Alternative report
on the implementation of the CEDAW concerning women living with HIV, women who use drugs and sex workers in the Republic of Moldova
for the 93rd session
of the UN Committee on the Elimination of Discrimination against Women
Geneva, Switzerland, 2026
Submitted by the Coalition of women-led organisations including Eurasian Women's Network on AIDS, NGO Association for Creative Development of Personality and the Sex Workers' Rights Advocacy Network

Introduction

1. This Alternative Report evaluates the implementation of the Convention on the Elimination of All Forms of Discrimination against Women in the Republic of Moldova regarding women living with HIV, women who use drugs, and sex workers. Submitted by a coalition of women-led civil society organisations—including the Eurasian Women's Network on AIDS, the NGO Association for Creative Development of Personality and the Sex Workers' Rights Advocacy Network —this document highlights critical implementation gaps between state commitments and the lived realities of key populations across both banks of the Dniester River. Despite legislative advancements, including the ratification of the Istanbul Convention, structural barriers severely infringe upon women's human rights under CEDAW Articles 2, 5, 12, 15, and 16:
    - HIV Criminalisation and Law Enforcement Abuse [Articles 2, 15, GR No. 35 on gender-based violence]: Article 212 of the Criminal Code continues to penalise HIV exposure and transmission, deterring women from testing and care. Abusive partners routinely weaponise status disclosure to enforce silence. Furthermore, law enforcement officers harass, extort, and sexually exploit sex workers and women who use drugs, while ignoring reported domestic abuse.
    - Healthcare Discrimination and SRHR Violations [Articles 12, 16, GR No. 24 on women and health]: Institutional stigma, breaches of patient confidentiality, and medical illiteracy are pervasive in healthcare settings. Women experience coercive pressures, including compulsory HIV testing without consent, discriminatory room isolation in maternity wards, and aggressive medical coercion to terminate pregnancies based on HIV status or sex work.
    - Exclusion from GBV Protections & Shelters [Articles 2, 5, GR No. 35]: Emergency shelters enforce rigid exclusionary clauses barring women with active infections, substance use histories, or mental health conditions. Mandatory entry testing, restrictive 7:00–17:00 operating hours, and a lack of childcare leave marginalised women without refuge, forcing many to remain in abusive environments.
    - Transnistrian Regional Crisis [Articles 2, 3, 12]: Legislative alignment with punitive Russian legal frameworks on the left bank of the Dniester River introduces strict anti-drug measures, HIV exposure criminalisation, and restrictive 'foreign agent' laws. This severely threatens civil society space and jeopardizes uninterrupted access to essential HIV treatment, harm reduction, and SRHR services. While Moldova lacks effective control over the Transnistrian region, the State Party retains positive obligations under international human rights law to deploy all available legal, political, and diplomatic measures to safeguard human rights, secure

humanitarian access, and ensure non-discriminatory healthcare support for women in the region.

2. The Coalition urges the CEDAW Committee to call upon the Government of Moldova to immediately decriminalise HIV exposure, sex work, and personal drug possession; eliminate entry barriers to GBV shelters; enforce healthcare accountability; and protect civil society operations across all regions.
3. The evidence is based on the focus group discussion comprising women activists representing the communities of women living with HIV, women who use drugs and sex workers from both the right and left banks of the Dniester River, as well as the data drawn from the community-led monitoring and research, and cases collected within REAct tool[1] and the state-guaranteed legal aid information system (E-AJGS).

Implementation of Article 2: Legal Reform and Decriminalisation of HIV

4. As of 2024, 156 countries criminalised HIV nondisclosure, exposure, or transmission through specific or general laws, or have conducted prosecutions based on general criminal laws within the past 10 years. Such laws breach human rights, including the rights to equality and non-discrimination, and undermine efforts to prevent new cases of HIV infection[2].
5. While legal reforms are gaining ground in multiple regions, unfair arrests, charges, and convictions still persist. The Global HIV Criminalisation Database, administered by the HIV Justice Network, included 112 reported cases in 2025, which represents the highest annual total recorded in the database in recent years[3].
6. Article 212 of the Criminal Code of the Republic of Moldova[4] entitled "Infecting with AIDS (HIV)" specifically criminalises both the exposure to and the transmission of HIV:
    - Part 1 of the Article penalises knowingly putting another person at risk of contracting HIV with up to one year of imprisonment;
    - Part 2 of the Article punishes the actual transmission of the virus by an individual aware of their positive status with a prison term of one to five years.
    - The statute outlines aggravating circumstances in Part 3, increasing the penalty to three to eight years of imprisonment if transmission involves multiple individuals or a known minor.
    - Part 4 addresses professional negligence, subjecting medical professionals who transmit HIV to patients through improper performance of their duties to up to five years of imprisonment alongside a professional practice ban.
    - Part 5 provides an exemption from criminal liability for exposure or transmission if the individual living with HIV informed their partner of their status in advance, or if the partner was already aware of the diagnosis and voluntarily committed actions that created the risk of infection.
7. HIV criminalisation creates severe obstacles to public health by deterring women from seeking vital HIV testing and counseling services. Furthermore, for women trapped in abusive relationships, safe disclosure of their status is often entirely unrealistic, since HIV status is frequently used as a tool of control or retaliation by intimate partners. Women are often threatened with disclosure or prosecution, and some face police inaction when reporting abuse especially in cases involving spouses, where law enforcement dismisses complaints as "family

[1] REAct, available at: https://react-aph.org/en/about-react/
[2] UNAIDS, HIV Criminalization. Human Rights Fact Sheet Series (2024), available at: https://www.unaids.org/en/resources/documents/2024/01-hiv-human-rights-factsheet-criminalization
[3] HIV Justice Network, 2025 in review: more reported cases, uneven reform (2026), available at: https://www.hivjustice.net/news/2025-in-review-more-reported-cases-uneven-reform/
[4] Available at: https://www.legis.md/cautare/getResults?doc_id=17781&lang=ru

matters"[5]. The State has a fundamental obligation to strengthen protection mechanisms against violence rather than creating additional barriers that restrict access to care and support.

8. A progressive draft law currently proposed in Moldova aims to de-specialise HIV within the criminal legal system by repealing Articles 211 and 212 of the Criminal Code, ensuring that HIV and sexually transmitted infections are no longer singled out as specific criminal labels. While the draft removes discriminatory specific provisions and related aggravating factors across various criminal statures, general criminal laws strictly determine liability by intent, actual transmission, harm, and established causal link.
9. While there have been no recent criminal convictions under Article 212 of the Criminal Code of the Republic of Moldova, the continued existence of this provision inflicts severe harm by creating a profound chilling effect. Regardless of conviction rates or increased awareness among law enforcement agencies on both banks of the Dniester River, the threat of prosecution drives women—particularly women living with HIV and those from key populations—away from essential health services. Out of fear of legal repercussions, exposure, and stigma, women are deterred from seeking voluntary HIV testing, disclosing their status to partners or medical staff, and adhering to treatment. To eliminate this harm, there remains a critical need to repeal or fully align legal and judicial practices with the Expert Consensus Statement on the Science of HIV in the Context of Criminal Law. Judicial interpretations must strictly reflect contemporary medical evidence: specifically, when an individual is successfully adhering to antiretroviral therapy and maintains an undetectable viral load, the possibility of transmission is scientifically zero (U=U), meaning the legal element of intent or endangerment cannot exist[6].
10. Criminal legal reform in Moldova must not increase the vulnerability of women living with HIV, but rather guarantee their safety. HIV decriminalisation must be structurally integrated with robust protections against gender-based violence and barrier-free healthcare access, ensuring that legal changes protect survivors instead of driving them away from essential services.

Implementation of Articles 2 and 12: Elimination of Discrimination, Institutional Violence and Healthcare Stigma

11. According to the Community-led monitoring on types of violence against women living with HIV in Moldova[7], women are subjected to various forms of violence, including psychological, economic, physical, and sexual violence, which are often interrelated and reinforced by HIV-related stigma, fear of disclosure, and institutional discrimination.
12. Psychological violence is the most frequent form of abuse endured by women living with HIV in Moldova, with 61% of the above study respondents experiencing it constantly. Overwhelming majorities of these women faced severe patterns of control and abuse, specifically: verbal insults (98%), public or private degradation (98%), restrictive jealousy and isolation (98%), threats of harm (95%), and persistent stalking or unwanted communication (90%).
13. Many women noted that their HIV status was often exploited by abusive partners as a tool of coercion. Perpetrators frequently use the threat of forced disclosure to isolate the victim and enforce silence, often combined with psychological manipulation involving their children—such as threatening to deprive them of parental rights or turn the children against them. Consequently, the intersection of police inaction and targeted domestic blackmail effectively traps women in abusive environments, completely cutting off their access to justice. *"He constantly told me I was no longer a woman. That I was dirty and should be ashamed." — woman living with HIV, left bank.* (Community-led monitoring: Types of violence against women living with HIV in Moldova, 2023)

[5] EWNA, Community-led monitoring: Types of violence against women living with HIV in Moldova (2023), available at: https://ewna.org/wp-content/uploads/2024/01/ewna_gbv-clm-final-report_moldova_2023_eng-1.pdf
[6] Expert Consensus Statement on the Science of HIV in the Context of Criminal Law (2018), available at: https://onlinelibrary.wiley.com/doi/full/10.1002/jia2.25161
[7] EWNA, Community-led monitoring: Types of violence against women living with HIV in Moldova (2023), available at: https://ewna.org/wp-content/uploads/2024/01/ewna_gbv-clm-final-report_moldova_2023_eng-1.pdf

14. Despite existing legal protections and human rights advocacy, women report systemic discrimination and psychological violence in healthcare settings. This includes breaches of confidentiality, judgmental attitudes, and outright denial of medical care. Such institutional stigma not only violates national laws on patient rights and equal opportunity but also discourages vulnerable women from seeking timely medical assistance, further endangering their health.
15. *Case in Tiraspol[8]: a woman returned to a clinic for a post-surgery dressing change. When the surgeon noted her wound was healing slowly and asked about her immune system, she disclosed her HIV-positive status. The doctor reacted with hostility, claiming she was obligated to inform him beforehand so he could have worn double gloves and a special protective suit. He then refused to perform the dressing change. The woman filed an official complaint, prompting the medical institution to conduct a corrective, preventive disciplinary session with the doctor.*
16. Women living with HIV in Moldova continue to report widespread incompetence, lack of sensitisation, and discriminatory practices among healthcare providers. A key systemic issue is the routine violation of patient confidentiality, where, inter alia, medical professionals explicitly stamp the patient's HIV-positive status on the covers or highly visible sections of medical charts, exposing them to public stigma and unauthorised disclosure.
17. *Case from 2025 REAct tool database: upon being hospitalised, a patient experienced an egregious breach of confidentiality on her very first day. In a shared ward, a nurse loudly interrogated her regarding her HIV status in the presence of two other patients. Although the patient quietly confirmed her status, the nurse repeatedly demanded she speak louder under the pretext of not hearing her, effectively forcing a public disclosure. Following the incident, the other patients in the ward openly gossiped about her status and subjected her to complete social ostracisation, causing the patient severe psychological distress and rendering her hospital stay deeply hostile.*
18. Furthermore, there is a profound deficit in basic medical literacy regarding HIV management. Women frequently encounter doctors who are unaware of ART or the scientific reality of U=U, with women being forced to educate healthcare providers about the existence and efficacy of their treatment. Human rights-based training on HIV, modern treatment protocols, medical ethics, and patient confidentiality must be established as a foundational requirement at the university level for all future healthcare professionals.
19. Women living with HIV frequently refrain from reporting domestic violence and abuse to law enforcement authorities due to a pervasive fear of forced disclosure or unauthorised breach of confidentiality regarding their HIV status, lack of trust that assistance would be provided, shame, fear for personal security. *"The NGO provided me with professional assistance. The police ignored because I used alcohol and drugs, and the hospital treated me with disdain".* (Community-led monitoring: Types of violence against women living with HIV in Moldova, 2023)
20. Sex workers in Moldova routinely refrain from seeking assistance from law enforcement due to entrenched institutional abuse, stigma, and fear of retaliation. Police officers often weaponise their authority to harass, extort, and sexually exploit women, transforming state institutions into spaces of trauma rather than protection. *Case in Bălți from the 2025 REAct tool database: A sex worker reported facing persistent, arbitrary police summonses via informal phone calls, which law enforcement officers justified with vague and contradictory explanations. The sex worker resisted visiting the station due to a prior traumatic incident where police detained her without formal notice, unlawfully confiscated and searched her phone, and attempted to coerce her into providing sex services under the threat of overnight detention.*
21. *Case in Bălți from the 2025 REAct tool database: A sex worker visited a gynaecologist at a private clinic in Moldova, where she was diagnosed with a sexually transmitted infection. During the examination, the doctor made stigmatising remarks, asserting that the illness was "her own fault" and calling it an "occupational hazard" due to her profession. When the patient demanded the*

[8] Case shared during the focus group discussion with women activists from both the right and left banks of the Dniester River.

clinic's official complaints log to report this unethical conduct, the facility refused to provide it to her. By shaming the patient and blaming her occupation for her medical condition, the healthcare provider subjected her to psychological violence and degraded her dignity in direct violation of Article 12 of the Convention and General Recommendation No. 24. Furthermore, the clinic's refusal to grant access to the official complaints log demonstrates a severe breakdown in administrative oversight and accountability, effectively denying the victim her right to seek remedy and protection under Articles 2 and 15.

22. Despite recent efforts to align Moldova's legislation with EU law and the 2020 UN CEDAW recommendation to the Government of Moldova to ensure access to the general healthcare system, free legal aid, and domestic violence shelters for women living with HIV and women who use drugs, these groups, alongside sex workers, continue to face systemic human rights violations and severe barriers when attempting to access essential protection services, particularly shelters and crisis centres.
23. Shelter regulations in Moldova contain explicit exclusionary clauses that deny access to the most vulnerable women. They often bar individuals based on conditions such as "the presence of an infectious disease in an active stage", "state of drug or alcohol intoxication", or "mental health conditions"[9]. These criteria are routinely used to turn away women who use drugs[10], those with mental health struggles, or women living with HIV, leaving them without any safe haven from violence.
24. The rigid operating hours of many crisis centres and shelters create obstacles for working women. Many shelters operate only from 7:00 am to 5:00 pm, making it impossible for women who work non-standard hours—including sex workers—to access them. Furthermore, strict rules prevent children from staying in the shelter without constant maternal supervision.
25. Rather than providing unconditional safety, shelters frequently act as sites of discrimination. Many facilities require women to undergo mandatory HIV testing or refer them for tests, subsequently denying them admission if they test positive. This practice stems directly from a profound lack of training among shelter and crisis centre staff, who harbour deep-seated fears and misconceptions about HIV transmission and lack the capacity to support women living with HIV.
26. Even when women living with HIV, women who use drugs, and sex workers manage to enter shelters, they frequently experience direct or indirect stigma, prejudice, and hostile treatment from both staff members and other women. Facing unbearable judgment and a lack of psychological safety, many of these women feel forced to leave the shelters and return to their abusers, exposing them to further violence and exploitation.
27. According to the Community-led monitoring: Types of violence against women living with HIV in Moldova, 80% of women reported experiencing economic violence. Women described being deprived of financial independence, access to property or housing, and being economically dependent on abusive partners. *From the 2025 REAct tool database: A woman reported severe economic abuse and coercive control by her husband, who prohibited her from gaining employment, strictly controlled all household finances, and refused to provide adequate funds for basic necessities for her and her children.*
28. After HIV status or drug use became known, many women were dismissed from their jobs or forced to leave due to pressure and stigma. Women are also reported being excluded from inheritance, property rights, or benefits, often justified by their HIV status, drug use or sex work. *From the 2025 REAct database: Following her mother's death, a woman was arbitrarily excluded from family inheritance discussions. Despite having achieved long-term recovery and maintaining*

[9] Republic of Moldova. Government Decision No. 798 "On amending Government Decision No. 129/2010 on the approval of the Framework Regulation on the organisation and functioning of the social service for the rehabilitation of victims of domestic violence" (Dec. 23, 2025), available at: https://www.legis.md/cautare/getResults?doc_id=152282&lang=ru

[10] EWNA, How Countries Address Barriers to HIV Services for Women Living with HIV, Sex Workers and Women Who Use Drugs (Women-led Gender Assessment) (2023), available at: https://ewna.org/wp-content/uploads/2023/07/ewna-gender-assessment-report_2023_eng.pdf

a stable lifestyle, relatives weaponised her past history of drug use to claim she was untrustworthy and lacked legal standing to participate, effectively stripping her of her decision-making rights regarding her inheritance.

29. Under the above mentioned CLM, more than half of the women surveyed (55%) reported experiencing physical violence, including being beaten, pushed, slapped, or locked inside their homes. This violence often got worse after they revealed their HIV status. Despite these dangerous situations, women living with HIV, sex workers, and women who use drugs rarely report physical violence. Reporting it forces them to share their HIV status, drug use, or sex work. Expecting stigma rather than protection, women lack faith that law enforcement will take their claims seriously, fearing their status will instead be weaponised against them. With no safe places or support services to go to, many women are forced to stay with their abusers. Moreover, they are driven further underground, where they become even more isolated and exposed to life-threatening situations, heightened exploitation, and increased risks of violence, with even fewer opportunities to seek protection or access essential services.

Implementation of Article 12: Access to SRHR services

30. Despite the information from the Seventh periodic report submitted by the Republic of Moldova that women's right to free gynaecological and obstetrical medical assistance is guaranteed, and based on 2025 REAct monitoring data, healthcare workers frequently act as primary perpetrators of discrimination against women living with HIV, sex workers, and women who use drugs, routinely violating their human rights through the systematic denial, coercion, or infringement of their SRHR.
31. Under the CLM in the Context of HIV Prevention and the Protection of Rights of People Living with HIV in Transnistria (2024), 30% of surveyed women experienced overt HIV-related discrimination during obstetric and gynaecological care, while 16% reported direct breaches of patient confidentiality. 46% of respondents were placed in isolation wards and 14% were forced into paid private rooms, often to avoid mixing with other patients or because hospital staff refused to accommodate them in general wards. *"I was kept separate from others in the maternity ward and was not allowed to leave the room. During labour, when I stepped out, they said I would infect everyone"* (Case from the CLM report).
32. Order No. 480 of the Ministry of Health of Transnistria (16 June 2021) legally stipulates that HIV testing prior to abortion must be voluntary, contingent on informed consent, and backed by mandatory pre- and post-test counseling. However, field evidence[11] reveals systematic non-compliance: 89% of tested respondents did not sign or give informed consent, and 100% received zero counseling. Women report coercive practices by healthcare workers, including conditional access to healthcare (case in Grigoriopol: *"If you don't take [a fresh test], we won't perform the procedure"*), as well as covert testing without explaining blood draw procedures. This demonstrates that normative legal protections fail in practice, subjecting women seeking abortion services to administrative coercion and dignity violations.
33. Although the same Order formally removed HIV from the list of medical and social indications for forced artificial termination of pregnancy in the Transnistrian region, medical professionals continue to subject pregnant women living with HIV to institutional stigma and coercive pressure to abort. The above-mentioned CLM revealed that 11% of pregnant HIV-positive respondents were actively pressured or advised by gynaecologists and primary care physicians to undergo an abortion solely due to their HIV status – *"I was told that with such a diagnosis, the child will be born sick"* and *"The doctor in Dubăsari said that I would not be able to carry the child to term because of my HIV status".* While all women resisted medical coercion and refused the abortion, these practices demonstrate that removing HIV from legal abortion indications has not

[11] Community-Led Monitoring in the Context of HIV Prevention and the Protection of Rights of People Living with HIV (Transnistria) (2024), unpublished.

eliminated pervasive medical prejudice, directly violating bodily autonomy and reproductive rights guaranteed under CEDAW Article 12 and General Recommendation No. 24.

34. Involvement in sex work is systematically used to justify restricting women's rights, specifically resulting in denial of essential services and coerced reproductive choices (systematic pressure on women to undergo pregnancy terminations). *"Why did you give birth to three children if you have HIV? You are going to die soon regardless"*. (Case from the REAct tool database, 2025). In another documented case, a pregnant sex worker seeking gynaecological care experienced direct reproductive coercion when her physician aggressively pressured her to terminate her pregnancy based on discriminatory assumptions regarding sex work as her profession and family size [woman has 4 children].
35. Women living with HIV residing in rural regions of Moldova encounter significantly higher levels of stigma, institutional discrimination, and social isolation compared to those in major urban centres such as Chișinău. Focus group discussion revealed that rural healthcare facilities routinely fail to provide basic, non-discriminatory reproductive care; in documented instances, pregnant women living with HIV seeking local maternal care were arbitrarily redirected to Chișinău simply because of their HIV status, effectively restricting their local access to healthcare. Furthermore, rural settings exhibit heightened risks of unauthorised status disclosure due to a lack of privacy in small communities, which is further exacerbated by a critical shortage of localised support services, expert medical advice, and legal aid.
36. Women who use drugs face pervasive stigma and dignity violations, particularly in reproductive health settings. In Chișinău, a pregnant woman who went into labour while harvesting berries was subjected to continuous verbal abuse throughout her transport to the hospital, with individuals questioning her right to motherhood. Following the birth, she faced severe social isolation as community members cut off all contact and refused to enter her home.

Implementation of Article 15: Access to Justice

37. Women living with HIV, sex workers, and women who use drugs in Moldova face major challenges in accessing legal remedies. Many do not believe their cases will be taken seriously or fear retaliation and public exposure. Demonstrating the severity of this issue, REAct data for 2025 recorded 61 cases of rights violations and discrimination against women living with HIV, with 39 requiring legal aid. Additionally, the Community-led monitoring on types of violence against women living with HIV in Moldova[12] reveals that 64% of the respondents who had experienced physical violence did not seek assistance. This is compounded by an acute shortage of state-guaranteed free legal aid and trained paralegals to support marginalised women in navigating the complex justice system—as evidenced by state data from the E-AJGS information system, which recorded a surge in demand for state-guaranteed legal aid involving women living with HIV or key populations during 2025. Furthermore, few mechanisms exist for documenting and responding to GBV that specifically address the unique experiences and vulnerabilities of women living with HIV.
38. The right to privacy and confidentiality is severely compromised within the criminal justice process. Under current procedural practice, victims can only request *in camera* proceedings once a case reaches the trial stage. During the initial police reporting and pre-trial investigation phases, a woman's private life—including sensitive health status, drug use history, or involvement in sex work—is left completely unprotected, remaining accessible to law enforcement officers and relevant legal parties. This structural exposure deters women from seeking justice, as reporting GBV directly threatens their privacy, safety, and social standing long before their case ever reaches a judge.
39. These structural procedural barriers directly violate Article 15 of the Convention and non-conform with the General Recommendation No. 33 on Women's Access to Justice.

[12] EWNA, Community-led monitoring: Types of violence against women living with HIV in Moldova (2023), available at: https://ewna.org/wp-content/uploads/2024/01/ewna_gbv-clm-final-report_moldova_2023_eng-1.pdf

40. Community-led monitoring highlights how abusers leverage the fear of public exposure and institutional stigma to prevent victims from seeking legal protection. *Case in Grigoriopol: "After beating me, my partner may "put up" like this, saying that he loves me, but as in cases of beatings, he believes that I will not go anywhere now and will not leave him because of HIV, and threatens to tell everyone about the diagnosis if I leave him"* (Community-led monitoring: Types of violence against women living with HIV in Moldova, 2023).

Recommendations

We ask the CEDAW Committee to recommend to the Government of Moldova to:

41. Building on the draft law currently before Parliament to repeal Articles 211 and 212 of the Criminal Code of the Republic of Moldova, adopt this legislation without delay; refrain from introducing any new specific criminal offences related to HIV or sexually transmitted infections, and ensure that any criminal prosecution is strictly restricted to general criminal law provisions governing intentional harm [Articles 2, 15; GR 33, 35].
42. Review and amend contravention and criminal frameworks to decriminalise sex work and the possession and use of controlled substances for personal use, replacing punitive measures with evidence-based harm reduction and voluntary social support systems [Articles 2, 12, 15; GR 33].
43. Prepare and implement binding guidance for judges and prosecutors to evaluate intent, causation, and voluntary consent in HIV-related cases strictly in alignment with contemporary medical science, including the Undetectable = Untransmittable principle [Articles 2, 15; GR 33].
44. Implement clear, transparent mechanisms to systematically document, investigate, and penalise human rights violations, discrimination, and abuses committed by public officials, healthcare workers, and law enforcement personnel against women living with HIV, sex workers, and women who use drugs [Articles 2, 12, 15; GR 33].
45. Formally recognise women living with HIV, women who use drugs, and sex workers as vulnerable groups within national gender-based violence policies and referral systems, while integrating specific indicators on HIV and stigma into the monitoring of national GBV action plans [Articles 2, 5; GR 35].
46. Guarantee equal access to state-funded shelters, legal aid, and social and psychological support services for women living with HIV, and expand state funding for dedicated crisis centres, emergency accommodations, and HIV-sensitive operating protocols tailored to the safety needs of sex workers, women living with HIV, and women who use drugs [Articles 2, 5; GR 35].
47. Abolish any practices of mandatory or coerced HIV testing as a prerequisite for admission to emergency shelters, ensuring absolute confidentiality of health status [Articles 2, 12; GR 24, 35].
48. Provide adequate childcare support within shelters, allowing mothers to seek employment, medical care, or legal assistance without fear of losing custody or being unable to shelter their children [Articles 5, 12, 16; GR 24, 35].
49. Systematically integrate community-led harm reduction, peer navigation, specialized HIV support services, and HIV-sensitive operating protocols into the national domestic violence protection, shelter, and crisis response frameworks [Articles 2, 5, 12; GR 35].
50. Develop and implement strict internal anti-discrimination policies, codes of conduct, and accessible complaint mechanisms within shelters for residents to report stigma or abuse by staff or other residents [Articles 2, 5; GR 35].
51. Establish an independent monitoring mechanism involving civil society organizations representing key populations to regularly assess the accessibility and quality of shelter services for marginalized groups of women [Articles 2, 5; GR 35].
52. Guarantee unrestricted access to comprehensive SRHR services, essential healthcare, and complete HIV prevention packages—including PrEP and modern testing modalities—for key populations without fear of stigma, coercive practices, or rights violations [Article 12; GR 24].
53. Ensure healthcare institutions strictly comply with patient rights legislation, maintain accessible, non-retaliatory grievance systems such as complaint logs, and enforce administrative,

disciplinary, and legal sanctions for non-compliance or breaches of patient confidentiality [Articles 2, 12; GR 24].

54. Implement strict medical data-protection regulations and binding operational protocols across all healthcare settings to eliminate practices that compromise patient confidentiality—such as stamping or displaying an individual's HIV status on the covers or visible sections of medical charts—and enforce clear administrative and disciplinary sanctions for unauthorised disclosure of health data [Articles 2, 12; GR 24].
55. Guarantee that women living with HIV, women who use drugs, and sex workers retain full reproductive autonomy and parental rights, ensuring HIV status or key population identity is never used as legal or administrative grounds to restrict adoption, guardianship, or maternal custody [Articles 12, 16; GR 24].
56. Revise core undergraduate medical university curricula to integrate mandatory modules on HIV management, modern treatment protocols (ART and U=U), medical ethics, and patient confidentiality [Article 12; GR 24].
57. Roll out continuous, trauma-informed human rights and gender-sensitivity training programmes for healthcare providers, social workers, emergency shelter staff, and police officers regarding non-judgmental service provision and support for survivors of violence [Articles 2, 5, 12; GR 24, 35].
58. Guarantee the formal inclusion of sex workers, women living with HIV, women who use drugs and community-led civil society organisations in the planning, implementation, monitoring, and evaluation of state health and social policies through advisory bodies and structured consultation mechanisms [Articles 2, 7, 14].
59. Allocate state funding to support peer-led networks, leadership development, community counselling, and legal literacy initiatives for sex workers and marginalised women to strengthen self-advocacy and access to justice [Articles 2, 7, 15; GR 33].
60. Launch public awareness campaigns to counteract HIV-related stigma, dismantle societal prejudices, and promote the human rights and dignity of women living with HIV [Articles 2, 5].
61. Coordinate with international entities and civil society to guarantee uninterrupted access to essential HIV treatment, harm reduction programs, and sexual and reproductive healthcare for women residing on the left bank of the Dniester River in the Transnistria region [Articles 2, 12; GR 24].
62. Adopt and adequately fund comprehensive programmes to strengthen the economic empowerment and financial independence of women, including women living with HIV, women who use drugs and sex workers, by expanding access to employment, vocational training, entrepreneurship, financial literacy, social protection and income-generating opportunities, recognising women's economic autonomy as an essential component of the prevention of gender-based violence and of enabling women to safely leave abusive relationships [Articles 2, 5, 11, 13; GR 19, 35, 39].