



# POPULATION SITUATION ANALYSIS IN THE REPUBLIC OF MOLDOVA

Chisinau, 2016





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## **Population Situation Analysis in the Republic of Moldova**

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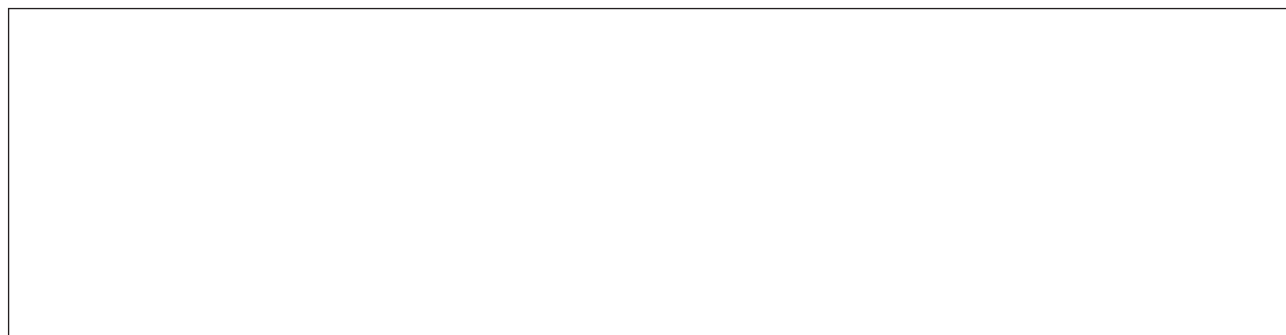
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Population Situation Analysis is prepared by the Center for Demographic Research at the decision of the National Commission on Population and Development under the UNFPA Global Methodology Situation Analysis on Population.

The report is intended for wide audience, primarily decision-makers, experts from the ministries concerned with the design and monitoring of economic and social policy, non-governmental organizations involved in promoting and protecting human rights, teachers, students and master specialized in the issue of population.



## ABBREVIATIONS

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ART</b>	Antiretroviral therapy
<b>BMI</b>	Body Mass Index
<b>CAC</b>	Comprehensive Abortion Care
<b>CEDAW</b>	Convention on the Elimination of all Forms of Discrimination Against Women
<b>CHI</b>	Compulsory Health Insurance
<b>CHIF</b>	Compulsory Health Insurance Fund
<b>CRHMG</b>	Center for Reproductive Health and Medical Genetics
<b>CSW</b>	Commercial Sex Workers
<b>D&amp;C</b>	Dilation and Curettage
<b>CDR</b>	Demographic Research Center
<b>EU</b>	European Union
<b>EVA</b>	Electric vacuum aspirator
<b>FDC</b>	Family Doctors Centre
<b>FDO</b>	Family Doctor's Office
<b>FP</b>	Family Planning
<b>GDP</b>	Gross Domestic Product
<b>HC</b>	Health Center
<b>HIV</b>	Human Immunodeficiency Virus
<b>HO</b>	Health Office
<b>IDU</b>	Injecting Drug User
<b>IMF</b>	International Monetary Found
<b>IUD</b>	Intrauterine Device
<b>LFS</b>	Labour Force Survey
<b>MDGs</b>	Millennium Development Goals
<b>MoH</b>	Ministry of Health
<b>MSM</b>	Men who have sex with men
<b>MVA</b>	Manual vacuum aspirator
<b>NBS</b>	National Bureau of Statistics
<b>NCHM</b>	National Centre for Health Management
<b>NGO</b>	Non-Governmental Organization
<b>NHIC</b>	National Health Insurance Company
<b>NPHC</b>	National Public Health Center
<b>NRHS</b>	National Reproductive Health Strategy
<b>OB/GYN</b>	Obstetrics and Gynecology
<b>OECD</b>	Organization for Economic Cooperation and Development
<b>PA ICPD</b>	Programme of Action of the International Conference on Population and Development
<b>PHC</b>	Primary Health Care
<b>PHRI</b>	People at High Risk of Infection
<b>RHO</b>	Reproductive Health Offices
<b>RHTC</b>	Reproductive Health Training Center
<b>SHOP</b>	Sexual Health of Older People
<b>SRH</b>	Sexual and Reproductive Health
<b>STI</b>	Sexually Transmitted Infection



<b>TFR</b>	Total Fertility Rate
<b>UN</b>	United Nations
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children’s Fund
<b>URSS</b>	Union of Soviet Socialist Republics
<b>VTC</b>	Voluntary Counseling and Testing
<b>WHO</b>	World Health Organization
<b>YFHC</b>	Youth Friendly Health Centre
<b>YFHS</b>	Youth Friendly Health Services



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## SUMMARY

In connection with the Sustainable Development Goals (SDGs) (2030) and “Moldova 2020” National Development Strategy on medium term, the Government of the Republic of Moldova committed to make efforts to ensure an inclusive and sustainable development, to integrate into national strategies and programs the aspects related to population dynamics, reproductive health and gender relations, thus ensuring the country’s medium and long term competitiveness.

**Goal of PSA** inform the relevant bodies and society about the key challenges in population dynamics, present and argue for a reference framework for the development and improvement of population and development policies.

### Objectives:

- Analyse comprehensively the situation on population and development, sexual and reproductive health and gender equality.
- Strengthen the analytical and information base for the development, implementation and monitoring of population policies.
- Improve national policies on population and development (National Strategic Program on Demographic Security, MIPAA/Roadmap on Ageing), based on the human rights-based paradigm and the priorities until 2020.
- Perform cost-benefit economic analyses of the benefits of the current policies on reproductive health and population.
- Provide and analyse comprehensive data on population and development, sexual and reproductive health,

gender equality to be used by UNFPA in establishing baselines for the next country program.

- Contribute to the establishment of indicators in the national SDG framework.

The PSA Report was developed in accordance with the general principles laid down in the conceptual and methodological Guidelines developed by UNFPA. The following priorities and national development strategies served as milestones for the development of the PSA: The National Strategic Program on Demographic Security (2011-2025), National Reproductive Health Strategy (2005-2015), National Gender Equality Program (2010-2015), other documents that indirectly target these areas.

### Main issues (problems)

*Economic* and political uncertainty. After a quarter century of reforms, Moldova’s economy is characterized by instability and low growth rates. Political uncertainty that exist in Moldova today is a major impediment for continuation of democratic reforms, promotion of sustainable socioeconomic policies that are linked to demographical changes, that have as result establishment of the rule of law and the welfare state, where will be respected human rights and freedoms, will be created decent living and working conditions, which would compete with those of developed countries.

### Population dynamics

According to the NBS data, the number of permanent residents of the Republic of Moldova as of 1 January 2015 amounted to 3555.1 thousand inhabitants, including the migrants who live abroad for more than 12 months. The present population constituted 2911.6 thousand, calculated in accordance

with the European standards and does not include the migrants which live abroad for more than 12 months.

In the following decades the population decline will continue at rapid pace. In accordance with the demographic forecast (2015-2035) the annual decrease in population will fluctuate between 1.1-2%. The number of births will be numerically very small and declining population will not recover, this phenomenon is determined both by low fertility and decrease of the female population of childbearing age (15-49 years). So, until 2035 the number of population in our country may decrease to 2085.8 thousand (by 28.4%).

Demographic dividend period is very short (only the years 2005 to 2020), because emigration has led population decline in the working age. However, demographic forecast shows that the share of this contingent in total population is favorable for facilitating economic growth, while increasing the age for retirement contribute for extension demographic dividend.

Demographic decline is largely determined by low TFR that remains in values from 1.6 to 1.65 children per woman of childbearing age (calculated on the present population). The decrease in fertility rate in the Republic of Moldova is part of general European trends, being part of the decrease of fertility rate in the Central and Eastern Europe countries, which go through radical political and socio-economic changes as well as through a second demographic transition, which began, in the second half of the 1990s of the past century.

The decrease of fertility rate is illustrated by the evolution of finale TFR of female generations. The complete fertility rate of female generations born in the first half of the 1960s was at the generation

replacement level or higher, while those born during 1973-1975, but especially those that were born in the late 1970s and more recently, will have a lower fertility.

**The most negative impact of the population decline determined by the decrease of the birth rate present the loss of national demographic potential to redress the situation, the demographic crisis becoming thus huge, and the depopulation process being harder to stop.**

High mortality of adult population, especially of men, is one of the most important problems. Today, the probability of dying at the age of 65 for a man who has reached 20 is of 40%, which is two times higher than in developed countries.

In the structure of mortality by cause of death, prevail the diseases of circulatory system, the share of that in total mortality is 53% for men and 64% for women. Neoplasms are ranked on the second place for both sexes (16% for men and 14% for women). For men, deaths due to external causes (10%) and digestive diseases (9%) rank third in the general mortality structure. For women, the digestive system diseases rank third among the leading causes of death (10%).

Mass emigration of the population has a significant impact on the dynamics of the Moldovan population. The results of the census of the host countries reveal that around 16% of Moldovan population in 2011 had stable residence abroad.

The largest migration losses were recorded in 2007-2011, when net migration varied between 33,000 and 43,000 people per year. For 2012-2013, the net migration is slightly over 30 thousand people. In 2012-2013, the Republic of Moldova has lost annually about 1% of the population left in the country.



## Sexual and reproductive health

The priority areas in reproductive health in that was focused efforts to ensure the exercise of sexual and reproductive rights of all citizens of Moldova are family planning, maternity risk-free sexual and reproductive health of adolescents and youth, infections of the reproductive tract, abortion and services abortion, prevention and management of infertility, early detection and management of breast and cervical cancer.

Actions taken by the Government in partnership with the scientific society and practice, and efforts across sectors, have contributed to achieving tangible results in some areas of sexual and reproductive health services such as abortion, sexual and reproductive health of adolescents and youth. However, there were also failures caused by fragmented and disproportionate efforts on priority areas, insufficient intersectional and interdisciplinary cooperation, including the community level.

Most progress has been made in reducing infant mortality. If in 1994 infant mortality constituted 22.6, ‰ in recent years this indicator is maintained at 9.4 to 9.7 ‰. However, compared to Western European countries (France, Germany) in Moldova infant mortality is 3-4 times higher, it is also higher than in Eastern Europe (Belarus, Russia, Ukraine) and Baltic Countries.

Despite the measures taken to restructure the health system, especially in the field of mother and child health, by implementing regionalized perinatal system in terms of reducing maternal mortality indicator it is not successful. Proposed target under MDG 5 is not reached, remaining to be about 5 times higher than the European average.

Although there exist a supportive legislative framework for the family planning section, practical situation it is far from the wanted one. The share of person with unmet need

for contraception remains high and is reported by 10% of women of reproductive age.

Sexual and reproductive health of adolescents and young people is one of the areas that were growing remarkably, aiming to improve sexual and reproductive health of adolescents and young people by informing and educating them to change the risky behaviour (leading to unwanted pregnancies, abortions, sexually transmitted infections, including HIV) and increase access to services focused to their specific needs.

Even though over the last decade we registered a positive dynamics (in 2000 the incidence of syphilis accounted for 114.9 per 100 thousand persons, while in 2015 – 53.8; in 2005 the incidence of gonorrhoea was of 60.1, while in 2015 – 26.4), the incidence of these infections is much higher than in other countries from the region. Although the HIV incidence has been relatively stable in the recent years, though it was not possible to achieve targets set in MDG 6, at both levels: general population and 15-24 age group.

Abortion and pregnancy interruption services can be considered a component of success. Thus, important results have been achieved in improving the quality of abortion due to the implementation safe methods recommended by WHO.

During the past 10 years it was registered an increase in morbidity rate of population of the Republic of Moldova caused by breast and cervical malignancy. In this context presents major importance ensuring women's access to preventive services (gynecological examination and mammography in accordance with existing protocols), limiting it under the pretext of crisis and budget cuts are unacceptable. To increase addressability to prevention

and early detection (screening by mammography screening cytology, HPV vaccination) increased attention to be paid to informing the population in this area.

### The situation of youth

Over the last decade 2004-2014, the number of persons aged 15-29 has decreased by 12%, thus shrinking from 826,9 thousand to 727,7 thousand. However, young people still represent a third of the country's population, thus they represent a strategic component of sustainable development, labour force, future families and human continuity. The number and share of young people in the total of country's population will constantly decrease over next decades.

Was achieved visible progresses in increasing of the people's education levels. The share of people with higher education increased by 2.4 times in age group 15-29 years (from 7% in 2004 to about 17% in 2014). Young aged 25-29 years have the highest level of education, or a third of young people aged 25-29 have higher education.

Between 2004-2014, the gross enrolment rate in tertiary education in Moldova was oscillating between 37-38%. We found that the main challenge regarding the access to tertiary education in the Republic of Moldova is the enrolment rates, which if compared to European countries (71% in 2014) are quite low. They are influenced by the low bacalaureate completion rates from the last years and by the low participation of people from rural area.

The share of young people who leave school early (with secondary education) fluctuated over the past decade around 22%, is more than three times higher among rural youth to urban youth (28.7% and respectively 8.8%).

Asignofdisappointmentandmarginalisation

of young people in education and labour market is share of young people who are neither employed, nor enrolled in any form of training or professional development (NEET - Not in Education, Employment, or Training), which constitutes approximately 29% (2013), which is two times higher than the average for EU countries.

Youth relationship with internal labour market attests that 3 in 10 young people (28%) are employed, and 2/3 (or 69%) are economically inactive, of which every second young person is placed in the education and professional training. Also an important category of inactive young people are formed by migrants who work or are seeking for a job abroad (21,1%), followed by people occupied with housework (including family responsibilities) in their own household (14.2%). Among employed young people, over 31% have informal jobs, and 11% among young employees working without individual employment contracts.

In the Republic of Moldova, the access of young people under 18 years of age and of those who continue their studies to health care is guaranteed by the state, through free health insurance. In 2014 every third person, aged 15-29 did not have an insurance policy, because they did not have a job and financial accessibility.

The specific mortality rate for the age group 15-29 accounted for 67.4 of deaths per 100 thousand inhabitants of this age. Is registered significant differences on sexes and residence areas. Mortality rates in young men are several times higher than in women. It also records the highest mortality rates for rural youth, especially for men: compared to urban areas in the age group 15-19 years mortality rate is two times higher in the age group 20-24 - 1.6 times, and in the age group of 25-29 years - about three times.

In case of young people (15-29 years) the main causes of death accidents, intoxications and trauma (57.0%), followed by neoplasm (10.4%), circulatory system diseases (8.7%), digestive system diseases (5.1%) and respiratory diseases (3.5%). The share of deaths from suicide among young people aged 15-19 constitute 16.5%, doubling in the last 15 years.

An overview on statistical indicators of young people's health concludes: 6 of 10 people are infected with sexually transmitted infections in the age group 15-29 and their share remains constant in the last decade. Approximately 14% of new HIV infection detected area assigned to 15-24 years young people.

Is growing number of drug users, most of them (95%) are single men with secondary education.

Even if Republic of Moldova has well drafted youth policies, their implementation is not encouraging. The legal framework for promoting youth policies in the Republic of Moldova presents the National Strategy for Youth Sector Development 2020 (GD No 1006 of 10.12.2014). Its effective implementation are affected now by many risks. The most important are: insufficiency of financial resources necessary to implement the Strategy's action plan, weak capacities of local implementation, coordination and monitoring across sectors.

### **Gender gaps**

The situation of gender equality in Moldova is examined under CEDAW and UPR, mentioning progress de jure and de facto. Although the legal framework in this area meets international standards we still assist at patriarchal perceptions, attitudes and stereotypes regarding the roles and responsibilities of women and men in family and society.

At the chapter reconciliation of family and professional life are registered limited possibilities for women to participate in the labour market because of the lack of educational services for small children (2-3 years old), discrimination by sex and age upon employment, discrepancies between the salaries of women and men (women's salaries compared to men's salaries was 87.6% in 2014) etc. Women are employed traditional in sectors with a low level salary and are rarely present in leadership positions. Differences in average wage and the period of contribution to the fund of social insurance determines differences in the average pension for age limit for men and women. On average, men pension cover the subsistence minimum for pensioners at a rate of 83%, and for women – 70%.

Other analysed aspect refers to response of state to gender-based violence and its impact on sexual and reproductive health. Is highlighted that in Republic of Moldova was approved guidelines for various categories of professionals (policemen, doctors, social workers) regarding their interventions in cases of domestic violence, there are still cases when female victims of violence are not identified and do not benefit from social assistance and protection services. Women victims of violence, most often, do not report violence to the authorities. Only 10 of a 100 female victims of severe violence and 1 of a 100 female victims of moderate violence on the part of husband/partner had reported the cases of violence to medical officers. Multiple gaps exist in providing legal and social assistance to victims of sexual violence.

### **Conclusion and policy recommendation**

#### **1. At the section population dynamics.**

The implementation of the *2011-2016 action plan of the National Strategic Programme*



on *Demographic Security (2011-2025)* has not delivered the expected results both because the demographic targets submitted were not supported by the respective changes in economic and social fields, and because of the lack of financing of the planned activities and low relevance of the proposed activities, as well as the low level of implementation as a result of lack of effective coordination across sectors.

The following action plan for the implementation of the *National Strategic Programme on Demographic Security (2011-2025)* will be drawn up considering the issues/risks outlined above, focusing on involving all state and civil society institutions in achieving the set objectives. Monitoring the implementation of the strategy and the results is indispensable for the implementation of corrections along the way, reconsideration of priorities and means, avoidance of negative effects.

Birth rate recovery can only be achieved through complex measures of support and social protection of families with children. It is important that these measures be perceived by the population as a significant and substantial support to families to facilitate their decisions about having children, guaranteeing this aid in further care and education.

*The reducing of mortality and the increasing life expectancy at birth* of population represents a priority. Among the priority directions of policies are highlighted:

- combating cardiovascular diseases by promoting health and health education;
- increasing the accessibility to quality healthcare services for vulnerable social categories;
- reducing disparities in morbidity and mortality between different socio-

demographic groups;

- increasing investments to improve the health status by means of a multi-sectoral approach, including additional allocation of resources for education, working conditions, housing and healthcare sector.

The country's economic development, increasing living standards, complemented by demographic policies to encourage the birth rate and return of Moldovan migrants back home are the most important objectives in the near future.

An important aspect of the population and development policies is to strengthen the analytical and informational basis for the decision-making process, to produce reliable data concerning the population number and structure, including by territory, publication of results of Population and Housing Census from 2014 and preparation for the 2020 Population Census.

## **2. At the section Sexual and Reproductive Health**

In the sexual and reproductive health area is recommended developing of a new framework for the organisation of the interventions for next years, with a consideration given to implementation of all the commitments made by the Republic of Moldova, including the objectives of the 2030 Agenda for Sustainable Development and 2016-2030 Global Strategy for Women's, Children's and Adolescents' Health. This framework must ensure universal and fair access to quality information and services in the sexual and reproductive health area, by defining of some key, efficient and impact interventions, ongoing monitoring and assessment, in the context of a human resources deficit in the system and limited available funds.

For monitoring of the implementation of RH policy documents is welcome the establishment of an inter-sectoral body responsible for directing which will include key ministries, agencies and non-governmental and professional organizations to implement political document will help ensure efficient interaction common to all stages.

In order to facilitate changes in communities that generate changes in society, it is essential to promote sustainable partnerships and intersectional collaboration in order to amplify efforts to improve sexual and reproductive health, including local partnerships.

In order to ensure equitable access to information and services related to sexual and reproductive health should be given special attention to population groups with special needs, namely teenagers, victims of domestic violence and human trafficking, vulnerable persons, persons with disabilities (physical and/or mental), the elderly.

A key importance presents consolidation of records in sexual and reproductive health, combating inequalities and measures undertaken to evaluating the impact of health policies in the field of argument. To guarantee results is principally to provide records attention assessing cost-effectiveness of interventions to promote, protect sexual and reproductive health, and prevention of diseases affecting the reproductive health of women and men.

### **3. At the section Situation of young people**

In implementing the *National Strategy for Youth Sector Development 2020* the priority directions are:

Coordination and integration between

the Strategy and national policies. The problems of young people are specific to all sectors, while many policies that have an impact on the youth situation are a part of the sector policies.

Ensuring active participation of young people in implementing the Strategy by expanding opportunities to be heard and encouraging more active participation in public life. Governments and other agencies must learn to communicate with young people, use their innovative and creative potential, form partnerships in service delivery.

Regular reviews of the implementation of youth policies. Systemic assessments and corrections of certain actions, is an important objective, helping to increase confidence of young people in actions and to ensure reasonable criteria in achieving objectives.

### **4. At the section Gender gaps**

The analysis conducted regarding gender equality highlights the need for further action by the joint governmental and non-governmental bodies and other stakeholders and development partners to achieve national and international commitments assumed. Is necessary to develop programs aimed at changing the population's attitude and behaviour towards female and male roles in family and society, closing the knowledge gaps, changing the gender stereotypes, promoting maternal and paternal values and gender equality.

Creation of favorable conditions for reconciliation of family and professional life can be obtained through: (i) develop early education services; (ii) control and punish employers who discriminate pregnant women and women with small children in employment and/or do not respect their

rights; (iii) reduce the pay gap by means of clear interventions focused on cases of pay gap – indirect discrimination on the labour market and direct discrimination at the workplace; (iv) reduce the pension gap by means of equalization of the length of employment and of the retirement age for women and men.

In scope of eradication of gender-based violence is required sign and ratify by Republic of Moldova of the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence and develop services for victims of domestic violence by allocating funds from the State Budget.





# INTRODUCTION

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The Republic of Moldova, like other countries from Central and Eastern Europe, undergoes a demographic transition – an evolutionary process characterised by the shift to an ageing society due to the lower fertility rate and gradual increase of life expectancy at birth, which overlapped with the recent economic and political changes. The population ageing escalates on the background of a population decline that began in 1999, and according to the demographic projections, the population decrease will continue during the following decades.

The democratization of the society and the increasing opportunities for free movement boosted the territorial mobility of the population, and the significant gap between the living standards from the Republic of Moldova and the developed countries caused a massive emigration of the young population, which emphasizes the negative trends in population dynamics.

The decreasing number of population and population ageing are the key challenges for the next decades, which call for the special attention of the Government and society. At the same time, the population and development policies have developed an increasingly complex character in the contemporary society, and are connected to all areas of life. Issues like observance of human rights, including with regards to health, living conditions, access to labor market, access to information, gender equality, personal security, etc., must be taken into account when developing and implementing national strategies and programs. The inter-sectoral approach, based on the use of a wide range of social policy tools, and the involvement of nongovernmental sector are the key elements in promoting the population and development policies.

In connection with the Sustainable Development Goals (SDGs), “Moldova 2020” National Development Strategy and several development frameworks agreed by the international community, the Government of the Republic of Moldova committed to make joint efforts to ensure an inclusive and sustainable development, to integrate into national strategies and programs the aspects related to population dynamics, reproductive health and gender relations, thus ensuring the country’s medium and long term competitiveness. According to the contemporary concept of human development, an increased position of the human factor in the society, social equity, efficient employment and ecological security are the main priorities.

The general policy agenda is simple: ensure living standards comparable to those in the EU, strengthen the rule of law, increase the quality of the business environment and education, invest in research and development, etc. Therefore, the result will depend on the policymakers, on their ability to implement the required reforms, taking into account that the delay in their implementation will result in permanent gaps in the economic development, the increase of the economic and social cost for future generations, thus jeopardizing the economic and social sustainability of the Republic of Moldova.

Choosing national priorities in population and development much depends on national capacity to analyze long-term demographic trends, to estimate their impact on economic and social development, to highlight key issues.

The Population Situation Analysis (PSA) Report, developed by the Center for Demographic Research of the National Institute for Economic Research of ASM, at the initiative of UNFPA – United Nations

Population Fund, analyses the latest trends in population dynamics, debates potential policy responses and considers potential scenarios for future development.

PSA is aiming at achieving a comprehensive analysis of the situation in the field of population and development in the Republic of Moldova, in terms of human rights observance, taking into account the complexity of intersectoral correlations (education, health, employment, social protection, etc.) to serve as a reference for informing decision makers in the development and implementation of socio-economic and demographic policies and for the international community involved in protecting human rights and promoting sustainable development in the Republic of Moldova.

PSA proposes to examine the dynamics of the population in the context of economic and social process, identify key issues and population groups whose situation requires special intervention or the review of the existing policies. PSA will strengthen the analytical and information base for the development and implementation of population policies and increase their effectiveness by assessing the economic impact of interventions or of the lack of social interventions on population dynamics and socio-economic development.

PSA will monitor the indicators related to the implementation of the *National Strategic Program on Demographic Security (2011-2025)*, *National Reproductive Health Strategy (2005-2015)*, *National Gender Equality Program (2010-2015)*.

PSA reflects a comprehensive analysis of the population situation to ensure that the rights of vulnerable groups are included in the existing policies, programs and sectoral plans, given their joint result. Given the above, PSA will become an important

tool in developing evidence-based and scientifically-supported policies.

**Goal** – inform the relevant bodies and society about the key challenges in population dynamics, present and argue for a reference framework for the development and improvement of population and development policies

#### **Objectives:**

- Analyse comprehensively the situation on population and development, sexual and reproductive health and gender equality.
- Strengthen the analytical and information base for the development, implementation and monitoring of population policies.
- Improve national policies on population and development (National Strategic Program on Demographic Security, MIPAA/Roadmap on Ageing), based on the human rights-based paradigm and the priorities until 2020.
- Perform cost-benefit economic analyses of the benefits of the current policies on reproductive health and population.
- Provide and analyse comprehensive data on population and development, sexual and reproductive health, gender equality to be used by UNFPA in establishing baselines for the next country program.
- Contribute to the establishment of indicators in the national MDG framework.

#### **Methodological Approaches in PSA Development**

The PSA Report was developed in accordance with the general principles laid down in the conceptual and methodological

Guidelines developed by UNFPA<sup>1</sup>, based on the theoretical and methodological framework on the regularities of population development and evolution of the main demographic processes, taking into account the national context and the economic costs of the interventions or of the non-interventions in the areas included in the report.

The following priorities and national development strategies served as milestones for the development of the PSA: The *National Strategic Program on Demographic Security (2011-2025)*, *National Reproductive Health Strategy*, *National Gender Equality Program*, other documents which indirectly target these areas.

PSA provides assessment and advocacy tools to different social stakeholders in the context of a comprehensive process of working with national authorities to

promote inter-sector activities, increase the efficiency of the implemented strategies and programs, save and use soundly the financial resources.

### Information Sources

Official statistics, researches conducted by the Centre for Demographic Research and other national and international institutions served as information and statistical base for the PSA.

The unavailability of the 2014 Population and Housing Census results limits the opportunities of a comprehensive analysis of the demographic situation and prospective trends.

The PSA Report will not include the situation analysis in the Transnistrian region of the Republic of Moldova due to the lack of data on population dynamics and other economic and social indicators.

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1 [https://www.unfpa.org/sites/default/files/pub-pdf/PSA\\_Guide\\_1.pdf](https://www.unfpa.org/sites/default/files/pub-pdf/PSA_Guide_1.pdf)



# OVERVIEW OF THE SITUATION IN THE REPUBLIC OF MOLDOVA

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## 1.1 Economic Context

Following its independence, the Republic of Moldova encountered a series of political, economic and social problems, which it had to deal with using its scarce potential of material, financial and natural resources. The economy was reformed in the context of an acute social and economic crisis and radical transformation of the economic system. The lack of experience in countering external shocks, and economic and social crises, in conducting systemic reforms, coupled with the instability in domestic politics and the territorial disintegration of the country following the 1992 armed conflict predetermined the essence of the transition to market economy.

The high degree of integration of the Moldovan economy into the economy of the former Soviet Union was determined by the absolute lack of fuel, non-agricultural raw materials, machinery, equipment etc. The USSR collapse destroyed the system of economic relations and created obstacles to the movement of goods, limiting the access of the new independent states to the newly established markets.

The deintegration processes affected not only the links between business operators, but also the banking, monetary and financial system. The number of barter operations and non-payments increased, undermining the economic and financial stability of the whole state. The scarce budgetary resources, on the background of relatively

high budget commitments, caused a deficit that led to skyrocketing inflation.

The transition from centralised and planned economy to the market economy focused on the main directions: the price liberalisation, development of the domestic market, privatization, introduction of the national currency were quite dynamic. A new banking system was created, the conditions and rules of economic activity were changed. However, the measures taken and reform methods were not always corrected in a timely manner, the reforms were often hampered, and Governments were often changed for unjustified reasons.

The mass privatisation of the state property on the basis of property bonds did not meet the expectations of developing a class of owners interested in increasing the production by enhancing the competitiveness, renovation, reengineering and modernization of production potential.

In the agriculture sector, the reform and land privatization were conducted in the absence of a Government support system for agricultural producers and without an appropriate infrastructure to provide information, technological, commercial, financial and consulting services.

The economic and territorial disintegration, in tandem with the errors committed during the reform led to the lengthy and deep crisis in the 90s. The consequences of the reform were particularly high during the first 5 years, when the main indicators deteriorated totally. The GDP decreased

by more than 60%, the Gross Added Value – by 70%, investments – by about 85%, consolidated budget revenues – by more than 70%, external trade volume – by about 60%, average monthly salary – by more than 73%.

The imbalance of the financial system, i.e. the high inflation and hyperinflation, increase in the number of outstanding payments, barter transactions, and the number of the unprofitable enterprises aggravated the massive decrease of production.

However, the first signs of economic recovery occurred in 1997: for the first time the GDP increased (+ 1.6%) and the inflation level decreased significantly. Despite this, the 1998 financial crisis from Russia generated a new shock for the national economy, heavily dependent on the market of that country, which was the target of almost 60% of the Moldovan exports. During the following two years (1998-1999), the GDP decreased again by 10%. The economic activity recorded an unprecedented decline, the volume of imports and exports dropped twice.

The depreciation of the Moldovan leu against the US dollar (2.5 times between December 1997 and December 1999) increased considerably the external debt-servicing costs, recalculated in the local currency. As a result, in 1999, the country's GDP accounted for only 34% of the level of 1990, the volume of industrial production – 32%, agricultural production – 50%. An accentuated degradation of the funds reproduction occurred after the 10-fold reduction of investments in fixed capital.

The changes occurred during the 1990s had serious consequences and impacted negatively the population's standard

of living and the quality of life. People's sources of income decreased due to massive dismissal of the labour force, high inflation and the shrinking actual Government spending for social needs. The actual average monthly salary amounted to only about 25% of the level of the 1990s, and the average pension – about 17%, and the unemployment rate exceeded 11%. The deteriorating conditions and quality of life of most Moldovan people caused negative changes in the demographic evolution of the country. People started to emigrate massively, hoping to find a decent living abroad.

Practically, after 10 years of continuous recession, the economic decline stopped. In 2000, the Moldovan economy registered a positive trend, the growth being driven by several factors, such as: stable situation on the Eastern European markets, especially the Russian market; higher domestic demand that was largely influenced by the increasing remittances of from residents working abroad; more active investment process; harsher measures taken by the National Bank to limit the growth of money in circulation, reduce inflation, etc. The non-repayable financial assistance from EU and USA was particularly useful. Since its independence, Moldova received from USA only non-repayable assistance of over one billion US dollars to implement a number of projects and programs.

During the period of economic growth (2000-2015), the real GDP grew twice and the investments in long-term tangible assets – 2.2 times. The annual growth rate of the GDP averaged at 4.7%, investments in long-term tangible assets – about 5.5%, industrial production – about 4%, agricultural production – over 1%.

The national economic structure had undergone significant changes during the economic changes. The decreasing trend in the weight of gross value added in agriculture and industry (from 34% in 1990 down to 12% in 2010 in agriculture and from 28% down to 13.3% in industry) was obvious during the whole period, and a relative stabilization occurred in the following five years. And vice versa, the weight of services in the structure of gross value added increased almost twice (from 32% in 1990 up to 57.8% in 2015). The weight of net taxes on products in the structure of the country's gross domestic product increased over 2.5 times (from 6% in 1990 up to 15.3% in 2015) (Table 1.1.1).

The GDP composition by end use highlights the growing trend of the final consumption

has been consuming more than producing, the difference being compensated by the net exports, which has always been negative.

The economic growth in the Republic of Moldova in tandem with the trend of poverty reduction are closely linked to the flow of remittances (Fig. 1.1.1) and the consumption generated by them. The income of Moldovan nationals working abroad fueled the disposable income of households, thus increasing the aggregate demand for consumption. In relation to GDP, the weight of remittances in the past 10 years has oscillated around 20%. However, it is known that a part of the remittances enters the country by other ways than the commercial banks and it is estimated that their share would add another 40-50% on the top of the ones sent officially, so that

Table 1.1.1.

**Table 1.1.1.**  
Changes in the  
GDP Structure  
by Main Types of  
Resources and  
Uses  
Source:  
Developed on the  
basis of statistics

	1990	1995	2000	2005	2010	2015
Gross added value	94,0	88,6	87,5	83,6	83,4	84,7
of which						
agriculture, hunting and forestry	34,0	29,2	25,4	16,4	12,0	12,8
industry	28,0	25,0	16,3	17,0	13,3	14,1
services	32,0	34,4	45,8	50,2	58,1	57,8
Net taxes on products and imports	6,0	11,4	12,5	16,4	16,6	15,3
Gross domestic product	100,0	100,0	100,0	100,0	100,0	100,0
Final consumption – total	72,4	82,9	103,0	109,9	115,0	107,7
Gross capital formation	29,9	24,9	23,9	30,8	23,7	22,6
Net export	-2,3	-7,8	-26,9	-40,7	-38,6	-30,3

and the ongoing decreasing trend of gross capital formation in relation to GDP. Thus, since 1990 the final consumption has been increasing at higher growth rates than the GDP, and as a result, since 2000 the country

their contribution could raise up to one third of the GDP.

The Figure below shows the evolution of the national economy since 1990, including in the neighboring countries: Romania,

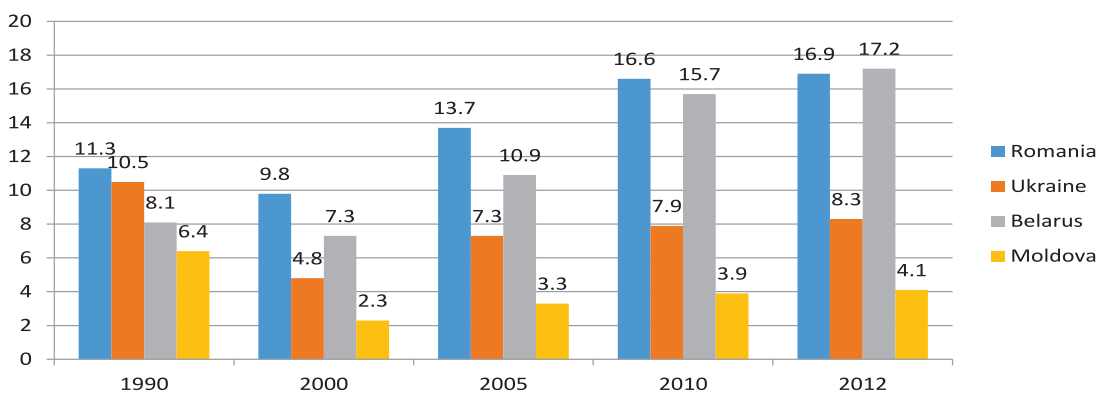
## Ukraine and Belarus

Speaking about the development of the main branches of the national economy - industry and agriculture, the Republic of Moldova lags behind the countries with medium level of development

The transition to the market economy occurred on the background of radical changes in the industry structure. Some branches, which once used to be priority, lost their significance and role, others, on the contrary, advanced. Thus, in 1990 the automotive manufacturing industry and light industry accounted for 43.5% of the total volume of the industrial production, while in 2013 these two branches did not cumulate even 15% of the total industrial production. If the light industry has gradually recovered its position since 2005 (increased from 5.4% in 2005 to 12.6% in 2013), then the automotive manufacturing industry is not progressing at all, decreasing from 20.9% in 1990 to 1.9% in 2013, i.e. more than 10 times.

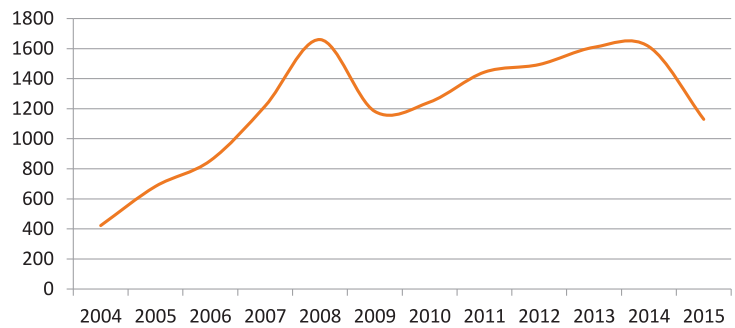
*This branch progresses so slowly is due to the*

Fig.1.1.2.



*limited number of valuable export-oriented companies in the country's economy. This explains the uncertain dynamics of the industrial production indices. After 6 years of phenomenal growth (2000-2005), a stagnation was registered in the following 3*

Fig. 1.1.1.



*years (2006-2008), and the global economic and financial crisis of 2009 hit the branch so severely that it dropped to the level of 2005, managing to surpass it only in 2014 (Fig. 1.1.3).*

To ensure a stable and qualitative growth of the industrial production it is necessary to re-engineer the Moldovan industry, facilitate the foreign trade and provide enterprises with skilled labor by reforming the educational system. These conditions can be achieved only by modernizing the national economy according to the European standards based on significant investments, which in turn will come when Moldova makes efforts to successfully implement the EU Association Agreement and the Action

Fig.1.1.1

Dynamics of Transfers from Abroad by Individuals via Banks (million US dollars)  
Source: Statistical data of those years

Fig. 1.1.2.

Evolution of per capita GDP based on the purchasing power parity (PPP) in Moldova compared to other countries in the region (thousand US dollars)  
Source: International human development indicators. <http://hdr.undp.org/en/>

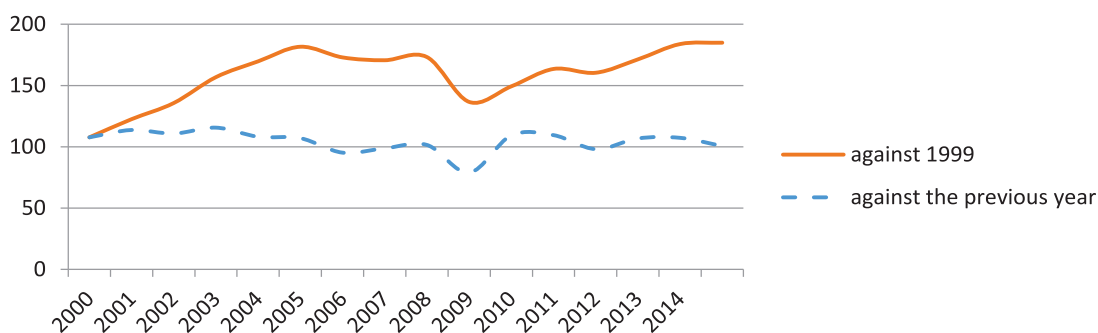
Plan implementing this Agreement.

In the Republic of Moldova, agriculture is a characteristic feature and one of the most widespread activity. This sector is and will



**Fig. 1.1.3.**  
Dynamics of  
the Industrial  
Production  
Indices during  
2000-2014  
Source: NBS.

**Fig. 1.1.3.**



remain one of the industries, which does not only impact the possibility to ensure a balanced power structure, but is also an important source of raw material for other branches of the economy. Along with the food industry, the agriculture provides about 25% of GDP and has an imposing share in the exports. About 40% of the country's workforce are engaged in agriculture.

At the current stage of reforming the agricultural sector, the situation has not dramatically improved and in some cases continues to deteriorate. This phenomenon is explained by the influence of several factors, such as the lack of knowledge among most of the new owners of production inputs in how to organize and manage the agricultural business, the small plots of land owned by peasants, their unwillingness to join in large manufacturing enterprises, massive migration, deplorable infrastructure and many other social factors that have negative consequences on the development of the country and improvement of the living standards of the population. The adverse weather conditions (drought, early frosts, floods, hail, etc.) and the poor attention from behalf of the government to the needs of peasants and farmers have also lead to the current complicated situation.

During the last years the increase of agricultural production was insignificant.

Thus, the average global production during the last ten years (2005-2014) was by about 15% higher compared to the previous ten years (1995-2004) due to the very good results of 2013 and 2014. During 2001-2014 the agricultural production indices fluctuated, if compared to 2000 and to the previous year, recording both increase and decrease, but the general line indicates a continued stagnation (*Fig. 1.1.4*).

The agricultural sector has a range of issues linked to the observance of crop-growing technologies, surface structure and crop rotation, reduction of areas for forage crops, etc. The considerable reduction of areas under forage crops led to a decrease in the number of animals and birds and, respectively, the production of the livestock sector.

The problems caused by the reform of the crop sector changed significantly the structure, maintenance and organization model of the livestock sector. The privatization of the fixed capital in this sector, including the flock, resulted in a considerable decrease of the livestock numbers in the country, first in the number of cattle and cows. If in 2001 the number of animals (cattle) was 394 thousand heads, then in 2014 – only 189 thousand heads, including cows – from 269 thousand heads to 131 thousand heads or more than two times less.

Fig. 1.1.4.

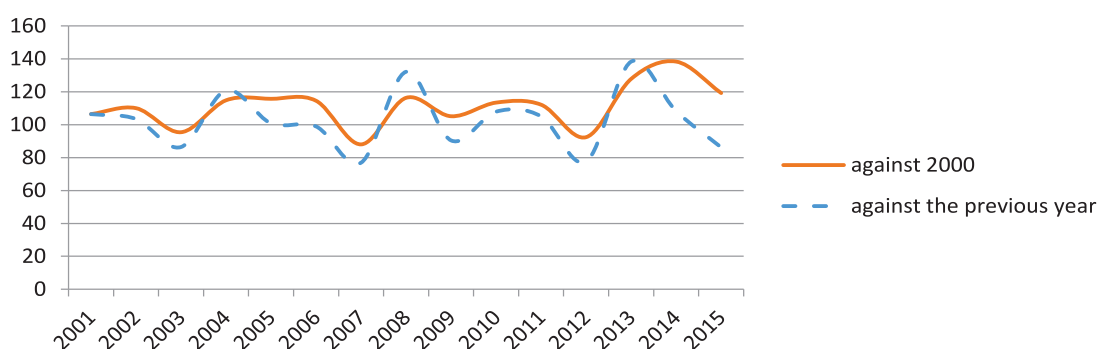


Fig. 1.1.4. Dynamics of the Agricultural Production Indices during 2001-2015  
Source: NBS

Due to a lower number of animals, the production per capita also decreased (Table 1.1. 2)

The privatization of the state property in conditions of free competition set the necessary preconditions in the country to establish, based on private property, new business operators of different size – small and medium enterprises (SMEs). The development of SMEs aimed to improve the factors of production, because they are more flexible and open to innovations.

During the past years progress has been made to adjust the legislation aimed at facilitating the conduct of business, but they proved to be just limited improvements to the quality of the business climate. However, remarkable successes were achieved in certain sectors, which resulted in a positive impact on SME development trends and contributed to the increase in the number of new enterprises.

During 2005-2014 the number of SMEs operating in all sectors increased more than

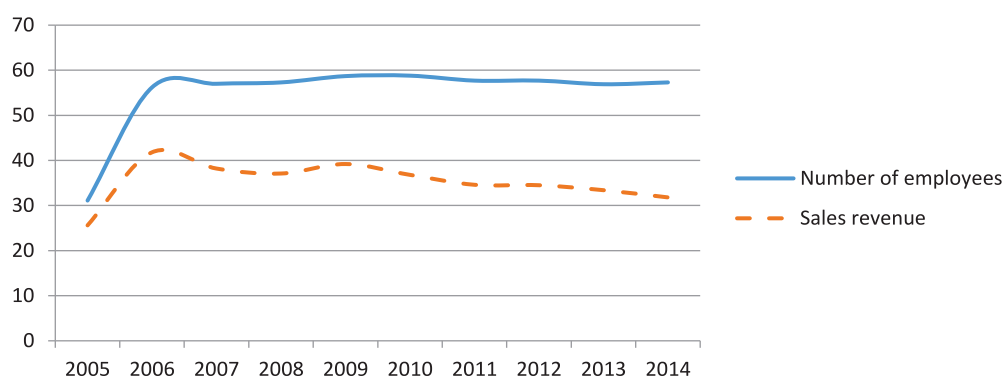
Table 1.1.2.

	1981-1990 (annual average)	1990	2000	2010	2014
Meat (weight after slaughter)	73	84	24	31	34
Milk and dairy products	326	346	158	166	148
Eggs (pcs.)	254	259	158	202	181
Cereals	599	581	532	680	822
Sunflower	61	53	74	107	154
Sugar beet	589	493	259	235	381
Vegetables	310	270	100	96	92
Fruits and berries	228	206	70	91	140
Grapes	294	215	193	135	168

Table 1.1.2. Production of the Main Agricultural Products per capita (kg per year)  
Source: NBS.

**Fig. 1.1.5.**  
Number of  
Employees and  
Sales Revenue of  
SME (share in the  
total economy, %)  
Source:  
Developed on the  
basis of statistical  
data for the  
respective years.

**Fig. 1.1.5.**



1.6 times. Over recent years, their share in the total number of enterprises has been stable over 97%. Also, during this period, the share of the number of employees increased from 31% to 57% and the sales revenue - from 26% to 32% (Fig. 1.1.5).

Although serious steps have been made to strengthen the small and medium business, it has not yet become the key element of the economic growth, the reduction of the unemployment and poverty. The overriding objectives, such as the rehabilitation of the infrastructure; export promotion; job creation and an attractive investment environment were not met. The number of deregistrated economic units increased, 3.9 thousand units were deregistrated in 2015 only, i.e. by over 40% more than in the previous year.

During the past ten years, the foreign trade had a more dynamic development than the overall economy. If in the last ten years (2005-2014), the GDP increased about 1.5 times, the exports increased 2.3 times and imports – 3 times. The results achieved in foreign trade could be more relevant, but the Republic of Moldova, during its independence years, faced major difficulties, most of them being external, such as the 1998-1999 Asian financial crisis when the financial markets of the Moldova’s main trading partners of the time

collapsed, followed by the global economic and financial crisis.

The development of the Moldovan foreign trade is manifested by greater imports than exports, thus increasing the trade balance deficit, which registered dangerous proportions, particularly since 2005. During 2011-2013 the trade balance deficit was 10 times greater than in 2000 (Fig. 1.1.6).

The analysis of the foreign trade development proves that the general increasing trend was maintained for both exports and imports until 2009, when a decrease was registered. As a result, exports and imports of goods in all directions decreased, in higher proportions towards CIS countries and, respectively, the share of these countries in the total trade shrunk. While in 2005 the share of exports to CIS countries amounted to 51%, then in 2014 - about 31% (incl. Russia - 32% and 18%) and the share of imports amounted respectively to 40% and 27% (incl. Russia - 17% and 14%). Imports and exports to EU and other countries developed inversely proportional (Fig. 1.1.7).

The development of foreign trade in the last years has seen some positive structural changes by groups of goods. The share of plant products increased, while the share of beverages, tobacco, etc. decreased.

**Current account.** The current account

Fig. 1.1.6.

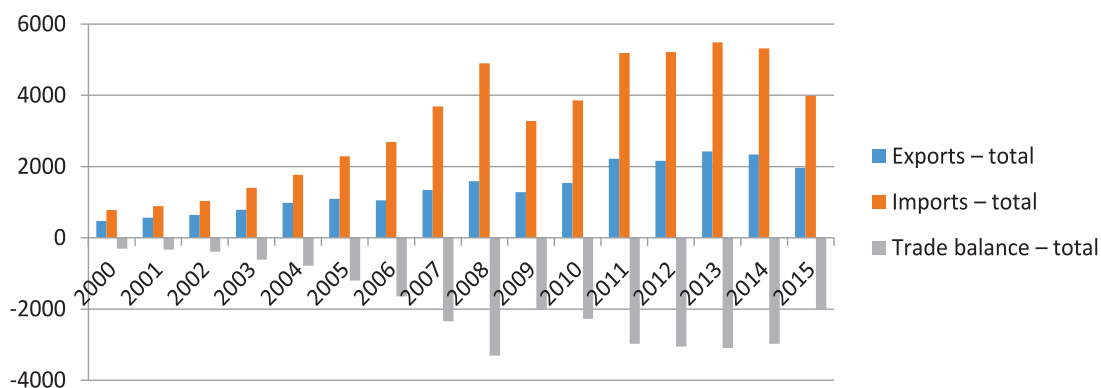


Fig. 1.1.6.  
Development of Foreign Trade of the Republic of Moldova during 2000-2015  
Source: NBS

deficit increased gradually from USD 28 million in 2001 to USD 226 million in 2005 and to USD 564 million in 2014, representing last year about 5.7% of the GDP. In 2013 it registered a downward trend, reaching 5% of GDP. The trend to contract the current account deficit did not last in 2014 due to the negative developments registered in the second half of the year, especially

The decreasing exports of goods, income earned abroad, mainly from the compensation of Moldovan residents work by non-residents and personal transfers and the decline in exports of services were the main contributors to the increase of the current account deficit.

Fig. 1.1.7.

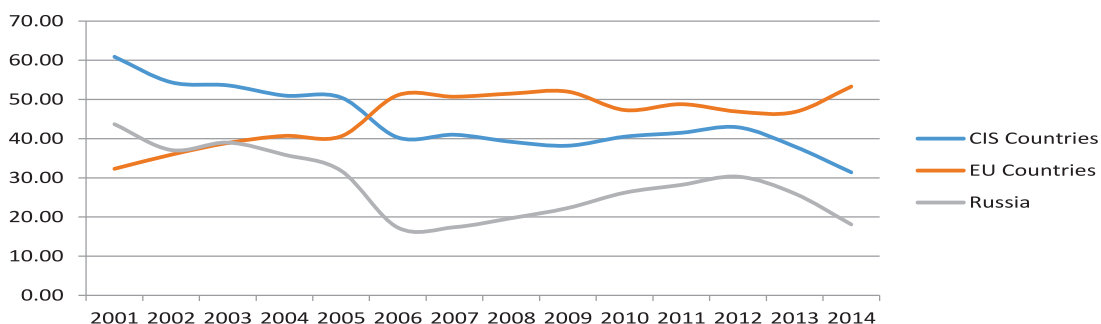


Fig. 1.1.7.  
Development of Exports of the Republic of Moldova to Groups of Countries and to Russia  
Source: Developed on the basis of statistical data for the respective years.

in the last quarter, which influenced the foreign currency inflows from exports and remittances..

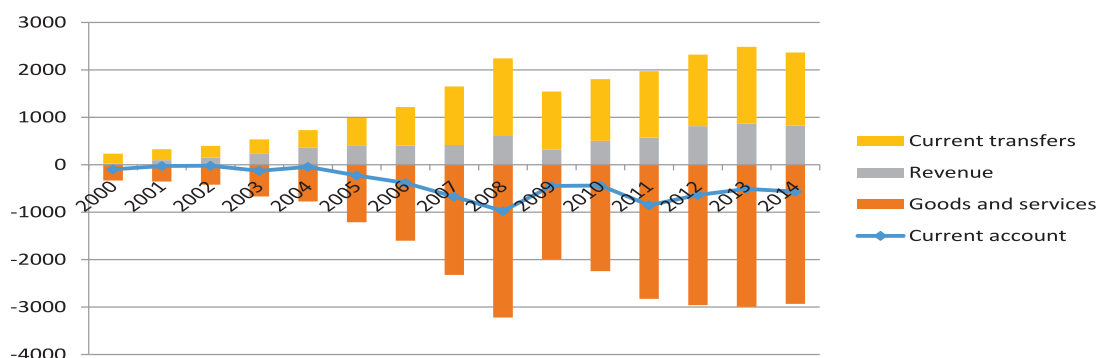
In the fourth quarter, the value of goods and services exports, revenue and current transfers made by non-residents in the Republic of Moldova declined, if compared to the same period of the last year. In general, in 2014 the current account deficit increased by 11.2% against the previous year or by USD 57 million after a contraction of 25.4% in 2013 compared to 2012 (Fig. 1.1.8).

contributing to the current account deficit, decreased in 2014 by 3.2% or by USD 175 million compared to the previous year, thus falling within the general trend of slow growth of the last two years. At the same time, the exports of goods decreased at a higher rate than imports due to the Russian embargoes and the difficult economic situation in Ukraine and the Russian Federation on the background of declining prices for agricultural products on the international markets.

The population "ageing" is a major issue for the Republic of Moldova, which has

**Fig. 1.1.8.**  
Dynamics of the Current Account of the Republic of Moldova, USD million, 2000-2014  
Source: Data of the National Bank of Moldova.

**Fig. 1.1.8.**



recently worsened. This issue intensifies the downward trend in the number of employees (taxpayers to the public budget) on the one hand, and increases the number of pensioners, on the other hand, which in future could become equal. This puts more evident and stronger pressures on the national budget (Fig.1.1.9).

The low level of economic activity is another serious issue, encountered by the Republic of Moldova. During the last 15 years, the number of economically active population decreased by over 400 thousand people, i.e. by almost a quarter. Currently, the economic activity rate (the ratio of economically active population to the population of 15 years and over) is 42.4% and is the lowest compared to other countries of the former USSR (Fig. 1.1.10).

In conclusion, during the transition to market economy the Republic of Moldova encountered major issues in

ensuring efficient and rapid economic transformations. Though reforms have been implemented for one quarter of a century, the country's economy failed to recover the losses from the recession years, which occurred mainly during the first 5 years of transition. The recession lasted too long, the losses were too high and the growth rates during the economic recovery were not sufficient to recover them. Currently, the country goes through a difficult period, having currently an economic potential of about 2/3 of the potential it had when the reforms started.

The Moldovan economy had grown at higher rates between 2001 and 2005. However, since 2006 the growth rates have declined, and in 2009, the country's economy, strongly affected by the global financial and economic crisis, for the first time since 2000 declined, with a decline in GDP by 6.0% compared to the previous year. After the 2009 decline, regressions

**Fig. 1.1.9.**  
Evolution of the Ratio of Employees to Pensioners, thousand persons  
Source:  
Developed on the basis of data of NBS

**Fig. 1.1.9.**

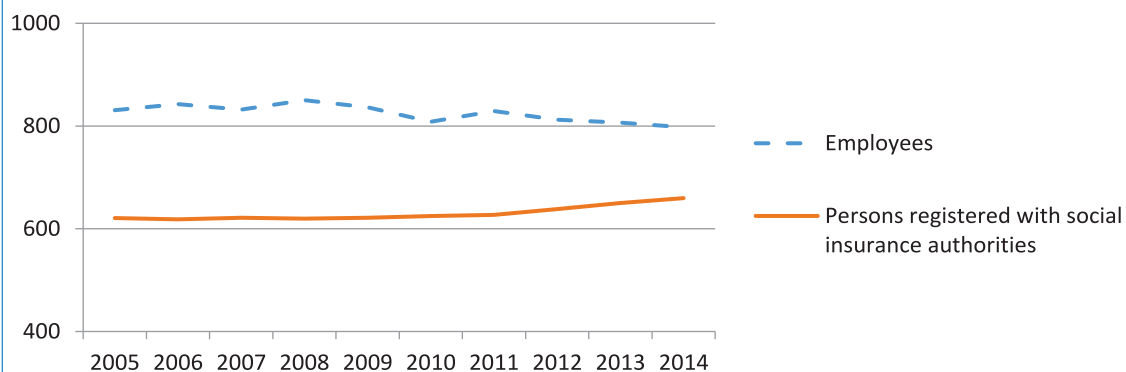




Fig. 1.1.10

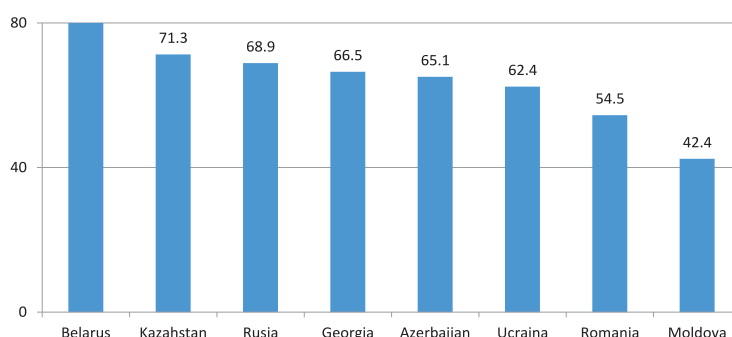


Fig. 1.1.10.

Economic Activity Rate in 2014

Source:

“Экономическое обозрение” of 29 April 2016, No 16

followed in 2012 and 2015 by 0.7% and 0.5% respectively.

The global financial and economic crisis, which coincided with the country's political crisis, further complicated the socio-economic situation. Although the country's new Government came with a well-developed and consistent anti-crisis program, its implementation was complicated by the political instability and unfavorable conjuncture on the external markets.

The World Bank experts, analyzing the situation of the Republic of Moldova (Economic Memorandum for Moldova), admit that about 40% of its workforce is abroad. This document states that “Moldova is the poorest country in Europe.. Income per head has been growing rapidly since 2000, but slower than the average for other Eastern European countries, and it remains well below the level Moldova had during Soviet times. Neither capital inflows, exports nor FDI drove Moldova's recent economic prosperity: rather it was laborers flowing out and sending back remittances. Moldova experienced jobless growth... The escape of migration has helped reduce poverty, but has completed a cycle of lower opportunity at home”.

The employment level shows the society's ability to create jobs and ensure a decent

life for its citizens. Unfortunately, since the beginning of the reforms, due to the lack of experience and the incorrect decisions taken by governors, often inspired by their own political ambitions and ideologies that were destructive and incompatible with the theories and practices already implemented during reforms, they have not produced satisfactory results, and moreover, this period could be regarded as stagnant.

The socio-economic situation of the Republic of Moldova has worsened significantly after the Parliamentary elections of November 2014, becoming gradually a great disappointment and indignation of the population, caused mainly by the disclosure of the theft of a huge amount of money from three large banks, qualified by the media sources as the “theft of the century”. In the following year (2015), the tense socio-political situation in the country pushed into the background the priority issues related to reforming the society by implementing the EU Association Agreement. In the turmoil of the political battles a number of Governments were appointed, and then had their vote of confidence withdrawn. The instability of the internal socio-political situation and the discontinuation of reforms resulted in the termination of the relations with international financial institutions and the loss of their support.

Along with the halting of structural and

institutional reforms, the distrust of businesses in authorities increased, the business activity was affected significantly, market and law enforcement institutions weakened and the inefficient state sector continued to degrade. In addition, the unfavorable weather conditions for agriculture also contributed to this situation. As a result, the first signs of entering into a new crisis phase were noticed as early as at the beginning of 2015, which intensified further and will have negative consequences both this year and in the future.

## 1.2. Social Context

The growth of human capital is linked to solving the problem related to social inequality, this indicator is included in the calculation of the 2010 Human Development Index. Human development opportunities (growth of labour productivity and therefore economic growth) are determined both by the individual income levels and the depth of inequality. Starting from a certain critical level, social inequality becomes an obstacle in the development of the human capital and hampers the economic growth<sup>2</sup>, with the lack of effective mechanisms to reduce the inequality leading to a significant increase in the revenue of the rich people and the impoverishment of the rest of the population<sup>3</sup>.

Currently, the income gap is one of the most acute social problems for the Republic

2 World Bank. Equity and Development: World Development Report 2006. – N.Y.: The World Bank and Oxford University Press, 2006.

3 A. Atkeson, R.E. Lucas Jr. On efficient distribution with private information. *Review of Economic Studies*, 1992, 59, No 3, 427-53; C. Phelan. On the long run implications of repeated moral hazard. *Journal of Economic Theory*, 1998, 79, No 2, 174-91; E. Farhi, I. Werning. Inequality, social discounting and estate taxation. NBER working paper No 11408, 2005, [www.nber.org/papers/w11408](http://www.nber.org/papers/w11408)

of Moldova, its causes are determined by several factors::

- low level of wages, especially in the agricultural sector;
- temporary employment and informal employment;
- insecurity of the individual earnings;
- real decrease in the amount of income following the devaluation of wages and social benefits.

Socio-demographic factors such as age, gender, health status, family and household composition had a significant impact on the income gap. The elderly, women, large families, people with health conditions have lower income, therefore they are more exposed to the risk of poverty. There also continues to be a significant difference by residence – villagers' disposable income being much lower than city residents'.

The poverty level in the Republic of Moldova reduced significantly in 2014, the absolute poverty rate decreased 2.6 times – from 30.2% to 11.4% compared to 2006. Thus, all objectives on poverty reduction set for 2015 (20%) were achieved ahead of schedule. Poverty incidence in relation to the international line of \$4.3 per day decreased from 34.5% in 2006 to 26.8% in 2010 to 14.2% in 2014, exceeding the final target by 8.8 percentage points), and the extreme poverty rate – 0.1% (4% is the target for 2015)<sup>4</sup>

The *poverty gap index* (difference between poverty threshold and poor people's consumption) is another indicator used to measure poverty. From 2006 to 2014, the

4 2014 Poverty Report Republic of Moldova. [http://www.mec.gov.md/sites/default/files/raport\\_privind\\_saracia\\_in\\_republica\\_moldova\\_2014.pdf](http://www.mec.gov.md/sites/default/files/raport_privind_saracia_in_republica_moldova_2014.pdf)

poverty gap index decreased continuously from 7.9% to 1.5%, thus the poverty gap decreased 5.3 times during this period.

The squared poverty gap index (inequality among poor people) characterizes the severity of poverty. In 2014, the squared poverty gap index decreased 10 times – from 3.0% to 0.3% compared to 2006 (Fig. 1.2.1).

The sociodemographic profile of the poverty is not very different from that of the last decade. Poverty incidence is higher than the national average among the rural population (16.4%), people with low level of education (21% for those with incomplete secondary education), people working in the agricultural sector (25.5 % for employees and 19.8% for the self-employed), pensioners (14.6%), people aged 60-64 and 65 and over (13.4 and 14.7% respectively), children (about 15%) and families with two or more children (13.7 and 27% respectively).

Remittances from abroad have an essential role in maintaining the well-being of the population. One in four households in the Republic of Moldova depends on remittances. The absolute poverty rate in the rural area would be twice higher (over 35%) should remittances not be sent, and 26,7% (2.3 higher) for the total population.

Pensioners are one of the most vulnerable categories of the population. It is noteworthy that poverty rates are higher for older people than for the young people only in Armenia and the Republic of Moldova out of the 26 countries with a relatively high elderly share in the population structure<sup>5</sup>.

In 2014, the minimum pension of the retirement-age workers in the agricultural sector amounted to MDL 710.72 and MDL 798.33 for other categories. The average monthly pension on 1 January 2015 was of MDL 1,087.6 (\$ 77.5 – at the exchange rate of the National Bank) and it has increased by 6.6% (in real terms – it has increased by 1.4%). However, the ratio between the average amount of pension and minimum standard of living is only of 80.9%.<sup>6</sup>

Poverty in the Republic of Moldova has a specific feature due to the fact the poor are well-educated – up to 80% of people in the poorest quintiles (first and second) have secondary education or specialized secondary education and the general literacy rate exceeds 90%. At the same time, the employment level is very low – in 2015, half of the men and women in poor quintiles

5 Golden Ageing. Prospects for healthy, active, and prosperous ageing in Europe and Central Asia. World Bank Group. 2015, p.220.

6 2014 Poverty Report Republic of Moldova. [http://www.mec.gov.md/sites/default/files/raport\\_privind\\_saracia\\_in\\_republica\\_moldova\\_2014.pdf](http://www.mec.gov.md/sites/default/files/raport_privind_saracia_in_republica_moldova_2014.pdf)

Fig. 1.2.1

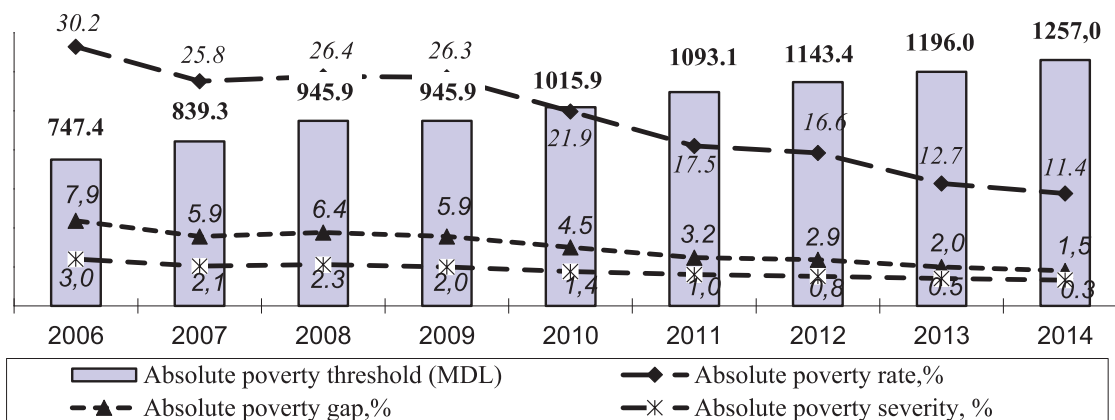


Fig. 1.2.1. Characteristic of absolute poverty indicators  
Source: NBS, Ministry of Economy

did not have a job in the last 12 months, and of those employed – the majority (e.g., 68% women) received smaller salaries (in agriculture, housework or unskilled manual labour), having to worry about job security and having a reduced capacity to make savings.

At the moment, child poverty is one of the most important social issues, the depth and severity of child poverty in the Republic of Moldova remain unacceptably high. In 2014, the level of poverty of households with children was of 12.7%, by 1.3 percentage point higher than the national average. Households with children are reported both in the group at the highest risk of poverty and in the category of those with the most modest income. The risk of poverty is increasing with the increasing number of children born in families, although it decreased substantially in the last decade. The highest level of poverty is registered among households with three or more children, the poverty rate in this category was of 27.1%, which is 2.9 times higher than that in households with one child (9.3%) and 2.7 times higher than in households without children (10.2%).

There is therefore an indissoluble link

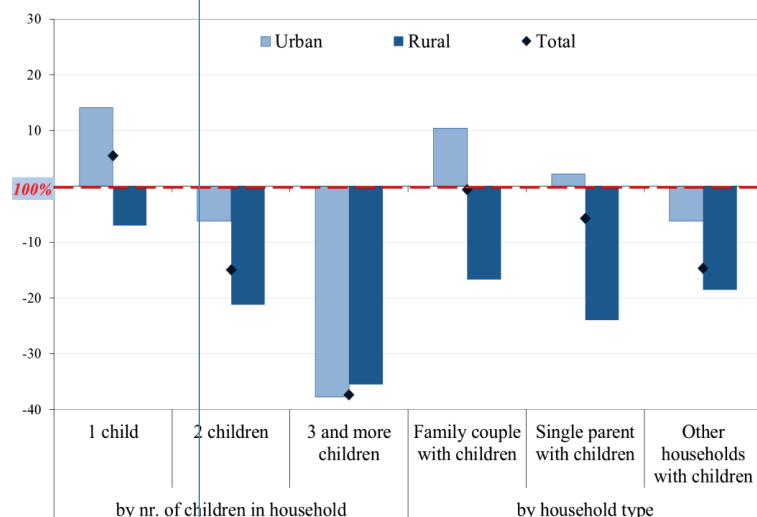
between children's well-being family well-being. Differences in income largely explain the differences in the non-financial prosperity of children. Income, consumption and living conditions of children vary significantly by a number of criteria, with a critical incidence depending on areas. The acute material shortage is highlighted in relation to the subsistence minimum, the number of children in the family being an important factor that determines the value of the deficit (Fig. 1.2.2). Rural families and large families experience the worst situation. Rural children have lower income (1.5 times lower) and lower consumptions (1.4 times lower) than those in urban areas, including for food, education and health.

It is worth mentioning that some households are poor for a long period of time. This phenomenon has adverse consequences on physical and mental health, emotional well-being, child development, school performance, crime levels, future earnings, etc. and cause the increase in poverty. Existing studies show that about 55% of households with three and more children were living in poverty for four years.<sup>7</sup> Children who grow up in poor families are exposed to a higher risk of becoming poor adults and the longer a child lives in poverty – the greater that likelihood<sup>8</sup>.

The income gap and poverty both reduce the welfare (providing a dwelling place, accessibility and enjoyment of certain services, etc.) and create impediments to handling risky situations that may occur during one's life (retirement, illness,

**Fig.1.2.2.**  
Deficit in the income of households with children in relation to the minimum subsistence level for children (%)  
Source: developed on the basis of NBS data, Databank; www.statistica.md

**Fig. 1.2.2**



<sup>7</sup> Rojco A. et al. Perfectionarea metodologiei și evaluarea nivelurilor de sărăcie și excluziune socială în contextul cerințelor UE (*Improving the methodology and assessing the levels of poverty and social exclusion in the context of UE requirements*). Chisinau, 2011, p.43.

<sup>8</sup> Vaalavuo M. *Poverty Dynamics in Europe: From What to Why*. Working Paper 03/2015.

periods of unemployment, etc).

The income gap is proven by the current level of income and the goods or income saved, the inequality for the last is higher. Although the last decade shows a relatively constant reduction trend of the Gini coefficient, from 0.3150 to 0.2579 or by 18.1% in 2006-2014, compared to European countries the Gini coefficient value (by the income available) is of 32.3%, by 1.3 percentage points higher than in the EU-28 (31.0%)<sup>9</sup>.

The gap reduction is proved by the distribution of the average consumption expenses per equivalent adult. The average consumption expenses of the 10% richest population in 2014 was 4.6 times higher than the expenses of the 10% poorest population, while in 2006 this difference was 7 times (Fig. 1.2.3).

A long-term vision of comprehensive development for the Republic of Moldova should be aimed at eradicating absolute poverty, increasing the well-being and social inclusion. Speaking about the prospective demographic dynamics, one of the question would be: Would these changes in the population structure cause

greater social inequality and poverty?.

The inequality and poverty risk are determined by a range of factors, including economic growth, globalization, technological changes, labor markets, social protection mechanisms and demography. Population ageing – associated with the increase in the number of social groups that are exposed the most to the risk of poverty (especially the elderly and lonely) – will be an important factor of this aspect in the coming decades.

Recent researches show that in European countries the age structure of the population and the age of the household head do not have a significant influence in increasing the income gap and that adequate pension systems ensure a decent life in old age<sup>10</sup>, although it is likely to increase the risk of poverty for older people under financial crisis and the complex modification of the structure of households<sup>11</sup>.

In the Republic of Moldova, the income gap and poverty are the most sensitive issues for the aging population, because older people are at higher risk of poverty and

9 2014 Poverty Report Republic of Moldova. [http://www.mec.gov.md/sites/default/files/raport\\_privind\\_saracia\\_in\\_republica\\_moldova\\_2014.pdf](http://www.mec.gov.md/sites/default/files/raport_privind_saracia_in_republica_moldova_2014.pdf)

10 Eurostat (2012b), Average household size (Source: SILC), [http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=ilc\\_lvph01&lang=en](http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=ilc_lvph01&lang=en)

11 Guerin B. *Demography & Inequality. How Europe's changing population will impact on income gap.* RAND Europe, 2013. 37 p.

Fig. 1.2.3

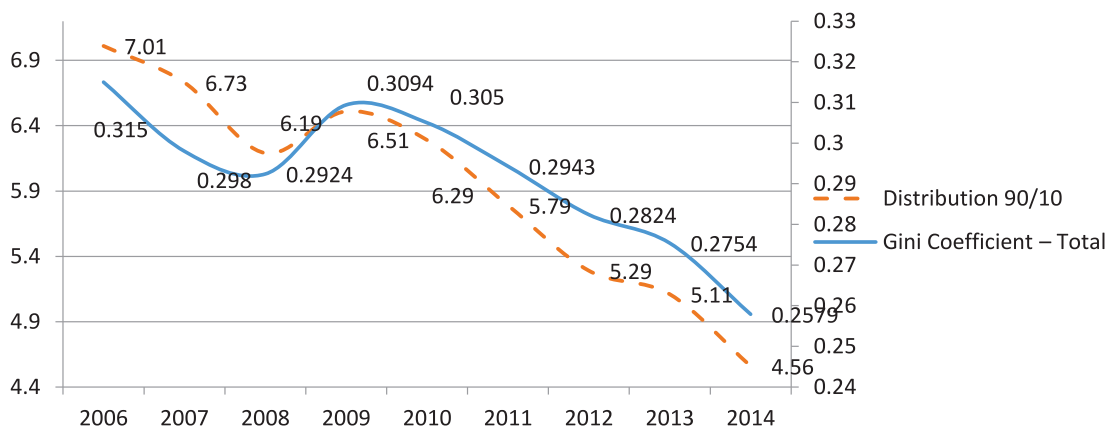


Fig. 1.2.3. Distribution of Consumption Expenses per capita  
Source: Ministry of Economy, NBS



the number and their share in the total population will continue to grow. Taking into account that the economic situation of the older people is determined by their past economic activity and the public transfers through pension systems, two important issues can be highlighted: first – the need to increase significantly the amount of the minimum wage<sup>12</sup> and improve the system of workers' social protection; the second issue is related to reforming the pension system and ensuring a decent living of the population after the retirement.

The current situation – the high share of the shadow economy and the reduction in the number of taxpayers – increases the risk of poverty for older people and endangers the long-term sustainability of the pension system. In the light of the above-mentioned, the achievement of the objectives of the “Moldova-2020” National Development Strategy that aims to reduce poverty level of more than 20% of citizens affected by poverty, largely depends on the sustainability of the social security system.

Other demographic changes, such as changing family structures and households (increasing number of non-marital partnerships, divorces and births outside marriage, increasing number of households consisting of one person, usually elderly) can cause great issues in terms of child upbringing and support for the elderly.

The joint impact of a higher life expectancy and education and the changing of households structure shows that future policy should take into account the

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12 According to the Minimum Wage Fixing Convention, the quantum of the minimum salary is established depending on the subsistence minimum and should be 2.5 times higher than the latter. C131. Minimum Wage Fixing Convention, 1970 (No 131). [http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100\\_INSTRUMENT\\_ID:312276](http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312276)

interactions between different demographic factors and their combined effect on the income gap in the coming decades.

It is to note that the economic growth does not automatically create opportunities to improve the living standards of the majority of the population, given that the premises and their improving conditions are determined both by the quantity and the structure of distribution of material goods. The socio-economic inequality is a systemic feature of the economic system. Thus, access to education and vocational training, health services, good housing, cultural values will be different, facilitating in some cases the development of the human potential and hampering in other cases the meeting of the basic needs, achievement of human working and creative capacities.

Currently, the income gap is not a priority of the national social policy. Focusing on absolute averages of living standards and their determination through economic growth and resource availability, social stratification is insufficiently addressed and income and asset gap are not included in the list of indicators to be monitored and regulated by the state.

The unequal distribution of income exposes economies to crises, makes the recovery process more difficult and hampers the achievement of the full potential. Recent studies<sup>13</sup> found that the governments that succeed in reducing the distance between rich and poor enjoy longer periods of economic growth. The positive practices of some countries and the European standards they reached reflect that the social inequality decrease and the welfare

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13 World Social Protection Report 2014/15 Building economic recovery, inclusive development and social justice. ILO, Geneva, 2014.



increase is possible, particularly through the special mechanisms of revenue regulation (special fees, taxes), through an effective social assistance system, public services supporting low-income groups.

### 1.3.Social Infrastructure: Need of an Adjustment to a New Demographic Structure

Demographic dynamics, on the one hand, has an impact on social infrastructure, while on the other hand, there is a vice versa situation: the social infrastructure development fosters the positive or negative demographic dynamics.

Keeping the existing infrastructure and public services will become more expensive due to the decreasing in total population and its concentration around the capital and several major centres of economic activity. Currently, Moldova's social infrastructure is characterized by an urban-rural imbalance which determines the inequality and presents a major challenge for the social development policy. Rural population is more disadvantaged in terms of access to public utilities and housing conditions due to the deficiency of social infrastructure and the insufficiency of the provided services: only a third of rural households have hot water, bath or shower, access to the natural gas network, most of them continuing to use mainly coal and wood stoves for heating<sup>14</sup>.

The nature of requests for public services will change once the needs of different age cohorts changes. At present, there are too

many tertiary education institutions which – as the number of students decreases because of smaller younger generations – won't be that highly sought. At the same time, lifelong learning will be necessary to provide people of working age, including those of pre-retirement age and the elderly opportunities to upgrade their professional skills and increase their capacity to adapt to the changing labour market.

Population ageing will require the adaptation of social and health services to the changes in types of diseases (increase of chronic diseases) and of patients. Making sure that the elderly can be active, healthy and independent for as long as possible is an objective that will need particular attention. The challenge is to develop effective strategies focused on prevention, including the improvement of nutrition quality, physical and intellectual activity, starting with young and middle-aged people's lifestyle.

It is particularly the increase in the number of people aged 75 and over that lays stress on the issue of health and care. This increase involves new demands on housing, movement opportunities and other public infrastructure. This population group needs many more healthcare services which are essentially different from those that the young and adult population needs.

The network of health care facilities is currently underdeveloped, particularly in rural areas (there are only medical offices providing a limited range of medical services), and the number of health professionals is insufficient. In 2015, as many as 86.1% of the primary healthcare sector were staffed with doctors<sup>15</sup>.

<sup>14</sup> 2014 Poverty Report Republic of Moldova. [http://www.mec.gov.md/sites/default/files/raport\\_privind\\_saracia\\_in\\_republica\\_moldova\\_2014.pdf](http://www.mec.gov.md/sites/default/files/raport_privind_saracia_in_republica_moldova_2014.pdf)

<sup>15</sup> [www.ms.gov.md](http://www.ms.gov.md)

It will be thus difficult for the health and long-term care system to guarantee the simultaneous achievement of three important objectives: access for all, regardless of income, high quality healthcare and financial sustainability of care systems.

Physical accessibility to social infrastructure for different categories of people, including those with disabilities, whose number tends to grow in the ageing population, and their home-based care are important. The national road condition may be an important impediment in achieving this objective. Currently, Moldovan roads are in a poor condition: about 54% of national roads are in poor condition and about 20% in bad condition<sup>16</sup>. Depopulation and ageing of Moldovan villages, the increasing the number of settlements with a small number of people, most of which are old, will be a challenge in ensuring their access to social services and infrastructure. The decrease in population density in rural areas will cause increased costs for the whole social infrastructure maintenance: electricity network, education system, cultural sites, fire and police services, healthcare and social assistance, etc., thus decreasing the accessibility of the socially vulnerable to these services.

Should the objective be to maintain the present networks of public infrastructure and services, then public investment will continue to be insufficient and the infrastructure will become more and more unbalanced: insufficient investments in the main centres of economic activity and too many investments elsewhere. The resulting poor quality will discourage private investments, hinder economic growth and

foster the people outflows. As a result, the model and the area covered by the public services will probably change.

It is obvious that the development of new approaches determined by the changes in the population structure and long-term demographic trends is needed to develop and ensure the access to social infrastructure. It is necessary to develop an optimal network of centres in districts/towns with complex social infrastructure and provide access to it through modern roads, both for the movement of population and in order to draw mobile services nearer to villages.

## 1.4 Political and Institutional Context

After gaining its independence following the collapse of the USSR in 1991, the Republic of Moldova experienced a three-dimensional transition – from an authoritarian political system toward a democratic-values-based-political system; from a republic in the former USSR composition toward sovereignty and independence; from a centralized and non-market economy to a market economy. Externally, our country committed to engage and adjust to the intense processes of globalization, European integration and transition to an information society.

This transition was not easy, the economic difficulties encountered in the early years of transition were exacerbated by the 1992 Transnistrian conflict and therefore the territorial disintegration of the Republic of Moldova, which caused a tension and splitting of the society, lead to substantial economic loss. The failure to solve the Transnistrian conflict continues to be one of the determinants of political instability

<sup>16</sup> Transport and Logistics Strategy for 2013-2022, GD of RM No 827 of 28 October 2013

which hinders the country's sustainable economic development.

Since December 1991 the Republic of Moldova is a CIS member state (Commonwealth of Independent States). No joint project was implemented so far among CIS countries that would have had a positive impact. The expectations of the Moldovan leadership with regards to the settlement of the Transnistrian conflict through the internal mechanisms of the CIS didn't materialise either.

Eight political governments came in power during the 25 years of independence of the Republic of Moldova: agrarian-frontist government (1990-1994); the agrarian-socialist government (1994-1998); the center-right Alliance for Democracy and Reforms government (1998-1999); the Dumitru Braghis transitional government (2000-2001); the communist (restoration) government (2001-2009); the center-right Alliance for European Integration governments (2009-present) – AIE1, AIE2 and AIE3. They oscillated between East and West, drew away from the democratic values by corrupting the electorate, emphasizing thus the lack of high political culture and the immaturity of the political class.

In 2009 the pro-European forces came to power and managed, thanks to the favourable international context and the events of 7 April 2009, to promote an active foreign policy, demonstrate firmness in the chosen direction, which contributed to the inclusion of the Republic of Moldova in the EU Neighbourhood Policy alongside countries like Armenia, Azerbaijan, Belarus, Georgia and Ukraine. The democratic reforms initiated by the Alliance in the Republic of Moldova allowed for major

European projects to be launched in their support. The signing in 2014 of the EU-Moldova Association Agreement, which created a framework for cooperation in areas such as trade, security policy and culture, and liberalized the visa regime for the country's citizens, was one of the major achievements.

Despite some successes, at present, the political and institutional environment of the Republic of Moldova is characterized by instability and lack of progress in the structural and systemic reforms carried out through the implementation of the European Union Association Agreement, which is also true for other reforms meant to ensure the social, political, institutional and legal modernization.

The Worldwide Governance Indicator (available for 2004-2014) shows government's successes, reversals and failures. Although the governance underwent some changes proclaimed by most political parties – the main indicators characterizing the quality of the governance are changing very slowly and do not lead to the achievement of irreversible values. Taking into account the indicators' confidence intervals there are insignificant changes/differences. At the same time, there is high political instability that manifests through citizens' perceptions that there is the possibility for the government to be destabilized and overthrown by unconstitutional means, including by violence and terrorism (42% for 2014). The level of control over corruption is an eloquent indicator of the political situation, being very low (21% for 2014) and a scourge that undermines the promotion of democratic reforms and sustainable socio-economic development (*Fig. 1.4.1*).

The confidence in institutions is part of the “social capital” and its high level has positive effects on the country’s socio-economic development. This confidence makes people get involved much more in public life, being significantly influenced by institutions’ representatives, their expressed professionalism, behaviour and opinions.

The economic deterioration, political instability alongside the inefficient operation of institutions responsible for the financial security of the country in recent years have contributed to the dramatic decrease in citizens’ confidence in the main state institutions: Parliament, President, Government, political parties, justice, etc. (Fig. 1.4.2). The uncertainty manifested in recent period in the banking system also essentially decreased people’s confidence in the banking system. The confidence in trade unions, non-governmental organizations and mass-media also decreased.

The establishment and strengthening of the Republic of Moldova as a democratic state requires the actual separation of powers

in the state as a prerequisite for building the rule of law and making it work. In 1994 the adoption of the RM Constitution and of other regulatory acts legitimized this separation of powers. Ensuring the rule of law, inalienability of human rights and fundamental freedoms, protection of individual rights and interests are the cornerstones of the rule of law, which grants the safety of a country’s population.

The Republic of Moldova is facing the following difficulties in achieving these objectives: outdated legal and political thinking; lack of experience and tradition in the legal field; still developing democratic institutions and state bodies; issuance of judgments on political command, and corruption that has deeply infiltrated the national legal system. All these have contributed to the creation of a negative image of the RM justice, which is also confirmed by the little confidence people have in its institutions (45% in 2004 and 20% in 2014).

Instead of contributing decisively to the development of the civil society and to

Fig. 1.4.1

Indicator	Year	Value, %	Definition
Voice and Accountability	2004	31	Citizens' perceptions about the degree of participation in selecting their government, freedom of expression, association and independence of the media.
	2009	37	
	2014	49	
Political Stability and Absence of Violence/Terrorism	2004	37	Citizens' perceptions about the possibility for the government to be destabilized and overthrown by unconstitutional means, including by violence and terrorism.
	2009	26	
	2014	42	
Governance Efficiency	2004	16	Citizens' perceptions about the quality of public services, their independence from political pressure, quality of policy formulation and implementation, and the accountability of the government towards them.
	2009	37	
	2014	40	
Regulatory Quality	2004	37	Citizens' perceptions about the government's ability to formulate and implement effective policies and regulations for the private sector development.
	2009	49	
	2014	54	
Rule of Law	2004	42	Citizens' perceptions about the degree of trust in the police, courts and legal compliance: quality of execution of decisions, the right to property and the risk of crime and violence.
	2009	40	
	2014	47	
Corruption Control	2004	15	Citizens' perceptions about the degree of corruption control.
	2009	28	
	2014	21	

Fig. 1.4.1. Worldwide Governance Indicator for the Republic of Moldova for 2004, 2009, 2014  
Source: <http://info.worldbank.org/governance>

Fig. 1.4.2

	2004	2009	2015
<b>Parliament</b>	58.5	49.6	87.4
<b>President</b>	43.8	44.5	86.5
<b>Government</b>	54.7	46.6	85.5
<b>Political Parties</b>	60.9	58.7	87.3
<b>LPAs</b>	44.3	37.8	55.1
<b>Army</b>	41.7	32.6	50.4
<b>Justice</b>	55.1	51	80.6
<b>Police</b>	64.8	54.4	66.5
<b>Banks</b>	49.4	44.4	74
<b>Trade Unions</b>	46.4	36.9	60.6
<b>NGOs</b>	39.8	31.2	49.9
<b>Media</b>	36.1	29.3	50.6

**Fig. 1.4.2.**  
Level of confidence of the Republic of Moldova population in public institutions (share of respondents who have some distrust or full distrust of public institutions), %  
Source: POB – 2004, 2009, 2015

the censorship of various politicians' or political parties' authoritarian aspirations, Moldovan mass-media placed, over the past decade, often artificially, "national interest" topics on the public agenda, without any connection to people's hardships and the priorities imposed by the social reality.

Libertatea presei nu se reduce doar la independența ei în relația cu puterea publică, dar este necesar să includă și libertatea profesională față de grupurile de interese private. Apariția monopolurilor mediatică în Republica Moldova creează premisele reducerii numărului de opțiuni la dispoziția cetățeanului și posibilitatea manipulării sale în mod subtil. Din aceste considerente, calitatea produsului media scade, iar pericolul dezorientării cetățeanului crește și aceasta înseamnă reducerea calității democrației. În acest context, are loc scăderea încrederii cetățenilor în instituțiile media.

The freedom of the media is not limited only to its independence in relations with the public power, but it should also include the professional freedom toward private interest groups. Because of the formation of media monopolies in the Republic of Moldova the number of options that citizens can choose from decreases and this also

makes it possible to subtly manipulate the population. Therefore the media product quality decreases, while the danger of citizen disorientation increases, both leading to a lower quality democracy. This is when the citizens start trusting media institutions less.

Administrative and Territorial Fragmentation. The current administrative and territorial organization of the Republic of Moldova is one that is typical of those states that lack a self-management practice and often this kind of organization is not based on needs, but is a consequence of geopolitical changes or of the domestic political processes. This territorial changes took place when in 1994 ATU Gagauzia was created, in 1998 Transnistria broke away, in 1999 ten counties were established, but in 2003 the former system of districts (33) was re-established.

Thus, there is a pressing need to conduct an administrative and territorial reform considering the new priorities, needs, requirements and available resources, that would be dictated by the economic logic, demographic situation and geographical regionalization principles.

*Citizenship.* The Republic of Moldova



adjusted its legal framework on citizenship, given the current geopolitical context and some strategic interests. The amendments to the law only legalized the process of obtaining dual or multiple citizenships which was already very intense due to the migration flows, especially in the case of Romanian citizenship requests (around 1 mln requests according to official data). The European citizenship through Romania grants the right to free movement, the right to travel, stay, work and study in all EU Member States.

*Population's mobility* thanks to several citizenships is a positive factor for the country's economic development and a negative one for the long-term demographic situation.

*Political Culture.* The political culture of various social groups depends on how their members perceive the political system, on their political passions and ambitions, on their political experience, on their ability to appreciate political phenomena and events, etc.

The political culture in the Republic of Moldova has a rudimentary and fragmentary nature arising from the existence of groups with opposing political orientations, forming conflicting isolated subcultures (ethno-linguistic, socio-economic, regional). The distrust in different social structures that reflect the lack or the weakness of democratic conflict solving procedures makes population prone to settle their issues independently.

The slow and sinuous transition to a parliamentary democratic regime over the last decade placed the Republic of Moldova on the last places among the former Soviet countries of Central and Southeastern Europe with delayed democracies. Social

inequalities, aggressive corruption that infiltrated all social levels, a state with politicized and inefficient institutions and a self-interested, manipulated and decadent political and intellectual quasi-elite thrived exponentially during the transition period.

The current political uncertainty in the Republic of Moldova is a major impediment to continuing democratic reforms, promoting sustainable socio-economic policies combined with demographic changes, the ultimate purpose of which is to establish the rule of law and well-being – creating thus a place where human rights and freedoms are observed, with decent living and working conditions worthy of competing with those in developed countries.

## 1.5. Cultural Context

The socio-cultural context of the Republic of Moldova determines the demographic developments, pinpointing the behavioural specifics of the population, which is why the demographic policy should be correlated at all times with the socio-cultural changes and developments.

The native population of the Republic of Moldova consists of Moldovans – about 75,8% and 2,2% proclaim themselves as Romanians. The main ethnic minorities include Ukrainians (8.4%), Russians (5.9%), Gagauzians (4,4%) and Bulgarians (1,9%). Other ethnic groups constitute about 1.4% of the population.<sup>17</sup> It is worth-mentioning that Moldovans, Gagauzians and Bulgarians live mostly in villages, whereas the Russians, Romanians and Ukrainians – in cities.

The gap between the education level of

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<sup>17</sup> According to the 2004 Republic of Moldova Population Census.



rural and urban population persists. In urban areas people with higher and general education (secondary and compulsory) represent 93.9% of all persons aged 15 years and over while in rural areas only 81.7% had this level of education.

The vast majority of the population (93.3%) says it is orthodox, this being an important factor for the social cohesion and integration.

According to its distribution, the population of the Republic of Moldova characterized by a high ruralization level, continuing to be the country with the lowest degree of urbanization in Europe. The data of the National Bureau of Statistics show that in early 2016 only 42.5% of the population lived in urban areas and 57.5% – in rural areas. About 49% of the urban population lives in the capital and should Balti be taken into consideration too, then about 59% of the urban population lives in these two cities.

According to the World Value Survey (WVS, 2006), the Republic of Moldova is a country transitioning from the domination of traditional values to the domination of secular-rational ones<sup>18</sup>, the values related to physical and economic survival having a higher priority than democracy, freedom of choice and autonomy. This is a normal phenomenon because as long as physical survival remains uncertain (only 19.8% of the population believe that they are very satisfied, and happy with the way they live<sup>19</sup>), the willingness to be physically and economically safe tends to be more important than democratic values. The utilitarian and pragmatic approach to

whatever happens is obvious. Given the slow change in the socio-cultural context and the moderate progress in country's socio-economic development, we can state that this specific feature of the cultural context is still typical of the present period.

Although the family remains a top value of the population, there is a pluralism of views on family life organization that shows as a modern, flexible and liberal attitude towards living together without registering the marriage, sex before marriage and childbirth outside marriage.<sup>20</sup>

82% of the population do not see marriage as an outmoded institution (WVS, 2006). Overall, people realize that the family is the institution which fulfills important social functions, such as reproductive, social, family solidarity functions. In addition, cultural traditions, customs and prejudices play a key role in regulating the marital life and the society still demands and appreciates the state of being married.

The attitudes and gender roles are an important component of the attitudinal and value orientations that determine the population's behaviour. In this regard, the cultural context of the Republic of Moldova is characterized by the prevalence of patriarchal traditional rules. This situation can be characterized as a "oscillation between traditionalism and modernism".

Perceptions that the roles of men in society are mainly linked to professional self-fulfilment and those of women – to families and children, are widely spread. The contemporary stereotypes of husband and wife do not follow a particular pattern

18 World Value Survey. <http://www.worldvaluessurvey.org/WVSContents.jsp>

19 [http://ipp.md/public/files/Barometru/BOP\\_04.2016\\_prima\\_parte\\_finale-r.pdf](http://ipp.md/public/files/Barometru/BOP_04.2016_prima_parte_finale-r.pdf)

20 Gagauz O. *Family from traditional and modern*. Chisinau, 2011, p.119; Bulgaru M., Chistruga I. *Young family: aspects on adjustment to the changing society*. Chisinau: CEP, USM, 2015. p. 190.

and are contradictory, being characterized by a mix of traditional and egalitarian perceptions. Nonetheless, one can see a clear advancement in making the requirements towards husband and wife equal. Their images are less differentiated than in the patriarchal system.

Women's experiences reflect the gender contract which prescribes specific roles and duties for women and men. We can see that there is a two-sided conflict in this context. On the one hand, men recognize women's rights and abilities to self-realization, including in their families, but, on the other hand, they do not want to take upon themselves some roles in attending to the needs of family members, nor in bringing children up, which are traditionally believed to be the prerogative of women. Thus, gender relations within families did not change essentially, which makes gender equity in the public and private life inconsistent<sup>21</sup>.

Low fertility levels in European countries explain that this phenomenon is not an inevitable consequence of changes in female roles in the public life, but rather the result of their retention in the family life. Women obtained equal education and labour opportunities without obtaining equal rights and obligations in families. They continue to fulfill all or almost all of the household responsibilities (childcare and housework), which limits their opportunities to participate in the public life, as compared to men. Given these circumstances, fertility reduction is an option in the individual strategies of women for professional or social self-fulfillment. In this way they can minimize the negative effects of the lack of

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21 Gagauz O. *Changes in gender contracts in the society in transition*. In the Journal "Philosophy, Sociology and Political Science", Chisinau, 2012, No 2, p. 133-142.

equality between men and women in the private life. This judgement suggests that an increased involvement of men in the performance of household responsibilities as women do can help increase fertility rates. For these reasons, experts support the view that gender roles transformation, namely in the private life, should go hand in hand with a public policy that would facilitate the reconciliation of the paid work and household responsibilities both for women and men, to ensure fertility at the level of generations replacement<sup>22</sup>.

Social values determine the way in which families are formed and organized. The desirable population value system concerning family and marriage has major implications both on macro-social level – which largely influences the dynamics of nuptiality and other demographic behaviours – and on micro-social level – the values representing parts of the psychosocial behaviour that guides one's day-to-day behaviour and builds some capacities of family and social adaptability.

## 1.6. Social Expenditure on Health and Education

Several studies developed by WHO<sup>23</sup> found that the changing health status of the population between countries and among different categories of the population are identified as health inequalities, with 25% to 75% of these inequalities being the result of social factors that are susceptible to social, economic and health failures, rather

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22 Olah L. *Should governments in Europe be more aggressive in pushing for gender equality to raise fertility? The second „YES” [Ar trebui guvernele din Europa să fie mai agresive în promovarea egalității de gen pentru a crește fertilitatea? Al doilea „DA”]* în: Demographic Research, 2011, Vol. 24, p.217-224.

23 The European health report 2012 : charting the way to well-being. WHO, 2013.

than to physical health factors.

Health services accessibility and healthcare quality are strong social problems in the Republic of Moldova. The paradox is that, on the one hand, health status indicators do not place the country on a good position compared to other countries while, on the other hand, the total and public health-related expenditures are relatively high and above the average of European countries (8.9% of GDP) and EU (10.2%).

However, health expenditures expressed in absolute values are very low compared to these states. The under-financing of the healthcare system is obvious, the Republic of Moldova ranking on the lower positions among European countries (with an average difference of 4.3 or lower) in terms of the lowest total health expenditure per person (USD 553 in PPP). Among the reference countries, Lithuania and Latvia are the most close to the average amount allocated per capita in terms of health-related expenditure in EU countries. Therefore, unlike the compared countries, the Republic of Moldova deals with severe deficiencies in terms of allocated material resources, impacting directly the availability of equipment, medicines and, especially, doctors' decent remuneration.

Given the low level of living standards, international statistics show that the high share of out-of-pocket expenditure for healthcare in the Republic of Moldova accounts for about 45% of the total health expenditure. These informal payments are almost 4 times higher than in Europe and European Union, and in most reference countries, except for Georgia, where such expenditures account for 62% of the overall health spending.

Obviously, healthcare system financing from budget appropriations is correlated with the country's economic situation. By 2009, the share of public spending for healthcare decreased from 6.4% to 5.3% of GDP in 2014. However, the salary contribution of the population for the compulsory health insurance continued to grow in the last three years (from 3.5% paid both by the employee and employer in 2013 to 4.5% in 2015).

Although the introduction of the compulsory health insurance system (since 2004) enhanced the financing of the healthcare system, the quality and accessibility of services remained sporadic and ineffective. Actually, the citizens of the Republic of Moldova have unequal access to the system's resources, with significant differences by residence to the detriment of rural population, persons with low income being the most disadvantaged. Meanwhile, the cost for health insurance policy increased significantly (from MDL 441 in 2004 to MDL 4860 being planned for 2015), and almost a quarter of the population remains outside the compulsory health insurance, the main reason being unemployment, informal employment and the impossibility to pay personally for the cost of insurance policy. NBS surveys<sup>24</sup> show that most of the people who do not have compulsory health insurance (over a quarter) have low income (first quintile group), while in rural areas every third person is in such a situation.

At the same time, the country's population has a low level of education on health maintenance and care due to living conditions and social deprivation, along with a healthcare system insufficiently oriented toward the avoidance and prevention of diseases. Moreover, relevant international

<sup>24</sup> Household Budget Survey. NBS, 2012-2014.

**Table 1.6.1.**  
Healthcare Expenditures, compared to 2013  
Source: World Development Index, World Bank.

**Table 1.6.1**

	Healthcare expenditure			
	Total (% of GDP)	Public (% of GDP)	Total expenses per capita (in int. PPP \$)	Out of pocket, % in total
Lithuania	6,7	4,1	1579	32,6
Latvia	5,9	2,6	1310	36,5
Serbia	10,6	6,3	987	37,9
Romania	5,6	4,2	988	19,7
Georgia	9,2	1,6	697	61,9
Ucraina	7,5	3,8	687	42,8
<b>Republic of Moldova</b>	<b>11,8</b>	<b>5,2</b>	<b>553</b>	<b>44,6</b>
Europe	8,9	5,7	2402	19,7
EU-28	10,2	7,8	3260	13,6

studies<sup>25</sup> show that employed people who also have higher education – besides their higher economic resources they can use for healthcare – have easier access to health

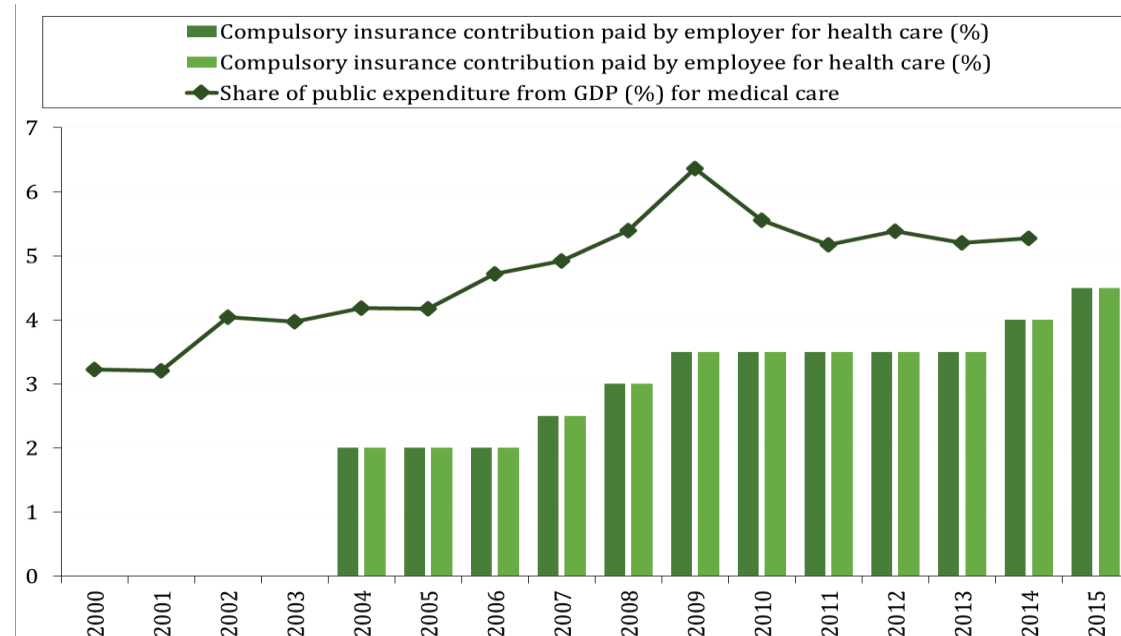
services and information, and they are also more concerned about adopting healthy lifestyles.

The income is another key factor influencing health-related expenditure. The relationship between health-related revenue and expenditure can be seen both

25 Alber, J., Köhler, U., *Health and care in an enlarged Europe*, Luxembourg, Office for Official Publications of the European Commission, 2004; *Communicating the economics of social determinants of health and health inequalities*. WHO, 2013.

**Fig. 1.6.1.**  
Share of expenditure in GDP and salary contributions made by the population of the Republic of Moldova for healthcare, 2000-2015  
Source: Ministry of Finance annual reports; Statistical data bank of NBS, www.statistica.md; NSIH

**Fig. 1.6.1**



at individual level and at the national one. At individual level, health-related expenditure is determined by the extent to which health insurance covers the health services. If the health insurance fully or largely covers a person's expenditure, the demand for healthcare does not depend on the decrease/increase of the individual income. If the health insurance only partially covers a person's expenditure, one can see the change in terms of income and demand.

Another important area for the development of human capital and insurance the country's competitiveness refers to education. The primary indicator of education is literacy of the population. In Republic of Moldova, adult literacy rate is 99% and for young people aged 15-25 years - 100%.

Even, at present, budgetary expenditures on education represents more than 8% of GDP (which exceeds the average of 5% recorded for Europe countries, Central Asia, as well as EU countries), however the average expenditure per person is 14 times lower than average of OECD countries and EU countries<sup>26</sup>. In the last decade, the impact on the quality of education was minimal and the performance of the education system in Moldova is much lower than in other countries. This substantially affects educational performance tests measured by the PISA (Programme for International Student Assessment)<sup>27</sup>. In the EU-27, average performance in science in 2009<sup>28</sup> was 501.3. The score obtained by students in Moldova is just 393 points, lower than, those of Bulgaria (439) and Romania

26 OECD Indicators. Available: <http://data.worldbank.org>

27 PISA test aims to highlight what students can do with their knowledge, being organized every 3 years for respondents aged 15 years in three main areas - reading, mathematics and science. Actual results are reported from an average score of 500 and is delimited by 6 levels of competence.

28 The Republic of Moldova participated in PISA only in 2009.

(428). This shows lower performance than European average, the performance gap between Moldova and its neighbours, including CIS, is estimated at two years of schooling<sup>29</sup>.

There are several insufficient investments in education costs. Recent researches show that European countries that invest more in human capital growth, including education, have higher performance in reducing the negative effects of demographic aging<sup>30</sup>. A well-educated and healthy population, is characterized by a higher level of labour productivity and longer duration of economic activity period.

Republic of Moldova should done smart investments in different levels of education, to achieve results comparable to EU countries. Investments in primary and secondary education should aim at reducing disparities in terms of frequency and school results, which can lead to economic growth

Investments in upper secondary education, in addition to their economic efficiency, would help improve technical and vocational education, having a positive impact on industrial development of Republic of Moldova. The experience of similar countries suggests that tertiary education provides the highest return on investment. However, the challenges faced by Moldova, early leaving of educational system, should be considered, when are given allocation of funds by level of education. Investment in tertiary education can generate economic growth, but can not reduce social disparities since, in general, people at risk of exclusion find it difficult to graduate from secondary school.

### The development of human capital through

29 Each 40 points are equivalent with 1 year of schooling

30 Population Trends and Policies in the UNECE Region. Outcomes, Policies and Possibilities. 2013, 79 p.



consistent investments in education and health will generate numerous benefits, such as improving health, labour productivity growth, reducing poverty, decreasing crime and dependency on welfare benefits.

## 1.7. The Progress Made in Implementing International Agreements (ICPD, MIPAA)

The Republic of Moldova signed various programs and strategies focused on general socio-demographic issues, but also on the needs of some specific categories of

population like, for example, the elderly, the young, and others. One of the key programs the Republic of Moldova acceded to in 1994 alongside 179 other countries, is the Programme of Action of the International Conference on Population and Development in Cairo (PA ICPD). By joining this program, the Republic of Moldova assumed the responsibility to observe human rights and promote gender equality, guarantee decent living standards and reduce poverty, ensure universal access to reproductive health information and services and to a favourable environment for childbirth, increase life expectancy and ensure quality health services. Another key document that the Republic of Moldova aligned to in 2002

Table 1.7.1

Table 1.7.1.  
Development and Implementation of National Strategies and Programs

Name of the program/strategy	Focus on MIPAA or PA ICPD	Implementation period
National Reproductive Health Strategy	PA CIPD	2006-2015
National Programme on Prevention and Control of HIV/AIDS and STI	PA CIPD	2011-2015
National Health Policy	PA CIPD	2007-2021
Programme on Mainstreaming Ageing Issues in Policies	MIPAA	2014-2016
National Youth Strategy	PA CIPD	2009-2013
National Healthy Lifestyle Program	PA CIPD, MIPAA	2007-2015
Child and Family Protection Strategy	PA CIPD	2013-2020
National Program for the Development of an Integrated System of Social Services	PA CIPD, MIPAA	2008-2012
Road map for mainstreaming ageing	MIPAA	
Action Plan and Strategy on Social Inclusion of People with Disabilities	PA CIPD	2010-2013
Moldova Social Inclusion Program	PA CIPD	2008-2013
National Gender Equality Program	PA CIPD	2010-2015
“Education for All” National Strategy	PA CIPD	2003-2015
“Moldova 2020” National Development Strategy	PA CIPD, MIPAA	2012-2020
National Strategic Programme on Demographic Security of the Republic of Moldova	PA CIPD, MIPAA	2011-2025
National Employment Policy Strategy	PA CIPD, MIPAA	2007-2015



is the Regional Implementation Strategy (RIS) of the Madrid International Plan of Action on Ageing (MIPAA), confirming thus its commitment to solve the problems of the elderly and to strengthen the dialogue, the partnerships and the planning process for improving the elderly's quality of life.

The implementation of these programs and strategies began with the completion of the legislative and regulatory framework. Thus, various strategies, policies and programs which meet the measures from each section of PA ICPD and MIPAA were developed. An important progress is the existence of the institutional framework – of public governmental and/or non-governmental– structures responsible for the implementation of measures of PA ICPD and MIPAA (Table 1.7.1).

It is important to mention that during this period, some important practical progresses were achieved. Nonetheless, the development indicators of the country are among the lowest in the Europe. Hereinafter, we will mainly focus on the achievements of the Republic of Moldova in the areas of health, reproductive health and gender equality (Table 1.7.2).

The achievements of the Republic of Moldova are still quite relative and the development indicators of the country are among the lowest in the Europe. Remarkable successes were achieved only for the indicator of the rate of mother-to-child transmission of HIV, which shows that important successes were achieved in the area of testing and treating HIV in pregnant women. This indicator is

Table 1.7.2

Objective	Indicator	Baseline year	Indicator value	Comparing year	Value indicator
Sănătatea reproductivă	Rate of mother-to-child transmission of HIV	2005	17,91%	2014	1,76%
	Modern contraceptive prevalence rate among married women, 15-49 years	2005	44%	2012	59,5%
	Fertility rate in adolescents, 15-19 years	2004	29,24‰	2014	26,73‰
Sănătatea	Life expectancy at birth, women	2000	71,4 ani	2014	75,4 ani
	Infant mortality rate	2004	12,2‰	2014	9,7‰
	Under-five mortality rate	2004	15,3‰	2014	11,7‰
	Maternal mortality rate	2004	23.5 per 100 thousand live births	2014	15.5 per 100 thousand live births
Egalitatea de gen	Share of female legislators, officials and managers	2006	40%	2015	43%
	Share of female professional workers and technical staff	2006	66%	2015	65%
	Share of women parliamentarians	2006	22%	2015	22%
	Share of women in ministerial positions	2006	11%	2015	28%

Table 1.7.2.  
ICPD Objectives

close to the objective set in PA ICPD.

The modern contraceptive prevalence rate in married women of 15-49 years is quite low, and far away from the desired objective. The fertility rate in adolescents is quite high, which determines the major disadvantages in teenage girls' development.

Infant mortality in the Republic of Moldova reduced but this reduction was quite small. Since 2008, the Republic of Moldova started implementing the European standards of statistical monitoring of newborns with birth weight from 500 g, which determined an increase in infant mortality rate. The under five mortality is also quite high, having experienced an insignificant reduction during the last decade. The situation of maternal mortality is similar.

Likewise, gender equality was not one of the most successful areas, the main indicators either staying at same level or registering some insignificant growths.

Thus, even if the regulatory framework is very complex and corresponds to the Constitution of the Republic of Moldova and to the ratified international treaties, its implementation registers successes. It is necessary not only to accelerate the implementation of this framework but also to develop some implementation monitoring tools. The Republic of Moldova should particularly invest efforts into improving women's and children's health, as well as into defending human rights and ensuring gender equality.

The PAICPD objectives are included in MIPAA but they mainly target the specific needs of the elderly, the following priorities being underscored: ensuring mainstreaming and social participation; promoting equitable and sustainable economic growth; aligning

the social protection system; employment; lifelong learning; quality of life: health, well-being and independent life; gender equality; intergenerational solidarity.

The Active Ageing Index data shows that the situation of the elderly in the Republic of Moldova is very different from the situation of the elderly in EU countries. In this respect, we must mention that there are big discrepancies in some specific areas: social participation, especially political participation and volunteering activities; employment, especially among persons of pre-retirement age; lifelong learning and independent, safe and healthy life (*Table 1.7.3.*).

The Active Ageing Index in the Republic of Moldova is very low, scoring only 27.1 points (the EU average is 33.9) and means that more than 70% of the human potential aged 55 and over does not have the possibility to participate in social and economic life and is not thus used in active and healthy ageing<sup>31</sup>.

Although the issue of population ageing is on the agenda of the Moldovan Government, being addressed by the adoption and implementation of the legal and regulatory framework, the creation of the institutional mechanism in the field, many actions from MIPAA are not implemented, either because of the lack of financial resources or because of the political instability in the country. At the same time, the proposed actions are relevant in relation to the proposed objectives and commitments<sup>32</sup>.

A range of actions need to be prioritised to

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31 Buciuceanu-Vrabie M. Active Ageing Index. Policy Paper, DRC, 2016. [http://ccd.ucoz.com/\\_ld/0/43\\_Policy\\_Paper\\_II.pdf](http://ccd.ucoz.com/_ld/0/43_Policy_Paper_II.pdf)

32 *Evaluation of the implementation of the Madrid International Plan of Action on Ageing / RIS for 2012-2017 in the Republic of Moldova*. National Report./ Bodrug-Lungu V., Stafii A. Chisinau, 2016.

Table 1.7.3

Objective	Indicator	Indicator value for EU-28	Indicator value for the Republic of Moldova
Ensure mainstreaming and social participation	Volunteering activities (55+)	8,9%	4,4%
	Grandchild care (and childcare) (55+)	32,5%	31%
	Political participation (55+)	17,2%	1,9%
	Elderly care (55+)	12,9%	3,8%
Employment	Employment rate 55-59 years	62,2%	49%
	Employment rate 60-64 years	31,5%	27,6%
	Employment rate 65-69 ani	11,6%	13,4%
	Employment rate 70-74 ani	6,1%	6,6%
Lifelong learning	Lifelong learning (55+)	4,5%	0,3%
The elderly's quality of life	Safe and healthy independent life	70,6%	54%
	Access to dental care and health (55+)	88,2%	72,6%
	Independent life (55+)	84,2%	72,6%
	Outside the risk of poverty (55+)	93%	84,1%
	Mental well-being (55+)	64,5%	62,1%

Table 1.7.3.  
MIPAA Objectives from the Perspective of Active Ageing Index (AAI), 2015

address the impact on the elderly. Under the current socio-economic conditions, focusing on major impact objectives will be more efficient than attempting to meet all the objectives.

As the Republic of Moldova lags behind in achieving the MIPAA objectives, it is necessary to work out a coherent policy with balanced approaches aimed at improving the quality of life of the elderly, with a priority focus on:

- increasing the accessibility of health services (physical, financial and

quality), especially for vulnerable social categories and rural population;

- creating opportunities to extend the duration of economic activity and to prevent early retirement;
- enhancing the security of the living environment adjusted to the needs of the elderly (infrastructure, transport, buildings, etc.) thus ensuring an autonomous lifestyle;
- preventing violence, abuse and discrimination of the elderly.



# LONG-TERM TRENDS IN THE EVOLUTION OF POPULATION



## 2.1. Population Dynamics

For more than 15 years the Republic of Moldova has been facing a process of depopulation without any visible evidence of recovery. The relative constant ratio of mortality and birth rates during the last years lead to a greater decrease in the population and to the degradation of the demographic structure, the intense migration outflow accelerating the aforementioned processes. The current demographic situation of the country is the cumulative result of the fertility and mortality dynamics, and out-migration during the past two decades. The long socio-economic crisis can be considered the cause of mortality stagnation and of rapid increase of out-migration. The economic and social context of this period had also impacted fertility, especially during the last years.<sup>33</sup>

Currently, there is an important issue that hinders the conduct of a reliable analysis of population dynamics – the population statistics. The data of the NBS on the number and structure of population by ages and sexes cover only the population and include migrants which live abroad for more than 12 months. This phenomenon is the result of registration of migrants based on the notion of “citizenship” and not on “usual residence” (European countries’ standard)<sup>34</sup>. Despite the massive migration, the national statistics show an insignificant migration outflow, while the statistic bodies of some host states show a big number of Moldovan migrants,

33 Gagauz O. Tendințele principale în evoluția populației Republicii Moldova: un semnal de alarmă pentru autoritățile publice (*The Main Trends of Population Evolution of the Republic of Moldova: an Alarm Signal for Public Authorities*). In: Economic growth under globalisation. Ed. X. “Demographic Structure and Quality of Human Potential” Scientific Session. International scientific conference. 15-16 October 2015. Chisinau, 2015, p.5.

34 Penina O. *What is the real population number of the Republic of Moldova?* Demographic Barometer. CDR, 2015. [http://ccd.ucoz.com/\\_ld/0/24\\_Barometru.pdf](http://ccd.ucoz.com/_ld/0/24_Barometru.pdf)

including those with long-term residence status. The demographic, economic and social indicators are measured against the *de jure* population, which leads to significant distortions because some of them are underestimated while others are overestimated. According to the NBS, the number of *de jure* population of the Republic of Moldova as of 1 January 2015 amounted to 3555.1 thousand inhabitants, including the migrants who live abroad for more than 12 months. The *de facto* population (with usual residence, alternative data, CDR)<sup>35</sup> constituted 2911.6 thousand, calculated in accordance with the European standards and does not include the migrants which live abroad for more than 12 months.

This chapter reviews the trends in population dynamics on the basis of alternative data on the number and structure of population of the Republic of Moldova, which meet the European migration flows standards and are based on the notion of “usual residence”<sup>36</sup>.

The key factor of population dynamics is the age and sex structure formed during the previous period as result of the natural evolution of demographic processes and of the impact of different historical cataclysms (wars, famine). The key vector in prospective dynamics of the population is the demographic ageing, being marked by the impact of “demographic waves” – the unequal development of the structure of population and the differences between the number of persons of different generations.

35 Penina, O., Jdanov, D. A., Grigoriev, P. Producing reliable mortality estimates in the context of distorted population statistics: the case of Moldova. MPIDR Working Paper WP-2015-011, 35 pages (November 2015). Rostock, Max Planck Institute for Demographic Research. [http://www.demogr.mpg.de/en/projects\\_publications/publications\\_1904/mpidr\\_working\\_papers/producing\\_reliable\\_mortality\\_estimates\\_in\\_the\\_context\\_of\\_distorted\\_population\\_statistics\\_the\\_case\\_5498.htm](http://www.demogr.mpg.de/en/projects_publications/publications_1904/mpidr_working_papers/producing_reliable_mortality_estimates_in_the_context_of_distorted_population_statistics_the_case_5498.htm)

36 The recalculation methodology is described in the Human Mortality Database Protocol.



Fig 2.1.1

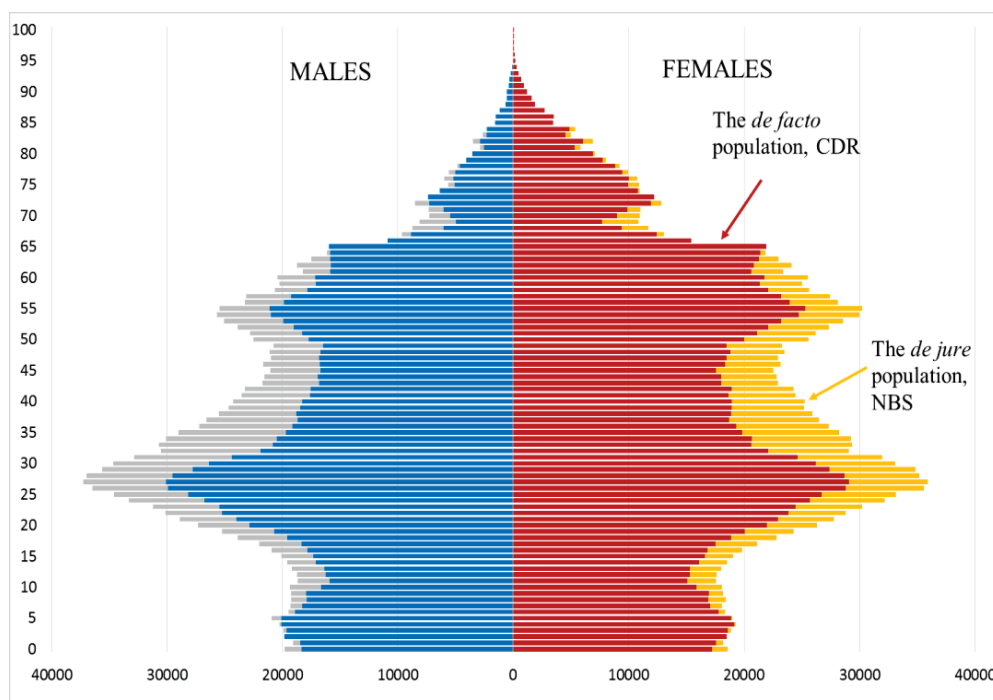


Fig. 2.1.1.  
Age-Sex Pyramid  
of the Population  
of the Republic of  
Moldova as of 1  
January 2015  
Source: NBS, CDR

In the early 1990s the demographic situation in the Republic of Moldova was quite favourable, and the so-called phase of “demographic dividend”<sup>37</sup> which has taken shape in the late 1990s – early 2000s, was to bring important benefits for the development of the economy. But the socio-economic crisis which caused the massive emigration of the population who left for abroad in search of work and the further transformation of temporary migration into definitive migration negatively affected the demographic potential of the Republic of Moldova. The population decline determined by the natural decrease and high migration reached enormous proportions. Thus, during 2004-2014, the population decreased by 350.4 thousand (by approximately 10%) from 3262 thousand to 2911.6 thousand, especially due to the young and working-age population (Fig. 2.1.1.).

<sup>37</sup>The demographic dividend represents a phase of demographic transition, which is expressed by the significant growth of the share of working-age population in the total number of population as a result of the decrease in fertility rates, creating thus opportunities for economic growth.

The demographic forecast (2014-2035)<sup>38</sup> shows a bleak demographic picture for the Republic of Moldova – in the following decades the population decline will continue at rapid pace, and the annual decrease in population will fluctuate between 1.1-2%. Staying at the current levels of fertility would accelerate catastrophically the population decline. According to the reference scenario

<sup>38</sup> The demographic forecast is based on the alternative estimates of the population number and age and sex structure.

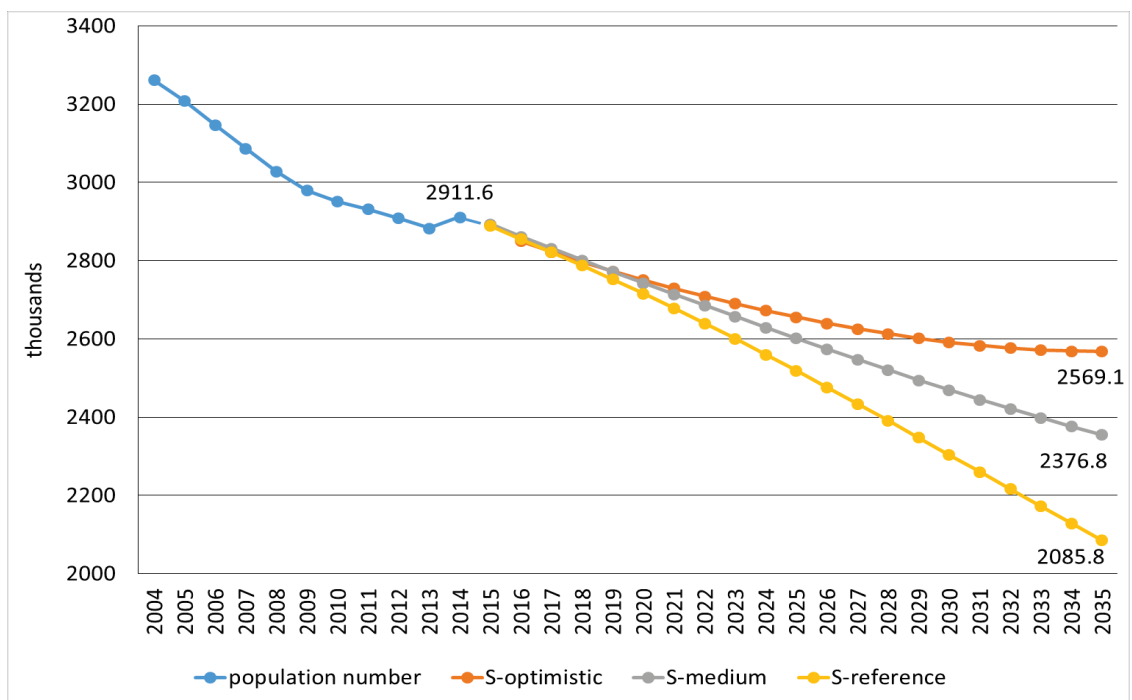
**Scenario I – reference**, begins with the hypothesis that the total fertility rate will not change and will be maintained at the 2014 level – 1.63 children per woman of reproductive age; mortality will decrease slowly so that the life expectancy at birth for men will increase from 64.9 years to 67 years, and for women from 73.7 years to 75.8 years; the migration outflow during the forecast period will slowly increase from -1% to -1.3%.

**Scenario II – medium**, Begins with the hypothesis of a moderate increase in fertility rate – from 1.65 to 1.85 children per woman of reproductive age by 2035; the decrease in mortality and the increase in life expectancy at birth (for men up to 69.1 years, for women up to 77.9 years); the migration will decrease gradually from -1% to -0.5%.

**Scenario II – optimistic**, is based on the assumption that the total rate of fertility will increase up to 2.1 children per woman of reproductive age by 2035; the substantial decrease in mortality rate and the increase in life expectancy at birth (for men up to 71 years, for women up to 80 years); the migration will gradually decrease and will amount 0% by the end of forecast period.

**Fig. 2.1.2.**  
Moldovan  
Population  
Estimation and  
Projection, 2004-  
2035  
Source: CDR

**Fig 2.1.2**



(the constant fertility) by 2035 the number of population in our country may decrease to 2085.8 thousand (by 28.4%). Given the complex economic and social context, the demographic development of the country is unpredictable, and without an efficient intervention, the regulatory approach is the only one that we can follow, if we think of the future positively. The population decline can be reduced only by increasing fertility, and this is confirmed by the two hypothesis about fertility dynamics that the medium and optimistic scenarios are based on. Should fertility increase up to 1.85 children per woman of reproductive age, the number of population would decrease from 2911.6 thousand to 2355.7 thousand (by 19.1%). Reaching a fertility level of 2.1 children per woman will make it possible to the keep the number of population at 2567.9 thousand, with a decrease by 11.8% (Fig. 2.1.2.)

The changes that can occur in Moldova's population age structure in the next decades have a double origin: some will be occur automatically, being already included in the

current age structure, while others will be the result of further joint developments of birth, mortality and migration rates. The complexity of the links between the status and movement elements of population, and especially the long-term effects of past and current developments, show that it would be a big mistake to think that the economic and social growth will automatically ensure a recovery of the demographic situation as a whole. However, it is not the decrease in the number of population that is the most worrying, but the fact that this development is associated with the continuous degradation of the age structure by moving up the pyramid – to the ages of economic inactivity of the numerous generations born during 1960-1990 which have already reached the working age (Table 2.1.1).

In previous years the proportion population of working age was a fairly high in the total population (in 2008 the highest share of working age population was registered – 66.6%). In the coming decades the population of working age will decrease continuously (up to 58-60% with some

Table 2.1.1

Age	Estimated		Projection*			
	2004	2014	2020	2025	2030	2035
Under 1 year	34.9	35.7	31.9	25.5	21.4	19.8
1-3	101.9	114.3	101.9	82.6	67.1	59.7
4-6	110.7	114.1	107.4	93.1	74.3	62.0
7-11	233.2	167.2	187.0	172.1	145.2	115.6
12-16	306.6	167.1	165.8	181.5	166.7	140.0
17-19	197.7	119.9	89.8	98.3	103.6	94.9
20-24	268.8	249.1	164.9	139.3	158.4	158.3
25-29	229.1	281.9	213.8	143.9	118.9	138.6
30-34	210.4	214.9	253.2	189.5	120.6	96.6
35-39	206.8	181.7	201.7	230.4	167.9	100.6
40-44	250.2	172.8	162.0	182.8	211.3	150.7
45-49	252.8	172.9	155.3	146.0	166.7	194.8
50-54	234.8	207.6	150.4	138.5	130.0	150.6
55-59	137.6	205.0	173.7	133.1	122.6	115.1
60-64	134.8	184.7	183.7	152.8	116.6	107.5
65+	352.8	322.7	373.6	409.7	413.1	380.9
Total	3263.0	2911.6	2716.2	2519.2	2304.1	2085.8

**Table 2.1.1.**  
Age Structure of  
the Moldovan  
Population, 2004-  
2035  
Source: CDR

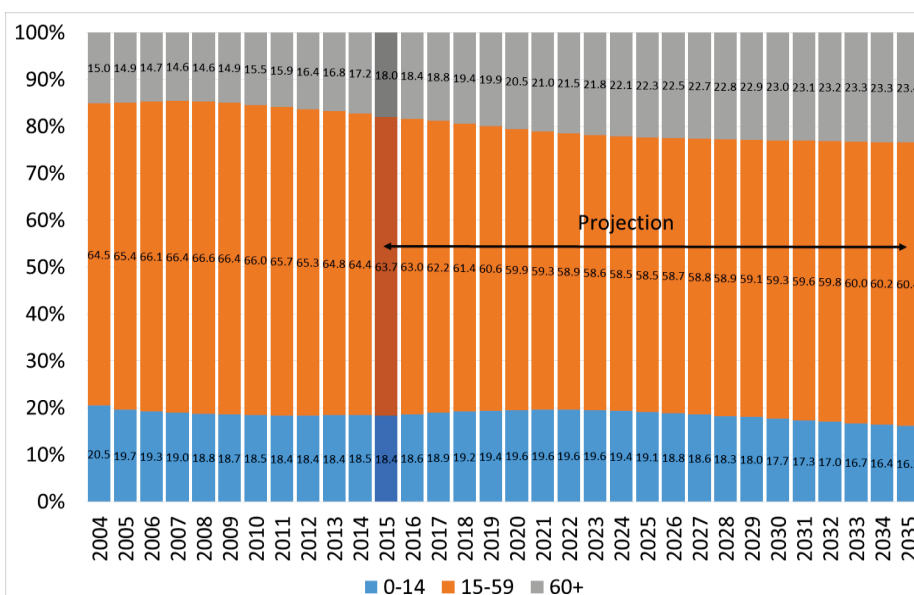
annual fluctuations), while the ageing population (60+) will increase significantly – up to 23.4% by 2035 (Fig. 2.1.3)..

The factor that dominated the change in the number of working age population is the relation between the positive impact of the “cohort effect” and the negative impact of excessivemortality, particularly among men. The role of migration in this process is only

about increasing the influence of these two components. Thus, the situation of the age group structure proves to be unfavourable because one of the most numerous age categories (50-55) nears retirement, which will considerably increase the number of dependent people and will put further pressure on the active population. The smaller the young contingents are, the more difficult the situation is, as the future active

Fig 2.1.3

**Fig. 2.1.3.**  
Population estimation and projection per three major age groups (children, adults, and the elderly), 2004-2035  
Source: CDR



generations will have to support a very big number of inactive persons. One of the key indicators that emphasize this situation is the demographic dependency ratio. This indicator, which is the ratio between the inactive age groups (young people and elderly) and the active population (15-19 years) gives valuable information on the economic burden of the productive population.

The stage of demographic dependency ratio decrease is over, and the Republic of Moldova entered a period where this indicator grows fast, especially due to the elder population. Compared to 2014, when the demographic dependency ratio was 55.2 – during 2022-2027 this indicator will achieve the highest values – around 70, and then it will decrease down to 65. The increase of fertility rates will determine the increase of demographic dependency ratio, especially after 2015 – the dynamics of scenario 3 – optimistic (Fig. 2.1.4). For all that, two-thirds of demographic burden lies elderly and only a third of the children. Raising the retirement age will ensure the increase of quota of working age thus will reduce the demographic burden.

The consequences of the change in the population age structure are usually limited to the increase in the number and the share of the elderly in the total population and the issues related to this phenomenon. The range of issues is much wider and it includes all the age groups, impacting the multiple social processes. The changes in the population age structure imply the change of the general structure of social needs and of social institutions that must meet all these needs and regulate the social interaction.

**The most negative impact of the population decline determined by the decrease of the birth rate present the loss of national demographic potential to redress the situation, the demographic crisis becoming thus huge, and the depopulation process being harder to stop.**

The significant differences of socio-demographic development of the Republic of Moldova in territorial profile, the advanced ageing in the Northern region, the intense migration outflow from peripheral areas towards centre and big cities will lead to the concentration of the population in several

Fig 2.1.4

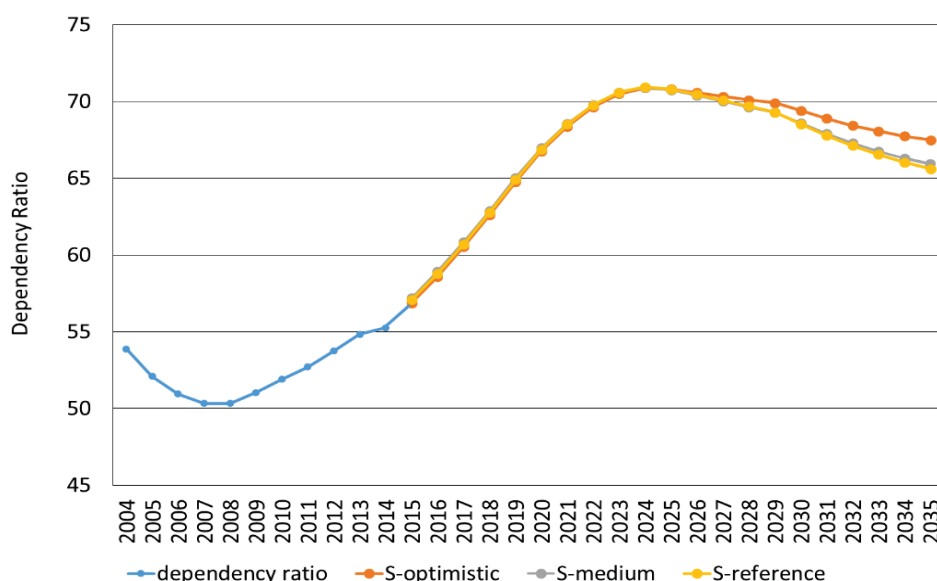


Fig. 2.1.4. Estimation and projection of the demographic dependency ratio indicator, 2004-2035  
Source: CDR

urban areas and to the rapid depopulation of the peripheral districts. The territorial demographic indicator<sup>39</sup> for certain districts like Ocnita and Donduseni is more than two times below the maximum one registered for Chisinau Municipality, Ialoveni and Dubasari Districts. The Northern districts have the lowest scoring because of the high level of demographic ageing, high negative natural and migration growth, which show a long-term depopulation trend in this region.

39 Gagauz O., Pahomii I. Territorial integral demographic security indicator. Policy paper. CDR, 2016.

Two municipalities –Chisinau and Balti attract the population of working age from all the districts of the country, and the migration growth in 2014 accounted for 6‰ in Chisinau Municipality and 3.7‰ in Balti Municipality (Fig. 2.1.5). During the last 5 years (2010-2014), following the internal migration, 81.7 thousand persons came to Chisinau, and only 49.7 thousand left.

Dubasari and Ialoveni Districts register a positive migration growth due to their closeness to Chisinau Municipality. Due to the fact that mainly the young and working

Fig 2.1.5

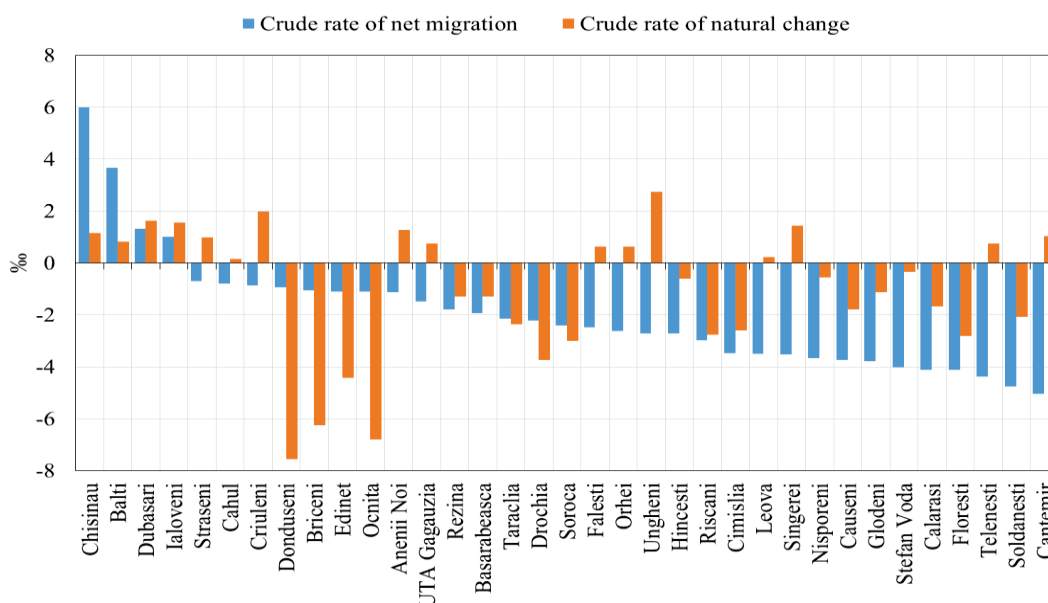


Fig.2.1.5. Natural and migration increase in administrative-territorial profile, 2014  
Source: NBS

age population migrates internally, Chisinau and Balti Municipalities, as well as Ialoveni and Dubasari Districts increase their reproductive potential, and the number of women of reproductive age deliver more babies, ensuring thus the natural increase in population.

Most of the districts lose people because of migration, and because of the natural decrease. In some districts, even if they register a positive population growth, their demographic potential deteriorates because of the migration outflow, which in the next years will cause the natural decrease in population.

In the long run, the income per capita and the purchasing power of the population will decrease in the depopulated areas, and the pensions will become the main income source for most of the inhabitants. The developed economic centres will be grow stronger and those underdeveloped ones will lose their economic potential because they will not be able to attract the necessary investments. In many districts this process is irreversible already. The production capacity and the return on investments will be concentrated in several economically developed settlements.

The number and the share of rural population will decrease – a phenomenon determined not only by the general population decline, but also by the global urban population growth thanks to the service sector. The world dynamics show that the sustainable economic growth is associated with the urbanisation process – in economically developed countries the share of rural population is decreasing, and the development of the agricultural sector is more and more based on the increase of labour productivity and on the

implementation of modern technologies.

Despite some important socio-economic implications of the population decrease and its age structure change, currently, the paradigm that *the society can prosper without the population increase too* is accepted more and more in the European region.<sup>40</sup> It is scientifically proved that the quality of human capital, the existence of opportunities for self-fulfillment, the well-being of people, the increase of the healthy life expectancy, as well as their active participation are much more important for the economic growth than the number of population. However, in the case of the Republic of Moldova, which did not manage to implement the institutional systemic reforms, the decrease in population number on the background of a fast ageing can have much more complex effects: a slowdown in economic growth, the worsening of the business environment, the decrease in consumption and production levels, the increase in expenses for the social insurance system, etc.

## 2.2. Demographic dividend

The so-called stage of “*demographic dividend*”<sup>41</sup>, that started to take shape in the Republic of Moldova in the early 2000s, was expected to bring important benefits for

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40 Population Trends and Policies in the UNECE Region. Outcomes, Policies and Possibilities. 2013, p.3.

41 *Demographic dividend* is a stage of the demographic transition, characterized by a significant increase in the share of working-age population in the total number of population as a result of lower fertility, offering thus opportunities for economic growth. With the fewer births per year in a young country, the number of dependants is increasing at a slower rate than the working-age population. With fewer people in need of support, the country has a window of opportunity for quick economic growth on the accounts of the benefits offered by the lower demographic dependency ratio (the working-age population is believed to produce more than it consumes, and the difference is distributed between the dependants - children and elderly).



the economic development. The estimated economic benefits of the demographic dividend for different countries show that this stage of demographic transition has a great potential for any country, provided that special policies are promoted to harness it.<sup>42</sup>

When has the demographic dividend period taken place in Moldova, how is it used and what measures should be taken to reap the maximum benefits?

When analysing the demographic trends and demographic dividend, one of the most important tasks is setting thresholds that mark the beginning and the end of productive age.

The lower threshold is the usual age when people start working. This threshold is often set at 15 years, at the UN recommendation. However, significant changes have occurred in education and on the labour market in the recent decades. The economic and technological development, and continuously growing demand for skilled labour force have extended the education period, and the number of young people in vocational education also increased considerably. As a result, young people start their economic activity several years later. In Moldova, in recent decades, a large part of young people aged 15-19 years, were enrolled in education (about 80%). Thus, during the past five decades, the age of entering the labor market increased from 17 to 20 years.

Retirement age is the upper threshold of the working age period. Until 1999, the

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42 Mason A. Demographic transition and demographic dividends in developed and developing countries. United Nations Expert group meeting on social and economic implications of changing population age structure. Population Division DESA, Mexico City, Mexico 31 August-2 September 2005.

retirement age in Moldova was 55 years for women and 60 years for men. In 1999-2002, the retirement age was increased to 57 years for women and 62 years for men.

Given the pressing need to change the parameters of the existing pension system, the demographic dividend period was determined on the basis of the assumption that since 2017 the retirement age for women will increase annually by 0.6 months, so that during 10 years the women's retirement age will become equal with men's.

Proceeding from the above, the following thresholds were used to estimate the number and share of working-age population with the view to determining the demographic dividend period in Moldova:

- For 1970-1989: 17-54/59 years.
- For 1990-1998: 19-54/59 years.
- For 1999-2002: 20 years - gradually increase of the retirement age from 55 to 57 years for women and from 60 to 62 years for men.
- For 2003-2016: 20-56/61 years.
- For 2017-2026: 20 years - retirement age for women will be increased gradually from 57 to 62 years, for men it remained at 62 years
- For 2027-2035: 20-62 years.

The demographic dividend occurs when the proportion of working-age population in the total population is 55% and higher. The dynamics of the working age population was calculated for *the facto* population<sup>43</sup> and the *de jure* population.<sup>44</sup>

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43 The NBS data, including the people who were out of the country more than 12 months

44 CDR data, according to the estimates of Penina, O., Jdanov, D. A., Grigoriev, P.

The situation in Moldova is characterized by large fluctuations in the share of working-age population, determined by the non-uniform structure of the age-sex population pyramid. The share of working-age population increased during 1976-1987, when the numerous generations born after the war entered the labour market. Then, this indicator has increased since late 1990s, when the numerous generations, born in the second half of the 1980s, reached the working age. This “demographic dividend” occurred as a result of the family policies promoted by the USSR during the mentioned period, when the birth rate increased significantly, and of the lower TFR after 1990.

The demographic dividend, calculated in relation to the *de jure* population, started in 2003, lasts for several decades and does not end at the end of the forecast period - 2035 (Fig. 2.2.1). During this period, the share of working-age population increases to 60% from 2010 to 2027, then decreases and stays at 59%.

The estimated demographic dividend in base of the *de facto* population shows that due to the massive emigration, Moldova

practically lost the opportunities offered by this stage of population evolution. The demographic dividend period is very short (only from 2005 to 2020) and the share of working age population does not exceed much the limit of 55% (by about 1%). From 2021 to 2031, there will be a slight decrease of this indicator, and at the end of the forecast period, from 2032 to 2035, the proportion of working-age population again will exceed the threshold of 55% (Fig. 2.2.1).

Though the demographic dividend is very small, the noticed oscillations in the share of working-age population show a very favourable situation for achieving economic growth. Note that a higher retirement age extends the demographic dividend period.

But the working-age people consists of only potential employees. It depends how this potential is used currently and will be used in the future. Labour migration of young people is high and, unfortunately, no signs of improvement are visible yet. The employment rate is also very low, and its structure does not indicate a favourable situation for economic growth (high level of informal employment in the agricultural

Fig. 2.2.1.

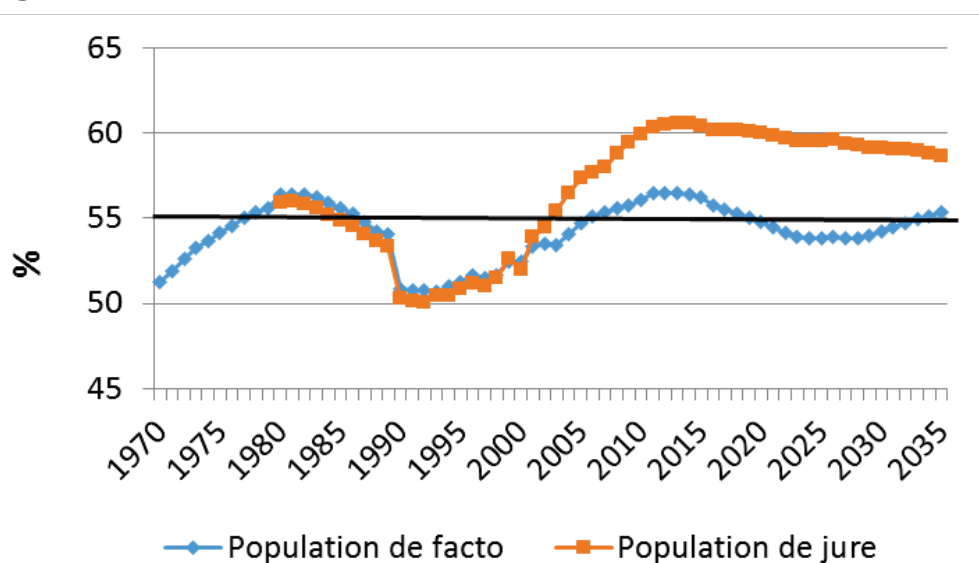


Fig. 2.2.1.  
Share of working-age population in the total population, 1970-2035  
Source: calculated on the basis of NBS and CDR data

sector). Another important issue is if planned pension reform, namely, raising the retirement age, will result in a real extension of the period of economic activity.

In the coming period, the population and development policies should focus on the four elements necessary for harnessing the demographic dividend:

- more investments in the development of young people's human capital;
- more opportunities for young people on the labour market;
- develop sex education and family planning programs;
- facilitate young people's access to financial systems.

The second demographic dividend is also possible, the occurrence of which is determined by the impact of demographic changes on capital accumulation. It is assumed that when demographic aging is caused by the increasing life expectancy at advanced ages (upper demographic aging), the middle-aged population can change their behaviour radically, starting to accumulate more resources for retirement period, strengthen material and capital resources, thus, helping to offset the global saving rate reduction caused by the increasing proportion of older people with low levels of accumulation.<sup>45</sup>

In the Republic of Moldova, the demographic aging is mainly determined by the decreasing TFR and the share of children in the total population (lower aging), the longer life expectancy at advanced ages having an insignificant role. However, the

<sup>45</sup> Bloom D. E., Canning D., Mansfield R. and Moore M. "Demographic Change, Social Security Systems, and Savings." NBER Working Paper No. 12621, National Bureau of Economic Research, 2006, Cambridge, MA. <http://www.nber.org/papers/w12621.pdf>

first demographic dividend is not harnessed appropriately and did not improve significantly the living standards of the population, and it is too early to speak about the second demographic dividend.

## 2.3. Low Fertility Rate and the Population Decline

Since early 1990s the patterns of reproductive behaviour in the Republic of Moldova have changed significantly, which caused the fast decrease of fertility rate and delayed the births until more mature ages. The total fertility rate (TFR), which during 40 years was much higher than the replacement level of generations, decreased unprecedentedly to 1.44 in 2002 (minimum value)<sup>46</sup>. The impacts of fertility are huge. The researches in the area show that the maintenance of TFR at a lower level than that of the replacement level of generations contributes to population ageing, decrease in labour force, and the population number<sup>47</sup>.

Though after the sudden fall of TFR, the back trend was recovered and the fertility rate started increasing, its level is much lower than the necessary one for population reproduction. Over the last years, the TFR stays at the value of 1.6-1.65 children per woman of reproductive age (*Fig. 2.3.1*).

The TFR values over the last years represent only compensatory dynamics after the disastrous decrease in the late 1990s of the past century – early 2000s, and do not

<sup>46</sup> For this paragraph, the fertility indicators were calculated in base of the alternative data (CDR) on the population number and structure.

<sup>47</sup> Billari, F., *Europe and its Fertility: From Low to Lowest Low*. National Institute Economic Review, Vol. 194, No 1, 2005, pp.56–73.

show any sign of positive trends regarding the increase of fertility rate. This indicator proves the strength of this phenomenon in different periods of time and does not characterise the intensity, being therefore an imperfect tool for fertility measurement.<sup>48</sup> The implementation of the TFR standardisation method determined a slower decrease in this indicator – from 2.3 in 1990 to 1.8 by 2014, while the non-standardized TFR fluctuations are very high, warning about the change of reproductive behaviour of the population in different periods<sup>49</sup>.

MICS also shows a higher fertility rate than the official data of NBS. Thus, the TFR for

In rural areas, the fertility rate is higher (2.5 births per woman), in comparison with the urban areas (1.8 births per woman).<sup>50</sup>

The decrease in fertility rate in the Republic of Moldova is part of general European trends, being part of the decrease of fertility rate in the Central and Eastern Europe countries, which go through radical political and socio-economic changes as well as through a second demographic transition which began in the second half of the 1990s of the past century<sup>51</sup>. The massive change of the timing of birth (delaying the births until more mature ages) is a strong factor that causes the fast decrease in the TFR for calendar years during a long period

Fig. 2.3.1.

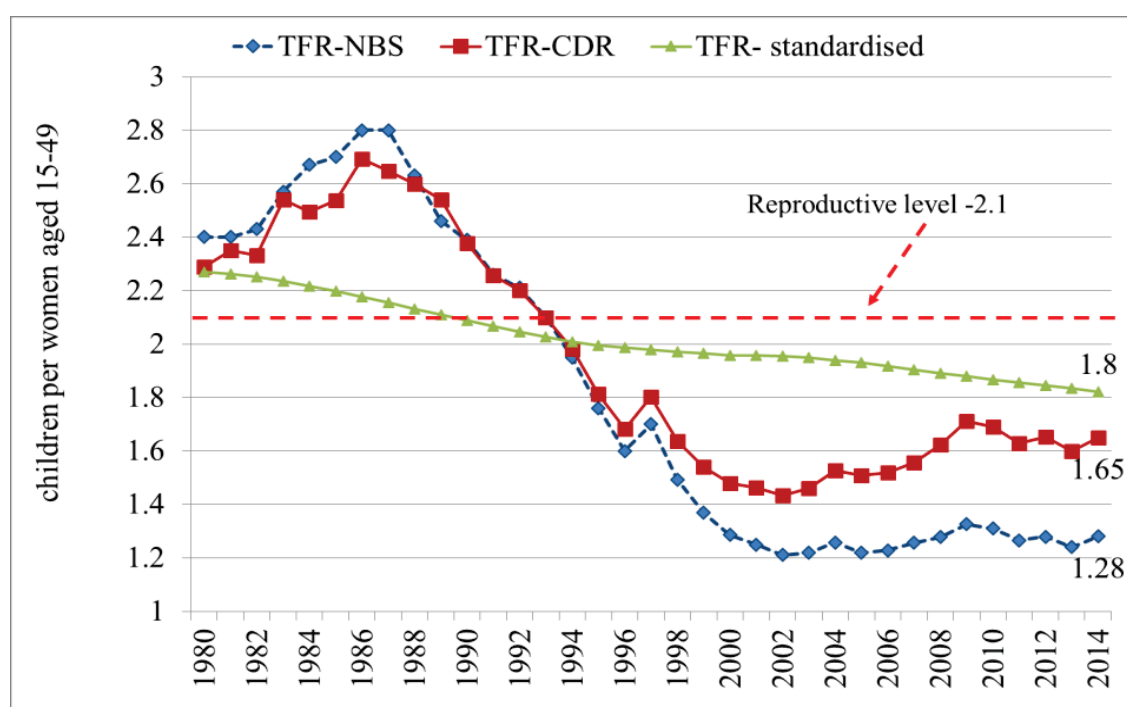


Fig. 2.3.1. TFR Dynamics, Official and Alternative Estimates, 1980-2014  
Source: O. Gagauz, Calculations based on NBS and CDR data

the 3 years prior to 2011 according to MICS Moldova accounts for 2.2 births per woman.

of time. The average age of mother at first birth was increasing continuously since the

48 Sobotka T., Lutz W. *Misleading Policy Messages from the Period TFR: Should We Stop using It* // European demographic Research/ Papers 4. Vienna: Vienna Institute of demography of the Austrian Academy of Sciences, 2009.

49 Gagauz O. Impactul restructurării ciclului reproductiv asupra indicatorilor fertilității (*The impact of restructuring reproductive cycle over fertility indicators*). In: Economic growth under globalisation. Ed. IX. "Demographic Structure and Quality of Human Potential" Scientific Session. International scientific conference. 16-17 October 2015. Chisinau, p.9-19.

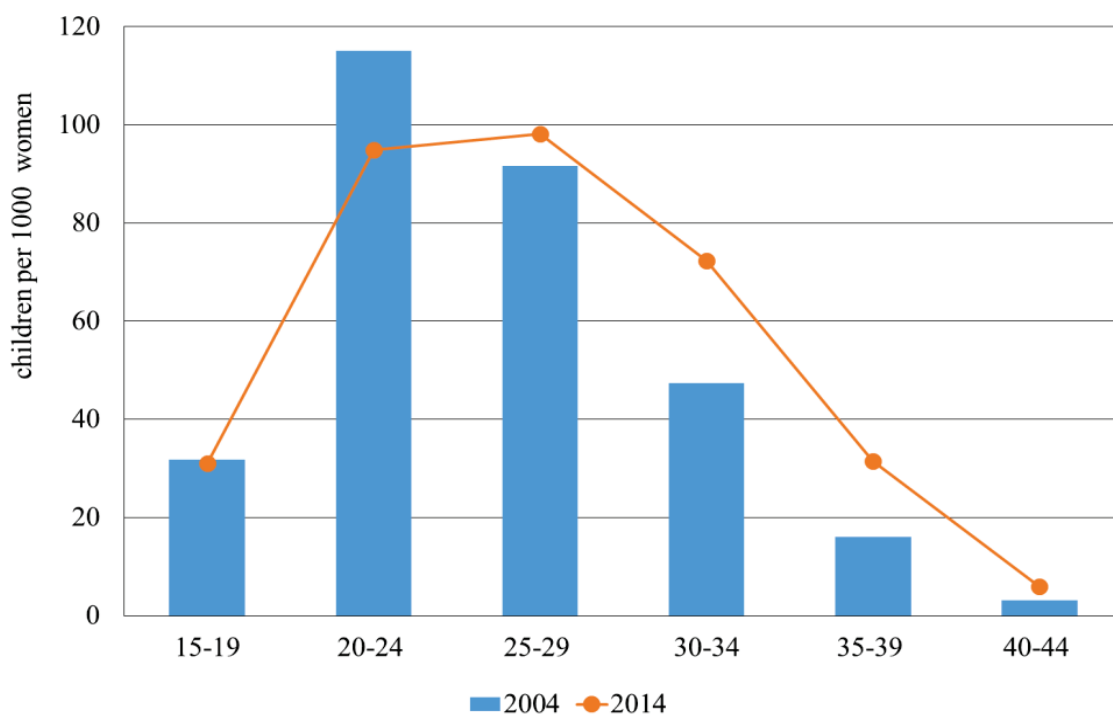
50 Republic of Moldova. *Multiple Indicator Cluster Survey, 2012* – National Centre of Public Health, 2014.

51 Gagauz O. Молдова на пути второго демографического перехода: структурные изменения рождаемости. Экономический рост в условиях глобализации (*The Republic of Moldova towards the second demographic transition: structural fertility changes. Economic progress in the context of globalization*), Ed. VIII. "Fertility development: challenges for social policy" Scientific Session, Internal scientific conference. 17-18 October. 2014, Chisinau, 2014, p.36-45.

mid-1990s, and increased during 1995-2014 from 21.9 up to 24.4 years. In the age-pattern of fertility, the changes are gradual – from a generation to another, reflecting the key transformation of the life cycle: longer duration of education, later initiation in professional activity and therefore later economic independence.

The comparison of age-specific fertility rates for 2004 and 2014 shows significant changes in the timing of birth: decrease in the number of births within the age group of 20-24 years and their increase at more mature ages, especially within the age groups of 30-34 and 35-39 years (Fig. 2.3.2).

Thus, the distribution of fertility per age Fig. 2.3.2.



**Fig. 2.3.2.** Age-Specific Fertility Rates, 2004 and 2014  
Source: O. Gagauz, Calculations based on NBS and CDR data

groups shows that the Republic of Moldova entered the transition of fertility from the early pattern to the late one, having an important impact over the final lineage.

The driving force in the change of the reproductive behaviour of the population is represented by the changes in the procreation of female cohorts, and the most reliable information on fertility

dynamics is delivered by the analysis of the phenomenon in generational profile. It is known that the TFR for calendar years is a cumulative indicator of the specific fertility rates of 35 female cohorts – a transverse appearance of the distribution in time of their reproductivity. The measurement of the fertility rate by female cohorts (longitudinal analysis) present a higher stability in the reproductive behaviour than the estimation of fertility for calendar years (transverse analysis).

The long time decrease in fertility rate is illustrated by the evolution of finale lineage of female generations. The estimations of completed fertility rates of female

cohorts whose reproductive period is over (female generations born in 1960-1970) and the forecasting of completed fertility of those who are in the most active age of reproduction shows a steady trend of fertility decrease. The completed fertility rate of female generations born in the first half of the 1960s was at the generation replacement level, while those born during

**Table 2.3.1.**  
Realised and  
Forecast Fertility  
of Female  
Cohorts by Birth  
Year 1960-1985  
Source:  
O. Gagauz,  
Calculations  
based on NBS and  
CDR data

1973-1975, but especially those that were born in the late 1970s and more recently, will have a lower completed fertility rate (Table 2.3.1.). However, the fertility analysis in generational profile provides solid proofs of the underestimation of fertility level based on the TFR for calendar years, which often is used by the competent bodies as benchmark to evaluate this phenomenon and develop some policies in this area.

Even if the situation of fertility dynamics in female cohort profiles is much more positive than that of the TFR for calendar years, the completed cohort fertility of younger cohorts is significantly lower than that of

the older ones, being below the necessary generation replacement level and cannot impact thus significantly the population change.

The population decline is mostly determined by the dramatic decrease in the number of births, and a recovery of the demographic situation of the country imposes, first of all, an increase in the number of births. But the annual evolution of the number of births depends on the fertility level, (average number of children per woman of reproductive age) and on the number of women of reproductive age, especially between 20 and 40 years. The increase

**Table 2.3.1.**

Birth year of the cohort	Age in 2015	Number of children born in 2015, per woman	Forecast fertility, in addition to the realised fertility	Completed cohort fertility
1960	55	2,29	-	2,29
1961	54	2,18	-	2,18
1962	53	2,07	-	2,07
1963	52	2,03	-	2,03
1964	51	2,0	-	2,00
1965	50	2,00	-	1,98
1966	49	2,03	-	2,00
1967	48	2,00	-	2,01
1968	47	2,00	-	2,00
1969	46	2,01	-	2,01
1970	45	2,01	-	2,01
1971	44	1,94	0,01	1,95
1972	43	1,91	0,01	1,92
1973	42	1,86	0,01	1,87
1974	41	1,86	0,01	1,87
1975	40	1,84	0,03	1,87
1976	39	1,89	0,07	1,97
1977	38	1,86	0,12	1,98
1978	37	1,83	0,15	1,98
1979	36	1,78	0,18	1,96
1980	35	1,70	0,26	1,96
1981	34	1,64	0,34	1,94
1982	33	1,58	0,38	1,96
1983	32	1,46	0,47	1,93
1984	31	1,33	0,55	1,88
1985	30	1,20	0,62	1,82



or decrease in this population causes automatically variations in the number of births even if the fertility continues to be constant. For the following 20 years, the size and the age structure of reproductive age female population (15-49 years) are known exactly because this population consists of women that are currently alive. In subsequent years a constant decrease in this category of population is envisaged due to emigration, and because the reproductive age will be achieved by small generations born in the late 1990s – early 2000s. Therefore, the positive effects that a recovery of fertility would have on the number of births, would be supported and amplified during the following decades by the number and structure of women of reproductive age. Thus, while in 2004 the number of women of reproductive age amounted to almost 887 thousand, by 2014 this number reduced to 735.5 thousand, and it can go down to 484.8 by 2035 (Fig. 2.3.3).

At the same time, the share of women of the most active reproductive ages of 20-40 years will decrease in the population structure. While during 2015-2022 their share will amount to around 62-63%, it will decrease gradually decrease to 49% (2031-2035).

Fig. 2.3.3.

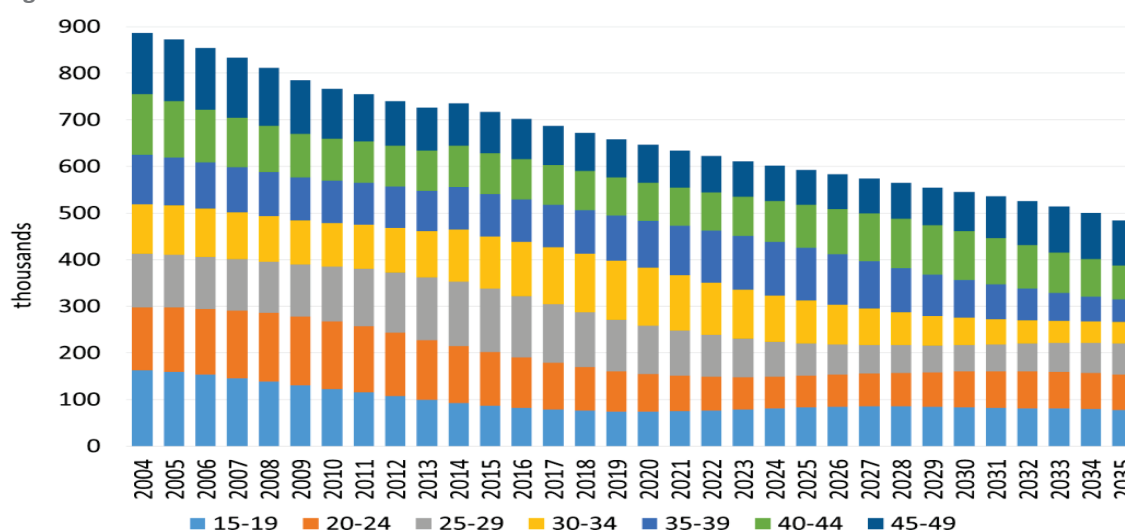


Fig. 2.3.3. Female Reproductive Age Population, Estimations and Forecasts, 2004-2035. Source: CDR

Thus, although during the next years the TFR will take on an increasing trend, the number of births will be very small and will not be able to offset the population decline caused by the growth of deaths as a result of demographic ageing. Should the TFR stay at the level of last years (about 1.65), then by the end of the forecast period, the annual number of births could decrease twice compared to 2009-2010, with an annual decrease of almost 3-4%. The medium scenario (the gradual increase of TFR up to 1.85 by 2035) will allow for the stabilisation after 2030 of the number of births at 26 thousand. Only the TFR increase to 2.1 children per woman of reproductive age ensures an ascending trend of the number of births up to 32.7 thousand by 2035, after the constant decrease during 2028-2030 (Fig. 2.2.4).

The researches in the field show that there are many drivers of fertility decline and they are associated with the economic, social, cultural and demographic changes the contemporary society deals with. In most European countries there is a strong link between the TFR and unemployment: the high unemployment rate among men and women delays the birth of the first child and also prevents the birth of second or third child. The worst effect on fertility

Fig. 2.3.4.

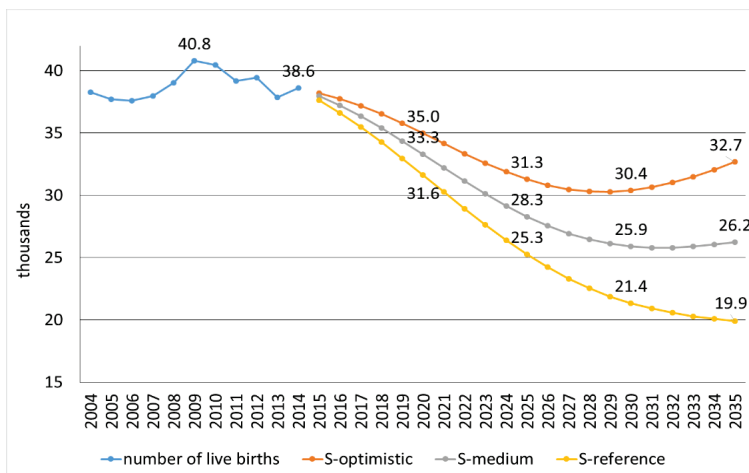


Fig. 2.3.4. Dynamics of the Number of Births, Actual and Forecast, 2004-2035  
Source: CDR

is noticed when the high unemployment rate is accompanied by a high share of self-employment. The employment of women in the public sector, which guarantees a stable job and the returning after maternity leave is associated with a higher fertility<sup>52</sup>. Moreover, there is also a powerful negative link between the increased unemployment among men and the fertility rate.<sup>53</sup>

The economic uncertainty was the main cause of the sudden fall of the TFR in post-communist countries during the first transition decades<sup>54</sup>. National surveys show that unemployment, low salaries, lack of a house, reduced accessibility to health services are the most complex issues that Moldovan families have to deal with, and are regarded as a barrier to the full realization of reproductive intentions<sup>55</sup>.

Among other factors – the increased

52 Adsera, A. 2004. *Changing fertility rates in developed countries. The impact of labour market*

*institutions*. Journal of Population Economics 17(1): 1-27.

53 Cazzola A., Pasquini L., Angeli A. *The relationship between unemployment and fertility in Italy: A time-series analysis*. Demographic Research, 2016. Vol.34, Article 1, p. 1-40.

54 Sobotka T. et al. *Czech Republic: A Rapid Transformation of Fertility and Family Behaviour after the Collapse of State Socialism*. Demographic Research, 2008, Special Collection, 19, p. 403-454,

55 Gagauz O. Unele aspecte ale perfecționării politicilor de protecție socială a familiei (Some aspects of improving the policies on social protection of families). In: "Philosophy, Sociology and Political Science" Journal. Chisinau, 2009 No 2 (150), p.36-48; Gagauz O., Buciuceanu-Vrabie M.

accessibility to hormonal contraceptives, the economic uncertainty and the uncertainty regarding the employment of young people, the reduction in the number of marriages and the increase in the share of cohabitation relationships – which are less stable – the increased economic status of women, the weakening of the role of cultural norms (religious especially) and the increased importance of self-assertion and self-fulfilment, all these are incompatible with a big number of children<sup>56</sup>. These are the factors that generated the second demographic transition, which – at the level of demographic indicators – is expressed by the increase in average marriage and birth-giving age, the increase of time intervals between consecutive births, the increase in the role of extramarital births, and the increased share of persons who were never married and did not have children<sup>57</sup>.

The policies meant to encourage fertility in the European countries prove there are three key points which ensure the increase of fertility: the promotion of gender equality in all the areas of social life, the creation of favourable conditions for professional and family life reconciliation, and the development of different services for extra-familial education of children, plus the sustainability and sequence of the undertaken measures<sup>58</sup>

Based on the aforementioned, we underline that there are many interconnected factors that influence the fertility rate and that dependant on the economic and social context, which make the pro-natalist policies

56 Basten S., Sobotka T., Zeman K. et al. *Future Fertility in Low Fertility Countries*. VID Working Paper, 2013, nr.5.

57 Zaharov S. V. *Fertility in Russia: the first and the second demographic transition*. 2002 [http://demoscope.ru/weekly/knigi/konfer/konfer\\_08.html](http://demoscope.ru/weekly/knigi/konfer/konfer_08.html)

58 Krieger H. *Demographic changes in Europe: Implications for family policy*. Paper presented to the Committee of Experts on Children and Families. Council of Europe. Strasbourg, 2005. 32 p.

more challenging. The economic and social policies influence the environment in which the individuals make decisions on the formation of a family and birth of children. Considering the complex interaction of factors which affect this environment, the impact of measures focused only on certain areas is usually very small, while the economic and social progress, and the cultural factors have a greater impact. Thus, the main objective of these policies is to change the paradigm of the social system, to create conditions which would encourage the reproductive behaviour, and to increase the fertility rate in the long run.

## 2.4. Mortality, Life Expectancy at Birth, Healthy Life Expectancy

**Mortality by ages and sexes.** The data quality in the Republic of Moldova has a crucial importance for reliable estimations of mortality in different periods. The tremendous under-registration of infant deaths and the underestimation of mortality at advanced ages are the two main causes for the overestimation of values for life expectancy at birth in the late 1970s<sup>59</sup>. On the other hand, the official data on this indicator for the post-independence period are also extremely problematic, due to a significant overestimation of the number of population because the national migration definitions were not in line with the EU recommendations.<sup>60</sup> Thus, in 2004,

59 Penina O., Meslé F., Vallin J., 2010, *Correcting for Under-Estimation of Infant Mortality in Moldova, Population (English Edition)*, 65(3), pp. 499–514.

60 Penina, O., Jdanov, D. A., Grigoriev, P. Producing reliable mortality estimates in the context of distorted population statistics: the case of Moldova. MPIDR Working Paper WP-2015-011, 35 pages (November 2015). Rostock, Max Planck Institute for Demographic Research.

Penina, O. 2016, *About the Republic of Moldova Data on Causes of Death*. <http://causesofdeath.org/Data/MDA/20160121/>

the values for life expectancy at birth, calculated based on alternative estimations on the number of population, are lower than the official data by 0.6 years for men and 0.4 years for women. Due to increased migration flows in recent years, this gap between the official and the alternative estimates for life expectancy at birth has increased and now constitutes 2.6 years for men and 1.6 years for women (*Table 2.4.1*).

The general trend of mortality in the Republic of Moldova is similar to that in Ukraine and Russia, and is characterized by significant fluctuations in the indicator values related to the anti-alcohol campaign in the 1980s and the socio-economic crisis, that affected the former Soviet republics after the collapse of the USSR during the period of transition to market economy. Despite these fluctuations, the Republic of Moldova could not obtain a steady increase in life expectancy values over the past five decades as opposed to the Western countries that even since the 1970s of the last century recorded an increase in this indicator due to mortality displacement through various pathologies, especially through the cardiovascular ones among people of advanced ages. These opposite trends in the countries from East and West have led to huge differences in life expectancy at birth (*Fig. 2.4.1*). Currently, the values of this indicator in the Republic of Moldova is 65.0 years for men and 73.4 years for women<sup>61</sup>, which by 7.4 and, respectively, by 6.7 years lower than in the EU (since 2004)<sup>62</sup>. High mortality of adult population, especially of men, is one of the most important problems for the Republic of Moldova. Today, the probability of dying at the age of 65 for a man who has reached

MDA\_bd.pdf

61 Based on the alternative estimates of the number of population.

62 Health for All Database (<http://data.euro.who.int/>).

Table 2.4.1.  
Life Expectancy  
at Birth: Official  
and Alternative  
Estimates, 2004-  
2014  
Source: (Penina  
Olga, Grigoriev  
Pavel and Jdanov  
Dmitrii, 2015

Table 2.4.1.

Year	Men		Women		Difference	
	Alternative estimates (years)	Official estimates (years)	Alternative estimates (years)	Official estimates (years)	Men (years)	Women (years)
2004	63.9	64.5	71.8	72.2	-0.6	-0.4
2005	62.8	63.8	71.1	71.7	-1.0	-0.6
2006	63.3	64.6	71.5	72.2	-1.3	-0.7
2007	63.3	65.0	71.6	72.6	-1.8	-1.0
2008	63.3	65.6	72.0	73.2	-2.3	-1.2
2009	62.9	65.3	72.1	73.4	-2.4	-1.2
2010	62.4	65.0	71.9	73.4	-2.6	-1.5
2011	64.4	66.8	73.4	74.9	-2.4	-1.5
2012	64.5	67.2	73.2	75.0	-2.7	-1.8
2013	65.3	68.1	73.8	75.6	-2.7	-1.7
2014	64.9	67.5	73.7	75.4	-2.6	-1.6

20 years is of 40%, being two times higher than in developed countries.

The general stagnation in life expectancy at birth in the Republic of Moldova over the last half a century stems from two opposite trends. On the one hand, the infant mortality rate and the death rate among children aged 1-14 has decreased considerably (Fig. 2.4.2). Between 1965 and 2014, the infant mortality rate decreased more than five times, while mortality amongst children dropped almost three times. Over the period of independence, the

progress in reducing infant mortality is also quite substantial (70% during 1991-2014), while the child mortality decreased nearly twice over the same period. Currently, the infant mortality rate is 9.7 deaths per 1,000 live births (2014), which is close to the level registered in the neighbouring countries – Ukraine (8.9 in 2012) and Romania (8.4 in 2014), but still much higher than in the EU (3.8 in 2013<sup>63</sup>).

63 For the EU the data are taken from the Health for All Database (<http://www.euro.who.int/en>); for Romania – from the National Institute of Statistics (<http://www.insse.ro>).

Fig. 2.4.1.  
Life Expectancy  
at Birth in  
the Republic  
of Moldova,  
Ukraine, Russia  
and France,  
for 1965-2014  
Source: For the  
Republic of  
Moldova:  
calculations  
based on the  
Human Cause  
of Death  
database ([www.causesofdeath.org](http://www.causesofdeath.org)); for other  
countries:  
Human Mortality  
Database ([www.mortality.org](http://www.mortality.org)).

Fig. 2.4.1.

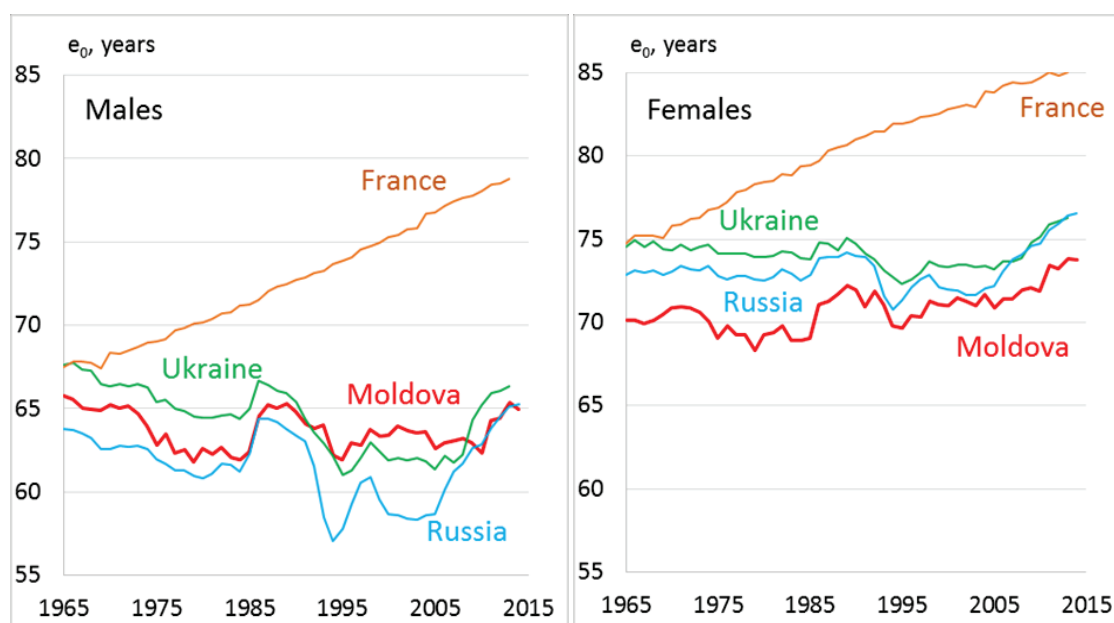


Fig. 2.4.2.

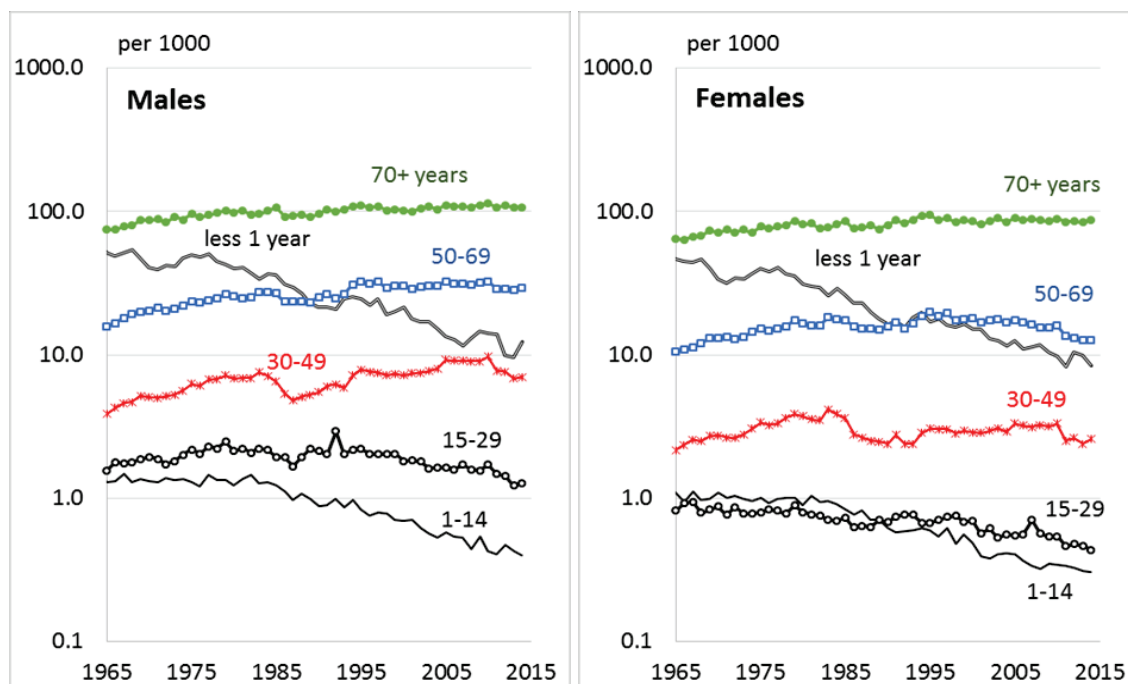


Fig. 2.4.2. Dynamics of Age-Specific Death Rates, by Sex, 1965-2014  
Source: calculations based on the Human Cause of Death database (www.causesofdeath.org)

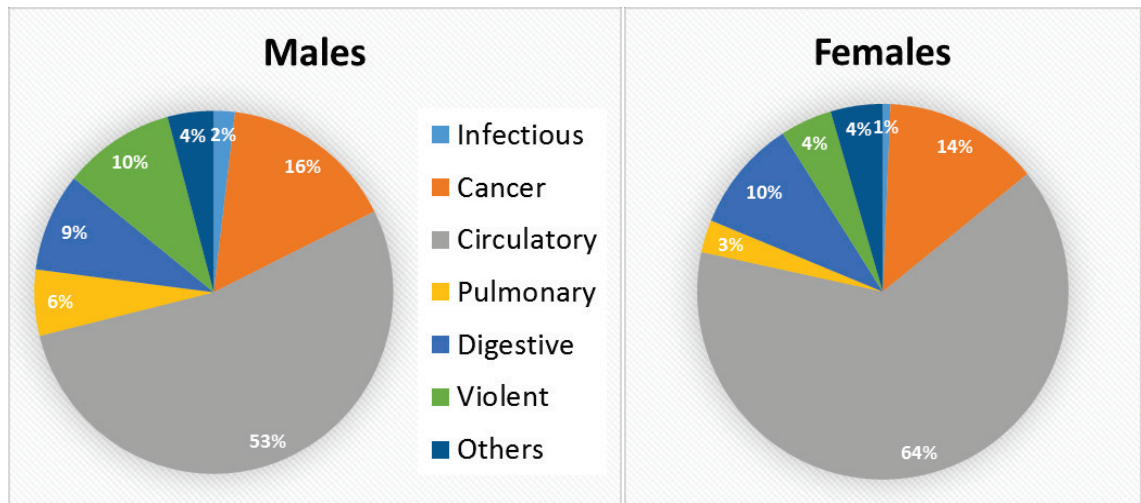
On the other hand, the progress in reducing infant and child mortality was completely levelled by the enormous increase in mortality among the working age population, especially among men aged 30-69. During 1965-2014, the standardized mortality rate for men aged 50-69 increased by more than 80% (from 15.7 to 29.3 per 1,000 persons). Among elderly men (70 years and above), the situation deteriorated significantly but to a lesser extent: the standardized indicators of mortality increased by 40% (from 74.7 to 106.9 per 1,000 persons). On the other hand, mortality among young men aged 15-29, after a long period of deterioration, has been moderately declining since the mid-1990s. Thus, between 1991 and 2014, the standardized mortality rate for this age group decreased by 50% (from 2.0 to 1.3 per 1,000 persons). These recent signs of improvement are also visible in the case of young women, although the mortality level for adult and older women remains at the same high level, typical for the past twenty years.

The ascending trend in adult mortality is marked by fluctuations related to the anti-alcohol campaign in the 1980s and the socio-economic crisis in the 1990s, aggravated by the military conflict in Transnistria in 1992. These fluctuations are more significant for working age men and less for women of advanced ages. It is important to stress that the trend of increased mortality among adults was established during the Soviet period, after large fluctuations related to the anti-alcohol campaign of 1985-1987 and the reforms in the 1990s, and resumed its upward trend, which is maintained up till now. To be noted that the situation is mostly devastating among male adults. The long-term increase in mortality among adults in the last five decades testifies about a severe health crisis of this category of people. The most vulnerable group consists of men aged 40-69 (Fig. 2.4.3.).

**Mortality by causes of death.** Fig. 2.4.3 shows the structure of mortality by cause of death in the Republic of Moldova in 2014, for the seven major causes of death. The share of deaths due to circulatory system



Fig. 2.4.3.



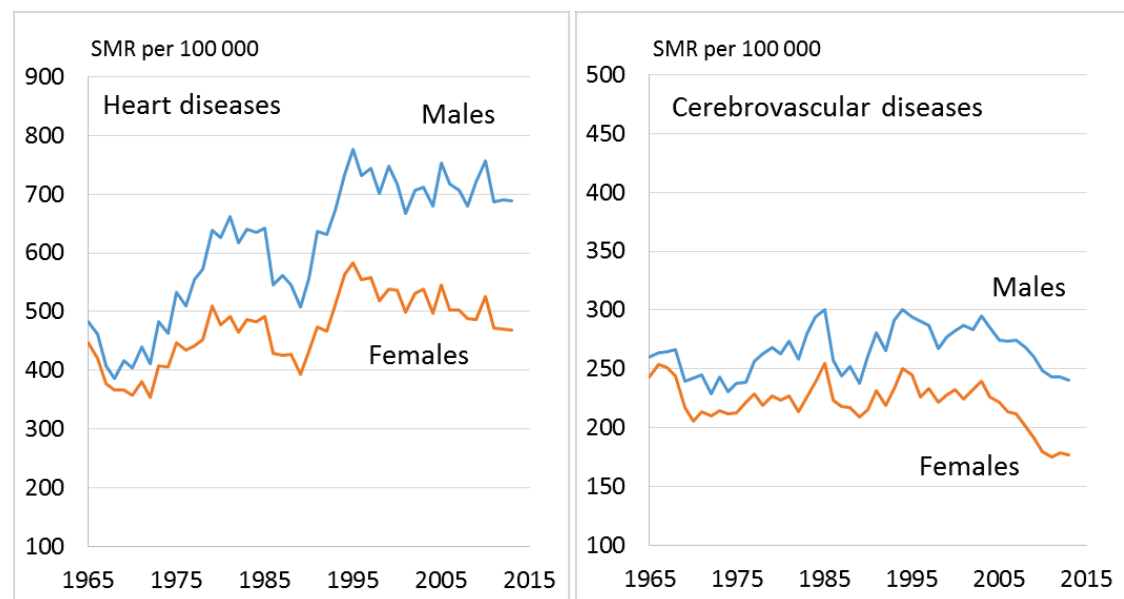
**Fig. 2.4.3.** Mortality Structure by Causes of Death and Sex, 2013  
Source: calculations based on the Human Cause of Death database ([www.causesofdeath.org](http://www.causesofdeath.org))

diseases in overall mortality is 53% for men and 64% for women. Neoplasms are ranked on the second place for both sexes (16% for men and 14% for women). For men, deaths due to external causes (10%) and digestive diseases (9%) rank third in the general mortality structure. For women, the digestive system diseases rank third among the leading causes of death (10%).

Mortality due to *heart diseases* (Fig. 2.4.4), the share of which in total mortality due to circulatory system diseases is over 70% for both genders, shows a dramatic increase over the past five decades. The anti-alcohol campaign in the early 1980s caused a significant but short-term reduction of this

kind of mortality for both sexes. Shortly after the campaign ended, the ascending trend in mortality due to heart diseases restored and even increased significantly during the 1990s. However, since the late 1990s, the standardized mortality rates due to this cause of death remained fairly stable for men and slightly decreased for women. Currently, heart disease mortality is at the same level as the one in the early 1990s for men (686 per 100,000 persons) and in the mid-1980s for women (472 per 100,000 people). Cerebrovascular diseases are the second cardiovascular cause of death after heart diseases, and recorded a very unfavourable dynamics in the last half century too. However, recent improvements

Fig. 2.4.4.



**Fig. 2.4.4.** Standardized Mortality Rates due to Heart and Cardiovascular Diseases, by Sex, 1965-2013  
Source: calculations based on the Human Cause of Death database ([www.causesofdeath.org](http://www.causesofdeath.org))



are visible for both sexes. Thus, in 2013, as compared to 2003, the standardized mortality rate due to cerebrovascular disease decreased from 295 to 243 per 100,000 for men, and from 240 to 175 per 100,000 for women.

The comparative analysis of mortality by cause of death between the Republic of Moldova and the countries with high life expectancy at birth is a good tool to determine the specific causes of death responsible for very low values of life expectancy at birth in the country. *Annex 2.4.1* presents standardized mortality rates by different causes of death in the Republic of Moldova compared to Western standards for men and women (France, Germany, Czech Republic, USA, Great Britain, Poland and Spain). Standardized mortality rates for all causes of death are 2.4 times higher for men and 2.1 times higher for women than the appropriate standard values. In terms of causes of death, the worst situation is seen in the case of circulatory system diseases, the mortality rate in the Republic of Moldova being approximately 4 times higher than the Western standards. Despite recent improvements in mortality due to cerebrovascular disease, the standardized indicator for the Republic Moldova is approximately 6 times higher for men and 5 times higher for women.

Although *neoplasms* rank second in the general mortality structure, the standardized mortality values due to this cause of death Republic of Moldova are quite comparable with the corresponding values of the Western standards, particularly for women. Nonetheless, the mortality structures by cause of death caused by various types of neoplasms vary. Thus, in Moldova, compared to the standard, the level of mortality due to digestive system

cancer, especially *stomach cancer* and *liver cancer*, is very high for both men and women (3 times and over two times higher). Moreover, for women, mortality due to *uterine cancer*, despite a general declining trend observed in the past decades<sup>64</sup>, is twice as high compared to the Western standards.

The ratio between the standardized mortality rate due to *digestive system diseases* in the Republic of Moldova and the compared countries is approximately 4.3 for both sexes, which is higher than for circulatory system diseases. For *hepatic cirrhosis*, representing approximately 80% of all digestive system diseases, this difference is striking and is 8.5 times for women and 6.0 times for men. The exceptionally high level of hepatic cirrhosis mortality, especially among female population, is a specific feature of the mortality structure by cause of death in the Republic of Moldova.

*Lesions, poisoning and other consequences of external causes* are another leading cause of death, which explains the high level of mortality for men in the Republic of Moldova compared to the Western countries (2.6 times). The mortality structure due to external causes for men is the following: suicide (17%), accidental falls, drowning and exposure to electricity and fire (17%), transport accidents (14%), accidental poisoning (10%), events of undetermined intent (9%), aggression (6%) and residual group (27%). The biggest difference between the Republic of Moldova and the Western standard in terms of external causes of mortality is registered for the *events of undetermined intent* (6.4 times),

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64 Penina O., 2012, *Tendințele mortalității după cauze de deces în Republica Moldova, anii 1965-2010 [Cause-specific mortality trends in the Republic of Moldova, 1965-2010]*, Ph.D. thesis, Chisinau, Academy of Sciences of Moldova, 263 p.

*residual group of death from external causes* (5.3 times) and external causes of death due to *accidental falls, drowning and exposure to electricity and fire* (2.9 times). The residual group by external causes of death among adult men is mainly presented by accidental inhalation of a foreign body, deaths due to overexposure to cold and residual causes of death.

Although infectious diseases do not contribute much to the overall mortality (only 2% for men and 1% for women), the standardized mortality rates due to tuberculosis in the Republic of Moldova as compared to the Western standards are 32 times higher for men and 14 times higher for women.

The population mortality analysis proves that the Republic of Moldova failed to achieve significant progress in the dynamics of life expectancy at birth. High mortality rate has multiple and complex consequences:

escalation of the depopulation process, devaluation of investments in education and staff training, slowdown of the economic growth, reduction of the opportunities to cater for pensioners. At the same time, the reserves for reducing mortality and increasing life expectancy are high. The mortality component that would have the most important and substantial contribution to increasing life expectancy is mortality due to circulatory system diseases. The *cardiovascular revolution* that took place in the Western countries in the 1970s, and spectacularly reduced mortality due to ischemic heart diseases and cerebrovascular disorders<sup>65</sup>, has yet to come to Moldova. The recoil of mortality will be possible only in the conditions of poverty reduction, sustainable economic growth, improved living standards and quality of health services.

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65 Vallin J., Meslé F., 2004, *Convergences and divergences in mortality: A new approach of health transition*, Demographic Research, S2, pp. 11–44.

## Annexis 2.4.1

Causes of death	The Republic of Moldova	The Western standard	Ratio (the Republic of Moldova/Western standard)
All causes	1755.61	738.33	2.38
Infectious Diseases	37.86	16.31	2.32
Tuberculosis	30.44	0.95	32.19
Neoplasms	261.38	210.55	1.24
Stomach cancer	24.66	7.70	3.20
Bowel cancer	56.95	36.13	1.58
Liver cancer	19.02	9.63	1.98
Lung cancer	58.90	55.93	1.05
Prostate cancer	14.36	18.67	0.77
Endocrinological, blood diseases	15.65	25.94	0.60
Nervous system diseases	23.21	48.66	0.48
Psychiatric disorders due to alcohol abuse	5.38	5.09	1.06
Epilepsy	3.27	1.38	2.37
Alzheimer's Disease	7.80	11.13	0.70
Circulatory system diseases	938.19	239.16	3.92
Heart diseases	686.35	182.69	3.76
Cerebrovascular diseases	243.35	41.33	5.89
Respiratory system diseases	107.50	65.06	1.65
Pneumonia	40.24	16.79	2.40
Digestive system diseases	153.79	36.16	4.25
Hepatic cirrhosis	118.90	19.94	5.96
External causes of death	183.50	69.47	2.64
Transport accidents	26.10	13.71	1.90
Falls, drownings, fire	30.80	10.42	2.96
Accidental poisoning	18.69	9.28	2.01
Suicide	31.81	19.31	1.65
Aggressions	10.31	4.83	2.14
Event of undetermined intent	16.04	2.50	6.43
Other causes	34.52	26.56	1.30

## Annexis 2.4.1

Table 1

Standardized mortality rate in the Republic of Moldova (2013) compared to the Western standards, by cause of death, all ages, men (per 100,000)

**Table 2**  
Standardized mortality rate in the Republic of Moldova (2013) compared to the Western standards, by cause of death, all ages, women (per 100,000)

**Table 2**

Causes of death	The Republic of Moldova	The Western standard	Ratio (the Republic of Moldova/Western standard)
All causes	1015.88	476.41	2.13
Infectious Diseases	7.12	10.89	0.65
Tuberculosis	3.90	0.27	14.31
Neoplasms	143.38	134.45	1.07
Stomach cancer	11.26	3.59	3.14
Bowel cancer	31.89	24.28	1.31
Liver cancer	8.78	3.51	2.50
Lung cancer	9.79	26.14	0.37
Breast cancer	28.55	21.97	1.30
Uterine cancer	15.32	7.22	2.12
Endocrinological, blood diseases	13.37	19.49	0.69
Nervous system diseases	8.24	42.99	0.19
Psychiatric disorders due to alcohol abuse	1.28	1.37	0.93
Epilepsy	1.03	0.81	1.28
Alzheimer's Disease	2.02	13.06	0.15
Circulatory system diseases	651.86	156.94	4.15
Heart diseases	472.41	111.47	4.24
Cerebrovascular diseases	175.48	35.22	4.98
Respiratory system diseases	35.79	40.38	0.89
Pneumonia	9.78	10.78	0.91
Digestive system diseases	95.26	21.86	4.36
Hepatic cirrhosis	80.34	9.42	8.53
External causes of death	38.90	26.43	1.47
Transport accidents	7.01	4.58	1.53
Falls, drownings, fire	5.80	5.22	1.11
Accidental poisoning	5.63	4.70	1.20
Suicide	4.47	4.91	0.91
Aggressions	3.37	1.40	2.41
Event of undetermined intent	3.88	1.04	3.72
Other causes	21.95	22.46	0.98

## 2.5. Population Ageing

Currently, population ageing caused by low birth rate and slow growth in life expectancy at birth is the most important demographic process that generates population dynamics. Compared to the economically developed countries where population ageing is due to significant increase in life expectancy at older age, in the Republic of Moldova this phenomenon is the result of low birth rate and of the percentage redistribution of the three large age groups (children, adults and elderly) in total population, while reduction in mortality and increase in life expectancy have little effect.

In the following decades the percentage of different age groups will determine the structure of the elderly population. By

2025, the age groups of 60-64 years old and 65-69 years old will predominate in the total population, accounting for about 37-43%, and a significant increase in the number of people aged 70 and above is predicted, up to 57% by 2035 (*Table 2.5.1., Fig. 2.5.1*)

Excessive mortality of working age men and their higher rate of migration will cause significant gaps in the dynamics of the elderly population by gender, with women prevailing, which is a feature of the population ageing process in the Republic of Moldova. While in 2015 the male/female ratio amounted to 64.2 men per 100 women, by 2035 this discrepancy will grow to 59.6 per 100 (*Table 2.5.2*).

Despite these worrying challenges – demographic ageing that is, this phenomenon represents a natural evolution,

**Table 2.5.1.**

	60-64	65-69	70-74	75-79	80-84	85+	Total
2015	181.6	122.7	81.2	69.3	40.7	23.8	519.3
2016	178.3	140.3	73.0	69.1	40.8	23.5	525.0
2017	177.6	152.4	68.8	68.8	41.1	23.2	531.9
2018	179.2	158.6	71.4	66.5	41.5	22.6	539.8
2019	181.5	158.4	82.9	62.4	41.4	22.0	548.6
2020	183.7	154.7	99.3	56.9	40.9	21.9	557.3
2021	183.9	152.0	113.6	51.1	40.9	22.0	563.5
2022	180.3	151.6	123.3	48.5	40.8	22.2	566.8
2023	173.8	153.2	128.2	50.9	39.4	22.2	567.7
2024	164.4	155.4	128.1	59.7	36.8	22.0	566.4
2025	152.8	157.5	125.3	71.8	33.4	21.7	562.5
2026	142.0	157.8	123.4	82.1	30.0	21.9	557.2
2027	133.5	154.8	123.3	89.0	28.8	22.0	551.5
2028	126.6	149.2	124.8	92.4	30.7	21.3	545.0
2029	120.7	141.2	126.9	92.4	36.5	20.0	537.6
2030	116.6	131.2	128.8	90.6	44.2	18.3	529.6
2031	113.6	121.9	129.1	89.5	50.4	17.0	521.4
2032	111.1	114.6	126.7	89.7	54.4	16.9	513.4
2033	109.3	108.7	122.1	91.0	56.2	17.9	505.3
2034	108.2	103.7	115.6	92.7	56.3	20.5	497.0
2035	107.5	100.1	107.4	94.3	55.4	23.6	488.4

**Table 2.5.1.**

Number of Elderly People (thousand) by Age Groups (reference scenario), 2015-2035

Source: CDR

**Table 2.5.2.**  
Numbers of Elderly People by Gender (reference scenario), 2015-2035  
Source: CCD.

	Women	Men	Men/women ratio
2015	316,3	203,0	64,2
2016	319,7	205,3	64,2
2017	323,8	208,1	64,3
2018	328,5	211,2	64,3
2019	334,0	214,6	64,2
2020	339,5	217,8	64,2
2021	343,6	220,0	64,0
2022	346,1	220,7	63,8
2023	347,3	220,3	63,4
2024	347,3	219,1	63,1
2025	345,8	216,7	62,7
2026	343,4	213,8	62,2
2027	340,8	210,7	61,8
2028	337,6	207,4	61,4
2029	333,7	203,9	61,1
2030	329,4	200,2	60,8
2031	325,0	196,4	60,4
2032	320,6	192,7	60,1
2033	316,2	189,2	59,8
2034	311,3	185,7	59,7
2035	306,0	182,4	59,6

with people living longer and in a better health. Life expectancy at birth is expected to increase in all countries, especially in the economically developed ones.<sup>66</sup>

To understand the current and future challenges of an ageing society, new tools

66 Population Trends and Policies in the UNECE Region. Outcomes, Policies and Possibilities. 2013, p.4

to measure demographic ageing became available. Due to the fact that life without disabilities becomes longer, it is better to examine ageing not only in relation to chronological age, but also in relation to the remaining life expectancy. It is assumed that the remaining life expectancy of 15 years is a relative threshold, when the probability of health worsening increases. Proceeding from this, it was proposed to calculate the *prospective old-age dependency ratio* indicator: the ratio between the number of people older than old-age threshold (with remaining life expectancy 15 years and less) and the number of people ages 20 to the old-age threshold (with remaining life expectancy 15 years and more)<sup>67</sup>. *The analysis of demographic ageing on the basis of this indicator shows a very different situation in Europe. The countries with the highest life expectancy in older age are in a more favorable situation, with the prospective old age dependency ratio lower than the chronological one.*<sup>68</sup>

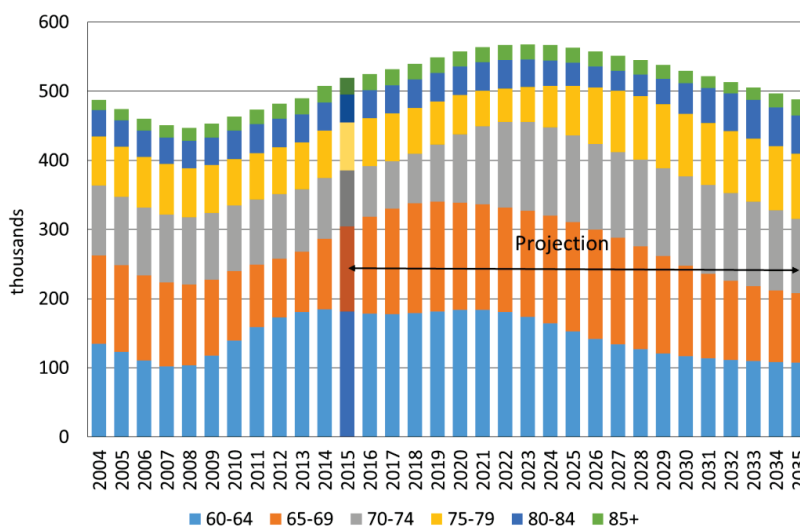
67 Sanderson, W, and S, Scherbov, *Conventional and Prospective measures of population ageing, 1995, 2005, 2025, and 2045*, Population Reference Bureau, Washington, DC, 2008.

[http:// www.prb.org/excel08/age-aging\\_table.xls](http://www.prb.org/excel08/age-aging_table.xls)

68 European Demographic Data Sheet, 2015. <http://www.oew.ac.at/en/vid/data/demographic-data-sheets/european-demographic-data-sheet-2014/re-measuring-ageing-in-europe/>

**Fig. 2.5.1.**  
Structure of the Elderly Population, estimated and projection, 2004-2035  
Source: CDR

**Fig. 2.5.1.**





When calculating the *prospective old-age dependency ratio* and comparing it with the old-age dependency ratio (based on chronological age) for the Republic of Moldova, a much worse situation is seen as compared to other European countries. With low life expectancy, the Republic of Moldova is ageing faster, and *the prospective old-age dependency ratio* is higher than *the old-age dependency ratio (chronological)*. Only the gradual increase in life expectancy (expected) can improve the situation (Fig. 2.5.2).

It is assumed that population ageing can bring about the second demographic dividend, which compared to the first demographic dividend is not linked with the structural changes in population, but with the change in individuals' life-cycles, broadening their horizons by increasing the life span. The significant increase in survival until the most advanced ages, under certain conditions, can bring about a change in the economic behaviour of people, "forcing" them to consume less and save more, or work more and longer and save more, without reducing the usual consumption of goods.<sup>69</sup>

69 Carstensen L. *The Influence of a Sense of Time on Human*

An important feature of demographic ageing is the increase in healthy life expectancy – the number of years lived in a good health condition, which increases in parallel with life expectancy at birth in all countries in the region. This means that more and more people will live with a good health status at the age of 65 and above, which gives them the opportunity to remain economically and socially active, to enjoy autonomy and not to be a burden for the healthcare and social assistance systems.

In 2013, in the Republic of Moldova, the life expectancy at the age of 65 is estimated at 14.7 years for women and 11.5 years for men. Men will spend 7 years (61% of the remaining years) in good health condition (very good, good and satisfactory) and 3 years (34% of the remaining years) without chronic diseases. Women will spend 7.6 years (52% of the remaining years) in good health condition, and 3.7 years (25% of the remaining years) without chronic diseases (Fig. 2.5.3).

Although the healthy life expectancy

Development // Science, Vol. 312, 2006. p. 1913 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2790864/>

Fig. 2.5.2.

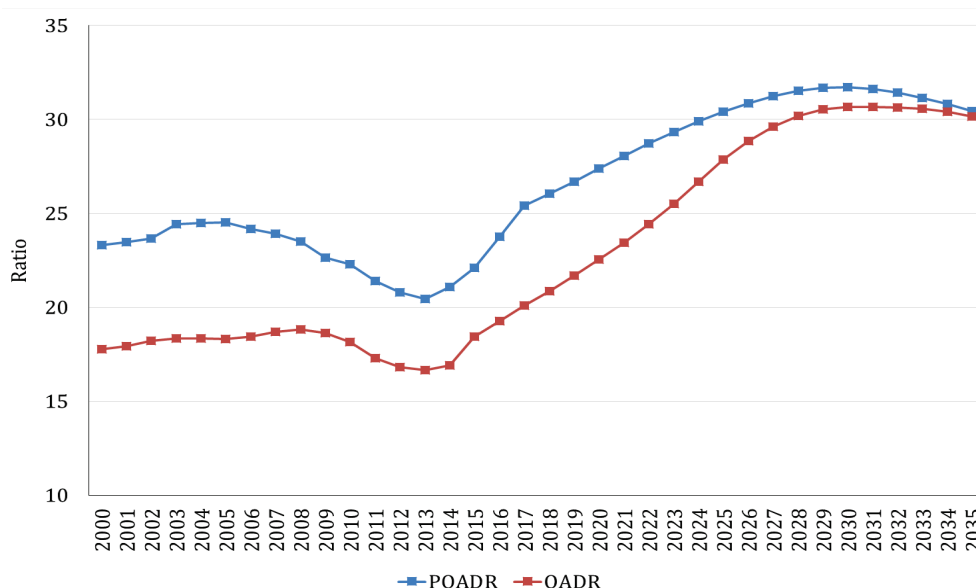


Fig. 2.5.2. The Old-Age Dependency Ratio (OADR) and the Prospective Old-Age Dependency Ratio. Source: CDR

indicator in the Republic of Moldova is much lower than in economically developed countries, the improvement of population health status and the increase in life expectancy at birth presents opportunities for active ageing, expanding the physical horizons for self-realization and self-fulfilling.

In this context, in promoting policies, the governments in the region are increasingly focusing on the concept of active ageing, which means ageing in optimal health status, having an active role in the society, reaching professional self-fulfilment, having an independent daily life, and getting involved in civic activities. Active ageing includes both an individual process and social opportunities of health structures, participation and integration. The fundamental objective of interventions in the field of active ageing is to optimize the opportunities for health, participation and security so as to enhance the quality of life with ageing<sup>70</sup>.

<sup>70</sup>Active Ageing Index 2012. Concept, Methodology and Final Results. Vienna, March 2013. (Authored by A.Zaidi / Project Coordinator/ and others).

In the conditions of demographic ageing, the role of older people in the society will increase, and this category of the population will have a growing influence, including through electoral vote, by giving preference to those parties and political leaders whose programs will be more geared towards supporting the elderly. This can prevent promoting reforms in the pension system, ensuring its stability, as well as the socio-economic development based on intergenerational consolidation.

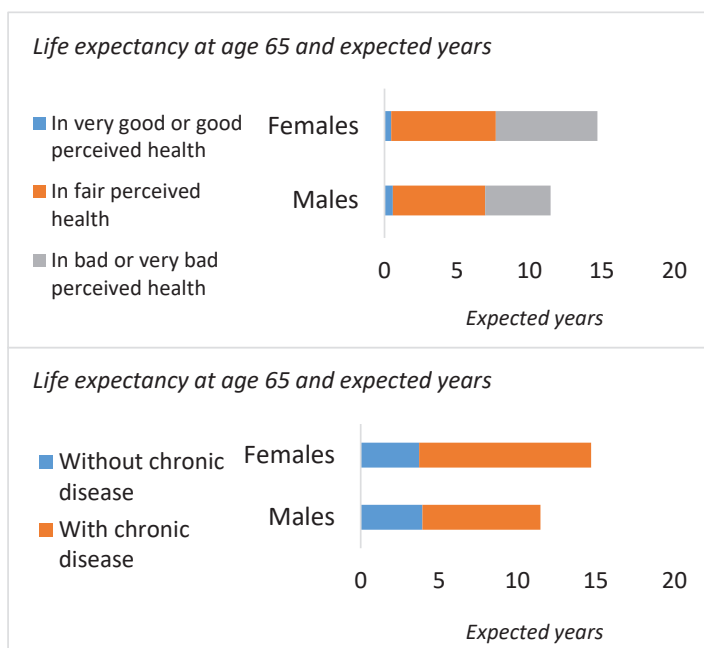
## 2.6 Emigration

Before the USSR collapsed, the population used to migrate from the Republic of Moldova exclusively to the countries of the union. Opening the borders made it possible for the population to move to other countries, too. Since the late 1980s, the migration processes in the Republic of Moldova have changed in the opposite direction. The old system of migration control has been destroyed and the migratory behaviour of the population and the causes of migration have changed. The choice of new routes by emigrants was influenced by a variety of factors, such as political, ethnic, socio-economic, cultural and linguistic factors.

The biggest drawback of the national statistics in the international migration is that the actual number of emigrants is underestimated. As there is no reliable data on emigration flows, the data of the host countries are a good source of indirect estimation of the size and characteristics of external migration. Estimates based on foreign data show that currently the number of Moldovan migrants settled down abroad is six times higher.

**Fig. 2.5.3.** Healthy life expectancy at the age of 65 based on self-assessment of health status and presence of chronic diseases, by sex, 2013  
Source: calculations based on the Households Budget Survey (www.statistica.md) and alternative estimates of the number of population (Penina O., Grigoriev P. and Jdanov D., 2015)

**Fig. 2.5.3.**



The period between the mid 1980s and 1990s differs by mass emigration of ethnic minorities. The flows of emigrants consisted specifically of Russians, Ukrainians, Hebrews, and the main destination countries were Russia, Israel, Ukraine, Germany and USA (Fig. 2.6.1). In some years, the flows of emigrants to Germany were exceeded by those to the USA.

In the second half of the 1990s, when the ethnic emigration virtually ended, the emigration with unauthorised residence for employment purposes became the most significant. The main destination countries for irregular migrants were the countries of South Europe such as Greece, Italy, Spain, Portugal, and the Czech Republic. Meanwhile, several laws adopted by host

countries offered amnesty to illegal workers from outside the EU countries, including Moldovan citizens. As a result thereof, the Portuguese statistics in 2001 recorded a total of slightly more than 10 thousand Moldovans who obtained residence in Portugal. In 2000, the flow of migrants to Spain increased 11 times compared to 1999, and to Italy – 7.5 times in 2003 compared to 2002 (Fig. 2.6.1).

From 2000 until now, Russia and Italy are the two main countries hosting the majority of Moldovan migrants (Fig. 2.6.1). The massive emigration to Italy was determined, in addition to economic factors, by the encouraging migration policy implemented through government programs of immigrants' social integration

Fig. 2.6.1.

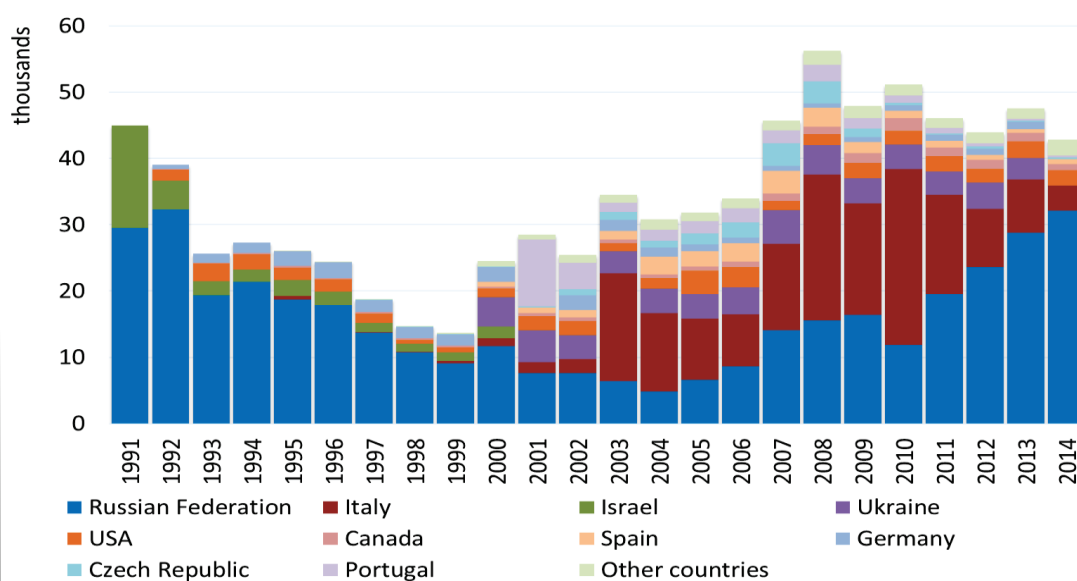


Fig. 2.6.1. Migration flow from the Republic of Moldova, 1991-2014

Sources: Russian Federal State Statistics Service, Italian National Institute of Statistics, National Statistics Institute of Spain, State Statistics Service of Ukraine, US Department of Homeland Security, Statistics Canada, the UN, OECD and Toltz M.<sup>1</sup>

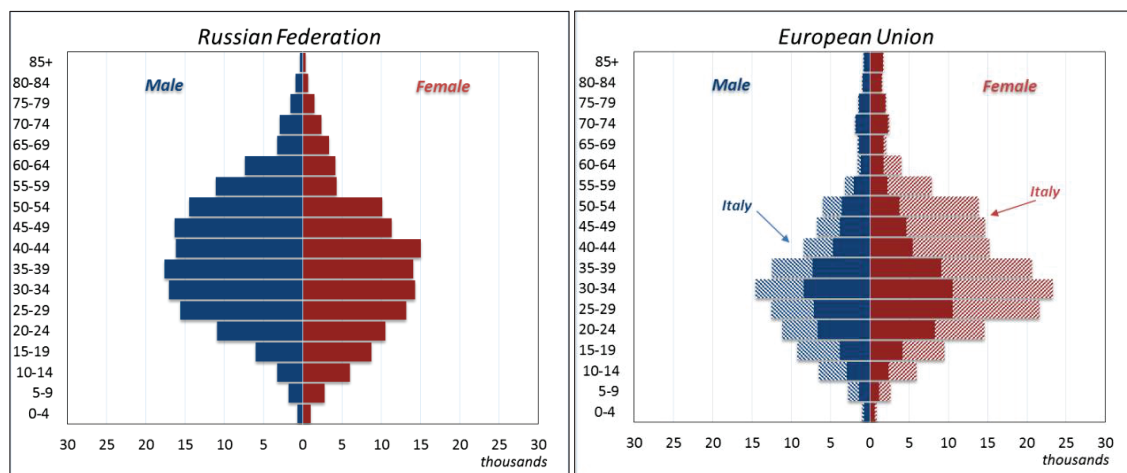
Note: Data on emigrant flows have been collected from sources of host countries on Moldovan citizens who immigrated to those countries. The data do not include the Moldovan citizens who emigrated based on an identity document issued by the Romanian authorities

1 Toltz M. Российская эмиграция в Израиль. (*Russian emigration to Israel*). Население и общество. Информационный бюллетень Центра демографии и экологии человека Института народнохозяйственного прогнозирования РАН, Nr.71, 2003.

and reunification of their families. The emigration to Russian was encouraged by a similar sociocultural environment, where Moldovan migrants face fewer difficulties in integration, and also less severe restrictions when entering the country compared to the restrictions imposed by the EU countries. These pull factors and the pay gaps between the Republic of Moldova and the host countries, as well as the lack of major language barriers intensified the population

**Fig. 2.6.2.**  
Age-sex pyramids of emigrants from the Republic of Moldova to Russia and the European Union (according to the 2011 census data)  
Source: Russian Federal State Statistics Service and Eurostat

**Fig. 2.6.2.**



migration to these two countries.

Since 2000 the migration flows to distant foreign countries like the USA and Canada have been increasing slowly, but constantly. The highest flow of Moldovans to the USA was registered in 2005 and 2006. Most Moldovans are admitted to the USA as refugees and asylum seekers (three of four emigrants) and less for work, studies, or family reasons<sup>71</sup>. As compared to 2010, the flows to Canada increased fourfold in 2007 and sevenfold in 2010. As a rule, highly qualified people (brain drain) and young families emigrate to Canada. Today, an average of 1,500 people emigrate to Canada and 2,500 people to the USA (Fig. 2.6.1).

In the second half of the 2000s, Italy, Spain, and Portugal adopted a series of legislative acts to stimulate migration from non-EU countries. As a result of these legislative changes, the workforce migration is gradually replaced by long-term migration or change of residence. Since 2008, in Italy, the number of children up to the age of 17 increase considerably, and the gender ratio decreased compared to previous years. In

<sup>71</sup> Tabac T. Moldovenii în "Tara Visurilor" (Moldovans in "Country of Dreams"). Buletin de informație și analiză în demografie, Nr.2, 2015, p.6

Portugal, the number the Moldovans who obtain Portugal citizenship increased, so that in 2008-2014 they amounted to 15.3 thousand people. For comparison, twice as few Moldovans obtained Italian citizenship in the same period – 7.3 thousand.

Since 2010, a downward trend in emigration flows to some European countries is observed. By 2013 the flow to Spain (~ 600 people), Portugal (~300 people) and the Czech Republic (~ 200 people) became almost insignificant. Emigration to the USA and Canada remains stable, these being the most preferred destination countries after Russia and Italy. Also, starting with 2010 the return migration from Italy and Russia increased.

#### **Size of Moldovan population abroad.**

According to the 2011 census data, the number of emigrants outside the country amounted to 584,6 thousand people, of whom nearly half lived in Russia (48%), and the other half in over 15 European countries (49.8%), of which 22.8% in Italy (Table 2.6.1). Impressive growth in the 2011 census as compared to 2001 was in Italy (31 times), France (12 times), the Czech Republic (11 times), Spain (9 times), Turkey (8 times), the UK (7 times),

Portugal and Cyprus (5 times). The number of Moldovans in Romania and the Baltic countries dropped because these are countries that people migrate from rather than to them.

The calculations based on the census data of the host countries reveal that around 16% of Moldovan population in 2011 had stable residence abroad. This is also confirmed by other researches on the size of (de facto) present population<sup>72</sup>.

A good tool for immediate visualization of emigrants' structure is the age-sex pyramid. According to the pyramids shown in *Fig. 2.6.2.*, there is a great disproportion between men and women depending on the destination countries. Thus, Russia is a destination country that men aged between 20-59 predominantly go to, while the share of women is comparatively lower. Female emigration was more intense to the EU countries, and by 2011 there was an increase in the number of women in these countries. The share of women increased particularly in Italy, where the emigrants' gender ratio is completely distorted. The large number of women of childbearing age (20-49 years) in Italy represents a big loss for the reproductive potential Republic of Moldova. Also, the Republic of Moldova has lost half a million of its working population to migration, which speeds up demographic ageing.

**Losses of population because of migration.** The largest migration losses were recorded in 2007-2011, when net migration varied between 33,000 and 43,000 people per year, the rate of

72 Penina, O., Jdanov, D. A., Grigoriev, P. Producing reliable mortality estimates in the context of distorted population statistics: the case of Moldova. MPIDR Working Paper WP-2015-011, 35 pages (November 2015). Rostock, Max Planck Institute for Demographic Research.

Table 2.6.1.

Country	2001	2011	2011-2001
Russia	270 591	280 871	10 280
Italy	4 335	133 218	128 883
Romania	39 440	37 370	-2070
Ireland	1 032	3 421	2 389
Greece	6 354	10 398	4 044
Spain	2 272	19 975	17 703
France	597	7 321	6 724
Turkey	2 333	19 800	17 467
Cyprus	474	2 348	1 874
The Czech Republic	819	9 369	8 550
Portugal	3 040	14 324	11 284
The UK	446	3 180	2 734
Germany	-	19 800	-
The USA	16 695	-	-
Canada	2 300	12 840	10 540
The Baltic countries	4 024	2 720	-1304
Other countries	2 379	7 673	5 294
Total	357 131	584 628	227 497

emigration constitutes about 16-18 ‰ and net migration rate - 12-14 ‰. In the years 2012-2013 Moldova has lost 30 thousand people per year or 1% of the present population by country (*Fig. 2.6.3*).

#### Short-term population emigration.

Temporary migration for work purposes is another model of emigration that persists in the Moldovan society. This type of migration is difficult to estimate because few emigrants work legally in the destination countries. In this regard, the Border Guard Service data allow us to observe some trends of short-term emigration (for a period shorter than 12 months). According to these data, short-term migration has been increasing in recent years, with slightly more than 284 thousand people in 2014 (*Fig. 2.6.4*). Like in the case of migration with change of residence, the share of women who temporarily migrate is higher and amounted to 55% in 2014. It was observed that every year most migrants

**Table 2.6.1.** Emigrants born in the Republic of Moldova residing abroad (according to the 2001 and 2011 census data) Source: Eurostat, Russian Federal State Statistics Service, the United States Census Bureau, Statistics Canada



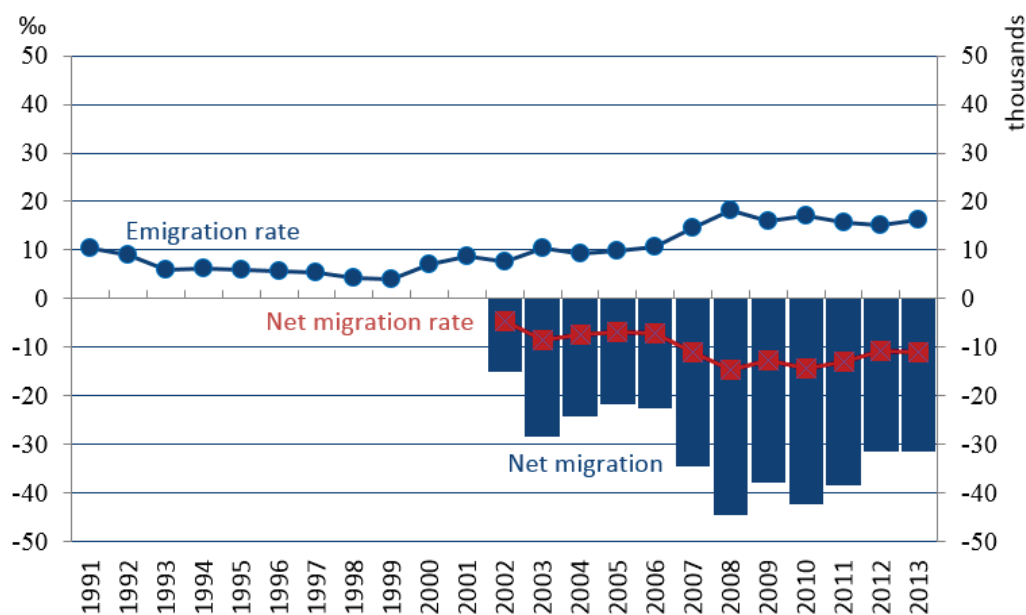
**Fig. 2.6.3.**

Moldovan population losses in absolute (net migration, left bar) and relative values (emigration rate and net migration rate).

Source: Russian Federal State Statistics Service, Italian National Institute of Statistics, State Statistics Service of Ukraine, US Department of Homeland Security, Statistics Canada, the UN, OECD and Toltz M. (2002)

Notes: Calculated according to the host countries' data on immigration and emigration of Moldovan citizens in relation to the present population (alternative data O. Penina, D. Jdanov and P. Grigoriev).

**Fig. 2.6.3.**



come from the 25-29 and 30-34 age groups.

This pattern of migration is particularly true in the case of emigration to the Russian Federation. As for why it persists – it is not because migrants consider it most advantageous or because they have no desire to settle down or reunite with their families. This happens because the Russian migration policy is geared more towards short-term migration and less towards the long-term one. This does not motivate the majority of migrants to

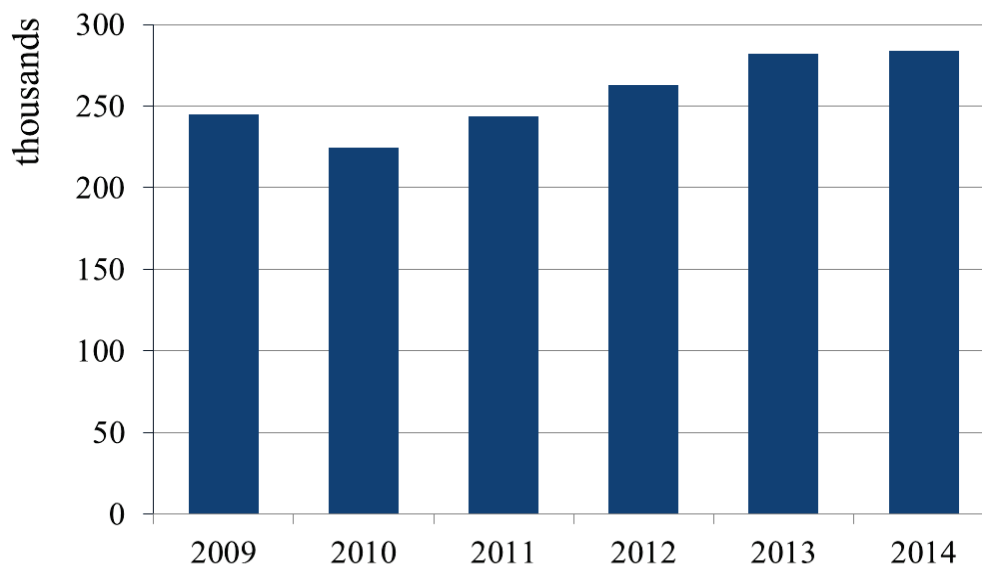
return home permanently, since they are forced by legislative conditions to travel to Russia several times a year. Currently, the Russian scientific community is making considerable efforts in lobbying for the long-term migration model. If the Russian migration policy changes, the Republic of Moldova may face greater losses of population. Experience has shown that long-term migration, integration into host countries and family reunification reduce the probability of returning home.

**Fig. 2.6.4.**

Short-term emigration of the population of the Republic of Moldova

Source: Moldovan Border Guard Service

**Fig. 2.6.4.**





## 2.7. Socio-demographic information – an important tool in developing and promoting policies based on expanding human rights and opportunities

The demographic statistics and the socio-demographic research findings underpin the evidence-based political decisions that have a significant impact on the population's welfare and life quality, the expansion of human rights and opportunities in accordance with the level of economic and technological development of the XXI century. The amount of data available, their quality, usability and public dissemination is an important feature of the national statistical system and its continuous improvement, production of information on a wide range of demographic and social issues, its aligning with the European standards is one of the main objectives in the context of the Republic of Moldova – EU Association Agreement.

The official statistics are an indispensable element of the information system of a democratic society, providing data on the economic, demographic and social state of the country to the Government, local public administration, economical sector and the population. The statistical information supports transparency and openness of the public policy decisions, the official statistics thus representing a public good which provides a basis for the proper functioning of society.

The Population Census is the backbone of any national statistical system, serving as a benchmark for annual calculations of

the population and multiple economical, demographic and social indicators that are calculated in relation to the number of population. Reliability and complexity of the population census data provides a solid analytical and informational basis concerning the priority issues of sustainable development, such as those concerning the development of human settlements and town planning, those concerning the quality of life aspects related to living conditions (including the use of housing units fund), concerning the foundation of development of housing construction and necessary urban facilities, those relating to the environment.

The census data are used as a reliable source of information for the implementation of the administrative-territorial reform budgetary process. Starting from the assumption that the aim of such a reform would be to create administrative-territorial units, the authorities of which should be able to provide high quality services for their residents, any activity of decision makers should relate to the number of resident population.

The social culture emphasizes the population values, attitudes and beliefs; the number of residents of a community and their administrative-territorial organization have a direct impact on the institution, and the social structure regards the segments of population, such as the employed versus the retired, the majority versus the minority etc. Thus, the public policies supported by the institution aim to satisfy all these segments of the population.

Forecasting and subsequent administration of socio-economic development of the country is impossible without knowing the structure of the population by working age, professional training, education level, etc. The demographic forecast is the basic

element from which future objectives for different systems stem, such as the education and healthcare systems. For policy making and efficient planning of the budget in the education system, the responsible authorities should take into account the current number of pupils and students, and also their number in the future, the availability of places in educational institutions etc, here all the decisions that relate to this system relate to the number of resident population.

The education statistics provide information about the achievement of citizens' rights to education, the proportions in training qualified professionals, providing jobs and the state of technical-and-material base in educational institutions of all forms of ownership and profits. The information is provided by the educational institutions of the Ministry of Education, of other ministries and departments.

The active use of socio-demographic information in policymaking and the public sector capacity to collect, analyze and disseminate data on healthcare are important elements in management, development and implementation activities in the public healthcare field.

The comprehensive information about the country population, given by the census, is also needed by international organizations that provide support to the Republic of Moldova in implementing various humanitarian programs, such as the poverty reduction program, healthcare and social protection reforms, etc.

Two population censuses were carried out in the Republic of Moldova during the period of independence: The 2004 Population Census and the 2014 Population and Housing Census in 2014. The latest

census results will appear as late as March 2017, and the difficulties in its performing can lead to a low level of confidence in estimating the population number and structure.

The statistics are a part of development planning. If such information is missing, then the idea of a sustainable and efficient development of the society cannot strike roots. Statistical information is useful and necessary to boost development, not only for monitoring the progress, but also for achieving the results it evaluates. These data are of particular importance for persons vested with the authority to develop and take decisions in the economic or social area, especially for those who adopt economic policies that are beneficial for society dynamics.

The state population registers and various administrative sources have an important place in the statistical system of the European countries. Moreover, many countries have switched from traditional censuses to censuses based on population registers (fully or partially). However, the use of population registers and other administrative sources is possible only under certain conditions. First, the administrative sources are of high quality – the central register covers the entire population. Equally important is the ability to mainstream demographic data at the micro level – information about individuals in several registers – of population, students, the unemployed, business entities, pensioners, tax, etc, which can be connected to the personal identification code assigned to each citizen of the country, or other features of their identities. In its turn, this mainstreaming is possible only in conditions of close cooperation between the institutions keeping separate registers.

The protection of personal data, while ensuring the use of data from the population register for statistical, administrative or scientific purposes, is of crucial importance. Currently, the Republic of Moldova has the State Register of Population and a number of sectoral administrative registers, but these are little used for statistical purposes, including for estimating the population and migration flows.

The selective population researches have an important role in providing analytical and informational base in the decision-making process. These are thematic scientific researches that bring considerable support in expanding the thematic area and forming solid analytical sources on different issues. An eloquent example is the labour market statistics based on selective researches applying the ILO methodology, representing a major source on the current situation on the labour market, as well as a basis for labour market forecasts.

Aligning with the European standards in realizing selective researches, and connecting to the European researches carried out according to unique methodology will help improve the process and ensure comparability of the obtained data.

Socio-demographic forecasts are an important tool in developing and promoting policies based on expanding human rights and opportunities. Nowadays, governments of many countries, particularly of those economically developed, attach great importance to demographic forecasts, taking into account the demographic dynamics in adopting various economic and social programs. In taking decisions, the competent bodies should know what will be the population structure in 1, 2, 10, 20 and even 50 years. Demographic forecasts is

the source of information for governments that allows them to know the situation of today and to plan the future activities and expenses in various fields (education, healthcare, public social security, social assistance, labour market, etc). At the same time, these are needed for the routing the demographic processes by developing and promoting demographic policies in line with the national interests, which would ensure the country's sustainable development.

The Republic of Moldova does not develop official forecasts, whereas the analytical ones, developed by CDR, or the forecasts of the European institutions are not properly used to develop, promote and monitor the population and development policies.

We notice thus that currently the Republic of Moldova faces several major issues/risks related to the statistical and informational support for the decision making:

- The national official statistics cannot provide reliable data on the actual size of Moldovan population (de facto population), which leads to significant distortions in assessing the demographic situation of the country, including the development of reliable demographic forecasts.
- Accordingly, the state institutions do not have a reliable analytical-and-informational basis for planning the state budget, organizing and planning sectoral activities: in healthcare, education, social protection and social insurance, labour market regulation, etc.
- The state institutions do not use demographic forecasts in planning and developing strategies for the socio-economic development of the country.

## 2.8. Conclusions and policy recommendations

Nowadays, the Moldovan socio-demographic development is characterized not only by reduction in the population number and increased depopulation pace, but also by unsatisfactory indicators of population reproduction (low fertility, high mortality, mass emigration flow). The demographic forecasts show a sharp deterioration in the age structure of the population, rapid ageing, which in the current socio-economic conditions poses a real threat that can undermine all the efforts to improve the economy and the living standards.

The population number and structure are determined by a number of social and individual factors that intersect among themselves, by economic conditions and the conditions for women and men on the labour market, by the population structure by marital status, income and costs related to the upbringing and education of children, all this make it extremely difficult to establish the causes and develop efficient policies to route the demographic processes.

It is obvious that the significant reduction in the Moldovan population size and rapid ageing have important implications for the socio-economic development. Today and in the following years the Republic of Moldova will have a relatively high share of population of working age in the total population (the demographic dividend), which under increasing employment rates and extended working life provides significant socio-economic opportunities. At the same time, the increase in the number

of the elderly involves the dependency ratio and adds a considerable burden to the state budget for pension insurance, healthcare and other social services. The decrease in the number of children and young people in the total population has always allowed and will allow saving and redistributing financial resources, but these are short-term gains, while the long-term outlook shows that without a substantial recovery of fertility the demographic situation of the Republic of Moldova cannot improve.

Currently, high mortality and low life expectancy lead to significant human capital losses. The current health status of young and middle-aged people in the Republic of Moldova, and the availability of quality medical services, particularly for socially vulnerable people decisively affect the evolution of life expectancy, disability or dependency, and the increasing need for long-lasting care. Increased life expectancy means more healthy years, active and productive lives.

The recovery of economic growth, which the Republic of Moldova needs so much, will inevitably contribute to an expanding demand for labour force and increasing labour costs. Considering that the decrease in the population number and population ageing represent a problem for most European economies, it is expected that the regional competitiveness for the labour force will increase in the coming decades, and the gap in living standards and wage levels in the Republic of Moldova and other European countries will still be a stimulus for migration.

This will also put more pressure on the pension funds as a result of substantial increase in the number of such beneficiaries – a much discussed issue, but with no

optimal solution found.

A fall in migration could turn out to be an important factor for the improvement of the demographic situation. In addition, the supported return and integration of migrants brings about socio-economic benefits, since they involve a possible transfer of accumulated financial capital (savings made abroad), of human capital (experience, skills, knowledge, ideas and business practices, etc.) and of social capital (contacts, relationships, networks).

These factors suggest that the country could mitigate the negative effects of demographic ageing by creating opportunities on the labour market, including for the elderly, improving health and reducing mortality of working age population, investing in youth and increasing the living standards, creating favourable conditions for raising children.

At the same time, according to the national and international researches, the current policy strategies are very poorly adapted to changes in population dynamics. The demographic drivers (low fertility, population ageing, migration) and the economic consequences thereof (the ratio between the active population and inactive, the quality of education, poverty) are not properly taken into account in the economic and social policies, therefore the Republic of Moldova needs to adjust to these two dimensions<sup>73</sup>.

Although since the late 2000s the demographic issues became a concern for the Moldovan Government, and the *National Commission on Population and Development (CNPDP)* was founded in 2007, and a number of regulatory acts including the *National Strategic Programme on Demographic*

<sup>73</sup> Golden Ageing. Prospects for healthy, active, and prosperous ageing in Europe and Central Asia. World Bank Group. 2015, p.5.

*Security of the Republic of Moldova (2011-2025)* have been approved, these activities had no positive impact on the demographic dynamics.

The implementation of the 2011-2016 action plan of the National Strategic Programme on Demographic Security (2011-2025) has not delivered the expected results both because the demographic targets submitted were not supported by the respective changes in economic and social fields, and because of the lack of financing of the planned activities and low relevance of the proposed activities, as well as the low level of implementation as a result of lack of effective coordination across sectors.

The following action plan for the implementation of the National Strategic Programme on Demographic Security of the Republic of Moldova (2011-2025) will be drawn up considering the issues/risks outlined above, focusing on involving all state and civil society institutions in achieving the set objectives. Monitoring the implementation of the strategy and the results is indispensable for the implementation of corrections along the way, reconsideration of priorities and means, avoidance of negative effects. Obviously, this plan should be comprehensive, coherent, unitary, realistic, which also requires considerable allowances.

Birth rate recovery can only be achieved through complex measures of support and social protection of families with children. It is not just about increasing the childbirth and care allowances or other incentives. These measures could be the following:

- support young families and families with children to improve their living conditions by providing preferential loans,



- improve the system of allowances for childbirth and childcare, increase the amount of allowances for childcare leave, strengthen the differentiation in sizes of allowances depending on the number of children. Increase the paid maternity leave for uninsured women from 1.5 to 2 years.
- help parents, particularly mothers, in carrying out simultaneously the family and professional duties by developing extra-familial education services, improving accessibility and quality of services for all categories of population;
- reduce the taxes for families with children to help increase their income and reduce expenses related to child upbringing;
- extending free services for children, developing a favourable environment for holidays and socio-cultural education;
- replace financial aid to socially vulnerable families with free services for children (kindergarten/nursery, nutrition in school canteens, school supplies, etc.), thus contributing to an increased addressability of the granted aid and improved the life quality of children.

It is important that these measures be perceived by the population as a significant and substantial support to families to facilitate their decisions about having children, guaranteeing this aid in further care and education. Any measures that will be contrary to the individual interests and choices will be less efficient, especially in the long run.

Promoting family values, raising the status of families with children and of children in society play an important role

in the demographic policies. This objective requires strengthening the long-term efforts of the whole society, involving the government, professionals, schools, the media, the civil society and public opinion.

*Reducing of mortality and increase of life expectancy at birth* of Moldovan population represents a priority in demographic policy-making for the coming decades. The reserves of the Republic of Moldova for reducing mortality and increasing life expectancy are high.

Currently, the main causes of the low health status of Moldovan population are the following:

- a large part of population has low income, limited possibilities to maintain a healthy lifestyle (malnutrition, lack of rest, psychological stress, alcohol abuse to offset stress) and marginalization of population (unemployment, professional and cultural degradation);
- reduced accessibility to quality healthcare services for socially vulnerable people caused by poor functionality of health insurance, healthcare services commercialization, high prices for medicines and services.

Proceeding from this, we highlight the following among the priority directions in the healthcare policies:

- combating cardiovascular diseases by promoting health and health education;
- increasing the accessibility to quality healthcare services for vulnerable social categories;
- reducing disparities in morbidity and mortality between different socio-demographic groups;
- increasing functionality of health



insurance policy and reducing personal expenses;

- increasing investments to improve the health status by means of a multi-sectoral approach, including additional allocation of resources for education, working conditions, housing and healthcare sector.

Increasing the knowledgeableness and general education of the population will work towards both improving health and raising the living standards.

Directing the migration processes. The demographic decline is also reinforced by the phenomenon of Moldovan migrants' family reunification, who began taking their children who initially stayed in the Republic of Moldova to the countries that they work in. Maintaining high rates of emigration of young people, leaving of secondary and higher education professionals, who give up their places of work they had in the Republic of Moldova, deteriorates the demographic potential of the country, diminishing thus human competitiveness.

Thus, the country's economic development, increasing living standards, complemented by demographic policies to encourage the birth rate and return of Moldovan migrants back home are the most important objectives in the near future.

The migration problem, which is currently extremely complex in Europe, should not be overlooked, as it may become a pressing problem for the Republic of Moldova, too. Immigration from other geographical area, especially cultural, can have important implications on the economic and social development of the country, and in this respect, the experience and realities of some developed countries must be taken

into account.

An important aspect of the population and development policies is to strengthen the analytical-and-informational basis for the decision-making process, to produce reliable data concerning the population number and structure, including by territory. In this context, the following objectives are to be achieved:

- build the capacity of NBS to produce reliable statistical data on population and evaluating systematically the level of the general alignment of the statistical system of the Republic of Moldova with the EU standards;
- speed up the processing of the data of the 2014 Population and Housing Census, disseminating the results indicating the population by administrative-territorial units;
- re-estimate the number and structure of the population age-sex structure based on the concept of habitual residence based on the final results of 2014 Population and Housing Census and on the administrative data;
- improve the recording of demographic events (births, deaths and migration), based on the concept of usual residence;
- change the national definitions for international migration, in line with the EU standards, and improve the system of international migration flow registration, using appropriate international migration data to estimate the de facto population for calendar years;
- record the demographic events (births, deaths, migration) in relation to the concept of "usual residence".
- supplement Law No 412 of 09 December

2004 on Official Statistics Article 9(2) The official statistical bodies are bound by the phrase to develop official forecasts.

- prepare for the 2020 Population Census, which aims to create a benchmark for the harmonization of the European countries statistics.
- increase the access to the NBS primary

databases, including population censuses, for scientific purposes, which will help produce ample information on the evolution of the demographic and socio-economic phenomena, and on consolidation of the analytical-and-informational basis for preparing, implementing and monitoring the population and development policies.

# SEXUAL AND REPRODUCTIVE HEALTH

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### 3.1. Sexual and Reproductive Health and Availability of SRH services

The SRH policy in the Republic of Moldova is developed in accordance with the international commitments and the national legal regulations in force.

The international framework was initiated through the International Conference on Population and Development in Cairo (1994) which recognized the sexual and reproductive health (SRH) as a fundamental component of each person's health. Following the ICPD-PA, the Moldovan Government has initiated a series of measures designed to improve the sexual and reproductive health of the population and ensure access to reproductive health services, especially in rural areas. The Republic of Moldova has signed all relevant international conventions and strategies on SRH: Global Reproductive Health Strategy; UN Declaration on HIV/AIDS; Beijing Declaration and Platform for Action – Fourth World Conference on Women; UN Convention on the Elimination of All Forms of Discrimination against Women; UN Declaration on the Elimination of Violence against Women; UN Convention on the Rights of the Child, etc.

The national SRH policy has followed the international commitments undertaken by the Republic of Moldova. Along with other UN countries, the Republic of Moldova has participated in the formulation of the Millennium Development Goals (MDGs) and has set its own targets under Objectives 3, 4, 5 and 6<sup>74</sup>. The ultimate goal of MDG 4, set

<sup>74</sup>The Millennium Development Goals (2004-2015)

for 2015, on infant mortality and under-five mortality, was achieved beforehand, being one of the areas with the greatest progress recorded. Despite the results achieved in promoting gender equality and women's empowerment, maternal health, combating HIV/AIDS, tuberculosis and other diseases, the end targets of MDG 3, 5 and 6 could not be achieved.

Moldova's accession to the UN 2030 Agenda for Sustainable Development, which includes a set of 17 Sustainable Development Goals (SDGs), requires in the coming period the formulation of national targets to be achieved through programs and specific interventions. The process of developing and approving the national targets is ongoing.

In the Republic of Moldova, the right to sexual and reproductive health is considered a fundamental human right<sup>75</sup>. The access to safe and effective sexual and reproductive healthcare services, as part of the right to healthcare, is enshrined in the Constitution and in the Law on Reproductive Health<sup>76</sup>. The state has the obligation to ensure access to sexual and reproductive person-centered healthcare services, including the groups of people with specific needs (e.g. adolescents, victims of sexual violence and human trafficking, groups of socio-economically vulnerable people, people with disabilities, the elderly, etc.) without discrimination<sup>77</sup>.

<sup>75</sup>Universal Declaration of Human Rights adopted by the United Nations General Assembly on 10 September 1948; Article No 673 of Law No 138/15 June 2012 on reproductive health. Published: 28 September 2012 in the Official Gazette No 205-207. Date of entry into force: 28 October 2012;

<sup>76</sup> The Constitution of the Republic of Moldova/29.07.1994, Article 36. Right to healthcare; Law No 138/15.06.2012 of reproductive health, Article 4. Reproductive health rights.

<sup>77</sup> The Declaration and Programme of Action of the UN International Conference on Population and Development (Cairo, 13 September 1994), the Resolution adopted at the special session of the United Nations General Assembly (ICPD+5) of June 1999, the United Nations General Assembly Resolution 65/234 on measures adopted following the International Conference on Population and Development after

The vulnerability of different groups of people is determined by complex factors and, therefore, different sectors have not yet managed to use a unique set of criteria to define the categories of persons requiring immediate measures. The protection measures against discrimination for some groups, such as people living with HIV, women, children, migrants, foreign and stateless citizens, are included in specific regulations<sup>78</sup>.

The compulsory health insurance (CHI) system of the Republic of Moldova ensures the access to reproductive health services. The principles underlying the CHI are: universal access, solidarity, co-participation, a single insurer (National Health Insurance Company), consistency of contribution with the level of income, insurance premiums paid by the government for the disadvantaged. In 2015, the share of insured persons was of 85.6% of the total population. As a social protective action, and to ensure the universal access to health services, the Government pays the insurance premiums for a range of population categories. Thus, children, pregnant women, mothers with four or more children, disabled people, etc. have access to health services without paying the insurance premiums. Currently, all the expenses for mother and child healthcare at all levels of the health system are incurred by the Government, including

2014 (December 2010), Beijing Declaration and Platform for Action – Fourth World Conference on Women on 15 September 1995, etc.

78 Law No 23-XVI of 16 February 2007 on Prevention of HIV/AIDS, published in the Official Gazette No 054, 20 April 2007, Law No 338-XIII *infra* note 67, Article 3, Law No 1518-XV of 06 December 2002 on Migration, published in the Official Gazette No 1-2, 15 January 2003, Article 2, Article 3(d), Law No 180-XVI of 10 July 2008 on Labour Migration, published in the Official Gazette No 162-164, 29 August 2008, Article 598, Article 4 Paragraph 2, and Law No 275-XIII of 10 November 1994 on the Legal Status of Foreign and Stateless Citizens in the Republic of Moldova, published in the Official Gazette No 20, 29 December 1994, Article 234, Article 5, Paragraph 3.

the insurance of pregnant women and children under the age of 5 in out-patient facilities with 100% subsidized medicines. The folic acid and iron preparations for pregnant women were subsidized from the Compulsory Health Insurance Fund (CHIF). The share of women who received folic acid varies from 85% to 93%, depending on the administrative territory. The share of women who received iron preparations varies from 90% to 94%<sup>79</sup>.

Besides the Law on Reproductive Health, the legal regulations that influence the sexual and reproductive health sector include a number of important documents: National Health Policy<sup>80</sup>, Health System Development Strategy (2008-2017)<sup>81</sup>, National Reproductive Health Strategy (2005-2015)<sup>82</sup> etc. The National Reproductive Health Strategy was developed in strict compliance with the European Strategy on Sexual and Reproductive Health, developed by the World Health Organization. The Strategy identified 11 priority areas (family planning, risk-free maternity, sexual and reproductive health of adolescents and youth, infections of the reproductive tract, abortion and pregnancy termination services, prevention and management of infertility, prevention and management of violence and sex abuse, prevention of human trafficking, early detection and management of breast and genital cancer, sexual health of the elderly, sexual health of men) that would focus on efforts to ensure

79 [www.cnam.md](http://www.cnam.md) National Health Insurance Company, Activity Report, 2014;

[www.ms.gov.md](http://www.ms.gov.md) Report on the implementation of the National Health Policy for 2015

80 National Health Policy, approved by Government Decision No 886 of 06 August 2006

81 Health System Development Strategy (2008-2017), approved by Government Decision No 1471 of 24 December 2007

82 National Reproductive Health Strategy (2005-2015), approved by Government Decision No 913 of 26 August 2005

the exercise of sexual and reproductive rights of all citizens of the Republic of Moldova. In 2015, with support from WHO and UNFPA, the final evaluation of the 2005-2015 National Reproductive Health Strategy was completed, and the Final Report was developed, showing indicators' dynamics<sup>83</sup>. In November 2015, the strategic planning process to develop a new policy document on sexual and reproductive health for 2017-2021 was initiated.

Sexual and reproductive health services are offered by primary healthcare, specialized out-patient, and hospital units in both public and private sectors.

A phenomenon of loss of professional human resources is observed in the last years. The primary healthcare is mostly affected by lack of professional human resources, compared to other healthcare levels. A large lack of personnel (family doctors and nurses) is recorded especially in rural areas<sup>84</sup>.

The access to sexual and reproductive health services correlates with the social and economic status of the potential beneficiary. Having analysed the factors limiting the access to services, it is important to note that there is a form of limited access to the services of SRH related to poor living standards of a segment of the insured population. Therefore, we can say that some people, although they are insured, have limited access to healthcare, including reproductive health services, amid extremely low family budget. Poor families cannot afford purchasing the necessary drugs, including contraceptives, paying the transportation costs which is a

matter of access to health services outside localities. Moreover, the doctor waiting time is seen as an obstacle by beneficiaries both in rural and urban areas. To increase access of vulnerable groups to sexual and reproductive health services, the State started to cover in 2015 the cost of contraceptive products through the National Health Insurance Company. This example represents an important achievement on the way to increase access to contraceptives for certain population groups, including people with low income, adolescent girls, people living with HIV, victims of sexual violence etc.

Although the percentage of uninsured persons in the Republic of Moldova is not very high (14.55% in 2015), this segment of population is only provided with a package of services of primary importance, which limits their access to SRH services.

Currently, besides the public system, the country also has a private one for health services, including SRH services. Some reproductive health services, such as "*in vitro*" fertilization provided only by the private sector. In the current economic situation, a large segment of the population, although insured, cannot access the private services because there are still no mechanisms for settlement services for unscheduled visits.

For the population to be able to access the services – their geographical location is essential. For the rural population – which often struggles financially – accessing services involves travelling, which can turn out to be difficult sometimes, to the central region of the country; wasting time and money, depending on the distance; the waiting period the district doctor to be acceptable.

83 Borbola KOO, Mihail Stratila, Victoria Ciubotaru. Final assessment report on the 2005-2015 National Reproductive Health Strategy, Chisinau, 2015

84 [www.cnms.md](http://www.cnms.md), Medical Statistical Yearbook, 2005, 2015.



Focusing on persons and their needs is one of the principles of healthcare services' quality management, including sexual and reproductive services, which has not been fully exploited in the Republic of Moldova. Needs-centered services involve patient's rights, including the reproductive rights. The Republic of Moldova included in its national law the main international human rights standards applicable in the sexual and reproductive health sector, by ratifying the key international and regional treaties and participating in the main international documents of consensus in this area.<sup>85</sup> The rights in the field of sexual and reproductive health are stipulated in the legislation in force<sup>86</sup>.

Discrimination on criteria of age, gender, sexual orientation, ethnicity, disability or any other status can affect health and human rights in different ways. Thus, gender discrimination and low social status of girls and women often lead to a low level of physical and mental health and little control over their sexual and reproductive lives. Compared to urban women, rural women may have less access to sexual and reproductive health services, which results from the indicators presented above.

Another element that can improve or decrease access to quality sexual and reproductive health is the training of healthcare providers (e.g. family doctors

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85 International consensus documents which the Republic of Moldova participated in: International Conference on Population and Development (1994) (ICPD), the Fourth World Conference on Women (1995) (FWCW), Special Session of the United Nations General Assembly on International Conference on Population and Development (1999) (ICPD+5), Resolution of the United Nations Millennium Declaration adopted by the General Assembly (2000) (MDG), the United Nations General Assembly Special Session on HIV/AIDS (2001) (UNGASS on HIV/AIDS), the United Nations General Assembly Special Session on the Fourth World Conference on Women (2000) (FWCW+5).

86 Law No 138 of 15 June 2012 on Reproductive Health, Article 4. The Reproductive Health Rights.

and nurses) in the field of sexual and reproductive health. For purposes of training and capacity building of sexual and reproductive health workers, including family planning, in 2014 the process of adjusting the undergraduate and postgraduate curriculum was initiated, particularly in training family doctors, and the curriculum for training mid-level healthcare personnel. Although the country has standards, guidelines and protocols in line with the international requirements, developed based on the principles of evidence-based medicine, the mechanisms for their implementation are poorly developed, and no plans to implement and monitor compliance with them have been developed.

In order to enhance the quality of healthcare provided to the population and to improve the healthcare services quality management, a system to monitor the quality of services was set up at the national level, by the MoH Order<sup>87</sup>. Virtually every healthcare facility has a Quality Council, but further efforts are needed for these structures to be functional and for the SRH/FP services to be integrated into the quality assurance systems in each healthcare facility providing SRH/FP services.

The relevant legislation gives the patient the right to decide on medical intervention through the right to voluntarily consent or deny a medical intervention<sup>88</sup>. In particular, the reproductive health sector recognizes the person's right to make free decision regarding the number of children and the

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87 Ministry of Health Order No 139 of 03 March 2010 on Ensuring Quality of Care in Health Care Facilities

88 Law No 263-XV of 27 October 2005 on Rights and Responsibilities of the Patient. Published: 30 December 2005 in the Official Gazette No 176-181, Article 867. Date of entry in force: 30 June 2006

time of their delivery<sup>89</sup>. For individuals to be able to make informed decisions regarding their own sexual and reproductive health, and to request quality services from service providers, it is necessary that they have an appropriate level of information about SRHR and the services in this area.

Informing and educating people on sexual and reproductive health is an important component of the right to health, as stated in the ICPD Programme of Action and General Comment No 14<sup>90</sup>.

The access to information on family planning and contraception, danger of early pregnancy, HIV/AIDS and other STIs prevention is part of the right to health, as provided for in Article 12 of the International Covenant on Economic, Social and Cultural Rights and in Article 11 of the European Social Charter (revised)<sup>91</sup>. This kind of information should be available without discrimination, regardless of gender, disability, marital status, age or consent of parents or guardians<sup>92</sup>.

Minors' right to sexual education is recognized by law<sup>93</sup>. Age-appropriate and scientific evidence-based comprehensive sexuality education helps prevent unplanned, inappropriate and unwanted pregnancies, reduces the need for abortion,

helps to prevent HIV and STI infection. Teaching young people to be responsible for their own sexual and reproductive health has long-term, even lifelong, positive effects, and a positive impact on society. The course "Health and life skills education" that promoted a healthy lifestyle in the compulsory public education, has not been adopted by the Government, although there were numerous demarches and recommendations from international organizations. Currently, training youth on skills for a healthy lifestyle is optional, which means that not all adolescents are trained.

The mass-media can have a decisive role in promoting health messages. In this context, the state has adopted a series of legislative measures to encourage the media to promote health, both by providing allowances and entitlements, as well as imposing promotion quotas in the media. First, promoting health represents non-profit social advertising, and its free production and dissemination is considered a charity activity and enjoys the entitlements provided by law<sup>94</sup>. Second, promoting sexual and reproductive health is one of the objectives of health promotion, including by campaigns and mass activities involving the mass media<sup>95</sup>. The law requires the State Service for the Supervision of Public Health – for any campaign and mass undertaking for information, communication and education meant to promote health – and advertisement broadcasters, to provide at least 5% of daily advertising space for information aimed to promote health, as established. But these requirements are not

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89 Law No 138 of 15 June 2012 on Reproductive Health. Published: 28 September 2012 in the Official Gazette No 205-207, Article No 673. Date of entry into force: 28 October 2012;

90 International Conference on Population and Development, Programme of Action, pt.8.22 [hereinafter ICPDPA] and General Comment No 14, note 143, ¶ 11.

91 General Comment No 14, *infra* note 143, ¶¶ 11, 12(b), 34-36.

92 Article 10 of UN Convention on Elimination of Discrimination Against Women, Article 21 of UN Convention on the Rights of Persons with Disabilities, General Comment No 4, *infra* note 63, ¶ 28.

93 Law No 138 of 15 June 2012 on Reproductive Health. Published: 11 July 2014 in the Official Gazette No 205-207, Article No: 673 Date of entry into force: 28.10.2012;

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94 Law on Advertising No 1227/27.06.97, published in the Official Gazette No 067, 16.10.1997, Article 555, Article 21.

95 Law on State Supervision of Public Health, No 10/03.02.2009, published in the Official Gazette No 67, 03.04.2009, Article 183, Article 46(3)(3), Article 48.

observed. The information and education campaigns of population through media, aimed to promote a healthy lifestyle and the sexual-reproductive health are sporadic.

Various UN bodies monitoring treaties on women's and children's rights, as well as the Council of Europe bodies acknowledged the importance of collecting statistical data disaggregated by gender, age, ethnicity. The official statistics regularly collected by the public authorities do not include a range of important indicators on reproductive health. The failure to systematically collect the data on certain indicators like for example on infertility, affects the public authorities' ability to identify the potential problems and needs, and the establishment of some efficient measures on reproductive health. The conduct of studies such as the 1997 Moldova Reproductive Health Survey, 2005 Moldova Demographic and Health Survey and MICS surveys represent important but sporadic initiatives. They are not coordinated, the data are not comparable, the time frames are not systematised, which makes it difficult to follow phenomena's dynamics.

## 3.2. Perinatal, Infant and Maternal Mortality

### 3.2.1. Perinatal and Infant Mortality

The tangible results on the decrease in perinatal and infant mortality rate were achieved during the last two decades. One of the PA ICPD objectives was to reduce the infant mortality rate by a third until 2000 and to maintain a positive dynamic. In 1994, infant mortality in the Republic of Moldova reached 22.6‰, registering by 2000 a decrease by only 20% (18.3‰). The value of this indicator reduced during the following years and reached 9.8‰ in 2012,

maintaining this trend by 2015 (9.7‰), (Fig. 3.2.1.1).

Thus, the ultimate target of MDG 4, set for 2015, on infant mortality were achieved earlier, being one of the areas with the greatest progress recorded.

Even if during the last decades, the Republic of Moldova had good results in this area, if compared to Western Europe countries (France, Germany) the level of infant mortality is 3-4 times higher but at the same time this indicator is higher in comparison with Eastern Europe countries (Belarus, Russia, Ukraine) and with Baltic countries (Fig. 3.2.1.2).

Looking at the structure of infant death causes, in 2015, there are three main causes: some diseases that occur during the perinatal period (46.9%), congenital and chromosomal malformations (25.3%) and respiratory diseases (10.9%). Thus, the structure of causes of infant deaths stayed practically the same during 1999-2015. Infectious and parasitic diseases (6.1%), injuries and poisonings (4.5%), nervous system diseases and other causes of death (5.0%) were added to the structure (Fig. 3.2.1.3).

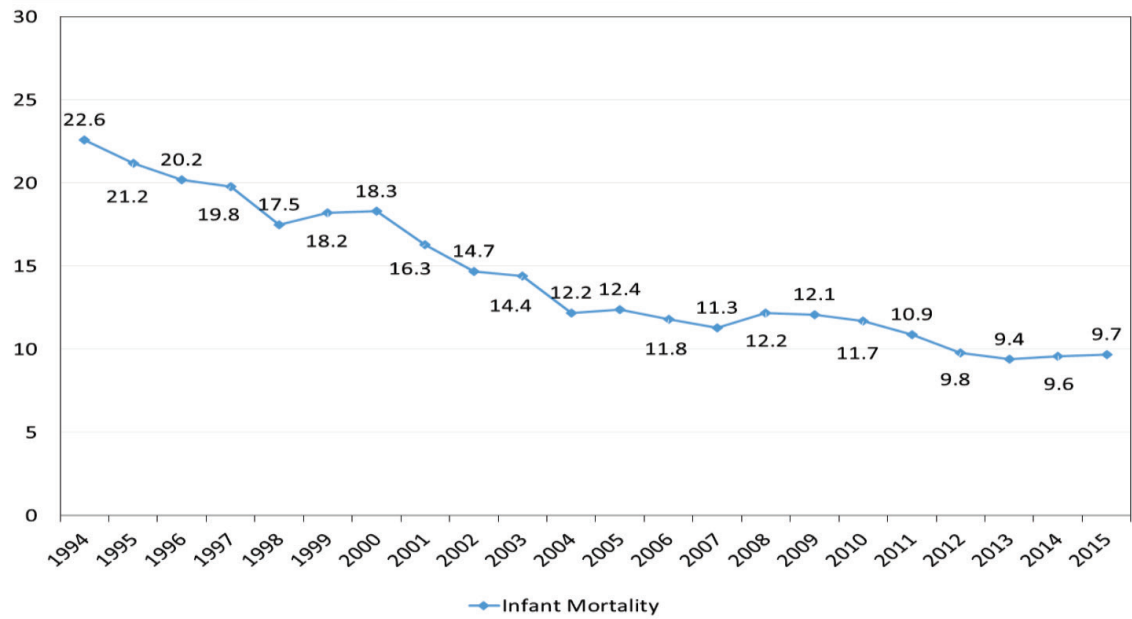
The analysis of infant mortality by age groups (early neonatal mortality, neonatal and post-neonatal mortality) shows a downwards trend during 1999-2015 (Fig. 3.2.1.4).

The perinatal mortality rate in the Republic of Moldova decreased slowly – from 13.9‰ in 1999 to 10.3‰ in 2007. In 2008 an increase in perinatal mortality rate was registered – 13.8 per 1000 live births and stillbirths<sup>96</sup>. This increase is explained by the transition to the new methodology of

<sup>96</sup> [www.cnms.md](http://www.cnms.md) National Centre for Health Management, Statistical Yearbook, 1999, 2007, 2008. These statistic data do not include the Eastern districts of the Republic of Moldova.

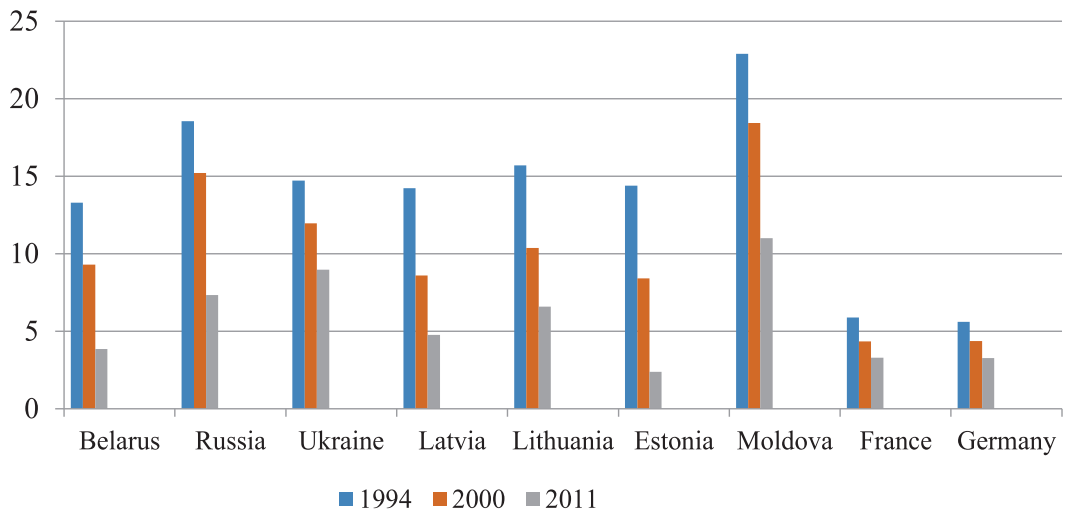
**Fig. 3.2.1.1.**  
Dynamics of Infant Mortality per 1000 Live Births, 1994-2015  
Source: NBS

**Fig. 3.2.1.1.**



**Fig. 3.2.1.2.**  
Infant Mortality Rate per 1000 Live Births, in Some Countries, 1994, 2000, 2011  
Source: WHO HFA-DB, www.euro.who.int/hfad/

**Fig. 3.2.1.2.**



**Fig. 3.2.1.3.**  
Structure of Infant Deaths, 2015  
Source: www.cnms.md National Centre for Health Management, Statistical Yearbook, 2015  
These statistic data do not include the Eastern districts of the Republic of Moldova.

**Fig. 3.2.1.3.**

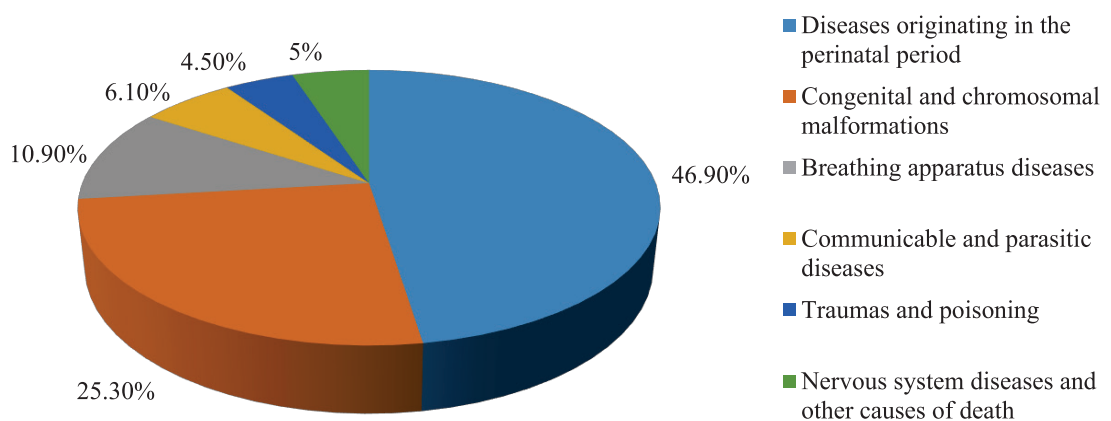
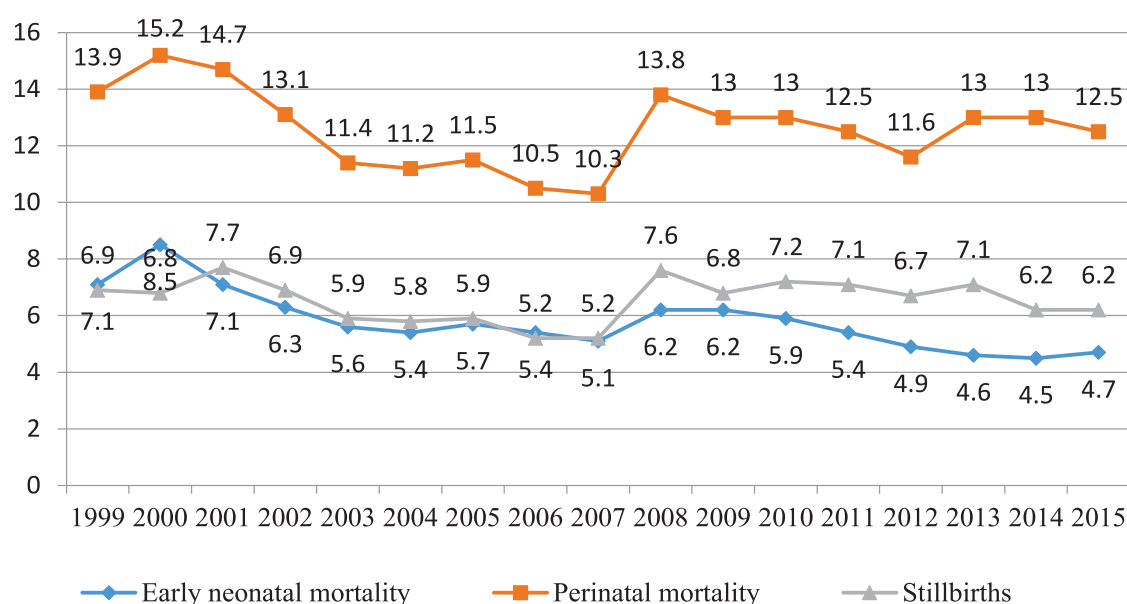


Fig. 3.2.1.4.



child mortality estimation recommended by WHO and set as an objective in the Republic of Moldova – European Union Action Plan. This way, in 2007 a new definition of “live birth” was adopted, according to the WHO criteria. According to this definition, a live birth represents the total expulsion of the fetus or his extraction at 22 weeks of gestation and/or weighting 500 grams and more, who is breathing or presenting evidence of life. Despite this fact, during the following period (2009-2015) a moderate decrease of this indicator was registered.

The perinatal mortality rate decreased especially due to the significant decrease in early neonatal mortality rate from 7.1‰ in 1999 to 4.7‰ in 2015. This achievement is due, to a great extent, to the implementation in the perinatology system of new scientific evidence-based technologies, both, in the field of obstetrics and in newborn care. During the past years, the stillbirths are at a constant level, registering 6.2‰ in 2015.

A major problem is the death of premature babies. The cases of premature babies’ death represent 50% of the perinatal mortality cases, 70% of neonatal mortality

cases and almost 1/3 of infant deaths. Over the recent period, about 1700-1900 premature-born children were registered in the Republic of Moldova, of which 170-180 children were born with extremely small body mass sometime between 22-28 weeks. The regionalization of perinatal services, the organisation of perinatal centres and their endowment with new technologies for premature-born children decreased perinatal mortality rate. Thus, the perinatal mortality among premature-born children decreased from 213‰ in 2000 to 135‰ in 2012, and the neonatal mortality – from 100.2‰ to 56.6‰<sup>97</sup>.

The perinatal deaths and the stillbirths are caused by the poor maternal health status, inadequate care during the pregnancy and birth (for example, the obstructed labour, the incorrect positioning of the fetus, asphyxia during delivery), poor hygiene during delivery and during the first hours after delivery (leads to infections that cause neonatal deaths) and the lack of an adequate care of the new-born baby<sup>98</sup>.

Fig.3.2.1.4. Dynamics of Perinatal Mortality, per 1000 Live Births, 1999-2015  
Source: NBS, www.statistica.md

97 The socio-demographic profile of the Republic of Moldova 20 years of Cairo Action Plan, Chisinau, 2014

98 Neonatal and perinatal mortality. Country, regional and



With respect to maternal and neonatal health monitoring, there is a monitoring system and an assessment mechanisms for risk-free maternity. The perinatal death indicator is monitored quarterly based on Annex 5 to the Statistical Form No 30 – “Babies” Table. However, Statistical Form 32a is used to monitor monthly five obstetric diseases (amniotic fluid embolism, eclampsia, complications of anesthesiology, haemorrhage of about 1000ml and uterine rupture) and five neonatal diseases (infections, asphyxia, congenital anomalies, RDS and HIV). Second, the quality of services provided in maternities, in perinatology, is assessed periodically, using 10 questionnaires recommended by WHO for this purpose, and in the area of antenatal assistance — provided as part of the primary health care (PHC).

### 3.2.2. Maternal Mortality

Maternal mortality is regarded as one of the most sensitive indicators of reproductive health, which reflects not only the quality of health services provided but also the socio-economic status of the woman, the cultural level and the standard of living of the population.

During the last two decades, the maternal mortality rate had an uneven evolution, being characterised by a slow decrease during 2002-2007, reaching 15.8 cases per 100,000 live births, and by the instability of this indicator during 2008-2015 with fluctuations between 15.3 and 44.5 per 100,000 live births (Fig. 3.2.2.1).

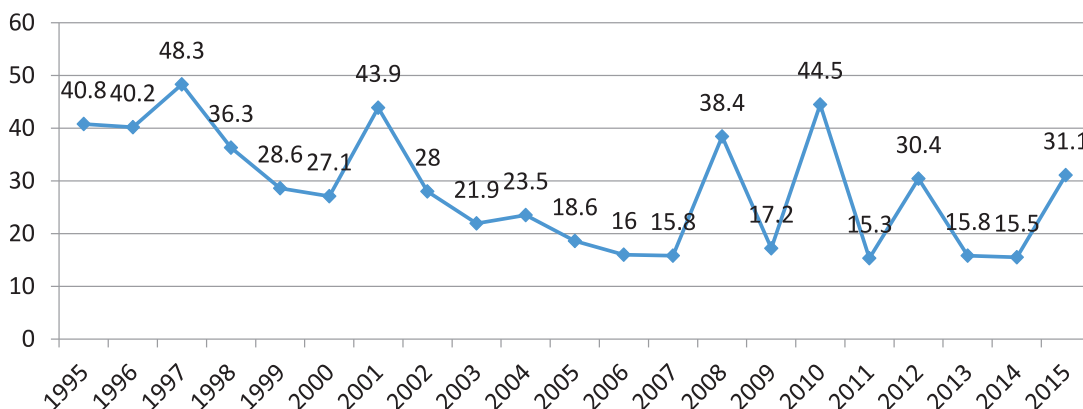
Note that the low number of deaths determines significant and unpredictable variations when reported to 100,000 live births. During the past 10 years, the number of births in the Republic of Moldova was more or less constant – around 37,000-39,000. In order to avoid the the small figures errors (small annual number of births) and to highlight the real level of maternal mortality, the maternal mortality rate can be calculated by an average, every three years<sup>99</sup>.

The comparative analysis of maternal mortality indicator of the countries in the region (European and East-European countries) show lower rates in comparison with the Republic of Moldova (less than 10 per 100,000 live births). The Republic of Moldova is included in the list of the countries with a relatively high level of maternal mortality, alongside Albania,

global estimates [Mortalitatea neonatală și perinatală], Geneva, 2006.

99 See the Ministry of Health, National Development Strategy for 2008-2011, p.6 [www.ms.gov.md](http://www.ms.gov.md)

Fig. 3.2.2.1.



**Fig. 3.2.2.1.**  
Maternal Mortality per 100,000 Live Births, Republic of Moldova, 1995-2015  
Source: NCHM, [www.cnms.md](http://www.cnms.md)



Fig. 3.2.2.2.

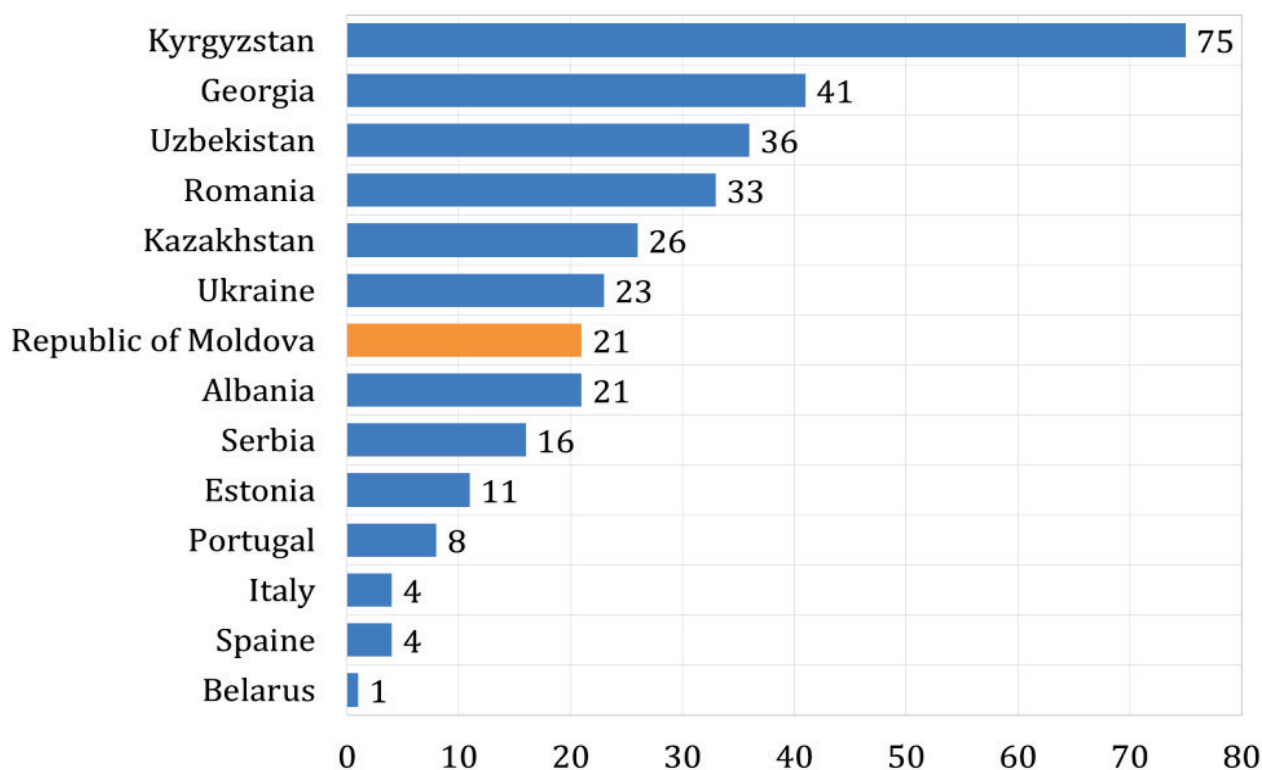


Fig. 3.2.2.2.  
Maternal  
Mortality in Some  
Countries, 2013  
Source: WHO  
HFA-DB, [www.euro.who.int/hfad/](http://www.euro.who.int/hfad/)

Ukraine and Kazakhstan (Fig. 3.2.2.2).

In spite of the measures taken to restructure the health care system, particularly the mother and child health care by implementing the regionalized system of referral to perinatal services,<sup>100</sup> the maternal mortality rate did not decrease as expected. According to WHO data, the maternal mortality rate in Moldova, over the last 20 years, has decrease by about 33%, but regrettably the target (13.3‰) within MDG 5 was not reached, staying about 5 times higher than the European average.

The access of women to healthcare and the efficiency of health system in responding to specific needs of each case, are essential factors in decreasing maternal mortality. The analysis of maternal deaths of the last two decades show that over 2/3 of women were from rural area, with a poor social status, whose pregnancy evolved in the

context of an extragenital pathology or an obstetric complication that were not treated timely. The risk factors for a high maternal mortality rate are still the inferior social status, the level of knowledge and education of women and of her family members on the necessity and importance of early medical surveillance during pregnancy<sup>101</sup>.

Ensuring access to good antenatal care during delivery and post-partum period is a constant concern of the Government of the Republic of Moldova. The pregnancy, delivery and post-partum are listed among the diseases and conditions that benefit of compulsory health insurance under the Single Program of Compulsory Health Insurance<sup>102</sup>.

In terms of the number of healthcare facilities providing obstetric care, there are 38 such facilities at the national level. Given the relatively small territory of the Republic

100 National Perinatology Guidelines "Principles of Organizing and Providing Perinatal Care", Chisinau, 2006

101 Ministry of Health of the Republic of Moldova, "Principles of Organizing and Providing Perinatal Care", Chisinau, 2006, Ministry of Health of the Republic of Moldova, [www.ms.gov.md](http://www.ms.gov.md)

102 National Health Insurance Company, [www.cnam.md](http://www.cnam.md)

of Moldova, the time to travel to the closest institution of this type does not exceed an hour. However, rural women have a lower access than the urban ones, sometimes due to transport difficulties. This was reported by some women as a barrier hindering their access to health services<sup>103</sup>. In addition, 11 of the 38 institutions provide comprehensive services, being better equipped and having highly qualified staff – 10 perinatal centers of level two and one perinatal centre of level three.

With regard to skilled assistance during delivery, the share of deliveries outside maternity wards decreased considerably in the last years – from 2.4% in 1999 to 0.5% in 2015.

During the past 10 years, the structure of maternal deaths was dominated by: hemorrhages, septic-purulent complications, eclampsia, extragenital diseases. In 2015, the maternal mortality through direct obstetrical risk was of 7.8 per 100,000 live births, out of which 5.2%<sub>000</sub> were caused by complications during pregnancy, delivery, and post-partum period, 2.6%<sub>000</sub> by abortions<sup>104</sup>; 23.3%<sub>000</sub> by indirect obstetrical risk<sup>104</sup>. The growing influence of maternal mortality's indirect factors (not related to pregnancy) is a matter of concern and it reveals gaps in antenatal supervision and in quality of provided healthcare services. Thus, there are some doubts as regards the quality of services, provided at the primary healthcare level, by the family doctor.

Even if the Republic of Moldova has a supporting legal basis in maternal health, there are still inequalities related to the access to and quality of the provided

services, in particular between rural and urban women, between the general population and marginalised groups (Roma women, women with special needs, etc.). The improvement of the access of vulnerable groups to services of primary healthcare and hospital care, by enhancing the quality of existent services, including family planning, are essential for a continuous decrease in maternal mortality.

A series of procedures for the compulsory investigation of maternal deaths were adopted in order to decrease the maternal death. In 2005 a confidential questionnaire was introduced to analyse the maternal mortality cases and near miss cases at the institutional level. The confidential questionnaire aims to identify the real, medical and non-medical causes of maternal deaths, including the social and familial ones; to perform a scientific evidence-based assessment of maternal deaths cases, by identifying the standard care factors at community and institutional level; to draft the realistic recommendations on how improve the quality of care services provided to pregnant women, women during the labour and women during the post-partum period; to participate at the intersectoral level in implementing the recommendations of the confidential questionnaire<sup>105</sup>. The confidential questionnaire does not replace the MoH formal procedure of maternal mortality investigation, does not have administrative or legal nature, and is carried out after the completion of the traditional procedure. These measures help identify the real causes and develop cost-effective recovery measures, aimed at improving the maternal health<sup>106</sup>.

103 Demographic Health Survey, Republic of Moldova (DHS), Chisinau, 2005.

104 Statistical Yearbook of the Health System of the Republic of Moldova, 2015, [www.cnms.md](http://www.cnms.md)

105 The MoH Order No 330 of 4.10.2005 on the implementation of the confidential questionnaire to analyze maternal mortality cases and near miss cases at the institutional level.

106 Annual Activity Report of the Ministry of Health for 2015, [www.ms.gov.md](http://www.ms.gov.md)

### 3.3. Provision of Perinatal Care Services (Antenatal, Labour and Post-Natal Care)

A perinatal care system is functioning in the Republic of Moldova, consisting of a network of institutions that provide perinatal medical care at three different levels. The first level includes the family doctor's office (FDO), health centres (HC), consultative departments (CD) from hospitals, district reproductive health offices (RHO) and level-one maternities. PHC institutions employ family doctors and nurses, one of whom has background in perinatology. The obstetric-gynecologic offices of the consultative departments employ a consultant obstetrician-gynaecologist and a midwife/nurse, and paediatric offices – a pediatrician and a nurse. RHO employs an obstetrician-gynaecologist and a midwife/nurse. Level-one maternities employ obstetrician-gynaecologists, neonatologists, midwives and nurses for new-born babies, according to the staffing list. Level-one maternities provide obstetric medical care to pregnant women without serious obstetrical history and extragenital diseases out of a forecast risk, medical assistance during the physiological birth at 38-40 weeks, care for healthy new-born babies with birth weight of  $\geq 2500$  gr. At this level, the caesarian section is an option only in emergency cases and in case of absence of transportation conditions of the woman.

Level-two medical perinatal care provided in specialised consultative out-patient facility and hospitals. In out-patient facilities, the pregnant women are consulted in the perinatology consultative section from level-three Perinatology Center by obstetrician-gynaecologists of specialised

offices, (prematurity, infertility), internist, geneticist, psychologist, prenatal diagnosis of congenital abnormalities (USG) and by a legal expert. At this level, perinatal care is provided to women with moderate obstetric risk, with 32-37 weeks of gestation and care for new-born babies with birth weight of 2000-2500 gr. In addition, level-two Perinatology Centres provide perinatal services to pregnant women within the area of the respective municipality/district.

The Perinatology Centre of level-three Perinatal Care Service provide inpatient and outpatient care. The polyclinic care is provided by the Republican Polyclinic for Women, the Center for Reproductive Health and Medical Genetics, the Republican Polyclinic for Children. At this level perinatal care is provided to women with high obstetric risk, the monitoring of birth at 22-32 weeks of gestation, and care for new-born babies with birth weight under 2000 gr<sup>107</sup>.

#### 3.3.1. Antenatal Care

Ideally, the antenatal care must start in the first quarter of pregnancy, according to the WHO recommendations for effective antenatal care. The antenatal care services in the Republic of Moldova are provided at all levels of medical care: primary healthcare, specialized outpatient healthcare, pre-hospital emergency healthcare, hospital healthcare.

The primary healthcare (PHC) is responsible for ensuring a risk free pregnancy. The primary health care in the Republic of Moldova is provided by the family doctor, assisted by nurses, one of them being specialised in perinatology. Most of prenatal

<sup>107</sup> National Perinatology Guidelines. Principles of Organizing and Providing Perinatal Care. Chisinau, 2006.

care are provided by doctors (98%) while a small number of women (1%) receive healthcare provided by a nurse/midwife. Thus, we can conclude that the primary health care facilities cover the needs of antenatal health care at a very high level.

In order to improve the maternal health, protect maternity, and decrease maternal morbidity and mortality, new Standards for Monitoring Pregnant Women in Outpatient Settings were developed and approved by a MoH Order. They include a wide variety of compulsory clinical and paraclinical examination during the antenatal period for all pregnant women<sup>108</sup>. According to these standards, during the pregnancy, women made 6 antenatal care visits to the family doctor (I – to record the pregnancy (until 12 weeks of pregnancy), II – 16-18 weeks, III – 22-24 weeks, IV – 28-30 weeks, VII – 35-36 weeks, VII – 38-40 weeks), where the pregnant women are consulted by the family doctor, undergo clinical examination, have the Body Mass Index (BMI) estimated, blood pressure measured, and data recorded in the pregnancy chart, and are referred to the following consultations/investigations. Pregnant women are tested for HIV, complete blood count, urogram, protein in the urine, blood glucose, blood type, Rh factor, antibody titer for Rh negative, biochemical screening (double and triple test). At the same time, the risk level is assessed in accordance with the national clinical guidelines and protocols. Pregnant women have the right to choose the obstetrician-gynecologist for pregnancy monitoring in outpatient settings within the consultative section of their District Hospital, Medical Territorial Association (Chisinau), regardless the

108 The Ministry of Health Order No 31 of 27.01.2016 approving the Standards for Monitoring Pregnant Women in Outpatient Settings

residence and place of medical record.

MICS data (2012) show that about 95% of women had at least 4 antenatal visits, with a similar distribution in rural and urban areas. Only 1% of all pregnant women never had a antenatal visits, most of all from the low welfare quintile (5.1%). 99% of the women who gave birth during those two years before the survey reported that during the antenatal visits blood sample was collected, in 98% of cases their blood pressure was checked, and in 99% cases a urine sample was collected<sup>109</sup>.

Almost 99.0% of the pregnant women under medical supervision get tested for HIV. During 2015, 92 pregnant women were detected with HIV out of the total number 50,317 pregnant women tested in laboratories<sup>110</sup>.

The preparation for birth begin during the antenatal period with group and individual meetings with the pregnant woman and her family. There are 4 meetings, focusing on topics appropriate for each gestation period (I meeting – after the registration of pregnant woman, II – 28-30 weeks of pregnancy, III – 32-33 weeks, IV – 35-36 weeks). The ultrasound screening is carried out at 11-13 and 18-21 weeks of pregnancy in order to identify the fetal diseases during the antenatal period. In 2015, 92.0% of pregnant women were subject to ultrasound test at 18-21 weeks of pregnancy. According to the standards, the pregnant woman shall be seen three times by the obstetrician-gynaecologist during the pregnancy (11-14, 28-30 and 35-36 weeks).

The mandatory standard for antenatal care is the Perinatal Medical Card (a form of

109 Final report, Multiple Indicator Cluster Survey (MICS), Republic of Moldova, 2012, Chisinau, 2014.

110 [www.cnms.md](http://www.cnms.md) Monitoring the HIV Control in the Republic of Moldova, 2015; Chisinau, 2016.

recording pregnant women) which is filled by the family doctor or by the obstetrician-gynaecologist. The Perinatal Card ensures a continuity between PHC and other health care levels in order to monitor the pregnancy and its result.

### 3.3.2. Assistance during Delivery

The presence of care during delivery is extremely important for the child and mother, because many deaths were registered during this period. It is known that improved care during delivery decreases maternal mortality by 50-89% and perinatal mortality by 30-40%.

One of the objectives of the “World Fit for Children” Action Plan is to ensure good conditions for delivering women. The proposed indicators represent the share of deliveries assisted by skilled health personnel (doctor, nurse or midwife) and the share of deliveries in healthcare facilities. The share of deliveries assisted by skilled health personnel was also used as an indicator to monitor the progress of the Millennium Development Goals on reducing infant mortality and improving maternal health by 2015. Assistance at birth by skilled health personnel, according to MICS survey (2012) constituted about 99% of which 95% – by a doctor, 4% – by nurse or midwife, with insignificant differences in rural and urban areas. Most deliveries (99%) in the Republic of Moldova take place in a healthcare facility, 98% of deliveries in public sector and less than 1% — in private facilities. An extremely small number of deliveries (1%) take place at home<sup>111</sup>.

The regionalised health service has been operational in the Republic of Moldova since 2004<sup>112</sup>. At the same time, according

111 Final Report, Multiple Indicator Cluster Survey (MICS), Republic of Moldova, 2012, Chisinau, 2014.

112 Ministry of Health Order No 97 of 31.03.2004 on Levels of

to the regulatory acts in force, pregnant women have the right to choose the healthcare facility where she wants to deliver the baby, regardless her residence, excepting the cases when according to the medical indications, it is necessary to respect the regionalization and screening principles of pregnant women in provision of perinatal medical care. However, pregnant women have the possibility to choose their obstetrician-gynaecologist within the hospital facilities for in-patient care, with their prior consent<sup>113</sup>. In the Republic of Moldova, in order to enhance the quality of care during delivery, obstetrical care in cases of emergency is successfully implemented, coupled with the presence of skilled medical personnel during delivery. The presence of skilled personnel during delivery includes the use of the partogram, which allows identifying and solving promptly the health conditions of the mother or the new-born baby, which in the end prevents the maternal and perinatal mortality. In addition, the near-miss cases and maternal and perinatal deaths are audited<sup>114</sup>. As a result of the activities carried out during 2005-2015, the following indicators of perinatal health were enhanced: perinatal mortality (11.5‰ – 9.7‰) early neonatal mortality (5.7‰ – 4.7‰) and the rate of stillbirths registered more or less constant during the last decade (5.8‰ – 6.2‰). The perinatology, medical genetics and family planning services have a special role in the provision of healthcare

Healthcare Services for Children

113 The Ministry of Health Order No 31 of 27.01.2016 approving the Standards for Monitoring Pregnant Women in Outpatient Settings

114 Order of the Ministry of Health No 330 of 04.10.2005 “On the implementation of confidential questionnaire for analyzing maternal deaths at the national level and near miss cases at the institutional level” and the Order of the Ministry of Health No 248 of 16.06.2006 “On the implementation of confidential questionnaire to analyse perinatal deaths at the national level”



for mothers and new-born babies in the Republic of Moldova.

### 3.3.3. Post-Natal Care

The early discharge (3-5 days after delivery) of mothers and new-born babies is a common practice in the Republic of Moldova. According to MICS data (2012), 4% of the respondents who delivered a live baby in a healthcare facility during the two years prior to the survey, spent less than 3 days in the healthcare facility, and 77% – 3-6 days after delivery. 19% of women were discharged in a week after delivery. The survey results show that the share of mothers and new-born babies, who stayed one week or longer in the maternity, is smaller in urban area than rural area (16% and 21% respectively), as well as smaller among mothers from wealthier households in comparison with the poor households (12% and 26% respectively)<sup>115</sup>.

The recent programs on safe maternity conditions, recommend that women and new-born babies must receive a medical check within 2 days after discharge. About 98% of new-born babies receive a health check after birth in a health care facility or at home. The first visits of post-natal support (PNS) of new-born babies during the first week after the discharge from the healthcare facility were carried out at home (96%), and the rest 4% in the public sector health facility.

The visit during the first week after birth, according to WHO recommendations, was carried out by 94% in a healthcare facility or at home. Thus, 93% of first visits of post-natal care for mothers, during the first week after birth took place at home, and only 7% in a public health care facility. Regarding the new-born babies, all post-natal visits

<sup>115</sup> Final report, Multiple Indicator Cluster Survey (MICS), Republic of Moldova, 2012, Chisinau, 2014.

for mothers took place in the first week after birth and was carried out by a doctor, a nurse or a midwife<sup>116</sup>.

## 3.4. Family Planning

One of the ICPD-PA objectives is the universal access to family planning by 2015 as part of broader approach to reproductive health rights.

Despite the favourable legislative framework in the Republic of Moldova, the actual situation with family planning (FP)<sup>117</sup> leaves much to be desired.

During the last decade, neither decision-makers provided enough support, nor professionals were involved actively in FP. Hence, the specific FP indicators decreased over time. The data on the use of contraceptives and people's preferences for contraception methods are available only from studies.

Contraceptive prevalence rate in the group of women of reproductive age (15-49 years) decreased from 67.8% in 2005<sup>118</sup> to 59.5% in 2012 (*Fig. 3.4.1.*). The use of modern contraceptives in the group of women of reproductive age (15-49 years) is also decreasing, reaching 41.7% in 2012 (with variations between 46.6% in the richest quintile and 34.3% in the poorest quintile)<sup>119</sup>, in comparison with 42.6% in 2005<sup>120</sup>.

The most popular contraception method is the Intrauterine Device (IUD), used by one

<sup>116</sup> Final report, Multiple Indicator Cluster Survey (MICS), Republic of Moldova, 2012, Chisinau, 2014.

<sup>117</sup> Law No 138 of 15.06.2012 on Reproductive Health; MoH Order No 695 of 13.10.2010 on Primary Health Care; MoH Order No 658 of 18.08.2015 on Providing Contraceptives.

<sup>118</sup> Demographic and Health Survey, Republic of Moldova 2005 (DHSM, 2005)

<sup>119</sup> Multiple Indicator Cluster Survey, 2012. Final Report. Chisinau, 2014

<sup>120</sup> Demographic and Health Survey, Republic of Moldova 2005 (DHSM, 2005)



in five married women or in a relationship (19.8% in 2012, in comparison with 17.7% in 2005). This preference of the population was induced during the former Soviet Union, when the health system was promoting the IUD in comparison with other contraception methods, such as the contraceptive pill. The prevalence of IUD over other methods can be explained by the preference of FP service providers, which are obstetricians-gynaecologists that can carry out medical interventions, like for example the insertion of IUD that, last but not least, is also profitable. A share of 5% reported the use of pills, and 11.9% – the male condom, 4.4% – the voluntary surgical sterilization, and less than 1% – vaginal methods, such as the diaphragm/foam/jelly.

The traditional family planning methods are still popular in the Republic of Moldova and constitute 16% of all contraception methods and thus have a negative impact on the unintended pregnancies. Withdrawal is used by 13% of women, periodic abstinence – 3%, and about 1% of women use other traditional methods.

With regard to the use of contraception methods, there are some differences depending on the age, education, and socio-economic status. Thus, contraception methods are less frequently used by women

of 15-24 years of age than by women of 25-45 years. Women with higher education use more frequently contraception methods (64%). The use of contraceptives is proportional with the level of well-being of the household the woman lives in – from 56% in 1<sup>st</sup> quintile households to 61% in 5<sup>th</sup> quintile households.

The data on the unmet needs are provided by the DHSM (2005) and MICS (2012) surveys. One woman of reproductive age in ten (9.5%), currently married or in a relationship, do not use any contraception method though they want to delay the next pregnancy (4.8%) or do not want to get pregnant at all (4.7%). Overall, the unmet needs is the highest among the youngest married women (15-19 years) and decreases with the increase in age. However, even if the unmet needs with respect to the interval between births decreases as they advance in age, the unmet needs on limiting the number of children increases slowly as they advance in age. Insignificant differences were identified between the unmet needs of women depending on their residence: (urban – 10.7%, rural – 8.7%), education (secondary – 9.9%, higher – 9.8%) and welfare quintiles (lower – 11.1%, higher – 9.6%)<sup>121</sup>.

121 Multiple Indicator Cluster Survey, 2012. Final Report. Chisinau, 2014

Fig. 3.4.1.

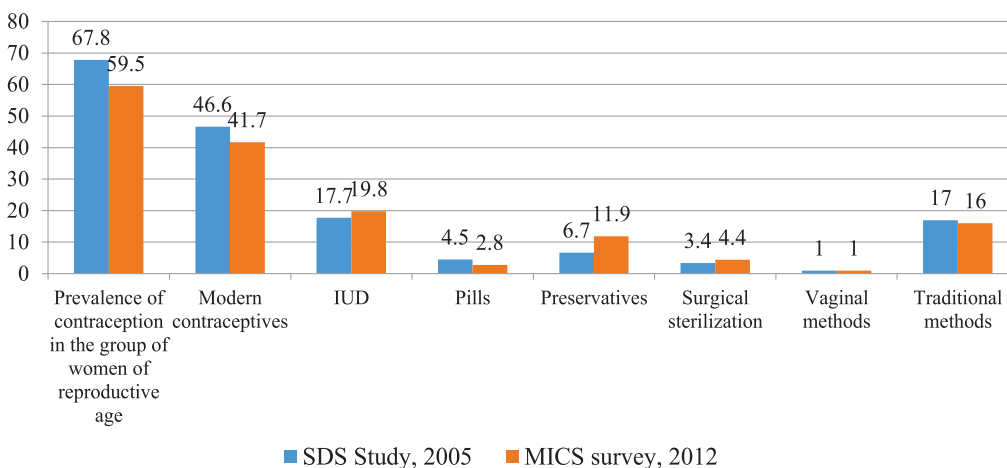


Fig. 3.4.1. Contraception Prevalence in the Group of Women of Reproductive Age (15-49 years), 2005, 2012.

In this context, it is important to bring family planning/contraception services as close to the potential beneficiary as possible, by integrating them in primary healthcare, which represents the first level of health system, and by maximising the use of the family doctor's team. During the past years visible steps were taken in order to enhance the role of primary healthcare when providing the FP services: it was established a legal framework, the family doctors and the nurses were trained, and the vulnerable groups of population were provided with contraceptives of CHI funds<sup>122</sup>. At the same time, it is worth mentioning that FP services are mainly provided by obstetrical/gynaecological service, which traditionally is not focused on promoting contraception methods and counselling.

Though the access to information, contraceptives and FP services has improved during the last decades, there are still challenges on the demand side, caused by the low awareness, knowledge and use of contraceptives. Insufficient knowledge among population and the price of contraceptives are the reasons for not using modern contraceptives. Contraceptives are not included in the list of essential drugs in the Republic of Moldova.

The Moldovan society still approaches family planning as purely women's issue. Information on men's involvement in family planning is limited, the statistics about knowledge and use of contraceptives refer to women only. At the same time, about 15% of men think that family planning concerns only women<sup>123</sup>. A good

example in this respect is the adoption of rules on the implementation of surgical female sterilization only and on the lack of special regulations regarding the surgical sterilization of men, even if the law in force ensures access to voluntary surgical sterilization for men and women in a non-discriminatory manner<sup>124</sup>. Gender equality underpins observance of all citizens' fundamental human rights and last but not the least, the rights to family planning/contraception<sup>125</sup>.

### 3.5. Abortion/Services of Pregnancy Termination

Abortion in the Republic of Moldova was legalised in 1955. From the 1960s to the 1990s, abortion was the main method of natality regulation due to the lack of modern contraception methods, and the level of population's knowledge of family planning was limited.

Thanks to the implementation of certain family planning methods, the absolute number of abortions decreased significantly – from 57 thousand in 1995 to almost 14 thousand in 2015. Since 2005 the number of abortions has remained constant, at about 14-15 thousand annually (*Fig. 3.5.1*).

According to the official statistical data, the rate of induced abortions per 1000 women of reproductive age (15-49 years) decreased almost three times, from 51‰ in 1995 to 15‰ in 2015 (*Fig. 3.5.2*).

If in 1995 there were 101 abortions per 100 births, by 2015 this indicator decreased three times (34 abortions per 100 live births), (*Fig. 3.5.3*).

122 Order Ministry of Health No 658 of 18.08.2015 on Providing Contraceptives.

123 Demographic and Health Survey, Republic of Moldova 2005 (DHSM, 2005)

124 Law on Health Care No 411-XIII of 28 March 1995 and Law No 138 of 15 June 2012 on Reproductive Health.

125 Government Decision No 933 of 31.12.2009 on the 2010-2015 National Gender Equality Program, Published: 19.01.2010 in the Official Gazette No 5-7, Article 27

Fig. 3.5.1.

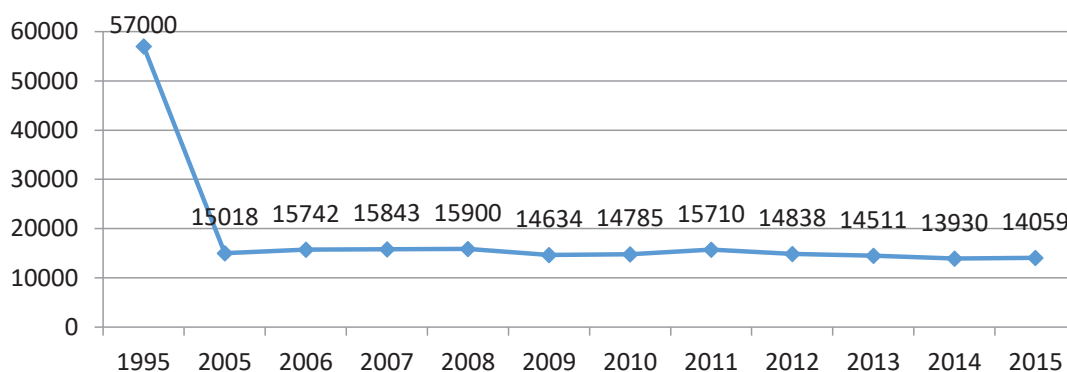


Fig. 3.5.1.

Abortions: Total (abs.), in the Republic of Moldova, 1995-2015  
Source: NBS, www.statistica.md

The share of abortions in the age group of 15-19 years, during the last 10 years, constituted about 10% of the total number of abortions among women of reproductive age (Fig. 3.5.4).

Several aspects could be improved with regards to collection of data and production of statistics on induced abortions. The official statistics do not reflect the actual number of abortions, because some of

Fig. 3.5.2.

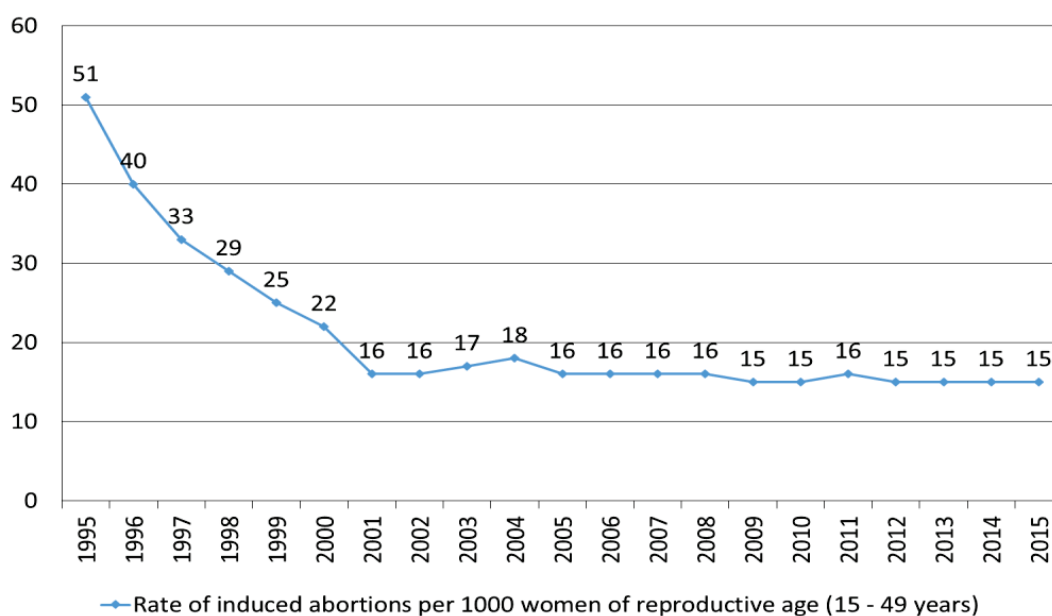


Fig. 3.5.2.

Rate of Induced Abortions per 1000 women of Reproductive Age (15-49 years), 1995-2015  
Source: National Bureau of Statistics, www.statistica.md

Fig. 3.5.3.

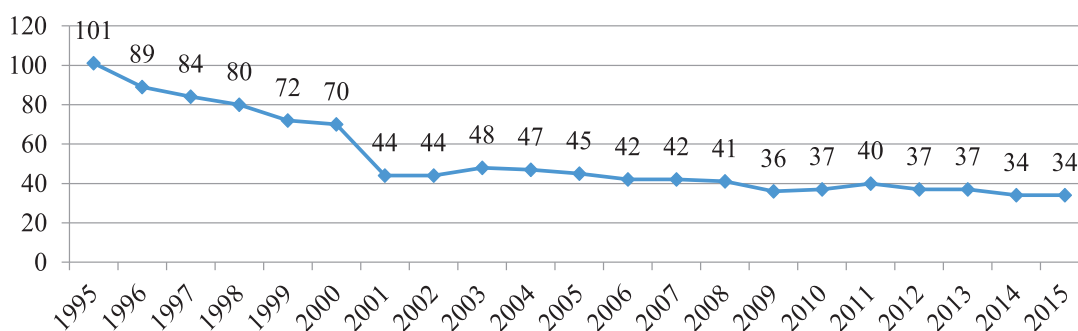


Fig. 3.5.3.

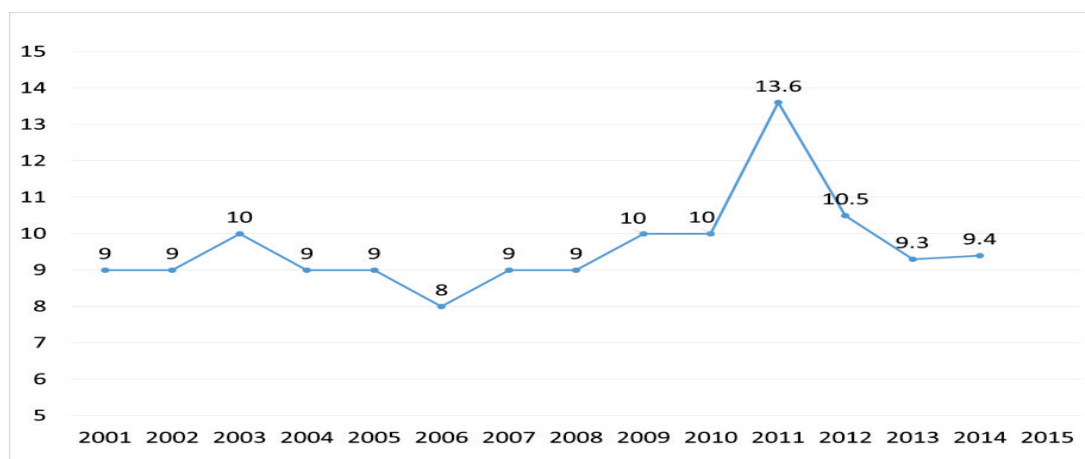
Number of Abortions per 100 Live Births, in the Republic of Moldova, 1995-2015  
Source: National Bureau of Statistics, www.statistica.md

**Fig. 3.5.4.**

Dynamics of Abortion Rate in Adolescent Girls, Republic of Moldova, 2001-2015

Source: NCHM, www.cnms.md, Statistical Yearbook of the Health System of the Republic of Moldova, 2001-2015; NBS, www.statistica.md

**Fig. 3.5.4.**



them are neither registered, nor reported (including the ones performed in private facilities). The existence of unregistered abortions in the country could be explained by the fact that abortions are a source of income for providers of pregnancy termination services<sup>126</sup>.

During the past decade, WHO paid increased attention and offered technical support for the pregnancy termination services. The WHO support coupled with the efforts of national experts improved significantly the quality of pregnancy termination services by implementing the safe methods recommended by the WHO. During 2007-2011, with the support of WHO and other international organizations, Moldova developed and approved Safe Abortion Regulations (2010) and Standards (2011), reviewed and approved the abortion curriculum, upgraded and institutionalized the system for statistical reporting of the number and quality of pregnancy termination services. Moreover, 6 model centers for outpatient abortion services were created in two stages<sup>127</sup>.

126 Strategic assessment of the policy on, quality of and access to contraception and abortion services in the Republic of Moldova, Report, Chisinau, 2006

127 Report on Assessing the Quality of Pregnancy Termination Services and Compliance with Safe Abortion Standards in the

At the same time, in some health care facilities the quality of abortion services is still at the lowest limit of safe abortion due to the obsolete equipment and because some service providers still perform the pregnancy termination by the traditional method of dilation and curettage (about 30% of the total number of abortions), failing to comply with the WHO recommendations and the regulatory acts in force of the Ministry of Health<sup>128</sup>.

The medical abortion, even if proved to be safe, is less accessible for certain segments of population because of the high price.

Maternal mortality is a frequent indicator associated with abortion. In the Republic of Moldova, during 1990-2002, abortion ranked the first (30.2%) in the structure of maternal mortality (*Fig.3.5.5*). During the following decade, an important decrease in maternal mortality caused by abortion complications was registered, and in 2000 its value was zero, but then it had a fluctuating character.

In the Republic of Moldova, the number of abortions per 1000 live births decreased

Republic of Moldova, Chisinau, 2015

128 Report on Assessing the Quality of Pregnancy Termination Services and Compliance with Safe Abortion Standards in the Republic of Moldova, Chisinau, 2015

Fig. 3.5.5.

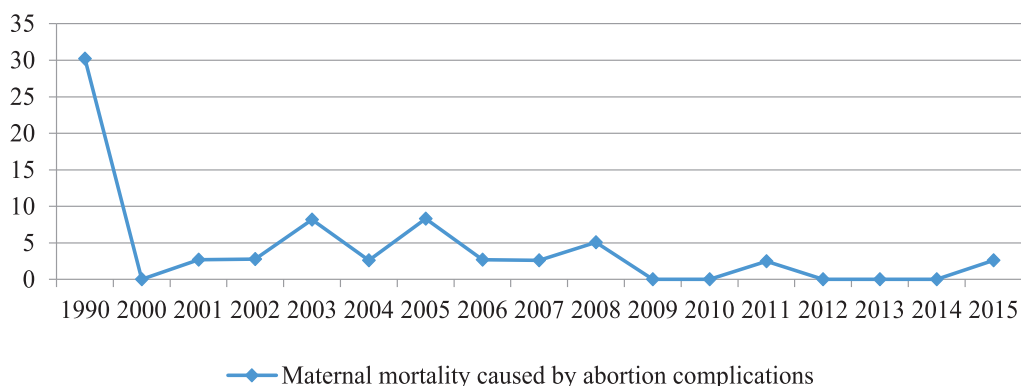


Fig. 3.5.5. Maternal Mortality through Pregnancy Termination (per 100,000 live births), Republic of Moldova, 1990-2015  
Source: National Centre of Health Management, www.cnms.md

during the past decade, similarly to other countries from Eastern and Western Europe and Baltic Countries. However, the number of abortions per 1000 live births is about 1.5-2 times higher than in the countries from Western Europe (Fig. 3.5.6).

The number of abortions is still high, despite the measures taken, which reveals an unmet need for making available modern contraceptives for the entire population, including the vulnerable groups.

Like in other countries from Eastern and Central Europe and the Former Soviet Union, the Moldovan law on abortions is one of the most permissive in the world. The Moldovan law allows women to have an abortion at their will before 12 weeks of gestation and until the end of the 21th

week of gestation on social and/or health grounds<sup>129</sup>.

In practice, the access of women from vulnerable groups, especially those from the rural area, the adolescent girls and poor women is more difficult due to the procedure according to which they must travel to district centres or in the capital in order to get the approval of the Medico Consultative Board.

Though a free mechanism was introduced, regarding abortions for certain groups of women, additional measures must be undertaken in order to inform doctors and patients about the access to these services

129 Ordinul Ministerului Sănătății nr. 647 din 21.09.2010 cu privire la efectuarea întreruperii voluntare a cursului sarcinii în condiții de siguranță (Order of the Minister of Health no. 647 of 21.09.2010 regarding voluntary interruption of pregnancy in safe conditions).

Fig. 3.5.6.

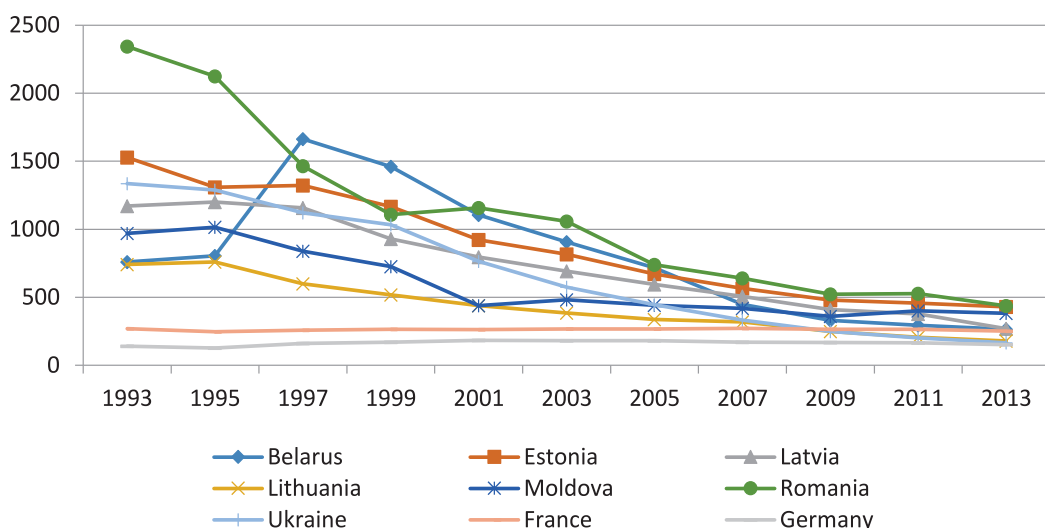


Fig. 3.5.6. Number of Abortions per 1000 Live Births in Some Countries, 1993-2013  
Source: WHO HFA-DB, www.euro.who.int/hfad/

and the overall regulatory provisions on abortions.

### 3.6. Genital and Breast Cancer

During the past 15 years the morbidity rate has increased in the Republic of Moldova due to breast and cervical malignancy. If in 2001 the breast cancer morbidity constituted 39.1, in 2014 — 50.8 per 100 thousand persons; the cervical, endometrial and placental cancer morbidity – 23.5 per 100 thousand person in 2001 and 32.2 in 2014; the prostate cancer morbidity has increased three times (from 6.3 per 100 thousand persons in 2001 to 22.2 in 2014), (Fig. 3.6.1).

Breast and cervical cancer have a significant share in the structure of morbidity and mortality. In 2013, the incidence of breast cancer constituted 969 new cases or 22.1% of the total number of new cases of cancer diagnosed among women. Cervical cancer ranks the third by the number of new cases recorded and the first most common cancer among women aged 15-44 years. This phenomenon has a negative impact on women’s sexual and reproductive life, as well as on her social and economic

condition.

The rates of deaths caused by breast and cervical cancer are still high, reaching up to 23.34 deaths per 100,000 women for breast cancer and 8.06 deaths per 100,000 women for cervical cancer, in 2013 (Fig. 3.6.2).

The main cause of deaths from breast and cervical cancer is late detection (stages III, IV), which influences negatively the patient’s survival rate. In Moldova the rate of breast cancer diagnosed in later stages is higher than in other European countries<sup>130</sup>.

To prevent gynaecological and breast cancers, women must have access to gynaecological and mammography tests, as requested by the existing protocols, therefore it is unacceptable for the State to limit such services under the pretext of crisis and budgetary cuts. At the same time, it is imperative to make sure that people are informed and educated appropriately as regards the breast and gynaecological cancers, so to increase the level of persons who report the need for available services and early detection (mammography and cytology screening, which are also used for anti HPV vaccination).

The Republic of Moldova did not have

130 www.cancerresearchuk.org

Fig. 3.6.1.

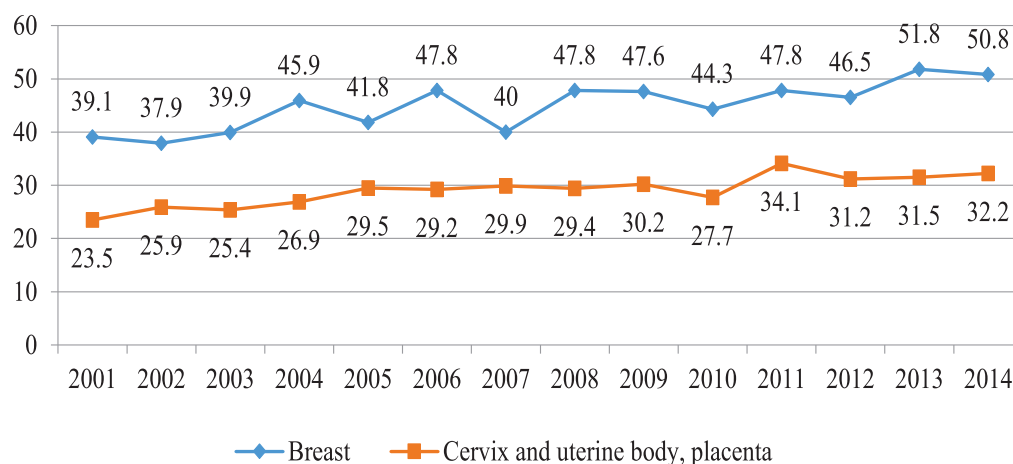


Fig. 3.6.1. Female Morbidity caused by Breast, Cervical and Endometrial, Placental Malignancy, per 100 000 persons, 2001-2014  
Source: NBS, www.statistica.md



a national breast and cervical cancer screening program, which lead, to some extent, to the unsatisfying late detection of these types of cancer. As a result, the incidence and mortality of cervical and breast cancer is a public health issues at the national level, particularly among women younger 45 years.

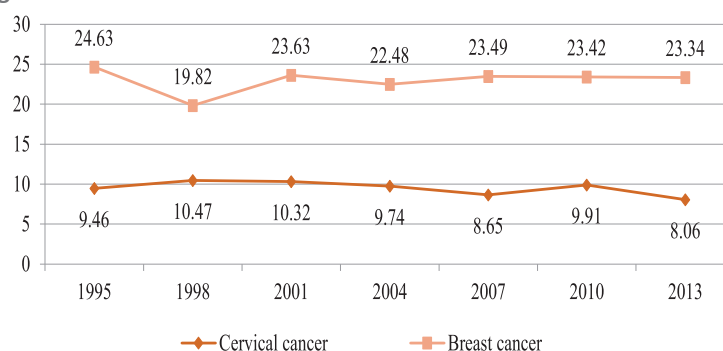
The National Cancer Control Program (including prostate, cervical and breast cancers) for 2016-2025, which is currently in the completion stage, aims at: streamlining and increasing the quality of healthcare services provided in cancer control area; improving the activity and implementation of the new cost-efficiency based technologies; social mobilising in cancer control; and monitoring health determinants. Service providers from PHC will have an important role in the implementation of this Program<sup>131</sup>.

### 3.7. Sexually Transmitted Infections, HIV/AIDS

Sexually transmitted infections and HIV/

131 www.ms.gov.md

Fig. 3.6.2.



AIDS is still a priority issue of public health in the Republic of Moldova. In 2005, the Republic of Moldova ranked the first among European states in terms of new syphilis cases (69.6 per 100,000 persons), while in 2006 it ranked the fifth in terms of new HIV cases. After the highest number of new syphilis cases recorded in 1996 (200.7 per 100,000 persons), we can see a downward trend in the incidence of syphilis and gonorrhoea over the last two decades, in the Republic of Moldova (Fig. 3.7.1).

Though a positive dynamics was registered over the last decade (in 2000 the incidence of syphilis accounted for 114.9 per 100 thousand persons, while in 2015 – 53.8;

Fig. 3.6.2. Breast and Cervical Cancer Mortality per 100,000 women, 1995-2013 Source: BNS, [www.statistica.md](http://www.statistica.md)

Fig. 3.7.1.

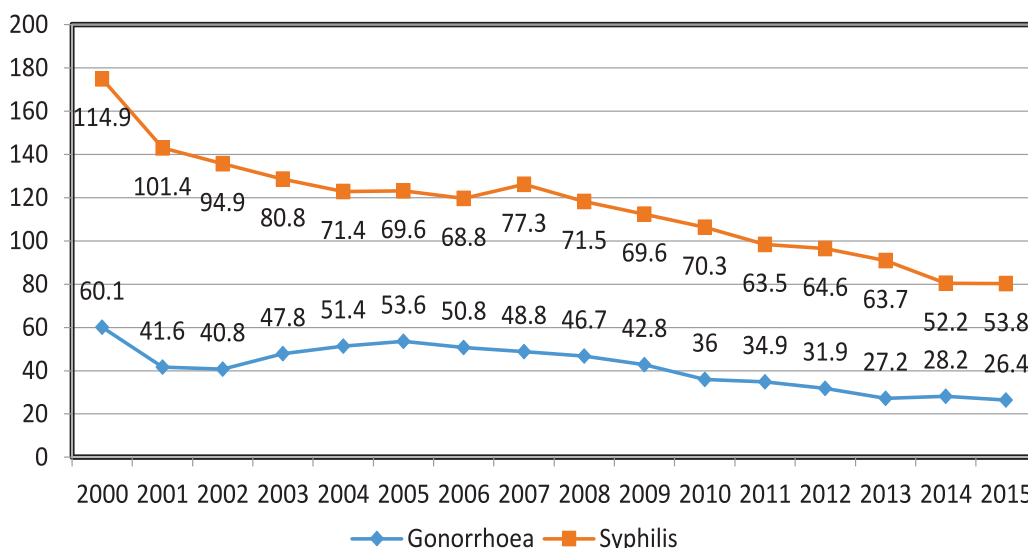
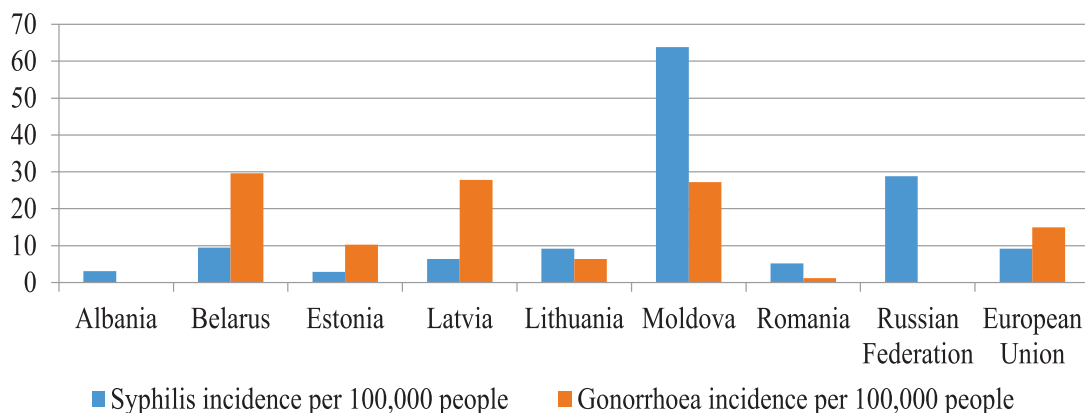


Fig. 3.7.1. Incidence of Syphilis and Gonorrhoea, per 100,000 persons, 2000-2015 Source: NCHM, [www.cnms.md](http://www.cnms.md)

**Fig. 3.7.2.**  
Incidence of Syphilis and Gonorrhoea in Some Countries, per 100,000 persons, 2014  
Source: WHO HFA, NCD

**Fig. 3.7.2.**



in 2005 the incidence of gonorrhoea was of 60.1, while in 2015 – 26.4), the incidence of these infections is much higher compared to other countries from the region (Fig. 3.7.2).

The first cases of HIV in the Republic of Moldova were recorded in 1987. During 1987–2015 (until 31 December) 10,213 new HIV cases were registered in the Republic of Moldova, of which 5,921 (58.0%) are male and 4,292 (42.0%) - are female, 68.3% - from the urban area. Male/female ratio – 1.38.

The HIV/AIDS trigger factors in the Republic of Moldova are the following: high population density, poor social and

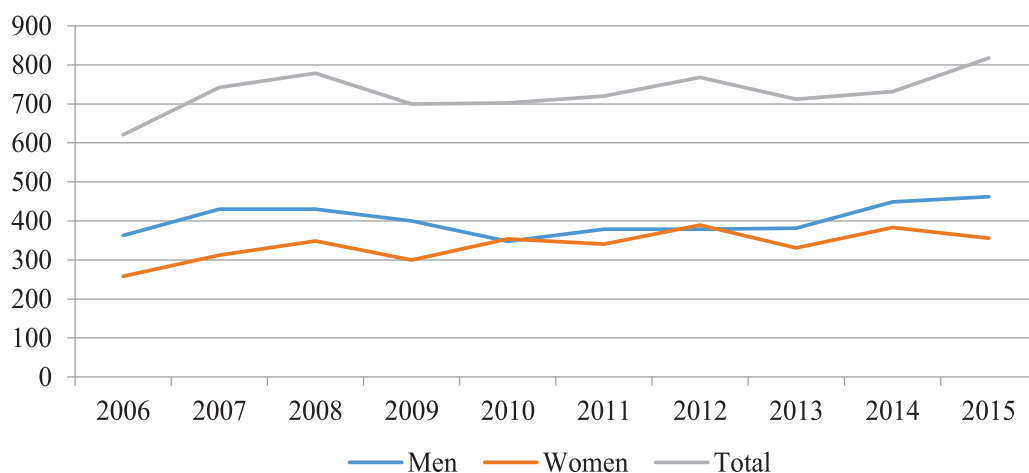
economic situation, intense migration, spread of drug use and higher morbidity via sexually transmitted infections<sup>132</sup>. The epidemic curve of new HIV cases registered during 2006-2015, shows a slight increasing trend (Fig. 3.7.3).

Most of HIV+ persons are young, of reproductive age and sexually active. In 2014, the HIV incidence among young people aged 15-24 years became lower than in the general population, but generally, it is unstable and tends to be higher than in general population. Taken all together, during 1987-2015, the share of young people

<sup>132</sup> Luminita Gutu, Epidemiological and Social Aspects of HIV/AIDS Infection in the Republic of Moldova, PhD thesis in medicine, 2009, page 25

**Fig. 3.7.3.**  
Number of New HIV cases per year, 2006-2015  
Source: NPHC, www.cnsp.md

**Fig. 3.7.3.**



aged 15-24 (when their HIV+ status was established) constituted 24.1% per country (on the right bank of the Nistru River – 24.9%, while on the left bank – 22.4%), thus registering a significant decrease during the last decade (2006 – 25%, 2015–12.6%), (Fig. 3.7.4).

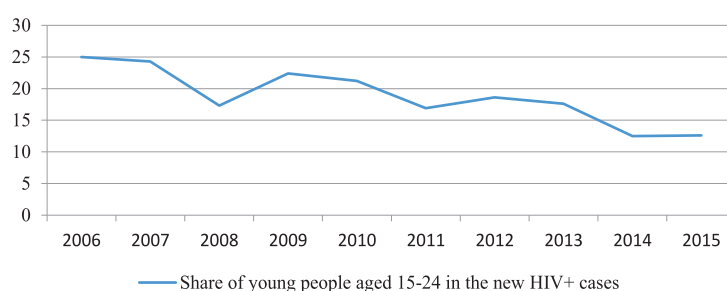
By the end of 2015, 818 new HIV+ cases were registered in the Republic of Moldova, of which 244 were in the Eastern areas of the country. Among cases registered in 2015, about 56.5% are men, 54.8% are persons living in urban area, while the share of young people aged 15-24 is about 12.6%.

The HIV incidence in 2015 was of 20.12, while the prevalence – 180.31 per 100 thousand persons. On the left bank of the Nistru River – both incidence and prevalence is 3-4 times higher if compared with the rest of the country (Fig. 3.7.5).

In the Republic of Moldova, HIV/AIDS is, currently, detected mostly in risk groups, thus particularly affecting drug users, commercial sex workers, men who have sex with men and also detainees from penitentiary institutions.

Significant changes are noticed in the structure of the HIV cases reported, namely

Fig. 3.7.4.



HIV transmission mode. In the last period, the highest number of new HIV cases occur through heterosexual transmission mode, while the number of new HIV cases among injecting drug users is decreasing. According to data provided by the National Public Health Centre, the HIV transmission modes were identified only in 267 of the new HIV+ cases registered on the right bank in 2015. Among them, there are the following transmission modes: via sexual transmission (92.1%), out of which heterosexual transmission (~89.9%) and homosexual transmission (~2.2%); injecting drug use (~2.2%) and mother-to-child transmission in 2 cases (~0.7%). There is no additional data on the possible transmission modes for the new HIV+ cases registered in 2015 in the Republic of Moldova.

Women are at a higher risk of contracting

Fig. 3.7.4. Share of Young People Aged 15-24 in the New HIV+ Cases, 2006-2015  
Source: NPHC, www.cnsp.md

Fig. 3.7.5.

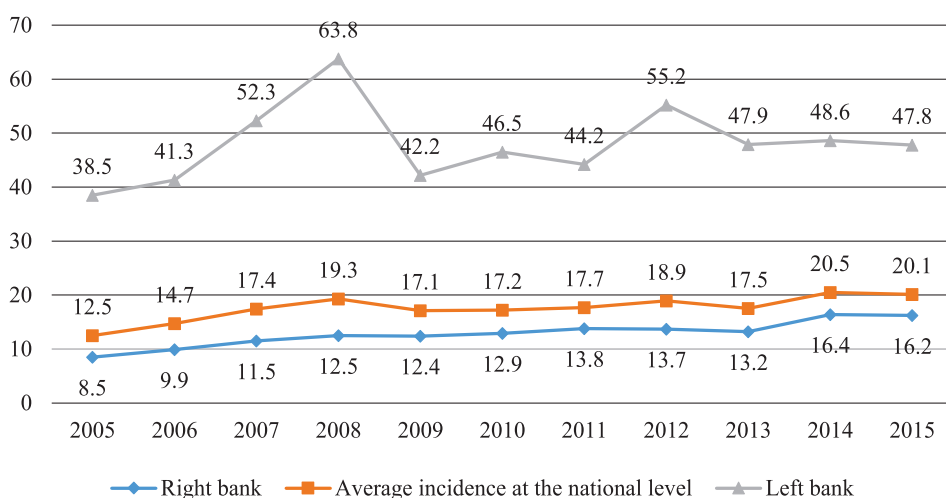
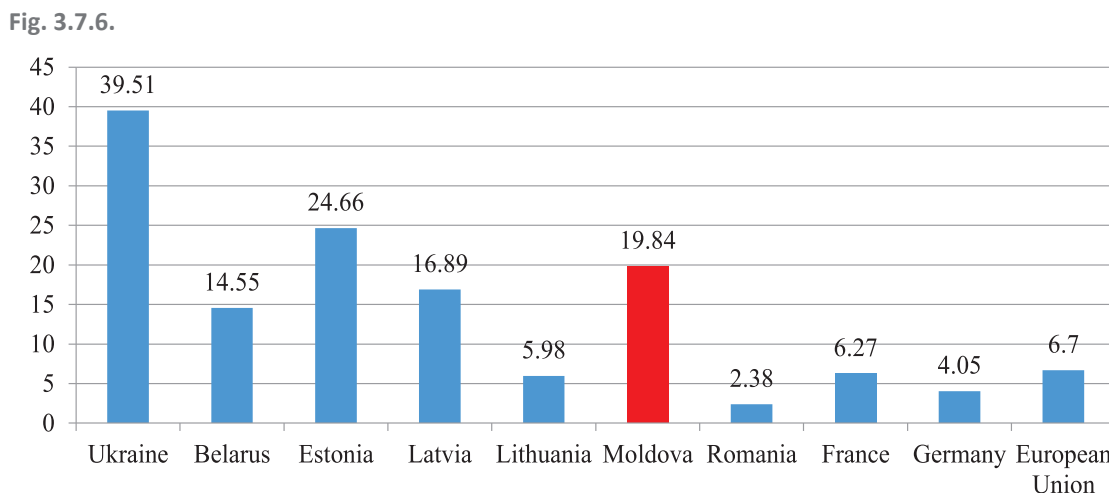


Fig. 3.7.5. HIV Incidence per 100,000 Persons, 2005-2015 (average at the country level, right and left banks)  
Source: MoH, NCHM

**Fig. 3.7.6.**  
HIV Incidence, in some countries, per 100,000 persons, 2013  
Source: WHO HFA-DB, www.euro.who.int/hfadb/



HIV than men. As of 2015, almost one in two persons with HIV was a woman, compared to 16% in the early 1990s<sup>133</sup>.

The Republic of Moldova ranks the fourth in the classification of the top five states from the region, by the number of HIV cases, preceded by Russia, Ukraine and Estonia (Fig. 3.7.6).

The access to counselling and voluntary testing is ensured at the state level for both Moldovan citizens and foreign citizens and stateless persons, who reside or are temporary on the territory of the Republic of Moldova and aims at early detection of HIV and AIDS. It is possible to test for HIV, upon people's request, according to the examination and medical supervision rules, developed and approved by Ministry of Health<sup>134</sup>.

In 2015, about 248 thousand persons were tested for HIV in laboratories. Over the past 5 years, the number of people tested for HIV has decreased annually, but given that HIV epidemic in Moldova is concentrated in groups at high risk of HIV infection, it is important that people from these groups, not the general population, get tested for prevention purposes. In 2015, about 72%

of all the tests for HIV were performed in laboratories were for pregnant women (20%) and donors, while prevention programs covered about 4% of tests. During 2015, 92 pregnant women were detected with HIV+ out of the total number 50,317 pregnant women tested in laboratories<sup>135</sup> (Table 3.7.1).

In 2015, 187 HIV-positive women gave birth and 114 women with known HIV+ status got pregnant. The routine statistics does not enable calculation of the percentage of pregnant women tested for HIV, but generally, it is believed that in Moldova over 99.0% of the pregnant women under medical supervision get tested for HIV.

The number of mother-to-child HIV transmission cases has decreased 4 times during the last decade (HIV+ status was detected in 3 children in 2015, compared to 12 children in 2005), (Table 3.7.2).

In the past ten years, the mother-to-child HIV transmission rate has decreased about 11 times (from 17.91% in 2005 to 1.60% in 2015), (Table 3.7.3).

In 2015, 285 persons were detected with AIDS, reaching the cumulative number of 3,126 persons since 1987, which accounts

133 Monitoring of the HIV Control in the Republic of Moldova, 2015; Chisinau, 2016.

134 Law on Prevention of HIV/AIDS No 23-XVI from 16.02.2007.

135 Monitoring of the HIV Control in the Republic of Moldova, 2015; Chisinau, 2016.

**Table 3.7.1.**

Indicator	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Pregnant women tested (thousand)	66	48	49	51	51	49	50	49	50	46	50
New HIV cases among pregnant women (absolute number)	71	84	81	83	70	86	80	93	79	87	92

**Table 3.7.2.**

Indicator	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Number of HIV positive women who gave birth in the reference year	67	81	86	140	137	143	146	186	160	173	187
Number of children detected with HIV+, born in the reference year	12	12	10	12	8	6	8	10	12	6	3

**Table 3.7.3.**

Indicator	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Rate of mother-to-child transmission of HIV	17,9	14,8	11,6	8,57	5,84	4,20	5,48	5,38	7,50	3,47	1,60

for 1/3 of new HIV+ cases registered in the country. The share of men detected with AIDS (32.3%) is higher than of women (28.3%), likewise the share of people detected on the right bank of the Nistru river (37.0%), which is higher than on the left bank (29.6%).

Since 1987, 2,880 deaths were registered among HIV persons, with an average age of 37.1 years at the date of death. During the past years, the age of HIV+ persons at the date of death has increased. According to the latest statistic, 7,331 people are living with an established HIV+ across the country, of which 4,952 people are living on the right bank and 2,379 people on the left bank of the Nistru River.

During 2015, 954 persons were included for the first time in ARVT program, 174 persons

gave up, 283 persons abandoned it and 104 persons receiving ARVT died. Thus, at the end of 2015, 3,850 persons with HIV were receiving ARVT, by 734 more persons than at the end of 2014. Out of 187 HIV women who gave birth in 2015, 12 did not receive preventive treatment, thus, the preventive treatment cover 93.6%<sup>136</sup>.

The fight against HIV is a major priority in the health policy of the Republic of Moldova. Over the past decades, several efforts were made to prevent and control HIV/AIDS and sexually transmitted infections (the first National Program for Prevention and Control of HIV/AIDS and Sexually Transmitted Infections (NP) was approved in 1995, then followed by NPs for 2001-2005, 2006-2010, 2011-2015). The 2011-

136 Monitoring of the HIV Control in the Republic of Moldova, 2015; Chisinau, 2016.

**Table 3.7.1.** Pregnant Women Tested for HIV in Laboratories (thousand women) and new HIV cases registered among pregnant women (absolute number), 2005-2015  
Sources: NPHC, www.cnsp.md, CNMS, www.cnms.md

**Table 3.7.2.** HIV-positive Women, who Gave Birth and Number of HIV-positive Children, 2005-2015  
Sources: NPHC, www.cnsp.md, NCHM, www.cnms.md [cnms.md](http://www.cnms.md)

**Table 3.7.3.** Rate of mother-to-child transmission of HIV, 2005-2015  
Source: NPHC, www.cnsp.md, NCHM, www.cnms.md

2015 National Program was updated once the new 2014-2015 program was approved.<sup>137</sup> The 2016-2020 NP is currently in the drafting phase<sup>138</sup>.

Since 2003, the country avails of significant financial contributions from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF). The allocated funds were used to enhance prevention of HIV spread, strengthen laboratory system used for HIV diagnosis, implement free antiretroviral therapy.

At the same time, the budget intended for prevention and control of HIV/AIDS and STIs registered a significant increase. According to the 2005-2010 NP, the budget for the program's last years amounted to approximately MDL 53 million, while the 2015 budget of 2014-2015 NP constituted approximately MDL 207 million<sup>139</sup>.

In the Republic of Moldova, a HIV-positive person is vulnerable due to the HIV status, social context and the existing stereotypes in the society. Despite the non-discrimination principle provided for in the national legislation, the HIV-positive persons are still discriminated in the Moldovan society<sup>140</sup>.

Due to both insufficient awareness raising of HIV infection among the general population and insufficient measures focused on most vulnerable categories of population, the results of the Republic of Moldova in HIV control are still poor. In spite of the efforts

made to stop the increase in HIV/AIDS incidence and programs implemented over the last two decades, this infection continue to be a major public health issue. Although the HIV incidence has been relatively stable in the recent years, though it was not possible to achieve targets set in MDG 6, at both levels: general population and 15-24 age group.

### 3.8. Infertility

Infertility is caused by genetic diseases, communicable and non-communicable diseases, including STIs, exposure to different chemical and physical factors etc. Infertility affects both women and men and represent a serious medical and social issue in the Republic of Moldova.

Delayed motherhood is an European trend, followed by Moldovan women, too. Late marriages, sexual relations before marriage and multiple sexual partners, poor culture as regards contraception worsen even more the existing situation. When couples want to have a baby, different factors may intervene and prevent them from fulfilling their wish. This is mainly caused by the wide spread of STIs and unsafe abortions. Sexually transmitted infections, such as syphilis and gonorrhoea, have serious consequences on the health and reproductive potential of an individual. Thus, more than a half of the couples that are planning to conceive a baby are encountering risk factors, that can prevent pregnancy.

It is difficult to analyse the issue of infertility as currently there is no national system to record the number of infertile couples that seek assistance. The official statistics does not provide data on female and male infertility, both primary and secondary as a result of STIs, unsafe abortions etc.

137 2014-2015 National Program for Prevention and Control of HIV/AIDS and Sexually Transmitted Infections, approved by Government Decision of the Republic of Moldova No 806 of 06 October 2014.

138 Draft 2016-2020 National Program for Prevention and Control of HIV/AIDS and Sexually Transmitted Infections.

139 Monitoring of the HIV Control in the Republic of Moldova, 2015; Chisinau, 2016.

140 Law on Prevention of HIV/AIDS, No 23-XVI of 16.02.2007.



Due to the lack of national indicators, the dimension of this phenomenon remains unclear.

According to international researches, primary infertility in the Republic of Moldova accounts for 2.5% and secondary infertility – 3.8%, similar levels have been recorded in other countries of the region (Fig. 3.8.1).

To encourage the infertile couples to seek specialised help, first it is necessary to inform persons with such health issues about the institutions and the type of services that can benefit of. To do this, people should be informed and educated in this regard by both healthcare service providers and mass-media, and by information and education campaigns about infertility.

Tradițional, în Republica Moldova, pentru servicii medicale în caz de infertilitate apelează femeile, iar bărbații, de obicei, sunt invitați pentru investigații, diagnostic și tratament. Actele normative ce se referă la managementul sterilității prevăd servicii acordate cuplului infertil și nu separat femeilor sau bărbaților<sup>141</sup>.

141 Evaluarea la mijloc de termen a implementării Strategiei Naționale a Sănătății Reproductive, anii 2006-2015, Chișinău,

Generally, the Republic of Moldova requires the healthcare services in case of female infertility, while in case of men, they are generally invited for investigations, diagnostic and treatment. Regulatory documents related to sterility management include services that are to be provided to infertile couple, not separately to women or men<sup>142</sup>.

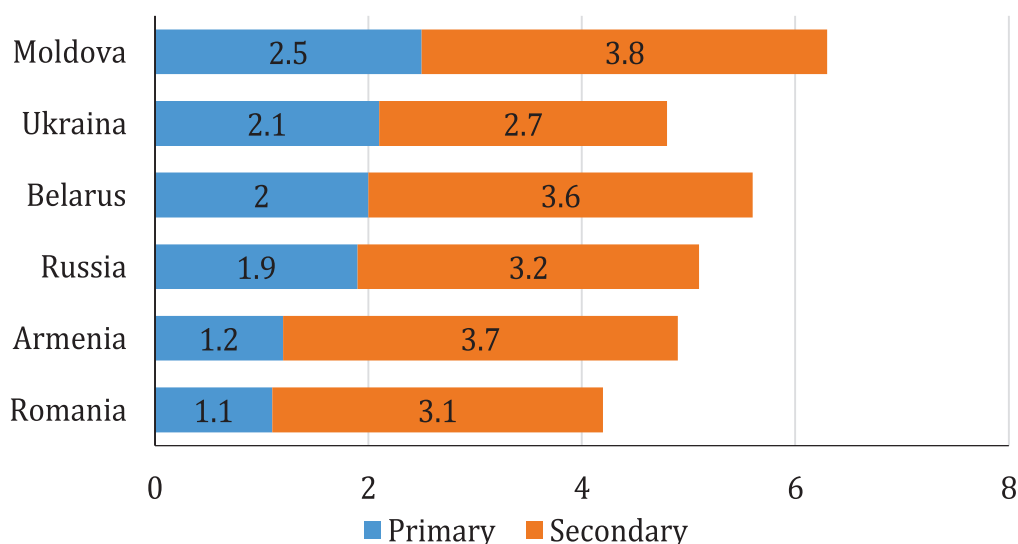
According to the Ministry of Health's regulatory acts in force, infertility healthcare is provided both in public and private sectors. Infertility healthcare in public sector is provided at three levels: first level – reproductive health facilities, that provide initial counselling and referrals to the second and third levels: second level – women's health centers, that perform complex diagnosis and treatment of hormonal disorders, urogenital infections; third level – National Center for Reproductive Health and Medical Genetics, that performs deep diagnosis of the infertility causes, approves latest treatment methods. Each woman or man has the right to request any of these three infertility care

2011.

142 Mid term assessment of the implementation of 2006-2015 National Reproductive Health Strategy, Chisinau, 2011.

Fig. 3.8.1. Primary and Secondary Infertility in Some Countries  
Source: Mascarenhas M.N., Flaxman S.R., Boerma T., Vanderpoel S., Stevens G.A. (2012) National, Regional, and Global Trends in Infertility Prevalence Since 1990: A Systematic Analysis of 277 Health Surveys. PLoS Med 9(12). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3525527/>

Fig. 3.8.1.



levels in order to availed of counselling, diagnostic and treatment of infertility.

By 2012, the State held the monopoly on the services in the medically assisted human reproduction area. With the approval of the Law on Reproductive Health, the State lost the monopoly in the healthcare technologies area, moreover, since 2012, the procedures of medically assisted human reproduction are performed only in the private sector, the costs of which limit the access of the disadvantaged social groups. Although Article 10(3) of the Law on Reproductive Health stipulates that: *“The National Health Insurance Company provides funds for only one in vitro fertilisation, on the basis of compulsory health insurance policy, for the couples employed in the Republic of Moldova and with monthly income lower than 50% of the average salary in the insured’ field of activity.”*, however, so far there is no mechanism to implement this legislative initiative.

A share of the diagnosis and treatment costs, incurred by infertile couples, are covered by the compulsory health insurance funds are included in the Single Program<sup>143</sup>. However, a significant share of costs related to laboratory diagnostic services, andrology services and procurement of medicines needed for the treatment of infertility, including by in vitro fertilisation, are covered by couples. In this context, it should be mentioned that the main obstacles to an efficient treatment of infertility are of financial nature.

### 3.9. Conclusions and Policy Recommendations

<sup>143</sup> Order No 400-219-a of 28.05.2015 approving the Methodological Norms for the implementation of the 2015 Single Program of Compulsory Health Insurance

### Perinatal, Infant and Maternal Mortality

Despite the measures undertaken to restructure healthcare system, particularly in the mother and child healthcare system, namely the implementation of the regionalized perinatal referral services system, the decrease in maternal mortality rate does not correspond to the desired results. According to WHO data, the maternal mortality rate in Moldova, over the last 20 years, has decrease by about 33%. The MDG 5 target (13.3‰) was not reached and is about 5 times higher than the European average.

The growing influence of the maternal mortality’s indirect factors (not related to pregnancy) is a matter of concern and it reveals gaps in antenatal supervision and in quality of provided healthcare services. Thus, there are some doubts as regards the quality of services provided at the primary health care level, by the family doctor.

Although a regionalized perinatal referral service system was implemented, however, the level of professionalism and promptness in interventions, particularly in emergency cases, could be improved.

In this context, the following is recommended:

- Enhance the antenatal supervision by increasing the quality of care provided to pregnant women, particularly, at the primary healthcare level, by the family doctor’s team.
- Improve the professionalism level of the service providers and the level of promptness in interventions, particularly in obstetrical emergency cases.
- Apply continuously the confidential inquiry for analyzing maternal mortality

and near miss cases.

- Develop progressively the national service of newborns' diagnosis and supervision.
- Improve inter-sector cooperation mechanisms in the medical and social areas in order to prevent and reduce infant and maternal mortality rates.

### Family Planning

We found that in the Republic of Moldova there is low demand for contraceptives, particularly modern ones, due to the low level of awareness, knowledge and use of contraception. Insufficient knowledge among population and the price of contraceptives are the reasons for not using modern contraceptives. Contraceptives have not been included so far in the list of essential medicines in the Republic of Moldova.

The Moldovan society still approaches family planning as purely women's issue. Information on men's involvement in family planning is limited, the statistics about knowledge and use of contraceptives refer to women only.

Given these findings, the following is recommended:

- Bring family planning/contraception services as closer to the potential beneficiary as possible, by integrating them in the primary healthcare and by maximising the use of the family doctor's team.
- Raise the awareness, acquire knowledge of contraception methods by information campaigns, that would promote use of contraception to prevent unwanted pregnancies and STIs, particularly HIV.
- Ensure active participation of men

in family planning, by increasing the men's knowledge on contraception and by raising the level of responsibility in preventing unwanted pregnancies and STIs.

- Include "Health education" as mandatory subject in the curricula of the primary, lower-secondary and upper-secondary education, and include psychosocial and healthcare aspects of sexual and reproductive health, with a consideration given to age, in order to ensure an ongoing health education, not a fragmented one, by different subjects (sports, civic education, biology, chemistry, homeroom class).

### Abortion/Pregnancy Termination Services

Over the last decades, the Republic of Moldova has achieved great results as regards: diminishing the number of abortions thanks to the use of modern contraception and improvement of the quality of abortion by implementing safe abortion methods thanks to technical support provided by international organisations, especially WHO.

However, the number of abortions made in Moldova is still high if compared to Western European countries. This is happening due to both unmet needs regarding modern contraception and low access of the vulnerable groups.

There are doubts regarding the quality of abortion services, because not all abortion services providers use safe abortion techniques recommended by WHO, but rather use the traditional method of dilatation and curettage. Medical abortion, which proves to be safe, is accepted and requested by women, however it is not so affordable among low-income groups.

An important component is people's demand for quality pregnancy termination services and the possibility to access free abortion services, for particular vulnerable groups, due to the low degree of knowledge regarding these facilities and sexual-reproductive rights.

In this context, the following recommendations are addressed at the policy level:

- Review the Ministry of Health's legal documents on pregnancy termination and adjust them to the latest WHO recommendations on safe termination of pregnancy.
- Enhance the ongoing training on safe abortion for medical staff and encourage them to comply with safe abortion methods, with a particular emphasis on elimination of curettage from the medical practice.
- Improve the mechanisms for monitoring and evaluation of the quality of pregnancy termination service and comply with the Ministry of Health's legal documents on collection and reporting of statistical indicators. Include quality abortion standards in healthcare facilities' accreditation system.
- Develop mechanisms to ensure universal access to quality abortion and post-abortion family planning services. Review the price setting mechanism for abortion services and improve the free services mechanism for vulnerable groups.
- Develop a system of information, education, and communication on sexual and reproductive rights and safe abortion in order to enhance the knowledge and, subsequently, increase the demand for quality services.

## Gynaecological and Breast Cancer

To prevent gynaecological and breast cancers, women must have access to gynaecological and mammography tests, as requested by the existing protocols, therefore it is unacceptable for the State to limit such services under the pretext of crisis and budgetary cuts. An important pillar in early diagnosis of cancer pathologies is informing people about the need to seek healthcare services for preventive purposes.

To ensure prevention, early diagnosis and treatment of breast and gynaecological cancer, the following is recommended:

- Develop and apply methods to organise and provide cervical screening services, as well as breast cancer early detection services.
- Streamline and enhance the quality of cancer control services provided to people, by improving the training offered to service providers, particularly to those working in PHC and implement new cost-effective technologies.
- Organise information and education campaigns about breast and gynaecological cancers in order to encourage more people to use the available services and increase the early detection of cancer (mammography and cytology screening, as well as anti-HPV vaccination).
- Mobilise the society for cancer control and health determinants monitoring.

## Sexually Transmitted Infections, HIV/AIDS

The HIV/AIDS trigger factors in the Republic of Moldova are the following: high population density, poor social and economic situation, intense migration, use of injecting drugs and higher morbidity via sexually transmitted

infections. The Republic of Moldova ranks the fourth in the classification of the countries from the region, by the number of HIV cases (preceded by Russia, Ukraine and Estonia). Most of HIV+ persons are young, of reproductive age and sexually active.

Based on these considerations, it is necessary to take measures to diminish the STIs/HIV incidence, particularly in groups at high risk of HIV infection (injecting drug users, commercial sex workers, men who have sex with men, detainees).

- Prevent STIs/HIV among persons at high risk of HIV infection by increasing their access to harm reduction programs, and prevent HIV transmission from these groups to the general population.
- Reduce the impact of HIV infection by ensuring universal access to antiretroviral treatment, care and support for people living with HIV and members of their families and by preventing the mother-to-child transmission of HIV.
- Involve several disciplines and sectors at both local and national levels to ensure an appropriate reaction to HIV epidemic.
- Strengthen the civil society capacities to create a supportive environment via advocacy and communication, promote human rights and gender equality.

### **Infertility**

The approach of the couples' infertility issue at the policy level is topical in the context of a negative population growth, reduction of total fertility rate and reproductive losses.

In this respect, the following is recommended:

- Develop mechanisms for collection

of data and reporting of statistical indicators on female and male infertility, including secondary infertility as a result of STIs and unsafe abortion.

- Review the Ministry of Health's legal documents on infertility and use of medically assisted human reproduction technologies and adjust them to the latest international recommendations in this area.
- Review price formation for the medically assisted human reproduction and improve the mechanism for free/partially-covered services for diagnosis and treatment of infertility, in line with regulatory acts in force.
- In order to increase people's access to such services as diagnostic and treatment of infertility, people should be informed and educated in this respect by both healthcare providers and mass-media by information and education campaigns.

### **In the sexual and reproductive health area, as a whole, the following recommendations are addressed at the policy level:**

- Develop a new framework for the organisation of interventions for next years, taking into account the implementation of all commitments taken by the Republic of Moldova, including the objectives of the 2030 Agenda for Sustainable Development and 2016-2030 Global Strategy for Women's, Children's and Adolescents' Health. This framework must ensure universal and fair access to quality information and services in the sexual and reproductive health area, by defining of some efficient and impactful key interventions, ongoing monitoring and evaluation in the context of scarce



human resources and limited budgets in the health system.

- Establish an inter-sectoral steering body, in charge of monitoring the implementation of RH policy documents, that will include the key ministries, agencies and non-governmental and professional organisations, in order to implement the policy document and ensure an efficient joint interaction, at all stages.
- Promote sustainable partnerships and inter-sectoral cooperation in order to streamline the efforts aimed at improving the sexual and reproductive health, including local partnerships that are essential in facilitating community changes, which subsequently result in social changes. All the governing sectors and society must realize the need for an integrated approach to sexual and reproductive health, stipulated in the policy document, that would delineate the most important priorities in SRH, provide a clear outline and concrete actions that shall be taken not only in health sector, but also in other social and economic sectors.
- Ensure universal and fair access to sexual and reproductive healthcare information and services. To ensure fair access, particular attention should be paid to people with special needs, particularly: teenagers, victims of domestic violence and human trafficking, socio-economically vulnerable people, people with disabilities (physical and/or mental), elderly.
- Develop and strengthen the sexual and reproductive data base to fight the existing inequalities and assess the impact of measures taken to justify the healthcare policies. Particular attention should be paid to data that are used to assess the cost-efficiency of promotion and protection of sexual and reproductive health, and prevention of diseases affecting the reproductive health of women and men.
- Implement the existing mechanisms to ask people's feedback and encourage them and vulnerable categories to participate actively in planning, implementation and monitoring of sexual and reproductive health policies and services.







# SITUATION OF YOUNG PEOPLE

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## 4.1. Young People in an Aging Society

Socioeconomic and demographic changes in the Republic of Moldova, as in other countries from the region, provide a growing number of opportunities and options, along with risks and constraints, for young people. Young people, more than ever before, will have to gain and be able to use life management abilities and competences to adapt to an ongoing and rapidly changing socioeconomic and cultural environment. A lot of young people do not have yet enough capacities to do that, and it is a major challenge for the youth policy for the next decades. In this context, the favourable conditions for the development of the young generation play an important role in strengthening human potential, enhancing its quality and competitiveness.

The quality of human potential is, currently, one of the most important dimensions of all the development programs at the global and national level. The investment in the young human capital, with a focus on quality development by *education, health and occupation*, represent an important pillar for increasing the country's sustainable development and competitiveness. According to international studies, the Republic of Moldova is the lowest ranking country in terms of human potential development and harnessing (66.8), and ranks the lowest among countries of Europe and Central Asia according to the Human Capital Index (HCI)<sup>144</sup>. Moldova incurs obvious losses, particularly, in harnessing the human capital of young people transitioning to adulthood, in other words future country's potential that currently

is 15-24 years (68.5 if compared to 74.4 in countries of Europe and Central Asia).

Three major factors will have the greatest impact on young people in the next decades: society ageing; knowledge-based economies and societies; new perceptions of life<sup>145</sup>.

The decrease in natality and emigration among young people have and will have serious social, economic and demographic impacts. Over the last decade (2004-2014), the number of persons aged 15-29 years decreased by 12%, shrinking from 826,9 thousand to 727,7 thousand. However, young people still represent a quarter of the country's population, thus they represent a strategic component of sustainable development, labour force, future families and human continuity. The number and share of young people in the total country's population will constantly decrease over the next decades. According to those three scenarios of the demographic forecast, this segment of population is expected to decrease significantly during the next five years, down to 531-539 thousand by 2020 or by about 37%. During 2021-2025 this trend will not change, so the number of young people will reduce by 15% more, while following 2025 it will stabilise, so the number of young people will reach the level of 450-455 thousand (as a reference scenario provides). A lower mortality and higher fertility (medium and optimistic scenarios) will help increase, after 2025, the number of young people – 490-519 thousand by 2035 (*Fig. 4.1.1*).

These major changes will be determined by the growing generation born in early 2000, who will transit to adulthood, and transition

144 The Human Capital Report 2015. World Economic Forum, 2015; The Global Competitiveness Report 2014–2015. WEF, Geneva, 2014.

145 Chisholm L. Kovatcheva S. Exploring the European youth mosaic. The social situation of young people in Europe. Information document 6th European Youth Ministers Meeting, Thessaloniki, November 2002. [http://pjp-eu.coe.int/documents/1017981/1668217/Exploring\\_the\\_European\\_youth.pdf/ef9a59df-e9c7-403f-b2cc-dab0890cd4bb](http://pjp-eu.coe.int/documents/1017981/1668217/Exploring_the_European_youth.pdf/ef9a59df-e9c7-403f-b2cc-dab0890cd4bb)

Fig. 4.1.1.

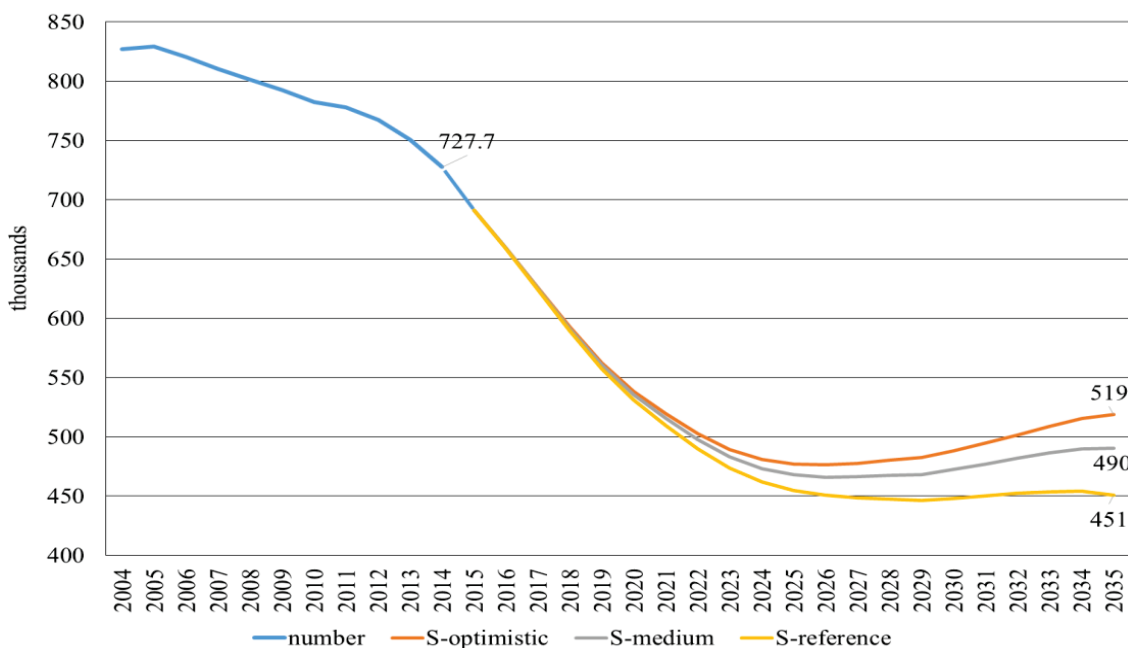


Fig. 4.1.1. Estimation and Forecast of the Number of Young People Aged 15-29, 2004-2035 Source: CDR

of today’s young generation born in mid 1980s to ageing. Thus, the share of young people will decrease from 25% in 2014 to 18% in 2025, reaching a stable level of 21% by 2035.

The structure of young population will change, too. If the age groups of 20-24 years (37%) and 25-29 years (40%) are currently predominating, then by 2035 the shares of both age groups will tend to be equal, thus

the share of 15-19 age group will increase by 35%, while the share of 25-29 age group will decrease by 30% (Fig. 4.1.2).

As revealed by the practice of past decades, the countries will enjoy strategic benefits if they are able to develop and use efficiently the innovative potential of young people, by creating appropriate conditions for socialisation and opportunities for the realisation of their individual potential.

Fig. 4.1.2.

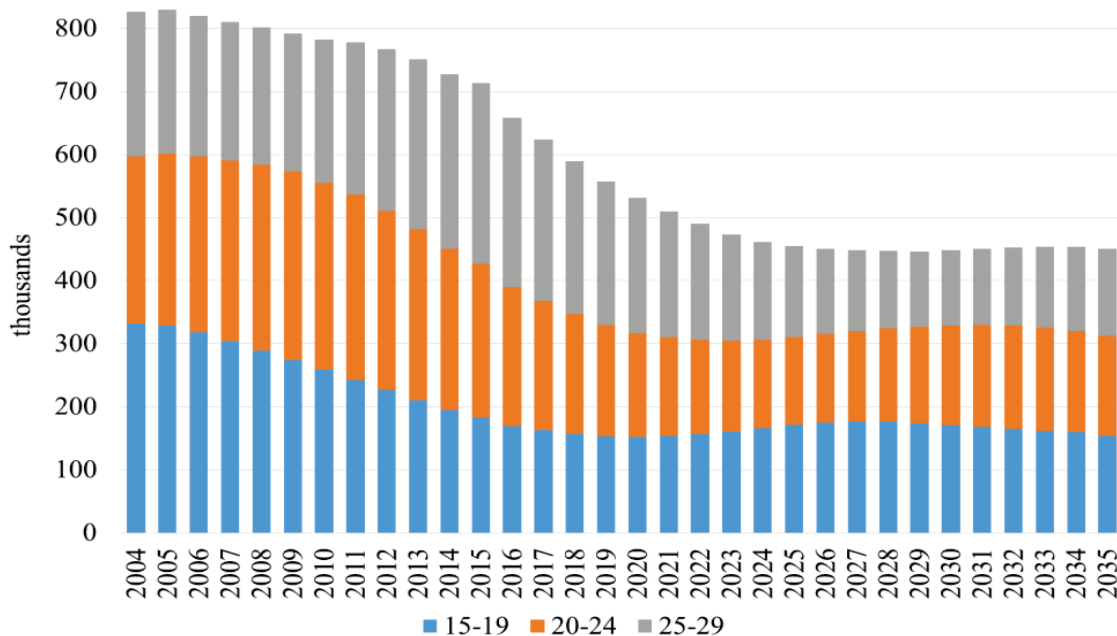


Fig. 4.1.2. Structure of Young Population by Age Groups, Estimations and Forecasts (reference scenario), 2004-2035 Source: CDR

## 4.2. Youth People Education

High quality vocational education represent an increasingly secure way for young people's social and economic integration and financial independence. The enrolment rates are increasing in all countries, however, in the former socialist countries, such as the Republic of Moldova, the tertiary education enrolment rates depend on the financial capacities to pay for tuition.

Education level has a direct impact on the young people's probability of employment. The risk of unemployment and time spent searching for the first job are smaller for young people with vocational education, especially for young people with higher education.

education level. The share of urban young people with higher education is 3.6 times higher than in the rural area: 28.7% and 8.0% respectively. A common feature for rural young people is the lower-secondary education (mandatory) – 43% of them have only this educational level.

Girls have a higher education level than boys and they account for more than half of the total number of pupils/students in the upper-secondary, secondary specialised and higher education, while vocational secondary education is mostly chosen by boys.

Compared to 2004, when the share of young people (15-29 years) with tertiary education level was almost the same for both girls and boys (6.4% and, respectively, 7.5%), in 2014 the share

Table 4.2.1.

Education level	Total		Men		Femei		Urban		Rural	
	2004	2014	2004	2014	2004	2014	2004	2014	2004	2014
Primary education or no education	1,2	1,8	1,4	2,3	0,8	1,3	0,4	0,8	1,9	2,7
Lower secondary education	19,0	24,3	19,7	26,3	18,4	22,1	7,2	10	30,6	37,3
Upper secondary education, vocational education	48,1	34,6	49,1	37,9	46,9	31	43,2	32,5	52,8	36,3
Post-secondary, non-tertiary education	12,2	7,7	11,2	8,1	13,4	7,4	17,3	8,5	7,3	7,2
Tertiary education	19,5	31,6	18,6	25,4	20,5	38,2	31,9	48,2	7,4	16,5

**Table 4.2.1.**  
Distribution of Young People aged 24-29, by Education Level, Sex and Residence Area, 2004-2014  
Source: based on NBS data

Thus, over the last decades, the Republic of Moldova has achieved visible progresses in the people's education levels. This change has occurred on accounts of the young generation (aged 15-29 years), where the share of people with higher education increased 2.4 times (from 7% in 2004 to about 17% in 2014) and is significantly higher than the share of older population group (12.3%).

The urban young people have a higher

of young girls (aged 15-29 years) with higher education increased 3 times – 20.5%, while the share of young boys increased 2 times – 13% (Table 4.2.1).

A lot of young people abandon the education system, without having the needed abilities for a successful integration on the labour market. Moreover, over the past decade, the early school abandonment rate among young people<sup>146</sup> reached up to 22%. As for

<sup>146</sup> Early school abandonment refers to the persons aged



young girls, this indicator is decreasing, while if assessed by residence areas, we can see that the early school abandonment rate of rural young people is over three times higher than of the urban ones (28.7% versus 8.8%)<sup>147</sup>.

If considering the duration of the studies and professional development of the young potential, as well as the age when active young people integrate on the labour market, we can find that a third of young people aged 25-29 years have higher education.

Education enrollment rates show, first, the vulnerability of children and young people to educational exclusion. Although over the last decade the Republic of Moldova registers clear progresses in education, however, the level of competitiveness in young people is lower than in other countries. In addition, the quality of and access to studies do not fully comply with the national and European standards.

Secondary and tertiary education cover young people aged 15-29 years. The statistics for 2004-2014 show a quite high secondary education rate, where the gross rate averages at 87% (Fig. 4.2.1). An insignificant difference can be noticed in the enrollment rates for boys and girls, where the latter is slightly higher. However, this indicator has slightly decreased after 2008. If we compare the secondary enrolment rates in Moldova and European countries, then the latter is higher (over 99% in 2014<sup>148</sup>).

Higher education has a decisive role in

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18-24 years, with a low education level (having at most lower secondary education (ISCED-2)), who had not been enrolled in any form of training (formal or non-formal) in the last four weeks before the interview.

147 NBS <http://www.statistica.md/newsview.php?l=ro&id=4480&idc=168>

148 According to UNESCO data, [http://data.uis.unesco.org/Index.aspx?DataSetCode=EDULIT\\_DS#](http://data.uis.unesco.org/Index.aspx?DataSetCode=EDULIT_DS#)

growing human potential competitiveness and respectively, in socio-economic development of a country. According to the available statistics, over the last ten years, the gross enrolment rate in tertiary education in Moldova oscillated between 37-38%. The gender gap is significant – over 12 p.p. in favour of women. As for residence areas, the gaps reach up to 27-28 p.p. and mark out educational exclusion and low opportunities for young people living in rural areas to enroll in tertiary education.

We found that the main challenge regarding the access to tertiary education in the Republic of Moldova is the enrollment rates, which if compared to European countries (71% in 2014<sup>149</sup>) are quite low. They are influenced by the low baccalaureate completion rates from the last years and also by the low participation of people from rural area. In addition, we found that the participation level of 25-29 age group and adults aged 30-34 in this education level is lower.

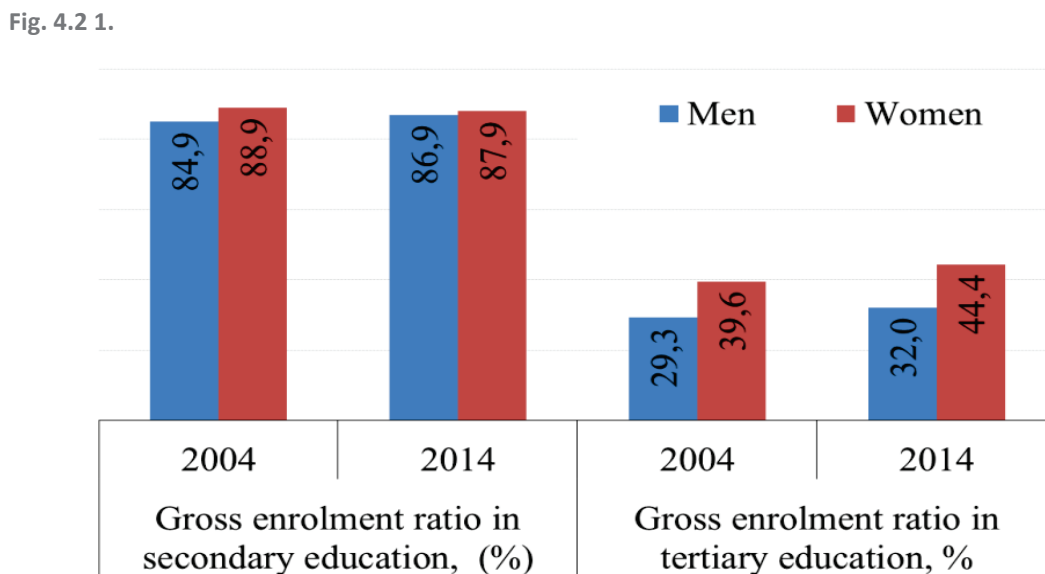
In the last decades, the emigration for education has amplified in the Republic of Moldova. Linguistic knowledge and desire to obtain quality education, as well as possibility to be employed abroad, motivate an increasing number of young Moldovan people to try to apply for education programmes in European universities. During the 2013-2014 academic year, 97.3 thousand students were enrolled in Moldovan universities, while 24.6 thousand Moldovan students were enrolled in foreign universities, which imply that about one in five students was studying abroad<sup>150</sup>. The greatest number of Moldovan students is registered in Romania, Russia, Italy

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149 According to UNESCO data, [http://data.uis.unesco.org/Index.aspx?DataSetCode=EDULIT\\_DS#](http://data.uis.unesco.org/Index.aspx?DataSetCode=EDULIT_DS#)

150 Grigoras E. Câți studenți moldoveni își fac studiile peste hotare? [How many Moldovan students are studying abroad?] DRC, 2014 [http://ccd.ucoz.com/\\_ld/0/1\\_CCD-Buletin-Pop.pdf](http://ccd.ucoz.com/_ld/0/1_CCD-Buletin-Pop.pdf)

**Fig. 4.2.1.**  
Enrolment Rate in Secondary (ISCED 3) and Tertiary (ISCED 5-8) Education, 2004-2014  
Source: [http://data.uis.unesco.org/#http://www.statistica.md/public/files/publicatii\\_electronice/Educatia/Educatia\\_RM\\_2015.pdf](http://data.uis.unesco.org/#http://www.statistica.md/public/files/publicatii_electronice/Educatia/Educatia_RM_2015.pdf)



and Ukraine. Note that according to host country statistics, the number of Moldovan students studying there is 4 times higher (5673 persons in the 2013/2014 academic year) than the national statistics provide, given that a great part of them try to apply for education programs directly at the foreign universities.

The share of young people who are neither employed, nor enrolled in any form of training or vocational development (NEET rate) show their disappointment and marginalisation in education and labour market. These young people are exposed to a higher risk of social exclusion, because they neither develop their competences in education system, nor gain experience in job.

It is worth-mentioning that official statistics calculate NEET rate without excluding young people that are not physically present in the country for more than a year, thus the value of this indicator is overestimated (40%) in relation to young people physically

present in the country. This argument is also put forward by the results of the 2013 *School-to-work Transition Survey*, where the NEET rate is lower – about 29%, because it excludes the number of young people who are abroad for more than one year (Table 4.2.2). If compared to EU, where the NEET rate accounts for 15.4%, in Moldova it is two times higher, which proves high level of vulnerability of this population category.

NEET rate goes beyond the usual limits in 25-29 age group (about 45%), which can be explained by the higher share of nonactive young people of this age, who work abroad. At the same time, women in this age group register the highest share in the NEET rate – 55%. This is due to the great number of inactive women, who spend this time on family responsibilities, particularly, childbearing and childcare and also due to gender inequalities on the domestic labour market.

The following factors contribute to the increasing NEET rate among women:

**Table 4.2.2.**  
NEET Rate among Young People (15-29 years), by age group, sex, residence area, 2013\*, %  
Source: ILO estimation based on NBS data from HS (2013)

**Table 4.2.2.**

Vârsta (ani)	Total	Bărbați	Femei	Urban	Rural
15-29	28,8	22,6	33,8	21,5	34,7
15-19	10,2	11,1	9,2	2,8	13,6
20-24	28,2	30,5	26,4	13,1	42,6
25-29	44,7	27,7	55	37,7	52,8

disappointment on the labour market, as a result of the past years' economic and social crisis, low income, that is not enough for a decent life, inequities in employment and so on. Thus, without any job opportunities, many young people, who are disappointed and had failed to integrate into the labour market, leave for abroad in search for a job. The young people who are abroad represent an important category in the group of inactive young people (30.4%), and their number has increased in the recent years. At present, over 16% of all young people are working abroad (compared to 13.1% in 2008), in urban area – about 11%, in rural area – over 22%<sup>151</sup>.

### 4.3. Young People on the Labour Market

From the perspective of the social, professional and economic background specific to this age group, which as a rule shape a number of peculiarities and behaviour patterns, youth is the transition period from childhood to the gradual uptake of social roles and establishment of a status in the social hierarchy. As a social group, young people totally fit in the working age population group<sup>152</sup>.

151 Buciuceanu-Vrabie M., Pahomi I. Situation of youth in the Republic of Moldova: from goals to opportunities. Demographic Barometer. Chisinau, 2015.

152 As a rule, international statistics qualify this occupational

Over the last ten years, young people had faced issues related to: employment; professional development that does not comply with labour market requirements; low salaries; unattractive job opportunities; mass labour migration etc.

Demographic, economic and social factors lead to an increase in young people, in both absolute value by 2010, and share of the total employed population. Thus, the share of young people in the total number of employed population increased by 2010, from 18% in 2004 to 23% in 2010. In recent years, this quota has already decreased: in 2014, one in five employed persons was from the 15-29 age group (Table 4.3.1).

These fluctuations can be explained by the transition into the economically active age of the numerous generations born in mid 1990s, registering the highest increase in 2010-2011. But as it was a temporary phenomenon, the number of active people (16-57/62 years) including young people, has decreased after 2011, and the losses are even more obvious in the long run, as the country did not manage to capitalize this potential on the labour market and to avail of this demographic dividend by proper investments in human capital. A lot of people of active age, particularly young

group in the 15-24 age group. At the same time, the employment policies focused on young people from the Republic of Moldova cover 15-29 age group.

Table 4.3.1.

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
The share of Youth in total:											
Employed population (%)	17,7	17,8	20,0	19,1	19,5	20,6	22,5	22,4	22,0	22,1	20,7
Unemployed Population (%)	37,6	37,5	40,3	41,7	41,6	40,0	45,1	43,9	40,9	39,1	40,0
Inactive population (%)	43,3	43,6	41,8	40,7	40,3	38,8	38,8	38,4	37,6	36,7	36,2

**Table 4.3.1**  
Young People (aged 15-29) and Labour Market, thousand persons  
Source: National Bureau of Statistics (NBS), Labor Force Survey (LFS), 2004-2014

people, are not integrated in the internal labour market either as a result of no jobs and, respectively, labour migration, or they rely on the financial support of their relatives working abroad.

The employment rate of young people had decreased significantly during 2000-2005, from 39% to 25.5%, in the context of the constant decrease of the employment rate of economically active people for more than ten years. Since 2006, a relative increase was registered, so this indicator reached 28%-27.3% during 2013-2014 (Fig. 4.3.1.).

It is worth-mentioning that the current statistics calculate the occupational and many other indicators by reporting them to the number of stable population, without skipping persons working abroad and those who are not physically present in the country for longer than 12 months. Thus, the value of several indicators is either underestimated, or overestimated. This argument is also supported by the results of the national survey (NBS 2014),<sup>153</sup> which estimates the employment rate for young people aged 15-29 years, remained in the country, at 31%.

The structure of employed young people

<sup>153</sup> School-to-work transition, 2014. NBS, Chisinau, 2014. Young people working abroad, about 150 thousand according to Labour Force Survey, are not covered in the survey.

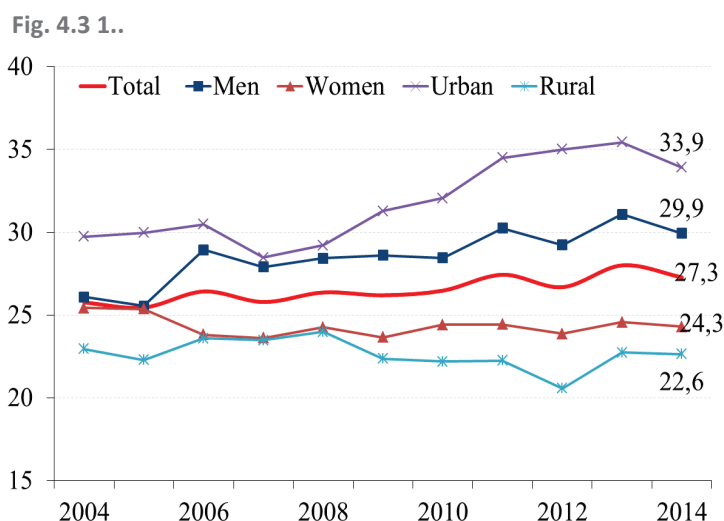
has clearly changed depending on age, gender, residence area, activity.

Over the past ten years, the gender employment rate has evolved differently: if men's employment rate was higher, with an uptrend from 26% (in 2004) to 30% (in 2014), then women's employment rate is more stable, with a downtrend (from 25.4% to 24.3%). The gender gap has amplified significantly after 2005, the women's employment rate for the age group of 15-29 years is currently by more than 6 percentage points lower than men's employment rate. The lower women's rate and delayed entrance into the labour market is caused by the longer duration of studies, marriage and childbearing. At the same time, empirical studies<sup>154</sup> indicate that, without an effective employment policy that would ensure reconciliation between family and professional roles, development of quality and affordable child care services, gender equality on the labour market and so on, the situation of women on labour market will not change in relation to men.

Urban young people were found to have higher chances to integrate into the labour market than the urban young people. The employment rate in urban young people has increased significantly, from 29.7% to about 34%, which was at its peak in 2011-2013 – a trend specific to this area of residence, while the employment rate in rural young people is rather decreasing, where values have oscillated around 23% over the last ten years (Fig. 4.3.1). This situation is caused, first, by low employment opportunities in rural area, which is a defining characteristic of the Moldovan labour market in the rural area, second, by the mass migration of rural young people either to cities, or for abroad

<sup>154</sup> Gagauz O., Buciuceanu-Vrabie M. Rolul profesional & rolul parental: oportunități de echilibrare pentru femeia contemporană. [Parental role and professional role: balancing opportunities for a modern woman.] Chisinau, 2011.

Fig. 4.3.1. Employment Rate of Young People (15-29 years), by sex and residence area, 2004-2014, %  
Source: National Bureau of Statistics (NBS), Labor Force Survey (LFS), 2004-2014.



in order to find a job ensuring a decent living. The empiric data on school-to-work transition<sup>155</sup> indicate uneven income and employment opportunities for rural young people and that after leaving educational system, the share of rural young people who found a good job is much lower than among the urban ones (54% versus 75%). Young people in rural area try to cope with this situation and often work occasionally, especially during the agricultural season, but by doing so they cannot earn enough money for a potential investment or for their own development.

In the Republic of Moldova, one in two young people aged 15-29 years started to look for a job at the age of 19, on the average<sup>156</sup>. However, the official statistics show that about 52% of young people aged 15-24 years, regardless of their residence area, are enrolled in the educational and vocational development system, not in the labour market. Obviously, the share of young people aged 15-19 years, enrolled in education system, is higher and accounts for

about 80% of the total number of people in this age group. These peculiarities explain to a large extent why the employment rate in younger groups (15-19 years/20-24 years) is lower than in 25-29 age group (Fig. 4.3.2.). During 2000-2014, the employment rate decreased at least twice, for each age group, which is a common feature.

The breakdown of young people by employment status shows that about 80% are employed. Almost one in six employed young people is self-employed. In the rural area, the share of self-employed young people is the highest, about 1/3 of employed young people. Most of these young people are employed in agricultural “day-labour”, which is a low productivity activity, that cant ensure neither a decent living, nor prospects for starting up their own business.

**Young Entrepreneurs.** Young people represent most suitable category of people for successful individual businesses, because they represent the skilled human resources, have initiative and entrepreneurial spirit and needed potential.

155 School-to-work transition. NBS, 2012/2013 and 2014/2015.  
156 School-to-work transition. NBS, 2012/2013 and 2014/2015.

Fig. 4.3 2..

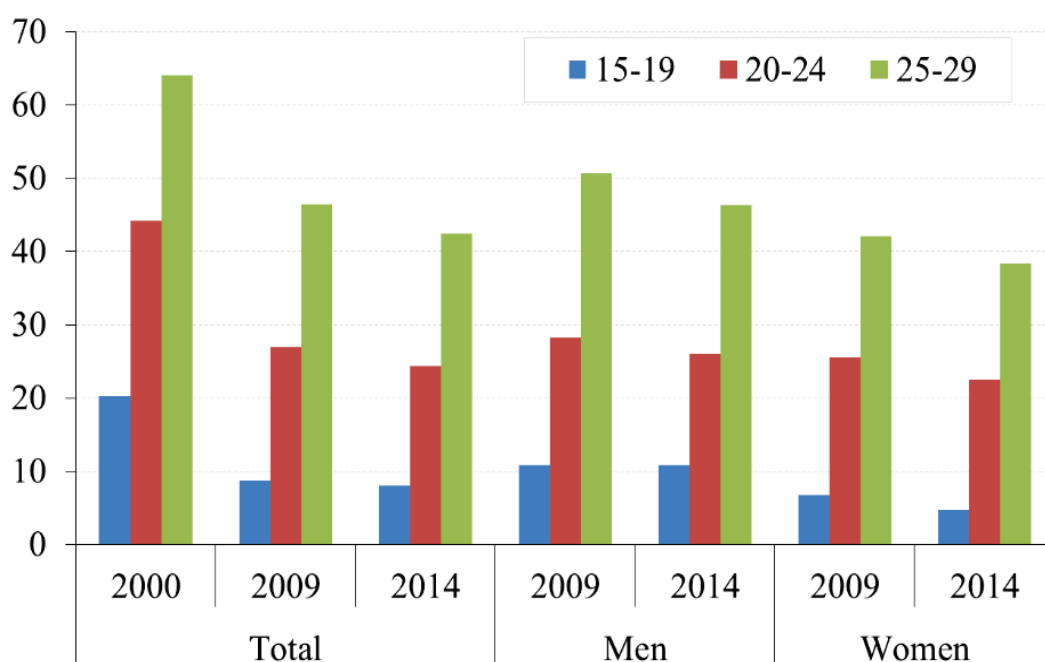


Fig. 4.3.2. Young People Employment Rate, by age group, for the available years, % Source: ILO data based on LFS Moldova, NBS.



Although the Republic of Moldova has programs to support young entrepreneurs, however, the share of young entrepreneurs is relatively low – 2.4% for up to 24 years age group and 20.3% for 25-34 age group<sup>157</sup> (more recent data does not exist). On the contrary, the share of young people who want to start their own business is quite high: about 56%. Agriculture (22%), trade (20%), service provision (17%), IT (4%) are areas of highest interest for starting up a business. The share of young entrepreneurs with higher education accounts for 82%. The main impediments that hinder the start-up are: lack of money – 45%, current political situation in the country – 14%, competition – 12%. Other impediments are the following: unpredictable situations, bureaucracy, high taxes, lack of support, lack of particular information, corruption or barriers imposed by state.<sup>158</sup>

157 Conditions for enterprises' creation and development: gender analysis / Elena Aculai; col. red.: Oleg Cara, Nina Cesnocova, Jana Mazur [et al.]. – Ch. : "Nova Imprim" SRL, 2009, NBS

158 Cine sunt tinerii antreprenori din Moldova și care sunt cele mai mari provocări ale lor. [Who are young entrepreneurs from Moldova and what are their main challenges?]. Magenta Consulting, September-October 2015.

### Informal Employment of Young People.

The presence of young people on the domestic labour market is also characterised by high level of informal employment: about 31% of young people are informally employed, and 10.4% of young people are employed without an individual employment contracts<sup>159</sup>. Although the informal employment rate in young people has decreased from 41.5% (the highest values reached up in 2006) to 30.7% (in 2014), however, it is still high in men (about 37%) and young people living in rural area (50%). The informal employment rate of rural young people may be explained by the high share of agricultural works.

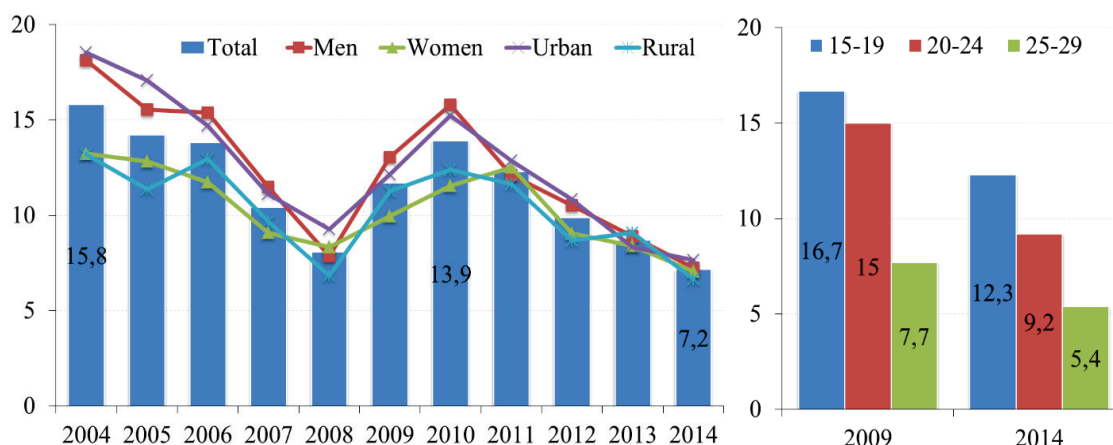
**Youth unemployment** (15-29 years) is relatively high, if compared to that of other age groups. Young people account for 40% of all unemployed. Over the last five years, youth unemployment rate registered a decrease (Fig. 4.3.3), nevertheless, if compared to average country unemployment rate (about 4%), it is among highest level (7.2% in 2014). This situation is caused particularly by the youth's issues related to professional integration.

3 out of 5 unemployed young people are men, and 7 out of 10 are from rural area. If compared to the previous years when

159 Based on the Labour Force Survey data, NBS, 2014.

**Fig. 4.3.3.**  
Youth Inactivity Rate (15-29 years), by gender, area of residence and age group, %  
Source: National Bureau of Statistics (NBS), Labor Force Survey (LFS), available data for 2004-2014.  
\* data for 2013, ILO Youth STATS

**Fig. 4.3 3..**





gender gap in unemployment rate was, as a rule, higher in men, nowadays it is almost insignificant. Although the employment rate in rural young people is lower, however, the unemployment rate in urban young people is higher. In the context of economic, political and social crisis of the past years, we can say that unemployment indicators in young people do not fully reflect the real situation. Or, the decrease in the youth unemployment rate is the result of the high migration flow in young people (the migration rate in young people living in rural area is higher than in young people living in urban area), that taken underestimate this indicator.

Moldovan young people are obviously disadvantaged on the labour market. There is a negative relation between the age and unemployment risk, thus the unemployment rate in 15-19/20-24 age group is almost twice higher than the following age group (25-29 years). This situation is reported to the quality peculiarities of the employment potential of older people, such as completed professional development, work experience, and availability and employers' desire to hire professionally developed persons. However, 9 of 10 unemployed young people are aged 20-29 years.

Over the last years, the distribution of unemployed young people shows significant changes: the share of young people with higher education has increased significantly (from 10.1% in 2004 to over 28% in 2014), given the continuous decrease in people with lower-secondary education (from 30.8% to 24.3%) and secondary vocational education (from about 49% to 39.2%). Thus, the vulnerability level, which is higher particularly in young people with secondary education, has touched young people with higher education too, which proves the outright failure of the labour

market, labour demand and supply, and inefficiency of professional and vocational education programs, that do not comply with the requirements of internal labour market.

Among unemployed young people with higher education, women and young people from urban area are affected the most: almost one in four people has tertiary education and could not enter the labour market. National studies identified several factors that could explain the increase in the share of unemployed young people with high education: unattractive job vacancies, low salary, difficulties met when being employed for the first time, lack of experience (in 2014, out of the total share of unemployed young people – 42% have never been employed) as well as improper professional development that does not comply with the requirements of labour market (41% of employers identify the qualification level of labour force as a major constraint for their business)<sup>160</sup>.

During 2004-2014, the youth (15-29 years) inactivity accounted for over 69%, thereby overcoming significantly the value of the indicator for the whole economically active population (59%). At the same time, the share of young people in the total of inactive population is the highest – 36% (in 2014), (*Table 4.3.2.*). The highest inactivity rate is registered in young people living in rural area and in young women – about 76% and, respectively, 74%. The inactivity rate has increased, with small fluctuations, in both social and demographical categories, if compared to 2004. The inactivity rate decreases in elder groups, although the

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160 Buciuceanu-Vrabie M. Oportunități și riscuri în dezvoltarea potențialului uman al tinerilor. [Opportunities and risks in the development of young people's human potential.] Economic growth in conditions of globalization. Scientific session: Demographic Structure and Quality of Human Potential. Chisinau, 2014, p.20-29.

**Table 4.3.2.**  
Youth Inactivity Rate (15-29 years), by gender, area of residence and age group, %  
Sursa: BNS , AFM,  
Source: National Bureau of Statistics (NBS), Labor Force Survey (LFS), available data for 2004-2014.  
\* data for 2013, ILO Youth STATS

**Table 4.3.2.**

	Total	Gender		Area of residence		Age*, years		
		Men	Women	Urban	Rural	15-19	20-24	25-29
2004	69,4	68,1	70,7	63,5	73,6	88,3	67,7	52,9
2014	70,6	67,7	73,9	63,3	75,8			

Moldovan youth inactivity rate registers higher values. This gap can be explained by the higher share of 15-19/20-24 years old youth enrolled in education system.

As the current statistics on labour force<sup>161</sup> provides, out of the total share of economically inactive young people, more than a half are enrolled in education and professional development system, over 20% are involved in household works, including family responsibilities, and a big share of them are working or seeking for a job abroad. Thus, about 17% of inactive young people aged 15-24 and 35.6% of inactive people aged 25-34 are labour migrants. Over the last years, the share of this category has increased, particularly in the younger age group (in 2008, 14% out of the total share of inactive young people aged 15-24 years were labour migrants). (Table 4.3.3.). At the same time, out of the total share of inactive young people (aged 15-24/25-34 years old) who neither seek for a job, nor want to work, about 15% are potential migrants, as they reported that are planning to go abroad for job opportunities in the near future<sup>162</sup>. According to NBS data, the share of young people living in urban area who have migrated accounts for 57.3%, while the share of those living in rural area – is of over 60%. Out of the total of men abroad, almost 2/3 are young men, while the share of women abroad is about–43%.

Overall, the proportion of young labour migrants was 16.2% out of the total young

population (aged 15-34 years<sup>163</sup> in 2014). Various official sources show that the number and the proportion of young people left for abroad increased in the last years (Table 4.3.3.). It was concluded that about 11% of all young people in urban areas are labour migrants and more than 22% are young people – in rural area, if reported to the area of residence.

It was found that the profile of the young candidate for an employment abroad changes qualitatively in time: the number of young people who have completed vocational training, including young people who have not yet establish their own family or household. In 2014, the share of young people with higher education accounted for 7% of the 15-24 age group and 16.6% of the 25-34 age group in the total number of young people working abroad or looking for a job, recording an increase compared to 2006 when it recorded 4.7% and 11% respectively. The intensity and socio-demographic characteristics of the migration flow among young people, as well as the time of stay abroad lead to direct losses of young generation with socio-demographic and economic risks for the country.

Certainly, the mass migration of the population looking for a job abroad is caused by the failures on the domestic labour market, lack of jobs and the employment inequalities for different social groups, in particular for young people, low income people etc.

161 Labour force in the Republic of Moldova. Employment and unemployment. NBS. Chisinau, 2015.

162 Ibidem.

163 Available age structure for youth migrants provided by the NBS.

Table 4.3.3.

According to NBS data on labour force				
Age	Young people working or seeking for a job abroad, thousand persons		*Share of young migrants in the total number of young population, %	
	2008	2014	2008	2014
15-24 years	75,9	72,3	11,2	13,6
25-34 years	85,8	121,2	15,3	18,3
15-34 years	161,7	193,5	13,1	16,2
According to data gathered from the crossing borders of the State Border				
Age	Young people abroad, thousand persons		Share of young people absent from the country for more than one year, %	
	2008	2014	2008	2014
15-24 years	144,3	125,1	27,4	33,3
25-34 years	214,6	253,1	36,2	41,6
15-29 years	259,8	254,1	31,2	35,9
15-34 years	358,9	378,1	32,7	38,8

Table 4.3.3.

Statistics on Mobility of Young People Abroad, %  
Source: calculations based on the data provided by: NBS (Labour force in the Republic of Moldova. Employment and unemployment. Chisinau, 2015); CRIS "Registru" (via Web-Access).  
\*calculations based on NBS data on average number of stable population and data on labour force in the Republic of Moldova.

Thus, the transition from an educational institution to a workplace is one of the most important and difficult issues for Moldovan young people. *The level of the educational potential of young people is not in line with the production requirements. Education system is self-reproducing and is becoming non-effective.* The educational issue starts from a formal education system, which is not accurate and adapted to daily life outside the education system, which caused some impediments to young graduate while entering the labour market. Once young people entered the labour market and became economically active, it is important to assess their perception related to finding a job. According to National Employment Agency, persons with higher and mid-level specialized education can benefit from 2546 vacant jobs, which is equivalent to about 29% of the total

vacant jobs, and persons with vocational secondary education, medium general and unskilled workers can benefit from 6314 jobs, which is equivalent to 71% of the total number of vacant jobs. The labour market provides more jobs for unskilled workers, which is not matched by the young people's choice of the future profession. Thus, usually, the admission programs of universities are not in line with the real demands on the labour market, and subsequently an excess of graduates is created in certain specialties and a shortage in others.

A frequent stereotype of young people is that they chose a profession by its dignity, and prefer to become lawyers and economists rather than choosing a less prestigious profession<sup>164</sup>, the total number of students cycle I and II enrolled in higher educational institutions for 2015/2016, in *economic sciences* is 18448 (about 23.70%) and *law* -

164 www.statistica.md

13006 (about 16.71%) of the total number of 77815 students. Given that the labour market provides few opportunities for a well-paid job, many young people prefer to seek a job abroad or stay unemployed. They usually prefer to study, take care of children often due to financial support provided by a relative that works abroad. According to official statistical data for the first quarter of 2016, the number of people aged 15-24, working or seeking for a job abroad amounts to 57.1 thousand and people aged 25-34 - to 111.4 thousand. The number of persons who stopped seeking for a job or don't take any measures to find one is increasing and this category of workers are economically inactive (inactive population of 15 years and above, for the first quarter in 2016 accounted for 59.9% of the total of population of the same age group). Many young people enter the labor market without having obtained the necessary qualifications during their studies, as the enrollment plans by specialties are not correlated with the real demands of the labor market, demonstrating ineffectiveness of the transition from education to working life.

About 34% of young people ask for help from their relatives and acquaintances

while seeking a job. The young people's decision to use the social networks while seeking for a job partially because they are discriminated on the labour market, employers refuse to hire young people that only know theory, but have no practical experience. Young people prefer to seek for a job via informal, rather than formal networks<sup>165</sup> and, usually they learn about vacancies via social networks (44.9%) and less from employment agents (24.8%). The Internet is the most important informational source (43.0%). Young people think the employers have great expectations from education institutions' graduates, but this is a disadvantage for them giving that they lack sufficient experience and qualifications. Among the most important abilities necessary while seeking for a job are: vocational training, computer skills and modern languages, this is why education institutions should pay a greater time to prepare young people for being employed and improve opportunities of language training and computer use, in particular, in young people from rural area, who have less access to information and Internet..

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<sup>165</sup> The survey on the situation of youth in Republic of Moldova in 2008, "Young people in Moldova, 2008", p.54

## 4.4. Young People's Health

Health is a key component of human capital and an important element of welfare and quality of life, given that individuals can perform their activities, achieve their objectives and participate as active members of the society<sup>166</sup>. If that aspect is taken as the basis of the economic growth, effective investments in the health system will become an imperative due to both strict economic and moral grounds.

EU Youth Strategy emphasizes the need to “promote the mental and sexual health, physical activity, sport and healthy lifestyle, prevent and treat injury, eat disorders, addictions and substance abuse”<sup>167</sup>.

In the Republic of Moldova, the access of young people under 18 years of age and of those who continue their studies to health care is guaranteed by the state, via free health insurance. At the same time, according to Household Budgets data in 2014, one in three persons aged 15-29 years did not have an insurance policy, because they did not have a job and could not afford one.

Maintaining the health of young people is

166 Alber, J., Köhler, U., Health and care in an enlarged Europe, Luxembourg, Office for Official Publications of the European Commission, 2004; Health in European Union. Trends and analyses. WHO, 2009.

167 European Commission (2011). COMMISSION STAFF WORKING DOCUMENT On EU indicators in the field of youth. Brussels, 25.03.2011, SEC(2011) [http://ec.europa.eu/youth/library/publications/indicatordashboard\\_en.pdf](http://ec.europa.eu/youth/library/publications/indicatordashboard_en.pdf)

Table 4.4.1.

	Total			Urban			Rural		
	15-19	20-24	25-29	15-19	20-24	25-29	15-19	20-24	25-29
Total	48,1	63,9	90,2	29,9	53,1	53,1	57,5	70,5	118,6
Men	72,6	87,3	138,6	40,4	62,2	62,2	89,3	102,4	173,0
Women	22,6	39,6	40,1	18,8	43,9	43,9	24,5	37,0	56,7

influenced significantly by subjective factors of their behavior – health behavior. Because of their lifestyle, proper to a high-risk behavior, rebellious nature, carelessness and lack of experience prevents young people from seeing the connection between current actions on their health and future consequences.

The health inequality is exacerbated by socio-economic differences. Young people in poor families, those living in poor areas, are usually characterised by a poor health and low access to quality healthcare services. Other factors, that are often associated to general socio-economic circumstances, also have an important role and refer to conditions of life and work, nutrition, smoking, harmful use of alcohol. Obviously, the access and quality of healthcare services, as well as the public policies determine the equality/inequality in terms of young people's health and social exclusion.

Young people's health status reflects the level of mortality, which has decreased in the past years. In 2014, the specific mortality rate for the age group of 15-29 years constituted 67.4 of deaths per 100 thousand inhabitants of this age. The mortality rate for this age group constituted 48.1 cases per 100 thousand of people of this age, for 20-24 years age group this indicator was 63.9, and the highest mortality rate was recorded for the 25-29 age group – 90.2 cases (Table 4.4.1.).

There are significant gaps by gender and area of residence. Thus, the mortality rates in young men are several times higher than

**Table 4.4.1.** Mortality Rate among Young People, by sex, areas and age groups (number of deaths per 100000 persons of this age)  
Source: calculations based on the data provided by NBS.



in women. Also high mortality rates are recorded in young people from rural areas, in particular, in men: the mortality rate for the 15-19 age group is twice higher if compared to urban area, for the age group 20-24 – 1.6 higher and for 25-29 age group – almost three times higher.

Reducing mortality among young people stands for most causes of death, especially of deaths caused by social illnesses, such as infectious and parasitic diseases. Most deaths are caused by external factors: accidents, intoxications and trauma (57.0%), followed by tumors (10.4%), circulatory system diseases (8.7%), respiratory system diseases (5.1%) and respiratory diseases (3.5%).

In 2014 the death rate caused by external factors for the 15-29 age group accounted for 40 cases per 100 thousand persons of the same age. The highest rate of death caused by external factors is recorded in young people aged 25-29 years (47.5 per 100 thousand), though a reduction trend in mortality for this group and 20-24 age group is noticed. The death rate for the 15-19 age group, fluctuating insignificantly during the analysed interval,

remained unchanged. The gender and area of residence, just like in other fields, determines the level of mortality caused by external factors. Mortality rates in boys are almost twice higher than in girls, in rural area, in particular in 25-29 age group is five times higher.

An overview on statistical indicators of young people's health concludes: even though the incidence of tuberculosis cases among young people is decreasing in the last years, the share of youth aged 25-34 years old among patients with active tuberculosis is constant – about 22%, and for those aged 15-24 years – 10,2% of all patients (Table 4.4.2.).

Young people are one of the target groups at risk HIV/AIDS risk. The incidence of infection of young people with human immunodeficiency virus (HIV) decreased by about 9% in recent years compared to 2008. In the HIV incidence structure for young people from 15-29 age group, one in two young people is 25-29 years, followed by the 20-24 age group (36.8%). Thus, the incidence rate increases with the aging from 7 cases per 100 thousand young people aged 15-19 years to 28 cases per 100 thousand

Table 4.4.2.

**Table 4.4.2.**  
Morbidity in  
Young People  
through Active  
Tuberculosis  
and Venereal  
Diseases  
Source:  
developed on  
the basis of data  
provided by NBS

Patients with active tuberculosis						
	young people under monitoring		share of young people in all sick people, %		Per 100000 inhabitants	
	2006	2014	2006	2014	2006	2014
15-24 years	653	280	17,7	10,2	94,5	52,8
25-34 years	841	613	22,8	22,3	151	92,5

Patients with syphilis						
	young people under monitoring		share of young people in all sick people, %		Per 100000 inhabitants	
	2006	2014	2006	2014	2006	2014
15-19 years	297	216	12	11,6	189	200
20-29 years	1064	770	43,1	41,5	168	117

Patients with gonorrhoea						
	young people under monitoring		share of young people in all sick people, %		Per 100000 inhabitants	
	2006	2014	2006	2014	2006	2014
15-19 years	329	147	18,1	14,6	209	246
20-29 years	1083	619	59,4	61,7	171	93,9



Fig. 4.4 1.

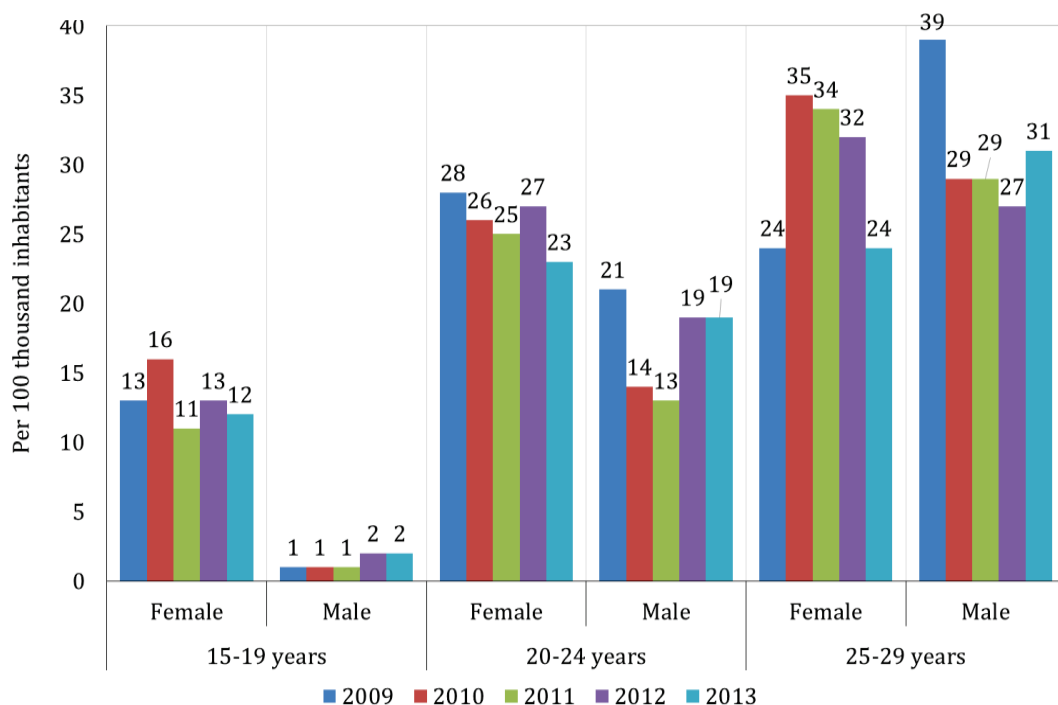


Fig. 4.4.1. Incidence of Young People with HIV Virus by Age Groups and Sex, per 100 thousand inhabitants of the respective age, 2009-2013 Source: NBS

young people aged 25-29 years (Fig. 4.4.1).

Even if joint efforts are made by the government and non-government institutions to inform young people about how to protect against sexually transmitted infections, 6 of 10 persons infected with sexually transmitted infections belong to 15-29 age group and their rate in the last decade has been constant. At the same time, about 14% (in 2013) of the new HIV cases registered were in people aged 15-24 years, and various studies show a decrease in the share of young people with comprehensive knowledge about HIV from 40.5% (in 2005) to about 32% (in 2013).<sup>168</sup>

Another risk behaviour is smoking, alcohol use, illicit drug use, teenage pregnancy, suicide.

The "young smokers" indicator refers to the share of young people aged 15-29 that smoke every day. According to national studies <sup>169</sup>, the share of young smokers accounted for 14.3%. About 77.1% of

young people stated they never smoked and 8.6% – smoked in the past. The most active smokers were persons aged 20-24 years, of whom 95% smoke every day up to 20 cigarettes per day and 4.8% – more than 20 cigarettes per day. The highest share of young people that only smoked in the past refers to 25-29 age group and accounted for 15.2%.

The rate of smokers by area of residence is higher in urban area (15.3% compared to 13.3% in the rural area), smoking being more frequently more by young people of 20-24 years (30.4%) (Fig. 4.4.2).

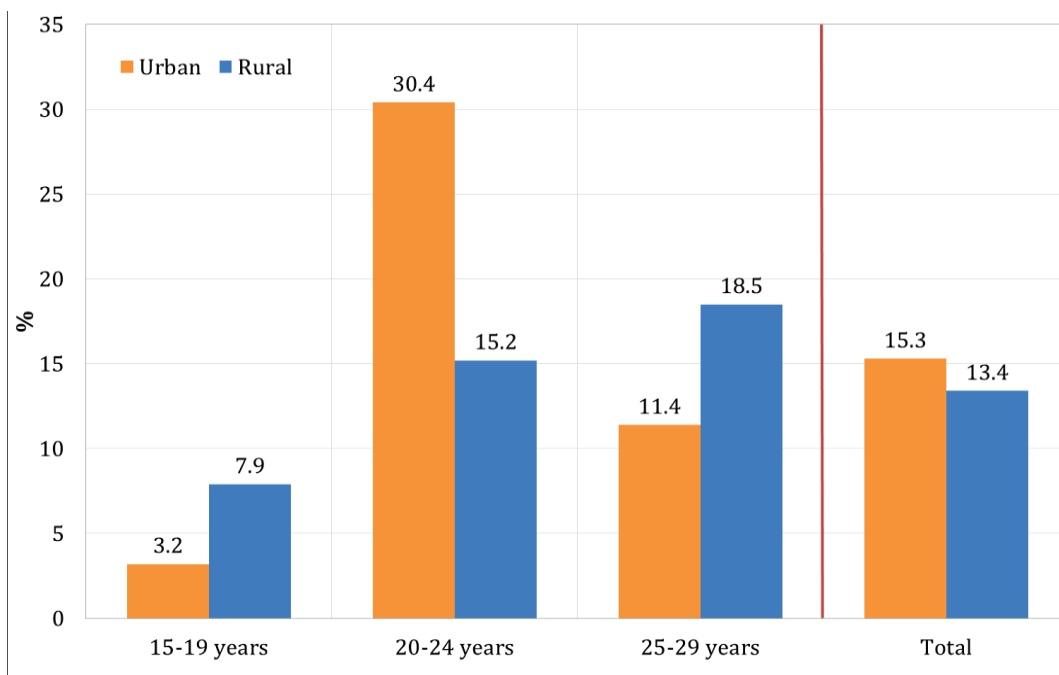
The share of smokers that consume more than 20 cigarettes per day is higher in the urban area (7.1% compared to 4.3% in the rural area), with some discrepancies by age groups. Thus, if in the urban area young people smoking more than 20 cigarettes per day are 25-29 years old (16.1% compared to 4.3% in the rural area) then in the rural areas – they are 20-24 years old (8.1% compared to 3.2% in the urban area).

In terms of gender, almost one out of

168 MICS survey, 2012

169 Population access to health services. NBS, Chisinau, 2011

**Fig. 4.4.2.**  
Share of Smokers  
by Age Group  
and Areas of  
Residence, 2012  
Source: NBS



three men aged 15-29 years smoke, while smoking women account for 3.1% only. Compared with the 2010 survey data, the number of male smokers is decreasing (by 1.2 percentage points), while the number of female smokers nearly tripled (from 1.0% in 2010 to 3.1% in 2012).

Tobacco use is closely linked to alcohol consumption, this correlation is especially true for early ages<sup>170</sup>. In addition, smoking is one of the harmful factors that affect young people’s health, especially of teenagers. According to the available<sup>171</sup> data, about 15% (in 2013) of teenagers aged 13-15 years use any tobacco products, their share is decreasing compared to 2008, when there were 21%<sup>172</sup>.

The results of HBSC survey in Moldova show that the share of students than never

smoked is decreasing with age (96% of 13 years old teenagers and 89% of 15 years old). NCHM–showed that boys start smoking at an earlier age compared to girls, 32.8% of boys reportedly started smoking at the age of 13 years or earlier, with only 9.4% of girls starting smoking at the same age<sup>173</sup>. Even though the use of tobacco seems to decrease, teenagers continue to consume it due to the easy access and relatively low prices for tobacco products.

*Alcohol consumption* presents a high risk for the young people’s health and well-being also due to the fact that they are more vulnerable to alcohol effects than adults, given that their body and brain is still developing, which is a risk factor that may endanger the development and integration of young people, becoming more serious in case of teenagers. NCHM study<sup>174</sup> shows students of 8th and 9th grade start consuming alcohol at the age of 13 years.

170 Use and Abuse of Alcohol in Moldova: Assessing the Situation and the Impact, Expert Group, Chisinau, 2008

171 WHO Report on the Global Tobacco Epidemic, 2015, Country profile, Republic of Moldova [http://www.who.int/tobacco/surveillance/policy/country\\_profile/mda.pdf](http://www.who.int/tobacco/surveillance/policy/country_profile/mda.pdf)

172 Global Youth Tobacco Survey (GYTS), Fact sheet, Republic of Moldova 2008 [file:///C:/Users/user/Downloads/MOLDOVA%20GYTS%202008%20Factsheet%20\(Ages%2013-15\)%20\(2\).pdf](file:///C:/Users/user/Downloads/MOLDOVA%20GYTS%202008%20Factsheet%20(Ages%2013-15)%20(2).pdf)

173 Alcohol, drugs and tobacco use by students of the 8th and 9th grade in the Republic of Moldova, NCHM, 2015

174 Alcohol, drugs and tobacco use by students of the 8th and 9th grade in the Republic of Moldova, NCHM, 2015

Likewise, the study carried out by Expert Group in 2007 showed that 47% of young people of 15-19 years old use alcohol. This is a low rate compared to other age groups, being equal only to the proportion of alcohol consumers of 60 years and elder <sup>175</sup>. Note that the proportion of strong drinks for the 15-19 age group is 4% and for the 20-29 age group – 17.8%.

*Drugs consumption.* According to Republican Narcological Dispensary (RND), the overall use of drugs grows, but more alarming is that 95% of all drugs consumers are young people, most of them are single persons with secondary education. Also, RND data show that the age of drugs consumers averaged at 30 years in 2014.

According to NCHM, 14% of sampled young people stated that they know people that use marijuana or hashish, 5.9% know people using *ecstasy* and 3.8% – *opium*.

## 4.5 Extending Young People's Chances, Opportunities and Rights

Perception of young people as a resource focuses on long-term solutions, identifying their needs and development policies to let young people fully develop their potential as citizens and to allow society to benefit from their intellectual capital. While the conditions for young people in the formal school and university system need to be addressed by putting in place some formal education policies, the most important for the “youth policy” is the manner they become active citizens and positive contributors for the society. This implies a much broader prospect and a focus on non-formal education, outside

the formal school system. But how could the Government policy encourage and promote an active education process of young people outside the official school system? Providing initiatives for youth, creating youth clubs and organizations that would involve actively young people at all levels and should they decide by themselves what activities to perform, would play a key role in their development as active citizens. Governments should prioritize the development of an active and strong youth sector, consisting of democratic, open and inclusive youth associations involving young people.

A youth information strategy should ensure the transparency of Government policy in relation to them. Such a strategy should inform them on the range of existing opportunities for them. A national youth policy should reveal measures to be taken and policies to be implemented both to national and all public administration levels. The youth policy cannot be achieved without focusing on what must be done at the local level and actively involving in ensuring open channels of communication with all key stakeholders.

A youth policy must focus on youth-related researches that would address the youth well-being and their situation. Youth-related research must focus on functional policy measures and vice-versa. Youth policy should have as basis the active involvement and participation of young people in the society, the manner they can be included in the decision-making processes. How will the young Government officials get involved in making decisions that affect young people directly? Moreover, how could a youth policy ease a process involving young people and actively contribute to the society?

A dynamic and complex policy must address all youth's needs in all sectors of activity.

<sup>175</sup> Use and Abuse of Alcohol in Moldova: Assessing the Situation and the Impact, Expert Group, Chisinau, 2008

An intersectoral approach in developing youth policies is needed, which means that a number of ministries with different portfolios like youth, sports, education, culture, defence, health, transport, labour, agriculture and so on must have a joint responsibility and cooperation. This cooperation may be ensured by setting out an intergovernmental board aiming at developing, implementing and monitoring a youth policy.

Young people have an unique experience of their situation, and views and ideas, which derive from this experience belong to them. They are social actors that have abilities and skills that settle their own issues in a constructive manner. Their involvement and participation represents a key strategy in ensuring an optimal development needed to fulfil broader development objectives for the society. Performances achieved until now due to youth participation and promotion should be supported and enhanced, and the involvement should become an integral part of the local, national and international policies for youth. Only in such circumstances traditional approaches of youth will start to evolve and the commitment declared so often for their participation will start to make sense. The approach has to promote the respect for them as social actors or agents of their own lives and citizens of their own society.

## 4.6. Conclusions and Policy Recommendations

A lower number of young people will cause huge disproportions in forming the labour force, able to develop and reproduce intellectual and material potential of the country and a decrease in the volume of training of the qualified personnel in secondary, vocational and higher education. The number of graduates from high-schools

will decrease every year, consequently, the number of students will also go down, and as a result the enrollment requirements in higher education institutions will not be such strict and the quality of the education will decline. Also, the reserve military contingent will diminish.

The Republic of Moldova, like other countries in the region, finds itself in a demographic trap when the decreasing number of working age persons may be compensated by the increase of the labour productivity only via advanced technologies, but, the size and share of innovation and information technology-oriented population, which are usually young cohorts, will constantly shrink.

In such circumstances, a state youth policy providing support to active participation of youth in economic, social, education, cultural and political life must be promoted to ensure equal access to education, employment and decent living conditions, paying special attention to socially vulnerable teenagers and young people.

The Republic of Moldova has well drafted youth policies, but their implementation is not encouraging. Transposition of policy documents in effective actions is affected by a range of reasons: failure to monitor implementation activities and mechanisms, lack of proper funding, and sometimes low political sensitivity.

The legal framework for promoting youth policies in the Republic of Moldova is formed of the *National Strategy for Youth Sector Development 2020* (GD No 1006 of 10.12.2014). Its effective implementation presents now many risks. The most important are: insufficiency of financial resources necessary to implement the Strategy's action plan, weak capacities of local implementation, coordination and

monitoring across sectors.

Three major issues need to be settled to mobilise political and economic resources in implementing the *National Strategy for Youth Sector Development 2020*:

The first relates to a closer coordination and integration between the Strategy and national policies. The problems of young people are specific to all sectors, while many policies that have an impact on the youth situation are a part of the sector policies. European countries' experience proves that the success can be achieved when a consistent action platform is developed in the youth field and which is supported by all ministries. This action platform must be integrated in the planning and budgetary processes of sector policies and shall not be a separated program given that the large number of regulations and instructions and the insufficient funding makes difficult its implementation.

The second one refers to ensuring active participation of young people in implementing the Strategy by expanding opportunities to be heard and encouraging more active participation in the public life. Governments and other agencies must learn to communicate with young people, use their innovative and creative potential, establish partnerships in service delivery.

The third problem relates to the regular reviews of the implementation of youth policies. Systemic assessments and corrections of certain actions, is an important objective, helping to increase confidence of young people in actions and to ensure reasonable criteria in achieving the objectives, proceeding from the current situation or in relation to indicators obtained.





# GENDER GAPS

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**G**ender equality and women's and girls' empowerment is the 5th objective of the 17 Global Objectives included in the 2030 Agenda for Sustainable Development, adopted at the Sustainable Development Summit of 25 September 2015. Elimination of all forms of discrimination against women and girls is not only a fundamental human right, but also a multiplier effect in all development areas.

Several monitoring indicators were set out in order to measure the achievements of Sustainable Development Goals proposed at the United Nations Statistical Commission and Expert Group Meeting. 6 international indicators (38-44 indicators) and 5 complementary national indicators were established for the objective on achieving gender equality and women's empowerment.<sup>176</sup> This chapter will analyze the gender gaps in the Republic of Moldova in the light of international and national indicators on equality in sexual and reproductive health, reconciliation between family and work, the response of healthcare system to violence against

women, including its consequences on sexual and reproductive health.

The Global Gender Gap Report 2015 ranks the Republic of Moldova the 26th of 145 of countries in Gender Gap Index (score 0.742, where 0.00 means inequality and 1.00 – equality).<sup>177</sup> Gender Gap Index, introduced in 2006, aimed at identifying gaps between women and men while accessing resources and opportunities in 4 different areas: economic participation and opportunities, education level, health and survival, political empowerment (Table 5.1).

Gender Equality Index, which measures the level of gender equality and annual progresses made by the Republic of Moldova in this area<sup>178</sup>, shows that now the Moldovan society is on the half-way in achieving gender equality (Table 5.2). The Gender Equality Index is an indicator of policy impact, as well as a field, resources and effort prioritization indicator to ensure an effective gender equality. Gender Equality Index measures the level of gender equality by the following most important areas: (i)

<sup>177</sup><http://reports.weforum.org/global-gender-gap-report-2015/economies/#economy=MDA>

<sup>178</sup> [http://www.progen.md/files/7562\\_raport\\_indexul\\_egalitatii\\_gen\\_2015final.pdf](http://www.progen.md/files/7562_raport_indexul_egalitatii_gen_2015final.pdf)

<sup>176</sup> Indicators and a Monitoring Framework for the Sustainable Development Goals. March 20, 2015.

**Table 5.1.**

**Table 5.1.**  
Gender Gap Index for the Republic of Moldova, 2010-2015  
Source: <http://reports.weforum.org/global-gender-gap-report-2015/economies/#economy=MDA>

Gender Gap Index	Place	Economic participation	Education	Health	Political empowerment
2015 (out of 145 countries)	26	18	50	42	58
2014 (out of 145 countries)	25	11	56	37	59
2013 (out of 145 countries)	52	32	74	34	87
2012 (out of 145 countries)	45	21	42	34	85
2011 (out of 145 countries)	39	14	64	1	88
2010 (out of 145 countries)	34	10	66	1	69

Table 5.2.

Relevant areas	Value of 2009 Index	Value of 2014 Index	Progresses/ Regressions
Labour market	70	63	-7
Politics	32	34	+2
Education	55	54	-1
Access to resources	77	75	-2
Perceptions and stereotypes	47	52	+5
Health	75	71	-2
Gender Equality Index	59	58	-1

**Table 5.2.**  
Gender Equality  
Index 2009, 2014  
Source: Center  
Partnership for  
Development.  
Gender Equality  
Index 2015, p.4.

labour market, (ii) policy (iii) education, (iv) access to resources, (v) perceptions and stereotypes, (vi) healthcare. Comparative data of the Gender Equality Index show small improvements between 2009 and 2014 in achieving gender equality in such areas as perceptions, stereotypes and politics, but setbacks in the labour market, health, access to resources, education.

Thus, international and national indicators underline some obstacles and difficulties in ensuring gender equality in the Republic of Moldova..

## 5.1. Gender Equality in Alignment with Sexual and Reproductive Health Priorities from CEDAW and UPR Framework

The legal framework, which sets out public policies and actions promoting gender equality in the Republic of Moldova is based on the international tools: Universal Declaration of Human Rights (1948), Convention on the Political Rights of

Women (1952), International Covenant on Economic, Social and Cultural Rights (1966), Convention on the Elimination of All Forms of Discrimination against Women (1979), Beijing Declaration and Platform for Action (1995), Millennium Declaration (2000) etc.

Republic of Moldova ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)<sup>179</sup> in 1994 – an international reference document that focuses on creating conditions for achieving an efficient equality for women in all areas of life and the obligations of states to uphold these conditions without delays and to ensure equal rights, *de jure* and *de facto*. By ratifying CEDAW, the Republic of Moldova assumed the obligation to promote the principle of equality between men and women in the national legislation of the Republic of Moldova and to ensure its effective implementation.

The 2010-2015 National Gender Equality Program, and the Action Plans for its implementation during 2010-2012 and

<sup>179</sup> UN Convention on the Elimination of All Forms of Discrimination against Women of 18.12.1979 // Special Edition "International treaties", 1998, Vol. I, page 114 // in force for the Republic of Moldova since 31.07.1994.

2013-2015<sup>180</sup>were approved by the Government Decision No 933 of 31.12.2009 with further amendments and addenda. The National Program was comprehensive and provided a comprehensive “mainstreaming” of gender equality in policy documents in all areas and at all levels of decision-making and implementation. The document made a detailed analysis on the gender equality, formulated the general and specific improvement objectives, describing concrete activities that must be performed by responsible persons and partners. Thus, the National Gender Equality Program specifies 8 priority areas: (i) employment and labour migration, (ii) budgetary sector, (iii) participation in public and political decision-making, (iv) social and family protection, (v) health, (vi) education, (vii) violence, (viii) public awareness raising and a number of complex measures aiming at ensuring a favourable environment to a proper treatment of women and men.

Despite all improvements, in particular those in drafting and adopting the legal framework on gender equality and adapting it to UN and Council of Europe standards<sup>181</sup>, the implementation of equal treatment between women and men remains crucial.<sup>182</sup>*De facto* ensurance of equality is a process that government and non-government structures and other social stakeholders and development partners must continue to consistently support and make joint efforts towards it.

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180 Government Decision No 933 of 31.12.2009 on the 2010-2015 National Gender Equality Program, Official Gazette No 5-7/27 of 19.01.2010.

181 See: Bodrug-Lungu V., Triboi I. Ganea E. Raport de evaluare a gradului de implementare a Programului national de asigurare a egalității de gen pe anii 2010-2015. [Report assessing the implementation of the 2010-2015 National Gender Equality Program]. – OSCE in Moldova, Chisinau, 2015.

182 Universal Periodical Review, paragraph 15 (a) of the annex to Human Rights Council resolution 5/1, Republic of Moldova, p.3

Article 5(a) CEDAW provides that States Parties of the Convention *shall take all appropriate measures to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.*

A separate area of the 2010-2015 National Gender Equality Program is the mainstreaming of gender equality in the education policies and educational process that would ensure family education and proper understanding of gender and maternity. Thus, the education system addresses now the gender perspective in connection with the human rights by thematic modules within continuing vocational training of primary school teachers, teachers of civic education and manual work, deputy principals in charge of education. The State University of Moldova provides the course “Gender and Education” for educational psychologist. Gender Equality was included as a topic in the optional course “Education for Human Rights” in the secondary education.<sup>183</sup>

Gender equality means protection, promotion and observance of human rights for men and women, ensuring and providing equal opportunities for women and men in all fields of life. Gender equity is expressed by a range of concrete actions by means of which all gender gaps, stereotyping and discrimination on grounds of gender are eliminated. We note, however, that the words “gender equality” is understood and interpreted differently by Moldovan citizens.

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183 Bodrug-Lungu V., Triboi I. Ganea E. Raport de evaluare a gradului de implementare a Programului national de asigurare a egalității de gen pe anii 2010-2015. [Report assessing the implementation of the 2010-2015 National Gender Equality Program] – OSCE in Moldova, Chisinau, 2015, p.54.

Most people have a wrong perception of gender equality due to stereotypes on the different roles of women and men in a family. Stereotypes are transmitted starting from pre-school institutions to higher educational institutions, labour market, media, by means of sexist advertising. Men and Gender Equality in the Republic of Moldova<sup>184</sup> Survey shows that stereotypes in the Republic of Moldova still prevail. According to them, all responsibilities related to family are performed by the woman and she "must find time to take care of the family and give up on her career" and the man must earn money. Often the woman's financial contribution to the family budget is neglected given that she also works and the family responsibilities must be equally distributed. Thus, 90.5% of men and 81.5% of women totally and partially agree that the most important thing for a woman is to take care of the household and cook for her family. The percentage of men who think that changing diapers, bathing and feeding children are responsibilities of the mother is even larger – 95%. This indicator is quite high also among women – 75.1% (3 of 4 women) agree to this statement (*Table 5.1.1*). 85.6% of men claim to have the final say in the decision-making process in the family (*totally agree and partially agree*), compared to 49.7% of women who accept such a situation. It can be noticed that the number of men who accept that the woman have a say in the decision making process in the family is quite low (14 percent).

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184 International Men and Gender Equality Survey (IMAGES), managed by Promundo and International Center for Research on Women (ICRW), is one of the most comprehensive studies on the life on men and women, their attitudes and behaviours with regards to gender equality, family relations, the role of the man and his involvement in the family relations, as well as in raising and upbringing children etc. Since 2014, this survey has been used in 10 countries as a tool to assess the attitudes and behaviours of men and women during the implementation of policies or program initiatives on gender equality. This survey was carried out for the first time in the Republic of Moldova in 2015.

However over 50 percent of women would like to change the manner the decisions are made in the family.<sup>185</sup>

The Gender Equitable Men (GEM)<sup>186</sup> scale, which aims at measuring the attitudes towards gender norms in intimate relationships and different social expectations for men and women with regards to household responsibilities, reproductive health and violence, reveals that the rate of women with a correct perception of gender equality is higher than the rate of men. Of the 4 reviewed areas (household responsibilities, violence, reproductive health, and intimate relations), the most correct perception of gender equality was found in the field of violence, followed by the reproductive health, intimate relations, with household responsibilities ranking the last.<sup>187</sup>

Men have an outright opinion on equal involvement in household chores and children upbringing, declaring that "*these are women's responsibilities*". Most people continue to see women in the role of housekeeper, giving birth to children, raising and upbringing children. This situation is reflected in many sociological<sup>188</sup> studies and reveals the need for awareness raising campaigns to change the men's attitudes.

Moldovan society recorded some changes

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185 Cheianu-Andrei D., Perevoznic I., Zaporojan-Pargari A., Grosu E. *Men and Gender Equality in the Republic of Moldova. Based on IMAGES methodology* – Women's Law Center, "SocioPolis" Investigations and Consultation Center, 2015, p. 61-62.

186 <https://www.c-changeprogram.org/content/gender-scales-compendium/gem.html>

187 Cheianu-Andrei D., Perevoznic I., Zaporojan-Pargari A., Grosu E. *Men and Gender Equality in the Republic of Moldova. Based on IMAGES methodology* – Women's Law Center, "SocioPolis" Investigations and Consultation Center, 2015, p. 64.

188 *Opinions, perceptions and experiences of young people on domestic/couple violence*. CBS AXA, Oak Foundation, La Strada, 2014, p.32-40; Malcoci L, Barbarosie A. *The Phenomenon of discrimination in Moldova: Perception of the Population. Comparative Study*. Soros Foundation Moldova, IPP and Soir Moldova, 2015, Cheianu-Andrei D., Perevoznic I., Zaporojan-Pargari A., Grosu E. *Men and Gender Equality in the Republic of Moldova. Based on IMAGES methodology* – Women's Law Center, "SocioPolis" Investigations and Consultation Center, 2015.

**Table 5.1.1.**  
Attitudes  
towards Family  
Obligations, %  
Source: Cheianu-  
Andrei D.,  
Perevoznic I.,  
Zaporojan-  
Pargari A., Grosu  
E. Men and  
Gender Equality  
in the Republic  
of Moldova.  
Based on IMAGES  
methodology  
– Women’s  
Law Center,  
“SocioPolis”  
Investigations  
and Consultation  
Center, 2015, p.  
61-62.

**Table 5.1.1.**

	Men (n=1515)		Women (n=503)	
	Total agreement	Partial agreement	Total agreement	Partial agreement
The most important thing for a women is to maintain her house and cook for her family	61,2	29,3	47,5	34,0
The mother is responsible for changing napkins, washing and feeding children	49,8	35,2	33,0	42,1
The man should take all decisions	51,7	33,9	16,5	33,2

on equal rights for women and men, but these are rather social rights – “more women driving”, “equity in professions”, “many women mayors” than family rights. Even though some men contribute to upbringing children and assume some of the household chores, most of the population believe that the man’s place is not in the kitchen.

Despite all regulations adopted by the Government of the Republic of Moldova with the view to eliminate all forms of discrimination against women, sociological data show little *de facto* progress in the field of gender equality. In the Concluding Observations by CEDAW regarding Moldova, the Committee expressed its concern regarding the persistence of patriarchal attitudes and deep-rooted stereotypes regarding the roles and responsibilities of women and men in the family and society. It notes that such attitudes and stereotypes are root causes of (1) women’s disadvantaged position in the State party in political and public life; (2) violence against women in the State party; and (3) gender segregation as reflected in women and girls’ educational choices and employment options.<sup>189</sup>

Article 5(b) of CEDAW provides that *each State Party shall take all appropriate*

*measures to ensure that family education includes a proper understanding of maternity as a social function and the recognition of the common responsibility of men and women in the upbringing and development of their children, it being understood that the interest of the children is the primordial consideration in all cases.*

As a result, in the Concluding Observations by CEDAW regarding Moldova, the Committee invites Moldova authorities to: (a) Eliminate all forms of sex and gender-based discrimination throughout the education system and in informal education programmes with a view to removing gender stereotypes from educational materials; incorporating human rights education in school curricula; and, introducing mandatory courses in all teacher training programmes on ways and which schooling reproduces gender inequalities; (b) Develop a comprehensive strategy across all sectors targeted at women and men, girls and boys, to overcome patriarchal and gender-based stereotypical attitudes concerning the roles and responsibilities of women and men in the family and in society; (c) Develop public awareness programmes and training programmes for decision-makers, employers, youth, and disadvantaged groups of women, including older women and women with disabilities,

<sup>189</sup> Concluding Observations on the Combined Fourth and Fifth Periodic Reports of the Republic of Moldova’ p4.



on women’s rights in all areas covered by the Convention; (d) Expeditiously adopt the Law on Publicity that aims, among other things, to prohibit the use of sexist advertisement and ensure its effective implementation; and (e) Ensure that local authorities promote policies based on gender equality principles, without interference of religious institutions.<sup>190</sup>

Nonetheless, sociological research data show that the presence of men at the childbirth is a rare practice in the Republic of Moldova. Only 18.1% of men reported that they were present during the birth of their last child (Table 5.1.2). Nevertheless, the number of men who support their wives/partners during childbirth is increasing among younger generations. About 30 percent of men of 30-39 years of age have assisted their wives/partners during the birth of their last child.

The men who reported that they were neither present in the delivery room with their wives, nor were busy with other activities invoked the following reasons – their wives did not want them to be present (19.3%), lack of practice in the community that husbands assist during childbirth (16.8%) etc. Answers offered by women concerning the lack of support from their husbands when they are in the delivery room include the following (in order of importance) – lack of practice in

their community for a man to be present during childbirth, fear of the husband to be present, unwillingness of the husband to be present, husband was not allowed to enter the delivery room although he wanted to be present, etc. Therefore, there is a need to provide more explanation on partnership during childbirth. Some men do not understand the role they have during the childbirth.

The practice of accompanying the wife/partner to the doctor during pregnancy is also not widely spread among families in Moldova. Only 23.1% of men, who have biological children in their household, accompanied their wives/partners to each doctor’s visit, 55.4% accompanied them only to several visits, 18.8% did not accompany them to any doctor visits.<sup>191</sup>

An important element in the childcare and education policies is to increase involvement of fathers in the process of upbringing children. *Law No 71 on Amendments and Addenda to Some Legislative Acts* of 14.04.2016 provides that the father of the newborn benefits from 14-day paternity leave, with possibility to maintain his average salary and this leave is granted in the first 56 days after the birth of the child, on the basis of employee’s request. Involvement of fathers in childcare from the first days will help change perception about

191 Cheianu-Andrei D., Perevoznic I., Zaporojan-Pargari A., Grosu E. *Men and Gender Equality in the Republic of Moldova. Based on IMAGES methodology* – Women’s Law Center, “SocioPolis” Investigations and Consultation Center, 2015, p. 75-76.

190 Concluding Observations on the Combined Fourth and Fifth Periodic Reports of the Republic of Moldova p4.

**Table 5.1.2.**

	In the maternity delivery room	In the maternity waiting room	At home	Work	Abroad
Men’s responses (n=677 persons)	18,1	27,9	25,1	16,0	11,0
Women’s responses (n=353 persons)	17,6	22,9	29,7	16,7	10,8

**Table 5.1.2.** Where was the husband/partner during the birth of the last child?, %  
Source: Cheianu-Andrei D., Perevoznic I., Zaporojan-Pargari A., Grosu E. *Men and Gender Equality in the Republic of Moldova. Based on IMAGES methodology* – Women’s Law Center, “SocioPolis” Investigations and Consultation Center, 2015, p. 75.

the role of a woman and man in raising and upbringing the child.

Article 12(1) of CEDAW declares that *States Parties shall take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to healthcare services, including those related to family planning.*

NBS data reveal gender discrepancies in access to healthcare services. The percentage of women attending healthcare services is 1.5 times higher than the percentage of men. In the last 4 weeks, before the interview, one woman in four benefited from healthcare services compared to one man in six. Children are those who request more often healthcare services (21% of the total number of persons under 15 years of age) and persons of 65 years and older (37%)<sup>192</sup>. Financial resources are an important condition in ensuring access to healthcare services. Though, 11.2% of the poorest population (first quintile) visited a doctor, compared to 25.5% of the fifth quintile population.<sup>193</sup> Women visit a doctor for preventive treatment also in a higher proportion than men – 34.6% and 24.5%, respectively.<sup>194</sup> These data show that the access to healthcare services in the Republic of Moldova is available and men accesses these services in a lower proportion. We highlight the presence of some differences in accessing healthcare services by different groups of disadvantaged women. One of these groups is Roma women. Only 35% of Roma women are covered by the health insurance system compared to 74% of non-Roma women.<sup>195</sup>

192 *Population access to healthcare services.* – NBS, Chisinau, 2011, p.12.

193 *Ibidem*, p.13.

194 *Ibidem*, p.17.

195 Study of the Situation of Romani Women and Girls in the Republic of Moldova. UN Women, UNDP, OHCHR, 2014, p.46.

The health education is promoted in the primary education during homeroom class, physical education, science, moral and spiritual education, ecological education. Aspects of health education are promoted in the secondary and high school, compulsorily in disciplines like Physical Education (module “Human health” – 34 hours in gymnasium and 22 hours in high school), Civic Education (module “Life and health – personal and social values”- 24 hours in gymnasium and 20 hours in high school), Biology (module “Reproductive system and reproduction in humans” – 8th grade, 10 hours and 11<sup>th</sup> grade, 12 hours), Chemistry (12 hours for gymnasium and high school when students learn organic chemistry), Homeroom (modules “Culture of wishes” and “Culture of behaviour” at all levels).

The education system in the Republic of Moldova includes an optional course for pupils of 5-12<sup>th</sup> grade – *Education for health*. This course has a section dedicated to *reproduction and healthy family*, but young people are not allowed to benefit from a compulsory education in the field of sexual and reproductive health, to understand the need of joint responsibilities of partners relating to sexual and reproductive health of the family due to the optional character of this course. The European Parliament reports also mention this aspect, specifying that sexual education programs in Eastern and Southern Europe are deficient.<sup>196</sup>

Reproductive health is a complex area comprising: *sexual health* (responsible, pleasant and safe sexual life), *family planning* (reproductive freedom, access to information, methods and services)

196 Beaumont, K, Maguire, M., *Policies for Sexuality Education in the European Union*, European Parliament, 2013, available at: [[http://www.europarl.europa.eu/RegData/etudes/note/join/2013/462515/IPOL-FEMM\\_NT%282013%29462515\\_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/note/join/2013/462515/IPOL-FEMM_NT%282013%29462515_EN.pdf)]

and *risk-free motherhood* (pregnancy and childbirth in safety conditions, healthy children). Currently, the educational system in the Republic of Moldova fails in providing complex knowledge to young people on reproductive and sexual health. We believe that a compulsory course is needed – *Education for Health* – in primary, secondary, high schools, which would include education in sexual and reproductive health, depending on the age of students. The compulsory courses within some disciplines do not ensure an ongoing and quality education at this chapter, due to the lack of knowledge about contraception, number of abortions and childbirths among teenagers etc.

The Republic of Moldova still records cases of early marriage among persons under 20 years (in 2004, 21.2% of the total number of girls under 20 years got married, in 2014 – 10.3%)<sup>197</sup>. According to the law, marriages under 18 years are only allowed in case of pregnant women. Thus, we underline that early marriages are accompanied by pregnancy, respectively, the Republic of Moldova must take measures to raise awareness of the negative effects of early marriages on health.

The Committee on the Elimination of Discrimination against Women, in its Concluding Observations is concerned about the high rate of abortions and low use, availability and accessibility of contraception methods, in particular in the Transnistrian region and rural areas, which indicates that abortion is a method of birth control. It is also mentioned that the Committee is very concerned about reports on coercive sterilization practice, in

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197 [http://statbank.statistica.md/pxweb/pxweb/ro/20%20Populatia%20si%20procesele%20demografice/20%20Populatia%20si%20procesele%20demografice\\_\\_POP050/POP050100.px/?rxid=2345d98a-890b-4459-bb1f-9b565f99b3b9](http://statbank.statistica.md/pxweb/pxweb/ro/20%20Populatia%20si%20procesele%20demografice/20%20Populatia%20si%20procesele%20demografice__POP050/POP050100.px/?rxid=2345d98a-890b-4459-bb1f-9b565f99b3b9)

particular used in women with disabilities, women from rural areas and Roma women. The Committee is also concerned about the lack of educational programs in schools on health and sexual and reproductive rights, lack of disaggregated data by gender and limited access of old women to healthcare services. As a result, in the Concluding Observations by CEDAW regarding Moldova, the Committee invites Moldova authorities to: (a) Ensure availability, accessibility and affordability of modern methods of contraception for girls and women, (b) Expand the availability of medically safe modern methods of abortion, including in Transnistrian region and rural areas, (c) Raise awareness about the importance of using contraceptives for family planning, and consider including abortion as well as contraceptives in the basic insurance package, (d) Amend and develop the regulatory framework as well as guidance provided to medical practitioners to ensure that sterilization is only carried out in conformity with international law, in particular with the free and informed consent of the women concerned, (e) Introduce age-appropriate education on sexual and reproductive health and rights in the school curricula, including on responsible sexual behaviour, (f) Ensure access and affordability of health care to older women and train health workers on geriatric care; and (g) Integrate a gender perspective in all health interventions and policies and collect and analyse sex-disaggregated data.<sup>198</sup>

As revealed above, a number of activities were carried out in the Republic of Moldova to promote gender equality and ensure the sexual and reproductive health of the population, but it is difficult now to identify any tangible progress.

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198 Concluding Observations on the Combined Fourth and Fifth Periodic Reports of the Republic of Moldova' p 7-8.

## 5.2. Reconciling the Family with Professional Life

The Constitution of the Republic of Moldova proclaims equality of citizens, irrespective of sex. The legislative framework of the Republic of Moldova also establishes equal rights for women and men to participate in economic and social life, to be trained for a certain profession, to be employed, to promote and participate in distribution of benefits, to receive social protection in certain situations, etc.

Nonetheless, the reality reveals a great number of problems. The Republic of Moldova is characterized by limited possibilities for women to participate in the labour market because of the lack of educational services for small children (2-3 years old), discrimination by sex and age upon employment, discrepancies between the salaries of women and men, etc.

*The Report assessing the implementation of the 2010-2015 National Gender Equality Program* reveals certain progress in employment: reduction between the remuneration of women and men, which decreased from 28% to 12.8%; less gender segregation on the labour market; multiple activities aimed at economic empowerment of women, more women trained in business, financial resources offered to women for business purposes, etc. At the same time, there were the following problems identified, among others: existence of cases of discrimination in employment of pregnant women, women with children, elderly women, etc. Despite the growing official number of women who launched their own businesses, the qualitative component still remains: how many women have managed to preserve their businesses, what capital

women use in their businesses, size of women's businesses, etc. Women, especially from rural areas and/or marginalized communities, who wish to start their own businesses, face the problems of access to resources (bank credits) and other services necessary for successful entrepreneurial activity. In spite of the favourable legal and regulatory framework on equal pay for work of equal value, some gender gap were noticed with regards to remuneration, which are determined by the fact that women are promoted less frequently than men: men have more chances to obtain higher, and respectively, better paid, positions. The likelihood that a woman will take a maternity leave, sustains employers' restraint in hiring or promoting women.<sup>199</sup>

In the Republic of Moldova there are no important gender gaps among the economically active persons. Thus, in 2015, the share of economically active men constituted 50.5% in comparison with that of women, which constituted 49.5%. The activity rate of the population aged 15 and above was 42.4%, the rate of men being higher than that of women (45.1% compared to 39.9%).

In spite of the increasing role of women in the society, as well as their participation in the labour market, there are still some differences between men and women in the occupational sector. The analysis of the workforce in the Republic of Moldova reveals that the employment rate of population aged 15 years and above in 2015 was 40.3%, and the rate of men was higher than that of women (42.3% compared to 38.4%). Over the years, the employment rate of women has been lower

<sup>199</sup>Bodrug-Lungu V., Triboi I. Ganea E. *Raport de evaluare a gradului de implementare a Programului national de asigurare a egalității de gen pe anii 2010-2015. [Report assessing the implementation of the 2010-2015 National Gender Equality Program].* – OSCE in Moldova, Chisinau, 2015.

in comparison with that of men (see Table 5.2.1). The employment of Roma women is even more difficult. According to the *Study of the Situation of Romani Women and Girls in the Republic of Moldova, 2014*, only 15% of Roma women aged 15 years or above are employed<sup>200</sup>.

According to NBS data, the employment rate of women depends on several factors, including their having or not having children under age of 16. Thus, for women aged 25-49 years without children (under age of 16) the employment rate reaches 56.9%. The employment rate of women with children decreases gradually depending on the number of children: from 52.2% in case of women with 1 child to 43.9% for women with 3 children and more. The employment rate also depends on the age of child/children; the most considerable difference is registered in case of people having children under age of two: the employment rate constitutes 15.3% for women and 53% for men.

The lower employment rate of women on the labour market is influenced by the

<sup>200</sup> [Study of the Situation of Romani Women and Girls in the Republic of Moldova. UN Women, UNDP, OHCHR, 2014, p.36.](#)

fewer employment opportunities, lower level of remuneration in “feminized” areas, on the one side, but also by various forms of latent discrimination of women at workplace, caused by prejudices and stereotypes related to gender roles in the family and society. Many employers are sceptical about hiring young women, giving preference to men, in order to evade direct and indirect expenses related to maternity leaves, childcare leaves, or sick leaves in case of ill child.<sup>201</sup>

From the perspective of age groups we have detected that in the age category of 35-49 years, the employment rate of women exceeds that of men (*Fig. 5.2.1*). This proves that women in the 15-24 age group and 25-34 age group face difficulties in reconciling their professional and personal life. Women in 15-24 age group usually continue their studies, and later, give birth to the first child. Thus, the average age of a mother at her first birth is 24 years. While the 25-34 age group is characterized by raising/taking care of the first child, followed by raising/

<sup>201</sup> Gagauz O., Buciuceanu-Vrabie M., *Rolul parental și rolul profesional: oportunități de echilibrare pentru femeia contemporană [Parental role and professional role: balancing opportunities for a modern woman]*. – Chisinau, 2011, p. 35.

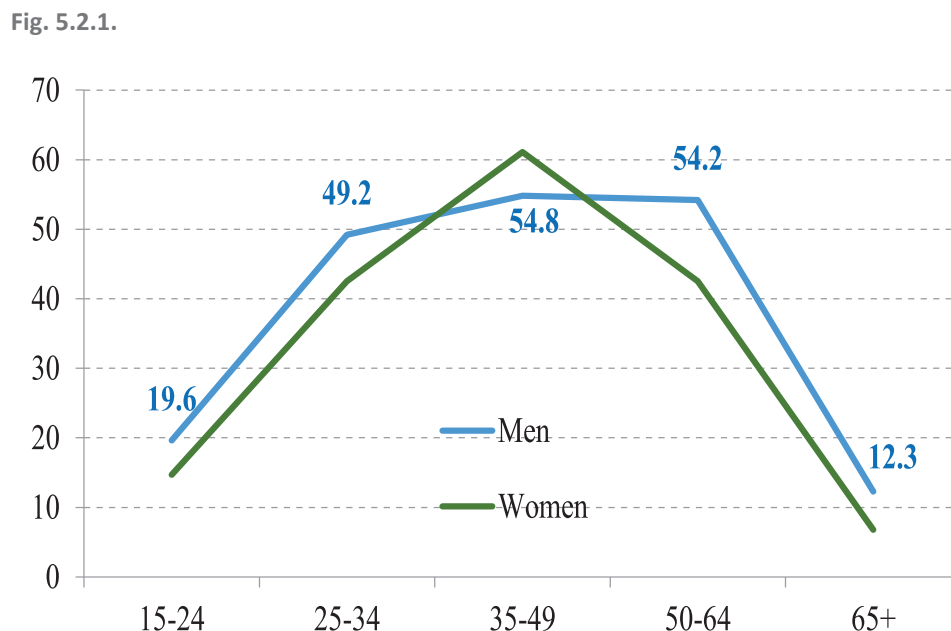
**Table 5.2.1.**

Year	Men			Women		
	Activity rate	Employment rate	Unemployment rate	Activity rate	Employment rate	Unemployment rate
2000	63,9	57,7	9,7	56,3	52,2	7,2
2005	50,4	46,0	8,7	47,7	44,8	6,0
2006	50,0	45,5	8,9	43,0	40,5	5,7
2007	47,8	44,8	6,3	42,2	40,5	3,9
2008	47,8	45,2	4,6	41,5	40,1	3,4
2009	46,2	42,6	7,8	39,7	37,7	4,9
2010	45,0	40,9	9,1	38,6	36,4	5,7
2011	45,6	42,1	7,7	39,3	37,1	5,6
2012	43,5	40,6	6,8	38,2	36,5	4,3
2013	44,5	41,8	6,0	38,6	37,0	4,1
2014	44,1	42,1	4,6	38,6	37,4	3,1
2015	45,5	42,3	6,2	39,9	38,4	3,6

**Table 5.2.1.** Evolution of Activity Rate, Employment Rate and Unemployment Rate by Sexes, 2000-2015,%  
Source: NBS



**Fig. 5.2.1.**  
Employment Rate of the Population aged 15 and above, by age and sex groups, 2014, %  
Source: NBS



taking care of the second child. The decrease of the employment rate of women after the age of 54 is explained by the difference in retirement age, which currently is 57 for women, if compared to 62 for men. We underline that the higher employment rate of women aged 35-49 in comparison to that of men is stable over time.

The official statistical data shows that employed women have higher level of qualification than men: 27.5% of them have university degrees and 17.6% have secondary specialized education, while for men these indicators constitute 21.4% and 10.7%, respectively.<sup>202</sup>

The analysis of women’s activity on

<sup>202</sup> <http://statbank.statistica.md/pxweb/Dialog/varval.asp?ma=MUN0201&ti=Populatia+ocupata+dupa+statutul+profesional%2C+nivelul+de+instruire%2C+pe++grupe+de+virsta%2C+sex+si+medii%2C+2000-2015+&path=../Database/RO/03%20MUN/MUN02/&lang=1>

the labour market reveals that women predominate in many economic sectors and there are “feminized” types of economic activity – health and social assistance (women constitute 80% of the employees), education (76%), public accommodation and catering activities (66%), financial and insurance activities (66%), art, recreation and entertainment (59%), etc. (Fig.5.2.2).

Legal and regulatory framework provides legal payments for work carried out regardless of person’s gender. Despite the principle of equal pay for equal work, women earn less than men, since traditionally they are being hired in sectors with lower salaries and are far less represented in management positions (Table 5.2.2).

The pay gaps between women and men are present virtually in all areas (exception – administrative services and support

**Table 5.2.2.**  
Evolution of Salary Earnings by Genders  
Source: NBS

**Table 5.2.2.**

	2009	2010	2011	2012	2013	2014
Men, MDL	3144,0	3439,5	3252,8	3638,3	3913,8	4374,9
Women, MDL	2403,0	2619,0	2819,0	3167,6	3459,6	3831,7
Women’s salaries against men’s salaries, %	76,4	76,1	87,3	87,1	88,4	87,6



Fig. 5.2.2.

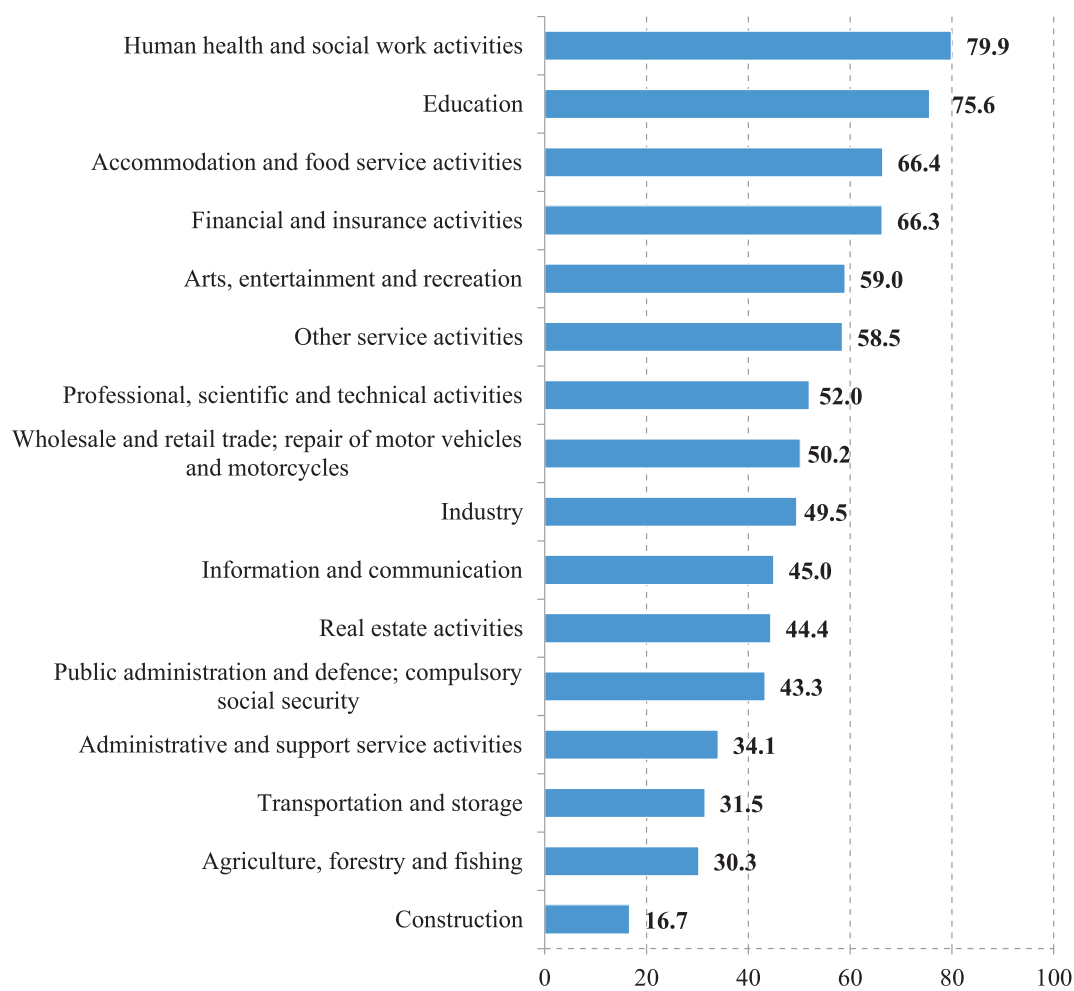


Fig.5.2.2.  
Share of  
Employed  
Women by Types  
of Economic  
Activities, 2014,  
%  
Source: NBS

services activities), including those were the majority of employees are women (Fig. 5.2.3). The following factors determine the gender pay gap: unequal distribution of men and women by professions and economic sectors (horizontal segregation), inequality of salaries within professions and types of activity (vertical segregation), fewer women at the top of professional pyramid, fewer women in management positions in these areas.

From the total number of managers of all levels (heads of economic and social entities and their structural subdivisions (sections, directorates, etc.) in 2015, 52% were men, and the remaining 48% – women. From the gender equality perspective, the situation in this field has improved compared to 2014, when the share of men among managers of all levels constituted 57%. The share of

women managing entities, subdivisions, etc. in 2015 was higher in the public sector (61%) than the private sector (40%).

We would like to underline the fact that less attractive, due to small salaries, jobs determine migration of a significant share of employed women abroad for work. The data of the NBS shows that 41.1% of women who migrated abroad had a paid job or a family business in the Republic of Moldova, while about 30% of migrant women, who had paid job or a family business, before leaving held positions or were involved in activities of high level, and only 28% of them were unqualified workers (while for men these shares constitute 9% and 46.8%, respectively).<sup>203</sup>

<sup>203</sup> Vremeş M. *Profilul femeilor migrante [Profile of migrant women]*. – NBS, UN Women, UNDP, Chişinău, 2016, p.17.

Employment, finding of well paid jobs and jobs corresponding to the skills obtained abroad is challenging for migrants at the stage of returning. More than 70% of migrant Moldovan workers who return home cannot find a job and face the problem of impossibility of recognition of skills obtained abroad. Women who return from migration also face multiple barriers in starting up a business.<sup>204</sup>

Differences in salaries and in periods of contributions to the state social insurance fund determine differences in the average amount of age pension for men and women. On the average, the men's pension covers the minimum subsistence level for pensioners in proportion of 83% and 70% — in case of women. Against this background, the Concluding Observations of the Committee on the Elimination of Discrimination against Women stated that

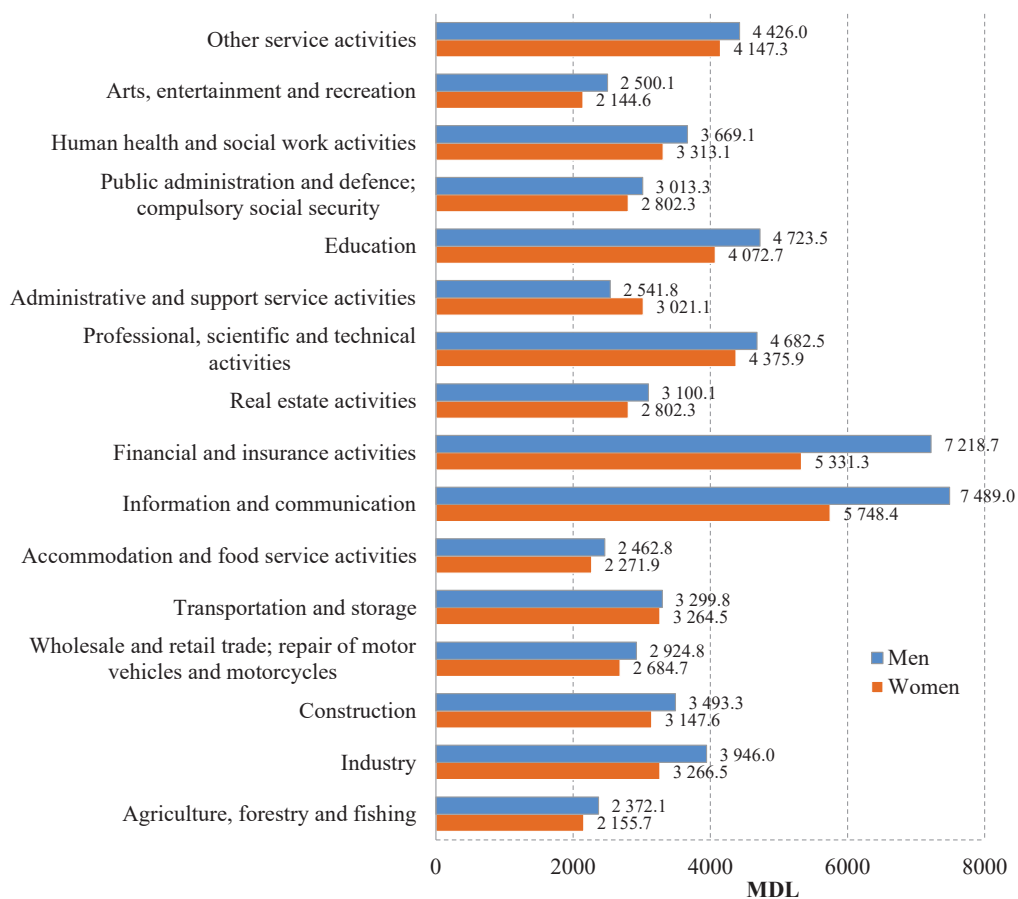
204 Ibidem, p.26.

the said Committee was concerned about continuous occupational segregation and over-representation of women in the most poorly paid sectors, which, eventually, determine the smaller pensions for women. Respectively, it is necessary to take actions aimed at equalizing of retirement age for men and women, and years of contributions to the pension scheme in order to reduce the differences in the average amount of age pensions for men and women.

The employment rate of women having at least one child of preschool age is lower than that of women without children of that age, which proves that the presence of children reduces women's participation in the labour market. Respectively, all countries have measures to support families with children oriented towards alignment of women's family lives with professional activity – maternity leaves, child care leaves granted to parents, various benefits, guarantees

**Fig. 5.2.3.**  
Net Average  
Monthly  
Salary Earning  
by Economic  
Activities and by  
Sexes, MDL  
Source: NBS

**Fig. 5.2.3.**



with respect to labour activity during the period of child care.

Decision of parents (as a rule, mother's decision) to return to office or to find employment, as well as the opportune moment to do so are conditioned by several factors: (i) individual preferences regarding returning to the office or employment; (ii) duration of paid child care leave; (iii) amount of child care allowance; (iv) family's possibility to apply to child care services; (v) accessibility of formal care services; (vi) spouses' income, etc.

Woman's position on the labour market is protected by various measures provided by the Labor Code of the Republic of Moldova No 154 of 28.03.2003 with later amendments. These measures are beneficial for child development and are aimed at protection of mother's and child's health, however, long-term child care leave frequently causes certain problems in woman's relation with labour market, reducing the possibilities of professional growth and career progression, since in conditions of economic liberalization the labour market has become more flexible, with increased requirements to professional training of employees and the need to preserve high level of qualification over the entire period of economic activity.

**Table 5.2.3.**

	Men (n=1515)			Women (n=503)		
	0-12 months	0-3 years	0-6 years	0-12 months	0-3 years	0-6 years
Total	9,8	72,7	11,9	8,1	75,5	13,5
18-29 years old	12,5	68,2	11,6	10,3	73,2	11,3
30-39 years old	7,6	75,1	13,0	3,6	82,7	13,6
40-49 years old	8,2	75,7	12,5	7,8	75,5	15,7
50-59 years old	8,7	75,5	10,4	9,2	72,2	15,5

An important aspect in the analysis of alignment of parental role with the professional one is the child care leave. Currently, in the Republic of Moldova the paid child leave for a parent or his/her close relative (grandmother, grandfather) is 3 years for the insured persons and of 1.5 years for the uninsured. The legislation also provides that upon request an insured person can also be granted an unpaid leave for taking care of child from age 3 to age 6, with the preservation of workplace. In comparison with the neighboring countries and a part of European countries, the Republic of Moldova is quite generous in this area, offering parents a rather long period for taking care of and raising their newborn child. This is mainly caused by the lack of nursery institution, since the vast majority of preschool institutions admit children only from the age of 3. This situation negatively affects women's possibilities of assertion in professional career, since in 95% of cases namely mothers take child care leaves.

The data of Men and Gender Equality in the Republic of Moldova survey show that 72.7% of men and 75.5% of women want the child care leave to last 3 years. The ones who to a greater extent advocate for a child care leave with the duration of 1 year are men and women aged 18-29 years (*Table 5.2.3.*). This fact reveals changes in the views of

**Table 5.2.3.** Opinions on the Duration of Child Care Leave, after birth, %  
Source: Cheianu-Andrei D., Perevoznic I., Zaporojan-Pargari A., Grosu E. Men and Gender Equality in the Republic of Moldova. Based on IMAGES methodology – Women's Law Center, "SocioPolis" Investigations and Consultation Center, 2015, p. 104

young generations, who pay more attention to professional career and try to reconcile maternal role with the professional one.

*“Too long”* child care leave has a negative impact on woman’s professional career. In this respect there is a need in awareness raising campaigns, which would show the benefits of alignment of family life with the professional one. Actions aimed at reducing the child care leaves have to be taken along with the development of the offer of services of early child care and education (children under 3 years), increase of the number of nurseries, equalizing of child care leaves for insured and uninsured persons, as well as introduction and institutionalisation of babysitting services.

Another factor causing difficulties in the reconciliation of a woman’s family with professional life is the low flexibility of working schedules in the Republic of Moldova. Annual data of the Labor Force Survey conducted by the NBS highlights the fact that women chose a more flexible working schedule due to family responsibilities. Therefore, it is important to promote flexible working schedules. The Labor Code of the Republic of Moldova contains several provisions facilitating employment, working conditions and recreation of pregnant women and women with children under the age of 6, placing them in special category of employees. It is prohibited to refuse employment on grounds of pregnancy or existence of children. However, various studies show that these legal guarantees cannot be used in practice. Young women of child-bearing age, pregnant women, women with small children are frequently labeled by employers, are being rejected in employment, etc.

*The Demand and Supply of Early and Pre-School Education Services from the*

*Perspective of Women’s Employability (Republic of Moldova case)* survey, carried out by UNICEF and UN Women in 2013, reveals that 9.4% of women with children aged 0-3 years, have faced real situations of discrimination, being rejected in employment on the grounds of having small children or being pregnant. Other 10.8% of women with children aged 3-6(7) years were rejected in employment on the grounds of having small children. Share of women with children under the age of 6(7) years, being rejected, is doubled in rural area, in comparison with the urban one.

The same survey shows that 5.9% of women were asked to quit their jobs due to the reason that they are pregnant or have small children. Women from rural areas face such situations more often (7.5%) than women from urban areas (3.0%).

The highlighted facts show that the actions of Moldovan authorities are oriented towards reduction of gender segregation on the labor market, as well as towards decrease of differences in remuneration of women and men. However, sociological studies reveal difficulties in reconciliation of women’s personal with professional life due to employers’ failure to comply with the regulatory framework on the one hand, as well as by the lack of early education services on the other hand. Based on the aforesaid, it is necessary to strengthen efforts aimed at eliminating occupational segregation, adopting measures to reduce the salary gap, retirement pensions, reintegrating migrants in the country of origin and developing early education services for children aged 2-3 years, as well as more rigid control of employees in respecting of rights of women with small children.

### 5.3. Response of the healthcare system to gender-based violence and its impact on sexual and reproductive health

Domestic violence against women is a result of gender inequality and discrimination. In order to fight the phenomenon of domestic violence it is important to know the population’s attitudes towards it. Thus, the *Men and Gender Equality in the Republic of Moldova* survey shows, that according to 27.7% of men, a woman has to tolerate violence in order to save her marriage. However, only 17.5% of women agree with this opinion. 41.1% of men believe that there are moments when a woman should be beaten. While the number of women who agree with this statement is more than twice smaller than that of men (Table 5.3.1).

More than 40% of men consider that women are also responsible for rape, and cases, when women have bad reputation or do not maintain physical resistance while being raped, cannot be considered as rape at all. The data of the aforementioned survey shows that together with the growth of education level and of income, the number of men who consider that women are guilty of being raped, decreases. However, there still exist prejudices and stereotypes regarding physical and sexual violence in

Moldovan society, both among men and women (Table 5.3.2).

Multiple actions have been taken during the recent years in the Republic of Moldova, aimed at gender equality, elimination of violence and development of social services in this area. Actions were taken to adjust the national regulatory framework and national policies<sup>205</sup> to the UN and the Council of Europe standards against domestic violence, as well as to implement CEDAW recommendations offered to the Government in 2013, adopt/ratify some international conventions, such as the Convention of the Council of Europe on preventing and combating violence against women and domestic violence (Istanbul Convention). Despite the advanced legislative framework against gender-based violence, in the Republic of Moldova, like in other countries that have started fighting this social phenomenon, there still exists a significant difference between the *de facto* and *de jure* exercise of rights. Although guidelines were approved for various categories of professionals (policemen, doctors, social workers)<sup>206</sup>

205 The Draft Law on Amendments and Addenda to Some Acts on Domestic Violence was approved in the second reading on 13.07.2016.

206 The Order of the Ministry of Labor, Social Protection and Family No 22 of 09.02.2012 approving the Guidelines for Social Assistance and Family Protection Offices/Directorates on Intervention in Cases of Domestic Violence;

Order of the Ministry of Health No 155 of 24.02.2012 approving the Guidelines for Healthcare Institutions on Interventions in Cases of Domestic Violence;

Order of the Ministry of Internal Affairs No 275 of 14.08.2012 approving the Procedural Guidelines for the Internal Affairs Agencies on Preventing and Combating Cases of Domestic

**Table 5.3.1.** Attitudes towards Violence, %  
Source: Cheianu-Andrei D., Perevoznic I., Zaporozjan-Pargari A., Grosu E. Men and Gender Equality in the Republic of Moldova. Based on IMAGES methodology – Women’s Law Center, “SocioPolis” Investigations and Consultation Center, 2015, p. 63.

Table 5.3.1.

	Men (n=1515)		Women (n=503)	
	Total agreement	Partial agreement	Total agreement	Partial agreement
A woman has to tolerate violence in order to save her marriage	8,5	19,2	6,6	10,9
There are moments when a woman should be beaten	13,0	28,1	6,0	13,1



**Table 5.3.2.**  
Attitudes towards Rape, %  
Source: Cheianu-Andrei D., Perevoznic I., Zaporozjan-Pargari A., Grosu E. Men and Gender Equality in the Republic of Moldova. Based on IMAGES methodology – Women’s Law Center, “SocioPolis” Investigations and Consultation Center, 2015, p. 92-93.

**Table 5.3.2.**

	Men (n=1515)		Women (n=503)	
	Total agreement	Partial agreement	Total agreement	Partial agreement
If a woman was raped, it means that she herself had done something to get into such situation	10,8	31,4	5,8	20,3
In some cases of rape, women themselves wanted it to happen	13,4	32,4	6,4	21,3
If a woman is not physically resisting while being raped, we cannot say that it was a rape	30,5	27,5	23,1	21,5
It is not a rape, when the victim is light-minded or has bad reputation	14,0	20,5	16,3	15,5

regarding their interventions in cases of domestic violence, there are still cases when female victims of violence are not identified and do not benefit from social assistance and protection services<sup>207</sup>, and there are also identified but unassisted victims of domestic violence. There are a lot of gaps in the provision of legal and social assistance to victims of sexual violence.<sup>208</sup>

Gender-based violence determines migration of women, and respectively growth of risks of labour exploitation and trafficking in human beings. There are deficiencies in effective implementation of the legal and regulatory framework, gaps in provision of relevant assistance to female victims of violence, including Roma women, migrant women, older women, women with disabilities, etc.<sup>209</sup>

Violence.

207 Rusu, V. *Study on observance of rights of domestic violence victims in the assistance and protection system of the Republic of Moldova*. “La Strada” International Center for Women Rights Protection and Promotion, Chisinau, 2013, p.6.

208 Cheianu-Andrei, D., Bayram, N. *Ensuring access of sexual violence victims to relevant legal and social protection*. “La Strada” International Center, “SocioPolis” Investigations and Consultation Center, Chisinau, 2015.

209 Bodrug-Lungu V., Triboi I. Ganea E. *Raport de evaluare a gradului de implementare a Programului national de asigurare a egalității de gen pe anii 2010-2015. [Report assessing the implementation of the 2010-2015 National Gender Equality Program]*. – OSCE in Moldova, Chisinau, 2015, p.73-74.

In this context, it is important to have data on prevalence of violence against women, factors determining this phenomenon, share of investigated and convicted cases of violence, as well as impact of violence on health.

In order to find out the situation of violence against women, the NBS has undertaken the *Domestic Violence against Women in the Republic of Moldova* survey in 2010. According to this survey, 63.4% of women and girls aged 15 years and older have been subjected to at least one form of physical, psychological or sexual violence throughout life. This survey reveals the prevalence of violence against women of 15-49 years of age on the part of husband/partner within the last 12 months<sup>210</sup> (Table 5.3.3.) Thus, the prevalence of physical and sexual violence against women aged 15-49 by husband/partner in 2010 constituted 13.4%, while the total prevalence of violence (psychological, physical or sexual) - 26.8%. Violence against women is more frequent among women from rural areas and those with low level of studies.

Studies on violence against women present the consequences of violent actions on victim’s physical and mental health. Most

210 Monitoring indicator No 38 of the Sustainable Development Goal 5



frequently women report pain and bruises, followed by eye injuries, luxations and dislocations. There also exist more severe cases – bone fractures, internal injuries, as well as lost pregnancies (Fig. 5.3.1.).

The sexual violence more frequently cause fractures and internal injuries, as well as lost pregnancies, in comparison with physical violence. Practically one in 10 victims of sexual violence on the part of husband/partner has fractures, internal injuries or lost pregnancies throughout life. When referring to the basic characteristics of female victims, we should underline, that reporting of the consequences of acts of violence on the part of husband/partner

increases together with ageing, which is explained by experience gained through the lifetime.

Female victims of violence most often do not report cases of violence to authorities. According to the NBS survey, approximatively half of the victims tell their parents about what had happened, and a smaller part of them tell the police, medical officers, etc. (Table 5.3.4.). We would like to underline that Roma women either conceal or minimize violence against them and do not seek help in case of violence.<sup>211</sup>

Only 10 of a hundred female victims of

<sup>211</sup> Study of the Situation of Romani Women and Girls in the Republic of Moldova. UN Women, UNDP, OHCHR, 2014, p.50.

Table 5.3.3.

Prevalence of women who suffered from psychological, physical or sexual violence on the part of husband/partner over the last 12 months	26,8
Share of women aged 15-49 who suffered from physical or sexual violence on the part of husband/partner over the last 12 months	13,4
Share of women aged 15-49 who suffered from physical or sexual violence on the part of persons other than husband/partner over the last 12 months	1,2
Share of women aged 15-49 who suffered from physical or sexual violence on the part of husband/partner throughout life	43,3
Share of women aged 15-49 who suffered from physical or sexual violence on the part of persons other than husband/partner throughout life	6,3
Rate of incidence of economic violence on the part of husband/partner	8,7
Rate of incidence of psychological violence on the part of husband/partner	57,1

Table 5.3.3.

Incidence and Prevalence of Violence against Women, 2010, %  
Source: Domestic violence against women in the Republic of Moldova. – NBS, Chisinau, 2011.

Fig. 5.3.1.

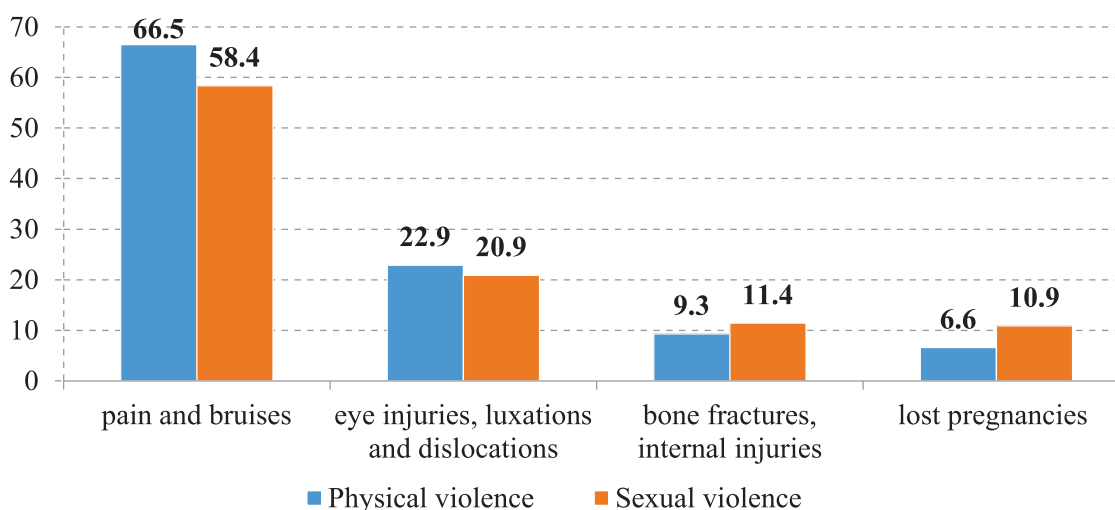


Fig. 5.3.1.

Distribution of Female Victims of Physical or Sexual Violence by the Type of Consequences for Women's Health, %  
Source: Domestic violence against women in the Republic of Moldova. NBS, Chisinau, 2011, p. 42

**Table 5.3.4.**  
Share of female victims who reported violence on the part of husband/partner and other persons throughout life, distributed by the persons they had reported such cases to, and by types of violence, % of the total number of violence victims  
Source: Domestic violence against women in the Republic of Moldova. – NBS, Chisinau, 2011, p.139.

**Table 5.3.4.**

	Violence on the part of husband/partner				Physical violence on the part of other persons
	Physical violence	Sexual violence	Physical or sexual violence	Physical and sexual violence	
Police	18,8	22,5	16,4	32,8	14,9
Parents	47,3	46,5	42,9	61,7	47,3
Other relatives	25,8	32,4	23,6	43,4	27,5
Friends	18,1	17,4	16,8	21,8	27,5
Neighbors	8,9	7,8	7,8	11,4	2,0
Medical officers	5,7	7,4	5,0	10,8	3,2
Other persons	8,6	9,4	7,5	13,7	4,8

severe violence and one of a hundred female victims of moderate violence on the part of husband/partner had reported the cases of violence to health professionals (Table 5.3.5.). Health workers are not quite trusted by violence victims, which implies additional challenges related to their capacities of identification and managing of cases of physical and sexual violence.

procedure of registration of such cases by police officers, the role of prosecutor's office and courts in settlement of domestic violence cases, role of professionals in the social assistance and protection system, issuance and monitoring of protection orders, sequentially treating the role of healthcare facilities in supporting this category of victims.<sup>212</sup>

The highlighted facts prove the need to study the impact of gender-based violence on women's health status in general, and on reproductive health in particular. Currently, in the Republic of Moldova there are no qualitative studies that would reveal the impact of violence on health in general, and on sexual and reproductive health in particular, including the response of the healthcare system to the needs of violence victims. Most studies refer to the existing system of assistance and protection for victims of domestic violence, to the

According to the Guidelines on Intervention of Healthcare Institutions in Cases of Domestic Violence, healthcare providers play an important role in identifying victims of domestic violence, provision of healthcare and emotional support, accurate documentation and referral of such victims to other services.<sup>213</sup> The guidelines

**Table 5.3.5.**  
Share of female victims who reported physical violence on the part of husband/partner throughout life, by the severity of violence cases,% of total number of victims who reported cases of violence  
Source: Domestic violence against women in the Republic of Moldova. – NBS, Chisinau, 2011, p.139.

**Table 5.3.5.**

	Physical violence on the part of husband/partner	of which:	
		Moderate violence	Severe violence
Police	26,0	3,5	39,1
Parents	65,3	66,3	64,7
Other relatives	35,6	36,1	35,3
Friends	25,0	21,4	27,0
Neighbors	12,4	9,3	14,2
Medical officers	7,8	1,1	11,8
Other persons	11,9	6,9	14,9

212 Rusu, V. Study on observance of rights of domestic violence victims in the assistance and protection system of the Republic of Moldova. "La Strada" International Center for Women Rights Protection and Promotion, Chisinau, 2013, p.66-67.

213 Order of the Ministry of Health No 155 of 24.02.2012 approving the Guidelines for Healthcare Institutions on

thoroughly describe health consequences of violence, including for children and pregnant women.

The *Ensuring access of sexual violence victims to relevant legal and social protection* survey of 2015 highlights that individual psychological counseling is a service provided by all organizations that offer services for the victims of domestic violence. Healthcare is offered by approximately half of all institutions offering services for the victims of domestic violence. In case of health issues, victims are referred to healthcare facilities. They can use these services on the basis of Health Insurance Policy. However, the vast majority of them do not have a valid policy (except for children who are obligatorily insured till they reach the age of 18).<sup>214</sup>

Victims of physical and sexual violence also seek the support to institutions of forensic medicine. An important component part of opening a criminal case against the perpetrator is the results of victim's forensic examination, which in the majority of cases constitute the main evidence for bringing accusation against the suspect. A problem in carrying out of forensic examinations is the duration of their arrangement. Police agencies and forensic medicine experts cooperate well. Knowledge and accurate performance of job duties directly contributes to successful settlement of cases. Legal professionals, however, have pointed to the fact that it is necessary to improve conditions of forensic medicine, since the equipment of these institutions is very outdated (from the 1970s). The lack of certain devices for forensic investigation in territorial departments also determines inconvenience for victims, who have to go

Interventions in Cases of Domestic Violence.

214 Cheianu-Andrei, D., Bayram, N. *Ensuring access of sexual violence victims to relevant legal and social protection*. – “La Strada” International Center, “SocioPolis” Investigations and Consultation Center, Chisinau, 2015, p. 41-56.

from one district to another.<sup>215</sup>

It is necessary to raise women's awareness of the legal and institutional framework on violence. According to the *Domestic Violence Against Women in the Republic of Moldova* survey, only 42.2% of the total number of women are aware of the Law No 45 on Prevention and Combating Domestic Violence. Women from urban areas and those with higher education are better aware of legal and institutional framework in this area.<sup>216</sup>

According to the *Men and Gender Equality in the Republic of Moldova* sociological survey, men and women have different views about the legal framework that regulates violence against women and the way it operates (Table 5.3.6): 36.9% of men and 49.7% of women do not agree with the statement that, in compliance with the regulatory framework regarding violence against women, it is easy for a woman to accuse a man of an act of violence; 55.8% of men and 73.2% of women do not believe the current regulations to be too severe for perpetrators; 81.3% of men and 84.1% of women acknowledge that current regulatory framework doesn't provide sufficient protection of violence victims; 58.7% of men and 69.1% of women stated that the current legal regulations on violence against women, to the contrary, expose women to greater stigmatisation and shame.

There is a need in “*more stringent punishments*” in order to reduce violence. Non-observance of Protective Orders by perpetrators has determined the introduction of Restriction Order as a special measure, which complements the measures on protection of victims aimed at immediate

215 Cheianu-Andrei, D., Bayram, N. *Ensuring access of sexual violence victims to relevant legal and social protection*. – “La Strada” International Center, “SocioPolis” Investigations and Consultation Center, Chisinau, 2015, p. 30.

216 *Domestic violence against women in the Republic of Moldova*. – NBS, Chisinau, 2011, p.54-55.

**Table 5.3.6.**  
Assessment of Regulatory Framework regulating Violence against Women, %  
Source: Cheianu-Andrei D., Perevoznic I., Zaporozjan-Pargari A., Grosu E. Men and Gender Equality in the Republic of Moldova. Based on IMAGES methodology – Women’s Law Center, “SocioPolis” Investigations and Consultation Center, 2015, p. 107.

**Table 5.3.6.**

	Men (n=993)		Women (n=314 persons)	
	Partial agreement	Acord parțial	Total agreement	Partial agreement
It is too easy for a woman to accuse a man of an act of violence	27,3	35,8	15,6	34,1
It is too stringent for a perpetrator	14,7	29,5	9,6	17,2
It is not severe enough for a perpetrator	38,2	33,2	52,9	24,2
Doesn’t provide sufficient protection for violence victims	41,8	39,5	52,9	31,2
Subjects women to greater stigmatisation and shame	28,3	30,4	36,9	32,2

intervention of the police and removal of the perpetrator from the house, criminal sanctions for non-execution of Protective Order and administrative sanctions for non-execution of Restriction Order, etc.<sup>217</sup>

It is also necessary to develop specialized services for perpetrators. All abusers have to be obligated to undergo therapy programmes which would make them hold responsibility and realize the need to change their behaviour.

No less important is recording and monitoring of cases where the abusers were convicted for violent actions against women and children in accordance with indicator No 39 on monitoring and evaluation of the Sustainable Development Goal 5

The analysis of the Healthcare section of the National Gender Equality Program shows the following progress: mainstreamed gender in certain strategic documents; developed/adjusted the procedural guidelines and standards in healthcare from the gender perspective; trained the healthcare staff and other professionals

<sup>217</sup> The Draft Law on Amendments and Addenda to Some Acts on Domestic Violence was approved in the second reading on 13.07.2016.

(members of the multidisciplinary teams) in women’s and girls’ health protection, including those affected by domestic violence, etc. Nonetheless, the analysed surveys show that it is necessary to continue activity in this area.

## 5.4. Conclusions and Policy Recommendations

- The Republic of Moldova shall fulfill its national and international commitments it adhered to, in the area of ensuring human rights, with a priority focus on ensuring gender equality.
- Development of programs aimed at changing the population’s attitude and behaviour towards female and male roles in family and society, changing the gender stereotypes, promoting maternal and paternal values and gender equality.

**Favorable conditions for reconciliation of family and professional life, while ensuring gender equality, can be obtained by promoting the following actions:**

Reduce the pay gap by means of clear interventions focused on cases of pay gap

– indirect discrimination on the labour market and direct discrimination at the workplace.

- Reduce the pension gap by means of equalization of the length of employment and of the retirement age for women and men.
- Develop early education services that would allow women to return to the labour market whenever they want.
- Control and punish employers who discriminate pregnant women and women with small children in employment and/or do not respect their rights.

**The following actions are recommended for eradication of gender-based violence:**

- Sign and ratify the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence.
- Develop services for victims of domestic violence by allocating funds from the State Budget for actions aimed at prevention and combating violence, including for long-term therapy, free health care for all victims of physical

and sexual violence without health insurance policies.

- Develop and approve minimum quality standards for services provided to victims of domestic violence.
- Develop services for abusers and introduction of obligation to undergo therapy programs. Monitor the cases where abusers were convicted for violent actions against women and children (indicator No 39 on monitoring and evaluation of the Sustainable Development Goal 5).
- Strengthen the partnerships between the representatives of legal, social, medical, civil society and other institutions, as well as development of inter-sector cooperation mechanisms in the field of prevention and combating violence against women and offering them protection.
- Carry out of qualitative (longitudinal or retrospective) surveys on the impact of violence on health in general and on sexual and reproductive health in particular, in order to develop evidence-based policies regarding healthcare for female victims of violence.