Final evaluation report

National reproductive health strategy 2005–2015 in the Republic of Moldova

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Acknowledgments

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Acronyms

D&C	dilation and curettage
EVA	electric vacuum aspiration
FDO	family doctor office
FMC	family medicine centre
FP	family planning
GDP	gross domestic product
HC	health centre
HP	health post
IUD	intrauterine device
LSBE	life-skills based education
MARP	most-at-risk populations
MDG	Millennium Development Goal
MoH	Ministry of Health (of the Republic of Moldova)
MMR	maternal mortality rate
MPSU	Medical and Pharmaceutical State University
MTCT	mother-to-child transmission (of HIV)
MVA	manual vacuum aspiration
NCRHMGFP	National Centre for Reproductive Health, Medical Genetics and Family Planning
NGO	nongovernmental organization
NHIC	National Health Insurance Company
NRHS	national reproductive health strategy
PHC	primary health care
RH	reproductive health
STIs	sexually transmitted infections
UNFPA	United Nations Population Fund
YFHC	youth-friendly health centre
YFHS	youth-friendly health service

CONTENTS

Introduction

The evaluation

The evaluation analysed achievement of objectives and expected results of the national reproductive health strategy 2005–2015 (NRHS), identified factors enabling and/or hampering the implementation process, and developed recommendations for the drafting of a new strategy for the next five years.

Evaluation method

The following general criteria were applied to guide the evaluation:

- **relevance** – the degree to which activities resulted in achieving the objectives and expected outcomes related to defined national priorities;
- **efficacy** – how the implementation of strategy led to improved access of different population groups to quality reproductive health (RH) services, backed by an enabling legal framework and involvement of communities in decision-making;
- **efficiency** – how activities followed the achievement of expected outcomes and monitoring systems installed to evaluate their effects;
- **impact** – the degree to which achieved results contribute to a better quality of life for recipients;
- **stewardship and coordination** – who leads implementation, coordination with other similar interventions and collaboration with civil society organizations; and
- **human-rights-based approach and cross-cutting principles** – such as gender equality, non-discrimination, population trends, young people's points of view and migration.

In particular, the following data were collected and analysed for the 11 priorities defined in the NRHS:

- health statistics
- coordination
- funding
- health service delivery.

Specific indicators were developed for each priority (Annex 1) and relevant papers identified and inventoried with support from WHO and United Nations Population Fund (UNFPA) country offices and key interviewee groups. Evaluators also developed interview guidelines using relevant excerpts from the NRHS that were used in discus-

sions with key groups across each priority area. Groups for interview were identified with support from the ministry of Health of the Republic of Moldova (MoH) and WHO and UNFPA country offices.

The evaluators developed a first draft that was summarized during a consultation meeting with specialists from the 11 priority areas organized under the aegis of the MoH on 30 October 2014. The outcomes of this process are reflected in this report. The consultation meeting validated the findings and allowed discussions on recommendations for approaches to developing the new sexuality and RH strategy, defining actions and priorities for the next phase. Discussions during the working groups were structured to focus on generating general recommendations for RH in general and the NRHS priority areas in particular.

Overview of RH

RH is a long-term priority in the Republic of Moldova. The modern concept of specialized RH services was realized by Ordinance No. 89/1994, to set up a national network of RH and family planning services. A national programme for family planning and RH was endorsed by Government Decision No. 527/1999, setting out a number of measures aiming to promote responsible sexual behaviours, 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.

The NRHS 2005–2015, which was developed following a participatory process under the aegis of the MoH and with WHO and UNFPA support, defined priority topics over a 10-year period to channel efforts towards ensuring that the sexual and reproductive rights of all citizens were observed. It was approved by Government Decision No. 913 of August 2005, alongside country commitments to achieving the Millennium Development Goals (MDGs) related to women's and children's health through Government Decision No. 288 of March 2005.

The principles underpinning the NRHS are in line with international standards and support the accomplishment of the Republic of Moldova's commitments to relevant RH-related strategies and conventions,[1] such as:

- the right to health is a fundamental human right;

1 These include: the International Conference on Population and Development, Cairo, 1994; Action Plan Cairo+5; Platform for Action of the Beijing International Conference; United Nations Convention on the Rights of the Child; United Nations Declaration on the Elimination of all Forms of Violence against Women; United Nations Convention on the Elimination of all Forms of Discrimination against Women; WHO global reproductive health strategy; the MDGs; United Nations Political Declaration on HIV/AIDS; and the WHO European strategy on sexual and reproductive health.

- access to RH information and services shall be equal to men and women;
- all people are entitled to access to quality RH services that are in line with latest developments in contemporary science;
- legal and normative frameworks for sexual and RH will be aligned with agreed international standards;
- public access will be ensured by integrating RH services into primary health care (PHC);
- service users' cultural values and personal beliefs will be observed;
- communities, nongovernmental organizations (NGOs) and civil organizations will be involved in promoting and upholding the health status of the population; and
- the NRHS will be coordinated with existing programmes and other strategies.

Strategic directions under the NRHS have been carefully selected. They are relevant and aim to achieve defined cost-efficiency indicators. Priorities focus on issues related to primary and secondary prevention, improving service quality by training health workers in principles of evidence-based medicine, best practices and creating better relations between providers and consumers, collaboration between facilities at national level, partnerships with international agencies, social mobilization and community involvement. The 11 priority intervention areas are:

1. family planning
2. making pregnancy safer
3. sexual and RH of adolescents and young people
4. prevention and management of reproductive tract infections
5. abortion and pregnancy termination services
6. prevention and management of infertility
7. prevention and management of domestic violence and sexual abuse
8. prevention of human trafficking
9. early detection and management of breast and cervical cancer
10. sexual health of older people
11. men's sexual and RH.

Evaluation findings

General

General implementation framework

The NRHS is based on a general implementation framework consisting of several components.

RH system reform was designed to improve services at three levels of care by integrating family planning (FP) and RH services within PHC, setting up structures at district/municipal level based on specific regulations, and providing patient-referral mechanisms appropriate to their health care needs. The legal framework and regulations support the integration of FP/RH into PHC and access for all to FP services. Regulations specify FP services as part of the basic PHC package provided by PHC facilities. The NRHS aims to bring these closer to people to increase their access to FP/RH services, in accordance with the strategic intention of integration within PHC.

PHC facilities are classified by several criteria:

- type of location
- population catchment area
- legal form of organization
- complexity of services being provided.

Family medicine centres (FMCs) operate in urban areas and health centres (HCs) in rural. Family doctors' offices (FDOs) and health posts (HPs) are subdivisions of FMCs or HCs that operate in rural areas. Of the 276 accredited PHC units, five are territorial medical associations, 47 are FMCs and 224 are HCs, most of which are located in rural settings.

RH services are structured around three levels of care. Currently, RH rooms at all levels are located in urban settlements only. Given that 58.4% of the population resides in rural areas *(1)*, this represents a major barrier to access. Even if a large number of family doctors and nurses trained before 2010 are now working in HCs or FDOs in rural areas, it is difficult to assess the degree to which they deliver FP services (there are no data with which to conduct an analysis), but the interviewees in the evaluation indicated that service delivery is limited to counselling and, occasionally, condom distribution. They do not issue medical prescriptions for contraception and generally hold no stocks for free distribution. Women are nevertheless referred to district RH

rooms on most occasions, even if their rural settlements are located 50 km or further away from a district centre, making it difficult for individuals and couples to travel due to lack of money, few transportation means and inappropriate appointment times. Regional coverage of FP services therefore does not meet the aspirations of the NRHS: at the end of the NRHS implementation period, only about 19% of PHC facilities were providing FP services.

FP services have been provided to the public through RH rooms, which, until recently, belonged to FMCs. Regulations in place at the time of drafting this report state that all people, irrespective of health insurance status, have access to PHC services, but only those with insurance can obtain drugs compensated by the National Health Insurance Company (NHIC). Vulnerable groups have access to free contraception, which currently is provided from two sources: UNFPA donations and public procurements using FMC funds. These options may, however, change in the future: the country's shift in economic classification from lower-income to lower-medium-income status means it may no longer benefit from UNFPA contraception donations.

The MoH issued Ordinance No. 812/414-A of 14 August 2014 to address this situation, covering the action plan for contraception delivery to vulnerable groups at PHC level fully from NHIC funds. There is as yet no clear-cut definition of which vulnerable groups can access free contraception (adolescents and people with disabilities, for instance, are not included), with only health conditions that increase the risk of pregnancy being defined in the ordinance. It also addresses socioeconomic vulnerabilities, but there are too many categories, many of which are ill-defined. There have been no discussions about ways to align different categories of people who could access free contraception with available budgets and no strategies to mobilize additional resources, given that available funding may be insufficient to cover needs.

Setting up youth-friendly health centres (YFHCs) in each municipality and district centre raised doubts about the future of RH rooms. FP/RH services are delivered by the same people in most locations, but some FMC managers decided to merge YFHCs with RH rooms. Donor organizations prefer a project-based approach, as indicated in the last two official development assistance reports in 2012 *(2)* and 2013 *(1)*. This situation requires careful coordination by the MoH to ensure the development of efficient and sustainable interventions.

Creating this new system of services was timely in terms of increasing young people's access to FP/RH services, but it was not backed by a comprehensive local situation analysis and measures to ensure the sustainability of the entire RH/FP service delivery system. It would be very useful to involve more representatives of local FMC managers in integration of services at local level.

Recently, RH rooms have been transferred from FMCs to specialist services in outpatient consultation departments (in secondary care). This move was justified by the problems experienced in trying to coordinate RH rooms at national level when they were subordinate to decentralized FMCs. It significantly affects access of uninsured people to RH services, as they may need referral from a family doctor or be

charged fees for using the services. Family physicians may refer someone only if the person is contributing to a health insurance scheme. People who are not on a family doctor's list may therefore no longer be able to access RH room services.

The NRHS aimed to ensure quality services by developing methodological guidance and standard-based guidelines to promote service providers' knowledge and hands-on skills. Methodological and training guidelines have been drafted for most priority areas through specific donor-funded projects, most of which have been approved by MoH ordinances and may be accessed from the MoH website *(3)*. No specific action plans and clear-cut monitoring measures imposing sanctions for identified digressions have been developed for most guidelines. Some lecturers have adapted the content of their course programmes for trainees to reflect the guidelines, but not all trainees have been formally integrated into the medical pre-service education system or in-service medical education curricula at colleges, universities or in residency programmes.

An important step forward improving service quality assurance was accomplished by MoH Ordinance No.139 of 2010, on ensuring a health care service quality assurance system, but there is need for additional efforts to ensure the integration of RH/FP services into systems of each health care facility providing RH/FP services.

The NRHS has a strong focus on aligning the concepts of international standards with better quality of services. In this context, the concept of services centred on user needs was intended to underpin the design and delivery of services and quality assurance procedures. The evaluation was able to identify no studies or reviews to provide a record of such an approach being adopted, however. Location of services has instead been driven by historical precedent or existing human resource availability.

Health professionals are leaving the system, resulting in failure to meet the needs of specific areas. Severe understaffing often makes health facilities accept compromises. Based on the accounts of one interviewee, the average age of gynaecologists is 50 years and over. Retirement-age physicians are working in many rural communities. The issue of the ageing of the workforce has been identified for quite some time but has not been tackled through the identification of viable solutions. Local community and service recipients are not currently involved in consultations about health service design.

The NRHS provides for the training of service providers (family doctors and obstetricians/gynaecologists) through pre-service (undergraduate) and postgraduate provision and continuing education opportunities for family doctors, obstetricians/gynaecologists, dermatovenereologists and RH nurses. The evaluation identified that undergraduate and postgraduate curricula have tended to maintain their traditional approach and have not been adapted to meet the provisions of the NRHS. Heightened attention has been paid to certain areas, but others have been ignored, with less attention given to FP, STIs, the specific needs of population groups such as men and older people, and the development of communication skills. It is difficult to evaluate to what extent curricula have been adapted to published guidelines, but

discussions with teaching staff suggest that the guidelines are being reflected in lectures even if curricula have not fully been updated.

Education facilities suggested topics for continuing education courses for health workers. No regulations link continuing medical education with key public health issues or strategies developed to tackle them. Topic selection for curricula seem not to be driven by situation analyses or consultations, training needs assessment, the emergence of new standards or practical guidelines. Health workers can collect the required number of credits for regular accreditation based on their own preferences.

There is clear evidence of staff involvement in continuing education, but health care facilities have neither clear-cut career development plans nor strategies for service quality assurance.

In terms of information and education, the NRHS prioritizes young people by integrating specific teaching hours into school education programmes, but also has elements that address the needs of the wider reproductive-age population. Information and education programmes for young people have been evolving. A mandatory course on life-skills based education (LSBE) was introduced in 2005. Teaching staff were trained and manuals developed to support implementation in schools, but it was removed from the school curriculum after just a few months. Thereafter, RH issues were reintroduced to other mandatory courses such as civil education or presented as optional courses (health education in lower secondary facilities and family life education in upper secondary). Extracurricular activities and advocacy campaigns have been launched in collaboration with other facilities and NGOs. LSBE was turned into a mandatory course for first-year students during the first half of the year in colleges in 2012.

There are no data at MoH or subordinate facility level on public information and education activities. Work on these topics has been conducted on an occasional basis through specific projects that are often taken forward by NGOs.

Coordination of NRHS implementation is performed by the National Centre for Reproductive Health, Medical Genetics and Family Planning (NCRHMGFP) through a methodological centre for RH coordination, documentation, analysis and reporting. This centre will develop a set of monitoring and evaluation indicators and an information system for management. An NRHS implementation coordination committee was established under the MoH, but the evaluation to date has been unable to identify papers on its work. Each priority area seems to have had its own coordination structure.

The NRHS was developed through a consultative process involving specialists from all the areas included in the strategy. Members of the NRHS development team drafted an implementation plan, but it was never finalized or approved. The NRHS therefore had no action plan to define objectives, activities and annual indicators. This led to discrepancies between priority areas, with some getting more resources than others. Those that were also high priority for traditional donors to RH programmes experienced rapid growth, while other areas failed to realize the resources required

for implementation. Only general statistical data were collected at MoH level by way of monitoring, although projects funded by donors had their own monitoring and evaluation indicators. The lack of an action plan made it impossible to define and develop specific indicators to track progress in reaching NRHS objectives.

Despite the lack of a management unit per se with sufficient resources to accomplish the tasks of a methodological centre for RH coordination, documentation, analysis and reporting, CRHMG has convened meetings with representatives of district RH rooms on a regular basis.

A comprehensive assessment of RH care was planned. The last large-scale population study was carried out in 2005, since when studies have been conducted only in defined priority areas. A multiple-indicator cluster survey (MICS), which monitors the situation of children and women, was last carried out in 2012 *(4)*: this is the only study collecting data from several priority areas. No comprehensive assessment of RH care has been performed.

A detailed assessment of all priority areas was carried out during the mid-term review of the NRHS. It listed all achievements, with detailed analyses in each priority area and specific recommendations. Annex 1 outlines the recommendations and progress made in implementation. Each chapter of this report has a table presenting specific recommendations made during the mid-term evaluation that have been implemented to date.

Priority 1. Family planning

The goal of this priority area was to provide opportunities to all population groups to practise responsible sexual behaviours. Suggested objectives included boosting the use of modern and efficient contraception through better access to FP services, improving the population's knowledge levels about FP benefits, and streamlining the FP monitoring and reporting system. The aim was to achieve coverage among the population of modern contraceptives of above 50%, with hormonal contraception accounting for 10% and voluntary surgical sterilization 5%. Such results, it was assumed, would be accomplished by integrating FP services into PHC and providing better information to the public about the benefits of FP and availability of FP services.

A summary of NRHS provisions and findings is shown in Table 1.

Table 1. Priority 1: family planning – summary of NRHS provisions and findings

NRHS provision	Findings
Updating of legislative and normative framework	
Developing FP services in all FMCs, HCs and FDOs	Existing regulations explicitly set out the provision of FP services in PHC facilities (FMC, HC or FDO) in urban and rural settings, or in any health care facility that includes a primary care physician in their workforce plan Regulations on the competences required for FP service provision state that intrauterine device (IUD) insertion shall be performed by an obstetrician/gynaecologist only, while providing for the work of youth-friendly health services (YFHS); There are no regulations, however, on service delivery by health status of patients
Adding FP to PHC services	Regulations describe access to PHC services irrespective of health insurance status, consequently ensuring access for all to FP services
Setting up mechanisms to provide vulnerable groups with modern contraception free of charge or at an affordable price	Contraception provided to vulnerable groups free of charge come from two sources: • UNFPA donations available to any individual from vulnerable groups; and • public procurement from FMC budgets available to the health-insured only A MoH ordinance on collection of forecast data regarding contraception supply to vulnerable groups was issued in August 2014
Accessibility and quality of services	
Developing standards of care for national FP services	Not developed
Integrating contraception services into other RH services	Formally, such integration is provided for in regulations, but it is difficult to evaluate in practice given the absence of practical protocols explicitly referring to contraception in the context of other RH services and systems to keep track of their enforcement.
Providing adolescents and young people, infertile couples, victims of violence or human trafficking with pre-conception, post-delivery and post-abortion counselling within the framework of FP services	A comprehensive evaluation based on existing data from statistical report form 13 on termination of pregnancy (before 21 weeks of gestation) and report form 49 is not possible

NRHS provision	Findings
Involving family doctors in FP and RH protection	There are no data to support specific situation analysis Aggregated morbidity data are reported per district and lack disaggregation by rural/urban setting Interviews revealed, however, that family doctors are seldom involved and, at most, provide contraception counselling while distributing contraceptive pills or condoms in certain locations Usually, rural women who want to use modern contraception means are referred to a gynaecologist in RH rooms located in the nearest urban area, who can prescribe hormonal pills or arrange IUD insertion; this might explain the low coverage of women with modern contraception, with travel costs adding to those of contraception The rural population accounts for 75% of the total population in 21 of the existing districts Over 1 400 family doctors have been trained in FP service delivery, at least for healthy women; there are no data yet on services they provide
Securing access for 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 dropped; these are no longer registered and no actions have been taken 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 are reported There are no data on surgical sterilization in males
Coverage of modern birth control methods of over 50%	The MICS report of 2012 *(4)* quoted 42% coverage, ranging from 47% in the richest quintile to 34% in the poorest. Modern methods considered included female sterilization, IUD, injectables or contraceptive pills, male condom, diaphragm, spermicide foam/gel and the lactational amenorrhoea method

NRHS provision	Findings
Coverage of hormonal contraceptives of above 10%	Coverage of 5% was achieved
Coverage of voluntary surgical sterilization of above 5%	No data are available
Training of health service providers	
Adding FP to graduate and postgraduate curricula	Adding FP to graduate and postgraduate curricula requires that a formal process be followed Optional training courses are available to students but only on an occasional basis: these comprise 14 hours overall, including seven lectures There is a mandatory six-hour course on family planning during the obstetrics/gynaecology discipline in year 5, consisting of two hours of lectures and a four-hour seminar; there is also a family planning course with a similar structure in the residency training element of the obstetrics/gynaecology discipline Seven hours of family planning, including three hours in seminar and four of hands-on practice, are taught under the reproductive health discipline during residency training in family medicine Only the syllabus topics could be evaluated, as training materials distributed to participants could not be accessed, but is seems that they are structured as lectures
Developing methodological guidelines, instructions and standards for knowledge and practical skills in RH for FP service providers	The mid-term evaluation of the NRHS refers to a practical guideline in RH, but an updated version could not be identified during the evaluation
Conducting continuing education workshops (including in the workplace) in RH for family doctors, obstetricians/gynaecologists, dermatovenereologists, physicians and nurses	FP is no longer a topic in continuing education courses as of2014; there is just one 25-hour course in adolescent health and care On-site (workplace) education is not provided; the only activities inclusive of FP-related professional topics are monthly meetings with representatives from RH rooms at the CRHMG and at the Neovita Centre (a YFHS resource centre) Dermatovenereologists were not enlisted in any FP or contraception-related training course

NRHS provision	Findings
Comprehensive training of RH room physicians, obstetricians/gynaecologists and family doctors in all RH-related areas: FP, making pregnancy safer, youth health, reproductive tract infections, abortion, infertility, violence, trafficking, breast and cervical cancers, menopause, and sexual and RH in men	No individual career development plans exist for any of the defined professional categories The Dean's Office for In-service Education at the Nicolae Testemitanu Medical and Pharmaceutical State University and MoH are developing an in-service training programme for physicians and pharmacists Enrolment in training courses is conducted as per individuals' priorities and preferences; management of health care facilities do not require staff to have specific training in the relevant topics they deal with
Information, education and communication	
Promoting education in FP in higher secondary schools, universities and other education facilities	The MoH has no data on this topic LSBE is available to young people through optional courses (health education in lower secondary facilities and family life education in higher); optional courses do not guarantee access to health education and family life education for all students
Organizing training sessions in family life education for teaching and health care staff from schools	This has not been achieved
Developing and distributing printed FP information materials to the lay population	Ad hoc and undirected actions have been taken Several state organizations and NGOs develop information materials in the context of projects financed by external partners, but there are no data on issues such as the type of materials, circulation methods or target audiences No data are available at central level
Engaging civil society in FP education, information and communication	No data are available at central level
Participation of the media in FP information and education campaigns	No data are available at central level
Engaging family doctors in contraception education	No data are available at central level
Gender equality	
Informing women and men about their right to choose in the area of FP	No campaigns have been conducted

NRHS provision	Findings
Targeting school education and extracurricular activities related to FP equally at boys and girls	Activities target boys and girls equally
Advocating for public education in RH for women and men	No campaigns have been conducted
Ensuring availability of contraceptive methods for women and men	There is no demand for voluntary surgical sterilization of men
Ensuring access to FP services equally for women and men	Services are equally available to women and men
Research and monitoring and evaluation	
Setting up an information system for FP	No information system has been created A single department or unit to collect data from different facilities does not exist; monitoring of activities, interventions and their outcomes is therefore not possible Data are collected by different facilities, subject to their specific responsibilities The NHIC is collecting data on service delivery and possibly on contraceptives purchased with FMC funds CRHMG is collecting data on the distribution of contraceptives from UNFPA donations Facilities with donor-funded projects are collecting data requested by donors
Setting up a national system for FP tracking and monitoring and evaluation	This has not been established
Conducting comprehensive FP evaluation studies	These has not been conducted

Conclusions

FP priorities varied during NRHS implementation. Initially, FP was in the spotlight. The regulatory system for implementation was created, a service guide was developed, training courses were organized for a number of PHC physicians and nurses, contraceptives were donated for distribution to vulnerable groups free of charge, and RH rooms were created in district towns and municipalities. These were key prerequisites for implementing strategic directions defined by the NRHS. Unfortunately, however, FP went off the radar during the second part of NRHS implementation. Initiated processes were not sustained at facility level, and while most PHC personnel had been trained in FP, no system for PF service delivery was developed to include them.

The resulting system was provider- rather than recipient-centred. The individual needs of different groups of women were not taken into account. Family doctors were not encouraged and supported to provide FP services and, with a few exceptions, had no contraceptives available to share. Medical education facilities did not embark on the training programmes developed during the first phase of NRHS implementation. Existing regulations were not updated to ensure that FP trainers could put their newly acquired knowledge and skills into practice.

From a recipient point of view, access to services is almost unchanged. They still have to seek services in RH rooms in urban areas, often the same services as before but with different names and offered by the same provider (currently they belong to PHC, but are not considered a priority within PHC services). The advantage for recipients comes with better quality of services, but this is rather an ephemeral gain given that the providers were trained more than five years ago and have had no means of improving their expertise, no forums for professional discussions and no publications to support their knowledge.

Failure to get PHC staff involved in FP service delivery represents a missed opportunity to develop community information and education programmes to reinforce positive messages about modern contraception.

Table 2 summarizes progress on recommendations.

Table 2. Family planning: progress on recommendations

Number of recommendations in mid-term review	Number of recommendations partially achieved	Number of recommendations fully achieved
5	0	0

Priority 2. Making pregnancy safer

This priority area was high-profile and had many important achievements. Its intended goal was to reduce maternal, perinatal and neonatal morbidity and mortality through better quality in, and better access to, health care services. Specific objectives focused on ensuring social equity in access and building healthy attitudes and skills in perinatal care.

In particular, the NRHS sought to reduce the maternal mortality rate (MMR) to under 20 per 100 000 live births, the perinatal to under 10 per 1000 live and stillborn births, the early neonatal mortality rate to under 5 per 1000 live births, and the early neonatal morbidity rate to under 200 per 1000 live births. It also provided for at least six antenatal visits, including one during the first trimester of pregnancy.

Trends in statistical data for selected indicators are outlined in Tables 3–5.

Table 3. MMR: actual, MDG targets and NRHS targets

Targets	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
MMR per 100 000 live births	23.5	18.6	16.0	15.8	38.4	17.2	44.5	15.3	30.4	15.8		
MDG targets			16.0				15.5					13.3
NRHS target												< 20.0

Source: National Centre for Health Management *(5)*.

Table 4. MMR per 100 000 live births (total, urban, rural)

Rates	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
MMR per 100 000 live births	23.5	18.6	16.0	15.8	38.4	17.2	44.5	15.3	30.4	15.8
Urban						6.7	52.8	6.8	13.4	7.1
Rural						23.2	39.5	20.3	40.7	20.9

Source: National Centre for Health Management *(5)*.

Table 5. Perinatal and early neonatal mortality rates and number of newborns by year

Rates	2004	2005	2006	2007	2008	2009	2010 NRHS target	2011	2012	2013
Perinatal mortality rate per 1 000 live and still births	11.2	11.5	10.5	10.3	13.0	13.0	13.0 < 10.0	12.5	11.6	11.7
Early neonatal mortality rate per 1 000 live births	5.4	5.7	5.4	5.1	6.2	6.2	5.9 < 5.0	5.4	4.9	4.6
Early neonatal morbidity per 1 000 live births	251.3	261.2	247.7	252.2	293.1	267.8	308.3 < 200.0	333.8	381.5	386.6

Source: National Centre for Health Management *(5)*.

A summary of NRHS provisions and findings is shown in Table 6.

Table 6. Priority 2: making pregnancy safer– summary of NRHS provisions and findings

NRHS provisions	Findings
Updating of legislative and normative framework	
Making sure that perinatal care standards, approved under mandatory health insurance, comply with evidence-based medicine and existing clinical guidelines	Accomplished
Updating accreditation criteria for health care facilities providing perinatal care in line with principles of the "Making pregnancy safer" initiative	Accomplished
Identifying protection mechanisms (safety nets) for vulnerable groups	Accomplished Current regulations provide health insurance to all women during pregnancy and one year after childbirth, entitling her to the full package of health services Children benefit from health insurance until the age of 18
Accessibility and quality of services	
Providing for at least six antenatal visits, including one during first trimester of pregnancy	The 2012 MICS *(4)* showed that 99% of women aged 15–49 with a live birth over the two years prior to the study had had at least one antenatal care visit to a qualified health worker, while 95% benefited from at least four antenatal visits to a health service provider The NHIC set up a system of material incentives encouraging the registration of pregnant women by a family doctor during the first trimester of pregnancy
Advocating for the concept of family-friendly perinatal services as a quality assurance tool	Accomplished
Continuing to update the system of perinatal care definitions and indicators and in-service education for staff dealing with data collection and processing	Accomplished

NRHS provisions	Findings
Training of health service providers	
Continuing postgraduate education for perinatal health care workers in priority issues, such as principles of perinatal care planning, total quality management, evidence-based medicine, essential care in obstetrics and neonatology, and prevention of mother-to-child transmission (MTCT) of HIV/AIDS	Methodological guidelines were developed Based on the interviews alone, it was not possible to ascertain whether the training materials used in undergraduate and postgraduate education of students, residents and physicians were aligned with the methodological guidelines
Health staff training needs assessment	No health staff training needs assessments were identified
Information, education and communication	
Assessing staff knowledge and behavioural skills and user satisfaction with perinatal services	No such studies or reports were identified as having been filed by quality assurance councils from perinatal health care facilities
Developing a national policy for the family–community interface in perinatal care	None identified
Developing partnerships between perinatal care services and communities	None identified
Setting up mechanisms to encourage active involvement of mothers and community representatives in bettering the quality of perinatal care services	None identified
Building the capacity and cross-cultural/interpersonal communication skills of health workers from the maternal and child health service	No reports identified
Gender equality	
Getting both parents-to-be in preconception, antenatal, intranatal and postpartum care	No reports identified
Planning and implementing interventions to identify and resolve any issues related to violence in pregnancy	No reports identified
Research and monitoring and evaluation	
Finalizing, adopting and implementing the guidelines on perinatal care indicators	Accomplished

NRHS provisions	Findings
Updating existing and adding new tools for perinatal care evaluation	Accomplished
Undertaking operational research on the direct impact on maternal and perinatal mortality and morbidity	No reports identified
Assessing risk factors for fulfilling reproduction function	No reports identified

Conclusions

Programmes in this priority area benefited from important projects, with interventions aiming to achieve the strategy's objectives and outcomes, but they have not necessarily matched its strategic direction. Effort has focused on hospital rehabilitation, grouping hospitals by level of competence and providing them with equipment accordingly. Much less effort has been spent on raising the quality of PHC services, with the exception of incentives for family doctors to register pregnant women during the first trimester.

Trends in statistical indicators are inconsistent with the target outcomes. Varying trends in MMR per 100 000 live births are due to the statistical significance of each individual case, given the small number of cases reported, but analysis of data disaggregated by residence shows that trends in rural areas differ from the target outcomes for each year. Perinatal mortality per 1000 live and still births has a similar picture and is highly unlikely to achieve the targets even with one more year to go (Table 7). Early neonatal mortality per 1000 live births is closer, but was under the target in 2013, and early neonatal morbidity per 1000 live births has had an upward sloping trend over the last five years and is almost double the target value.

Table 7. Gap analysis of proportional perinatal mortality rates by birth weight and set of interventions

Set of interventions	2001/2002	2011/2012	Difference between 2001/2002 and 2011/2012	
Maternal health	8.9	5.2	3.7	41%
Maternal care in PA[a]	3.4	3.1	0.3	10%
Maternal care in PI[b]	2.4	1.2	1.2	51%
Before discharge	5.5	2.7	2.8	51%
After discharge	8.3	4.4	3.9	47%
After/VLWB[c]	0.3	0.5	–0.2	–72%
Total	**28.9**	**17.1**	**11.8**	**41%**

Significant improvements in the monitoring and evaluation system and national professional capacity-building have laid the foundations for developing effective future interventions. The monitoring system has already revealed the inadequacy of interventions at PHC level, recording the little progress achieved. A project funded by the Swiss Agency for Development and Cooperation, however, had a sizeable community mobilization component. It will be important to review the results of this project when published.

Results achieved in hospital care reflect a systematic and coordinated approach. A service delivery system structured by levels of competence was developed for hospitals, with detailed responsibilities for care and patient-referral mechanisms. The physical infrastructure of hospital facilities was improved (including the introduction of modern equipment), guidelines were developed and health workers trained in putting them into practice. A reliable monitoring system has been put in place, with data generated by the system analysed on a regular basis and corrective measures based on the review findings applied.

Table 8 summarizes progress on recommendations.

Table 8. Making pregnancy safer: progress on recommendations

Number of recommendations in mid-term review	Number of recommendations partially achieved	Number of recommendations fully achieved
19	9	2

Priority 3. Sexual and RH of adolescents and young people

This was the second priority area benefiting from growing support during strategy implementation through a systematic and comprehensive approach. Interventions largely matched the provisions of the NRHS and aimed to improve the sexual and RH of adolescents and young people through information and education to encourage healthy behaviours, enable access to health services tailored to their specific needs and achieve fewer unwanted pregnancies and abortions and lower STI incidence. A specific NRHS target was that 80% of education facilities should provide their students with sexual education, reducing unwanted pregnancy in adolescents by 30% and syphilis incidence by 20% and making information and education available to over 80% of adolescents and young people. It also called for YFHS to be operational in each district. There were 29.3 births per 1000 live births reported among adolescents in 2013 *(6)*. In 2012, 7.5% of adolescents aged 15–19 years had had one birth or were pregnant with their first child *(4)*. Data on pregnancies, terminations, live births and STIs in young people are shown in Tables 9–13.

Table 9. Proportion of pregnancy terminations in 15–19-year olds (%)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Proportion of pregnancy terminations	10.7	9.5	9.4	9.0	8.9	8.4	10.3	9.1	11.2	9.3	8.6

Source: National Centre for Health Management *(5)*.

Table 10. Pregnancy terminations per 1 000 women in 15–19-year olds

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Number of abortions	9.0	9.0	8.0	9.0	8.0	10.0	10.0	13.0	11.0	10.5

Source: National Centre for Health Management *(5)*.

Table 11. Pregnancy termination before 15 years (absolute values)

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Number of abortions (absolute)	10	14	18	19	26	13	11	9	9	9

Source: National Centre for Health Management *(5)*.

Table 12. Number of live births born to adolescents under 16 years, 2000–2012

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Number of births in adolescents (absolute)	75	66	71	75	64	68	68	67	77	9

Source: National Bureau of Statistics *(7)*.

Table 13. Live births by mother's age group and year

Age	2005	2006	2007	2008	2009	2010	2011	2012	2013
< 20 years	5 057	4 882	4 291	4 081	4 033	3 791	3 448	3 172	3 012
20–24	14 932	14 762	15 079	15 076	15 406	14 900	13 684	13 022	12 058

Source: National Bureau of Statistics *(6)*.

Table 14. Population morbidity due to STIs by age-group, sex, indicator, disease and year, per 100 000

	Syphilis									Gonorrhoea								
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2005	2006	2007	2008	2009	2010	2011	2012	2013
< 14 years																		
All	5.5	2.6	2.7	3.8	3.9	4.9	3.3	3.5	3.7	2.0	1.4	1.8	2.0	2.5	1.7	2.1	1.4	0,7
Male	7.9	3.6	3.1	3.2	2.3	4.3	2.7	2.7	3.4	1.9	0.3	0.9	0.3	1.0	0.3	1.7	0.3	0,3
Female	4.9	1.6	2.3	4.4	5.5	5.6	3.9	4.3	4.0	2.5	2.5	2.6	3.7	4.1	3.1	2.5	2.5	1,1
15–17 years																		
All	59.9	38.8	55.7	67.6	54.9	72.2	69.7	67.8	75.6	51.5	46.5	39.6	41.7	43.7	27.9	38.7	36.7	37,8
Male	37.9	23.1	40.0	28.8	25.5	34.5	25.3	35.3	29.0	70.1	59.3	47.4	58.6	50.9	36.9	49.4	46.1	60,9
Female	82.7	75.9	71.9	107.8	85.5	111.4	115.8	101.6	124.2	32.3	33.3	31.6	24.1	36.1	18.6	27.6	26.8	13,6
18–19 years																		
All	163.0	150.6	176.1	166.7	179.3	157.3	155.4	165.2	133.0	199.0	162.2	135.6	138.3	134.5	104.3	100.5	96.3	95,5
Male	155.1	138.4	132.9	135.1	139.4	109.5	122.8	138.7	99.3	308.7	229.8	197.3	199.7	218.4	162.8	174.2	159.5	156,3
Female	171.2	163.1	220.6	199.5	220.5	206.6	189.2	192.7	168.0	85.6	92.6	72.1	74.6	47.9	43.8	24.1	30.6	32,5

Table 15 summarizes progress on recommendations.

Table 15. Priority 3: sexual and RH of adolescents and young people – summary of NRHS provisions and findings

NRHS provisions	Findings
Updating of legislative and normative framework	
Develop a national concept of YFHS	Accomplished
Setting up YFHS in each district/ municipality	Accomplished
Implementing family-life education within the higher secondary education school curriculum	Sporadic and unsystematic

NRHS provisions	Findings
Accessibility and quality of services	
Providing youth-friendly and affordable services to meet their sexual and reproductive needs, including: • providing information and education in RH • counselling of adolescents in gender equality and relations • advocating for responsible sexual behaviours • preventing violence against adolescents • preparing for family life and responsible planning of childbirth • averting unwanted pregnancy, STI and HIV These services shall provide for and secure the right of adolescents to privacy, confidentiality and informed consent	Accomplished
Sharing information, counselling and delivery of STI prevention and RH services to sexually active adolescents	Accomplished
Making sure that specific support is provided to pregnant adolescents by family, service providers and communities throughout the pregnancy, childbirth and postpartum periods	Accomplished. Rooms have established working links with child protection services
Special focus on vulnerable and disadvantaged young people	Accomplished
Integrating prevention, counselling, diagnostic, treatment, information, education and communication activities into YFHS	Accomplished
Training of health service providers	
Drafting methodological/training guidelines for the sexual and RH of adolescents and young people	Accomplished Guidelines are available on the website
Organizing in-service training seminars for family doctors, obstetricians/gynaecologists, dermatovenereologists and nurses in sexual and RH of adolescents and young people	Accomplished A training course of 25 hours was added in 2014.

NRHS provisions	Findings
Information, education and communication	
Engaging and training those who can provide support to adolescents in responsible sexual and reproductive behaviours, particularly parents and family, communities, schools, the media and peer educators	Partially There are papers on peer education programmes
School education: • advocacy for sexual education in schools, universities and other education facilities • adding education on responsible sexual behaviour issues, gender relations, violence against adolescents, responsible family planning, family life, and prevention of STIs and HIV/AIDS to the curricula at all levels of education	Sexual education is almost non-existent in schools (occasional only)
Engaging parents: • advocating for education programmes targeting parents to provide children with all necessary information on sexual and RH	No papers to this end have been published
Peer to peer: • advocating for peer-to-peer programmes, including seminars, group discussions, artistic works, media publications and radio broadcasts	In progress Youth-friendly rooms have their own volunteers engaged in community work
Getting young people on board: • involving young people in planning, implementation and evaluation of information, education and communication activities • involving them in planning and implementation of YFHS	In progress Youth-friendly rooms have their own volunteers engaged in community work
Health service providers: • involving family doctors and FP room health workers in the sexual and RH education of adolescents and young people	No clearly defined links between YFHS and other PHC facilities exist

NRHS provisions	Findings
The media: • developing and disseminating up-to-date materials through public campaigns/events to inform young people about their sexual and RH	No papers available
Education materials: • drafting and sharing of education and information materials for adolescents and young people	Accomplished
Community involvement: • engaging civil society and public organizations in information, education and communication activities with adolescents and young people	Not possible to assess
Gender equality	
Preparing information and education programmes on sexual and RH for girls and boys Supporting mechanisms for the education and counselling of adolescents in building equitable relationships between genders	Partially accomplished The information/education component is performed in RH rooms, but not in schools
Research and monitoring and evaluation	
Integrating data on sexual and RH of adolescents and young people into the national system for the management of RH data	The network of YFHS has its own monitoring system
Conducting an adolescent/young people's needs assessment study	Accomplished
Undertaking regular studies on sexual and RH of adolescents and young people	No

Conclusions

This is the most successful component of the NRHS, with most of the planned objectives being achieved. Comprehensive interventions dealing with multiple issues, including legal regulations, setting up new services in districts across the country, renovating and providing equipment for all rooms, and promoting staff recruitment and training were carried out. Guidelines have been developed to underpin specific training programmes: initially, these were used in the preparatory

stage but later were integrated within continuing professional education curricula.

YFHCs have links with communities and benefit from groups of volunteers involved in youth education and RH room advocacy. The project has been integrated into the PHC system, and services are reimbursed through the health insurance system, granting recipients access to condoms. A specific feature of this model is the provision of a broad spectrum of services for adolescents and young people rather than just RH services. This may become a good practice example that can be followed by other components of the strategy.

Table 16 summarizes progress on recommendations.

Table 16. Sexual and RH of adolescents and young people: progress on recommendations

Number of recommendations in mid-term review	Number of recommendations partially achieved	Number of recommendations fully achieved
18	7	3

Priority 4. Prevention and management of reproductive tract infections

This priority area aimed to prevent the spread of STIs and HIV infection among the sexually active population by improving: access to prevention, diagnostic and treatment services; medical consultations; diagnostics in RH rooms; and public awareness and education. Interventions aimed to integrate counselling for STI patients into FP and family medicine services, ensuring that at least 75% of the population is aware of, and educated about, STIs and HIV/AIDS and keeping HIV/AIDS incidence at the 2004 level. It also aimed to reduce MTCT of HIV to below 1%.

Data on disease incidence and HIV are shown in Tables 17–19 and Fig. 1.

Table 17. Incidence for selected diseases (per 100 000 people)

Diseases	2005	2006	2007	2008	2009	2010	2011	2012	2013
Syphilis	69.6	68.8	77.3	71.5	69.6	70.3	63.5	64.6	63.7
Gonorrhoea	53.6	50.8	48.8	46.7	42.8	36.0	34.9	31.9	27.2
Trichomoniasis	356.8	345.7	370.2	377.3	414.3	396.9	344.7	312.8	328.1
Chlamydia	92.7	80.4	78.8	105.1	90.4	66.0	99.9	88.4	166.4

Source: National Centre for Health Management *(5)*.

Table 18. Trends in HIV testing of pregnant women (000s) and new cases (absolute)

Indicator	2005	2006	2007	2008	2009	2010	2011	2012	2013
HIV-positive cases among pregnant women (absolute)	71	84	81	83	70	86	80	93	78

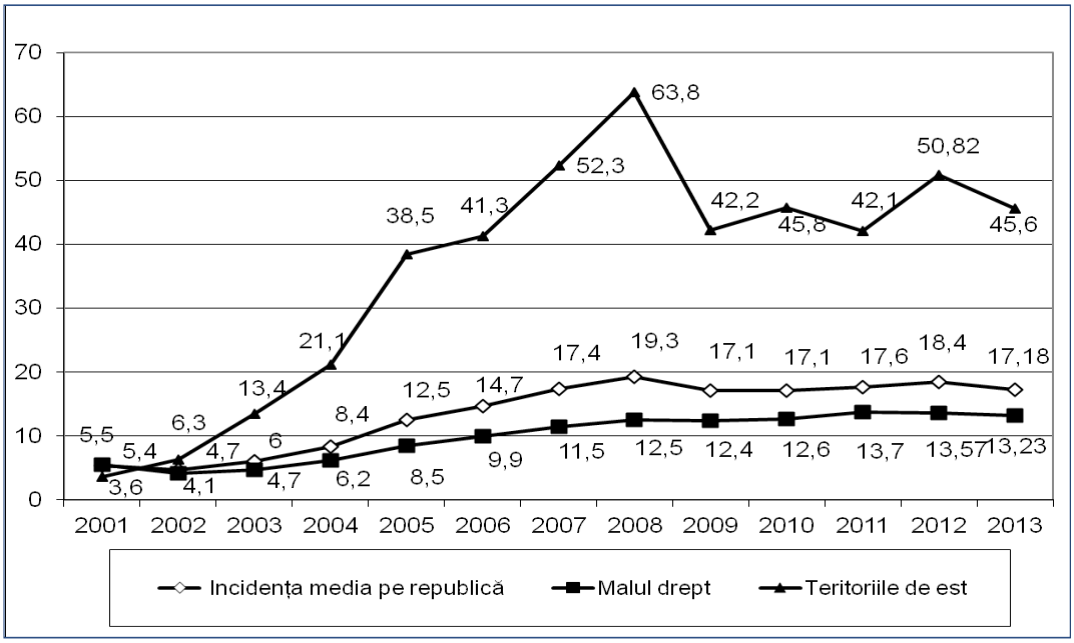
Source: National Public Health Centre *(8)*.

Table 19. Number of HIV-positive women giving birth, by year and MTCT rate

	2005	2006	2007	2008	2009	2010	2011	2012	2013
Number of HIV-positive women giving birth during the year	67	79	86	139	134	143	144	182	151
HIV MTCT rate	17.91	12.66	11.63	7.91	3.73	4.20	4.17	3.3	1.99

Source: National Public Health Centre *(8)*.

Fig. 1. HIV incidence per 100 000 people, 2001–2013 (country average, right bank versus left bank)[a]



[a] Right bank refers to the Republic of Moldova; left bank refers to Transnistria region.

Source: National Public Health Centre *(8)*.

A summary of NRHS provisions and findings is shown in Table 19.

Table 20. Priority 4: prevention and management of reproductive tract infections – summary of NRHS provisions and findings

NRHS provisions	Findings
Updating of legislative and normative framework	
Implementing the diagnosis and treatment of STIs and HIV infection in FP services	There are regulations to this end: • MoH Ordinance No. 425 of 12 October 2006 on the establishment and work of district (municipal) RH rooms and women's health centres
Combining the efforts of FP services and the PHC system in prevention and early diagnosis of STIs and HIV/AIDS	• MoH Ordinance No. 695 of 13 October 2010 on PHC in the Republic of Moldova Low involvement of PHC physicians
Updating the normative framework on prevention and management of STIs and HIV/AIDS in line with WHO recommendations	Accomplished
Adopting and implementing international classification and definitions for STI and HIV diagnosis and treatment	Accomplished
Accessibility and quality of services	
Improving access of the reproductive-age population to STI and HIV prevention, diagnostic and treatment services	Partially accomplished: there is a system for patient referrals to dermatovenereology rooms, but no syndromic therapy is administered in PHC
Developing care protocols for STI and HIV/AIDS patients	Accomplished
Raising the quality of counselling for STI and HIV/AIDS patients	Partially accomplished
Training of health service providers	
Developing methodological and training guidelines for the care provided to STI and HIV/AIDS patients	Accomplished
Organizing training workshops for health workers providing STI and HIV/AIDS prevention, diagnostic and treatment services	Partially accomplished
Information, education and communication	
Developing and sharing information materials with the reproductive-age population regarding STIs and HIV/AIDS protection	Uncoordinated and unsystematic

NRHS provisions	Findings
Involving family doctors involved in counselling STI and HIV/AIDS patients	Not accomplished
Research and monitoring and evaluation	
Conducting studies on a regular basis on STI and HIV/AIDS prevalence in the reproductive-age population	Partially accomplished (in HIV)
Conducting a comprehensive assessment of STI and HIV/AIDS prevention, diagnostic and treatment services	Not accomplished

Conclusions

Following strategy implementation, dermatovenereology services became well established through the Republican Dermatovenereology Dispensary and municipal dermatovenereology dispensaries in Chisinau and Balti. Specialized STI services are provided by dermatovenereologists in district consultative departments, municipalities of Chisinau and Balti, and in the Republican Dermatovenereology Dispensary. Some support for STI care is also provided by other physicians, such as obstetricians/gynaecologists, urologists and family doctors.

Excellent results have been reported in reducing the mother-to-child transmission rate of HIV infection, from 17.99% in 2004 to 1.99% in 2013. Remarkable progress has also been achieved in securing services for pregnant women and providing counselling/testing and anteretroviral therapy for HIV-positive women and newborns.

The final evaluation of the NRHS revealed that this priority has built on findings and recommendations from the mid-tern review that were not put into practice in relation to integrating STI and HIV services in the RH system, reviewing the regulations allowing for anonymous STI testing, using rapid tests and applying syndromic management of cases (particularly for high-risk groups) at PHC level. No funding mechanisms were devised to ensure free-of-charge STI treatment for people in high-risk groups who have health insurance policy.

The 75% target set for knowledge about HIV/AIDS and STIs for the reproductive-age population was not achieved due to the sporadic and inconsistent nature of information, education and communication efforts.

Table 20 summarizes progress on recommendations.

Table 21. Prevention and management of reproductive tract infections: progress on recommendations

Number of recommendations in mid-term review	Number of recommendations partially achieved	Number of recommendations fully achieved
12	2	0

Priority 5. Abortion and pregnancy termination services

This priority area aimed to reduce the use of abortion as a birth-control method and make abortion safe. Its specific objectives were to reduce morbidity and mortality from abortion complications and overall and repeated abortion rates, raise the quality of pregnancy termination services by implementing new methods recommended by WHO, and integrate and improve access to safe abortion services within other RH services.

The NRHS set out to conduct an abortion assessment based on a WHO methodology and ensure higher levels of public awareness and education about abortion. It resulted in:

- an abortion rate below 15 per 1000 reproductive-age women;
- fewer post-abortion complications;
- averted maternal deaths due to abortion complications; and
- post-abortion counselling to ensure more than 70% of patients discharged from abortion facilities had selected a contraceptive.

Tables 21–24 show various data about abortion.

Table 22. Evolution of abortion rates per 1 000 reproductive-age females

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Abortion rate per 1 000 reproductive-age women	15.8	14.7	15.7	15.8	15.9	14.6	15.0	16.1	15.3	15.1

Source: National Centre for Health Management *(5)*.

Table 23. Proportion of abortions in the 15–19 age group (%)

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Proportion of abortions in the 15-19 age group (%)	10.7	9.5	9.4	9.0	8.9	8.4	10.3	9.1	11.2	9.3	8.6

Source: National Centre for Health Management *(5)*.

Table 24. Number of abortions per 1 000 women in the 15–19 age group

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Number of abortions per 1 000 women, 15–19 years	9.0	9.0	8.0	9.0	8.0	10.0	10.0	13.0	11.0	10.5

Source: National Centre for Health Management *(5)*.

Table 25. Abortion rate in under-15s age group (absolute)

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Absolute number of abortions before the age of 15	10	14	18	19	26	13	11	9	9	9

Source: National Centre for Health Management *(5)*.

Table 26 summarizes progress on recommendations.

Table 26. Priority 5: abortion and pregnancy termination services – summary of NRHS provisions and findings

NRHS provisions	Findings
Updating of legislative and normative framework	
Reviewing the regulations on termination of pregnancy	Accomplished Final recommendations are in progress and will be inclusive of provisions on medication abortion
Developing clinical guidelines, standards and protocols for abortion care	Partially accomplished The MoH issued Ordinance No. 482 in 2011 to endorse the standards for safe termination of pregnancy in an attempt to unify and bring existing practices in line with European standards and WHO recommendations for safe abortion
Implementing pregnancy termination methods such as manual vacuum aspiration (MVA) and medication abortion	Partially accomplished Health care facilities do not provide MVA equipment to pregnancy termination practitioners – it is either purchased by health workers or not available at all Electric vacuum aspiration (EVA) equipment is either outdated or not used at all The number of abortions performed by dilation and curettage (D&C) has been continuously high, accounting for about 30% of all abortions in 2013
Developing and implementing the accreditation/licensure methodology and criteria for health professionals and health care facilities providing pregnancy termination services	Accomplished in terms of defining the level of health care to perform these specific services
Accessibility and quality of services	
Developing standards of quality, by level of health care, for health care facilities providing abortion services	Accomplished

NRHS provisions	Findings
Implementing MVA and EVA in all health care facilities in the country for termination of pregnancy during first trimester	Partially accomplished In most district centres (except for model centres), termination of pregnancy is still performed in hospital settings (gynaecology wards) and, in most cases, by D&C, consequently not complying with MoH regulations and WHO recommendations Health care facilities do not provide MVA equipment to pregnancy termination practitioners – it is either purchased by health workers or not available at all EVA equipment is either outdated or not used at all MVA and medication abortion are seldom or never performed
Implementing medication abortion in pregnancy termination services	Medication abortion is still available only to women who can afford to meet its high price Price is not regulated, with high cost for pills in pharmacies, so is not affordable to all A significant number of medication abortions are not reported
Implementing the patient-centred care concept in abortion services	Partially accomplished Patients can access quality pregnancy termination services in six model centres only
Making use of pain control methods recommended by WHO: psychological support and verbal reassurance before and during the procedure; paracervical block with lidocaine in abortion during first trimester of pregnancy	Pursuant to report form 13 on termination of pregnancy, paracervical block with lidocaine in abortion during first trimester was performed in about 55% of cases in 2013
Developing standards for prevention, diagnosis, treatment and referral of patients with abortion complications	Accomplished
Training and involving family doctors in pre- and post-abortion counselling	Family doctors are poorly trained and are basically not involved in pre- and post-abortion counselling Patients consequently do not get appropriate pre- and post-abortion counselling

NRHS provisions	Findings
Training of health service providers	
Setting up and implementing an in-service training system for pregnancy termination service providers	Partially accomplished
Training of FP and PHC health workers in pre- and post-abortion counselling	Partially accomplished Gynaecologists from RH rooms have been trained PHC providers (physicians and nurses) have not received training in pre- and post-abortion counselling to date
Information, education and communication	
Organizing and carrying out public education campaigns about abortion in general and unsafe abortion risks in particular on a regular basis	Occasional campaigns, but there is neither a communication strategy nor a clear-cut programme
Developing and making information materials about abortion available to the reproductive-age population	Unsystematic, in particular at the Reproductive Health Training Centre
Research and monitoring and evaluation	
Performing a strategic assessment of abortion services	Accomplished
Setting up a monitoring and evaluation system for pregnancy termination services	Statistical reporting form 13 on termination of pregnancy
Conducting assessments of abortion and its complications on a regular basis	There have been no studies on abortion and its consequences conducted since 2005
Developing and implementing a tracking system for patient feedback concerning pregnancy termination services	Not accomplished

Conclusions

It may be concluded that this component, alongside the priority on adolescents and young people's health, has been successful. Actions taken reflect the NRHS provisions.

Despite considerable efforts being spent on improving access to, and quality of, abortion services, termination of pregnancy is still being performed by D&C in some health care facilities, contrary to MoH provisions and WHO recommendations. Medication abortion is still unaffordable to the general public. In this context, it is important to scale-up the positive experience of outpatient service delivery in model centres countrywide and have more quality service-providing facilities and review

price-setting for services and mechanisms to ensure free-of-charge abortion services, particularly for vulnerable groups.

The mid-term evaluation suggested a review of this component of the NRHS with the definition of new outcomes, as per assessment recommendations. No such NRHS review has been performed.

Table 27 summarizes progress on recommendations.

Table 27. Abortion and pregnancy termination services: progress on recommendations

Number of recommendations in mid-term review	Number of recommendations partially achieved	Number of recommendations fully achieved
13	3	7

Priority 6. Prevention and management of infertility

This priority area aimed at ensuring population access to quality health care services for infertility. Its specific objectives focused on:

- reviewing the normative framework for the management of infertility;
- developing national regulations and standards for management of infertile couples;
- building institutional capacity for modern diagnosis and treatment of infertile couples;
- creating better access to specialized medical services for infertility diagnosis and treatment;
- performing an in-depth analytical applied study to assess the multifaceted issue of infertility in the country; and
- raising public awareness and providing education on prevention of infertility.

Its expected outcomes included better access to, and use of, health care services and heightened awareness of, and education on, infertility prevention for the reproductive-age population.

Table 28 summarizes progress on recommendations.

Table 28. Priority 6: prevention and management of infertility – summary of NRHS provisions and findings

NRHS provisions	Findings
Updating of legislative and normative framework	
Updating the normative framework in the area of infertility	Legal provisions are in place to make sure that infertility management services are operational in public and private sectors Some investigations are paid for by the NHIC
Developing standards for the management of infertile couples	There are no updated standards – existing standards are almost 10 years old – but private clinics usually have their own protocols
Building the capacity of the NCRHMGFP in diagnosis and treatment of infertile couples	The NCRHMGFP benefited from projects providing appropriate equipment and supplies in the beginning only; as soon as the legislation changed, projects focused on the creation of private services
Accessibility and quality of services	
Better access of infertile couples to FP services	Access improved only for couples with health insurance or the money needed to cover the cost of procedures in the private system
Implementing modern technologies for infertility diagnosis and treatment	Available in the private sector only
Training of health service providers	
Developing clinical guidelines and standards for service providers dealing with infertility	Not developed
Organizing training courses in infertility for health service providers	Not organized systematically
Information, education and communication	
Developing and making information materials about infertility available to the public	Occasionally, in particular through projects by private health service providers and traders of specific products
Organizing public-awareness and education campaigns about infertility	Occasionally, in particular through projects by private health service providers and traders of specific products
Research and monitoring and evaluation	
Undertaking studies on infertility on a regular basis	No studies conducted recently

NRHS provisions	Findings
Assessing and tracking infertility at population level	No studies to that end
Setting up a database on infertility	Not set up

Conclusions

The Republic of Moldova has a high infertility incidence (15%) caused mainly by the high incidence of STIs, the significant number of abortions and changing societal attitudes regarding the number of sexual partners. Legal provisions are based on international standards and have been updated to account for rapid technological advances in this area. A system providing services at district level was in place at the beginning of NRHS implementation, but pressure applied by the private sector has led to the concentration of specialized services in the private sector and in the municipality of Chisinau, with fewer investments in medical institutions for first- and second-level referrals and at district level. This limits access both geographically and economically.

The public sector has low interest in developing standards and methodological guidelines and building competences in PHC due to health worker migration to the private sector. Each of the specialized private clinics uses its own protocols. Currently, limited mechanisms are in place to protect patient rights in relation to health care services that are mostly delivered in the private sector.

Table 29 summarizes progress on recommendations.

Table 29. Prevention and management of infertility: progress on recommendations

Number of recommendations in mid-term review	Number of recommendations partially achieved	Number of recommendations fully achieved
20	5	4

Priority 7. Prevention and management of domestic violence and sexual abuse

This priority area was designed to reduce domestic violence and sexual abuse by providing an appropriate legal and normative preventive framework to:

- organize specific services for domestic violence and sexual abuse victims;
- raise public awareness and provide education about domestic violence and sexual abuse;
- set up social support services for families in which parental responsibilities are not fully observed; and
- implement psychological rehabilitation programmes for children who are victims or have witnessed violence and set up counselling services for abusers.

Expected outcomes included higher public awareness and more education about prevention of domestic violence and sexual abuse and fewer cases.

Table 30 summarizes progress on recommendations.

Table 30. Priority 7: prevention and management of domestic violence and sexual abuse – summary of NRHS provisions and findings

NRHS provisions	Findings
Updating of legislative and normative framework	
Updating national legislation on prevention of domestic violence and sexual abuse and protection of victims' interests	Accomplished, but outside of the NRHS Law No. 45–XVI of 1 March 2007 on domestic violence prevention and control (Official Monitor Paper No. 55–56 of 18 March 2008) regulates the legal and organizational setup of domestic violence control and prevention activities and defines health care facilities' duties in this area The national programme for gender equality 2010–2015 (Government Decision No. 933 of 31 December 2009) explicitly stipulates violence and human trafficking as priority areas for interventions (across the eight areas identified) The Department for Gender Equality and Violence Prevention Policies in the Ministry of Labour, Social Protection and Family can develop, advocate and keep track of such policies
Building partnerships between government agencies and civil society	No such documents were identified

NRHS provisions	Findings
Accessibility and quality of services	
Setting up specialized centres for the counselling of domestic violence and sexual abuse victims	Accomplished, pursuant to Law No. 45–XVI A multidisciplinary team works in each district
Getting the FP service involved in the counselling of domestic violence and sexual abuse victims	Training was provided to some of the FP/RH room physicians, but their involvement is sporadic
Training of health service providers	
Developing methodological and training guidelines for the counselling of domestic violence and sexual abuse victims	Not accomplished
Organizing seminars for PHC and FP room physicians and training of specialists from multidisciplinary teams (police officers, social assistants, educators) in counselling and management of domestic violence and sexual abuse victims	Training workshops have been organized under different projects supporting the programme, but aggregated data on participants are missing
Developing a postgraduate curriculum in counselling and support of domestic violence and sexual abuse victims	Not accomplished
Information, education and communication	
Developing and making information materials about prevention of domestic violence and sexual abuse available to the public	Occasionally, in certain projects
Organizing public awareness campaigns on domestic violence and sexual abuse	Occasionally, in certain projects
Gender equality	
Ensuring equal terms and opportunities for women and men in information and education campaigns	There are no gender barriers for access to information and education
Ensuring equal access for women and men to counselling and support services available for domestic violence and sexual abuse victims	There are no gender barriers for access to counselling and support services available for domestic violence and sexual abuse victims
Research and monitoring and evaluation	
Conducting studies on domestic violence and sexual abuse	Accomplished outside NRHS

NRHS provisions	Findings
Monitoring and evaluating the phenomenon of domestic violence and sexual abuse	Accomplished outside NRHS
Setting up a database and developing relevant indicators in this area	Accomplished outside NRHS

Conclusions

Domestic violence is a cross-sectoral consideration which, pursuant to Law No. 45–XVI, falls under the purview of the Ministry of Labour, Social Protection and Family. The MoH and health care facilities have clearly defined roles and responsibilities in ensuring access to health services. The NRHS was developed before the law existed: following endorsement of Law No. 45–XVI, it would be important to conduct a review of this priority area and present specific objectives and interventions designed to enforce health care facilities' roles and responsibilities, as prescribed by law.

The mid-term review made an in-depth analysis of developments up to 2009, but existing data suggest that interventions have not focused on the strategic directions outlined in the NRHS, specifically to increase the population's access to specialist counselling services by involving PHC and assuring service quality by developing practical standards and methodological guidelines for integration into health workers' professional education programmes.

Interventions benefited from significant donor support but there is no evidence to substantiate their sustainability in the wake of dwindling international development support funds.

Table 31 summarizes progress on recommendations.

Table 31. Prevention and management of domestic violence and sexual abuse: progress on recommendations

Number of recommendations in mid-term review	Number of recommendations partially achieved	Number of recommendations fully achieved
10	4	0

Priority 8. Prevention of human trafficking

Specific objectives for this priority included: providing an appropriate normative framework to combat human trafficking and ensure social support and health care

for victims; organizing specific services for victims; and raising public awareness and education about combating human trafficking. Expected outcomes included heightened public awareness and more education about the human trafficking phenomenon and its consequences and fewer victims.

Table 32 summarizes progress on recommendations.

Table 32. Priority 8: prevention of human trafficking – summary of NRHS provisions and findings

NRHS provisions	Findings
Updating of legislative and normative framework	
Updating the normative framework on the combating of human trafficking and support for victims	Partially accomplished. Law No. 241–XVI of 20 October 2005 on prevention and combating of human trafficking established a national committee to fight against human trafficking (Article 8) Other strategic measures in this area include: • a strategy for a national referral system to protect and support the victims and potential victims of human trafficking 2009–2011, and its accompanying action plan (Government Decision No. 257 of 5 December 2008); and • a national programme on gender equality 2010–2015 (Government Decision No. 933 of 31 December 2009), explicitly stipulating the issue of violence and human trafficking as priority areas for intervention (among eight such priorities) There are no regulations to secure victims' access to health services
Building partnerships between government entities and civil society to fight human trafficking	Partially accomplished, based on projects
Accessibility and quality of services	
Developing specialized care centres for human trafficking victims	Accomplished, but their financing is contingent on foreign donor funding

NRHS provisions	Findings
Engaging FP room physicians, family doctors and social assistants in counselling and care for human trafficking victims	Not accomplished
Training of health service providers	
Developing methodological and training guidelines in counselling and care for human trafficking victims	Not accomplished
Carrying out workshops for training FP room physicians and family doctors in counselling of human trafficking victims	Not accomplished
Developing a postgraduate curriculum for physicians in counselling and care for human trafficking victims	Not accomplished
Information, education and communication	
Developing and making information materials about prevention of human trafficking available to various social strata	Occasionally, in projects There is no evidence of a centralized approach being adopted
Organizing and carrying out public awareness campaigns about the human trafficking phenomenon	Occasionally, in projects There is no evidence of a centralized approach being adopted
Gender equality	
Ensuring equal access for women and men to information and education about combating human trafficking	There are no barriers to hinder equal access
Ensuring equal access for female and male victims of human trafficking to relevant care and support services	There are no barriers to hinder equal access
Research and monitoring and evaluation	
Conducting studies on human trafficking on a regular basis	Yes, but outside of the NRHS
Monitoring and evaluating the human trafficking phenomenon at national level	Yes, but outside of the NRHS
Setting up a database and developing relevant indicators for human trafficking	Yes, but outside of the NRHS

Conclusions

As is the case with domestic violence and sexual abuse, human trafficking is a comprehensive and cross-sectoral issue at the borderline of several areas of work. It is

likely that Law No. 241–XVI of 2005 was not enacted at the time the NRHS was developed. Enactment was supposed to be followed by a review of the relevant chapter of the NRHS to align its content to the provisions of the law regarding roles and responsibilities of the MoH and health care facilities. A thorough analysis of those two areas was conducted during the mid-term review, which recommended the development of an action plan for the two components.

Of the specific interventions suggested, training of some FP room physicians in counselling of human trafficking victims and ensuring access to health services were the only ones (partially) accomplished (more than five years ago). Training was limited to individuals from multidisciplinary teams working in district towns, but were never scaled-up to include other PHC physicians and nurses or any additional category of health workers in multidisciplinary teams after project closure.

Access to health services is limited because victims often lack IDs or are displaced from their place of residence, which makes it impossible for them even to access PHC services.

Table 33 summarizes progress on recommendations.

Table 33. Prevention of human trafficking: progress on recommendations

Number of recommendations in mid-term review	Number of recommendations partially achieved	Number of recommendations fully achieved
10	4	0

Priority 9. Early detection and management of breast and cervical cancer

Specific objectives of this priority included:

- updating the normative framework for early diagnosis of cervical and breast cancer;
- finalizing the development and endorsement of the national cancer programme 2005–2010;
- creating better public access to diagnosis and prevention of breast and cervical cancer;
- performing cytological screening to detect precancerous processes and cervical cancer;
- training health service providers in early detection of cervical and breast cancer;
- training obstetricians/gynaecologists and midwives from rural settings in how to properly perform a Papanicolaou (Pap) smear on the cervix and endocervical canal for cytological investigation;

- developing a modern concept for public information and education in breast and cervical cancer;
- promoting primary and secondary female reproductive tract cancer-prevention actions through the media;
- developing brochures and leaflets on methods of early detection of cervical and breast cancer; and
- engaging the public at large in actively fighting cervical and breast cancer.

It resulted in higher public awareness and education about fighting breast and cervical cancer, with over 25% of cervical cancer detected in stage 0 and over 45% in stage I–II.

Table 34 shows cancer morbidity by site and year per 100 000 population and Fig. 2 rates of cervical cancer.

Table 34. Cancer morbidity by site and year per 100 000 population[a]

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Breast cancer	45.9	41.8	47.8	40.0	47.8	47.6	44.3	47.8	46.5	51.8
Cervical/ uterine/ placenta cancer	26.9	29.5	29.2	29.9	29.4	30.2	27.7	34.1	31.2	31.5
Prostate	10.9	10.7	11.4	12.9	14.2	14.5	16.8	16.8	18.9	22.7

[a] Starting from 2004, data are not inclusive of the left bank and municipality of Bender.

Source: National Bureau of Statistics *(7)*.

Fig. 2 Cervical cancer

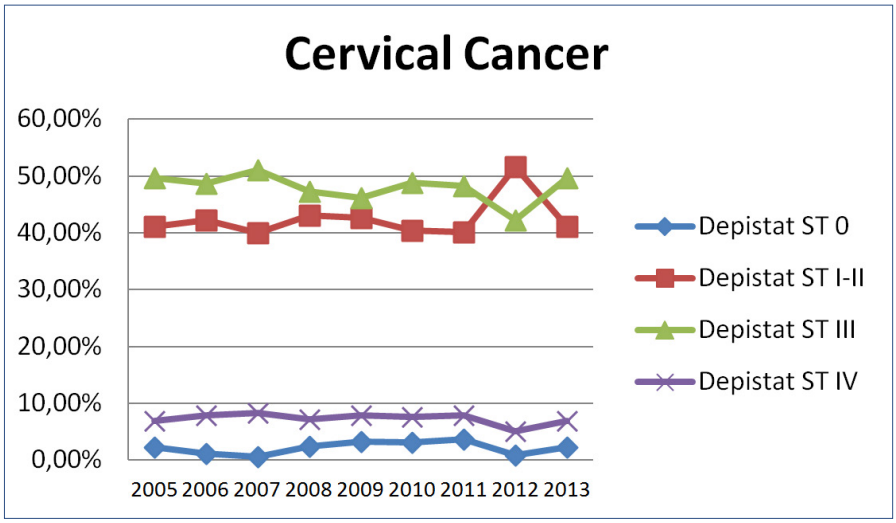


Table 35 summarizes progress on recommendations.

Table 35. Priority 9: early detection and management of breast and cervical cancer – summary of NRHS provisions and findings

NRHS provisions	Findings
Updating of legislative and normative framework	
Developing a national concept for early detection of breast and cervical cancer	Breast and cervical cancer is part of the national cancer programme
Providing cervical cancer screening for women	Part of the national cancer programme
Accessibility and quality of services	
Performing cervical and breast cancer screening in women within the PHC system	Each district town has a specialized room for prophylactic check-ups, with facilities to collect and transport biological samples, but no sampling is done in rural settings
Engaging FP room physicians in early detection of breast and cervical cancer	Not accomplished The two networks of services (cancer and RH) are not integrated in one operational system
Training of health service providers	
Developing methodological and training guidelines for diagnosis of breast and cervical cancer	Accomplished
Organizing workshops for the training of FP room physicians and family doctors in counselling, early detection and management of breast and cervical cancer patients	Continuing education of health workers from the network of preventive check-up rooms is provided each year, which does not cover health workers from FP rooms and family doctors
Information, education and communication	
Developing and making publicly available information materials about prevention of breast and cervical cancer	Occasionally
Organizing and carrying out public awareness campaigns about breast and cervical cancer prevention	No sustained campaigns have been organized
Research and monitoring and evaluation	
Updating the national registry of breast and cervical cancer	Accomplished
Conducting research studies on breast and cervical cancer on a regular basis	No reports were identified

Conclusions

Cancer services are delivered by a specialized network reaching down to district town level. The MoH runs a national cancer programme developed independently of the NRHS and coordinated by the Oncology Institute. Current efforts are focusing on developing actions and interventions for the next five years, with technical support from WHO. The biggest challenge in this priority area is the high proportion of late diagnosis in advanced stages.

The specialized network has an internal programme in place to update the knowledge of health staff in addition to formal continuing education activity. Monitoring indicators are analysed on a regular basis and findings are reported back to regional providers. Key challenges being faced by the network include understaffing of specialist workers, particularly cytology specialists (very few young physicians are interested in this discipline, which involves a lengthy training schedule), and low preventive care and early detection-seeking behaviours of the population (such as accessing the human papillomavirus vaccine, screening by mammography and cytological investigation) as a result of low public awareness and education about breast and cervical cancer issues.

Significant efforts have been made over time to increase the proportion of cases diagnosed early, but they seem to have been unsuccessful. Detection of stage III and IV breast cancer dropped from 43.31% in 2006 to 34.67% in 2013, but at the expense of more cases being diagnosed in stages I and II (55.23% in 2006 versus 63.26% in 2013). There was a minor increase in the detection of stage 0 cancer – from 1.46% in 2006 to 2.06% in 2013. For cervical cancer, detection of stage III and IV basically did not change much – 56.53% in 2006 against 56.62% in 2013 – and has been over 50% in all years except 2012 (47.44%).

A status report was developed during the mid-term review. Despite significant concerns, no processes to solve problems were documented. Actions taken to date have been driven mostly by referring women to existing services, at times even as a mandatory measure, rather than tailoring services to women's needs and bringing services closer to them in the communities in which they live. No community mobilization measures have been reported to top-up insufficient funding of the health system, particularly in terms of public awareness and education.

A strategy for noncommunicable diseases for 2012–2021 has been enacted by the Parliament.

Table 36 summarizes progress on recommendations.

Table 36. Early detection and management of breast and cervical cancer: progress on recommendations

Number of recommendations in mid-term review	Number of recommendations partially achieved	Number of recommendations fully achieved
14	6	5

Priority 10. Sexual health of older people

This priority aimed specifically to increase access to sexual health services for older men and women, encourage their care-seeking behaviours and raise their awareness and education about sexual health. Expected outcomes included 60% and above of older people being aware of sexual health issues and specific older people's counselling services for sex-related issues being set up all over the country.

Table 37 summarizes progress on recommendations.

Table 37. Priority 10: sexual health of older people – summary of NRHS provisions and findings

NRHS provisions	Findings
Updating of legislative and normative framework	
Developing and approving regulations on the provision of health care for older people in sexual health issues	No relevant papers identified
Integrating sexual health care for older people into RH services	No specific documents identified
Accessibility and quality of services	
Improving older people's access to RH services	No progress from the mid-term review findings could be identified Like any other age group, older people benefit from PHC free of charge under the health insurance system, with insured people being granted access to specialist consultations by gynaecologists or andrologists (there are only eight physicians specializing in andrology in the country) Hormone replacement therapy drugs are not included in the list of pharmaceuticals reimbursable from the NHIC

Engaging FP room physicians and family doctors in counselling older people with sexual health issues	Physicians from the FP/RH rooms who had training in 2008 benefited from a special module on sexual health of older people, but no such training has been offered since then Health workers may access up-to-date information through various events supported by the pharmaceutical industry when launching new products for sexual health issues
Developing health care standards for sexual and endocrine disorders in older people	No papers identified
Training of health service providers	
Developing methodological and training guidelines for the management of older people with endocrine and sexual disorders	A protocol for the management of menopause and premenopause is in place, but there was no evidence of integration into medical students' and residents' training curricula
Organizing workshops for the training of health workers providing services to older people with sexual health issues	No documents found to that end
Information, education and communication	
Developing and making information materials about sexual health available to older people	No data identified to that end Pharmaceutical companies develop information materials about specific products being marketed
Organizing and delivering public awareness campaigns about sexual health of older people	No documents found to that end
Research and monitoring and evaluation	
Conducting studies on the sexual health of older people on a regular basis	Not conducted

Conclusions

The final review of the NRHS fully concurs with the mid-term review conclusions. No actions have been taken to reach the planned objectives, no data are available to allow an evaluation of whether sexual health services for older people are in place, and no data on awareness and education activities in this area are available. The final review concurs with the mid-term review team's view that sexual health care soliciting by older people is increasing, but that this is not being driven by the impact

of interventions carried out under the strategy: rather, it is the result of better public access to health care services generally following the implementation of mandatory health insurance.

Table 38 summarizes progress on recommendations.

Table 38. Sexual health of older people: progress on recommendations

Number of recommendations in mid-term review	Number of recommendations partially achieved	Number of recommendations fully achieved
4	0	0

Priority 11. Sexual and RH of men

The goal of this priority area was to improve the sexual and RH of men and their active involvement in FP. The purpose was to:

- raise men's awareness of FP and protection of RH
- improve access to FP/RH and increase men's care-seeking behaviours
- help men to participate actively in FP decision-making.

Expected outcomes included over 70% of men being more aware of protecting their sexual and RH, and provision of sexual and RH counselling to men in all FP services across the country.

Table 39 summarizes progress on recommendations.

Table 39. Priority 11: sexual and RH of men – summary of NRHS provisions and findings

NRHS provisions	Findings
Updating of legislative and normative framework	
Restructuring the FP service to include counselling for men	This component was not reviewed
Developing standards for counselling men in FP rooms	Not developed
Accessibility and quality of services	

Providing men with health care services that are friendly, accessible and focused on their unmet needs and wh include: • prevention, screening for and treatment of STIs, including HIV/AIDS • counselling on FP and contraceptive means • diagnosis and treatment of infertility • counselling and treatment of sexual disorders • screening for genitourinary cancer • facilitating men's participation in couple-counselling on contraception	Specialized services are provided by andrologists (there are about eight physicians specialized in andrology), most of whom work in Chisinau Services could also be provided by urologists Specialized services delivered in the private sector have prospered recently Initial consultations in the PHC are accessible to all under the health insurance scheme, while specialist consultations, investigations and surgery are funded by the NHIC only for those who are insured
Implementing vasectomy as an elective contraceptive method for couples who have met their reproductive needs	Regulations on the performance of vasectomy were updated in 2011, outlining the criteria, indications, contraindications and health workers who can perform the procedure
Advocating for education and counselling of boys within YFHS	Integrated
Training of health service providers	
Developing methodological and training guidelines for FP service providers on counselling and communication with men	Not developed
Training of FP room and YFHC workers in counselling for men	Not carried out Specialist services for men are delivered by andrologists (who have additional specialization following training in urology) or urologists Special counselling courses are included in the additional specialization curriculum only
Organizing workshops for the training of family doctors, obstetricians/gynaecologists, dermatovenereologists and nurses in counselling for men	Training can be of several kinds: • for medical students – optional course in sexual medicine during year V (20 hours) • residents of obstetrics/gynaecology – two months of andrology plus an option (20 hours) • in-service education – one course in sexology (50 hours) and two in erectile dysfunction (75 hours) for urologists, endocrinologists and andrologists
Information, education and communication	
Developing and making information materials (leaflets, posters) about FP available to men	Occasionally, with no evidence at central level

Getting public organizations and the media involved in sexual education of men	Occasionally, with no evidence at central level
Organizing education and awareness campaigns aiming at: • encouraging couples to communicate • making joint decisions on reproductive options and planning a child • increasing the role of men in prevention of STIs and unwanted pregnancy • increasing the role and accountability of men during pregnancy, childbirth and after delivery • preventing and reducing domestic violence in men	Occasionally, with no evidence at central level
Research and monitoring and evaluation	
Assessing the RH-related knowledge, attitudes and practices of men	No assessments conducted since 2005
Developing a monitoring and evaluation system for male contraception and men's RH	Not developed

Conclusions

Legal regulations pose no barriers to men accessing sexual and RH services, except for the limitations imposed by health insurance. Access to specialist services improved as a result of a market-economy approach that prompted the development of private services in this area. Their location, mostly in the municipality of Chisinau, and their service-delivery approach that focuses exclusively on secondary and tertiary health care facilities, are nevertheless significant barriers.

The NRHS emphasized service delivery at PHC level, which is accessible to all people and now has better geographic coverage, but it failed to produce any noteworthy results. No training has been organized for PHC physicians and nurses, apart from in-service education courses that have less appeal to PHC staff located in areas at distance from Chisinau. Apart from RH/FP physicians who were trained in 2008 and workers from YFHC, other PHC professionals lack training in RH counselling in general and in men's health-related issues specifically. Provisions under the NRHS do not seem to have had any impact on the development of services in this area, and no significant progress was reported in relation to public awareness and education. It may be concluded that sexual and RH of men was not a priority.

Table 40 summarizes progress on recommendations.

Table 40. Sexual and RH of men: progress on recommendations

Number of recommendations in mid-term review	Number of recommendations partially achieved	Number of recommendations fully achieved
9	2	1

Financial resources

The health budget is set by the Law on the State Budget. The country spent 9.9% of its gross domestic product (GDP) on health in 2013, accounting for a significantly higher share than the average 7.6% earmarked for health in the 27 European Union Member States. Health spending by GDP between 2002 and 2013 is shown in Table 41.

Table 41. Health spending by GDP, 2002–2013

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Health spending, total (% of GDP)	8.1	8.3	8.5	9.2	10.6	10.9	11.4	12.5	11.7	11.4	11.7	9.9

The NHIC and state budget comprise the two sources of funding for public health costs. Mandatory health insurance fund premiums come from employee payrolls, transfers from the state budget to 15 categories of unemployed recipients and direct payments by individuals who self-insure. Private health system developments have resulted in user fees becoming a significant source of health sector funding, accounting for 41% of all health expenditure.

Mandatory health insurance covers the treatment costs of patients during hospital stays and in specialist outpatient services and for a limited number of pharmaceuticals for outpatient treatment, making up the basic package of health services. Policy-holders may benefit from partially compensated drug costs, while those without insurance do not have such an option. Emergency health care and PHC services are free of charge, irrespective of health insurance status.

The country received significant donor funds during the reporting period. A review of the official development assistance reports produced by the MoH with WHO support *(1,2)* shows that the biggest share of donor funding in 2013 (73.1%) was for communicable diseases, followed by mother and child health and RH (15.1%), then adolescent health (3.6%) *(2)*.Table 41 shows the development partners involved in RH between 2012 and 2013.

Table 42. RH partners, 2012/2013

Year	Programme	Development partner
2012	Mother and child health, young people's health	SDC,[a] TIKA,[b] UNFPA,[c] UNICEF,[d] WHO
2013	National RH strategy 2005–2015	WHO, SDC,[a] UNFPA,[c] UNICEF,[d] Government of Estonia
2013	National HIV/STI programme 2011–2015	WHO, GFATM,[e] UNODC,[f] UNDP,[g] UNAIDS,[h] UNFPA,[c] UNICEF,[d] CoEi

Scrutiny of the number of partners who have either been involved in recent years or have declared an intention to do so in the future reveals a significant reduction in foreign support. This poses huge challenges to ensuring access to, and quality of, RH services and prioritizing actions to those proven to be cost–effective. Official development assistance funds topped up total public spending on health by 17% in 2013: the top priority was communicable diseases, meaning mother and child health, RH and young people's health were considered less of a priority. Table 42 shows the diminution in donor support for mother and child health and young people's health between 2013 and 2015.

Table 43. Donor support for mother and child health and young people's health, 2013–2015

Year	Donors
2013	TIKA,[a] UNICEF,[b] UNFPA,[c] WHO
2014	UNICEF,[b] UNFPA,[c] WHO
2015	UNFPA,[c] WHO

General conclusions

Important achievements in improving the RH status of the population and observing their sexual and reproductive rights were reported between 2005 and 2014. Updating the legal framework was **relevant** to NRHS implementation, laying down the prerequisites for the accomplishment of its objectives.

Actions taken to improve population access to services include the following:

- several RH services were structured by specialty (perinatal care services, cancer services, RH services);
- FP services were integrated within PHC;
- YFHC were set up at district town level;
- a system of material incentives was put in place for family doctors to register women early in pregnancy (first trimester);
- services for the early detection of cervical cancer were developed by setting up preventive cancer control rooms at district town level for sampling and transporting samples to cytology laboratories; and
- legal provisions were updated to allow for the development of RH services provided in private settings (infertility services, maternities for physiological births and caesarean sections, the provision of pregnancy termination services upon request and andrological care).

The quality of services has been improved by:

- enforcing methodological guidelines through MoH ordinances (14 RH-related guidelines have been developed); and
- enforcing a quality assurance system for health care services by establishing and running quality councils in each health care facility and a coordination entity at MoH level (the National Council for Health Evaluation and Accreditation).

The legal framework in place was therefore also **efficient** in that it delivered the prerequisites for achieving the expected outcomes and enforcing the strategy, but no monitoring systems were developed to keep track of implementation.

Service accessibility

A key goal of the strategy was to improve public access to RH services, with a primary focus on their integration into PHC. The aim was therefore to bring services closer

to users, while ensuring integrated services at PHC level that would be accessible to the whole population irrespective of health insurance status.

The foundation for this approach should have been the building of new professional competences among the PHC workforce, defining a division of responsibilities for quality assurance and ensuring effective patient referral systems. This component of the strategy fared less well.

Strengthening secondary health care was the goal of all priority areas and was largely accomplished. No significant progress has been reported, however, at PHC level and in service integration. Services remain fragmented, reacting to standalone health problems for which patients are seeking care and lacking a comprehensive approach to RH, resulting in poor quality. The view that RH falls under the purview of obstetrics/gynaecology for women and andrology for men continues to prevail.

This situation is restricting population access to services, as health professionals in these disciplines have rooms only in urban areas and their services are accessible only to insurance policy-holders. Specialized service delivery PHC units in rural village settings by visiting specialists is neither cost–efficient nor sustainable in the light of growing financial pressure on the health insurance system. It was not designed to bring services, which remain firmly rooted in urban settings, closer to users. Overuse of medication and excessive specialization has resulted in services further concentrating at municipal level, particularly in Chisinau, reflecting the way integration of services into PHC was defined and the lack of a specific action plan and effective coordination mechanism to oversee strategy implementation.

Of all the groups with special needs identified in the strategy, only adolescents and young people received heightened attention. A network of friendly services has been developed for them in district towns. Victims of domestic violence and human trafficking were the primary target groups of strategies developed at a later stage and coordinated by the Ministry of Labour, Social Protection and Family. The NRHS was neither revised nor adjusted, however, to meet the new requirements for roles assigned to the MoH and health care facilities. For the time being, health care for these population groups is provided through international donor projects, but ensuring their sustainability will be a big challenge further down the road.

Men and older people benefited from no targeted interventions.

Quality of services

A framework for service quality assurance has been developed and an institutional framework is in place, represented by quality councils in all health care facilities. Evidence-based standards, guidelines and protocols in line with international requirements have been developed, but enforcement mechanisms are insufficient, action plans for implementing the guidelines are lacking and monitoring of compliance is inadequate.

Alignment of health staff pre-service and in-service education curricula with the new requirements defined in the guidelines is inconsistent, and the MoH's ability to step in is limited, given the autonomy of universities. The lack of a strategy implementation plan means it was not possible to coordinate the health staff training component and education curricula could not be aligned with the professional qualifications inherent to the strategy. In addition, training programmes have not been driven by health worker training needs assessments, and training of health workers has varied considerably across the priority areas. Neither family doctors nor any other professionals involved in RH delivery have been trained in integrated RH service delivery.

Public awareness and education

This is one of the NRHS areas that saw least achievements. Investments dropped over time. Basically, no public awareness and education campaigns have been carried out in recent years, although occasional actions have been taken within some small-scale projects. Young people have limited access to information and education. The school education curriculum has been facing important challenges, and the Ministry of Education has undertaken some new steps to address this in recent times. Even if health education is yet to become a mandatory subject, it is available in schools as an optional course, and some topics are covered during class hours or as extracurricular activities.

Research and monitoring and evaluation

This area got least attention of all. Some qualitative research on young people was done, but the MICS survey in 2012 *(4)* is the only piece of work carried out to try and assess the reality of people's lives, and its findings have not yet been validated. Monitoring and evaluation was addressed as part of some specific projects, but not as a component of strategy implementation: in the absence of an action plan, no monitoring plan was developed.

The absence of a coordination mechanism means that data collected by the National Centre for Health Management have not been analysed. The mid-term review of the NRHS was performed in 2010, but with no follow-up on recommendations. The establishment of an e-health system nevertheless provides opportunities for an effective monitoring and evaluation system in future.

Recommendations

The analysis of findings under the NRHS 2005–2015 review shows significant achievements, but it is clear that efforts commenced in each of the 11 priority areas need to be continued. Key issues for consideration include:

- better RH indicators on:
    - maternal mortality
    - perinatal mortality and morbidity
    - the abortion rate
    - use of modern contraception
    - incidence of STIs and HIV infection
    - genital cancers (in men and women);
- better access to RH (services and commodities), particularly for certain groups (rural residents, socially vulnerable individuals, older people, men and those with disabilities, for example);
- services that are user-centred and of higher quality through implementing existing regulations and developing systems to track compliance with regulations on service quality;
- training for health workers of all professional categories at undergraduate, postgraduate and in-service education levels, aligned with developed standards and guidelines; and
- better public awareness and education through a coherent, coordinated and consistent approach.

Before starting the process of developing a new strategy on sexuality and RH, it is important to complete an inventory of all RH-relevant strategies. Several that have been developed and approved recently or are being endorsed have sexual and RH components. The most important are:

1. National Health Policy, Government Decision No. 886 of 6 August 2007;
2. Health System Development Strategy 2008–2017, Government Decision No. 1471 of 24 December 2007;
3. National Strategy on Migration and Asylum (2011–2020), Government Decision No. 655 of 8 September 2011;

4. National Strategy for Prevention and Control of Noncommunicable Diseases 2012–2020, Government Decision No. 82 of 12 April 2012;

5. National Public Health Strategy 2014–2020, Government Decision No. 1032 of 20 December 2013;

6. Strategy of the National Referral System for Protection and Assistance of Victims and Potential Victims of Trafficking (Annex 1, Parliament Decision No. 257 of 5 December 2008); and

7. Sector Development Strategy 2012–2020.

Work in progress and pending approval include:

8. Youth Sector Development Strategy 2014–2020

9. Child and Adolescent Health, Development and Welfare Strategy 2014–2020.

National programmes have also addresse some of the issues relevant to the NRHS 2005–2015, such as breast and cervical cancer.

In this context, the following options may be considered.

- A new medium-term (five years) or long-term (10–15 years) sexual and RH strategy structured similar to that of 2005–2015 could be developed, including an action plan for 1–3 years with annual targets and specific actions. The challenge would be to ensure coordination with similar issues from other strategies, in particular across teams responsible for targets under different strategies. It would be important that in the domestic violence and human trafficking areas, the focus would be on RH. Overlaps are not only costly, but also run contrary to existing legal provisions.

- An umbrella policy paper for the entire area of sexual and RH, covering existing and emerging strategies and programmes to provide a platform for drafting new approaches to as-yet unidentified priorities, could be developed. Such a paper would define measurable objectives and outcomes in all strategies (this would mean revisiting the objectives and outcomes of existing strategies and reviewing emerging ones prior to endorsement) and would develop or review new chapters specific to sexuality and RH in other relevant strategies (such as that to fight domestic violence and human trafficking). The paper would make it mandatory to develop indicators for objectives and outcomes and monitoring systems to observe compliance.
- A new RH strategy could be developed to focus only on topics not addressed in the other existing or developing strategies – RH of men and sexual health of older people, for example.

Irrespective of the approach adopted or type of document developed, it is paramount to develop specific implementation plans with annual targets, indicators and monitoring and evaluation plans. Coordination, cost–efficiency and sustainability will be the issues that govern this process.

The most important recommendation of this review is that a strategic approach to responding to needs be adopted as a first step, rather than developing a new paper on RH in the Republic of Moldova. The strategic approach should be based on a participatory process and reflect the real needs identified by assessments; decisions should be made within available resources.

The recommendation is for a multistage approach within a participatory process that involves representatives of all stakeholders, government and nongovernmental entities, the private sector, recipients and all types of providers, with a special focus on those from the regions. The stages would be as follows.

- The first stage would involve identifying and discussing current sexual and RH needs (all needs, no matter whether they are part of ongoing or planned strategies or not).
- The second step would be to identify all legal issues related to the needs that are embedded in other strategies or programmes to outline and define any unmet needs.
- At the next stage, identified unmet needs would be prioritized and grouped into four categories:
    1. needs to be covered with national budget funds;
    2. those for which it is planned to fund-raise from known international sources;
    3. needs to be considered if as-yet unidentified additional funding becomes available; and
    4. those for which no funding is foreseen to deal with the problem.
- The next step would be to cost the identified needs.
- National and international resources would then need to be realistically earmarked for the next five years (the duration may vary depending on the planning period).
- Depending on the amounts anticipated, needs to be financed from the national budget, those that require fund-raising from known funding sources and those to be met in the future once additional funding becomes available outside of current financial provision would be confirmed.

Once these issues have been addressed, the papers needed to implement the provisions and in what way could be considered.

This type of strategic approach represents an ongoing process that reflects the constant changes in society under the influence of a great variety of factors. Some or all steps would be taken when significant changes to the social or economic context occurred.

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Annex 1

Progress status in implementing the mid-term review recommendations of 2010

1. Family planning		
1.	Publish the report on the assessment of RH services conducted at the end of 2007	No
2.	Make copies of WHO's decision-making tool for health care providers in FP and contraception and distribute it all over the country. In the meantime, consider making it available in Romanian	No
3.	Publish annual statistics on the use of contraception methods, disaggregated by sex, residence, age groups and social status, to track trends in people's behaviour as regards contraception use, including access for people from the high medical or social risk groups	No
4.	Provide training for physicians/nurses working in RH in delivering the services set out under all of the NRHS priority areas	No
5.	There is a need to conduct a nationwide population-based RH study which should also include data on the quality and use of FP and contraception services	No
2. Making pregnancy safer		
1.	Build up a monitoring and evaluation mechanism to track/assess implementation of the NRHS	No
2.	Follow up rigorously, at all levels, on the compliance and use of guidelines, clinical protocols, MoH ordinances and regulations in the regions	Partially
3.	Review enforcement procedures for the national Medical and Pharmaceutical State University (MPSU) protocols and guidelines, which are not being used	Partially
4.	Update the criteria for the accreditation of antenatal care facilities in line with the provisions set out for perinatal health care as per the national guidelines and protocols	Yes
5.	Expand the range of investigations available to pregnant women at high risk for infections under the basic package of services	No
6.	Expand the package of subsidized drugs prescribed to pregnant women in outpatient settings	No
7.	Centralize procurement of disposable consumables for maternity wards (sterile sets for deliveries, catheters for intravenous drips, diapers for newborns, etc.)	Yes
8.	Retrain midwives in PHC to strengthen RH services (antenatal and postpartum care, FP and screening for reproductive system and breast cancers)	No

9. Centres in rural areas should be staffed with highly qualified health workers: family doctors, neonatology physicians, paediatricians, and obstetricians/gynaecologists	Partially
10. More health care professionals need to be trained to ensure a sufficient number of highly qualified specialists to cover the gaps left by the fleeing of highly qualified health professionals	Partially
11. Managers should provide incentives to highly qualified health care workers working in obstetrics and neonatology in an attempt to reduce the high health care staff turnover rates	No
12. In-service training should be provided for health care workers to provide mothers and children with cost-efficient health care services	Partially
13. Build up the capacity and interpersonal communication skills , in culturally diverse settings, of health care staff working in the maternal and child care system	No
14. Enhance the professionalism and knowledge of antenatal care trainers to improve the training they provide to pregnant women and their families in pregnancy, childbirth, child care, and postpartum issues	Partially
15. Update the curricula of the MPSU and medical colleges (pre-service and in-service education) for quality training of health care providers in maternal and child care services	Partially
16. Make sure that the NHP includes family and community involvement for better maternal health and newborn care	Partially
17. Build up communication channels between perinatal care services and the community	Partially
18. Set up mechanisms to encourage the active participation of mothers and community representatives in improving the quality of perinatal health care services	No
19. Undertake public awareness and community mobilization campaigns on a regular basis to improve the quality of perinatal care services	No
3. Sexual and reproductive health of adolescents and young people	
1. The need to review the wording of objectives and expected outcomes under priority III of the reproductive health strategy	Yes
2. The need to improve the access of adolescents to modern contraception (condoms, contraceptive pills, emergency contraception)	Partially
3. As part of the sexual education programmes for adolescents, include a chapter on developing responsible parenthood skills	No
4. Train health workers in the specifics of the management of pregnancy in adolescent girls, who account for about 10% of the total number of childbirths and 2.4% of the maternal mortality cases over the period 2005–2009	No
5. Improve the access of adolescents and young people to confidential voluntary counselling and testing for HIV and other STIs through the YFHS network, with mobile teams to take testing to extremely vulnerable groups (using rapid tests)	Partially

6.	Provide socially vulnerable adolescents and young peeople with medication required for the syndromic management of RTI/STIs within the above network	No
7.	Bring the national legal and regulatory framework in line with the Convention on the Rights of the Child (acting in the best interest of the child) in terms of parental consent for health interventions, in particular abortions	Partially
8.	Train YFHS network staff in safe abortion provision of services	Partially
9.	Given that tubal infertility is the most common type of infertility, and making allowance for the wide spread of STIs among adolescents, one suggestion would be to run screening programs for *Chlamydia tr.,* in addition to gonorrhoea, among sexually active adolescents to reduce the risk of infertility	No
10.	Include domestic violence and sexual abuse issues in existing LSBE programmes in schools	Partially
11.	Develop and enforce a clear-cut referral system for domestic violence and sexual abuse among children and adolescents, and define the role of the health system	Yes
12.	Train health workers, in particular those working in the YFHS network, in the specifics of care in cases of sexual assault against children and adolescents	Partially
13.	Include human trafficking issues in existing LSBE programmes in schools	Partially
14.	Promote human papilloma virus vaccination among adolescents before sexual debut	No
15.	Develop and implement education programmes for boys to encourage their involvement and responsible decision-making in SRH through all information channels rather than through the YFHS network alone	No
16.	Increase the staffing dedicated by NCRHMGFP for monitoring and evaluation activities	No
17.	Set up a resource centre to promote YFHS within a properly functioning YFHC	Yes
18.	Widen the membership of the National Group for NRHS Implementation Coordination to include the Ministry of Education and NGOs operating in this area	No
4. Prevention and management of RTI, including HIV&AIDS		
1.	Rescind Article 45 of the Law on Health Care No. 411 from 1995	No
2.	Change MoH Ordinance No. 284 to make it more sensitive to human rights (including for most-at-risk populations (MARP)), gender-sensitive, youth-friendly, as well as permitting evidence-based interventions to facilitate the access of MARP to services (syndromic management and counselling at PHC level, rapid tests for STIs, regular preventive treatment for female sex-workers)	No

3. Integration of STI and HIV services into the RH system may be facilitated by: a. accurately defining (following research) vulnerable groups and MARP, as outlined in all components of the RH Strategy; b. regulatory facilitation by the MoH of the transfer of syndromic or semisyndromic STI diagnosis, treatment (for MARP), HIV/STI counselling and referral skills (by using rapid tests for STIs) from specialist physicians to family doctors and RHR staff; and c. aligning performance indicators to the implementation of aggregate indicators for RH services, STIs and HIV/AIDS: for instance, (a) cumulative incidence (over five years) of congenital syphilis, (b) cumulative incidence (over five years) of *Ophthalmia neonatorum,* (c) share of MTCT for HIV, etc.	No
4. Develop a national consensus between health care facilities and across service providers, NGOs and other stakeholders over the best model to provide care for MARP	No
5. Review current regulations to allow for anonymous STI testing, use of rapid tests and syndromic management of STIs in MARP at PHC level	No
6. Launch a pilot project for STI provision of services to men who have sex with men, intravenous drug users and female sex-workers through the inclusion of local NGOs (or national NGO spin-offs) and local suppliers/service providers to provide MARP with STI services	No
7. Upgrade the national systems for STI surveillance reporting by including reporting by syndromic criteria from all the centres providing syndromic management of STI cases	No
8. Improve the compliance of dermatovenereology specialists with single-dose treatment regimens for gonorrhoea, chlamydia, syphilis and trichomoniasis, which are first-choice options in the national STI guidelines, and develop national STI protocols	Partially: yes for primary syphilis and gonorrhoea, no for other infections
9. Develop a financing mechanism to provide MARP with free treatment for STIs, given their uninsured status, and identify funding sources	No
10. Widen the mandate of RHR and voluntary counselling and testing rooms to provide STI counselling services and perform rapid testing for STIs/HIV	No
11. Develop a training strategy for health workers, focusing on stigma and discrimination against MARP in particular and stigma and discrimination within the health system in general	No
12. Integrate an optional RH course into the university syllabus/curriculum for the general medicine major, to include all the components set out under the NRHS	Partially: some modules at some disciplines
5. Abortion and pregnancy termination services	
1. Development of NRHS national implementation programme, government financing of priority areas, obtaining financial support from international donors	No

2.	Establishing by MoH ordinance a multidisciplinary working group and a committee for NRHS implementation	No: it was set up in 2005 but does not operate
3.	Urgent approval through the Order of the MoH on Abortions Regulation and the practical guidelines to pregnancy interruption as an annex to the Regulation; development of a mechanism of guidelines implementation and for monitoring implementation	Yes
4.	Development of an implementation mechanism for regulation and guidelines and for monitoring its implementation	Partially
5.	Revision of medical–financial standards on abortion based on the provision of the regulations and practical guidelines	Partially
6.	Amendment of the legislation by awarding the right to provide pregnancy interruption services to private clinics, under the condition of observance by them of the standard acts in force	Yes
7.	Inclusion of miferistone and misoprostole into the list of essential compensated medications	No
8.	Improvement of the mechanism of providing free pregnancy interruption service sat medical and social indications and treatment of abortion complications, as well as of family planning methods in services covered by the obligatory health insurance	Yes
9.	Improvement of women's access to pregnancy interruption services during the second quarter (the decision should be taken by three specialists in the health facility where the pregnant woman sought services, cancellation of the need of decision of a special commission)	Yes
10.	Incorporation of reproductive health modules, including in comprehensive care in abortions into the training programmes for interns obstetricians/gynaecologists and into continuous training courses; and incorporation of pre- and post-abortion counselling modules into training programmes for family doctors and their training	Yes
11.	Development of accreditation criteria related to abortion for health facilities according to the provisions of the practical guidelines	Yes
12.	Implementation of the comprehensive care in abortions model at outpatient level in 12 perinatal centres (staff training, provision of MVA and EVA equipment, modest renovation of premises, implementation of monitoring and evaluation system)	Yes
13.	Organization of public awareness campaigns concerning safe abortion in the context of sexual-reproductive rights	Partially
6. Prevention and management of infertility		
1.	Improve the law on reproductive health protection and family planning	Yes
2.	Development of new regulations for the MoH on medically assisted human reproduction services in the Republic of Moldova	Partially
3.	Develop the standards of infertile couples' management	No, there is an older version only

4.	Develop some mechanisms of support for vulnerable population groups in infertility diagnosis and treatment	No
5.	Provide state support for medically assisted human reproduction programme	No, although Law 138 of 15 June 2012 on RH provides for it
6.	Implement modern technologies: cryoconservation of oocytes and embryos, percutaneous and testicular epididymal sperm aspiration methods, assisted hatching in medically assisted reproduction	Partially, in private clinics
7.	Provide the NCRHMGFP and the specialized clinics from Chisinau, Balti and Cahul with modern equipment for infertility diagnosis and treatment	No
8.	Develop the andrological service in reproductive health centres in Chisinau, Balti and private centres	Yes
9.	Organize two 12-day courses for training doctors in RHO (60 people) in reproductive health issues, including for infertile couples	Partially, trained in some topics
10.	Perform practical NCRHMGFP-based training of doctors in RHO (15 people each year in two-week courses)	No
11.	Carry out training of family doctors in infertility issues	No
12.	Organize seminars and thematic training and support participation in conferences, congresses and international retraining courses on infertility	Yes
13.	Publish teaching materials: protocols, standards, guidelines for professionals on female and male infertility	No
14.	Publish the *Reproductive gynaecology* handbook	Yes
15.	Publish some methodological recommendations on modern diagnosis and management of infertility	No
16.	Conduct research on the incidence of infertility and the need of people in such services, and optimize infertility treatment methods	Partially
17.	Publish some booklets about infertility by the NCRHMGFP	No
18.	Place information for the population about infertility on the NCRHMGFP website	No
19.	Produce TV and radio programmes, social publicity programmes and materials for disseminating medical information on infertility	Partially
20.	Develop a national system for recording, monitoring and evaluating in the field of sterility	No
7&8 Prevention of domestic violence, sexual abuse and human trafficking		
1.	Develop an action plan for the implementation of the NRHS, indicating the appropriate resources	No
2.	Strengthen the involvement of the health care system as a whole, including the reproductive health segment, in settling the domestic violence and human trafficking cases: develop work standards, specialized guidelines, train various categories of doctors in providing assistance to the subjects of domestic violence and the victims and potential victims of human trafficking	Partially, see the chapter on education

3.	Ensure the functionality of the legal and regulatory framework by strengthening the capacity of the national referral system branches	Partially
4.	Merge the system of domestic violence and human trafficking data collection	No
5.	Ensure sustainable activity of existing services through adequate financing, development of the system of accreditation of services provided by the NGOs specialized in the area	No
6.	Create a social fund (based on grants and donations), the sources of which will also be allocated to NGOs active in the field	No
7.	Ensure sustainable public information about the phenomena under discussion and their consequences	Partially
8.	Reintroduce the course "Life skills" in schools; promote non-violence education and strengthen capacities of the school system to identify, provide primary assistance and yearly prevention of domestic violence cases	Partially
9.	Ensure access of various population categories, particularly of vulnerable persons, to sexual education	No
10.	Organize a new demographic and health study, with the inclusion of new indicators related to domestic violence and human trafficking	No
9. Early detection of breast and cervical cancer		
1.	Creation of a normative basis concerning breast examination	Yes
2.	Development of clinical protocols (for cervical cancer etc.)	Yes
3.	Development of a mechanism for clinical and paraclinical screening setup and implementation (echography, mammography) for early detection of breast cancer	Yes
4.	Organize the screening of women for cervical cancer detection	Yes
5.	Strengthening prophylactic gynaecological examinations rooms (training of health care staff, equipment of gynaecological rooms)	Partially
6.	Organize screening for the detection of breast and cervical cancer within PHC	Partially
7.	Involvement of doctors from reproductive health offices in early detection of breast and cervical cancer	Partially
8.	Increase family doctors' responsibility for the growth in the incidence of tumours in advanced stage, establishing adequate preventive measures	No
9.	Strengthening human resources' capacities in counselling and early detection of patients with breast and cervical cancer	No
10.	Development of instructive-methodological guidelines for the diagnosis of breast and cervical cancer	Yes
11.	Special training of staff, particularly in PHC, and improvement of staff skills through special training courses for gynaecologists and nurses on opportune examination and exploration	Partially
12.	Promotion of primary and secondary prevention for the detection of precancerous processes (through TV, radio, literature etc.)	Partially
13.	Publishing and distribution of information materials for the population about the prevention of breast and cervical cancer	Partially

14. Organization and development of population information campaigns about the prevention of breast and cervical cancer	No
10. Sexual health of older people	
1. Create a committee for the coordination and monitoring of the NRHS with the inclusion of a specialist geriatrician	No
2. Re-evaluate the current situation in sexual health of older people to identify the priority problems and assess the volume of adequate interventions for implementation of the strategy	No
3. Create a standing working group comprising different specialists (psychologists, sociologists, geriatrician, representatives of civil society etc.) for implementation of the sexual health of older people element of the strategy	No
4. Develop real strategy implementation plans concerning sexual health of older people based on available resources	No
11. Sexual and RH of men	
1. Developing a mechanism to control and verify competences at all levels	No
2. Inclusion of prostate cancer screening as a compulsory measure at PHC level	No
3. Integration of men's RH-specific services into PHC	No
4. A human resources study must be carried out concerning men's sexual RH services delivery for the purpose of achieving the goals defined in the NRHS	No
5. Organizing a population survey (particularly men) to assess the knowledge about rights to male reproductive and sexual health	No
6. Carrying out information, education and communication activities on the sexual and RH of men, and development of information materials on this topic	Partially
7. Develop national guides and standards related to men health services	Partially
8. Creating a national referral body that would coordinate, promote and monitor health services provided to men with specific problems related not only to RH, but also to other aspects, such as teenagers' health (including sexual health), the health of older people, problems of couple incompatibility, problems related to erectile dysfunction, transgender problems etc.	No
9. National health policies and strategies, including SRH, shall be gender-sensitive	Yes

Raportul a fost elaborat sub egida Ministerului Sănătății și se referă la activitățile realizate în cadrul Acordului bienal de colaborare 2014-2015, semnat între Guvernul Republicii Moldova și Biroul Regional OMS pentru Europa și Programul de Țară UNFPA 2013-2017.