



**Ministry of Health
of the Republic of Moldova**



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Reproductive Health Commodity Security Situation Analysis in the Republic of Moldova

by

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As an integral part of its reproductive health commodity security strategy, UNFPA strives to improve access to and use of reproductive health (RH) products in developing countries. To this end, UNFPA/CO in the Republic of Moldova provides support and assistance to assess the current situation, to identify gaps and draw a road map to ensure commodity security as the base of a successful reproductive health program. UNFPA applies effective approaches for delivering services in priority RH areas, including availability of and access to high quality RH products in several countries.

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Abstract

Reproductive health commodity security (RHCS) exists when every person is able to choose, obtain, and use quality contraceptives and/or other RH products every time he or she desires. The goal is thus to make sure that supply corresponds to demand.

Republic of Moldova used to receive RH/FP commodities as donation from UNFPA, with last donation in 2011 which lasted in some facilities until 2014; and MOH needed to carry out the responsibility of quantify needs, procure, distribute, store and dispense to clients. To do this MOH endorsed many decrees to enable the policy environment. In a country with high percent of traditional method use, induced abortion, and limited budget for RH services, it was not an easy job; there were a need to do efforts to ensure the availability of RH products to correspond with demand at all PHC centers, especially for the vulnerable groups.

The country’s new SRHR National Program is currently being finalized and will be endorsed by the national Government in the near future. The current situation shows that at the level of primary healthcare facilities exists stock-outs of contraceptives and that determined the Ministry of Health and UNFPA to undertake a situational analysis to better understand the RHCS country status and to address the existing bottlenecks related to reproductive health commodity security and to strengthen the supply chain management system.

This RHCS situational analysis provides information to increase awareness in the efforts to improve RHCS in the Republic of Moldova. It provides information necessary for the development of a national strategic plan for contraceptives, and program linkages to obstetrical and neonatal health care, and HIV/AIDS commodity security.

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ACRONYMS AND ABBREVIATIONS

AIS PHC	Automated Information System for Primary Health Care
AMMD	Agency of Medicines and Medical Devices
CCPPH	Center for Centralized Public Procurements in Health
CS	Commodity Security
DBFI	Department of Budget, Finance and Insurance
DMPM	Department for Medical Personnel Management
DMMD	Department of Medicines and Medical Devices
DPECHC	Department of Primary, Emergency and Community Health Care
EDL	Essential Drug List
FDO	Family Doctor Office
FMC	Family Medicine Centre
FP	Family Planning
GDP	Gross Domestic Product
HC	Health Center
HCf of PHC	Health Care Facilities of Primary Health Care
HHCD	Hospital Health Care Department
HIV	Human Immunodeficiency Virus
LMIS	Logistics Management Information System
MCI	Mother and Child Institute
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
MOF	Ministry of Finance
MOH	Ministry of Health
MLSPF	Ministry of Labor, Social Protection and Family
NCPH	National Center for Public Health
CRHMG	Centre for Reproductive Health and Medical Genetics
NGO	Non-government Organization
NHIC	National Health Insurance Company
NRHS	National Reproduction Health Strategy
NSRHCS	National Strategy for Reproductive Health Commodity Security
OOP	Out-of-Pocket Payment
PHCF	Primary Health Care Facility
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RHO	Reproductive Health Offices
RHTC	Reproductive Health Training Centre
STGs	Standard Treatment Guidelines
TOR	Terms of References
UNFPA	United Nations Population Fund
WHO	World Health Organization
YFHC	Youth Friendly Health Center

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Hope that this report helps to strengthen reproductive health commodity security in the Republic of Moldova and goes some small way toward repaying the kindness and hospitality received during the mission.

Executive Summary

Reproductive health commodity security (RHCS) exists when every person is able to choose, obtain, and use quality contraceptives and other essential reproductive health products whenever she or he needs them. This means, having different choices of commodities available and accessible is essential, to ensure that clients can have the suitable method to use.

The concept of CS or RHCS is a critical component of the national family planning programs. It ensures a reliable supply of contraceptives, so that every person is able to choose, obtain and use quality contraceptives when and if they need them. This indicator demonstrates whether national policy acknowledges and supports CS/RHCS and if it is willing to implement a strategy to attain their CS goals. Republic of Moldova needs to do efforts to meet RHCS objectives.

To this end, in collaboration with UNFPA, this assessment report was developed and a road-map to achieve RH commodity security was drawn to identify required actions in short-term (1-2 years) and mid-term (2-5).

The methodology for this assessment is based on the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) Framework. The framework consists of seven components: context, commitment, coordination, capital, capacity, commodities, and client use and demand.

Assessment activities included desk review of all available documents, interview with key persons, and field visits to PHCFs, including YFHCs at the district level. Main findings were gathered and road map was drawn reflecting short-term (1-2 years) and mid-term (2-5 years) recommendations. Main findings from the assessment showed that the policy environment is supportive for RH/FP Programs that needs to be reflected on actions, allocating required funds and filling the system gaps.

Development of the RHCS Strategy, or including RHCS strategic interventions in the National Sexual and Reproductive Health and Rights Program is a key to strength the logistics management and the supply chain.

To achieve RHCS targets there are required actions to be realized such as, to create a Steering Committee on SRHR (to coordinate all important issue in the area of SRHR, including on Reproductive Health Commodity Security), to expand the role of RH Cabinets to include RHCS activities etc.

To ensure the allocation of the required funds for RH/FP commodities - there is need to design and implement the advocacy campaigns with aim to gain decision makers support to increase the allocated resources for commodities procurement.

Several ministerial orders related to RH/FP were issued during the last few years; unfortunately, their cost implications was not considered and not all of them released with implementation plan.

MoH Order on PHC stipulates that family doctors among other duties have the obligation to provide family planning services. No provisions are included in the respective order stipulating that family doctors aren't allowed to insert IUD.

At the same time the MOH Order No 658 of 18.08. 2015 On Providing Contraceptives stipulates:

"...When choosing intrauterine device, the beneficiary who can come to the district center shall have a prior appointment with the gynecologist of a Youth Friendly Health Centre or Reproductive Health Office to insert the device. In case of persons who cannot travel from rural area to district centers, the head of the primary health care facility shall organize visits of the gynecologists from

the Youth Friendly Health Center or Reproductive Health Office, and ensure the consultation of women from socially vulnerable groups and the insertion of intrauterine devices. ...”

That is due to the fact that currently the postgraduate Family Medicine residential program doesn't include development of practical competences and skill in IUD insertion of the family doctors. In this regard, only the continuing medical education curriculum includes development of practical skills in IUD insertion in case of family doctors.

Available family planning contraceptives are very limited – only three modern methods of contraception are being provided: condoms, IUD and pills.

There is a need to design RH/FP interventions for youth including IEC campaigns, to extend the spectrum of contraceptives; advocate for integration of comprehensive sexuality education, including RH/FP topics in the secondary school curriculum.

The logistics information is not available at any level. There is a need to build staff capacity at all levels in many areas such as logistics management, logistics management information, advocacy, policy analysis and formulation, problem solving, decision making, and data for evidence-based decision making.

After development of this report, an advocacy round table was conducted attended by relevant key stakeholders, who by the end of the presentation were asked to rank short-term recommendations according to three criteria: importance, feasibility and impact. The ranking analysis considered classification of these recommendations to be implemented on three phases as following:

Short-Term Recommendations

Phase (1)

Context, Commitment and Coordination

- To include the RHCS activities in the newly developed draft National Program on SRHR. A unified Action Plan for all activities (including commodity procurement) is important to be developed as an integral part of it; as well, to ensure budget allocation for its implementation.

Capital

- Develop/Implement advocacy campaigns on RHCS issues and their importance in order to strengthen commitment and ownership and to increase the budget allocated to RHCS

Commodities

- Explore and consider the possibility to procure the reproductive health quality life-saving medicines, including contraceptives through UNFPA Procurement System

Client Use and Demand

- Develop/implement IEC Campaigns to raise community awareness on the importance of using modern contraceptives and available FP services

Capacity

- Design/implement regular national forecasting process, under the supervision of the MoH, with lead of the newly established Center for Centralized Public Procurements in Health, in collaboration of all related stakeholders such as: PHCFs, YFHC, RH Cabinets etc
- Develop/Strengthen the implementation of the standard of using contraceptives on the basis of WHO recommendations, and use different communication channels to raise both service providers and clients' awareness about it

Phase (2)

Context, Commitment and Coordination

- To develop the Terms of Reference of the Steering Committee on SRHR to include provisions on planning and monitoring of all RHCS activities (the proposed Terms of Reference being reflected in the Annex 2 of the respective report).
- Within the newly established Center for Centralized Public Procurements in Health, assign two persons as focal points on RHCS (the proposed Terms of Reference being reflected in the Annex 3 of the respective report).
- Expand the TOR of the existing RH/FP Cabinets at the district level to incorporate required RHCS activities such as: monitoring pipeline, ensure gathering required LMIS data
- Monitor progress in the implementation of the Action Plan endorsed for 2016-2017 on Providing Contraceptives to Vulnerable Groups at the level of PHC.
- Design/implement advocacy campaigns to include contraceptives in the Compensated Drugs List

Capital

- Review, analyze and estimate the cost of implementation of Ministerial Orders related to RH/FP. Develop a cost effective analysis on the benefits of RH/FP program and use it to advocate for support

Commodities

- Register Injectables, as well as Implants and incorporate them in the procurement process

Client Use and Demand

- Explore and pilot the introduction of the new methods of modern contraception, such as female condoms

Capacity

- Develop/implement advocacy campaigns to incorporate logistics management topic in the medical curriculum for family doctors, family medical assistants and PHCFs managers
- Integrate logistics information data with the database on the vulnerable groups with aim to monitor the use of contraceptives by the vulnerable groups at the level of PHC facilities

- Build national capacity of PHCFs, including RH Cabinets and YFHCs managers, in the area of :
 - RHCS framework
 - Forecasting, Logistics Management, and Supply Chain Management and LMIS
 - Advocacy, M&E Mechanisms, Policy Analysis and Formulation, Problem Solving, Data Utilization and Data for Evidence-Based Decision Making
- Design/implement M&E Mechanisms to monitor PHCFs performance in the area of RHCS, and explore the possibility to introduce performance indicators on RHCS in PHC
- Design/implement advocacy campaigns for decision makers and service providers on the newly adopted Total Market Approach for Family Planning
- Improve Logistics Information Availability and Utilization:
 - Review/Unify/Develop manual input forms, inventory keeping-records - to collect logistics data from PHCFs, including RH Cabinets and YFHCs
 - Design/Test templates for comprehensive reports to support decision making on FP/RHCS
 - Develop mechanism to ensure collecting on regular base required logistics management information from the PHCFs, RH Cabinets and YFHCs and to generate required reports
 - Build capacity of PHC staff to use developed with UNFPA support contraceptive logistics management information module integrated into PHC automated information system (SIA-AMP).

Phase (3)

Context, Commitment and Coordination

- Review and strengthening existing RH/FP regulatory framework to ensure integration of policies and to assess obstacles for their implementation;
- Develop/Strengthen the implementation of the Standards and Protocols of FP/Contraceptives dispense (particularly Clinical Practice Protocol on Family Planning to be developed for Family Doctors).

Capacity

- Design/implement training on IUD insertion within postgraduate Family Medicine residential program. Provide as well on-job training for family doctors on IUD insertion, under Gynecologists' supervision; and design/implement advocacy campaigns to encourage FDs to practice IUD insertion at the level of PHC.
- Conduct advocacy campaigns about the importance of LMI and generated reports targeting PHCFs and RH Cabinets and YFHCs managers'.
- Provide required support to the Pharmaceutical Storage "Sanfarm-Prim" to ensure the possibility to utilize it as the main warehouse for RH/FP commodities when the procurement through international platforms, including UNFPA Procurement Services will be carried out

Mid-Term Recommendations

1. The SRHR Steering Committee to conduct regular meetings to identify areas for RH/FP/RHCS analyses and researches.
2. Develop program to create FP champions from social workers at the district level. The idea here is to build social workers capacity to carry RH/FP IEC activities including RHCS.
3. Explore the possibility to include RHCS indicators, including monitoring stocks indicators and on contraceptive distribution, in the assessment of the PHCFs, carried every 5 years by the National Council on Evaluation and Accreditation in Health.
4. Develop/implement IEC campaigns to raise community awareness about modern methods of contraception, especially on long term methods of contraception, with aim to reduce the prevalence of traditional methods of contraception, focusing on target groups such as youth, women in the post-partum period, PLHIV and other groups (to prevent unplanned, high-risk pregnancies and to allow people to make an informed choice about family planning).
5. Design/implement advocacy campaigns to facilitate integration of the Comprehensive Sexuality Education, including RH/FP issues into the secondary school curriculum.
6. Design and implement media campaigns to raise awareness of target population, especially youth, about reproductive health and family planning and RHCS issues. These campaigns have to cover Journalists, TV/Radio program makers, Film authors and script writers.
7. Explore the possibility and feasibility to have mobile clinics to provide RH/FP out-reach youth-friendly services for the most vulnerable and most-at-risk adolescents and youth living in communities.
8. Utilize the flexibility of NHIC to contract NGOs and/or private sector, to apply Total Market Approach, by designing and implementing advocacy campaigns (to encourage more private sector and NGOs' involvement in providing RH/FP services, including required contraceptives; as well as to strength partnership between public sector and both private and NGOs for more effective implementation of total market approach.
9. Build capacity of MOH departments and subordinated institutions in the area of stakeholder analysis', Problem Solving, and other training needed to facilitate the partnership and help on providing client with more options for RH/FP services, as well as more choices for contraceptive methods to use.
10. Design/implement advocacy plans and materials to ensure increase of the allocated resources for RH/FP services and commodities procurement at the level of PHC facilities.
11. Develop mechanism to collect on regular base data about client' satisfaction with regard to provided FP services and commodities
12. Design and conduct studies to better understand:
 - youth needs for more choices of contraceptive methods
 - reasons for unmet needs, discontinuation, method choices, family planning methods use and demand.
 - market segmentation (analysis of market segments) for better understanding client perceptions and preferences.

Introduction

Reproductive health commodity security (RHCS) exists when every person is able to choose, obtain, and use quality contraceptives and other essential reproductive health products whenever she or he needs them. This means, having different choices of commodities available and accessible is essential, to ensure that clients can have the suitable method to use.

To achieve RHCS a number of elements are essential to establish a supportive environment, including: developed and approved policies and regulations favorable to RH/FP, generating awareness and demand on RH/FP, mobilizing resources, and developing in-country capacity to ensure availability and accessibility of contraceptives.

Republic of Moldova faced challenges when UNFPA phase out from donating RH/FP commodities, with last donation in 2011. Responding to the new situation MOH started to enable the environment and took a proactive approach to ensure that reproductive health commodities are incorporated in the essential drug list and that RH services are provided through primary health care service delivery points.

UNFPA is providing technical assistance to the MOH to conduct this assessment to be used with aim to increase awareness and determine a better understanding and familiarity with RHCS among partners and decision makers.

Methodology

The methodology for this assessment is based on the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) framework (see figure 1), which UNFPA and other partners developed and adapted several years ago. SPARHCS framework' included seven components: Context, Commitment, Coordination, Capital, Capacity, Commodities, Client Demand and Utilization.

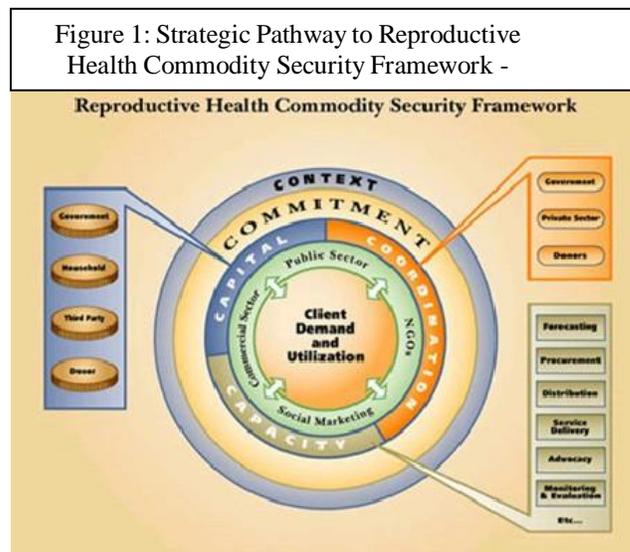
In each country, the general context affects the chances of attaining RHCS, including national policies and regulations affecting reproductive health, and in particular the availability of reproductive health services and family planning commodities; also, more general factors, such as social, economic and cultural conditions, as well as, other competing priorities have an impact.

In this context, engagement (which includes policy support, government leadership and targeted advocacy), is an important component of RHCS. This engagement is the basis on which the stakeholders invest the necessary funds, coordinate their activities in the area of commodity security (CS), and develop the necessary capacities to achieve RH. The boxes in the diagram explain each of these components.

Coordination involves the national Government, the private sector, and the development donors/partners to better ensure the most effective allocation of resources. Households, third parties (employers, social insurance), the national Government and donors - are all sources of funding.

Furthermore, there must be capacity for a range of functions, including policy (policies favorable to RH/FP); forecast, purchase and distribution; creation of client demand; service provision, supervision, monitoring and evaluation, to name a few.

The clients, which are found in the middle of the diagram, are the final beneficiaries of RHCS as commodity recipients, but also, shown in double lines, being the initiators: the system must meet their needs.



Objectives of the Situation Analysis

The objective of the situation analysis is to provide information and recommendations to improve the RHCS situation, by looking at reproductive health in the public sector. In addition, the situation analysis helps to build consensus among the relevant stakeholders on the priority actions that must be taken, to ensure the effective delivery of RHCS and to develop an implementation plan for RHCS in the public sector.

In the Republic of Moldova, the situation analysis will help on drawing a map to ensure RHCS in short and medium run, taking into consideration limited budget available and its priority in decision makers' agenda.

Situation Analysis Activities

A series of activities were conducted to collect the necessary information for the situational analysis and to develop recommendations.

Before arriving to the Republic of Moldova, with assistance from UNFPA CO, list of required available documents were identified and reviewed as background material, available on the Internet and sent by the UNFPA Country Office.

Again in country, more background papers were received, as well as, ministerial orders related to RH/FP; a series of discussions were realized with UNFPA CO staff, representatives of MOH, NHIC, AMMD, Pharmaceutical Storage "Sanfarm-Prim" S.A., PHC facilities staff from both - municipal and district level (during the field visits), as well as NGOs, WHO, UNICEF and UNDP COs staff. The respective series of activities allowed better understanding of the current situation and possibility to develop practical recommendations.

At the end of the mission, a debriefing meeting with UNFPA CO was realized with aim to discuss the main findings and to provide an overview of the recommendations to be included in the report.

The RHCS assessment took place starting with 10th of October 2016 for 5 days and included the following activities:

- Desk review of the background documents that relate to the orientation of policy and strategies in the field of reproductive health (RH).
- Individual meetings with Ministry of Health (MOH), firstly with Deputy Minister and then with Deputy Head of Hospital Health Care Department, Head of Primary, Emergency and Community Health Care Department, Head of Medicines and Medical Devices Department, Head of e-Health and e-Transformation Division, Head of Budget, Finance and Insurance Department
- Individual meetings with the Director of Mother and Child Institute, Head of Reproductive Health and Medical Genetics Center, Deputy Director of the National Center of Health Management, Deputy General Director of the Agency of Medicines and Medical Devices, Deputy Director responsible for Mother and Child Health Care, Consultative and Diagnostic Center of the Territorial Medical Association Centre, the National Health Insurance Company General Director and team, the Director of the “Dalila” Woman’s Health Center, Territorial Medical Association Botanica
- In addition, the meetings with the Director of the “Neovita” Youth Friendly Health Center, as well as with the General Director of the Pharmaceutical Storage ”Sanfarm-Prim” S.A were held.
- Meetings with WHO, UNCEF and UNDP CO staff were realized as well.
- Field visits to selected PHC facilities were realized to Orhei district, as well as Magdacești and Peresecina villages, and Durlesti and Ialoveni suburbs areas of Chisinau Municipality.

Situation Analysis Limitations

The situation analysis in the Republic of Moldova was limited to a review of the public sector’s RHCS related issues. The analysis focused on the availability of RH commodities at service delivery points (particularly of family planning commodities).

The RHCS situation analysis is a qualitative study; it does not provide information on the quantities of products assessed during the study. The observations and comments in this report relate to the ongoing delivery of RH/FP services at the level of health facilities. At each visited facility, interviews were carried out with key informants and health officials.

The results of the situation analysis, including the recommendations presented in this report, are limited to the scope of the activities that were designed and carried out at the central and district levels. The situation analysis has not been realized based on the representative sample of all PHC facilities, but it is rather a qualitative and anecdotal picture of the supply situation.

National Ministerial orders were translated in English and made available for review. Changing on roles and establishment of a new unit responsible for centralized public procurement in health - Center for Centralized Public Procurements in Health - starting during the mission, made the information on procurement process not available.

Background

• Socio-Demographic Indicators

The Republic of Moldova is a lower-middle-income country in Eastern Europe with a population of 3.5 million (1st January 2016 data do not include the districts on the left side of the river Dniester and the municipality of Bender) and a gross domestic product of US\$ (current) 1,843 per capita¹ in 2015. The economy is heavily based on remittances from Moldovan citizens working abroad.

The country was part of the former Soviet Union, from which it obtained independence in 1991. Since independence, Moldova, including its health sector, has undergone profound social, political and economic transformations. While some reforms were introduced in the hospital sector, much remains to be done; and the most important changes so far were compelled by the introduction of a mandatory health insurance system in 2004. These included: strengthening of primary health care and ensuring access to medicines in privatized pharmacies and through selected national programs (e.g. diabetes, tuberculosis, HIV/AIDS, immunization etc).

According to the National Bureau of Statistics data, the number of permanent residents of the Republic of Moldova as of 1 January 2015 amounted to 3 555.1 thousand inhabitants, including the migrants who live abroad for more than 12 months. The present population constituted 2 911.6 thousand, calculated in accordance with the European standards and does not include the migrants which live abroad for more than 12 months.

The decrease of fertility rate is illustrated by the evolution of finale TFR of female generations. The complete fertility rate of female generations born in the first half of the 1960s was at the generation replacement level or higher, while those born during 1973-1975, but especially those that were born in the late 1970s and more recently, will have a lower fertility.

The most negative impact of the population decline determined by the decrease of the birth rate, presents the loss of national demographic potential to redress the situation, the demographic crisis becoming thus huge and the depopulation process being harder to stop.

Another factor in the population decline presents high population mortality. Life expectancy at birth (calculated on base of present population) is 65.0 years for men and 73.4 years for women, which is by 7.4 and, respectively, by 6.7 years lower than in the EU.

High mortality of adult population, especially of men, is one of the most important problems. Today, the probability of dying at the age of 65 for a man who has reached 20 is of 40%, which is two times higher than in developed countries.

In the structure of mortality by cause of death, prevail the diseases of circulatory system, the share of that in total mortality is 53% for men and 64% for women. Neoplasms are ranked on the second place for both sexes (16% for men and 14% for women). For men, deaths due to external causes (10%) and digestive diseases (9%) rank third in the general mortality structure. For women, the digestive system diseases rank third among the leading causes of death (10%).

Mass emigration of the population has a significant impact on the dynamics of the Moldovan population. The results of the census of the host countries reveal that around 16% of Moldovan population in 2011 had stable residence abroad.

¹ <http://data.worldbank.org/country/moldova>

The largest migration losses were recorded in 2007-2011, when net migration varied between 33,000 and 43,000 people per year. For 2012-2013, the net migration is slightly over 30 thousand people. In 2012-2013, the Republic of Moldova has lost annually about 1% of the population left in the country².

Overall, the young population ratio has declined along with the increase in the elderly population, thus further increasing the demographic dependency ratio, which is an important indicator from an economic standpoint. Consequently, the demographic dependency ratio (i.e. population aged 0-14 years and population aged 60 or more per 100 persons aged 15-59 years) was 45.0 percent in 2011, compared to 44.4 percent in 2009.

In 2011, the population under the employable age (0-15 years aged population) constituted 17.5 percent (being 18.2 percent in 2009), while the working-age (16-56/61 years aged population) reached 66.6 percent (being 66.5 percent in 2009) and the over-working-age (57/62 years aged population) – 15.9 percent (being 15.3 percent in 2009)³.

As shown in table (1), the annual population growth rate is -0.1% and total fertility rate is 1.3 which is below the replacement level.

Table (1) Republic of Moldova Selected Demographic indicators		
Population (proj., 000)	2016	4063
Pop. density (per sq km)	2016	123.7
Population growth rate (average annual %)	2010-2015	-0.1
Urban population (%)	2015	45.0
Urban population growth rate (average annual %)	2010-2015	-0.7
Fertility rate, total (live births per woman)	2010-2015	1.3
Life expectancy at birth (females/males, years)	2010-2015	75.4/67.2

• Family Planning Indicators

Access to safe, voluntary family planning services, including modern contraceptives is a human right. Family planning is central to gender equality and women's empowerment, and it is a key factor in reducing poverty. Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility⁴

² Population Situation Analysis, Demographic Research Center, Chisinau, October 2016

³ There is a difference between the classification used in official country statistics and the international classification (0-14, 15-64 and 65 and over). The country-specific age groups are as follows: under-working-age (0-15 years), working-age (16-56 years for women/61 years for men) and the over-working age (57 years or more for women /62 years or more for men).

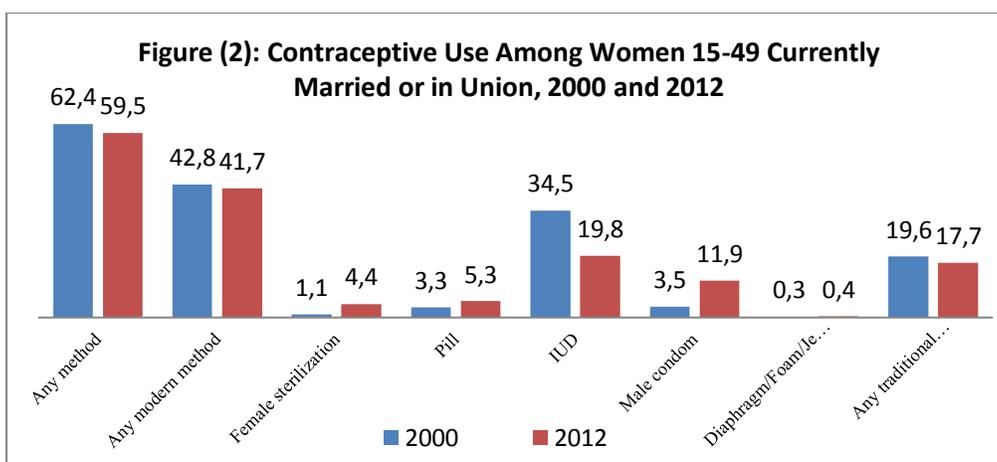
⁴ WHO; Family planning/Contraception; Fact sheet N°351, Updated May 2015

Contraception lets women and couples have the number of children they want, when they want them and if they want them. This is everybody's right under the United Nations Declaration of Human Rights.

Delaying or spacing babies allows women and men to follow education and career goals that may be interrupted by having children. This empowers people and increases their ability to earn more. With fewer children, families are also able to invest more in each child.

Two MICS surveys were conducted in the Republic of Moldova in 2000 and 2012 that allow to gather information on family planning. Their results showed that the family planning program is in need for more efforts that being clearly reflected by the decrease in contraceptive use among married women or women in union from 62.4% to 59.5% (see Figure (2)).

The method mix changes need more deep analysis to understand the reasons of reducing IUD usage from 34.5% to 19.8%. In general, the traditional method usage decreased from 2000 to 2012, the use of IUD decreased as well, and the use of condoms increased from 3.5% to 11.9%.



Focusing on adolescent needs who are 15-19 years old, as table (2) shows - more young people are using contraceptives, having a positive attitude toward modern methods. Thus, high percentage of young people shifted from traditional methods to modern methods of contraception (traditional methods decreased from 18.6% to 9.5% and modern methods use increased from 23.8% to 35.8%).

The reduction of IUD use from 13.5% to 5.7% need more analysis, as it might be due to stock-out of IUD, insufficient geographical access of young people from communities to Gynecologist/YFHC for IUD insertion, or need to raise their awareness about all modern available methods of contraception.

	2000	2012
No method	57.7	54.7
Any method	42.3	45.3

Any modern	23.8	35.8
Pills	0.9	2.2
IUD	13.5	5.7
Any traditional method	18.6	9.5
Withdrawal	9.3	9.5
Condom	9.4	27.9
LAM	3.1	U
Periodic Abstinence	6.1	0
Unmet need		23.4

According to MICS survey carried on 2012, as shown in table (3), the percentage of all women age 15-49, currently married or in union, who have heard of any contraceptive method is about 99.8%, and using any method is 59.5%. For modern method, percentage of knowledge is 99.8% and the use is 41.7%. Knowledge on pill is 95.9% and on IUD is 95.6%.

	Knowledge	Using
Any method	99.9	59.5
Any modern method	99.8	41.7
Female sterilization	77.7	4.4
Male sterilization	57.2	0
Pill	95.9	5.3
IUD	95.6	19.8
Injectables	61.3	0
Implants	37.1	0
Male condom	98.7	11.9
Female condoms	39.5	0
Diaphragm/ Foam/Jelly	28.5 40.8	0.4
Emergency Contraceptives	62.8	0
Any traditional method	91.8	17.7

Furthermore, Family Planning/Contraception can be used for Reducing Pregnancy-Related Risk. Girls and young women are especially at increased risk of health problems during pregnancy. Contraception allows them to put off having children until their bodies are fully able to support a pregnancy. It can also prevent pregnancy for older women who face pregnancy-related risks.

Access to modern contraception and contraceptive use reduce the need for abortion by preventing unplanned pregnancies. It therefore can reduce the cases of unsafe abortion, one of the leading causes of maternal death worldwide.

Also, contraceptive use reduces teenage pregnancies. Adolescent Birth Rate in Moldova shows a declining trend - from 63.2 births per 1,000 women aged 15-19 years old in 1992 to 35 births per 1,000 women aged 15-19 years old in 2012⁵. Nevertheless, despite the declining trend, the adolescent birth rate remains twice higher in Moldova than in European Union (11.0 birth per 1,000 women aged 15-19 years in 2014).

⁵ MICS, 2012, Table RH.2 Page 63

The proportion of women aged 15-49 years who had live births by the age of 15 is less than one percent, while the proportion of those who have had a live birth before the age of 18 is 4%; in rural areas being higher -6% and in urban being 3%⁶. By using contraception, young women can prevent unintended pregnancies that can have negative impacts on their future relationships, aspirations and potential.

Early pregnancy can also cause health problems for the newborn babies. Infants born in case of teenage mothers are likely to have underweight before and at birth and are at higher risk of neonatal mortality (dying within 28 days of birth). Furthermore, it is well known that spacing pregnancies too close together (poorly timed pregnancies) contribute to high infant mortality rates – that is, the rate of babies that die within their first year of life. Contraceptive use lets women plan their pregnancies so they can make sure the baby is getting the best care before and after birth.

The unmet need for contraception, which is defined as percent of fertile women who wish to postpone the next birth (spacing) or who wish to stop childbearing (limiting), but are not using any method of contraception, in Moldova is around 9.5%. The highest percent of women with an unmet need for contraception is in Chisinau - 11.4%, among women with secondary education unmet need for contraception being - 9.9%.⁷

Statistics indicate that while in the developed world only one in every 17,400 women is at risk of dying during pregnancy or during childbirth, in low-income countries, this could be as much as one in eight.⁸ In counteracting this, the Reproductive Health Supply Chain notes that problems related to reproductive health can be greatly reduced if reproductive health supplies are made available, are affordable, are of good quality, are properly used, are sustainable, and are provided through an efficient and effective supportive system.

⁶ MICS, 2012, Table RH.4 Page 64

⁷ MICS, 2012. Table RH.8

⁸ Inequities are killing people on grand scale, reports WHO's Commission, Press release, WHO

Assessment Findings

A. Context, Commitment and Coordination

The success of an RHCS Strategy depends on a range of contextual factors affecting individuals' ability to choose, obtain and use RH supplies. To define the broader health, political, and economic environment as it affects RHCS, this section considers: policies and regulations that bear on the ability of public and private sector programs to secure and deliver reproductive health supplies; and basic demographic, health, and other development indicators.

• Health Context

In 2012, a health system review was conducted by the European Observatory on Health Systems and Policies titled "Health System in Transition". This review showed that the Republic of Moldova health system is organized according to the principles of universal access to basic health services and equity and solidarity in health care financing; it is funded from both the state and individuals, through Mandatory Health Insurance (MHI). The health system includes a mix of public and private medical facilities, as well as public agencies and authorities involved in the provision, financing, regulation and administration of health services.

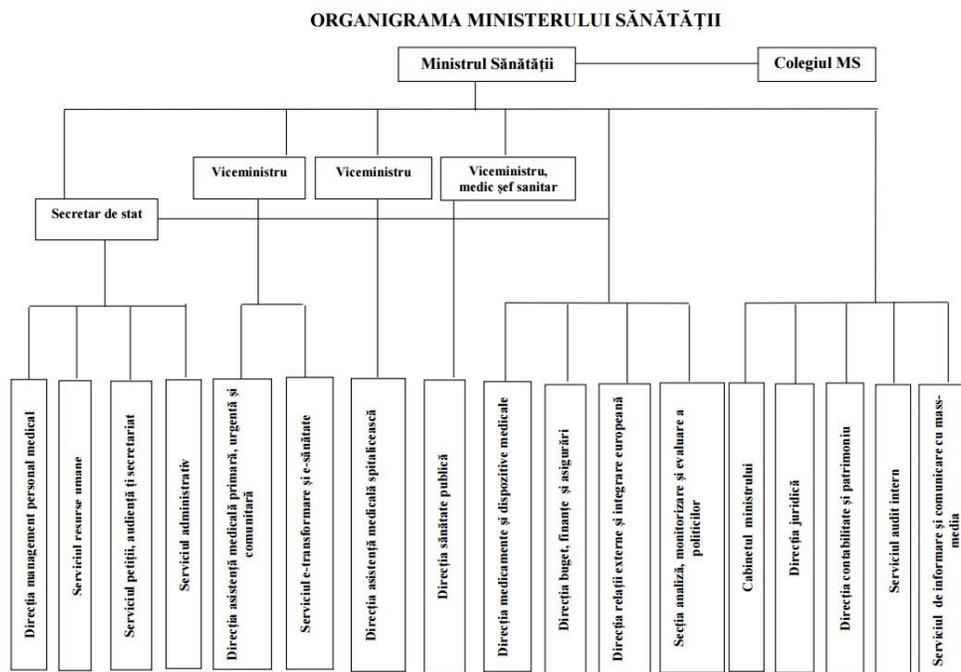


Figure (3): Ministry of Health Organigram

Public medical facilities at primary and secondary levels provide services to the community and belong to local public authorities. In every district, there are also providers of emergency care (ambulance services) belonging to the Ministry of Health.

Medical facilities at the tertiary level provide specialized and highly specialized medical care for the whole population; almost all of these tertiary facilities are located in Chisinau and belong to the Ministry of Health. Public medical facilities are autonomous, self-financing, non-profit making organizations that are directly contracted by the National Health Insurance Company (NHIC) for the provision of medical services under MHI.

Some health services are provided by the private sector, and private health care providers can be contracted by the NHIC. A significant number of parallel health care services are also provided through public medical institutions belonging to other branches of the national Government, which are financed from the state budget through the respective line ministries, but can also contract with the NHIC.

Institutions with regulatory functions, such as licensing, supporting the development of health policies, or conducting public health surveillance, are financed from the state budget through the Ministry of Health, to which they are subordinated. Through these institutions, the Ministry of Health collects and analyses data, and generates relevant information to contribute to the development of evidence-based policies. Regulatory functions are centralized in the Ministry of Health rather than being the responsibility of independent bodies.

The Ministry of Health addresses the major challenges in the health sector and promotes the principle of Health in All Policies through multi- and inter-sectoral collaboration, including the coordination of public health activities within the sector and beyond it. This has meant greater transparency in health policymaking and more patient influence on policy-making through the involvement of nongovernmental organizations (NGOs), representing patients' rights and interests in the development process.

• **Health Financing**

Since 2004, health financing in the Republic of Moldova has been organized as MHI. Total health expenditure in 2014 was 10.3% of GDP. Based on revenue source, 40.3% of total health expenditure was from MHI contributions and 44.9% from OOP payments (World Health Organization, 2012).

The relatively high level of total health expenditure as well as the balance of prepaid and OOP payments have been maintained, despite the ongoing global financial crisis. Contributions from the working population come predominantly through payroll contributions of a fixed percentage of salary (9% in 2016; 4.5% to be paid by the employee and 4.5% to be paid by the employer); the self-employed are expected to purchase their own cover for the year at a fixed price.

The non-working population (15 categories, including pensioners, students, children, registered unemployed, and other population categories, is covered through transfers from the central budget to the NHIC, which is the pooling agency for prepaid health care funding. Voluntary health insurance (VHI) accounted for less than 0.1% of total health expenditure in 2014⁹.

The NHIC is also the sole purchaser of health services, which has enabled a purchaser-provider split, and payments for services are made on the contracts basis, most of which are prospective.

⁹ Voluntary health insurance in Europe: role and regulation, 2016 and the European Observatory on Health Systems and Policies

Access to emergency and primary care is universal, regardless of insurance status and so are services connected to key public health issues, such as HIV infection and AIDS, TB, immunization.

The package of benefits available under MHI covers specialized outpatient and hospital care and a very limited range of pharmaceuticals.

For those without insurance cover, these services are paid in full, as OOP payments. OOP payments account for 45 % of total health expenditures. Sixteen percent of outpatients and 30 % of inpatients reported that they made OOP payments when seeking care at a health facility in 2012, more than two-thirds of whom also reported paying for medicines at a pharmacy.

Among those who paid anything, 36 % of outpatients and 82 % of inpatients reported paying informally, with the proportion increasing over time for inpatient care. Informal payments occur at almost all levels of the system, but they are much more widespread for inpatient care.

The Ministry of Health is committed to reducing informal payments in the system and it is hoped that increasing the salaries of health care workers, as well as, adding performance-related payment mechanisms, together with improvements in transparency through external auditing, will help to achieve this aim.

Combining payroll and budget contributions in a single pool has helped to build equality and solidarity into the system. However, universal coverage has not been achieved; as is always the case with insurance-based systems, there is an explicitly uninsured population (14.4% of the resident population was uninsured in 2015)¹⁰.

Those without insurance are most often self-employed agricultural workers or those in informal employment in urban areas; the uninsured often also have low incomes. From 2010, households registered as being below the poverty line, automatically receive MHI cover.

Over 70 % of patients who sought facility-based care ended up paying for medicines in 2012 (an increase of 9 % since 2009). This suggests that while the policy to extend free coverage for primary care services has reduced the likelihood of making OOP payment at outpatient facilities, access to medicines still requires an ability to pay.

• **Reproductive Health Program**

Reproductive Health is a long-term priority in the Republic of Moldova. The modern concept of specialized RH services was realized by Order No. 89/1994, to set up a national network of RH and Family Planning services.

A national program for family planning and RH was endorsed by the Government Decision No. 527/1999, setting out a number of measures aiming to promote responsible sexual behaviors, avoid unwanted, or high-risk pregnancies and prevent sexually transmitted infections (STIs); resulting in a significant drop in the number of unwanted pregnancies, unsafe abortions, pregnancy-related morbidity and maternal mortality. An increase in the prevalence of modern contraceptive use has also been seen, although it remains significantly lower than in Western European countries.

Since 1993 the United Nations Population Fund (UNFPA) has provided free contraceptives for vulnerable groups in Moldova, and consequently the general abortion rate has decreased consistently to 19 per 1000 in 2012. In 2005, the Republic of Moldova developed a national reproductive health

¹⁰ Improving access to the healthcare services in Moldova, NHIC, 2015

strategy (2005–2015) that was approved and implemented with aim to make further progress in the area of RH.

The quality of abortion services was improved using the methods suggested by WHO, and 35% of obstetricians and gynecologists have received extra training. The standard of provided youth-friendly health services has been raised (services being evaluated in 2015). Many seminars and training workshops have been held addressing gender-based violence, family planning, cervical screening, development/adaptation and implementation of clinical guidelines and protocols on RH.

Moldova has done much work in recent years on reproductive health. RH/FP services are provided by family doctors and specialized out-patient health facilities through the Networks of Reproductive Health Cabinets and Youth-Friendly Health Centers, located at the municipal and districts levels, as well as, few Centers for Women's Health, established with partners' support.

The formally adopted National Reproductive Health Strategy 2005-2015, clearly establish Family Planning as a priority area, from the 11 stipulated areas which were: family planning, making pregnancy safer, sexual and RH of adolescents and youth, prevention and management of reproductive tract infections, abortion and pregnancy termination services, prevention and management of infertility, prevention and management of domestic violence and sexual abuse, prevention of human trafficking, early detection and management of breast and cervical cancer, sexual health of older people and men's sexual and RH.

The National RH Strategy defined many important interventions, including support couples and individuals in meeting their reproductive goals, prevent unintended and high-risk pregnancies, improve sexual and reproductive health of teenagers, and assure access to quality, affordable, convenient, acceptable reproductive health services, as well as comprehensive sexuality information, education and communication.

One key element regarding increasing accessibility to FP services is related to the integration of FP services into PHC. As mentioned in the assessment report of the National RH Strategy, the adoption of this strategic document was not followed by the development and implementation of Annual Programs or Plans of Actions. The objectives of the National RH Strategy did not mention specific targets; therefore monitoring the implementation progress was difficult. Two assessments (mid-term and final) were carried out with aim to evaluate the performances achieved in the context of the Strategy implementation.

A Mid Term Evaluation resulted in a development of a very comprehensive document, but, in the absence of specific, measurable objectives, it was hard to interpret if the implementation of the Strategy progressed as expected. Important efforts were invested in training of the family doctors and nurses from PHC for providing FP services. Nevertheless, based on existing data it was hard to assess how many of them are actually providing FP services, especially those of them working in smaller rural villages.

An important step forward improving service quality assurance was accomplished by MOH Order No.139 of 2010, on health care service quality assurance, but there is need for additional efforts to ensure more integration of RH/FP services within other services provided at PHC facilities level.

The second assessment was done by the end of the Strategy implementation (in 2015) reflecting important findings related to RHCS.

• RHCS legislation and regulations

Several ministerial orders related to RH/FP were issued during the last few years, which reflect political support to such programs. One of the current assessment activities was to collect, review and analyze these orders. A summary of the related RH/FP legal acts and Ministry of Health Orders' are as follows:

Law No. 138 of 15/06/2012 on Reproductive Health. This law constitutes of 23 Articles to establish the legal framework in the field of RH; determines the principles of state policy in the field of reproductive health care, establishes legal framework, formulated rights, duties, powers and responsibility of RH working staff. In addition, this law stipulates all terminologies in the RH area.

MOH Order "On Providing Contraceptives" No 658 of 18/08/2015, amended on 7/10/2015 stipulates:

- PHC facilities have to procure modern contraceptives for vulnerable groups from the PHCF's annual budget, based on the contract they concluded with NHIC. The per capita mechanism of payment being used for financing PHC facilities by the NHIC.
- To ensure free distribution of contraceptives to categories of reproductive age beneficiaries from vulnerable groups, according to the approved Regulation; ensure accounting of contraceptives in accordance with legislation in force and/or in the AIS PHC; and submit reports on contraceptive consumption in the manner and terms set by the MOH and the NHIC, within the AIS PHC. These activities are to be done with the support of the Director of MCI, CRHMG and RHTC, and under supervision of Head of Division for Primary, Emergency and Community Health Care.
- To improve access to contraceptives of the vulnerable populations, PHC clinics have to estimate annually the population's needs for modern contraceptives, with the consultative support of the social workers, YFHCs and RH Cabinets. Based on the estimated needs of the covered vulnerable populations, each PHC shall procure contraceptives as per the contract with NHIC.
- Vulnerable groups, who receive free of charge contraceptives, are defined as: sexually active adolescents; persons with low incomes¹¹, HIV positive persons, persons who abusively consume alcohol and illegally use drugs and other psychotropic substances and are registered at the specialist doctor in narcology, people with mental health problems, registered at the psychiatrist and family doctor, victims of sexual abuse (for emergency contraceptives), and women who had abortion during the last year.
- The plan for the financial amounts intended for the procurement of contraceptives, aims to cover 80% of the needs of persons from socially vulnerable groups in the served community, identified at the end of the previous year (according to the database);
- the ministerial order allow procurement of different modern contraceptive methods (nevertheless, the procurement process includes only very limited methods and in most of the visited clinics during the mission, only one or two types of methods are available and staff reported stock out status for the other types).

¹¹ income lower than the minimum consumer basket for each family member

- Needed commodities are calculated according to international standards which are: oral contraceptives – 13 packs/year per person; barrier contraceptives (male condoms) – 120 pieces/year per person; emergency contraceptives – for emergency cases (based on the previous year's consumption); intrauterine devices – 1 device/in 3-5 years/per woman; injectable contraceptives – 1 injection (e.g. Medroxyprogesteron acetate, 1.0 ml – 150.0mg) every 3 months/per woman.
- Rules to dispense contraceptive methods to beneficiaries from socially vulnerable groups are: 2 packs of oral contraceptives or 30 condoms during the first visit; during his/her next visit (in one month): 6 packs of oral contraceptives or 60 condoms; where persons had previously used this method, they may receive 6 packs of oral contraceptives during their first visit.
- Organize visits of gynecologists from the Youth Friendly Health Center or Reproductive Health Cabinets to the local level for those persons who cannot travel from rural area to district centers.
- Record keeping about stocks and accounting of contraceptives is the responsibility of the PHC' nurse/medical assistant
- Keep sufficient stocks of contraceptives to ensure continuity in FP services, contraceptives should be stored in doctor' office.
- PHCF's accountant keeps records on the funds used for the procurement of the contraceptives from the total annual budget of the PHC facility (the PHC facilities are receiving funds from NHIC, based on the contracts signed; a per capita payment model being applied for PHC providers).

MoH and NHIC Order "Approving the Action Plan on providing Contraceptives to Vulnerable Groups at the Level of Primary Health Care " No 228/139-A of 30/03/2016.

The order was issued with aim to approve the Action Plan on Providing Contraceptives to Vulnerable Groups at the Level of Primary Health Care for 2016-2017, according to which the MOH and NHIC in collaboration with other institutions foresee to organize effective measures to implement the Action Plan on providing contraceptives to vulnerable groups at the level of primary health care.

Government Decision no. 1128 of 10/10/2016, on the Center for Centralized Public Procurements in Health.

The respective Government Decision was approved with aim to: establish the Center for Centralized Public Procurements in Health, which is a non-profit public institution with financial autonomy responsible for procurement of all the required medicines and medical devices; and to approve regulations on the purchase of medicines and other health products and medical devices for the needs of the health system.

Main Findings

- MoH Order no 695 din 13/10/2010, stipulates that family doctors among other duties have the obligation to provide family planning services. Although no provisions are included in the respective order stipulating that family doctors aren't allowed to insert IUD, family doctor don't have the courage to do it.

At the same time the MoH Order No 658 of 18.08. 2015 On Providing Contraceptives stipulates: *"...When choosing intrauterine device, the beneficiary who can come to the district center shall have a prior appointment with the gynecologist of a Youth Friendly Health Centre or Reproductive Health Office to insert the device. In case of persons who cannot travel from rural area to district centers, the head of the primary health care facility shall organize visits of the gynecologists from the Youth Friendly Health Center or Reproductive Health Office, and ensure the consultation of women from socially vulnerable groups and the insertion of intrauterine devices. ..."*

The latest Ministerial order is conveying the message that the IUD has to be inserted by Gynecologist, not Family Doctor.

- Family doctors are seldom involved and, at most provide contraception counseling, while distributing contraceptive pills or condoms in certain locations. Usually, rural women who want to use modern contraception means are referred to a gynecologist from RH Cabinet located at the level of districts and municipalities and who can prescribe hormonal pills or arrange IUD insertion; this might explain the low coverage of women with modern contraception (the travel costs being not affordable for all women).
- Reproductive Health, including Family Planning services, are provided for free for vulnerable groups; at the same time non-vulnerable groups have to buy modern methods of contraception, as well as other medications from private sector.
- MoH Order 975 of 29. 09. 2014 On the List of Contraceptives Recommended to be procured at the Level of Primary Health Care includes a wide range of modern contraceptives, while only three methods are available at the PHC.
- The rural population accounts for 57.5% of the total population in 32 districts. Over 1 400 family doctors have been trained in FP service delivery; nevertheless there are no data yet available on the quality of services they provide.
- In the RH Strategy implemented during 2005-2015, one of the stipulated interventions was to secure access of the population to all contraception means, including modern hormonal contraception and voluntary surgical sterilization; ensuring the accomplishment of this objective was not considered during NRHS implementation. People's access to hormonal contraceptives (such as Injectables) dropped; the Injectables, as well as Implants are not registered and no actions have been taken so far to tackle this issue. Voluntary surgical sterilization in females is usually performed at the patient's request at caesarean section, rather than as a standalone procedure; but not all laparoscopic surgery performed in the private sector is reported. Access to permanent method of FP such as voluntary female sterilization is limited to post-partum period, which violates reproductive rights of women who would like to stop reproductive function. There are no data on surgical sterilization in males.
- The objective of the RH Strategy was to achieve coverage of modern birth control methods of over 50%; The MICS report of 2012 quoted 42% coverage, ranging from 47% in the richest quintile to 34% in the poorest. Modern methods considered included: female sterilization, IUD, injectable

contraceptive pills, male condom, diaphragm, spermicide foam/gel and the lactation amenorrhea method. While for the objective of coverage with hormonal contraceptives of above 10%, only 5% was achieved; for the objective on coverage with voluntary surgical sterilization of above 5%, no data were available to assess the changes in the situation.

- MOH with support from UNFPA integrated a CHANEL-based module into the newly established electronic system of HMIS which is about to be launched at the PHC level. It is important to acknowledge the respective progress, as well as the existing still limitations that create barriers for properly functioning LMIS. For the objective of setting up an information system for FP, no information system is in place yet, currently the health sector doesn't have efficient capacity to collect data from different facilities and monitor activities, interventions and outcomes. Collection of data on RH commodities at service delivery level is fragmented and poorly coordinated for being used by decision makers, including for forecast. Data are collected by different facilities, subject to their specific responsibilities. For instance, the NHIC is collecting data on service delivery in line with signed contract provisions and in accordance with approved national clinical protocols provisions. CRHMG previously collected data on the distribution of contraceptives from UNFPA donations. NGOs that distribute modern contraceptives to key populations, offered in the framework of donor-funded projects are collecting data requested by donors (Global Fund projects).
- Woman Health Center "Dalila" is well providing required RH/FP services. All registered at the national level contraceptive methods are available at the level of institution, including Emergency Pills (this was the only place who make this method available).
- YFHCs Network's coordination mechanism with Ministry of Health, Ministry of Education, Ministry of Youth and Sports is working well, and support for strengthening capacities of YFHCs is currently provided by SDC, UNICEF, UNFPA and WHO.
- Family Doctors don't have courage to provide IUD insertion. The mechanism to refer the client and set up an appointment with the gynecologist of a Youth Friendly Health Centre or Reproductive Health Office to insert the IUD (if it is the chosen contraceptive), can affect the RH/FP program by losing some clients.
- Not enough training for PHC staffs' on logistics management, which leads to poor forecasting, procurement and storage monitoring.
- Procurement principle stipulated by the regulation in force, is to procure 80% of the needs, according to the previous year consumption – that means that the quantities doesn't incorporate the targets to meet the unmet needs, or to increase coverage of target groups and no chance as well to introduce new modern contraceptive methods.
- Republic of Moldova Ministry of Health issued many ministerial orders to organize/integrate the RH/FP services within PHC and to provide required commodities and ensure quality of RH/FP services. These orders reflect the political support to RH/FP issues. At the same time, cost implications of released ministerial orders were not considered, these being released without implementation plan. The provisions of some of these orders are not clear understood yet by the PHC managers', such as "Total Market Approach" (during the assessment mission interviewed managers were not able to explain it). To ensure good implementation of these orders, there is a need to build further PHCF staff capacity.

Strengths

- A new policy to include RH/FP program performance indicators onto the assessment of PHCFs manager's performance is being considered currently and may be endorsed in the near future.
- Ministerial orders well-explain the dispense rules for contraceptives which can be considered as STGs for FP services provided by FDs.
- Many ministerial orders are currently in force with aim to organize/integrate the RH/FP services within PHC and to provide required commodities, and ensure quality of RH/FP services at the PHC facility level.
- Vulnerable groups, who receive free of charge modern contraceptives, are well defined in the Republic of Moldova and each PHC clinic has a list of vulnerable populations in the catchment area.

Weaknesses

- Lack of explicit RHCS strategy, although, there have been some successes in efforts to strengthen commodity supply; there are continued limitations in national capacity to develop and implement policy/strategy for procurement and supply management and forecasting, and for demand creation.
- Lack of a fully developed set of RHCS indicators that relate to policy, financing, supply, logistics and distribution, and utilization.
- No clear RHCS indicators in the endorsed Action plan on Providing Contraceptives to Vulnerable Groups at the Level of Primary Health Care (it was disseminated as an annex to Order No.228/139-A of 30.03 2016)
- RH commodity security is not consider yet a priority on the agenda of PHC Managers.
- No Contraceptive Security Working Group exists to: plan, coordinates and implements RHCS activities.
- Lack of complete required information about vulnerable groups in need for RH/FP services; the Action Plan on providing contraceptives to vulnerable groups at the level of Primary Health Care, was approved, but to implement its activities there is a need for accurate information which is not available.
- PHCF' managers are not capable to implement required assignment to collect information and develop required reports about needs for modern contraception and the distribution and utilization of the modern contraceptives by the vulnerable groups. Quantification and forecasting capacities either not exist or are very weak.
- Not all family doctors working at the PHC facility level have been trained with aim to develop their practical skills on IUD insertion. And some of the trained doctors on IUD insertion don't have the courage to insert IUD, referring women to the nearest gynecologists (working in the YFHC or Reproductive Health Cabinet at the district or municipal level).
- There is need to disseminate contraceptives dispense rules to beneficiary, to ensure that clients know and understand their rights.
- No accurate data on vulnerable groups' needs for modern contraception, as well as the contraceptives distribution and consumption.

- Lack of M&E mechanisms to monitor PHCF performance in the area of RHCS, and commodity stocks at the level of PHCFs.
- Need to establish a mechanism to gather feedback and comments of PHCFs, including YHFCs managers' on applying ministerial orders on FP.
- Monitoring contraceptives dispensed to vulnerable groups is difficult as there is no database for them yet. Monitoring stock on hand situation needs tools and records which do not exist so far.
- Only 80% of the contraceptives needed for vulnerable groups in the served community are procured.

Recommendations

A. Context, Commitment and Coordination

- Expand the spectrum of contraceptive methods available at the national level to ensure that clients have the possibility to choose the most convenient method
- Strengthen the information system for the health sector including RH/FP component. To include in the e-HMIS data on trained physicians on RH/FP services to ensure national capacity building in this area, based on the analyzed needs. A strong LMIS is needed as well to avoid stock-out of modern contraceptives at the PHC level.
- More efforts need to be done to ensure better access to RH (services and commodities), particularly for certain groups (rural residents, youth, socially vulnerable individuals, men and people with disabilities). This can include well-designed, tailored and intensive IEC campaigns to provide correct, full and comprehensive knowledge concerning RH/FP methods and services. Out-reach programs are needed in order to target rural residence and youth. Designed advocacy campaigns targeting men is needed to gain their involvement and support for RH/FP program and using modern contraceptive methods.
- The further implementation of the action plan approved by the Ministerial order No. 228/139 of 2016 is important (that stipulate interventions to be realized with aim to ensure RHCS, including the amendment of the national legislation to allow procurement of contraceptives through UNFPA Procurement Services).
- Ensure continuity of contraceptives' distribution to the vulnerable population in the served territory, avoiding running out of stocks, while complying with the regulatory acts in force;
- Ensure sound management and accounting of contraceptives procured at the level of primary health care; submit, upon request, including via the AIS PHC, the information on distribution of contraceptives and on the stocks of contraceptives available at the PHC facilities level;
- Improve estimation of the required commodities, based on the vulnerable groups' actual needs, by means of the good collaboration between the managers of PHC, the specialist from YFHCs and RH Cabinets, as well as social workers, in order to avoid stock-out of contraceptives.

B. Capital

NHIC has a relatively limited budget, including 5 components: 96% of the budget represents the Main Fund for Reimbursement of the Health Services; 1% of the budget constitutes the Fund for Prophylactic Measures, financial resources being allocated according to determined jointly with the Ministry of Health priorities; 1% of the budget represents the Fund for the Development and Modernization of public medical facilities; 1% represents the Administrative Fund, and 1% represents the Reserve Fund. NHIC reported that 32 % of its budget is for primary health care activities¹². The Action Plan on Providing Contraceptives to Vulnerable Groups at the Level of Primary Health Care was developed in collaboration and coordination between MOH and NHIC.

RH/FP is not considered yet a priority on the agenda of PHC Managers. The allocated budget for RH/FP' services, commodities and contraceptives is not adequate to cope with demand. PHCF' managers are responsible of PHCF budget, taking decisions on the share of institutional budget to be allocated for RH/FP contraceptives procurement.

“Neovita” Youth Friendly Health Centers’ is allocating around 10% of its budget for medications, including contraceptives. The available methods of contraception at the level of institution are: pills, IUD, and Condoms. Injectable and Implants are not registered at the national level, so they are not purchased and offered to the beneficiaries.

“Dalila” Woman’s Health Center is part of the PHCF/Territorial Medical Association Botanica and the budget of the respective institution, as well, doesn’t include a separate line item for commodity procurement. Around 9% of the budget is allocated for commodities procurement and only around 5%-10% of their commodity budget is for FP contraceptives procurement (depending on the manager awareness of FP importance). The available methods of contraception at the level of institutions are: pills, IUD, and Condoms.

Main Findings

- The FP services at the PHCFs level don’t have a priority for budget allocation, comparing with Heart Diseases, TB, Cancer and other health problems.
- There is not yet implemented a National Sexual and Reproductive Health and Rights Program, which can be considered as another resource for funding of RHCS activities.
- The cost implication of the Action Plan on Providing Contraceptives to Vulnerable Groups at the Level of Primary Health Care, as well as other RH/FP Ministerial Orders is not estimated to ensure their feasibility within the available budget.
- Managers of PHCFs are responsible to allocate required funds for each activity and due to the their low awareness on the importance of the RHCS, as well as due to a relatively limited budget available, the modern contraceptives for the vulnerable groups are not procured in accordance with the estimated needs.

¹² Improving access to the health care services in Moldova, Presented by Diana GROSU-AXENTI, Deputy General Director National Health Insurance Company Republic of Moldova, 2015. http://new.med.kg/densooluk/images/MyFiles/2016/30092016/29092016/eng/3_Bishkek%20PresentationDP_eng.pdf

Strengths

- The NHIC has the flexibility to contract NGOs and private entities that are providing good quality health services.
- Decision on budget allocation at the level of PHC, including for contraceptives procurement is fully decentralized.
- The draft NPSRHR will be presented to the Government for consideration in the near future.

Weaknesses

- There is no a separate Fund for FP commodities in NHIC budgetary system
- There is no currently a National Sexual and Reproductive Health and Rights Program in force
- Low PHCFs managers' awareness on RHCS importance.
- Inadequate funds for RH/FP commodities procurement are allocated from PHCFs budget, and YFHCs budget.
- Weak capacity of quantification and no accurate estimates on needed budget for procurement of contraceptives at the level of PHCFs and YFHCs.

Recommendations

- Strengthen national capacity on quantification and forecasting, to better estimate required commodities to be procured for PHC facilities
- Increase PHCFs, including YFHCs budgets, as well as to increase efficiency of the available resources utilization.
- Increase funds allocation for contraceptives procurement at the level of PHCFs and YFHCs.
- Raise PHCFs and YFHCs managers' awareness on the importance of RH/FP services and commodities.
- The quantification and costing capacity of the PHC facilities is important to be further strengthened.

C. Commodities

In Moldova, legal provisions require marketing authorization (registration) for pharmaceutical products on the market. The process to register new commodity depends on the source of the medication: if it is from economic developed countries such as United States, Canada, Japan, Australia, etc. – the procedure lasts 90 days; while if the source is one of the developing or transitional countries, such as: China, India, Turkey,...etc. – the procedure lasts around 210 days. Once a new commodity is registered, the economic agent can make promotions and participate in the bidding.

According to the study done in 2014¹³, as in-depth analysis of pharmaceutical regulation, there were no consistent procedure and criteria for development of the EDL, leading to using WHO standard

¹³ A.Ferrario, N.Sautenkova, Z. Bezverhni, R.Seicas, J.Habicht, P.Kanavos, V. Safta “An In-depth Analysis of Pharmaceutical regulation in the Republic of Moldova”, J Pharm Policy Pract. 2014; 7: 4.

EDL, without adjusting it to actual needs of the country. Further, there are no efforts in place to promote among physicians, the medicines prescribing based on EDL. The EDL was updated to better reflect the epidemiological profile of the country and there is a need to assess the results of such actions, to find out if it helped to increase the level of accountability and transparency in the selection process with focus on RH/FP commodities.

Few contraceptives methods are available at the PHCFs and YHFCs level. Most of the PHCFs only have pills (2 or 3 brands) and condoms; the IUDs are not available in all visited PHC facilities. Injections were available in one place only and we have been told that it is what remained from UNFPA donation of 2012 (its expiration date being June 2018). The procured contraceptives in 2015 and 2016 didn't include Injectables (since Injectables are not registered yet at the national level).

The PHCF managers are taking decisions on funds allocated for the modern contraceptives procurement, which are not always based on the real estimated needs of the vulnerable groups of populations. Although, ministerial orders allow different type of commodities to be procured, only three types of modern contraceptives are procured, being available at PHC level. As shown in table (4), 3 types of Injectable are included in the EDL, in addition to the Implants, as important long term methods.

Table (4): Contraceptive Methods According to Ministerial Order No. 975 of 29/9/2014	
18.3 Contraceptivele	
18.3.1 Contraceptivele orale	
<input type="checkbox"/> Etinilestradiol + <input type="checkbox"/> levonorgestrel	Comprimate 30 mcg +150 mcg
<input type="checkbox"/> Etililestradiol + <input type="checkbox"/> noretisteron	Comprimate 35mcg + 1 mg.
Levonorgestrel	Comprimate: 30 mcg, 750 mcg (două în cutie); 1,5mg.
18.3.2 Contraceptive hormonale injectabile	
Estradiol cypionat + Medroxiprogesteron acetat*	Soluție injectabilă: 5 mg+ 25 mg.
Medroxiprogesteron acetat*	Injectie depou: 150mg/ml în fiolă de 1ml
Noretisteron enantat	Soluție uleioasă: 200mg/ml în ampulă de 1ml
18.3.3 Dispozitivele intrauterine	
Dispozitive cu conținut de cupru	
18.3.4 Metode de bariera	
Prezervative	
Diafragme	
18.3.5 Contraceptive implantabile	
Levonorgestrel-eliberare implant	Sistem cu cedare intrauterină 52 mg (20mcg/24h); Două tije levonorgestrel implant, fiecare tija conținând* 75 mg de levonorgestrel (150mg în total)

More than one type of pills are available at PHCF level and their prices range from 47 to 226 Lei.

Main Findings

- Two mechanisms exist to register new medications, the duration depending on source countries: developed countries (90 days) and developing countries (210 days).
- EDL includes three types of pills, three types of Injectables, IUD, Vaginal barriers and Implants.

Strengths

- Most of the known contraceptives are in the EDL including Injectables.
- The EDL includes different options of each contraceptive methods
- Process to register and required documents are not complicated.

Weaknesses

- No consistent procedure and criteria for development of the EDL, leading to use the WHO standard EDL, without adjusting it to actual needs of the country.
- Although most contraceptive commodities were included in the EDL according to table (4), only three commodities are available at the PHC facilities level, which are: pills, condoms and sometimes IUDs. Information about access and use of these commodities at PHC facility level is also lacking.
- Lack of choices of contraceptive methods: the Injectable are not available at PHCFs, although it is a preferred method for many clients, and the client doesn't need a gynecologist to have it.
- Lack of advocacy campaign to convince PHCFs managers about the importance of RH/FP program and the need to make required commodities available.
- Injectables and Implants are not registered yet at the national level.
- Vaginal barriers are not available at any PHCF or YFHCs.
- RH/FP commodities don't have priority when there is a need to procure medications for heart diseases, TB or cancer.

Recommendations

- Increase the range of the modern contraceptive methods available on the market, by registering Implants and Injectables and procure them.
- Design and implement advocacy campaigns, targeting PHCFs managers, to consider RH/FP commodities as a priority.
- Improve updating of EDL process to ensure new contraceptive commodities integration at any time.

D. Client Use and Demand

Data from MICS (2012) showed that the percentage of all women age 15-49 currently married or in union, who heard about any contraceptive method is about 99.8%, while using is only 59.5 %. For modern methods of contraception, percentage of knowledge is 99.8% and the use is only 41.7%.

This contradiction is even more when analyzing each method: knowledge for pill is 95.9%, while using is only 5.3%; in case of IUD - knowledge is 95.6% and use is 19.8% respectively. The MICS, 2012 showed that women know about modern methods of contraception while PHCFs and YFHCs don't have more than 3 methods of contraception available to offer as choice to beneficiaries. These

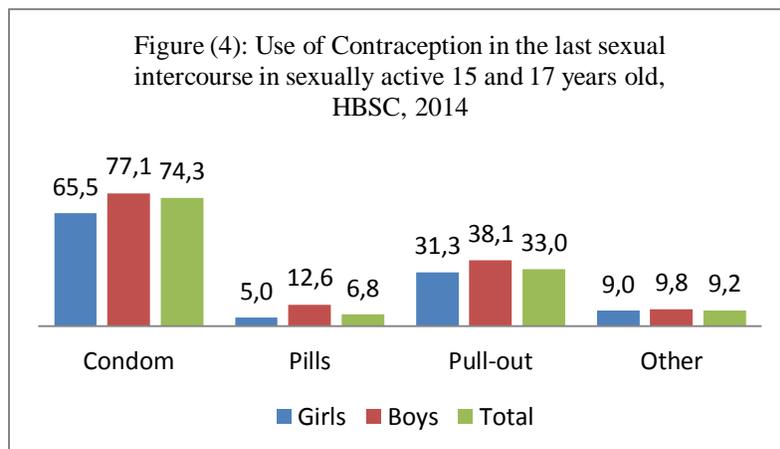
limited choices of modern methods of contraception are affecting use, resulting in unmet need and make traditional methods as preferred option.

Primary, Emergency and Community Health Care Department of the Ministry of Health representative mentioned that Family Doctors are prescribing Condoms, and Pills; for IUDs insertion, they have to refer the patient to the Gynecologists.

Young people aged 16-30 constitute 25% of the total population in the Republic of Moldova and adolescents represent over 11 % of the country population, according to the National Bureau of Statistics data. Improving adolescent health is one of the main objectives of the MOH. The “Neovita” Youth Friendly Health Center is providing good quality of SRH services to youth. The contraceptives methods available are: condoms and pills, and the gynecologist is providing IUD insertion as well.

To understand youth RH/FP needs there were need to collect information. “Neovita” that is a National Resource Center for Youth Friendly Health Services, with WHO support carried out a research in 2014 exploring the behavioral and social determinants of Adolescent Health in the Republic of Moldova. The summary report of the Health Behavior in School-Aged Children study¹⁴ (HBSC) showed that 18.3% of 15-years old and 38.8% of 17-years old have had a sexual intercourse (the percent of boys is higher than girls in this regard). It is important to be mentioned that - 6.2% of respondents who had sexual contact, remarked that it was at the age 11 or earlier; 8.1% at the age of 12-13; 12.6% at the age 14; 28% at the age of 15 and 44.9% at the age of 16 years old. Two third of sexually active adolescents mentioned that they used condoms; one third of adolescents reported using a traditional method which is coitus interrupts (pull-out) and 5% of girls and 12.6 % of boys mentioned that pills were used as contraceptive method (see Figure (4)).

More concerns on teenage pregnancy are determined by the fact that the research showed that one third of adolescents aged 15, and more than 50% of those aged 17 - haven't used contraceptives on their last intercourse.



YFHC “Neovita” representative mentioned that there is a need to provide more contraceptive choices, especially taking into account that they have capable staff with required training for providing and counseling on new contraceptive methods to their clients.

¹⁴ Sample from 386 clusters; for 6642 respondents out of them 3258 Boys, and 3384 Girls, data was collected from 118 educational facilities; 90 Secondary general/high schools and 38 colleges/vocational schools.

Interviewed specialists during the field visits, as well as from “Neovita” YFHC, reported that sexual education in secondary schools is facing challenges. Life skills-based education was introduced in schools in 2005 in Moldova as a mandatory course (teaching staff being trained and manuals developed to support implementation), but that initiative was met with opposition and after two months, the discipline was withdrawn from the school curriculum. Thereafter, sexual and reproductive health issues were reintroduced into another mandatory discipline named “Civil Education”, and into optional courses (named “Health Education” in lower secondary facilities and “Family Life Education” in upper secondary).

Main findings

- There is a contradiction between knowledge and use of contraceptive methods
- Limited choices for modern methods of contraception at the PHCFs level; supplies are not consistently available, which make people believe visiting the FP service at the PHC level as a waste of their time. Where only a few methods are available, this limitation clearly compromises a full, free, and informed choice.
- IUD can be inserted only by Gynecologist, which can explain the low level of IUD usage.
- Contraceptives are dispensed for free for vulnerable groups at the level of PHCFs while others groups of population have to buy it from private pharmacies.
- Injectable and Implants are not registered at the national level, so they are not purchased and offered at the level of PHCFs, including YFHCs.
- The courses of “Life Skills-Based Education” were turned into a mandatory discipline only for the first-year students in vocational schools in 2012. Due to insufficient health education effort in the school environment many adolescents and youth in Moldova adopt risky behaviors and are facing a wide spectrum of health problems such as, unintended pregnancies, STI, including HIV/AIDS.

Strengths

- Modern contraceptives are dispensed for free for vulnerable groups at the level of PHCFs.
- Youth Friendly Health Centers Network was established to respond to health need of youth and to encourage them to use available RH/FP services and contraceptive methods.

Weaknesses

- Limited modern contraceptives methods available for youth at the level of YFHCs, as well supplies are not consistently available at PHCs.
- Not enough information collected from the community about the methods of contraception used, reasons for unmet needs, reasons for discontinuation, reasons to prefer specific method, reasons for high traditional method use, etc.
- Not enough IEC effort to raise target group awareness about modern method of contraception.
- Unavailability of Injectables (although it is one of the preferred contraceptive method), as well as of the Implants.

- Weak capacity of PHCFs on gathering information and generating required reports for decision making on RHCS. As an example, records about contraceptive consumption at “Dalila” Woman Health Center are kept as Microsoft-Word documents, which makes reports generating impossible.
- Need to update the normative framework that doesn’t encourage Family Doctors to insert IUD, ensuring at the same time the development of their practical skills, including by means of on-job training under gynecologists supervision
- Insufficient comprehensive sexuality education effort and lack of monitoring and evaluation system in place in the secondary schools, with aim to assess coverage, effectiveness and quality of the taught disciplines (“Health Education” in lower secondary facilities and “Family Life Education” in upper secondary).

Recommendations

- More investment in family planning programs have to include developing, revising, or implementing policies to ensure contraceptive security, including consistent access to a wide range of methods within public, private, and nongovernmental sectors.
- Awareness on teenage pregnancy is needed to be increased. Need to design comprehensive messages to raise target population awareness about FP modern contraceptives.
- Strengthen information environment and build national capacity on RHCS data collecting, producing and use in decision making process.
- Improve PHC and YFHC managers’ capacity in the area of logistics managements and logistics management information area.
- Design/implement comprehensive researches and studies for better understanding discontinuation, unmet need reasons.
- Provide more contraceptive choices at the level of PHC facilities, including YFHCs and RH Cabinets (taking into account that they have capable staff with required training for providing and counseling on new contraceptive methods to their clients).
- Amending the normative framework in force and conduct required on-job training to encourage family doctors to insert IUDs.

E. Capacity

In low and middle income countries, there is often a gap between that segment of the supply chain that entails the production and transport of the commodities to the port of entry and the segment, which further distributes the commodities from the port of entry to the end-user.

The data on distribution and consumption of the commodities is often untimely, unreliable and incomplete, leading in turn to poorer forecasting and quantification which in turn affects commodity production and attendant higher costs at the beginning of the chain. This leads to the sub-optimal decisions being made and ultimately to an increased risk of stock-outs.

There is a need to focus more closely on forecasting and optimizing in country distribution processes of RH commodities to ensure that commodities reach those who need them, when they need them.

This entails a stronger focus on the last mile of distribution, and attention to gathering and ensuring quality data on distribution and consumption, which in turn can inform the start of the supply chain through better forecasting and appropriate production to meet needs.

Yearly, in June, each PHC facility quantifies the estimated needs along with estimated costs for contraceptive procurement for the vulnerable groups; nevertheless, this cost estimation is misleading quantifications, as the considered price is for pharmacies which include pharmacy' marginal profit and make the price of the contraceptives higher than what can be procured centralized.

A positive step toward ensuring obtaining required medical devices and medications, is the fact that a new entity was established - the Center for Centralized Public Procurements in Health - with aim to realize centralized procurement and ensure accuracy of quantification, conduct bidding and develop contracts with suppliers.

Information is an issue with reference to RH/FP services in Moldova. During the mission there were no reports produced on RHCS/FP at any level. When the FD is asked to estimate his requirements on contraceptives, he with assistance provided by the nurse/medical assistant, has to review their list of people from vulnerable groups to determine their requirements. When prioritizing the needs with other requirements, FP contraceptives are on the bottom of the list, and from the PHCF manager' view it has no priority to allocate funds for it.

Suggested forms to be used and sample of generated reports for LMI are proposed as the annex of this report. (see Appendix no.4).

Main Findings

- A new entity was established - the Center for Centralized Public Procurements in Health - with aim to realize centralized procurement and ensure accuracy of quantification, conduct bidding and develop contracts with suppliers.
- The main Pharmaceutical Storage "Sanfarm-Prim" S.A. is well established, enough space is available, being well organized and managed. The institution is keeping records and is capable to generate reports. In addition, they have the capacity and staff to carry out responsibility of store, and distribute procured RH/FP commodities, if procuring through the UNFPA Procurement Services:
 - "SanFarm" storage provide 55 feet available space for medication, the storage being well organized, with well quality control process, including required tests to ensure quality of commodities.
 - the institution has 26 branches (pharmacies) all over the country, providing a good opportunity for well distribution and storing of RH/FP commodities.
 - the software used at "Sanfarm-Prim" is powerful, the system being easy to use and provides alarms when there are out-of stock, or over stock, or expiration' commodities.
 - there are no MOH instructions concerning keeping strategic stock (nevertheless 2-3 months is the principle for strategic stock in case of all medications at "Sanfarm-Prim"); Currently there are not enough family planning contraceptives at the SanFarm" storage which lead to absent of the strategic stocks of FP commodities.
 - lead time¹⁵ is 2 months, expiration dates has to be from 2-5 years.
 - a physical inventory control is carried out once yearly.

¹⁵ The lead time is defined here as the time it takes a supplier to deliver the goods once the order is placed,

- Almost all modern contraceptives are included in the EDL approved by means of ministerial order Nr. 144. of 28.02.2011 On Amendments to the MoH Order nr. 162 of 23 April 2007 on approval of the Regulation and List of Essential Medicines.
- MOH delegated many responsibilities to PHCF managers' such as forecasting the commodities needs for vulnerable groups, allocation of required funds and supervision and control of the supply chain, as well as making services and commodities available.
- Estimation of required commodities is carried out by Family Doctors, in collaboration with specialists from YFHCs and RH Cabinets. Cost estimation of required procurement is misleading quantifications, as the considered price is for pharmacies, which include pharmacy 'marginal profit and make the price of the contraceptives higher than what can be procured centralized.
- Prioritization of required commodities doesn't give RH/FP commodities any priority at the PHC level.
- Logistics Management Information doesn't exist at any level in health sector on regular base. The required information for forecasting is not available.
- No stock card was observed at any visited PHC centers. No mechanism exists for reporting, as well as no templates for reports (some forms exist in many places but not filled on regular base).

Strengths

- Almost all contraceptives were included in the EDL.
- Establishment of the Center for Centralized Public Procurements in Health.
- Decentralization of forecasting required commodities and allocation of the budget.
- Accepted lead time – 2 months- for RH/FP commodities.
- "SanFarm" storage is a strong entity to store RH/FP commodities. Keeping (2-3 months) stocks' is one of the principles for all medications at "Sanfarm-Prim"

Weaknesses

- Weak awareness of the decision makers on the logistics information importance and absence of a mechanism to ensure collection on regular base of the required LMI. The data quality on distribution and consumption of the commodities is unreliable and incomplete.
- There are no unified templates as input form for logistics data at PHCFs and YHFCs.
- No instructions are available, neither at "Sanfarm-Prim", nor PHCFs about keeping stocks, stock cards, inventory conditions, dispense medications rules (FIFO, FEFO), pull or push mechanism, and strategic stock.

- Insufficient capacity of PHCF managers in the area of Logistics Management, Supply Chain Management¹⁶, Logistics Management Information Systems, Forecasting, Quantification, Distribution, Policy Analysis and Formulation, Advocacy and Report Writing and Interpretation.
- Need to raise PHC managers' awareness about RHCS importance, taking into account that the decision on budget allocation is fully decentralized. PHCFs' managers are responsible to allocate required funds for each activity that resulting in limited budget allocation for contraceptives procurement and RHCS activities.
- Need to realize advocacy activities to raise the awareness of the representatives of the newly established Center for Centralized Public Procurement in Health on RHCS importance.
- Need to strengthen the capacity of the Medicines and Medical Device Department of the Ministry of Health and other relevant subordinated to the MoH institutions on logistics management and logistics management information.
- Need to develop a standard clinical practice protocol on family planning for family doctors.

Recommendations

- Review existing policies, instructions and operation orders to ensure incorporation of RHCS issues.
- Strengthen the capacity of the national staff in the area of logistics management and logistics data.
- Develop required policies to ensure monitoring and control of storages, avoiding stock out status.
- Design/implement advocacy campaigns to ensure that RHCS is a priority on PHCs and YFHCs managers' agenda.
- Considering the possibility of procuring modern contraceptives through UNFPA Procurement System, using "SanFarm" as central storage and distributor.

Road-Map to achieve RHCS

Ministry of Health is focusing on providing quality SRH services for Moldovan citizen, its objectives being: support the couples and individuals in accomplishing their reproduction goals; prevent unintended or high-risk pregnancies; provide access to legal and safe abortion; decrease the maternal and perinatal morbidity and mortality; prevent sexually transmitted infections and HIV/AIDS; improve the sexual and reproductive health of teenagers and youth; encourage the active participation of men in family planning; prevent and manage efficiently the infertility; provide protection from violence and sexual abusive practices; provide quality, accessible, acceptable and convenient medical reproductive health services to everyone; improve the access to quality comprehensive sexuality information, education and communication.

Making required modern contraceptives available and accessible is an important component to achieve the respective objectives.

¹⁶ Supply chain management is not the same as logistics, which concern the movement of goods from one place to another. Supply chain management is complex management of the flow of information, finance and goods from end-to-end to ensure the right product, at the right place and at the right time.

The concept of CS or RHCS is a critical component of the national sexual and reproductive health and rights programs, including family planning. It ensures a reliable supply of contraceptives, so that every person is able to choose, obtain and use quality contraceptives when and if they need them. This indicator demonstrates whether national policy acknowledges and supports CS/RHCS and is willing to implement a strategy to attain their CS goals. Republic of Moldova needs to do efforts to meet RHCS objectives. To this end, in collaboration with UNFPA this assessment was developed and a road-map to achieve RH commodity security was drawn to identify required actions in short-term (1-2 years) and mid-term (2-5).

Phase (1): Short-Term

1. The National Programme on Sexual and Reproductive Health and Rights which will be approved in the near future, stipulates the establishment of a Steering Committee on SRHR. To ensure achievement of RHCS, we can consider the Terms of Reference of the Steering Committee on SRHR to be established (including all relevant key stakeholders), to include RHCS activities. This Committee should be the main platform for coordinating activities relating to SRHR, including RHCS (Appendix-2 is the suggested TOR for the potential committee.)
2. Integration of RHCS provisions in the newly developed National Programme on Sexual and Reproductive Health and Rights, which will be presented to the Government for consideration and approval in the near future. A unified Action Plan for all activities, including commodity procurement is important to be developed as an integral part of it; and national Government commitment to adequately allocate budget for the implementation of the respective national programme is important too.
3. Within the newly established Center for Centralized Public Procurements in Health, to assign two focal point persons on RHCS, with information technology and pharmaceutical background (suggested TOR for the respective focal points on RHCS being reflected in Annex no.3)
4. Expand the Terms of Reference for the existing RH Cabinets at the district level, to incorporate required RHCS activities such as monitoring pipeline, ensure gathering required LMIS data etc.
5. Develop and implement a regular national forecasting process, under the supervision of the Ministry of Health; the Center for Centralized Public Procurements in Health can take the lead in this respect, with the participatory approach of other related stakeholders such as: PHCFs, YHFCs, and RH Cabinets. The team will be assigned to reach consensus about forecasting assumption, gathering required data from different resources at all levels, regularly update the forecasting and advocate to get required funds for the needs, develop, set-up assumption, collect required data for forecasting commodity needs.
6. Review, analyze and estimate cost of implementation of Ministerial Orders related to RH/FP. Develop a cost effective analysis for the benefits of RH/FP program and use it in the context of the advocacy efforts.
7. Design/implement training within postgraduate family medicine residential programme and in addition, provide on-job training for family doctors on IUD insertion under gynecologists' supervision; at the same time design/implement advocacy campaigns to encourage FDs to practice IUD insertion.

8. Explore and consider the possibility to procure the reproductive health quality life-saving medicines, including contraceptives through UNFPA Procurement System.
9. Develop and implement advocacy campaigns on RHCS issues and importance in order to strengthen commitment and ownership and to increase the budget allocated to RHCS, in order to ensure the universal access to contraceptives (targeting representatives of the Parliament, MOH, MOF, NHIC, PHCFs, YFHCs, RH Cabinets etc)
10. Develop/implement advocacy campaigns to incorporate logistics management topic in the curriculum for family doctors, and family medical assistants, as well as PHC managers.
11. Build national capacity of PHCFs, including YFHCs managers, in the area of RHCS issues and framework: Forecasting, Logistics Management, LMIS, Supply Chain Management, Advocacy, M&E Mechanisms, Policy Analysis and Formulation, Advocacy, Problem Solving, Decision Making, Data Utilization and Data for Evidence-Based Decision Making.
12. Monitor progress on the implementation of the Action Plan on Providing Contraceptives to Vulnerable Groups at the Level of Primary Health Care approved on 30/03/2016 and conduct the implementation assessment, identifying challenges and lessons learned.
13. Review existing RH/FP regulatory framework to ensure policies integration and assess obstacles in their implementation, as well as develop standard clinic practice protocol on family planning for family doctors.
14. Design and conduct advocacy campaigns to include contraceptives in the Compensated Drug List.
15. Develop mechanism to monitor the use of contraceptives by vulnerable groups.
16. Develop/implement IEC Programs and Campaigns to raise community awareness concerning the importance of using modern contraceptives and available FP services (these campaigns have to include pamphlets, posters, TV/Radio' announcement, being realized with the support of the Network of RH Cabinets).
17. Improve Logistics Information Availability and Utilization:
 - Develop mechanism to ensure collecting of the required logistics management information from the PHCFs and YFHCs on regular base with aim to generate required reports.
 - Review/Unify/Develop manual input forms, inventory keeping-records to collect logistics data from PHCFs and YFHCs, RH Cabinets. When the PHC automated information system (SIA-AMP) will be applied, the contraceptive logistics management information/data will be entered into the module developed with UNFPA support (based on CHANNEL software) and which is an integral part of the SIA-AMP
 - Introduce and build capacity of PHC staff to use developed with UNFPA support contraceptive logistics management information module integrated into PHC automated information system (SIA-AMP) and to be able to generate reports
 - Design/Test templates for comprehensive reports to support decision makers.
18. Conduct advocacy campaigns about the importance of LMI and its generated reports among PHCFs and RH Cabinets and YFHCs managers'.
19. Develop/Strengthen the implementation of the standard of using contraceptives on the basis of WHO recommendations, and use different communication channels to raise both service providers and clients' awareness about it.

20. Start registration process for Injectables and Implants and include them in the procurement process.
21. Explore and piloting introducing new methods of contraception, such as Female Condoms to be added to the available methods at the PHCFs and YFHCs. It can be first as piloting with limited quantities to explore community acceptance and then determine required commodities to be added to the available methods to be increased with 1% yearly in order to change method mix toward more effective one.
22. Provide required support to the Pharmaceutical Storage "Sanfarm-Prim" to switch it to be fully government entity, scan existing mechanism to make required adaption to use its resources (space, staff, management, quality control, etc.) when procuring contraceptives from international platforms, including UNFPA Procurement Services .
23. Design/implement M&E mechanisms to monitor PHCFs performance in the area of RHCS, and commodity stocks, as well as gather feedback, gaps and comments of PHCFs, including RH Cabinets and YFHCs managers' on applying ministerial orders. In addition, explore the possibility to introduce performance indicators on RHCS in primary health care (performance based incentives).
24. Design/implement advocacy campaigns for decision makers and service providers on the newly adopted Total Market Approach for Family Planning.

Phase (2): Mid-Term

1. The SRHR Steering committee to conduct regular meetings to identify required areas for RH/FP/RHCS analyses and researches.
2. Develop program to create FP champions from social workers at district level (the idea here is to build social workers capacity at district level to carry IEC activities on RH/FP, including RHCS).
3. Explore the possibility to include RHCS indicators, as well as monitoring modern contraceptives stocks indicators and contraceptive distribution level, in the context of assessment of PHC facilities, carried every 5 years, by the National Council for Evaluation and Accreditation in Health.
4. Develop/implement IEC campaigns to raise community awareness on modern methods of contraception, especially on long term ones with aim to reduce the prevalence of traditional methods of contraception, focusing on target groups such as youth, women in the post-partum period, PLHIV and other groups, to prevent unplanned, high-risk pregnancies and to allow people to make an informed choice about family planning.
5. Design/implement advocacy campaigns to facilitate integration of the Comprehensive Sexuality Education, including RH/FP issues into the secondary school curriculum.
6. Design and implement Media campaigns to raise awareness of target population, especially youth, on reproductive health and family planning and RHCS issues. These campaigns have to cover Journalists, TV/Radio program makers, Film authors and script writers.
7. Explore the possibility and feasibility to have mobile clinics to provide RH/FP out-reach youth-friendly services for vulnerable and most-at-risk adolescents and youth living in communities.

8. Utilize the flexibility of NHIC to contract NGOs and/or private sector to apply Total Market Approach, by designing/implementation of advocacy campaigns (to encourage more private sector and NGOs involvement in providing RH/FP services including required contraceptives; as well as to strength partnership between public sector and both private and NGOs for more effective implementation of total market approach.)
9. Build capacity of MOH departments and subordinated institutions in the area of stakeholder analysis', Problem Solving, and other training needed to facilitate the partnership and help on providing client with more options for RH/FP services as well as more choices for contraceptive methods to use.
10. Design/implement advocacy plans and materials to ensure increasing available resources for RH/FP commodities as well as their sustainability and efficient utilization.
11. Develop mechanism to collect on regular base data about client' satisfaction.
12. Design/Conduct studies to better understand:
 - Youth needs for more choices of modern contraceptive methods
 - Reasons for unmet needs, discontinuation, method choices, family planning methods use and demand.
 - Market segmentation (analysis of market segments) for better understanding client perceptions, and preferences.

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List of Contacts

Name	Position
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Dr. Luminița Avornic,	Deputy Head of Primary, Emergency and Community Health Care Department, MoH
Dr. Maria Lăpteanu,	Head of Medicines and Medical Devices Department, MoH
Dr. Galina Morari,	Deputy Head of Hospital Health Care Department, MoH
Mr Sergiu Ungureanu,	Head of e-Health and e-Transformation Division, MoH
Mr. Denis Valac	Head of Budget, Finance and Insurance Department, MoH
Ms Lilia Gantea	Deputy Head of Budget, Finance and Insurance Department, MoH
Dr Sergiu Gladun,	Director of Mother and Child Institute
Dr Mihail Strătilă	Head of Reproductive Health and Medical Genetics Center
Dr. Victoria Ciubotaru,	Scientific Researcher, Reproductive Health and Medical Genetics Center.
Mr. Petru Crudu	Deputy Director of the National Center of Health Management
Mr. Valeriu Pleșca,	Head of Health Care M&E Division, NCHM
Mr. Ivan Antoci,	Director of the Center for Centralized Public Procurements in Health
Ms Raisa Golovei	Head of Medicines Procurement Division, Center for Centralized Public Procurements in Health
Dr. Elena Robu	Deputy Director, Territorial Medical Association Centre
Mr. Dumitru Parfentiev	General Director of the National Health Insurance Company
Mr. Ghenadie Damașcan	Head of Contracting and Relations with Providers Department, NHIC
Mr. Nicolae Onilov	Head of Medicines Department, NHIC
Mr. Stefan Harea,	General Director of the Pharmaceutical Storage "Sanfarm-Prim" S.A.
Dr. Galina Leșco	Director of the "Neovita" Youth Friendly Health Center
Dr. Vera Melniciuc	Director of the "Dalila" Woman's Health Center, Territorial Medical Association Botanica
Dr Haris Hajrulahovic	WHO Representative in the Republic of Moldova
Ms Margarita Tileva	UNICEF Moldova Deputy Representative
Ms Doina Munteanu	Assistant Resident Representative /Head of Programme, UNDP
Dr. Tatiana Zatić	Head of Primary, Emergency and Community Health Care Department, MoH
Dr Stefan Virtosu	Director of the Primary Health Center from Durlesti village
Dr. Stelian Cucu,	Director of the Primary Health Center, Ialoveni village
Dr. Iurie Lupacescu	Director of PHC #1, Orhei
Dr. Svetlana Taras	Director, YFHS from Orhei
Ms. Angela Lupacescu,	Reproductive Health Office, Orhei
Dr. Tudor Levința	Manager of PHC from Peresecina village
Dr. Nadejda Negura	Manager of the PHC from Măgdăcești village
Dr. Rita Columbia,	UNFPA Representative in the Republic of Moldova
Ms Natalia Cojohari,	UNFPA/Assistant Representative
Ms Eugenia Berzan,	UNFPA/Programme Analyst RH and Youth
Ms Victoria Dochîțcu,	UNFPA/ Programme Associate RH and Youth

Sexual and Reproductive Health and Rights Steering Committee

Terms of Reference

A formalized cross-sectoral and interministerial Steering Committee on Sexual and Reproductive Health and Rights is envisaged to be established with aim to ensure the coordination of all issues related to SRHR.

Leadership

Chaired by the Deputy Prime-minister, this Steering Committee will provide a framework for coordination and monitoring the implementation of the National Programme on SRHR, as well as representing a platform for policy dialog, advocacy and resource mobilization in the field of SRHR, including RHCS, SRH in emergencies and disasters etc. The leadership will convene regular meetings, support and promote co-ordination efforts and information sharing among key multi-sectoral actors.

Membership

The membership is sought to be as wide as possible, the Committee bringing together all relevant SRHR stakeholders: representatives of the relevant line ministries, Moldova's Ombudsman's office, Emergency Situations and Civil Protection Service, representatives of UN Agencies and Donors, public & private sector SRH service providers, including non-governmental organizations, private commercial sector (including importers of contraceptives), professional associations and consumer representatives, representatives of medical education institutions and academia, as well as representatives of the local authorities.

Technical Secretariat of the SRHR Steering Committee

The Centre for Reproductive Health and Medical Genetics will serve as a Technical Secretariat for the Sexual and Reproductive Health and Rights Steering Committee, being responsible for organization of the ordinary and extraordinary meetings of the SRHR Steering Committee.

The Technical Secretariat shall present to the SRHR Steering Committee once a year a monitoring report on the implementation of the National Programme on Sexual and Reproductive Health and Rights (NPSRHR).

The Mid-term review and final review of the NPSRHR will be realized by the Centre for Reproductive Health and Medical Genetics with the technical assistance provided by the partners for development.

Meetings of the SRHR Steering Committee

The Sexual and Reproductive Health and Rights Steering Committee will meet once in six months on ordinary base, being convened by the Chair.

Extraordinary meetings might be called by the Chair or at the request of members of the SRHR Steering Committee, when this is considered necessary to address an issue of urgent matter.

A draft agenda will be circulated by the Technical Secretariat to members of the SRHR Steering Committee two weeks before the regular meeting, giving the members the opportunity to suggest additional items for discussion.

Draft minutes will be circulated within one week of the meeting by the Technical Secretariat to members of the SRHR Steering Committee.

Key Responsibilities of the SRHR Steering Committee

The Steering Committee shall consider and discuss all relevant matters in the area of SRHR, and in particular on:

1. Co-ordination and cooperation in the area of SRHR and information sharing among relevant key multi-sectoral actors.
2. Legal and human rights issues relating to SRHR, including the right to have access to CSE integrated into the mandatory school curricula.
3. SRH data collection, analysis, dissemination and timely utilization, including on RHCS and LMIS; the reports of qualitative and quantitative studies and situation analysis in the field of SRHR, including on RHCS.
5. Funds available/committed by all key actors for SRHR programme, exploring other sources of funding and informing the donor community how and where donor funds for SRHR activities can be most effective.
6. Access to quality and affordable SRH services, including FP services and modern contraceptives (in particular for the most vulnerable and most-at-risk groups of population) and strategic activities planned and implemented for achieving Reproductive Health Commodity Security.
8. Awareness-raising activities that highlight the importance of SRHR and inform the population about the availability of the provided SRH services
9. Preparedness and response to SRH needs of population in case of emergencies and man-made or natural disasters (including integration of MISP into the national preparedness plans).

RHCS Focal Points

Terms of Reference

Within the newly established Center for Centralized Public Procurements in Health it is suggested that two persons, one of them with Information Technology background and the second one with Pharmaceutical background - to be assigned for providing 'state of the art' technical and consultative support to the national authorities, including to the National Steering Committee on SRHR

Main responsibilities:

- Regularly update the Steering Committee on SRHR on emerging issues in RHCS
- Collaborate with all partners in the context of the national forecasting and supply planning of commodities
- Validate national requirements of RH commodities and assist in the preparation of requisitions for submission to procurement.
- Provide technical assistance with regard to RHCS management functions: distribution, stock taking and inventory, pipeline and supply chain monitoring
- Cooperation with national institutions on training and other forms of capacity building on RHCS.
- Monitoring and Evaluation of the implementation at the national level of the RHCS strategic plans
- Development of the required reports to be presented to the higher level to support decision making in the area of RHCS

Monthly Activity Report

District:

PHCF:

Summary of nd Quarter

Number using contraceptives "1st" visit of the year:

Number using contraceptives "2nd" or more visit of the year:

AGE of USER and Method (in years):

Method	15-19	20-24	25-29	30-34	35-39	40 ET +	TOTAL
Orals							
IUD							
Injectable							
Condom							

Number of Living Children:

0	1	2	3	4	5	6 et +	TOTAL

Age of Oldest Living Child:

0-1 yr	1-2 yr	2-3 yr	3-4 yr	over 4 yr	Total

Intra-Uterine Devices

1 st insertion	Check-up	Removal	Re-insertion	Rejected	Pregnancies

Oral Contraceptives

1 st Use	Re-supply

Barrier Methods (Spermicides and condoms)

1 st Use	Re-supply

IUDs used:	Condoms:	Cycles used:
Mirena: Copper T:		Oralcon: Marvelon: Jasmine: Eval:

SAMPLE MONTHLY LOGISTICS REPORT

SECTION A: STOCK MOVEMENT

	A	B	C	D	E			F	I
					Losses and Adjustments				
	Stock on Hand Start of Month	Qty Rec'd during the Month	Qty Distributed during the Month	Average Monthly Consumption	Damaged	Expired	Transfers (+/-)	Stock on Hand End of Month	Order Quantity (D*7) - H
Code	Product								
xxx	Oral contraceptive 1 (cycles)								
xxx	Oral contraceptive 2 (cycles)								
xxx	Oral contraceptive 3 (cycles)								
xxx	Oral contraceptive 4 (cycles)								
xxx	IUD 1 (pieces)								
xxx	IUD 2 (pieces)								
xxx	Injectable 1 (doses)								
xxx	Implant 1 (sets)								
xxx	Male condoms								

SECTION B: STOCK OUTS

Code	Description	Duration (Days)

SECTION C: PRODUCTS EXPIRING IN THE NEXT 3 MONTHS

Code	Description	Quantity	Expiration Date

SECTION D: COMMENTS

SECTION E: SIGNATURES

Completed by	Name and Title:	Date:
	Signature:	
Checked by	Name and Title:	Date:
	Signature:	