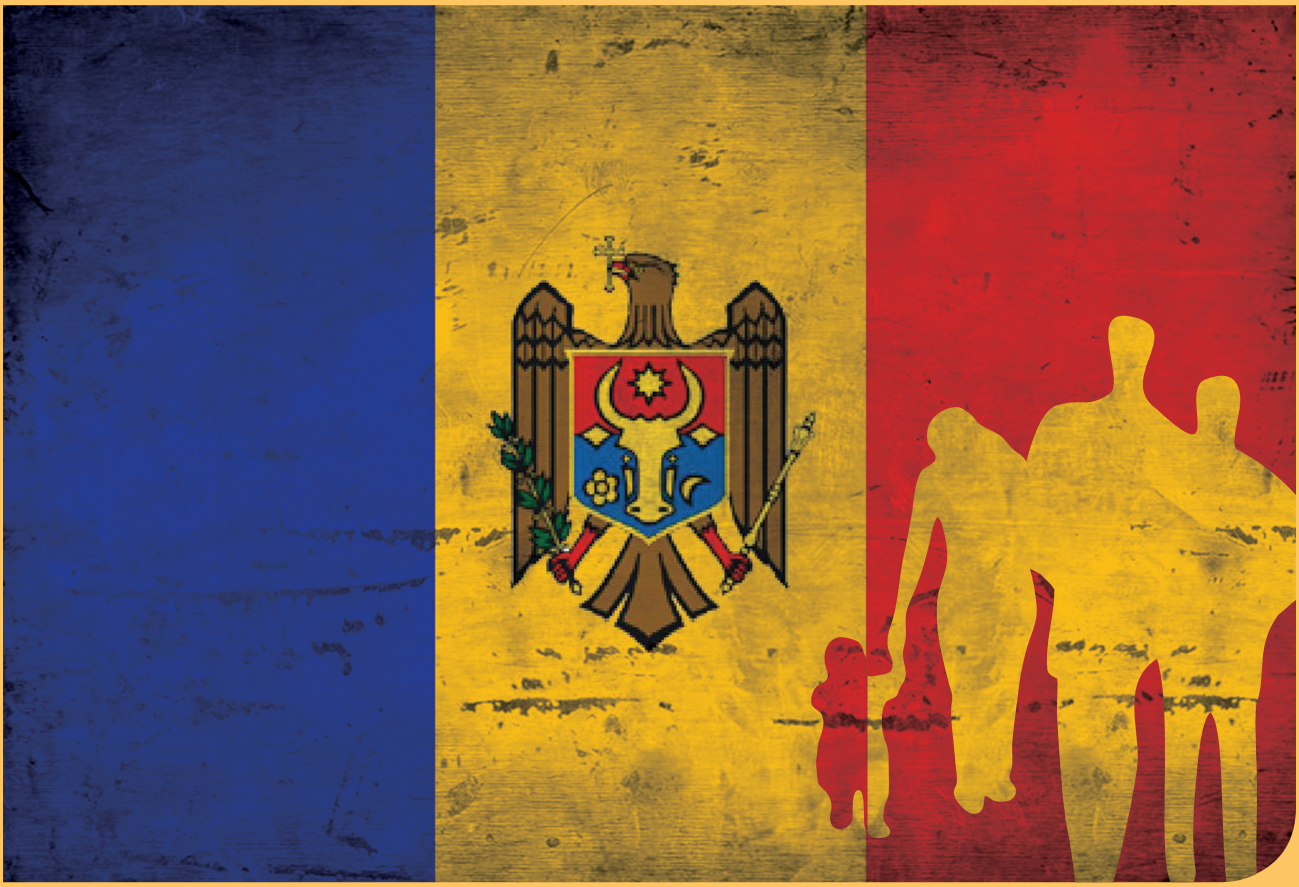
POSITIVE HEALTH, DIGNITY AND PREVENTION IN MOLDOVA:

FINDINGS AND RECOMMENDATIONS FROM STUDIES LED BY PEOPLE LIVING WITH HIV



GNP+ GLOBAL NETWORK OF PEOPLE LIVING WITH HIV

UKaid from the British people

Acronyms

AIDS:	Acquired Immunodeficiency Syndrome
DFID:	Department for International Development (UK Government)
ECHR:	European Convention on Human Rights
GDP:	Gross Domestic Product
GIPA:	The Greater Involvement of People with HIV
GNP+:	Global Network of People Living with HIV
HIV:	Human Immunodeficiency Virus
IDOM:	Institutul pentru Drepturile Omului din Moldova/Moldovan Institute for Human Rights
IDUs:	Injecting Drug Users
LPLH:	League of People Living with HIV in Moldova
MDGs:	Millennium Development Goals
MSM:	Men having Sex with Men
NCPH:	National Centre for Public Health
NAP:	National AIDS Programme
NDS:	National Development Strategy
NGO:	Non-Governmental Organisation
PLHIV:	People Living with HIV
PMTCT:	Preventing Mother-to-Child Transmission
STIs:	Sexually Transmitted Infections
SW:	Sexual Worker
UNAIDS:	Joint United Nations Programme on HIV/AIDS
VCT:	Voluntary Counselling and Testing
WAC:	World AIDS Campaign

Contents

Overview

The Republic of Moldova is the poorest country in Europe (in terms of per capita income). The country is divided into 32 districts, five municipalities, the autonomous territorial region of Gagauzia and the administrative-territorial region located on the left bank of the Dniester River known as Transnistria.

While Moldova registered a growth in GDP in recent years, unemployment remains high, wage arrears increased dramatically and external migration continues. There is a widening gap between rural and urban areas and also high levels of gender inequality. Moldovan women are mostly employed in low-paying jobs and occupy lower positions in the job hierarchy where they are employed.

People of Moldova

- Around 48% live in urban areas
- The average birth rate is 1.5 children per woman
- Life expectancy is 69 years
- 29 % live below the poverty line[1]

The epidemic

The HIV epidemic in the Republic of Moldova is a concentrated one, mainly affecting people who use drugs. The results of the last HIV sero-prevalence survey among people who use drugs carried out in 2009 showed an HIV prevalence of 16.4% in the capital of the country. However in the last three years, the number of newly registered HIV cases among the tested people who use drugs is decreasing, according to the 2012 *Country Progress Report*.[2]

There is evidence of spread of the infection in the general population. According to the estimations made in 2012 there are 1882 new estimated HIV cases (1283 cases on the right bank and 599 cases on the left bank of the Nistru River). In the last 5 years, sexual transmission is the main probable route reported by newly registered HIV cases in the Republic of Moldova.

Apart from key population groups such as injecting drug users (IDU), sex workers (SW) and men who have sex with men (MSM), other subpopulation groups have become increasingly affected by HIV, such as the youth and the migrant community. Increasingly, women in stable partnerships are at risk due to low-level condom use. The percentage of women living with HIV increased from 24.1% % in 2001 to 52.3% in 2011, pointing to the increased vulnerability of women.[3]

Moldova is recognised in the region for its successful implementation of Harm Reduction Programmes for key populations at risk. There are information, education, outreach, and needle exchange activities, as well as referrals to medical and social services. Methadone substitution treatment is provided in a few sites in four localities and in some penitentiary institutions. But the Government acknowledges that there is uneven coverage and low quality of services for key populations.

The 2012 *Country Progress Report* sees “ensuring access to HIV treatment…and decentralisation of treatment services and HIV care throughout the country” as some of the most important achievements nationally. Despite this however, less than a third (29.3%) of those needing antiretroviral treatment are currently receiving it.

[1] All data http://hdr.undp.org/en/media/HDR_2011_EN_Tables.pdf
[2] REPUBLIC OF MOLDOVA PROGRESS REPORT ON HIV/AIDS January 2010 – December 2011, 2012
[3] Government of the Republic of Moldova, National AIDS Centre Epidemiological Bulletin 2011 and National Programme to Prevent and Control HIV/AIDS and STIs for the years 2011-2015.
Accessed online: www.aids.md/aids/index.php?cmd=item&id=250&lang=ro

National Laws and Policies

The Government's policyframework guiding the national, multi-sectoral HIV response is implemented through the National Programme on Prevention and Control of HIV/AIDS and STIs (NAP). A new National Programme on Prevention and Control of HIV/AIDS and STIs 2011–2015 was developed through a participatory, evidence-based strategic planning process and approved by the Government on 16 December 2010. The current NAP follows the previous three programs implemented in years 1996-2000, 2001-2005 and 2006-2010.

The NAPs have been largely funded by international donor assistance (including substantial funding from the Global Fund - Rounds 1, 6 and 8 - to community-based organisations), with the Moldovan government contributing about 20 per cent overall.

Response to HIV/AIDS and tuberculosis in the Republic of Moldova is part of the National Ministry of Health programs, other ministries and health institutions with central government agencies / local authorities and civil society. **However, the sustainability of national programs to combat HIV and TB are at risk due to changes in the policy of funding from the Global Fund. Activists are concerned that, as of now, there are no guaranteed funds for the procurement of antiretroviral medicines from March 2014 onwards.**

The current NAP has been designed along five public health principles:

1. based on evidence generated and analysis of previous NAP,
2. promotes human rights, non-discrimination, equity and social inclusion,
3. is gender sensitive that takes into account the responsibilities and opportunities of men and women,
4. ensure universal access to HIV prevention, treatment, care and support, through setting and tracking national targets,
5. ensuring rights of people living with HIV and involving their representatives in NAP design, implementation and evaluation to strengthen the quality and efficiency of national response to HIV.

Since 2002, the legal framework surrounding HIV has seen some progressive developments. Many social policies and legal frameworks demonstrate country's political commitment to responding to the HIV epidemic, including those related to general health policy and HIV issues. HIV prevention is an integral part of a number of broader national initiatives, including the Government's Activity Programme 2009-2013; the National Development Strategy (NDS) for 2008-2011 that aims to achieve MDG 6; the National Health Policy approved in 2007; and the National Strategy for Health System Development 2008-2017, which aims at decreasing HIV incidence by consolidating actions and policies.

The money

As highlighted in the 2012 *Country Progress Report*, expenditures for the national AIDS response registered an increase of around 27.5 million MDL (+20,3%) in 2011 compared with 2010 and reached the value of 162.9 million MDL or 13,881,886 US dollars, of which, public financial resources constituted 37%. International resources for this period constituted 61% and national private resources constituted 2%. **The share of public expenditure has been falling from 47% in 2009 to 37% in 2011.**

In 2011, the largest share of the budget was allocated to Prevention(46%), followed by Treatment and Care (25%), Programme Management (16%), Enabling Environment(6%), Human Resources (5%), and Social Mitigation (2%).

According to the 2009 Human Development Report,[4] public expenditure on health was 4.2% of the GDP and private expenditure on health 3.2%. There are about 264 physicians per 100,000 people. Health expenditure was 138 US$ (PPP) per capita in 2004.Since the breakup of the Soviet Union, the country has seen a decrease in spending on health care and, as a result, the tuberculosis incidence rate in the country has grown. Because of this, Moldova is struggling with one of the highest incidence rates of multidrug-resistant tuberculosis in the world.[5] A particular problem is the prevalence of HIV infection among new cases of tuberculosis, which is 42 times higher than the prevalence of HIV infection in the general population.[6]

Human rights

Like other countries, the Government of Moldova is a party to the main human rights conventions. Although the Constitution of the Republic of Moldova does not contain a specific non-discrimination clause with regard to HIV status, it states that everyone should be treated equally before the law. Furthermore, as a result of significant efforts made by national stakeholders, including the Ministry of Health and other line ministries, the National Centre for Public Health (NCPH), with the support of civil society and international organisations, the Government has developed harmonized national standards and legal instruments related to HIV prevention and control, as listed above. However, in practice, the enforcement of these normative documents is far from perfect and incidences of stigmatisation and discrimination can still be observed.

Improving Laws

With the support and advocacy of the UN Agencies in Moldova and NGOs, the Ministry of Health initiated a working group to revise a series of laws, including the Law on Prevention and Control of HIV/AIDS, the Law on Migration, the Law on the Legal Regime of Foreigners, as well as subordinate normative documents (i.e. Instruction on HIV Testing of Young People before Registration of Marriage, Instruction on HIV Testing of Pregnant Women, etc.). In accordance with the Ministry of Health Order Nr. 36 dated 17.01.2011, a series of amendments to the provisions were made to remove the discriminatory elements of the aforementioned legal documents and ultimately approved in 2012. In parallel, after controversial discussions and debates, and as a result of advocacy by civil society, the Law on Ensuring Equality[7] - or the Anti-Discrimination Bill - has been developed and adopted by Parliament on 25 May 2012. The Bill guarantees the right to privacy; the right to non-discrimination and equality of people living with HIV; and the right of people living with HIV to freedom of movement.

[4] Human Development Report 2009, Moldova, UNDP
[5] Epidemiology of anti-tuberculosis drug resistance 2002–07, Global Project on Anti-Tuberculosis Drug Resistance Surveillance, The Lancet - 30 May 2009
[6] Programul National Tuberculosis Control 2011-2015. www.pas.md
[7] The full text of the draft Law on Ensuring Equality can be found on: http://parlament.md/ProcesulLegislativ/Proiectedeactelegislative/tabid/61/LegislativId/1203/Default.aspx

The Moldovan Government developed and approved the Law on the Prevention and Control of HIV/AIDS (Law N° 23-XVI dated 16.02.2007[8]), which is largely considered to be one of the few laws developed in compliance with the human rights-based approach. This Law is currently the only binding document that provides a legal basis for the protection of the rights of people living with HIV; including non-discrimination of people living with HIV at the work place, provision of medical treatment and services, as well as education. It also contains provisions that ensure the right to confidentiality of people living with HIV, as well as voluntary counselling and testing. The Law provides for prevention measures for several sub-population groups; including children and youth, women, including pregnant women, people with disabilities, people who use drugs, representatives of armed forces/uniformed services, prisoners, as well as mobile groups (immigrants, emigrants, refugees and asylum seekers). However, the law, in its final and adopted version does not provide specific provisions on prevention measures for other vulnerable groups, such as, MSM and sex workers.

Despite the many gains won by activists, there remains concern about the potential criminalisation of HIV transmission as included in the Criminal Code (amended by Law N° 985-XV dated 18.04.2002). Article 212 of the Code states that people living with HIV who intentionally transmit HIV or a venereal disease, are subject to criminal offence and can be sentenced from 1 to 8 years of imprisonment. This article was largely disputed but it still remains in the Criminal Code.

Women and other key populations

The Constitution of the Republic of Moldova proclaims equality of women and men before the law. The Law on Ensuring the Equality between Women and Men (2006), and the National Plan for Promotion of Equality between Women and Men in Society 2006-2009 has led to the establishment of a specific legal and regulatory framework in the field. Moldova is also a signatory to international covenants promoting women's rights.

The National Strategy on Gender Equality 2008-2015 highlights pervasive gender inequality across political, social and economic spheres and sets out specific objectives of the policy on gender equality in the Republic of Moldova until 2015, as well as priority actions in the field.

Moldova became one of the first countries in the region to address domestic violence with specific legislation in both the civil and criminal systems. In 2008 the Republic of Moldova passed the Law on Preventing and Combating Family Violence (Law 45), which provided a foundation for increasing access to justice and safety for domestic violence victims. However, due to the lack of specific directives on requesting, issuing, and extending protective orders, Law 45 was rarely implemented in its early years but in 2010 the necessary directives were passed.

As a 2012 report[9] published by Advocates for Human Rights summarises "while the government of Moldova has taken important steps to combat domestic violence, monitoring revealed that there is an urgent need for reform of legal provisions, additional resources for shelters and services for victims, and multi-sector training".

In 2011 following recommendations made as a result of an external evaluation of the NAP, there is greater focus on key populations and objectives include the prevention of transmission of HIV, Hepatitis and STI and reducing the impact of the epidemic through offering treatment, care and support.

[8] This Law was amended as per provisions of the Law No. 76 of 12.04.2012. More details can be found on: http://lex.justice.md/md/343384/

[9] Implementation of the Republic of Moldova's Domestic Violence Legislation, A Human Rights Report. The Advocates for Human Rights, 2012

According to national legislation, having sex with people of the same sex does not constitute a criminal offence. However, according to the representatives of GENDERDOC-M,[10] there are cases of discrimination of the LGBT community on sexual orientation grounds; this discrimination is further exacerbated where MSM living with HIV are concerned. MSM living with HIV, although few in number claim that discrimination outside and inside the community of people living with HIV is even more acute than in the case of other people living with HIV.

In 2011, the HIV prevalence among people who use drugs constituted 8,04%.[11] Moldova does not have any laws or regulations that prohibit needle exchange programmes for injecting drug users.[12] On the contrary, it has one the most progressive legal frameworks that promotes risk reduction and provides for the decriminalisation of drug possession. Since 2004, there has been a marked shift in drug enforcement strategies towards prioritising the prosecution of drug dealers and the identification of drug trafficking networks and drug producers, rather than the criminalisation of drug use. In addition, in 2008, personal drug use was decriminalised. Major amendments have been made to the Criminal Code and the Administrative Offences Code. These reforms include the promotion of alternative punishments to imprisonment and prohibit arrest for personal drug use. These now constitute an administrative rather than a criminal offence. The illegal purchase or possession of narcotic drugs or psychotropic substances in small quantities without the intention to distribute them, as well as their consumption without a medical prescription, is sanctioned by a fine or community service.

[10] Global Criminalisation Scan, Moldova Report, League of People Living with HIV of Moldova, March 2012
[11] Government of the Republic of Moldova, National AIDS Centre Epidemiological Bulletin 2011
[12] Provisions related to the needle exchange programme can be found in the Law on Prevention and Control of HIV/AIDS, NAP 2011-2015, Anti-Drug National Policy 2011-2018

Human rights

Rights, laws and policies

- Over half of respondents had heard about the UNGASS Declaration[13] and the national HIV law that protects the rights of people living with HIV, with 35.5% having heard about both.
- Over one fifth of respondents perceive that their rights had been violated in the previous year and only 36% of them had sought legal help.
- 16.4% of respondents reported that they were subjected to one or more discriminatory practices by governmental, legal, and/or medical institutions. The most frequent violation, reported by 14.9% of respondents, was having been forced to submit to a medical procedure, including HIV testing.
- Nearly three quarters of respondents indicated that they had felt unable to influence policies, laws and programmes at the local, national or international levels in the previous year.

Source: 2011PLHIV Stigma Index report [14]

Violations and discrimination

"In May 2010, an acquaintance with whom I discussed my HIV status told me about the vacancies in the firm where she used to work. I got the job and then my brother and mother (who are HIV negative) also got jobs with the same firm. After several working shifts, my acquaintance spread the word about my HIV positive status among our colleagues, and this information also reached the firm's management. The director of the firm fired me, as well as my brother and mother without paying our salaries. The reason provided by the director was that, "HIV positive people have no place among healthy people". I ended up with a nervous breakdown, depression and deprivation of my only income source." Silvia, 33, Balti, Human Rights Count 2011

Research for the *Human Rights Count*[15] study show that in the 99 provided cases, a total of 190 rights were violated (some respondents reported more than one incident). Most violations (83 cases) took place during 2006-2010. When asked why they thought the violations had occurred, almost all the respondents (97%) stated that it was because of their HIV-positive status. When asked whether people living with HIV reported their human rights violation cases to the relevant government institutions, 21 per cent declared that they had reported their cases, while 73 per cent did not report their cases at all. These findings indicate that despite of the development and establishment of legal and human rights protection mechanisms in Moldova, people living with HIV do not benefit from effective protection of their rights.

The weak economic status, as well as poor legal education of people living with HIV makes them unable to effectively demand the protection of their rights. Most of people living with HIV do not have recourse

[13] The 2001 Declaration of Commitment at: http://www.unaids.org/en/aboutunaids/unitednationsdeclarationsandgoals/2001declarationofcommitmentonhivaids/
[14] The PLHIV Stigma Index, Moldova2010-2011, League of People Living with HIV of Moldova, October 2011
[15] Human Rights Count! Moldova Country Assessment 2011, League of People Living with HIV of Moldova, March 2012

to state institutions for the protection of their rights. At best, they get access to legal aid services through NGOs such as IDOM or Credinta, which provide such services under the auspices of different specialised projects funded by the Global Fund. This is partly due to the fact that there is no clear human rights protection mechanism in place for people living with HIV. Although the Republic of Moldova has a National Legal Aid Council and an Ombudsman Institution (Human Rights Centre), according to this survey, there is little evidence that people living with HIV accessed or benefited from the services provided by these institutions when it comes to protecting their rights and confronting the perpetrators.

Graphic 1

Stigma and exclusion

"I used to work abroad. When I got pregnant I decided to come home and deliver the baby in my home village. I passed the medical tests and I was diagnosed with HIV. My HIV status was communicated to the primary care clinic in our village. The nurse, who was working there, disclosed my HIV status to somebody else. Everybody in the village found out and my normal life ended. I couldn't walk in the streets, shops, cafeteria, primary care clinic, etc. Everybody was asking me to leave the places and called me a drug user and prostitute. I understand that I have no future in this village. I can't get a job, have my child placed in the kindergarten, or have a normal life. " **Olga, 28, Criuleni, Human Rights Count! 2011**

The findings of the *PLHIV Stigma Index* study in Moldova show various forms of internal stigma and isolation of PLHA. HIV status served as a motive for not having children; every third respondent decided not to build a family. A large number of respondents (27%) refused medical services and 17%avoided visits to the clinics and hospitals.

Nearly 40% of respondents reported that they had been gossiped about at least once in the last year with half indicating that it occurred, in whole or in part, because of their HIV-positive status. Significant percentages of respondents reported having been verbally insulted/harassed/threatened (19.4%); physically assaulted or threatened (7.5%); and/or physically assaulted (6.2%) at least once in the last year.

There was discrimination reported by respondents in the areas of accommodation, employment and education.

Graphic 2

- While approximately 84.9% (n=343) of respondents had not been forced to change residence or being unable to secure rental accommodation in the previous 12 months, 15.1% (n=60) had. Of these, five (8.3%) thought that the reason was their HIV-positive status; while 46 respondents (76.7%) did not identify the cause as HIV status.
- Of those who were employed (54.3% n=219,) in the last 12 months, 79.9% (n=175) did not lose their job or income source, though over one in five (20.1%, n=44) did. Of those who have been employed in the last 12 months and changed/lost their job (n=44), 81.8% (n=36) identified causes other than HIV-positive status. Furthermore, 4.6% (n=10) of respondents reported being refused employment due to their HIV-positive status, and a further 4.6% (n=10) reported changes in their job responsibilities or being refused a carrier promotion due to their HIV-positive status.
- From a sample of 403 respondents, none indicated that they had been dismissed, suspended, or prevented from attending an educational institution in the previous 12 months. Furthermore, from a sample of 403 respondents, only 4 (1%) had experienced their child(ren) being dismissed, suspended or prevented from attending an educational institution because of the respondent's HIV status during the last 12 months. Over half of the respondents (53.7%, n=216) reported no such problems in last 12 months and for 45.2% (n=182) the question were not applicable.

- Respondents' experience of stigma and discrimination when accessing health services was more pronounced. 13.3% (n=52) of respondents reported being denied health services, including dental care, at least once in the last 12 months; while 60.9% (n=238) reported no such refusal and 25.8% (n=101) did not seek services in last 12 months. This means that over one quarter did not receive any HIV-related or other care in the last year. Furthermore, after excluding this last category, about one fifth (18.5%, n=52) of people living with HIV who sought health services in last 12 months were refused due to their HIV status. While males more frequently reported accessing health services in last 12 months (80.0%, n=156) compared to females (68.6%, n=142); the latter reported being denied services more frequently due to their HIV status (21.1%, n=30) than males (16.0%, n=25).
- Only 1.7% (n=7) of respondents reported having been refused family planning services in the last 12 months with 53.2% (n=214) experiencing no difficulties and 45% (n=181) had not sought such services. Furthermore, when excluding the latter category, of those respondents who had sought family planning services in the last 12 months, 3.2% (n=7) had been refused. Furthermore, 2.7% of respondents (n=11) reported being refused sexual and reproductive health services in the last 12 months. These results should be viewed in the context of over 80% of respondents (80.3%) reporting being sexually active; with little difference between males (81.4%) and females (79.1%); and underscore the need for awareness raising of SRH among people living with HIV.

Key populations

The *PLHIV Stigma Index* study found differences in the percentages of respondents identifying as belonging to key populations when disaggregated by length of HIV diagnosis. Trends include:

- a reduction in the percentage of people identifying as people who use drugs e.g. 75% for those living with HIV for 15 or more years compared to 11% for those living with HIV for 4 or less years
- a reduction in the percentage of people identifying as prisoners e.g. 51% (for those living with HIV for 15 or more years compared to 13% for those living with HIV for 4 or less years
- an increase in the percentage of people identifying as migrants e.g. 26% for those living with HIV for 4 or less years compared to 0% for those living with HIV for 15 or more years.

Empowerment of people living with HIV – the GIPA Report Card

What is Greater Involvement of People living with HIV (GIPA)?

The GIPA principle was endorsed by 192 United Nations member states in 2006.The origins of the GIPA principle started in 1983 in Denver (US), when people living with people living with HIV first voiced and demanded that people living with HIV should be included at every level of decision-making. This became known as the Denver Principle, and it states that: *"PLHIV be involved at every level of decision–making; for example, serve on the boards of directors of provider organisations, and participate in all AIDS-related meetings with as much credibility as other participants, to share their own experiences and knowledge"* (UNAIDS 1999).

Research for the GIPA Report Card[16] indicates that although the GIPA principle has not become part of the official lexicon, its spirit and intention is present in regulations for HIV prevention and control that stipulate that people living with HIV must participate in the process of developing, implementing and evaluating such measures. This is specifically included in principle 5 of the National Programme on

[16] GIPA Report Card Moldova Country Assessment 2010, League of People Living with HIV of Moldova, October 2011

Prevention and Control of HIV/AIDS and STIs for 2011-2015. This study demonstrates that the principle of better integration of people living with HIV in decision-making (GIPA) is perceived as the formal inclusion of people living with HIV in the national structures to combat HIV.

The National HIV and AIDS Plan

The majority of respondents agreed that the GIPA principle is included in the National Plan to Combat AIDS and that people living with HIV participated significantly in the development of this Plan. However, only 2 of the 18 respondents believe that there is a national plan for implementing the GIPA principle in Moldova.

GIPA at National and Regional Levels

The prevailing opinion is that the GIPA principle was properly considered when planning activities at the national and regional levels. Still, respondents were ambivalent about the level of actual participation of people living with HIV in decision-making.

> **"In fact, involving people living with HIV is formal and made only to be recorded in the proceedings to follow international recommendations! After signing the documents (to apply or participate in the preparation of the Plan) they are not informed about the progress of programmes. Representatives of people living with HIV are not key players and are limited in influence on policy issues, in particular those regarding participation in making decisions on financing. Their potential is not developed enough and their organisations lack coordination in their actions on changing policy towards significant participation."**

Policy Development

Regarding the stage at which people living with HIV are most involved in programmes, the majority of respondents selected the conception stage (five respondents) or the development stage (seven respondents). It was hard to assess HIV-positive women's participation in the process. Some respondents completely deny it happens, citing the absence of networks and organisations of HIV-positive women in the country, while others state that HIV-positive women have participated as representatives of the PLHIV League.

Universal Access and UNGASS commitment

Almost all respondents interviewed were aware of universal access commitments but not all were sure if the government had set national targets. Only about a fifth of the respondents strongly agree and about 55% somewhat agree that people living with HIV were meaningfully involved in the universal access target-setting process. Most respondents feel they are familiar with UNGASS and international commitments to the HIV response from the Republic of Moldova. A large proportion of respondents (13 out of 18) noted that the organisations they represent are actively involved in the preparation of the UNGASS report.

Representation and Networks of People Living with HIV

Nearly 40% of respondents were not sure or disagreed that people living with HIV are represented in one way or another on various decision-making bodies at national, regional and local levels. However, most felt that the representatives were effective and there was good communication with the networks.

Barriers to Involvement

When asked to select the three greatest barriers to the greater involvement of people living with HIV, half the replies were in one way or another connected to the explicit discrimination or fear of discrimination, stigma and rejection by family, friends and community.

Health rights

Prevention, Treatment & Care

Current national statistics (2011)[17] show there is still much to be done for Moldova to meet its national and international targets on universal access to prevention, treatment and care for people living with HIV.

- 14.5% have had an HIV test in the past year and know the result
- 74.5% pregnant women living with HIV received ARV prophylaxis to prevent vertical transmission of HIV
- 29.31% of people living with HIV and needing antiretroviral treatment received it

The discontinuation of funding from the Global Fund from 2014 onwards threatens the sustainability of the efforts initiated to promote the rights of people living with HIV; as well as the delivery of legal and medical services, including ARV treatment. Also, Moldova has recently adhered to the WTO TRIPS agreement, which requires the country to switch to brand name drugs and could increase the costs of ARV treatment. Under these circumstances, people living with HIV could face significant challenges in accessing effective medical services, ensuring that their rights are protected and recognised, and in their fight against discrimination and stigmatization.

Testing and diagnosis

12.4% of respondents in the *PLHIV Stigma Index* were referred for HIV testing when already symptomatic. **About one quarter (26.6%) reported being tested without their knowledge, 12.7% accepted HIV testing under pressure and for 12.4% testing was forced or mandatory.** Just under one in five respondents (19.9%) received both pre- and post-test counselling; however, over a third (37.6%) received no counselling at all.

Disclosure and confidentiality

Respondents reported that someone else had disclosed their HIV status to their health care workers (68.5%), friends (27%), other family member (24.1%), permanent partner (12.3%), social workers and other counsellors (11.4%); showing significant levels of breaches of confidentiality. **Overall half the respondents reported that a health care professional (for example, a doctor, nurse, counsellor, laboratory technician) had told other people about their HIV status without their consent.**

Treatment

Most of the respondents indicated that they could access ART if needed. 68.5% of respondents had discussed HIV treatment options and 41.9% had discussed other subjects such as sexual and reproductive health, sexual relations, emotional well-being, drug use, etc., with a health care professional during last 12 months.

[17] REPUBLIC OF MOLDOVA PROGRESS REPORT ON HIV/AIDS January 2010 – December 2011, 2012

IN FOCUS: Sexual and reproductive rights of women living with HIV

Knowing our rights

While the majority of the respondents in the SRHR study[18] agreed that people living with HIV had sexual and reproductive rights, there were a significant number who did not agree that they had the right to freely decide on sexual relations and whether or not to have children. The study also revealed that a) just a minority of people living with HIV are aware that their sexual and reproductive rights are protected, (in existing law) and b) the information about their rights is not disseminated by medical staff who should be best able to provide correct and comprehensive information. 20% of the respondents had direct experience from having their sexual and reproductive rights violated by medical staff and other public employees.

Reproductive choices

The study sample showed much lower birth rates and number of children among women living with HIV than the national average. Some participants stated that they do not want more children, as their health does not allow them to give birth to healthy children. Some mothers mentioned that should they have known that they had HIV, they would not risk giving birth since there is no guarantee that the child will be born healthy. Although usually, women living with HIV are pressured by medical staff to terminate the pregnancy, there are also cases when medics tried to convince the women to keep the child even though she requested termination for socio-economic reasons.

Access to tools and services

HIV status caused unequal access to maternity services for women living with HIV. Only 20% of the women who responded to the question believe that women living with HIV may receive the same care and maternity services as other women.

Most respondents felt that access to male condoms was not a problem unlike access to female condoms and other kinds of contraceptives. Services most accessible for people living with HIV were: testing for syphilis; treatment of STIs and care; information and consulting on prevention of STIs. However, access to substitution therapy with opiates was highlighted as problematic.

Safer sex and family planning

Taking into account the fact that HIV is sexually transmitted, it is problematic that two thirds of the respondents were not provided any information regarding safer sex. Furthermore, a majority know no program or services encouraging men to seek services for HIV testing and counselling, family planning and advice on issues relating to sexual and reproductive health. While most think that family planning was primarily a woman's issue, some also think men do not seek services for reproductive health because of stigma and discrimination or a lack of understanding of their role in preventing HIV and undesired pregnancies.

[18] A Study on the Sexual and Reproductive Health and Rights of Women Living with HIV, Moldova, League of People living with HIV, July 2012

Stigma and discrimination

Out of sixteen women who gave birth interviewed, six had experienced stigma or discrimination in health care settings (either in antenatal clinic or family health centres). Three of them are the women who were diagnosed with HIV before pregnancy, two during the last pregnancy. However, many stated that the attitude of medical staff to HIV positive women and services offered to them have improved significantly over the years.

Reproductive rights denied

In the *PLHIV Stigma Index* study, only half of the respondents (52.6%)had ever been counselled on reproductive health and childbearing, since learning their HIV status. Over one quarter of respondents (26.8%) had been advised to have no more children and 7.7% had sterilisation suggested to them. **Almost one third of the female respondents (29.6) who have been pregnant in last 12 months reported pressure from the health care staff to undergo an abortion.**

In relation to preventing vertical transmission of HIV, of 64 pregnant women, 18.3% indicated that they did not know that treatment to prevent vertical transmission existed, 4.8% did not have access to this treatment, and 1.9% had been refused this treatment.

The above, confirm key findings from earlier research[19] conducted by NGO *Childhood for Everyone* in 2009:

- A majority of HIV-positive women interviewed said that the quality of pre- and post-testing counselling is very poor.
- Knowledge about prevention of vertical transmission in general was relatively limited among focus group participants, including the importance of adherence to antiretroviral regimens and awareness of the risks of mixed feeding.

[19] Failing Women, Failing Children: HIV, Vertical Transmission and Women's Health, ITPC December 2009

Economic and Social Rights

Poverty and unemployment

The effects of poverty on the sample of people living with HIV who took part in the PLHIV Stigma Index study are clearly evident. The average number of persons living in a respondent's household, excluding the respondent, was 2.6 persons. In terms of economic resources, the study population's average per household member income of US$53.8 per month is considerably less than the national average of US$ 88.6.[20] **In addition, the level of unemployment among respondents of 52.9% is significantly higher than the national average of 7.4%.**[21] Females more frequently reported being unemployed (60.4%) than males (44.9%).

Most of the human rights violations against people living with HIV recorded in the Human Rights Count study are also related to such basic rights, as the right to privacy and the right to health, as well as socio-economic rights. According to the sociological study "The Socio-Economic Status of the PLHIV",[22] launched by the Soros-Foundation Moldova in 2012, most people living with HIV live in poverty.

However, this is not being addressed in national policy. Two thirds of respondents in the study for the GIPA Report Card felt that that of national poverty reduction strategies had not taken into account the differing impact of HIV on women and men and many agreed that people living with HIV were not sufficiently involved in the development of such policies.

> **"In our country, people living with HIV are not protected socially (no pensions and other public assistance). People living with HIV receive care and treatment free of charge only out of funds from outside the country (Global Fund)".**

Nutrition and food security

35% of the respondents in the *Stigma Index* had felt hungry at least once in the last month for an average 10 days a month. Furthermore, nearly half of unemployed respondents (47%) reported household food deficits during the last month, for a period of 5 days on average.

Education

Over 80% of respondents have an educational level of secondary school or lower with some 12.2% of respondents reporting a university or higher degree. Only 4.2% of respondents reported no formal

[20] www.statistica.md

[21] According to the National Bureau of Statistics of the Republic of Moldova official unemployment rate (as of February 2011) was 7.4% - accessed athttp://www.indexmundi.com/moldova/unemployment_rate.html

[22] More details on the sociological survey "The Socio-Economic Status of the PLHIV" can be found on: http://soros.md/files/publications/documents/Raport_Soros_2012_statut%20HIV.pdf

education and 3.5% reported only primary school education. Female respondents were over twice as likely to report a university or higher degree (16.6%) compared to male respondents (7.7%).

Graphic 3

Recommendations

Reform of laws/policies

- The Government should support the active participation of people living with HIV in the development of laws, polices and guidelines; and in providing community-based services and support;
- The League of People Living with HIV in Moldova should form partnerships with government institutions, health and other professional organizations, associations of lawyers and judicial officials, and national human rights institutions to advocate for greater attention to sexual and reproductive health and human rights, within and beyond the national HIV response.

Addressing human rights violations, discrimination and stigma

- The National AIDS Programme must prioritise HIV-related stigma and discrimination reduction, particularly against people living with HIV and key populations in national strategic planning, funding and programmes, including support for scaled up implementation of promising programmes;
- The Government must develop a sound and sustainable mechanism for the protection of the rights of people living with HIV, either under the Ombudsman Institution or an alternative, more relevant and capable structure;
- The National AIDS Programme must ensure effective monitoring and evaluation of the implementation of the Law on the on the Prevention and Control of HIV/AIDS, the Law on Ensuring Equality, as well as other related or subordinated laws;
- The League of People living with HIV and other civil society organisations must intensify education efforts with people living with HIV on positive health, dignity and prevention; challenge rights violations and advocate for the rights of all people living with HIV, including key populations.

Prioritising women and other key populations

- The Government in collaboration with organisations women living with HIV, should develop specific guidelines for counselling, support and care for women and girls in programs for the national response to HIV;
- Governments, international agencies, and NGOs should set and monitor concrete targets for involving people living with HIV and key populations in all relevant activities, including programmes to support the prevention of HIV.

Respecting sexual and reproductive rights

- The National AIDS Programme must scale up the provision of correct information and appropriate options for the sexual and reproductive health for people living with HIV, including on preventing vertical transmission of HIV;
- The National AIDS Programme must ensure that the sexual and reproductive health needs of people living with HIV are addressed in the National Plan to Combat HIV and the National Strategy on Reproductive Health, including their right to have children and to build families.

Access to comprehensive healthcare

- The National AIDS Programme must invest more in promoting voluntary counselling and testing as an entry point for timely diagnosis and to start treatment, care and support at the earliest opportunity;
- The National AIDS Programme must review and update, if needed, protocols to ensure they are rights-based and include pre-service training for health care workers as well as in-service training refresher courses for health providers and other health facility staff to foster non-judgmental and non-discriminatory practices towards people living with HIV.

Promoting economic and social rights

- The Government must ensure involvement of people living with HIV in the development, implementation, monitoring and evaluation of poverty reduction strategies, with a particular focus on the relationship between HIV and poverty, and on their differing impact on women and men;
- The Government must ensure that Moldovan labour legislation conforms to the ILO Code of Practice on HIV/AIDS, and that workplace policy and programmes allow people living with HIV to work in environments free of stigma and discrimination. HIV-related programmes and projects in particular should implement affirmative action policies and practices that encourage the hiring of people living with HIV.

Notes

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