ALBANIA
HEALTH SECTOR ASSESSMENT

For an evidence based decision making
in light of the new Country Strategy 2014-2017

of the
Swiss Cooperation with Albania
SDC/SECO - SCO-A

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Abbreviations

CME	Continuous Medical Education
DHS	Demography and Health Survey
FM	Family Medicine
FoM	Faculty of Medicine
FoN	Faculty of Nurses
GoA	Government of Albania
GPs	General Practitioners
HC	Health Centre
HII	Health Insurance Institute
HIS	Health Information System
IPH	Institute of Public Health
IUED	Institut Universitaire des Etudes du Développement
MoH	Ministry of Health
MoEd	Ministry of Education and Sciences
NCCE	National Centre of Continuous Education
NCD	Non Communicable Diseases
NCQSA-HI	National Centre of Quality, Safety and Accreditation of Health Institutions
NSDI	Albanian Strategy for Development and Integration
PDS	Professional Development System
PH	Public Health
PHC	Primary Health Care / Primary Health Center
SDC	Swiss Development Cooperation
SDC-A	SDC - Albania Office
UdeM	Université de Montréal
UNFPA	UN Agency for Family Planning
USAID	United States Agency for International Development

A Introduction and Methodology

After almost 50 years of isolation, under-development and poverty under Stalinist dictatorship, the Albanian government and people have made strong efforts to move towards a free and democratic society. And this despite major setbacks in the '90s as e.g. the 'pyramidal schemes crisis' or the Kosovo war, with an influx of thousands of refugees into the country. Today, Albania considers itself a 'functioning market economy', reflected in a steady economic growth and an increase in GDP per capita, a trend only curved down in the recent years (latest official INSTAT figures show a population of 3.2 millions and a GDP/cap of 4'076 US$). Regardless of this positive overall trend, unemployment remains high, social inequities are growing, and the rural-urban development gap is widening, resulting in a rising flow of people towards cities, mainly towards Tirana.

The health sector is one of the sectors which had major problems to cope with this transformation, due to its heritage from the communist past in terms of inadequate infrastructure and workforce. That is the reason why soon after the opening of the country, many international aid agencies opted to support reform efforts within this sector, among them Swiss NGOs, Swiss medical institutions and – last but not least – SDC and SECO.

In 2005, a new and big reform effort has been lounged by the Albanian government with a National Strategy for Development and Integration NSDI 2007-13, reaffirming Albania's Vision to become a country with European standards:

> *A country with high living standards, which is integrated in the European and Euro-Atlantic structures, is democratic and guarantees the fundamental human rights and liberties.*
>
> *A country with social policies oriented towards the respect of human rights, equality and non-discrimination. Good quality social services will improve living standards and ensures social cohesion. In the health sector, new solutions for an adequate financing of services will guarantee good quality.*
>
> *A country with improved quality and efficiency of the public administration. Their services and their commitment for the implementation of this strategy will contribute to successfully meet the challenge of European integration.*

SDC/SECO, by its 2010-13 cooperation strategy, offered support to this comprehensive reform efforts with coherent projects in various sectors. A health component was introduced under the heading of 'democratization and decentralization' with the Professional Development Program PDS, establishing a national center for continuous education: the NCCE. The main role of this center is accreditation of training activities & institutions for doctors as well as the management of the compulsory re-certification process.

For the drafting of the next cooperation strategy (2014-17), with the option for a continued commitment in health, an up-to-date 'health sector assessment' was considered essential to get the necessary evidence for the forthcoming planning process. The method proposed to and chosen by the international and local expert were as follows:

- Desk studies of available documents like former assessments, project proposals and evaluation reports from SDC or other agencies, Albanian strategy and legal documents related to health, plans concerning structural, managerial and financing reform, recent mortality and morbidity as well as risk factor data.
- Interviews with key stakeholders in health of institutions like Ministry of Health, Health Insurance Institute, Ministry of Finance, health worker associations and 'frontline' personal in some selected health facilities, including a short visit to a regional hospital and health centers outside Tirana (Leshe).
- A synopsis of former Swiss support to Albania, establishing a complete record of projects along with criteria like target, impact, good practice and reasons for success of Swiss interventions, in order to deduce key characteristics for a future commitment.

This approach enabled the experts to collect many relevant documents, a broad range of opinions, ideas and proposals and to get a good insight in the health sector. Nevertheless, the mission should rather be called a 'rapid' assessment, because little 'real world' information or data could be collected by the consultants themselves during the short stay. As a consequence, the 'reality check' is often based on information of limited quality, on data that is not really representative or credible and frequently not up-to-date. Also, many interviewees had the tendency to represent their domain of activity in an overly optimistic way and to confound their perfectly drafted plans, goals and objectives with the reality – they sometimes tended to present a fiction of the Albanian health system.
Despite this lack of trust in the obtained information, the experts feel confident that they did grasp the essence of the problems of the health sector enabling them to recommend a number of options for the Swiss Cooperation which have the potential to impact on the progress of reforms and - finally - on the health of the Albanian population.

B The Albanian health system: reality, goals and fictions

1) The reality: an average[mk] medical case

L.P., spouse of a farmer from a village near Fushë-Arrëz, a municipality in the Pukë District, Shkodër County, northern Albania. Age 48, gave birth to 5 children, youngest 2 years old.

Five years ago, L.P. went to the health post in the neighbouring village: first because of her severe pharyngitis and second for one of her kids' smallpox. Twice it was closed, no nurse, no doc; both problems finally healed without medical support. Still, she wanted to show to a nurse/doctor a dark mole on her upper arm, which was growing.

Half a year after these failed attempts, she started complaining to her husband about strong pain in the back, and he observed strange changes in his spouses' behaviour. They decided to go to the regional hospital, where they had to queue up and were finally not attended that day; the next day they had to make an informal payment to 'jump the queue' and to get attended. The nurse asked for her 'health booklet'. They didn't know what she was talking about. They were told: if you don't have the booklet, you are not insured, so you have to pay for the service. The doctor quickly saw her. Than he expected a bribe for his service and for the provision of a recipe for analgesics, which they had, again, to pay out of their own pocket.

But the symptoms did not improve, and one day she was found on the floor, acting strange and barely conscious. She woke up and did not know what had happened. The husband consulted with family members and decided to go down directly to a 'policlinic' in Tirana with her. Again queuing and informal payments in order to obtain accelerate attendance. The family doctor sends her to the specialist policlinic for RX and other analysis, with fees to pay. Diagnoses: metastasis in vertebrae The 4/5 and various smaller metastasis in the brain. She was admitted to the University Hospital, where again informal payments and fees were due.

There, two months later, the farmer lady died from metastasizing melanoma. The farmers' total expenses summed up to over 15'000 ALL (at a monthly income of <13'800 ALL or 130 US$); fortunately he was supported by his family (a cousin did send money from Switzerland). The benefit from free, tax-paid inpatient care at the Tirana University Hospital level came too late to safe his wife. Consequences for the family: it lost a crucial contributor to its income, a mother for the children, and this heavy social and psychological burden will be carried by the farmer and his family alone.

How avoid such a sad story? Better health literacy enables people to know simple preventative measures and their civic obligations (like registering at a HC in order to obtain the 'health card'). The use of modern guidelines in clinical care by HC-staff, through continuous medical education for nurses and GPs, would allow for early detection of potentially lethal diseases (90% of melanoma can be cured, if detected early, by a very cheap intervention). Investing in management, training, infrastructure and equipment improves the credibility of Primary Health Care. Such a 'comprehensive package of interventions' would help to save young and productive lives and reduce sufferings.

[mk] This case is fictive and has been 'invented' by the consultants based on their insights in the Albanian health system and their interviews during the mission; in the view of various Albanians, to whom the 'case' had been introduced, it corresponds fully to the daily reality.

2) Goals and plans – a reality check

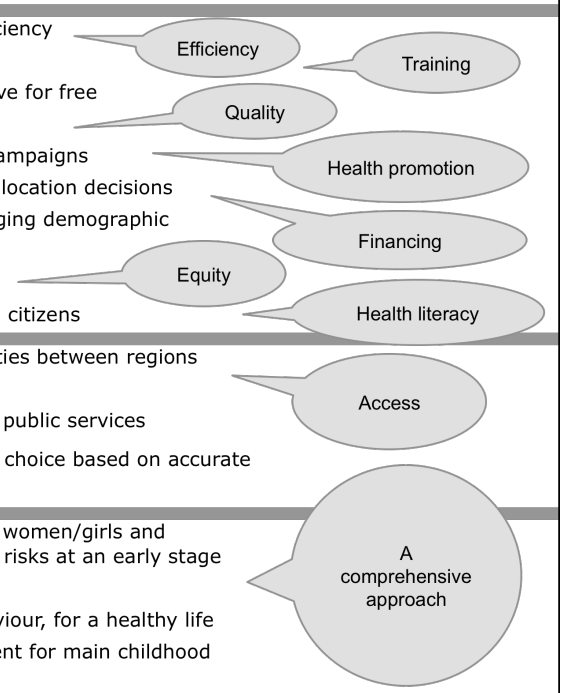
Albania has a health system which has served people in the past and is still functioning with a modest level of quality; doctors and nurses have been trained, are available in a reasonable number and a minimal service infrastructure exists. For certain aspects, Albania claims even to perform better than many countries in Europe, e.g. for vaccination coverage of children. And over the past ten years the burden for many disease groups has declined.

But there is no doubt: if Albania aspires the EU membership, the country must make a huge effort to reach European standards in performance and quality and to establish administrative and institutional structures which guarantee the implementation of the 'acquis communautaire' This chapter tries to cross-checks some selected elements of the health related Albanian legislative framework, strategies, goals and plans, against the reality – based on recent assessments (two from USAID published 2012[1] [2]), the 2012 EU-commission progress report[3] and own observations of the consultants.

Implement the National Strategy for Development and Integration NSDI 2007-13: this is the superordinate instrument for the reform of the health system, adopted 2005 by the Government of Albania. Main strategy elements related to health are presented in table 1:

Table 1:

Domain	Issue	The reform for health development encompasses:
sectoral	Health	A basic service for all, of acceptable quality and efficiency
		An improvement of managerial capacities
		A set of services that people will be entitled to receive for free
		An improvement of clinical pathways
		A shift to preventive health care and public health campaigns
		A single strategic purchaser for all public resource allocation decisions
		An adjustment to the new pattern of risks and changing demographic
		An encouragement of private initiative
		A focus on inequalities in service provision
		A regulatory framework to ensure responsiveness to citizens
intersectoral	Inequalities	A balanced regional development to reduce inequalities between regions
	Corruption	A gradual reduction of corruption
		The introduction of effective/transparent systems in public services
	Empowerment	An empowerment of consumers (patients) for a real choice based on accurate information, for self-determination and confidence
cross-cutting / transversal	Gender	An increase of awareness related to health needs of women/girls and men/boys, promoting measures that address health risks at an early stage
		Prevention of domestic violence
	Youth	Education activities for the prevention of risky behaviour, for a healthy life
	Social inclusion	For children: an integrated outpatient managemement for main childhood diseases
		For Roma: availability of health services in Roma communities



(An excerpt of the complete health related reform agenda of NSDI is annexed, with its sectoral, inter-sectoral and cross-cutting aspects in more detail: annex 2.1)

This abstract table shows that the Albanian health reform strategy follows a 'modern, comprehensive approach' to health development as recommended by global health authorities like WHO, the World Bank and other big players in this field – the only way to successfully address the burden of disease shift from infectious to chronic, non communicable illness.

- In the field of health, progress in most strategy areas mentioned in the NSDI is very slow and implementation remains mainly **a fiction**, and this only one year prior to the end of the seven year strategy phase.

Prioritize the budget of health and education: this goal has been stated by the general budget director at the Ministry of Finance; but while the public share of total Albanian GDP is only 28%, the public share for the health sector is as little as 2.6%. With an annual deficit of 3% and a shortfall of revenues in 2011, the fiscal situation becomes tense and there is – apart from already allocated expenditures (55% of total public investment for road infrastructure!) or mandatory public obligations (dept service) – little 'residual money' to increase the public health budget.

- Despite a declaration from budgetary decision makers to give priority to health, a bigger share of the public budget for this sector is **a fiction** – health remains under-financed and will probably remain so for the coming years in view of the economic crisis (Albania's revenues depending strongly on two export destinations, Greece and Italy).

Guarantee free basic public health services: in Albania**,** everybody has the right to be insured and to get free basic medical services in public facilities; a 1995 established Health Insurance Institute HII (Law on Health Insurance) was initially remunerating the GPs in health centers and had a fund to reimburse drugs to pharmacies; since 2007 it became the purchaser of a complete 'basic benefit package' at primary health care facilities, including salaries of all staff at this level. The latest law on health financing (Law on Collection of Compulsory Contributions for Health and Social Insurance), approved by the parliament and in vigor from 2013 onwards, will make HII the single purchaser of all public services in the country, including hospitals. However, no standard framework for cost and budget calculations exists yet. Social insurance and pension schemes, in general, are not functioning well, among others because of difficulties with contributions and therefore a distorted contributor/recipient ratio.

- Despite the right for all to be insured, full insurance coverage remains **a fiction**. Current estimates range from an optimistic 90% (HII) to less than 60%, the latter figure standing for rural areas, where farmers and poor people are still not insured.

Establish a better statistical infrastructure: A **'**National Health Account' contributes to the improvement of transparency and accountability of the health sector. A critical element in the governance of the health system is the capacity to monitor and evaluate its performance. The institutionalisation of health accounts is a key element in strengthening the overall health information system.

In 2009, the Ministry of Health of Albania started this process (supported by the 'Health System Modernization Project' of the World Bank), a long-term process: usually, it takes several years until the human resources are trained, before the core health accounting framework can be extended to human resources development and disease accounts.

Therefore, continuity and stability of staff is essential for sound and reliable results. Presently, sensitive data areas are private sector expenditures, whose consistency can only be fully checked if further data on the health care provider side will be made available.

- Work in progress, first results available. Insufficient quality of raw/input data from provider and demand side. The current legal and regulatory framework of statistics is inadequate to deal with the growing and increasingly sophisticated private sector and should be further developed. Evidence based decision processes, using a sound NHA, is still **a fiction**.

Reorganize health services structure and human resources in order to be cost-effective and accessible: according to the MOH, Albania counts with about 420 HCs, about 40 district or regional hospitals and the university and maternity hospital in Tirana; low bed occupancy rates (from as low as 24% till max. 46%) of secondary hospitals as well as short average hospital stays (<6 days) illustrate the inefficiency of the system; there are plans who define the size of a catchment area per health facility, number of staff, minimal equipment requirement as well as scope of services to be delivered: with exception of the 'basic benefit package' at HCs and used by HII for reimbursement, these plans are not implemented, for lack of funds, managerial capacities and – frequently - for political reasons.

- A cost-efficient human resource, equipment and infrastructure management and allocation is still **a fiction**.

Improve quality and performance of Albanian health services to reach European standards: The National Center for Quality, Safety and Accreditation of Health Institutions NCQSA-HI has elaborated a comprehensive set of measures with precise indicators allowing to evaluate quality and performance level of services for primary care and hospital level, in close collaboration with WHO. In near future, health facilities must be accredited to be eligible for funding of their running costs by HII. Three Tirana 'policlinics' (= urban HCs) have since been accredited of overall 420 health centers throughout the country, as well as one regional hospital (Durres, for a limited test period of one year).

- Quality standards are still **a fiction** in Albania's health facilities.

Establish a national CME-mechanism, including accreditation of providers of CME and re-certification of health professionals: according to the director of the National Centre for Continuous Education NCCE, CME-activities are still scarce, mainly outside Tirana, making it difficult for family medicine physicians and general practitioners to get their credits for re-certification – and this in the third year of a five year time window before reaching the certification deadline.

- Despite a rapid start-up with a successful establishment of a central CME-structure, CME remains – at least for those most in need for it, i.e. the rural GPs and family doctors – **a fiction**; CME for nurses is still not institutionalized.

As a conclusion, while recognizing the reform efforts and good intentions in many health relevant areas, implementation and enforcement of the legislation remain very weak.

Not surprisingly, the verdict of the EU-Commission in its recent progress report concerning the missing link between legislation and implementation, between plans and action, is explicit and serious:

- *"Staff turnover and weaknesses in analytical capacity still have a negative impact on the quality of legislation drafted;*
- *The legislative and institutional framework for public administration is still marked by deficiencies that need to be addressed with a view to strengthening professionalism, de-politicization, transparency and accountability;*
- *The civil service continues to suffer from shortcomings related to a lack of meritocracy in recruitment, promotion and dismissal of civil servants;*
- *More attention should be paid to the implementation and enforcement of legislation;*
- *Awareness in the health protection system is weak, both amongst professionals and the public, which is hampering transparency and enforcement."*

C Albanian health services

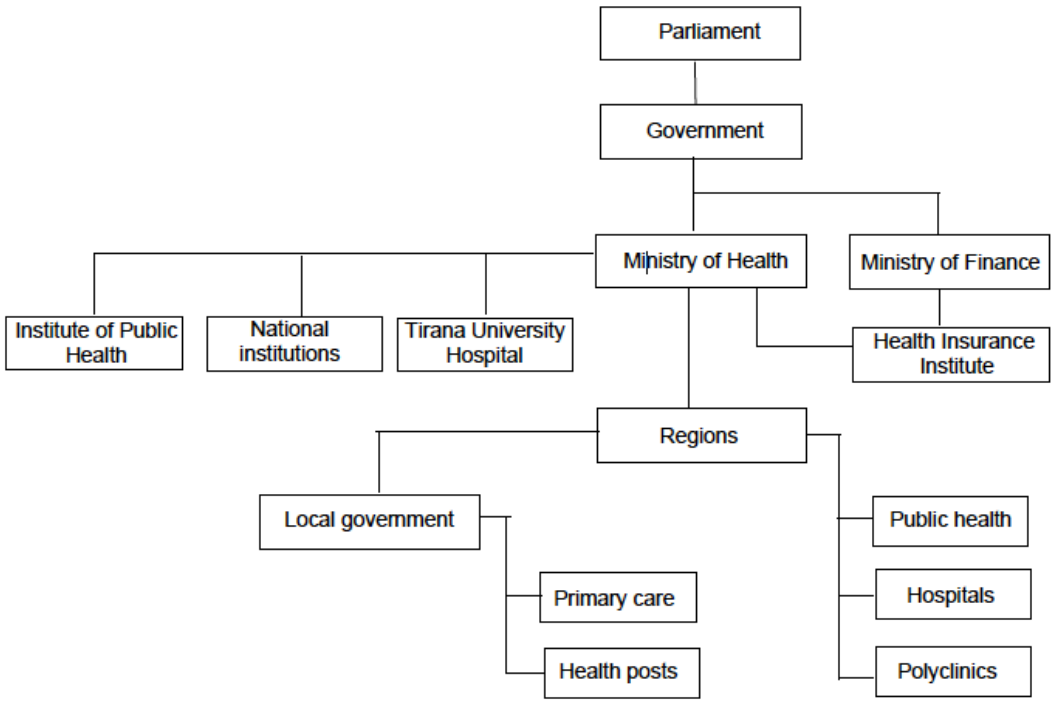
Albania has 12 prefectures and 36 districts (map see annex 1); municipalities (in cities) or communes (in rural areas) are the administrative divisions at the third level. The official 2009 population figure from INSTAT is 3.194 million inhabitants, with 23% under 15 years of age and only 6% over 60. One quarter of the whole population lives in the capital Tirana.

The health system in Albania is mainly public. The state is the major provider of health services, health promotion, prevention, diagnosis and treatment. The private sector is the largest provider of pharmaceutical and dental services; still a minor role play private specialist clinics and hospitals mainly in the area of Tirana. The Ministry of Health (MoH) is the line ministry for policy development and planning and for the implementation of health strategies.

1) Structure and human resources

Diagnostic and curative health services in Albania are organized in three levels: primary health care, secondary and tertiary hospital services.

Table 2 (for a more detailed scheme see annex 3.1):



a) Primary health care PHC

Structure and management. PHC is provided in small health posts (or 'ambulances'), health centers (or some bigger 'policlinics') and - only in urban areas - women and baby clinics; patients have the right to choose their GP, an asset mainly for the urban population.

With the exception of Tirana, where the primary care service has been reorganized and a Regional Health Authority has been established, coordination of all primary health service provision is under the responsibility of a district Public Health Directorate. In the 12 largest towns there are also specific directorates like the Hospital Directorate and the Directorate for Primary Health Care along with the Districts' Public Health Directorates. In Tirana, the Regional Health Authority is planning and managing primary health care services and public health programs under the supervision of a regional health board, which has to endorse the proposed regional policies, plans and budgets.

The MoH, in it's 2010 annual report, counts with 2450 facilities at PHC-level, of which 475 health centers (HC) and 48 'policlinics', 12 of them in Tirana; the remaining 1927 facilities are

'ambulances', the smallest element of the PHC-system. The local government authorities of rural communes own their PHC facilities and are thus partly responsible for PHC.

Activities and quality of services. In 2010, a number of 6.5 million consultations have been registered at PHC-level, with an average of 2 contacts per patient and over 200'000 home visits. Apart from this aggregated figures, information on individual centers were not collected at MoH level; but rumors were spread that, despite a seemingly high number of consultations, **their quality was poor and many HC's (up to 50%?) were only partly functioning (or even not at all).** A lack of qualified staff and equipment – hence a lack of confidence and the bypassing of the primary level – was claimed as a reason. Another explanation might be the out-migration of rural population which reduced demand to such a low level that village posts were abandoned. Besim Nuri[4] suggested in his 2004 health sector assessment that 'PHC services do not respond to people's needs and are not effective in solving their problems'. A survey in 2005 by PHRplus[5] showed that 'over 70% of chronic patients by-pass PHC-facilities of their village because 'required service not available', 'facility hours not suitable' or 'poor quality'. **The gatekeeper role of the PHC-level is not functioning** despite the introduction of a fee system which does oblige patients who go directly to a higher level facility to pay for diagnostics and treatment there. The 'USAID NCD Assessment' confirmed still in 2012 a poor performance of many PHC-facilities, especially related to the growing problem of NCDs: only a small proportion of NCD patients got simple and efficient, so called 'best buy' treatments or a counseling support for a change of their risk behavior.

Activity of HEALTH CENTRES, POLYCLINICS & AMBULANCES

Item	2010
Number of institutions total:	**2450**
– Health centers	475
– Ambulances	1927
– Polyclinics	48
Total visits (in thousands)	6555
from witch :	
Visits of persons <= 14 years old	1598
Visits of persons > 14 years old	4734
Visits at home	218
Average no, of contacts per person	2.04

The 'PHRplus' assessment identified a number of reasons and conditions contribu-ting to this situation: *'PHC facilities have weak linkages to the broader health care system and their financing and management has been fragmented due to recent decentralization efforts. Central budget constraints have left them with minimal resources for operations and maintenance, thus reducing the number and quality of services that they can provide. Facilities themselves possess little management autonomy and lack processes to improve quality of care. Lack of training for providers – especially in family medicine – further compromises quality of care. PHC facilities have little connection with the communities they serve. There are no mechanisms for the population to provide information about their perceptions of quality and efficiency of care, in order for facilities to better respond to individual and community health needs. Patients frequently self-refer to higher level facilities. This latter dynamic incurs additional costs in terms of travel, time, and higher out-of-pocket costs, and contributes to greater cost and inefficiency within the health care system overall.'*

Concerning the physical quality of PHC premises, no detailed information is available. The observation made by the evaluators of the USAID NCD Assessment[6] could apply to many Albanian rural health centers: *'Constructed during the Soviet era, many health care centers in the region lacked basic, modern amenities such as efficient heating and plumbing systems. Polyclinics tend to be large cement block structures with high ceilings and long hallways punctuated by closed doors leading to rooms that usually co-function as a provider office and patient-care area.* ***Buildings are often in poor condition*** *with little to no insulation against the cold. It was not uncommon in rural ambulatory health care centers to see groups of providers clustered around a small central portable heater during the winter.'*

In December 2006, the MoH introduced the 'Reform of Primary Health Care' with the main goal of redirecting the PHC system into a single-source purchaser setting (Council of Ministers decision on 'Financing of the Primary Health Care Services'). The implementation of the reform started in January 2007 with the reimburse of a complete 'basic benefit package' including salaries of all staff by the Health Insurance Institute HII (see Chapter C.2 and annex 5, details on financing of Health Care in Albania)). No up-to-date impact evaluation of these reform steps has been done, but HII is confident that it will make a big difference in the attitude of staff and quality of services.

b) The secondary level health care

Secondary service for patients is provided by the hospitals of their closest city, mostly by public hospitals, including 22 District Hospitals and 11 Regional Hospitals, offering outpatient policlinics and inpatient care. They provide a minimum of four basic services: internal medicine, pediatrics, general surgery and obstetrics-gynecology. Albania has less hospitals at this level than comparable countries of the region, and equally the lowest number of beds/inhabitants. This means that Albanian hospitals are, in average, very small (Table 3). A cost-efficient management of this hospital structure is not realistic.

According to various older and more recent assessments, the situation of the secondary care level has not changed and improved substantially in the past years. The outdated network of public out- and inpatient facilities continues to persist, the quality of services and equipment remains poor – with some exception like e.g. Leshe regional hospital under Swiss and USAID support.

Most facilities, despite their small number of beds, present occupancy rates from as low as 25% (rural), or 45% (regional) and 70% (Tirana hospitals), respectively. This paradox, which seems not to have changed in the past 10 years, is a clear sign that the referral system does not work at all. As at the primary care level, the poor quality, deficient equipment and lacking drugs do oblige patients to seek care directly in the better equipped policlinics in Tirana or directly at the University hospital, with the result that these facilities are overcrowded and that long queuing is the norm. Reform efforts are hampered not only by financial constraints (too small budgets for infrastructure and investment), but mainly by the fact that hospital managers have little incentive, capacity and authority to undertake changes, being generally medical doctors without managerial training, appointed rather by political affiliation than professional qualification.

Table 3: Some indicators on human resources, structure and financing of the Albanian health sector

Indicator	Albania	Average of similar regional LMCs	other average or range
Number of physicians	3'685		
Number of physicians/1000 inhabitants	1.2	2.8	3.3
Number of nurses and midwifes	12'455		
Number of nurses-midwifes/1000 inhabitants	3.9	6.7	6.9
Nuber of pharmacists	3'300		
Number of dentists	1'035		
Health posts/centers per 100'000 inhabitants	13.0	13.6	
Rural district hospitals/100'000 inhabitants	0.72	1.34	
Regional hospitals/100'000 inhabitants	0.34	0.85	
Specialist hospitals/100'000 inhabitants	0.28	0.35	
Number of hospital beds /10'000 inhabitants	27	50	(34-66)
Total health expenditure as % of GDP	5.5%	7.6%	(2.5-10.4%)
General government health expenditure as % of total expenditure on health	40.0%	52.9%	(24-85%)
General government health expenditure as % of total government health expenditure	8.4%	11.0%	(4.2-14.1)

Source: WHO data base and MoH Albania

c) The tertiary care:

The Tirana University Hospital (2685 employees, all functions) is the biggest in the country and the only one providing tertiary care. It tends to be utterly overcrowded.

Two University Maternity Hospitals 1 and 2 (659 employees) act as tertiary referral centers for gynecologic and obstetric cases.

The University Dentistry Clinic (43 employees).

But this level encompasses equally the following institutions, all under the responsibilities of the Ministry of Health (131 employees). For details an each of them consult annexes 3.1, and 3.2 for the organizational chart of the MoH.

The Public Health Institute (199 employees)
The National Center for Drug Control (64 employees)
The National Center for Child Upbringing, Development and Rehabilitation (62 employees)
The National Center for Blood Transfusion (or Blood Donation Center) (57 employees)
The National Center of Biomedical Engineering (31 employees)
The National Center for Continued Education (19 employees)
The Helicopter Transport Unit (14 employees)
The National Center for Quality, Safety and Accreditation of Health Institutions (10 employees)

d) Developments in the private health sector

The private sector (dentistry and pharmaceuticals) employs already 11.5% of the health workforce (data of 2009). Besides drug distribution and dentistry it is growing into medical care, mainly through diagnostic outpatient clinics in urban areas, some run by foreign enterprises, religious organizations or NGOs (list see annex 3.5). Private hospitals started to function earliest 2004 when a law on hospital care was approved by the parliament. But accessibility to these services is limited to the wealthier strata of the population, fees are high compared with the public sector, even taking into consideration the bribing obligations in urban policlinics and hospitals.

As the provision of private medical care is growing and the regulatory framework is still weak, government must ensure that new providers contribute to the country's overall health goals and offer quality not only in infrastructure and equipment, but equally in their medical tasks. A positive impact is expected from 2013 onward when the new standard and performance based financing procedure will be introduced (see chapter C.2 financing and annex 5), including public as well as private provider.

Staff of public facilities are allowed to work equally in private practice after their duty hours. This is mainly true for physicians at secondary and tertiary level. Claims were made that these doctors, in order to top up their income, motivate public patients to attend their private practice, with the argument of better infrastructure and equipment (sometimes even 'borrowed' from public facilities). Because up to now the quality of private and public medical care is still considered equal by the population (because carried out by the same professionals), a real, quality boosting competition does not take place yet.

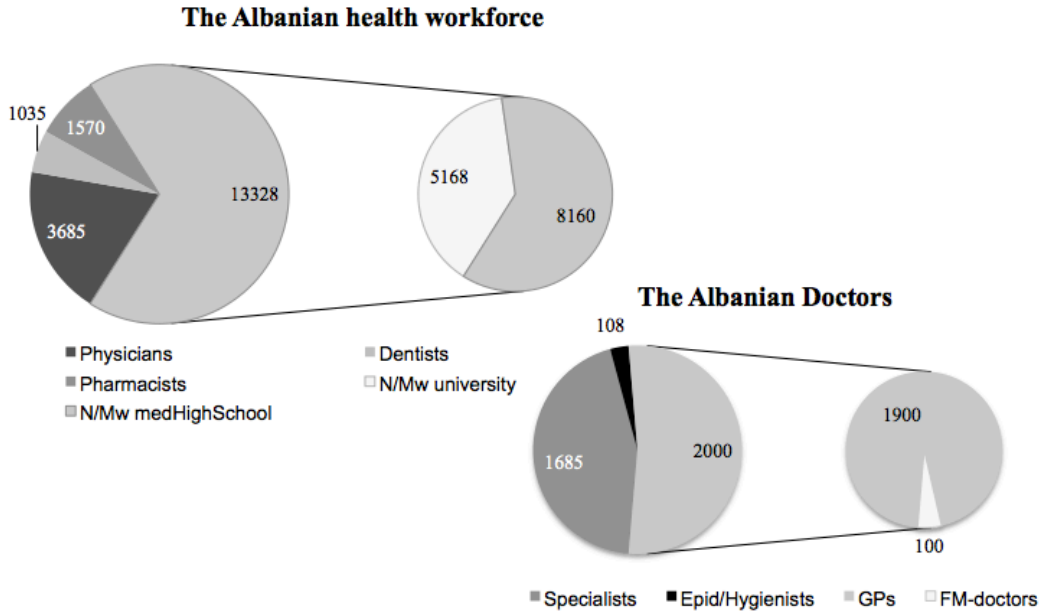
Nevertheless, one strategy element in the NSDI calls for 'encouragement of private initiatives in health'. Apart from the establishment of private health facilities, attempts from the public sector were launched to 'outsource' certain specific functions to private enterprises, e.g. for cleaning and maintenance of premises, laundry, etc: a successful example is the regional hospital of Leshe, where, as a first step, laundry and kitchen services have been delegated to a local enterprise.

e) Human resources

Albania counts presently with about 20'000 health workers, including medical and nursing staff as well as pharmacists and dentists. Compared with other regional MICs, the overall density of doctors and nursing staff is under average (see annex 4.1 and 4.2), with an unequal rural-urban distribution. Within Albania, high density variations exist for specialists and pharmacists while primary care

doctors are relatively evenly distributed, reflecting a Government effort to motivate GP's to move to remote areas (or remain there) by increasing substantially their salaries in the past years. Another imbalance is the proportion of GPs to specialists: on 10 GPs come 8 specialist physicians. These skewed distributions need correction to make the health system work in a cost-effective manner.

Furthermore, the professional qualifications of health workers are often not up-to-date and below (European) standards, with important differences within specific groups. Supposedly, urban specialists are the best trained with access to some CME-activities, in Albania or abroad, sponsored frequently by pharmaceutical companies. In contrast, basic education and continuous training of PHC-staff is not yet adequate. Two categories of doctors working in health centers or policlinics must be distinguished: the great majority of General Practitioners who had a minimal formal education (but often a long experience) and the still very small amount of physicians with the new, four year, family medicine



specialization. For nursing staff, a similar dichotomy exists with nurses/midwifes with or without university degree. The differentiation of training needs among these groups, including so called 'bridging trainings' for those with basic education only, poses challenges for design and implementation of CME-procedures.

An important and under-estimated function in the Albanian health system is that of management, at central as well as at lower levels. Few people have specialized capacities in health policy, in health system and facility management – and those with qualifications don't reach decision making positions at the MoH or health facilities. This is one of the main reasons that most health reform processes are slowly progressing. Behind this fact lies the culture of favoritism and politicisation of public administration. Efforts are underway at the Faculty of Medicine of Tirana to establish a 'School of Health Policy, Economics and Management'.

f) Reform and external support needs in the structure & human resources domain

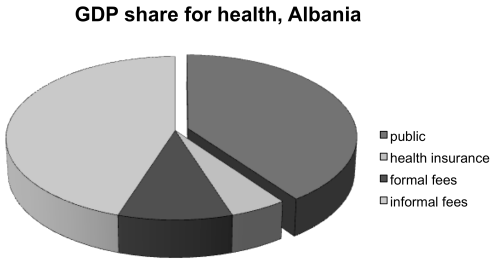
The health facility map must be adjusted according to real needs of the population and towards a more cost-effective function. This requires the implementation of the planned, performance based, financial incentives for health facility staff at all levels. It requires equally a better qualified and motivated health workforce through better basic and continuous training, as well as an attractive work environment with adequate equipment and premises.

Albanian counterparts are convinced that only a strong and coordinated commitment of foreign actors, through their policy dialogue, technical assistance and stewardship, will help Albania to overcome its own intrinsic cultural and political obstacles impeding a timely implementation of reforms.

2) Financing of the health sector

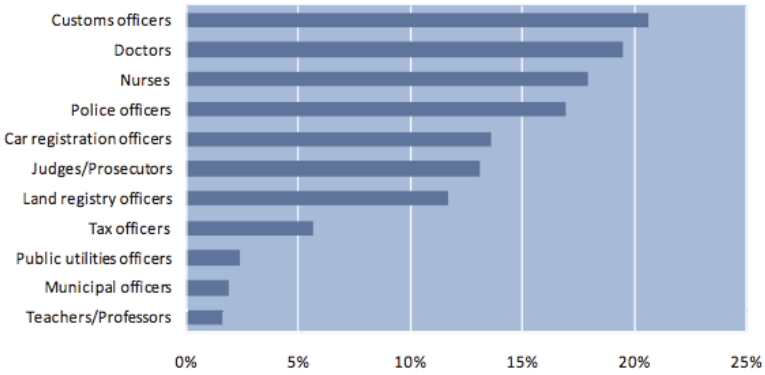
a) The source of money

While the economy of Albania is growing steadily and the GNI per capita (in PPP$) has doubled over the last decade, the public share of the countries GNP remains low with only 28%. And of the health expenditures of Albania's GNP (2011 5.5%), only 40% were public expenditures, which corresponds to as little as 580 PPP$/capita, the lowest figure among other neighboring middle income countries. Because of this low public spending on health, the remaining 60% must come from direct out-of-pocket contribution by the citizens (OOPs, estimates based on household survey data). The smallest part of OOP were health insurance fees (mandatory, but coverage probably still under 50%) and 'formal' fees for certain services (although the law provides for free basic care).



The bigger part of OOP are 'informal fees', i.e. under the table payments or bribes. As a result, essentially everybody who is hospitalized incurs substantial costs which 'creates serious inequities in access, has a considerable poverty impact and limits effectiveness of the Government's sectoral stewardship'[7]. According to another household survey[8], the incidence of informal payment is higher in inpatient than in outpatient services, where a certain decline did occur over the past years. Astonishingly, health services are among the sectors with the highest prevalence of bribing, the doctors ranking just behind the custom officers and before the nurses[9]:

Figure 10: Prevalence of bribery for selected types of public officials receiving the bribe, Albania (2010)



b) The distribution of money

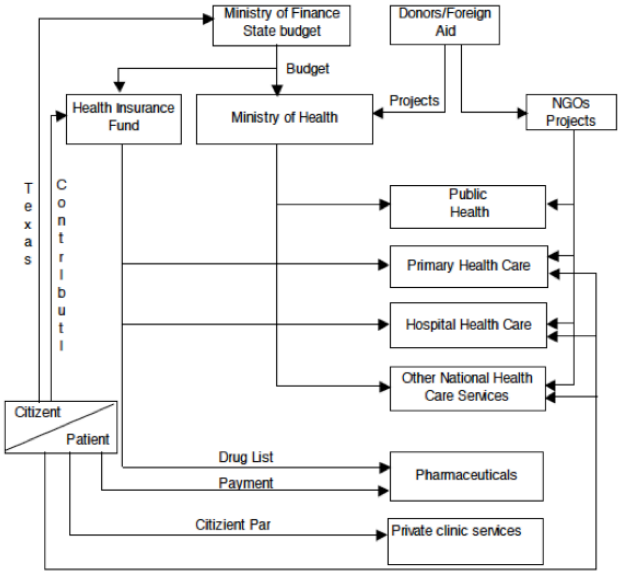
The public health financing is fragmented and still 'under construction' until the new and approved 'Law on Mandatory Health Insurance' is fully implemented. At the moment, MoH pays still for capital expenditures at all levels and salaries for some regional and Tirana hospitals; the Health Insurance Institute HII covers costs of all staff and consumables at PHC-level as well as, since 2009, some hospitals; local governments cover a very small part of costs, mainly for maintenance of premises.

75% of HII's budget stems from tax money (as a reimbursement of services to the 'inactive population' covered by the insurance without contributing, like pensioners, children<18, students, unemployed, vulnerable groups), while the remaining 25% comes from insurance fees of the 'active population' (all employed, people, with social assistance, self-employed persons who contribute voluntarily). Cost of the voluntary insurance: between 30-80$/year (rural-urban). The proof for insured status is a health 'card' (today still a 'booklet) which people only get following certain bureaucratic procedures (you need to find out where and with which GP you are registered, etc.) HII says to have distributed 1.5 million 'cards: estimation of the rate of uninsured people depends on (a) the size of the 'inactive population' (who doesn't need to be insured) and (b) the current size of the Albanian population, both unreliable figures. HII prefers to calculate with a big (a) and a small(b) and obtains a (over-optimistic) insurance coverage of close to 90%; others count with over 40% uninsured people, all subject to high OOP payments in case of illness!

For details see flow-chart below (source NHA, final report[10], see also annex 5 for more details).

c) Financial management at facility level

Chart of money flow in the health sector:



According to HII, since 2007, a total umber of 420 HC's have been reimbursed based on pilot model established by WB/PHRplus, which aims to change the mentality and culture of facility management: a HC is an autonomous entity, self-organized and managed, with a board including representatives from MOH, HII and local government; the reimbursement key encompasses 80-85% fix budget according to an annual plan and 20-15% performance based reimbursement, of which 5-10% as a 'quality-bonus' depending on the accomplishment of 9 output indicators (this approach was piloted by USAID and replicated since 2007).

A quarterly reporting of data is required (number of hypertension, diabetes, % first visit, % pregnant women, % children vaccinated, etc., including CME data with % of credit requirement earned by doctors). If the bonus criteria are fulfilled, the incentive money is paid twice a year as an add-on to salaries. This health information procedure is supposed to work because most HC (as well as decentralized HII offices) have now a computer (WB-program) in order to fill in the reporting form which is transferred to HII, MoH, IPH (also to representatives at regional level); the latest annual report has been established 2011.

The new law "On Mandatory Collection of Compulsory Contributions for Health and Social Insurance" has been approved and is set to be enforced in March 2013. This law strengthens the role of HII, as a single strategic purchaser of health services. The Health Insurance Institute will be transformed in a Health Insurance Fund and it is going to pay providers based on performance rather than input. But this new financing procedure is not ready for implementation: too many different authorities are still involved in decision making. The hospitals have contracts with regional directories, with HII, but the budget is still influenced by MoH, and HII cannot take any budgetary decisions yet!

Under the new law on financing from 2013 onwards HII should become single purchaser of public and private services, based on a new package for hospital services, monitored through a criteria list which will include financial, medical and social indicators. While good rules and regulation exist for the PHC-level (e.g. number of GPs/nurses/midwifes per catchment area and population density[a], proposed and defined by a board on the basis of real needs) no standards or criteria are defined yet for hospitals: MoH designs the budget (mostly based on the previous one) and decides upon the level of investment and running costs, and the Council of Ministers approves. Power is therefore only formally transferred to HII and the providers, who are fighting for more autonomy… Hospital financing and human resource management is a very delicate political issue, especially in Albania.

d) Reform and external support needs in the health financing domain

More financial resources for the public health service must be mobilized. The balance between public and OOP spending in health must be improved in order to reduce informal payments. Financial resources must be allocated in a more cost-effective manner. Strategies and action plans are available and piloting activities are under way (HII as single purchaser), but progress is slow.

Albanian counterparts believe that foreign support can make a difference in speeding up and de-politicizing the implementation process – through policy dialogue at central and technical cooperation at decentralized levels.

[a] Example: number of staff in HC - urban 1FamDoc/2000-3000 inhabitants; rural 1FamDoc/700-1500 inhabitants

D Health status of the Albanian population

1) Data reporting and processing quality

Albanian health professionals collect and report a great number of information and channel it towards their authorities. The 2008-09 demographic and health survey ADHS (co-sponsored by Switzerland) is probably one of the best examples of the recent years, where the two main players in data collection and processing, the Institute of Public Health IPH and the Institute of Statistics INSTAT, worked closely together. Many of the evidence presented in their impressive volume is still valid, should be consulted and used for decision making.

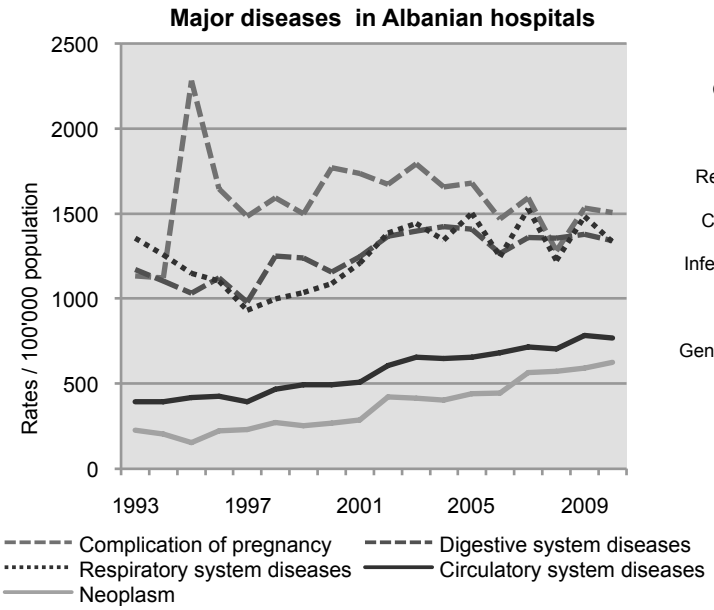
But the success of this concerted once-in-time effort shouldn't hide the fact that the awareness and capacity for rigorous data collection, reporting and processing on a regular basis is still weak. While the EU progress report[11] states some progress 'in the area of sectoral statistics', mentioning especially the development of 'sectoral accounts', it cautions at the same time that basic IT infrastructure and internet access is lacking in many parts of the country.

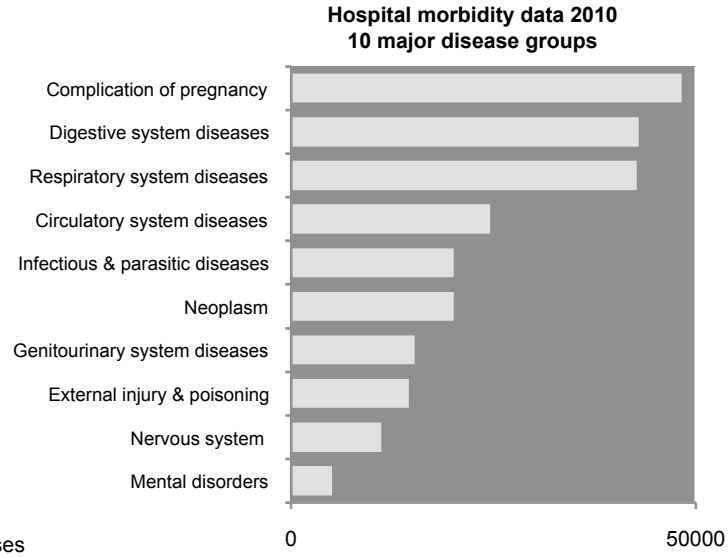
In the health sector, according to the HII, an improvement of the data quality can be observed due to the WB Health System Modernization project, through which infrastructure (computers) have been made available in many PHC facilities and the obligation to report performance indicators has increased the amount of data collected and reported. But no independent field information is available to confirm the views of HII; it is evident that internet access doesn't exist in many remote areas and the new procedures are probably not applied broadly yet. Realistically though the morbidity and mortality data presented below must be treated with some caution.

2) Burden of disease, status and trends

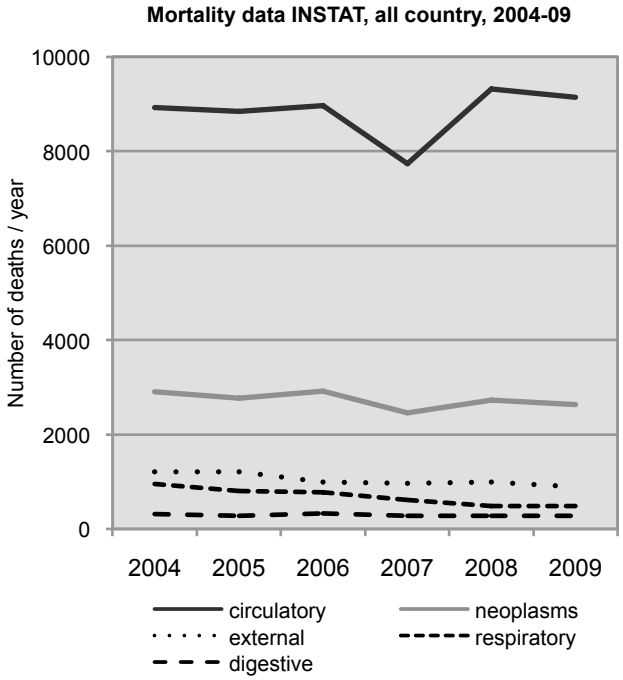
a) **Overview** (see also annex 6, all graphs on morbidity and mortality)

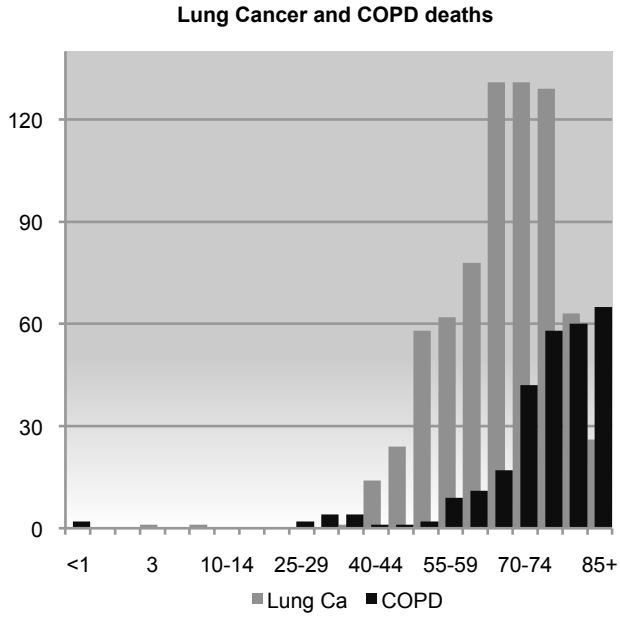
The following **morbidity** graphs give a compelling evidence on the main causes of illness of the Albanian population and their progress over the past two decades.
Astonishing is the persisting high rate of pregnancy complications as the most frequent cause for admission in Albanian hospitals. Frequent but with a more or less stable rate are health problems of the digestive and respiratory tract, as an example chronic obstructive pulmonary disease COPD as one of the consequences of smoking. A strong upward trend is observed in cardiovascular diseases and cancers, which are twice and three times as frequent, respectively, than twenty years ago – and the trend seems unbroken.
Caution: in a country with improving data collection discipline over the past decade, an 'under-reporting' in the past might bias trend perceptions (overestimation). But the specter of the ten most frequent morbidities treated in hospitals 2010 is probably a good indicator of today's disease reality.





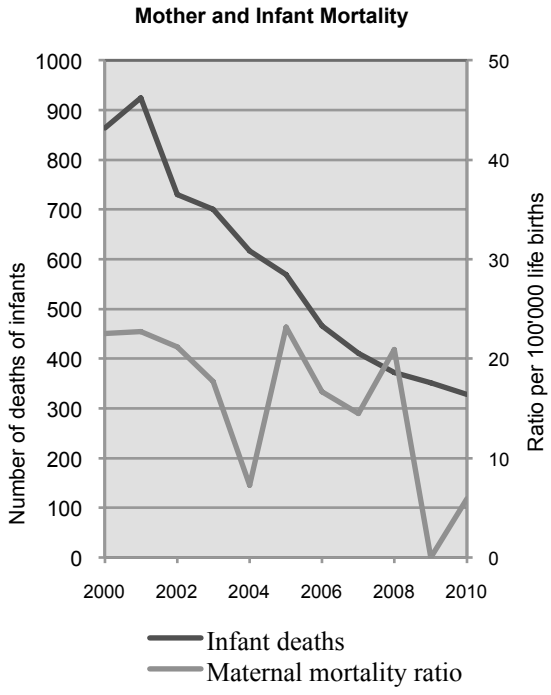
The national **mortality** figures show circulatory diseases (stroke and heart attacks) and neoplasias (cancers) as the most frequent causes of death, followed by 'external causes' (accidents: see below) and respiratory diseases. More productive life years are lost by lung cancer than by COPD, because cancer develops earlier in life than COPD (graph on the right). The slight decrease in 'external causes of death' is in contrast to the intuitive perceptions of most interviewees who saw in the increase of traffic and the many road accidents a major public health problem.





b) Maternal and child health

This steady and strong trend in **infant deaths** since 2000 is astonishing. The same tendency is reported for **maternal mortality** (deaths of women while pregnant and 42 days after termination of pregnancy). These trends contrast with the high number of hospital admissions for 'complications during pregnancy', a fact supporting the reports of 'low accessibility to pre-natal care in remote areas' and 'substandard delivery practices' at PHC level. Insufficient care of pregnant women at primary (and secondary?) care levels, a lack of early detection of problems leads to an overload of the tertiary level maternity in Tirana. Nevertheless, Albania 'is making progress' [12] with a reduction of MMR since 1990 of -44%, (comparable to surrounding MIC's like Serbia with -46%, B&H -56%). This is the result of a strong focus in the region (by USAID and others) on promoting routine adherence to best practices in labor, delivery, and the early post-partum period[13] since the early 2000s.



Another interesting issue is the development in **contraceptive use and abortion**. The 2005 ADHS found a very low use of modern contraception methods (12% living in urban vs. only 2% living in rural areas). Abortion has been seen as an 'alternative method of contraception': back in 1993, 73% of registered abortions were induced, in 2000, this rate was still 40% and has declined, according to MoH data, to one third in 2010. Despite progress in mother care, education in and promotion of contraceptive use (and protection against STD's) is still a neglected field.

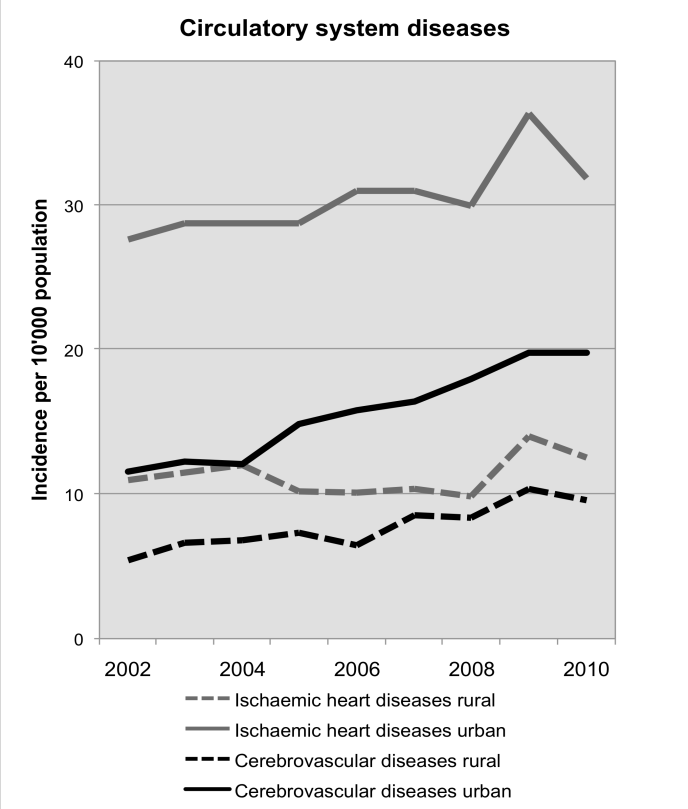
Child health: with a child vaccination rate of close to 100%, child morbidity and mortality due to complications of childhood diseases has been lowered substantially; the remaining problems of child health are linked mainly to discrimination in terms of access to health for the poor section of the population and to malnutrition (64% anemia observed among children of low income households). Abuse and violence against children of marginalized groups like the Roma is another reason for persisting inequities in the health status of Albanian children. In contrast to this, overweight is rising concern among children of wealthier, urban families.

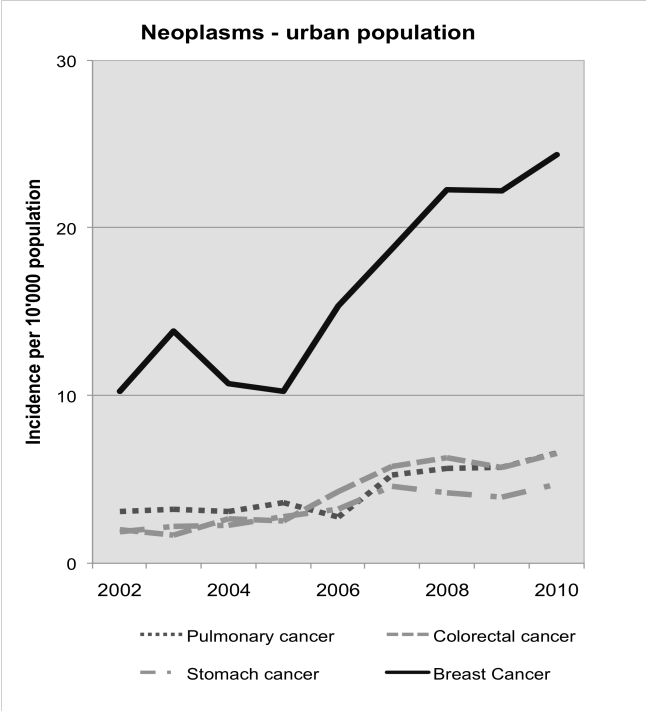
c) Non communicable diseases NCD's

NCD's encompass most cardiovascular and chronic respiratory diseases, metabolic diseases like diabetes, many tumors and neuropsychiatric conditions. They have now surpassed all other causes of illness combined and became the main cause of mortality in most regions of the world, including the Western Balkans.

WHO has recently communicated the latest figures on NCD's, revealing that age-standardized death rates are twice or three times higher in the region than in Western Europe (e.g. for men the rate has reached on average 1000 deaths per 100'000 population vs. 400 in France). And a big share of these deaths, namely 38% in Albania, occur prior to 70 years of age.

Besides human suffering, this leads to a massive increase of costs for health care, a reduction of the workforce and, in a country like Albania, to a sometimes 'catastrophic' financial burden on families as a result of formal and informal payments.





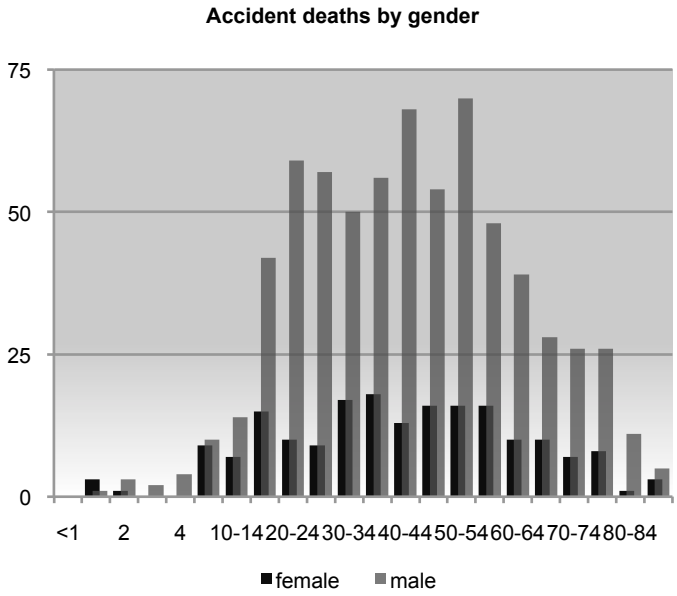
Late diagnostics (e.g. for carcinomas), together with low quality oncology, results in higher case fatality and survival rates than in Western Europe (only an average of 45% of patients survive vs. 70-80%, respectively).

As the two graphs of NCD-trends for Albania show (INSTAT/MoH data 2002-2010), the incidence of newly detected cases per year is rising constantly, most dramatic for breast cancer and for cerebro-vascular diseases. Strokes frequently do not lead to death but to a year-long disability and a heavy burden on family and society.

d) Accidents

In 2009, 14'008 people were hospitalized and 891 people died because of an 'external cause', 216 (24%) as consequence of a road accidents. While the number of admissions is raising since 2000 (in absolute terms and as rate/100'000 inhabitants), the death tall seems to have a slight downward trend, including road accident deaths. This can be interpreted as result of an improved emergency and hospital service. But the fact that among the 891 casualties only 150 (17%) died in a hospital raises a doubt on this assumption.

Data on accident victims, disaggregated by gender and age group, illustrate a dramatic sex differential: nearly four times more men (most of them in their productive age) than women die from accidents. An intervention on male risk behavior should be a priority.



e) Mental disorders

WHO has put mental health high on the agenda: *'Mental, neurological, and substance use disorders is affecting every community and age group across all income countries; while 14% of the global burden of disease is attributed to these disorders, most of the patients do not have access to the treatment they need.'* Mental health is considered as a particularly important problem in the 15-44 year old female population, contributing to a big share of a population's DALY load. In Albania, 'mental disorders' rank as number ten in the 2010 national hospital admission statistics. For details see annex 7.

Mental Health MH Screening in Albanian PHC facilities

	Indicator	% charts with best practice	
		Albania	Average 4 study MIC
Screening for Depression	% charts with diagnosis of depression recorded	2.5%	2.5%
	personal depression history recorded	1.0%	0.8%
Screening for anxiety	Question re anxiety: 'feeling sad' with specified duration	2.0%	1.8%
	Documentation of anxiety symptoms	4.0%	3.8%
	Documentation of suicidal thoughts	0.0%	0.0%
	Documentation of depression screening or diagnostic questions	7.0%	3.8%
Evidence based treatment	MH consultation note or referral to MH professional	1.0%	0.8%
	Referral to psychiatrist	12.0%	5.0%
	Special follow up w/PHC provider	19.0%	5.0%
	Serotonin re-uptake inhibitor SSRI prescribed	5.0%	2.0%
	Tricyclic antidepressant prescribed	2.0%	1.5%
	Benzodiazepin (anxiolytic) prescribed	5.0%	4.8%
	Insomnia medication prescribed	2.0%	2.0%
	Antipsychotic medication prescribed	12.0%	3.0%
	Stimulant medication prescribed	4.0%	13.0%

The table above represents the result of patient chart analysis in Albanian PHC facilities (results from the 'NCD Four country Assessment'[14]). In contrast to the high prevalence of 'mental disorders' in hospital admissions, very little documentation was found on these charts on personal history of depression, on symptoms like sadness, anxiety or thoughts about suicide. The mention 'follow-up with PHC-provider' was most frequent (19% of charts), but prescription of modern antidepressant treatment by the facility doctor himself a rare practice (only marked on 2-5% of the charts). Untreated mental health conditions affect, in addition to their independent human suffering and economic costs, the control of other chronic diseases.

Up-to-date protocols for an adequate screening and treatment of mental disorders have not yet reached the PHC-level in Albania. Nurses and doctors must urgently be sensitized and specifically trained for this underestimated problem.

f) Communicable diseases, STDs, HIV-AIDS and TB

In the last decade, the absolute number of hospital admissions for '**Infectious and Parasitic diseases**' has remained stable. It can be assumed, that the main causes were gastro-intestinal diseases (still critical water supply situation) and respiratory infections. Vaccine preventable infections of children did become rare, no measles case reported in the past three years (proof of good vaccine coverage). Hepatitis is still a problem (hygiene, iv-drug use), but the rate has continuously decreased from averages around 50 in the Nineties to 11/100'000 inhabitants 2010 (epidemic peaks of hepatitis did occur during the political crisis in '93 and '99 reaching rates up to 200/100'000 population).

No surveillance results or specific morbidity data exist on **STDs**! But the situation as described in the 2008-09 ADHS might still be pertinent today concerning sexual behavior parameter like age of first sexual intercourse (average 18 years), condom use (only 50% at first time or at most recent high risk sexual intercourse) or knowledge of **HIV/AIDS** transmission and prevention (less than one third of men or women had adequate knowledge). In order to change this unsatisfactory situation, the Global Fund to Fight AIDS, TB and Malaria has started to invest in 'strengthening Albania's national response to HIV/AIDS among vulnerable groups', since 2007 with a grant of 5.1 million US$; currently 160 people are on antiretroviral therapy. Estimates on prevalence of HIV or STDs are not available, but the ADHS survey reported 5% of men and 11% of women having had an STD in the 12 months preceding the survey.

Tuberculosis is still of certain importance with 160 new smear positive cases detected and treated with DOTS last year. The TB incidence and death rate are both decreasing since 2000 (from 23 to 14 and from 0.8 to 0.4 per 100'000 population, respectively) and the treatment success rate is high with 89%. Since 2007, the Global Fund has funded the 'Scaling-up' of the National Response to TB with a grant of 1.2 million US$.

3) Trends in determinants of health

Many NCDs share common, modifiable physiologic and behavioral risk factors that could be targeted simultaneously to reduce the risk for multiple NCDs. Leading shared **behavioral risk factors** include tobacco use, physical inactivity, unhealthy eating, and alcohol abuse, and shared **physiologic risk factors** include hypertension, high cholesterol, and obesity.

The determinant assessment of the ADHS obtained the following information through their household survey (target group 15-49 age old; more details see annex 8.1):

- over 40% of men and women had a moderate, and 10% a severe hypertension, not more than 5% of them were on medication;
- over a quarter of Albanians were overweight, 10% obese with a BMI>30, at least a quarter of them with elevated lipidemia;
- close to 50% of men are smokers, have started smoking at 19years of age; 15% of urban women smoke (much less in rural areas); two third of them made an attempt to stop smoking in the past year;
- over 15% of men have been identified as 'heavy drinkers of alcohol' (>5 drinks on any day of week);
- over 60% of interviewees in the survey didn't engage in 'vigorous physical activity'

Based on these data, the MoH calculated 'Burden of Disease share estimates' and came to the result that: smoking is contributing with 22%, obesity with 10%, alcohol with 6% and physical inactivity with 5% to the overall burden of disease of the Albanian population!

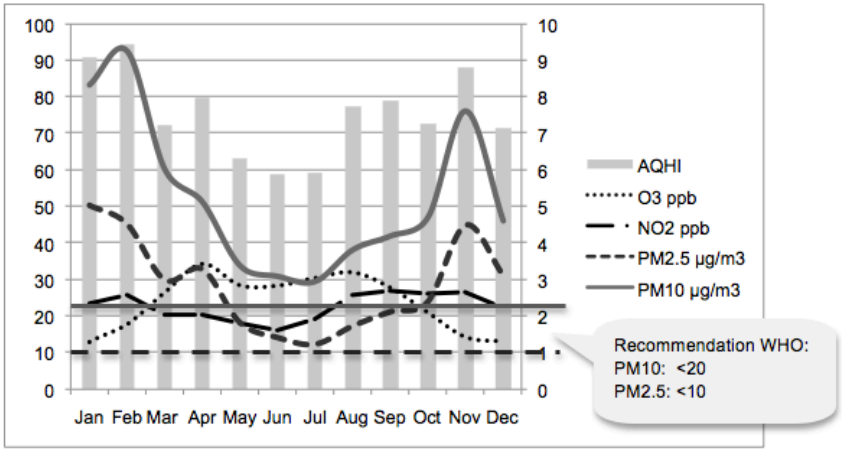
Multiple social, psychological, and biological factors determine mental disorders. For example, persistent socio-economic pressures are recognized risks to mental health for individuals and communities. The clearest causal correlation exist between mental disorders and both, poverty and low levels of education. Poor mental health is also associated with rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, risks of violence, human rights violations and physical ill-health in general.

Therefore, national mental health policies should not be solely concerned with the curative aspects of mental disorders, but should also recognize and address the broader issues which promote mental health. This includes mainstreaming mental health promotion into policies and programs in

government and business sectors including education, labor, justice, transport, environment, housing, and welfare. **Promoting mental health depends largely on intersectoral strategies**.

The environment is another determinant of health. In Tirana (and presumably in other bigger cities) traffic and air pollution are the most visible factors influencing health. The number of cars increases by 25% every three years and that of trucks doubles in the same period. The table below shows the effect this has on air quality: particulate matters in the air (PM10 and the worst PM2.5 with a diameter <2.5µm, passing even the blood-brain barrier) remain high over the norm, especially during the winter

Graph: Air Pollution Indicators for Tirana (Center) in 2011



Source: Public Health Institute, 2012

The pollutions like PM10, PM2.5, NO2 and the Air Quality Health Index AQHI are above the recommended values of WHO and EU standards. The origin of particulate matters is mixed, 47% from street dust and 53% from diesel vehicules.

months. WHO estimates that fine particulate air pollution (mainly the PM2.5 from car exhaust) causes about 3% of mortality from cardiopulmonary disease, about 5% of mortality from cancer of the trachea, bronchus, and lung, and about 1% of mortality from acute respiratory infections in children under 5 yr.

Other environmental health hazards are less visible, as contaminated drinking water and the effect of bad sanitation or the transmission of epizoonotic infections from domestic animals to humans, etc. And others are not visible, but audible as the urban noise pollution.

Awareness of health protection outside the health sector is crucial to address many of these factors and influence in a positive way the health determinants: the claim for 'health in all sectors' is more than justified.

4) Reform and external support needs to combat major disease trends

The continuous rise of NCDs claims for a stronger focus on 'modifiable shared NCD risk factors', which means a strengthening of preventive measures and promotion of public health (ant-smoking / life-style / stress / road safety). This implies dialogue between various sectors, community participation and empowerment of patients. Health professionals must close the gap between known best practices and inadequate, outdated practices still used. This needs better training and CME. But prevention and cure of frequent, treatable neoplasias like cervical, colon or breast cancer requires financial investments, too, in order to make e.g. mammography and laboratory services available at the regional level. Finally, to fight successfully against the NCD epidemic, a strong political will and broad commitment for a comprehensive approach is necessary.

This endeavor needs, at least on a short term, foreign technical and financial support, because Albania has neither the human capacity nor the political maturity to do it on its own.

As a proof for this view, the conclusion of the '4 country MCH survey'[15] can be cited: *"the strong results in sampled Albanian maternities were undoubtedly in part attributable to high stakeholder investment in the region, including by USAID, and most importantly are reflected in the decreasing maternal and neonatal mortality rates."*

E Past and actual Swiss support to the health sector

1) A record of success stories

Switzerland has been a key player in the field of health in Albania from as early as 1993. The predominant focus was mostly capacity building of personnel involved – in one or the other way - in health service delivery. To a large extend, all projects have produced sustainable impact and are, even after years, still remembered as successful and useful contributions: thus, Switzerland has become a renowned partner in health development in Albania. While there are objective criteria to confirm this perception in most cases, some failures can be identified – or some risks that did or still can limit the success.

Table: Summary list of Swiss support to the Albanian health sector

	Swiss project	Focus	Target	Scope	Duration	CHF spent (millions)	Comments
1	**Microbiology lab project**	Equipment / training	Laboratory staff	Tirana University Hospital	1993-1996	0.4	no report
2	**Development Program Nurses / Midwifes**	Training / Institution building	Nurses/Midwifes	National	1994-2005	n.a.	
3	**Project Environment Albania EPFL**	Training / Institution building	PH professionals	National	1995-1997	n.a.	(till 2000?)
4	**Summer School in PH Policy, Economics and Management**	Training	PH professionals	Region: EE, Balkan, Central Asia	1996-2012	0.64	last 4y phase
5	**Humanitarian Aid Kosovo crisis**	Infrastructure / Equipment	HCs, hospital	Lezhe district	1996-1998	n.a.	no report
6	**Lezhe Health Deveklopment project LHDP**	Infrastructure / Training	Hospital Lezhe	Lezhe district	1998-200??	n.a.	no report
7	**Health Planning/Management TP-HPM**	Training	Health professionals, hig/middle level	National	2005-2008	n.a.	
8	**Professional Development System PDS**	Institution building / Training	Health professionals	National	2007-2012	3.53	(budget phase 2: 1.83 mill.)
9	**Dewvelopment of Special Pedagogy Section DSPS**	Training / Institution building	personnel working with handicapped	National and Vlora University	2007-2010	4.7	
10	**Albanian Demography and Health Survey ADHS**	Health Information System	Social science and health professionals	National	2007-2008	n.a.	
11	**Hospital twinning HUG, others**	Training	Radiologists, other health professionals	Regional; Tirana University Hospitals	2010-2012	n.a.	HUG in Prishtina, too

Below, all projects are presented (in chronologic order, based on launching year), with a short assessment of their success, the failures or risks incurred and a concluding remark (a detailed description of each project is annexed to the report, annex 9).

a) Microbiology lab project

Focus: Equipment / training – Target group: Laboratory specialists – University Hospital Tirana (1993-1996)

During four years, a modern microbiology laboratory has been established at the University hospital. A number of lab-kits were purchased and premises organized. Six lab specialists were trained by Swiss microbiology professors.

Total amount of Swiss money spent: 400'000.-

Success / failure: The infrastructure is still functioning today, but trainees (who didn't all satisfy) had to be changed, the best one left abroad (brain drain!)

(Information provided by Prof.Petrella, Neurologist and former Dean of Faculty of Medicine).

b) Development Program Nurses / Midwifes

Focus: Training / Institution building – Target group: nurses / midwifes – National (1994-2005)

Total amount of Swiss money spent: n.a.

Success: The program led to a sustained modernization of care procedures and working culture in hospitals; nursing management professionalized; modern nursing high schools established (n=6); pedagogic skills of nursing and midwifery lecturers improved; training materials provided.

Failure: a comprehensive strategy for nurses training not achieved; homologation issue as a result of divergent training levels and diplomas not resolved; sustainability and 'albanisation' only partly reached (slow progress, lack of Albanian materials and equipment, institutional conflict).

Conclusion: a program which is still well known as one of the most important training efforts in health ever and very much appreciated by Albanian stakeholders at government as well at health facility levels; had an impact on quality of services and did lead to important and sustained changes; the success is a result of long term commitment and sustained technical assistance; a greater subtlety in dealing with the Albanian institutional idiosyncrasies (MoH vs. MoEd) might have opened opportunities for a broader strategic approach (diplomacy, policy dialogue).

c) Project Environment Albania - EPFL

Focus: Training / institution building – target group: public health professionals – National (1995-1997)

Swiss money spent: n.a.

Potential of the project: improvement of the knowledge base and professional capacity of environment inspectors in the whole country; reinforcement and modernization of the national reference center; higher degree of national cohesion relative to objectives for a better environmental hygiene; creation of a group dynamics through practical work in the local reality, with the potential of rapid and visible results; establishment of a new reporting culture (manual) which allows better controlling and planning, and an assessment of needs and gaps in environmental health knowledge and research. This project is an example of an inter-sectoral approach for health.

Success / failure: No evaluation of outcome or sustainable impact of this program was available; but according to IPH, the professional capacities of staff and the equipment of the Department of Environmental Health was upgraded during the three years of the project and an intense exchange with Swiss experts took place.

Conclusion: The relevance for health of this project is obvious, and the design convincing, thus – in theory - a sustainable impact seems possible. It applied a classical and established formula, i.e. scholarships for few leaders in the domain, training of trainers in short foreign courses to expose them to modern views, procedures and techniques - and a dissemination of knowledge and attitude through on-the-job trainings for local people exposed to the reality on the ground. All combined with some hardware supply.

No external review was available to check whether the 'environmental hygiene', and the functioning of hygiene inspection, has improved as an effect of the project. The reference center at IPH seems to fulfill its role till today.

d) Summer School in Public Health Policy, Economics and Management, Lugano

Focus: Training – Target population: public health professionals - Eastern Europe, Western Balkan and Central Asia (1996-2012; Albania since 2003)

Albanian health sector representatives have attended Summer School courses since 2003: at least 60 health sector employees have benefited from the courses (summer 2010).

Swiss money spent (whole region, last phase 2010-2013): 647'000 SFr.

Success: The Summer School offered to an impressive number of public and private health sector workers the possibility to update their technical skills and to learn the basics of health economics and management. Sharing pertinent tools, methodologies and expertise represents a value for all the transition countries Therefore, the courses can be a relevant factor in the process of change. An additional asset is the exchange among health professionals of the region and the discussions with participants of more developed countries: they see what can be done.

Limitation of success: The one week courses are only a 'small step', participants get not more than a first insight into the topics and thus the impact must not be over-estimated. And, individual capacity building is only successful if – in parallel – an institutional capacity building takes place in their respective countries, e.g. better governance at Ministry levels, merit based public human resource management, etc.: the 'friendlier' the political and institutional environment, the better the impact…

Conclusion / perspectives: This training set-up runs now since nearly 20 years, with a constant rise in quality and integration in the international framework of CME. It is maybe time now for a step into a more 'regional ownership': it has been proposed to study *'the mid-term feasibility of a Summer University in South-East Europe, with the condition that it should preferably be integrated in a regional structure and the courses be accredited by the respective university or training centre'*.

e) Humanitarian Aid during Kosovo Refugee Crisis

Focus: Infrastructure/equipment – Target: village HCs/ambulances, small hospitals – Districts Lezhe, Shkoder (1996-1998)

Swiss money spent: n.a.

f) Lezhe Health Development Program LHDP

Focus: Infrastructure and training – Target: Hospital - Lezhe district (1998-200?)

Swiss money spent: n.a.

Success: aspects of sustainable impact of the Swiss investment could be noticed during a short hospital visit; according to the director and a former coordinator of the project, this is mainly true because of a good balance between 'soft and hard' support, i.e. an emphasis on educating people and on improving their physical work environment.

No further details (report) obtained at Caritas Swiss.

g) Training in Health Planning and Management TP-HPM

Focus: Training – Target group: high and middle level health professionals with managerial functions - National (2005-2008)

Total amount of Swiss money spent: n.a.

Success: A highly committed group of health professionals, 71% female and mostly under 40 years old, got a profound training in a domain, where more capacities are desperately needed in Albania. They got the potential for progress and change if placed in key managerial positions in the health sector.

Failure: The evaluation showed that the rigid institutional and political environment, the culture of favoritism, curbs strongly this potential: only 14% of the alumni reported, in a later survey, having obtained a new position with increased autonomy and responsibility.

Conclusion: This program is still well known by most of the people interviewed during the assessment; but as a sponsor 'behind the operational scene', it was less perceived as a 'Swiss' contribution. Despite an important Albanian ownership in planning and execution of this 'Joint Initiative' and a high professional quality, the effect on health system reform has probably been small

and the new capacities under-exploited. Lesson learnt: without a political will to change an inherited culture which is obstructing progress, even the best program has a limited impact.

h) Professional Development System PDS

Focus: Training, institution building – Target group: health professionals – National (2007-2012)

Swiss money spent: phase 1 1.7 million SFr.; budget phase 2 1.83 million SFr.

Success: Due to the vision and commitment of Switzerland, a Continuous Medical Education System for health professionals, this cornerstone of all modern health systems in Europe, has finally been developed in Albania, too. Big foreign aid agencies always invested in health training and claimed for a national CME-strategy, but no one dared to engage in such a systemic, strategic approach which is essential for reform. Now, CME is on the political agenda and the success has been recognized up to the Prime Ministers level.

Failure/risk: The demand for CME, which is now compulsory, cannot be covered by the offer. And this especially in areas, where the main focus for the PDS-extension should be: the rural, more remote areas, where many general practitioners and other health staff still work since years with very basic medical education and no up-grading. NCCE is not ready for a full-fledged execution of its tasks because still overloaded with the double role of implementing the strategic plan for organizational development and capacity building, and, at the same time, carrying out the functions and responsibilities (accreditation, re-certification) according to MoH policy-documents and orders. There is no unanimity concerning the degree and the organization of the devolution of CME-functions to decentralized institutions (NCCE branches? CME-antennas in district hospitals and other regional health institutions?). In the meantime, many health professionals have no access to training and cannot earn their compulsory credits.

Conclusion: The following sentence of the 'fathers' of the PDS-project is still true: 'while NCCE remains the central pillar of the approach and its first step, it is important to notice that developing a PDS is more comprehensive than building simply such a Centre'. Too much emphasis on this first step has impaired the path towards a systemic development. Whether till the end of the planned phasing out of this project (2014) a complete 'CME-house' can be built around this 'central pillar' is questionable. But without modern training procedures for the Albanian health workforce, health reform and aspiration to European standards will not work. SDC, which was since its commitment in Albania a major player in health training: it shouldn't risk to drown this flagship by jumping from board too early….

i) Development of an Special Pedagogy Section (SPS) at the University of Vlora

Focus: Training, institution building – Target population: personnel working with handicapped persons – National and regional (Vlora) (01.2007-06.2010)

Swiss money spent (three phases): SFr. 4.7 millions.

Success (according to SDC): An SPS is established and functions at the University of Vlora; Bachelor (two or three years duration) and Masters programs were developed fulfilling the Bologna standards for pedagogues; five full time professors are prepared for the training of the specialized pedagogues and the director of the SPS is trained, in addition to special pedagogy, on administrative and financial management issues; SPS has established new concepts of training for staff of handicapped peoples homes.

The project is compatible with the National Social Strategy promoted by the Ministry of Labor and Social Affairs, which is part of the National Strategy Development and Integration (NSDI). The development of the SPS in Vlora citizens –and advocacy for disabled citizens in general - has been one of the most important elements of the Swiss contribution to enhance social inclusion in Albania.

This project is an example of an inter-sectoral approach for health.

No external review of the project was made available to assess the project's impact more in depth.

j) The Albanian Demography and Health Survey ADHS

Focus: Health Information System – Target group: social science and public health professionals – National (2007-2008)

Swiss money spent: n.a.

Success: there is no doubt that the exhaustive field work, information collection and data processing is a big achievement for Albania's health professionals involved; the result is presented as a document with high quality standards and can be used as the evidence base for decisions in the health and other sectors.

Failure: The funding of such an endeavor is surely no failure; the problem lies in the fact that the 'next step' in the process of change, progress and reform, i.e. taking into consideration the scientific findings for decisions, is lagging behind – for non-scientific reasons.

Conclusion: The rich database obtained through this survey and professionally presented in the report is even five years after data collection still relevant; it is difficult to judge whether it had an impact on state, function and quality of today's health system; intuitively, doubts can be raised if this nice evidence of priorities, of risk behaviors and system malfunctions are really taken into consideration by those who decide on financing and staffing the health system…

k) Hospital twinning's

A regional program for all EE, Balkan and Central Asia countries. For Albania, several hospital twinning's might take place which were not known to the consultants and the SCO-A, except the one of the Geneva University Hospital HUG/Department of International and Humanitarian Medicine DIHM:

Focus: training – Target group: radiologists at emergency services – Kosovo, Albania (2010-2012)

Swiss money spent: n.a. (funding by HUG, too)

An example of a small, bilateral Hospital Twinning project; others might exist between Albanian and Swiss Hospitals; good example of concrete and direct support in a very specific area – generally very much appreciated by the concerned specialists. Effect on change of procedures and quality of specific services can be imminent, but impact on broader reform issues is limited. Nevertheless such twinning's are valuable contribution to Albanian CME-efforts, i.e. to increase the amount of in-country CME-activities. An approach to a larger group of health professionals, as e.g. 'all nurses' or 'PHC-staff' requires obviously a more elaborate approach and is not feasible through such twinning formulas.

2) Reasons for success

The interviews during the assessment mission have nearly unanimously shown that collaboration and support by 'the Swiss' has been highly appreciated. Why is this so? What is different from other aid agencies? Some of the reasons put forward were on **attitude**: 'the Swiss' involve Albanian counterparts at the very beginning of a project; they are coherent in argumentation and reliable in procedures during the whole project lifespan. This creates confidence and a sense of ownership – and allows them to manage in a 'low profile' (but still efficient) manner. Other reasons were on **focus**: 'the Swiss' identify for their projects rigorously needs and priorities, define clear goals and outputs and reach a high level of implementation; they build on previous experience and offer best expertise. And finally, **empathy and flexibility** in approach and dialogue was appreciated: it was observed that 'the Swiss', besides being sincere and demanding partners, were open minded and flexible, willing to take into consideration the Albanian points of view, or honestly collaborate and cooperate with other foreign actors.

The following citations might illustrate these summarized opinions: 'the Swiss are good friends', or 'the more a donor come from the North the better the project' and 'the Swiss are more effective than the WB – it has studies on the shelf but no implementation in the field'…

In more general terms, Swiss projects were successful, because they obtained sustained changes

(a) in terms of institutions that persisted after phasing out (high schools for nursing, a reference center for environmental health and hygiene, a national center for continuous education, a special pedagogy section in the University of Vlora) and

(b) in terms of a health workforce, which has not only more and updated knowledge but equally a changed attitude towards its role and function in a modern health system; and even if these trained people cannot put into practice their knowledge, they represent a potential for the future.

The right attitude, a relevant focus, combined with empathy and flexibility, were the main ingredients for sustainable success of 'the Swiss' in institution building and human resource development.

F Partners in health

1) Donor mapping

In Albania, the main partners for health were the WB, USAID and WHO; a 'Coordination Group Health' is lead by USAID and WHO in alternation. Other UN-agencies like UNICEF, UNFPA and FAO are joining the group in a less regular manner. A recently drafted 'One UN-program, Development Albania' encompasses a health component, where the respective responsibilities of UN agencies concerned are enumerated (see details in annex 10):

Outcome 4.3: Health insurance is universal and quality, gender sensitive and age appropriate public health services are available to all, including at-risk populations

Outputs	Partners	UN Agencies
Health insurance coverage increased by expanding benefits, simplifying procedures and enhancing information for all	HII, MoH, INSTAT, MoLSAEO, MoF	WHO, UNICEF, UNFPA, UNAIDS
Demand for, **equitable access** to and utilization of quality health services increased, especially for children, young people and elderly, and other vulnerable or at risk groups.	MoH, IPH, MOA, Regional health authorities, CSOs	WHO, IAEA, UNICEF, UNFPA, UNAIDS
Prevention measures and **Promotion** of Public Health enhanced through multi-sectorial dialogue and community participation	MoH, IPH, CSOs, MoEd Patients groups	WHO, UNICEF, UNFPA, UNAIDS

The following table gives an overview on the ongoing and planned commitments of individual foreign actors in health as they have been identified by the assessment team. USAID is running two projects, while the World Bank has just closed its big 'health system modernization' project, but is envisaging a comeback with an important health grant from 2014 onwards. The other UN-agencies are doing health related work in their respective fields of competence, mainly MCH, social service reform / social inclusion and nutrition.

On the bilateral or NGO side, no major player remains with a longer term commitment after the withdrawal of several of them in the recent years. An exception is the Japan International Cooperation Agency JICA with a substantial support to the emergency medicine system of the country over the last two years, but the project is now closed.

For a detailed view of individual agency projects see annex 11 (donor mapping).

Table: Actual and future projects in Albania of multi- and bilateral donors

Donor	Name of the project	Amount (Millions)	Duration	Content
USAID	Enabling Equitable Health Reforms	$ 8.6	2010-2015	Strengthen health system
	Telemedicine and e-Health Program	$ 1.25	2009-2013	Create nationwide telemed/e-health network
World Bank	Health System Modernization	$ 19.1	2001-2012 (closed)	Improve access to PHC; increase effectiveness of reforms
	Health Project	$ 40.0	2014 onwards	Regional imbalances, payment system, resource use and management
WHO	Biennial collababoration WHO-Euro		2012-2013	Introduce 'European Health Policy 2020'
	Food Control Institutions	€ 2.00	2009-2012 (t.b.closed)	Legal frame 'food safety', inspection services
WHO, UNICEF, FAO	JP Reducing malnutrition in children	$ 5.0	2010-2013	Progress towards MDGs (poverty, child&maternal mortality
UNICEF & UN AGENCIES	Health Financing	?	2012-2016	Health financing: analysis of financial barriers
UNICEF	Equitable access to MCH services	?	2012-2016	Mothe&child consulting centers services
UNFPA	Country Program	?	2012-2013	Strengthen Reproductive Health services
Global Fund AIDS, TB	Country Program	$ 6.35	2007-2012	Strengthen Response to HIV / TB
Adriatic Cross-border Cooperation Program IPA	Blood Safety project (BESSY)	?	2012-2013	Establishing Adriatic cross-border network
Japan International Cooperation Agency JICA	Emergency Medicine support	€ 6.10	2010-2012 (closed)	Establish emergency medical services

For most actors involved in health, the common denominator of focus in their support is 'inadequate health insurance coverage', 'inequitable access to health services' and 'lack of health literacy'. They consider the existing health reform plans of the government as a relevant and valuable blueprint for progress. But because Albania still has poor capacity and many intrinsic obstacles for implementation, foreign presence, expertise and assistance is essential – especially in the area of health.

And in the opinion of UNICEF country representative Detlef Palm, 'small projects do not change the system; a systemic approach is necessary, a more comprehensive, coherent and longer term technical assistance program,'; and 'without a strategic discussion, lead by the government, we won't make the system work'. In general, there is optimism that the donor community is bold enough to impact on implementation obstacles like over-politicization, nepotism and corruption, if they put their efforts together and adhere to a policy dialogue with one, coherent and coordinated voice.

This donor map illustrates, that the perception of the Albanian counterparts is justified that Switzerland is the most important bilateral donor in the domain health, today and in the past. The fact that the current SDC/SCO country program doesn't have an explicit 'health portfolio' seems not to influence this perception.

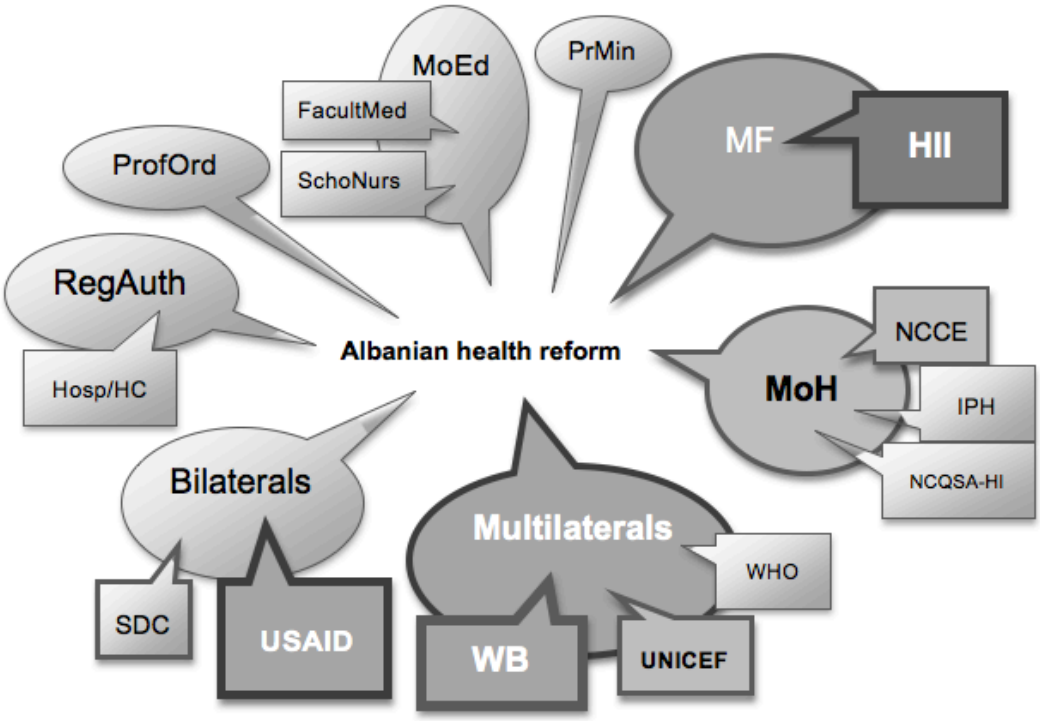
2) Political analysis

At the **'macro level'**, the EU Enlargement Commission, after assessing the accomplishment of reform efforts in Albania, has declared that 'Albania has made significant progress during the last year, notably on stronger cross-party agreement on the European Union reform process', and that 'in view of this progress, the Commission recommends that the Council should grant Albania the status of candidate country subject to key judicial and public administration reform measures being completed…'. If Albania really should receive EU candidate status, it must demonstrate progress in implementation of reforms in order to move forward to the next stage. And this will be much tougher to achieve than the 'aquis communautaire'. This pressure might help the reform efforts in the health sector, too.

For another reason, health should have a priority in the reform agenda: both, the Albanian Prime Minister, Dr.Berisha (Democratic Party) and the actual Minister of Health, Dr.Tavo (small coalition Socialist Movement of Integration) are physicians - a cardiologist the first and a gynecologist the latter. So they were predestined to promote a strong and serious commitment for health reform. And,

indeed, as the budget director at the Ministry of Finance has stated, health has been declared a priority by the Council of Ministers. But the 2013 elections might change this constellation, a new Minister might appoint – a questionable custom in Albania - his own people in key positions. **'Meso level'** counterparts will be replaced in prefectures and districts, making project implementation exhausting and inefficient. Another deplorable phenomenon in the health sector, bribing for services and corruption, will aggravate this culture of nepotism.

At the **'micro level',** when it comes to project or program planning, design and implementation, many players can be involved, as shows the graph below. Their respective roles and relevance for involvement vary according to objective and focus of a project. Main players on the government side are the MoH and HII (MF): the influence of the latter is expanding with its increasing importance as a 'single purchaser' of out- and inpatient services, while the MoH is considered as 'weak' (headed 'only' by a member of the small coalition party). On the other side, the Bi- and Multilaterals are powerful and can bring about change, especially if they coordinate their policy dialogue and try to act in a concerted manner. The UN-agencies have initiated an effort in this direction with their 'One UN approach'. The bilateral agencies, and SDC, should try to play in the same concerted approach and find the appropriate niche.



If it comes down to concrete project work, the quality of interaction between the individual stakeholders and a subtle handling of conflicts is relevant . A program on health professional training must consider the delicate relationship between MoH and MoEd and be responsive to their respective responsibilities. A project on structural reforms, like adjusting hospital distributions and size, will have to deal with conflicting interests between regional and national authorities, between population expectations and cost-effectiveness targets of the authorities. And a health promotion program must deal with tenacious cultural prejudices and the fact that behavior change, and measurable impact, takes time. Some actors are proactive and keen to collaborate (e.g. order of pharmacologists), others reticent and inactive (order of physicians) and others have high but unrealistic expectations (e.g. exaggerated standards for accreditation of health facilities by NCQSA).

SDC has experience in dealing with such complexities, has good relations to powerful partners and was always able to convey to the Albanian counterparts a sense of ownership in common endeavors: therefore, and despite a difficult political environment, a Swiss health program in Albania has – in the view of the consultants - the potential for success and sustainable impact.

G A future SDC-support to Albania's health sector

1) Agency framework

a) 2010- 2013 priorities of the Swiss Cooperation in Albania

Presently, the strategic orientation of Swiss Cooperation 2010–2013 concentrates on two domains of intervention, (a) Democratization and Rule of Law (SDC) and (b) Economic Development (mainly SECO). Gender equality, (economic) governance and the environment are strategies included in all the domains (cross-cutting themes / mainstreaming).

These areas of intervention of Swiss cooperation have been chosen to support Albania's efforts to evolve towards the fulfillment of European integration requirements. They include the implementation of reforms in the fields of decentralization, health and education; the strengthening of civil society to play a more active role in furthering good governance and rule of law; the adoption of European standards and policies; and private sector reforms to gain sustainable competitiveness.

Within this strategy, the health component was defined as a contribution to the decentralization process, meaning that decentralized health services, mainly at the PHC-level, should offer better services. Through improved professional capacity of its staff they should become more attractive for the local population. SDC supported therefore the government to create a 'system for continuous medical education' as one of the most essential components to obtain this goal: this PDS-project introduced – for the first time in Albania – an obligation to physicians to engage in continued post-graduate trainings in order to get re-licensed for their job.

b) SDC's Health Policy

The new health policy makes specific reference to the fact that in Eastern Europe and Balkan region NCDs are the most prominent cause of mortality and morbidity, together with a high burden of neuropsychiatric conditions among women. To contribute to the improvement of this situation, the policy stipulates a **Focus on three Priorities**:

Reduce the growing burden of NCDs (including AIDS and vaccine preventable child diseases)
- with the promotion of healthy lifestyles, disease prevention, locally adapted community-based approaches, multi-sectoral collaboration for healthy policies and the creation of supportive environments
- through reforms that improve community mental health services

Improve mother, child and reproductive health
- by expanding access and quality of reproductive health services and post-natal care, including adolescent- and male-friendly structures

Strengthen health systems for universal coverage
- by identifying and addressing key constraints related to service delivery, the health workforce, financing, governance and management
- by supporting health sector reform processes
- by focusing on the (public) primary and secondary health care levels with special attention paid to the needs of poor and vulnerable populations (pro-poor targeting)
- by supporting health promotion and empowerment initiatives at the level of communities, service users and disadvantaged groups, leading to more 'health literacy' (better informed choices lead to better health).

As **principles for a successful implementation**, the following statements are made:

- Use systems thinking and integrated approaches to address complex today's health challenges
- Provide capacity building and technical support
- Strengthen capacities for health beyond the health sector and foster inter-sector collaboration
- Improve routine data collection and the use of performance indicators, use sex-disaggregated data and assess results specifically at the level of poor and vulnerable populations
- Promote research and the use of data to strengthen evidence based interventions and policy making
- Support East-East and tripartite collaboration

This frame of priorities and principles apply perfectly to the Albanian health context and is a useful guide for the design of a future cooperation with Albania in health.

2) Potential of a Swiss health engagement in Albania

Switzerland has a long tradition in cooperation with Albania in the health sector; it is considered as the most important bilateral donor in this domain; its interventions were in general successful and sustainable.

Switzerland can build on its reputation of a reliable and efficient partner in health reform and capitalize on the long history of support to Albania's health sector.

To make a project work, good networking and relationships with all stakeholders concerned is crucial; in Albania's health sector, Switzerland has established - over many years - profound ties with people in the government or in multi- and bilateral agencies.

Switzerland's asset of an established network of Albanian partners in health amplifies the potential of success and sustainability.

The health status of a population depends more and more on its 'health literacy', especially in relation to non-communicable diseases; this literacy must be strengthened to prevent NCDs; Switzerland has experience with health promotion, with 'empowering' its civil society.

Switzerland can offer a comparative advantage in the fight against the NCD-epidemic.

Albania's health system is building up slowly; reform plans are established and approved, the direction to go is clear and first efforts are under way; but, still, the government needs foreign support and expertise, and there is almost no area in which a foreign support wouldn't make a difference in speed of progress, in quality and accessibility of services, and finally in reduction of suffering and premature death. Therefore, many reasonable options for support exist.

Switzerland can tailor its support according to its own strategy and possibilities, between a classical medical equipment supply (SECO) or a more comprehensive contribution, e.g. an technical assistance to the reform of a district health system (SDC).

3) Risks of a Swiss health sector support

In general terms, the health sector is subject to the same risks as other sectors in Albania. As described above, a project has to deal with the intrinsic culture of nepotism, obstructing a performance based human resource management and, as a consequence, a poor functioning of (public) administrations and services. In a health project, this can seriously affect the impact and sustainability e.g. of a training component, because trainees with up-dated capacities will not get to positions where they can make a difference.

Bureaucratic barriers in the public administration are a risk and can obstruct especially complex programs.

A hardware component of a project might run the risk to suffer under the corruption and an attitude towards equipment maintenance which is far from European standards.

Another risk concerns medical equipment: if the required material is not available in Switzerland (which seems to be the case for simple equipment e.g. for PHC-centers) but has to be purchased abroad, the compulsory quota for a SECO investment might difficult to reach.

4) Specific options and recommendations

A comparison of health support of the foreign donor community shows that it has basically a common view how best to reform Albania's health system (One UN program, WB, USAID projects[bp]), a view consistent with strategies promoted by EU, WHO and others. This approach coincides with the Albanian strategic and legal frameworks for health reform established by the government.

[bp] see communalities and complementarities of respective projects in extensive donor map, annex 11

This common 'blueprint' should inspire Switzerland, because it coincides broadly with the general Swiss foreign development policy and with SDC's health policy: synergies and complementarities with the other foreign actors should guide the identification of a Swiss health support!

The key words of this shared strategy for health reform were:

- **Equitable access to health services,**
- **Social protection for all (health insurance),**
- **Prevention and health promotion.**

In addition, the following key criteria must be fulfilled in a future health commitment:

- **Poor, disadvantaged and marginalized people must benefit,**
- **Decentralized health structures (primary, secondary level) must, direct or indirectly, profit from the support,**
- **The assistance should contribute to system reform efforts and encompass a comprehensive, holistic approach,**
- **A specific emphasis must be on the NCD epidemic and MCH-services.**

Synthesizing these prerequisites and the findings from the assessment, the following broad options for a new Swiss health strategy in Albania are proposed (see summary table in annex 12):

a) Domain: Human Resources for Health

Argument: better trained health professionals will make performance of the health system, of health services, better; they will – over time –culture in the work environment and attitude towards the patients and civil society; efficiency and effectiveness will increase as well as the confidence in service quality; it can be assumed, that these changes have a positive effect on the accessibility of health services, with relevance mainly for remote areas, poorer segment of the population and marginalized people; if the focus of training is on MCH services, pregnant women and children will benefit, too; trained health personal can equally be used as promoters of healthy lifestyles. Al in all: training of human resources of the health sector is a strong cornerstone of health reform and sustainable impact can be achieved.

Risk: as mentioned above, if good people don't get good posts, training is of little use; training quality depends on the quality of trainers, teachers, lecturers – and even modern e-learning depends on the stuff you find (in your language) in the e-modules: obtain good quality training inside Albania is a challenge; training abroad is costly and hosts the risk to foster 'brain-drain' (people prefer to stay abroad after being exposed to 'a modern world' with good salaries…

The PDS project: this project covers the most important aspect of health professional training; if working in a full-fledged mode, it would have the potential to reach close to 20'000 health professionals (physicians, nurses and other health personnel), and this in an institutionally clearly defined setup (a administrative and strategic center, accredited training offers, compulsory licensing); such a CMS-system is a must for a modern health sector.
It is questionable if Albania is able, on its own, in the two years to come, to reach the full-fledged functioning of the CME-system; big problems lie in the decentralized availability and in the quality of training offers. The further development of new dissemination tools like distance-learning, e-health, telemedicine, or the launching of a monthly newsletter or Albanian Medical Journal, are still big challenges ahead of NCCE. SDC should consider keeping this important project as a cornerstone in the next country strategy.

Specific training offers: People with sound knowledge in management and financing of the health system and its facilities are still rare in Albania; short-time courses on these topics have a limited effect ('eye-opener' courses at Summer School) and long-term courses do not exist anymore (TP-HPM till 2008). All stakeholders in Albania and across the whole region have identified this training gap as one of the most important problems in the health sector at this stage of reform (recent evaluation of summer school).

Switzerland could engage in the re-launch of such a training; various institutional formulas could be envisaged: (a) support a new 'TP-HPM' based on a similar formula (courses in Albania with foreign lecturers of renowned institutions); (b) support the project of the Medical Faculty of Tirana for a 'School of Health Management and Economics' (plans approved by the faculty and idea supported by the Prime Minister); (c) contributions to scholarships for Studies at foreign Health Management Schools

PHC-team training program: a training program tailor-made for primary health care level staff, including family doctors/GPs, nurses of various basic training and administrative/social worker; an analogous programs runs since years in B&H and experiences can be obtained there. This can (should) be an integral part of the future PDS, but an independent institutional setup might ease the animosities between MoH and MoEd on this issue…

PS: modern trainings of health professionals encompass - as integral parts - modules on health promotion, patients rights, human rights and health, gender issues, on financing and management and on data collection and processing aspects.

b) Domain: Infrastructure and Medical Equipment

Argument: A referral system in health services can only work if – first – at primary level there is the necessary equipment as defined for this level; and – second – if at the next, the secondary referral level, the district or regional hospitals, equipment is available that allows to go a reasonable step further in diagnostics and treatment. This is not the case in Albania, resulting in an overcrowding of the tertiary level, an excessive inefficiency in resource usage and a big economic load especially on poor patients and their families. In addition, late detection of curable diseases leads to premature death and suffering.

Risks: see above, chapter G.3

Switzerland could help improving this referral system – coherent with the restructuring plans of the government and in close coordination with WB and USAID – by providing in a limited area of Albania essential primary level equipment as well as more sophisticated secondary level laboratory and other diagnostic equipment. Some investments in rehabilitation of PHC and hospital premises might be necessary, too. The focus should be on improvements in case finding of NCDs, like cancer screening (mammography, colonoscopy, Pap-smear, etc.) and on equipments for therapeutic interventions corresponding to the secondary level (surgery, anesthesia, etc.).
An additional component to be evaluated in this context could be the establishment – at the PHC-level – of mobile health units for visits to remote areas (an ageing, multi-morbid population living in remote areas does not have anymore access to health care due to the closure of many health posts – and is not mobile enough to get to health centers further away).

c) Domain: Support to a Regional Health Reform Process

Argument: Dealing successfully with health problems of a society is, especially in transition countries with rapid changing life styles, a complex challenge. Like a puzzle, only correctly assembled pieces give a full picture, i.e. a functioning health system. The Albanian's were strong in designing such a health reform puzzle but weak in assembling it. They need technical assistance and financial support to create a showcase of such a complex endeavor. A smaller scale pilot project could demonstrate how it would look like if the health reform strategy would be implemented and transformed in reality. This could facilitate the 'national roll-out': people could see what is feasible, what ingredients were necessary to make the system work – and would see results: access without discrimination, a new relationship between citizens and health professionals, improved quality of services and a population aware of health risks.

Switzerland could help to make such a dream true, in an area where SDC and SECO were already well rooted, have shown commitment and established good relationships with authorities at municipality or district level; in an underserved region, e.g. in the North-East of the country, where an impact on the poor would be important.

In short, a support could encompass steps and elements like:

- A field survey to assess the status quo in terms of infrastructure and human resources.
- A proposal to the public stakeholders concerned, at central (MoH, HII) and regional level (health directorates), drafted in close coordination with other donors in the region (UNICEF, UNFPA and WB) to concert efforts and identify potential synergies.
- A participatory process with the regional authorities, representatives of health professionals and the civil society, to discuss the impact of reform, to agree on implementation pace and to define the needs, and to select a steering committee for the reform process.
- A coaching of this process by national and foreign experts, in order to define training requirements (link with NCCE – establishment of local training offers for family doctors and nurses) or make available planning and managerial capacities (link with the Center of Quality, Safety and Accreditation of Health Institutions).
- An identification of potential multipliers of health and life-style information, like NGOs, media, community nurses, teachers etc. to introduce - with expert support – the concept of health promotion and 'health literacy'.
- A hardware support based on the restructuring plans and need assessments resulting from the participatory process, with physical rehabilitation and equipment components for the primary and secondary level.
- An adequate operational setup, e.g. with a local implementing unit to coordinate the project.

Potential, risks: such a project would be a (too ?) big challenge; but it is based on what is postulated by international authorities, in the Albanian reform strategy – and it corresponds to the approach suggested in the SDC health policy; it is based on the hypothesis, that a piecemeal approach is not anymore suitable in the fight against the NCD epidemic. Only if all components start working in synergy together, an impact on the main burden of disease, cancers and cardiovascular diseases, can be expected. The risk lies not only in the complexity of such an approach, but in Albania's centralized decision making structure, where regional autonomy and local initiatives are obstructed. But such a project could be a test for the declared will (and obligation in view of Europe integration) of the central government to decentralize decision making – in general and in the health sector.

In that sense, such a project would be a continuum – in concrete terms – of the SCO-A efforts over the past years on 'Democratization and Decentralization'. Based on progress in some regions (Shkodra/Lezha), the ground for the establishment of a comprehensive regional health reform project might now be fertile.

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I References:

[1] USAID technical report: Assessment of NCD Prevention, Screening and Care Best Practices for Women of Reproductive Age (Albania, Armenia, Georgia, Russia), April 2012
[2] USAID technical report: Assessment of Selected Best Practices for Maternal and Newborn Care (Albania, Armenia, Georgia, Russia), June 2012
[3] European Commission staff working document: Albania, 2012 Progress Report, October 2012
[4] Health Sector Assessment 2004, Besim Nuri and Dana Farcasanu, for SDC
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[6] USAID technical report: Assessment of NCD Prevention, Screening and Care Best Practices for Women of Reproductive Age (Albania, Armenia, Georgia, Russia), April 2012
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[8] WB, OOP payments in Albania's Health System, 2011
[9] UNDOC and INSTAT: corruption in Albania, bribery as experienced by the population, 2011
[10] Support to the Albanian National Health Account, final report 2010 (part of the 'Health System Modernization Project of the WB)
[11] European Commission staff working document: Albania, 2012 Progress Report, October 2012
[12] Trends in maternal mortality 1990 to 2010, WHO/UNICEF/UNFPA/WB, report 2012
[13] Assessment of selected Best Practice for Maternal/Newborn Care, 4 country technical report, 2012
[14] USAID technical report: Assessment of NCD Prevention, Screening and Care Best Practices for Women of Reproductive Age (Albania, Armenia, Georgia, Russia), April 2012
[15] USAID technical report: Assessment of NCD Prevention, Screening and Care Best Practices for Women of Reproductive Age (Albania, Armenia, Georgia, Russia), April 2012

Annex 2.2: National Strategy for Development and Integration NSDI 2007-2013, Summary of Health Related Texts

The Vision for Albania, according to the NSDI:

A country with high living standards, which is integrated in the European and Euro-Atlantic structures, is democratic and guarantees the fundamental human rights and liberties.

Social policies will be oriented towards the respect of human rights, equality and non-discrimination. The delivery of good quality social services is another important aspect of living standards and ensures social cohesion. In the health sector, the problem of financing the service will be solved to ensure quality.

The improvement of the quality and efficiency of the public administration to deliver these services and its commitment to the implementation of this strategy is the key to successfully meet the challenge of European integration.

Health related strategic priorities and goals as defined in the NSDI are:

- ***The public health system*** *will offer a basic, good quality and effective service for all through managerial improvements and encouragement of the private initiative:*
  - *In the medium-term (2007-2010), conditions will be created to encourage the provision of health services by the private sector; there will be a set of services that people will be entitled to receive for free; and a single strategic purchaser will concentrate on balancing all public resource allocation decisions.*
  - *In the long-term (2011-2013), the management of health service delivery institutions and clinical pathways will be improved; and a clearer regulatory framework will be established to ensure responsiveness to citizens.*
  - *By 2013, the infant mortality rate will be reduced to 5 per 1000 live births.*
- ***An integrated and coherent policy*** *will be implemented aiming to achieve balanced regional development and to reduce inequalities between regions.*
- ***Corruption*** *will be reduced in a gradual and sustainable manner; the establishment of an anti-corruption culture in government, politics and society remains a major aim; in the long-term (2011-2013), effective and transparent systems will be introduced in public services such as health provision; by 2013, Albania will reach the same level as the Central and Eastern European countries on the year they became members of the European Union, according to the 'Corruption Perceptions Index'.*
- ***Empower consumers*** *for a real choice based on accurate information, for self-determination and confidence that comes from effective protection, which presupposes the development of an information and advisory system for consumers:*
  - *promote consumer education in schools, including concepts of consumer protection in the curriculum, teacher training, joint action of schools with local communities and consumer associations*
  - *treat consumer complaints in a cheap and fast way, before cases reach courts, in order to raise consumer confidence*
  - *raise awareness of consumers for their rights and duties and inform economic operators of their responsibilities in the market and towards consumers protect*
  - *Protect the economic interests of consumers on issues of price, choice, quality, diversity, affordability and safety, through:*
    - *ensuring and encouraging the participation of not-for-profit organizations in the process of consumer protection policy design and implementation*

- *establishing a national consumer advisory network, including consumer associations or other central and local actors*

Under the heading of **'Social policy'** the NSDI states:

- *attract and retain more people in employment as a vital means "to sustain economic growth, promote socially inclusive societies and combat poverty"; this includes a health system that responds to the new pattern of risks, in view of the rapidly changing demographic structure, and improves the health of the population but also addresses inequality in health care service provision.*

- ***Youth:***
  - *encouraging young people to lead a healthy life through their inclusion in education activities for the prevention of negative phenomena and risky behavior*
- ***Gender:***
  - *improve the response of the health system and increase awareness in the population related to health needs of women/girls and men/boys; promote measures that will address health risks at an early stage;*
  - *prevent domestic violence through: educating the children, the youth and the general public to appreciate good family relationships and to consider that domestic violence is an unacceptable crime; improving teaching curricula, school and non-school textbooks; training health, social and education service professionals to be able to identify victims of abuse early and provide support.*
- ***Social inclusion – Children:***
  - *make available integrated outpatient management, including examination, treatment and combined counseling, for the main childhood diseases*
- ***Social inclusion – Roma:***
  - *make available health services in Roma communities in order to improve family planning, immunization coverage, ante- and post-natal care*
- ***Health:***
  - *Vision: The health system will offer a basic health service for all, of acceptable quality and efficiency:*
    - *the health care system needs to adjust to the lengthy and costly treatments associated with these diseases and shift to preventive health care and public health campaigns.*
    - *transfer of the financing of primary health care to the Health Insurance Institute (HII), but payroll tax-based health insurance results in further inequity in access to health care. Only a small part of the population contributes in the absence of a formal labor market, administrative capacity, and oversight structures.*

  - *Strategy 1: Increase the capacity to manage services/facilities in an effective way:*
    - *Introduce a new public-private mix and innovative organizational schemes. A new concept will be introduced to reorganize public and private structures, as complementary to each other, aiming to privatize primary health care services and public specialties without beds.*
    - *Improve facility and clinical management at all levels. Improving efficiency calls for better and more effective management of service delivery facilities and of the clinical pathways used to address patients' treatments.*
    - *Continuously improve health system quality and safety. Perfection of service provision quality is needed, based on the continuous education system, accreditation of the institutions providing health services on the basis of standards approved and published in advance.*

- *Improve health services management. Training and continuous education efforts are needed to improve the managerial skills and competencies of decision makers and to strengthen capacities among the staff in key positions of the health system.*

- *Strategy 2: Increase the possibility to receive effective health services:*
  - *Reduce financial, geographic, cultural and professional barriers.*
  - *There will be a set of services that people clearly perceive as being entitled to receive for free and which are affordable for the country.*
  - *A geographically and population-wise balanced distribution of services will also be deployed throughout Albania.*
  - *The right of employees for health protection, information and care at the public and private work environment will be promoted.*
  - *Articulate a network of services able to ensure continuity of care.*
  - *A sustainable primary health care system should act as the gatekeeper of the health system on the basis of an efficient service delivery of good quality.*
  - *Provide widespread free essential public health services.*
  - *Provide solid pharmaceutical coverage. Drugs play an important role in any health care delivery scheme.*

- *Strategy 3: Improve the system of health financing:*
  - *Increase pre-paid coverage. Funds-pooling is the only way to protect the weakest sectors of the population, regardless of their ability to pay.*
  - *Reduce informal money flows. The above priority must go in parallel with a strong reduction of informal payments including through the introduction of the co-payment mechanism.*
  - *Improve resource allocation by a single strategic purchaser. A single purchaser will effectively concentrate on balancing all public resource allocation decisions.*

- *Strategy 4: improve the governance of the health system:*
  - *Strengthen the capacity of the Ministry of Health to develop policies, strategies and planning at national level. It will improve its capacity to provide policy leadership, leaving direct health service provision activities for others.*
  - *Regulate better. A clearer and more enforceable regulatory framework is needed to guarantee that the rights of all stakeholders are respected when addressing issues such as responsiveness to citizens, entitlement to specific services, privatization, the role of professional organizations, labor legislation for health professionals etc.*
  - *Improve transparency and accountability. A critical element in the governance of the health system is the capacity to monitor and evaluate its performance.*
  - *Establish a health information system. The establishment of a special centre will be promoted, which - on the basis of research and available scientific evidence - will be able to provide responses on the alternative cost-effective solutions in the health sector.*

Annex 2.3: Laws, Implementation by-laws, Strategies and Plans relevant for Health

Main Health Care Law and reforms

1. The National Strategy for Development and Integration 2007-2013, approved by Council of Ministers on 12 March 2008 (excerpt 'health aspects' see annex 2.1 and 2.2).
   It is the synthesis of a comprehensive set of sector strategies and is guided by a selective set of crosscutting strategies. The health sector strategy succeeds the previously approved long-term strategy for the development of the Albanian health care system with the aim to meet the newly introduced standards. Its strategic priorities are to: (i) increase the capacity to manage services and facilities in an efficient way; (ii) increase access to effective health service; (iii) and improve health system governance and financing.
2. Implementation Plan on the Stabilization and Association Agreement on Health sector 2008-2014, approved 2008.
3. Law on Health Care in the Republic of Albania , no. 10 107, date 30.03.2009
   This law defines the basic principles and the legal framework for the regulation, organization and functioning of the health care system in the Republic of Albania. Health care is provided by an integrated system of health services with a network of public and private institutions that apply a referee approach.
4. On Public Health, no 10 138, date 11.05.2009
   The objective of this law is the protection and promotion of health and healthy living of the population in the Republic of Albania, by organized actions that are delivered and impact equally all groups of the population. This law defines the activities and services of public health, their implementation, the role of the state in financing public health services and the division of responsibilities between the responsible institutions.

Social inclusion:

1. Strategy for Social Inclusion for 2007-2013
2. Legislation implementing the Law on Social Services and Assistance: adopted
3. Amendment on Law nr. 8626, date 22.06.2000 'On the Status of the Paraplegia and Tetraplegia Invalidity', no 9506, date 03.04.2006

Financing:

1. Law on Health Insurance in the Republic of Albania , no. 7870, date 13.10.1994
2. Law on Ratification of the "Financing Agreement Between Albania and the International Development Association (IDA) for the Project 'On the Modernization of the Health System'", no. 9579, date 11.07.2006
3. Law on Ratification of the "Financing Agreement Between the Council of Ministers of the Republic of Albania and ARTIGIANCASSA S.P.A for financing the programme on 'Five Policlinics in the Cities of Tirana, Gjirokastra, Korca and Peshkopia'", no. 9493, date 2006
4. Reform of hospital services financing: decision adopted by the government in January 2011
5. Law on Collection of Compulsory Contributions for Health and Social Insurance: amended in February 2012

Communicable diseases:

1. A gap analysis on communicable diseases legislation in order to compare Albania's legislation with the acquis: is being conducted
2. Guidelines on control of hospital infections: adopted April 2012.
3. Implementing legislation ensuring the right to health for persons and children living with HIV/AIDS and people at risk: adoption pending.
4. Law on Prevention and Control of Infectious Diseases, no. 7761, date. 19.10.1993
5. Law on Prevention and Control of HIV/AIDS, no.9952, date 14.07.2008

Non-communicable diseases:

Cancer:

1. The national strategy for cancer control 2011-2020: approved

Mental Health:

1. Law on Mental Health: no. 44 adopted June 2012.
2. A ten-year mental health strategy and action plan for the development of mental health services: awaiting adoption.

Tobacco Control:

1. Law on Ratification of WHO Convention 'On Tobacco Control', no. 9474, date 09.02.2006
2. Law on Health Protection from Tobacco Products, no. 9636, date 06.11.2006
3. The tobacco advertising ban: applied
4. Introducing pictorial warnings on tobacco packets: plan prepared

Alcohol Control:

1. National Strategy on Prevention and Reduction of the Alcohol-related Damages (2011-2015)
2. Law on Protection of Minors from Alcohol Usage, no. 9518, date 18.04.2006

Drug control:

1. Law on Drugs and Pharmaceutical Services , no. 9323, adopted on 25.11.2004, amended by law no. 9523, date 25.04.2006
2. Law on the Control of the Substances Used in the Illegal Manufacturing of Narcotic and Psychotropic Compounds, no. 8874, date 29.03.2002.
3. New National Drug Control Strategy 2012-2016: adopted June 2012.
4. A National Information Centre for Drugs: set up as a unit of the Department of Epidemiology and Health Systems in IPH.
5. A Drug Dependence Treatment Centre at the Mother Theresa Hospital in Tirana: opened

Gender:

1. National Strategy on Gender Equality: 2011-2015
2. Gender Mainstreaming in the Medium-term Budget Programme for all Line Ministries: approved in July 2012

Health-IT / Telemedicine / e-learning

1. The national electronic health strategy is pending

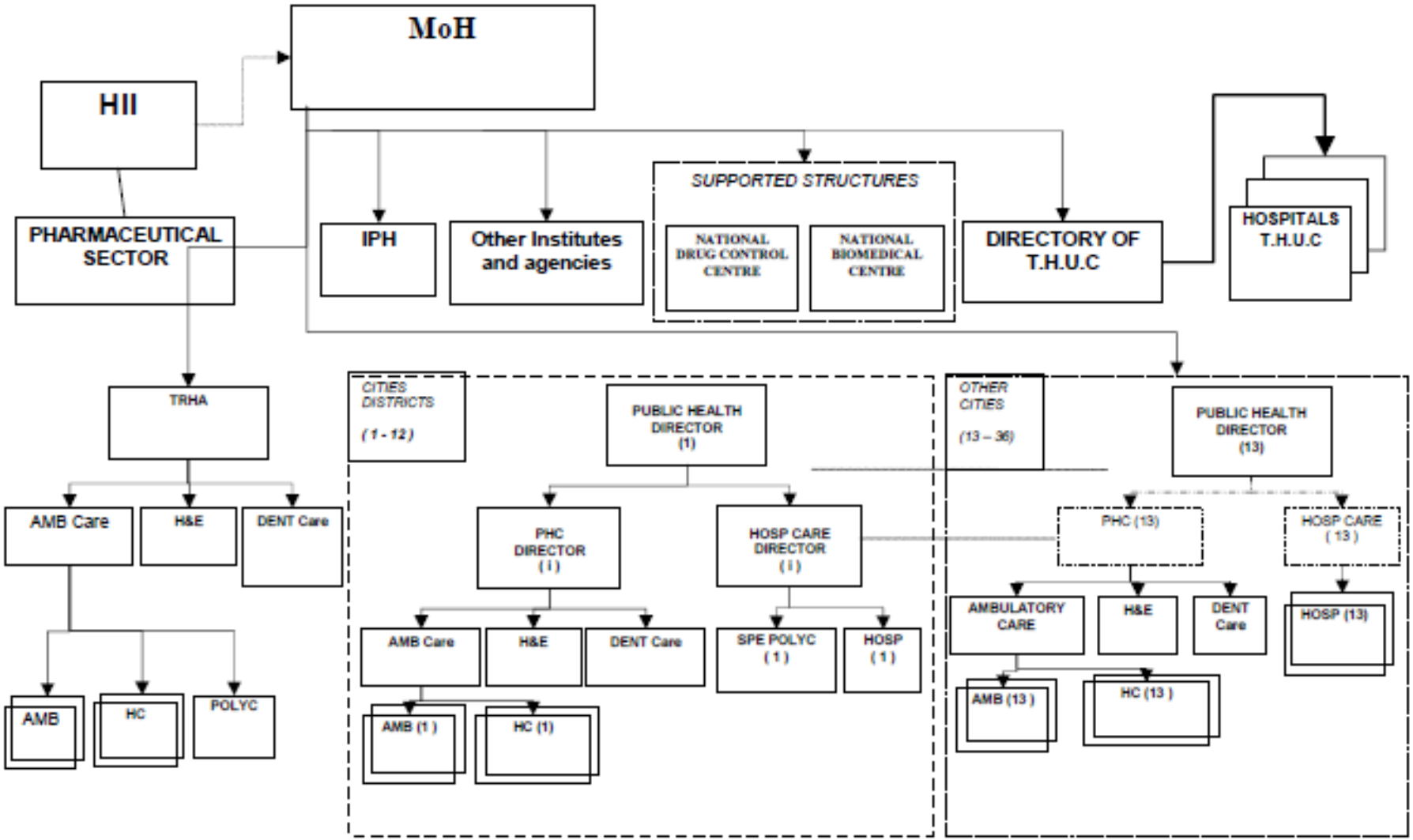
Other Health Related

1. Law on Promotion and Protection of Breastfeeding, no. 8528, date 23.09.1999
2. Law on Reproductive Health, no. 8876, date 04.04.2002
3. Law on Interruption of Pregnancies, no. 8045, date 07.12.1995
4. Law on Transplantation of Tissues, Cells and Organs in the Republic of Albania, no. 10 454, date 21.07.2011

5. Law on Blood Transfusion in the Republic of Albania, no.9739, date 21.05.2007
6. Law on Autopsy , no. 7830, date 15.06.1994

7. Law on Dental Health Services in the Republic of Albania, no. 9928, date 09.06.2008
8. Law on Disorders Prevention Caused by Iodine Deficiency in Human Body, no.9942, date 26.06.2008
9. Law on Protection from Ionizing Radiation, no. 8025, date 09.11.1995
10. Law on State Sanitary Inspectorate, no. 7643, adopted on 02.12.1992, amended by law no. 9635, date 06.11.2006.
11. Law on Physicians' Order in the Republic of Albania, no. 8615, adoption date 01.06.2000, amended by law no. 9318, date 18.11.2004
12. Law on Nurses' Order in the Republic of Albania, no. 9718, date 19.04.2007
13. Law on Pharmacists' Order in the Republic of Albania, no.9150, date 30.10.2003
14. Decision of the Council of Ministers on "Licensing of Private Activities in the Health Sector', no. 910, date 18.06.2008
15. Law on Food, no. 9863, date 28.01.2008
16. Law on Territorial Planning: adopted in 2009.

Annex 3.2: Scheme of structure of Albanian health system



Annex 3.3: List of Private Hospitals and their service offers

Licences approved by the Ministry of health for activites related to "Hospital services"

No	Private hospital name	Approved	Licence	Services	No of beds	Technical director	Address	Phone contact
1	Universal German Hospital Albania	21.05.2009	1	Chirurgical services (general, cardiovascular, pulmonary,neurosurgery, plastic surgery, urology), dialysis, internal diseases, dermatology, infectious diseases, orthopedics, ORL, oculistics, pediatrics, obstetrics and gynaecology, dentistry, imaging, oncology.		Ibrahim Pozhari	Rr."Kavajes" prane Fabrika Birres , Tirana	04 22 33 400
2	Dora e Arte' name changed into EUROPIAN hospital	08.07.2009 26.05.2010	2	Pathology, gastroenterology, endoscopy, chemotherapy, chirurgy (thoracic, oncologic, gyneacologic oncology, ORL), orthopedics, histopathology laboratory, clinical-biochemistry laboratory, imaging, dentistry, cardiology, hemodynamics, cardiac surgery, urology.	43	Mehdi AHMETI	Austrada Tirane-Durres, mbikalimi I Kasharit, Tirana	069 20 80 320 047 800 117
3	American Hospital 1	28.08.2009	LN-0228-08-2009	Imaging, cardiology, cardiac surgery, vascular surgery, plastic surgery, transplantation, nephrology, hemodialysis, ORL, obstetrics and gynaecology, oncology, orthopedics, gastrohepatology	100	Blendi HORJETI	Rr."Lord Bajron",prane QSUT, Tirana	235 65 00
4	CARDIO & DIAGOSTIC CENTER HAMBURG/TIRANE (C.D.C)	12.03.2010	LN-1127-03-2010	Cardiac surgery and general diagnosis	22	Lefter Sulkaj	Kryqezim Rr."Nikolla Lena" me rrugen e Kavajes, P. I ri 30 m poshte Kishes Orthodokse, Tirana	692092138
5	HYGEIA HOSPITAL-TIRANA	14.06.2010	LN-1659-06-2010	Nuclear medicine for diagnosis, services on cardiac catheterization and vascular interventions, gastroenterology and gastroscopy examinations, colonoscopy and enteroscopy, dermatology, cardiology, allergology, ORL, neurology, laboratories (hematology, biochemistry, microbiology, serodiagnosis, urinalysis), anatomical pathology, medical urgent care, chirurgy (general, cardiac, vascular, thoracic, neuro surgery, urology, orthopedic, ORL), intensive care, daily service service (ophtamology, gyneacology, ORL, orthopedics, general chirurgy, plastic surgery), nephrology and hemodialysis, radiotherapy with linear accelerator, oncology centers and chemotherapy, ophtamology, services on pulmonary health, clinical services for ambulatory patients and check-up services, therapetical services and physical rehabilitation, obstetrics and gyneacology services, neonatal intensive care, pediatry	220	Leonard SOLIS	Km 01 i Rruges Dytesore, Austrada Tirane-Durres, Fushe Mezes, Tirana	682064299 2380640 ext 7006
6	AMAVITA private hospital	17.01.2011	LN-2692-01-2010	Diagnostics: medical visits, imaging, clinical-biochemistry laboratory; surgical intervention for biopsy; chemotherapy	11	Lutfi Zhegu	Rr.P.Budi,Nr.75/3, Tirana	

2.1	Europian Hospital	21.11.2011		Added services: cardiology, hemodynamics, cardiac surgery, neurosurgery, urology		Arqile Andrea		
7	American hospital 2	05.01.2012	LN-4398-01-2012	1. Allergology, immunology. 2. anesthesiology/intensive care 3. dermatology 4. endocrinology 5.gastroenterology 6. hematology 7. advanced imaging 8.cardiology 9. general surgery 10. nephrology 11. neurosurgery 12. neurology 13. obstetrics and gyneacology 14. oculistics 15. oncology 16. ORL 17. orthopedics -traumatology 18. pediatrics 19. pneumology 20.Proctology 21. Rheumatology 22. Urology 23.Toxicology 24. Emergency Care 25. Closed pharmacy network 26. Clinical-Biochemistry laboratory	54	Redi Capi	RR.Dibres	686067788
8	SALUS hospital	13.01.2012	LN-4441-01-2012	1. Gastroenterology 2. Cardiology 3. General surgery 4. Neurosurgery 5. Neurology 6. Oculistics 7. ORL 8. Orthopedics 9. Dentistry 10. Anesthesiology-Intensive Care 11. Radiology 12. Emergency Care 13.Pharmacy 14 Clinical-Biochemistry Laboratory	44	Arben Preza	Komuna Kashar	682670951
9	FMES hospital	14.02.2012	LN-4621-02-2012	1. Cardiology 2. Invasive cardiology (coronarography-stent-pacemaker) 3. cardiac surgery 4. anesthesiology-intensive care 5. clinical biochemistry laboratory	14	Roland Xhaxho	Rr.'"Naim Frasheri", ish Shkolla e Lirë, Tiranë	06820 33 101
7.1	American Hospital 2	23.05.2012	LN-4398-01-2012	Added services : plastic surgery	54	Redi Capi	RR.Dibres	

Annex 4.2: Human Resources by Hospitals and in PHC facilities

Hospitals

No	DISTRICT HOSPITALS	Nb employees
33.	TIRANA UNIVERSITY HOSPITAL	2685
31.	SHKODER	807
6.	ELBASAN	661
13.	KORCE	609
38.	VLORE	578
7.	FIER	530
1.	BERAT	415
5.	DIBER	389
34.	TIRANA MATERNITY HOSPITAL 1	378
16.	KUKES	325
20.	LUSHNJE	315
36.	SANATORIUM (TIRANA)	299
18.	LEZHE	287
35.	TIRANA MATERNITY HOSPITAL 1	281
27.	POGRADEC	262
9.	GJIROKASTER	250
19.	LIBRAZHD	218
23.	MAT	214
24.	MIRDITE	211
29.	SARANDE	202
14.	KRUJE	191
32.	TEPELENE	174
11.	KAVAJE	170
8.	GRAMSH	169
28.	PUKE	167
37.	TROPOJE	167
30.	SKRAPAR	146
12.	KOLONJE	142
26.	PERMET	134
2.	BULQIZE	108
17.	KURBIN	101
15.	KUCOVE	78
4.	DEVOLL	54
10.	HAS	43
22.	MALLAKASTER	40
3.	DELVINE	32
25.	PEQIN	30
21.	MALSI E MADHE	17
	TOTAL	**11879**
	Avarage/facility	248
	Range	(17-807)

Remark: number include all staff, professional, administrative and auxiliary personal (laundry, kitchen, etc.); exception Tirana University Hospital, which has outsources certainof auxiliary functions

Primary Health Care Institutions and some other Health Institutions

No	District	INSTITUTION	Nb employees
36.	TIRANE	TIRANA REGIONAL HEALTH AUTHORITY	487
7.	ELBASAN	PSYCHIATRIC HOSPITAL	193
6.	DURRES	PUBLIC HEALTH DIRECTORY	123
15.	KORCE	PUBLIC HEALTH DIRECTORY	122
8.	ELBASAN	PUBLIC HEALTH DIRECTORY	121
34.	SHKODER	PUBLIC HEALTH DIRECTORY	120
9.	FIER	PUBLIC HEALTH DIRECTORY	110
33.	SHKODER	MENTAL HEALTH CENTERS	105
1.	BERAT	PUBLIC HEALTH DIRECTORY	98
18.	KUKES	PUBLIC HEALTH DIRECTORY	75
22.	LUSHNJE	PUBLIC HEALTH DIRECTORY	75
11.	GJIROKASTER	PUBLIC HEALTH DIRECTORY	71
20.	LEZHE	PUBLIC HEALTH DIRECTORY	67
5.	DIBER	PUBLIC HEALTH DIRECTORY	62
29.	POGRADEC	PUBLIC HEALTH DIRECTORY	47
13.	KAVAJE	PUBLIC HEALTH DIRECTORY	45
30.	PUKE	PUBLIC HEALTH DIRECTORY	44
26.	MIRDITE	PUBLIC HEALTH DIRECTORY	39
25.	MAT	PUBLIC HEALTH DIRECTORY	38
28.	PERMET	PUBLIC HEALTH DIRECTORY	38
16.	KRUJE	PUBLIC HEALTH DIRECTORY	37
35.	TEPELENE	PUBLIC HEALTH DIRECTORY	36
10.	GRAMSH	PUBLIC HEALTH DIRECTORY	32
31.	SARANDE	PUBLIC HEALTH DIRECTORY	32
32.	SKRAPAR	PUBLIC HEALTH DIRECTORY	32
14.	KOLONJE	PUBLIC HEALTH DIRECTORY	31
21.	LIBRAZHD	PUBLIC HEALTH DIRECTORY	31
19.	LAC	PUBLIC HEALTH DIRECTORY	30
3.	BULQIZE	PUBLIC HEALTH DIRECTORY	21
4.	DEVOLL	PUBLIC HEALTH DIRECTORY	21
17.	KUCOVE	PUBLIC HEALTH DIRECTORY	21
23.	MALSI E MADHE	PUBLIC HEALTH DIRECTORY	21
27.	PEQIN	PUBLIC HEALTH DIRECTORY	19
2.	DELVINE	PUBLIC HEALTH DIRECTORY	18
24.	MALLAKASTER	PUBLIC HEALTH DIRECTORY	18
12.	HAS	PUBLIC HEALTH DIRECTORY	17
		SUBTOTAL	**2497**
		Avg/facility	69
		Range	(17-193)
40.	TIRANE	PUBLIC HEALTH INSTITUTE	199
49.	VLORE	PSYCHIATRIC HOSPITAL	157
45.	TIRANE	MOH ADMINISTRATE	131
50.	VLORE	PUBLIC HEALTH DIRECTORY	103
43.	TIRANE	THE NATIONAL CENTER FOR DRUG CONTROL	64
37.	TIRANE	THE NATIONAL CENTER FOR CHILD UPBRINGING, DEVELOPMENT AND REHABILITATION IN TIRANA	62
41.	TIRANE	BLOOD DONATION CENTER	57
39.	TIRANE	UNIVERSITY DENTISTRY CLINIC	43
48.	TROPOJE	PUBLIC HEALTH DIRECTORIES	34
42.	TIRANE	THE NATIONAL CENTER OF BIOMEDICAL ENGINEERING	31
38.	TIRANE	MEDICAL HEALTH SERVICES	21
46.	TIRANE	NATIONAL CENTER OF CONTINUING EDUCATION	19
44.	TIRANE	HELICOPTER TRANSPORTATION UNIT	14
47.	TIRANE	NATIONAL CENTER OF QUALITY, SAFETY AND ACCREDITATION OF HEALTH INSTITUTIONS	10
		SUBTOTAL	945
		TOTAL	**3442**

Annex 5.1: Health Sector Financing - Figures from MF, MoH, HII, NHA

Public GDP total	1'089'300	1'148'100	1'222'500	1'301'700	1'360'914	1'430'920	1'501'456	1'576'866

Budget of the Health Sector 2008-2015

BF=Budget Forecast

Health Sector	2008	2009	2010	2011	2012	BF 2013	BF 2014	BF 2015
mln ALL	28'167	31'728	36'718	35'866	36'020	36'604	37'771	39'946
as % of GDP	*2.59%*	*2.76%*	*3.00%*	*2.76%*	*2.65%*	*2.56%*	*2.52%*	*2.53%*
Ministry of Health	22'615	25'392	29'325	28'775	29'114	26'779	27'457	29'109
MoH-Administration	-388	-300	-248	-274	-227	-234	-241	-248
Health services of Ministry of Defense	717	757	1'053	755	697	732	768	807
Revenue from HII (OPP)	5'223	5'879	6'588	6'610	6'436	9'327	9'786	10'278

Ministry of Health Budget 2008-2015

Ministry of Health	2008	2009	2010	2011	2012	BF 2013	BF 2014	BF 2015
mln ALL	22'615	25'392	29'325	28'775	29'114	26'779	27'457	29'109
as % of GDP	*2.08%*	*2.21%*	*2.40%*	*2.21%*	*2.14%*	*1.87%*	*1.83%*	*1.85%*

Source: Ministry of Finance, 2012

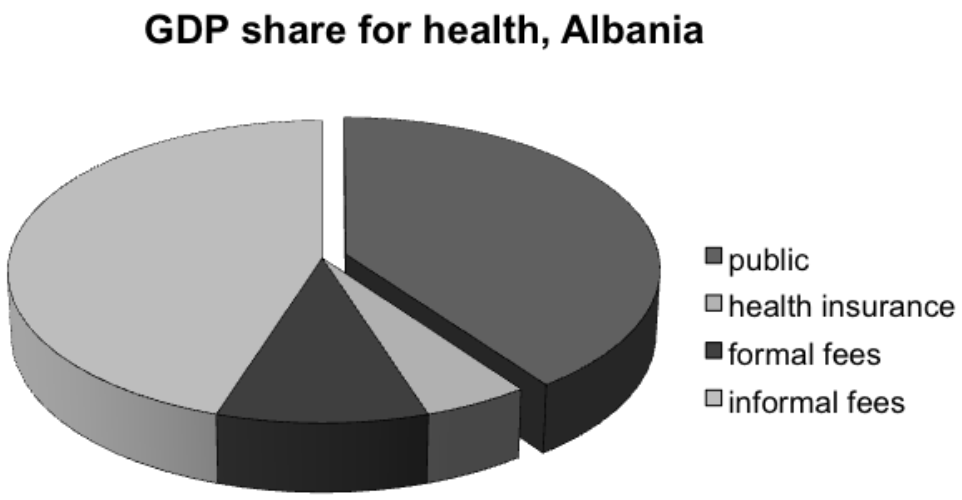
Table 2: Financing of health expenditures, 2007-2009 [1000 LEK]

Variable		2007	2008	2009
			in 1000 LEK	
HF.1	Public Financing	25.441.700	29.112.314	32.414.293
HF.2	Private Financing	25.940.352	28.923.492	30.647.333
HF.3	Foreign Aid	622.926	1.582.959	2.104.734
Sum	Total Health Expenditures	52.004.977	59.618.766	65.166.360
			as % of GDP	
HF.1	Public Financing	2,63	2,68	2,81
HF.2	Private Financing	2,68	2,66	2,66
HF.3	Foreign Aid	0,06	0,15	0,18
Sum	Total Health Expenditures	5,38	5,48	5,65
	Total health expenditures	52.004.977	59.618.766	65.166.360
International functions			as % of THE	
HC.1	Curative Care	35,7	39,6	37,8
HC.2	Rehabilitative Care	5,8	5,9	7,0
HC.3	Long-term nursing care	0,1	0,1	0,1
HC.4	Ancillary services	2,6	2,5	3,6
HC.5	Medical goods	42,5	41,5	40,6
HC.6	Public health *	6,2	3,5	3,2
HC.7	Administration	1,3	1,4	1,0
HC.R	Investments	5,7	5,3	6,7
	Total health expenditures	100,0	100,0	100,0
Albanian functions			as % of THE	
SC.1	Primary care	61,0	59,4	59,6
SC.2	Secondary care	29,4	32,3	31,3
SC.3	Public health *	6,9	4,0	3,7
SC.4	Administration **	2,7	4,2	5,4
	Total health expenditures	100,0	100,0	100,0

* Break in 2008 because of changes in classifications

** Including investments

GDP share for 2010: approximate figures provided by MF / HII



Selected Health financing indicators:

Albania - National Expenditure on Health

A. SELECTED RATIO INDICATORS* FOR EXPENDITURES ON HEALTH	2010
I. Expenditure ratios	
Total expenditure on health (THE) as % of GDP	**6.5**
Financing Sources measurement	
External resources on health as % of THE	*1.8*
Health share of domestically funded government expenditure	
Financing Agents measurement	
General government expenditure on health (GGHE) as % of THE	*39.0*
Private expenditure on health (PvtHE) as % of THE	*61.0*
GGHE as % of General government expenditure	8.4
Social security funds as % of GGHE	70.9
Private insurance as % of private HE	0
Out of pocket expenditure as % of PvtHE	99.8
II. Selected per capita indicators for expenditures on health	
Total expenditure on health / capita US$ at exchange rate	*241*
Total expenditure on health / capita at PPP (NCU per US$)	*577*
General government expenditure on health / cap x-rate	*94*
General government expenditure on health / cap PPP (NCU per US$)	*225*

PPP = Purchasing Power Parity

Albania - Tredn of National Expenditure on Health 2000-2010

A. SELECTED RATIO INDICATORS* FOR EXPENDITURES ON HEALTH	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
I. Expenditure ratios											
Total expenditure on health (THE) as % of GDP	*6.4*	*6.0*	*6.3*	*6.2*	*6.9*	*6.8*	*6.7*	*6.9*	*6.7*	*6.9*	*6.5*
Financing Sources measurement											
External resources on health as % of THE	*6.0*	*5.2*	*2.9*	*3.8*	*4.4*	*3.5*	*3.9*	*4.2*	*2.2*	*2.7*	*1.8*
Financing Agents measurement											
General government expenditure on health (GGHE) as % of THE	*36.1*	*38.2*	*36.1*	*35.9*	*39.7*	*40.2*	*39.4*	*38.2*	*39.6*	*41.2*	*39.0*
Private expenditure on health (PvtHE) as % of THE	*63.9*	*61.8*	*63.9*	*64.1*	*60.3*	*59.8*	*60.6*	*61.8*	*60.4*	*58.8*	*61.0*
GGHE as % of General government expenditure	*7.0*	*7.2*	*7.3*	*7.6*	*9.2*	*9.8*	*9.1*	*8.5*	*8.2*	*8.4*	*8.4*
Social security funds as % of GGHE	*20.4*	*22.2*	*25.6*	*23.7*	*28.1*	*32.2*	*26.7*	*39.8*	*38.2*	*70.9*	*70.9*
Out of pocket expenditure as % of PvtHE	*99.9*	*99.8*	*99.8*	*94.3*	*93.2*	*94.4*	*93.8*	*93.6*	*96.5*	*99.8*	*99.8*
II. Selected per capita indicators for expenditures on health											
Total expenditure on health / capita at exchange rate	*75*	*80*	*90*	*113*	*161*	*178*	*192*	*232*	*275*	*260*	*241*
Total expenditure on health / capita at PPP (NCU per US$)	*266*	*279*	*303*	*326*	*380*	*407*	*451*	*494*	*557*	*591*	*577*
General government expenditure on health / cap x-rate	*27*	*31*	*33*	*41*	*64*	*71*	*76*	*89*	*109*	*107*	*94*
General government expenditure on health / cap (NCU per US$)	*96*	*107*	*109*	*117*	*151*	*163*	*178*	*189*	*221*	*244*	*225*

PPP = Purchasing Power Parity

Comparison of health indicators of some middle income countries (2009 data)

Country	Total health expenditures as % of GNP	Total health expenditures per capita internat $
Romania	5.4	773
Cyprus	6.0	1'825
Albania	**6.5**	**582**
Poland	7.1	1'359
Hungary	7.3	1'441
Croatia	7.8	1'553
Serbia	9.9	836
Bosnia & H	10.9	929
CH	11.3	5'072

On informal payments as part of OPP [*]:

Figure 5: Percentage distribution of bribes paid in cash by amount paid (in Lek), Albania (2010)

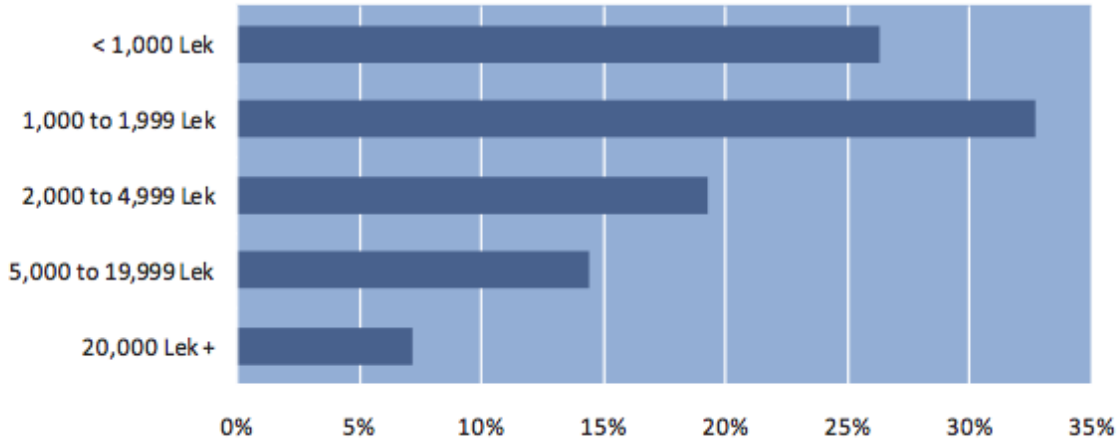
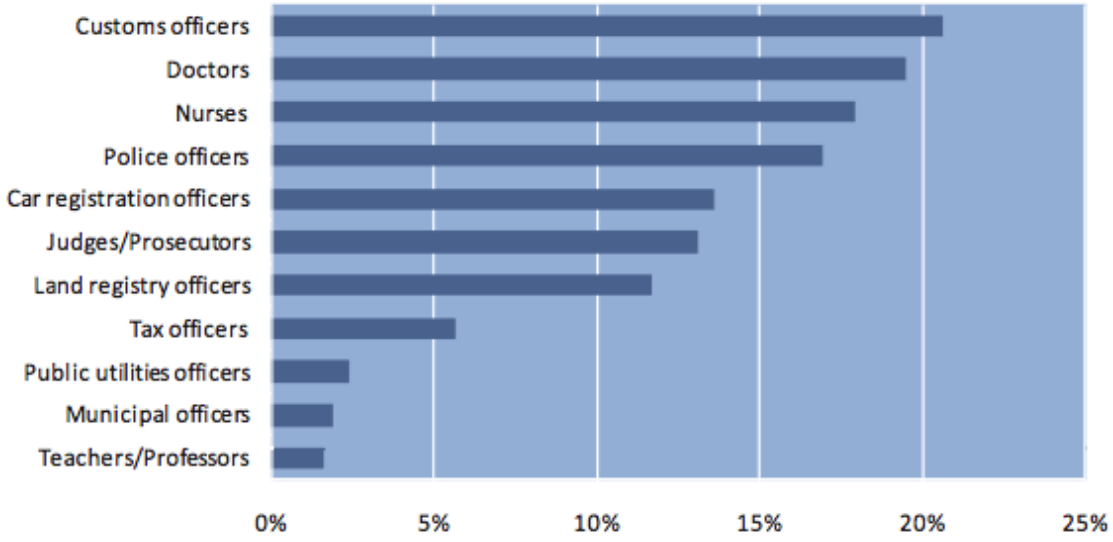


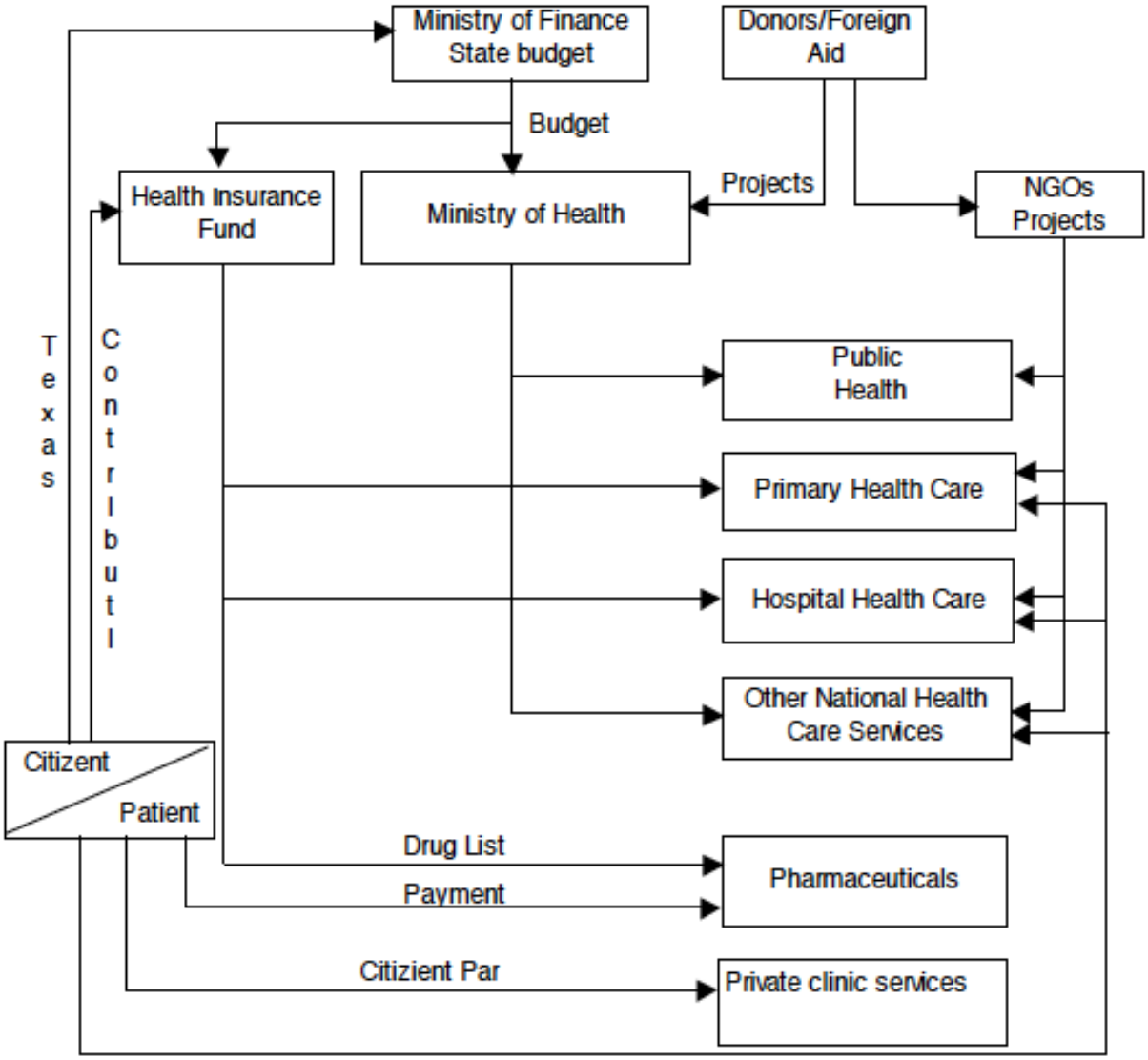
Figure 10: Prevalence of bribery for selected types of public officials receiving the bribe, Albania (2010)



[*] Figure 5 and 10 from UNODC / INSTAT publication: Corruption in Albania, 2011

Annex 5.2: Money flows for health sector

Chart of money flow in the health sector:



Annex 9.1: Determinant of NCDs in Albanian Population

Table: Some determinants for NCDs

Definition	Sex	Age Group	Prev. (%) or Mean
Alcohol use		**15-49**	
Percentage of abstainers (who did not drink alcohol in the last year)	M		25%
	F		68%
Percentage of heavy drink (men/women: 5 or more drinks on any day of last week)	M		16%
	F		1%
Average number of drinks per day	M		1.7
	F		1.2
Tobacco Use		**15-49**	
Percentage who current smoke tobacco	M		43%
	F		4%
Average age started smoking (years)	M		19.2
	F		21.1
Percentage smoking manufactured cigarettes	M		43%
	F		4%
Percentage who tried to stop smoking in the past year	M		67%
	F		60%
BMI, Overweight, Obesity		**15-49**	
Mean body mass index -- BMI (kg/m^2)	M		25.4
	F		24.5
Percentage who are overweight (BMI≥25 kg/m^2 and < 30 kg/m^2)	M		45%
			30%
Percentage who are obese (BMI≥30 kg/m^2)	M		9%
	F		10%
Blood Pressure		**45-49**	
Percentage with raised BP (SBP ≥140 and/or DBP ≥90 mmHg or currently on medication for it)	M		45%
	F		40%
Percentage with raised BP (SBP ≥160 and/or DBP ≥100 mmHg or currently on medication for it)	M		7%
	F		10%
Cholesterol		**25+**	
Mean total blood cholesterol [choose accordingly: mmol/L or mg/dl]	both		5.4
Percentage with raised trigliceridemy (>1.69mmol/l)	M		24%
Percentage with raised trigliceridemy (>1.69mmol/l)	F		19%
Diabetes		**20+**	
Mean fasting blood glucose [mmol/L], excluding those currently on medication for raised blood glucose	both		210
Percentage with raised blood glucose as defined below or currently on medication for raised blood glucose	both		4%
Physical Activity		**15-18**	
Percentage not engaging in vigorous physical activity	both		59%
Percentage engaging on moderate activity (30 minutes) during the last week (more than five per week)	both		14%
Percentage enagaging on high activity (20 minutes) during the last week (more than 3 per week)	both		22%
Diet (Fruit/Vegetable)		**15-18**	
Percentage who ate more than 4 servings of fruit a day	both		15%
Percentage who ate more 4 servings of vegetable a day	both		4%
Percentage who ate less than 3 serving of fruit a week	both		27%
Percentage who ate less than 3 serving of vegetable a week	both		44%

Annex 11: Partner in Development – the 'Donor Mapping'

Donor	Name of the project	Amount	Start/End Date:	Focus of health support	Basic strategic approaches
USAID	**Enabling Equitable Health Reforms in Albania**	$ 8,605,712	Oct 1, 2010 – Sept. 30, 2015	The project aims to strengthen Albania's health system to provide better access to health services for the poor by a) helping remove the existing barriers and constraints to the reforms at the national level and b) field testing approaches and tools that define a feasible set of implementable reforms in Albania.	**The project** selected three regions namely, Tirana, Maternity Hospital "Queen Geraldine" Lezha regional Hospital and Korca Regional Hospital to help improve capacities to implement a set of health reform interventions in selected sites. Interventions address the six health systems strengthening building blocks of: Service Delivery, Health Workforce, Health Information Systems, Medical Products and Technology, Health Financing, and Governance.
	Integrated Telemedicine and e-Health Program in Albania (ITeHP)	$ 1,249,612	September 22, 2009-September 30, 2013	The mission of ITeHP is to create a nationwide telemedicine and e-health network in Albania and to train and educate the healthcare providers in the use, adoption, practice, and implementation of telemedicine, e-health and medical electronic libraries.	It consists of a network of six centers (in two years will be 11 centers) that provides a highly useful technical tool at each hospital. The program will establish the basic infrastructure, info-structure, policies and procedures and training of human capacity needed in Albania in order to create an Integrated Telemedicine and e-Health Program.
World Bank	**Health System Modernization Project**	Total project cost: $ 19.1 mil • $ 15.4 mil (IDA) • $ 2.1 mil (Gov.A) • $ 1.6 mil (Gov. Japan)	3 July 2001-30 June 2012	The Project Objectives are to improve physical and financial access to, and the actual use of, high-quality primary health care services, with an emphasis on those in poor and under-serviced areas; diminish the unnecessary use of secondary and tertiary care facilities; increase the effectiveness of the Ministry of Health and Health Insurance Institute (HII) in formulating and implementing reforms; and improve governance and management in the hospitals. In May 2010, the project was restructured. The new or expanded activities include: (i) developing and implementing a rationalization plan for hospitals, including proposals for privatization of selected services; (ii) improving public awareness through developing and implementing the national communication strategy; and (iii) improving quality of hospital services through purchasing of additional medical equipments	Key achievements: include universal retraining of primary health care providers, unification of primary and secondary health care purchasing, and adoption of performance based contracts in the funding of public hospitals.
	Health Project	$ 40 mil (not yet defined)	FY14 (FY14 - 1 July 2013 – 30 June 2014), but could be postponed in FY15	In health, key challenges pertain to addressing regional imbalances in service provision, modifying payment systems to promote greater efficiency in resource use and strengthening management.	National

World Health Organization	**The biennial collaborative agreement (BCA) 2012–2013 between WHO/Europe and Albania**		2012–2013	The document reflects the new vision of WHO/Europe as approved by the sixtieth session of the Regional Committee for Europe – Better Health for Europe, as well as the concepts, principles and values underpinning the development of WHO/Europe's new Country Strategy and the European Policy for Health – Health 2020. The aim of the BCA is to impact health, i.e., to raise the level of health and reduce inequity in the distribution of health within the population.	Document priorities: European health policy – Health 2020: 1. A new legal framework, especially the health care law, will be an important stepping stone to achieve these important goals. 2. Health systems strengthening and public health 3. Noncommunicable diseases, health promotion and healthy lifestyles 4. Communicable diseases, health security and environment 5. Health information, evidence, research and innovation
	Strengthening Food Control Institutions in Albania	€ 2,000,614	April 2009– November 2012	To create a sound legal framework for specimen collection and laboratory analyses in regard to food safety system in Albania To modernize and upgrade the scientific and managerial capacity of food laboratories and inspection services in Albania to meet international standards and accreditation requirements, and provide a sound basis for the work of the new national food safety authority	The strengthening of the food control institutions in Albania in line with the recommendations in the WHO European Action Plan on Food and Nutrition Policy 2007-2012
World Health Organization, UNICEF, FAO	**Joint Nutrition Program (WHO, UNICEF, FAO): Albania- Reducing malnutrition in children**	Budget $ 1.003.660 (WHO) out of $ 4.000.000(Total Grant) Funded: Spanish MDG Achievement Fund for children, Nutrition and Food Security	3 and a half years (2010- June 2013)	JNP promotes progress towards: MDG 1(eradication of poverty) , MDG4 (reducing child mortality) and MDG5 (reducing maternal mortality). Goal: Prevention and addressing malnutrition and food insecurity in Albania among high risk child population groups through strengthening national policy development and enhancing technical capacity at national and local levels.	Target areas: six districts of Northern Albania - in Kukes and Shkodra Prefectures - and in two peri-urban Municipalities of Tirana (Kamez and Paskuqan) Outcomes: Increased awareness of nutrition as a national development priority at all levels Coordination and capacities to design, implement and monitor nutrition and food security interventions are enhanced at all levels Public Health Nutrition repositioned within the primary health care services The JP is implemented by the Ministry of Health Ministry of Agriculture, Food and Consumer Protection (MOAFCP), Institute for Statistics (INSTAT), specialized institutions, regional authorities, and civil society organizations. The JP is supported by three participating UN agencies – Food and Agriculture Organization (FAO), United Nations Children's Fund (UNICEF) as the lead agency and World Health Organization (WHO).

UNICEF & UN AGENCIES	**Health Financing**		2012 - 2016	Focus: Health financing in PHC	**Strategy :** analysis of financial barriers to PHC services; costing of PHC basic package of services (intervention here combined with other UN agencies)
UNICEF	**Equitable access to MCH services**		2012-2016	MCH services	**Strategy:** Assessment of preventive MCH services (mother and child consulting centers); Development of standards and guidelines for these services; capacity development of health care providers in standard case management and MCH consulting services
IPA Adriatic Cross-border Cooperation Program	**The Blood Ethical good for Social capital and Safety (BESSY) project**.		2012-2013	It aims at establishing a sustainable network in the Adriatic cross-border area of Policy Makers, NGOs and Health Care Providers involved in blood donation in order to provide an effective common answer to the problems of scarcity and safety of donated blood, respecting autonomies and single identities, and promoting blood as an ethical good for safety and social capital.	The countries participating in the development and implementation of the BESSY project are Italy, Croatia, Slovenia and Albania. The project is implemented both at the institutional level (Ministry of Health, Regions) and at the NGOs-Blood Transfusion Organizations level (Red Cross organizations, blood transfusion centers, promotion and recruitment organizations), in order to arrange an adequate policy context and at the same time support health structures and NGOs to reach high performance levels with regard to blood donation.
UNFPA	**Country Program**		2012-2013	To strengthen technical and Institutional capacities and to integrate comprehensive Reproductive Health services and standardized and oversight mechanisms into primary health care and maternity units, and to implement the National RH Strategy.	Building capacities of national health institutions experts in the area of health services' cost. Support the development of the national contraceptive security strategy.
Swiss	**Environment Albania**		1994-2000	Project focus was transforming the PHI's Department of Hygiene in the Environmental Health Department as reference center for the country and as the professional source of the environmental health indicators for supporting MOH in the policymaking process.	The approach chosen for the implementation was a comprehensive one including: a)infrastructure improvements, b) Contemporaneous equipments for measurement of air pollution, water quality –chemical and bacteriological indicators, for controlling food safety etc. c) Training of most of the experts of the department in Switzerland and in the country, and especially training the professionals for the equipment use. d) The scholarships provided for master studies abroad for three experts (in Netherlands and in UK). e) The first manual of sanitary inspectorate prepared the training process for its implementation took place over all the country in each Public Health Directory.

Annex 12: One UN Program – Health (Pre-consultation)

Outcome 4.3: Health insurance is universal and quality, gender sensitive and age appropriate public health services available to all including at-risk populations				
Outputs	**Indicators, Baseline, Target**	**MOV**	**Partners**	**UN Agencies**
4.3.1 Health insurance coverage increased by expanding benefits, simplifying procedures and enhancing information for all	**Indicator 4.3.1-1** % of persons covered with health insurance. **Baseline:** 40% of the active labor force is covered as reported by HII **Target:** 90% of the active labor force is covered **Indicator 4.3.1-2** % of blocks included in the health insurance package. **Baseline:** Prevention and treatment are covered by the health insurance package **Target:** Prevention, treatment and rehabilitation are covered by the health insurance package	Admin records and surveys (DHS census etc)	HII, MoH, INSTAT, MoLSAEO, MoF	WHO, UNICEF, UNFPA, UNAIDS
4.3.2 Demand for, equitable access to and utilization of quality health services increased, especially for children, young people and elderly, and other vulnerable or at risk groups.	**Indicator 4.3.2-1** % of most at risk groups, including children, young people, accessing and utilizing the Basic Package as per defined protocols and clinical guidelines **Baseline:** TBD **Target:** TBD **Indicator 4.3.2-2** % of at risk population that have access to preventive and treatment services for HIV/AIDS, STIs and unwanted pregnancies. **Baseline:** TBD **Target:** % of at risk population including MARA that have access to preventive and treatment services for HIV/AIDS, STIs and unwanted pregnancies **Indicator 4.3.2-3** % of children stunted under age 5 **Baseline:** 19% of children under 5 are stunted **Target:** reduction of stunting by 30% of to-date figure. **Indicator 4.3.2-4** Number of promotional activities for prevention of non-communicable diseases (cancer, cardiovascular diseases, diabetes, suicide, road safety, violence and injury) **Baseline:** 0 **Target:** Yearly activity for each one of the clusters under non-communicable diseases **Indicator 4.3.2-5** Number of patients who have access to quality diagnosis and treatment services for non-communicable diseases (cancer and cardiovascular) **Baseline:** Number of patients having access in 2011 (updated data to be provided by the Ministry of Health) **Target:** 2 x Number of patients having access in 2011 by 2016	Surveys, administrative data, DHS Bio BSS	MOH, IPH, MOA, Regional health authorities, CSOs	WHO, IAEA, UNICEF, UNFPA, UNAIDS
4.3.3 Prevention measures and Promotion of Public Health enhanced through multi-sectorial dialogue and community participation	**Indicator 4.3.3-1** % of vulnerable children covered by preventive health, nutrition and early childhood development services including patronage nursing visits. **Baseline:** TBD **Target:** 80% in target areas **Indicator 4.3.3-2** % of adolescents that have access to correct information on HIV, drugs and STIs **Baseline:** 35, 8 % of girls aged 15-19 years old and 21,2 % boys of the same age group have HIV correct information **Target:** increase by 40 % **Indicator 4.3.3-3** % of families that have access to quality maternal, neonatal and child health services **Baseline:** 20% of parents in target areas have knowledge on children social and emotional development **Target:** 30 %	Surveys, administrative data DHS	MOH, IPH, CSOs Ministry of Education Patients groups	WHO, UNICEF, UNFPA, UNAIDS