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IMPROVING PRIMARY HEALTH CARE IN ALBANIA: PRO SHËNDETIT



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HEALTH SYSTEMS

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END OF PROJECT REPORT

DISCLAIMER

The authors view expressed in this publication do not necessary reflect the views of the United States Agency for International Development or the United States Government.

Table of Contents

LIST OF ACRONYMS	7
EXPRESSION OF APPRECIATION	9
PROLOGUE	10
EXECUTIVE SUMMARY (ES)	11
1 BACKGROUND ALBANIA AND USAID	18
2 INTRODUCTION	19
3 KEY PARTNERS	21
4 LEVERAGED OPPORTUNITIES	22
5 GEOGRAPHIC COVERAGE	23
6 ACHIEVING INTERMEDIATE PROGRAM RESULTS AND THEIR IMPACT	25
6.1 IMPROVED PHC POLICY AND REGULATORY ENVIRONMENT.....	25
6.1.1 <i>Background</i>	25
6.1.2 <i>Partners and Achievements</i>	25
6.1.3 <i>Lessons Learned</i>	29
6.1.4 <i>Products</i>	29
6.2 BETTER MANAGEMENT OF PHC RESOURCES	30
6.2.1 <i>Background</i>	31
6.2.2 <i>Partners and Achievements</i>	32
6.2.3 <i>Lessons Learned</i>	35
6.2.4 <i>Products</i>	36
6.3 HIGHER QUALITY PHC SERVICES	37
6.3.1 <i>Background</i>	37
6.3.2 <i>Partners and Achievements</i>	38
6.3.3 <i>Lessons Learned</i>	41
6.3.4 <i>Products</i>	41
6.4 INCREASED ACCESS TO ESSENTIAL PHC SERVICES	42
6.4.1 <i>Background</i>	42
6.4.2 <i>Partners and Achievements</i>	43
6.4.3 <i>Lessons Learned</i>	47
6.4.4 <i>Products</i>	49
7 SUMMARY OF RESULTS	50
8 LOOKING FORWARD	55
ANNEX A - GRAPHIC PORTRAYAL OF THE RESULTS FRAMEWORK FOR PHASE I AND II OF PRO SHËNDETIT	57

LIST OF ACRONYMS

AAFP	American Academy of Family Physicians
ABC	Activity Based Cost
ANC	Antenatal Care
AFPP	Albanian Family Planning Program
CCE	Center for Continuous Education for Health workers
CME	Continuing Medical Education
COPE	Client Oriented Provider Efficient Services
COTR	Contracting Officer Technical Representative
CPD	Continuing Professional Development
CPG	Clinical practice guidelines
CYP	Couples Years of Protection
DFM	Department of Family Medicine
EOPR	End of Project Report
ES	Executive Summary
GP	General Practitioner
FM	Family Medicine
FoM	Faculty of Medicine
FoN	Faculty of Nurses
FP	Family planning
GoA	Government of Albania
HC	Health Center
HP	Health Promotion
HPIAG	Health Promotion Inter Agency Group
HII	Health Insurance Institute
HIS	Health Information System
HRF	Health Reform and Financing
IEC	Information, Education & Communication
INSTAT	Institute of Statistics
IPH	Institute of Public Health
IR	Intermediate Result
JSI	John Snow Inc.
LoA	Letter of Agreement
MCH	Mother and Child Health
MoH	Ministry of Health
MoU	Memorandum of Understanding
M&E	Monitoring and Evaluation
MBP	Minimum Basic Package

MSH	Management for Science and Health
NCQSAHI	National Center of Quality, Safety and Accreditation of Health Institutions
NGO	Non Governmental Organizations
NRT	Neonatal Resuscitation Training
NTP	National Tuberculosis Program
PHC	Primary Health Care
PHR	Partners for Health Reform
PSD	Professional Development System
PSh	PRO Shëndetit
PHC	Primary Health Care
QI	Quality Improvement
SDC	Swiss Agency for Development and Cooperation
RH/FP/MCH	Reproductive health/family planning/maternal and child health
TB	Tuberculosis
ToT	Training of Trainers
WB	World Bank
WHO	World Health Organization
USAID	United States Agency for International Development
UNFPA	United Nations Population Fond
UNICEF	United Nations Children's Fond
UNDP	United Nations Development Program
URC	University Research Co., LLC

EXPRESSION OF APPRECIATION

It is impossible to achieve the accomplishments of PRO Shëndetit without an extraordinary set of partners. Staffs at the Ministry of Health, Health Insurance Institute and other institutions, have been patient and untiring in their collaborative work. It was often “extra work” for them to push the PRO Shëndetit agenda along. Even though the agenda was to benefit them and their organizations, they had a normal work load prescribed by everyone else. Working with PRO Shëndetit was often extra work. The leadership and staff at the Department of Family Medicine at the Faculty of Medicine assisted by the American Academy of Family Physicians played an essential role in developing modules and training General Practitioners (GPs) in six prefectures. Their insights on how to make the training process function were essential. Management Sciences for Health from the US and the Faculty of Nursing in Tirana assured that the material for nurses was correct and up to date. The Institute of Public Health and the Health Educators Network helped create a web of health information that reached a previously unimagined breadth of coverage in Albania. The gracious and tireless Neonatology Department at the Maternity Hospital “Koço Glozheni” helped PRO Shëndetit take an opportunity and turn it into national coverage for training maternity staffs in neo natal resuscitation. The National Center of Quality, Safety and Accreditation of Health Institutions has been a supportive collaborator at many points during the past six year, as has the Order of Physicians, and most recently the new Center for Continuing Education. During the ups and downs of project life and achievement of major objectives, USAID has played a supportive, cheering, and guiding role. Bearing Point was a contracting partner during Phase I of the project and assisted in helping establish the agenda in health financing. The American Association of Family Physicians was a sub-contracting partner during both phases and deserves strong recognition for the role it played in modular development and training of General Practitioners and in proffering useful guidance in family medicine. Hellenicare (through a USAID supported projected) provided resources for PRO Shëndetit to extend GP and nurse’s training into an additional, sixth, prefecture. The staff associated with the local Liahona Foundation worked tirelessly with PRO Shëndetit, the MoH, and USAID to ensure equipment, trainers of trainers, and Albanian text books were provided to establish the national training program in neonatal resuscitation. There have been many Albanian specialists that have served as consultant in guiding the program. To all of the above groups and individuals a very hearty expression of appreciation is offered. And last, but certainly not least, URC has been exceedingly fortunate to have the staff that has been PRO Shëndetit. The story that is the rest of this report would not have happened without them.

PROLOGUE

USAID's PRO Shëndetit (Improving Primary Health Care) program, implemented by University Research Co. LLC (URC) consisted of two phases. The first phase was from August 2003 through October 2006, and the second phase from October 2006 through September of 2009. Both phases were competitively bid by USAID, won and implemented by URC. This End of Project Report (EOPR) – at the request of USAID Albania – incorporates both phases into a single report. Phase I was earlier reported as if there may not be a Phase II, but both phases are seamlessly presented in this report.

A DVD is part of the report. All of the major products produced by PRO Shëndetit, over its six-year period, are electronically included on the DVD, rather than interspersed throughout the report or assembled in annexes at the end of the report. The DVD is set up so that a reader can easily move between documents and other products and copy those that might be most relevant for further use.

EXECUTIVE SUMMARY (ES)

PRO Shëndetit has been USAID Albania’s largest project in health care, over a period of six years. PRO Shëndetit (phases I and II) represented a \$12 million United States commitment to improving Albanian’s health. The objective of this commitment has been to improve health for Albanians through primary health care – basic maternal and child health care that reaches all of Albania.

USAID had good reasons to look at supporting primary health care in Albania. During the Communist era and coming out from it, there had been considerable neglect of primary health care. The Government of Albania initiated a number of programs, including one that compensated General Practitioners for accepting assignments to serve in remote areas. Nevertheless, the combination of a neighboring war with an influx of refugees, the collapse of a national economic pyramid system that led to civil unrest, and a large migratory movement from rural to urban areas, especially to Tirana, placed the basic health care system of Albania, and the health of its citizens, in a precarious situation at the turn of the century. USAID decided to make a difference through primary health care, hence smaller projects in restoring health centers and a small demonstration project and then the two contracts to University Research Co., LLC that covered six years (2003-2009) divided into two three-year contracts.

In 2004, with limited resources, USAID determined to influence selected primary health care services in targeted geographic areas. PRO Shëndetit focused of five prefectures: Berat, Dibër, Korçë, Lezhë, and Shkodër; however, the reach and impact on the project extends to other prefectures, and, with some activities, to all Albania. Half way through the first phase of the project USAID had an external team conduct an assessment of its health portfolio. The team recommended that the Strategic Objective of the results framework – the over arching logical guide for the project – be changed from “improved selected primary health care in targeted areas” to “better health care for Albanians.” The assessment team also recommended a specific intermediate result of “improved PHC policy and regulatory environment.” In phase I, policy and regulatory had been a cross cutting agenda, but was not explicitly stated as an intermediate result. The intermediate results, leading to the strategic objective, are shown in the four rows of the grid. The team also recommended the fourth intermediate result (in the lower left cell of the grid) from “use of PHC services” to “access to PHC services.”

The changes did not appreciably affect on-the-ground activities of the project. Consequently, the grid on the right adequately reflects the strategic framework for both Phases I and II¹.

The mostly blue columns represent the four working units or components of the project, formed to achieve the intermediate results and through them the strategic objective.

ES FIGURE 1: STRATEGIC OBJECTIVE: BETTER HEALTH CARE FOR ALBANIANS

Intermediate Results (IR)	Project Components for Achieving Results			
	Health Financing	Health Information	Health Promotion	Service Delivery
Improved PHC <u>policy</u> and <u>regulatory</u> environment	X	X	X	X
Better management of PHC resources	X	X	X	X
Higher quality PHC services	X	X	X	X
Increased <u>access to</u> essential PHC <u>services</u>	X	X	X	X

The Xs under a component show that the component had an impact on and was partially responsible for achieving the intermediate result of a particular row. The darker shaded cells and Xs reflect that a strong and fairly direct impact was made by the component. A lighter shade and X indicates there was an impact by the component but not as strong of an impact as represented by the darker shade and X.

¹ Graphic presentation of the logical frameworks for phase I and II can be found in Annex A

One clear observation is that all of the components had moderate to strong impact on each of the intermediate results. A single example is given for each intermediate result

Improved Policy and Regulatory Environment: The best single way to show that the often nebulous concept of “environment” (trust, attitudes, willingness-to-collaborate, give-and-take in discussion and debate, and committed decision makers at appropriate levels) was improved is to list the policies and regulatory outcomes resulting from the improvement. Health Financing and its partners were a strong driving force for the policy on single source payer in PHC.

Better Management of PHC Resources: Health information – training and implementation of HIS in five prefectures and establishment of a policy for a national PHC information system.

Higher Quality PHC Services: The Service Delivery component and partners excelled with this intermediate result, including Basic Package of Services for Primary Health Care, CPD for nurses and GPs, and Quality improvement tool developed and implemented.

Increased Access to Essential PHC Services: One of the easiest ways to convey the success of Health Promotion and its partners in creating awareness of services and community involvement – sub elements to be achieved under the intermediate result – are the results shown in the following table. It comes from a June 2009 survey. HP and partners taught over 204 thousand individuals (one third male) in five topics.

ES FIGURE 2: PERCENT OF MARRIED WOMEN 15-44, WHO HAVE HEARD OF HEALTH PROMOTION ACTIVITIES, FROM WHOM DID THEY LEARN ABOUT ACTIVITIES, KNOWLEDGE OF WHO ORGANIZES ACTIVITIES, AND WHETHER THEY HAVE PARTICIPATED IN ACTIVITIES

Women in 2009 selected group	From whom did you learn about HP activities?			Do you know who organizes activities	Have you participated in activities
	Doctor	Nurse	Other community member		
50 percent who heard of HP activities	36.8	75.0	10.0	73.9	62.3
All women in 2009 selected group	18.5	37.7	5.4	37.1	31.3

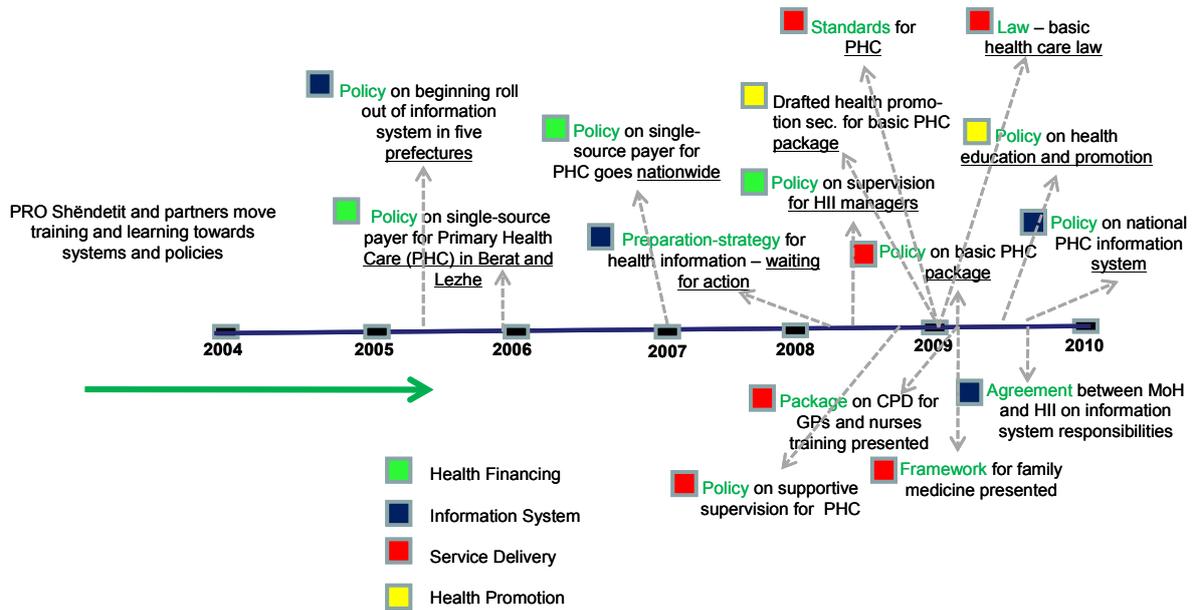
The results on the right show that 50 per cent of all married women in the prefectures had heard about health promotion. As can be seen, the persons they heard from were health professionals. Out of all women in the three prefectures sampled, nearly a third had participated in HP activities. Among those women who had heard of HP activities, 62 percent had participated. In reference to community awareness, involvement, knowledge, and an increased expectation regarding both services and quality, the figures speak loudly.

Highlights within the report are time lines associated with each of the four intermediate results. The timelines provide a thumbnail sketch of key activities, events, and results associated with working towards the achievement of that IR over a six year period. By color coding each of the four project components, it becomes clear how each one – along with its partners – contributed toward achieving the IR.

The time line permits a reader to see the combined effort of each component and its specific partners.

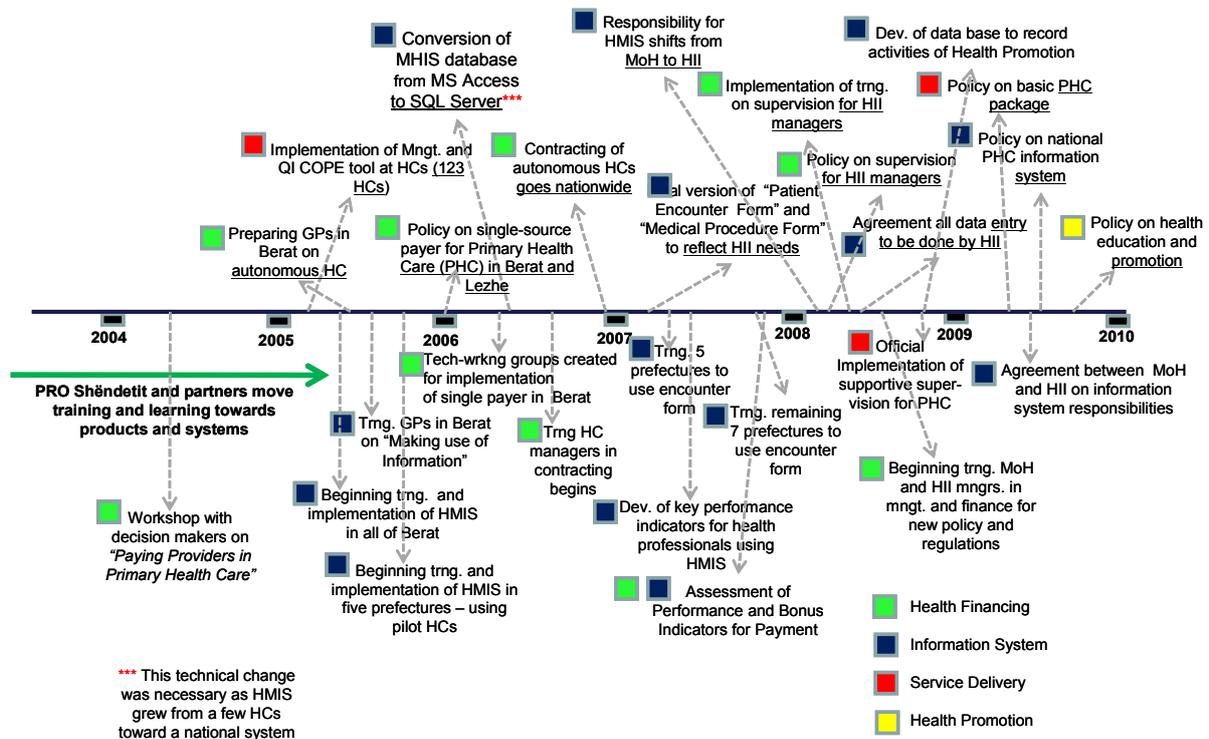
The improved PHC policy and regulatory environment time line – ES figure 3 – shows key outcomes and results, which were products of the “improved environment”. The comment and arrow on the left of the figure reflect – only in a very small way – the amount of training and work that each component and its partners entered into in order to move towards the systems and policies represented along the line.

ES FIGURE 3: TIMELINE OF IR: IMPROVED PHC POLICY AND REGULATORY ENVIRONMENT



The second intermediate result, better management of PHC resources, (ES Figure 4) included working to improve management at the systems level as well as management down to health centers. Many of the achievements made in the area of management were results of changes in policies and regulations. Consequently, some of the achievements from one time line show up as contributing inputs, outcomes, or results on another time line; it is a reflection of the nature of how interrelated things are.

ES FIGURE 4: TIMELINE OF IR: BETTER MANAGEMENT OF PHC RESOURCES

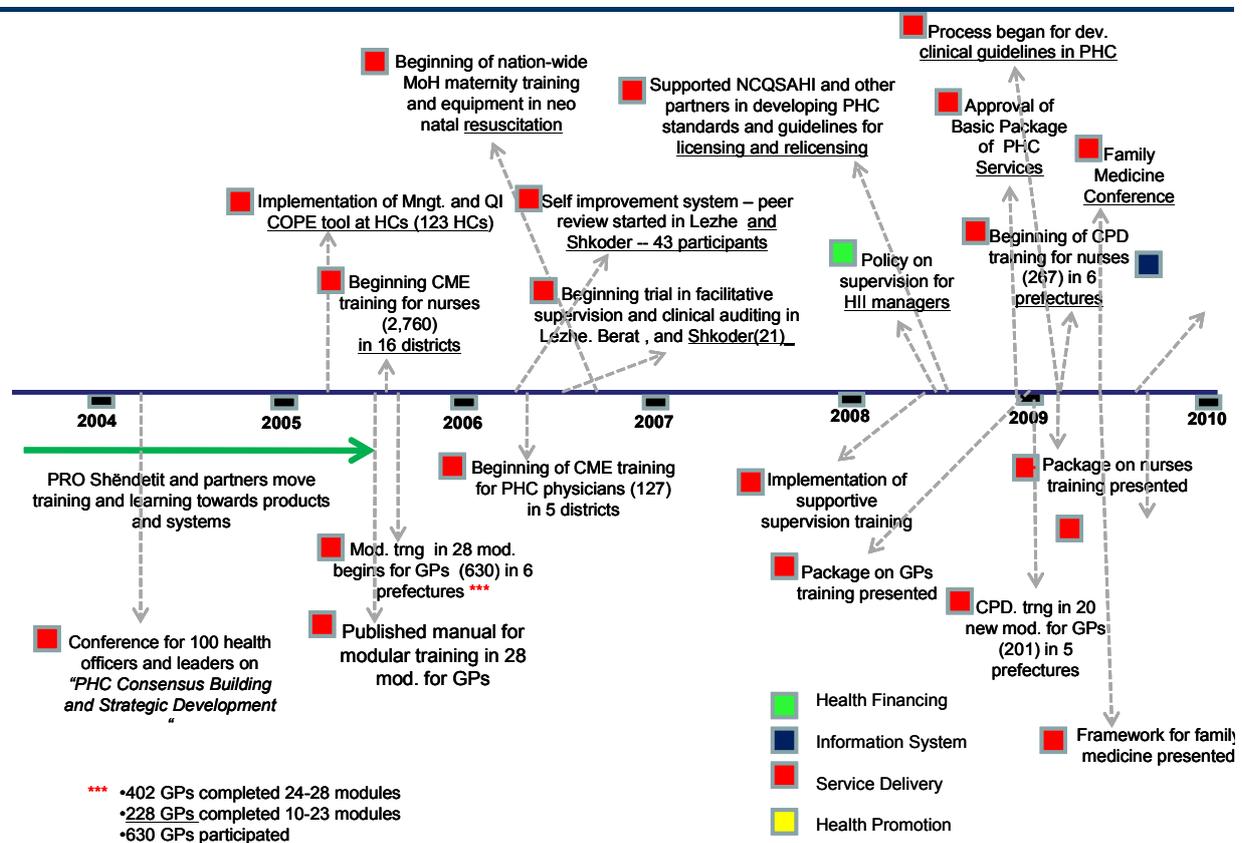


Given the objective of “better management of PHC resources,” it can be seen that many of the achievements, leading toward results reflect key steps taken to move towards products and systems. If the time line is followed from left to right, the major outcomes leading toward many of the important policies and regulatory guidelines that take place near the end of the project can be seen.

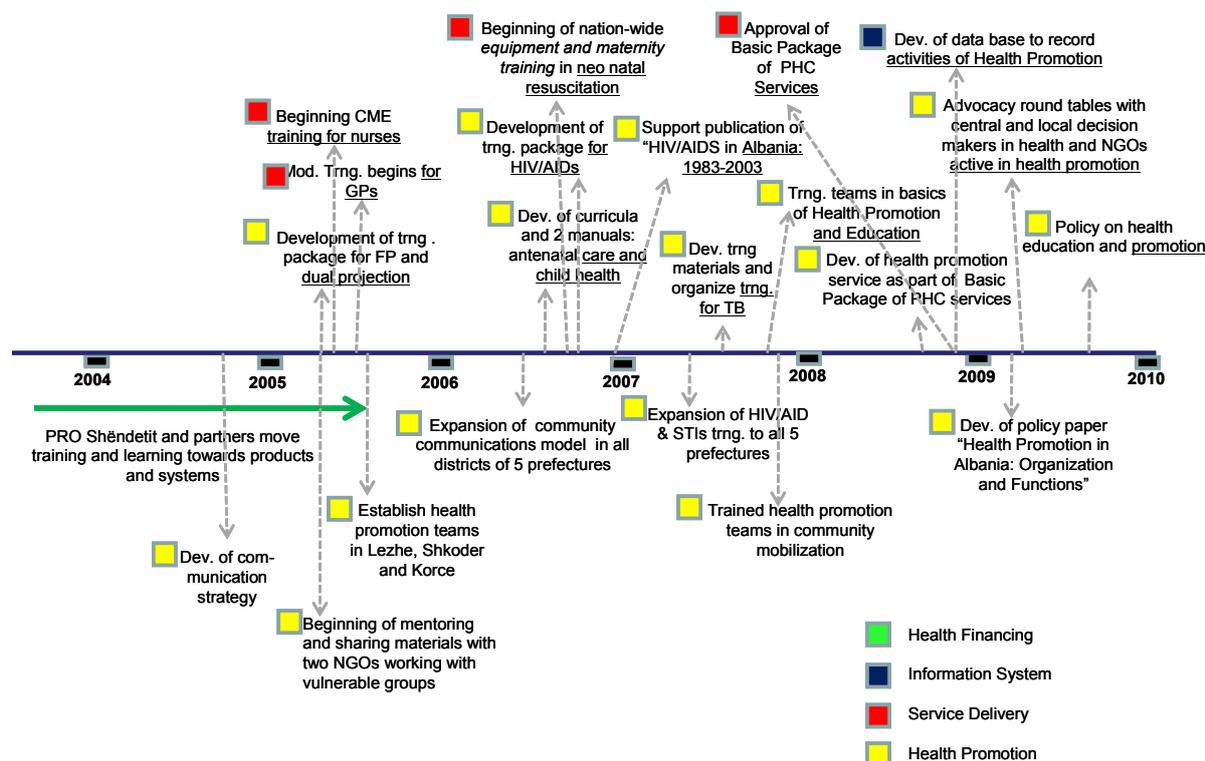
The Intermediate Result: higher quality of PHC services, (ES Figure 5) was influenced by every component and the components’ partners, but was the central focus of the Service Delivery component. In the case of this Intermediate Result, as with the others, additional key outcomes or policies could be added as things that bear an influence on the quality of PHC services. In order to show key events or outcomes and simplify the mix and overlap that is the real world, decisions have been made to present just the events portrayed on the accompanying time lines.

The next time line for Intermediate Result increased access to essential PHC services (ES Figure 6), demonstrates that there was multiple component influence in achieving success. However, it was the Health Promotion component that had central focus on this IR. This was because the objectives that were emphasized in achieving the IR were greater awareness of health priority areas, PHC services and community participation.

ES FIGURE 5: TIMELINE OF IR: HIGHER QUALITY OF PHC SERVICES



ES FIGURE 6: TIMELINE OF IR: INCREASED ACCESS TO ESSENTIAL PHC SERVICES



The success of the Health Promotion component and its partners can be seen from their achievement of a policy about health education and promotion, where none previously existed.

In the full report, not only the time lines provide evidence of achievements, but lists of major products – many not shown on the time lines – are provided. With the electronic version of the report the user can click on any item in the lists and be taken directly to an electronic copy of the product – many in both Albanian and English.

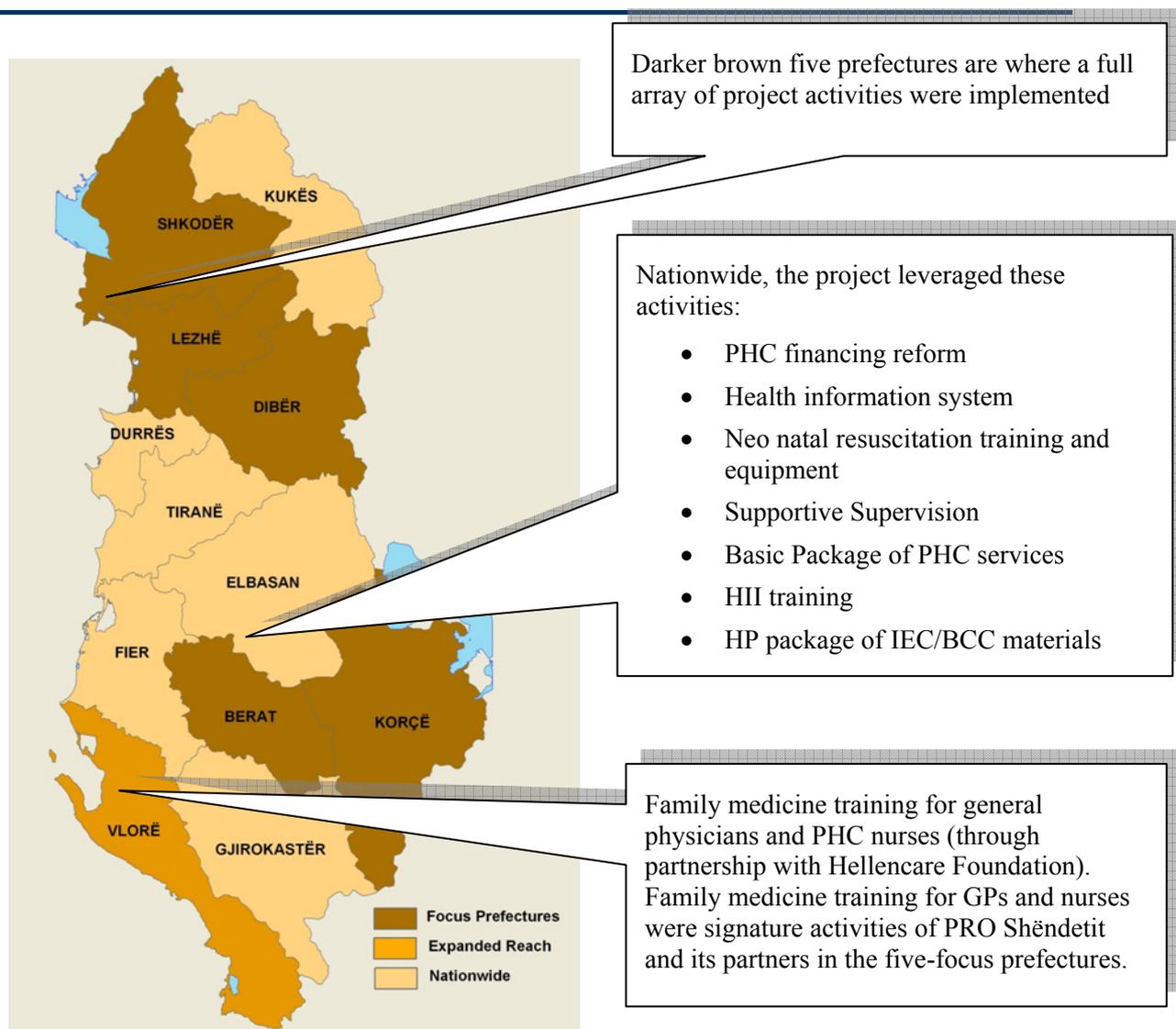
ES FIGURE 7: PERCENT OF MARRIED WOMEN 15-44 WHO HAVE KNOWLEDGE OF 3 OR MORE MODERN METHODS OF CONTRACEPTION IN 2002, 2005, AND 2009 (SELECTED GROUP): SHKODER, LEZHE, AND KORCE

Method	Reproductive Health Survey - 2002		Pro Shëndetit Survey - 2005		2009 Selected Group
	All Albania	3-Prefec-tures	3-Prefec-tures	Percent Change	
Know 3 or more modern methods	68.2	62.2	63.7	1.5 +	95.3

Besides the results evident on time lines and in lists of products, there are three population based surveys for different points in time that show change in knowledge and behavior over time: people-level results. The first two surveys, 2002 and 2005, use similar methodology and are comparable. The survey in 2009 is a purposive sample in that it surveyed only villages where HP had been active. This means the percentage should be higher than random samples of all persons would produce. It is, and provides a rough comparison of change in knowledge of modern methods of FP. There are ten people-level tables similar to this figure that provide strong argument that both knowledge and behavior have changed in PRO Shëndetit prefectures and they are changing in the direction of “better health for Albanians.”

PRO Shëndetit and partners were able to expand project impact into areas far beyond the five initial focus prefectures. The final ES figure, Figure 8, shows the success of the project and its partners in leveraging successes into other prefectures, and, in some instances, nationwide.

ES FIGURE 8: INITIAL FIVE-FOCUS PREFECTURES AND PRO SHËNDETIT AND PARTNERS' LEVERAGED REACH



What was achieved by PRO Shëndetit and partners is a firmer foundation and framework for PHC, from which the GoA can effectively move forward. The strategic objective of the project still remains – improving the health of Albanians; it is a continuing process. Improving health will always require attention and effort. Based on the experiences of PRO Shëndetit and partners, and looking forward, a few key recommendations are provided.

Improved PHC Policy and Regulatory Environment

- Distribute PHC resources – staffs, HCs, and equipment –rationally based on population size, geography, and defined health needs, for example, chronic diseases and MCH services. As soon as new census results are available, the updated population numbers should be used to allocate resources.
- Continue to improve the performance-based payment approach for the health centers (HCs);

- Develop a public-private partnership framework in primary health care. This will entail further costing studies and clarification through regulation and legislation of what being “insured” or “uninsured” means in terms of access to benefits and posted co-payments.

Better Management of PHC Resources

- Continue to use the health information system for PHC, at all levels of the health system, for 18 months (end of 2010) without changing the software or overall system. At the end of 18 months there should be a health information team formed to recommend the future direction that the PHC information system should take.
- Continue to implement the Supportive Supervision System in HII in predefined areas for 18 months, until the end of 2010. At that time a thorough assessment needs to be undertaken to determine how best to alter and expand the system for HII throughout Albania.
- Hire appropriate family medicine staff for strengthening the Supportive Supervision System in PHC and monitoring and evaluation units at prefecture level. Separate budget for supervision visits should be provided at all levels.

Higher Quality PHC Services

- Organize accredited CME session for nurses in PHC to unify the many different categories of nurses that exist in PHC.
- Set up system for qualifying GPs working in PHC to become certified family physicians.
- Launch an aggressive campaign to: 1) ensure that all PHC workers understand the Basic Package of PHC Services (BPS), and 2) based on the rationalization of the distribution of PHC resources (see first bullet) that MoH and HII undertake to ensure that every HC has what is needed to offer the BPS.

Increased Access to Essential PHC Services

- Reorganize health promotion department at the Institute of Public Health to reflect the goals and objectives of the new policy on health education and promotion.
- Allocate dedicated budget for health promotion within the Institute of Public Health; also provide rationalized, dedicated budgets for health promotion at the Regional and Public Health Directorates.
- Develop continuous education program in health promotion, accredited by the National Center of Continuous Education, and managed by the Department of Health Promotion at the Institute of Public Health.

1 BACKGROUND ALBANIA AND USAID

Albania inherited the Russian Semashko health model² based on centrally-directed public health care, dominated by medical specialties and neglecting holistic primary health care. Under the system, there were high numbers of providers and hospital beds. At health centers there was a trio of services: internal medicine (“pathology”), pediatrics, and gynecology, delivered by general physicians. Over 50 percent of patients visiting the health centers were referred to the secondary level. Today it is estimated by most informed observers that 80 to 90 percent, or even more, of the cases that come to a health center as a first stop, should be able to receive the treatment needed at the health center.

USAID stands out in Albania among donors in recent years as the major contributor to primary health care. USAID contributed to rehabilitation of health centers and health posts during the latter part of the nineties and during the first part of the current decade. Other USAID programs, such as the program to train providers in family planning and establish the logistical management of contraceptives, have been important and reached all Albania. The pilot health-center program in Berat (PHRplus) made an important contribution to exploring a new model for PHC.

² A uniform model of organizing health services introduced in Central and Eastern Europe/Commonwealth of Independent States countries after the Second World War and abolished in the early 1990s. Financing of health services is entirely through the state budget, with publicly owned health care facilities and publicly provided services. Different levels of state administration—central, regional, and local—were responsible for planning, allocation of resources and managing capital expenditures

2 INTRODUCTION

There were two separate contracts for the program URC implemented in Albania; the strategic objectives were similar, and both contracts are melded into a single program report. Contract one³ (Phase I) had the strategic objective of “Improved selected primary health care services in targeted areas.” Midway during URC’s implementation of Phase I there was a USAID assessment of all its health investments in Albania,⁴ and, as a result, the second contract⁵ (Phase II) had a slightly expanded strategic objective of “Better health care for Albanians.” Both objectives were focused on primary health care.

The intermediate results (general strategies) selected to achieve the strategic objectives received slightly varied emphasis in the strategic frameworks of the two phases. The intermediate results used in phase II are captured in the first column of Figure 1. The only difference in the intermediate results between the two phases is that “Improved PHC Policy and Regulatory Environment” was added as an explicit intermediate result in Phase II, and the fourth (final) intermediate result was changed from “Use of PHC Services Increased” (Phase I) to “Increased Access to Essential PHC Services” (Phase II). These changes were made because it was felt they better conceptualized how the project should work to achieve the strategic objective. It did not change the on-the-ground activities of the project to any large extent. Consequently, the intermediate results shown in the table from phase II, effectively lend themselves to both phases of the project.⁶

The remaining four columns of Figure 1 are devoted to the four units or components of the project. The X in the cells of all four rows in a column reflects that each component had an influence and impact on each of the intermediate results. The bold darker cells and bolder Xs indicate that the influence on that IR was strong and direct. The less dark cells and Xs indicate that the health financing and health information components had an influence on access and use of services, but the influence was not as strong as in other areas. The same can be said for health promotion, while having an influence on the policy and regulatory environment, it did not have as direct or as strong of an influence as the other three components.

To most easily show the progress made by PRO, Shëndetit and its partners the bulk of the report is divided into four sub sections, each representing one of the intermediate results. Each of these subsections is further broken down into four sections as follows:

- A brief background of important issues associated with the intermediate result.

³ Contract 182-C-00-03-00105-00 from 8/1/03-10/31/06 for \$6,502,647.

⁴ Strategic Appraisal, USAID/Albania Health Strategy and Portfolio Achievements: Opportunities and a Way Forward, Harriett Destler, team leader, Joyce Holfeld, and Nathan Blanchet, USAID October 2005

⁵ Contract GHS-1-00-03-00029-00 from 9/30/06 – 9/29/09 for \$5,499,453.

⁶ The graphic portrayal of the results framework from Phases I and II can be seen in Appendix A.

FIGURE 1: PROGRAM INTERMEDIATE RESULTS AND PROJECT ORGANIZATION TO ACHIEVE THE RESULTS

Intermediate Results	Strategic Project Components for Achieving Results			
	Health Financing and Reform	Health Information System	Health Promotion	Service Delivery
Improved PHC <u>policy</u> and <u>regulatory</u> environment	X	X	X	X
Better management of PHC resources	X	X	X	X
Higher <u>quality</u> of PHC services	X	X	X	X
Increased <u>access</u> to essential PHC <u>services</u>	X	X	X	X

Component Legend

-  Health Financing
-  Information System
-  Service Delivery
-  Health Promotion

- A second section is titled “achievements and partners.” This section uses table and time-line formats, as they are useful ways to highlight achievements and key partners associated with components of the project. The time line provides a visual of when – over time – components and partners accomplished various achievements.

In this section color coding is introduced. It can be confusing to read about activities, partners, program components, and achievements and understand who did what, when, and with whom. The color legend shown with a color for each component, is used to associate project components with achievements.

- The third section is titled “lessons learned” and the content is precisely what the title states.
- The fourth and final section under each intermediate result is titled “products.” In this section a list of products produced by PRO Shëndetit and partners is provided. For a reader using the electronic report, it is only necessary to click on the name of products to be taken to an electronic copy.

3 KEY PARTNERS

To achieve the targeted results and objectives, it was important to have good partners. Key partners within Albania were;

- The Ministry of Health (MoH);
- The Health Insurance Institute (HII);
- The Faculty of Medicine (FoM) and most important within the Faculty, the Department of Family Medicine (DFM);
- National Center of Quality, Safety and Accreditation of Health Institutions (NCQSAHI);
- Institute of Public Health (IPH);
- The Order of Physicians;
- New Center for Continuing Education (CCE);
- Maternity Hospital “Koço Glozheni”;
- Health Educators Network (developed by the Health Promotion component);
- Faculty of Nursing (FoN);⁷
- World Health Organization;
- USAID funded health projects (Access FP, C-change);
- Other organizations (UNFPA, UNICEF, UNDP, Peace Corps, ACPD, Action Plus, Stop Aids, American Red Cross, Albanian Red Cross, etc.).

Outside of Albania:

- American Academy of Family Physicians;
- Bearing Point (Phase I only);
- Hellenicare, a US based Foundation (provided PRO Shëndetit the opportunity to expand training to include doctors and nurses in Vlore through a USAID Grant);
- Liahona Foundation (NGO arm of The Church of Jesus Christ of Latter-day Saints). This provided PRO Shëndetit the opportunity to work with MoH and Maternity Hospital “Koço Glozheni” to develop a national neonatal resuscitation program);
- Management Sciences for Health (MSH) provided very useful assistance in developing modules for nurses training.

3.1 Partner Agreements and Operation

In order to assure clear understanding of objectives and commitments a Memorandum of Understanding was developed between the MoH, USAID, and PRO Shëndetit early in Phase II. Further, to assure common understanding of objectives and needed operations to attain these objectives, a Technical Assistance Group (TAG) was established. The TAG was made up of key persons from relevant partners and met each quarter to review progress, make joint decisions about needed changes and continuing implementation. The MOU outlining major goals and commitments and the regular TAG meetings contributed toward smoother project implementation and jointly shared successes.

⁷ The Faculties of Nursing are in Tirana, Vlorë, Shkodër, and Korçë.

4 LEVERAGED OPPORTUNITIES

URC was committed to leveraging the resources of the project not only for having greater coverage geographically, but also for producing impact in PHC areas closely associated with program activities. There are a number of distinct areas where the leveraging efforts proved highly beneficial

Notably, PRO Shëndetit collaborated with the Ministry of Health in various phases of implementing the World Bank funded Health System Modernization Project. Initially, PRO Shëndetit staff worked with WB officials as they designed the project. The objective of the project is to improve physical and financial access to, and use of, high quality primary health care. An emphasis has been on the poor and under-served areas, as well as on decreasing unnecessary use of secondary and tertiary care facilities. PRO Shëndetit efforts have assisted the MoH and HII to be more effective in implementing reforms in provider payments and health system performance nation-wide.

PRO Shëndetit staff worked closely with USAID when the Swiss Agency for Development and Cooperation (SDC) first began the process of designing its current Professional Development System (PDS) program in Albania. PRO Shëndetit activities on the ground influenced the design of the program. There has been continuing collaboration with the Swiss funded program's Center for Continuing Education (CEE) since it started. PRO Shëndetit provided to CEE a training package for nurses training, a set of modules to be used in training GPs, and a framework for family medicine. Through PRO Shëndetit's initiation of programs in five-focus prefectures and continuing collaboration, programs will now spread nation-wide.

PRO Shëndetit, the MoH, Maternity Hospital "Koço Glozheni", and USAID worked together to engage a faith-based organization⁸ to bring its training expertise and equipment to Albania. This program resulted in nation-wide training in neonatal resuscitation for health professionals working in maternities.

PRO Shëndetit also worked closely with the MoH and USAID to partner with Hellenicare, a US-based foundation, to expand the GP and nursing modular training, which have become important signatures of PRO Shëndetit, into an additional prefecture.

PRO Shëndetit worked vigorously to leverage its resources available for health promotion to produce a much larger impact than would be expected. Specifically, PRO Shëndetit coordinated efforts with the JSI FP program in Albania in training Health Care providers and community workers in FP. PRO Shëndetit also proposed to and received support from UNFPA in developing and printing the whole set of IEC materials in FP and MCH. Leveraging the project's initial resources has resulted in a nation-wide supply of IEC materials in these areas.

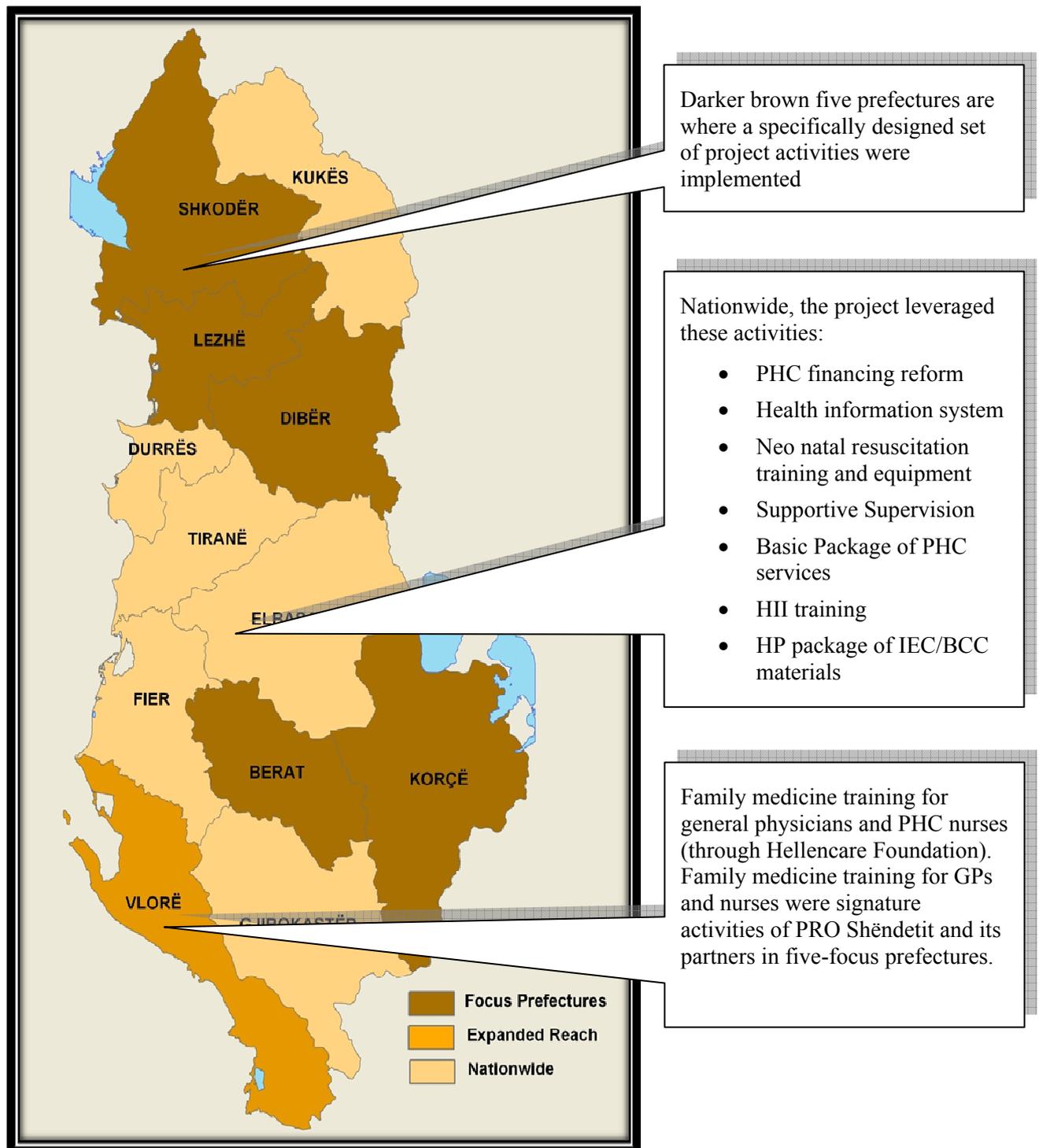
⁸ The Church of Jesus Christ of Latter-day Saints has an active neo natal resuscitation training program in which they provide equipment trainers, and training materials to many countries.

5 GEOGRAPHIC COVERAGE

The strategic objective of Phase 1 states, there were to be targeted areas, i.e., in discussion with the MoH and USAID the project initially selected five-focus prefectures: Berat, Diber, Korce, Lezhe, and Shkoder. The five were selected because of the mix of rural, urban, and small village composition and because they represented major geographical regions within Albania. Nevertheless, URC maintains an interest in leveraging successes achieved through its projects into coverage of other geographical areas when possible. Through successful partnerships with the MoH, the Health Insurance Institute, The Faculty of Medicine, Local health Authorities and others, PRO Shëndetit has been able to achieve results and have impact in prefectures beyond the original five, and, in fact, to achieve national coverage with selected interventions.

The map on the following page (Figure 2) shows the geographic leverage PRO Shëndetit was able to achieve beyond the initial targeted five prefectures. A specific array of project and partner intervention activities were developed and conducted in the five-focus prefectures. In addition, financing reform and the health information system, and the quality improvement, have expanded nationwide; PRO Shëndetit has assisted with that expansion. Further, working with the MoH, Maternity Hospital “Koço Glozheni”, and USAID, PRO Shëndetit was able to recruit and work with a faith-based organization that provided equipment and training in neo natal resuscitation for MoH maternities nationwide. As mentioned previously, PRO Shëndetit partnered with Hellincare/USAID to be able to provide coverage in one additional prefecture (Vlorë) for modular training of GPs and nurses.

FIGURE 2: INITIAL FIVE-FOCUS PREFECTURES AND PRO SHËNDETIT'S LEVERAGED REACH



6 ACHIEVING INTERMEDIATE PROGRAM RESULTS AND THEIR IMPACT

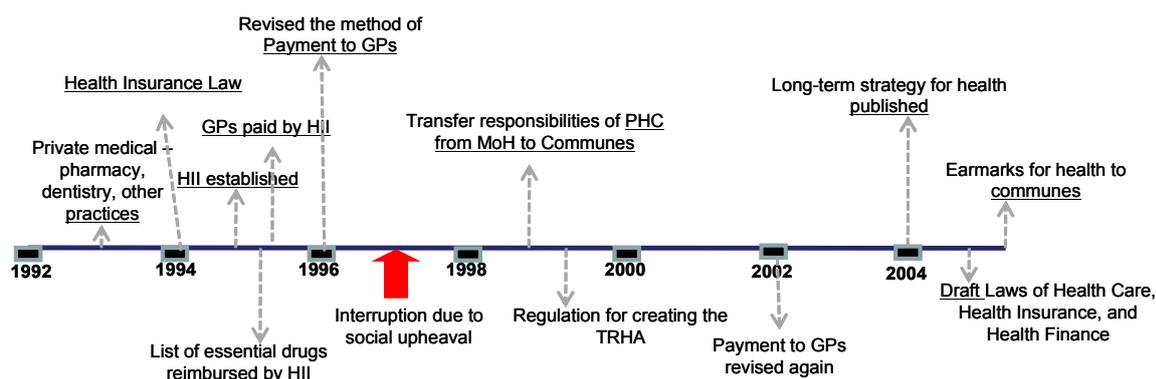
6.1 Improved PHC Policy and Regulatory Environment

Policy is a product of the country. PRO Shëndetit worked with appropriate GoA officers and staffs in assisting the developmental process. It is sometimes wrongly thought that policy is born only at the highest of levels and then trickles down to all relevant units or elements within a country. Except in the most highly centralized systems, e.g., communistic, policy seldom takes place in this manner. Professionals at many levels try out various ideas that they believe might help them move good health practices forward. Some of these work well enough that they percolate up the system and result in policies. It is often necessary for advocacy groups, representing professionals as well as businesses and other private organizations to lobby and “sell” their ideas about what should become policy. It is also true that countries have many external organizations giving advice and applying pressures and these organizations do not always have the same perspective as to what should be priority in the policy arena. It is part of the role of a good, collaborative project to work with partners as they sift through competing ideas in order to resolve what will work best in the country. PRO Shëndetit worked from many directions and at various levels to assist in improving the PHC policy and regulatory environment.

6.1.1 Background

The first time line shown in Figure 3 highlights key policy and policy-like decisions, with direct or potential impact on PHC, that had been made in years preceding the project up until its early beginning. Very important was the privatization of some health care (1993), the formation of the Tirana Regional Health Authority, and the creation of the Health Insurance Institute (HII). Various PHC responsibilities were shifted to HII (payment of general practitioners) and to local government offices (responsibility for running costs of health centers). The long-term strategy for health of 2004⁹ was not immediately implemented as a plan, although it did reflect national and international beliefs about how the health program should be moved forward. The strategy appeared almost as a guide for much of the PRO Shëndetit program (as did separate WB and WHO documents): policy, quality improvement, better management, and health promotion. The current Health System Strategy: 2007-2013¹⁰ continues to list three of its four priorities as – management, access, and financing.

FIGURE 3: TIME LINE OF PRECEDING PHC POLICY –RELATED EVENTS



6.1.2 Partners and Achievements

Since the key set of partners most important to PRO Shëndetit in working to improve the PHC policy and regulatory environment often serve different roles, the matrix shown as Figure 4 assists in

⁹ Long Term Strategy for the Development of the Albanian Health System, April 2004

¹⁰ Health System strategy: 2007 to 2013, p. 12 (DRAFT).

clarifying the partners and their multiple roles. The listing of the policy and regulatory areas (in the rows) and dates, summarizes much of PRO Shëndetit’s achievement for this particular intermediate result.

PRO Shëndetit was fortunate to have a number of exceptionally dedicated and committed partners. Even through many organizational changes there were key persons who remained in senior positions and assisted the project to move forward. Figure 4 lists partner organizations that were essential to the work. Mostly GoA organizations are listed, although occasionally assistance was provided by other entities, projects, the Order of Physicians in Albania, NGOs, and from time to time international entities such as WHO and UNFPA. USAID is not listed, although staff there provided continual and essential assistance. USAID staff proved particularly useful in the policy and regulatory portion of PRO Shëndetit’s work. Figure 4 does not include Bearing Point, an important contractual partner assisting in work with the health finance policy environment during Phase I of PRO Shëndetit. In addition, the project’s collaborative work with the Neonatology Department at the Maternity Hospital “Koço Glozheni” and the Liahona Foundation led to drafting a charter for forming a neonatology accreditation program. Although PRO Shëndetit believes that the accreditation will take place in the future, there is no reference to those organizations in Figure 5.

FIGURE 4: PRO SHËNDETIT KEY PARTNERS AND ACHIEVEMENTS IN THE POLICY AND REGULATORY ENVIRONMENT

Policy and Regulatory Areas	Key Partners									
	MoH	HII	FoM (DFP)	FoN	AAFP	CCE	NCQS AHI	IPH	INST AT	
Starting implementation of the plan for the new HIS rollout- <i>Order of the Min. (March 05)</i> 	X									Component Legend  Health Financing  Information System  Service Delivery  Health Promotion
Single source payer for PHC (Common Regulation) – <i>Decree of Council of the Ministers (Dec. 05)</i> ¹¹ 	X	X								
Single source payer for PHC – Decree of Council of Ministers (<i>Dec. 06</i>) 	X	X								
Basic PHC package – Order of the Min (<i>Feb. 09</i>) 	X	X	X		X		X	X		
Framework for Family Medicine – presented to MoH, HII, CCE, and Faculty of Medicine (<i>Feb. 09</i>) ¹² 	X	X	X		X	X	X			
Package of modules for nurses training, TOT, and Job Aids – presented to Min and CCE (<i>Feb 09</i>). 	X	X		X		X				
Package of modules for GPs training (<i>Jan 09</i>) 	X	X	X		X	X				
Supportive Supervision system for PHC– <i>Order of Minister (Sept 08)</i> 	X	X	X			X				

¹¹ The single-source payer agreement is referred to as the Common Regulation and includes how to contract between health centers and HII, payment to professional staff partially on performance, and an initial listing of what should be contained in the basic package of primary health care.

¹² The framework includes recommended teaching modules, job aids, and a proposal for recognizing GPs who have received modular training be certified as family physicians.

Supervision program instituted for HII management – <i>Order of Dir. Gen. HII (08)</i> 	X	X							
Policy on Health Ed. and Promotion, – <i>Order of Min (June 09)</i> 	X	X					X	X	
National PHC information system (CSIS) – <i>Order of Minister (June 09)</i> ¹³ 	X	X							X
Agreement between MoH and HII on CSIS responsibilities – <i>(June 09)</i> 	X	X							
Preparation Strategy for CSIS waiting for action – <i>(2008)</i> 	X	X							X

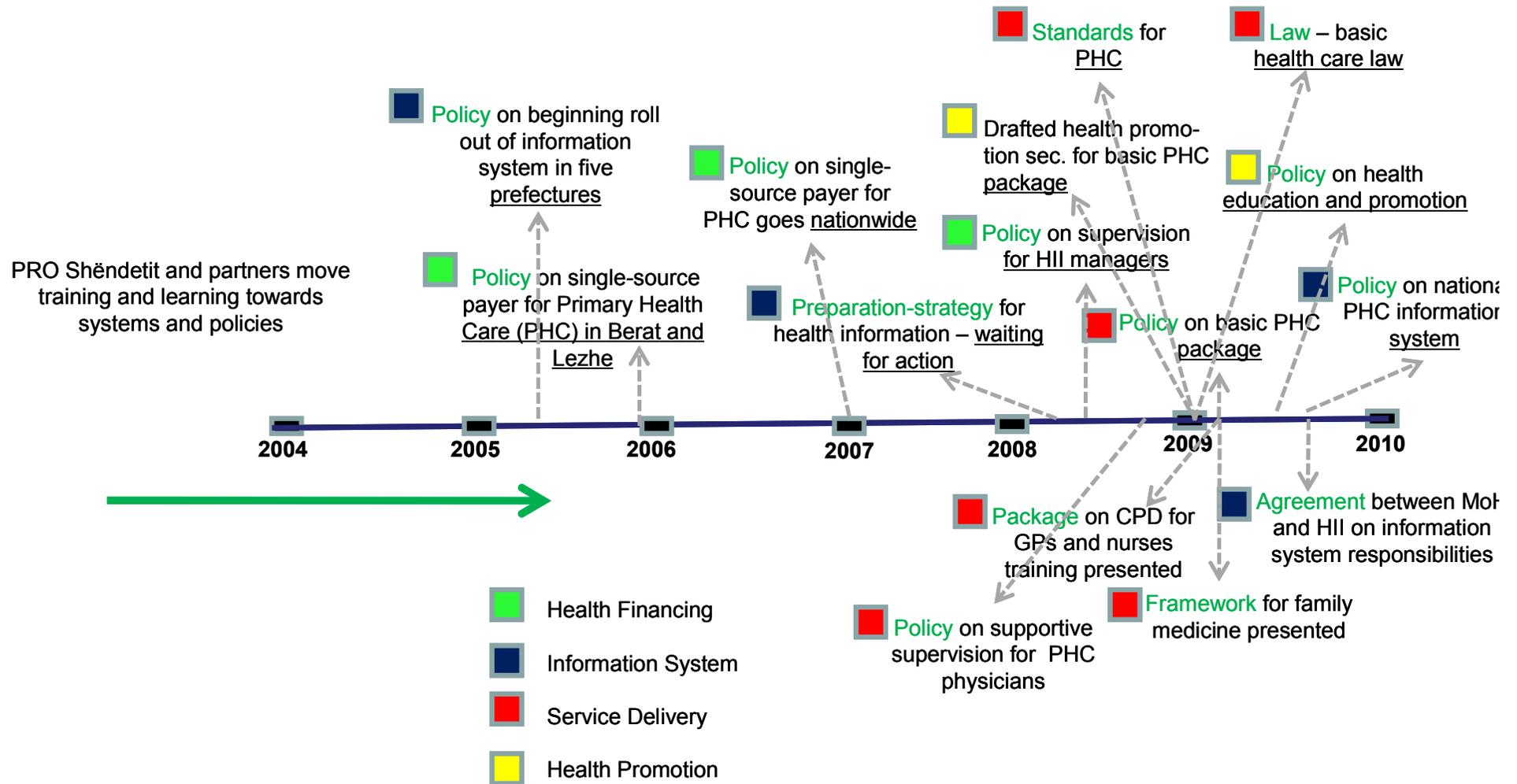
While this section of the report is focused on the policy and regulatory environment, it cannot be adequately understood without acknowledging the sometimes long gestation period of policy and regulatory change. Many activities were undertaken and working relationships entered into during the early part of the project that only later found their way into policy and regulatory-related outcomes. A simple example from project experience illustrates these points.

The Health Financing Component of the project became engaged with partners in a lengthy education process in order to assist the appropriate persons to understand and then make decisions to move PHC from a multi- to a single-payer system. Although the potential benefits of a single-payer system were being discussed before the beginning of PRO Shëndetit, a great amount of energy and resources of the project were given to having partners become comfortably informed as to what might be involved: 1) training sessions with prefecture, district, and HC heads on a single-payer autonomous system, budgeting, and contracting; 2) an ongoing study group with key professionals; 3) two study tours for decision makers, 4) sponsored conferences, and 5) writing of reports and drafting exemplary materials. In hindsight these can be seen as contributing to a predefined end – policy changes. Nevertheless, at the time of the single events with their energy and other resource costs – to an outside observer – did not necessarily appear to be leading toward the desired end. Similar examples can be drawn from the work of all components of the project. The process involved reflects the incremental nature of the policy and regulatory environment and of policy and regulatory changes.

The two time lines of Figures 3 and 5 show selected PHC-related policy and regulatory changes over the past almost 18 years. Earlier in this report, comment was made about a few of the changes made pre PRO Shëndetit. In order to provide a comparative perspective, it should be noted that Figure 3 time line has two-year intervals and Figure 5 has single-year intervals. The time line in Figure 5 reflects the incremental nature of building towards policy and regulatory change.

¹³ This order states that the “patient encounter form” and “medical procedure form” are the official formats for recording clinical services and health promotion at PHCs.

FIGURE 5: TIME LINE OF PHC POLICY RELATED EVENTS DURING PRO SHËNDETIT



The lengthy process shown in summary format simplifies PRO Shëndetit and partners' areas of achievement for the reader, but oversimplifies to a very large degree the efforts and accommodations that were necessary for partner organizations and project staff to accomplish the achievements. For example, there were two national elections during the achievement period, five ministers of health, two directors of HII, and a myriad of other changes among partner staff with whom PRO Shëndetit was directly working, sometimes for months to achieve an objective. In addition, on a very large scale, a significant part of the responsibility for PHC was transferred from the MoH and communes to HII during the latter part of 06 and the beginning of 07. Everyone involved was defining new roles, learning new responsibilities, and developing new relationships.

6.1.3 Lessons Learned

It is a truism, but in policy development, as in no other area, flexibility and adaptation are very important parts of a successful intervention. There is, however, more that underlies the project's success than this truism. It was essential to work with partner staff all up and down the lines of authority. As the lines changed, in most instances, already informed new colleagues were ready and willing to collaborate on the work at hand. Equally important was an effort to share information and borrow useful ideas that then became a shared pool of expertise from which everyone, new or old, benefited. Perhaps it will be seen as another truism, but, especially in the area of policy, working closely with the USAID COTR, who often knew (or needed to know) changes and decisions that were being made that could affect program success was essential.

6.1.4 Products

Key products are provided in the following list. For those readers using the DVD it is only necessary to click on the link to be taken to a copy of the product.

The first intermediate result, for which products are listed, is "improved policy and regulatory environment." The best single way to show that the sometimes nebulous concept of "environment" (trust, attitudes, and willingness to collaborate, give-and-take in discussion and debate, and committed decision makers at appropriate levels) was improved, is to list the policies and regulatory outcomes resulting from improvements. On the time line of Figure 5 and in the grid of Figure 6, outcomes or products are listed. As policy and regulatory products in this report often have influence on, say, management improvement or quality of services, as well as policy, the results or products may appear in more than one intermediate result section.

FIGURE 6: INTERMEDIATE RESULT – IMPROVED POLICY AND REGULATORY ENVIRONMENT

PRO Shëndetit Phase I			PRO Shëndetit Phase II		
Products	English	Albanian	Products	English	Albanian
Health Care Financing and Reform in Albania	▲	▲	Analysis of HII Expenditures toward the Minimum Benefit package of PHC in Five Prefectures	▲	Abstract
Primary Health Care Financing Contract	▲	▲	Analysis of HII Expenditures towards the Minimum Benefit Package of PHC in five Prefectures – Technical Brief	▲	▲
Common Regulation for Contracting of Primary Health Care Services	▲	▲	Health Reform in Albania: Results achieved and tasks remaining. The role of PRO Shëndetit Project, 2003-2009	Abstract	▲
Training Needs Assessment	▲	▲	Supportive Supervision – Training Manual	Abstract	▲

FIGURE 6: INTERMEDIATE RESULT – IMPROVED POLICY AND REGULATORY ENVIRONMENT

PRO Shëndetit Phase I			PRO Shëndetit Phase II		
Products	English	Albanian	Products	English	Albanian
Situational Analysis (Funding of Primary Health Care)	▲	▲	The Reform in PHC: Management and Financing of Health Centers – Training Manual I	Abstract	▲
Budgeting Information for HC in Berat and Lezhë	▲	▲	The Reform in PHC: Management and Financing of Health Centers – Training Manual II	Abstract	▲
Council of Ministers Agreement on the Pilot Project in Berat Region	▲	▲	Preparation-strategy for Health Information – waiting for action	Abstract	▲
Contracting and Performance Management in the Health Sector	▲	▲	Policy on Supervision for HII Managers	Abstract	▲
Report on training needs and curriculum development	▲	▲	Framework for Family Medicine in Albania	▲	▲
A Proposal for the design and Development of Relicensing and Accreditation systems for Family Physicians in Albania – A White Paper for Discussion	▲	Abstract	Basic Package of Primary Health Care Services	▲	▲
Information Technology and Wide are Network (WAN) Feasibility Study (for HII)	▲	Abstract	CPD Nurses Package	Abstract	▲
Council of Ministers Decision on National Health reform	▲	▲	CPD Doctors Package	Abstract	▲
			Policy on Health Education and Promotion	Abstract	▲
			Agreement between MoH and HII on Information System Responsibilities	Abstract	▲
			Policy on National PHC Information system	Abstract	▲

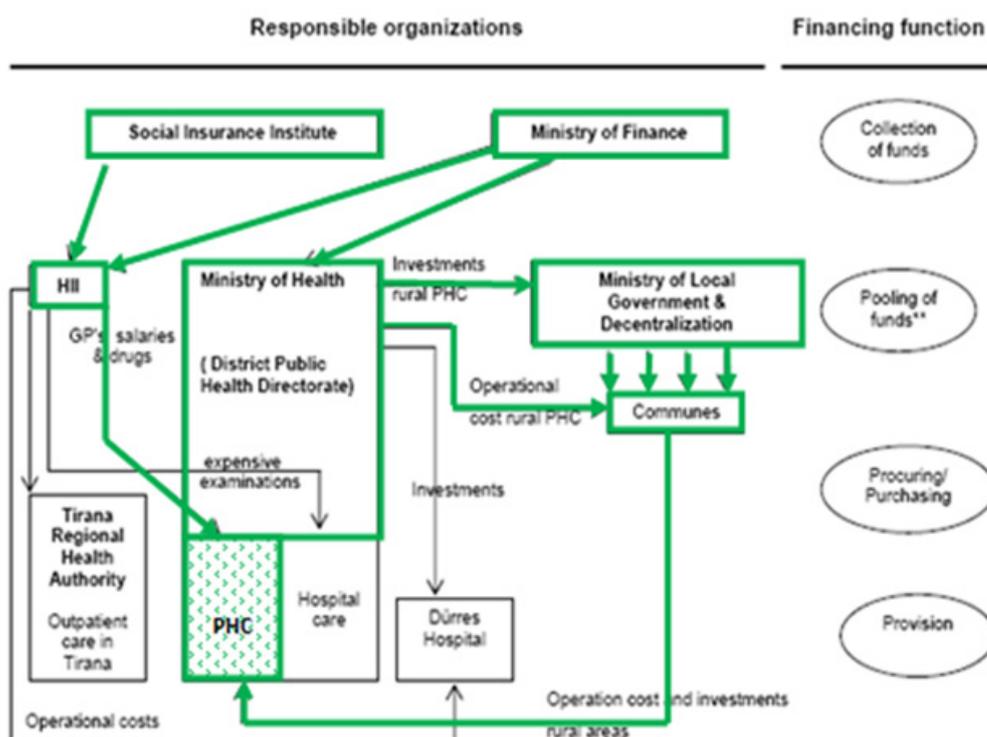
6.2 Better Management of PHC Resources

While it is true that the Albanian health system, like those in almost all lower-income countries, is in need of many additional resources, it is equally the case that there can be better management of available resources. The need for improved management often extends from very top ministerial levels down to the bottom HC levels. For example, there has been need for improved management at the system level in health, e.g., the way that funds flowed and were managed, the way that the overall system collected information to use in decision-making, and on down to health centers where physicians and nurses were not always making good time and resource decisions.

6.2.1 Background

After the fall of Communism, the flow of funds to PHC had evolved in various directions, based on differing attempts to “fix” concerns and problems as they arose. As shown in Figure 7, this led to multiple – and sometimes competing if not conflicting flows of resources to PHC. Easy and clear management of the overall PHC process was, as it is shown in the figure, impossible. The color green has been used to show PHC-related flows of resources within the larger health system.

FIGURE 7: FLOW OF FUNDS TO PHC PRIOR TO FINANCING REFORM



Funds were pooled from government in three organizations – HII, MoH, and MoLG&D – and then distributed through multiple mechanisms as resources to PHC. No one organization or department was clear as to what all of the resources were or who was responsible for them.

To make the whole system even more unwieldy, up-to-date information for making decisions, whether at the system level or at the health center clinic level, were not available. HII was in the process of developing information for its needs; the MoH relied on the written registry system that existed at each health center. While this system provided data, it was slow in making its way into the arena of decision makers.

No effort was made to build a Health Management Information System that would support the management of human and financial resources at the PHC health centers based on accurate data collected in a timely and appropriate way. No common consensus between institutions interested in health data like MoH, HII, IPH, INSTAT, SII was achieved to help drafting a strategy for the development of a national HIS. No experience in inter-institutional data sharing for management purposes and decision making. One could find some fragmented, manually collected and processed pieces of health data coming from the registries instead. There was a very little use of information because of poor quality of data (no reliable data to support decision making), fragmented information flow, no feedback of the information to the providers and the health centers, time consuming data consolidation and processing, extracting the data from the paper – based registries was asking for enormous efforts from the providers leading to errors and nullifying the information value. The centralized vertical power system was allowing very little management responsibility to the providers and the directors of the health centers causing a total indifference in the health data utility and use. No

incentives for the providers to self-improve, providers not well trained in use of ICD9 codes and HII focused at the management of the fund for reimbursed prescriptions only. All these factors were working against the use of information for quality improvement.

The plight of those working in the field was made even more difficult as few of the physicians and almost none of the nurses had management skills other than what they had developed on the job. For a few health professionals, developed skills were good; for most professionals they were not. With an expanding work force in PHC, it was difficult to find fairly-well functioning health centers let alone well managed operations.

It was against this backdrop – the HII struggling to manage PHC funding, the MoH without timely and accurate information on PHC, and doctors and nurses at the health center level besieged with expectations to be both care givers and managers – that USAID developed the ideas leading to PRO Shëndetit. USAID had funded a demonstration project in a few health centers in Berat (PHR+) and believed it was time to deal with the problems surrounding PHC on a broader level.

6.2.2 Partners and Achievements

The discussion of partners and achievements for this intermediate result is similar to the discussion of partners and achievements for the preceding IR (improving the policy environment). The key partners working with PRO Shëndetit to achieve “better management of PHC resources,” often served multiple roles. A matrix similar to Figure 4 is used here. The matrix, shown as Figure 8, assists in identifying key partners and their multiple roles. The listing of factors contributing to the better management of PHC resources (in the rows) and dates indicating initial development summarizes much of PRO Shëndetit and partners’ achievements for this particular intermediate result.

FIGURE 8: PRO SHËNDETIT KEY PARTNERS AND ACHIEVEMENTS IN BETTER MANAGEMENT OF PHC RESOURCES

Management of PHC Resources	Key Partners						
	MoH	HII	FofM (DFM)	CCE	NCQS AHI	IPH	INSTA T
Initiating COPE HC management tool – 123 HCs (<i>Jan. 05</i>) 	X						
Beginning trng. and use of HIS in all of Berat (<i>Mar. 05</i>) 	X						
Trng. GPs in Berat in making use of information (<i>June, 05</i>) 	X						
Beg. trng and use of HIS in 4 new prefectures – 2 pilots each prefecture (<i>Oct. 05</i>) 	X						
Single source payer for PHC in Berat and Lezhe (<i>Dec. 05</i>) 	X	X					
Working group on Design of the Single Source Payer for PHC (<i>Jan, 06</i>) 	X	X				X	
Trng. of GPs in Contract Management and payment of Providers (<i>March, 06</i>) 	X	X					
Conversion of MHIS database from MS Access to SQL Server (<i>April, 06</i>) 	X						
Contracting of autonomous HCs goes nationwide (<i>Jan. 07</i>) 	X	X					
Trng HC manager in contracting begins (<i>Jan. 07</i>) 	X	X					

Component Legend

-  Health Financing
-  Information System
-  Service Delivery
-  Health Promotion

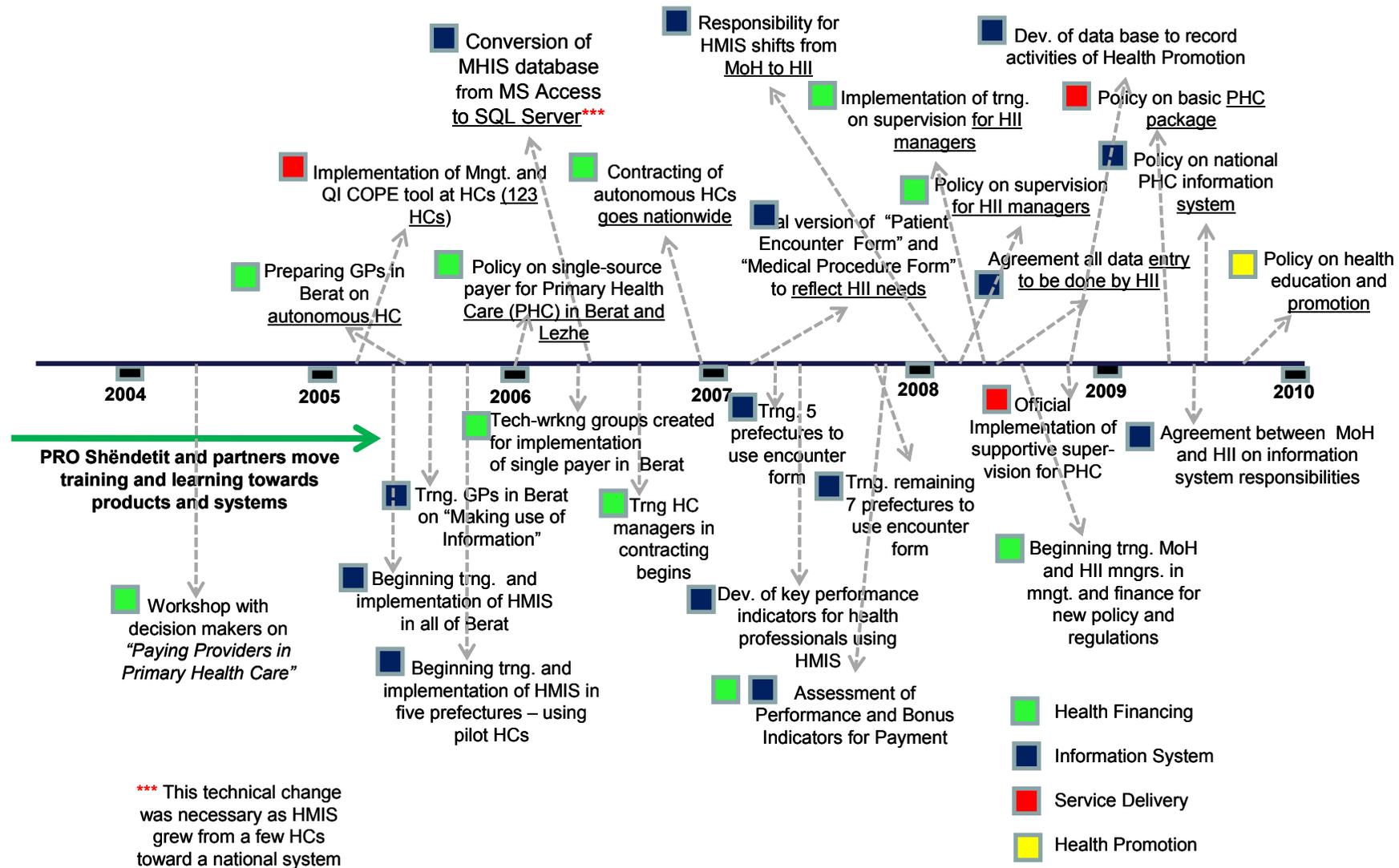
FIGURE 8: PRO SHĒNDETIT KEY PARTNERS AND ACHIEVEMENTS IN BETTER MANAGEMENT OF PHC RESOURCES

Management of PHC Resources	Key Partners						
	MoH	HII	FofM (DFM)	CCE	NCQS AHI	IPH	INSTA T
Final version of encounter form and medical procedure form (Feb. 07) 	X	X					
Trng in HIS for all 12 prefectures (Mar. 07) 	X						
Dev of performance indicator (May 07)  	X	X					
Agreement all data entry to be done by HII (Jun. 08) 	X	X					
Trng. on supervision for HII managers (Oct. 08) 		X					
Implementation of supportive supervision for PHC (Sept 08) 	X	X	X	X			
Development of data base to record health promotion activities (last of 08) 	X	X				X	
Basic PHC package officially accepted (Apr. 09) 	X	X			X		
Implementation of supervision for HII managers (Apr. 09) 	X	X					
Health Ed. and Promotion accepted (June 09) 	X	X				X	
National PHC information system accepted (June 09) ¹⁴ 	X	X					X
Agreement between MoH and HII on CSIS responsibilities – (June 09) 	X	X					

The following time line for this intermediate result, Figure 9, shows how all components of the project contributed to achieving a result. Owing to color coding it can easily be seen that all components (and their respective partners) were involved. Health Financing (green color) and the Health Management Information (blue color) were involved in improving system management. This required working from health centers upwards. Service delivery (red color) and health promotion (yellow color), were often working at health centers and communities only. These two components culminated their project work on creating better management of PHC resources by having their work at the “ground level” become policy and regulatory mechanisms to improve management, on a system-wide scale.

¹⁴ This order states that the “patient encounter form” and “medical procedure form” are the official formats for recording clinical services and health promotion at PHCs.

FIGURE 9: TIME LINE FOR WORK ON BETTER MANAGEMENT OF PHC RESOURCES



6.2.3 Lessons Learned

A lesson that stands out from PRO Shëndetit's work on this intermediate result is what might be thought of as "alternative persistency". Two examples will be given, one in health financing and one in health information; they are actually linked.

The project component quickest in beginning activities was Health Reform and Financing. This was in part simply due to the way the project began, but it was also due to earlier high level decisions that were supposed to lead to legal changes and new ways of funding PHC. A government decision had been made to move PHC to a single-source payer. However, as a result of politics, personnel changes, differing advice from both internal and external advisors, and remaining uncertainty, there was little movement at higher decision making levels.

Health financing looked for alternative ways to "work on" the issue, while top level decision making was on hold. This resulted in a large amount of training-information-sharing at all levels, from health centers to the highest levels among partners. One of the very important outcomes of persistently working where work could be done is that it created a very large pool of people who understood a great deal about single-source payment in PHC and what the implications meant for them. This large pool of knowledgeable professionals was important in assisting decision makers to eventually take decisions that began the movement reflected in Figure 9. The lack of movement at higher levels in Phase I of the project was taken quite seriously – by an assessment team – and seen as a possible reason that PRO Shëndetit should not be involved in health financing in phase II.¹⁵

At first, health information activities moved slowly. USAID's PHRplus project had introduced the initial HIS in a few health centers in Berat. The minister of health said he believed the new "system" should be used nationally. PRO Shëndetit made the decision to develop the system initiated by PHRplus and assist the MoH to expand it. It was a philosophical (or developmental) position of PRO Shëndetit that you could not make system-wide changes by focusing only a few heavily supported HCs and then leave the MoH to push national expansion forward on its own. Given MoH organization in Albania, the health management information "system" had minimally to be district- if not prefecture-wide.

A decision was made to expand the system in Berat prefecture and then in PRO Shëndetit's four other focus-prefectures: Shkoder, Lezhe, Diber, and Korca. Partners, at all levels, were interested, but in going five prefectures-wide, PRO Shëndetit was definitely "pushing the envelope", as a popular expression states. MoH budgets were not set up and human resources were not in place.

As the new HIS gained attention, and, at least in concept, picked up momentum, hurdles appeared. Some were as "simple" as decisions needing to be made by MoH prefecture directors, as where to set up data entry rooms, to persons concerned that establishing the HIS would not be as personally beneficial as some other option might. It would have been possible to wait for budgets and human resources to be in place or to be persistent in looking for other alternatives; PRO Shëndetit chose the latter, while increasing the efforts to achieve a wide consensus in HIS strategy. Several meetings and round tables were facilitated by the project to create a common vision for all the health data people, concrete efforts were made to push and approve the legal framework to lay down the basis for the further development of national HIS.

On the basis of partner requests and agreements, PRO Shëndetit assisted activities to progress by, initially, furnishing the encounter forms, filled by nurses to later be entered into the HIS, and paying for data entry. There was project angst as to how long these types of activities could go on and whether PRO Shëndetit should continue to take the risk. In the end, all of the effort with the MoH changed as HII became the single-source payer of PHC, and the organization responsible for the new HIS.

Today the autonomous HC concept is in the early stages of being fleshed out and in place nationally. The functioning HIS in five prefectures was a very important factor in operationally developing the

¹⁵ *Strategic Appraisal: USAID/Albania Health Strategy and Portfolio*, USAID October 2005, Harriet Destler, Joyce Holfeld, and Nathan Blanchet, pp 31-34

autonomous HC, in determining partially-based performance remuneration at HCs, and in estimating the costs of PHC. Had there not been a functioning HIS in the five prefectures, the responsibility for data entry being taken over by HII and a national policy on HIS quite simply, would not be.

The lesson earlier referred to as alternative persistency has as much relevance for donors as it does for projects and their partners:

- For optimum success, projects should be designed for and allowed flexibility;
- For optimum success, projects should be willing to look for alternatives, be persistent after choosing them, be willing to take risks; and
- The stronger the partners and the level of confidence in them should guide the level of risk the project takes.

6.2.4 Products

Many products are relevant for more than one intermediate result and, consequently, appear in more than one list of products. For example, the Policy on Basic Package of Primary Health Care speaks to how the system should be set up and managed and, at the same time, gives important guidance for impacting the quality of services in PHC. Activities and resources often are associated with more than one intermediate result.

FIGURE 10: INTERMEDIATE RESULT 2 – BETTER MANAGEMENT OF PHC RESOURCES

PRO Shëndetit – Phase I			PRO Shëndetit Phase II		
Products	English	Albanian	Products	English	Albanian
Contracting and Performance Management in the Sector (DFID)	▲	Abstract	Analysis of HII Expenditures toward the - Minimum Benefit package of PHC in Five Prefectures	▲	Abstract
Report on Training Needs and Curriculum Development for HC Reform in Albania	▲	▲	Analysis of HII - Expenditures towards the Minimum Benefit Package of PHC in five Prefectures – Technical Brief	▲	▲
Manual for Encounter Form Filling	▲	▲	Health Reform in Albania: Results achieved and tasks remaining. The role of PRO Shëndetit Project, 2003-2009	Abstract	▲
HIS Data Base Entry	Abstract	▲	Supportive Supervision – Training Manual	Abstract	▲
Human Resource Data Base	Abstract	▲	The Reform in PHC: Management and Financing of Health Centers	Abstract	▲
IT Strategy and WAN Feasibility Study	▲	▲	Training Manual I - The Reform in PHC: Management and Financing of Health Centers – Training Manual II	Abstract	▲
Needs for Information at Local, District, and National Level and Recommendations for a Basic Set of PHC Indicators	Abstract	▲	Costs of PHC – ABC Analysis	▲	▲
Patient Encounter Form	▲	▲	Preparation-strategy for Health Information – waiting for action	Abstract	▲

FIGURE 10: INTERMEDIATE RESULT 2 – BETTER MANAGEMENT OF PHC RESOURCES

PRO Shëndetit – Phase I			PRO Shëndetit Phase II		
Products	English	Albanian	Products	English	Albanian
COPE (Folder) ¹⁶	▲	▲	Policy on Supervision for HII Managers	Abstract	▲
Equipment (Folder)	▲		Framework for Family Medicine in Albania	▲	▲
Relicensing and Accreditation (Folder)	▲	Abstract	Package on nurses training	Abstract	▲
Neonatal Resuscitation	▲	▲	Package on GPs training	Abstract	▲
Council of Ministers Decision on National Health reform	▲	▲	Policy on Health Education and Promotion	Abstract	▲
			Agreement between MoH and HII on Information System Responsibilities	Abstract	▲
			Policy on National PHC Information system	Abstract	▲
			Basic Package of PHC Services	▲	▲
			Assessment of CPD Experience in Albania	▲	Abstract
			Development of a structured CME program	▲	Abstract
			Establishing Standards in Primary Health Care	▲	Abstract
			Basic Package of PHC Services (poster)	Abstract	▲
			Policy on Health Promotion in Albania: Organization and Functions	Abstract	▲

6.3 Higher Quality PHC Services

There is always room for improvement in quality. Given the very early phase of establishing and developing PHC in Albania, the “room to improve” has been huge. PRO Shëndetit and partners have worked from numerous angles to improve the quality of PHC services.

6.3.1 Background

USAID and other donors, during the mid to late 90s and into the current century, contributed a great amount of resources to building health centers and some health posts. An initial step in quality improvement was to build places where doctors and nurses could practice (where tools and medicines could be stored) and where clients would come for services. PRO Shëndetit conducted a survey and found that a majority of the HCs in its five-focus prefectures did not have electricity and not too many fewer had running water. Sometimes the lack of electricity and water was the condition of a good part of the village and sometimes it reflected where the local government chose to put its resources. The doctors and nurses assigned to the health centers had almost no practical training when they began as health center doctors or nurses. Very few doctors and virtually no nurses had received additional training once they began practicing. PRO Shëndetit, in its five-focus prefectures found roughly 20%

¹⁶ There are a number of resources from Phase I, where a folder contains multiple items. Rather than list each item separately, the subject matter is indicated, i.e., COPE and the term “folder” used to indicate there are multiple items.

of the health centers were well organized, appeared to have motivated and competent staffs. At the other end of the continuum there were remote health centers where the assigned physician lived in a sometimes distant city and could not be relied upon to be on sight to treat patients and provide services. As indicated previously, there was a lot of room for improving quality.

6.3.2 Partners and Achievements

PRO Shëndetit and partners found working with PHC doctors and nurses stimulating and rewarding. They were hungry for new information and eager to participate in training and in becoming trainers for some activities themselves. An assessment was made of PRO Shëndetit by an external USAID team in 2005. The MoH PHC Director in Lezhe made the comments shown the text box.

One Health Center – following the COPE analysis – successfully lobbied the mayor’s office to provide funding to install running water to the center.
A head doctor proudly reported that they had more motivation, confidence, and information to make requests to the local government.

Another example is provided by the continuing medical education (CME) started for nurses. Each district selected topics in which they were most interested, the trainers were their more knowledgeable colleagues in the district. In the beginning, given the low salaries of nurses, PRO Shëndetit paid for the transportation to the central town or village where classes were held. There was so much interest from nurses and such a great effort made by them to attend classes that PRO Shëndetit could not bear the transportation costs, even at 100 Leke per trip. A total of 2,760 nurses from 16 districts attended multiple classes. Participants were told that transportation could not be reimbursed, but it hardly caused a ripple in attendance. Much of the subject matter of these courses was borrowed and edited by nursing school staff in Phase II; this became part of the nurses training package given to the new Center for Continuing Education.

Some of PRO Shëndetit’s partners were very exceptional and permitted the leveraging of project impact, as mentioned earlier. It was through the efforts of USAID and the MoH that PRO Shëndetit was able to use resources from Hellenicare (a Greek support foundation) to organize the training of GPs and nurses in Vlorë (not one of the project’s five focus prefectures). Through working with the MoH and exceptional leadership at the Maternity Hospital “Koço Glozheni” in Tirana, it was possible to recruit an outside donor that specializes in providing training equipment and training in neo natal resuscitation. The foundation is locally known as the Liahona Foundation. The training – overseen and implemented by the Neonatology Department – included staffs from 10 different maternity hospitals and 368 professionals across all of Albania, including some physicians from the five-focus prefectures who did deliveries outside of the maternities.

FIGURE 11: PRO SHËNDETIT KEY PARTNERS IN ACHIEVING HIGHER QUALITY PHC SERVICES

Higher Quality PHC Services	Key Partners							
	MoH	HII	FoM/D FM	FoN	AAFP	CCE	NCQS AHI	Mat. Hospital
Initiating COPE HC management tool (Jan. 05) 	X							
Published manual for modular training in 28 mod. for GPs (Mar 05) 	X		X		X			
CME training for nurses (Apr 05) 	X	X		X				
Mod. trng in 28 mod. begins for GPs (Apr 05) 	X	X	X		X			
Self improvement system – peer review started in Lezhe and Shkoder (Feb 06) 	X							
Beginning of CME training for PHC physicians (April 06) 	X	X						

Component Legend

-  Health Financing
-  Information System
-  Service Delivery
-  Health Promotion

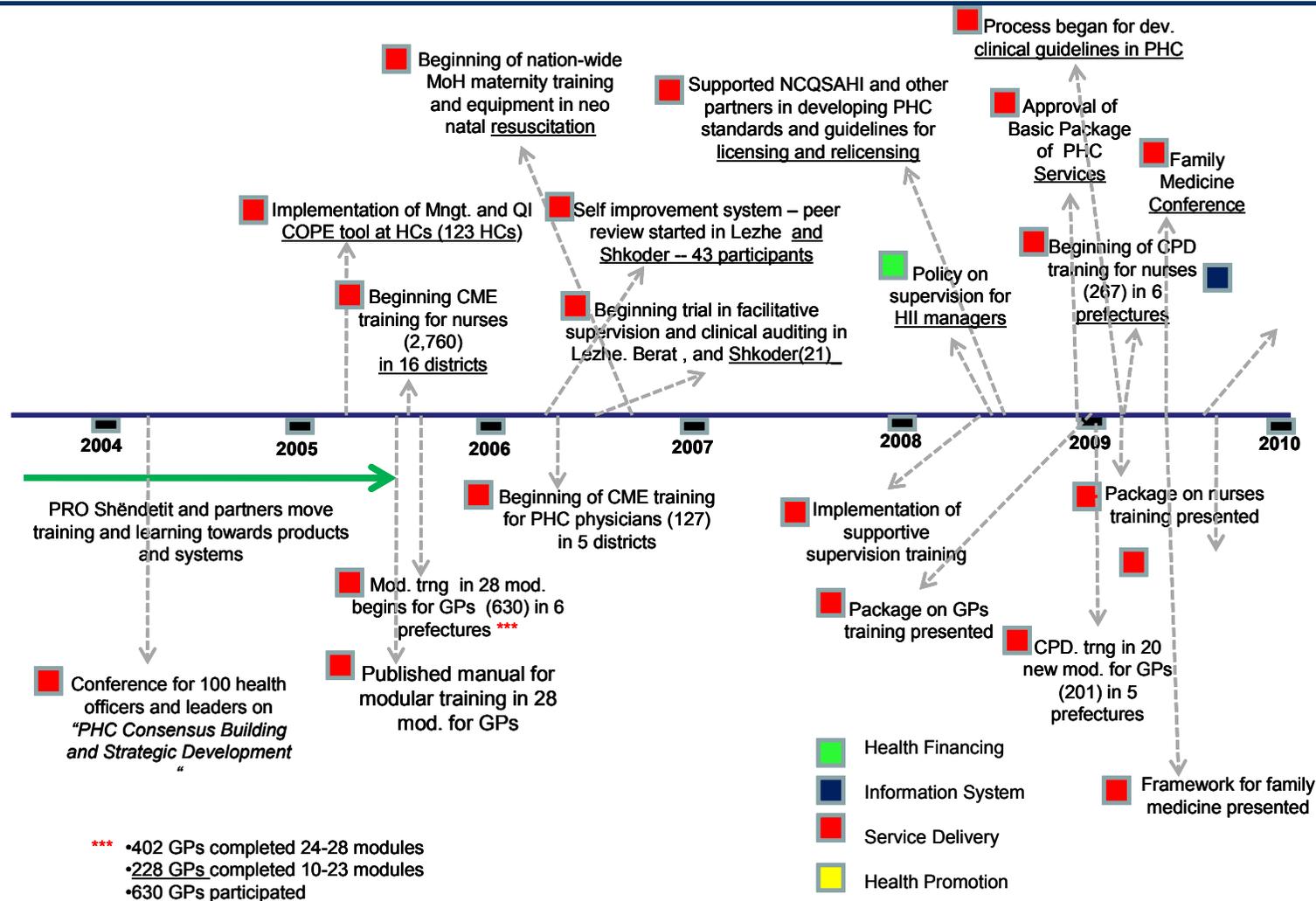
FIGURE 11: PRO SHËNDETIT KEY PARTNERS IN ACHIEVING HIGHER QUALITY PHC SERVICES

Higher Quality PHC Services	Key Partners							
	MoH	HII	FoM/D FM	FoN	AAFP	CCE	NCQS AHI	Mat. Hospital
Beginning trial in facilitative supervision and clinical auditing in Lezhe and Berat (June 06) 	X							
Beginning of nation-wide MoH Maternities training and equipment in neo natal resuscitation (Sept 06) 	X							X
Implementation of supportive supervision training for PHC (May 08) 	X							
Policy on supervision for HII managers (June 08) 		X						
Supported NCQSAHI and other partners in developing PHC standards and guidelines for licensing and relicensing (June 08) 	X		X				X	
Approval of Basic Package of PHC Services (Dec 08) 	X	X	X		X		X	
Mod. trng in 20 new mod. for GPs (Jan 09) 	X	X	X		X			
Package on nurses training presented (Feb 09) 	X			X				
Package on GPs training presented (Jan 09) 	X	X	X					
Beginning of CPD training for nurses (Feb 09) 	X	X		X				
Family Medicine Conference (May 09) 	X	X	X		X	X	X	
Framework for family medicine presented (May 09) 	X		X		X			
Policy on national PHC information system (Jun 09) 	X	X						
Re-edited manual for all 48 modules in training GPs in family medicine (Sept 09) 	X	X						

The following time line (Figure 12) lays out the preceding information (less the listing of partners) so that a comprehensive view can be shown of project and partners achievements in contributing towards higher quality PHC services (the third of four intermediate results).

An attempt has been made to place “achievements” – whether they are the initiation and implementation of a successful conference or training program or whether they are outcomes like a regulation or policy – in the appropriate intermediate result section of this report. Even so, some achievements, like the implementation of COPE, belong under both management and quality improvement. Equally so, achieving a national policy on the PHC information system is a policy/regulatory achievement and something that contributes directly to improved quality. It is important in understanding the project, to know all of the approaches and tools used to achieve each intermediate result

FIGURE 12: TIME LINE OF HIGHER QUALITY PHC SERVICES



6.3.3 Lessons Learned

There has surely been as much relearning of lessons as there has been learning of new lessons during the life of the project. That said, it is the case that things are always changing. A lesson learned of what will or will not work today may not be the same tomorrow. Some things simply have to be explored and sometimes tried before it is known whether they will work.

- A project cannot move too fast or operate too far ahead of where the country’s systems are, or are headed. This is a pretty simple lesson, relearned in different countries by many projects. The difficulty is that all too frequently it is not known where or at what pace the systems are headed.
- Trust between the project and in-country partners is one if not the most important ingredients to a successful project. How trust is developed – as in any organization or relationship – is not easily prescribed. While project staff do have ideas of how it was developed for PRO Shëndetit, perhaps it is best discussed elsewhere and just the fact that staff learned or relearned its importance listed here.

6.3.4 Products

FIGURE 13: INTERMEDIATE RESULT 3 – HIGHER QUALITY PHC SERVICES

PRO Shëndetit – Phase I			PRO Shëndetit – Phase II		
Products	English	Albanian	Products	English	Albanian
Report on Training Needs and Curriculum Development for Health Center Reform in Albania	▲	▲	Policy on Supervision for HII Managers	▲	Abstract
A Modern Paradigm for Improving Healthcare Quality (URC)	▲	Abstract	Framework for Family Medicine in Albania	▲	Abstract
COPE Handbook: A process for Improving Quality in Health Services (EngenderHealth)	▲	▲	Supportive Supervision Training Manual	Abstract	▲
PRO Shëndetit Quality Management Guide for Health Centers	▲	▲	Basic Package of PHC Services	▲	▲
Report on the Self-improvement System Peer Review pilot in Lezhë and Shkodër	▲	▲	Assessment of CPD Experiences in Albania	▲	Abstract
Role of Supervisors and managers In Quality Improvement (URC)	▲	▲	Establishing Standards in Primary Health Care in Albania	Abstract	▲
CME Doctors (folder) ¹⁷	▲	▲	Re-edited manual for all 48 modules in training GPs in family medicine	Abstract	▲
CME Nurses (folder)	▲	▲	Package on nurses training presented	Abstract	▲

¹⁷ “Folder” indicates that there is more than one file to be found at that site. Each item was not thought important enough to list separately, but is available electronically for anyone who might find the items useful

FIGURE 13: INTERMEDIATE RESULT 3 – HIGHER QUALITY PHC SERVICES

PRO Shëndetit – Phase I			PRO Shëndetit – Phase II		
Products	English	Albanian	Products	English	Albanian
A Proposal for the design and Development of Relicensing and Accreditation systems for Family Physicians in Albania – A White Paper for Discussion	▲	▲	Training Manual for Neo Natal Resuscitation (cover shown only – manual at Maternity Hospital Koço Glozheni)	Abstract	▲
Modular training in FM Manual-28 Modules	Abstract	▲	CPD Doctors II – training Manual	Abstract	▲
Quick reference guide	▲	▲	CPD Doctors II Reference reading	Abstract	▲
			CPD Nurses TOT Manual	Abstract	▲
			CPD NursesII Training manual	Abstract	▲
			CPD Nurses II Reference reading	Abstract	▲
			CPD Nurses II Job Aids	Abstract	▲
			Development of a structured CME program	▲	Abstract

6.4 Increased Access to Essential PHC Services

6.4.1 Background

At the beginning of PRO Shëndetit in 2003, the Ministry of Health (and Institute of Public Health) had placed one to three persons in a health promotion directorate in each district. The positions were the least well paid of all of the district health professionals and without operating budgets. In fact, in some districts they were without a physical office. There was a recognition that health promotion “should” be something the MoH was about, but that is what it was – a recognition.

Knowledge about health in the general population was low and practical knowledge and interest in health promotion among doctors and nurses at health centers was equally low. A 2002 national survey¹⁸ shows that 33% of married women had visited a health facility in the preceding year (this includes Tirana, Durres and other urban centers, where rates can be expected to be higher). The percentage was expectedly lower for men at 14%. Further, only 56% of married women who had given birth reported being told about danger signs during pregnancy, 80% had no follow up check-up after the birth of their last baby, and while 57% (low in comparison to many countries) of women said they heard of self examination for breast cancer, only 16% had ever done a self examination.

This IR is about access to PHC services. The preceding paragraphs talk only about knowledge on the part of Albanians; they only briefly mention knowledge and interest on the part of providers. There are, of course, other major well known factors contributing to access. Although it oversimplifies the complex issue of “access to PHC services,” the following five items highlight areas that are important:

- Presence of the necessary physical facilities (whether stationary or mobile).
- Equipment and medicines

¹⁸ CDC IPH national survey

- The means (especially in more rural areas) to traverse the distance from home to where services are provided
- Competent and willing providers
- Knowledge about health – in general – on the part of citizens or the main family care givers. This becomes more important when talking about preventive medicine, which is an important element of PHC

PRO Shëndetit’s areas of potential impact were most closely associated with four and five. The project was active in providing the WB and MoH a list of proposed equipment when the loan for PHC was being developed, but did not itself purchase equipment on a large scale. Project and partners recognize the difficulty for rural people to travel in this mountainous country, item three, but four and five were things that PRO Shëndetit thought it could influence.

There is a large body of literature dealing with the necessity of having client-oriented providers if good access to services is to be achieved. Access is not only the responsibility of clients it is equally the responsibility of providers. PRO Shëndetit and partners made a strong contribution to the provider side of the issue, and listed those achievements mostly with IR 3 “higher quality of PHC Services”. A few of the most relevant achievements of IR3 – related to access – are included in this section, but only a few. The task of IR 4 was clearly centered on the community, but the linkages, between community and providers has been essential to PRO Shëndetit and partners’ successes.

There is a simple logic that says if you have better trained and more confident providers you are going to have more clients. Beyond this logic, however, topics that were taught to physicians and nurses included attitude toward and treatment of clients, as well as community outreach. In fact, staff believes that a separate report on change in attitudes of providers would be an achievement the project could easily report. Nevertheless, for heuristic purposes and simplicity in presentation, health promotion is the major focus as increased access to PHC services is discussed; this is no way should ignore the fact that great improvements toward access was made by providers.

- Better communication with patients
- More specific in diagnosis and differential diagnosis
- Improved use of medical record
- Number of new patients increased
- Quality of service improved time with patient is utilized better, and
- Improved caring and communication with patient

One brief caveat, resulting from project activities, will make the point. AAFP conducted an evaluation of the CPD program. Doctors who had undergone training were asked, “what have been the most significant results of your CPD training?” with specific reference to change in provision of preventive health services in health centers. Some of the self observed most frequent answers are shown in the text box.¹⁹

6.4.2 Partners and Achievements

FIGURE 14: PRO SHËNDETIT KEY PARTNERS IN INCREASED ACCESS TO ESSENTIAL PHC SERVICES

Increased Access to Essential PHC Services	Key Partners						
	MoH	HII	UNFPA	Mat. Hospital	IPH	WHO	Health Educators Net ²⁰
Beginning of CME training for nurses (Apr 05) 	X						

¹⁹ Dr. Calvin Wilson and Dr. Warren Heffron, *Evaluation of Continuing Professional Development Program*, May 10-25, 2009, p. 21.

²⁰ Health Educator’s Network refers to on-the-ground health promotion educators – under the direction of IPH and MoH structures

FIGURE 14: PRO SHËNDETIT KEY PARTNERS IN INCREASED ACCESS TO ESSENTIAL PHC SERVICES

Increased Access to Essential PHC Services	Key Partners						
	MoH	HII	UNFPA	Mat. Hospital	IPH	WHO	Health Educators Net ²⁰
Beginning of modular training for GPs (<i>Apr 05</i>) 	X						
Development of curricula and manual for family planning and dual protection (<i>Apr 05</i>) 	X		X	X	X		
Begin the establishment of health promotion teams (<i>May 05</i>) 	X				X		X
Training HP teams and TOT in FP (<i>July 05</i>) 	X	Component Legend  Health Financing  Information System  Service Delivery  Health Promotion			X		X
Expansion of community communications model in all districts of five prefectures (<i>July 05</i>) 	X				X		X
Began long-term mentoring and sharing of information and materials with Bathore Womens' Organization, School Doctors of Tirana, other national and local organizations and Health Promotion Dept. of Tirana (<i>August 05 onward</i>) 	X				X		X
Expansion of FP training in four ²¹ prefectures (<i>Jul 05-May 06</i>) 	X				X		X
Development of curricula and 2 manuals: antenatal care (ANC) and child health (<i>06</i>) 	X		X	X	X		
Expansion of training for HP teams in ANC and Child Health (<i>06</i>) 	X				X		X
Dev of training package for HIV/AIDS (<i>Oct-Nov 06</i>) 	X				X		
Support publication of HIV-AIDS in Albania: 1983-2003 (<i>Oct-Nov 06</i>) 	X				X		
Expansion of HIV/AIDS & STIs training in five prefectures (<i>06-07</i>) 	X				X		X
Development of training package in TB (<i>Jan-Apr 07</i>) 	X				X		
Expansion of training in 16 districts (<i>2007</i>) 	X				X		X
Refresher training in FP, ANC and child health (<i>2007</i>) 	X				X		X
Training of HP teams in community mobilization [in collaboration with National Democratic Institute] (<i>2007</i>) 	X				X		X
Training of HP teams in "Basics in Health Promotion and Health Education" (<i>2007</i>) 	X				X		X

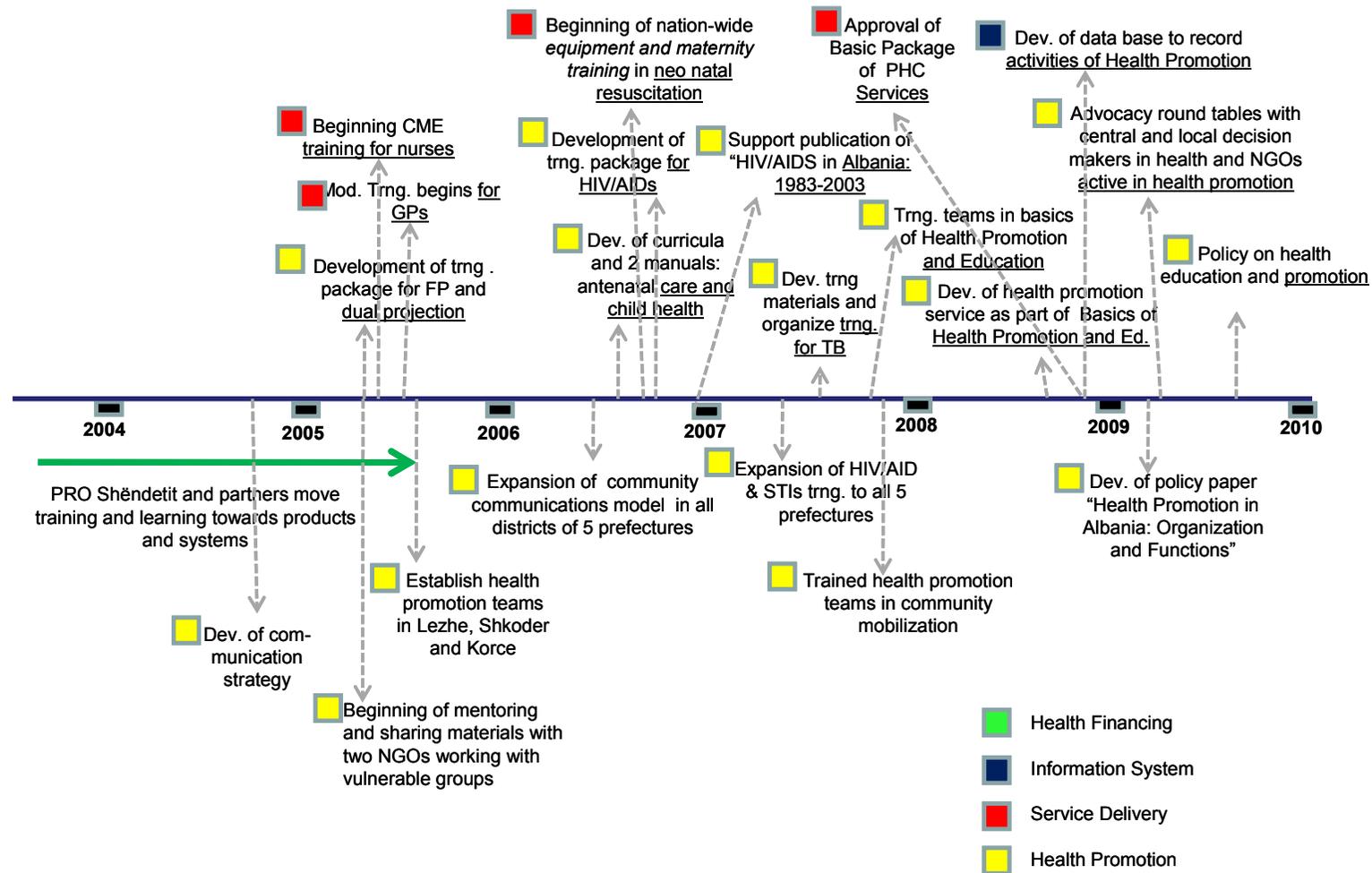
²¹In Diber prefecture the Albanian and American Red Cross had a project in family planning.

FIGURE 14: PRO SHËNDETIT KEY PARTNERS IN INCREASED ACCESS TO ESSENTIAL PHC SERVICES

Increased Access to Essential PHC Services	Key Partners						
	MoH	HII	UNFPA	Mat. Hospital	IPH	WHO	Health Educators Net ²⁰
Development of IEC set of materials in ANC and child health (booklets and laminated cards) (2008) 	X		X	X	X		
Development of health promotion service section for the Basic Package of PHC Services (08-09) 	X	X			X		
Basic PHC package officially accepted (Apr. 09) 	X	X			X		
Development of data base to record health promotion activities (last of 08) 	X				X		
Organization of five regional conferences on HP activities – Achievements and Challenges (07-08) 	X	X			X		X
Organization of Advocacy Round Tables with central and local health authorities and NGOs active in the HP (2008-2009) 	X	X			X	X	
Developed the policy paper “Health Promotion in Albania: Organization and Functions” 	X	X			X	X	

The time line in Figure 15 provides a visual flow of how activities began towards the front of the project and how they evolved towards the end. It can be noted under the long green arrow in each time line are the words “PRO Shëndetit and partners move training and learning towards products and systems.” With each intermediate result this happened. Training leads toward products to be used in training and work. These products also provide direction for further movement and for strengthening systems that will be in place to make use of the learning and products after the project. The time line figure also shows how activities and products from other project components contribute toward or support those being developed in health promotion.

FIGURE 15: TIME LINE OF INCREASED ACCESS TO ESSENTIAL PHC SERVICES



6.4.3 Lessons Learned

As discussed in the preceding section, under “lessons learned,” there has been as much or more relearning as there was new learning. In this instance it may be more accurate to speak of being *reminded* about human nature, rather than relearning. The community focused health promotion efforts associated with IR4 reinforce the adage that “common people are quite capable and willing to do things that – for them – are quite uncommon.”

USAID officials, the US Ambassador to Albania, Albanian MoH officials and other visitors to ongoing community-based health promotion activities have been impressed. Rural women who are poor in resources and low in formal education have over and over again demonstrated a grasp of the health issues they are working on, a commitment to educate their communities, and a presentation of self that showed confidence as well as commitment.

It is amazing to think of the largely rural and poor volunteer network holding 22,500 events and reaching over 204 thousand people over the past five years with health promotion and education messages; 35 percent of those reached were men. These numbers represent only those who were counted, not sisters, brothers, other family members, and friends with whom the information was shared.

And why did these common people rise to the occasion to do these uncommon things? The answers may appear less than scientific, but they work:

- First, people were selected by locals, in the know as persons with potential
- People were educated about things that related to the well being of their own families and friends. People love learning things that are relevant to themselves and those who they care about.
- People were given tools to help them teach and promote health.
- People were provided with “social-cash” – honest expressions of appreciation and encouragement – lots of it.
- People were given incentives.

The use of “incentives” was left to last, as it deserves further comment. In some instances, where there was no gasoline or transportation available for health promotion workers at the district level, they were provided with transportation costs to meet, organize, and work with community teams. When the program first began, the teams from one or more districts, at a time, were brought to Tirana for training. This proved too costly for the project to maintain, but initially it said to the common people who made the program work “we’re investing in you.” Most of the people who came had never been to Tirana, never been taught by knowledgeable specialists, and never done things like role plays and presentations. The meetings were moved to prefectures, but they were still held and people understood that others were investing in them.

In a report looking for hard facts of what led to success in specific areas, what is being offered are soft facts, a great deal of continuing human contact, encouragement, expressed appreciation – all organized well by project staff and partners. It works. Well over 204 thousand people were directly contacted, informed, and educated; the MoH has included health promotion as an ingredient written into the “Basic Package of Services in Primary Health Care,” and a separate policy on health education and promotion has been accepted.

In an attempt to help quantify what has happened in the area of health promotion a purposive cluster sample survey was conducted in June 2009. The sample clusters were drawn only from those villages where HP had been working in three prefectures.²² The three prefecture limitation was due to resource availability. While results can most strictly be claimed to “represent” a population of 595,663 (the population within the sampled three prefectures where at least one HP activity had taken place), the

²² More details on the survey are provided in later paragraphs.

whole project and partners did work in five prefectures. The estimated population of the five prefectures is 1.3 million.

Given the preceding caveats it is of interest to see the size of the potential population of married women (and men, although not reported here) who have been reached through HP.

Figure 16 provides some interesting findings. It was found that 50 per cent of married women 15-44 had heard of HP. A very high 75 percent of those women learned about HP activities through a nurse – showing how the MoH system and HP were working together.²³

FIGURE 16: PERCENT OF MARRIED WOMEN 15-44, WHO HAVE HEARD OF HEALTH PROMOTION ACTIVITIES, FROM WHOM DID THEY LEARN ABOUT ACTIVITIES, KNOWLEDGE OF WHO ORGANIZES ACTIVITIES, AND WHETHER THEY HAVE PARTICIPATED IN ACTIVITIES

Women in 2009 selected group	From whom did you learn about HP activities?			Do you know who organizes activities	Have you participated in activities
	Doctor	Nurse	Other comm. member		
50 percent who heard of HP activities	36.8	75.0	10.0	73.9	62.3
All women in 2009 selected group	18.5	37.7	5.4	37.1	31.3

A very high percentage of women who knew about HP had participated in one or more HP activities. While the percent is only 31, among all women, it is still phenomenal when it is considered that one third of all married women talk to their husband, sisters, and friends and then use much of their new gained knowledge for their own families.

One other table provides additional, instructive information. It is presented as Figure 17. The topics that women participated in are shown in the table. It can be said that over one quarter of women in the whole sampled area of the three prefectures were exposed to such topics as ANC, MCH, FP, and breast cancer.

When the group of women who participated in HP is reviewed, it is seen that the percentage goes up into the mid eighties for some topics.

It bears repeating, the reach of the health education net and health promotion activities is very impressive. These activities often took place in very rural areas, where health information has been non-existent. Here, data can be shown, methodologically speaking, only for a population of 595 thousand. The reality, however, is that possible population is up to an estimated 1.3 million.

FIGURE 17: PERCENT OF WOMEN WHO PARTICIPATED IN DIFFERENT HEALTH TOPICS

Topics	Two different sub groups of women from the 2009 survey	
	Women who said they had participated in HP activities	All women
HIV/AIDs	67.8	21.2
TB	47.8	14.9
ANC care	84.2	26.3
MCH	84	26.3
FP	83	26.0
Breast Cancer	80.7	25.3
Cervical Cancer	52.5	16.4
Smoking	48.7	15.2
Drugs	47.3	14.8
Other	13.4	4.2

²³ More than one reference could be given as to who informed them about HP.

6.4.4 Products

FIGURE 18: INTERMEDIATE RESULT 4 – INCREASED ACCESS TO ESSENTIAL PHC SERVICES

PRO Shëndetit – Phase I			PRO Shëndetit Phase – II		
Products	English	Albanian	Products	English	Albanian
Family Planning and STI-HIV-AIDS, an Exploration of Knowledge, Attitudes, and Practices	▲	▲	General Knowledge of TB - Leaflet	Abstract	▲
Antenatal Care Manual	Abstract	▲	Prevention of TB – Leaflet	Abstract	▲
Family Planning and dual Protection Manual	Abstract	▲	Treatment of TB -- Leaflet	Abstract	▲
Increasing Community Knowledge on HIV-Aids Manual	Abstract	▲	ANC and New Born Care -- Booklet	Abstract	▲
Basics on health Promotion and health Education - Manual	▲	▲	Family Planning and Dual Protection – Laminated Card (updated)	Abstract	▲
Family Planning- Leaflet	Abstract	▲	TB—Laminated Card	Abstract	▲
General information tuberculosis - Manual	▲	▲	ANC – Laminated Cards	Abstract	▲
Neonatal Care – Manual	Abstract	▲	Child Care – Laminated Cards	Abstract	▲
General Knowledge on HIV-AIDS and sexually Transmitted Diseases - Manual	▲	▲	Health promotion service section for the Basic Package of PHC Services	▲	▲
Antenatal Care - Manual	Abstract	▲	White paper “Health Promotion in Albania: Organization and Functions”	Abstract	▲
New Born Care	Abstract	▲			
Publication of HIV-AIDS in Albania: 1983-2003	Abstract	Abstract			

7 SUMMARY OF RESULTS

PRO Shëndetit has two types of results to present. First, there are the achievements and products shown with the intermediate results in the preceding pages. There are a number of major accomplishments and products documented in those pages. For example, the policy on autonomous health centers, the Basic Package of Primary Health Care, the acceptance of the CSIS as the national system, or the accepted policy on health promotion. A second set of people-level results are available from three population-based surveys. Further, in addition to the results presented in this EOP report, there are the indicators that have been tracking progress; these are included on the DVD in the reports section. What follows is the second type of result mentioned – a discussion and presentation of some people-level results from surveys.

In 2002 the Albania Reproductive Health Survey²⁴ was conducted, with technical assistance from CDC in Atlanta. This survey has been considered by technical analysts as the best population-based survey on health in Albania. It covered a wide array of topics. In 2005 PRO Shëndetit using the same methodology replicated, as nearly as possible, a limited topic survey in three of the five-focus prefectures.²⁵ The survey was published under the title “Primary Health Care in Albania: A Study of changes in Knowledge and Behavior – Shkodër, Lëzhe, and Korçë: 2002-2005.”²⁶ Some of the same personnel associated with INSTAT participated in the sampling design and interviewing of both 2002 and 2005 surveys. These two surveys permitted PRO Shëndetit and partners to look at knowledge and practices, in a number of areas, over time, to determine if project and partner inputs were creating the desired people-level changes.

Nearing the end of the project it was determined to survey one more point in time, closer to the end of PRO Shëndetit. Resources did not allow the same type of known probability, population-based survey Methodology. It was decided to conduct a purposive cluster sample survey of three prefectures. It was purposive in that only married women 15-44 and living in villages where at least one health promotion activity had been underway were sampled. With limited resources, the intent was to see what changes had taken place in those geographical areas where Health Promotion, as well as other inputs, had been active.

FIGURE 19: PERCENT OF MARRIED WOMEN 15-44 WHO HAVE KNOWLEDGE OF SPECIFIC CONTRACEPTIVE METHODS AND 3 OR MORE: 2002, 2005 AND 2009 (SELECTED GROUP)

Method	Reproductive Health Survey - 2002		Pro Shëndetit Survey - 2005		2009 Selected Group
	All Albania	3 Pref	3 Pref	Percent Change	
Know 3 or more modern methods	68.2	62.2	63.7	1.5 +	95.3
Condom	75.1	79.7	92.4	12.7+	92.4
Tubal Ligation	71.5	74.9	54.9	20 -	87.9
Pills	58.9	60.0	76.9	16.9+	94.0
Injectables	33.5	36.5	55.1	18.5 +	80.3
Rhythm/Calendar	22.0	24.0	14.7	9.3 -	72.1
IUD	18.8	18.9	37.4	18.5 +	76.3
Emergency Cont.	10.3	10.4	18.5	8.1 +	53.5
Vasectomy	5.8	7.2	23.6	16.4 +	41.0
Foam/Jelly	3.5	5.2	4.9	0.3 -	24.1
LAM	--	--	55.6	--	65.5

²⁴ This volume had a number of sponsors, including USAID, and was under operational management by CDC (or Atlanta) and the Institute of Public Health, Albania. INSTAT assisted in designing and drawing the sample. The survey was edited by Leo Morris, Joan Herold, Silva Bino, Alban Yllii, and Danielle Jackson. Although the survey was conducted in 2002 it was not published until May 2005.

²⁵ There were only enough resources to survey three of the five prefectures.

²⁶ This survey was funded by USAID. It was prepared by Altin Malaj, Dhimitër Tole and Richard Sturgis.

As results are presented in the following pages, there are instances where it may be uncertain whether patterns changed over three points in time or differing methodologies produced inconsistent results. These will be commented upon as they are encountered. Nevertheless, it is believed that sampling three points in time gives stronger confirmation of results than if there were not a third point in time, nearer to the end of PRO Shëndetit.

Tables, where data are available follow the format shown in the first table, which is called Figure 19. Results are available from the 2002 survey for “all Albania.” The second data column is available as CDC graciously provided assistance in extracting from the larger survey, data for three of the focus prefectures: Shkodër, Lezhë, and Korçë. This allows an observer to see how similar or different those three prefectures may have been from the rest of the nation in 2002. The next heading shows two columns of information from the PRO Shëndetit 2005 survey. The first of the two columns presents 2005 data that were obtained using the same or similar questions as in 2002. The fourth data column indicates whether the people-level results went up or down between 2002 and 2005.

The final column presents data from the purposive cluster survey conducted in June 2009. Because the nature of the final survey was quite different, there are no percent change indicators shown. The results should not be seen as precisely comparable to the earlier two surveys. Nevertheless, the reader will note the continuing general direction of trends that began showing in the 2005 survey.

FIGURE 20: PERCENT OF ALL MEN 15-49 WHO HAVE KNOWLEDGE OF SPECIFIC CONTRACEPTIVE METHODS: 2002, 2005

Method	Reproductive Health Survey - 2002		Pro Shëndetit Survey - 2005	
	All Albania	3-Prefec-tures	3-Prefec-tures	Percent Change
Condom	92	88.8	95.8	7.0 +
Tubal Ligation	16.5	17.2	45.6	28.4 +
Pills	40.1	41.2	73.6	32.4 +
Injectables	8.6	8.4	54.6	46.2 +
IUD	11.6	10.4	30.6	20.2 +
Vasectomy	6.7	6.0	31.1	25.1 +
Foam/Jelly	5.7	5.6	6.9	1.3 +

Figure 19 shows change in knowledge of contraceptive methods. It can be seen that knowledge had changed by 2005. In those areas where health promotion was most active, the data in the final column suggest that women in those villages are well informed.

The 2009 survey did not include men, although approximately one third of the persons reached through health promotion activities were men.

Figure 20 presents data from the 2002 and 2005 surveys. Although data

FIGURE 21: PERCENT OF MARRIED WOMEN 15-44 WHO HAVE EVER-USED SPECIFIC MODERN METHODS OF CONTRACEPTION: 2002, 2005 AND 2009 (SELECTED GROUP)

Method	Reproductive Health Survey - 2002		Pro Shëndetit Survey - 2005		2009 Selected Group
	All Albania	3-Pref	3-Pref	Percent Change	
Any modern method	17.7	18.1	39.5	21.4 +	42.3
Condom	8.1	8.8	31.8	23.0 +	17.2
Tubal Ligation	4.1	2.1	1.0	1.1 -	3.0
Pills	5.5	7.8	15.2	7.4 +	13.2
Injectables	1.7	2.9	4.2	1.3 +	4.1
IUD	1.3	1.5	1.9	0.4 +	3.3
Emergency Cont.	0.3	0.3	2.5	2.2 +	5.1
Foam/Jelly	3.5	5.2	4.9	0.3 -	1.0
LAM	--	--	34.4	--	17.8

for all of the methods in Figure 20 are not available for Figure 21, it is easy to see that FP commodity knowledge increased for men. Unfortunately, we do not have 2009 data for men.

Figure 21 begins to show some irregularities (compared to Figure 20), although the trend continues to be in a positive direction. It appears that percent of women who have ever-used any modern method

has increased. At this point it is not clear, but the more rural nature of the 2009 sample may be partial reason for a drop in use of condoms and pills, which are frequently purchased from the more urban, private sector.

At the time of writing this EOP report, there is a national reproductive health survey soon to be released. Given the difficulty and serious undertaking to calculate results for “current use”, presentation and discussion of the current prevalence rate (CPR) will be left to that survey team.

The people-level results, shown in relation to contraceptive knowledge and use, argue strongly the success by PRO Shëndetit and partners in enhancing knowledge and use of modern contraceptives.

The next set of figures (tables) present people-level results associated with changes associated with ante natal, breast feeding, and post natal behavior.

Figure 22 shows the 2002 already high level of mothers who had pre natal check ups. It was 85 percent and then rises to 93 percent in 2005 and in the 2009 selected group the percentage goes to 100 percent. The final row shows that 72 percent of all women in the three prefectures had three or pre natal visits and it went to 86 percent by 2005 and in the selected group of 2009 it is 93 percent.

Breastfeeding is recommended to begin within the first hour or second hour after birth, depending upon varying guidelines. While there is

not a smooth continuing increase, Figure 23 shows that the percentage of women who breastfed within the first or second hour after birth increased between 2002 and 2005 and remains high among the selected group surveyed in 2009.

FIGURE 22: PERCENT OF MARRIED WOMEN 15-44 WHO HAD PRE-NATAL VISITS, AVERAGE NUMBER OF VISITS AND WITH THREE OR MORE VISITS

Pre Natal	Reproductive Health Survey - 2002		Pro Shëndetit Survey - 2005		2009 Selected Group
	All Albania	3-Pref	3-Pref	Percent Change	
Percent with pre natal visit	85.4	85.7	93.4	7.7 +	100
Pre-natal Check was in first trimester	--	--	--	--	79.0
Average visits	4.7	4.4	5.3	0.9 +	5.3
Percent with 3 or more visits	75.6	72.0	85.5	13.5 +	93.0

FIGURE 23: PERCENT OF WOMEN WHO BREASTFED AFTER LAST BIRTH AND TIME AFTER BABY’S BIRTH MOTHER STARTED

Breast feeding	Reproductive Health Survey - 2002		Pro Shëndetit Survey - 2005		2009 Selected Group
	All Albania	3-Prefs	3-Pref	Percent Change	
Ever	--	--	96.5	--	100
Less than 1 hour	7.6	10.0	20.8	10.8 +	11.4
2-23 hours	57.2	54.8	50.3	3.5 -	59.1
24- 47 hours	21.7	21.6	18.3	3.3 -	18.1
48 + hours	13.6	13.6	10.6	3.0 -	11.4

FIGURE 24: PERCENT OF WOMEN WHO HAD A CHECK-UP AFTER THEIR LAST DELIVERY BY LENGTH OF TIME OF CHECK-UP AFTER BABY’S BIRTH

Check-up	Reproductive Health Survey - 2002		Pro Shëndetit Survey - 2005		2009 Selected Group
	All Albania	3-Pref	3-Pref	Percent Change	
No check-up	80.4	84.2	28.0	56.2 -	32.9
Less than 1 week	7.0	3.1	58.6	55.5 +	37
1-2 Weeks	3.1	3.3	11.6	8.3 +	16
3 or more weeks	9.5	9.4	1.8	7.6 -	10

The more striking behavior change shown in Figure 24 is the greatly decreased percentage of new mothers who had no post natal check up after the birth of their baby. When it comes to behavior change – people-level results – associated with birth and breastfeeding, information shown in the preceding three tables speak loudly to the strong results of PRO Shëndetit and partners.

Figure 25 shows results obtained from 2002 and 2009 regarding married women and their knowledge of STIs. The level of knowledge was quite low, as can be seen for all Albania and PRO Shëndetit’s three-focus prefectures in 2002. Unfortunately, the data for 2005 are not available, but there are results from the 2009 selected group survey.

FIGURE 25: MARRIED WOMEN’S 15-44 KNOWLEDGE OF THE SYMPTOMS OF SEXUALLY TRANSMITTED INFECTIONS, FOR ALL ALBANIA AND THREE FOCUS PREFECTURES 2002 AND SELECTED GROUP IN THREE FOCUS PREFECTURES 2009

Groups	Heard of STIs	Know 5 symptoms	Genital itching	Vaginal discharge	Foul smell discharge	Abdominal pain	Burning pain on urination	Redness in genital area	Weight loss	Hard to get pregnant	Swolleness in genitals	Genital ulcers	Genital warts	Blood in urine	Don't know
All Albania 2002	---	---	27.6	26.8	26.4	19.5	12.6	8.4	7.4	5.8	4.9	2.9	--	--	0.0
Three Prefectures 2002	---	---	25.9	22.4	24.7	16.5	13.8	7.6	6.9	7.4	5.6	2.6	--	--	0.0
2009 Selected Group	69.0	35.1	52.2	45.6	42.7	38.0	40.0	35.9	16.9	27.0	26.9	17.8	28.4	20.0	4.0

Results show that 69 percent of the women surveyed in 2009 knew of STIs and 35 percent knew of five symptoms. It can be seen that in the surveyed 2009 area – and it is assumed in many other PRO Shëndetit focus areas as well – knowledge has apparently increased appreciably.

As Figure 26 shows, the percent of women who had heard of HIV/AIDS was high in 2002 and remained so, according to the later surveys. It is of interest to note that knowledge of where to go for testing increased appreciably between 2002 and 2005 and apparently remained about the same in the 2009 selected group. With such low levels of knowledge showing for knowledge that HIV can be asymptomatic, it is all the more important for women who think they may be at risk that knowledge of where to go for testing is as high as possible. Unfortunately, the same statistics were not available from all three surveys.

FIGURE 26: PERCENT OF WOMEN 15-44 WHO HAVE HEARD OF HIV/AIDS, KNOW WAYS TO REDUCE RISK, HIV CAN BE ASYMPTOMATIC, WHERE TO GO FOR TESTING, AND THAT HIV CAN BE TRANSMITTED FROM MOTHER TO CHILD

HIV/AIDS	Reproductive Health Survey - 2002		Pro Shëndetit Survey - 2005		2009 Selected Group
	All Albania	3 Pref	3 Pref	Percent Change	
Have heard about HIV/AIDS	95.7	94.9	95.3	0.4 +	97.3
Ways to reduce risk	--	-	74.3	--	87.4
HIV can be asymptomatic	55.5	60.4	46.5	13.9 -	--
Know mother can transmit to child	--	--	90.3	--	90
Know where to go for testing	16.9	22.5	40.9	18.4 +	39.8

Because men were surveyed in both 2002 and 2005, there is information for those two points in time regarding information about men’s knowledge of HIV/AIDS. As can be seen from Figure 27, men, as well as women, show a high level of awareness since 2002. Similar to females, between 2002 and 2005, there was a large increase in the reported percentage of men that knew where to go for testing, in the three prefectures.

PRO Shëndetit and partners were affective in creating strong or increased knowledge in the more rural selected groups shown for women in Figure 26. Knowledge of where to go for testing increased rather dramatically for both women (18%) and men (61%).

Figure 28 shows the levels of knowledge about TB, among married women 15-44, in three of PRO Shëndetit's focus prefectures. Data were collected in 2005 and again in the 2009 selected group. Unfortunately the base line data for 2002 are not available. It can be seen that knowledge was high in 2005 and for the most part stayed that way in 2009. There was an effort by HP to have people learn that TB could be cured and that is why 87 percent of the women surveyed in 2009 reflect that they were well taught.

The people-level results shown in the preceding ten tables, make strong statements regarding the knowledge and practices of Albanians changing – towards better health – in PRO Shëndetit and partners focal areas.

FIGURE 27: PERCENT OF MEN 15-49 WHO HAVE HEARD OF HIV/AIDS, NOW – WAYS TO REDUCE RISK, HIV CAN BE ASYMPTOMATIC, WHERE TO GO FOR TESTING AND THAT HIV CAN BE TRANSMITTED FROM MOTHER TO CHILD

HIV/AIDS	Reproductive Health Survey - 2002		Pro Shëndetit Survey - 2005	
	All Albania	3 Pref	3 Pref	Percent Change
Have hear about HIV/AIDS	96.1	96.4	96.	No change
Ways to reduce risk	--	--	88.3	--
HIV can be asymptomatic	44.7	53.4	43.1	1.3 -
Know mother can transmit to child	--	--	56.9	--
Know where to go for testing	33.2	40.1	61.3	21.2 +

FIGURE 28: PERCENT OF MARRIED WOMEN 15-44 KNOWLEDGE ABOUT TUBERCULOSIS

Group	Heard of TB	Common Signs	Where to get Treatment	Length of Treatment	Do you pay for Treatment	Know if curable
Three prefectures 2005	95.0	83.8	95.2	23.3	22.6	--
2009 Selected Group	99.6	90.2	87.5	--	--	87.0

8 LOOKING FORWARD

What was achieved by PRO Shëndetit and partners is a firmer foundation and framework for Primary Health Care (PHC), from which the Government of Albania (GoA) can effectively move forward. The strategic objective of the project still remains – improving the health of Albanians; it is a continuing process. Improving health will always require attention and effort. Based on the experiences of PRO Shëndetit and partners, and looking forward, a few key recommendations are provided below:

Improved PHC Policy and Regulatory Environment

- Distribute PHC resources – staffs, HCs, and equipment –rationally based on population size, geography, and defined health needs, for example, chronic diseases and MCH services. As soon as new census results are available, the updated population numbers should be used to allocate resources.
- Continue to improve the performance-based payment approach for the health centers (HCs);
- Develop a public-private partnership framework in primary health care. This will entail further costing studies and clarification through regulation and legislation of what being “insured” or “uninsured” means in terms of access to benefits and posted co-payments.

Better Management of PHC Resources

- Continue to use the health information system for PHC, at all levels of the health system, for 18 months (end of 2010) without changing the software or overall system. At the end of 18 months there should be a health information team formed to recommend the future direction that the PHC information system should take.
- Continue to implement the Supportive Supervision System in HII in predefined areas for 18 months, until the end of 2010. At that time a thorough assessment needs to be undertaken to determine how best to alter and expand the system for HII throughout Albania.
- Hire appropriate family medicine staff for strengthening the Supportive Supervision System in PHC and monitoring and evaluation units at prefecture level. Separate budget for supervision visits should be provided at all levels.

Higher Quality PHC Services

- Organize accredited CME session for nurses in PHC to unify the many different categories of nurses that exist in PHC.
- Set up system for qualifying GPs working in PHC to become certified family physicians.
- Launch an aggressive campaign to: 1) ensure that all PHC workers understand the Basic Package of PHC Services (BPS), and 2) based on the rationalization of the distribution of PHC resources (see first bullet) that MoH and HII undertake to ensure that every HC has what is needed to offer the BPS.

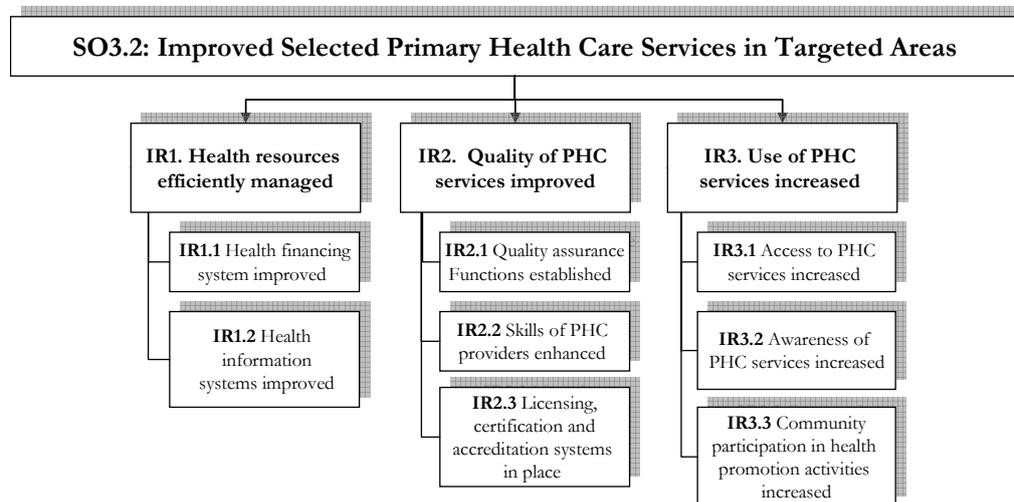
Increased Access to Essential PHC Services

- Reorganize health promotion department at the Institute of Public Health to reflect the goals and objectives of the new policy on health education and promotion.
- Allocate dedicated budget for health promotion within the Institute of Public Health; also provide rationalized, dedicated budgets for health promotion at the Regional and Public Health Directorates.
- Develop continuous education program in health promotion, accredited by the National Center of Continuous Education, and managed by the Department of Health Promotion at the Institute of Public Health.

**ANNEX A - GRAPHIC PORTRAYAL OF THE RESULTS FRAMEWORK FOR
PHASE I AND II OF PRO SHĚNDETIT**

PHASE I

USAID/Albania Results Framework for SO 3.2



PHASE II

USAID/Albania Results Framework for SO 3.2

