Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

PROPOSAL FORM

SIXTH CALL FOR PROPOSALS

The Global Fund to Fight AIDS, Tuberculosis and Malaria is issuing its Sixth Call for Proposals for grant funding. This Proposal Form should be used to submit proposals to the Global Fund. **Please read the accompanying Guidelines for Proposals carefully before filling out the Proposal Form**.

Timetable: Sixth Round

Deadline for submission of proposals: 3 August 2006
Board consideration of recommended proposals: 31 October - 3 November 2006

Resources available: Sixth Round

As of the date of the Sixth Call for Proposals, the funding available for this Call is forecast to be in the range of US$ 0 to US$ 565 million, depending mainly on the amount and timing of new pledges to the Global Fund. The amount forecast to be available will be updated on the Global Fund website.

Geneva, 5 May 2006

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ATTACHMENTS TO THE PROPOSAL FORM FOR COMPLETION BY APPLICANTS

A. Targets and Indicators Table *(Complete as separate table for each component)*

B. Preliminary Procurement List of Drugs and Health Products

A list of all annexes to be attached to the Proposal Form by the applicant can be found at the end of sections 3 and 5 the Proposal Form

OTHER REFERENCE DOCUMENTS FOR APPLICANTS

(These and other documents are available at http://www.theglobalfund.org/en/apply/call6/documents/)

Country Coordinating Mechanisms:	The Global Fund's Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility (**CCM Guidelines**)
Monitoring and Evaluation:	Multi-Agency 'Monitoring and Evaluation Toolkit', Second Edition, January 2006 (**M&E Toolkit**)
Procurement and Supply Management:	The Global Fund's "Guide to Writing a Procurement and Supply Management Plan" (**PSM Guide**)

How to use this form

1. **Before you start** - Ensure that you have all documents that accompany this form:
   - The Guidelines for Proposals (Sixth Call for Proposals)
   - A complete copy of this Proposal Form
   - The Attachments to this Proposal Form.

2. Please read the accompanying **Guidelines for Proposals** before filling out this Proposal Form.

3. For detailed information on how to use the electronic version of the Proposal Form, please see Attachment 4 to the Guidelines for Proposals.

4. In **this Proposal Form** further guidance for completing specific sections is also included in the Form itself, printed in *blue italics*. Where appropriate, indications are given as to the approximate length of the answer. Please try to respect these indications.

5. To **avoid duplication of effort**, we recommend you to make maximum use of existing information (e.g., program documents written for other donors/funding agencies).

6. **Complete the Checklists** at the end of sections 3 and 5 of the Proposal Form to ensure that you are sending a fully completed proposal.

7. **Attach all documents** requested throughout the Proposal Form.

8. Consult our "Frequently Asked Questions" link: *http://www.theglobalfund.org/en/apply/call6/*

Please note that any information submitted to the Global Fund may be made publicly available.

WHAT IS DIFFERENT COMPARED TO ROUND 5? The main difference compared to the Round 5 Proposal Form is that **Health Systems Strengthening** is no longer a separate component. It is important to recognize that applicants can still apply for funding for health systems strengthening activities by including such activities in the specific disease components. In other respects the Round 6 Proposal Form is similar to the Round 5 Proposal Form, and changes have mainly been made for the purpose of improved clarity and presentation.

1 Proposal Overview

1.1 General information on proposal

Applicant Name	Country Coordination Mechanism on National HIV/AIDS/STI Prophylaxis and Control and TB control and Prophylaxis Programmes (CCM on TB/AIDS)
Country/countries	Republic of Moldova

Applicant Type

Please tick one of the boxes below, to indicate the type of applicant. For more information, please refer to the Guidelines for Proposals, section 1.1 and 3A.

☒ National Country Coordinating Mechanism

☐ Sub-national Country Coordinating Mechanism

☐ Regional Coordinating Mechanism (including small island developing states)

☐ Regional Organization

☐ Non-Country Coordinating Mechanism Applicant

Proposal component(s) and title(s)

Please tick the appropriate box or boxes below, to indicate components included within your proposal. Also specify the title for each proposal component chosen. For more information, please refer to the Guidelines for Proposals, section 1.1.

	Component	Title
☒	HIV/AIDS[1]	Scaling up Access to Prevention, Treatment and Care under the National Program for Prevention and Control of HIV/AIDS/STI 2006-2010
☒	Tuberculosis[1]	Strenghtening tuberculosis control in the Republic of Moldova
☐	Malaria	

Currency in which the Proposal is submitted

Please tick the appropriate box. Please note that all financial amounts appearing in the proposal should be denominated in the selected currency only.

☐ US$

☐ Euro

[1] In contexts where HIV/AIDS is driving the tuberculosis epidemic, HIV/AIDS and/or tuberculosis components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO Interim policy on collaborative TB/HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

1 Proposal Overview

1.2 Proposal funding summary per component

Funds requested for each component (i.e. HIV/AIDS, tuberculosis and/or malaria) in table 1.2 below must be the same as the totals of the corresponding component budget in table 5.1.

Table 1.2 – Total funding summary

Component	Total funds requested (Euro / US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV/AIDS	3,645,486	2,765,586	2,864,861	3,164,584	3,500,194	15,940,711
Tuberculosis	3,359,837	2,427,053	2,194,573	2,075,021	1,920,149	11,976,633
Malaria	0	0	0	0	0	0
Total	7,005,323	5,192,639	5,059,434	5,239,605	5,420,343	27,917,344

1.3 Previous Global Fund grants

Table 1.3 – Previous Global Fund grants

Component	Previous grants	
	Rounds	Current Amount* (Euro / US$)
HIV/AIDS		
Tuberculosis		
Malaria		
HSS/Other	GF Round 1	11,719,047.00

* *Aggregate all past grants, including approved but as yet unsigned amounts. These amounts should include Phase 2 where this has been approved/signed. For more detailed information, see the Guidelines for Proposals, section 1.3.*

2 Eligibility

<u>Only</u> those Proposals that meet the Global Fund's eligibility criteria will be reviewed by the Technical Review Panel.

Eligibility is a multi-step process that depends on the income level of the country (or countries) applying for funding and, in some cases, disease burden.

Please read through this section carefully and consult the Guidelines for Proposals, section 2, for further guidance on the steps to be followed by each applicant.

2.1 Technical eligibility

2.1.1 Country income level

*Please tick the appropriate box in the table below. **For proposals from multiple countries**, complete the referenced information separately for each country (see the Guidelines for Proposals, section 2.1).*

Country/countries	Republic of Moldova	
☒	Low-income	➔ *Complete section 2.2 <u>only</u>*
☐	Lower-middle income	➔ *Complete sections 2.1.2, 2.1.3 <u>and</u> 2.2*
☐	Upper-middle income	➔ *Complete sections 2.1.2, 1.2.3, 2.1.4 <u>and</u> 2.2*

2 Eligibility

2.1.2 Counterpart financing and greater reliance on domestic resources

Please enter information on counterpart financing in table 2.1.2 below if the country(ies) listed above are classified as Lower-middle income or Upper-middle income.

Non-CCM Applicants do not have to fulfill the counterpart financing requirement.

The table should be filled in for each component included in this proposal. For definitions and details of counterpart financing requirements, see the Guidelines for Proposals, section 2.1.2.

***Important note:** The field "Total requested from the Global Fund" in table 2.1.2 below should equal the request in section 5 and table 5.1 for each corresponding component.*

Table 2.1.2 – Counterpart financing

Component	Financing sources	(Euro / US$)				
		Year 1	Year 2	Year 3 estimate	Year 4 estimate	Year 5 estimate
HIV/AIDS	**Total requested** from the Global Fund **(A)** [from table 5.1]	3,645,486	2,765,586	2,864,861	3,164,584	3,500,194
	Counterpart financing (B) [linked to the disease control program]	2,139,111	1,200,000	1,300,000		
	Counterpart financing as a **percentage** of total financing: **[B/(A+B)] x 100 = %**	36.98%	30.26%	31.21%	0.00%	0.00%

Table 2.1.2 – Counterpart financing continued

Component	Financing sources	(Euro / US$)				
		Year 1	Year 2	Year 3 estimate	Year 4 estimate	Year 5 estimate
Tuberculosis	**Total requested** from the Global Fund **(A)** [from table 5.1]	3,359,837	2,427,053	2,194,573	2,075,021	1,920,149
	Counterpart financing (B) [linked to the disease control program]	516,930	0	0	0	0
	Counterpart financing as a **percentage** of total financing: **[B/(A+B)] x 100 = %**	13.33%	0.00%	0.00%	0.00%	0.00%

Table 2.1.2 – Counterpart financing continued

Component	Financing sources	(Euro / US$)				
		Year 1	Year 2	Year 3 estimate	Year 4 estimate	Year 5 estimate
Malaria	**Total requested** from the Global Fund **(A)** [from table 5.1]	0	0	0	0	0
	Counterpart financing (B) [linked to the disease control program]					
	Counterpart financing as a **percentage** of total financing: **[B/(A+B)] x 100 = %**	**!Zero Divide**	**!Zero Divide**	**!Zero Divide**	**!Zero Divide**	**!Zero Divide**

2.1.3 Focus on poor or vulnerable populations

*All proposals from Lower-middle income and Upper-middle income countries must demonstrate a focus on poor or vulnerable population groups. Proposals may focus on both population groups but **must** focus on at least one of the two groups. Complete this section in respect of each component.*

Describe which poor and/or vulnerable population groups your proposal is targeting; why and how these populations groups have been identified; how they were involved in proposal development and planning; and how they will be involved in implementing the proposal *(Maximum half a page per component).*

2.1.4 High disease burden

Proposals from Upper-middle income countries must also demonstrate that they face a very high current disease burden. Please enter such information in the section below in respect of each component. Please note that if the applicant country falls under the "small island economy" lending eligibility exception as classified by the World Bank/International Development Association, this requirement does not apply (see section C in Attachment 1 to the Guidelines for Proposals).

Confirm that the country(ies) is(are) facing a very high current disease burden, as evidenced by data from WHO and UNAIDS. *(Please see the Guidelines for Proposals, section 2.1.4 for more information on the definition of high disease burden.)*

2.2 Functioning of Coordinating Mechanism

To be eligible for funding, all applicants, other than Non-CCM Applicants and Regional Organizations must meet the Global Fund's minimum requirements for Coordinating Mechanisms.

For additional information regarding these requirements, see:

- *The Guidelines for Proposals, section 2.2 and*
- *The CCM Guidelines.*

Please note that your application must provide documentation to show how the applicant meets these minimum requirements. You will be asked to re-confirm this in the Checklist at the end of section 3.

2.2.1 Broad and inclusive membership
a) People living with and/or affected by the disease(s) Provide evidence of membership of people living with and/or affected by the disease(s). *(This may be done by demonstrating corresponding Coordinating Mechanism membership composition and endorsement in table 3B1.2, and 3B.1.3 in section 3B of the Proposal Form.)*
People living with HIV/AIDS are represented in CCM on TB/AIDS as of 2005, when the CCM extended its functions from the oversight of Global Fund to Fight AIDS, Tuberculosis and Malaria and World Bank financed programmes to the oversight and monitoring of National Programmes on TB/HIV/AIDS/STI. The nongovernmental sector delegated representatives for the CCM decisional and operational levels during the Forum of NGOs working in TB and AIDS, which took place in April, 4th, 2005, including representatives of people living and/or affected by the disease. The transparecy of the process was ensured by observers from CCM and International organizations and by an open voting. The candidates

selected through the voting procedure at the NGO forum became official members of the CCM through the Government decision nr. 825 from the 3rd of August 2005.
See Attached.
Annex 1/CCM. Government decision Nr. 825 from the 3rd of August 2005 regarding the CCM Terms of Reference (Rom. and Eng.);
Annex 2/CCM. Minutes and decisions of the 1st National Forum of NGOs from the Republic of Moldova working in the field of HIV/AIDS and TB;
Annex 7/CCM. Minutes of the CCM meeting from the 11th of May 2006;
Annex 9/CCM. Minutes of the CCM meeting from March 2006;
Annex 11/CCM. CCM membership list, also available on the webpages: www.ccm.md and www.aids.md;
Annex 14/CCM. Minutes of the extended meeting of the Technical Working Group on HIV/AIDS;
Annex15/CCM. Minutes of the extended meeting of technical working groups on TB;
Annex 16/CCM. Minutes of the meeting of the local technical review committees

b) Selection of non-governmental sector representatives

Provide evidence of how those Coordinating Mechanism (CM) members representing each of the non-governmental sectors (*i.e. academic/educational sector, NGOs and community-based organizations, private sector, religious and faith-based organizations, and multi-/bilateral development partners in country)* have been selected by their own sector(s) based on a documented, transparent process developed within their own sector.

(Please summarize the process and, for each sector, attach as an annex the documents showing the sector's transparent process for CM representative selection, and the sector's minutes or other documentation recording the selection of their current representative. Please indicate the applicable annex number.)

Each CCM member represents a constituency. All nongovernmental sector representatives in the CCM are leaders of networks, unions or NGO facilitator organizations: Soros-Moldova Foundation - NGOs working in HIV/AIDS prevention with vulnerable groups (NGO facilitator); "Tineri si Liberi" – leader of the Social Network (includes AIDS network – information available on www.retea-sida.md); NGO"Credinta" – organizations of people living with HIV/AIDS in Moldova; AIHA - NGOs active in TB; and Red Cross Society in Moldova represents the network of branch organizations throughout Moldova.
The nongovernmental sector selected their representatives for the CCM decisional and operational levels in a democratic and transparent way during the Forum of NGOs working in TB/AIDS fields in April, 4th, 2005, including representatives for people living and/or affected by the disease. See Annex 2 and Annex 8. All NGOs members were approved through the Government decision nr. 825 from the 3rd of August 2005. See Annex 1.
The representatives of international organizations have been delegated to CCM through a UN Theme Group on HIV/AIDS resolution in 2002. See Annex 18.
See Attached:
Annex 1/CCM. Government decision Nr. 825 from the 3rd of August 2005 regarding the CCM Bylaws;
Annex 2/CCM. Discussions and decisions of the First Monitoring Workshop of the Resolution of the 1st National Forum of NGOs from the Republic of Moldova working in the field of HIV/AIDS and TB;
Annex 8/CCM. List of CCM Technical working groups members and the institutions they represent;
Annex 18/CCM. Minutes of the UNTG on HIV/AIDS from 2002.

2.2.2 Documented procedures for the management of conflicts of interest

Where the Chair and/or Vice-Chair of the Coordinating Mechanism are from the same entity as the nominated Principal Recipient(s) in this proposal, describe and provide evidence of the applicant's documented conflict of interest policy to mitigate any actual or potential conflicts of interest arising in regard to the applicant's operations or responsibilities.

(Please summarize and attach the policy as an annex. Please indicate the applicable annex number.)

Annex 3/CCM. Policy of conflicts of interests in Republic of Moldova

2 Eligibility

2.2.3 Documented and transparent processes of the Coordinating Mechanism

As part of the eligibility screening process for proposals, the Global Fund will review supporting documentation setting out the CCM's proposal development process, the submission and review process, the nomination process for Principal Recipient(s), as well as the minutes of the meeting where the CCM decided on the elements to be included in the proposal and made the decision about the Principal Recipient(s) for this proposal.

Please describe and provide evidence of the CCM's documented, transparent and established:

a) **Process to solicit** submissions for possible integration into this proposal.
(Please summarize and attach documentation as an annex and indicate the applicable annex number.)

The decision to apply to the VI round of the Global Fund to fight AIDS, tuberculosis and Malaria was taken during the CCM meeting from the 11th of May 2006. See Annex 7 and Annex 4. The same meeting approved the Development and Approval Mechanism of the Grant Proposal to Global Fund by Republic of Moldova Following the agreed mechanism, the draft proposals were developed by the CCM Technical Working Groups (TWG)., widely and multisectorally represented: representatives of governmental institutions, NGOs, multilateral and biletaral organizations, (the TWG were approved at the CCM meeting from March 2006. See Annex 5.). CCM has 10 functional TWG: 5 - in HIV/AIDS field; 4 – in TB field; one common TB/AIDS– monitoring and evaluation. Every group in HIV/AIDS field has representatives of people living/or affected by the disease (See Annex 8).
The consultation process may be followed in its dynamics on www.aids.md and the results of the discussions are posted on www.ccm.md. Also, information about the sites and solicitation of submissions was published in "Moldova Suverana" newspaper (Romanian language) and "Economiceskoie obozrenie" newsletter (Russian language) at the end of May 2006 (See Annex 6). The information was published in the CCM Info Bulletin (Annex 6). UNAIDS Moldova offered support to incorporate the proposals from the TWG into the national one on the HIV/AIDS component, whereas AIHA Moldova – on Tuberculosis. In parallel, the draft proposals summitted by the TWG were revised in 2 extended meetings of the technical working groups for both TB and HIV/AIDS components (See Annexes 14 and 15).The consolidated proposals were reviewed, discussed and approved by 2 local technical review committees (one for TB and one for HIV/AIDS - responsible chiefs of the TWG, international organizations representatives, PLWA, NGO, representatives from Transnistria region. See Annex 16.
See attached.
Annex 4/CCM. CCM decision from the 11th of May 2005. The mechanism of elaboration annexed;
Annex 5/CCM. CCM decision from March 2006. Approval of TWG;
Annex 6/CCM. The text of CCM information of Global Fund process in the newspapers;
Annex 7/CCM. Minutes of the CCM meeting from the 11th of May 2006.
Annex 8/CCM. List of CCM Technical working groups members and the institutions they represent
Annex 14/CCM. Minutes on the meeting of the extended meeting of the TWG on HIV/AIDS;
Annex 15/CCM. Minutes on the meeting of the extended meeting of the TWG on TB;
Annex 16/CCM. Minutes on the meeting of the local technical review committees.

b) **Process to review** submissions received by the CCM for possible integration into this proposal.
(Please summarize and attach documentation as an annex and indicate the applicable annex number.)

The proposal to the Global Fund was developed though the CCM TWG. There are a total of 10 TWG: 5 on HIV/AIDS, 4 on TB and 1 mixed on M&E. The membership of the TWG was approved at the CCM meeting from March 2006. See Annex 5. The TWG are widely and multisectorally represented and are focused on key area objectives. Every group in HIV/AIDS field has representatives of people living/or affected by the disease. See Annex 8. Each of the TWG received submissions, reviewed them, and developed drafts based on the key areas under the National HIV/AIDS/STI/TB Programs. Also, in order to ensure transparency and communication among stakeholders, all submissions, all drafts developed and discussed by the TWG, as well as all the meetings scheduled for discussion have been posted on http://www.aids.md/coordination/consultation/.
The draft proposals of TWG were reviewed in 2 meetings of extended TWG representativeness: one for TB and one for HIV/AIDS components. See Annexes 14 and 15. All the revised proposals were incorporated in a consolidated document with the assistance of UNAIDS Moldova (HIV/AIDS/STI

component) and AIHA (TB component). The consolidated proposals were reviewed, discussed and approved by the 2 local technical review committees (one for TB and one for HIV/AIDS), which include leaders of the TWG, international organizations, PLWA, NGO, etc. See Annex 16.
See attached:
Annex 5/CCM. CCM decision from March 2006. Approval of TWG;
Annex 8/CCM. List of CCM Technical working groups members and the institutions they represent
Annex 14/CCM. Minutes on the meeting of the extended meeting of the TWG on HIV/AIDS;
Annex 15/CCM. Minutes on the meeting of the extended meeting of the TWG on TB;
Annex 16/CCM. Minutes on the meeting of the local technical review committees

c) Process to nominate the Principal Recipient(s) and **oversee** program implementation.
(Please summarize and attach documentation as an annex and indicate the applicable annex number.)

Under the previous 5-year Global Fund grant, the managemement and disbursement of fund was carried out through one national organization – Project Coordination, Implementation and Monitoring Unit, Ministry of Health and Social Protection. According to its status, the Unit is subjected to the Ministry of Health and Social Protection and is under the oversight of the CCM.
The discussions related to the principal recipient were held at the CCM meeting from the 11th of May 2006. The detailed discussion is described in the minutes of the CCM meeting from the 11th of May 2005. See Annex 7. It was decided that the principal recipient will remain the Ministry of Health and Social Protection through Project Coordination, Implementation and Monitoring Unit. See Annex 4.
See attached:
Annex 4/CCM. CCM decision from the 11th of May 2005. The mechanism of elaboration annexed.
Annex 7/CCM. Minutes of the CCM meeting from the 11th of May 2006..

d) Process to ensure the input of a broad range of stakeholders, including CCM members and non-CCM members, in the proposal development process and grant oversight process. *(Please summarize and attach documentation as an annex and indicate the applicable annex number.)*

A broad range of stakeholders, represented in the CCM through technical working groups (TWG) developed the drafts of the proposal. The operational level of CCM is functional through 10 TWG: 5 – in HIV/AIDS field and 4 in TB field, 1 mixed on M&E. TWG members are representing different constituencies: government, nongovernament, academic and international organizations, as well as from different regions of the country, including Transnistria region. See Annex 8.
TWG members were responsible to analyse and discuss the proposals submitted by non CCM members. The non CCM members (representatives of private, religiouse, academic, civil society members, mass media) were invited by CCM Secretariat to participate at the elaboration of the proposal through mass media. See Annex 6. The technical working groups met for several times in order to discuss and develop the drafts proposals. All the summaries of the meetings were placed on http://www.aids.md/coordination/ccm/ and www.ccm.md.
See attached:
Annex 6/CCM. The text of CCM information of Global Fund process in the newspapers
Annex 8/CCM. List of CCM Technical working groups members and the institutions they represent

3A Applicant Type

This section contains information on the applicant. Please see the Guidelines for Proposals, section 3A, for more information regarding the nature of different applicants.

***All Coordinating Mechanism Applicants** (whether national, sub-national, regional (C)CMs) and Regional Organizations **must also** complete section 3B of this Proposal Form and provide the documented evidence requested.*

***Non-CCM Applicants** do not complete section 3B. These applicants must fully complete section 3A.5 of this Proposal Form and provide documentation as an attachment to this proposal supporting their claim to be considered as eligible for Global Fund support outside of a Coordinating Mechanism structure.*

3A.1 Applicant

Table 3A.1 – Applicant

Please tick the appropriate box in the table below, and then go to the relevant section in this Proposal Form, as indicated on the right hand side of the table.	
National Country Coordinating Mechanism	*complete sections 3A.2 and 3B*
Sub-national Country Coordinating Mechanism	*complete sections 3A.3 and 3B*
Regional Coordinating Mechanism (including small island developing states)	*complete sections 3A.4 and 3B*
Regional Organization	*complete section 3A.5 and 3B*
Non-CCM Applicants	*complete section 3A.6*

3A Applicant Type

3A.2 National Country Coordinating Mechanism (CCM)

For more information, please refer to the Guidelines for Proposals, section 3A.2, and the CCM Guidelines.

Table 3A.2 – National CCM: basic information

Name of national CCM	**Date of composition** (yyyy/mm/dd)
Country Coordination Mechanism on National HIV/AIDS/STI Prophylaxis and Control and TB Control and Prophylaxis Programmes	2005/08/03

3A.2.1 Mode of operation

Describe how the national CCM operates. In particular:

- **The extent to which the CCM acts as a partnership between government and other actors in civil society**, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the diseases and the organizations that support them; the private sector; religious and faith-based organizations; and multi-/bilateral development partners in-country; and
- **How it coordinates its activities with other national structures** (such as National AIDS Councils, Parliamentary Health Commissions, National Monitoring and Evaluation Offices and other key bodies).

(For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc. The recommended length of response is a maximum of one page. Please provide terms of reference, statutes, by-laws or other governance documentation relevant to the CCM, and a diagram setting out the interrelationships between all key actors in the country as an annex to this proposal. Please indicate the applicable annex number.)

The Country Coordination Mechanism of the National HIV/AIDS/STI Prophylaxis and Control and TB Control and Prophylaxis Programmes (hereinafter CCM) was approved through the Government Decision nr.825, from the 3rd of August 2005. It represents the successor of the CCM for monitoring the TB/AIDS programme, financed by the Global Fund to fight AIDS, TB and Malaria and the World Bank, created in March 2002.
The CCM plays a leading role in coordinating and implementing the country's multisectoral response to the epidemics since its establishment in 2002 and currently counts 22 members: 9 from governmental constituency, 5 – nongovernmental sector, including people living with HIV, 8 – donor, multilateral and bilateral development agencies. See Annex 1.
The CCM aims to contribute to the effective implementation of the National Program for Prevention of HIV/AIDS and the National Program on TB Control, acting as a nexus point for coordinating and overseeing donor financing in support of the national commitment and priorities to fight HIV/AIDS/STIs and TB. CCM has assumed oversight responsibilities for programs funded by the World Bank, the Global Fund, USAID, Swedish governments, and UN agencies ensuring harmonized approach towards achieving the national program goals and Moldova's health-related MDGs. The CCM is an integral part of the "Three Ones" system in the country serving as the national HIV/AIDS and TB coordinating body. CCM approves the national documents elaborated by technical working groups. See Annex 5 and 9. The CCM members meet at least 4 times a year (or more frequently if needed).
The members of the nongovernment sector were selected for both decisional and operational levels through a transparent and democratic process, during the NGO Forum of the nongovernmental organization working in the TB/AIDS field. See Annex 2.
The CCM's structure is organized on three levels: decisional (22 representatives), coordination (CCM Secretariat), and operational (10 technical working groups). The technical working groups (5 active in HIV/AIDS field, 4 in TB field and 1 mixed monitoring and evaluation TB/AIDS) are responsible to assess the needs in their specific areas, to identify solutions, to develop drafts of the national documents, strategies and policies. The technical working groups are widely represented, including nongovernment sector, governmental and international ones, as well as representatives from different regions of the country, including Transnistria.

3A Applicant Type

The Secretariat of the CCM (supported financially by World Bank and UNAIDS) is responsible for the coordination and information activities, as well as facilitating the nation wide consultancy processes, and CCM meetings: information on the CCM processes and news is mostly shared through email, via a daily online newspaper to every CCM member. CCM members are always asked to distribute the materials to their constituencies. There is also a printed quaterly newspaper “CCM Informational Bulletin” distributed to a large range of beneficiaries. See Annex 17. UNAIDS office is providing information related to Global Fund processes via the online daily news distributed through email to a wide range of stakeholders.

In the course of grant implementation the CCM has been contributing to the efficient implementation of the grant in different ways: from timely addressing the implementation constraints, considering and endorsing proposals for utilization of program savings realized due to efficient procurement processes to harmonizing coordination with partners.

See attached:

Annex 1/CCM. CCM Nr. 825, Government decision from the 3rd of August 2005 regarding the CCM Bylaws;

Annex 2/CCM. Discussions and decisions of the First Monitoring Workshop of the Resolution of the 1st National Forum of NGOs from the Republic of Moldova working in the field of HIV/AIDS and TB.

Annex 5/CCM CCM decision from March 2006. Approval of TWG;

Annex 9/CCM. Minutes of the CCM meeting from March 2006;

Annex 12. CCM Info Bulletin sample;

Annex 17/CCM. List of Informational Bulletin beneficiaries;

Annex 19/CCM. The diagram setting out the interrelationships between main key actors.

➔ *After completing this section, complete section 3B.1.*

3A Applicant Type

3A.3 Sub-national Country Coordinating Mechanism

For more information, please refer to the Guidelines for Proposals, section 3A.3, and the CCM Guidelines.

Table 3A.3 – Sub-national CCM: basic information

Name of sub-national CCM	**Date of composition** (yyyy/mm/dd)

3A.3.1 Mode of operation
Describe how the sub-national CCM operates. In particular: • **The extent to which the sub-national CCM acts as a partnership between government and other actors in civil society**, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the diseases and the organizations that support them; the private sector; religious and faith-based organizations; multi-/bilateral development partners in-country; and • **How it coordinates its activities with other national structures** (such as National AIDS Councils, Parliamentary Health Commissions, National Monitoring and Evaluation Offices and other key bodies). *(For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc. The recommended length of response is a maximum of one page. Please provide terms of reference, statutes, by-laws or other governance documentation relevant to the sub-national CCM, and a diagram setting out the interrelationships between all key actors as an annex to this proposal. Please indicate the appropriate annex number.)*

3A.3.2 Rationale
a) Explain why a sub-national CCM has been chosen. *(Maximum of half a page.)*
b) Describe how this proposal is consistent with and complements the national strategy for responding to the disease and/or the national CCM plans. *(Maximum of half a page.)*

➔ *After completing this section, complete section 3B.1.*

3A Applicant Type

3A.4 Regional Coordinating Mechanism (including small island developing states)

For more information, please refer to the Guidelines for Proposals, section 3A.4, and the CCM Guidelines.

Table 3A.4 – Regional Coordinating Mechanism: basic information

Name of regional Coordinating Mechanism (RCM)	**Date of composition** (yyyy/mm/dd)

3A.4.1 Mode of operation

Describe how the RCM operates. In particular:

- **The extent to which the RCM acts as a partnership between government and other actors in civil society**, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the diseases and the organizations that support them; the private sector; religious and faith-based organizations; multi-/bilateral development partners in-country; and
- **How it coordinates its activities with the national structures of the countries that are included** in the proposal (such as national AIDS councils, national CCMs, or the national strategies of small island developing states who do not have their own national CCM or other national coordinating body.)
- **The RCM's governance structure and processes,** and how the implementation strategy and timelines have taken into account the regional context, including the need to coordinate between multiple entities.

(For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc. The recommended length of response is a maximum of one page. Please provide terms of reference, statutes, by-laws or other governance documentation relevant to the RCM, and a diagram setting out the interrelationships between key actors across the included countries as an annex to this proposal. Please indicate the appropriate annex number.)

3A.4.2 Rationale

a) Explain why a RCM approach has been chosen. *(Maximum of half a page.)*

b) Describe how this proposal is consistent with and complements the national strategies of countries included and/or the national CCM plans. *(Maximum of half a page.)*

c) Provide details of how this proposal will achieve cross-border or multi-country outcomes that would not be possible with only national approaches. *(Maximum of half a page.)*

d) Explain how the RCM represents a natural collection of countries and describe what measures will be taken to maximize operational efficiencies in administrative processes of the RCM. *(Maximum of half a page.)*

➔ *After completing this section, complete section 3B.1.*

3A Applicant Type

3A.5 Regional Organizations (including Intergovernmental Organizations and International Non-Government Organizations)

For more information, please refer to the Guidelines for Proposals, section 3A.5.

Table 3A.5 – Regional Organization: basic information

Name of Regional Organization
Sector represented by the Regional Organization

3A.5.1 Mode of operation *In addition to answering the sections below, Regional Organizations should provide, as additional annexes to this proposal documentation describing the organization, such as:* • *Statutes, by-laws of organization (official registration papers); and* • *A summary of the main sources and amounts of funding.* Describe how the Regional Organization operates. In particular: • The manner in which the Regional Organization gives effect to the principles of **inclusiveness and multi-sector consultation** and partnership in the development and implementation of regional cross-border projects; and • **The coverage and past experience** of the Regional Organization's operations. *(Maximum of half a page.)*

3A.5.2 Rationale
a) Explain why a Regional Organization has been chosen and the added value of the proposed regional approach beyond the national response of individual countries. *(For example, address cross-border or regional issues. Maximum of half a page.)*
b) Describe how this regional proposal is consistent with and complements the national plans for responding to the disease of each country involved. *(Maximum of half a page.)*
c) Provide details of how this proposal will achieve cross-border or multi-country outcomes that would not be possible with only national approaches. *(Maximum of half a page.)*

3A Applicant Type

d) Explain how the Regional Organization represents a natural collection of countries and describe what measures will be taken to maximize operational efficiencies in administrative processes. *(Maximum of half a page.)*

➔ *After completing this section, complete section 3B.2.*

3A Applicant Type

3A.6 Non-CCM Applicants

*Non-CCM proposals are **only eligible for funding under exceptional circumstances listed in section 3A.6.2 below**. For more information, please refer to the Guidelines for Proposals, section 3A.6.*

In addition to answering the sections below, all Non-CCM proposals should include as annexes additional documentation describing the organization, such as: statutes and by-laws of organization (official registration papers) or other governance documents, documents evidencing the key governance arrangements of the organization; a summary of the organization, including background and history, scope of work, past and current activities; and a summary of the main sources and amounts of existing funding.

Table 3A.6 – Non-CCM Applicant: basic information

Name of Non-CCM Applicant	
Street address	

	Primary contact	**Secondary contact**
Name		
Title		
Organization		
Mailing address		
Telephone		
Fax		
E-mail address		

Indicate the type of your sector (tick appropriate box):

- ☐ Academic/educational sector
- ☐ Government
- ☐ NGOs/community-based organizations
- ☐ People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria
- ☐ Private sector
- ☐ Religious/faith-based organizations
- ☐ Multilateral and bilateral development partners in country
- ☐ Other
  (please specify):

3A.6.2 Rationale for applying outside a Coordinating Mechanism
a) Non-CCM proposals are **only eligible** if they satisfactorily explain that they originate from one of the following: i) Countries without legitimate governments; ii) Countries in conflict, facing natural disasters, or in complex emergency situations (which will be identified by the Global Fund through reference to international declarations such as those of the United Nations Office for the Coordination of Humanitarian Affairs [OCHA]); or iii) Countries that suppress, or have not established partnerships with civil society and NGOs. Describe which of the **above conditions** apply to this proposal. (*Maximum of two pages. Please refer to the Guidelines for Proposals, section 3A.6.2 for further information.)*

b) Describe your organizations **attempts to include this proposal in the relevant CCM's final approved country proposal** and the responses, if any, from the CCM. *(Maximum of one page. Please provide documentary evidence of these attempts and any response from the CCM (national, sub-national or regional) as an annex to the proposal.)*

*If this Non-CCM proposal originates from a country in which no CCM exists (for example, a small island developing state), please **also** complete section 3A.6.3.*

3A.6.3 Consistency with national policies
Describe how this proposal is consistent with, and complements, national policies and strategies (or, if appropriate, why this proposal is not consistent with national policy). *(Maximum of one page. Provide evidence (e.g., letters of support) from relevant national authorities in an annex to the proposal.)*

➔ After completing this section, complete section 4.

3B Proposal Endorsement

3B.1 Coordinating Mechanism membership and endorsement:

All national, sub-national and regional Coordinating Mechanisms must complete this section. Regional Organizations must complete section 3B.2.

National/Sub-national/Regional Coordinating Mechanisms

3B.1.1 Leadership of Coordinating Mechanism

Table 3B.1.1 – National/Sub-national/Regional (C)CM leadership information
(not applicable to Non-CCM and Regional Organization applicants)

	Chair	Vice Chair
Name	Ion Ababii	Viorelia Moldovan-Batrinac
Title	Minister of Health and Social Protection	Deputy Minister of Youth and Education
Organization	Ministry of Health and Social Protection	Ministry of Youth and Education
Mailing address	2, V. Alecsandri str, MD 2009, Chisinau, Republic of Moldova	1, Piata Marii Adunari nationale str, Chisinau, Republic of Moldova
Telephone	+ 373 22 72 99 07	+ 373 22 23 34 22
Fax	+373 22 73 87 71	NA
E-mail address	silmunt@mednet.md	preuniversitar@edu.md

3B.1.2 Membership information

Please note that to be eligible for funding, national/sub-national/regional Coordinating Mechanisms must demonstrate evidence of membership of people living with and/or affected by the diseases. It is recommended that the membership of the CCM comprise a minimum of 40% representation from non-governmental sectors. For more information on this, see the Guidelines for Proposals section 3B.1, and the CCM Guidelines.

*The table below must be completed for **each** national/sub-national/regional Coordinating Mechanism **member**, and the table will therefore need to be extended to cover numerous members.*

Use the "Add_Member" button in the standard toolbar.

*Under "**Type**", please specify which sector the CCM member represents: academic/educational; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; or multi-/bilateral development partners in country.*

Table 3B.1.2 – National/sub-national/regional (C)CM member information

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Ministry of Health and Social Protection	Website	www.ms.md
Type	Government		
Name of representative	Ion Ababii	CCM member since	2005, the entity from 2002
Title in agency/organization	Minister of Health and Social Protection	Fax	+373 22 73 87 71
E-mail address	silmunt@mednet.md	Telephone	+ 373 22 72 99 07
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	CCM Chair (strategic overview, ensuring synergies, overall coordination and approval etc.)	Mailing address	2, V. Alecsandri str, MD 2009, Chisinau, Republic of Moldova
Member			
Agency/organization	Ministry of Youth and Education	Website	www.edu.md
Type	Government		
Name of representative	Viorelia Moldovan-Batrinac	CCM member since	2005, the entity from 2002
Title in agency/organization	Deputy Minister of Youth and Education/Ministry of	Fax	+373 22 23 35 15

	Youth and Education		
E-mail address	preuniversitar@edu.md	Telephone	+ 373 22 23 34 22
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Vice Chair (review and approval)	Mailing address	1, Piata Marii Adunari nationale str, Chisinau, Republic of Moldova
Member			
Agency/organization	Ministry of Finance	Website	NA
Type	Government		
Name of representative	Ion Chicu	CCM member since	2006, the entity from 2002
Title in agency/organization	Vice Minister of Finance	Fax	+ 373 22 22 82 27
E-mail address	NA	Telephone	+373 22 24 37 26
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, financial input	Mailing address	7, Cosmonautilor str. Chisinau, Republic of Moldova
Member			
Agency/organization	Ministry of Justice	Website	NA
Type	Government		
Name of representative	Nicolae Esanu	CCM member since	2002
Title in agency/organization	Vice - Minister of Justice	Fax	NA
E-mail address	NA	Telephone	+373 22 20 14 18
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator,*	member, reviewed and approved the proposal	Mailing address	82, 31 August 1989 street. Chisinau, Republic of Moldova

financial input, review, other)			
Member			
Agency/organization	AIDS Centre	Website	NA
Type	Government		
Name of representative	Stefan Gheorghita	CCM member since	2005
Title in agency/organization	Prime-vice Director, AIDS Centre	Fax	+ 373 22 72 97 25,
E-mail address	naac@sanepid.md	Telephone	+ 373 22 46 92 95, + 373 22 46 94 43
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, participated at proposal preparation, review, approval	Mailing address	7/1 Studentilor str. MD 2020, Chisinau, Republic of Moldova
Member			
Agency/organization	Swedish International Development Cooperation Agency /Sida	Website	www.sida.se
Type	bilateral development agency		
Name of representative	Hans Lundquist	CCM member since	2005
Title in agency/organization	First Secretary, Embassy of Sweden, Head of Sida	Fax	+ 373 22 23 29 85
E-mail address	office@asdi.md, hans.lundquist@asdi.md	Telephone	+ 373 22 23 29 83
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, technical input, proposal review and approval	Mailing address	108/1, 31 August 1989 str. MD 2005 Chisinau, Republic of Moldova

3B Proposal Endorsement

Member			
Agency/organization	Ministry of Internal Affairs	Website	NA
Type	Government		
Name of representative	Valentin Zubic	CCM member since	2005, the entity from 2002
Title in agency/organization	Vice Minister of Internal Affairs	Fax	NA
E-mail address	NA	Telephone	+ 373 22 25 53 42
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	member, approved the proposal	Mailing address	75, Stefan cel Mare str,
			Chisinau, Republic of Moldova
Member			
Agency/organization	World Bank	Website	www.worldbank.org.md
Type	multilateral development agency		
Name of representative	Edward Brown	CCM member since	2002
Title in agency/organization	Country Manager	Fax	+ 373 22 23 70 53
E-mail address	ecorman@worldank.org	Telephone	+ 373 22 23 35 65
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, review and approval of the proposal	Mailing address	76/6, Sciusev str.,
			MD 2012, Chisinau, Republic of Moldova
Member			
Agency/organization	UN	Website	www.undp.org
Type	multilateral development agency		
Name of representative	Bruno Pouezat	CCM member since	2002
Title in agency/organization	UN Resident	Fax	+ 373 22 22 00 41

	Coordinator in Moldova		
E-mail address	registry.md@undp.org, bruno.pouezat@undp.org	Telephone	+ 373 22 22 00 45
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	member, reviewed and approved the proposal	Mailing address	MD 2012, 131, 31 August 1989 str, Chisinau, Republic of Moldova
Member			
Agency/organization	UNICEF	Website	www.unicef.org
Type	Multilateral development agency		
Name of representative	Ray Virgilio Torres	CCM member since	2005, the entity from 2002
Title in agency/organization	UNICEF Representative in Moldova	Fax	+ 373 22 22 02 44
E-mail address	chisinau@unicef.org	Telephone	+ 373 22 22 00 34
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, reviewed and approved the proposal	Mailing address	131, 31 August 1989 str, MD 2012, Chisinau, Republic of Moldova
Member			
Agency/organization	WHO	Website	www.who.int
Type	Multilateral development agency		
Name of representative	Pavel Ursu	CCM member since	2002
Title in agency/organization	Head of WHO Country Office in Moldova	Fax	+ 373 22 23 73 46
E-mail address	pursu.who@un.md	Telephone	+ 373 22 23 73 48
Main role in the Coordinating Mechanism and the proposal development	CCM member, reviewed and approved the proposal.	Mailing address	27 Sfatul Tarii str. MD 2012, Chisinau,

3B Proposal Endorsement

(proposal preparation, technical input, component coordinator, financial input, review, other)	The organization provided assistance in the preparation and review of the drafts.		Republic of Moldova
Member			
Agency/organization	UNAIDS	Website	www.aids.md
Type	multilateral development agency		
Name of representative	Gabriela Ionascu	CCM member since	2002
Title in agency/organization	UNAIDS Programme Coordinator in Moldova	Fax	NA
E-mail address	gabriela.ionascu@un.md	Telephone	+ 373 22 22 00 45, + 373 691 23 392
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member. Prepared, reviewed, provided technical assistance, financial input, coordinated, approved the proposal	Mailing address	131, 31 August 1989 str.
			MD 2012, Chisinau, Republic of Moldova
Member			
Agency/organization	Soros-Moldova Foundation	Website	www.soros.md
Type	Nongovernmental organization		
Name of representative	Victor Ursu	CCM member since	2002
Title in agency/organization	Executive Director	Fax	+ 373 22 27 05 07
E-mail address	vursu@soros.md	Telephone	+ 373 22 27 02 32, + 373 22 27 00 31
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	NGO facilitator. Reviewed and aproved the proposal. Th eorganization provided assistance in preparing, coordinating with Harm Reduction network, reviewing the proposal.	Mailing address	32, Bulgara str.
			MD 2021, Chisinau, Republic of Moldova
Member			
Agency/organization	USAID	Website	www.usaid.org

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Type	Bilateral Development Agency		
Name of representative	Diana Cazacu	CCM member since	2002
Title in agency/organization	USAID/Moldova Project Manager	Fax	+ 373 22 23 72 77
E-mail address	dcazacu@usaid.gov	Telephone	+ 373 22 20 18 16
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, reviewed and approved the proposal	Mailing address	57/1 Banulescu Bodoni str, Chisinau, Republic of Moldova
	Member		
Agency/organization	AIHA	Website	www.aiha.com
Type	NGOs/Community-Based Organisations, representative of TB NGOs in the country		
Name of representative	Viorel Soltan	CCM member since	2005
Title in agency/organization	Chief of party / Project Director	Fax	+ 373 22 22 67 37
E-mail address	viorel@aiha.moldnet.md	Telephone	+ 373 22 27 93 80
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, participated at proposal preparation, review, technical input, approval.	Mailing address	29/1, Armeneasca str. MD 2012, Chisinau, Republic of Moldova
	Member		
Agency/organization	Project Coordination, Implementation and Monitoring Unit of the Ministry of Health	Website	NA
Type	Government		
Name of representative	Victor Volovei	CCM member since	2002
Title in agency/organization	Director Executive, Project Coordination Unit	Fax	+ 373 22 23 87 51

3B Proposal Endorsement

E-mail address	vvolovei@ucimp.md	Telephone	+ 373 22 23 87 51
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, reviewed and approved the proposal. Provided technical input	Mailing address	101, Sciusev str. MD 2012, Chisinau, Republic of Moldova
Member			
Agency/organization	Young and Free: Training Resource Centre	Website	www.retea-sida.md
Type	NGO		
Name of representative	Antonita Fonari	CCM member since	2005
Title in agency/organization	Executive Director	Fax	+ 373 22 567 551
E-mail address	presedinte@retea-social.md, secretariat@retea-sida.md	Telephone	+ 373 22 567 551
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, AIDS Network. particiapted at proposal preparation, review and coordiantion with AIDS network (around 40 NGOS)	Mailing address	C/P 3036, MD 2072, Chisinau Moldova Chisinau, Republic of Moldova
Member			
Agency/organization	Red Cross Society in RM	Website	http://www.icrc.org/
Type	GOs/Community-Based Organisations		
Name of representative	Larisa Birca	CCM member since	2005
Title in agency/organization	Chair	Fax	+ 373 22 72 58 24
E-mail address	crucearosie@moldnet.md	Telephone	+ 373 22 72 96 44
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical*	Member, reviewed and approved the proposal	Mailing address	67 a, Asachi str. Chisinau, Republic of Moldova

input, component coordinator, financial input, review, other)			
Member			
Agency/organization	Credinta Association	Website	www.aidsmd.narod.ru
Type	People living with HIV/AIDS		
Name of representative	Igor Chilcevschii	CCM member since	2005
Title in agency/organization	Chair	Fax	+ 373 22 43 81 35
E-mail address	credinta@hotmail.ru	Telephone	+ 373 22 43 81 35, + 373 22 44 65 10
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, participated at the elaboration, preparation, review and approval of the proposal	Mailing address	C/P 2839, MD 2068, Chisinau Chisinau, Republic of Moldova
Member			
Agency/organization	UNFPA	Website	www.unfpa.org
Type	Multilateral development Agency		
Name of representative	Boris Gilca	CCM member since	2005
Title in agency/organization	Programme Coordinator	Fax	+ 373 22 21 40 03
E-mail address	boris.gilca@un.md, boris@unfpa.org	Telephone	+ 373 22 22 00 45
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member . Participated at proposal development, review and approval	Mailing address	UN House, 4th floor, 31 August 1989, N 131 street MD 2012, Chisinau, Republic of Moldova
Member			
Agency/organization	Government of Republic of Moldova	Website	www.gov.md
Type	Government		

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Name of representative	Rodica Scutelnic	CCM member since	2006, the entity from 2002
Title in agency/organization	Senior Consultant, Social Development Department, State Chancellory	Fax	+ 373 22 250 447
E-mail address	rchimirciuc@yahoo.com	Telephone	+ 373 22 250 447
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	CCM Executive Secretary, facilitated the organization of CCM proposal development	Mailing address	1, Piata Marii Adunari Nationale str. Chisinau, Republic of Moldova
Member			
Agency/organization	Ministry of Health and Social Protection	Website	www.ms.md
Type	Government		
Name of representative	Boris Golovin	CCM member since	2005, the entity from 2002
Title in agency/organization	Vice Minister of Health and Social Protection	Fax	+ 373 22 73 87 81
E-mail address	bgolovin@mednet.md	Telephone	+ 373 22 72 95 90
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, facilitated the organization of CCM proposal development and provided technical input	Mailing address	2, V. Alecsandri str, MD 2009, Chisinau, Republic of Moldova
Member			
Agency/organization		Website	
Type			
Name of representative		CCM member since	
Title in agency/organization		Fax	
E-mail address		Telephone	

3B Proposal Endorsement

<table>
<tr><td rowspan="4">Main role in the Coordinating Mechanism and the proposal development
(proposal preparation, technical input, component coordinator, financial input, review, other)</td><td rowspan="4"></td><td rowspan="4">Mailing address</td><td></td></tr>
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<tr><td colspan="4">Member</td></tr>
<tr><td>Agency/organization</td><td></td><td>Website</td><td></td></tr>
<tr><td>Type</td><td colspan="3"></td></tr>
<tr><td>Name of representative</td><td></td><td>CCM member since</td><td></td></tr>
<tr><td>Title in agency/organization</td><td></td><td>Fax</td><td></td></tr>
<tr><td>E-mail address</td><td></td><td>Telephone</td><td></td></tr>
<tr><td rowspan="4">Main role in the Coordinating Mechanism and the proposal development
(proposal preparation, technical input, component coordinator, financial input, review, other)</td><td rowspan="4"></td><td rowspan="4">Mailing address</td><td></td></tr>
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</table>

3B Proposal Endorsement

3B.1.3 National/Sub-national/Regional (C)CM endorsement of proposal

Coordinating Mechanism members must endorse the proposal. Limited exceptions are described in the Guidelines for Proposals in section 3B.1.3. Please note that the ***original*** *(not photocopied, scanned or faxed) signatures of the CCM members should be provided in table 3B.1.3. The minutes of the CCM meetings at which the proposal was developed and endorsed must be attached as an annex to this proposal. The entire proposal, including the signature page and minutes, must be received by the Global Fund Secretariat before the deadline for submitting proposals.*

Applicant name	Country Coordination Mechanism on National HIV/AIDS/STI Prophylaxis and Control and TB Control and Prophylaxis Programmes
Country/countries	Republic of Moldova

"Each of the undersigned, hereby certify that s/he has reviewed the final proposal and supports it."

Table 3B.1.3 – National/sub-national/regional (C)CM endorsement of proposal

Agency/organization	**Name of representative**	**Title**	**Date** (yyyy/mm/dd)	**Signature**
Ion Ababii	Ministry of Health and Social Protection	Minister of Health and Social Protection	2006/07/20	
Viorelia Moldovan-Batrinac	Ministry of Education and Youth	Vice Minister of Education and Youth	2006/07/20	
Rodica Scutelnic	Government of Republic of Moldova	Senior Consultant, State Chancellory	2006/07/20	
Boris Golovin	Ministry of Health and Social Protection	Vice Minister of Health and Social Protection	2006/07/20	
Ion Chicu	Ministry of Finance	Vice Minister of Finance	2006/07/20	
Nicolae Esanu	Ministry of Justice	Vice Minister of Justice	2006/07/20	
Stefan Gheorghita	Ministry of Health and Social Protection	Prime-Vice Director, AIDS Center	2006/07/20	
Hans Lundquist	Swedish International Development Cooperation Agency / Sida	First Secretary, Embassy of Sweden, Head of Sida	2006/07/20	
Valentin Zubic	Ministry of Internal Affairs	Vice Minister of Internal	2006/07/20	

		Affairs		
Edward Brown	World Bank	Country Manager	2006/07/20	
Bruno Pouezat	UNDP	UN Resident Coordinator	2006/07/20	
Ray Virgilio Torres	UNICEF	UNICEF Representati ve in Moldova	2006/07/20	
Pavel Ursu	WHO	Head of WHO country office in Moldova	2006/07/20	
Gabriela Ionascu	UNAIDS	Programme Coordinator	2006/07/20	
Victor Ursu	Soros-Moldova Foundation	Executive Director	2006/07/20	
Diana Cazacu	USAID	Moldova Project Manager	2006/07/20	
Viorel Soltan	AIHA	Chief of party/Project Director	2006/07/20	
Victor Volovei	Project Coordination, Implementation and Monitoring Unit	Director Executive	2006/07/20	
Antonita Fonari	Young and Free: Training Resource Centre	Executive Director	2006/07/20	
Larisa Birca	Red Cross Society in Moldova	Chair	2006/07/20	
Igor Chilcevschii	Credinta Association	Chair	2006/07/20	
Boris Gilca	UNFPA	Programe Coordinator	2006/07/20	

For sub-national and regional Coordinating Mechanisms only, *the Chair and the Vice Chair of the national CCM of each country must also endorse the proposal. Please refer to the Guidelines for Proposals, section 3B.1.3.*

List below each of the national CCMs that have agreed to this proposal and provide documented evidence of this endorsement.

Table 3B.1.3b – Sub-national or regional (C)CM proposal endorsement by national CCMs

Country	Name of CCM	Annex number

3B Proposal Endorsement

3B.2 Regional Organization contact information and proposal endorsement:

3B.2.1 Regional Organization contact information

Please provide full contact details for two persons; this is necessary to ensure fast and responsive communication.

Table 3B.2.1 – Regional Organizations: contact information

	Primary contact	Secondary contact
Name		
Title		
Organization		
Mailing address		
Telephone		
Fax		
E-mail address		

3B.2.2 National CCM endorsement of Regional Organization proposal:

Please note that Regional Organizations must receive the agreement of the national CCM membership of each country in which they wish to work.

List below each of the national CCMs that have agreed to this proposal and provide documented evidence of this endorsement. (If no national CCM exists in a country included in the proposal, include evidence of support from relevant national authorities.)

Table 3B.2.2 – Regional Organization proposal endorsement by national CCMs

Country	Name of CCM	Annex number

LIST OF ANNEXES TO BE ATTACHED TO PROPOSAL

The table below provides a list of the various annexes that should be attached to the proposal. Please complete this checklist to ensure that everything has been included. Please also indicate the applicable annex numbers on the right hand side of the table.

Relevant item on the Proposal Form	**Description of the information required in the Annex**	**Name/Number given to annex in application**
Section 2: Eligibility		
Coordinating Mechanisms only:		
2.2.1 b)	Comprehensive documentation on processes used to select non-governmental sector representatives of the Coordinating Mechanism.	Annex 2. Discussions and decisions of the First Monitoring Workshop of the Resolution of the 1st National Forum of NGOs from the Republic of Moldova working in the field of HIV/AIDS and TB. Annex 18. Minutes of the UNTG on HIV/AIDS from 2002.
2.2.2	Documented procedures for the management of potential Conflicts of Interest between the Principal Recipient(s) and the Chair or Vice Chair of the Coordinating Mechanism.	Annex 3. Policy of conflicts of interests in Republic of Moldova
	Documentation describing the transparent processes to:	
2.2.3 a	- solicit submissions for possible integration into the proposal.	Annex 4. CCM decision from the 11th of May 2005. The mechanism of elaboration annexed; Annex 5. CCM decision from March 2006. Approval of TWG; Annex 6. The text of CCM information of Global Fund process in the newspapers; Annex 7. Minutes of the CCM meeting from the 11th of May 2006. Annex 8. List of CCM Technical working groups members and the institutions they represent

LIST OF ANNEXES TO BE ATTACHED TO PROPOSAL

Relevant item on the Proposal Form	Description of the information required in the Annex	Name/Number given to annex in application
2.2.3 b	- review submissions for possible integration into the proposal.	Annex 14. Minutes on the meeting of the extended meeting of the TWG on HIV/AIDS; Annex 15. Minutes on the meeting of the extended meeting of the TWG on TB; Annex 16. Minutes on the meeting of the local technical review committees
2.2.3 c	- select and nominate the Principal Recipient (such as the minutes of the CCM meeting at which the PR(s) was/were nominated).	Annex 4. CCM decision from the 11th of May 2005. The mechanism of elaboration annexed. Annex 7. Minutes of the CCM meeting from the 11th of May 2006.
2.2.3 d	- ensure the input of a broad range of stakeholders in the proposal development process and grant oversight process.	Annex 6. The text of CCM information of Global Fund process in the newspapers Annex 8. List of CCM Technical working groups members and the institutions they represent
Section 3A: Applicant Type		
Coordinating Mechanisms:		
3A.2.1, 3A.3.1 **or** 3A.4.1	Documents that describe how the national/sub-national or regional Coordinating Mechanism operates (terms of reference, statutes, by-laws or other governance documentation and a diagram setting out the interrelationships between all key actors)	Annex 1. Nr. 825, Government decision from the 3rd of August 2005 regarding the CCM Bylaws; Annex 19. The diagram setting out the interrelationships among all key actors
Regional Organizations:		
3A.5.1	Documents that describe the organization such as statutes, by-laws (official registration papers) and a	

LIST OF ANNEXES TO BE ATTACHED TO PROPOSAL

Relevant item on the Proposal Form	Description of the information required in the Annex	Name/Number given to annex in application
	summary of the main sources and amounts of funding.	
Non-CCM Applicants:		
3A.6	Documentation describing the organization such as statutes and by-laws (official registration papers) or other governance documents, documents evidencing the key governance arrangements of the organization, a summary of the organization, including background and history, scope of work, past and current activities, and a summary of the main sources and amounts of funding.	
3A.6.2 b	Documentary evidence of any attempts to include the proposal in the relevant CCM's final approved country proposal and any response from the CCM.	
3A.6.3 *(if from country where no CCM exists)*	Provide evidence from relevant national authorities that the proposal is consistent with national policies and strategies.	
Section 3B: Proposal Endorsement		
3B.1.3 *(Coordinating Mechanisms)*	Minutes of the meeting at which the proposal was developed and endorsed. For Sub-CCMs and RCMs, documented evidence that national CCM(s) have agreed to proposal.	Annex 10. CCM Decision N3, July 20th, 2006 Annex 13. CCM minutes on the meeting from the 20th of July, 2006 www.ccm.md www.aids.md
3B.2.2 *(Regional Organization)*	Documented evidence that the national CCMs have agreed to proposal.	
Other documents relevant to sections 1-3 attached by applicant:		
2.2.1.a	Minutes of the CCM meeting from March 2006	Annex 9. Evidence of Technical working groups approval Evidence of participation of people living or affected by the disease at CCM discussions and decisions taking processes
2.2.1.a	Minutes of the CCM meeting from May 2006	Annex 7. Evidence of the decision to apply to

LIST OF ANNEXES TO BE ATTACHED TO PROPOSAL

Relevant item on the Proposal Form	Description of the information required in the Annex	Name/Number given to annex in application
		the VI round and to solicit the broad range of stakeholders participation
2.2.1.a 2.2.3.d	CCM membership list, also available on the webpages: www.ccm.md and www.aids.md List of CCM Informational Bulletin beneficiaries Samples of CCM Info Bulletin	Annex 11 Annex 17. Annex 12.

4 Component Section *HIV/AIDS*

PLEASE NOTE THAT THIS SECTION AND THE NEXT MUST BE COMPLETED FOR EACH COMPONENT. *Thus, for example, if the proposal targets three components, sections 4 and 5 must be completed three times.*

For more information on the requirements of this section, please refer to the Guidelines for Proposals, section 4.

4.1 Indicate the estimated start time and duration of the component

Please take note of the timing of proposal approval by the Board of the Global Fund (described on the cover page of the Proposal Form). The aim is to sign all grants and commence disbursement of funds within six months of Board approval. Approved proposals must be signed and have a start date within 12 months of Board approval.

Table 4.1.1 – Proposal start time and duration

	From (yyyy/mm)	**To** (yyyy/mm)
Month and year:	2008/01	2012/12

4.2 Contact persons for questions regarding this component

Please provide full contact details for two persons; this is necessary to ensure fast and responsive communication. These persons need to be readily accessible for technical or administrative clarification purposes, for a time period of approximately six months after the submission of the proposal.

Table 4.2 – Component contact persons

	Primary contact	**Secondary contact**
Name	Liviu Vovc	Stefan Gheorghita
Title	Head of General Department	Deputy Director
Organization	Ministry of Health and Social Protection (MHSP)	National Applied Research Center for Preventive Medicine
Mailing address	2, Vasile Alecsandri Street, Chisinau MD 2009	67 Gheorghe Asachi Street, Chisinau, MD 2009
Telephone	+ 373 22 72 93 88 (fixed) + 373 69 00 00 13 (mobile)	+ 373 22 57 46 66 (fixed) + 373 79 57 56 30 (mobile)
Fax	+373 22 72 93 88	+373 22 72 97 25
E-mail address	lvovc@mednet.md	naac@sanepid.md

4.3 Component executive summary

4.3.1 Executive summary

Describe the overall strategy of the proposal component, by referring to the goals, objectives and main activities, including expected results and associated timeframes. Specify the beneficiaries and expected benefits (including target populations and their estimated number). *(Please include quantitative information where possible. Maximum of one page.)*

The CCM of the Republic of Moldova requests $ 15 940 711 USD to implement the Scale-Up of Access to Prevention, Treatment and Care project in the framework of the National Programme on Prevention and Control of HIV/AIDS/STIs supported by government, non-governmental organizations (NGO) and other partners. Starting in 2008, the five–year proposal, with the Ministry of Health and Social Protection as the primary recipient, seeks to expand HIV prevention, treatment and care to ensure universal access to highly active antiretroviral treatment (HAART), to increase voluntary counseling and testing among those

at highest risk, and to scale up prevention for those most vulnerable. Specifically, the grant seeks to meet three objectives:

• Objective 1: Reduce sexual and mother-to-child transmission (MTCT) of HIV/STIs, and transmission of HIV via needle shraing by scaling up the access of population to prevention and testing services;
• Objective 2: Foster equal access of people living with HIV/AIDS (PLWHA) through expansion of social and health services and measures to combat discrimination and stigma; and
• Objective 3: Strengthen government and community capacity to cope with the HIV epidemic, through partnerships and enhanced coordination.

In the five-year period, support from the Global Fund will:

1) Expand free, voluntary confidential HIV testing and counseling to reach the estimated 60,000 women who become pregnant annually in Moldova; deliver medication to prevent MTCT to 950 women and newborns; increase from 13 to 34 the number of centers offering VCT and establish a hotline for anonymous counseling and information; increase to four the number of reference laboratories able to confirm HIV infection and perform other diagnostics; create and deliver HIV education materials to youth aged 15-24 and integrate VCT into Family Planning and Youth Friendly Clinics; and to train counselors and support NGOs to scale up accessible prevention and VCT for other vulnerable groups including injecting drug users, migrants, MSM, and FSW.

2) Increase to 6,000 the number of PLWHA receiving HAART and institute PLWHA peer support and other measures to increase adherence to treatment; establish two new inpatient/outpatient HIV clinics in Balti and Slobozia; increase integration of TB and HIV testing; create a framework for monitoring of discrimination and support services made available to at least 6 000 PLWHA nationwide.

3) Develop the capacity of the technical working groups of the CCM and assist with programme coordination and the development of the annual workplans; train staff and provide equipment and support to enable computerization and integration of HIV and TB surveillance and implementation of a comprehensive national monitoring and evaluation(M & E) system; conduct joint trainings for technical working groups and other key government staff; strengthen NGO participation through subcontracting of services, trainings, increase in budget and HIV data collection transparency, and support of advocacy networks.

Particularly important will be support for HIV prevention and the establishment of a laboratory and site for ARV provision in Transnistria, the breakaway region which has remained in perpetual conflict and separated from national HIV prevention and treatment systems or support from international donors. No facilities exist for the confirmation of HIV-positive blood tests, measurement of viral load or CD4+ testing in Transnistria, and triple combination ARV and opiate substitution treatment are unavailable,. The proposal, supported by Transnistrian authorities, will relieve this inequity, and the CCM will play a key role in facilitating dialogue between the central authorities in Chisinau and local authorities in Transnistria.

At the grant's conclusion, advocacy and capacity building supported will have sharply increased government support for HIV/AIDS initiatives, allowing for tapering/phase out of GFATM support.

4.3.2 Synergies

If the proposal covers more than one component, describe any synergies expected from the combination of different components—for example, TB/HIV collaborative activities. *(By synergies, we mean the added value that the different components bring to each other, or how the combination of these components may have broader impact.)*

The CCM proposal covers activities from both the National Program for the Prevention and Treatment of TB, and the National Program for the Prevention and Control of HIV/AIDS for years 2006-2010 (Annex 20/AIDS) . A mixed Technical Working Group (TWG) on TB/HIV has developed the TB/HIV/AIDS collaborative activities for both national programs with expert opinions and specialists from the two areas of interest. One of the nine strategies of the NAP 2006-2010 specifically includes HIV-TB co-infection and

commits funds to address the issue.

The budgets for the national programs on HIV and TB were both approved at the end of 2005, allowing for synergy and implementation of joint activities in 2006-2010. As per the WHO/UNAIDS recommendations, the CCM provides a coordination framework for both diseases in Moldova. A common set of indicators has been set up within the framework of one M&E system to monitor progress with respect to the TB/HIV activities and one M&E Unit is charged with assessing the control of both diseases. In addition, the surveillance systems for TB and HIV/AIDS are based on the same platform and are currently being integrated. The revised TB reporting forms in Moldova include information about testing of TB patients for HIV; and the revised HIV/AIDS reporting forms include information about testing of HIV-positive patients for TB. This will allow for cross-referencing of cases and improved case finding among target populations for both diseases. Moreover, one project coordination unit was in charge of both previous components – TB and HIV/AIDS – to streamline the pooling of funds and to better interaction, while keeping an eye on both projects at the same time, resulting in better financial, program, M&E coordination for the two projects.

Importantly, since TB is the most common opportunistic infection among those with HIV in Moldova, the proposal revises the vertical structure of treatment and integrates TB treatment for AIDS patients. TB patients will be offered VCT for HIV, and patients with HIV/AIDS will be tested and treated for TB. Specific treatment regimens were considered when ordering specific drugs, making allowance for the DOTS-HAART medication interaction, where the case.

The proposal also builds on synergies between government and civil society structures in order to ensure the access of vulnerable groups to prevention. Using a pragmatic, non-judgmental, and cost-effective approach, the project proposal suggests that community and home-based care, and HIV prevention strategies, be provided primarily by NGOs and CBOs. The collaboration will simultaneously build capacity of affected communities and alleviate the pressure put on health services. PLWHA groups will play a vital role in the ongoing project implementation and evaluation, further strengthening their role beyond that of passive recipients of care. Promoting self-organization and peer education, this approach will empower PLWHA and reduce stigma and discrimination. HIV prevention activities will be similarly designed and implemented with the direct participation of people at higher risk for HIV/AIDS. All activities are geared towards promotion of safer sex practice for people with different lifestyles through their own involvement. Integration of HIV VCT with family planning and youth-friendly services, along with increased availability of medications for treatment of STIs, will build synergies between reproductive health and HIV/AIDS, and strengthen overall HIV surveillance and epidemiological monitoring.

In keeping with best practices and realities of the Moldovan HIV and TB epidemics, which strike the poorest and most marginalized, the project will target the communities with a high prevalence of infection, communities with limited access to financial, social or technical resources, and vulnerable groups, such as PLWHA and unemployed youth.

Finally, the proposed project will address a number of issues to reduce the economic hardships of families in line with the Economic Growth and Poverty Reduction Strategy Paper (EGPRSP Annex 24/AIDS), including:

- Reduce out-of-pocket expenses while accessing the basic health care for the PLWHA by bringing services closer to them geographically, create home-based care activities; for young people through communication activities and peer education networks; and scale up access to VCT for the mainstream population;
- Increase illness-free days and productivity, psychological care and community-based support, which will contribute to better life expectancy for the PLWHA in the long run, and will reduce the economic impact of HIV/AIDS on the government budget;
- Improved content and targeting of poverty alleviation programs; and
- Comprehensive care and mechanisms to improve care for children infected with and affected by HIV.

The impact of the measures laid out above will be augmented as the project services and support becomes accessible to the public at large and to the poorest members of the community. This means the project will focus on communities with a high prevalence of infection, communities without access to financial, social or technical resources to respond to the epidemic, and vulnerable groups, such as PLWHA and unemployed youth, who have not been able to access information and services due to social

marginalization and other factors.

4.4 National program context for this component

The information below helps reviewers understand the disease context, and which problems the proposal will address. Therefore, historical, current and projected data on the epidemiological situation, disease-control strategies and broader development frameworks need to be clearly documented. Please refer to the Guidelines for Proposals, section 4.4.

4.4.1 Indicate whether you have any of the following documents (tick appropriate box), and if so, please attach them as an annex to the Proposal Form:

☒ National Disease Specific Strategic Plan

☒ National Disease Specific Budget or Costing

☒ National Monitoring and Evaluation Plan (health sector, disease specific or other)

☒ Other document relevant to the national disease program context (e.g. the latest disease surveillance report)
Please specify:

Annex 22/AIDS - "Financial Needs Assesment in dollar equivalent, Annex to the Budget of the National Programme on Prevention and Control of HIV/AIDS/STIs 2006-2010, Government of the Republic of Moldova Government Decision no. 948 of 05.09.2005

Annex 23/AIDS - Situation Analysis "Socio-Economic impact of HIV/AIDS in Moldova, draft, 2006

Annex 24/AIDS – Economic Growth and Poverty Reduction Strategy Paper (EGPRSP)

Annex 25/AIDS – Universal Access Initiative Moldova 2006

Annex 26/AIDS – Mid-Term Review of the National AIDS Programme 2001-2005

Annex 27/AIDS – WB Mid-Term Review of the WB HIV/AIDS/TB Project

Annex 28/AIDS – HIV sentinel surveillance in high risk groups in Azerbaijan, Republic of Moldova and in the Russian Federation, WHO, 2004

Annex 29/AIDS – National HAART Protocols, Moldova, 2005

Annex 30/AIDS – Republic of Moldova –Summary Country Profile for Treatment Scale-Up, WHO 2005

Annex 31/AIDS – HIV/AIDS Surveillance Moldova, IDUs, Inmates and Commercial Sex Workers, 2004

Annex 32/AIDS – Report of the Government of the Republic of Moldova to UNGASS

Annex 33/AIDS – "Partnerships and NGOs networks in area of HIV/AIDS, STDs, Drug Abuse and TB: Succseful experiences of the Republic of Moldova at national, regional and international level"

Annex 34/AIDS – Republic of Moldova –Summary Country Profile for Treatment Scale-Up, WHO 2005)

Annex 36/AIDS – WHO Report on Scaling Up Access for Transnistria, 2006

Annex 37/AIDS – National PMTCT Protocols

Annex 38/AIDS –2-nd Generation HIV/AIDS Surveillance Protocols, 2006

Annex 39/AIDS – MHSP Activity Review Report 2005

Annex 40/AIDS – Financing Sources and other Ways to Support the activities/projects in the social field.

Annex 41/AIDS – Young People Health and Development, KAP Study, 2005

Annex 42/AIDS – DHS, Preliminary Report, 2005

Annex 43/AIDS – Workplan for the Global Fund Proposal

Annex 44/AIDS – Procurement Plan, Attachment B
Annex 45/AIDS – Detailed budget to the proposal
Annex 46/AIDS – Target and Indicators Table, Attachment A
Annex 47/AIDS – Draft Law on AIDS, Republic of Moldova, 2006
Annex 48/AIDS – Communication Strategy on AIDS, Moldova
Annex 49/AIDS – Situation and Response Analysis in HIV/AIDS, 2005
Annex 50/AIDS – AFEW Behavioural Study, Knowledge of AIDS and Attitudes Towards PLHA
Annex 51/AIDS – Concept Note on the Health Information System
Annex 52/AIDS – National Health Policy Concept
Annex 53/AIDS - "Report on HIV/AIDS Situation, NAC, 2006
Annex 54/AIDS – Detailed Description of Activities
Annex 55/AIDS – Principal Recipient Instituional and Programmatic Assesment
Annex 56/AIDS – Principal Recipient M&E Assesment
Annex 57/AIDS – Programme Gap Analysis Table
Annex 58/AIDS – National Standard in HIV Surveillance
Annex 59/AIDS – Key Expenditure Items
Annex 60/AIDS – Human Resouces Costs
Annex 61/AIDS – WHO Annual HIV/AIDS Survey, WHO, 2005
Annex 62/AIDS – WHO Annual HIV/AIDS Survey, WHO, 2006
Annex 63/AIDS – WHO Annual STI Report, WHO, 2005
Annex 64/AIDS – WHO Annual STI Report, WHO, 2006
Annex 65/AIDS – Description of the Health System in HIV/AIDS, 2004

4.4.2 Epidemiological and disease-specific background

Describe, and provide the latest data on, the stage and type of epidemic and its dynamics (including breakdown by age, gender, population group and geographical location, wherever possible), the most affected population groups, and data on drug resistance, where relevant. With respect to malaria components, also include a map detailing the geographical distribution of the malaria problem and corresponding control measures already approved and in use. Information on drug resistance is of specific relevance if the proposal includes anti-malarial drugs or insecticides. In the case of TB components, indicate, in addition, the treatment regimes in use or to be used and the reasons for their use.

The Republic of Moldova is a predominantly agricultural, land-locked country, of some 13,000 square miles and a population of around 4.2 million located in the South Eastern Europe between Romania and Ukraine. A critical implication for the spread of HIV in the country is the high density of population, accounting for 129 people per square kilometer and by the political isolation of the break-away region of Transnistria, a post-war frozen conflict zone.

Following the break-up of the former Soviet Union, the incidence of sexually transmitted infections (STI) in Moldova soared. Throughout 1988-1996, the incidence of syphilis increased from 7.0 to 200.1 per 100,000 inhabitants in the country, which further has gradually dropped, yet still was high at 60.46 per 100,000 in 2004. The incidence of gonorrhea was high at 100 cases per 100,000 inhabitants in 1995, somewhat dropping down to 34.52 per 100,000 in 2002, to further slightly go up to 43.57 in 2004 (WHO, C.I.S.I.D. 2006). High figures can attributed to budget deficits and accompanying service shortfalls, loosening of social constraints, poor knowledge about STIs and prevention measures, relatively low access to even the simplest of preventative measures, unsafe sex practices, under-estimation of personal risks, and increases in the number of those engaged in commercial sex work. More details on the epidemiologic situation owing to HIV/AIDS may be found in Annex 53/AIDS "Report on HIV/AIDS situation, NAC, 2006.

The Republic of Moldova started systematically doing epidemiologic surveillance for HIV/AIDS in 1987. Since then 2,782 people have been diagnosed with HIV (National AIDS Center (NAC), 2005), including

220 reported cases of AIDS by the end of 2005 (64 people were diagnosed with AIDS in 2005 alone). The cumulative AIDS death toll rose to 105 people (WHO Survey 2006, NAC 2005), but these figures are thought to be sharply underestimated (WHO/UNAIDS). The average HIV/AIDS prevalence rate in Moldova accounted for 33.79 per 100,000 at the end of 2001, and reached 44.80 per 100,000 in 2005. The second largest city in the country – Balti – recording the highest prevalence of 503.3, more than six times the rate of 80.7 in the capital city of Chisinau. In the break-away region of Transnistria, prevalence was 132.4 per 100,000 in Tiraspol, Transnistria in 2004 (Annex 30/AIDS, Republic of Moldova –Summary Country Profile for Treatment Scale-Up, WHO 2005).

HIV infection has been concentrated mainly in injecting drug users (IDUs), who accounted for little over 80% of all HIV/AIDS cases in 2000. Relatively lax border control from the East, a geographic position that makes Moldova a transit country for illicit drugs bound for the Balkans, and production of poppy and cannabis locally, all contribute towards high rates of opiate use in Moldova. The Ministry of Interior estimated around 50,000 IDUs in the Republic of Moldova in 2004, and sharing of needles is believed to be widespread. According to the Ministry of Justice, the prevalence of HIV/AIDS in prisons was 3,600 per 100,000 in 2004. , A growing share of new HIV cases, however, are via sexual transmission. Of new HIV cases reported in 2004, for example, a majority (55.4%) were linked to heterosexual intercourse, 42.41% were linked to IDU, and 2.23% were attributed to mother-to-child transmission (MTCT) (NAC 2004). IDU share with HIV decreased to only 19% in 2005, while new cases attributable to sexual transmission of HIV increased (20% in 2001, 28% in 2002, 43.8% in 2003 and 55.36% in 2004). There has been a corresponding increase in risk of HIV transmission among young women of reproductive age and of vertical transmission; women with HIV accounted for 24.3% in 2000, 31.15% in 2002, and 45.37 in 2004) (NAC 2005). Approximately 97 pregnant women with HIV had received medication to prevent MTCT in Moldova as of the end of 2005. The share of men having sex with men and commercial sex workers with HIV is still relatively low, at 1.4% and 4.69% of HIV cases, respectively (Annex 28/AIDS and Annex 31/AIDS).

The HIV/AIDS epidemic may be said to have four stages in the Republic of Moldova. Stage one dating back to late-1980s until the end of 1995 was characterized by occasional outbreaks in small foreign communities, migrants or travelers. There were no specific public efforts other than the mass screening of people and tightening up border controls in an attempt to detect or prevent HIV. The epidemic entered a second, concentrated stage between 1996 and 1999, when a series of rapid outbreaks were reported in IDUs brought forward for testing. There was a sharp increase from 7 HIV cases reported in 1995 to 408 (about 9 per 100,000 population) in 1997, 80% of those infected were young IDUs, and about 18% believed to have been infected by sexual transmission. Moreover, registered syphilis cases also reached their peak then, signaling that needle sharing was not the only risk factor and that sexual HIV transmission could also soon explode. The upsurge in STIs and HIV/AIDS was accompanied by a decline in the economy and government resources earmarked for health, resulting in scarcity of HIV test kits for long periods. The third HIV stage in the RM was marked by the start of the generalizing of the epidemic, and resurgence of funding for broad screening and testing programs and resumption of some sentinel surveillance. The overall crude incidence of reported HIV remained relatively stable at about 200 to 300 HIV/AIDS cases reported each year, heterosexual transmission begins to increase. At the end of 2003, the country entered a new stage when HAART was made available to all people living with HIV/AIDS who qualified for it at no cost to the end-user. As of end of 2005 there have been 222 people on HAART, including those in the penitentiary system. Of the 4 children diagnosed with HIV in 2004 (MTCT rate of 0.28%), two were receiving antiretroviral treatment. As noted above, 97 pregnant women had received preventive treatment during the last trimester of pregnancy and during birth, with their newborns also receiving therapy at birth (NAC 2005). Overall adherence to HAART is at around 80% (National Center for Dermatovenereology, 2005), with drop outs estimated to occur because of financial constraints, political issues with Transnistrian authorities, inconvenience to travel long distances etc. Currently, there are 5 patients on dual therapy (Combivir) in Transnistria, thus posing a threat to developing a drugs-resistant strain of HIV virus in the years to come, unless specific measures are taken to improve access to HAART.

There are about 20 harm reduction programs in the country, mostly dealing with IDUs (including convicts), female commercial sex workers (FSW), people in uniforms, truck drivers, children and youth, men having sex with men (MSM) and others. About 26 opiate dependent individuals enrolled in two Opiate Substitution Therapy (OST) programs in Moldova, two of whom are allegedly HIV infected, and there are needle and syringe exchange programs. Besides door-to-door outreach activities performed by the network of PLWHA and HIV/AIDS NGOs, there are general population awareness campaigns and education training,(including life skills based education (LSBE), although with some problems and issues owing to

opposition of faith based organizations. As HAART becomes more available and the lifespan of AIDS patients increases, HV/AIDS prevalence in the country is expected to increase in the short run; this underscores the importance of ongoing preventative measures through harm reduction and HIV prevention programs for sexual transmission in years to come.

Officially, there were 7,564 IDUs reported in 2002, but the Ministry of Interior estimated that the real figure should be around 50,000. According to official statistics, there are approximately 5,200 CSW in the country, but this figure is also likely to be underestimated.

Details on the socio-economic impact of HIV/AIDS in Moldova and on the epidemiologic situation may be found in Annex 23/AIDS "Socio-Econimic Impact of HIV/AIDS, 2006 and 32/AIDS "Moldova UNGASS Report" and Annex 53/AIDS "Report on HIV/AIDS Situation, NAC, 2005). Technical epidemiological data could be found under Annexes 61-62/AIDS (WHO Annual HIV/AIDS Survey, WHO, 2005, and 2006), Annexes 63-64/AIDS (WHO Annual STI Report, WHO, 2005, 2006), and Annex 30/AIDS (Republic of Moldova –Summary Country Profile for Treatment Scale-Up, WHO 2005).

4.4.3 Disease-control initiatives and broader development frameworks

Proposals to the Global Fund should be developed based on a comprehensive review of disease-specific national strategies and plans, and broader development frameworks. This context should help determine how successful programs can be scaled up to achieve impact against the three diseases. Please refer to the Guidelines for Proposals, section 4.4.3.

a) Describe comprehensively the current disease-control strategies and programs aimed at the target disease, including all relevant goals and objectives with regard to addressing the disease. (Include all donor-financed programs currently implemented or planned by all stakeholders and existing and planned commitments to major international initiatives and partnerships.)

National responses. The overall strategy of the Ministry of Health and Social Protection is based on the National Health Concept Policy (Annex 52/AIDS). Legal and policy frameworks related to HIV/AIDS in Moldova are generally strong. The exercise recently undertaken by stakeholders in HIV/AIDS within the framework of "Scaling Up the Universal Access to Care, Treatment and Prevention" (Annex 25/AIDS) showed high capacity in Moldova for problem identifying and strategic planning. A new comprehensive Law on HIV/AIDS (47/AIDS) has been developed pending approval in Parliament, addressing gaps in previous legislation, and strengthening human-rights protections for PLWHA. Moreover, the Mid Term Review (MTR) (MTR Annex 26/AIDS) conducted for the National AIDS Program (NAP) for 2001-2005 showed that the country had achieved impressive results with respect to HIV/AIDS control. The same results have been reported by the mission of the World Bank (WB) (Annex 27/AIDS) recently undertaken to evaluate the HIV/AIDS project financed with its funds in support of NAC 2001-2005.

Commitment to HIV/AIDS prevention, treatment and care are demonstrated by a number of recent developments:

Adoption of the National AIDS Programme for 2006-2010 (Annex 20/AIDS). The NAP is the third national program for HIV/AIDS following the first two (NAP 1996-2000, and NAP 2001-2005). Following the final review and evaluation of the NAP 2001-2005 (Annex 49/AIDS), the Technical Working Groups under CCM were charged with the responsibility of developing the draft of the NAP for 2006-2010. The NAP consists of nine key strategic priorities agreed upon by joint government – non-government technical working groups and approved by a decision of the government of the Republic of Moldova. 1. Streamline Coordination and Build Capacity of the Country Coordination Mechanism (CCM) for HIV/AIDS Control; 2. Primary prevention of HIV/AIDS; 3. Vulnerable groups at high risk for getting HIV/AIDS and harm reduction activities; 4. Voluntary and Confidential Counseling and Testing (VCT); 5. HIV/AIDS Treatment and Care; 6. HIV/AIDS-TB co-infection control; 7. Education and communication; 8. HIV/AIDS Monitoring and Evaluation; 9. Prevention of mother-to-child transmission (pMTCT)].

The NAP highlights steps and activities to be undertaken in the next five years to respond in a more effective and targeted manner to the epidemic. A set of indicators has been developed and agreed by all stakeholders to support monitoring and evaluation, and the technical groups have developed a log-frame

to support the implementation of the NAP. Procedures for stakeholder engagement have also been identified. Thematic areas in HIV/AIDS were selected in the country with wide participation from all stakeholders by means of joint meetings convened under the Technical Working Groups and open for participation to NGOs and affected communities. Written papers in support of the NAP were also welcomed. Minutes of the working group meetings, and themes raised there, are reviewed by participants, and working group members invited to report to the plenary CCM meetings.

Increased national coordination through the merging of the National AIDS Committee and the existing Country Coordinating Mechanism (CCM) (Annexes to CCM). With support from the UN Team Group (UNTG) on HIV/AIDS and in keeping with the Three Ones, a single national coordination entity was created. Support was provided for the development of its comprehensive Terms of Reference, which also include the operational structure of the CCM, and extension of its membership to include PLWHA and NGOs as well as international community and government stakeholders.

The Government has endorsed a comprehensive national Monitoring and Evaluation system (M&E) (Annex 35/AIDS) and recognized its advantages and importance.The Government established a multi-stakeholder technical working group (TWG) within the framework of the CCM. The National Center for Public Health and Management was tasked with leadering the national M&E system, and a pilot project to design a M&E System for two programs - the National Program on Prevention and Control of HIV/AIDS/STIs and the National Program on Prevention and Control of TB - was initiated by the UN TG on HIV/AIDS. The pilot project is currently successfully implemented and known as SYMETA (System for Monitoring and Evaluation of TB/AIDS) with UNAIDS/Global Fund/WB funds. The first output of the recently established M&E Unit was the development of UNGASS report with all the proper consultations and data collection (Annex 32/AIDS).

Opening of 13 ELISA screening centers with wide geographic reach all over the country, and one western blot confirmation center in the capital city of Chisinau. Rapid tests for HIV have been suggested for maternity wards and for surveillance purposes. National protocols for blood and saliva rapid testing for HIV/AIDS are being developed now with WHO support (Annex 39/AIDS, Activity Report of the Ministry of Health and Social Protection, 2005).

Legalization of harm reduction programmes for IDUs in 2001 including opiate substitution treatment (OST) and needle exchange for IDUs both inside and outside of prison.

HAART and preventative ART became available in the country in October 2003 as a result of GFATM/WB support. Teams of physicians, nurses and social workers were trained at the WHO-accredited knowledge hub in Kiev on ART treatment. National Protocols based on WHO recommendations have been developed and approved (Annex 29/AIDS)

There a number of ongoing public HIV/AIDS awareness campaigns in the country based on the frameworks of the National Communication Strategy in HIV/AIDS (Annex 48/AIDS). Life-Skills Based Education (LSBE) in schools—despite controversy and opposition of the faith-based organizations - are generally deemed a success.

Civil society participation in the fight against HIV/AIDS has been institutionalized through the establishment of several coordination mechanisms such as the harm reduction network, and a network of NGOs working in the field of HIV/AIDS, including a sub-network of PLWHA organizations (Annex 33/AIDS). The government has expressed its interest in support for mainly advocacy for meaningful involvement of NGOs and international organizations in scaling up the national response to HIV/AIDS. Special attention will be paid to the establishment and maintenance of a PLWHA network and to the support and development of partnerships between NGOs working in the area of HIV/AIDS through information dissemination and capacity building. An NGO Capacity Building Forum was organized for the organizations working in the area of HIV/AIDS, with 20 NGOs being trained in program management, including planning, budgeting and M&E; legislative framework; resource mobilization; and possible mechanisms for government allocations / contributions to the work of NGOs were brought up. Following that, the development of a draft proposal to facilitate government support to the NGO sector (from allocations to the state budget from individual tax contributions) was initiated.

Discussions with representatives of trade unions on the HIV/AIDS workplace strategies were held. The NAP includes activities aimed at the implementation of workplace policies in the largest Moldovan

companies. Stipulations on workplace policies were included in the newly developed Law on HIV/AIDS (47/AIDS, Draft law on AIDS). Support was provided to the M&E Unit for the development of an M&E Manual.

Internationally supported responses were coordinated around providing support to the NAP. .

Transnistria Assessments. A series of joint visits by representatives of all UN Agencies helped explore possibilities for cooperation and scaling-up of HIV/AIDS-related activities in the Transnistrian part of the country. Representatives of Transnistrian health authorities were involved in a number of joint trainings and workshops aimed at development of the draft National Action Plan, matrix of indicators for monitoring and evaluation etc., and in the drafting of the current NAP for 2006-2010. Scaling up of prevention, treatment and care plans have been developed in support of health authorities in Transnistria (Annex 36/AIDS)

Monitoring and Evaluation. All of the above has been planned to be sorted out by an efficient operation of the M&E Department, but the department was established as a structure only in 2002 only and has lacked the financial resources to support its work. Further, development of M&E tools is regarded by the government as one of the most valuable contributions that the UN TG on HIV/AIDS can provide. In this respect, development of a legal framework for quality control of services and goods, development of standards of the cost-effectiveness of activities and programmes, studies on socio-economic impact of HIV/AIDS and estimation of costs for interventions are viewed as top priorities. Additional efforts will be also required in terms of technical assistance for M&E and second generation surveillance and VCT. No incentives exist for the implementation of workplace strategies regarding HIV/AIDS.

b) Describe the role of HIV/AIDS-, tuberculosis- and/or malaria-control efforts in broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) Initiative, the Millennium Development Goals or Sector-Wide Approaches. Outline any links to international initiatives such as the WHO/UNAIDS ‘Universal Access Initiative’ or the Global Plan to Stop TB or the Roll Back Malaria Initiative.

Pursuant to the 'Three Ones', the National AIDS Committee has been merged with the CCM. The CCM, with a widened mandate and mechanisms to involve the government, civil society representatives including PLWHA, and appropriate international agencies, now coordinates HIV/AIDS activities in the Republic of Moldova. There are also three large networks operating with HIV/AIDS and associated issues (Network of Social Services, including HIV/AIDS as a component the Network of PLWHA, and the Harm Reduction Network). While the CCM is a decision-making body, there are a number of standing working groups within it (WG on Treatment and Care, WG on Monitoring and Evaluation, WG on Surveillance and Sentinel Surveillance, WG on Vulnerable Groups, WG on Communication and Education) meeting on a regular basis to bring up outstanding issues relevant for HIV/AIDS control, as well as on an as-needed basis to work out urgent matters. Also, policy-wise, the GOM legalized the operation of harm reduction programmes both IDUs and in prisons, it approved a Palliative Care Strategy for PLWHA and opted in for a methadone substitution therapy (OST). The UN Theme Group on AIDS also assists in resolving emerging HIV/AIDS related issues and with coordination of donor and international assistance.

The last component of the 'Three Ones' is a single M&E framework for HIV/AIDS, as reflected in the unit set up within the Ministry of Health and Social Protection subordinate structures. This is in line with the Republic of Moldova’s endorsement of the UNGASS declaration, and national M & E efforts produce reports on progress toward the UNGASS indicators. Besides having developed a comprehensive list of indicators to report on HIV/AIDS and assocaited activities for the years to come, efforts are underway to develop an automated system for HIV/AIDS reporting and evaluation capable of integrating HIV and TB monitoring and reporting.

UNDAF. Additionally, the UN agencies working in the area of HIV/AIDS (UNAIDS, UNFPA, WHO, IOM, UNICEF, UNHCR, UNDP etc.) have recently developed the United Nations Development Assistance Framework (UNDAF) to help the government cope with the increasing burden of HIV/AIDS/STI and associated problems. The UNDAF for 2007-2011 has three major areas of cooperation with a number of objectives and outputs: (i) Governance and Participation; (ii) Access to Quality Services; and (iii) Regional and Local Development. The second component is

focusing heavily on vulnerable groups enjoying increased equitable and guaranteed access to basic services of good quality provided by the government with the support of civil society (including contraception, VCCT for HIV/AIDS, youth-friendly health services), people of reproductive age adopting safe behaviors and seeking health commodities and information on HIV/AIDS/STIs and Reproductive Health; all people, especially belonging to vulnerable groups, enjoying improved access to essential health care of good quality (including pMTCT and HAART).

Following the conclusion of the '3-by-5' initiative, the country and the entire region alike, should be moving towards universal access to HIV/AIDS treatment and care, while continuing to strengthen prevention activities (both primary and secondary prevention). In this vein, the country adopted the WHO protocols for HAART and care (Annex 29/AIDS), guidelines for PMTCT (Annex 37/AIDS), has developed a 2nd generation surveillance plan (Annex 38/AIDS), CBO and NGO implemented harm reduction projects etc. Still, the country is facing several major problems like relatively few PLWHA in HAART due to restricted access owing to various factors (financial, geographical, political, personal such as confidentiality etc.); children born to HIV-positive mothers due to inconsistent testing strategies for pregnant women; high drop-outs of ART treatment due to low adherence to the treatment regimens; inconsistency in meeting the needs of the PLWHA (current MTCT rate is around 2.8% and could increase retroactively); and reduced implementation of prevention programmes aimed at youth and especially vulnerable youth.

Among other emerging issues are the lack of high-quality VCT services, internal disputes surrounding the mandatory LSBE curriculum, increased access to HAART for PLWHA and access to HIV rapid tests for pregnant women and surveyed populations, enforcement of otherwise adopted acts (counseling, testing, confidentiality etc.) Transnistria, if further 'overlooked', could become a local time-bomb ready to burst at any time, as it still reports one of the highest rates of HIV/AIDS due to IDU in the region, it is not subject to formal prevention and treatment policies adopted elsewhere within the country. The LSBE issues encountered are going to be solved by involving representatives of the various confessions into the review of the curriculum.

MDGs. The Government's strategy for combating poverty, Economic Growth and Poverty Reduction Strategy Paper (EGPRSP Annex 24/AIDS) 2004-2006, lays out Moldova's commitment to the U.N. Millennium Development Goals (MDG) and addresses health care and HIV/AIDS. The strategy calls for increased access to good quality medical services for the poor in support of sustainable development and poverty reduction. This is to be achieved by developing primary health care (PHC) services, improving the skills of practitioners, and preventing and treating "socially determined diseases," which include HIVAIDS and TB. These policies are also related to health reform efforts under way, which are reorienting health care towards more accessible PHC services and increasing resources through mandatory health insurance. The poverty strategy links AIDS indicators to the MDGs. Under medium- and long-term priorities, the goal will be to reduce the incidence of HIV/AIDS from 4.66 (per 100,000 people) reported in 2002 to 4.00 in 2006, although epidemiologically speaking the prevalence could slightly go up in the short run with the treatment becoming available.

More generally, the proposed project will support the goals of poverty reduction and alleviating economic hardships by reducing out-of-pocket expenses for medical care for PLWHA through income generating activities; reduction of travel and travel costs; increased illness-free days and productivity.

Universal Access Initiative. This proposal, and the NAP on which it is based, was developed with attention to multiple elements supported by WHO/UNAIDS Universal Access to Prevention, Treatment , and Care. Moldova became part of the Univeral Access Intitaive by approving the Action Plans under the NAP in line with its recommendations (Annex 25/AIDS).

Human Trafficking and migrants. Moldova is also working with international development partners to evaluate where HIV/AIDS can be integrated as a logical component into ongoing programs on trafficking and migrants, among others. In the Republic of Moldova, economic hardship and vulnerability have often made women vulnerable to trafficking: NGOs working in trafficking are being encouraged to add HIV/AIDS to their educational and public awareness messages. The IOM representative in Moldova has indicated that IOM will add a tag line regarding HIV/AIDS prevention to future OIM anti-trafficking campaign materials.
More generally, HIV/AIDS efforts also dovetail with efforts to improve access to preventive, therapeutic, support and informational services for migrants, started jointly with UN, IOM and the SFM in the

Republic of Moldova.

4.4.4 National health system

a) Briefly describe the (national) health system, including both the public and private sectors, as relevant to reducing the impact and spread of the disease in question.

Beginning in the late 1990s, Moldova engaged in reforming the health care system to adapt the obsolete Soviet system to international standards and requirements. The reforms strengthened primary health care (PHC) and down-sized the hospital sector in an attempt to streamline the scarce funding available for health care. In 2005, 4.7% of GDP was spent on health, almost double the amount spent in 2001 (2.8% of GDP). Per capita health expenditures tripled since 2001, reaching 40.7 USD in 2005. The budget for the health sector in 2005 accounted for MDL 1,738.4 million (equivalent to USD 144.9 million). About 70% of the population is covered by health insurance and 80% of the population has access to a family physician.

Health service provision in Moldova is by and large two-pronged, delivered through state-owned public health providers, and newly emerging and developing private health providers. Most of the health services are provided within the framework of a mandatory health insurance fund, run by the National Health Insurance Company, with whom most health care providers in Moldova contract for services rendered. The employer and employee alike chip in an equal share from their revenues for health insurance. It is worth noting that many public health care facilities could also provide services for money to certain categories of people (user fees), thus making up for their relatively scanty budgets. The self-employed, such as farmers, contribute a fixed annual amount to the Insurance Fund. Some categories, such as children, the elderly, pregnant women, disabled people, order enforcement and military, are exempted from paying it. The Government covers the full payment on their behalf. Those without insurance are provided with free care for specific services only, such as health emergencies, TB, and some other national programs, including the HIV/AIDS. Most of the patients receiving HAART, specifically those with drug addiction history, are not part of the National Health Insurance system.

The Insurance Fund covers a "basic package" of health services and benefits. While for PHC services, the Insurance Fund pays providers on per capita basis for a specific catchment area, for other health care services, the Fund is paying providers based on a set rate per treated case. Patients must pay for services provided outside the basic package. The longest length of hospital stay is 75 days under the set Insurance Fund. A treated AIDS case costs about MDL 2,500 on average.

The health care sector is a three-tier system in Moldova: national facilities serving the needs of the country; district-level and municipal health care facilities at the middle; and primary health care at the local level. Most services are governmental along with some private specialty services, clinical laboratories, and a private pharmacy sector.

Primary Health Care (PHC) - Following the Government of Moldova Health Investment Fund (HIF) project, funded with the World Bank money, a comprehensive network of primary health care facilities is being developed countrywide. It basically consists of family physicians offices (FPOs), and health centers (HCs) with primary care physicians. These are scattered all over the country, with FPOs mostly located in smaller communities, and HCs in larger district-level or urban areas, and each of these facilities are serving a certain catchment area. Some are located within Medical Territorial Associations (MTA) in municipalities. Ideally, family physicians should act as gate-keepers and entry-points for HIV infection, to later refer patients, if needed, further down the health provider chain.

Specialized Health Care (SHC) - SHC is hospital-based (inpatient) and outpatient. There are district-level hospitals scattered all over the country, one per each district. They serve the needs of people living in that given region that cannot be by the PHC. In urban areas there are municipal clinical hospitals (MCH) taking care of people’s needs in terms of secondary health care. Most of these hospitals have basic and general inpatient facilities (general surgery, obstetrics and gynecology, internal therapy and pediatrics, resuscitation units etc.) The outpatient clinics next to the hospitals deal with less severe specialized cases that could not be dealt with by a PCP (with referral from the PHC), and that should not be treated in an inpatient ward (hospitals). The range of services provided in outpatient facilities is

comprehensive (cardiologist, neurologist, internal therapist, physical therapist, surgeon, ENT etc.)

Tertiary Health Care (THC) - THC are highly specialized country-level facilities rendering narrow and quite sophisticated procedures. No private structures could afford running these expensive sites, so all of them are government-owned. There are some attempts from the private sector to open more specialized and narrow clinics, but those mostly focus on esthetic and plastic medicine. Basically, each major health care issue has a facility in charge of dealing with it. The largest of its kind is the National Clinical Hospital (it is a multi-profile clinical hospital with basically most of the narrow specialties one could imagine, ranging from cardiac and kidney surgery, to endocrinology and other internal medicine areas).

Emergency Health Care (EHC) - The "903" service for 24/7 emergency care has a public network of ambulances and emergency care units all over the country, with the largest ones located at the district level and in municipalities. Besides the Municipal Clinical Emergency Hospital (MCEH) in Chisinau, providing comprehensive EHC, ranging from neurosurgery to trauma surgery and other, a number of MCH provide specialized emergency care according to their profile and on a rotational basis (e.g., MCH#3 serving emergency calls for poisonings). Apart from the above MCEH, there are number of private clinics providing emergency care with ambulance services, such as AcasaMedica, and Calmed. Besides, the same MCEH runs the so-called "sanitary aviation" services, with ambulances made available for patient transportation at long distances between health care facilities.

Diagnostic and Laboratory Services (Dx) - Although each of the bigger SHC facilities has its own basic lab and diagnostic equipment (blood count, biochemistry, X-Ray, ECG, urinalysis, blood glucose, liver tests etc.), the biggest hub for diagnostic and laboratory facilities in the country for the public sector is the National Diagnostic Center in Chisinau. Of course, THC facilities also have the relevant laboratory facilities and equipment necessary to perform their specific narrow tasks (e.g., CAT scan, MRI, endoscopy, Doppler US etc.) However, one could use the services of private providers for diagnostic and laboratory services, such as Calmed, ImunoTehnoMed, and the National Center for Dermatovenereology (NCDV) for sexually transmitted infections. Usually, these facilities, alongside the THC sites, have the most up-to-date and sensitive equipment specific to their narrow specialization. The only PCR for HIV viral load is also located at the NCDV. Besides, there are two flow cytometers in the country - one at the National AIDS Center and another one - at the NCDV for treatment monitoring. Other health facilities make use of fluoroscopic microscopy for immunological CD4 count.

AIDS control is integrated in the health system, through the National Center for Preventive Medicine (NCPM), and the National Center for Public Health and Management (NCPHM) that has principal responsibility for M&E. Cases are diagnosed by infectionists and they have joint roles in case management and treatment. The Center for Preventive Medicine is staffed with 103 epidemiologists, who are responsible for contact investigation and infection control. The 300 infectionists from the district level have to inform the NCPM about infectious cases for follow-up and testing of contacts. The National AIDS Centre (NAC)- a subdivision of the NCPM - is in charge of the surveillance system, with all reporting sites turning in data to the NAC. Thus the reporting system is done from the NAC and the NDVC to the unified system - SYMETA - managed by the NCPHM A more detailed description of the health care system in HIV/AIDS and STIs can be found in Annex 65/AIDS, Health Care System in HIV/AIDS, 2004.

The structure and financing of AIDS control is not centralized in the hands of the MOHSP.
The financing of activities is carried out both with the national budget funds and local level budgets allocations earmarked for the local public authorities.

The HIV/AIDS control system is entirely public in the Republic of Moldova, consisting of both government and non-government (civil society, international agencies) efforts, as there are no private health care providers rendering HIV/AIDS related services. The screening of HIV is performed in 13 national laboratories (ELISA), with conformation at the National AIDS Center (western blot). Primary prevention (condom promotion, education campaigns) is done by both government health facilities, as well as NGOs. Secondary prevention (harm reduction) is carried out almost but entirely through the CBOs (needle exchange, condoms etc.), while opiate substitution therapy (OST) with methadone is done through the National Center for Drug Addiction (NCDA) and is government regulated. All donation blood is tested for infection, universal precautions are in place in health care settings, and there have been no instances reported of iatrogenic transmission of infection to date
Immunology tests (CD4/CD8 count) and viral load (PCR) are performed at the National Center for

Dermatovenereology (NCDV) where the HIV/AIDS Unit is located. This unit has been providing inpatient and outpatient HAART treatment to almost 222 patients (end of 2005), alongside the penitentiary system. It is suggested that another inpatient unit be opened in the breakaway region of Transnistria and another outpatient site in Balti, the second largest city in Moldova. pMTCT services are provided at two maternity wards in the country (Chisinau, Balti). NGOs and their networks (social, including HIV/AIDS; harm reduction;PLWHA) run grant- and donor-funded projects in support of government efforts (education, awareness, condom, harm reduction, advocacy, social support and care etc.)

The epidemiological surveillance is done through the NCPM and district-level subordinate Centers for Preventive Medicine (CPM). These centers represent standalone government entities under the health epidemiological service, subordinated to the Ministry of Health at the national level and, to Local Public Authorities and to municipalities, at the regional level. The NAC as a sub-structure of the NCPM is carrying out the surveillance for HIV in the country. The Immune Status Diagnosis Reference Laboratory operating within the NAC is the only laboratory for confirmation (western blotting) in Moldova. The epidemiological screening, testing of donor blood and diagnostics of HIV/AIDS in the Republic of Moldova started being performed back in 1987, first at the National Clinical Hospital, and since October 1987 - at the National Epidemiological Station (currently, the NCPM). During the next few years a series of laboratories for the diagnosis of HIV were established in different districts of the country, five of which vanished over time for different reasons. A more detailed description of the surveillance in HIV/AIDS may be found in Annex 58/AIDS “National Standard in HIV surveillance”

In 1997, following the ordinance of the Ministry of Health of the Republic of Moldova "On streamlining the laboratory diagnostic system for HIV/AIDS, hepatitis and other viral infections in the Republic of Moldova", the laboratory service for HIV/AIDS diagnosis has been reorganized. The majority of regional laboratories have been transferred to the bacteriological laboratories within the CPM and further reorganized into units for the diagnosis of HIV/AIDS, hepatitis and other viral infections. As a result of that reorganization, all laboratories became subject to common subordination to the preventive medicine service, followed by improvements in technical, working and space conditions and resulted in a centralized supply of equipment and modern diagnostic kits, for epidemiological surveillance on HIV/AIDS and prevention, monitoring of HIV prevalence within a set timeframe and in different population subgroups; assuring the security of blood transfusion, transplants and biologic fluids: screening of blood and blood components, tissues, organs, and sperm collected from donors; diagnosis of HIV/AIDS; identification of most vulnerable groups of population, planning of activities aimed at reducing their vulnerability; and exercising control over the efficiency of prevention and epidemic-control activities to correct them.

For each blood sample forwarded to the laboratory (unit) for the diagnosis of HIV/AIDS, hepatitis and other viral infections, the medical facility collecting the blood sample shall complete a special card index with specific information. In the regions this information is generalized and reported promptly to the NAC laboratory. The reporting of cases tested positive and confirmed is done by the NAC laboratory by notifying the Deputy Director of the NCPM. Further, based on the reports submitted, the relevant information is sent to the district CPM and health units for the above-mentioned facilities to implement epidemic-control activities in line with the ruling legal framework. The number of STIs are under-reported as government laboratories have limited capacity to do some basic tests (for instance, testing for chlamydia, mycoplasma and HPV are done only at some labs only).

Anonymous testing and pre-test counseling for HIV is in line with the provisions of the 1993 Law, article 1, stating that the HIV testing is done free of charge. However, the free testing for HIV is done only for blood donors and some vulnerable groups due to financial constraints. Some HIV testing is also done in few private medical facilities holding a license for such kind of activity, in this case the blood testing is performed in government laboratories, the payment being usually higher for testing (about USD 2.00), but confidentiality of diagnosis is more reliable.

As noted above, the Government appointed the NCPHM to be in charge of the national M&E system, and a pilot project for developing a M&E System for the two programmes - NAP and NTP - was initiated by the UNTG on HIV/AIDS with UNAIDS/Global Fund/WB money. The M&E Unit is located inside the NCPHM and is staffed with five relevant professionals plus operators. At present, a full design of the system has been prepared with a set of indicators agreed upon by all major stakeholders.

4 Component Section *HIV/AIDS*

The provision of health care to AIDS patients is abiding by the Ordinance no. 236 dated 08.10.1993 of the MOH stating out the measures for planning of the work of health facilities with respect to HIV/AIDS prevention and control. Provisions were made dealing with recommendations on the organization and the rules guiding the health care rendered to PLWHA; list of health facilities providing urgent and relevant health care; listing of specialists consulting the PLWHA; and the national standards for HAART. The relevant government health care facilities and national counterparts have been in the process of updating the national protocols as to make them comply with international standards of care (pMTCT, AIDS treatment and care, VCCT, Law on HIV/AIDS Control, National AIDS Program for 2006-2010 etc.)

There is no health specialization in AIDS in the Republic of Moldova (extreme verticalization), but rather ordinary physicians working in general health facilities identify the PLWHA when they ask for health care and based on the results of HIV/AIDS screening. The PLWHA are further referred to an infectionist. There is one inpatient ward for AIDS patients (at the NCDV), with outpatient treatment being provided in the penitentiary system too. The general precautionary rules should apply in all health facilities alike irrespective of the HIV status of a patient. However, considering the high stigma on the side of some health workers, there are "preferred clinics or wards" for the infected people, for instance, pregnant infected women could deliver at the National Center for Maternal and Child Health. The outpatient health care in case of somatic conditions, including traumas and surgery, should be provided within the regional health care facilities at the outpatient clinics by physicians and nurses with special training in HIV/AIDS prevention. The health care rendered to HIV+ children in outpatient settings is provided in polyclinics (consultations) for children. Specialized health care needs to be centered around specialized teams - surgical, therapeutic, trauma etc. The medical staff of the given teams have special training in HIV/AIDS related issues and prevention. These teams are supplied with personal protection means. Infectionists are called upon to provide consultative assistance, when the case.

Pursuant to another MOH ordinance, specific measures for improvements and AIDS prevention have been adopted, as outlined: approving of a number of organizational, training and methodical papers, that make up the system of evidence keeping, accumulation and sharing of relevant data to evaluate the level of epidemiological control and HIV/AIDS control and prevention measures; raising the awareness and body of knowledge about the HIV/AIDS epidemic among the leadership of health facilities and health workers; efforts have been bent to raise the public awareness about the epidemic in question, the leaders of plants and factories, various organizations and educational institutions, making them knowledgeable about the requirements of the Law and above Regulations; training of the public at large in HIV/AIDS prevention; medical university and college curricula have been changed to accommodate for the evidence and knowledge about HIV/AIDS; hands-on training and methodical recommendations for epidemiologists from the CPM have been developed for the epidemiological control over HIV/AIDS, hospital admission and follow-up of the PLWHA. Those with confirmed HIV status, children up to 3 years of age born to HIV-positive mothers, those having sexual intercourse with PLWHA, those with ELISA positive and Western Blot negative tests during the first year, medical personnel with professional exposure to infected products are in follow-up control for good. The follow-up is done by the NAC and regional Infection Diseases Rooms by infectionists with participation of family physicians.

With respect to inpatient care, it is provided to PLWHA as follows: in emergencies - provided by national specialized health care facilities depending on the condition, patient status and whether they could be transported; planned HAART treatment at the AIDS Unit within the NCDV; narrow mono-profile care is provided by specialized regional facilities and wards. Special teams (surgical, therapeutic, obstetrical, gynecological, pediatric, trauma etc.) are organized to provide other kinds of care. The Ob/Gyn care is provided to women with HIV and PLWHA at the regional consultations for women, equipped with separate beds/wards for these people, especially for Ob/Gyn care. Dental care is provided at the regional outpatient facilities in a specialized room with specialists competent in HIV/AIDS issues.

All epidemiological and HIV/AIDS diagnosis services are centralized at the NAC. All patients suspected are re-referred to the NAC for further investigations. It makes sense to install equipment and train specialists in HIV/AIDS diagnosis at least at two additional settings up in the north and the Eastern part of the country. It is generally accepted that HIV/AIDS is severely underestimated in Moldova with nearly 3,000 cases officially registered and 29,000 estimated by WHO/UNAIDS.

Details on the health care system in Moldova may be found in the "Analytical Report on the Activity of the MoH and Social Protection for 2005" attached as Annex 39/AIDS.

b) Given the above analysis, explain whether the current health system will be able to achieve and sustain scale up of HIV/AIDS, tuberculosis and/or malaria interventions. What constraints exist?

The Government of the Republic of Moldova, based on the Universal Access to Prevention, Treatment and Care Initiative and supported by UNAIDS has developed a detailed plan that would ensure implementation of the initiative by the year of 2015 and that would come in support of the NAP (Annex 25/AIDS). Thus, from the planning point of view the government has ensured a strategy to support scaling up of access.

The Moldova proposal to the Global Fund is based on a strategy that has set a goal of keeping Moldova as a low prevalence country with less than 1% of population infected with HIV/AIDS. In overall, the entire proposal has been built as to ensure implementation and attaining of objectives set in the NAP. To reach goals of the NAP, the TWGs have tried to define realistic and achievable activities. In some cases activities are built on the principle of scaling up existing services such as testing, in some cases activities will support building of infrastructures to be further maintained by government institutions such as establishment of ART sections in the northern part of the country and in Transnistria. Some activities were clearly aimed at improving knowledge, education, social tolerance and capacity building as for example of PLHA which will serve as good investment for the country and that will result in sustainable and irreversible change for the better.

In principle, the entire project was designed in such a way as to make use of the existing systems within the health care system or integrate some of the services with the services that are similar by nature, as for example scaling of VVCT is planned to be done through the existing Family Planning rooms and Youth Friendly Services.

A great deal of attention was paid to optimizing the existing services in order to attain maximal geographic coverage at reduced costs by setting up mobile services for outreach to vulnerable populations and PLHA. A detailed planning for access has revealed that services for testing and ART should be decentralized in order to achieve higher attendance and lower down withdrawal from ART for which the project seeks equipment and infrastructure setting for the northern and eastern part of the country. All activities have been designed based on the existing staffing schemes thus practically the grant money will not be used for incentives for the staff employed under government contracts.

In addition, planning of activities has been designed in such a way as to ensure rolling out of the greatest majority of activities from the donor support and passing gradually to financing from the state budget. One of the most important exercises undertaken by the TWG was trying to identify among activities those that have proven to be the most cost-efficient. This approach was used during development of activities under the present grant as well. Cost-efficient activities are preferred by the government since their sustainability can be achived even based on reduced allocations from the state budgets.

Nevertheless, there are several constraints identified in the framework of the Universal Access to Prevention, Treatment and Care Initiatives that can be classified under four thematic areas:

- Lack of sustainable funding for the AIDS response
- Lack of capacities of human resources and health and social systems
- Reduced availability of affordable commodities and low cost technologies
- High levels of stigma and discrimination

Financial constraints are closely linked with reduced budget allocations to HIV/AIDS due to the shaky economic situation which result in reduced implementation of activities. The issue of increased financial allocations earmarked for HIV/AIDS have been extensively discussed during CCM meetings and during hearings in Parliament in regards of MDG. One of the most rational solution is to try to make use of the most cost-efficientt interventions that would both allow for use of reduced budgets and increase coverage. A second proposal that was highly supported by the MHSP is to subcontract part of services such as VCT, testing to syphilis and rehabilitation of drug users to the National Medical Insurance Schemes.

In terms of coordination, a weak interaction between stakeholders in the area of HIV/AIDS has been reported between different government institutions (e.g., between the MHSP and Department of Penitentiary Facilities under the Ministry of Justice, between NGOs and government institutions and between various NGOs themselves). This situation currently showed clear signs of improvement since the establishment of the CCM.

Another important difficulty derives from the low prevalence of the AIDS epidemic in Moldova. The limited number of PLHA in Moldova does not create enough leverage for reducing the cost of medicine and other HIV related technologies. This situation is well seen in other fields of health care, and therefore the

MoHSP decided to adopt a model of bulk procurement associated with procurements with neighbouring countries.
The stigma and discrimination is addressed in the project both through capacity building of NGOs of PLHA and networks, mass media campaigns aimed at educating tolerance in the general population and by training of health workers.

Migration is another important issue factoring in that can still impact dramatically the shift in the spread of the epidemic since an estimated 25% of the lay population is in seasonal migration to countries with high prevalence of HIV/AIDS such as Russia, Ukraine etc.

c) Please describe national health systems strengthening plans as they relate to these constraints. If this proposal includes a request for resources to help overcome these constraints, describe how the proposal will contribute to strengthening health systems.

Based on the constraints described within the Universal Access Initiative (Annex 25/AIDS), the Technical Working Groups of the CCM have developed a gap analysis of weaknesses that will prevent the government from successfully initiating, scaling-up and sustaining programmes to address HIV disease. As noted in the preceding section, four areas have been identified as health system weaknesses and constraints:
i) Lack of sustainable funding for the AIDS response; ii) Lack of capacities of human resources and health and social systems; iii) Reduced availability of affordable commodities and low cost technologies; and iv) high levels of stigma and discrimination. The following outlines plans to address these constraints.
Lack of sustainable funding for AIDS response could be overcome by:
• Increasing domestic investments on HIV and AIDS at both central and local level and establish National AIDS Accounts for monitoring and evaluation of financial flows and spending.
• Strengthening budget planning capacities and ensure effective financial management by promoting cost effective interventions.
• Encouraging the engagement of the private sector in HIV prevention and treatment by establishing adequate incentive systems
• Working to harmonize and align funding with national priorities and shift from project financing by donors to programme financing.
Reduced capacities of human resources and health and social systems could be overcome by:
• Developing appropriate and specific human resources development plans based on the assessment and mapping of existing capacities and develop national guidelines and protocols for prevention, treatment, care and support based on international best practices
• Integrating HIV and AIDS prevention and care into existing health and social structures, expand HIV services for most at risks populations at community level through existing systems
• Establishing quality assurance systems and standards for health and social services related to HIV and AIDS.
Difficulty in accessing affordable commodities and low cost technologies could be overcome by:
• Establishing national procurement systems to ensure universal and consistent access to a treatment package (combining antiretroviral (ARV) and medication for opportunistic infections) under National AIDS Programmes
• Accelerating the application of PEP guidelines for healthcare workers and promote their availability for other groups of populations
• Scaling up geographic accessibility to substitution therapy and encourage adherence to ARV among Injecting Drug Users (IDUs)
• Scaling up and strengthening harm reduction programmes through mobile points and through the primary health care system
• Ensuring maximal access to condoms by providing them free of charge to groups of population most at risk including prisoners and members of uniformed services.

In this vein, considering the quite big share of grant money earmarked for capacity building (local and international workshops and trainings, including at the WHO Knowledge Hub in Kiev, Ukraine), this money from the grant will help accomplish it, resulting in local expertise and skills-mix being built up, with foreign TA whenever appropriate (WHO, UNAIDS, UNFPA, UNICEF etc.) The stronger emphasis on treatment and care of this proposal will help deal with a backlog of PLWHA who require treatment, however not coming at the expense of preventative measures which are also paid a lot of attention to. The social aspects of the PLWHA are deemed important, and various incentives were thought of in order

to increase the patients' adherence to the treatment and have lower drop-outs and default cases (food stamps, social support, advocacy, reimbursements etc.) This proposals heavily draws upon updated standards of care, (Annex 29/AIDS – Moldova ART and Care Protocol 2005 based on new WHO guidelines for testing and treatment) to allow the health system in Moldova to apply to most modern and relevant techniques for diagnosis, prevention, treatment and care, monitoring, surveillance etc. (blood and saliva based rapid tests in maternity wards and for surveillance purposes, better treatment regimens, PCR in the monitoring of HAART treatment, facility and home based palliative care etc.) As the donor funding earmarked for HIV/AIDS will be tapering off following the completion of the grant project, the Government is considering to increase its share in the financing of this area of the health sector. This could be achieved first of all by increasing the local ownership over services, streamlining of costs to avoid overlapping and duplication of services, and eliminate redundancy where appropriate. This proposal will provide the government with an opportunity to build up an automated system for real-time monitoring and reporting of HIV/AIDS and other relevant data, once implemented and put in place of the old paper-based and time-consuming procedures. By having the HIV/AIDS control process jointly steered by the Government and non-government entities, the burden of the State will be alleviated as many of its social tasks will be taken over by CBOs and NGOs.

Donor funding is extremely important for financing the NAP for the next 5 to 10 years.
Though part of the frameworks has been established at the country level, there still is much work to be done to have a full-fledged institutional framework that will be able to self sustain. The external money in the NAP make up at least 70% of all investments today.

This money is used for prevention activities among vulnerable populations implemented by NGOs, because to the existing arrangements are not supported from the state budget along with the ARV treatment provided to PLWHA. In the current situation with underdeveloped national capacities it is extremely important to further support the NAP. One of key contributions that donors are providing now to the NAP is Technical Assistance and human resources.

4.5 Financial and programmatic gap analysis

Interventions included in relation to this component should be identified through an analysis of the gaps in the financing and programmatic coverage of existing programs. Such an analysis should also recognize gaps in health systems, related to reducing the impact and spread of the disease. Global Fund financing must be additional to existing efforts, rather than replacing them, and efforts to ensure this additionality should be described. For more information on this, see the Guidelines for Proposals, section 4.5.

Use table 4.5.1-3 to provide in summarized form all the figures used in sections 4.5.1 to 4.5.3.

4.5.1 Overall needs assessment

a) Based on an analysis of the national goals and careful analysis of disease surveillance data and target group population estimates for fighting the disease component, describe the overall **programmatic** needs in terms of people in need of these key services. Please indicate the quantitative needs for the 3-5 major services that are intended to be delivered (e.g. anti-retroviral drugs, insecticide-treated bed nets, Directly Observed Treatment Short-Course for TB treatment). Also specify how much of this need is currently covered in the full period of the proposal by domestic sources or other donors. *Please note that this gap analysis should guide the completion of the Targets and Indicators Table in section 4.6. When completing this section, please refer to the Guidelines for Proposals, section 4.5.1.*

Identification of target populations for the present proposal is based on several processes and documents developed by the Technical Working Groups for the NAP. Analysis for the development of the 2006-2010 plan identified the most vulnerable to HIV and activities were developed aimed at addressing their needs. Greater detail may be found in the indicators created for the Universal Access Initiative (Annex 25/AIDS) and NAP, but the proposal seeks to achieve a comprehensive prevention response needed to contain the epidemic, 100% rates of treatment and care for HIV-infected individuals by 2012, and full support for orphans and vulnerable children by 2012 thorugh day care centres.
Despite the progress accomplished to date in attempting to curtail the spread of HIV/AIDS, a number of

outstanding issues underscore the importance of strengthening Moldovan response to HIV.
Testing and prevention shortfalls. Inconsistent testing patterns and inadequate MTCT have resulted in children born to HIV-positive mothers (current MTCT rate is around 2.8%). The proportion of perinatal transmission has worsened recently in Moldova, with increasing rates of vertical transmission documented. The access of HIV+ women to comprehensive PMTCT services that are integrated with maternal and child health (MCH) services remains limited, too. Highly vulnerable women, such as IDUs, do not access appropriate perinatal counseling and consultations, including care and support measures to prevent the abandonment of children born to HIV+ mothers, family planning, milk formulas etc. UNICEF, in partnership with WHO, have provided technical assistance and support during 2004-2005 to review / endorse the National PMTCT guidelines (Annex 37/AIDS), development of the PMTCT curriculum and training modules for pre-and in- service training and the provision of PMTCT training to health workers and managers of the health care system. Nonetheless, these have been insufficient to secure the necessary expansion.

Generally with HIV testing, quality of pre- and post-test counseling, if any is provided, is variable. Breaches in confidentiality are common. Increases in HIV prevalence from 4.4. new HIV cases per 100,000 in 2003 to 6.2 in 2004, and concentration of HIV cases among the young (more than four of five in Moldova with HIV are age 20-40) indicates greater need for prevention programmes, particularly those aimed at vulnerable youth. Despite the concentration of HIV cases among IDUs, there is uneven geographic location of sterile syringe programs and other harm reduction approaches (low coverage in the South and Transnistria). Reports of risky behavior among young DUs continues to be widespread. Migration is another important factor that can dramatically influence the spread of HIV and highlights the need for testing, since an estimated 25% of the population of Moldova is in seasonal migration to countries with high prevalence of HIV/AIDS such as Russia, Ukraine etc.

Treatment shortfalls. A WHO Euro assessment on need for HAART and HIV care (Annex 34/AIDS and 36/AIDS) made at the request of the Government for Moldova found serious constraints in treatment. There were 222 people with AIDS on HAART at the end of 2005. However, patients have dropped out of treatment due to poor compliance and low adherence to treatment regimens. Many PLWHA eligible for ART are not able to come to Chisinau, the only locality to provide ARV, because of geographic distances and cost of travel. Knowledge about ARV is poor amongst PLWHA and in mainstream population alike. Despite an HIV epidemic that has been concentrated among IDUs, few patients with HIV are also on the substitution therapy demonstrated to increase adherence. Stigma against IDUs and PLWHA adds an additional disincentive. Palliative care for the people living with HIV/AIDS is scarce (no oral morphine or hospice services).

The coordination of the monitoring of the HIV/AIDS disease is very low. There is no active monitoring and evaluation of HAART (first- and second-line drugs, resistance, drop-outs), and little or no integration of STI and HIV testing or care. TB and HIV testing and treatment are similarly discoordinated as a result of the vertical silos in which HIV, TB, and STI care are delivered, and because of centralization of HIV epidemiology and diagnosis at the NAC.

Centralization has meant lack of capacity outside the capital. No site for HIV provision is available in Balti, with theighest of prevalence of HIV in the country (502 HIV cases per 100,000) or in Tiraspol (132 cases per 100,000).

Transnistria represents a particular urgent example of need for strengthened HIV/AIDS systems. The breakaway region is in a dire plight in terms of access to quality HIV/AIDS testing, HIV/AIDS treatment and care services. Transnistria’s status as a self-proclaimed republic means the region uses a different health reporting system, and Transistria's separation from country-wide diagnostic, prevention and treatment efforts has resulted in poor access for the population living on the left bank of the Nistru river. Transnistria has no equipment to determine a patient's immune status (flowcytometer), no PCR for viral load assessment, no confirmatory tests for HIV infection. Local authorities there started dual therapy with Combivir after Chinsinau’s failure to provide triple therapy and lack of local funds to purchase a third medication. There are few if any harm reduction programs running there, and no Opiate Substitution Therapy (OST) with methadone at all.

Funding shortfalls. Increased contributions to HIV/AIDS efforts by government is also essential, if unlikely

in the short term given the realities of Moldova's economic situation. International donors such as the World Bank, GFATM contribute the largest share of funds, and Moldovan NGOs remain "unsustainable", supported almost exclusively by contributions of international donors. Donor funding is likely to remain extremely important for financing the NAP for the next 5 to 10 years. Though a framework to address HIV/AIDS has has been established at the country level, there still is much work to be done to have a full-pledged institutional framework that will be able to self sustain. External money in the NAP make up at least 70% of all investments today. This money is used for prevention activities among vulnerable populations implemented by NGOs, because existing arrangements are not supported from the state budget, as well as for ARV treatment provided to PLWHA. More details on on Financing Sources and other ways to support the activities/projects in the social filed may be found in Annex 40/AIDS.

Shortfalls in coordination, technical capacity, and political commitment. Funds alone will not be enough in dealing with many direct and interrelated challenges. While the NAP calls for coordination of the national response and existing systems, significant engagement by implementing partners and international donors will be required. Within this framework, there is a need to strengthen the national AIDS body, which in turn will need to help strengthen the administrative capacities of national organizations and foster the partnerships between the government and CBOs. Technical assistance and capacity building and development is one of the key components in achieving the program's goals, as is advocacy to mobilize political leadership. Key areas where such strengthening is needed include:

Measures to increase national leadership and ownership. Although the government of Moldova supports and advances HIV/AIDS efforts, high political level leadership remains lacking. The president of the country is never reported to be speaking about HIV/AIDS or related issues. During parliamentary hearings, such as those held with respect to MDG 6, Combating HIV/AIDS and Other Infectious Diseases, lack of knowledge of HIV/AIDS issues of the deputies in Parliament is noticeable.

Activities of the CCM and implementation of decisions of Technical Working Groups. Areas in need of strengthening include
i) Coordination of activities and partnerships. Even if existing initiatives by international donors meet most of the financial needs of HIV/AIDS efforts, coordination of all stakeholders, assistance in developing working plans and setting up a project management office, assistance in developing a smooth mechanism for the distribution and management of funds, once received, are all essential. Strategic planning and program management assistance are particularly important for local officials from rural areas

ii) Mechanisms for follow up on Technical Working Group recommendations. No such mechanisms currently exist.

iii) Transparency of information and decision making. At present, the access to information on statistics and activities implemented are mainly made through an Information Bulletin put out by the CCM and through the web page www.aids.md <http://www.aids.md/>. Stakeholders report that lack of access to information is quite a problem, especially for NGOs who seek not just statistical data on HIV/AIDS, but also information on activities implemented, financial resources earmarked etc. NGOs report the lack of knowledge of criteria for selection of sub-grantees.

iv). Management of supply. The government lacks capacity to deal with the supply management, a function currently being fulfilled by the WB/GF PCU. This capacity will be lost when the grants will roll out and the donor-funded current projects may be facing the need to shrink..

Strengthening of engagement by NGOs and affected communities. With NGOs fighting for survival and heavily dependent on the financing allocated by the government and international donors, it is difficult to speak of a strong NGO sector in Moldova. Recently the government has reported the underdevelopment of the NGOs capacities which prevents the government from implementing a number of important activities and strategies under the NAP, such as adherence programmes, palliative care, increased testing etc. As noted above, NGOs report little transparency of information.

Monitoring and Evaluation. All of the above has been planned to be resolved through efficient operation of the M&E Department, but the department was established as a structure only in 2002 only and has lacked the financial resources to support its work. Further, development of M&E tools is regarded by the government as one of the most valuable contributions that the UN TG on HIV/AIDS can provide. In this respect, development of a legal framework for quality control of services and goods, development of

standards of the cost-effectiveness of activities and programmes, studies on socio-economic impact of HIV/AIDS and estimation of costs for interventions are viewed as top priorities. Additional efforts will be also required in terms of technical assistance for M&E and second generation surveillance and VCT. No incentives exist for the implementation of workplace strategies regarding HIV/AIDS. Details on programmatic Gap Analysis may be found in Annex 57/AIDS.

b) Based on an analysis of the national goals and objectives for fighting the disease component, describe the overall **financial** needs. Such an analysis should recognize any required investment in health systems linked to the disease. Provide an estimate of the costs of meeting this overall need and include information about how this costing has been developed (e.g., costed national strategies, medium term expenditure framework). *(Actual targets for past years and planned and estimated costing for future years should be included in table 4.5.1-3 [line A].)*

Since 2003, all ARV drugs in Moldova were bought with GFATM/WB money. Government has contributed human resources, physical premises for treatment and care, operational and other associated costs, and in kind goods and benefits. An exception is in Transnistria, where Transnistrians pay for the entire HIV/AIDS control system from their local budgets, since no donor funding has been available to them. Part of overall training activities in Moldova have been paid for by the GFATM and World Bank through the respective projects; other agencies provided technical assistance and international expertise (WHO, UNAIDS, UNICEF, UNFPA).

Future budget needs have been assessed through a detailed analysis of funds required to cover the NAP 2006-2010 developed by the TWG. Financial needs and a proposed budget have been officially approved with the NAP for 2006-2010 through a Government Decision of Nr. 948 of 05.09.2005, and appended to the NAP. The document, and rationale behind the estimations, is also attached here (Annex 21/AIDS), and indicates total needs for each year, with clear demarcation of funds to be disbursed from the government budget as well as already approved grants and anticipated external contributions. It also identifies those needs unmet by any agency or organization. As such, the NAP budget provides the most complete assessment available of needs and resources for the HIV/AIDS response in Moldova. For ease of reference, an additional table has been developed (also in Annex 22/AIDS) showing dollar equivalents for estimates in the NAP budget. Government share in the total funding earmarked for HIV/AIDS over the next five years starting in 2008 should be increasing at the expense while external donor commitments taper off. Estimates of the relative value of non-tangible assets and in-kind goods contributed by the government are difficult to assess, particularly given low spending on health care in general and on HIV/AIDS in particular. Many international agencies also contribute to HIV spending through collaborative agreements with the Government of Moldova, as reflected for instance in the UNDAF where UN agencies (UNICEF, UNDP, UNAIDS, WHO, IOM, UNFPA etc.) that provided funding for technical assistance and other activities.

The resource requirements for 2006–2010 would result in the following achievements.

• Based on the current coverage of prevention services and the most recent evidence on actual rates of scaling up interventions, it appears to be realistic and achievable through planned activities to get to at a comprehensive prevention response by 2010, as is required to turn around the AIDS epidemic. Especially so because the AIDS resource needs estimate also incorporates the resources required to enhance capacity for scaling up (human resources and programme costs). Prevention interventions include programmes to reduce risk behaviours by vulnerable groups, decreasing infections in infants, and improving access to testing.

• For treatment and care, current coverage rates and rates of growth in coverage have been carefully estimated and consulted with WHO. By 2012, coverage of 100% could be reached, which is better than the expectations of what can be reached under global “universal” access, set at 75% access rate.

• The support for orphans and vulnerable children is assumed to scale up from current low levels to full coverage by 2012. This includes support for all orphans and vulnerable children in need of support. Because expansion of services requires a significant investment in human resources, training costs have been included in the estimates. Improved estimation of human resource requirements will be developed in the future. These are distinct from programme costs, which have been are not included in these estimates and are defined as costs that are incurred at administrative levels outside the NAP. Programme costs cover services such as management of AIDS programmes, monitoring and evaluation (M&E),

advocacy, and maintenance and telecommunications that are estimated at 1,2 million per year.

It is crucial to recognize the fact that any estimate has its limitations, due to the inherent uncertainty about the future and limited data availability. For example, resource needs estimates in the attachment to the NAP are based on hypotheses about future behaviour of donors, governments and various agents (companies, households, individuals), as well as about the way in which increased coverage will affect unit costs. Moreover, estimations necessarily use proxies and generalizations to fill in incomplete empirical data. Even when validated by expert opinion, such assumptions remain uncertain. Therefore, resource needs estimations must be continuously improved, in close cooperation with programme implementers in country, as additional data become available to inform the assumptions about unit costs, numbers of people in need and activities to be included.

4.5.2 Current and planned sources of funding

a) Describe current and planned financial contributions, from all relevant domestic sources (including loans and debt relief) relating to this component. *(Summarize such financial amounts for past and future years in table 4.5.1-3 [line B].)*

The absence of a national health accounts system in Moldova makes it impossible to use methodologies (HIV/AIDS spending in the context of national health accounts and stand alone national accounts for HIV/AIDS) recommended for monitoring spending in low and middle income countries. Financial reporting in Moldova also makes it impossible to break down public expenditures by categories such as HIV control, prevention, treatment and care. The budget for the NAP, as noted in 4.5.1., includes contributions from state and local public authorities, international organizations, NGOs, donations from private institutions, individuals and private sector companies.

For the purposes of the current application, assessment of domestic contributions have been restricted to resources from the government budget line titled "centralized allocations for the prevention and control of HIV/AIDS/STIs". After adjusting for possible duplication, annual expenditures for each year were aggregated and converted to USD equivalents using the exchange rate of the National Bank of Moldova. In 2004, the spending for HIV/AIDS calculated in US dollars has shown a slight decrease compared to the previous year by about 12.5 per cent. The expenditures of national funds in US dollar equivalent has increased by 2.8 per cent in 2004 versus 2003. Differences in spending are actually greater, as a result of changes in the exchange rate for US dollars.

Assuming continuous economic growth, the Government of the Republic of Moldova will take over a larger share of national expenditures for HIV/AIDS in the future. A similar situation obtained with the National Vaccination and Immunization Program, which was originally supported by international donors and for which the government assumed increased responsibility until external support was phased out completely. Additionally, some of the activities are planned to be covered by the National Health Insurance plan.

b) Describe current and planned financial contributions, anticipated from all relevant external sources (including existing grants from the Global Fund and any other external donor funding) relating to this component. *(Summarize such financial amounts for past and future years in table 4.5.1-3 [line C].)*

International assistance in the Republic of Moldova is relatively limited, specifically in in the area of HIV/AIDS and STIs. In addition to the Global Fund and World Bank grants totaling $ 11,719,047 USD, a recent study conducted by NGOs and attached here (Annex 40/AIDS) shows bilateral and multilateral support from the UN, USAID, DFID and SIDA in the country. The limited support is due primarily to the relatively low prevalence of HIV in Moldova, and the fact that its size (4 million people) and economy make donors perceive it to be of limited strategic importance. Perception that the GF and WB grants were sufficient to address the Moldovan HIV epidemic further decreased interest from other donors, though the World Bank grant will conclude in 2008. To the extent that bilaterals do contribute, they appear to invest in areas that match national interests and that cover efforts not previously supported. This is the case with VCT, where USAID has pledged an estimated $900,000 to strengthen and scale up VCT centers. The UN supports a number of projects, including HIV prevention for the uniformed services ($300,000 USD),

supporting youth friendly services by UNICEF, condom promotion by UNFPA and technical assistance by UNAIDS.

In both instances, funding under the current proposal to the GFATM will be used to supplement and extend existing grants. The USAID grant, for example, will support establishment of 40 VCT and support incentives for the staff, refurbishment and equipment, while the GFATM funds are sought to raise the number of centers into a countrywide network of 34 mainly providing informational materials, training and furniture.

HIV/AIDS grants from external sources, detailed in the attached document entitled "Financing Sources and other Ways of Support for Activities/Projects in the Social Field (Annex 40/AIDS) are attached.

4.5.3 Financial gap calculation

Provide a calculation of the gap between the estimated overall need and current and planned available resources for this component in table 4.5.1-3 and provide any additional comments below.

The National contributions and donor funds are incrementally coordinated through the CCM and reflected in the budget of the NAP for 2006-2010. For many reasons, the government was not in the position to financially meet all the needs of the NAP. Thus, the gap in funding between the government contributions and donor funding will be at a turning point in 2012, when the government is planning a roll-out from the donor financing, provided that no big economic pitfall or windfall occurs. This will be greatly supported by shifting some of the services from the NAP allocations to the National Health Insurance Scheme along with increased budgets earmarked for the new NAP.

4 Component Section *HIV/AIDS*

Please summarize the information from 4.5.1, 4.5.2 and 4.5.3 in the table below.

Table 4.5.1-3 - Financial contributions to national response

	Financial gap analysis (*please specify currency:* Euro / US$)						
	Actual		Planned		Estimated		
	2004	2005	2006	2007	2008	2009	2010
Overall needs costing (A)	1,674,004	1,674,004	4,627,407	3,838,074	3,704,338	3,916,992	4,113,918
Current and planned sources of funding:							
Domestic source: Loans and debt relief (*provide donor name*)							
Domestic source: National funding resources	350,000	360,000	929,443	1,000,000	1,100,000	1,200,000	1,300,000
Total domestic sources of funding(B)	350,000	360,000	929,443	1,000,000	1,100,000	1,200,000	1,300,000
External source 1 Global Fund Grants	924,405	2,342,963	811,459	893,916	313,456		
External source 2 (IDA Grant)	578,371	1,116,472	1,843,816	1,462,271	725,655		
External source 3 (*UN Agencys*)	672,360	908,300	931,750	584,300			
Total external sources of funding (C)	2,175,136	4,367,735	3,587,025	2,940,487	1,039,111	0	0
Total resources available (B+C)	2,525,136	4,727,735	4,516,468	3,940,487	2,139,111	1,200,000	1,300,000
Unmet need (A) - (B + C)	-851,132	-3,053,731	110,939	-102,413	1,565,227	2,716,992	2,813,918

4.5.4 Additionality Confirm that Global Fund resources received will be additional to existing and planned resources, and will not substitute for such sources, and explain plans to ensure that this will continue to be true for the entire proposal period.
The reason underpinning the development of the present project proposal to the GFATM is to integrate all efforts bent in meeting the HIV/AIDS needs of the country and come up with activities that are either not covered by other donor organizations and partners or could not be scaled up due to scarce financial resources within the public central and local budgets. Most of the money spent on HIV/AIDS control in Moldova come from external funds, with the remaining part being provided as government contribution to the stamping out of the epidemic. However, other sorts of resources made up for the lack of funds, such as time and efforts, human resources, volunteer work, involvement of civil society organizations and PLWHA, all of which account for a big share of activities despite being done with relatively little money. Yet, despite donor funding (of which GFATM is part of) prevail in the overall amount earmarked for HIV/AIDS/STI, the Government is keen on the need to increase its share in the total funding as the external assistance will taper off. Considering that the huge costs associated with HAART, that by the way account for the largest part of the amount asked for, the GFATM money is the only funding channel to cover the country's needs in treatment, as no other donor is addressing this issue. Moreover, such an approach was used, for instance, in VCT, where the greatest share of assistance is provided by USAID and where the Global Fund money will be used to complement that grant. In addition, a big share of assistance from the GF grant will be redirected to the Transnistrian region that due to its political isolation has not benefited from any external assistance to date, with HIV/AIDS epidemic not being an exception from the rule. In Transnistria, the GFATM money will be used to provide people with prevention (including harm reduction, primary prevention), treatment and care services. Not only will it stomp on the epidemic there, but it will also indirectly benefit the whole country, as there will be enough funds to provide triple therapy rather than the two-drug treatment they can afford now, thus reducing the risk of drug resistance for the entire population. Besides covering areas not funded by any other organization or government, the GFATM money will add up to the number of existing activities (prevention and counseling in youth friendly centers, education campaigns, M&E automated systems, capacity building) in line with the government's target of scaling up HIV/AIDS control and care all over the country. This will be done in a transparent way and all key stakeholders will have access to the information of how this money is used in a bid to minimize duplication, redundancy and overlapping, specifically in view of the mandatory mid-term evaluation of the project. The PR to manage these funds will have to cooperate with all key partners and will report back to the government, thus enhancing accountability and transparency. The Government should also think of an exit strategy following the completion of donor funding, as to take over most of the activities started up with the GFATM/World Bank money, having to less rely on external money.

4.6 Component strategy

This section describes the strategic approach of this component of the proposal, and the activities that are intended in the course of the program. Section 4.6 contains important information on the goals, objectives, service delivery areas and activities, as well as the indicators that will be used to measure performance.

For more detailed information on the requirements of this section, see the Guidelines for Proposals section 4.6.

In support of this section, all applicants must submit:

- A **Targets and Indicators Table.** This is included as **Attachment A** to the Proposal Form. *(When setting targets in this table, please refer explicitly to the programmatic need and gap*

analysis in section 4.5.1 a. All targets should show clearly the current baseline. For definitions of the terms used in this table, see the M&E Toolkit provided by the Global Fund. Please also refer to the Guidelines for Proposals, section 4.6.

and

- A component **Work Plan** covering the first two years of the proposal period. The Work Plan should also be integrated with the detailed budget referred to in section 5.2.

*The **Work Plan** should meet the following criteria (Please refer to the Guidelines for Proposals, section 4.6):*

a. It should be structured along the same lines as the Component Strategy - i.e. reflect the same goals, objectives, service delivery areas and activities.

b. It should cover the first two years of the proposal period and should:
   i be detailed for year 1, with information broken down by quarters;
   ii be indicative for year 2.

*c. It should be **consistent with the Targets and Indicators Table** (Attachment A to the Proposal Form) mentioned above.*

*d. It should be integrated with the first two years of the **detailed budget** (please refer to section 5.2).*

Please note that narrative information in this section 4.6 should refer to the Targets and Indicators Table (Attachment A to this Proposal Form), but should not consist merely of a description of the table.

4.6.1 Goals, objectives and service delivery areas

Provide a clear description of the program's goal(s), objectives and service delivery areas (provide quantitative information, where possible).

Building on the substantial experience and capacity, the CCM of the Republic of Moldova is proposing to implement the Scale-Up of Access to Prevention, Treatment and Care project under the purview of the National AIDS Program (NAP) for 2006-2010, with the support of government, non-governmental organizations (NGO) and other local institutions for 5 years starting in 2008. Goals of the proposal are in keeping with joint WHO/UNAIDS global initiative for universal access to treatment and care. The proposal is a joint initiative of government facilities, NGOs and the community at large, . The project proposal takes into account financial and programmatic gaps, as identified within the framework of the above-said NAP and assessments by WHO and other international entities, and builds on technical knowledge, expertise, experience and financial tools developed during the implementation of prior national AIDS programs, and under previous WB and GFTAM grants.

The Ministry of Health and Social Protection has been designated as the primary recipient of the funds to be channeled to other agencies, subject to their specialization and kind of activities carried out in the area of HIV/AIDS. The NAP is committed to providing universal access to prevention, care and treatment in order to keep Moldova a low prevalence country at <1% HIV prevalence. By coordinating HIV/AIDS prevention and treatment efforts and seeking co-funding from donors other than the GFATM, the CCM seeks to match those of various stakeholders in meeting the needs of the country and its people, as well as to ensure the most effective use of local and international resources. To ensure sustainability, the proposal also recognizes the importance of seeking increases from the Moldovan government funds within the total funds from national and international sources earmarked for those activities.

The proposal seeks to achieve the following key objectives.

- Objective 1: Reduce sexual and mother-to-child transmission (MTCT) of HIV/STIs and transmission of HIV via needle sharing by scaling up the access of population to prevention and testing services;
- Objective 2: Foster equal access of people living with HIV/AIDS (PLWHA) through expansion of

social and health services and measures to combat discrimination and stigma; and
- Objective 3: Strengthen government and community capacity to cope with the HIV epidemic, through partnerships and enhanced coordination.

The first objective of the project targets primarily the young and people of reproductive age, who in Moldova number some 800,000 people in a given year, including an estimated 60,000 pregnant women; street and out-of-school children; parents; and some 600,000 migrants. Health, education, social protection and workplace services, and communications will be targeted to these groups, as will direct outreach prevention work with vulnerable groups such as IDUs estimated to number 50,000 (WHO/UNAIDS), and 5000 commercial sex workers (FSW).

The second objective primarily targets 6,000 PLWHA, whose needs will be met through the scaling up of treatment, care, support and referral services, and through anti-stigma campaigns. It will also target nearly 1,000 service providers and managers through capacity building and empowerment to strengthen human rights protections. Provision of diagnostic tools, facilities and ARV will be essential in helping to set up effective ARV treatment for people with HIV in Transnistria and elsewhere outside the capital.

The third objective targets the CCM and its eight technical working groups, government officials, NGOs and the 2 networks with their sub-networks, and community leaders to strengthen their capacity in evaluating the HIV/AIDS/STI policies and ensuring implementation of plans of actions. Advocacy activities will also be undertaken to ensure the adequate earmarking of resources for effective implementation of the given policies and plans. It is anticipated that the CCM Secretariat, itself strengthened across sectors by the current proposal, will help strengthen the administrative capacities of national organizations and foster the partnerships emerging between the government and NGOs for a more effective implementation of the GFATM grant and the NAP in accordance with the “Three Ones.”

The cumulative impact of these will be to reduce the percentage of young women and men aged 15-24 reported to have an HIV+ status, to change risky behaviors in 80 per cent of young people reporting a high degree of condom use with a non-regular partner, to reduce the ratio of HIV-positive infants born to HIV-infected mothers; to increase the numbers of those receiving voluntary confidential HIV testing; to reduce AIDS-related mortality; and to reduce stigma and discrimination against PLWHA.

In cooperation with stakeholders, the CCM will aim to develop a countrywide network of 34 VCT services to scale up access to testing for about 500,000 people for regions not covered by the USAID grant, deliver HAART to an estimated 6000 patients in need by 2012, will implement adherence support and a comprehensive program aiming at capacity building for at least 10 NGOs of PLWHA and designed to reduce stigma and discrimination. The capacity of the NAC will be strengthened in order to act as a first-tier provider in a well-coordinated VCT referral system. Together with the Ministry of Health and Social Protection (MOHSP), the project will facilitate the opening of HAART in-patient/out-patient facilities in the municipality of Balti (Northwest of the country) and Slobozia (Transnistria, Eastern part of Moldova) and will strengthen the laboratory network in 4 regional offices, including Transnistria. A framework for stigma and discrimination monitoring will be developed alongside with psychosocial support services made widely available for at least 6,000 PLWHA countrywide, pursuant to grant-funded programs implemented by NGOs. Joint trainings and joint initiatives for the eight Technical Working Groups will enhance the capacity for national response. The comprehensive national monitoring and evaluation (M&E) system recently developed will become operational by conducting DHS and KAP studies, as well as by setting up a second-generation surveillance system.

All activities under the three objectives, and measures of impact, have been structured around 23 service delivery areas (SDAs).

Objective 1: Reduce sexual and mother-to-child transmission (MTCT) of HIV/STIs by scaling up the access of population to prevention and testing services

The expected result from the objective is a significant and sustainable increase in the level of motivated safe behavior based on knowledge, increased access to services, products and commodities. The proposed activities include the rollout of model intervention, which are in line with the objectives and priorities of the new NAP for 2006-2010. The project will be implemented nationwide, including in Transnistria. At the impact level, the activity will be measured by an indicator collected by means of DHS

and KAP Studies, computing the share of young people aged 15-24 who both correctly identified ways of preventing the sexual transmission of HIV and who rejected major misconceptions about HIV transmission, as well as by the number of lay population making use of VCT services.

The first objective of the project targets some 800,000 young people of reproductive age in Moldova, with communication activities aimed at behavior change in line with the National Communication Strategy on HIV/AIDS (Annex 48/AIDS). Pre. This is achieved through Prevention SDA 1 BCC - Mass Media

Previous experience has shown the importance of participation of a wide range of stakeholders, specifically population from the rural areas in the discussion of the programmes and activities to be implemented within the NAP. Thus, specific attention will be paid to the careful organization and conducting of TV public debates on aspects pertaining to sensitive issues such as condom promotion, harm reduction, methadone etc. One of the activities in the mentioned SDA will aim at training mass media representatives on non-discriminatory language to be used in HIV/AIDS and in delivering messages about PLHA and AIDS. The participation of mass media in the project will also be strongly encouraged through the yearly award for the best media message. A large need remains for video films with educational character that can be broadcasted but which were unavailable first due to the low capacity of local TVs to produce films of both educational and advertising character. To save costs, translation and adaptation of existing films for use by local TVs and NGOs for broadcasting purposes is proposed. Two TV films and social clips will be produced to try to increase the local capacity to produce such products. In the end, one of the most important activity of the SDA 1 will be based on implementing of two big nationwide communication campaigns, one aimed at encouraging the general population to undertake an HIV test and a “Dance for Life” campaign aimed at increased awareness of young people about HIV/AIDS. The component has been designed in such a way as to ensure a multiplier effect, thus it is expected that such indicators as number of HIV/AIDS TV and radio programmes broadcasted, number of social events conducted, number of people reached by communication activities, number of articles on HIV/AIDS submitted by journalists for the national contest, and number of journalists participating in mass media training on HIV/AIDS will better reflect the progress made as to regards of involvement of mass media in communication and HIV/AIDS and can be routinely monitored. A special attention will be paid to ensuring a proper coordination of communication activities that will be ensured by subcontracting SDA 1 to an NGO to build local capacities.

In addition to media coverage the activity will help to mobilize communities in organizing and planning communication activities at reduced costs and will encourage local public authorities to co-finance the events, since the events will be financed based on a small grants programme launched for NGOs and public administration from rural areas.

Expansion of PMTCT efforts will be supported through SDA 2 Prevention PMTCT. The PMTCT SDA has been carefully considered by the Technical Working Groups as one of priority prevention SDAs. Overall, the strategy calls for scale up HIV testing by making it free of charge for pregnant women and also offering a rapid HIV test to pregnant women before delivery in case when she has not been registered with a health facility. This will offer an opportunity to reduce the risk of transmission from mother to child by offering both short course ARV. The progress of the SDA will be checked against several indicators, first there will be an attempt to increase the % of HIV positive pregnant women receiving a complete course of ARV and % of infants born from HIV+ mothers that were checked up within 2 months after birth in 950 pregnant women and children.

To support the achievement of the overall objective the SDA 2 will employ the following activities:
- advocacy and technical assistance for the integration of new services in antenatal care;
- organization of advocacy meetings at the national and local levels; orientation and follow up workshops for health care managers from all regions;
- development, editing and distribution of IEC materials for prevention of unwanted pregnancy
- capacity building for health care providers to offer PMTCT services in the area of pre- & post-HIV test counselling,
- offering a free of charge test for HIV and syphilis to pregnant women,
- provision of short course ARV treatment during pregnancy, delivery and postpartum,
- HIV and infant feeding counselling and support

An important outcome of Prevention SDA 3 VCT is an increase in the number of people coming for HIV

testing and knowing their HIV status and applying the knowledge to reduce risk behavior and thus the risk of passing on the infection. Currently, high quality VCT is practically available only at the NAC in Chisinau and is not integrated with any other testing. There is neither a coordinated referral system nor designated responsibility at the local level for VCT. The approach in line with the NAP strategy is to increase the capacity of the NAC to teach VCT and to serve as a referral center; improve referral systems and planning processes; and train first- and second-tier practitioners and peer counselors. In order to ensure that VCT is provided to the most stigmatized and at-highest-risk populations — IDUs, FSWs, and MSM — the training will focus on evidence-based information on HIV prevention among these group and measures to increase safety, reducing misinformation that leads to stigmatization.

The project will assist the MOHSP in adapting the national protocols to meet international standards and provide equipment, material such as rapid testing kits, and training to create 34 VCT sites throughout the country. The development of a conceptual framework for national and district level referral systems will be facilitated through a specific working group. In order to expand VCT services in Moldova, capacity will be built among existing trainers. Since 2003, SIDA/Sweden, the GFATM and the World Bank have funded training sessions conducted by the AFEW. About 150 practitioners from ante-natal clinics received basic training in universal VCT (second-tier). At present, AFEW is training 100 trainers of trainers (TOT) around the country. The current proposal will allow 10 of these trainers to become core TOT and will further act as core trainers for the NAC. To increase reach of VCT to at-risk youth, the primary care network of Family Planning Rooms and Youth Friendly Clinics (YFC) located within Family Doctor Centers (FDC) all over Moldova will be used.

Creation of a collaborative VCT working group with the objective to formulate protocols and an operational plan as well as overseeing its implementation has been discussed with the Ministry of Health and Social Protection. The principal partners will be the National Centre for Preventive Medicine for the establishment of VCT through the NAC; the Departments of Infectious Diseases and Epidemiology at SMPU for the development of guidelines; the GFATM, World Bank, and AFEW for provision of TOT; the ProDidactica Centre for training on teaching methods; and NGOs for referring vulnerable groups to VCT services.

The project activities are focused on the following:

- Development of the regulatory framework and operational strategy for VCT. The working group will develop an operational plan for national VCT, including referral systems between first- and second-tier services, type and protocols for rapid tests, and increased capacity for quality pre- and post-test counselling. The group will evaluate adapting best practices to Moldova, including ORC Macro's instrument for assessing VCT referral networks. To ensure that first-tier services meet standards, the VCT working group will develop reviewer checklists and protocols for monitoring pre- and post-test counselling and a patient questionnaire. The procedures and frequency of audits and questionnaires will be submitted to the National Centre for Preventive Medicine for approval. Periodic sessions for journalists to learn about VCT, with the first event combined with a press conference to launch the national VCT concept, will be organized. Cooperation with SDA 1 radio and TV broadcasters along with the BCC campaign will be further strengthened for placing VCT as a topic in health programmes.
- Develop capacity of NAC. The capacity of the NAC in VCT training for all health professionals will be developed and institutionalized. As a first-tier national provider, the Centre will be strengthened as a referral and consultation point for second-tier counsellors for more in-depth professional pre- and post-test counselling.
- Training of VCT councillors and providers for VCT. An extensive training programme will cover first- and second-tier providers and peer counsellors. The 10 core trainers will train 100 first-tier counsellors and peer counsellors for outreach to IDUs, SWs, and MSM. Training for second-tier providers, such as primary care physicians and gynaecologists, will be conducted.
- Establishment of VCT sites. Detailed analyses will be done based on the existing infrastructures as to the establishment and equipping of 34 additional VCT sites. VCT sites shall be fully equipped and made operational. Special attention will be paid to the establishment of VCT sites in Transnistria where no such services are made available to the population under current infrastructure.
- Open a hotline (green line) to offer a highly confidential, non-judgmental, compassionate and anonymous service to those individuals with anxieties about HIV infection and AIDS, to decrease the incidence of HIV transmission by providing a listening, referral and educational service and to encourage the increase of community participation in HIV/AIDS awareness / prevention / education. One major asset of the green line is that VCT is done by phone at no cost for the caller. Further, based on agreement with the Ministry of Health and Social Protection the green line service will be taken over by the Dermatovenerological dispensary which has offered premises for the establishment of the green line.

Strengthening of laboratory facilities and testing capacity. Along with scaling up VCT services, the need to secure proper facilities for evaluation of test results is critical. The proposal will strengthen laboratories in four districts to ensure access to high quality laboratory testing for HIV for blood donor recruitment and blood transfusion, including testing for HIV for people referred by VCT sites, as specified by Supportive Environment SDA 4: Laboratory. Special attention will be paid to establishing a laboratory site in Transnistria, where no high quality services are available under the current circumstance.

The project activities under this SDA thus are focused on the following:

Additional equipment and support for 4 regional reference laboratories to provide an even and equitable coverage nationwide (Balti, Cahul, Tirspol and Chisinau). The selected laboratory sites will be strengthened with modern equipment and materials where missing (or outdated), with special focus on Balti city (northern part) and Slobozia (Transnistria) as future sites for ARV treatment. Staff at the selected lab facilities will be re-trained in how to use the new equipment and quality standards by a group of trainers from the AIDS Centre (reference laboratory). A national work group will be created to develop the quality standards and conduct the quality control of the HIV laboratory facilities. Some of activities have been designed to sure high quality of testing, proper temperature of stocking reagents and transportation of blood samples, reduced the risk of contamination of samples etc. Previously, quality control has not been available.

A mixed team of specialists will be convened to be trained in the development of a comprehensive 2nd generation surveillance plan for the Republic of Moldova, including the type and methodology of surveillance to be carried out in Moldova.

Blood safety still is an important issue on the agenda of the MOHSP. In that respect, some changes to the testing policy have been brought about to make safety measures more cost-efficient. Hence, along with VCT sites scaling up in the country, the HIV testing of mainstream population ought to be performed with saliva rapid tests, which will increase the access of people to test services geographically, while safety of blood shall be still secured through a Supportive Environment SDA 5 Blood Safety, which implies the procurement of roughly 230,000 ELISA tests from various manufacturers.

The prevention policy set under the new NAP was developed in such a way as to better ensure free access for population to STI treatment and diagnostics under the SDA 6: STI Diagnosis and Treatment. Approximately 500,000 tests for syphilis will be performed each year, with 5,000 treatment kits to be provided at no cost to the end-user.

During the last few years, UNICEF Moldova and the Global Fund project has supported the development of a national curriculum on Life Skills Based Education (LSBE) for grades 1-12 that has been piloted in several geographically distinct areas. The subject later turned out to be controversial, but finally the government managed to advocate for the curriculum in question and a recent survey s (Annex 50/AIDS) showed that 86 per cent of population was supportive of it. Prevention SDA 7: Youth Education and Prevention has been developed in such a way as to support the implementation of LSBE in general secondary and upper secondary education, to support additional training of teachers that has proven to be a weak link in LSBE during previous years. The component will also aim at scaling up the national network of Youth Friendly Health Services (YFHS) that provide young people with an array of health, social, psychological, and informational services to Transnistria. Under the current scheme, the YFC will be used to scale up VCT to HIV/AIDS. Twelve YFH centres are operational courtesy of support received from the GFATM and WB grants to cover geographically country needs. The MOHSP recently approved a national concept on YFHS and is committed to the financial integration of those into the existing health system by making them part of the mandatory health insurance. The involvement and participation of young people in HIV/AIDS prevention projects have considerably soared up over the last years. Twelve pilot regions have been covered with peer-education activities with UNICEF and UNFPA support. The peer education network became member of the international Y-PEER network. Innovative tools, like social theatre forum and the youth media network, proved to be efficient, too. The project activities will focus on scaling up the existing peer-education network and communication to foster peer-education activities for both in- and out-of-school young people.

Communities, parents and religious organizations were the groups with reduced involvement and coverage under the previous NAP. The current program pays specific attention to working with parents, workplace policies and to capacity-building and provision of services by faith-based organizations. It is

anticipated that faith-based organization representatives will be involved in training sessions and that 6 projects implemented by faith-based organization will become operational by the end of 2012. In addition, the project will pilot the development and implementation of HIV/AIDS workplace policies in 5 big companies across the country. The activities for the mentioned groups have been embedded into the Prevention SDA 8 BCC Outreach to Community – Parents and Faith Based Organizations.

Though increasing numbers are infected with HIV through sexual transmission, IDUs. migrants, FSW, MSM and others remain at high risk. Prevention SDA 9,10,11,12 – Community Outreach to Vulnerable Populations IDUs, LGBT, FSW and Mobile Populations seeks to scale up HIV prevention for these groups. The strategy for scaling up these activities is based on a shift from NGO-based service providers to the government facilities to ensure largest coverage, since the existing NGO capacity is quite limited in geographic terms. The coverage will be ensured in two ways: by mobile services using vehicles moving around, and by involving health staff from the primary health care (PHC) in remote areas. The same is applicable for harm reduction activities in penitentiary facilities, where the costs will be cut down by shifting part of work responsibilities to the prison staff. Within the scope of the present SDA, the scaling up of opiate substitution therapy (OST) programs with methadone to Balti is envisaged alongside with developing rehabilitation services for IDUs, with support from NGOs that have proven to have positive experience in dealing with it. The strategy will set a framework for consistent free-of-charge distribution of condoms, syringes, needles, and other protection means to groups at high risk for HIV: CSW, MSM, IDUs, young people, and it will set benchmarks for a gradual commitment of funds from the national budget for the purchasing of condoms and free distribution.

Proper coordination of all SDAs and activities under SDAs aimed at vulnerable groups will be ensured through the SDA 13 Coordination and Partnership Development that ought to be sub-contracted.

Objective 2: Foster equal access of the people living with a HIV/AIDS (PLWHA) through expansion of social and health services, and measures to combat discrimination and stigma;

Based on estimates provided by WHO, the second objective seeks to meet the treatment needs of PLWHA through scaling up the treatment, care, support and referral services, and through capacity building of PLWHA organizations. the proposal seeks to cover 6 000 patients with first- or second-line ARV treatment by 2012, and to support associated needs, including purchase of immunology monitoring equipment where none exists and training of health care workers. The proposal also targets \nearly 1,000 service providers and managers through capacity building and training to act responsibly and safeguard the rights of PLWHA. The activities in terms of scaling up HAART have been compiled under the SDA 1 Treatment: ARV and Monitoring and include:

Expansion of ARV provision to two new sites. The proposal seeks to add inpatient/outpatient sites for HAART and AIDS care in Balti in the North and Slobozia in Transnistria. As noted earlier, both locations face particularly serious shortfalls in terms of equipment, knowledge, human resources, and chronic lack of funds. The new sites will be provided with ARV drugs and medication for opportunistic infections, pursuant to the national protocols for ART and care, and the National AIDS Programme for 2006-2010.

Training for staff on provision of ARV. Training for the Balti team will be provided by the WHO knowledge hub in Kiev, with particular attention to ARV for IDUs who make up the majority of those infected.

Adherence support. i) Peer support through PLWHA groups. Trainings in treatment education for PLWHA groups, and small grants for the formation of adherence support teams, will be conducted.
ii) Food stamps, social rehabilitation to reduce economic impact. A recent UN household survey on the socio-economic impact of HIV/AIDS (Annex 23/AIDS) has shown that 70 percent of HIV cases in Moldova are connected to injecting drug use, and that socioeconomic status of HIV-infected IDUs and their families is extremely low. These economic constraints poses impediments in adherence to HAART, particularly difficulties in meeting costs of travel to the health clinic for treatment or monitoring, tradeoffs between meeting transportation costs and food, etc. The initiative will also provide food stamps to reduce economic impact on households and to help ensure adherence, advocacy to increase reimbursements, and efforts to connect PLWHA with social enterprise efforts to increase economic and social reintegration.

Establishment of a viable ARV supply chain to procure and distribute medication. The WHO assessment in February 2006 identified procurement, and the need for centralized distribution across the country, including to Transnistria, as an ongoing issue.

5 Component Budget *HIV/AIDS*

The novelty of the second objective in support of ART is built around a key component that is a new practice to the country, such as the SDA 2 Supportive Environment Monitoring Drug Resistance. Through the given SDA, the project will support the building up of an infrastructure and ensuring the procurement of relevant equipment and tests required to perform the monitoring of drug resistance.

An additional SDA 3 Treatment: Prophylaxis and Treatment of OI will bring additional value to the HAART and will ensure lower rates for mortality owing to AIDS by appropriate testing and treatment of opportunistic infections (OI). The same result is expected to result from the SDA 4 TB/HIV collaborative activities: Prevention of TB Disease in PLWHA, which will secure the supply of tests and drugs to provide for proper diagnostic and treatment of PLWHA for TB.

The aim of SDA 5: Care and Support for Chronically Ill under the present project is to provide the best possible quality of life both to the terminally ill and to their families and care-takers. It will be based on a comprehensive approach to care and support, including attention to emotional, psychological and spiritual needs. Support for caregivers is an essential part of palliative care, whether they are family members or professional care-takers where training courses will be provided. For professional care-givers, one side of providing palliative care through outreach is to work with families and friends in order to ensure effective communication. This role lately has been undertaken successfully by NGOs of PLWHA in Moldova, in close partnerships with the medical community. The activities under the SDA have been planned based on the best practice achieved by certain NGOs of PLWHA from Moldova on a pilot basis.

Despite the presence of ARV in Molodova, the life span is quite short for some PLWHA due to the withdrawal from ARV treatment (drop-outs) or failure to seek treatment in the first place. For the PLWHA themselves, palliative care is an essential part of treatment, not only when death is getting close, but also through the treatment of potentially lethal OIs. Such treatment prolongs life for quite some time and renders a quite decent quality of life.
A wide range of palliative care is needed for PLHA including pain relief, treatment of other symptoms such as nausea, weakness and fatigue, psychological support, spiritual support and help with preparations for death when needed, support for families and caregivers, help with nursing, infection control and psychological support. To ensure that effective palliative care is provided for all PLHA the project is planning to tackle the misconceptions that palliative care is only for people approaching death. The activities will also aim at:

- improving the training of health and community workers, including tackling stigmatization;
- make palliative care available in hospitals, hospices and at home for PLWHA;
- provide access to necessary drugs;
- provide support for careers, counselors and health care workers;
- recognize the special needs of children with HIV;
- create PLHA self support groups to reduce withdrawal from ARV treatment.

Stigma and discrimination against HIV and AIDS continues to fuel the AIDS epidemic in Moldova and is addressed under the SDA 6 Stigma Reduction in all Settings. According to the recent studies conducted on a large sample of population by AFEW on issues related to stigma and discrimination, almost 70% of the population showed a high degree of intolerance for PLWHA. In Moldova, stigma stems mainly from underlying stigmatization of the sex work and injecting drug use, two of the primary routes still fueling the HIV transmission. Those not in such “risk groups” assume falsely assume they are not at risk, despite the latest statistics showing an increase in the HIV/AIDS transmitted sexually. Deterring those with HIV from seeking testing or services, stigma leads to faster disease progression for the individuals and also to a higher risk of further passing down the disease.

The project seeks to break the cycle of stigma and discrimination by increasing the capacity of NGOs and government authorities to assess and quantify the change in stigma and discrimination by developing a framework for monitoring the direct experience of PLWHA in terms of stigma and discrimination. An assessment tool will be developed to gauge fear of stigma and discrimination, disclosure, quality of care etc. Additionally, as noted under objective 1, the project will aim at using media as a tool for changing the attitude of the public at large about the PLWHA by training media representatives in using non-discriminatory language, non-discriminatory approaches to present information about HIV/AIDS, developing guides and curricula for universities doing training of media professionals.

An additional important activity to be undertaken is the training of primary care physicians (PCP) on issues

related to HIV, since it has been shown that the PLWHA experience the highest degree of stigma and discrimination coming from health workers in Moldova.

As part of a broader program for home-based care provided to orphans, the PLWHA supported the idea of developing within the framework of the SDA 7 Support to Orphans and Vulnerable Children of a day-care centre to cater to the orphans and vulnerable children aged 5-15. The children will be taught practical skills, such as handicrafts, computer skills, painting etc. This idea was supported by the MOHSP which planned to offer premises for the above-said day-care centre to be equipped through the proposal. Additionally, summer camps for family members will be organized to train family members in securing better quality of life for children at home.

Objective 3: Strengthen government and community capacity in coping with the epidemic, through partnerships and enhanced coordination.

Legislative reform and measures to ensure implementation of new laws, increased capacity and cooperation between technical working groups, a national, consolidated and computerized surveillance effort, effective M&E, and improved coordination and mobilization of national and international funds or all addressed under this objective. This component supports the "Three Ones" initiative, i.e. the merger of relevant entities into one National Coordination Authority for HIV/AIDS/STIs, one strategic framework, and one M&E System, and complies with Strategy 1 in the new NAP.

The objective will be achieved through a set of activities structured around 3 service delivery areas. SDA 1: Human Resources seeks to strengthen of the Country Coordination Mechanism (CCM), including the CCM Secretariat and respective secretariats of the Networks of NGOs working in the area of HIV/AIDS in the country. Significant progress has been achieved toward reaching the "Three Ones" targets, including the consolidation of the CCM. The role of the CCM Secretariat and working groups has been re-defined in the wake of these reforms. The presence of many partners and availability of financial resources have scaled up resources available in Moldova, but lack of staff capacity at both national and regional levels limit implementation of a number of programs. There is an urgent need for better co-ordination of national response and bringing the existing systems in line across different partners. Activities undertaken under the present component are expected to boost up the capacity of the Technical Working Groups in proper strategic planning, monitoring and evaluation.

SDA 2: Coordination and Partnership Development specifically concerns increasing the capacity and operationalizing the two networks of NGOs working in HIV/AIDS in the country – the network of NGOs working in HIV/AIDS and the network of NGOs of PLWHA, including with relevant sub-networks.

The project will support the CCM in developing the capacities of the technical working groups which will encompass technical expertise and will provide guidance to the various partners. In order to make CCM an operational, dynamic and participatory body, effective to respond to the demands within the new attributed role the project will perform the following activities:

- strengthen CCM capacity to set priorities, policies and monitor the programme implementation;
- support broad partnership forums where NGOs and PLHA can channel policy and programme recommendations to CCM;
- assist CCM with the development of annual work-plan and implementation of the activities set under the plan by providing technical assistance;
- assist CCM with the establishment and maintenance of partnerships and networks of NGOs, including of PLHA;
- organize trainings for CCM and technical working groups members on thematic areas, including estimation of costs and principles of evaluating of national programmes;
- establish a mechanism to assure transparency of implemented activities and of disbursements of funds (funds spending mechanisms and website).

The Government appointed the National Center for Public Health and Management to be in charge of the national M&E system. A pilot project for designing a working M&E System for the two Programs in question, namely the NAP, and the National Program for TB (NTP), is being recently implemented with support from donors. The pilot project is in progress, a system known as SYMETA (System for the Monitoring and Evaluation of TB/AIDS) with joint UNAIDS/Global Fund support.

SDA 3 Information System and Operational Research was designed in support of the National Health

Information System which encompasses the M&E System of the new NAP (Annex 51/AIDS). The proposed project aims at fully implementing the components aimed at M&E of the NAP on HIV/AIDS/STIs and TB through capacity building provided to the staff involved in data reporting at national and local levels. Besides, the project will build up the capacity of the M&E Unit to process and develop policies based on data review and will supply the equipment needed for data reporting. The National M&E System is Government-based and Government-led. The Government, being overall responsible for the national response to the HIV/AIDS epidemic, needs to be able to measure the progress achieved, ensure accountability and identify the most effective approaches. The operationalizing of a 2nd generation surveillance system (Annex 38/AIDS) is an integral part under the given SDA.

The national M&E system is designed as a comprehensive system (Annex 35/AIDS) that will collect epidemiologic, program, and financial data. At a later stage, a research database will be made part of the M&E system. The system is designed to include data capture to data processing, data storage, data reporting and analysis. The main sources required for an integrated system include: statistics delivered by health care providers, laboratory, specific surveys, behavioral studies, epidemiological surveillance studies, vital statistics, and financial monitoring. At present, a full design of the system has been conceived with a set of indicators agreed upon by all major stakeholders; plus technical description for each and all the indicators was developed, with detailed explanation, based on the flow of information provided by the newly developed reporting forms. According to the plan, the implementation of the designed system should be completed by the end of 2009, provided that additional financial resources are made available for capacity-building and additional equipment procurement to ensure the timely reporting of data at all levels, from the primary tier to the top-most M&E Units.

4.6.2 Link with overall national context

Describe how these goals and objectives are linked to the key problems and gaps arising from the description of the national context in section 4.4. Demonstrate clearly how the proposed goals fit within the overall (national) strategy and how the proposed objectives and service delivery areas relate to the goals and to each other.

The goal and objectives of the proposed program are related closely to a series of strategic documents developed by the Government of the Republic of Moldova such as:

1. Economic Growth and Poverty Reduction Strategy Paper, Annex 24/AIDS
2. National Health Policy, Annex 52/AIDS
3. National Programme for Prevention and Control of HIV/AIDS/STIs 2006-2010 in Moldova, Annex 20/AIDS
4. National Communication Strategy on AIDS, Annex 48/AIDS

Since the present project proposal has been developed along the strategies of the NAP the greatest majority of objectives, SDAs and activities are linked to it. This proposal to the GFATM addressed all 9 strategies in the National AIDS Programme under the three objectives proposed.

Objective 1 of the present proposal supports implementation of Strategy II on Capacity Building and Expanding IEC Activities for the General Public and Youth in HIV/AIDS/STI Prevention and Strategy V aimed at vulnerable groups. PMTCT Strategy VII of NAP, STI, Laboratory and Blood Safety under Strategy VIII are also reflected in Objective I of the present proposal.

Objective 2 has encompassed Strategy V of NAP on Infrastrucure Development and building capacity of medical staff along with provision of assistance to PLHA and Palliative Care. Strategy IX on TB/AIDS fit naturally also under Objective II.

Objective 3 aimed at implementation of activities set fourth in Strategy I on CCM and networks of NGOs and Strategy III that deals with M&E.

4.6.3 Activities

Provide a clear and detailed description of the activities that will be implemented within each service delivery area for each objective. Please include all the activities proposed, how these will be implemented, and by whom. *(Where activities to strengthen health systems are planned, applicants are also required to provide additional information at section 4.6.6.)*

See attached as Annex 54/AIDS.

4.6.4 Performance of and linkages to current Global Fund grant(s)

This section refers to any prior Global Fund grants for this disease component and requests information on performance to date and linkages to this application. For more information, please refer to the Guidelines for Proposals, section 4.6.4.

a) Provide an update of the current status of previous Global Fund grants for this disease component, in the table below.

Table 4.6.4. Current Global Fund grants

	Grant number	Grant amount*	Amount spent
GF Grant 1	MOL-102-G01-C-00	11,719,047	7,641,072
GF Grant 2			
GF Grant 3			
GF Grant 4			

* *For grants in Phase 1, this is the original two year grant amount. For grants that have been renewed into Phase 2, this is the total amount, inclusive of Phase 1 and Phase 2. For unsigned Round 5 grants this is the two year TRP approved maximum budget.*

b) Please identify for each current grant the key implementation challenges and how they have been resolved.

The CCM reports 3 major challenges identified during GF implementation under Round 1 proposal implementation:

1. Weak capacity of CCM to ensure proper coordination among stakeholders. This has been resolved by establishing a Secretariat and by making Technical Working Groups operational.
2. Weak representation of the NGO sector and PLWHA in CCM. This was overcome by building capacity of NGOs and of associations of PLHA. Support to NGOs has been provided to organize National NGO Forums to allow NGOs to participate in a joint and transparent process of delegating representatives to CCM. Additionally, NGOs have been supported and encouraged to establish networks which resulted in a more coordinated approach by the NGO sector. This was supported partially by the GF/WB grants and by bilaterals and UN Agencies.
3. Limited transparency in terms of sharing of information among stakeholders on the NAP and on the implementation process under the GF/WB grants. This has been partially addressed by printing a CCM Informational Bulletin, launching of an e-mail news bulletin shared through the network and by launching a CCM website. The information was also placed on the www.aids.md website accessed frequently by stakeholders and by the general population that is seeking information on HIV/AIDS.

c) Are there any linkages between the current proposal and any existing Global Fund grants for the same component? (e.g. same activities, same targeted populations and/or the same geographical areas.)	☒ Yes ➔ *complete d)* ☐ No ➔ *go to 4.6.5.*

d) If yes, clearly list such linkages and describe how this proposal builds on, but is not duplicative of the funding provided under current Global Fund grants.

The proposal under implementation of the GFATM Round 1 covers a 5 years timeframe starting with 2002 and was linked to the previous NAP 2001-2005. Thus, the last implementation year for both WB and GFTAM grants to support activities in HIV/AIDS/STIs and TB is 2007. The current proposal covers the period starting with 2008 to 2012 and is linked to support activities under the National Programme on Prevention and Control 2006-2010. The rationale behind the present proposal can be clasified as follows:

1. The current proposal builds on activities proven success stories during implementation of the previous proposal and basically it boils down to improving the geographical coverage and access to services such as PMTCT, support to PLHA, harm reduction to IDUs, activities for migrant populations and youth etc.
2. The current proposal ensures sustainability of some activities that have been implemented under the previous grants, such as ART, treatment of OI
3. The current proposal will support pilot activities and activities aimed at strengthening health system infrastructures, such as operationalisation of the M&E system, VCT, support to networks of NGOs and CCM, communication activities

4.6.5 Linkages to other donor funded programs

a) Are there any linkages between the current proposal and any other donor funded programs for the same disease	☒ Yes ➔ *complete b)* ☐ No ➔ *go to 4.6.6.*

b) If yes, clearly list such linkages and describe how this proposal builds on, but is not duplicative of the funding provided by other donors, including in respect of health system strengthening activities.

As a general practice CCM keeps track of all financial resources made available from the state budget and by donors. The budget of the National Programme on Prevention and Control is inclusive of the budgets coming from external resources which makes it easier to keep track of needs and identify activities for which fundraising is needed but also to exclude duplication and overlapping. Since 1997 donors in the Republic of Moldova coordinate activities in HIV/AIDS within the UN TG on HIV/AIDS which reduced overlapping and increased donor funding to support National AIDS Programme rather than to finance separate projects.

The proposal under implementation of the GFATM Round 1 covers a 5 years timeframe starting with 2002 and was linked to the previous National Programme on Prevention and Control of HIV/AIDs/STIs 2001-2005. Thus, the last implementation year for both WB and GFTAM grants which represents the highest share of external funding to support activities in HIV/AIDS/STIs and TB is 2007. Local donors have reported limited support to the NAP 2006-2010 starting with the year of 2008 due to the launch of new programme cycles for which the funds have not been commited yet. The current proposal covers the period starting with 2008 to 2012 and is linked to support activities under the National Programme on Prevention and Control 2006-2010. The rationale behind the development of all proposals in the country builds on ensuring complementarity of activities within the NAP financed by all sources.

4.6.6 Activities to strengthen health systems

Certain activities to strengthen health systems may be necessary in order for the proposal to be successful and to initiate additional HIV/AIDS, tuberculosis, and/or malaria interventions. Similarly, such activities may be necessary to achieve and sustain scale-up.

Applicants should apply for funding in respect of such activities by integrating these within the specific disease component(s). Applicants who have identified in section 4.4.4 health system constraints to achieving and sustaining scale-up of HIV/AIDS, tuberculosis and/or malaria interventions, but do not presently have adequate means to fully address these constraints, are encouraged to complete this section. For more information, please refer to the Guidelines for Proposals, section 4.6.6.

a) Describe which health systems strengthening activities are included in the proposal, and how they are linked to the disease component. *(In order to demonstrate this link, applicants should relate proposed health systems interventions to disease specific goals and their impact indicators. See the Multi-Agency M&E Toolkit.)*

Activities aimed both at supporting system-wide and health system strengthening activities have been included in the proposal. The activities range from training health professionals, managers and administrators in financial management or strengthening of coordination and partnerships through CCM Secretariat and networks of NGOs to more vertical health system strengthening activities such as the establishment of a VCT system and of two ART sections in the northern and southern region of the country One general feature of all activities proposed under health system strengthening is that they all will have an immediate impact. As a general practice, the government has already a highly positive practice of health system strengthening activities such as establishment of the youth friendly services throughout the country based on the WB/GF/UNICEF support that currently have been integrated into the health system and are maintained by them. Generally, all activities for health system strengthening in Moldova can be classified under the following components:

1. Health workforce mobilization, training and management capacity development
2. Health infrastructure renovation and enhancement, such as the Day Care Centre for PLHA and vulnerable children, rehabilitation centre for IDUs, ART treatment centres for Balti and Slobozia, life-skills based education with development of support materials and trainings for teachers
3. Laboratory capacity, such as 4 additional labs for Tiraspol, Cahul, Balti and Edinet
4. Health information system, such as ensuring operation of the M&E entry points nationwide
5. High level management and planning capacity, such as support for CCM Secretariat and CCM Technical Working Groups for trainings and joint consultations
6. Engagement of community and non-state providers, such as trainings and strategy development for faith based organizations and development and implementation of the workplace policies
7. Operations research, such as DHS and KAP studies

The activities have been designed in such a way as to avoid harm to other health services, thus no incentives or benefits have been foreseen for health care workers working in the HIV/AIDS/STIs fields as not to cause discrimination to other health care workers. Another important factor while developing the activities was that new services have been designed as to be integrated into the existing services rather than the development of new or parallel infrastructures. Thus, the scaling up of activities for IDUs has been planned through the narcological service, scale up of VCT through youth friendly centres and family planning cabinets.
Also, a specific strategy for the health system strengthening within the present proposal is scaling up of activities that have proven to be successful as pilots such as outreach to vulnerable groups, ART and VCT.

b) Explain why the proposed health systems strengthening activities are necessary to improve coverage to reduce the impact and spread of the disease and sustain interventions. *(When completing this section, applicants should refer to the Guidelines for Proposals, section 4.6.6.)*

The health system strengthening activities have been designed as to fill in the gaps in the existing service provision structure where the greatest majority of high quality services are built at the national level and are present mainly in the capital city. The strategic approach under the present proposal will build on establishment of lacking yet essential prevention, treatment and

care structures located in areas outside of the capital city, build capacity of staff and operationalise a system to ensure a proper M&E. All the three components are considered to be critical to ensuring a proper response to HIV/AIDS as suggested by international practice. The skill mix-up, the degree of supervision and the existing structures are currently deemed not enough and have contributed to a high number of default cases and failures to meet the universal access to prevention, care and treatment. The bottom line is that this project proposal will allow to strengthen the health system to control HIV/AIDS by rolling out the service country-wide, including the breakaway region of Transnistria, and secondly by filling in the gaps not covered by others and with other funds, in line with the changing patterns of the disease in question.

c) Describe how activities to strengthen health systems, integrated within this component, will have positive system-wide effects and how it is designed in compliance with the surrounding context and aligned with government policies.

The HIV/AIDS epidemic knows no boundaries, and the political dissoance with Transnistrian authorities is downplaying the efforts bent by all stakeholders in the country. Again, in line with the "Three Ones", there should be only one CCM, M&E Unit, and framework. This project proposal is expected to scale up treatment and prevention to Transnistria, thus consolidating the national efforts. Having a unified screening, diagnosis, treatment, care, reporting and M&E systems should improve and harmonize HIV/AIDS control measures, avoiding overlappings and duplication of efforts, thus making the system truly operational and cost-efficient. Secondly, by having Transnistria on board in triple therapy, as recommended by the WHO, the country will minimize the risk of drugs-resistant strains due to their using of dual therapy nowadays. This program targets social equity and universal access, and by carrying out health system strenghtening activities these goals could be sooner achieved.
The Government of Moldova committed to the scaling up of HIV/AIDS response, yet it lacked the funds necessary to implement it in the country. This grant will provide the financial means and the capacity required to properly and timely implement it. The proposed activities make allowance for the ongoing projects in the country, either purely national or internationally-assisted, as well as the WB-funded major health system reforms (development of primary health care network, downsizing of redundant hospital care, mandatory health insurance fund etc.) The project is deemed to become a success story for government – civil society partnership for HIV/AIDS control, thus leading to national ownership and leadership over the process, by building up a comprehensive multi-tier system for HIV/AIDS response.

Question	Answer
d) Are there cross-cutting health systems strengthening activities integrated within this component that will benefit any other component included in this proposal?	☐ Yes ➔ *complete e) and f)* ☒ No ➔ *go to g)*

e) If you answered yes for d), describe these activities and the associated budgets and identify and explain how the other components will benefit. *Please refer to the Round 6 HSS Budget Information Sheet on http://www.theglobalfund.org/en/apply/call6/documents/ before completing this section.*

f) If you answered yes for d), confirm that funding for these activities has not also been requested within the other component. *Please refer to the Round 6 HSS Budget Information Sheet on http://www.theglobalfund.org/en/apply/call6/documents/ before completing this section.*

Question	Answer
g) Is this component reliant on any cross-cutting health systems strengthening activities that have been included within other components of this proposal?	☐ Yes ➔ *complete h)* ☒ No ➔ *go to 4.6.7.*

h) If you answered yes for g), describe these activities and the associated budgets and identify and explain how this component will benefit. *Please refer to the Round 6 HSS Budget Information Sheet on http://www.theglobalfund.org/en/apply/call6/documents/ before completing this section.*

4.6.7 Common funding mechanisms

This section seeks information on funding requested in this proposal that is intended to be contributed through a common funding mechanism (such as Sector-Wide Approaches (SWAp), or pooled funding (whether at a national, sub-national or sector level).

a) Is part or all of the funding requested for the disease component intended to be contributed through a common funding mechanism?	☐ Yes → *answer questions below.*
	☒ No → *go to 4.8*

b) Indicate in respect of each year for which funds are requested the amount to be funded through a common funding mechanism.

c) Describe the common funding mechanism, whether it is already operational and the way it functions. Identify development partners who are part of the common funding mechanism. Please also provide documents that describe the functioning of the mechanism as an annex. *(This may include: The agreement between contributing parties; joint Monitoring and Evaluation procedures, management details, joint review and accountability procedures, etc.)*

d) Describe the process of oversight for the common funding mechanism and how the CCM will participate in this process.

e) Provide an assessment of the incremental impact on projected targets as a consequence of the funds being requested for this component, which are to be contributed through the common funding mechanism.

f) Explain the process by which the applicant will ensure that funds requested in this application, that are contributed to a common finding mechanism, will be used specifically as proposed in this application.

4.6.8 Target groups

Provide a description of the target groups, and their inclusion during planning, implementation and evaluation of the proposal. Describe the impact that the program will have on these group(s).

The proposed project represents a significant expansion and scale-up of the activities currently performed under the National Programme on Prevention and Control of HIV/AIDS/STIs (NAP) 2006-2010 recently approved through a Government of the Republic of Moldova resolution, following wide consultations with government agencies, civil society groups, and international agencies while developing the draft.

5 Component Budget *HIV/AIDS*

The proposal takes into account lessons in HIV/AIDS that have proven successful in Moldova during the implementation of the last programme of 2001-2005 as well as experiences of other countries. One of the most important lessons learned was that success was achieved only by programmes and projects that have been designed to meet the needs of vulnerable populations. In the given proposal the approach of targeting vulnerable populations that are at the highest risk of getting HIV based on their specific behaviour patterns will be used. Thus, the proposal per se puts emphasis on targeting populations that have not been previously covered by other programmes or projects or have been covered only partially through pilot projects in the past. Secondly, again considering the changing trends of the HIV/AIDS epidemic while shifting away from confined groups of vulnerable groups to the mainstream population by sex, thus making it necessary to target the mainstream population, specifically teenagers and the young. Besides aiming at prevention actions, the project has a strong link to helping the PLWHA by providing them with social support services (counseling, social packages, care, treatment etc.)

The project has been designed in such a way as to ensure building the skills and capacities of stakeholders, changing bahavious and approaches in the targeted groups as to reduce the risks of possible infection. This is planned to be achieved mostly through bringing the services geographically closer to the vulnerable groups as to ensure universal access to treatment, care and support. There are regions with higher number of cases of IDU-related HIV, still an impressive driving force of the epidemic in the country, and specific services should be made available to them as closely to the communities, as possible, whenever possible employing peer-to-peer approaches. Besides the regular 17+ harm reduction projects working in the country, there are about twenty-something IDU on methadone, with two of them reportedly being HIV-positive. Although deemed as a minor success, it is a huge step foward, considering the amount of pressure and obstacles created by order enforcement authorities.

One component of the present proposal will specifically target the population from the breakaway region of Transnistria, where lately no progressive interventions to prevent HIV/AIDS have been undertaken. Moreover, dual therapy instead of WHO recommended triple therapy, is being administered locally, with few if any harm reduction projects operating in the region, and no methadone substitution therapy at all. The PLWHA have to pay for the hospital stay and additional drugs while the treatment itself is provided free of charge. Many couldn't afford traveling, especially considering the social groups they belong to.

The success of targeting mostly will depend on the following assumptions and actions:

* The interventions targeting vulnerable groups will be based on early, aggressive prevention interventions aimed at preventing the further spread of HIV/AIDS;
* Cross-sector response, i.e. selected relevant sectors (other than the health sector) will be involved in stomping the HIV/AIDS;
* Public health approach, with civil society partners (NGOs), groups at highest risk of HIV, PLWHA and affected by HIV/AIDS, as well as community leaders all having to play important roles in the implementation of HIV/AIDS activities within the scope of the present project;
* A working procurement system to ensure reliable supply of quality drugs, equipment and other supplies is essential to the success of a public health project, nonetheless the success of such projects relies mostly on the distribution of goods in a way as to ensure participation of the vulnerable groups in the process;
* Incentives (including social support) for patients and providers are foreseen in the proposal, especially aiming at resource poor settings. Such incentives have been designed with greater caution to avoid moral hazard and planning for financial and political sustainability;
* Good surveillance, monitoring and evaluation which is critical to HIV control has been designed in such a way as to ensure participation of the representatives of the vulnerable populations, especially people living with HIV/AIDS;
* Innovative or unused approaches that are currently missing in the country, yet which are critical to keeping the infeciton at bay down the road, such as the implementation of rapid tests (for maternity wards and surveillance purposes in surveyed individuals); better understanding and targeting of groups through behavioral changes; community involvement (peer-to-peer); communication and awareness raising campaigns etc.
* Streangthening VCT services, as to minimize discrimination and fight stigma, as well as to improve confidentiality by reducing the number of government agencies the information about one's HIV status is being passed onto, etc.

The main benefit expected is a reduction in the pace at which HIV is spreading amongst the vulnerable

groups along with building national capacity to cope with HIV/AIDS. Hence, in terms of primary prevention, the program is supposed to prevent the further spread of HIV from vulnerable groups and bridge populations to mainstream population via heterosexual route (by communication and awareness campaigns, promotion of safe sex and/or astinence, leading to more knowledgeable people, tolerant and willing to get involved in the support and care for the PLWHA etc.). Secondly, from the secondary prevention point of view, existing harm reduction programs operating in the country will further be strenghtened, while also opening new projects in new vulnerable groups, and/or new geographic locations, including the scale-up of OST, especially among the PLWHA. Third point is that the adolescents and youth, while accounting for a huge proportion of the entire population at risk for HIV, will become the agent of HIV control by adopting safer behaviors. Fourth, the number of PLWHA enrolled in HAART will go up to reach as many as 950 something by 2012 on the right bank of the Nistru river, while to reduce as much as possible the mother-to-child transmission rate below 2%, and fewer than 1 HIV+ child born to HIV+ mothers per 100,000 births. Yet, one of the most important targets to be accomplished is to increase the acccess of people from the left bank of the Nistru river (Transnistria) to diagnostic, prevention, treatment and care services (harm reduction, condoms, communication and awareness, OST, HAART, preventative ART, VCT, education etc.)

No accurate figures agreed by all exist as of today for the number of people belonging to vulnerable populations to be targeted. In the first year, the project will look to establish more accurate figures for these, which will aid the government to plan activities and interventions more accurately. Moldova already have some 3,000 formally reported PLHWA. This project targets improving medical and social services for them with the intended outcome of improving their quality of life. A very important part of tackling the problems of PLHA according to the recent research are the issues of building the capacity of PLWHA to get them back into society and integrate them through outreach and capacity building activities that would enable PLHA as well as members of their families to live their lives as fully as possible. All of these planned benefits are contingent on the programme successfully boosting national capacity and stimulating a truly co-operative response to Europe's most severe HIV/AIDS epidemic.

The National Programme on Prevention and Control of HIV/AIDS has declared as one of the priorities the issue of spread of HIV/AIDS in general population and activities that should be aimed at making VCT services available to a larger number of people. The target for the implementation of all preventive activities stipulates active participation of beneficiaries themselves to form more sustainable response to the epidemic. Such activities as outreach work, peer education, "positive movement", self-support movement will be conducted directly by the beneficiaries.

Broad involvement of communities into the accomplishment of the objectives of this project proposal is planned through involvement of the local public authorities that are lacking such experience. This project proposal has been developed jointly with representatives of different governmental and non-governmental agencies. This cooperation will be continued during the project implementation.

The first objective primarily targets young people, people of reproductive age, including pregnant women, street and out of school children, separated children, children in residential care and with special needs, and youth - through health, education and social protection services, communications, as well as direct outreach prevention work with vulnerable groups.

The second objective primarily targets people living with and affected by HIV/AIDS, whose needs will be addressed through the development of treatment, care, support and referral structures, and anti-stigma campaigns. It will also target service providers and managers through capacity building and empowering them to act as responsible duty bearers, especially in relation to human rights. Provision of tools and equipment will serve as a first step in setting up comprehensive ARV treatment for people with HIV in Transnistria.

Lastly, the proposal will target government officials, local public authorities, and community leaders to strengthen their capacity in developing, monitoring and evaluating the HIV/AIDS/STI policies and plans of actions. A number of advocacy activities will be undertaken to ensure an adequate earmarking of funds for an effective implementation of given policies and plans.

4.6.9 Social stratification

Provide estimates of how many of those expected to be reached are women, how many are youth, how many are living in rural areas and other relevant categories. The estimates must be based on a serious assessment of each objective.

Table 4.6.9 Social stratification

	Estimated number and percentage of people reached who are:			
	Women	Youth (<18)	Living in rural areas	Other*
SDA 1 HAART	45	*63*	54	
SDA 2 PMTCT	100	87	30	
SDA 3 IDUs	20	74	35	
SDA 4 Chron ILL	45	63	54	

* *"Other" to include target groups according to country setting, e.g. indigenous populations, ethnic groups, underprivileged regions, socio-economic status, etc. Targets should be defined according to country disease programs.*

4.6.10 Gender issues

Describe gender and other social inequities regarding program implementation and access to the services to be delivered and how this proposal will contribute to minimizing these gender inequities.

Currently, the burden of disease is almost equally shared between men and women. The situation somewhat changed following a shift from IDU driven epidemic in the 1990's (mostly men) to a more generalized epidemic more recently (sexually driven). In all the major areas of intervention proposed under this component, gender issues were given front-line consideration. All activities will consider gender issues and will determine interventions adequate to male and female roles, and will look at responsibilities and opportunities from a social, cultural, and political perspective. Various tools for monitoring, evaluation and surveillance will be designed accordingly to provide gender disaggregated data and to determine gender focused interventions, making allowance for gender characteristics. The focus of prior actions taken to stomp on the early epidemic was not that much gender-centered, but rather prevention prone and targeting mostly the vulnerable groups at higher risk for contracting the infection. Considering that four-fifths of all cases at the beginning were due to IDU men, who later shed the virus through bridge populations into the mainstream population. However, considering the important role that women play in reproductive health and the child-bearing functions she has in the family and community, specific emphasis is put on prevention of mother-to-child stransmission (pMTCT), such as prevention of unwanted pregnancy in HIV+ women; counseling and support, plus family planning; before and intra-partum administration of preventative ART to infected women and children born to HIV-positive mothers; social care and support after birth, including milk formulas and counseling. In all the major areas of the project interventions gender issues have been carefully considered. All activities consider gender issues and determine interventions adequate to male and female roles, and look at responsibilities and opportunities from a social, cultural, and political perspective. Various instruments for monitoring, evaluation and surveillance will be designed accordingly to provide gender disaggregated data and to determine gender-focused interventions. The project sustainability is enhanced by several factors. There is a high-level political commitment expressed through the National AIDS Coordination Authority headed by the Minister of Health and Social Protection. The present project proposal is fully aligned with the National AIDS Programme, Economic Growth and Poverty Reduction Strategy Paper (currently under implementation) and the Millennium Development Goals and builds upon existing health, education and social protection systems. Moreover, the project promotes the establishment of partnerships within the public and private sector and civil society. In terms of financial sustainability, the Government assigned significant personnel and resources to the national response.
Underlying factors of vulnerability associated with rapid social change and economic transition are

set to fuel the epidemic of HIV in Moldova and exacerbate its impacts. Gender inequality and changing gender relations is one dimension of this. Women in Moldova are less likely to receive education on prevention of HIV (e.g. through sex) and less likely to be able to implement safe behaviors such as condom use, since often their male partners refuse. Moreover, CSW, most of which are women, face violence and the refusal of their partners to use condoms during sexual intercourse, thus exposing them and themselves to higher risks of getting the disease. This project proposal is targeting CSW as one of the vulnerable groups through its harm reduction activities, as well as it is reaching out for youth by means of public communication campaigns and awareness raising events. The project will seek to redress gender imbalances in the following ways:

• Indicators for monitoring and evaluation will as far as possible be disaggregated so that trends in access and use of services can be seen for men and women, to ensure that the access to prevention and care will be promoted among women.

• Capacity building processes will monitor the numbers of men and women given training and capacity building opportunities, female participation in decision making processes within the project will be monitored and responses developed to ensure equity in access.

• Assessments and planning processes in objective one will include specific sessions to analyse the different impacts of HIV on men and women and the different causes of HIV among men and women, including different access to information and community resources, in order to identify approaches which will benefit all community members.

• Vertical transmission programs will be based on the principle of full information for women to make choices about birthing options and infant feeding options based on information about the impacts of these options on their child and their own health.

• Differences between men and women in the ability to negotiate safer sexual behavior will be considered and prevention campaigns will include development of condom negotiation skills for women.

• Male participation will be stressed out in programs for prevention of HIV through sexual transmission such that women are better supported in negotiating condom use, support of male partners will also be stressed for vertical transmission programs so that male partners will be able to support women in their choice of birthing and infant feeding options.

4.6.11 Stigma and discrimination

Describe how this component will contribute to reducing stigma and discrimination against people living with HIV/AIDS, tuberculosis and/or malaria, as applicable, and other types of stigma and discrimination that facilitate the spread of these diseases.

By nature, the present proposal is a combination of new approaches and practices and scaling-up of interventions and activities that have proven successful during the implementation in the previous National Programme such as pilot home-based care projects, peer education and youth friendly services.

To ensure access to the vulnerable groups, the proposal builds on the best practices in HIV prevention and will implement activities that are based on a cost-effective, pragmatic, non-judgemental approach. The novelty of the project is in the massive participation of the civil society in a cross-cutting response to HIV/AIDS: NGOs and community groups will provide the bulk of community and home-based care services, thereby responding to community needs and reducing pressures on health services. It uses PLHA groups, who will play a vital role in the ongoing project implementation and evaluation, which will strengthen their role beyond being passive recipients of care. Availability of funds will be used to catalyze the creation of a pool of strong new NGO`s that are involved in different aspects of HIV/AIDS prevention, treatment and care. The project will greatly contribute to upgrading the surveillance, monitoring and evaluation system. Second generation surveillance will be introduced. A strengthened laboratory service, coupled with continuous supply of drugs for HAART and preventative ART, STI and OI treatment will create an impact on the overall AIDS situation in the country.

There are several effects that we expect to result from the project: first, reduce stigma and discrimination and, second, to empower the PLWHA. This proposal is based on promotion of self-organization and peer education designed and implemented by people under increased risk. All activities are geared towards promotion of safe sex practice among people of difference lifestyles themselves. The CCM is a cross-sector body with considerable representation of NGOs and associations of people under increased risk or living with HIV/AIDS.

5 Component Budget *HIV/AIDS*

The proposed project support will address a number of issues to reduce the economic hardships of families including:

- Reducing out-of-pocket expenses in accessing the basic health care for PLHA through income generating activities, home-based care activities; for young people in expanding nationwide youth friendly services and peer education networks; for the general population expanding access to VCT services;
- Increasing illness-free days and productivity, psychological care and community based support;
- Improving content and targeting of poverty alleviation programmes;
- Comprehensive care and mechanisms to improve care for children affected and infected by HIV.

The impact of the measures mentioned will be maximized as the services and support of the project will become accessible to the communities and poorest members of the community. This means that the project will work with communities with a high prevalence of infection, communities without access to financial, social or technical resources to respond to the epidemic, and people such as PLHA and unemployed youth who because of social marginalization have not been able to access information and services. The project will consider differential access to resources in selecting sites and mechanisms for work, so that the programme promotes equity of access. Social equality will be accomplished within the following programme activities and through the following tools:

- Baseline assessments conducted will identify which communities are less able to access services to ensure monitoring of impact on these communities;
- Services will predominantly be located at the community level, for example through outreach workers, peer educators, VCT sites and youth friendly services to ensure that lack of access to transport, or inability to leave farming responsibilities does not mean that treatment programmes are inaccessible;
- Local level planning processes will require communities themselves to identify which members should be targeted for services, including medical or home based care services, to ensure that parts of communities identified as most vulnerable can access project benefits;
- This planning can also identify candidates for capacity building work, to ensure representation of government and non-government agencies, men and women and people living with HIV/AIDS;
- Substantial care costs, including ARV and OI costs will be met by the governmental GFTAM and WB Programmes, thus promoting access to additional resources by affected communities and increasing the benefits of the proposed programme;
- The project will support county steering groups to consider the links between HIV and poverty and relevant bureaus can identify their own potential contribution, for example in providing better access to microcredit for affected families;
- Communication interventions will help raise community awareness and decrease discrimination and stigmatization towards children, and PLHA. Skills building exercises for mothers and vulnerable children will enable them to take greater roles in peer education and counselling;
- Advocacy to local authorities will stress the rights of vulnerable communities to information and services for the treatment of RTI/STIs as well as condom promotion.

Developing human capacity will be a key element for project implementation at all levels and an assessment of gaps in local capacity to undertake components of the programme will be an early activity. The project will identify appropriate sources of technical support to develop capacity, either at national level agencies (e.g. hospitals) or other projects in the districts and elsewhere. A range of capacity building activities will be developed, including training courses and professional attachments. Methodology for capacity building will be participatory and involve “training of trainers” and “back bone” systems whereby higher level training mechanisms will provide preliminary training and ongoing support for county and community levels. In addition, new technologies such as income generating activities, which are not available at present, will also be used for training and follow up where they exist. These strategies will monitor representative and equitable access for women and men from both Government and Non-Government sectors at the community level, as well as PLHA themselves. National technical expertise will be contracted by the programme, and officers in national and local level offices will manage the technical inputs thus provided. The CCM will be approached for assistance in providing national and provincial management/technical teams with international technical assistance and expertise. Any international experts utilized throughout the programme will be matched with a Moldova counterpart to help transfer the knowledge and skills.

4.6.12 Equity

Describe how principles of equity will be ensured in the selection of patients to access services, particularly if the proposal includes services that will only reach a proportion of the population in need (e.g., some antiretroviral therapy programs).

The project will consider differential access to resources in choosing sites and mechanisms for work, such that the program promotes equity of access. Social equality will be achieved within the following program activities and by employing the following tools:

It is essential that program activities are allowed to follow needs across the districts covered by the project. This means the project will work with communities with a high prevalence of infection, communities without access to financial, social or technical resources to respond to the epidemic, and vulnerable groups, such as commercial sex workers, PLWHA and orphans who, by virtue of social marginalization, have not been able to access information and services. The project will consider a differential access to resources in selecting sites and mechanisms for work, in such a way that the program promotes equity in access. Social equality will be realized within the following program activities and mechanisms:

- Conduct baseline assessments to identify which communities are less able to access services and ensure the monitoring of impact on these communities.

- Services will predominantly be located at the community level, for example through NGO outreach workers and local representatives of religious groups, when the case, to ensure that lack of access to transportation, or inability to leave farming responsibilities does not mean that treatment programs are inaccessible.

- Service delivery planning processes and tender development processes will ask communities themselves to identify which members should be targeted for services, including medical or home based care services, specifically for palliative care, to ensure that parts of communities identified as most vulnerable can access project benefits.

- This planning can also identify candidates for capacity building works, to ensure representation of government and non-government agencies, men and women, as well as that of people living with HIV/AIDS (PLWHA).

- Substantial care costs, including ARV and OI costs will be met by Government of Moldova under the NAP, thus promoting access to additional resources for affected communities and increasing the benefits of the proposed program.

- Communication interventions will help raise community awareness and decrease discrimination and stigmatization towards orphans, and PLWHA. Skills building exercises for older orphans and vulnerable children will enable them to take greater roles in peer education and counseling.

- Advocacy to local authorities will stress the rights of sex workers and other vulnerable communities to information and services for the treatment of STIs as well as condom promotion.

In terms of geographical equity, this project proposal is focusing on the breakaway region of Transnistria, too, thus making it possible for the Transnistrians to access the relevant treatment and care services. In this vein, in-patient/out-patient care sites will be opened in Balti (up North) and in Slobozia (Transnistria) to make up for the lack of adequate access to HAART treatment that is currently provided in Chisinau only (including in the penitentiary system). There will be as many as 920 patients from the right bank of the Nistru river, and another 505 - from the left bank (Transnistria) enrolled in HAART and getting first-line treatment regimens. Four more laboratories for the screening and confirmation of HIV will be strengthened in the country, getting closer to communities. The same is relevant for the laboratory equipment for the monitoring of treatment (immunology, viral load).

Harm reduction programs will spur up in Transnistria too, following the implementation of the given project, as NGO will spin off their activities there too, or new NGO and CBOs will pop up, with the

financial support of the Global Fund and political commitment of local authorities. An audacious target is to scale up the opiate substitution therapy with methadone to Transnistria, too.

4.6.13 Sustainability

Describe how the activities initiated and/or expanded by this proposal will be sustained at the end of the program term. *(When completing this section, applicants should refer to the Guidelines for Proposals, section 4.6.13.)*

A key principle of the project design is the development of sustainable and equitable programmes at the community level requiring community and primary stakeholder participation in the project, including in the recruitment of participants, decisions on the allocation of benefits, identification of the poorest and most vulnerable layers in the community, and in the delivery of services themselves, including delivery of VCT and other home and community based care. The project will work with different agencies, which have strong capacities and networks at the local level, to develop participation in all stages of project activity from assessment, planning, implementation and monitoring. County level planning and mobilisation processes will bring together key stakeholders, leaders, beneficiaries and agencies at the local level to identify local needs for people living with and affected by HIV and help to design response to meet these needs.

The main reasoning behind developing a full-fledged proposal was the idea of trying to achieve universal access to services aimed at prevention, treatment and care. The proposal was designed in a two phase approach, where phase one will try to respond to the most urgent needs of targeted populations, such as distribution of life-depending goods, procurement of equipment for diagnosis etc., and phase two, which will build up frameworks and infrastructures that could ensure a long lasting effect, such as behaviour change interventions.

Underlying factors of vulnerability associated with rapid social change and economic transition are set to fuel the HIV epidemic in Moldova and exacerbate its impacts. Gender inequality and changing gender relations is one dimension of this. Women in Moldova suffer from disproportionately high levels of unemployment, particularly in remote rural areas. In the greatest majority of cases the access to any kind of information is highly reduced and as a result they are less likely to receive education on prevention of HIV (e.g. through sex) and less likely to be able to implement safe behaviors such as condom use, since often their male partners refuse to do so. On the other hand, the burden of providing care for people who are infected and in addition are drug users falls disproportionately on women. The project will seek to address gender imbalances in the following ways:

- Indicators for monitoring and evaluation are set to be disaggregated so that trends in access and utilization of services can be seen for men and women, to ensure that the access to prevention and care will be promoted among women;
- Capacity building processes will monitor the numbers of men and women given training and capacity building opportunities, female participation in decision making processes within the project will be monitored and responses developed to ensure equity in access;
- Assessments and planning processes include specific sessions to analyze the different impacts of HIV on men and women and the different causes of HIV among men and women, including different access to information and community resources, in order to identify approaches which will benefit all community members;
- Vertical transmission programmes will be based on the principle of full information for women to make choices about birthing options and infant feeding options based on information about the impacts of these options on their child and their own health. In case of need, free of charge sterilization will be offered to women that after counseling decided so;
- Differences between men and women in the ability to negotiate safer sexual behavior will be considered and prevention campaigns will include development of condom negotiation skills for women;
- Male participation will be stressed out in programmes for prevention of HIV through sexual transmission so that women are better supported in negotiating condom use; support of male partners will also be stressed for vertical transmission programmes so that male partners are able to support women in their choice of birthing and infant feeding options.

This project recognizes the importance of involving PLHA by giving them both the means to define their

needs and to participate in responding to those needs, as well as a voice in broader decision-making processes. Their involvement will in itself empower the individuals and it will lead to a better overall response in meeting their needs. Furthermore, their greater involvement is a powerful way of helping to reduce discrimination and fear within society, a key issue that this project seeks to address. This PLHA involvement will require sustained capacity building of PLHA groups, since many PLHA are not used to participating actively in projects and may feel disempowered at the beggining. Presently, in Moldova, whilst the involvement of PLHA in the national response is limited, the establishment of such PLHA groups has enabled and supported other local level aid networks to be established with training and technical support. The proposed project will make use of these resources in developing PLHA groups. This project will seek both to support PLHA to conduct their own activities and to involve PLHA in all aspects of the project and at all levels, including planning, implementation (including advocacy and training activities, BCC/IEC campaigns, community and home based care interventions) and monitoring activities.
Specifically the project will

- Build the capacity of PLHA groups in organizational and project planning, management and implementation to enable greater local responses in the project counties;
- Strengthen communication networks between PLHA to facilitate information exchanges and experience sharing;
- Support facilitation of self-support group activities, including community and home-based care and psycho-social support activities;
- Promote the involvement of PLHA as resource persons, to raise awareness of needs and rights of PLHA as well as ensuring a more effective response;
- Reduce stigma and discrimination through training of the media and empowering PLHA through income generating activities.

Beneficiaries and target populations, including male and female PLHA, members of vulnerable groups and community leaders will be asked to participate in the ongoing monitoring and periodic evaluations of the project. At the time with the development of the baseline and follow-up surveys and M&E plans, PLHA will have a key role in determining the most appropriate ways of collecting, analyzing, storing and disseminating information. Information on the effect of the project on the target populations will be collected using participatory methods, such as focus group discussions, interviews, questionnaires, etc., and used to further reinforce behavioural change and supportive environments. As far as possible PLHA outreach workers and volunteers themselves will be trained to implement these participatory evaluation activities. PLHA will be provided feedback on evaluation findings and through the PLHA representatives at the county level steering groups and the CCM, PLHA will have a formal mechanism.

4.7 Principal Recipient information

In this section, applicants should describe their proposed implementation arrangements, including nominating Principal Recipient(s). See the Guidelines for Proposals, section 4.7, for more information. Where the applicant is a Regional Organization or a Non-CCM, the term 'Principal Recipient' should be read as implementing organization.

4.7.1 Principal Recipient information

Every component of your proposal can have one or several Principal Recipients. In table 4.7.1 below, you must nominate the Principal Recipient(s) proposed for this component.

Table 4.7.1: Nominated Principal Recipient(s

Indicate whether implementation will be managed through a single Principal Recipient or multiple Principal Recipients.	☒	Single
	☐	Multiple

Responsibility for implementation			
Nominated Principal Recipient(s)	**Area of responsibility**	**Contact person**	**Address, telephone, fax numbers and e-mail address**
Project Coordination, Implementation and Monitoring Unit, of the Ministry of Health and Social Protection of the Republic of Moldova	PCIMU will be responsible for the project implementation, procurement, financial, management, coordination and M&E with related implemnting agencies in and outside country	Dr. Victor Volovei	Executive Director, 101 Scuisev str, MD 2012 Chisinau, Republic of Moldova, Tel/Fax: + 373 22 23 87 51 E-mail: vvolovei@ucimp.md

4.8 Program and financial management

4.8.1 Management approach

Describe the proposed approach of management with respect to planning, implementation and monitoring the program. Explain the rationale behind the proposed arrangements. *(Outline management arrangements, roles and responsibilities between partners, the nominated Principal Recipient(s) and the CCM. Maximum of half a page.)*

The CCM aims to contribute to the effective implementation of the National Program for Prevention of HIV/AIDS and the National Programme for TB Control, acting as a nexus point for coordinating and overseeing donor financing in support of the national commitment and priorities to fight HIV/AIDS/STIs and TB. CCM on TB/AIDS the has assumed oversight responsibilities for programs funded by the World Bank, the Global Fund, USAID, Swedish government, UN agencies ensuring harmonized approach towards achieving the national program goals and Moldova's health-related MDGs and other commitments. The CCM is an integral part of the "Three Ones" system in the country serving as the national HIV/AIDS and TB coordinating body. CCM approves the national papers developed by the TWGs. Generally, the CCM on TB/AIDS will play a leading role in coordination and oversee the overall implementation of the project.

The CCM's structure is organized on three levels: decisional (22 representatives), coordination (CCM Secretariat), and operational one: TWG (10). The latter ones (5 active in HIV/AIDS field, 4 in TB field and one mixed (TB/AIDS): monitoring and evaluation TWG is responsible for assessing the needs in their specific areas, identify solutions, develop drafts of the national strategic papers and policies. The TWGs are broadly represented: nongovernment sector, governmental and international agencies, as well as representatives from different regions of the country, including Transnistria.
The Secretariat of the CCM (supported financially by the World Bank and UNAIDS) is responsible for the coordination and information of activities, as well as facilitating the nation-wide consultancy processes, CCM meetings: information on the CCM processes and news is mostly shared through email, via a daily online newspaper to every CCM member. CCM members are always asked to distribute the materials to their constituencies. There is also a printed quaterly newspaper "CCM Informational Bulletin" distributed to a large range of beneficiaries.

The PCIMU will be in charge of day-to-day coordination and implementation of the project, while also monitoring of activities, progress towards reaching the targets and outcomes etc. Moreover, the regular staff of the PCIMU involved in the project will facilitate the process along the way by making available its existing staff and facilities (human resources, premises, expertise etc.) It will be responsible for making

contractual arrangements with the sub-recipients. PCIMU will assure the coordination of efforts with other partners that will be involved in the implementation: National TB control Programme / National TB Institute, Medical Service of Penitentiary Department Ministry of Justice, NAC, CPHM, and technical partners of project and international agencies. Procedures for sub-contracting, procurement and financial management, M&E, audit and oversight will be provided according with Operational Manual of the PCIMU. The specific procurement activities under the project, which require competitive biddings for the commodity purchased (e.g., HIV lab equipment, condoms, rapid tests for HIV etc.) will be coordinated by PCIMU with the support of financial assistant. Publishing contracts will be agreed with printing agencies for printing of various publications, including informational booklets and pamphlets, where necessary.

In the areas where little national consensus exists (e.g., Transnistria), or where national expertise is poor, international consultants (e.g., WHO, UNAIDS, UNFPA etc.) will be involved to express their neutral expert opinion on the issues (laboratory capacity and quality control, HAART needs assessment, VCT analysis).

Advocacy and awareness raising meetings will be organized with relevant national counterparts, with involvement of civil society, including the PLWHA. The project will communicate with lay people through the written media, and radio/TV broadcasting, as well as through the YFHS and peer-to-peer (IEC, telephone green line). Media will be trained in using non-discriminatory language, while university curricula will accordingly be changed for the education facilities training media professionals. Certain innovative methods, like the social theatre forum, and the youth media network, will be employed as well; specific frameworks (e.g., human rights) will be developed where missing to provide enough legal ground for the activities to take place.

Please note that if there are multiple Principal Recipients, section 4.8.2 below has to be repeated for each one.

4.8.2 Principal Recipient capacities

a) Describe the relevant technical, managerial and financial capacities for each nominated Principal Recipient. Please also discuss any anticipated shortcomings that these arrangements might have and how they will be addressed, please refer to any assessments of the PR(s) undertaken either for the Global Fund or other donors (e.g., capacity-building, staffing and training requirements, etc.).

The PCIMU has been created courtesy of a GoM Decision no. 391, as of 19th April 2000, on the implementation of World Bank and Dutch Government loan and grant for the restructuring of health system in the Republic of Moldova.
Following the approval of the application for the GFATM first round in 2003, the MHSP decided to implement the grant through PCIMU, and the following additional personnel has been hired for the implementation of the TB/AIDS project: TB/AIDS coordinator, procurement officer, financial officer and M&E officer, after careful consideration was given to other options deemed to have less experience and expertise in this area.

The PCIMU capacity has been evaluated by the Local Fund Agent during the years 2003-2004 (Institutional and Programmatic Assessment Report & Monitoring and Evaluation Assessment Report are attached as Annex 55/AIDS and 56/AIDS). During the implementation of the grant the PCIMU activity has been quarterly monitored by the Local fund Agent. The Local Fund Agent concluded that PCIMU has sufficient technical, managerial and financial capacity for adequate management of the grant.

b) Has the nominated Principal Recipient previously administered a Global Fund grant?	☒ Yes ☐ No
c) Is the nominated PR currently implementing a large program funded by the Global Fund, or another donor?	☒ Yes ☐ No

d) If you answered yes for b) or c), provide the total cost of the project and describe the performance of the nominated Principal Recipient in administering previous grants (Global Fund or other donor).
The project “Support to the National Programme for the Prevention and Control of HIV/AIDS and STIs and the National Programme for control of Tuberculosis” has been approved by GFATM in March 2002. The programme grant agreement has been signed on March 24, 2003. The total grant for five years is US$ 11,719,047.00, divided into two phases: first phase - US$ 5,257,941.00 for the first two years and second phase – US$ 6,461,106.00 for the last free years. In 2005 the GFATM evaluated the project implementation performance and appreciated it with the Qualificativ “A” and the second phase has been approved for implementation. By July 01, 2006, PCIMU disbursed according to the approved activity plans 7,641,072.09 US$, which represent 65 % from the total grant amount. Aditionaly to the GFATM Grant, the PCIMU is implementing since October 2003 the IDA Grant totalling US$ 5,500,000.00 for the “AIDS Control in RM”. By July 01, 2006, PCIMU disbursed 2,671,800.94 US$, which represent 49 % from the total grant amount. The activities implemented by PCIMU within this grant have been evaluated during the World Bank Mid-Term Review being satisfactorily appreciated (the Mid-Term Review Mission Aide Memoire is attached). The PCMIU have Operational Manual which include guidelines for the procurement and financial management according to the World Bank rules. Annually activity plans are prepared for both grants and the budgets are revised. The M&E plan includes a list of indicators approved for both grants and a list of targets to rich. Additionally, PCIMU (TB/AIDS staff) implemented the PHRD Grant totalling US$ 91,783.00, from December 2002 to June 2003, and the SIDA Sweden Grant totalling US$ 604,615.00, from December 2001 to September 2003, both grants aimed at supporting the Control of HIV/AIDS and TB in Republic of Moldova.
e) If you answered yes for b) or c), describe how the PR would be able to absorb the additional work and funds generated by this proposal.
The financing of activities within both grants, GFATM grant second phase and World Bank grant, will end in the second quarter of 2008. Considering this, no obstacles are envisaged for the implementation of the activities proposed within the application for the GFATM 6th round. Available human capacity with experience in GFATM and WB grants implementation will be involved. Except for that, due to the firt GFATM grant and WB grant implementation the capacity of potential sub-recipients such as NGOs, government instituions and PLHA has increased. The total workload of implementation of the grant will be distributed between sub-recipents which will be selected on a tender basis in a fair and transparent way. In addition, compared to the previous proposal under GFATM Round 1 it is planed to sub-contract up to 5 sub-receipients which will ensure timely implementation, financial management and M&E of the subcontracted activities thus reducing the workload of PR.

4.8.3 Sub-Recipient information	
a) Are sub-recipients expected to play a role in the program?	☒ Yes ➔ *complete the rest of 4.8.3*
	☐ No ➔ *go to 4.9*
b) How many sub-recipients will or are expected to be involved in the implementation?	☒ 1 – 5
	☐ 6 – 20
	☐ 21 – 50

	☐ more then 50
c) Have the sub-recipients already been identified?	☐ Yes ➔ *complete 4.8.3. d) -e) and then go to 4.9* ☒ No ➔ *go to 4.8.3. f) – g)*

d) Describe the process by which sub-recipients were selected and the criteria that were applied in the selection process (e.g., open bid, restricted tender, etc.).

e) Where sub-recipients applied to the Coordinating Mechanism, but were not selected, provide the name and type of all organizations not selected, the proposed budget amount and reasons for non-selection in an annex to the proposal.

f) Describe why sub-recipients were not selected prior to submission of the proposal.

The decision not to select sub-recipients was based on a joint decision coming from the TWG. The reasoning for non-selection has to do first of all with the timeframe for the implementation of the present proposal which is planned to start in 2008. Assumptions were made that in the following two years there could be additional capacities and potential sub-recipents and existing potential sub-recipients will develop capacities. One more reasoning for non-selection is the previous experience with the GF and WB that the country went trhough where sub-recipients were selected in open bids or on a tender basis with full project proposal development that both allowed for the best candidate to implement activities and that built capacities in all participants at the bids to plan strategically and develop results based activities. The project proposal was specifically designed in such a way as to ensure an increased participation of NGOs, government institutions and communities in the grants programme. Additionally, grants usually are released based on a co-financing conditionality that encourages local communities and local public authorities to make allocations from the local budgets thus creating a multiplier effect for the project budget and ensures sustainability of the activities proposed under the projects.

g) Describe the process that will be used to select sub-recipients if the proposal is approved, including the criteria that will be applied in the selection process.

Sub-recipients will be subcontracted on an open bid basis. The decision on the selection of sub-recipients will be taken by the CCM at an open meeting. The eligibility criteria for the sub-recipients are described below relating to:

- organizations which may participate as sub-recepients
- partnerships and eligibility of partners for sub-recipients

I. Eligibility for sub-recipients: who may apply

(1) In order to be eligible for a sub-recipent, applicants must:

- be non-profit-making legal entities; and
- belong to one of the following categories:

\- local communities, NGOs, community-based organizations, faith-based organizations and other non-for-profit natural and legal entities from the private sector;

\- international organizations, United Nations and its agencies, as well as development banks, financial institutions, global initiatives, international public/private partnerships

\- research institutes and universities;

and

- have offices, representations or headquarters in the Republic of Moldova
- be directly responsible for the preparation and management of the grant, not acting as an intermediary;

(2) Potential applicants may not participate in calls for proposals or be awarded grants if:

(a) they are bankrupt or being wound up, are having their affairs administered by the courts, have entered into an arrangement with creditors, have suspended business activities, are the subject of proceedings concerning those matters, or are in any similar situation arising from a similar procedure provided for in national legislation or regulations;
(b) they have been convicted of an offence concerning professional conduct by a judgement which has the force of res judicata (i.e., against which no appeal is possible);
(c) they are guilty of severe professional misconduct proven by any means;
(d) they have not fulfilled obligations relating to the payment of social security contributions or the payment of taxes in accordance with the legal provisions of the country;
(e) they have been the subject of a judgment which has the force of res judicata for fraud, corruption, involvement in a criminal organisation or any other illegal activity detrimental to the state' financial interests;
(f) they have been declared to be in serious breach of contract for failure to comply with their contractual obligations in connection with a procurement procedure or other grant award procedure financed by the state's budget.
Applicants will be also excluded from participation in the process of selection of sub-recipients, at the time of the call for bid, if they:
(g)are subject to a conflict of interests;
(h) are guilty of misrepresentation in supplying the information required by CCM or the Principal Recipient as a condition of participation in the process of selection of sub-recipients or fail to supply this information;
(i) have attempted to obtain confidential information or influence the evaluation committee or the CCM or Principal Recipient in any way.
(k) are closely related by blood or by marriage with key decision persons in CCM and within the office of the Principal Recipient.
In the cases referred to in points (a), (c), (d), (f), (h) and (i) above, the exclusion applies for a period of two years from the time when the infringement is established. In the cases referred to in points (b) and (e), the exclusion applies for a period of four years from the date of notification of the judgment.
Applicants must supply with their applications a statement on the honour that they do not fall into any of the above categories (a) to (f).
II. Partnerships and eligibility of partners
Applicants may act individually or in consortium with partner organisations.
Applicants' partners participate in designing and implementing the grant, and the costs they incur are eligible in the same way as those incurred by the grant beneficiary. They must therefore satisfy the same eligibility criteria as applicants. However, in addition to the categories referred to in section II, they may belong to one of the following categories:

- administrative authorities and agencies at national, regional and local levels and other decentralized organisms;
- organizations from commercial and/or profit making private sector provided they do not derive any profit from the grant;
- non-government organization and community organizations with a legal status, including associations of PLHA, networks and faith based organizations.

4.9 Monitoring and evaluation

The Global Fund encourages the development of nationally owned monitoring and evaluation plans and monitoring and evaluation systems, and the use of these systems to report on grant program results. By completing the section below, applicants should clarify how and in what way monitoring the implementation of the grant relates to existing data-collection efforts.

4.9.1 Plans for monitoring and evaluation

Describe how the targets and activities indicated in the Targets and Indicator Table (attached as Attachment A to this proposal, see section 4.6) will be monitored and evaluated. Please identify any surveys to which this proposal is contributing.

The indicators for the given project proposal were selected from a number of indicators set in the M&E Plan designed to monitor the progress of the NAP 2006-2010. In general terms, the indicators selected for the M&E Plan fully comply with UNGASS indicators, and are aligned with the UNAIDS CRIS Reporting System and match the indicators recommended by the Global Fund as per the Multi-Agency Monitoring and Evaluation Toolkit, Second Edition, January 2006. All indicators specified under the Indicators Table as indicators for monitoring the progress with respect to the GF money are part of the National M&E Plan.

Considering that the current Global Fund proposal is in line with the cycle of the NAP for 2006-2010, the data collection for reporting the progress to the Global Fund will be done without any duplication of efforts or study redundancy, thus allowing for cost reduction to be achieved when collecting data. Generally, input and process data will be collected routinely on a day-to-day basis and impact and outcome indicators will be collected by conducting big studies, such as DHS, second generation surveillance studies, and KAP studies. Copies of earlier studies are attached to the proposal as follows: “KAP 2005, Annex 41/AIDS and DHS – 2005 Preliminary Report, Annex 42/AIDS. A mid-term evaluation will provide inputs in whether most of the targets set and benchmark used are doing well in terms of implementation and outputs/outcomes. Considering the quite long five-year timeframe for this project proposal, coupled with 1.5 years of lead time before the project could kick off, targets could be viewed as estimated figures rather than set values, and should be subject to change to better reflect the situation at the time of implementation. Besides, the automated SYMETA system for HIV/AIDS will aid in looking into the relevant data, once completed and filled in, allowing for data review and comparisons, if needed.

The PCIMU has developed a M&E Plan which provides an overview of the data that will be collected, describes the data flow collection process and the methodology, stipulates the baseline and the timeframe for implementation.

According to the M&E Plan, the PCIMU will collect the following regular quarterly data from implementing organizations (sub-recipients and implementing partners):

- Quarterly activity reports.
- Quarterly financial reports.
- List of indicators.

The activity and financial reports submitted by the implementing instituions will be archived by the PCIMU and the values of M&E indicators will be inserted to the database of the PCIMU.

Subsequent to the verification of the reports and indicators from the implementing organizations PCIMU will produce reports further to be submitted to donors. The majority of indicators will be collected quarterly and only a few of them will be collected on an annual basis (epidemiological indicators) or once in 3 years (surveys).

PCU will be responsible for the quarterly (or annually) data collection and periodic site visits to the implementation organizations.

4.9.2 Integration with national M&E Plan

Describe how performance measurement for this program is proposed to contribute to and/or strengthen the national Monitoring and Evaluation Plan for this component. If a national Monitoring and Evaluation strategy exists, please attach it as an annex to the proposal, and provide a summary of key linkages with the national Monitoring and Evaluation Plan and data collection methods.

In 2001 the Government of Moldova has approved the National Programme on Prevention and Control of HIV/AIDS/STIs 2001-2005 based on a thorough Situational and Response Analysis. Once officially approved, the National Programme became the basic strategic framework for reducing the spread of HIV/AIDS and STIs. At the time of the development of the National Programme the capacity of the Government to plan a monitoring and evaluation component for the National Programme was limited, thus the indicators stipulated in the National Programme against which it was originally planned to perform the monitoring and evaluation do not longer satisfy the country needs. In addition the Government has committed itself to the monitoring of the Millennium Development Goals (MDGs) and the Declaration of Commitment (DOC), resulting from the United Nations Generally Assembly Special Session on HIV/AIDS (UNGASS). Moreover the Government has recently undertook a strategic planning exercise, which resulted in the development and approval of the new National Programme, requiring data to evaluate the course of the epidemic and the appropriateness of the national response to the epidemic.

The Government has endorsed the concept of a comprehensive national Monitoring and Evaluation system (M&E) and recognized its advantages and importance over separate systems addressing the monitoring needs of each major initiative. The Government established a multi-stakeholder technical working group (TWG) within the framework of the One National Authority, Country Coordination Mechanism for HIV/AIDS/STIs, which has recently enlarged its mandate and overtook the responsibilities of the National AIDS Committee. The NCPHealthM was identified by the government to be in charge of the national M&E system and a pilot project for designing of a M&E System for two programmes, the National Programme on Prevention and Control of HIV/AIDS/STIs and the National Programme on Prevention and Control of TB was initiated by the UN TG on HIV/AIDS. The pilot project is currently successfully implemented and known as SYMETA (System for Monitoring and Evaluation of TB/AIDS) with UNAIDS/Global Fund/WB funds.

The national M&E system is Government-based and Government-led. The Government is overall responsible for the national response to the HIV/AIDS epidemic, and is able to measure progress made, ensure accountability and identify the most effective approaches.

SYMETA is based on a cross-cutting approach, and obtains input from all government sectors, as well as civil society organizations and the private sector, to ensure that the country can report on internationally agreed goals and targets, such as the MDGs and the targets spelled out in the DoC.

SYMETA is a joint system, agreed upon by all major stakeholders. By determining reporting needs and through a process of consensus, a set of commonly agreed upon indicators were adopted and data are collected accordingly. The work undertaken by UNAIDS and WHO, being leading UN agencies in the field of M&E, guided the development of the national set of indicators.

The national M&E system was designed as a comprehensive system. It does not only collect data on the epidemiological situation, but also programmatic and financial data. At a later stage a research data base will be included into the M&E system. The technical specifications for the research database have been finalized and made open source to the public.

An incremental approach was applied to set-up the M&E system, to allow the timely collection of baseline data and also to ensure a systematic approach.

The M&E Unit is located at the CPHM which is also responsible for the function of the system. The M&E Unit was staffed with five professionals except for operators. Terms of reference for each of them have been developed. A website was developed and made functional to ensure free access to information of epidemiological nature, recent development and other relevant news.

As of today, the full design of the system in question has been pondered upon with a set of indicators

already approved and the technical description for each of indicator groups delivered, as per the information flow pursuant to the newly developed reporting forms. A prototype software-based system for the monitoring and reporting on HAART treatment, to later be integrated as a module of the larger SYMETA, has been developed by the M&E Unit with WHO support, in order to pre-test it and find the shortcomings. A sample of 40 patients have been entered into the database, with information available on the treatment and testing of each patients in that sample, thus making it easier for the clinicians to administer them drugs and follow them up by making appointments or changing treatment regimens, when the case. According to the national plan, the implementation of the designed system should occur by the end of 2010, provided that additional financial means are made available to build capacity and for additional procurement of equipment to assure timely reporting of data from the primary level M&E Units.

Nevertheless, there is a considerable shortfall in this area, as the local authorities in Transnistria make use of a separate health reporting system, which is not compliant with the recent developments occurred elsewhere in the country and that should be worked out. It is planned that some of the Global Fund money be used for integrating it into a single national system.

The performance measurement for this project will contribute to the strengthening of the national Monitoring and Evaluation Plan through providing support to the operationalisation of the M&E System which in Moldova is known as SYMETA. Such plans refer to training of entry points, training of the staff from M&E, subcontracting IT services and procurement of equipment to ensure proper processing and transfer of data. Relevant resources are requested under Objective 3 to assure the training of staff, including in M&E activities, to support the procurement of cars and the regular supervision visits in civillian and penitentiary, which represent a instrument for strenghening M&E activities.

In addition relevant resources are included to assure the maintenace and to strenghthening of the SYMETA: extension of the system infrastructure, support and trainings of the personnels, implementation of the opeartional research and support to the M&E Unit of the NCPHM.

5 Component Budget *HIV/AIDS*

4.10 Procurement and supply management of health products

In this section, applicants should describe the management structure and systems currently in place for the procurement and supply management (PSM) of drugs and health products in the country. When completing this section, applicants should refer to the Guidelines for Proposals, section 4.10.

4.10.1 Organizational structure for procurement and supply management Briefly describe the organizational structure of the unit currently responsible for procurement and supply management of drugs and health products. Further indicate how it coordinates its activities with other entities such as National Drug Regulatory Authority (or quality assurance department), Ministry of Finance, Ministry of Health, distributors, etc.
Procurement practices in Moldova regarding the purchase of drugs and health equipment are regulated by the Law of the Republic of Moldova No. 1166/XIII as of 30.04.1997 " On the Procurement of Goods and Services for Government Needs". In line with this, all procurement of goods within the entire health system and HIV/AIDS/STIs components are being done in a centralised manner. First, this practice ensures lump procurement of drugs, goods and equipment which reduces costs, second, this practice increases participation of big suppliers located outsite Moldova specifically because there are no representations of big firms or providers of drugs and medical equipment in Moldova due to its low procurement capacity conditioned by its reduced needs in terms of quantities. From previous experience, the responsibility for procurement and supply management has been distributed between the Principal Recipent and Sub-Recipients where the same rule of bulk procurement was applied. Since this approach has proven successful during the implementation of the previous grants it will be applied for the present proposal as well. In addition, one of the most important benefits of the centrelised of procurement and supply is reducing possibilities for corruption and misuse of financial resources. The purchase of any commodities, drugs or services under this proposal will be done based on open bids or tenders. The procedure is based on the comparison of offeres from at least three suppliers by a Committee where the following criteria will be used to choose the best offer: - compliance with the required quality standards - cost of products - availability of products Based on previous experience, where for instance syringes for IDUs in harm reduction sites in different lots had different quality or condoms in different lots also differed in quality a system to ensure that products purchased and distributed meet the needs of the target group regular focus group, needs assessment and surveys in clients will be conducted and reported back to the Principal Recipent. The PR is conducting its activities based on a written Project Operational Manual. PCU was initially created to implement WB projects, including Moldova AIDS control project. As a result the POM was developed in accordance with the WB procurement policies, and procedures for carrying out procurement and supply management activities. These documents ensure open and transparent competition and have explicit evaluation and award criteria that guarantee efficiency and value for money. The main methods used for procurement of goods will be: i) open international tenders; ii) request for quotations iii) procurement from UN agencies and non-profit international agencies. To ensure quality and reliability of the orders the PCU will prefer the procurement of pharmaceuticals, condoms and standard tests (ELISA, Viral Load, CD4-CD8) from the well established international non-profit agencies such as – WHO procurement department, GDF, UNICEF, UNFPA, IDA Amsterdam Consultants will be procured using the following methods i) Individual consultants (for individuals) ii) Consultant Qualifications iii) Quality Cost Based Selection (amounts bigger then 200 000 USD) iv) Least Cost Selection (ex. Audit services) All the procurement principles and methods are in line with the i)Guidelines for Procurement under IBRD Loans and IDA Credits 2004 (for goods, works and services) ii) Guidelines on Selection and Employment of Consultants by World Bank Borrowers Management capacity and coordination

NTP the coordinator. Coordinates the implementation of treatment strategy. Develops, adjusts the treatment guidelines in accordance with the WHO recommendations; epidemiological data; morbidity, resistance, categories of patients

PR – is responsible for the overall Procurement and Supply Management. For adherence to GF and national policies, for organising efficiency and transparency of the procurements.

Drug Management Team of the NTP selects and determines the items and forms of pharmaceuticals for the procurement. Monitor the distribution and use of drugs.

National Drug Agency is responsible for the drug policy. It co-participates at the development of quality assurance requirements (registration and authorisation of the drugs on the market, state control of the quality)

Coordination will be preformed at every step of the supply chain
1. Selection.
It is the responsibility of the Drug Management Team, that is under the NTP, to organise the process of selection. WHO will consult the Ministry of Health on adherence of selected pharmaceuticals to the WHO treatment protocols and practices.
Monitoring and Evaluation of the national Programme Department of the Scientific Practical Centre of Public Health and Sanitary Management provides morbidity rates, categories of patients and other statistical data. The selected products will be coordinated with the MOHSP

2. Procurement.
It is the responsibility of the PR to conduct all the procurements in line with the GF and National policies and rules.
During the quantification process the PR will advise on the unit prices, based on the big procurement experience obtained during the implementation of the WB and GF grants
PR will collect the specifications from the beneficiaries. For simple orders the PR will start the procurement process immediately. For the procurement of complex health sector goods, the specifications will be coordinated with the working group on procurements of drugs and health products of the MOHSP.
To ensure a transparent but at the same time efficient evaluation process, the evaluation committee will differ depending on the value of the contract. Contracts less then 50 000 USD will be evaluated within the PIU with the involvement of the beneficiaries of the procurement.
Contracts with between 50 000 USD and 200 000 USD will be evaluated in coordination with the MOHSP.
Contracts of 200 000 USD and higher (this refers to open tender procedures) will be evaluated by a commission the includes members from: MOHSP, UN agencies (UNAIDS), Ministry of Justice (penitentiaries), Beneficiaries.
3. Distribution.
All the import procedures for the tenders performed are the responsibility of the PR. MOHSP will issue the import authorisations based on the invoices submitted by the PCU. Customs department will issue letters for tax exemptions. Where it will be possible the health goods and pharmaceuticals will be delivered directly to the beneficiaries, thus avoiding central storage. But in some cases for drugs distribution (1st and second line TB drugs) the state company “San-FarmPrim” will be used as the central store. The drugs will be stored there and distributed in accordance with the distribution scheme prepared by the NTP and approved by the MOHSP

4. Use.
To ensure the rational use of pharmaceuticals the NTP has developed the treatment strategy of using fix dose combinations in treatment guidelines and in the selection and procurement practices. Also the packing requirements have been modified to use blisters, that improved the quality of the rendered services, inventory management and storing and distribution practices. The system for monitoring adverse drug reactions and drug resistance is implemented in the country. Measures have been taken to supervise the rational use of pharmaceuticals authorised on the territory of Moldova and namely:
- periodic review of the essential drug list
- study of the rational use of the pharmaceuticals in certain diseases (by analysing the patients cards) and further informing the practitioners by means of publications

The MOHSP has approved the regulation of data collection on the adverse reactions.

Quality Assurance

5 Component Budget *HIV/AIDS*

It is the responsibility of the PR to ensure that products being purchased with GF financing are of high quality and correspond to the National Drug Regulatory Authority (NDRA) and Global Fund requirements. Quality assurance of the drugs involves several levels and coordination of different institutions and namely:

- Formulation of the specifications and quality requirements of the drugs to be procured. That includes procurement only of the WHO prequalified products and adherence to GF policies on Procurement and Supply Management. The quality systems of the GDF and GLC (IDA), including pre-shipment inspections performed by international agencies (Ex. SGS)
- national system of quality assurance of the drugs before they reach and are used on the local market and includes: authorisation of drugs that includes expertise, homologation and drug registration by the Drug Commission of the Drug Agency; state control of all the batches of the imported and locally manufactured drugs
- post marketing quality surveillance. With the participation of the pharmaceuticals inspection of the National Drug Agency, Monitoring Department of the NTP.

4.10.2 Procurement capacity

a) Will procurement and supply management of drugs and health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient or will sub-recipients also conduct procurement and supply management of these products?	☐ Principal Recipient only
	☐ Sub-recipients only
	☒ Both

b) For each organization involved in procurement, please provide the latest available annual data (in Euro/US$) of procurement of drugs and related medical supplies by that agency.

From the beginning of the GFATM R 1 and IDA Grants in 2004, the PCIMU has spent $ US 5,053,562.84 for procurement of drugs and medical supplies (for Tuberculosis and HIV/AIDS components).

4.10.3 Coordination

a) For the organizations involved in section 4.10.2.b, indicate in percentage terms, relative to total value, the various sources of funding for procurement, such as national programs, multilateral and bilateral donors, etc

Grant of the GFATM Round 1 and IDA Grant (100%)

b) Specify participation in any donation programs through which drugs or health products are currently being supplied (or have been applied for), including the Global Drug Facility for TB drugs and drug-donation programs of pharmaceutical companies, multilateral agencies and NGOs, relevant to this proposal.

ARV line I and II drugs, tests and condoms have procured through IDA Amsterdam

4.10.4 Supply management (storage and distribution)		
a) Has an organization already been nominated to provide the supply management function for this grant?	☒ Yes ➔ *continue*	☐ No ➔ *go to 4.10.5*

b) Indicate, which types of organizations will be involved in the supply management of drugs and health products. If more than one of the boxes below is ticked, describe the relationships between these entities.	
	☒ National medical stores or equivalent
	☐ Sub-contracted national organization(s) *(specify which one(s))*
	☐ Sub-contracted international organization(s) *(specify which one(s))*
	☐ Other *(specify)*

c) Describe the organizations' current storage capacity for drugs and health products and indicate how the increased requirements will be managed.

National medical warehouse "San Farm Prim" has sufficient capacity and territorial branches to ensure the storage of drugs, goods and commodities. The drugs will be stored there and distributed in accordance with the distribution scheme prepared by the NTP and approved by the MOHSP.
This mechanisms is used and works from 2005, when the first procurement of TB dugs has started by PCIMU.

d) Describe the organizations' current distribution capacity for drugs and health products and indicate how the increased coverage will be managed. In addition, provide an indicative estimate of the percentage of the country and/or population covered in this proposal.

It is estimated that the project will ensure a national coverage and will reach 1/4 of the population, including Transnistria. "San Farm Prim" is a national medical store with a long history of cooperation with the MHSP and has managed during the last years large stocks of medical goods and drugs. This is true specifically after 1997 when the procurement practice of the MHSP shifted from the decentrilezed procurement to the centrilezed bulk procurement.

[For tuberculosis and HIVAIDS components only:]

4.10.5 Multi-drug-resistant TB	
Does the proposal request funding for the treatment of multi-drug-resistant TB?	☐ Yes
	☒ No

If yes, please note that all procurement of medicines to treat multi-drug-resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee (GLC) of the Stop TB Partnership. Proposals must therefore indicate whether a successful application to the Committee has already been made or is in progress. For more information, please refer to the GLC website, at http://www.who.int/tb/dots/dotsplus/management/en/. Also see the Guidelines for Proposals, section 4.10.5.

5 Component Budget *HIV/AIDS*

4.11 Technical and Management Assistance and Capacity-Building

Technical assistance and capacity-building can be requested for all stages of the program cycle, from the time of approval onwards, including in respect of , development of M&E or Procurement Plans, enhancing management or financial skills etc. When completing this section, applicants should refer to the Guidelines for Proposals, section 4.11.

4.11.1 Capacity building

Describe capacity constraints that will be faced in implementing this proposal and the strategies that are planned to address these constraints. This description should outline the current gaps as well as the strategies that will be used to overcome these to further develop national capacity, capacity of principal recipients and sub-recipients, as well as any target group. Please ensure that these activities are included in the detailed budget.

Developing human capacity will be a key element of project implementation at all levels and an assessment of gaps in local capacity to undertake components of the program will be an early activity. The project will identify appropriate sources of technical support to develop capacity, either at national level agencies (e.g. hospitals) or other projects in the country and elsewhere. A range of capacity development activities will be developed, including training courses and professional attachments. Methodology for capacity building will be participatory and involve the "training of trainers" and "back bone" systems whereby higher level training mechanisms will provide preliminary training and ongoing support for county and community levels. These strategies will monitor representative and equitable access for women and men from both Government and Non-Government sectors at the community level, as well as PLWHA themselves. National technical assistance will be contracted by the program, and officers in national and provincial offices will manage the technical inputs thus provided. The CCM will be approached for assistance in providing national and provincial management/technical teams with international technical assistance and expertise. Any international experts used throughout the program will be matched with a local counterpart to help knowledge and skill transference.

The project heavily draws on capacity building, including a number of training and re-training activities for first-tier and second-tier providers/professionals, mostly to be carried out by national trainers with expertise in the area (e.g., AFEW, Pro-Didactica), or at recognized knowledge and expertise sites, or by known professionals (e.g., WHO Knowledge Hub).

4.11.2 Technical and management assistance

Describe any needs for technical assistance, including assistance to enhance management capabilities. (*Please note that technical and management assistance should be quantified and reflected in the component budget section, section 5.6)*

Technical and management assistance planned in the project is intended for developing guidelines and communications materials, quality assurance, project management, and evaluation. The budget includes funding for technical assistance on guidelines for TB/HIV and infection control in facilities and in the population.
In order to ensure prompt implementation of the project, all necessary arrangements for coordination will be made in a timely manner. These already include an agreement on the division of responsibilities for technical assisitance among participating agencies for the implementation of the activities based on a TA assistance plan under development, coordination arrangements, management of funds, and review of programme results. PCIMPU will be responsible for overall coordination of the project and taking decisions on specific project implementation aspects, ensuring optimal transformation of inputs into outputs through appropriate monitoring and evaluation of actions pertaining to the relevance, performance and progress towards intended outcome, facilitating the cooperation of the project with relevant partners, public and private, and ensuring continuous and effective communication between the programme and its beneficiaries.

5 Component Budget *HIV/AIDS*

PLEASE NOTE THAT THIS SECTION IS TO BE COMPLETED FOR EACH COMPONENT.

In this section, applicants will need to provide summary budget information for the proposed duration of the component. Applicants are also required to provide a more detailed budget as an annex to the proposal. For more information on budget requirements, please refer to the Guidelines for Proposals, section 5.

If part or all of the funding requested for this component is to be contributed through a common funding mechanism (consistent with section 4.6.7), **applicants should provide:**

- Compile the Budget information in sections 5.1 – 5.6 on the basis of the anticipated use, attribution or allocation of the requested funds within the common funding mechanism; and
- Provide, as an annex, the available annual operational plans/projections for the common funding mechanism and explain the link between that plan and this funding request.

5 Component Budget *HIV/AIDS*

5.1 Component budget summary

Insert budget information for this component broken down by year and budget category, in table 5.1 below.
(The "Total funds requested from the Global Fund" should be consistent with the amounts entered in table 1.2 relating to this component.)

The budget categories and allowable expenses within each category are defined in the Guidelines for Proposal, section 5.1. The total requested for each year, and for the program as a whole, must be consistent with the totals provided in sections 5.1.

Table 5.1 – Funds requested from the Global Fund

	Funds requested from the Global Fund (in Euro/US$)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	419,678	443,698	421,044	373,894	334,468	1,992,782
Infrastructure and equipment	874,025	292,885	238,850	74,810	76,210	1,556,780
Training	453,610	267,950	261,470	357,050	230,650	1,570,730
Commodities and products	1,201,810	1,001,960	967,190	1,170,050	1,024,650	5,365,660
Drugs	577,143	700,993	820,107	1,146,280	1,750,816	4,995,339
Planning and administration	119,220	58,100	156,200	42,500	83,400	459,420
Other (*please specify*)						0
Other (*please specify*)						0
Other (*please specify*)						0
Total funds requested from the Global Fund	3,645,486	2,765,586	2,864,861	3,164,584	3,500,194	15,940,711

5 Component Budget *HIV/AIDS*

5.2 Detailed Component Budget

The Component Budget Summary (section 5.1) must be accompanied by a more detailed budget covering the proposal period, attached as an annex to the proposal. The detailed budget should also be integrated with the Work Plan referred to in section 4.6.

***The Detailed Component Budget** should meet the following criteria (Please refer to the Guidelines for Proposals, section 5.2):*

a) *It should be **structured along the same lines as the Component Strategy**—i.e., reflect the same goals, objectives, service delivery areas and activities.*

b) *It should cover the term of the proposal period and should:*
   - i) *be **detailed for year 1 and year 2** of the proposal term, with information broken down by **quarters for the first year**;*
   - ii) *provide summarized information and assumptions for the balance of the proposal period (**year 3 through to conclusion of proposal term**).*

c) *It should state all key assumptions, including those relating to **units and unit costs**, and should be consistent with the assumptions and explanations included in section 5.3.*

d) *It should be integrated with the detailed **Work Plan** for year 1 and indicative Work Plan for year 2 (please refer to section 4.6).*

e) *It should be **consistent** with other budget analyses provided elsewhere in the proposal, including those in this section 5.*

5 Component Budget *HIV/AIDS*

5.3 Key budget assumptions

Without limiting the information required under section 5.2, please indicate budget assumptions for year 1 and year 2 in relation to the following:

5.3.1 Drugs, commodities and products

Please use Attachment B (Preliminary Procurement List of Drugs and Health Products) in order to compile the budget request for years 1 and 2 in respect of drugs, commodities and health products. Please note that unit costs and volumes must be fully consistent with the information reflected in the detailed budget. If prices from sources other than those specified below are used, a rationale must be included.

a) Provide a list of anti-retroviral (ARVs), anti-tuberculosis and anti-malarial drugs to be used in the proposed program, together with average cost per person per year or average cost per treatment course. *(Please complete table B.1 in Attachment B to the Proposal Form.)*

b) Provide the total cost of drugs by therapeutic category for all other drugs to be used in the program. It is not necessary to itemize each product in the category. *(Please complete table B.2 in Attachment B to the Proposal Form.)*

c) Provide a list of commodities and products by main categories e.g., bed nets, condoms, diagnostics, hospital and medical supplies, medical equipment. Include total costs, where appropriate unit costs. *(Please complete table B.3 in Attachment B to the Proposal Form.)*

(For example: *Sources and Prices of Selected Drugs and Diagnostics for People Living with HIV/AIDS.* Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, June 2003, (http://www.who.int/medicines/organization/par/ipc/sources-prices.pdf); Market News Service, *Pharmaceutical Starting Materials and Essential Drugs*, WTO/UNCTAD/International Trade Centre and WHO (http://www.intracen.org/mns/pharma.html); *International Drug Price Indicator Guide on Finished Products of Essential Drugs,* Management Sciences for Health in Collaboration with WHO (published annually) (http://www.msh.org*); First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility (*http://www.stoptb.org/GDF/drugsupply/drugs.available.html*).)*

Attached as Annex 44/AIDS.

5.3.2 Human resources costs

In cases where human resources represent an important share of the budget, explain how these amounts have been budgeted in respect of the first two years, to what extent human resources spending will strengthen health systems' capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over. *(Maximum of half a page. Please attach an annex and indicate the appropriate annex number.)*

As previously mentioned the project practically does not envisage incentives or salaries for health care workers since it has been agreed upon that supporting the health workforce is a national priority. In this respect, recently, the MHSP has adopted a special decision on a plan of incentives in terms of financial allowance and stimulation of young doctors to work in rural areas which looks very attractive. Additionally, a decision was taken to remove all existing fees that would prevent people from accesing services and that all services in respect of HIV/AIDS/STIs shall be provided free of charge and largely advertsied. This refers to all services starting with VCT, PMTCT, ART etc. This approach of having free of charge services rendered in the field of HIV/AIDS/STIs lies at the basis of the NAP and as a common practice the government has ensured throughout the last 10 years a steady financing of the staff involved in the filed of HIV/AIDS/STIs such as supporting staff of laboratories, dermatovenerologic services, infectious disease docts, councellors where existent. Additionally, the government has signed an agreement for taking over salaries of staff from youth friendly services and is currently fulfilling obligations under the agreement. Nevertheless, a big share of expenditures under the human resources will be used for trainings and study missions of the health care workers which is expected to result in capacity building. A particular attention will be paid to the issiues of financial and organizational sustainability both for trainings, site visits and conferences and knowledge transfer. Overall, the human resources account for 13% of the total programme budget. The vast majority of human resources costs planned in the programme will be spent on incentives for outreach workers usually hired from among representatives of the vulnerable groups such as outreach to deliver services to IDUs, FSW, peer-to-peer educators, supporting Secretariats of NGO networks. Starting with the third year the greatest majority of costs, including costs for support of

CCM Secretariat Staff will be taken over by the government budget. Human Resources Costs can be found in annex 60/AIDS.

5.3.3 Other key expenditure items

Explain how other expenditure categories (e.g., infrastructure, equipment), which form an important share of the budget, have been budgeted for the first two years. *(Maximum of half a page. Please attach an annex and indicate the appropriate annex number.)*

Following the trends over time in the number of people in need of HAART, and considering the expected one-off full accession of Transnistria to the country's treatment program, the figures reported in the past months have been extrapolated. The amounts asked for the patients in treatment for the first two years took into account the changing patterns of drug prices (usually decreasing as more generics enter the market and bulk procurements are made – economies of scale). There will be one-time procurement of equipment during the first year (e.g., a flowcytometer for the initiation and monitoring of the immune status). More details see in Annex 59/AIDS.

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5.4 Breakdown by service delivery area

Please provide an approximate allocation of the annual budget for each service delivery area (SDA). The objectives and service delivery areas listed should resemble those in the Targets and Indicators Table (Attachment A to the Proposal Form). It is anticipated that this allocation of the budget across SDAs should be derived from the detailed component budget (see section 5.2).

Table 5.4: Estimated budget allocation by service delivery area and objective.

		Budget allocation per SDA (in Euro/US$)				
Objectives	**Service delivery area**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
OBJECTIVE 1: SCALE UP ACCESS TO PREVENTION AND TESTING	PREVENTION SDA 1: Behavioural change communication - mass media	154,845	137,975	171,076	164,576	43,800
	PREVENTION: SDA 2: Prevention of Mother to Child Transmission	152,835	160,219	195,859	238,627	281,395
	PREVENTION SDA 3: Testing and Counseling	138,000	47,000	40,000	40,000	47,000
	SUPPORTIVE ENVIRONMENT: SDA 4 Laboratory	615,092	140,692	272,092	97,992	97,992
	SUPPORTIVE ENVIRONMENT: SDA 5 Blood Safety	147,500	147,500	147,500	147,500	147,500
	PREVENTION: SDA 6 STI diagnosis and treatment	58,568	60,568	58,568	58,568	58,568
	SDA 7: Youth Education and Prevention	111,600	130,100	70,100	313,100	70,100
	PREVENTION SDA 8: Prevention BCC-community outreach to parents	0	43,200	13,200	94,650	23,000

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		Budget allocation per SDA (in Euro/US$)				
Objectives	**Service delivery area**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
	PREVENTION SDA 9- Community outreach to vulnerable groups IDUs	458,700	502,100	361,800	310,600	390,200
	PREVENTION SDA 10: PREVENTION - Community outreach to vulnerable groups FSW	119,720	79,600	79,720	70,600	70,600
	PREVENTION SDA 11: - Community outreach to vulnerable groups LGBT community	22,120	16,400	14,400	14,400	14,400
	SDA 12 PREVENTION SDA - Community outreach to mobile population, migrants and repatriated persons	60,920	54,200	51,200	33,200	33,200
	SDA 13 Supportive environment: Coordination and partnership development (national, community, public-private)	57,900	56,250	56,250	56,250	56,250
OBJECTIVE 2: Enhance and foster universal access of people living with and affected by HIV/AIDS to social and health services, along with combating discrimination and stigma.	SDA 1: TREATMENT: Antiretroviral treatment of (ARV) and monitoring	568,132	690,878	803,992	1,122,117	1,729,485
	SDA 2 SUPPORTIVE	132,000	12,000	12,000	12,000	12,000

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		Budget allocation per SDA (in Euro/US$)				
Objectives	**Service delivery area**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
	ENVIRONMENT: Monitoring Drug Resistance					
	PREVENTION SDA 3: Treatment: Prophylaxis and treatment of for opportunistic infections	38,786	38,786	38,786	38,786	38,786
	SDA 4 TB/HIV collaborative activities: Prevention of TB disease in PLWHA	3,630	3,630	3,630	3,630	3,630
	SDA 5: Care and support for chronically ill	111,800	139,800	118,800	127,800	141,400
	SDA 6: Stigma Reduction in all settings	10,000	20,000	10,000	10,000	10,000
	SDA 7: Support to orphans and vulnerable children	188,350	28,400	28,400	28,000	10,000
OBJECTIVE 3: IMPROVED COORDINATION AND PARTNERSHIP	SDA 1: Human resources	77,100	73,100	53,900	53,900	53,900
	SDA 2 Total Coordination and partnership development (national, community, public-private)	56,900	56,900	56,900	56,900	56,900
	SDA 3 : Information system & Operational research	360,988	126,288	206,688	71,388	110,088
Total:		3,645,486	2,765,586	2,864,861	3,164,584	3,500,194

5.5 Breakdown by implementing entities

Indicate in table 5.5 below how the resources requested in table 5.1 will, in percentage terms, be allocated among the following categories of implementing entities.

Table 5.5 – Allocations by implementing entities

	Fund allocation to implementing partners (in percentages)				
	Year 1	Year 2	Year 3	Year 4	Year 5
Academic/educational sector	0.00%	0.00%	0.00%	0.00%	0.00%
Government	67.00%	71.00%	73.00%	77.00%	82.00%
Nongovernmental / community-based org.	32.00%	25.00%	26.00%	22.00%	18.00%
Organizations representing people living with HIV/AIDS, tuberculosis and/or malaria					
Private sector	1.00%	2.00%	1.00%	1.00%	0.00%
Religious/faith-based organizations	0.00%	2.00%	0.00%	0.00%	0.00%
Multi-/bilateral development partners					
Others. *Please specify:*					
Total	100.00%	100.00%	100.00%	100.00%	100.00%

5.6 Budgeted funding for specific functional areas

The Global Fund is interested in knowing the funding being requested for the following three important functional areas—monitoring and evaluation; procurement and supply management; and technical and management assistance. Applicants are required in this section to separately identify the costs relating to these functional areas. In each case, these costs should already be included in table 5.1. Therefore, the tables below should be subsets of the budget in table 5.1., rather than being additional to it. For example, the costs for monitoring and evaluation may be included within some of the line items in table 5.1 above (e.g., human resources, infrastructure and equipment, training, etc.).

Table 5.6 – Budgets for specific functional areas

	Funds requested from the Global Fund (in Euro/US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Monitoring and Evaluation	207,300	164,700	260,000	158,000	210,800	1,000,800

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	Funds requested from the Global Fund (in Euro/US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Procurement and Supply Management	3,087,081	1,850,860	1,990,115	2,500,708	2,819,944	12,248,708
Technical and Management Assistance	351,105	750,025	614,746	505,876	469,450	2,691,202

Monitoring and Evaluation: *This includes: data collection, analysis, travel, field supervision visits, systems and software, consultant and human resources costs and any other costs associated with monitoring and evaluation.*

Procurement and Supply Management: *This includes: consultant and human resources costs (including any technical assistance required for the development of the Procurement and Supply Management Plan), warehouse and office facilities, transportation and other logistics requirements, legal expertise, costs for quality assurance (including laboratory testing of samples), and any other costs associated with acquiring sufficient health products of assured quality, procured at the lowest price and in accordance with national laws and international agreements to the end user in a reliable and timely fashion. Do not include drug costs, as these costs should be included in section 5.3.1.*

Technical and Management Assistance: *This includes: costs of consultant and other human resources that provide technical and management assistance on any part of the proposal—from the development of initial plans, through the course of implementation. This should include technical assistance costs related to planning, technical aspects of implementation, management, monitoring and evaluation and procurement and supply management.*

LIST OF ANNEXES TO BE ATTACHED TO PROPOSAL *HIV/AIDS*

The table below provides a list of the various annexes that should be attached to the proposal. Please complete this checklist to ensure that everything has been included. Please also indicate the applicable annex numbers on the right hand side of the table.

Section 4 (Component specific): Component Strategy		
4.4.1	Documentation relevant to the national disease program context, as indicated in section 4.4.1.	Annex 20/AIDS National Disease Specific Strategic Plan, National Programme on Prevention and Control 2006-2010, Decision of the Government of the Republic of Moldova 948 of 05.09.2005 Annex 21/AIDS Budget to the National Programme, Decision of the Government of the Republic of Moldova 948 of 05.09.2005 Annex 35/AIDS National Monitoring and Evaluation Plan (health sector, disease specific or other)
4.6	**A completed Targets and Indicators Table**	Attachment A to the Proposal Form
4.6	**A detailed component Work Plan** (quarterly information for the first year and indicative information for the second year).	Annex 43/AIDS
4.6.7 c) *(if common funding mechanism)*	Documentation describing the functioning of the common funding mechanism.	N/A
4.8.3 e) *(where SRs applied but were not selected)*	Name and type of all Sub-Recipients not selected, the proposed budget amount and the reasons for non-selection.	N/A
4.9.2	National Monitoring and Evaluation strategy (if exists)	Annex 35/AIDS
Section 5 (Component specific): Component Budget		
5.2	**Detailed component Budget**	Annex 45/AIDS
5.3.1	Preliminary Procurement List of Drugs and Health Products (tables B1 – B3)	Attachment B to the Proposal Form
5.3.2	Human resources costs.	Attachment B Annex 44/AIDS

5.3.3	Other key expenditure items.	Annex 59/AIDS
5.1 - 5.6 *(if common funding mechanism)*	Available annual operational plans/projections for the common funding mechanism, and an explanation of any link to the proposal.	N/A
Other documents relevant to sections 4-5 attached by applicant:		
1.	- "Financial Needs Assesment in dollar equivalent, Annex to the Budget of the National Programme on Prevention and Control of HIV/AIDS/STIs 2006-2010, Government of the Republic of Moldova Government Decision no. 948 of 05.09.2005	Annex 22/AIDS
2.	Situation Analysis "Socio-Economic impact of HIV/AIDS in Moldova, draft, 2006	Annex 23/AIDS
3.	Economic Growth and Poverty Reduction Strategy Paper	Annex 24/AIDS
4.	Universal Access Initiative Moldova 2006	Annex 25/AIDS
5.	Mid-Term Review of the National AIDS Programme 2001-2005	Annex 26/AIDS
6.	WB Mid-Term Review of the WB HIV/AIDS/TB Project	Annex 27/AIDS
7.	HIV sentinel surveillance in high risk groups in Azerbaijan, Republic of Moldova and in the Russian Federation, WHO, 2004	Annex 28/AIDS
8.	National HAART Protocols, Moldova, 2005	Annex 29/AIDS
9.	Republic of Moldova –Summary Country Profile for Treatment Scale-Up, WHO 2005	Annex 30/AIDS
10.	HIV/AIDS Surveillance Moldova, IDUs, Inmates and Commercial Sex Workers, 2004	Annex 31/AIDS
11.	Report of the Government of the Republic of Moldova to UNGASS	Annex 32/AIDS
12.	"Partnerships and NGOs networks in area of HIV/AIDS, STDs, Drug Abuse and TB: Succseful experiences of the Republic of Moldova at national, regional and international level"	Annex 33/AIDS
13.	Republic of Moldova –Summary Country Profile for Treatment Scale-Up, WHO 2005)	Annex 34/AIDS
14.	WHO Report on Scaling Up Access for Transnistria, 2006	Annex 36/AIDS
15.	National PMTCT Protocols	Annex 37/AIDS
16.	2-nd Generation HIV/AIDS Surveillance Protocols, 2006	Annex 38/AIDS

17.	MHSP Activity Review Report 2005	Annex 39/AIDS
18.	Financing Sources and other Ways to Support the activities/projects in the social field.	Annex 40/AIDS
19.	Young People Health and Development, KAP Study, 2005	Annex 41/AIDS
20.	DHS, Preliminary Report, 2005	Annex 42/AIDS
21.	Workplan for the Global Fund Proposal	Annex 43/AIDS
22.	Procurement Plan, Attachment B	Annex 44/AIDS
23.	Detailed budget to the proposal	Annex 45/AIDS
24.	Target and Indicators Table, Attachment A	Annex 46/AIDS
25.	Draft Law on AIDS, Republic of Moldova, 2006	Annex 47/AIDS
26.	Communication Strategy on AIDS, Moldova	Annex 48/AIDS
27.	Situation and Response Analysis in HIV/AIDS, 2005	Annex 49/AIDS
28.	AFEW Behavioural Study, Knowledge of AIDS and Attitudes Towards PLHA	Annex 50/AIDS
29.	Concept Note on the Health Information System	Annex 51/AIDS
30.	National Health Policy Concept	Annex 52/AIDS
31.	“Report on HIV/AIDS Situation, NAC, 2006	Annex 53/AIDS
32.	Detailed Description of Activities	Annex 54/AIDS
33.	Principal Recipient Instituional and Programmatic Assesment	Annex 55/AIDS
34.	Principal Recipient M&E Assesment	Annex 56/AIDS
35.	Programme Gap Analysis Table	Annex 57/AIDS
36.	National Standard in HIV Surveillance	Annex 58/AIDS
37.	Key Expenditure Items	Attachment B to the Proposal Form Annex 59/AIDS
38.	Human Resouces Costs	Attachment B to the Proposal Form Annex 60/AIDS
39.	WHO Annual HIV/AIDS Survey, WHO, 2005	Annex 61/AIDS
40.	WHO Annual HIV/AIDS Survey, WHO, 2006	Annex 62/AIDS

41.	WHO Annual STI Report, WHO, 2005	Annex 63/AIDS
42.	WHO Annual STI Report, WHO, 2006	Annex 64/AIDS
43.	Description of the Health System in HIV/AIDS, 2004	Annex 65/AIDS