Health for All Programme Albania: External Review of Phase 2

Prepared by:
David Beran and Klodian Rjepaj

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Acronyms

ANHS	Albanian National Health Strategy 2016–2020
CBA	Cost Benefit Analysis
CEA	Cost Effectiveness Analysis
CME	Continuing Medical Education
COPD	Chronic Obstructive Pulmonary Disease
DALY	Disability Adjusted Life Year
EU	European Union
HAC	Health for All Centre
HAP	Health for All Project
HIF	Health Insurance Fund
MoHSP	Ministry of Health and Social Protection
NCD	Noncommunicable disease
OECD	Organisation for Economic Co-operation and Development
OOP	Out of Pocket
PHC	Primary Health Care
PG	Peer Groups
SDC	Swiss Agency for Development and Cooperation
SDG	Sustainable Development Goal
Swiss TPH	Swiss Tropical and Public Health Institute

Executive Summary

Background

Given the current health system context in Albania, the ageing population as well as the main burden of morbidity and mortality being caused by Noncommunicable diseases there is the need to strengthen Primary Health Care. The Swiss Agency for Development cooperation has mandated Swiss Tropical and Public Health Institute to implement Health for All project Phase 2. As the project is nearing the end of its current phase and there is a need to evaluate the Project's accomplishments to date, identify and analyse bottlenecks and challenges with regards to project relevancy in the changing country context, its operational efficiency and propose specific recommendations to address these challenges for its ongoing implementation as well as recommendations for future support.

Methods

This evaluation which took place in January and February 2022 includes a review of all project documents complemented by key stakeholder interviews and site visits to the two pilot regions. Interviews were carried out by a team comprised of an international and national consultant. Two parallel "methods" were used to structure this work. One focused on the Primary Health Care elements and was based on the on the Operational Framework for Primary Health Care developed by the WHO and UNICEF and the other on actual implementation using the OECD's "DAC Criteria for Evaluating Development Assistance". A matrix combining both the Primary Health Care elements evaluated and the relevance, efficiency, effectiveness, impact and sustainability was developed by the international consultant to facilitate data analysis and reporting. This allowed to link the Primary Health Care specific outcomes to their relevance, efficiency, effectiveness, impact and sustainability in this context.

Results

First and foremost, the project team should be commended for managing a complex project in a challenging political environment during the COVID-19 pandemic. All people interviewed described the professionalism, catalytic effect of the Health for All Project, the alignment of Health for All Project activities with national guidance and local needs. The project's activities are synergistic, well thought out and complementary.

Four successes should be highlighted. The impact the project has had on the motivation and engagement of health personnel, especially nurses should be commended as a major success of Health for All Project. The enthusiasm and personal value described by nurses following their training and receiving equipment is most noteworthy. This support has defined the new roles of nurses through the development of profiles, specific training and continuous training. The next success was the development and implementation of the home-based care model which addresses a challenge within the Albanian context and meets the needs of certain vulnerable populations. This model also enabled nurses to do a job they were doing before on a limited scale, but to be able to do this with more confidence and sense of professionalism thanks to the knowledge and physical tools provided by the project. Continuing Medical Education is also an element that Health for All Project has worked on with the main success of this being Peer Review Groups which all stakeholders saw as innovative and impactful. It is important to note that beyond the pilot regions Peer Groups have also been implemented in other areas of Albania. Finally, the project has been able to get political commitment for

Primary Health Care through the approval of the Primary Health Care Strategy, but true leadership is lacking as the Operator should now play a role in the implementation of this strategy, but seems to lack the resources to do this.

Rehabilitation activities had an impact on the infrastructure of the facilities. The involvement of local authorities from the beginning of this process should be seen as positive as well as the co-funding mechanism established. It is clear that this had a catalytic effect in providing a propitious environment for health professionals to work and people to be seen.

The main challenge facing the project in this phase as well as in the view of sustaining and scaling up project activities is that although the Operator should be playing a leading role with regards to strengthening Primary Health Care it has not been able to do this. The Health for All Project did provide support to the Operator with some equipment and technical support, but this was insufficient to "boost" and empower the Operator to assume its role. Another challenge the Health for All Project faced was a lack of political commitment to the development of a Human Resources Strategy, which is a key element of the overall Primary Health Care reform as well as being seen as essential by many key stakeholders.

The Health for All Project's success was due to its ability to engage different stakeholders in an effective way. However, community engagement was missing from activities in this phase. Local governments were engaged in the rebuilding of facilities and at a national level many stakeholders were engaged in different ways. There is a necessity to further support Health for All Project through better coordination with other Swiss Agency for Development and Cooperation funded projects as well as with other actors involved in health and social care, e.g., other UN agencies beyond WHO. This could be aligned with the view/need of a donor mechanism in the health sector which the Swiss Agency for Development and Cooperation has taken the lead on.

The main overall area for further focus identified by the consultants is the project's sustainability and the integration of the different activities and initiatives into the health system building off the solid foundations the project has established. This challenge is in addition to the scalability of the project activities beyond the two pilot areas. Albania offers a complex environment to work in and this is recognised as a factor that has impeded sustainability and scalability of the project's activities. Clearly the majority of the work being done by the project should be the responsibility of the Operator. Although the project states it is a "health systems strengthening project" as of yet it has not fully realised this.

Recommendations

The recommendations put forward in this report, include:

Activities to be addressed in the current phase:

- Ongoing support to both the Masters in Health Management and the Masters in Family Nursing should be phased out during the current phase
- The research component as it is currently implemented should not be continued in the next phase, but needs to be rethought during the current phase to make it more relevant to policy and practice

- It is proposed to develop a human resource plan or needs assessment versus the human resources strategy that has to date note progressed as planned
- Consider the organisation of a workshop on lessons from COVID-19 focusing on the positive aspects and lessons learnt from Health for All Project and partners.
- Costing of the different packages Health for All Project has developed is needed, e.g. how much does a nurse bag cost and their resupply, or an average home visit in order to help with scaling up and handover to Health Insurance Fund
- Build stronger links with the Operator and jointly develop an operational manual to be agreed and approved to define the way of working together between the Operator and Health for All Project in the next phase.
- Investigate links and collaboration with Agency for Quality Improvement and Assurance
- Showcase project more widely

Activities to be considered in possible future support of the Swiss government to Primary Health Care in Albania:

- Health promotion is a core component of PHC this should be further strengthened. This was a core component of the project's previous phase and it is understood that some health promotion activities are now the responsibility of another Swiss Agency for Development of Cooperation supported project, but future funding should include this as part of the community engagement and empowerment. Health promotion activities could be developed as part of the support towards the efforts of the PHC for the Check-up Programme and create synergies. Also, promotional activities could be developed for the vulnerable populations creating synergies with the 'Shkollat per shendetin' project.
- Community engagement and psychological and social support to vulnerable groups, as targeted by the Primary Health Centres, could be a potential area for development through involvement of the Civil Society Organisations.
- The following activities need to be scaled up in any future phase of the project
    - The home-based care model
    - Continuous Medical Education programmes, especially the peer review groups
- Develop and implement a new model of Primary Health Care based on lessons and approaches developed by the Health for All Project
- Investigate Swiss support to pre-graduate medical and nursing education
- Swiss Agency for Development of Cooperation to explore the investment (time, resources both financial and non-financial) needed and role of a possible donor platform in health

Conclusions

All the work Health for All Project has done on nursing has clearly shown success and needs to be scaled up. An innovation from the Health for All Project recognised by all stakeholders was the home-based care model. It was mentioned during the evaluation that this model was of interest to UNFPA given their work with elderly populations, UNICEF and their focus on children, and WHO to learn more about the overall model. This model clearly also needs to be scaled up. The activities developed as part of Continuous Medical Education need to be scaled up, including all the protocols, training materials, and Peer Review Groups as well as further develop the content offered.

The creation of the Agency for Quality Improvement and Assurance should be seen as an opportunity for Health for All Project given this Agency's role in Continuous Medical Education. In addition, as the Agency is also responsible for the accreditation process some more support is needed with regards to highlighting the importance of this process for facilities, dissemination of the materials Health for All Project has developed as well as possibly addressing any weaknesses in the current process. From the very beginning Health for All Project should work closely with the Agency regarding the accreditation process for facilities building off its experience by supporting the development of indicators as well as organisational support.

In order to scale up and make the project activities sustainable two elements are seen as necessary. The first element is how to translate the Health for All Project "philosophy" and approach to the Operator. Although sustainability and scalability are issues in the current phase, one could argue that increasing the capacity of the Operator is one of the best ways to ensure sustainability and scalability of the work Health for All Project is implementing. Secondly, there is the need to rethink the physical organisation of Primary Health Care in Albania based on changes in demography. The redesign would include both possible infrastructure investments as well as the "soft" components developed by Health for All Project. There is a possibility to design the new face of the Primary Health Care for the next generation. Given that Albania has seen high internal mobility during the past 30 years, the current location of health centres is no longer adapted to the current needs of the population. Therefore, new health centres in locations where communities are now located is required. This would also include a series of guiding principles, such as: continuous quality improvement with indicators to be monitored and evaluated; standards; continuity of care; multidisciplinary teams and approaches; outreach; geographical coverage and access to all with a specific attention to vulnerable groups.

A significant element for reflexion in the Albanian context is the need to consider strengthening pre-graduate and postgraduate training for nurses and doctors, especially practical skills training and education. The range of activities developed for nursing in the project is significant, but if the quality of nurses leaving their training is not sufficient the activities implemented and Continuous Medical Education needs to not only upskill nurses but also address shortcomings from pre-graduate training. The same applies for medical students.

The Health for All Project provides the Swiss Agency for Development and Cooperation with a useful model project with regards to addressing the complexities of Primary Health Care as well as empowering nurses and the nursing profession. This needs to be showcased and promoted by the Swiss Agency for Development and Cooperation. The Swiss Agency for Development and Cooperation should also involve the Health for All Project in different policy discussions. The utility of a donor platform remains an open question and the Swiss Agency for Development and Cooperation may want to consult on this and if it proceeds take the unique lead on this without WHO.

The activities implemented by the Health for All Project should be the responsibility of the Operator. The project needs to see how to build stronger links with the Operator and devise a way to scale up the activities and implement any new activities that might be part of a future

phase of the project. The professionalism and recognition of the work done by Health for All Project is undeniable. The challenge for Health for All Project now is how to work with local partners to scale-up these interventions and ensure their sustainability.

1. Background

Primary Health Care (PHC) is defined as a "whole-of-society approach to health that aims to ensure the highest possible level of health and well- being and their equitable distribution by focusing on people´s needs and preferences (as individuals, families, and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment."[1]

The Swiss Agency for Development and Cooperation (SDC) has mandated the Swiss Tropical and Public Health Institute (Swiss TPH) to implement the second phase of the Health for All Project (HAP). The objectives of this report are to present the assessment: of the Project's achievements to date against defined expected outcomes; the project's performance and the implementation process in terms of approach, strategic orientation, project set up, implementation modality and capacities; the relevance, effectiveness and efficiency of PHC interventions; and to provide strategic orientation for the adjustment of priorities and objectives for possible next phase. Additional background information is presented in Appendix 1.

1.1. Country context

Albania is located in the Balkans (Map included in Appendix 1) with a population of 2.9 million with total population decreasing by 0.6% from January 2020 to January 2021.[2] The median age of the Albanian population was 37.6 years in 2021 with an increase in the dependency ratio for older populations (ratio of people above 65 years of age compared to the population aged 15-64 years) from 21.6 % to 22.3 % between January 2020 to January 2021 showing an ageing of the population (See age pyramid included as Appendix 2).

1.2. Health Status of the Albanian Population

Albania has seen an increase in the life-expectancy, with current life-expectancy for males and females being 77 years and 80 years respectively.[3] As in other countries this might have decreased in 2020 and 2021 due to the COVID-19 pandemic. Differences between female and male life-expectancy are explained by higher rates of smoking and alcohol use, as well as road traffic accidents. Data from the Global Burden of Disease shows that most deaths in Albania are due to NCDs in the elderly populations.[4] (Appendix 3)

1.3. The Albanian Health System

The Right to health is enshrined in the Albanian Constitution[5] and healthcare is mainly delivered by the public sector and Albanian law guarantees equal access to health care for all citizens.[3] An overview of the Albanian Health System is included in Appendix 4 . The Ministry of Public Health and Social Protection (MoHSP) is responsible for policy and normative work. This is complemented by the Health Care Services Operator ("Operator") established in July 2018 with a Central Directorate and 4 regional directorates (Tirana, Shkoder, Vlore, Elbasan) responsible for the actual operation of the health system (human resources, infrastructure, equipment, operation of the health system, etc.) and the Health Insurance Fund (HIF) responsible for health financing.

1.4. Primary Health Care in Albania

PHC in Albania is organized through a network of public providers of health services, through primary health centres in urban areas, and primary health centres and their satellites (ambulances) in rural areas, dispersed across all 61 municipalities. In 2021 a total of 412 health centres had a contract with the HIF.[6] In theory PHC offers services for 8,000 to 20,000 people with variations between urban and rural areas.[7] The ratios of doctors to population is 1 to 2,500 and 1 to 400 population for nurses. In Albania 1,538 general practitioners and 6,864 nurses and laboratory technicians work at PHC level.[8]

2. Project context

Switzerland is the largest donor to the health sector in Albania. Health was a priority in the Swiss Cooperation Strategy Albania from 2018-2021 and will continue to be part of the Swiss commitment to the Albanian population. The engagement of Switzerland in the health sector will continue to have as priority areas of support a) strengthening PHC to improve access to essential health services for the population including vulnerable populations; b) promoting healthy behaviours at school aged children to reduce exposure to NCDs risks factors; and c) Improving emergency preparedness and response (having as a foundation PHC) to increase trust of people in a resilient health system.

HAP is in its second phase (April 2019-March 2023) following a first phase which was implemented between January 2015 and March 2019. In its first phase the project was implemented by the Swiss TPH as the leader in collaboration with Terre des Hommes, Save the Children.[9] In the current phase the project is being implemented by the Swiss TPH. In both phases the target regions of the project were the Regions of Diber and Fier. (See map in Appendix 1) The project outcomes are included as Appendix 5.

3. Objectives of the evaluation

Based on the terms of reference (Appendix 7) the objectives of the evaluation are to:

- Assess the project based on the Organisation for Economic Co-operation and Development (OECD) evaluation criteria (relevance, effectiveness, efficiency, coherence, impact, sustainability)
- Analysis of the results achieved so far and the efficiency of the Swiss investment.
- Assess the relevance of the modalities of the Swiss support the health sector and assess the risks (political, institutional, fiduciary, force majeure etc.)
- Assess relevance of the project in the current context providing a forward looking prospective
- Learn with a view to improving the quality and results of Swiss interventions in health by gathering knowledge about what works, and why

Within the evaluation the SDC seeks specific answers to a series of questions. These are answered in Section 0.

3.1. Methods

Details of the review are in included in Appendix 8 and the programme and organisations met during the visit are included as Appendix 9. Two parallel “methods” were used to structure this work both with regards to the evaluation as well as the formulation of recommendations. One focused on PHC and was based on the Operational Framework for Primary Health Care

developed by the WHO and UNICEF[1] and the other on actual implementation using the OECD's "DAC Criteria for Evaluating Development Assistance"[10,11]. By combining these two frameworks the consultants were able to see if a given activity was successful, aligned with specific guidance on PHC as well as meeting the DAC criteria. These are detailed in Appendix 8.

A matrix combining both the PHC elements evaluated, and the relevance, efficiency, effectiveness, impact and sustainability was developed to facilitate data analysis and reporting (See Table 2). This allowed to link the PHC specific outcomes to their relevance, efficiency, effectiveness, impact and sustainability in this context. All these elements also enabled KR and DB to answer the direct questions posed by the SDC with regards to this project. (See Section 0)

4. Results

The results are presented in 3 parts. The first part (Section 4.1) highlights the overall progress to date and relies on the different reports and discussions on the project. Section 4.2 focuses on the technical aspects of the project using the different "levers" described by the WHO and UNICEF framework described in Section 3.1. Section 4.3 assesses the overall management of the project.

4.1. Assessment of progress

First and foremost, the project team should be commended for managing a complex project in a challenging political environment during the COVID-19 pandemic. All people interviewed described the professionalism, catalytic effect of the HAP Project, the alignment of HAP activities with national guidance and local needs. Although initially the view of the refurbishment of health facilities was perceived as not aligned with the overall "ethos" of the project, in the two pilot regions the support to refurbishment and the provision of materials, training and support to nurses had a significant impact on environment and perception of staff as to their role. The positive and dynamic environment created by the project in the PHC facilities where it has worked is a significant impact of the project and hard to document. At a national level the project is well recognised and most important stakeholders have a good understanding of the project. Although the overall contribution of the HAP Project is well recognised and its support to the PHC Strategy and development of models and materials acknowledged a lack of true ownership at the level of the Albanian government is to be noted. A specific mention is needed with regards to the impact of the project on nursing from a macro, meso and micro perspective in that at all these levels of the system a significant impact can be seen. Detailed in Appendix 10 is the progress with regards to the different project outcomes as assessed by the review of project documents complemented by key stakeholder interviews and field visits. Table 1 gives the overall appreciation of the progress to date on the different outputs.

Table 1 – Overall appreciation of progress on each output of the HAP Project (Green fully; Orange partially; and Red not accomplished)

Output	Progress*	Comments
Output 1. The elaboration of PHC and Human Resources for Health strategies in Albania	PHC Strategy	The PHC Strategy should be seen as a major success of the project at a policy level
	Human Resources for Health Strategy	No meaningful progress for the Human Resources for Health Strategy is to be noted
Output 2. The job profiles of PHC personnel with a focus on nurses are outlined and tested		Materials developed and are being piloted with positive feedback. Only missing component is approval by MoHSP
Output 3. New Master programme in Family Nursing		First cohort of students has started the programme in 2021
Output 4. Master program in Health Management		Programme is developed; materials and support have been provided; evaluation is positive
Output 5. Enhancement of capacities of the Operator		Although equipment was provided as well as the development of a Strategic Plan 2020-2023 for the organisational development of the Operator this Output is seen as falling short of what was planned
Output 6. Operational research capacities on health system and services		This Output has achieved all its targets, but it is felt that its main shortcoming is the actual dissemination of policy relevant findings
Output 7. Quality of PHC services is improved		Besides the ongoing accreditation process this should be seen as another big success of the project
Output 8. Develop and pilot new service models for home-based care		This should be seen as another big success of the project, especially the home-based care model. However, there is the need to have the models approved and integrated within the system
Output 9. Support continuing education of PHC personnel		PGs a huge success of the project and expansion of model beyond pilot regions a good measure of the success and value of this approach within Albania
Output 10. Collaboration across local stakeholders for maintenance of infrastructure		Planned infrastructure support completed
Output 11. Support health services to cope with the emergency created by COVID-19		Planned support completed as per plan

4.2. Technical review

This section will use the different "levers" described by the WHO and UNICEF framework for PHC[1] to assess how this project addresses the complexity of improving PHC in Albania.

4.2.1. Political commitment and leadership

This component of the WHO and UNICEF framework highlights the need for political commitment and leadership to establish PHC as a core component of the health system to achieve universal health coverage and its contribution to the attainment of the SDGs.[1] This has been achieved with the approval of the PHC Strategy. (Appendix 12) However, synergies between different government strategies, e.g. overall Health Strategy (Appendix 13), NCD Strategy and Strategy for the Elderly lack some coherence and synergies as well as placing PHC as an essential component of the government response. The lack of progress on the Human Resources for Health Strategy is also an area showing a gap with regards to moving and operationalising the PHC Strategy with a focus on human resources.

HAP has been able to get political commitment for PHC through the approval of the PHC Strategy, but true leadership is lacking. At the government level the MoHSP has developed the policy and this seems to be their main contribution as the government agency responsible for setting policies. The Operator now should play a role in the implementation of the PHC Strategy, but seems to lack the resources to do this. In addition, leadership for PHC is also lacking from academic and civil society organisations (including professional medical and nursing associations) which could play an important role in promoting its role within the Albanian health system.

4.2.2. Governance and policy frameworks

The second component proposed by the WHO and UNICEF are governance structures and policy frameworks for regulations that support PHC that build partnerships within and across sectors, and promote community leadership and mutual accountability.[1] Within the PHC Strategy there is a recommendation to strengthen the role of municipalities in supporting PHC.[8]

Albania has undergone significant structural reforms: the merger of health and social policy-making institutions at the national level, an institutional reform that has led to the establishment of new institutions, such as: the National Operator of Health Care with its 4 regional directorates, which are undertaking a series of functions of health care planning and administration in the field of primary and secondary health care services. In addition, a new Agency for accreditation and CME has been established on paper and is now part of the overall environment that HAP operates in.

In parallel broad territorial reform with the integration of small communities into larger municipalities and a decentralization process that aims to provide more power and accountability at local government level have taken place.

Through the rehabilitation of facilities municipalities have played an important role. In addition, through home-based care links have been established between health and social services. This link is made at PHC as well as at local level and the project played a key role in this by developing the nurses skills, providing them tools for home visits as well as fostering

linkages between different actors. Although these links are not institutionalized there is a great potential that social care department at the local municipalities work closely with the PHC staff to address the needs of the vulnerable populations in their communities. This can be considered as the local authorities contribute to the project in parallel to the contribution for the infrastructure. Furthermore, this links could be supported by civil society organisations in reaching vulnerable populations and contributions with promotion and education services as well.

The accreditation process gives more responsibility to facilities and contributes to governance. However, feedback on the needed elements for facilities to be accredited highlight many challenges, including the need for resources to do this as well as a lack of clarity as to the benefit for going through this process. The main weakness within this component is that the Operator should be playing a leading role with regards to strengthening PHC, but to date has not been able to do this. HAP did provide support to the Operator with some equipment and technical support, but this was insufficient to "boost" and empower the Operator to assume its role. It was reported by different stakeholders during interviews that in the previous phase of HAP, community engagement activities enabled communities to play an active role in the different elements of the project. These activities were no longer present in this current phase.

4.2.3. Funding and allocation of resources

Adequate funding for PHC needs to be allocated to promote equity in access, to provide a platform and incentive environment to enable high-quality care and services and to minimize financial hardship.[1] Lack of resources available at PHC are a major barrier and a review of the previous national health strategy found a lack of financial autonomy of PHCs.[12] Within the PHC Strategy this element is included as a priority to be addressed.[8]

As mentioned previously PHC and overall investment in equipment is low in Albania.[13,14] (See Appendix 1) PHC facilities also have very limited independence in allocating resources. The HAP project through its provision of equipment was able to address some gaps in resources available.

4.2.4. Engagement of communities and other stakeholders

Engagement of communities and other stakeholders from all sectors is defined as the roles these actors can plan in expressing problems and solutions and prioritizing actions through policy dialogue.[15] The role of civil society can be to ensure that the population receives quality care and that citizens are able to hold the system accountable.[16] Within the PHC Strategy, it is mentioned that, "Ensuring sustainable cooperation between individuals, families and communities and PHC facilities" is a specific objective.[8] In addition the strategy aims to improve services for vulnerable populations.

The HAP Project was able to engage different stakeholders in an effective way. However, community engagement is missing from this. Although successful in engaging policy level stakeholders to develop the PHC Strategy a missed opportunity seems to have been engaging the national, regional, municipal and health facilities in one forum. Recommendation from mid-term review of the previous phase of the project in 2017 suggested that HAP develop a strategy, specifically in conjunction with the consortium members, on how best to strengthen

civil society organisations working in health with vulnerable groups and including an approach for mapping civil society organisations and building their capacity.[17] In a management response letter from the SDC it was stated that the project would strengthen civil society in its second phase.[18] However, it should be noted that it was then decided to split HAP from 2019 into two projects (including splitting the funding), (i) one focusing on health promotion and civil society strengthening which is implemented by Save the Children and (ii) the second one remaining HAP with a focus on the supply side. In the previous phase there was mention that the project had implemented a complaints box in different facilities. During interviews at health facilities this was not mentioned.

Local governments were engaged in the rebuilding of facilities and at a national level many stakeholders were engaged in different ways. In the previous phase of HAP it seemed that civil society and communities were more involved. Some PHC facilities visited mentioned having had community engagement activities and presenting the work of the facility to increase accountability. These activities were absent in the current phase.

4.2.5. Models of care

Having models of care that promote high-quality, people-centred care and essential public health functions, taking a life-course approach are an essential component for PHC.[1] A WHO evaluation of PHC found that people only seek care when they are unwell as well as bypassing PHC.[7] One interesting model of care that has been developed in Albania is the free annual check-up for people aged between 35 and 70 years established in 2015. This programme aims to facilitate early detection of disease and tackle common risk factors. People in this age range receive an annual invitation to a check-up usually carried out by a nurse, which includes an assessment of risk factors, counselling and selected diagnostic tests for chronic conditions including cardiovascular disease, diabetes, chronic respiratory diseases, and some types of cancer. The PHC Strategy although not describing models of care necessary highlights the following, which will require rethinking how services are delivered at PHC:[8]

- Adapting PHC services to the population needs based on the demographic, epidemiological and social analysis.
- Organizing PHC service integrated with social care at local level
- Supporting the vertical integration of PHC services

The Albanian National Health Strategy 2021-2030[19] also calls for new models to be developed with a focus on community care, integrated long-term and rehabilitation services. HAP has responded to this need with the development of the home-based care model including a measure of vulnerability bringing together health and social care needs for the population. This should be seen as a success of the project. In addition, the different guidelines developed for NCDs provide useful clinical tools for the management of different NCDs, but it is unclear how this may have impacted the complex pathway needed for the management of people with NCDs to the higher levels of healthcare system in Albania.

4.2.6. Primary health care workforce

A focus on human resources is also a core component of the levers proposed by WHO and UNICEF. This requires the adequate quantity, competency levels and distribution of multidisciplinary PHC human resources.[1] In Albania there are motivational factors of health personnel that need to be explored further. It seems that training and continuous medical

education are a strong motivational factor.[20] Still the healthcare workforce faces internal and external migration, low recognition of family medicine and nurses as well as low salaries and lack of incentives. There is also a difference in staff available in urban and rural areas.[7] General practitioners in Albania specialise in the treatment of people aged 15 and above at PHC. In urban areas paediatricians will be present at PHC whereas in rural areas this is most likely not the case with General practitioners caring for all age categories. Nurses often have a narrow role in the provision of care. Specifically for school nurses it has been noted that this cadre of professionals lacks a clear job definition, knowledge and tools.[21] It is important to address the shortage of health personnel in PHC, but also address the productivity and performance of staff.[1] In addition to these challenges in health professionals there is also a lack of capacity of PHC managers and a lack of autonomy in decisions of PHC providers.[20] Human resource development and strengthening features prominently in the PHC Strategy[8] and strengthening human resources is also a specific objective of the Albanian National Health Strategy 2021-2030[19].

Support given to health personnel, especially nurses should be commended as a major success of HAP. The motivation and personal value described by nurses following their training and receiving equipment is most noteworthy. Impact on patients could not be directly measured, but as proposed in the Theory of Change(Appendix 6) the activities included should ultimately benefit the population. This support has defined the new roles of nurses through the development of profiles, specific training and continuous training. Continuous education is also a strength of the Albanian system with long-term investment from the SDC and support from Swiss partners in this area. In Phase 1 of the HAP Project PGs were introduced. This approach is now recognised as part of Continuous training and has not only enabled an innovative approach for training, but also a means to establish collaborations between doctors and nurses. PGs offer an interesting platform for the implementation of training, support to nurses, fostering interdisciplinary exchanges, etc. The Human Resources Strategy is a key component of this, but as mentioned previously this has not progressed. Overall, an overarching challenge mentioned by many stakeholders was how medical and nursing training in Faculties is quite weak resulting in the skill base of young doctors and nurses being poor.

4.2.7. Physical infrastructure

The physical infrastructure of PHC is also an essential component.[1] Overall facilities in Albania are seen as outdated and lacking even the basic tools for care.[12,20] In the assessment of the National Health Strategy 2016-2020 it is noted that even basic equipment "such as thermometers, nebulizers, otoscopes, ophthalmoscopes, spirometers, diapasons, sight screen tables, etc." are lacking.[12] For nurses there is no standardised equipment and in most settings nurses have no equipment at all. This is not the case for the Check-up programme where the necessary equipment is guaranteed through a public-private partnership. The PHC Strategy mentions the need to address infrastructure and equipment aligned with the basic packages of services.[8]

Clearly the rehabilitation activities had an impact on the infrastructure of the facilities. The involvement of local authorities from the beginning of this process should be seen as positive as well as the co-funding mechanism established. It is clear that this had a catalytic effect in providing a propitious environment for health professionals to work and people to be seen. Providing equipment was also a benefit to the facility and moral of health professionals. A

missed opportunity was that some facilities outside of the pilot areas (Fier and Diber) were rehabilitated, but the "soft" components (training, protocols, PGs, etc.) were not provided.

4.2.8. Medicines and other health products

Availability and affordability of appropriate, safe, effective, high-quality medicines and other health products through transparent processes to improve health are also part and parcel of PHC.[1] Expenditures on medicines were found to have increased in Albania between 2015 and 2018.[22] For people with chronic diseases median expenditure on medicines increased from €14 in 2015 to €18 in 2018 and for those with acute conditions the increase was from €11 to €15. The price differentials between originator medicines and lowest priced generics is significant in Albania. For example, Metformin (medicine used in the treatment of diabetes) the co-payment for the originator product being 70 times higher than that for the lowest priced generic.[23] The review of the previous national health strategy highlighted the need to improve the evidence-based selection of medicines and align these with treatment guidelines and protocols.[12] Beyond the cost of medicines studies in Albania have also found poor prescribing practices.[24] Although there is recognition of this problem there is no direct involvement of HAP in this component. The improved clinical protocols and training should hopefully ensure more rational prescription by health providers.

4.2.9. Engagement with private sector providers

Public and private partnerships to ensure integration of services is another lever proposed.[1] Although the project does not include any such public-private partnership the model of the Check-up programme offers an example of a public-private partnership within the Albanian health system. The project has involved the ABC health centre, a private provider in some of the development of manuals and training, as well as Mary Potter Clinic for home based care. Otherwise there has been no direct engagement with private sector providers.

4.2.10. Purchasing and payment systems

The focus of this component is how the payment of services can ensure that models of care are centred on PHC.[1] Financial access to healthcare in Albania is still complex. For people with NCDs the MoHSP has abolished co-payments by patients with NCDs at the level of PHC providers, whether insured or not.[22] In addition they can access medicines through a reimbursement scheme of essential drugs. Data from the WHO shows that OOP as a percentage of current health expenditure in 2018 was 44.6% down from 52.1% in 2014.[25] However, data generated by the HAP Project found that in 2018 despite these initiatives the OOP for the population has not decreased.[22] In the review of the National Strategy of Health 2016-2020 stated that the HIF could achieve better value for money at the current level by taking a more active role in the purchasing of health services.[12] The project has not really worked with the HIF or addressed this issue. To a certain extent this component of PHC in Albania is functioning well given that in general the population benefits from free services.

4.2.11. Digital technologies for health

Digital tools to improve effectiveness and efficiency, and promote accountability are needed and should be part of PHC.[1] Clearly digitalisation at the level of PHCs needs improvement, although Albania has implemented a variety of electronic based tools within its health system, for example the e-prescription, e-visit and e-register systems. The PHC Strategy and new

National Health Strategy mention the need to develop digital tools, but is quite vague as to how this will be done.[8,19]

The only tool developed by HAP was for COVID-19 and the appointment system was implemented in some facilities. Although much equipment was provided there was no real investment in this area especially for example in digitalisation of patient records.

4.2.12. Systems for improving the quality of care

Systems for the improvement of the quality of care are needed at local, subnational and national levels for continuous assessment and improvement of services.[1] In order to improve quality of care all the other levers included in the WHO and UNICEF model need to be addressed as "system wide action" is needed.[16] Quality of care should be an integral part of PHC and this should, "consistently delivering care that improves or maintains health outcomes, by being valued and trusted by all people, and by responding to changing population needs."[16] Currently, systems and accountability are lacking in Albania.[20] A study by Peabody et al.[26] in 2017 looking at quality of care in Eastern Europe and Central Asia using clinical performance and value vignettes found that providers in Albania had one of the lowest scores. The PHC Strategy aims to align the quality of care with the financing of services.[8] Beyond this the Strategy also aims to develop indicators, support accreditation procedures and include the population in quality improvement mechanisms. Quality is also a focus within the Albanian National Health Strategy 2021-2030.[19]

The project has supported the accreditation process of facilities including the development of quality managers. It could be argued that the piloting of appointment systems also helped improve quality. The protocols have also improved quality as well as the capacity building of nurses and doctors. Both Master courses can also be seen as improving quality, with the Masters of Family Nursing developing the role of an important cadre of health professional. For health managers the Master of Health Management is a means to achieve this. That said both Master courses are yet to show true impact in the health system.

4.2.13. Primary health care-oriented research

In order to strengthen PHC research is needed including the dissemination of findings.[1] Throughout the interviews research capacity, environment and funding were stated as weaknesses in Albania. In parallel many interviewees also highlighted that data generated by system e.g., HIF was not used for research. The positive aspect is that the project has invested in research capacity development. However, the research carried out in Phase 2 of the HAP Project has lacked a clear link with PHC and the projects areas of activity and especially been weak with regards to dissemination. For example, the project has carried out three studies on the element of quality one an overall assessment of quality of care in the two project pilot sites,[27] one looking at non-clinical aspects using the WHO Responsiveness framework[28] and finally a study assessing the factors influencing choice of provider[29]. It is unclear how the results of these studies were disseminated and used to improve the project and awareness based on the results.

4.2.14. Monitoring and evaluation

The final component proposed by the WHO and UNICEF is monitoring and evaluation through well-functioning health information systems that generate reliable data and support the use

of information for improved decision-making and learning by local, national and global actors.[1] The WHO has identified a lack of accountability of local and regional authorities with regards to health outcomes.[20] It has been argued that what health systems should report on are factors that are important to populations such as "competent care, user experience, health outcomes, and confidence in the system."[16] The evaluation of previous Health Strategy recommended strengthening of monitoring and evaluation activities.[12] The current PHC Strategy includes mention of the need strengthen the MoHSP and Operator with regards to monitoring and evaluation[8] and the Albanian National Health Strategy 2021-2030[19] also emphasises the importance of this.

This component was part of the strengthening of the Operator, but as mentioned previously this was not successful. Data reporting has been put in place by the project for M&E of its activities, but this is not part of the system. Also data generated by system e.g. HIF is not used for M&E and planning.

Appendix 14 presents the above technical elements of the project together with the OECD DAC criteria.

4.3. Assessment of the management of the project

In parallel to the technical assessment of the different elements of the project above, the overall management of the project was evaluated based on document reviews and interviews. Overall, the management and quality of the work done was viewed as extremely professional by all interviewees. The review of documents and materials produced by the project support this as well.

4.3.1. Coordination and implementation

From the perspective of coordination and implementation the project has succeeded on both fronts. The project is well coordinated with all partners at all levels and knowledge of project activities is high. With regards to implementation again the project has achieved high quality work and linked this to all the necessary partners.

The only element to include here is possible better coordination with other SDC funded projects as well as with other actors involved in health and social care, e.g., other UN agencies beyond WHO. This could be aligned with the view/need of a donor mechanism in the health sector which the SDC has taken the lead on. That said many of these elements are for SDC to take the lead on and for the project to see how to participate.

With regards to the project's role as an implementor many activities carried out by HAP, it could be argued, are part of the role of the Operator. Clearly, the Operator does not have the resources to implement such a complex project and the strengthening of the Operator in this phase of the project has not succeeded. It could be argued that the Operator still remains a new organisation, but based on its role in the system it needs to play a larger role in both implementation and coordination. In a possible next phase of the HAP project or in further SDC support to health in Albania this needs to be considered.

Another element is the role of HAP versus Health for All Centre (HAC). Is HAP just a project with HAC as a coordinator and implementor or does HAC have a role to play in the health system beyond HAP as a project. Clearly, the expertise of HAC and its perception by most stakeholders would allow the organisation to play an important role in the further coordination and implementation of PHC related changes in the system as well as other developments needed to improve healthcare in Albania.

4.3.2. Communication and reporting

HAP has been successful in communicating about the project as all main stakeholders were aware of the different activities. The website, reports and other materials are useful, well presented and clear. Although no formal mechanisms for communication were described, HAP has been successful in raising awareness of its activities with a variety of stakeholders. One weakness identified was the communication and reporting of research results beyond specific activities and their "translation" to useful outputs for policy makers and practitioners.

4.3.3. Cost-effectiveness

Cost effectiveness of such a project is hard to measure. Given the wide range of activities in two pilot regions as well as the types of activities, e.g., national strategies, refurbishment of PHC facilities, PGs, home-based care models, etc. this funding is being used for quite a significant amount of work. Overall, the budget allocated is CHF 6.45 million (Appendix 15), in contrast to CHF 9.7 million for Phase 1. The allocation of the overall budget is as follows:[30]

- Services Headquarters: 6.8%
- Long-term experts: 19.1%
- Short-term experts: 3.3%
- Local support: 10.7%
- Activities: 60.1% (24.9% for Outcome 1 and 35.1% for Outcome 2)

One could argue that potentially this project benefits the whole population of Albania thus at a cost per beneficiary of CHF 2.2. Another view is that the project is focused mainly on those with an NCD (estimated at 566,000 for diabetes, cardiovascular disease, asthma, COPD) the cost per beneficiary then increases to CHF 11.4. Based on the budget provided, list of activities and the numbers of individuals benefitting from different activities, or the outputs generated an estimate was made as to the cost per beneficiary/output of different activities developed by the project. (Appendix 16) It should be noted that it was sometimes difficult to align activities with specific budget lines and that only activity costs are included and not the time for staff and experts to implement these. Also, the aim of this exercise is to just show the varying cost per possible beneficiary/output in an attempt to address the complex question of cost-effectiveness of this project. That said the consultants feel that such an exercise is of limited use given that what is important for this project is the overall activities and their cumulative benefit to improving PHC in Albania. The range of cost per beneficiary/output is from CHF 0.1 to over CHF 32,000.

In addition, in the project document the project will carry out a Cost Effectiveness Analysis (CEA) and a Cost Benefit Analysis (CBA) on the different activities.[20] This is seen as essential to see how these can be integrated into the system in a sustainable and scalable way. In the proposed analysis to be carried out by the project the actual cost per element is missing. For example, what is the cost per visit of the home-based care model developed by the project which should include all the "ingredients" needed, training, equipment, etc. Or for example the cost of the equipment bags and their regular resupply. Clearly, CEA and CBA are needed to show if the intervention is effective, but this misses the practical element of can the system afford to provide this service if HAP stops supporting it. Something can be cost effective or provide a benefit, but still be unaffordable.

4.3.4. Sustainability and synergies with other initiatives

The main overall weakness identified by the consultants in this project is its sustainability and the integration of the different activities and initiatives into the health system. This is also linked to the scalability of the project activities beyond the two pilot areas. Albania offers a complex environment to work in and this is recognised as a factor that has impeded sustainability and scalability of the project's activities. Clearly the majority of the work being done by the project should be the responsibility of the Operator. Although the project states it is a "health systems strengthening project" as of yet it has not fully realised this. Health system strengthening requires "permanently making the system function better, not just

filling gaps or supporting the system to produce better short-term outcomes."[20] Although it could be argued that some of the trainings, materials developed and protocols might permanently have an impact on the health system, by no fault of the project, many materials have yet to be approved and fully integrated within the system. As mentioned previously the impact on health personnel and especially nurses is a fundamental change in the system. That said it is still "fragile" and needs to be systematised as currently it is seen as too reliant on the project or on specific individuals within the system.

Overall the project's activities are synergistic, well thought out and complementary. Beyond the synergies within the project, in Albania there are other unique opportunities for synergies with other projects and especially other initiatives supported by the SDC. These include:

- Decentralisation – how can decentralisation activities impact health-related issues. This was tested with the rehabilitation of facilities by involving local governments. Home based care also offers an opportunity to work with local governments. As a cross-cutting area supported by the SDC this could be explored further for possible synergies.
- Civil Society / LëvizAlbania – is a project supported by the Swiss government that promotes democracy and civil action at local level in 36 municipalities throughout Albania to engage civic action and improve local government. This again is an opportunity for HAP to see how to engage civil society at a local level in the area of health and see what synergies might exist with existing initiatives.
- Leave no one behind project – focusing on vulnerable populations has focused on improving social services. Possible synergies with the home-based care model could be made.
- Employment focused projects – Switzerland supports projects focusing on employment especially for young people. Given the current and future needs of health professionals at different levels, including for example carers for the elderly, health can be seen as a promising market for future job seekers. This synergy seems like one that could be an "easy win".
- "One stop shop centres" have been supported throughout Albania for providing easy access to a variety of government services. An opportunity could be to see how health could be integrated with this focusing also on digital literacy for vulnerable groups.
- Check-up programme – this innovative approach in Albania of providing free services for the early detection of NCDs is a "platform" that the HAP project can build from. The synergies with this programme are both thematic and in its approach. From a thematic perspective the Check-up programme and HAP are fully aligned and how to link the two at facility level should be explored. However, the main synergy from the Check-up programme is how such an initiative was able to be implemented, implanted and sustained within the system.

Table 2 presents the sustainability, scalability and possible synergies for the different outputs of the project. A traffic light system is used in this table to highlight those areas that fully (green), somewhat (orange) or do not (red) meet the criteria.

Table 2 – Sustainability, Scalability and Synergies of activities implemented by the HAP Project

Activity or Project Component	Sustainability	Scalability	Synergies
Elaboration of PHC and Human resources for health policies and strategies in Albania	Policy is developed and present, at least for PHC.	Issue is about scalability and implementation given current challenges in Albania and weaknesses of key actors in Albania	Yes with overall aim of National Health Strategy, UHC and NCD agenda as well as SDGs
Updated job profiles of PHC personnel	These are now developed and used. Still require formal approval.	These should be relatively easy to scale-up, but the question is which organisation would be responsible for this.	This activity is synergistic and complementary to the whole momentum the project has generated for nurses.
New Master's Program for Family Nurses is established	This is now well established within the Faculty of nursing, but the first intake has only started in December.	Question is how many possible students this programme can attract.	This activity is synergistic and complementary to the whole momentum the project has generated for nurses.
The Master program in Health Management is consolidated	Established programme with students taking the course. Question as to whether without HAP support this will continue.	Question is how many possible students this programme can attract and also the value of this Masters in filling gaps in skills within the system.	This activity is synergistic and complementary to needs of the health system in strengthening its management capacity.
Capacities of regional directorates of health service Operator and/or public health directorates are enhanced	Not sustainable.	Weaknesses in Operator seem too large for any scalability.	Although sustainability and scalability are issues with this component, one could argue that this increasing the capacity of the Operator is one of the best ways to ensure sustainability and scalability of the work HAP is implementing.

Activity or Project Component	Sustainability	Scalability	Synergies
Operational research capacities on health system and services in Albania are strengthened	Input from HAP has been significant here and not fully integrated within the system.	Scalability without HAP support seems unlikely.	Research is a key element needed for any health system. The priority research agenda of the Ministry of Health might be an opportunity here.
Quality of PHC service delivery is improved through the accreditation procedures and the promotion on use of clinical protocols	This will be dependent on the role of the new Agency on CME and quality being established. The importance of accreditaiton for facilities needs to be strengthened so that the value of this is seen. This will help ensure its sustainability.	Scalability is questionable until protocols are approved and an organisation (governmental or non-governmental) is identified to scale this. Also the importance of this for facilities will help ensure its scalability.	This activity is synergistic and complementary to needs of the health system in strengthening the quality of care provided to the Albanian population.
New services models for home-based care are outlined and tested and related to specialized services	Input from HAP has been significant here and not fully integrated within the system. However, facilities where this has been implemented see the value of this.	Scalability without HAP support seems unlikely.	This activity is synergistic and complementary to needs of the health system in strengthening the quality of care provided to the Albanian population, especially vulnerable groups who lack access to facilities.
CME of PHC personnel is carried-forward and scaled-up and recertification of health managers is embedded in national processes and standards	The existence of a structure for CME activities and the fact that PGs are easy to implement would make this element sustainable within the system given this is a requirement for doctors and nurses.	Has already shown scalability with other areas taking on PGs.	This activity is synergistic and complementary to needs of the health system in capacity of health professionals through CME.
Collaboration across relevant local stakeholders is fostered for	Focusing on the refurbishment of facilities the sustainability of the	Scalability will be difficult without HAP's involvement.	The need to provide adequate working conditions for staff and a

Activity or Project Component	Sustainability	Scalability	Synergies
health service development and public health action	refurbished facilities is dependent on local governments and their involvement in the whole process could make this sustainable.	However, the model of co-financing might be scalable if the Operator for example adopts this model of co-financing.	welcoming facility for the population is a key component improving access and quality care.
	If focusing on the sustainability of refurbishing the facilities needed in Albania this is probably not sustainable given the large needs and lack of resources.		

As can be seen in the Table above the challenge with many of the activities implemented by the project are their sustainability and scalability within the Albanian environment. With regards to their synergies within the project there are many and this shows how coherent the project is. In addition to these synergies as detailed in Section 4.3.4 there are many other synergies which might enable improved sustainability and scalability.

4.3.5. Governance

Governance in the area of PHC is complex. Focusing on this project five areas of governance are important:

1. Governance of the project
2. National PHC-related governance
3. Facility and local related governance
4. Involvement of civil society
5. Integral health systems view

With regards to the project the governance structure is presented in Appendix 17 and overall no concerns were raised internally or externally about this. The consultants would like to note that the Operator is part of the Steering Committee, but unlike the MoHSP and HIF this is without voting rights. It should be noted that when the second phase of the project was launche the Operator only existed on paper.

At a national level there seems to be three actors needed to address the governance of PHC. These are the MoHSP, HIF and Operator. Each actor has a specific role to play, but for PHC this seems to be lacking. The PHC Strategy might help with this, but as mentioned previously in this report strengthening management capacity of the Operator needs to be addressed. It is also important to note that there was a lack of engagement of civil society in the development of these strategies.

Governance at the level of the facility would seem to be very person dependent. The links the project has created between health facilities and local authorities need to be fostered and strengthened.

Although in the technical working group of the PHC Strategy established by MoHSP one representative of the professional association of GPs and one representative from a private non-for-profit health care service organization participated, there is no real engagement of civil society. This might be complex in Albania at a national level, but in line with governance at facility and local levels this might be an opportunity for engaging citizens. Organisations such as Together for Life, Mary Potter, ABC Clinic as well as the NCD Coalition that HAP had tried to develop in the first phase of the project might be organisations to involve in different ways. Although different disease specific patient organisations exist, these are seen as quite weak. Also 8,000 civil society organisations exist in Albania, but lack of professionalism and funding.

In terms of governance there is also the need to look at the whole health system and how PHC fits into this. This does not mean HAP in a possible next phase needs to address these directly, but it should ensure these are taken into account. For example, the issue of medicine costs for people in Albania or how to ensure links with other projects such as the World Bank

Hospital project. For this HAP should find ways with the support of SDC to be active in different policy discussions to help integrate PHC and HAP's experience at a policy level in Albania.

4.3.6. Gender

The consultants feel that although gender is included as an issue the project integrates in all its components and reports on these, gender needs to be addressed in a deeper way. For example, studies in Albania highlight differences in health and health outcomes between males and females. A study from 2015 looking at hospitalisations for acute myocardial infarction at the Mother Teresa Hospital in Tirana found that women had higher complication rates and less use of treatment, such as revascularization, than men.[31] Using data from the 2008/2009 Albanian Demographic and Health Survey, Petrela et al.[32] found that: hypertension was more common in men than women; that the impact of being overweight or obese was larger in women than in men with this increasing with age; that alcohol use and smoking were major risk factors in men, but not women; and that education had a protective effect on hypertension in women, but not men. In looking at risk factors for NCDs a study in Albania argued for the need of gender specific approaches to tobacco control considering that the prevalence of smoking is higher in men, but that this is increasing in women.[33] Also socio-economic considerations need to be added to the gender approaches with smoking in men being more predominant in low socio-economic strata versus being more prevalent in higher income groups in women. At a level the National Strategy and Action Plan on Gender Equality 2016-2020 has set as one of its objectives the reduction of women's unpaid domestic work by increasing access and quality of social services.[34] All these elements require adapting approaches to take into account how gender differences might impact risk factors, health seeking behaviour, health system use, etc. Also seeing as the nursing profession and many professionals interviewed for this report were females this also needs to be considered within the project's mode of addressing gender-related issues.

4.3.7. Vulnerable populations

HAP identifies older people, rural dwellers and people with chronic diseases as the vulnerable populations included in the project activities. Although Roma and Egyptian populations are identified specifically as vulnerable populations in Albania no specific mention was made as to activities specifically targeting these populations during the evaluation. The Albanian health system has implemented free PHC services which should benefit vulnerable populations, but many times these populations do not know what they are entitled to and have challenges navigating the system.[12]

Clearly home-based care has been a core approach aimed at addressing the needs of vulnerable populations. Overall, the project by aiming to strengthen PHC as the first point of entry to the health system, ensuring services are provided close to communities and by involving nurses has also created the foundations for meeting the needs of vulnerable populations. Answers to the SDC questions that were part of the Terms of Reference are include in Appendix 18.

5. Recommendations

In looking at HAP and its implementation in Albania it is important to separate the technical aspects important for PHC and those that are relative to the overall Albanian context. From a technical perspective HAP proposes a comprehensive multi-component project, that is well

thought out, planned, and implemented, as well as being aligned with priorities for Albania. The main challenge is with regards to the sustainability and scalability of the project and how this can be done given the weakness of the MoHSP and Operator. The recommendations below are presented as elements that could be included in the current phase of the project and others that might be part of possible future support of the Swiss government to Primary Health Care in Albania. Recommendations for 9 out of the 14 levers are presented in Table 3. No recommendations for the following levers were found to be relevant either because they are beyond the scope of the project or are addressed appropriately: Funding and allocation of resources; Engagement with private sector providers; Purchasing and payment systems; Digital technologies for health; and Monitoring and evaluation.

Table 3 – Recommendations

Lever	Activities to be addressed in the current phase	Activities to be considered in possible future support of the Swiss government to Primary Health Care in Albania
Political commitment and leadership	Although the support to the Masters in Health Management should be halted the project should see how this course could be used to strengthen the Operator. In addition, the course should be used to develop CME courses on different areas of management that can be useful for healthcare workers, e.g. human resource management, budgeting, planning, etc. The project needs to see how to build stronger links with the Operator and devise a way to scale up the activities proposed in Section 4.2.1 and implement any new activities that might be part of a future phase of the project. **Stronger links should be built with the Operator and the HAP Project together with the Operator should develop a bilateral operational manual to be agreed and approved for working together in the next phase** The creation of the Agency for Quality Improvement and Assurance should be seen as an opportunity for HAP and from the very beginning HAP should work closely with the Agency regarding the accreditation process building off its experience by supporting the development of indicators as well as organisational support. **Another activity to consider is the organisation of a workshop on lessons from COVID-19 focusing on the**	

	positive aspects and lessons learnt from HAP and partners. This could include, the use of online consultations in Korce, the increased role of nurses and the importance of PHC during the pandemic.	
Governance and policy frameworks	**Given the difficulties with the development of the human resources strategy it is proposed to develop a human resource plan or needs assessment**. This could for example use a similar approach to a "Horizon scanning future health and care demand for workforce skills in England: Non communicable disease and future skills implications".[35] Also seeing as a new census will be carried out this strategy could also look at the planning of facilities based on new demographic reality of Albania.	
Engagement of communities and other stakeholders		**Community engagement and psychosocial support to vulnerable groups, as targeted by the Primary Health Centres, could be a potential area for development through involvement of the Civil Society Organisations**. In the previous phase of the HAP Project community engagement activities enabled engagement and accountability to communities. These activities were no longer present in this current phase, but should possibly be revived in a possible next phase. The HAP project should also investigate ways of increasing participation of populations in the HAP project • Role of local community in home-based care • Order of doctors and Order of nurses as civil society
Models of care	**Investigation of how to scale-up the home-based care model**, as well as see how this model could be interest to	Rethinking of the home-based care model and its adaptation to:

	UNFPA given their work with elderly populations, UNICEF and their focus on children, and WHO to learn more about the overall model. The appointment system might need further evaluation, as during this assessment there was mixed impressions about the relevance of this.	• Home based care in in larger urban areas versus rural areas – Is it relevant? How can it be adapted to an urban setting? • Does home-based care fill the gap in PHC services especially in rural areas versus having a health post? How could this be linked to the ongoing census? • Further thoughts about how home-based care can be used to reach different vulnerable populations with possibly different needs taking into account gender • Engagement of local authorities to define their roles, investigate possibilities of co-financing (as was done for rehabilitation work) and develop a closer link with social services. One missing component in the current phase of the project is that of health promotion. This was a core component of the project's previous phase and it is understood that some health promotion activities are now the responsibility of another SDC supported project. **However, as health promotion is a core component of PHC this should be included within this project with possible synergies with the Check-up programme as this model besides being free has had an impact on people accessing PHC beyond the early detection of NCDs and related risk factors**. Also, promotional activities could be developed for the vulnerable populations creating synergies with the "Shkollat per shendetin" project.
Primary health care workforce	**It is proposed that the ongoing support to both the Masters in Health Management and the Masters in**	**CME needs to be scaled up as well including all the protocols and training materials developed by HAP as well as PGs**.

	Family Nursing be phased out in this phase and not supported in a possible next phase. As the Agency for Quality Improvement and Assurance will also be responsible for CME. HAP has another opportunity to work closely with this Agency and build off its experience. Overall, any training delivered should ensure that practical components are included. In order to do this some trainers might need to be exposed to the reality of PHC or the Albanian health system. This could be done for example by having a field visit of teachers in Health Management Masters to one of the HAP pilot sites.	Clearly there is the need to increase offer of CME credits and within the HAP project there are some opportunities worth investigating: • Management training for healthcare workers – building off links from Masters in Health Management and also the Masters in Public Administration • Use of the Masters in Family Nursing to develop short courses or other continuing education for nurses • On the job training for health professionals in Family Medicine for doctors and nurses at ABC Clinic and Patos Health Centre • Communication and patient rights with Together for Life • On the job training for nurses and home care in Korce in collaboration with the Order of nurses • Find a way for the Order of nurses to use skill laboratory developed at Nursing Faculty for CME activities **There is also the need to strengthen role of Department of Family Medicine**. A significant element for reflexion in the Albanian context is the need to consider strengthening pre-graduate and postgraduate training for nurses and doctors. This issue for nurses is included in the Project document for Phase 2.[30]
Physical infrastructure		There is the overall need to scale up and transform PHC in Albania to meet the current needs of the population

		which might require further investments in physical infrastructure. This recommendation is detailed below.
Medicines and other health products	**One aspect that is needed is a costing of the different packages HAP has developed**. For example, how much does a nurse bag cost and their resupply, or an average home visit.	
Systems for improving the quality of care	For the accreditation process some more support is needed with regards to highlighting the importance of this process for facilities, dissemination of the materials HAP has developed as well as possibly addressing any weaknesses in the current process.	All the work HAP has done on nursing has clearly shown success and needs to be scaled up. This includes the training, competencies development, protocols, job profiles and nursing bags. For this as mentioned in Section 4.2.1 this will require the Operator to fully play its role. Beyond the Operator HAP should identify other partners, such as the Order of Nurses, to help with this process. **There is the overall need to scale up and transform PHC in Albania to meet the current needs of the population**. This recommendation is detailed below.
Primary health care-oriented research	**Another area to be phased is the operational research component. The research component needs to be rethought to make it more relevant to policy and practice**. For this the project should: foster research activities that are linked with the project activities; integrate research training and doing research as part of CME; link research activities with MoHSP operational research agenda; ensure nurses are also included in research training and research projects; and further develop a research agenda together with the MoHSP and other stakeholders taking into account the needs of PHC facilities and communities.	

All actors met mentioned the unique model in Patos which was created through the support of HAP. The question is how to replicate and scale up this model throughout Albania and ensure its sustainability. In order to do this the consultants, believe two elements need to be implemented within a possible next phase. The ambition of this will be dependent on capacity and budget for a possible next phase. The first element is how to translate the HAP "philosophy" and approach to the Operator. Although sustainability and scalability are issues in the current phase, one could argue that increasing the capacity of the Operator is one of the best ways to ensure sustainability and scalability of the work HAP is implementing. Secondly, there is the need to rethink the physical organisation of PHC in Albania based on changes in demography. Although this is included in the PHC Strategy to date no operational plan for this has been developed. This will be helped by the ongoing census. The redesign of the health facilities would take into account data from the census, catchment area/population, existing infrastructure and human resources, and geography and accessibility. The redesign would include both possible infrastructure investments as well as the "soft" components developed by HAP. This would also include a series of guiding principles, such as: continuous quality improvement with indicators to be monitored and evaluated; standards; continuity of care; multidisciplinary teams and approaches; outreach; geographical coverage and access to all with a specific attention to vulnerable groups. In implementing this new model different scenarios are possible as presented below and would need to be considered by the Ministry of Health. (Table 4)

Table 4 – Scenarios for implementation of transformational model of PHC in Albania

	Possible implementation options (non-exhaustive and just presented as an example)		
Role of HAP	**Current pilot Regions only**	**Additional Regions**	**X number of facilities in each Region**
HAP remains an independent project			
HAP supports national and regional Operator to implement project			
HAP integrated/seconded within Operator			
HAP becomes project arm of Operator			

This approach is included in the PHC Strategy with the following: "Remodelling the geographical distribution of PHC in order to provide more efficient care, while ensuring access to PHC services for all categories of the covered population and reorganizing HCs at different levels."[8] Should this option of "remodelling" not be feasible the approaches presented in Table 4 could apply for a national upscaling of HAP's nursing activities and/or taking a focus on more vulnerable populations and further developing the home based care model and adapting this to different contexts, including for example Tirana.

5.1. Management recommendations

Overall, HAP has done an excellent job. This was recognised by everyone. One element is that the HAP Project together with other stakeholders and/or the Steering Committee might want to explore the question on how to make HAP an engine for the future development of PHC in

Albania? This question should be answered with the perspective of a project versus the perspective of an organisation.

One aspect for HAP to explore and address is the issue of institutional sustainability versus individuals. For example, Patos is cited as an example, but this is possibly mainly driven by the individuals versus any systematic change. The challenge therefore for sustainability and scalability is how to address this. A few proposals to do this are:

- Document success, e.g. Patos
- Learn from other experiences Korce and Check-up Programme
- Develop governance policies at different levels to show roles and responsibilities
- Identify champions at different levels, including policy champions (e.g. Parliamentary commission on health) who can support HAP at a political level
- Promote a bottom-up approach of adoption of the models and approaches developed by HAP by health professionals and PHC to then influence the national level
- Engage civil society
- With support from SDC actively participate in different policy-related forum

The project has communicated well about its activities and visibility and knowledge is high. However, two elements of communication are necessary to include. Firstly, spaces for dialogue and knowledge sharing at different levels. Secondly, to communicate about any changes in the project between this phase and a possible next phase.

5.2. Management recommendations for SDC

As highlighted in Section 4.3.4 there are many synergies possible between HAP and other SDC supported projects. HAP also provides the SDC has a useful model project with regards to addressing the complexities of PHC as well as empowering nurses and the nursing profession. The utility of a donor platform remains an open question and the SDC may want to consult on this and if it proceeds take the unique lead on this without WHO. The upcoming visit by a Federal Councillor to Albania should be an opportunity to possibly put this on a high-level agenda as well as again highlight the Swiss contribution to health in Albania.

6. Conclusion

The professionalism and recognition of the work done by HAP is undeniable. The overall knowledge of what the project has done by many stakeholders attests to the efforts accomplished. The project team should be commended for their work in often difficult situations, during COVID-19 and in a complex political environment. The main success of this project has been the empowerment of nurses. This accomplishment requires ongoing support and collaboration with various stakeholders. Beyond this result the adoption of the PHC Strategy, the home-based care model and PGs are also notable successes. All elements of HAP have enabled PHC to be strengthened. The challenge for HAP now is how to scale-up these interventions and ensure their sustainability. One of the major barriers to progress is the weakness of the Operator.

In terms of impact on populations this still requires documentation. The project has a clear focus on vulnerable populations through home-based care and the strengthening of PHC, but Roma and Egyptian populations need to be better integrated in these approaches. As mentioned in the report the gender approach of the project also needs to be widened.

As the project starts to plan for its next phase the different lessons learnt, and pilots implemented need to be processed and assessed as to how they can be integrated into the next phase which should focus on scaling and sustaining progress to date. HAP will need to see how to build off its successes whilst adding components to its approach without forgetting overarching challenges within the system, such as the affordability of medicines or weaknesses in medical and nursing training at pre-graduate and postgraduate level.

The PHC strategy that HAP developed as part of the project lays the foundations for ongoing work in Albania. HAP now needs to see what activities it needs to scale up and further develop in parallel to defining its role as an organisation in strengthening the health system. To do this HAP will need to find ways of developing capacity and positively engaging with the MoHSP and Operator.

7. Appendices

Appendix 1 – Additional background to the overall project

Primary Health Care (PHC) is defined as a "whole-of-society approach to health that aims to ensure the highest possible level of health and well- being and their equitable distribution by focusing on people´s needs and preferences (as individuals, families, and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment."[1] From a conceptual perspective there are three overarching principles of PHC. These include meeting people's health needs through health promotion and prevention measures, as well as curative, rehabilitative and palliative care services. Beyond health PHC has a role in addressing the wider determinants of health as well as individual behaviours. Finally, PHC has a responsibility in empowering individuals, families, and communities for their own health as well as being partners in the development of health services and as care givers.[22]

Many studies have identified a range of challenges that exist in ensuring access and use of PHC services in general and specifically for Noncommunicable diseases (NCD). These include trust in PHC services, training of health professionals, lack of human resources, availability of medicines and laboratory equipment, referral pathways, and lack of education and support for prevention and treatment for the population.[36-44]

The Astana Declaration celebrating the 40 years since the Alma-Ata Declaration on PHC has refocused attention on this key component of improving health worldwide.[45] Although not formally mentioned in the Sustainable Development Goals (SDG) many argue that PHC is an integral part of achieving the health-related SDG as well as wider impacts such as poverty, gender, inequalities, etc.[40]

Given the current health system context in Albania as well as the main burden of morbidity and mortality being caused by NCDs strengthening of PHC is a necessity for the Albanian health system in order to meet the needs of its population. The World Health Organization (WHO) within its Global Action Plan for NCDs focuses its attention on five risk factors, tobacco use, unhealthy diets, lack of physical activity, harmful use of alcohol and air pollution and five diseases cardiovascular diseases, diabetes, cancers, chronic respiratory diseases, and mental health. One of the overarching objectives of WHO's action plan is: "to strengthen and orient health systems to address the prevention and control of NCDs and the underlying social determinants through people-centred primary health care and universal health coverage."[46]

The Swiss Agency for Development and Cooperation (SDC) has mandated the Swiss Tropical and Public Health Institute (Swiss TPH) through the Health for All Centre (HAC) based in Tirana to implement the second phase of the Health for All Project (HAP). As the project is nearing the end of its current phase there is a need to evaluate the Project's accomplishments to date, identify and analyse bottlenecks and challenges with regards to project relevancy in the changing country context, its operational efficiency and propose specific recommendations to address these challenges for its ongoing implementation.

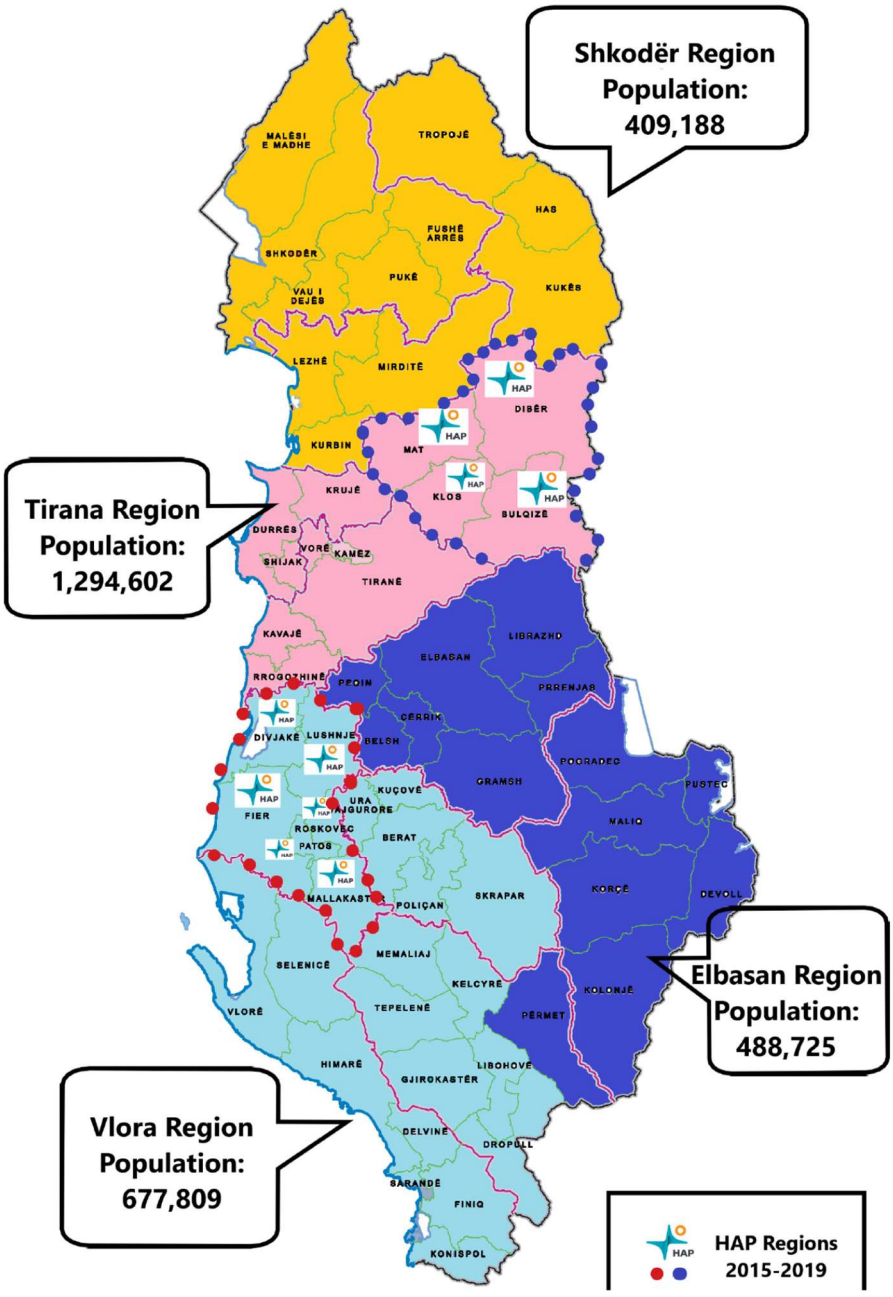
The objectives of this report are to present the assessment: of the Project's achievements to date against defined expected outcomes; the project's performance and the implementation

process in terms of approach, strategic orientation, project set up, implementation modality and capacities; the relevance, effectiveness and efficiency of PHC interventions; and to provide strategic orientation for the adjustment of priorities and objectives for possible next phase.

Country context

Albania is located in the Balkans (Figure 1) with a population of 2.9 million with total population decreasing by 0.6% from January 2020 to January 2021.[2] The median age of the Albanian population was 37.6 years in 2021 with an increase in the dependency ratio for older populations (ratio of people above 65 years of age compared to the population aged 15-64 years) from 21.6 % to 22.3 % between January 2020 to January 2021 showing an ageing of the population (See age pyramid included as Appendix 2).

Figure 1 – Map of Albania and Regions where the project is working

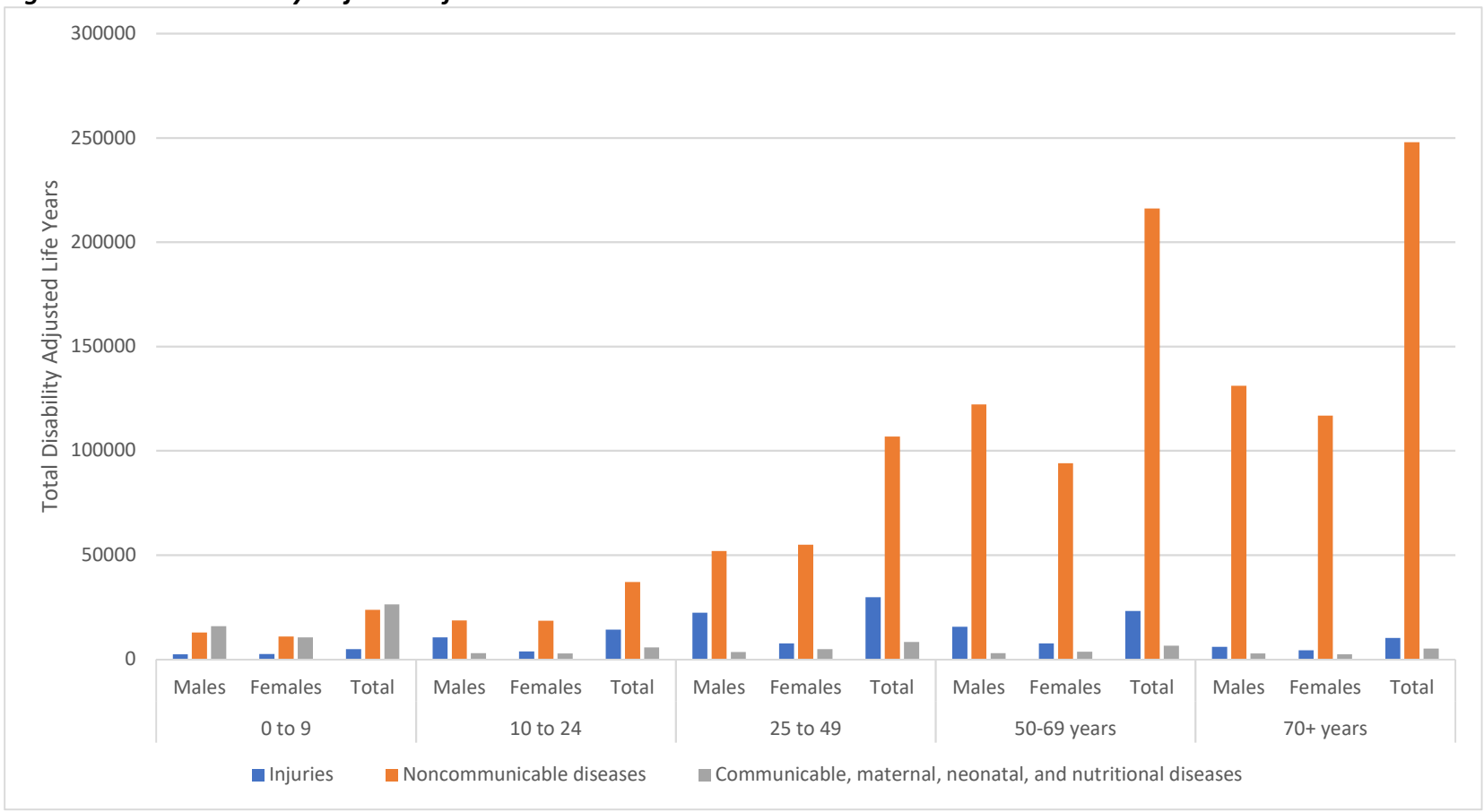


Albania is divided into 12 counties (Qark-singular, Qarqe-plural) and 61 municipalities (Bashki). (Figure 1) The capital Tirana is the country's most populated city (representing 32.2% of the total population of Albania) and the main economic centre. Albania has seen dramatic economic development from one of the poorest countries in Europe in the 1990s to an upper-middle-income country, with an estimated Gross Domestic Product per capita (at current US$) of US$ 5,246.[47] Beyond economic development Albania has also had extensive political and social changes.[3] One of the priorities of the Albanian government is the European Union (EU) integration process meaning that all sectors, including health, are all undergoing substantial reforms.[12]

Health Status of the Albanian Population

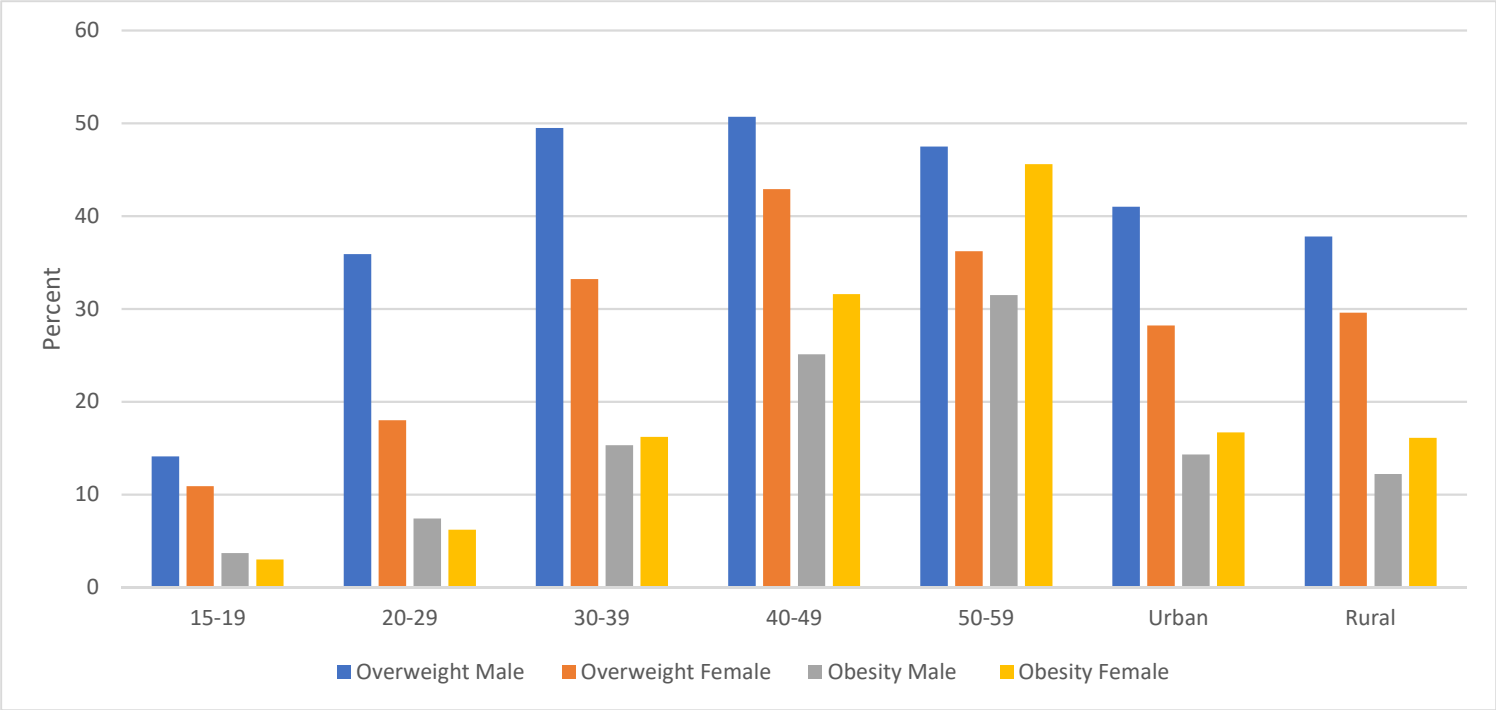
Albania has seen an increase in the life-expectancy, with current life-expectancy for males and females being 77 years and 80 years respectively.[3] As in other countries this might have decreased in 2020 and 2021 due to the COVID-19 pandemic. Differences between female and male life-expectancy are explained by higher rates of smoking and alcohol use, as well as road traffic accidents. Data from the Global Burden of Disease shows that most deaths in Albania are due to NCDs in the elderly populations.[4] (Appendix 3) Looking at Disability Adjusted Life Years (DALY: measures the overall burden of disease combing premature mortality and years lived with disability) in all ages, except 0-9, NCDs are the leading cause of morbidity and mortality.[4] (Figure 2) The top risk factors for poor health in Albania are high blood pressure, tobacco use and unhealthy diets.

Figure 2 – Total Disability Adjusted Life Years in Albania[4]



Overweight and obesity are a problem in Albania, even in children.[3] In Albania undernutrition in children still exists in some settings in the country, with underweight in children also being a future risk factor for the development of NCDs in adulthood. In the Albania Demographic and Health Survey 2017-2018[3] it can be seen that overweight is more prevalent in men in all ages, in contrast to obesity in ages 30 and above being more prevalent in women. (Figure 3) Overweight and obesity in Albania is both an urban and rural issue. Factors linked to this are for example the consumption of sugar sweetened beverages and juices was found to be more common in younger ages and decreasing with increasing age. Twice as many men than women (10% versus 5%) consume unhealthy amounts of animal fats. Only 5% of women and 2% of men aged 15-49 consumed the recommended number of portions of fruit and vegetables in the day preceding the survey. Physical activity rates were found to be low in men and women with only 10% frequently being active.

Figure 3 – Distribution of overweight and obesity in Albania[3]



Other risk factors for NCDs include tobacco use with 5% of women and 36% of men age 15-49 smoking cigarettes.[3] Cigarette smoking is most prevalent in the 30-34 age group in both men and women (men: 44%; women: 7%). Smoking in Albania is an urban phenomenon with 38% versus 32% and 7% versus 2% of men in urban and rural areas and women in urban and rural areas smoking respectively. For men smoking rates decrease with increasing education level.

Alcohol consumption in 15-49 year olds is more than double in men versus women, 60% versus 28%. Between 2008-2009 and 2018-2019 alcohol consumption (consuming alcohol 1 to 3 days per month or less) increased in both women and men. For women alcohol consumption was more prevalent in urban areas and increased with increasing education levels.

As shown in Appendix 3 and Figure 2 NCDs represent the highest burden of morbidity and mortality. In 2020 the Institute of Statistics found that cardiovascular diseases accounted for more than half of overall mortality in Albania.[48] From the Albania Demographic and Health Survey 2017-2018[3] the large burden of NCDs in Albania can be seen as well as low awareness of people knowing if they have an NCD or not. (Table 5) Data from 2018 from a national screening programme for hypertension found that the prevalence of hypertension was 37.2%, but only 52.1% of the individuals were aware of their hypertensive status and of this only a quarter of people diagnosed as having hypertension were taking the appropriate treatment and had their blood pressure under control.[49] Other studies in Albania found similar gaps between awareness, treatment and control of hypertension.[50-52] These gaps must also be present for diabetes with an estimated 95,400 people with diabetes in Albania (11.5% prevalence) in adults aged 20-79 years of age.[53]

Table 5 – NCD data from Albania Demographic and Health Survey 2017-2018[3]

	Male	Female
Hypertension as measured at the time of the Demographic Health Survey (15-49 years)	38%	24%
Previously diagnosed hypertension (15-49 years)	20%	25%
Self-reported NCDs (15-49 years)	20%	17%
Self-reported chronic disabilities (15-49 years)	2%	3%
Recent experience of depression (15-59 years)	18%	13%
Diagnosed depression (15-59 years)	4%	2%

In 2020 it was estimated that there were 7,037 new cases of cancer and 3,978 total deaths in Albania.[54] Estimates for cancer in Albania show that the three leading cancers with regards to new cases in 2020 for both sexes are lung (15.7%), breast (13.3%) and prostate (11.3%). For men lung, prostate, and stomach are the leading cancers with breast (32.9%), uterine (6.9%) and lung (6.5%) the leading cancers in women. More data on the burden of cancer in Albania can be found in Table 6. It is important to note that people with cancer in Albania are often diagnosed with advanced stages of the disease.[55]

Table 6 – Top 10 cancers (new cases and deaths) for Albania[54]

Type of Cancer	New cases		Deaths	
	Rank	Percentage of total	Rank	Percentage of total
Lung	1	15.7%	1	24.3%
Breast	2	13.3	5	6.5%
Prostate	3	11.3	3	8.5%
Stomach	4	6.7%	2	9.7%
Bladder	5	5.4%	7	4.5%
Pancreas	6	3.9%	4	6.5%
Brain, central nervous system	7	3.2%	6	4.6%
Leukaemia	8	3.1%	9	3.7%
Colon	9	3.0%	10	3.3%
Kidney	10	3.0%		
Liver			8	3.9%

For Chronic Respiratory Diseases a cross-sectional study in Albania found that prevalence of Chronic Obstructive Pulmonary Disease (COPD) was on average 12.4% and was higher in men (17.4%) than in women (7.7%).[56] The main drivers were smoking as well as an ageing population.

Mental health is an increasing problem in Albania.[19] These problems affect low income families the most. Beyond the health-related challenges mental health is still very stigmatised in Albania as well as seeing an increase in mental health issues due to COVID-19.

Different studies have also shown high rates of complications for different NCDs highlighting the need for better prevention and care.[57]

The Albanian Health System

The Right to health is enshrined in the Albanian Constitution[5] and healthcare is mainly delivered by the public sector and Albanian law guarantees equal access to health care for all citizens.[3] An overview of the Albanian Health System is included in Appendix 4 . The Ministry of Public Health and Social Protection (MoHSP) is responsible for policy and normative work. This is complemented by the Health Care Services Operator ("Operator") established in July 2018 with a Central Directorate and 4 regional directorates (Tirana, Shkoder, Vlore, Elbasan) responsible for the actual operation of the health system (human resources, infrastructure, equipment, operation of the health system, etc.) and the Health Insurance Fund (HIF) responsible for health financing. The HIF was established in 1995 and is financed through payroll taxes and general taxation.[5]

The HIF covers only about two thirds of the population, with uninsured populations able to access free emergency care (since 2013), a free basic health check-up once a year (since 2015) and free visits at PHC (since 2017).[5] All other services, medicines, diagnostic tests, and non-emergency specialist care require out of pocket (OOP) payments by individuals. For those covered by the HIF, employees and other economically active persons who pay contributions to the tax authority, the package includes visits to PHC, outpatient and inpatient specialist

services with referrals. Outpatient prescriptions and some diagnostic tests require a co-payment. For economically inactive parts of the population (children aged under 18 years; students under 25 years; pensioners (65 years for men and 60 years for women); people registered to receive social assistance or disability benefits; registered unemployed people; asylum seekers and a few other categories set out in special laws) the government transfers funds to the HIF. Local governments also have a role with regards to the upkeep of health facilities in their jurisdictions.

Included in the Albanian National Health Strategy 2016–2020 (ANHS) was a focus on the financial protection of the Albanian population.[12] This included possible lifting of fees for the uninsured and the financing of healthcare through general taxation. The Albania Demographic and Health Survey 2017-2018 found positive trends with regards to different services being provided to the population. For example different antenatal care services showed an increase between 2008-2009 and 2017-2018.[3]

One of the main challenges faced by the Albanian population is high OOP expenditure on medicines.[5,12] OOP expenses impacted 12.5% of Albanian households in 2015 with this impacting households which are poor, elderly and have children.[5] In 2016 OOP accounted for more than half of health expenditure.[5]

A cross-sectional survey to investigate health service utilisation by adults aged 18-59 in Albania found that the vast majority of people with an NCD sought care in the public sector with the elderly most likely to use PHC compared to those aged between 18-59 years more likely to seek care in hospitals.[58] In the ANHS specific programmes addressing NCDs were included, with for example the National Check-up programme for people aged 35–70 years and breast cancer screening program.[12] The Check-up programme was initiated in 2015 for people aged 40–65 years, with this being extended to people from 35–70 years in 2016.[12] This is provided at PHC with the aim of this programme is to detect certain NCDs. It is an example of a public-private partnership with the private partner responsible for logistics, equipment, maintenance, IT support and laboratory testing.

The Albanian National Health Strategy 2021-2030 has as its overarching theme of "A stronger and more accessible health care system" and includes the following areas of focus:[19]

- Increasing healthy life expectancy of the Albanian population
- Modernising infrastructure and improving safety and quality of hospitals
- Improving medicine quality and safety aligned with EU standards
- Enhancing transparency and accountability to improve the public's confidence in the health system

Overall the strategy included five policy goals:[19]

1. Investing in the population health through life course approach
2. Progress towards universal health coverage
3. Strengthened citizen-centred and integrated health system
4. Strengthened emergency response and services
5. Digital health

The new Health strategy aims to include mechanisms for engagement of a variety of stakeholders in the policy and planning process with a focus on equity and inclusion of vulnerable groups.

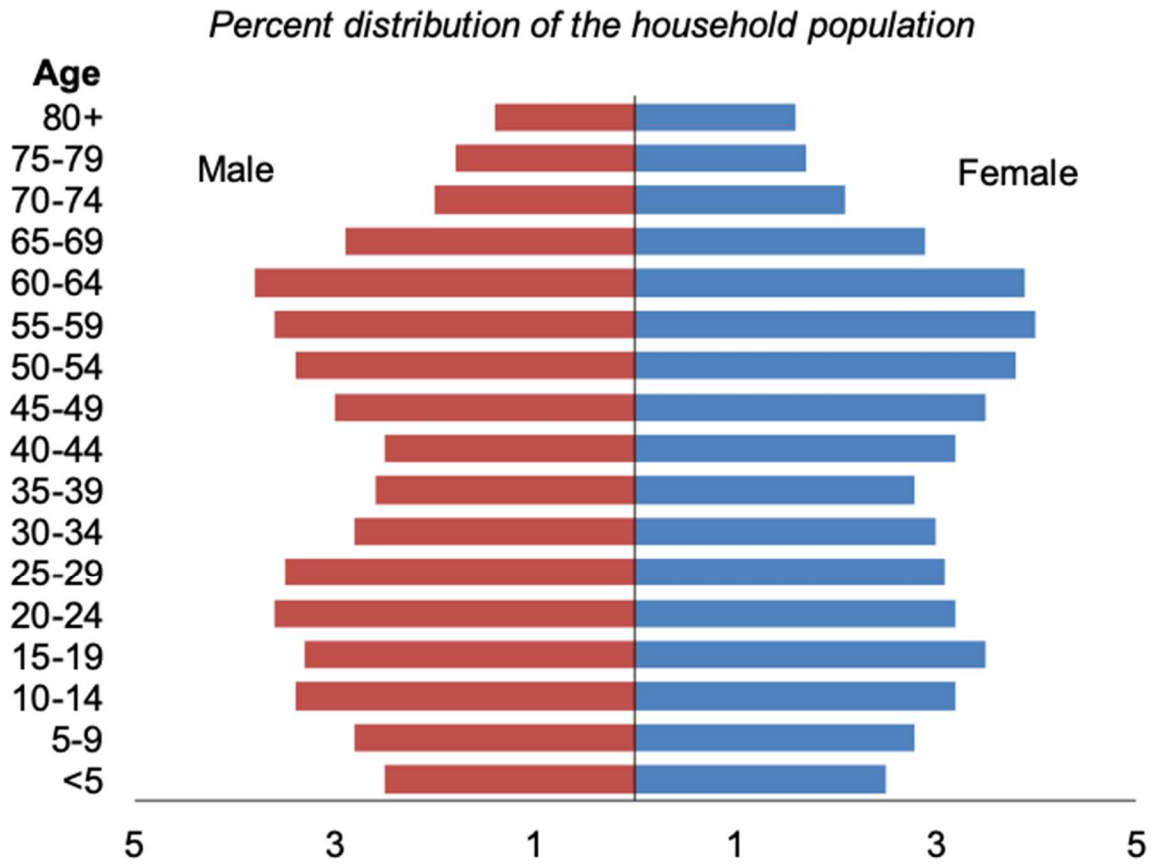
Primary Health Care in Albania

PHC in Albania is organized through a network of public providers of health services, through primary health centres in urban areas, and primary health centres and their satellites (ambulances) in rural areas, dispersed across all 61 municipalities. In 2021 a total of 412 health centres had a contract with the HIF.[6] In theory PHC offers services for 8,000 to 20,000 people with variations between urban and rural areas.[7] The ratios of doctors to population is 1 to 2,500 and 1 to 400 population for nurses. In Albania 1,538 general practitioners and 6,864 nurses and laboratory technicians work at PHC level.[8] Since 2018 all recruitment of health personnel is done through the two Electronic Portals (Portali Infermiere per Shqiperine dhe Portali Mjeke per Shqiperine). Primary health centres used to be under the direct supervision of the MoHSP, with regard to human resources recruitment and investments in infrastructure, but in 2018 these responsibilities were shifted to the newly created structure of the Operator.

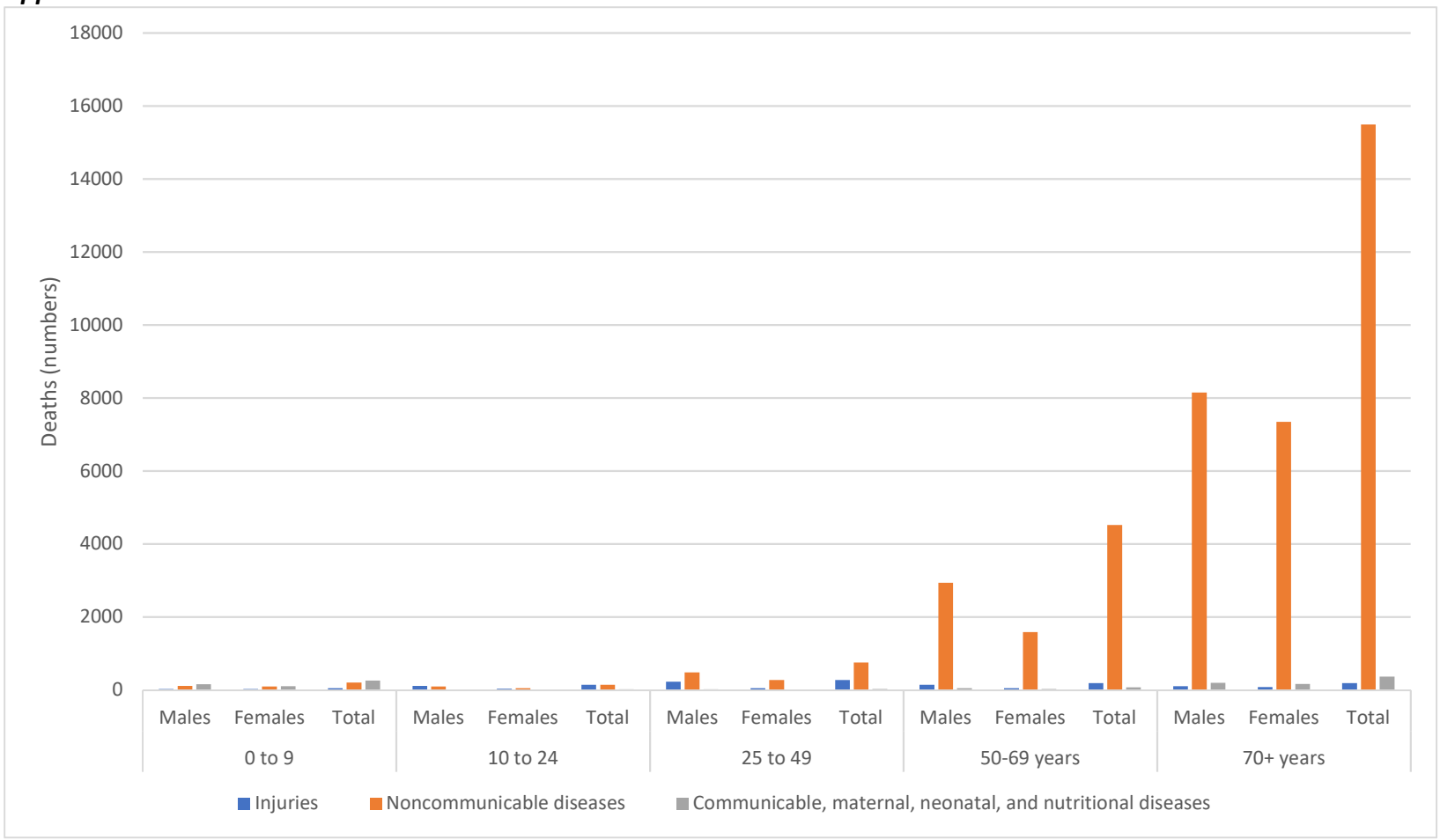
In Albania primary health centres are contracted to provide a variety of services to the population including health promotion and education.[5] However, most government expenditure is allocated to hospitals.[19] At PHC there is a lack of even basic equipment, even thermometers, sight tables, etc. for both doctors and nurses.[12] On average doctors at PHCs carry out 11.3 visits per day. PHC in Albania has traditionally been organized to meet the mother and child health challenges, but must now adapt to the specific needs associated with increasing the NCD burden. One measure taken to address this was the development, as mentioned previously of the Check-Up programme.

The Albanian government in 2020 approved a new strategy for PHC from 2020-2025.[8] Within this approval the government mandated the MoHSP and its associated institutions and local government organisations to implement this strategy. Demographic changes in Albania have not been translated into territorial reorganisation of PHC and the PHC strategy calls for "A territorial redistribution of health centres is needed and, in order to create models of a new comprehensive and integrated family medicine and social support services, in areas with greater needs and sufficient capacities." A study in 2015 looking at perceptions of PHC providers found a variety of weaknesses within PHC services including: close to 70% of respondents stating their work environment was average or bad; close to 60% stating a lack of adequate equipment; 48% highlighting a lack of access to scientific information; and 67% stating a lack of autonomy.[13] In parallel to this HIF expenditure for hospital services represented 52% of the overall budget in 2019 and PHC services only 18%.[14] The other areas of spending included medicines and medical equipment 26%, Administrative costs 2% and investments 1%.

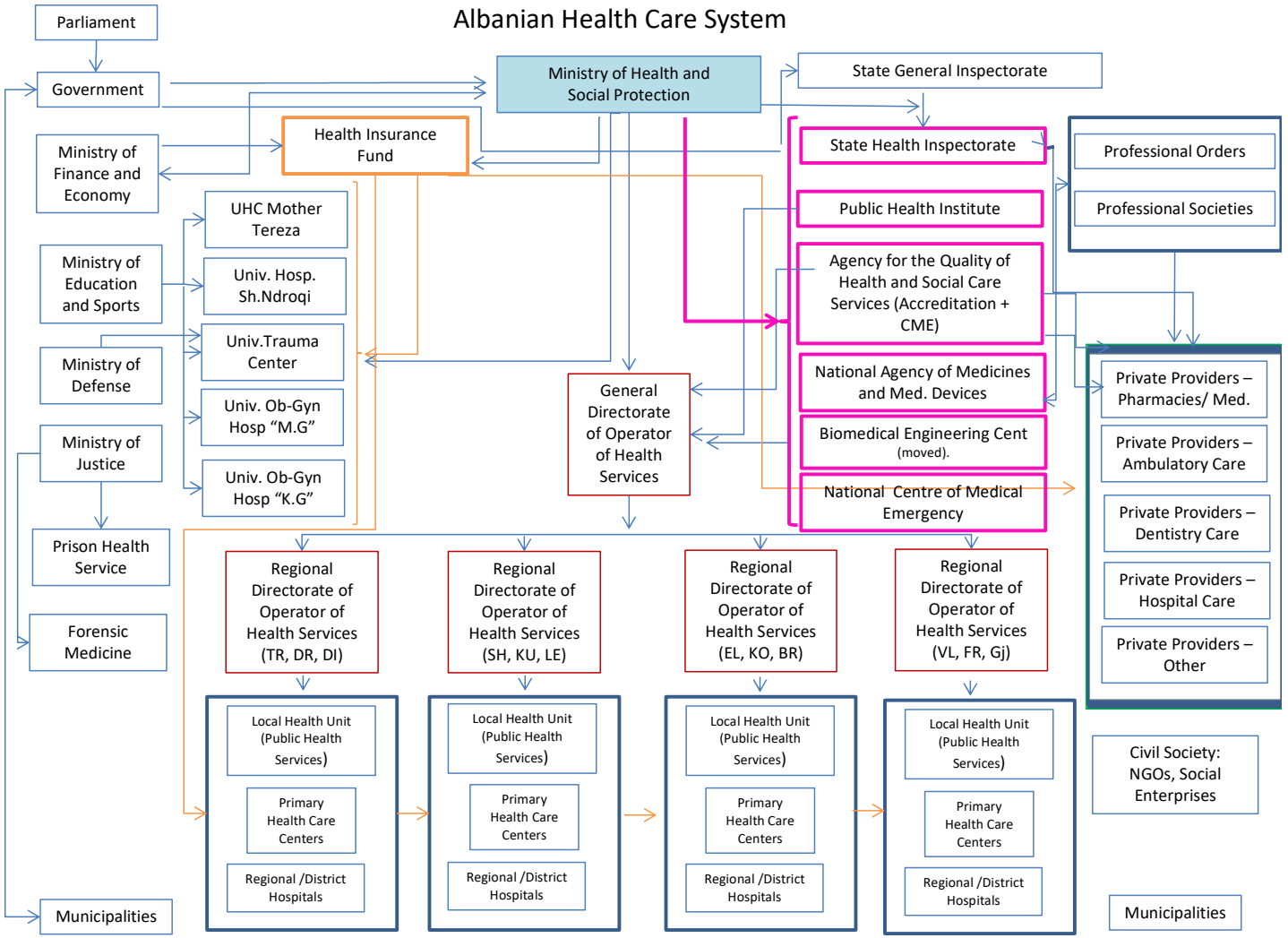
Appendix 2 – Population pyramid[3]



Appendix 3 – Total deaths in Albania[4]



Appendix 4 – Organisation of the Albanian Public Health Care System



Appendix 5 – Project outcomes

The current phase of the project has as its goal: "The Albanian population benefits from better health thanks to improved primary health care service."[59] This phase has the following expected outcomes:

The MoHSP and its regional entities manage more effectively and efficiently primary health care service

Citizens in target regions have access and use effectively primary health care services of better quality

Under these two outcomes the following outputs are included within the project:[59]

The elaboration of PHC and human resources for health policies and strategies in Albania is assisted based on inclusive approaches associating the educational sector and civil society

Updated job profiles of PHC personnel with the purpose of task shifting between physicians and nurses are outlined and tested

New Master's Program for Family Nurses is established

The Master program in Health Management is consolidated jointly with the Faculty of Medicine, Faculty of Economy and the Swiss partners

Capacities of regional directorates of health service Operator and/or public health directorates are enhanced in support of the local public health functions.

Operational research capacities on health system and services in Albania are strengthened

Quality of PHC service delivery is improved through the accreditation procedures and the promotion on use of clinical protocols as well as e- and digital health solution at PHC level

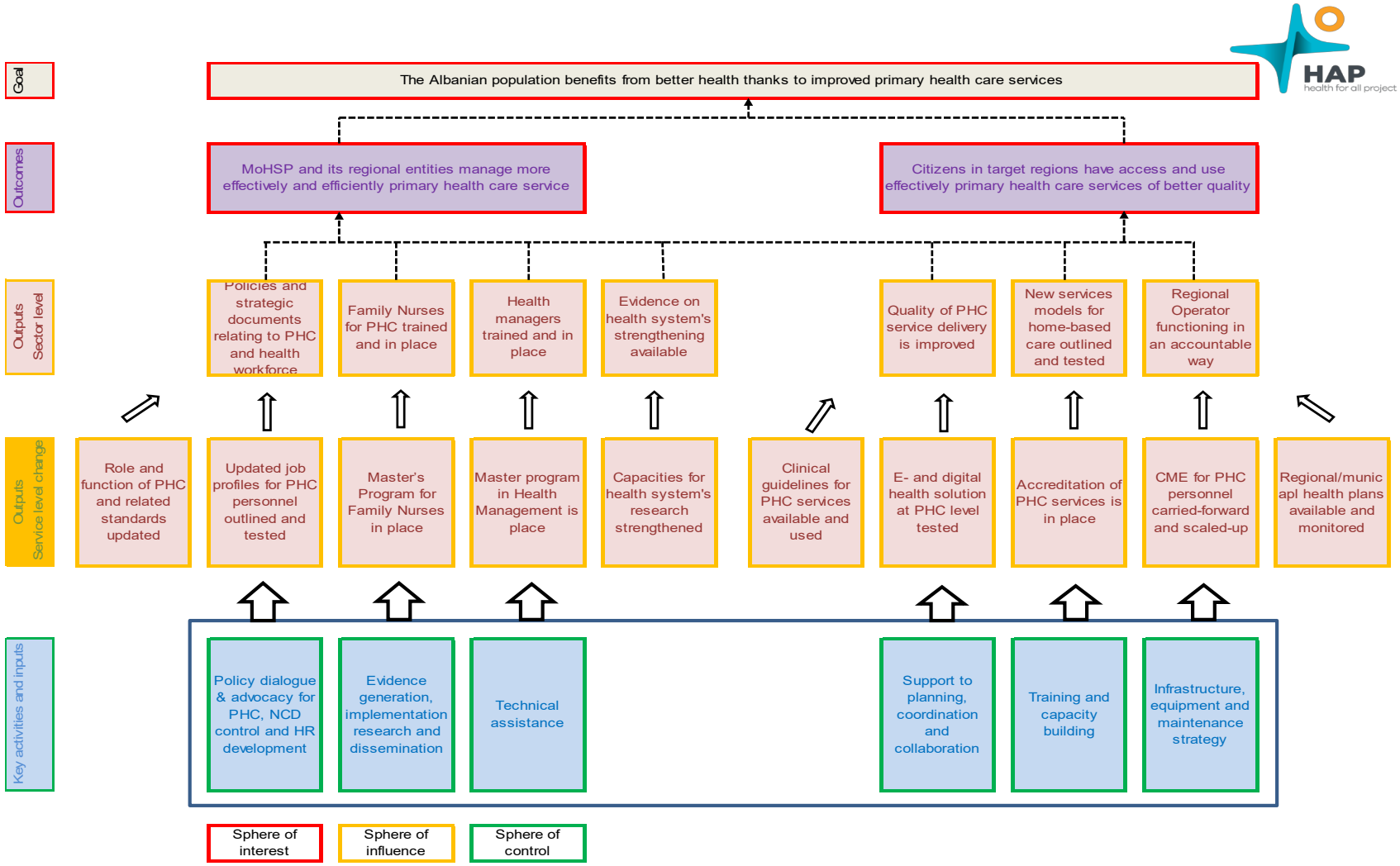
New services models for home-based care are outlined and tested and related to specialized services (partially overlapping with output 3)

Continuing Medical Education (CME) of PHC personnel is carried-forward and scaled-up and recertification of health managers is embedded in national processes and standards

Collaboration across relevant local stakeholders is fostered for health service development and public health action

The Project Theory of Changes is included as Appendix 6. In the project documents it is stated that the project takes a health system strengthening approach by, "various players in the health system are supported in a first instance on the supply side (PHC providers health managers both at local, regional and national level) but also to some extend on the demand side (current and potential users of PHC services)."[30]

Appendix 6 – Project Theory of Change



Appendix 7 – SDC Terms of Reference for evaluation

Annex

Terms of references

Contract no. (B Mandate)
External evaluation Health for All (HAP) Phase II

I. Context

Albania is facing a demographic ageing due to emigration of young adults, fertility decline, as well as increased life expectancy. The last decades have been associated with a steep increased bur-den of non-communicable diseases (NCDs). NCDs are estimated to account for 93% of deaths in Albania. From a health system perspective, insufficient considerations are given to the demographic change and the raising NCDs burden. Main challenges range from issues of health service financing, resource mobilization, health service management, as well as challenges regarding steering and governance of the sector. The country has a health system which is relatively wide-ranging but not efficient enough. Both the earthquake of 2019 and COVID 19 pandemic showed the vulnerability and fragility of the health system. Unfortunately the poor emergency preparedness and response of the system contributed to a further decrease of the heath care access and trust from citizens. Both shocks showed as well the weak donors coordination in the health sector.

Regardless of COVID 19, quality of care suffers as there are no rules on implementation of evidence based clinical guidelines and limited trainings conducted. Regarding the financing of the health sector, public spending on health remains constant at 2.9% of GDP and continues to be dominated by hospital expenditures, amounting to 53% of expenditures (much higher than the OECD average of below 40 percent). To address COVID 19 health crisis, GoA adopted in 2020 two financial packages increasing public expenditures on health from 2.9% to 3.4% of GDP. The health system still depends more on out of pocket payments currently at 58% creating financial barriers for citizen to access health care. In view of health personnel, the role of nurses in dealing with NCDs is ill defined. Nursing education on PHC is weak without any special training on family medicine. These patterns are further aggravated by migration of health professionals, from rural to urban areas as well as from Albania to Western Europe, leading to inadequate health service coverage and regional inequities in the health workforce distribution. The COVID crisis made more visible some weaknesses in the health system as, for example, the lack of specialist (e.g. epidemiologist, reanimation specialist) as well as the severe shortage and unequal distributions of physician and public health professionals in the country including specialists and family doctors. This situation also contributed to the very centralized management of the COVID crisis in Tirana.

A health governance reform started in 2018 with the establishment of a National Health Service Operator and its four regional branches aiming to decentralize the functions of the management of health services. However despite this reform, a vertical and centralized management of the health system as well as limited impact on the quality of service delivery and the health coverage of the population are observed. This centralization was made even more visible during both shocks - earthquake and COVID 19 pandemic. Besides, the governance reform didn't improve the already very fragmented health information system in the country which is a very important base for any design, monitoring and evaluation of national policies. .

Overall the health system needs strengthening of management, planning and steering capacities at national, regional and local level for improved planning and oversight in order to move towards a more efficient service. Albania endorsed the National Health Strategy (ANHS) 2016-2020 in the year 2017, aligning its commitments to "WHO European framework policy for health and wellbeing Health 2020" as well as on the UN 2030 SDG agenda, in particular SDG 3. The ANHS 2016 – 2020 encompasses 22 action plans and strategies. In addition, in 2020 Albania approved a primary health care strategy 2021-25 for the first time. However, the monitoring of the implementation of all these actions plans and strategies are missing. Despite this lack of systematic implementation of the actions plans, the Ministry of Health and Social Protection (MoHSP) made effective vertical investments (e.g reconstruction of hospitals and PHC centers, breast cancer programmes, etc.). A good example of a vertical intervention of the MoHSP is the national preventive check-up of programme, targeting the population aged from 35 to 70 years old (approx. 1.2 mio people) implemented since 2015, in order to increase the population's use of PHC and to improve the early detection of NCDs and associated risks. In 2019 about 39% of the population between 35 and 70 years old benefitted from the program. As a result, there is an increase of 4% of PHC utilization by citizens. Another good example is the MoHSP's engagement in the rehabilitation program of 300 Health Centers. Today 180 PHC have already been rehabilitated. Under the lead of MoHSP and coordination of WHO, supported by SDC and the WB, an assessment of AHNS 2016-2020 took place during the period January - June 2020. The assessment was not officially endorsed by the GoA. The main findings and key recommendations of the assessment are

presented in Annex 1. Since January 2021, the Ministry of Health and Social Protection (MoHSP) supported by WHO is preparing the new health strategy 2021-2030.

II. Swiss Cooperation in Albania and support to health sector

Switzerland is the main bilateral development parnter in the health sector in Albania. Since 1993, Swiss support has been oriented toward capacity building of nurses, doctors and to develop health managers, culminating in the establishment of the national continuing medical education system in the country. Throughout these years Switzerland has supported health authorities to improve quality and utilization of primary health care services in the target regions. A home based care model is developed. This model was a solution to provide health services for elderly especially during COVID 19 pandemic. With the support of Switzerland Albania has for the first time a primary health care strategy 2021-25. The strategy addresses deficiencies related to the quality and management of PHC services, human resource development including the expansion of the role of nurses to provide comprehensive care for families and communities, adequate forms of service delivery to increase access and continuity of care for the most vulnerables and standardization of clinical practice to ensure coordinated care.

Health sector will continue to be a priority area of engagement for Swiss support during 2022 – 2025. The focus will continue to be strengthening of primary health care for better coverage (including emergency care) especially for the most vulnerables (roma, elderly, poor) and improved health literacy for better health status and trust of population in a resilient health system.

Currently Switzerand support in health consists of two projects: a) HAP: addressing the health system strengthening (supply side) and b) Shkollat per Shendetin: increasing health literacy of population and creation of a healthy conducive envirionment (demand side). A 3rd project to support health preparedness and emergency in currently in preparation.

In its new country programme (2022 – 2025), Switzerland will engage more in climate change and partnerships with the private sector. Looking for opportunities in the health sector in relation with these 2 topics will also be important.

Health for All project

Health for all project started on 1 Janaury 2015 and is currently at its second phase (1 April 2019 - 31 March 2023) with a total budget of CHF 16`500`000. The overall goal of HAP 2 is:
Goal: The Albanian population benefits from better health thanks to improved primary health care service.
The expected outcomes of this phase are:
1. MoHSP and its regional entities manage more effectively and efficiently primary health care service.
2. Citizens in target regions have access and use effectively primary health care services of better quality.

The project is being implemented by Swiss Tropical and Public Health Institute (SwissTPH).

HAP has followed a health system strengthening approach - working with the system actors. Under outcome 1 support is focused primarily at the national level. The project has adviced the process of development and adoption of PHC strategy and is putting efforts in a human resources for health strategy and also other related policies/guidelines led by MoHSP and other national health actors. Health management capacities are being addressed through cooperation with academic health institutions to consolidate of master of health management established during first phase and a new master in Family Nursing is being supported and expected to start in 2021.
Under outcome 2 support is provided mostly at the regional and local level, the project facilitated the development of a strategic health development plan of the health service operator including regional ones. A Co-funding mechanisms - minimum 30% contribution - with municipalities is being supported and implemented. Key streamlines of activities planned in PHC strategy, are being piloted by the project in selected areas and lessons learned will inform scale up plans nationwide by country health structures. The introduction of innovative interventions developed by the project have started the municipalities where it has heavily invested during Phase 1 and that have demonstrated a good potential for success. Overall intervention at local level being currently implemented include use of clinical guidelines, new role of nurses, CME – peer review group, new models of service delivery like home based care.

Please refer to annex 3 for a summary of main achievements during phase 1 and lessons learned.

The signed project agreement defines the roles and responsibilities of Swiss embassy and MoHSP as well as the functions of the Steering Committee as the governing body of the project. Gender and governance are integral part of the intervention as transversal themes.

III. Objective and Scope of the External Evaluation

The external evaluation is foreseen in the Credit Proposal, to take place by mid of the second phase. The Embassy in Tirana mandates a team of consultants to perform an External Evaluation with a strong focus on the results achievement as well as risks and opportunities focus. As Switzerland will continue supporting PHC in the next country programme, forward looking recommendations will also be included. The evaluation is guided by the core principles derived from the OECD DAC, ALNAP and SEVAL quality standards for evaluations *(please check SDC evaluation policy for details).*

The main objectives of the external evaluation are to:

- Assess the project based on the Organisation for Economic Co-operation and Development (OECD) evaluation criteria (relevance, effectiveness, efficiency, coherence, impact, sustainability);
- Analysis of the results achieved so far and the efficiency of the Swiss investment.
- Assess the relevance of the modalities of the Swiss support the health sector and assess the risks (political, institutional, fiduciary, force majeure etc.)
- Assess relevance of the project in the current context providing a forward looking prospective;
- Learn with a view to improving the quality and results of Swiss interventions in health by gathering knowledge about what works, and why

Through this mandate, the Embassy of Switzerland is looking for responses to the following guiding questions[1]:

1. Scope of the Evaluation

The external evaluation is expected to:

1) Assess the **Relevance** of intervention - the extent to which is suited to the national health priorities and as well as of SDC.
    a. How much the project is relevant to the needs of the health system in Albania?
    b. To what extend has the MoHSP managed to address its challenges with the support of the project?
    c. Is the project aligned with current or forthcoming needs and priorities of the country ?
    d. Has the evolution of the context in the country been adequately taken into consideration during the Project implementation?
    e. How did earthquake and COVID 19 affect the relevance of the project ?
2) To which extent the design of HAP is **adequate** to achieve the goal and objectives (definition of the target groups; choice of approach and operational elements; articulation of components; choice of partners; consistency with SDC policy and experience)?
3) Assess the **Effectiveness** of intervention: a measure of the extent to which HAP achieves its objectives.
    a. To what extent were the objectives (outcomes) achieved or are likely to be achieved?
    b. To what extent the project is effective in delivering the results?
    c. What are the expected and unexpected effects of the programme or trends, including the effects on the beneficiaries (both at the system level and at population level)
4) Assess the **Efficiency** of intervention: the results – qualitative and quantitative – in relation to the inputs.
    a. What is current assessment of the cost-benefits of the intervention?
    b. Are there more cost-effective ways for achieving the same results?
    c. Has the intervention led to tangible institutional change (being at central or local level)?
5) Assess **coherence**: level of compatibility of the intervention with other interventions in the country, in particular with other multilateral and bilateral supports as well as national programmes and interventions
6) Assess the **Sustainability** of intervention: measuring at what extend the results and benefits of the project are likely to be sustained after the completion of the project.
    a. How is the project ensuring its interventions are sustainable?

[1] With a specific emphasis on the assessment of sustainability aspect. Please note that the contracting agency does not expect answers to all these questions, but they are rather meant to guide the mandate.

b. Is the project introducing models together with national and local actors, setting a solid basis for a scaling up by the health system? Is the domestic financing of the processes supported by the project ensured?

7) Assess the level of **ownership** from the MoHSP to create an enabling environment for the interventions introduced and supported by the project.
8) What are **the key lessons learned (including challenges faced)** of the current Project phase and what are their implications for next steps?
9) How did the project adapt to the challenges of COVID 19 and earthquake? Have innovations been introduced ?
10) What are the key results/elements of the project which should be a priority for Swiss support to PHC in the future? What are the main innovations with potential?
11) How did the project work with the private sector? Are they any opportunity for the future?
12) Are they any opportunities for the project to contribute to climate change mitigation?
13) How did the project contribute to gender equality?
14) Assessment of how the implementing partners have used the Risk Assessment and Mitigation strategies throughout the implementation (Annex of project document).

IV. Evaluation Approach and Methods

The evaluation will make use of data to be collected from project reports, meetings with partners and involved actors, briefings and debriefing with Swiss Embassy.

More specifically the assessment will comprise the following:

- Desk study of relevant documents (project documents, project reports, communication, country strategies milestones, other development partner's assessments and reviews of the health sector, etc.)
- Briefing with the Embassy of Switzerland in Tirana;
- Exchange and interview with HAP team members in Tirana and HAP project director in Basel
- Interviews with the stakeholders: Ministry of Health, Department of public health, Faculty of Nurses, Health service operator, target municipalities in Diber and Fier Region, National Center for Continuing Medical education, PHC nurses and doctors, Swiss Foundation for Innovation/ERA
- Interviews with WHO and WB.
- Debriefing with the Embassy of Switzerland in Tirana (discussing key conclusions and recommendations).
- Preparation of the draft external evaluation report.
- Final external evaluation report.

The above list of activities is not exhaustive and the consultant may engage in other activities deemed important for accomplishing this mandate. A proposal on the methodology from the consultants can be agreed upon with Swiss Embassy after the mandate is awarded.

V. Organization of the Evaluation

An international consultant will be responsible for the preparation and organization of the evaluation process and preparation of the draft and final report.

A local consultant will be engaged to support the international consultant by providing relevant context-related information and documents. Logistics will be facilitated by HAP.

VI. Evaluation Timetable

Activity	Dates*	Workdays	
		International Consultant	Local Resource Person
Preparation			

• Desk evaluation and preparation for the interviews; • Briefing with the Swiss Embassy in Albania on the evaluation		5	5
Field Mission (if possible) in Albania			
• Submitting list of interviews to the Swiss Embassy • Field visits and interviews (if circumstances don't allow for physical meetings, the interviews will be conducted online)		10	10
Reporting			
• Preparing draft evaluation report		7	7
• Finalizing the report based on Swiss embassy comments		4	4
TOTAL		**26**	**26**

VII. Requirements of the Evaluation Deliverables

The evaluation report shall be written in English and not be longer than 15 pages (excluding annexes); it shall comprise the following sections:

1) Table of content
2) Acronyms and abbreviations
3) Executive summary of one page;
4) Background of the evaluation and applied methodology
5) Findings
6) Recommendations
7) Conclusions
8) Annexes
    a. Assessment Grid for the DAC Criteria (mandatory annex of the evaluation report). See annex 3
    b. Others

The Embassy of Switzerland in Albania reserves the right to request changes in the structure of deliverables or the inclusion of additional information. Nevertheless, the international consultant has the full ownership of the report; s/he is free to express her/his independent assessment of the project and its performance.

A first draft report shall be delivered not later than 30 November 2021.

The final evaluation report reflecting comments of Embassy shall be submitted on 15 December 2021.

VIII. Required expertise and qualifications of the External Consultant

- Advanced university degree (Master's Degree or equivalent or above) in public health.
- Consolidated experience and record on external evaluations of development projects in the health sector as well as designing approaches of support.
- Experience in health sector in Eastern Europe and Western Balkans countries could be an advantage but is not a requirement.
- Experience with SDC project evaluations in health is preferable
- The candidate must have proven abilities to prepare reports in a clear and concise manner.
- Excellent command of English (written and oral)

IX. Required profile of the Local Resource Person

- Sound understanding of the health sector of Albania
- Previous experience of participation in donor reviews or related activities
- Very good command of written/spoken English

X. Contract and logistics

The external consultant and local resource person will sign a contract with the Swiss Embassy in Albania. Logistics for the contracted services will be led by the local expert and supported by HAP, for the field mission in the country (if the COVID context allows any field mission).

Annex 1: Findings and recommendations from the assessment of National Health Strategy

The main findings of the external assessment are:

- Overall priorities and goals of national health strategy seem sound and comprehensive providing sound platform for further health system strengthening and drive toward universal health coverage
- Monitoring and reporting of national health strategy suffers from
    - Several errors in indicator baselines and targets, source data collection not initiated for some indicators and there are observed various and sometimes conflicting sources for available data.
    - Annual and mid-term indicator reviews are not conducted and indicator data not are readily and freely available
    - Large number of targets are not achieved for indicators where source data are available
- Linkages to action-plans and specialized strategies remain largely unclear.
- Public spending on health as a share of GDP is low and remains at 2.9, while the target for 2020 was 4.5% of GDP
- The publicly financed benefits package is relatively comprehensive. While uninsured people tend to be informal workers, poor people, minorities (Roma people), and people living in deprived areas (rural and peri-urban areas). Uninsured people are entitled to publicly financed emergency care, a free annual health check-up (since 2015) and free visits to general practitioners (since 2017). The basis for entitlement to health insurance benefits is payment of contributions. As a result, a significant share of the population does not have access to all publicly financed health services.
- Over time, higher share of people covered by the check-up program. However, coverage is below the target of 50% coverage in 2017 and 70%
- Financial protection is weak in Albania in comparison to many other European countries. The share of out-of-pocket spending (58%) in Albania's total health spending is high compared to other countries in the WHO European Region. If a high share—around 20%—of total health spending comes in the form of out-of-pocket payments, it is likely that financial hardship is present. 65% of OOP is spent on outpatient medicines with the highest burden on the poorest.
- Unmet need in health care and dental care are an issue. In 2018, 22% of population self-reports unmet needs in medical care while and 24% unmet need of dental care.

Some key recommendations are mentioned below:

- Continue and deepen the **shift toward a health system organized around PHC**, in complementarity with the other levels of the Health system, including finance mechanisms and priority, management of human resources, investment in infrastructure and the geographical coverage.
- Invest in the consolidation of **a health information system** as there is a huge gap of health-related data and statistics that cannot be replaced with impressions or perceptions. Build a set of dedicated electronic tools around a central electronic medical record to improve disease management and care coordination
- **Public spending** on health needs to increase to make progress towards universal health coverage.
- Increase MoHSP capacities for **policy development and implementation** in view of promoting sound policy making.
- Establish a **multi-stakeholder and multi-sectoral** steering committee with the whole of society and whole of government approach, to develop and monitor the implementation of the new health strategy currently in elaboration

Annex 2: Key results and lessons learned from the first phase – excerpt from end of phase report

- Quality and utilisation of services has been increased by: improving clinical skills of PHC providers; improving infrastructure and basic equipment (20% of centers covering 27% of population; health promotion activities (30% of population reached).
- Increased use and better access of population of PHC services (in Diber the rate of PHC visits/person/year was 1,6 in 2015 and 1,7 in 2017; in Fier, the same rate was 1.9 in 2015 and 2.2 in 2017). 93% of patients in target regions indicate to be satisfied with PHC services.
- Albanian Demographic and Health Survey 2018 provides reliable data for policy making
- New continuing medical education (Peer review groups) tools introduced and used (75% family physicians and 41% nurses in both regions)
- Professional Master in Health Management established (graduate 30 students each year)
- National health promotion action plan elaborated and being implemented

Lessons learnt

Narrowing the focus of the project: The mid-term review conducted in 2017 referred to a range of positive results. At the same time the external evaluation team observed HAP being made up by a broad range of activities ranging from health policy interventions at national and regional level up to community based interventions on improved health literacy among marginalised and vulnerable population groups and recommended a reduction in the range of activities. Consequently and so to further increase the effectiveness, HAP phase 2 is proposed to sharpen the scope of activities thereby focussing on supply side interventions (PHC strengthening, NCD control and health workforce development) for improving population access to PHC services. For example, health promotion activities at population level are being phased out by the end of phase 1, albeit good results with high coverage rates of the target populations have been produced by HAP in this area.

Need for stronger emphasis on health workforce development and NCD control: Within HAP phase 1, quality of PHC services could be improved. This has been going along an increased in the utilisation of PHC services in regions covered by the project. While in phase 1 no specific emphasis was given to NCD control, there is increasing evidence (e.g. ageing of the population, changing patterns of the burden of disease) that stronger emphasis has to be given to NCD control and nurse development within PHC settings. Indeed a range of diseases such as diabetes or hypertension can be dealt with in an important way through PHC services thereby nurses have an essential role to play. This shall become the main focus of phase 2.

Investments in continuing medical education (CME) / professional development systems have been highly successful and need to be carried forward and further developed: Given the achievements in introducing jointly with NCCE new forms of low cost but effective CME approaches for improved quality of care, namely peer-review groups for doctors and nurses, they need continued attention thereby scaling them up across Albania and coupling them to new tools such as e-health and clinical guidelines.

Infrastructural investments for PHC: Over phase 1 there has been a high demand from MoHSP for rehabilitation and construction of PHC. Since Albania is an upper middle income country, efforts in the second phase will be put to increase capacities of municipality as the entity in charge for maintenance of PHC facilities. Consequently, future infrastructural investments for PHC services have first and foremost to be made through the governmental and local budgets thereby giving increased emphasis to adequate and good maintenance practices. This is anticipated to result in a strong sense of ownership and pride of the local administration. Since the new term of the Government in 2018, a big investment in rehabiliting PHC facilities has started. This is an achievement the Swiss Embassies policy dialogue to reiterate the importance and need of PHC in Albania.

Annex 3 – Assessment Grid

Tool 7: Assessment Grid for the DAC Criteria

Assessment Grid for project/programme evaluations of the SDC interventions
Version: 30.06.2020

Note: this assessment grid is used for evaluations of SDC financed projects and programmes (hereinafter jointly referred to as an 'intervention'). It is based on the OECD Development Assistance Committee evaluation criteria.[2] In mid-term evaluations, the assessment requires analysing the likelihood of achieving impact and sustainability. All applicable sub-criteria should be scored and a short explanation should be provided.

Please add the corresponding number (0-4) representing your rating of the sub-criteria in the column 'score':
0 = not assessed
1 = highly satisfactory
2 = satisfactory
3 = unsatisfactory
4 = highly unsatisfactory

Key aspects based on DAC Criteria	Score (put only integers: 0, 1, 2, 3 or 4)	Justification (please provide a short explanation for your score or why a criterion was not assessed)
Relevance **Note**: the assessment here captures the relevance of objectives and design *at the time of evaluation*. In the evaluation report, both relevance at the design stage as well as relevance at the time of evaluation should be discussed.		
1. The extent to which the objectives of the intervention respond to the needs and priorities of the target group.		Click here to enter text.
2. The extent to which the objectives of the intervention respond to the needs and priorities of indirectly affected stakeholders (not included in target group, e.g. government, civil society, etc.) in the country of the intervention.		Click here to enter text.
3. The extent to which core design elements of the intervention (such as the theory of change, structure of the project components, choice of services and intervention partners) adequately reflect the needs and priorities of the target group.		Click here to enter text.
Coherence		
4. Internal coherence: the extent to which the intervention is compatible with other interventions of Swiss development cooperation in the same country and thematic field (consistency, complementarity and synergies).		Click here to enter text.
5. External coherence: the extent to which the intervention is compatible with interventions of other actors in the country and thematic field (complementarity and synergies).		Click here to enter text.
Effectiveness		
6. The extent to which approaches/strategies during implementation are adequate to achieve the intended results.		Click here to enter text.
7. The extent to which the intervention achieved or is expected to achieve its intended objectives (outputs and outcomes).		Click here to enter text.
8. The extent to which the intervention achieved or is expected to achieve its intended results related to transversal themes.		Click here to enter text.
Efficiency		
9. The extent to which the intervention delivers the results (outputs, outcomes) cost-effectively.		Click here to enter text.
10. The extent to which the intervention delivers the results (outputs, outcome) in a timely manner (within the intended timeframe or reasonably adjusted timeframe).		Click here to enter text.
11. The extent to which management, monitoring and steering mechanisms support efficient implementation.		Click here to enter text.
Impact		
12. The extent to which the intervention generated or is expected to generate 'higher-level effects' as defined in the design document of the intervention. **Note**: when assessing this criterion, the primary focus is the intended 'higher-level effects'. In the event that *significant* unintended negative or positive effects can be discerned, they must be specified in the justification column, especially if they influence the score.		Click here to enter text.
Sustainability		
13. The extent to which partners are capable and motivated (technical capacity, ownership) to continue activities contributing to achieving the outcomes.		Click here to enter text.
14. The extent to which partners have the financial resources to continue activities contributing to achieving the outcomes.		Click here to enter text.
15. The extent to which contextual factors (e.g. legislation, politics, economic situation, social demands) is conducive to continuing activities leading to outcomes.		Click here to enter text.

Additional information (if needed): Click here to enter text.
Title of the intervention: Click here to enter text.
Assessor(s): Click here to enter text.
Date: Click here to enter text.

[2] For information on the 2019 revisions of the evaluation framework see: Better Criteria for Better Evaluations. Revised Evaluation Criteria. Definitions and Principles for Use, OECD/DAC Network on Development Evaluation, 2019.

Appendix 8 – Details of Methods for the Review

The team for this evaluation comprised Klodian Rjepaj (KR), MD, PhD in Medicine, PhD Fellow, Manchester Metropolitan University, Faculty of Arts and Humanities, Department of Politics and Philosophy and David Beran (DB), MSc, PhD, Assistant Professor, University of Geneva and Geneva University Hospitals.

The initial step in this project was a review of all project documents sent to the team by the SDC. These documents helped to better understand the scope of the project, define additional necessary information needs (documents and interviews) and plan the visit to Albania. In parallel KR and DB carried out a review of published literature on the topic of PHC and other relevant issues in Albania to help complement the overall project information as well as to gain better insight into some issues relevant to assessing the context and approaches of this project.

Due to COVID-19 the first week of the assessment (24-28 January 2022) was carried out online. In person field visits to the two project regions were carried out as well as DB being in Albania for the week of 31 January 2022.

All meetings with key stakeholders had as their aim to gain a better overall understanding of the project landscape in terms of its implementation and barriers. Both KR and DB carried out the interviews, with only the visit to Fier being carried out by KR alone. KR sent introductory e-mails to all stakeholders to introduce the team of evaluators and the aim of the specific discussion and the overall project, and made it clear that the information provided is done so in a confidential manner. Detailed notes were taken by KR and DB with a debriefing session to compare notes, discuss main findings and plan following interviews or additional data needs done at the end of each day.

Appendix 9 – Programme for the evaluation - internal only

Appendix 10 – Assessment of progress

Outcome 1 has as its aim to improve service delivery for the general population through improved stewardship, management and planning. This had as its focus improving the health workforce as well as addressing management of the health system. Two strategies were part of this work. Firstly, the PHC Strategy 2020-2025 which has been developed and approved (May 2020) is seen by many as an excellent basis for the future development of PHC. Also included in this Outcome was a review of the National Strategy of Health 2016-2020 by WHO, the MoHSP, World Bank and HAP. This review was completed, but it is unclear how this contributed to the overall aims of the project. The Human Resources strategy has not even commenced its development as of the time of the assessment. Some activities have taken place such as the: elaboration of a tool for a situation assessment of human resources for health in Albania; establishment of a Working Group; supporting the process with two national experts; elaboration of a draft situation assessment of human resources for health and approval of the draft by MoHSP in January 2020. Since then, no further activities have been carried out. Although this was still seen as an important contribution the project could bring to Albania stakeholders at the MoHSP, Operator and HIF were unclear as to next steps to get this process moving. Clearly, a lack of interest has hampered this process and it is unclear what more the project can do to initiate this process and ensure its success.

One of the project's major successes has been the materials, training and empowerment of nurses. The impact of this can be seen at facility level as well as in discussions with organisations involved in nurse training or the Nurses Order. This view is possibly not fully adopted by the MoHSP, but awareness has been raised as to the importance of nurses in Albania especially in PHC. In terms of human resource development the main focus has been on defining roles through the development of profiles and training. Using this experience the aim was then to develop a plan for scaling up at a national level. The first step of this component was a detailed and comprehensive assessment of the role of nurses in 2019 within the health system. This assessment found: nurses perform a limited range of services in contrast to those outlined in the Basic Package of Services; home care is rarely delivered; lack of equipment impacts the role of nurses and the care they can deliver; unclear roles for nurses; lack of role of nurses in health education and promotion, prevention activities and chronic disease management; and underutilisation of nurses overall. To address this the project together with partners developed three nursing profiles: family nurse working with a family physician; community nurse operating in a health post; and profile of home care nurse. These documents were shared with local partners and validated by international experts. These were implemented in 8 pilot sites in total (Fier: Patos, Roskovec, Ballagat, Portez; Diber: Melan, Zerqan, Shupenze, Klos). In parallel to these profiles the project has also implemented initial training courses. This was done in a very comprehensive way with the development of teaching documents, guides for trainers, supportive supervision, and coaching. As of March 2021, 255 nurses were trained, including 99 nurses (Fier and Diber) through a Training of Trainers approach; 156 nurses (Fier and Diber) organized in 9 Peer Groups (PG) focused on new profiles. Three additional job profiles are under development: Health prevention/promotion nurse; School nurse; and Physical rehabilitation therapist in PHC. Although the health profiles were sent to the MoHSP in September 2020 they are still awaiting formal approval. Beyond this practical capacity building in the health system, the project has also assisted in the development of a Masters program in family nursing with a specific focus on NCDs and communities. The HAP Project has provided materials, including a simulation

laboratory to the Faculty of Nursing, training of nurse teachers as well as development of different materials. The programme was approved by the Ministry of Education in September 2021 with 14 students registered in December 2021 to start this programme. Development of capacity in Health Management was an innovation in this project and clearly fills a gap in the Albanian setting. The creation of a joint Master programme between the Faculty of Economics and Faculty of Medicine should be seen positively and provides a foundation for the future development of key competencies needed within the health system. Added to this programme has been an internship to increase practical knowledge for students. However, this has yet to bear any fruit in terms of improved management within the system. To date 75 students have graduated from this programme and an evaluation of this course found that this had a positive impact on the jobs of graduates. In parallel, the empowerment of doctors and nurses in facilities, as well as support given to facility managers (e.g. accountants) and the provision of different tools (planning schedules, assessment forms, appointments systems, etc.) has also improved management at a facility level, but more is needed at facility level. For both Masters programmes there have been issues with demand for these programmes.

Within this Outcome the project also aimed to support evidence-based planning and decision making. To achieve this the project invested in research training as well as the production of research. Many courses were organised, micro grants given to different researchers and different research outputs were produced. Where many stakeholders stated the gaps in research knowledge and capacity in Albania was a weakness, overall the research generated through the project was seen as disconnected with the aim of the project and not shared widely with project partners.

Support to the Operator was also part of Outcome 1. However, this did not yield the expected results. COVID-19 did impact this as did the overall weak capacity of the Operator. It should be noted that although in theory the Operator plays an important role in the day-to-day running of the health system in practice it does not have the capacity and/or power to do this.

As mentioned above the capacity development delivered by the project is clearly one of its major successes. Within Outcome 2 which focused on improving services delivery with a view of improving the quality of services and contributing to UHC the materials, training, provision of the "doctor and nurse bags", PGs as well as in some facilities the rebuilding or refurbishment had a cumulative effect in not only upskilling professionals, but also providing them the necessary tools to deliver services and be empowered. The improved facilities also had a positive impact by giving the staff the proper environment to work and delver care. This mix of "soft" tools (training) and "hard" interventions (refurbishment and bags) provides an interesting model and highlights the need to address both the knowledge and infrastructural gaps in a context like Albania. Protocols on management of NCDs were developed, including: diabetes; hypertension; asthma; dyslipidaemias; and chronic obstructive pulmonary disease. These include treatment protocols presented as algorithms; description of the roles of family medicine team members in the management of NCDs; remote consultation quick guide; indicators to monitor internally and externally implementation; and the respective training manual. Two additional protocols are under development: management of mental health disorders; and care for elderly patients in PHC. These materials were seen to be adapted to the Albanian context and useful tools for PHC, as well as address the main NCDs impacting Albania (See Section 1.2, Appendix 1 and Appendix 3). To date training on these materials has

been delivered through a 5-day training of trainers to 171 health professionals (72 family physicians and 99 nurses from 80 health facilities) and 115 PHC staff attended 9 PGs on these tools. These tools have yet to be integrated into the health system and receive approval from the necessary government agencies.

The project has also supported the accreditation process by providing technical support to different PHC facilities. A "Set of standard procedures and documents" was developed by HAP and 58 PHCs in Diber and Fier, (72.5%) have appointed a Quality Coordinator for the work on quality standards. Twenty-three PHCs have started the preparatory work for accreditation, with eight of these being "advanced in their" accreditation process and 3 already having submitted an application. Overall though the accreditation process was described as time consuming and over ambitious in the Albanian context. In addition, there were no real incentives in participating in this process.

In terms of new service delivery models, the development and implementation of the home-based care model should be commended in addressing a challenge within the Albanian context and meeting the needs of certain vulnerable populations. This model also enabled nurses to be more active and with the knowledge and physical tools the project provided to do a job they were doing before, but to be able to do this with more confidence and sense of professionalism. Nine pilot PHCs and 70 health posts have implemented this new model of home-based care with 268 people having benefited from these. Some facilities have also established an appointment system and commented on its benefit in terms of organisation and planning. Others stated that given the population make-up and distance between facility and the population served this was not a model applicable to their setting. This was mentioned mainly in Melan, where that landscape covered is mountainous and not very accessible. People living in remote villages might visit the doctor when they come for other business in the centre. These two models have yet to be institutionalised within the MoHSP or Operator.

CME is also an element that HAP has worked on. The main result of this has been PGs which all stakeholders saw as innovative and impactful. Materials, equipment and training were provided and PGs are recognised as part of continuous education. It is important to note that beyond the pilot regions PGs have also been implemented in other areas of Albania. To date close to 400 health professionals have participated in these activities. Overall, it was stated that options for continuous development were weak in Albania.

Part of the HAP Project also included the rebuilding or refurbishment of certain health facilities. The project established a co-financing mechanism in the pilot regions of Fier and Diber with 30% of the funding coming from municipalities and 70% from the HAP Project. Co-financing agreements were signed with 5 municipalities for partial or full rehabilitation of 12 health facilities: 4 health centres in Toshkez, Gjorice, Lis and Ruzhdie and 8 health posts in Mallunxe, Zenisht, Dushaj, Peladhi, Gjuras, Çerenec, Dukas and Suk. At present 5 municipalities are in the process of rehabilitation of 12 health facilities (4 HC and 8 health posts). In addition, post-earthquake reconstruction of 2 health facilities (Ishem and Borizane) has been completed with additional furniture and equipment also supplied. Procedures for the third facility (Ndroq) are blocked.

In response to COVID-19 the project also supported different health facilities with equipment, personal protective equipment, different educational leaflets, and materials as well as the CoronaCheck platform. The project also ensured that continuing education could move forward through the use of online tools and PGs as well as providing the CoronaCheck Albania platform.

Appendix 11 – Frameworks used in the evaluation

For PHC the different "levers" described by the WHO and UNICEF framework are presented for HAP in this report, namely:[1]

- Political commitment and leadership
- Governance and policy frameworks
- Funding and allocation of resources
- Engagement of communities and other stakeholders
- Models of care
- Primary health care workforce
- Physical infrastructure
- Medicines and other health products
- Engagement with private sector providers
- Purchasing and payment systems
- Digital technologies for health
- Systems for improving the quality of care
- Primary health care-oriented research
- Monitoring and evaluation

These 14 elements provide a structure to look at PHC issues in Albania and will be described form the project perspective. From the development perspective, the project was also assessed based on its relevance, efficiency, effectiveness, impact and sustainability. These elements were assessed as follows:

- Relevance – project is adapted to local needs and priorities as well as the SDC's goals
    - Is the project aligned with government priorities?
    - Is its design adapted to the local context and health system?
- Efficiency – use of resources (inputs) with regards to results (outputs)
    - As much as possible a Cost Benefit Analysis will be carried out
    - Results achieved to date
    - Cost effectiveness of approach and activities
- Effectiveness – meeting the outcomes established
    - Is the project achieving its stated goals, as well as having any unintended impact?
    - Areas of the project that are effective in the results they achieve
    - Results of the project at different levels and for different stakeholders
- Impact – as this is a mid-term review the impact will not be assessed, but rather if given current progress this can be achieved or not
    - Overall changes brought about by the project
    - Health system strengthening
    - Focus on specific areas of importance to the SDC:
        - Vulnerable populations
        - Good governance
        - Gender
- Sustainability – whether or not the activities supported by the SDC could continue once its support ends
    - Uptake of the project by local stakeholders
    - Sustainability issues included in project design

Appendix 12 – Priority policy areas from the Strategy on the Development of Primary Health Care Services in Albania 2020-2025[8]

Policy Goals	Specific Objectives
Institutional Strengthening for better PHC Governance	• Building the organizational capacities of the Ministry of Health and Social Protection and the Health Service Operator at the central, regional and local level regarding the strategic planning and performance monitoring of PHC. • Strengthening, improving and expanding the capacities of the Public Health institutions network • Strengthening the local government units' (LGUs) support role towards PHC
Human resources in the PHC system	• Supporting general practitioners in becoming family physicians • Improving basic education programs for PHC professionals • Improving the role of continuing education in order to support critical developments of PHC services provision • Expanding and redefining the role of nurses within the PHC professional teams • Creating a stimulating and motivating environment for professional and responsible teamwork in PHC
Health infrastructure and technology in PHC facilities	• Sustainably strengthening the construction infrastructure of HCs • Increasing access to diagnostic and treatment services at the PHC level as per a revised basic package
PHC Information System	• Establishing and implementing the PHC-focused Health Management Information System
Basic PHC Services for Universal Health Coverage	• Improving and adjusting the basic health care package in accordance to needs, while simultaneously increasing the clinical autonomy in PHC • Ensuring sustainable cooperation between individuals, families and communities and PHC facilities
Financing and Contracting for Universal Health Coverage	• Ensuring adequate and sustainable financing of PHC • Coordinating the service contracting with the improved quality/performance of PHC services • Strengthening financial protection for all residents in the Republic of Albania
Determining, piloting new types of services and geographical redistribution	• Adapting PHC services to the population needs based on the demographic, epidemiological and social analysis. • Organizing PHC service integrated with social care at local level • Supporting the vertical integration of PHC services • Improving PHC services by prioritizing vulnerable and high-risk groups • Remodeling the geographical distribution of PHC in order to provide more efficient care, while ensuring access to PHC services for all

Policy Goals	Specific Objectives
	categories of the covered population and reorganizing HCs at different levels
Continuous improvement of PHC service quality	• Providing quality PHC service (basic quality benchmarks and further quality improvement) • Supporting the accreditation procedures implementation in all HCs • Including patients and consumers in the quality improvement mechanisms
Management of PHC facilities	• Improving the management efficiency of PHC facilities

Appendix 13 – Priority policy areas from Albanian National Health Strategy 2021-2030[19]

Policy Goals	Specific Objectives
Investing in the population health through life course approach	• Promote healthy lifestyles and ensure enabling environments for healthy choices including building collaborations to facilitate the achievement of this objective • Promote, enable and contribute to "Healthy Living Citizen" in urban planning and healthy food production • Strengthen and expand screening and other programs and vaccination coverage • Tackle behavioural NCD risk factors through prevention and promotion activities taking into account behavioural and cultural insights • Further improve maternal, child and adolescent health as well as sexual and reproductive health • Strengthen climate resilient health system and response to antimicrobial resistance • Address regional and other variation in access and use of population health activities and support regional and local action for improved population health • Improve availability of mental health supportive programs as well as resources and capacities for early detection and interventions for mental health problems • Develop and implement national regular and routine monitoring of population health behaviour across regions and population groups
Progress towards universal health coverage	• Strengthen regional and international cooperation in order to enhance the response to global health issues • Strengthen further the public consultation mechanisms to increase population participation along with increased transparency accountability of public offices and service providers • Review, update and strengthen health sector governance mechanisms to take into account administrative, structural, organisational and procedural changes in health sector and in Albania in general • Strengthen and mobilise cross-sectoral approach for population health improvement both in rural and urban setting including health behaviour improvement, community care, long-term care and environmental health • Strengthen the health system to address population-specific health needs and barriers to equity across the life course • Strengthen national capacities for evidence collection, analysis and publication along with strengthening capacities for evidence use in policy development, and monitoring and evaluation • Review and further develop health care financing and payment mechanisms along with service package covered by public funds along with coverage policies • Strengthen planning and strategic purchasing mechanisms and capacities in health care financing

Policy Goals	Specific Objectives
	• Improved access to safe and quality assured medicines, vaccines, diagnostics and devices • Review and expand medication reimbursement policies and rules as well as distribution mechanisms • Scale up measures to address antimicrobial resistance • Develop National Health Accounts and publish the results annually
Strengthened citizen-centered and integrated health system	• Further strengthen primary health care as a first contact point for patients and coordinator of care process • Review and adjust specialised care provision network for increased efficiency, cost-effectiveness and overall performance • Strengthen quality of care management systems as well as discharge management, patient management, patient pathways and care coordination across levels of care and between care providers • Develop further community care, integrated long-term (including home and institutional nursing care, palliative care and hospice care) and rehabilitation services for increased availability to ensure equitable need for all that need this • Review and strengthen human resource policies and capacities for health • Develop further electronic health services with focus to support streamlining care services, empowering patients and strengthening evidence-supported health care service delivery • Continue development of single health system with integration and synergies among all public and private health care providers, including expansion and wide-spread use of electronic health records • Develop and implement national regular and routine monitoring of population satisfaction with health care services, their quality and access across regions and population groups • Collect and annually publish information on health care service use, quality of care, medication use and human resources along with related costs
Strengthened emergency response and services	• Strengthen policies, procedures and capacities to prevent epidemics, pandemics and emergencies • Ensure national and regional preparedness for coordinated response to health emergencies • Ensure policies, procedures, resources and capacities for rapid detection of and response to health emergencies in a coordinated manner • Strengthen areas of food-, bio- and chemical safety • Strengthen surveillance and national laboratory system • Invest in human resources in the area of emergency response and strengthen risk communication • Strengthen patient empowerment and digital literacy as well as trust and access to health care services using digital tools

Policy Goals	Specific Objectives
	• Ensure interoperability of e-health services through standardisation, collaboration and security measures • Develop new digital models of care and support integration of existing models of care and care processes • Improve user experience of digital health services as well as support to clinical decision-making for health care professionals • Strengthen health informatics for improved health and well-being • Foster innovation, investment and digital market in health care and health in general • Review and develop further governance of e-health

Appendix 14 – Reporting matrix

PHC related factors/Project related factors	Relevance	Efficiency	Effectiveness	Impact	Sustainability	Level of Challenge
Political commitment and leadership	Highly relevant	Much investment from the project	PHC strategy high return on investment; Human Resources for Health no return on investment	Guiding document now available as well as this activity contributing to overall perception of HAP project	Strategy approved by government	High, but success with PHC Strategy's approval now the challenge is with its implementation. High with Human Resources Strategy, but major barriers exist moving it forward.
Governance and policy frameworks	Highly relevant	Much effort from the project and a variety of activities needed to achieve this, including rehabilitation, home based care model, etc.	Some success overall, but lack of strengthening of Operator	Some impact and possibly variable dependent on different models implemented, i.e. just rehabilitated health facility versus pilot facility and no rehabilitation and pilot facility with rehabilitation	Very person dependent	High given the overall complexity of this and weakness of main actor responsible, Operator, for addressing this.

PHC related factors/Project related factors	Relevance	Efficiency	Effectiveness	Impact	Sustainability	Level of Challenge
Funding and allocation of resources	Highly relevant, but no real activities from project	No real activities from project	No real activities from project	No real activities from project	No real activities from project	High
Engagement of communities and other stakeholders	Relevant, but lacking from the project's activities	No real activities from project	No real activities from project	No real activities from project	No real activities from project	High for both national and local engagement
Models of care	Highly relevant and a success of the project	Much energy and resources allocated to this	Very effective	Positive impact on staff, especially nurses	Person dependent and dependent on HAP support	Medium to High although the feedback from interviews was that these activities would not be sustained beyond HAP. The check-up programme provides a model for how an innovative intervention can be integrated within the system
Primary health care workforce	Highly relevant and a success of the project,	Efficient, but large investment of resources for	Highly effective in increasing the role of nurses	Positive impact on staff, especially nurses	Person and environment dependent to	High especially given environment, low

PHC related factors/Project related factors	Relevance	Efficiency	Effectiveness	Impact	Sustainability	Level of Challenge
	especially the nursing component	different activities training; Masters programmes, equipment purchases, etc.	Masters programmes questionable, but can be seen as long-term investments	Masters programmes questionable, but can be seen as long-term investments	keep staff motivated and pursuing activities	salaries, poor working conditions, and migration
Physical infrastructure	Highly relevant given that infrastructure and low investment in facilities is a recognised problem in Albania	Questionable given some facilities were rehabilitated in areas where they may not have been best suited to serve the population. Also lack of training components in some of the rehabilitated facilities.	Short-term positive for population and staff as much improved environment. Long-term will require ongoing support	Short-term positive for population and staff as much improved environment. Involvement of local governments.	Questionable given lack of resources in the system for rehabilitation	High given the needs of existing facilities
Medicines and other health products	Highly relevant, but no real activities from project	No real activities from project	No real activities from project	No real activities from project	No real activities from project	High, extremely complex, and political issue
Engagement with private sector providers	Not relevant in a context like Albania for the	No real activities from project	No real activities from project	No real activities from project	No real activities from project	Medium, lessons to be learnt from check-up

PHC related factors/Project related factors	Relevance	Efficiency	Effectiveness	Impact	Sustainability	Level of Challenge
	majority of the population					programme model?
Purchasing and payment systems	Highly relevant, but no real activities from project	No real activities from project	No real activities from project	No real activities from project	No real activities from project	High, extremely complex and political issue
Digital technologies for health	Somewhat relevant	No real activities from project	No real activities from project	No real activities from project	No real activities from project	Medium as some tools exist as well as maturity of system and technological capacity to absorb new technologies
Systems for improving the quality of care	Highly relevant	All activities of the project have contributed to this	Some positive data, but more need to show improvements in quality	Yet to be fully achieved as all elements contributing to this element as presented in the project's Theory of Change (***Appendix 6***) are not fully operational	Person and environment dependent to keep staff motivated and pursuing activities	High as multiple components are need to ensure quality improvements
Primary health care-oriented research	Relevant	Low given type of research carried out	Low as unclear how results were used.	Low	Training would need to be sustained and	Medium to Low overall issue of research to policy

PHC related factors/Project related factors	Relevance	Efficiency	Effectiveness	Impact	Sustainability	Level of Challenge
		and level of resources invested	However, medium for the area of capacity development.		research mechanisms and funding established	and how research done is used.
Monitoring and evaluation	Highly Relevant	Project has its own mechanisms.	Works well for project's needs	Allows project to report, but not system	Not sustainable	High need to have M&E systems in place.

Appendix 15 – HAP Phase 2 project budget

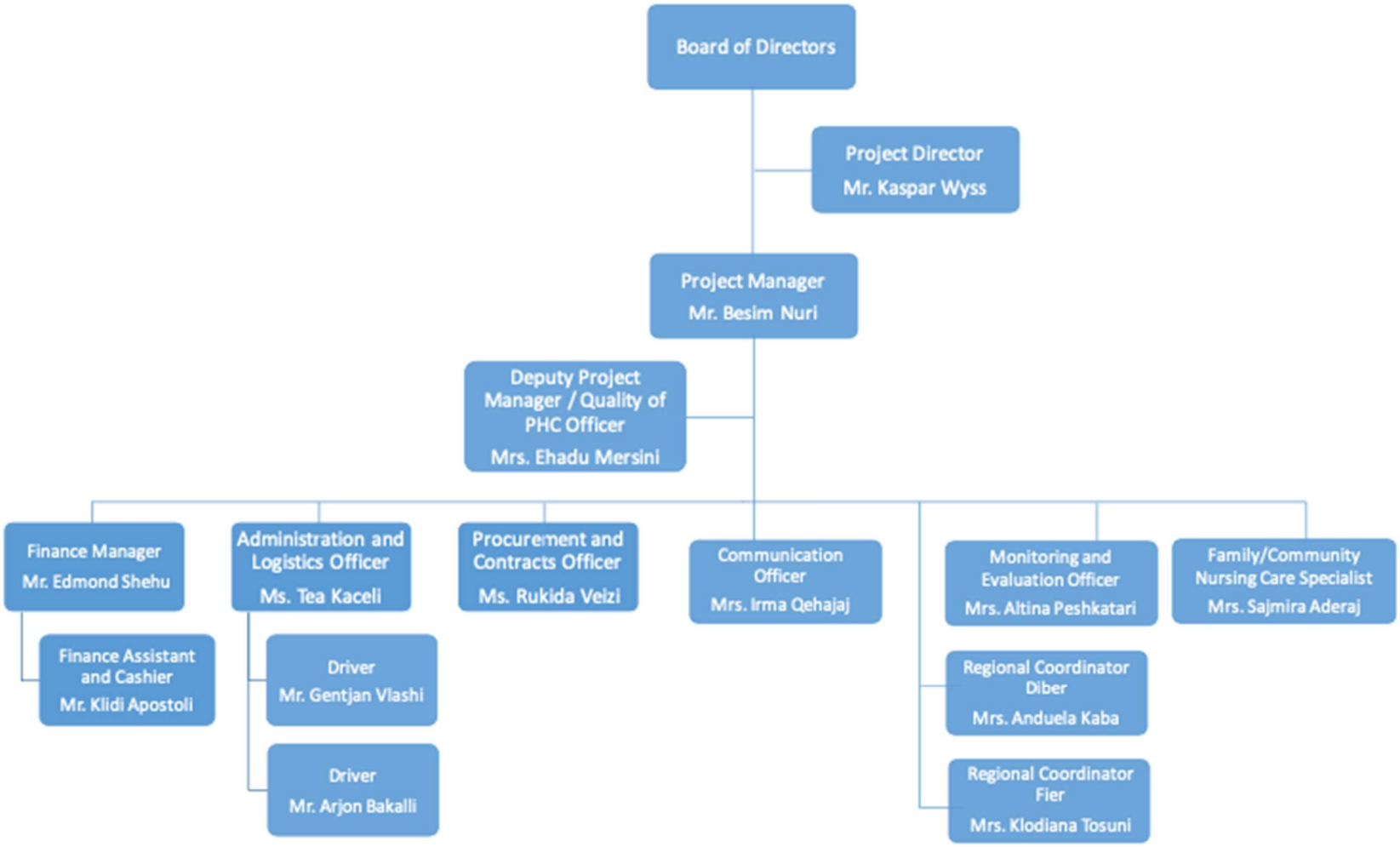
	CHF	Percentage of total
Services Headquarters [HQ]		
Fees HQ staff of Contractor	375460	
Reimbursable costs HQ staff	64650	
Subtotal	440110	6.8%
Local Office [LO] of Contractor	0	
Fees local office staff of contractor	0	
Reimbursable costs	0	
Subtotal	0	
Long-term experts		
Fees Professionals (expat and national)	1169520	
Travel expenses of resident expatriates and dependants	3200	
Expenses of foreign residence	60000	
Subtotal	1232720	19.1%
Short-term experts (Consultants)		
Fees international and national short-term experts	184360	
Reimbursable costs	26175	
Subtotal	210535	3.3%
Local support		
Remuneration of national support staff	407480	
Reimbursable costs		
Total Purchase of equipment for PIU	61000	
Total operating costs PIU	224000	
Subtotal	692480	10.7%
Administrated Project funds		
Outcome 1. MoHSP, regional entities and PHC providers improve ….		
Output 1	261500	
Output 2	221700	
Output 3	450000	
Output 4	150000	
Output 5	186000	
Output 6	338600	
Subtotal	1607800	24.9%
Outcome 2: Access of citizen's (incl. poor groups) to PHC, health promotion and accountability		
Output 7	373000	
Output 8	135000	
Output 9	166065	
Output 10	1172935	
Output 11	418500	
Sub-total outcome 2	2265500	
Subtotal administrated project funds	3873300	60.1%
Grand Total	**6449145**	

Appendix 16 – Cost analysis of different outputs

Output	Total cost as per budget (CHF)	Nunber of beneficiaries	Description of beneficiairies	Cost per beneficiary / output (CHF)
Elaboration of PHC and HRH policies and strategies in Albania	261500	2900000	All populaiton of Albania potentially benefits from an improved plicy environment	0.1
Updated job profiles of PHC personnel	221700	255	Nurses involved in different trainings in pilot sites	869.4
New Master's Program for Family Nurses is established	450000	14	New students registered	32142.9
The Master program in Health Management is consolidated	150000	75	Number students who have graduated	2000.0
Capacities of regional directorates of health service Operator and/or public health directorates are enhanced	186000	307487	Total population of Pilot Regions	0.6
Operational research capacities on health system and services in Albania are strengthened	338600	26	Number of research outputs (on HAP website)	13023.1
Quality of PHC service delivery is improved through the accreditation procedures and the promotion on use of clinical protocols	373000	307487	Total population of Pilot Regions	1.2
New services models for home-based care are outlined and tested and related to specialized services	135000	268	Number of people who have received home based care services	503.7
Continuing Medical Education (CME) of PHC personnel is carried-forward and scaled-up and recertification of health managers is embedded in national processes and standards	166065	400	Number of people who have benefitted from CME activities	415.2

Output	Total cost as per budget (CHF)	Nunber of beneficiaries	Description of beneficiairies	Cost per beneficiary / output (CHF)
Collaboration across relevant local stakeholders is fostered for health service development and public health action	1172935	600792	Population of locations where facilities have been rehabilitated (this is based on total population of municipalities as specific population data was not available. It should be noted that for example in Mallunxe where a facility was rehabilitated the total population is 481 inhabitants)	2.0

Appendix 17 – HAP organigramme



Appendix 18 – Answers to SDC questions

From the consultants the SDC asked to answer the following questions:

1. **Assess the Relevance of intervention - the extent to which is suited to the national health priorities and as well as of SDC.**

a. **How much the project is relevant to the needs of the health system in Albania?**

As can be seen in Table 2 this project is highly relevant and aligned both to SDC priorities and the needs of the Albanian health system.

b. **To what extent has the MoHSP managed to address its challenges with the support of the project?**

The project has answered many elements needed to improve PHC in Albania as described in Sections 4.2.1 to 4.2.14.

c. **Is the project aligned with current or forthcoming needs and priorities of the country?**

Very much so as described in Section 1.2, Appendix 1, Appendix 2 and Appendix 3 and the ageing of the population and increase in NCDs requires strong PHC, an active role of trained nurses, new models of care including home based care and an overarching policy framework. The only element missing would be to strengthen health promotion activities at PHC and increase the roles of nurses in this.

d. **Has the evolution of the context in the country been adequately taken into consideration during the Project implementation?**

Yes and no. Yes, as responded to in question b. above the project is tackling the main drivers of morbidity and mortality in Albania through strengthening PHC. However, given demographic changes and rural areas becoming less populated the project had an opportunity to rethink the delivery of services and where PHC facilities were located given the current population distribution.

e. **How did earthquake and COVID-19 affect the relevance of the project?**

Hard to say for the earthquake, but clearly rehabilitation was needed and also enabled the project to have an entry point with the health system. For COVID-19 this project increased its relevance as vulnerable people, elderly and people with NCDs were at higher risk of developing COVID-19 and having adverse outcomes as well as the need to have services as close to populations as possible.

2. **To which extent the design of HAP is adequate to achieve the goal and objectives (definition of the target groups; choice of approach and operational elements; articulation of components; choice of partners; consistency with SDC policy and experience)?**

The design of the project in all its elements is fully aligned with all these elements. One critique to be made would be the design of Phase 2 versus Phase 1 and the lack of explanation to partners about why some components were dropped, e.g. health promotion.

3. **Assess the Effectiveness of intervention: a measure of the extent to which HAP achieves its objectives.**

a. **To what extent were the objectives (outcomes) achieved or are likely to be achieved?**

See Table 1 with most outcomes showing substantial progress.

b. To what extent the project is effective in delivering the results?

The project is highly effective. See Table 1 and Sections 4.1 and 4.2.

c. What are the expected and unexpected effects of the programme or trends, including the effects on the beneficiaries (both at the system level and at population level)

The expected benefits are linked to all the tangible components the project has delivered, such as improved infrastructure, access to tools, training, etc. These have all shown benefits to professionals. However, as presented in the Theory of Change (Appendix 6) this has not translated into data that shows at this stage an impact on the population. Overall though the main unexpected effect of the project has been the empowerment of nurses and raising their profile.

4. Assess the Efficiency of intervention: the results – qualitative and quantitative – in relation to the inputs.

a. What is current assessment of the cost-benefits of the intervention?

This is hard to assess as to date no measurable benefits are presented. This will be done as part of the project. See Section 4.3.3 and Appendix 16 for the views of the consultants on this.

b. Are there more cost-effective ways for achieving the same results?

It is hard to answer this question as is this the cost-effectiveness of a given approach, e.g., home based care or the overall project. For the approaches the project has developed there are countless ways of addressing a specific element and some might be cost-effective, but the question would be how adapted they are to the Albanian context. In looking at the overall cost-effectiveness this again is hard to measure both in terms of cost and effectiveness of a given activity versus the overall project. What is a strength of this project as described above is the way all these components come together to deliver a holistic approach to strengthen PHC. Overall, in terms of efficiency a missed opportunity of the refurbishment process outside of the pilot regions was to also provide the "soft elements" of HAP to these facilities.

c. Has the intervention led to tangible institutional change (being at central or local level)?

Impactful changes have happened at the level of the different health facilities involved in the project. Some change was perceptible in local governments through their involvement in the refurbishment of facilities and links the project created with social care. At a national level, and especially with the Operator the project was not successful in changing the institution. See Sections 4.2.1 and 4.2.2.

5. Assess coherence: level of compatibility of the intervention with other interventions in the country, in particular with other multilateral and bilateral supports as well as national programmes and interventions

Fully coherent, see Section 4.3.4. However, as described more opportunities are present and require SDC to work with the project to strengthen possible synergies with other projects supported by the Swiss government.

6. **Assess the Sustainability of intervention: measuring at what extend the results and benefits of the project are likely to be sustained after the completion of the project.**
   a. **How is the project ensuring its interventions are sustainable?**
      This is clearly a weakness of the project as presented in Section 4.3.4 and Table 2.

   b. **Is the project introducing models together with national and local actors, setting a solid basis for a scaling up by the health system? Is the domestic financing of the processes supported by the project ensured?**
      This is another weakness of the project with many issues with regards to scalability as presented in Table 2.

7. **Assess the level of ownership from the MoHSP to create an enabling environment for the interventions introduced and supported by the project.**
   Unfortunately, this is very weak. Beyond the MoHSP and their weak level of ownership there is also the weak capacity of the Operator to implement any of the interventions introduced. To add a positive note although ownership is lacking knowledge of HAP and its capacity to implement projects is highly viewed by government partners

8. **What are the key lessons learned (including challenges faced) of the current Project phase and what are their implications for next steps?**
   There are two lessons to take away from this phase of the project. Firstly, that by having a wide range of approaches and activities the project was able to truly impact the role of nurses. On the other hand the main challenge with regards to the weakness of the Operator impacts the sustainability of the project activities and their potential to be scaled up.

9. **How did the project adapt to the challenges of COVID-19 and earthquake? Have innovations been introduced?**
   The project managed both events perfectly and professionally adapting its activities and providing additional support. No true innovations were introduced beyond possibly some trainings and other components shifting to an online mode. Although the project introduced the CoronaCheck platform this was not mentioned as a significant contribution. Another innovation not linked to the earthquake or COVID-19 was the introduction of appointment systems in some facilities.

10. **What are the key results/elements of the project which should be a priority for Swiss support to PHC in the future? What are the main innovations with potential?**
    It is suggested, with more details presented in Section 4, that the following elements continue to receive ongoing support:
        - All activities linked to nursing (Training; Competencies; Job profile)
            - Home based care with interest from UNFPA (elderly); UNICEF (children); WHO (overall HAP model)
        - Development of further protocols and training materials
        - Roll out of appointment system
        - Further develop CME (PGs, new areas of courses, etc.)

- HAP know-how and capacity to develop and implement 'innovative' models in PHC. This could be boosted further by overall perception that local and central institutions have for HAP not just as a project, but as a "way of reaching out".

11. **How did the project work with the private sector? Are there any opportunities for the future?**
    The project of course worked with the private sector in the reconstruction of facilities. ABC clinic was also involved in some material development and training for PHC. ABC could be further involved in the future with regards to trainings and providing a centre of excellence for PHC. Although the private sector does play a role in the provision of healthcare in Albania engagement of this sector does carry certain "political risks".

12. **How did the project work with Civil Society organisations? Is there any opportunity for the future?**
    A recommendation from mid-term review of the previous phase of the project in 2017 suggested that HAP develop a strategy, specifically in conjunction with the consortium members, on how best to strengthen civil society organisations working in health with vulnerable groups and including an approach for mapping civil society organisations and building their capacity.[17] In a management response letter from the SDC it was stated that the project would strengthen civil society in its second phase.[18] In the previous phase there was mention that the project had implemented a complaints box in different facilities. During interviews at health facilities this was not mentioned. See Section 0

13. **Are they any opportunities for the project to contribute in the future to a) climate change mitigation and b) medical waste management?**
    The only possibility could be that any future rehabilitation of facilities possibly includes solar panels or other energy saving/efficient approaches. In addition e-learning between foreign experts and Albania as well as within Albania would reduce carbon emissions due to travel. For medical waste management modules on this thematic could be integrated into the different trainings the project has developed, as well as a manual like others prepared by the project.

14. **How did the project contribute to gender equality?**
    It was not possible to assess this, see Section 4.3.6.

15. **Assessment of how the implementing partners have used the Risk Assessment and Mitigation strategies throughout the implementation (Annex of project document).**
    Looking at the shortcomings of the project as presented in Table 1 all risks were properly identified with regards to the approval of protocols, human resource strategy and role of the Operator. Clearly, despite the mitigation strategies proposed, which seem coherent to the consultants, the complexity of addressing these challenges due to inherent systematic weaknesses means that some risks could not be fully addressed.

The assessment grid for SDC projects is included in Appendix 19.

Appendix 19 – Assessment grid for evaluations of SDC projects

Key Aspects based on DAC criteria	Score	Justification
Assessment of relevance		
1. The extent to which the objectives of the SDC project/programmes are consistent with the needs of the target groups (incl. gender-specific requirements)	1 Very good: fully consistent	See Sections: 1.1, 1.2 1.3, 1.4 and 24 See: Appendix 1, Appendix 2 and Appendix 3,
2. The extent to which the objectives of the SDC project/programme are consistent with the demands and the needs of partner country (institutions respectively society) as well as the sector policies and strategies of the partner country	1 Very good: Obvious consistency with demands and needs of society and in line with relevant sector policies and strategies	See Sections: 4.2.1 to 4.2.14 See: Table 2
3. The extent to which the design of projects/programmes is adequate to achieve the goal and objectives (definition of target groups; choice of approach and operational elements; articulation of components; choice of partners; consistency with SDC policies and experiences)	1 Very good: Fully adequate	See Section: 4.3 See: Table 2
Assessment of effectiveness		
4. The extent to which the planned objectives at outcome level have been achieved taking into account their relative importance. If possible distinguish the quality and quantity of results achieved.	2 Good: Largely achieved	See: Section 4.1 See: Table 1
5. The extent to which the projects/programmes contribute to poverty reduction, inclusion and/or reduction of vulnerabilities.	2 Good: Evidence of contribution	See Sections: 1.2 and 4.3.7 The Score of Good is based on design and the appreciation of

Key Aspects based on DAC criteria	Score	Justification
		the consultants. Specific data to measure this is missing.
6. The extent to which the outcomes achieved contribute to improved governance for a system perspective.	2 Good: Evidence of contribution (Facility and local level, as well as adoption of PHC Strategy) Poor: Few evidence of contribution (Overall system-wide and role of Operator)	See Sections: 4.2.1, 4.2.2 and 0 Governance at a facility level and to a certain extent the involvement of local authorities in refurbishment activities is positive as is the development of the PHC Strategy. That said the lack of role of the Operator is a weakness.
7. The extent to which the outcomes achieved contribute to gender specific results	3 Poor: Few evidence of contribution	See Section: 4.3.6
Assessment of efficiency		
8. The extent to which the relation between resources (mainly financial and human resources) and time (e.g. delays compared to planning) required and results achieved is appropriate (Cost-benefit ratio – CBR)	0 Not assessed / Not applicable	See Section: 4.3.3 See: Appendix 16
9. The extent to which the approaches and strategies used by the SDC project/programmes are considered efficient (cost-efficiency)	0 Not assessed / Not applicable	See Section: 4.3.3 See: Appendix 16
Assessment of sustainability		
10. The extent to which the positive results (outputs and outcomes) will be continued beyond the end of the external support. Considering also potential risks in the context.	3 Poor: Little likelihood based on evidence	See Sections: 4.1 and 4.3.4 See: Table 2 and Appendix 14

Key Aspects based on DAC criteria	Score	Justification
11. The extent to which partner organisations are capable to carry on activities. Capacity included technical, financial capacity, human resources and importance of the activity to the organisation	3 Poor: Little capacity (require further support)	See Sections: 4.1, 4.3 and 0 See: Table 2

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