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REPORT

Assessing progress in strengthening national capacities to respond to humanitarian crises, exceptional situations or public health emergencies by providing the Minimum Initial Service Package for Sexual and Reproductive Health

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REPORT

Assessing progress in strengthening national capacities to respond to humanitarian crises, exceptional situations or public health emergencies by providing the Minimum Initial Service Package for Sexual and Reproductive Health

CHISINAU, 2025

This report was prepared based on the Assessment of the preparedness of the Republic of Moldova to respond to the needs in case of possible public health emergencies, or natural or man-made disasters/calamities, in particular by ensuring the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH), in accordance with the provisions of Order No. 551-d as of 27.10.2025, by the following group of national experts:

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The development of this document was coordinated by the Centre for Health Policies and Studies under the auspices of the Ministry of Health, with the support of the United Nations Population Fund (UNFPA). The Assessment Report reflects solely the opinion of the authors and does not necessarily represent the views of the UNFPA or any other affiliated organization.

The Assessment Report was presented and discussed during the thematic dialogue held on 9 December 2025 in Chisinau, in accordance with the provisions of Ministry of Health Order No. 624-d as of 2 December 2025.

Raportul de evaluare a fost elaborat și coordonat de către Centrul pentru Politici și Analize în Sănătate (Centrul PAS), sub egida Ministerului Sănătății, cu susținerea Fondului ONU pentru Populație (UNFPA) în Republica Moldova.

Documentul reflectă în exclusivitate opinia autorilor și nu reprezintă în mod neapărat punctul de vedere al UNFPA sau al oricărei alte organizații afiliate.

CONTENTS

LIST OF ACRONYMS AND ABBREVIATIONS

PHC	Primary Health Care
TMA	Territorial Medical Association
NPHA	National Agency for Public Health
CCPPH	Centre for Centralized Public Procurement in Healthcare
VCTO	Voluntary Counselling and Testing Office
NEPHC	National Extraordinary Public Health Commission
CES RM	Commission for Exceptional Situations of the Republic of Moldova
YFHC	Youth-Friendly Health Centre
RHR	Reproductive Health Rooms
PPE	Personal Protective Equipment
EmOC	Emergency Obstetric Care
MHIF	Mandatory Health Insurance Funds
HIV	Human immunodeficiency virus
IEC	Information, education, and communication
GPI	General Police Inspectorate
STI	Sexually transmitted infections
MIA	Ministry of Internal Affairs
FD	Family doctor
MHLSP	Ministry of Health, Labour and Social Protection
WHO	World Health Organisation
NGO	Non-governmental organisation
UN	United Nations Organization
IPC	Infection prevention and control
MISP	Minimum Initial Service Package

NPSRHR	National Program on Sexual and Reproductive Health and Rights
UNDP	United Nations Development Program
PEP	Post-Exposure Prophylaxis for HIV Infection
PrEP	Pre-Exposure Prophylaxis for HIV Infection
PLHIV	People living with HIV
RM	The Republic of Moldova
ES	Exceptional situation
AIDS	Acquired Immune Deficiency Syndrome
SRH	Sexual and Reproductive Health
ARVT	Antiretroviral Therapy
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
PHE	Public Health Emergency
SV	Sexual violence
SVV	Sexual violence victims

CHAPTER 1.

General preparedness at the national level: policies, coordination and resources

Objective No. 1 of the MISP

During the period between 2021 and 2025, the segment of preparedness and response to exceptional situations and emergencies in public health in the Republic of Moldova was significantly strengthened through the adoption of new national strategies and sectoral plans in the field of public health and risk management. New national policies and strategies have better integrated the principles of healthcare system resilience, and the lessons learned from COVID-19 and the refugee crisis have prompted the adoption of a more coordinated and rapid approach to crisis situations. The sexual and reproductive health (SRH) component has been partially integrated into these documents, being recognized as part of the essential services that must be sustained during the crisis. However, the full integration of MISP remains an ongoing process, particularly at the sub-national level, where implementation mechanisms are uneven and still under way of being put in place.

1.1 Policies and Plans for Disaster Management at National and Sub-national Levels

The humanitarian and development context in the Republic of Moldova has changed significantly since the MISP assessment in 2021. Since 2022, the Republic of Moldova has faced a major regional humanitarian crisis generated by the war in Ukraine, which has led to a massive influx of refugees, including women and children, amplifying the need to integrate sexual and reproductive health (SRH) services and protection against gender-based violence (GBV) into response mechanisms. During this period, with the support of the UNFPA, WHO, and other UN agencies, the capacity of national and territorial institutions to provide MISP

was strengthened through training, supply of IARH kits, and the development of operational guidelines adapted to the refugee context.

Demographic trends of population decline and aging, as well as significant labour migration, influence human resource planning and equitable access to SRH services, especially in rural areas. These changes have created a comprehensive context for the systemic strengthening of the MISP preparedness and response by integrating humanitarian, public health, and social development dimensions.

The influx of refugees from Ukraine, the amplified climate risks (heat waves, drought, extreme weather events), and the updated health policy framework have directly influenced the mechanisms for ensuring the continuity of essential health services, including MISP for SRH. From this perspective, the healthcare system has had to scale up its preparedness, coordination and response functions, adapting to a much more complicated operational environment compared to the situation reflected in the MISP 2021 assessment report.

At the institutional level, the Ministry of Health (MoH) has initiated structural reforms in the public healthcare system, strengthening the role of the National Public Health Agency (NPHA) in emergency preparedness and response. The strategic framework was reviewed, with the development of the National Health Strategy "Health 2030", the National Strategy for Disaster Risk Reduction 2024–2030, and the approval of a new International Health Regulations (IHR) Implementation Plan (2005) 2023–2027. Although the Ministry of Health is now the main founding body and funder of hospitals, there is currently no report assessing the level of funding allocated to the implementation of the SRH at the PMSI level.

In 2025, new legislation was adopted. This laid the foundations for the institutionalisation of the SRH in crisis management. Law No. 248/10.07.2025 on Crisis Management introduces an integrated all-hazards management model covering all four phases of the crisis cycle: prevention, preparedness, response and recovery. The law defines the types of crises and establishes coordination structures at three levels (strategic, operational and tactical). It also establishes the National Risk Register and requires public authorities to develop sectoral preparedness plans, appoint crisis preparedness coordinators and contact points available 24/7. The law promotes an integrated 'all-hazards' approach and provides for inter-institutional cooperation and the integration of EU standards for crisis management. In the same context, Government Decision No. 579/10.09.2025 established the National Crisis Management Centre (NCMC) as the central administrative authority responsible for coordinating crisis management. The NCMC mission is to develop the National Crisis Management Plan and coordinate inter-institutional response 24/7. However,

work is currently underway on the NCMC's operating procedures and emergency coordination methods. Notably, it has not yet been activated to determine these procedures and activities.

At the national level, a series of policies have been adopted in the field of universal access to health services, provision of essential services, and emergency and crisis management:

- **The National Health Strategy "Health 2030" (Government Decision No. 387/14.06.2023)** provides for equitable access to essential health services, including sexual and reproductive health, as well as the resilience of the healthcare system to emergencies.
- **The National Development Strategy "European Moldova 2030" (Law No. 315/2022)** sets objectives related to social inclusion, gender equality and the protection of vulnerable groups, with direct relevance to SRH and GBV in crisis situations.
- **The National Strategy for Disaster Risk Reduction 2024–2030** → adopts an all-hazards approach and includes essential service continuity, such as SRH. However, it requires the explicit strengthening of the SRH/MISP indicators.
- **Istanbul Convention (Law No. 126/2021, in force since 01.05.2022)** → strengthens the legal framework for preventing and responding to gender-based violence (GBV), including in emergency situations.
- **Law No. 248/2025** on Crisis Management and Response and **Government Decision No. 579/2025** on the Organisation and Functioning of the National Crisis Management Centre (NCMC) → creates an integrated all-hazards management system, including healthcare and the possibility of institutionalising SRH in planning, response and recovery.
- **GD 306/2025** on the Approval of the National Programme for the Accession of the Republic of Moldova to the European Union for 2025-2029 focuses on the development of information infrastructure and healthcare monitoring systems.
- **GD 30/2024** on the Early Warning and Rapid Response System Established in Relation to Serious Cross-border Health Threats, Alert Notification Procedures, and Procedures for Information Exchange, Consultation and Coordination of Responses to Such Threats.
- In the context of the refugee crisis, the SRH has been explicitly integrated into temporary protection measures: **GD No. 21/2023**, **GD No. 1066/2023**, **MoH Order No. 222/2024** and **CES Order No. 80/2023**, which guaranteed access to the SRH services and reimbursed medicines for refugees.

The National Health Strategy, "Health 2030" (Government Decision No. 387/2023), establishes healthcare as a national priority, aligning reforms with EU policies and guiding the medical system towards modernisation and resilience in order to meet the needs of the population. The strategy pursues Sustainable Development Goal 3, including improving reproductive, maternal, child and adolescent health. The document emphasises the need to adapt domestic policies to EU legislation, including in the area of preparedness and response to public health emergencies. The strategy highlights the following major challenges in the field of sexual and reproductive health (SRH): the adolescent birth rate is 27.3 per 1,000 girls (aged 15–19), which is three times higher than the European average; the rate of modern contraceptive use is only 38.1%; the unmet need for family planning is 16.9% among women aged 15–49 (twice as high in rural areas as in urban areas). Women and girls with disabilities also face significant barriers in accessing SRH services – many health facilities are not physically accessible, and some healthcare workers have discriminatory attitudes. Studies indicate that about 50% of women with disabilities (and 17% of family doctors) believe that lack of physical accessibility reduces access to reproductive health services. These data, reflected in the strategy, highlight inequalities that can be exacerbated in times of crisis and justify the integration of the SRH into contingency plans. The National Health Strategy "Health 2030" also sets out specific relevant objectives:

- **Objective 1.3.1**: increasing the resilience and capacity of the healthcare system to prevent, prepare for and respond to public health emergencies, natural disasters and humanitarian crises — a provision that reinforces the need to maintain SRH services in times of crisis.
- **Objective 2.2.3**: improving the capacity to provide SRH information, services and goods, with a focus on inclusion and human rights — directly aligned with MISP principles.
- **Objective 2.4.5**: strengthening medical infrastructure to ensure security and continuity of operation in exceptional situations — an essential element in ensuring the availability of the SRH services in crisis situations.

The National Development Strategy "European Moldova 2030" (Law No. 315/2022) includes among its priorities: ensuring universal access to sexual and reproductive health services, including family planning, information/education, reproductive health services and specialised support. The strategic document provides for strengthening the public healthcare system to address the following risks — disease prevention, health promotion, prevention of risky behaviours (including risky sexual behaviours), reduction of premature mortality and increase in life expectancy. At the same time, the agenda recognises the importance of

inclusiveness and non-discrimination. It ensures that access to health services, including sexual and reproductive health (SRH), is guaranteed for all citizens, regardless of their age, gender or social status. The agenda also promotes the modernisation of the healthcare system, which includes infrastructure, integrated services, sustainability and resilience. These factors are conducive to the sustainable implementation of the SRH.

The National Strategy for Disaster Risk Reduction 2024–2030 has strengthened the link between risk management, resilience and the continuity of essential services, including sexual and reproductive health services. An action plan for the implementation of that strategy is currently being developed, which will reflect SRH aspects. The strategy creates the conditions for the systematic inclusion of the MISP and namely:

- promotes multisectoral capacity building for prevention, preparedness and response;
- emphasises the importance of protecting vulnerable populations in crisis contexts;
- establishes the framework for integrating essential services (including SRH) into the full cycle of risk management (prevention, preparedness, response and recovery).

At the same time, the ratification of the Istanbul Convention (Law No. 126/2021, in force since 01.05.2022) has strengthened the framework for preventing and responding to gender-based violence, including in crisis situations.

According to Cluster 2 of the EU Accession Programme (HG306/2025), the process of aligning with the EU acquis in the fields of information infrastructure development and health monitoring systems has begun. This will also improve the collection of the SRH data. Development of e-Health and the Electronic Health Record: Actions have been planned for the approval of the National Programme for Digitalisation and Innovation in Healthcare 2025-2030 (GD[1] No. 556 as of 03-09-2025, MoH responsible, deadline Dec. 2025) and for the creation of a national entity for e-Health (GD No. 556 as of 03-09-2025, MoH responsible, deadline Dec. 2026). At the same time, the Electronic Patient Record is being implemented (Action 15 in Annex B, technical documentation developed, budget ~30 million MDL) and new modules of the Information System on Human Resources in Healthcare System (SI ERUSS) are being developed. These electronic systems will enable the collection of

1 https://www.legis.md/cautare/getResults?doc_id=150979&lang=ro

data disaggregated by gender, age, diagnosis, etc., facilitating the monitoring of the SRH indicators (e.g., maternal mortality rate, incidence of cervical cancer, access to contraception) and their reporting in accordance with the EU requirements.

At the operational level, the crisis of refugees from Ukraine has generated a massive influx of women and children, putting direct pressure on SRH services. Rapid interventions were needed to provide access to prenatal, intrapartum and postnatal care, contraception and services for victims of sexual violence. According to the CES reports for 2021–2023, these groups were prioritised and the provision of the SRH services was scaled up in collaboration with UN agencies. Contextual changes between 2021 and 2025 have significantly influenced the way in which the Republic of Moldova plans, coordinates and delivers sexual and reproductive health (SRH) services in emergency situations. The humanitarian crisis triggered by the war in Ukraine led to a rapid mobilisation of the healthcare system to ensure refugees' access to essential SRH services and support against gender-based violence (GBV). The COVID-19 pandemic demonstrated the initial vulnerabilities of the system, but stimulated the integration of the SRH into essential service continuity plans. Subsequently, the lessons learned were applied to the development of operational protocols and logistical capacities.

Recent public healthcare reforms have contributed to improving the governance framework by clarifying institutional roles (MoH, NPHA, NHIC) and creating conditions for the inclusion of the SRH in preparedness and response plans. However, the lack of a formal SRH coordination mechanism, particularly at the sub-national level, and limited financial resources continue to affect the degree of preparedness for integrated and sustainable responses.

Overall, the period between 2022 and 2025 showed clear progress in integrating the SRH into humanitarian and public health responses. This was achieved with substantial support from international partners. However, further institutional strengthening is needed to ensure the long-term sustainability of the Minimum Initial Service Package (MISP) mechanisms at all levels. General provisions on the organisation of the SRH measures in the event of a public health emergency are partially integrated into the Ministry of Health's Public Health Emergency Preparedness and Response Plan (at the national level), which is currently under review and being aligned with the EU acquis, and the Plan for preparedness, response and liquidation of the medical consequences of exceptional situations and public health emergencies of administrative-territorial units (at the territorial level). However, the latter plan needs to be revised.

Version 2 of the Preparedness and Response Plan for the Infection with a Novel Virus (Covid-19) included regulations for maintaining essential medical services during

the public health emergency. These regulations referred to the SRH, including care services during pregnancy and childbirth.

In the field of healthcare, the Healthcare System Preparedness and Response Plan for Public Health Emergencies (updated for 2020–2022) includes references to the SRH as part of the essential services that must be maintained during a crisis. Compared to 2021, the SRH has been better integrated into emergency preparedness and response plans. This has been achieved by including the principles of gender equality and universal access in public health plans and the IHR (2005), as well as by strengthening the regulatory coordination framework (CES and NEPHC), and by establishing the new National Crisis Management Centre (NCMC) through Government Decision No. 579/2025.

In March 2022, a Rapid Assessment was conducted in the Republic of Moldova with the support of the UNFPA. The aim was to identify the sexual and reproductive health needs of young girls and women of reproductive age who are refugees from Ukraine, and to determine solutions that would ensure their access to the Minimum Initial Service Package (MISP) for sexual and reproductive health in a humanitarian context. This included field visits to refugee entry points in the Republic of Moldova, as well as to Temporary Refugee Placement Centres and PMSI hospitals at national and subnational levels, to assess their capacity to provide MISP for sexual and reproductive health in a humanitarian context. Following the assessment and visits, the UNFPA with financial support from the US Government purchased and donated over 10 tonnes of IARH kits (including medicines, devices, and consumables) to the healthcare system in the Republic of Moldova. The kits were distributed to hospitals and Youth-Friendly Health Centres across the country and are used for emergency obstetric care, family planning, safe abortion and post-abortion care, STI prevention and treatment, and the clinical management of rape. They are used for refugees from Ukraine as well as women from the Republic of Moldova.

Despite progress in updating the regulatory and strategic framework, the effective implementation of sexual and reproductive health (SRH) policies and plans in emergency situations remains uneven, especially at the sub-national level. Differences persist between territorial capacities, resource constraints and the lack of clear operational mechanisms for MISP implementation. Inter-sectoral coordination is often done ad hoc, and the integration of the SRH into district preparedness and response plans needs to be strengthened. At the same time, the implementation of the SHR policies is hindered by the lack of an approved National Programme on Sexual and Reproductive Health and Rights after 2022, uneven capacity at the sub-national level due to limited resources and inconsistent training, partial integration of the SHR into local emergency plans, lack of the SHR

indicators in monitoring, incomplete logistics chain for IARH kits and insufficiently formalised intersectoral cooperation. Reports and observations from the period of the outbreak of the SARS-CoV-2 virus and the refugee crisis show that effective ad hoc actions were taken. However, there was a lack of a sustainable network for the provision and distribution of the SRH kits and consumables.

Although the legislative and strategic framework for emergency management was updated and strengthened between 2021 and 2025, there are still several challenges that prevent the complete integration of sexual and reproductive health (SRH) and the MISP into national and sub-national policies and plans. Current legislation, such as Law 248/2025, has not been fully implemented. Laws such as No. 212/2004 and No. 271/1994, as well as the National Strategy for Disaster Risk Reduction for 2024–2030, address healthcare in general, including sexual and reproductive health services. However, they do not contain any explicit, detailed provisions relating to the SRH, gender-based violence (GBV), or access to reproductive services in crisis situations.

Although the Public Health Emergency Preparedness and Response Plan and the IHR Plan (2005) both refer to essential services, the MISP has not yet been formalised as a separate subchapter in either of these plans. Institutional fragmentation and the absence of a unified SRH coordination mechanism complicate systemic coordination. Responsibilities for SRH, GBV, humanitarian response, and risk management are divided among several institutions (MoH, MLSP, NPHA, NHIC, GIES, and MIA). The absence of both a functional National Coordinating Committee on Sexual and Reproductive Health and Rights and an active, inter-institutional working framework reduces the coherence of policy implementation.

We also note a dependence on the support of international partners, and most recent initiatives and improvements in SRH in emergencies have been financially and technically supported by the UNFPA, WHO and other partners, while domestic involvement and funding remain limited.

1.2 Coordination Mechanisms for Disaster Management Related to the SRH

The current legal framework imposes clear responsibilities on public institutions for crisis preparedness and coordination. Law No. 248/2025 requires each public authority to appoint a crisis preparedness coordinator and a 24/7 contact point, to contribute to the development of the National Risk Register and to integrate risk assessments into their own sectoral policies. The law also establishes cross-sectoral cooperation as a basic principle in crisis management, promoting a unified approach

at the national level ("one government"). Government Decision No. 579/2025 sets out the following immediate organisational measures for enforcing the law: Within 45 days of the decision coming into force, ministries and other public authorities must establish the position of crisis management preparedness coordinator and designate a permanent (24/7) contact point for this issue from among the institution's approved staff. The details of the designated persons shall be communicated to the NCMC for the creation of the national network of coordinators. The NCMC has the role of coordinating the inter-institutional response throughout the entire crisis cycle and mobilising state resources through the National Crisis Response Platform, while ensuring the rapid flow of information and decisions between authorities. In practice, the NCMC focuses on strategic coordination at the government level, while 24/7 operational centres in the field ensure operational management and the permanent exchange of data between the responding institutions.

In order to ensure unified leadership, the NCMC has standardised the responsibilities of coordinators by issuing the Director General's Order No. 3/20.11.2025 pursuant to Government Decision 579/2025. According to this order, three levels of coordination are established in each institution: strategic, operational and tactical, each with clearly defined responsibilities. At the strategic level, the Secretary of State or Deputy Head (from the Ministry or Agency) is responsible for supervising the crisis preparedness strategy, integrating sectoral policies with national security requirements, monitoring the allocation of necessary resources and participating in the NCMC meetings. At operational level, the coordinator (typically a Head of Directorate or Subdivision) is responsible for developing sectoral preparedness plans, organising exercises and simulations, and supervising the institution's response to crisis situations. At the tactical level, the designated coordinator (e.g. a section or service manager) ensures staff training, implementation of specific procedures and regular reporting on the state of preparedness. In addition, the 24/7 contact point must notify the NCMC immediately of any crisis affecting the sector, and ensure that information transmitted to the Centre is constantly updated. Thus, through this network of coordinators, each public institution is integrated into the national crisis management system, ensuring a direct and continuous link between sectoral authorities and the NCMC. Once operational, these mechanisms will contribute to increasing the efficiency of the coordination process and to the systematic integration of the sexual and reproductive health (SRH) and gender-based violence (GBV) issues into preparedness, response and recovery processes. The NCMC will strengthen strategic coordination at government level. The 24/7 operational centres will ensure the continuity of operational leadership and permanent information exchange between support authorities. The National Risk Register will facilitate a unified approach to risk assessment and the planning of

risk reduction measures. Meanwhile, the National Crisis Management Plan will establish a general framework for the cooperation and coordination of the involved institutions, including the integration of humanitarian and public health dimensions in line with the standards of the WHO, the UNFPA and the European Union Civil Protection Mechanism.

At the same time, in 2024, Government Decision 30/2024 was approved, concerning the early warning and rapid response system that was set up in order to deal with serious cross-border threats to health. This Government Decision establishes the Regulation for an Early Warning and Rapid Response System (EWRS) concerning serious cross-border health threats. It sets out procedures for alert notifications, information exchange, consultation, and the coordination of responses between the relevant authorities. The system provided for in GD 30 provides for the exchange of information, consultation and coordination between various institutions (public health, laboratories, border institutions, etc.). This is essential for an integrated response to the PHE, as public health threats do not remain solely within the 'healthcare sphere' — they can involve borders, transport and communications. The permanent coordination and consultations established by regulations enable a rapid and unified response — not fragmented reactions.

If we analyse the management and coordination of preparedness and response measures in exceptional situations between 2021 and 2025, until the NCMC was established and Law 248/2025 was adopted, we find that these aspects were managed by the Commission for Exceptional Situations of the Republic of Moldova (CES RM) established by the Government. The CES RM is a multisectoral coordination body, chaired by the Prime Minister of the Republic of Moldova and including representatives of the ministries and departments. The national authority responsible for implementing policies in the field of emergency situations (ES) is the General Inspectorate for Emergency Situations of the MIA. The CES RM includes representatives of the central specialised bodies of public administration, other central administrative authorities, institutions, including representatives of the Ministry of Health, delegated to ensure cooperation, consultation and information exchange throughout the management of the emergency situation.

The coordination of preparedness and response to public health emergencies is carried out through authorities and mechanisms at the governmental, ministerial and local levels. The coordination mechanism in the PHE at the national level is carried out by the National Extraordinary Public Health Commission (NEPHC), which is responsible for the integrated approach to all public health threats, the application of prevention and management measures in the PHE, multisectoral mobilisation and ensuring a coordinated response. The NEPHC is headed by

the Prime Minister, with the Minister of Health acting as vice-chair, and includes representatives from all ministries and departments. The NEPHC's operational arm is the NPHA, which runs the Public Health Emergency Operations Centre (PHEOC) that ensures information and decision-making support, coordination, control and management support for PHEs.

The Ministry of Health is responsible for managing and coordination of the healthcare system preparedness and response measures to PHE/ES through the Ministry of Health Commission for Exceptional Situations and Public Health Emergencies (CES of the Ministry of Health), established by Order 371/2018. The Minister of Health is the chair of the CES of the Ministry of Health. The members of the Commission include Secretaries of State, heads of Ministry of Health departments, and heads of relevant medical and health agencies and institutions. The NPHA fulfils the role of the Secretariat of the Commission.

At the level of administrative-territorial units, the coordination mechanism in the PHE is carried out through the Territorial Extraordinary Public Health Commissions (TEPHC), whose activity is coordinated by the NEPHC. Medical coordinators appointed at the territorial level are responsible for activities concerning preparedness, response and elimination of the medical consequences of ES/PHE. (Heads of the Health and Social Protection Department of the Chisinau Municipal Council, of the ATU Gagauzia, of the Health Department of the Balti Mayor's Office, and Territorial Public Health Centres).

Maintaining historical mechanisms (CES, NEPHC) as coordination structures for general situations and public health; these mechanisms ensured a coordinated response to COVID-19 and the refugee crisis, and UN partners (UNFPA, WHO) facilitated ad hoc technical groups and EMTs (emergency medical teams) for SRH/GBV during periods of crisis.

With regard to SRH/GBV, coordination during the crisis of refugees from Ukraine was achieved through ad hoc technical groups between the Ministry of Health, NPHA, UNFPA, WHO, UNICEF, UN Women and IOM, with a focus on refugees' access to SRH services and the response to GBV. At the sub-national level, coordination remained at the level of territorial extraordinary public health commissions, but these have limited powers to formally integrate SRH into local mechanisms.

Several operational support lines were set up in the context of strengthening coordination mechanisms for emergency management and ensuring the continuity of the MISP. These include **Green Line 080080011**, which is operational for managing the flow of refugees, as well as the **toll-free number 080000008**, a service specializing in cases of GBV (domestic violence and sexual violence), the **NPHA**

Green Line 080012300 for providing support related to refugees, vaccination, vaccination certificates, and other public health issues.

1.3. Data on the SRH at the National and Sub-national Level

Current national risk assessments are coordinated by the Government, through the State Chancellery, and technically carried out by the General Inspectorate for Emergency Situations of the Ministry of Internal Affairs, with the contribution of relevant ministries, including the Ministry of Health. The latter is responsible for analysing public health risks, integrating the sexual and reproductive health dimension (Law No. 10/2009 on State Surveillance of Public Health)[2].

In the field of sexual and reproductive health, risk assessments partially target vulnerable populations: women, people living with HIV, adolescents and young people, SOGIESC persons, commercial sex workers and persons with disabilities, considered a priority for access to integrated services (UNAIDS, 2020; UNFPA, 2021). National policies and international partnership programmes provide for measures to reduce inequalities and expand access to modern contraception, family planning services, comprehensive sexual education and services for victims of sexual violence. These are reflected in the National Programme on Sexual and Reproductive Health and Rights for 2025–2027 (pending approval), the UNFPA Country Programme 2023–2027 for the Republic of Moldova[3] and the strategic priorities of the UN Women Moldova 2023–2027[4], which focus on equitable access to SRH services and the protection of the rights of vulnerable groups.

Significant progress was made in 2024, when the Ministry of Health, together with the WHO and other interministerial institutions, applied the standardised methodology Strategic Tool for Assessing Risks (STAR)[5] at a national workshop (4–6 June 2024) and subsequent regional sessions. This exercise made it possible to identify and prioritise major risks to public health, including those affecting access to essential sexual and reproductive health services (WHO, 2024).

At the territorial level, risk assessment in the field of sexual and reproductive health is carried out within the general civil protection and public health mechanism, but with specific responsibilities assigned to local healthcare and social protection

2 https://www.legis.md/cautare/getResults?doc_id=122828&lang=ro

3 https://moldova.unfpa.org/sites/default/files/pu

4 https://moldova.unwomen.org/ro/digital-library/publications/2022/12/un-women-moldova-prioritati-strategice-2023-2027

5 https://www.who.int/europe/teams/who-health-emergencies-programme-(whe)/strategic-tool-for-assessing-risks-(star)

structures. Territorial public health departments, together with medical institutions from districts and municipalities, identify and monitor risks related to the population access to family planning services, modern contraception, prevention and control of sexually transmitted infections, including HIV, as well as medical and psychological assistance for victims of sexual violence.

Local public administration authorities, through social assistance departments and in collaboration with non-governmental organizations, contribute to identifying vulnerable groups at the community level—women, adolescents and young people, persons with disabilities, persons living with HIV, SOGIESC persons, sex workers, and ethnic minorities—and to assessing their level of exposure to risks in terms of access to information, education, and sexual and reproductive health services.

The results of these assessments are reflected in territorial healthcare plans and local civil protection plans and are forwarded to the Ministry of Health and the General Inspectorate for Emergency Situations for integration into the national risk assessment. Thus, the dimension of sexual and reproductive health is included in the territorial risk assessment process, but the coverage is still fragmented. It depends on the availability of disaggregated data and the capacity of local institutions to identify community-specific vulnerabilities systematically.

However, significant gaps still remain. There is no systematic approach to the risks affecting SOGIESC persons, and the enforcement of legal provisions on non-discrimination remains limited (Law No. 2/2023[6]; Council of Europe, 2024), moreover the disaggregated data for ethnic minorities, particularly the Roma community, are insufficient to inform evidence-based policies (Country Gender Profile, EU, 2021[7]). Furthermore, recent research shows that the level of sexual and reproductive health literacy among young people, including refugees, is low and requires innovative interventions, such as the community digital initiatives developed in 2024–2025 (Enhancing Sexual and Reproductive Health Literacy among Local and Refugee Youth in Moldova, 2025)[8].

At the same time, assessments do not consistently capture the intersection of vulnerabilities, such as the combination of poverty, disability, HIV status and ethnicity, which reduces the capacity for integrated public policy responses (Ombudsman's Report on the Implementation of the CRPD, 2025)[9].

6 https://www.legis.md/cautare/getResults?doc_id=135489&lang=ru

7 https://www.eeas.europa.eu/sites/default/files/country_gender_profile.pdf

8 https://www.researchgate.net/publication/390277437_Enhancing_sexual_and_reproductive_health_literacy_among_local_and_refugee's_youth_in_Moldova_-_a_community_participation_digital_health_initiative

9 https://ombudsman.md/wp-content/uploads/2025/04/raport-anual-privind-respectarea-drepturilor-si-libertatilor-omului-in-anul-2024.pdf

Currently, according to the MISP Checklist the integration of indicators related to the Minimum Initial Service Package for Emergency Situations (MISP) into the Healthcare Information Systems (HIS) of the Republic of Moldova is limited and fragmented. Although certain components of the SRH are reflected in national programmes — such as maternal and child health (monitoring of maternal morbidity and mortality, essential care during pregnancy and postpartum), HIV/STI surveillance (screening, treatment and prevention), family planning (use of modern methods, distribution of contraceptives) and interventions for gender-based violence (identification, referral, specialised services) — these data flows are not harmonised to cover the entire set of the MISP indicators.

In particular, there is a lack of standardised mechanisms for collecting data on rapid access to essential SRH services in crisis situations, data on the availability at the level of medical institutions of providers trained in MISP, in managing cases of sexual violence in emergency contexts, targeting the level of critical stocks of contraceptives and medical supplies, as well as indicators on the continuity of services for vulnerable groups during periods of system disruption in crisis/emergency contexts.

Current reporting is predominantly sectoral and depends largely on projects implemented with the support of international partners, in particular the UNFPA and WHO, which leads to discrepancies between official data and realities on the ground. The absence of an integrated national reporting mechanism reduces the possibility of monitoring progress in real time, affects the capacity for forward planning and limits institutional accountability for the implementation of the MISP.

The application of the WHO *Strategic Tool for Assessing Risks* (STAR) methodology in 2024 highlighted systemic vulnerabilities in the collection, integration and use of the SRH data in emergency situations. STAR demonstrated that, in the absence of formalised MISP indicators in the HIS, authorities cannot systematically assess the risks affecting access to SRH services, nor can they determine the system's response capacity in crisis conditions, including for marginalised populations.

Thus, the failure to integrate the MISP Checklist into the HIS represents a major structural gap, which affects: the continuous monitoring of the availability and quality of essential SRH services in emergencies; strategic planning of human, logistical and financial resources; intersectoral coordination in crisis situations, particularly between the healthcare, social protection, public order and civil protection sectors; reporting capacity of the Republic of Moldova in line with the international standards (WHO, UNFPA, Inter-Agency Working Group for

Reproductive Health in Crises, Sendai Framework for Disaster Risk Reduction (2015-2030) / Sendai Gender Action Plan[10]).

Therefore, the formal inclusion of the MISP indicators into the HIS is not just a technical element, but a fundamental condition for strengthening the resilience of the healthcare system, ensuring the continuity of vital services and complying with international obligations in the field of Sexual and Reproductive Health and Rights.

The standard rapid assessment forms used in the Republic of Moldova **for emergency response –** be it the multisectoral rapid assessments, sectoral healthcare assessments or tools activated under the national civil protection mechanism – do not include dimensions essential to sexual and reproductive health (SRH) or the collection of disaggregated data in accordance with the international standards in a systematic way. In their current form, these tools predominantly focus on general indicators of the functionality of medical infrastructure, the availability of resources, the epidemiological status, and the immediate medical needs of the affected population. They do not provide a dedicated analysis of the sexual and reproductive health (SRH) components set out in the Minimum Initial Service Package for Emergency Situations (MISP).

In particular, the forms do not ensure the collection of data disaggregated by **sex, age and disability (SADD)** – a mandatory standard set by the IASC, WHO and Inter-Agency Working Group (IAWG) for reproductive health in crises. The lack of SADD disaggregation prevents the identification of the specific needs of pregnant women, adolescents, persons with disabilities, survivors of sexual violence or other vulnerable groups, which limits the accuracy of planning and resource prioritisation.

In recent years, some tools developed or adapted with the support of the UNFPA and WHO have begun to include modules on the continuity of family planning services, access to contraception, the availability of clinical kits for managing cases of sexual violence, the functioning of maternal and neonatal care services, and the provision of STI/HIV screening. However, these tools are used on an ad hoc basis, mainly in pilot projects, tabletop exercises or emergency preparedness exercises, without being integrated into the standard procedures of national authorities.

Rapid assessments carried out in practice under the auspices of the General Inspectorate for Emergency Situations (GIES), the Ministry of Health or the National Public Health Agency (NPHA) focus mainly on: the state of healthcare infrastructure

10 https://www.google.com/search?q=Sendai+framework+Sendai+Framework+for+Disaster+Risk+Reduction+(2015-2030)+%2F+Sendai+Gender+Action+Plan&rlz=1C1PNBB_enMD1097MD1097&oq=Sendai+framework+Sendai+-Framework+for+Disaster+Risk+Reduction+(2015-2030)+%2F+Sendai+Gender+Action+Plan&gs_lcrp=EgZjaHJvbWUyBggAEEUYOTIHCAEQIRiPAjIHCAIQIRiPAtIBCDIzNDIqMGo3qAIAsAIA&sourceid=chrome&ie=UTF-8

and the functional capacity of institutions; the availability of human and logistical resources; stocks of medicines and consumables (mainly for general services); epidemiological dynamics and public health risks; general access to medical services in affected areas.

In this context, critical aspects for the SRH are either absent, addressed superficially or addressed in a fragmented manner, and namely: the availability and accessibility of modern contraceptive methods, including LARC; the functionality of referral mechanisms for survivors of sexual violence; the availability of trained staff to implement the emergency rape case management protocol; the continuity of prenatal, perinatal and postpartum care; the identification of vulnerable groups, including pregnant women, minors, persons with disabilities and survivors of violence.

Although there has been real progress towards alignment with the international standards – particularly through the use of *the MISP Readiness Checklist*, *the MISP Distance Learning Module*, IASC recommendations on SADD and the STAR/WHO methodology applied in 2024 – these developments have not yet been formalised in the official procedures and forms used at the national level. In the absence of institutionalised integration, the collection of the SRH data in emergency situations remains dependent on sectoral initiatives, international projects or the ad hoc availability of teams trained in SRH in emergency contexts.

These limitations reduce the capacity of the Republic of Moldova to: quickly identify the specific needs of vulnerable populations; anticipate disruptions to essential SRH services; plan and prioritise resources during crises; report in accordance with the international standards on the protection of affected populations; ensure the continuity of vital SRH services, in accordance with the MISP requirements.

The national data collection tools used in the Republic of Moldova for emergency response, including medical reporting forms, epidemiological surveillance tools and forms activated under the civil protection mechanism, **do not fully and systematically integrate the indicators related to the Minimum Initial Package of Services** (MISP), as defined in the MISP Readiness Checklist and IAWG standards.

Although certain components of sexual and reproductive health (SRH) are partially reflected in routine forms, this integration is fragmented, uneven and dependent on sectoral programmes, and does not ensure a coherent approach across the entire healthcare system. Thus, elements of maternal and neonatal health (e.g. number of pregnant women, access to antenatal care or availability of obstetric services) are reported through national programmes, but are not adapted for rapid assessment in emergency situations.

Indicators on HIV/STI prevention and treatment are collected through epidemiological surveillance, but standard forms do not include questions on the continuity of these services in crisis contexts or on access for vulnerable groups.

Data on gender-based violence (GBV) are collected through separate social protection mechanisms or projects supported by international partners, without direct correlation with the rapid assessment tools used by the healthcare sector.

The availability of contraceptive methods, including LARC, or the level of essential stocks for MISP (sexual violence response kits, oxytocin, antibiotics, emergency obstetric care supplies) are not reported in a standardised manner in current emergency response tools.

As a result, the full set of MISP indicators, which includes both preparedness and response components, is not present in the national tools, creating a number of structural limitations: the inability to quickly identify SRH needs in the first 48–72 hours of a crisis, which contravenes international standards for humanitarian response; the lack of a comprehensive picture on the availability and functionality of essential SRH services, such as family planning, Emergency Obstetric and Newborn Care (EmONC) or sexual violence case management; difficulty in assessing specific risks for women, girls, adolescents and other vulnerable groups, in the absence of systematic collection of data disaggregated by sex, age and disability (SADD); dependence on ad hoc tools or projects developed with the support of the UNFPA, WHO or other partners, which prevents the institutionalisation of a unified SRH monitoring system in emergency situations.

Despite these gaps, the Republic of Moldova has made notable progress towards alignment with the international standards, including: the application in 2024 of the WHO Strategic Tool for Assessing Risks (STAR), which highlighted the need to integrate SRH indicators into risk assessments and national data collection forms; the adaptation and testing of the SRH modules in simulation exercises and MISP training conducted with the support of the UNFPA and WHO; the use of extended forms for GBV assessment or for monitoring contraceptive stocks in certain institutions. However, these advances in the MISP data availability remain sporadic, uneven and non-mandatory. They are not yet reflected in the institutional architecture of the national data collection systems.

The new crisis management framework introduces essential components for the collection, integration and use of information and data relevant to prevention, preparedness and response. Law No. 248/2025[11] and Government Decision No. 579/2025[12] set out the establishment of the National Risk Register and the development of a unified information system for crisis management. This system is designed to ensure a coordinated, data-driven approach at the national level. In this context, the National Crisis Management Centre (NCMC) is designated as the authority responsible for collecting and centralising data provided by all institutions involved, as well as ensuring effective, coherent and rapid communication to the population in crisis situations. This institutional architecture involves integrating sectoral data, including that relating to health, into centralised databases of the National Risk Register.

In practice, each ministry and relevant agency will periodically send to the NCMC assessments, risk indicators and analyses specific to their area of expertise. In the case of the healthcare sector, this mechanism creates the conditions for the inclusion of relevant sexual and reproductive health (SRH) indicators, which have a direct impact on public health and population protection. Thus, such issues as access to modern contraception methods, the capacity of maternity wards and obstetric services to function in emergency situations, and the incidence of sexual and gender-based violence can be systematically reflected in the National Risk Register.

In the medium and long term, the consistent integration of the SRH indicators into risk register and early warning systems will enable decision-makers to better anticipate the need for interventions, resources, and protective measures in the field of reproductive health. This approach contributes to strengthening the state's capacity to respond to crises in a preventive, coordinated manner focused on reducing the vulnerabilities of the population, especially women and groups facing increased risks.

1.4 Resources for Setting up and Implementation of the MISP

In order to ensure ES management, there have been approved national regulations with reference to mechanisms for the rapid mobilization of funds for ES/PHE response actions, regarding non-military civil protection units, requisitioning of goods, and provision of services in the public interest; regarding the introduction, reception, storage, distribution, and record-keeping of humanitarian aid provided

11 https://www.legis.md/cautare/getResults?doc_id=150247&lang=ro

12 https://www.legis.md/cautare/getResults?doc_id=150843&lang=ro

to the Republic of Moldova; regarding the procedure for requesting international assistance to address the consequences of exceptional situations (mechanism activated in the context of the COVID-19 pandemic).

From the report on MISP for 2021, we note stable but limited and partially dedicated availability: The Government and the NHIC have reserve/emergency use funding mechanisms; the National Program on SRHR for 2018–2022 included costed lines for SRH activities. However, funds explicitly dedicated exclusively to SRH preparedness in emergencies (e.g. national MISP training, IARH stocks) are often provided through projects or external implementation partners (UNFPA, UNICEF, CEB) rather than through constant allocations from the core budget.

The refugee crisis attracted additional short-term funding (from multilateral partners and donations), which covered some medical costs and purchases of consumables, but this boost did not solve the need for permanent funding for preparedness and stockpiling. In addition, due to the delay in approving the new National Programme on Sexual and Reproductive Health and Rights for 2023–2027, there were no specific budget allocations for SRH preparedness in emergencies. National resources were used mainly for response (Government Reserve Fund, MHIF, CES Intervention Fund), not for systematic preparedness.

Funds used for SRH services during the COVID pandemic and refugee crisis:

- Government emergency funds — activated by CES/NEPHC decision (existing legal mechanism used in crisis).
- NHIC — reserve funds/mechanisms to cover emergency medical services (used for services provided to refugees).
- Request for international assistance (UN partners/donors) — UNFPA (purchase of IARH kits, equipment, ambulances, financial coverage of services), UNICEF, WHO, CEB provided financial support, kits and equipment.
- Local reserve funds (district councils) — can be used for urgent expenses, but capacity and volume vary.

Strengthening procedures for accessing emergency funds within the CES/NEPHC and using international partnerships for rapid procurement have increased the speed of response. However, the availability of dedicated funding for SRH has remained limited and fragmented.

Ministry of Health Order No. 191/2022 ensured access to immunisation for refugees on the territory of the Republic of Moldova. In the context of the response to the refugee crisis in the Republic of Moldova, the UNFPA provided support to pregnant women and breastfeeding mothers, including refugees from Ukraine and those in host communities, through the Governmental Fund for Vulnerability. This support was distributed by the UNFPA via perinatal centres and NGOs. From 2022 to 2024, refugees from Ukraine were able to access sexual and reproductive health services free of charge in the Republic of Moldova at all levels of healthcare, including primary care, specialised outpatient services, and hospital facilities. Financial coverage for these services was provided by the UNFPA based on a partnership agreement with the National Health Insurance Company. This agreement provides special budgetary support to the National Mandatory Health Insurance Fund, which covers sexual and reproductive health services.

In addition, with the support of the UNFPA, the quality of sexual and reproductive healthcare for detained refugee women was improved by equipping gynaecological examination rooms in the medical wards of Penitentiary No. 13 and Penitentiary No. 16 with necessary furniture, modern medical devices and consumables. Furthermore, modern equipment was provided for gynaecological examination rooms at the Medical Service of the Ministry of Internal Affairs.

SUMMARY OF PROGRESS

A comparative analysis between 2021 and 2025 shows that the Republic of Moldova has taken important steps towards increasing the resilience of the healthcare system in terms of sexual and reproductive health in crisis contexts. The current strategic and operational framework is better defined and more closely aligned with the international standards, including the UN's MISP guidelines. It is also supported by stronger partnerships, providing a more solid foundation for protecting the sexual and reproductive health of population in emergency situations than it was in 2021. This progress is due both to the commitment of the authorities to learn from recent crises (COVID-19, refugees) and to the considerable support provided by the international community.

However, in order to fully integrate the SRH into the national disaster preparedness and response system, these initial advances need to be translated into permanent and sustainable mechanisms. The proposed strategic recommendations and specific actions represent essential next steps. Their implementation will require political will, additional financial investment and close coordination between institutions. The effort is justified: a system that systematically incorporates SRH into emergency plans will ensure a more equitable response (addressing the specific

needs of women, children, and vulnerable people) and reduce the long-term impact of crises on the health and demographic situation in the country.

In conclusion, the Republic of Moldova is in a better position in 2025 than in 2021 in terms of MISP preparedness, but maintaining and accelerating this positive trend depends on addressing the remaining challenges. By implementing the recommended measures, Moldova can move from a reactive model, based on ad hoc projects and interventions, to a proactive and sustainable model, in which sexual and reproductive health becomes an integral and inherent component of human security and the management of all emergencies. This will lead to a more systematic, equitable and effective national response, ultimately protecting the lives and dignity of citizens even in the most difficult times.

CONCLUSIONS

1. The national legal and strategic framework provides comprehensive coverage of planning, preparedness and response to exceptional situations and public health emergencies at both the central and territorial levels. It has been significantly strengthened between 2021 and 2025 through the approval of the National Health Strategy, 'Health 2030', and the National Strategy for Disaster Risk Reduction (2024–2030), as well as through updates to the institutional framework for crisis management. These documents integrate the principles of resilience, continuity of essential services and protection of vulnerable groups.

2. The dimension of sexual and reproductive health in humanitarian crises, exceptional situations and public health emergencies has begun to be included to a greater extent in healthcare system policy documents and preparedness and response plans, in line with the objectives of the National Health Strategy 'Health 2030' and the experience gained in managing refugee flows. However, the integration of the SRH/MISP remains inconsistent at the subnational level, with standardised procedures not yet fully in place.

3. There is still no formalised and permanent coordination mechanism for the implementation of MISP, both at the national and territorial level. Although some ad hoc structures have been developed during crises (including hotlines and consultation mechanisms for medical staff), SRH coordination in emergencies is not yet institutionalised as a systemic function in the national crisis management architecture.

4. Logistical, operational, and resource capacities for ensuring MISP in crisis situations remain underdeveloped, including difficulties in assessing needs, procuring SRH kits and consumables, storing and pre-positioning stocks, and

the absence of a formalized logistics chain for their sustainable distribution in emergencies. The operational vulnerability is stressed by heavy reliance on donor support and the absence of in-house budgetary mechanisms for SRH response.

5. **Integration of the SRH into risk assessment and national planning.** The Republic of Moldova has made progress in aligning with the WHO STAR methodology and international strategic frameworks in the field of the SRH. However, the application of these principles at the national level is still in the process of consolidation, particularly with regard to the consistent use of disaggregated data and the reflection of the situation/needs of all vulnerable groups.

6. **Integration of the MISP indicators into Healthcare Information Systems.** Healthcare information systems include elements relevant to SRH monitoring, but their correlation with the MISP indicators could be further developed to support more integrated monitoring of emergency preparedness and response. The experience gained from the application of the WHO STAR in 2024 provides a solid ground for the development of a unified framework to facilitate strategic resource planning and use.

7. **SRH indicators and SADD data in rapid assessment forms.** The forms used in rapid assessments partially reflect elements related to SRH and disaggregated data, also the initiatives implemented with the support of the UNFPA and WHO demonstrate openness to alignment with IASC, WHO and IAWG standards. Scaling up and institutionalising of these practices would contribute to a more prompt and comprehensive assessment of the needs of affected populations, in line with the MISP provisions.

8. **Integration of the MISP indicators into national emergency data collection tools.** National emergency data collection tools include useful components, but could evolve towards a more coherent framework for SRH monitoring, particularly in the first 48–72 hours of a crisis. Recent initiatives, such as STAR 2024 and piloted SRH modules, provide an important background for developing institutionalised mechanisms to support system resilience and alignment with the international humanitarian standards.

RECOMMENDATIONS

1. **Institutionalisation of the SRH coordination in the national emergency response architecture.** It is recommended to create a permanent SRH coordination mechanism (e.g. a technical subcommittee within the National Crisis Management Centre), scaled up at the territorial level through the SRH focal points in each district. This mechanism would ensure integrated SRH planning and coordination at all stages of emergency management.

2. **Strengthening the integration of the SRH into national risk assessment and planning processes.** It is recommended to develop a more coherent institutional framework for integrating sexual and reproductive health into risk assessment, including through the consistent use of disaggregated data and the systematic reflection of the needs of all vulnerable groups. Aligning the procedures with the WHO STAR methodology and international obligations will facilitate the uniform application of standards at the national level.

3. **Setting up of dedicated budget lines for SRH preparedness and response** It is recommended to allocate internal resources for the MISP (training, SRH kits, risk communication) within the framework of the national SRHR programmes, reducing dependence on external support. A dedicated SRH/PHE reserve fund would allow for the rapid mobilisation of resources in crises.

4. **Strengthening territorial capacities through continuous training and simulation exercises**. It is suggested to develop a uniform national training programme in the MISP for medical staff and intervention units. Regular exercises at the local level and sharing of good practices will reduce territorial disparities and increase the overall level of preparedness.

5. **Development and implementation of standard operating procedures (SOPs) for the MISP.** It is recommended to develop a set of national SOPs for the provision of the SRH services in all types of emergencies, integrated into the contingency plans of medical institutions. SOPs should be systematically tested, updated and disseminated.

6. **Developing of stocks and pre-positioning mechanisms for the SRH materials** It is recommended to create a national stockpile system for medicines, devices and consumables needed to provide SRH services (IARH kits/packages, containing essential medicines and consumables), with regional warehouses and clear logistics protocols for rapid distribution in emergencies in place. Regular rotation and agreements with suppliers will ensure continuity of stocks.

7. **Enhancing the integration of the MISP indicators into Healthcare Information Systems.** To support the monitoring of emergency preparedness and response, it is recommended to develop a dedicated SRH-emergency module within the HIS, which will progressively integrate the MISP indicators. This will also allow for post-action assessments after each significant crisis. Correlating the information collected through sectoral programmes and leveraging the experience generated through WHO STAR 2024 will contribute to adjusting strategies, streamlining planning, resource allocation and institutional accountability.

8. **Scaling up and institutionalisation of the SRH indicators and SADD data in rapid assessment forms**. It is recommended that standard rapid assessment forms be reviewed and updated to include SRH components and the systematic collection of data disaggregated by sex, age and disability, in line with IASC, WHO and IAWG standards. Institutionalising the modules piloted with the support of the UNFPA and WHO will contribute to a more prompt and accurate identification of the needs of affected populations.

9. **Developing a unified framework for collecting and using SRH data in emergencies**. In order to strengthen the coherence of the national response, it is recommended that the MISP indicators and SADD data be integrated into the data collection tools used by the civil protection mechanism and the healthcare system in a phase-by-phase manner. Strengthening the institutional framework based on recent initiatives – such as STAR 2024 and tested SRH modules – will ensure adequate monitoring in the first 48–72 hours and stronger alignment with the international humanitarian standards.

CHAPTER 2.

Getting ready to provide services as outlined in the MISP

MISP Services: Overview

Correlation of Essential MISP Products with the National List of Essential Medicines of the Republic of Moldova. The implementation of the Minimum Package of Services in reproductive health in emergency situations (MISP) requires the availability of essential medicines and devices, in line with the international standards defined in the 6th edition of the Inter-Agency Reproductive Health Kits (IARH), developed by the UNFPA in 2019. In the Republic of Moldova, the availability of these products is regulated by the National List of Essential Medicines (LEM), approved by Order of the Ministry of Health No. 1033 as of 11.11.2021[13], which serves as the main tool for ensuring access to life-saving treatments at all levels of healthcare. A comparative analysis of the contents of the IARH kits and the LEM reveals a high degree of correspondence in terms of medicines considered indispensable in crisis situations. Thus, uterotonics such as oxytocin, ergometrine and tranexamic acid are included in the LEM, which allows for adequate management of postpartum haemorrhage, but thermostable carbetocin – particularly useful in contexts with cold chain limitations – is not included in the list. For the treatment of pre-eclampsia and eclampsia, injectable magnesium sulphate is available nationwide, ensuring compliance with the WHO recommendations and the contents of IARH kits.

In the field of incomplete abortion and post-abortion management, the LEM includes misoprostol, an essential drug for medical management, but does not cover manual vacuum aspiration (MVA) and related cannulas, which are classified

13 https://www.google.com/search?q=Ordinul+Ministerului+S%C4%83n%C4%83t%C4%83%C8%9Bii+nr.+1033+din+11.11.2021&rlz=1C1PNBB_enMD1097MD1097&oq=Ordinul+Ministerului+S%C4%83n%C4%83t%C4%83%C8%9Bii+nr.+1033+din+11.11.2021&gs_lcrp=EgZjaHJvbWUyBggAEEUYOTIHCAEQABjvBTIHCAIQABjvBTIHCAMQABjvBTIHCAQQABjvBdIBCDg4MGowajE1qAIAsAIA&sourceid=chrome&ie=UTF-8

as medical devices, regulated and procured through other mechanisms. With regard to contraception, the National List includes the main hormonal methods commonly used – combined oral contraceptives, progestin-only pills, medroxyprogesterone injectables and levonorgestrel for emergency contraception – but does not include contraceptive implants, which are recommended in IARH kits as safe and effective options for emergency situations. Intrauterine devices and condoms, although essential for preventing unwanted pregnancies and sexually transmitted infections, are not included in the LEM due to their status as consumables or medical devices.

The treatments for sexually transmitted infections recommended in IARH kits are largely covered by the LEM, including azithromycin, cefixime, ceftriaxone, doxycycline, metronidazole and clotrimazole, allowing for the adequate management of STIs in crisis situations. Post-exposure prophylaxis regimens for HIV are also available at the national level, as the LEM includes tenofovir disoproxil fumarate, lamivudine, and dolutegravir, drugs necessary for implementing PEP schemes in accordance with the international standards. However, a number of products essential for the implementation of the MISP – such as pregnancy tests, collection kits, safety boxes and other consumables – are not included in the LEM and are managed through separate procurement and supply mechanisms.

Overall, the assessment indicates that the Republic of Moldova has most of the essential medicines needed to implement IARH kits, which reflects an advanced level of emergency preparedness to ensure the continuity of reproductive health services in emergencies.

In conclusion, although the National List of Essential Medicines covers a significant part of the MISP requirements, the full effectiveness of the implementation of this package in the Republic of Moldova depends on ensuring constant and predictable access to devices and consumables that are not included in the LEM. It is recommended to analyse the opportunity to integrate these products into national emergency planning and to strengthen, together with international partners, alternative procurement mechanisms so that essential sexual and reproductive health services can be provided without interruption in any crisis context.

National capacities for remote delivery of sexual and reproductive health services. There are functional mechanisms and evolving initiatives that support the remote delivery of health services, including in the field of sexual and reproductive health. Telemedicine has become an essential tool, used both to scale up the access to medical expertise and to reduce geographical inequalities in access to services. The Mother and Child Institute has implemented a robust teleconsultation system that allows obstetric and neonatal expertise to be provided to district hospitals,

facilitating remote management of complicated cases and reducing the need for physical transfer of patients. During the COVID-19 pandemic, these mechanisms were expanded by piloting dedicated reproductive health consultation platforms, which allowed pregnant women and women at obstetric risk to obtain specialist opinions from university centres without travelling, thus contributing to the continuity and safety of services.

Remote service delivery was also developed in the area of family planning through initiatives supported by the UNFPA and the Ministry of Health, which enabled the expansion of online contraception counselling within the network of Youth-Friendly Health Centres and Reproductive Health Rooms. These services included both individual consultations by telephone or digital platforms and the distribution of educational materials tailored to the needs of adolescents and young people, contributing to increased access to accurate information on sexual and reproductive health.

For survivors of sexual and gender-based violence, the remote support infrastructure was strengthened through national helplines, online psychological counselling services and digital tools developed in collaboration with international partners, in line with the WHO "LIVES" model. These mechanisms have enabled confidential access to psychological support and essential medical information, including in situations where the mobility of those affected was limited or where physical access to services was difficult.

The development of digital healthcare is supported by national strategic documents. The National Health Strategy "Health 2030"[14] provides for the modernisation of digital infrastructure and the expansion of telemedicine use for all priority healthcare areas, including sexual and reproductive health. At the same time, the Strategy for Digital Transformation of the Republic of Moldova for 2023-2030[15] provides the necessary framework for accelerating digital transformation, facilitating the scaling up of these services nationwide and contributing to the reduction of territorial disparities, especially for rural communities and vulnerable groups. The National Program for Digitalization and Innovation in Healthcare for 2025-2030[16], which aims to provide doctors, nurses, and other healthcare professionals with modern digital solutions designed to reduce the administrative burden and streamline workflows. At the same time, patients will benefit from faster, more efficient,

14 https://ms.gov.md/comunicare/comunicate/strategia-nationala-de-sanatate-sanatatea-2030-aprobata-de-executiv/

15 https://mded.gov.md/transparenta/64373-2/

16 https://www.legis.md/cautare/getResults?doc_id=150979&lang=ro

and more accessible healthcare services using electronic health records, online appointments, electronic prescriptions, and telemedicine services, including in underserved or remote areas.

These developments indicate that the Republic of Moldova has a solid foundation for integrating telemedicine into the provision of the SRH services, and the continued strengthening of digital infrastructure will enable greater access and quality of interventions, including in emergency or crisis contexts.

The Republic of Moldova already has functional telemedicine and online reproductive health counselling services: teleconsultations for obstetric cases, online counselling for contraception and family planning, and psychological support services for survivors of violence. These are complemented by government strategic directions on digital healthcare, which provide a solid ground for scaling up and institutionalisation of telemedicine in the field of the SRH in the period of 2025–2027.

Ensuring the protection and continuity of the SRH services in emergency situations. The preparedness of the Republic of Moldova for public health emergencies includes strengthened mechanisms for the supply of personal protective equipment (PPE) and infection prevention and control (IPC) materials, applicable to all healthcare institutions, including those providing sexual and reproductive health (SRH) services. National response plans, developed and coordinated by the Ministry of Health and the National Public Health Agency (NPHA), set up responsibilities and standard procedures for maintaining reserve stocks, distributing PPE and complying with IPC protocols. Strategic documents such as the National Health Strategy "Health 2030" and the health security framework include explicit provisions on strengthening the protection infrastructure and continuity of medical services in the context of an epidemic.

Institutions providing SRH services are integrated into the general supply mechanism of the Ministry of Health and the NHIC, without having dedicated SRH stocks. In the context of the COVID-19 pandemic, Reproductive Health Rooms, Youth-Friendly Health Centres and Units for the care of survivors of gender-based violence were supplied with PPE from centralised stocks, distributed through the Department of Emergency Situations and the territorial public health directorates. Internal hospital regulations stipulated the mandatory use of masks, gloves, gowns, visors, N95/FFP2 respiratory equipment, disinfectant solutions and hand hygiene materials, ensuring the protection of staff and beneficiaries.

Support from international partners has been essential in strengthening national capacities. The UNFPA, WHO, UNICEF, the European Union and other partners have donated significant quantities of PPE and ICP consumables during the period of 2020–2022, including to facilities providing obstetric care and other SRH services. These support mechanisms remain active and are stipulated by the emergency preparedness plans, which include rapid mobilisation of donors to cover critical needs.

However, the analysis of the field reveals several structural challenges. Although general procurement mechanisms ensure access to essential SRH medicines—such as hormonal contraceptives, oxytocin, misoprostol, magnesium sulphate, and antibiotics—there is no strategic reserve dedicated exclusively to the SRH services. Human resources are mobilised based on the general response system, but the SRH teams formalised as 'rapid response teams' have not yet been established, despite the experience gained in the context of the pandemic and the response to the refugee crisis.

The pandemic has highlighted the need to adapt the infrastructure for the continuity of the SRH services. Although obstetrics and gynaecology units have created separate circuits for COVID and non-COVID patients, primary healthcare services — including SRH rooms and YFHCs — have experienced significant disruptions. This experience highlights the importance of developing operational continuity plans, including telemedicine and online consultations.

International cooperation continues to play a central role, and maintaining partnerships with the UNFPA, WHO, and UNICEF is essential to ensuring an effective logistical response in crisis situations. Furthermore, although the MISP is internationally recognised as the standard package for humanitarian emergencies, it is not yet formalised in the national public health emergency response plans of the Republic of Moldova.

Integration of the MISP and health emergency management into the training and education of medical staff in the Republic of Moldova. The training of medical staff in health emergency management and the application of the Minimum Initial Service Package for Sexual and Reproductive Health (MISP) is carried out through a series of formal and non-formal educational mechanisms, distributed across different levels of training.

At the university level, the curricula of the State University of Medicine and Pharmacy Nicolae Testemitanu include public health disciplines, health emergency management and clinical modules in obstetrics and gynaecology. These cover essential skills for managing obstetric emergencies such as severe haemorrhage, eclampsia, sepsis or incomplete abortion. However, the MISP does not appear as a separate module, being reflected only in relevant clinical or public health content.

The School of Public Health offers training programmes in health services management and public health emergencies, where the MISP is presented as an international reference tool. However, the package is not included as a separate curriculum unit.

As a part of the annual continuing professional training programme for doctors and pharmacists, including obstetricians-gynaecologists, as well as family doctors, a formal module dedicated to the Minimum Initial Service Package (MISP) was introduced with the support of the UNFPA. The module is designed to cover all components of the package. The module was an important tool for strengthening professional capacities in the field of sexual and reproductive health in emergency and crisis contexts. However, the consistent implementation of the MISP module trainings has experienced some interruptions. The analysis of the causes indicates several determining factors. These include the declining interest shown by medical institution managers and staff, their tendency to prioritise more relevant training for immediate clinical practice, and the perception that financial resources to support participation in such training are insufficient. Another relevant factor is the absence of a firm institutional decision to maintain the MISP module systematically and annually within the continuing vocational training programme for doctors and pharmacists. This situation highlights the need not only to strengthen the institutional decision-making framework, but also to promote the MISP module more actively in order to increase demand for this type of training and raise awareness of its relevance for ensuring the continuity of sexual and reproductive health services in crisis situations.

With regard to the training of mid-level medical staff, medical colleges do not formally include the MISP as a discipline or module. However, relevant elements, such as family planning, prenatal and postnatal care, obstetric emergencies and support for victims of gender-based violence, are integrated through practical activities, clinical internships and additional training carried out in collaboration with the Ministry of Health and UNFPA. The MISP is not part of the official continuing education training offer for mid-level medical staff in 2025. Topics that are important for implementing the package are scattered across other courses and do not constitute a unified module.

At the same time, online platforms and international training courses are an important channel for strengthening professional capacities in this area. The Moodle platforms of the SUMP, the learning hub OpenWHO of the WHO, courses dedicated to the MISP developed by the Inter-Agency Working Group (IAWG), the UNFPA e-learning modules and numerous webinars have contributed significantly to the training of doctors, midwives and nurses, especially during the COVID-19 pandemic, when distance learning became the main tool for rapid training.

Mechanisms for mobilising and redeploying medical staff in emergency situations, with relevance to the SRH services. The existing legal framework allows for the mobilisation and redeployment of medical staff in exceptional situations, including in the field of sexual and reproductive health (SRH). The Labour Code[17] and Law No. 212/2004[18] on the State of Emergency, Siege and War, give the Ministry of Health and the Commission for Exceptional Situations the power to order the temporary deployment of medical staff to institutions or areas with staff shortages. In this regard, the Ministry of Health may issue orders whereby specialists from republican or municipal hospitals are delegated to work in district institutions or at border points, depending on operational needs. Additionally, the **GIES, NPHA and NCPEMA** have their own operational teams that can be supplemented by deployments from other regions of the country. These teams were activated at border crossings to provide medical support to refugees in the weeks following the start of the war in Ukraine.

Recent practice demonstrates the applicability of these mechanisms in the field of the SRH. During the COVID-19 pandemic, obstetricians-gynaecologists, anaesthesiologists and nurses were redeployed to institutions under increased pressure, including designated COVID-19 hospitals. University centres such as the Mother and Child Institute provided both teleconsultation support and direct interventions by sending specialists to district hospitals to manage severe cases. In obstetric emergencies, interregional transfer mechanisms allow for the mobilisation of specialists and support for local institutions when their capacities are exceeded.

In terms of human resources organisation, the Republic of Moldova does not yet have a formalised structure of "reserve staff" dedicated to the SRH. Mobilisation continues to be carried out through ad hoc orders by the Ministry of Health, adapted to the epidemiological or humanitarian situation. During the pandemic, medical staff were redeployed by temporarily changing their duties. This included specialists from other fields being involved in activities such as triage and patient monitoring. In the field of the SRH, especially in rural areas, midwives and nurses took on additional responsibilities to compensate for the shortage of doctors.

International partners played a key role in mobilising human resources. In the context of the COVID-19 pandemic and the refugee crisis in 2022, the UNFPA and WHO supported the Ministry of Health in rapid training of the staff and organising multidisciplinary mobile teams, consisting of gynaecologists, psychologists and social workers, who intervened in regions with increased pressure and demand in the SRH services, particularly at the subnational level.

17 https://www.legis.md/cautare/getResults?doc_id=113032&lang=r

18 https://www.legis.md/cautare/getResults?doc_id=27024&lang=ro

Response teams and operational capacities for the SRH in emergency situations. At the national level, in accordance with the Ministry of Health Order No. 1505 as of 31.12.2014 on the Establishment of Health Care Teams for Intervention in Public Health Emergencies, the Republic of Moldova has specialized teams, including psychotherapeutic and obstetric-gynaecological teams, which can be mobilized to provide psychological support, emergency assistance in reproductive health, and management of sensitive cases in the context of the MISP implementation. However, analysis of the institutional framework shows that, at present, medical institutions have not yet created, equipped and maintained these teams in line with the provisions of the order so that they could be dedicated to sexual and reproductive health (SRH) interventions in emergency situations. The NPHA and GIES, for example, are institutions that have intervention teams but with a general mandate in public health or urgent medical interventions, and without an explicit focus on the SRH or MISP services.

Public health response teams, coordinated by the National Agency for Public Health (NPHA), are dedicated to combating public health emergencies, including undertaking sanitary and anti-epidemic measures to control communicable diseases, applying infection prevention and control (IPC) measures, and sanitary and hygiene measures to control chemical and radiological poisoning and contamination. At the same time, the teams of the General Inspectorate for Emergency Situations (GIES) are designed primarily to prevent and effectively manage emergency situations, including firefighting, extrication, first aid by SMURD (Mobile Emergency, Resuscitation, and Extrication Service), rescue of persons, damage limitation (floods, landslides, earthquakes) and intervention in various types of disasters (technological, radiological, nuclear, biological). At the same time, the pre-hospital emergency medical teams of the National Centre for Pre-hospital Emergency Medical Assistance (NCPMA) consist of emergency doctors and nurses, paramedics and ambulance drivers, specialised in triage and management of urgent cases and in assisted medical transportation. These teams are not systematically trained in the MISP components and do not have defined roles in specific SRH interventions.

An important precedent is the experience gained during the COVID-19 pandemic and the refugee crisis of 2022, when multidisciplinary mobile teams were set up with the support of the UNFPA and WHO. These included gynaecologists, psychologists, social workers and, in some cases, midwives, who were mobilised to intervene in regions with high pressure on the SRH services, particularly at the sub-national level. These teams provided gynaecological consultations, psychosocial support, assistance to victims of sexual violence, and information on reproductive health. However, their functioning is temporary in nature and not structurally integrated into the national emergency response system.

Specialised units in the field of gender-based violence (GBV), organised within the emergency departments of 11 hospitals, constitute another relevant segment of the national response infrastructure. These units have trained multidisciplinary staff — including obstetricians-gynaecologists, nurses and psychologists — with expertise in managing cases of rape and sexual violence, in accordance with the standardised national clinical protocol on the clinical management of rape cases, which is in force and has been developed in line with the international recommendations. However, the GBV units currently operate as separate hospital services, without being formally integrated into public health rapid response mechanisms or the national crisis response architecture. Such organisation limits institutional interoperability and intersectoral coordination capacity in emergency or large-scale crisis contexts, reducing the capacity for effective use of existing expertise and for ensuring a coherent and timely response for survivors of sexual violence.

Overall, the current situation reveals the existence of scattered professional resources, but not a coherent, permanent and institutionalised mechanism for the SRH interventions in emergency situations. This fragmentation reduces the capacity for rapid and coordinated mobilisation of specialists and highlights the need for structural consolidation of this area within the national response architecture.

Communication channels for informing the population about SRH/MISP services in emergency situations. The current situation highlights the existence of a diverse public communication ecosystem capable of supporting the rapid dissemination of essential information in emergency situations, including on the SRH and MISP. Although the existing mechanisms are robust, their systematic use for SRH-specific communication needs to be optimised and formally integrated into the response plans.

The official channels of the Government and the Ministry of Health constitute the main public information infrastructure in crisis situations. The Ministry of Health website, the platforms of the National Public Health Agency (NPHA) and the National Health Insurance Company (NHIC) are used to publish urgent warnings, operational instructions and news on the mobilisation of healthcare services. These platforms proved to be highly effective during the COVID-19 pandemic and the refugee crisis of 2022, when they were continuously updated. In addition, the official Facebook, Telegram and YouTube pages of the Ministry of Health and the NPHA enabled real-time messaging, reaching large segments of the population, including vulnerable groups.

A particularly valuable tool is the system of text messaging (SMS) through mobile phone operators. During periods of epidemiological risk, the authorities have used

this channel to send rapid alerts and health recommendations. Thanks to the almost universal coverage of mobile phone networks, this mechanism remains one of the most effective for immediately informing the population, including about the availability of the SRH/MISP services or changes in access to them.

Traditional media continue to play an essential role in rapid and widespread communication. Radio, especially regional stations, is an accessible source of information for rural communities and older populations, while public and private television can broadcast uniform messages nationwide. In crisis situations, these channels are frequently used to broadcast official briefings and messages concerning public health.

Social media and instant messaging apps are important tools for rapid dissemination of information to different segments of the population. Platforms such as Facebook, Viber, WhatsApp and Telegram are heavily used by both authorities and partner organisations, including the UNFPA and UNICEF, for reproductive health information campaigns. Community groups – especially those on WhatsApp and Viber – are widespread in rural and peri-urban communities and can facilitate the rapid circulation of messages concerning the access to SRH services, including referrals to nearby centres.

Hotlines are a direct channel of communication with an immediate impact on access to information. The hotline of the Ministry of Health, the thematic hotlines of the NPHA and dedicated services provided by the UNFPA, UNICEF and specialised NGOs offer both counselling and referral to the SRH/MISP services, including in cases of sexual violence, unplanned/unwanted pregnancy, family planning needs or youth healthcare services.

Community channels and NGO networks add up to the national communication infrastructure. Youth-Friendly Health Centres, women's organisations, relevant NGOs and community networks use printed information materials, community meetings, social media campaigns and support helplines to convey information tailored to vulnerable groups. In the times of crisis, these organisations have the capacity to reach areas with limited access to official information and can contribute significantly to directing the population towards essential SRH services.

Overall, the Republic of Moldova has a wide range of formal and informal communication channels that, if coherently integrated into national preparedness and response plans, can facilitate rapid, clear and accessible information for the population on the SRH/MISP services in emergency situations.

Barriers in accessing the SRH services for vulnerable and marginalised groups in the Republic of Moldova. Multiple population groups face persistent obstacles in accessing sexual and reproductive health (SRH) services. These barriers are structural, financial, social and cultural in nature, and their impact varies depending on the characteristics and vulnerabilities of each group. Overall, they reflect both the infrastructural limitations of the healthcare system and deeply rooted socio-economic disparities and stigmatising attitudes.

Women and girls with disabilities face considerable difficulties in accessing SRH services, mainly due to the poor physical accessibility of medical facilities, the lack of adapted equipment and the lack of training for staff on the provision of disability-friendly services. In addition, discriminatory perceptions about the sexuality of persons with disabilities can discourage the demand for and provision of necessary services.

Adolescents and young people continue to be affected by barriers related to consent, confidentiality and the lack of friendly services in rural areas. Limitations in the implementation of holistic sexual and reproductive health education in schools exacerbate their vulnerability, reducing their ability to access appropriate information and services.

Sex workers face stigma, discrimination and the perceived risk of reporting to the authorities, which significantly affects their access to the SRH services. The lack of dedicated services in rural areas and poor access to HIV and sexually transmitted infection (STI) prevention programmes amplify the health risks for this category.

SOGIESC (sexual orientation, gender identity and expression, and diverse sexual characteristics) people face institutional discrimination, negative attitudes from medical staff, and the absence of tailored services, especially for trans and intersex people. Fear of stigmatisation, lack of confidentiality and previous negative experiences lead to avoidance of the SRH services, even in situations of urgent need.

People living with HIV receive treatment and support through national programmes, including international partnerships, but continue to experience stigma and lack of well-integrated services that combine ARV care with the SRH services. Fragmentation of services leads to drop-outs and delays in accessing necessary interventions.

Refugees and migrants, especially those without documents, face language barriers, lack of clear information about available services, and administrative difficulties in accessing medical services free of charge. Their dependence on the NGOs and UN agencies for contraception, psychological support and reproductive health information highlights the need for more robust inter-agency coordination.

Ethnic minorities, particularly the Roma community, continue to be affected by poverty, social exclusion and low educational attainment, which limits access to the SRH information and services. Structural barriers are accompanied by cultural discrimination and stereotypes, which discourage people from seeking medical services and reduce the use of preventive interventions.

Overall, these barriers highlight the need to strengthen the inclusion policies, develop services tailored to vulnerable groups and reduce stigma at all levels of the healthcare system in order to ensure equitable access to the SRH services in the Republic of Moldova.

Access to the SRH services in crisis situations: legal framework, practical applicability and existing limitations. The current situation highlights the existence of a general legal framework that guarantees the access of the population to essential medical care, including in crisis situations. Law No. 411/1995 on Healthcare enshrines the right of all persons on the territory of the country to emergency medical assistance, without discrimination. Similarly, Law No. 212/2004 on the State of Emergency, Siege and War provides for the continuity of basic medical services for affected populations, establishing the obligation of the authorities to maintain the functioning of the healthcare system in exceptional circumstances.

In the context of recent crises — the COVID-19 pandemic and the massive influx of refugees from Ukraine in 2022 — the legal framework has been strengthened by Government Decisions and Orders by the Ministry of Health, which have clarified that access to medical services cannot be conditioned by the person's legal or administrative status. Thus, refugees and undocumented migrants have benefited from access to essential services based on special provisions issued by the authorities. Ministry of Health Order No. 212/2022 sets an important precedent, ensuring refugees free access to basic medical services, including obstetric and perinatal care.

During the COVID-19 pandemic, the Ministry of Health and the National Health Insurance Company (NHIC) issued orders classifying certain sexual and reproductive health (SRH) services, such as family planning, pregnancy and childbirth/obstetric care, as essential in order to prevent disruptions that could seriously affect women's health. During the refugee crisis, the UNFPA supported national authorities by providing the IARH kits necessary to provide the MISP for SRH and by organising mobile SRH teams operating at the sub-national level, facilitating rapid access to family planning services, psychosocial support and other services in the regions with the highest number of refugees.

However, analysis of the regulatory framework shows that, despite these ad hoc measures, there is still no explicit regulation in national legislation enshrining the systematic implementation of the MISP in all types of crisis situations. The application of the MISP depends largely on the mobilisation of international partners — in particular the UNFPA, WHO and UNICEF — and its temporary inclusion in response interventions, which limits the institutionalised nature of its implementation.

In addition to legal limitations, there are also practical barriers that affect the full implementation of the MISP. Underdeveloped infrastructure and a shortage of trained medical staff, especially in rural areas, reduce the capacity of institutions to provide SRH services on a continuous basis in crisis situations. The lack of a tailored national protocol on the MISP, in line with the operational realities in the Republic of Moldova, leads to fragmented and uneven implementation, especially outside projects implemented by international partners.

Overall, although the general legal framework guarantees universal access to medical services and there have been positive experiences in applying the MISP principles in recent crisis situations, the sustainable and comprehensive implementation of the MISP in the Republic of Moldova requires strengthening of the regulatory framework, integrating it into the national emergency preparedness policies and developing operational capacities at the healthcare system level.

CONCLUSIONS:

1. **Favourable pharmaceutical framework, with gaps concerning medical devices**. The majority of essential medicines included in IARH kits are also on the National List of Essential Medicines. This facilitates the rapid implementation of the MISP in emergency situations. However, the exclusion of medical devices and some consumables from the list (contraceptive implants, IUDs, MVA, condoms, rapid tests) requires the development of additional financing and supply mechanisms to ensure the continuity of the SRH services in a crisis.

2. **Remote SRH services are functional, but unevenly used.** The Republic of Moldova has telemedicine tools, online counselling and support lines that have proven useful in recent crises. However, their use remains uneven, influenced by digital infrastructure and territorial disparities.

3. **Operational capacity is in place, but insufficiently prepared for major crises.** Although centralised procurement mechanisms and a functional infrastructure for the provision of the SRH services are in place, structural gaps affecting the resilience of the system in epidemiological or humanitarian situations include the absence of a strategic stockpile dedicated to the SRH and formalised

response teams, as well as the missing integration of the MISP into national response plans.

4. **Fragmented and insufficiently institutionalised professional training**. The MISP is not integrated as a distinct module in university and residency training. Although the MISP components are addressed in continuing education, the dedicated module introduced with the UNFPA support is not consistently implemented due to low demand, perceived financial constraints, and the lack of a firm institutional decision on its annual maintenance. Dependence on external initiatives and online platforms limits the sustainability of professional training.

5. **Mobilisation of medical staff is possible, but not formalised for the SRH.** There are legal mechanisms for the deployment of medical staff in emergencies, but in the field of the SRH there is no institutionalised reserve staff, which leads to ad hoc mobilisations and reduces the capacity for rapid and coordinated response.

6. **Relevant expertise is in place, but it is poorly integrated operationally**. National emergency response structures do not include specialisations dedicated to the SRH, and the MISP competencies are not formalised in their mandates. The positive experiences of the SRH mobile teams and specialised GBV units demonstrate the capacity for institutionalising effective models, which require systemic integration into the national response mechanisms.

7. **Robust, but not formalized communication infrastructure for the SRH/MISP.** Official digital channels, mass media, SMS systems and community networks enable rapid dissemination of information in crisis situations. However, the lack of clear procedures for the specific communication with regard to the SRH/MISP limits the consistency and predictability of messages addressed to the population.

8. **Persistent inequalities for vulnerable groups.** Access to the SRH services remains affected by structural barriers, stigma and absence of tailored services for vulnerable groups. Significant dependence on the NGOs and international partners, as well as insufficient integration with related services (HIV, mental health, GBV), leads to fragmentation of care and limits the sustainability of interventions.

9. **Regulatory gap regarding the MISP in emergency situations.** Although the general legal framework guarantees access to essential medical care in crises, there are no explicit provisions on the implementation of the MISP for SRH.

Current implementation process relies on ad hoc orders and external support, which affects the predictability and resilience of the system. Strengthening the regulatory framework would allow for the full integration of the SRH into the national preparedness and response architecture.

RECOMMENDATIONS

1. **Broadening of the regulatory and procurement framework for the MISP products.** It is recommended to examine the opportunity to amend the national regulatory and procurement framework so that products necessary for the MISP implementation that are not included in the List of Essential Medicines, in particular medical devices and consumables used in emergency situations, are integrated into the national preparedness and response plans. An intersectoral approach, carried out in collaboration with relevant institutions and international partners, would strengthen the operational capacity of the healthcare system to respond promptly to the SRH needs in a crisis.

2. **Strengthening the framework for the remote delivery of the SRH services.** It is recommended to develop the regulatory framework and digital infrastructure for telemedicine, scale up dedicated platforms and provide continuous training for medical staff, with a focus on ensuring equitable access for rural populations and vulnerable groups. Integrating telemedicine as a standard tool in the healthcare system, including in emergency situations, will contribute to the continuity of the SRH services.

3. **Institutionalisation of the SRH services continuity in emergency situations.** It is recommended to create a consolidated national framework that includes: (i) a strategic stockpile dedicated to the SRH; (ii) multidisciplinary SRH response teams integrated into the national response mechanisms; (iii) operational continuity plans adapted to crisis contexts; (iv) formalised and predictable mechanisms for cooperation with international partners; and (v) explicit integration of the MISP into national preparedness and response plans. These measures will increase the resilience of the system and its capacity for rapid response.

4. **Formal integration of the MISP into the national medical training system.** It is recommended to maintain the MISP module, based on a unified curriculum, at all levels of medical training (university, residency, secondary medical education), as well as to ensure its annual inclusion in continuing vocational training programmes. In order to ensure the sustainability of staff capacity building, it is essential to strengthen training through digital platforms and resources adapted to the national context, and to create a permanent coordination mechanism between the Ministry of Health, medical education institutions, and international partners.

5. **Development of an institutionalised mechanism for the SRH reserve staff.** It is recommended to create a national mechanism for reserve staff, supported by a database of specialists trained in the SRH, available for rapid mobilisation in emergency situations. The development and approval of standardised protocols for the redistribution of tasks and the activation of mobile SRH teams will ensure the continuity and quality of services in the affected regions.

6. **Institutionalization of multidisciplinary emergency response SRH teams.** It is recommended that rapid response teams specialised in SRH be integrated into the existing structures of the Ministry of Health, NPHA and GIES, so that they can build on positive experiences from previous crises. Systematic training of these teams in the MISP components will enable a coherent and effective response. At the same time, strengthening operational links with units specialising in GBV will facilitate integrated interventions for survivors of violence.

7. **Formalisation of public communication on the SRH/MISP in emergency situations.** It is recommended that communication on the SRH/MISP be institutionalised in the national preparedness and response strategies and plans through standardised protocols defining key messages, institutional responsibilities and communication channels. Strengthening collaboration with the media, mobile phone operators, NGOs and community networks will ensure rapid, accessible and tailored dissemination of information, including to vulnerable groups.

8. **Reducing inequalities and ensuring equity in access to the SRH services.** It is recommended to implement minimum standards for accessibility, adapted communication and mandatory training of medical staff applying beneficiary-centred and human rights-based approaches. Developing the SRH services tailored to young people, persons with disabilities and persons from marginalised groups, expanding community services and mobile SRH teams, as well as strengthening intersectoral coordination mechanisms will contribute to reducing disparities. Monitoring based on disaggregated data should guide the continuous adjustment of public policies.

9. **Strengthening the regulatory framework for the implementation of the MISP in emergencies.** It is recommended to introduce explicit legal provisions guaranteeing access to the SRH services in accordance with the MISP in all types of emergencies. Making this commitment institutional will enable the transition from ad hoc interventions to a sustainable, predictable and integrated mechanism. This will strengthen the resilience of the healthcare system and align the Republic of Moldova with international SRH standards.

Objective 2:
Preventing Sexual Violence and Meeting the Needs of Victims

Regulations, protocols, policies

The Republic of Moldova ratified the Istanbul Convention on 14 October 2021, thereby strengthening the state's commitment to preventing and combating violence against women, including sexual violence. The lodging of the ratification instrument with the Council of Europe on 31 January 2022 and the entry into force of the Convention on 1 May 2022 marked the beginning of a comprehensive process of aligning the national framework with European standards, as well as the development of integrated measures designed to meet the needs of sexual violence survivors.

During the review period, from late 2021 to 2025, key documents were drafted and approved. These included the **Working Methodology and Working Instructions for the Intervention Team in Cases of Sexual Violence**[1], as well as Decision No. 223 as of 19.04.2023. The latter focuses on identifying victims of sexual violence, assessing their risks and needs, and referring them to specialised services and also includes coordinated intervention by the police and medical institutions.

Another significant step was the approval in 2021 of the **Standardised Protocol for the Clinical Management of Rape Cases**[2]. This was approved by Order No. 908 as of 30 September 2021 of the Ministry of Health and represents a uniform framework for the effective management of rape cases in medical institutions. The Standardised Protocol on Clinical Management of Rape Cases was developed by the staff of Nicolae Testemitanu SUMP, specialists in obstetrics and gynaecology, family medicine, paediatrics and forensic medicine.

Provisions on sexual and reproductive health and rights (SRHR) have been included in both **the National Programme on Preventing and Combating Violence Against Women and Domestic Violence for the period of 2023–2027**[3], approved in 2023, and in **the National Health Strategy "Health 2030"** of the Republic of Moldova (with the support of the UNFPA).

With the support of the UNFPA and WHO, a team of national experts developed **the draft National Programme on Sexual and Reproductive Health and Rights (SRHR) for 2023–2027**. The policy document aims to ensure universal access to sexual and

reproductive health services, including in humanitarian crisis situations, by applying innovative approaches to reach the most vulnerable groups. The programme focuses on improving the quality of healthcare by applying a human rights-based and beneficiary-centred approach, on informing and educating the population about the SRHR, and on coordination across sectors to address the sexual and reproductive health needs of the population, including in cases of sexual violence. It is important to note that the National Programme on the SRHR had not yet been approved at the time of writing of this report. The programme includes a costed action plan and a monitoring and evaluation framework. The costed plan provides for budget lines for purchases from the state budget, including contraceptives for those 12 vulnerable population groups, as well as kits for post-rape treatment for survivors of rape.

In 2024, the **Standard on the Organisation and Functioning of Clinical Management of Rape (CMR) Services** in Hospitals for the assistance of survivors of gender-based violence, including sexual violence was developed with the support of the UNFPA. This draft normative act was developed taking into account the main findings, conclusions and recommendations of the assessment, which was conducted in collaboration with the Mother and Child Institute. It is still to be approved.

In the same year, the WHO country office supported managers of medical institutions in developing **Standard Operating Procedures** for setting up clinical services for survivors of sexual and intimate partner violence. These SOPs were developed at the institutional level (institutional protocol) in line with the WHO guidelines on the clinical management of rape and intimate partner violence (CMR/IPV). The Standardised Clinical Protocol on the Clinical Management of Rape, which is in force at the national level was also drafted. Institutional protocols have been developed and approved in five medical institutions from Moldova: PMSI Emergency Hospital, Mother and Child Institute, Cahul District Hospital, Ialoveni District Hospital, Orhei District Hospital.

Also in 2024, the WHO country office came up with the initiative to develop **Regulations on the Procedure for Preventing, Examining and Reporting Cases of Harassment within the Ministry of Health, Public and Private Medical Service Providers, and Medical Education Institutions**[4]**.** Consultations were held with representatives of the gender equality coordination group within the Ministry of Health; heads of public and private medical institutions; the Rector of N. Testemitanu State University of Medicine and Pharmacy of Moldova; and the director of the Centre of Excellence in Medicine. The events brought together 66 participants (34 in the first workshop and 32 in the second) and aimed to present

the proposed regulation, and namely: the context and necessity of adopting the Regulation; the purpose, standards and national/international recommendations; the current regulatory framework (terminology and forms of sexual harassment), including provisions of the Labour Code; the procedure for preventing, examining and reporting cases of harassment in medical institutions; protective measures for persons making complaints. The approval of this regulation (Ministry of Health Order No. 173-PS2 as of 15 October 2025) is a significant step in the development of the regulatory framework for the prevention of sexual violence, contributing to the institutionalisation of protection mechanisms and their systematic application, including in medical institutions and medical education institutions.

In the context of aligning criminal legislation with the provisions of Directive 2011/92/EU of the European Parliament and of the Council of 13 December 2011 on combating the sexual abuse and sexual exploitation of children, as well as child pornography, and replacing Council Framework Decision 2004/68/JHA, the Ministry of Justice has drafted a law amending the Criminal Code with regard to the prevention and combating of the sexual exploitation and sexual abuse of children. The draft law was approved by the Government Decision as of 08.07.2024 and was registered in the Parliament under No. 223, being adopted in first reading on 11.07.2024. Also during the same period, Government Order No. 206d/2024 was approved, setting out the measures to be implemented in accordance with the Lanzarote Committee's recommendations for 2025-2026, as set out in the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse **(Lanzarote Convention)**. The set of measures provides for a series of actions to be taken to amend the regulatory framework in this area.

Between 19 and 21 November, the Republic of Moldova hosted the 46th Plenary Meeting of the Lanzarote Committee of the Council of Europe. The event was held under the auspices of the Presidency of the Republic of Moldova at the Committee of Ministers of the Council of Europe (November 2025 – May 2026) and brought together representatives of member states, non-governmental organisations and international partners.

The national mechanism for removing child sexual abuse materials from online environments was presented along with cooperation with the General Police Inspectorate and hosting providers. In the first half of 2025, the National Reporting Service for Online Child Sexual Abuse Materials recorded 1,246 reports, which led to the removal of over 2,000 illegal materials. The discussion also covered relevant statistics, best practices that have already been implemented, challenges that have been encountered, and recommendations that have been made[5].

Training of healthcare professionals

In **2022**, with the support of the UNFPA as part of the humanitarian response, **1,046 healthcare professionals** were trained in Clinical Management of Rape (CMR) through nine online information workshops conducted by teaching staff from Nicolae Testemitanu State University of Medicine and Pharmacy. The training was attended by: 171 specialist from the National Centre for Pre-hospital Emergency Medical Care and its territorial subdivisions; 172 professionals from the emergency, obstetrics-gynaecology and paediatrics departments of republican, municipal and district hospitals; 337 professionals from Reproductive Health Rooms, Youth-Friendly Health Centres and Community Mental Health Centres; 104 teachers from medical education institutions; 218 primary healthcare professionals from across the country; 44 specialists from the Forensic Medicine Centre and its territorial subdivisions[1].

In the same year**, 295 professionals** from hospital emergency departments subsequently received practical on-the-job training in the use of post-rape care kits (IARH No. 3 "Post-Rape Treatment"), donated by the UNFPA and distributed to public hospitals throughout the country, as well as to the network of Youth-Friendly Health Centres.

Specialists from hospital emergency departments (84 participants), Youth-Friendly Health Centres, Community Mental Health Centres, as well as the Forensic Medicine Centre and its territorial subdivisions (both in districts and in Chisinau municipality) received additional training in autumn of 2022, during four in-person training sessions on "Interdisciplinary Approach to Clinical Management of Rape: Questions and Answers", organised at the Mother and Child Institute.

Also in 2022, the Mother and Child Institute – a tertiary-level republican hospital institution, was designated by the Ministry of Health as the coordinating institution within the national healthcare system for the clinical management of rape. A **National support line for medical staff (080000008)** was created and has been operational 24/7 since July 2022. Representatives of the Mother and Child Institute have been providing advisory and methodological assistance to medical staff in hospitals and Youth-Friendly Health Centres on how to apply the provisions of the Protocol on the clinical management of rape. A total of 56 consultations were provided to medical staff through this support line in response to their requests in 2022.

At the same time, the Mother and Child Institute ensured the monitoring of stocks of post-rape assistance kits (Kits No. 3 "Post-Rape Treatment") in medical institutions that provide CMR services for rape survivors, as well as their replenishment throughout the year, as needed.

In addition, **125 specialists** (including staff from the National Forensic Medicine Centre and its territorial subdivisions, Youth-Friendly Health Centres, Community Mental Health Centres, and hospital emergency departments) received training in an interdisciplinary approach to the clinical management of rape in 2023. This training was organised by the Mother and Child Institute and took place face-to-face.

290 primary healthcare professionals were trained in the clinical management of rape. As a result, 88% of primary healthcare institutions contracted by the NHIC in 2023 have at least one healthcare provider trained in this field. The training was carried out by Nicolae Testemitanu State University of Medicine and Pharmacy with the support of the UNFPA.

In May 2023, the World Health Organisation Country Office supported the organisation of specialised trainings for managers of medical institutions, focusing on the application of the Standardised Clinical Protocol on the Clinical Management of Rape Cases. The training sessions aimed to strengthen the managers' knowledge of coordinating medical interventions, correctly applying clinical procedures and ensuring a uniform response at the institutional level. Particular emphasis was placed on mechanisms for referring survivors to specialised services, respecting the principles of a victim-centred approach, and the essential role of medical institution management in implementing an effective, safe, confidential and well-coordinated pathway for those affected by sexual violence.

Between 13 October and 17-20 October 2023, the initial training consisting of 40 hours was organised for the staff of the Regional Integrated Service for Victims of Sexual Violence on the multidisciplinary response to cases of sexual violence. Between 31 October and 16 November 2023, information sessions were organised for multidisciplinary teams from 12 localities in Ungheni district. These sessions covered the concept of Ungheni Regional Integrated Service, the assistance it provides, how the Service is organised and functions, and how local multidisciplinary teams can cooperate with it. A total of 88 professionals (75 women and 13 men) were informed during the session. In November 2023, a training seminar on investigating sexual offences was organised for prosecutors and heads of PDs from six districts, with 29 people (eight women and 21 men) being trained[7]. In April 2023, the Ministry of Internal Affairs held four training workshops entitled "Sexual Offences: Enforcement of Legislative Amendments". The workshops were attended by 104 (53 men and 51 women) police employees, 72 criminal investigation officers, and 32 investigative officers.

In October 2023, the GIM, in partnership with the IOM and UNHCR, held a training workshop on "Prevention of Sexual Exploitation and Abuse" (PSEA) as part of the "Operational Assistance for Moldova" project implemented by INTERPOL. The workshop was held by INTERPOL experts together with two experts in the field of sexual crime investigation from the PI. Twenty-four GIM employees were trained during the event. The objective of the workshop was: to raise awareness and strengthen the capacity of the authorities of the RM to manage sexual offences committed against vulnerable communities/beneficiaries of assistance, with a focus on prevention, detection, recognition and response to sexual exploitation and abuse, using a victim-centred approach in accordance with fundamental humanitarian principles and without harmful effects[8].

In 2024, the UNFPA supported the further strengthening of the resilience of medical institutions in responding to the needs of survivors of sexual violence through the application of an integrated, beneficiary-centred approach. As a result**, 184 healthcare professionals** (staff of the National Centre for Pre-hospital Emergency Medical Care) were trained in the clinical management of rape cases (the result achieved in collaboration with the Mother and Child Institute). In 2025, the UNFPA continued to strengthen capacities of healthcare institutions in the clinical management of rape by training 50 professionals as sub-national focal points for CMR/clinical management of rape cases.

In May 2024, the International Organisation for Migration, in collaboration with the Ministry of Labour and Social Protection, set out the objectives to strengthen the capacities of frontline responders, plan and implement a long-term strategy, scale up and strengthen existing protection mechanisms, and improve inter-institutional coordination as part of the project "Strengthening the National Capacities of the Republic of Moldova to Provide Quality Protection, Education, Health and Socio-Economic Opportunities for Ukrainian Refugees", funded by the European Commission Service for Foreign Policy Instruments. In this context, the IOM supported the Government in developing and implementing the new National Referral and Management Mechanism for Victims (NRMVC) Programme and its implementation plan, and organised training for multidisciplinary teams working within the NRMVC at the local level to improve the provision of assistance to refugees and third-country nationals (TCNs) within local communities (including refugees), including by the provision of services to victims of rape.

Throughout 2024, the Ministry of Education and Research collaborated with UNICEF and the IC "La Strada" to organise activities aimed at strengthening the capacities of youth centre employees in responding to cases of online violence. Seven training workshops were organised, with 150 specialists and volunteers attending. These

activities aimed to inform participants about online safety and provide them with the necessary skills to respond effectively to cases of online sexual abuse.

In November 2025, IC "La Strada" organised a Workshop Training of National Trainers - Multidisciplinary Response to Cases of Sexual Violence, for professionals in the social, medical, legal and law enforcement fields, with a comprehensive programme addressing the multidimensional phenomenon of sexual violence in order to create a national network of trainers on the multidisciplinary response to cases of sexual violence in the Republic of Moldova. The training workshop is organised by the International Centre "La Strada", in partnership with the National Agency for the Prevention and Combating of Violence Against Women and Domestic Violence (NAPCV), with the support of Danish research centre KVINFO and the Embassy of Denmark to Chisinau[1].

Renovations/Facilities/Equipment/Consumables

In addition to the post-rape assistance kits provided and distributed within the national healthcare system in 2022, the capacity of medical institutions to respond to the needs of survivors of sexual violence was further strengthened in 2023 with the support of the UNFPA. Thus, **the Forensic Examination Unit for survivors of physical and sexual violence**, within **the Forensic Medicine Centre**, was renovated and equipped with state-of-the-art medical and forensic equipment.

A **network of specialised GBV units** has been set up in **11 hospitals across the country** to provide an integrated, multidisciplinary response to cases of sexual violence. These include offices equipped with cutting-edge medical equipment, such as gynaecological chairs adapted for examination of women and girls with disabilities, and sampling kits for forensic examinations. There are also rooms for psychological counselling of rape survivors, equipped with the necessary furniture and equipment. Standard sets of equipment, modern and high-quality medical devices and consumables have been provided in **gynaecological examination rooms** in other **26 hospitals**. These include gynaecological chairs adapted to the needs of women and girls with disabilities.

Beneficiary-centred services

In recent years, several initiatives have been developed to improve support for victims of gender-based violence, including sexual violence and rape, with a view to ensure a coordinated and effective response. A relevant example is the project launched in 2021 by the National Centre for Child Abuse Prevention (NCCAP), with the support of the UNICEF Moldova, which aims to adapt the Barnahus model in the Republic of Moldova. This model, which is well established in the Nordic countries,

integrates all the services needed by children who are victims or witnesses of sexual abuse, domestic violence or human trafficking into a single space — from medical examination and psychological counselling to legal support and social protection. This approach aims to reduce secondary traumatisation and speed up access to appropriate support. The implementation of the Barnahus model is a significant step towards strengthening the multidimensional response to child protection. It contributes to the increased effectiveness of interventions undertaken by state and non-governmental organisations for the benefit of the most vulnerable.

Another important initiative in support of victims of sexual violence was the launch in 2023 of **the Specialised Service for Victims of Sexual Violence in the municipality of Ungheni**[10], as part of the EVA project aimed at promoting gender equality in the districts of Cahul and Ungheni, funded by the European Union and implemented by the UN Women in partnership with the UNICEF. The Specialised Service offers victims of sexual violence a wide range of integrated services, all provided under one roof, facilitating quick and efficient access to medical, psychological, legal and social assistance. The main purpose of this service is to create an environment where victims can receive the necessary support in a coordinated manner and without having to travel between different institutions. This reduces additional trauma and improves the effectiveness of interventions, ensuring a faster recovery and easier social reintegration. This initiative is further proof of the commitment of international authorities and organizations to support victims of sexual violence and promote gender equality. It also has a significant impact on the community in the targeted regions and on the entire victim protection system in the Republic of Moldova. In its first two years of operation, the Service provided assistance to **101 women**, including **49 survivors of rape**, **23 survivors of attempted rape** and **29 women affected by domestic violence** who required psychological assessment at the request of the prosecution authorities. Most of the victims (**88%**) came from rural areas, with the highest number of cases recorded in **Ungheni (51%)** and **Nisporeni (18%)**, and fewer cases reported in other districts.

The establishment and operation of the Integrated Regional Service in Ungheni represents a significant step towards fulfilling by the Republic of Moldova of commitments under the Istanbul Convention. The GREVIO Committee welcomed the establishment of this specialised service and stressed the necessity to scale up the pilot model implemented in Ungheni to other regions of the country so that victims of sexual violence can benefit from support services regardless of where they live.

The Family Justice Centre, also known as the Centre for the Prevention and Combating of Domestic Violence and Gender-Based Violence, was created in the Republic of Moldova as part of a project financially supported by the US Department of State and the Criminal Justice and Law Enforcement Section of the US Embassy in Chisinau. The centre aims to strengthen the capacity of the justice system to prevent and combat domestic and gender-based violence, while providing a comprehensive and coordinated response for victims of violence, including sexual violence. Those affected have access to legal assistance, counselling, psychological support and social support in a single setting, thus facilitating prompt and effective intervention. The implementation of this project highlights the ongoing commitment of national authorities and international partners to protect victims and develop a safer and more supportive environment for them.

In January 2024, UN Women advocated for and supported the establishment of the first National Agency for the Prevention and Combating of Violence Against Women and Domestic Violence (NAPCV), with financial support from the European Union. The National Agency for the Prevention and Combating of Violence Against Women and Domestic Violence has strengthened its operational efficiency to effectively fulfil its mandate. The capacity of the Agency has been strengthened through the implementation of a tailored strategic communication plan, which is designed to deliver powerful messages on preventing and responding to gender-based violence.

One of the conclusions of the Report on the assessment of progress in strengthening national capacities for preparedness and response to humanitarian crises, exceptional situations or public health emergencies through the provision of the Minimum Initial Service Package for Sexual and Reproductive Health (MISP) in 2021, was that despite the existence of several legal provisions describing the rights of victims of sexual crimes, there was no clear, well-defined, cross-sectoral mechanism for reporting cases of sexual violence. The majority of actions are carried out by individual professionals, lacking an effective mechanism for collaboration and a well-coordinated response from specialists in the fields of law enforcement, medicine and social services. Currently, there have been visible improvements in this area, although certain gaps remain, and the provision of services for rape victims remains uneven at the national level. However, collaboration between state institutions and non-governmental organisations has become more effective. Victims are now referred to specialised NGOs according to their age and needs, avoiding automatic and bureaucratic referrals to other institutions.

All developed and approved Instructional Protocols on the Clinical Management of Rape cases have an annex with the contact details of relevant institutions providing legal, psychological, shelter and other services. Further details can be found in the

Report entitled "Assessment of the Quality of Services Provided by Public Health Institutions, particularly Inpatient Medical Care (IMC), to Victims/Survivors of Sexual Violence/Rape"[11].

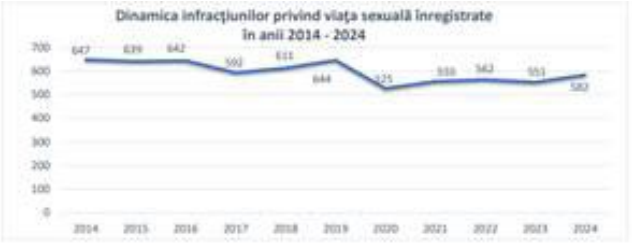
In 2024, IC "La Strada" became a full member of the global INHOPE network, thus joining other services of this type around the world in the rapid identification and removal of child sexual abuse materials from the virtual space in order to ensure a safe and clean internet for children. These reporting services work without borders, offering everyone the opportunity to report illegal content anonymously and securely, regardless of their geographical location. Close collaboration between these services helps to create an effective global network that facilitates the rapid exchange of information, resources and best practices, thus contributing to a faster and more coordinated response to online abuse. In 2024, the Hotline SigurOnline (Safe Online) recorded 11,894 reports and 29,620 pieces of child abuse material were removed from the virtual space[12].

The National Agency for the Prevention and Combating of Violence Against Women and Domestic Violence (NAPCV), in partnership with the UNFPA Moldova, has brought the issue of technology facilitated violence to the public agenda. In the context of recent abuses in Telegram groups, which involved the illegal distribution of photos and videos with sexual content, specialists in combating gender-based violence, authorities and civil society discussed future strategies to prevent and combat this growing phenomenon. Experts identified the need to involve the private sector from the tech field and make them accountable for cybersecurity measures, including confidentiality and personal data protection. The proposals made during the meeting will be included in a strategic plan of the National Agency for the Prevention and Combating of Violence Against Women and Domestic Violence, which will be developed in collaboration with ministries, civil society and international organisations to provide effective protection in the online environment.[13]

Statistical data/Magnitude of the problem

Data from the Assessment Report on MISP for 2021 show that relatively consistent statistics on cases of violence, including sexual violence, are collected and analyzed by the Ministry of Internal Affairs. The data collected in different sectors are not harmonised in terms of common indicators, and in some sectors there is a lack of relevant indicators. In the medical sector, there is currently no indicator for collecting data on cases of rape or suspected rape recorded in inpatient wards or emergency departments of hospitals. At the time of writing this Report, the situation remains the same.

The Centre for Forensic Medicine publishes annual data on the number of forensic examinations. Thus, 555 examinations related to sexual violence were performed in 2022, 455 examinations in 2023, and 488 forensic examinations in 2024[14].



The General Prosecutor's Office has recorded an increase in sexual offences against adults and children, with 582 cases logged in 2024 — the highest number of cases in the last five years. The number of reported rapes is also the highest in the last five years. It is 296 cases for 2024.

The National Centre for the Prevention of Child Abuse presents data obtained from the General Police Inspectorate for 2024 concerning minors. Thus, in the case of child victims, there were 217 reports of sexual violence (192 girls and 25 boys), of which: - under the age of 13 – 86 children (64 girls and 22 boys); - aged 14-15 – 99 children (99 girls and 0 boys); - aged 16-17 – 32 children (29 girls and 3 boys).

Of the number of children who were victims of sexual abuse, domestic violence and trafficking, 536 children were identified as victims of crime in 500 criminal cases, namely: sexual abuse – 399 child victims in 386 criminal cases.

	Number of crimes	Number of victims
Sexual abuse	**362**	**372**
Art. 171 Rape	150	153
Art. 172 Violent actions of a sexual nature (Non-consensual actions of a sexual nature)	63	70
Art. 173 Sexual harassment	23	23
Art. 174 Sexual intercourse with a person under the age of 16 (Sexual act with a person under the age of 16)	105	105
Art. 175 Perverted actions (Sexual actions committed with a person under the age of 16)	10	10
Article 175[1] Solicitation of a minor for sexual purposes	4	4

At the same time, while the number of criminal cases related to the solicitation of minors for sexual purposes increased significantly in 2023, rising by more than twofold compared to the previous year, this figure decreased in 2024, returning to the level recorded in 2022. [16]

The General Police Inspectorate recorded a 10% increase in sexual violence cases in 2024 compared to 2023, with 266 cases in 2024 versus 242 cases in 2023. According to the same report, the GPI identified the perpetrators in 57% of sexual offence cases during criminal prosecution and investigation activities.[17] According to the Activity Report of the General Prosecutor's Office for 2024, 386 criminal cases were initiated for sexual offences involving 399 children victims (compared to 347 cases involving 339 children victims in 2023). In 2024, the General Prosecutor's Office analysed the effectiveness of the practice of investigating sexual violence offences. Following checks carried out by a higher supervisory authority, which found that the criminal investigation body had failed to ensure that the rights of victims of crime relating to sexual life and domestic violence were respected during criminal proceedings, the General Prosecutor's Office issued written instructions on taking procedural measures to ensure that victims are informed of their rights, referred to the authorities and institutions available to provide them with assistance, and informed of the support services they can benefit from (medical assistance, psychological counselling, shelter services, legal assistance). Ensuring their access to the necessary assistance and protection would guarantee effective access to justice, early identification and intervention in cases of domestic violence, and would encourage them to participate in the administration of evidence in order to hold perpetrators accountable and prevent violence.

Relevant studies in the field provide data showing that the magnitude of the phenomenon is much greater than that presented in the official statistics available. According to the HBSC Moldova Study (2022), 3.2% of 15-year-olds reported engaging in sexual relations with someone at least five years older than themselves within the previous 12 months[18]. In 2024, the NCCAP, in partnership with the General Directorate for the Protection of Children's Rights, provided psychosocial assistance and rehabilitation services to children victims of violence in Chisinau municipality. A total of 191 children (109 girls and 92 boys) who were victims of psychological, physical and sexual abuse and exploitation benefited from this service during the year.

The Ministry of Labour and Social Protection mentions this in its Annual Progress Report (2024) on monitoring the implementation of the National Child Protection Programme for 2022-2026. **The National Mechanism for Reporting Child Sexual Abuse Materials** was developed with the support of the IC "La Strada" and development partners UNICEF and IOM (with the assistance of the US Embassy in Chisinau). Development partners have guaranteed the continued operation and sustainability of this service, contributing to its effective implementation and maintenance in the long term.[19]

In 2024, the Ministry of Internal Affairs developed a profile of victims in cases of sexual exploitation. The following characteristics were identified: 100% women; vulnerable age: 19-35 years; origin: rural environment for most victims; social status: from a socially vulnerable family (no permanent source of income, incomplete/without one parent or with many children in the family, or with parents dependent on alcohol); education: level of education does not exceed secondary education; systematic departures abroad due to social vulnerability.

In November 2025, the Government of the Republic of Moldova approved the draft decision on the Concept of the Information System "VioData State Register"[20] and the related Regulation, which sets out the functioning of this national register. The new integrated information system aims to collect, record, monitor and report cases of violence against women and domestic violence. According to the authorities, implementing "VioData" will enable better coordination between state institutions, strengthen intervention capacities, and establish a standardised database for analysing and planning of public policies in this area. The register will include the functional and organisational structure of the system, the types of data collected, information flows and cybersecurity measures. At the same time, the processes of recording, updating, accessing and sharing data will be regulated, keeping a history and traceability of interventions. The protection of personal data, especially of minors and other vulnerable categories, is guaranteed in accordance

with the national and European standards. The Government emphasises that using automated national indicators reporting systems will reduce administrative burdens and the risk of errors for institutions, while increasing efficiency and public confidence in the way the state handles cases of violence. The implementation of "VioData" is an important step towards strengthening victim protection and streamlining the institutional response in the field of preventing domestic violence and violence against women.

Assessment of services

In 2024, a national assessment was conducted to identify the strengths and remaining challenges faced by the healthcare system, particularly by public healthcare institutions within inpatient medical care (IMC) in managing rape cases. The assessment also aims to identify solutions to improve the medical and psychological care provided to victims and survivors of rape. This assessment contributes to improving the institutional response to cases of sexual violence, facilitating the implementation of effective protection and intervention measures for victims. The report "Assessment of the Quality of Services Provided by Public Health Institutions, Particularly Inpatient Medical Care (IMC), to Victims/Survivors of Sexual Violence/Rape" highlights the progress made so far and the need to further strengthen capacities (result achieved in collaboration with the UNFPA, the Mother and Child Institute and N.Testemitanu SUMP). The report was presented to the MoH of the RM and discussed with all actors involved in providing services to rape victims[21]. The conclusions of the above-mentioned report are comprehensive and have been grouped into sections as follows:

- **Quality and uniformity of services for rape victims remain uneven at the national level.** Although most institutions have the infrastructure, equipment, and protocols in place, their implementation varies. There are still gaps in the availability of trained medical staff, the absence of operational procedures in all institutions, lack of psychologists, an insufficient number of forensic pathologists (especially women) and ambiguities regarding informed consent in the case of minors. In some situations, doctors do not participate in forensic examinations, which affects the quality of interventions.
- **The victim-centred approach is often subordinated to legal requirements and regulatory barriers.** Mandatory reporting of cases to the police remains a major obstacle to accessing assistance and discouraging victims from seeking help. The victim's journey — especially in the case of children and adolescents — often remains unclear, fragmented and insufficiently

coordinated. The victim/survivor-centred approach involves reducing the number of examinations, referrals and interviews. Healthcare providers often have in place and provide victims with information on referral options for other types of services — legal, psychological, shelter, etc.

- **Inter-institutional cooperation has improved, but remains insufficiently consolidated.** There has been progress in collaboration between healthcare, police, forensic medicine, YFHC, CMHC and NGOs, but vertical and horizontal coordination is still incomplete. There are not enough specialists (forensic pathologists) in each district, which requires additional referral of victims, longer waiting times and hinders access to prompt medical services. CMHCs are not adequately integrated into the victim's journey, and the absence of case managers limits the continuity of services and personalised referral. Also, sometimes the follow-up of victims after they leave the medical institution where they received post-rape emergency medical care is problematic, because some do not want to be monitored by their family doctor according to their residence visa, because they live in another region, or for reasons of confidentiality. Other victims, due to lack of knowledge or information, do not seek follow-up visits to prevent the consequences of sexual violence.
- **Access to specialised services remains limited in critical situations.** Non-stop services (including at night and on weekends) are insufficiently developed (in rural areas, for example), affecting rapid intervention. Stocks of medicines and consumables (post-rape kit no. 3) may be depleted (e.g. ARV therapy is out of stock because some donated medicines have already expired and have been withdrawn by the Dermatology and Communicable Diseases Hospital, and others have not been brought in to replenish kits/stocks in hospitals). Institutions have to request antiretroviral drugs and replenish stocks.
- **Underreporting, stigmatisation and lack of public education on sexual violence persist.** Children and adolescents are particularly vulnerable. Stigmatisation, fear of the police, distrust of institutions, and a lack of informational materials can all contribute to delayed or avoided access to medical services. Information and awareness campaigns have to be more intensive.
- **There is still a great need to strengthen professional capacities.** There is a need for continuous training for medical and non-medical staff, including nurses, updating of the Standardised Clinical Protocol (this can be done after amendments are made to the legal framework to replace the

provisions on mandatory reporting of cases of sexual violence involving adult victims with provisions on **voluntary reporting** so as not to restrict their access to medical services), developing internal plans for implementing the SCP, and clarifying roles within multidisciplinary teams. Providers request the inclusion of services for victims of sexual violence (those not covered by the compulsory health insurance system in the Republic of Moldova) in the category of socially-determined diseases, for full financial coverage of services by the Government.

Mandatory reporting

As noted in the aforementioned Assessment Report, in the opinion of healthcare professionals the mandatory reporting of rape cases remains a barrier to victims of rape accessing assistance. In 2022, an "Analysis of the Legal Framework Concerning Mandatory Reporting of Gender-Based Violence (GBV) in the Republic of Moldova" was carried out as part of the Technical Guidelines of the Gender-Based Violence Sub-Sector Working Group (GBV SWG) for the prevention of and response to gender-based violence in humanitarian contexts (with support from the WHO, UNFPA, UN Women and others). The document was drafted by the members of the GBV Working Group, with facilitation from the UNFPA. Since 2023, the WHO Office in Moldova has had various initiatives on this topic, initiating advocacy actions to eliminate mandatory reporting in cases of gender-based violence (GBV) in the Republic of Moldova. So far, no systematic analysis has been carried out in Moldova to demonstrate whether mandatory reporting contributes to addressing impunity or reducing crime, or whether it is the main reason why victims do not access services. Internationally, mandatory reporting mainly applies to child abuse in many countries, while in others, this provision has been extended to include adult women. However, this extension must respect all the pillars/principles of a victim-centred approach: autonomy, confidentiality, informed consent and choice.

On the one hand, current national legislation stipulates that medical staff is obliged to report cases of domestic violence to the police when the life or health of the person is in danger, even in the context of medical confidentiality. The reporting obligation applies to medical staff in all medical institutions, regardless of whether the healthcare provider is public or private.

On the other hand, "GREVIO continues to urge the authorities of the Republic of Moldova to ensure that women victims of violence do not experience delays or obstacles in accessing medical care due to reporting requirements. We must ensure that the reporting threshold remains high by monitoring victims' access to and use of services following the reporting of offences" (Excerpt from GREVIO's baseline

assessment report for the Republic of Moldova, published on 26 October 2023. Paragraph 249).

The UN inter-agency guidelines, developed by the WHO, UN Women, UNFPA, UNDP and UNODC, also strongly discourage/do not recommend mandatory reporting. However, healthcare providers are advised to report any case of violence to the relevant authorities, including the police, if the victim wishes to do so and is aware of her/his rights.

Thus, in the above-mentioned context, a round-table discussion on 'Mandatory reporting of cases of violence against women by healthcare providers' was held on 27 May 2024. This event was organised by the National Agency for Preventing and Combating Violence Against Women and Domestic Violence, in partnership with the World Health Organisation. The event brought together representatives of the Parliament of the Republic of Moldova, relevant ministries, the Office of the Ombudsman, the Forensic Medicine Centre, healthcare providers, civil society organisations, development partners of the Republic of Moldova, independent experts and human rights defenders. The discussion focused only on cases where the victims are adults with full legal capacity and discernment. As part of the analysis presented at the round table "Analysis of the Regulatory Framework Governing the Mandatory Reporting of Rape Cases in the Healthcare System of the Republic of Moldova" (2024), the WHO representative put forward the following arguments:

"Mandatory reporting on adult women is NOT recommended. Evidence shows that mandatory reporting is a barrier for women seeking medical assistance. Why?

- Women often do not want to report their husbands or intimate partners, on whom they depend financially or with whom they have children. They want to stop the violence, but not necessarily put them to prison.
- It is important that any healthcare sector intervention restores their decision-making capacity, empowerment and autonomy, but mandatory reporting fails to restore that capacity or respect women's autonomy and choices.
- Instead, the WHO recommends that service providers offer to help women report if survivors wish to do so and do everything possible to facilitate reporting".

Thus, it is important to strike a balance between encouraging the reporting of cases of gender-based violence without infringing on the rights of victims. Unlike medical practice, where personalised treatment is preferable, individual approach is not

possible in legal practice. The legal provision needs to be revised and detailed so that a balance can be identified that ensures both the rights of the individual and the obligation to report in specific cases. If mandatory reporting by the healthcare system is removed without ensuring that services empowering the victim are in place during the reflection period necessary for making a decision, and without guaranteeing the collection and storage of biological evidence vital for proving the perpetrator's guilt in court, this will create conditions in which individuals who have not been punished in a timely manner are likely to repeat the offence, and the state will be blamed for inaction.

Following the round table held in 2024, it was decided to launch a national study entitled "**The Response of the State to the Needs of Victims of Sexual Violence in the Period of Deciding to Report the Case to Law Enforcement Authorities",** which is necessary to inform subsequent public policy measures. The study is carried out by the National Agency for the Prevention and Combating of Violence Against Women and Domestic Violence in partnership with the Ministry of Health and the Ministry of Internal Affairs, with the support of the World Health Organisation Country Office. The purpose of the research is to assess the needs of victims of sexual violence, as well as the capacity of the state and the medical system to respond to these needs, particularly with regard to the collection and storage of biological evidence during the period when the adult victim decides whether to report the case to law enforcement agencies. The main data collection tool is a questionnaire addressed exclusively to professionals involved in the victim assistance, aimed at identifying good practices, structural barriers, legislative gaps and possible regulatory solutions. The answers are anonymous and will enable relevant recommendations to be made for improving the institutional response. The research methodology included: collecting administrative data; distributing questionnaires to criminal investigators, prosecutors, judges, doctors, and forensic pathologists; conducting 14 focus groups with doctors and forensic pathologists from various medical institutions; conducting 14 documentation visits to medical institutions for direct observation of how cases of sexual violence are handled. In total, questionnaires were filled in by: 28 forensic pathologists, 95 criminal investigation officers, 24 judges, 158 doctors and 38 prosecutors. The last documentation visits were carried out on 30 and 31 October 2025. The study is currently in the data analysis and processing stage and is expected to be completed in December 2025.

Strengthening the capacity of hospital emergency units to respond to cases of sexual violence in a multidisciplinary and comprehensive approach

With the support of the UNFPA, the Ministry of Health has established 11 units to assist victims of violence, including sexual violence, within hospital emergency departments. These units are strategically located throughout the country in 11 medical institutions. Their purpose is to provide immediate assistance to victims of sexual violence in a friendly and confidential environment, to avoid revictimization and ensure access to services in accordance with the provisions of the Standardized Clinical Protocol for the Clinical Management of Rape Cases in force at the national level. The assistance units for victims of violence operate 24/7 and are designed as specialised spaces for gynaecological examinations and the provision of necessary medical care, as well as psychological counselling, being strategically integrated into the Emergency Department of medical institutions. Thus, these units are strategically positioned to provide vital interdisciplinary assistance and interaction/ referral to other services as needed. Hospital units operate on the basis of an integrated approach in assisting victims of sexual violence. This approach focuses on the unique needs of beneficiaries, respecting the principles of confidentiality and safety.

The report for 2023 on actions taken and results achieved, in order to implement the Action Plan for the National Programme on Preventing and Combating Violence Against Women and Domestic Violence for 2023–2027, provides for an annual analysis and assessment of practices used to investigate crimes of violence against women, sexual violence and domestic violence. Between January and June 2023, the Prosecutor General's Office analysed the practice of investigating and prosecuting rape and other sexual offences. The study analysed criminal proceedings, including cases that were not brought to trial, as well as the sentences delivered by courts for offences in this category. The conducted study revealed violations committed by some prosecutors and representatives of criminal investigation bodies, including: failing to ensure the promptness and effectiveness of investigations; failing to clarify all the circumstances of cases involving rape and other sexual offences; conducting superficial and incomplete investigations of reports concerning sexual violence against vulnerable persons (e.g. persons with disabilities, the elderly and persons in state custody); delaying the prosecution and trial of cases in court; and erroneously individualising criminal penalties when representing the prosecution on behalf of the state. In view of the above, in order to ensure the quality of the prosecuting authority's work in investigating and representing the prosecution in criminal cases involving rape and other sexual offences, the Prosecutor General's Office (PGO) has drafted Recommendations requesting organisational and hierarchical control

measures. These measures are intended to ensure that investigations and the representation of the prosecution comply with the efficiency standards required by the national and international legislation, thereby enabling the effective prevention and combatting of sexual violence from the standpoint of respect for fundamental human rights [22].

Information/Education

In 2022, with the support of the UNFPA, the **online communication campaign on sexual and reproductive health and rights** aimed at the general public was expanded through Gyneco.md platform and covered topics such as the clinical management of rape.

Together with development partners, civil society, government authorities and opinion leaders, the UNFPA Moldova launched a national appeal in 2023 to combat sexual violence, recognise the seriousness of this problem and identify common solutions to prevent new cases of rape and provide a holistic response to the needs of survivors. The UNFPA, in partnership with the Government and the Parliament, IC "La Strada" and Women's Law Centre, launched the social awareness and mobilisation campaign against sexual violence "Prinde aripi. Set Free", which promoted zero tolerance for sexual violence, amplified the messages of the #UntoldStories campaign through service providers, and encouraged a more empathetic and supportive attitude toward survivors of sexual violence.

In 2024, dozens of influential men in the Republic of Moldova – decision-makers, artists, sportsmen, ambassadors, businessmen, lawyers, opinion leaders – took a proactive stance against digital violence and joined an online manifesto launched by the United Nations Population Fund (UNFPA) in partnership with the National Agency for the Prevention and Combating of Violence Against Women and Domestic Violence (NAPCV), as part of the "16 Days of Activism against Gender-Based Violence" campaign[23]. Under the slogan "United against digital violence against girls and women!", men have posted black-and-white photos on social media, promoting a positive public discourse in favour of equality and mutual respect, highlighting solutions and measures needed to increase the protection of girls and women in the digital space. Under the hashtag #bodyright, men call for the protection of images of the human body on the internet and condemn all forms of misogyny and online harassment.

Between 2022 and 2025, the UN Women ran and supported awareness-raising and prevention campaigns in collaboration with various partners to combat harmful social norms and raise public awareness. In 2024, the awareness campaign **"Do you see me? Believe me. Stand with me"**, carried out by the UN Women in the

context of the 16 Days of Activism against Gender-Based Violence (GBV) — from 25 November (International Day for the Elimination of Violence against Women) to 10 December (International Human Rights Day) — generated a total of **1,905,431 online interactions**. The campaign aimed to highlight the realities of gender-based violence and stimulate community engagement. It included visually striking art installations and interactive testimonies from women and survivors of gender-based violence, helping to shift the narrative from silence and stigma to active engagement and social change. The campaign was implemented in partnership with the Government of the Republic of Moldova, the National Agency for the Prevention and Combating of Violence Against Women and Domestic Violence (NAPCV) and with financial support from the European Union, Sweden and Denmark.

- Between January and December 2024, a total of 7,404 women and girls (including 7,314 women and 90 girls) had access to information, goods and services through the partnership between the UN Women Moldova and specialised civil society organisations (CSOs). This initiative aimed to provide multisectoral, gender-sensitive services to individuals and communities affected by the crisis, within the framework of the Ukrainian Refugee Response Plan (RRP), with financial support from the Women's Peace and Humanitarian Fund (WPHF). It is noteworthy that 30% of the beneficiaries, i.e. 2,156 people, are women and girls who are refugees from Ukraine.
- Throughout 2024, through the Women's Peace and Humanitarian Fund (WPHF), 1,732 women and girls, including 263 refugees, were trained and empowered with knowledge on Gender Equality in Humanitarian Action (GEiHA), which includes concepts such as Gender-Based Violence (GBV) and Protection from Sexual Exploitation and Abuse (PSEA). In addition, 1,612 women developed leadership skills and 120 professionals were trained to provide specialised assistance to refugee women and children. At the same time, 279 local and refugee women benefited from prevention and response interventions, including social assistance, counselling and referral in cases of GBV. 98% of the beneficiaries were Roma refugees.
- In 2023, 7,011 refugee women learned about the services available in the country, their rights and the types of support offered, as well as received specific information about sexual and gender-based violence (SGBV) in the context of the humanitarian crisis. This information was provided through materials developed by partner civil society organisations (CSOs) and distributed in Refugee Accommodation Centres (RACs) in communities with the highest numbers of refugees.

- Also in 2023, a project funded by the Women Peace and Humanitarian Fund (WPHF) strengthened institutional capacities and facilitated knowledge exchange through training and mentoring activities. Fifty-one representatives of maternal centres and NGOs improved their skills in GBV protection and assistance, focusing on the early identification of GBV, the post-traumatic consequences of GBV, and support measures to prevent and combat GBV in the context of the war in Ukraine. In addition, 197 professionals improved their knowledge through training on Protection from Sexual Exploitation, Abuse and Harassment (PSEAH), contributing to a more responsible and effective response to the GBV challenges.

Annually, in order to raise awareness of sexual offences, the #DenimDay campaign was carried out at the national level (NGOs, relevant ministries). The campaign aimed to increase society's understanding of zero tolerance for sexual violence by promoting consensual relationships in any couple.

According to data from the Progress Report on the implementation of the Action Plan for the implementation of the Crime Prevention and Combating Programme for 2022-2025, at the press conference on "The National Mechanism for Reporting and Removing Materials Depicting Child Sexual Abuse" held on 12 September 2023, the Ministry of Internal Affairs publicly launched a video tutorial guiding the steps and content of reporting on the platform www.siguronline.md.

In 2022 the Ministry of Education and Research (MER) organised six activities on the topic "Talking to Your Child about Online Sexual Abuse", which were attended by 105 parents. [25] In 2023, over 15,000 cards, posters, and guides for women, girls, and professionals on sexual violence were developed and printed with the support of development partners IC "La Strada" and Mercy Corps. To promote assistance services for victims of domestic violence, IC "La Strada" and OXFAM distributed 750 copies[26].

On 6 February 2024, on Safer Internet Day, the Ministry of Labour and Social Protection, in partnership with the CI "La Strada", launched an awareness campaign with the slogan "It's more than an image, it's abuse". The aim of the campaign was to raise awareness of the problem of online sexual abuse of children and to encourage society to report such content on the Internet.

On 17 July 2024, the MLSP, together with the Council of Europe Office in Chisinau, launched a national campaign to prevent and report abuse and violence against children, including online, by promoting a free helpline for children – **Child Helpline 116 111.** This National Campaign for the Prevention and Reporting of Child Abuse

and Violence reflects the Ministry's commitment to addressing issues of abuse and violence in a systematic, effective and accessible manner. Promotion of the free helpline service Child Helpline 116 111 contributes significantly to raising awareness of abuse and violence against children, both in the physical and online environments, and provides children with a direct and confidential channel through which they can ask for help by reporting situations of abuse or violence they are facing. The campaign ran from July to October. The campaign messages, including the video spot, were promoted on social media, television, radio, in public transport and on playgrounds within a network of restaurants in Chisinau and Balti. The free helpline for children, managed by MLSP, has been operating for almost 11 years, providing crisis support and free psychological counselling to all children to protect them against any form of violation of their rights.

The platform for the prevention of sexual abuse and exploitation of adolescents www.12plus.md and the online chat 12plus were maintained throughout 2024 with the support of NCCAP. A total of 950 children (818 girls and 132 boys), including 151 refugee child, benefited from the services offered by the Platform. With the support of the UNHCR and UNICEF, NCCAP published and disseminated information materials for adults and children on violence prevention: the brochure for adolescents "Work in adolescence"; the brochure for children "Online safety"; the leaflet "8 safety rules"; and the toolkit for specialists.

In November 2025, the Council of Europe Office in Chisinau, the Ministry of Internal Affairs and the Ministry of Labour and Social Protection, in partnership with the International Centre "La Strada", organised the international conference "Strengthening the Protection of Children Against Sexual Exploitation and Abuse Through Evidence-Based Policy Development". The event marked the Day for the Protection of Children against Sexual Exploitation and Sexual Abuse, launched in 2015 by the Council of Europe to raise public awareness and highlight the importance of preventing this crime, prosecuting perpetrators and protecting victims of sexual abuse and exploitation. The conference, organised under the auspices of the Presidency of the Republic of Moldova at the Committee of Ministers of the Council of Europe, brought together high-level officials, international experts and practitioners to discuss how data and evidence can lead to more sustainable policies to protect children from sexual exploitation and abuse.

CONCLUSIONS

1. **The Republic of Moldova has made substantial progress in harmonising its regulatory framework with the international standards** by ratifying the Istanbul Convention, developing standardised clinical protocols for the clinical management of rape, developing regulations on sexual harassment and initiating adjustments to criminal legislation in line with the European Directives. However, the approval of certain key documents, such as the National Sexual and Reproductive Health and Rights (SRHR) Programme, which includes provisions on the prevention of sexual violence and assistance to rape survivors, is still pending. This is affecting the coherence of policy implementation.

2. **The capacities of the medical system have been considerably strengthened** through the development of institutional protocols, the creation of assistance units for victims of violence in strategic hospitals, and comprehensive training for over 2,000 professionals at the national level. In 2022, a national support line was launched for medical staff, and in 2025, professionals/focal points in hospitals at the sub-national level were trained to provide advisory and methodological support to colleagues in the field. These measures are intended to continuously improve the quality of Clinical Management of Rape Cases. However, the system remains vulnerable due to the persistent shortage of psychologists and forensic pathologists in medical institutions, fluctuations in stocks (including ARVs) for post-rape kits, and the inconsistent application of protocols.

3. **Significant progress has been made in developing integrated, beneficiary-centred services** through initiatives such as the Barnahus model, the Network of Specialised Units for the Assistance of Victims of Violence in Hospitals, the Specialised Service for Victims of Sexual Violence in Ungheni, the Family Justice Centre, which aims to prevent and combat domestic and gender-based violence, and psychosocial support services for children. These models and approaches they use reduce the risk of re-victimisation and facilitate access to comprehensive services. However, their geographical coverage is still limited and needs to be scaled up nationwide.

4. **The capacities of healthcare professionals have been significantly expanded, but the need for continuous training persists.** Hundreds of doctors, nurses, psychologists, teachers and specialists from related services have been trained in the clinical management of rape cases and interdisciplinary approaches, with a central role in this context played by Nicolae Testemitanu SUMP, the Mother and Child Institute, and international partners. However, there are still gaps in the uniform application of protocols by medical staff, the need to update the SCP and clarify roles in multidisciplinary teams.

5. **The infrastructure and clinical services for survivors of sexual violence have been considerably developed.** The renovation of the specialised unit at the Forensic Medicine Centre, the creation of 11 hospital units to assist victims of violence/CMR, the supply of modern equipment (including equipment adapted for people with disabilities) to gynaecological examination rooms in dozens of hospitals, and the availability of post-rape kits have improved the capacity for clinical and forensic responses, although risks remain regarding the sustainability of stocks of medicines needed for post-rape care and continuous 24/7 service coverage, especially in rural areas.

6. **The data and monitoring system reveals both an increase in reporting and a real underestimation of the phenomenon.** Data from the FMC, MIA, the General Prosecutor's Office and the GPI indicate an increase in the number of forensic examinations and criminal cases involving sexual offences, including those against children. However, the absence of specific indicators in the medical sector relating to cases of rape or suspected rape, and the lack of harmonisation of indicators across sectors, limits the scope for comprehensive analysis. HBSC studies and NCCAP research confirm that the actual prevalence is higher than that reflected in official statistics. The transfer of responsibility for the VIODATA system to the social sector is an important step towards strengthening data collection, but cross-sectoral integration and the development of a common reporting and monitoring mechanism are still needed to enable comprehensive and consistent assessment at the national level.

7. **Inter-institutional cooperation and referral mechanisms have been strengthened, but are not yet fully functional and unified.** The creation of the National Referral and Case Management Mechanism for Victims Programme, the training of local multidisciplinary teams, and the involvement of NGOs (La Strada, NCCAP, WLC, etc.) and international organisations (UNFPA, WHO, IOM, UNICEF) have improved collaboration between healthcare, police, social protection and justice services, but the lack of case managers, insufficient integration of CMHCs and difficulties in post-emergency monitoring show that the victim's journey is still fragmented.

Mandatory reporting remains one of the most sensitive and controversial components of the institutional response. Analyses by the WHO, GREVIO and advocacy initiatives show that mandatory reporting in cases of gender-based violence for adult women can discourage them from seeking services and may contravene the principles of autonomy, informed consent and confidentiality. At the same time, the state has an obligation to prevent impunity; hence the need for a balanced review of the legal framework, based on evidence and

the results of the ongoing national study concerning the response of the state during the decision-making period for reporting.

8. The Republic of Moldova has made substantial progress in preventing sexual violence and meeting the needs of victims by strengthening the regulatory framework, developing infrastructure and equipment, strengthening professional capacities, **information campaigns** and innovative online reporting mechanisms (SigurOnline, INHOPE, Child Helpline 116 111, 12plus.md platform). However, sustained efforts are still needed to reduce territorial inequalities, ensure continuity and uniform quality of services, combat stigma and under-reporting, and fully integrate a victim-centred approach into all institutional policies and practices. **Awareness raising and prevention campaigns have become more visible, but they need to be intensified and sustained.**

Overall, the period between 2021 and 2025 is characterised by substantial, but still uneven progress in preventing sexual violence and meeting the needs of victims. Significant progress has been made in terms of regulations, services, infrastructure and professional training. However, challenges remain regarding the full approval of all policy documents (particularly the National SRHR Programme), harmonising the legal framework on mandatory reporting with the international standards, ensuring the financial sustainability of services and strengthening a truly victim-centred approach across all sectors involved.

RECOMMENDATIONS:

1. **Strengthening of the regulatory framework and approval of pending strategic documents.** It is recommended that the National SRHR Programme for 2025–2027 be finalised and approved, with explicit inclusion of provisions on the prevention of sexual violence, access to specialised services and assistance to survivors, in order to ensure consistency and stability in the national policies.

2. **Reviewing of the mandatory reporting framework.** It is recommended that an intersectoral working group (Ministry of Health, Ministry of Internal Affairs, NAPCV, WHO, GPO, NGOs) be set up to analyse the impact of mandatory reporting in the case of adults, evaluate international evidence and draft a balanced solution that protects the autonomy of victims, reduces impunity and improves access to justice. (The recommendation is supported by the WHO report currently awaiting publication.)

3. **Scaling up of integrated services to all regions of the country.** It is recommended to expand the Network of Assistance Units for Survivors of

Sexual Violence, currently available in the Emergency Departments of 11 hospitals, to ensure equitable access to services for survivors of sexual violence throughout the country. Similarly, the Integrated Regional Service in Ungheni should be replicated, with the development of similar centres in at least four regions (North, Centre, South, ATU Gagauzia) to ensure equitable access to medical, psychological, social and legal services for victims of sexual violence. It is recommended that the Barnahus model be extended to the municipalities of Chisinau and Cahul in order to reduce the revictimisation of children and provide an effective multidisciplinary response.

4. **Development and full integration of institutional protocols.** It is recommended that all public health institutions adopt and implement Standard Operating Procedures (SOPs) at the institutional level, in accordance with the Standardised Clinical Protocol, with periodic quality audits by the Ministry of Health, NAPCV and the MCI to ensure a uniform and professional response in cases of sexual violence.

5. **Strengthening continuous training for professionals and building up skills in the collection of forensic evidence.** It is recommended that a standardised annual training programme be implemented for medical staff in the clinical management of rape cases. Moreover, it is recommended that additional medical staff be trained in the collection of forensic evidence, given the lack of specialists in 10–11 districts, by developing an advanced training programme for nurses (the "SANE – Sexual Assault Nurse Examiner" model, practised in the USA), in collaboration with the SUMP.

6. **Enhancing the data system and digitalizing reporting.** It is recommended to put in place the VIODATA platform in all relevant sectors (healthcare, MIA, prosecution, social protection), define common indicators and introduce a specific indicator in the medical sector for cases of rape/suspected rape, to ensure uniform monitoring, analysis and response based on real data.

7. **Ensuring the continuity of critical stocks and the availability of services 24/7.** At the same time, it is recommended that each public medical institution keep complete records of post-rape kits distributed in emergency, inpatient and gynaecology departments, replenish them after each use and ensure the systematic replenishment of antiretroviral medicines through direct collaboration with Toma Ciorba Clinical Hospital for Infectious Diseases and the Network of Regional/District Rooms for the Diagnosis and Treatment of HIV/AIDS and Viral Hepatitis B, C and D, so as to prevent any complete depletion of stocks and guarantee immediate access to medical interventions for survivors of sexual violence.

8. **Strengthening inter-institutional cooperation and functioning of the National Referral Mechanism.** It is recommended to ensure the full implementation of the National Referral and Case Management Mechanism, the appointment of case managers in all districts and the development of standardised referral pathways that are easily accessible and clear to both professionals and the population. It is recommended to strengthen the role of the NGO sector in preventing and responding to sexual violence by developing standardised educational materials for schools and communities, supporting non-governmental organisations in creating and coordinating groups of volunteers who can accompany and support victims in their interaction with medical services and law enforcement agencies, and developing a training programme for volunteers, with a minimum duration of 40 hours, accompanied by a system of continuous monitoring and supervision to ensure ethical, professional and survivor-centred support.

9. **Monitoring the activities of internal structures responsible for preventing and combating sexual harassment.** It is recommended that an annual monitoring mechanism be established for Gender Units and Coordination Groups in healthcare and medical education institutions to assess their functionality, case management capacity and accessibility for victims. The process will include data collection, analysis of compliance with new regulations and drafting of recommendations for improvement.

Objective 3:
Preventing the Transmission of HIV and Other STIs and Reducing the Morbidity and Mortality Caused by Them

Legal context in the Republic of Moldova

In the Republic of Moldova (RM), sexually transmitted infections (STIs), including HIV infection, remain a priority public health issue. In accordance with the legislation in force, the Government of the RM assumes responsibility for strictly monitoring the spread of HIV infection, carrying out activities to prevent HIV/AIDS and other STIs, and providing medical, social, psychological and legal assistance to infected persons (Government Decision No. 886 as of 06.08.2007 on the approval of the National Health Policy, Chapter XIII Control of Contagious Diseases). It is important to note that there are no provisions in the national legislation and policy that would limit the population's access to STI diagnosis and treatment services, including HIV. The national legislative framework in the field of STIs/HIV is aligned with the international one.

An important element of the country's political commitment to controlling and combating HIV infection is *the National Coordination Council of the National Programme for the Prevention and Control of HIV/AIDS, Sexually Transmitted Infections and the National Tuberculosis Control Programme (NCC).* The NCC was established by GD no.825 as of 03.08.2005 in order to ensure efficient implementation of the activities within the framework of the mentioned programmes by attracting, coordinating, monitoring and managing the grants offered by international organisations in response to the country's needs in achieving the Millennium Development Goals. Since 2003, the Republic of Moldova has benefited from substantial financial contributions from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF). They have contributed significantly to intensifying activities to prevent the spread of HIV infection and sexually transmitted diseases, in particular through interventions among people at increased risk of infection, strengthening the laboratory system for diagnosing infection and monitoring HIV patients, ensuring universal access to treatment, care and support services, strengthening the management of the national programme, etc.

The National Programme (NP) for the Prevention and Control of HIV/AIDS and STIs for 2022-2025 was approved by Government Decision No. 134/202 and is the

fundamental policy document on national interventions in the field of HIV and sexually transmitted infections. It sets out guidelines and priorities for actions to prevent the spread of HIV and sexually transmitted infections and reduce their impact. The NP on HIV/AIDS and STIs is designed as a comprehensive, cross-sectoral framework to guide the activities of organisations involved in the national response to reduce HIV transmission and mitigate the negative impact of the HIV epidemic. The main focus of the Republic of Moldova efforts to implement a national response to the HIV epidemic is to prevent HIV transmission within populations at increased risk of infection, ensure that HIV does not spread from these populations to the general population and guarantee universal access to treatment, care, and psychosocial support for people living with HIV (Monitoring HIV Infection Control in the Republic of Moldova, 2022, Chisinau, 2023).

The epidemiological situation in the Republic of Moldova

HIV infection in the RM continues to be a priority health concern. The HIV epidemic is considered to be concentrated in groups at increased risk of infection, particularly among men who have sex with men (MSM), sex workers (SW) and people who inject drugs (PWID).

According to administrative statistics, from 1987 to 31 December 2024, there were 17,914 cases of HIV in the Republic of Moldova (12,995 on the right bank and 4,919 on the left bank), of which 5,648 were AIDS cases (4,086 on the right bank and 1,542 on the left bank), resulting in 5,533 deaths (4,065 on the right bank and 1,458 on the left bank).

In 2024, 880 HIV-positive cases were registered (including 145 in the territories on the left bank of the Nistru River), of which 51 were pregnant women whose HIV+ status was established at the time of taking them under medical supervision as pregnant women (44 on the right bank of the Nistru and 7 on the left bank). Disaggregation of new HIV+ cases by age group: <15 years – 6 people; >15 years – 874 people, with the cumulative number of HIV cases registered by 31 December 2024 reaching 17,914.

In 2024, AIDS was confirmed in 298 persons[19], including 31 in the eastern territories. The diagnosis of AIDS was confirmed in 77.5% of cases in the same year as the confirmation of HIV infection, in 11.41% of cases after 1 year, in 2.01% of cases after 2-4 years, in 5.03% of cases after 5-9 years, in 3.69% of cases after 10-15 years and in 1.01% of cases after 15 years and more. The diagnosis of AIDS

19 Source: NPHA, Report "On Epidemiological Surveillance of HIV Infection, Control and Response Measures, reference year 2024"

in the same year as the confirmation of HIV infection indicates a late diagnosis of HIV-positive individuals.

Stakeholders involved in the provision of HIV and STI services

The government authorities/public institutions responsible for ensuring the provision of HIV and sexually transmitted infection (STI) services are: the Ministry of Health (MoH) of the Republic of Moldova (RM), the National Public Health Agency (NPHA), the National Health Insurance Company, the PMSI Toma Ciorba Clinical Hospital for Infectious Diseases (CHID), Consultative departments within municipal and district public health institutions, the National Penitentiary Administration (NPA), Regional social centres for PLHIV and their families (North, Centre, South). *International organisations* involved in supporting interventions in this area in the Republic of Moldova are: the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, the UNAIDS, the UNDP, the WHO, UNICEF and the UNFPA. *Civil society organisations* involved in combating HIV/AIDS and STIs are: PA Pas cu Pas Sud, PA Pentru prezent si viitor, PA Tinerele Femei Cernoleuca, PA Adolescentul, PA Uniunea pentru Echitate si Sănătate (UES), PA Initiativa Pozitiva, PA Aliance Zdorovie, PA Triniti, Medical and Social Programmes, PA Act For Involvement (AFI), Respiratie II, PA Credinta, IC Genderdoc-M.

The MoH of the RM is the central authority responsible for national policies in the field of HIV/AIDS and STIs for 2021-2025 (Government Decision No. 134/02.03.2022), which develops strategies, national programmes and regulations and also has the function of approving the Action Plan for STI prevention and control, standards and clinical guidelines.

Toma Ciorba CHID acts as the national coordinating institution for the prevention and control of HIV/AIDS and STIs. It is also an important player in STI diagnosis, supply of antiretroviral treatment and the monitoring of the implementation of the National Programme.

The *NPHA* carries out epidemiological surveillance of HIV. In the area of STIs this institution collects data, monitors prevalence and is involved in collaboration for prevention/education. *Territorial Public Health Centres* carry out testing and counselling, surveillance and work with key populations.

Public medical institutions (PMSI) provide services such as testing, treatment, care and support. These include health centres, Youth-Friendly Health Centres, Reproductive Health Rooms, district hospitals, the Network of Regional/District Clinics for the Diagnosis and Treatment of HIV/AIDS and Viral Hepatitis B, C and D, which provide diagnosis (STI tests), treatment and counselling; laboratories.

The National Penitentiary Administration (NPA) is actively involved in HIV prevention, providing testing and ARV treatment services in detention facilities.

The *UNAIDS — The United Nations Programme on HIV/AIDS* provides assistance in coordination, advocacy, technical support in the development of policy documents, national strategies, national reports, etc. *The Global Fund to Fight AIDS, Tuberculosis and Malaria* provides financial support for the implementation of the National Programme for the Prevention and Control of HIV/AIDS and STI for 2022-2025, including prevention programmes among key populations and risk reduction. The *WHO* provides technical support and assists in the development of policy documents, national response plans, guidelines, etc. The *UNDP* provides assistance with legal assessments and support for the rights of people living with HIV. During the reference period, the UNICEF supported interventions to prevent mother-to-child transmission of HIV. From 2021 to 2023, the UNFPA supported HIV prevention interventions among key populations at increased risk of infection. From 2024 to 2025, the organisation ensured the integration of HIV prevention into other nationally supported sexual and reproductive health (SRH) interventions, such as family planning, the clinical management of sexual violence cases, safe motherhood and youth-friendly mobile SRH services.

NGOs working in the field of HIV and STIs are involved in community work, advocacy, prevention services in key groups, legal support, and also in testing, information, and support for adherence to ARV treatment. They offer confidential support and counselling lines for HIV-positive people, including during the pandemic and refugee crisis, set up at the initiative of hospital administrations as needed. Community organisations offer voluntary testing, counselling and referral to medical services, with an emphasis on confidentiality and psychological support. *The PAS Centre* develops and is involved in projects to strengthen the capacity of NGOs and provide technical/policy support for the HIV/STI response (including testing policies). *Regional social centres for PLHIV and families* provide counselling and support to people with HIV and their families, and, when necessary, referral to clinical and community services, in accordance with the legislation in force.

Prevention programmes among key populations

In order to organise and provide effective HIV prevention services for key populations, including young people, and to ensure the quality of these services while taking into account the national epidemiological situation and international recommendations in this field, the "*Standard for the Organisation and Functioning of HIV Prevention Services for Key Populations, Including Young People"* (developed with the support of the UNAIDS and UNFPA) was developed and approved by MHLSP Order No. 278

as of 18 March 2020. The standard expressly stipulates that its provisions apply including in the context of humanitarian crises, exceptional situations and public health emergencies.

HIV prevention programmes among PWID

These are implemented in 29 territorial administrative units and 18 penitentiary institutions on both sides of the Nistru River. These projects are implemented through 10 NGOs and the National Penitentiary Administration. In 2024, 11,792 PWID (43% of the estimated population) benefited from at least two services (17,345 in 2023), with needle exchange being a basic service, at least 6 times/year (including 1,999 beneficiaries from the penitentiary system). 4,383 people of the above-mentioned beneficiaries were covered by the NHIC sources.

Opioid substitution programme. In 2024, opioid substitution treatment (OST) services are available in 10 localities across the country and in 13 penitentiary institutions. At the end of 2024, 658 PWID were in OST, including 131 in the penitentiary system. Currently, opioid substitution programmes are implemented exclusively in the territories on the right bank of the Nistru River.

HIV prevention programmes among MSM

In 2024, prevention programmes among MSM were implemented through 8 NGOs, covering 29 territorial andadministrative units on both banks of the Nistru River. A total of 7,251 people (5,644 - MSM in 2023), accounting for 49.6% of the estimated MSM population, benefited from prevention services. This number included 1,261 people covered by the NHIC funds. Each beneficiary accessed at least two services at least 4 times/year (one of which is mandatory condom distribution). 496,550 condoms were distributed during the reporting period. The comprehensive package of services offered to beneficiaries included: distribution of condoms and lubricants, peer counselling services, information, education and communication activities, training and counselling for LGBT beneficiaries and parents, community testing, counselling for HIV, STI, hepatitis B and C testing, and information activities in the penitentiary system.

HIV prevention programmes among SW

In 2024, prevention programmes among SW were implemented in 29 territorial and administrative units in the country through 13 NGOs active in the field. A total of 7,730 people (8,464 in 2023) or 49% of the estimated SW population benefited from at least two services at least four times a year (one of which was the mandatory provision of condoms). Over the reporting period, 769,373 condoms were

distributed. Of the above-mentioned beneficiaries, 1,101 persons were covered by the NHIC funds. The comprehensive package of prevention services includes: condom distribution, information, communication and education activities, risk reduction counselling services, peer education activities, referral services for medical care, including testing and counselling for HIV, syphilis, hepatitis B and C, community testing, and management of sexually transmitted infections.

The provision of prevention services through mobile clinics for key populations has been implemented since 2014. Between 2021 and 2024, three mobile clinics were active, covering all territories across the country, including the left bank. As part of the programme, it was planned that 30% of beneficiaries of prevention services would be served by mobile units by 2025, with the baseline rate of 14.8%.

Prevention of mother-to-child transmission of HIV (PMTCT)

At the PHC level, *the family doctor and the obstetrician-gynaecologist at the polyclinic/outpatient clinic* perform HIV and syphilis screening during pregnancy (mandatory testing at the first prenatal visit; repeat testing in the third trimester in high-risk cases), provide counselling on the prevention of HIV/STI transmission to the foetus; refer to specialised HIV centres for confirmation and initiation of ARV treatment in case of a positive result. *Regional and district offices specialising in the diagnosis and treatment of HIV/AIDS and viral hepatitis B, C and D* are involved in the following activities: confirming an HIV diagnosis in pregnant women, initiating and monitoring ARV treatment during pregnancy, coordinating with obstetrician-gynaecologists to determine the method of delivery, and monitoring the mother and child after childbirth. *Maternity wards/perinatal centres:* apply intrapartum measures to reduce risk (intrapartum ARV prophylaxis, choice of delivery method according to recommendations); provide prophylactic treatment for newborns. Implementing partners in projects funded under the National Programme are involved in providing psychosocial support for HIV-positive pregnant women; facilitating access to antenatal care and ARV treatment; reducing stigma and ensuring continuity of care.

In 2024, pregnancy was confirmed in 148 HIV+ women, of whom 41 were diagnosed with HIV+ for the first time during pregnancy. During the year 145 HIV+ women gave birth (46 by caesarean section) to 148 live babies, of whom 147 (99.3%) received prophylactic ARV treatment. Out of 145 HIV-positive women who gave birth in 2024, two did not receive prophylactic treatment to prevent mother-to-child transmission of HIV. Prophylactic treatment to prevent vertical transmission of HIV infection is administered in accordance with *the National Clinical Protocol "Prevention of Mother-to-child Transmission of HIV Infection",* developed in 2018 and updated in 2022 in accordance with the latest WHO recommendations. At the

end of 2024, HIV+ status was established in 1 child born in 2024, thus the rate of mother-to-child transmission was 0.7%.

Pre- and post-exposure prophylaxis

Pre-exposure prophylaxis was introduced in the Republic of Moldova in 2018 and is available to all key groups through both the healthcare system and community services. This intervention is essential for reducing HIV transmission, especially among people at increased risk. The activity is carried out in accordance with the Protocol "Pre-exposure Prophylaxis for HIV Infection" updated in 2025 and approved by Order of the Ministry of Health of the Republic of Moldova No. 395 as of 02.05.2025.

There has been a steady increase in the absolute number of people who have benefited from PrEP at least once a year, from 337 people in 2021 to 623 people in 2024. An analysis of the distribution of beneficiaries in the period between 2022 and 2024, according to key groups, shows an increasing concentration of the service among men who have sex with men, with an increase from 72.5% in 2022 to 89.25% in 2024. The service needs to be adapted and actively promoted for other key groups, including people who inject drugs, women at increased risk, and partners of HIV-positive people. Better integration of PrEP into sexual and reproductive health services can help increase the accessibility and attractiveness of the service.

Post-exposure prophylaxis is carried out in accordance with the SCP on the Clinical Management of Rape Cases. During 2024, 107 people benefited from post-exposure prophylaxis, including 58 people who experienced occupational accidents and 49 people who experienced non-occupational accidents. One of these cases involved violence on the right bank.

HIV testing and treatment cascade

In accordance with the UN Political Declaration on HIV Control, signed in 2021, the global 95-95-95 targets were set, which entail:

- 95% of people living with HIV to know their serological status;
- 95% of those diagnosed to be enrolled in antiretroviral treatment;
- 95% of treated individuals achieve viral suppression.

Achieving these targets is essential for controlling the epidemic, preventing transmission of the infection and ensuring the best possible quality of life for PLHIV.

During the assessment period, the National Programme operated with the 90-90-90 targets, namely:

90% of PLHIV estimated to know their HIV status.

To achieve this goal, several interventions were implemented:

- Scaling up of rapid testing, including in vulnerable groups, using combined tests;
- Motivating medical staff to actively promote testing;
- Facilitating self-testing, including through the free distribution of rapid tests in pharmacies and the installation of vending machines with tests;
- Promoting INDEX testing and testing of sexual/biological partners of diagnosed individuals.

According to the latest estimates from 2024: out of 16,917 people estimated to be living with HIV in the Republic of Moldova, 11,887 (i.e. 70.3%) know their HIV status. Although progress has been made compared to 2021, with 66% of people having been identified, approximately 5,030 people have not yet been identified.

90% of PLWHAs administer ART – HIV diagnosis and referral to treatment and care services.

One of the essential components of HIV epidemic control is universal access to antiretroviral treatment for diagnosed individuals.

Family doctors do not initiate ARV treatment, but are responsible for early identification, HIV testing (including referral for confirmation), counselling, adherence monitoring and referral to a specialist doctor to prevent HIV/STI transmission and reduce morbidity. Family doctors participate in case surveillance and ensure access to reproductive health services and antenatal screening for pregnant women.

Regional/district offices for the diagnosis and treatment of HIV/AIDS and viral hepatitis B, C and D initiate, adjust and monitor ARV treatment. Services include diagnosis confirmation, clinical and immunological assessment, ARV prescription, viral monitoring, co-infection treatment. Dispensing of treatment is also available (on a regular basis or, in emergency cases, for longer periods).

There have been no reports of interruptions or changes in treatment regimens due to interruptions in drug supply. At the same time, there are no waiting lists or

prioritisation in terms of ARV treatment prescription conditioned by the patient's situation. All people living with HIV have access to treatment and all other HIV-related services immediately after diagnosis, in line with the *test-and-treat* strategy and regardless of health insurance coverage.

The proportion of people estimated to be living with HIV and receiving ART has shown a positive trend between 2021 and 2024: from 72% in 2021 to 73% in 2022, reaching 75% in 2023, a level that has been maintained in 2024. This gradual increase reflects improved access to treatment, in particular through: decentralisation of HIV services to 24 *regional/district offices for the diagnosis and treatment of HIV/AIDS and viral hepatitis B, C and D;* policies for rapid testing and initiation of the ART, in line with the World Health Organisation (WHO) recommendations.

90% of PLHIV have viral suppression.

According to the third component of the 95-95-95 target, it is essential that 95% of people receiving antiretroviral treatment achieve viral suppression, i.e. an undetectable viral load. This outcome is crucial both for the health of the infected person and for the prevention of HIV transmission. In 2024, the viral suppression rate among PLHIV on treatment reached 90%, which represents significant progress compared to previous years and a step closer to the international target. This achievement reflects the performance of the HIV treatment system, particularly in terms of the ART adherence.

Implementation of psychosocial support programmes

In the Republic of Moldova, psychosocial support services for PLHIV are provided both in institutional/public settings (primary or hospital healthcare institutions) and in the community – RHR and NGOs active in the field (10 at present), and are available in localities on both sides of the Nistru River.

The key objectives of psychosocial support services are: early inclusion of PLHIV in ART, training/ensuring adherence to ART, preventing cases of ART discontinuation, contributing to a sustained reduction in viral load, acceptance of HIV diagnosis by PLHIV, reduction of self-stigmatisation/stigmatisation among PLHIV.

Psychosocial support services are provided by a psychologist/social worker or peer social worker and/or peer counsellor and include psychosocial counselling/consultation, psychosocial support, referral/accompanying of PLHIV to RHR, as well as other specialised services available in the community/region. In 2024, psychosocial support services were provided to 1216 PLHIV belonging to the "priority beneficiaries" category, including 193 people from the left bank of the

Nistru River, and to 3.324 PLHIV belonging to the category of beneficiaries who are offered psychosocial support services as needed, including 1,379 people from the left bank of the Nistru River.

TB/HIV co-infection

Tuberculosis remains one of the most common opportunistic diseases in the context of HIV infection, and is also a major cause of death among people living with HIV.

An analysis of the evolution of TB/HIV co-infection cases between 2021 and 2024 reveals notable differences between the two banks of the Nistru River:

- On the right bank, the number of co-infection cases increased from 156 in 2021 to 225 in 2023, followed by a slight decrease in 2024 (184 cases). The number of extrapulmonary tuberculosis cases remained relatively stable, ranging between 15 and 19 cases annually.
- On the left bank, the trend is different, with a decrease in the total number of co-infection cases from 60 in 2021 to 36 in 2023, followed by an increase to 48 in 2024. At the same time, cases of extrapulmonary tuberculosis increased from 5 cases in 2021 to 11 in 2024.

Free distribution of condoms

Sexual transmission has been the most common route of HIV transmission/spread in recent years. All unprotected sexual practices are theoretically accompanied by a risk of HIV/STI infection. Women are at higher risk of STI/HIV infection because they are more likely to be victims of sexual violence during a humanitarian crisis. Condoms are a key method of preventing HIV and other STIs. Condoms should be available in accessible and private areas from the very first days of the crisis, so that anyone familiar with the method, both among the affected populations and humanitarian aid workers, has unlimited access to them. It is important to order sufficient quantities of condoms to ensure their continued use by the population.

The distribution of free condoms is part of the SRH services and is carried out by the NGOs that distribute lubricated male condoms through stationary and mobile points and at community events, especially for key populations (MSM, sex workers, injecting drug users, vulnerable young people). These services are funded by the National HIV/STI Programme 2022–2025 (GD No. 134/2022) and the Global Fund. Distribution is accompanied by information materials and prevention counselling. In primary healthcare institutions, Reproductive Health Rooms and Youth-Friendly Health Centres, condoms are distributed free of charge, especially during consultations for adolescents and family planning, and are included in the package of preventive services according to the Report of the MoH of the RM for 2024.

Pharmacies and supermarkets sell condoms, but these do not fall under the category of "free prevention services"; however, they contribute to universal access. Female condoms have limited availability, being distributed mainly through pilot projects and the UNFPA programmes. For example, in 2022, the UNFPA Moldova provided IARH kits with medicines, devices and consumables, including contraceptive kits that were distributed to beneficiaries through Youth-Friendly Health Centres[20]. The WHO recommends female condoms as part of the HIV/STI prevention package, but their use in the RM is limited/marginal. During the COVID-19 pandemic and the crisis of refugees from Ukraine, male condoms were distributed on a regular basis through collaboration between the Ministry of Health of Moldova, the UNFPA and NGOs. Some reproductive health kits also included female condoms (UNFPA Moldova – annual report).

In 2024, 30 vending machines were operational, distributing consumables to beneficiaries from groups at increased risk of infection, included in HIV prevention projects (condoms or other risk reduction materials). The machines were placed in the following localities: Chisinau (8), Balti (3), Tiraspol (2), Cahul, Rezina, Orhei, Bender, Cantemir, Comrat, Causeni, Ungheni, Falesti, Drochia, Floresti, Riscani, Soroca, Dubasari, Camenca and Ribnita, contributing to increased accessibility and discretion in accessing prevention materials for vulnerable people. One device was installed in the penitenciary system, marking an important step in expanding access to HIV prevention services in closed settings.

Capacity building for the providers of the SRH services

A curriculum for the professional development of specialists was implemented through digital platforms, as part of the training programme organised by the Department of Infectious Diseases of Nicolae Testemitanu State University of Medicine and Pharmacy. The distance learning module is operational, facilitating specialists' access to continuing education in a modern and flexible format, thus contributing to strengthening professional capacities in the field of prevention, diagnosis and treatment of HIV/AIDS and STIs.

Healthcare service providers have at their disposal a complete set of protocols, guidelines and national and international standards that guide their work in the prevention, diagnosis and treatment of STIs, including HIV, thus contributing to maintaining a favourable epidemiological situation and avoiding a significant increase in the morbidity of the population caused by HIV and other STIs.

20 https://moldova.unfpa.org/ro/news/unfpa-%C8%99i-guvernul-statelor-unite-au-livrat-spitalelor-din-republica-moldova-un-lot-de-zece-tone

Although healthcare service providers play a key role in HIV prevention activities among the general population, health sector institutions must also collaborate effectively with other important partners, such as local public administration authorities, educational institutions, NGOs supporting key populations and people living with HIV, religious denominations and other organisations, to deliver education, information, and communication activities that prevent STIs/HIV in everyday life and during humanitarian crises or public health emergencies.

Medical staff received ongoing training in HIV/STI prevention and management under the National HIV/STI Programme (Government Decision No. 134/2022). In 2022, the PAS Centre provided trainings with support of the UNFPA and the UNAIDS[21]. The following thematic module on digital training for HIV prevention was delivered: "Strengthening the Interconnections Between HIV Prevention Programmes and Sexual and Reproductive Health Services" integrated into the Platform www.formare.md._However, the Report of the MoH of the RM for 2024 mentions a shortage of staff in some rural areas and the need for additional training for PHC institutions in HIV/STI counselling.

Representatives of the Ministry of Justice and NGOs were trained to provide HIV prevention services to people who use drugs, both injectable and non-injectable. Out of these, 58 participants from the left bank of the Nistru River were trained, while no training activities were carried out on the right bank during the reference period. In 2024, 87 people were trained to provide integrated services for people living with HIV.

In 2024, 42 specialists from NGOs active in HIV prevention received training on the use of rapid combined HIV&Syphilis tests.

The national reference laboratory for HIV/STIs was established within the PMSI Toma Ciorba CHID laboratory, strengthening national capacities in the field of diagnosis, surveillance and control of HIV and STI infection.

Consumables, medicines and tests are available - ARV, cotrimoxazole for the prophylaxis of opportunistic infections, antibiotics for STIs and rapid HIV/syphilis tests are included in the list of essential medicines and provided through the National Programme (Government Decision No. 134/2022). The Report of the MoH of the RM for 2024 confirms the general availability of consumables, but points to specific stock issues in crisis situations and supply delays in some rural areas. Regional and district HIV/STI services have laboratories for diagnostic confirmation (ELISA, PCR), and rapid HIV and STI screening tests are available in PHC facilities.

21 https://www.facebook.com/CentrulPAS/posts/pfbid033v1wAqhH28DYE6Sn3vdiraEE5pqz7x5iVV2BQipHW3ih-p5Wpnwi7yWSyjZQkGJd1l

There is a **clear and up-to-date referral system for HIV/ARV services** that can be used during emergencies. The guide on planning actions in crisis situations is the document *"Report-Moldova: Action plan in case of unforeseen situations related to the provision of HIV services for key populations during the COVID-19 pandemic and other emergency situations in Moldova."* It includes references to emergency care and support services, such as decentralizing ARV treatment to allow access in areas where the HIV centre is difficult to reach; dispensing ARV drugs at home, where access is limited by restrictions (transport, COVID, etc.); algorithms for assessing the risk that a person may not be able to pick up ARV drugs, taking into account distance from the center, mobility, etc.

Between 2020 and 2022, in response to COVID-19 restrictions, the authorities, together with NGOs, implemented a mechanism whereby ARV drugs were delivered to the homes of people who could not reach the centre. The algorithm included the identification of beneficiaries from risk groups, transport and collaboration with NGOs.

The RM has adopted procedures for continuing treatment for refugees from Ukraine, who can go to HIV confirmation centres and start ART, receiving medication for a period of three months during their stay in the RM.

The National Clinical Protocol (NCP) "HIV in Adults and Adolescents" sets out standard procedures for diagnosis, treatment, ARV initiation criteria, etc. This document provides a framework for HIV treatment, but does not explicitly mention referral procedures in emergency situations or specific continuity in crises. Thus, there is no updated document after 2022 that formalises a standardised and universally accepted referral system that would be active in any type of emergency (natural, conflict, pandemic, etc.), not just for COVID-19.

There are no clear published documents/sources describing how ARV referrals are managed if the medical infrastructure is severely affected (e.g. destruction, lack of physical access, lack of pharmacological resources), requiring a fully formalised, robust and verified system covering all types of emergencies. The barriers cited by beneficiaries are the following: stigma, limited access in rural areas, transport and communication problems in situations of isolation, etc.

Syndromic management of STIs

Based on the idea that there are enough dermatologists and well-equipped laboratories in the RM to diagnose STIs, syndromic management of STIs has not become widespread. At the same time, there are experiences of providing syndromic treatment of STIs for people in STI and HIV risk groups who do not want or are

unable to undergo laboratory tests. Youth-Friendly Health Centres (YFHCs) working with adolescents and young people from groups at risk of infection also have experience in this regard. These facilities are equipped with a minimum package of medicines necessary for the provision of services (provided by the MHIF).

Upon recognition of clinical syndromes (e.g. urethritis, cervicitis, genital lesions, vaginal discharge, pelvic pain, genital ulcer), empirical treatment may be prescribed according to the NCP. In such a situation, the following is provided: counselling for the patient, referral to a specialist or dermatovenerologist in case of complications, recurrence, resistance or comorbidities.

Specialised dermatovenerological services include: confirmatory diagnosis (laboratory tests, culture, PCR); specific treatment and adjustment of complicated cases, as well as monitoring and reporting to the NPHA.

NGOs, including through mobile points, are involved in information, counselling, condom distribution, rapid testing (HIV, syphilis), referral to specialised services for treatment. They do not apply syndrome management per se, but ensure linkage-to-care and reduce delays.

Blood transfusion

The National Healthcare Policy stipulates that the state will ensure the safety of blood transfusions and medical procedures, and that public health institutions will be provided with the necessary equipment and materials to perform these procedures.

Blood transfusion services and practices are adjusted to international standards, with the rational use of blood components in medical care. Blood reserves and blood products are stored at the national level to meet the state's needs in accordance with the safety requirements. Ensuring that the healthcare system has sufficient supplies of blood components is a civic responsibility of the society, through voluntary and unpaid blood donations.

In this context, considering the main ways of HIV infection transmission, in order to reduce the incidence of STIs/HIV during the humanitarian crisis, it is important to focus on three priority areas: ensuring safe and rational blood transfusions and compliance with universal standards of protection; compliance with measures to prevent mother-to-child transmission of HIV; ensuring the availability of free condoms.

As the competent authority in this field, the MoH promotes the safety of blood donation, transfusion of blood and blood components through blood transfusion centres, departments and rooms, which operate in accordance with the approved

regulations. The MoH has established a Haemovigilance Committee, a body responsible for monitoring and reporting various incidents in the field that affect the quality and safety of blood donation, transfusion of blood and blood components. The RM has a well-organised network of 71 blood service units: centres, departments, blood transfusion rooms and blood banks.

The RM has clear and up-to-date procedures for ***safe blood transfusion*** and rational use, implemented through the National Blood Transfusion Centre (NBTC) and the network of transfusion departments in hospitals. In emergency situations, the flows are functional (mandatory testing of each unit, rapid release and redistribution of components), but immediate availability depends on stocks and the mobilisation of donors.

There are *National quality standards for blood services,* which include information on donor selection, medical examination, counselling, donation, traceability and risk management; they provide the basis for safe transfusion at all stages of the transfusion chain.

The operational institutional network (NBTC + transfusion departments in PMSI) coordinates, produces and distributes blood products; continuously assesses infectious risks in the donor population and selection criteria to minimise the risk of transmission.

Availability in emergencies

The NBTC and transfusion departments can redistribute blood components between units; hospitals maintain stocks and apply protocols for judicious use (in accordance with the national standards). In practice, immediate access may vary in small localities depending on stocks and donor mobilisation. *National standards for universal precautions* and regulations for the prevention of healthcare-associated infections (HAIs) are applicable in the RM.

Ministry of Health Order No. 581/2024 on *Quality System Standards for Blood Service Units* and the NPHA regulations include mandatory hygiene measures, use of personal protective equipment (PPE), safe handling of sharps, disinfection and sterilisation.

Public and private medical institutions are required to comply with universal precautions: hand hygiene, use of gloves, gowns, eye protection, disposal of biomedical waste. In emergencies such as pandemics, refugee influxes and crises, precautions have been reinforced through training, the distribution of PPE and special guidelines, which are considered basic measures.

According to the Reports of the MoH of the RM (2024), precautions are implemented "consistently", although some shortages of consumables supply have been reported in district hospitals during periods of overload. Availability in emergency situations is ensured, as these precautions are part of the daily practice of medical staff. The national healthcare system has standardised procedures for infection control, and in recent years, multiple staff training sessions have been conducted (including within the framework of the WHO and the NPHA projects). In emergencies, universal precautions remain the first line of defence, being integrated into all hospital and community protocols. During the reference period, in the context of the response to the refugee crisis, the UNFPA provided support to strengthen the Blood Transfusion Service by providing the necessary equipment for the period of 2022-2025. Blood transfusion is a critical component in the clinical management of gynaecological and obstetric emergencies[22].

PEP for survivors of sexual violence and occupational exposure is provided in accordance with *NCP-314 "Post-exposure Prophylaxis for HIV Infection",* which sets out the indications for immediate ARV administration after accidental exposure or in the context of sexual violence since 2022. PEP is an integral part of the National HIV/STI Programme, approved by Government Decision No. 34/2022, which ensures universal and free access to ARV treatment in these situations. In cases of sexual violence, survivors can access PEP through hospital emergency departments, where there are standard procedures for administering ARV within the first 72 hours. According to the reports of the MoH of the RM and national guidelines on reproductive health and women's rights, PEP is included in the package of forensic and gynaecological services for victims of sexual violence. NGOs and international partners (UNFPA, UNAIDS) provide support through counselling and referral to emergency services for access to PPE, including for occupational exposure (needlestick injuries, contact with infected blood) is available to medical staff in all hospitals through internal infection prevention and control protocols. The MoH of the RM and the NPHA have updated occupational exposure control procedures in line with the WHO recommendations on healthcare-associated infections.

Informing beneficiaries about STI/HIV services

The events aimed to familiarise and inform the general population about STI/HIV counselling services are held at least six times a year - in the context of World AIDS Day, International Day Against Drug Abuse and Illicit Trafficking, International AIDS Remembrance Day, Campaign Against Sexual Violence, etc.

22 https://moldova.unfpa.org/ro/news/na%C8%99teri-sigure-%C3%AEn-moldova-unfpa-donat-echipament-modern-%C8%99i-instruit-speciali%C8%99

The National HIV/STI Programme, approved by Government Decision No. 134/2022, provides for the development and distribution of IEC materials for HIV/STI prevention, including brochures, guides and online resources, with a focus on confidential counselling and informed choice. The strategy aims to ensure that, even in emergency situations (the COVID-19 pandemic, the crisis of refugees from Ukraine), IEC materials are adapted and disseminated in the community, including through NGOs and with the support of international partners.

The MoH of the RM and the NAPH have developed and distributed guidelines and information brochures on HIV/STI prevention, confidential counselling and patients' rights. These are mentioned in the Report of the MoH of the RM on HIV/STI for 2024, which shows that IEC materials have been targeted at vulnerable groups and crisis situations.

The *UNFPA*, in response to the refugee crisis, supported the development and distribution of IEC materials on sexual and reproductive health services, including HIV/STI prevention, among refugees and young people, with an emphasis on confidentiality and access to clear and user-friendly information. *UNAIDS and national NGOs* developed information materials and community campaigns on HIV testing, voluntary choice and access to confidential services, distributed both physically and online. During the COVID-19 pandemic, digital IEC materials were adapted to inform patients about the continuity of HIV/STI testing and treatment services, including home delivery of ARVs and access to online counselling.

CONCLUSIONS

1. The Republic of Moldova has a solid legislative and institutional framework for the prevention and control of HIV and STI infection, aligned with the international standards. Universal access to diagnosis, treatment, care and support services is ensured, with a focus on populations at increased risk and well-coordinated public health interventions, in collaboration with international organisations and civil society.

2. Although significant progress has been made in testing, monitoring and treatment, the epidemiological situation remains alarming, with the epidemic continuing to be concentrated within key groups. Trends in late diagnosis and the increase in the average age at which HIV status is established indicate the need to strengthen efforts in early prevention, education and rapid access to testing services.

3. HIV prevention programmes for key populations are widely implemented. Clinical services and the implementation of risk reduction programmes have

made significant progress. Although services are available in most districts of the country, including penitenciaries, and the prevention package has been supplemented with services (community testing, overdose management, gender-specific services), still the coverage remains insufficient, access is uneven, and territorial differences persist (especially in the Transnistrian region).

4. The scaling up of innovative mechanisms (vending machines, mobile clinics, community testing) has improved the access, but does not compensate for the lack of resources and capacity of the NGOs. Limited financial resources, dependence on the Global Fund and the reduced operational capacity of the NGOs contribute to a considerable gap between the proposed national targets and the actual results in terms of meeting the needs of beneficiaries.

5. Programmes targeting HIV-positive pregnant women remain one of the most effective components, maintaining a low rate of mother-to-child transmission. Universal screening, rapid initiation of ARV treatment, coordination between service providers, and prophylactic treatment for newborns have maintained prophylactic coverage of over 90%.

6. The ARV treatment system in the Republic of Moldova is well established, with universal access, an expanding service network, and stable results in viral suppression. The increase of the number of territorial units, the continuous operation of regional rooms and community support mechanisms (including home delivery of ARV treatment in crisis situations) have ensured treatment continuity. However, treatment dropout remains a constant problem, and adherence declines after 24 and 60 months, indicating the need for strengthened interventions and psychosocial support.

7. STI management is based on laboratory diagnosis, and the Republic of Moldova has well-equipped networks of dermatology and venereology services and laboratories, which is why syndromic treatment is limited in its application. However, among young people in high-risk groups and populations that avoid accessing medical services, the syndromic approach continues to be a useful tool.

8. National blood transfusion standards are well regulated and aligned with the international standards, and the haemovigilance system, mandatory testing of each blood unit and the network of units coordinated by the NBTC guarantee a robust framework for preventing HIV/STI transmission through transfusion, including in emergency situations.

9. Psychosocial support services for people living with HIV are well institutionalised and available on both sides of the Nistru River, contributing substantially to early inclusion in treatment, maintaining adherence and reducing stigma.

10. Public awareness and STI/HIV prevention are reinforced by a modern regulatory framework, recurring campaigns, IEC materials tailored to vulnerable groups, and new human rights protection mechanisms that remain functional even in crisis situations.

RECOMMENDATIONS

1. Strengthening of early prevention and access to HIV testing by scaling up rapid testing, especially for key populations and young people, and increase the number of educational interventions to reduce late diagnosis.

2. Reduction of territorial disparities in access to services and prioritise regions with limited access, including Transnistria, through mechanisms adapted to the local context.

3. Improving adherence and reducing ARV treatment dropout by expanding psychosocial support services, peer-to-peer support, ongoing counselling and combating stigma. Developing mechanisms for monitoring and communication with beneficiaries.

4. Strengthening the capacities of NGOs by increasing the funding for prevention and risk reduction programmes. Developing training programmes in management, reporting and sustainability.

Objective 4:
Preventing Excessive Morbidity and Mortality among Mothers and Newborns

Maternal and neonatal mortality are considered representative indicators of the quality of health services. In a humanitarian crisis, against a background of major stress, access to medical facilities and qualified service providers is more limited, and therefore significantly increases the risk of mortality and morbidity due to pregnancy-related complications. Preventing excessive mortality and morbidity among mothers and newborns is a priority at the national level, regardless of whether or not there is a crisis situation in the country.

The current demographic situation in the Republic of Moldova

According to data presented in the previous report for 2021, national legislation and policies place a major emphasis on the health of mothers and newborns under normal conditions. There is no specific law dedicated to maternity protection, but relevant provisions are included in various general legislative acts, particularly those in the field of labour and social protection. The state guarantees the protection of maternal and child health, and medical institutions provide women with qualified medical care during pregnancy, childbirth and the postnatal period, as well as curative and preventive care for mothers and newborns. It is stipulated that all pregnant women, regardless of ethnicity, social or marital status, political or religious orientation, as well as all newborns, must receive equitable and free access to a defined set of quality medical services during pregnancy, childbirth and the postnatal period.

According to data from the National Bureau of Statistics on the demographic situation in the Republic of Moldova (RM), 27,000 children were born in 2022, which is down by 2,400 (8.1%) compared to the previous year. More than half of the live births were boys – 13,900, and 13,100 were girls, with a sex ratio of 107 boys to 100 girls. The birth rate in 2022 fell to 10.6 live births per 1,000 residents, compared to 11.3 live births per 1,000 residents in 2021. The average age of mothers at first birth in 2022 was 25.3 years, a slight increase compared to the previous year (25.1 years). The maternal mortality rate was 16 cases, or 59.2 per 100,000 live births, signalling a considerable increase compared to 2021 (14

cases – 47.7 per 100,000 live births) and compared to 2020[23] (5 cases – 16.2 per 100,000 live births).

The number of children under one year of age who died in 2022 was 243, a decrease by 5 children compared to 2021. On the other hand, the infant mortality rate increased slightly from 8.5 deaths per 1,000 live births in 2021 to 9.0 in 2022. At the same time, there is also a "male excess mortality" in the case of deaths under one year of age - 9.6 deaths per 1,000 live births for boys, compared to 8.4 deaths per 1,000 live births for girls. Compared to 2021, the infant mortality rate increased in 2022 for boys by 7.7 deaths, compared to 3.3 deaths per 10,000 live births for girls. The lowest infant mortality rates were recorded in the districts of Nisporeni (2.0‰), Soldanesti (2.9‰), ATU Gagauzia (4.5‰), districts of Basarabeasca (5,5‰) and Edinet (5,6‰). The highest infant mortality rates (between 17‰ and 24‰) were recorded in the districts of Ialoveni, Rezina, Cantemir, Dubasari, Telenesti and Glodeni.

In 2023, 24,000 children were born, approximately 3,000 (or by 11.0%) fewer than in the previous year. More than half of the live births were boys – 12,200, and 11,800 were girls, with a sex ratio of 104 boys to 100 girls. The birth rate in 2023 fell to 9.8 live births per 1,000 residents, compared to 10.7 live births per 1,000 residents in 2022. The average age of mothers at first birth in 2023 was 25.3 years, the same as in the previous year. The maternal mortality rate showed a significant decrease, with 4 cases reported[24] (16.6 per 100,000 live births). The number of children under one year of age who died in 2023 was 240, a decrease by 3 children compared to 2022. On the other hand, the infant mortality rate increased slightly from 9.0 deaths per 1,000 live births in 2022 to 10.0 in 2023. At the same time, there is also a "male excess mortality" in the case of deaths under one year of age - 11.2 deaths per 1,000 live births for boys, compared to 8.7 deaths per 1,000 live births for girls. Compared to 2022, the infant mortality rate increased in 2023, with 15.9 deaths among boys and 3.9 deaths among girls per 10,000 live births. The lowest infant mortality rates were recorded in: Briceni (2.6‰), Soldanesti (3.5‰), Chisinau municipality (5.8‰), districts of Cimislia, Telenesti (6.3‰) and Balti municipality (6.6‰). The highest infant mortality rates (between 15‰ and 21‰) were recorded in the districts of Donduseni, Singerei, Hincesti and Edinet.

23 https://statbank.statistica.md/PxWeb/pxweb/ro/50%20Statistica%20gender/50%20Statistica%20gender__GEN04/GEN041490pop_rcl.px/table/tableViewLayout2/?rxid=b2ff27d7-0b96-43c9-934b-42e1a2a9a774

24 https://statbank.statistica.md/PxWeb/pxweb/ro/50%20Statistica%20gender/50%20Statistica%20gender__GEN04/GEN041490pop_rcl.px/table/tableViewLayout2/?rxid=b2ff27d7-0b96-43c9-934b-42e1a2a9a774

In 2024, 23.6 thousand children were born, about 0.5 thousand (or 2.0%) fewer than in the previous year. More than half of the live births were boys – 12,100 – and 11,500 were girls, with a sex ratio of 105 boys to 100 girls. The birth rate in 2024 was 9.8 live births per 1,000 residents, remaining at the same level as in 2023. The average age of mothers at first birth was 26.8 years, an increase compared to 2023 (25.3 years). There was a decrease in the maternal mortality rate, with only 2 cases reported, which constituted 8.5 per 100,000 live births[25]. The decrease in the maternal mortality rate was due to the implementation of the regionalised perinatal network, as well as the implementation of existing protocols, the modernisation of Perinatal Centres with state-of-the-art equipment, and the training of medical staff in the clinical management of obstetric emergencies. At the same time, the capacities of the Pre-hospital Emergency Medical Service were strengthened by equipping it with type B and C ambulances. The medical staff was also trained in the clinical management of obstetric emergencies. The number of children under one year of age who died in 2024 was 279, an increase by 38 children compared to 2023. Accordingly, the infant mortality rate increased from 10.0 deaths per 1,000 live births in 2023 to 11.8 in 2024. At the same time, there is also a "male excess mortality" in the case of deaths under one year of age - 12.5 deaths per 1,000 live births for boys, compared to 11.1 deaths per 1,000 live births for girls. Compared to 2023, the infant mortality rate increased in 2024 by 1.3 deaths for boys and 2.3 deaths per 1,000 live births for girls. The lowest infant mortality rates were recorded in the districts of Cantemir (2.6‰), Rezina (3.1‰), Dubasari (4.5‰), Cimislia (5.8‰), Orhei (6.1‰), Hincesti (6.3‰) and Soldanesti (6.4‰). The highest infant mortality rates (between 15‰ and 31 ‰) were recorded in the districts of Taraclia, Sangerei, Chisinau municipality, Leova and Donduseni districts.

A significant component in reducing maternal and neonatal mortality and morbidity is the provision of standardised medical care and services to all pregnant women, women in labour, new mothers and newborns.

Regionalised perinatal network

The Republic of Moldova has a *regionalised perinatal system,* which operates on three levels and has been approved by the Ministry of Health (MoH) of the RM, which clearly establishes the referral pathway to adequate care for pregnant women and newborns (Order by the Ministry of Health No. 570 as of 30.06.2025 on the Organisation of the National Perinatal Service)[26]. This system operates on the

25 https://statbank.statistica.md/PxWeb/pxweb/ro/50%20Statistica%20gender/50%20Statistica%20gender__GEN04/GEN041490pop_rcl.px/table/tableViewLayout2/?rxid=b2ff27d7-0b96-43c9-934b-42e1a2a9a774

26 https://ms.gov.md/wp-content/uploads/2025/06/Ordin-570.pdf

basis of the *Regulation on the Organisation of Perinatal Services* and national clinical protocols for pregnancy, childbirth and the postnatal and neonatal periods (MoH of the RM – ms.gov.md). Such organisation has enabled the standardised provision of essential services for mothers and newborns, including emergency obstetric and neonatal care (BEmONC and CEmONC)[27].

Level I (health centres, district maternity hospitals) provides skilled birth assistance, post-abortion care and stabilisation in emergency cases. Birth is assisted by qualified midwives and obstetricians, in accordance with perinatal clinical protocols, which stipulate that all births must be assisted by qualified medical staff.

Level II (large district maternity wards, regional perinatal centres) provides *Basic Emergency Obstetric and Newborn Care* (BEmONC), management of common/moderate complications, management and treatment of advanced and complicated obstetric and neonatal cases, with stabilisation of patients until transfer to a higher level[28]. The service package includes: administration of uterotonics for the prevention and treatment of postpartum haemorrhage, administration of antibiotics for severe infections, treatment of convulsions (anticonvulsants), newborn care (basic resuscitation, temperature maintenance), as well as simple manoeuvres for the removal of the placenta or placental debris. According to the World Health Organization (WHO) standards, all these interventions are part of the minimum mandatory set for BEmONC-capable centres. The RM has integrated these standards into national regulations and has received support from the UNFPA and UNICEF to equip maternity wards with critical medicines and supplies (UNFPA Moldova, UNICEF Moldova)[29].

Level III (municipal maternity wards and the Mother and Child Institute) provides **Comprehensive Emergency Obstetric and Newborn Care** (CEmONC), management of complicated cases of pre-eclampsia, eclampsia, severe haemorrhage, extreme prematurity, etc., and provides surgical interventions in obstetric emergencies, blood transfusion services, and neonatal intensive care. The CEmONC service package includes all BEmONC interventions, as well as caesarean section, blood transfusion, advanced neonatal care (including neonatal intensive care) and treatment of severe obstetric complications.

Between 2022 and 2025, access to well-equipped medical facilities has increased, mainly due to the support from the UNFPA and UNICEF.

27 https://ms.gov.md/wp-content/uploads/2025/06/Ordin-570.pdf
28 https://ms.gov.md/wp-content/uploads/2025/06/Ordin-570.pdf
29 https://ms.gov.md/wp-content/uploads/2025/06/Ordin-570.pdf

Although rapid transfer mechanisms for pregnant women and critically ill newborns are not yet functioning uniformly in some regions; and emergency medical transport is limited, delays in transfer can compromise maternal and/or neonatal prognosis. A clear framework for organisation by level (district, regional and tertiary) that includes specialists such as obstetricians, neonatologists, anaesthetists and midwives in teams can save lives. Experience in recent years has shown that safe motherhood depends on not only infrastructure, training of medical staff and strengthening of the regulatory framework, but also on cooperation and coordination between levels, which must be maintained even in emergency situations.

Sexual and reproductive health service providers

Since 2022 to date, the responsibility for services designed for mothers and newborns in the Republic of Moldova has been *multisectoral*, carried out by government authorities and public institutions. These include the MoH of the RM, the National Agency for Public Health (NPHA), the Tertiary Perinatal Centre within the Mother and Child Institute (MCI), district and municipal hospitals with maternity wards, as well as health centres and family doctors at the pre-hospital level.

The MoH of the RM coordinates policies and standards on maternal and child health, including the implementation of the *National Perinatology Programme* and national clinical protocols (ms.gov.md). *The NPHA* monitors maternal and neonatal health indicators and is responsible for implementing prevention, vaccination and neonatal screening programmes.

The MCI is the main tertiary-level perinatal centre, responsible for specialised care for pregnant women, women in labour, new mothers and newborns, including in particularly complex and complicated cases. *District and municipal hospitals with maternity wards* provide prenatal care, delivery and postnatal care services at the subnational level.

Health centres and family doctors provide basic prenatal care, pregnancy monitoring, as well as postnatal care for mothers and newborns at home, being the level closest to the population.

At the national level, UN agencies, notably the *UNFPA Moldova*, provide support for sexual and reproductive health, encompassing maternal care, by equipping maternity wards with essential equipment and by enhancing the regulatory framework through contributions to the drafting of clinical protocols on antenatal, intrapartum, and postnatal care. Furthermore, UNFPA Moldova facilitates training for sexual and reproductive health service providers through continuing education

for medical staff with higher and secondary education (UNFPA Moldova)[30]. Similarly, *UNICEF Moldova* supports interventions for maternal and child health, such as those related to feeding behaviour, breastfeeding and immunisation, including in emergency situations.

Accessibility and equity

Infrastructure. In recent years, the RM has modernised the infrastructure of its medical institutions, which allows for the provision of high-quality services in the area of maternal and child healthcare in the country. Eleven anaesthesia and intensive care units in strategic medical institutions across the country, including the MCI and Gheorghe Paladi MCH, which are level 3 and level 2 perinatal centres, respectively, have been modernised and undergone major repairs. A key strategic element was the modernisation of the conditions in which high-quality services are provided in the MCI. This was achieved by carrying out repairs in the obstetrics and gynaecology resuscitation department, the only department in the country that provides multidisciplinary medical care to patients (pregnant women, new mothers). The department serves over 850 patients from across the country annually (MoH of the RM, World Bank, UNICEF and the Government of Poland).

The Methodological Advisory Centre on Immunisation within the Integrated Specialised Advisory Department of the MCI, which ensures the vaccination of children throughout the country, including refugees from Ukraine, has been modernised (budget of the MoH of the RM and UNICEF). The same applies to the Premature Babies Unit, which has been fully equipped with state-of-the-art medical devices (radiology unit, incubators for newborns, patient monitors, syringe pumps, resuscitation tables, warming tables, nCPAP ventilators, heated beds, phototherapy lamps, etc.).

The Emergency Reception Units (ERUs) in district hospitals have been repaired, providing expectant mothers and newborns with the highest standards of care, including in the triage and referral system (UNFPA). Over 30 emergency medical stations and sites have been renovated in various localities across the country.

The experience of the pandemic and the crisis of refugees from Ukraine has shown that infrastructure can be quickly adapted to meet the SRH needs. Large hospitals and regional centres have put in place separate triage areas and confidential premises, but these solutions have been rather reactive and dependent on international projects, which raises sustainability issues. Infrastructure for the SRH and services

30 https://moldova.unfpa.org/en.

for mothers and newborns has become more accessible and better organised due to the regionalised perinatal system and international support. However, there is still a disparity in access between urban and rural areas.

It has been noted that infrastructure has evolved significantly in urban areas, but significant gaps remain in rural areas, where a lack of human resources limits access to the SRH services. Recent reports have highlighted temporary shortages of supplies and delays in procurement during crises, although regional and tertiary centres have maintained strategic stocks.

Consumables and equipment.

BEmONC involves a package of essential services such as: administration of uterotonic drugs, antibiotics and anticonvulsants, immediate care of the newborn, basic neonatal resuscitation, treatment of postpartum haemorrhage, manual removal of the placenta. Essential medicines (e.g. uterotonics, antibiotics, anticonvulsants), equipment for performing surgical procedures in obstetrics and for caesarean sections, blood banks for transfusions, and neonatal intensive care units are available in *CEmONC* units, such as the MCI https://ms.gov.md/wp-content/uploads/2025/06/Ordin-570.pdf. These services can also be provided at the district and municipal level: Uterotonic preparations (oxytocin, misoprostol), antibiotics and anticonvulsants are included in the list of essential medicines and provided through the National Programme (Government Decision No. 134/2022); basic equipment for newborn care (heating lamp, aspirator, resuscitation mask) has been distributed to maternity wards with the support of the *UNFPA* and *UNICEF* (UNFPA Moldova, UNICEF Moldova).

The *UNFPA Moldova* has equipped half of the maternity wards in the country (12 Perinatal Centres out of a total of 24 Perinatal Centres currently existing in the Republic of Moldova) with complete sets of medical equipment, devices, consumables and necessary furniture, as well as emergency obstetric and neonatal care kits between 2022 and 2024 (UNFPA Moldova)[31]. Nine Perinatal Centres have also been equipped with type A ambulances to strengthen the referral mechanism within the Perinatal Centres Network[32].

For emergencies or situations where access to medical facilities is impossible, the UNFPA Moldova has distributed birth kits and reproductive health kits (RH Kits) in

31 https://moldova.unfpa.org/en/news/ministry-health-%E2%80%93-host-unfpa-photo-exhibition-dedicated-modernization-12-perinatal-centers-0

32 https://moldova.unfpa.org/ro/news/9-maternit%C4%83%C8%9Bi-din-%C8%9Bar%C4%83-au-prim-it-ambulan%C8%9Be-moderne-din-partea-ministerului-s%C4%83n%C4%83t%C4%83%C8%9Bii-donate-de

vulnerable areas and to refugees, which include: sterile gloves, cord cutters, sterile dressings, soap and antiseptic solutions. These kits have been integrated into emergency response plans (the crisis of refugees from Ukraine) to prevent maternal and neonatal mortality in cases where access to medical facilities is delayed[33].

During 2022-2023, a series of activities and purchases/donations of equipment and consumables took place in maternity wards in the RM. With the support of the UNFPA, 12 Perinatal Centers across the country were equipped with state-of-the-art medical equipment, namely: 3-section delivery chairs, adapted gynecology chairs, hot air sterilizers, 4-section electrically operated operating tables, intensive care beds, mobile cardio-fetal monitors, bilirubin meters for newborns, neonatal ventilators, laryngoscopes for newborns, resuscitation tables for newborns, and phototherapy lamps. The transfusion departments were equipped with special chairs for blood collection, blood storage equipment, rapid plasma thawing devices, agitators and platelet incubators. Nine of these centres were equipped with type A ambulances (UNFPA).

Another donation was made by the Government of the French Republic in collaboration with the MoH of the RM, which provided a second-hand ambulance for the MCI, as well as the state-of-the-art reproductive health equipment for the Perinatal Centre (beds and lamps for delivery and operating rooms, resuscitation tables for newborns, state-of-the-art anaesthesia equipment, equipment for sterilisation and storage of medical equipment, furniture for patient wards and medical furniture).

Five strategic medical institutions, including the MCI, were equipped with the state-of-the-art medical devices, namely: ultrasound diagnostic equipment, digital X-ray devices, defibrillators, haemodialysis machines, state-of-the-art stretchers and operating tables, etc. (Government of Japan). The following donations were received from the association Save the Children Romania in 2023: 700 single-use respiratory circuits for newborns for the Neonatal Intensive Care Unit and the Premature Baby Unit at the MCI; 278,000 nappies, wet wipes and absorbent pads.

As part of the partnership with the National Platform for Early Intervention in Childhood, the Voinicel Centre, due to the support of the USAID Moldova and UNICEF Moldova, received a donation of hygiene products for vulnerable families receiving medical services at the MCI. Similarly, the MCI received a batch of humanitarian aid from Sweden, which included medical supplies and devices, medical consumables,

33 https://moldova.unfpa.org/ro/news/unfpa-%C8%99i-guvernul-statelor-unite-au-livrat-spitalelor-din-republica-moldova-un-lot-de-zece-tone

mattresses, nappies and other essential goods (Swedish Human Bridge Foundation). Ten Health Centres in the districts of Cahul and Ungheni (including HC Cahul, Slobozia Mare, Gavanoasa, Crihana Veche and Bucuria in the district of Cahul and HC Ungheni, Macaresti-Costuleni, Pirlita, Valea Mare and Radenii Vechi in the Ungheni district) received equipment and furniture for 10 child development rooms as a donation within the framework of the project "Strengthening Capacities of Healthcare Workers at the Level of Primary Health Care in Provision of Quality Mother, Child and Adolescent Health Services in Cahul and Ungheni Districts".

Modern teaching equipment in the field of sexual and reproductive health (anatomical models for training practical skills in gynaecological and obstetric care) was donated by the UNFPA. It is used to train students, resident doctors and practitioners, as well as for the continuous development of medical staff with secondary education in the field of sexual and reproductive healthhttps://bolitropicale.usmf.md/ro/noutati/unfpa-moldova-donat-usmf-nicolae-testemitanu-un-lot-de-echipament-educational-modern.

The availability of modern equipment and essential products for maternal and neonatal health has improved significantly, particularly through the strengthening of the perinatal network with the support of international partners (UNFPA, UNICEF). Medicines needed in emergency situations (oxytocin, misoprostol, antibiotics, anticonvulsants) are included on the national list and distributed through MoH programmes. Regional and tertiary centres have neonatal resuscitation equipment and emergency obstetric kits. As a result, the access to emergency obstetric and neonatal care (BEmONC, CEmONC) has increased in institutions of the II–III level. The supply and maintenance of the availability of uterotonics, antibiotics, anticonvulsants and neonatal resuscitation equipment has had a direct impact on reducing avoidable complications and deaths. Emergency preparedness must include buffer stocks and robust logistics mechanisms, especially for rural areas.

The UNFPA supported the supply of equipment sets to 200 gynaecological examination rooms in primary healthcare institutions in 2024. By the end of 2025, another 22 gynaecological examination rooms within the PHC will be equipped to ensure the quality of the SRH services provided by family doctors and their teams, including antenatal and postnatal care services https://moldova.unfpa.org/ro/news/servicii-ginecologice-moderne-pentru-femeile-din-mediul-rural.

Integration into the emergency dimension

The National Pre-hospital Emergency Medical Assistance Service (NPEMAS), which operates through the *112* system and covers all regions of the country, is responsible to ensure the transport of pregnant women and newborns with

complications to appropriate level II or III institutions. The *NPEMAS (112)* provides 24/7 transport and rapid referral between levels, which helps prevent excessive morbidity in mothers and newborns through standardised interventions tailored to each level of complexity. This ensures medical transport and rapid evacuation to the appropriate centres in case of obstetric and neonatal complications. Referral for emergency obstetric and neonatal care is an integral part of the national network of maternal and child services (Government Decision No. 134/2022). The system has been tested in major crises (the COVID-19 pandemic, the crisis of refugees from Ukraine). The Report of the MoH of the RM for 2024 confirms that obstetric and neonatal referral routes have been maintained, including through logistical adaptations (mobile teams, additional transport, interregional coordination). During the COVD-19 pandemic and the crisis of refugees from Ukraine (2022-2025), the obstetric referral system continued to function, being adapted by supplementary number of mobile teams, inter-institutional coordination and fast-track procedures for pregnant women experiencing complications. *The Report of the MoH of the RM for 2024* confirms the maintenance of the obstetric referral route, with timely transfers to higher-level Perinatal Centres. International partners (UNFPA, UNICEF) contributed to providing ambulances, equipment and training on the clinical management of obstetric emergencies for staff involved in the emergency transport of pregnant women and newborns (UNFPA Moldova, UNICEF Moldova). The UNFPA equipped nine Perinatal Centres with Type A ambulances in order to strengthen the referral mechanism between levels of perinatal care[34].

The Republic of Moldova has a clear and up-to-date referral system for emergency obstetric and neonatal care (EmONC), based on the regionalisation of perinatal services, national clinical and standardised protocols, and 112 system, which has proven its functionality and adaptability in emergency situations such as the COVID-19 pandemic and the refugee crisis. In this context, the *WHO Office in Moldova* provides technical support and recommendations for clinical and standardised protocols in perinatal health. NGOs and civil society are actively involved in providing services. Thus, the MCI Simulation-Based Training Centre in Emergency Obstetrics and Neonatology is involved in health education and counselling for pregnant women.

The Association Positive Initiative and *the League of People Living with HIV* support HIV-positive pregnant women in accessing services to prevent mother-to-child transmission of HIV. *GenderDoc-M* contributes to sexual and reproductive education, including for pregnant women in vulnerable communities (key populations at increased risk of infection).

34 https://moldova.unfpa.org/ro/news/9-maternit%C4%83%C8%9Bi-din-%C8%9Bar%C4%83-au-prim-it-ambulan%C8%9Be-moderne-din-partea-ministerului-s%C4%83n%C4%83t%C4%83%C8%9Bii-donate-de

Private clinics and laboratories offer pregnancy monitoring services, tests for pregnant women and newborns, as well as paid childbirth services. *Pharmacies and commercial networks* sell medicines, nutritional supplements and care products for mothers and children.

The Medical Certification of Birth and Death Information System (SI eCMND) has been established. It provides for inter-institutional data exchange and the generation of detailed statistical reports, contributing to better monitoring of demographic trends, in line with European standards. The establishment of this system contributes to the intensification of the digitisation process of the healthcare system in the RM, taking into account that, until now, there has been no information system for recording births and deaths at the national level.

Qualified training of sexual and reproductive health service providers (continuing education)

A significant component in reducing maternal and neonatal mortality and morbidity is the provision of standardised care and medical services to all pregnant women, women in labour, women who have recently given birth and newborns. Clinical management in accordance with national and standardised clinical protocols, medical standards adapted to international clinical protocols and based on existing evidence, as well as on the WHO, RCOG, NICE, SCOG and other guidelines is an important aspect. Teachers of the Department of Obstetrics and Gynaecology of Nicolae Testemitanu SUMP and staff of the Obstetrics Laboratory of the MCI have developed a series of national and standardised clinical protocols, which are periodically reviewed and adjusted according to the requirements of the international guidelines and cohort studies. These protocols address the main causes of maternal mortality: hypertensive conditions, sepsis and obstetric septic shock, premature detachment of the normally inserted placenta, etc.

Standardised clinical protocols have also been developed, some of which are directly aimed at reducing maternal and neonatal mortality and morbidity, and namely: postpartum haemorrhage, labour induction, electronic foetal monitoring during pregnancy and childbirth, etc.

In 2025, in collaboration with the UNFPA Moldova, a series of standardised clinical protocols were developed that refer to the positive experience in the perinatal period, a concept taken from the WHO recommendations: Antenatal Care for a Positive Pregnancy Experience; Intranatal Care for a Positive Birth Experience; Standardised Clinical Protocol: Postnatal Care for a Positive Experience during the Postpartum Period; Thromboprophylaxis during Pregnancy, Childbirth and Postpartum. Taking

into account that pregnancy, childbirth, and the postpartum period may be more complicated in adolescents, another protocol has been developed that includes provisions specific to this age group: Integrated Management of Pregnancy, Childbirth, and the Postpartum Period in Adolescents.

Taking into account that **insufficient integration of psychosocial support** has been identified, as team training is predominantly focused on medical interventions, but the counseling and psychological support component for mothers in perinatal emergencies is less developed, both the aforementioned protocols and the continuing education sessions for providers focused on communication as an important pillar in the management of clinical cases for the prevention of maternal and/or fetal mortality and/or morbidity. This aspect is important for a holistic approach to maternal and neonatal healthcare.

The national clinical protocol for hypertensive conditions in pregnancy has also been revised, and work is currently underway to revise a series of national clinical protocols in obstetrics for obstetricians-gynaecologists and family doctors, the topics of which are directly related to the causes of maternal mortality and morbidity, such as: Premature Detachment of the Normally Inserted Placenta, Multiple Pregnancy, Premature Birth, etc. The following Standardised Clinical Protocols are reviewed: Postpartum Haemorrhage, Antenatal Fetal Death, Premature Rupture of Membranes at Term, Electronic Foetal Monitoring during Pregnancy and Birth, Umbilical Cord Prolapse.

In the field of neonatology, specialists from the Paediatrics Department of Nicolae Testemitanu SUMP are working on a series of protocols to reduce neonatal mortality and morbidity rates.

In municipal and republican (level III) hospitals, including the MCI and maternity wards in Chisinau and Balti, there are multidisciplinary teams of obstetricians-gynaecologists, neonatologists, anaesthesiologists, as well as midwives and nurses trained in emergency obstetric and neonatal care (CEmONC). At the level of district and municipal maternity hospitals of levels I and II, assistance with vaginal deliveries is provided by obstetricians-gynaecologists, assisted by midwives and trained nurses. According to the national perinatal protocols developed by the MoH of the RM, all births must be assisted by qualified staff, regardless of the complexity of the case (MoH of the RM – ms.gov.md). The Report of the MoH of the RM for 2024 shows that over 98% of births in the country were assisted by qualified medical staff, including in district-level institutions. Thus, within the regionalised perinatal system, multidisciplinary teams play an essential role in rapid interventions and in the transfer of critical cases to higher levels (regional centres or the MCI). Therefore,

the coverage with qualified staff at birth remained at a high level (over 98%), which reflects the capacity of the system to respond to most obstetric emergencies.

It is well known that while regional and tertiary centres have trained staff and multidisciplinary teams, other district hospitals with level I Perinatal Centres face a shortage of specialised human resources and frequent staff turnover, which reduces the quality of the response to obstetric emergencies. Although basic resuscitation is implemented, not all primary and secondary institutions have trained staff for complex interventions (assisted ventilation, neonatal intensive care). In the absence of a sustainable national mechanism to ensure regular and uniform training in all regions continuing education depends on external projects.

In this context, the integration of clinical management of obstetric and neonatal emergencies into the continuing education curriculum for medical staff has seen visible progress between 2022 and 2025. Nicolae Testemitanu SUMP and medical simulation centres in the country (the University Centre for Simulation in Medical Training – CUSIM and the Simulation-Based Training Centre in Emergency Obstetrics and Neonatology at the MCI) continued to include modules dedicated to emergency obstetric and neonatal care (BEmONC and CEmONC) in their training and continuing education programmes. These cover important topics such as the management of natural childbirth, the use of uterotonics, the management of postpartum haemorrhage, neonatal resuscitation and the treatment of severe complications. Medical staff in level I, II, and III perinatal centres have benefited from training organised with the support of the UNFPA, UNICEF, and WHO, using practical simulation methods to increase their level of preparedness in critical situations. In this regard, medical staff have been trained periodically through national programmes and international support provided by the UNFPA, UNICEF, including in the use of national and standardised clinical protocols for emergencies such as severe pre-eclampsia, eclampsia, fetal distress, postpartum haemorrhage, prematurity and neonatal resuscitation, and out-of-hospital births (UNFPA Moldova, UNICEF Moldova). Similarly, the continuing education component for sexual and reproductive health service providers is carried out through simulation training at the Simulation-Based Training Centre in Emergency Obstetrics and Neonatology at the MCI.

As part of the continuing medical education programme at Nicolae Testemitanu SUMP, the Department of Obstetrics and Gynaecology has conducted several training sessions on topics related to the prevention of maternal and/or neonatal mortality and morbidity. In the context of training on the Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations (MISP), particular attention was paid to Objective No. 4 – Preventing excessive morbidity and mortality among

mothers and newborns – emphasising once again that a potential crisis situation can be caused by various causes: natural disasters, pandemics, armed conflicts. The beneficiaries (obstetricians-gynaecologists, family doctors) were trained in providing emergency medical care to mothers and newborns in a crisis situation, using a minimum of equipment. Thus, the integration of BEmONC and CEmONC practical training, with the support of simulation centres and international partners, has shown that trained medical staff respond more quickly and effectively to the need in the SRH services of the affected population in critical situations https://usmf.md/ru/node/31297

During the period of 2022-2025, midwives and community health workers were trained in providing basic neonatal care services: maintaining the warm chain, umbilical cord hygiene, simple resuscitation of the newborn by bag-mask ventilation. In rural areas, healthcare centres have been supplemented with minimal equipment for basic neonatal interventions, but for severe cases, newborns are immediately transferred through the 112/NPEMAS system to level II or III maternity wards (NPEMAS). UNICEF Moldova has supported the equipping of maternity wards and community centres with neonatal resuscitation kits and has developed educational materials for parents and community workers (UNICEF Moldova). Thus, according to the Report of the MoH of the RM for 2024, all tertiary institutions have qualified specialists for the management of complex maternal and fetal emergencies.

In 2022, 10 simulation training sessions were organised and over 120 specialists trained (obstetricians-gynaecologists, neonatologists, anaesthesiologists, midwives, nurses) in accordance with MoH Order 921 as of 05.10.2022 on the organisation of the simulation training course Medical Care in Obstetric and Neonatal Emergencies in the Context of the SARS-CoV-2 Pandemic. Likewise, there were held 4 online training seminars entitled Antenatal Follow-up of Pregnant Women in Outpatient Conditions for 100 family doctors from PMSI and private institutions, from the PHC in Cahul and Ungheni districts and other 20 training seminars entitled Monitoring the Development of Children from 0 to 3 Years at the PHC Level. In 2023, simulation training was organised and a total of 127 specialists (including obstetricians, gynaecologists and midwives) were trained in Management of Obstetric Emergencies and the Use of Cardiotocography (UNFPA). A total of 21 psychologists from perinatal centres across the country were trained in Management of Obstetric Emergencies and Psychological Aspects of Communication with Beneficiaries. Similarly, 18 teachers from Raisa Pacalo Centre of Excellence in Medicine and Pharmacy and from four regional medical colleges of the Republic received training in Management of Obstetric Emergencies with the support of the UNFPA.

In order to maintain the concept of continuous provision of safe maternal and child health services, a number of specialists received training on Early Identification of Signs of Concern and Strengthening Parenting Skills to Stimulate Children with Mild Developmental Disorders with 400 medical workers (family doctors and family nurses) being trained in 2022. As part of the organisational and methodological support provided by the MCI to medical and health institutions of the RM, 45 training seminars were held in 2023 for 650 family doctors and nurses on the implementation of the International Child Development Monitoring Guide, in the context of the Action Plan for the implementation of Government Decision No. 507/2023 (UNICEF).

The implementation in the RM of the maternal and fetal medicine programme (2022-2025) as an ongoing programme became possible due to the Memorandum signed between the MoH of the RM, the Government of the Hellenic Republic and the Fetal Medicine Foundation from the United Kingdom. The Programme also includes setting up of the Maternal and Fetal Medicine Unit within the MCI. In this context, a total of 148 imaging specialists, obstetricians-gynaecologists from across the country participated in the training course Advances in Fetal Medicine during 2023. Similarly, six employees of the institution participated in the Advanced Training Course on Fetal Medicine Therapy held in Abu Dhabi, United Arab Emirates. Medical staff from the tertiary perinatal center was involved in the cross-border project: The Best Chance of Life for Neonates – Improving Neonatal Outcome in the Romania-Republic of Moldova Border Area, the partner in the project was Vaslui County Emergency Hospital from Vaslui town. The project was implemented within the framework of the Joint Operational Program of Romania and the RM.

The course Obstetric Emergencies in Pre-Hospital Settings was delivered in 2024, with attendance from 60 professionals, including 15 emergency doctors and 45 midwives. Furthermore, in 2025, the course Clinical Management of Obstetric Emergencies enabled the continuing education of 96 healthcare providers, including 24 doctors and 72 nurses. The training course Clinical Management of Obstetric Emergencies was attended by 16 doctors and 88 nurses (104 healthcare workers). Thus, 4 regions providing emergency medical assistance (EMU) and 41 EMU substations were covered during the period of 2024-2025. These continuing education courses, held at the MCI Simulation-Based Training Centre in Emergency Obstetrics and Neonatology, provided information on the management of out-of-hospital births at the pre-hospital stage, with the aim of preventing perinatal complications, particularly those leading to maternal and/or neonatal mortality.

Between September and November 2025, the MoH of the RM organised training courses for 323 health specialists in the country (116 service providers from all

perinatal centres and 207 professionals from primary healthcare institutions of the country). It was done with the support of the UNFPA Moldova and the Government of the United Kingdom of Great Britain and Northern Ireland, UK in Moldova - British Embassy Chisinau, in partnership with Nicolae Testemitanu SUMP. The specialists were trained to provide antenatal, delivery and postnatal care, centred on the woman, with an emphasis on respecting the rights, safety and dignity of each expectant mother. The programme included five workshops for obstetricians-gynaecologists and midwives in perinatal centres, on the following topics: Training workshops for medical staff in Perinatal Centres on Intrapartum Care for a Positive Birth Experience (September 2025) and eight workshops for family doctors and nurses in primary care, on the topic: Training workshops for medical staff in primary care on Antepartum and Postpartum Care for a Positive Experience during Pregnancy and the Postpartum Period (October-November 2025). The training was based on the provisions of the new standardised clinical protocols developed by the teaching staff of the Department of Obstetrics and Gynaecology of Nicolae Testemitanu SUMP for antenatal, intrapartum and postnatal care, approved by the MoH of the RM in 2025.

In 2022, medical consultants from the MCI working with AVIASAN performed: 765 requests/719 visits by neonatologists, 95 requests/61 visit by obstetricians and gynecologists. There were 136 visits by attending doctors, including obstetricians-gynaecologists, neonatologists, paediatricians and paediatric surgeons. These were aimed at assessing the quality of medical services provided to mothers and children in PMSI hospital and primary healthcare facilities in the municipalities and districts of the republic. In 2023, medical consultants from the MCI working with AVIASAN performed 767 requests/733 visits by neonatologists, including 64 requests/43 visits by obstetricians and gynecologists, at the request of the PMSIs of the RM.

National and international scientific events were held, featuring the presentation of reports. Notable events included the 8th *Rare Disease Day*, registered with EURORDIS, which was attended by over 184 specialists. The scientific and practical conference, *The Impact of Immunisation on the Morbidity and Mortality of Children from Respiratory Diseases in the Republic of Moldova*, brought together over 200 participants in 2023. Online training seminar in accordance with the Ministry of Health Order No. 385-d as of 01.08.2023 on the organisation of remote information sessions for medical staff in Perinatal Centres, Health Centres and Consultative Departments consolidated the knowledge of specialists in the field of maternal and child health, giving them the opportunity to share their experience. The Guidelines for Communication between Medical Workers and Paediatric Patients and Families (2022) was developed and published.

Community outreach

In the RM, *the MoH of the RM and the NAPH* have developed and distributed IEC (Information, Education, Communication) materials on maternal and neonatal health, family planning and the prevention of pregnancy complications. These materials are available in Romanian and Russian, covering the main internally spoken languages (NPHA – ansp.md). The materials focus on the importance of pregnancy monitoring, giving birth in medical institutions, preventing obstetric complications and emergency neonatal care. They are distributed through the network of family doctors and community assistants.

Similarly, *the MoH of the RM* and NPHA have carried out public education campaigns on maternal and child health, including informing pregnant women about the need to attend medical institutions for childbirth and about the existence of emergency obstetric and neonatal care (EmONC) services. Beneficiaries were also informed about the availability of services and the importance of seeking medical assistance by going to medical institutions. *The Report of the MoH of the RM for 2024* confirms that between 2021 and 2025, information sessions were held in communities, particularly through family doctors and community health workers, who are primarily responsible for educating pregnant women and families about the risks of home birth and the importance of access to maternity facilities equipped for emergencies.

The *UNFPA Moldova and UNICEF Moldova* supported community education activities, including campaigns targeting women in rural areas and refugees, to inform them about safe delivery services and emergency care for mothers and newborns (UNFPA Moldova, UNICEF Moldova).

NGOs such as *Positive Initiative* and *Women's Law Centre* contributed through community sessions and IEC materials that emphasise confidentiality and equitable access to maternal and neonatal health services (UNAIDS Moldova). During the COVID-19 pandemic and the crisis of refugees from Ukraine, community outreach was strengthened through the development of multilingual materials (Romanian, Russian, Ukrainian), brochures and media campaigns to encourage pregnant women to seek safe delivery and emergency care services in maternity wards. *UN partners* also distributed reproductive health kits and guidelines with information on access routes to safe obstetric and neonatal services (UNHCR Moldova)[35]. In high-risk regions (Transnistria, Gagauzia, southern districts), the IEC materials were drafted and disseminated in Romanian, Russian and Gagauz, in collaboration with local authorities and with the support of international partners (UNICEF Moldova).

35 https://moldova.unfpa.org/ro/news/unfpa-%C8%99i-guvernul-statelor-unite-au-livrat-spitalelor-din-republica-moldova-un-lot-de-zece-tone

The annual Breastfeeding Caravan brought together dozens of current and future mothers, fathers and other family members, who were informed by healthcare, nutrition and breastfeeding experts about the benefits of breastfeeding, how breast milk is produced, and about correct breastfeeding positions and the correct way to hold the baby. The Breastfeeding Caravan 2024 was organised by the MoH of the RM and the WHO, with the support of the European Union Delegation to Moldova and the Government of the United States of America. The following information events took place in 20 localities: Chisinau, Balti, Cantemir, Leova, Hincesti, Ialoveni, Orhei, Criuleni, Anenii-Noi.

The online campaign Vaccines are Safe and Effective to promote vaccination, supported by the MoH of the RM, NPHA and UNICEF, with organised activities to promote and encourage parents to vaccinate their children on time, according to the National Vaccination Calendar. A series of informational materials were distributed, with advice from medical workers on preparing the child before, during and after vaccination, contraindications to vaccination, and adverse reactions that may occur after vaccination. The "Child Development Booklet (family diary)" was updated, printed in 16,000 copies and distributed to all PMSI of the PHC.

There has been a moderate improvement in the preparedness for the implementation of MISP in the field of maternal and neonatal health in the RM. The most visible achievement was the strengthening of the regionalised perinatal system, which operates on three levels and allows for a differentiated and coordinated approach to critical cases. This framework has facilitated a better-defined flow of patients and contributed to reducing delays in accessing specialised services. Another significant achievement is the provision of essential equipment and supplies for emergency obstetric and neonatal care to level II and III perinatal centres. The availability of uterotonics, antibiotics, anticonvulsants, neonatal resuscitation equipment and obstetric kits has increased in level II and III perinatal institutions, largely due to the support of the UNFPA and UNICEF. This has led to increased capacity to manage major complications such as postpartum haemorrhage and neonatal asphyxia. The staff in perinatal centres received regular training, which has led to improved response in critical situations and better implementation of the standard protocols.

However, these advances cannot be considered "significant" on a national scale, as obvious territorial disparities persist. Level I perinatal centres in particular and the PHC institutions in rural areas continue to face medical staff shortages, temporary shortages of supplies and limited infrastructure for advanced interventions. In addition, the continuous training of medical staff is not sustainable, even in the context of the integration of training modules into the Continuing Professional Development Programme for Doctors and Pharmacists, as it is often dependent on

external projects and international support. This means that equitable access to life-saving services remains incomplete.

The level of preparedness of the RM for the implementation of the MISP for SRH in crisis situations in the field of maternity and neonatology has improved moderately: real steps have been taken to strengthen infrastructure and train staff, but persistent challenges – urban-rural disparities, human resource shortages, logistical vulnerabilities and dependence on external support – show that national preparedness is still fragile and needs systematic strengthening to become uniform and sustainable. To this end, it is necessary to: reduce urban-rural disparities by strengthening maternal and neonatal services at level I Perinatal Centres and the PHC institutions in rural areas, continuously develop/improve specialised human resources, and create an integrated national system for monitoring and managing resources in the field of maternal and neonatal care.

CONCLUSIONS

1. Maternal mortality declined substantially between 2022 and 2024 due to the consolidation of the regionalised perinatal network and its modernisation with the state-of-the-art equipment and ambulances, medicine kits, devices and consumables, alongside with strengthening of the regulatory framework and training of medical staff to facilitate the practical implementation of clinical protocols and improve response capacity in critical situations. The capacities of the Pre-hospital Emergency Medical Assistance Service will also be strengthened by equipping ambulances and training medical staff in the clinical management of obstetric emergencies; as well as by strengthening the capacity of the Blood Transfusion Service, which is a critical component in the clinical management of obstetric and gynaecological emergencies (by providing the state-of-the-art equipment and training for medical staff). Infant mortality is on the rise and varies significantly across regions.

2. The regionalised perinatal network functions efficiently, especially in level III and II Perinatal Centres, ensuring CEmONC in accordance with the WHO standards, but delays in the transfer of pregnant women and/or newborns in critical condition and limitations in medical transport in some districts compromise uniform access to life-saving care.

3. The supply of essential equipment, consumables and medicines to perinatal institutions has improved considerably due to national investments and the support of the international partners (UNFPA, UNICEF, WHO). Persistent urban-rural disparities and dependence on external projects keep the system in a state of “moderate” preparedness.

4. National clinical protocols have been expanded and updated to include the management of the main causes of maternal and/or neonatal mortality, with an emphasis on antenatal, intrapartum and postnatal care for a positive experience during pregnancy, childbirth and the postpartum period. The integration of psychological support and counselling into perinatal management is underdeveloped, but recognised as necessary in crisis situations and beyond.

5. Continuing education of medical staff has made significant progress in BEmONC/CEmONC, maternal and fetal medicine and obstetric emergencies, including through simulation methods. Human resources remain insufficient/deficient in district institutions, affecting their response capacity, especially in critical situations.

6. The integration of emergency components (the 112/NPEMAS system, transfer protocols and logistical adaptations during the pandemic and refugee crisis) demonstrates the functionality of the national framework, but also the need to improve medical transport, especially in rural areas.

7. Community informing and IEC actions have been scaled up and diversified, including multilingual materials, information campaigns on safe childbirth, breastfeeding, vaccination and access to emergency services. The impact of these activities is uneven, with coverage being more effective in urban centres than in rural or hard-to-reach areas.

RECOMMENDATIONS

1. Strengthen monitoring and targeted interventions to reduce maternal and neonatal mortality through regular detailed analysis at district level, including clinical supervision, mentoring and support visits. Audit of cases of maternal death proximity and Confidential Maternal Mortality Questionnaire - applying tools for assessing maternal deaths in order to identify their real causes and implement systemic measures to reduce maternal mortality. Methods based on confidentiality and non-punitive policies allow for in-depth analysis of the factors contributing to maternal death, in line with the 'Beyond the Numbers' concept/approach.

2. Optimisation of referral and transfer pathways in obstetric/neonatal emergencies through standardisation and periodic testing of transfer pathways (assessment of perinatal centres and emergency services). Strengthening of the emergency and perinatal medical transport component by equipping ambulances with specific equipment for mothers and newborns.

3. Systematic integration of the psychological support into perinatal care by defining the role of the perinatal psychologist and minimum counselling standards for pregnant women, new mothers and families in crisis situations.

4. Scaling up and tailoring the IEC actions for vulnerable groups and rural areas, adapted culturally and linguistically. Adjusting messages based on the results obtained.

5. Approval of the Guide, including the Standardised Training Curriculum for Information/Education Sessions in Schools for Future Parents at the PHC and Perinatal Centres level.

Objective 5
Prevention of Unplanned Pregnancies

Preventing unplanned pregnancies is a central strategic element of the Minimum Initial Service Package for Sexual and Reproductive Health (MISP), with the aim of immediately reducing the risk of maternal morbidity and mortality in contexts characterised by instability, limited medical access and increased vulnerabilities. In crisis situations, the likelihood of unplanned pregnancies increases significantly due to the disruption of reproductive health services, the deterioration of protection mechanisms and the increased incidence of sexual violence.

By ensuring rapid access to modern methods of contraception, including emergency contraception, the MISP prevents unplanned pregnancies, which, in the absence of adequate care, can lead to severe complications or unsafe abortions. This intervention directly contributes to protecting the health and lives of women and girls, while also strengthening their reproductive autonomy in circumstances where it is often compromised. In addition, preventing unplanned pregnancies alleviates pressure on emergency medical services, which often operate at reduced capacity in crisis situations, and supports an integrated response for survivors of sexual violence. Thus, the prevention component of the MISP is an indispensable intervention with an immediate and substantial impact on the protection of reproductive health in the critical phases of emergencies.

I. **An analysis of policy documents adopted or updated between 2021 and 2025 in the field of family planning and contraception** shows a clear trend towards:

1. strengthening the regulatory and institutional framework for family planning,
2. expanding public funding and guaranteeing access for vulnerable groups,
3. diversifying contraceptive methods, including the introduction of a new LARC contraceptive method,
4. integration of emergency preparedness into the SRH policies,
5. standardising and professionalising counselling and continuous alignment with the WHO and the UNFPA recommendations.

Strengthening the regulatory and institutional framework for family planning. Between 2021 and 2025, the Republic of Moldova made significant progress in strengthening the regulatory framework governing family planning services by updating and adopting national policy documents that explicitly or transversally reflect commitments to family planning and access to modern contraceptive methods. These developments are in line with the alignment of the national healthcare system with the international standards developed by the WHO, the UNFPA and in accordance with the global sustainable development goals (SDG 3.7 and SDG 5.6).

The National Health Strategy "Health 2030" (NHS), officially approved on 14 June 2023 by Government Decision 387/2023, is the fundamental framework document guiding the development of the healthcare sector over the next decade. The SRH is recognised as an essential component of public health, and family planning is integrated as a preventive intervention of major importance. The strategy promotes expanding access to integrated services in primary healthcare (PHC), strengthening the professional capacities of providers, and reducing unwanted pregnancies by increasing the use of modern contraceptive methods. As it is focused on equity and quality, the document reaffirms the need for public funding for contraceptives and for expanding the portfolio of available methods, including LARC.

National Plan for Preparedness and Response to Public Health Emergencies (2021–2023; subsequent updates). Family planning is becoming increasingly relevant in the context of crisis preparedness. Preparedness and response documents adopted after 2021 explicitly include the principles of the Minimum Initial Service Package for SRH (MISP), which involves ensuring continuity of access to contraceptives, maintaining emergency stocks, and training medical staff for rapid interventions. Thus, contraception is no longer considered only a routine intervention, but also an essential service that must be guaranteed in exceptional situations, contributing to the protection of the reproductive health of women, adolescents and vulnerable groups.

The Single Package of Services of the Compulsory Health Insurance (CHI), updated annually (2022–2025). The CHI updates after 2022 confirm the role of the PHC as the main level of service provision for counselling in family planning and contraceptive distribution to vulnerable groups. The documents define mandatory preventive activities, referral pathways and clear responsibilities for family doctors, strengthening the institutional nature of these services. The CHI also provides the basis for assessing the performance of providers, which is essential for monitoring of the vulnerable groups coverage.

The regulations in the PHC have also been reinforced by ministerial orders that establish clear responsibilities for family doctors, thus strengthening the institutional architecture necessary for implementation. Ministry of Health Order No. 547/2022 on strengthening integrated services in the PHC promotes the integrated provision of preventive and curative services at the PHC level and explicitly confirms the responsibilities of family doctors and nurses in providing family planning counselling. Although it does not directly regulate contraceptive methods, the document strengthens the institutional framework for their provision and contributes to the standardisation of services.

The technical orders by the Ministry of Health on the procurement and distribution of contraceptives (2021–2025) directly enshrine free access to contraceptives for 12 vulnerable groups and regulate the logistical process of distribution. They include the introduction of hormonal implants in 2023, an important achievement that marks the diversification of modern methods available at the national level. The documents define responsibilities, procedures, logistical flows and reporting mechanisms, and are an essential tool for ensuring the functioning of the supply chain. Recently, the Ministry of Health Order No. 925/2025 on primary healthcare (PHC) introduced explicit clauses on the provision of sexual and reproductive health services, including family planning services, strengthening the role of the PHC in ensuring the population access to these essential services.[36]

Clinical protocols and standards of practice in SRH, updated after 2021, bring forth a framework for the providers that is harmonised with the WHO guidelines, ensuring uniformity in the provision of counselling and contraceptive methods. This ensures uniformity in service delivery and quality of counselling, which is an indispensable element for standardising services at the national level.

Given that the integration of sexual and reproductive health and rights goes beyond the exclusive framework of the medical sector, thanks to advocacy efforts and technical assistance provided by the UNFPA, the SRH elements, including family planning, were included in two policy documents approved by the Government in 2024: The National Strategy for Disaster Risk Reduction 2024–2030 and the National Programme for the Promotion and Respect of Human Rights 2024–2027.

Expanding public funding and ensuring access for vulnerable groups. Since 2021, the Republic of Moldova has seen a gradual strengthening of public funding mechanisms for the procurement and distribution of modern contraceptive methods for vulnerable population groups. The state budget continues to support

36 https://ms.gov.md/wp-content/uploads/2025/10/Ordin-AMP.pdf

the procurement of modern contraceptives, which allows them to be provided free of charge to the 12 vulnerable categories defined in the national policies. By covering the costs of these methods, the state contributes to reducing financial barriers, especially for low-income populations and people living in rural areas.

An important step forward has been the diversification of the portfolio of contraceptive methods purchased with public funds. While the range initially included a limited number of modern methods, since 2023, hormonal implants have been included in public procurement as a long-acting reversible contraceptive (LARC) method, reflecting both the diversification of methods and increased investment in equitable access to contraception. Expanding the range of contraceptives available to vulnerable groups creates the conditions for better adaptation of methods to the needs and preferences of beneficiaries and for reducing unmet needs in family planning.

Through its financial and institutional dimensions, the expansion of public funding for contraceptives contributes to strengthening the role of primary healthcare in the provision of family planning services and is a central element of efforts to reduce inequalities in reproductive health. Annual updates to the Single Package of Services of the CHI consolidate funding for counselling services, defining the PHC as a central pillar for the population access to contraception. Through this mechanism, the state undertakes to guarantee free access for eligible categories, reducing socio-economic and territorial disparities.

Diversification of contraceptive methods, including the introduction of the LARC. Diversification of the national contraceptive portfolio, including the introduction of the long-acting reversible methods (LARC), takes on particular strategic relevance when analysed in the context of emergencies, humanitarian crises or major disruptions to the public healthcare system. According to the international MISP framework, continued access to modern contraceptive methods should be considered an essential intervention in any crisis context to prevent increased risks related to unwanted pregnancies, sexual violence, interruptions in medical treatment and worsening of previously existing vulnerabilities.

In this regard, the diversification of contraceptive methods in the Republic of Moldova, notably marked by the introduction of the hormonal implant in 2023, represents essential progress including from an emergency preparedness perspective. The LARCs have multiple advantages in a crisis context: they are highly effective methods, do not depend on daily use or regular access to medical facilities, do not require frequent replenishment, and provide long-term protection, even when mobility, access to services, and product availability may be affected.

By including hormonal implants in the list of products purchased from the State Budget, the Republic of Moldova has created the conditions for greater resilience of the family planning system in emergency situations. Beneficiaries, especially women from vulnerable groups, can access a safe and long-lasting contraceptive method that continues to provide protection regardless of disruptions to regular medical routines or logistical disruptions associated with crises. At such times, short-acting methods (such as pills, injections or condoms) can become difficult to obtain due to disruptions in the supply chain, limited mobility or reduced contact with healthcare services. The LARCs, on the other hand, significantly reduce dependence on healthcare system infrastructure.

Furthermore, the introduction of the LARC is fully in line with the WHO and UNFPA recommendations on preparing healthcare systems for crises, which emphasise the importance of long-acting contraceptive methods in contexts of socio-economic or humanitarian instability. These methods are internationally recognised as particularly valuable in situations involving population displacement, impaired access to safety, increased risk of sexual violence or disruption of routine health services.

In addition, the availability of hormonal implants in the public system, distributed free of charge to vulnerable groups, helps to reduce the risks associated with interrupted access to contraception in crisis conditions. Women from rural areas, adolescents, people with disabilities, women living with HIV, or those in difficult socio-economic situations can benefit from a robust contraceptive method that continues to provide effective protection even when mobility is restricted or resources are limited.

Diversifying the contraceptive portfolio and including the LARC therefore strengthens the healthcare system's ability to maintain access to family planning services in all circumstances. This development contributes to strengthening the resilience of the SRH sector, in line with the integrated approach to emergency preparedness, and reflects significant progress in protecting women's reproductive autonomy, regardless of the social context or crises that may affect the public healthcare system.

Integration of emergency preparedness into sexual and reproductive health policies. National documents approved after 2021 explicitly include the dimension of emergency preparedness in public health. National Plan for Preparedness and Response to Public Health Emergencies integrates the MISP principles and emphasises the continuity of access to contraceptives even in crisis contexts. This entails: *maintaining essential stocks, training of providers for rapid response, and intersectoral coordination in the distribution of methods to vulnerable groups.*

In accordance with policies that came into effect after 2021, medical institutions are encouraged to closely monitor stocks and ensure *reserves of contraceptives* that can ensure continuity of use during periods of supply disruption. This practice is vital for short-acting contraceptive methods, which depend on constant renewal, but also for the LARCs, which require a supply of sterile materials, insertion kits and medical consumables.

It should be noted that the implementation of the MISP requires *staff who are trained* to act effectively under pressure and in complicated logistical contexts. Training for service providers (family doctors, nurses, perinatal centre staff) includes elements such as: providing rapid, person-centred counselling; selecting and administering contraceptive methods safely; managing risk situations, including for victims of sexual violence; tailoring services for people with limited mobility or at increased risk.

Crises require a coordinated response between the healthcare sector, social protection, emergency services, non-governmental organisations and international actors. Distributing contraceptives to vulnerable groups may involve: collaboration with social workers and community teams, support from civil society organisations, alternative supply mechanisms when medical institutions are inaccessible. This cross-sectoral coordination is essential for expanding access to services when traditional channels are disrupted.

By integrating emergency preparedness into the SRH policies, the Republic of Moldova is sending a strategic message: *contraception is not an optional service*, but a central element of sexual and reproductive rights that must be protected and ensured regardless of context. This approach is fully in line with the international recommendations that, over the last decade, have redefined the concept of the SRH as a fundamental part of the essential health services package. The integration of the emergency preparedness component represents an advanced conceptual step, recognising contraception as an essential service that must be protected in all circumstances.

Standardising and professionalising of family planning counselling. In accordance with updated clinical protocols, family planning counselling must be based on the principles of informed choice, free will and non-discrimination. Order 547/2022 on strengthening integrated services in the PHC reiterates the role of family doctors and of nurses in providing personalised counselling focused on the needs of beneficiaries.

The use of digital training implemented between 2022 and 2025 has facilitated the flexible updating of knowledge, the strengthening of skills in contraceptive counselling and the standardisation of clinical practices. At the same time, they

have contributed to expanding the professional capacities of medical staff, including in contexts of system overload or crisis situations, ensuring the alignment of the national practice with the WHO and UNFPA recommendations.

In the context of integrating the MISP into national policies, family planning counselling plays an essential role in crisis situations. Providers are trained to offer rapid, objective and effective counselling in conditions of stress and uncertainty, ensuring that beneficiaries can continue to use contraceptive methods or switch to methods more appropriate to the emergency context (including LARC). Online training on the Minimum Initial Service Package (MISP) conducted in 2022 explicitly included the family planning (FP) component, in line with the World Health Organisation and UNFPA recommendations on ensuring the continuity of sexual and reproductive health services in emergency situations. This component aimed to strengthen the skills of medical staff in providing client-centred contraceptive counselling, ensuring access to modern contraceptive methods, including in crisis contexts, and integrating human rights and equity principles into clinical decision-making[37].

Continuous alignment with the WHO and UNFPA recommendations. After 2021, the Republic of Moldova maintained a high degree of alignment with the international standards in the field of the SRH. Clinical protocols are updated in accordance with the WHO Medical Eligibility Criteria (MEC) and Selected Practice Recommendations (SPR), which ensures safety and effectiveness in the provision of contraceptive methods. By adopting these principles, Moldova promotes crisis-adapted practices such as: rapid transition to highly effective and long-acting methods (LARC), simplification of prescription procedures, use of telemedicine for counselling, flexible distribution of methods to beneficiaries when mobility is limited.

Policy documents, including the National Health Strategy 2023–2030 and the SRHR Programme 2025–2027 (pending approval), reflect the approaches promoted by the UNFPA in the areas of equity, reproductive autonomy, universal access, and the integration of the SRH into crisis response. This continuous alignment strengthens the credibility of the national healthcare system and facilitates international cooperation.

According to the WHO and UNFPA guidelines for emergency supply chains, states must ensure: buffer stocks for basic methods, alternative distribution routes in case of logistical disruption, continuous monitoring of consumption, flexibility in regional

37 https://usmf.md/ro/noutati/fortificarea-capacitatii-de-raspuns-personalului-medical-situatii-de-criza-umanitara

redistribution of products. The Republic of Moldova is beginning to integrate these principles into its policies, recognising that contraceptive management in times of crisis is a critical element of healthcare system resilience.

Training programmes for 2022–2025 include modules on: counselling in situations of stress and instability, rapid and non-barrier approaches to method choice, protecting vulnerable groups in crisis (women with disabilities, adolescents, refugees, victims of sexual violence), simplified procedures for providing the LARC during periods of reduced access to services. These trainings are in line with the UNFPA methodologies for training staff in the implementation of the MISP.

By aligning with the international recommendations (WHO and UNFPA), the country adopts the principle that *access to contraception cannot be suspended in times of emergency* because: it prevents further vulnerability, reduces the risks of exposure to sexual violence, protects the health of mothers and children, and reduces pressure on the medical system in crisis. This principle is integrated into recent policies, strengthening the resilience of the SRH system in the face of major disruptions.

Together, these trends reflect the strengthening of the national framework for family planning and contraception, with an increasing focus on equity, quality, resilience and alignment with the international standards. The period of 2021–2025 marks a transition from isolated interventions to a coherent system capable of ensuring universal access, integrated and tailored services, and continuity even in emergency situations.

II. Responsibility for providing family planning services

During the period of 2022–2025, responsibility for the provision of sexual and reproductive health (SRH) services, including family planning, in the Republic of Moldova was exercised within a consolidated institutional architecture, marked by efforts to modernise, integrate rights-based approaches and adapt to the pressures generated by regional crises and public health emergencies. The system operated in a context where the need to ensure the continuity of essential services, including contraception, became a priority, particularly as a result of the influx of refugees from Ukraine in 2022, and also in the context of pressure on medical infrastructure, and the need to implement the Minimum Initial Service Package (MISP).

At the strategic level, the Ministry of Health played a central role in defining policy directions and coordinating national interventions in the field of the SRH. During this period, the Ministry developed and updated relevant policies, regulations and programmes, including the National Programme on Sexual and Reproductive Health and Rights for 2025–2027, approved clinical protocols and integrated emergency

preparedness and response principles into policy documents. The Ministry of Health also coordinated the intersectoral actions necessary to maintain access to family planning during times of crisis, ensuring the inclusion of the SRH in national response mechanisms, in line with the international standards.

Responsibility for financing and contracting of the SRH service providers fell to the National Health Insurance Company (NHIC), which, during the period of 2022–2025, maintained financing mechanisms for the procurement and distribution of contraceptive methods, particularly for vulnerable groups. The NHIC played a key role in ensuring the continuity of service funding and adapting contractual mechanisms to crisis-induced fluctuations, thereby contributing to the maintenance of essential services during the period under review.

The National Public Health Agency (NPHA) strengthened the monitoring of reproductive health indicators during 2022–2025, tracking the impact of crises on access to services and analysing emerging vulnerabilities, including among refugees, adolescents and women in rural areas. The NPHA played an important role in coordinating public health communication, developing evidence-based technical recommendations and ensuring the continuity of health education activities during periods of operational disruption.

At the operational level, primary healthcare (PHC) institutions (family doctor offices, health centres, health offices, and autonomous PHC centres) remained the main structures responsible for the direct provision of the SRH services during 2022–2025. They continued to provide counselling, short-acting contraceptive methods, monitoring and referral pathways to specialised services for the long-acting reversible methods (LARC). In the context of crises, the role of the PHC was particularly important, as proximity institutions ensured continuous access to services for the population, including during periods of logistical disruptions or reduced mobility.

Reproductive health clinics and Youth-Friendly Health Centres enhanced the infrastructure of specialised services during this period, providing both modern contraceptive methods and counselling tailored to the needs of adolescents and young people. These structures were also essential in implementing communication, information and psychosocial support actions during critical periods, including ensuring access to emergency contraception and referring vulnerable women to the necessary services.

Non-governmental organisations and private actors played a complementary role, amplifying the public system's capacity to respond to the needs of the population, particularly in interventions focused on refugees and vulnerable groups. These

organisations contributed with information, counselling and community support services, but formal responsibility for the provision of clinical SRH services remained with the public healthcare system.

Overall, the period of 2022–2025 has consolidated an integrated institutional model for the provision of sexual and reproductive health services. The Ministry of Health exercised strategic leadership; the NHIC maintained the financial sustainability of services; the NPHA coordinated public health surveillance and communication; and public health institutions ensured the direct provision of essential services. This model has allowed access to family planning and SRH to be maintained even under crisis-induced pressures, helping to protect reproductive rights, reduce vulnerabilities, and strengthen the resilience of the healthcare system in the Republic of Moldova.

III. Ensuring access to modern contraceptives, including LARC.

The Action Plan for 2019–2022 on strengthening national response capacities in humanitarian crises, exceptional situations or public health emergencies by ensuring the MISP for sexual and reproductive health, *Objective 6 – Preventing unwanted pregnancies and unsafe abortion in HC/ES/PHE situations* – provided for universal access to contraception and safe abortion services for all affected persons. This provision aimed to maintain the continuity of essential services and protect reproductive rights in crisis contexts, in accordance with the international standards.

Between 2022 and 2025, the Ministry of Health significantly strengthened the capacity of primary healthcare institutions in the area of procurement, management and distribution of contraceptive methods. During this period, contraceptives were purchased entirely from the State Budget, highlighting the Republic of Moldova's firm commitment to ensuring universal, equitable and sustainable access to family planning services. This effort is fully aligned with SDG 3.7 targets on universal access to sexual and reproductive health services and SDG 5.6 on reproductive rights and free and informed decision-making in the use of contraceptive methods.

At the national level, expanding access to free contraceptives for people in vulnerable groups has been accompanied by a steady diversification of methods available in primary healthcare. In 2021, the PHC institutions provided a portfolio of five contraceptive methods: combined oral contraceptives, progestin-only pills, intrauterine devices, injectable contraceptives and condoms - intended for those 12 vulnerable categories of the population.

The progress made in recent years reflects the impact of advocacy interventions aimed at expanding the range of contraceptive products. Thus, since 2023, the list

of available methods was expanded with the introduction of the hormonal implant (Levoplant 75 mg no. 2), a long-acting reversible method that had previously been registered nationally in 2020 by the Agency for Medicines and Medical Devices.

At the primary healthcare (PHC) level, the population access to modern contraceptives is ensured through family doctors' offices and health offices in villages and small communities, where nurses and midwives are the first point of access for the rural population. They provide family planning counselling, health education and distribute short-acting contraceptive methods such as pills, injections, condoms and emergency contraception.

In health centres, services are more comprehensive. These centres have reproductive health rooms which, together with family doctors, offer counselling and provide short-acting contraceptives, as well as insertion and removal services for long-acting reversible methods such as intrauterine devices and implants. Youth-Friendly Health Centres (YFHCs) also operate within the structure of health centres, representing a specialised segment for adolescents and young people. They provide consultations, counselling and, where trained gynaecologists are available, direct provision of the LARC services.

At the secondary and tertiary levels, district, municipal and republican hospitals, including the Mother and Child Institute, intervene in complex cases requiring hospital supervision or treatment associated with certain pathologies. At the same time, these institutions play an important role in the continuous training of providers at lower levels.

IV. Access to and distribution of modern contraceptives (2022–2025).

The distribution of modern contraceptive methods in the Republic of Moldova is carried out through a mixed system that integrates public services within primary healthcare, the hospital sector, non-governmental organisations and the pharmaceutical network. This model ensures access for both vulnerable groups and the general population, contributing to the diversification of contraceptive options and increasing the use of modern methods at the national level.

Condoms. Between 2022 and 2025, the primary healthcare network distributed between 1.8 and 2.2 million condoms annually, according to procurement reports of the Ministry of Health. Data from the Generations and Gender Survey confirm a moderate, but steady increase in male condom use: from 15.8% in 2020 to 16.7% in 2024. This trend reflects the strengthening of preventive behaviours among the population, including young people. Non-governmental organisations working in the field of sexual and reproductive health enhance the efforts of the public system by

distributing between 300,000 and 500,000 condoms annually through community programmes, mobile units and outreach activities targeting vulnerable young people, key populations at increased risk of infection and mobile populations. The pharmaceutical network also remains a major channel of access to condoms for the general population, meeting the needs of people who prefer direct purchase.

Contraceptive pills. Between 2023 and 2024, purchases from the State Budget enabled the free distribution of over 120,000 blister packs of contraceptive pills per year, targeted at women from disadvantaged backgrounds, high-risk adolescents and other vulnerable groups. According to GGS 2024, the prevalence of contraceptive pill use among women aged 18–49 increased slightly, from 8.4% in 2020 to 8.6% in 2024, with higher use in urban areas. Pharmacies continue to be an important complementary channel, through the over-the-counter sale of contraceptive pills, including emergency contraception.

Intrauterine device (IUD). Access to intrauterine devices (IUDs) in the Republic of Moldova is organised through a mixed network of public and private sector providers, covering all levels of the healthcare system and allowing for diversification of access options for the population.

At the primary healthcare level, IUDs are provided through reproductive health rooms, Youth-Friendly Health Centres, and by gynaecologists trained in insertion and monitoring procedures, thus ensuring continuous access to quality services for the population. For vulnerable groups, this method is available free of charge, thanks to purchases made from the State Budget, which helps to reduce financial barriers and increase equity of access, especially in rural areas and among people from vulnerable groups, including those with limited resources.

At the hospital level, gynaecology departments and consultation departments of level I, II and III perinatal centres offer IUD insertion and follow-up/monitoring after insertion, providing the necessary expertise for complicated medical cases. In these units, services are tailored to the needs of patients with comorbidities, obstetric history or contraindications that require additional assessment.

The private sector is an additional alternative, offering IUD insertion and monitoring services for a fee. Private medical institutions are attractive to people who are not part of vulnerable groups and who prefer quick appointments, flexible hours, personalised consultation conditions and access to a wider range of IUD models.

The pharmacy network plays a complementary role in access to IUDs by offering the product itself in pharmacies for a fee. Although insertion cannot be performed in this setting, the availability of IUDs in pharmacies allows for direct purchase by

patients who wish to use the services of private providers or public institutions that request purchasing of the device by individuals who are not part of vulnerable population groups.

This complementarity between the public, private and pharmaceutical sectors contributes to expanding universal access to IUDs, offering the population a wide range of options and allowing each person to choose the provider and mode of access that best suits their needs and preferences. The mixed delivery model facilitates service continuity, reduces territorial inequalities and ensures the availability of the method for both vulnerable groups and the general population.

Injectable contraceptives. Injectable contraceptives are provided in primary healthcare through reproductive health rooms, Youth-Friendly Health Centres and family doctors, including those in autonomous primary healthcare centres. For people in vulnerable groups, the method is provided free of charge thanks to purchases made from the State Budget, which helps to reduce financial barriers and increase equity of access.

At the hospital level, injectable contraceptives can be administered in gynaecology departments and in the consultation departments of level I, II and III perinatal centres, where the necessary resources and expertise are available.

National data indicate a gradual increase in the use of injectable methods among women aged 15–49, although their prevalence remains lower than other modern methods, such as male condoms or intrauterine devices. This trend reflects both a traditional preference for the long-acting reversible contraception (LARC) and the need to intensify information and counselling on the benefits of injectable contraceptives, especially for women who prefer methods that are discreet, easy to use and highly effective.

The integration of injectable contraceptives into the public and private provider network is an important element in diversifying contraceptive options and contributes to expanding universal access to family planning. Continuity of distribution and monitoring of their use are essential for maintaining service quality and responding adequately to the reproductive needs of the population.

Contraceptive implants. Contraceptive implant insertion and monitoring services (Levoplant) are provided in reproductive health rooms and Youth-Friendly Health Centres, where medical staff are trained in specific insertion and post-insertion monitoring techniques. Services can also be provided in gynaecology departments and in the consultation departments of level I, II and III perinatal centres, which have the necessary expertise for adequate case management.

In addition to being provided free of charge to vulnerable groups, contraceptive implants are also available for purchase in the pharmaceutical network, which provides an additional option for the general population and contributes to the diversification of access channels. This complementarity between the public and pharmaceutical systems facilitates the adoption of modern long-acting methods and responds to the individual preferences of users.

Emergency contraception. Emergency contraception plays an essential role in preventing unwanted pregnancies in situations involving high reproductive risk, such as unprotected sex, failure of the method used, or sexual violence. It is an indispensable component of the reproductive health service package, contributing to the protection of reproductive autonomy and reducing the undesirable consequences of risky situations.

In primary healthcare, emergency contraceptive pills are provided free of charge to people in vulnerable groups through reproductive health rooms, youth-friendly centres, and family doctors. For victims of sexual violence, emergency contraception is integrated into the multidisciplinary care/clinical management protocol for rape cases at hospital level, in accordance with the World Health Organisation recommendations on prompt and non-discriminatory access to post-rape services.

The pharmaceutical network plays an essential complementary role, ensuring immediate access to emergency contraception for the general population requesting no medical prescription. Continuous availability in pharmacies allows the method to be used within the optimal time frame for effectiveness, reducing dependence on the operating hours of medical institutions.

It should be noted that, although several contraceptive products are available in the pharmacy network, including emergency contraception methods, male condoms, combined pills and progestogen-only pills, which provide the population with rapid, direct and confidential access to modern methods, regardless of the opening hours of medical institutions, still the supply on the domestic market remains limited in relation to international recommendations. Certain methods, such as the combined contraceptive patch, the progestin vaginal ring, combined injectable contraceptives with monthly administration, or female condoms, are currently not available in the Republic of Moldova.

This unavailability reduces the possibility for individuals and couples to choose the method that best suits their needs and preferences, limiting the options for users who would benefit from discreet, easy-to-use methods or those requiring minimal medical intervention. Expanding the portfolio of contraceptive methods on the national market is crucial for respecting the right to informed choice, increasing the acceptability of methods, and reducing the risk of unwanted pregnancy.

Expanding the range of products available, accompanied by appropriate regulation, public information, and provider training, would bring the Republic of Moldova in line with the international standards and contribute to more equitable and effective access to family planning.

The mixed model of contraceptive distribution, which combines public mechanisms coordinated by the Ministry of Health, private provider services, interventions by non-governmental organisations and the availability of products in the pharmaceutical network, has enabled the Republic of Moldova to make considerable progress towards guaranteeing universal access to modern contraceptive methods. The progress made between 2022 and 2025, reflected both in the increase in distribution volumes and in the evolution of usage indicators, confirms the effectiveness of this integrated model and its capacity to respond to a variety of reproductive needs.

At the same time, the analysis highlights the persistence of territorial and socio-economic disparities, underscoring the need to strengthen information, counselling and equity in access interventions, especially for vulnerable groups, rural women and adolescents. Expanding communication and education efforts, developing provider skills and maintaining a functional logistics chain remain essential to reducing existing inequalities.

In the context of emergencies, the mixed distribution model has demonstrated increased resilience. The availability of contraceptive methods through multiple channels — including pharmacies, community services and NGOs — has allowed access to be maintained even during periods of disruption to the functioning of medical institutions or pressure on the healthcare system. This structural redundancy is fully in line with the international recommendations on the continuity of essential reproductive health services in crisis situations, helping to prevent method discontinuation and protect the reproductive autonomy of women and girls.

Overall, the mixed model has not only strengthened access to contraception under normal conditions, but has also created the conditions for a rapid and flexible response in emergency contexts, ensuring the continuity of a fundamental public health service. This integrated framework provides the necessary basis for further optimising public policies and aligning the national system with the international standards on sexual and reproductive health.

It is also worth mentioning the relevant experience from 2022, when, with the support of the UNFPA, the Republic of Moldova received a donation of IARH (Inter-Agency Reproductive Health Kits), intended to support the continuity of sexual and reproductive health services in the context of multiple crises, including the influx of refugees. The kits included an essential set of modern contraceptives and related

consumables, in line with the international standards for the implementation of the Minimum Initial Service Package (MISP), contributing to the prevention of unwanted pregnancies and the protection of the reproductive health of affected populations. The distribution of contraceptives from these kits was carried out through the Network of Youth-Friendly Health Centres, leveraging their existing operational capacity to provide accessible, confidential and tailored to the needs of young people and other vulnerable groups services. This approach enabled rapid and targeted dissemination of resources, particularly to young people, women and people in situations of increased vulnerability, including refugees and displaced persons. The integration of IARH kits into the service delivery circuit through Youth-Friendly Health Centres has facilitated not only the distribution of contraceptives, but also the provision of family planning counselling, in accordance with the principles of informed choice, free will and non-discrimination. The experience gained in 2022 highlighted the essential role of international partners in ensuring the continuity of the SRH services in crisis situations, as well as the importance of using existing national structures for the effective implementation of emergency interventions. At the same time, this intervention highlights the need to strengthen national preparedness and response mechanisms so that critical resources for the SRH can be integrated in a more predictable, coordinated and sustainable manner into the national healthcare system[38].

V. National referral system for sustained access to emergency contraception.

In the Republic of Moldova, there is currently no formalised national referral system designed for access to emergency contraception. Access is provided through the usual mechanisms of the public health network, but these are not systematically adapted to crisis contexts, which reduces the predictability and uniformity of services.

Currently, family doctors mainly provide short-acting methods (SARC), while reproductive health rooms and youth-friendly centres provide access to all types of methods, including the LARC. Hospitals manage cases that require specialised expertise. However, in the absence of a unified referral protocol, institutional roles are not harmonised within an operational framework dedicated to emergency situations.

During times of crisis, such as the COVID-19 pandemic, continuity of access to contraceptives was maintained through local adaptations and support from

38 https://moldova.unfpa.org/ro/news/unfpa-%C8%99i-guvernul-statelor-unite-au-livrat-spitalelor-din-republica-moldova-un-lot-de-zece-tone

international partners. However, these interventions were ad hoc and are not part of an integrated mechanism at the national level.

The formalisation of a National Referral System for Access to Contraception in Emergency Situations, aligned with the MISP and the National Preparedness and Response Plan, would improve the resilience of the system, clarify the roles of providers and ensure continuity of access to the SARC and LARC methods in contexts of reduced mobility, pressure on services or logistical disruptions in crisis/emergency situations.

VI. Strengthening the professional capacities of medical staff.

Strengthening the professional skills of family planning service providers is an essential strategic direction in the Republic of Moldova's efforts to expand access to modern contraception and prevent unwanted pregnancies. Between 2022 and 2025, continuing education programmes for family doctors, nurses and community centre staff played a decisive role in professionalising services, improving the quality of counselling and strengthening the logistical management of contraceptives at all levels of the healthcare system.

The continuing education process had two main directions: (1) developing clinical and counselling skills, and (2) strengthening capacities in contraceptive logistics management. The first major direction of the training programmes focused on updating the clinical and counselling skills of providers. The focus was on the uniform application of national family planning protocols, person-centred counselling in line with the WHO standards concerning the respect for reproductive autonomy, and the adaptation of interventions to the specific needs of different vulnerable groups. The training included both theoretical content and practical sessions designed to strengthen essential clinical skills.

A distinctive feature was the training of medical staff in the insertion and removal procedures for the long-acting reversible contraceptive (LARC) methods. The introduction of Levoplant hormonal implant in 2023 required the adaptation of training curricula and the organisation of supervised practical sessions to ensure the acquisition of the technical skills necessary to provide safe and quality services. In this process, the anatomical models donated by the UNFPA played an essential role in supporting the training of medical staff in practical skills in the field of sexual and reproductive health, including the application and insertion of contraceptive methods. The use of these models in training allowed for the practice of procedures in a controlled environment, facilitating a safe transition from theoretical training to clinical practice and contributing to the standardisation of the professional skills of the SRH service providers.

The second direction focused on developing contraceptive logistics management skills, which are essential for the efficient functioning of the supply chain. The UNFPA actively supported the Ministry of Health efforts to organise the most extensive training programme in recent years in March–April 2024. Over 250 health workers were trained in forecasting needs, managing stocks and reporting contraceptive consumption.

The workshops were delivered by the Centre for Reproductive Health and Medical Genetics of the Mother and Child Institute, in collaboration with specialists from the Department of Obstetrics and Gynaecology and the Department of Family Medicine at Nicolae Testemitanu State University of Medicine and Pharmacy. As a result, by the end of 2024, approximately 54% of institutions contracted by the NHIC had at least one specialist trained in logistics management, contributing to the standardisation of practices and the reduction of stock interruptions. This intervention has significantly reduced the frequency of stock shortages, previously reported in approximately 18% of primary institutions.

Medical staff, including family doctors and nurses, also benefit from access to digital training modules in family planning, including Virtual Contraceptive Consultation (VIC). These modules, developed as modern continuing education tools, have been integrated in the previous years into the curricula of Nicolae Testemitanu State University of Medicine and Pharmacy (SUMP).

The integration of the acquired skills into routine work has contributed to a consistent improvement in the quality of family planning services. Trained staff reported more rigorous planning of quarterly needs, increased accuracy of reporting to the NHIC and the Ministry of Health, and more efficient management of resources allocated for the purchase of contraceptives from the State Budget.

In addition, the continuity of modern contraceptive stocks was essential for maintaining access, especially for people in vulnerable groups, for whom discontinuation of the method can lead to increased risks of unwanted pregnancies. Reducing stockouts/complete stock depletion directly contributed to a more predictable and secure experience for beneficiaries.

Strengthening these capacities is fully in line with the WHO recommendations on reproductive health supply chain management and rights-based service delivery. The training conducted in 2024 is an essential step in strengthening the resilience of the national family planning system, ensuring that universal access to modern methods is maintained even in contexts of pressure on the healthcare system or in emergency situations.

Between 2022 and 2025, the Republic of Moldova made significant progress in the field of reproductive health by strengthening the regulatory framework, expanding access to modern contraception and systematically targeting services to vulnerable groups. Analysed in the context of emergencies, these developments demonstrate an increase in the resilience of the system, reflected in the maintenance of essential services even in crisis situations, such as the COVID-19 pandemic, when access to contraceptive methods was affected due to logistical and operational constraints.

The subsequent introduction of additional methods, diversification of distribution channels and strengthening of professional capacities have helped to reduce the risks of methods disruption and protect women's reproductive autonomy. The mixed delivery model — public, private, NGO and pharmaceutical — has enabled continuity of access and reduced inequalities, even when pressure is placed on the healthcare system.

Overall, the progress made between 2022 and 2025 reflects the national system's ability to translate lessons learned from emergencies into more robust policies and equitable services, strengthening the foundation for achieving the goal of every pregnancy being wanted and every birth being safe.

VII. Communication and information on pregnancy prevention.

Over the past four years, information efforts in the area of family planning and modern contraceptive methods have intensified, targeting both service providers and the general population. These initiatives have sought to raise awareness of the importance of preventing unwanted pregnancies and the central role of modern contraception in promoting reproductive health. Activities have also focused on increasing understanding of how family planning services are provided and accessed, including in public health emergencies, where the continuity of these services becomes essential.

A key achievement during this period was the strengthening of the evidence base underpinning communication decisions. In 2023, a qualitative study was conducted on the factors influencing contraceptive use among vulnerable groups, providing valuable insights into existing perceptions, barriers and myths. The results of this study were analysed and validated under the coordination of the Ministry of Health, becoming an important benchmark for the development of subsequent public information messages and interventions.

At the same time, communication efforts were strengthened by developing accessible and visually appealing information materials for the general public. Ten social cards were produced to debunk myths about contraception and promote

evidence-based truths, and five thematic articles were published on the social media accounts of the Ministry of Health and partner institutions. These materials played an important role in increasing the visibility of accurate information on pregnancy prevention, especially among young people and women in rural areas, where persistent myths and incomplete information remain a challenge.

The development and promotion of these materials complemented the thematic campaigns carried out during this period, which included information on the availability of contraceptive methods in primary healthcare, beneficiaries' rights to family planning services, and access routes to free contraceptives for vulnerable groups.

With the support of the UNFPA and in partnership with the Nicolae Testemitanu State University of Medicine and Pharmacy and the NGO Youth Media Centre, informative video materials[39] were developed and distributed. These materials aimed to combat prejudices, increase acceptance of modern methods, and facilitate communication between providers and beneficiaries. To ensure equitable access to information, the materials were also adapted into sign language, helping to improve access for persons with disabilities to essential information on family planning and reproductive health[40].

Particular attention was paid to providing information in crisis situations, especially in the context of the refugee flows of 2022–2023. Public messages included clear information on rapid access to reproductive health services, the availability of emergency contraception, referral routes to service providers and contact numbers for immediate support, in line with the MISP package.

Communication actions were also supported by training medical and non-medical staff in delivering messages tailored to women and girls in vulnerable situations. At the community level, family doctors and nurses played a central role in providing information on pregnancy prevention, both in individual consultations and in community activities. The expansion of their capacities was evident, including in the fact that, in 2024, over 54% of primary healthcare institutions contracted by the NHIC had staff trained in contraceptive logistics management and contraceptive counselling, which improved the quality of communication at the local level.

39 https://suntparinte.md/videouri-informative-despre-toate-cele-20-de-metode-de-contraceptie-pe-o-singura-platforma/.

40 https://www.facebook.com/crcsm1989/videos

Strengthening the evidence base, producing communication materials and integrating messages into the public space reinforced the role of information as a pillar of reproductive health policies and created an environment conducive to equitable access to family planning services in the Republic of Moldova.

CONCLUSIONS

1. **Favourable and internationally aligned regulatory framework.** The Republic of Moldova has a legislative and policy framework in the field of family planning and contraception that is harmonised with the WHO recommendations and reproductive rights principles, with no restrictive provisions for the reproductive-age population, including vulnerable groups. The integration of elements related to service continuity in emergency situations reflects a focus on system resilience.

2. **Adequate clinical protocols, but uneven implementation.** Although standardised clinical protocols are aligned with the international standards, their implementation remains uneven due to limited mechanisms for monitoring, supervising and evaluating service quality, therefore highlighting the need to strengthen institutional capacity.

3. **PHC – central pillar, with persistent territorial disparities.** Primary healthcare plays a key role in counselling and distributing modern contraceptives, supported by continuing education programmes. However, territorial differences in infrastructure, logistics and protocol implementation affect the uniformity of service quality.

4. **Differentiated access to the LARC methods**. The hierarchical structure of service delivery allows for a response to diverse needs, including access to the LARC at certain levels of care. However, the effective availability of these methods is limited by insufficient numbers of trained providers, incomplete referral pathways and variability in clinical practices.

5. **Progress in logistics management, with persistent risks.** Improvements in logistics management, including through trainings held in 2024, represent important progress, but the risk of stockouts persists due to insufficient digitisation of forecasting, reporting and consumption monitoring processes.

6. **Public funding targeted towards equity.** State budget allocations for contraceptives for vulnerable groups serve as a pillar of equity policies, helping to reduce inequalities and ensure access to essential family planning services.

7. **Diversification of methods, demand below required level.** The introduction of the hormonal implant in 2023 expanded the portfolio of the LARC methods and brought the country in line with international best practices. However, demand for modern methods remains limited due to misinformation, cultural barriers and low levels of reproductive health literacy.

8. **Persistent disparities for vulnerable groups.** Territorial and social differences in access to services indicate the need for targeted interventions tailored to disadvantaged areas and groups with increased vulnerability.

9. **Progress in communication, but the impact is still limited.** Recent public communication initiatives (videos, social cards, thematic articles) have increased the visibility of evidence-based information and helped combat misinformation. However, the impact remains fragmented in the absence of a coherent national strategy.

10. **Strengthened evidence base for communication.** The qualitative study on contraceptive use among vulnerable groups provided relevant data to guide communication interventions, increasing the relevance and effectiveness of messages when they are linked to identified barriers.

11. **Absence of an integrated crisis communication strategy.** Although information mechanisms have been activated in crisis situations, the absence of standardised inter-institutional communication procedures limits the coherence and predictability of the response.

12. **Insufficient cross-sectoral coordination.** The lack of an integrated data collection and analysis mechanism and limited collaboration between healthcare, education, social protection and civil society affects the capacity for evidence-based planning and decision-making.

RECOMMENDATIONS

1. **Strengthening the enforcement of the regulatory framework and clinical protocols.** Developing of clear operational mechanisms for implementing regulations and setting up monitoring, evaluation and clinical audit tools to ensure compliance and quality of services across all providers.

2. **Ensuring the sustainability of public funding for contraceptives.** Maintenance and strengthening of the State Budget procurement based on periodic assessments of needs and cost-effectiveness of methods, so that vulnerable groups benefit from a comprehensive and diverse range of contraceptive options.

3. **Continuous development of professional capacities.** Intensification of the standardised training, refresher and clinical supervision programmes for primary healthcare staff, with continuous updating of skills in counselling and application of clinical protocols.

4. **Optimisation of the tiered care delivery network.** Clarifying and consolidating the roles of family doctors offices, health centres, reproductive health rooms and Youth-Friendly Health Centres to ensure continuity of care, efficient referral pathways and constant availability of methods appropriate to each level.

5. **Setting up of an integrated data system on contraception.** Development of an integrated system for collecting and analysing data on the availability, distribution, use and demand for contraceptives, as a basis for strategic planning and efficient resource allocation.

6. **Implementation of logistics information systems.** Deployment of the Contraceptive Management Information System (CMIS) for real-time monitoring of stocks and consumption, using the data generated to inform budgetary decisions and identify unmet needs.

7. **Improving forecasting and planning in crisis situations.** Development of demographic and contraceptive consumption forecasting models, applicable in both normal and emergency conditions, with periodic reassessments based on available logistical data.

8. **Integration of the MISP into national and local planning.** Integration of the Minimum Initial Package of Services (MISP) into preparedness and response plans, maintaining essential stocks, training staff, and establishing intersectoral coordination mechanisms to ensure continuity of access to contraception in crisis situations.

9. **Ensuring continuity of counselling and services in emergencies.** Supporting family planning counselling, including through telemedicine, and free distribution of contraceptives to vulnerable groups during health emergencies to prevent disruptions and protect reproductive health.

10. **Expanding intersectoral distribution mechanisms.** Strengthening collaboration between the public sector, private providers and civil society organisations for the distribution of contraceptives to vulnerable groups, including in crisis situations, by adapting regional and international good practices to the national context.

11. **Integration of family planning into the PHC performance system.** Introduction of a dedicated family planning indicator in the primary healthcare provider performance assessment system to encourage counselling, distribution of methods and monitoring of vulnerable groups coverage.

12. **Enhancing public information and education.** Intensification of information and educational interventions through public campaigns, educational programmes and personalised counselling adapted to different age groups and socio-cultural contexts to reduce the disparity between current needs and the use of modern methods.

13. **Ensuring equitable access to information and counselling**. Ensuring the availability of accessible information materials, including for persons with disabilities and vulnerable groups, on available contraceptive methods and conditions for free access, accompanied by counselling provided by trained staff to ensure informed choice.

Other Priority Services: Safe Abortion Services in Accordance with the Law

The role of safe abortion services in emergency situations. According to the World Health Organisation (WHO), safe abortion services, provided in accordance with national legislation, are an essential component of the package of sexual and reproductive health services that must be maintained and protected in all contexts, including in situations of crisis, public health emergencies or humanitarian disasters. Their status as "essential services" derives from the obligation of healthcare systems to prevent avoidable morbidity and mortality associated with unsafe abortions, which are one of the main causes of severe complications, hospitalisations and maternal deaths in the absence of access to safe and quality interventions.

During the COVID-19 pandemic, the WHO explicitly reiterated the need to ensure the continuity of safe abortion services globally, emphasising that restricting them can lead to a significant increase in clandestine abortions, delays in seeking medical care and worsening complications associated with unwanted pregnancies. In this context, the WHO recommended adapting the provision of these services through flexible measures, such as the use of telemedicine, safe prescription of medication, reorganisation of flows in medical institutions, and integration of abortion procedures into standard emergency circuits[41].

41 Maintaining essential health services: operational guidance for the COVID-19 context: interim guidance, 1 June 2020, Https://apps.who.int/iris/handle/10665/332240

The recognition of safe abortion as an essential service is based not only on clinical evidence of the effectiveness and safety of the procedures, but also on the principles of human rights, non-discrimination and the continued protection of reproductive health. In crisis situations, women and girls are at increased risk of violence, sexual exploitation, interruptions in contraceptive continuity and other factors that increase the likelihood of unwanted pregnancies, which is why maintaining access to safe abortion becomes an indispensable public health measure.

Consequently, the WHO recommendations position safe abortion services not as additional options, but as critical interventions that must be integrated into emergency preparedness and response plans, ensuring the protection of women's reproductive health and autonomy, including during periods of major disruption to the healthcare system.

National legislative and regulatory framework on safe abortion. In the Republic of Moldova, access to safe abortion services is regulated by a coherent legislative and regulatory framework based on the principles of the right to health, reproductive autonomy and the protection of women's physical and psychological integrity.

The legal framework on termination of pregnancy is shaped by a set of complementary normative acts that establish the conditions, legal limits and responsibilities of healthcare providers in the field of safe abortion. A central element is the Criminal Code of the Republic of Moldova, which, in Article 159 of Law No. 985/2002[42], expressly stipulates the legal limits for performing abortions and sanctions any intervention carried out outside the regulatory framework. The provisions of this Article address the criminal liability of individuals performing abortions without the necessary medical qualifications, in unauthorised institutions, or in violation of legal provisions. The aim is to protect patient safety and prevent unsafe abortions, thereby reinforcing the principle of professional responsibility. Complementarily, Law No. 411-XIII of 1995 on Healthcare[43] establishes the general principles for exercising the right to health, including the state's obligation to ensure safe, accessible and quality medical services, providing the general framework within which abortion services are integrated. Law No. 138 of 2012 on Reproductive Health[44] explicitly regulates reproductive rights, access to family planning, conditions for legal abortion and the responsibilities of medical institutions, therefore strengthening the legal basis for the provision of safe abortion services in ethical conditions and in accordance with the international standards.

42 https://www.legis.md/cautare/getResults?doc_id=121991&lang=ro
43 https://www.legis.md/cautare/getResults?doc_id=119465&lang=ro
44 https://www.legis.md/cautare/getResults?doc_id=106297&lang=ro

National standards and their alignment with fundamental legislation. The application of these legislative principles is detailed at the operational level by the Ministry of Health Order No. 766/2020[45], which approves the National Standards for Safe Abortion. This document establishes clinical procedures, permitted methods of termination of pregnancy, types of authorised institutions, professional competencies required of providers, requirements for informed consent, counselling, post-abortion care and quality assurance mechanisms, representing the technical instrument that enforces the legal provisions and ensures the uniform and safe termination of pregnancy.

The regulatory framework is aligned with the WHO Guidelines on Safe Abortion (2022), the 2030 Agenda, SDG targets 3.7 and 5.6, and the UNFPA recommendations on universal access to sexual and reproductive health services, reflecting the commitment of the Republic of Moldova to protect women's reproductive health and ensure access to safe, evidence-based services that respect human rights.

By aligning legislative provisions with clinical standards, the national framework contributes to the prevention of unsafe abortions, the reduction of complications and the enhancement of patient safety, while ensuring the protection of reproductive rights and access to evidence-based services, including through the integration of counselling, informed consent and post-abortion care as a mandatory part of the medical procedure.

Ways to access safe abortion: abortion on demand and abortion on medical and social grounds. Safe abortion is regulated in the Republic of Moldova through two distinct modes of access, explicitly established by the national regulatory framework. The first category is voluntary termination of pregnancy during the first 12 weeks, for which the law guarantees a woman's right to request abortion on demand, without having to justify her reasons. The procedure is carried out in authorised medical institutions/facilities by qualified medical staff and includes prior counselling focused on women's rights and informed decision-making, the choice of method (medication or surgical) in accordance with the standardised protocols set out in Order 766/2020, in compliance with clinical protocols on safety, confidentiality and informed consent, as well as the provision of post-abortion care and immediate access to modern contraceptive methods. This approach is fully aligned with the WHO recommendations, which consider first-trimester abortion to be a safe, effective and low-risk medical procedure when performed in accordance with the international standards.

45 https://ms.gov.md/standardul-privind-efectuarea-intreruperii-sarcinii-in-conditii-de-siguranta/

The second option concerns the voluntary termination of pregnancy after 12 weeks, based on medical and social indications. Beyond the 12-week threshold and until the end of the 21st week of gestation, abortion can be performed based on the indications provided for in the regulatory framework, and in situations where severe fetal malformations are identified that are incompatible with life or incurable, termination of pregnancy can be authorised throughout the entire gestation period. These cases are mandatorily assessed at the PMSI Mother and Child Institute by a representative Medical Council appointed annually, which analyses each situation in detail, confirms the diagnosis and clinical recommendations, and ensures that the medical decision is based on professional and ethical criteria and complies with the national standards in force.

Access to abortion after 12 weeks is permitted in situations clearly defined by legislation and regulations of the Ministry of Health, including medical indications (major risks to the woman's health or life; severe complications of pregnancy; serious fetal malformations incompatible with life) and social indications (pregnant woman under 18 or over 40; pregnancy resulting from rape, incest or human trafficking; divorce or death of spouse during pregnancy; deprivation of liberty or loss of parental rights of one or both spouses; migration; multiparity with 5 or more children; care for a child under 2 years of age; the presence of one or more family members with severe disabilities, according to the conclusion of the Medical Expertise Council of Vitality; a combination of at least two vulnerable circumstances such as homelessness, lack of financial resources, alcohol or drug abuse, domestic violence, vagrancy), as well as other circumstances in which continuing the pregnancy could significantly worsen the woman's living conditions or psychological health. In all these cases, the decision is based on a comprehensive medical assessment, multidisciplinary counselling and full respect for the woman's rights.

National standards and the exclusion of classic curettage. The National Standards for Safe Abortion (Order No. 766/2020) is the key document that standardises the provision of services in all medical and health institutions. They incorporate WHO evidence-based protocols for medical and surgical abortion, requirements for provider competencies, respect for confidentiality and informed consent, and recommendations for post-abortion care and immediate contraception.

The ban on dilation and curettage method due to the increased risk of haemorrhage, infectious complications and perforations reflects the system's shift towards modern, minimally invasive methods with a superior safety profile. This framework contributes to increasing the safety of procedures and reducing unsafe abortions, which pose a major risk to public health.

Continuity of safe abortion services in a crisis context and the role of telemedicine. Between 2022 and 2025, in line with the WHO recommendations, the Republic of Moldova has integrated safe abortion services into its plans for the continuity of essential services in crisis situations (the COVID-19 pandemic, refugee flows from Ukraine, temporary disruptions to medical services). The WHO emphasises that interrupting access to safe abortion services increases the risk of clandestine abortions, with a direct impact on the women's health. For this reason, Moldova has maintained access to outpatient medical abortion, reorganised flows for instrumental procedures, ensured the continuity of post-abortion counselling and care, and integrated services into the minimum package of primary healthcare and specialised obstetrics and gynaecology facilities. The national standard on safe abortion explicitly provides for the possibility of using telemedicine for medical abortion in emergency or crisis situations, reflecting the need to ensure the continuity of essential services when physical access to medical facilities is limited or impossible (natural disasters, armed conflicts, movement restrictions, major infrastructure malfunctions). The WHO confirms that medical abortion up to 12 weeks is a safe procedure when accompanied by adequate medical support, including through telemedicine, which allows for counselling, prescription, guidance on administration and monitoring of progress without the patient having to travel to a medical facility. Overall, telemedicine for medical abortion stands out as a strategic solution for ensuring equitable access to safe abortion in exceptional circumstances, strengthening the resilience of healthcare systems and supporting the uninterrupted exercise of the women's reproductive rights.

Organisation of the service network and institutional levels of service provision. The organisation of safe abortion services is based on a diverse network of authorised medical and health institutions with qualified staff and infrastructure that meets national standards. For first-trimester pregnancies without associated pathology, medical or vacuum aspiration abortion can be performed at the Territorial Medical Associations, Women's Health Centres, Reproductive Health Rooms, Youth-Friendly Health Centres, the consultation departments of Perinatal Centres and the Reproductive Health and Medical Genetics Department of the PMSI MCI, provided that trained obstetrician-gynaecologist and appropriate equipment are available. Authorised private medical institutions may also provide these services, provided that they comply with regulatory requirements regarding the quality of medical care and patient safety. In cases where the pregnant woman has comorbidities or major risk factors, the termination of pregnancy procedure is performed exclusively in hospital-type institutions (district and municipal hospitals and level II and III Perinatal Centres) capable of providing multidisciplinary care and management of possible complications. For pregnancies between 12 and 21 weeks of gestation, as

well as in cases of severe fetal malformations incompatible with life, termination of pregnancy is performed exclusively in institutions with the highest level of competence, in particular in high-level Perinatal Centres and in the PMSI Mother and Child Institute, where complicated cases are assessed by a representative Medical Council, appointed annually.

Absence of an operational mechanism for emergency situations. Currently, service providers within the national healthcare system have clear information on the institutions where safe abortion services are provided under normal operating conditions, and the existing regulatory framework and mechanisms for organising services in normal times ensure a good understanding of the clinical pathway, the responsibilities of providers and the competent institutions. However, there is no dedicated operational document that explicitly specifies the organisation, responsibilities and institutions responsible for providing safe abortion services in emergency or crisis situations.

The lack of dedicated operational provisions means that the Standard on Safe Termination of Pregnancy does not cover scenarios in which physical access to regular medical institutions is disrupted (natural disasters, armed conflicts, major infrastructure failures, epidemics or other situations that limit population mobility and the availability of medical resources). Although the possibility of performing medical abortion through telemedicine is provided for in exceptional circumstances, the referral mechanisms, eligibility criteria, patient pathways, or redistribution of responsibilities between levels of the healthcare system are not detailed. The absence of a chapter dedicated to referral and organisation of services in crisis situations reduces the system's ability to ensure the continuity of an essential service, recognised as such by the WHO, and providers may encounter difficulties in identifying available facilities, adapting medical flows and coordinating the referral of cases in exceptional circumstances.

Consumables, equipment and logistical capacity. The availability of essential consumables and equipment is a central component of the healthcare system's capacity to provide consistent and safe abortion services. In the Republic of Moldova, Mifepristone and Misoprostol are integrated into clinical practice for medical abortion, in line with the WHO recommendations, and vacuum aspiration (manual or electric) is recognised as the standard method for the first-trimester abortion. However, the analysis highlights significant disparities between institutions and regions: drug stocks are not always sufficient or evenly distributed, leading to periods of unavailability and fluctuations in the capacity of institutions to provide medical abortion, especially in rural areas or in localities with limited infrastructure. The situation is similar for vacuum aspiration equipment, which,

although available in most district and municipal institutions, is lacking in some small or rural health centres, limiting access to modern, minimally invasive methods and reducing the autonomy of institutions to respond promptly to requests for safe abortion. In addition, the logistical capacity of institutions varies considerably, affecting their ability to maintain sufficient stocks and respond to fluctuating demand, including during periods of overload or crisis. Discontinuities in access to medicines and equipment are directly reflected in the system's ability to provide uniform and predictable services, affecting the quality of care and the timeliness of interventions. Therefore, the availability of consumables and equipment remains a central element of the functionality of the entire safe abortion system, determining the capacity of institutions to provide safe, standard-compliant interventions that are accessible to all women, regardless of geographical location or level of medical institution.

Human resources, continuing education and territorial disparities in access. In terms of human resources, the medical structures and services that provide safe abortion services can be considered satisfactory overall, with most gynaecologists having previously been trained in the use of modern methods. However, providers need retraining in pre-abortion counselling, the provision of medical abortion and patient-centred approaches. Institutions providing abortion services do not exist in all localities; women and adolescents in rural areas have more limited access, being forced to travel to district centres, and the lack of manual vacuum aspiration kits in some institutions accentuates territorial differences.

In the area of information and communication on safe abortion, the existing national framework is characterised by one-off initiatives that are not linked to a standardised information, education and communication (IEC) system. The absence of a unified approach limits the consistency of messages and equitable access to essential information on safe abortion services, especially in crisis or emergency situations.

Currently, information materials on the types of abortion services available and their location is mainly accessible through the online platform www.avort.md, administered by the Centre for Information and Documentation on Reproductive Health (CIDRH). The platform provides lists and maps of medical institutions that provide safe abortion services, representing a valuable information tool. However, the exclusively digital nature of this resource limits access for women in rural areas, vulnerable groups or those with limited access to the internet, especially in emergency situations.

Various IEC materials, such as posters and information brochures, have been developed in the past, but they need to be updated in terms of both content and

adaptation to the current context. In particular, the existing materials do not include clear and systematic information on the medical institutions that patients can address to in crisis situations, the routes for accessing services or the options available depending on the level of care.

An analysis of existing IEC materials content highlights a predominant focus on general sexual and reproductive health topics, such as reproductive rights, prevention of unwanted pregnancies, contraceptive options, and maternal and child health. Specific information on access to safe abortion, the types of interventions available, and the institutions where these services are provided is insufficiently reflected, indicating a communication framework focused more on prevention and general education than on the explicit presentation of safe abortion services as an integral part of the essential health services package.

In the absence of standardised and easily accessible IEC materials, information on safe abortion is mainly provided through direct interactions between patients and medical staff – family doctors, obstetricians-gynaecologists and staff at the Youth-Friendly Health Centres. This method of information delivery, limited to individual contact with the healthcare system, contributes to significant disparities in access to information, disproportionately affecting women in marginalised communities, rural areas or those with limited access to health services. **Ad hoc initiatives in times of crisis and the need for a formal IEC framework.**

During recent crises, including the COVID-19 pandemic and the massive influx of refugees from Ukraine, the UNFPA, in collaboration with civil society organisations, developed ad hoc information materials on access to sexual and reproductive health services. These materials were primarily operational in nature, designed to support the rapid orientation of the affected population within the healthcare system and to facilitate access to essential services such as emergency care, contraception and maternal and child care.

Although these initiatives helped mitigate the impact of crises on access to the SRH services, they were not integrated into a standardised national IEC framework and did not systematically include explicit information on access to safe abortion services. This gap highlights the need to develop and institutionalise official, standardised and culturally appropriate IEC materials that provide clear, accurate and accessible information on safe abortion services, including in emergency and humanitarian crisis contexts. Such an approach is essential to ensure compliance with the principles of confidentiality, dignity and respect for women's reproductive rights, as well as to reduce inequalities in access to essential health information and services.

CONCLUSIONS

1. **The legislative and policy framework on safe abortion in the Republic of Moldova is consistent and aligned with the WHO recommendations**, guaranteeing access to safe procedures by establishing legal deadlines, professional responsibilities and approved methods (medical abortion and vacuum aspiration). However, the implementation of this framework is uneven. Territorial differences in resources, infrastructure and operational capacity limit equitable access, and the absence of standardised support and coordination mechanisms reduces the functionality of the system in practice.

2. **The national standards set out in Order 766/2020 ensure uniform procedures** through clinical protocols, professional criteria for providers, requirements for informed consent, confidentiality and post-abortion care. The ban on classic curettage (D&C) reflects the national commitment to modern, safe and minimally invasive methods.

3. **The national network of safe abortion services is operational at both the primary healthcare level and in hospitals**. However, persistent regional imbalances remain evident: not all institutions are fully equipped for vacuum aspiration, and the availability of essential medicines (Mifepristone and Misoprostol) varies from one institution to another.

4. **Human resources are qualified but require ongoing training**, including updating knowledge on medical abortion, telemedicine management in special situations, and counselling focused on the patients' rights. Although gynaecologists have been trained in modern methods, periodic skills refresher training and the inclusion of family doctors in the information and referral circuit are still underdeveloped.

5. **The piloting of medical abortion through telemedicine in the context of the COVID-19 pandemic has demonstrated the feasibility, acceptability and usefulness of this method**, especially for women with reduced mobility or living in rural areas. However, the Republic of Moldova does not yet have a stable regulatory framework that would allow for the standardised, safe and sustainable application of telemedicine, both in times of crisis and under normal conditions.

6. **The absence of a chapter dedicated to the organisation of safe abortion services in emergency situations within the existing standardised clinical protocol is a gap in the current regulation.** Currently, there are no official provisions establishing the responsible institutions, clinical referral criteria,

mechanisms for ensuring continuity of services, or methods for redistributing capacities in contexts such as pandemics, natural disasters, or humanitarian crises. In the absence of such guidance, access to services in crisis situations may become dependent on ad hoc solutions and external support, which reduces the level of predictability and coordination in the provision of essential interventions.

7. **The social stigma and political sensitivity associated with the topic of abortion can influence the content and visibility of official IEC materials**, including in times of crisis. In this context, materials developed ad hoc by international partners during the pandemic and refugee crisis predominantly focused on general sexual and reproductive health services. Explicit information on accessing safe and secure abortion services and provider institutions was included less frequently in order to reduce the risk of stigmatisation and social pressure.

RECOMMENDATIONS

1. **Strengthening of the regulatory and operational framework for providing safe abortions, including in emergency situations.** Updating the National Standards (Order No. 766/2020) by including a chapter dedicated to the organisation of abortion services in crisis contexts and develop an operational protocol defining institutional responsibilities, clinical pathways, referral criteria and mechanisms for service continuity in situations of pandemics, disasters or humanitarian crises.

2. **Reduction of territorial inequalities by expanding institutional capacities.** Ensuring the uniform provision of primary and hospital healthcare institutions with vacuum aspiration equipment and essential medicines (Mifepristone and Misoprostol), as well as expand the provision of medical abortion services to health centres, reproductive health rooms and YFHCs, especially in rural areas.

3. **Strengthening of mechanisms for the supply and management of essential consumables.** Development of an integrated system for the management and distribution of equipment and consumables for safe abortion, including through continuous monitoring of stocks and the establishment of buffer stocks at regional and national level to prevent supply shortages and ensure continuity of services.

4. **Continuous development of the professional skills of service providers.** Updating, standardising and strengthening continuing education programmes for gynaecologists, family doctors, nurses and YFHC staff, with a focus on modern

methods of safe abortion, women's rights-based counselling, management of special situations and telemedicine, in accordance with the WHO standards.

5. **Institutionalisation of an IEC system dedicated to safe abortion.** Development and distribution of standardised IEC materials, in hard copies and digital formats, providing clear information on safe abortion methods, access conditions, women's rights and the location of authorised institutions, including for use in emergency situations, through a constantly updated official platform.

6. **Reduction of stigma and promotion of human rights-based approach.** Development of public information and awareness-raising interventions to reduce the stigma of abortion, complemented by training providers in non-judgmental communication and value clarification, in collaboration with civil society, youth networks and international partners.

7. **Improvement of monitoring, evaluation and quality assurance systems.** Strengthening the collection and analysis of data on access to and quality of abortion services by updating the set of disaggregated indicators and implementing periodic clinical audits to inform policy decisions based on a solid empirical basis.

8. **Strengthening cross-sectoral cooperation and partnerships with international organisations.** Strengthening collaboration between the Ministry of Health, the NPHA, the NHIC, medical institutions, academic institutions, civil society and local authorities to ensure a coordinated and effective approach. At the same time, partnerships with the UNFPA, WHO, UNICEF and other international organisations should be leveraged for training, technical support, provision of essential medicines and development of information resources.

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Action Plan for 2026-2030

on building capacity of national response in case of humanitarian crisis, exceptional situations or public health emergencies by ensuring the Minimum Initial Service Package for Sexual and Reproductive Health (MISP)

No.	Objective	Intervention	Actions	Implementation term	Responsible	Partners	Indicator
1.	Strengthening coordination, cooperation, and advocacy to provide sexual and reproductive health (SRH) services in humanitarian crises/exceptional situations/ or public health emergencies (HC/ES/PHE)	a) Integration of provisions on delivery of the Minimum Initial Service Package for Sexual and Reproductive Health (MISP) into intersectoral, sectoral and territorial plans for risk and humanitarian crises/exceptional situations/public health emergencies management.	Participation in annual working meetings to ensure the integration and up-keeping of MISP in intersectoral plans, health system plans (MoH and territorial plans for preparedness and response to public health emergencies)	2026-2030	Ministry of Health (MoH) National Crisis Management Center (NCMC) National Public Health Agency (NPHA) LPA	National Coordinating Committee in the field of SRHR (NCC in SRHR) UNFPA WHO	Number of meetings where MISP issues were discussed Approved/reviewed plans with integrated MISP
		b) Approval of the National Program on Sexual and Reproductive Health and Rights	Promotion of the NP SRHR for approval	2026	MoH CRHMG/MCI SUMP Nicolae Testemitanu NPHA	UNFPA WHO Other partners	Approved National Program
		c) Creation of effective coordination and cooperation mechanisms for implementation of MISP provisions in humanitarian crises/exceptional situations/ public health emergencies	Establishment of an inter-institutional mechanism (NCMC-MoH-NPHA-MoHLSP-GIES-specialized NGOs) for coordination of SRH services in HC/ES/PHE situations.	2027	NCMC, MoH; NPHA CRHMG/MCI	Ministries that countersigned the draft Government Decision on the approval of the mechanism, UNFPA, WHO, other partners	Institutionalized coordination mechanism
			Development and operationalization of standard operational procedures for MISP, including in case of HC/ES/PHE	2026-2027	NCMC, MoH NPHA SUMP Nicolae Testemitanu CRHMG/MCI		Approved and implemented SOP for MISP
			Integration of SRH indicators into national risk assessment and planning processes, including for rapid assessment.	2027	NCMC, MoH NPHA CRHMG/MCI		List of risk assessment indicators supplemented with integrated SRH indicators.
			Drafting of logistics protocols for the creation and development of a national stockpile system for rapid distribution of SRH materials	2026	NCMC MoH NPHA CRHMG/MCI		Approved protocols
			Drafting of the regulatory framework regulating the provision of health care services, including SRH through telemedicine, including in cases of HC/ES/PHE	2026-2027	MoH SUMP Nicolae Testemitanu CRHMG/MCI		Approved regulatory framework

No.	Objective	Intervention	Actions	Implementation term	Responsible	Partners	Indicator
			Integration of SRH into contingency plans of hospitals and primary health care institutions (including for the flows of violence victims).	2027	MoH NPHA PMSI	National Coordinating Committee in the field of SRHR;	Provisions on SRH integrated into the contingency plans of hospitals and PHC institutions
			Drafting and approval of the regulatory framework to ensure financial sustainability for the work of mobile teams providing SRH (YK Mobile Clinics), including in cases of HC/ES/PHE	2026-2027	Neovita NRCYFHC MoH NHIC CRHMG/MCI; NPHA	National Coordinating Committee in the field of SRHR	Approved regulatory framework
			Establishing, equipping, training and maintaining of appropriate level of proficiency of specialized multidisciplinary SRH intervention teams	2026-2030	NCMC MoH SUMP Nicolae Testemitanu CRHMG/MCI PMSI	National Coordinating Committee in the field of SRHR	Appointed teams (consolidated annually)
			Conducting periodic assessment of the progress made in evaluating the preparedness of the Republic of Moldova to respond to the needs of the population in case of a potential HC/ES/PHE, in particular with regard to ensuring the Minimum Initial Package of SRH Services	2029	NPHA SUMP Nicolae Testemitanu MoH, NCMC CRHMG/MCI;	National Coordinating Committee in the field of SRHR; MIA/GIES, UNFPA, WHO other partners	Drafted and validated assessment report
		d) setting up of a reserve fund intended for MISP in case of humanitarian crisis/exceptional situation/public health crisis	Allocation of dedicated budget lines for MISP within national programs on SRHR	2026-2030	MoH, MF, NHIC, NPHA, CRHMG/MCI	NCMC	Allocated budget for MISP within the NP on SRHR

2	Strengthening national capacities for the provision of SRH services in situations of humanitarian crisis/ exceptional situations/or public health emergencies, and integrating comprehensive SRH services into primary health care	Professional training /strengthening the capacities of specialists in the provision of MISP services for SRH in case of HC/ES/PHE	Formal integration of the MISP training at all levels of the medical education system — university, residency, mid-level medical personnel. Integrated maintenance of the MISP training module within the annual continuous professional education program for doctors and nurses	2026	MoH SUMP Nicolae Testemitanu Raisa Pacalo CEMP Colleges of Medicine and Pharmacy in Balti, Unghen, Orhei and Cahul	National Coordinating Committee in the field of SRHR; CRHMG/MCI	Approved medical education curricula that includes MISP training modules on SRH in case of HC/ES/PHE
			Provision of continuous education for health care specialists and managers of relevant medical institutions on MISP in HC/ES/PHE situations	2026-2030	MoH SUMP Nicolae Testemitanu Raisa Pacalo CEMP Colleges of Medicine and Pharmacy in Balti, Unghen, Orhei and Cahul	National Coordinating Committee in the field of SRHR; CRHMG/MCI	Number of specialists trained annually in medical education institutions
			Regular organization and conduct of simulation exercises (national and sectoral) on preparedness and response to humanitarian crises/exceptional situations/public health emergencies, including the MISP component of SRH	2026-2030	NCMC Ministry of Health Departments; NPHA; SUMP Nicolae Testemitanu CRHMG/MCI;	National Coordinating Committee in the field of SRHR; MIA/GIES, GPI, BMA, WHO, UNFPA, other partners	Simulation exercises (national and sectoral) conducted annually
		Ensuring the resources for providing MISP for SRH in situations of HC/ES/PHE	Ensuring the storage and efficient management of emergency kits for the provision of MISP for SRH in the event of HC/ES/PHE	Permanently	MoH, NHIC, CCPPH, CRHMG/MCI;	National Coordinating Committee in the field of SRHR; NCMC MIA/GIES	Functional stock management mechanism
			Creation of a mechanism for managing MISP product stocks, rapid distribution in the event of HC/ES/PHE, and replenishment of stocks based on rapid needs assessment.	2026	MoH Departments; NHIC, CCPPH, NPHA; CRHMG/MCI	National Coordinating Committee in the field of SRHR; NCMC	Approved and implemented mechanism
		Ensuring the availability of the information and communication package on provision of MISP for SRH in the event of HC/ES/PHE	Integration of MISP components for SRH in case of HC/ES/PHE into the healthcare system communication strategy in crisis situations at all levels	2026-2030	NPHA; MoH	National Coordinating Committee in the field of SRHR; NCMC WHO, UNFPA, other partners	Integrated provisions on the MISP in the healthcare system communication strategy in crisis situations, including at the territorial level
			Regular update and validation of communication package concerning the provision of MISP for SRH in case of HC/ES/PHE in line with international recommendations and the national context	2026-2030	NPHA; MoH CRHMG/MCI	National Coordinating Committee in the field of SRHR; NCMC UNFPA, WHO, other partners	Updated information and communication package available for use in case of HC/ES/PHE stored at NPHA and NCMC
			Supplementing of communication package on MISP for SRH in case of HC/ES/PHE with materials adapted for different vulnerable groups.	2026-2030	NPHA; MoH SUMP Nicolae Testemitanu CRHMG/MCI	National Coordinating Committee in the field of SRHR; UNFPA, WHO, other partners	Information and communication package adapted and available for use in case of HC/ES/PHE stored at NPHA and NCMC
		Monitoring the degree of preparedness of national institutions providing SRH services to respond promptly in the event of a humanitarian crisis/public health emergency	Assessment of the degree of preparedness and response to HC/ES/PHE of the health care system at the territorial level, with examination of the MISP component within the civil protection status control and implementation of civil protection measures	2026-20 30	NPHA; NCAAH, Emergency Medicine Institute CRHMG/MCI; MoH	National Coordinating Committee in the field of SRHR; NCMC MIA/GIES, MEI/ATS	Number of annual monitoring visits carried out Drafted monitoring reports

3	Prevention of gender-based violence, including sexual violence, and improvement of assistance provided to survivors of violence	Strengthening the health care system response to cases of gender-based violence and sexual violence, including in situations of HC/ES/PHE	National evaluation of the impact of mandatory reporting, consideration of international evidence, and drafting of a balanced solution that protects the autonomy of victims. Extending the network of Support Units for survivors of sexual violence within hospital emergency departments to ensure equitable access to services integrated by clinical management of rape cases	2026 2026-2030	MoH, MIA, NAPCV, CRHMG/MCI MoH, NHIC, CRHMG/MCI PMSI	WHO, GPO, NGOs NAPCV	Assessment report with recommendations for protecting the victims' autonomy Network of Support Units for survivors of sexual violence within the emergency departments of hospitals, scaled up at the subnational level
			Scaling up of Barnahus-type integrated assistance services for children victims to other regions of the country, in accordance with the regulatory framework in force	2026-2028	NAPCV, MLSP, MoH, MIA		Barnahus-type services scaled up to other regions of the country, in accordance with the regulatory framework in force
			Adoption and implementation of SOP in accordance with SCP in all MSI providing assistance to survivors of violence	2026	MSI NCAAH CRHMG/MCI NAPCV		Number of MSI that have Standard Operational Procedure available and apply/ comply with it
			Evaluation of competence/ preparedness degree of medical institutions and heath care service providers (any MSI regardless of legal form of organisation) to respond/intervene in cases of sexual violence, including situations of HC/ES/PHE, in accordance with Standard Operational Procedure (SOP availability, case managers, completion of F 091/e form)	2028	NCAAH, CRHMG/MCI; NPHA; MoH; MSI of all types and levels;	National Coordinating Committee in the field of SRHR; UNFPA, UN Women Women's Law Center NGO La Strada PA	Drafted and validated assessment report
			Annual monitoring of availability of services and consumables necessary for providing assistance to survivors of sexual violence in situations of HC/ES/PHE, in accordance with MISP for SRH	2026-2030	CRHMG/PMSI MCI; NPHA; Neovita YFHC MoH	National Coordinating Committee in the field of SRHR	Drafted and validated monitoring report
		Building the capacity of medical staff to prevent and manage cases of sexual violence in situations of HC/ES/PHE	Ensuring continuous training of healthcare providers on the Protocol provisions regarding clinical management of sexual violence and abuse cases, which should be applied in situations of HC/ES/PHE too, as well as for people from different specific population groups.	2026-2030	SUMP Nicolae Testemitanu Raisa Pacalo CEMP MoH		Number of specialists trained annually
			Consolidation of continuous training for specialists and advancing skills in forensic evidence collection by creating a standardized annual training program for mid-level medical staff/ nurses in forensic evidence collection	2026-2030	SUMP Nicolae Testemitanu Raisa Pacalo CEMP		Number of specialists trained annually
		Providing information, education and communication (IEC) to the population, including vulnerable groups and people with special needs, about the importance of preventing sexual violence in HC/ES/PHE situations and about the assistance services available when necessary	Working together with the representatives of population groups at risk of sexual violence, including people with disabilities, to update continuously the informational materials on the prevention of sexual violence, available services and place of their provision, the importance and benefits of seeking timely medical, psychosocial and legal assistance, taking into account the specific needs and characteristics of beneficiary groups (**e.g.,** people with sensory or mental disabilities, etc.); distribution of IEC materials through various communication channels.	2026-2030	CRHMG/MCI NPHA Neovita Center MoH SUMP Nicolae Testemitanu	National Coordinating Committee in the field of SRHR NGOs	Number and type of materials developed/adjusted and distributed

4	Prevention and reduction of HIV and other STI transmission in situations of HC/ES/PHE	Strengthening the provision of HIV and STI prevention, diagnosis and treatment services in HC/ES/PHE situations	Development of a mechanism for implementing/ providing HIV and STI prevention, diagnosis and treatment services in HC/ES/PHE situations	2026	CHID Toma Ciorba; NPHA; CRHMG/MCI; MoH	NPSRHR Coordination Committee; SUMP Nicolae Testemitanu UNAIDS UNFPA WHO other partners	Developed and implemented mechanism
			When updating the HIV-related NCP, integration of provisions on MISP for SRH in HC/ES/PHE situations in accordance with the provisions of the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings	2026-2028	SUMP Nicolae Testemitanu CHID Toma Ciorba; NPHA; CRHMG/MCI; MoH	NPSRHR Coordination Committee; UNAIDS WHO UNFPA other partners	Number of NCPs that include provisions on MISP for SRH in HC/ES/PHE
5	Prevention of maternal and neonatal mortality and morbidity in HC/ES/PHE situations	Assessment of the capacity of medical institutions providing obstetric and neonatal emergency care services, and that of referral institutions at the territorial and national levels to meet the requirements for providing safe maternal care services in HC/ES/PHE situations	Assessment of the supply of medical institutions providing maternal care services, regardless of their legal status, with the necessary consumables and equipment for obstetric and neonatal emergencies, including in cases of HC/ES/PHE	2028	NCAAH, PMSI MCI; NPHA; NCBT; MoH	NPSRHR Coordination Committee; SUMP Nicolae Testemitanu UNFPA, WHO, other partners	Number of institutions evaluated Assessment reports
		Strengthening the capacity of obstetric and neonatal care providers in HC/ES/PHE situations	Continuous education of healthcare workers on provision of obstetric services and neonatal care, with the integration of MISP regulations for SRH in HC/ES/PHE	2026-2028	SUMP Nicolae Testemitanu PMSI MCI MoH	NPSRHR Coordination Committee; WHO, UNFPA, other partners	Number of trained persons

6	Prevention of unwanted pregnancies and unsafe abortion in HC/ES/PHE situations.	Ensuring universal access to contraception and safe abortion in HC/ES/PHE situations	Supplementing the SCP on family planning/ contraceptive methods with a section dedicated to organization of services for prevention of unwanted pregnancies and abortion in crisis situations	2026	PMSI MCI; NPHA; MoH	NPSRHR Coordination Committee; WHO, UNFPA, other partners	Updated national standard
			Providing healthcare institutions with at least 5 methods of contraception to the extent that would cover the real needs of the reproductive-age population, including in situations of HC/ES/PHE, in accordance with the provisions of the actual Regulation on providing vulnerable groups of reproductive age with contraceptives	2026-2030	CRHMG/MCI; CCPPH; MoH	NPSRHR Coordination Committee	Number of medical institutions provided with 5 methods of contraception, including long-acting methods
			Supplying of medical-sanitary institutions authorized to provide abortion services with the necessary medicines /equipment and contraceptives for the immediate post-abortion period	2026-2030	CRHMG/MCI; CCPPH; Medical-sanitary institutions that provide abortion services; MoH	NPSRHR Coordination Committee;	Number of medical-sanitary institutions authorized to provide safe abortion services supplied with the necessary medicines and equipment in accordance with the Standard on Safe Termination of Pregnancy
		Strengthening the knowledge of healthcare providers in family planning and safe abortion services, in counselling people on the use of contraceptives and respecting the rights of beneficiaries, including in situations of HC/ES/PHE	Continuous training of health care service providers, including those in rural areas, in the provision of family planning and safe abortion services, including in situations of HC/ES/PHE, including vulnerable groups	2026-2030	SUMP Nicolae Testemitanu PMSI MCI MoH	NPSRHR Coordination Committee	Number of people trained annually
		Ensuring effective IEC for the reproductive-age population in vulnerable groups, including people with disabilities, on the availability of contraceptives at the PHC level and the possibility of obtaining them, including in HC/ES/PHE situations.	Informing the community, in particular people of reproductive age, about the institutions/organizations where contraceptives are available, in particular which institutions provide modern contraceptives free of charge to vulnerable population groups, including in HC/ES/PHE situations.	2026-2030	CRHMG/MCI PMSI PHC; NPHA; Neovita Center; MoH	NPSRHR Coordination Committee Mass media NGO UNFPA WHO Other partners	Number of materials developed and distributed annually
		Providing information to people of the reproductive age, including people with disabilities, about safe abortion services and the possibility of obtaining them, including in situations of HC/ES/PHE	Developing and distributing informative materials with clear and non-discriminatory messages tailored to different groups of people, including people with disabilities, about safe abortion services, including the possibility of obtaining them in cases of HC/ES/PHE	2026-2030	CRHMG/MCI PMSI PHC; NPHA; Neovita Center; MoH	NPSRHR Coordination Committee Mass media NGO WHO Other partners	Number of developed materials
		Ensuring effective monitoring of the implementation by healthcare providers of the regulatory framework in force regarding counselling and provision of family planning services	Annual monitoring of healthcare providers capacity in contraception counselling services delivery, with a focus on the individual's rights to informed choice and informed consent, the effectiveness and safety of the method, respect of privacy and confidentiality, equity and non-discrimination	2026-2030	CRHMG/MCI PMSI PHC, NEOVITA YFHC NCAAH NPHA MoH	NPSRHR Coordination Committee; SUMP Nicolae Testemitanu, Relevant NGOs	Effective monitoring mechanisms in place (exit interviews, analysis of data collected annually from medical institutions providing FP services, visits made, etc.) to monitor the practical application of the actual regulatory framework provisions in force, including the provision regarding contraception counselling respecting the rights of beneficiaries

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