I. INTRODUCTION

The Albanian health sector is currently under reform, which focuses on the following key elements: a) Streamlining health services, including a rationalization of the PHC facility network; b) Improving the quality of health services; c) Protecting and increasing financial resources for the health services; d) Developing human resources; e) Strengthening the health information system.

Primary MCH care in rural areas is delivered through health centres and village clinics, with services provided by Family Doctors, nurses and nurse/midwives. In urban areas primary MCH services are delivered through Women and Child Consulting Centres (WCCCs), which are responsible for the provision of key services for disease prevention and control and health promotion, including reproductive health, maternal ante-natal and post-natal care, child nutrition, growth monitoring and immunization.

Within the context of the health sector reform, the Albanian Ministry of Health intends to reorganize the WCCCs in Albania. The reorganization should be coherent with the key principles of the HS reform mentioned above.

An assessment of the current organization of the centres and of the services provided was carried out in order to provide the MoH with the best possible evidence and rationale for an effective reorganization of primary MCH care in the urban settings. The current report describes the findings of the assessment, suggests a reorganization model based on discussion of advantages and disadvantages of various options in the context of the Albanian Health System and proposes a phased roadmap to implement the proposed model.

II. SITUATION ANALYSIS

II. A. INSTITUTIONAL AND LEGAL FRAMEWORK FOR THE WCCCS IN ALBANIA

The tasks of the WCCCs are, in principle, identified by the following documents issued by MoH:

1. “Regulation on the services of reproductive health in the primary health sector” (Decision no. 147, of 11/04 2003) which describes, among other services provided at PHC level, the tasks of women’s and child consultation centres and of the health professionals involved in providing the above services (see box).
The Reproductive Health Sector is part of Primary Health Care Directorate at the Ministry of Health. The mission of the sector of the reproductive health is the continuous protection and improvement of the health of women and children, trying to prevent and resolve problems of this group of population. Reproductive health sector, organizes, directs and controls work in reproductive health services, mainly in primary health care (health centers and village clinics, maternal and child consultation centers…). The Reproductive Health Services in the districts of the country are managed by the Reproductive Health Inspector, who is dependant on the Director of Public Health, and has as a main objective to protect and improve the health of women and children. The different services and sectors of the district’s health organization, dealing with the health of women and children, are of two types: preventive and curative.

2. Decision no.146, of 11.04.2003 which integrates the previous one by providing detailed technical guidelines on how the tasks listed in the previous documents should be carried out.

3. “Basic package of services in primary health care” (December, 2008) which describes the tasks to be carried out at PHC level, which include those that should be provided by WCCCs in the urban areas.

The three documents provide a rather complete description of objectives, tasks and technical guidelines for preventive and curative services to be delivered at PHC level.

However, while the overall mission of WCCCs is clear and in principle should include the whole range of health improvement strategies\(^1\), a closer view of tasks and technical guidelines as described in decision no.146 and 147, and the “Basic package of services” suggests that:

1. the vision of PHC in the above documents appears mainly limited to disease prevention and does not include public health approaches and demand generating aspects (health protection and health promotion), which are important dimensions to be considered particularly when addressing aspects such as reproductive health and child health and development, which are strongly influenced by social factors and cultural norms.

2. the above documents emphasize specific technical tasks, whilst other key professional tasks aimed at ensuring, for example, effective data collection, communication among health professionals, communication between health professionals and users are overlooked.

3. the care of physical problems gets much more emphasis than care for wellbeing and development.

4. the basic package should acknowledge that the health promotion and prevention services for mothers and children are delivered through WCCCs in the urban areas and through the family doctors and health centers in the rural areas.

5. finally, it provides detailed indications on how specific tasks should be performed, and some of these indications may be outdated or insufficient, since technical guidelines are under continuous development.

According to these general observations, some modifications to be above documents are suggested (Annex 1, pages 12-15, child care and pages 19-21, women’s health).\(^2\). International Guidelines are included as reference.

\(^1\) Health improvement encompasses Health protection, Health promotion and Disease Prevention
II B. CURRENT ORGANIZATIONAL STRUCTURE AND STAFFING OF THE WCCCs

In the country there are 112 Women’s and 142 Children’s centres, located in 13 urban areas, for a total catchment population of 1,371,000 (of which 310,000 children 0-14). The staff of the centres is described in tables 1a and 1b.

Table 1a. Women’s CCs

<table>
<thead>
<tr>
<th></th>
<th>Population</th>
<th>gynaecologists</th>
<th>midwives/nurses</th>
<th>pop/doctors</th>
<th>pop/nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berat</td>
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<td>0</td>
<td>15</td>
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<td>5,533</td>
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<tr>
<td>Diber</td>
<td>14,000</td>
<td>0</td>
<td>12</td>
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</tr>
<tr>
<td>Durres</td>
<td>170,000</td>
<td>4</td>
<td>15</td>
<td>42,500</td>
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</tr>
<tr>
<td>Elbasan</td>
<td>121,000</td>
<td>3</td>
<td>35</td>
<td>40,333</td>
<td>3,457</td>
</tr>
<tr>
<td>Fier</td>
<td>98,000</td>
<td>3</td>
<td>34</td>
<td>32,667</td>
<td>2,882</td>
</tr>
<tr>
<td>Gjirokaster</td>
<td>16,000</td>
<td>1</td>
<td>9</td>
<td>16,000</td>
<td>1,778</td>
</tr>
<tr>
<td>Korce</td>
<td>110,000</td>
<td>4</td>
<td>28</td>
<td>27,500</td>
<td>3,929</td>
</tr>
<tr>
<td>Kukes</td>
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<td>5,833</td>
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<tr>
<td>Lehze</td>
<td>59,000</td>
<td>2</td>
<td>23</td>
<td>29,500</td>
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</tr>
<tr>
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<tr>
<td>Tirane</td>
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<td>46</td>
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<tr>
<td>Vlore</td>
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</tr>
<tr>
<td>Saranda</td>
<td>32,000</td>
<td>0</td>
<td>4</td>
<td>N/A</td>
<td>8,000</td>
</tr>
</tbody>
</table>

Total: 1,371,000  44  259  31,159  5,293

Table 1b. Children’s CCs

<table>
<thead>
<tr>
<th></th>
<th>Population</th>
<th>paediatricians</th>
<th>nurses</th>
<th>pop/doctors</th>
<th>pop/nurses</th>
</tr>
</thead>
<tbody>
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<tr>
<td>Durres</td>
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<td>61</td>
<td>3,700</td>
<td>607</td>
</tr>
<tr>
<td>Elbasan</td>
<td>23,000</td>
<td>1</td>
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<td>23,000</td>
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</tr>
<tr>
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<td>53</td>
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<td>453</td>
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<tr>
<td>Gjirokaster</td>
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<td>8</td>
<td>47</td>
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<td>Kukes</td>
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<tr>
<td>Lehze</td>
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<td>455</td>
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<tr>
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<td>5,250</td>
<td>538</td>
</tr>
<tr>
<td>Tirane</td>
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<td>2,700</td>
<td>1,069</td>
</tr>
<tr>
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<td>N/A</td>
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</tr>
<tr>
<td>Saranda</td>
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<td>0</td>
<td>8</td>
<td>N/A</td>
<td>1,125</td>
</tr>
</tbody>
</table>

Total 0-14: 310,000  69  511  4,493  607
The total number of staff working in the centres, according to data provided by the HII, is 113 doctors and 770 nurse/midwives.

A survey among health professionals of WCCC (see Annex 4) has been carried out showing that their educational background (years of specific professional training and curricula) is quite variable, depending on the year of graduation/diploma and that only the youngest nurse/midwives have a University degree for nurses. Nurses and midwives have the same training in nursing, there is no special course in midwifery, but only a module during the university nursing course of 4 years (or during the 6 months course post high school for those who have not a university degree). From 2012 only nurses with university degree will be accredited to practice their profession. In the meantime - since 2009 - all the others have been given the chance to upgrade their qualification. Similarly, only the youngest doctors have a specialization according to European standards. The survey also showed that a substantial proportion of the staff (over 50%) is over 50 years. Due to a relatively high number of staff in a rather advanced age, it is envisaged that over the next few years a significant proportion of the staff will retire, including doctors and nurses/midwives.

the Reproductive Health Unit (Sektori), within the Public Health Directorate of the MoH provides policy, strategy directions and technical guidance on RH and MCH services. At district level, the centers are under the direct responsibility of the Public Health Directorate in the district.

The WCCC staff report to the manager of the PHC center they belong to. The managers are doctors, with no systematic training in management, although some of them have received some form of training on management and the MoH/Continuous education programme has planned a training on management for all of them. They devote about 20% of their time on managing the PHC center (they are alleviated of some clinical duties) and receive some supplementary salary.

A specialist in RH is appointed in most districts, with a coordination and supervisory role (see box). The professional qualification of such inspectors is variable, ranging from doctors to University degree Nurses. Their technical competence on the range of tasks of WCCCs is also variable and their supervisory skills were never assessed and are limited. The position exists since a long time, but has been reviewed only recently (2 years) and it is still not well defined. These positions are generally filled by young doctors who are not specialized and who leave the position as soon as they find their way towards clinical work. Therefore there is a high turn over and a low motivation. Their tasks are not yet entirely clear to them, although there are checklists that they have to regularly fill up in order to monitor the activities and inform the District.

This means that, due to a relatively high number of staff in a rather advanced age, it is envisaged that over the next few years a significant proportion of the staff will retire, including doctors and nurses/midwives By 2012 retirement age for women will be 60 and for men 65 years.

The WCCC staff report to the manager of the PHC center they belong to. The managers are doctors, with no systematic training in management, although some of them have received some form of training on management and the MoH/Continuous education programme has planned a training on management for all of them. They devote about 20% of their time on managing the PHC center (they are alleviated of some clinical duties) and receive some supplementary salary.
Box. THE DUTIES OF THE REPRODUCTIVE HEALTH INSPECTOR/ SPECIALIST FOR RH\textsuperscript{2}

**Technical tasks**
The reproductive health inspector must be a qualified practitioner in public health (family doctor).

The reproductive health inspector, in collaboration with the other Public Health Directorate structures, is directly responsible for solving problems related to the health of women and children by exercising his/her influence to increase the efficiency at all levels of health services, be that at primary care and in the hospital of the district.

Coordinates the projects and is responsible for the implementation of any project that deals with the reproductive health at the district level. This means his/her active participation in organizing the different approaches of the Public Health Directorate for the implementation of various activities such as: training, supplies, distribution of medicines, supervision on the implementation of activities, cooperation with national project coordinators etc.

Immediately informs the reproductive health sector in the Ministry of Health on extraordinary events, death of the mother, increased level of mortality and illnesses among the infants and children, epidemic situations that endanger the health of women and children.

Reports to the reproductive health sector in the Ministry of Health every three months on mortality level of mothers, children and infants in accordance to the structure of mortality, and also reports on the usage of contraceptives.

Informs through a report the operational data associated to mortality of mother and infants, the results of tests undertaken for the problems of mortality and illnesses of women and children in the district.

**Administrative tasks**

The inspector of the reproductive health depends on the Director of Public Health. He/she has the duty to:

1. Follow rigorously the enforcement of decisions, instructions and orders by the Ministry of Health. He/she has also the right to make propose suggestions on them.
2. To demand from all the services and sectors of the health system in the district to set goals of work on reproductive health, based on data derived from analysis of the situation.
3-Submit detailed information, on cooperation with different donors various, on activities in the field of reproductive health, on the performance and implementation of these projects, periodically and whenever it is required by the reproductive health sector at the Ministry of Health.

IIC. WOMEN AND CHILDREN’S HEALTH STATUS IN ALBANIA

An overview of the most recent data on reproductive health, maternal health, child health and development is very useful to identify main issues and priorities, and understand the role that primary MCH services can play in improving such outcomes.

Most of the available data derive from the ADHS, others from official MoH statistics and UN estimates.

Information that is deemed relevant for the work of WCCC (as well as for the whole PHC network in Albania) is in bold characters.

\textsuperscript{2} According to doc no.147. Since 2009 years the RH Inspectors have been transformed into "specialists for RH", within the M&E PH district team of 3 doctors (one is the responsible person, one is in charge of quality and one of RH)
IIC 1. Reproductive and maternal health

Fertility has declined substantially in Albania during the last two decades, the last data showing a total fertility rate (TFR) of 1.6 children per woman in reproductive age and a general fertility rate (GFR) of 46 birth per 1000 women 15-44. The reasons for the decline in births is attributed to many factors, including the emigration of young people and the internal migration from rural to urban areas.

The TFR for rural areas (1.8 births) is higher than that for urban areas (1.3 births). This urban-rural difference in childbearing rates can be attributed almost exclusively to the younger age groups, the rural rate being almost twice as high as the urban rate in women 15-24. Age-specific fertility rates peak in age group 25-29, regardless of residence, and with a small differential between urban and rural areas and decline to about half their peak in age group 30-34. A negative association between fertility and education and between fertility and wealth status is observed.

Table 2: Main fertility indicators, ADHS 2008-9

<table>
<thead>
<tr>
<th></th>
<th>Urban</th>
<th>Rural</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>TFR (/W 15-49)</td>
<td>1.3</td>
<td>1.8</td>
<td>1.6</td>
</tr>
<tr>
<td>GFR (/1000 W15-44)</td>
<td>39</td>
<td>51</td>
<td>46</td>
</tr>
<tr>
<td>CBR (/1000 pop)</td>
<td>8.4</td>
<td>11.3</td>
<td>10.0</td>
</tr>
</tbody>
</table>

Fifteen percent of births occurred within 24 months of the previous birth, an interval considered to be too short. Births to women with higher levels of education and at higher wealth quintiles are more likely to have a longer birth interval than births to women with primary education or less.

Childbearing begins relatively late in Albania: three fourths of women age 20-24 years have never given birth. The percentage of women age 15-19 who were mothers or were pregnant with their first child at the time of the 2008-09 ADHS was only 3 percent.

Maternal Mortality ratio in Albania is reported at 17 per 100,000 live births in 2008, according to the latest available source. The main causes of maternal deaths are haemorrhage, eclampsia, Sepsis.

19 percent of the women were found to be anaemic. Sixteen percent of women are mildly anaemic.

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3 ADHS data related to 2008-2009. Previous estimates on TFR were of 3.3 children per woman in 1993-1996 and 2.6 in 1999-2002 (CDC, IPH, and INSTAT, 2005). The CBR decreased to 10 births per 1,000 women in the 2008-09 ADHS, from 13 births per 1,000 women in 2005 and 18 births per 1,000 women in 2001 (INSTAT, 2008a).

4 ADHS data related to 2008-2009. (10 and 64 births per 1,000 women aged 15-19 and 20-24 in urban areas, compared with 21 and 120 births per 1,000 women age 15-19 in rural areas).

5 ADHS data related to 2008-2009. 113 and 138 births per 1,000 women, respectively.

6 ADHS data related to 2008-2009. The TFR decreases from 1.9 for women with primary education, to 1.5 for women with secondary education and even lower, to 1.1 for those with university education. Women in the poorest households give birth to about 50 percent more children than women in the richest households (1.9 and 1.2 births per woman, respectively).

7 ADHS data related to 2008-2009

8 UN estimates, 2010
and 3 percent are moderately anaemic.9

IIC 2. Child Health and Development

Mortality rates

The level of under-five mortality has been found at 22 deaths per 1,000 live births while the infant mortality rate was 18 deaths per 1,000 live births (table 3), according to the most recent available data. Therefore, most early childhood deaths take place in the first year of life. Looking at the pattern of infant mortality, almost two-thirds of infant deaths take place in the first month of life; the neonatal and post-neonatal mortality rates are 11 and 7 per 1,000 births, respectively. The perinatal mortality rate (stillbirths plus early neonatal deaths) is 11 deaths per 1,000 pregnancies.10 The infant mortality rate estimated by the MoH is much lower, indicating a low quality of vital statistics/routine information system.11

Table 3. trends in neonatal, infant and child mortality rates (ADHS 2008-9 referring to 4 year periods from 1996 to 2008)

<table>
<thead>
<tr>
<th></th>
<th>NMR</th>
<th>IMR</th>
<th>U5MR</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004-2008</td>
<td>11</td>
<td>18</td>
<td>22</td>
</tr>
<tr>
<td>2000-2003</td>
<td>10</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>1996-1999</td>
<td>15</td>
<td>35</td>
<td>39</td>
</tr>
</tbody>
</table>

Comparisons between child mortality rates in Albania (1996-2008) and in other countries in the Balkan region indicate infant and under-five mortality, although showing a decreasing trend, were higher in Albania than in neighboring countries.12 Infant and under 5 mortality in rural areas is twice as high as in urban areas.13

The differences in the mortality rates by mother’s level of education show that children of mothers with primary education or less are more likely to die before their first or fifth birthday than children of mothers with secondary education or higher.14

Mortality estimates by household wealth status show that infant and under-five mortality rates are lowest for children in households in the highest wealth quintiles and highest for those in the lowest wealth quintiles.15

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9 ADHS data related to 2008-2009
10 ADHS data related to 2008-2009
11 Ministry of Health, 2009. The Ministry of Health estimated infant mortality at 12 deaths per 1,000 births in 2007. INSTAT registration estimated infant mortality at 6 deaths per 1,000 births at about the same time.
12 While the infant mortality rate was estimated at 18 per 1,000 births in Albania, it ranged in the same period from 4 to 16 deaths per 1,000 births in the other countries of the SEE Region. The same pattern was seen for under-five mortality rates; while under-five mortality is 22 deaths per 1,000 births in Albania, it ranges from 5 to 19 deaths per 1,000 births in the other Balkan countries. According to UNICEF SOWC 2011, child mortality in Albania was estimated at 15 in 2008.
13 ADHS data related to 2008-2009. In rural areas IMR 24/1000, U5MR 28/1000); in urban areas IMR12/1000, U5MR 13/1000.
14 ADHS data related to 2008-2009. In lower and higher educated mothers, neonatal mortality, infant mortality and under 5 mortality rates are respectively 13 and 6, 21 and 15, 24 and 18 per 1000 live births.
15 ADHS data related to 2008-2009. Infant mortality is 21 deaths per 1,000 births in the lowest 60 percent of the population, compared with 15 deaths per 1,000 births in the highest 40 percent of the population. Thus, there are 40 percent more infant deaths in poorer households than in wealthier households. An important risk factor for infant mortality is represented by short birth interval.
Neonatal deaths represent the major component of child deaths in Albania, and depend not only on quality of obstetric services but on quality of reproductive and antenatal care, on behaviours and lifestyles. Since 2006 infant mortality due to ARI has been reduced by more than half, from 23 to 11 percent, and under-five mortality has declined from 21 to 14 percent, even though ARI still remains the leading cause of death among young children. In 2007, deaths from diarrhoeal disease accounted for 2 percent of infant deaths and 1 percent of deaths among children under age five  

**Nutrition**

Among children for whom birth weight was reported, 4 % had a low birth weight (less than 2.5 kg). The proportion of low birth weight infants decreases as mother’s level of education increases. Overall, **19 % of children under age five are stunted and 11 % are severely stunted.** Stunting occurs even among children **under six months** of age (33 %)  

There are some socio-economic differentials in stunting. Stunting levels decreased as mother’s level of education increases. **Children in the lowest wealth quintile are twice as likely to be stunted** as children in the highest wealth quintile  

Nine % of children under five years are wasted, and 6 percent are severely wasted while five % of children under five years are underweight for their age and 2 percent are severely underweight. Children under six months of age are most likely to be underweight **22 percent of children under five years are overweight or obese** and there is little difference by urban-rural residence (22 and 21 percent, respectively). **17 % of children 6-59 months** in Albania have some level of anaemia, including 11 % of children who are mildly anaemic (10.0-11.9 g/dl) and 6 % who are moderately anaemic (7.0-9.9 g/dl)  

Overall, 19 percent of breastfed children received a prelacteal feed. Only 68 percent of children under two months of age are exclusively breastfed. Exclusive breastfeeding drops to 39 percent at age 2-3 months and to 18 percent at age 4-5 months. Breastfeeding decreases substantially after

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17 ADHS 2008-9. Levels of stunting decrease with age, from 33 percent among children less than six months of age to 12 percent among those age 48-59 months. In-between, there are substantial fluctuations, with 18 percent of children age 12-17 months stunted and 29 percent of children age 18-23 months stunted. Thereafter, stunting declines with minor fluctuations to 12 percent in the oldest age group.  
18 27 % compared with 13 %  
19 ADHS 2008-9. Looking at the differentials by background characteristics, it can be seen that wasting is highest among children under six months (27 percent); it is higher among boys (11 percent) than girls (7 percent), higher in urban areas (11 percent) than rural areas (8 percent), and higher in Urban Tirana (13 percent) than the other regions. Twelve percent of children whose mothers have university or higher education and children in the highest wealth quintile are wasted.  
20 ADHS data 2008-2009. The highest levels of overweight are seen among children whose prior birth interval is 24-47 months and children in the lowest (poorest) wealth quintile (28 percent each); 25 percent of children are overweight among children under six months of age, children age 18-23 months, children in the Central region, and children of mothers with university or higher education; 24 percent of children under five in Urban Tirana are overweight.  
21 ADHS 2008-2009. Anaemia increases slightly from age 6-8 months to age 12-17 months, and declines steadily among older children. The prevalence of anaemia varies slightly by the sex of the child. Anaemia is considerably higher in rural areas than in urban areas, for children of women with no education and for lowest wealth quintile.  
22 Ibid. Mothers with higher education were slightly more likely to introduce prelacteal feeding than mother with less education. Mothers who gave their child something to drink other than breast milk in the three days following delivery were asked what was given to the child. The most common prelacteal liquid given was milk (other than breast milk) followed by sugar or glucose water. Other common prelacteal liquids were plain water and infant formula.  
23 ADHS 2008-2009. Overall, half of children age 0-3 months and 39 percent of children age 0-5 months are exclusively breastfed. In 2008-09, exclusive breastfeeding among children age 0-3 months and 0-5 months was 50 and
At age 6-8 months, only 55% were receiving timely complementary feeding (breast milk and complementary foods). The level of complementary feeding is still low, at 66% percent at age 9-11 months and then decreases to 54% percent at age 12-17 months, when 46% of children are no longer being breastfed.

Only 25% of children 6-23 months both consume foods from three or more food groups and is fed the minimum number of times per day. Eleven percent of non-breastfed children age 6-23 months are fed according to the three infant and young child feeding (IYCF) practices. **When breastfeeding and non-breastfeeding children are combined, it is seen that most children age 6-23 months are not fed according to IYCF recommendations. Only 19 percent are fed according to all three IYCF practices.**

**Child Development**

The results of the DHS component related to the adult involvement in child development indicate that adult involvement in activities with the children is higher for older children age 24-59 months (88%) than for younger children age 0-23 months (62%). Adult involvement in four or more activities that promote learning and school readiness generally increases with mother’s level of education and household wealth status.

Eight percent of children age 0-59 months were left in the care of children, while 7% were left alone during the week preceding the survey. Overall, combining the two care indicators, 11 percent of children were left with inadequate care during the week preceding the survey.

The DHS results also show that only about one in five Albanian children (22%) experienced violent behaviour as a means of discipline or punishment. In fact, sixty-eight percent of children were subjected to psychological punishment. Minor physical punishment was reported for 58 percent of children, while 14 percent were subjected to severe physical punishment.

The proportion of children who experience severe physical punishment is somewhat higher among children age 5-9 years and among boys, compared with children in other age groups and girls. Children in rural areas are twice as likely as those in urban areas to undergo severe physical punishment (18 and 9 percent, respectively).

**Children of mothers with no education or with primary 4-year education are seven times as likely to experience severe physical punishment as children of mothers with university or higher education** (28 and 4 percent, respectively). Likewise, 22 percent of children in the lowest wealth quintile experienced severe physical punishment, compared with 4 percent of children in the highest wealth quintile.

Only 13 percent of household respondents were reported to believe that a child needs to be physically punished in order to be disciplined.

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39 percent, respectively, compared with 49 and 40 percent, respectively, in the 2006 survey.

24 ADHS data 2008-2009. At 12-15 months, only 61% are still being breastfed, and by age 20-23 months, only 31 percent of children are being breastfed. 16 percent of children age 2-3 months and 33 percent of those age 4-5 months were receiving complementary foods (solid and semi-solid foods) in addition to breast milk.

25 ADHS data 2008-2009. Questions were asked on the involvement of adults with children in the following activities: (1) reading books or looking at picture books; (2) telling stories; (3) singing songs; (4) taking children outside the home compound or yard; (5) playing with children; (6) and spending time with children naming, counting, or drawing things.
Conclusions
Overall, the findings from DHS indicate the need to strengthen the quality of the work and improving the coverage in a number of areas ranging from family planning and antenatal care to infant nutrition and early child development.

II D ASSESSMENT OF CURRENT SERVICE PROVISION

1 CONCEPTUAL APPROACH AND METHODS

The assessment was based on the guiding principles of the UNICEF CEE/CIS Health System Strategy, which focuses on four main dimensions: 1) equity, 2) quality, 3) continuity and integration of care and 4) public health approach. The Strategy views the health system as contributing, besides to health promotion and health care, to optimal child development and social protection and to promotion of women’s empowerment as key to reproductive and child health.

Financial sustainability within the current HS development plans has also been taken into consideration. Preliminary proposals take into account the ongoing health sector reform and health system strategy in Albania.

The present preliminary proposals are based on field visits to 4 health WCCCs in Tirana, Kruja and Durres carried out between October 11 and 15, 2010. Direct observations and interviews with health providers and directors of the centres have been performed on the basis of a tool mainly covering issues related to quality and continuity of care. Key informants from MoH, IHI, PHI, CPU, IQH etc have also been interviewed. Data on human resources and distribution of the WCCC have been collected through IHI.

More detailed information related to the health facility network (particularly on human resources training background and age of retirement) was collected through a health facility survey, using a self administered questionnaire distributed to all WCCCs in Albania. User perspectives are also explored through focus groups of women during pregnancy and within the first year after delivery (annex 1), including barriers to access.

2 KEY FINDINGS

2.1 Relevance to tasks and quality of service provision

The main responsibilities of the WCCCs, according to MoH, are:

a. Antenatal and postnatal care
b. Health education and promotion for reproductive health
c. Prevention, treatment and follow up of the existing pathologies in reproductive health
d. Monitoring, controlling of growth and development for children (0-6 years).
e. Prevention, education, promotion of child health care.
f. Immunizations and infant and young child nutrition.

According to the results of the assessment, the above listed tasks are only partially carried out in WCCCs:

a) **Antenatal care** is mainly limited to administrative tasks. Women are not physically examined in the WCC and they receive the prescription for lab test and ultrasound, both to be performed in separate health facilities (either hospitals or polyclinics).

However, the coverage for antenatal care is high in Albania. DHS shows that 97% of pregnant women in Albania receive antenatal care (ANC) from a skilled provider at least once during their pregnancy, this coverage having substantially increased since 2002. In three quarter of cases a specialized doctor (obstetrician/gynaecologist) was the provider of ANC. Sixty-seven percent of women had the recommended number of ANC visits (4 or more) during pregnancy. 78% of them had their first ANC visit during the first trimester, proportion that indicates a substantial increase in the last years. Therefore, this evidence suggests that other providers, alternative to the WCC staff, are providing ANC to women, three quarters of which are represented by specialists.

Postnatal care for women provided by the WCC is very limited. 97% of deliveries took place in a health facility, the vast majority being a public facility. 99% of the total deliveries are attended by a skilled health provider. 19% of births were delivered by caesarean section, this percentage having increased from 13 percent in 2002. These has been a substantial increase in the proportion of woman receiving a postnatal check-up, from 19% in 2002 to 88% in 2008-9. However, these data refer to the medical examination provided by the maternity unit shortly after delivery, which in fact most women receive.

b) **advice and promotion regarding reproductive health** is very limited; family planning and prevention of STIs and cancer of the cervix are not covered, although specific programs (FP) have been recently introduced by the MoH, with distribution of information materials and contraceptives made available by MoH only, while all other prescriptions are delegated either to gynaecologists in polyclinics or hospitals or to Family Doctors.

Data from the DHS shows that forty-eight percent of all women in reproductive age, are using a method of contraception, although only a minority of them use a modern method. The most common public source of contraceptive methods in Albania is government hospitals or maternities, which supply 37 percent of all users of modern methods. Government primary health care services supply only 16 percent of users with their methods.

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27 Reproductive Health Survey, 2002.
28 ADHS 2008-9. 75% of women received antenatal care from an obstetrician or gynaecologist, 4% received antenatal care from a family doctor, and 18% received antenatal care from a nurse or midwife.
29 Reproductive Health Survey, 2002. ANC coverage was 59% in 2002.
30 ADHS data 2008-2009. 97% of deliveries are in public health facilities with less than 1% taking place in private facilities and almost 3% taking place at home.
31 ADHS data 2008-2009. Eighty-three percent of deliveries are attended by an obstetrician or gynaecologist, while 15% are attended by a nurse or midwife. There are no major variations by background characteristics in the percentage of women who are assisted by a skilled health provider.
33 CDC, IPP, and INSTAT, 2005.
34 RHS 2002.
36 ADHS data 2008-2009. Fifty-nine percent received a medical check-up less than four hours after delivery, 13 percent received a checkup within the first day, 12 percent received a check-up within the first two days, and 4 percent received a check-up 3-41 days after the birth. 65% of women received their first postnatal check-up from an obstetrician or gynaecologist, 22% received their first check-up from a nurse or midwife, and 1% received their first postnatal check-up from a family doctor.
37 ADHS data 2008-2009. Including 69% of currently married women, and 72% of sexually active unmarried women. The majority of currently married women in Albania rely on a traditional method, while only 11% use a modern method. The most commonly used method among currently married women is withdrawal (58%), followed by the male condom (4%), female sterilization (3%), and the pill (2%). All other methods are less than 1 percent.
38 ADHS data 2008-2009.
c) Treatment and follow up of reproductive health problems is also quite limited, and essentially delegated, in most cases through self-referral, to specialists. Prevention of cervical and breast cancer is not performed, although in some WCC (e.g. Skoder) plans are made to introduce the screening of both conditions. STI’s are not covered, there are some information materials available.

d) Growth monitoring is regularly carried out in terms of measuring weight and height of children. However, when a child with growth delay is identified, action is limited to referral. Growth charts are not regularly used and - possibly also in relation to this - there is evidence indicating that the system has limited capacity to detect malnourished children (e.g. statistics from routinely collected data show malnutrition rates that are much lower than those detected through household surveys).

e) Prevention, education, promotion of child health care is routinely performed both in home visits and at WCCCs. Whilst health education is always given to the mothers on general topics regarding child care, most information provided is generic and sometimes incorrect. On the other hand, key advice to the mother that reflect interventions of proven effectiveness is not delivered (e.g. danger signs in newborns, baby’s back sleeping position, correct the baby’s attachment to the breast in case of sore nipples, etc). There is very limited assessment and promotion of child’s development.

DHS shows that for example, in the majority of children under five with diarrhoea, feeding practices were not optimal. Only 37 percent of children with diarrhoea were given more liquids than usual\textsuperscript{39}. Overall, 63 percent of the children with diarrhoea continued feeding and were given ORT and/or increased fluids. However, a large majority (81 %) of women who gave birth in the past five years knew about ORS packets\textsuperscript{40}.

f) Immunizations are effectively carried out. The WCCCs play a crucial role in ensuring the immunization coverage among children, mainly through the very intensive home visiting programme. As a result, 95 percent of children age 18-29 months are fully vaccinated, and less than 1 percent have never received any vaccines. The rates for vaccination by 12 months of age are slightly lower (1 percent or less) than those observed for vaccination at any age, indicating that almost all vaccinations are given within the first year of life, as recommended. Vaccination cards or child health books were seen by the interviewer for only about seven in ten children (68 percent). However, immunization records at the health facilities were seen for almost all children (96 %) indicating that a strong immunization programme is in place\textsuperscript{41}. During the immunization campaign carried out in Tirana city on occasion of the European week of immunization, the screening process which included “door to door “ activities, was able to identify and vaccinate 1222 children 0-14 year-old, out of which 895 were children from the Roma community. 633 children had no full vaccination documentation or improper vaccine documentation and 21 were without any vaccination. This shows that to achieve high immunization rates among Roma children specific ad hoc initiatives need to be taken

\textsuperscript{39} ADHS data 2008-2009 More than one-third (36 percent) of children received the same amount of fluids as usual, and fluid intake was curtailed in one-fourth (26 percent) of children with diarrhoea, a practice that increases the risk of dehydration. 14 percent of children with diarrhoea either were given much less food than usual or no food at all to eat.

\textsuperscript{40} ADHS data 2008-2009 . Mothers age 25 and older (83 percent) are more likely than younger mothers (73 to 74 percent) to know about ORS. Knowledge of ORS packets or ORS pre-packaged liquids increases with women’s level of education and household wealth status.

\textsuperscript{41} ADHS data 2008-2009
Breastfeeding promotion and support and education on complementary feeding is carried out, but the staff knowledge and skills on this topic appeared, with some exceptions, extremely limited, although most staff showed a good awareness on the importance of infant nutrition. Distinction between exclusive and prevalent BF are not always clear and support and advice are often limited to encouragement, with little communication skills and ability to provide advice on appropriate positioning, care of common problems etc.

Care for sick children is not provided by the WCCCs. This responsibility is assigned, in urban settings, to paediatricians who work in polyclinics, more frequently by hospital paediatricians. DHS data shows that among children with ARI, with fever, or with diarrhoea six or seven in ten were taken to a health facility or provider for advice or treatment, and six (ARI or fever) and four (Diarrhoea) in ten received antibiotics. Out of children with diarrhoea who were taken to a health facility, 68 % received ORT, 75 % received ORT or increased fluids and 5 percent received zinc supplements. Overall, one in six children with diarrhoea (17 percent) did not receive any treatment.

The physicians working in WCCCs (gynaecologists and paediatricians) can only prescribe in relation with preventive interventions (e.g. Fe sulfate, vitamins). If any other drug is needed, the women are referred to the specialists who recommend the prescription and then to the family doctor who provides the prescription for obtaining the drug within the limits of insurance coverage.

Activities in the centres are complemented by a very robust outreach program, especially in relation to post natal care. An average of 25 home visits are carried out during the baby’s first year of life most of them by nurses, some by paediatricians. Nurses working in the centre are made responsible for a share of the centre catchment area, and visit every day between 5 to 10 families each. Paediatricians working in the centre also do some home visits, including the first one which is scheduled during the first days after hospital discharge. During the visit, staff examines the child and gives advice on baby care, though without following particular guidelines or standardized procedures (i.e.with specific items to be covered at each age of the child).

Home visits carried out by midwives are in theory mandatory according to MoH (3rd, 8th and 14th days after birth, doc n.146), but in practice this is frequently limited to only one visit.

No protocols are available to the staff. There are mothers and child records, which have been recently revised (new versions are still to be distributed). Health education materials for mothers are scarce.

Continuous education activities for the staff have been limited and not homogeneous across centres.

2.2. Continuity of care

Services for maternal and child health and reproductive health appear to be fragmented. The current separation between preventive and curative services, as well as between maternal and child services often obliges users to seek care to several different providers and services in order to obtain a response to their problems, which could otherwise be provided in an integrated manner. Home visits also lack an integrated approach and two different teams – one obstetric and one paediatric – go visiting the family in parallel. As a result, there are substantial gaps in continuity of care for users and ultimately low efficiency and cost-effectiveness.

In terms of information flow, during the first ANC visit a file is open at the WCCC, where information is recorded at every contact at the center. The file (or the information in it) is not then transferred to the maternity ward during childbirth, nor to the WCCC for post natal care. However,
the new file opened by the maternity hospital during childbirth is transferred to the WCCC for postnatal care. Nurses from the WCCC regularly go to the maternity hospital and identify from the register all newborns resident in the catchment area of the centre, and collect their file. This system is meant to reasonably ensure that all newborns are detected and will receive postnatal care.

Information on birth and postnatal visits are recorded in an MCH booklet on child care which is given to mothers. Child’s vaccinations are recorded in another card, which also remains with the mother. Both booklets represent a reasonable tool - if consulted by the staff - for ensuring continuity of care in the areas of child care and immunization.

The system will be much more efficient if linked to a computer based health information system.

MOH and the HII have recently issued orders the with clear referral criteria but their implementation remains a challenge to the system.

2.3 Equity

Access to the Child Centers’ services is showed to be good by two main indictors: immunisation coverage for children, which is very high and coverage of post natal baby care visits, which is reasonably good. Access to Women Centres is probably high on average although unequally distributed, if measured by antenatal care coverage. Available information in fact shows that while the proportion of women who received antenatal care from a skilled provider does not vary by background characteristics, the percentage of women who had four or more ANC visits is substantially lower in rural areas than in urban areas. Women with first-order births, women in urban areas, women in Urban Tirana, better educated women, and women in the highest wealth quintile are more likely than other women to receive postnatal care from a skilled provider. Also, of all pregnant women, only 34% receive iron supplements, this percentage being lower among women with low level of education and wealth status. 48% of pregnant women receiving antenatal care were informed about the signs of pregnancy complications. This percentage increases with the level of education and wealth status. 80% of pregnant women were weighed, while above 90% of women underwent other basic tests like blood pressure measurement, urine and blood test, ultrasound examination.

There is substantial variation in the percentage of pregnant women who underwent basic tests and measurements by background characteristics. 63% of mothers reported receiving two or more injections against tetanus during their last pregnancy. Women with university or higher education, and women in the fourth and fifth wealth quintiles are more likely to have received two or more TT injections during the last pregnancy or to have their last birth protected against neonatal tetanus.

The Albania RH survey 2002 shows that more than 85% of newborn babies were seen by a health professional and almost everyone used baby health care as a part of a routine health exam; 45% of these visits took place during the first week after the delivery, while slightly more than 20% was done only after the second week of the baby’s life.

ADHS data 2008-2009. 57% in rural areas compared with 82% in urban areas.

ADHS data 2008-2009. 22% of women with no education or with primary 4-year education did not receive a postnatal check-up, compare to 1% among women with university or higher education. Similarly, while 17-18% of women in the two lowest wealth quintiles did not receive a postnatal check-up, the proportion declines to 3% among women in the highest wealth quintile.

ADHS data 2008-2009. 21% among women with no education or with primary 4-year education compared to to 56% among women with university or higher education. Likewise, 21% of women in the lowest wealth quintile receive iron during pregnancy, compared to 55% of women in the highest wealth quintile.

ADHS data 2008-2009. 91% of women had their blood pressure measured, 88% had a urine sample taken, 87% of women had a blood sample taken, and 95 percent had an ultrasound examination. The percentage of pregnant women who underwent basic antenatal tests and measurements increases with level of education and wealth status.
In spite of good overall immunization services Roma children have lower access to immunization and child health services and specific ad hoc campaigns have been necessary to reach high coverage of immunizations levels in Roma children.

Possible financial barriers are only represented by informal payments, given that all services provided by the WCCCs are free of charge. Low socio-economic status is in fact one of the indicators defining groups with lower access e.g. to ANC.

The home visiting program, by reaching out those more vulnerable and facilitating their access to the health services, plays an important role in preventing lack of access by at risk families.

The potential of the WCCCs to identify, reach out and respond to the population at risk is not fully valued. For example, the home visiting program has the potential to detect psycho-social risk and provide multidisciplinary work with the social services for support to families at risk. However, the patronage nurses lack capacity and tools to do so and rarely refer to the social services, e.g. to the Child Protection Units, where available.

There are signs of increasing awareness among the staff on domestic violence (e.g. posters, leaflets in the centres).

### 2.4. Public health approach

A public health approach to health promotion and protection in MCH is necessary, since lifestyles and behaviours play a key role in influencing reproductive health, antenatal and postnatal care, child nutrition, child development etc. and they can be modified by effective communication strategies at both national and community level.

The WCCCs should play a key role in information communication and education, but at present they do not, due to lack of specific training of the staff, including in communication skills, and lack of appropriate materials and guidelines.

There seems to be limited capacity overall in the country to use the media and other channels to influence lifestyles and behaviours, although the IPH is now developing some capacity and programmes.

### 2.5 Links to ECD and social protection

Links with early child education and development institutions (crèches, kindergarten etc.) appear very limited as well as the social sector, although there are recent experiences, such as in Durrës, of collaboration with the Social Protection Unit. Health professionals have very limited training in such areas, an insufficient training in basic counselling skills, legal implications of reporting, etc.

These areas should gradually become a priority area for the work of WCCCs, and would imply the inclusion in the WCCCs or close collaboration with specific professionals (psychologists and social workers).

### 3. Strengths and weaknesses of the current organization and service provision of the WCCCs

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47 Ibid. In addition to women living in rural settings, two further socioeconomic factors increase the risk of not having any prenatal visits: the level of education and a low socioeconomic index.
Based on the above findings, strengths and weaknesses of the present WCCCs have been identified and discussed at a meeting at the MoH on October 15, 2010.

Main strengths
1. The centers represent important “access gates” to health services, and through home visits reach out for the great majority, included minority groups such as Roma.
2. The staff is strongly rooted into the community they serve
3. The number of staff is overall more than adequate (although distribution seems haphazard)
4. The centers play a key role in the immunization program and in providing advice to mothers on general baby care
5. The staff shows interest in improving their performance and increase their responsibilities
6. The current system includes the role of the district reproductive health inspectors/RH specialists, who, with appropriate revision of tasks and adequate training, could play a key role in improving the effectiveness and quality of the PHC NMCH activities and improve their links with hospital activities

Main weaknesses
1. Antenatal care is mainly limited to administrative procedures, and delegated to specialists
2. Cancer and STI prevention related tasks are not performed
3. Family Planning programmes seem to be starting here and there, but do not include full assessment and counselling which remains delegated to specialists
4. Postnatal care/ Home visits: little attention is paid to mothers’ postpartum issues; the number of visits is high, but there are no clear objectives and tasks according to age and problems identified; the frequency of visits is not modulated according to risk; this results in missed opportunities for effective health promotion, care for development and social protection
5. Breastfeeding promotion, complementary feeding and growth monitoring: staff knowledge and skills in promotion and support of BF is variable but generally suboptimal; Growth monitoring is not used for decision making but mainly to refer in cases of insufficient growth, nor for public health purposes (surveillance)
6. Child development and social protection are not covered
7. Nurses and midwives, but to certain extent also doctors, have a mainly administrative role
8. Health information system: information collected is fragmented, indicators used are often inappropriate (e.g. growth monitoring, BF, complementary feeding)
9. The infrastructure is of variable quality: the visited WCCCs were in good conditions in Tirana and Durres, while in Kruja conditions were rather poor, although some renovation was ongoing.
10. There are insufficient efforts to strengthen the role of civil society organizations, focusing on Municipalities and Regions (as elective representatives of communities who play important roles in boards addressing policies of primary care at district level), and NGOs (focusing on Women’s and Families Centres, Women’s organisations etc.) in disseminating knowledge and information and promotion of good practices related to reproductive health maternal and child health and child upbringing

III. REORGANIZATION OPTIONS AND PROPOSED MODEL FOR REDEFINITION OF THE ROLE AND TASKS OF WCCCS

III A. REORGANIZATION OPTIONS

The assessment shows that the current system of urban WCCCs has the potential in terms of facility network, infrastructure and staff numbers, to deliver equitable and quality services in key areas
currently included in the basic package (FP, antenatal and postnatal women’s care, STIs, cancer prevention, growth nutrition and development in children, immunizations).

However, at present, there are a number of serious deficiencies that hamper the role of WCCCs in effectively promoting and protecting the health of women and children:

- WCCCs deliver effectively only on immunizations
- many of the preventive and all the curative MCH functions are delegated to other services in the system
- there is a lack of updated guidelines and protocols and of relevant tools
- health professionals’ knowledge and skills, including communication skills, are often insufficient or outdated, so that a quality service cannot be provided.
- supervision, in-service training and opportunities for continuous education are insufficient.

A thorough discussion of options for reorganization needs to take into account the additional information which was collected regarding the personnel (levels of training, turn-over,) as well as the broader context of Health System reorganization in Albania. The main question to be asked is which model should be adopted to reorganize the system of WCCCs. Several options have been considered, based on existing European models (see box).

**Box. Models for organization of MCH PHC services. European examples**

**1. UK model.** Primary health care of mothers and children in the U.K is carried out the by the primary health care team: doctors (general practitioners), practice nurses, and health visitors. Community midwives also carry out - independently - MCH prevention and promotion. PHC teams may also have other related medical professionals within the team including psychologists, physiotherapists, speech therapists etc. A MCH Paediatric consultant (district level) guarantees monitoring and supervision to the teams including individual support in complex cases (e.g. case conference)

**PROS:** Integration between preventive and curative is favoured. High responsibilities to nurses and midwives. Excellent home visiting program. Lower costs since it does not rely on specialists but it delegates most functions to the FD and paramedics.

**CONS:** The risk is that, in this organizational mode, FD, community midwife and paediatrician work individually rather than as a team. However, team work could be guaranteed through organizational issues and case conferences.

**FEASIBILITY:** In Albania, given the limited training background on MCH of family doctors and the lack of well trained community midwives, nurses as well as the absence of MCH consultants, this model is hardly applicable. If applied to the current service organization in urban settings, it would not ensure the capacity to deliver quality care on a number of key MCH tasks and will likely lead to lose the current reach-out capacity ensured by the WCCCs through the home visits.

**2. Spanish model.** A second hypothesis of reorganization could be based on the Spanish model of Centros de Atención Primaria (Centres of primary care), where family doctors work in multidisciplinary teams jointly with paediatricians, nurses, midwives, social workers, therapists and administrative personnel. The PHC teams are formally assigned a comprehensive set of functions that include a broad range of services: general medical care—treating children, adults, and the elderly—twenty-four-hour availability, diagnostic services, minor surgery, family planning, prenatal and obstetric care, pharmaceutical prescriptions, home visits, certifications, ambulance services and patient transport, nursing care and palliative care, preventive services and health promotion, and specific services for the mentally ill. Home care is ensured by visiting midwives and nurses, while centres include all other services. All health professionals working at primary care centers, including physicians, are salaried.
**PROS:** This is a good option to provide integrated preventive and curative PHC care. Also, this option has the advantage of creating the conditions for teamwork and to provide users the access to multidisciplinary services in the same location and provide a comprehensive package of services.

**CONS:** Effective teamwork among all these professionals is difficult to implement and when effectively carried out it is highly resource and time consuming.

**FEASIBILITY:** It would require a redefinition of the Albanian health system focussing on the primary health care team, with all the functions of the WCCCs gradually incorporated into the primary care teams and FDs being part of the team. Obst gyn and paediatric specialists would still be involved in PHC. This may be in contrast with the common aspiration of specialist to be involved in secondary care.

3. **Italian model.** The third hypothesis is based on the Italian model of Consultori Familiari, which covers the tasks originally attributed to WCCCs and have similar staffing (nurses, midwives, paediatricians and obst/gyns, plus psychologists and social workers who are also part of the team and cover psychosocial issues). Family paediatricians and Family doctors work individually, outside the CF team and in different premises.

A variant of the above model, which is currently being considered in Emilia Romagna, is to differentiate - within the CFs - two levels of care: the first level includes midwives only, which in collaboration with the FDs provide antenatal care (excluding US) postnatal care including postpartum and breastfeeding support, information on fertility and sterility and information on prevention of cervical cancer and pap test. The second level includes US, gynaecological endoscopy, consultation visit in obstetrics, gynaecology and sexuology, screening organization and surveillance, group sessions (perinatal classes etc., parental education, adolescent groups).

**PROS:** Multidisciplinary care, comprehensive package of services, high responsibilities given to midwives

**CONS:** Limited integration prevention-cure. It contains the risk of some redundancies, particularly in cities where hospital specialists are available.

**FEASIBILITY:** The Italian model is in line with the current system in Albania and would not need a major modification of the current organizations. However, it would require a strong effort in ensuring quality and building capacity in order to deliver in areas that at present are not covered or are covered in a substandard way. Therefore, major investments in both infrastructure and equipment as well as in recruitment, selection and/or training of health personnel should be pursued.

These three main models have been proposed and they have been discussed with the national team on the 20th of January, 2011.

### III B. PROPOSED MODEL

In synthesis the outcome of this analysis was as follows:

1. In principle, it would be possible to assign all essential preventive MCH tasks to family doctors and community nurses and nurse/midwives. In practice, given the current training background of family doctors in MCH and the scarcity of well trained community nurses and nurse/midwives, this does not seem to be applicable in Albania for the near future. It would not ensure the capacity to deliver quality care on a number of key MCH tasks and will quite likely lead to lose even the current reach-out capacity ensured by the WCCCs through the home visits, at least for immunizations and well baby care.

2. A second hypothesis of reorganization could be based on the Spanish model of Centros de Atenciòn Primaria (Centres of primary care), where family doctors work jointly with paediatricians,
nurses, midwives, therapists and administrative personnel. Home care is ensured by visiting midwives and nurses, while centres include all other services. This is a good way to provide integrated preventive and curative PHC care, and has the advantage of creating the conditions for team work and to provide users the access to multidisciplinary services in the same location. However, it would require a redefinition of the Albanian health system focussing on the primary health care team, with FDs seen as part of the team, and a greater number of obst gyn and paediatric specialists involved in PHC, while Albania has already made a choice in the direction of the Family Doctor model. This option, which would gradually incorporate all the functions of the WCCCs in the primary care teams, does not seem to be in agreement with the current structure and with directions of the Albanian health system, based on the family doctor model.

3. The third hypothesis is based on the Italian model, where Family Doctors and Family paediatricians ensure most of PHC but reproductive health services and preventive child health are provided by the “Consultori Familiari”, which cover the tasks originally attributed to WCCCs and have similar staffing (nurses, midwives, paediatricians and obst/gyns). Psychologists are always part of the team to cover also psychosocial issues. This model would not need a major modification of the current organizations, but would require a strong effort to ensure quality and to build capacity to deliver in areas that at present are not covered or are covered in a substandard way. It would also need to develop a capacity to deliver on curative paediatric PHC, alone or in collaboration with polyclinics, and capacity to prescribe.

This solution is more in line with the current system in Albania. It would not require major investments in infrastructure and equipment, but rather in recruitment, selection and/or training of health personnel at all levels. It would maintain a somewhat redundant system particularly in cities where polyclinics and hospital specialist are available, so that clear distinction or complementarity of roles will need to be established.

An adjunctive advantage of this solution is that by strengthening the role and the capacity of MCH inspectors, it will be possible to improve the quality of primary MCH care also in rural areas. The WCCCs could expand their role to rural areas by providing part-time outreach services and by articulating peripheral centres, operating with limited personnel and on a part-time basis, similarly to what exists in some neighbourhoods of Tirana. Once improved in their capacity of delivering quality services, the WCCCs could provide a substantial support to the work of FDs and nurses/midwives even in rural areas, through supervision, guidelines, educational aids etc.

The team agrees that the RH specialist (MCH supervisor) will be a key position in which to invest for coordination and supervision purposes and also as agents of change. The team recognizes that the professionals occupying this position at the moment do not have all the needed competences, that their role and responsibilities (and salary, including incentives) need to be expanded. In principle, this position could also be held not only by doctors but also by nurses/midwives with a University degree. It will require in all cases an appropriate public health and managerial training.

The national team also agreed that, according also to tasks originally identified by Decision no.146 and 147:
- the tasks should include both preventive and ambulatory curative services, and over child

48 A variant of this option, currently being considered in Emilia Romagna region, is to differentiate within the CFs two levels of care: first level includes midwives only, who in collaboration with the FDs provide antenatal care, postnatal care including postpartum and breastfeeding support, information on fertility and sterility and information on prevention of cervical cancer including pap test. The second level includes ultrasound, gynaecological endoscopy, sexuology, screening organization and surveillance, perinatal classes etc., parental education, adolescent groups.
development and child protection, with the inclusion in the team of psychologists and social workers (or, alternatively, with close collaboration with specific ECD and CP services - the role of nurse/midwives should be enhanced.

Based on the above the duties of WCCC their overall mission within the district should be redefined as follows (box, from Doc no.147), while the tasks should be revised according to suggestions (annex 1).

<table>
<thead>
<tr>
<th>Box. DUTIES OF THE CONSULTATION CENTER IN THE urban setting</th>
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<tbody>
<tr>
<td>The mission of the consultation center of women in primary health care is:</td>
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<tr>
<td><strong>Protection and promotion of women’s reproductive health, of health and well being of mothers and children; protection and promotion of child development.</strong></td>
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### III C. REQUISITES FOR ESTABLISHMENT OF THE NEW WCCC MODEL

In all cases, in order to gradually improve the WCCCs’ capacity to deliver quality services in all main preventive MCH areas including FP, STI prevention, ANC, immunization, infant and young child nutrition and growth monitoring, child development and child protection, the following will be needed:

1. Revision of tasks of WCCCs. Current regulations and tasks of WCCC should be revised to include child development (CD) and child protection (CP), and to better reflect international recommendations concerning reproductive and antenatal care, infant and young child feeding and growth monitoring (IYCF&GM). Suggestions are included in Annex 1.

2. Definition of the composition of the WCCC’s team and staffing standards. Standards need to be defined according to the new tasks and then gradually adopted based on the availability of newly trained staff and of current staff after training. Suggestions are included in Annex 2.

3. Development of guidelines and related tools for each task. The home visitation system will be revised and the number of visits slightly reduced in number. Each visit will be given specific objectives according to the age of the child and problems/risks encountered, the setting (home or centre) and the kind of professional conducting the visit (nurse/midwife or doctor). Criteria for referral (hospital, child development centres and social protection units) will be defined.

4. Thorough revision of the role and capacity of the reproductive health district specialist. Suggestions are included in Annex 3.

5. In-service training of the currently available personnel (based on 1 and 2) and of the newly recruited personnel. Suggestions are included in Annex 4.

6. Incorporation of the new training contents in pre-service training and curricula, starting with midwives and nurses (based on 1 and 2).

7. Introduction of accreditation criteria – structured along the principles of equity, quality, continuity of care and public health approach, and of 3 to 4 selected performance based salary components, which will need to be consistent national plans by MoH and IHI.

8. Development of a communication strategy for MCH and of related materials, in collaboration with...
with the IPH.

9. Development of a PC based health information system, based on relevant MCH indicators, for more effective follow-up and surveillance, in collaboration with IPH and MoH.

We think it should be possible to reorganize the system in this way within the current budget, by reducing unnecessary activities and paper work, by gradually reducing the number of health personnel (e.g. limiting the turn-over of retired staff) and by deploying newly trained personnel according to a need assessment for each WCCC. In principle, the proportion of paediatricians and obstetricians could be gradually reduced with respect to nurses and nurse/midwives, and the role of midwives and nurses increased. The role of RH specialist could also be filled by University degree nurses/midwives, once appropriately trained. This option needs to be verified based on assessment of users’ views and possibilities to re-train and train new nursing and midwifery personnel.

The management of the WCCCs will have to be revised to ensure efficiency and quality. Mechanisms that may be considered to improve the cost-effectiveness of the system could include:

1. investment in managerial capacity. Besides the thorough revision of the role of inspectors/MCH supervisors, the current programmes for PHC managers will have to be strengthened.
2. identification and use of quality indicators for performance-based bonus incentives (to be agreed with HII)
3. introduction of supervisory systems (to be seen as linked to no.1 and 2) and revision of the package of the supportive supervision package from the Centre of quality, standards and accreditation
4. introduction of users’ perspective mechanisms, and of users’ participation and collaboration to the activity of the WCCCs (women’s association, voluntary associations, NGOs)

Whatever reorganization option may be considered, it will need a phased incremental approach by gradual introduction of new tasks accompanied by appropriate training, indicators and supervision systems. Roles of MoH, IPH, HII and Regional managers will need to be identified

III D COHERENCE WITH KEY ELEMENTS OF HS REFORM IN ALBANIA

The proposed reorganization fits the key elements of the health reform process in Albania:

a) Streamlining health services, including a rationalization of the PHC facility network;

The proposal introduces criteria and directions to make the current service delivery in the MCH area, including in rural areas, more uniform and coherent

b) Improving the quality of health services

The proposal is essentially focusing on improving quality of services, in all its dimensions: quality: safety, effectiveness and responsiveness to patients’ and users’ needs, including mother and child friendly attitude.

c) Protecting and increasing financial resources for the health services;

The proposal takes into account the need to contain costs, by envisaging an overall reduction of
health professionals employed and a shift of emphasis on qualified (university degree) nurses and midwives

d) Developing human resources;

The proposal has in human resource development, including training, motivation and incentives one of its main focuses.

e) Strengthening the health information system.

The proposal aims at creating the knowledge and organizational basis to contribute to a surveillance system in Albania in the areas of reproductive health and child health and development.

The proposal, by improving both horizontal and vertical links throughout the health system and between health sector and other sectors, should also strengthen the collaboration between MoH, IPH, HII, professional organizations and other sector and civil society organizations in implementing public health approaches to reproductive health, antenatal health, child health and development .

IV PROPOSED PLAN OF ACTION

The following plan of action is proposed to gradually implement the new system (time line to be established by MoH).

<table>
<thead>
<tr>
<th>Nr</th>
<th>Activity</th>
<th>Timeline</th>
<th>Budget</th>
<th>Comments/implementation requisites</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Discussion and approval of final document by MoH</td>
<td>March 2011</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Organize a one-day conference to present WCCC reorganization proposal</td>
<td>March 2011</td>
<td></td>
<td>Endorsement of the reorganization plan by all stakeholders</td>
</tr>
<tr>
<td>3</td>
<td>Establish a technical working group to revise tasks of WCCC personnel, RH specialists and the contents of the basic package of services at PHC</td>
<td>May 2011</td>
<td></td>
<td>Redefine salary and performance based incentive systems – MOH and HII to discuss how and when to incorporate suggested changes</td>
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<tr>
<td>4</td>
<td>Establish a technical WG for development of guidelines and related tools for each tasks</td>
<td>June 2011</td>
<td></td>
<td></td>
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<tr>
<td>5</td>
<td>MOH to approve new guidelines based on suggested international references</td>
<td>October 2011</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Development of a communication strategy for MCH and of related materials, in collaboration with IPH</td>
<td>September 2011</td>
<td></td>
<td>Revision of current IEC strategies and tools and proposals for strengthening and improvement; Establishment of a Working group MoH /IPH</td>
</tr>
<tr>
<td></td>
<td>Identification of key MCH indicators to be included in the</td>
<td>November</td>
<td></td>
<td>Assessment of MCH related information system and Relevant</td>
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<tr>
<td></td>
<td>Activity Description</td>
<td>Year</td>
<td>Details</td>
<td></td>
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<tr>
<td>6</td>
<td>Prepare training modules for in-service training</td>
<td>2011</td>
<td>Bodies (MoH IPH) to discuss how to incorporate suggested indicators</td>
<td></td>
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<tr>
<td>7</td>
<td>Conduct in-service training: capacity building for RH specialists</td>
<td>2012</td>
<td>Select candidates (25 to 30) to fill the post of RH supervisor</td>
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<td></td>
<td>Run a first 10-day introductory training course (Public Health</td>
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<td></td>
<td></td>
<td></td>
<td>Approaches to MCH)</td>
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<tr>
<td>8</td>
<td>Conduct in-service training: capacity building for Child health</td>
<td></td>
<td>Select candidates (25 to 30)</td>
<td></td>
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<tr>
<td></td>
<td>consulting centers</td>
<td></td>
<td>Organize first two 10-day courses (ToT?)</td>
<td></td>
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<tr>
<td>9</td>
<td>Conduct in-service training: capacity building for women</td>
<td></td>
<td>Select candidates</td>
<td></td>
</tr>
<tr>
<td></td>
<td>consulting centers</td>
<td></td>
<td>Organize first two 10-day courses (ToT?)</td>
<td></td>
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<tr>
<td>10</td>
<td>Incorporation of the new contents in pre-service training and</td>
<td></td>
<td>Approval by University/Schools of Nursing; Proposals discussed with</td>
<td></td>
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<tr>
<td></td>
<td>curricula, starting with nurses/midwives</td>
<td></td>
<td>Heads of Schools</td>
<td></td>
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</table>

The costing of the above activities, plus an estimate of the running costs of the system once reorganized should be done by MoH, also as a basis for donors’ contribution (only to starting costs, training, guidelines development, etc.)

V. LIST OF ANNEXES

1. REVISED TASKS OF WCCC (BASED ON BASIC PACKAGE OF PHC SERVICES AND TAKING INTO ACCOUNT DECISION NO. 146 AND 147)
2. SUGGESTED STAFFING STANDARDS
3. REVISED TASKS OF DISTRICT MCH INSPECTORS
4. SUGGESTED TOPICS AND ORGANIZATION FOR TRAINING ACTIVITIES FOR THE HEALTH PROFESSIONALS
5. MAIN FINDINGS OF THE SURVEY ON HEALTH PERSONNEL OF WCCCS
6. LIST OF INTERNATIONAL GUIDELINES TO BE USED AS MAIN REFERENCES
7. DOCUMENTS USEFUL TO ILLUSTRATE THE ITALIAN MODEL (CONSULTORI FAMILIARI)

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50 This kind of course is currently offered by the European School for Maternal Newborn Child and Adolescent health in Trieste, Italy and could be adapted for the specific Albanian context.