizations the set of the distributed materials is periodically changed and does not meet their demands. According to the organizations' representatives, the set of materials depends on the timely procurement (which is centralized) and delivery.

Beneficiaries report that only syringes' distribution is not attractive and does not motivate them to refer to the organizations and undergo HIV testing. In their opinion, getting syringes is not a problem due to low price and easy access at the pharmacies. Also, some of the beneficiaries notes that buying injecting drugs with the pre-filled syringes is also quite frequent. However, this practice is decreasing. As motivating elements, the beneficiaries list testing on viral hepatitis with further access to free treatment, possibility to get medications containing heparin and other materials, referrals to medical specialists for free services and, for some, referrals to the opioid substitution therapy. Demand for condoms is low and is explained with low sexual activity and low number of occasional sexual contacts.

It shall be highlighted that viral hepatitis treatment program as well as opioid substitution therapy is not functioning on the left bank of the Dniester, and this decreases PWUD motivation for enrollment in the prevention programs.

Outreach services are functioning. Outreach service is not considered as social work. Mainly outreach consists of peer intervention in the field. Competence of peers in some issues (counseling, informing, social support) is quite low. In fact, outreach workers are connecting unit between social workers and beneficiaries. This diminishes the role of social workers, too, as they are not able to study environment of their beneficiaries and cannot take some specifics into consideration. No structured mapping is conducted, there are protocols for mapping (partially due to the reason that mapping is not mentioned in the national guidelines of working with the key populations).

According to some of the beneficiaries, getting narcological services is not popular among their peers, since no one is willing to get into narcologic registry, and at the same time, since there are no long-term rehabilitation programs, they do not see particular benefit and any good results for the community.

Some respondents note that law enforcement representatives deliberately chase them, especially on the left bank of Dniester.

Opinions of the beneficiaries regarding receiving medical services were different. Some noted that it is quite comfortable to get services at the medical facilities, because it is not necessary to reveal belonging to any particular group and STI testing or other examinations as well as treatment is accessible. Others describe that there are a lot of unemployed in the group because of the reason they invoke the impossibility of accessing medical services. Beneficiaries don't know about the possibility to register with their family doctor (at their choice or according their place of residence) regardless of their insurance by the government in case they are in main eligible categories. Also, the beneficiaries don't know or perceive difficult the procedure of registering as unemployed with the territorial employment agencies in order to become a person insured by the Government. Many refuse to get referrals from NGOs to these services, as they expect to get inappropriate attitude and confidentiality breach. This was especially highlighted by women PWUDs.

The highest level of satisfaction was expressed with psychological counseling and legal support services.

There are no active initiative groups or community organizations in the country. There are separate PWUD initiative groups, but their involvement in the HIV prevention programs is low, resources are limited, civil activism is also low and work with the community members includes mainly psychosocial support. In the country there is no system targeting empowerment of these groups or organizations, which would aim at leadership development and capacity strengthening. There are organization that position themselves as community-based organizations, still, this is not sufficient to speak about active involvement of the community in formulation of HIV policy and planning of services.

Female Sex Workers

In Moldova sex workers within HIV prevention programs are represented by females, although, organizations working with MSM do segregate the group of male sex workers and provide them services based on their needs. Female sex workers mainly congregate in the big cities, however, in the smaller dwellings there are separate groups with few members. Sex work is mainly unstructured and pimping is rarely mentioned (it is a criminal offense).

Condom use during the last sexual contact with the commercial partner is not low and is almost the same in Chisinau and in Balti. It is noteworthy that this indicator is lower during the last anal intercourse, compared to the vaginal one, which indicates that condom use in this groups is mostly motivated by contraceptive purposes and less connected with the disease prevention.

Condom use during the last intercourse with the commercial partner, according to the 2016 research conducted in Chisinau and Balti[13]*:*

	Chisinau	Balti
Vaginal sex	87,5%	85,4%
Anal sex	83,8%	83,4%
Oral sex	56,2%	54,5%

Indicator of consistent condom use with the commercial partner during the last 12 months is low and also is much lower in Balti, compared to Chisinau.

Consistent condom use with the commercial partner during the last 12 months, according to the 2016 research conducted in Chisinau and Balti[14]*:*

	Chisinau	Balti
Vaginal sex	25,5%	7,8%
Anal sex	45,5%	5,7%
Oral sex	22,5%	3,8%%

Prevention programs targeting sex workers were implemented in 12 locations by 6 non-governmental organizations. 5 620 female sex workers have used minimum of two services (one of them is condom)[15] . Comprehensive package of prevention services includes:

- Distribution of condoms, disinfection materials, ointments, lubricants, hygiene packages, pregnancy tests etc.;
- Needles and syringes exchange;
- Distribution of informational materials;
- Informational-educational work;
- Peer counseling;
- Psychological and social support;
- Outreach, including outreach with the mobile ambulatories;
- Referrals and social accompany to VCT on HIV, hepatitis testing and other medical services.

Currently several non-governmental organizations work with the female sex workers. They work on both right and left bank of Dniester. It shall be mentioned that the work is mainly conducted in the big cities and smaller regional settlements are not covered. Resources and development levels of the organizations is uneven and cooperation among them is weak. Work with

13 http://pas.md/ro/PAS/Studies/Details/72.

14 http://pas.md/ro/PAS/Studies/Details/72.

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the beneficiaries is based on various documents, such as: quality standards for HIV prevention services among key populations (national), harm reduction programs regulations (national), consolidated guideline for HIV prevention, diagnostic, treatment and care for key populations (WHO), territorial program on HIV/AIDS (municipal), as well as internal organizational mechanisms. The organizations are involved in the country networks, regional and international partnerships and based their work on both international and regional best practices. However, they report that due to financial constraints (costing of service package per one beneficiary in the current program) they are not able to increase motivation for attracting more beneficiaries.

Beneficiaries note that quality of condoms varies within the programs and not always responds to the quality required. Also, specific characteristics of condoms (size, width of latex) is not strictly observed. The respondents mention that it is quite often that sexual contacts happen under influence of alcohol or drugs; violence from the clients is frequent; majority of the clients refuse to use a condom and fear of losing income forces sex workers to agree. Interviewed sex workers highlight their interest in STIs and some express satisfaction with the service that they receive in this regard from specialists (STI specialist, gynecologist) on NGO basis. Still, majority of the interviewed could not list the most widespread STIs and responded negatively to the direct questions (such as "Have you heard of a disease called chlamydiosis?"). Part of the respondents' expresses satisfaction with the medical services at medical facilities. They state for them it is comfortable to get services in a format where it is not necessary to reveal their belonging to a particular group, and STI testing and other examinations and treatment are accessible. Some mentioned that there are a lot of unemployed in the group because of the reason they invoke the impossibility of accessing medical services. Beneficiaries don't know about the possibility to register with their family doctor (at their choice or according their place of residence) regardless of their insurance by the government in case they are in main eligible categories. Also, the beneficiaries don't know or perceive difficult the procedure of registering as unemployed with the territorial employment agencies in order to become a person insured by the Government. At the same time, such services are rarely offered by the NGOs. It is possible to get direct referral from NGOs to the medical facilities, still, some fear that they will not get proper attitude and there will be confidentiality breach.

There are outreach services targeting female sex workers. In this case, outreach does not represent a peer intervention and is conducted by trained outreach workers. Outreach work includes also constant mapping, however, this part

of work is not structured and not described in the internal documentation of the organizations.

Note that law enforcement representatives deliberately chase them, threaten and use other forms of violence, which is particularly notable on the left bank of Dniester. Part of the sex workers mentioned that due to the unfavorable conditions for work on the left bank (persecution, low number of clients, low pricing) they migrate to the big cities on the right bank (mainly they name Chisinau).

The highest level of satisfaction while assessing services from NGOs was expressed towards psychological counseling and legal support services.

There are no active initiative groups or community organizations of female sex workers in the country. In the country there is no system targeting empowerment of these groups or organizations, which would aim at leadership development and capacity strengthening.

MSM

Prevention programs targeting MSM were implemented in 4 locations, including left bank of Dniester. Service provision was done by organization Genderdoc-M. 3636 MSM have used minimum of two services (one of them is condom and/or lubricant) during 2017 year[16]. Comprehensive package of prevention services includes:

- Distribution of condoms and lubricants;
- Distribution of informational materials;
- Informational-educational work;
- Psychological, legal counseling;
- Peer counseling;
- Self-help groups;
- Outreach, including outreach with the mobile ambulatories;
- Referrals and social accompany to VCT on HIV, hepatitis testing and other medical services;
- SaferSex PROMOTION Parties;

Work with MSM population is relatively structured; dividing the group into separate segments (young MSM, aged MSM, MSM sex workers, etc.) provides for more specifics during work. Interventions are more oriented to meet specific needs.

Prevention work targeting MSM has expanded during the recent years,

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however, it is not wide in terms of geography and coverage is still low. It shall be mentioned that according to the epidemiological surveillance surveys, HIV prevalence is increasing in Chisinau and decreasing in Balti. This might be caused by intensified internal migration as well as by reaching new hidden groups for increasing program coverage.

According to the 2016 survey data, condom use during the last sexual contact is not high, but it has increased compared to the data of 2013 in Chisinau. Yet, in Balti this indicator has decreased (in Balti 2016 data are higher than in Chisinau).

Condom use during the last sexual contact with the different types of partners in Chisinau and Balti (2016)[17]

	Chisinau, %	Balti, %
Total	45,5	60,1
Male partner, lover	33,4	40,6
Regular male partner	46,5	64,5
Male commercial partner	35,4	43,3
Male occasional partner	50,4	52,8
Female partner	51,5	84,2

The main reason for not using a condom is "no need", which underlines that, despite intensive interventions targeting provision of information and knowledge increase, awareness about the risks and overall about the problem is low.

During the recent years, HIV testing indicator has increase. In 2016, 89% of the interviewed MSM knew where to get HIV test, 63.1% had been tested at least once and 41.2% were tested during the last 12 months and knew their test result[18]. According to the representatives of NGOs working with MSM, increase in the testing indicator is caused by introducing rapid blood and saliva screening tests. In Balti municipality, interviewed MSM note that it is quite comfortable for them to get services at the organizations that mainly implement youth-targeted programs and have also possibility to provide services to the key populations.

Majority of the MSM respondents expressed willingness to get services at the medical facilities; however, they are afraid of confidentiality breach

17 http://pas.md/ro/PAS/Studies/Details/72.

18 http://pas.md/ro/PAS/Studies/Details/72

and improper treatment. Several respondents note that they use services of medical facilities, when they are referred by NGOs, but they prefer to visit only particular friendly specialists at those facilities.

It is clear from interviews that some organizations that provide services to MSM do not have knowledge on specifics of this group; existing funding of the programs is low and does not allow that work is implemented based on the needs of beneficiaries and include expanded package of services; work with transgenders is constrained and needs-oriented services cannot develop.

The country has announced launching PrEP program. Currently clinical guidelines for PrEP are elaborated, however, communication strategy for this process as well as strategy for involvement of the non-governmental organizations are not in place.

Using mobile ambulatories during HIV prevention targeting key populations

Mobile ambulatories became functional by the end of 2016, in order to reach territories where prevention services were not available.

Mobile ambulatories provide the following services:

- •Syringes exchange;
- Overdose management;
- Condoms distribution;
- Information and education on HIV;
- VCT on HIV, viral hepatitis and syphilis;
- Medical consultations of medical specialists (dermatology, gynaecology, etc);
- Referrals to medical services;
- Etc.

During 2017 the following numbers of beneficiaries received services through mobile ambulatories: harm reduction services - 2932 persons; 619 sex workers and 233 MSM. Rapid testing on HIV/syphilis (combined) was conducted on 2613 persons on hepatitis C – on 2162 persons[19].

HIV testing among Key Populations

During the year 2017, 250 788 tests were performed for the simultaneous detection of anti-HIV1, anti-HIV2 and HIV-1 antigens.

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Within the program, in order to expand access for key populations 10 non-governmental organization conducted 2242 tests using saliva tests and tests for capillary blood (finger-prick). Out of these screening tests, 66 results were positive and 48 were handed over to the medical system for final diagnostics[20].

Main findings and conclusions

Based on the information gathered during the presented assessment some conclusions were drawn, which form the basis for particular recommendations.

As of today, the Republic of Moldova has a concentrated epidemic among key populations (PWUDs, sex workers, MSM) and their coverage by preventive programs is not high.

The country is in the transition period as international funding is steeply decreasing and, consequently, Moldova is in the process of maximal mobilization of national funds and elaboration & refinement of effective system for use of these funds.

In the field of fighting HIV infection, the country has a well-established coordination mechanism, with functional structures and regulatory documents.

There is a stigma towards key populations in the society, and it is strengthened by marginalizing approaches in the existing legislation.

Program management

Funding of HIV prevention programs from the Global Fund to fight AIDS, TB and Malaria has decreased and quite big proportion of the financial gap is covered by the state funding. Still, the needed budget has not been maintained, which laid the ground for elaboration of the new mechanisms of more structured management of the program and effective control of the spending. As a result, the financing mechanism selected was funding per capita, which was based on the existing costing of the services and after calculating average amount was defined as 33 Euros (25 Euros on provided service in total and 8 Euros on procured materials). Under this new mechanism, project budgets of the organizations working with the key populations became totally dependent on their promises of reaching coverage indicators. The organization receives 25 Euros for services it will provide to one beneficiary. Since this approach was applied, the organizations started claiming high coverage and reaching other groups which were not their target groups before. During the interviews, it was revealed that starting from 2018 several organizations started working with the groups that they did not have experience of working with before. At

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the same time, it shall be taken into consideration that key populations have different needs and services packages – basic, recommended and even more so expanded – are very different. Consequently, these packages need different costing.

Each organization implementing the prevention program has to reach two indicators: coverage by services and testing on HIV. The first indicator is considered achieved (i.e. covered by services) if the organization provides beneficiary with minimum of two services (e.g. a syringe and a Peer counseling, or a condom and a booklet). Defining coverage indicator by two services increases number of attracted (covered) beneficiaries, but decreases quality parameter, since the beneficiary might not receive even the basic package of services. The implementing organization is less interested in provision of more than two services to its beneficiaries, priority is to cover as many persons as possible with these two services and if the beneficiary has some other needs, responding to those needs with some other services is not a priority. Fight for the numbers of beneficiaries translates into competition between organizations in reaching and enticing beneficiaries. The organization registers a beneficiary as a primary contact in its coverage and for other organizations (which might have additional services), this particular beneficiary is not interesting any more since it is not possible to count him/her in the coverage. Registration is done by a unique code in a basic server, so one beneficiary cannot be counted twice. As a result, referrals to the organizations working with the similar groups as well as service provision procedures at such organizations do not work properly. Competition has weakened partnership among organizations, which will ultimately influence coordinated activities and advocacy processes of civil society.

Setting only quantitative targets for the organizations increases risks of data manipulation, which is difficult to check through monitoring. Hence, there is a need for new approaches and more funding for monitoring purposes. There is no united database, which would generate and elaborate data in real time. This provides for possibility for errors and data manipulation in the multi-stage system.

The special emphasis should be given to transgender issues. The special health needs of transgender population has not been studied. The package of transgender oriented specific services does not exist. Therefore, no costing estimates have been conducted either. National strategic plan does not mention transgenders as key population group.

Conclusions:

- Existing scheme of funding projects targeting key populations does not

create basis for provision of comprehensive and recommended service packages to representatives of these populations. Also, it does not contribute to high quality of the provided services. In such conditions the implementing organizations are not motivated to expand/improve their activities and beneficiaries are not motivated to enroll in such services.

- Main quantitative indicators of performance (e.g. coverage by services) is counted by two services. This does not contribute to motivation for provision of expanded service packages and quality parameters are ignored while chasing numbers.
- Existing schemes of monitoring cannot assess factual performance of the organization and especially provide qualitative evaluation of this performance. Data generation is multi-stage and does not mitigate risks of errors.
- The health needs of transgender population has not been studied and therefore, specific health services are not designed for theme.

Organizations working with the key populations – their development and involvement in HIV prevention

Development level of the organizations working with the key populations, as well as scope, specifics and quality of the provided services are different. Beneficiaries' motivation to enroll in the programs and receive services are defined by different approaches and applied guiding principles. Organizations working with MSM population have relatively structured and diverse approach. They try to base their work on renewed international recommendations and regional-level best practices. Targeted program interventions based on the beneficiaries' needs are implemented towards subgroups, e.g. aged MSM, young MSM, sex worker MSM, MSM living with HIV. Peer programs, outreach, internet-interventions, various events, etc. are used for attracting clients to the services. Organizations are involved in advocacy processes and actively participate in program planning and coordination. Beneficiaries report that such organizations are quite friendly and trusted. However, there is small number of such organizations and existing resources are not enough for MSM-targeted interventions on the country level. It should be mentioned that activities of these organizations are result of active fundraising and is not dependent solely on financing from the Global Fund and national program. Additional resources received from other donors are also used. Compared to MSM-targeting organizations, NGOs working with the female sex workers are weak. Also, since 2018, female sex workers have become target group for some organizations that did not have experience of working with this group, hence, they are not fully aware of the specifics of this population.

Main barriers, influencing beneficiaries' active enrollment in the service provision, are as follows:

- Not all organizations have institutional service provision protocols (how to do the work) and job descriptions. This does not allow for proper planning and implementation of the interventions and for quality monitoring of provided services. Continuous re-training of the personnel does not happen mainly due to lack of funds. Low salaries cause outflow of human resources. Frequent changing of personnel influences relationship with the beneficiaries (level of trust) and, consequently, their referrals to the services. Furthermore, due to low levels of funding it is difficult to attract specialists (medical doctors, psychologists) to work in the regions. Also, one of the reasons for this is migration of specialists to the capital in search of better working conditions.
- Not all organizations have constant monitoring of the activities and of their quality. It is difficult for the organizations' management to assess ongoing processes, monitoring is done based only on the results data. Interpretation of such monitoring is also difficult, which results in the lack of ongoing and timely reaction to the changes.
- The implementing organizations have different understanding of the outreach process and its functions. In some organizations outreach does not constitute part of the social work and is mainly defined as peer interventions in the field. At the same time, competence of the peer is quite limited in some issues (counseling, providing information, social support). Actually, outreach workers are connecting unit between social workers and beneficiaries. This diminishes the role of social workers as well, since they are unable to observe, study and consider specifics of the beneficiaries' environment. No structured mapping is conducted, there are no mapping protocols (partially because of the fact that mapping is not mentioned in the national guidelines of working with the key populations).
- Some organizations use mobile laboratories for testing and counseling beneficiaries in the field. During the interviews beneficiaries report that the schedule of the mobile labs is not convenient for them, so this service is not in high demand. Along with this, these cars attract attention of the passers-by and some beneficiaries avoid using this service. During the testing saliva or finger-prick tests are used. Screening is possible mainly for HIV, hepatitis C and syphilis. Some organizations do not have hepatitis C tests; as for HIV, majority of test kits are combined HIV and syphilis tests, which is apparently cost-effective, but decreases free choice of the beneficiaries. At the same time, it shall be taken into consideration that existing program does not offer to beneficiaries free

treatment in case of positive syphilis results (some organizations are able to provide free STI treatment with support of other donors, but this service is limited in numbers).

- Moldova has started interventions suggested by international recommendations, e.g. PrEP program has been launched. There is a national PrEP clinical protocol, but there is no communication strategy in regards to PrEP.
- Some of the organizations do not conduct needs' assessment among beneficiaries and do not use data from such surveys for advocacy or program planning. There is no documented feedback on quality and scope of the existing services.
- There is no unified registration system for beneficiaries. Only coding system is unified. The organizations usually have their own cards, vouchers, which are used during provision of the services. However, these cards do not work everywhere. In the referral system these cards do not play an important role. In majority of cases, referral is not based on some document about cooperation with description of the procedures. Usual practice is that social or outreach worker or a counselor notifies via telephone call the organization or a specialist where the beneficiary is referred with or without social accompaniment. Communication chain is interrupted at this stage and there is no information about referred beneficiaries or services provided to them.
- In majority of the organizations there is no guidelines for provision of psychological support. It is difficult to assess effectiveness or quality of this service, since no results are documented.
- Some organizations do not have proper knowledge about specifics of the beneficiaries' groups, and they depend on the hired personnel, majority of which have received experience at other organizations. Low or no knowledge about specifics of the target populations at the management level hinders proper planning and management of the projects.
- The organizations have not developed internet-based interventions. At the MSM-targeting organizations such interventions exist but there is no guidelines or evidence based on research; also, these interventions are not properly administered (e.g. the intervention is not agreed with the websites administration). Internet-based outreach is not planned, since services provided through this channel cannot be counted in the coverage (due to no possibility to provide main elements of the coverage indicator, such as a condom or a syringe).
- Organizations positioning themselves as community-based are in general not developed and do not actively take part in the processes. Out of the interviewed representatives of People who use Drugs, none could remember a community-based organization or an initiative group,

although they expressed desire to have such an organization and be in active communication with the members of their community. As for female sex workers, initiative groups cannot be formed, because the community is not empowered and does not perceive necessity of their involvement in active advocacy processes.

Conclusions:

- Development level of the organizations is very different and on the partnership level it is rare for them to use each other's' resources.
- Not all organizations have protocols and guidelines for service provision. This hinders processes of internal monitoring and activities depend mainly on skills, knowledge and attitudes of a particular staff member.
- Due to different reasons there is no system of continuous re-training of the personnel. This has direct influence on the quality of provided services.
- Some organizations do not conduct beneficiaries' needs assessment and relies on the data of sentinel surveys. Planned interventions often do not correspond to needs and requests of the beneficiaries.
- Beneficiaries' referral regulations are not structured and documented. It is not possible to systematize referral data and document results. Various organizations manage referrals only in verbal format. Registration vouchers/cards are not unified.
- Some interventions, e.g. outreach, are conducted differently in different organizations. Approaches and forms also differ. At the stage of interventions' planning organizations rely on different sources (guiding principles), which hinders holistic assessment of the interventions.
- In some organizations knowledge about specifics of the target populations among management and program staff is low, not systematized and mainly based on the experience.
- Community organizations and initiative groups are weakly presented. Some communities are insignificantly involved in advocacy and decision-making processes. Community strengthening processes are also weak.

Medical services

Within the frames of mandatory health insurance system, it is possible to get specialized medical services at medical facilities in case a person has health insurance.

The status of insured person in the mandatory health insurance system is obtained by categorizing one of the three categories[21]:

21 http://lex.justice.md/viewdoc.php?action=view&view=doc&id=311622&lang=2

- Employees. The premium of mandatory health insurance per employee is calculated based on the percentage contribution from salary and other rewards. The active period of medical insurance is equivalent to the term of employment.
- Persons insured by the Government. There are 16 categories of persons insured by the state.
- Persons who purchase their own cover health insurance (self-employed people, such as agricultural workers, but not only). They pay in fixed amount. The medical policy is valid until 31 December of the year for which the mandatory health insurance premium was paid.

Without medical insurance it is possible to get free medical services from family doctor and also, to get free hospital emergency medical services. According to the beneficiaries interviewed, some of them said that they were not able to get medical insurance because of insurance's price or because of absence of necessary documents for getting the insurance. During the interviews with the specialists, it was found that there are some official ways to solve problems related to the health insurance, such as written regulations on how to get free medical insurance, e.g. there is a multidisciplinary committee to which person may apply in order to go through this process. Still, neither organizations nor beneficiaries could say something about these ways – interested parties do not have this information and they don't know about the possibility to get medical care from family doctors free regardless of their insurance status. Apart from HIV testing (which does not need a medical insurance), other medical services cannot guarantee anonymity. According to the beneficiaries, this decreases motivation for referring to medical facilities. They describe that there are some medical institutions, which are preferable for them due to attitudes towards beneficiaries' groups (acceptance). Also, there is a practice of connecting with the particular doctors (based on the friendly attitude). Information about friendly specialists is spread among representatives of the key populations and demand for this particular specialist increases. Such specialists cannot manage their patients' load and, consequently, beneficiaries refer to them late, which increases risks of complications. Also, beneficiaries mention problems connected with personal data safety (confidentiality).

The interviews demonstrated that medical institutions have quite good attitude towards key populations and are ready to receive them and provide them with the services. However, the personnel lack knowledge about specifics of these populations, they are not sensitized. Medical doctors expressed willingness to undergo training about specifics of the key populations and to have appropriate guidelines in their institutions. According to them it is good if such trainings are provided by the organizations that directly work with the key populations or represent community organizations.

Referrals from NGOs to the medical services are also not structured or systematized. Every organization has its own rules and forms for such referral. In majority of the cases, social workers call particular specialists or provide beneficiaries with the social accompaniment. Referrals are not registered at the medical facilities. There is no feedback to the organization that referred the beneficiary. Hence, it is difficult to assess effectiveness of the referral system due to lack of data.

The country has methadone substitution therapy. All PWUDs who are in need of OST can be enrolled in the program without health insurance. However, none of interviewed beneficiaries knows about this possibility and they believe that absence of health insurance is the main obstacle to be enrolled in OST program. During the interviews, the beneficiaries reported that there are geographical (impossible to get to OST site because it is far away or transportation costs cannot be paid) as well as time-connected (some beneficiaries are working and their schedule does not allow them to be enrolled in the program) barriers in access to everyday OST program. However, it is possible to take home OST dose necessary for certain period of time. Beneficiaries mentioned that opiate use is decreasing day by day and instead use of synthetic, non-opiate, home-made drugs is increasing. It is not possible to include people who use these new types of drugs into the methadone program, and furthermore, it is not effective. Some patients report that doses are not always acceptable and are lower, than needed, so the only solution for them is to get additional drugs at the black market. It should be mentioned that from June 2018 Buprenorphine substitution program became available for PWUDs.

One of the main barriers for attracting more patients to the OST programs is existence of the narcology registry. Potential beneficiaries of the program do not want to be registered in the system and face all the consequences, related to this, such as limitation of some rights, risk of confidentiality breach, risk of losing a job, etc.

There are very few rehabilitation programs for those persons (people who use drugs), that have chosen sobriety. There are some support programs, but no structured, long-term rehabilitation program. This increases risks of relapse and repeated risk behaviors.

There is a hepatitis C treatment program in the country. However, because the beneficiaries report that despite their wish, they cannot get involved in this program because health insurance is required for inclusion in this program. Even if it is purchased for primary diagnosis, an examination such as fibro scan is not included in the Unic Program of the compulsory Health Insurance system and needs to be paid out of pocket.

Conclusions:

- The system of health insurance gives any citizen, including representatives of the key populations, possibility to receive particular package of medical services for free. However, representatives of the key populations do not receive information about how to solve problematic issues connected to getting health insurance (such as not having available funds, or not having necessary documents). Also, some non-governmental organizations are not informed about these topics, which decreases probability of using these services from beneficiaries' side.
- Personnel of medical institutions is not sensitized and aware of specifics of key populations, which decreases trust and referral rates from beneficiaries' side.
- Some PWUDs (those not involved in the OST) do not know on possibility to be enrolled in OST program for free even without having the health insurance.
- Non-opiate home-made drugs are becoming more and more popular among people who use drugs, and relevance of methadone substitution therapy is decreasing.
- People who use drugs do not want to be regitered in the narcology registry, hence they avoid using drug-related services. This is considered as one of the barriers for services access among people who use drugs.
- There are not long-term rehabilitation programs for people who use psychoactive substances, which increases risks of relapse.
- Diagnostic tests necessary for enrollment in Hepatitis C treatment program are charged and hence are considered as an accessibility barrier among representatives of the key populations.

Main recommendations:

- Revise country legislation, concerning key populations, in relation to decriminalization and de-marginalization.
- Alignment of national standards, protocols and guidelines on services for key populations to international documents and instruments such as MSMIT, TRANSIT, SWIT, IDUIT etc.
- Revise existing schemes for financing HIV prevention projects targeting key populations and consider provision of recommended (or expanded) package of services for representatives of the key populations during program costing.
- Elaborate expanded packages for the key populations, which would be based on the needs assessed through research, and ensure their incorporation into the existing programs.
- Study the health needs of transgender population and based on evidences

received elaborate package of services for them.

- Create a sustainable system for provision of technical support to the service organizations, in order to increase the quality of services and qualification level of the personnel.
- Along with the main quantitative indicators of performance, elaborate additional (national) quantitative and qualitative indicators, for services provided to key population. That would contribute to provision of expanded package of services and motivation of beneficiaries to enroll in more services.
- Increase cooperation and interaction between national coordination unit and the organizations working with the key populations and medical service providers in the direction of program planning and monitoring.
- Creation of real-time data generating system to better monitor the organizations performance, its activities and their contribution to prevention work.
- Strengthening the partnership between non-governmental organizations and medical institutions and creating a mutual collaboration concept that will also include sharing of experience, knowledge, etc.
- Create guiding documents describing services provided to the key populations by various non-governmental organizations for better cooperation of these organizations and coordination with governmental and other decision-making bodies.
- Conduct training on use of above mentioned guidelines and protocols for the staff of non-governmental organizations.
- While planning projects for non-governmental organizations consider continuous re-training of the organizations' staff.
- Plan and conduct repeated beneficiaries' needs' assessment research by non-governmental organizations.
- Agree upon referral system between non-governmental organizations working with the key populations and other service-provider organizations; elaborate referral guidelines and regulations.
- Conduct training for the organizations working with the key populations and medical service providers on international approaches how to work with the key populations and use of existing instruments (MSMIT, SWIT, IDUIT).
- Promote strengthening of community organizations and initiative groups and their participation in program planning, coordination and implementation.
- Use international and domestic expertise (UNFPA, UNAIDS, UNDP, etc.) existing in the country for knowledge and best practice sharing
- Spreading the information on the possibilities/ways of obtaining medical

insurance for HIV prevention program beneficiaries from key populations and obtaining the medical services through family doctors

- Conduct trainings among medical personnel for sensitization and development of skills necessary for working with key populations, with participation of community and service-provider organizations; create corresponding guidelines/manuals and hand them over to the medical facilities.
- Revise substitution therapy interventions, take into consideration changing drug scene and drug use tendencies.
- Elaborate and implement long-term rehabilitation programs for sobriety-oriented people who use drugs, based on international and national recommendations.
- Revise accessibility to existing universal programs (e.g. hepatitis C treatment program) and conduct appropriate research.

Annexes

Annex 1 (The structured questionnaire for NGOs working with Key Populations)

Organizational profile

1	Name of the organization		Comments
2	Type of the organization (NGO, CBO, Medical center, other)		
3	When the organization was created? (year/month)		

4	Contact information		Comments
	Address		
	Tel/fax		
	Email		

5	Location of the organization (Offices and branches)		Comments
	1		
	2		

6	Human resources		Comments
	Qualification and number of paid staff:		
	Number of volunteers:		
	All staff of the organization underwent relevant trainings	Yes/No	
	Re-training of the staff is conducted permanently	Yes/No	
	All staff of the organization has service provision protocols and jobs descriptions	Yes/No	

7	Financial resources		Comments
	Main donors		
	Organizations' staff is involved in the process of fundraising	Yes/No	
	The organization has a separate fundraising group of staff	Yes/No	

8	Support		Comments
	From whom does the organization get technical support?		
	What kind of technical support does the organization get?		

9	Target groups within the projects:		Comments
	MSM	Yes/No	
	TG	Yes/No	
	Sex Workers	Yes/No	
	PWUD	Yes/No	
	PLHA	Yes/No	
	Youth	Yes/No	
	Other (specify)		

10	Projects overview		
	Your projects are related to:		Comments
	HIV/STIs	Yes/No	
	Topics of Sexual and Reproductive Health	Yes/No	
	Topics of psychoactive substances use	Yes/No	
	Mental health	Yes/No	
	Human Rights	Yes/No	
	Other (specify)		

11	Program planning		Comments
	The organization plans programs based on own experience and routine information	Yes/No	
	The organization plans programs based on existing international or regional practices	Yes/No	
	The organization plans programs based on existing national practices and guidelines	Yes/No	
	Other (specify)		

12	Beneficiaries' needs assessment		Comments
	The organization periodically conducts needs assessment of its beneficiaries, documents results and uses them while program planning or in advocacy work	Yes/No	
	The organization uses needs assessment of the beneficiaries, conducted by other organizations, while program planning or in advocacy work	Yes/No	
	Other (specify)		

13	Developing partnership		Comments
	The organization has a map of partner and friendly organizations in the country/region/city	Yes/No	
	The organization has conducted mapping of the friendly service organizations and/or specialists	Yes/No	
	The organization has memorandums (partnership agreements) or other partnership documents with other organizations	Yes/No	
	The organization is a member of networks, coalitions, unions on the national level	Yes/No	
	Other (specify)		

The organization has partner relationship with:		
NGOs working with MSM/TG	Yes/No	
NGOs working with sex workers	Yes/No	
NGOs working with PWUDs	Yes/No	
NGOs working with PLHA	Yes/No	
NGOs working on Human Rights	Yes/No	
Medical Service organizations	Yes/No	
State organizations	Yes/No	
Other (specify)		

14	Monitoring system		Comments
	The organization has an organized system (a written document) for monitoring of the projects	Yes/No	
	The organization periodically conducts monitoring of the projects	Yes/No	
	Monitoring is conducted by a staff member qualified in M&E	Yes/No	
	The organization has an organized system (a written document) for monitoring quality of the services	Yes/No	
	Monitoring is conducted by a staff member qualified in monitoring of quality of services	Yes/No	
	Other (specify)		

15	Main obstacles		Comments
	What are main problems and issues that the organization faces?		
	1		
	2		

16	Future plans		Comments
	What are future directions of work of the organization? *(For example, the organization plans to expand its work through increasing coverage or reaching new groups?)*		
	1		
	2		

Please, select the tabs of the document, which correspond to your target groups (MSM, Sex workers, PWUDs), as well as the last tab of the document, and fill them in.

Working with MSM/TG

			What coverage (in numbers) by services is planned for 2018? (If possible, by cities)	What coverage (in numbers) by HIV testing is planned for 2018? (If possible, by cities)	Comments
1	In which cities does the organization work with MSM and TG?				

				Indicate the title of the document	Comments
2	The organization works with MSM/TG based on the international guidelines for working with MSM/TG		Yes/No		
3	The organization works with MSM/TG based on the guidelines for working with MSM/TG approved on	The national level	Yes/No		
		The local (municipal) level	Yes/No		
		The organizational level	Yes/No		
		There is no such guidelines	Yes/No		

			Does the organization provide specific services to the subgroups? (provide an example)	The organization has a guideline/protocol/description of working with subgroups	Comments
4	The organization divides the group of MSM/TG on subgroups	Yes/No			
	If yes, which subgroups?		Yes/No	Yes/No	
			Yes/No	Yes/No	
			Yes/No	Yes/No	
			Yes/No	Yes/No	
			Yes/No	Yes/No	

			The organization has protocols for staff on issues of	The organization has qualified staff on issues of	Comments
5	What kind of services does the organization provide to representatives of MSM and TG?				
	Information:	Yes/No	Yes/No	Yes/No	
	on HIV/AIDS	Yes/No	Yes/No	Yes/No	
	on STIs	Yes/No	Yes/No	Yes/No	

on viral hepatitis	Yes/No	Yes/No	Yes/No	
on HTC	Yes/No	Yes/No	Yes/No	
on harm reduction	Yes/No	Yes/No	Yes/No	
on issues of reproductive health	Yes/No	Yes/No	Yes/No	
on issues of mental health	Yes/No	Yes/No	Yes/No	
on issues of sexuality and gender	Yes/No	Yes/No	Yes/No	
on human rights	Yes/No	Yes/No	Yes/No	
on issues of violence	Yes/No	Yes/No	Yes/No	
Other (specify)				
Information using internet/mobile application	Yes/No	Yes/No	Yes/No	
Counseling:	Yes/No	Yes/No	Yes/No	
on HIV/STIs sexual transmission risk reduction	Yes/No	Yes/No	Yes/No	
pre-test counseling on HIV	Yes/No	Yes/No	Yes/No	
post-test counseling on HIV	Yes/No	Yes/No	Yes/No	
on STIs	Yes/No	Yes/No	Yes/No	
on viral hepatitis	Yes/No	Yes/No	Yes/No	
on harm reduction when using psychoactive substances	Yes/No	Yes/No	Yes/No	
on issues of reproductive health	Yes/No	Yes/No	Yes/No	
on issues of mental problems	Yes/No	Yes/No	Yes/No	
on issues of violence	Yes/No	Yes/No	Yes/No	
Other (specify)				
Counseling using internet/mobile application	Yes/No	Yes/No	Yes/No	
Distribution materials:	Yes/No	Yes/No	Yes/No	
on HIV	Yes/No			
on hepatitis B	Yes/No			
on hepatitis C	Yes/No			
on STIs (specify)	Yes/No			

Other (specify)				
Screening	Yes/No	Yes/No	Yes/No	
on HIV	Yes/No	Yes/No	Yes/No	
on hepatitis B	Yes/No	Yes/No	Yes/No	
on hepatitis C	Yes/No	Yes/No	Yes/No	
on STIs (specify)	Yes/No	Yes/No	Yes/No	
Other (specify)				
Social work:	Yes/No	Yes/No	Yes/No	
Social support	Yes/No	Yes/No	Yes/No	
Case management	Yes/No	Yes/No	Yes/No	
Referral	Yes/No	Yes/No	Yes/No	
Social accompaniment	Yes/No	Yes/No	Yes/No	
Other (specify)				
Meetings/training:	Yes/No	Yes/No	Yes/No	
for beneficiaries	Yes/No	Yes/No	Yes/No	
for leaders	Yes/No	Yes/No	Yes/No	
for activists	Yes/No	Yes/No	Yes/No	
Other (specify)				

6

Other services (specify):		Comments
1		
2		

7

Services for MSM/TG+		Comments
Treatment adherence counseling	Yes/No	
Counseling for discordant couples	Yes/No	
Support in revealing status and psychological support for partner	Yes/No	
Legal services	Yes/No	
Other (specify)		

8	The organization implements prevention activities and provides social support related to HIV to MSM/TG in penitentiary establishments	Yes/No	
	"MSM/TG in penitentiary institutions" are listed in the organization's projects as a separate target group	Yes/No	
9	The organization implements prevention activities and provides social support to MSM (or trans) sex workers	Yes/No	
	MSM (or trans) sex workers re listed in the organization's projects as a separate target group	Yes/No	

10	During working with MSM/TG the method of Outreach is used	Yes/No	
	Outreach includes:		
	Mapping	Yes/No	
	Primary registration of a beneficiary	Yes/No	
	Secondary registration of a beneficiary	Yes/No	
	Providing information on HIV/AIDS	Yes/No	
	Providing information on STIs	Yes/No	
	Providing information on viral hepatitis	Yes/No	
	Providing information on harm reduction	Yes/No	
	Risk reduction counseling	Yes/No	
	Counseling on HIV/AIDS	Yes/No	
	Counseling on STIs	Yes/No	
	Counseling on viral hepatitis	Yes/No	
	Psychological counseling	Yes/No	
	Provision of informational materials	Yes/No	
	Provision of condoms and lubricants	Yes/No	
	Provision of wet wipes	Yes/No	
	Distribution of needles and syringes	Yes/No	
	Distribution of alcohol pads	Yes/No	
	Collecting used needles and syringes	Yes/No	
	Distribution of medications contained Heparin	Yes/No	

	Referrals to specific services	Yes/No
	Social accompaniment	Yes/No
	Using internet/mobile applications	Yes/No
	Other (specify)	
	Outreach is conducted by:	
	Social workers	Yes/No
	Outreach workers	Yes/No
	Peers	Yes/No
	Volunteers	Yes/No
	Other (specify)	

11	Screening is conducted		Comments
	In door	Yes/No	
	During outreach	Yes/No	
	In a mobile laboratory	Yes/No	
	through self-testing (distribution of test kits)	Yes/No	
	Other (specify)		
	HTC is conducted by:		
	Counselors	Yes/No	
	Social Workers	Yes/No	
	Medical workers	Yes/No	
	Outreach workers	Yes/No	
	Peers	Yes/No	
	Volunteers	Yes/No	
	Other (specify)		
	Tests are conducted on		
	saliva	Yes/No	

	capillary blood	Yes/No	
	venous blood	Yes/No	
	Other (specify)		

12	Referrals		Comments
	Organization has written system for referring MSM/TG into service organizations, which is agreed with the partners	Yes/No	
	Organization receives feedback from service organizations after referring MSM/TG	Yes/No	
	Organization receives feedback from MSM / TG, which were referred to medical service organizations	Yes/No	
	Referrals are done:	Yes/No	
	Verbally	Yes/No	
	Using referral forms	Yes/No	
	Electronic cards	Yes/No	
	Online	Yes/No	
	Other (specify)		

13	Organization or its representative represents MSM / LGBT community in structures for coordination and/or program planning regarding HIV / AIDS prevention, treatment and care on the national level	Yes/No	
	If yes, please specify, in which structure is your organization presented		
	Organization's representative is in active contact with MSM / LGBT community for further advocacy of their needs in the coordination and/or program planning structure regarding HIV/AIDS prevention, treatment and care on the national level	Yes/No	

14	Organization conducts activities for		Comments
	Capacity building of MSM/LGBT community	Yes/No	
	Technical support for MSM / LGBT organizations and initiative groups	Yes/No	
	Advocacy for provision of accessible services for MSM/LGBT	Yes/No	
	Advocacy for reducing stigma and discrimination towards MSM/LGBT	Yes/No	
	Involvement of MSM/LGBT representatives into advocacy process	Yes/No	
	Other (specify)		

15	Organization has		Comments
	Social enterprise for MSM/MSM+/TG	Yes/No	
	Social contract from the stat for prevention work with MSM/TG	Yes/No	
	Projects for rehabilitation/resocialization of MSM/MSM+/TG	Yes/No	
	Other (specify)		

16	Additional information *(Add details or write your comments and explanations, if the questions above do not cover fully activities of your organization)*

Working with FSWs (Female Sex Workers)

			What coverage (in numbers) by services is planned for 2018? (If possible, by cities)	What coverage (in numbers) by HIV testing is planned for 2018? (If possible, by cities)	Comments
1	In which cities does the organization work with Sex workers?				

				Название документа	Comments
2	The organization works with Sex Workers based on the international guidelines for working with Sex Workers		Yes/No		
3	The organization works with Sex Workers based on the guidelines for working with Sex Workers approved on	The national level	Yes/No		
		The local (municipal) level	Yes/No		
		The organizational level	Yes/No		
		There is no such guidelines	Yes/No		

				The organization has a guideline/protocol/description of working with subgroups	Comments
4	The organization divides the group of Sex Workers on subgroups	Yes/No	Does the organization provide specific services to the subgroups? (provide an example)		
	If yes, which subgroups?		Yes/No	Yes/No	
			Yes/No	Yes/No	
			Yes/No	Yes/No	
			Yes/No	Yes/No	
			Yes/No	Yes/No	

5	What kind of services does the organization provide to representatives of Sex Workers?		The organization has protocols for staff on issues of	The organization has qualified staff on issues of	Comments
	Information:	Yes/No	Yes/No	Yes/No	
	on HIV/AIDS	Yes/No	Yes/No	Yes/No	
	on STIs	Yes/No	Yes/No	Yes/No	

on viral hepatitis	Yes/No	Yes/No	Yes/No	
on HTC	Yes/No	Yes/No	Yes/No	
on harm reduction	Yes/No	Yes/No	Yes/No	
on issues of reproductive health	Yes/No	Yes/No	Yes/No	
on issues of mental health	Yes/No	Yes/No	Yes/No	
on human rights	Yes/No	Yes/No	Yes/No	
on issues of violence	Yes/No	Yes/No	Yes/No	
Other (specify)				
Information using internet/mobile application	Yes/No	Yes/No	Yes/No	
Counseling:	Yes/No	Yes/No	Yes/No	
on HIV/STIs sexual transmission risk reduction	Yes/No	Yes/No	Yes/No	
pre-test counseling on HIV	Yes/No	Yes/No	Yes/No	
post-test counseling on HIV	Yes/No	Yes/No	Yes/No	
on STIs	Yes/No	Yes/No	Yes/No	
on viral hepatitis	Yes/No	Yes/No	Yes/No	
on harm reduction when using psychoactive substances	Yes/No	Yes/No	Yes/No	
on issues of reproductive health	Yes/No	Yes/No	Yes/No	
on issues of mental problems	Yes/No	Yes/No	Yes/No	
on issues of violence	Yes/No	Yes/No	Yes/No	
Other (specify)				
Counseling using internet/mobile application	Yes/No	Yes/No	Yes/No	
Distribution materials:	Yes/No	Yes/No	Yes/No	
Informational materials	Yes/No			
Condoms	Yes/No			
Lubricants	Yes/No			

	Wet wipes	Yes/No			
	Other (specify)				
	Screening	Yes/No	Yes/No	Yes/No	
	on HIV	Yes/No	Yes/No	Yes/No	
	on hepatitis B	Yes/No	Yes/No	Yes/No	
	on hepatitis C	Yes/No	Yes/No	Yes/No	
	on STIs (specify)	Yes/No	Yes/No	Yes/No	
	Other (specify)				
	Social work:	Yes/No	Yes/No	Yes/No	
	Social support	Yes/No	Yes/No	Yes/No	
	Case management	Yes/No	Yes/No	Yes/No	
	Referral	Yes/No	Yes/No	Yes/No	
	Social accompaniment	Yes/No	Yes/No	Yes/No	
	Other (specify)				
	Meetings/training:	Yes/No	Yes/No	Yes/No	
	for beneficiaries	Yes/No	Yes/No	Yes/No	
	for leaders	Yes/No	Yes/No	Yes/No	
	for activists	Yes/No	Yes/No	Yes/No	
	Other (specify)				

6

Other services (specify):		Comments
1		
2		

7

Services for Sex Workers +		Comments
Treatment adherence counseling	Yes/No	
Counseling for discordant couples	Yes/No	
Counseling for pregnant	Yes/No	
Support in revealing status and psychological support for partner	Yes/No	
Legal services	Yes/No	
Other (specify)		

8	The organization implements prevention activities and provides social support related to HIV to Sex Workers in penitentiary establishments	Yes/No	
	"Sex Workers in penitentiary institutions" are listed in the organization's projects as a separate target group	Yes/No	

10	During working with Sex Workers the method of Outreach is used	Yes/No	
	Outreach includes:		
	Mapping	Yes/No	
	Primary registration of a beneficiary	Yes/No	
	Secondary registration of a beneficiary	Yes/No	
	Providing information on HIV/AIDS	Yes/No	
	Providing information on STIs	Yes/No	
	Providing information on viral hepatitis	Yes/No	
	Providing information on harm reduction	Yes/No	
	Providing information on contraception	Yes/No	
	Risk reduction counseling	Yes/No	
	Counseling on HIV/AIDS	Yes/No	
	Counseling on STIs	Yes/No	
	Counseling on viral hepatitis	Yes/No	
	Psychological counseling	Yes/No	
	Provision of informational materials	Yes/No	
	Provision of condoms and lubricants	Yes/No	
	Provision of wet wipes	Yes/No	
	Distribution of needles and syringes	Yes/No	
	Referrals to specific services	Yes/No	

	Social accompaniment	Yes/No
	Using internet/mobile applications	Yes/No
	Other (specify)	
	Outreach is conducted by:	
	Social workers	Yes/No
	Outreach workers	Yes/No
	Peers	Yes/No
	Volunteers	Yes/No
	Other (specify)	

11	Screening is conducted		Comments
	In door	Yes/No	
	During outreach	Yes/No	
	In a mobile laboratory	Yes/No	
	through self-testing (distribution of test kits)	Yes/No	
	Other (specify)		
	HTC is conducted by:		
	Counselors	Yes/No	
	Social Workers	Yes/No	
	Medical workers	Yes/No	
	Outreach workers	Yes/No	
	Peers	Yes/No	
	Volunteers	Yes/No	
	Other (specify)		
	Tests are conducted on		
	saliva	Yes/No	
	capillary blood	Yes/No	
	venous blood	Yes/No	
	Other (specify)		

12	Referrals		Comments
	Organization has written system for referring Sex workers into service organizations, which is agreed with the partners	Yes/No	
	Organization receives feedback from service organizations after referring Sex workers	Yes/No	
	Organization receives feedback from Sex workers, which were referred to medical service organizations	Yes/No	
	Referrals are done:		
	Verbally	Yes/No	
	Using referral forms	Yes/No	
	Electronic cards	Yes/No	
	Online	Yes/No	
	Other (specify)		

13			
	Organization or its representative represents Sex workers' community in structures for coordination and/or program planning regarding HIV/AIDS prevention, treatment and care on the national level	Yes/No	
	If yes, please specify, in which structure is your organization presented		
	Organization's representative is in active contact with Sex workers community for further advocacy of their needs in the coordination and/or program planning structure regarding HIV/AIDS prevention, treatment and care on the national level	Yes/No	

14

Organization conducts activities for		Comments
Capacity building of Sex workers community	Yes/No	
Technical support for Sex workers organizations and initiative groups	Yes/No	
Advocacy for provision of accessible services for Sex workers	Yes/No	
Advocacy for reducing stigma and discrimination towards Sex workers	Yes/No	
Involvement of Sex workers representatives into advocacy process	Yes/No	
Other (specify)		

15

Organization has		Comments
Social enterprise for Sex workers/Sex workers+	Yes/No	
Social contract from the stat for prevention work with Sex workers/Sex workers+	Yes/No	
Projects for rehabilitation/resocialization of Sex workers/Sex workers+	Yes/No	
Other (specify)		

16

Additional information *(Add details or write your comments and explanations, if the questions above do not cover fully activities of your organization)*

Working with PWUDs

			What coverage (in numbers) by services is planned for 2018? (If possible, by cities)	What coverage (in numbers) by HIV testing is planned for 2018? (If possible, by cities)	Comments
1	In which cities does the organization work with PWUDs?				

				Indicate the title of the document	Comments
2	The organization works with PWUDs based on the international guidelines for working with PWUDs		Yes/No		
3	The organization works with PWUDs based on the guidelines for working with PWUDs approved on	The national level	Yes/No		
		The local (municipal) level	Yes/No		
		The organizational level	Yes/No		
		There is no such guidelines	Yes/No		

4			Does the organization provide specific services to the subgroups? (provide an example)	The organization has a guideline/protocol/description of working with subgroups	Comments
	The organization divides the group of PWUDs on subgroups	Yes/No			
	If yes, which subgroups?		Yes/No	Yes/No	
			Yes/No	Yes/No	
			Yes/No	Yes/No	
			Yes/No	Yes/No	
			Yes/No	Yes/No	
	The organization takes care of gender specifics while program planning	Yes/No			

5

What kind of services does the organization provide to representatives of PWUDs?		The organization has protocols for staff on issues of	The organization has qualified staff on issues of	Comments
Information:	Yes/No	Yes/No	Yes/No	
on HIV/AIDS	Yes/No	Yes/No	Yes/No	
on STIs	Yes/No	Yes/No	Yes/No	
on viral hepatitis	Yes/No	Yes/No	Yes/No	
on HTC	Yes/No	Yes/No	Yes/No	
on harm reduction	Yes/No	Yes/No	Yes/No	
on OST				
on issues of reproductive health	Yes/No	Yes/No	Yes/No	
on issues of mental health	Yes/No	Yes/No	Yes/No	
on human rights	Yes/No	Yes/No	Yes/No	
on issues of violence	Yes/No	Yes/No	Yes/No	
Other (specify)				
Information using internet/mobile application	Yes/No	Yes/No	Yes/No	
Counseling:	Yes/No	Yes/No	Yes/No	
on HIV/STIs sexual transmission risk reduction	Yes/No	Yes/No	Yes/No	
pre-test counseling on HIV	Yes/No	Yes/No	Yes/No	
post-test counseling on HIV	Yes/No	Yes/No	Yes/No	
on STIs	Yes/No	Yes/No	Yes/No	
on viral hepatitis	Yes/No	Yes/No	Yes/No	
on harm reduction when using psychoactive substances	Yes/No	Yes/No	Yes/No	
on issues of reproductive health	Yes/No	Yes/No	Yes/No	
on issues of mental problems	Yes/No	Yes/No	Yes/No	
on legal issues	Yes/No	Yes/No	Yes/No	
on issues of violence	Yes/No	Yes/No	Yes/No	
Other (specify)				
Counseling using internet/mobile application	Yes/No	Yes/No	Yes/No	
Distribution materials:	Yes/No	Yes/No	Yes/No	
Informational materials	Yes/No			

Needles/syringes	Yes/No			
Alcohol pads	Yes/No			
Distribution of medications contained Heparin	Yes/No			
Condoms	Yes/No			
Lubricants	Yes/No			
wet wipes	Yes/No			
Other (specify)				
Screening	Yes/No	Yes/No	Yes/No	
on HIV	Yes/No	Yes/No	Yes/No	
on hepatitis B	Yes/No	Yes/No	Yes/No	
on hepatitis C	Yes/No	Yes/No	Yes/No	
on STIs (specify)	Yes/No	Yes/No	Yes/No	
Other (specify)				
Social work:	Yes/No	Yes/No	Yes/No	
Social support	Yes/No	Yes/No	Yes/No	
Case management	Yes/No	Yes/No	Yes/No	
Referral	Yes/No	Yes/No	Yes/No	
Social accompaniment	Yes/No	Yes/No	Yes/No	
Other (specify)				
Meetings/training:	Yes/No	Yes/No	Yes/No	
for beneficiaries	Yes/No	Yes/No	Yes/No	
for leaders	Yes/No	Yes/No	Yes/No	
for activists	Yes/No	Yes/No	Yes/No	
Other (specify)				

6

Other services (specify):		Comments
1		
2		
3		

			Comments
7	Services for PWUDs +		
	Treatment adherence counseling	Yes/No	
	Counseling for discordant couples	Yes/No	
	Support in revealing status and psychological support for partner	Yes/No	
	Legal services	Yes/No	
	Other (specify)		
8	The organization implements prevention activities and provides social support related to HIV to PWUDs in penitentiary establishments	Yes/No	
	"PWUDs in penitentiary institutions" are listed in the organization's projects as a separate target group	Yes/No	
10	During working with PWUDs the method of Outreach is used	Yes/No	
	Outreach includes:		
	Mapping	Yes/No	
	Primary registration of a beneficiary	Yes/No	
	Secondary registration of a beneficiary	Yes/No	
	Providing information on HIV/AIDS	Yes/No	
	Providing information on STIs	Yes/No	
	Providing information on viral hepatitis	Yes/No	
	Providing information on harm reduction	Yes/No	
	Providing information on OST	Yes/No	
	Risk reduction counseling	Yes/No	
	Counseling on HIV/AIDS	Yes/No	
	Counseling on STIs	Yes/No	
	Counseling on viral hepatitis	Yes/No	

Psychological counseling	Yes/No	
Provision of informational materials	Yes/No	
Provision of condoms and lubricants	Yes/No	
Provision of wet wipes	Yes/No	
Distribution of needles and syringes	Yes/No	
Distribution of alcohol pads	Yes/No	
Collecting used needles and syringes	Yes/No	
Distribution of medications contained Heparin	Yes/No	
Referrals to specific services	Yes/No	
Social accompaniment	Yes/No	
Using internet/mobile applications	Yes/No	
Other (specify)		
Outreach is conducted by:		
Social workers	Yes/No	
Outreach workers	Yes/No	
Peers	Yes/No	
Volunteers	Yes/No	
Other (specify)		

11	Screening is conducted		Comments
	In door	Yes/No	
	During outreach	Yes/No	
	In a mobile laboratory	Yes/No	
	through self-testing (distribution of test kits)	Yes/No	
	Other (specify)		
	HTC is conducted by:		
	Counselors	Yes/No	

Social Workers	Yes/No	
Medical workers	Yes/No	
Outreach workers	Yes/No	
Peers	Yes/No	
Volunteers	Yes/No	
Other (specify)		
Tests are conducted on		
saliva	Yes/No	
capillary blood	Yes/No	
venous blood	Yes/No	
Other (specify)		

12	Referrals		Comments
	Organization has written system for referring PWUDs into service organizations, which is agreed with the partners	Yes/No	
	Organization receives feedback from service organizations after referring PWUDs	Yes/No	
	Organization receives feedback from PWUDs, which were referred to medical service organizations	Yes/No	
	Referrals are done:		
	Verbally	Yes/No	
	Using referral forms	Yes/No	
	Electronic cards	Yes/No	
	Online	Yes/No	
	Other (specify)		

13			
	Organization or its representative represents PWUD community in structures for coordination and/or program planning regarding HIV/AIDS prevention, treatment and care on the national level	Yes/No	
	If yes, please specify, in which structure is your organization presented		
	Organization's representative is in active contact with PWUDs community for further advocacy of their needs in the coordination and/or program planning structure regarding HIV/AIDS prevention, treatment and care on the national level	Yes/No	

14	Organization conducts activities for		Comments
	Capacity building of PWUD community	Yes/No	
	Technical support for PWUD organizations and initiative groups	Yes/No	
	Advocacy for provision of accessible services for PWUDs	Yes/No	
	Advocacy for reducing stigma and discrimination towards PWUDs	Yes/No	
	Involvement of PWUD representatives into advocacy process	Yes/No	
	Other (specify)		

15	Organization has		Comments
	Social enterprise for PWUDs/PWUDs+	Yes/No	
	Social contract from the stat for prevention work with PWUDs/PWUDs+	Yes/No	
	Projects for rehabilitation/resocialization of PWUDs/PWUDs+	Yes/No	
	Other (specify)		

16	Additional information *(Add details or write your comments and explanations, if the questions above do not cover fully activities of your organization)*