



Republic of Moldova

Market Segmentation Analysis for Modern Contraceptives in the Republic of Moldova

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Acronyms

AMMD	Agency of Medicines and Medical Devices
ATP	Ability to pay
CCPPH	Center for Centralized Public Procurements in Health
CDC	American Centers for Disease Control and Prevention
CoC	Combined hormonal oral contraceptive pill
CIS	Commonwealth of Independent States
CYP	Couple year of protection
DHS	Demographic and Health Survey
EDL	National essential drug list
FGP	Family Group Practitioners
FDC	Family Doctors Centre
FDO	Family Doctor Office
FP	Family Planning
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNI	Gross National Income
HF	Health Facilities
HC	Health Centre
HO	Health Office
HIV	Human Immunodeficiency Virus
IUD	Intrauterine Device
LMIS	Logistics Management Information System
MHI	Mandatory health insurance
NHIC	National Health Insurance Company
MICS	Multiple indicator cluster survey
MLSPF	Ministry of Labor, Social Protection and Family
MoH	Ministry of Health
MPA	Medroxyprogesterone acetate
NGO	Non-government Organization
NPSRHR	National Program on Sexual and Reproductive Health and Rights
NRHS	National Reproductive Health Strategy
OOP	Out-of-Pocket Payment
PHC	Primary health care
PHCF	Primary Health Care Facility
RH	Reproductive Health
RH/FP	Reproductive health including family planning
RHCS	Reproductive Health Commodity Security
SRH	Sexual and reproductive health
TFR	Total fertility rate
TMA	Total market approach
UNFPA	United Nations Population Fund
WB	World Bank
WHO	World Health Organization
WRA	Women of Reproductive Age
WTP	Willingness to pay
YFHC	Youth Friendly Health Centre



Figure 1: Map of the Republic of Moldova

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Executive Summary

Introduction

There is a clear case for improving access to modern contraceptives to all segments of the population in Moldova. Use of contraceptives has declined over the past 20 years from just over a half of married women to 42 percent. Unmet need for modern contraception has increased over this time and is high at 27 percent and even higher at 35 percent when all women of reproductive age are considered¹. The figures of 27 percent and 35 percent unmet need represent estimations applying the definition used by the American Centers for Disease Control and Protection (CDC) in Reproductive Health Surveys (as explained on the pages 18-20 of the present report) and are based on data from the 2012 Multiple Indicator Cluster Survey (MICS) together with figures provided by the Demographic Research Center.

The prevention of unintended pregnancies should be a priority in modern societies and enabling people to choose if and when they become pregnant, and how many children they have, is a basic right. Women empowerment, employment and integration are crucial elements for the wellbeing of women and of society as a whole, particularly in the current economic climate. It is therefore crucial that decision makers and competent authorities include modern contraceptive choice as a key component of integrated policies in the area of sexual and reproductive health.

There are important cost implications to providing contraceptive services to the increasing number of women needing modern contraceptives and to offering comprehensive, high-quality services to all users. At the same time, money spent on contraceptive services to help women avoid unintended pregnancies, has large health, social and economic benefits for women, families and society, and results in net savings to the health care system.

This market segmentation analysis for modern contraceptives in Moldova has shown that the market is divided into several segments. Most women of reproductive age do not have the 'ability to pay' for contraceptives. While the richest twenty percent of people of reproductive age is able to afford most types of contraceptives, the poorest forty percent segment only have the ability to purchase the cheapest IUDs and the middle segments - a very limited range of contraceptives.

In order to meet the various requirements of these different segments, a total market approach to modern contraceptives is required. The commercial sector should concentrate on marketing contraceptives for the most affluent segment of the population and the National Health Insurance Company should consider including a number of modern contraceptives on the list for medicines reimbursement. The poorest forty percent vulnerable segment of the population should have a limited range of contraceptives provided 'free' by the Ministry of Health, as part of a national programme.

A total market approach to the provision of modern contraceptives requires co-ordinated actions on the part of the public sector (principally the Ministry of Health and as part of that, the Medicines and Medical Devices Department; and also the Ministry of Labor, Social Protection and

¹ See, Special tabulation provided by the Demographic Research Center to UNFPA of data from: National Centre of Public Health of the Ministry of Health of the Republic of Moldova, United Nations Children's Fund (UNICEF). 2012 Republic of Moldova Multiple Indicator Cluster Survey, Final Report. Chişinău, Republic of Moldova, 2014.

Family), parastatal organisations (specifically the National Health Insurance Company), non-governmental organisations (such as Reproductive Health Training Centre), pharmaceutical companies (including Bayer Pharmaceuticals, JV “RihPanGalFarma” Ltd. and the Joint Stock Company “MoldFarm”), pharmaceutical wholesalers (e.g. Sanfarm-Prim S.A.), commercial pharmacies (such as Felicia, Hippocrates, Farmacia Familiei and Odeon). And importantly medical and pharmacy undergraduate, postgraduate and continuing education establishments (particularly the Obstetrics and Gynaecology Departments, the Family Medicine Department, the Center for Simulation in Medical Training of the State Medical and Pharmaceutical University “Nicolae Testemitanu”) have a crucial role in achieving improved family planning care.

The Government (Ministry of Health) should as a matter of urgency establish a statutory technical group to develop a plan for the phased transition of the country to a total market approach, for the provision of modern contraceptives.

Recommendations on specific issues concerned with provision of modern contraceptives

After an assessment of the situation related to the availability of contraceptives and specifically the segmentation of the market in the country the following recommendations are made:

- Steps should be taken to explore how the two long-term contraceptives (medroxyprogesterone acetate injection and either the single-rod etonogestrel implant or the two-rod levonorgestrel implant) can be registered in the country and a commercial pharmaceutical company encouraged to import and market them. They should of course be made available through the Ministry of Health’s National Program on Sexual and Reproductive Health and Rights 2018-2022. It will be necessary to support training programmes for family doctors and gynaecologists in insertion and removal of hormonal implants.
- Representation should be made to the National Health Insurance Company for consideration to be given to placing a limited number of modern contraceptives on the list eligible for reimbursement e.g. Microgynon® - Bayer (30 mcg Ethinylestradiol and 150 Levonorgestrel) and Regulon® – Gideon Richter (Ethinylestradiol 0.03 mg, Desogestrel 0.15 mg), and possibly an emergency contraceptive (Levonorgestrel 1.5 mg) and a copper T IUD. When Medroxyprogesterone acetate and hormonal Implants are registered in the country, than these should also be included on the NHIC’s list of reimbursable pharmaceuticals. The inclusion of modern contraceptives in the NHIC’s list of reimbursable drugs would ease access of the middle segments of the population to contraceptives.
- Discussion should be had with representatives of pharmaceutical companies, importers and wholesalers of contraceptives and commercial pharmacies to market and promote cheaper combined hormonal contraceptives. This would help more affluent segments of the population to afford to purchase if they wish modern contraceptives.
- Continuing education initiatives, involving family doctors and gynaecologists, should be strengthened and based on objective evidence regarding different types of hormonal combinations and the absence of any discernible clinically significant difference between them.

- The draft NPSRHR 2018-2022 is a significant and far sighted development for which the Government deserves praise. It includes an Action Plan, a Monitoring and Evaluation Framework and a Costed Budget and the Ministry of Health needs to follow through with its implementation after approval. This should include acquiring expertise in estimation, procurement, distribution and monitoring of implementation. The establishment of a contraceptive logistics management information system is crucial for the effectiveness of the Program. The draft National Programme on Sexual and Reproductive Health includes an estimated Budget with a separate budget line for the procurement of modern contraceptives for vulnerable groups - equivalent to €300,000 per year. When approved by the Government - the respective amount will be available from the State Budget for the procurement of modern contraceptives in the period 2018-2022. According to the estimations reflected in Table 7 of this report – the €300,000 per year will not cover the needs of all the people in the seven categories of vulnerable groups, but in the initial stage it is worth to start with at least €300,000 per year allocated for procurement of modern contraceptives for vulnerable groups. When the contraceptive logistic management information system is established and well-functioning, then efforts to increase the budget allocation for the procurement of modern contraceptives for vulnerable groups from State Budget can be attempted.
- An information, education and communication campaign will be necessary to explain the objectives of the National Program on Sexual and Reproductive Health and Rights 2018-2022 and who (the vulnerable groups) is entitled to free contraceptives, and where they are available. This should include pamphlets and posters, to be displayed at appropriate MoH facilities.
- At a later stage, consideration might be given to establishing a social marketing programme for condoms and even of an oral contraceptive pill. For this to happen initially it would be useful to arrange a visit to the social marketing programme in Romania².
- Monitoring implementation of the total market approach, will be important to assess if it is meeting its objectives. This could include periodic surveys of who is receiving contraceptives, from where and whether they are covered by the NHIC reimbursement scheme, or free contraceptives under the NPSRHR, or a purchasing them. The last Multiple Indicator Cluster Survey was carried out in 2012 and apparently a decision has not yet been taken on when, or if a further MICS will be undertaken, but there is a suggestion that it might be replaced by a mini-MICS. It is not clear what this might cover, but it is important if one is carried out, that it should include questions on contraceptive use, unmet need and supply and source of contraception.

Activities which UNFPA could consider, supporting the Government to strengthen family planning

It is suggested that UNFPA might consider providing assistance in: the development of standard care protocols (based on WHO's Eligibility criteria for Contraceptive Use³) and one sheet algorithms for family doctors for different contraceptives in Romanian and Russian; training in estimation of contraceptive needs; training on establishing and running a contraceptive LMIS; continuing education in modern contraceptive technology; training on IUD insertion and use of Implants; development, printing and distribution of information

² See for description of Romania social marketing programme <http://www.psi.ro/who-we-are/technical-expertise/product-social-marketing/> http://www.psi.org/wp-content/uploads/drupal/sites/default/files/publication_files/romania-familyplanning.pdf PSI Romania can also provide technical advice see <http://www.psi.ro/who-we-are/technical-expertise/>

³ WHO. Medical eligibility criteria for contraceptive use. Fifth edition, 2015. Geneva: WHO, 2015,

posters explaining eligibility for specific contraceptives under the NHIC, and for vulnerable people under the MoH's National SRHR Programme 2018-2022.

Market Segmentation Analysis for Modern Contraceptives in the Republic of Moldova

Terms of Reference for the Consultancy

This consultancy does not go into an extensive review of issues related to the recent history of reproductive health concerns in the Republic of Moldova, as this has been presented on several recent occasions elsewhere⁴. However, key issues which have a bearing on the availability and use of modern contraceptives, are reviewed.

This report is concerned with assessing the market segmentation for modern contraceptives in the country. It aims to:

1. provide an overview of the evidence on the availability of modern contraceptives and contraceptive methods mix on the national market;
2. give an analysis of access to, preferences and use of modern contraceptives by different population segments (segmentation by age, place of residence/location, education, wealth/income quintiles), as well as to underline the determinants of consumption, and of the unmet need;
3. provide an analysis of the ability and willingness of different segments of population to pay for modern contraceptives in the commercial sector;
4. recommend interventions for meeting the needs of different segments of the population for modern contraceptives, particularly of the most vulnerable groups, as well as other disadvantaged segments of population;
5. develop a roadmap for implementation of the Total Market Approach, targeting all key players (public sector, social marketing, and commercial sector), with the aim to ensure a continuous supply of the spectrum of modern family planning (FP) commodities in the Republic of Moldova, meeting the need of all segments of population and particularly the most vulnerable groups;
6. define anticipated challenges and possible responses during the shifting to and implementation of the Total Market Approach.

⁴ See: WHO. Evaluation of the structure and provision of primary care in the Republic of Moldova. A survey-based project. Primary care in the WHO European Region. Republic of Moldova Health Policy Paper Series No. 5. Copenhagen: WHO Regional Office for Europe, 2012; Koo B, Stratila M, Ciubotaru V. Final evaluation report National reproductive health strategy 2005–2015 in the Republic of Moldova. Chisinau: MoH, 2015; El-Fiki M. Reproductive Health Commodity Security. Situation Analysis in the Republic of Moldova. Chisinau: UNFPA Country Office, October 2016; Centre for Demographic Research. Population Situation Analysis in the Republic of Moldova. Chisinau: UNFPA, 2016; Government of the Republic of Moldova. National Program on Sexual and Reproductive Health and Rights 2018-2022. Draft. Chisinau: no date.

Methods

The assessment has used a variety of methods in order to obtain a realistic view of the situation regarding the segmentation of the market for modern contraceptives in the country.

The methods used consisted of several surveys and analyses of existing information. In summary, information was compiled and analysed concerned with:

- Data on the availability of different contraceptives were reviewed.
- Existing information was sought on client and provider perspectives, related to the need for, and access to modern contraceptives.
- Information available from surveys was reviewed: on the use of a range of contraceptives (oral combined hormonal, IUDs, male condoms, and vaginal sprays and diaphragms), by different population segments (levels of wealth; location – rural/urban and regions; and education levels).
- Surveys were undertaken to obtain information on the costs charged for modern contraceptives. This was obtained from surveys of pharmacies and other outlets selling contraceptives.
- Analyses were performed of and estimates of the 'ability to pay' and the 'willingness to pay' of different income quintiles (segments) of the population.

A number of meetings were held with a range of key stakeholders in the regions, cities and districts (rayons), and visits were made to various health care facilities. Most importantly, to obtain data on the availability and costs of modern contraceptives in pharmacies, visits were made to over 20 pharmacies in different parts of the country. Interviews were made with pharmacists and the costs charged for a range contraceptives were recorded in order that variation in costs and 'ability to pay' could be carried out (see Appendix 1 for the schedule of visits).

Background

Introduction - Country Context

Moldova (Figure 1) is a former Soviet Republic and has been a fully independent nation since March 2, 1992, when Moldova also gained membership of the United Nations. The nation had declared its independence from the Soviet Union on August 27, 1991, and was a co-founder of the post-Soviet Commonwealth of Independent States.

While this report does not go into an extensive review of issues related to the recent history of reproductive health concerns in the Republic of Moldova, it does summarise relevant issues. The present economic situation, organisation and structure of health care in the country - affects the provision of reproductive health services, including those for family planning, and these relevant matters are briefly presented.

Poverty and its implications for reproductive health, including the provision of modern contraception

Moldova is classified by the World Bank as a lower middle income country with a per capita gross national income (GNI) in 2014 equivalent to US \$2,240⁵ and ranks 107 on the Human Development scale, with an overall Human Development Index of 0.699⁶. This low level of income in comparison to most other European countries means, that the ability to provide or purchase many commodities, including modern contraception, is severely constrained. In addition, while the proportion of the population living in poverty have fallen from a high of 30.2 percent of the population in 2006 to 11.4 percent in 2014 (latest figure)^{7,8} this means that over one in 10 families continue to be below the nationally defined poverty level.

Although Moldova has made considerable economic gains over the past decade, sustaining growth continues to be a challenge, as the gross domestic product (GDP) gains are led by remittances and export growth is dependent on volatile external markets. Remittances are estimated to account for almost 38 percent of Moldova's GDP and there are high levels of income disparity. Per capita gross national income was estimated in 2015 (the most recent year for which information is available) at US \$ 2,240 having fallen for the first time since 2001 from a high of US \$ 2,560 in 2014⁹. Over the 10 years from 2003 to 2013 the percentage of national income, held by the highest 10 percent, has fallen slightly from 27.3 percent in 2004 to 23.3 in 2013, but inequality in income continues to be substantial. There are specific issues related to corruption and Transparency International's Corruption Perception Index 2016 ranks Moldova 123 on the list of a total 176 countries¹⁰.

Public expenditures on health services are relatively low at 5.3 percent of the GDP (2011-2015) and out-of-pocket payments (OOPs) remain very high, compared to European Union countries - at 38.4 percent (2011-2015) of total health expenditure¹¹. A study carried out in 2012, found that OOPs were at 45 percent of total health expenditures, with more than two-thirds of outpatients having to buy prescribed medicines at a pharmacy¹². In addition, a considerable proportion of patients reported making informal payments for care. Though many patients consider these payments to be gifts, around one-third had no choice but to make payments and thought this, a reflection of the limited list of reimbursable medicines, a desire to receive better treatment, and fear or extortion.

A study¹³ published in 2011, using data from the 2005 demographic health survey (DHS) examined the relationship between traditional contraceptive use and poverty and isolation, and found that economic disadvantage increases the probability of use of traditional methods, but the overall effect is small. The authors found that although higher family planning media

⁵ World Bank, Moldova. <http://data.worldbank.org/country/moldova> accessed 15 April 2017

⁶ UNDP. Human Development Indicators. <http://hdr.undp.org/en/countries/profiles/MDA> Accessed 15 April 2017

⁷ World Bank. Poverty and Equity Database. <http://databank.worldbank.org/data/reports.aspx?source=poverty-and-equity-database> Accessed 16 April 2017.

⁸ Human Development Report, 2014. Supporting human progress: reducing vulnerability and building resilience. Chisinau: UNDP; 2014 http://www.md.undp.org/content/dam/moldova/docs/Publications/HDR2014/Moldova_Explanatory_Note_RO.pdf/ .

⁹ World Bank, Moldova. <http://data.worldbank.org/country/moldova> accessed 15 April 2017.

¹⁰ See https://en.wikipedia.org/wiki/Corruption_in_Moldova

¹¹ World Bank. Health expenditure, public (% of GDP). <http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS> Accessed 15 April 2017.

¹² Vian T, Feeley FG, Domete S, Negruta A, Matei A, Habicht J. Barriers to universal health coverage in Republic of Moldova: a policy analysis of formal and informal out-of-pocket payments. BMC Health Services Research 2015; 15:139-134.

¹³ Lyons-Amos MJ, Durrant GB, Padmadas SS. Is traditional contraceptive use in Moldova associated with poverty and isolation? Journal of Biosocial Science, 2011; 43(3): 305-327

exposure decreased reliance on traditional methods among younger women, it had only a marginal effect in increasing modern method use among older women. Family planning programmes designed to encourage women to switch from traditional to modern methods have some success, although the effect is considerably reduced in regions outside Chisinau. The study concluded that family planning efforts, directed towards the poorest may have limited impact, but interventions targeted at older women could reduce the burden of unwanted pregnancies and abortions, and addressing differentials in accessing modern methods, could improve modern contraceptive uptake in rural areas.

Provision of reproductive health care including family planning

Reproductive Health (RH) has been a long-term priority in the Republic of Moldova and reform of health services since independence and particularly from 1994, have progressively led to the establishment of a national network of RH and family planning services. In 1999 a national programme for family planning and RH was endorsed by the Government¹⁴. This set out a number of measures aiming to promote responsible sexual behaviours, avoid unplanned, or high-risk pregnancies and prevent sexually transmitted infections (STIs).

The Family Planning Context

A basic reproductive right is for all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, to have the information and the means to do so, and the right to attain the highest standard of sexual and reproductive health. This implies access to modern contraception.

Moldova has achieved its MDG goal regarding poverty reduction, but access to universal education and reproductive health were not achieved. The Sustainable Development Goals (SDGs) came into effect in January 2016 and replaced the Millennium Development Goals. They comprise 17 goals designed to focus global development through 2030¹⁵. Unlike the Millennium Development Goals, which preceded them, family planning is not explicitly stated in any of the SDGs. However it has been agreed, that reproductive health, including family planning is implicitly included under three goals - Goal 3 Ensure healthy lives and promote well-being for all at all ages, Goal 4 Ensure inclusive and quality education for all and promote lifelong learning and Goal 5 Achieve gender equality and empower all women and girls. Sustainable Development Goals 3 and 5 pledge universal access to sexual and reproductive health services and reproductive rights, and to integrate reproductive health into national policies. More broadly, other goals also commit to advancing gender equality, empowerment of women and girls, and improving child, adolescent and maternal health.

As mentioned earlier this market segmentation study does not intend to review all issues related to the provision of family planning services in the country, as these have been summarised elsewhere recently¹⁶. However, some basic items concerned with the context in Moldova, are relevant.

¹⁴ Koo B, Stratila M, Ciobotaru V. Final evaluation report National reproductive health strategy 2005–2015 in the Republic of Moldova. Chisinau: MoH, 2015.

¹⁵ UNFPA. Advancing contraceptive choices and supplies for universal access to family planning. UNFPA Eastern Europe and Central Asia Regional Contraceptive Security Strategic Framework 2017-2021. Istanbul: 2016.

¹⁶ El-Fiki M. Reproductive Health Commodity Security. Situation Analysis in the Republic of Moldova. Chisinau: UNFPA Country Office, October 2016.

The Republic of Moldova is one of the most densely populated European countries. The population structure of Moldova is rapidly changing with negative population growth, decrease in the proportion of adolescents, and increase in the proportion of the elderly. Emigration, mainly for work, is very common in Moldova and has a major impact on the demography and economy. Moldova is a source, and to a lesser extent, a transit and destination country - for human trafficking, both for sex and labour¹⁷.

- The 2014 national census enumerated the population at 2,804,801¹⁸ divided between three 'regions' north, centre and south, 32 districts, three municipalities and two autonomous territorial units.
- Over a half of the population are rural (57 percent) and the remaining 43 percent are urban. This figure is almost a quarter less than that estimated from earlier population projections.
- Fertility is below replacement with a total fertility rate (TFR¹⁹) of 1.24 (2016)^{20, 21} and this has steadily declined since 2006 when it was 1.85^{22, 23}.
- It is estimated that almost a fifth (18 percent) of the population are aged 15 to 24 years, 10 percent 15 to 19 years and 8 percent 20 to 24 years²⁴.
- In 2012 the adolescent birth rate was 35 per 1,000 girls 15 to 19 year olds (Figure 2). Adolescent birth rates²⁵ are considerably higher among those living in rural areas and the less affluent, and are the lowest for adolescents living in Chisinau, and the richest 40 percent of people.

The situation regarding the sexual behaviour of young people has implications for the future population of the country and adolescent birth rates in Moldova are relatively high in comparison to other European countries. This probably reflects difficulties young people experience in accessing modern contraception.

A study²⁶ carried out in 2014 on health behaviour among school aged children found that almost a fifth (18.3 percent) of 15-year olds and 38.8 percent of 17-year olds reported having had sexual intercourse. Among boys this was higher than among girls - 6.2 percent of those who had had sexual intercourse reported their first experience at age 11 or earlier, 8.1 percent at 12 to 13, 12.6 percent at 14, 28 percent at the 15, and 44.9 percent at the age of 16.

¹⁷ Cojohari N, Reed S, Caraseni G. Final Report Independent Second Country Programme 2013-2017 Evaluation: Republic of Moldova. New York: UNFPA, 2016.

¹⁸ See NBS website <http://www.statistica.md/pageview.php?l=ro&idc=479>

¹⁹ The TFR of a population is the average number of children that would be born to a woman over her lifetime if she were to experience the current age-specific fertility rates through her lifetime.

²⁰ See: <http://eeca.unfpa.org/news/improving-demographic-policies-moldova-international-expertise> but the 2012 MICS for the three years preceding 2012 found a rate of 2.2 births per woman.

²¹ UNdata. http://data.un.org/Data.aspx?q=fertility+rate&d=WDI&f=Indicator_Code%3aSP.DYN.TFRT.IN Accessed May 2017

²² UNICEF TransMonEE. Monitoring Situation of Women and Children in Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS). <http://www.transmonee.org/index.html> Accessed May 2017

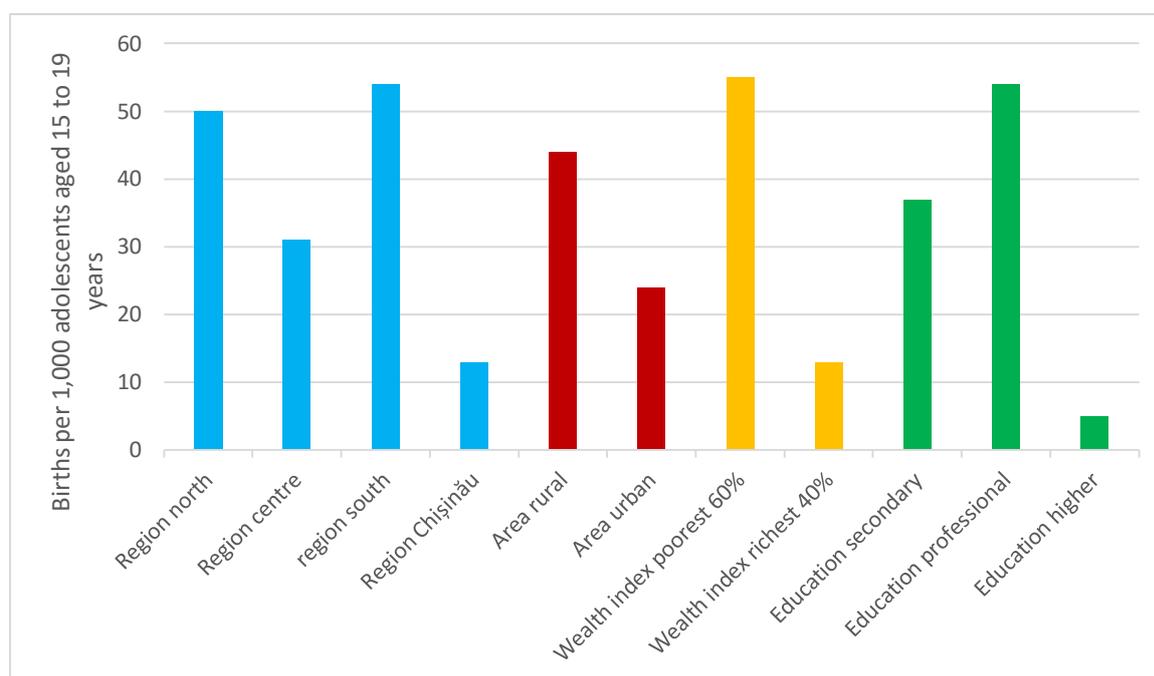
²³ Centre for Demographic Research. Population Situation Analysis in the Republic of Moldova. Chisinau: UNFPA, 2016

²⁴ See <http://www.statistica.md/category.php?l=en&idc=103>

²⁵ UNdata. http://data.un.org/Data.aspx?q=fertility+rate&d=WDI&f=Indicator_Code%3aSP.DYN.TFRT.IN Accessed May 2017

²⁶ Lesco G. Behavioral and social determinants of adolescent health. Summary report of the health behaviors in school-aged children study in the Republic of Moldova. Chisinau: MoH, WHO Europe, Swiss Agency for Development and Cooperation, 2015.

Figure 2: Adolescent birth rates, 2012 by region, urban or rural, wealth and education level



Source: National Centre of Public Health of the Ministry of Health of the Republic of Moldova, United Nations Children’s Fund (UNICEF). 2012 Republic of Moldova Multiple Indicator Cluster Survey, Final Report. Chisinau, Republic of Moldova, 2014.

One third of sexually active adolescents reported using “coitus interruptus” during their last sexual intercourse, the 17-year olds indicating it 10 percent more often than 15-year olds, and boys seven percent more frequently than girls. It is a matter of concern that about one third of 15-year old boys and more than half of 17 year old boys have never used contraception in their last sexual intercourse, this being lower among girls.

Health service reform and its impact on issues related to access to modern contraceptives

Reform of the reproductive health (RH) system began shortly after independence and the modern concept of specialized RH services was realized by Ordinance No. 89/1994. This aimed 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 and has been designed to improve services at three levels of care, by integrating family planning (FP) and RH services within Primary Health Care (PHC), setting up structures at district/municipal level based on specific regulations, and providing patient referral mechanisms appropriate to their health care needs²⁷. PHC in the districts includes autonomous Health Centres, as well as units under them - Family Doctor’s Offices and Health Offices. In Chisinau, the PHC structure is comprised of comprehensive Territorial Medical Associations (TMAs) which each includes a few Centres of Family Doctors and one Consulting Diagnostic Center (staffed with medical specialists providing specialized ambulatory care). Besides TMAs, in Chisinau municipality there are - autonomous Health Centres

²⁷ Koo B, Stratila M, Ciubotaru V. Final evaluation report National reproductive health strategy 2005–2015 in the Republic of Moldova. Chisinau: MoH, 2015.

and under them - Family Doctor's Offices and Health Offices. In Balti Municipality – there is one Center of Family Doctors and responsible to it Health Centers and Family Doctor's Offices.

PHC facilities in the Republic of Moldova are managed by the municipal/district authorities and are contracted by the National Health Insurance Company.

PHC services are funded by the Mandatory Health Insurance Fund on the per capita principle. Additionally, a performance-based incentive scheme in primary health care was introduced with aim to improve the performance (15% of the total PHC facilities Budget is provided by the NHIC to the respective institutions based on the level of achievement of a number of performance indicators). The package of medical services provided in PHC is stipulated in the 'Unique Programme of Mandatory Health Insurance'.

RH cabinets are currently part of PHC facilities, located at the district/rayon level, as well as the municipal level. Government regulations 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 should have access to free contraception, provided through centralized public procurements using PHC institutions funds²⁸, but until recently, definition of which vulnerable groups can access free contraception have been not very clear.

The National Reproductive Health Strategy (NHRS) 2005–2015 has just been completed²⁹ and the National Public Health Strategy 2014-2020 was endorsed in line with the European policy "Health 2020"³⁰. This aims to improve access to high quality health services, and a healthier lifestyle remain national priorities. A draft document describing the National Programme on Sexual and Reproductive Health and Rights 2018-2022 has recently been developed and this includes an annual budget line for modern contraceptives procurement for vulnerable groups from State Budget³¹. The draft policy document is due to be presented to the national Government for approval.

The Ministry of Health (MoH) has seen reproductive health, including family planning, as a priority concern, including improving access and coverage of services for the whole population. This has led to a series of orders covering these concerns: nr. 144 (2011) on Essential List of Drugs; nr 975 (2014) on the List of Contraceptives Recommended to be Procured at the Level of Primary Health Care; nr 600/320 (2015) on the mechanism for including medicines for compensation from the compulsory health insurance funds; nr 658 (2015) on Providing Contraceptives to Vulnerable Groups, procured at the level of primary health care from the compulsory health insurance funds; nr 786 (2015) on Amendments and Addenda to Annex to Order Nr 658 of 18 August 2015 on Providing Contraceptives; nr 228/139-A (2016) on Approving the Action Plan on providing contraceptives to vulnerable groups at the level of Primary Health Care.

We were informed that some family doctors are reluctant to prescribe hormonal contraception and this even applies in some cases to gynecologists. We were told that many women would prefer to have an IUD for contraception. However, although some of the family doctors have received training in the insertion of IUDs on inanimate models, they seldom, if ever, do this in

²⁸ Managers of PHC facilities are allowed to use part of their budgets to purchase pharmaceuticals, including contraceptives, at prices determined by central tenders, but only some of them use this available resources for contraceptives procurement.

²⁹ Koo B, Stratila M, Ciubotaru V. Final evaluation report National reproductive health strategy 2005–2015 in the Republic of Moldova. Chisinau: MoH, 2015

³⁰ See, El-Fiki M. Reproductive Health Commodity Security. Situation Analysis in the Republic of Moldova. Chisinau: UNFPA Country Office, October 2016.

³¹ Government of the Republic of Moldova. National Program on sexual and reproductive health and rights 2018-2022. Draft. Chisinau: no date.

practice. Consequently for women to have an IUD inserted, they have to be referred and travel to a rayon level for a gynaecologist from Reproductive Health Cabinets to insert it. Occasionally gynaecologists based at the rayon level will visit PHC facilities from villages for IUD insertion, when needed.

When we asked pharmacists about the popularity of different brands of oral hormonal contraceptives, we were informed that often family doctors prescribed the more expensive brands and told women these were 'best', and consequently women, if they could afford them, would choose these brands.

Even though important steps have been taken in securing access to sexual and reproductive health (SRH) services, access is still influenced by the economic status of the population³². Access to a number of SRH services depends on insurance status, because not all SRH services are included in the Unique Programme of Mandatory Health Insurance. The percentage of uninsured persons is about 15 percent (in 2014) and these people only benefit from the package of essential care, which does not include all SRH services. In addition, some people, although they are insured and should receive free services, cannot afford additional expenses associated with the use of the free services. This includes poor families, being unable to afford to purchase medicines, including contraceptives, or paying travel cost necessary to get to health services located in places other than where they live.

The Ministry of Health regulation (Order nr.695 of 13.10.2010) on Primary Health Care was meant to enable the provision of family planning services in primary health care institutions, in urban and rural areas - family doctors' centers (FDCs), health centers (HCs), family doctor's offices (FDOs) - where there are family medicine practitioners (FMPs). Legislation is designed to ensure access to PHC services regardless of insurance status, theoretically allowing everyone to benefit from FP services. The Order no. 695 stipulates explicitly that FP is one of the obligations of the family doctor and family nurse (Section 11, Work organization, functions and rights of the family doctor, and Section 12, Work organization, functions, responsibilities and rights of family nurse). The MoH Order no.658 of 2015 lists categories of groups defined as 'vulnerable'³³ including - sexually active adolescents, persons with low incomes, HIV positive persons, people addicted to alcohol, illegal and other drugs, those with psychiatric problems, victims of sexual abuse and women having had an abortion in the previous year - who should be able to access health services, including family planning services, without having paid insurance premiums.

However many financial, organizational, administrative and logistical reasons, why this has not been able to be achieved, were identified in a survey carried out in 2015³⁴. The most obvious reason is unavailability of contraceptives for free distribution. This is partly due to the limited funds available at the PHC level to purchase any pharmaceuticals, including contraceptives. Although managers of PHC level services are allowed to purchase contraceptives at prices agreed by central tenders, few do so; and since the ending of UNFPA donation of contraceptives, many PHC units do not have any modern contraceptives available. Most family doctors interviewed in

³²Government of the Republic of Moldova. National Program on sexual and reproductive health and rights 2017-2021. Draft. Chisinau: no date.

³³ See: Ministry of Health. Order nr 658. 18.08.2015. Regulation on Providing Contraceptives to Vulnerable Groups, procured at the level of primary health care from the compulsory health insurance funds.; Ministry of Health. Order nr. 786. 7. 10.2015. On Amendments and Addenda to Annex to Order No 658 of 18 August 2015 on Providing Contraceptives; Ministry of Health. Order nr. 228/139-A. 30.3.2016. Approving the Action Plan on providing contraceptives to vulnerable groups at the level of Primary Health Care.

³⁴ Ministry of Health of the Republic of Moldova, Center for Reproductive Health Training (CIDSR), United Nations Population Fund (UNFPA). Assessing barriers and factors that facilitate the provision of and access to family planning services in primary health care in the Republic of Moldova and graduate and postgraduate, vocational technical and post-secondary non-tertiary education curricula on reflecting the subject of family planning. Report. Chisinau, 2015.

the 2015 survey, recommended that the MoH assumed responsibility for procuring and distributing contraceptives to PHC units.

To an extent, one vulnerable group - adolescents and young people, have benefited from the establishment of a network of Youth Friendly Health Centres located in Chisinau, Balti and at the districts level, where they can benefit from an array of services tailored to their specific needs, including free condoms³⁵; however only a limited number of them have easy access to free contraceptives³⁶.

The quality of PHC services is monitored by various mechanisms, such as internal controls and inspections. Institutions such as the National Evaluation and Accreditation Council and the National Health Insurance Company conduct periodic evaluations of institutions, including aspects of service quality. In general, however, quality assurance is still very limited³⁷.

Reform of health financing in Moldova began in earnest in 2004 with the introduction of a mandatory health insurance (MHI) system³⁸. Since then, MHI has become a financing mechanism, which has helped to further consolidate the prioritisation of primary care in the system that has been based on a family medicine model since the 1990s³⁹. However improving equity in financing and access to care, by reducing out-of-pocket (OOP) payments, remains a major challenge and OOP spending on health is dominated by the cost of pharmaceuticals⁴⁰. Public medical facilities are autonomous self-financing non-profit making organisations that are directly contracted by the National Health Insurance Company (NHIC) for the provision of medical services under MHI.

Initially there were issues regarding the third of the population who were uninsured, which included those self-employed (particularly in agriculture), unemployed, younger age and low income people. Those self-employed in agriculture were over 27 times more likely to be uninsured, than those who were employed. Agricultural workers were responsible for purchasing their own cover and most of these gave cost as the main reason for not doing so⁴¹. In 2010 a WHO study advised on options to extend population coverage under the mandatory health insurance scheme and these included: 1) changing the way in which subsidies for insurance are targeted; 2) changes to improve the design and management of the mandatory health insurance scheme; and 3) proposals to further extend the package of health services provided, as a universal guarantee for all Moldovan citizens, irrespective of their health insurance status⁴². This WHO study analysed - who was excluded and who covered by the MHI.

³⁵ Carai S, Bivol S, Chandra-Mouli V. Assessing youth-friendly-health-services and supporting planning in the Republic of Moldova. *Reproductive Health* 2015; 12: 98-109.

³⁶ Kempers J, Ketting E, Lesco G. Cost analysis and exploratory cost-effectiveness of youth-friendly sexual and reproductive health services in the Republic of Moldova. *BMC Health Services Research* 2014; 14: 316-325.

³⁷ WHO. Evaluation of the structure and provision of primary care in the Republic of Moldova. A survey-based project. Primary care in the WHO European Region. Republic of Moldova Health Policy Paper Series No. 5. Copenhagen: WHO Regional Office for Europe, 2012.

³⁸ Much of the information is obtained from: Turcanu G, Domente S, Buga M, Richardson E. Republic of Moldova: health system review. *Health Systems in Transition*, 2012, 14(7):1–1510, El-Fiki M. Reproductive Health Commodity Security. Situation Analysis in the Republic of Moldova. Chisinau: UNFPA Country Office, October 2016 and Koo B, Stratila M, Ciubotaru V. Final evaluation report National reproductive health strategy 2005–2015 in the Republic of Moldova. Chisinau: MoH, 2015.

³⁹ Mathauer I, Theisling M, Mathivet B, Vilcu I. State budget transfers to health insurance funds: extending universal health coverage in low- and middle-income countries of the WHO European Region. *International Journal for Equity in Health* (2016) 15:57-77.

⁴⁰ Vian T, Feeley FG, Domente S, Matei A, Habicht J. Barriers to universal health coverage in Republic of Moldova: a policy analysis of formal and informal out-of-pocket payments. *BMC Health Serv Res* 2015; 15: 319-34.

⁴¹ Richardson E, Roberts B, Sava V, Menon R, McKee M. Health insurance coverage and health care access in Moldova. *Health Policy and Planning* 2012; 27:204–212.

⁴² Jowett M, Shishkin S. Extending population coverage in the national health insurance scheme in the Republic of Moldova. Strategic options. *Health Financing Policy Paper* 2010/1. Copenhagen: WHO, 2010.

WHO has supported and contributed to development of the health sector in Moldova in several ways. The approach has ranged from specific work on maternal health, perinatal care and structural aspects of service provision in primary care and hospitals, as well as medicines. Concern about universal health coverage and concentrating on access to services, financial protection and quality of care, provided an opportunity to launch the process of strengthening quality of care systems throughout the entire Moldovan health sector in 2014, supported by the “EU-WHO Universal Health Coverage Partnership: Supporting policy dialogue on national health policies, strategies and plans and universal coverage”⁴³.

To improve equity in the system, amendments to the Law on Mandatory Health Insurance in 2009 and 2010 sought to expand access to services by making access to primary care universal, and to increase the financial protection of vulnerable households by extending automatic MHI cover to families registered as living below the poverty line, even if they are formally “self-employed”. However recent studies by the WHO European Region have emphasised continuing challenges where supply side constraints and quality gaps, as well as informal payments are common⁴⁴. The implementation of MHI has had substantial achievements as recently noted⁴⁵, but there remains an unfinished agenda of attaining universal health coverage particularly in constraining excessive costs of pharmaceuticals including modern contraceptives⁴⁶. Efforts, to expand financial protection, need to focus on reducing household spending on medicines⁴⁷ and to consider ways to reduce medicine prices, and promote rational use, strengthen administrative controls and increase incentives for quality health care provision.

Health services and provision of pharmaceuticals, including modern contraceptives: an overview of the evidence on the availability of modern contraceptives and contraceptive methods mix in the national market

Major changes to pharmaceutical pricing and procurement policies have been attempted over recent years to improve access to pharmaceuticals, by introducing reference pricing and to ensure pharmaceuticals are not more expensive in Moldova than in neighbouring countries. This has included centralising procurement of essential medicines for public health facilities, which was meant to optimise purchasing power, but also to ensure that the supply of medicines is sufficient.

The Medicines Agency was created by the government in 2005 (now called the Agency of Medicines and Medical Devices) under the Ministry of Health and financed from the state budget. The Agency is responsible for the authorization of medicines, quality control of medicines, regulation of pharmaceutical activity, monitoring and coordinating of medicines supply and pharmaceutical care at the national level, and for collecting data on the pharmaceutical sector. The Agency maintains a National Essential Drug List (EDL); however a study⁴⁸ in 2014 found there

⁴³ Shaw CD. Quality and safety of health care in the Republic of Moldova. Health Policy Paper Series No. 19. Copenhagen: WHO, 2015.

⁴⁴ Vilcu I, Mathauer I. State budget transfers to Health Insurance Funds for universal health coverage: institutional design patterns and challenges of covering those outside the formal sector in Eastern European high-income countries. *Journal for Equity in Health* 2016; 15:7DOI: 10.1186/s12939-016-0295

⁴⁵ Richardson E, Roberts B, Sava V, Menon R, McKee M. Health insurance coverage and health care access in Moldova. *Health Policy Plan.* 2012 May; 27(3):204-12. doi: 10.1093/heapol/czr024. Epub 2011 Mar 26.

⁴⁶ Hone T, Habicht J, Domete S, Atun R. Expansion of health insurance in Moldova and associated improvements in access and reductions in direct payments. *J Glob Health.* 2016 Dec; 6(2): 020702.

⁴⁷ Vian T, Feeley FG, Domete S, Matei A, Habicht J. Barriers to universal health coverage in Republic of Moldova: a policy analysis of formal and informal out-of-pocket payments. *BMC Health Serv Res* 2015; 15: 319-34.

⁴⁸ Ferrario A, Sautenkova N, Bezverhni Z, Seicas R, Habicht J, Kanavos P, Safta VB. An In-depth Analysis of Pharmaceutical regulation in the Republic of Moldova. *J Pharm Policy Pract.* 2014; 7: 4.

is no consistent procedure and criteria for development of the national EDL, as advocated by WHO. The EDL includes - combined hormonal and progesterone only oral contraceptives, three types of injectable hormonal contraceptives, emergency contraception, IUDs, male condoms, female diaphragm and hormonal implants (see Table 1).

Table 1: Contraceptives included in National Essential Drug List

18.3 Contraceptivele	
18.3.1 Contraceptivele orale	
Etinilestradiol + levonorgestrel	Comprimate 30 mcg +150 mcg
Etinilestradiol + noretisteron	Comprimate 35mcg + 1 mg.
Levonorgestrel	Comprimate: 30 mcg, 750 mcg (două în cutie); 1,5mg
18.3.2 Contraceptive hormonale injectabile	
Estradiol cypionat + Medroxiprogesteron acetate	Soluție injectabilă: 5 mg+ 25 mg.
Medroxiprogesteron acetate	Injectie depou: 150mg/ml în fiolă de 1ml
Noretisteron enantat	Soluție uleioasă: 200mg/ml în ampulă de 1ml
18.3.3 Dispozitivele intrauterine	
Dispozitive cu conținut de cupru	
18.3.4 Metode de bariera	
Prezervative	
Diafragme	
18.3.5 Contraceptive implantabile	
Levonorgestrel-eliberare implant	Sistem cu cedare intrauterină 52 mg (20mcg/24h); Două tije levonorgestrel implant, fiecare tija conținând* 75 mg de levonorgestrel (150mg în total)

Source: El-Fiki M. Reproductive Health Commodity Security. Situation Analysis in the Republic of Moldova. Chisinau: UNFPA Country Office, October 2016.

Physical access to places where pharmaceuticals, including modern contraceptives are available, is dependent on the location and coverage of commercial pharmacies. There has been some progress in reducing the number of villages with primary health-care facilities, but without a pharmacy⁴⁹. Yet, even when there are local pharmacies, challenges persist in ensuring the availability of essential medicines. A 2011 study showed that less than half of public and private community pharmacies had in stock the cheapest generic drug and less than half had the full list of EDL reference generic drugs⁵⁰. Rural areas were particularly disadvantaged⁵¹.

The present study found this continues to be the situation, with pharmacies in urban areas being more likely to stock the cheaper brands of modern contraceptives.

There are three main ways in which pharmaceuticals can be procured, or made available in the Republic of Moldova: centralized tendering (currently with the support of the Center for Centralized Public Procurements in Health (CCPPH), hospital tendering and direct purchase by

⁴⁹ WHO. Barriers and facilitating factors in access to health services in the Republic of Moldova. Copenhagen: WHO Regional Office for Europe, 2012.

⁵⁰ Ferrario A, Sautenkova N, Bezverhni Z, Seicas R, Habicht J, Kanavos P. An in-depth analysis of pharmaceutical regulation in the Republic of Moldova. *Journal of Pharmaceutical Policy, and Practice* 2014 7:4-15.

⁵¹ Sautenkova N, Ferrario A, Bolokhovets G, Kanavos P. Availability and affordability of medicines and assessment of quality systems for prescription of medicines in the Republic of Moldova. Final report. Copenhagen: WHO, 2012.

pharmacies⁵². The pharmaceutical market relies heavily on imported medicines (91 percent of total value) and, to a lesser extent, on local production (9 percent of total value). Public and private pharmacies, on the other hand, acquire medicines through direct negotiation with wholesalers and/or local manufacturers.

The 2011 study found the majority of drugs (this study did not include modern contraceptives) available in pharmacies were unaffordable for many people owing to high prices, incomplete coverage and limited benefits for drugs under the social health insurance scheme. This study made many recommendations on all aspects of medicines in the country.

The NHIC maintains a list of pharmaceuticals which are eligible for reimbursement at 50, 70 or 90 percent of their commercial cost charged in pharmacies. The list of reimbursed medicines, including the fixed percent to be reimbursed, is approved jointly by the Ministry of Health and the NHIC. However modern contraceptives are not included on the medicines reimbursement list. We were informed by the General Director of the National Health Insurance Company that a committee meets monthly in connection with the list and while it considers new items for inclusion it has never met to remove items. He said resources to cover reimbursable drugs is limited, with many requests to include additional drugs. However, the list of reimbursed medicines is gradually being extended each year, depending on the funds available in the MHI system.

The NHIC contracts with individual pharmacies for the supply of MoH approved pharmaceuticals, and the NHIC reimburses the pharmacy at the agreed percentage of the cost price for each prescription. The allocation for reimbursed medicines is quite modest and constitutes only 4.3 percent of the basic MHI fund.

The list of reimbursed drugs continues to be limited and there are weak protection mechanisms for the chronically ill and the elderly. To approach universal health coverage and the comprehensiveness of the basic benefit, package for drugs needs to be broadened and safety-nets introduced for vulnerable groups. Apparently Moldova has a clear and efficient system for procurement and supply management of pharmaceuticals⁵³. Medical institutions act as independent contracting authorities and procure and use a centralized system for tendering and making medicines available. Medicines are delivered from the stores of the importer, or commercial agents to the destination.

There are eight national programmes (but not yet one for modern contraceptives) where selection, forecasting, procurement and monitoring is centralized. These national programmes are organized centrally by the MoH and are for: tuberculosis (TB); HIV/AIDS for antiretrovirals; diabetes mellitus; rare diseases; organ transplant; blood safety; mental health drugs; and oncology. These programmes from 2017 receive support from the UNDP procurement project mechanism and most use the centralized 'Sanfarm-Prim' storage facility in Chisinau. These programmes use an electronic system of logistics for managing the supply and distribution of medicines and it is possible, this will in the near future take part in the E-procurement system of Government.

The Medicines and Medical Devices Agency is responsible for the authorization of pharmaceuticals, based on the examination of documentation presented for each pharmaceutical item and on selective quality control testing to register medicines. Registration takes 90 days from European Union countries, the USA and other countries with similar well established registration

⁵² Sautenkova N, Ferrario A, Bolokhovets G, Kanavos P. Availability and affordability of medicines and assessment of quality systems for prescription of medicines in the Republic of Moldova. Final report. Copenhagen: WHO, 2012.

⁵³ Ionesii L. Procurement and Supply Management in Moldova. Powerpoint. No date.

procedures; for products from other countries registration takes about 120 days. The cost for registration are very modest. Medicines are classified as prescription-only medicines, or medicines available 'over-the-counter' without a prescription.

Most pharmacies are private, but a few are publicly owned, or of a mixed form. Private pharmaceutical outlets can only dispense pharmaceuticals, if they have a licence issued by the Chamber of Licensing. The prices for medicines and other pharmaceutical products are established according to legal provisions, including a maximum mark-up of up to 40 percent from the delivery price of the local producer, and up to 15 percent for enterprises that import and/or distribute wholesale imported and locally produced medicines, and a further retail mark up of up to 25 percent can go to the pharmacies and their branches. A value added tax of eight percent is also applied. The Ministry of Health approves producers' prices on medicines included in the National EDL Catalogue, which is the average price of the lowest three prices for the same medicine in certain reference countries. For products from CIS Member States, the information regarding the comparison between the proposed price and the authorized producer's price is presented for two reference countries. For producers' prices from other countries, the comparison between the proposed price and the authorized producer's price is compared with at least three reference countries, taken from Romania, Greece, Bulgaria, Serbia, Croatia, Czech Republic, Slovakia, Lithuania and Hungary.

The following 20 oral hormonal contraceptives are registered⁵⁴ in the country: Artizia[®], Belara[®], Dimia[®], Dvella[®], Escapelle[®], Lactinette[®], Lindynette[®] 30, Lindynette[®] 20, Logest[®], Microgynon[®], Midiana[®], Novynette[®], Postinor[®], Qlaira[®], Regulon[®], Rigevidon[®], Tri-regol[®], Yasmin[®], Yaz[®] and Zoely[®],

In 2015 the Ministry of Health with the Center for Reproductive Health Training (CIDSR) with the assistance of United Nations Population Fund (UNFPA) - carried out a wide ranging assessment of the barriers and factors which limit the provision of and access to family planning services in primary health care in the country⁵⁵. This included interviews with family doctors and other providers and a review of education curricula on family planning for service providers.

This assessment report identified many barriers to the provision of family planning and in particular modern contraceptives to all groups in the population, and specifically those who are socially vulnerable. To improve the situation, recommendations were provided, included: developing efficient mechanisms for the supply of contraceptives; increasing the role of the family doctor and their team in providing FP services; streamlining their cooperation with other institutions and actors in reproductive health; development of a system for the accreditation of facilities offering family planning services; delegation by the Ministry of Health to a single structure/republican institution the role to manage the system for the procurement and distribution of contraceptives. This would ensure centralized procurement, monitoring and evaluation of the provision of contraceptives and particularly those to persons of reproductive age in socially vulnerable groups, and monitoring stocks; development of criteria for defining socially vulnerable groups and mechanisms for identification and registration of them and monitoring their use.

⁵⁴ Information provided Medicines Agency May 2017

⁵⁵ Ministry of Health of the Republic of Moldova, Center for Reproductive Health Training (CIDSR), United Nations Population Fund (UNFPA). Assessing barriers and factors that facilitate the provision of and access to family planning services in primary health care in the Republic of Moldova and graduate and postgraduate, vocational technical and post-secondary non-tertiary education curricula on reflecting the subject of family planning. Report. Chisinau, 2015.

In line with the MoH order no. 658 of 2015, PHC service providers have suggested the vulnerable group eligible for free contraceptives should be the following categories: poor women, those addicted to alcohol/drugs, those with many children, sexually active teenagers, women who have had an abortion in the previous year, women with mental health disorders and those with children aged up to three years, and also those at obstetric and extra genital risks. The report recommended that a centralised system for procurement of contraceptives should be established and the existing logistics system for distributing contraceptives would allow health facilities to cover the needs of socially vulnerable groups in specific localities. Small value contracts for the purchase of contraceptives devolved to Primary Health Care facilities would cease.

Fertility and use of contraception: analysis of access to, preferences and use of modern contraceptives by different population segments (segmentation by age, place of residence/location, education, wealth quintiles), and the determinants of consumption and unmet need

Over the past 20 years, four population based surveys have been carried out and information collected on reproductive health, including family planning in the country⁵⁶. These have provided an insight into changing patterns of knowledge about, availability and use of contraceptives.

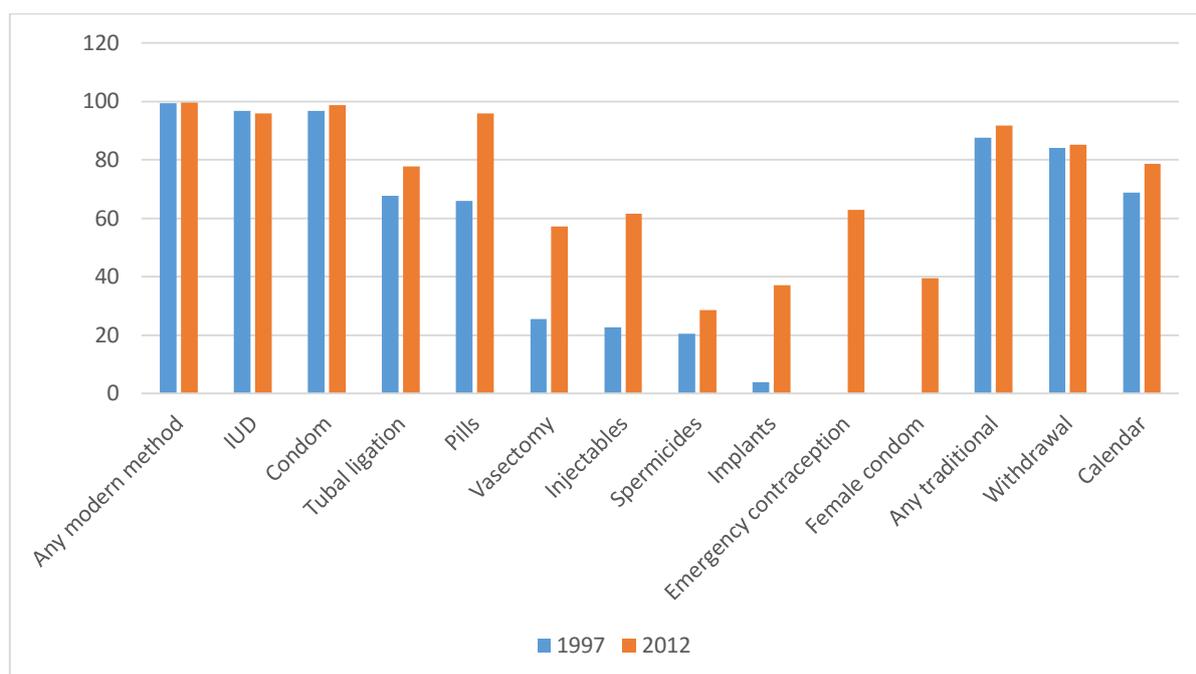
Knowledge of modern contraceptives

The level of awareness of different methods of contraception has increased slightly over the 20 years and overall is very high (see Figure 3, Figure 4). Not surprising, certain contraceptives such as, the female condom and emergency contraception were not known in 1997; but by 2012 over 60 percent knew of emergency contraception (see Figure 3, Figure 4). In 2012 there was virtually no difference in knowledge by residence (urban and rural), age, education, or wealth.

Very limited information is available on the extent to which people understand the precise nature, and how to use different types of modern contraception. There is also very little information on myths and misconceptions about modern contraceptives and particularly hormonal methods, but it is alleged that there is some reluctance by physicians to prescribe hormonal contraceptives, largely due to historical reasons with concerns about the side effects of high levels of particularly oestrogens used during Soviet times, while now only low dose products are available.

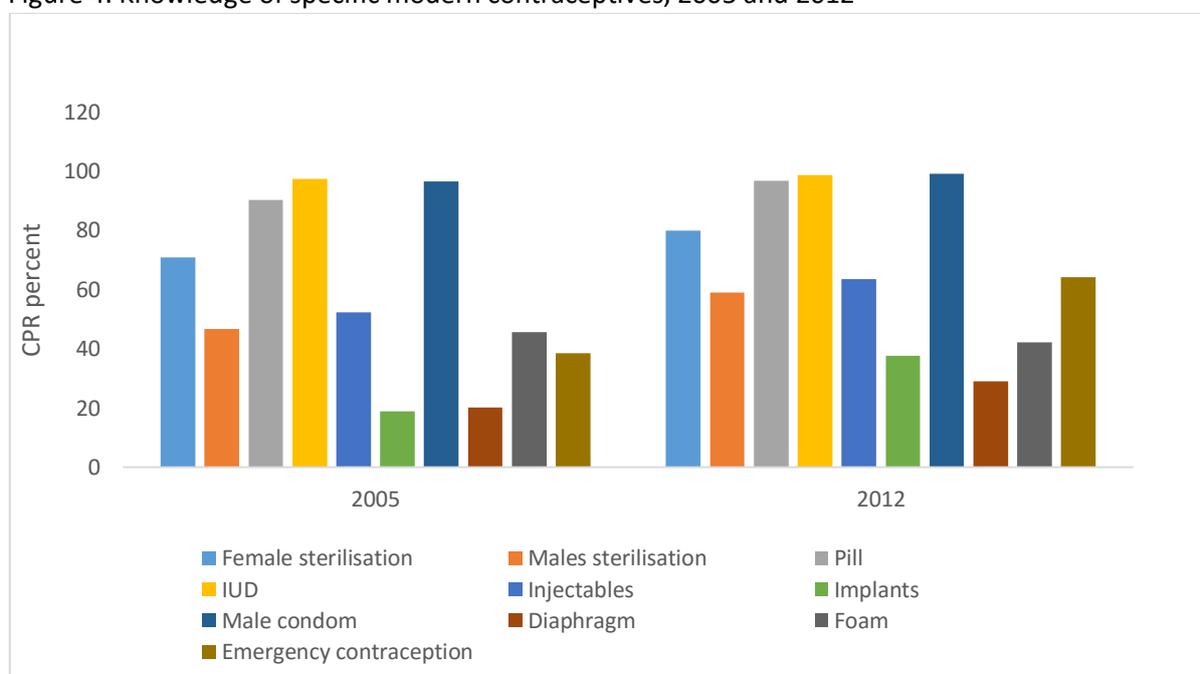
⁵⁶ Serbanescu F, Morris L, Stratila M, Bivol D. Reproductive Health Survey Moldova, 1997. Moldovan Ministry of Health, Institute for Scientific Research of Mother and Child Care, Moldovan State Department of Statistics, Family Planning Association of Moldova, Centers for Disease Control and Prevention, USA, UNFPA, USAID and UNICEF. Atlanta: 1998; UNICEF. Multiple Indicator Cluster Survey, Republic of Moldova, 2000. Chişinău: UNICEF; National Scientific and Applied Center for Preventive Medicine (NCPM) [Moldova] and ORC Macro. Moldova Demographic and Health Survey 2005. Calverton, Maryland: National Scientific and Applied Center for Preventive Medicine of the Ministry of Health and Social Protection and ORC Macro, 2006; National Centre of Public Health of the Ministry of Health of the Republic of Moldova, United Nations Children's Fund (UNICEF). 2012 Republic of Moldova Multiple Indicator Cluster Survey, Final Report. Chişinău, Republic of Moldova, 2014.

Figure 3: Knowledge of specific contraceptive methods, 1997 and 2012



Source: Serbanescu F, Morris L, Stratila M, Bivol D. Reproductive Health Survey Moldova, 1997. Moldovan Ministry of Health, Institute for Scientific Research of Mother and Child Care, Moldovan State Department of Statistics, Family Planning Association of Moldova, Centers for Disease Control and Prevention, USA, UNFPA, USAID and UNICEF. Atlanta: 1998 and National Centre of Public Health of the Ministry of Health of the Republic of Moldova, United Nations Children’s Fund (UNICEF). 2012 Republic of Moldova Multiple Indicator Cluster Survey, Final Report. Chişinău, Republic of Moldova, 2014.

Figure 4: Knowledge of specific modern contraceptives, 2005 and 2012



Source: National Centre of Public Health of the Ministry of Health of the Republic of Moldova, United Nations Children’s Fund (UNICEF). 2012 Republic of Moldova Multiple Indicator Cluster Survey, Final Report. Chişinău, Republic of Moldova, 2014.

The Demographic and Health survey (DHS) carried out in 2005 provides the most recent, more detailed information on knowledge of modern contraceptives, including side effects. This DHS found that 45 percent of users of modern contraceptives were informed about the side effects, or health problems of the method they were provided with. Forty four percent were informed of what to do if they experienced side effects, but only 37 percent of women who were using a modern method said they were told about other methods that they could use.

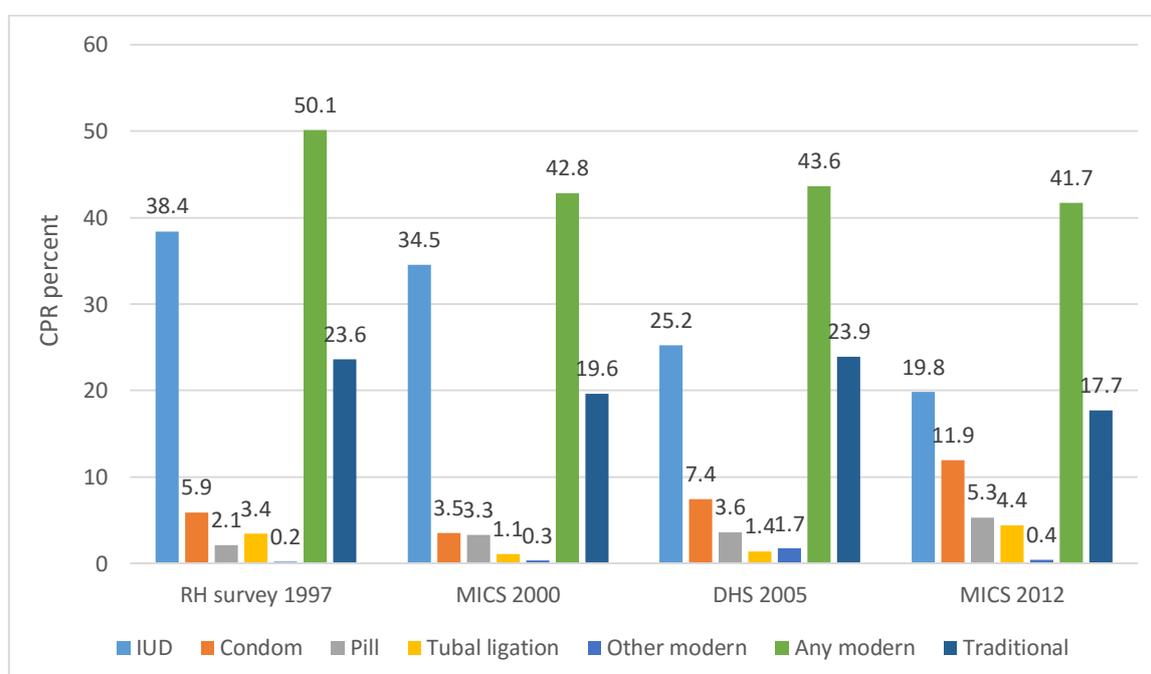
Almost half of women said they have seen a family planning message on the television, while about one-third said they heard about family planning on the radio, or read about it in a newspaper, or magazine in the previous few months. Only about one in four women said they heard about family planning in a pamphlet/brochure, or at a community event. Men were far less likely than women to say they have been exposed to family planning information. Less than one-third of men heard about family planning on the television, while less than one-quarter were exposed to information through the radio, newspaper or magazines, and only about 10 percent through pamphlets/brochures, or community events.

It is likely that these largely positive attitudes to modern contraception and reasonable levels of knowledge continue to apply at the present time.

Use of modern contraceptives

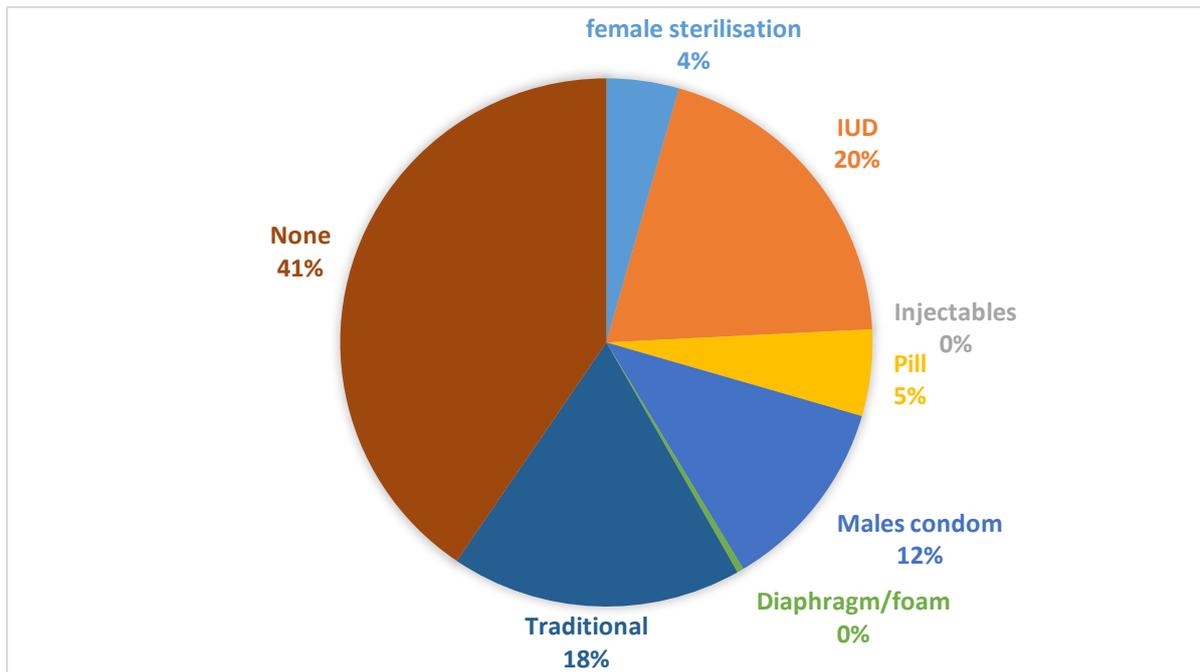
The level of use of modern contraceptives among married or in union women has declined over the past twenty years from just over a half (50.1 percent) in 1997 to 41.7 percent in 2012 (Figure 5).

Figure 5: Contraceptive use, women in union aged 15 to 49 years, 1997 to 2012 by contraceptive method



Source: National Centre of Public Health of the Ministry of Health of the Republic of Moldova, United Nations Children's Fund (UNICEF). 2012 Republic of Moldova Multiple Indicator Cluster Survey, Final Report. Chişinău, Republic of Moldova, 2014.

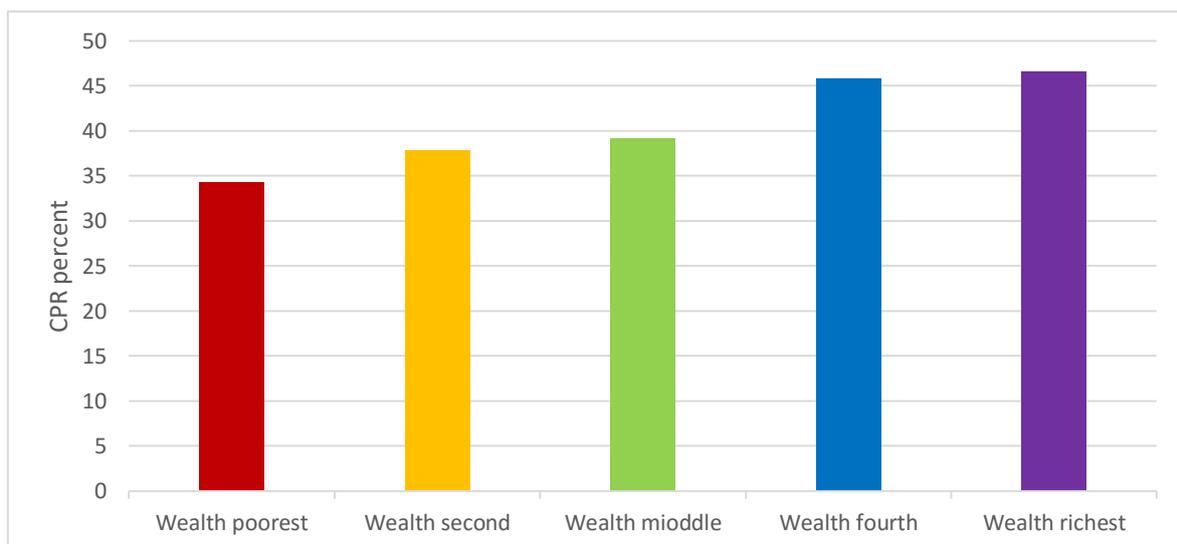
Figure 6: Use (and non-use) of contraception, currently married or in union women aged 15 to 49 years, 2012



Source: National Centre of Public Health of the Ministry of Health of the Republic of Moldova, United Nations Children’s Fund (UNICEF). 2012 Republic of Moldova Multiple Indicator Cluster Survey, Final Report. Chişinău, Republic of Moldova, 2014.

There has been a marked fall in the use of IUD (from a prevalence of 38.4 percent in 1997 to 19.8 percent in 2012), and an increase particularly in use of condoms and pills. However, overall the most frequently used modern contraceptive continues to be the IUD (Figure 6).

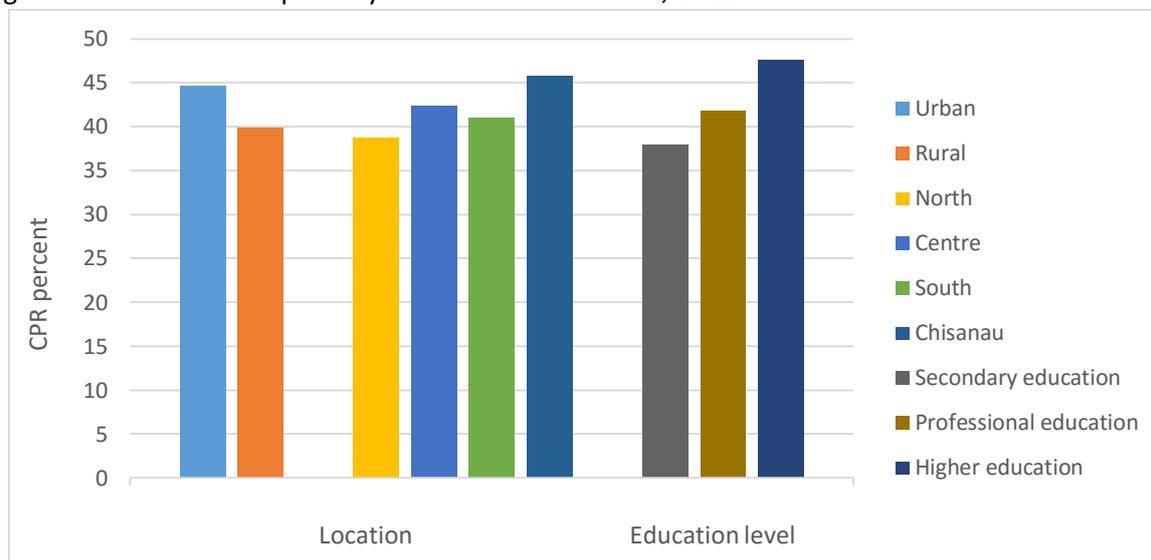
Figure 7: Use of modern contraception by wealth quintiles, 2012



Source: National Centre of Public Health of the Ministry of Health of the Republic of Moldova, United Nations Children’s Fund (UNICEF). 2012 Republic of Moldova Multiple Indicator Cluster Survey, Final Report. Chişinău, Republic of Moldova, 2014.

Use of modern contraceptives is highest among the wealthiest 40 percent of the population at 45 percent compared to the poorest 20 percent whose use is 34 percent (Figure 7). Those living in urban areas and particularly Chisinau have higher use of modern contraceptives compared to rural people (Figure 8). Similarly, those with higher levels of education, are more likely to use contraception.

Figure 8: Use of contraception by location and education, 2012



Source: National Centre of Public Health of the Ministry of Health of the Republic of Moldova, United Nations Children’s Fund (UNICEF). 2012 Republic of Moldova Multiple Indicator Cluster Survey, Final Report. Chişinău, Republic of Moldova, 2014

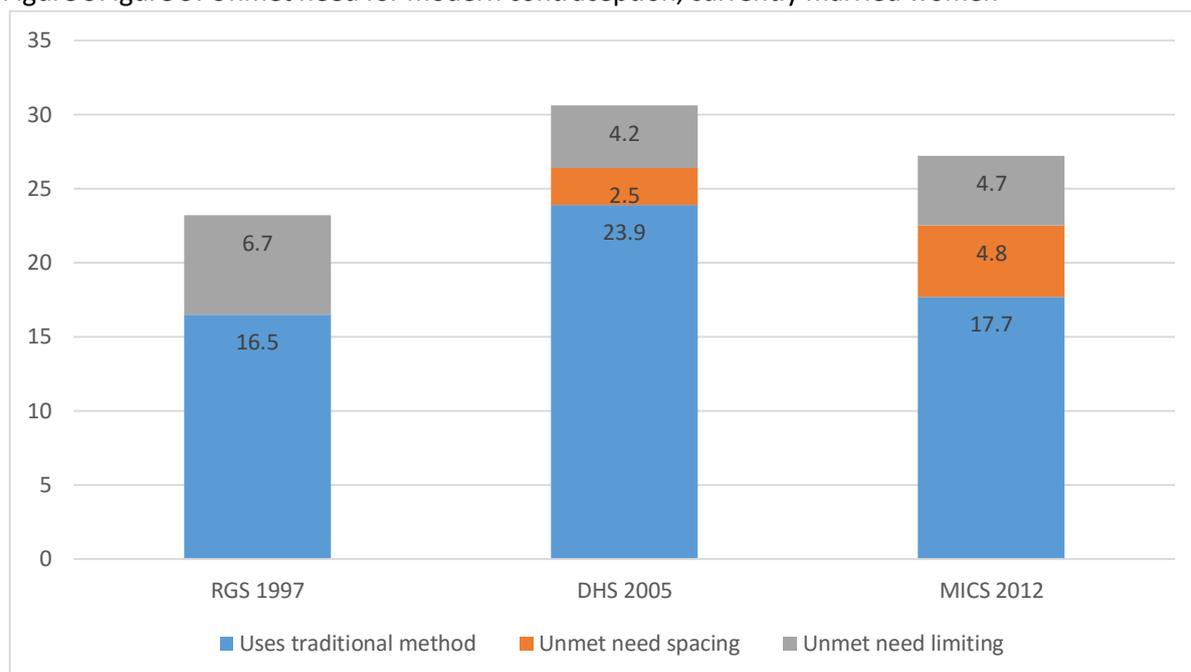
There are marked differences in the method mix within these categories (see appendix 2). For instance: IUD use is more common in the south region (at 23.1 percent), compared to the other regions and particularly Chisinau (at 13.1 percent); condom use is more frequent in urban areas (at 17.6 percent), compared to those in rural areas (at 8.2 percent); older people are more likely to use IUDs and younger ones - condoms.

Unmet need for modern contraception

Unmet need (fecund women who are married or in union and are not using any method of contraception, but who wish to postpone the next birth, or want to stop childbearing) is high. However if the definition used by the CDC in Reproductive Health Surveys⁵⁷, which also includes those using traditional methods, and is considered to be more appropriate for countries including Moldova, then unmet need for modern contraception is very high at 27.2 percent of married couples in 2012 (see Figure 9 and Figure 10).

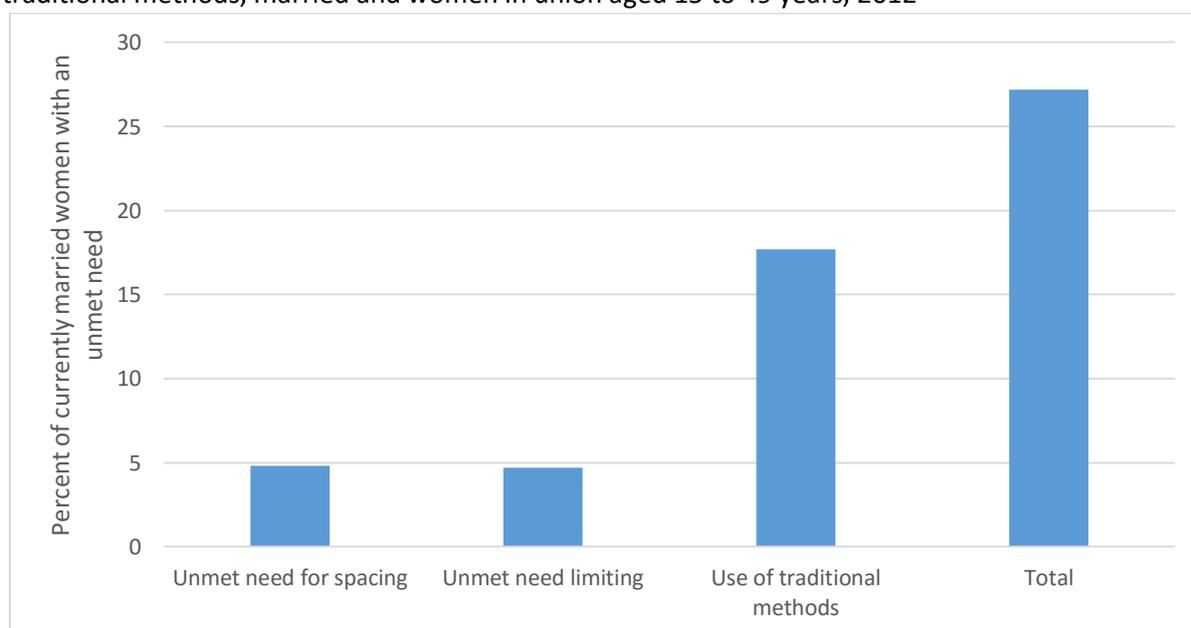
⁵⁷ See, https://www.cdc.gov/reproductivehealth/productspubs/pdfs/epi_module_04_tag508.pdf

Figure 9: Unmet need for modern contraception, currently married women⁵⁸



Source: Serbanescu F, Morris L, Stratila M, Bivol D. Reproductive Health Survey Moldova, 1997. Moldovan Ministry of Health, Institute for Scientific Research of Mother and Child Care, Moldovan State Department of Statistics, Family Planning Association of Moldova, Centers for Disease Control and Prevention, USA, UNFPA, USAID and UNICEF. Atlanta: 1998, National Scientific and Applied Center for Preventive Medicine (NCPM) [Moldova] and ORC Macro. Moldova Demographic and Health Survey 2005. Calverton, Maryland: National Scientific and Applied Center for Preventive Medicine of the Ministry of Health and Social Protection and ORC Macro, 2006 and National Centre of Public Health of the Ministry of Health of the Republic of Moldova, United Nations Children’s Fund (UNICEF). 2012 Republic of Moldova Multiple Indicator Cluster Survey, Final Report. Chisinau, Republic of Moldova, 2014.

Figure 10: Unmet need for modern contraception, for spacing, for limiting and present use of traditional methods, married and women in union aged 15 to 49 years, 2012

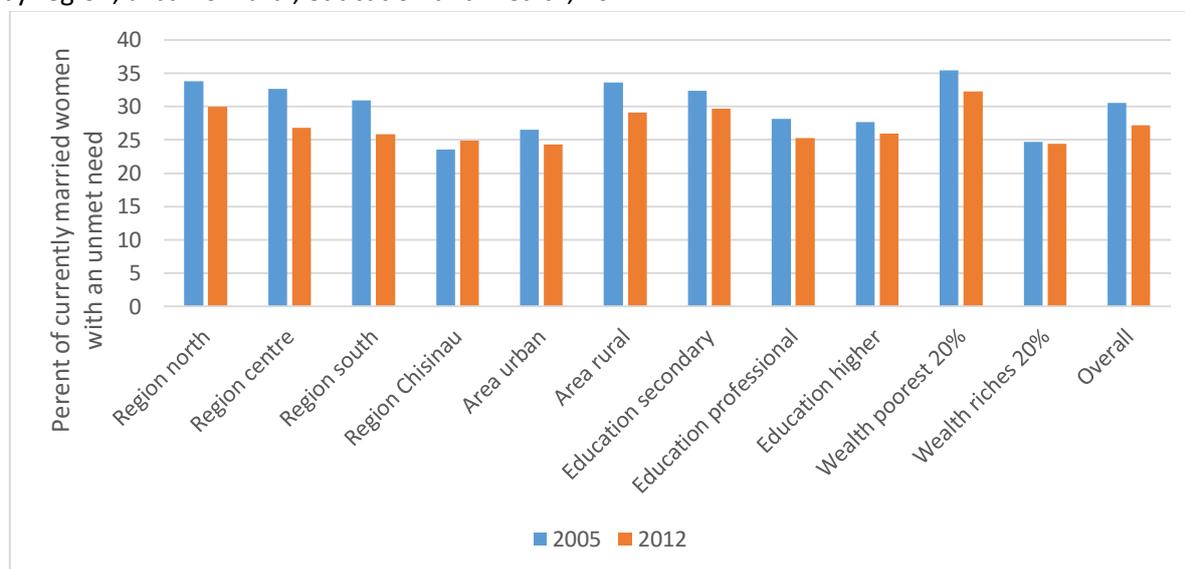


Source: National Centre of Public Health of the Ministry of Health of the Republic of Moldova, United Nations Children’s Fund (UNICEF). 2012 Republic of Moldova Multiple Indicator Cluster Survey, Final Report. Chisinau, Republic of Moldova, 2014.

⁵⁸ The definition of unmet need is the one used by the CDC reproductive health surveys, see Measure evaluation. https://www.measureevaluation.org/prh/rh_indicators/specific/fp/unmet-need-for-family-planning Unmet need for family planning For the 1997 RHS is women 15 to 44 years, for the 2005 DHS and the 2012 MICS it is women 15 to 49 years

Unmet need for modern contraception is highest among those living in rural areas, the north of the country, those with the lowest levels of education and significantly among the poorest 20 percent at 32.3 percent compared to 24.4 percent among the wealthiest (see Figure 11).

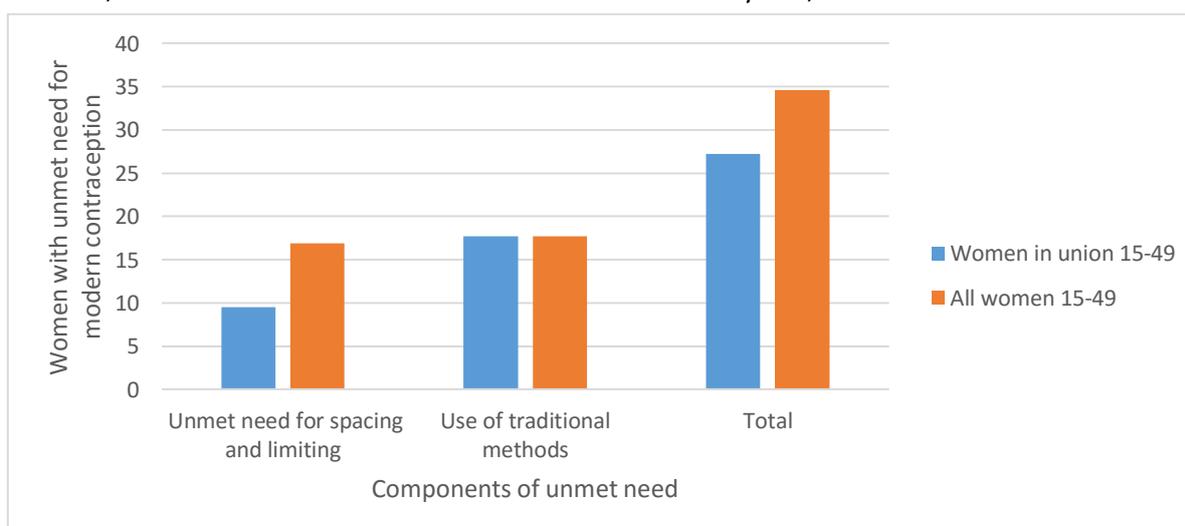
Figure 11: Unmet need (married and in union women aged 15 to 49 years) for modern contraception by region, urban or rural, education and wealth, 2012



Source: National Centre of Public Health of the Ministry of Health of the Republic of Moldova, United Nations Children’s Fund (UNICEF). 2012 Republic of Moldova Multiple Indicator Cluster Survey, Final Report. Chişinău, Republic of Moldova, 2014.

Unmet need for modern contraception is considerably higher when all women aged 15 to 49 years (at over a third) are included as against restricting consideration only to women who are married or in union (at about a quarter) (see Figure 12). These increased percentages among all women are particularly higher for the poorest, those with the least education and women living in rural areas.

Figure 12: Unmet need for modern contraception, for spacing and limiting and use of traditional methods, women married or in union and all women 15 to 49 years, 2012



Source: Special tabulation provided by UNFPA from Demographic Research Center of the Republic of Moldova, United Nations Children’s Fund (UNICEF). 2012 Republic of Moldova Multiple Indicator Cluster Survey, Final Report. Chişinău, Republic of Moldova, 2014. The estimated figures for the 2012 MICS on unmet need and use of contraception for ALL Women were provided by the Demographic Research Center.

Induced abortion

Reliance on induced abortion was an important form of fertility control throughout the former Soviet Union, including the former Soviet Republic of Moldova. In the decade after Moldova's independence in 1991, abortion rates began to decrease, as the practice of modern contraception became more widespread. However, as has been made clear earlier, prevalence of modern contraception over the past 15 or so years, has plateaued. Induced abortion continues to be an important form of fertility control.

Like other countries in Eastern and Central Europe, and the former Soviet Union, Moldova's abortion laws are among the most liberal in the world. They allow women to obtain a voluntary abortion upon request up to the 12th week of pregnancy, and up to 21st week in case of socioeconomic and medical reasons. For various reasons, including limited access to modern contraception, abortion continues to be an important form of fertility control. The abortion rate in Moldova has declined sharply since independence from in 1989 a rate of 93.0 abortions per 1,000 women aged 15 to 44 years, which was among the highest reported rates in the Soviet Union. The reported rate fell to 50 in 1994, 38.8 in 1996, 30.8 in 1998, 17.6 in 2004, and 18.0 in 2010, and in 2015 the rate was 21.5 abortions per 1000 women aged 15-44 years⁵⁹. However probably figures for recent years are under reported⁶⁰ because many are carried out privately and also by using Cytotec (Misoprostol) and Mt Pill (mifepristone), as medical abortion has become widely accepted and practised⁶¹.

Data from the 2005 DHS found a lifetime total abortion rate for the three-year period prior to the survey (from mid-2002 to mid-2005) of 1.1 abortions per woman. The TAR was slightly higher in urban areas than rural areas (1.3 and 1.0, respectively). These rates are lower than for the neighbouring countries of Romania (2.2) and Ukraine (1.6).

The lowest TAR of 0.7 was seen for women in the poorest wealth quintile, while the highest TAR (1.4) was for women in the highest quintile, and also for women in Chisinau⁶². Higher abortion rates among these wealthier women are probably due to the fact that because abortions are no longer covered by the state, women with adequate resources are more likely to have access to abortion and to be able to afford the procedure.

Advice on access to different types of induced abortion are available from the Reproductive Health Training Center of the Republic of Moldova (RHTC), a non-governmental organization, founded in 1998⁶³, the Center with the MoH maintains a monitoring system and the coverage of these statistics are considered to be high. Based on this system it is estimated that the annual abortion rate is 15 abortions per 1,000 women aged 15 to 49 years or 12,635 per year.

We were informed by Dr Rodica Comendant, the Director of the RHTC that of termination of pregnancies - about 15 percent were by medical means, 70 percent by aspiration and 15 percent by D&C. We were informed that an abortion carried out by aspiration costs about € 20 and one carried out by medical means € 30, and although we were told that misoprostol and mifepristone

⁵⁹ See <http://www.johnstonsarchive.net/policy/abortion/ab-moldova.html>

⁶⁰ Reproductive Health Training Center of the Republic of Moldova (RHTC). Evaluating and mapping comprehensive abortion care in the Republic of Moldova; WHO, 2014-2015. <https://womenhelp.org/en/page/688/whw-resources-and-publications>

⁶¹ See Comendant R. Medical abortion implementation in Moldova: from the clandestine use to the incorporation into National abortion Standards. <http://www.sanatateafemeii.md/wp-content/uploads/2016/06/Comendant.pdf> Accessed May 2017

⁶² National Scientific and Applied Center for Preventive Medicine (NCPM) [Moldova] and ORC Macro. Moldova Demographic and Health Survey 2005. Calverton, Maryland: National Scientific and Applied Center for Preventive Medicine of the Ministry of Health and Social Protection and ORC Macro, 2006

⁶³ See: Reproductive Health Training Center of the Republic of Moldova (RHTC). Evaluating and mapping comprehensive abortion care in the Republic of Moldova; WHO, 2014-2015. <https://womenhelp.org/en/page/688/whw-resources-and-publications>

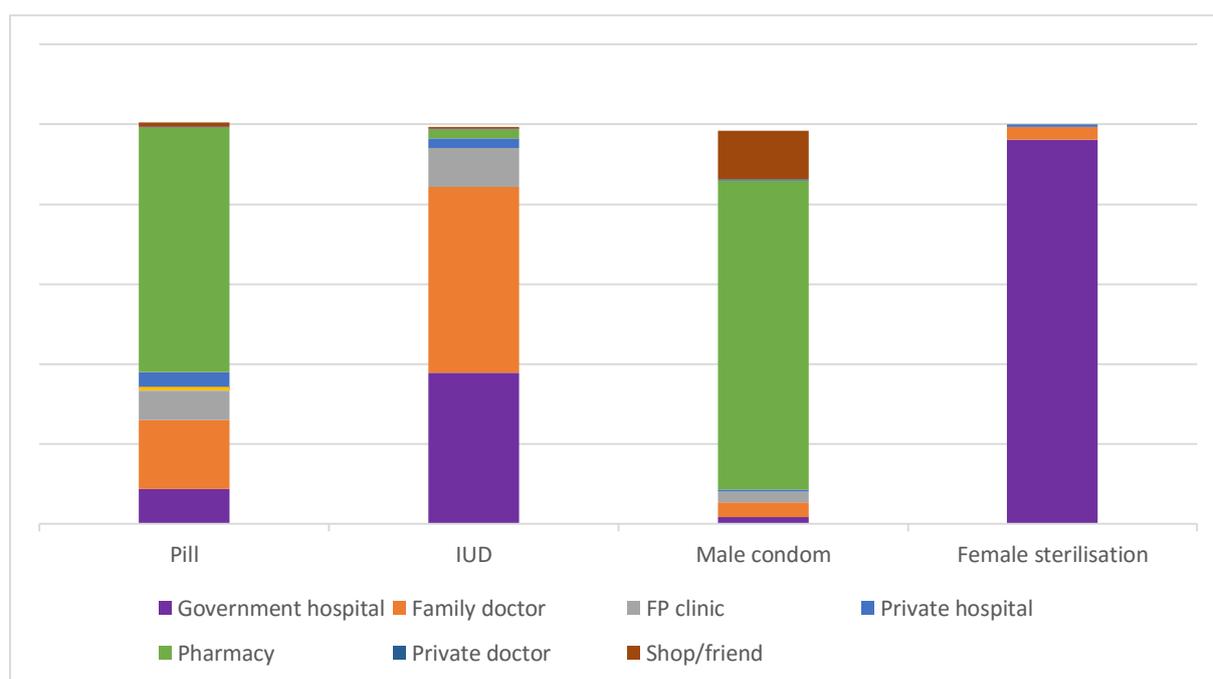
is only available on prescription, we could have purchased them without a prescription in some pharmacies at a cost of about € 34. Induced abortion is not covered by the NHIC.

An overview of the evidence on the availability of modern contraceptives and contraceptive methods mix on the national market

Source of modern contraceptive methods

It is helpful to have an understanding of where people are obtaining their contraceptive supplies, in order to see the adequacy of access and coverage of modern contraceptives. The only representative information on the source from which people are obtaining their contraceptives is from the DHS of 2005⁶⁴. This shows that at that time in 2005, public (government) facilities provided contraceptives to more than two in three users (69 percent), while 28 percent of users obtained their contraceptives from commercial pharmacies and private medical sources, and three percent through other private sources such as shops (Figure 13).

Figure 13: Source used by people for modern contraceptives, 2005



Source: National Scientific and Applied Center for Preventive Medicine (NCPM) [Moldova] and ORC Macro. Moldova Demographic and Health Survey 2005. Calverton, Maryland: National Scientific and Applied Center for Preventive Medicine of the Ministry of Health and Social Protection and ORC Macro, 2006.

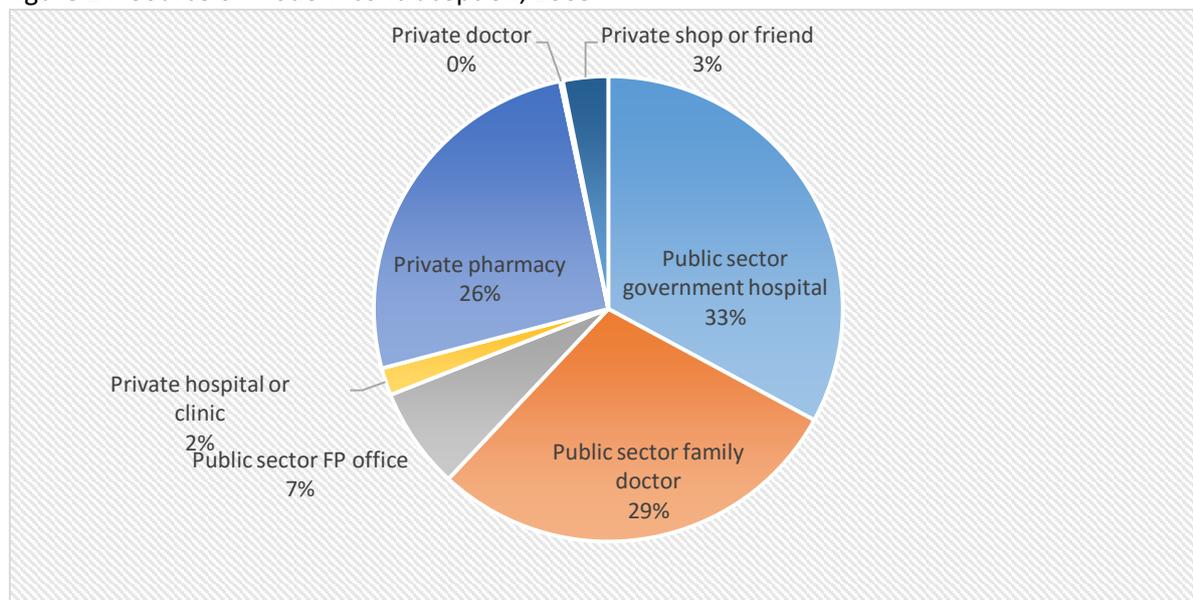
The most common single source of contraceptives in Moldova was government hospitals, which supplied one-third of all users of modern methods. Family doctors and pharmacies, each supplied about one-quarter of users, while government family planning offices only supplied seven percent

⁶⁴ National Scientific and Applied Center for Preventive Medicine (NCPM) [Moldova] and ORC Macro. Moldova Demographic and Health Survey 2005. Calverton, Maryland: National Scientific and Applied Center for Preventive Medicine of the Ministry of Health and Social Protection and ORC Macro, 2006.

of users. Private hospitals and clinics, and private doctors at that time accounted for only a very small share (two percent) of contraceptive provision.

Government sources, supplied almost all users of long-term methods, such as female sterilization (99 percent) and IUD (95 percent). However, the large majority of pill and condom users obtained their methods from private sources, especially pharmacies. Nevertheless at that time, one-third of pill users obtained their supplies from government sources (see Figure 14).

Figure 14: Source of modern contraception, 2005



Source: National Scientific and Applied Center for Preventive Medicine (NCPM) [Moldova] and ORC Macro. Moldova Demographic and Health Survey 2005. Calverton, Maryland: National Scientific and Applied Center for Preventive Medicine of the Ministry of Health and Social Protection and ORC Macro, 2006.

It is not clear to what extent the source of contraceptives, which people use, has changed over the past 10 or so years, but given the change in the method mix of contraceptives used by people with less reliance on long acting methods over this time, and that UNFPA ceased to donate contraceptives in 2012, there must have been a considerable shift in people obtaining their contraceptives from the public to the private sector.

There is a dynamic commercial market in a range of modern contraceptives, which are available for purchase from pharmacies and other outlets; and many pharmacies have over 15 different brands of contraceptive pills on sale.

UNFPA has provided supplies of modern contraceptives (combined hormonal pills, copper IUDs, Depo-Provera® and condoms) since the mid 1990 until 2012 (see Table 2), when with the designation of Moldova, as a lower middle income country, this ceased⁶⁵.

⁶⁵ El-Fiki M. Reproductive Health Commodity Security. Situation Analysis in the Republic of Moldova. Chisinau: UNFPA Country Office, October 2016. See also: UNFPA. Final country programme document for the Republic of Moldova (2013-2017). New York: 2012 and Cojohari N, Reed S, Caraseni G. Final Report Independent Second Country Programme 2013-2017 Evaluation: Republic of Moldova. New York: UNFPA, 2016.

Table 2: Contraceptives provided by UNFPA 2011 and 2012

Year purchased	Contraceptive	Quantities
2011	IUDs copper T 380A	30,000 pieces
	Depo-Provera® and syringes	4,000 sets
	Microgynon® 30	149,760 cycles
2012	Condoms, male	2,016,000 pieces
	Marvelon	149,580 cycles
	Exluton	39,936 cycles

Through the UNFPA Procurement Services – the Public Institution “Coordination, Implementation and Monitoring Unit of the Health System Projects” (UCIMP) which implements the Global Fund to Fight Aids, TB and Malaria grants, procured in 2012, Standard Male Condoms 53 mm (2.200.032 pieces) (Table 3).

Table 3: Male condoms procured from 2012 to 2016 by local implementing partners of Global Fund to Fight AIDS, TB and Malaria grants (NGO PAS Center; UCIMP), including via UNFPA Procurement Services.

Year purchased	Contraceptive	Quantities
2012	Condoms, male	2,200,032
2015	Condoms, male	1,280,160
2016	Condoms, male	1,883,232

On our visits to PHCFs and YFHCs we found very few contraceptives available at primary healthcare facilities and youth friendly health centres (YFHCs)⁶⁶. Although, the commercial pharmacies in some Primary Healthcare facilities have a range of oral hormonal contraceptives and condoms (Figure 15).

Figure 15: Contraceptives in one commercial pharmacy in a Primary Healthcare facility



⁶⁶ El-Fiki M. Reproductive Health Commodity Security. Situation Analysis in the Republic of Moldova. Chisinau: UNFPA Country Office, October 2016.

Towards the end of 2016 some PHCFs had very limited quantities of pills and condoms and virtually none had IUDs or injectable contraceptives. In some instances, the limited amounts of modern contraceptives available in PHCFs, are those remained from the final UNFPA donation provided in 2012.

Figure 16: The limited quantities of modern contraceptives (male condoms and IUDs) available at one health centre visited during this consultancy. These had been recently purchased locally, using available funds.



Some PHCFs managers purchase locally contraceptives using their discretionary funds allocated for purchase of pharmaceuticals and other supplies (Figure 17). Although, there are many demands on these limited funds available, and contraceptives are one of many pharmaceuticals and other supplies in short supply (Figure 16).

Figure 17: Modern contraceptives bought locally by one Health Center in early 2017 from discretionary available budget. This included Depo-Provera® bought through the local office of Gideon Richter.



A similar situation was found at one YFHC, see Figure 18.

Figure 18: Examples of condoms available in one Youth Friendly Health centre



Key Concepts – ability and willingness to pay and contracepting couple income

The ability to pay (ATP) refers to how easy it is for consumers to find the money necessary to pay for, in this case, contraceptives. An ATP analysis assumes that the lower the relative cost of contraceptives, in relation to income, the greater the ability of users to pay for them, and there is good international evidence for this. The approach used to measure ATP involves deriving the average annual income of contracepting couples by income quintile (five equal population subgroups), and comparing this to the cost of a couple year of protection (CYP) for different methods and brands, and from different sources.

An estimate frequently used to measure ATP, assumes that expenditure on contraceptives should be no more than one percent of per couple income⁶⁷. Couples who would have to exceed one percent of income on contraceptives, are considered to be unable, or less likely to pay. However the one percent estimate may be biased toward middle income populations with more disposable income, than toward poorer income groups.

There is a large amount of evidence from many countries that the use of modern contraceptives is very sensitive to price, with quite small increases in price, resulting in reductions in use of contraception⁶⁸. Using per capita income to estimate affordability - is not a perfect solution. Some contracepting couples have access to either household, or spousal income and it is reasonable if you assume that contraceptives are purchased by one or the other, but not by both members of couples⁶⁹. Therefore, estimates of ATP often consider a lower income threshold, such as 0.5 percent, for the poorest 40 percent of the population.

⁶⁷ See: Singh S, Darroch JE, Ashford LS, Vlassoff M. Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health. New York: UNFPA and the Guttmacher Institute, 2009; Singh S, Darroch JE. Adding It Up: Costs and Benefits of Contraceptive Services Estimates for 2012. New York: UNFPA and the Guttmacher Institute, 2012; Harvey PD. The Impact of Condom Prices on Sales in Social Marketing Programs. Studies in family planning 1994; 25(1): 52-58.

⁶⁸ Harvey PD. The Impact of Condom Prices on Sales in Social Marketing Programs. Studies in family planning 1994; 25(1): 52-58.

⁶⁹ See: Hudgins T, Walker G, Stan L. Ensuring Contraceptives for Disadvantaged Populations in Romania. Bucharest: JSI and UNFPA, 2003; and Karim AM, Sarley D, Hudgins AA. Bangladesh: Family Planning Market Segmentation— Update of the 2003 Analysis. Arlington, Va.: USAID | DELIVER PROJECT, Task Order 1, 2007.

Analysis of RH accounts in several countries by the World Bank suggest estimates of around 0.5 percent of couple income on contraceptives may be more realistic, given household expenditures on other (reproductive) health care services and commodities. To obtain an indication of ATP, contraceptive costs by method and brand, and by source are then compared to income quintiles, producing a cost to income ratio expressed as a percentage. This analysis provides an indication of what methods and brands are affordable to each income quintile.

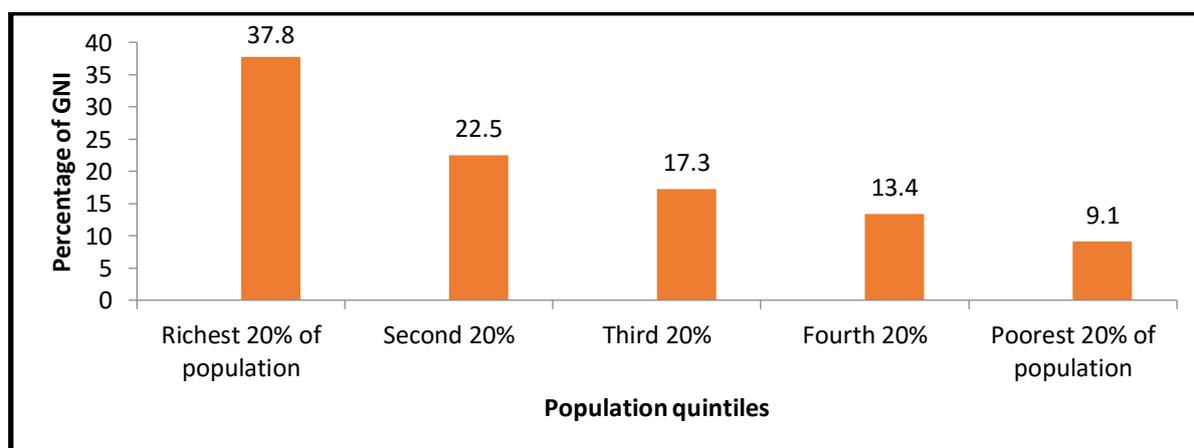
In contrast to ATP, willingness to pay (WTP) reflects the value customers place on contraceptives. Consumers, of course, may make decisions to spend more than one percent of couple income, because of the value they place on the product. Interviews with pharmacists and physicians indicated that some women were willing to pay very high prices for the oral contraceptives (e.g. Yasmin® € 8 for one cycle, Yaz® € 10 for one cycle). While this evidence is only anecdotal, there is a marked distinction between the ability and willingness to pay. In the absence of an alternate for defining a benchmark, analyses in this report categorizes users as unable to pay, if the price exceeds 1.0 percent of annual couple income (2 x per capita income). This does not necessarily mean households are unwilling to pay, but are certainly less likely, given their income. Couples will be considered able to pay, if the price is below 1 to 1.5 percent of income.

Deriving average income by population segments and sampling of pharmacies for collecting costs of contraceptives

Estimating the ATP for contraceptives first requires data on the percentage of national income, by population segments or quintiles. Mean per capita income for each quintile was calculated using World Bank income data for 2015 and income distribution data from 2015 (Figure 19) the most recent year for which this data is available⁷⁰.

The World Bank's most recent estimate of the per capita gross national income (GNI) is for 2015 and came to an equivalent to US 2,240⁷¹. This is based on an estimated population of 3.5 million which is the figure available when the World Bank's estimate was made. However the results of the 2014 national census are now available and this enumerated the population at 2,804,801⁷². This figure has been used and the GNI per capita adjusted to take account of the lower population figure from the 2014 national census (Figure 20).

Figure 19: Percentage distribution of income by quintile, Moldova 2015



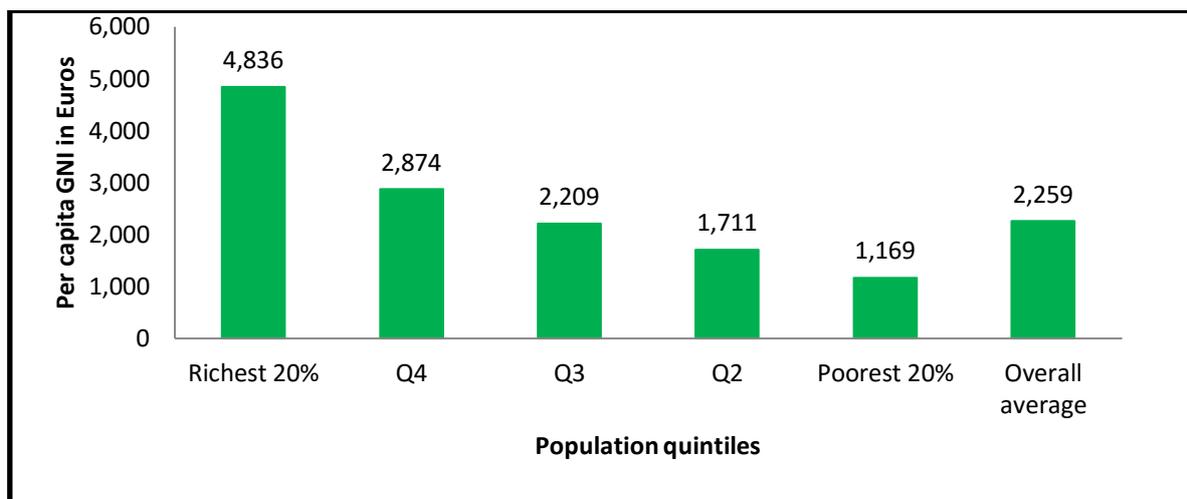
Source: World Bank, Moldova data <http://data.worldbank.org/country/moldova> accessed 12 April 2017

⁷⁰ A conversion rate of US\$ 1 = € 0.9144 was used; <http://www.xe.com/> accessed May 2017.

⁷¹ World Bank, Moldova. <http://data.worldbank.org/country/moldova> accessed 15 April 2017

⁷² See NBS website <http://www.statistica.md/pageview.php?l=ro&idc=479>

Figure 20: Estimated per capita income in Euros by population quintiles, 2015



Cost of modern contraceptives at pharmacies; prices charged for contraceptives in the commercial sector

Over 20 private pharmacies selling contraceptives⁷³ were visited to determine available brands, methods and price of contraceptives. The pharmacies represented convenience samples, however, in a sense, the sample was also purposive. An effort was made to obtain a diverse sample, including urban and rural pharmacies in all of the regions in the country, and various parts of Chisinau.

Table 4 presents data on median unit prices recorded from the pricing survey, by method and brand charged for condoms, pills, IUDs, emergency contraception, vaginal foams and other contraceptives sold in Moldova. For most specific brands there is some price variation between pharmacies in different parts of the country. This probably largely reflects competition and availability from a range of outlets.

In general, there was a wide range of contraceptives available, including many brands of and oral combined hormonal pills, several brands of emergency contraceptives, IUDs and contraceptive foams (Figure 21 and Figure 22). In a few pharmacies there were even hormonal vaginal rings and Mirena® the hormone-releasing IUD. Pharmacies reported the sales of condoms with prices ranging from € 8 cents to the most expensive at € 90 cents per piece, and from € 11 for one cycle of the most expensive oral contraceptive to € 2.5 for the cheapest CoC (Table 4).

When speaking with pharmacists, and asking which oral contraceptives are the most popular we were told that generally is Yaz®, Dimia® and Yasmin®. These are all the most expensive of the range of over 15 oral hormonal contraceptives on sale, and when asked, the pharmacists said that these were the brands that the family doctors and gynecologists often highly recommend to women. We also understand that Gideon Richter, Bayer and local pharmaceutical distributors have numbers of representatives (detail men) who regularly visit pharmacies and family doctors and gynecologists and give free 'samples' to them of the products they are marketing.

⁷³ Pharmacies in central Chisinau, several areas of Chisinau Municipality, Cimislia District, Hincesti District, Ungheni District, Calarasi district, Causeni District Anenii-Noi District and Bulboaca Village, Costesti village from Ialoveni District were visited and cost figures for contraceptives obtained.

Figure 21: A selection of some male condoms on sale in a commercial pharmacy



Figure 22: A selection of some oral hormonal contraceptives on sale in a commercial pharmacy



Table 4: Prices⁷⁴ of contraceptives in sampled pharmacies, May 2017

Brand of contraceptive	Median price in € at pharmacies in sample
Lindynette® 20	3.1
Rigevidon®	4.4
Dimia®	7.0
Tri-regol®	7.1
Regulon®	4.1
Yaz®	10.0
Belara®	9.4
Qlaira®	10.8
Midiana®	4.7

⁷⁴ A conversion rate of € 1 = MDL 20.44 was used; <http://www.xe.com/>, accessed May 2017,

Logest®	5.2
Diane® 35 ⁷⁵	4.3
Yasmin®	7.7
Novynette®	4.7
Regulon®	4.5
Artizia®	3.6
Angeliq	12.1
Microgynon®	2.5
Progestone only	
Lactinette®	9.1
Emergency contraception	
Postinor®	6.6
Escapelle®	8.2
IUDs	
Mirena®	130.2
Yunona® T cu	19.6
Yunona® Bio T	3.4
Yunona® bio multi	*
Yunona® T super	6.3
IUD generic T Chinese	2.7
Condoms	
Durex®	0.9
Lex	0.3
Vizit	0.7
Dolphin	0.5
Playboy	0.9
One Touch	0.5
Wadex	*
You libido	0.3
Masculin	0.5
Romed	0.1
Innotex	0.4
Sico	0.5
Vaginal ring	
Nova ring	10.0
Vaginal tablets	
Pharmatex, vaginal suppositories, pack of 10	5.0

* Insufficient numbers to obtain a reasonable indication of price.

The prices charged for contraceptives are high in comparison to income and the cost of living. Prices are slightly higher in rural and are less accessible, and particularly, less affordable.

⁷⁵ See information on side effects, http://www.ema.europa.eu/ema/index.jsp?curl=pages/news_and_events/news/2013/05/news_detail_001801.jsp&mid=WC0b01ac058004d5c1 and <http://omr.bayer.ca/omr/online/diane-35-pm-pt3.pdf>

Preparing ability to pay estimates for modern contraceptive in the country

The annual cost of contraceptive protection for each type and brand being sold in pharmacies, was determined by multiplying the median unit price (Table 4) by the standard couple-year of protection (CYP) factor for each method⁷⁶. Internationally agreed CYP factors used for the analysis, were 120 condoms per year, 15 cycles of pills, 4.6 years per IUD, 3.3 years for a five year LNG-IUS IUD, and 20 doses for emergency contraceptive pills.

The cost of a year's protection from becoming pregnant, as a percentage of annual income, was determined by dividing the annual cost per CYP for each brand by contracepting couple income, for each income quintile segment of the population (see Figure 19 and Figure 20). As discussed earlier, household expenditures of amounts spent for contraceptives above 1.0 percent of annual contracepting couple income are usually considered excessive and generally unsustainable. Unusually contracepting couples may be willing to pay in excess of 1.5, 2.0, or even 3.0 percent of income; however, an assumption was made that 1.0 percent, for the situation in Moldova, is the ceiling where customers reach their maximum ATP. In Table 5 percentages of income exceeding 2.0 percent are shaded yellow, between 1.0 and 1.9 are shaded in red and below 1.0 percent in blue.

Table 5: Cost of contraceptives (using median price) as a percentage of annual income for couples

Affordable Marginally affordable Unaffordable

Contracepting Couple (i.e. Double the per capita figure) Gross National Income in Euros							
Source: Commercial Pharmacies and drug stores	Euros	Q1 Poorest 2,338	Q2 3,422	Q3 4,418	Q4 5,748	Q5 Richest 9,672	Mean 4,518
Method	Brand	Cost per CYP	Cost as a Percentage of Annual Income				
Condoms							
	Lex	36	1.5	1.1	0.8	0.6	0.4
	Vizit	84	3.4	2.5	1.9	1.5	0.9
	Playboy	108	4.6	3.2	2.4	1.9	1.1
	Dolphin	60	2.6	1.8	1.4	1.0	0.6
	One Touch	60	2.6	1.8	1.4	1.0	0.6
	Durex®	108	4.6	3.2	2.4	1.9	1.1
	You libido	36	1.5	1.1	0.8	0.6	0.4
	Masculin	60	2.6	1.8	1.4	1.0	0.6
	Romed	12	0.5	0.4	0.3	0.2	0.1
	Innotex	48	2.1	1.4	1.0	0.8	0.4
	Sico	60	2.6	1.8	1.4	1.0	0.6

⁷⁶ MEASURE Evaluation PRH. Family Planning and Reproductive Health Indicators Database. Couple-years of protection (CYP). http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp/cyp
http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp/cyp Accessed May 2017.

COCs							
	Diane® 35 ⁷⁷	64.5	2.8	1.9	1.5	1.1	0.7
	Tri-regol®	106.5	4.6	3.1	2.4	1.9	1.1
	Yaz®	150	6.4	4.4	3.4	2.6	1.6
	Yasmin®	115.5	4.9	3.4	2.6	2.0	1.2
	Lindynette® 20	46.5	2.0	1.4	1.1	0.8	0.5
	Microgynon®	37.5	1.6	1.1	0.8	0.7	0.4
	Dimia®	105	4.5	3.1	2.4	1.8	1.1
	Regulon®	61.5	2.6	1.8	1.4	1.1	0.6
	Belara®	141	6.0	4.1	3.2	2.5	1.5
	Qlaira®	162	6.9	4.7	3.7	2.8	1.7
	Midiana®	70.5	3.2	2.1	1.6	1.2	0.7
	Logest®	78	3.3	2.3	1.8	1.0	0.8
	Novynette®	70.5	3.2	2.1	1.6	1.2	0.7
	Artizia®	54	2.3	1.6	1.2	0.9	0.6
	Angeliq	181.5	7.8	5.3	4.1	3.2	1.9
	Rigevidon®	66	2.8	1.8	1.4	1.0	0.6
Progestone only pills							
	Lactinette®	136.5	5.8	4.0	3.1	2.3	1.4
Emergency contraception							
	Postinor®	132	5.6	3.9	3.0	2.2	1.4
	Escapelle®	164	7.0	4.8	3.7	2.9	1.7
IUDs							
	Yunona® T cu	4.4	0.2	0.1	<0.1	<0.1	<0.1
	Yunona® Bio T	*					
	Yunona® bio multi	*					
	Yunona® T super	*					
	IUD generic Chinese	0.6	<0.1	<0.1	<0.1	<0.1	<0.1
	Mirena®	37.2	1.6	1.1	0.8	0.6	0.4

⁷⁷ See information on side effects, http://www.ema.europa.eu/ema/index.jsp?curl=pages/news_and_events/news/2013/05/news_detail_001801.jsp&mid=WC0b01ac058004d5c1 and <http://omr.bayer.ca/omr/online/diane-35-pm-pt3.pdf>

Segments of the population which are disadvantaged and high priority for the provision of modern contraceptives

The case for subsidizing the provision of family planning in Moldova

The prevention of unintended pregnancies should be a priority in modern societies. Women empowerment, employment and integration - are crucial elements for the wellbeing of women and of society as a whole, particularly in the current economic climate. It is therefore crucial that decision makers and competent authorities, include modern contraceptive choice as a key component of integrated policies, in the areas of sexual and reproductive health, gender equality, women empowerment, family planning, employment and education.

There are important cost implications to providing contraceptive services to the increasing number of women needing modern contraceptives, and to offering comprehensive, high-quality services to all users⁷⁸. At the same time, money spent on contraceptive services to help women avoid unintended pregnancies has large health, social and economic benefits for women, families and society, and results in net savings to the health care system. The benefits of practicing contraception are broad, spanning social, economic and health outcomes, and they stem from women's and couples' ability to achieve the size of family they want, time their pregnancies to fit their lives, reduce maternal mortality and morbidity, and provide their infants with the best chances for health and well-being. Moreover, real success should ultimately be measured in terms of important health outcomes, including better birth spacing, reductions in adolescent pregnancy and early childbearing, and reductions in unintended pregnancy and unsafe abortion, leading to improved maternal health and child survival. Limiting access to modern contraception does not result in increased fertility, as women with an unplanned pregnancy frequently resort to unsafe abortion. There is good evidence that increased access to modern contraception leads to decreasing rates of induced abortion⁷⁹. In addition, the use of condoms is effective in preventing sexually transmitted infections, including HIV.

Ability to pay analyses and follow-up of these analyses

The scope of this ability to pay analysis was not intended to be comprehensive, or final. Rather, it is intended to be one examination, among several, that seek to support a broader range of contraceptive supply initiatives. Incomes, prices, and the accuracy of data change. Therefore, analyses regarding pricing, affordability, and willingness to pay should be regularly performed.

Specific findings: ability to pay analyses

Table 5 indicates how a total market approach (TMA) to the provision of modern contraceptives might provide for different segments of the population.

- Q1 and Q2 – the poorest 40 percent of the population—can afford the cheapest condoms, but none of the available oral combined hormonal contraceptives, progesterone only pills, or emergency contraception, on a regular basis. However they could afford most types of copper T IUDs. These IUDs in terms of cost per CYP are significantly less expensive, than

⁷⁸ Singh S, Darroch JE. Adding It Up: Costs and Benefits of Contraceptive Services Estimates for 2012. New York: UNFPA and the Guttmacher Institute, 2012.

⁷⁹ Westoff, Charles F. 2000. The Substitution of Contraception for Abortion in Kazakhstan in the 1990s. DHS Analytical Studies No. 1. Calverton, Maryland: ORC Macro.

any other available method of modern contraception. The poorest forty percent segment of the population is estimated to include 281,622⁸⁰ women aged 15 to 49 years.

- For Q3 and Q4 - the cheaper condoms are affordable, as well as the cheapest oral pills, in addition to IUDs.
- Even most couples in Q5, the richest 20 percent of the population, probably find it difficult to pay for the more expensive oral contraceptives (Yasmin®, Yaz®, Belara®, Angeliq and Qlaira®), on a regular basis. Most vaginal foams, cervical hormonal rings and brands of emergency contraception are too expensive, even for the richest 20 percent segment, on a regular basis.
- There is scope for extended commercial sales of several of cheaper brands of oral contraceptives. There is potential for commercial pharmacies for expansion of their market sales to the most affluent 20 percent of the population. This would be partly dependent on good objective promotion.
- Higher-priced oral pills are unaffordable to middle-income earners (Q3), and even many high earners (Q4 and Q5). There is a possibility that the commercial sale of cheaper CoCs and progesterone only pills, could be extended further to Q3 – the middle income earners.
- Copper T IUDs are the least expensive of all types of contraceptive method.
- Free public sector contraceptives should possibly be targeted to the bottom 40 percent of the population.

Recommendations for meeting the contraceptive needs of different segments of the population and particularly the most vulnerable ones

Issues related to registration of contraceptives and the availability of contraceptives through the National Health Insurance Company

This overall market segmentation research has confirmed that several segments of the population, who have a high need for family planning, cannot afford commercially available modern contraception. Generally, there is a substantial level of unmet need for modern contraception in the country and the ability to pay for this is for almost all couples extremely limited. But there are certain groups who are particularly vulnerable and specifically marginalized, and have significantly higher unmet need. This applies particularly to the poorest forty percent segment of the population.

In order to increase the availability of modern contraception, it is important that choice is extended, and particularly by making available more long term hormonal contraceptive methods. Specifically urgent consideration should be given to taking steps to encourage the registration and availability of two long acting contraceptives - i.e. injectable medroxyprogesterone acetate (Depo-Provera®) and hormonal implants (the two most common versions are - the single-rod etonogestrel implant, and the two-rod levonorgestrel implant). The introduction of hormonal implants would have to be accompanied by a programme to train family doctors and gynecologists in their insertion and removal.

⁸⁰ Figure from the 2014 population census. See NBS website <http://www.statistica.md/pageview.php?l=ro&idc=479>

It is understood that medroxyprogesterone acetate was registered in the country until 2007. At this time UNFPA donated appreciable quantities of this injectable hormonal contraceptive for vulnerable people. We understand that medroxyprogesterone acetate has been imported in 2017 by Gideon Richter, probably through an arrangement with a Romanian subsidiary. The MoH might be able to make a special arrangement for importing medroxyprogesterone acetate via a Romanian pharmaceutical firm. If such an arrangement is made, it would be important that the package insert is in Romanian, and probably Russian.

The NHIC has high coverage of the population, but does not include any modern contraceptives in the list of pharmaceuticals eligible for reimbursement. It is strongly recommended that the NHIC includes in the list of reimbursable medicines - a limited number of modern contraceptives. Particularly for couples in the more affluent 60 percent segments of the population, the NHIC should include two of the lower cost combined hormonal oral contraceptives, e.g. Microgynon® - Bayer (30 mcg Ethinylestradiol and 150 Levonorgestrel) and Regulon® – Gideon Richter (Ethinylestradiol 0.03 mg, desogestrel 0.15 mg), and possibly an emergency contraceptive (Levonorgestrel 1.5 mg) and a copper T IUD. When medroxyprogesterone acetate and hormonal implants are registered in the country, than these should also be included on the NHIC's list of reimbursable pharmaceuticals.

The level of reimbursement should be decided by the appropriate committee, but initially could be set at 70 percent, and the coverage and financial cost, be reviewed after one year. When the procurement of modern contraceptive for vulnerable groups of population will be realised from the State Budget within the National Programme on Sexual and Reproductive Health and Rights 2018-2022, then this will mean there will be no need to use any of funds provided by the NHIC to primary health care facilities for purchase of contraceptives for vulnerable groups. This would provide cost-saving to the NHIC, which could be used for reimbursement of contraceptives, by means of including a number of modern contraceptives on the NHIC's reimbursable drugs list.

Provision of modern contraceptives for vulnerable populations

The Ministry of Health in Order No 658 of the 18 August 2015 has already identified seven 'vulnerable' groups who warrant the provision of free modern contraceptives, and this market segmentation study confirms these groups (sexually active adolescents, persons with low incomes - an income lower than the minimum consumer basket for each family member, HIV positive persons, persons who abusively consume alcohol and illegally use drugs and other psychotropic substances, registered with the addictionologist, people with mental health problems, registered with the psychiatrist and family doctor, victims of sexual abuse, women who aborted during the last year).

There have been suggestions that an additional group of people with disabilities should also be included in the population defined as vulnerable⁸¹. They certainly have many characteristics of vulnerable or marginalized, but although the Ministry of Labor, Social Protection and Family has figures on some of these people, they are not readily available. It is suggested that efforts are made to clarify what disabilities would be appropriate to include in the vulnerable group and what numbers are involved.

⁸¹ Sirbu L, Comendant R, Sagaidac I, Salaru V, Vieru V. Situation analysis of the issues confronting women and girls with locomotor disability in Moldova in exercising their sexual and reproductive rights. Chisinau: RHTC, 2016.

The following are the identified vulnerable groups agreed by the MoH and for each of them estimates of the likely numbers in each group are given with suggestions on the most appropriate form of modern contraception. The source for these estimates and suggestions are indicated.

1. **Sexually active adolescents.** Information from a survey carried out in 2015 provided information on the proportion of adolescents who are sexually active. This survey was supported by the MoH, WHO, and the Swiss Agency for Development and Cooperation and collected figures on behavioural and social determinants of adolescent health. The survey found that about 40 percent of 17 year olds are sexually active⁸². This suggests that about 90,000⁸³ adolescent boys and girls are sexually active. WHO⁸⁴ and other authorities^{85, 86} indicate the most commonly used contraceptive among adolescents is the male condom, but it is important that emergency contraception is available, as well as other modern contraceptives, particularly long acting ones such as - IUDs and medroxyprogesterone acetate (MPA), and combined oral hormonal pills are appropriate for some of this group.
2. **Persons with low incomes (an income lower than the minimum consumer basket for each family member).** It is difficult to estimate the number of people that fall into this category. From discussions with the staff of the Ministry of Labor, Social Protection and Family it is clear that this Ministry has established procedures to review the economic situation of vulnerable people, and this is undertaken principally together with rayon based social workers. However the Ministry was not able to provide numbers for people categorized as receiving economic and social support. They agreed that while the proportion of the population living in poverty has fallen from a high of 30.2 percent of the population in 2006 to 11.4 percent in 2014 (latest figure)^{87, 88} and this means that over one in 10 families continue to be below the nationally defined poverty level; however they estimated only about five percent of families and consequently women of reproductive age might be classified as in receipt of social support. This would suggest a figure of about 35,203 women in this group. We were informed by many health workers in our visits to several rayons in the country that family doctors with, if necessary, the assistance of the rayon social worker would know who was receiving social support, and thus eligible for free contraceptives. WHO and other experts do not provide specific advice on which contraceptives might be appropriate for this group of women, but imply long acting methods, such as medroxyprogesterone acetate (MPA) and IUDs, would be a higher priority, than oral hormonal pills or other methods.
3. **HIV positive persons.** There are several estimates of the numbers of people aged 15 to 49 years living with HIV. UNAIDS estimates this figure to be 18,000⁸⁹. However at the end of 2016 there were only 7,906 people living with HIV registered in the country (5,340 people on the right bank and 2,566 on the left bank of Nistru)⁹⁰. An estimate between

⁸² Lesco G. Behavioral and social determinants of adolescent health. Summary report of the health behaviors in school-aged children study in the Republic of Moldova. Chisinau: MoH, WHO Europe, Swiss Agency for Development and Cooperation, 2015.

⁸³ See NBS website <http://www.statistica.md/pageview.php?l=ro&idc=479>

⁸⁴ WHO. Medical eligibility criteria for contraceptive use. Fifth edition, 2015. Geneva: WHO, 2015.

⁸⁵ American Academy of Pediatrics. <http://pediatrics.aappublications.org/content/pediatrics/early/2014/09/24/peds.2014-2299.full.pdf>

⁸⁶ Faculty of Sexual and Reproductive Healthcare. Contraceptive Choices for Young People Clinical Effectiveness Unit. London: March 2010.

⁸⁷ World Bank. Poverty and Equity Database. <http://databank.worldbank.org/data/reports.aspx?source=poverty-and-equity-database> Accessed 16 April 2017.

⁸⁸ Human Development Report, 2014. Supporting human progress: reducing vulnerability and building resilience. Chisinau: UNDP; 2014 http://www.md.undp.org/content/dam/moldova/docs/Publications/HDR2014/Moldova_Explanatory_Note_RO.pdf/.

⁸⁹ UNAIDS. Republic of Moldova. HIV and AIDS estimates (2015).

<http://www.unaids.org/en/regionscountries/countries/republicofmoldova> accessed 30 May 2017.

⁹⁰ Republic of Moldova, South-East European Region National Coordination Council. Progress Report on HIV/AIDS. January – December 2016. Chisinau 2017.

these two is 11,043⁹¹. WHO recommends that “women taking any nucleoside/nucleotide reverse transcriptase inhibitor (NRTI) can use all hormonal contraceptive methods without restriction: combined oral contraceptive pills (COCs), contraceptive patches and rings, combined injectable contraceptives (CICs), progestogen only pills (POPs), progestogen-only injectables (DMPA and NET-EN), and levonorgestrel (LNG) and etonogestrel (ETG) implants”⁹². Probably long acting contraceptive methods are most appropriate for these people, and sexually active HIV positive men and women should also use condoms.

4. **Persons who abusively consume alcohol and illegally use drugs and other psychotropic substances, registered with the addictionologist.** The most recent national estimate of the population of injecting drug users (e.g. people who have injected drugs in the past 12 months) was obtained in 2009–10 and “together with the estimate derived from narcological registers in all cities, harm reduction programmes and human immunodeficiency virus (HIV) testing among the population of injecting drug users from integrated bio-behavioural studies suggests that around 31,600 injecting drug users live in the Republic of Moldova”⁹³. The sex ratio is around 44 percent female and 56 percent male. It is suggested that long acting methods, such as medroxyprogesterone acetate (MPA) and IUDs, would be a higher priority than oral hormonal pills, together with male condoms⁹⁴.
5. **People with mental health problems, registered with the psychiatrist and family doctor.** Information on people with alcohol and psychiatric problems is not readily available, although we asked people at the Ministry of Health, as well as at the Ministry of Labor, Social Protection and Family for figures. We were advised that social workers and family doctors at the rayon level would know these people. It is estimated that around 3,500 WRA might be in these categories. It is recommended that long acting methods such as medroxyprogesterone acetate (MPA) and IUDs would be a higher priority, than oral hormonal pills or other methods⁹⁵.
6. **Victims of sexual abuse**⁹⁶. The number of women subjected to sexual abuse is considerable. At the present time it is only possible to concentrate on those who are most severely affected and who seek refuge, but efforts should be made to obtain figures for women reporting such abuse to the police. There are 14 shelters in Moldova for women who have suffered domestic and other violence, with a capacity of 181 places. There are an average of 314 monthly beneficiaries of these shelters i.e. 3,768 per annum⁹⁷. Long acting forms of contraception such as - MPA injection or an IUD are recommended for the longer term, and emergency contraception if necessary, for the initial contact with health services⁹⁸.
7. **Women who aborted during the last year.** The Reproductive Health Training Center (RHTC) together with the MoH maintains a monitoring system for induced abortions and the coverage of these statistics is considered to be high. Based on this system, it is

⁹¹ HIV situation in the Republic of Moldova. 2017. http://aids.md/aids/files/1599/2016_Moldova_GAM_Report_Eng.pdf

⁹² See: WHO. Medical eligibility criteria for contraceptive use. Fifth edition, 2015. Geneva: WHO, 2015, p 82-67.

⁹³ See: European Monitoring Centre for Drugs and Drug Addiction. Country overview: Moldova. <http://www.emcdda.europa.eu/publications/country-overviews/md#gps> Accessed 30 May 2017 and http://www.who.int/hiv/HIVCP_MDA.pdf

⁹⁴ WHO. Medical eligibility criteria for contraceptive use. Fifth edition, 2015. Geneva: WHO, 2015.

⁹⁵ WHO. Medical eligibility criteria for contraceptive use. Fifth edition, 2015. Geneva: WHO, 2015.

⁹⁶ Women against Violence, Europe. Capacity gap analysis study of the service providers working with women victims of domestic violence in Moldova. Chisinau: 2014. <https://mail.google.com/mail/u/0/#label/moldova/15c1fc1669d4033a?projector=1> Accessed 30 May 2017.

⁹⁷ Women against Violence, Europe. Capacity gap analysis study of the service providers working with women victims of domestic violence in Moldova. Chisinau: 2014. <https://mail.google.com/mail/u/0/#label/moldova/15c1fc1669d4033a?projector=1> Accessed 30 May 2017.

⁹⁸ WHO. Medical eligibility criteria for contraceptive use. Fifth edition, 2015. Geneva: WHO, 2015 and Gottlieb AS. Domestic violence: a clinical guide for women’s health care providers. The Obstetrician & Gynaecologist 2012;14:197–202.

estimated that the annual abortion rate is 15 abortions per 1,000 women aged 15 to 49 years, or 12,635 per year. Once again, long acting forms of contraception such as MPA injection, or an IUD are the most appropriate contraceptives for this group of women, but other contraceptives are not contraindicated. Contraception can be initiated immediately post-abortion and all contraceptive options may be used, but longer term methods including IUDs, injectable hormonal contraception and implants are probably the most appropriate⁹⁹.

The draft 'National Program on Sexual and Reproductive Health and Rights (NPSRHR)'¹⁰⁰ for the years 2018 to 2022 is due to be submitted by the MOH for consideration to the national Government. One of the aims of this Program is to provide modern contraceptives for the seven vulnerable groups mentioned earlier. The Program would have an annual budget line equivalent to €300,000 for the purchase of modern contraceptives.

As part of the provision of PHC services, an indicator has been agreed to assess progress to achieving coverage of contraceptives for these vulnerable groups - the indicator of the percentage of at risk women aged up to 35 and vulnerable groups receiving modern contraceptives. It is intended that the indicator acts as an incentive to PHC facility managers, as part of the performance-based incentive scheme in primary health care, introduced with aim to improve PHC performance. Fifteen percent of the PHC facilities budget is to be provided by NHIC to the respective PHC institutions based on the level of achievement of a number of performance indicators. However the FP indicator lacks precision and it will be difficult to obtain consistently reliable figures. And this was the situation found at the various PHC facilities visited during this mission.

Forecasting contraceptive needs for the vulnerable population use and estimating costs

To estimate future consumption of contraceptives, it is useful to have past consumption data to establish a trend. This data usually takes the form of contraceptive logistics data, from a logistics management information system (LMIS). In Moldova only a partial LMIS exists. Health facilities simply refer patients, usually with a prescription, to commercial pharmacies to purchase contraceptives and this 'use' is not adequately captured in any reporting.

Because actual past consumption data is not available, this forecasting of modern contraceptive needs - used demographic or population data to estimate future contraceptive requirements. The forecasts made here are dependent upon making informed assumptions regarding future CPR for the various vulnerable groups. Using 2012 baseline data from the MICS, including CPR, possible consumption estimates have been developed for the seven priority segments of the vulnerable population. The estimates also take into account informed assumptions from the people met during this consultancy about likely changes in CPR and method mix, and information on what are appropriate contraceptives for the different groups.

⁹⁹ WHO. Health worker roles in providing safe abortion care and post-abortion contraception. Geneva: WHO, 2015.

¹⁰⁰ Government of the Republic of Moldova. National Program on sexual and reproductive health and rights 2017-2021. Draft. Chisinau: no date.

Table 6 gives cost figures for different modern contraceptives, if obtained from the UNFPA Procurement Services¹⁰¹. This service is available to governments and other organisations, the procedures are relatively straight forward (see <https://+www.unfpaprocurement.org/order>).

Table 6: Indicative international prices for procuring a range of modern contraceptives

Contraceptive method	Unit	Average cost per unit/set/cycle/pack/vial (US\$)	Quantity required per couple year of protection (CYP)	CYP conversion factor	Cost per CYP (US\$)	Cost per CYP (€) ¹⁰²
Male condom	Gross	3.15	120 items	0.83	2.61	2.32
IUD CopperT ¹⁰³	Set	0.317	4.6 CYP per IUD inserted	0.22	0.07	0.06
Progestagen only pill	Cycle	0.90	15 cycles	15	13.5	12.00
Combined low dose pill (Microgynon®30®)	Cycle	0.78	15 cycles	15	11.7	10.39
Emergency pill	Pack	0.25	20 doses	20	5	4.44
Injectable contraceptive	Vial	0.758	4 doses	4	3.03	2.69
Subdermal implants	Set	8.50	3.8 CYP per implant	0.26	2.21	1.96

Source: Costs. <https://www.unfpaprocurement.org/products> accessed May 2017. CYP. MEASURE Evaluation PRH. Family Planning and Reproductive Health Indicators Database. Couple-years of protection (CYP); http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp/cyp Accessed May 2017

¹⁰¹ See: <https://www.unfpaprocurement.org/products> accessed 6 June 2017

¹⁰² A conversion rate of US\$ 1 = € 0.9144 was used; <http://www.xe.com/> accessed May 2017

¹⁰³ 3.3 CYP for 5 year IUD, e.g. LNG-IUS)

Table 7: Vulnerable priority segments of the population for provision of free family planning, projections for 2018 including indicative costs

Priority group	Numbers of women (unless stated otherwise) 15-49 years, 2016 projection (total)	Contraceptive methods to be included (method mix)	Indicative costs UNFPA Procurement prices ¹⁰⁴ €	Indicative costs at existing pharmacy prices ¹⁰⁵ €	How contraceptives might be delivered
1) Sexually active adolescents aged 15 to 19 years	90,000	Condoms (50 %), CoCs (15%), IUDs (15%), and emergency contraception (20%). MPA to be included when available	325,395	3,430,350	Ministry of Health through Youth Friendly Health Centres and Family Doctors from PHC facilities and rayon gynaecologists from RH Cabinets
2) Low income families	35,203	CoCs (20%), IUDs (60%) and condoms (20%). MPA and implants to be included when available	90,758	285,160	Ministry of Health, through Family Doctors from PHC facilities in conjunction with social workers, and rayon gynaecologists from RH Cabinets
3) HIV positive people who know their status ¹⁰⁶	11,043 ¹⁰⁷	CoCs (50%), IUDs (40%), emergency contraception (10 %). MPA and implants to be included when available. It is assumed condoms are provided by GFATM for all HIV positive people	73,974	355,453	Ministry of Health through Family Doctors from PHC facilities, rayon gynaecologists and NGOs working with PLHIV.

¹⁰⁴ UNFPA Product Catalog. <https://www.unfpa.org/procurement/products> accessed 6 June 2017

¹⁰⁵ Cheapest CoCs, condoms, EC and IUDs available in commercial pharmacies see Table 4

¹⁰⁶ Assumption most are aged 15 to 49 years

¹⁰⁷ HIV situation in the Republic of Moldova. 2017. http://aids.md/aids/files/1599/2016_Moldova_GAM_Report_Eng.pdf

4) People with alcohol, other drug problems, who are registered with an addictologist	31,600 ¹⁰⁸	IUDs (60%), CoCs (30%), condoms (10%), MPA and implants to be included when available	106,966	404,796	Ministry of Health, through Family Doctors from PHC facilities and rayon gynaecologists from RH Cabinets
5) People registered with psychiatrist	3,500	IUDs (60%), CoCs (30%), and condoms (10%). MPA and implants to be included when available	11,848	44,835	Ministry of Health through Family Doctors from PHC facilities and rayon gynaecologists from RH Cabinets, as well as through Community Mental Health Centers
6) Women suffering domestic violence and in refuges	3,768	Emergency contraception (30%), IUDs (60%), CoCs (10%). MPA and implants to be included when available	9,070	164,655	Through the MLSPF social workers, Family Doctors from PHC facilities and rayon gynaecologists from RH Cabinets and NGOs providing assistance to survivors of domestic violence
7) Women having had an abortion in previous year	12,635	IUDs (70%), CoCs (30%). MPA and implants to be included when available	39,919	147,470	Rayon gynaecologists from RH Cabinets, hospitals and other units performing abortions
Total costs			657,930	4,832,719	

¹⁰⁸ Assumption that most are aged 15 to 49 years

Given that there is no existing consumption data for modern contraceptives for vulnerable groups in Moldova, to base projections for the future, initial estimates should be treated as tentative.

These prices are less than a seventh of those available at the present time for similar contraceptives in commercial pharmacies in Moldova.

Indicative international prices (see Table 6) have been applied to the different scenarios, as set out in Table 7. The mix of methods has been suggested which is likely to be most appropriate for the different segments; for instance for 'sexually active adolescents' - a mix of condoms (60%), emergency contraception (20%) and CoCs (15%); and for low income families - CoCs (20%), IUDs (60%) and condoms (20%)

Building on the identification of the disadvantaged segments for high priority for provision of modern contraception, it is possible to propose several scenarios that might warrant the provision of free family planning. In most of these scenarios, the segments will, to a varying extent, overlap. Thus for instance, low income families will necessarily include HIV positive people and people with alcohol, and other drug problems. However, initially considering the different segments separately highlights the cost of providing contraceptives for each segment. The prices used to cost the procurement of different contraceptives are based on current May 2017 international tender costs from UNFPA (see Table 6).

The development of more sophisticated demographic-based forecasts requires numerous calculations to predict consumption patterns¹⁰⁹. Assumptions made to develop the following forecasts will need to be regularly re-examined, in the light of any additional data, notably accurate logistics-based consumption figures, when they become available.

The costs of providing modern contraceptives for WRA in low income families are estimated to be € 90,758, if the contraceptives are procured from UNFPA Procurement Services, and € 285,160 if they were purchased from local pharmacies; and for women following an abortion € 39,919 from UNFPA Procurement Services, and €147,470 from local pharmacies. Similar comparisons are given for all seven priority vulnerable segments.

The total cost of providing complete coverage for all these seven groups is estimated to be considerably more than is proposed in the draft National Program on Sexual and Reproductive Health and Rights 2018-2022, that includes an Estimated Budget with a separate Budget line for the procurement of modern contraceptives for vulnerable groups (equivalent to €300,000 per year). When approved by the Government – this amount will be available from State Budget for the procurement of modern contraceptives in the period 2018-2022. According to the estimations reflected in Table 7 of this report – the proposed €300,000 per year will not cover the needs of all those in the seven categories of vulnerable people, but at the initial stage it is worth starting at least with €300,000 per year allocated for procurement of modern contraceptives for vulnerable groups from State Budget. When the logistic management information system is established and well-functioning, then the efforts to increase the budget allocation for the procurement of modern contraceptives for vulnerable groups from State Budget can be attempted.

¹⁰⁹Because of this, The Futures Group International (TFGI) developed a software program called *Spectrum11* that performs the forecasting calculations and takes into account the impact of projected mortality, women of reproductive age (WRA), and other variables to produce forecasts. Contact the Futures Group International in Washington, DC, to request a copy of *Spectrum*. The software can also be downloaded from their website: http://futuresgroup.com/resources/software_models/spectrum. See also: Family Planning Logistics Management (FPLM). 2000. Contraceptive Forecasting Handbook for Family Planning and HIV/AIDS Prevention Programs. Arlington, Va.: FPLM/John Snow, Inc., for the U.S. Agency for International Development, 2008 and USAID | DELIVER PROJECT, Task Order 1. The Logistics Handbook: A Practical Guide for the Supply Chain Management of Health Commodities. Arlington, Va.: USAID | DELIVER PROJECT, Task Order 1, 2011.

Consequently, for the possible seven priority groups for receiving free contraceptives, it will be best, if modern contraceptives are provided by the Ministry of Health, via the NPSRHR 2018-2022. This will need detailed careful planning, including the establishment of a reliable computerized contraceptive Logistics Management Information System (LMIS). This would allow estimating, procuring and the requisitioning of contraceptives, based on the consumption of contraceptives over the previous three months. It would also allow the monitoring of stock levels in all primary healthcare facilities.

Roadmap for implementation of the Total Market Approach

There is a clear case for improving access to modern contraceptives to all segments of the population in Moldova. Use of contraceptives has declined over the past 20 years from just over a half of married women to 42 percent. Unmet need for contraception has increased over this time and is high at 27 percent and even higher at 35 percent when all women of reproductive age are considered¹¹⁰.

The prevention of unintended pregnancies should be a priority in modern societies, and enabling people to choose if, when they become pregnant, and how many children they have - is a basic right. Women empowerment, employment and integration are crucial elements for the wellbeing of women and of society as a whole, particularly in the current economic climate. It is therefore crucial that decision makers and competent authorities include modern contraceptive choice as a key component of integrated policies in the areas of sexual and reproductive health.

There are important cost implications to providing contraceptive services to the increasing number of women needing modern contraceptives, and to offering comprehensive, high-quality services to all users. At the same time, money spent on contraceptive services to help women avoid unintended pregnancies has large health, social and economic benefits for women, families and society, and results in net savings to the health care system.

This market segmentation analysis for modern contraceptives in Moldova has shown that the market is divided into several segments and to meet the various requirements of these different segments, a total market approach is required. These need co-ordinated actions on the part of the public sector (principally the Ministry of Health and as part of that, the Medicines and Medical Devices Department; and also the Ministry of Labor, Social Protection and Family), parastatal organisations (specifically the National Health Insurance Company), non-governmental organisations (such as Reproductive Health Training Centre), pharmaceutical companies (including Bayer Pharmaceuticals, JV "RihPanGalFarma" Ltd. and the Joint Stock Company "MoldFarm), pharmaceutical wholesalers (e.g. Sanfarm-Prim S.A.), commercial pharmacies (such as Felicia, Hippocrates, Farmacia Familiei and Odeon). And importantly medical and pharmacy undergraduate, postgraduate and continuing education establishments (particularly the Obstetrics and Gynaecology Departments, the Family Medicine Department, the Center for Simulation in Medical Training of the State Medical and Pharmaceutical University "Nicolae Testemitanu"), have a crucial role in achieving improved family planning care.

¹¹⁰ See, Special tabulation provided by the Demographic Research Center to UNFPA of data from: National Centre of Public Health of the Ministry of Health of the Republic of Moldova, United Nations Children's Fund (UNICEF). 2012 Republic of Moldova Multiple Indicator Cluster Survey, Final Report. Chişinău, Republic of Moldova, 2014.

The Government (Ministry of Health) should as a matter of urgency establish a statutory technical group to develop a plan for the phased transition of the country to a total market approach, to the provision of modern contraceptives.

Specific issues which need early attention

- Steps should be taken to explore how the two long-term contraceptives (medroxyprogesterone acetate injection and either the single-rod etonogestrel implant, or the two-rod levonorgestrel implant) can be registered in the country, and a commercial pharmaceutical company persuaded to import and market them. They should of course be made available through the Ministry of Health's National Program on Sexual and Reproductive Health and Rights 2018-2022. It will be necessary to support training programmes for family doctors and gynaecologists in insertion and removal of hormonal implants.
- Representation should be made to the National Health Insurance Company for consideration to be given, to placing a limited number of modern contraceptives on the list eligible for medicines reimbursement e.g. Microgynon® - Bayer (30 mcg Ethinylestradiol and 150 Levonorgestrel) and Regulon® – Gideon Richter (Ethinylestradiol 0.03 mg, Desogestrel 0.15 mg), and possibly an emergency contraceptive (Levonorgestrel 1.5 mg) and a copper T IUD. When Medroxyprogesterone acetate and hormonal Implants are registered in the country, than these should also be included on the NHIC's list of reimbursable pharmaceuticals. Once these are registered, and if they were included in the reimbursement list of pharmaceutical, then pharmaceutical companies have indicated, this would be an incentive for them to import them.
- Discussion should be had with representatives of pharmaceutical companies, importers and wholesalers of contraceptives and commercial pharmacies, to market and promote cheaper combined hormonal contraceptives. In addition continuing education initiatives, involving family doctors and gynaecologists, should be based on objective evidence, regarding different types of hormonal combinations, and the absence of any discernible difference between them.
- The draft NPSRHR 2018-2022 is at significant and far sighted development. It includes an Action Plan, a Monitoring and Evaluation Framework and a Costed Budget and the Ministry of Health needs to follow through with its implementation after approval. This should include acquiring expertise in estimation, procurement, distribution and monitoring of implementation. The establishment of a contraceptive logistics management information system is crucial for the effectiveness of the Program. The draft National Programme on Sexual and Reproductive Health includes an estimated Budget with a separate budget line for the procurement of modern contraceptives for vulnerable groups - equivalent to €300,000 per year. When approved by the Government – this amount will be available from the State Budget for the procurement of modern contraceptives in the period 2018-2022. According to the estimation reflected in Table 7 of this report – the €300,000 per year will not cover the needs of all people from those seven categories of vulnerable groups, but in the initial stage it is worth to start with at least the €300,000 per year allocated for procurement of modern contraceptives for vulnerable groups. When the logistic management information system is established and well-functioning, then the efforts to increase the budget allocation for the procurement of modern contraceptives for vulnerable groups from State Budget can be attempted.

- An information, education and communication campaign will be necessary to explain the objectives of the National Program on Sexual and Reproductive Health and Rights 2018-2022 and who (the vulnerable groups) is entitled to free contraceptives, and where they are available. This should include pamphlets and posters to be displayed at appropriate MoH facilities.
- At a later stage, consideration might be given to establishing a social marketing programme for condoms, and even of an oral contraceptive pill. For this to happen, initially it would be useful to arrange a visit to the social marketing programme in Romania¹¹¹
- Monitoring of implementation of the total market approach, will be important to assess if it meeting its objectives. This could include periodic surveys of who is receiving contraceptives, from where and whether they are covered by the NHIC reimbursement scheme, or covered with free contraceptives under the NPSRHR 2018-2022, or a purchasing them. The last Multiple Indicator Cluster Survey was carried out in 2012 and apparently a decision has not yet been taken on when, or if a further MICS will be undertaken, but there is a suggestion that it might be replaced by a mini-MICS. It is not clear what this might cover, but it is important if one is carried out, that it should include questions on contraceptive use, unmet need and supply and source of contraception.

Activities which UNFPA could consider supporting the Government to strengthen family planning

It is suggested that UNFPA might consider providing assistance in: the development of standard care protocols (based on WHO's Eligibility criteria for Contraceptive Use¹¹²) and one sheet algorithms for family doctors for different contraceptives in Romanian and Russian; training in estimation of contraceptive needs; training on establishing and running a contraceptive LMIS; training on modern contraceptive technology; training on IUD insertion and use of Implants; development, printing and distribution of information posters, explaining eligibility for specific contraceptives, under the NHIC and for vulnerable people under the MoH's National SRHR Programme 2018-2022.

¹¹¹ See for description of Romania social marketing programme <http://www.psi.ro/who-we-are/technical-expertise/product-social-marketing/> http://www.psi.org/wp-content/uploads/drupal/sites/default/files/publication_files/romania-familyplanning.pdf PSI Romania can also provide technical advice see <http://www.psi.ro/who-we-are/technical-expertise/>

¹¹² WHO. Medical eligibility criteria for contraceptive use. Fifth edition, 2015. Geneva: WHO, 2015

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Appendix 1: Draft Agenda. In-country mission of Dr. Godfrey Walker, UNFPA International Expert to conduct the Market Segmentation Analysis for Modern Contraceptives in the Republic of Moldova

Time	Activities	Address	Participants
15.05.2017 (Monday)			
Arrival to Chisinau International Airport (RO209 OTP-KIV at 22:30 p.m.)			
16.05.2017 (Tuesday)			
9:00 –10:30	Meeting at the UNFPA Moldova CO	Chisinau, 31 August, 131 Str.	Dr. Rita Columbia, UNFPA Representative in the Republic of Moldova Dr. Godfrey Walker, UNFPA International Expert Ms. Eugenia Berzan, Programme Analyst RH and Youth Ms Victoria Dochițcu, Programme Associate RH and Youth
11:00 –11:45	Meeting with Deputy Minister of Health, Dr. Liliana Iașan	Chisinau, 2, V. Alecsandri Str.	Dr. Rita Columbia, UNFPA Representative in the Republic of Moldova Dr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
11:45 -12:30	Meeting with Dr. Maria Lăpteanu, Head of Medicines and Medical Devices Department, MoH	Chisinau, 2, V. Alecsandri Str.	Dr Godfrey Walker, UNFPA International Expert Dr Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
12:30-13:30	Lunch break		
13:30-14:30	Meeting with Dr. Tatiana Zatić, Head of Primary, Emergency and Community Health Care Department, MoH	Chisinau, 2, V. Alecsandri Str.	Dr Godfrey Walker, UNFPA International Expert Dr Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
14:30-15:00	Meeting with Dr. Natalia Popa, Deputy Head of Hospital Healthcare Department, MoH	Chisinau, 2, V. Alecsandri Str.	Dr Godfrey Walker, International Consultant Dr Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
15:00-15:30	Meeting with Mr Denis Valac, Head of Budget, Finance and Insurance Department, MoH	Chisinau, 2, V. Alecsandri Str.	Dr Godfrey Walker, UNFPA International Expert Dr Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
16:00-16:45	Meeting with Dr Vladislav Zara, General Director of the Agency of Medicines and Medical Devices (as well as with Mr. Adrian Scripcari, Head of Certification, homologation and registration division, Department of Medical Devices and Ms Tamara Chetrari, Head of	Chisinau 2/1 Korolenko Str.	Dr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth Translator

	Medicines and Food Supplements Authorization Division, Department of Medicines Evaluation and Registration)		
16:45-17:30	Meeting with Mr. Ivan Antoci, Director of Center for Centralized Public Procurements in Health (as well as with Ms. Raisa Golovei, Head of Medicines Procurement Division and Mr. Eduard Țernă, Head of Medical Devices Procurement Division)	Chisinau, 2/1 Korolenko Str.	Dr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth Translator
17.05.2017 (Wednesday)			
9:00 – 10:00	Meeting with Mr. Dumitru Parfentiev, General Director of the National Health Insurance Company (as well as with Mr. Ghenadie Damașcan, Head of Contracting and Relations with Providers Department)	Chisinau, 46, Vlaicu Pircalab str.	Dr. Rita Columbia, UNFPA Representative in the Republic of Moldova Dr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
10:30-11:30	Meeting with Mr. Stefan Harea, General Director of the Pharmaceutical Storage "Sanfarm-Prim" S.A.	Chisinau, 149 A, Grenoble Str.	Mr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth Translator
11:30-13:00	Lunch break		
13:00-13:45	Meeting with Mr Tudor Crigan, Director of the Joint Stock Company "MoldFarm"	Chisinau 3, Cosmescu Str.	Dr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth Translator
14:15-15:30	Meeting with Dr Sergiu Gladun, Director of Mother and Child Institute (as well as with Dr Mihail Strătilă, Head of Reproductive Health and Medical Genetics Center, Mother and Child Institute and Dr. Victoria Ciubotaru, Scientific Researcher, Reproductive Health and Medical Genetics Center)	Chisinau, 93, Burebista Str.	Mr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth Translator
16:00-17:00	Meeting with Dr. Rodica Comendant, Director of NGO "Reproductive Health Training Centre" (RHTC)	Chișinău, 20, Melestiu Str.	Mr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth Translator
18.05.2017 (Thursday)			
8:00- 10:00	Departure to Cimislia district	8:00- 10:00	Departure to Cimislia district
10:00-12:00	Meeting with Dr. Ludmila Capcelea, Manager of Health Center. Visiting the Health Center from Cimislia, including the	Cimislia district 135, Alexandru cel Bun Str.	Dr. Rita Columbia, UNFPA Representative in the Republic of Moldova Ms Ganna Iovchou, Communication Officer, UNFPA Moldova Mr Godfrey Walker, UNFPA International Expert

	Reproductive Health Office, Youth Friendly Health Center (YFHC) and a local pharmacy		Ms Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
12:00-13:00	Lunch time		
14:00-16:00	Meeting with Dr. Vera Munteanu, Manager of Health Center. Visiting the Health Center from Hîncești, including the Reproductive Health Office, Youth Friendly Health Center and a local pharmacy	Hîncești district 151, Mihalcea Hîncu Str.	Dr. Rita Columbia, UNFPA Representative in the Republic of Moldova Ms Ganna Iovch, Communication Officer, UNFPA Moldova Mr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
16:00-17:00	Departure to Chisinau		
19.05.2017 (Friday)			
9:00-10:00	Meeting with Dr Haris Hajrulahovic, WHO Representative in the Republic of Moldova (as well as with Dr. Larisa Boderscova, National Professional Officer, Health Systems, WHO Moldova)	Chisinau 27, Sfatul Tarii Str.	Dr. Rita Columbia, UNFPA Representative in the Republic of Moldova Ms Natalia Plugaru, Assistant Representative, UNFPA Moldova Mr Godfrey Walker, UNFPA International Expert
10:30-11:30	Meeting with Ms Doina Munteanu, Assistant Resident Representative / Head of Programme, UNDP Moldova	Chisinau, 131, 31 August Str. UNFPA Office	Ms Natalia Plugaru, Assistant Representative, UNFPA Moldova Dr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth
11:30-13:00	Lunch break		
13:00-14:00	Meeting with Ms Margarita Tileva, UNICEF Moldova Deputy Representative (as well as with Mrs Angela Capcelea, UNICEF Health Officer)	Chisinau, 131, 31 August Str. UNFPA Office	Ms Natalia Plugaru, Assistant Representative, UNFPA Moldova Dr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth
14:00-17:30	Site visits to private pharmacies located in Chisinau Municipality (“Felicia” , “Hippocrates” , “Farmacia Familiei” , “Odeon”)	Chisinau Municipality	Mr Godfrey Walker, UNFPA International Expert Ms Victoria Dochițcu, Programme Associate RH and Youth, UNFPA Moldova Translator
22.05.2017 (Monday)			
9:30-10:30	Meeting with Dr. Asia Odobescu, General Director of JV “RihPanGalFarma” LTD	Chisinau 36, N. Milescu Spataru Street	Dr. Rita Columbia, UNFPA Representative in the Republic of Moldova Ms Natalia Plugaru, Assistant Representative, UNFPA Moldova Mr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
11:30-12:30	Meeting with Dr Elena Armașu, Executive Manager, “Bayer Pharmaceuticals” Office in the Republic of Moldova	Chisinau 196 Stefan cel Mare Blvd., 3rd floor	Dr. Rita Columbia, UNFPA Representative in the Republic of Moldova Ms Natalia Plugaru, Assistant Representative, UNFPA Moldova Mr Godfrey Walker, UNFPA International Expert

			Ms Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
12:30-14:00	Lunch break		
14:00-17:30	Site visits to private pharmacies located in Chisinau Municipality (“Felicia”, “Hippocrates”, “Farmacia Familiei”, “Odeon” etc)	Chisinau Municipality	Mr Godfrey Walker, UNFPA International Expert Ms Victoria Dochițcu, Programme Associate RH and Youth, UNFPA Moldova Translator
23.05.2017 (Tuesday)			
9:00- 10:00	Meeting with Prof. Olga Cernetchi Vice Rector, Head of Gynaecology Department of the State Medical and Pharmaceutical University “Nicolae Testemitanu”	Chisinau, 165, Stefan cel Mare si Sfint Blvd.	Ms Natalia Plugaru, Assistant Representative, UNFPA Moldova Mr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth Translator
10:30-11:30	Meeting with Prof. Ghenadie Curocichin Head of Family Medicine Department of the State Medical and Pharmaceutical University “Nicolae Testemitanu”	Chisinau, 137, 31 August 1989 Str. University Clinic of PHC	Ms Natalia Plugaru, Assistant Representative, UNFPA Moldova Dr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
11:30-13:00	Lunch break		
13:30-14:30	Meeting with Elena Robu, Deputy Director responsible for Mother and Child Health Care, Territorial Medical Association Centre	Chisinau, 63, 31 August Str.	Dr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
15:00-16:00	Meeting with Dr. Vera Melniciuc, Director of the “Dalila” Woman’s Health Center, Territorial Medical Association Botanica	Chisinau, 5/2 Dacia Bld.	Dr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth Translator
16:40-17:40	Meeting with Dr. Galina Leșco, Director of the “Neovita” Youth Friendly Health Center	Chisinau, 19, Socoleni Str.	Dr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
24.05.2017 (Wednesday)			
8:00 -10:30	Departure to Ungheni district		
10:30-12:30	Meeting with Dr Lilia Scurtu, Manager of Health Center. Visiting the Health Center from Ungheni, including the Reproductive Health Office, Youth Friendly Health Center and a local pharmacy	Ungheni district 27, Romana Str.	Ms Natalia Plugaru, Assistant Representative, UNFPA Moldova. Mr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
12:30-13:30	Lunch Break		
15:00-17:00	Meeting with Dr. Nicolae Lupu, Manager of Health Center. Visiting the Health Center from Călărași, including the Reproductive Health Office, Youth Friendly Health Center and a local pharmacy	Călărași district 1, Bojole Str.	Ms Natalia Plugaru, Assistant Representative, UNFPA Moldova. Mr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
17:00-18:00	Departure to Chisinau		

25.05.2017 (Thursday)

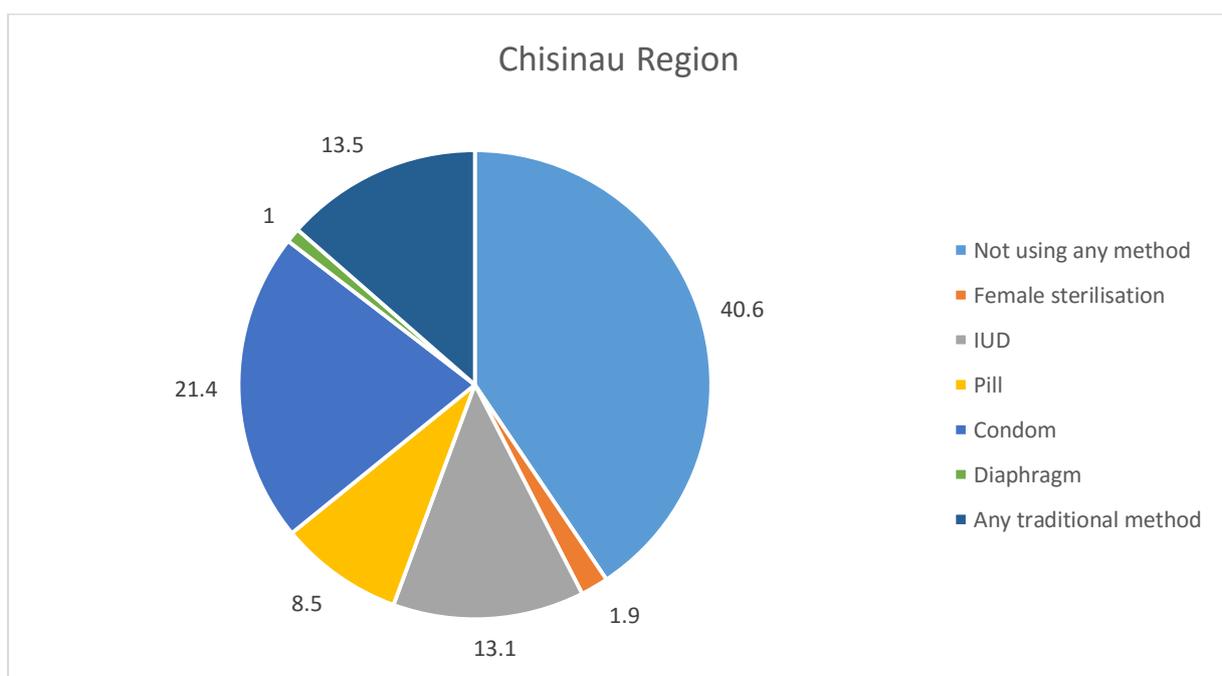
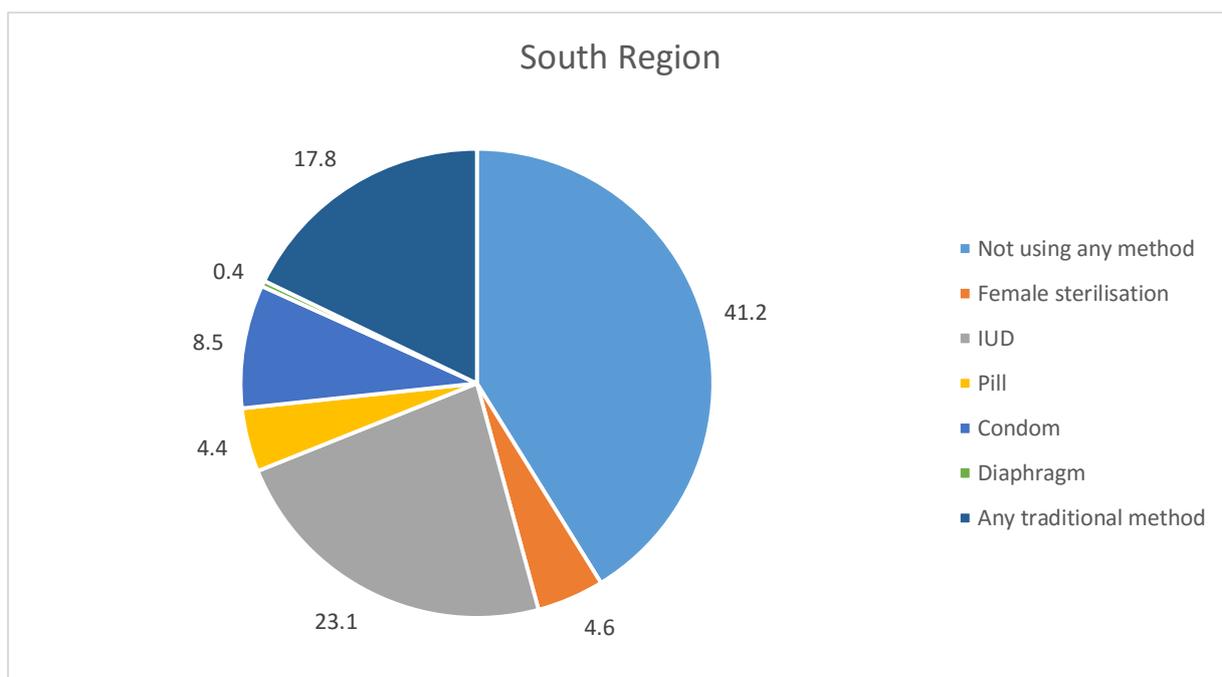
8:00- 10:00	Departure to Căușeni district		
10:00- 12:00	Meeting with Dr Valentina Panfilov, Manager of Health Center from Causeni. Visiting the Health Center from Căușeni, including the Reproductive Health Office, Youth Friendly Health Center and a local pharmacy	Căușeni district 14, Ana și Alexandru Str.	Dr. Rita Columbia, UNFPA Representative in the Republic of Moldova Mr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
12:00-13:00	Lunch Break		
15:00-16:30	Meeting with Dr. Nelli Buruian , Manager of Health Center. Visiting the Health Center from Anenii-Noi, including the Reproductive Health Office, Youth Friendly Health Center and a local pharmacy	Anenii-Noi district 30/1 Uzinelor Str.	Dr. Rita Columbia, UNFPA Representative in the Republic of Moldova Mr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
17:00-17:45	Visiting the Health Center from Bulboaca village, Anenii-Noi district	Bulboaca village 43, M. Eminescu, Str.	Dr. Rita Columbia, UNFPA Representative in the Republic of Moldova Mr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
17: 45-18:30	Departure to Chisinau		

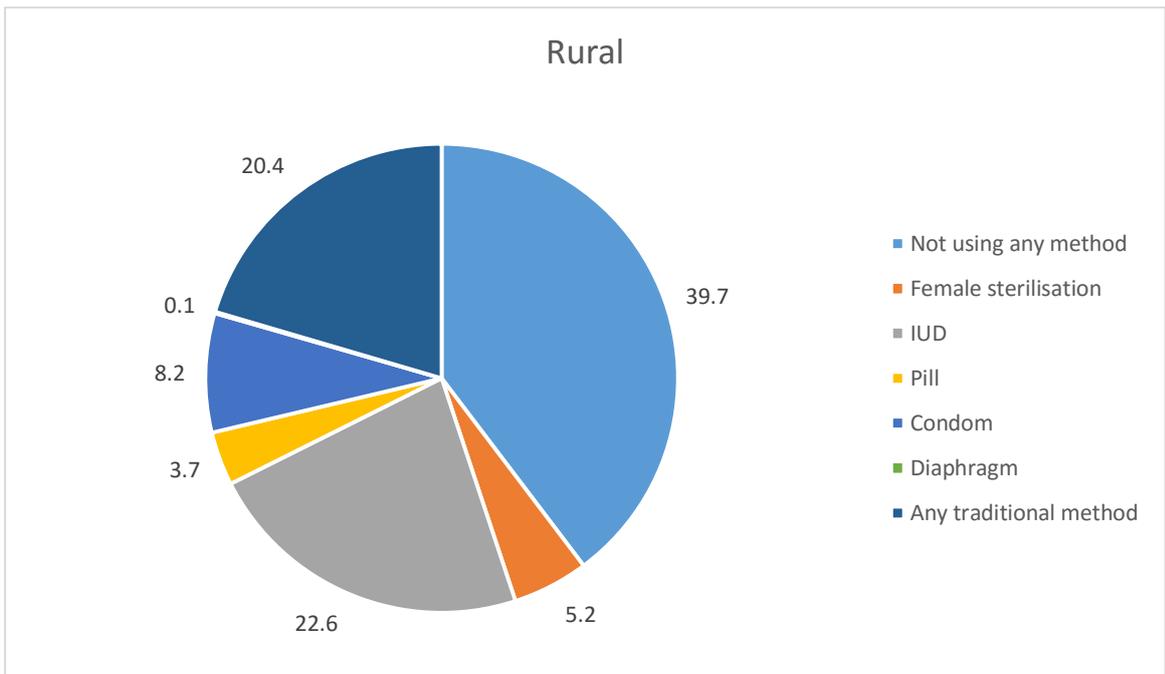
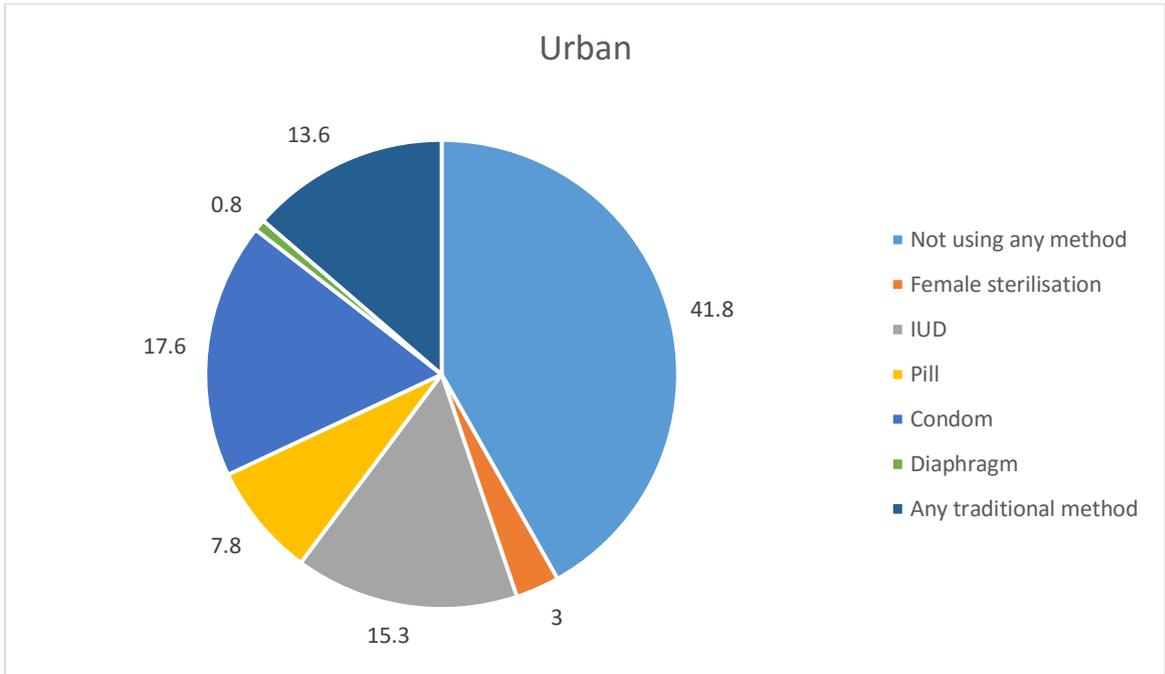
26.05.2017 (Friday)

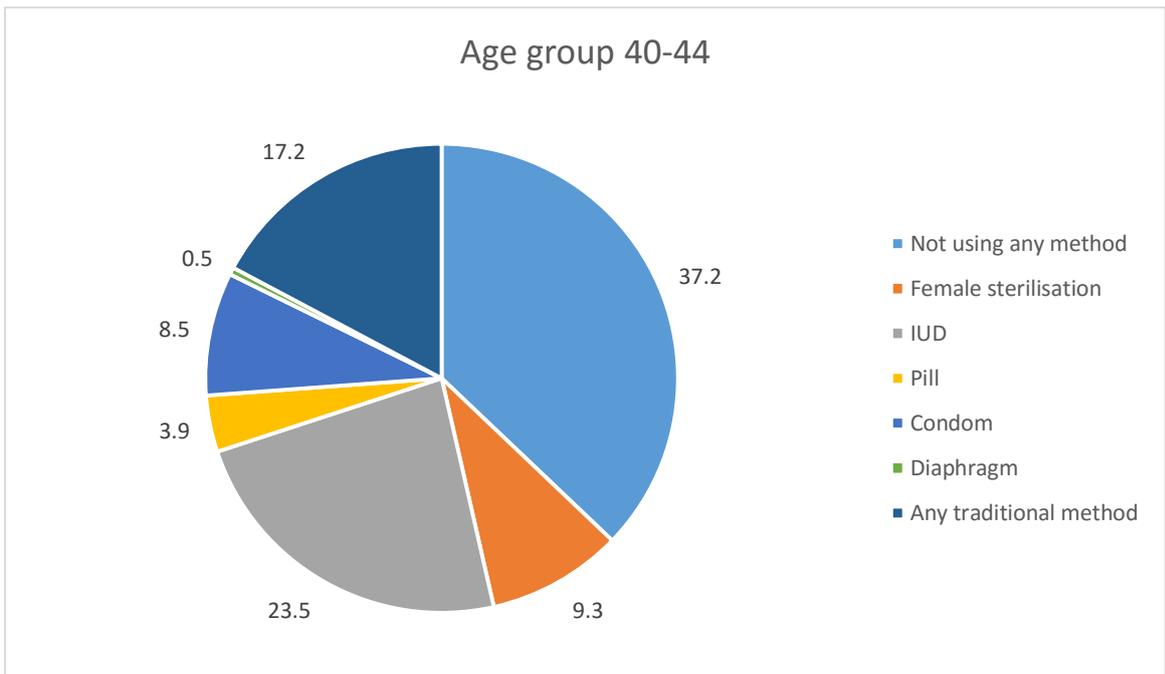
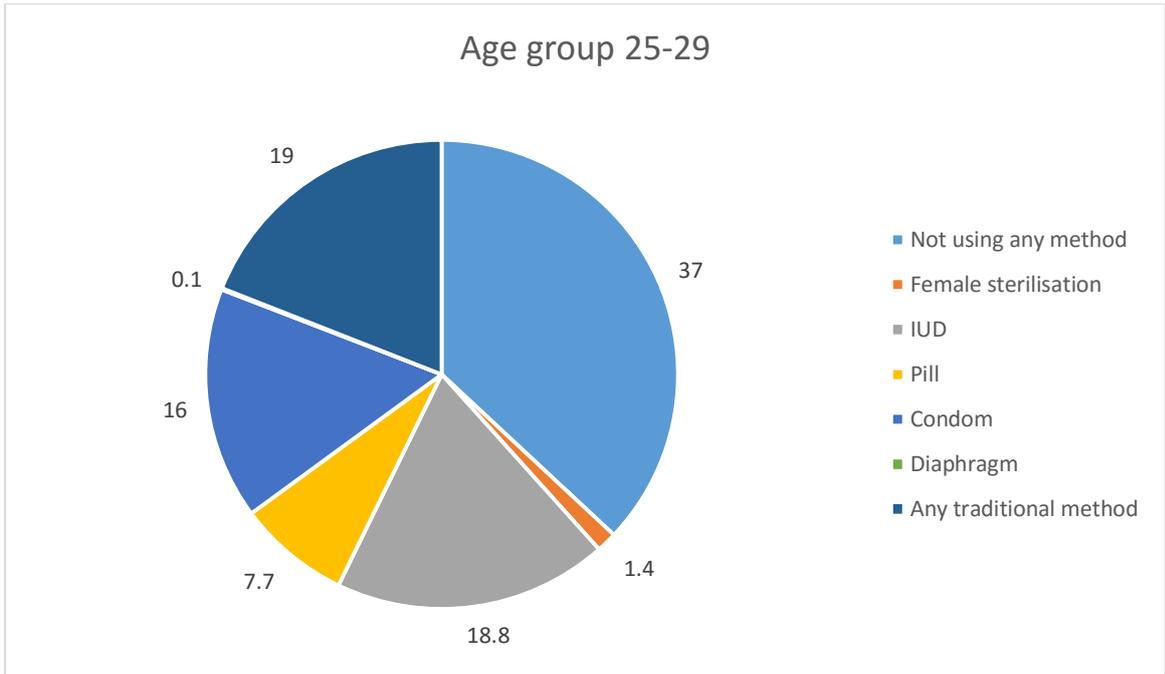
9:00-10:00	Departure to Costesti village, Ialoveni district		
10:00-11:30	Meeting with Manager of Health Center from Costesti and with Dr. Maria Bivol, Director of YFHC "Avante". Visiting the Primary Healthcare Center from Costesti village, Ialoveni district, as well as YFHC "Avante" located in Costesti	Ialoveni district Costesti village 7, Stefan cel Mare Str.	Mr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth, UNFPA Moldova Translator
12:00-13:30	Lunch Break		
13:30-15:00	Debriefing Meeting at the UNFPA Moldova CO	Chisinau, 131, 31 August Str.	Dr. Rita Columbia, UNFPA Moldova Representative Ms Natalia Plugaru, UNFPA Moldova Assistant Representative Dr Godfrey Walker, UNFPA International Expert Ms Eugenia Berzan, Programme Analyst RH and Youth Ms Victoria Dochițcu, Programme Associate RH and Youth

**Departure of Dr. Godfrey Walker from Chisinau International Airport
– 26/05.2017 W63797 KIV-LTN at 21:35 p.m.**

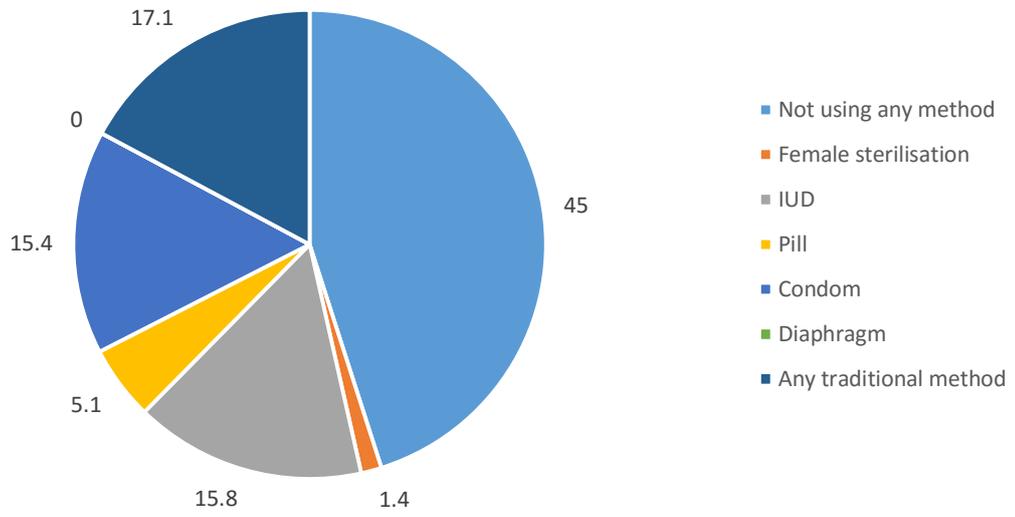
Appendix 2: A series of pie charts showing the method mix for contraceptives used by women in 2012, by region of residence, urban and rural, woman's age, number of living children, woman's education level and wealth



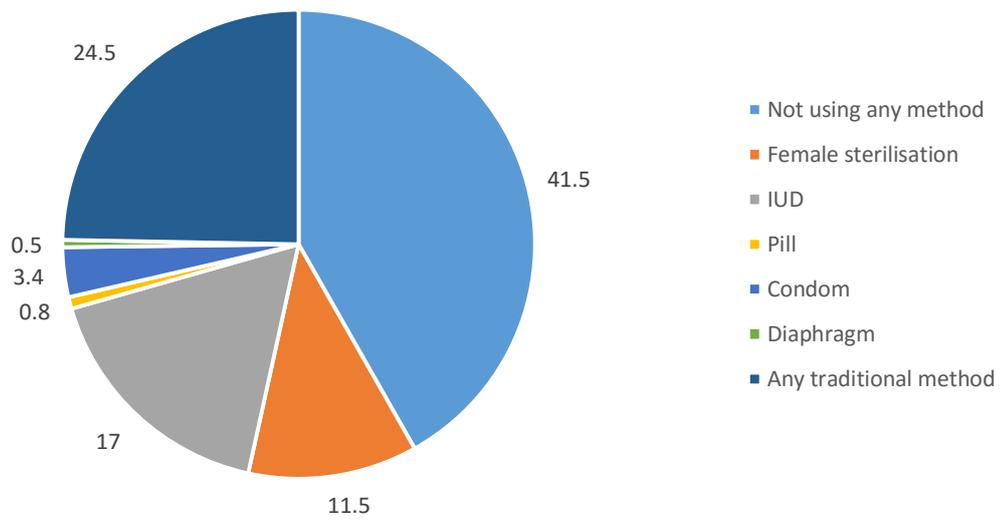




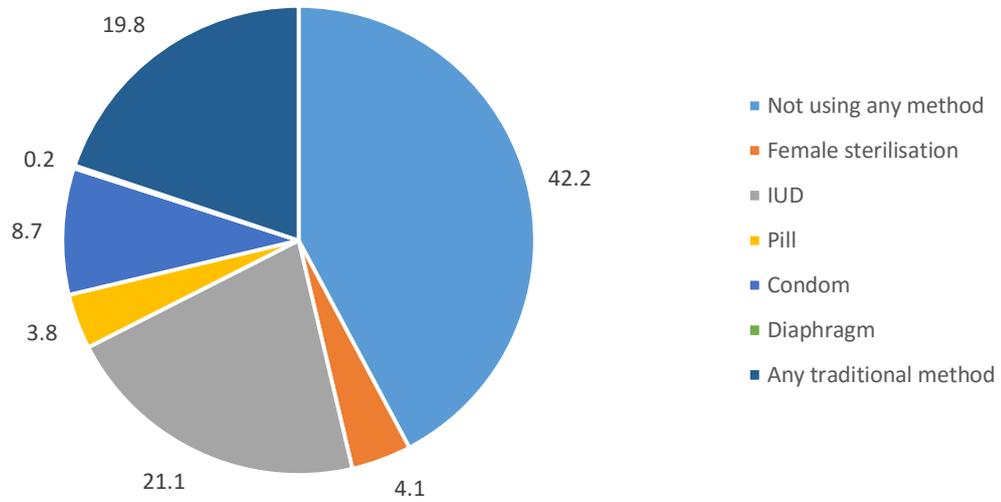
One living child



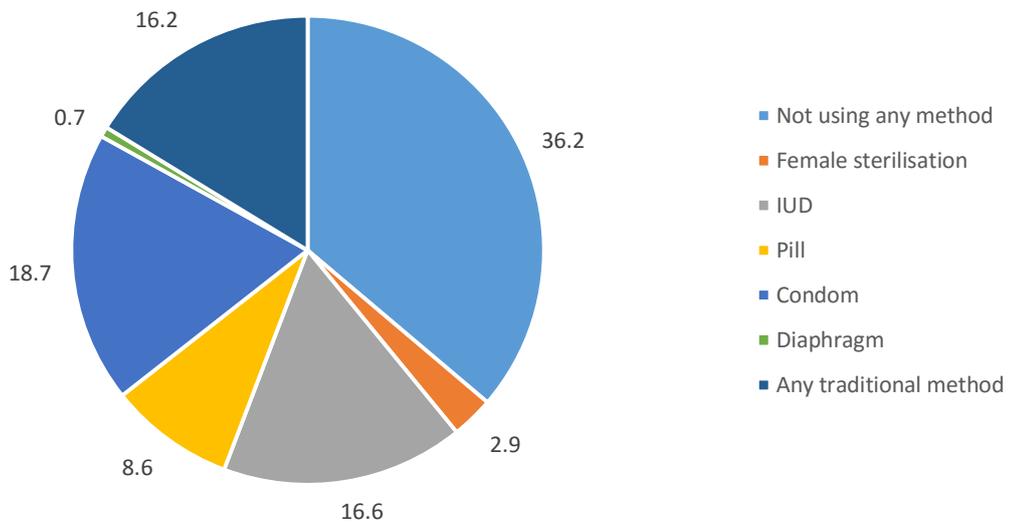
Four living children



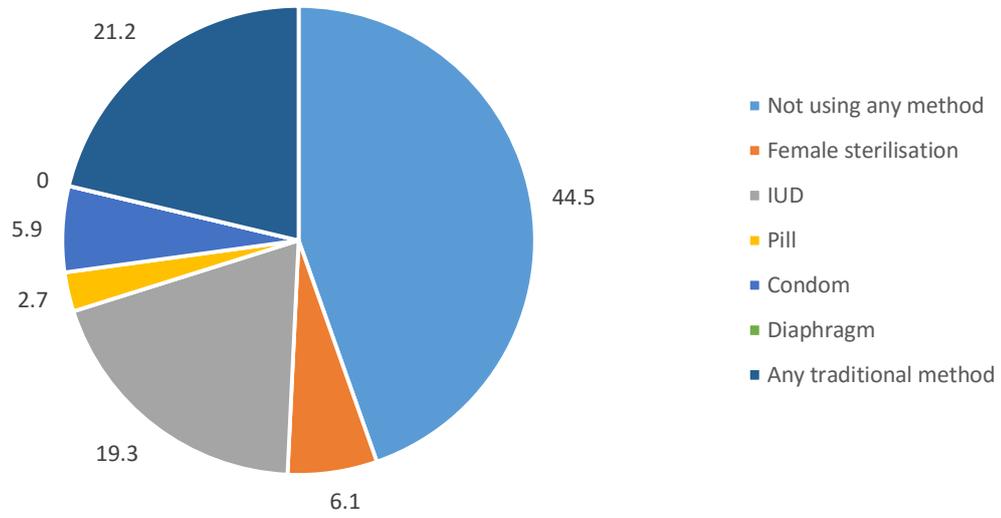
Woman's educational level - secondary



Woman's educational level - higher



Poorest 20 percent of women



Richest 20 percent of women

