

**Assessment of sexual, reproductive, maternal, newborn, child and adolescent health in the context of universal health coverage in Albania**



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# Abstract

Achieving universal health coverage (UHC) – meaning that everyone, everywhere can access essential high-quality health services without facing financial hardship – is a key target of the Sustainable Development Goals. Sexual, reproductive, maternal, newborn child and adolescent health (SRMNCAH) is at the core of the UHC agenda and is among the 16 essential health services that WHO uses as indicators of the level and equity of coverage in countries. In this context, WHO undertook an assessment of SRMNCAH in Albania. This report examines which SRMNCAH services are included in policies concerning UHC in the specific country context; assesses the extent to which the services are available to the people for whom they are intended, and at what cost; identifies potential health system barriers to the provision of SRMNCAH services, using a tracer methodology and equity lens; and identifies priority areas for action. A set of policy recommendations provides the basis for policy changes and implementation arrangements for better SRMNCAH services and outcomes in the context of UHC.

## Keywords

SEXUAL AND REPRODUCTIVE HEALTH  
MATERNAL AND NEWBORN HEALTH  
CHILD AND ADOLESCENT HEALTH  
UNIVERSAL HEALTH COVERAGE  
HEALTH CARE SYSTEM  
QUALITY OF HEALTH CARE  
DETERMINANTS OF HEALTH  
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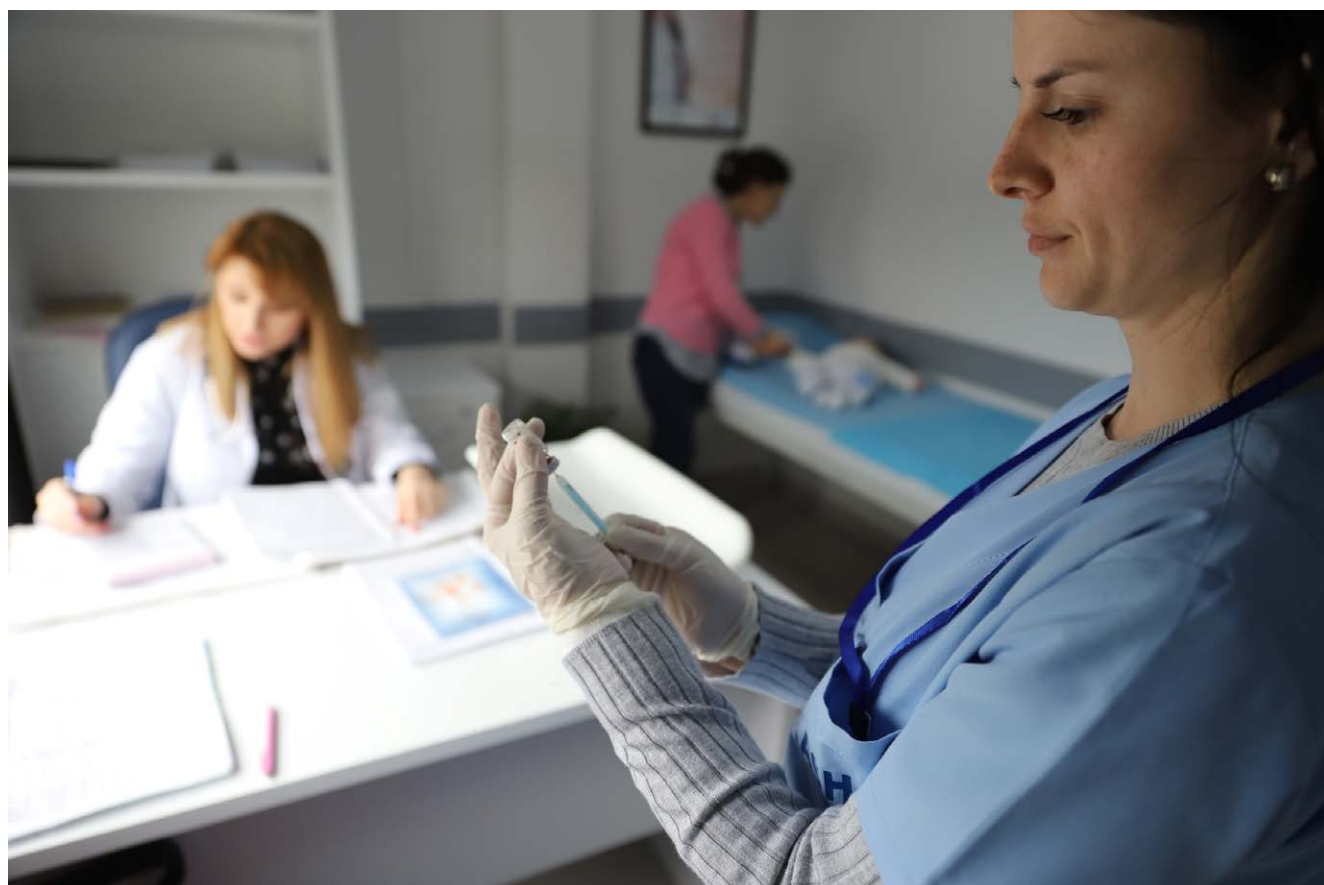
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The authors' views expressed in this report do not necessarily reflect the views of the World Health Organization or the Ministry and Social Protection of Health of Albania.

# Abbreviations

ADHS 2017–2018	Albania Demographic and Health Survey 2017–2018
CHIF	Compulsory Health Insurance Fund
GDP	gross domestic product
HPV	human papillomavirus
INSTAT	Institute of Statistics
LRD	list of reimbursed drugs
NIPH	National Institute of Public Health
OOP	out-of-pocket payment
SRMNCAH	sexual, reproductive, maternal, newborn, child and adolescent health
STI	sexually transmitted infection
UHC	universal health coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund



# Executive summary

An assessment of sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) in the context of universal health coverage (UHC) was conducted in Albania on 10–14 December 2018. It included document reviews; interviews with policy-makers, health facility managers, service providers and clients; and visits to health facilities. Six SRMNCAH “tracer” interventions were investigated in greater depth, identifying barriers to access and utilization of services along the essential pillars of UHC.

The assessment found that Albania has demonstrated willingness to move towards UHC by adopting health policies and financing strategies aimed at increasing coverage, reducing inequities and expanding financial protection, and has made progress. The health of women, children and adolescents is given high priority, expressed through the intended full coverage of health services for pregnant women, women in delivery and postpartum and children aged 0–18 years, among others.

Analysis of the tracer interventions revealed that protocols and legislation and the range of services included in the SRMNCAH health packages are good in general and follow WHO standards and guidelines. The most critical challenge is at the level of implementation. Despite well intended policies, not all SRMNCAH services are provided free of charge in reality, with adequate quality at the relevant level or reaching the most vulnerable population groups.

Given the overall resource limitations in Albania, finding savings and efficiency gains in service organization, delivery and financing are crucial to ensure greater coverage of SRMNCAH while maintaining the quality of services provided. The assessment identified a number of areas where improvements could be made without necessarily increasing the total budget. A set of policy recommendations intends to provide the basis for policy changes and implementation arrangements for better SRMNCAH services and outcomes in the context of UHC.

# Introduction

Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. This definition of UHC embodies three related objectives:

- equity in access, meaning that everyone who needs health services should get them, not only those who can pay for them;
- health services of good enough quality to improve the health of those receiving services; and
- protection against financial risk, ensuring that the cost of using services does not put people at risk of financial harm.

Achieving UHC is one of the targets the nations of the world set when adopting the Sustainable Development Goals in 2015.

Sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) is at the core of the UHC agenda and is among the 16 essential health services that WHO uses as indicators of the level and equity of coverage in countries. Essential SRMNCAH services used as indicators for UHC are:

- family planning
- antenatal and delivery care
- full child immunization
- health-seeking behaviour for pneumonia.

An assessment of SRMNCAH in the context of UHC in Albania was conducted on 10–14 December 2018. Its specific objectives were to:

- delineate which SRMNCAH services are included in policies concerning UHC in the specific country context;
- assess the extent to which the services are available to the people for whom they are intended, and at what cost;
- identify potential health system barriers to the provision of SRMNCAH services, using a tracer methodology and equity lens;
- highlight good practices and innovations in the health system, with evidence of their impact on SRMNCAH services;
- identify priority areas for action and develop policy recommendations jointly with the country to address health system barriers to the provision of SRMNCAH services.

The assessment was carried out on behalf of the WHO Regional Office for Europe and it is intended that similar assessments will be conducted in other countries in the WHO European Region.



# Methodology

A methodological approach was developed prior to the assessment and underwent several revisions. The visit to Albania was the second visit in a series, the first taking place in the Republic of Moldova in September 2018. The steps in the assessment included:

- a preliminary document review, including health policy and strategy documents, sexual and reproductive health and child and adolescent health strategy documents, UHC guiding documents, service package descriptions and similar;
- a country visit, including:
  - interviews with policy-makers from the Ministry of Health and Social Protection, health facility managers (primary health care and hospital), service providers (doctors, nurses and others) and beneficiaries (patients and clients);
  - visits to health care facilities at primary, secondary and tertiary health care levels;
- a presentation and discussion of findings and recommendations with key stakeholders at the end of the visit.

Semi-structured questionnaires were developed to conduct interviews with key informants, including:

- representatives of the Ministry of Health and Social Protection;
- health facility managers (primary health care and hospital);
- health workers including nurses, doctors and midwives, where applicable;
- patients and clients, including adolescents;
- partners and stakeholders, including representatives of the United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA).

## Tracer interventions

To assess the extent to which services are available to the people for whom they are intended, and at what cost, six "tracer" interventions were identified and analysed in depth. These were:

- immunization
- transport of sick neonates
- antenatal care
- adolescent-friendly sexual and reproductive health services
- sexually transmitted infections (STIs) (excluding HIV)
- case management of common childhood conditions.

As an analytical framework for the findings and identification of barriers and challenges to access to and utilization of SRMNCAH services, WHO's six "essentials of UHC" were used (Fig. 1).

**Fig. 1. Essentials of UHC**



Source: Universal health coverage [website]. Geneva: World Health Organization; 2019 ([http://www.who.int/universal\\_health\\_coverage/en/](http://www.who.int/universal_health_coverage/en/), accessed 23 April 2019).

## Limitations

The methodology aims to triangulate information through document reviews, visits to health facilities and interviews with policy-makers, health managers, providers and clients. The depth of the assessment depends on the completeness of documents provided by the Ministry of Health and Social Protection and partners, as well as the extent to which the health facilities visited and key informants interviewed are representative and reflect the national context and situation. The appraisal of tracer interventions and health systems barriers and challenges represents the judgement of the assessment team, based on the information obtained.

## Country context

Albania is a sovereign state located in Europe in the western Balkans, with a total surface area of 28 748 km<sup>2</sup> and a population of about 2 870 324 inhabitants as of 1 January 2018, most of whom are ethnic Albanians, according to figures from the national Institute of Statistics (INSTAT).<sup>1</sup> Politically, the country is a unitary parliamentary constitutional republic, with an upper-middle-income economy. Albania is also an official candidate for membership of the European Union; accession will be reviewed in mid-2019. Albanian life expectancy at birth is 77.1 years for men and 80.0 years for women (figures from INSTAT). Over the last two decades there has been a rapid process of transition in Albania associated with intensive migration, both internal and external.

The reforms to the health sector that followed immediately after the fall of the communist regime in 1991 focused mostly on reorganizing responsibilities across health care centres, but the majority of processes – including human resource policies and financing for hospitals – remained centralized. The main reform measures in primary health care have sought to transfer financing to a health insurance fund in addition to taxation.

<sup>1</sup> INSTAT: Institute of Statistics [website]. Tirana: Institute of Statistics; 2019 (<http://www.instat.gov.al/en/Home.aspx>, accessed 9 July 2019).

Changes are planned, however, including consideration of a national health service, offering free health care to all and thereby acting as a step towards achieving UHC for its citizens.<sup>2</sup>

Table 1 sets out some key socioeconomic and macroeconomic indicators.

**Table 1. Key socioeconomic and macroeconomic indicators**

Socioeconomic indicators	Value	Year	Source
Total mid-year population	2 870 324	2018	INSTAT
Population growth (annual)	–0.2%	2018	INSTAT
Population aged 0–14 years (proportion of total)	17.6%	2018	INSTAT
Life expectancy at birth, total (years):	78.5	2017	INSTAT
Inflation, consumer prices (annual)	1.8%	2018	INSTAT
Poverty headcount ratio (proportion of population living below the national poverty lines)	14.3%	2012	INSTAT
Unemployment, total (proportion of total labour force)	12.2%	2018	INSTAT (modelled International Labour Organization estimate)
Macroeconomic indicators			
Gross domestic product (GDP) per capita (current US\$)	4537.9	2017	World Bank
GDP per capita growth (annual)	3.9%	2017	World Bank
GINI index (World Bank estimate)	29	2012	World Bank
Revenue, excluding grants (proportion of GDP)	24.2%	2016	World Bank
Gross national income per capita growth (annual)	3.2%	2017	World Bank
Gross national income per capita, Atlas method (current US\$)	4.3	2017	World Bank

Sources: INSTAT: Institute of Statistics [website]. Tirana: Institute of Statistics; 2019 (<http://www.instat.gov.al/en/Home.aspx>); World Development Indicators [online database]. New York: World Bank; 2019 (<https://databank.worldbank.org/source/world-development-indicators/preview/on>, both accessed 9 July 2019).

<sup>2</sup> Albanian national health strategy for 2016–2020; Albania Demographic and Health Survey 2017–2018. Tirana: Institute of Statistics, Institute of Public Health; 2018; Programme of Cooperation for Sustainable Development: UN Sustainable Development Framework 2017–2021. New York: United Nations; 2017 (<https://www.un.org.al/publications/programme-cooperation-sustainable-development-un-sustainable-development-framework-2017>, accessed 9 July 2019).

# Health care system

The Albanian health care system is mainly public. The state provides the majority of services to the population: prevention, diagnosis, treatment and rehabilitation. The private sector mainly covers pharmaceuticals and dental services, as well as some high-technology diagnostic services. There are 14 private hospitals (holding a valid license). The health system is organized as three levels: primary, secondary and tertiary health care services.

Health services within primary and hospital care are purchased by the Compulsory Health Insurance Fund (CHIF), which was founded in 1994 as a state institution – independent, non-budgetary and non-profit – originally called the Compulsory Health Insurance Institute. It initially reimbursed medicines and paid the salaries of primary health care providers, then gradually expanded to purchasing almost all public primary and hospital care services. CHIF is currently regulated by Law no. 10 383 of 24 February 2011 “on compulsory health care insurance in the Republic of Albania”. It is organized and functions according to the provisions of its statute, approved by Decision of the Council of Ministers no. 124 of 5 March 2014. The Administrative Council, which is CHIF’s governing body, comprises the minister responsible for health or his/her representative, the minister of finance or his/her representative, the minister responsible for social welfare or his/her representative, the general director of CHIF, the general director of the Social Insurance Institute, a representative of trade unions and a representative of an organization of health professionals.

CHIF is funded through a salary tax (of 3.4%) and budgetary subsidies for the unemployed population, disabled people, war veterans, retired, children, students, army recruits, cancer patients and HIV patients. Voluntary registration is available for those who are not covered.

# Health care financing

The transition from a centrally planned to a market-oriented economy, with international assistance, has helped the country’s economic growth. According to the World Bank, Albania is an upper-middle-income country, and the country’s economic transformation continues to build on its huge potential and opportunities. However, the global financial crisis exposed the weaknesses of its growth model and highlighted the need to shift from consumption-fuelled to investment- and export-led growth.<sup>3</sup>

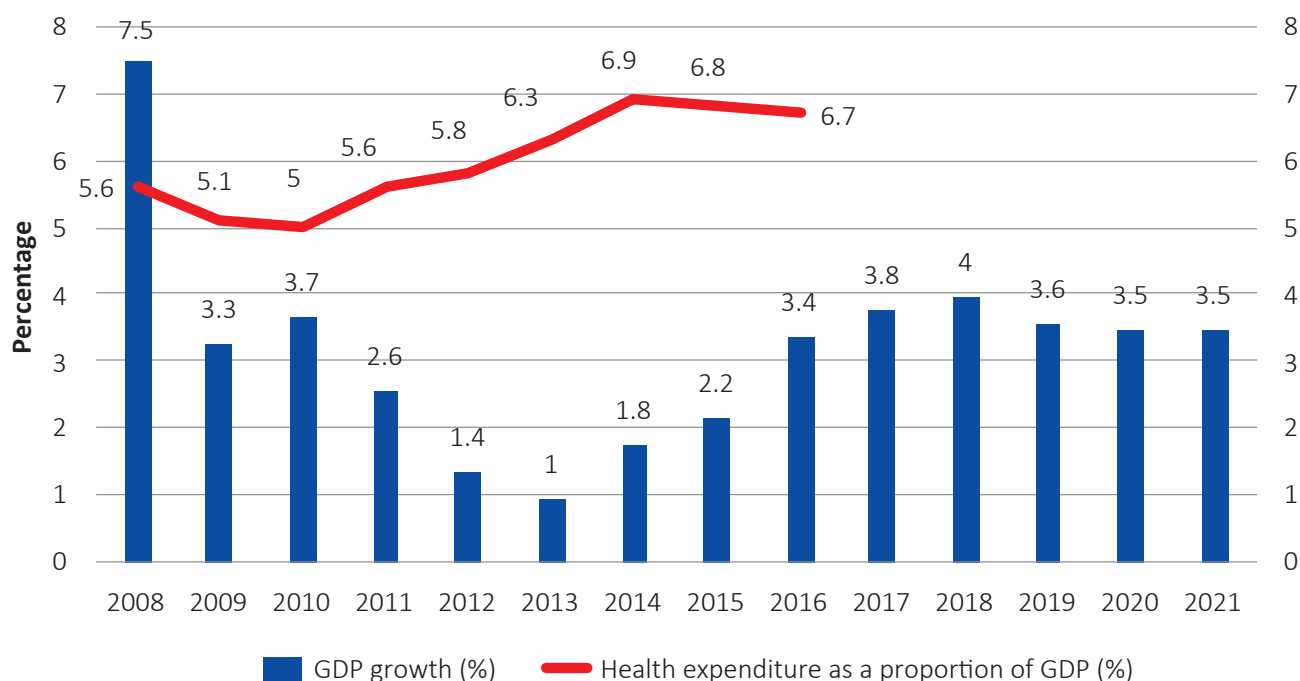
With economic growth, Albania is trying to increase expenditure on health (see Fig. 2) but is spending less than the average for Europe and central Asia, which is 7%.<sup>4</sup> Government expenditure on health as a proportion of total government expenditure is steady at around 9–10% but is still lower than the average share in the WHO European Region and that for upper-middle-income countries (12%, as estimated by the World Bank Group).

To accelerate the pace of equitable growth, Albania needs to implement structural reforms that will raise productivity and competitiveness in the economy, create more jobs and improve governance and public service delivery. Enhanced regional connectivity and access to regional and global markets, coupled with export and market diversification, could also help to promote faster growth.

<sup>3</sup> The World Bank in Albania [website]. New York: World Bank; 2019 (<http://www.worldbank.org/en/country/albania/overview>, accessed 30 June 2019).

<sup>4</sup> World Development Indicators [online database]. New York: World Bank; 2019 (<https://databank.worldbank.org/source/world-development-indicators/preview/on>, accessed 9 July 2019).

**Fig. 2. GDP growth (annual %) and health expenditure as a proportion of GDP**



Sources: World Development Indicators [online database]. New York: World Bank; 2019 (<https://databank.worldbank.org/source/world-development-indicators/preview/on>); The World Bank in Albania [website]. New York: World Bank; 2019 (<https://www.worldbank.org/en/country/albania/overview#1>, both accessed 4 July 2019).

Note: Data for 2020 and 2021 are forecasted.

## Compulsory health insurance

In 1994 the government introduced Law no. 7870 of 13 October “on health insurance in the Republic of Albania”, creating a compulsory health insurance scheme to ensure universal access to health services for its population. Since its inception, the scheme has covered a basic list of reimbursable medicines and family doctors’ salaries. It has gradually evolved, expanding the range of services covered to include non-differentiated funding and payments for health service packages.

### Strengths

The model of the health insurance scheme is a mixed one (Bismarck and Beveridge<sup>5</sup>), based on compulsory and voluntary contributions as well as state budget funding. Law no. 7870 clearly defines categories of population and the share of contributions they have to pay, while state budget funds (which come from general taxation) cover the inactive population and vulnerable groups, giving the scheme a solidarity approach. For self-employed people in urban areas the contribution is set at 3.4%.<sup>6</sup>

The health insurance scheme is based on the single payer model: CHIF manages the scheme in accordance with national health care policies. CHIF uses payment methods for health services to influence increases in access, prevention and improvement of health indicators of the population. The health insurance scheme is implemented through annual contracts with public and private providers of health services for the provision of health care packages.

<sup>5</sup> In the Bismarck model the insurance system is financed jointly by employers and employees through payroll taxes called “sickness funds”, which are directly deducted from pay checks (the United States of America has adopted a form of the Bismarck model). The Beveridge model, designed by the United Kingdom’s National Health Service creator Lord Beveridge, provides health care for all citizens and is financed by the government through tax payments.

<sup>6</sup> Law no. 10 383 of 24 February 2011 “on compulsory health care insurance in the Republic of Albania”, updated in 2013.

Law 10 383 of 24 February 2011 and appropriate legal documents outline the package of services covered:

- visits, examinations and medical treatments in primary health care centres and public hospitals;
- visits, examinations and medical treatments in private providers of primary health care services and private hospitals;
- drugs, medical products and other medical treatments offered by contracted providers of health services.

Services available from public health care providers, as well as selected packages offered by some private providers, are free of charge for everyone insured, if the patient is referred by primary health care (the gatekeeper) and follows the referral system. General practitioners only prescribe the generic name of the drug included among the reimbursable medicines and the patient chooses the drug in the pharmacy. Full reimbursement is made for the first option and co-payments are required for the remaining alternatives.

People with chronic diseases can access the reimbursable medicines list regardless of their insurance status. As noted above, the first option on this list is always free of charge. People who bypass the primary health care gateway, whatever their insurance status, pay fees for consultations or examinations. Informal payments may be another barrier, but their volume has not been quantified in recent years.

The government has also implemented national preventive check-up programmes for citizens aged 35–70 years.<sup>7</sup> These ensure that all citizens enrol with a family doctor; have an annual general health check; are screened for noncommunicable disease risk factors, leading to early detection; have access to basic health services and benefits free of charge; and are channelled into the health system, thereby moving towards UHC for the population.

Services provided at the primary care level for each population group are detailed in a document approved by Decision of the Council of Ministers No. 857 of 20 December 2006,<sup>8</sup> which is the result of a collaboration between the Ministry, UNICEF and UNFPA. CHIF purchases primary health care services, and 24% of the CHIF budget is distributed to primary health care. Salaries of primary health care doctors are partly capitation-based, but facilities budgets are based on historical allocation and consumption.

Financing of services at the hospital level is regulated by Decision of the Council of Ministers no. 17 of 12 January 2018 and reviewed annually. CHIF covers salaries of hospital staff, their social and health insurance and goods and services required for hospitals. From its global budget CHIF covers services according to prices approved by Council of Ministers. Each hospital receives a detailed budget approved by the Administrative Council. During interviews at CHIF it was mentioned that service packages are added annually, but these are not always followed by budget allocations. Hospital capital investments are covered by the Ministry of Health and Social Protection. Services that should be provided according the policy are listed in Table 2.

## Weaknesses

It is difficult to estimate the exact coverage of the population by the insurance scheme because the electronic registration system is still in development. Access to primary health care is universal (100%). If uninsured people follow the referral system, they have access to secondary and tertiary health care and only need to pay a symbolic fee. If referred by a general practitioner, uninsured people pay as little as 100 lek (US\$ 0.9) for a visit to a specialist ambulatory care unit and 500 lek (US\$ 4.6) for a visit to the university hospital. If hospitalization is required, all services are provided free of charge, regardless of insurance status.<sup>9</sup>

<sup>7</sup> National program on prevention and control of NCDs in Albania 2016–2020. Tirana: Ministry of Health and Social Protection; 2017 ([https://extranet.who.int/ncdccs/Data/alb\\_B3\\_NCD%20strategy%20albania\\_english.pdf](https://extranet.who.int/ncdccs/Data/alb_B3_NCD%20strategy%20albania_english.pdf), accessed 9 July 2019); see also an unpublished WHO assessment report on implementation of the screening programme “Primary care for citizens aged 40–65 in Albania”; 2015.

<sup>8</sup> Basic package of services in primary health care (revised version). Tirana: Ministry of Health and Social Protection; 2014.

<sup>9</sup> Decision of the Council of Ministers no. 74 of 7 February 2018 “on the registration and identification of insured citizens for compulsory health insurance”.

**Table 2. Benefits provided by CHIF**

Benefit	Primary health care	Specialized ambulatory care	Hospital
Antenatal care in accordance with WHO recommendations	10 visits for Primiparous women and seven visits for multiparous women	3 visits	Yes
Micronutrient supplements	Yes	Yes	No
Vaginal delivery/caesarean section	No	No	Yes
Postpartum care	Yes	Yes	Yes
Home visits for postpartum/postnatal care	Yes	No	No
Family planning	Consultations, pills, injectables <sup>a</sup>	Consultations, pills, injectables <sup>a</sup>	Intrauterine device insertion <sup>b</sup>
Emergency contraception	No	No	No
Abortion	No	No	Yes
STI diagnosis	Smear collection for STI testing	Yes	Yes
STI treatment	No	Yes <sup>c</sup>	Yes
Human papillomavirus (HPV) immunization	No	No	No
Cervical cancer screening <sup>d</sup>	No	No	Yes
Cervical cancer treatment	No	No	Yes

<sup>a</sup> Commodities for family planning are offered free of charge through the national family planning programme, which is managed by the National Institute of Public Health and is funded directly from the Ministry of Health and Social Protection budget, not through health insurance. The programme offers only selected contraceptives – essentially one for each category (combined pill, progesterone-only pill, injectable or copper intrauterine device) – and condoms. The Ministry recently approved the addition of emergency contraceptives to the list. The service is provided in all public sector health facilities, where CHIF covers personnel salaries.

<sup>b</sup> Intrauterine device insertion is done by obstetrician-gynaecologists in outpatient departments of hospitals, in private specialized ambulatory clinics. The service depends on the availability and skills of the clinician.

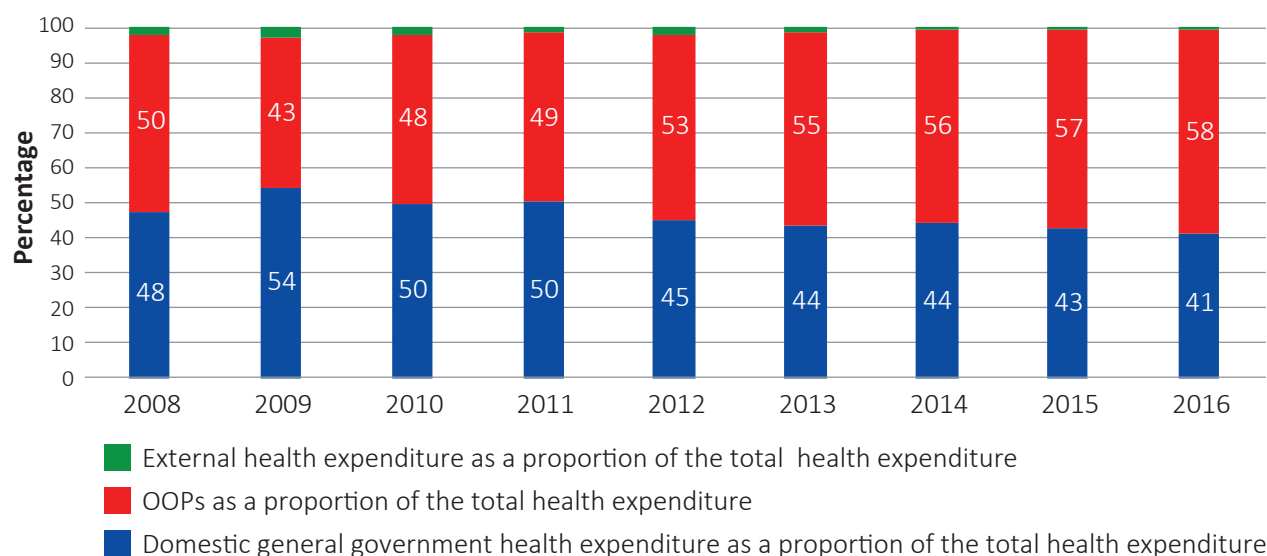
<sup>c</sup> STI treatment is covered by CHIF, subject to specific protocols. Not all medicines available on the market are reimbursed, but alternatives for each therapeutic class are reimbursed.

<sup>d</sup> The national programme on cervical cancer screening was approved and implementation started in February 2019.

Albania spends around 7% of GDP on health, which is lower than the average in the WHO European Region. WHO estimates that almost 58% of total health expenditure in 2016 (Fig. 3) was on out-of-pocket payments (OOPs), including formal co-payments for services. The high share of OOPs prevents households on low incomes from seeking care and fails to protect them from financial risk. Overall, it is difficult to judge how equitable access to health care is. Unpooled financial flows do not give the government the ability to provide stewardship to the sector or to use financial incentives to improve service quality.

Furthermore, CHIF revenue depends heavily on subsidies from the state budget: almost 69% of its revenue in 2018 was from the government (Fig. 4). The share of contributions from the economically active population is gradually increasing but is still very low compared to state transfers. Reforms are thus needed to improve the funding of the health care system to ensure equitable access of the population, as set out in strategic and policy documents.

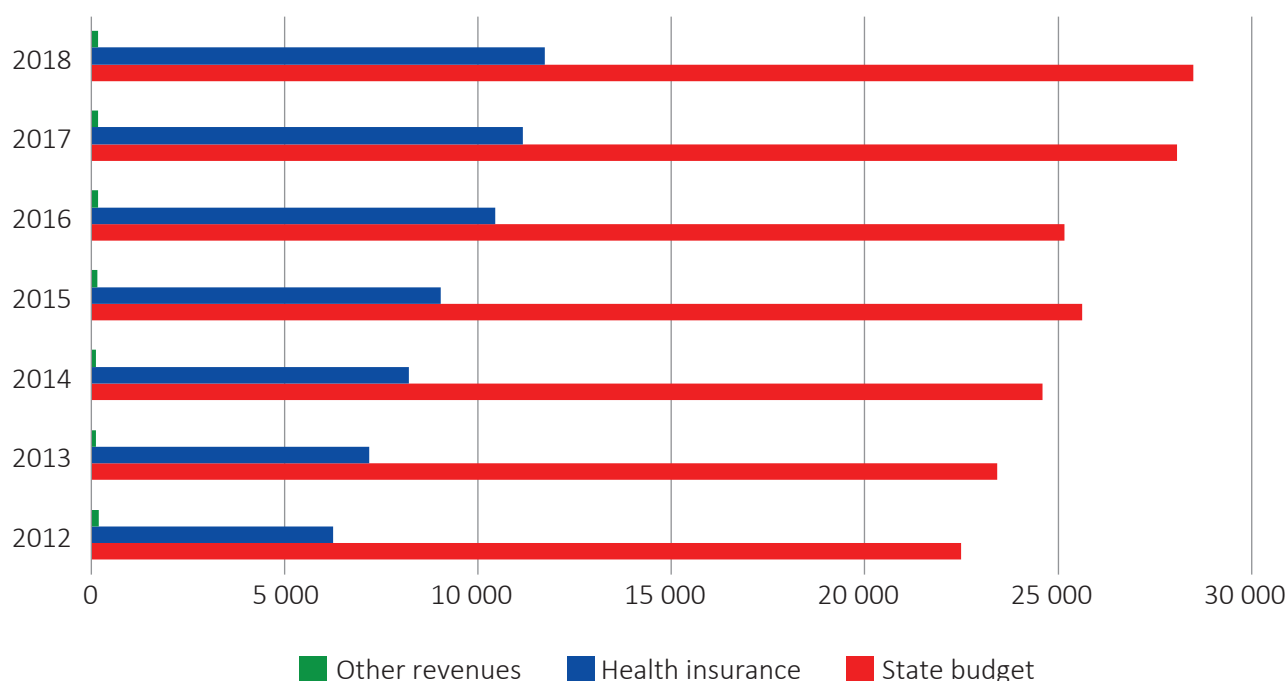
**Fig. 3. Total health expenditure by source (%)**



Source: WHO Global Health Expenditure Database [online database]. Geneva: World Health Organization; 2019 (<https://apps.who.int/nha/database>, accessed 1 July 2019).

When developing the budget, the number of cases and increases in prices of services and consumables are not taken into account. Adjustment is only possible if a service is added to the hospital package. Prices paid by CHIF for services are estimated by the government and approved by Decision of the Council of Ministers no. 737 of 5 November 2014.

**Fig. 4. CHIF sources of revenue (million lek)**



Source: data from Compulsory Health Insurance Fund.

At the policy and legal levels, CHIF covers almost all SRMNCAH services. During interviews, however, both providers and clients complained that services included in the package according to the guidelines were not always covered. For example, some tests to diagnose genetic malformations during pregnancy were not



available in public facilities and women instead had to go to private clinics and pay for them. Further, providers described situations where facilities had run out of tests and women were going to private clinics instead, including for STI testing. In summary, for some services that were supposed to be provided free of charge, either facilities required co-payments or patients had to go to private facilities and pay because of a shortage of supplies. Table 3 sets out a summary of the assessment's findings on health care financing.

**Table 3. Summary of findings on health care financing policies**

Policy	Rating	Criteria for rating
Coverage by CHIF	Some need for improvement	<p>Coverage by CHIF is estimated to be low by various sources, but it is difficult to ascertain accurate coverage. An explicit policy describes the principles of the insurance scheme, as well as defining vulnerable groups who are entitled to government-subsidized insurance. However, CHIF is mainly funded through government transfers, which made up almost 69% of its revenue in 2018.</p> <p>The service package covered by CHIF includes all services for pregnant women and children under 18 years. Not all services and medicines required are included outside those groups.</p>
Financial protection	Some need for improvement	<p>The share of OOPs in total health expenditure is high. Evidence shows that OOPs include both formal and informal payments at the point of service provision. This might create financial barriers for households on low incomes to access services. Financial protection issue requires further review and analysis.</p>
Financing mechanisms for primary health care	Some need for improvement	<p>Primary care is funded based on capitation and historical budgets, with adjustments. This does not provide many incentives to focus on quality of care.</p>
Financing mechanisms for hospital care	Some need for improvement	<p>Hospitals are funded through global budgets for services covered by CHIF, with some adjustments. When developing budgets, case-load and increases in prices for services and consumables are not taken into account. Budgets are only increased when services are added to the package.</p> <p>The rest of the budget required to run hospitals is also provided by CHIF but is detailed.</p>

# Human resources

The strengths of the health workforce in Albania are set out in Box 1.

## **Box 1. Strengths of human resources for health for SRMNCAH**

- Maternal and neonatal staff at all levels receive evidence-based perinatal training courses.
- Continuing health care education, with a system of accreditation, is in place.
- The government has acknowledged the shortage of specialists and is addressing it through:
  - patronage and bonus systems;
  - binding contracts for new specialists to work in districts outside the capital, Tirana, for free training (from February 2019);
- allowing those not on a government contract to apply to work in districts for bonus payments.

The Albanian national health strategy for 2016–2020 reports that the health system suffers from a shortage of health professionals. The personnel per capita ratio is 1.2/1000 for doctors and 3.6/1000 for midwives and nurses. A nursing bachelor's degree is a three-year course, with an additional two years' work in hospitals; training for midwives is of the same duration. The undergraduate medical course in Albania requires six years at university then one year's pre-registration work. Family medicine training is an additional two years. Medical specialization requires four years for obstetrics and gynaecology and for paediatrics. An additional two years' training is required following paediatric training to qualify as a neonatologist. Fewer young people are entering the medical profession and those who are trained tend to migrate externally, leading to a skills shortage. Care provided by doctors has been criticized by patients and in the media, which is affecting interest in joining the profession.

In 2018 Together for Life published the results of a survey of 1000 doctors across Albania to assess the factors leading to doctors' emigration. The findings showed that 24% were planning to leave immediately and 54% would leave if given the chance. Reasons for leaving included financial support and better working conditions. Doctors reported shortages in services and job insecurity, and 71% of doctors stated that they were over-criticized. The authors recommended infrastructure interventions, a review of legislation related to medical errors, creation of opportunities for professional and academic growth, work to improve the image of physicians and reducing pressure put on doctors by patients.<sup>10</sup>

At the policy level key informants believe that the lack of specialists in the districts will be resolved in the next three years as a result of several strategies:

- a patronage system, where every university hospital specialist will visit several districts to provide a clinical service and on-the-job training for a per diem/small fee;
- a bonus system through which the government will pay a fee of €2200 in addition to a salary of approximately €500–600 per month for those willing to work in remote areas for a period of time, while their position is held open at the hospital of origin;
- free specialist training for those who engage in a binding contract with the Ministry of Health and Social Protection to work in a district for three years;

<sup>10</sup> Gjypi AS. Together for Life: Friedrich Ebert Foundation. Doctors leaving Albania. Tirana: Friedrich-Ebert-Stiftung; 2018 (<http://togetherforlife.org.al/wp-content/uploads/2018/12/Doctors-leaving-Albania.pdf>, accessed 9 July 2019).



- the ability of those not on a government contract to work anywhere but to have to pay for specialist training – these professionals can join the government binding contract system by applying to work in districts for the bonus.

Family doctors in rural areas work as paediatricians in both well child and sick child clinical areas. A one-year clinical attachment for family doctors was available at Mother Teresa Hospital, enabling family doctors to gain additional paediatric skills to cover the shortfall of paediatric specialists; it is not clear whether this course is continuing. There is no adolescent health physician specialization in Albania.

Continuing professional education for health care providers was introduced in 2009–2010: health professionals can participate in various programmes and training linked to a system of accreditation. Regional directorates monitor doctors participating in continuing professional education activities at the primary health care level. It is the responsibility of hospitals to monitor such activities for hospital doctors, but it is not obligatory.

At the policy level it is believed that the poor quality of care perceived by clients in districts, and the subsequent care-seeking in Tirana, is related to a lack of specialists outside the capital city, even if the infrastructure is in place. Albania has no human resources strategy and a human resources for health needs analysis has not been conducted.

# Essential medicines and health products

The reimbursable medicines list is an important package financed by CHIF. Based on a contract with pharmaceutical entities, drug reimbursement is realized according to a list approved by the Council of Ministers. Different categories of the population are entitled to different co-payment levels.

Contraceptives are provided free of charge for some beneficiary groups. Further, not all drugs required for treatment of STIs are included in the list, so patients have to make OOPs when these are prescribed.

Albania's pharmaceutical market is dominated by imports; most major international brands are present in the country. Locally manufactured products account for a small share of the total market. The Ministry of Health and Social Protection monitors the pharmaceutical industry, and all drugs must be registered with the National Agency of Drugs and Medical Devices. The government sets profit margins for actors involved in the distribution chain for both reimbursable and non-reimbursable medicines.

CHIF has a list of reimbursed drugs (LRD), updated annually, which outlines which drugs are subsidized by the government for primary and hospital health care. Two commissions approve the LRD and define profit margins for importers and secondary distributors, as well as pharmacies. This helps to regulate the prices on the market.

The LRD is extensive: in 2016 it contained 1070 trading alternatives – a higher figure than in 2015,<sup>11</sup> and in 2018 it had 1175 more alternatives than in 2016. Generics are usually the first choice of drug on the list and are therefore received free of charge by patients, but if only one alternative is available, it is provided free of charge, regardless of whether it is generic or patent. Certain categories of the population, including veterans and infants, receive any drug from the LRD free of charge, but the list does not include medical devices and no similar list for reimbursable medical devices exists. A regulatory framework for inclusion of medical devices is also missing. There are no clear criteria for the inclusion of food supplements in the LRD.

Albania has defined the criteria based on which drugs are included in LRD.

- All conditions should be covered.
- All treatment alternatives should be present.
- No redundancy is allowed without a sound rationale.
- A cost-effectiveness study should be performed and presented for each addition or removal from the list.
- Proposals for additions or removals should be submitted by university hospital centre departments and professional organizations.
- Pharmaceutical companies are not allowed to submit proposals.
- The medicines should be registered at the National Centre of Medicines and Medical Devices.

The pharmaceutical market seems to be well regulated. In most eastern European and central Asian countries high OOPs are caused by pharmaceutical expenditure, which is usually not reimbursed by state insurance schemes. There is no evidence of a similar process in Albania, unless an absence of treatment protocols causes irrational drug prescription (polypharmacy), but this requires further study.

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<sup>11</sup> Annual Report 2017. Tirana: Compulsory Health Insurance Fund; 2018.

# Health information system

The National Institute of Public Health (NIPH) is not the only entity responsible for the health information system, and it cannot share information without permission from INSTAT. According to the law, both public and private entities are entitled to submit information required for specific conditions: surveillance of communicable diseases, vaccine and immunization, management and use of contraceptives, surveillance of abortion, congenital malformations and breast cancer screening. Cervical cancer screening is expected to start in mid-2019. This information is compiled by NIPH and sent to INSTAT.

The paper-based health information system shares the fragmentation that characterizes the overall health system in Albania. For example, there are three parallel STI reporting systems: syndromic; laboratory-confirmed and syphilis. Different parts were developed with assistance from international partners during the project implementation periods, but none of them have been integrated into a national system.

The following problems were identified during the interviews with NIPH personnel.

- Existing systems are not compatible, which complicates the process of integration.
- The paper-based system makes accurate aggregation of data and data analysis difficult.
- There is no motivation at lower-level facilities to fulfil the multiple data collection and accurate reporting requirements of the complex system; documentation of information on different reporting forms takes a great deal of time.

CHIF also suffers from a weak information system that does not allow an accurate list of registered beneficiaries to be created.

## Findings on tracer interventions

Six tracer interventions were examined in particular detail during the assessment. This section provides a description and analysis of each, concluding with summary tables reviewing different dimensions or attributes, with colour codes based on a traffic-light system:

- red – considerable need for improvement or equating to service not being provided/totally inadequate care/potentially life-threatening practices;
- yellow – some need for improvement to reach standards;
- green – good practice or showing little need for improvement.

The attributes of the tracer interventions were reviewed using the following themes and associated questions.

- Protocols and legislation: do protocols and legislation exist for the intervention package and are they in line with WHO recommendations?
- Scope of services: are the services provided within the intervention package adequate and in line with WHO recommendations?

- Population coverage and/or access: what is the population coverage of the intervention package or the proportion of the target population that has access to the intervention package?
- Quality of services: is the quality of provision of the intervention package adequate?

## Immunization

The strengths of the immunization programme are set out in Box 2.

### Box 2. Strengths of immunization for SRMNCAH

- Almost all children aged 12–23 months (97.6%) completed the diphtheria, tetanus and pertussis vaccine series, according to the Albania Demographic and Health Survey (ADHS) 2017–2018.
- Supply, procurement and distribution of vaccines are functional.
- The system for immunization at the primary health care level is efficient.
- The schedule includes pneumococcus and haemophilus influenza type B.
- The Ministry of Health and Social Protection works directly with the community through advocacy and capacity-building of health workers to access hard-to-reach population groups.

Overall childhood immunization coverage is reported as 99%.<sup>12</sup> The ADHS 2017–2018 stated that almost all children aged 12–23 months (97.6%) completed the diphtheria, tetanus and pertussis vaccine series. The proportion of neonates protected at birth against tetanus is reported as 92% (WHO Global Health Observatory data<sup>13</sup> for 2015).

The Basic package of services in primary health care (revised version) includes details of a national immunization programme. An efficient system for immunization is in place at the primary health care level. The schedule consists of all WHO-recommended vaccines, including haemophilus influenza type B in the pentavalent vaccine, pneumococcus and measles, mumps and rubella vaccines. HPV vaccine is not currently available in Albania, but HPV testing will be piloted for young females in Tirana in 2019.

Immunization refusals, hesitancy and postponement have occurred in some populations, including Roma and Egyptian populations that do not access the health system, parent groups concerned about vaccine safety (such as the perceived association of measles, mumps and rubella vaccine with autism) and some communities on religious grounds (including the Muslim community). Measles vaccine coverage has been below 95% in some communities, leading to a measles outbreak from late November 2017 to 2018. The Ministry of Health and Social Protection is addressing immunization challenges by working directly with communities and using high-level advocates including the Minister of Health to visit hard-to-reach populations. There is also a plan to develop capacity of health personnel through education on vaccine safety.

No problems were identified regarding vaccine safety, supply and procurement or distribution during the assessment. Vaccines are procured through UNICEF but fully funded by the Ministry of Health and Social Protection. Computerized modules are available to track immunization stock and assess vaccine eligibility, but they are only functioning in a limited number of districts.

<sup>12</sup> Levels and trends in child mortality report 2018: estimates developed by the UN Inter-agency Group for Child Mortality Estimation. New York: United Nations; 2018 (<https://www.un.org/en/development/desa/population/publications/mortality/child-mortality-report-2018.asp>, accessed 4 July 2019).

<sup>13</sup> Global Health Observatory (GHO) data [online database]. Geneva: World Health Organization; 2019 (<https://www.who.int/gho/en/>, accessed 4 July 2019).

Primary health care facilities were visited in Tirana and in the Durres region and one village. In the village facilities immunization is provided on most days. The vaccines come from the regional centre to primary health care facilities and are kept in fridges. More remote villages are visited with vaccine cold boxes to maintain the cold chain. Community nurses advise families to bring their children to the clinic for vaccination according to the schedule. No concerns were raised regarding vaccine quality or safety at any level of health facility visited. Children are observed for 20–30 minutes after immunization; the family is called the next day to detect any problems; and home visits are conducted if necessary. The doctor at the primary health care facility examines the child before vaccination to determine whether there are any contraindications to immunization.

Table 4 sets out a summary of the assessment’s findings on immunization.

**Table 4. Summary of findings on immunization**

Attributes	Rating	Criteria for rating
Protocols and legislation	Good practice/ little need for improvement	The national immunization schedule is consistent with WHO Expanded Programme on Immunization schedule.
Scope of services	Some need for improvement	Pneumococcal vaccine is included in the schedule.  HPV vaccine is not included.
Population coverage	Good practice/ little need for improvement	Immunization coverage is high.  Vaccine refusals, hesitancy and postponement occur among Roma and Egyptian populations and among parent groups with non-evidence-based vaccine safety concerns.
Quality of services	Good practice/ little need for improvement	Vaccine supply, procurement and distribution are functional. Vaccines are of good quality.

## Transport of sick neonates

The strengths of the neonatal transport programme are set out in Box 3.

### Box 3. Strengths of neonatal transport for SRMNCAH

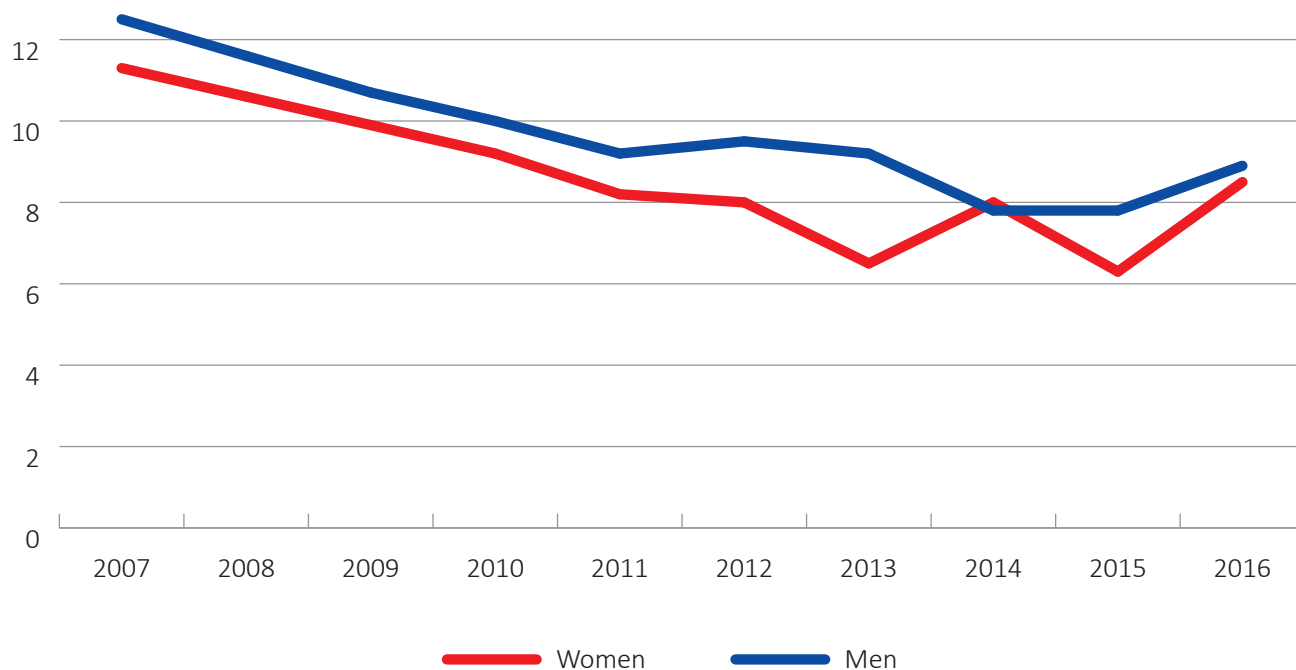
- Neonatal resuscitation, essential newborn care and sick newborn care training has a long history in Albania and has been implemented in all districts.
- Standard treatment guidelines for perinatal care are consistent with WHO guidelines; they were available and interviewees reported that they were used.

The United Nations Interagency Group for Child Mortality Estimation<sup>14</sup> reports the infant mortality rate as 8/1000 live births and the neonatal mortality rate as 6/1000 live births (Fig. 5). This remains unchanged from the 2015 WHO Global Health Observatory data, which shows the infant mortality rate as 8.3/1000 and the neonatal mortality rate as 5.9/1000. The main causes of infant mortality are respiratory diseases and perinatal causes, followed by congenital abnormalities. According to key informants from different sources, neonatal mortality contributes to approximately 75–80% of infant mortality in Albania.

<sup>14</sup> Child mortality estimates [online database]. New York: United Nations Inter-agency Group for Child Mortality Estimation; 2017 (<https://childmortality.org/>, accessed 4 July 2019).



**Fig. 5. Albanian data on infant mortality rates**



Source: Thomo L, Subashi B, Gorçe I, Hoxha R, Berbiu A. Women and Men in Albania. Tirana: Institute of Statistics; 2017.

Regionalization of perinatal services has been discussed in Albania, based on the country's administrative structure and clear standards for regionalized services; however, the assessment team was not able to identify any regulatory document that described the procedure, conditions and pathways for neonatal transportation. Sick babies are brought to hospital in ambulances that are not equipped with the specific equipment required





for safe neonatal transportation. They are transported by a nurse or occasionally a doctor who has not been specifically trained in neonatal transport and care. Advice before transfer relies on relationships between individuals at the central and regional levels.

There are two tertiary maternity referral hospitals for Albania in Tirana: Koço Gliozheni and Mbretëresha Gjeraldinë. Almost a third of Albanians live in the Tirana region and both hospitals also serve as secondary maternity hospitals for Tirana inhabitants. They are equipped with bubble continuous positive airways pressure, high-flow nasal oxygen, mechanical ventilation, exchange transfusion and phototherapy. Surfactant is used only as a rescue therapy at the discretion of the neonatologist, as it is expensive. Families do not have to pay for its use. Surfactant is not available elsewhere in the country.

Koço Gliozheni hospital neonatal unit is overloaded because not all neonates admitted require tertiary care. It has 16 places for intensive and sub-intensive care but often twice as many neonates are admitted. Many babies are transferred from elsewhere, and a proportion of the transfers are inappropriate. Women from the districts prefer to deliver in Tirana: 40% of pregnant women who come to this hospital come from the districts. There is no coordination system for referral and acceptance of neonates to the tertiary facility.

One role of the new National Medical Emergency Centre is to transport the mother by road in an ambulance as a first choice but no capacity for neonatal transfer. The country has some appropriate technology for neonatal care in place but lacks continuity of care. Neonates with surgical problems are transferred to the paediatric hospital. Neonates with cardiac problems may be operated on by international cardiac surgery teams visiting Albania or sent to other countries through charity-supported programmes. An agreement with Italy is in place to transfer a certain number of babies for surgery; this programme is free for families.

A regional hospital reported that few sick neonates require transport to Tirana. Those that do are transported by an ambulance with a neonatologist accompanying the baby. A transport incubator is available, equipped with temperature control and oxygen but with no ventilation or continuous positive airway pressure facilities.

The World Bank has provided 18 neonatal transport incubators that can be placed in ambulances. These are available at the Trauma University Hospital of Tirana and in 11 regional hospitals. It was not clear whether training in using the equipment had been provided. There are issues with transport from remote areas, particularly concerning women being able to reach the nearest facility from where they can be taken to tertiary level care in Tirana.

Clinical guidelines based on WHO guidance have been in place in Albania since at least 2009. Evidence-based neonatal guidelines have been developed with support from the WHO Collaborating Centre for Maternal and Child Health in Trieste, Italy. Many perinatal training activities have been conducted with doctors and nurses in central and regional hospitals, including WHO essential newborn care, WHO effective perinatal care, Helping babies breathe and other programmes on neonatal resuscitation and care of sick neonates. National neonatal guidelines were available in the regional hospital visited, including “Protokollet klinike perinatale kombetare [National perinatal clinical protocols]” from 2012, updated in 2016. Further, at least three assessments of maternal and neonatal health have been conducted, and recommendations and indicators for monitoring provided.<sup>15</sup> Despite all efforts, however, key informants reported problems with the quality of maternal and neonatal health care related to lack of use of evidence-based guidelines and not following standard procedures.

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<sup>15</sup> Gori G, Pivetta S, Tamburlini G. Assessment of maternal and child health consulting services in Albania: final report. Pennsylvania: CiteSeerX; 2010 (<http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.638.5008&rep=rep1&type=pdf>, accessed 10 July 2019); Bali D, Kuli-Lito G, Ceka N, Good A. Maternal and child health care services in Albania. *J Pediatr.* 2016;177S:S11–20; Macaluso A, Ronfani L, Bacci A, Cattaneo A. Safe motherhood needs assessment in Albania: final report (September–October 1999). Copenhagen: WHO Regional Office for Europe; 2000 (<https://apps.who.int/iris/handle/10665/108329>, accessed 4 July 2019); Maternal, newborn and child health care reform: final project technical report October 2007 – July 2012. Tirana: WHO Country Office in Albania; 2012; Hill K, Chitashvili T, Trevitt J, Panajyan G, Korotkova AV. Assessment of selected best practices for maternal and newborn care in Albania, Armenia, Georgia, and Russia, June 2012. Washington, DC: United States Agency for International Development; 2012 (<https://www.usaidassist.org/resources/assessment-selected-best-practices-maternal-and-newborn-care-albania-armenia-georgia-and>, accessed 4 July 2019).

Developmental follow-up is offered to families following discharge, but they may not attend as they live elsewhere. No computerized system is in place to follow up discharged babies.

Table 5 sets out a summary of the assessment's findings on neonatal transport.

**Table 5. Summary of findings on transport of sick neonates**

Attributes	Rating	Criteria for rating
Protocols and legislation	Some need for improvement	Clinical protocols for management of pre-term and sick neonates are available. Protocols and indications for neonatal referral are not available.
Scope of services	Considerable need for improvement	No functional neonatal transport service is in place.
Population coverage	Considerable need for improvement	Services are fragmented and related to human and material resources at specific facilities.
Quality of services	Considerable need for improvement	Neonatal transport incubators were reported to be available in Tirana and some regional centres, but staff are not trained in use of equipment.  Most staff transporting sick neonates are not specifically trained.

## Antenatal care

The strengths of the antenatal care programme are set out in Box 4.

### Box 4. Strengths of antenatal care programme

- Antenatal care protocols in place are consistent with WHO guidelines and are reported to be followed at all levels.
- Consultations and investigations are free of charge.
- WHO effective perinatal care is implemented, including emergency care and referral for eclampsia and pre-eclampsia.
- The Albanian national health strategy for 2016–2020 focuses on emergency care, and referrals for pregnant women with severe hypertension are recommended.

The maternal mortality rate in Albania decreased from 22.7 deaths per 100 000 live births in 1990 to 11.8 in 2013 and 9.7 in 2017. The major causes reported were bleeding, infections after birth, pre-eclampsia and eclampsia during pregnancy and unsafe abortion (figures from INSTAT). WHO Global Health Observatory data from 2015 reported the maternal mortality rate as 29 (confidence interval of 16–49)/100 000 live births (11 deaths).

The recent ADHS 2017–2018 reported the following.

- Most women aged 15–49 years with a live birth in the past five years (88%) received antenatal care from a skilled provider during their most recent pregnancy; 78% completed more than four visits.

- Almost all women who received antenatal care for their most recent pregnancy in the past five years had a blood sample taken (98%), their blood pressure measured (94%) and a urine sample taken (98%).
- Almost all live births in the past five years were delivered in a health facility (99%) and with skilled birth attendants (100%).
- For the most recent births in the past two years, 88% of women and 86% of neonates received a postnatal check within two days of delivery.

The Basic package of services in primary health care (revised version), in the section on “adult care”, recommends referrals for pregnant women with severe hypertension – “severe persistent high blood pressure >180/120; high blood pressure that does not return to normal values after standard treatment with at least two drugs of different classes; progressive increase of blood pressure in pregnant women; all hypertension emergencies” – and pregnancy-induced diabetes. Albuminuria and oedema are indications for referral but not specifically in relation to pregnancy.

The antenatal care package is included in the section on “women’s health care and reproductive health”. The contents address WHO-recommended components for healthy eating and iron and folic acid supplementation, screening, prevention and treatment of infections including syphilis and HIV, screening for anaemia and interventions for physiological symptoms. It includes 10 antenatal visits for primiparous women and seven for multiparous women and four free-of-charge ultrasonography examinations during 0–10 weeks, 13 weeks, 20–21 weeks and 33–34 weeks.

A list of drugs and consumables at the primary health care level is provided, including magnesium sulfate. According to the government document minimum available laboratory services should include urine dipstick, blood glucose testing, pregnancy testing, pH paper for testing vaginal secretions for infections and quick tests for HIV, syphilis and hepatitis B; however, reports have shown that primary health care centres often lack rapid tests.

The “emergency care” part of the “non-traumatic medical emergencies (including referral and transportation)” section of the Basic package of services includes management of bleeding and first aid in pre-eclampsia and eclampsia during pregnancy. It also includes a list of recommended referrals. Pregnancy conditions are not specifically mentioned but could be subsumed under “life-threatening diseases and injuries”.

The Albanian national health strategy for 2016–2020 includes medical emergency services as one of its priorities. The National Medical Emergency Centre in Tirana was established in 2016; its role is to ensure a rapid and professional response countrywide. It sets standards for emergency care and contains a coordination unit, whose role is to receive all incoming calls for medical assistance and coordinate between ambulance vehicles, paramedics, hospitals and primary care providers.

All deliveries occur in hospitals in Albania. Antenatal care protocols are in place consistent with WHO guidelines, including management of pre-eclampsia and eclampsia. WHO effective perinatal care has been implemented, including emergency care and referral for eclampsia and pre-eclampsia. Key informants at the regional hospital in Durres reported that although women receive antenatal care locally they choose to go to Tirana for delivery.

The Ministry of Health and Social Protection, supported by UNFPA, has worked to improve the quality of care by implementing a WHO effective perinatal care training programme, national maternal and newborn protocols for all health facility levels and essential newborn and sick newborn training. As part of the minimum service package for pregnant women in remote areas, a clear birth preparedness plan has also been established in the event of pregnancy emergencies or complications.

Table 6 sets out a summary of the assessment’s findings on antenatal care.

**Table 6. Summary of findings on antenatal care**

Attributes	Rating	Criteria for rating
Protocols and legislation	Good practice/ little need for improvement	The protocols for antenatal care are in line with WHO recommendations.
Scope of services	Good practice/ little need for improvement	All WHO-recommended antenatal care interventions are included in the protocols and are covered by CHIF.
Population coverage	Some need for improvement	The majority of pregnant women receive four antenatal care visits.
Quality of services	Some need for improvement	Providers at different levels lack appropriate knowledge and skills for routine care and management of complications.

## Adolescent-friendly sexual and reproductive health services

The strengths of the adolescent-friendly sexual and reproductive health services programme are set out in Box 5.

### Box 5. Strengths of adolescent-friendly sexual and reproductive health services for SRMNCAH

- Albania's health promotion strategy, sexual and reproductive health strategy targeting adolescents and Basic package of services in primary health care (revised version) include information on sexual and reproductive health, family planning and STIs.
- Contraceptives are available free of charge to those aged under 18 years.
- For students aged 18–25 years a defined list of contraceptives is offered free of charge by the Ministry of Health and Social Protection through primary health care centres and outpatient services at maternity hospitals/clinics. This includes condoms, combined contraceptive pills, progesterone-only pills, injectable contraceptives and non-hormonal intrauterine devices.
- Emergency contraception has recently been approved for use within health facilities.

The authors accessed two sources of data for adolescent birth rate (births to adolescent women per 1000 women of all ages). National INSTAT data from 2017 reported a rate of 17.5/1000 and 2015 data from the WHO Global Health Observatory reported 18.9/1000.

The ADHS 2017–2018 reported that the percentage of women aged 15–19 years who have begun childbearing had increased to 3.5% from 2.8% in 2008–2009.

- The proportion of young women who have begun childbearing increases with age, from almost 1% among women aged 15 to 7% among women aged 19 years.
- The proportion initiating childbearing is slightly higher in rural areas, at 5% compared to 3% in urban areas.
- The percentages of adolescents who have begun childbearing is 9% among teenagers with primary education only, 1% among teenagers with secondary, professional or technical education, and 0% among those with university or postgraduate education.
- Household wealth influences the likelihood of early initiation: 6% of teenagers in the lowest wealth quintile had initiated childbearing, compared with 1% of those in the highest quintile.

The ADHS 2017–2018 reported that 2.8% of all women aged 15–49 years and 0.4% of women aged 15–19 years were using any modern method of contraception. Unmet need for family planning among married women aged 15–19 years was 27.4% and in all women of this age group was 2.3%. The ADHS 2017–2018 also reported a 27% rate of unmet contraceptive need amongst married women aged 15–19 years. Table 7 shows knowledge of contraceptive methods according to age.

**Table 7. Knowledge of contraceptive methods, by age**

Background characteristic	Women			Men		
	Heard of any method	Heard of any modern method <sup>1</sup>	Number	Heard of any method	Heard of any modern method <sup>1</sup>	Number
<b>Age (years)</b>						
15–19	94.3	87.4	113	*	*	*
20–24	98.1	96.6	627	(95.6)	(83.5)	57
25–29	98.5	96.2	1 073	98.4	90.5	190
30–34	98.2	95.2	1 238	97.6	93.2	349
35–39	98.0	95.4	1 236	97.5	95.5	452
40–44	97.9	94.6	1 468	96.6	94.6	491
45–49	97.4	92.6	1 649	96.3	92.0	643

Note: <sup>1</sup>last had sexual intercourse within 30 days preceding the survey.

Source: ADHS 2017–2018.

The ADHS 2017–2018 also reported that of all women using a modern method of contraception, 56% obtained it from the private sector.

Table 8 shows abortion numbers in adolescents.

**Table 8. Number of abortions among adolescents, by age**

Age of girls	Number of abortions	Number of births	Abortion rate
15	3	54	56
16	13	112	116
17	41	281	146
18	59	553	107
19	102	952	107

Source: Thomo L, Subashi B, Gorçe I, Hoxha R, Berbiu A. Women and Men in Albania. Tirana: Institute of Statistics; 2017.

Albania's health promotion strategy, sexual and reproductive health strategy and Basic package of services in primary health care (revised version) target the needs of adolescents. The documents are aligned with the action plan on contraceptive security for 2017–2021. Contraceptives are available free of charge to those aged under 18 years and are partly reimbursed for students aged 18–25 years.

The country's health promotion strategy targets adolescents and young people by raising health awareness and creating supportive environments for healthier lifestyles, addressing issues including nutrition, physical activity,



violence, smoking, alcohol, drugs, mental health, sexual and reproductive health and family planning. It also includes a target that “at least 50% of young people use youth-friendly health services”. The Basic package of services includes providing information on sexual and reproductive health, family planning and STIs to young people. Any suspected STIs should be referred for diagnosis and treatment. Referral is also recommended for young people with mental health issues.

Parental consent is legally required to access contraception for young people aged less than 18 years, as well as for both instrumental and medical abortion. The law on abortion states that women requesting an abortion require counselling from a doctor and written confirmation of the request.

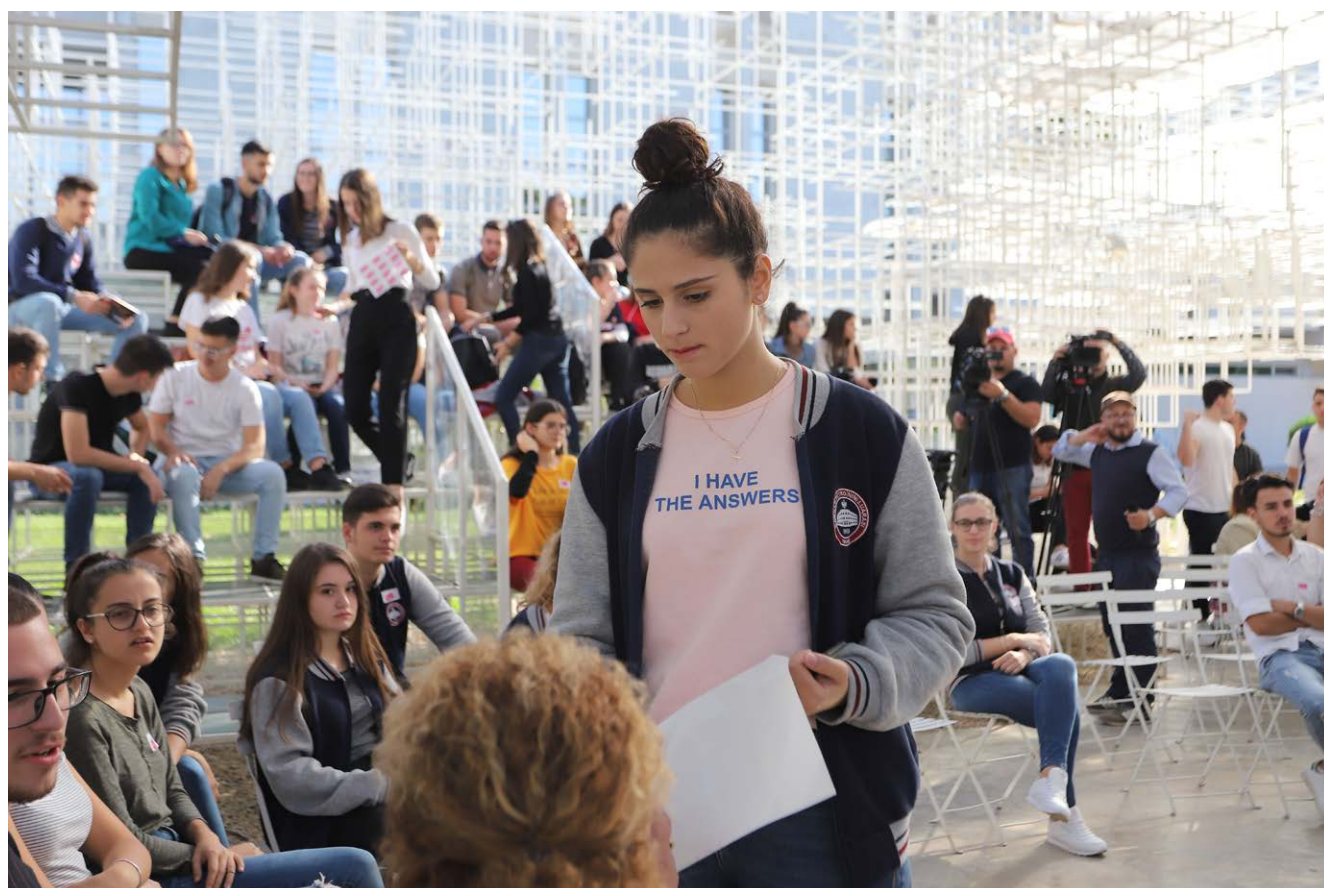
The Shadow report 2016 healthcare field – case of Albania<sup>16</sup> reported that women and girls seem to have little or no knowledge of the health legal framework and their rights to access health services.

According to the Ministry of Health and Social Protection the government is currently drafting a strategy for child and adolescent health, which will focus on improving adolescent health services targeting mental health and sexual and reproductive health, and on integrating health and social protection services.

### Service delivery for adolescents

Adolescent-friendly services are no longer available in Albania. In 2015 UNFPA assisted the Ministry of Health and Social Protection to set up standards for youth-friendly health services, which were endorsed but not implemented as the decision was made to integrate youth-friendly services in the Basic package of services in primary health care (revised version), which stated that all family doctors were expected to see young people. International standards of service provision require policies to ensure confidentiality and separate areas or a

<sup>16</sup> “Shadow” report: 2016 healthcare field – case of Albania. Tirana: Albanian Centre for Population and Development; 2016 (<http://acpd.org.al/wp-content/uploads/2016/08/eng-raporti-hije-3.pdf>, accessed 4 July 2019).



separate entrance in a facility to provide youth-friendly services. This is of particular concern in rural areas, where ability to maintain confidentiality is limited.

UNFPA is working with young people, particularly in rural areas, to provide education in sexual health and ways in which they can more readily seek referrals. Access to services for young people with disabilities is a significant issue, because of a lack of physical access and poor attitudes and practices of health personnel towards those with disabilities. Some work is being done on family doctors' job descriptions to make them more accountable for services. UNFPA has developed guidelines for young people with disabilities at a high level and will provide training on a national framework on guidelines and protocol development with a focus on sexual and reproductive health alongside the National Centre of Quality, Safety and Accreditation.

Since 2010 Albania has been completely self-reliant and independent of outside donor support for contraceptives by providing 100% financial coverage for the public sector. A national logistics management information system was established with donor support to collect service statistics for contraceptive logistics and decision-making, to ensure contraceptive security. UNFPA provides support to the Ministry of Health and Social Protection for contraceptive commodities, delivers training to service providers and supports the logistics management information system, which is linked to all service providers.

Four modern methods of contraception are provided, including two types of oral contraceptive pill (combined and progesterone-only), a copper intrauterine device (requiring insertion by a trained gynaecologist at the hospital level), injectable contraceptives and condoms. No concerns were raised regarding contraceptive quality, although there may be public misconception about this, as they are provided free of charge. Currently, a prescription is required for purchase of emergency contraception at pharmacies.

Adolescents need to go to the main health service at the primary health care level to receive contraceptives. The lack of adolescent-friendly services in Albania means that adolescents may avoid both primary health care and private facilities, leaving them without access to contraceptives or liable to OOPs from other sources. A wide range of contraceptives is available at pharmacies, and some clients choose to purchase these directly. In the past pharmacists were trained in family planning methods, and people tend to know that pharmacists can also provide advice in case of need.

Since 1995 induced abortion can be performed legally in Albania for medical and social motives during the first 22 weeks, and for psychosocial reasons during the first 12 weeks. Since 2007 abortion surveillance has been conducted by the Ministry of Health and Social Protection. It is now reported to NIPH. Data are collected on a paper-based form (although some districts have a database) by the doctor performing the abortion in public maternity hospitals in Tirana and districts and in two private hospitals in Tirana licensed to perform abortions. Information is also available from maternity abortion registers. Data collected include date of birth, place of residence, civil status, year of marriage, education, insurance status, type of abortion (induced or spontaneous) and reason for abortion. The information is analysed by NIPH and sent to the Ministry of Health and Social Protection and INSTAT, but not all disaggregated data are reported publicly. Data are not collected on medical abortions. There is one registered medication for medical abortion in Albania. Key informants reported that medication may be given without prescription by doctors, and may be bought from pharmacies or on the black market for unregistered medication.

Table 9 sets out a summary of the assessment's findings on adolescent-friendly sexual and reproductive health services.

**Table 9. Summary of findings on adolescent-friendly sexual and reproductive health services**

Attributes	Rating	Criteria for rating
Protocols and legislation	Some need for improvement	Government documents describe needs of adolescents.
Scope of services	Considerable need for improvement	Adolescent care is included in general health care and no adolescent-friendly sexual and reproductive health services are available.
Population coverage	Considerable need for improvement	No adolescent-friendly sexual and reproductive health services are available. Adolescents are reluctant to seek care in public or private facilities, particularly in districts.
Quality of services	Considerable need for improvement	Staff are not trained in adolescent-friendly sexual and reproductive health service standards.

## STIs (excluding HIV)

The strengths of the STI programme are set out in Box 6.

### Box 6. Strengths of STI programme for SRMNCAH

- Consultations and microbiology tests are free for insured people.
- No co-payment is in place for HIV testing, which is free of charge, regardless of insurance status.
- Medication for STIs is available and reimbursable through CHIF.
- Medication for STIs is free for pregnant women and women on maternity leave.

Table 10 sets out data on syphilis incidence.

**Table 10. Global Health Observatory data on syphilis incidence**

Category	2016	2013
Congenital syphilis number of cases	1	2
Congenital syphilis rate per 100 000 live births	3.2	5.6

Source: Global Health Observatory (GHO) data [online database]. Geneva: World Health Organization; 2019 (<https://www.who.int/gho/en/>, accessed 4 July 2019).

Three STI surveillance systems in Albania collect data on separate forms (see details in the Health information system section). Data are collected from districts and Tirana and sent to NIPH, where they are collated and sent to the Ministry of Health and Social Protection monthly. The data are disaggregated but the disaggregated data are not reported publicly.

Key informants at NIPH reported that prevalence trends for all three surveillance systems remain unchanged since 2010. Many STIs are unreported as clients avoid health care facilities and go to pharmacies, where they can purchase medications without a prescription, although this is not legal. Health providers may not want to report, and no incentives or motivations are in place for family doctors to report on STIs.



Most clients with suspected STI cases go to the tertiary level for consultation and diagnosis or choose to pay directly for a complete service at private clinics. Service is fragmented because patients diagnosed with STIs at specialized facilities have to return to the family doctor to receive a prescription to obtain access to reimbursable medications; otherwise they will have to pay out of pocket for medication. Furthermore, problems were identified with laboratory testing for STIs: tests may not be available at primary or secondary levels, or may be of poor quality, with unreliable results.

In the regional facility visited during the assessment, STI diagnostics were available, but some tests – such as for chlamydia and gonorrhoea – were sent to the epidemiology service at the regional health directorate as they could not be performed at the hospital. Increased occurrence was reported of all types of STI except syphilis, especially in adolescents. Pap smears and cervical biopsies were performed at hospital women's health centres.

In general, some gynaecologists at the primary health care levels in Tirana are trained in the pap smear procedure, but more often patients have to be sent to secondary or tertiary facilities for the test, where there is a delay in conducting the test and receiving the results. The consultation and procedure are free of charge.

Table 11 sets out a summary of the assessment's findings on STIs.

**Table 11. Summary of findings on STIs**

Attributes	Rating	Criteria for rating
Protocols and legislation	Some need for improvement	Protocols are available for management of STIs. Three separate STI surveillance systems are in place, causing administrative burdens.
Scope of services	Some need for improvement	Disconnects exist between consultation, diagnosis and treatment of STIs.
Population coverage	Some need for improvement	STI testing and treatment is free of charge for those insured. Free services are provided for pregnant women and those on maternity leave. For uninsured population groups only HIV testing is free (with a symbolic co-payment), and they have to pay out of pocket for testing and treatment.  Coverage may be compromised by fragmentation in services, as clients are required to see multiple providers for consultation, diagnosis and treatment. Clients also make OOPs for private laboratory diagnosis.
Quality of services	Considerable need for improvement	Referral to specialists or hospital is often required for STIs, as the appropriate level of care is not provided at lower levels, resulting in fragmentation of services.  Syndromic management of STIs only is done, creating a risk of antibiotic resistance.

## Case management of common childhood conditions (cough and pneumonia)

The strengths of case management of common childhood conditions are set out in Box 7.

### **Box 7. Strengths of case management of common childhood conditions for SRMNCAH**

- Essential antibiotics, oxygen and X-rays are readily available at all levels and free of charge for children.
- Children are followed up after discharge at the primary health care level.
- Immunization coverage is good, reducing the burden of pneumonia.

The under-5 mortality rate in Albania is reported as 9.2/1000 live births by INSTAT (2017 data) and as 9/1000 live births by the UN Inter-agency Group for Child Mortality Estimation (2015 data).<sup>17</sup> The ADHS 2017–2018 reported that 2% of children under the age of 5 years experienced symptoms of acute respiratory infection in the two weeks before the survey; 82% received advice or treatment.

The “child care” section of the Basic package of services in primary health care (revised version) sets out management of the main childhood diseases, including respiratory conditions. It includes national clinical protocols and mentions Integrated management of childhood illnesses – the WHO strategy to reduce under-5 mortality. Available standards are listed but these are preventive or promotive. The final point mentions “national paediatrician protocols” but does not give specific details. Promotion and follow-up of the infant’s health 0–28 days after birth is included and is consistent with WHO recommendations.

A primary health care centre visited had 2014 guidelines (supported by UNICEF) on growth and development for children aged 0–6 years available. It was unclear what clinical guidelines were used for paediatric visits at the primary health care and hospital levels. Several respondents mentioned using guidelines available on the Ministry of Health and Social Protection’s website, but these were for specific conditions, such as type 1 diabetes mellitus, epilepsy and Crohn’s disease, and not for common paediatric conditions.

In the framework of the WHO maternal, newborn and child health project in Albania (2009–2012), and following recommendations from a WHO paediatric hospital quality of care assessment, a national working group developed 29 paediatric and seven neonatal protocols according to international standards on the most frequently seen conditions. These protocols could not be accessed during the visit, however. The WHO Pocketbook of hospital care for children has not been implemented in Albania, although was translated in Kosovo (in accordance with Security Council resolution 1244 (1999)), where the language is almost the same. The WHO Country Office in Albania received a number of copies, which were distributed among paediatricians. The assessment team was told that clinical guidelines for paediatrics are prepared by the Paediatric Society, using materials available on the Internet, including the “UpToDate” application. The team was unable to validate this information, and no rigorous structure is in place to regulate clinical guidelines and protocols development. Integrated management of childhood illnesses was not implemented in Albania following the pilot phase, reportedly due to unsuitability for the country context and epidemiology.

### **Service delivery**

In urban areas, well child visits are conducted by well child paediatricians or doctors with some paediatric experience. If the child is sick they have to go to another facility or different area of the facility to be assessed.

Regional hospital representatives reported that bronchiolitis, pneumonia and gastroenteritis were the most common reasons for admissions. Children with pneumonia were generally managed with ampicillin and at times

<sup>17</sup> Levels and trends in child mortality report 2018: estimates developed by the UN Inter-agency Group for Child Mortality Estimation. New York: United Nations; 2018 (<https://www.un.org/en/development/desa/population/publications/mortality/child-mortality-report-2018.asp>, accessed 4 July 2019).

third-generation cephalosporins. Oxygen was usually available from a central source, and chest X-rays could be accessed 24 hours a day, 7 day a week. There was no shortage of antibiotics, but salbutamol for nebulizers may not be available in hospitals, according to information from key informants, so families may be asked to purchase it from pharmacies. There was no paediatric surgeon, so simple surgical cases – including appendicitis in young children – were referred to Tirana. The key informants reported no standard treatment guidelines at the regional hospital and stated that the prescribed treatment depended on the doctor’s assessment of the patient, based on their historical knowledge. It was not clear whether doctors were participating in continuous medical education. A paediatric cardiologist was available but no paediatric echocardiogram facilities, and children with cardiac problems were referred to Tirana. Emergency paediatric care was reported as a problem, with no training in this area. The regional hospital had no designated paediatric emergency area or emergency equipment ready for use for children.

During the regional hospital visit, children with respiratory conditions were admitted that could have been managed at home. Parents’ expectation is that even minor illnesses in children should be treated with strong medication and intravenous fluids, and that the child should be admitted, so families frequently present directly to hospitals for treatment rather than visiting family doctors first, who would otherwise act as gatekeepers.

Table 12 sets out a summary of the assessment’s findings on case management of common childhood conditions.

**Table 12. Summary of findings on case management of common childhood conditions**

Attributes	Rating	Criteria for rating
Protocols and legislation	Considerable need for improvement	National protocols developed in 2012, but health professionals not aware or not using them, and protocols could not be accessed during the visit.
Scope of services	Considerable need for improvement	Non-evidence-based treatment for respiratory conditions is leading to antibiotic resistance and OOPs.
Population coverage	Some need for improvement	Services are available throughout the country, but children are overtreated for common childhood illnesses.
Quality of services	Some need for improvement	Use of unnecessary invasive treatments (such as intramuscular injections) and hospitalization of cases that could be safely managed as outpatient are both due to health provider practice and parents’ expectations.

# Policy recommendations

Albania has demonstrated willingness to move towards UHC by adopting health policies and financing strategies aimed at increasing coverage, reducing inequities and expanding financial protection, and has made progress. The health of women, children and adolescents is given high priority, expressed through the intended full coverage of health services to pregnant women, women in delivery and postpartum and children aged 0–18 years.

At a policy level, Albania has set priorities and attempted to reorganize the health system to fulfil its commitments. The most critical challenge remains implementation of the existing laws, regulations, protocols and standards, as well as financial protection mechanisms. Not all SRMNCAH services are in fact provided free of charge or with the adequate quality at the relevant level. This results in barriers to access to essential services, and some patients seek alternative ways of obtaining treatment and care in the private sector.

Albania has succeeded in increasing utilization of primary health care through the introduction of a national preventive check-up programme.<sup>18</sup> The issue of increasing insurance coverage needs to be reviewed in the context of the broader health system. Finding savings and efficiency gains in service organization, delivery and financing will be crucial to ensuring greater coverage of SRMNCAH while maintaining the quality of the services provided. The recommendations proposed below are intended to provide the basis for policy changes and implementation arrangements along the essential pillars of UHC, with a focus on SRMNCAH.

## Strengthening governance, health literacy and multisectoral action

Albania has health policies and financing strategies to move towards UHC for SRMNCAH, but implementation requires strong leadership and governance to ensure that services reach the most vulnerable groups. Low government expenditure on health as proportion of total government expenditure illustrates that priorities have not been placed sufficiently on health. As a consequence, OOPs for health are high and the population faces direct informal payments at facilities. A health workforce supported and protected by high levels of government is essential for steady economic growth and adequate SRMNCAH services.

The assessment team recommends the following.

- SRMNCAH should be made a government priority, reflected in adequate funding for high-quality services. Policies should ensure access to services according to international standards, regardless of ability to pay.
- Legislation should be reviewed in relation to the legal age of consent to allow adolescents formalized legal access to autonomous, confidential, non-judgemental and appropriate health services, based on their ability to make informed decisions without parental consent.
- Measures should be put in place to reduce informal payments for health services and to ensure that the services included in the CHIF benefit package can realistically be financed by the premium and delivered to all who are insured. Measures should also be put in place to protect those unable to pay for health insurance.
- Work with the educational sector should be undertaken to introduce health literacy programmes (including information on access to contraception, sex education and promotion of early detection of cervical cancer) and to develop initiatives with the aim of obtaining full coverage, including of the most vulnerable population groups.
- Multisectoral collaboration in the area of SRMNCAH should be analysed, with the aim of identifying and optimizing the most important entry points for action, such as sex education and prevention of and response to gender-based violence.

<sup>18</sup> Primary health care in Albania: rapid assessment. Copenhagen: WHO Regional Office for Europe; 2018 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0011/373718/alb-phc-ra-eng.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0011/373718/alb-phc-ra-eng.pdf?ua=1), accessed 9 July 2019).

- Current accountability mechanisms should be reviewed and areas for improvement identified, including for joint action and monitoring across sectors.
- Rights-based approaches to health, achieving equity and “leaving no one behind” should become an explicit objective for all SRMNCAH policies, implementation and monitoring/evaluation activities. This would include:
  - involving a broad range of partners within and outside government, including representatives of the populations concerned, in the formulation of strategies and action plans to provide services to population groups with specific needs;
  - setting policy targets for closing equity gaps – for example, between geographical areas and population groups – presenting all SRMNCAH data disaggregated for sex, age, geographical location, ethnicity and wealth and monitoring the data over time to ascertain that equity gaps are closing;
  - targeting SRMNCAH services to population groups with specific needs, including people with lower socioeconomic status and other vulnerable, disadvantaged and hard-to-reach groups, and ensuring that the services are provided free of charge and made accessible.

## **Orienting health financing to improve support**

Albania spends less than the European and central Asian average on health. Total government expenditure on health (9–10%) is lower than the average share for upper-middle-income countries estimated by the World Bank (12%). With limited resources, CHIF covers the entire population with an extensive package of services, but in reality it is difficult to estimate exact coverage, and high OOPs show that some services are not provided for free, even for those insured. This also applies to SRMNCAH services.

To improve the financial protection and effectiveness of CHIF, the assessment team recommends that Albania should develop a more targeted programme.

- Currently, the entire population is entitled to compulsory health insurance. To be able to use available resources more effectively, the country should move to a targeted, selective scheme, where population groups most vulnerable to financial risks – unemployed people, pensioners, people living below the poverty line, women, children and adolescents – will benefit most from the government-funded insurance scheme.
- Services included in CHIF should reflect the current epidemiological situation in the country.
- An extensive costing exercise should be performed to estimate the realistic basis for the CHIF budget development process.

These recommendations should be viewed as a short-term strategy to improve coverage and reduce OOPs.

Financing mechanisms in Albania are fragmented and complicated. This makes it difficult to track expenditure. Key informants mentioned the existence of informal payments, which are difficult to quantify. The country is planning to implement the System of Health Accounts 2011.

- To be able to track expenditure by source, Albania should institutionalize and systematically implement the Health Accounts. This will allow efficient management of available resources for health care.
- A high share of OOPs compromises the financial protection of the population. In rural areas, costs related to travel to health facilities in particular, coupled with potential cost for services that are not available in the public sector, prevent the population from accessing health facilities. These are assumptions, because there is no exact information on what drives OOPs, so it is important to analyse this issue further.

- High OOPs are an indication that not only uninsured people but also those who are involved in the scheme face direct formal and informal payments at facilities. To improve this situation, pooling mechanisms should be reviewed and a more efficient mechanism chosen.

## **Strengthening human resources for SRMNCAH service provision**

Albania is experiencing a shortage of specialized human resources, particularly doctors, as many are leaving the country and fewer young people are choosing to enter the medical profession. Although the country has an understanding of the causes, a comprehensive human resources strategy to address the problem has not yet been developed. Health workforce development to provide high-quality services and implement policies is an essential health system component, which goes beyond SRMNCAH issues.

The assessment team recommends the following.

- The role of family doctors in providing SRMNCAH should be reviewed and strengthened. This would include an assessment of:
  - skills, competencies, training and supervision/mentoring needs;
  - professional development related to re-certification;
  - incentives for working in rural areas (accommodation, education for children, professional development);
  - incentives/disincentives for providing a core package of SRMNCAH services, since referral is currently the “easy” choice;
  - other factors that may undermine the perception of family doctors and their competencies, and the roles of specialists versus generalists.
- The Ministry of Health and Social Protection’s proposed strategic approaches to the lack of specialists in districts should be reviewed. In addition to existing support mechanisms (which include additional material support and the patronage system), medical staff should receive the support and protection required during public discussions of cases.
- The norms and need for staffing in the area of SRMNCAH at the hospital level should be reviewed, using data from the health management information system, considering the many patients with ambulatory-sensitive conditions that continue to be treated as inpatients, leading to over-hospitalization.

## **Developing a more effective service delivery model, improving coordination between providers and strengthening evidence-based practice**

A wide number of protocols have been developed through consultative processes and based on evidence and international guidelines in the area of SRMNCAH. Despite this, however, significant gaps remain, particularly in the management of common childhood conditions and adolescent health. No national structure is in place to develop and regulate clinical guidelines and protocols. Over-hospitalization of patients with ambulatory care-sensitive conditions, which could be treated better and more efficiently at the outpatient level, is a major challenge. At the primary health care level, services are often fragmented, resulting in multiple referrals.

The assessment team recommends the following.

- Evidence-based guidelines and protocols for all levels, including guidance on when to admit and refer patients to hospital, should be developed and followed, and measures put in place for their re-enforcement at both the primary health care and hospital levels.

- Self-referrals to hospital should be addressed by strengthening the quality of care at the primary health care level and enabling the gatekeeping function of family doctors. Measures should be put in place that do not allow patients to go directly to hospital for minor conditions that could be better managed at the primary health care level.
- Purchasing and payment mechanisms should be reviewed, with the aim of incentivizing more effective service delivery at the primary health care level and avoidance of unnecessary hospitalization.
- The system for referral of sick neonates should be reviewed and strengthened, ensuring that waiting times for transport are reduced and that equipment for transportation is up to date.
- Access to high-quality comprehensive sexual and reproductive health services at the primary care level should be strengthened, as core issues should be diagnosed and treated at that level. For example, the system for STI treatment should be reviewed in the light of advances in rapid tests moving towards testing and treatment at the point of care, with the aim of avoiding multiple referrals and fragmentation.

## Essential medicines and health products

The LRD is extensive, but regulations regarding medical devices and criteria for their inclusion are lacking.

The assessment team recommends the following.

- The LRD should be reduced to help save resources by:
  - using the WHO essential drug list as a basis for it;
  - standardizing and unifying treatment guidelines and protocols.
- Developing criteria for inclusion of medical devices in the LRD would assist in controlling what medical devices are introduced and used, in addition to facilitating more efficient resource spending on equipment.
- The introduction of point-of-care testing for STI diagnostics, urine tests and haemoglobin should be considered at the primary health care level.
- Facilities should have a stock of tests and reagents that are essential to fulfil the obligations included in the CHIF service package.





## The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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