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PERFORMANCE EVALUATION OF THE ENABLING EQUITABLE HEALTH REFORM PROJECT

FINAL REPORT

JUNE 2014

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ACRONYMS

ADHS	Albanian Demographic and Health Survey
BCC	Behavior change and communication
COP	Chief of Party
EEHR	Enabling Equitable Health Reform (USAID-funded project)
GoA	Government of Albania
HA	Health Authorities
HCs	Health Centers
HII	Health Insurance Institute
HIS	Health/Hospital Information System
HRISG	Health Reform Implementation Support Group
INSTAT	National Institute of Statistics
IPH	Institute of Public Health
KII	Key informant interview
M&E	Monitoring and evaluation
MCH	Maternal and child health
MoH	Ministry of Health
MoLG&D	Ministry of Local Government and Decentralization
NCCE	National Center of Continuing Education
NCQSA	National Centre of Quality, Safety and Accreditation
PBMP	Performance Based Management Plan
PHC	Primary Health Care
PHRplus	Partners for Health Reform plus (USAID-funded project)
PPC	Progress per Civilizim
SOW	Scope of Work
TA	Technical assistance
TFR	Total fertility rate
TQM	Total Quality Management
USAID	United States Agency for International Development
USG	US Government
WHO	World Health Organization

EXECUTIVE SUMMARY

Although there have been many barriers to health sector reforms in Albania, the government has charted a course that includes a single payer system, operated by the Health Insurance Institute (HII), and the separation of the provision of health services from the financing of health services, through HII. By 1995, HII had become a major funder of doctor salaries as well as drugs for primary health care (PHC) services. Beginning in 1998, as part of the government's decentralization initiative, the Ministry of Local Government and Decentralization channeled budgets for operating and maintenance costs of PHC facilities (previously funded by the Ministry of Health) through block grants to local governments, which then determined how much was allocated to PHCs.

Steady progress has been made in health sector reform during the past 20 years, though, many challenges remain. These include: lack of political consensus around the development and/or implementation of policies; chronic underfunding of the health sector; difficulty in enforcing universal participation in the HII system; corruption in the form of "informal" out-of-pocket fees and procurement of commodities; frequently changing institutional leadership with many political appointees, including hospital directors and, consequently, hospital staff; the greater complexity of the hospital sector compared with PHC; and other many other exogenous factors.

Beginning in 2000, USAID planned and funded a series of technical assistance (TA) projects in the health sector, including: a) Partners for Health Reform Plus (PHR plus) which provided technical assistance to the Government of Albania (GoA) from 2001 to 2005 in the design and implementation of a subset of the GoA's health sector reform strategy plans, focused on strengthening the PHC sector; and, b) PRO Shëndetit which developed a basic package of services at PHC centers that was adopted nationwide, and now serves as a basis for funding of PHC by the HII. During this period, USAID also supported family planning initiatives, including behavior change communication (BCC) through the C-Change project and improvement of post-partum and post-abortion care through the ACCESS-FP project.

Both prior to and following the completion of the PRO Shëndetit project, USAID worked on the design of another flagship project for the health sector. The Health Sector Review that supported the design of the new project observed that returns on investment in the Albanian PHC system were beginning to decline for USAID, and that another approach, would be:

> "to target USAID assistance … on efforts to assist the GoA implement its own health reform agenda. … That ambitious agenda includes a wide array of strategies, policies, laws and regulations which, if enacted and implemented, would affect significant and lasting improvement in the quality and responsiveness of the Albanian health care delivery system. Yet, despite years of discussion, debate and donor exhortation, virtually none of those nominal reforms have been finalized and implemented."

This planning work came to fruition in the Enabling Equitable Health Reform (EEHR) Project, awarded to Abt Associates in September 2010. Phase I of the contract was allotted up to two years, and was envisioned as the period "to help narrow the health reform agenda to a feasible set of priority actions that will likely have the greatest impact nationally." Based on this feasible set of priority actions, the main objective of Phase II was "to use the produced tools and mechanisms in designated pilot region(s) field testing this way the defined feasible set of priority reform actions and b) to produce evidence to guide national implementation of health reforms". However, a joint decision was made by USAID and EEHR staff to shift the focus of Phase II to practical interventions that could be piloted as a set of reforms in the *hospital* sector rather than the broader *regional* scope with subsequent evidence limited to a sector rather than an agenda of overall

national health reform. Beginning in early 2012, EEHR began to implement a set of activities focused on the hospital sector in three pilot hospitals that, in part, paralleled earlier strategies employed in the PHC sector.

USAID commissioned a performance evaluation after slightly more than three years of EEHR being implemented. To fully complete the analysis for this performance review, two evaluation teams were fielded. The first team conducted fieldwork in Albania from November 4 to November 19, 2013. The second team conducted additional key informant interviews (KIIs) from March 31 – April 4, 2014. Prior to beginning fieldwork, the evaluation teams reviewed a variety of background materials, and then following the initial in-country meetings with USAID and EEHR staff, the first evaluation team held in-depth interviews with key stakeholders at the Ministry of Health; Health Insurance Institute; National Center of Quality, Safety and Accreditation of Health Institutions; National Center of Continuing Education; World Health Organization (WHO); and the World Bank. The team made site visits to the three pilot hospitals and held 19 focus group discussions or interviews with 73 stakeholders from the hospitals as well as regional offices of the Public Health Institute and HII. The second evaluation team focused on interviewing USAID staff, EEHR project staff, and members of the Health Reform Implementation Support Group (HRISG).

The teams based their data collection and development of subsequent semi-structured interview guides on the following five evaluation questions, per the SOW:

> 1) To what extent have EEHR activities resulted in removing key barrier/obstacles to the health reform process?
>
> 2) How successful was the project in producing tools and mechanisms that are tested as successful in pilot regional hospitals?
>
> 3) Based on the perception of outside stakeholders, do the selected regional hospitals have better performance as a result of the approaches and implemented activities, than they otherwise would have had?
>
> 4) How successful was the contractor in designing and implementing the small grants program?
>
> 5) What were the challenges (internal and external) faced by the program and lessons learned?

Similar to most evaluations that are conducted well after activities have been implemented, this evaluation may be limited by recall bias. Additionally, interviewees may self-select by either making themselves available for interviews or in the amount of time they allot for the interview. Further, the main approach for this evaluation was qualitative and the full capture and analysis of qualitative data is difficult. Finally, it should be noted that by the time that the second evaluation team was fielded, a decision had been made to end the project earlier than originally anticipated. This knowledge may have influenced the final group of interviewees (primarily USAID and EEHR staff) in their responses to the evaluation questions. It is believed by the evaluation teams, though, that the robustness of the various methods employed will allow the team to present solid findings, conclusions, and recommendations.

The main findings and conclusions from this evaluation are that EEHR has had limited impact in removing key barriers/obstacles in the health reform process and most of the project's success should be measured by the activities done at the pilot hospital level. However, the sustainability of the management and technical changes done at the pilots is questionable given the potential turnover in hospital leadership (hospital directors are political appointees). While almost all key informants were unanimous in that the pilot hospitals were the project's key success, the findings and conclusions for the small grants program point to it being the weakest component of EEHR. Only approximately 10% of the original budgeted amount of $400,000 will be expended by the time of the project's closure. Compounding the technical challenges that the project faced were additional management challenges with all stakeholders. During the life of the project, there were six individuals who served either as a temporary, acting or permanent EEHR Chief of Party, four Ministers of Health, and an uncertainty on the part of USAID, per key informant interviews, whether it had a

shared vision of EEHR with project staff and, similarly, how the project's success should be measured. Finally, it should be noted, that to definitively determine the answers to some of the evaluation's questions, primarily those aimed at better understanding the outcomes at the pilot hospitals, additional methods should be utilized, including facility-based and patient/client satisfaction surveys.

Currently, there is a World Bank project in its initial phase of feasibility and scoping studies and, if possible, USAID and EEHR staff should collaborate with the World Bank on the design of its new project and consider how initiatives undertaken or planned during Phase II of EEHR might be sustained as potential catalysts and models for reform in Albania's health sector. Further, any relevant research which was conducted as part of Phase I of EEHR should be shared freely with the World Bank. During the few remaining months of the project, no new programmatic initiatives should be undertaken. Ongoing initiatives should be reinforced so that they are more likely be sustained. New initiatives, especially those for which plans have been made, should be suggested for the World Bank health sector project design. USAID might also consider avenues for sustaining the local capacity for technical assistance that has been developed which itself builds on previous USAID projects, through supporting the possible creation of a local NGO that houses the existing capacity, or through other mechanisms that might sustain the capacity in some institutional form. Finally, while the Project was noted for building the local counterpart capacity in monitoring and evaluation, its internal level of M&E requirements was set quite low. Had additional resources been dedicated to measurements at the higher outcome level, perhaps, stronger findings conclusions, and recommendations would be forthcoming from any external evaluations conducted.

BACKGROUND & OVERVIEW

In the early- to mid-1990s, Albania entered a new phase of political and social change. It transitioned from a totalitarian to a democratic system and shifted gradually to a free market economy, a process that contributed to changes in various demographic and health characteristics throughout the country. During the next two decades, the total fertility rate (TFR) fell to 1.6 births per woman, a rate consistent with surrounding countries. While the contraceptive prevalence rate rose to 69 percent, the use of modern methods remained at only 11%. Antenatal and delivery care by a trained provider achieved more than 98 percent coverage and 95 percent of children aged 18-29 months were fully vaccinated. Other important child survival indicators improved, including nutritional status and low levels of anemia for both children and women (ADHS 2010).

Albania's strategies in developing its health sector have aligned more with those of Western Europe than with the United States, the one Western nation with a health system run primarily through the private sector. Although there have been many barriers to health sector reforms in Albania, the government has charted a course that includes a single payer system, operated by the Health Insurance Institute (HII), and the separation of the provision of health services from the financing of health services, through HII.

During the 1990s, the Albanian health system went through organizational and budgetary changes that shifted important roles to relatively new agencies. By 1995, HII had become a major funder of doctor salaries as well as drugs for primary health care (PHC) services. Beginning in 1998, as part of the government's decentralization initiative, the Ministry of Local Government and Decentralization (MoLG&D) channeled budgets for operating and maintenance costs of PHC facilities (previously funded by the Ministry of Health) through block grants to local governments, which then determined how much was allocated to PHCs (Fairbank and Gaumer, 2003).

Although steady progress has been made in health sector reform during the past 20 years, particularly in primary health care, many challenges remain. These include: lack of political consensus around the development and/or implementation of policies; chronic underfunding of the health sector; difficulty in enforcing universal participation in the HII system (especially within the informal labor market); corruption in the form of "informal" out-of-pocket fees and procurement of commodities; frequently changing institutional leadership with many political appointees, including hospital directors and, consequently, hospital staff; the greater complexity of the hospital sector compared with PHC; and other many other exogenous factors.

USAID SUPPORT TO THE ALBANIAN HEALTH SECTOR

While these changes in Albania's health sector were taking place, USAID and other donors partnered with the Government of Albania (GoA) to rehabilitate and re-equip many health facilities that had been damaged during the civil unrest earlier in the 1990s. Beginning in 2000, USAID planned and funded a series of technical assistance (TA) projects in the health sector.

The USAID-funded Partners for Health Reform Plus (PHR plus) provided technical assistance to the Government of Albania (GoA) from 2001 to 2005 in the design and implementation of a subset of the GoA's health sector reform strategy plans, focused on strengthening the PHC sector. An integrated PHC service delivery model was designed, implemented, and evaluated in two districts to inform national health policy and to be replicated on a wider scale. The model integrated five major components: (1) family medicine training for PHC providers; (2) a facility-based health information system; (3) service-delivery reorganization and quality improvement; (4) financing reforms; and (5) community involvement. The model addressed the low quality of PHC services, lack of any data on PHC patients or costs, the bypassing of PHC clinics for specialty polyclinics or hospitals, fragmented financing and management of PHC, and the absence of community involvement (Cook et al., 2005).

This earlier work in PHC was built upon and reinforced by the USAID flagship project PRO Shëndetit. PRO Shëndetit provided a foundation for the World Bank's "Albania Health Sector Modernization" Project, which required GoA adoption of several tools and interventions developed under the PRO Shëndetit project as pre-conditions for World Bank assistance. PRO Shëndetit developed a basic package of services at PHC centers that was adopted nationwide, and now serves as a basis for funding of PHC by the HII. This approach provided a model for the MoH and HII to establish a comparable "basic services package" of care for hospitals. PRO Shëndetit also worked to turn GoA Health Centers (HCs) into autonomous facilities responsible for the delivery of PHC services to the population based on contracts executed between the HCs and the HII. PRO Shëndetit also developed and installed a pilot Health Information System (HIS) in five regions that is now in use nationwide, and it serves as the primary basis for HII reimbursement to HCs and pharmacies for services and drugs, respectively. During this period, USAID also supported family planning initiatives, including behavior change communication (BCC) through the C-Change project, managed out of Washington, D.C. (USAID/W), and improvement of post-partum and post-abortion care through the ACCESS-FP project, also managed by USAID/W (Bowers and Johnson, 2010).

Both prior to and following the completion of the PRO Shëndetit project which ended in September 2009, USAID worked on the design of another flagship project for the health sector. The Health Sector Review that supported the design of the new project observed that returns on investment in the Albanian PHC system were beginning to decline for USAID, and that another approach, which the review proposed and was "endorsed by the leadership of the MoH and HII", would be:

> "to target USAID assistance … on efforts to assist the GoA implement its own health reform agenda. … That ambitious agenda includes a wide array of strategies, policies, laws and regulations which, if enacted and implemented, would affect significant and lasting improvement in the quality and responsiveness of the Albanian health care delivery system. Yet, despite years of discussion, debate and donor exhortation, virtually none of those nominal reforms have been finalized and implemented."

The review proposed that the USAID assistance strategy take on the tasks left undone by the GoA (Bowers and Johnson, 2010). This planning work came to fruition in the Enabling Equitable Health Reform (EEHR) Project, awarded to Abt Associates in September 2010. The original contract noted some of the challenges that EEHR would face:

> "The Contractor will convert ambitious but unrealistic and unfunded reform mandates into action plans supported by key stakeholders.… The Contractor shall provide technical assistance to overcome a number of complex factors that have hampered progress including: institutional and political rivalries, lack of transparency and accountability, diffusion of responsibility, lack of reliable data, and relative absence of evidenced-based integration of lessons learned in strategic and action planning.…The Contractor shall provide technical assistance to promote inter-agency cooperation in strategic and operational planning in order to advance the reform agenda. The communication barriers between institutional silos will be lowered, enabling collective efforts to address priorities, identify sequential actions with timetables, resources, and ensure participation of stakeholders" (USAID, 2010).

Phase I of the contract was allotted up to two years, and was envisioned as the period "to help narrow the health reform agenda to a feasible set of priority actions that will likely have the greatest impact nationally." Based on this feasible set of priority actions, the main objective of Phase II was "to use the produced tools and mechanisms in designated pilot region(s) field testing this way the defined feasible set of priority reform actions and b) to produce evidence to guide national implementation of health reforms". However, a joint decision was made by USAID and EEHR staff to shift the focus of Phase II to practical interventions that could be piloted as a set of reforms in the *hospital* sector rather than the broader *regional* scope with subsequent evidence limited to a sector rather than an agenda of overall national health reform. Beginning in early 2012, EEHR began to implement a set of activities focused on the hospital sector in three pilot hospi-

tals that, in part, paralleled earlier strategies employed in the PHC sector. The three hospitals chosen through a consultative process and assessment were Queen Geraldine Maternity Hospital (Tirana), Korca Regional Hospital, and Lezha Regional Hospital.

METHODOLOGY

To fully complete the analysis for this performance review, two evaluation teams were fielded. The first team conducted fieldwork in Albania from November 4 to November 19, 2013. The second team conducted additional key informant interviews (KIIs) from March 31 to April 4, 2014. During both periods of fieldwork, the teams held in-briefs and out-briefs with USAID with the first team having additional meetings with USAID staff at approximately the mid-point of the field work.

Per the Task Order's Statement of Work (SOW), a detailed work plan was submitted to USAID as part of the original proposal. The work plan included the evaluation's methodology and activities, an illustrative list of individuals and organizations the evaluation teams planned to interview, along with a preliminary schedule. Prior to beginning fieldwork, the evaluation teams reviewed a variety of background materials, including reports on the Albanian health sector, previous USAID projects in the sector, project documents, and other documents produced by EEHR.

Following the initial meetings with USAID and EEHR staff, the first evaluation team held in-depth interviews with 19 key stakeholders at the Ministry of Health; Health Insurance Institute; National Center of Quality, Safety and Accreditation of Health Institutions; National Center of Continuing Education; World Health Organization (WHO); and the World Bank. The team made site visits to the three pilot hospitals and held 19 focus group discussions or interviews with 73 stakeholders from the hospitals as well as regional offices of the Public Health Institute and HII.

A full listing of focus group members is given in *Annex E: Individuals Contacted* under Korca Regional Hospital, Lezha Regional Hospital, and Queen Geraldine Maternity Hospital. In general, focus groups were comprised of hospital senior administration, department heads, physicians and other care providers, and representatives from relevant departments (human resources, environmental services, infection control, and monitoring and evaluation). The evaluation team's local member also participated in one of the teleconference sessions that the project organized between the three hospitals. The second evaluation team focused on interviewing four members of USAID staff, EEHR project staff, and members of the Health Reform Implementation Support Group (HRISG).

The teams based their data collection and development of subsequent semi-structured interview guides[1] on the following five evaluation questions, per the SOW:

1) To what extent have EEHR activities resulted in removing key barrier/obstacles to the health reform process?

2) How successful was the project in producing tools and mechanisms that are tested as successful in pilot regional hospitals?

3) Based on the perception of outside stakeholders, do the selected regional hospitals have better performance as a result of the approaches and implemented activities, than they otherwise would have had?

4) How successful was the contractor in designing and implementing the small grants program?

5) What were the challenges (internal and external) faced by the program and lessons learned?

[1] The original question matrix from the evaluation work plan is included in Annex B.

Both teams were careful not to prompt or lead interviewees to specific opinions or conclusions. Though interviews were structured around the five evaluation questions, if subjects raised an issue or topic that was outside the interview guide, the teams would probe the subject matter further and during the interviews would ask if there were any particular topics not covered during structured portion. For external interviews, no USAID or EEHR staff members were present for any of the interviews or focus group discussions. USAID and EEHR staff were interviewed individually to avoid any influence that might have occurred due to lines of reporting.

The evaluation teams cross-checked what was heard, read, or observed to ensure consistency and accuracy of fact finding. The teams considered preliminary findings and, when needed, requested additional information or confirmation of interpretations. As with any primarily qualitative evaluation, the teams' methodology relied on the experience and training of evaluation team members for the analysis and interpretation of findings. After all data collection was complete, the teams reviewed and synthesized their findings, drew conclusions, and made recommendations based on the findings and conclusions.

LIMITATIONS

Similar to most evaluations that are conducted well after activities have been implemented, this evaluation may be limited by recall bias. In other words, EEHR was awarded in September 2010 and began activities shortly thereafter. The first team was fielded more than three years later and the second team began interviews approximately three and a half years after the project's start. This lag may influence how well interviewees can recall certain events and activities and result in either a positive or negative bias. Additionally, interviewees may self-select by either making themselves available for interviews or in the amount of time they allot for the interview. Persons with stronger vested interests in the results of the evaluation (either negatively or positively) may spend more time with the interviewers to ensure that the evaluation results skew in their favor. As noted previously, the main approach for this evaluation was qualitative and the full capture and analysis of qualitative data is difficult. Evaluation team members may fail to record important data for a variety of reasons and, subsequently, that data will not be part of the findings, conclusions, or recommendations. Finally, it should be noted that by the time that the second evaluation team was fielded, a decision had been made to end the project earlier than originally anticipated. This knowledge may have influenced the final group of interviewees (primarily USAID and EEHR staff) in their responses to the evaluation questions. Some of the limitations noted have been mitigated by the number and scope of interviews, focus groups, and use of available quantitative data, when available. It is believed by the evaluation teams that the robustness of these various methods will allow the team to present solid findings, conclusions, and recommendations.

FINDINGS AND CONCLUSIONS

EVALUATION QUESTION 1: To what extent have EEHR activities resulted in removing key barriers/obstacles to the health reform process?

FINDINGS

1) Staff from EEHR and USAID interviewed as key informants were unanimous that EEHR activities had and would have limited effect in removing key barriers/obstacles in the national health reform process; though, the activities implemented within the pilot hospitals could serve as focal points for technical and managerial lessons learned in moving the reform process forward within the hospital sector. However, none of the KIIs were certain whether the changes instituted at the hospital level would be sustainable after the project's end date. The most cited reason for doubting the sustainability of the hospital-level changes was because hospital directors are political appointees and there has been and, most likely, will continue to be frequent turnover in their positions. Thus, the probability that a succeeding director would support his or her predecessor's position on reform was unknown.

2) The Health Reform Implementation Support Group, a key body supported by EEHR and a potential structure which could continue to move the reform agenda forward, currently has high member turnover due to approximately 70% of its membership being GoA officials and subject to replacement by successive governments. Further, due to membership turnover and some members with little prior experience in the health sector, the capacity of HRISG members to address barriers and obstacles in the health reform process varies substantially.

3) EEHR did reach its Year 2 targets, per the Performance Based Monitoring Plan (PBMP), of: a) having two of the HRISG decisions enacted; b) producing a policy brief for the MoH based on HRISG recommendations; and, c) having three decisions, policies, and plans drafted with EEHR assistance.

4) By the second quarter of its third year of implementation (March 2013), EEHR had: a) the Hospital Board Bylaws approved for recommendation to the Minister of Health; b) begun preparations for the national roll-out of the human resources policies, tools for job descriptions, as well as, the new employee orientation; and, c) had approved the National Guidelines for Incident Reporting.

5) Responses by key informants regarding the usefulness of the research documents produced during Year 1 / Phase 1 in moving the health reform process forward were mixed. Some key informants believed that they helped focus EEHR project activities and generated new information while other respondents believed some of the research was repeating work previously completed. This "repeated" work included the general governance review, some of the monitoring and evaluation studies, and some of the special studies focused on identifying the socio-economic, health, and demographic characteristics of proposed project beneficiaries.

6) More than three-quarters of the EEHR, USAID and other key informants stated that the sharpening of the focus from the larger-scale goals as stated in the original SOW within the contract to a more specific set of objectives and activities was needed by the end of Year 1. This was in order to produce more tangible results (versus on-going formative research) to ensure constituency buy-in from all stakeholders, as well as, provide evidence for potential expansion of pilot efforts. It also necessitated some re-working of the Results Framework and PBMP. Specifically, as can be seen in Figures 1 (Year 1 Results Framework) and Figure 2 (Year 2 Results Framework) below, many of the lower level expected results have been reformulated to focus specifically on the hospital sector while the

third "intermediate result" (see far right branch) was rewritten to highlight the role of non-state actors participation in supporting the project's overall goal.

Figure 1: EEHR Results Framework (Year 1 Annual Report)

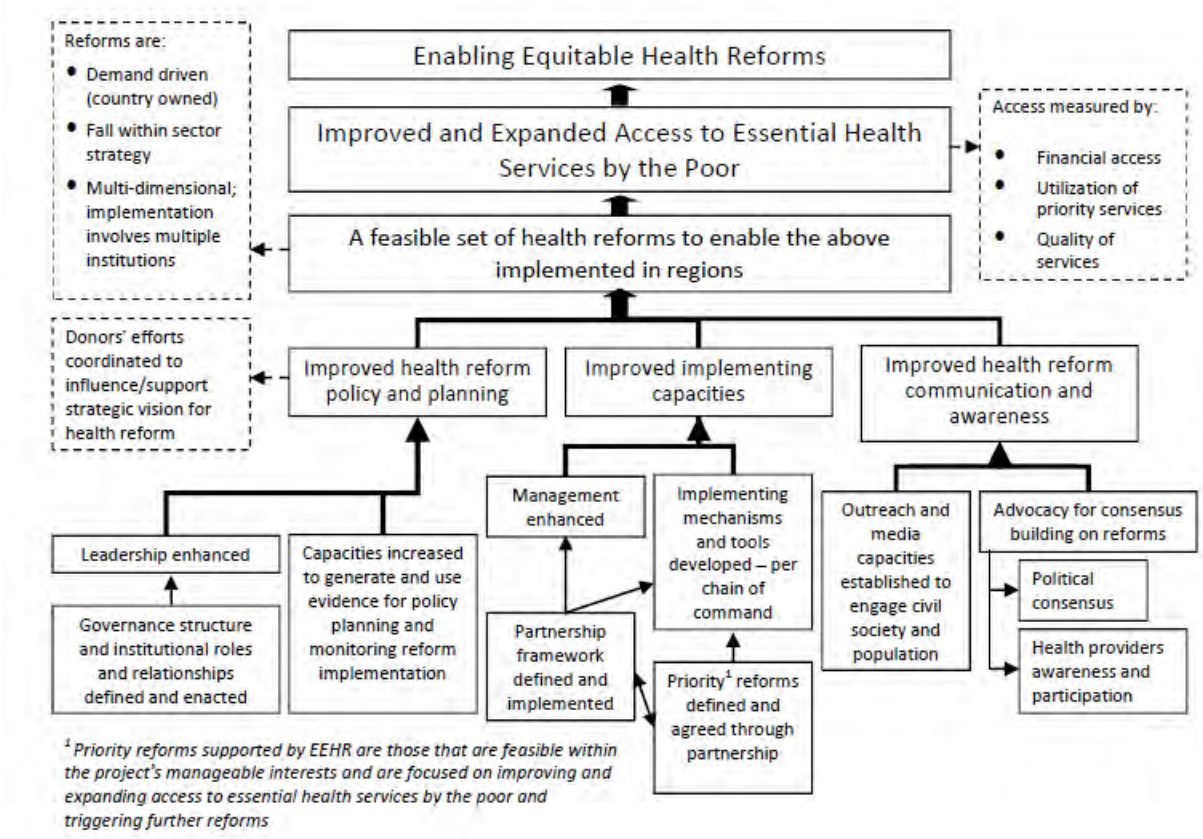
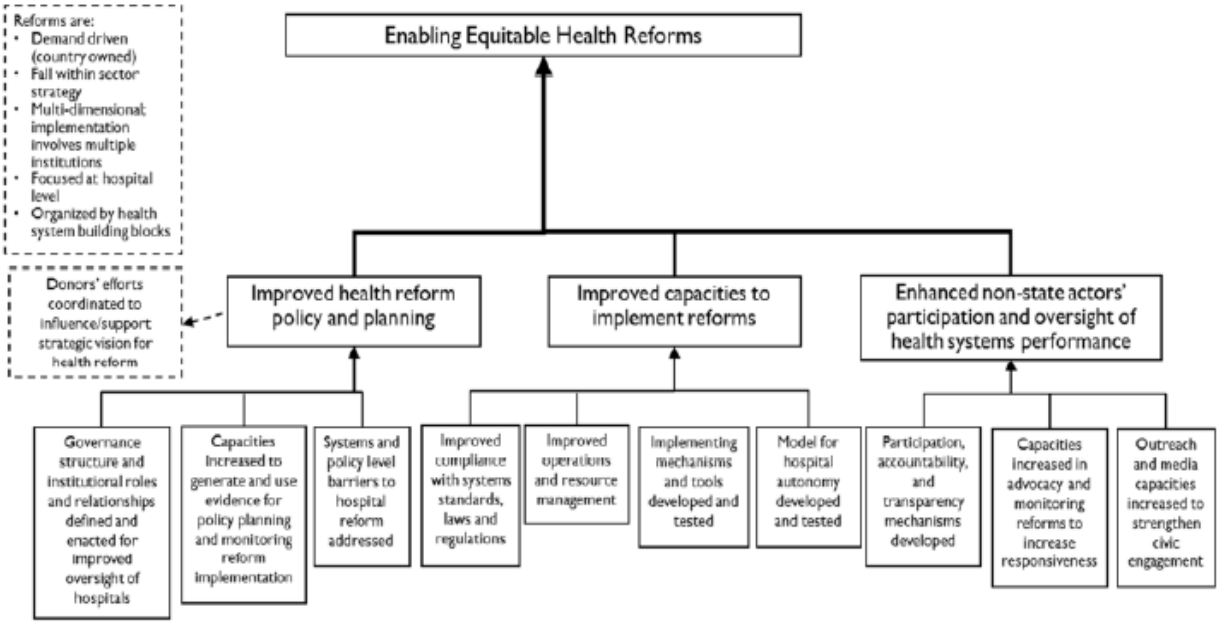


Figure 2: EEHR Results Framework (Year 2 Annual Report)



7) The project was able to at least partially address gender considerations both through the overall work it did at the three pilot hospitals, as well as, establishing working groups within the three pilot sites as shown in Table 1.

Table 1: Sex disaggregation of pilot hospital working groups and employees				
	Working Groups		Employees	
	Females	Males	Females	Males
Korca Regional Hospital	27	21	402	186
Lezha Regional Hospital	29	20	211	64
Tirana Maternity	29	11	322	50
Totals / Percent	85 (62%)	52 (38%)	935 (76%)	300 (24%)

8) Two consultants engaged in the development of the EEHR tools also worked on the World Bank health sector project, which should provide continuity between donor agency projects on one specific aspect of the health sector.

9) Per KIIs, all three pilot hospitals are sharing their experience and lessons learned through teleconference and live meetings arranged with support from the EEHR project.

CONCLUSIONS

EEHR has had a limited effect in removing key barriers/obstacles in the health reform process. The project was originally envisioned to have a much broader impact as described by the following statement in the contract SOW:

> "Specifically, the purpose of this project is to provide access to health services for the poor by a) helping remove the existing barriers and constraints to the reforms at the national level and b) field testing approaches and tools that define a feasible set of implementable reforms…".

Based on the key informant interviews conducted, these goals were more narrowly focused near the end of the first year of project implementation when both USAID and EEHR recognized that the original goals of large-scale national health reform might be too ambitious to be accomplished during the life of the project. Thus, while Phase 2, per the original SOW within the contract, did envision a narrowing of objectives, the focus on pilot hospitals was a more indirect approach to increasing access to health services for the poor and removing constraints to reforms at the national level.

Further, it is unclear whether any of the piloting activities (up to 11 different activities given in Question 2 below) done at the hospital level will be sustainable or rolled-out. Because of changes in GoA counterparts which effected individuals from the Minister of Health to the hospital director level, it is difficult to decisively conclude that there has been any true "country ownership" of the process. This was also reflected in the KII results in which no respondent could give a definitive answer about the project's sustainability.

Additionally, given changes in Ministry of Health leadership and varying levels of support for the project's health reform goals by GoA officials, a joint decision, according to the KIIs, was made to pilot tools and mechanisms at the regional/hospital level to examine whether these changes might serve as a broader catalyst of change similar to previous projects which had worked at the primary health care level. Per the Year 2 Annual Report PMP, as well as, the most recent Quarter Report (Q2, Year 3, March 2013) PBMP provided to the evaluation team, the project appeared to be on track in terms of meeting output level targets.
Finally, EEHR made considerable progress in addressing gender considerations as given in the contract's SOW which stated:

"To the greatest extent possible, the Contractor shall seek to include both men and women in all aspects of this program including participation in leadership in [e.g., meetings, trainings, etc.]."

As noted in Table 1 above, the majority of individuals with whom the project interacted at the hospital level, either via working groups or more generalized training were, indeed, female.

EVALUATION QUESTION 2: How successful was the project in producing tools and mechanisms that are successful in tests at pilot regional hospitals?

FINDINGS

1) Implementation of the various tools and mechanisms did not fully begin until April 2012; thus, it is likely too soon to fully assess whether they were successful in being fully adopted. Additionally, to fully confirm whether the tools and mechanisms were successful, additional information would need to be gathered via a client/patient satisfaction survey to ascertain whether the practices had any impact on the experience of the end-user of hospital services. While EEHR's PBMP and the hospital composite indicator contain several indicators to measure improved management practices within the pilot hospitals, the project did not include metrics to assess client/patient satisfaction with the new tools, mechanisms, and practices being implemented. Hospital staff feedback via focus groups about some of the tools as given in 6a (Improved human resources management) and 6c (Incident reporting) below point to improvements in, at least, management practices around patient care and a strengthened understanding of roles and responsibilities.

2) The process undertaken to design and implement the tools and mechanisms began with analysis and consultant reports developed by project staff and/or consultants, and culminated in customized operational tools (e.g., job descriptions, guidelines, manuals, etc.) and analysis (e.g., M&E and incident reporting) developed by local counterparts, with support from the project's staff and consultants. The project helped train members of these groups and engaged them in a learn-by-doing process to develop tools and mechanisms uniquely designed for their hospital setting, considering what was required and drawing on models of tools and mechanisms that had been developed for and used in other country contexts; thus, avoiding the duplication of efforts.

3) By the end of Year 2 of implementation, EEHR had produced four tools and/or mechanism exceeding its target of two, had engaged 81 persons at the pilot hospitals to implement proposed interventions exceeding its target of 15, and had provided training to 128 persons exceeding its target of 30. All of these targets, likewise, appear to have continued to have been exceeded in terms of actual results by the end of the second quarter in the third year of implementation (March 31, 2013). That these targets were greatly exceeded despite the on-going variations in project and MoH leadership can either be interpreted as a need to better set (higher) project targets or that at the output level project staff were able to continue implementation even with leadership challenges.

4) EEHR staff were unanimous in asserting that this part of the project was perceived as quite successful. Specifically, EEHR staff noted that the greatest achievement was a change in how hospital staff are working in teams, have more autonomy to make decisions, and that the silos between departments have been lowered. They also cited the improvement in environmental services (hospital cleanliness) which should lower nosocomial infections.

5) Likewise, the approximately 100 stakeholders interviewed either individually or in focus groups were nearly unanimous in indicating that this component was successful. A large number of stakeholders cited specifically the strengthening of M&E capacity and its ability to assist in lowering communication barriers between institutional silos in a constructive and strategic manner to encourage

evidence-based decision-making as a key outcome. During focus group sessions, stakeholders often stressed that the "mentality" of the staff or the culture within the pilot hospitals was changing.

6) Specific tools and mechanisms produced for piloting at the regional hospitals included:

   a. *Improved human resource management*: This involved the development of job descriptions, a system for performance review, and the introduction and utilization of identity badges. In some cases there were existing job descriptions for staff, but they were inaccurate. Having job descriptions was a legal requirement for all hospitals, but the requirement was theoretical - i.e., on paper but not enforced or implemented in practice. Staff members whose jobs were to be described were involved in the process, sometimes as the primary authors of the descriptions and sometimes through a review process. More than 70 job descriptions were developed at Korca Hospital, which had the largest number of staff (approximately 600). In parallel with the development or refinement of job descriptions, the project helped staff develop a system of performance review. This had been implemented in one regional hospital and was about to be implemented in the other at the time of the evaluation.

   b. *A training program in support of all interventions*: More than 2,000 credit hours of training were provided to 306 people over a period of 12 months, after which the project was fully launched into the implementation of the selected mechanisms and tools beginning in mid-2012. As shown in Table 2 below, almost all of the training was multidisciplinary, with physicians, nurses, and administrators involved.

Table 2: EEHR-Supported Trainings

National Center of Continuing Education

(Data on EEHR Project from NCCE)

306 people trained for a total of 2,057 credit hours

Title of Activity	CME Credits	Category and Number of Participants	Format
Planning and utilization of hospital space	10	25 Multidisciplinary	Workshop
Cost allocation in health care facilities	7	20 Multidisciplinary	Training
National Monitoring and Evaluation Capacity Building	15	25 Multidisciplinary	Training
Public Relations in healthcare institutions	12	28 Multidisiplinare	Seminar
Training of trainers on National Monitoring and Evaluation	7	13 Multidisciplinary	ToT
Management of Human Resources	5	25 Multidisciplinary	Training
Infection Control Committees – Roles and responsibilities	4	60 Multidisciplinary	Seminar
Quality Monitoring of Environmental Services	4	60 Multidisciplinary	Seminar
Use of ASTRAIA program	10	20 Specialists (physicians) + nurses	Training
Financing the hospitals and its impact	2	30 Multidisciplinary	Training

   c. *The introduction of incident reporting*: Incident reporting in hospitals is a variant of total quality management (TQM) in that the staff took ownership for identifying and analyzing the real or potential problems and developing solutions to those problems. Incident reporting was a formal obligation of the hospitals under MOH regulations, but it was with the

help of EEHR that the requirement was implemented. The form introduced for reporting incidents was approved by the MoH, and the MoH has distributed it to all hospitals and made it a requirement for hospitals throughout Albania. The focus group members described how they had to break down resistance from the staff because of the fear that reporting incidents (or potential incidents) generated and the tendency to feel that reporting incidents would result in blame or criticism of staff members. According to focus group members, the number of incidents reported monthly had been rising, indicating that the fear of reporting was going down.

d. *Better space allocation:* The project engaged an architect with expertise in hospitals to review the current configuration of the two regional hospitals and make recommendations for appropriate changes (Hoey 2012). This work resulted in plans to make changes in such things as consolidation of the storage areas for pharmaceuticals and creating one or more reception areas. For example, Lezha Hospital had four small pharmaceutical warehouses, which have now been consolidated into one, which allows more efficient management and the reduction of "leakage" of products.

e. *Improving visitor management*: This initiative encompassed behavior modification, not only for staff, but for the visitors from the general public. The reception areas were designed to provide an introduction or orientation for both patients being admitted and visitors, and a channel of communication with the public where people could be informed about visiting hours. In Lezha Hospital, visiting hours were established; visitors were informed about the new rules, and congestion had gradually been controlled or stopped. In the Queen Geraldina Maternity Hospital, magnetic cards are being provided to visitors and the hospital is not only limiting the visiting hours but the number of visitors allowed at any given time. The evaluation team could observe the difference in the Lezha Hospital because the ambulatory section of the hospital was still heavily congested, as visiting hours did not apply there.

f. *Environmental Services and Infection Control*: The pilot hospitals were each divided into three zones: high-risk for infection control, medium-risk, and low-risk. Different degrees of attention or different procedures for infection control were applied in the three different zones. A new human resources department for Environmental Services was created, and all cleaning staff members were assigned to this department rather than being assigned to a particular ward. Manuals were developed and staff members were trained in new procedures, from how to clean a toilet properly to how to dispose of biological or other high-risk waste. All aspects of this intervention were seen by hospital staff as very important in controlling nosocomial infection within the hospitals, in reducing other problems related to the hospital environment, and in giving cleaning staff a new sense of professionalism. However, there were also some limitations of funding for basic equipment and cleaning supplies that were practical barriers to full implementation.

g. *Developing better public relations*: EEHR supported work in customer and public relations. In addition to more traditional training, staff from the hospitals received training directly in the hotel industry, where the concept of customer relations is most relevant to hospitals. Hotel managers who provided the training came to visit the hospitals so as to have a better idea of what would be most relevant for hospital staff. Further, Lezha Hospital has created an informal board with 15 representatives from different organizations and districts in Lezha. This "Citizens' Advisory Panel" may be able to both improve public relations and also build the kind of platform that would support strong and active community involvement on a future hospital board. The hospital's website had also been made more functional with

support from EEHR, and the Lezha Hospital staff organized a fundraising event, which is not a normal practice in the MoH system.

h. *Cost accounting and payment mechanisms*: Although the hospitals have been involved with this aspect of EEHR's work, the discussion of this initiative and its ownership of it came primarily from staff working with the Health Insurance Institute. As with other interventions, the feedback from HII stakeholders was supported by EEHR documentation (Kenny 2013, three documents). If the project had proceeded further with this activity, such as defining and reaching formal agreement on a package of services to be reimbursed from HII and the payment mechanism to be utilized, then linking the services and costing via a Health Information System, could have led to improved performance in this area.

i. *Outsourcing of hotel and food services*: Both of the regional hospitals had outsourced laundry services, and both had done preliminary analysis and are planning to outsource meal services. Tirana's Queen Geraldina Maternity Hospital had outsourced both laundry and meal services and the hospital staff was pleased with the quality and cost of the outsourced services in comparison with the prior arrangement.

j. *Patient Medication Management and Pharmaceutical Supply*: The mini-warehouses for pharmaceuticals inside Lezha Hospital were consolidated and record-keeping for pharmaceuticals prescribed and dispensed to patients was introduced. EEHR has recently completed a technical report that analyzes the situation and provides clear recommendations that range from the consolidation and enforcement of treatment protocols in the hospitals, to adherence to regulations, to improved stock and inventory management in the hospitals, and finally to the financing and procurement of pharmaceuticals by HII (Li Bassi, 2013).

k. *Monitoring and Evaluation (M&E)*: M&E core working groups were created with EEHR support and the M&E Directorate within the MoH can now provide analysis and evidence that can be used to prioritize health sector efforts and better inform policy formulation. M&E reports are shared with all institutions, not just the MOH. In terms of the pilot hospitals, they are collaborating with the regional offices of the Public Health Institute and the Health Insurance Institute to improve and strengthen monitoring and evaluation at the regional level. The hospital-level M&E working groups came together to: (1) clarify and better define for their reporting purposes the indicators they collected; (2) eliminate duplication of reporting of the same indicators from the three different institutions; (3) consolidate the reporting of indicators into a single report submitted to the MoH Directorate of M&E at the central level; and (4) better analyze and report the data to the MoH. Each institution has responsibility for one section of the consolidated regional M&E report, but the three hospitals work collaboratively on the analysis and presentation of the report. This work has been actively supported by EEHR, including assistance with graphics and lay-out.

l. *MoH's M&E Directorate strengthening*: While not directly related to the activities done at the pilot hospitals, the MoH M&E Directorate has also been strengthened by the project. For the first time, this unit of the MoH has a clear mandate and is actively collaborating with other institutions at the central and regional level. The directorate is also serving as a secretariat for the HRISG.

CONCLUSIONS

Per both the objective measure of PBMP targets versus actual results (primarily output-level indicators) and key informant interviews, the development of tools and mechanisms for the pilot regional hospitals should be considered one of the more successful elements of EEHR. However, as noted previously, this statement

cannot be considered definitive as the various tools and mechanisms were only implemented two years prior to this evaluation and higher-level outcomes were not examined during this assignment nor were they tracked as part of the project's PBMP.

Similar to behavior change initiatives, the adoption of new practices via the development and introduction of tools would require dissemination of knowledge (usually via trainings), a change in attitude away from previous practices, and consistent and sustained usage of the new practices. This would require more than the two year timeframe between the introduction of the tools and mechanisms and the initiation of this evaluation[2].

Both the process for the development of the tools and their subsequent utilization and, per the focus groups and the unanimous opinion of the EEHR KIIs, improvement of staff performance, point toward the potential for sustained usage and a longer-term effect. Anecdotal evidence in terms of shared consultants for EEHR and the upcoming World Bank health project further this conclusion, as well as, the pilot hospitals sharing lessons learned in the usage of the tools. However, any sustainable use might be undermined by a change in a hospital's leadership (i.e. the Hospital Director) and, thus, sustainability of this part of EEHR's activities is not ensured.

EVALUATION QUESTION 3: Based on the perceptions of outside stakeholders, do the selected regional hospitals have better performance as a result of the approaches and implemented activities than they would otherwise have?

FINDINGS

1) In general, the findings for this question are uncertain because of the need for objective measures in addition to the limited outside key informant interviews which were conducted as part of this evaluation. Current indicators within the PBMP do not capture this information and, most likely, an additional study, such as a facility and staff satisfaction survey, outside the scope of this evaluation, would be able to make this determination.

2) The limited number of outside stakeholders (four persons chosen in conjunction with USAID representing HRISG members, other technical agencies, and donors) queried by the evaluation teams do believe that there is better performance at the pilot hospitals both in terms of before and after EEHR's pilot interventions, as well as, in comparison to other similar current hospital settings in Albania. For example, at least one MoH Deputy Minister interviewed as part of the evaluation, requested the expansion of this initiative to all Albanian hospitals. The two Directors of professional orders who were interviewed, likewise, believed the activities have benefited the pilot hospitals' performance.

3) EEHR staff were unanimous in their opinion that the pilot activities have resulted in better hospital performance; however, their feedback must be qualified in that they are not outside stakeholders.

4) The large number of pilot activities implemented by EEHR as cited in Question 2 above should, in theory, result in better hospital performance.

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[2] *Hospital Quality Improvement: Strategies and Lessons from U.S. Hospitals*, Sharon Silow-Carroll, Tanya Alteras, and Jack A. Meyer, April 2007, The Commonwealth Fund.

CONCLUSIONS

Unfortunately, there were insufficient outside stakeholders interviewed to draw any definitive conclusions for this question; thus, a number of theoretical assumptions must be made. Based on the number and types of activities implemented by EEHR, it can be reasonably concluded that, theoretically, the regional hospitals should have better performance post project interventions. The small number of outside stakeholders who were interviewed did, indeed, cite that they believed that the three hospitals were functioning better after the project activities and were also better in comparison to similar hospitals in Albania. Additionally, the questioning of outside stakeholders alone would not allow definitive conclusions to be made. A facility-based survey along with a pre- and post- patient satisfaction survey are needed to examine hospital performance more thoroughly and answer this question. The PBMP did include an indicator "Improved operations and resource management", which was based upon the hospital composite indicator and baselines were set. While some progress was seen by the end of Year 2 and by Quarter 3 of the third year of implementation, which appears to exceed the targets set, this is an insufficient measure. Without the aforementioned surveys along with an established counterfactual to determine how much improvement is due to EEHR efforts, the most robust conclusions can only be theoretical.

EVALUATION QUESTION 4: How successful was the contractor in designing and implementing the small grant program?

FINDINGS

1) The implementation of the small grants programs was delayed by more than one year than its original start date, per the first year work plan. The reasons for this delay are unclear as different key informants attributed to the delay to different factors. Some KIIs cited that EEHR staff needed to be more pro-active in seeking civil society organizations with which to work (in addition to building their capacity), while other KIIs cited an overly bureaucratic grant procurement process, and other KIIs noted that the size of the potential pool of small grantees had been greatly overestimated.

2) A total of three grants were awarded. Per EEHR staff, two additional grants were considered for award, but not funded due to the early close of the project. The three grants awarded were as follows:

    a. *IDRA Research and Consulting*: for qualitative research on perceptions and attitudes toward public hospitals among residents of Tirana, Korca and Lezha regions.
    b. *Together for Life*: an NGO of journalists to strengthen the role of media in informing the population on issues of health reform, work with journalists to strengthen their knowledge on health issues, and engage young people through social media and other Internet tools on health and health reform topics.
    c. Progress Per Civilizim (PPC): for activities related to maternal and child health referral, including current status assessment of problems in the perinatal referral system, categorization of perinatal services, preparation of guidelines and referral algorithms for the MCH/perinatal system.

3) The original budgeted amount for the small grants program was $400,000. The actual monies expended by April 2014 (nearly 3.5 years into project implementation) were approximately $34,537 or 8.7% of the original amount. It was projected by EEHR staff that when the final payment is made under the remaining grant, the total monies expended will be approximately $40,577 or 10% of the original budgeted amount.

4) The EEHR Small Grants manager had multiple job titles and duties, including occasionally serving as the acting Chief of Party during part of the first two years of project implementation. Additionally, during the key informant interview, the Small Grants Manager was unaware of some relatively

common granting procedures which would have allowed a more unbiased and, potentially quicker, granting procedure (i.e. discarding the high and low scores from the grant review panel), as well as, expressing dissatisfaction with the granting process in general.

5) Three formative research documents[3] produced by international consultants highlighting the challenges of engaging with civil society on the issue of public health and health services were finalized in March 2012, and May and June 2013, approximately 1.5 and 2.5 years after EEHR began implementation. Some of the barriers noted lack of capacity among civil society organizations, a general public distrust of non-governmental organizations, and cultural barriers to civil society engagement and volunteerism.

CONCLUSIONS

This element of the project can be considered the weakest of those examined by this evaluation. Only a small portion of the original budgeted amount for grants was utilized, the awarding of grants started much later than anticipated, and the capacity of EEHR staff dedicated to this activity was, most likely, insufficient both in terms of quantity (one individual with multiple duties) and quality (inadequate experience managing granting procedures). Though two of the grants (IDRA and Together for Life) could be considered as having a direct link to the project's goal of influencing health care reform, the linkage of EEHR's goals with the third grant (PPC) is unclear.

Although three documents were produced as formative research by EEHR which noted some of the challenges which might be encountered in trying to engage non-state actors into the health sector, the first of these documents was finalized in March 2012 or 1.5 years into project implementation. Thus, the findings from the research were, most likely, not timely enough to allow EEHR to mitigate any challenges it might encounter in the small grants activity.

EVALUATION QUESTION 5: What were the challenges (internal and external) faced by the program and lessons learned?

FINDINGS

1) At least six individuals served as either an official, temporary or acting EEHR CoP during the life of the project; though, EEHR has had a consistent CoP since February 2012. All key informants interviewed noted that each CoP had a different management style and vision for the project.

2) EEHR staff varied in their opinions on the usefulness of Phase 1/Year 1. All agreed that Phase 2/Year 2 was a positive turning point for EEHR.

3) EEHR staff varied in their opinion on the working relationship and partnership with USAID with the emergent theme that the partnership worked best on the practical, activity-based level and faltered at the higher conceptual level. This was particularly cited as an issue around the concept of "country ownership". All EEHR staff cited examples of USAID not providing rationales behind its decisions. All also cited the delays with the work plan approval process as a hindrance to project implementation.

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[3] Joanne Jeffers and Palushaj, Ornela , March 22, 2012. Increasing Non-State Actors' Engagement in Health System Governance, Technical Report. Bethesda, MD. Enabling Equitable Health Reform Project in Albania, Abt Associates, Inc.

IDRA Research and Consulting, May 08th, 2013. Health Care System in Albania: A Formative Research with Consumers to Increase Non-State Actors Engagement in Health System Governance. Bethesda, MD. Enabling Equitable Health Reform Project in Albania, Abt. Associates Inc.

O'Sullivan, Gael. June 25, 2013. Civil Society Engagement and Communication Strategy and Action Plan - Technical Report. Bethesda, MD. Enabling Equitable Health Reform Project in Albania, Abt Associates Inc.

4) No USAID staff could easily articulate what should be the benchmark for determining the project's success or measurement of performance. EEHR staff responded more readily to this line of questioning citing the pilot hospitals as the primary source for measuring performance.

5) No USAID staff interviewed was certain if they and EEHR had a shared vision for the project. Likewise, no EEHR staff was completely certain of a shared vision, though, some cited the work plan approval process as a proxy for a shared vision.

6) The SOW of in the original contract instructed the implementing partner that "All activities should be conducted in close cooperation and partnership with local counterparts to ensure their full ownership and transition, future sustainability and growth of targeted sectors". During the life of the project, there were four Ministers of Health. Additionally, the political appointee system in Albania extends down to the hospital level, including Hospital Directors; thus, there was leadership turnover at the pilot hospitals as well.

7) The HRISG (and to a lesser extent hospital boards) were established by the project to, among other activities, assist in mitigating the MoH turnover and, thus, weak country ownership. However, the HRISG was primarily composed of GoA officials and suffered from the same turnover and, most likely, a lack of institutional memory.

8) Continued underfunding of the health sector was not a large obstacle for the project, but it was an obstacle. The project was able to provide some financial support such as the minor renovation work in the hospitals. However, limitation of funding to the sector could undermine the project's potential for rolling out reforms to all hospitals.

CONCLUSIONS

The three major stakeholders for this project, EEHR staff, USAID, and Government of Albania / Ministry of Health officials, all had significant challenges which needed to be addressed in order to better ensure successful project implementation. It can be reasonably concluded that the number of individuals which served in the Chief of Party role was detrimental in the project forming a cohesive vision until the final CoP arrived in February 2012 or nearly 1.5 years after the project's start. Further, this turnover in senior leadership and changing project vision combined with Phase 1 activities which were designed to better clarify the vision of the remaining life of the project, could also reasonably be assumed to have resulted in project delays. Until there was a focal point of responsibility for ensuring an internal unified vision for EEHR, any activities undertaken as part of a work plan could be considered tentative. Finally, the working relationship with USAID, the project's donor, may have needed strengthening as the EEHR staff interviewed cited examples of not being provided enough information, along with, uncertainty of whether there was a shared vision of project success with USAID.

USAID may have had during the initial phases of the project's lifecycle, including the project design phase, a clear vision of what would be considered a successful project. However, that vision appears to have evolved and become more unclear during actual implementation. Further, perhaps, more frequent and higher-quality communication was needed with EEHR staff as USAID KIIs were uncertain whether there was a shared vision and all EEHR staff shared examples of not being fully informed of the rationale behind USAID decisions.

Finally, it should be noted that the underlying pillar for EEHR's success was the idea of "country ownership". In other words, it was anticipated that Government of Albania counterparts, primarily Ministry of Health officials, would take a strong leadership role in moving forward with needed reforms. However, given that there were four Ministers of Health within the 3.5 years of the project's life, it would be difficult to conclude that this ever occurred. The development of the HRISG may have been one activity designed to mitigate the changing MoH leadership; but, given that the HRISG was primarily composed of GoA officials, it too probably did not contribute significantly to instituting country ownership of the reform process.

RECOMMENDATIONS

1) Prior to the second evaluation team's departure, USAID had an initial meeting with the World Bank regarding a proposed health sector project that the MoH had requested from the World Bank. Though the World Bank project is still in its initial phase of feasibility and scoping studies, if possible, USAID and EEHR staff should collaborate with the World Bank on the design of its new project and consider how initiatives undertaken or planned during Phase II of EEHR might be sustained as potential catalysts and models for reform in Albania's health sector. The focus should be on: (1) hospital autonomy (both legislation and building blocks needed to prepare hospitals for autonomy); (2) HII's reimbursement mechanism for the hospitals; (3) conceptualizing nationwide roll-out of the strengthening activities undertaken in the pilot hospitals; and (4) M&E as instrumental to supporting informed policy formulation through the HRISG. Further, any relevant research which was conducted as part of Phase I of EEHR should be shared freely with the World Bank. By building upon the lessons learned from EEHR, the primary objective of the EEHR project of identifying barriers and obstacles to more effective health policy and reforming implementation to increase access to health services, particularly for the poor, could be built upon. This would further efforts to ensure sustainability of the project's goals and the three years of EEHR implementation combined with the multiple years of activities under the World Bank project should lead to higher level impacts given sufficient time.

2) During the few remaining months of the project, no new programmatic initiatives should be undertaken. Ongoing initiatives should be reinforced so that they are more likely be sustained. New initiatives, especially those for which plans have been made, should be suggested for the World Bank health sector project design. Those initiatives currently successfully underway in the hospitals include: human resource management activities; incident reporting and analysis of reports; space allocation renovations; visitor management activities; environmental services and infection control activities; contracting of hotel-type services; visitor management and public relations (including activities designed to engage the community and eventually support community involvement in an independent hospital board). The ongoing work in strengthening M&E at the regional and central levels should also be supported, along with the HRISG's continuation.

3) USAID should consider continued funding for the HRISG via one of its on-going governance projects since the HRISG does function as a quasi-governing advisory board for the Ministry of Health. However, prior to the continued funding being granted, USAID along with the World Bank and other development partners should consider pressing the GoA to reform the HRISG such that the total percentage membership of the GoA on the HRISG is no more than 33%. Given the continued turnover in GoA leadership, this reduced GoA percentage may allow a greater institutional memory to develop if the remaining 67% were divided equally between civil society /patients' rights organizations and development/technical assistance partners. Further, as has been shown with similar governance mechanisms, such as the Global Fund's Country Coordinating Mechanisms, the strong presence of civil society organizations and health sector beneficiaries provides an important feedback mechanism in health reform.

4) USAID can also continue to support health reform activities by engaging in a dialogue (along with the World Bank representative) with the new Minister of Health about: (1) the pending legislation on hospital autonomy; (2) the M&E work, and especially sustaining the HRISG as an inter-institutional policy-making group; and (3) in supporting future work with the HII on reimbursement mechanisms for the hospital sector, as well as, improving participation in the HII, particularly in the informal sector.

5) Time and funding permitting, it would be useful to hold a conference or similar event prior to the end of the project, or as an end-of-project event, that engages those in positions of leadership in a discussion about the findings and recommendations in key project documents. In this manner, USAID could support the new leadership within the MOH and HII by ensuring that the analytical work produced under the EEHR project is provided to those in new positions of leadership. The substance of materials created by the project could be converted to "teaching case studies" to support an analytical decision-making process around topics such as the basic package of hospital services and HII payment mechanisms.

6) USAID might also consider avenues for sustaining the local capacity for technical assistance that has been developed under the EEHR Project, which itself builds on previous USAID projects, through supporting the possible creation of a local NGO that houses the existing capacity, or through other mechanisms that might sustain the capacity in some institutional form, whether public or the private sector. The support of indigenous organizations is a worldwide trend for USAID, and apparently other USAID-funded projects have been converted to indigenous NGOs in Albania, which may provide useful models.

7) While the Project was noted for building the local counterpart capacity in monitoring and evaluation, its internal level of M&E requirements was set quite low. The great majority of PBMP indicators were at the output level and very few internal evaluative activities were planned. Though the broader sector-wide scope of the project was scaled back to focus on reforming and improving tertiary (hospital) management and care through pilots, this does not relieve any of the stakeholders from the obligation of ensuring that outcomes are monitored and evaluated. To definitively determine the answers to some of the evaluation's questions and for the improvement of the project's performance during implementation (primarily those aimed at better understanding the outcomes at the pilot hospitals), additional methods should have been utilized. This could have included facility-based surveys, staff surveys, verification of improved staff practices and use of improved infrastructure through direct observation, community surveys, and patient/client satisfaction surveys. Further, by engaging the communities being served by the facilities in the monitoring and verification of results, project beneficiaries would not only have been better educated and informed about their health rights, but, potentially, become advocates for those rights as well. Had additional resources been dedicated to measurements at the higher outcome level, perhaps, stronger findings conclusions, and recommendations would be forthcoming from any external evaluations conducted.

ANNEX A: STATEMENT OF WORK

SECTION C – DESCRIPTION / SPECIFICATIONS/STATEMENT OF WORK

C.1 PURPOSE
The Contractor will conduct two performance evaluations of the USAID-funded EEHR and PLGP Projects during the period of September 2013 to November 2014 in Albania.

C.2 BACKGROUND
Albania has made many notable improvements in rule of law and good governance in the last twenty-two years but – coming out of decades of harsh communist rule and a tradition of fragmentation and localism – the country has not been able to move forward with the momentum required to introduce strong and sustainable democratic institutions that form the bedrock of representative, stable, prosperous, and equitable societies. In late 2011, USAID began implementation of a new Country Development Cooperation Strategy (CDCS) for Albania, covering the period 2011-2015. Under this strategy, the Mission will continue to engage in areas of past investment, including democracy and governance, and economic growth to help ensure sustainability of reforms and progress in these areas.

USAID/Albania's overarching goal for the 2011 - 2015 strategy is "European Integration through strengthened democratic institutions and inclusive economic growth." In support of this goal, USAID has set two primary objectives:

- Strengthened Rule of Law and Improved Governance
- Conditions Created for Broad Based, Sustainable and Inclusive Economic Growth

The synergies between these two objectives are exceptionally strong, in that success in achieving greater transparency and reduced corruption positively impacts the private sector and, looking at it the other way, economic growth helps to create a stable environment for a free and open democracy. Greater emphasis will be put on increasing sustainability of development impacts and potential legacy partners through enhanced use of host-country systems and local institutions and organizations.

In compliance with the Automated Directives Systems (ADS) 203.3.2 and the New Evaluation Policy, USAID Albania will conduct two performance evaluations to determine progress of these programs implemented in the final phase of Albania's aspirations for EU candidacy.

C.3 PURPOSE OF THE EVALUATIONS
The purpose of the two performance evaluations subject to this Statement of Work (SOW) is to provide USAID with external evidence for development outcomes and performance of the defined interventions in the two projects mentioned in the above summary. Each evaluation will be conducted at the mid-point of program implementation, which will allow for a thorough assessment of activities as well as enough time to modify/improve the approaches for the remaining period before the end of program. These evaluations will assist USAID in determining the degree of the success in current programs based on collected evidence and external analysis of the models of cause and effect using a broad range of qualitative, quantitative, or mixed methods.

This is an umbrella SOW that covers two performance evaluations and provides overall guidance for the potential implementer. More specificity is provided in the separate statements of work for each individual evaluation.

C.4 METHODOLOGY

The Contractor, in collaboration with USAID/Albania, will finalize the overall evaluation methodology once in-country. However, the Mission expects that, at a minimum, the team will:

- use methods that generate the highest quality and most credible evidence that corresponds to the questions being asked;
- take into consideration time, budget, and other practical considerations; and
- consider both qualitative and quantitative methods as they both yield valuable findings.

Depending on the SOWs of each of the two performance evaluations where the purpose and key questions of the evaluation are identified, the design and the types of methodology used may be relatively simple or more complex.

C.5 EVALUATIONS TEAM

Evaluation Team Leader: Each of the teams will be comprised of one independent evaluation expert who has experience with the subject matter of the particular evaluation with no relations to the project whatsoever in order to ensure unbiased reporting and avoid even a perception of a potential conflict of interest. The team leaders of each of the two evaluations should have significant experience in evaluating development assistance and working on or evaluating projects aimed at improving the specific subject matters.

Local team members: Each of the evaluation teams will have one or two local experts (depending on the specific scope for the evaluation) who have excellent understanding of the subject matters and are able to establish contacts and communicate effectively with both government officials, businesses, non-governmental organizations and other independent entities as necessary. They must be proficient in English. To avoid conflict of interest, none of the local team members should have current or past business relationships with the Project whose evaluation will be conducted.

Assistants: Each of the evaluation teams will have one assistant responsible for translation with counterparts and logistical support.

While the contractor is responsible for assembling the team described above, USAID/Albania may include a member of the staff to participate in the evaluation team. Although led by the external evaluation expert, the evaluation teams should consider including customers and partners (implementing partners, host-country government partners, other donors' staff, etc.). More details on each team will be provided in the specific SOWs for each of the performance evaluations.

C.6 SCHEDULE AND LOGISTICS

The evaluation efforts will commence as scheduled in the individual SOWs for each of the two evaluations. The table below provides tentative timeframes for the different phases of the evaluations. For each evaluation, the Independent Team Member should arrive in Tirana, Albania and be prepared to begin work as soon as the individual SOW is issued. USAID/Albania will provide the team with input and guidance in setting up a schedule of interviews and site visits, but the responsibility for the schedule for each evaluation resides with the Contractor.

Enabling Equitable Health Reform	September – November 2013 – Field work of the Performance Evaluation
Planning and Local Governance Program	September – November 2014 – Field work of the performance evaluation

The schedules should be defined as much as possible before the Independent Team Member arrives in country and should be finalized as soon as possible after the full Team is assembled in Albania. Draft schedules should be ready for review and discussion at the initial team planning meetings with USAID, which should take place within two days of when the team first convenes in Albania.

Prior to beginning of the field work in Albania, all team members will review background program documents to gain a firm understanding of the situation in Albania and the two USAID Projects subjects to evaluations.

The Independent Team Member will spend at least two weeks in Albania. The team will interview key USAID and Project staff, beneficiaries of USAID's assistance, representatives of the Government of Albania (GOA), other appropriate donor organizations providing assistance in the local governance, health sector management and civil society. Additionally, in its response, the Contractor shall propose its plan for selecting a representative number of Project activities for the evaluation team to assess based on the evaluation questions.

The Contractor is encouraged to identify and visit additional Albanian organizations and groups, both formal and informal, based on its review of materials.

C.7 DELIVERABLES
For each evaluation, the Contractor will provide the following:

1. The work plan for approval, which should include:

    a. Evaluation Design Document including: a detailed evaluation design matrix (the key questions, methods and data sources used to address each question and the data analysis plan for each question), draft questionnaires and other data collection instruments or their main features, known limitations to the evaluation design, a Final Evaluation Report outline and a dissemination plan.

    b. The anticipated schedule and logistical arrangements, delineating the roles and responsibilities of members of the evaluation team to ensure coverage of all elements of the Statement of Work. The work plan shall include briefing with USAID and timing of deliverables. Work Plan for the overall evaluation shall be completed by the lead evaluator within two weeks of the award of the contract and presented to the M&E Specialist and AOR.

2. All proposed team members must provide a signed statement of interest attesting to a lack of conflict of interest or describing an existing conflict of interest relative to the project being evaluated.

3. Regular briefings for USAID representatives during the field work.

4. An out brief for USAID/Albania at the end of the field work, including written materials (a power point presentation or an outline of the Evaluation Report – no more than 5 pages) which should include data from the baseline survey, as well as data from field visits, background of the local context and the projects being evaluated, the main evaluation questions, the methodology or methodologies, and preliminary findings.

5. Final Evaluation Report. The following sections shall be included in the document:

    i. Table of Contents

ii. An Executive Summary – (2-3 pages) containing a clear, concise summary of the most critical elements of the report, including the recommendations/impact.

iii. Evaluation Findings (no more than 15 pages), which provides analysis and answers the questions listed in the specific Statements of Work including baseline data and counterfactual data collected.

iv. Detailed Recommendations for the interim period between the data collection and the final evaluation.

v. Report Appendices, including:

a. A copy of the evaluation Statement of Work;
b. Cross-reference guide listing the evaluation questions and specifying on which page the questions are answered in the report.
c. Team composition and study methods (2 pages maximum);
d. A list of documents consulted, and of individuals and agencies interviewed; and
e. More detailed discussions of methodological or technical issues as appropriate.

6. Turn over all data collected while conducting the evaluations to USAID Albania at the end of the contract. All the records from the evaluation (e.g., interview transcripts or summaries) must be provided to the Task Order Contracting Officer's Representative (TOCOR.) All quantitative data collected by the evaluation team must be provided in an electronic file in easily readable format agreed upon with the TOCOR. The data should be organized and fully documented for use by those not fully familiar with the project or the evaluation. USAID/Albania will retain ownership of the survey and all datasets developed.

The Contractor will be responsible for providing the final deliverables to USAID/Albania no later than ten working days after the departure of the Evaluation Team leader from Albania. This period includes also the feedback from USAID mission to the draft of the Evaluation Report.

The Contractor will be responsible for providing the final deliverables to USAID/Albania via email and in hard copy. The Contractor, upon approval of the final Evaluation report by USAID/Albania, will also provide an electronic copy to DEC, the database of the USAID Development Experience Clearinghouse (DEC) within 30 days of completion. http://dec.usaid.gov

C.8 PROPOSED LEVEL OF EFFORT
Specific guidance on the level of effort/team composition will be provided in each of the two separate SOWs for the two evaluations.

C.9 SPECIAL CONSIDERATIONS
Duty Post: Tirana, Albania

Access to Classified Information: The Contractor will not have access to any Government classified material.

Workweek: A six-day workweek is authorized.

Logistical Support: The Contractor is responsible for providing all logistical support. Office space shall not be provided by USAID. The Contractor will be responsible for providing office supplies, equipment, computers, copiers, printers, etc. Translation services and vehicle rentals are the responsibility of the contractor.

USAID/Albania will provide assistance with scheduling appointments and meetings, at the possible extent.

Supervision: The team will work under the technical direction of the USAID/Albania TOCOR, i.e., the Monitoring & Evaluation specialist assisted by the Contracting Officer Representative (COR) of the specific project undergoing evaluation.

C.10 SCOPE OF WORK FOR EEHR
Enabling Equitable Health Reform in Albania

C.10.1 GENERAL DATA

TITLE	ENABLING EQUITABLE HEALTH REFORM (EEHR)
AWARD TYPE AND #	CONTRACT # 182-C-00-10-00104-00
IMPLEMENTER	ABT ASSOCIATES
AWARD VALUE	$8,605,712
LIFE OF PROGRAM	OCT. 01, 2010 – SEP 30, 2015
COR	AGIM KOÇIRAJ

I. BACKGROUND
EEHR Project is designed to directly support USAID's health governance program area in Albania.
The EEHR Project aims to strengthen the Albanian health sector's capability through the implementation of equitable health reforms, moving from strategies into implementation action plans, by providing instruments and tools and testing those in selected districts.

The purpose of this project is to provide access to health services for the poor by a) helping remove the existing barriers and constraints to the reforms at the national level and b) field testing approaches and tools that define a feasible set of implementable reforms in Albania.

The expected result under this project is to produce progress toward equity for the poor in the following priority areas:

- *The first priority* is to improve access, identify costs, reduce informal payments, and improve provider responsiveness at primary and secondary levels of care.
- *The second priority* is health systems strengthening to improve overall quality of care and efficiency of the health delivery systems:
- *The third priority* is to improve overall performance of the health care delivery system by better linking performance based health financing with improved resource allocation, improvement of capacity and enforcement of standards.

The above results are expected to be partially achievable at a national level during the life of the project and beyond.

Nevertheless, they are first expected to be tested at a regional level to become the driving force which practically and conceptually directs strategic and operational planning at a national level. The EEHR project is designed to be implemented in two phases:

Phase One Objectives are: a) to help narrow the health reform agenda to a feasible set of priority actions that will likely have the greatest impact nationally and b) to produce tools and mechanisms that will enable the implementation of action plans.

Phase One - Expected results

- Removed key barriers/obstacles to the reform processes;
- Established Institutional framework for implementation plans;
- Defined feasible parameters that include but are not limited to:
    a. Standard packages of PHC and hospital care to be covered by health insurance;
    b. Referral mechanisms between different levels of care;
    c. Costing of the defined services;
    d. Performance measures needed to for health delivery system;
    e. Standards and protocols developed etc.

Phase Two Objectives are: a) to use the produced tools and mechanisms in designated pilot region(s) field testing this way the defined feasible set of priority reform actions and b) to produce evidence to guide national implementation of health reforms.

The phase II of the project is planned to start by the end of the second year of the project life, following a thorough review process of the phase I. A commonly agreed plan for regional implementation will be delivered and approved.

Phase II - Expected Results

- Improved access, coverage and utilization of health services at the pilot region (s);
- Increased technical and financial efficiency;
- Improved health performance and outcomes through integrated services;
- Ensured sustainability;
- Removed barriers to institutional collaboration;
- Improved GoA's capacity to implement reforms at the regional levels;
- Provided guidance to national government reform efforts; and
- Expected results related to the material assistance:
    - Visitor control; system installed and functional at Tirana Maternity Hospital
    - Software deployed; IT infrastructure improvements completed in Lezha Hospital
    - IT equipment delivered, configured and installed in Lezha and Korça hospitals
    - Refurbishment work completed in Korça and Lezha Hospitals.

C.10.3 PURPOSE

The Purpose of this performance evaluation is to provide rigorous, evidence-based and independent analysis on EEHR's performance at the mid-term of the project and inform the Mission of continuing unmet needs in the sector. Specifically, the performance evaluation will serve to examine the processes, outcomes and the effectiveness of the project activities implemented to date; to determine whether the project has achieved the expected results according to the plan, to identify gaps in performance against targets, and to provide broad recommendations to the Mission for future interventions.

The evaluation will focus on both management and technical aspects of the program and its implementation. The evaluation will assist USAID in determining the degree of the success in current programs and identifying lessons learned for the development of future programs.

Qualitative and quantitative data will be used to illustrate the processes and outcomes of the program. Data generated from the evaluation should be specific to each of the programs and provide solid evidence for conclusions and recommendations that will be made by the evaluation team(s).

It's expected that the Evaluation Team will not simply provide an accounting of performance against targets, but provide an independent analysis on why targets were met or not achieved. Of particular interest will be the analysis of the reasons behind any gaps between expected and actual performance, including the identification of the likely source(s) of these gaps (design, project management, changes in operating environment, success factors, etc.). This analysis will inform future decisions regarding the project's focus by the Mission, particularly by the Democracy and Governance Office.

C.10.4 EVALUATIONS QUESTIONS
In conducting the performance evaluation for the EEHR program, the Evaluation Team will provide detailed answers to the following questions:

1. To what extent have EEHR activities resulted in removing key barriers/obstacles to the health reform processes;
2. How successful was the project in producing tools and mechanisms that are tested as successful in pilot regional hospitals?
3. Based on perception of outside stakeholders, do the selected regional hospitals have better performance as a result of the approaches and implemented activities, than they otherwise would have?
4. How successful was the contractor to design and implement the small grant program?
5. What were the challenges (internal and external) faced by the program and lessons learned?

The report will summarize the findings from interviews, discussions, and evaluations of relevant EEHR reports, studies and assessments. Pitfalls and gaps, if any, should be analyzed, justified and addressed by recommendations. The evaluators are encouraged to be as specific as possible in its recommendations, so as to best inform our Mission for the sake of prompt reaction if needed. Recommendations should be action-oriented, practical and specific, with defined responsibility for the action.

The evaluation (data collection, analyses and reports) should reflect the cross-cutting issues of gender and environmental considerations.

C.10.5 SUGGESTED METHODOLOGY AND STUDY TASKS
The Evaluation is described in the section C.4 at page 4 above. In addition to that the Mission is looking for additional suggestions on the methodologies, data collection instruments for conducting the evaluation, and it is anticipated that the Contractor will provide a more detailed explanation of the proposed methodology, for carrying out the work and appropriate to the Evaluation questions.

It is anticipated that the evaluation team will first complete a desk study that will be used to establish an understanding of EEHR's activities and environment before the field work.

The desk study will include, (but not limited to) the following steps:

Review of the relevant portions of the project's contract (original and modified).
Review of all relevant project reports, assessments, annual and life of project work plans.
Review of the project's grants documentation.
Review of the project's annual and life of project performance management plans (PMP).
Review of USAID/Albania Strategy.
Meetings with Abt Associate, relevant staff in USA (by phone) as necessary.
Briefings with USAID/Albania's relevant staff (Program Office, project COR, etc.)

Based on this understanding, the team will prepare a work plan that will be presented to the Mission prior to arrival in-country. The work plan will include a design matrix that demonstrates how the team plans to answer each evaluation question (data collection methods, sources, methods of analysis, limitations, etc. The methodology will include a mix of tools appropriate to evaluation's research questions.

C.10.6 TEAM COMPOSITION
The evaluation team will consist of three members: two technical specialists, and an interpreter/administrative assistant. The US expert will serve as the Evaluation Team Leader.

The evaluation experts shall demonstrate familiarity with USAID's Evaluation Policy
http://www.usaid.gov/evaluation/USAIDEvaluationPolicy.pdf

Specific responsibilities and requirements for each of the Evaluation team members include the following:

a) *Evaluation Team leader/Social scientist*: The incumbent must have extensive and documented relevant prior experience in leading evaluation of development projects and programs, designing evaluations, writing evaluations reports. S/he should possess experience and knowledge related to similar health reforms in countries in transition, preferably Western Balkans countries. The proposed individual will meet the minimum level of academic and the work experience qualifications required for the Senior level expert in the health field.

b) *Evaluation Team member/Social scientist (locally hired)*: S/He should have experience in evaluating development programs especially those of health governance and management focus. This team member is expected to have excellent knowledge and professional background that demonstrates extensive experience and understanding of Albanian context, Albanian health sector, and related policies and management systems. S/he should be fluent in English and in Albanian. S/He will meet the minimum level of academic and the work experience qualifications required for the Junior level expert.

c) *Interpreter/administrative assistant (locally hired)*: This team member will provide logistical, administrative, clerical and translation support to the team throughout the evaluation. Special attention should be paid to this team member's ability to translate technical language as it relates to the health systems management and health policies terminology.

C.10.7 SCHEDULE AND TIMELINE
USAID/Albania anticipates having this evaluation conducted in fiscal year 2014 during the period September 2013 – November 2013. The number of working days will include up to four days of prearrival preparation and up to ten days of post in-country work for writing and finalizing the evaluation report. A six-day workweek for the Evaluation Team(s) and travel days will be authorized accordingly for expatriate Evaluation Team members.

USAID/Albania will provide assistance with scheduling appointments and meeting. The Level of Effort for the technical team members is 18 days and for the Team Leader 27 days. Deadline for submission of deliverables and a suggested breakdown is shown in Table 1.

ANNEX B: EVALUATION QUESTION MATRIX

Research Question	Evaluation Tools	Specific Data Sources	Data Analysis Plan
1. To what extent have EEHR activities resulted in removing key barriers/obstacles to the health reform processes?	EEHR document review Informant interviews Focus group discussions	EEHR reports, existing health-related legislation, EEHR partners (Ministry of Health, Institute of Public Health; HII; National Center for Continuing Education; the National Center for Quality, Safety and Accreditation; Regional Public Health Departments; Regional HII Offices; and health centers), documents produced by and those working in other health-related assistance projects, NGOs and other organizations involved with health reform.	Identifying key barriers/obstacles in place prior to EEHR launch. Matching EEHR program activities (and their intended outputs and outcomes) to particular barriers/obstacles. Analyzing the incentives and relative influence of key stakeholders. Assessing the current status of identified barriers.
2. How successful was the project in producing tools and mechanisms that are tested as successful in pilot regional hospitals?	EEHR document review Informant interviews Focus group discussions Site visits to three regional testing hospitals and surrounding urban and rural areas	EEHR performance monitoring plan and reports, results framework, M&E reports, testing hospital documents and personnel, EEHR partners, other key project stakeholders	Assessing the process of designing and implementing tools. Evaluating collaboration among all relevant stakeholders. Assessing whether tools address specific, identifiable health care problems. Assess ongoing implementation of tools (obstacles, successes, etc.)
3. Based on perception of outside stakeholders, do the selected regional hospitals have better performance as a result of the approaches and implemented activities, than they otherwise would have?	EEHR document review Informant interviews Focus group discussions Site visits to three regional testing hospitals and surrounding urban and rural areas	EEHR partners, testing hospital documents and personnel, urban and rural citizens near testing hospitals	Develop baseline understanding of situation prior to pilot testing. Assess current status of health care access, financing, and insurance at testing sites, and relate that to data from comparable non-testing sites.

4. How successful was the contractor in designing and implementing the small grant program?	EEHR document review Informant interviews Focus group discussions	EEHR small grant recipients (including project objectives and activity reports)	Identify objectives of grants, and match them with recipient advocacy efforts and campaigns. Assess the application process as well as the systems of accountability. Analyze the added value of the grants to NGO capacity. Assess prospect for sustainability of NGO advocacy following the program
5. What were the challenges (internal and external) faced by the program and what are the lessons learned to date?	Document Review Informant interviews Focus groups Site visits to three regional testing hospitals and surrounding urban and rural areas	EEHR documents and reports, M&E plans and reports, key stakeholders and implementing partners, citizens who interacted with testing hospitals and other EEHR activities; popular press articles on health sector reform.	Aggregating data from all relevant stakeholders, partners, and beneficiaries, and synthesizing their impressions of the health care environment, its challenges, needed reforms, and obstacles. Assess the degree of collaboration among all relevant actors, and their commitment to health sector reform. Identify the degree of administrative and political will among key stakeholders, and their relative influence. Assess level of internal teamwork and EEHR project efficiency, and the project's interactions with and influence within the operating context. Assess major assumptions, linked to a theory of change, of the existing health sector reform environment.

ANNEX C: TEAM COMPOSITION

EVALUATION TEAM LEADER

Tim Clary served as the Evaluation Team Leader for the second portion of the evaluation, with primary responsibility for overall conduct of the evaluation process and report. He was the team's principal point of contact with USAID/Albania and assumed responsibility for coordinating evaluation activities. He also assisted with the development and refinement of the revised work plan and evaluation methodology and lead the preparation and delivery of all presentations and briefings to USAID and other stakeholders. Dr. Clary led key informant interviews and other data collection activities and served as the lead author of the revised evaluation report. Dr. Clary is an expert in the health sector, with over 14 years of experience. He holds a Ph.D. and an M.S. in Epidemiology and Geography from UCLA, an EMBA in Business Administration from the Instituto de Empresa in Madrid, an M.A. in Geography from UCLA, and a B.S. in Journalism from the University of Florida.

EVALUATION TEAM MEMBER

Lindita Çaçi served as Local Team Member for the evaluation. She assisted the Team Leader in the overall management of the evaluation. As a health care policy professional in Albania, Ms. Çaçi provided subject matter expertise and local country contextual knowledge, and she identified additional documents for review and was particularly instrumental in arranging for meetings with interview candidates on short notice. The evaluation team drew on her expertise to design the evaluation methodology and data collection instruments as well as to inform subsequent analysis, conclusions, and recommendations. Ms. Çaçi conducted background research, assisted with the development and refinement of the instrument design and evaluation methodology, and participate in fieldwork. Ms. Çaçi also worked with the Team Leader to draft and edit the evaluation report and present key findings and recommendations to USAID Mission staff and other key stakeholders.

Ms. Çaçi brought both formal academic training and first-hand experience with the Albanian MOH to bear on the findings and recommendations of the evaluation. She has a M.Sc. in Health Institutions Management from the University of Montreal. Following an earlier stage of her career in the Economic Department of the MOH, she served as the Director of the Policy and Planning Department of the MOH for four years before relocating to Canada.

LOCAL TRANSLATOR AND LOGISTICS ASSISTANT

Laura Kolaneci served as the team's local translator and logistics assistant. In addition to her role as a translator for the Team Leader, she provided logistical support for meetings, interviews, site visits, daily travel, and other administrative tasks as needed. Ms. Kolaneci's role went beyond these activities. She also has Master's level training in Health System Management, and she actively participated in all team sessions, beginning with the translation of interviews and focus groups, and continuing through to the subsequent discussion and analysis of findings with the two main technical members of the team.

ANNEX D: DOCUMENTS REVIEWED

ADHS. 2010. Albanian Demographic and Health Survey: 2008-2009. Institute of Statistics, Institute of Public Health Tirana, Albania, and ICF Macro, Calverton, Maryland, US. March, 2010.

Bowers, Gerard and William Johnson. 2010. USAID/Albania Health Sector Review, January 23 – February 10, 2010.

Chee, Grace and Joanne Jeffers. 2011. The Albania Health Sector Governance Study: Technical Brief. Abt Associates, Bethesda, MD. July 15, 2011.

Cook, Margaret, Mark McEuen, and Jan Valdelin. February, 2005. Primary Health Care Reform in Albania: A Pilot Project to Provide Evidence for Health Policy. Abt Associates, Partners for Health Reformplus Project.

EEHR. 2011. Enabling Equitable Health Reforms Project in Albania: First Annual Report. Abt Associates, Bethesda, MD. October 14, 2011.

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EEHR. 2011. Year One Work Plan (October 1, 2010 – September 30, 2011). Abt Associates, Bethesda, MD. October 14, 2010.

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EEHR. 2012. Initiation of Hospital Improvement Plans: Space Programming. (Trip Report) Abt Associates, Bethesda, MD. July 30, 2012.

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Kenny, Steve. 2013. Package of Hospital Services in Albania. Trip Report. Enabling Equitable Health Reforms Project in Albania, Abt Associates, Bethesda, MD. April 26, 2013.

Kenny, Steve. 2013. Hospital Funding in Albania. Technical Report. Enabling Equitable Health Reforms Project in Albania, Abt Associates, Bethesda, MD. September 25, 2013.

Kenny, Steve. 2013. Package of Hospital Services in Albania. Technical Report. Enabling Equitable Health Reforms Project in Albania, Abt Associates, Bethesda, MD. September 26, 2013.

Kongoli, Zyhrada. 2012. Analysis of Legal and Regulatory Framework for Health Facility/Hospital Autonomy in Albania. Enabling Equitable Health Reform Project in Albania, Abt Associates, Bethesda, MD. October 9, 2012.

Li Bassi, Luca. 2013. Supply and Demand Management for Inpatient Pharmaceuticals. Equitable Health Reform Project in Albania, Abt Associates, Bethesda, MD. October 18, 2013. Enabling

Myers, Louise. 2012. The Albania Pilot Hospitals Baseline Survey. Technical Report. Abt Associates, Bethesda, MD. March 16, 2012.

O'Sullivan, Gael. 2013. Civil Society Engagement and Communication Strategy and Action Plan. (Technical Report) Enabling Equitable Health Reform Project in Albania, Abt Associates, Bethesda, MD. June 25, 2013.

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ANNEX E: INDIVIDUALS CONTACTED

ABT ASSOCIATES

1. Steve Kenny, International Consultant, Hospital Financing
2. Mark McEuen, Vice President, Abt Associates (telephone interview)
3. Louise Myers, International Consultant, Hospital Management

EEHR PROJECT

1. Ervis Bregu, Manager for Hospital Information Systems
2. Blerina Dudushi, Manager for Engaging and Communicating with Non-State Actors
3. Mirela Cami, Policy Process/M&E Manager
4. Ornela Palushaj, Project Information Manager
5. Julian Simidjiyski, Chief of the Party, EEHR Project
6. Zamira Sinoimeri, Policy Senior Advisor
7. Filip Vila, Site Manager

HEALTH INSURANCE INSTITUTE (HII)

1. Astrit Beci, General Director, appointed 3 weeks prior to interview
2. Nora Horanlliu, Chief of Budgeting Department, formerly Chief of Development and Policies, Hospital Directorate
3. Naun Sinani, Chief of Hospital Service Directorate, formerly Advisor

HEALTH REFORM IMPLEMENTATION SUPPORT GROUP (MEMBERS)

1. Din Abazaj, President Order of Physicians
2. Sabri Skenderi, President, Albanian Nursing Order

KORCA REGIONAL HOSPITAL

1. Entela Bardhi, Economist, Head of Hospital Biostatistics Office
2. Edlira Bode, Physician, Hospital Coordinator (for EEHR Project)
3. Loreta Bode, Physician, PHC, Health Insurance Institute, Regional Directorate
4. Vasilika Cuti, Specialist, HR Sector
5. Mirela Dhembi, ES Monitoring Specialist
6. Anila Dishnica, Head of Finance Office
7. Piro Dishnica, Specialist, M&E Sector
8. Doriana Frasheri, Head Nurse, Infectious Disease Unit
9. Netreta Gjoshe, Specialist, M&E Sector, Regional Public Health Institute Office
10. Ligor Golka, General Head Nurse
11. Stela Guci, Specialist, HR Sector
12. Bashkim Ibi, Physician, Head of ICU
13. Margarita Jazxhi, Nurse in Emergency Room
14. Edion Kollcinaku, Neonatalist, Head of Neonatology Unit
15. Rezarta Korance, Nurse at Cardiology Service
16. Para Kosta, Head Nurse, Emergency Ward
17. Entela Madhi, Head of Hostelry Office
18. Anastas Mitace, Head Nurse, Pediatrics Unit
19. Ylli Qirinxhi, Hospital Director

20. Edmond Remacka, Head of Maintenance Office
21. Ornela Ruco, Physican, Head of Infectious Disease Unit
22. Anila Sedo, Nurse, IPC Unit

LEZHA REGIONAL HOSPITAL

1. Ardinana Barbullushi, Lawyer
2. Nevruz Bare, Hospital Director
3. Vjollca Begaj, Secretary
4. Erjona Brungaj, Chief of Costing Service
5. Tonin Bushi, Chief of Finance
6. Suada Danaj, M&E Sector, Regional Public Health Department
7. Donina Doda, Head Nurse, Obstetrics Ward
8. Aida Gega, Statistics, Regional HII
9. Aferdita Gjoni, Site Coordinator (EEHR)
10. Bardha Gjoni, Physican, Quality Coordinator
11. Roza Hilaj, Chief of Pathology Ward
12. Edvin Hoxha, Head of Environmental Services
13. Denjola Kadija, Head Nurse for Hospital
14. Almir Keli, Head of M&E, Regional
15. Pranvera Lushi, Head Nurse, Intensive Care
16. Mark Marku, Chief of Pediatric Ward
17. Martin Marku, Chief of Infection Service
18. Teuta Marku, Head of Technical Department
19. Vladimir Martini, Chief of Policlinic
20. Taulant Mergjyli, Nurse, Emergency Ward
21. Angje Ndoci, Head Nurse, Surgery Ward
22. Silva Nikolli, Head of Human Resources, Hospital
23. Valentina Nikolli, Economic Director
24. Valbona Prenga, Chief of Emergency Ward
25. Tonin Rumija, Physican, Hospital Coordinator for EEHR Project
26. Valdete Sherri, Head Nurse of Pathology

MINISTRY OF HEALTH

1. Halim Kosova, Former Director of Maternity Hospital (15 years), Former Minister of Health (6 months); current Member of Parliament
2. Jonela Leka, Specialist, M&E Sector, MOH
3. Petro Mersini, Director, Hospital Planning Directorate, MOH
4. Silva Novi, Head of Hospital Sector, Hospital Planning Directorate, MOH
5. Pellumb Pipero, Former Director of Policy and Planning, MOH; current MD at University Hospital
6. Klodian Rjepaj, Vice Minister of Health, Former Director of Institute of Public Health
7. Petraq Shtrepi, Head of M&E Sector, MOH
8. Ledia Xhafa, Specialist, M&E Sector, MOH

NATIONAL CENTER OF CONTINUING EDUCATION (NCCE)

1. Entela Shehu, Director

NATIONAL CENTRE OF QUALITY, SAFETY AND ACCREDITATION OF HEALTH INSTITUTIONS (NCQSA-HI)

1. Professor Isuf Kalo, Director

QUEEN GERALDINE MATERNITY HOSPITAL

1. Aurora Bajraktari, General Head Nurse
2. Vera Beca, Microbiologist
3. Dhurata Boka, General Head Midwife
4. Maksim Gjoni, Deputy Director of Quality and Accreditation, and staff physician
5. Eda Hushi, Pharmacist
6. Adriana Kopani, Human Resources Specialist
7. Mirlinda Krasniqi, Health of Human Resources
8. Blenard Nonaj, Director
9. Ervina Nuri, Psychologist/Social Worker
10. Marizeta Oili, Public Relations Specialist
11. Anxhela Palla, Attorney
12. Vera Pashollari, Head Midwife
13. Altin Pasko, Economic Director
14. Mimoza Pipero, Receptionist
15. Robert Qirko, Former Director (for 7 months in 2013), on-going role as staff physician
16. Anjeza Sadiku, Midwife
17. Lirie Shehaj, Head Nurse
18. Fuat Zhabjaku, Head of Technical Sector
19. Ermira Zhupa, Midwife

USAID

1. Jim Barnhart, Mission Director
2. David Cowles, Acting Mission Director, and Senior Private Enterprise Advisor
3. Marc Ellingstad, General Development Officer
4. Agim Kociraj, Health Specialist & COR for EEHR Project
5. Clare Masson, Program Officer
6. Alken Myftiu, Monitoring and Evaluation Specialist
7. Zhaneta Shatri, Deputy General General Development Officer (seconded to USAID/Iraq)
8. Laura Slaughter, Regional Contracting and Agreement Office

WORLD HEALTH ORGANIZATION

1. Vasil Miho, WHO Representative

WORLD BANK

1. Lorena Kostallari, Senior Operations Officer, World Bank

ANNEX F: STATEMENTS OF CONFLICT OF INTEREST

Name	Timothy Allen Clary
Title	Consultant
Organization	Democracy International
Evaluation Position?	☑ Team Leader ☐ Team member
Evaluation Award Number *(contract or other instrument)*	AID-OAA-I-10-0004
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Enabling Equitable Health Reform, Abt Associates, Contract # 182-C-00-10-00104-00
I have real or potential conflicts of interest to disclose.	☐ Yes ☑ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	Timothy A. Clary
Date	March 24, 2014

Name	LINAITA CACI
Title	
Organization	Democracy International
Evaluation Position?	☐ Team Leader ☒ Team member
Evaluation Award Number *(contract or other instrument)*	AID-OAA-I-10-0004
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Enabling Equitable Health Reform, Abt Associates, Contract # 182-C-00-10-00104-00
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

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Signature	
Date	23.10.2013.

Name	Laura Kolaneci
Title	Translator and administrative assistant
Organization	Democracy International
Evaluation Position?	☐ Team Leader **X Team member**
Evaluation Award Number*(contract or other instrument)*	AID-OAA-I-10-0004
USAID Project(s) Evaluated*(Include project name(s), implementer name(s) and award number(s), if applicable)*	Enabling Equitable Health Reform, Abt Associates, Contract # 182-C-00-10-00104-00
I have real or potential conflicts of interest to disclose.	☐ Yes **X No**
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* *1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* *2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* *3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* *4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* *5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* *6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

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Signature	Laura Kolaneci
Date	22/10/2013

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