THE REPUBLIC OF MOLDOVA

STATE ROAD ADMINISTRATION

ROAD SECTOR PROGRAM SUPPORT PROJECT

SOCIAL ASSESSMENT REPORT

DRAFT

October 2007

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Abbreviations

AIDS	-	Acquired Immune Deficiency Syndrome
CAS	-	Country Assistance Strategy
CCM	-	Country Coordination Mechanism of National HIV/AIDS/STIs & TB Control Programmes
CIS	-	Commonwealth of Independent States
CSW	-	Commercial sex worker
EBRD	-	European Bank for Reconstruction and Development
EGPRSP	-	Economic Growth and Poverty Reduction Strategy Paper
EIB	-	European Investment Bank
EU	-	European Union
Euro or €	-	currency of the of the EU participating in the European Monetary Union
GF	-	Global Fund to Fight AIDS/TB/Malaria
GDP	-	Gross Domestic Product
GRM	-	Government of Republic of Moldova
HIV	-	Human immuno-deficiency virus
IDA	-	International Development Association
IDU	-	Intravenous or injecting drug user
IEC	-	Information-Education-Communication
ILO	-	International Labour Organisation
IOM	-	International Organisation for Migration
Lei	-	currency of Moldova 1 lei €16 (approx. as at October ’07)
MoHSP	-	Ministry of Health & Social Protection
MOT	-	Ministry of Transport
NCCTHB	-	National Committee for Counter Trafficking in Human Beings
NGO	-	Non-governmental organisation
OSCE	-	Organisation for Security and Cooperation in Europe
PLWHA	-	People living with HIV and AIDS
SRA	-	State Road Administration
STI	-	Sexually transmitted infection
UN	-	United Nations
UNAIDS	-	Joint United Nations Programme on HIV/AIDS
UNCT	-	United Nations Country Team
UNDP	-	United Nations Development Programme
UNFPA	-	United Nations Population Fund
UNJT	-	United Nations Joint Team
US	-	United States of America
USAID	-	United States Agency for International Development
USD or $	-	United States Dollars
USSR	-	Union of Soviet Socialist Republics
WB	-	World Bank
WHO	-	World Health Organisation

1 Summary

The Government of the Republic of Moldova (GRM) is undertaking road improvement projects with the assistance of various international donors. One such project is the Road Sector Program Support Project which seeks to improve several sections of the road transport network in Moldova. On behalf of the GRM, the project is administered by the project office of the State Road Administration (SRA).

The preliminary phase of the project requires the Consultant to examine the feasibility of about 225 km of roads (Balti – Sarateni – Orhei – Chisinau – Hincesti). The second phase of the project will comprise the final design for Balti – Sarateni – Orhei – Chisinau – Hincesti road sections complete with tender documentation for the three proposed contracts. A Social Assessment has been completed in order to meet the required deliverables.

The specific terms of reference (TOR) for the social assessment are to complete a social screening, following the World Bank (WB) guidelines, and:

- Assess the terms of agreement between owners of kiosks/structures that may exist on the right-of-way (ROW) and SRA; and
- Review existing literature and interview knowledgeable individuals, and assess the risk of HIV/AIDS/STIs transmission that may result from the inflow of construction workers and increase of transit traffic.

The conclusions of the social assessment are that; (i) there will be no land acquisition required by the road improvements, all widening can be undertaken within the roads' protection zones and therefore a resettlement plan within the meaning of WB's *Involuntary Resettlement* policy is not required; and, (ii) there is an identifiable risk of spread of HIV/AIDS and STIs during both construction and operation stages of the project and this risk should be mitigated through implementation of a project-specific HIV/AIDS and STIs awareness and prevention programme.

The social assessment includes an outline TOR for the programme and a cost estimate. The programme will include training, awareness and prevention for (i) construction workforces engaged on each of the contracts; and (ii) the communities within the project area, focusing on high risk and vulnerable groups. There is a small risk associated with human trafficking, which already occurs within the project area. The programme outlined above will include a component to address awareness and prevention of trafficking.

The assessment also included review of impacts on ethnic minorities, and concluded that the Project will not incur any impacts that trigger the WB's *Indigenous People* policy (OP 4.10, January 2005).

2 Introduction

2.1 Background to the Project

The Government of Republic of Moldova (GRM) has sought assistance from international donors to improve key sections of its road network. The Republic of Moldova (Moldova) is a small, landlocked country in Eastern Europe located to the east of Romania and to the west of Ukraine, as shown on Figure 1.

Figure 1 – Location Map

Under an Agreement dated 11th June 2007 Roughton International of UK in association with TRL (Transport Research Laboratory) of UK and Blizzard Design of Romania undertook to provide consultancy services required for the first phase of the Road Sector Program Support Project with services commencing on 27th June 2007. On behalf of the GRM, the project is administered by the project office of the State Road Administration (SRA).

The project is intended to provide a holding action which will prevent further deterioration of two principal trunk road routes within Moldova:

- Chisinau – Orhei – Sarateni - Balti; and
- Chisinau - Hincesti.

Initially the project is to examine the feasibility of rehabilitating these routes and then is to prepare final designs and documentation works to be carried out by tender.

Using finance from European Bank for Reconstruction and Development (EBRD), European Investment Bank (EIB) and the World Bank (WB) this project aims to rehabilitate as much as possible of three sections of the routes examined; (i) Balti – Sarateni (56 km) funded by WB; (ii) Chisinau – Orhei (approx 40 km) funded by EBRD; and, (iii) Chisinau – Hincesti (25 km.) funded by EIB.

It is intended that the subsequent construction work will be arranged in three contracts corresponding to the sections defined above, with each contract being funded by the agency indicated above. The proposed construction work does not currently include the section Orhei – Sarateni.

The preliminary phase of the project requires the Consultant to examine the feasibility of about 225 km of roads (Balti – Sarateni – Orhei – Chisinau – Hincesti), as shown on Figure 2. Deliverables of this phase will include: (i) a comparative table of possible improvements with relevant information; (ii) the optimal alternative for each section; and, (iii) the category of the improvement in terms of environmental and social impact together with preliminary designs.

The second phase of the project will comprise the final design for Balti – Sarateni – Orhei – Chisinau – Hincesti road sections complete with tender documentation for the three proposed contracts. The final design and contract definition will take into account the available funding and will tailor the extent of the proposed contracts to suit. In the event that construction costs are substantially higher than the proposed funding then the work may be divided into more than three contracts on the basis of consultations with the Client and the funding agencies.

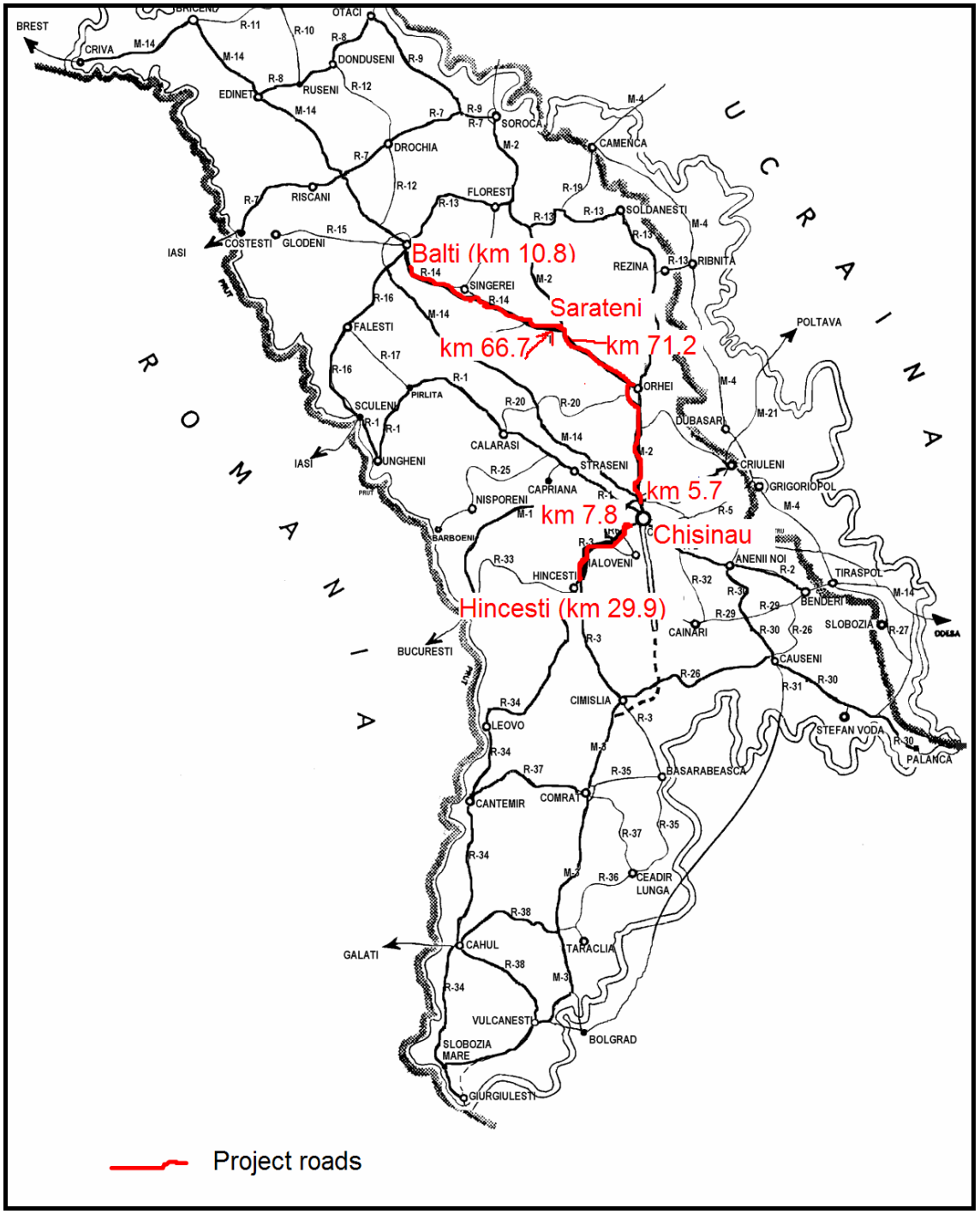
This report is the Social Assessment, completing part of the third deliverable as described above.

2.2 Scope of Social Assessment

The terms of reference (TOR) for the social assessment component of the project include assessing the potential social risks of the project, focusing on the likely impact of any land acquisition or relocation of vendors from the project roads, and the risk of spread of HIV/AIDS and sexually transmitted infections (STIs) during construction and operation phases of the project. In particular the specific TOR are to complete a social screening, following the WB guidelines, and:

- Assess the terms of agreement between owners of kiosks/structures that may exist on the right-of-way (ROW) and SRA; and
- Review existing literature and interview knowledgeable individuals, and assess the risk of HIV/AIDS/STIs transmission that may result from the inflow of construction workers and increase of transit traffic.

Figure 2 – Project Roads



3 Socio-Economic Context for Assessment

3.1 Overview

3.1.1 General

Moldova has a total land area of 33,700 km^2, the terrain consists mainly of rolling plains with the highest point in the country measuring an altitude of 430 meters (m).

Moldova became independent from the Soviet Union in August 1991, and a new constitution was adopted in 1994.

For administrative purposes Moldova is divided into territorial units; as at 01st January 2006 these units consisted of three regions (north, central, and south), 32 districts (raions), five municipalities, 60 towns and 917 villages (communities), and 1,575 rural settlements. There are two territorial units to which special terms of autonomy are attributed: the autonomous territory of Gagauz, and the territory of Transnistria located on the east side of the Dniester River.

In 1992, Moldova underwent a short but bloody conflict in the territory situated to the east of the Dniester River (Transnistria). This conflict resulted in over 1,000 deaths and casualties and over 130,000 refugees.

3.1.2 Economy

The crisis related to Moldova's transition lasted until 2000, when the economy finally started to manifest a sustainable growth. Between 2001 and 2004, Moldova's economy grew by over 30 per cent, while the gross domestic product (GDP) average annual growth constituted about seven per cent. The economic growth has determined a marked decrease in poverty rates, which, according to estimates, have dropped in 2004 to over a half of the highest levels in 1999 (refer to Section 3.1.7).

Moldova is an agrarian-industrial country. The main crops are cereals, maize, sugar beet, sunflower, tobacco, vine, vegetables, and fruit. Agricultural products account for approximately 60 per cent of export values.

Moldova's industry is concentrated mainly on processing agricultural raw materials, in particular, the production of wine and cigarettes and the processing of tobacco. This activity is complemented by light industries such as chemical industry, wood processing, machine building, and the manufacturing of some equipment.

The GRM has made progress in implementing economic reforms, including the introduction of a stable currency, privatization of enterprises, liberalization of prices and interest rates, etc. Overall, the reforms implemented in recent years have had positive results. For example, the private sector currently contributes over 60 per cent of the GDP and the market is functioning with commercial banks, stock exchanges, and free economic zones. The distribution of GDP per economic sector is; agriculture (48 per cent); industry (28 per cent); and, services (24 per cent).

3.1.3 Labour and Employment

Between 1991 and 2005 there was a steady decline in the local labour market, as is evidenced by the reduction in activity rate of the population aged > 15 years from 60 per cent to 49 per cent. At the same time, the number of persons actively engaged in the economy decreased by 12 per cent.

The decreases were not uniform across the sectors, in comparison with 1999, the number of people engaged in agricultural sector decreased by 50 per cent, female employees decreased by 53 per cent, and people engaged in construction decreased by 30 per cent. The negative dynamics of jobs has an unfavourable influence on human development as wages have the greatest share in household income.

Table 3.1.1 shows that despite the decreases outlined above, the agricultural sector is still the largest employer overall (43 per cent), followed by the public administration sector (17 per cent). The construction and transport and communications sectors are dominated by men (91 and 71 per cent respectively) while the public administration sector and commerce/service industry are dominated by women (69 and 60 per cent respectively).

Table 3.1.1 – Employment by Sector

Sector	Employed persons by sector (2005)					
	Total (000 pers.)	%	Men (000 pers.)	Women (000 pers.)	% Men	% Women
Agri, forestry, fishing	580.7	42.6	277.2	303.5	47.7	52.3
Industry	162.0	11.9	89.9	72.1	55.5	44.5
Construction	59.8	4.4	53.9	5.9	90.1	9.9
Commerce, hotel, restaurant	180.8	13.3	72.4	108.4	40.0	60.0
Transport & communications	67.0	4.9	47.7	19.3	71.2	28.8
Public admin, ed, hlth, soc. assist.	232.7	17.1	70.7	162.0	30.4	69.6
Other activities	80.7	5.9	38.5	42.2	47.7	52.3
Total	1,363.7		650.3	713.4	47.7	52.3

Source: Annual Social Report 2005; Ministry of Health & Social Protection (2006)

Unemployment among those aged 15-24 is high (19 per cent) and has increased over the period 2000 – 2005 (from 15 per cent). The relation between unemployment and the level of post-secondary education is particularly strong. The rate of unemployment decreases as the level of education goes up. This fact, however, does not seem to be of too much in advantage for the youth, most of them experiencing extremely difficult periods after graduation.

3.1.4 Population

According to the most recent Census (2004) the population of Moldova (excluding the districts in the region of Transnistria) was 3.4 million. Compared with the population count in the 1989 Census, Moldova's population has decreased by 274,000 people.

Moldova has the highest population density of any of the former Soviet Republics; on average, there are 111 people/km^2, and 1,255 people/km^2 in the capital Chisinau.

Ethnically the population is 76 per cent Moldovan (increasing from 64 per cent in 1989), Ukrainians accounted for eight per cent and Russians six per cent. The Gagauzi minority which mainly lives in a compact administrative autonomous region in southern Moldova makes up four per cent of the population. Bulgarians and Romanians each account for just under two per cent.

Over 61 per cent of the population lives in rural areas making Moldova the European country with the largest proportion of rural population.

The rate of population decline, determined both by a greater number of deaths than live births, as well as a surplus of outward, over inward, migrants, results in a negative population growth estimated to be about -0.5 percent. An aging population is a consequence of a declining population; since 1989, there has been a decrease in the proportion of young people under age 15 and a simultaneous increase in the proportion of working-age and elderly people (> 60 years of age).

3.1.5 Human Development

The United Nations Development Programme (UNDP) measures and compares countries according to their human development using five indices; the Human Development Index (HDI), Human Poverty Index (HPI-1) for developing countries, Human Poverty Index (HPI-2) for selected high-income OECD countries, Gender-related Development Index (GDI) and Gender Empowerment Measure (GEM). The HDI is normally the most suggestive indicator of overall development. Its calculation is based on three important aspects including (i) longevity as measured by life expectancy at birth; ii) education, measured as a weighted average of the adult literacy rate, and gross enrolment rate in primary, secondary and tertiary education; and (iii) living standards measured as GDP per capita as USD dollars adjusted at purchasing power parity (PPP) of the national currency.

In 2003, UNDP's human development indicators ranked Moldova only 117th out of a total of 177 countries, and in last place among all Commonwealth of Independent States (CIS) countries except Tajikistan (UNDP, 2005), the situation had not improved much by 2006 with Moldova ranking 114th out of 177 countries and still only second to Tajikistan in terms of overall performance of CIS countries.

The following is a summary of the data presented, for the period 2000 – 2006, in the most recent UNDP report for Moldova:[1]

- Moldova remains below the global average regarding the HDI (0.741 in 2003);
- The discrepancy between longevity of women and men increased from 7.3 to 7.7 years in 2000-2005. Life expectancy remains 10 years shorter than in EU countries. In 2005, longevity decreased to 67.8 years;
- The quite low GEM indicates that in Moldova women still do not benefit from all existing opportunities for getting more involved in development processes;
- While life expectancy registered some positive trends, it still remains below the European average. Although women live on average seven years longer than men, their life expectancy is shorter than in Central Europe and CIS countries;
- Infant mortality has been steadily reducing from 18.4 per 1,000 live births to 12.4. In 2005, the mortality rate of children under five years old was 14.7 per 1,000 live births compared with 20.3 in 2001. Maternal mortality has also decreased significantly, from 43.9 to 18.6 cases per 100,000 live births; and
- While the rate of population with access to improved water sources increased from 38 per cent to 45 per cent and the rate of population with access to sewerage increased from 41 per cent to 44 per cent. Improved access to safe water supply and sanitation is not universal, rural households with sewage and safe water systems is only four per cent of total households (less than one per cent of rural families have bathrooms and showers indoors), and only ten per cent of households are connected to the gas distribution system.

[1] UNDP; *Quality of Economic Growth and its Impact on Human Development - National Development Report 2006*, Chisinau (2006)

Large disparities in the level of human development persist across the country, Moldovan villages being particularly destitute. Moreover, in a number of small towns and even in the suburbs of big Moldovan cities, living standards prevail which are uncommon for a genuine urban settlement.

3.1.6 Health

Socially conditioned diseases have become a major risk for Moldova. From 2001 to 2005 the global incidence of tuberculosis (TB) followed an upward trend from 93.2 cases per 100,000 inhabitants to 130.5 cases per 100,000 inhabitants which is ten times more than in the EU and twice that of the group of other transition countries.

The mortality rate associated with TB, which mainly affects men, was extremely high during the period and in 2005 there were 18.9 deaths per 100,000 inhabitants (compared with 15.5 in 2001). Alcoholism registered an alarming rate of growth; in 2005, chronic alcoholism incidence affected 112.8 per 100,000 inhabitants (compared with 81.8 in 2001) while the incidence of alcoholic psychoses registered 19.6 per 100,000 inhabitants compared with 5.9 in 2001.

The demographic processes in the country are characterised by mortality prevailing over the birth-rate. The rate of 12.4 per 1,000 inhabitants while being one of the lowest among the CIS countries is higher than in the transition countries (10.4) and much higher than the average in the EU (8.0). In certain districts the 2005 increase of mortality was alarming indeed; Dubasari with 15.8‰ (12.9‰ in 2004); Nisporeni with 12.5‰ (10.5‰ in 2004); and, Taraclia with 14.2‰ (12.1‰ in 2004).

As in most European countries, the diseases of the circulatory system represent the main cause of death (56 per cent in 2003), followed by malignant tumours (17 per cent). Mortality from cancer diseases constitutes a major problem of the public health, in 2001-2005 the incidence of malign tumours increased from 163.1 to 192.9 per 100 thousand inhabitants.

Just under a third (29 per cent) of the total number of deaths are reported among those of working age, and the rate of death outside hospitals is very high (83 per cent). The issue is exacerbated by the fact that the working age population from rural areas is little integrated in the health insurance system.

Compared to other CIS countries, the death rate from AIDS associated illness or prevalence of HIV is not high, but according to preliminary data, HIV incidence reached a level of 13.3 cases per 100,000 inhabitants in 2005, and as an absolute figure, some 538 new cases were registered, which was an increase of 50 over 2004.[2] This issue, in respect of project-related risks is discussed in more detail in Section 5.

3.1.7 Poverty

Despite attaining some macro-economic benchmarks, the sharp decline of economic activity in the first decade after independence lead to an acute growth of poverty in the 1990s—Moldova went from a country with an overall medium income level to one with an overall low income level. Moldova remains the poorest country in Europe, and according to the World Bank, even if Moldova's economy grows at eight per cent per year, more than one in five Moldovans would still be in poverty in 2007.[3]

The risk of poverty is highest in small towns where the safety net provided by subsistence farming is absent and employment is scarce. People in rural areas fare better mainly because they can live off the land. Residents of Chisinau and Balti are

[2] UNDP; op cit

[3] World Bank; *Recession, Recover and Poverty in Moldova*, Washington DC (November 2004), and *Moldova: Poverty Update*, Washington DC (June 2006)

the least likely to be poor due to better employment opportunities and higher wages. A quarter of the population has remained poor throughout the recession and recovery, this group is disproportionately represented by under-educated heads of household. The poverty risk is even higher in households where the head is engaged in agriculture, especially as a hired worker.[4]

The level of poverty increased over the period 1992 to 1999, when Moldova was economically devastated, followed by a period in which the incidence of absolute poverty decreased substantially from 74 per cent to 27 per cent (1999 – 2004). In the same period, the incidence of food poverty (extreme poverty) decreased from 37 per cent to 15 per cent. The situation of monetary poverty has improved, the number of people living at the national poverty line (202 lei per person/month) decreased from 68 per cent in 2000 to 27 per cent in 2004. Comparatively, the decline was very rapid in Chisinau and Balti but inert in rural areas, where three-quarters of poor people live.

While women and men seem equally exposed to the risk of poverty, the socio-economic groups that are facing the greatest risk of poverty are, in one way or another, related to agriculture with 35 per cent of farmers and 37 of agricultural sector employees being poor, and the poorer the household, the higher the share of income from agriculture (and mainly in kind). Possession of land assets does not automatically solve the problem of poverty, which is demonstrated by the fact that all poor people from rural areas hold plots of land as private property.

3.2 The Project Area

The three project roads traverse nine districts as outlined in Table 3.2.1.

Table 3.2.1 – Project Roads by District

Road ID	Road Name	Districts
R-3	Chisinau - Hincesti	Ialoveni, Hincesti
M-2	Chisinau - Sarateni	Chisinau, Straseni, Criuleni, Orhei
R-14	Balti - Sarateni	Balti, Telenesti, Singerei

Source: Various

As shown on Figure 3, the project area is mainly located in the central region but includes two districts (Balti and Singerei) in the north region.

3.2.1 Population Data

The population of the project area (nine districts) is 1.49 million, with most being located in Chisinau. Overall the population is 59 per cent urban, but this ranges from 10 per cent in Criuleni and Telenesti to 96 per cent in Balti. Across the project area the average household size is three persons.

Table 3.2.1 – Population of Project Area by District

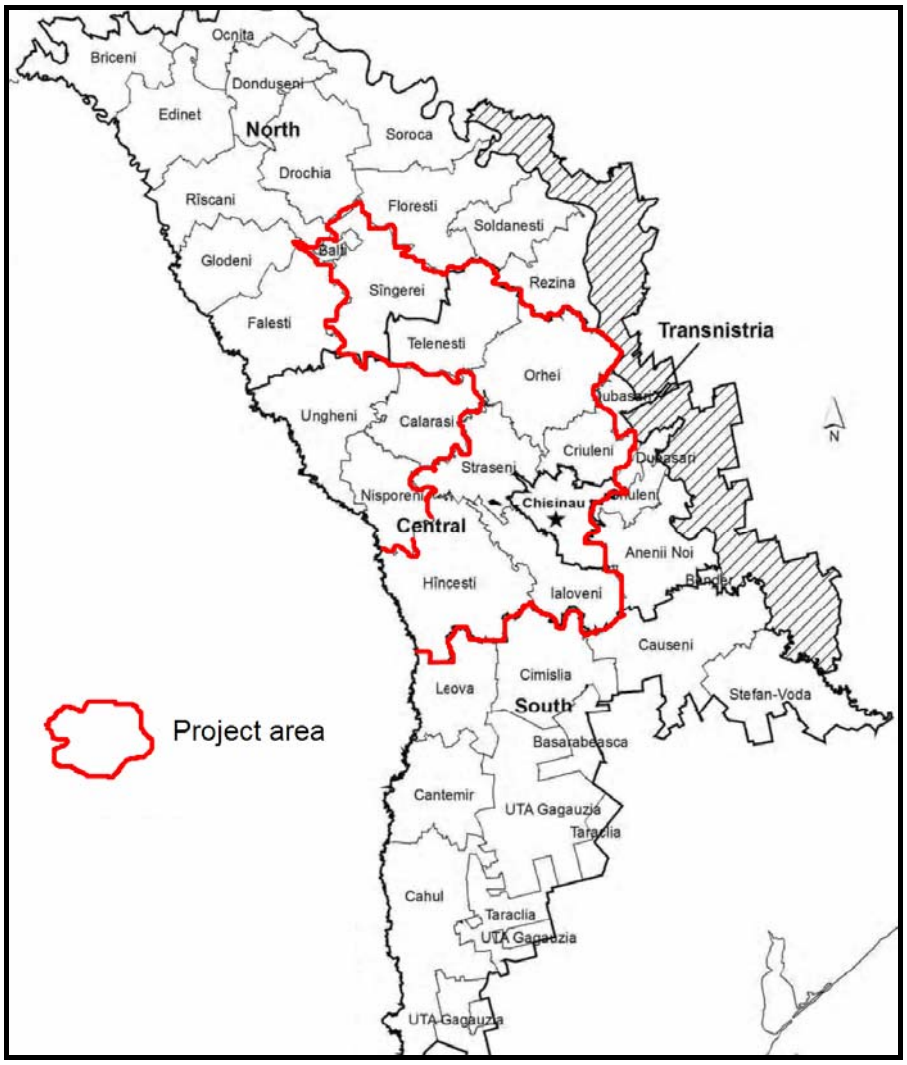
District	Total h'holds	Total	Urban		Rural	
			No. of people	%	No. of people	%
Chisinau	216,123	712,218	644,204	90.5	68,014	9.5
Balti	42,800	127,561	122,669	96.2	4,892	3.8
Criuleni	22,442	72,254	7,138	9.9	65,116	90.1
Hincesti	36,096	119,762	15,281	12.8	104,481	87.2

[4] UNDP; op cit

Ialoveni	28,141	97,704	15,041	15.4	82,663	84.6
Orhei	36,609	116,271	25,641	22.1	90,630	77.9
Singerei	28,617	87,153	15,760	18.1	71,393	81.9
Straseni	26,747	88,900	19,633	22.1	69,267	77.9
Telenesti	22,391	70,126	6,855	9.8	63,271	90.2
Project Area	**1,081,498**	**1,491,949**	**872,222**	**58.5**	**619,727**	**41.5**

Source: Population Census 2004

Figure 3 – Administrative Boundaries and Project Area



The project area is fairly ethnically homogenous with 84 per cent being Moldovan, higher than the national proportion of 76 per cent, six per cent Ukranian, five per cent Russian, three per cent Romanian, and less than one per cent either Gagauzi or Bulgarian. The exception is Balti which includes Ukranians accounting for nearly a quarter of the population and Russians accounting for 19 per cent of the population.

Table 3.2.2 – Ethnicity of Project Area by District

District	Moldovan	Ukranian	Russian	Gagauzi	Romanian	Bulgarian
Chisinau	67.6	8.3	13.9	0.9	4.5	1.2
Balti	52.4	23.7	19.2	0.2	1.8	0.2
Criuleni	92.8	3.7	1.4	0.1	1.6	0.1
Hincesti	90.3	5.2	1.2	0.1	2.5	0.2
Ialoveni	93.5	1.1	1.1	0.1	2.7	1.0
Orhei	86.4	3.9	1.9	0.1	7.1	0.1
Singerei	85.1	9.7	3.5	0.1	1.3	0.0
Straseni	93.8	1.1	1.8	0.1	2.9	0.1
Telenesti	96.0	1.3	0.8	0.0	1.8	0.0
Project Area	**84.2**	**6.4**	**5.0**	**0.2**	**2.9**	**0.3**
Moldova	**75.8**	**8.4**	**5.9**	**4.4**	**2.2**	**1.9**

Source: Population Census 2004

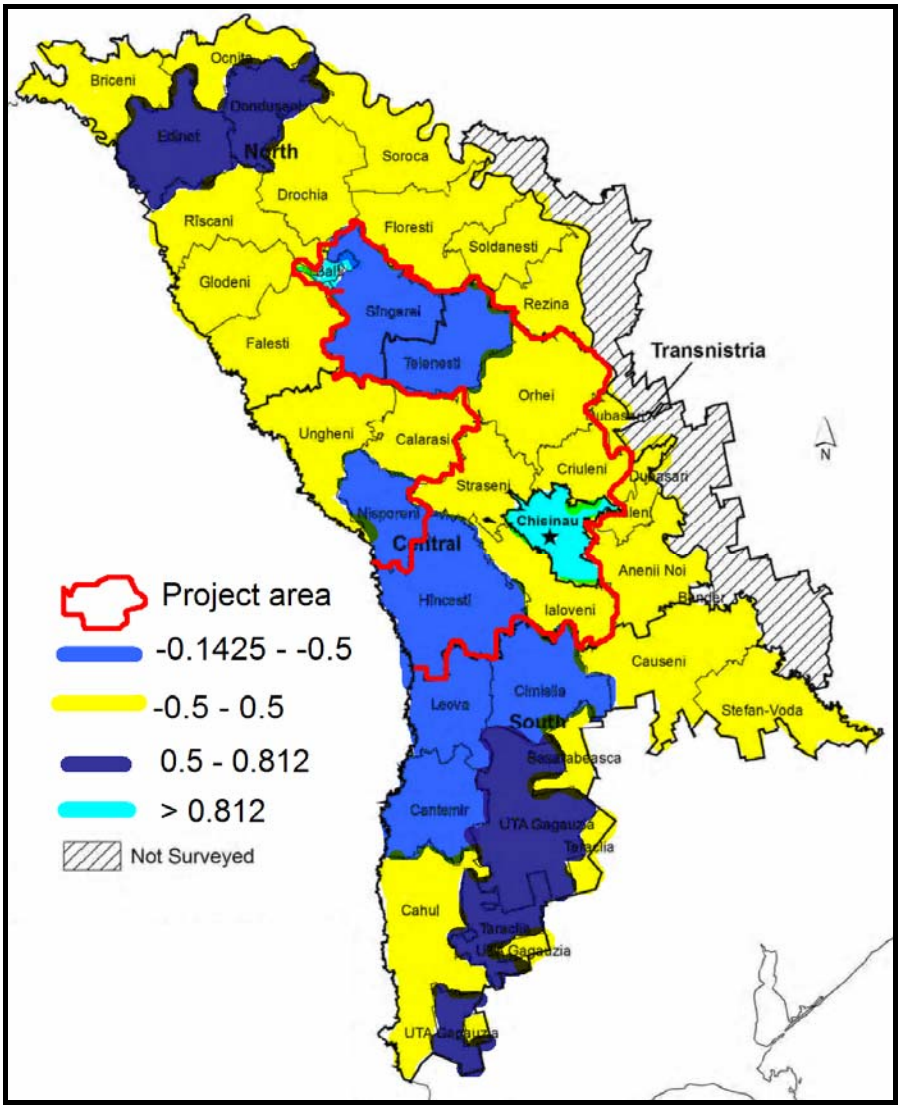
In terms of age distribution, Chisinau has the smallest proportion of people in the 0-15 year age group (16 per cent) compared with between 18 per cent (Balti) and 26 per cent (Telenesti) across the rest of the project area. Chisinau (71 per cent) and Balti (68 per cent) have the largest population in the 16-61 age group (compared with between 60 per cent and 66 per cent). Singerei has the largest proportion of older population (62+) with 16 per cent, the range across the remainder of the project area is from 11 per cent (Chisinau and Ialoveni) and 14 per cent (Orhei).

3.2.2 Socio-Economic Development

Economic activity in Moldova was extremely polarised in 1997, and became even more so during the period of economic growth. Even though Chisinau municipality accounts for a fifth of the population, in 2004-2005 it contributed half of the industrial production, retail sales, and capital investment.

Clearly it cannot be said that at the regional level there are no positive economic trends at all, Balti becomes an increasingly more important regional pole of economic growth. Certain positive tendencies are observed in several districts and in autonomous area of Gagausia. Eliminating Chisinau and Balti municipalities from the picture, it becomes obvious that there are significant differences in the socio-economic development among the districts, as shown on Figure 4.

Figure 4 – Distribution of Districts by Index of Socio-Economic Development



Source: UNDP; National Human Development Report 2006 after Rocovan and Galer (2006)

Note: the larger the number, the higher the level of social-economic development.

According to the development rating of districts, on the top of the hierarchy are the districts from the North and the South of the country and the districts from the central part of the country are situated lower. According to this indicator, districts can be classified into three zones: 1) zones with restructuring potential; 2) assisted zones; and, 3) depressed zones. The UNDP report notes that even in the zones with restructuring potential, the positive economic dynamics did not last long and in 2006 they reversed back in many cases.

The geographically unbalanced economic growth has an impact on many dimensions of human development. The more acute economic recession of the early transition in the districts, as compared with the capital, combined with the instability of re-launching during the recent period of economic growth, amplified the gaps in per capita income between the centre and the districts. With the exception of Chisinau and Balti, the districts in the project area are depressed and rates negative socio-economic development.

3.2.3 Human Development

Taking into account the fact that the districts average share of the rural population is 80 per cent, and in villages educational performance and longevity are much lower, the conclusion is that outside of Chisinau and Balti, human development is considerably less advanced. Table 3.2.3 presents a number of indices of human development identified in the UNDP 2006 report, which illustrate this point.

Table 3.2.3 – Indices of Human Development for Project Area

District	Infant mortality rate (per 000 live births)	Mortality rate chn < 5 yrs (per 000 live births)	Mortality rate adults (per 000)	Dependency rate (%)	No. of school aged chn per school
Chisinau	9.7	11.0	8.7	28.5	658
Balti	14.4	17.6	10.3	34.1	767
Criuleni	14.8	18.2	13.7	42.0	498
Hincesti	15.6	20.0	12.3	45.2	513
Ialoveni	11.5	13.0	11.6	39.7	595
Orhei	12.7	17.2	13.4	42.3	392
Singerei	14.0	16.8	11.6	52.0	416
Straseni	11.9	19.3	13.1	40.9	474
Telenesti	12.6	17.2	12.5	50.9	422
Project Area	**13.0**	**16.7**	**11.9**	**41.7**	**546**

Source: UNDP – National Human Development Report 2006

The data shows that Balti has high infant and child mortality, on a par with the other districts in the project area and much higher than in Chisinau. The districts show higher adult mortality rates than in either Chisinau or Balti. Also the two centers have much lower dependency rates, indicating higher employment and less unemployment or under-employment than is the case in the districts.

4 Impacts on Land and Ownership

4.1 Reform and Land Ownership

As with other former Soviet republics, the Moldovan state used to own and allocate all land and most buildings. After the break up of the Soviet Union, Moldova initially focused on privatizing state-owned property.

Privatisation of agricultural land was based on the distribution of land to people who had worked in agricultural households or enterprises that served agricultural households. Even though the selected model ensured the impartiality of the distribution of land, the mechanism of running the land reform was defective. After the completion of agricultural reform, over 86 per cent of agricultural land was in the hands of the private sector, with most agricultural plots being worked by peasant households who owned an average lot of 1.36 ha; the small size of agricultural plots generated intense debates regarding agricultural policy, especially when compared with the average size of agricultural plots in European Union is 18.7 ha.[5]

To support the GRM which had by this time recognized that Soviet-era land and building registration systems would not effectively support real estate market development the WB (funded by IDA) implemented the First Cadastre Project. The project sought to develop and implement a national and unified real estate registration programme for urban and rural land, and establish a system of clear, secure and enforceable ownership rights which promoted land privatization and real estate market development in Moldova.[6]

The project included four components: (i) a mapping programme to produce new maps, and updating of existing maps; (ii) an urban cadastral services programme to provide the basis for registration of ownership rights in urban areas, and storage and administration of ownership information; (iii) a rural cadastral services programme to provide the basis for registration of ownership rights in rural areas, and storage and administration of ownership information; and (iv) an institutional capacity building programme consisting of training, technical assistance, and the establishment of a project implementation office.

The project was provided parallel with parallel support from United States USAID through the Land Privatization Support Project.

The outcomes of the project have contributed to a functioning land registration system and real estate market in Moldova in which:

- The country ranks better than its neighbours in terms of speed of land registration (48 days compared with an average of 102 days in Europe and Central Asia region;
- More than three-quarters of all real estate has been registered;
- Sales transactions quintupled from 17,907 in 1999 to 89,451 in 2005;
- The new real estate registration system provides for the first time (i) property owners with security of ownership rights such that they can sell or rent real estate at fair market prices and pass on their holdings as inheritances; (ii) commercial banks with the confidence to give secured

[5] UNDP; op cit

[6] Project ID: PO35771. The total project cost was US$24.6 million (IDA provided US$15.9 million).

credit against real estate; and, (iii) government agencies and institutions with basic information for urban planning and land management.

4.2 Land Acquisition Procedures

In Moldova there are two pieces of legislation which govern the process of, and procedure for, land acquisition; Law of Expropriation for the Purpose of Public Use - Nr. 488-XIV (1999); and, Law of Standard Price for, and Buying and Selling of, Land - Nr. 1308-XIII (1997).

Under the Law of Expropriation, expropriation is defined as the means of transfer of any private property to public property for the purpose of national or local interest works for public use, under the conditions of the law and after award of fair compensation for the loss.

Article 5 lists some 17 forms of public utility for which land can be expropriated, including item (d) planning for the alignment, or widening, of roads.

Articles 15 and 16 set out the calculation and payment of compensation. Compensation should constitute the real value of the property (land and fixed assets thereon [including improvements made]). When calculating the compensation, a commission of experts (or the court if the owner is objecting to the expropriation proceeding) will take into account the actual prices of property and for the same rights based on the prices of land being sold in the area.

In addition to the above, a number of clauses of the Law of Standard Price are relevant, namely Chapter 5 – Normative Price of Land when Forced Alienation Occurs:

- Article 15 – scope and causes of forced alienation;
- Article 16 – rights of persons and entities when land is alienated by the state; and
- Article 17 – compensation of losses caused by forced alienation;

In terms of SRA practice, the organisation was established in 2002 and has not undertaken any projects that require land acquisition. The Ministry of Transport (MOT) is undertaking land acquisition in respect of the southern railway development, and is following the procedures set out in the Law of Expropriation.

SRA noted, during consultation, that the official right-of-way is very wide (dating back to Soviet era) and in many cases is wider than necessary to accommodate traffic volumes. The right-of-way is an area which includes the pavement, shoulders and embankments as well as in some cases an area beyond, this area is designated as the “protection zone”.

4.3 Risks Associated with the Project

The potential risks of land acquisition and/or displacement associated with road improvement projects result from where widening requires removal of structures, crops or trees, or where improvement works are such that existing uses adjacent to the road need to be cleared or moved back.

No fixed structures (including kiosks) or assets will be affected by the proposed improvements or works.

Mobile vendors (primarily selling vegetables and fruit) sell from various locations along the roads, the current practice is to either sell from the back of van or small truck, or from the side of the road, after transporting the goods to a location by vehicle. These locations are not fixed, and sellers move between selling points. Refer to Plate 1.

Plate 1 – Example of Mobile Vendor (Chisinau – Hincesti Road)

Along the Chisinau – Hincesti road widening is required through in six locations where the existing road is only two lane, in order to accommodate a passing lane. The locations where passing lanes are proposed are:

- Km 19.100 – km 20.300;
- Km 21.325 – km 23.875;
- Km 24.050 – km 25.350;
- Km 25.550 – km 26.650;
- Km 27.050 – km 27.250; and
- Km 28.300 – km 29.900.

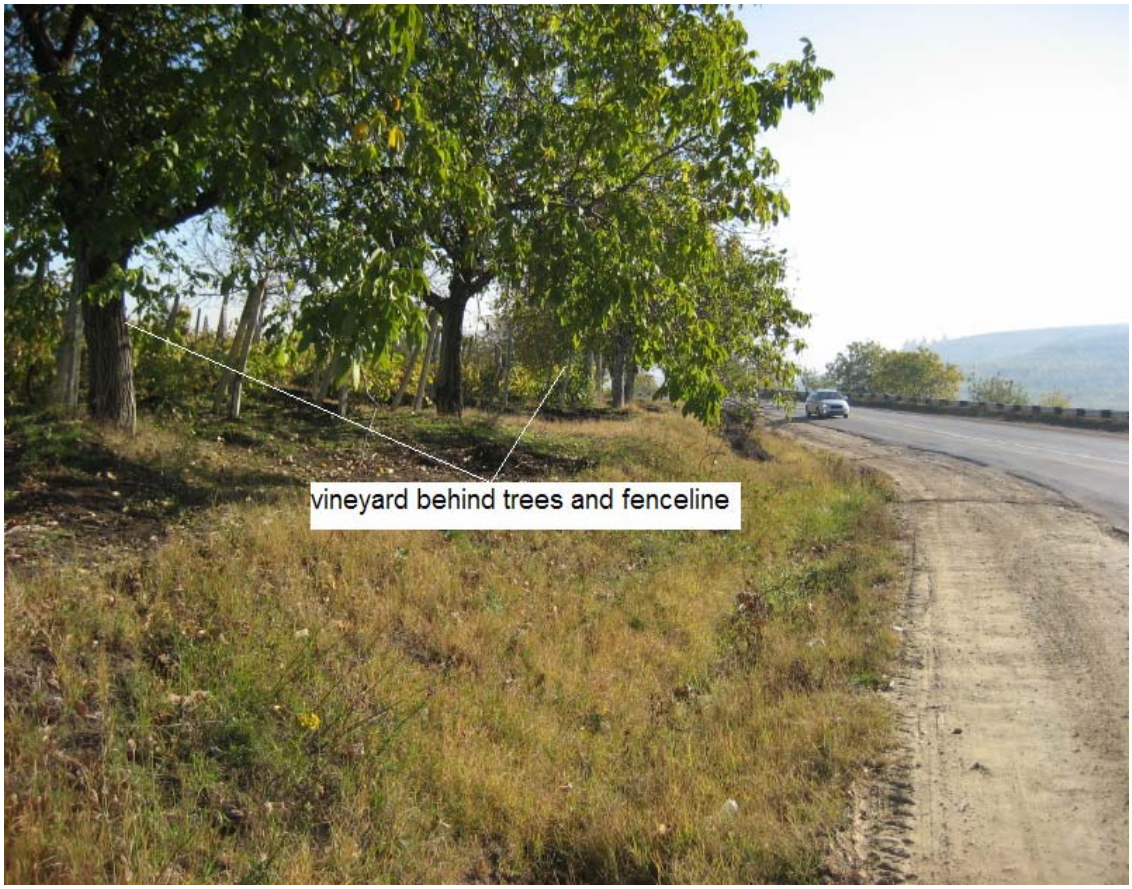
The most critical section is between km 19.100 and km 20.300. At the start of this section the road narrows from four to two lanes on the approach to a curve, there are vineyards on both sides of the road, on the left-hand side the planting is below the road in the valley, on the right-hand side of the road the planting is on top of an embankment, behind a fence and row of trees. The fence marks the boundary between the state owned land (SRA) and privately owned vineyard.

Due to the road being in cut through this section, widening can not be accommodated on the left-hand side of the road as the shoulder is narrow and is not of a uniform width. Extending the width of the road by one lane will be provided by the existing unsealed shoulder and cutting into the embankment on the right-hand side of the road. These works can be wholly accommodated within the existing right-of-way (protection zone), and will not require encroaching into the vineyard. It is also unlikely that the trees will need to be removed.

Refer to Plates 2 and 3.

Plate 2 – Vineyard adjacent to road km 19.7, looking to Hincesti (Chisinau – Hincesti)

Plate 3 – Vineyard adjacent to road km 19.7, looking to Chisinau (Chisinau – Hincesti)



The road sections Chisinau – Sarateni and Balti – Sarateni do not require works beyond the existing sealed section, the works for these sections will include resealing, overlaying with asphalt, re-marking, and formation of shoulders. The terrain is much flatter and these roads do not require climbing or passing lanes for trucks. Furthermore, for most of their length the road sections are four lane, and intermittent three lane sections are already wide enough to accommodate any passing vehicles.

For the Chisinau – Sarateni section, through one six-lane section (km 9.4) there is a location where several vendors are selling construction materials, household goods, grocery items (water, soda etc), and vegetables. Some of the vendors are mobile, selling from the road-side out of vans or from piles of goods on the shoulder, while others are more permanently attached to this location and have either erected small kiosks or brought in shipping containers to use as storage/kiosk facilities (set-back from shoulder 2-3 m). Refer to Plates 4 – 7.

The works proposed for this section include overlaying with asphalt, there are no other significant works proposed. There will be no effects on the kiosks and shipping containers as these are set-back from the shoulder. The mobile vendors do not have permanent kiosks or fixed structures and will be either required to move further back (i.e. from immediately adjacent to the road to the farthest edge of the shoulder) or be relocated to another section of road.

In either case there will be no impacts on their livelihood as they will not be required, as a result of the project, to stop selling. If SRA wishes to pursue removal or relocation of road-side vendors for safety reasons, refer to Section 6.1.1, this is a policy decision which goes beyond the purview of this project.

4.4 Conclusion on Risk Associated with Land Acquisition

There will be no impact on existing agricultural land or other productive land, or housing or other structures (including kiosks and small commercial enterprises).

Further, the project will avoid the temporary taking of land or affecting structures during the works. For Chisinau – Sarateni and Balti –Sarateni roads, are already wide enough to accommodate three lanes and future predicted traffic volumes. For Chisineau – Hincesti Road minor widening will be required in six locations to expand the road from two to three lanes and provide a passing lane, this work will not encroach on adjacent land uses and can be accommodated wholly within the existing right-of-way (including shoulder and berm/verge area) known as the road's protection zone.

Therefore, the conclusions of the social assessment are that the World Bank policy on *Involuntary Resettlement* (OP 4.12),[7] is not triggered by the project and there is no requirement for preparation of a resettlement framework for the project or preparation of resettlement plans for any of the three subprojects.

[7] January 2001, as updated March 2007

Plate 4 – Section of vendors along road-side Chisinau – Sarateni (km 9.4)

Plate 5 - Section of vendors along road-side Chisinau – Sarateni (km 9.4)

Plate 6 – Section of vendors Chisinau (using shipping containers) – Sarateni (km 9.4)

Plate 7 – Section of vendors Chisinau – Sarateni (looking back to Chisinau)

5 Risk of Spread of HIV/AIDS and STIs

5.1 Status and Situation

5.1.1 Epidemiological Situation of HIV/AIDS

In the East European and Central Asian region, the early stages of the HIV epidemic in the 1990s were mainly fuelled by intravenous drug users (IDUs), this was followed by the epidemic being transmitted to the wider population and countries in the region started reporting a higher proportion of sexually transmitted HIV cases with a disproportionate number of young people being infected.

The situation in Moldova reflects that of the region. Aside from isolated cases of HIV identified in the late 1980s, the onset of the epidemic is recognized to be 1996. Initially in the post-socialist transition period, the disease was primarily spread by IDUs and, to a lesser extent, among the prison population.[8] After the late 1990s, however, the proportion of cases transmitted by IDUs declined while the proportion of sexually transmitted cases began increasing. In 2003, for the first time, more new cases were due to infections transmitted by sexual contact than by IDUs—a signal that the virus had begun to spread to the general population. Along with the crossover in mode of infection, another shift was occurring in infection rates by sex; i.e. until 2000, females represented only about a quarter of all persons infected with HIV but by 2004 they represented 49 per cent.[9]

According to the most recent Information Bulletin,[10] as of 2006 there are 3,400 people with HIV, 314 people with AIDS, and there have been 187 deaths from AIDS associated illness. HIV/AIDS infection continues to remain a major problem of public health, showing sharp increases in both absolute number and rate of infection; in 2006, 616 new cases were registered (14.72 per 100,000), compared with 2001 at which time there were 210 new cases (5.81 per 100,000). The first sharp increase was noted in 1996 when the number of reported cases jumped from seven to 48, by 1997 the number had risen to 404 where it stabilised somewhat at between 400 and 500 new cases per year and then increased again in 2006 when 616 new cases were registered.[11]

As noted above, until 2000 the epidemic was mostly prevalent in the IDU population, since 2001 the rate amongst IDUs has been decreasing from 78.1 per cent in 2001 to 42.4 per cent in 2004 while the rate of people infected through heterosexual transmission has increased from 19 per cent to 55.4 per cent over the same period.

The age groups most affected are 20–29-year olds (59 per cent of cases), followed by 30–39-year olds (22 per cent) and 15–19-year-olds (14 per cent).

Some regions show higher prevalence than the national average. In 2006, the highest rates have been found in Balti (928 cases), Chisinau (787 cases) and Transnistria including Bender (873 cases). Balti also has, by far, the highest incidence per 100,000 with 58.6, followed by Transnistria with 41.4:100,000, Glodeni with 18.8:100,000, and

8 National Scientific & Applied Centre for Preventative Medicine, Ministry of Health & Social Protection; *Moldova Demographic and Health Survey 2005*, Chisinau (September 2006)

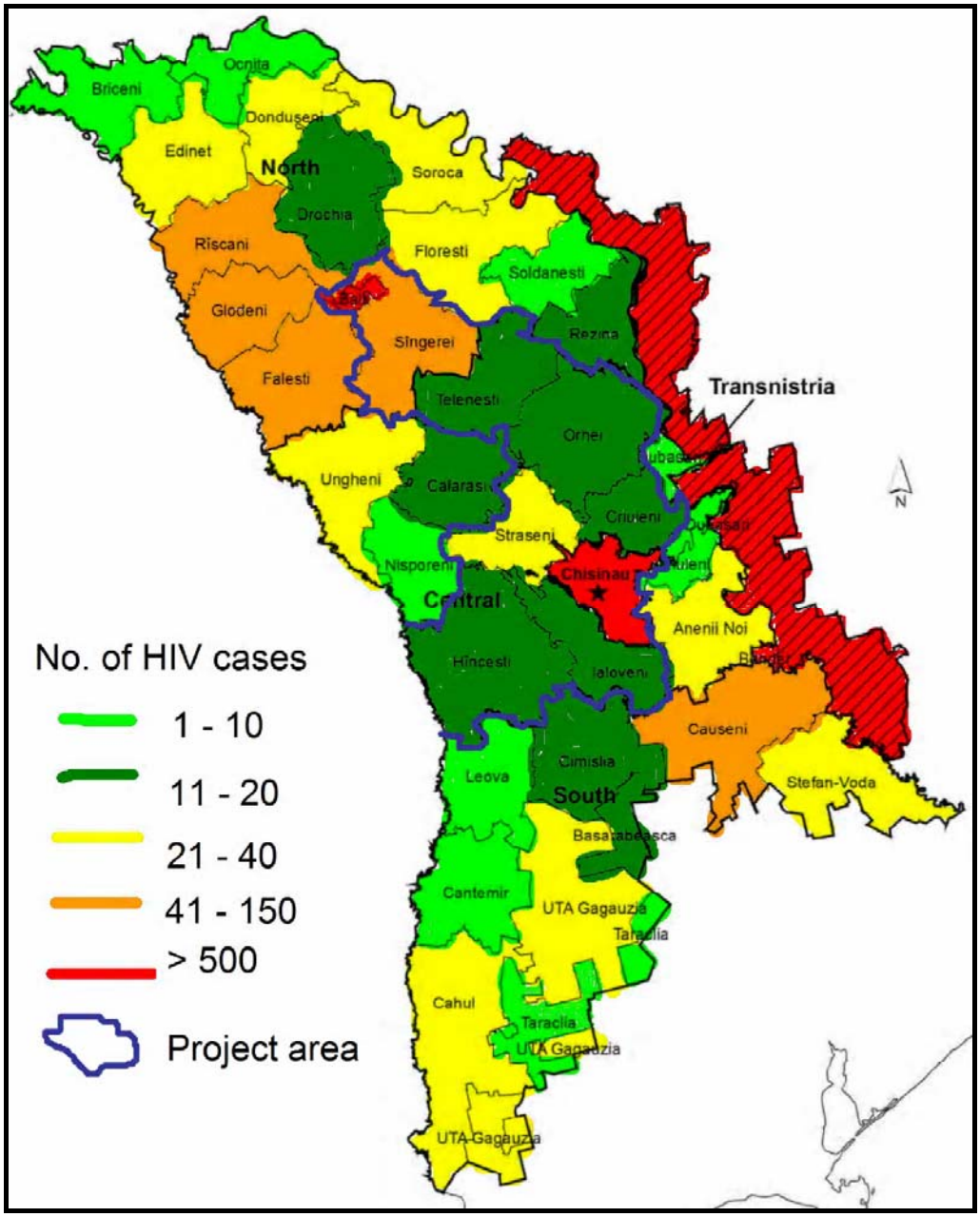
9 UNDP; op cit

10 National Scientific & Applied Centre for Preventative Medicine; *Information Bulletin on Situation of HIV/AIDS Epidemic*, Nr. 10.a-7/132 (February 2007)

11 Ibid

Singerei (a district in the project area) with 17.8:100,000. A map showing the regional distribution of HIV based on cumulative cases to 2006 is presented in Figure 5.

Figure 5 – Cumulative HIV Incidence



Source: Information Bulletin on Situation of HIV/AIDS Epidemic, Nr. 10.a-7/132 (February 2007)

5.1.2 HIV Testing

Based on data provided in the Health Survey, 36 per cent of women have been tested at some time for HIV, compared with 30 per cent for men. Women age 30-39 are more likely than respondents of other ages to have been tested while men age 25-39 are more likely to have been tested than men in other age groups. Both women and men age 15-19 years are the least likely to have ever had an HIV test.

Patterns are similar for women and men who have been tested and received their results in the last 12 months. Regional variations are substantial in that the proportion of respondents who had an HIV test and received results in the past 12 months is significantly higher in Chisinau (13 percent for women and 14 percent for men) than other regions (6-9 percent for women and 7-10 percent for men).

HIV testing varies substantially by background characteristics, but not by sex. The most highly educated and wealthiest respondents are more likely to be tested than those with less education and a lower standard of living.

By wealth quintile, for example, less than 15 per cent of men in the lowest wealth quintile have been tested, while in the wealthiest households more than 40 per cent have been tested. Similarly there is a marked difference by residence with about 30 per cent of rural women and 24 per cent of rural men having been tested, while in urban areas 45 per cent of women and 42 per cent of men have been tested.

5.1.3 Epidemiological Situation of STIs

Information about the incidence of sexually transmitted infections (STIs) is not only useful as an indicator of unprotected sexual intercourse, but also as a determinant of possible HIV transmission.

The Health Survey asked respondents who have ever had sex whether they had an STI in the past 12 months. Less than one per cent of women and men in Moldova reported having an STI in the past 12 months; six per cent of women and one per cent of men reported having had an abnormal genital discharge, and about the same proportions reported having had a genital sore or ulcer (seven per cent of women and one per cent of men); while 11 per cent of women and two per cent of men reported having an STI, or an abnormal discharge, or a genital sore.

The Health Survey noted that STI-related estimates are likely to be under-estimates because respondents may be reticent or ashamed to admit having an STI or STI symptoms.

STI incidence in Moldova is high, as shown in Table 5.1.1. Some 9,181 STIs were recorded in 2005, although the number of people infected is probably less than this total due to the high probability of some people carrying multiple infections.

Table 5.1.1 – STIs by Gender Registered in 2005

STI	Women	Men	Total
Syphilis	1,198	1,303	2,502
Gonorrhoea	360	1,567	1,927
Chlamydia	2,073	1,260	3,333
Herpes Simplex	1,012	407	1,419

Source: WHO; Annual Country Report 2005 (April 2006)

Slightly more men than women were recorded being infected by syphilis (52 per cent of cases were in men), and 81 per cent of people with gonorrhoea are men. Nearly two-thirds (62 per cent) of cases of Chlamydia and nearly three-quarters of cases of herpes simplex (71 per cent) were in women. Syphilis, unlike any other STI is showing a downward trend, with the number of people infected with syphilis in 2004 having decreased from the 2003 cases by 11 per cent.

A total of 2,222 people were infected with either syphilis or gonorrhoea in the project area in 2005. Table 5.1.2 shows that STI incidence (syphilis and gonorrhoea only) per 100,000 people is significantly higher than the incidence of HIV, which could be indicative of a substantial under-reporting of people with HIV.[12] Chisinau and Balti again stand out as areas of very high incidence, but some districts that had indicated low HIV prevalence i.e. 20 cumulative cases or less, such as Criuleni, Ialoveni, Orhei and Telenesti have very high STI incidence rates per 100,000 people.

[12] This is also confirmed by Health Survey which reports that only about a third of the sample surveyed in 2004 had ever undertaken an HIV test.

Table 5.1.2 – Regional Incidence of STIs Registered in 2005

District	STI Incidence per 100,000 pop.	No. of Cases	
		Syphilis	Gonorrhoea
Balti	172.2	87	84
Criuleni	167.6	68	21
Chisinau	261.9	747	736
Hincesti	69.4	46	14
Ialoveni	172.5	98	27
Orhei	141.0	79	42
Singerei	69.1	37	5
Straseni	100.0	50	16
Telenesti	132.9	50	15

Source: WHO; Annual Country Report 2005 (April 2006)

5.2 Government Response & Stakeholders

5.2.1 Government Response

The national response to combat with HIV/AIDS and STIs is successful despite the difficulties of GRM in financing public services including health. The success is mainly due to a strong political commitment to fight the epidemic and substantial funding from international donors.

At the national level, the state policy on HIV/AIDS is implemented through the National Programme on Prevention and Control of HIV/AIDS and STIs for 2006-2010, which determines national strategies of priority for prevention, epidemiological surveillance and treatment. The National Programme has been developed as a result of a consensus-based consultation with key stakeholders in the field, including government, international organizations, non-governmental organizations (NGOs) and people living with HIV and AIDS (PLWHA). The National Programme was approved by the GRM in September 2005.

The National Programme includes the following strategies:

- Development, consolidation and ensuring the functioning of a national inter-departmental system to coordinate activities of state and NGOs in control and prevention of HIV/AIDS and STIs;
- Capacity building and expanding of information-education-communication (IEC) activities for the general public, youth and vulnerable groups in HIV/AIDS/STI prevention;
- Capacity consolidation and development of an epidemiological surveillance system of HIV/AIDS/STI infection with second generation elements (behavioural surveillance);
- Expansion of HIV/AIDS/STI prevention activities among vulnerable groups which aim at consolidating NGO and state efforts;
- Infrastructure development and development of medical assistance capacities, social and palliative care of PLWHA, members of their families and children affected by HIV/AIDS;
- Extending coverage activities for voluntary counselling and testing services in state medical institutions and their development within the framework of friendly youth health services;

- Capacity building of prevention transmission of HIV/AIDS and STIs from mother to child;
- Integrating the provision of blood transfusions and other medical interventions into the system for prevention of spread on HIV/AIDS infection and syphilis; and
- Complementing and expanding activities diagnosis, treatment and care for people with infection, including penitentiaries.

The main executors of the programme are: GRM - Ministry of Health & Social Protection (MoHSP); Ministry of Education, Youth & Sport; Ministry of Finance; Ministry of Internal Affairs; Ministry of Defence; Ministry of Foreign Affairs & European Integration; Ministry of Justice; the Public Company Teleradio-Moldova; local public administration authorities; mass-media; and, NGOs working in the field of HIV/AIDS and TB.

In addition to the National Programme, in 2007 GRM passed the Law on Prevention and Control of HIV/AIDS (Nr. 23-XVI). The purpose of the law is to provide an effective framework of legal relations regarding HIV/AIDS infection aimed at decreasing vulnerability to infection, by stopping the exponential growth of HIV/AIDS and reducing its impact by ensuring with medical, social, psychological care of PLWHA and their family members; and by guaranteeing and respecting their rights; as well as sustaining prevention and control efforts over the epidemic.

The objectives of the law are similar to the strategies included in the National programme.

5.2.2 Government and Bilateral Stakeholders

GRM works through Country Coordination Mechanism of National HIV/AIDS/STIs and TB Control Programmes (CCM).[13] The CCM oversees and manages all HIV/AIDS related activities involving various partners from both public sector, NGOs, and international donors. The CCM is chaired by the MoHSP. Most of the UN bodies and other international agencies are permanent members of the CCM including UNAIDS, UNICEF, WHO, UNFPA, WB.

Under CCM there are seven Technical Working Groups (TWGs) working on HIV/AIDS, where UN agencies are also active members:

- TGW 1 - Epidemiological and Sentinel Surveillance in HIV/AIDS-STIs;
- TGW 2 -Social Services, Education and Social Assistance;
- TGW 3 - Vulnerable Population;
- TGW 4 - Treatment and Care for PLWHA;
- TGW 5 - Communication and Prevention;
- TGW 6 - Monitoring and Evaluation; and
- TGW 7 - TB/ HIV Coordination.

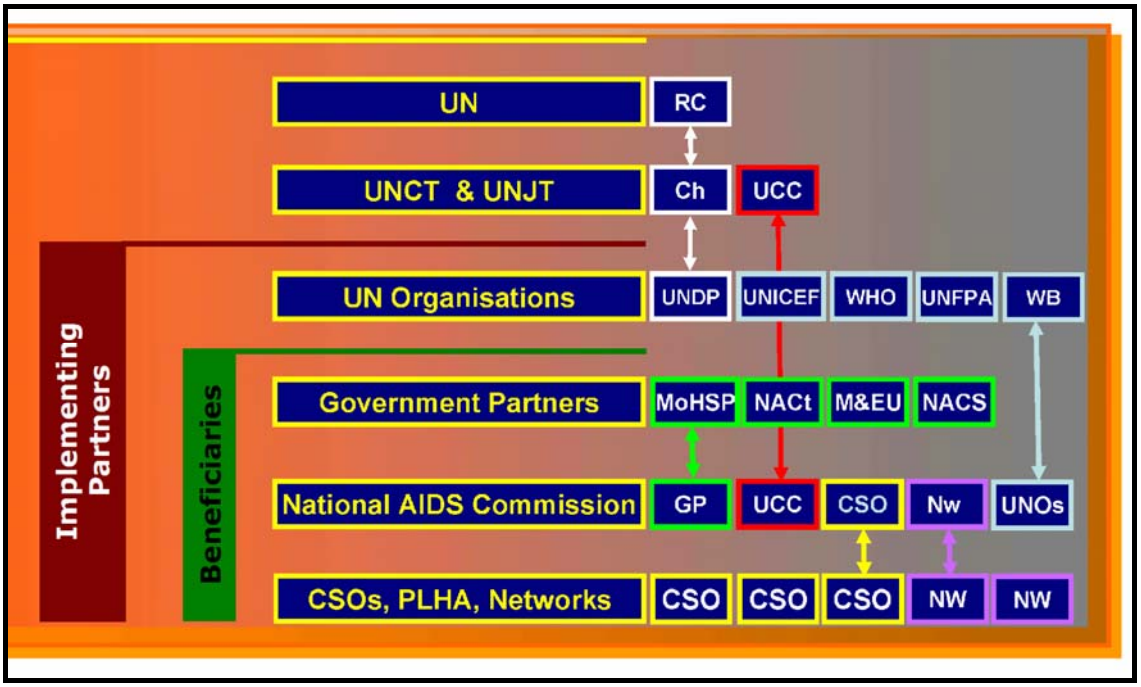
Besides the CCM, UN agencies work jointly under UN Country Team (UNCT) and UN Joint Team (UNJT). UNCT is the decision making body on HIV/AIDS in the UN, which directs, coordinates and gives approval for the activities of all UN agencies on cross-cutting areas, including HIV/AIDS, whereas UNJT acts as a special team bringing

[13] Sometimes referred to as the National Coordination Council (NCC) or National AIDS Centre (NAC).

together the technical staff together from relevant UN agencies and other international donor organisations working on HIV/AIDS activities.

The linkages between the stakeholders is shown in Figure 6.

Figure 6 – Stakeholders in HIV/AIDS and STIs Control Programme



Source: Report of a UNAIDS Mission to Review & Assess Programme Acceleration Fund Activities (2006)

GRM's activities in the implementation of National Programme strategies are supported technically and financially by international organizations, as well as grants from the Global Fund to Fight AIDS/TB/Malaria (GF). These organizations have contributed to the implementation of commitments undertaken through the Declaration signed by the GRM at the Special Session of the General Assembly of the UN on HIV/AIDS in June 2001.

5.2.3 Non-Government Organisations

The GF is providing an initial US$16 million to GRM under Round 6 of funding the HIV/AIDS and TB control activities of various countries, additional funding is being provided by IDA. A large proportion of this funding is provided to NGOs, with one recipient being the TB/AIDS Program in Moldova (TAPM) which is primarily funded by GF and WB, the TAPM coordinates and implements a number of projects and programs for control of TB and HIV/AIDS. The TAPM has secured in the order of US$28 million for projects and programmes to 2012, in the HIV/AIDS awareness, prevention and treatment sector activities will include:

- Working with vulnerable and high-risk groups (including truck drivers);
- Scaling-up support and anti-retroviral treatment for PLWHA;
- Scaling-up testing and diagnostic facilities and capacities; and
- Increasing capacity for response to HIV/AIDS.

The TAPM works with SOROS Foundation, the lead agency coordinating the Public Health Programme under which 30 NGOs receive funding.

There are in the order of 67 NGOs working in the HIV/AIDS and STIs control and prevention sector. The NGOs work with at risk groups such as teenagers and youth, PLWHA, drug addicts and IDUs, street children, victims of trafficking, and partner with a range of organisations such as medical and health centres, institutions, and the

police to provide support and services to the different groups. Some 22 of the NGOs participate in the Harm Reduction Network which implements a number of projects for the most at risk coordinated by SOROS Foundation Moldova and Youth with a Right to Life (Balti Branch).

The types of projects and activities implemented by various NGOs active in the sector include:

- Various events coordinated with World AIDS Day;
- Training and seminars for target (at risk) groups, distribution of IEC materials and social marketing of condoms;
- Nation-wide mass media campaigns (radio, TV, dance events and concerts, sports competitions);
- Soup kitchens and rehabilitation financial support for PLWHA and victims of trafficking;
- Needle/syringe exchange programmes, distribution of disinfectants and condoms along with information on hygiene and safety amongst IDUs;
- Re-socialization programmes for CSWs i.e. provision of training and skills in alternative income generation fields (i.e. hair-dressing, book keeping, tailoring etc);
- Support for consultations, diagnosis, treatment and counselling amongst at risk groups;
- Establishing and operating a telephone "hot-line" for people needing information on HIV/AIDS or STIs; and
- Establishment and operation of "youth friendly" clinics and associated activities and services.[14]

With the support of NGOs harm reduction projects have been implemented, including projects in penitentiaries, among sexual minorities, persons with high risk of infection, training of trainers and volunteers in life skills and peer education (adolescents, youth, army personnel, carabineers, border guards), social and psychological support, hotline counselling, journalists training.

Appendix 1 contains the list of stakeholders consulted during completion of the social assessment and Appendix 2 presents the list of the NGOs active in the sector.

The UNFPA, in association with Family Planning Association, is coordinating and implementing the regional programme for the Youth Peer Education Network. Some 80 youth (16 – 25 years old) have participated in a "training-of-trainers" programme and are maintained as part of the national youth network, the aim of the program is to train in the order of 1,100 youth as peer educators. UNICEF runs a parallel programme aimed at youth younger than 14 years of age.[15] The current focus is vulnerable youth and young people especially those in boarding schools, reform schools or prisons who have no access to age-appropriate information and materials on HIV/AIDS and STIs awareness and prevention.

[14] From 2007 the youth friendly clinics are being sponsored by GRM through medical insurance, previously they were funded through NGOs.

[15] UNICEF also has a Most At Risk Adolescents Programme which is developing a national action plan for at risk teenagers and homeless/street-kids.

In 2008 UNFPA's training programme will include the Reproductive Health Cabinets (RHCs) which operate at district level across the country. The RHCs are part of the primary health-care system targeting prevention of STIs and HIV and distribute free condoms to at risk people including rural women, young people, women with three or more children, and informally to CSWs. As part of the overall peer education programme UNFPA will be providing training to RHCs to facilitate "youth friendly" health, awareness and prevention programmes.

5.3 Risk Associated with the Project

There is a risk of spread of HIV/AIDS during both the construction and operation phases of the project. The civil works phase of subprojects can pose risks for both the construction workforce and the communities in which subprojects are located for the civil works/construction period.

High risk groups in the project area include the construction workers themselves, many of whom are likely to be migrants either from other areas in Moldova or part of an international contractor's workforce, the mobile population such as traders, people from household who travel for marketing or selling, seasonal migrants, poor men (who risk passing it on to their spouses or partners), IDUs, and CSWs (including women who might engage in sex work infrequently).

5.3.1 Risks during Construction Phase

The anticipated construction workforce required for the project will be in the order of 900 workers, about a quarter of whom could be brought in from outside Moldova by an international contractor. While preference will be given to recruiting locally (including women and those living below the poverty line), it is unlikely that the local workforce required for the three road improvement contracts (approximately 675 workers) can be sourced entirely from within the nine districts making up the project area, and Moldovans from other areas could respond to calls for work, therefore there will be an inflow of construction workers associated with the project.

The lack of adequate knowledge of HIV/AIDS among migrant workers, and the likelihood of engaging in behaviours they would not at home, contributes to risk behaviours such as increased alcohol intake, unsafe sex and injection of drugs. The vulnerability of migrants is compounded by their mobility and their social separation from the local community which in turn prevent them from accessing social and health care services, this is exacerbated when the migrant workers are not Moldovan. For example, migrant laborers often do not want to use local medical systems, and thus STDs and possibly HIV amongst foreign migrant workers remains unchecked. The risk of HIV/AIDS infection is therefore increased.

As two of the road sections start in the vicinity of Chisinau and the third in Balti, it is assumed that construction camps will not be required for worker accommodation, but that rather, the contractors would elect to find accommodation for the workers in houses, flats or dormitories in Chisinau or Balti or expect the workers to arrange their own accommodation.

The project will be divided into three contract packages. The contract packages will either be a combination of Moldovan contractors and international contractors. Packages will require construction workforces of approximately 300 people (sealing crews, erosion control crews, pavement work crews, manager, and ancillary staff such as cook and security guards). Pavement work and sealing can be undertaken at a rate of 1 km/day, and it is likely that a construction team will travel along a section of 30 km on gravel road and 60 km on a sealed road before needing to relocate the base work-camp. Therefore any one construction force could be working in an area for between 1.5 months to 3 – 4 months, while the workers are most likely to live in the Chisinau and Balti (based on assumptions set out above).

Even assuming that most of the civil work can be undertaken by local unskilled labor, there will still be about a fifth – a quarter of the workers who will need to be skilled and semi-skilled and most likely to come with the international contractor or be out-sourced.

5.3.2 Risks during Operation Phase

The project will facilitate an increase in transit traffic. Some of the already roads carry significant traffic, across the project area traffic volumes in terms of average annual daily traffic (AADT) vary from 8,784 (Chisinau – Hincesti) to between 4,072 and 16,608 (Chisinau – Sarateni), and 4,766 along the Balti – Sarateni road.

The data shows that heavy traffic (truck, truck and trailer, and articulated truck) ranges from 7.5 per cent along Chisinau – Hincesti road, 10.8 per cent along the Balti – Sarateni road and between 10.9 and 13.9 per cent along Chisinau – Sarateni road, while high occupancy traffic (buses and mini-buses) accounts for 20 per cent of traffic (Chisinau – Hincesti and Chisinau - Sarateni) and 18 per cent of traffic along the Balti – Sarateni road.

In terms of risk of transmission of communicable diseases during operation, roads and highways have the potential to pose a risk as a pathway for disease transmission. The risk increases with the hierarchy of road, its location, and number of villages and towns connected with a larger town or city.

Further, each of the roads in the project is directly connected to an international border, or links with another road that is connected to an international border, as shown in Table 5.3.1.

Table 5.3.1 - Road Connections to Major Internal Markets & International Borders

Road	Major Internal Markets	International Border
Chisinau - Hincesti	Chisinau, Ialoveni, Hincesti, Causeni, Cahul, Gagauzia	Romania (via R-33, R-34, R-37)
Chisinau - Sarateni	Chisinau, Orhei, Ungheni, Telestini,	Ukraine (via R-2, M-21, M-2)
Balti, Sarateni	Soroca, Balti, Falesti, Orhei, Chisinau	Ukraine (via M-4, R-7, R-9) Romania (via R-16, R-7)

With improved access to Chisinau and Balti, as well as facilitating international trade, truck traffic is likely to only increase with the roads potentially becoming major thoroughfares. Truck drivers known to be a high risk group (largely due to their mobility)

The risk of truck drivers engaging in high risk behaviour is increased by hospitality service industries (restaurants, bars, beer gardens, truck/bus stops, massage parlours etc) locating along the roads and acting as conduits for sex work to communities, travelling businessmen and officials, and truck/bus drivers.

The high migration patterns that exist in the project area, and in Moldova generally, s is also considered to increase the risk of spread of HIV/AIDS. This is exacerbated by low knowledge of HIV/AIDS awareness and prevention. The findings of the Health Survey report showed that in terms of levels of knowledge of HIV prevention there are notable differences in terms of location.

There is ten per cent difference in the level of knowledge of all prevention methods between urban and rural residents, with rural residents less likely to know HIV prevention methods. As expected, women and men with higher levels of schooling are significantly more likely than those with lower levels of schooling to be aware of various preventive methods.

5.4 Mitigating the Risk

A project aimed at increasing awareness of HIV and STI issues and control of same in registered truck and bus drivers funded through the TB/AIDS Programme in Moldova and implemented by the NGO Medical Reform was completed in November 2006. The project was implemented with the assistance of Road Safety Centre in MOT, and reached some 7,463 truck and bus drivers. A second project is due to be implemented in 2008. The road project can link with this initiative as set out below.

Potential effects on construction workers, communities and road-users will be mitigated through implementation of an awareness and prevention programme, as well as an item to be included in the loan covenant which clearly requires the implementation of the HIV/AIDS prevention and awareness campaigns for construction workers and communities, and this should be translated into a clause in subproject contract documentation.

The objective of the programme will be to raise public awareness and address the risk of HIV/AIDS and STIs transmission and human trafficking among construction workers, sex workers, local communities, truck drivers, border officers, and other road users, and should focus on capacity building by utilizing international expertise in addressing HIV/AIDS, STIs, and human trafficking, concentrating on HIV/AIDS and STIs through sexual transmission rather than IDU, which is the main mode of HIV transmission in general, as road projects tend to be associated more with sexual transmission.

As previously shown in Table 3.2.1, there are high Russian and Ukranian populations in Balti, and therefore any IEC materials need to be presented in both Romanian and Russian languages.

The programme includes the following components:

(a) HIV/AIDS in the workplace training for contractors

HIV/AIDS in the workplace training for contractors – a series of 3 workshops and seminars will be provided for contractors and their construction force, these will be facilitated through ILO and implemented by an NGO or consultant. The training will include; basic information on HIV/AIDS – history, terminology, statistical data (global, regional CIS, and Moldova), legal background (law and regulations etc); ILO Code of Practice on HIV, HIV in the workplace issues, paths of transmission, high risk groups (how and why); prevention measures; stigma and discrimination issues. In addition to the training the costs of this component of the programme include HIV and STIs testing for the construction workforce every year for the two-year contract period;

(b) Promotion of behaviour change

Promotion of behaviour change - intensive health education campaigns and peer education will be undertaken to promote behaviour change among construction workers, and local people in the project area. Information will be disseminated through posters, pamphlets, and launch events in Romanian and Russian languages during the rehabilitation of the project's roads.

Outreach to most vulnerable and at risk youth will be included through the youth peer educators network (supported by UNFPA). Condoms will be made available free of charge to workers, communities, during the first year of rehabilitation of the project roads. The programme will also cover additional requirements of the mobile populations to augment condom distribution programmes of other agencies, this part of the programme will include co-financing of the TAPM which is due to include a second project aimed at truck and bus drivers starting in 2008;[16]

[16] The first project was commenced in 2004 and completed in November 2006. It was implemented by the NGO Medical Reform working with MOT's Center for Road Safety. The approximate cost of the first project was US$23,500 (excluding condoms which were provided through SOROS Foundation).

(c) Human trafficking prevention

Human trafficking prevention – linking with the work of IOM and Winrock International the project's programme will provide training in HIV/AIDS, STIs, and human trafficking (especially dealing with migrant issues) through working with relevant government agencies, local institutes, and NGOs for capacity building. Workshops will be organized for relevant participants to discuss activities to combat HIV/AIDS and human trafficking, and establish a coordination network on human trafficking prevention; and

(d) Advocacy workshops and policy development

Advocacy workshops and policy development - to improve understanding of the awareness and prevention programme on HIV/AIDS, STIs, and human trafficking among stakeholders, advocacy workshops will be conducted, including information and education campaigns. The workshops will target local governments and communities, local business owners, relevant NGOs, transport operators, media, local police, road construction companies, and the local units of the SRA. The aim of this component will be to facilitate MOT's participation in CCM activities and formulation of an internal policy statement and action plan for HIV/AIDS and STIs prevention within the transport development sector.

5.5 Programme Implementation & Cost

The awareness and prevention programme will build on the ongoing efforts of the Government and other agencies, including the UNAIDS, GF/TAPM, UNDP, United States Agency for International Development (USAID), and WB, which are the major actors supporting the national HIV/AIDS control programme.

In terms of anti-trafficking, the programme will link with International Organization for Migration (IOM), Organization for Security and Cooperation in Europe (OSCE), and (USAID funded) Winrock International as key contributors to the GRM programmes for human trafficking prevention.

In respect of implementation, NGOs with proven experience in HIV/AIDS and STIs awareness and prevention, training-of-trainers, workshop organization and delivery, and community participation will be required. The NGOs will have, and provide evidence of, a track record in providing similar services to that required by the project's programme. At this stage it is envisaged that the project's programme will be implemented as follows:

- An NGO to coordinate and manage the delivery of the overall programme, coordinating the activities of NGOs or consultants recruited to deliver specific components of the programme. This NGO will also be responsible for engaging the experts recruited to prepare and deliver the training and information to the contractors (including the adaptation of existing materials); and this NGO will be responsible to deliver the community awareness and prevention component.

The peer educators will initially be identified by UNFPA through its youth peer education network, the peer educators will have already received initial training through UNFPA's program. The NGO will provide further on-the-job training to the peer educators, they will support the activities of the awareness and prevention programme and will provide outreach activities based on the model already established with funding from Global Fund.

Any IEC materials to be adapted, and general contents of the community and contractors' training courses and awareness programs, will be presented to TWG-5 – Communication and Prevention of CCM, for advice and approval.

Any materials and overall content will conform to the draft guidelines and framework prepared by the TWG-5.[17]

The NGO will prepare a proposal describing their relevant experience, detailing how they intend to implement the programme (with an implementation schedule), and budget (in line with cost estimate provided in Table 5.5.1).

The programme will co-finance the TAPM in respect of its project for increasing awareness and providing training to truck and bus drivers in HIV/AIDS and STIs prevention. Therefore, an NGO will not be recruited separately under the project for this component.

It is recommended that the GRM request WB to provide a parallel or ancillary technical assistance for awareness and prevention of HIV/AIDS, STIs, and human trafficking associated with the project which will fund the programme outlined above. The GRM will be expected to finance the remaining local currency cost by providing in-kind contributions of counterpart staff, office space, and workshop facilities.

An outline Terms of Reference (TOR) has been prepared, and is included as Appendix 4.

[17] CCM-TWG-5; *Mechanism for Evaluation and Approval of Information and Materials in Field of HIV/AIDS and STIs*, Chisinau (2007)

6 Other Social Impacts & Issues

6.1 Comments on Safety Issues

There are safety issues associated with vendors using the side of the road, without a formal lay-by from which to access the kiosks and shops. This situation is exacerbated by non-motorised traffic (NMT) and the motorized carts mixing with regular traffic, even though they are much slower, swerve in and out of the main traffic stream, and make frequent stops.

Most of the NMT is horses drawn carts, and pedestrians, there is also usage of motorbikes and motorized carts (either motorbike with side car or three-wheel motorbike with a cart at the rear). Traffic count data indicates that NMT along the Chisinau – Sarateni road section is in the order of 14/day.

The main reason that users of NMT and the motorized carts travel with main traffic stream, despite it being hazardous, is because the road shoulders are either largely unformed or are unsealed (gravel or earth), in many cases the gravel has disappeared leaving large holes and in other cases the existing shoulders also act as the drain and are often filled with water, making it impossible for use by NMT or pedestrians.

Reducing the risk of accidents and improving the safety of pedestrians, NMT users and road-side sellers can be achieved by providing hard (sealed) shoulders in the road design. Providing hard, instead of soft shoulders, is also preferred from an engineering point of view because it prolongs the life of the road pavement. Road markings and signage would further enhance safety and indicate that NMT and pedestrians should use the shoulders, rather than mix in the main stream if traffic. Providing hard shoulders will also encourage road-side sellers to shift their operation from the road to the shoulder.

Safety issues have also been addressed in the environmental assessment and environmental management plan.

6.2 Impacts on Ethnic Minorities

The ethnicity of the project area has been described in Section 3.2.1. In addition to the predominantly Moldovan population (84 per cent) there are Russians and Ukranians, as well as people of other nationalities found in the former Soviet Union in small proportions in some areas. In the project area, the Russians and Ukranians are ethnically in a minority but are urbanised, concentrated in Balti, and do not necessarily present other characteristics that would lead them to be described as an ethnic minority or indigenous people in the context of World Bank's policy on *Indigenous People* (OP 4.10, January 2005).

Further, the households within the project area who may have lived in traditional ways for centuries were collectivized and integrated into the economic and social structure of the Soviet Union during the 1920s and 1930s, in line with the Soviet goals to industrialize and mainstream rural production and rural ways of life, who stated that the different ethnic groups have been living together in mixed communities since this time.

No disproportionate adverse impacts or changes to the livelihoods or culture of non-Moldovan people are anticipated and therefore the World Bank's policy on *Indigenous People* is not triggered and there is no requirement for a specific action or development plan in favour of ethnic minorities/indigenous people within the project area.

6.3 Risk of Human Trafficking Associated with the Project

6.3.1 Current Situation: Human Trafficking

The widespread poverty and lack of job opportunities drive many Moldovans to look for work elsewhere. According to official local sources, it is estimated that between 600,000 to one million Moldovan citizens are working abroad, most of them illegally, in Russia, Italy, Ukraine, Romania, Portugal, Spain, Greece, Turkey, and Israel. Only about 80,000 are estimated to be in their destination country legally. According to the 2004 Census, some eight per cent of the population are registered as outward migrants.

The high number of irregular migrants has left the door wide open to criminal organizations ready to exploit an already vulnerable group. Moldova, by far, has the greatest number of trafficking victims in the region.[18] However, of the Moldovans living abroad, no reliable data on the total number of trafficked persons is available given the multi-faceted nature of the crime and the absence of a standard identification procedure. None the less, information from countries of destination confirms a prominent number of Moldovan citizens among the identified trafficked persons.

Between January 2000 and December 2004, the total number of Moldovan nationals assisted as victims of trafficking by the IOM and other NGOs was 1,633, and more than 1,144 women and minors have been returned home through the IOM's counter-trafficking reintegration programme, but this is only a fraction of the numbers of those still trafficked abroad.

Most Moldovan victims are women and children trafficked for the purpose of sexual exploitation, although a number of men have also been trafficked for forced labour and begging. Children are trafficked for sexual exploitation and begging.[19]

The IOM reports that Moldovan victims have been trafficked to 32 destination countries in Western Europe, South Eastern Europe, the Middle East, the former Soviet Union, including Russia, and the United States. In 2004, the destination countries included Turkey (45 per cent), South Eastern Europe (18 per cent), the Middle East (15 per cent), Russia (11 per cent), and Western Europe (8 per cent). Thus, the number of trafficked persons returning to Moldova, especially from the Western Balkans, is slowly declining, whilst the number of trafficked women returning from Turkey and Russia is increasing. There is also more information about trafficking from Moldova to Israel and the Middle East, as well as more evidence of children being trafficked to Russia.[20]

As the western border of Moldova is better controlled, there is less evidence of trafficking through Romania and more evidence of trafficking through Ukraine to Russia. Internally, border control issues affecting the separatist region of Transnistria in eastern Moldova and the autonomous territorial unit of Gagauzia in southern Moldova are considered to facilitate trafficking. In addition, internal trafficking inside Moldova is said to be increasing, whereby traffickers bring young girls from rural areas to the cities and force them into prostitution, and then sometimes later traffic them abroad as well.

Women constitute the largest portion of the overall number of trafficked persons, and the majority of them find themselves trapped in debt bondage, servitude, or slavery-like conditions in sweatshops, agricultural work, domestic and other forced labour, and

[18] IOM & SIDA; *Migration Management Assessment in Moldova* (2003)
[19] Winrock International; *Moldova Anti-trafficking and Gender Network website* (2007)
[20] MoHSP; *Annual Social Report 2005*, Chisinau (2006)

marriage situations. Demand for "voluntary" or "coerced" employment in the sex industry further drives trafficking for sexual exploitation. Arguably the strongest factor luring women into being trafficked is their desperate economic situation and their inability to find satisfactory employment in Moldova or abroad.

6.3.2 Government Response

The GRM has been responding to the issues of human trafficking since 2000 when it established a special anti-trafficking unit within the Office of the General Prosecutor. In 2001, GRM undertook further anti-trafficking efforts, including the establishment of an ad hoc National Committee to Combat Trafficking in Human Beings (NCCTHB), chaired by the Deputy Prime Minister. The NCCTHB is composed of some 15 national officials, mostly at the level of deputy minister and NGOs and international organizations may participate as observers in open sessions. Local multi-disciplinary anti-trafficking committees have also been established in all districts of Moldova.

Moldova became IOM member number 101 in 2003 when in May GRM accepted the IOM Constitution (Resolution no. 215-XV) and assisted by IOM and SIDA developed a migration strategy for Moldova.

The OSCE has had a field presence in Moldova since 1993. In 2003 the OSCE Mission expanded its human dimension portfolio to work to combat trafficking in human beings and promote gender issues. More specifically, the Anti-Trafficking and Gender Programme of the Mission seeks to prevent and combat trafficking in human beings; to prevent and combat domestic violence; to promote gender equality and women's rights; to enhance identification, protection and assistance to victims and vulnerable persons; to support the observance of human rights and fundamental freedoms; and to encourage the observance of the rule of law. The total authorized strength of the Mission is fourteen international members, supported by thirty-two local staff.

In 2005 GRM and the US entered into a Letter of Agreement committing themselves to working together on the creation of a new inter-agency Center for Combating Trafficking in Persons.

The OSCE Mission, in partnership with Winrock International's project *New Perspectives for Women*, developed an Anti-Trafficking & Gender Network Website in English, Romanian, and Russian languages. This Website, launched in 2006, includes a database of organizations, projects, and activities, as well as news and events.

The main framework for combating trafficking is contained with the following documents:

- Articles 165 and 204 of the Criminal Code of the Republic of Moldova (No. 985-XV, 2002);
- National Plan of Actions in Human Rights (Nr. 415-XV, 2003) included provisions on prevention of trafficking in human beings and proposal of a new law prohibiting trafficking;
- Decision of the Supreme Court of Justice on application of legislative provisions in cases of trafficking in human beings and trafficking in children (No. 37, 2004);
- Law on Preventing and Combating of Trafficking in Human Beings (No. 241-XVI, 2005);
- National Action Plan to Prevent and Combat Trafficking in Human Beings (No. 903, 2005); and
- Decision of National Committee to Combat Trafficking in Human Beings – excerpt on creation of a unified system for monitoring the implementation of the National Plan to Prevent and Combat Trafficking in Human Beings (February 2006).

6.3.3 Project Risk and Mitigation

A preliminary assessment whether project impacts will increase vulnerability to people from within the project area being trafficked and identifying opportunities to prevent or minimize the risks has been undertaken.

During the construction phase of subprojects, there are many opportunities to target those most vulnerable to trafficking with benefits such as job opportunities with construction work. The construction phase will also bring temporary laborers into the surrounding area with impacts on the communities such as increased demand for CSWs from construction workers (also refer to Section 5, discussing risk of spread of HIV/AIDS and STIs), introduction of new ideas as well as employment opportunities, increased demands on existing health services from construction workers, and temporary disruptions for some community members, that might lead to increased vulnerability to being trafficked, and disintegration of social networks.

In respect of potential for trafficking associated with the operation phase of the project the main factors include; (i) high unemployment and poverty in the project area; (ii) location along transit and international traffic routes; (iii) connection to international borders; and, (iv) large population centers with an already known steady outward migration (registered and illegal). Based on data provided in the 2004 Census the project area has overall six per cent, and between four per cent (Chisinau) and 11 per cent (Singerei) of its population migrating out of Moldova, this is the declared or registered migrants only, the number of illegal emigrants will be much higher. In most districts the migrants are men, the exception being Chisinau which registers slightly more migrating women than men. Work is the primary reason given for the migration and the period of migration is less than a year for 48 per cent of the migrants.

Table 6.3.1 – People Migrating from Project Area

District	Registered emigrants	% of total pop	% men	% migrating for work	% migrating for < 1 yr
Chisinau	27,380	3.8	49.8	76.8	43.5
Balti	8,593	6.7	54.9	84.0	50.1
Criuleni	4,231	5.9	56.5	90.3	49.1
Hincesti	11,410	9.5	52.1	92.2	37.4
Ialoveni	7,619	7.8	57.9	90.6	48.3
Orhei	9,060	7.8	58.5	89.9	45.7
Singerei	9,678	11.1	64.1	91.9	67.0
Straseni	7,618	8.6	54.8	89.3	44.0
Telenesti	6,082	8.7	61.5	88.4	60.0
Project area	**91,671**	**6.1**	**55.1**	**85.9**	**47.8**

Source: Population Census 2004

In terms of anti-trafficking, any measures that bring greater economic opportunities to rural communities can reduce vulnerabilities to trafficking, and particularly projects that broadly support the agricultural sector have the potential to target the poor and vulnerable and seek to increase access to productive resources by those most marginalized.

Mitigating the social impacts of construction phase include:

- Assessment of the risk and how project activities could affect migration patterns and provide opportunities for traffickers to become active in the project area. Safe migration packages need to be included and these are addressed through the anti-trafficking component of the HIV/AIDS awareness and prevention programme;

- The incorporation of awareness messages into project components already addressing community impact issues, and codes of conduct for construction workers that raise concerns about commercial sex workers and child prostitution can also be a means to address some trafficking issues; and
- Awareness messages with commercial sex workers and construction workers can be combined with anti-trafficking and safe migration messages because migrant construction workers are a high-risk group for HIV/AIDS.

Ensuring that the most vulnerable to being trafficked are aware of the risks and are provided with the opportunities to resist risks associated with migration under unsafe conditions and the temptations of traffickers. The project includes a range of anti-trafficking measures and components as shown in the Table 6.3.2.

Table 6.3.2 - Anti-trafficking Components of Project

Component	Actions	How Addressed in Project
Improving access	Risk of trafficking associated with roads addressed during social assessment; Ensuring most marginalized (and at risk from trafficking) are part of subproject construction employment opportunities	Social Assessment (identifying specific risks); HIV/AIDS and STIs awareness and prevention programme incorporating anti-trafficking measures
Reducing vulnerability and risk (female farmers, single women, women and children left vulnerable from migration of husband/father)	Encouraging the most vulnerable to participate in project activities to increase access to productive resources; Providing direct employment opportunities during project construction	HIV/AIDS and STIs awareness and prevention programme incorporating anti-trafficking measures; Encouragement of participation of women in project activities including construction and O&M;
HIV/AIDS and STIs and trafficking awareness and prevention	Raising community awareness of trafficking operations in project area, included into social mobilization activities	HIV/AIDS and STIs awareness and prevention programme incorporating anti-trafficking measures

7 Conclusions

The conclusions of the social assessment are that; (i) there will be no land acquisition required by the road improvements, all widening can be undertaken within the roads' protection zones and therefore a resettlement plan within the meaning of WB's *Involuntary Resettlement* policy is not required; and, (ii) there is an identifiable risk of spread of HIV/AIDS and STIs during both construction and operation stages of the project and this risk should be mitigated through implementation of a project-specific HIV/AIDS and STIs awareness and prevention programme.

The social assessment includes an outline TOR for the programme and a cost estimate.

The contracts for each road package should also include enforceable provisions or clauses as follows:

- The contractor shall implement the HIV/AIDS and STIs awareness and prevention training as specified in the project's Social Assessment;
- The contractors shall implement all health and safety provisions including in the project's environmental management plan, including provision of all necessary safety equipment such as goggles, helmets, reflector vests and ear-muffs etc;
- The contractor shall not use child labour in the construction workforce (including being engaged as ancillary staff such as guards, cooks or cleaners);
- The contractor shall not employ any persons that have been trafficked or illegal migrants in the construction workforce (including being engaged as ancillary staff such as guards, cooks or cleaners);
- The contractor shall comply with all local labour regulations in terms of minimum wages and working conditions (including observances of national holidays); and
- The contractor shall employ local labour to the maximum extent possible and will include women and the poor in the local workforce.

The above will also be incorporated into the project's monitoring plan in order that contractors' compliance can be verified or otherwise.

Appendices

Appendix 1 – Record of Stakeholder Consultation

Date	Organization	Person Consulted	Designation
11.10.07	AIDS Center	Stefan Gheorghitza	Vice Director CCM
18.10.07	UNAIDS	Gabriela Ionascu	Country Coordinator
19.10.07	UNFPA	Dr. Angela Alexeiciuc	Youth Programme Coordinator
		Alexandrina Iovita	National Programme Officer
22.10.07	ILO	Elena Jidobin	National Focal Point HIV/AIDS
22.10.07	Health Communication Network	Irina Zatusevski	President
23.10.07	CCM of National HIV/AIDS/STIs Prog.	Svetlana Plamadeala	Stakeholder & Comm. Adviser
23.10.07	Medical Reform	Dr. Alexei Leorda	President
23.10.07	TB/AIDS Program in Moldova	Victor Burinschi	Project Coordinator
		Liliana Caraulan	M&E Specialist
23.10.07	AIDS Foundation East-West	Olga Osadcii	Project manager Media Campaigns
	CCM TWG Comm. & Prevention		Head
25.10.07	SRA - PIU	Usatii Anatolii	Director
		Veaceslav Vladicescu	Soc & Env Consultant (WB funded)
31.10.07	Youth with a Right to Life (Balti)	Ina Biriucova	President

Appendix 2 – List of NGOs Working in HIV/AIDS & STIs Awareness & Prevention Sector

Location	Name of Organization	Contact Person
Chisinau	AIDS Foundation East-West	Olga Osadcii
Chisinau	Voice of the Youth - Initiative of the World Bank	Iulia Sarghi
Chisinau	Information Centre Gender Doc-M	Alexei Maricov
Chisinau	Medical Reforms	Dr. Alexei Leorda
Chisinau	New Life	Irina Gorskaya
Chisinau	Migration Program	Jana Costachi
Chisinau	Faith	Igori Chilicevschii
Chisinau	Young People for the Right to Life	Antonita Fonari
Balti	Young People for the Right to Life	Ina Biriucova
Chisinau	Resource Centre - Young and Free	Oxana Turcanu, Ana Caireac
Chisinau	Your Choice	Valerii Antonov
Chisinau	Dream – Life, Information, Health	Ion Bologan
Rezina	Our Future	Ion Cheptene
Balti	The Second Breath of Aged & Inactive People	Irina Baicalov
Chisinau	P.A. My Generation	Maria Boico
Falesti	Let's Save Together the Future	Iurie Osoianu
Orhei	Teenagers	Tatiana Sorocovici
Causeni	Thinking of Future	Ion Calmic
Chisinau	Innovative Projects in Penitentiaries	Larisa Pintilei
Sangerei	CASTITAS – National Assoc. for Family Health	Arcadi Covaliov
Chisinau	Health for the Youth (Neovita)	Galina Lesco
Chisinau	Society-Individual-Health- Future	Silvia Stratulat
Chisinau	Caritas Luxemburg Foundation in Moldova	Valentin Laticevschi
Chisinau	American International Health Alliance	Viorel Soltan
Chisinau	Netherlands Royal organization of TB Control	Vitalie Morosan
Chisinau	Moldova Health Communication Network	Irina zatusevschi
Edinet	Centre of Health Promotion and Education	Vasile Sofronie
Ungheni	Vis-Vitalis	Gheorghe Obada
Soroca	Ed. Centre for Alcohol and Drug Addiction	Ion Marcoci
Donduseni	Young Women –Cernoleuca	Tatiana Cojocaru
Chisinau	IMSP DNR	Tudor Vasiliev
Tiraspol	Future Generation	Valeriu Stepanov
Tiraspol	Assoc. of Young Journalists of Transnistria	Liuza Dorosenco
Chisinau	Assoc. of Young Trainers of Moldova	Elena Racu
Chisinau	AIDS Centre	Stefan Gheorghita
Chisinau	Health Communication Network	Irina Zatusevski
Hincesti	O. Social-Rural	Maria Brodescu
Ungheni	Midas	Aurel Chiorescu
Dubasari	Doctors for Ecology	Elena Stepanova
Tighina	Mercy	Turcan Maria

Tighina	Young People's Choice	Alexandru Gonciar
Chisinau	Assoc. of Social Rehab. of PLWHA & Drug Addicts	Nina Tudoreanu
Chisinai	Anti-HIV	Ruslan David
Location	**Name of Organization**	**Contact Person**
Chisinau	AIDS Network	Victoria Rusu
Pelinia	Motherland	Tamara Grivceanschi
Sofia, Drochia	Native Country	Lucia Edu
Budesti	Group of Peer Trainers	Aliona Luca
Causeni	Medical Preventive Centre	Iurie Panzaru
Chisinau	Penitentiary Institutions of Ministry of Justice	Vladimir Taranu
Chisinau	Republican Drug Users Dispensary	Tudor Vasiliev
Causeni	Tighina District Youth Council	Olga Pusca
Tiraspol	Republican Hygiene and Epidemiologic Centre	Piotr Olievski
Chisinau	National Youth Council of Moldova	Iosif Moldovanu
Moldova	Rural 21	Iurie Cheptanari
Chisinau	World without Drugs	N/A
Chisinau	Youth Development Centre	Ion Moldovanu
Chisinau	CIVIS	Eduard Mihailov
Chisinau	International Relief Friendship Foundation Moldova	Nicolae Cirpala
Stefan Voda	Healthy Family	Iurie Cheptanari
Moldova	Life and Health	Vasile Enciu
Giurgiulesti	Local Agenda 21	Olga Bucinschi
Causeni	CMP	Elizaveta Iordan
Chisinau	SOROS Foundation	Virginia Revenco
Chisinau	Italian Solidarity Consortium	Veaceslav Balan
Chisinau	AMAS	Viorel Prisacari
Drochia	PF and SR Society	Nicov Svetlana
Chisinau	ADSESTO	Tatiana Munteanu
Chisinau	ONSM	Valentina Ursu
Chisinau	Hoffnung	Iovleva Anna
Chisinau	Families Federation	Ghitac Marcel

Appendix 3 – Detailed Breakdown of HIV/AIDS & STIs Awareness and Prevention Programme for the Project

Overall Programme					
	Item	**Basis**	**Rate (US$)**	**No.**	**Total (US$)**
	Contractor Awareness Training				
	IEC materials (incl. folder) - total	LS			2,500
	Reprint AIDS Foundation cards & booklets	pax	0.6	900	540
	Reprint ILO materials	pax	0.6	900	540
	Reprint posters	pax	1.0	900	900
	Experts/trainers presenting	pax/day	100	2*3	600
	Condoms (10,000 piece)	per	0.15	10000	1500
	Delivery of Community A&P				
	Materials, cards & booklets	LS			2,000
	NGO or consultant to provide A&P	0.33	10,000		3,300
	Transport	LS			550
	TOTAL				**12430**

Appendix 4 – Outline Terms of Reference for HIV/AIDS & STIs Awareness and Prevention Program for the Project

A. Project Background

The Government of Republic of Moldova (GRM) is undertaking road improvement projects with the assistance of various international donors. One such project is the Road Sector Program Support Project which seeks to improve several sections of the road transport network in Moldova. On behalf of the GRM, the project is administered by the project office of the State Road Administration (SRA).

The project is intended to provide a holding action which will prevent further deterioration of two principal trunk road routes within Moldova:

- Chisinau – Orhei – Sarateni - Balti; and
- Chisinau - Hincesti.

Using finance from European Bank for Reconstruction and Development (EBRD), European Investment Bank (EIB) and the World Bank (WB) this project aims to rehabilitate as much as possible of three sections of the routes examined; (i) Balti – Sarateni (56 km) funded by WB; (ii) Chisinau – Orhei (approx 40 km) funded by EBRD; and, (iii) Chisinau – Hincesti (25 km.) funded by EIB.

It is intended that the subsequent construction work will be arranged in three contracts corresponding to the sections defined above, with each contract being funded by the agency indicated above.

The project area includes the districts through which the roads traverse, and comprises nine districts (including the municipality areas of Chisinau and Balti) as shown in Table 1.

Table 1 – Project Roads by District

Road ID	Road Name	Districts
R-3	Chisinau - Hincesti	Ialoveni, Hincesti
M-2	Chisinau - Sarateni	Chisinau, Straseni, Criuleni, Orhei
R-14	Balti - Sarateni	Balti, Telenesti, Singerei

B. Situation of HIV/AIDS and STIs and the Project Area

In 2003, for the first time, more new cases were due to infections transmitted by sexual contact than by IDUs—a signal that the virus had begun to spread to the general population. Along with the crossover in mode of infection, another shift was occurring in infection rates by sex; i.e. until 2000, females represented only about a quarter of all persons infected with HIV but by 2004 they represented 49 per cent.[21]

According to the most recent Information Bulletin,[22] as of 2006 there are 3,400 people with HIV, 314 people with AIDS, and there have been 187 deaths from AIDS associated illness. HIV/AIDS infection continues to remain a major problem of public health, showing

[21] UNDP; op cit

[22] National Scientific & Applied Centre for Preventative Medicine; *Information Bulletin on Situation of HIV/AIDS Epidemic*, Nr. 10.a-7/132 (February 2007)

sharp increases in both absolute number and rate of infection; in 2006, 616 new cases were registered (14.72 per 100,000), compared with 2001 at which time there were 210 new cases (5.81 per 100,000).

The first sharp increase was noted in 1996 when the number of reported cases jumped from seven to 48, by 1997 the number had risen to 404 where it stabilised somewhat at between 400 and 500 new cases per year and then increased again in 2006 when 616 new cases were registered.[23]

Some regions show higher prevalence than the national average. In 2006, the highest rates have been found in Balti (928 cases), Chisinau (787 cases) and Transnistria including Bender (873 cases). Balti also has, by far, the highest incidence per 100,000 with 58.6, followed by Transnistria with 41.4:100,000, and Singerei (a district in the project area) with 17.8:100,000. With the exception of Singerei which has 50 cases, the other districts in the project area have much lower HIV prevalence with less than 20 cumulative cases to 2006.

Information about the incidence of sexually transmitted infections (STIs) is not only useful as an indicator of unprotected sexual intercourse, but also as a determinant of possible HIV transmission. STI incidence in Moldova is high, some 9,181 STIs were recorded in 2005, although the number of people infected is probably less than this total due to the high probability of some people carrying multiple infections.

Slightly more men than women were recorded being infected by syphilis (52 per cent of cases were in men), and 81 per cent of people with gonorrhoea are men. Nearly two-thirds (62 per cent) of cases of Chlamydia and nearly three-quarters of cases of herpes simplex (71 per cent) were in women. Syphilis, unlike any other STI is showing a downward trend, with the number of people infected with syphilis in 2004 having decreased from the 2003 cases by 11 per cent.

A total of 2,222 people were infected with either syphilis or gonorrhoea in the project area in 2005. STI incidence (syphilis and gonorrhoea only) per 100,000 people is significantly higher than the incidence of HIV, which could be indicative of a substantial under-reporting of people with HIV.[24] Chisinau and Balti again stand out as areas of very high incidence, but some districts that had indicated low HIV prevalence i.e. 20 cumulative cases or less, such as Criuleni, Ialoveni, Orhei and Telenesti have very high STI incidence rates per 100,000 people.

C. Risks Associated with the Project

The Social Assessment completed for the Project (October 2007) concluded that there were risks of spread of HIV and STIs during both the construction and operation phases of the project.

The civil works phase of subprojects can pose risks for both the construction workforce and the communities in which subprojects are located for the civil works/construction period.

High risk groups in the project area include the construction workers themselves, many of whom are likely to be migrants either from other areas in Moldova or part of an

[23] Ibid

[24] This is also confirmed by Health Survey which reports that only about a third of the sample surveyed in 2004 had ever undertaken an HIV test.

international contractor's workforce, mobile population such as traders, people from household who travel for marketing or selling, seasonal migrants, poor men (who risk passing it on to their spouses or partners), and commercial sex workers (CSWs) (including women who might engage in sex work infrequently).

In terms of risk of transmission of communicable diseases during operation, roads and highways have the potential to pose a risk as a pathway for disease transmission. The risk increases with the hierarchy of road, its location, and number of villages and towns connected with a larger town or city. Further, each of the roads in the project is directly connected to an international border, or links with another road that is connected to an international border.

The high migration patterns that exist in the project area, and Moldova generally, is also considered to increase the risk of spread of HIV/AIDS. This is exacerbated by low knowledge of HIV/AIDS awareness and prevention.

D. Expertise and Personnel Requirements for the Program

Overall, the awareness and prevention campaign will build on the ongoing efforts of the Government and other agencies, including the UNAIDS, Global Fund for the Fight against HIV/AIDS, UNDP, United States Agency for International Development (USAID), and World Bank, which are the major actors supporting the national HIV/AIDS control program, and IOM, Organization for Security and Cooperation in Europe (OSCE), and (USAID funded) Winrock International as key contributors to the GRM programs for human trafficking prevention.

NGOs with proven experience in HIV/AIDS and STIs awareness and prevention, training-of-trainers, workshop organization and delivery, and community participation will be required. The NGOs will have, and provide evidence of, a track record in providing similar services to that required by the TOR. At this stage it is envisaged that the project's program will be implemented as follows:

- An NGO to coordinate and manage the delivery of the overall program, coordinating the activities to deliver specific components of the program. This NGO will also be responsible for engaging the experts recruited to prepare and deliver the training and information to the contractors (including the adaptation of existing materials); and will deliver the community awareness and prevention component, being for each road contract.

The NGOs are required to have the following characteristics, experience and qualifications; (i) enthusiasm for contributing to GRM's commitment to controlling and preventing the spread of HIV/AIDS and STIS in Moldova; (ii) for facilitation training and participatory processes, (iii) good listening skills, (iv) experience in dealing with a variety of social groups and sub-populations, including vulnerable and high-risk populations; (v) strong inter-personal and communication skills; (vi) workshop presentation experience, and (vii) experience in KAPB assessment, survey and analysis.

NGO will be required to select a peer educator (one from each district) to assist with the youth at risk outreach program. The peer educators will initially be identified by UNFPA through its youth peer education network, the peer educators will have already received initial training through UNFPA's program.

The NGO will provide further on-the-job training to the peer educators, they will support the activities of the awareness and prevention programme and will provide outreach activities based on the model already established with funding from Global Fund.

Any IEC materials to be adapted, and general contents of the community and contractors' training courses and awareness programs, will be presented to TWG 5 – Communication and Prevention of CCM, for advice and approval. Any materials and overall content will conform to the draft guidelines and framework prepared by the TWG.[25]

The NGO will prepare a proposal describing their relevant experience, detailing how they intend to implement the programme (with an implementation schedule), and budget (in line with cost estimate provided in Section F).

E. Terms of Reference for Project Awareness and Prevention Program

The Project will fund a program specifically designed to mitigate the risks associated with the project's activities and impacts.

Potential effects on construction workers, communities and road-users will be mitigated through implementation of an awareness and prevention program, as well as an item to be included in the loan covenant which clearly requires the implementation of the HIV/AIDS and STIs prevention and awareness campaigns for construction workers and communities.

The program includes the following components:

E.1 HIV/AIDS & STIs in the Workplace Training for Contractors

HIV/AIDS in the workplace training for contractors will be provided through a series of 3 workshops and seminars to be provided for contractors and their construction force, these will be facilitated through International Labour Organisation (ILO) and implemented by an NGO or consultant. The training will include; basic information on HIV/AIDS – history, terminology, statistical data (global, regional CIS, and Moldova), legal background (law and regulations etc); ILO Code of Practice on HIV, HIV in the workplace issues, paths of transmission, high risk groups (how and why); prevention measures; stigma and discrimination issues. In addition to the training the costs of this component of the program include HIV and STIs testing for the construction workforce every year contract period.

E.2 Promotion of Behaviour Change

Promotion of behaviour change will include intensive health education campaigns and youth peer education will be undertaken to promote behaviour change among construction workers, sex workers, and local people in the project area.. Information will be disseminated through posters, pamphlets, and launch events in Romanian and Russian languages during the rehabilitation of the project's roads.

Outreach to most vulnerable and at risk youth will be included through the youth peer educators network (supported by UNFPA). Condoms will be made available free of charge to workers, communities, during the first year of rehabilitation of the project roads.

The program will also cover additional requirements of the mobile populations to augment condom distribution programs of other agencies, this part of the program will include co-financing of the TB/AIDS in Moldova Program which is due to include a second project aimed at truck and bus drivers starting in 2008.

[25] CCM-TWG 5; *Mechanism for Evaluation and Approval of Information and Materials in Field of HIV/AIDS and STIs*, Chisinau (2007)

E.3 Human Trafficking Awareness and Prevention

Human trafficking awareness and prevention linking with the work of International Organization for Migration (IOM) and Winrock International the project's program will provide training in HIV/AIDS, STIs, and human trafficking (especially dealing with migrant issues) through working with relevant government agencies, local institutes, and NGOs for capacity building. Workshops will be organized for relevant participants to discuss activities to combat HIV/AIDS and human trafficking, and establish a coordination network on human trafficking prevention.

E.4 Advocacy Workshops & Policy Development

Advocacy workshops and policy development to improve understanding of the awareness and prevention program on HIV/AIDS, STIs, and human trafficking among stakeholders, advocacy workshops will be conducted, including information and education campaigns. The workshops will target local governments and communities, local business owners, relevant NGOs, transport operators, media, local police, road construction companies, and the local units of the SRA. The aim of this component will be to facilitate MOT's participation in CCM activities and formulation of an internal policy statement and action plan for HIV/AIDS and STIs prevention within the transport development sector.

F. Budget Estimate

A provisional budget has been prepared and this is summarized in Table 2.

Table 2 – Budget & Cost Estimate for Programme

Overall Programme					
	Item	**Basis**	**Rate (US$)**	**No.**	**Total (US$)**
	Contractor Awareness Training				
	IEC materials (incl. folder) - total	LS			2,500
	Reprint AIDS Foundation cards & booklets	pax	0.6	900	540
	Reprint ILO materials	pax	0.6	900	540
	Reprint posters	pax	1.0	900	900
	Experts/trainers presenting	pax/day	100	2*3	600
	Condoms (10,000 piece)	per	0.15	10000	1500
	Delivery of Community A&P				
	Materials, cards & booklets	LS			2,000
	NGO or consultant to provide A&P	0.33	10,000		3,300
	Transport	LS			550
	TOTAL				**12430**