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Health sector assessment Moldova

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Disclaimer

The views and ideas expressed herein are those of the authors and do not necessarily imply or reflect the opinion of the Institute or the Swiss Agency for Development and Cooperation.

All reflections and ideas in relation to the option “health systems governance through improved policy analysis and management capacities” outlined in this report have been developed and written by Kaspar Wyss. Given that the co-author of this report Stela Bivol is a collaborator to the Centre for Health Policy and Studies and may have a possible conflict of interest, she did not contribute and participate in any way to the writing of the respective sections.

Contents

1 Executive Summary

The Swiss Cooperation Office in Moldova (SCO-M) has started development of its cooperation strategy for Moldova covering the period 2014 to 2017 in which health is likely to be a main pillar. In this context, the present document has the following two objectives:

- Assist SCO-M and SDC in making informed decision about the need and relevance of enhancing support to health sector development in Moldova;
- Identify priority fields of action and recommend entry points for Swiss interventions in the Moldovan health sector with specific reference to new sub domains.

To respond to these objectives, a literature review on available evidence in relation to health/disease and health sector development in Moldova was conducted and face to face interactions with a broad range of key actors and institutions engaged in health sector development took place in the period 10 to 14 September 2012.

Moldova is experiencing a double epidemiological burden as rates of communicable diseases have increased since independence, while non-communicable diseases, such as cardiovascular diseases and cancer and digestive causes, have continued to increase as a cause of premature mortality. The priorities and reforms of the Moldovan Government emphasise among else access to quality public health and health services. At the same time, the existing and on-going health sector programs are marked by a possible reduction in the number of donors and amount of external assistance to health sector development. Given all this, there is a strong rationale for SDC to maintain or better to increase its support to health sector development in Moldova. Indeed, there is a clear commitment of governmental and non-governmental actors for continued reform of the health sector and a scarcity of funds and external resources, coupled to relatively good health sector results measured through a improvement of some key indicators over the past decade.

Five options for possible future additional support are identified. They are:

1. Community empowerment through health prevention and promotion
2. Improved home based care through testing and scaling-up new models of care
3. Support to family medicine through nurse capacity strengthening
4. Improvement of access to hospital care through strengthening of adult emergency services
5. Addressing health systems governance through improved policy analysis and management capacities (possibly including e-health)

These options are likely to be complemented by 2 to 3 projects which are presently being funded and included in SDC cooperation strategy 2014-2017 which are the (1) regionalization of the Pediatric Emergency and Intensive Care Medical Services System (REPEMOL); (2) Healthy Generation (Youth Friendly Health Services in Moldova); and possibly (3) the Development of Community Mental Health Care Services in Moldova.

The SDC cooperation strategy framework is proposed to be embedded in health systems thinking, implying the recognition of dynamic and holistic approaches that appreciate the multifaceted and interconnected relationships among health system components, as well as the views, interests and power of its different actors and stakeholders. The possible domains for future Swiss investments in health sector development may be entrenched around the general SDC domain goal formulated as follows:

- Population in Moldova benefits from better health due to improved access to quality primary health services with emphasis on NCDs

An initial outline for the results framework for Health domain in the new cooperation strategy 2014-2017 is provided by the report. To be noted that the framework needs to be further expanded and fine-tuned depending on the funding decisions with regard to outlined options.

So to adequately track the outputs and outcomes of Swiss investments within the cooperation strategy 2014-2017, it will be necessary to adequately emphasise monitoring and evaluation activities within and across the future projects, through allocating dedicated staff and adequate resources to these activities. The outcome monitoring could eventually be an inherent element of option 5 on policy analysis and evidence for decision-making.

All five options are considered as being fully in line with the draft SDC health policy as of March 2012. The options are considered being cost-effective approaches to strengthen the Moldovan health system. They further offer the opportunity to address adequately concerns of poor and vulnerable groups. The extent of this being the case obviously depends of exact nature and the main lines of activities of the future SDC funded projects. Emphasis on the poor and vulnerable may also be addressed through agreeing on a disadvantaged geographical area where SDC funded activities shall at least operate.

At this stage they do correspond to general sketches which do need to be further detailed. This could be done once SDC has indicated which of the options are of interest. The related feasibility studies would entail the detailing of key characteristics such as objectives, implementing strategy and main lines of activities and the proposed institutional setup and management arrangements.

2 Background and rationale for the assessment

Moldova is in the process of economic transition towards a market-oriented economy but remains the poorest country in Europe. Its economy is not diversified and is based on the service sector, as a result of decrease in industry and agriculture, and makes up 75 percent of the Gross Domestic Product (GDP). It estimated that 600,000 to one million Moldovan citizens (almost 25% of the population) are working abroad, most illegally. Poverty and the related migration of large segments of the population are central development issues in Moldova. Poverty, although declining steadily, remains very high. In 2007, it was estimated that 30% of the population were living below the minimum poverty line. The problems of the health sector in Moldova are multiple and broad ranging resulting in a sup-optimal performance of the health system. Challenges touch on aspects such as health services financing, resource management (including drug, infrastructure and human resources management), and health services organization - with a remaining over emphasis on the hospital sector - as well as the steering and governance of the health sector. Reforms of the Government of Moldova and Ministry of Health (MoH) focus since 1997 among else on strengthening of family medicine and the financial protection of the population through improved health insurance coverage. Indeed, Moldova, like many other countries struggling with transition of its economy and especially its health system, has been prime for taking up the international health challenge of establishing a well-functioning and adequately financed Primary Health Care (PHC).

Switzerland, through the Swiss Agency for Development and Cooperation (SDC) as well as number of other institutions such as the Swiss Red Cross or Caritas, has been assisting health sector development in Moldova for more than a decade. In line with national priorities, SDC alone supports the efforts of the Government to guarantee to all its citizens equal access to quality infrastructure in the water and health sector with an annual expenditures in range of 6.5 to 7 million CHF. Given the recent decision of the Swiss Parliament to increase its budgetary allocations to development aid gradually to 0.5% of the GDP, the Swiss assistance to Moldova and SDCs health sector support portfolio is likely to grow in the coming years.

The Swiss Cooperation Office in Moldova (SCO-M) has started to engage in the development of its cooperation strategy for Moldova covering the period 2014 to 2017 in which health will continue to be a main pillar. In this context SDC has competitively recruited two experts and assigned the task to establish a health sector review of Moldova with specific reference to current and possible future Swiss contributions to health sector development. In consequence and based on the jointly agreed on Terms of Reference, the present document has the following two objectives:

- Assist SCO-M and SDC in making informed decision about the need and relevance of enhancing support to health sector development in Moldova;
- Identify priority fields of action and recommend entry points for Swiss interventions in the Moldovan health sector with specific reference to new sub domains.

So to respond to the objectives, the two consultants conducted a literature review on available evidence in relation to health/disease, access to health services and health sector development in Moldova and interacted with a number of key actors and institutions through face to face interviews and additional Skype discussions in the period 10 to 14 September 2012. The documents consulted are itemised in annex 1 and the persons and institutions met are listed in annex 3.

Chapter 3 of the present report establishes an analysis on current and emerging disease patterns and health needs, and links them to priorities of governmental reforms and existing programs of development partners of the Moldovan Ministry of Health (MoH). Chapter 4 develops priority areas and options for support by SDC, thereby taking into account the current SDC health portfolio and relates them to SDC policies especially the provision of assistance to the poor and vulnerable as well as opportunities and barriers to change. In chapter 5 the main identified options for new sub domains are compared and recommendations for possible future assistance by SDC are established.

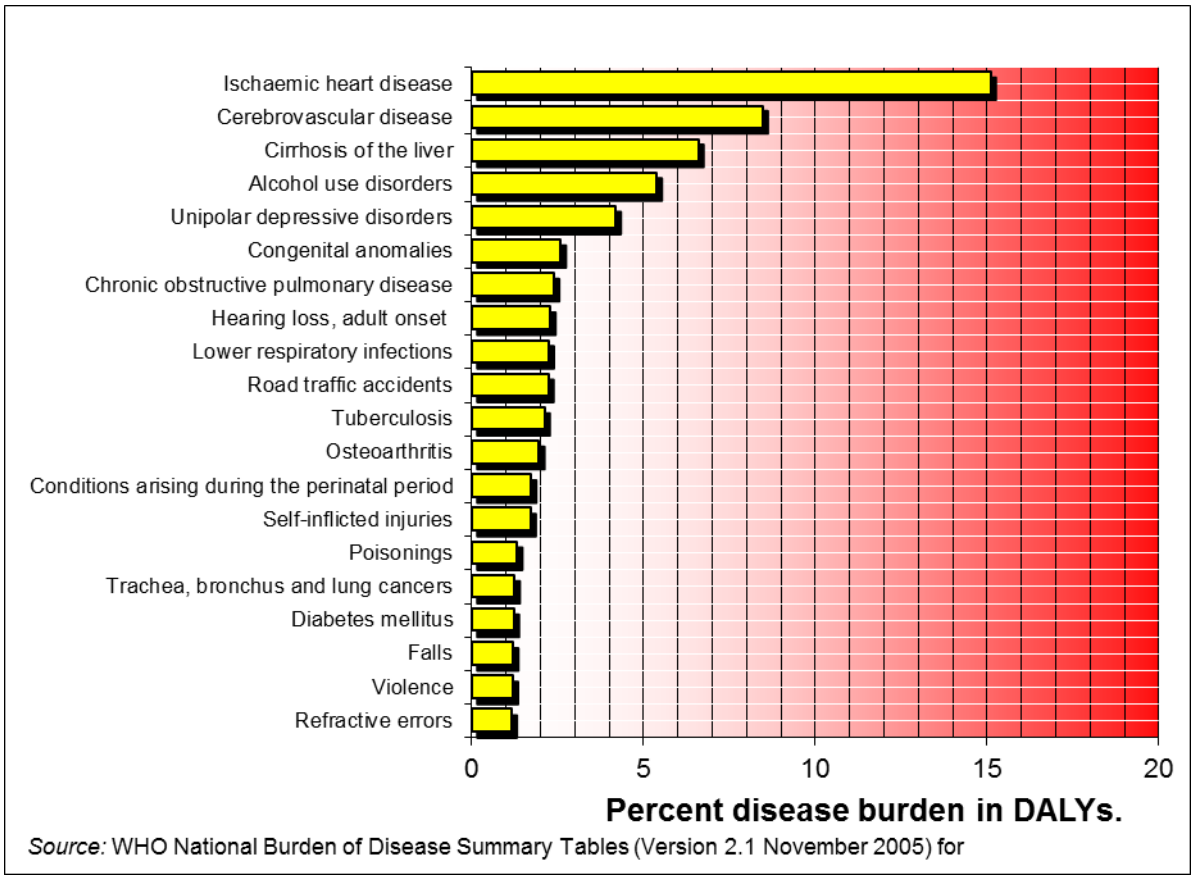
3 General analysis

3.1 Disease and population needs, in particular of the poor and for the system

Statistical facts in relation to health and disease can be found in annex 6. Key indicators for health and diseases have shown positive trends over the past decade and life expectancy in 2010, at least for those regions to the west of the Nistru River where data are available, was 69 years. There are however marked differences between men and women, with men having a life expectancy which is around 10 years less than the one of women. Similarly, the infant mortality rate has been falling steadily since the mid-1990s reaching 11.8 per 1000 live births in 2010, which is close to average for countries of the CIS (11.7 per 1000 live births in 2010), but still more than double the European Union average of 4.2 per 1000 live births in 2010 (WHO, 2012).

Moldova has a double epidemiological burden as rates of communicable diseases have increased since independence while non-communicable diseases, such as cardiovascular diseases and cancers, have also increased as a cause of premature mortality. Heart disease and stroke, cancers and digestive diseases (mostly liver-related) predominate as the main causes of mortality in the Republic of Moldova for both men and women. Poverty, alcohol and tobacco are the key health determinants for most Moldovans and mortality and morbidity from these factors account for a sizeable burden on society. The distribution of Years of Life Lost (YLL) by causes in the year 2008 show that communicable diseases represent 62 percent of the total YLL, followed by non communicable diseases (NCDs) with 32 percent and injury 6 percent. However, cardiovascular diseases (ischemic heart disease, followed by hypertensive heart disease and cerebrovascular disease) represent the largest cause of death, followed by malignant neoplasms, respiratory diseases and diabetes mellitus. Figure 1 below shows this situation at the example of Disability Adjusted Life Years (DALY).

Figure 1. Moldova top 20 causes of DALYs for all age groups



Source: WHO National Burden of Disease Summary Tables (Version 2.1 November 2005) for

Higher mortality rates for the top causes of mortality are registered and increasing in rural compared to urban areas and life expectancy was 3.6 years higher in cities compared to rural areas in 2010 (NBS 2012). In the light of these substantial inequalities in health and given the premature burden of chronic diseases and high prevalence of risk factors, there is a stringent need for community-based health promotion and non-communicable disease prevention, particularly in rural areas.

While total health expenditure is ten times lower than the European Union (EU) average and twice lower than Commonwealth of Independent States (CIS) average in absolute terms, at 12 percent of Gross Domestic Product (GDP) it is higher than the average in both the EU and the (CIS). (WHO HFA 2012). Financial access to health services has increased with the introduction of health insurance, yet there are still significant inequities in access and coverage by socio-economic status and rural and urban residency. The government spending for health has significantly increased over the past decade from PPP$ 89 per capita in 2004 to PPP$ 165 per capita, yet it only accounts for 45.6 percent of total health expenditure and is likely to decrease given the current budgetary constraints related to modest GDP growth. Pharmaceutical expenditure is heavily reliant on patient out-of-pocket for outpatient medicines and the compensation rate for medicines is still modest, as the government covers only 27.9% of the total pharmaceutical expenditure (see annex 7, WHO HFA 2012). Some 20% of the population remains uninsured, and these are more likely to be rural residents working in agriculture and informal sector and labour migrants. Even when the population is covered by health insurance, their access to health care is in direct relationship to their socio-economic status, as the recent national household budget surveys have shown (NBS 2011).

The rural and urban divide is also significant in physical availability of essential primary health care, as some rural areas are well-staffed with nurses but face a decline in the number of physicians and increasing average age of physicians, with declining willingness of young physicians to relocate, despite government monetary incentives. In addition, villages lack access to the essential medicines list, as rural pharmacies have shown a significantly lower availability of medicines compared to cities.

Labour migration also affects access to health services in several dimensions. Labour migrants are a group with one of the lowest health insurance coverage rates who prefer instead to access directly specialist care and pay out-of-pocket (IOM, 2010). Migration has been mentioned as a factor to recently increasing maternal mortality rates, as pregnant women present late for labour without in-country antenatal care. Elderly and children left behind often experience difficulties in accessing care available outside their community in conditions when specialized home-based care for chronic disease management is only starting to develop.

3.2 Priorities and reforms of the Government

The Ministry of Health has developed a series of documents under which it lays out the strategic goals and shorter-term objectives for the health reform. The main documents are the National Health Policy of the Republic of Moldova for 2007–2021, Healthcare System Development Strategy for the period 2008-2017 and a series of shorter-term national programs for priorities in public health and two roadmaps for health reforms and in pharmaceutical area.

Priorities in these documents converge and are in line with the general framework as outlined in the health priorities of the Government of the Republic of Moldova for the period 2011 to 2014 (GoM 2011). The document outlines five “governance” objectives which are:

1. Make sure all Moldovan citizens have access to quality public health, healthcare and pharmaceutical services, including for the purpose of achieving the MDGs.
2. Monitor performance of all providers of healthcare services and health insurance companies; formulate and apply minimum quality standards; curtail administrative corruption in the health sector.
3. Revise the legislative and regulatory framework on financing, resource allocation and delivery of healthcare services in line with the provisions and advice of the World Health Organization and EU standards.
4. Develop and put in place mechanisms to ensure and control quality of healthcare services delivered to population, by developing the human, technical and material potential and providing public healthcare institutions with proper medical and laboratory devices, medicines, advanced technologies.

5. Increasing citizens' responsibility for their own health, preventing the risk factors, protecting health are the key priorities in protecting the population exposed to real or potential risks for health.

The objectives are underlined with a number of priority interventions emphasising the need to reduce discrepancies between rural and urban areas in influencing determinants of health, the need for upgrading primary healthcare for family and community and the reorganization of the hospital sector, implementing programs to reduce impact on health, to develop access to pharmaceuticals and increase participation of health sector partners.

The past several years have seen increased government attention to optimising the hospital sector and regionalization of the hospital network, introducing DRG-payment system for the hospital services, strengthening rural PHC infrastructure, addressing medicines pricing through price registration and centralized procurements. The government has addressed inequity in coverage with health insurance, by providing universal access to PHC consultations and emergency services, by entitling those under poverty line for PHC coverage, and by introducing incentives and requirements for those self-insured, with moderate success. Several priority areas where progress is still incipient relates to developing and approving the non-communicable disease strategy and action plan, mental health strategy, E-health strategy, development strategy for human resources in health. Reforms that envisage change of service delivery networks and models and inter-sectoral collaboration are much slower.

3.3 Existing programmes and partners and potential of cooperation

In line with national development priorities, a variety of development partners have over the last decade provided support to different parts of the health sector, both at the central Ministry of Health level, but also at the regional and local level.

In the area of health reform and health service delivery, the Moldovan Ministry of Health is assisted by a series of bi-and multi-lateral donors and NGOs and the World Health Organization has recently released an overview on official development assistance to the Republic of Moldova (WHO, 2012). The most important projects and programs are presently the following (for further details please consult annex 10):

- The European Union (EU) is providing direct budgetary support to the Ministry of Finance earmarked for health and specifically in 2013 for the procurement of equipment for laboratories overseen by the Public Health institute respectively for equipment relating to the patient simulator centre of State Medical and Pharmaceutical University.
- The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) is funding two multi-million US$ programmes focusing on HIV prevention and treatment and TB control
- The Swiss Agency for Development and Cooperation (SDC) see below
- The World Bank through the Health Service and Social Assistance Project (HSSA) provides support to various levels including MoH capacity building, development of PHC and hospital infrastructure and the introduction of new payment mechanisms of hospitals.
- WHO provides technical assistance to support reform in a vast number of areas including human resources, hospital modernisation, health financing, and donor coordination and further collects and disseminates evidence on relevant topics such as access to care or drugs.
- JICA will contribute in the near future to hospital strengthening principally through the procurement of equipment. Yet is however not known which areas exactly will benefit.

Main programs listed above, especially those funded by the European Union and the World Bank will come to an end in the course of 2013, and both institutions will draft their future plans for further support to the health sector development in Moldova in the last quarter of 2012 and early 2013. Thereby there is a risk that at least one of these institutions will discontinue or decrease its support to the health sector in Moldova.

SDC is a main partner of the Government of the Republic of Moldova respectively the Ministry of Health. Details on the programs are summarised in annex 10 and can also be consulted through the website of SDC. In a nutshell, SDC is funding as per September 2012 the following portfolio:

1. Modernising Moldovan Perinatolgy system's project (PERINAT) with a budget of CHF 3.2 million is in its last phase (2011-2013) and a focus on further improving obstetric and neonatal emergency and perinatal care
2. Regionalization of the Pediatric Emergency and Intensive Care Medical Services System (REPEMOL) with a budget of CHF 4.8 million (2010-2013) and aiming at contributing to a better health status of infants and children through a systemic approach to the pediatric care.
3. Healthy Generation (Youth Friendly Health Services in Moldova) Project with a budget of CHF 1.8 million (2011-2014) and aiming at improving the sexual and reproductive health of young men and women in Moldova through increasing the demand, access to and utilization of quality youth friendly services and health related education programmes
4. Development of Community Mental Health Care Services in Moldova with a budget CHF 0.7 million (2009-2012) and focusing on the establishment of a community mental health centre serving as a model for a new community mental health centers and the development of curricula for medical students, and the drafting of a national mental health strategy.

While PERINAT is coming to an end by 2013, SDC is strongly considering the continuation of funding of REPEMOL as well as Youth Friendly Health Services in Moldova. Yet it is less clear how exactly how the development of mental health care services will further be assisted.

A total number of 6 bi-and and 10 multi-lateral agencies have provided official development assistance to health sector development to Moldova. For example, the Global Alliance for Vaccines and Immunization (GAVI) is assisting with the introduction of Penta and rotavirus vaccine in the routine immunization program or UNICEF is helping with the establishment of youth-friendly services and the implementation of a multiple indicator cluster survey, among other priorities. Further, a number of NGOs, such as Swiss Red Cross (AICF), Caritas are running their programmes at PHC level in different regions of Moldova and covering various topics such as home based care for elderly persons.

Over the last years the WHO Country Office in Republic of Moldova has played a constructive role in relation to the coordination of inputs of development partners, the harmonization of their activities as well as in carrying forward key strategic developments through collecting, analysing, compiling and disseminating key evidence on relevant topics such as access to care and health financing, pharmaceutical reform, hospital reform, alcohol and tobacco policies. This role is also eased by the limited number of development partners and relatively small circle of development partners so that regular communication and exchange of key information and development is greatly facilitated.

As WHO will continue to substantially depend on funding channels made available by the EU, World Bank programs and/or SDC, a decrease in health sector support by one or several of these agencies may undermine their current role and as importantly shake up the current balance between the different development partners. For SDC this entails the risk that the relative importance as development partner of the Ministry of Health may further grow and that additional funding and assistance requests may be addressed to SDC.

3.4 Main opportunities and risks

In view of the upcoming SDC cooperation strategy for Moldova covering the period 2014 to 2017, we briefly list some principal opportunities and risks of future investments in health sector development.

An exogenous risk to any current and future SDC funded activity is that economic change and prevailing levels of low salaries for civil servants will encourage and even possibly accelerate the widespread migration, including of health workers. In consequence any Swiss investments will need to take into account this and need to establish project specific risk assessments against this possible menace.

As indicated in the previous section there is the possibility that the number and the level of funding of development partners of MoH will decrease over the next years. If so, this entails for SDC opportunities and risks at the same time and some of them are further detailed below. Opportunities relate to increased importance and attention given to Swiss investments and more generally accrued importance to the Swiss position for example in relation to access of the poor and vulnerable to health care. At the same this would require from SDC to position itself more explicitly in relation to domestic policy issues with the risk that SDC may either not be good in doing this and/or be in opposition to governmental positions.

Selected opportunities are as follows:

- Moldovan authorities have showed significant commitment to increase the financial support for PHC. This accompanied to capacity strengthening measures, the reform of medical education curricula for family medicine and especially the introduction of higher pays of primary care providers through the health insurance have resulted in a situation where the use and service provision through primary care is incentivised. Future investments of SDC will be able to build on this achievement.
- Over the last years substantial investments in health service infrastructure (building and equipment), especially in PHC services, have been done. The relatively important investments in infrastructure made the WB and local sources, coupled to the possible interest and willingness of some development partners such as JICA for further investments in this area, allow SDC and other development partners to primarily focus on the “soft-” and human-related aspects of the health system. In other words, given that minimal infrastructure and equipment at least at PHC level is generally available, make it possible to tailor new activities to human resource and service delivery models, for example in areas such as nursing strengthening and home based care.
- In Moldova there is a strong will for continued reform of the health sector. Relatively comprehensive sector plans do exists and are applied to health reform steering. A number of areas ranging from health information, health service financing, health services delivery as well as human resources for health have and continue to undergo reform. Albeit some complain about limited implementation capacities and diverging interests at level of MoH (e.g e-health or mental health), SDC investments will occur in a context which is generally spoken reform minded.
- More generally, priorities of the Government of the Republic of Moldova for health sector development in the period 2011 to 2014 respectively the five “governance” objectives are well in line with the revised SDC Health Policy (draft March 2012).
- Through its presence over ten years, sustained commitment to Moldova as well as achievements of projects funded by SDC (e.g. PERINAT, REPEMOL), SDC is a well-recognized and accepted partner for the government. This and the mutual respect and confidence which prevails, is likely to greatly facilitated future investments of SDC in health sector development in Moldova.
- Last but not least, the political situation in relation to Transnistria has evolved. The Government of Moldova is particularly interested in joint efforts of sectoral ministries to collaborate. The Ministry of Health has a focus on continued dialogue and transfer of reform models on the right bank of Nistru to the left bank, namely the primary health care model and reform and the national health insurance reform. Under certain conditions this evolution may allow SDC to invest also in health sector development in Transnistrian region for example through the extension of certain “packages” of existing projects.

Selected risks are as follows:

- There is a political will to carry forward the optimisation of the hospital sector, but it is not clear if the same holds for decentralisation of decision-making, planning and management. The role of regional hospitals are recognised and acknowledged as a primary aim by the Government. However, modalities for implementation need to be further outlined especially roles and responsibilities of the regional level and their relations to PHC. Further, the hospital reform has hardly progressed over the last years, and there is a risk of further delays in the implementation of the rationalisation plan, including in the area of mental health. In case future activities of SDC will focus on access to primary care, this will have only a moderate impact on future activities of SDC as the hospital reform and hospital investments (possible exception mental health) will not be in the focus of SDCs interest.
- The idea that the demand side of interventions must be considered through adequate health prevention and promotion, to ensure that the behaviour and attitudes of target populations are understood and taken into account in designing service models, and to associate the population more closely with service delivery, are relatively new in the Moldovan context and will consequently need careful attention. Changes, and their acceptance by the population, may take longer than anticipated. SDC may encounter potential divergence between local/community and national priorities through encouraging the recognition of community identified health issues and approaches, for instance in the area of non-communicable disease control.
- Household expenditures for drugs remain the single biggest access barrier at the outpatient level for the Moldovan population. Indeed patients get reimbursed only a certain percentage of

selected drugs they purchase in relation to the use of PHC services. Expenditures for drugs are thus a major concern for a better uptake of available family medicine services, including in the area of treatment of NCDs (exception diabetes where insulin is funded through governmental budget lines and cardio-vascular drugs that are compensated through a positive list). Given that this situation is unlikely to change in the near future and given that that the availability of drugs determines in an important way the use of health services, future investments of SDC will need to take into account this.

- Some of the proposed options for future activities of SDC in Moldova will rely in an important way on inter-sectoral collaboration especially at the interface between health and social services. This is for example the case for home based care where social and family support is in many instances as important as medical clinical aspects. In a context which is extremely resource scarce as the one in Moldova, it will require strong leadership from the central government so to align mandates and strategies of the social and the health sector. If this is not the case, there is a risk that new initiatives and forms of service delivery are likely to fail.
  At present, WHO is assuring coordination of development assistance to the health sector and the monitoring report mentioned in the previous section is an excellent example for achievements in this area. However aid coordination remains a challenge, with many donors providing assistance in a discontinued and fragmented way, often also occasionally.

4 Options for concrete support in the short run

SCO-M is currently examining various options for health sector support to Moldova and is in this context in discussion with a number of partners on specific proposals, such as e-health, mental health, support to simulation center at the Medical University, scaling-up health technology management components to the whole health sector. Albeit not explicitly listed in the ToRs, the consultant team was asked to give an opinion on possible projects and areas of intervention in the short-run, during the forthcoming months and in 2013. This against a background that the projects currently funded (PERINAT, REPEMOL, Youth Friendly Health Services and Community Mental Health Care Services) will not absorb in 2013 the full budget available to SCO-M.

During the country visit to Moldova, four principle options were discussed with SCO-M. Selected considerations in relation to these options are listed in table 1 below. As can be seen for each one there are specific opportunities and risks associated with. Some further show a higher potential for an impact on the poor and vulnerable as well as the inclusion of gender and governance aspects.

Generally the following can be observed in relation to the 4 options:

1. **Strengthening of health services in Transnistrian region through an extension of PERINAT and/or REPEMOL**: This option requires a political decision by Switzerland embedded into a broader vision of collaboration with the Transnistrian region as well as strong support from Moldovan authorities. It offers however the opportunity to transfer selected achievements and successful components of PERINAT and/or REPEMOL to Transnistrian regions and it has been the case of SDC's IMCI program implemented by UNICEF in Transnistrian region.
2. **Strengthening of adult emergency services (at regional hospital level):** This option corresponds to a relatively clearly delineated area of hospital strengthening, thereby selected Swiss experiences within PERINAT and REPEMOL can be used. Opposite, there might be a relatively lengthy preparation and planning phase given reliance on other donors to invest in infrastructure of regional hospitals. Funding may also require a mid-term commitment of SDC commitment in areas such as quality assurance, CME of hospital staff so to assure effectiveness and sustainability
3. **Scale-up health technology management (HTM) know-how from REPEMOL and PERINAT projects to all health facilities:** This option also corresponds to a relatively clearly delineated area of institutional strengthening thereby selected Swiss experiences within PERINAT and REPEMOL can be used. The national counterparts have specifically identified this component as highly useful and innovative for institutional strenghtening in conditions where new medical equipment is brought to most medical facilities. An opportunity is that the newly restructured Drugs Agency is responsible for medical device management and will need technical assistance strengthening in this area. Another strength is that the SDC's implementing partners already have the capacity to manage this component in case of national scale-up.

4. **Assistance to development plans of the State University of Medicine and Pharmacy (SUMP)**
    a. **Investments in the clinical skills laboratory (simulation centre):** SUMP has requested SDC's support to equipment procurement to the EU and SDC. Given the planned substantial investments by the European Union in this area, there is a need to determine the cost-effectiveness and the complementarity of possible Swiss investments in a patient simulation centre. Further there is a need to examine the business model and running costs of the proposed simulation centres.
    b. **Investment into IT infrastructure and configuration**: SUMP has drafted an IT investment plan on which SDC investments could build However need to be thoroughly assessed and examined. Further co-funding by SUMP and maintenance plan would require further discussions and agreements on with SUMP.
5. **Poverty fund channelled through NHIC**: The feasibility and design of fund allowing poor and vulnerable groups through insurance coverage would need to be further outlined and discussed/negotiated with NHIC including in relation to gender. There is a high risk that such a scheme is not sustainable and requires lengthy negotiations with NHIC and other actors.

Table 1. Possible options for SDC support in the short-run (2013)

Key feature		Selected considerations
1. Strengthening of health services in Transnistria		
1a PERINAT 1b REPEMOL	Extension of selected components (especially infrastructure and equipment) of current projects to the hospital and possibly PHC sector of Transnistria	• Needs a political decision by Switzerland embedded into a broader vision of collaboration with Transnistrian region • So to account on the substantial differences in health financing and delivery, requirement for continued political will and acceptance of Moldovan authorities to collaborate with Transnistrian region • As based on past and on-going activities, possibility to relatively rapidly identify suitable activities and adopted approaches • Possibility to transfer selected achievements and successful components of SDC support to Transnistrian region
2. Strengthening of Adult emergency services		
	Infrastructure and equipment investments in emergency departments or regional and possibly rayon hospitals accompanied by capacity building of staff and strengthening of referral patterns	• So to avoid duplication, close follow-up of upcoming JICA investments necessary • Can build on selected Swiss experiences within PERINAT and REPEMOL for example in the area of equipment procurement or maintenance policies & practices • Relatively clearly delineate area of hospital strengthening • Possible relatively long preparation and planning phase (requirement to identify through a competitive tendering process an implementing agency; identification of equipment needs and configuration; beneficiary hospitals, etc.) • The process will need to be planned in accordance with MoH plans to build new regional hospitals • Infrastructural and equipment investments, will most likely require SDC commitment in quality assurance, CME of hospital staff beyond 2013 so to assure effectiveness and sustainability
3. Scale-up health technology management (HTM) know-how		
	Extension of HTM component of current projects to national level and all health facilities (or only hospitals)	• Welcomed and highly regarded component of the current PERINAT and REPEMOL projects by hospital managers. • Newly restructured Drugs Agency is responsible for medical device management and will need technical assistance strengthening in this area. • Existing capacity of SDC's implementing partners to manage this component in case of national scale-up. • Mostly technical assistance and might take time to implement
4. Support to development plans of the State University of Medicine and Pharmacy		
4a Clinical skills laboratory	Contribute to the equipment procurement (for example mother and child-health) for the clinical skills laboratory of SUMP along capacity building and management organisation strengthening	• Need to determine cost-effectiveness of possible investments as EU invested already EUR 1.5 millions in building renovation and will provide another up EUR 3.0 million of equipment procurement, through direct budget support mechanism, thus not clear how much will truly be allocated for equipment procurement • Need for close collaboration with EU for the procurement of equipment • Need for a competitive international tender for equipment procurement and thus need to determine implementation responsibilities (e.g for procurement) and possibly an implementing agency

		• On-going running costs to be determined and plan for coverage of these costs to be agreed-on • Relation to training of medical doctors and curriculum to be determined
4b IT Investment	Along the IT investment plan of SUMP strengthen the IT infrastructure and processes (network, etc.)	• An appropriately established investment plan is available • Needs a specific appraisal so to determine approach and components of SUMP investment plan of interest to SDC • Need for an implementing agency to be clarified, but possible direct execution by SDC • Co-funding by SUMP and maintenance plan to be discussed
5. Poverty fund channelled through NHIC		
	A specific fund is made available to the NHIC so that insurance coverage can be extended to poor and vulnerable groups not yet covered	• Feasibility and design needs of the poverty fund needs further outlined and discussed/negotiated with NHIC • High risk that funding scheme is not sustainable • Potentially counterproductive to current efforts to improve coverage mechanisms to provide health insurance based on means testing of those below poverty level who are eligible for social assistance. • Possibility to target the poorest and most vulnerable and to address gender aspects • Does most likely not require an implementing agency, but at a specific monitoring mechanism so to assure that poor and vulnerable groups effectively benefit

5 Options in relation to SDC cooperation strategy 2014 to 2017

5.1 Embedment of SDC cooperation strategy 2014-2017 in health systems strengthening

The SDC cooperation strategy framework is proposed to be embedded in the health systems thinking. Indeed, the publication of the World Health Report 2000, focusing on "Health Systems: Improving Performance" (WHO 2000) was a landmark event in health systems' thinking. Its operational definition and delineation of the health system as "all the activities whose primary purpose is to promote, restore or maintain health" broadened the conventional conceptualisation beyond health service delivery and administration. The increasing recognition of the complexity of both health systems and the international response to the challenges of the MDGs called for frameworks that moved beyond the existing mechanical health system representation. The dynamic interrelations between blocks in the 6 building blocks model were stressed in a report in 2009 (de Savigny and Adams, 2009) thereby developing a framework based on systems thinking, drawing attention to the complex character of health systems, the interactions and feedback loops between the blocks, the role of populations and the resulting unpredictability of effects of changes.

This said and taking into account the prevailing disease profile (section 3.1), the priorities and reforms of the Moldovan Government (section 3.2), the existing and on-going health sector programs (section 3.3.) and the main opportunities and risks (section 3.4) detailed in this report the SDC cooperation strategy 2014-2017, may anchor its activities on improving access to quality care as follows:

Domain goal:
Improving access to quality primary health services with emphasis on NCDs

An initial outline for the results framework for Health domain in new cooperation strategy 2014-2017 is provided in annex 11. To be noted that such the framework needs to be further elaborated depending on the projects to be funded within the SDC cooperation strategy 2014-2017.

At this stage the result framework is partially populated by five options which are further outlined in the next chapters. They are:

1. Community empowerment through health prevention and promotion
2. Improved home based care through testing and scaling-up new models of care
3. Support to family medicine through nurse capacity strengthening
4. Improvement of access to hospital care through strengthening of adult emergency services
5. Addressing health systems governance through improved policy analysis and management capacities (possibly including e-health)

Figure 1 on the next page indicates how these five options as well as the pre-existing and possibly continued SDC funded projects in Moldova may relate to the health systems thinking. Weaknesses and obstacles exist across the system, including overall stewardship and management issues; critical supply-side issues such as human resources, infrastructure, information, and service provision; and demand side issues such as people's participation knowledge and behaviour. Addressing these challenges and understanding and working with complexity requires a paradigm shift from linear, reductionist approaches to dynamic and holistic approaches that appreciate the multifaceted and interconnected relationships among health system components, as well as the views, interests and power of its different actors and stakeholders. We interpret systems thinking in the health system context to require us to stand back from a fixation on the individual components and always keep the whole system in mind when designing and evaluating health systems strengthening innovations (de Savigny and Adams, 2012).

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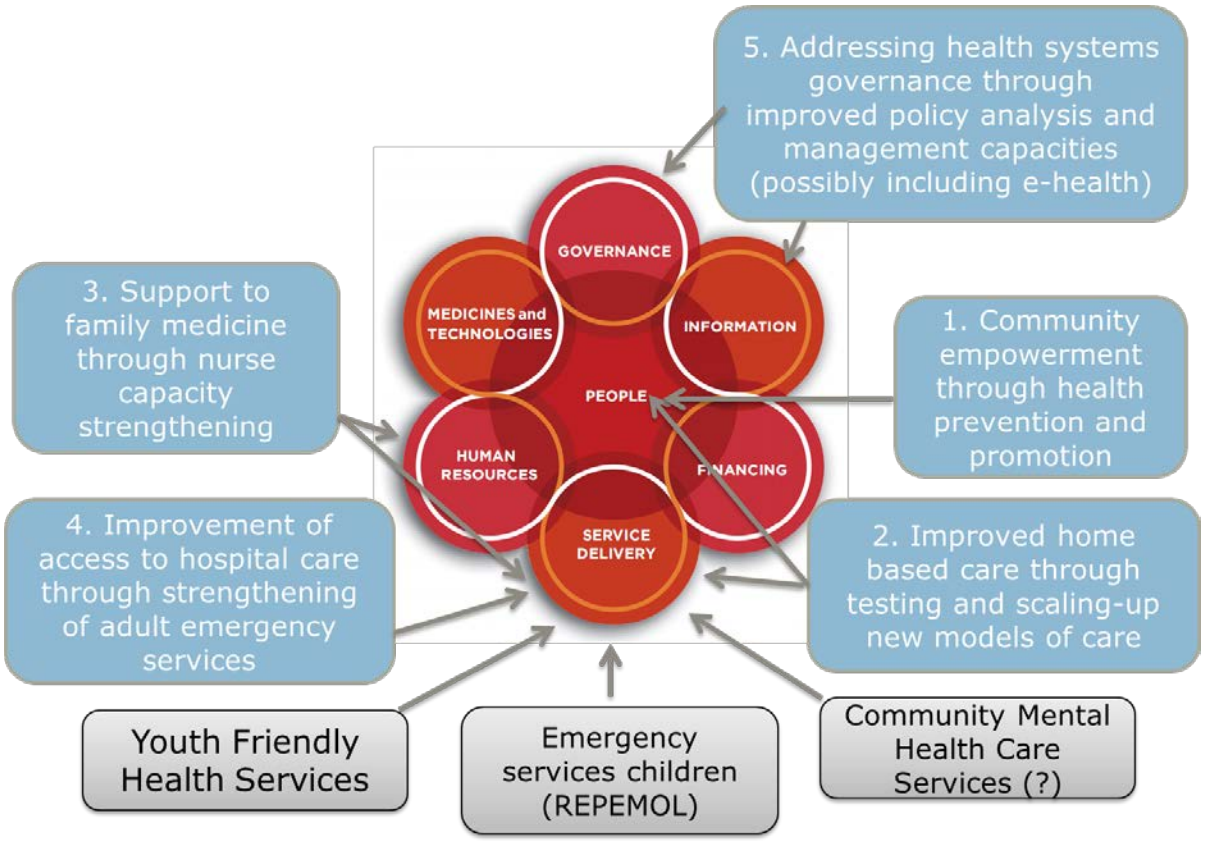
Figure 2. Embedment of identified options (dark blue) and pre-existing project (grey) into health systems thinking. Only main entry points shown



5.2 Key features and considerations of identified options

During the meetings of stakeholders, various options have been voiced and suggested, and some of them were not further considered as possible for funding by SDC. Several of them were considered, but decided to not be included further in the options.

1. **Financial access to medicines** seems to be an important barrier affecting access and effective coverage with services; most of the tools to address pharmaceutical market regulation, drug pricing and government pharmaceutical spending seem to be limited by financial limits and political sensitive and less amenable to technology transfer and possibly outside SDC's current portfolio.
2. **Shortages of human resources in primary health care are** an important barrier in access to PHC services, particularly in rural and underserved areas. While the government makes strides to attract PHC physicians and infuse younger generations among rural family doctors, the consultants considered more cost-effective and realistic to invest in increasing the role and competencies of nurses, as they are more willing to relocate to rural areas and this option is described in possible option 3.
3. **E-Health** was an option requested by the Ministry of Health, being very high on government reform agenda to promote e-Governance. However, the understanding of this domain varies and the needs are not well-defined, and, although it has received significant support from WHO and EU, it still needs a clearer vision, strategy and plan of action. Its links to access and population needs seem to be also unclear. Possibly some parts of e-Health might be further supported by SDC, as part of possible option 5 outlined below.

As a result of the discussions held with various stakeholders during the site visits, the consultants identified five options to be considered for future support by SDC. They are outlined in table 2 below. At this stage they do correspond to general sketches which do need to be further detailed. This could be done once SDC has indicated which of the options are of interest. The related feasibility studies

would entail to further detail key characteristics such as main objectives, implementing strategy and main lines of activities and the proposed institutional setup and management arrangements.

Table 2. Key features and considerations of possible options for SDC support within the SDC cooperation strategy 2014 to 2017

Key feature	Selected considerations
1. Community empowerment through health prevention and promotion	
Through an umbrella organisation provide support, both financial and technical, to local NGOs and communities engaged in health promotion and prevention activities with emphasis on NCDs	• Addresses well the determinants of health and potentially high-impact while the least covered need by both government and donors • Allows synergies and complementarity to other possible SDC funded projects (e.g. home based care and/or nurse strengthening, adolescent health) • Allows competitive tendering among local NGOs • Allows giving emphasis on innovative ideas especially in relation to NCD control and prevention for example in the area of hypertension • Yet approach to health prevention and promotion still understood by many in a classical way consisting of "propaganda" and mass information campaigns • Role and willingness to engage in health prevention and promotion through community empowerment of the National Centre for Public Health to be clarified • Main stakeholders (MoH and CNAM) are reticent towards taking over costs entirely for this type of interventions, as these require multi-sectoral contributions
2. Improved home based care through testing and scaling-up new models of care	
Through an umbrella organisation and jointly with local NGOs and communities, develop and if successfully scale-up new models of home based care and social assistance to poor and vulnerable	• Allows synergies and complementarity to other possible SDC funded projects (e.g. community empowerment and/or nurse strengthening) • Allows competitive tendering among local NGOs • Allows emphasis on innovative approaches to home based care especially in relation to NCD management among elderly persons • Allows inter-sectoral collaboration with the social sector but at the same entails the risk of unclear responsibilities • Financial sustainability of home based care models may be undermined by lack of funding and unclear responsibilities • Will require early on commitment of the health sector and CNAM to provide further support to most cost-effective models
3. Support to family medicine through nurse capacity strengthening	
In rural areas underserved by doctors, strengthen the role, competencies and skills of nurses working within family medicine setting so to improve quality and access to services	• Allows synergies and complementarity to other possible SDC funded projects (e.g. home based care and/or community empowerment) • Allows emphasis on new service delivery forms embedded in a health systems approach • Addresses staff shortage in rural areas and emphasis gender dimensions • Self-esteem and understanding of nursed potentially difficult to change • May face opposition from medical doctors and other actors • May need regulatory changes to diversify and increase roles and responsibilities for nurses •

4. Improvement of access to hospital care through strengthening of adult emergency services	
Re-organising and strengthening of adult emergency services at the level of regional and possibly district hospitals	• Infrastructure and equipment investments in emergency departments or regional and possibly rayon hospitals accompanied by capacity building of staff and strengthening of referral patterns • Can build on Swiss experiences within PERINAT and REPEMOL for example in the area of equipment procurement or maintenance policies & practices • Hospital reform may be further delayed and hinder a comprehensive approach • Links and synergies to other options identified, will need additional thinking
5. Addressing health systems governance through improved policy analysis and management capacities (possibly including e-health)	
Assist policy analysis institution providing analysis and independent opinion on health sector development and key reforms in Moldova possibly coupled to implementing selected elements of e-health and management training for the regional and district managers	• Allows to build up an independent and national monitoring function for health sector development given the current and likely future week institutional capacities at MoH level • Allows collection of evidence in selected areas for informed policy-making • Credibility of the centre of excellency will strongly depend on the quality of products and committed key persons • Financial sustainability possibly not assured through domestic funding channels • May face opposition from MoH and other actors

One issue to be solved will also be the geographical coverage of future projects and programs being funded by SDC. The consultants did not specifically look into this aspect, but they consider that a minimal geographical focus across the various future activities being funded by SDC will be to benefit of each single project by creating synergies across the projects. Albeit this may stretch institutional capacities in the geographical region selected, potential benefits through synergies and collaboration may out-weigh them.

5.3 Impact on poor and vulnerable and cost-effectiveness considerations

In this section we briefly relate the five options for SDC support within the SDC cooperation strategy 2014 to 2017 to their possible impact on poor and vulnerable groups as well as cost-effectiveness considerations and a summary of considerations is provided in table 3 below.

Emphasis given to poor and vulnerable groups may among else be adequately emphasized through choosing across SDC funded projects a geographical area being disadvantaged (e.g. in the Southern region of Moldova). Albeit this may stretch institutional capacities of governmental and non-governmental actors in the given zone, advantages in terms of synergies and concerted actions across projects are likely to out-weigh the possible drawbacks.

As shown in the analysis of health status, there is an important divide between urban and rural populations in life expectancy, burden of disease and financial access. Poverty is higher in rural areas, thus, focusing program implementation on rural population and some specific geographic areas with poorer outcomes seem rational form epidemiologic point of view, but might pose an additional managerial burden on implementing agencies and SDC local office. Thus, interventions with highest impact on poor and vulnerable will be most human-resource intensive.

Table 3. Impact on poor and vulnerable and cost-effectiveness considerations of possible options for SDC support within the SDC cooperation strategy 2014 to 2017

Impact on poor and vulnerable	Cost-effectiveness considerations
1. Community empowerment through health prevention and promotion	
Potential to specifically target poor and vulnerable groups (including men as lower users of health services and with higher prevalence of main risk factors) for example through tailoring health promotion activities to specific population groups and specific geographical areas Given differences in premature burden of disease in rural areas, focus on rural areas might best address the needs of poor and vulnerable	Investments in health promotion are generally considered as cost-effective and there is substantial international evidence available that investments in promotion and prevention are less costly than providing health care.
2. Improved home based care through testing and scaling-up new models of care	
Potential to specifically target poor and vulnerable groups (including women) for example through offering home based care to elderly persons without adequate household support and those left behind by migrants	Cost-effectiveness of home based care challenging to show. However deinstitutionalised care for elderly at home is clearly less costly than offering the same services at hospital level or long-term care
3. Support to family medicine through nurse capacity strengthening	
Potential to specifically target poor and vulnerable groups, including women, for example through tailoring health promotion activities to specific population groups and specific geographical areas	Primary care services are internationally recognized to be a cost-effective way of delivering health services (compared to providing the same services through hospitals) and nurses to be more cost-effective than doctors
4. Improvement of access to hospital care through strengthening of adult emergency services	
Emergency services for adult are first of all for the whole population and thus do not entail a specific focus on poor and vulnerable. This may be altered through prioritising underserved geographical areas where relevant segments of the population are poor and vulnerable	In a system's perspective hospital services (including emergency services) may be considered cost-effectiveness as long as they are connected to primary care and fulfil complementary functions than those found at primary care level
5. Addressing health systems governance through improved policy analysis and management capacities (possibly including e-health)	
Policy analysis and management support may specifically emphasis poor and vulnerable group and thus indirectly contribute to improve access of poor and vulnerable groups to health services	Cost-effectiveness of governance and management interventions challenging to show. Improved health systems governance and management has however to be seen essential enhancer for better health system performance (bad governance is an essential factor for bad health systems performance)

5.4 Governance and gender

The current and most likely also future SDC cooperation strategy to Moldova outlines two transversal themes which are: (1) governance and, (2) gender.

The term "governance" defines the way in which power is exercised and applied at different levels. Within the SDC cooperation strategy 2014-2017, the application of governance principles may be pursued across the five options outlined as follows:

- Transparency and access to information: the distribution of evidence for example in relation to access to care, and key features of change is a decisive factor. Any of the options presented, may give emphasis to make information systematically available to all those concerned in a transparent way. In case SDC considers option 5 “addressing health systems governance through improved policy analysis and management capacities (possibly including e-health)” for funding a key element of the future program will relate to transparency.
- Participation: as in the past any of the options considered for funding by SDC should promote inclusiveness of relevant national and local actors as well communities. Most options will require structural changes in service delivery models that can only be done at central level and by setting up new policies and regulations in place. Therefore, any option will entail significant participation of both central authorities and local actors, as well as communities and NGOs.
- Promotion of accountability: any of the options presented shall give high attention to accountability for example through transparently sharing plans and results (as well as failures) and large participation of various actors.

All outlined options offer the opportunity to give emphasis on gender dimensions. This will be done through specific activities of both analytical and programmatic nature. At the analytical level, strategic documents or example based on study/survey results may promote gendered assessments relating to health/disease and gender differences in access to services. At the programmatic level, most of the options (exception option 5) may put women in the spotlight of activities. In this sense the possible focus given to nurse strengthening or health promotion and prevention through community activities may be an important cornerstone of the gender dimension of future SDC investments. All options further may make sure that women are adequately represented at the level of project employees and emphasis male/female relations both at institutional but more importantly at community level.

5.5 Availability of Swiss and/or local expertise

With regard to all proposed options Swiss expertise is likely to be available either through specific experts who may contribute to the design, implementation and monitoring of future activities or through institutions being interested in the implementation of the project or selected parts.

It is likely that most of outlined options will require a specific international tender so to select the implementation agency and this will need to be considered in the planning process.

In relation to the availability of local expertise, the situation looks more mixed. For some of the proposed options expertise and qualified persons and institutions with a solid track record are available. This holds true for example for nurse capacity strengthening (option 3) or policy analysis (option 5). Opposite there is only very limited in-country expertise in home based care or health prevention and promotion such as defined in this report. Here however, individual and institutional capacity strengthening components would be an inherent project element.

Table 4. Availability of Swiss and/or local expertise in relation to possible options for SDC support within the SDC cooperation strategy 2014 to 2017

Swiss expertise	Local expertise
1. Community empowerment through health prevention and promotion	
A number of Swiss NGO’s do have specific expertise on specific health promotion aspects such as addressing diabetes or cardio-vascular disease respectively implementing smoking or alcohol prevention activities	Local expertise is limited but it would be an integral part of a future project to build-up and to invest in local expertise Soros Foundation and PAS Center are umbrella organizations that implement community empowerment activities for people living with HIV and communities affected by TB, mental health and palliative care through NGO sub-recipients
2. Improved home based care through testing and scaling-up new models of care	
A number of governmental and non-governmental actors do have expertise in home based care (e.g. SPITEX or Swiss Red Cross)	Local expertise is limited but it would be an integral part of a future project to build-up and to invest in local expertise Angelus Moldova provides home-based palliative

	care
3. Support to family medicine through nurse capacity strengthening	
Two University (Basel and Lausanne) maintain a nursing faculty and further there are a number of other actors who potentially can provide expertise in the area of nurse capacity strengthening (e.g. Pflegefachverband)	Some expertise available at the level of Medical colleges Functioning National Nurse Association and National Midwifery Association
4. Improvement of access to hospital care through strengthening of adult emergency services	
Various Swiss actors do have expertise in conceiving, planning and implementing hospital reform through emergency care strengthening	Through REPEMOL and a smaller extent PERINAT local expertise on emergency care is available
5. Addressing health systems governance through improved policy analysis and management capacities (possibly including e-health)	
Swiss expertise on policy analysis and advise is available at various institutions. The same holds for management strengthening and e-health topics	The Centre for Health Policy and Studies as well the School of Public have institutional capacities to take up at least selected elements of this proposed option. A new E-health unit staffed with UNDP consultants developed at MoH

6 Summary observations on options and recommendations

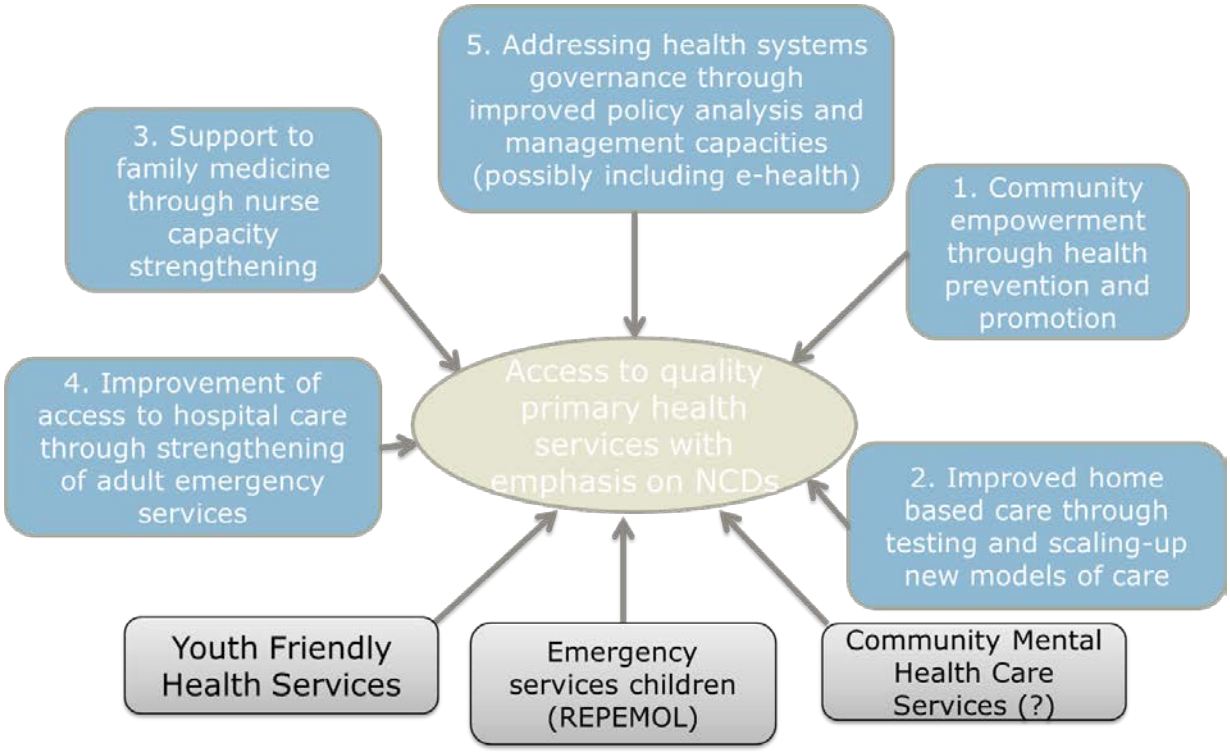
In the following paragraphs we indicate how a domain goal might be underlined by specific possible projects and fit into broader health systems strengthening efforts. Indeed in the following section we outline 5 options for future domains of possible interest to SDC. They are:

1. Community empowerment through health prevention and promotion
2. Improved home based care through testing and scaling-up new models of care
3. Support to family medicine through nurse capacity strengthening
4. Improvement of access to hospital care through strengthening of adult emergency services
5. Addressing health systems governance through improved policy analysis and management capacities (possibly including e-health)

These options for further funding are likely to be complemented by 2 to 3 projects which are already currently funded and which would also benefit from under the SDC cooperation strategy 2014-2017. Main features of these programs are summarised in chapter 3.3 as well as annex 10. However at the time of the writing of this report, the future of the community mental health care program is not guaranteed and is likely to depend on the availability of a clear and concise national mental health strategy:

1. Regionalization of the Pediatric Emergency and Intensive Care Medical Services System (REPEMOL)
2. Healthy Generation (Youth Friendly Health Services in Moldova)
3. Development of Community Mental Health Care Services in Moldova

Figure 3. Links of possible options and current projects to access to health services



The SDC cooperation strategy framework is proposed to be embedded in health systems thinking implying the recognition of dynamic and holistic approaches that appreciate the multifaceted and interconnected relationships among health system components, as well as the views, interests and power of its different actors and stakeholders. The possible domains for future Swiss investments in health sector development may be entrenched around the general SDC domain goal formulated as follows:

Domain goal:
Improving access to quality primary health services with emphasis on NCDs

An initial outline for the results framework for Health domain in the new cooperation strategy 2014-2017 is provided in annex 11 and selected indicators for monitoring the progress against the stated goals are included. To be noted that such the framework needs to be further elaborated and expanded depending on the funding decisions with regard to outlined options.

So to adequately track the outputs and outcomes of Swiss investments within the cooperation strategy 2014-2017, it will be necessary to adequately emphasise monitoring and evaluation activities within and across the future projects, through allocating dedicated staff and adequate resources to these activities. For example, other funding agencies provide an indicative range of 5 to 10% of program funds which have to be allocated to monitoring and evaluation activities. The outcome monitoring could eventually also be an inherent element of option 5 on policy analysis and evidence for decision-making.

Table 5. Funding range and weighting of impact on poor and vulnerable and cost-effectiveness across possible options for SDC support within the SDC cooperation strategy 2014 to 2017

Impact on poor and vulnerable	Cost-effectiveness considerations	Indicative annual funding range*
1. Community empowerment through health prevention and promotion		
++	++	CHF 300'000 - 600'000 annually
2. Improved home based care through testing and scaling-up new models of care		
++	+/-	CHF 400'000 - 800'000 annually
3. Support to family medicine through nurse capacity strengthening		
++	++	CHF 500'000 - 1'000'000 annually
4. Improvement of access to hospital care through strengthening of adult emergency services		
+	+	CHF 700'000 – 1'200'000 annually
5. Addressing health systems governance through improved policy analysis and management capacities (possibly including e-health)		
+	+/-	CHF 300'000 – 600'000 annually

++= strong relation; += moderate; +/-=neutral

* Funding range will substantially depend on the scope of the project and components included especially if infrastructure and equipment procurement is part of the funding scheme. In consequence amounts listed are indicative and may substantially change depending on SDC's decisions.

Table 5 weighs the options against the cost-effectiveness criteria and the potential for targeting poor and vulnerable groups. As indicated, all options offer the opportunity to address adequately concerns of poor and vulnerable groups. The extent of this being the case obviously depends of exact nature and the main lines of activities of the future SDC funded projects. Emphasis on the poor and vulnerable may also be addressed through agreeing on a disadvantaged geographical area where SDC funded activities shall all focus on.

All five options are considered as being fully in line with the draft SDC health policy as of March 2012. Nevertheless, at this stage they do correspond to general sketches which do need to be further detailed. This could be done once SDC has indicated which of the options are of interest. The related feasibility studies would entail the detailing of key characteristics such as objectives, implementing strategy and main lines of activities and the proposed institutional setup and management arrangements.

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Annex 2. Abbreviations

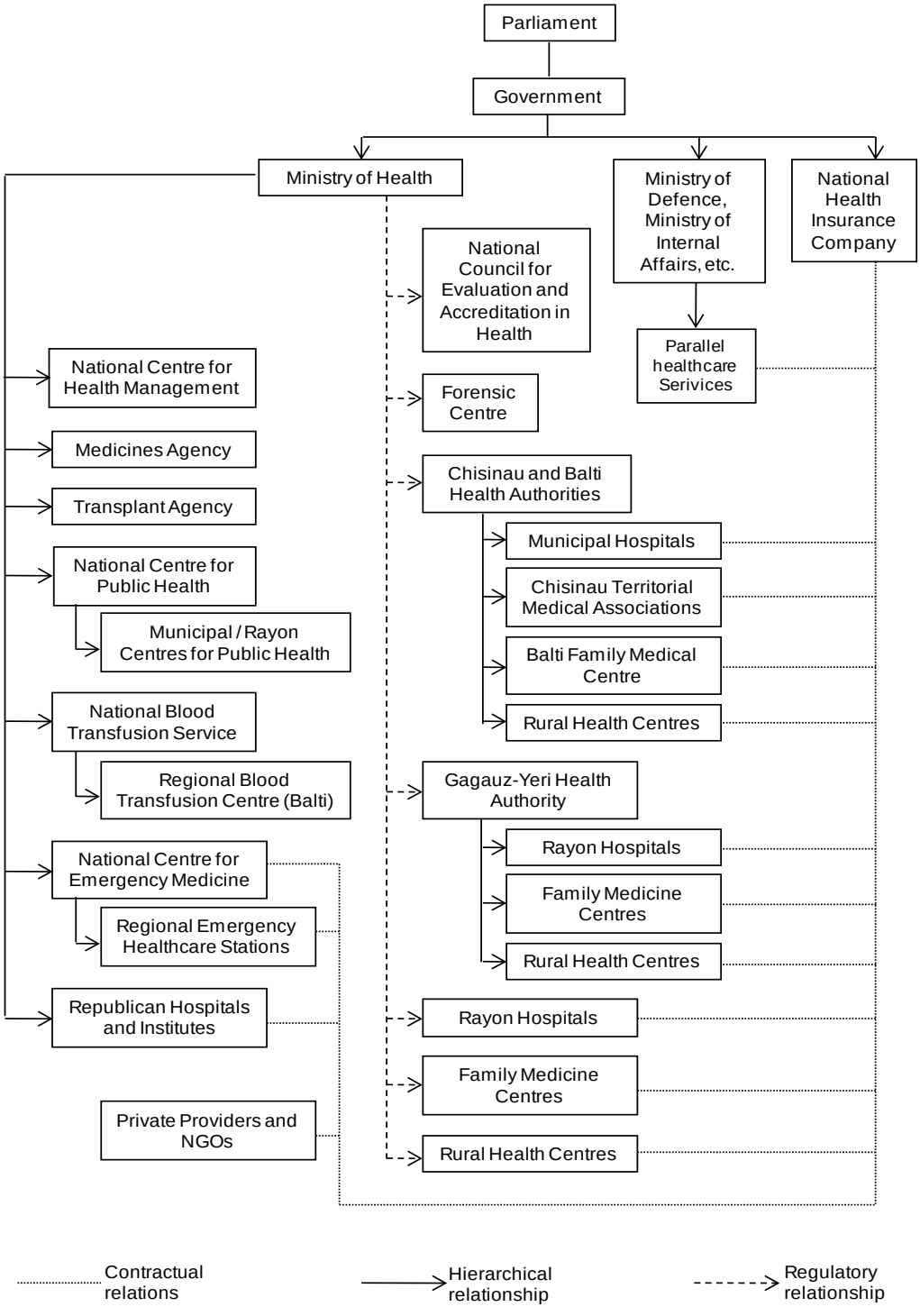
CME&L	Continuing Medical Education and Learning
DALY	disability-adjusted life years
FD	Family Doctor
FM	Family Medicine
GDP	Gross Domestic Product
HMIS	Health Management Information System
IMR	Infant Mortality Rate
JICA	Japanese International Cooperation Agency
MCH	Maternal and Child Health
MoH	Ministry of Health
NBS	National Bureau of Statistics (NBS)
NGO	Non-Governmental Organization
NHIC	National Health Insurance Company
PHC	Primary Health Care
SDC	Swiss Agency for Development and Cooperation
SUMP	State University of Medicine and Pharmacy “Nicolae Testemitanu”
Swiss TPH	Swiss Tropical and Public Health Institute
Tb	Tuberculosis
WB	World Bank
WHO	World Health Organization

Annex 3. Agenda and persons met

Activity	When	Who
Monday 10 September		
Arrival Chisinau	0:25	
WHO	10:00 12:00	- Silviu Domente, Heath Systems Officer
SCO-M	12:00 13:30	- Georgette Bruchez, Country Director Swiss Cooperation Office Valeriu Sava, National Program Officer, Swiss Cooperation Office
Ministry of Health	14:00 15:30	- Octavian Grama, Prime Deputy minister Gheorghe Turcanu, Deputy minister Rodica Scutelnic, head of department, hospitals and emergency medicine Tatiana Paduraru, Office external affairs Rodica Mamaliga, Office external affairs
UNICEF	15:45 17:30	- Alexandra Yuster, Representative Moldova Svetlana Stefanet, Chief EAQC Angela Capcelea, Adolescent Health Officer
Tuesday 11 September		
Briefing meeting SCO-M	09:00-11:30	Georgette Bruchez, Country Director Swiss Cooperation Office Viorica Cretu, Deputy Country Director, Swiss Cooperation Office Valeriu Sava, National Program Officer, Swiss Cooperation Office
Soros Foundation-Moldova	10:45-12:00	Liliana Gherman, Director, Public Health Program
Swiss Red Cross	12:00-13:00	Hannelore Gut, country representative Swiss Red Cross
	13:00	Lunch
SDC Implementer meeting	14:00 16:00	- Daniel Ciurea coordinator CPSS, REPEMOL Silvia Morgoci, project director, REPEMOL Galina Lesco, National Coordinator, Health generation project Viorel Babii Albia, manager, Health generation project Petru Stratulat, Local coordinator, PERINAT Ala Curteanu, coordinator, PERINAT
EU Delegation	16:30-17:30	Cornel Riscanu, Project Manager, Social Protection, Health, Research, Education and Youth
Wednesday 12 September		
National Center for Health	09:00 10:00	- Oleg Barba, Director

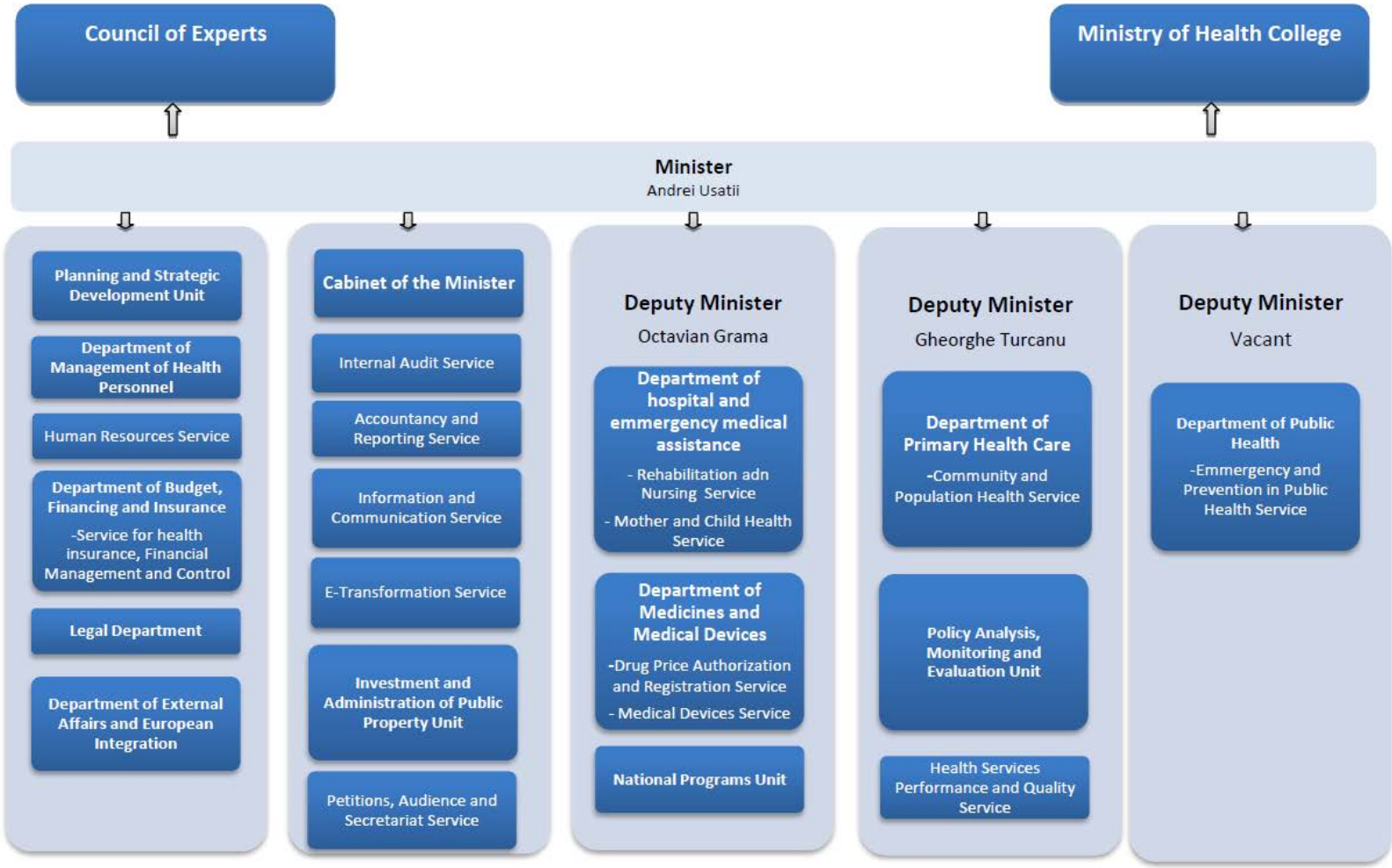
Management		
Somato	10:30-12:30	Jana Chihai, Director
Lunch	12:30 - 13:30	
National Health Insurance Company	14:00	Iurie Osoianu, deputy director Adrian Jucican, administrative director
World Bank	16:00	Irina Guban, Consultant, Health and Social Protection
Thursday 13 September		
Municipal hospital Balti	10:00 - 11:30	Alexandru Munteanu, head of information systems department Alexandru Pavlic, head of medical audit department REPEMOL pediatric emergency site visit
Family Medicine Center	11:30-12:30	Valeriu Postolachi, chief physician
Municipal hospital	12:30-13:30	Petru Nedelciuc, Maternity ward, PERINAT project
Municipal hospital Orhei	15:00-16:00	Elena Palanciuc, Director
Family medicine centre Orhei	16:00-17:00	Valentina Gutan, Director
Health Center, Peresecina	17:30:18:30	Tudor Levinta, manager
Friday 14 September		
School of Public Health	9:00–10:30	Oleg Lozan, director
State Medical and Pharmaceutical University	11:00-12:30	Ion I. Ababii, Rector Valeriu Chicu, deputy rector, Department of Foreign Affairs Didina Nistreanu, research secretariat Gabriela Iacob, head of department for international cooperation
National Center of Public Health	13:00–14:30	Ion Bahnarel, Director
Debriefing meeting SCO-M	15:00 - 17:30	Georgette Bruchez, Country Director Swiss Cooperation Office Viorica Cretu, Deputy Country Director, Swiss Cooperation Office Valeriu Sava, National Program Officer, Swiss Cooperation Office
Minister of Health National Health Insurance Company (CNAM)	19:30-21:00	Dinner Andrei Usaty, Minister of Health Mircea Buga, director of CNAM
Departure Chisinau	6:40	

Annex 4. Organizational chart of the health care system



Source: Turcanu Gh, Domente S, Buga M, Richardson E. (2012). Republic of Moldova: Health System Review. In print.

Annex 5. Chart of the Ministry of Health



Source: Ministry of Health, Organizational structure. Available in Romanian at: http://www.ms.md/ministry/structure/ Accessed 21 September 2012

Annex 6. Health indicators 2010

Indicator	Moldova	Romania	Ukraine	CIS	EU members after 2007	EU members before 2004 or 2007
Life expectancy at birth	69.1	73.8	70.3	69.7	75.6	81.1
Life expectancy at 65 years	13.6	15.9	14.5	14.7	16.9	20.1
Standard death rate (0-64 years), per 100,000						
Cardio-vascular all causes	164.8	108.9	176.8	201.8	93.3	30.7
Cerebro-vascular	50.4	30.2	38.5	46.1	20.1	5.5
Malignant neoplasms	96.9	98.3	97.1	88.0	94.0	65.8
External injury and poison	94.2	47.4	85.7	105.2	47.7	22.7
Suicide and self-inflicted injury	17.8	11.2	16.9	16.7	14.0	8.4
Digestive causes	126.2	66.0	51.4	58.5	45.5	26.4
Tobacco related	762.4	427.7	…	…	330.6	164.8
Alcohol related	217.9	108.0	…	…	90.4	50.6
Infant mortality rate, WHO report	16.0	11.0	11.0	17.4	6.6	3.5
Maternal mortality rate	44.5	24.0	23.3	20.9	8.7	5.5
Morbidity						
Communicable diseases						
TB incidence	115.7	85.8	74.1	80.9	32.5	7.1
HIV incidence	19.7	0.7	36.4	32.0	2.5	6.7
Syphilis incidence	70.3	10.9	16.2	30.7	6.0	3.7
Non-communicable diseases						
Cancer incidence	220.4	275.5	…	270.0	446.5	…
Diabetes prevalence	1.7	2.9	…	1.7	4.0	…
Mental disorders incidence	576.1	1'330.6	…	333.1	928.6	…

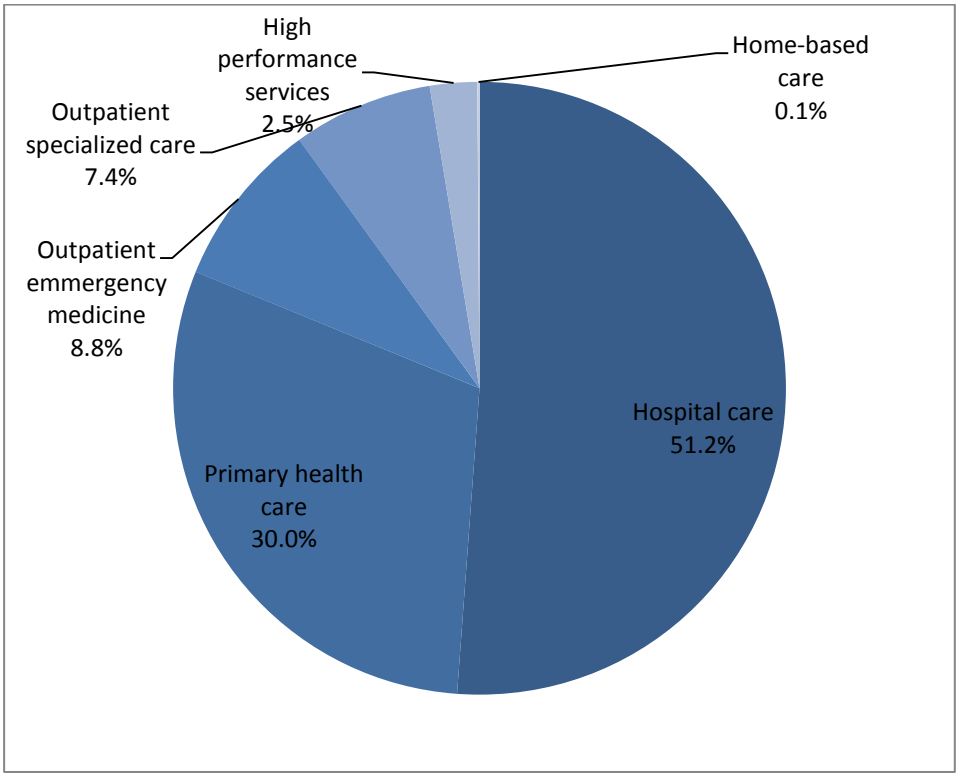
Source: WHO Health For All Database. http://www.euro.who.int/en/what-we-do/data-and-evidence/databases/european-health-for-all-database-hfa-db2. Accessed 21 September 2012

Annex 7. Public expenditure on health by sub-sector

Indicators	2004	2005	2006	2007	2008	2009	2010	CIS average	EU after 2007	EU before 2004
Total government expenditure as % of GDP	35.1	37.0	40.2	42.0	41.6	45.3	**40.8**	37.4	43.6	50.9
Total health expenditure as % of gross domestic product (GDP), WHO estimates	8.5	9.2	10.6	10.9	11.4	12.5	**11.7**	5.7	7.1	10.6
Public sector expenditure on health as % of GDP, WHO estimates	4.2	4.2	4.7	4.9	5.4	6.1	**5.4**	3.2	5.2	8.2
Total health expenditure, PPP$ per capita, WHO estimates	180	216	272	296	343	357	**360**	713	1'398	3'708
Public expenditure on health, PPP$ per capita, WHO estimates	89	99	121	134	162	173	**165**	425	1'017	2'874
Public sector health expenditure as % of total health expenditure, WHO estimates	49.3	45.6	44.4	45.2	47.2	48.5	**45.8**	56.6	72.5	77.3
Total pharmaceutical expenditure as % of total health expenditure	23.2	45.6	39.9	40.5	35.7	32.7	**34.2**	…	…	…
Public pharmaceutical expenditure as % of total pharmaceutical expenditure	36.7	20.1	20.5	27.5	24.8	27.9	**…**	…	…	…

Source: WHO Health For All Database. http://www.euro.who.int/en/what-we-do/data-and-evidence/databases/european-health-for-all-database-hfa-db2. Accessed 21 September 2012

Fund allocation and expenditure of National Health Insurance by subsectors, 2011



Source: CNAM annual report 2011

Annex 8. Data on health care personnel available

Total number of physicians, years 2003-2010

Level of health system	2003	2004	2005	2006	2007	2008	2009	2010
Republican	3'157	3'112	3'748	3'803	3'519	3'686	3'730	3'626
Chisinau and Balti (number)	3'220	3'153	2'668	2'629	2'767	2'743	2'733	2'729
Chisinau and Balti (per 10,000)	34.7	33.9	28.8	28.4	29.7	29.4	29.3	29.1
Rayons (number)	4'601	4'488	4'417	4'335	4'360	4'294	4'321	4'264
Rayons (per 10,000)	17.2	16.8	16.6	16.3	16.5	16.3	16.4	16.3
Total (number)	12'649	12'555	12'577	12'674	12'733	12'684	12'783	12'780
Total, per 10,000	**35.1**	**34.9**	**35**	**35.4**	**35.6**	**35.6**	**35.9**	**35.9**

Source NCHM 2012

Total number of mid-level health personnel, years 2003-2010

Level of health system	2003	2004	2005	2006	2007	2008	2009	2010
Municipal	59.4	57.1	48.0	47.5	49.1	48.4	50.8	50.4
Rayon	54.6	52.8	51.7	50.9	50.4	49.7	50.1	50.3
Total	**67.8**	**65.5**	**65.5**	**65.1**	**63.4**	**63.5**	**65.0**	**64.6**

Source NCHM 2012

Total number of primary health care doctors, years 2003-2010

Level of health system	2003	2004	2005	2006	2007	2008	2009	2010
Chisinau and Balti (per 10,000)	6.9	7.1	7.1	7.1	6.9	6.8	6.7	6.8
Rayons (per 10,000)	5.4	5.3	5.2	5.1	5.0	4.8	4.7	4.6
Total, per 10,000	**5.8**	**5.8**	**5.8**	**5.7**	**5.7**	**5.5**	**5.4**	**5.3**
Total (number)	2'106	2'101	2'082	2'054	2'027	1'961	1'929	1'899

Source NCHM 2012

Total number of primary health nurses, years 2003-2010 (per 10,000 inhabitants)

Level of health system	2003	2004	2005	2006	2007	2008	2009	2010
Municipal	8.3	7.8	7.4	7.5	7.4	7.4	8.1	8.3
Rayon	19.4	19.6	19.2	18.6	18.3	17.6	17.6	17.3
Total	**16.6**	**16.6**	**16.2**	**15.8**	**15.7**	**15.0**	**15.2**	**15.0**

Source NCHM 2012

Annex 9. Utilization of health facilities

Total number of medical visits per person per year, years 2004-2010

	2004	2005	2006	2007	2008	2009	2010
Large urban	6.1	6.6	6.6	6.6	6.8	6.9	6.7
Rayon	4.0	4.5	4.5	4.7	4.7	4.8	4.9
Total	**5.5**	**6.0**	**6.0**	**6.2**	**6.3**	**6.3**	**6.5**

Source: NCHM 2012

Number of visits to PHC physician, per person per year, years 2004-2010

	2004	2005	2006	2007	2008	2009	2010
Large urban	2.8	2.9	3.1	3.0	3.1	3.2	3.2
Rayon	2.3	2.7	2.6	2.6	2.6	2.7	2.8
Total	**2.4**	**2.8**	**2.7**	**2.8**	**2.8**	**2.9**	**2.9**

Source: NCHM 2012

Number of emergency requests (per 1,000 inhabitants) years 2004-2010

	2004	2005	2006	2007	2008	2009	2010
Large urban	265.1	299.2	302.3	317.8	347.4	385.0	338.2
Rayon	196.7	237.5	249.1	265.8	256.5	267.7	260.1
Total	**215.8**	**254.6**	**266.3**	**281.4**	**282.7**	**301.9**	**282.7**

Source: NCHM 2012

Hospital admission rates (per 100 inhabitants), years 2004-2010

	2004	2005	2006	2007	2008	2009	2010
Large urban	15.0	…	12.5	12.9	13.3	13.4	13.4
Rayon	10.1	…	10.2	10.5	11.0	11.3	11.3
Total	**15.2**	**…**	**15.7**	**16.1**	**16.9**	**17.1**	**17.0**

Source: NCHM 2012

Access to levels of care in the past four weeks, by type of service, year 2010, in %

	I	II	III	IV	V
Has accessed medical services in the past 4 weeks	11.2	16.0	20.6	23.4	25.5
of them, went to see:					
a PHC physician	66.5	60.5	59.1	50.5	37.0
a specialist	22.8	28.0	27.8	36.9	40.3
a dentist	8.1	6.5	5.1	3.0	14.3
Was hospitalized	12.7	4.2	6.6	8.9	6.0

Source: National Bureau of Statistics 2011. National Household Budget Survey

Access to levels of care in the past four weeks, by residence and gender, year 2010, in %

	Urban	Rural	Men	Women	Total
Home care	6.5	9.9	7.4	8.7	**8.2**
Family doctor's office	6.4	36.4	20.6	22.4	**21.7**
Health Center	75.5	41.1	59.3	57.1	**57.9**
Hospital	6.1	8.5	8.7	6.5	**7.3**
Pharmacy	5.6	3.5	3.7	5.0	**4.5**
Other	…	0.6	0.3	0.3	**0.3**

Source: National Bureau of Statistics 2011. National Household Budget Survey

Annex 10. Overview on main externally funded programs (incl. programs funded by SDC)

Overview on main externally funded programs including their focus

Development partner of MoH	Focus of current (2011 -2012) and planned interventions (2013)	Planned activities 2014 and beyond
EU	General budget support to the Ministry of Finance earmarked for: 2011 (around Euro 14.5 million) - cost effectiveness studies on tobacco and alcohol control strategies - rehabilitation of patient simulator centre of State Medical and Pharmaceutical University - other smaller activities 2013 (Euro 6 millions) - Equipment for laboratories overseen by the Public Health institute - Equipment for the patient simulator centre of State Medical and Pharmaceutical University	Sector strategy for the period 2014 - 2020 determined in the last quarter 2012
Global Fund	Support to one HIV/AIDS and one TB control program each one administered by two principal recipients 2011 and 2012 (around Euro 12.4 mil) - Reducing morbidity, mortality and HIV-related impact on people living with HIV/AIDS - Empowerment of People with Tuberculosis and Communities in Moldova - Strengthening Tuberculosis Control (including MDR) 2013: not yet known, as Phase 1 come to an end by 31 December 2012	Not yet known
SDC	see separate table below	see conclusions presented in report
WB	2011 and 2012 (around US$ 16 million): - Rehabilitation/construction of primary health care infrastructure - Development and update of clinical protocols - Strengthening institutional capacities of MoH - Support to the introduction of DRGs 2013: same as above	Sector strategy for the period 2014 - 2017 TBD in the last quarter 2012
WHO	2011 and 2012 (around US$ 2 million): - analytical reviews in health financing - various studies and assessments (e.g. access to health services, drugs etc.) - assistance to the development of national strategies (e.g human resource development plan, mental health, e-health) - health sector coordination 2013: see above	Priorities not yet determined
JICA	Financing medical equipment - exact intervention areas not known as per September 2011	Not yet known

Overview on main programs funded by SDC including their focus

SDC	Focus of current phase and planned interventions up to 2013	Planned activities 2014 and beyond
PERINAT	Phase III: 2011-2013 (budget: CHF 3,240,000): - Strengthen the capacity of medical personnel the area of obstetric and neonatal emergencies, and perinatal care (including referral system). - Promote the availability and use of innovative information and communication tools e.g. distance learning, telemedicine, etc. - Procure and supply additional essential medical equipment in the area of obstetric and neonatal emergencies, and perinatal care - Upgrade and scale up the health technology health technology management. - Build the capacity of the quality management teams to engage in planning, implementing and monitoring of local quality-improvement projects at their hospitals	will not be extended
REPEMOL	Phase II: 2010-2013 (budget: CHF 4,470,000): - Strengthen the regionalized paediatric emergency and intensive care services network (including referral system and funding) - Establishing two well-equipped paediatric emergency and intensive care units in hospitals in Cahul and Chisinau. - Supply essential modern medical equipment and run health technology management workshops for appropriate use of equipment in the emergency and intensive care units. - Improve the ability of healthcare personnel (physicians, nurses) at hospital and pre-hospital levels - Develop and implement quality assurance and monitoring mechanisms (including quality management boards - Conduct behavioural change communication campaigns, to raise awareness about domestic accidents and the availability of emergency services	Likely that a phase III covering the period 2014 to 2017 will be funded
Youth Friendly Services	Phase I: 2011-2014 (budget: CHF 1,780,000): - Building the capacity of the staffs of the existing 12 youth-friendly health centres, of the reproductive health offices across the country, and of the schools and primary health centres in 16 districts - Establish financial, accreditation and quality assurance systems and monitoring mechanisms - Review and adapt university curricula for health professionals so as to enable them to better serve young people. - Develop and implement protocols and guidelines of youth-friendly health services and implement life skills education programmes in schools. - Train personnel from 800 schools (nurses, psychologists, teachers, peer educators) - Promote, encourage and gain support from parents, local authorities, specialists to adopt a positive attitude towards youth friendly health services and life skills programs.	Likely that a phase II covering the period 2014 to 2017 will be funded
Mental Health	Phase II: 2009-2012 (budget: CHF 730,000) - Draft and approve a regulatory document for the creation of a new type of social and healthcare institution called the Community Mental Health Centre (CMHC). - Develop and approve, based on the experience of the piloted services, appropriate financing mechanisms of the CMHC. - Conduct a feasibility study on the development of CMHCs in Moldova and replicate the model on a national scale. - Strengthen the newly created national methodological and consultative resource centre in community mental health in Chisinau. - Train personnel from the three CMHCs using a new, updated curriculum. - Organize training sessions and seminars for family doctors, nurses and other medical professionals.	Possibly to be continued but details to be determined

Annex 11. Initial outline of results Framework for Health domain in new cooperation strategy

This annex corresponds to an initial outline of the results framework. The framework needs to be further elaborated depending on the projects to be funded within the SDC cooperation strategy 2014-2017.

Domain of intervention 1: Health Moldova		
Domain goal: **Population in Moldova benefits from better health due to improved access to quality primary health services with emphasis on NCDs.**		
(1) Swiss portfolio outcomes	**(2) Contribution of Swiss Programme**	**(3) Country development or humanitarian outcomes**
Outcome statement 1 The population especially those with NCDs plays an active role in health promotion and prevention, and is empowered to demand better health services in dialogue with local and national health authorities. Indicator • # and % of home based patients covered • # of local NGO's offering NCD services • # of local NGO's with health promotion activities • # of family medicine facilities work collaboratively on health prevention / promotion and care with their communities	**Intermediate results / sequence** • Stronger emphasis of home based care for elderly and poor and vulnerable groups • Stronger community participation in the prevention of NCDs and in the promotion of health are achieved through the continuation of health community activities • Civil society in the health sector is strengthened in its organizational development and in advocating for health care needs **Assumptions** • NHIF is willing to cover at least a part of the funding of NCD treatment • Informed NCD patients increasingly ask for	**Outcome statement 1** The population especially those with NCDs plays an active role in health promotion and prevention, and is empowered to demand better health services in dialogue with local and national health authorities. Indicator • # and % of home based patients covered • # of local NGO's offering NCD services • # of local NGO's with health promotion actvities • # of family medicine services work collaboratively on health prevention / promotion and care with their communities

to address local health priorities • % of patients with chronic diseases having appropriate health behaviour	quality primary care services • Essential drugs for key diseases are available through NHIF • Health awareness rising through health promotion reinforces trust towards primary care providers and facilitates access for women **Risks** • Financial sustainability for home based care not assured Poor implementation of MoH regulations and poor • Collaboration and agreements between social and health sector may be challenging	to address local health priorities % of patients with chronic disease having appropriate health behaviour
Outcome statement 2 Poor and vulnerable groups have better access to quality family medicine and emergency hospital services in Moldova. Indicator • Number primary health care visits per inhabitant per year • Population coverage by family medicine nurses • No of patients treated by Emergency Departments (ED) and Intensive Care Units (ICU) • Emergency referral rates	**Intermediate results / sequence** • Family medicine services in disadvantages rayons are improved • Roles and tasks of nurses are revised • Nurse capacities are increased • Emergency hospital services for adult and children are rehabilitated and provided with minimal equipment • Referral system between primary health care centers and hospitals is strengthened • Mechanisms for continuous quality improvement are introduced for nurses and further strengthened for hospital emergency staff **Assumptions** • Redefining the role of nurses working in rural areas is acceptable to doctors and poliy-makers • Availability of essential drugs at family mcare level as a key element for quality services **Risks** • Limited self-esteem of nurses	**Outcome statement 2** Poor and vulnerable groups have better access to quality family medicine and emergency hospital services in Moldova. Indicator • Number primary health care visits per inhabitant per year • Population coverage by family medicine nurses • No of patients treated by Emergency Departments (ED) and Intensive Care Units (ICU) • Emergency referral rates

	• Hospital reform in Moldova is not carried forward especially in relation to regional hospitals • Migration, brain drain of health staff	
Outcome statement 3 Policy analysis, decision-making and management of health services is improved thereby the efficiency, equity, sustainability and transparency is promoted. Indicator • % of governmental budget allocated to health • % of governmental health budget allocated to primary health care • # national policy documents of appropriate quality • # of evidence made available to • # of regional and local managers trained	**Intermediate results / sequence** • Assistance to an independent policy analysis institution • Monitoring and production of evidence on health sector development in Moldova • Capacity building of health managers at regional and rayon level to better resource, manage and monitor the primary health care system • Switzerland together with donors and implementing agencies are involved in a policy dialogue with the **Assumptions** • Commitment of the government of Moldova to health sector increases • Willingnes of managers to use and implement tools and procedures **Risks** • Non-acceptance of independent advisory body with the mandate of policy analysis • Unwilligness to further promote decentralisation of planning and decision-making • Scarcity of financial resources • Limited performance capacity of managers	**Outcome statement 3** Policy analysis, decision-making and management of health services is improved thereby the efficiency, equity, sustainability and transparency is promoted. Indicator • % of governmental budget allocated to health • % of governmental health budget allocated to primary health care • # national policy documents of appropriate quality • # of evidence made available to • # of regional and local managers trained
(4) Lines of intervention (Swiss Programme)		
Descriptive text pinpointing lines of intervention leading to outcome achievement *If appropriate intermediate results/key outputs or required performance milestones to be included*		
(5) Resources, partnerships (Swiss Programme)		
Planned financial resources per domain (or outcomes) and per period *If available/appropriate: information on co-financing* *Other aspects of partnership (joint results, complementary support)* *Human resources*		