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CHILD AND ADOLESCENT HEALTH SERVICES IN THE REPUBLIC OF MOLDOVA



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MINISTRY OF HEALTH OF
THE REPUBLIC OF MOLDOVA

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The report forms an integral part of the Health Policy Papers Series launched in 2011 to strengthen health systems in the Republic of Moldova in line with national health policy and health care system development strategies. It was developed under the guidance of Andrei Usatii, Minister of Health of the Republic of Moldova, and Jarno Habicht.

The work contributes to the 2012/2013 biennial collaborative agreement between the Government of the Republic of Moldova and the WHO Regional Office for Europe and is also part of the WHO/European Union initiative "Supporting policy dialogue on national health policies, strategies and plans in selected countries".

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The views expressed in this report do not necessarily reflect the views of WHO, the European Union, the Ministry of Health of the Republic of Moldova and NHS Health Scotland.

Acronyms and abbreviations

BCA	2012/2013 Biennial collaborative agreement (between WHO and the Government of the Republic of Moldova)
CIS	Commonwealth of Independent States
EU	European Union
HBSC	(WHO) Health Behaviour of School-aged Children (study and survey)
IMCI	Integrated management of childhood illnesses
MDGs	(United Nations) Millennium Development Goals
MoE	Ministry of Education (of the Republic of Moldova)
MoH	Ministry of Health (of the Republic of Moldova)
NGO	Nongovernmental organization
SHS	School health service
STI	Sexually transmitted infection
TB	Tuberculosis
UNICEF	United Nations Children's Fund
YFHS	Youth-friendly health services

Executive summary

This report has been prepared at the request of the WHO Regional Office for Europe to support the process of developing a child and adolescent health strategy for the Republic of Moldova through facilitation of policy dialogue. It is the seventh report in the Health Policy Paper Series that will contribute to the 2012/2013 biennial collaborative agreement between WHO and the Republic of Moldova and is part of the WHO/European Union initiative “Supporting policy dialogue on national health policies, strategies and plans in selected countries”.

The report considers four key areas (strategy development; people, partners and players; information systems; and implementation) and offers conclusions and recommendations for action.

Strategy development

Policy and strategy development in the Republic of Moldova draws upon a range of international guidelines and initiatives, including the United Nations Millennium Development Goals. There is at present no discrete child and adolescent health strategy in the country.

Wholesale reforms of government health service financing were made in 2004. Since then, health care coverage has been provided through a combination of mandatory social health insurance from a single insurance company and government- and internationally-funded national programmes on specific priority areas. An income tax for health has led to growth in total government health spending. Children up to 18 years and students up to 23 (depending on the selected study profile) are insured by the state under a law passed in 1998.

Seven years after the introduction of the 2004 reforms, however, more than 20% of citizens remained uninsured. New reforms starting in 2009 addressed gaps in population coverage under mandatory health insurance, with legislative measures taken to ensure that all citizens have access to primary health care and poorer populations receive subsidized health insurance. Fiscal constraints have limited the full implementation of these reforms. Recent activity has produced a clear agenda for the next phase of priority health reforms, focusing principally on service delivery reorganization and health financing.

The Republic of Moldova is among those countries recognized as making progress in the core health systems functions of delivering services to individuals and populations, financing the system, creating resources and providing stewardship. The first publication in this Health Policy Paper Series provides the specific basis for reform of the hospital system. The recent review of the school health service, including the development of standards and competencies, extends that

process beyond the health system. And the proposed development of a child and adolescent health strategy, which this report contributes to, aims to take a whole-system approach to the development and provision of services for children, adolescents and their families/carers.

However, it is clear that many challenges remain. Formal measures to promote children's and adolescents' rights within the health system are in place but tend to operate slowly. Examples of child and adolescent involvement in strategy development exist and should be further integrated. National protocols and guidance based on international standards are in place and are being implemented for children in relation to main disease groups, but only partially so for adolescents.

People, partners and players

Strategic responsibility for child and adolescent services, including health, lies with a number of government ministries. There is a Youth Parliament, but it does not sit as a permanent body. The National Council for Children's Rights plays a positive role in responding to specific incidents and problems, although its focus is limited, and an Ombudsman for Children's Rights is in place.

Adolescent involvement in decision-making is currently sporadic. Collaboration involving key stakeholders in government, international agencies, academic institutions and nongovernmental organizations tends to be unsystematic and requires stronger cross-sectoral approaches and agreements.

Preregistration training for doctors and nurses is provided within the main higher and further education system. Specialist training in paediatrics is also available, but some staff have difficulty accessing opportunities. A new training programme for school health service nursing staff has recently been developed; this could provide an opportunity for further multiagency and multidisciplinary training. Existing ongoing professional development activity relating to care of children could be further improved through the provision of evidence-based postgraduate education opportunities.

Health care managers have a key role to play in planning and delivering services, but may not be fully aware of the complexity of child and adolescent health needs. Human resources are described as scarce, particularly in remote and rural parts of the country, leading to an imbalance of skilled health professionals across services. An assessment has nevertheless been carried out to determine the number of staff necessary to support the implementation of a child and adolescent health strategy.

Information systems

Specific information systems to support child and adolescent development are in place in the country and have been delivering data sets for 20 years or more. Significant gaps in information systems on child and adolescent health remain, however. Disaggregation of data by socioeconomic status, ethnic background, gender and age is inconsistent and requires further development. An integrated, computerized medical records system is needed to improve continuity of care between agencies.

Implementation

Child and adolescent-centred health services include the provision of prevention and health promotion, and primary, secondary and tertiary health care services. The revised regulation framework for the schools health service, featuring an increased emphasis on health promotion and health education, will be presented in September 2012. An expanding network of youth-friendly health services clinics provides services to children and young people from ages 10–24 years.

Despite these strong elements of service delivery (and others), gaps in service provision exist in areas such as quality review systems, budgeting for health promotion and prevention, and regular cross-sectoral collaboration and coordination.

Family planning services tend to be female-oriented, making them less attractive to young men. Some pregnant adolescents perceive that health workers “judge” them negatively. Relevant staff training is important, but a cultural shift away from judgemental attitudes is also required. Provision of gender-sensitive advice on common health problems is provided inconsistently to young people and is often not age-specific. Communication between services around child and adolescent referrals is sometimes lacking, and there is a need for improved diagnostic systems and provision of accommodation on hospital sites for parents/guardians of hospitalized children.

The development of a formal child and adolescent health strategy for the Republic of Moldova provides an opportunity to take a “whole-of-government” approach to address issues of concern. The report’s recommendations for action focus on the factors identified as the most significant obstacles to progress in promoting children’s and adolescents’ health. They aim to improve:

- regular cross-sectoral collaboration and cooperation;
- supervision of quality standards;
- data on gender inequity and the needs of vulnerable populations;
- managers’, health workers’ and wider society’s awareness and understanding of the specific needs of adolescents;
- health promotion and health education; and
- access arrangements, including transport, for people living in remote and rural areas.

1. INTRODUCTION AND CONTEXT

This report

This report has been prepared at the request of the WHO Regional Office for Europe to support the process of developing a child and adolescent health strategy for the Republic of Moldova through facilitation of policy dialogue. It is the seventh report in the Health Policy Paper Series that will contribute to the 2012/2013 biennial collaborative agreement (BCA) (1) between WHO and the Government of the Republic of Moldova and is part of the WHO/European Union (EU) initiative “Supporting policy dialogue on national health policies, strategies and plans in selected countries”.

The report uses as its foundation:

- the WHO European strategy for child and adolescent health and development assessment tool (2) and development information tool (3) (see Annex 1); and
- the WHO tool for assessing health system performance in improving maternal, newborn, child and adolescent health care (4), which provides a particularly strong link with health system reforms by structuring data collection around three health system functions – stewardship, adequate and sustainable resources, and health service delivery.

It also reflects information from a number of other sources, including the *Improving the hospital system in the Republic of Moldova report* (5) and WHO country-specific data (6).

Three experts from the Republic of Moldova health system working in the field of child and adolescent health, supported by colleagues from the WHO Country Office, completed the assessment documents. These were then sent to the authors, who met the experts in June 2012 to review and discuss findings and analyse additional information.

The report is presented under four headings reflecting the key areas of the WHO child and adolescent health strategy assessment tool (2):

1. strategy development
2. people, partners and players
3. information systems
4. implementation.¹

It highlights the positive work that has been taken forward in the country but also raises issues that need to be considered in moving the strategy development process forward.

¹ “Implementation” in the WHO assessment tool refers to implementation of the child and adolescent health strategy in the relevant country. As the Republic of Moldova has no such strategy at the current time, “implementation” in this report refers to child and adolescent health services and existing programmes.

Main socioeconomic characteristics of the Republic of Moldova

Despite the Republic of Moldova being the poorest country in the WHO European Region (per capita gross national income of US\$ 1820 in 2011), life expectancy estimates are 2–5 years higher than richer countries of the Commonwealth of Independent States (CIS). There is nevertheless a significant and growing gender gap in life expectancy (66 years for males and 75 years for females (2011 figures)). The country still experiences negative population growth despite slight increases in the birth rate (6). Some selected statistics on the country are shown in Table 1.

Table 1. The Republic of Moldova: selected statistics

Indicator	Year	Value
Population (mid year), in millions	2011	3.5
Percentage of population aged 0–14 years	2011	16
Infant deaths per 1 000 live births	2011	11
Life expectancy at birth, in years, female	2011	75
Life expectancy at birth, in years, male	2011	66
Live births per 1 000 population	2011	11
Physicians per 100 000 population	2011	282
Total health expenditure as percentage of gross domestic product, WHO estimates	2010	11

Source: WHO (5)

Health systems approaches

The WHO Ministerial Conference on Health Systems in Tallinn, Estonia issued *The Tallinn Charter “Health Systems for Health and Wealth”* (7) in June 2008. This presents a holistic view of the contribution the entire health system can make to promoting health and wealth within Member States of the European Region.

While acknowledging that health systems are diverse, the Tallinn Charter recognizes that they also share a common set of functions, including:

- delivering health services to individuals and to populations
- financing the system
- creating resources
- providing stewardship.

Member States agreed to work towards achieving these functions, and the Republic of Moldova is among those that are making progress. The first publication in this Health Policy Paper Series, *Improving the hospital system in the Republic of Moldova* (5), provides the specific basis for reform of the hospital system. The recent review of the school health service (SHS), including the

development of standards and competencies, extends that process beyond the health system. And the proposed development of a child and adolescent health strategy, which this report contributes to, aims to take a whole-system approach to the development and provision of services for children, adolescents and their families/carers.

It will be important for the Ministry of Health (MoH) of the Republic of Moldova to consider the findings from this report when taking forward proposals from the *Improving the hospital system in the Republic of Moldova (5)* report within the spirit of the Tallinn Charter.

The Republic of Moldova has expressed strong interest in the new WHO European policy framework for health and well-being, Health 2020 (8), and is ready to transpose its provisions into health policies and strategies at national level. Support from Regional Office and the WHO Country Office, along with EU technical assistance, budgetary support and promotion of policy dialogue on national health policies, strategies and plans, will be central to this endeavour.

MoH capacity in policy analysis and performance assessment will be strengthened and a sector-monitoring instrument will be developed and implemented through periodic review and policy dialogue involving major stakeholders. The MoH's leadership in sector coordination will be further strengthened by promoting an integrated systemic approach to health reforms. Additional capacities will be built to mainstream gender and social determinants of health and integrate rights-based approaches into national health policies and programmes (1).

A strategic focus on healthy living for younger people is particularly important. Numerous factors influence children's social and emotional well-being, from their individual characteristics and family background to the community in which they live and wider society. Initiatives to support children and young people, can include policies to improve the socioeconomic status of children living in disadvantaged circumstances, whole-school approaches to school-based activities to develop and protect children's social and emotional well-being (including school-based health literacy programmes), peer-to-peer education and the development of youth organizations. Integrating work on mental and sexual health into these programmes and activities is particularly important (8).

Health service stewardship and financing

The MoH and municipal health departments share overall responsibility for establishing priorities and strategy in public health and for health care services.

Specific details on financing of maternal and child health services are provided in Atun et al. (9) and Jowett & Shishkin (10) and are considered in more detail in Chapter 2.

United Nations Millennium Development Goals

The eight United Nations Millennium Development Goals (MDGs), each of which has been agreed by the world's countries and has a target achievement date of 2015, provide a blueprint for meeting the needs of the world's poorest populations. The MDGs cover a wide range of relevant issues in the fight against poverty, discrimination, inequity and ill health. Of particular relevance to this report are MDG 4, "Reduce child mortality", and MDG 5, "Improve maternal health."

The Regional Office supports Member States in strengthening health systems to enable them to deliver equitable health outcomes based on a comprehensive approach to achieving MDGs 4 and 5. It advocates for the need to reaffirm the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action, transparency, accountability, decentralization and community participation and empowerment. It also supports actions that recognize that the MDGs are interlinked and that advancing women's status and gender equality is crucial to achieving MDGs 4 and 5.

The Republic of Moldova has made encouraging yet variable progress towards meeting the targets of MDGs 4 and 5. The infant mortality rate has been falling steadily since the mid-1990s, reaching 11 per 1000 live births in 2011 (the MDG target for 2015 is 13.2%, so it has already been achieved). This is close to the average for CIS countries (11.26 per 1000 live births in 2010), but still more than double the EU average of 4.2 (6). Under-five mortality was 13.4 per 1000 live births in 2011, down from 23.2 in 2000 (11): the MDG target for 2015 is 15.3, so again, this target has been achieved ahead of time.

Maternal mortality levels have fluctuated in recent years, ² with 16 per 100 000 births in 2006 and 15.3 in 2011 (the latter of which was more than double the average for CIS countries (20 per 100 000) in 2010 and greater than seven times the EU average of 6.1). Due to the relatively low birth rate (around 40 000 annually), actual numbers of deaths are low (7 in 2009, 18 in 2010 and 6 in 2011) (6). There was a temporary rise in mortality in 2008 secondary to the H1N1 influenza epidemic, but these very regrettable deaths were invariably due to late presentation rather than lack of access to health care.

Child immunization levels have been consistently high for all vaccine-preventable diseases, with 97.1% of children being immunized against measles in 2010 (up from 91.3% in the previous year) (6). Sexually transmitted infections (STIs) sharply increased following the country's independence in 1991, particularly syphilis, but the main challenges the Republic of Moldova faces in communicable disease control are tuberculosis (TB) and HIV/AIDS. TB incidence has more than doubled since 1990, with the most dramatic increase being seen among children.

² Maternal mortality rate fluctuations are determined by health conditions, quality of care and estimation methods. The absolute number of maternal deaths is small, but the nonlinear evolution of the maternal mortality rate causes concern.

Collaboration between WHO and Republic of Moldova

The 2012/2013 BCA between the Regional Office and the Government of the Republic of Moldova aims to raise the level of health and reduce inequity in the distribution of health within the population. Priorities for 2012/2013 include:

- transposing provisions from the Health 2020 policy framework (8) into health policies and strategies at national level, supported by WHO and the EU;
- strengthening MoH policy analysis and performance assessment capacity and promoting an integrated systemic approach to health reforms;
- strengthening health systems and public health in line with current policy and legislation, with an emphasis on achieving health-related MDGs through equitable policies for improving maternal, newborn, child, adolescent and sexual and reproductive health;
- broadening the evidence base for policy development, with a focus on sustainable health financing policies and arrangements;
- implementing the hospital modernization plan (5);
- regarding human resources for health as a priority issue through the use of WHO tools for assessment and strategic planning; and
- updating national medicines policy.

Legislation

Various pieces of legislation developed over the years apply to child and adolescent health, although some have yet to be fully implemented. Relevant legislation is listed in Annex 2.

2. STRATEGY DEVELOPMENT

National-level activity

There is at present (September 2012) no discrete child and adolescent health strategy in the country, although children from birth to age nine are included in the national health strategy approved in 2006 and feature in national strategies for sexual and reproductive health and poverty reduction. National programmes set specific targets with achievement under regular review by the MoH, but there is need to design specific targets for children and adolescents. There seems to be little evidence of child and adolescent health influencing policies in other ministries.

This is a complex issue with many difficulties, but it is reasonable to conclude that more work is required to finalize a child and adolescent health strategy. This report is designed to contribute to that process.

Work has been undertaken to review paediatric services in primary health care and in hospitals in the country (12,13), with outcomes relating to hospital care for children yet to be formally adopted. A legal framework has been developed to support the country's efforts to achieve the MDG targets, with a strategy on health care system development that ensures universal access to health services for all pregnant women regardless of insurance status being of particular relevance. A report on MDG implementation is submitted to the United Nations Development Programme (UNDP) every five years.

Funding and infrastructure

Since 2004, health care coverage has been provided through a combination of mandatory health insurance from a single insurance company and government- and internationally-funded national programmes in specific priority areas. People in employment pay into the scheme through taxation and the self-employed through a flat-rate lump sum (9). Fourteen categories of vulnerable people, including all children up to 18 years, and students up to 23 (depending on the selected study profile) are insured by the state under a 1998 law on mandatory health insurance (and further amendments). This includes: preschool children; primary, gymnasium, high school and secondary pupils; students in secondary vocational education (colleges); students in tertiary education (universities); compulsory postgraduate resident students; children not enrolled in school to age 18; and disabled children.

This combination of measures has made it possible to achieve 100% coverage of compensated drugs for children under five years, in accordance with WHO standards on integrated management of childhood illnesses (IMCI) (see below) (11). Legislation passed in 2010 extended full primary health care services to all citizens irrespective of their status under the national health insurance programme, effectively ensuring universal access to essential services for all (14).

Regional differences in per capita public funding of health care decreased within the first year of introducing mandatory health insurance, and inequality in spending across rayons reduced significantly between 2003 and 2010 (15). Shishkin & Jowett (15) state that the centralization of government funds “has had a positive outcome for equity in per capita government expenditures on health across rayons”.

Fiscal restraints have nevertheless reduced the effectiveness of these measures. Seven years after the introduction of the 2004 reforms, more than 20% of citizens remained uninsured (15). Recent activity has produced a clear agenda for the next phase of priority health reforms, focusing principally on service delivery reorganization and health financing.

Evidence of the effects of the reforms is emerging in recent research into primary care in the Republic of Moldova (16). This shows that while most patients have access free of charge to a range of services, including a visit to their family doctor, almost all have to pay for prescribed medicines and injections. Some patients also highlight financial barriers to access to care, including 30% reporting that they have to pay for a visit to a medical specialist after referral, 20% indicating that they have to pay for a home visit by the family doctor, and around 13% having to pay for a regular check up for a baby or young child. Some patients even have to pay for a regular visit to the family doctor (16).

Pressure on resources and funding is affecting the ability of services to reach out to ensure access to universal health services for all, including migrants and asylum seekers (and their children), and to progress vital health promotion activities. There does not appear to be a specific focus on providing services for children and adolescents from poor and socially marginalized groups nor on promoting gender equality. There is no single definition of “vulnerability” in the country, raising questions over whether health professionals, particularly primary care physicians, are able to identify relevant individuals and groups among their populations. This is particularly pertinent in relation to children and adolescents. Departments of social protection within local public authorities may be able to offer some support to the MoH in this area.

Awareness about the need for positive health promotion among children and adolescents is limited. Specific plans are in place to develop measures relating to dissemination of health information, communication and prevention, but with limited funding available for implementation. Similar plans need to be put in place around early years and confidentiality issues for adolescents.

Appropriately resourced facilities with adequate access and outreach mechanisms are needed to deliver SHS and youth-friendly health services (YFHS) (see Chapter 5), and drug and equipment

budgets are based on the lowest quantities required. While YFHS clinics are increasing from the current number of 12, the network of primary, secondary and tertiary health care facilities for adolescents is not adequate to meet needs and is irrationally distributed across the country. The limited amount of health insurance funding available mainly covers salaries and maintenance costs, with less being allocated for consultations and educational and prevention activities. Outreach services are not covered.

Implementation of plans to develop public health infrastructure (water, sanitation, information systems) with appropriate maintenance mechanisms is similarly patchy.

Ministries and other actors contribute to child and adolescent health outcomes in the Republic of Moldova. In the spirit of moving forward in a partnership approach, it would be appropriate to consider how financial, human and infrastructure resources can best be used across government and other sectors to achieve desired outcomes.

Rights, involvement and integrated approaches

Formal measures to promote children's and adolescents' rights within the health system are in place but tend to operate slowly. There is a need to refine and simplify legal support services for children and adolescents, making them less formal and more accessible, particularly for vulnerable groups and for those who do not have parents. While recent changes to legislation reducing the age of consent to receiving health services to 16 years signal positive intent, further action is required in this area, with questions persisting around the need for parental consent to allow young people to attend YFHS.

Generally, the need to address inequities, adopt intersectoral public health approaches, involve the public (including children and adolescents) in developing and monitoring services and adopt a life-course approach to strategy development are informally accepted within the country. Examples of child and adolescent involvement are present and should be better integrated. Integrated approaches currently exist in relation to management of childhood illnesses, perinatal care, oral care, prevention of abuse and neglect, nutrition, breastfeeding, immunization, early detection and management of vision and hearing disabilities, and prevention, detection and treatment of parasitic infections and infestations.

Guidance and protocols

Policy and strategy development tends to reflect a range of international guidelines, including the WHO IMCI modules: the Republic of Moldova was among the first European Region countries to implement this initiative back in 1998, which is recognized as being the most effective strategy for improving child health and survival (11). United Nations Children's Fund (UNICEF) guidelines in areas such as child development, early childhood and abuse and neglect, WHO standards on child

physical development, WHO/UNICEF guidance on breastfeeding, WHO guidance on integrated YFHS and the MDGs are also used to inform policy and strategy development. National protocols and guidance based on international standards are in place and are being implemented for children in relation to main disease groups, but only partially so for adolescents.

Improvement outcomes, indicators and standards

Identified outcomes for improving child and adolescent health in the Republic of Moldova include:

- full adoption of WHO guidelines on IMCI, immunization, breastfeeding and other topics;
- provision of training for health workers on WHO and UNICEF strategies on child and adolescent health;
- development of national clinical protocols for identified childhood diseases;
- incorporation of evidence-based training materials into undergraduate and postgraduate medical curricula;
- development of guidance for parents on managing common illnesses and promoting health;
- increased capacity of senior medical personnel to support and supervise junior medical staff and to conduct external quality reviews of services;
- inclusion of the IMCI package, including approved medications, in the insurance package on child care in primary care; and
- implementation of state regulations (published in 2010) on social and health supervision of children and vulnerable groups.

Policy measures to achieve these outcomes focus on legislation (smoking in public places, environmental improvements), regulation (consumer protection, food labelling, industrial and vehicle emissions), organizational change, public education, professional development for health workers, budget allocation, fiscal measures, welfare policy, research and performance-related public service funding.

Priorities for child and adolescent health adopted by the European Region are inspiring some activity in the country. In relation to nutrition, measures have been taken to support breastfeeding, introduce iodine and iron supplements to flour and water and ensure access to safe food and water. The IMCI package and guidelines on prevention of diarrhoea, as well as initiatives to address HIV/AIDS, have been adopted to tackle communicable diseases and measures have been taken to prevent domestic abuse and reduce childhood abuse and neglect as part of efforts to minimize injuries and violence. The physical environment is being improved through anti-tobacco legislation, children's and adolescents' psychosocial development and mental health is being promoted through the actions of an MoH commission on the detection of developmental difficulties and chronic disease and disability are being tackled through annual health checks.

Young people can now access optional premarital checks for HIV and be screened for cancer, mental illness and genetic conditions.

In addition:

- policy measures have been taken to reinforce parents' responsibilities for their children if they work abroad;
- maternal centres have been established to support mothers in the first six months of their child's life to try and reduce abandonment levels;
- action is being taken to increase fostering of children in institutions;
- special centres have been set up for people who are "trafficked"; and
- an improved regional perinatal and neonatal care programme has been developed.

Curriculum development in schools is identified as being significant in this area, but "life skills" has been removed as a compulsory subject in the school curriculum. Similarly, environmental change is an important factor, but problematic issues remain around school toilets and drinking water in rural areas. There is also concern that existing legislative measures on protecting women and children from hazardous environments and domestic violence are not being fully enacted or enforced. This raises the issue of the importance of developing current child protection training for relevant personnel, such as doctors, nurses, teachers, social workers, the judiciary and law enforcement officers.

A subjective assessment of the comprehensiveness of indicators carried out by the country experts as part of the WHO assessment tool exercise, based on WHO standards on child health, data on infant mortality, under-five mortality rate, the birth rate and standards on child physical development, scored just above the mid-range. A more objective assessment of one particular group of standards – those for supervision of healthy children in outpatient settings – found that while the standards offered family doctors specific activity targets, provided structure to the medical check-up process for healthy children, identified critical periods in child development and promoted multidisciplinary review, no performance evaluation had been conducted since their introduction in 2005 and no updates to reflect changes in health care and society had been introduced (17). New standards were developed following this review and currently await MoH approval.

Other indicators used in the country include immunization coverage, breastfeeding rates, prevalence and incidence of childhood diseases, and WHO YFHS standards. There are no specific indicators for YFHS at present but they are being developed. Quality standards for YFHS (18) are not applied in all areas and there is a need for better monitoring for quality assurance purposes.

3. PEOPLE, PARTNERS AND PLAYERS

Government level

Children's health and enhancement of their life quality depends not only on the level of organization and quality of health care, but also on non-medical issues such as infant nutrition, family and education setting and other socioeconomic factors (9). Strategic responsibility for child and adolescent services in the Republic of Moldova, including health, consequently lies with a number of government ministries.

Ministerial responsibilities for children and young people tend to be shared by the ministries for health, education, youth and sport, and labour, social protection and family. There is a Youth Parliament, but it does not sit as a permanent body. Similarly, while a focal point for children exists within the Parliamentary Committee for Health and Social Protection, there is no permanent intersectoral or ministerial body for children and adolescents and no dedicated parliamentary committee, although appropriate groups are convened when specific strategy development is necessary in areas such as violence prevention. The National Council for Children's Rights (under the leadership of the Vice Prime Minister for Social Protection) plays a positive role in responding to specific incidents and problems, although its focus is limited, and while an Ombudsman for Children's Rights is in place (reporting to Parliament), the service requires further development.

Coordination of antenatal and perinatal services with child and adolescent health services and other relevant health programmes, such as women's health, falls within the framework of the Reproductive Health Strategy Coordination Committee, but active involvement of other sectors beyond the MoH is limited, including generic children's services.

Children, young people and families

As was suggested in Chapter 2, the need to include children and adolescents (or their advocates) in planning, implementing and reviewing policies and strategies designed to improve the health of young people is informally accepted within the country. Good examples of involvement exist, but they are neither universal nor equitable. There is a defined need to embed children and adolescents' involvement in all relevant policy and strategy development. Adolescent involvement in decision-making currently tends to be sporadic, but YFHS have devised a strategy for engaging young people and others, such as parents and religious leaders.

Nongovernmental organizations

In addition to a range of patient groups being involved with clinicians in developing services for specific diseases, some nongovernmental organizations (NGOs) are actively involved in planning services for children and adolescents and in delivering services. These include:

- PAS (Policies in Health), which focuses on evaluation;
- the National Centre for Prevention of Abuse, providing support to policy development, offering advice and developing training guidelines; and
- Pas cu Pas [Step by Step], which specializes in childcare and services in the early years.

The 12 YFHS clinics also work with local NGOs on planning and development issues and delivering services. Collaboration involving key stakeholders in government, international agencies, academic institutions and NGOs tends to be unsystematic and requires stronger cross-sectoral approaches and agreements. Government is already active in this area, with the implementation in 2011 of a mechanism for cross-sectoral medical and social collaboration. The specific aims of this initiative are to prevent and reduce child and under-five mortality in the home and improve the quality of life of children and families (particularly those who are vulnerable) by ensuring equitable access to high-quality services. The mechanism establishes responsibilities, standardizes the process of cross-sectoral coordination and cooperation and promotes cross-sectoral partnerships involving public agencies and civil society organizations with the aim of solving problems for children and families at risk (9). A high-level policy decision to establish closer links between health and social care, with a focus on disadvantaged families and young children, was taken in 2010. Some promising examples of strong cooperation between health and social workers and local administrations are now beginning to emerge.

There are, however, no specific mechanisms in place to contract NGOs and private health clinics to provide YFHS, although examples do exist and could be used as exemplars to encourage further activity in this area.

Health professionals

Preregistration training for doctors and nurses is provided within the main higher and further education system. Specialist training in paediatrics is also available, but some staff have difficulty accessing opportunities. A new training programme for SHS nursing staff has recently been developed; this could provide an opportunity for further multiagency and multidisciplinary training.

Existing university and college health curricula address adolescent health issues only marginally, with a particular dearth of modules on communication and counselling skills and SHS/YFHS approaches; again, the revision of the SHS initiative offers an opportunity to address this imbalance. Generally, primary health care specialists have not been trained in providing the basic package of YFHS.

Evidence-based, gender-sensitive health education aimed at promoting gender equality is not a mandatory component of the curricula of the main professions. These curricula are currently being reviewed to ensure adherence with international standards, which provides an opportunity to consider adding relevant modules at undergraduate and postgraduate levels on topics such as communicating with children and young people and confidentiality issues. Consistent and widespread availability of training on SHS/YFHS approaches could also be ensured through the review process.

Existing ongoing professional development activity relating to care of children could be further improved through the provision of evidence-based postgraduate education opportunities on the needs of children and adolescents, exploiting opportunities offered by electronic delivery of learning materials. Within this context, there appear to be particular issues of access to training opportunities for staff working in YFHS that need to be considered.

An online resource through which health care workers will be able to access information, clinical updates and educational materials is currently being planned, despite some issues around access to computer technology for staff in different clinical locations. There is therefore a need not only to ensure that information posted on the new web site is evidence-based and reliable, but also to enable relevant staff to access computers.

Health care managers have a key role to play in planning and delivering services, but may not be fully aware of the complexity of child and adolescent health needs, particularly in relation to service transitions and YFHS approaches. Consequently, adolescents may find themselves attending adult services because access to YFHS is limited or managers are unaware of the approaches they offer. It is anticipated that this situation will improve when YFHS are scaled up within the country.

A national human resources plan has been developed for workers supporting children, and while no such plan currently exists for those working with adolescents, nor in YFHS and SHS, an assessment has been carried out to determine the number of staff necessary to support a child and adolescent health strategy. Human resources are described as scarce, particularly in remote and rural parts, leading to an imbalance of skilled health professionals across services. While national measures on health and safety in the workplace are in place, there is a need for more family-friendly policies to reflect the fact that the workforce providing children's and adolescents' services is predominantly female.

Staff salaries and payments

Salary levels for staff in children's and adolescents' services do little to promote working in this area as a career aspiration. In most cases, workers in these services are paid the lowest salaries on the scale. There are concerns that low salaries are not providing sufficient motivation for staff, especially school nurses, to develop themselves professionally. Professional associations, such as the League of Physicians, could be developed through creating a specific branch for medical staff working with children and adolescents to promote improvement in practice and protect physicians' rights. There is currently a question, however, about the League's focus on adolescent health issues, as there is for the professional association for nursing staff.

There are few working mechanisms in place to minimize unofficial payments to health professionals. Adolescents rarely have the capacity to cover informal payments, which limits their access to certain specialist health care services, including abortion services. This could also affect families seeking services for children.

4. INFORMATION SYSTEMS

National- and international-level systems

Specific information systems to support child and adolescent development are in place in the country and have been delivering data sets for 20 years or more. These include the National Centre for Health Management within the MoH (which holds overall responsibility for information systems on child and adolescent health), the National Bureau of Statistics (which also delivers data on social determinants of health), WHO and UNICEF. The National Centre for Health Management circulates data monthly and hosts quarterly seminars, while other ministries also publish relevant data regularly. Generated data are used to inform policy development, programme planning, monitoring of implementation and evaluation.

The WHO Health Behaviour of School-aged Children (HBSC) survey provides a wealth of important data disaggregated by age and gender and includes health and social information that could support the development of child and adolescent health services in the country. The Republic of Moldova is not currently a member of the HBSC study but can still access its materials, including the recently published fifth international report (19).

Data problems

Information systems on child and adolescent health could further be strengthened, with significant data gaps currently existing. Little of the data generated are disaggregated by socioeconomic status and ethnic background, gender and age (which are required under WHO guidelines). The Ministry of Labour, Social Protection and Family produces an annual report on gender equity and the National Bureau of Statistics also has some data in this area, but no national platform to act on the results of the data appears to exist.

Some collected data are only partially readjusted to international definitions, and data on financial and social capital, the environment and output and input results of interventions in implemented programmes are either lacking or incomplete. Operational research, including ad hoc surveys, are used only sporadically to assess needs, programmes and interventions.

As examples of the inconsistencies in information collected, it appears that while there are much data on asthma incidence among children and young people (national data, regional breakdown and population breakdown, although no gender breakdown), there are none on exposure of children

aged 0–4 to household environmental tobacco smoke. Data on numbers of visits to dentists for prophylactic care among children and young people aged 0–17 exist, but are not broken down by age or gender. There is also a disconnect between data sets and intelligence collected by different ministries, with limited integration with NGOs and civil society.

Coordination and continuity of care for children and adolescents is hampered by the underdevelopment of mechanisms designed to ensure integration of community, hospital and social services and the sharing of protocols for management of common and chronic conditions, and there is a need to pool child and adolescent health information at central level. An integrated, computerized medical records system is required to improve continuity of care between agencies.

Information to service users

Providing information to service users about what they can expect within a service is standard practice for high-quality providers, but it appears that only YFHS are delivering this kind of information to adolescents. In addition, national guidelines on drugs that patients can access from pharmacies provide little information for children and adolescents, if any; specific advice needs to be developed for children, adolescents and their parents/guardians.

5. IMPLEMENTATION

Service provision

Child and adolescent-centred health services in the Republic of Moldova include the provision of prevention and health promotion services (by, for instance, family medicine, SHS and YFHS), primary care (including screening and early detection) and secondary and tertiary care (for discussion of secondary and tertiary care, see Edwards (5)).

Two of the essential service provision elements are SHS and YFHS.

SHS

The SHS was established during the 1960s and 1970s as part of Soviet Union five-year plans. The goal was to establish health care services in schools that would offer prevention, health screening, immunization, nutrition advice and supervision of sanitary conditions (20).

SHS initial priorities were eyesight problems, preventing infectious diseases and trauma, and organizing pupil health examinations. School health care workers were charged with enhancing children's physical development through promoting sports and healthy lifestyles. A joint order of the MoH and Ministry of Education (MoE) in 1989, however, identified significant problems in pupils' health and in the quality of health care services provided at schools. The order highlighted the need for health education in areas such as sexuality, alcohol, tobacco and substance use and promotion of healthy lifestyles. It also addressed professional training of health care personnel employed at schools and defined an approved model list of medical equipment and medications for school health care consulting rooms (21).

The order was replaced in 1995, with job descriptions for school physicians and nurses, hygiene standards and annual reporting of morbidity rates introduced. The order that remains in force today was introduced in 2002, making local public authorities responsible for health care workers' pay (20).

To date, the SHS focus is very much on treatment-centred clinical care provided by doctors and nurses within and outside the school system. Consequently, generic health promotion and multi-agency working, as advocated by the WHO health-promoting schools approach, have been limited.

The Republic of Moldova recognized this and reviewed SHS standards and competencies, with a revised service and curriculum currently being considered by the MoH and MoE. The new service will

be presented in September 2012 with the training programme being rolled out across the country. SHS will feature an increased emphasis on health promotion and health education, in addition to continuing commitments to fulfil the clinical requirements of the service.

The new SHS will be an integral element of the proposed child and adolescent health strategy for the Republic of Moldova. Together with YFHS, it will provide an excellent vehicle through which to promote positive health and well-being for children and adolescents and to foster intersectoral collaboration.

YFHS

The national concept paper on YFHS (22) underpins the approach adopted in the Republic of Moldova. This paper:

- defines YFHS in the country;
- sets working principles and components of YFHS;
- outlines the model of implementation of YFHS and their integration into the existing health system;
- sets the minimum and extended packages of YFHS and coordination mechanisms;
- defines responsibilities at national and local levels; and
- sets a monitoring and evaluation framework (21).

The concept paper (and the YFHS clinics) emphasize that services are oriented towards promoting healthy development in adolescents and preventing (and responding to) health problems if (and when) they arise. Interventions aim to create a safe and supportive environment, supply information to build life skills and provide health and counselling services. The approach aspires to be nonjudgemental (23).

A network of 12 YFHS clinics has now been established in the country, providing services to children and young people from ages 10–24 years (most being between 14 and 18). The network has developed quality standards (18), created primary and specialized data linked to indicators and developed guidance for, and trained providers of, YFHS. It has also created information materials for young people, provided training for parents and teachers and engaged in advocacy activity with decision-makers, local authorities, religious leaders, parents and the national health insurance company (to encourage them to contract services from YFHS and extend the range of services within the contract). Study visits to the Russian Federation, Estonia, Sweden and Denmark have been undertaken to share knowledge and experiences.

YFHS are funded by the national health insurance company through standalone budget lines allocated to the primary health care facilities hosting the YFHS.

Other key service delivery mechanisms

The perinatal programme is considered one of the most important in the country, and several other programmes link with it. This regionalized perinatal care system ensures that pregnant women and neonates are triaged according to their needs for care. Health care staff trained under WHO's Making Pregnancy Safer initiative are supported to use evidence-based guidelines and protocols (24). A national system of monitoring has been introduced, under which data-based recommendations are produced. The Japanese Government and Swiss Development Agency have provided funding to support well-equipped perinatal centres.

The IMCI strategy was introduced in the Republic of Moldova in 1998 as an integrated approach aiming to address leading causes of childhood mortality and morbidity through improved case management at health facilities, strengthened health system support and better child care provided by families and communities. A UNICEF evaluation of IMCI implementation in the Republic of Moldova between 2000 and 2010 (13) showed that the strategy's training and supervision components were well designed, of high quality and achieved high coverage. Some 90% of family physicians from the right bank of the **Dniester river in the region of Transnistria who were surveyed as part of the evaluation** and 95% on the left bank were covered with standard IMCI training; for nurses, coverage was lower at 41% (right bank) and 71% (left).

The IMCI strategy is now an integral part of the basic benefit package, which includes universal coverage for children with services and standard drugs. Health managers believe it provides equitable access to evidence-based health care and it is recognized that it has had a positive effect on decreasing under-five and infant mortality rates, although it is difficult to evaluate the extent of its specific contribution to reductions because of parallel interventions.

Ongoing priority actions for quality-assuring paediatric care based on IMCI principles are focused on developing policy and tools on integrated supportive supervision, reducing unnecessary paperwork linked to reporting, and strengthening family physicians' and nurses' counselling skills on child nutrition, growth and development.

The country has now adopted near-miss case reviews and confidential inquiries into maternal deaths as part of monitoring mechanisms (25,26). It is hoped that this activity will identify useful information that will enable the development of protocols to help to save lives in the future. Ongoing priority actions for ensuring maternal and newborn safety include:

- fully implementing near-miss case reviews at national level within perinatal centres;
- strengthening medical resources, including those at primary care level;
- developing and implementing clinical protocols and medical standards of care;
- developing monitoring and evaluation mechanisms for implementing standards and clinical protocols at national level;
- developing protection mechanisms for vulnerable groups to increase their access to quality medical services; and
- developing public–private partnerships in enhancing services to women in the reproductive years.

Service gaps

Despite these strong elements of service delivery, shortcomings in service provision remain, including:

- ineffective quality review systems for services, with underdeveloped capacity among suitably qualified staff to conduct external and internal reviews of services;
- insufficient budget to support health promotion and prevention work;
- inconsistent intersectoral collaboration and coordination; and
- little synergy and coordination between the work of health services and NGOs.

The delivery of some obstetric, neonatal and paediatric services is being hampered by inadequate supplies of medicines, consumables and equipment. Medicines used in the syndromic treatment of STIs and contraceptives are not included in the basic package of medicines provided by the Government, with particularly serious implications for young sex workers. Family planning services in the country tend to be female-oriented, making them less attractive to young men. No strategies are currently in place to encourage young men to accept greater responsibility and take more involvement in family planning services.

The 12 YFHS clinics provide contraceptive advice and counselling only, along with free HIV testing (18) – all other requirements have to be accessed through mainstream services covered by the health insurance contract. Adolescents tend to be reluctant to access advice and support on pregnancy or safe abortion due to fear of family disapproval. This also applies to issues around mental health and well-being, with young people and their families believing they will experience negative attitudes within their communities if they seek assistance. In addition, adolescents (in particular) feel that services are not necessarily sensitive to their particular needs.

In addition to the need to develop measures to increase access to services for young people, including legal measures around consent and confidentiality, and for better training in care of adolescents for workers in obstetric and gynaecological services, there is also a need to address the culture that perpetuates these kinds of problems for young people. Some pregnant adolescents perceive that health workers “judge” them negatively, which is the antithesis of a service that provides holistic care, promotes dignity and respects personal choice. Training for staff in the specific features of adolescent pregnancy and childbirth management is important, but more significantly, a cultural shift away from judgemental attitudes towards a YFHS approach is required.

Gender-sensitive advice on common health problems, including mental health, substance misuse and reproductive and sexual health issues, is only partially provided to young people. Offered advice commonly takes little account of age and does not follow YFHS approaches. There is a clear staff training issue here, focusing on YFHS approaches and issues around mental health and well-being.

The system of obstetric, neonatal and paediatric care being organized by levels (primary, secondary and tertiary), with clear definitions of functions at each and referral criteria in place, seems to work well for children, but there is as yet no comparable structure for adolescents. The same situation applies to protocols and standards for care throughout pregnancy and beyond, appropriateness of referrals and provision of adequate and prompt transport for emergencies. The issue of emergency transport is also problematic for children, as current practice dictates that the request for transport must first be approved by a nurse, which can (and does) delay responses. Poor communication between services around referrals is common for both children and adolescents, with a need for improved diagnostic systems and provision of accommodation on hospital sites for parents/guardians of hospitalized children.

Shortage of suitable transport makes access to YFHS difficult for children and adolescents with special needs (such as wheelchair users). The YFHS standards (18) address this area and provide alternatives for ensuring access to services for all, but they are not widely implemented due to funding issues. Outreach services for those in remote and rural regions are similarly affected by inadequate transport arrangements.

Recent research into primary care in the country (16) also raises issues about transport. It found that while 40% of patients can reach their family doctor and pharmacist within 20 minutes, the proportion drops to 20% in relation to travel to the nearest hospital. Travel times to all care providers are longer in rural areas, with times of 40 minutes to the nearest hospital and preferred dentist being common for more than 50% of rural patients (16). These issues will inevitably impact on children and adolescents as well as their families.

Quality assurance mechanisms

Quality assurance mechanisms are in place only for YFHS clinics. There is a need to spread the quality assurance culture from YFHS to all other services for children and adolescents, taking into account previous quality measurement initiatives that have focused on maternity services and, to a lesser extent, paediatric hospital care.

There is no ministry or independent agency dedicated to monitoring quality and standards in child and adolescent services. Quality assurance processes are nevertheless in place, currently involving joint efforts from relevant departments from MoH, National Health Accreditation Council, national health insurance company and monitoring departments from respective health facilities. Approaches tend to be reactive (responding to problems that arise) rather than proactive (seeking to identify potential problems and opportunities in advance and taking steps to avoid or exploit them). Public health needs to recognize the contribution it could make to planning and monitoring the quality of child and adolescent health services, with the National Institute for Public Health having a potentially significant role in this area.

Approval and monitoring of quality standards for SHS are more challenging as the SHS is jointly managed by the MoH and MoE. The two ministries would find potential benefits in working more closely together on approving and monitoring mechanisms and defining SHS funding.

Opportunities for health professionals from different levels of care to review and discuss information of common interest, such as patient flows and outcome indicators, are available only patchily for those involved in care of children and rarely for those caring for adolescents. A case review system following deaths or “near-miss” incidents exists, but it would be prudent to review this system with a view to considering how stakeholders outside the health system can contribute.

6. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

During a visit to the Republic of Moldova on 3–5 June 2012, Dr Zsuzsanna Jakab, WHO Regional Director for Europe, remarked:

I am really impressed with the work done so far in the health sector and the approaches used. The Republic of Moldova has managed to preserve good practices from the past, such as maintaining high immunization coverage, while at the same time moving towards a modern health system, with a focus on family medicine, mandatory health insurance and comprehensive public health services (27).

As this report indicates, there has been progress within the country in terms of health system reform and consideration of the need for a formal child and adolescent health strategy. The detail provided by the experts from the Republic of Moldova health system for the assessment documents provided an overview of the technical reality of child and adolescent health services in relation to issues such as stewardship, financing, data and evidence sources, and staffing and training issues. These are reflected throughout the report and in the following recommendations.

Analysis of the data supplied was not, however, without its challenges. A key complicating issue was the formal definition of “children’s services”, which are described as services for those “aged 1 month to 17 years, 11 months and 29 days”. Within this definition, services are provided to children and young people across the health system. While the 12 YFHS clinics provide services for 10–24-year-olds, paediatric specialist services, family doctors and others also contribute to the overall package of prevention, care and treatment offered. It would seem appropriate, therefore, to consider actions to secure the provision of specific age-appropriate services.

A number of challenges are hindering this kind of progression. The report highlights several, but they include:

- the availability (or lack of availability) of age- and gender-disaggregated data;
- lack of clarity on which professions and services should be providing services to children and young people in specific age groups;

- legal issues, including child protection, access to confidential services (including sexual and reproductive health) linked to age of consent, and protection for health staff;
- responsibilities of different ministries within government and the impact on multi-agency/ multidisciplinary working and collaboration; and
- staff training (or lack of staff training) on age-appropriate interventions in prevention and care services.

The proposed development of a formal child and adolescent health strategy for the Republic of Moldova provides an opportunity to take a “whole-of-government” approach (in line with the Health 2020 policy framework (8)) to address these issues. The commitment of personnel who provided the underpinning data for this report, working with national and international colleagues, children, young people and families, should be harnessed in taking this process forward.

Recommendations

Despite the obvious progress and the enthusiasm for improvement within the country, certain structural weaknesses persist, with areas and problems that still need to be addressed. While this report has highlighted a number of areas in which action seems to be required, such as the need to refine and simplify legal support services for children and adolescents and to develop solid, evidence-based postgraduate education opportunities for health care workers, the recommendations for action that follow focus on the factors identified as the most significant obstacles to progress in promoting children’s and adolescents’ health. These are:

1. inadequate regular intersectoral collaboration and cooperation on child and adolescent health issues;
2. inadequate supervision of quality standards within the health system and lack of recognition by public health (National Institute of Public Health) of its potential contribution to planning and monitoring the quality of services;
3. inadequate data on gender inequity and the needs of vulnerable populations, with insufficient use of data that do exist;
4. limited health care management awareness of the complexity of child and adolescent health needs;
5. poor awareness and understanding within the health system and wider society of the specific needs of adolescents;
6. inadequate focus on health promotion and health education across the health system; and
7. inadequate transport and hospital access arrangements for people living in remote and rural areas.

The MoH may wish to consider the following recommendations to address these issues

1. Inadequate regular intersectoral collaboration and cooperation on child and adolescent health issues.

The National Council for Children's Rights could become a permanent body, thereby providing leadership for intersectoral collaboration at district and local levels. Evaluation of the existing mechanism for cross-sectoral collaboration may provide learning and a model for progressing intersectoral collaboration across the country.

2. Inadequate supervision of quality standards within the health system and lack of recognition by public health (National Institute of Public Health) of its potential contribution to planning and monitoring the quality of services.

The MoH may wish to consider increasing the capacity of senior medical staff to undertake service reviews and to supervise and support junior medical staff in child and adolescent health services. Support could be offered to the National Institute of Public Health to enable it to maximize its contribution to planning and monitoring child and adolescent health services.

3. Inadequate data on gender inequity and the needs of vulnerable populations, with insufficient use of data that do exist.

The development of the child and adolescent health strategy offers an opportunity to take a whole-of-government approach (in line with the Health 2020 policy framework (8)) to developing, sharing and integrating existing data on gender inequity and vulnerable populations, thereby improving current information and intelligence systems. This could create an environment in which providers of child and adolescent health services could more readily access evidence-based information to underpin approaches, and would require investment in infrastructure. The WHO European strategy for child and adolescent health and development gender tool (28) provides a mechanism to help address this. Consideration could also be given to the possibility of joining the WHO HBSC network and undertaking the HBSC survey in the Republic of Moldova.

4. Limited health care management awareness of the complexity of child and adolescent health needs.

As a first step, it may be useful for the coordinator of YFHS to meet with health care managers to discuss how YFHS approaches can enhance their service delivery.

5. Poor awareness and understanding within the health system and wider society of the specific needs of adolescents.

Health care workers within the health system need support to adopt the underpinning approaches of YFHS, with an emphasis on respecting confidentiality, facilitating access to sexual and reproductive health services and removing stigma around mental health. In relation to wider

society, the National Council for Children's Rights would seem well placed to provide leadership and advocacy in addressing current cultural norms that prejudice children's and adolescents' rights and freedoms.

6. Inadequate focus on health promotion and health education across the health system.

YFHS require sufficient resource to undertake proactive health promotion and health education activities to complement the improved function of the SHS.

7. Inadequate transport and hospital access arrangements for people living in remote and rural areas.

YFHS standards on access to health service premises could be promoted and adopted across the whole health system, particularly in relation to children's services. Consideration may be given to reforming the current system for accessing emergency services (particularly the need for nurse confirmation of the need for transport, which can delay responses) and to ensuring adequate transport availability to meet needs.

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Annex 1

WHO child and adolescent strategy toolkit

The *WHO European strategy for child and adolescent health (1)* presents a four-part toolkit that provides resources to enable Member States to determine gaps in their plans and clarify priorities for future investment. The toolkit consists of:

- an assessment tool to assist countries in assessing existing policies and strategies (2);
- an information tool that supports countries to identify necessary data and information to aid policy and strategy development (3);
- an action tool, which helps countries get started on actions (4); and
- a gender tool, designed to enable countries to incorporate gender analysis into their child and adolescent health programmes and identify effective interventions that have a gender perspective (5).

The first two tools were used as part of the process of gathering evidence to inform this report and, in conjunction with the WHO tool for assessing health system performance in improving maternal, newborn, child and adolescent health care (6), provide the basis for the current analysis.

The assessment tool facilitated an audit of current policies within the Republic of Moldova in relation to child and adolescent health and the possibilities for future development, and the information tool allowed the collection and analysis of data to support the development of an objective and evidence-based strategy based on identified needs and relative priority. It also created the opportunity to review the strengths and weaknesses of current data and information processes.

The third and fourth tools can assist the Republic of Moldova in taking forward the next phase in the process. The action tool is structured to reflect the seven key priority areas identified within the WHO child and adolescent development strategy, with the additions of chronic disease and disability. Using the tool will support the Republic of Moldova to draw on the information collected as part of this report process and decide which priorities and objectives are paramount.

The action tool provides a table for each area with the following key headings and a complete set of suggested actions:

- priority
- cross-sectoral action
- health system action
- health services action.

It has recently been revised to provide a specific focus on evidence for gender-responsive actions to prevent and manage injuries and substance abuse, violence, overweight and obesity, chronic conditions, HIV/AIDS, sexually transmitted infections and adolescent pregnancy, and to promote mental health and well-being.

The gender tool can be used as part of this process and also as a standalone document that allows policy-makers and programme staff to assess the gender sensitivity of their current child and adolescent health programmes and policies. The tool is based on evidence that shows how gender differences and inequality influence various aspects of illness and health among girls and boys. Its objectives are to support countries, institutions and policy-makers to incorporate gender analysis into their child and adolescent health programmes and policies and identify interventions with a gender perspective that have proven effective in protecting the health and promoting the development of children and adolescents.

The purpose of gender analysis is to unearth sex differences and gender inequality and inequity and identify how they affect specific health problems, health services and successful responses. Inequality and inequity often create, maintain and exacerbate exposure to risk factors that threaten health and affect control over, and access to, resources such as decision-making processes that are conducive to promoting and protecting health. These differences influence the responsibilities and types of relationships established between service providers (including health services) and the population served, a field that has not yet been thoroughly explored for the early stages of life.

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Annex 2

Current legal framework for adolescent health and development

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