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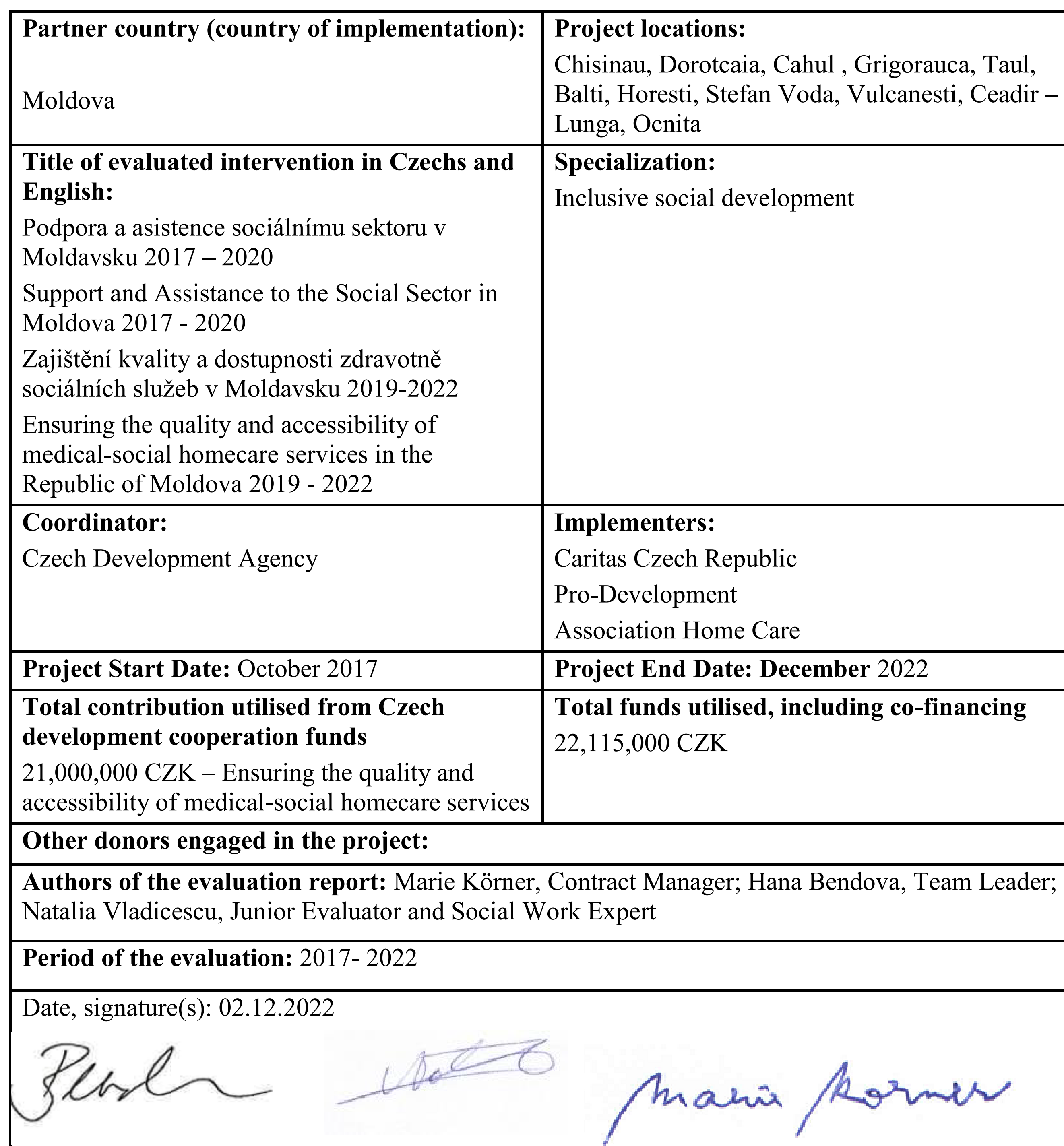
DRAFT EVALUATION REPORT

EVALUATION OF TWO PROJECTS IN THE PRIORITY SECTOR OF INCLUSIVE SOCIAL DEVELOPMENT IN MOLDOVA

December 2022

Identification form



Partner country (country of implementation):	Project locations:
Moldova	Chisinau, Dorotcaia, Cahul , Grigorauca, Taul, Balti, Horesti, Stefan Voda, Vulcanesti, Ceadir – Lunga, Ocnita
Title of evaluated intervention in Czechs and English: Podpora a asistence sociálnímu sektoru v Moldavsku 2017 – 2020 Support and Assistance to the Social Sector in Moldova 2017 - 2020 Zajištění kvality a dostupnosti zdravotně sociálních služeb v Moldavsku 2019-2022 Ensuring the quality and accessibility of medical-social homecare services in the Republic of Moldova 2019 - 2022	**Specialization:** Inclusive social development
Coordinator: Czech Development Agency	**Implementers:** Caritas Czech Republic Pro-Development Association Home Care
Project Start Date: October 2017	**Project End Date: December** 2022
Total contribution utilised from Czech development cooperation funds 21,000,000 CZK – Ensuring the quality and accessibility of medical-social homecare services	**Total funds utilised, including co-financing** 22,115,000 CZK
Other donors engaged in the project:	
Authors of the evaluation report: Marie Körner, Contract Manager; Hana Bendova, Team Leader; Natalia Vladicescu, Junior Evaluator and Social Work Expert	
Period of the evaluation: 2017- 2022	
Date, signature(s): 02.12.2022	

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EXECUTIVE SUMMARY

Purpose of the evaluation

The main purpose of this evaluation was to obtain independent, objective and consistent findings, conclusions and recommendations which can be utilized in the decision making by MFA, in cooperation with CzDA and with other participants, about the future focus and implementation of development projects in the evaluated sector, considering the 2030 Agenda for Sustainable Development and the Bilateral Development Cooperation Programme between the Czech Republic and Moldova 2018-2023. The evaluation focused on the assessment of effectiveness and impacts as well as on the verification of sustainability and identification of lessons learned from the completed project including relevance of the approach to increasing access to affordable, quality social and medical homecare services for the elderly and persons with disabilities.

The interventions and the context of evaluation

The evaluation focused on two projects implemented by Caritas Czech Republic in Moldova and Asociația Obștească Pro-Development in the sector of medical and social homecare services implemented in 2017-2020 and 2019-2022 respectively. The projects built on the support provided to the integrated medical and social homecare services by Caritas Czech Republic (CCR) since 2007. The evaluation also considered work carried out in the previous projects in the sector as sustainability was a key learning focus of the assignment. The two evaluated projects focused on planning and development of a decentralized and deinstitutionalized system for the provision and social services in the form of social and medical home care centres (CMS), capacity building of local home care service providers (NGOs, relatives, volunteers, multidisciplinary teams of the homecare centres), strategic dialogue between key actors, setting up legal and regulatory framework and strengthening operational and financial sustainability of home care services sector. One Theoretical Practical Care Centre (CTP) Estera was established in Chisinau and two new CMS in Vulcanesti and in Ocnita, with further 8 CMS, established in the previous projects, receiving equipment and trainings. Beneficiaries receive the services free of charge.

The evaluation team

The evaluation was conducted by the evaluation team of 4G eval s.r.o., an independent consulting company, specializing in providing comprehensive services in the areas of monitoring and evaluation, environmental management, social development, water supply and sanitation, gender equality and good governance.

Most important findings and conclusions

Evaluation criteria		Rate of fulfilment
Relevance		High
Coherence		High
Efficiency		High
Effectiveness		Rather high
Likelihood of impacts		Rather high
Sustainability		Rather low
Cross-cutting principles	Good governance	High
	Environment and climate	High
	Human rights and gender	High
Visibility of CZ DC		High

Relevance

Interventions were relevant to the overall partner country needs as well as to the Bilateral Development cooperation programme. While social and medical homecare to the elderly is recognized as highly needed by all interviewed stakeholders, financial resources available from central government as well as local municipal budget are entirely insufficient and in light of the current political and social situation, significantly exacerbated by the war in Ukraine, it is unrealistic to expect that the country will be able to increase the financial allocations in the near future. Primarily rural areas were covered with additional two new centres established in the distant rural areas, reflecting the difficult living conditions and access to services for the elderly residents of these areas. The services provided in the framework of the projects encompassed wide array of the elderly beneficiaries needs and were often the only source of assistance to the elderly. Focus was placed on improving capacities of staff as well as organisations in the sector, in line with maximising efficiency given the limited resources available. A gap only partly addressed is the fact that social services have extremely insufficient budget that is distributed via LPAs' general budget and there are no obligations to use this budget for social services, nor there are sufficient guidelines for LPAs on how to manage and plan a budget or how to get additional or external financing. There is also a lack of collaboration between state actors on social affairs. ***Relevance*** *is rated as* ***high.***

Coherence

The evaluated interventions were in line with the priorities of the sector of inclusive social development in Moldova. This was mainly supported by ongoing presence of the implementing organisations in the field and intensive cooperation with authorities both at national and local level. Expertise and support made available through the interventions and active participation of the implementers in USCP have produced outputs relevant to the development of the sector and developed/strengthened necessary skills of care providers' staff as well as public institution workers. All partial steps and elements elaborated in the legal framework with input from the intervention were viewed as highly needed by the Ministries. These include not only legal and methodological tools developed but also relevant trainings being offered to support the implementation of the framework. Specifically, methodology of calculation of the tariff for social homecare services and as well as normative framework for the organization and functioning of the new home care profession were singled out as highly useful for the sector. The training support available through the projects was also appreciated – both at national as well as municipal level. Through active advocacy and developing the pilot Standards for integrated services aiming to promote the concept of integration and offering practical ways forward in this regard solutions, the interventions also tried to address some of the key challenges of the sector – the fact that medical and social services fall under two different Ministries and are also financed from two different budgetary levels as well as insufficient communication and cooperation between the state actors. The overall long-term focus on homecare services allowed for in-depth understanding of the needs of the sector and creation of good working relationships with state actors as well as actors in the NGO sector. Cooperation with the relevant Ministries from the onset of Czech homecare interventions enhanced internal system coherence as location of all centres was consulted at all relevant levels and training content was also approved by the Ministries. The clarity of conditions for establishing new centres, commitment needed as well as financial participation of local public authorities were secured from the start - the team identified examples of other projects implemented in the social sector where this was not ensured and led to closure after exit of the donor. Further strengthening and supporting the members of UCSP as well as supporting the planned system reform may address the key challenges. ***Coherence*** *is rated as* ***high.***

Efficiency

Continuous investments in the equipment of centres as well as ongoing training of staff have strongly contributed to full use of the centres by clients and overall growing demand for the services with long waiting lists of clients to be served. The equipment used as well as specific skills of centre's staff are unique in the context of Moldovan health and social sector and are being fully used as witnessed directly during data collection. The medical services provided are often not available in standard health centres in Moldova. Numbers of clients keep growing and the recently established centres also report numbers which indicate that the quantitative indicators regarding numbers of clients served will be fulfilled. Given the limited number of staff, the hybrid model of the centres functioning (in-centre services in the morning and home visits in the afternoon) is efficient. Implementers as well as the donor also reacted swiftly to challenges occurring in the course of the

project and duly adapted to the changing context, without significantly affecting the overall planned outcomes and outputs. ***Efficiency*** *is rated as* ***high.***

Effectiveness

The projects have significantly contributed to increasing quality and accessibility of integrated homecare services. These are uniquely provided by NGOs in Moldova and their **quality is also much higher than the care available from state**. The quality of care provided in the framework of the interventions was further supported by in-depth initial and regular continuous trainings provided to all relevant staff of the centres. The trainings directly reflect on the knowledge and skill set of the staff. A **key added value of the trainings is the focus on communication with clients, personalised and empathic approach**. All of the benefits of trainings perceived by staff also play out in highly positive client experience of the services. In the rural areas which are targeted by the interventions, it is possible to state that the interventions **created access** to the services. Numbers of clients served have grown significantly and there is growing demand for the services from the served as well as neighbouring communities. Yet, the existing needs in the communities are not covered to the full extent due to limited capacities of the centres and the neighbouring communities are unserved. The three-month cycle service cycle supports access of more clients to the services but also means that the services are of short term whereas most clients would welcome the services on permanent basis. The teams are addressing this issue and serve the most vulnerable clients on ongoing basis though the frequency of visits may drop. **The contribution of the intervention to developing legal framework for homecare services is strong and clear and all the outputs produced in the evaluated interventions are considered relevant and useful.** However, they are being **applied in differing levels**, in some cases there was no information on follow-up due to staff turnover issues (particularly at MLSP.)

Key supporting factors include long-term focus of the Czech interventions on homecare services and thus creating in-depth understanding of the sector, context and needs, and active inclusion of all local stakeholders (national as well as local level) in project formulation and project planning, ongoing consultations with relevant stakeholders and focus on creating long term partnerships with relevant institutions. **Key inhibiting factors largely fall out of the possibility of the interventions to address** and require higher level interventions impacting on overall economic development of the country and generation of resources to sufficiently allocate to the health and social sector, including boosting capacity of staff at national institutions. **Effectiveness** is rated as **rather high.**

Likely Impact

Raising the profile of integrated homecare services as a necessary and relevant model for Moldovan authorities is the key identified impact of the intervention. There are numerous factors which are not possible to effectively address at this intervention level which prevent further systemic changes. While some of the drafted documents are being used by state authorities and actively followed up, this does not yet fully impact on the ground. There is now, however, significant expertise built up in Moldova which can further support implementation of the legislative changes into practice and is also a good basis for further share of expertise in the country. **Impact** is rated as **rather high.**

Sustainability

It is difficult to assess the sustainability of the centres established in the most recent interventions as the handover was not finalised. Visited centres established in previous projects are all functional but strongly dependent on AOHC who provides most of the medical and hygienic equipment and also supplements staff salaries, though from resources other than CZDA. Further, the dominant role of the AOHC director is quite obvious. If this support stops, the centres will likely not be able to continue providing the services at the same level or at all. Now, their capacity to attract additional funds is very low. Overall lack of financial resources of Local Public Authorities (LPAs) in the selected localities is a key challenge though they are able to uphold their contractual obligations, and all keep financing the state level staff salaries as well as utilities. The interventions have, however, placed emphasis on sustainability, which is reflected in a careful, systematic approach to selecting interested LPAs based on clear and complex criteria and clearly stipulating future responsibilities of the LPAs in the contracts signed. Sustainability of the interventions is rated as **rather low.** AOHC plays a key

role in continuing the activities of the centres while LPAs are only partly able to maintain the activities of the centres. Given their highly limited resource capacities, ongoing financing of the centres, albeit partial, can be considered a success.

Visibility and crosscutting principles

Visibility requirements were found to be fulfilled in the interventions along with awareness of the source of funding by key stakeholders from relevant institutions. Visibility is rated as **high.**

No negative environmental impact of the interventions was identified. Principles of good governance were of key importance for the implementers who made sure that all key stakeholders were consulted and participated in all relevant decision-making moments of the interventions, including formulation and planning. The processes of drafting legislative documents were consultative and reflecting priorities and needs of all parties. Gender equality is not a relevant principle in case of this intervention – access is open to all, but women in general seek out the services more, a trend which is in line with national statistics. Needs and rights of vulnerable clients are addressed to the maximum degree possible given the limited capacities of the centres and high demand for the services. **Reflection of crosscutting principles** is rated as h**igh** especially with regards to good governance.

Recommendations

Recommendation	Addressee	Degree of priority
Recommendations regarding the focus of the interventions and possible continuation		
Continue to support the homecare sector in Moldova with focus on supporting the system reform. Czech Republic now has long-term experience and understanding of the context, issues and challenges and equally a well-established position and relations with the key stakeholders.	MZV CZ, CzDA	1
Focus on further strengthening the fundraising skills of AOHC and consider how fundraising skills can also be strengthened at the level of centres. Models of external mentoring, ideally not associated with AOHC, may be a solution. While not all the centres have the right staff to take up fundraising, there are some centres where the managers or responsible LPAs (Balti, Taul) are already actively seeking out donor funding and at this point are heavily reliant on AOHC expertise in fundraising as well. The centre in Vulcanesti, where the administrator has relevant education (management, economics) and potential to further develop professionally, could be another example. It is important to keep in mind that this responsibility cannot be added on to the responsibilities of caregivers in the team.	CzDA	1
Consider possible expansion of the centres and adding mobile teams which could serve neighbouring communities with the highest need. There may be willingness from the neighbouring municipalities to share part in financing the teams, though this was not something that this evaluation explored. Expanding the services of the centres may not only create access to these services in the neediest rural communities but, in the long term, it could also enhance the chances of the medical services to be contracted by the National Health Insurance Company.	CzDA	2
Consider options for interventions which would lead to income generation in the municipalities/districts where centres are present. Creating social enterprises or supporting local business could be an option to generate at least partial financing for these centres and at the same time create employment opportunities in the area.	CzDA	1
Making the services paid or partially paid by the clients is not advisable. The clients are struggling to cover the costs of medications they need and would be unable to contribute to the cost of these services. In practice, it would be barring the neediest and vulnerable population from accessing the services and creating a system where only those in better financial position would be able to benefit – something which directly contradicts the idea of increasing accessibility.	CzDA	1
Recommendations regarding process issues		
Actively support and motivate AOHC in internally delegating responsibilities to other staff members. The overt reliance of the centres on the director of AOHC and possibly also internal management of the AOHC with one person strongly dominating the situation may be a risk to future sustainability of AOHC and the interventions on overall level.	Implementer	1

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1. INTRODUCTION

1.1 Context

This report is an evaluation of two projects in the priority sector of inclusive social development in Moldova - a key priority area identified by the Bilateral Development Cooperation Programme of the Czech Republic and Moldova 2018-2023. In particular, the evaluation focused on two projects implemented by Caritas Czech Republic in Moldova. The two projects build on the support provided to the integrated medical and social homecare services by Caritas Czech Republic (CCR) under different projects since 2007. The evaluation also considered work carried out in the previous projects in the sector as sustainability was a key learning focus of the assignment.

1.2 Purpose of the evaluation

The **main purpose** of this evaluation was to obtain independent, objective and consistent findings, conclusions and recommendations which can be utilized in the decision making by MFA, in cooperation with CzDA and with other participants, about the future focus and implementation of development projects in the evaluated sector, considering the 2030 Agenda for Sustainable Development and the Bilateral Development Cooperation Programme between the Czech Republic and Moldova 2018-2023.

The evaluation focused on the assessment of effectiveness and impacts as well as on the verification of sustainability and identification of lessons learned from the completed project including relevance of the approach to increasing access to affordable, quality social and medical homecare services for the elderly and persons with disabilities. The evaluation also focused on factors hindering or facilitating the implementation of the ongoing project, analysis of assumptions and risks and the likelihood of achieving its specific and overall objectives within the given time frame and budget. Systemic aspects including processes and procedures for cooperation with public institutions were also included.

Conclusions should serve to formulate specific and feasible recommendations based on consistent findings and conclusions, pertaining among other to replicability of the approach in other countries, to follow up activities in the ongoing project as well as to modalities of involving public institutions in the implementation of projects in the Inclusive Social Development sector of the CzDC.

Scope of the evaluation
Following criteria were used by the evaluation team:

a) Internationally recognized **OECD-DAC** (The Organization for Economic Co-operation and Development (OECD) Development Assistance Committee) **evaluation criteria:** Relevance, coherence (including coordination and integrated approach), effectiveness, efficiency, impacts and their sustainability, (the criteria of effectiveness, impact and sustainability took into account the external influences of the environment in which the project was implemented and specify the objective obstacles that may have affected the results of the intervention).

b) External presentation (**visibility)** - intensity of communication activities and awareness of the target group about the outputs and impacts of the project.

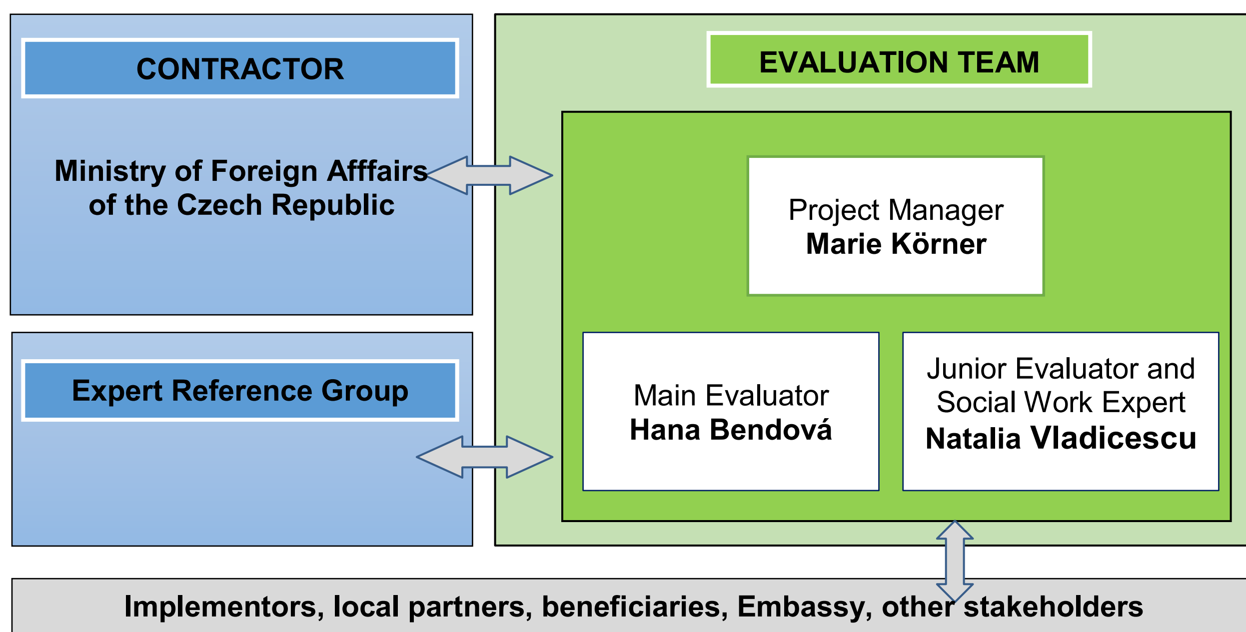
c) **Application of cross-cutting themes** of the Czech Development Cooperation defined in the Development Cooperation Strategy of the Czech Republic 2018 – 2030: Good (democratic) governance; environment (sustainable development); human rights (specifically needs and rights of most disadvantaged and vulnerable clients) and gender equality, including assessment whether and how the cross-cutting themes or some of them (as applicable) were directly associated with the sector/theme of evaluated interventions; whether and how the crosscutting principles were reflected and implemented.

An **assessment of the intervention logic** of the evaluated project incl. key assumptions and risks for achieving the objectives or analysis of methodological obstacles and evaluation limit was also carried out and the logic was modified. The revised intervention logic is attached in Annex C.

1.3 Evaluation team

The evaluation was conducted by the evaluation team of 4G eval s.r.o., an independent consulting company based in Prague, specializing in providing comprehensive services in the areas of monitoring and evaluation, environmental management, social development, water supply and sanitation, gender equality and good governance. 4G eval operates worldwide and has implemented projects in Africa, East Asia, Europe and Central Asia, the Middle East and South Asia regions for a variety of clients including the Czech Ministry of Foreign Affairs, EU, AFD, UNDP, UNICEF, international finance institutions, Czech and International NGOs and the private sector. Evaluations and surveys conducted by 4G eval are in accordance with the IDEAS Code of Ethics adopted in November 2014, the United Nations Evaluation Group's (UNEG) Code of Ethics and related evaluation guidelines (2008), the Evaluator's Code of Ethics (2011) and the Formal Evaluation Standards (2013). The management structure of the evaluation is provided in Figure 1.

Figure 1: Management structure of the evaluation



2 INFORMATION ON THE EVALUATED INTERVENTIONS

2.1 Context of the interventions

In the light of the demographic structure of its population, Moldova is experiencing rapid ageing of its population and an increasing demand for social and health services. Furthermore, large scale emigration (about 40% of the working age population works abroad) poses serious socio-economic challenges in Moldova. The reasons for migration are mainly the lack of job opportunities and low salaries in the country. Decreasing fertility rates pose another problem as they have hastened the pace of aging in Moldova, making the pension system fiscally and socially unsustainable.

The Czech Republic's 2010-2017 External Development Cooperation Conception classed Moldova among priority countries and set out the following sector priorities: access to drinking water and sanitation, support for governance and civil society, support for education and other social infrastructure and services, support for agriculture (especially SMEs), improvements in food safety, and environmental protection. In the social sphere,

the Czech Republic´s projects have long focused on inclusive social development, specifically the introduction of an appropriate system of social protection, an increase and improvement in social protection for vulnerable groups. Particular attention is paid to the needs of vulnerable population groups including the elderly and people with disabilities and emphasis is placed on increasing the share of home and community care and on integrating these population groups into society. Czech Republic also helps to promote the social inclusion of vulnerable groups, such as unsuccessful returning migrants, preschool children with special needs, and abandoned children. The Czech Republic's development cooperation also encompasses diabetes prevention and groundwork for the reform of care for people with mental illnesses and/or mental disabilities.[1]

In line with the above strategy, Czech Republic has supported a number of projects in this sector as apparent from the table below.

The last two projects focused on planning and development of a decentralized and deinstitutionalized system for the provision and social services in the form of social and medical home care centres (CMS), capacity building of local home care service providers (NGOs, relatives, volunteers, multidisciplinary teams of the homecare centres), strategic dialogue between key actors, setting up legal and regulatory framework and strengthening operational and financial sustainability of home care services sector. The CMS have trained medical and social staff and are under the umbrella of the Homecare Public Association (Homecare Asociatia Obsteasca or Homecare AO)[2]. One Theoretical Practical Care Centre (CTP) Estera was established in Chisinau and two new CMS in Vulcanesti and in Ocnita, with further 8 CMS, established in the previous projects, receiving new equipment. Defined categories of beneficiaries receive the services free of charge.

Table 1: Overview of projects supported in inclusive social development

Project	Period	Implementers	Donor	CMS/CTP		# of patients served annually[3]
				Name	Location	
Ensuring the quality and accessibility of medical-social homecare services in the Republic of Moldova	2019 - 2022	CCR AO Pro-Development Homecare AO	CzDA	St. Agata	**Ocnita** town	
				St. Anna	**Vulcanesti** town, ATU Gagauzia	
Support and Assistance to the Social Sector in Moldova	2017 – 2020	CCR People in Need Moldova, Homecare AO	CzDA	CTP Estera	**Chisinau** municipality	350
Support to the Development of Home care services in the south of Moldova	2015 - 2017	CCR Homecare AO	CzDA	St. Pantelimon	**Ceadir – Lunga** town, ATU Gagauzia	300
				Maria Magdalena	**Stefan Voda** town	150
Home care services in the west of Moldova	2014 - 2016	CCR Homecare AO	CzDA	St. Theodora	**Horesti** village, Falesti district	300
Development of home care services in the north of Moldova	2013 - 2016	CCR Homecare AO	CzDA LPA	Rebeca	**Balti** municipality	350
				St. Iuliana	**Taul** village, Donduseni district	300
Crisis support to the social-health centre of Caritas Moldova	2014		CCR, Diocesan Caritas Ostrava & Opava	Grigorăuca	**Grigorauca** village, Singerie district	
Increasing the quality and accessibility of medical-social home care services	2011 - 2013	CCR Homecare AO	CzDA	Avicenna Hippocrates Estera		
		CCR		Avicena	**Cahul** town	300

[1] Bilateral Development Cooperation Programme of the Czech Republic and Moldova – 2018-2023

[2] https://homecare.md/en/services/ accessed on 13 April 22

[3] Numbers of patients served are reproduced from the Project Document for the project Ensuring the quality and accessibility of medical-social homecare services in the Republic of Moldova

Support to the development of home care services	2007 - 2010	Homecare AO	Czech Ministry of Labour and Social Affairs	**Hippocrates**	**Dorotcaia** village, Dubasari region	200
HOME CARE (Piloting medico-social home care in Chisinau, Balti, Edinet	1999 - 2008	Caritas Moldova	Cordaid, ICCO, Netherlands			

2.2 Key Stakeholders

Following key stakeholders and their key responsibilities were identified

- Ministry of Foreign Affairs of the Czech Republic (MFA): programming and evaluations of projects and programs
- Embassy of the Czech Republic in Moldova: representation and monitoring
- Czech Development Agency (CzDA): administration and monitoring of projects
- Expert Reference Group – monitoring of the evaluation
- Caritas Czech Republic : implementor of the projects
- AO Pro-Development – local partner of Caritas Czech Republic
- Association HomeCare – partner organisation: advocacy and direct contact with centres, trainings
- Union of Community Service Providers (UCSP) – partner organisations: advocacy
- Clients of the homecare services and their families
- Staff and volunteers of the Integrated centres for medical and social care
- Ministry of Health of the Republic of Moldova
- Ministry of Labour and Social Protection of the Republic of Moldova
- Local Public Authorities responsible for the Centres after their handover
- National Medical Insurance Company (NMIC): contracts medical services
- National Council for Accreditation of Social Service Providers (NCASSP): provides accreditations

2.3 Key assumptions and risks

Key assumptions and risks of the intervention identified in the Project Document and included in the LFM and those needing verification during the next phase of the evaluation are presented in the table below. The evaluation team also included their own assessment of the probability of occurrence on the scale low, medium and high and impact on the project using the same scale.

Table 2: Analysis of risks [4]

Assumptions and risks identified	Probability	Impact	Measures taken
The supported NGOs and LPAs will continue to develop the homecare sector.	high	high	Frequent contact of the implementers with the NGOs and LPAs, understanding the needs and providing further support. In cases of LPAs, MOUs were signed in all cases with responsibilities and commitments clearly defined.
Political instability will delay the increase of accessibility and quality of homecare services	medium	medium	Political instability at highest levels did not negatively impact on the homecare sector. It was rather lack of structural consistency to the approach to homecare services at the level of Ministry of Health and Ministry of Social Protection and mutual cooperation and communication between those two bodies. This could not be directly addressed by the projects.
Ongoing adjustment of the institutional, procedural, and legislative framework in accordance with the provided concepts and documentation.	medium	high	Active advocacy of the project towards goals that were realistic given the difficult situation described above.

[4] Source: project documents and own analysis

Assumptions and risks identified	Probability	Impact	Measures taken
Changes in government lead to abandoning the commitment to the reform process and expansion of homecare services.	medium	high	Active advocacy of the project towards goals that were deemed realistic. Changes in the government did not lead to abandoning the commitment but overall difficult economic and social situation of the country means that clear priorities are placed on creating opportunities and incentives for young people to stay in the country.
2 newly established centres and 8 existing continue to provide integrated homecare services after the project closing	high	high	MOUs with clearly stated responsibilities, agreed jointly with the LPA, were signed.
The centres capacities are constrained by the internal issues.	high	medium	The only internal issues identified were lower salaries coming as per state salary standards. Association Homecare provides additional sums to maintain the salary at a higher level.
The involved NGOs will keep increasing their capacities and continue their operation.	high	high	The NGOs were continuously offered training and consultation opportunities.
The NGOs capacities are constrained by the internal issues.	medium	medium	No internal issues were identified during the evaluation.
The MH and MLSP is willing to develop and approve the new profession in homecare field.	medium	high	Expert group from the USCP developed all necessary drafts of the legal and methodological documentation which was then offered for comments to the working group which included the representatives of MH and MLSP. The project also reacted swiftly to an additional requirement of developing qualification standards for the new profession and actively participated in the development process.
The delay in the process of approving the draft of the normative framework for the organization and functioning of new profession in homecare services due to the unstable political situation	medium	medium	No measures could be taken by the projects other than active contact and expert support to the national ministries.
The MLSP and NMIC is willing to develop and approve the criteria of contracting the homecare services	medium	high	While the criteria were developed and approved, their application is still questionable. While USCP NGOs keep advocating for greater transparency in contracting homecare services, greater motivation to functionally apply the criteria should be created at higher levels.
The delay in the process of approving the criteria of contracting the homecare services due to the unstable political situation	high	high	The criteria were developed ad approved but their application still remains a question.
Starting conditions (input assumptions) National, regional and non-governmental actors in the target country are interested in the project.	medium	high	

3 EVALUATION METHODOLOGY

3.1 Approach

The approach complied with **international criteria and professional norms and standards**, especially the *Formal Standards for Implementing Evaluations of the Czech Evaluation Society Formal Evaluation Standards of the Czech Evaluation Society* the *IDEAS Code of Ethics* adopted in November 2014, with the *Code of Ethics for Evaluators adopted by the Czech Evaluation Society*, OECD-DAC *Quality Standards for Development Evaluation* and follows the Principles and Good Practice of Humanitarian Donorship. As part of the processing of sources of verifiable findings, the evaluation team has also respected the right to protect the privacy of respondents and anonymized the sources of its findings. In case of this evaluation, the beneficiaries featured in the case studies were impossible to contact for validate the case studies descriptions in this report.

The approach was also participatory, **based on consultation and dialogue, with the aim of maximizing stakeholder involvement and considering their views.** This was reflected in the utilized data collection methods. Following the introductory meeting with the reference group in the Czech Republic, similar meetings were held online with implementors in Moldova ahead of the field data collection to also reflect on their learning expectations and better understand the country and field context. Further introductory and concluding briefings were held for the main stakeholders in Moldova (including a detailed consultation with the Embassy in Chisinau) to present preliminary findings and, in the case of the final briefing, also to discuss preliminary conclusions and recommendations.

The evaluation team has presented preliminary findings to the key stakeholders in Moldova and further discussed preliminary conclusions and recommendations with them. Feedback from the meeting in Moldova was considered in formulating conclusions and recommendations in this draft report. Following the feedback from the reference group, the report will be finalised.

Data was triangulated to the maximum extent possible and helped to improve accuracy of the information as well as to reduce data.

Evaluation questions and sub-questions, sources of information and methods of information collection are presented in the form of an **evaluation matrix in Annex D.**

The **approach to data collection** was semi-structured (systematic and, where possible, based on common procedures). Semi-structured interviews were based on pre-prepared lists of questions generated by the evaluation matrix.

3.2 Methods for data collection and verification

Data collection methods were mainly qualitative; quantitative data were obtained from secondary sources such as project reports or statistical data available. Utilized data collection tools are described below. **Data was collected from the following six centres:**

- MSC “St Anna”, Vulcanesti – founded in the most recent project and still fully supported by the project
- MSC “St. Agata”, Ocnita – founded in the most recent project and still fully supported by the project
- Theoretical-Practical Care Centre Estera (CTP) – new location was ensured for the centre (founded in 2011) in as part of the project implemented from 2017-2020 and still partially supported
- MSC “Rebeca”, Balti – founded in previous project and managed by an NGO created for this purpose
- *MSC “Maria Magdalena”, Stefan Voda* - founded in previous project and managed by a health centre
- MSC St. Iuliana, Taul – founded in previous project and managed by the village municipal office

The centres were selected so that **diverse modes of current functioning of the centres** were represented in the evaluation - this means type of institution managing the centres after their handover.

The following methodological tools for data collection were used:

- **Review of secondary data.** Overview of the resources used is stated in Annex I.
- **Interviews or group discussions with stakeholders** List of the participating institutions/stakeholders is stated in Annex E.
- **12 case studies of clients of the centre** (2 clients per each centre visited)
- **Group meetings with key stakeholders.** In the Czech Republic these were semi structured and included initial meetings with the reference group and interviews two members of the reference group. In Moldova a final evaluation briefing was organised where key conclusions of the data collection were presented and the participants were invited to jointly draw their own recommendations for future interventions in the social sector.

Evaluation of Cross-cutting themes

In compliance with Certified Methodology for the Evaluation of Cross-cutting Themes in Development Cooperation (by INESAN), the structure Cross-cutting Theme Indicator Matrix was developed (Table 3) involving only the dimensions and subdimensions the evaluation team considered relevant for the evaluated project. Appropriate questions were developed and included in the evaluation matrix.

Table 3: Structure of Cross-cutting Theme Indicator Matrix

Cross-cutting Theme	Dimension	Subdimension
Good governance	1. Participation 2. Transparency and accountability 3. Rule of Law	1.1. Stakeholders' engagement and participation 2.1. Transparency and accountability of governments and other actors (local public authorities) 3.2. Regulatory enforcement
Environment and sustainable development	1. Environmental Effects	1.4 Waste and waste management
Human rights	1. Human Rights	1.2 Inclusion of most disadvantaged groups
Gender equality	3. Distribution of development resources and benefits	3.1 Basic needs, livelihoods and productive assets

3.3 Limitations to the evaluation

Key limitations of the evaluation are stated below

- **Availability, quality and credibility of data, namely from national statistics in Moldova was limited,** other primary data was collected and triangulation was carried out.
- **Fluctuation of staff namely at key governmental institutions in Moldova and** therefore insufficient institutional memory and information on history of projects. Information was also acquired from former staff members.
- **Availability of key stakeholders during field data collection –** the field mission was organised well in advance. Interviews were mainly carried out in Romanian or Russian, with English interpretation used for the lead evaluator.

3.4 Ethical principles

The evaluation team respected the right to privacy of the respondents. The primary sources of information were anonymized in accordance with the Code of Ethics of the evaluator adopted by the Czech Evaluation Society in 2011[5].

3.5 Evaluation team and allocation of tasks

The evaluation team comprised three members. The structure is provided in figure 1. ***Marie Körner, project manager, quality assurance: Overall*** responsibility for contractual obligations and communication with the Contracting authority, Methodological support of the evaluation team, Cooperation on the quality control, editing and finalizing all deliverables, Participation at team meetings

Hana Bendová, lead evaluator: Overall coordination and management of the project and the evaluation team, communication with the implementors, responsible for deliverables

Natalia Vladicescu: Support with preparation of all deliverables including the inception phase, preparation of the evaluation mission, field work and data collection.

[5] Česká evaluační společnost (2011): Etický kodex evaluátora. Available on https://czecheval.cz/cs/Aktivity/Kodex-a-standardy

4 EVALUATION FINDINGS

4.1 Relevance

4.1.1 To what extent were the proposed and achieved outputs of the Projects relevant from the perspective of the partner country needs, local conditions and capacities of the country in the sector of inclusive social development and from the perspective of the Bilateral Development Cooperation Programme of the CR and Moldova?

Not all stakeholders were fully aware of the details of the two projects and thus **had no prior expectations.** All the interviewed stakeholders at national level however expressed satisfaction with the focus of the projects and achievements they were aware of. Inclusive social development is one of the priority areas of the Bilateral Development Cooperation Programme. The program places particular attention to the needs of vulnerable population groups (the elderly, disabled persons, children, addicts or those who constitute an addiction risk) and on increasing the share of home and community care and on integrating these population groups into society.[6] A study conducted for the EC further concludes that the major problem in the delivery of home care services is the limited number of persons who can benefit from home care services (single elderly and disabled since childhood). A large part of the population in need of home care services does not have access, generating a high demand for institutional care. As per estimates of the Assessment jointly commissioned by UCSP NGOs, only 18% of the current need is covered.[7] The situation is especially critical in rural areas which was also reflected in the project – rural areas distant from the capital city were included in the interventions. Living conditions in rural areas are significantly worse than urban areas[8] which intensifies the urgency for services for the elderly. The trend of aging of the population in Moldova (data from 2022 show 24 ratio for rural areas compared to 21 in urban areas – compared to 18.1 and 16.7 respectively in 2014) further confirms the need, particularly in the rural areas.[9] The interviewed stakeholders at national as well as local level further confirmed these **needs and gaps** identified and appreciated the focus of the projects on these.

Financial resources available from the central government budget were described as insufficient by all interviewed stakeholder from national as well as local level institutions. It is difficult to assess the precise resources allocated as medical and social services administered separately at national level and the level of budgetary responsibility also differs. While medical services are covered in the central governmental budget through the National Medical Insurance Company, social services are managed at municipal level and are also covered from the municipal budget. Furthermore, budget data is often presented in a generic form, and it is not possible to determine the amount allocated to the needs of elderly and related services. The assessment conducted as part of the intervention found that in 2019 the registered expenses for social HBC services in year 2016 were 103.7 million MDL (3.9 million more than in year 2015). Community and medical HBC services had the lowest share of expenditures in the main fund. It is only 0.2% out of total and counted 8.7 million MDL in one year (7.7 million MDL exclusively for medical HBC services). [10]

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[6] Bilateral Development Cooperation Programme of the Czech Republic and Moldova, 2018 - 2023

[7] Home-Based Medical and Social Care Services Assessment in The Republic of Moldova, Centre of Investigations and Consultation "SocioPolis", 2018

[8] In urban areas, the construction of block housing requires connection to water, sewage and heating networks, i.e. urban elderly live in better conditions than rural elderly. Thus, in urban areas 97.2% of households with only elderly people were equipped with water supply, 94.4% - with sewage systems, 84.6% - with bath or shower in the house and 68.8% - with central or independent heating. In rural areas, on the other hand, only 65.7% of households had a water supply, 52.2% had sewage systems, 39.3% had a bath or shower and 89.1% used wood or coal stoves for heating. Source Elderly population in the Republic of Moldova in 2021 - https://statistica.gov.md/newsview.php?l=en&id=7553&idc=168, accessed on October 3rd 2022

[9] https://statistica.gov.md/en/statistic_indicator_details/25

[10] Home-Based Medical and Social Care Services Assessment in The Republic of Moldova, Centre of Investigations and Consultation "SocioPolis", 2018

At municipal level, **overall available resources are often prioritised to support young people and families** and to create incentives for them to stay as Moldova has faced migration of young people of productive age abroad due to lack of opportunities in the country. In interviews, representatives of the five interviewed local municipalities or other institutions at local level stated infrastructure repair and facilities for children and youth as the key areas where their budgets are spent. The current situation with energy costs and other issues related to the war in Ukraine means that even greater percentages of budgets are allocated to cover costs and makes financial planning difficult.

All representatives of local municipalities asserted that homecare services are a key priority in their respective area but at the same time majority of them stated that the budgets available for the social sector are completely insufficient. One representative was unable to comment on budgetary issues.

All beneficiaries interviewed as parts of case studies stated that the **assistance provided through the centres really fits their needs**. In some cases, these needs were of rather medical character but in most cases the needs were integrated – this means required both medical as well as social care. Aside from services such as cleaning, washing and taking care of administrative issues, such as bringing the pension, the clients specifically appreciated human contact – high majority of them were living alone with family members abroad and had very little social contact in general. For most of them, these services were the first time they experienced any type of social assistance.

All interviewed stakeholders stated that there is significant need for more services which can be identified as **gap only partly addressed by the projects.** Another gap only partly addressed by the interventions is the fact that social services have extremely insufficient budget that is distributed via LPAs' general budget and there are no obligations to use this budget for social services, nor there are sufficient guidelines for LPAs on how to manage and plan a budget or how to get additional or external financing. There is also a lack of collaboration between state actors on social affairs.

4.2 Coherence

4.2.1 What aspects (achievement of goals, aims, outputs, activities etc.) did or did not contribute to the coherence within the sector of inclusive social development in Moldova?

Both current and former representatives of Ministry of Labour and Social Protection **highly value contribution of the intervention to the sector of social inclusive development**. One of the representatives stated that the ongoing reform of the homecare services was only possible thanks to external support and expertise, mainly provided by the USCP NGOs where project implementors are one of the key driving partners. Due to high workload and fluctuation of the ministry staff, and insufficient resources, this expertise is very welcome. In 2017 e.g., the department of social work only had five staff members responsible for social services and cash support. To further illustrate the situation, the staff member of MLSP interviewed for the evaluation left the Ministry a few days after the interview and currently there is no focal person for homecare services. The contribution of the intervention is also appreciated by Ministry of Health. Both institutions appreciated the continuous cooperation in establishing and improving the legal basis for the sector. The continuous aspect of this cooperation and expertise was also emphasized as key by the Embassy of the Czech Republic. All partial steps and elements elaborated in the legal framework with input from the intervention were viewed as highly needed by the Ministries. These include not only legal and methodological tools developed but also relevant trainings being offered to support the implementation of the framework. Specifically, methodology of calculation of the tariff for social homecare services and as well as normative framework for the organization and functioning of the new home care profession were singled out as highly useful for the sector.

Both ministries also appreciated the **soft activities** such as training support available through the projects – both at national as well as municipal level as **particular valuable components of the interventions** and asserted the need to further develop and widen expertise in this area. An important factor was that all trainings (agenda, content) were approved by the ministries to make sure they aligned with necessary standards and

the certificates were applicable outside of the projects. They stated that now there is expertise among medical and social workers needed to provide quality services and there is also strengthened capacity at national level in terms of systemic issues, as many of the outputs of collaboration with USCP were accompanied by trainings of relevant staff. Ministry of Health specifically appreciated trainings available for public institution workers and stated that as a result, the curriculum of the National college was modified, and homecare was included. The Czech Embassy also sees increased appreciation of accompanying soft project activities such as trainings whereas previously, the key demand from state institutions was mainly around buildings, equipment and infrastructure. No **aspects seen as having lesser value** were identified.

A key challenge posed is the fact that while medical services are managed and covered by the Ministry of Health from state-level budget, social services fall under the Ministry of Labour and Social Protection and are covered from municipal-level budget. While both ministries agree that it is important to collaborate and communicate, they also acknowledge that at present medical homecare services are more clearly structured and their source of funding is more stable. Both ministries also understand that homecare services should be integrated – this means creating multidisciplinary approach offering complex and quality services. Advocacy and involvement of USCP in this regard has been very strong and well understood but the different sources of funding for these services is viewed by majority of the interviewed stakeholders as a key obstacle for integration. Lack of effective communication and willingness to collaborate among the relevant ministries (with frequent reason being stated as separate budgets and budgetary levels) was also found as a challenge. The Standards for integrated services, developed as pilot initiative to integrate the services by USCP NGOs and currently implemented by CASMED, was only approved as a pilot project by Ministry of Labour and Social Protection but is currently being not followed up on by the Ministry. However, USCP plans to present the results of the pilot phase to MLPS in 2023 to continue the promotion of the standards and support the argument of having the services integrated.

4.2.2 Are there any replicable examples of good practices within the evaluated projects or in their cooperation with external stakeholders?

The continuity of Czech funded projects focused on the same sector allowed for long-term systemic work. Relevant ministries stated that they have been in continuous contact with the organisations, that they were always consulted on new plans/intentions of the project and that their particular needs and priorities were also reflected. External support and expertise were available to them and supported them in fulfilling their own internal strategies and plans. E.g. the latest project swiftly reacted to the need of establishing qualification standards for the new homecare profession which was not originally foreseen but then identified as necessary by the Ministry. A Memorandum of Collaboration was also signed between Ministry of Health and USCP.

When planning establishment of the new centres, projects not only worked with data available at national level to determine areas with the greatest need but also considered willingness of local authorities to participate in the establishment of homecare services and the degree of priority ascribed to the social sector. All interviewed LPA representatives in the areas with centres already handed over, stated that they were aware of the need for their commitment and financial participation from the onset of cooperation and were willing to cooperate and participate in financing the centres functioning.

The above-described aspects were also singled out as good practices by the Embassy of the Czech Republic who sees the projects as fine examples of carefully thought out in terms of sustainability and cooperation with local stakeholders and **possible to transfer to different contexts.**

4.3 Efficiency

4.3.1 To what extent were the projects efficient (in terms of value for money)?

Tender documentation shows **that equipment was procured and selected based on the lowest price offered**. Project reports state that quality was also considered when making the decisions. Delivery of equipment was hampered by import issues due to COVID 19 and was thus carried out in two rounds, with

household appliance delivered in July 2020 and medical appliances in October 2020. Thus, four centres providing medical services by using medical equipment, only starting with November 2020. Thus, CZDA has approved the amendments decreasing of the number of beneficiaries from 250 to 500 who benefited from social medical services within the four centres provided with new equipment. Financial report from 2019 shows that costs for establishing new and supporting existing centres had not been fully spent at that moment. As the project is still ongoing, final data about financial expenditures nor numbers of new clients is not yet available.

Investments in the centres have supported growing quality, positive reputation and demand from local community. The last narrative midterm report for 2021 indicates that **overall number** of clients benefiting from medical and social services in the two newly established centres amounted to 538 beneficiaries and 206 primary clients of TPC Estera. All six centres visited during the field data collection reported full capacity. Msc St. Iuliana in Taul reported 240 primary clients and additionally cases that are visited on permanent basis due to their severity – compared to the 150 served when the centre was fully supported by the project. Msc. Maria Magdalena in Stefan Voda reported 160 clients for in-visit centres and 40 included in home visits. (previously the centre served around 300 clients on annual basis and was the only one which reported decrease in the number of clients. This is due to the fact that the staff worked full time when financed by CZDA and currently only work 50% of their time in the centre). Finally, Msc St. Rebecca in Balti estimated the number of current clients to somewhere between 700 – 800 compared to the 360 served during their full involvement in the project. Clients now know about the centre, and they also trust the services. Furthermore, the centre actively collaborates with state social assistants who are now conducting the home visits and the centre staff focus mainly on in-centre services.

Furthermore, all three centres established during previous projects reported **growing demand** for their services and all have demonstrated **waiting lists of clients** to be served. Managers of all centres, medical staff as well as some of LPA representatives shared that the centres provided unique services as they have equipment which is usually not available at standard medical institutions. During the evaluation visits, the team has seen active use of the equipment in the three centres established during the previous projects and staff performing procedures. There were no clients being served in the newly established centres in Vulcanesti and Ocnita, as well as TPC Estera Centre – the centre managers explained that they allocated the full day to the evaluation team and intended to have the staff fully focused on the evaluation. As per the data collected, over 1800 clients are currently being served in the six centres during the evaluation. The **hybrid model of the centres** where morning hours are dedicated to in-centre services and the afternoon hours are used for home visits is also seen as functional by the centres' staff, management as well as implementers. In light of the limited numbers of staff, it is also the only possible mode of covering the diverse needs of the clients.

Two **monitoring** visits of CzDA were carried out in 2018 and 2019. While the first one aimed to verify the contents of the submitted project reports and identify key risks for achieving project objectives, the second visit closely focused on exploring functionality of the Msc Maria Magdalena centre in Stefan Voda. Furthermore, 9 changes to either project or timeline of the activities were approved in the course of the two evaluated interventions, also reflecting on the challenges connected to COVID-19 pandemic. Frequent contact and support from the Czech Embassy was also present, including visits to the centres. One key change in expected outputs was the lower increase of the cost of tariff for medical home visits - from the original 30 percent planned increase, which at that time was unrealistic, the increase was achieved at a rate of 4.3 percent. The tariff was however increased by 47% in 2021.[11] The USCP NGOs believe that there is a strong attribution from their part as an assessment of the real costs versus cost coverage was conducted by them and the results were then provided to Ministry of Health and NMIC. Furthermore, the NMIC reviews the cost on annual basis and also considers current inflation during this review. Another change is the inclusion of the Qualification standard for the new homecare profession as a new, originally unplanned output. A key factor in timely achievement of project outputs was COVID-19 pandemic. Centres were closed during the peaks of the pandemic and trainings had to be either delivered online or entirely postponed. Frequent contact has however been maintained between the centres and project implementers (Caritas CZ and AO Homecare) as reported by all parties.

[11] Data acquired from the National Health Insurance in physical copy during the interview. While in 2019 the cost of medical home visit was approximately 137 lei, in 2021 this amounted to 210 lei, which indicates 47% increase.

Furthermore, majority of the staff interviewed also reported that the frequency of trainings and contact with the implementers motivated them on professional as well as personal level. Online training for social assistants and workers on COVID-19 was organised as a new activity reflecting the pandemic situation. Initially, the training of 140 social workers was planned, but due to the mobilization of the local authorities, and the requests received from the Social Assistance Directorates from districts and municipalities, the given indicator was exceeded by 40%. No **significant delays affecting the fulfilment of overall project objectives** were reported by implementing organisations and were also not identified in the project documentation.

4.4 Effectiveness

4.4.1 To what extent were the project objectives achieved?

Extent to which the quality of homecare services increased

The interventions provided continuous trainings to staff in the centres. AOHC reported that requests from trainings keep rising from, including requests from external institutions as well and actual suggestions of concrete topics for trainings, such as intersectoral collaboration, occupational therapy, care provision to client with cardiovascular diseases and others. Medical staff in the centres are all trained nurses with prior experience of working in health institutions. As none of the staff members are recent graduates from medical colleges, it means that when joining the centres, they have no specific skills in homecare provision – this was only recently added onto the national curriculum. The trainings thus start with an initial in-depth training on homecare provision in general and is later further continued with refreshers and topical trainings. The trainings for social workers employed in the centres are focused on the same topics but offer different content. The social workers come from different backgrounds and their initial qualifications may be very low.

All of the medical as well as social staff interviewed have valued the trainings and found them very beneficial for their own professional development. Exchange of experience during the training sessions was also seen as very useful, often leading to unexpected discoveries and learning. High majority of staff were able to identify at least three concrete skills they have acquired during these trainings. In addition, practical focus of the trainings was highly appreciated by the nurses compared to the reportedly rather theoretical education received in medical colleges. Following were the most frequently stated skills:

Medical staff:

- Communication with the client, sense of empathy, personalising approach, specificities of working with elderly and vulnerable clients.
- Dealing with clients with diabetes, educating them about their disease and measures necessary to take such as proper diet
- Palliative care
- Treatment of bedsores
- Using some of the appliances newly introduced
- Massage skills
- Caring for clients with oncologic disease
- Prevention of burnout

Social workers:

- Communication with the client, sense of empathy, personalising approach, specificities of working with elderly and vulnerable clients.
- Useful medical skills such as caring for paralysed clients, which means that social workers are able to actively assist the nurses
- Hygiene for elderly vulnerable people
- Prevention of burnout

- Working with a database

Volunteers:

Majority of volunteers were interviewed in Balti where the Rebecca centre actively collaborates with local medical college which sends nursing and medical students to the centre. Only one other volunteer was identified in TPC Estera. In the case of this volunteer, she attended trainings with other staff members at the centre and her responses are included in the findings above. The volunteers in Balti were trained by the centre director and have stated following useful information and skills acquired through their involvement in centre activities:

- Communication with the clients
- Useful practical aspects of providing first aid and other medical issues (whereas the college education remains at a very theoretical level)
- Dealing with immobilised clients, treatment of bedsores
- Physiotherapy

All of the volunteers also stated that their involvement has further motivated them to take up the profession they are studying and two of them stated they would like to continue volunteering in the centre in the future.

The clients have all appreciated the quality of services provided and stressed the human approach of the staff. All the clients were able to describe the services received and also confirmed regular visits, lasting about 30 minutes each. All of the clients also expressed incredible gratitude for the services – for many, especially those with impaired mobility, it was one of the few contacts they have with the outside world. Two of the visited case studies were clients unable to communicate and, in this case, it was the caregivers who were interviewed – they also confirmed the high quality of services received. Selected statements from the clients are provided below to illustrate the perceived benefits and quality of the services:

The nurses are very good girls, they bring my pills from the medical centres and do procedures for my knee. I was referred by family doctor because I was chronical. As an alternative to hospital, he proposed this. At first, they offered procedures in the centre, they saw how hard it is to move for me and started to visit me at home 2-3 times a week. They also clean my home, and we chat about politics. The procedures are easing my pains and I can sleep better and get up easier. I want to write a letter of gratitude about what your organisation is doing – in the 80 years of my life, I have not seen this.

Female client,
Vulcanesti

I am alone, nobody is helping me. And nobody needs me. There are some people who visit me and bring food - one neighbour through the fence and another lady who was very nice but died recently. I come here (to the centre) sometimes. They usually bring me by car. Sometimes I come walking but mostly by car. I come here for bath and to wash my clothes. Sometimes I wash at home, but it is more difficult because I have to wash by hand. I feel good when I come to the centre (smiling) – Larisa (nurse) is also bringing different things, sweets, nice food for holidays.

Male client with mental and physical disability,
Taul

I started receiving their services about 4 or 5 years ago, I was still able to attend the church. So initially I was able to go to the centre, then I started to have issues with my legs and hands. When I felt worse, they came to my house, they help to wash bedsheets, curtains, I didn't know how to say thank you to them. My kids are not taking care of me, and they are so much. Also bathe there twice per month and wash my bedsheets twice a month. They also cut my hair. Around 3 years constantly twice per month I go to have a bath. If it wasn't for this centre, many people would be dead. I feel like Marina – it is her purpose in life to encourage us, sometimes there are people with whom you can't find common language. When I complain to my family doctor, he tells me „Look at your age, what do you want? "
But Marine is always encouraging.

Female client,
Stefan Voda

The nurses are their best, whenever I ask for help, they are trying. The always check the blood pressure, sometimes I call them to come because I see the pressure is low. There is nobody else from social services or LPA who helps, they have their own problems. Maybe in other countries this is different…I spend almost all money on medication for my wife, I had to take a loan of 2000 lei to buy a new fridge as the old one broke. The nurses come about twice a week; I am so grateful they actually come. I know there are villages around who have nothing. And there are many other patients, not just us….

Husband – caregiver for a female patient in terminal stage of cancer, receiving palliative care,
Razeni

The interviewed USCP NGOs provided following examples of skills and knowledge acquired through their involvement in the interventions:

- Importance of diversifying resources and learning how to approach a potential donor
- Awareness of a larger range of services (as seen in the study visit in the Czech Republic) and inspiration for future improvement of service in Moldova
- Developing network strategy and learning how to work in group
- Ability to consult with the group whenever necessary
- Using entrepreneurial schemes such as own bakery to generate funding

Extent to which accessibility of homecare services increased

Prior to Czech funded interventions focusing on homecare, the services were basically absent in Moldova as per accounts of the implementing partners. The existing services available from state funds are only of medical character and are conducted by general practitioners (referred to as family doctors in Moldova). These services are very limited both in time and scope. In Ocnita, e.g.the health clinic director reported that for the entire district of 27 0000 people, encompassing Ocnita and 16 other villages, 453 homecare visits were allocated by the National Health Insurance Company. In Stefan Voda, the health clinic reported that for a population of 42 000 people, they are allowed to serve 32 patients with 36 visits per each patient per year. The visits, if they take place the visits are of rather symbolic character, not allowing for longer term care in line with the real needs of the patient. Furthermore, at least three LPA representatives stated in that in reality many of these visits are not even happening and are just reported on paper due to general overload of general practitioners. Statistical data[12] estimate 2.6 general practitioners per 1000 persons, interviewed stakeholders in Moldova, namely heads of centres and representatives of LPA estimated that on average one rural general practitioners' cares for 1700 patients. Medical specialists are largely unavailable in the country, most of them being concentrated in the capital city.

In terms of social homecare services, according to data from the National Agency for Social Assistance, in 2021, 1100 social workers were active, providing free home care services for 15 900 beneficiaries, including 13 000 elderly people who have reached retirement age.[13] Again, stakeholders at field level have reported that the capacity of state social workers is very limited and often the visits simply consist of bringing pension or shopping to the clients. Interviewed LPA representatives as well centres staff confirmed that services offered by the centres are much more accessible than those offered by the state both in terms of health as well as social issues. At the same time, all centres reported that they actively collaborate with state social workers who actively refer clients identified as in need. In some cases, this collaboration is not fully formalised but reported as functional. There is also collaboration with general practitioners who also actively refer patients mainly for medical services. Many of the interviewed clients also stated that they were referred to the centres by their general practitioner. The centres are now well known in the professional community and combined with functional referral system; this further supports improved accessibility. Furthermore, some staff members also mentioned that they often help clients to acquire disability status, which many of those who would qualify do not have, and the clients are thus entitled to further support from state.

The project centres render services for a period of 3 months (with the possibility to extend it up to 6 or 1 year), which enables a rotation of the beneficiaries and delivery of services to a larger number of people requiring these services. A standard practice discovered during the centre visits is that some clients are being admitted to the centre services on annual basis for a period of three months, depending on their needs. The most vulnerable clients are visited continuously, in some cases for years. In these cases, the frequency of visits can drop to 2 visits per month. High majority clients interviewed as part of case studies shared that **visits from the project centres**

[12] Elderly population in the Republic of Moldova in 2021 -
https://statistica.gov.md/newsview.php?l=en&id=7553&idc=168 (accessed 03.10.20222)

[13] Elderly population in the Republic of Moldova in 2021 -
https://statistica.gov.md/newsview.php?l=en&id=7553&idc=168 (accessed 03.10.20222)

were the first time, they had medical and social services in their own home. Equally, high majority of the clients were living alone, with family members either residing in the capital city or, in most cases, abroad. Many of them expressed a degree of disbelief that services of this character were even possible and all of them were very grateful. They also appreciated the length of time the centre workers spent in their home, range of services provided (medical, cleaning, washing, shopping etc.). Those **who were especially vulnerable also stated that they have been receiving the services for years** which confirmed the practice described by the centres' staff. Majority of the clients also shared that initially they did not trust the centres and suspected that it was a scam. The trust is now firmly established and many of the clients also share this information with their neighbours and friends which again leads to growing awareness and demand from the community. There is also growing demand from communities from neighbouring villages or towns (reported e.g. in Taul) but certainly also existing elsewhere[14] – the centres are however unable to serve neighbouring communities due to limited capacities.

Interviewed members of USCP also stated that in their experience access to the services is improving. One member shared that the referral system is working well and there is no reluctance from general practitioners to refer patients to the centres. All members reported that they have waiting lines of patients. One of the NGOs reported 100 percent increase in the number of patients compared to last year. None of the NGOs reported coverage of a new geographical area (an indicator in the last project logframe) and the project report states that this indicator will be achieved by the end of the project. One exception is the AOHC, which is now also covering rural communities Razeni and Carbuna outside of Chisinau where the highest need was identified in cooperation with local and state authorities. In terms of extended service provision (another indicator in the LFM), one of the USCP members stated that following study visit in the Czech Republic, they are now planning on including recuperation services as part of their portfolio. Another stated that they have now included palliative care in their services and open a day-care centre for clients with chronical and terminal diseases. Furthermore, another member stated that prior to their collaboration with AOHC they were only providing food to vulnerable clients and now they include medical home care in their services. (this makes it 3 out of 4 jointly interviewed members, the 4th one being AOHC representative) All members said that their focus is to cover the current need with existing services and reported that at this point they are unable to cover the full need in their target areas. Overall, they assess that they are able to cover between 14-20% of the actual need. One of the NGOs, contracted by NMIC assesses that even with the recent tariff increase, only 1 out five people in need have access to their services in the region they cover. Furthermore, the number of visits allocated to them (72) does not cover the needs of those, who need visits on daily or more frequent basis. Another key focus for the NGOs is to secure funds from other donors.

Extent to which legislative documents submitted are considered useful and relevant

The contribution of the USCP active advocacy in which project partners play a key role and are one of the most active members, was confirmed by all representatives of ministries interviewed. (see section 4.2.1. for further details.) Following legislative documents were commented on in the interviews:

- **Methodology of calculation of the tariff for social homecare services.** Following the approval of the methodology, MLSP reported that all the territorial structures approved the cost of the services and started providing the service for money. MLSP also reported that group of beneficiaries enlarged a lot but provided no data to support the statement.
- **Draft of the law for the social protection of elderly people.** None of the interviewed MLSP representatives was able to comment on the follow up of the draft law. It is unclear how this is being followed up – at the time of data collection the person in charge of homecare at MLSP left the institution. However, the previous MLSP representative stressed high need of the law to be approved and also growing understanding within the Ministry of the importance of the law.
- **Normative framework for the organization and functioning of the new home care profession.** Creation of this is considered an achievement by the implementing organisations and plans for trainings following the approval were described by the implementing partners. However, no comments from

[14] own analysis based on observations and visits to the rural communities in Moldova

MLSP were received on this issue – possibly also because the interviewed person was relatively new to the position and left the position soon after the evaluation interview took place. Ministry of Health acknowledged usefulness of the framework and stated that it made it possible for them to instruct and train family members to provide homecare services to the patients after their return home.

- **Criteria for contracting the medical homecare servic**es. Though the criteria were developed and approved, they are not actively applied. The project implementers describe the process as nontransparent and state that NMIC keep contracting the same providers. Data[15] from the NMIC show that numbers of providers have been almost stagnant between 2017 – 2021, even though in 2021 budget for the services grew by 30 percent – this confirms the statement of the implementing partners. MoH also acknowledges the existence of preferential providers but also argues that this does not mean that one organization is disproportionately contracted. But the representative also agreed that they keep contracting the providers with whom they have had positive experience. At the same time, MoH also agreed that it is important to have more providers and acknowledged high quality of integrated services provided by NGOs. In order to be contracted by NMIC, the MoH advised that the NGOs should be bigger, have established network and cover several regions and ideally also mobile teams accessing the neighboring areas/villages.

4.4.2 *What were the major factors influencing the achievement or non-achievement of outcomes? How were possible impediments overcome?*

Key supporting factors were identified as follows, mainly from own analysis:

- Long-term focus of the Czech interventions on homecare services and thus creating in-depth understanding of the sector, context and needs
- Active inclusion of all local stakeholders (national as well as local level) in project formulation and project planning, ongoing consultations with relevant stakeholders and focus on creating long term partnerships with relevant institutions.
- High level of dedication of implementing partners
- Cooperation among USCP NGOs – not competition for funds - which increased the chance of success when working with state level institutions.
- High level of dedication of staff in the centres – good initial selection of staff, focus on human centred approach while working with the staff, focus on team functionality and developing good personal relations. Also, frequent motivation actions – informal meetings, certificates of appreciation, providing some opportunities to increase their income through other projects, frequent and practical training of

15 Data received during the interview with NMIC in a printed form

	2017	2018	2019	2020	2021
Number of service providers	140	146	141	142	142
Contracted amount	6 520 942.45	7 053 826.50	6 970 241.50	7 601 353.70	12 935 790
Paid out amount	7 098 622.55	7 296 621.75	7 459 263.00	7 808 846.70	12 964 350.00
Number of visits contracted	49 555	51 394	50 785	57 812	61 599
Number of visits carried out	53 945	53 163	54 348	53 817	61 735
Tariff per visit	131.59	137.35	137.35	145.1	210

personnel, including in the period of COVID with topics relevant to the needs and requests of the staff members.

Three stakeholders mentioned that the director of AOHC plays a key role in achieving success. The evaluators, however, identified this reliance on one person as a potential issue for sustainability.

Key inhibiting factors were identified as follows:

- Overall difficult economic situation in Moldova, migration abroad and thus insufficient resources. The resources are being prioritized for youth and families to create incentives for them to stay in the country.
- Overall inadequate national budget available to fund health and social services creating huge demand for services from non-profit providers
- Medical and social services are being covered from different budgetary levels making any effort to standardize integrated services at state level very complicated.
- High turnover of staff at MLSP and in state-level institutions in general, jeopardizing continuity of work.
- High demand in communities and limited staff capacities in the centre despite high level of dedication, motivation and work skills.
- Political changes influencing the work of ministries and not always reflecting the need on the ground

4.5 Likely Impact

4.5.1 How did the project contribute/is likely to contribute to creating a system of quality, affordable and sustainable social services in Moldova?

The **legislative changes implemented with contribution of the interventions** are listed above in section 4. Acknowledgement of the relevant institutions of the indispensable role of the USCP was also described. The drafted documents are being used by the state authorities, but the degree of application differs (see above). Only one the interviewed CARE providers was able to provide examples of **how these changes impact on their work** – this is also due to the fact that this provider is contracted by NMIC. The provider stated that now there is a clear set of rules describing caregiver's responsibilities and that prior to this, many social workers would simply just bring groceries. This makes it easier to evaluate quality of work provided. This provider also stated that due to the increased tariff, they have more resources for basic medical equipment and can e.g. change bandages more often. The rest were unable to state any impact of the drafted documents on their organisations and work. The new contracting criteria for NMIC could be of specific interest here as their application could lead to more equitable distribution of resources among home care providers. As they are not applied, the resources are still being distributed inequitably. Increase of the tariff for home visits is also not playing out in lives of the clients of the centres as the visits are allocated to other providers and in general are described as really scarce. **There is no change in affordability of the services** – most clients are unable to pay for the services. In fact, due to the recent price increase, inflation and overall difficult situation further exacerbated by the conflict in Ukraine, it is safe to assume that elderly people have fewer resources to cover their basic needs, unless they have families abroad actively supporting them financially. However, a working referral system is now in place connecting health care professionals, LPA social workers and the centres, supporting increased access to these services. **No other changes, further brought about on the legal and regulatory framework, were identified.**

The numerous inhibiting factors are described in section 4.4.2. An overall reform of budgetary responsibilities connected to the expected administrative reform in Moldova is the key step to resolve the main barrier to establishing integrated medical and social services in the country – a view shared by most respondents who commented on legislative issues.

However, the consistent advocacy throughout the Czech funded interventions in homecare, building capacity of local experts, creating opportunities for exchange, learning and inspiration has maintained issues connected

to the care and protection of the elderly present and has produced consistent steps towards improving existing legal framework and raising the awareness on the need of integrating the services. The interventions also helped to build significant expertise in homecare at local level and embed homecare into national medical curricula which is something that can be built on in the future.

4.6 Sustainability

4.6.1 What is the sustainability of establishing centres of home care after their take-over by the local municipalities (in terms of ownership, financing, management, continuous training of the staff, fluctuation of staff, interest of the municipalities, role of the Home Care Association, cooperation with other stakeholders etc.)?

Exit strategy has not been included in the project documents. However, the locations of the two new centres in the most recent intervention were carefully established. A list of clear criteria was used to assess the five applying LPAs. **Degree of availability of medical, social, and other services, number of elderly and those identified as elderly in need as well as additional statistical data** (e.g., mortality rate, numbers of social and medical workers was considered for each district. Data was obtained from Ministry of Health and Ministry of Social Protection and LPAs, where possible. Criteria also included **existence of a local strategy for the development of social protection services** corresponding to the request (there is not national level strategy in Moldova at this point). **Financial aspects** such as percentages of resources from the total funds of the district / municipality allocated for social assistance and primary healthcare, assessment of whether local elderly may partially pay for the services (in 4 out of 5 cases the answer was no) as well as existence of public-private partnerships in the locality where the development of socio-medical assistance services is planned. Assessment of the **capacity of the local public authority to develop and provide community social and medical services** was also included. Political will present, ability to provide adequate space and be involved in the maintenance, cover utility costs, willingness to ensure sustainability and availability of medical staff and social workers to provide services (both for at 10 least years after the end of the project) were among the sub-criteria here. Clear expectations as to both current and future financial as well as other responsibilities were also clearly stipulated in the contracts signed with the LPAs upon establishing the centres.

The interviewed manager of the centre in **Ocnita** as well as the representatives of health clinic are, however, worried about the future of the centre. During data collection it was still unclear which institution will take over the centre. The budget of the municipality reportedly does not even have sufficient resources for schools and is in deficit. There is no industry and no options for generating income. Furthermore, a lot of resources were reportedly used in response to the Ukrainian crisis and with current increase of energy costs, the situation looks bleak as per accounts of the centre manager as well as Ocnita health clinic. There are few options of other resources. One resource suggested was becoming contracted by the National Health Insurance Company but even in this case the coverage of costs necessary is very low – number of homecare visits assigned is minimal (453 for the population of 27 000) and the coverage does not fully cover key medical costs (with some exceptions). Furthermore, the coverage only applies to medical services. The health clinic assesses that salaries of the team will not be possible to provide from municipality resources in the following year and reportedly already started negotiating with AOHC about the possibility to keep providing the salaries. The only possibility may to continue covering utilities. The centre is heavily dependent on support from AOHC (through the funds from the evaluated intervention) – all stakeholders in Ocnita shared that they would not be able to work without the presence of AOHC. For the social worker from the centre, the key reference point is also AOHC and not local authorities.

In case of the centre in **Vulcanesti**, the key contact point at the local LPA (in Comrat, the regional capital) was not present during data collection. The person interviewed was only partly informed about the centre. Based on her assessment, the centre may be handed over to the Central Medical Office of Gagauzia (an autonomous territorial unit) as has happened with another similar centre and later was assigned to local level. There are examples of similar services handed over and still functioning – e.g. mobile teams of KeyStone International. There is also reportedly understanding that these services are needed and useful. Decisions at this level are

made by the Executive Committee of Gagauzia which is also going to decide about the centre in Vulcanesti. No information about budget available was possible to obtain. The manager of the centre in Vulcanesti shared that all communication with regards to sustainability is happening with AOHC and the Executive Committee and was only able to express hope for continued functioning. At this point, all expenses with regards to utilities are covered by the district, AOHC covers the remaining expenditures. This also includes costs of medical material. Medication is partly covered by NMIC but as per accounts of majority of stakeholders from the centres, including the clients, large part of medical costs is required from the patient. Frequent mentions of corruption in the healthcare systems were also made. To illustrate this, one stakeholder mentioned that the only thing he does not have to pay for, when he goes to the hospital, is the bed.

In both of the centres, all of the originally trained staff remains. In case of medical staff, the job in the centre is an additional source of income as they also work at local state healthcare facilities. The social workers only work for the centres. While medical staff in Ocnita shared that the salary is better than what they are getting from the state, the opposite was stated by medical staff in Vulcanesti. This may be due to the fact that they have the possibility of night shifts in the local hospital, which are reportedly better paid. All staff members in the centres expressed motivation to continue working in the centres but stressed that it is important to maintain the salary level.

Looking at **TPC Estera**, AOHC is actively seeking out resources from other donors - donor aid was at this point identified as the only alternative source of funding. At the end of 2020, the budget was partially covered from other source, the total amount represented 37% of the overall Estera budget.[16] As part of fundraising activities in the most recent intervention, 32 letters to potential donors were distributed, five project proposals to donors other than CzDA were submitted, two of them were awarded. COVID-19 pandemic was an obstacle for fundraising as many public activities had to be cancelled. The team remains the same with only a few members retiring due to age. In 2022, AOHC has raised 2/3 of the annual budget for Estera and continues to diversify the donor portfolio.[17] It is thus able to continue supporting the centres from previous projects (Taul, Balti, Stefan Voda and others) via provision of care and medical supplies (diapers, creams, detergents, medication) as well as supplementing staff salaries while using resources other than CZDA (see table in the footnote). CZDA resources from the project "Technologies for the future - telemedicine in home care in Moldova" are also partly used in this regard as some of the centres (Balti, Stefan Voda) from previous projects participate in the project activities.

4.6.2 *What is sustainability of enhanced services/resources of the centers supported through the project after the project end (in terms of financing, management, resource management and maintenance, staff, fluctuation of staff, interest of the municipalities, role of the Home Care Association, cooperation with other stakeholders etc.)?*

Three centres established under the previous projects have been visited:

- MSC "Rebeca", Balti –managed by an NGO created for this purpose
- *MSC "Maria Magdalena", Stefan Voda* – handed over to and still managed by a health centre

[16] Annual project report 2020

[17]

Total costs Estera for 2022	**86400 Eur**
Income for ESTERA for 2022 year	**TOTAL, Eur**
CNAM/ Contract 05-08/397 from 31.12.2020 (medical insurance company)	11 900,00
Kerk in Actie	23 160,00
HELP	8 543,23
UNFPA	12 560,58
Button "Donate"	3 560,00
CZDA	3 600,00
Proiect „Towards equity through social accountability", funded by the Swiss Red Cross	1 800,00
TOTAL	**65 123,81**

- MSC St. Iuliana, Taul –managed by the village municipal office

All of the centres were found functional with clients present when the evaluation team visited. As reported in section 4.4.1., number of clients served are rising in Taul and Balti, while in Stefan Voda the numbers are decreasing. In All of the centres, **medical as well as social services continue being provided and teams have remained the same** (with the exception of staff member leaving for maternity leave) since the handover to local authorities. However, a key factor here is that in the cases of all centres, AOHC keeps supplementing the state level salaries to provide further incentive to the staff. In Taul staff salaries reportedly dropped by 15-30%. In Balti, the salaries dropped by about 40% and in Stefan Voda the income of the staff remains the same (but AOHC supplements about 30% of the salary). However, the resources used by AOHC to further support these centres come from sources other than CZDA, with the exception of medical equipment for in-centre use. At the same time, high level of dedication and sense of attachment as well as responsibility towards the clients was apparent in the teams, added by good atmosphere and staff relations.

The responsible LPAs continue to financially support the centres though in varying degrees.

- In Taul, the municipality covers utilities, heating, fuel for transport and also covers 50% of the repair and maintenance costs for the vehicles. The municipality also provides 50% of the staff salary and in some cases uses creative ways to be able to report that – social workers are e.g. formally employed in the municipality, cleaning lady officially by the school but in reality, they work at the centre. This is because the municipality budget is limited (the most recent one reportedly around 1 mil lei) and thus resources from the district are being used for the salaries. Detergents, medical equipment mainly comes from AOHC (estimated 90%) but the municipality is also trying to help with limited amounts available. Furthermore, AOHC is supplementing the staff salaries. The mayor is also actively trying to identify donor resources to cover other needs in the community.
- In Balti, the Municipality is covering utilities and parts of staff salaries. The estimate of the centre director is that 40% of the centre's funds come from the Municipality and about 35% from AOHC (these cover additions to the staff salaries as well as care equipment (detergents, creams, diapers etc.). In addition, medical equipment and medications are covered by a church organisation. The centre director is actively trying to identify other donor resources and has been able to secure funding from a couple short term projects (1-2 months long).
- In Stefan Voda, the medical centre is covering 50% of the salaries but in case of the nurse, half of her working time is allocated to the medical clinic. The social worker also works part time at the reception desk of the clinic. The remainder of their time, spent in the centre, is financed by AOHC. Utilities are covered by the LPA but all materials necessary to provide the services (creams, diapers, etc.) comes from AOHC. Even the reported 50 000 lei requested for utilities is difficult for the LPA to cover. This is also due to political changes as the original representatives signing the contract with AOHC are now replaced by people from a different political party. The likelihood of the LPA actively trying to seek for other resources is very low in the opinion of the clinic representative. The district is unable to generate any income (no production or industry present) and all the funds come from central level. Estimated 80% of the budget goes to covering salaries in education and social assistance as well as maintenance of buildings. Even in this case, funds to repair a dilapidated hospital are missing. AOHC is seen as a lifeline offering permanent support.

4.6.3 What are the key lessons learned with regards to sustainability of established and/or supported centers?

Good practices identified:

- Careful, in-depth and complex assessment has been carried out in order to select relevant locations with high sustainability potential – this means high need of services, understanding of the LPAs of this high need and ability to address the needs at least partly. LPAs were involved in the process from the very beginning.

- LPAs were aware of the conditions of cooperation in advance and the conditions were also clearly stipulated in the contracts.
- Continuous focus on team building, motivation and well-being of the staff (trainings on burnout, informal and friendly atmosphere, open communication, developing close relations)

Key challenges identified:

- Insufficient financial resources of LPAs to fully cover costs of the centres – salaries are being supplemented by AOHC and more than 90% (in the case of Stefan Voda 100%) of the medical and other necessary equipment is provided by AOHC
- Strong dependence of the centres on AOHC, with the director of AOHC being constantly mentioned as the key contact point
- Overall difficult financial situation of LPAs with budgets not allowing to cover other key needs in the locations
- At the moment centres' staff do not have the ability and skills to identify other sources of funds or to write a project proposal, with the exception of the manager of the Rebecca centre in Balti.

4.7 Visibility and crosscutting principles

4.7.1 Visibility

Visibility requirements such as donor logos on the premises and vehicles were observed during all evaluation visits. Leaflets shown to the evaluation team also carried the logos. Some of the photos from trainings reviewed by the evaluation team also showed that visibility requirements were fulfilled during those events. Source of funding of the interventions was also known to all the key stakeholders interviewed (LPAs, ministries)

4.7.2 Crosscutting principles

Environmental impact.
All centres reported that they dispose of medical and hygienic materials at the site of local health facilities. No negative environmental impact of the interventions was identified.

Good governance
As already described in the sections above, all key stakeholders were consulted and participated in all relevant decision-making moments of the interventions, including formulation and planning. They were also consulted with regards to selecting localities for new centres, agenda and contents of trainings. Their needs and priorities were also reflected in the implementation with e.g. adding new outputs into the projects and continuous provision of external expertise. Though not all the legislative documents are currently actively applied, the process leading up to their drafting was consultative and reflected the priorities and needs perceived by the respective institutions. The role of civil society organisations was described as essential for legislative processes in homecare by all stakeholders and a high degree of transparency was identified, with the exception of NMIC.

Human rights and gender equality
There is no presence of gender disaggregated indicators in the project proposals, but it is irrelevant in the case of this intervention. The access to the centres is open equally to men and women but men are less likely to show interest in the services. Women accounted for about 80% of the centres beneficiaries which is confirmed by national statistics on service provision. The centres report that men in general die younger, there is frequent problem with alcohol, and they are much likely to actively seek out help than women. The most vulnerable clients are served by the centres on ongoing basis and are exception to the three-month service period. They are also top priority of the centres and if identified, they are served immediately with no waiting list.

5 CONCLUSIONS

Stupnice míry naplnění evaluačního kritéria (zdroj: zadávací dokumentace MZV ČR): ***Vysoká*** *– postupy, výsledky a předpoklady plně odpovídají potřebám a stanovenému cíli, resp. příkladům dobré praxe,* ***spíše vysoká*** *– v konkrétním kontextu intervence naplnila maximum požadavků, existují však omezení na úrovni externích faktorů nebo drobné nedostatky týkající se realizace,* ***spíše nízká*** *– významnější nedostatky při nastavení intervence nebo v aplikovaných postupech a/nebo závažné problémy na úrovni externích faktorů,* ***nízká*** *– postupy nebo výsledky intervence neodpovídají stanoveným cílům a/nebo existují kritické problémy na úrovni externích faktorů*

5.1 Relevance

Interventions were relevant to the overall partner country needs as well as to the Bilateral Development cooperation programme. While social and medical homecare to the elderly is recognized as highly needed by all interviewed stakeholders, financial resources available from Moldovan national budget are entirely insufficient and in light of the current political and social situation, significantly exacerbated by the war in Ukraine, it is unrealistic to expect that the country will be able to increase the financial allocations in the near future. Primarily rural areas were covered with additional two new centres established in the distant rural areas, reflecting the difficult living conditions and access to services for the elderly residents of these areas. The services provided in the framework of the projects encompassed wide array of the elderly beneficiaries needs and were often the only source of assistance to the elderly. Focus was placed on improving capacities of staff as well as organisations in the sector, in line with maximising efficiency given the limited resources available. *Relevance of the intervention is rated as* ***high.***

5.2 Coherence

The evaluated interventions were in line with the priorities and needs of the socially inclusive development sector. This was mainly supported by ongoing presence of the implementing organisations in the field and intensive cooperation with authorities both at national and local level. Expertise and support made available through the interventions and active participation of the implementers in USCP have produced outputs relevant to the development of the sector and developed/strengthened necessary skills of care providers' staff as well as public institution workers. Through active advocacy and developing a pilot project offering possible solutions, the interventions also tried to address the key challenge of the sector – the fact that medical and social services fall under two different Ministries and are also financed from two different budgetary levels.

The overall long-term focus on homecare services allowed for in-depth understanding of the needs of the sector and creation of good working relationships with state actors as well as actors in the NGO sector. Cooperation with the relevant Ministries from the onset of Czech homecare interventions also supported sustainability at local level as establishment of all centres was consulted. The clarity of conditions for establishing new centres, commitment needed as well as financial participation of local public authorities were also found to be examples of good practices which are generally applicable to all development cooperation initiatives. The key challenge posed by separate treatment of medical and social services is not something that an intervention at a level of development cooperation programme can solve but requires a much more robust reform.

The project implementers have cooperated with national state level actors as well as other NGOs on long-term basis. Planned outcomes and focal areas of the projects, as well as geographical locations of the centres were discussed with relevant stakeholders. Key objectives and needs of the key relevant actors were actively considered. Coherence of the intervention is therefore rated as ***high.***

5.3 Efficiency

Continuous investments in the equipment of centres as well as ongoing training of staff have strongly contributed to full use of the centres by clients and overall growing demand for the services. The equipment used as well as specific skills of centre's staff are unique in the context of Moldovan health and social sector and are being fully used. Numbers of clients in two out of three centres from previous projects keep growing

and the recently established centres also report numbers which indicate that the quantitative indicators regarding numbers of clients served will be fulfilled. Given the staff numbers, the hybrid model of the centres functioning is efficient. Implementers as well as the donor also reacted swiftly to challenges occurring in the course of the project and duly adapted to the changing context, without significantly affecting the overall planned outcomes and outputs.

*Overall efficiency is rated as **high.** The intervention has fulfilled maximum of the indicators possible to achieve given the national context. Resources available were actively used with growing numbers of clients with the exception of one centre. Changes necessary were made in time and mainly resulted either from COVID-19 pandemic or national level processes.*

5.4 Effectiveness

Quality

Integrated homecare services are uniquely provided by NGOs in Moldova and their quality is also much higher than the care available from state. The quality of care provided in the framework of the interventions is further supported by in-depth initial and regular continuous trainings. The trainings directly reflect on the knowledge and skill set of the staff. They are very practical as compared to rather theoretic education provided by medical colleges. A key added value of the trainings is the focus on communication with clients, personalised and empathic approach. All of the benefits of trainings perceived by staff also play out in highly positive client experience of the services. Interventions have also positively influenced skillsets of USCP member NGOs with concrete results displaying in their work practices.

Accessibility

The interventions significantly increased accessibility to both health as well as social services. The resources for these services provided by the state are very limited and overall, the system is able to cover bare minimum of the needs, mainly at health level. In the rural areas which are targeted by the interventions, it is even possible to state that the interventions **created access** to the services. Numbers of clients served have grown significantly and there is growing demand for the services from the served as well as neighbouring communities. Yet, the existing needs in the communities are not covered to the full extent due to limited capacities of the centres and the neighbouring communities are unserved. The three-month cycle service cycle supports access of more clients to the services but also means that the services are of short term whereas most clients would welcome the services on permanent basis. The teams are addressing this issue and serve the most vulnerable clients on ongoing basis though the frequency of visits may drop. The existing project indicators focusing on USCP NGOs extended service provision are only partly relevant to describe the situation in the field where most NGOs focus on addressing the needs of clients in the communities they are already serving, in light of limited capacities and funding sources. Majority of the NGOs interviewed either extended or plan to extend their services.

Usefulness of submitted legislative documents

The contribution of the intervention to developing legal framework for homecare services is strong and clear and all the outputs produced in the evaluated interventions are considered relevant and useful. However, they are being applied in differing levels, in some cases there was no information on follow-up due to staff turnover issues.

Influencing factors

All the supporting factors identified can be used as positive practices for other development interventions. Inhibiting factors largely fall out of the possibility of the interventions to address and require higher level interventions impacting on overall economic development of the country and generation of resources to sufficiently allocate to the health and social sector, including boosting capacity of staff at national institutions.

The services provided are of high quality, which is further nurtured by trainings, it is also possible to say that the interventions created access to the services in some of the most distant communities. Level of need and demand is higher than the interventions can currently satisfy. Legislative outputs of the project are considered

*relevant but not always fully applied by the national institutions. Effectiveness of the interventions is therefore rated as **rather high.***

5.5 Likely Impact

Raising the profile of integrated homecare services as a necessary and relevant model for Moldovan authorities is the key identified impact of the intervention. There are numerous factors which are not possible to effectively address at this intervention level which prevent further systemic changes. While some of the drafted documents are being used by state authorities and actively followed up, this does not yet fully impact on the ground. There is now, however, significant expertise built up in Moldova which can further support implementation of the legislative changes into practice and is also a good basis for further share of expertise in the country.

*Impact is rated as **rather high.** Examples of changes were identified along with significant external barriers to achieve further systemic changes planned in the interventions.*

5.6 Sustainability

It is difficult to assess the sustainability of the centres in Vulcanesti and Ocnita as the handover was not finalised at the time of data collection. While the situation in Vulcanesti is unclear and yet to be finalised, stakeholders in Ocnita have expressed fears about the future due to lack of financial resources available.

National programmes in Moldova do not always benefit from adequate financing, endangering achievement and sustainability of the measures envisaged by the programmes. As a rule, donor aid is a temporary source of financing. Similar situation was also identified in the cases of the centres established in the previous projects and supported in the most recent intervention. Overall lack of financial resources of LPAs in the selected localities is a key challenge though they are able to uphold their contractual obligations. All the centres continue to be very dependent on AOHC, which is however to keep supporting the centres mainly with resources other than CZDA funds, and often associate AOHC with its director only. At the moment, the capacity of the teams of the centres (except MSC Rebeca (Balti)) to attract additional funds is very low. If this support stops, the centres will likely not be able to continue providing the services at the same level or at all. The centres are built on very solid and stable teams who, together with AOHC, are the backbone of the centres. In most cases, after the centers are transferred to the management of public institutions, the workload increases but the remuneration decreases, or remains the same but additional duties are introduced.

*Sustainability of the interventions is rated as **rather low.** AOHC plays a key role in continuing the activities of the centres while LPAs are only partly able to maintain the activities of the centres. Given their highly limited resource capacities, ongoing financing of the centres, albeit partial, can be considered a success. Proper sustainability measures were also taken during project implementation.*

5.7 Visibility and crosscutting principles

5.7.1 Visibility

Visibility requirements were found to be fulfilled in the interventions along with awareness of the source of funding by key stakeholders from relevant institutions. *Visibility is rated as **high.***

5.7.2 Crosscutting principles

No negative environmental impact of the interventions was identified. Principles of good governance were of key importance for the implementers who made sure that all key stakeholders were consulted and participated in all relevant decision-making moments of the interventions, including formulation and planning. The processes of drafting legislative documents were consultative and reflecting priorities and needs of all parties. Gender equality is not a relevant principle in case of this intervention – access is open to all, but women in general seek out the services more, a trend which is in line with national statistics. Needs and rights of vulnerable clients are addressed to the maximum degree possible given the limited capacities of the centres and high demand for

the services. *Overall, the reflection of crosscutting principles is rated as **high** especially with regards to good governance.*

6 RECOMMENDATIONS

6.1 Recommendations related to the projects and continuation of CZ DC

Table 4: Recommendations related to the projects and continuation of CZDC

Recommendation	Addressee	Degree of priority	Reasons behind and further comments
Continue to support the homecare sector in Moldova with focus on supporting the system reform.	MZV CZ, CzDA	1	Reasons behind are stated in conclusions to section on coherence, relevance and effectiveness. Czech Republic now has long-term experience and understanding of the context, issues and challenges and equally a well-established position and relations with the key stakeholders.
Focus on further strengthening the fundraising skills of AOHC and consider how fundraising skills can also be strengthened at the level of centres. Models of external mentoring, ideally not associated with AOHC, may be a solution.	CzDA	1	Reasons behind are stated in conclusions to section on sustainability. While not all the centres have the right staff to take up fundraising, there are some centres where the managers or responsible LPAs (Balti, Taul) are already actively seeking out donor funding and at this point are heavily reliant on AOHC expertise in fundraising as well. The centre in Vulcanesti, where the administrator has relevant education (management, economics) and potential to further develop professionally, could be another example. It is important to keep in mind that this responsibility cannot be added on to the responsibilities of the caregivers in the team.
Consider possible expansion of the centres and adding mobile teams which could serve neighbouring communities with the highest need.	CzDA	2	Reasons behind are stated in conclusions to section on effectiveness. There may be willingness from the neighbouring municipalities to share part in financing the teams, though this was not something that this evaluation explored. Expanding the services of the centres may not only create access to these services in the neediest rural communities but, in the long term, it could also enhance the chances of the services to be contracted by the National Health Insurance Company.
Consider options for interventions which would lead to income generation in the municipalities/districts where centres are present.	CzDA	1	Reasons behind are stated in findings and conclusions to section on sustainability. Creating social enterprises or supporting local business could be an option to generate at least partial financing for these centres and at the same time create employment opportunities in the area.
Making the services paid or partially paid by the clients is not advisable.	CzDA	1	Reasons behind are stated in findings and conclusions to section on effectiveness and sustainability. The clients are struggling to cover the costs of medications they need and would be unable to contribute to the cost of these services. In practice, it would be barring the neediest and vulnerable population from accessing the services and creating a system where only those in better financial position would be able to benefit – something which directly contradicts the idea of increasing accessibility.

6.2 Recommendations regarding process issues

Table5: Process recommendations

Recommendation	Addressee	Degree of priority	Reasons behind and further comments
Actively support and motivate AOHC in internally delegating responsibilities to other staff members.	Implementer	1	Reasons behind are stated in conclusions to section on sustainability. The overt reliance of the centres on the director of AOHC and possibly also internal management of the AOHC with one person strongly dominating the situation may be a risk to future sustainability of AOHC and the interventions on overall level.