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Medical and Pharmaceutical State University “N.Testemitanu”

Reproductive Health Training Center

Assessing the Quality of Pregnancy Termination Services and Compliance with Safe Abortion Standards

Republic of Moldova

REPORT

Rodica Comendant, Stelian Hodorogea, Natalia Zarbailov, Irina Sagaidac

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1. Rodica Comendant, associate professor, department of obstetrics and gynecology, MPSU "N.Testemitanu"; Reproductive Health Training Center, director
2. Stelian Hodorogea, associate professor, department of obstetrics and gynecology, MPSU "N.Testemitanu"; Reproductive Health Training Center, deputy director
3. Natalia Zarbailov, associate professor, department of family medicine, MPSU "N.Testemitanu"; master in PH
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7. Cornelia Sirbu, obstetrician - gynecologist, head of admissions room IMSP SCM #1
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Abbreviations

AM	medical abortion
DH	district hospital
EVA	electric vacuum aspiration
FIGO	International Federation of Gynecology and Obstetrics
IMSP	public healthcare facility
MoH	Ministry of Health
MPSU	Medical and Pharmaceutical State University “N.Testemitanu”
MVA	manual vacuum aspiration
NHIC	National Health Insurance Company
NCHM	National Center for Health Management
SCM	Municipal Clinical Hospital
US	ultrasound
WHO	World Health Organization
YFHC	youth-friendly health center

Content

Introduction

Since gaining its independence in 1991, like with many of the former Soviet Union countries and Western Europe, abortion has been widely practiced in the Republic of Moldova as a substitute of effective contraceptive methods for birth control. Dilation and curettage (D&C) was the most common pregnancy termination procedure, performed under general anesthesia, rather than safer methods recommended by WHO and IFGO, such as medical abortion and vacuum aspiration under local anesthesia[1,2].

As a consequence of lacking evidence-based guidelines and protocols, poor quality and limited access to pregnancy termination services and modern contraceptives, circa 30% of the maternal mortality cases reported in Moldova during 1995-2005 were owing to abortion complications. That is why birth control and improving the quality of abortion services were made priority areas under the National RH Strategy 2005-2015 endorsed through a Government Decision in 2005. In order to comply with the provisions of this Strategy, the MoH adopted the WHO Strategic Approach to Strengthening RH Policies and Programs, and a first step taken was the assessment of quality and access to contraception and pregnancy termination services conducted in 2005. Key recommendations of the strategic assessment included:

- Developing and approving the clinical guidelines and standards promoting the concept of comprehensive pregnancy termination services;
- Developing a comprehensive set of indicators and upgrading the system for reporting the quantity and quality of pregnancy termination services;
- Reviewing of training curriculum of abortion service providers;
- Set up a model for comprehensive pregnancy termination services in outpatient settings, piloting it in specific healthcare facilities – intervention centers (hereinafter, Cenyre-Model) to make use of WHO recommended methods, i.e. medical abortion and vacuum aspiration with local anesthesia, while observing one's privacy and confidentiality, ensuring counseling, post-abortion contraception and national scale-up of those innovations.

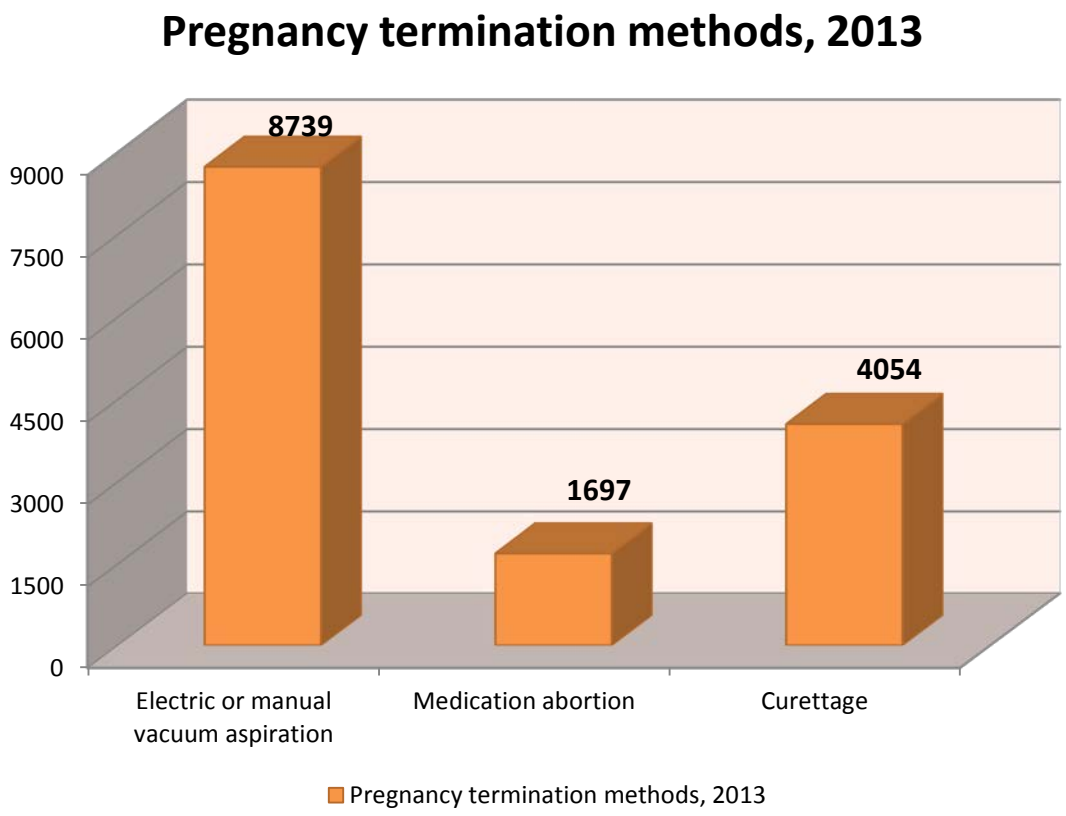
With the support provided by the WHO and other international organizations, between 2007 and 2011 Moldova developed and approved Safe Abortion Regulations (2010) and Standards (2011), reviewed and approved the abortion training curriculum, upgraded and institutionalized a system for statistic reporting of the quantity and quality of pregnancy termination services. Moreover, there were 6 model-centers for outpatient safe abortion delivery services created in a two-stage approach. Initially, this concept was piloted in the Perinatal Care Centers in Chisinau and Balti. Then, buildings were renovated, necessary equipment was provided and health workers from the outpatient departments (consultative-diagnostic service) of tier-II perinatal care centers in Cahul and Orhei and polyclinic of the district hospital in Cantemir and Women Health Center "Ana" in

[1] Safe Abortion: Technical and Policy Guidance for Health Systems (2003). World Health Organization
[2] FIGO (2012) Consensus Statement on Uterine Evacuation

Drochia were trained. To date, according to the National Center for Health Statistics, about one-third of all terminations of pregnancy in the country were performed in outpatient settings within these 6 facilities by making use of WHO recommended methods, i.e. vacuum aspiration and medical abortion.

A provisional assessment of the quality of pregnancy termination services in model-centers performed in 2012 showed a very low proportion of abortion complications, higher user satisfaction (both patients and providers) with service setup, a higher proportion of women adopting a post-abortion contraceptive method. Given the extremely positive experience of model-centers, the MoH recommended to other relevant healthcare facilities in the country to implement the concept of comprehensive abortion care, as per the national Regulations and Standards in effect.

Several of Moldova's healthcare facilities reorganized their abortion care services recently to align them with MoH recommendations and national Standards, by using vacuum aspiration and medical abortion instead of D&C.



Hence, the share of pregnancy termination procedures by vacuum aspiration and medical abortion increased up to 72% in 2013. Nevertheless, it is staggering that, contrary to the provisions of the MoH normative papers in force, quite a few health care facilities in the country continue practicing just D&C as pregnancy termination method (28% of all); general anesthesia is widely used; and no

effective post-abortion contraceptive methods are suggested / offered to a significant proportion of women.

In the beginning, at the preparatory stage of this assessment (August 2014), the assessment team members together with MoH representatives and WHO experts looked into the statistic data and indicators related to abortion care in Moldova for 2013, as collected by the National Bureau of Statistics and the statistic form no.13 on termination of pregnancy (Annex 2). Data from the health care facilities providing pregnancy termination services in Moldova were systematized, grouped and analyzed by a number of basic criteria: share of D&C performed vs. MVA or EVA and medical abortion, proportion of D&D performed in adolescents, proportion of complications etc.

Hence, there were working visits undertaken to:

I. Model-centers;
II. Healthcare facilities mostly practicing safe pregnancy termination methods, in line with Standard provisions, but which had no support under the WHO project;
III. Healthcare facilities, in which the share of D&C exceeds 80%, complying least with national Standards in effect.

MoH issued ordinance no.455-d of 12.09.2014 endorsing the carrying out of this assessment, timeframe (13-22 October 2014), nominal membership of the assessment teams and list of facilities to visit (Annex 1).

During the assessment, teams paid visits to the medical procedure rooms where termination of pregnancy is performed, appraising the access to, physical condition of the equipment and supplies, discussing with the physicians working in the wards and with facility managers, making use of the semi-structured questionnaires developed by team members in advance.

Provisionally, a number of questions were shared with all relevant healthcare facilities in the country about the number of abortions performed by each facility and methods used, user fees paid for abortion services and the amount they invest in keeping the quality of services up.

There were wrap-up meetings convened by the two teams having completed the working visits to selected healthcare facilities to discuss the provisional findings of the assessment and content, conclusions and recommendations of this Report.

Chapter 1 Purpose of assessment

The **purpose** of this assessment was to look into the quality of, access to, funding for and setup of pregnancy termination services, as well as to see to what extent quality abortion services are available country-wide and are in line with current Standards,, including in the 6 model-centers (Chisinau, Balti, Orhei, Cantemir, Cahul and Drochia).

Key objectives of the model-center assessment included a review of abortion trends, document the physical condition of premises used for pregnancy termination services, access to services, availability of equipment, medication and supplies, quality of services being provided, including pregnancy termination methods and type of analgesia, availability and quality of pre- and post-abortion counseling, making available and acceptance of post-abortion contraception, frequency and severity of abortion complications, as well as the availability of an effective system for quality assurance. Moreover, it was suggested to analyze the pricing methodology for termination of pregnancy by different healthcare facilities, estimate the amount of funds collected as a result of abortion service delivery and appraise to what extent these funds are used to support quality abortion services (renovation / maintenance of premises, equipment upgrade, provision of supplies and motivation of health workers). Another objective of the model-center assessment was to evaluate the opinion of managers and health workers about comprehensive abortion service delivery, sustainability, upholding and better quality of services.

Other objectives of the assessment included appraising the extent to which quality abortion services that are in line with existing national Standards are available country-wide. To that end, it was suggested to have working visits to the healthcare facilities in which the quality of services meet the requirements of national Standards (besides model-centers), but also the ones that are not compliant with those and WHO recommendations (using mainly D&C, general anesthesia, lack or poor quality of counseling etc.); analysis of causes and barriers to quality service delivery; assess the support needed by such facilities in order to make the services provided by those meet existing standards and be sustainable.

The data generated by this assessment shall be used in planning and implementing future actions for better quality and access to contraception and abortion services. Moreover, the assessment data shall be used to create an interactive map of Moldova, listing all health care facilities providing pregnancy termination services, the kind of abortion methods used and their quality, to make it accessible by both potential clients and decision-makers from the Republic of Moldova.

Chapter 2 Legal framework, monitoring, registration / documentation

Voluntary termination of pregnancy in the Republic of Moldova is performed based on the provisions of the ***Law on Healthcare no.411-XIII of 29.03.1995,*** article 32. The Law sets forth the right of women to decide in person on their motherhood. Line 3 of this article mandates the MoH to set the modality to perform termination of pregnancy after 12 weeks of gestation.

The ***Law on Reproductive Health no.138 of 28.09.*****2012** also grants each woman access to safe pregnancy termination methods, pursuant to the normative framework of the MoH. This Law states that "any adult woman and any adult man have the liberty to decide upon the number of own children and upon the proper time for childbirth, as well as on any RH related issues, without constraint or any influence from outside".

In order to ensure affordable and quality voluntary pregnancy termination services, MoH issued ***Ordinance no.647/1*** *of* 21.09.2010 ***on the performance of voluntary termination of pregnancy in safe conditions****.* This ordinance endorsed the Regulation on the performance of voluntary termination of pregnancy and papers / forms required for the registration of an abortion procedure: medical record (form 003-3/e) and registry for voluntary termination of pregnancy (form 003-4/e). Noteworthy, for the first time ever a medical record includes not just a section to document surgical abortions (MVA, EVA and D&C), but also a chapter on medical abortion.

The Regulation approved by MoH ordinance no.647 provides for the normative framework for the work of healthcare facilities providing abortion services, namely: conditions required to run such services, the modality of termination of pregnancy before 12 weeks of gestation and in second trimester of pregnancy (12-21 weeks). The Regulation also provides a list of medical and social indications for termination of pregnancy at 12-21 weeks of gestation, as well as the informed consent forms required for EVA / MVA interventions and for mediation abortion.

Contrary to all previous normative papers, the Regulation makes it possible to perform pregnancy termination procedures not just in public healthcare facilities, but also in private ones, perform medical abortion before 9 weeks gestation and surgical abortion by MVA / EVA under local anesthesia before 10 weeks in outpatient settings; the number of pre-abortion investigations was kept low. The Regulation prescribes pre- and post-abortion counseling with mandatory signing of an informed consent; documentation of the issuance of contraceptives and strict monitoring of performed procedures and reporting of any complications following abortion. According to the Regulation, termination of pregnancy after 10 weeks of gestation or at any time if associated conditions are present or if 16 years of age or younger shall be performed in hospital settings only. Pregnancy termination related costs beyond 12 weeks of gestation are covered by the NHIC.

In order to unify and align existing practices with European standards and WHO recommendations for safe abortion, MoH issued Ordinance no.482 in 2011 whereby the ***safe abortion standards*** were endorsed. These Standards promote the use of the abortion methods recommended by the WHO and FIGO: EVA / MVA and medical abortion instead of D&C in first trimester of pregnancy; dilation and evacuation or medical abortion instead of intra- or extra-amniotic administration of different pharmaceuticals and solutions in second trimester of pregnancy; discourage the use of general anesthesia, which has been associated with more complications and higher costs as compared with local anesthesia. As efficient and evidence-based practices, the Standards prescribe routine preventive administration of antibiotics following a surgical abortion,

examination of aspirated tissues, cervical ripening with prostaglandins, observance of universal precautionary measures for infection prevention and non-contact techniques, informing patients about the normal evolution of post-abortion period and signs of possible complications. There is a detailed description of actions to be taken by physician for specific issues that might occur during a pregnancy termination procedure (no tissue following an MVA abortion, tissue remnants or prolonged bleeding following MA) or emerging complications.

Moreover, the Standards present an exhaustive list of mandatory equipment and supplies for the health care facilities providing pregnancy termination procedures, forms for follow-up at home for the patients who underwent a medical abortion or an EVA / MVA procedure. There is a framework-list of requirements for the healthcare facilities providing elective safe pregnancy termination services presented in the last Annex to the Standards, which may be used when setting up a service or for abortion care quality M&E purposes.

In order to ensure effective M&E of the quantity and quality of pregnancy termination services, a number of changes have been made in 2008 to the list of indicators reported by the healthcare facilities providing pregnancy termination services. Currently, the National Bureau of Statistics from Moldova is collecting data on a quarterly and annual basis on the total number of abortions, indications/modality of termination of pregnancy (voluntary, on medical or social indications, miscarriage, illegal), woman's age, pregnancy termination method (MVA, EVA, D&C, medication) and anesthesia (paracervical block or general anesthesia), as well as indicators on the quality of services being provided (performing counseling, cervical ripening, offering a contraceptive, incidence and severity of complications). This information may be used both by the MoH and other responsible entities for a situation analysis in this area and for developing strategies and programs to improve the quality of pregnancy termination services.

Chapter 3 Assessment of abortion services in 6 intervention sites

According to the recommendations of the Strategic Review of Policies, Quality and Access to Contraception and Abortion Services in the Republic of Moldova (Report, 2006, available at: www.avort.md) during 2006-2010, there were 6 model-centers created in the Republic of Moldova to provide comprehensive pregnancy termination services in outpatient settings. Model-centers were opened in the following locations: municipalities of Chisinau and Balti, towns of Drochia, Orhei, Cantemir and Cahul.

1. Physical condition of the building / ward, technical and sanitary condition of premises, equipment and supplies

In all of the assessed healthcare facilities, abortion services were provided in outpatient settings: two sites are located within the Family Medicine Centers (Cantemir, Drochia), and the other four – within the consultations department of Perinatal Care Centers (Chisinau, Balti, Orhei and Cahul). All model-centers have been refurbished, renovated and equipped so as to comply with the requirements set forth in Annex 1 to the Standards for safe termination of pregnancy: equipment and supplies of facilities providing VMA / EVA.

Hence, the technical shape of premises in all model-centers (procedures room, counseling and recovery rooms, WC) was assessed as “good” or “very good”, getting the looks of a modern health care facility (see Figure 1). All sites have heating, uninterrupted cold and hot water supply, separated WC next to the procedures or recovery rooms (see Figure 2). Most of premises were furbished with new furniture. Even where older furniture could be noticed, it has been kept and adjusted to the needs of the service (see Figure 3).

In most of visited facilities, the inner planning of premises is fully compliant with patients’ privacy / confidentiality needs: recovery room is located next to the procedures room and may accommodate 1 to 3 beds or chairs, depending on the daily flow of women. In just one of the model-centers the recovery room did not fully provide for the patient’s comfort / privacy, as it was too big in size, being intended to accommodate several persons at the same time following the performance of procedure. But even in this case, in an attempt to solve this drawback, the privacy space of each woman was ensured by using separation screens.

Figure 1 General aspect of one of the model-centers

The procedures and recovery rooms were clean and well heated and lighted. The personnel of centers was bending every effort to provide for the upmost level of patient comfort: all metal parts of gynecological chairs in the procedures rooms were isolated; drinking water was available in the recovery rooms at some sites.

By and large, model-centers are well supplied with equipment, consumables and medication, rising up to the standard. At the time of the assessment, almost all facilities had enough quantities of MVA syringes and cannula to cover the daily needs of the procedures being performed there. Moreover, in most centers, there were proper stocks of lidocaine solution, gloves, disinfectants, syringes and other supplies, which were provided by the management of the healthcare facility. In some facilities, patients were also given contraceptives and antibiotics.

The way the equipment and supplies were provided varied across sites, depending on the attitude and engagement of senior management. In some centers, the costs of new equipment (MVA syringes and cannula) and supplies / pharmaceuticals were fully covered with the funds generated from abortion service user fees. In one of the centers, the management has been providing all sorts of medical commodities based on a special request form, and another facility was providing women after abortion with free antibiotics for infection prevention.

In other centers, however, there was room for improvement in terms of proper equipment and supplies. At one site, health workers from the model-center had to pay for the new syringes and cannula with their own money to replace the broken ones, despite considerable funds being generated by abortion services. In another one, the request filed with the management of the facility by health personnel asking to renew MVA equipment was not fulfilled.

Besides, for the purpose of purchasing supplies and current renovation, patients from a model-center for termination of pregnancy were asked to voluntarily donate another MDL 10 on top of the official cost of abortion services paid in that facility. In another one, patients had to buy their own lidocaine, syringes and gloves, despite paying for the pregnancy termination procedure.

Figure 2 The look of WC unit in some model-centers

Figure 3 The aspect of some recovery rooms in model-centers


Figure 4 The look of procedures room in model-centers

In all visited centers there was a specially designated place to keep the medication and supplies needed for the procedure (lidocaine, gloves, syringes, disinfectants) or potential medical emergencies (shock management set).

Figure 5 Storage of medication in a model-center

2. **Access to abortion services; vulnerable groups; people with special needs; youth**

It was found that model-centers were providing services to the women residents of cities, district towns and rural areas irrespective of location. Getting an appointment, which was mostly applicable in the case of rural residents, was available in most centers. An appointment could be done for the convenience of patients and to ensure their confidentiality. In some facilities, no

appointment is needed due to the low flow of patients, therefore it was not used.

In order to access services, in the majority of sites no referral for abortion is needed. Just in one of the visited model-centers, a prerequisite for the performance of abortion was a referral slip from either the family doctor or the gynecologist from the consultations department of the same facility, issued after having paid for the medical consultation and pre-abortion counseling first.

According to providers, the cost of surgical abortion (MVA or EVA) was not high and did not limit the access of women to pregnancy termination services. The assessment team found that the official price paid by women for MVA or EVA was not high, varying between MDL 46 and MDL 218. The lower amount covered just the cost of performing the procedure. In other facilities, the cost of procedure was topped up by the price of local anesthesia, medical consultation, swab or other investigations, bed cost per day, with women bearing somewhat higher costs, ranging between MDL 95 and MDL 218.

Nevertheless, the cost of surgical abortion in model-centers was much lower than the one paid for termination of pregnancy elsewhere in the country or those performed in the hospital settings of the same centers. Hence, the price for an abortion procedure performed in a gynecology ward at visited sites varied between MDL 213 and 350, mostly due to the cost of bed-days factored in, i.e. MDL 144. If I/V anesthesia was used for termination of pregnancy, MDL 119 was charged on top.

Mediation abortion was less accessible, even in outpatient settings. Women had to buy the drugs used in the medical abortion performed in outpatient settings and were usually prescription drugs. The cost of medication was very high and basically identical at all sites, averaging about MDL 500: MDL 360 for mifepristone and MDL 120 for 4 pills of misoprostol. Medical consultation costs (ranging between MDL 19 and MDL 30) and bed-day costs in some facilities (day care hospital) of MDL 56 increased the bill. In early pregnancy, it is often required to undergo echography, which cost at least MDL 29.

One of the pending issues for the access to pregnancy termination services was the limited working hours of visited centers. Unfortunately, in most facilities the working hours started between 8.00 AM and 9.00 AM and closed at 15.00 or 16.00-16.30 at the latest. In reality, in most facilities, service delivery stopped at around 13.00-14.00, the explanation provided being the need to disinfect premises and intervention equipment. In just one model-center the working hours lasted from 8.00 AM to 18.00, due to the fact that the same physician providing abortion services was engaged in youth-friendly health services, working at the same location in the afternoon.

In some cases, the health workers performing termination of pregnancy were receptive to women's needs, working extra hours as an exception.

Therefore, women that may not come to the model-centers during their working hours had to seek care in other facilities, bearing additional travel costs, or were referred to the gynecology ward of the hospital, where, quite often, the termination of pregnancy was done by the methods not recommended by the WHO, i.e. D&C under general anesthesia, which was also costlier.

Staffing varied across centers. In most facilities there were enough health workers trained in comprehensive abortion services, including in MVA techniques and local anesthesia. It was found that all the physicians with proper training in this area were holding a permit and performed the abortion procedure at the model-center, irrespective of their main site of employment (outpatient or inpatient).

In some facilities, however, there was only one physician and one midwife trained in safe abortion; in one model-center there was only one physician who had relevant training.

The access of vulnerable groups or those with special needs, and youth

In the vast majority of assessed facilities, providers considered that adolescent girls and socially disadvantaged women faced no major challenges to access abortion services. When needed, they were exempt from paying for the abortion services upon completion of required paperwork: referral form (Form 027-e) approved at the Medical Consultation Board meeting in each PHC facility or issued by any other clinical public healthcare facility. Service providers did not consider the paperwork to be a real barrier to access abortion services, relying on the goodwill of their colleagues responsible for the issuance of such documents.

At the same time, some women were displeased by the high number of people involved in the paperwork and the waiting time, averaging 3 to 5 days, to get such a certificate. These women preferred to find money and get the abortion for a charge in a shorter time, while not disclosing their identity.

The cost of termination of pregnancy on medical / social grounds was covered by the NHIC. Health care facilities faced no difficulties in collaborating with NHIC to cover abortion care related costs. Just in one of the assessed facilities adolescents and the socially disadvantaged women had access and could terminate their pregnancy free of charge if referred by the PHC and only if admitted to the gynecology ward, which may be regarded as a challenge in getting an abortion procedure.

3. Statistics, registration and reporting

In all centers, surgical abortions and medical abortions alike were registered in patients' medical record (form 003-3/e) and registry for voluntary termination of pregnancy (form 003-4/e). Information on the number of terminations of pregnancy, the methods used, the demographic features of women, as well as a number of indicators on the quality of the services provided (counseling, cervical ripening, offering of contraceptive method, incidence and severity of related complications) are reflected in the statistic report no.13 of the National Bureau of Statistics of the Republic of Moldova. Despite being the only facility providing medical abortion, it was not registering and reporting that procedure.

At the same time, there were several instances when model-centers reported terminations of pregnancy at the administrative unit (district) level only, with that abortion data missing from the national statistical data. For instance, there were 80 abortions reported in one of the country's districts in 2013: 45 D&C, 30 EVA procedures, and just 5 medical abortions. All these procedures were performed in the gynecology ward, in hospital settings. During the same year, there were 166 terminations of pregnancy performed in outpatient settings in the model-center, including 42 MA and 119 MVA. Hence, the total number of terminations of pregnancy in that particular district should have been 246, and the proportion of the WHO recommended procedures (119 MVA, 30 EVA and 47 MA) should have exceeded 80%.

In another instance, of the 343 abortions performed in a district over 2013, there were only 176 reported to the National Bureau of Statistics that were performed in the gynecology ward, including 100 D&C and 76 vacuum aspirations. During the same time interval, in model-centers there were 197 terminations of pregnancy performed in outpatient settings: 145 MVA, 16 EVA and 36 medical abortions.

It seems that if all terminations of pregnancy performed in model-centers were reported to the National Bureau of Statistics to be included in the annual statistical reports, the total number of abortions performed at country level would have been by circa 2.5% higher, and the share of abortions by using a WHO recommended method (MVA or EVA or MA) would have reached almost 73%.

Table 1 Number and methods of termination of pregnancy in model-centers and at national level, 2013

Indicators	Model-center for termination of pregnancy located in:						Total abortions, model-centers	Total for Moldova, official	Total for Moldova, actual
	Balti	Cahul	Cantemir	Chisinau (SCM #1)	Drochia	Orhei			
Abortions, total, including:	1269	197	71	1959	161	555	4212	14511	14874
MVA	1156	145	64	1328	119	445	3257	5071	5444
EVA	-	16	-	-	-	-	16	3668	3684
MA	113	36	7	631	42	110	939	1597	1675
D&C	-	-	-	-	-	-	-	4054	4054
WHO recommended methods, %	100	100	100	100	100	100	100	72.1	72.8

It is worth mentioning that since 2014, all of the aforesaid health care facilities have been reporting statistical data on termination of pregnancy to the National Bureau of Medical Statistics.

4. Quality of services

a. Abortion procedure, management of pain

In all model-centers the termination of pregnancy was performed by safe, WHO-recommended, methods only: most – by MVA or MA; some centers also perform EVA (see Table 1). In most facilities, surgical abortion was performed before 10 weeks of gestation: medical abortion – before week 9 of gestation. In one of the centers MVA could be performed before week 12 of gestation, whereas in another one – the upper limit for a surgical abortion was week 9 of gestation.

In most instances, the abortion was performed under local paracervical anesthesia with lidocaine, resulting in fewer complications and which was cheaper than general anesthesia. Another advantage of local anesthesia was that following a short recovery period, the woman was ready to get post-abortion counseling, including on contraceptive methods and could leave the healthcare facility. At the same time, if requested by women, general anesthesia was performed in 2 centers (biggest ones) in outpatient settings.

The practice of routine control curettage following the aspiration of uterine content to confirm the absence of remnants of any products of conception was abandoned altogether: in order to make sure that a procedure was complete and to prevent any possible complications, in most instances an inspection of tissues would be performed.

Before performing a surgical abortion, in particular in primipara and gestation age 7-8 weeks or higher, cervical ripening with Misoprostol was widely used.

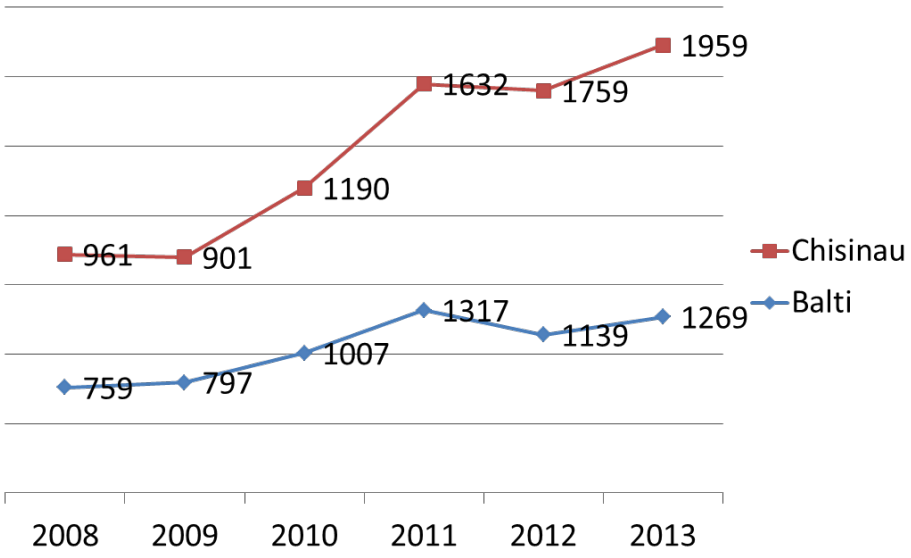
At the same time, there was further room for improvement in terms of quality of pregnancy termination services. Thus, in one facility, the interviews with patients showed a quite high number of MVA procedures being performed under general anesthesia (mainly with ketamine). According to the assessment team, this situation could be the result of misunderstanding by the personnel working in that facility of the advantages of local anesthesia and the poor quality of counseling regarding the type of anesthesia to be used in abortion.

Routine inspection of tissues following an MVA procedure was not performed in all centers.

Professionals from one facility were seldom offering MA, absolutely refusing to use it in women from rural areas. They believed that if some complications would eventually develop, women residing in villages would not be able to get fast enough to the clinical facility from the district town to get the medical care they need.

It should be noted, though, that after these model-centers were created, providing high-quality services, in line with national standards and based on WHO recommendations, the number of women seeking to terminate an unwanted pregnancy in those facilities has significantly increased. Thus, about one-third of all abortions in the country (29%) in 2013 were performed in these 6 health care facilities. The annual increase in the total number of terminations of pregnancy was more obvious in the first two and biggest pilot centers in Chisinau and Balti (see Chart 1).

Chart 1 Trends in termination of pregnancy in model-centers from Chisinau and Balti (2008-2013)



b. Information and pre- and post-abortion counseling; informed consent; observance of confidentiality

Based on providers' statements, all termination of pregnancy procedures were preceded by counseling. Counseling was provided by a physician and subsequently by a midwife. Midwives also answer the women's questions before those leave the clinic. Pre-abortion counseling included discussions about the advantages and disadvantages of abortion methods and types of anesthesia,

and issues related to decision-making about termination of pregnancy. Women may choose the appropriate time for the procedure – either the same day they sought care or any other day.

Having performed the procedure or having made a decision about whether to use MA, one has to discuss the signs of possible complications and side effects; the patient is being told how and where to seek care in case of emergency; a contraceptive method is suggested and discussed. The quality and content of counseling were not based on a single protocol and were not evaluated by managers. Despite recommended by standards, no facility has been providing written instructions for the post-abortion period.

The informed consent form complied with national standards in all model-centers, being signed off and attached to the patient's medical records.

Patient confidentiality and privacy were top priority in all centers. In some, there were few patients and there could be only one patient in a facility at any particular point in time; in other bigger ones, there was need for an appointment to perform the procedure to ensure smooth patient flow and protect confidentiality.

In all centers the abortion procedure was performed in premises separated from other services. In two facilities, there could be more patients in the same recovery room, which could be considered a breach of confidentiality.

c. Investigations

The majority of assessed healthcare facilities complied with the provisions of national Standards regarding the volume of investigations, recommended before performing an abortion procedure. Some routine investigations were cancelled, such as STI screening (RW, HIV), complete blood count, blood type and Rh factor, fluorography, echography etc.

Most of the times, investigations are performed only when indicated: complete blood count when anemia is suspected; blood typing and Rh factor when those are not known or documents are missing; Pap smear when there are clinical signs of lower reproductive tract infections. Echography was mandatory only in on model-center and patients had to pay for it.

In most cases, however, routine echography was not performed. Ultrasound investigation was mostly indicated in early pregnancy, when physicians were not sure about the presence of pregnancy and whenever certain complications were suspected (e.g., ectopic pregnancy, uterine myoma or ovarian tumors).

To date, however, there were also some failures to comply with national Standards for termination of pregnancy. Hence, some centers continued to practice routine Pap smear; women were usually not told about the purpose of performing one. Besides, routine tests oftentimes implied additional costs, e.g. the price of Pap smear was MDL 14 and the price of smear collection was MDL 6.

d. Infection prevention

In all model-centers the staff was aware about the importance of infection prevention measures. There were all conditions (water, liquid soap, disinfectant, written instructions) for hand washing and observance of hygiene. Sterile or disposable gloves and supplies were made use of; while fully complying with the provisions of national Standards on medical equipment disinfection methods

and waste disposal, along with universal infection control measures.

Unfortunately, there were cases reported when the senior management failed to provide for the required quantity of gloves or disinfectants, and physicians had to ask patients to buy supplies.

In the majority of cases, pursuant to the national Standards, routine treatment with antibiotics was prescribed for infection prevention following MVA abortion, usually – doxycycline. In one model-center not only doxycycline was prescribed, but it was also provided free of charge to all.

At times, however, there were non-recommended drugs used instead, for instance, Venflox or cephalosporins. Antifungal medication was routinely prescribed in two model-centers, which was not justified and was contrary to the national Standards and WHO recommendations.

e. Complications

The total number of complications reported by model-centers was low, varying between 0.1 and 1%. Most of the times there were single minor complications reported (post-abortion remnants, hematometra). In 2013 major complications were reported in 3 centers only (1 case of perforation and 2 cases of endometritis). In our opinion, this situation is indicative of accurate reporting of the actual number of abortion complications and high quality of pregnancy termination services (making use of MA and MVA or EVA only, mostly under local anesthesia, inspection of aspiration tissue, cervical ripening, routine preventive administration of antibiotics, counseling on possible complications).

5. **Post-abortion contraception; integration with other RH services**

Termination of unwanted pregnancy is reckoned the best time to suggest safe contraceptives to women, with best odds of being accepted. Service providers from the model-centers reported that in recent years about 80% of the patients after abortion leave with a contraceptive method selected. Health workers mentioned also that if provided free of charge immediately after termination of pregnancy, most women accept a contraceptive method and use it longer.

Unfortunately, currently there is no clear-cut procedure in place to provide the abortion service with contraceptive medication free of charge. Contraceptive methods (IUD, COC and male condoms) have been historically provided by foreign donors. By and large, one may notice contraceptive stock-outs today. At the time of the assessment, two health care facilities were still providing free contraception (most of the times, COC and male condoms) from donations. Yet, when they run out of stock, it will no longer be possible to provide free contraceptives to the patients undergoing termination of pregnancy there.

Examples of more efficient integration of contraceptive services in pregnancy termination services were found in 3 of the assessed model-centers. Hence, two facilities had male condoms, COC and IUD available, which were purchased by PHC, but supplied to the pregnancy termination rooms to shorten the pathway of selecting a contraceptive method before getting it. In those cases contraceptives were registered in a special registry kept by the pregnancy termination service. According to the health workers from those facilities, more than 90% of women terminating their unwanted pregnancy accepted such modality and received a contraceptive method. In one center, in order to get a contraceptive method, patients were referred to the RH room, located on a different floor of the same building. In those three districts, based on the basic package of services, a certain quantity of COC was purchased in 2014 for the needs of the socially vulnerable

women, some of which were distributed to the pregnancy termination service.

Contraceptive medication was missing in one model-center only: providers from that facility just counseled patients about contraceptive methods. Then, women purchased COC, condoms or IDU from the pharmacy, which were inserted by the health workers from the center at first menstruation after termination of pregnancy.

During the assessment of model-centers, the team found out that in one territorial unit (district) there were several RH services, the staffing of which included the same professionals. Hence, there were a number of distinct RH services at district level, as follows:

1. Youth friendly health center (YFHC);
2. Obstetrician/gynecologist consultation room;
3. Cervical pathology room;
4. Cancer gynecologist room;
5. Pregnancy termination service

The staff of these 5 services consisted of two physicians and three midwives.

Not only such division was not cost-efficient (one has to keep 5 different premises up and running), but it was also inconvenient for and caused access problems to patients. Thus, in order to get a contraceptive, the patient wishing to terminate a pregnancy shall make an appointment or queue up to see a family doctor, which is assumed to have contraceptives available for distribution. Should the doctor suspect a uterine cervical condition during abortion, the woman shall be referred to the respective room. An adolescent visiting an YFHC would be referred to a pregnancy termination room for abortion or to a family doctor for contraception etc. Moreover, one may not be sure that the family doctor would have enough time (given his/her level of knowledge and competences) to discuss with women the contraceptive options and to provide the woman with the contraceptive method of choice (e.g., IUD insertion).

In order to ensure a better integration of abortion services into family planning services and other RH areas and streamline the use of the health workers and premises available at district or TMA level, we deem it would make more sense to review the current number and division of services available in the RH area and to better integrate those by being provided by the same health workers within the same premises.

6. **Cost of services and financing**

All manager and service providers confirmed that the cost of a termination of pregnancy procedure was set in line with Annex 3 to the Government Decision no.1020 of 29 December 2011 on the Catalogue of Unified Tariffs for the Health Services provided against a fee by public health care facilities and for the services covered by the mandatory health insurance funds which were provided by public and private healthcare facilities: Tariffs of medical services provided for a fee" ('Official Monitor' newspaper no.7-12/25 of 13.01.2012).

At the same time, it was ascertained that the official price paid by women for the surgical termination of pregnancy differed significantly across facilities – MDL 46, 95, 121, 140, 161 and 218 respectively. The lowest price (MDL 46) included the mere cost of vacuum aspiration procedure with local anesthesia ("mini-abortion"). In other facilities, the cost of procedure was topped up by the: price of local anesthesia (ranging between MDL 30 and MDL 57); consultation

by a physician (ranging between MDL 19 and MDL 30), inpatient bed-day (between MDL 18 and MDL 56) and cost of investigations (swab, ultrasound), which also differed. In one model-center it was found out that the price of the procedure performed in outpatient settings was the same as if performed in hospital settings, i.e. MDL 87.

The most expensive service provided in outpatient settings (price of surgical abortion) was MDL 218, including:

1. One bed-day / day care – MDL 18
2. Medical abortion (termination of pregnancy before week 12 of gestation) – MDL 87
3. Consultation of gynecologist – MDL 30
4. Pre-abortion counseling – MDL 30
5. Local anesthesia – MDL 53

The termination of pregnancy performed with i/v anesthesia would cost an extra MDL 119.

In most visited facilities, the price of abortion was visibly displayed, showing clearly what it was composed of (procedure per se, anesthesia, consultation etc.)

Noteworthy, there was no directly proportional relationship between the cost and quality of abortion services. In the healthcare facility with the lowest price for surgical termination of pregnancy, the quality of services was not lower, but at times was even higher than in the facilities in which the price was 2 to 5 times higher. Moreover, the health facility provided the pregnancy termination room with all the necessary medicines and supplies, including free preventive antibiotic therapy (doxycycline). The manager of the facility with the lowest-price abortion services (MDL 46 for outpatient settings and MDL 54 for inpatient settings) explained the very low (almost symbolic) price of abortion by the need to ensure universal access for all social groups and avoid illicit abortions and complications associated with those. Yet, it seems that this pricing modality was not the best one. Hence, one shortcoming was the little funds accrued to cover the maintenance costs of pregnancy termination services, including equipment and supplies. Also, there was no motivation in place (to top up one's salary) for health workers to incentivize them to providing higher quality services. The price of medical abortion was usually much higher and consisted, most of the times, of the cost of medication (MDL 360 for mifepristone and MDL 120 for 4 pills of misoprostol; tallying up to about MDL 500) and the cost of medical consultation. In one center, the cost of medical abortion included also the cost of one bed-day (day care) of MDL 56, and an echography of pelvic organs in early pregnancy for MDL 29. Therefore, the minimum cost of MA in that facility could go above MDL 600.

Providers believed that the price of abortion, in particular for the surgical one, was affordable for the biggest majority of women, but was not enough to cover the costs incurred by service delivery. Managers of healthcare facilities, including at the PHC level, considered that the price of abortion had to be increased up to about MDL 200-300 in order to reimburse any incurred costs, although the actual costs for the pregnancy termination services were not estimated by either of them. According to other hospital managers, the abortion performed in the first trimester shall be covered in the basic package of health services provided by the NHIC.

At the same time, some managers became aware of the cost-efficiency of the abortion services in outpatient settings. To that end, a telling example is that of one of the assessed facilities that was quite in demand among the patients for its pregnancy termination services. The facilities managed

to accrue over MDL 280,000 from abortion payments over 2013. That amount was enough to fully cover the maintenance costs of the pregnancy termination room, payroll of staff, utility costs, purchase of pharmaceuticals and supplies, and renovation of equipment. More than that, a salary top-up was offered to the personnel working in that service to determine better quality. That model-center was as of lately the only termination of pregnancy facility that was completely self-sustained.

In other facilities the money accrued by providing pregnancy termination services in 2013 was much smaller, ranging between MDL 3,288 and MDL 53,176. Just in few of those health facilities the funds raised as a result of abortion service delivery were also used to cover the needs of the service. Hence, from a rather small amount of MDL 12,533 collected by providing abortion services, just MDL 4,100 got back to the pregnancy termination services. Despite this, the department was fully supplied with all the stuff required for the termination of pregnancy: lidocaine as local anesthesia, syringes, and gloves.

At the same time, one could reveal less-inspiring examples of how the funds generated by the abortion service delivery were used. Hence, one facility raised MDL 53,176, but only a very small proportion of funds was earmarked for the needs of the termination of pregnancy ward to merely buy 2 MVA syringes (one each for the model-center and gynecology ward). Although the amount generated by the abortion services was relatively high, the management of that health care facility provided the pregnancy termination room with neither enough medication nor supplies; at the time of the assessment there were not enough gloves there to begin with. In other two model-centers, likewise, of the total amount collected in 2013 from abortion care user fees (MDL 3,288 and MDL 14,445), nothing was reinvested to supply the room or develop the termination of pregnancy service. Moreover, in one facility, although paying for the abortion, women had to additionally buy syringes, lidocaine for local anesthesia and antibiotics for infection prevention.

*7. **Monitoring and quality assurance***

The quality of services was monitored by service providers in all model-centers, once established, by applying a mini-questionnaire to evaluate patient satisfaction (also documented in the medical record), but also by using a framework self-assessment checklist for specific issues related to the abortion procedure / service, included in existing national Standards. That information has been used to plan for further actions for higher quality services, in particular, those to be taken by the health workers working in model-centers in their capacity of direct beneficiaries of the higher quality service and building the trust of service users. Managers monitored and controlled the quality of the abortion services provided in their facility in just 2 of the 6 visited centers.

Hence, in one of the largest healthcare facilities, not only the director was actively involved in the process of setting up a model-center and necessary conditions, as prescribed by the standards in place, but also was effectively monitoring the quality of services they were providing: kept track of the number of performed procedures, planning of resources required to keep that service up and running, developed a staff remuneration mechanism for the personnel working in the model-center. In other instances, managers were not involved in quality assurance: deeming unimportant to earmark some funds generated by the service to support and develop that service; while also overlooking the need of motivation and remuneration of the staff engaged in termination of pregnancy.

Chapter 4 Assessment of compliance with national safe abortion standards

1. Physical condition of the building / ward, technical and sanitary condition of premises, equipment and supplies

The assessment team visited 13 health care facilities providing pregnancy termination services, including 11 where abortion was performed only in the gynecology ward, and one instance where abortion was also performed in outpatient settings, in the consultative/diagnostic department's (TMA) day care inpatient unit. The assessment considered: the general, technical and sanitary conditions of wards and procedure rooms, availability of equipment and supplies, as per Annex 1 to the Standards for safe termination of pregnancy: equipment and supplies for the healthcare facilities performing EVA / MVA.

The technical condition of the building and the gynecology wards where the terminations of pregnancy were performed differed significantly across facilities, but in most cases it was featuring renovations and they were generally in good shape. Surprisingly, in some health facilities featuring renovated / refurbished wards with modern diagnostic and surgical laparoscopic equipment available, there was either no vacuum aspiration equipment at all or it was purchased recently, but not using it, and abortions were performed by D&C.

Once again it showed that compliance with MoH recommendations and observance of the Standards for safe abortion service delivery were not a function of funds availability only, but also depended on the attitude to that issue.

In most instances the abortion procedure room was shared with other gynecological manipulations, being the only one within the ward. Less often there was a manipulations room in the ward set forth for termination of pregnancy purposes only.

There were some pervasive shortcomings identified in most rooms, such as no hot water and no conditions to ensure privacy and confidentiality. There was no adjacent space to allow patients to get undressed before the procedure, and recovery occurred in shared rooms within the ward. To that end, the conditions of the day care hospital in visited TMA (outpatient clinic) were more in line with confidentiality recommendations, although there was also much room for improvement. The equipment for termination of pregnancy in the majority of visited healthcare facilities was in poor condition: D&C instruments were outdated (specula, curettes) or even rusty at times.

EVA equipment, where present, was outdated, has not been tested for some time, the procedure was performed with metal cannula, available in 1-2 sizes only.

MVA equipment in the outpatient settings (syringe and cannula of all sizes) was in good working condition, and were stored and used according to the instructions.

There were facilities with MVA equipment in place, but which was not using it because the staff was not training in handling it or because they did not trust that procedure, with preference given to D&C.

In terms of providing procedure rooms with emergency medication, such as uterotonic drugs, shock management kit and AIDS management kit, were generally available, but with some medication expired or missing. Likewise, Ambu masks and diazepam to handle the toxicity of lidocaine were missing in most procedure rooms.

2. Access, vulnerable groups, people with special needs, youth, post-abortion contraception, integration with other RH services

The access to abortion services improved since the findings of the "Strategic assessment of policies, quality and access to contraception and abortion services in the Republic of Moldova" in 2006. Women were free to seek care in any pregnancy termination facility in Moldova, irrespective of their residence and no longer required referrals by family doctors or any other paperwork that might hinder their access.

Yet, even if the MoH allowed for the establishment of abortion service delivery in outpatient settings in 2010, in most healthcare facilities the abortions were still performed in hospital settings, both the management and providers stating the shortage of funds or lack of suitable premises as justification. This is understandable, given the lucrative nature of those, as the cost of services and amounts generated by inpatient service delivery were higher as compared to outpatient services, because of the bed-day cost factoring in. The amounts accrued by facilities providing abortion services varied depending on the number of services, in 2013 ranging between MDL 4,780 and MDL 329,569.

At the same time, it is noteworthy that very few, if any, of those funds were getting back to the abortion service for the purchase or refurbishment of equipment or premises.

When performed in outpatient settings, abortions were both cheaper for the health delivery system and higher quality, with better observance of national Standards and WHO recommendations.

The situation improved in terms of payment for the management of miscarriage: the procedure was provided free of charge, with the NHIC covering these costs. There was just one case when a health facility had difficulty to validate the miscarriage forms, and as such, getting NHIC payment.

There was still quite difficult to get an authorization for free abortion, the woman having to go first see a family doctor etc. That was equally true for the poor women from villages and adolescents. It was a violation of their confidentiality, first of all, thereby making them willing to pay rather than seeking care at the family doctor so that "everyone in the village would know".

Anyway, women from villages had to go to the district town, bearing additional travel costs. Therefore, the access to services in rural areas did not change much since 2006, getting to become even more difficult as compared to urban settings, where several health care facilities were concentrated in one location. Women from rural areas were also disadvantaged in terms of quality, as most of the times they could access abortion services only by D&C with riskier general anesthesia.

Access to medical abortion was still a challenge. Given the high price of pills (circa MDL 499), coupled with absence of such medication in private pharmacies in some district towns and lack of a pricing regulation for this procedure, this particular method continued to be available to richer women.

It should be noted that even if YFHC provide for the conditions and capacities needed to provide an array of RH services, with observance of confidentiality and all WHO recommendations regarding such services, the abortion was not included so far in the list of provided services. Hence, youth were in a difficult situation: on the one hand, they were referred to YFHC for any health related issues; on the other hand, they had to go somewhere else for termination of

pregnancy related counseling, undergoing at times disabling curettages. According to the official statistic data of the MoH, D&C accounted for 25% of all abortions performed in adolescents.

Some elements related to observing the sexual and RH rights of adolescents improved: in most of visited facilities, healthcare service providers were performing termination of pregnancy without parental consent in 16 years of age and older, as provided for by the Standards on safe termination of pregnancy and Moldova's legislation. Yet, for the time being, not all providers were fully aware of these provisions and might request not just parental consent, but also their mandatory physical presence there, or the presence and consent of the legal custodian, often breaking their right to confidentiality, which is paramount at this point in their lives.

Women had also low access to post-abortion contraception, as contraceptives were provided by a physician in the RH rooms or by a family doctor. Being part of tier-II specialized healthcare service, the healthcare facilities providing abortion services were not entitled to buy and distribute contraceptives, even if termination of pregnancy was regarded very appropriate for counseling and offering of a contraceptive, as also recommended by the national Standards. Women were referred to RH rooms or PHC, most of the times failing to get there. Many providers concurred with the statement that such a mechanism was inconvenient both for the patient and the provider ensuring post-abortion counseling in FP, yet not being able to provide a contraceptive.

3. Statistics, registration and reporting

Pursuant to Law no.412-XV of 9 December 2004 'on official statistical data', the National Bureau of Statistics endorsed the "intra-annual statistic form 13". Hence, the healthcare facilities from Moldova performing termination of pregnancy procedures were filling it out on a quarterly basis. Some reporting indicators were updated and approved by MoH in 2008, adding in termination of pregnancy methods, including medical abortion and other indicators indicative of the quality of services (anesthesia, counseling, cervical ripening etc.) The assessment team reviewed the statistical data for 2013, based on the statistic report form 13, on termination of pregnancy (Annex 2), including by individual healthcare facility.

Thus, there were 14,511 abortions in total reported in 2013, of which 9,862 (68%) were voluntary abortions before 12 weeks' gestation, 782 (5%) were artificial terminations of pregnancy on medical indications, including 535 (68%) before 12 weeks, 163 (1%) were abortions on social indications, including 104 (63%) before 12 weeks, and 3,701 (25%) were miscarriages, including 3,260 (88%) before 12 weeks of gestation and 441 (12%) in second trimester (Table 2).

Table 2 Snapshot of terminations of pregnancy in Moldova, 2013, by trimester of pregnancy

	< 12 wks.	13-21 wks.	Total
Voluntary artificial termination of pregnancy	9,862	-	9,862
Artificial termination of pregnancy on medical grounds	535	247	782
Artificial termination of pregnancy on social grounds	104	59	163
Miscarriages	3,260	441	3,701
Total			**14,511**

The review of statistic indicators on termination of pregnancy, by age, revealed the following:

There were 9 abortions performed in <15 y.o., of which 6 – in the first trimester (1 on medical indications, 1 on social indications, 4 voluntary terminations) and 3 abortions in the second trimester. The abortions performed in second trimester were on medical grounds (1 case) and on social grounds (2 cases). The pregnancy was terminated by aspiration in 5 cases and by D&C in 4 cases.

There were 1,241 (8%) terminations of pregnancy reported in adolescents from the 15-19 y.o. age group in 2013. Of those, 1,179 (95%) were performed in the first trimester; including 874 (74%) voluntary abortions, 45 (4%) on medical indications, 20 (1%) on social indications and 240 (14%) were miscarriages. Termination of pregnancy in the second trimester was reported in 62 cases (5%): 26 on medical grounds, 11 on social grounds, 24 miscarriages and one illegal abortion.

In the 15-19 age group, pregnancy was terminated by MVA/EVA in 705 cases (56%), D&C in 313 cases (25%) and medical abortion in 218 cases (17%).

Hence, there were 1,250 abortions performed in <19 y.o. adolescents, accounting for 8% of the total number. Their share is lower than in previous years: it was 9.2% (1,361 cases) in 2011 vs. 11.3% (1,777 cases) in 2012.

There were 3 illegal abortions reported in total in 2013 – all in the second trimester of pregnancy; one was a case of an adolescent from the 15-17 age group, another case – 20-34 y.o., and a third case – 35+ y.o.

What was not clear was how those were identified, by whom and what punitive actions were taken to those performing those.

In terms of geographical distribution of abortions, of the total number of 14,511 reported in 2013, 6,686 (46%) were performed in women residents of rural areas. Of those, 72 abortions (1.07% of all) on social grounds in the first trimester, and 59 abortions (0.88% of all) in the second trimester. There were 313 abortions (2.15% of all) performed on medical grounds in the first trimester, and 81 (0.55% of all) in the second trimester.

Cervical ripening with Misoprostol pills was performed in 1,691 instances, accounting for merely 11% of the total number of terminations of pregnancy.

In terms of type of anesthesia used during termination of pregnancy, paracervical block was used in 8,124 cases (55%), and general anesthesia – in 4,402 cases (45%). Reporting these indicators is difficult, as sometimes it was reported local paracervical anesthesia with lidocaine, but they performed i/v anesthesia, failing to record that in the medical record, and no accounts as to the accurate cost of the procedure. At the same time, the D&C was often performed with local anesthesia, causing discomfort and pain.

There were some reporting gaps identified during the assessment:

One could explain the small proportion of reported MA (12%) by the limited access to this service due to its higher cost, on the one hand, and by problems related to MA registration / reporting faced by providers, on the other hand, as pointed out in the assessment. The assessment team found that in some healthcare facilities the MA was performed, but were reported only in the internal papers of the pregnancy termination room without any written proof in a patient's file /

medical record and not part of the official quarterly reporting. Providers claimed they did not know how to register it and that directors or statisticians did not ask for it.

The big number of miscarriages reported in some health facilities (up to 80% vs. the country average of 25%). We consider that this phenomenon may be explained by the registration of progressing medical abortions and unawareness by health providers of the MA process, on the one hand, but also by the veiling of some abortions, upon request, under this diagnostic category, just to make someone benefit from a free service, on the other hand.

4. Quality of services

a. Abortion procedure

According to the statistic reporting form 13, VMA ranks top in the breakdown of pregnancy termination methods with 5,071 cases (35%), followed by 4,054 (28%) D&C, 3,668 (25%) EVA, and 1,697 (12%) medical abortions. Hence, 10,457 women terminated their pregnancy by safe abortion methods, or 72% vs. 4,054 (28%) by D&C.

Having reviewed these statistic data together with the WHO experts, the assessment teams concluded that this report was a success story of implementing safe abortion methods in Moldova. The statistics looked the other way around in 2005, when the project kicked off: 70% of abortions were performed by D&C vs. 30% so-called mini-abortions, i.e. abortions performed in early pregnancy by EVA (Table 3).

Table 3 Methods used for termination of pregnancy in 2013, Moldova

Abortion method	Number of abortions	Safe methods	Share of total, %
MVA	5,061	**10,426**	**72%**
EVA	3,668		
MA	1,697		
D&C	4,054	**4,054**	**28%**
Total	**14,511**	**14,511**	**100%**

Regretfully, there were healthcare facilities still practicing D&C, thus breaking the normative acts of the MoH and WHO recommendations.

In most of visited healthcare facilities, however, pregnancy was terminated by D&C. In some facilities all abortions by D&C were performed with local anesthesia – paracervical block with lidocaine, invoking different reasons: lack of equipment, lack of relevant knowledge etc. Noteworthy, many healthcare facilities were provided with such equipment only recently, before the assessment visits just started, and was not used.

The attitude of all health care facilities towards medical abortion was not quite positive for the time being: physicians did not trust in its efficiency, were afraid of complications, did not know how to register one, did not know how much a patient was supposed to pay etc. A barrier to wider access was that the pharmaceuticals needed to perform an MA were not available in healthcare facilities, patients being referred to pharmacies, where also those occasionally were not available.

Yet, the majority of providers were aware of the need to change current practices to performing vacuum aspiration abortions or use of abortion pills.

The majority of providers voiced a request to get trainings in safe abortion methods. None of the interviewees mentioned to have been trained in safe abortion as part of the in-service education.

Cervical ripening with Misoprostol pills before surgical abortion was not practiced in most of visited facilities, as the drug is not available.

Not all healthcare facilities complied with the national Standards prescription for infection prevention by administering doxycycline or metronidazol. Unfortunately, we found that providers were not aware of such provisions set forth in the Standards for safe termination of pregnancy, or used an antibiotic other than the one recommended, and at times more expensive (e.g., ceftriaxone, cefazolin, azithromycin, gentamicin, ampicillin, erythromycin). Fluconazol was administered to women after abortion in some healthcare facilities etc.

Regarding the inspection of tissues following vacuum aspiration, it was found that physicians from the ward performed no control curettage only in one of the visited facilities performing vacuum aspiration. They were confident of the outcomes of their procedure, as they were using a metal sieve for tissue inspection, as recommended in the national Standards.

b. Pain management, information and pre-/post-abortion counseling, informed consent and protection of confidentiality

The psychological support provided through counseling before, during and after the procedure was performed helped a lot to reduce anxiety, in particular when local anesthesia was used without sedatives. If properly offered, the psychological support reduces women's fears and anxiety, but also mitigates pain. The assessment team did not attend a pre-/post-abortion patient counseling session, and although it was reported to do counseling in 100% of cases, many providers failed to ensure comprehensive and objective counseling, and psychological support delivered by providers was not comprehensive enough. One may draw the same conclusions from the statistic data countrywide, indicating general anesthesia use in 30% of cases.

Use of general anesthesia has many more risks and is not recommended by the WHO for the abortions performed in the first trimester. The assessment of patient files also showed combined use of both types of anesthesia: general and local, but also the use of local anesthesia in D&C and use of fentanyl or other non-recommended pharmaceuticals for anesthesia.

According to the WHO recommendations, sharing objective, full and non-accusatory information with the patient before performing the procedure is a must in abortion care. The concept of counseling also includes suggestion to and discussing with the patient of all possible options for any given pregnancy, confirmation that an abortion decision is final and taken by the patient in cognizance and without being coerced by anybody, with an evaluation of feelings, making allowance for the patient's fears and mood. Contrary to the findings of the assessment team in 2006, indicating the absence of counseling altogether, currently pre-/post-abortion counseling was provided in some healthcare facilities.

At the same time, it was difficult to objectively appraise the quality of counseling, or whether provided at all, because there was no evaluation of patient opinions carried out as a tool to assess the quality of services, as recommended by the national Standards. A number of providers

reiterated that counseling was first of all about persuading a woman to keep her pregnancy.

We believe that health service providers were not fully observing a woman's confidentiality, which remained a challenge, especially for women from villages.

That is why many women choose to have an abortion done in another district or in the capital city. Confidentiality breaches included the presence of patient before and after the abortion in the same room or performing an abortion in the general gynecology ward or pregnancy pathology ward, together with other patients with other health problems from the same community.

Form 003-3/e was used to keep track of abortions, subsequently being updated by the MoH in 2010, enclosing an informed consent form, customized to the abortion specifics and mandatory for patients to sign. Although the team found the updated abortion forms to be available in all visited health care facilities, not all of those had an informed consent enclosed. Therefore, the informed consent was missing from the medical record in some facilities. Some providers have never heard of one, making use of a typical informed consent form, which patients usually sign upon admission to a facility.

c. Investigations

According to the Standards for safe termination of pregnancy, there were several investigations recommended to women undergoing a voluntary abortion. Hence, if needed, if suspecting anemia, the patient may perform a hemoglobin and hematocrit test; blood typing and Rh-factor could be performed when those were not known or documents were missing.

On STIs, if needed and before a voluntary termination of pregnancy, having explained to the patient first the need to perform those and getting her informed consent, one could perform a screening test for STIs.

It was important that the legislation prescribes mandatory information and counseling for patients about the purpose of a suggested investigation and her informed consent, especially when it comes to HIV-testing.

In most of the assessed facilities there were way too many investigations performed before an abortion procedure. Hence, of all the clinical investigations, the commonest prescribed to women were: swab, complete blood count, WR (for syphilis), and HIV-testing. Basically, in all cases an ultrasound of the minor pelvic organs was performed. Additionally, in some facilities a general urinalysis and chest x-ray were done. We believe that having such a wide spectrum of clinical and instrumental investigations was limiting the accessibility of the method, while driving the cost of the procedure up for either the patient or for the facility or NHIC.

d. Complications

According to the statistic form 13, the rate of post-abortion complications was 0.47% in 2013, or 69 cases. The commonest complications were: incomplete termination of pregnancy (23%), endometritis (14%), uterine bleedings (7%), or other complications (26%).

The rate of complications was quite low and the good news was that no perforations occurred in 2013.

In visited facilities our team found the same types of complications. We noticed no attempts to

mask or not report any post-abortion complications.

5. Cost of services and financing

Each healthcare facility set forth their price of procedure, intervention or any other services provided for a user fee based on a "Catalogue of unified tariffs for healthcare services", including for the services paid from the mandatory health insurance funds and provided by public or private health care facilities, endorsed by Government Decision no.1020 of 29 December 2011.

The Catalogue of Unified Tariffs sets forth several lines for termination of pregnancy, as follows:

1. Chapter B. General healthcare services

IX. Outpatient surgical care

Gynecological surgery: vacuum aspiration with local anesthesia (mini-abortion) – MDL 46;

2. Chapter C. Inpatient healthcare services

III. Surgical services:

- Abortion on medical grounds (before 12 weeks' gestation) – MDL 87;
- Uterine curettage in incomplete miscarriage – MDL 41;
- Uterine curettage for termination of pregnancy on demand – MDL 54

One bed-day, net of the cost of paraclinical investigations and surgical intervention, as per the aforesaid Catalogue for gynecology, cost MDL 144. As mentioned before, it is more cost-efficient to provide abortion services in outpatient settings.

Prices listed in the Catalogue of unified tariffs did not provide for one price for the voluntary termination of pregnancy, so that facilities could charge either MDL 87 for an "abortion on medical indications" or MDL 54 for "uterine curettage, termination of pregnancy on demand". Noteworthy there was no single price officially established for medical abortion in either of the visited health care facilities, therefore all information provided in there was relevant for surgical abortions only.

In most of the assessed facilities the price was not listed in a place visible for patients, and the latter had to ask the physician about it.

The team reviewed the price of abortion in each visited facility and the pricing mechanism.

The price of abortion varied across all 13 facilities visited, with managers of those facilities stating that the price consisted of several ingredients, in line with the Catalogue of Unified Tariffs. Hence, besides the procedure *per se*, patients were paying for the cost of bed/day, while in other facilities they were additionally paying for anesthesia / sedations / premedication, absolutely necessary investigations (urinalysis, swab, WR etc.) or medicines used.

We would like to remind you that the national Standards set forth that, before abortion, it was enough to estimate the gestational age, vaginal examine of the patient to identify potential STIs, and only if needed, to perform a screening for STIs, having first properly counseled the patient.

The price paid by women for anesthesia differed, too: premedication cost MDL 40, sedation – MDL 49, i/v anesthesia of category II – MDL 119. In some facilities, including the assessed TMA, a fee of MDL 19 was levied for local anesthesia. In other facilities, there was no extra cost for local anesthesia. Annex 4 lists the health care facilities being assessed, price of abortion and the pricing mechanism in each.

When levied as user fees, the patient had to pay to the payment office, and the money was accruing in the general budget of the facility, being then used by the managers of the facility

according to their free will, to cover the different needs of their facility. Assessment methodology provided for a short questionnaire to be filled out by facilities beforehand, regarding terminations of pregnancy, whereby the managers were asked about the income generated by the abortion service in 2013.

Hence, the income generated by facilities varied between MDL 4,780 and MDL 329,569, depending on the number of abortions performed and the user fee paid by women.

In visited facilities no penny from the funds generated by the abortion service was reinvested in refurbishment or procurement of equipment, or in creating better conditions for service delivery. Moreover, we could not notice at least one example where health workers would be paid based on the number of pregnancy termination procedures performed, or the quality of those. Even in the case of the facility with the highest income – MDL 329,569 – an electric aspirator was purchased only recently, following an inspection by the Health Department of the Municipality of Chisinau, but still continued to perform abortions by D&C.

It is worth mentioning that managers of some facilities had difficulty in sharing data on the incomes generated by abortion service delivery, as no such computations were needed until now.

Conversely, the managers of some fully self-sustained model-centers were well versed in the total income from the abortion service in 2013 and how those funds were handled.

6. Monitoring and quality assurance

One of the recommendations laid down in the 2006 report on the "strategic assessment of policies, quality and access to contraception and abortion services in the Republic of Moldova" was the need to set up a national system to M&E the system performance, accreditation of health care facilities and uninterrupted provision of quality services.

Hence, a streamlining of statistic reporting indicators took place in 2008. Currently, all facilities were filing data with the National Bureau of Statistics on a quarterly and annual basis, and the data on termination of pregnancy were presented in the statistic report 13. These data reflected the quality of abortion service delivery in Moldova. Hence, some quality indicators were added: pregnancy termination methods, use of anesthesia, cervical ripening, pre-/post-abortion counseling, and number of complications.

For the M&E of quality, specific patient satisfaction questionnaires were added to the National Standards and a framework self-assessment checklist for the procedure and which could be carried out by managers or service providers on a regular basis.

Unfortunately, despite being endorsed by the MoH ordinance no.647 of 21.09.2010 'on voluntary safe termination of pregnancy', those were used in the model-centers only and were disregarded in the facilities we visited.

An incentive to make the managers of healthcare facilities comply with the Standards would be to make those provisions part of the national accreditation system.

This was done as soon as this assessment was completed.

7. Termination of pregnancy after 12 weeks of gestation and before the end of week 21

This assessment did not aim at appraising the quality of abortions in the second trimester of pregnancy. Yet, following some discussions with providers and a review of statistic data, the

experts provided some findings related to the quality of abortion during gestation weeks 13-21.

There were 750 abortions reported in 2013 between week 13 and 21 of pregnancy, accounting for 5% of the total number of abortions. Of those, 247 (33%) were performed on medical grounds, and 59 (7.8%) – on social indications.

Of concern was the high number of late miscarriages: 441 (circa 60% of abortions during the second trimester). Likewise, there were 3 cases (0.02%) of illegal abortions performed in the second trimester. Those could be the result of considerable barriers that women were facing in order to be allowed to undergo abortion after 12 weeks of pregnancy. This phenomenon requires additional review.

Compared to 2012 data, when 759 abortions were reported to have been performed in the second trimester, or 5%, the number of abortions performed in the second trimester of pregnancy in 2013 remained at the same level.

The assessment conducted in 2005 showed that dangerous methods, not recommended by the WHO, were used for abortions in the second trimester, and most complications following abortions, in particular those contributing to maternal mortality, occurred in particular following late abortions. When comparing with the findings from 2005, one may see that in most of the assessed facilities providing abortion services between weeks 13 and 21 of gestation, pregnancy was terminated by abortion pills.

Some facilities failed to observe the provisions of the Standards on safe termination of pregnancy, making use of other doses of misoprostol at intervals other than the prescribed ones. Unfortunately, after fetal and placental expulsion, some facilities still performed unnecessarily control curettage, posing a threat to woman's life and health, while also lowering the efficacy of induction medication.

In terms of supplying the healthcare facilities with abortion medication, in most facilities such medication was available, but in 2 facilities patients were buying their own drugs, contrary to the provisions of the basic package.

Chapter 5 Assessment findings (summary), conclusions and recommendations

The access to and quality of pregnancy termination services significantly improved over the last ten years since publishing the recommendations of the Strategic assessment. Hence, there was a change in the paradigm from 70% of abortions performed by D&C, most with general anesthesia, to about 72% of abortions through safer methods, as recommended by the WHO and national Standards: MVA or EVA, mostly with local paracervical anesthesia, and MA. The access of women to abortion services improved, as they may seek care now in any healthcare facility without referral from a family doctor; abortions are performed with a reasonable number of justified investigations; the pre-/post-abortion counseling concept was implemented, including on contraceptive methods, informed consent, protection of confidentiality and privacy etc.

It has to be mentioned, though, that better quality of abortion services at country level is largely due to the MoH endorsing the WHO strategic approach with all its stages, developing and implementing a comprehensive abortion care model and setting up at country level, with the technical support provided by the WHO, of 6 model-centers providing quality pregnancy termination services. About one-third (over 29%) of all abortions in the country are currently performed in these centers, as well as over 40% of all safe abortion procedures. **Listed below are the strengths identified during the assessment of quality of and access to abortion services in model-centers:**

- Pregnancy termination services started to be provided in outpatient settings, thus significantly improving the access of women, including price-wise: no hospital bed-day costs and (in most cases) general anesthesia costs are now factored in to the price of procedure;
- All model-centers provided comfortable conditions for providers and patients alike: premises were renovated, furnished and equipped, isolated from the rest of the ward. Rooms have heating, cold and hot water supply, and direct access to WC;
- All health workers providing abortion care (physicians and nurses) were trained in comprehensive abortion services (MVA, MA, advantages of local anesthesia, counseling etc.), being well aware and observing the national standards and legislation on abortion;
- All terminations of pregnancy (100%) are performed by the WHO recommended methods, i.e. MVA / EVA or MA, mostly with local anesthesia;
- The battery of investigations before an abortion procedure was cut to a minimum; common procedures include now the cervical ripening with Misoprostol and routine administration of antibiotics for infection prevention following a surgical abortion; routine inspection of tissues following MVA was implemented;
- There were conditions created and efforts are being bent to respect the confidentiality and privacy of women; pre- and post-abortion counseling is a must, promoting MVA and MA, local anesthesia and contraceptives;
- Immediately after an abortion procedure, a whole range of contraceptive methods are suggested and made available in the majority of centers;
- In many centers, the funds generated by user fees levied from abortion service delivery are used to provide the facility with equipment and supplies. In one facility, the accrued funds made it possible to fully cover the maintenance cost of the abortion room, utility costs, staff

payroll; more than that, the salary of staff was topped up as motivation for better quality;

- Observance of women's rights and quality of services are checked by documenting and keeping record of the procedure and through patient satisfaction survey after abortion;
- Number of complications reported in model-centers is extremely low and does not exceed 1% of the total number of performed procedures, thus being indicative of the high quality of abortion services and accurate reporting of the actual number of abortion complications.

Listed below are the quality issues related to termination of pregnancy in model-centers requiring further attention:

- A number of barriers to access abortion care prevail: pregnancy termination services not listed under the list of services provided by a health facility, price not indicated, limited working hours in most centers, and very few staff that had training in this area;
- Provisions of the national Standards for safe abortion procedures are not systematically followed: unjustified routine investigations are prescribed before abortion from time to time (vaginal smear, echography), use of antibiotics or antifungals for infection prevention other than those recommended, tissues not always inspected after MVA;
- The quality of counseling provided by some facilities requires considerable improvement on matters regarding the type of anesthesia in surgical abortion and choice of post-abortion contraceptive methods;
- There are considerable discrepancies in abortion prices charged by different health facilities providing termination of pregnancy services in outpatient settings; price is still estimated based on different methodologies;
- In some centers, no penny from the funds generated by abortion service delivery is earmarked for the procurement and supply of equipment and consumables. As a result, women have to bear the costs of certain drugs (lidocaine, antibiotics) or supplies (gloves) or are kindly asked to make "voluntary donations"; service providers buy supplies (syringes or cannula) and consumables from their own money;
- There is no written information about the post-abortion period, signs of possible complications and how to seek emergency care if needed;
- A system problem identified by the assessment team is the separation of abortion services from other RH services.

Listed below are the trends noticed during the assessment of the quality of and access to pregnancy termination services in other visited healthcare facilities:

- In some health care facilities, including TMA in Chisinau, which were not part of the WHO project, supported by the MoH, appropriate actions were taken to improve the access to and quality of the abortion services performed in line with MoH and WHO recommendations;
- However, in the majority of district towns visited by the team, terminations of pregnancy were still performed in hospital settings, within the gynecology wards and most of abortions performed were by D&C, disregarding the normative acts adopted by the MoH and WHO recommendations;

- MVA and MA are seldom performed, if at all: therefore, the high share of riskier and non-recommended i/v general anesthesia;
- Medical abortion is still a method for women who can afford paying a relatively high price. The price of MA is not regulated, and the cost of pills in pharmacies is high and unaffordable for most;
- A significant proportion of medical abortions is not reported;
- Health care facilities do not provide the abortion service with MVA equipment: it is still either purchased by physicians themselves or is not available at all; EVA equipment is either outdated or not used;
- No cervical ripening with Misoprostol is practiced, as it is not available in health facilities;
- Routine infection prevention after surgical abortion is either not done or non-recommended drugs are used instead;
- In the majority of visited facilities, a number of unjustified investigations are prescribed, which are not recommended by the Standards for safe termination of pregnancy, thus dragging the price of procedure up for the patient and healthcare facility alike;
- Patients do not get adequate counseling, including post-abortion;
- Being part of tier-II specialized healthcare services, the facilities providing abortion care are not entitled to procure and distribute contraceptives, even if termination of pregnancy is an excellent opportunity for counseling and provision of contraception, as recommended by national Standards. Oftentimes, patients after abortion leave without a contraceptive and are not counseled in FP issues;
- Abortion is performed in conditions not conducive to ensuring patient confidentiality and privacy, in unheated or unsuitable procedure rooms;
- Managers failed to bend all efforts to improve the access to abortion and develop outpatient services, as allowed by the MoH, thus resulting in lower costs in the abortion service and higher quality of / access to such services;
- The access to abortion service for poor women and adolescents, in particular in rural areas, is still problematic given the laborious pathway to getting this service free of charge;
- Abortion is not listed among the services provided in YFHC, although the majority of such centers meet the criteria for providing such;
- Abortion customized informed consent is not universally used in all facilities, as prescribed by the Regulation on termination of pregnancy and is not read and signed by the patient and service provider;
- There is a considerable difference in fees levied for abortions across same-level facilities. It often includes unjustified costs. The cost of service is not visibly displayed for users;
- The funds collected for abortion service delivery, quite significant at times, are not invested back to service delivery ward or room to upgrade the equipment (plastic cannula, electric or manual aspirators), consumables or payment of providers. No equipment was purchased for EVA/MVA in the facilities performing D&C only due to scarce funding;

- There is further room improving the training of providers in the area of safe abortion; many of the interviewees attended such coursed many years ago or participated in none.

Recommendations*:

1. Review and update the normative papers of the MoH (Regulation and Standards) to include the latest WHO recommendations on safe abortion, focusing on getting rid of D&C and on adding and observing all elements ensuring quality safe abortion service delivery;
2. Develop mechanisms to ensure universal access to quality abortion and FP services following abortion, by scaling up countrywide the positive experience of model-centers for outpatient service delivery and more facilities providing quality services, review the pricing for services and mechanisms to get services free of charge;
3. Update the M&E of the quality of abortion services and compliance with the MoH normative papers, collection and reporting of statistic indicators, including by making the standards for the quality of abortion services part of the healthcare facility accreditation system;
4. Develop a system for training and retraining of health workers in the area of safe abortion;
5. Develop the system for public information, education and communication about sexual and RH rights and safe abortion.

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* These recommendations shall be discussed at the Assessment outcomes presentation meeting, and development of an action plan for their implementation

Annex 1

Assessment team membership

Team assessing the quality of abortion services provided in model-centers:

1. Stelian Hodorogea, associate professor, department of Obstetrics / Gynecology, MPSU "N.Testemitanu"; regional coordinator for ECA region within the FIGO project "Prevention of unsafe abortion"; WHO consultant in making pregnancy safer, CIDSR deputy director
2. Natalia Zarbailov, associate professor, PhD, department of Family Medicine, MPSU "N.Testemitanu" ; MPH
3. Ronnie Johnson, WHO, HQ
4. Larisa Boderscova, program officer, WHO, Moldova

Team assessing the quality of services provided by other visited facilities:

5. Rodica Comendant, associate professor, department of Obstetrics / Gynecology, MPSU "N.Testemitanu" ; WHO consultant in safe abortion, Gynuity Health Projects consultant, CIDSR director
6. Ronnie Johnson, WHO, HQ
7. Larisa Boderscova, program officer, WHO, Moldova
8. Uliana Tabuica, associate professor, PhD, department of Obstetrics / Gynecology FECMF, MPSU "N.Testemitanu"
9. Cornelia Sirbu, obstetrician/gynecologist, head of admissions, IMSP MCH #1.
10. Irina Sagaidac, assistant, department of Obstetrics/Gynecology, FECMF MPSU "N.Testemitanu", CIDSR

Additional participants joining the assessment of some facilities:

11. Maria Cumpana, director, National Health Accreditation Board
12. Maria Tabirna, head, Woman's Health Center, TMA Center, Department of Health of the Municipality of Chisinau

Annex 2

List of facilities visited during assessment

List of model-centers:

1. Chisinau – I.M.S.P. “Municipal Clinical Hospital #1”, consultations department
2. Balti – Perinatology Center, consultations department
3. Orhei – Perinatology Center, consultations department
4. Drochia – Woman’s Health Center “Ana”
5. Cahul – Perinatology Center
6. Cantemir – Perinatology Center, consultations department

List of other visited facilities:

1. I.M.S.P. „District Hospital Ocnita”
2. I.M.S.P. „District Hospital Glodeni”
3. I.M.S.P. „District Hospital Soroca”
4. I.M.S.P. „District Hospital Falesti”
5. I.M.S.P. „District Hospital Telenesti”
6. I.M.S.P. „Municipal Clinical Hospital “Sfintul Arhanghel Mihail”
7. I.M.S.P. „Municipal Clinical Hospital “Sfinta Treime”
8. Territorial Medical Association “Riscani” (TMA “Riscani”)
9. I.M.S.P. „District Hospital Ialoveni”
10. I.M.S.P. „District Hospital Nisporeni”
11. I.M.S.P. „District Hospital Ceadir–Lunga”
12. I.M.S.P. „District Hospital Comrat”
13. I.M.S.P. „District Hospital Vulcanesti”

Annex 3

Statistic report 13, termination of pregnancy, 2013

Item	No.	ICD X	Total	Including women from the age group:					Rural population of the total number
				<15	15-17	18-19	20-34	35+	
A	B	C	1	2	3	4	5	6	7
Termination of pregnancy - total (sum of **2 to 10)**	1		14511	9	296	945	10387	2874	6686
Artificial voluntary termination of pregnancy: - before 12 weeks' gestation	2	O 04	9862	4	183	691	7047	1937	4369
Artificial termination of pregnancy on medical indications: - before 12 weeks' gestation	3	O 04 some	535	1	13	32	377	112	313
- 13 to 21 weeks' gestation	4	O 04 some	247	1	6	20	176	44	81
Artificial termination of pregnancy on social indications: - before 12 weeks' gestation	5	O 04 some	104		9	11	74	10	72
- 13 to 21 weeks' gestation	6	O 04 some	59	2	5	6	34	12	40
Miscarriages: - before 12 weeks' gestation	7	O 03	3260	1	69	171	2351	668	1576
- 13 to 21 weeks' gestation	8	O 03	441		10	14	327	90	233
Illegal abortions: - before 12 weeks' gestation	9	O 05							
- 13 to 21 weeks' gestation	10	O 05	3		1		1	1	2
Primipara of the total number of abortions (row 1)	11		2336	7	233	542	1508	46	981
Number of abortions (from row 1) before 12 weeks' gestation - total	12		13761	6	274	905	9849	2727	6330
Cervical ripening with Misoprostol	13		1691	2	65	209	1179	236	518
Type of anesthesia during abortion: - paracervical block	14		8124	7	160	513	5771	1673	4027
- general anesthesia	15		4402	2	98	249	3166	887	1978
Method of termination of pregnancy: - **MVA**	16	Z 30.3 some	5071	4	117	282	3715	953	2293
- **EVA**	17	Z 30.3 some	3668	1	62	244	2482	879	1773
- **D&C**	18	O 03 O 04 some	4054	4	81	232	2904	833	2146
- **Medication (pills)**	19	O 04 some	1697		35	183	1274	205	463
Pre-abortion counseling	20		14511	9	296	945	10387	2874	6686
Post-abortion counseling	21		14511	9	296	945	10387	2874	6686

Item	No.	ICD X	**Total**	Including women from the age group					Rural population of the total number
				<15	15-17	18-19	20-34	35+	
A	B	C	1	2	3	4	5	6	7
Number of abortion related complications – total (sum of rows 22.1-22.13)	22	O 03 0-4; O 06; O 08 Z30.3	69		2	4	51	12	40
including: - incomplete termination of pregnancy	22.1	O 03. 0-4 O 04. 0-4	16				13	3	9
- cervical lesions	22.2	O 08.6 some							
- uterine perforations: mild	22.3	O 08.6 some	4				3	1	2
severe	22.4	O 08.6 some	2				2		1
- genital and pelvic infection: endometritis	22.5	O 08.0 some	10		1	1	6	2	6
Salpingo-oophoritis	22.6	O 08.0 some	1				1		1
pelvioperitonitis	22.7	O 08.0 some							
peritonitis	22.8	O 08.0 some							
septic shock	22.9	O 08.0 some							
Other genital and pelvic infections	22.10	O 08.0 some	4		1		2	1	4
Uterine bleeding requiring hospitalization and blood transfusion	22.11	O 08.8 some	5			2	2	1	1
Allergic reactions	22.12	O 08.8 some	1				1		1
- other abortion-related complications	22.13	O 08. 2-5,7,9 Z30.3	26			1	21	4	15
Number of IUD inserted in: outpatient and inpatient settings **-total***	23		10626	3	65	689	6361	3508	5404
- including, immediately after termination of pregnancy	24		188			15	118	55	50
Number of women provided with combined oral contraceptive (COC) pills immediately after abortion	25		1737		43	195	1144	355	737
Number of women provided with male condoms immediately after abortion	26		1727		29	161	1301	236	439

Annex 4 Pregnancy termination methods – medical statistic annual data, 2013 (NCHM)

	Total	Pregnancy termination method			
		MVA	EVA	Medication	D&C
RDD mun. Chisinau	**5377**	**2424**	**498**	**917**	**1482**
RDD North	**2754**	**1355**	**276**	**130**	**984**
municipality Balti	1559	1156	-	113	290
Briceni	61	25	-	-	36
Donduseni	82	-	51	-	31
Drochia	80	-	30	5	45
Edinet	77	39	38	-	-
Falesti	126	-	-	1	125
Floresti	68	-	26	-	42
Glodeni	185	-	41	11	133
Ocnita	78	-	-	-	78
Riscani	132	-	90	-	42
Singerei	182	131	-	-	51
Soroca	115	4	-	-	111
RDD Center	**1695**	**316**	**806**	**11**	**547**
Anenii-Noi	81	-	25	-	56
Calarasi	74	-	74	-	-
Criuleni	134	-	74	-	56
Dubasari	-	-	-	-	-
Hincesti	94	-	79	-	15
Ialoveni	170	32	-	-	138
Nisporeni	148	-	-	-	148
Orhei	459	59	348	-	43
Rezina	89	81	-	-	8
Straseni	130	122	-	6	-
Soldanesti	75	18	-	5	52
Telenesti	31	-	-	-	31
Ungheni	210	4	206	-	-
RDD South	**1516**	**934**	**266**	**2**	**312**
Basarabeasca	28	-	12	-	14
Cahul	799	698	1	-	100
Cantemir	145	66	-	2	77
Causeni	219	-	219	-	-
Cimislia	95	95	-	-	-
Leova	106	75	-	-	31
Stefan-Voda	77	-	18	-	59
Taraclia	47	-	16	-	31
RDD UTA Gagauzia	**277**	**-**	**116**	**-**	**161**
Comrat	98	-	-	-	98
Ceadir-Lunga	130	-	116	-	14
Vulcanesti	49	-	-	-	49
Total, municipalities	**6936**	**3580**	**498**	**1084**	**1772**
Total, districts	**4674**	**1449**	**1464**	**30**	**1714**
Republican facilities	1377	-	632	334	411
Total, MoH	**12987**	**5029**	**2594**	**1448**	**3897**
Other line-ministries	1524	42	1074	249	157
Total, Moldova	**14511**	**5071**	**3668**	**1697**	**4054**

Annex 5

Pricing of services in visited facilities

Facility	Price of service, total, MDL	Pricing modality
1. I.M.S.P. "District Hospital Nisporeni"	271	1 Bed-day – MDL 144 2. *Abrasio cavi uteri* – MDL 87 3. Premedication – MDL 40
2. I.M.S.P. "District Hospital Ceadir-Lunga"	231	1. Bed-day – 144 lei 2. Medical abortion – MDL 87 3. I/V anesthesia, additionally – MDL 119
3. I.M.S.P. "District Hospital Comrat"	268	1. Bed-day – MDL 144 2. *Abrasio cavi uteri* – MDL 87 3. Medication used – MDL 37.90
4. I.M.S.P. "District Hospital Ocnita"	258	1. Bed-day – MDL 144 2. Medical abortion – MDL 87 3. Local anesthesia – MDL 25
5. I.M.S.P. "District Hospital Falesti"	231	1. Bed-day – MDL 144 2. Medical abortion – MDL 87
6. I.M.S.P. "Municipal Clinical Hospital "Sfintul Arhanghel Mihail"	410	1. Bed-day – MDL 144 2. *Abrasio cavi uteri* – MDL 87 3. Anesthesia, category II – MDL 119 4. Pap smear – MDL 13 5. Complete blood count – MDL 26 6. Consultation by gynecologist – MDL 21
7. I.M.S.P. "Municipal Clinical Hospital "Sfinta Treime"	274	1. Bed-day – MDL 144 2. Surgery – MDL 69.0 3. Sedation – MDL 49.0 4. Pap smear – MDL 13
8. I.M.S.P. "District Hospital Glodeni"	385	1. Bed-day – MDL 144 2. Medical abortion – MDL 89 3. Anesthesia – MDL 119 4. Medication – MDL 14 5. Nutrition – MDL 19.25

9. I.M.S.P. "District Hospital Ialoveni"	209	1. Bed-day – MDL 144 2. MVA – MDL 69 3. Swab – MDL 13 4. MRS – MDL 17 5. HBS Ag – MDL 35 6. Curettage – MDL 47
10. I.M.S.P. "District Hospital Soroca"	389	1. Bed-day – MDL 144 2. *Abrasio cavi uteri* – MDL 87 3. Anesthesia, category II – MDL 119 4. Pap smear – MDL 13 5. Complete blood count – MDL 26
11. I.M.S.P. "District Hospital Telenesti"	330	1. Bed-day – MDL 144 2. Curettage – MDL 67 3. Anesthesia, category II – MDL 119
12. I.M.S.P. "District Hospital Vulcanesti"	87	1. Medical abortion – MDL 87
13. TMA Riscani, Chisinau	186	1. Day care hospital – MDL 18 2. Vacuum aspiration – MDL 46 3. Local anesthesia – MDL 19 4. Consultation by physician MDL 15 x 2 = MDL 30 5. Collection of swab – MDL 6 6. Swab (smear) – MDL 13 7. Drawing blood for WR – MDL 5 8. Bimanual exam – MDL 30 9. Preparation of vagina – MDL 19