

CAPACITY/CAPABILITY ASSESSMENT

ECDC country visit to Moldova to discuss surveillance of communicable diseases

ECDC Accession Support

Introduction and background

ECDC cooperates with countries under the EU enlargement policy to improve their infectious disease prevention and control systems and public health workforce to prepare them for their future participation in ECDC's work.

Under this policy, ECDC has been implementing technical cooperation activities with EU candidate countries and potential candidates, i.e. the Western Balkans and Türkiye [1] aiming, *inter alia*, to support capacities to implement EU legislation on communicable diseases.

Upon request from the national public health authorities of Moldova, as a new EU candidate country, ECDC conducted a technical visit to the country in April 2025 with similar scope, objectives, and methodology as for visits to the Western Balkans and Türkiye. The agenda for the visit was developed jointly with the National Public Health Agency of the Republic of Moldova. During the visit, findings for all areas of surveillance were discussed and the assessment tool was filled out in collaboration with colleagues from the country.

The ECDC country visit to Moldova is part of the [EU Initiative on Health Security](#) work package on progressive integration of the partner countries in the work of ECDC.

Specific objectives

The specific objectives of country visits to the EU candidate and potential candidate countries are:

- to better understand the existing structures, systems, tools and processes involved in the national surveillance of communicable diseases, as well as any planned changes;
- to identify needs, vulnerabilities, strengths and areas for improvement related to the surveillance of communicable diseases, including aspects that might benefit from ECDC's technical support;
- to document the current situation concerning the strengths, vulnerabilities, needs and potential action plans;
- to discuss and potentially agree upon next steps, as well as setting priorities for further surveillance activities that ECDC could support with technical guidance and assistance.

To help ECDC ensure consistency across country visits and support the follow-up of progress, the same assessment tool for national communicable disease surveillance systems is used throughout [4]. The tool includes eight topics regarded as core areas for successful communicable disease surveillance and control and was used to guide discussions. The insights gained during the assessment mission are used to identify areas where surveillance operations could be further strengthened and areas that would benefit from ECDC's technical support or guidance.

Suggested citation: European Centre for Disease Prevention and Control. ECDC country visit to Moldova to discuss surveillance of communicable diseases. 2025 Stockholm: ECDC; 2025.

Stockholm, October 2025.

ISBN 978-92-9498-834-8

doi: 10.2900/1594443

Catalogue number TQ-01-25-064-EN-N

1. Surveillance system description

Communicable disease surveillance in the Republic of Moldova is part of the 2030 National Health Strategy [5], which sets the overarching objective of 'reducing the burden of communicable and non-communicable diseases through disease prevention, health protection and health promotion'. The operational basis for surveillance is mainly provided by the following set of laws and regulations:

- Law No. 10/2009 [6] on Public Health, which defines the responsibilities for disease detection, notification and response.
- Government Decision No. 885/2022 [7], which establishes the Information System for Surveillance of Communicable Diseases and Public Health Events (SI SBTESP) as the national platform for electronic notification.
- Order No. 533/2023 [8], which provides the list of notifiable communicable diseases (currently 72 diseases and 4 special health conditions) and their case definitions, partially aligned with EU case definitions listed in the Commission Implementing Decision (EU) 2018/945 of 22 June 2018 [9].
- Government Decision No. 30/2024 [10], defining the early warning and response mechanism, including the use of EU/WHO information platforms.
- Government Decision No. 741/2024 [11], which aligns Moldova's epidemiological surveillance and early warning response with the EU Regulation 2022/2371 on serious cross-border threats to health.

The National Public Health Agency (ANSP), under the Ministry of Health, is the central authority responsible for communicable disease surveillance in Moldova. National legislation mandates the notification of communicable diseases by both public and private healthcare providers at all levels of care.

Since 2023, electronic surveillance has been implemented through the national platform '*Sistemul Informațional de Supraveghere a Bolilor Transmisibile și Evenimentelor de Sănătate Publică*' (SI SBTESP) [7]. This system is used for the notification of all diseases under passive surveillance and includes modules for specific disease groups. Notification is the responsibility of the attending physician and must be completed within 24 hours of diagnosis.

As of December 2024, Moldova has made progress in strengthening event-based surveillance (EBS) through the implementation of the WHO Epidemic Intelligence from Open Sources (EIOS) platform. Key milestones include appointing a national coordinator for the platform, developing standard operating procedures, establishing a daily scanning routine. While the platform is not yet fully integrated into national surveillance and response workflows, these foundational steps provide a strong basis for further operationalisation and routine use of EIOS to enhance early threat detection and public health response.

Sentinel surveillance systems have been in place for influenza-like illness (ILI), acute respiratory infections (ARI) and severe acute respiratory infections (SARI) since 2009. These systems include nine sentinel sites that cover approximately 40% of the population. Surveillance is conducted year-round, with samples and data collected weekly and analysed both nationally and at four regional laboratories. The data from the sentinel sites are reported weekly in the European surveillance portal for infectious diseases (EpiPulse). Partnerships with WHO reference laboratories are in place for confirmatory testing and quality control, such as the Crick Institute in London for influenza and the Charité Institute in Berlin for SARS-CoV-2.

Two sentinel systems are implemented for acute diarrhoeal disease in Moldova. One is to monitor outbreak dynamics and early identification of infectivity indicators of cholera and other acute diarrhoeal diseases, both in human populations and in environmental reservoirs such as rivers, lakes, and other water source. This is carried out annually between May and September. The other sentinel system is to study the aetiology of diarrhoea among hospitalised children under five years of age and includes genotyping of rotavirus samples and monitoring the presence of blood in the stool. It is part of the Global Paediatric Diarrhoea Surveillance networks and includes two sentinel hospitals in Chisinau (one paediatric and one that covers infectious diseases.). Data are reported to WHO monthly.

A team of specialist biologists conduct field missions across designated administrative territories, where sentinel points are established to study and monitor the epizootiology situation. Their activities include assessing existing natural foci, identifying new natural foci, and analysing the periodicity of epizootic processes. The team also monitors public health threats of biological, environmental, or unknown origin, and implements measures to prevent the transmission of highly dangerous diseases. These efforts support epizootiological forecasting and assessing the risk for a transmission to humans.

Surveillance objectives are further defined within national public health programmes, such as:

- the National Programme for the Prevention and Control of HIV/AIDS and Sexually Transmitted Infections [12],
- the National Tuberculosis Response Programme [13],
- the National Immunisation Programme 2023–2027 [14],
- the National Programme for Combating Antimicrobial Resistance [15],
- or the National Programme for Viral Hepatitis B, C and D [16].

Intersectoral collaboration is established with multiple sectors. The ANSP coordinates with the Department for Animal Health and Welfare under the Ministry of Agriculture and Food Industry, the National Food Safety Agency, the Ministry of Environment (particularly on biosafety and laboratory cooperation), and the Customs Service and Border Police for cross-border health threats. These partnerships are supported by legal agreements, and regular trainings and exchanges of information take place.

Epidemiological response capacity is maintained through a 12-hour on-site duty system and a 24/7 on-call epidemiologist, ensuring continuous availability for urgent public health events.

Although no formal mechanism for the systematic evaluation of the surveillance system exists, Moldova's surveillance system has been subjected to external evaluations and assessments, namely a country assessment mission led by ECDC in 2014 [17], and a Joint External Evaluation [18,19] focusing on IHR core capacities. Moldova participated in the Electronic IHR States Parties Self-Assessment Annual Reporting Tool self-assessment, with a score of 62 points in 2024 (versus 74 points in the WHO EURO area) [20]. Notably, the lowest score was attributed to the human resources component, and the highest score to the surveillance component.

2. Data collection

Communicable disease data in the Republic of Moldova are collected primarily through the electronic surveillance platform SI SBTESP which has been operational since 2023 [7]. The system supports case-based and event-based reporting and is used by family doctors, clinicians, infectiologists (e.g. for HIV and viral hepatitis), epidemiologists (for follow-up investigations), and public health laboratories. While most data are submitted electronically, several primary care facilities still rely on paper-based reporting. In such cases, forms are completed manually and later transcribed into the system by epidemiologists at the local level. The level of granularity in data collection is very high with, for example, some case-based reporting of respiratory viruses.

SI SBTESP is a modular system, with each module tailored to a disease or group of diseases. Modules may implement modified case reporting forms depending on surveillance needs. Data entry is mainly the responsibility of family doctors but can vary by module. For example, in the hepatitis module, separate forms exist for acute and chronic hepatitis, and disease notification is the responsibility of the infectiologist managing the case.

Sentinel surveillance systems operate year-round. The surveillance system for respiratory viruses is based on nine standardised sentinel sites, each of which includes two family doctors, emergency medical care units, kindergartens, schools, and large industrial facilities. Data are collected in Excel spreadsheets using standardised templates, disaggregated by age and sex, and transmitted weekly to national authorities via email. Similarly, sentinel data for acute diarrhoea are maintained at the facility level using Excel-based reporting and are submitted for national aggregation and analysis.

Event-based surveillance is also supported through SI SBTESP. Local public health centres report an estimated 100–300 public health events per month.

In addition to routine data collection, Moldova has conducted specific studies to supplement surveillance data. A point prevalence survey of healthcare-associated infections (HAIs) and antimicrobial use in hospitals was conducted in 2018–2019, and a follow-up study is scheduled for 2025.

Moldova participates in international surveillance networks such as the Global Antimicrobial Resistance Surveillance System and the Central Asia and Europe Antimicrobial Resistance Surveillance Network. Internationally, data are shared with ECDC and/or WHO for ILI, ARI, SARI, HIV/AIDS and mpox.

3. Data quality

The quality of communicable disease surveillance data in the Republic of Moldova is primarily supported by the architecture of SI SBTESP. The platform enforces the use of standardised case reporting forms with mandatory fields and automated coding, contributing to uniformity and consistency of data entry.

SI SBTESP has nationwide coverage. No population groups were reported as being systematically excluded from the surveillance system, however the Transnistria region, with a population of approximately 475 000, only reports aggregated data in SI SBTESP. Overall, adoption of the electronic system has been gradual. During the first year of implementation, electronic notifications represented approximately 20% of prior paper-based reporting levels. As of 2025, this figure has increased to an estimated 50%, indicating a gradual improvement but still a significant gap in system coverage. This shortfall is attributed largely to the recency of the system and challenges in adoption among the ageing medical workforce.

SI SBTESP includes some automated functionalities, such as generation of summary reports by disease and geographical region, which can be accessed by all users of the system, including data providers. Although a formal framework for monitoring data quality is not yet established, efforts are made to ensure data completeness—this dimension is periodically reviewed by national-level heads of departments. Key performance indicators, such as completeness or timeliness, are not systematically tracked, and no minimum thresholds or targets have been defined for these parameters. No formal assessments have been conducted to quantify underreporting or under-ascertainment within the surveillance system, nor has the proportion of laboratory-confirmed cases been formally assessed.

4. Data management

SI SBTESP is a modular web-based standalone platform hosted on secure government servers. The system is administered independently of the wider national health information infrastructure and is accessed via government-verified authentication protocols. The national identification number is used to uniquely identify and track individuals within SI SBTESP. The platform integrates with the national population registry, enabling the auto-completion of core demographic fields upon initiation of a notification (Form 058/e). Demographic details can also be added manually for individuals without a Moldovan ID. No anonymisation or pseudonymisation mechanisms are implemented. SI SBTESP does not support case tracking across different levels of care over time.

SI SBTESP includes a dedicated module for outbreak and cluster management. This module enables the tracking of epidemiologically linked cases and supports the automated generation of alerts based on space-time clustering algorithms. For example, two notifications of invasive meningococcal disease within a ten-day window in the same region will trigger an alert.

Data can be manually exported from SI SBTESP. The system does not include automated pipelines or interfaces for external data transfer. Interoperability with the wider system is defined as a requirement for additional modules that may be developed.

Vaccination data are accessible in a dedicated module, which is not linked to case-based disease surveillance. Laboratory data are not integrated with SI SBTESP. Public laboratories operate a separate information system that is not interoperable with the surveillance platform. The typical workflow involves the patient receiving a printed or emailed test result, which must then be manually uploaded to SI SBTESP by the physician who initiates the notification. This manual process can result in delays and gaps in laboratory data capture and limits the system's ability to automatically validate reported cases with confirmatory testing.

5. Data analysis

Surveillance data are routinely used for descriptive epidemiological analyses, including case counts, incidence rate and temporal trend calculations. SI SBTESP supports basic analytical functions through automated reporting features. These include aggregation of cases by key epidemiological variables such as age, sex, region, risk factors, and special categories (e.g. pregnancy status). Data analysis is performed by epidemiologists from each department within ANSP and there is no staff exclusively dedicated to data analysis. Public health actions, if required, are implemented by each department.

Trend analyses for syndromic surveillance of respiratory viruses are performed and visualised through charts that incorporate epidemic thresholds. These outputs are used to monitor seasonal patterns and detect anomalies. Data from sentinel sites are aggregated and summarised weekly.

For broader reporting purposes such as ad-hoc bulletins and annual epidemiological reports, data are manually extracted from SI SBTESP and processed using standard office tools. These reports typically include summaries by disease, geographical distributions, and comparisons with historical trends.

6. Dissemination of surveillance data

Surveillance outputs produced by ANSP are shared internally with the Ministry of Health and other stakeholders.

Public-facing information is available on the ANSP website. Some examples of surveillance outputs include weekly situation reports on respiratory virus circulation [21], ad-hoc outputs such as on the epidemiological situation of measles in Moldova [22] or annual reports such as the one on HIV [23]. In addition to disease-specific reports, a broader 'Public health surveillance in the Republic of Moldova' report [24] is available that covers surveillance activities in depth. Analyses are disaggregated at the regional level to highlight geographical variations in disease dynamics. These outputs are produced and updated manually.

7. Outbreak detection

There are guidelines and standard operating procedures in place for investigating and reporting outbreaks, developed jointly with the Norwegian Institute of Public Health. Outbreaks are typically detected and investigated at the local or territorial public health level. Physicians or other healthcare providers who suspect an outbreak, especially of diseases with high epidemic potential such as measles or polio, are required to notify regional or national authorities without delay. In urgent cases, telephone notification is used to initiate rapid risk assessment and control measures before formal notification is completed.

SI SBTESP supports outbreak management by allowing epidemiological linking of cases within its outbreak/cluster module. This module facilitates case grouping and assists outbreak report generation.

In the Republic of Moldova, outbreaks of foodborne diseases, one of the major public health problems, are recorded throughout the year. Statistical data highlight that many people from different age groups are exposed to risks and affected by outbreaks. In 2024, 16 outbreaks of foodborne diseases were recorded, affecting 215 people, including 131 children. There is limited laboratory capacity for molecular characterisation of specimens during routine outbreak investigations.

8. Capacity

Moldova operates a network of public health laboratories with standardised diagnostic methodologies and Biosafety Level 3 (BSL-3) capability. These laboratories are equipped to confirm all notifiable diseases under surveillance. During outbreak investigations, a portion of collected samples is referred to national laboratories for quality assessment. The main reported limitation related to laboratory response was the lack of laboratories operating on a 24/7 basis, limiting their responsiveness to urgent situations. Gaps between human and veterinary laboratories were reported, with human laboratories having standardised methodologies across the country, which may not be the case for veterinary laboratories. The lack of trained bioinformaticians further constrains molecular surveillance and genomic analysis efforts. The national BSL-3 laboratory maintains strategic reserves of diagnostic kits for highly contagious diseases, particularly for those pathogens known to circulate in natural foci or historically reported in the country, as evidenced by surveillance studies.

Training on using SI SBTESP is provided by ANSP for personnel involved in infectious disease surveillance [25].

Moldova has benefited from participation in regional workforce development initiatives, such as the MediPIET, FETP and PHEM programmes. However, human resource gaps persist for public health services, most notably epidemiologists at the local/territorial and medical assistants at the local level.

There is a low number of trained personnel for data management and analysis is , with most analysis being performed in spreadsheet software.

Conclusions and recommendations

Moldova's communicable disease surveillance system has undergone significant improvements with the rollout of the SI SBTESP platform in 2023, aligning it more closely with EU frameworks and modernising data collection processes. The modular structure allows for future expansion while maintaining a common underlying logic to surveillance in the electronic platform.

However, these advancements also highlight persistent structural challenges. The SI SBTESP system imposes a high administrative workload on clinicians, who must navigate multiple forms and often multiple data entries in the absence of integration with laboratory information systems or primary care electronic records. The ageing medical workforce and incomplete national adoption of electronic reporting have contributed to underreporting and a lag in full system utility.

In summary, while Moldova's surveillance system boasts a comprehensive legislative foundation, structured data collection, and a growing suite of analytical tools, ECDC recommends the following improvements in system usability, data quality assessment, and cross-system integration to fully realise its potential.

Integrate laboratory data with SI SBTESP

- Currently, laboratory data are managed separately from the SI SBTESP system, requiring manual uploads by clinicians, which may delay confirmation and introduce risks of data loss. Establishing direct interoperability between SI SBTESP and the laboratory information ecosystem would enable automatic importation of test results, enhance real-time case validation, and reduce the administrative burden on physicians.

Review and streamline data collection

- The current level of granularity in data collection imposes a high burden on SI SBTESP data providers, such as reporting physicians, which may reduce compliance. Data needs should be reviewed to streamline reporting while prioritising variables that are internationally recognised as relevant for communicable disease surveillance—such as those defined in ECDC’s TESSy/EpiPulse metadata standards [26]. One area where simplification might be useful is the case-based reporting of respiratory viruses, which currently overlaps with some parts of the sentinel surveillance system. Reducing this duplication would help decrease unnecessary workload and improve the efficiency of data collection.

Implement data quality monitoring

- The surveillance system currently lacks a framework for evaluating core data quality metrics such as completeness, timeliness, or the proportion of laboratory-confirmed cases. Establishing key performance indicators (KPIs), regular monitoring procedures, and benchmark thresholds will provide a mechanism for accountability and system improvement. Indicators should be tracked at both the national and territorial levels.

Enhance analytical capacity and methods

- Most data analysis is currently limited to basic spreadsheet operations. Improvements should be made in analytical capacity, including using statistical software tools and training epidemiologists in advanced methods. Outputs should incorporate these improved analytical methods as well as outcome-related measures (e.g. case-fatality rate, hospitalisation rate) and be standardised across disease areas.

Strengthen communication and dissemination strategies

- While some reports are available online, the communication strategy could be improved. Targeted dissemination should consider the needs of clinicians, policy makers, and the public. Regular bulletins, visual dashboards, and automated summaries would facilitate better use of data for decision-making and public awareness.

Estimate under-ascertainment and under-reporting

- Moldova does not currently quantify levels of under-reporting or under-ascertainment. Targeted studies (e.g. capture-recapture analysis, seroprevalence surveys, external audits) are needed to estimate surveillance gaps and inform corrective actions. Priority should be given to diseases with discrepancies between expected and reported incidence.

Operationalise public health functions at all levels in healthcare

- To support effective communicable disease surveillance and response, public health functions should be fully operationalised at the national, regional, and local levels. This includes ensuring adequate capacity and continuity of operations through a skilled and appropriately trained public health workforce, supported by clear roles, responsibilities, and coordination mechanisms. Capacity-building efforts should be reinforced to maintain functionality across all tiers of the system, especially for frontline implementation of surveillance, outbreak investigation, and data reporting.

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Annex 1. Practical arrangements for the assessment process

Country visit agenda

Day 0, 22 nd April 2025		
Time	Topic	Participants
19:10	Arrival of ECDC team at Chisinau	
Day 1, 23 rd April 2025		
09:00 – 09:30	Welcome and introduction to the meeting	ANSP, ECDC
09:30 – 10:00	Surveillance of infectious diseases at EU/EEA level and strengthening surveillance in Moldova	ANSP, ECDC
10:00 – 10:30	Presentation on Description of infectious disease surveillance system in Moldova, Republic of	ANSP, ECDC
10:30 – 10:45	Break	ANSP, ECDC
10:45 – 11:45	Epidemiological surveillance of influenza and acute viral respiratory infections (15 min – Questions/Discussion) <i>Data: collection, quality, management, analysis, dissemination</i> <i>ECDC experience</i>	ANSP, ECDC
11:45 – 12:45	Epidemiological surveillance of HIV infection and viral hepatitis (15 min – Questions/Discussion) <i>Data: collection, quality, management, analysis, dissemination</i> <i>ECDC experience</i>	ANSP, ECDC
12:45 – 13:45	Lunch break	ANSP, ECDC
13:45 – 14:45	Epidemiological surveillance of foodborne and waterborne diseases (15 min – Questions/Discussion) <i>Data: collection, quality, management, analysis, dissemination</i> <i>ECDC experience</i>	ANSP, ECDC
14:45 – 15:45	Epidemiological surveillance of highly contagious, zoonotic and parasitic diseases (15 min – Questions/Discussion) <i>Data: collection, quality, management, analysis, dissemination</i> <i>ECDC experience</i>	ANSP, ECDC
Day 2, 24 th April 2025		
09:00 – 10:00	Epidemiological surveillance of healthcare-associated infections and antimicrobial resistance (15 min – Questions/Discussion) <i>Data: collection, quality, management, analysis, dissemination</i> <i>ECDC experience</i>	ANSP, ECDC
10:00 – 11:00	Epidemiological surveillance of vaccine preventable diseases (15 min – Questions/Discussion) <i>Data: collection, quality, management, analysis, dissemination</i> <i>ECDC experience</i>	ANSP, ECDC
10:45 – 11:00	Break	ANSP, ECDC
11:00 – 11:45	Outbreak detection <i>Priority on Food borne disease</i> <i>(strengths, weaknesses, experience)</i> <i>ECDC experience</i>	ANSP, ECDC
11:45 – 12:30	Capacity description of communicable diseases surveillance system <i>ECDC experience</i>	ANSP, ECDC
12:30 – 13:00	Lunch break	ANSP, ECDC
13:00 – 14:00	Discussion on selected diseases reported to ECDC	
14:00 – 16:00	Training on EpiPulse CASES/TESSy reporting in the context of new EpiPulse portal European laboratory methodology approach in outbreak investigation and acute diarrheal diseases. ECDC HAI surveillance and HelicsWin.Net	ANSP, ECDC
16:00 – 16:30	Debriefing session: Draft conclusions and way forward	ANSP, ECDC
Day 3, 25 th April 2025		
	Departure of ECDC team	



Funded by
the European Union