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STAFF APPRAISAL REPORT

REPUBLIC OF ALBANIA

HEALTH SYSTEM RECOVERY AND DEVELOPMENT PROJECT

May 14, 1998

Human Development Sector
Albania and Croatia Country Unit
Europe and Central Asia Regional Office

CURRENCY EQUIVALENT
Currency Unit - Albanian Leke (LK)

AVERAGE EXCHANGE RATES
(Albanian Leke per US$)
March 1998 US$1.00 = LK 159

WEIGHTS AND MEASURES
Metric System

FISCAL YEAR
January 1 - December 31

ABBREVIATIONS AND ACRONYMS

CEE	Central and Eastern Europe
CEM	Country Economic Memorandum
CIF	Cost Insurance Freight
EBRD	European Bank for Reconstruction and Development
EME	Established Market Economies
GDP	Gross Domestic Product
GOI	Government of Italy
GP	General Practitioners
HIF	Health Insurance Fund
HII	Health Insurance Institute
ICB	International Competitive Bidding
ICU	Intensive Care Unit
IDA	International Development Agency
IMF	International Monetary Fund
IS	International Shopping
LS	Local Shopping
MOF	Ministry of Finance
MOH	Ministry of Health and Environment
NIPH	National Institute of Public Health
PCU	Project Coordination Unit
PHC	Primary Health Care
PIP	Project Implementation Plan
RHA	Regional Health Authority
RHMT	Regional Health Management Team
RMB	Regional Management Board
SOE	Statement of Expenditure
TOR	Terms of Reference
UKKHF	United Kingdom Know How Fund
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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REPUBLIC OF ALBANIA

HEALTH SYSTEM RECOVERY AND DEVELOPMENT PROJECT

STAFF APPRAISAL REPORT

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This report is based on the findings of World Bank missions which visited Albania between December 1996 and November 1997. The missions were comprised of Guy Ellena (formerly Senior Health Economist, ECSHD and Task Manager for the early stages of the Project), Olusoji Adeyi (Health Specialist, ECSHD), Virginia H. Jackson (Operations Officer, ECSHD), Besim Nuri (Project Officer, ECCAL), and Ross Pavis (Program Assistant, ECSHD). Elira Sakiqi (formerly Project Officer, ECCAL) worked with the team throughout the process. Dena Ringold (Research Assistant, ECSHD) contributed to the statistical profiles and the sections on project benefits. Staff Member/Task Manager: Olusoji Adeyi (ECSHD); Sector Leader: Chris Lovelace (ECSHD); Albania Country Director: Arntraud Hartmann (ECSAL); Peer Reviewers: Alexandre Abrantes (LASHD), Verdon Staines (EMTHR).

REPUBLIC OF ALBANIA

HEALTH SYSTEM RECOVERY AND DEVELOPMENT PROJECT

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REPUBLIC OF ALBANIA

HEALTH SYSTEM RECOVERY AND DEVELOPMENT PROJECT

Credit and Project Summary

BORROWER:	Republic of Albania
BENEFICIARIES:	Ministry of Health and Environment (MOH) Health Insurance Institute (HII) Selected primary health care centers and polyclinics Tirana Hospital Health care providers in Tirana Region The population of Tirana Region
CREDIT AMOUNT:	SDR 12.6 million (US$17.0 million equivalent)
TERMS:	40 years, including 10 years of grace, at standard IDA service charge
PROJECT OBJECTIVE:	The Project will help develop institutions and national capacity for an effective and sustainable health care system. Its specific objectives are to: (i) establish/strengthen institutional and human resource capacities for an effective and sustainable health sector; and (ii) improve the accessibility, quality and efficiency of health services.
PROJECT DESCRIPTION:	The proposed Project will provide financing for civil works, general services equipment, computer hardware and software, medical equipment, fellowships, study tours, foreign and local training, expert advisory services, public education materials, and incremental recurrent costs. The estimated total cost of the Project is US$28.0 million, of which US$17.0 million will be financed by the IDA Credit. The Project will be implemented over a period of four years by MOH, and consists of four components: National Capacity Building (estimated base cost US$1.9 million). This component will develop and strengthen institutions and competencies required to implement the sector development strategy. The strategy was developed over the past three years by Albanians with international donor collaboration, and endorsed by

the MOH in letters to the Bank, in December 1997. The target institutions are the MOH and the Health Insurance Institute (HII).

Governance and Management of Health System in Tirana Region (estimated base cost US$ 1.2 million). This component will support the establishment and functions of institutions to undertake the decentralization of planning and management to the regional level in Tirana, through assistance to two entities: the Regional Health Management Team (RHMT) and its Management Board.

Upgrading of Tirana Health Care Delivery System (estimated base cost US$20.9 million). This component will support civil works, medical equipment, and supplies for a network of one hospital, three polyclinics, and 37 health centers; technical assistance to improve the functional relationships among the health services and facilities; technical assistance for the adaptation and use of standard clinical protocols; and technical assistance in support of selected public health interventions of potentially high impact on health status.

Project Management (estimated base cost US$0.5 million). This component will provide support to overall management of the Project, in the form of additional office equipment, technical assistance, staff and training, for the existing Project Coordination Unit (PCU) in the MOH.

BENEFITS: The Project will support the immediate restoration of health services to the population, thereby preventing outbreaks of communicable diseases and needless complications of common illnesses. Beyond the immediate future, it will support fundamental improvements in the structure and functions of the health system. It will also support improvement of quality of clinical services and an increased emphasis on the prevention of communicable and non-communicable diseases.

In terms of economic benefits, the Project finds its strongest justification in the fact that it is consistent with and supports the Bank's proposed economic strategy for Albania, i.e., the restoration of fiscal balance through a wide-ranging reform program. When applied to an underfinanced sector of the economy like the health sector, where resource cuts are neither justified nor feasible, the economic rationale translates into ways of raising effectiveness, productivity and quality. The benefits of the Project will therefore accrue from the difference between incremental costs and savings attributable to the Project. Most of the cost savings will come from improvements in organization, management and

administration, and the reduction in the costs of poor quality of care.

Finally, the proposed Project is a powerful tool for the Government to make the best use possible of external resources. Donors have expressed their support for the strategy outlined by the Government. The Project provides the required framework to implement this strategy. Although impossible to measure, a major benefit of the Project is its potential to minimize wasteful gaps and overlaps due to difficulties in coordinating national and international resources, especially during the post-crisis period.

RISKS:

There are three major sets of risks to the Project. The first is that political and social upheavals could preclude the stability needed for effective implementation and institutional development. This risk will be mitigated by: (a) the benefits to major stakeholders of cooperation in all aspects of the recovery program, and (b) the emphasis on improving community ownership of, and involvement in, health service planning, organization and management. Specifically, Local Health Advisory Committees will be established at the commune level, with inputs into the local planning of health service delivery. Health Advisory Committees will be established at the Regional/District Levels, to work with District Health Management Teams and the proposed Tirana Regional Health Authority in health planning, service delivery and management, and to improve responsiveness of the health sector to local problems. Representatives of the NGO Forum will be encouraged to participate as members of the management teams for districts and hospitals. Further details are shown in the Health Sector Strategy Matrix (Annex 6, Section C). The second -and project specific- risk is that weak national capacity for implementation could hinder effective implementation. This risk will be mitigated by specifying responsibilities for implementation prior to project effectiveness and by appropriate use of external technical assistance. Prior agreement with the Government on the need for technical assistance for the Project Coordination Unit has been emphasized. Finally, fiscal instability could make it difficult for the Government to meet its counterpart financing commitments under the Project and to operate services effectively beyond the initial phase. This risk will be mitigated by limiting required counterpart funds to the most essential recurrent expenditures. Given the weaknesses of the Albanian economy and its recent history of political and social strife, expectations of local implementation capacity, counterpart funds and speed of implementation must remain realistic and modest.

Estimated Costs and Financing Plan[1]

	Local	Foreign (US$ Million)	Total
1. National Capacity Building	0.3	1.7	1.9
2. Governance and Management of Health System Tirana Region	0.3	0.9	1.2
3. Upgrading of Tirana Health Care Delivery System	7.1	13.8	20.9
4. Project Management	0.1	0.4	0.5
TOTAL BASE COSTS	7.7	16.8	24.5
Physical Contingencies	0.8	1.5	2.3
Price Contingencies	0.4	0.7	1.2
TOTAL PROJECT COSTS[2]	8.9	19.1	28.0
Financing Plan:			
Government	2.4	0.0	2.4
IDA	5.1	11.9	17.0
Other Donors	1.4	7.2	8.6
TOTAL	8.9	19.1	28.0

Estimated Disbursements (US$ Million)

	FY98	FY99	FY00	FY01	FY02
Annual	1.0	4.0	6.3	4.6	1.1
Cumulative	1.0	5.0	11.3	15.9	17.0
Cumulative as % of Total	6%	29%	66%	94%	100%

[1] Detailed numbers may not add to totals due to rounding.

[2] Including taxes and duties equivalent to US$0.9 million. Most imported items financed by international agreements are exempt from duties and taxes.

1. INTRODUCTION

A. COUNTRY/SECTOR BACKGROUND

1.1 At the onset of its transition to a democratic society and a market economy, Albania had inherited a health system conditioned by forty years of a command economy and isolation from the rest of the world. Table 1 shows a summary of health status, services and finance in Albania, as well as those of Central and Eastern Europe (CEE), Established Market Economies (EME), and Pakistan, a country with comparable income. Yet, the average life expectancy at birth, estimated at 73 years, is superior to that of any other country in Central and Eastern Europe (CEE). This profile is substantially due to lower adult death rates, in turn the result of healthy diets with low fat, high vegetable contents, low prevalence of sedentary lifestyles and low incidence of automobile accidents and industrial injuries. The infant mortality rate in Albania, estimated at 36 per 1,000 live births in 1994, is worse than those of its wealthier neighbors in CEE, but substantially better than the performances of other countries at similar income levels, such as Pakistan (95 per 1,000 live births). This favorable outcome is largely attributable to superior achievements in female education and childhood immunization. However, aggregate numbers mask inequities in access among geographical sub-groups and the poor quality of health services. In addition, a major increase in the burden of non-communicable diseases is imminent, due to the epidemiological transition in Albania. Some population sub-groups, for example, women of childbearing age, have higher risks of premature deaths: the maternal mortality ratio, estimated at 40.6 per 100,000 live births in 1994, is much higher than the weighted averages for CEE and the EME.

Table 1: HEALTH SERVICES AND STATUS

Indicators	Albania			CEE	EME	Pakistan
	1990	1994	% change	1994	1994	1994
Physicians per 1,000 population	1.4	1.3	-7.1%	2.4	2.2[a]	0.5[b]
Hospital beds per 1,000 population	4.0	3.0	-25.0%	8.8	8.4[a]	0.7[b]
Life Expectancy at birth	72.1	73.7[b]	2.2%	71.1[b]	76.9[c]	60
Males	69.3	69.5	0.3%	--	--	62[d]
Females	75.4	75.6	0.3%	--	--	64[d]
Crude death rate (per 1,000 persons)	5.4	5.3[b]	-1.9%	11.4[b]	10.1[c]	8.4
Infant mortality rate (per 1,000 live births)	28.3	31.0[d]	9.5%	14.4[b]	6.8[c]	92
Maternal mortality ratio (per 100,000 live births)	37.7	40.6	7.7%	20.9[b]	6.7[c]	340

Sources: World Bank, WHO/HFA, UNICEF/ICDC

a) OECD 1992; b) 1993; c) EU 1993; d) 1995

Table 2: HEALTH FINANCING

	1990	1991	1992	1993	1994
Health to GDP Ratio	3.4	4.4	3.3	3.0	2.8
Real health spending as % of 1990	100	95	79	40	42
Real per capita health spending as % of 1990	100	93.0	75.5	37.7	39.3
Real GDP as % of 1990	100	73	67	73	80

Source: SCT and MultiQuery Databases

1.2 Albania began the transition from central planning to a market economy with two main objectives for the health sector: (a) preventing further deterioration in basic health services through rehabilitation of the most essential infrastructure, and upgrading the skills of personnel; and (b) undertaking the initial stages of transition to a cost-effective and financially sustainable service system, emphasizing health outcomes and an efficient management system. These objectives were widely supported by the international community, including the World Bank, through substantial investments in infrastructure restructuring and rehabilitation, through reorganization and operational support to its supplies procurement and distribution system, and most importantly for the longer term, through sustainable development of its sectoral institutions and human resource capacity.

Immediate and Medium Term Challenges

1.3 Although the health sector did not suffer a complete collapse, the recent economic, social and political upheavals have caught it in a phase of mid-recovery from the past inefficiencies and inadequate functioning. This resulted in uneven disruptions of primary health care and hospital services, ruptures of fragile supplies and maintenance systems, damage and/or destruction of basic infrastructure and equipment, and the undermining of confidence among the health professionals in the system. In addition, the events have resulted in large but unspecified numbers of injuries, mainly from physical assault and firearms. The health system was not prepared for a sudden and increased caseload. The Ministry of Health and Environment (MOH), which has articulated an Emergency Aid Program, reports a depletion of surgical materials and consumables, equipment for blood transfusion and laboratory reagents for public health services, and communicable disease control. In some districts, health centers, stores of Public Health Departments and hospitals have been robbed of equipment and in some cases, damaged or destroyed. Vaccine availability and cold chain equipment have also been affected in some places, threatening the effectiveness of basic control of communicable diseases which are at risk of re-emergence in the current context of economic recession.

Sector Issues

1.4 In the current post-crisis period, the main sector issues are not fundamentally different from those of the pre-crisis period. Nevertheless, the crisis phase has raised their acuteness, calling for a quick and effective response. There are four main issues currently facing the health sector in Albania, namely: (i) a potential breakdown of basic clinical and public health services, due to shortages of essential supplies and equipment -- to be addressed through short-term relief and supplies, while developing adequate mechanisms to ensure an effective and affordable provision of these basic inputs on a sustainable basis; (ii) weak planning and management capacity, which will be addressed through the revised Policy and Governance Framework, both at the national and regional/district levels: (iii) low level of resources and inadequate financing and payment mechanisms, to be addressed through the revised financing and Provider Payment Framework; and (iv) a structural mismatch between health services provided and population needs that, beyond the needed immediate recovery interventions, should be addressed through the proposed reforms of policy making, governance and management, as well as investments in upgrading the health care delivery system. These main issues and priorities are detailed below.

1.5 A potential breakdown of basic clinical and public health services. There is a shortage of laboratory reagents, spare parts and consumables for running a system of simple clinical and public health functions. The risks are that uncomplicated illnesses will get worse, resulting in more suffering, disability and deaths. Equally important is the risk of major epidemics if public health functions are not restored immediately. For example, reductions in immunization coverage could result in epidemics of measles.

1.6 Weak planning and management capacity. At the national and regional/district levels, definitions of tasks are insufficiently specified and/or overlapping, and human resource capacity remains weak. Responsibilities for planning, managing and implementation are not clearly delineated. This is particularly acute for the region of Tirana, which covers two distinct administrative structures, the City and a rural district, which manages separate funds. In addition, other services are directly managed by the central MOH. At all levels of health facilities, information systems and modern resources management methods are still embryonic.

1.7 Low level of resources and inadequate financing and payment mechanisms. At about 5 percent of GDP, total health expenditures (including foreign aid) are among the lowest in Europe, but are in line with countries of comparable wealth. While economic growth should progressively allow a larger share of GDP to be spent on health care, service availability will continue to be constrained by resources, and stringent priorities will need to be set. Despite the laudable efforts to develop health insurance, most of the resources continue to originate from the Government budget. Expenditures are, and will remain, very sensitive to fiscal adjustments, and are still largely allocated on an input-basis (salaries, historical budgets), irrespective of their relative performance. These are subject to large fluctuations in light of Albania's political and social upheavals. To that extent, financing remains constrained by inefficiencies inherited from the socialist regime, when resource allocation among institutions, cities and regions was largely driven by political considerations and followed neither a demographic, epidemiological nor geographic rationale. Overall funding of health institutions still depends mainly on central

Government institutions (MOF, MOH) and still results in inequitable and unbalanced resource distribution. Despite progress, the absence of incentives still fails to motivate health sector staff. Overstaffing and low productivity are sustained through low salaries, low non-wage operational inputs and minimal medical technology at all levels of care.

1.8 Structural mismatch between health services provided and population needs. The health of Albanians shows a mixed picture typical of countries undergoing the epidemiological transition. On the one hand, there is a persistent burden of communicable diseases and relatively high maternal mortality ratios. On the other hand, there is an increasing load of non-communicable diseases. However, the health service delivery system is substantially incongruent with the health service needs. The system still suffers from the inefficiencies inherited from central planning: services are concentrated in large institutions, with emphasis on curative services that without appropriate primary care and public health interventions, provide poor return on investments. Lower-level facilities -- health centers and polyclinics -- are still characterized by an "over-specialization" of physicians, which results in a damaging fragmentation of services. Technical skills and competencies remain, in general, weak and inappropriately allocated. Prevention and promotion activities are still notably underdeveloped, and there is an under-appreciation of the potential impact of public health interventions on aggregate health status.

B. The Government's Sector Recovery and Development Strategy

1.9 The Government's strategy, shown in Annex 6 (Health Sector Strategy), stresses the concurrent development of (a) effective governance, policy formulation and management capacity, as well as (b) upgrades of the service delivery infrastructure to meet the needs of the population. Each of these is necessary, and neither is sufficient by itself. The strategy was formulated through a careful and deliberative process involving major stakeholders in Albania's health sector, in consultation with foreign partners. It is being further elaborated and will be formally launched by the Ministry of Health in the third quarter of 1998. For the last four years, and with support of the donor community, the MOH has been developing the elements of an overall policy framework. Several policy and planning documents [2] have been drafted that cover overall health care reform, the development of Primary Health Care, and the country's hospital strategy and master plans for the rehabilitation and development of Tirana University Hospital and two regional hospitals in Shkodra and Vlora. In parallel, the Government has initiated a comprehensive reform of its financing system, aimed at providing a sustainable foundation for the sector operation and development, and gradually reducing the inefficiencies of the past

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2 Health Care Reform in Albania. Background document 1: Situation Analysis; Background document 2: Policy Options Appraisal. Ministry of Health and Environment Protection - WHO/EURO. April 1996.

Primary Health Care Policy. Ministry of Health and Environment Protection. 1995

1996-2001 Hospital Policy In Albania. Ministry of Health and Environment Protection - Assistance Publique Hopitaux de Paris (APHP). July 1996.

Master Plan for Tirana University Hospital. Ministry of Health and Environment Protection - Assistance Publique Hopitaux de Paris (APHP). 1996.

system. Most notably, the issue of major overstaffing has begun to be tackled through an initial program of privatization (pharmacies and most dental/stomatology services). With the establishment of the Health Insurance Institute (HII) in 1995, a powerful instrument for health financing reforms and regulation has been launched. Specific achievements are specified below.

1.10 Health services: Reforms have addressed inefficiencies in resource use and allocation, including overstaffing and duplication of physical resources. The structure of health care services has been streamlined, and hierarchical and operational links have been established among levels of services. This has been achieved through the closure of some rural hospitals, reduction in the number of day-nurseries, privatization of some services (mostly pharmacies and dental services), and the emigration of medical specialists who have left Albania to work abroad. Following the design of a rational "health care map" of primary care units, hospital beds were sharply reduced in most districts, and more than 40 small rural hospitals were shut down. In 1996, the total number of public employees in the health care system was 28,371, in comparison with 35,000 in 1991.

1.11 Health financing: Government-backed reforms have been characterized by a pragmatic move towards a rational financing mechanism. Initial measures to secure essential resources have included: (i) stabilization of the sector budget by combining foreign aid and resources raised from national taxes; (ii) privatization of selected health services (pharmacies and dental/stomatological services); (iii) elimination of subsidies for drugs prescribed in out-patient services; and (iv) decentralization of fiscal responsibilities to municipalities, which has not translated, however, into additional resources for the sector in the absence of local sources of revenue. The reform strategy has sought to diversify sources of financing for the health sector, and to introduce new provider payment mechanisms, in order to shift emphasis from input to output financing. In the two years since its establishment, the HII has developed into a useful instrument for health financing reforms, contracting with private sector providers of dental and pharmaceutical services, and regulation at the primary health care level. The scheme remains modest (13 percent of total health expenditures including foreign aid, and 22 percent of public expenditures in 1996), but has met its assigned initial objectives: (i) developing effective operational structures and human resources capabilities; (ii) devising and implementing new output-based provider mechanisms and operational procedures to manage benefits; (iii) maintaining sound financial status; and importantly: (iv) drawing a pragmatic medium-term strategic development plan.

1.12 Sustained efforts should facilitate the attainment of basic health services coverage objectives set for the year 2000. To optimize these favorable developments and achieve further health gains, additional investments are required in the health sector to: (i) ensure the development of an effective health services delivery system, encompassing preventive and curative services; and (ii) improve policies and strategies to guarantee the efficiency and sustainability of investments. The Government is committed to developing a three-pronged reform strategy. First, new efforts will be made to strengthen the overall policy and governance framework. Second, the financing and providers payment framework will be further elaborated. Third and concurrently, investments will be directed toward supporting the development of the capacities required to implement the new policy framework, and the development of effective

health care services, encompassing preventive and curative services consistent with the needs of the population.

(a) A revised Policy and Governance framework. The Government strategy will aim at the development of the capacity to plan and regulate health services according to needs.

- *At the national level*, emphasis will be put on strengthening core skills required to fulfill the responsibilities of the Ministry of Health (MOH) and the Institute of Public Health (IPH). The MOH, in the medium-term, will evolve into a policy-making and regulatory institution, leaving planning and routine management functions to the regional and/or district authorities. The MOH will concentrate on policy formulation, setting standards of care, accreditation and quality assurance, monitoring of professional licenses, consumer protection, health promotion, public health development, and private practice supervision to ensure that the public and private sector play their respective roles under appropriate limits. The IPH will, within the parameters established in the national health policy, provide the technical framework and guidance for development and implementation of cost-effective, preventive, and promotional health interventions.

- *At the regional level -- and in a first phase, in the region of Tirana* -- the Government will decentralize the responsibilities for organization and overall management of services through the establishment of a Regional Health Authority (RHA) comprising two entities. A Regional Health Management Team (RHMT) will assume the functions of financial and organizational planning and supervision for public health, primary health care, specialized out-patient services (polyclinics) and in-patient services (hospitals). The RHMT will be responsible to, and serve as, the executive arm of a Regional Management Board (RMB). The approach will first be developed in the Tirana Region. In the remainder of the country, in the short term, and pending what is learned from the experience of Tirana, the district health teams will be in charge of most of the functions envisaged for the RHMT in Tirana.

(b) A Revised Financing and Provider Payment Framework. The objective of the Government program will be to reinforce the role of the Health Insurance Institute (HII) through the development of its capacity to contract (purchase) services. On the revenue side, efforts to improve the collection of contributions will have to be emphasized together with a redefined distribution of responsibilities and improved coordination mechanisms between the Social Insurance Fund and the Health Insurance Fund at the national and districts levels. Consideration will be given to widening the contribution base, increasing the premiums in line with the expansion of benefits covered through health insurance and reducing the scope of exemptions from contributions. The HII will be entrusted to develop and implement new provider payment mechanisms, the priority being to complete the actions that have already been undertaken, in order to achieve a full, coherent set of payment mechanisms and, concurrently, initiate new actions to broaden the scope of financing

reforms. The nature and pace of the introduction of revised mechanisms will carefully balance the need to enlarge the benefit package covered through health insurance and the feasibility of doing so in order to guarantee HII's capacity to control expenditures and maintain financial soundness. Accordingly:

- ***Cover the entire costs of primary health care.*** In the short term, in addition to the remuneration of General Practitioners (GPs), the HII will define mechanisms to remunerate other PHC personnel (nurses, mid-wives, etc.). Such mechanisms will be output-based as much as possible so as to serve as incentives for higher performance. The current capitation mechanism for GPs will be reviewed to reinforce the link between the performance (the number of patients registered) and the remuneration. The HII will, therefore, define thresholds under which GPs will no longer be contracted, and enforce the revised regulation under a time frame to be defined. Finally, consideration will be given to allocate non-salary operational expenditures directly to the providers, in order to reinforce accountability and simplify administrative procedures. The KHF is currently providing valuable assistance to the HII in these areas.

- ***Over the short to medium-term, contract specialist out-patient services and in-patient services in hospitals.*** Feasibility analyses to define specific mechanisms, tools, and a gradual, pragmatic schedule for implementation will be developed by the HII. The objective will be to shift progressively towards performance-based allocation of resources. The European Commission is providing technical assistance for this exercise.

C. ROLE OF THE INTERNATIONAL DONOR COMMUNITY

1.13 Since the beginning of international donor involvement in 1992, an amount estimated to exceed US$100 million has been committed by donors for the rehabilitation of the health care delivery system, as well as for overall reform of its institutional structures. Bilateral donors such as Germany, Italy, Switzerland, the Netherlands, United Kingdom, France and the United States have provided aid to various aspects of the health system. The European Union (EU) is providing assistance in the amount of US$16 million within several programs involving broad interventions. UNICEF has provided aid in primary health care activities, e.g., Expanded Program of Immunization, and maternal and child health care. UNFPA has committed US$4 million in support of a national reproductive health program. WHO is providing technical support, mainly in the area of policy development. Many charitable and/or non-governmental organizations have provided aid, in most areas of the health sector. The Catholic Foundation is supporting the construction of a new general hospital for the Region of Tirana (see Table 3 below).

Table 3: SUMMARY OF FOREIGN ASSISTANCE BY DONOR AND ACTIVITIES

Organization	Principal activities	Estimated Amount (US$000)	Estimated disbursements (as of July 97) (US$000)
Catholic Church	New General Hospital; specialized polyclinic in Tirana.	31,000	7,000
OPEC / Islamic Bank	New General Hospital in Durres, specialized polyclinic in Tirana	10,500	150
EU-Phare	Rehabilitation of hospital labs; management training; emergency services equipment; equipment maintenance; rehabilitation of intravenous solution line production, etc.	16,000	8,000 (other 4,000 contracted)
Government of France	Preparation of Hospital Strategy and masterplan for Tirana Hospital	NA	NA
Government of Germany	Rehabilitation of three north district hospitals, MCH and Family Planning	12,000	7,000
Government of Italy	Support for University Hospital, the health services of the Region of Elbasan, the Institute of Public Health, etc.	12,000	5,000
Government of Kuwait	New orthopedic Surgery/Physical Rehabilitation Hospital in Tirana	NA	NA
Government of Netherlands	Support for Tirana National Blood Center and Institute of Public Health	3,200	3,200
Government of Switzerland	Support for Institute of Public Health	2,200	2,200
UNICEF	Primary health care	1,545	NA
UNFPA	Family planning and reproductive health	6,000	2,000
United Kingdom(Know How Fund)	Support for the Health Insurance Institute HII)	NA	NA
USAID	Mother and child health, family planning, Hospital Management Training	800	NA
WHO	Preparation of health services policy document; overall policy advice.	180	50
World Bank (IDA)	Primary Health care; Hospital Rehabilitation; Policy and Institutional Development	12,800	3,500

D. RATIONALE FOR BANK'S INVOLVEMENT

1.14 The principal rationale for the Bank's continued involvement in the health sector is as a part of the overall Economic Recovery Program: to enable the development of an effective governance and management framework that will (a) accelerate poverty alleviation through sustained improvements in health status, and (b) improve efficiency, equity and effectiveness by: limiting the role of the state to core policy and regulatory functions; decentralizing management responsibilities and authority for implementation to the regional/district levels -- closer to stakeholders at the community level; and facilitating the involvement of the private sector in those health services most suited to private sector delivery. Beyond the limited financial support, the extensive policy discussions with Government, workers and representatives of civil society at large all provide the proposed Project, and the program of which it is a part, with credibility and prospects for medium-term financing by partner agencies.

1.15 The International Development Association (IDA) has been active in Albania since the early stages of the transition. Following initial sector assessment and strategy development, a first operation in the health sector (Health Services Rehabilitation Project, Credit Number 2659-ALB) was approved in 1994 and is under implementation. This on-going project focuses on physical rehabilitation of basic health infrastructure and capacity building. The following is a summary of progress to date:

- Health Services Rehabilitation Component: Out of the planned total of 100 Primary Health Care Centers, 52 have been completed. Procurement is underway for the rehabilitation of regional hospitals in Shkodra and Vlora. Medical equipment for the same hospitals will be procured in 1998.

- Capacity Building Component: Training activities started in 1996 for District Health Management Teams. Plans have been completed for the continuing education for hospital physicians and the training will start by mid-1998. Rehabilitation work has been completed on the School of Nursing.

- Health Planning and Financing: The United Kingdom, through the Know How Fund, has provided most of the requirement for technical assistance for the Health Insurance Institute. The USAID has supported the MOH. The Health Insurance Institute is a modest and effective establishment. It covers about 13 percent of total health expenditures including foreign aid, and 22 percent of public sector expenditures. It has met its initial objectives of: (a) maintaining financial solvency; (b) developing effective operational structures and human resource capacity; and (c) defining a modest and achievable development plan for the medium term.

1.16 Project implementation was slowed down by the crisis of 1997. It has returned to a faster pace of implementation in 1998. On the basis of progress achieved so far, it is expected that both development and implementation objectives of this project will be fulfilled. Other donors, as well as the Government, have enabled accelerated infrastructure rehabilitation, and these

sustained efforts should facilitate the attainment of basic health services coverage objectives set for year 2000. The proposed IDA involvement is justified on the grounds specified below.

1.17 First, the proposed Health System Recovery and Development Project is complementary to the ongoing Health Services Rehabilitation Project. The Health Rehabilitation Project concentrates on the regions of Shkodra in the north and Vlora in the south, and on a network of primary health centers and basic capacity building. The proposed Project will concentrate on the region of Tirana in the central part of the country, as well as more profound capacity building across the entire health sector. Second, the proposed Project is part of the IDA commitment to support the economic recovery of Albania. During the course of implementation of the first project, the Bank has been actively involved in developing its policy dialogue with the Government and, together with other major international agencies, helping it develop its strategy and priorities for action. Third, over the past few years, the Bank has been active in helping the Government better coordinate other donors' involvement -- to minimize wasteful overlaps and gaps among various activities. As a result, the proposed Project consists of the core priority modules of a broader Government-backed program to be supported by the international community and national resources. Finally, the Bank's experience in investments and reforms in the health sector, as well as its more recently acquired body of knowledge in post-crisis situations in Central and Eastern Europe on bridging the potential gap between emergency and development, provide a substantial comparative advantage for assisting Albania in its health sector recovery and development.

1.18 Preparation of the proposed Project was completed before work began on the Country Assistance Strategy (CAS), to be presented to the Board of Directors later this year. However, the objectives of the proposed Project are consistent with the CAS, including the emphasis on sustainability, improved governance and management capacities, and the participatory approach to implementation (see Annex 6, Section C for details). The proposed Project is designed to support the Government Strategy, and is intended to address all four main issues currently facing the health sector in Albania (Section A above). It has been designed as a crucial part of a wider Government-backed program to be supported by the international community and national resources. It will support the following components:

(a) Improving management and governance of the health sector. This must first be done on a national basis. There is no alternative to developing a national capacity that will serve the entire health sector's efficient development. The Project, therefore, will strengthen the national institutions by building up their managerial and regulatory capacities, through support to the MOH and the HII. The MOH will, in the medium-term, evolve into a policy-making and regulatory institution, concentrating on setting standards of care, accreditation and quality assurance, monitoring of professional licenses, consumer protection, health promotion and public health development and private practice supervision. Health system management will be improved through the decentralization and professionalization at the regional/district level through the establishment of a Regional Health Authority (RHA). Since this is a new concept in Albania, the proposed Project will support such innovations on a pilot basis, initially in the Region of Tirana.

(b) Improving the efficiency and fiscal sustainability of the health sector requires the development of a national strategy and plan of actions. This is a rationale for the Government Strategy and will be supported by the Project. Specifically, the Project will support Government reform efforts to establish sustainable and efficient financing mechanisms, through the strengthening of the Health Insurance Institute (HII). The establishment of the HII in 1995 has increased the Government's ability to secure financing for health care by diversifying sources of financing and introducing new provider payment mechanisms. Rather than setting high contribution rates, the HII currently collects minimal and variable contributions from employees, supplemented by State budget contributions on behalf of uninsured groups. Expenditures have been similarly constrained by limiting the package to essential in-kind benefits covered by the HII. The Project will further enhance the capacity of the HII to develop and implement new payment mechanisms, while helping the HII build its needed analytical and managerial capacities to progressively enlarge the package of essential services covered through health insurance.

(c) Additional investments in the health service delivery system are a precondition for sustained gains in health status. The positive effects expected from the governance and financing reform agenda developed by the Government need to be matched by improvements in service delivery. Due to resource and absorptive capacity constraints, however, this cannot be accomplished in the short term, if it is to be done in a comprehensive manner. In order to maximize the synergy between improvements in governance and management on the one hand and in service delivery on the other hand, the Project will concentrate its support on investments in the region of Tirana. The Project will directly affect and benefit the health of the population by: (a) facilitating the provision of preventive and promotve public health interventions -- communicable diseases of childhood, and chronic diseases; and (b) improving the quality of clinical, primary, out-patient and essential hospital services, thereby increasing the probability of better health outcomes and limiting the costs resulting from inadequate and poor quality services.

2. THE PROJECT

A. Project Objectives and Components

2.1 The proposed Project is consistent with and guided by the Sector Recovery and Development Strategy of the Government. It is designed to support the health sector in addressing the pre-crisis priorities, which remain valid, and to alleviate the needs resulting from the disturbances. The Project's objectives are to: (a) establish/strengthen institutional and human resource capacities for an effective and sustainable health sector; and (b) improve the accessibility, quality and efficiency of essential health services in fulfillment of a precondition for sustained improvements in health status. These objectives will be achieved by : (a) rationalizing and strengthening the governance structure and the management capacity at the national, regional, and district levels; and (b) improving the effectiveness and quality of health service delivery in Tirana Region through the upgrading of selected health facilities as part of a regional health system. The Project will consist of the following four components:

(a) National Capacity Building (estimated base cost US$1.9 million).

(b) Governance and Management of the Health System in Tirana Region (estimated base cost US$1.2 million).

(c) Upgrading of Tirana Health Care Delivery System (estimated base cost US$20.9 million).

(d) Project Management (estimated base cost US$0.5 million)

B. Project Description

2.2 National Capacity Building. This component will support the development and strengthening of institutions and competencies required to implement the sector development strategy. The strategy has been endorsed by the Ministry of Health in a letter to the Bank in December 1997 (see Annex 3). The target institutions concerned are the Ministry of Health (MOH) through its various Directorates and the Health Insurance Institute (HII). Activities to be supported under the Project will consist of:

(a) specification and provision of required infrastructure -- limited civil works, equipment and information technology -- for policy and regulatory functions of the two national institutions concerned, i.e., MOH and HII;

(b) technical assistance, training and study tours for MOH staff to develop skills for legislation and regulation, formulation of public health policy, performance assessment, monitoring and evaluation of health system performance, revenue generation, budget formulation, decentralization of authority and responsibility for mid-level functions to sub-national levels (region/district); and

(c) technical assistance, training and study tours for HII to develop its capacity to specify and enforce its current mandate and new responsibilities under the sector development strategy, including but not limited to provider payment mechanisms at the primary care level.

2.3 **Assurances were received at Negotiations that the Government will: a) commit adequate resources to capacity building, including the training of nationals and procurement of crucial external technical assistance; and b) strengthen priority public health policies and services, while also improving the quality of clinical services (para. 5.1 (c)). Additionally, assurances were received that the Government will procure technical assistance from IDA resources under the Project, as planned, unless alternative Grants satisfactory to IDA are secured in writing (para. 5.1 (b)).**

2.4 Governance and Management of Health System in Tirana Region. The Project will support the decentralization of planning and management functions to the regional level in Tirana. The responsibilities will be fulfilled by a Regional Health Authority, which would consist of two bodies: the Regional Health Management Team (RHMT) and its Management Board. Activities to be supported under this component consist of:

(a) specification and provision of priority infrastructure – limited civil works, equipment information systems; and

(b) technical assistance, training and study tours to develop skills for planning, organizing and managing a cost-effective regional health system.

2.5 **During Negotiations, the Government provided assurances that the Tirana Regional Health Authority (consisting of the Tirana Regional Health Management Team and its Management Board) will be established through an order of the Minister of Health before Project Effectiveness and maintained throughout Project implementation (para. 5.1 (a))**

2.6 Upgrading of Tirana Health Care Delivery System. Activities supported by the Project include civil works, medical equipment, and supplies for the reconfiguration and streamlining of one hospital, three polyclinics, and 37 health centers. The Project also supports:

(a) technical assistance and training for the improvement of functional relationships among public health interventions, primary health care, out-patient specialist care and in-patient hospital services.

(b) technical assistance, training and equipment for information, education and communication activities aimed at sensitizing the population to high-impact interventions of known cost-effectiveness, including health promotion and chronic disease prevention, clinical services at the primary level and out-patient, in-patient and emergency services at the secondary level; and

(c) training and use of clinical protocols by health professionals. The Project will build upon activities started under the Hospital Physicians' Retraining component of the Health I Project and the EU-PHARE supported training programs in family medicine; and technical assistance and training for developing management procedures at all three levels of the health care delivery system (PHC, specialized out-patient, specialized in-patient). Emphasis will be on secondary-level service requirements at the Tirana Hospital.

(d) investments in diagnostic equipment and reagents for clinical and public health laboratories, cold chain equipment for vaccines, and medical consumables and supplies, as requested by the Government in its Emergency Aid Program Document of March 28, 1997.

2.7 Project Management. This component will provide support to overall management of the Project, in the form of additional office equipment, technical assistance, staff and training for the existing Project Coordination Unit (PCU) in the MOH. (Refer to the PIP, Annex 1 for a detailed description of this component.)

2.8 **During Negotiations, the Government provided assurances that:**

(a) With regard to the PCU, it was agreed that the Health System Recovery and Development Project would have a separate Project Director, in addition to the existing Project Director for the on-going Health Rehabilitation Project, i.e., each Project would have its own Director. Terms of References (TORs) for this position (Project Director, Health System Recovery and Development Project) were agreed upon and are attached to the Minutes (para. 5.1 (d) (i)).

(b) A new position of overall Coordinator of the PCU would be created. TORs for this position were agreed upon and are attached to the Minutes (para 5.1 (d) (ii)).

(c) A new PCU Procurement Specialist would be hired specifically for the Health System Recovery and Development Project. It was agreed that, initially, this person would work with and be mentored by the existing Procurement Specialist, and would receive technical assistance and training during the course of Project implementation (para. 5.1 (d) (iii)).

C. Environmental Impact

2.9 This is a Category C Project: "No appreciable environmental impact." Upgrading of unsanitary hospital buildings will contribute to improved environmental safety, as will the replacement of old equipment -- radiology and laboratory -- that present health risks. Sanitary procedures will be introduced for dealing with waste management.

3. PROJECT COSTS, FINANCING, MANAGEMENT AND IMPLEMENTATION

A. INTRODUCTION

3.1 This chapter provides a summary of the Project Implementation Plan (PIP) which was prepared in conjunction with the Borrower and reviewed and deemed satisfactory by the Bank. The PIP includes detailed information on the project description, costs, financing, management and implementation arrangements, procurement, disbursements, audit reporting, and status of preparation. The PIP is attached as Annex 1.

B. PROJECT COST

3.2 The total cost of the Health System Recovery and Development Project is estimated at about US$28.0 million, or about Leke 4.5 billion equivalent, including contingencies, taxes and duties. The total base cost is estimated at US$24.5 million. Physical contingencies are estimated at US$2.3 million. Price contingencies between negotiations (March 1998) and the end of the four-year project implementation period will amount to about US$1.2 million, or 5 percent of base cost. The foreign exchange component is estimated at about US$19.1 million, including contingencies, or about 68 percent of total project cost. Taxes and duties are estimated at US$0.9 million equivalent.

3.3 The total project cost includes fellowships, training, technical assistance, studies, computer hardware and software, medical and office equipment, teaching and public education materials, refurbishment of facilities, and incremental recurrent costs incurred during project implementation. The estimated cost distributed among project components is shown in Table 3 of the PIP. Project costs are summarized by expenditure category in Table 4 of the PIP. The project costs include about Leke 239 million or US$1.5 million to cover incremental operating costs directly attributable to the Project during the four-year implementation period. Equipment operation and maintenance, and materials and supplies account for most of the project's incremental recurrent costs. Table 4 below shows summary costs by expenditure accounts and project components.

Table 4: SUMMARY COSTS BY EXPENDITURE ACCOUNTS AND PROJECT COMPONENTS

	National Capacity Building			Governance & Mgt. of Tirana Health System	Tirana Health Service Delivery						
	Ministry of Health	Institute of Public Health	Health Insurance Institute	Regional Health Authority	PHC Rural Areas	PHC Urban Areas	Polyclinics	Hospitals	Upgrading Professional Skills	Project Manage-ment	Total
I. Investment Costs											
A. Rehabilitation of Physical Facilities											
1. Rural Primary Health Centers	-	-	-	-	844.9	-	-	-	-	-	844.9
2. Urban Primary Health Centers	-	-	-	-	-	1,811.4	-	-	-	-	1,811.4
3. Specialized Polyclinics	-	-	-	-	-	-	630.9	-	-	-	630.9
4. Tirana Hospital	-	-	-	-	-	-	-	6,715.4	-	-	6,715.4
5. Other Building Rehabilitation	-	-	-	201.7	-	-	-	-	-	-	201.7
Subtotal Rehab. of Physical Facilities	-	-	-	201.7	844.9	1,811.4	630.9	6,715.4	-	-	10,204.4
B. Architectural/Engineering Services	-	-	-	11.9	49.9	107.0	37.4	345.8	-	-	551.9
C. Medical Equipment/Supplies	-	-	-	-	194.8	125.3	3,898.6	5,682.7	-	-	9,901.4
D. Pharmaceuticals	-	-	-	-	-	-	-	1,084.1	-	-	1,084.1
E. Office Equipment and Vehicles	63.8	-	351.6	209.2	-	-	-	132.7	81.7	66.8	905.8
F. Furniture	-	-	-	49.0	-	-	-	-	-	27.8	76.8
G. Technical Assistance											
1. Policy Development	306.7	-	-	-	-	-	-	-	-	-	306.7
2. Capacity Building	673.5	-	197.9	441.6	-	-	-	154.8	65.2	-	1,533.0
3. Project Implementation	-	-	-	43.0	-	-	-	130.8	-	387.1	560.9
Subtotal Technical Assistance	980.2	-	197.9	484.6	-	-	-	285.6	65.2	387.1	2,400.6
H. Training											
1. External Training	177.5	-	229.3	294.3	-	-	-	21.8	97.8	30.0	850.8
2. Local Training	9.2	-	21.7	23.0	-	-	-	13.7	485.9	23.0	576.5
Subtotal Training	186.7	-	251.0	317.3	-	-	-	35.5	583.7	53.1	1,427.3
Total Investment Costs	1,230.8	-	800.5	1,273.7	1,089.5	2,043.7	4,566.8	14,281.9	730.5	534.7	26,552.3
II. Recurrent Costs											
B. Medical Equipment O&M	-	-	-	-	12.3	4.2	427.8	400.9	-	-	845.1
C. Office Equipment O&M	-	-	45.7	25.4	-	-	-	-	-	6.4	77.5
D. Vehicle O&M	-	-	11.5	23.0	-	-	-	-	-	11.5	46.1
E. Building O&M	-	-	-	11.1	40.8	82.3	34.2	291.0	-	-	459.5
F. Other	-	-	23.0	-	-	-	-	-	-	9.2	32.2
Total Recurrent Costs	-	-	80.2	59.6	53.1	86.5	461.9	691.9	-	27.2	1,460.4
	1,230.8	-	880.7	1,333.2	1,142.6	2,130.3	5,028.8	14,973.8	730.5	561.9	28,012.7
Taxes	-	-	-	18.3	76.8	164.7	57.4	610.5	-	-	927.7
Foreign Exchange	1,071.4	-	752.7	997.0	465.3	710.7	4,080.8	10,354.2	230.8	416.9	19,079.9

C. PROJECT FINANCING

3.4 The proposed IDA Credit of US$17.0 million will finance about 60 percent of total project costs, comprising 62 percent of the foreign exchange cost (US$11.9 million) and 64 percent of the local cost, excluding taxes (US$5.2 million). Co-financing is being sought to cover technical assistance, and rehabilitation and equipping of the major institutions to be supported under the Project, namely: Tirana Hospital, 3 polyclinics, the 37 primary health care facilities, the Tirana Regional Health Authority, Ministry of Health, and the Health Insurance Institute. Possible donors include the Government of Italy, Government of Switzerland, United Kingdom Know-How Fund (UKKHF), Assistance Publique Hopitaux de Paris (APHP) and USAID. The Government will finance the balance of project costs (US$2.4 million), including duties and taxes. Financing of incremental operating costs comprising equipment maintenance services and annual maintenance costs of computers and software (US$1.5 million equivalent), will be shared by the Government with IDA contributions on a declining basis. Averaged over the project life, the Government portion of recurrent expenditures represents less than one percent of the projected 1998 operating budget for the MOH.

D. PROJECT MANAGEMENT AND IMPLEMENTATION

3.5 Overall responsibility for implementation of the Project rests with the MOH, while the planned project activities will be managed and implemented by the various national and regional institutions involved. The concerned MOH Departments, under leadership of the Minister of Health, will maintain global oversight. Responsibility for day-to-day coordination, management and monitoring will rest with the on-going Health Services Rehabilitation Project (Credit #2659-ALB) PCU which will be strengthened to provide needed coordination and implementation support. The enlarged PCU will comprise: a PCU Coordinator (for both IDA-financed projects), two Project Directors (one for each Project), two accountants, a construction engineer, two procurement specialists, two administrative assistants and a driver. Since the proposed Project is expected to be supported by several donors, it is likely that they will choose to maintain their own oversight mechanisms, with overall coordination of project activities to be carried out through the PCU. All appointments for project management will be done according to criteria satisfactory to IDA. Within the MOH, an interim Project Advisory Group has been established to provide overall policy guidance for the health sector program, including the Bank- and other donor-financed projects, and works in conjunction with the existing PCU. **The Government confirmed at Negotiations that, prior to Credit Effectiveness, the Project Advisory Group will be formalized and will be maintained throughout project implementation. It will be chaired by the Minister of Health and Environment, with the following as members: Director of Economics and Finance Department, Director of Health Education Directorate, Director of Human Resources Department, Director of Pharmaceuticals Department, Director of Primary Health Care Department, Director of Hospital Department; Director of Tirana Hospital; and Director, Health Insurance Institute (para. 5.2 (a)).** The capacity of the existing PCU will be strengthened accordingly under the proposed Project to accommodate

the additional responsibilities resulting from the increased activities. Arrangements for specific components are as follows[3]:

National Capacity Building. This component supports the strengthening of the institutions carrying out the Government's health sector strategy, and consists primarily of technical assistance and training. Because most of this technical assistance and training will be provided by other agencies, it is anticipated that the PCU role will provide mainly a coordination function to ensure that the project activities are carried out in an integrated manner by the respective Departments and other entities.

Regional Capacity Building for Governance and Management of the Health System in Tirana Region. This component supports the establishment and operation of the Tirana Health Authority, with its two operational bodies, the Regional Health Management Team and the Management Board. Activities supported by the Project will consist of limited civil works, provision of equipment and introduction of an information system, technical assistance and training. The limited civil works activities under this component will be overseen by the PCU and carried out by an external construction firm.

Upgrading of Tirana Health Care Delivery System. This component will support selected investments in civil works, medical equipment and supplies for health care facilities at primary, out-patient specialist and in-patient hospital levels, technical assistance to improve the delivery system, and training of health professionals. Given the very limited capacity in the MOH, civil works to be carried out under the Project will likely best be handled through hiring of a construction management firm to provide the assessment, design and works supervision competencies, with oversight from the related MOH departments, beneficiary management institutions and the PCU. Technical assistance and training activities will be managed by the respective MOH departments, with oversight from the PCU.

3.6 The Project will require about 20 weeks of Bank supervision per year during the four-year implementation period. It must be stressed that the proposed Project will require consistent supervisory support from the Bank.

E. PROJECT PROCUREMENT ARRANGEMENTS

3.7 Items to be procured are grouped into major packages to encourage competitive bidding and permit bulk procurement. The standard procurement table is shown in Table 6 of the PIP. Procurement will be carried out in accordance with World Bank Guidelines. Major procurement categories include: about US$14.2 million to be procured through international competitive bidding (ICB) procedures; US$0.8 million for National Competitive Bidding (NCB); US$450,000 through international shopping (IS); and US$50,000 through national shopping (NS). US$46,000 will be procured through direct contracting (books, intellectual property, etc.). It is anticipated that the bulk of the technical assistance will be procured in nine packages, at a

[3] Detailed plans are specified in the Project Implementation Plan, Annex 1. Since the proposed Project focuses on health system development, its Director will have technical skills and relevant experience in health system.

cost of about US$4.3 million. Four of the nine packages will be implemented through parallel financing. Total technical assistance using IDA funds will be US$2.1 million using World Bank Consultant Guidelines. These assignments will be filled through a competitive process (Quality Cost-Based procedures, according to World Bank Guidelines for Selection and Employment of Consultants by World Bank Borrowers (Jan. 1997)). Procurement arrangements and packages, including estimated cost and time of completion, are presented in the PIP. Appropriate Bank standard bidding documents will be used for the Project. A description of the capacity of the implementing agency to carry out procurement is found in the PIP.

F. Disbursements

3.8 The proposed Project is expected to be disbursed over a period of four and a half years, which is considerably shorter than the relevant profile in the Region (about seven years). The shorter implementation period is possible due to the strong commitment of the MOH and the fact that there is an on-going Health Services Rehabilitation Project (Cr. #2659) implementing successfully. The closing date will be January 31, 2003. A summary of the disbursement plan is shown in Tables 6 and 7 of the PIP.

3.9 To facilitate timely project implementation, the Government will establish, maintain and operate, under terms and conditions acceptable to the Bank, a Special Account denominated in US dollars. The authorized allocation will be US$900,000. However, during the initial stage of the Project, an amount limited to US$300,000 will be deposited. When the aggregate amount of disbursement reaches SDR 1.8 million, the amount deposited in the Special Account will be increased to the full authorized allocation of US$900,000.

3.10 All disbursements against contracts for goods and services exceeding US$300,000 equivalent will be fully documented. For expenditures below that level, disbursements will be made on the basis of certified Statements of Expenditure (SOEs). This documentation will be made available for the required audit as well as to Bank supervision missions, and will be retained by the PCU for at least one year after receipt by the Bank of the audit report for the year in which the last disbursement was made. The processing, disbursement and monitoring of the allocations of the proceeds of the IDA Credit and Borrower counterpart financing will be managed by the PCU in coordination and consultation with the Ministry of Finance.

G. Project Audit Reporting and Evaluation

3.11 The PCU will be responsible for coordinating annual project audits and for fulfilling reporting requirements. With respect to project accounts, including the Special Account, they will be audited in accordance with the Bank's "Guidelines for Financial Reporting and Auditing of Projects Financed by the World Bank" (March 1982), and will be provided by the Borrower within six months of the end of each fiscal year. Further information concerning auditing is provided in para. 38 of the PIP.

3.12 In addition, the PCU will be responsible for preparing semi-annual progress reports, which will include: a summary of progress under each component, proposals for rescheduling of

activities where necessary, and actual disbursements and projections for the subsequent six-month reporting period. The PIP includes a framework for systematic monitoring and evaluation of progress in project implementation. It identifies a set of performance indicators to be used in project supervision. Progress reporting under the Project is provided in more detail in para. 40 of the PIP. **During negotiations, assurances were provided that MOH will prepare semi-annual descriptive and financial reports on each project component, objective and activity (beginning from the date of Credit Effectiveness) (para. 5.1 (e)).**

3.13 Mid-Term Review and Evaluation. By August 30, 2000 (or about two years after Credit Effectiveness), the PCU will undertake jointly with IDA a mid-term review of progress in project implementation to determine whether: i) the Project's intended objectives remain valid; ii) implementation is advancing satisfactorily to justify its continued implementation; and iii) any adjustments to, or significant restructuring of the Project are necessary to improve its effectiveness. The Project Operational Manual (POM) will be updated following the mid-term review and the annual work program for the following year will reflect the recommendations made. **During negotiation the Government provided assurances that a mid-term project review will be conducted no later than August 30, 2000, according to terms of reference agreed with IDA (para. 5.1 (f)).**

H. Status of Preparation

3.14 During preparation, the MOH working groups which were established under the Health Services Rehabilitation Project prepared detailed proposals for each component. This structure has remained in place and, under the Project, the heads of these working groups will form the Project Advisory Group which will be maintained throughout Project implementation. Based on the working group proposals, the detailed PIP was prepared; this document will serve as the basis for the more detailed POM which will be developed for use by Project management in the implementation of the Project. The POM will be prepared according to standards satisfactory to IDA, by Project Effectiveness. The organizational structure for project implementation as described in the PIP has been established.

3.15 Implementation and coordination responsibilities between the MOH and the other agencies involved in the Project have been defined. The principal staff for implementation are in place and are supported by technical staff within the MOH. The PIP includes a detailed description of the project coordination and implementation responsibilities. The existing PCU of the Health Services Rehabilitation Project is in the process of being expanded to include a new team to manage the proposed Project.

4. JUSTIFICATION, BENEFITS AND RISKS

A. PROJECT JUSTIFICATION AND BENEFITS

4.1 The Project will support the immediate restoration of health services to the population, thereby preventing outbreaks of communicable diseases, avoidable complications of common illnesses and premature deaths. It will support fundamental improvements in the structure and functions of the health system, thereby fulfilling pre-conditions for effectiveness and sustainability. It will also support improvements in the quality of clinical services and an increased emphasis on the prevention of communicable and non-communicable diseases.

4.2 Estimated productivity gains: The Project is consistent with and supports the Bank's proposed economic strategy for Albania, i.e., the restoration of fiscal balance and an emphasis on medium-term sustainability and national capacity building. In an under-financed sector of the economy like the health sector, where resource cuts are neither justified nor feasible, and where the human development consequences of failure are substantial, the economic rationale lies in increasing effectiveness, productivity and quality. It is estimated that most of the productivity gains will come from improvements in organization and management. The Project will yield efficiency gains from a restructured system at the National and Regional (Tirana) levels. Given the extremely unwieldy state of the current bureaucracy, the potential for improvements is large and an estimated efficiency gain of 10% is reasonable. If the health sector expenditure (including foreign aid) remains at 5% of GDP, the Project will result in a stream of productivity gains equivalent to 0.5% of GDP per year in the medium term. The following paragraphs provide detailed considerations underpinning the quantitative estimates cited above.

4.3 National capacity building for health system reform will support improvements in the economic efficiency of the health sector by strengthening the institutions responsible for governance and regulation, the MOH, the HII and the IPH. Efficiency gains in the sector are contingent upon the existence of accountability, clarity of managerial and administrative roles, and appropriate incentive structures. Improvements in institutional capacity and governance will enhance the sustainability of the overall reform strategy and facilitate improvements in financing and delivery mechanisms. In this regard, the emphasis on the Health Insurance Institute (HII) is appropriate. It is an ongoing, and so far successful element of the Government's reform strategy for health. The Government's gradual introduction of health insurance is well conceived, especially when compared to recent experience with payroll-based health insurance in other former

socialist countries, where tax evasion and high unemployment rates have eroded the revenue base for health care. Expansion of the role of the HII, and its ability to contract services and raise revenues (moves that are supported by the Project) are essential for the overall viability of the health financing system at a time when the traditional budget financing structures are threatened with collapse. But it must be pursued carefully as planned so that the proposed limited investments in infrastructure, information systems and technical assistance for the HII will ensure the success of the HII as a vehicle for health sector reform.

4.4 Improvements in the governance and management of health system in Tirana will initiate actual decentralization of management and regulation of the health system to the most populated region of the country, where the full range of health services (although at a low quality level) exist and where the need for restructuring is the most acute. To that extent, the benefits could be the most visible in the quickest time. Rational decentralization will have a dual effect, enhancing systemic efficiency and cost-effectiveness, while improving accessibility of the health system to the population. As is the case throughout Albania, the structure of health services in the Tirana region is highly fragmented and uncoordinated, resulting in very inefficient resource allocation. Restructuring of management functions through the Regional Management Authority will reduce waste, and facilitate major efficiency gains. Successful implementation of the Tirana pilot will allow the adoption of similar measures in the rest of the country.

4.5 Upgrading of Tirana health care delivery system: Two considerations are central to the expected benefits from this component:

(a) On the one hand, being a feeble, under-equipped system with poor infrastructure, the health sector requires significant investments to meet the minimum criteria for a modern health care delivery system, even at Albania's level of income.

(b) On the other hand, once the structures are upgraded, and the management and clinical skills meet current standards of effectiveness, the improvements in organization, accessibility, population coverage, service utilization and quality of care will result in significantly better health outcomes in the medium term.

4.6 The benefits will accrue from (b) minus (a) above, due to reductions in the costs of poor quality (i.e., doing things right the first time, thereby avoiding the costs of needless complications and deaths).

4.7 Finally, as a major vehicle to implement its Sector Recovery and Development Strategy, the proposed Project constitutes a powerful tool for the Government to make the best use possible of external resources. Donors have expressed their support for the strategy defined by the Government and the Project provides the required mechanism to implement this strategy. Although impossible to measure, a major benefit of the Project

will be its potential to minimize inefficiencies, wasteful overlaps and gaps related to poor donor coordination.

B. Project Risks

4.8 There are three major sets of risks to the Project. The first is that political and social upheavals could preclude the stability needed for effective implementation and institutional development. This risk will be mitigated by: (a) the benefits to major stakeholders of cooperation in all aspects of the recovery program, and (b) the emphasis on improving community ownership of, and involvement in, health service planning, organization and management. Specifically, Local Health Advisory Committees will be established at the commune level, with inputs into the local planning of health service delivery. Health Advisory Committees will be established at the Regional/District Levels, to work with District Health Management Teams and the proposed Tirana Regional Health Authority in health planning, service delivery and management, and to improve responsiveness of the health sector to local problems. Representatives of the NGO Forum will be encouraged to participate as members of the management teams for districts and hospitals. Further details are shown in the Health Sector Strategy Matrix (Annex 6, Section C). The second risk is that weak national capacity for implementation could hinder effective implementation. This risk will be mitigated by specifying responsibilities for implementation prior to project effectiveness and by appropriate use of external technical assistance. Prior agreement with the Government on the need for technical assistance for the Project Coordination Unit has been emphasized. Finally, fiscal instability could make it difficult for the Government to meet its counterpart financing commitments under the Project and to operate services effectively beyond the initial phase. This risk will be mitigated by limiting required counterpart funds to the most essential recurrent expenditures. Given the weaknesses of the Albanian economy and its recent history of political and social strife, expectations of local implementation capacity, counterpart funds and speed of implementation must remain realistic and modest.

5. AGREEMENTS REACHED AND RECOMMENDATION

The following actions are required to assure successful implementation of the Project and attainment of the broader Project objectives.

Assurances Provided at Negotiations

5.1 During negotiations, the Government provided assurances that:

(a) The Tirana Regional Health Authority (consisting of the Tirana Regional Health Management Team and its Management Board) will be established through an order of the Ministry of Health and Environment before Project Effectiveness and maintained throughout project implementation (para. 2.5).

(b) Technical assistance to be procured from IDA resources under the Project will be procured as planned, unless alternative Grants are secured, in writing and satisfactory to IDA (2.3)

(c) The Government will: (i) commit adequate resources to capacity building, including the training of nationals and procurement of crucial external technical assistance; (ii) strengthen priority public health policies and services, while also improving the quality of clinical services; and (iii) assure that all project personnel meet criteria satisfactory to the Minister of Health and Environment and the Association (para. 2.3).

(d) Agreements related to the PCU:

(i) With regard to the PCU, it was agreed that the Health System Recovery and Development Project would have a separate Project Director, in addition to the existing Project Director for the on-going Health Rehabilitation Project, i.e., each Project would have its own Director. Terms of References (TORs) for this position (Project Director, Health System Recovery and Development Project) were agreed upon and are attached to the Minutes (para. 2.8).

(ii) A new position of overall Coordinator of the PCU would be created. TORs for this position were agreed upon and are attached to the Minutes (para. 2.8).

(iii) A new PCU Procurement Specialist would be hired specifically for the Health System Recovery and Development Project. It was agreed that, initially, this person would work with and be mentored by the existing Procurement Specialist, and would receive technical assistance and training during the course of project implementation (para. 2.8).

(e) The PCU will prepare semi-annual descriptive and financial reports on each component (para 3.12);

(f) A mid-term project review will be conducted in accordance with TORs agreed with IDA no later than August 30, 2002 (para 3.13).

Condition of Effectiveness

(a) The Project Advisory Group will be established before Project Effectiveness and maintained throughout project implementation. The Project Advisory Group will be chaired by the Minister, with the following as members: Director of Economics and Finance Department, Director of Health Education Directorate, Director of Human Resources Department, Director of Pharmaceuticals Department, Director of Primary Health Care Department, Director of Hospital Department; Director, Tirana Hospital; and Director, Health Insurance Institute (para 3.5).

Recommendation

Subject to the above, the proposed operation provides a suitable basis for a Credit of US$17.0 million to the Government of the Republic of Albania.

REPUBLIC OF ALBANIA

HEALTH SYSTEM RECOVERY AND DEVELOPMENT PROJECT

PROJECT IMPLEMENTATION PLAN

ANNEX 1

REPUBLIC OF ALBANIA

HEALTH SYSTEM RECOVERY AND DEVELOPMENT PROJECT

PROJECT IMPLEMENTATION PLAN

INTRODUCTION

This Project Implementation Plan (PIP) reflects largely the outcomes of the preparation and appraisal missions for the proposed Project, and the proposals and technical discussions with the working groups established by the Ministry of Health (MOH). The PIP presents the general framework for project implementation by the Borrower, and outlines: (a) the project objectives; (b) project management and implementation responsibilities and activities; (c) project costs and financing plan; (d) procurement arrangements; and (e) implementation, monitoring and evaluation processes and procedures. While the implementation of the Project is inherently dynamic, this PIP seeks to clearly outline the general principles agreed with the MOH, according to which the Project will be carried out.

REPUBLIC OF ALBANIA

HEALTH SYSTEM RECOVERY AND DEVELOPMENT PROJECT

PROJECT IMPLEMENTATION PLAN (PIP)

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APPENDICES

I. THE PROJECT

A. Project Objectives

1. The overall goal of the proposed Project is to improve health status and contribute to increased well-being and productivity of the population, as described in Chapter 1 of the SAR. Specifically, the Project aims to: (i) establish/strengthen sound institutional and human resource capacities to ensure effectiveness and sustainability of the health sector; and (ii) support efforts to reduce avoidable illnesses and premature deaths. Therefore, the Project will:

(a) rationalize and strengthen the governance structure and management capacity at the national and regional levels; and

(b) improve the effectiveness and quality of health service delivery in the Tirana Region through upgrading of selected health facilities as part of a rational regional health system. The proposed Health System Recovery and Development Project will build upon the initial achievements and lessons learned from the on-going Health Services Rehabilitation Project by expanding the geographic scope of infrastructure rehabilitation and by supporting the institutionalization of techniques to improve the quality of service delivery.

B. Project Description

2. The proposed Project has four components: National Capacity Building; Governance and Management of Health System in Tirana Region; Upgrading of Tirana Health Care Delivery System; and Project Management. It will be implemented over a period of four years. Total project costs, including contingencies, taxes and duties, are estimated at US$28.0 million equivalent (US$24.5 million base cost). The Project will finance medical and office equipment, external and local training and specialist services, civil works for medical facilities and office upgrading for the Health Insurance Institute (HII) and Tirana Regional Authority (TRHA), and incremental operational costs generated by the investments.

II. PROJECT MANAGEMENT AND IMPLEMENTATION

A. Project Management

3. Overall responsibility for implementation of the Health System Recovery and Development Project rests with the Ministry of Health, while the activities planned under the Project will be managed and implemented by the various national and regional institutions concerned. The MOH departments, under leadership of the Minister, will maintain global oversight. Responsibility for day-to-day coordination, management and monitoring will rest with the on-going Health Services Rehabilitation Project Coordination Unit (PCU) which will be strengthened to provide needed coordination and implementation support. Since the proposed Project is expected to be supported by several donors, it is likely that they will choose to maintain their own oversight mechanisms, with overall coordination of project activities to be carried out by the PCU. The capacity of the existing PCU will be expanded and strengthened accordingly under the proposed Project to accommodate the additional responsibilities resulting from the increased activities. In order to carry out its functions, the PCU will continue to be staffed by a Project Coordinator, supported by a core team financed under both the existing Project and the proposed Project. The PCU team, with the added responsibilities of the proposed Project, will comprise: (i) a PCU Coordinator; (ii) two Project Directors, one for each Project; (iii) two accountants; (iv) one construction engineer; (v) two procurement specialists; (vi) two administrative assistants; and (vii) one driver. The PCU management, i.e., Project Coordinator and the two Project Directors, will report directly to the Minister of Health and Environment. The PCU Coordinator will be responsible for coordination of both the existing and the proposed projects and other donor-related activities within the MOH, as well as assuring coordination between MOH and Regional and District authorities. The two Project Directors will be responsible for implementation of their respective projects. To assist this team, external technical support for the PCU will be provided for under the Project, mainly in the development and implementation of procurement procedures and organization of training programs, considering the limited experience of MOH in these areas.

4. The Heads of Departments in the MOH, the Director of Tirana Hospital and the director of HII will form a Project Advisory Group which will be chaired by the Minister of Health and Environment. This group will advise the Minister on policy issues related to the implementation of the Project. The number of members of the Group, units/organizations to be represented in the group, and the frequency of meetings may be revised as required, on recommendation of the PCU Manager. The Advisory Group will be responsible for providing policy advice and guidance during the project implementation period. The Advisory Group will be assisted by special task forces which it will convene as necessary.

B. Agreements Between Borrower and Implementation Agencies

5. The Borrower is the Government of the Republic of Albania represented by its Ministry of Finance (MOF). The MOH will be the implementing agency for the Project.

Assurances have been obtained from the MOH administration that adequate funding, based on the project financing plan, will be made available in a timely manner and necessary steps will be taken to expedite the procurement procedures related to major equipment.

C. Summary of Implementation Responsibilities

6. The Project will be implemented in close coordination and collaboration with the central and regional/district offices of the MOH, other donor-funded activities in the health sector (e.g., EU, Government of Italy, United Kingdom Know-How Fund [KHF], USAID), and other ongoing projects in related sectors (e.g., Health Services Rehabilitation (Cr. # 2659-ALB), and Social Safety Net Project (Credit # 2543-ALB).

7. From the operational point of view, the Project will be implemented by the existing departments of the MOH with technical assistance provided, as needed. In each Department of the MOH, a contact person has been identified to work with the project team for implementation activities.

8. The responsibilities regarding general project management are:

(a) MOH:

(i) to establish and secure the functional operation of the PCU and the Project Advisory Group;

(ii) to supervise project activities to ensure the successful and timely implementation of the project;

(iii) to set the policies, strategies and targets to ensure achievement of project objectives; to review them as required; and to take necessary steps to secure the Government's political commitment required for implementation of health sector reform activities; and

(iv) to ensure that financial resources are provided from the Credit and that Government funds are made available in a timely manner.

(b) Project Advisory Group:

(i) to set the policies, strategies and targets in order to ensure the achievement of the project objectives, and review them as required;

(ii) to provide guidance and advice to the PCU Manager on the timely implementation of project activities;

(iii) to ensure the coordination of public and private agencies involved in the implementation of the Project; and

(iv) to set the principles and procedures to be applied in coordinating with international institutions.

(c) PCU:

(i) to undertake planning, coordination, management, monitoring and reporting functions for all activities financed under the Project;

(ii) to monitor project expenditures and costs (local and foreign), process credit disbursement applications in collaboration with the Savings Bank of Albania, and track disbursements of the Credit and Government funds; and maintain project records and accounts;

(iii) to ensure compliance with the procurement procedures to be agreed with the Bank in the acquisition of equipment and software packages, administration of suppliers' and technical assistance contracts; to ensure consolidation of requests and procurement of goods and services, in accordance with World Bank Guidelines;

(iv) to ensure preparation and distribution of consolidated periodic reports (Progress Report) to the relevant government and other participating institutions, including the Bank, reflecting: (a) the status of implementation progress, problems encountered and corrective actions needed; and (b) current costs of each project component and estimated costs of completion;

(v) to ensure the timely preparation and submission to relevant government institutions and the Bank of annual audit reports of project expenditure, including Statement of Expenditures (SOEs) and accounts;

(vi) to ensure the movement of official documents and contracts through the usual approval processes and undertake measures to expedite their release;

(vii) to ensure the most efficient use of project resources; financial, staffing and time; to develop administrative and operational procedures for this purpose;

(viii) to ensure coordination with other donor-funded activities to ensure that all externally funded activities support the MOH's medium-term strategy for sector reform; and

(ix) to ensure the preparation of the Implementation Completion Report (ICR) within six months after Project completion.

D. Implementation Arrangements by Component

9. The paragraphs below discuss implementation arrangements and activities for each of the four components of the Project. Detailed cost tables and implementation schedules related to the specific components are found in the Appendices to this Annex.

Component 1: National Capacity Building

10. This component comprises two subcomponents covering national capacity building for: Ministry of Health (MOH) and Health Insurance Institute (HII). The first subcomponent - MOH Capacity Building - will be implemented by the Ministry of Health itself, with the help of the PCU. The respective departments - Pharmaceutical, Hospital, Primary Health Care/Public Health, Health Education Directorate, and Economics and Finance - will be responsible for the implementation of this sub-component. The Pharmaceutical Department will be responsible for coordinating activities to strengthen capacity for policy formulation in pharmaceutical sector through staff training and technical assistance. Initial technical assistance will be for assessment of needs for policy formulation, drafting of TORs for further specialist assistance, and definition of next steps required in policy development, based on earlier work done under the on-going Health Services Rehabilitation Project. The Department, based on the assessment, will send two staff abroad (3 months each) to be trained on pharmaceutical policy issues, and afterwards, they will work in conjunction with the technical experts in policy formulation.

11. The Hospital Department, with the support of technical assistance provided under the Project, will be responsible for organizing all necessary activities for changes in legislation and regulations, i.e., setting minimum standards for health care and health outcomes. These activities will be coordinated by this department, with cooperation and involvement of the Faculty of Medicine, and of the University Hospital. A committee will be established comprising key specialists from these institutions, and will be supported by technical assistance provided under the Project. The committee will focus on the development of minimum standards and the adaptation of clinical protocols for use in Albania.

12. Primary Health Care/Public Health Department is already receiving substantial assistance from EU PHARE. Strategy has been designed and documented. Assistance will be for them to implement this strategy country-wide.

13. The Economics and Finance Department comprises two units - Investment and Finance. For the Investment Unit, the Project will support technical assistance (12 months in the first two years) and fellowships (2 persons for 1 year each abroad) in asset planning (physical facilities - equipment and financial). For the Finance Unit, support will be provided for development of information and accountability systems (USAID technical assistance), and for budgeting procedures. In addition, one staff member will be sent abroad on a one-year fellowship in the area of health finance planning and budgeting.

14. The Head of the Health Education Department will be responsible for collaborating with the technical assistance provided under the Project to develop a strategy for health promotion.

15. The second subcomponent - Capacity Building in the Health Insurance Institute - will include activities designed to build on initial institutional development begun under the on-going project. HII will assume an increased level of financial management from the Ministry of Health through introduction of a new financial management system. It is envisioned that during the course of the project, this system will be expanded to include the primary health care sub-sector in the Tirana Region (as a pilot intervention) and, based on this experience, the system will eventually expand to cover the whole country. The Director of the HII will have overall responsibility for coordination of these activities and in addition will direct the establishment of a basic information system designed to link peripheral/district offices with Tirana headquarters. MIS systems will be utilized to enable HII to manage these peripheral/district centers. HII staff will be trained in decentralized financial mechanism procedures and in computer skills. EU PHARE is currently providing technical assistance to support further extension of the health insurance scheme in specialist services (out-patient and in-patient), and is expected to continue this support. EU PHARE is also providing support for the development of legal and regulatory framework for private practice. UK Know How Fund has been involved since the inception of the Health Insurance Fund, through assistance in organizational and management procedures, as well as in developing the provider payment mechanisms at the primary care level and related training activities. The Director of the Institute will select two staff during the first year to participate in long-term training abroad in health planning and health financing. The Director will also select individual branch office staff (eight staff for 2 months each) to participate in short-term overseas training in financing mechanisms and procedures.

Component 2: Governance and Management of Health System -- Tirana Regional Health Authority

16. Under the Project, a new decentralized health management structure will be established to provide health planning and management for the Tirana Region. The Ministry of Health will be responsible for organizing legislation and regulations for the establishment of the Regional Board and Regional Team. Initially, the Ministry of Health will identify a building to be renovated for use by the Regional Health Authority, i.e., Board and Team, and will be responsible for the overall supervision of civil works, and purchase of furniture and equipment. During the same period, six staff, to be selected by the Minister of Health, will be sent on overseas long-term training in the areas of public health and health planning and management. Technical assistance will be required for 27 person-months to provide support for planning, finance and management. Short-term fellowships and study tours, as well as local training, will be coordinated by the Regional Health Authority during years 2 and 3 of the Project, as needed.

Component 3: Tirana Regional Health System Delivery

17. The Regional Health Authority (RHA), with support from the PCU, will have overall responsibility for implementation of the urban and rural rehabilitation programs. The RHA Technical

Unit (comprising architects and engineers), in coordination with the PCU, will be responsible for the procurement of rehabilitation contracts as well as the day-to-day supervision of civil works. Training will be provided to the an engineer in the RHA Technical Unit in procurement methods for medical equipment, and he or she will be responsible for preparing the technical specifications for the bidding process. The PCU will conduct the bidding process in collaboration with the Technical Unit.

18. The hospital rehabilitation program will be under the overall responsibility of the Director of the Tirana University Hospital Center (THC). The THC Technical Unit of the Center will be responsible, in coordination with the PCU and MOH Investment Sector, for the review and approval of preliminary and final hospital rehabilitation plans. Within the management unit of the hospital, two Albanian professionals (architect, engineer) will be assigned full-time to the hospital rehabilitation program. Their task will be to prepare the architectural program as well as the specification of equipment and preparation of all bidding documentation for civil works and goods. Hospital planning technical assistance will be contracted to assist the technical arm of the Center in this task. The procurement of the hospital rehabilitation contract, which will be awarded through ICB, will be conducted by the PCU, in close coordination with the Technical Unit. Equipment lists and specifications for both general services and medical equipment will be prepared by the Technical Unit with the assistance of equipment specialists contracted for this purpose. Training will be provided to the Technical Unit staff in procurement methods for medical equipment. The PCU will conduct the bidding process in collaboration with the Technical Unit. In the post-crisis period, to guarantee adequate functioning of the hospital, and therefore maximization of the planned investments, the Project will support the non-salary operational expenditures of the hospital through financing of procurement of carefully selected and essential consumables and supplies. This support will be on a declining basis. Based on 1996 actual expenditures, the Project will finance 50%, 30% and 20% respectively over years 1, 2 and 3, in order to gradually restore the internal capacity to sustain operations. For hospital management training, beginning in year one, two hospital administration staff will be selected for short-term overseas training (each course will be 3 months in length) in specific areas of hospital management. In the second year, two two-week courses will be held for Department Heads (Tirana Hospital), with support of external advisors. Chief Nurses' training will be carried out in year 2, with four one-month courses (20 participants in each), and assisted by two technical advisors to design curriculum and run courses.

Upgrading Professional Skills. The Tirana Regional Health Authority will be responsible for implementation of the training program for general practitioners and nurses/midwives of Tirana Region. EU PHARE is currently financing a similar program on a national basis, and this proposed training will supplement and eventually complete training of all general practitioners and nurses/midwives for Tirana Region. It is expected that around 250 general practitioners and 900 nurses/midwives will be trained by the end of the Project. Training methodology for general practitioners will involve training of trainers abroad (6 persons for 6 months each), followed by training of staff locally (3 month sessions). Two expatriate nurses will train 12 local trainers, followed by training of staff locally (1 and 1/2 month sessions). The Project could use professionals already trained under the current EU PHARE program, according to their availability.

Component 4: Project Management

The detailed information concerning project management is outlined in Section 2a of the Project Implementation Plan.

E. Detailed Project Activities by Component

19. Detailed activities under each component are summarized below. A detailed project implementation schedule is given in Appendix 1.

Component 1: National Capacity Building.

(i) Capacity Building in the Ministry of Health (MOH). For the **Pharmaceutical Department**, technical assistance for initial assessment of needs for pharmaceutical policy formulation (3 months) will be selected shortly after Project Effectiveness. Staff overseas training (3 months for 2 persons) for specific aspects of pharmaceutical policy will take place after topics for training and staff have been selected (second half of year one). Also after Project Effectiveness, office equipment and materials will be procured for the Pharmaceutical Department. After TORs are specified, the additional technical assistance (12 months over years 1 and 2) will begin. **For the Hospital Department**, technical assistance for hospital sector policy (4 months) will be selected only after the establishment of a committee for setting minimum standards for health care and health outcomes. Technical assistance for strategy implementation for **Primary Health Care/Public Health Department** will begin in year 1 and continue for project life (3 months each year). Annual workshops for relevant staff in the MOH (Headquarters and district offices) will be arranged. For **Health Education Directorate**, technical assistance will be provided for situation assessment of non-communicable diseases and injuries (3 months for year 1). In addition, 9 months of technical assistance will be provided for national strategy formulation on health education promotion. For the **Economics and Finance Department**, some activities will be supported by donor funding.

(ii) Capacity Building - Health Insurance Institute (HII). The MOH and HII will prepare the necessary legal framework (Government decree) to include the PHC of Tirana Region in the Health Insurance scheme on a pilot basis. TA for overall management of HII development activities will begin at Effectiveness (3 months/year for 4 years). With the support of this TA, HII staff in Tirana Region will begin training (seminars) in management and financing procedures for the new system. Also directly after Effectiveness, the procurement process for the management information system, e.g., 50 computers, software, etc., for Tirana Region, which will be carried out using International Shopping procedures, will begin. Training seminars for the HII district staff to familiarize them with new procedures will take place during years 3 and 4. Two Headquarters HII staff will be sent for overseas training in health finance and planning (9 months each) during the first year of the Project. Eight staff from the branch offices will be trained in two months courses, starting in year 1. This training will be complemented by a series of study tours organized throughout the duration of the project.

Component 2: Tirana Regional Health Authority (TRHA) System Delivery.

(i) Rehabilitation work on the selected building for TRHA management will begin as soon as possible after Project Effectiveness, with one contract being let under

National Competitive Bidding (NCB) procedures. At the same time, six staff, to be selected by the MOH, will be sent on overseas training in health planning and management, public health, etc. (4 people for 9 months each), while two equipment engineers will be trained for 6 months each in biomedical standards during year 2. Technical assistance (4 people in the areas of: 6 months to support developing structure and strategy of TRHA, 9 months for health planning and finance; 6 months for human resources planning and development; and 6 months for health information collection and elaboration) will be selected to provide support and guidance in developing the new institutional framework, and to start the process of planning and implementation, as well as to give on-the-job training to local staff. Parallel to building rehabilitation, office equipment and furniture will be procured. Ten staff will be selected for three months training in specific aspects of health planning and finance, public health, etc., according to needs and timing defined by the Director of TRHA. Staff will also be selected in years 2 and 3 for study tours (US$32,000) to provide exposure to similar organizations in different countries, while at the same time fostering relations with foreign counterpart organizations.

Component 3: Tirana Regional Health System Delivery.

(i) During the second year of project implementation, the already established TRHA, in close coordination with the PCU, will carry out the rehabilitation program of the PHC centers: procurement of civil works for rural and urban areas and equipment packages. To this end, the TRHA will contract outside architectural, procurement and supervising civil works services. The technical assistance experts hired for rehabilitation of the Tirana University Hospital will provide assistance to the TRHA in developing specifications for civil works for the polyclinics. The equipment specialist hired by TRHA will prepare the specifications for the equipment lists with special attention to the outpatient specialized polyclinics, during his training in year 2.

(ii) For the Technical Unit of the Tirana University Hospital, two Albanian professionals will be appointed full time in year 1 of the project. The Technical Unit at the Tirana Hospital and the PCU will contract services for architectural program and preparation of all bidding documents for civil works (rehabilitation and new construction) and general services equipment, beginning in year 1. At the same time, for the preparation of medical equipment lists and technical specifications, an external equipment specialist will be contracted for 8 months over the course of the project.

(iii) During years 2 and 3, the Director of the Tirana University Hospital will select two people to be trained in specific aspects of hospital administration (three months each). During year 2, the Directorate will make a twinning arrangement for the implementation of hospital management training activities for department heads and chief nurses.

(iv) Professional Skills Training. The overall training program to upgrade professional skills for general practitioners and nurses/midwives will be carried out with the support of a technical assistance contract. Selection process for the consulting firm contract will begin immediately upon Project Effectiveness. It is envisioned that

the training will proceed in the following manner: In year 2, the Director of Tirana Regional Health Team will select 6 GPs to be trained abroad for six months each to develop a methodology based on the existing curricula prepared by the EU PHARE program. At the same time, 12 nurses will be trained as trainers locally through 2 month courses taught by two external consultants. Parallel to the training, didactic materials will be reproduced and 6 classrooms will be equipped with furniture and AV to be used for 3 months training courses for GPs and 6 weeks training courses for nurses/midwives.

Component 4: Project Management

To achieve effective management of the Bank interventions in the health sector, the capacity of the current PCU management team will be increased to provide the expertise required to handle the increased needs of project implementation. A PCU Coordinator will be appointed with overall responsibility for the PCU and external relations with donors. Each project -- Health Services Rehabilitation and Health System Recovery and Development -- will have a Project Director. A new PCU Procurement Specialist will be hired specifically for the Health System Recovery and Development Project. Initially, this person will work with and be mentored by the existing Procurement Specialist, and will receive technical assistance and training during the course of Project implementation. A vehicle, and additional furniture and office equipment to meet their needs will be procured according to International Shopping procedures. Technical assistance will be provided for project management support on a declining basis throughout project implementation. Training for PCU staff will be provided in the form of fellowships, study tours, and workshops.

F. Project Operational Manual

20. Each implementing technical department/unit will ensure that its respective project activities are carried out in accordance with agreed project objectives and performance targets. A Project Operational Manual (POM) is being compiled by the PCU from documents developed during project preparation and appraisal, using the PIP as the basis. The POM will be subject to prior review and approval by the Bank. The POM will constitute the implementation guidelines for each component, and will include detailed TORs for consulting services, base implementation schedules and procedures, performance targets and monitoring indicators, detailed cost estimates, and technical background as appropriate. Specific tasks assigned in the POM for which the implementing departments/units will typically be responsible include:

(a) in collaboration with the PCU: (i) finalizing TORs for the specialist services, feasibility studies, and training required in their respective parts of the Project; (ii) assigning bid evaluation committees; (iii) evaluating proposals received for consulting services; and (iv) authorizing the award of contracts;

(b) monitoring the implementation of local training and seminars; and identifying and tapping local expertise to assist in activities such as preparation of detailed procedures and updating implementation schedules;

(c) preparing periodic reports on the implementation progress of their respective components and submitting these to the PCU for inclusion in the semi-annual report of project performance; and

(d) preparing physical and financial forecasts of future activities required to implement the components of the Project, and forwarding these estimates to the PCU for inclusion in budgetary proposals for the succeeding implementation year.

III. PROJECT COSTS, FINANCING, REPORTING AND SUPERVISION

A. Project Costs

21. **Summary of Project Costs**. The total cost of the Health System Development Project is estimated at about US$28.0 million, or about 4.5 billion Albania Leke equivalent, including contingencies, taxes and duties. The total base cost is estimated at US$24.5 million. Physical contingencies are estimated at US$2.3 million. Price contingencies between negotiations (March 1998) and the end of the four-year project implementation period will amount to about US$1.2 million, or 5 percent of base cost. The foreign exchange component is estimated at about US$19.1 million, including contingencies, or about 68 percent of total cost. Taxes and duties are estimated at US$0.9 million equivalent. The tax project exempt status of technical assistance expenditure will be confirmed at negotiations.

22. The total project cost includes fellowships, training, technical assistance, studies, computer hardware and software, training materials, refurbishment of facilities, and incremental recurrent costs generated by the Project. The project costs include about 239 million Leke, or US$1.5 million to cover incremental operating costs directly attributable to the Project during the four-year implementation period. Equipment operation and maintenance, and materials and supplies account for most of the project's incremental recurrent costs. The estimated project costs by component and expenditure category are summarized in Tables 1 and 2 below. Detailed costs are shown in detail in Appendix 2.

Table 1: PROJECT COST SUMMARY BY COMPONENT

	(US$ '000)			% Foreign	% Total Base
	Local	Foreign	Total	Exchange	Costs
A. National Capacity Building					
Ministry of Health	148.1	998.0	1,146.1	87	5
Health Insurance Institute	112.6	680.0	792.6	86	3
Subtotal National Capacity Building	260.7	1,678.0	1,938.7	87	8
B. Governance and Management of Health System - Tirana					
Regional Health Authority	296.8	912.9	1,209.7	75	5
Subtotal Governance and Management of Health System - Tirana	296.8	912.9	1,209.7	75	5
C. Tirana Health Service Delivery					
PHC Rural Areas	587.1	406.8	993.9	41	4
PHC Urban Areas	1,226.6	615.5	1,842.1	33	8
Polyclinics	824.4	3,581.0	4,405.4	81	18
Hospitals	3,983.3	9,014.5	12,997.9	69	53
Upgrading Professional Skills	438.6	209.4	648.0	32	3
Subtotal Tirana Health Service Delivery	7,060.0	13,827.2	20,887.2	66	85
D. Project Management	130.2	379.8	510.0	74	2
Total BASELINE COSTS	7,747.7	16,797.9	24,545.6	68	100
Physical Contingencies	756.5	1,547.8	2,304.2	67	9
Price Contingencies	428.6	734.2	1,162.9	63	5
Total PROJECT COSTS	8,932.8	19,079.9	28,012.7	68	114

Table 2: PROJECT COST SUMMARY BY CATEGORY OF EXPENDITURE

	(US$ '000)			% Foreign	% Total Base
	Local	Foreign	Total	Exchange	Costs
I. Investment Costs					
A. Rehabilitation of Physical Facilities					
1. Rural Primary Health Centers	499.0	232.9	731.8	32	3
2. Urban Primary Health Centers	1,066.5	497.7	1,564.2	32	6
3. Specialized Polyclinics	375.0	175.0	550.0	32	2
4. Tirana Hospital	3,155.7	2,629.8	5,785.5	45	24
5. Other Building Rehabilitation	144.0	32.0	176.0	18	1
Subtotal Rehabilitation of Physical Facilities	5,240.2	3,567.3	8,807.5	41	36
B. Architectural/Engineering Services	217.8	267.1	484.8	55	2
C. Medical Equipment/Supplies	432.9	8,225.6	8,658.5	95	35
D. Pharmaceuticals	48.0	912.0	960.0	95	4
E. Office Equipment and Vehicles	40.2	763.2	803.4	95	3
F. Furniture	10.4	58.7	69.0	85	-
G. Technical Assistance					
1. Policy Development	42.8	242.3	285.0	85	1
2. Capacity Building	212.6	1,204.9	1,417.5	85	6
3. Project Implementation	110.1	403.4	513.5	79	2
Subtotal Technical Assistance	365.4	1,850.5	2,216.0	84	9
H. Training					
1. External Training	0.8	789.8	790.5	100	3
2. Local Training	504.9	-	504.9	-	2
Subtotal Training	505.6	789.8	1,295.4	61	5
Total Investment Costs	6,860.5	16,434.1	23,294.5	71	95
II. Recurrent Costs					
B. Medical Equipment O&M	434.1	289.4	723.5	40	3
C. Office Equipment O&M	50.3	16.8	67.1	25	-
D. Vehicle O&M	30.0	10.0	40.0	25	-
E. Building O&M	353.2	39.2	392.4	10	2
F. Other	19.6	8.4	28.0	30	-
Total Recurrent Costs	887.2	363.8	1,251.0	29	5
	7,747.7	16,797.9	24,545.6	68	100
Physical Contingencies	756.5	1,547.8	2,304.2	67	9
Price Contingencies	428.6	734.2	1,162.9	63	5
	8,932.8	19,079.9	28,012.7	68	114

23. **Bases of Cost Estimates.** Project costs were estimated as follows:

(a) Base Costs. Base and unit cost estimates are derived from: (a) costs of consultant services, fellowships and training based on the rates currently charged by local, European and North American consultants and training programs; (b) recent quotations obtained from suppliers of computer equipment; (c) applications software costs from comparisons with ongoing software development activities and estimated requirements for technical books and journals; (d) building and refurbishment costs from consultants' surveys of the current costs for these items; (e) funds allocated for the preparation of studies, estimated on the basis of the aggregated costs of local and foreign specialized services, unit costs for internal travel and subsistence, and mission estimates of material and logistic needs; (f) staff-unit costs from current public service

salary scales with some adjustments for the remuneration of local technical staff to a level deemed competitive with the market for specialized services; and (g) non-salary recurrent costs (materials and supplies) based on current Government rates. All project costs have been estimated in US dollars on the basis of March 1998 prices at the official exchange rate of 159 Leke per US dollar.

(b) Contingency Allowances. Project costs include a contingency for unforeseen physical variations (US$2.3 million) equivalent to nine percent of the base cost of technical assistance, training and fellowships and 10 percent for all other project items. These contingencies are justified because of the uncertainties created by the current political situation. The following rates were used to cover expected price escalation: foreign costs at 2.3 percent for CY1998-2003. Since the crisis erupted in March 1997, the substantial decline of the value of the lek makes it impossible to make meaningful projections in leke. Therefore, the project costs have been estimated in US dollars.

(c) Foreign Exchange Component. The foreign exchange component (see breakdown in Table 3) is estimated at about US$19.1 million, including contingencies, or 68 percent of total project cost. Calculations of the foreign exchange component were derived from an item-by-item analysis resulting in the following: 95 percent for office equipment, computer hardware and software, books and journals; 95 percent for pharmaceuticals, 85 percent for furniture,; 35 percent for civil works; 85 percent for technical assistance; and 100 percent for external training. The foreign exchange component in incremental recurrent expenditure was estimated at 40 percent for medical equipment; 25 percent for the operation and maintenance of office equipment; 25 percent for vehicle maintenance; 10 percent for building maintenance, and 30 percent for supplies and operations.

(d) Customs, Duties and Taxes. With the exception of technical assistance and training contracts, works and goods required under the Project will not be exempt from payment of customs duties and local taxes. The MOH will ensure that local resources for the payment of import duties and taxes on goods and works to be purchased under the Project are available when needed. Project costs include an estimated US$0.9 million equivalent in direct and indirect taxes and duties to be financed by the Government.

24. **Incremental Recurrent Costs**. Included in the Project are about US$1.5 million to cover incremental operating costs directly attributable to the Project during the four-year period. These consist of incremental operation and maintenance expenditure for equipment, and supplies and operations. During implementation, MOH will pay extra attention to monitoring the adequacy of recurrent funds for maintenance and operation of facilities and newly instituted programs, and take the necessary actions to rectify any deficiencies.

B. Project Financing

25. The proposed IDA Credit of US$17.0 million will finance about 60 percent of total project costs, comprising 62 percent of the foreign exchange cost (US$11.9 million) and 64 percent of the local cost, excluding taxes (US$5.2 million). Co-financing is being sought to

cover technical assistance, and rehabilitation and equipping of the Tirana Hospital, 3 polyclinics, at least some of the 37 Primary Health Care facilities in Tirana Region, the Tirana Regional Health Authority, the Ministry of Health and Health Insurance Institute. Possible donors include the Government of Italy, the Government of Switzerland, United Kingdom Know-How Fund (KHF), and USAID. The Government will finance the balance of project costs (US$2.4 million), including duties and taxes. IDA will finance the foreign exchange component of incremental operating costs (comprising equipment maintenance services and annual maintenance costs of computers and software). Averaged over the project life, the Government portion of recurrent expenditures represents less than one percent of the projected 1998 operating budget for the MOH.

26. Table 3 below shows the summary of costs by component and financier. Table 4 shows the summary of costs by expenditure category and financier.

Table 3: SUMMARY OF COSTS BY COMPONENT AND BY FINANCIER
(US$'000)

	Govt.	IDA	USAID	Italian Government	UK	Other	Total
	Amount	Amount	Amount	Amount	Amount	Amount	Amount
A. National Capacity Building							
Ministry of Health	0.0	265.2	95.6	870.1	-	-	1,230.8
Health Insurance Institute	82.8	349.0	-	-	448.9	-	880.7
Subtotal National Capacity Building	82.8	614.1	95.6	870.1	448.9	-	2,111.5
B. Governance and Management of Health System - Tirana							
Regional Health Authority	68.9	1,266.8	-	-	-	-	1,335.7
C. Tirana Health Service Delivery							
PHC Rural Areas	133.4	1,009.2	-	-	-	-	1,142.6
PHC Urban Areas	267.7	1,862.6	-	-	-	-	2,130.3
Polyclinics	519.3	-	-	4,509.5	-	-	5,028.8
Hospitals	1,276.7	11,750.2	-	-	-	1,947.0	14,973.8
Upgrading Professional Skills	0.0	-	-	730.5	-	-	730.5
Subtotal Tirana Health Service Delivery	2,197.1	14,621.9	-	5,240.0	-	1,947.0	24,006.0
D. Project Management	23.4	542.6	-	-	-	-	566.0
	2,372.2	17,045.5	95.6	6,110.1	448.9	1,947.0	28,019.3

Table 4: SUMMARY OF COSTS BY EXPENDITURE CATEGORY AND FINANCIER (US$'000)

	The Government	IDA	USAID	Italian Government	UK	Other	Total
	Amount	Amount	Amount	Amount	Amount	Amount	Amount
I. Investment Costs							
A. Rehabilitation of Physical Facilities							
1. Rural Primary Health Centers	84.5	760.4	-	-	-	-	844.9
2. Urban Primary Health Centers	181.1	1,630.3	-	-	-	-	1,811.4
3. Specialized Polyclinics	57.4	-	-	573.6	-	-	630.9
4. Tirana Hospital	671.5	6,043.9	-	-	-	-	6,715.4
5. Other Building Rehabilitation	20.2	181.5	-	-	-	-	201.7
Subtotal Rehabilitation of Physical Facilities	1,014.7	8,616.1	-	573.6	-	-	10,204.4
B. Architectural/Engineering Services	0.0	514.6	-	37.4	-	-	551.9
C. Medical Equipment/Supplies	16.2	5,308.7	-	3,898.6	-	1,762.0	10,985.5
E. Office Equipment and Vehicles	4.7	765.3	-	139.3	-	-	909.3
F. Furniture	1.8	76.1	-	-	-	-	77.9
G. Technical Assistance							
1. Policy Development	0.0	258.9	-	47.8	-	-	306.7
2. Capacity Building	0.0	443.9	95.6	643.1	197.9	154.8	1,535.3
3. Project Implementation	0.0	565.0	-	-	-	-	565.0
Subtotal Technical Assistance	0.0	1,267.8	95.6	690.9	197.9	154.8	2,407.0
H. Training							
1. External Training	0.0	331.3	-	275.3	229.3	16.5	852.5
2. Local Training	-	46.1	-	495.1	21.7	13.7	576.5
Subtotal Training	0.0	377.4	-	770.4	251.0	30.1	1,429.0
Total Investment Costs	1,037.4	16,926.0	95.6	6,110.1	448.9	1,947.0	26,565.0
II. Recurrent Costs							
B. Medical Equipment O&M	756.3	88.9	-	-	-	-	845.1
C. Office Equipment O&M	67.5	3.9	-	-	-	-	71.4
D. Vehicle O&M	40.2	5.9	-	-	-	-	46.1
E. Building O&M	440.5	18.9	-	-	-	-	459.5
F. Other	30.4	1.9	-	-	-	-	32.2
Total Recurrent Costs	1,334.8	119.5	-	-	-	-	1,454.3
	2,372.2	17,045.5	95.6	6,110.1	448.9	1,947.0	28,019.3

C. Administration of Project Funds

27. The IDA Credit of US$17.0 million will be made to the Government of Albania. The Ministry of Health will be responsible for the implementation of the Project.

D. Project Procurement Arrangements

28. Project procurement arrangements are summarized in Table 5 below. It is envisaged that the Bank's latest Standard Bidding Documents conforming to the latest issue of the Procurement Guidelines will be used for the procurement of Bank-financed works, goods and related services. The General Procurement Notice (GPN) for the Project will be issued by end April 1998. A project launch workshop is planned by end September 1998. Incremental recurrent expenditures, which are financed almost entirely with Government counterpart funds, as well as technical assistance and training financed by other donors, are shown under the N.B.F. (Non-Bank Financed) column.

Table 5: PROCUREMENT ARRANGEMENTS
(US$ Million)

Category of Expenditure	ICB	NCB	Other	N.B.F.[b]	Total
Civil Works	8.5	0.8	0.2	0.7	10.2
	(7.7)	(0.8)[c]	(0.2)	(0.0)	(8.7)
Technical Assistance					
a) Policy Development			0.2	0.1	0.3
			(0.2)[d]	(0.0)	(0.2)
b) Capacity Building			0.4	1.1	1.5
			(0.4)[d]	(0.0	(0.4)
c) Project Implementation			1.1		1.1
			(1.1)[d]		(1.1)
Fellowships and Training			0.4	1.0	1.4
			(0.4)	(0.0)	(0.4)
Medical Equipment and supplies	5.1		0.2[e]	5.7	11.0
	(5.1)		(0.2)	(0.0)	(5.3)
Office Equipment	0.6		0.4[e]	0.0	1.0
(including vehicles, furniture)	(0.6)		(0.2)	(0.0)	(0.8)
Recurrent Expenditures			0.1	1.4	1.5
			(0.1)	(0.0)	(0.1)
TOTAL	14.2	0.8	3.0	10.0	28.0
	(13.4)	(0.8)	(2.8)	(0.0)	(17.0)

Note: Numbers may not add up due to rounding.

a/ Figures in parentheses are the respective amounts financed by the IDA Credit

b/ Non-Bank Financed

c/ National Competitive Bidding procedures, using Bank Guidelines

d/ Procurement according to Bank Guidelines for Use of Consultants

e/ Prudent National Shopping/off-the-shelf purchases (aggregate US$50,000) of less than US$50,000 per contract; international shopping (aggregate US$450,000) of less than US$250,000 per contract, direct contracting (aggregate US$46,000) for books, intellectual property, spare parts.

29. **Procurement through ICB**. Computer, medical equipment and hospital furniture contracts which are estimated to cost more than US$250,000 equivalent per contract will be procured following **international competitive bidding** (ICB) procedures in accordance with the Bank's "Guidelines for Procurement Under IBRD Loans and IDA Credits" (January 1995 amended in September 1997). Computers and medical equipment (for tenders) procured through ICB will account for about 50 percent (US$5.7 million) of the total goods value. In the comparison of bids for equipment to be procured through ICB, local manufacturers, if any, competing under ICB will receive a preference in bid evaluation of 15 percent of the CIF price or the prevailing custom duty applicable to non-exempt importers, whichever is less, provided they can establish to the satisfaction of the purchaser and the World Bank that: (i) labor, raw material and components from within Albania will account for more than 30 percent of the EXW price of the product offered, and (ii) the production facility in which those goods will be manufactured or assembled has been engaged in the manufacturing/assembling of such goods

at least since the time of bid submission. A detailed list of equipment to be procured is found in Appendix 3. The Bank's latest Standard Bidding Documents, Standard Form of Consulting Contracts and Requests for Proposals, and Standard Bid Evaluation Report Forms will be used for procurement of IDA financed works, goods and services.

30. **Other Forms of Procurement**. The remaining 50 percent of the equipment requirements will be in packages (listed below) suitable for procurement other than ICB (see Tables 6-8 for listing of all equipment packages).

(a) International Shopping (IS). Procedures for IS will be used for contracts for equipment estimated to cost less than US$250,000 (i.e., first batch of computer equipment, laptops, audio visual and office equipment) where the cost of ICB will clearly outweigh possible price advantages. The aggregate value of IS is estimated at US$450,000 equivalent. **International shopping** procedures will based on comparing price quotations obtained from at least three suppliers from two different countries in accordance with Bank Guidelines.

(b) National Shopping (NS). Minor sundry items not exceeding US$50,000 per contract may be purchased on the basis of prudent **national shopping** by comparing price quotations obtained from at least three local suppliers, in accordance with Bank Guidelines. Aggregate amount of national shopping is estimated at US$50,000 equivalent.

(c) Direct Contracting (DC). DC (aggregate US$46,000) will be used for proprietary items for reasons of compatibility and standardization, and in any other justified case such as textbooks and spare parts. Any direct contracting during project implementation will need prior Bank approval.

(d) Civil Works. Civil works contracts include the rehabilitation and upgrading of health care facilities at the primary, out-patient specialist and in-patient hospital levels in Tirana Region, and rehabilitatiaon of the selected building for TRHA, as well as minor upgrading of the MOH and HII offices in Tirana to accommodate the computer equipment coming in under the Project. Works contracts estimated at US$250,000 and above will be awarded through ICB. This includes the contract for rehabilitation of the hospital, and the construction and rehabilitation of 10 urban primary health centers. Works contracts below US$250,000 (rehabilitation of 27 geographically dispersed rural primary health centers) will be awarded through **National Competitive Bidding** (NCB) (aggregate US$800,000). The Borrower will use the latest version of ECA's Sample NCB Documents. Contracts below US$50,000 (MOH and HII offices, estimated at US$200,000 in the aggregate) will be procured on the basis of the lowest of at least three written quotations from domestic contractors with proven qualitative and financial resources, and using the Bank's sample contract documentation for minor works. These minor works are geographically dispersed, and of small value (estimated to range between US$10,000 and US$20,000). To the extent feasible, these minor works will be combined into packages suitable for NCB. The rehabilitation of three polyclinics (US$600,000 aggregate) which are financed by the Italian Government will

be procured in accordance with procedures (**Non-Banked Financed Procurement -- NBF**) agreed between the Government and Italy.

Table 6: SUMMARY OF PROCUREMENT PACKAGES FOR CIVIL WORKS

(US$ Million)

Packages	Estimated Cost (US$ million)	Procure-ment Method	Prepare Tendering	Invitation to Bid	Award Contract	Contract Completion
Rehab. of IPH, HII, TRHA	0.2	Minor Works	9/98	10/98	11/98	6/99
Rural PHCs (27 Centers)	0.84	NCB	9/98	1/99	4/99	9/00
Urban PHCs (10 Centers)	1.81	ICB	9/98	1/99	6/99	9/00
Tirana Hospital	6.7	ICB	2/99	5/99	9/99	6/01
Polyclinics (3 Clinics)	0.63	NBF	9/98	1/99	6/99	9/00
TOTAL	10.18					

Table 7: SUMMARY OF PROCUREMENT PACKAGES FOR EQUIPMENT

(US$ Million)

Packages	Estimated Cost (US$ million)	Procure-ment Method	Prepare Tendering	Invita-tion to Bid	Award Contract	Contract Completion
1. HII Computers	0.32	ICB	9/1/98	11/1/98	1/5/99	4/1/99
2. RHA Computers	0.15	ICB	9/1/98	11/1/98	1/5/99	4/1/99
3. AV Equipment	0.04	IS	10/1/98	12/1/98	2/1/99	4/4/99
4. Vehicles	0.11	IS	6/1/98	8/1/98	10/1/98	12/1/98
5. Hospital Furniture	0.23	IS	6/1/00	8/1/00	11/1/00	1/15/01
6. RHA Office Furn.	0.05	NS	10/1/98	12/1/98	2/1/99	4/1/99
7. Training Materials	0.05	DC	7/1/98	--	9/1/98	--
8. PCU Office Equip.	0.07	IS	6/1/98	8/1/98	9/1/98	11/1/98
9. Medical Equipment	5.1	ICB	9/1/98	12/1/98	2/1/99	6/1/00
10. Pharmaceuticals	1.1	NBF	N/A	N/A	N/A	N/A
11. Hospital Computers	0.13	ICB	9/1/98	11/1/98	1/1/5/99	4/1/99
12. Other Medical Equip.	4.6	NBF	N/A	N/A	N/A	N/A
TOTAL	11.95					

Table 8: SUMMARY OF PROCUREMENT PACKAGES FOR TECHNICAL ASSISTANCE AND TRAINING

(US$ Million)

Packages	Estimated Cost	Procure-ment Method	Prepare Tendering	Invitation to Bid	Award Contract	Contract Completion
MOH TA/Training (ITA)	0.8	NBF	7/1/98	8/15/98	9/1/98	
MOH TA/Training (IDA)	0.3	QCBS	7/1/98	8/15/98	9/1/98	
MOH TA (USAID)	0.1	NBF	7/1/98	8/15/98	9/1/98	
Project Audit (IDA)	0.1	LCS[2/]	5/1/99	6/1/99	7/1/99	9/1/99
HII TA/Training (UK)	0.4	NBF	7/1/98	8/15/98	9/1/98	
TRHA TA/Training (IDA)	0.7	QCBS	10/1/98	12/15/98	1/1/98	
Hospital Mgt./Trng. (IDA)	0.1	IC	10/1/98	12/15/98	1/1/98	
Hospital Mgt./Training (other)	0.2	NBF	7/1/98	8/15/98	9/1/98	
Professional Skills/TR (ITA)	0.6	NBF	7/1/98	8/15/98	9/1/98	
Architectural & Engineering Servs.	0.6	QCBS	9/1/98	11/15/98	3/1/99	
Project Mgt. TA/Training (IDA)	0.3	QCBS	7/1/98	8/15/98	9/1/98	
TOTAL	**4.3**					

Numbers may not add up due to rounding.

1/ Short-term individual specialists.

2/ Least Cost Selection

31. **Technical Assistance**. There are nine technical assistance packages to be procured under the project at a total cost estimated at US$4.3 million. Of this amount, US$2.1 million (five packages) will be financed by IDA and will be procured in accordance with the "Guidelines for the Use of Consultants by World Bank Borrowers and by the World Bank as Executing Agency" (Revised September 1997). The rest (four packages, aggregate approximately US$2.1 million) are financed by other sources and will be procured in accordance with procedures agreed between the cofinanciers and the Government. To keep the evaluation process manageable, proposals for comprehensive packages of consultant services and management of fellowships and training, will be sought from no more than six, but at least three firms, following a short listing acceptable to the Bank. These packages will include management of related training as well. It is anticipated that about US$100,000 of the aggregate for technical assistance will be for highly specialized individual consultants (except for management services). Table 8 shows procurement packages for technical assistance and training.

32. Recurrent expenditures will be carried out in accordance with annual budgets to be agreed with IDA and will include such expenditures as utilities, supplies, and vehicle maintenance.

33. **Prior Review**. In compliance with IDA procedures, standard model bidding documents will be used for all procurement financed by IDA. IDA's prior review of procurement will cover all contracts of US$250,000 and above, and in particular, the following: a) master lists of equipment, packaging of bids and updated cost estimates; b) all ICB contracts for goods; c) ICB contracts for works; d) the first two contracts for NCB for works; e) the first two contracts for minor works; f) terms of reference for all consulting assignments; g) all direct contracting; and h) consulting contracts above US$100,000 with firms and above US$50,000 with individual consultants. With respect to prior review, the

procedures set forth in paragraphs 2 and 3 of Appendix 1 of the Guidelines shall apply. It is estimated that this prior review will cover about 80 percent of the value of all contracts combined for works, equipment and technical assistance financed by the IDA. The remaining 20 percent of contracts will be subject to selective post award reviews. Progress of procurement activities will be monitored by the PCU, and periodic reports on procurement progress, including variations in schedule, will be reported to IDA on a regular basis.

34. Although existing PCU staff already have some experience with procurement procedures, funding for additional training for both current and new PCU staff at the ILO Training Center in Turin, Italy, is included in the Project. To provide overall support for project management, including management of processing tasks, the Project will support the financing of an external project consultant on a declining basis through project implementation. In addition, project-specific procurement training will be provided at the Project Launch Workshop planned for September 1998.

E. Disbursements

35. The proposed Project is expected to be disbursed over a period of four and a half years. The disbursement profile of the Project has been based on experience gained during current IDA operations in the sector. The Project has been designed within the capacity of the MOH to execute over a four and a half year period, and loan funds are expected to be fully disbursed by the end of that period. **The Project Closing Date will be January 31, 2003.** A summary of the disbursement plan is shown in Table 9.

Table 9: DISBURSEMENTS BY YEAR
(US$ Million)

Estimated Disbursements:

	FY99	FY00	FY01	FY02	FY03
Annual	1.0	4.0	6.3	4.6	1.1
Cumulative	1.0	5.0	11.3	15.9	17.0
Cumulative as % of Total	6%	29%	66%	94%	100%

36. Disbursement categories and projected disbursements under the Credit are shown in Table 9 below. The Project is expected to be fully disbursed over a period of four and a half years from Date of Effectiveness, scheduled for August 1, 1998.

Table 10: DISBURSEMENT CATEGORIES

CATEGORY	AMOUNT OF CREDIT (Expressed in Dollar Equivalent (US$ Million)	% OF EXPENDITURE TO BE FINANCED
1. Civil works	7.8	90% (net of taxes)
2. Goods	5.5	100% of foreign expenditures, 100% of local expenditures (ex-factory costs); and 85% of local costs for other items procured locally.
3. Consultant services and training	1.9	100%
4. Recurrent expenditures	0.1	8%
5. Unallocated	1.7	
TOTAL	**17.0**	

37. All disbursements against contracts for goods and works exceeding US$300,000 equivalent, and services and training exceeding US$100,000 equivalent for consulting firms and US$50,000 equivalent for individual consultants will be fully documented. For expenditures below those levels, disbursements will be made on the basis of certified Statements of Expenditure (SOEs). This documentation will be made available for the required audit as well as for Bank supervision missions, and will be retained by the Project Director for at least one year after receipt by the Bank of the audit report for the year in which the last disbursement was made.

38. **Special Account**. To facilitate timely project implementation, the Government will establish, maintain and operate, under terms and conditions acceptable to the Bank, a Special Account denominated in US dollars. The authorized allocation will be US$900,000. However, during the initial stage of the Project, an amount limited to US$300,000 will be deposited. When the aggregate amount of disbursement reaches SDR 1.8 million, the amount deposited in the Special Account will be increased to the full authorized allocation of US$900,000.

39. **Project Account and Audits**. Separate project accounts will be maintained by the PCU. The project accounts, including the PCU accounts and the Special Account, will be audited in accordance with the Bank's "Guidelines for Financial Reporting and Auditing of Projects Financed by the World Bank" (March 1982). *The Borrower will provide the Bank (within six months of the end of each fiscal year), an audit report of such scope and detail as the Bank may reasonably request, including a separate opinion by an independent auditor acceptable to the IDA, on disbursements against certified statements of expenses (SOEs).* The separate opinion should mention whether the SOEs submitted during the fiscal year, together with the procedures and internal controls involved in their preparation, can be relied upon to support the related withdrawal applications.

F. Role of the World Bank in Supervision

40. The Project will, on average, require about 20 staff-weeks of Bank supervision per year on average during implementation, as reflected in the proposed supervision plan below:

Table 11: STAFF WEEKS BY SPECIALIZATION

Timing	Staff Weeks	Staffing
CY1998	22 weeks	IDA resources (22 weeks) of which: - Project Team Leader (7 weeks) - Health Specialist (6 weeks) - Health Economist/Information Systems (3 weeks) - Operations Officer (6 weeks)
CY1998	21 weeks	IDA resources (21 weeks) of which: - Project Team Leader (7 weeks) - Health Specialist (6 weeks) - Health Economist/Information Systems (2 weeks) - Operations Officer (6 weeks)
CY1999	19 weeks	IDA resources (19 weeks) of which: - Project Team Leader (7 weeks) - Health Specialist (5 weeks) - Health Economist/Information Systems(1 week) - Operations Officer (6 weeks)
CY2000	15 weeks	IDA resources (15 weeks) of which: - Project Team Leader (7 weeks) - Operations Officer (7 weeks) - Health Economist/Information Systems (1 week)

G. Administrative Arrangements

41. The Project Coordinator will be responsible for carrying out all necessary administrative arrangements recommended and approved by the Project Advisory Group. Full-time attention of the relevant senior officers will be required in development and implementation of the new administrative systems.

H. Implementation Schedule

42. The Project is expected to be completed within a four year implementation period beginning August 1, 1998. The Project Completion Date is July 31, 2002. Negotiations took place in March 1998. Prior to Effectiveness, it is expected that TORs for major technical equipment lists for project institutions will be drawn up, and bidding documents for major procurement packages put together. Appendix 1 includes the detailed schedule of implementation by activity for each sub-component. The schedule takes into account the work to be carried out during project preparation and reflects the detailed implementation activities.

Based on the quality of the work already completed, it is planned that the implementation of project activities will start prior to Project Effectiveness.

43. Project Progress Reports, Mid-Term Review and Evaluation. **During Negotiations, the Government provided assurances that: (i) MOH will prepare semi-annual descriptive and financial reports on each project component, objective and activity (beginning from the date of Credit Effectiveness).** No later than August 30, 2000 (or about two years after Credit Effectiveness), the PCU will undertake jointly with IDA a mid-term review of progress in project implementation to determine whether: (a) the Project's intended objectives remain valid; (b) implementation is advancing satisfactorily to justify its continued implementation; and (c) any adjustments to, or significant restructuring of the Project are necessary to improve its effectiveness. The Project Operational Manual will be updated following the mid-term review and the annual work program for the following year will reflect the recommendations made. **During negotiations, the Government will be asked to provide assurances that a mid-term project review will be conducted no later than August 30, 2000, according to terms of reference agreed with IDA.**

IV. MONITORING AND EVALUATION

A. Indicators for Monitoring and Evaluation

44. The indicators were selected, in consultation with the MOH, on the basis of sensitivity to project inputs, conceptual relevance to project objectives, ease of calculation and parsimony. Three sets of indicators will be used to monitor project progress and achievements: (a) **input indicators** will be used to keep tack of the extent to which implementation meets stated expectations and schedule; (b) **output indicators** will be used to track immediate results of implementation are in accordance with project plans; and (c) **outcome indicators** will be used to evaluate the extent to which attributable health system improvements were achieved by the Project. In this regard, it should be stressed that while the Project will help to fulfill crucial preconditions for sustained improvements in health system performance and health status, it will not, by itself, result in immediate, measurable and attributable changes in health status. Stated differently, achievement of the Project objectives is necessary but not sufficient for measurable (and attributable) impacts on health status, given the multiple determinants of health status.

Quantitative targets will be specified during the Project Launch Workshop, to be held in Tirana no later than September 30, 1998.

B. Indicator Tables

45. Tables 9, 10 and 11 below provide basic formats for tracking input, output and outcome indicators.

Table 12: INPUT INDICATORS
(US$000's equivalent)

Component/Expenditure Category	Dec. 98[1]		Jun. 99		Dec. 99		Jun. 00		Dec. 00		Jun 01		Dec 01		Jun 02		Total Expected
	Expected	Actual	Expected	Actual	Expected	Actual	Expected	Actual	Expected	Actual	Expected	Actual	Expected	Actual	Expect d	Actual	
I. National Capacity Building																	
A. Ministry of Health																	
B. Health Insurance Institute																	
Subtotal																	
II. Governance & Management (Tirana Region)																	
Subtotal																	
III. Tirana Region (Service Delivery)																	
A. PHC Rural																	
B. PHC Urban																	
C. Polyclinics																	
D. Urban																	
E. Professional Development																	
Sub-total																	
Recurrent Costs																	
Project Management																	
TOTAL																	

[1] Dates of semi-annual Progress Reports will be adjusted based on date of effectiveness of the IDA Credit.

Table 13: OUTPUT INDICATORS[1/]
(US$000's equivalent)

Component/Expenditure Category	Dec 98		Jun 99		Dec 99		Jun 00		Dec 00		Jun 01		Dec 01		Jun 02		Total Expected
	Expected	Actual	Expected	Actual	Expected	Actual	Expected	Actual	Expected	Actual	Expected	Actual	Expected	Actual	Expected	Actual	
I. National Capacity Building																	
# Fellowships.																	
# People trained - local.																	
# People trained - foreign.																	
Seminars.																	
II. Governance & Management (Tirana Region)																	
# Fellowships.																	
# People trained - local.																	
# People trained - foreign.																	
Seminars.																	
III. Tirana Region																	
Service Delivery)																	
# equipped as planned:																	
A. PHC Rural																	
B. PHC Urban																	
C. Polyclinics																	
D. Urban																	
E. Hospital (Departments.)																	
# using standard clinical protocols:																	
A. PHC Rural																	
B. PHC Urban																	
C. Polyclinics																	
D. Urban																	
E. Hospital (Departments) Project Management																	

tinued)

[1/] Dates of semi-annual Progress Reports will be adjusted based on date of Effectiveness of the Bank loan.

Table 14: OUTCOME INDICATORS

Project Objective	Outcome Indicator	Yr. 1	Yr. 2	Yr. 3	Yr. 4
1. Develop national capacity for an effective and financially sustainable health system.	1a. MOH produces three-year rolling plans consistent with Health Policy objectives by the end of Project Yr 2. 1b. HII is financially solvent and autonomous by the end of the Project. 1c. HII covers primary health care by the end of the Project. 1d. Public Health Institute develops a National Public Health Policy against Non-Communicable Diseases and Injuries by the end of Year 2 of the Project.				
2. Establish an effective system for governing and managing the health system in Tirana Region.	2a. Tirana Regional Health Authority functioning according to its Terms of Reference (See Annex 2) by the end of the Project.				
3. Improve the quality and effectiveness of essential health services in Tirana Region.	3a. % increase in population with access to primary health services in rehabilitated health centers in Tirana Region. 3b. % increase in service utilization per health center. 3c. % patients in eligible health facilites treated according to new clinical protocols. 3d Non-communicable disease program launched by end of year 3 of the Project. 3e Injury control program launched by end of the Project.				

REPUBLIC OF ALBANIA

HEALTH SYSTEM RECOVERY AND DEVELOPMENT PROJECT

PROJECT IMPLEMENTATION PLAN: APPENDIX 1

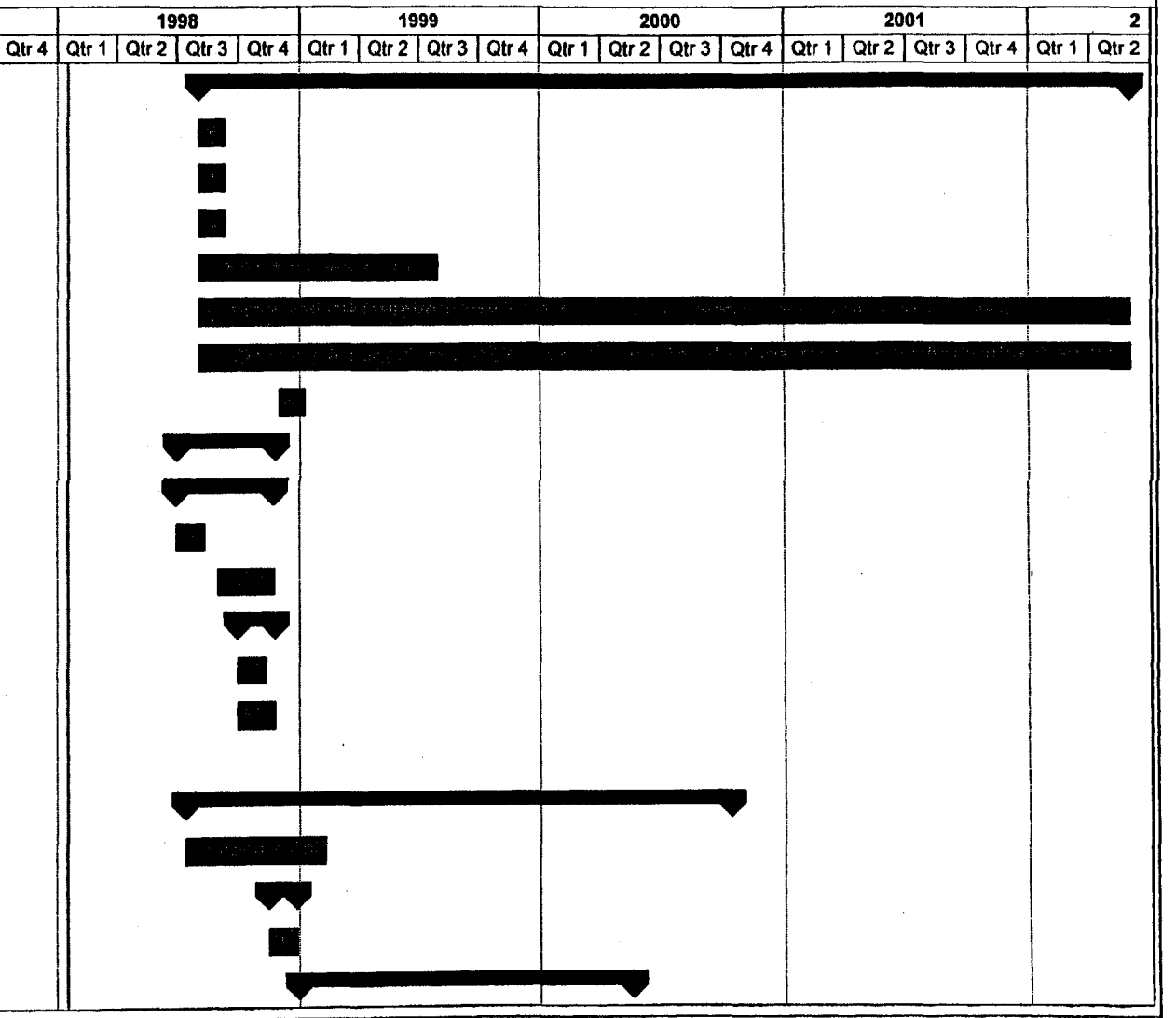
Detailed Implementation Schedule

ALBANIA **Appendix 1**

Health System Recovery and Development Project

Detailed Implementation Schedule

ID	Task Name	Start	Finish
1	PIU Strengthening	8/3/98	5/31/02
2	TA Selection/Award Contract	8/3/98	9/11/98
3	Office Equipment Procureme	8/3/98	9/11/98
4	Vehicle Procurement	8/3/98	9/11/98
5	Staff Fellowships	8/3/98	7/30/99
6	Study Tours	8/3/98	5/31/02
7	Workshops	8/3/98	5/31/02
8	Audit	12/1/98	1/8/99
9	MOH Capacity Building	7/1/98	11/25/98
10	TA - Pharmaceuticals	7/1/98	11/23/98
11	TA Selection/Award Co	7/1/98	8/11/98
12	TA Implementation	9/1/98	11/23/98
13	TA - Hospital Policy Develo	10/1/98	11/25/98
14	TA Selection/Award	10/1/98	11/11/98
15	TA Implementation	10/1/98	11/25/98
16			
17	NIPH Capacity Building	7/15/98	10/12/00
18	Civil Works Rehabilitation	7/15/98	2/9/99
19	Health Policy and Mgt. Dep	11/17/98	12/28/98
20	Office Equipment Proc	11/17/98	12/28/98
21	Staff Training	1/1/99	5/18/00



Project: Health Services Developmen
Date: 1/16/98

Task
Progress
Milestone
Summary
Rolled Up Task
Rolled Up Milestone
Rolled Up Progress

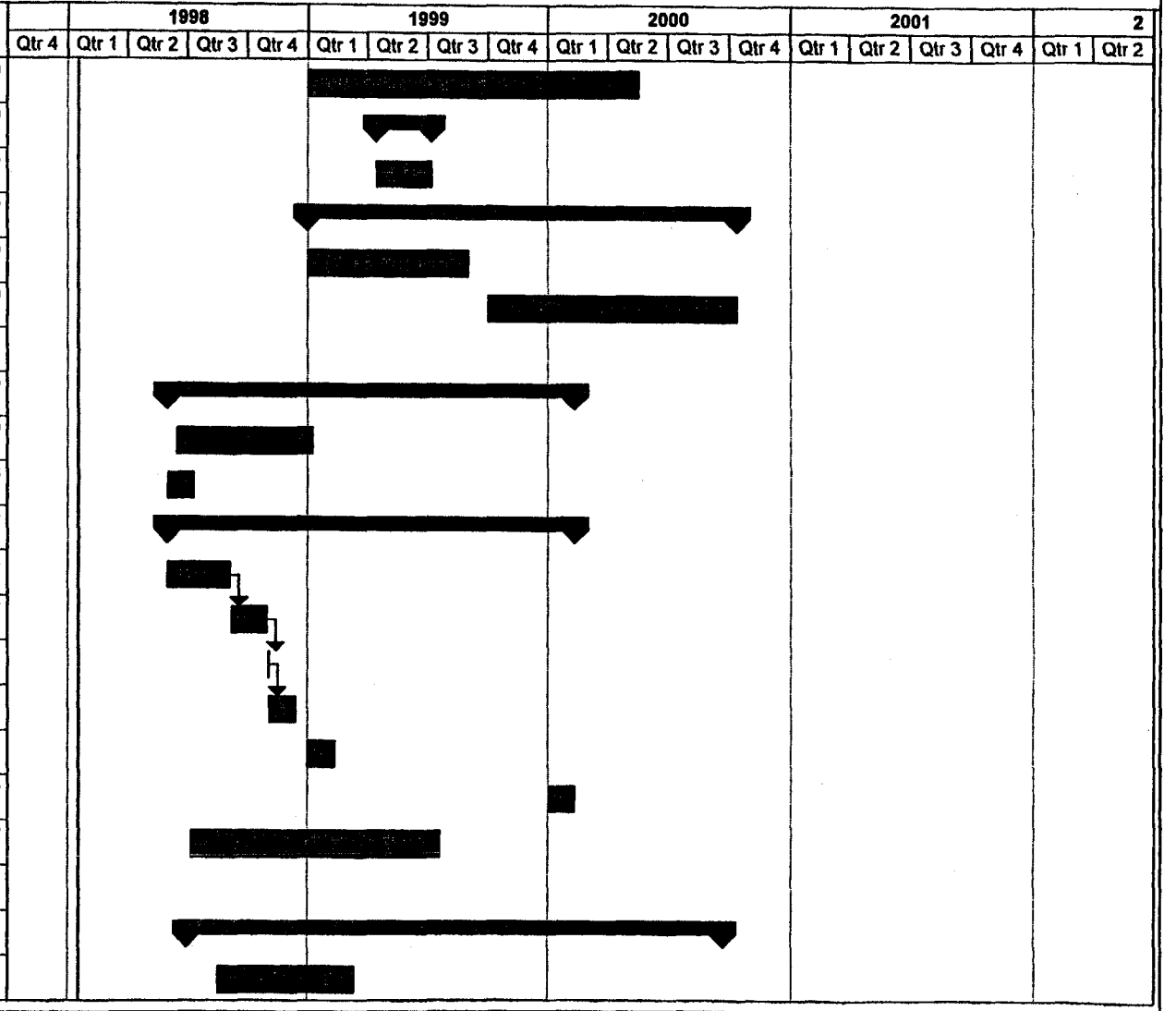
ALBANIA

Health System Recovery and Development Project

Detailed Implementation Schedule

Appendix 1

ID	Task Name	Start	Finish
22	Staff Fellowships	1/1/99	5/18/00
23	Library Establishment	4/15/99	7/7/99
24	Books/Equipment Proc	4/15/99	7/7/99
25	Health Education Dept.	1/1/99	10/12/00
26	Staff Fellowships	1/1/99	9/1/99
27	TA - Health Promotion	10/1/99	10/12/00
28			
29	HII Capacity Building	6/1/98	2/11/00
30	Civil Works Rehabilitation	6/15/98	1/8/99
31	Staff training	6/1/98	7/10/98
32	MIS Equipment Procureme	6/1/98	2/11/00
33	Bid Package Preparati	6/1/98	9/4/98
34	Invitation to Bid	9/7/98	10/30/98
35	Contract Award	11/2/98	11/2/98
36	Lot 1 Equipment Delive	11/3/98	12/14/98
37	Lot 2 Equipment Delive	1/1/99	2/11/99
38	Lot 3 Equipment Delive	1/3/00	2/11/00
39	Staff Fellowships	7/7/98	7/19/99
40			
41	Tirana Regional Health Authorit	7/1/98	9/21/00
42	Civil Works Rehabilitation	8/17/98	3/12/99



Project: Health Services Developmen
Date: 1/16/98

Task
Progress
Milestone
Summary
Rolled Up Task
Rolled Up Milestone
Rolled Up Progress

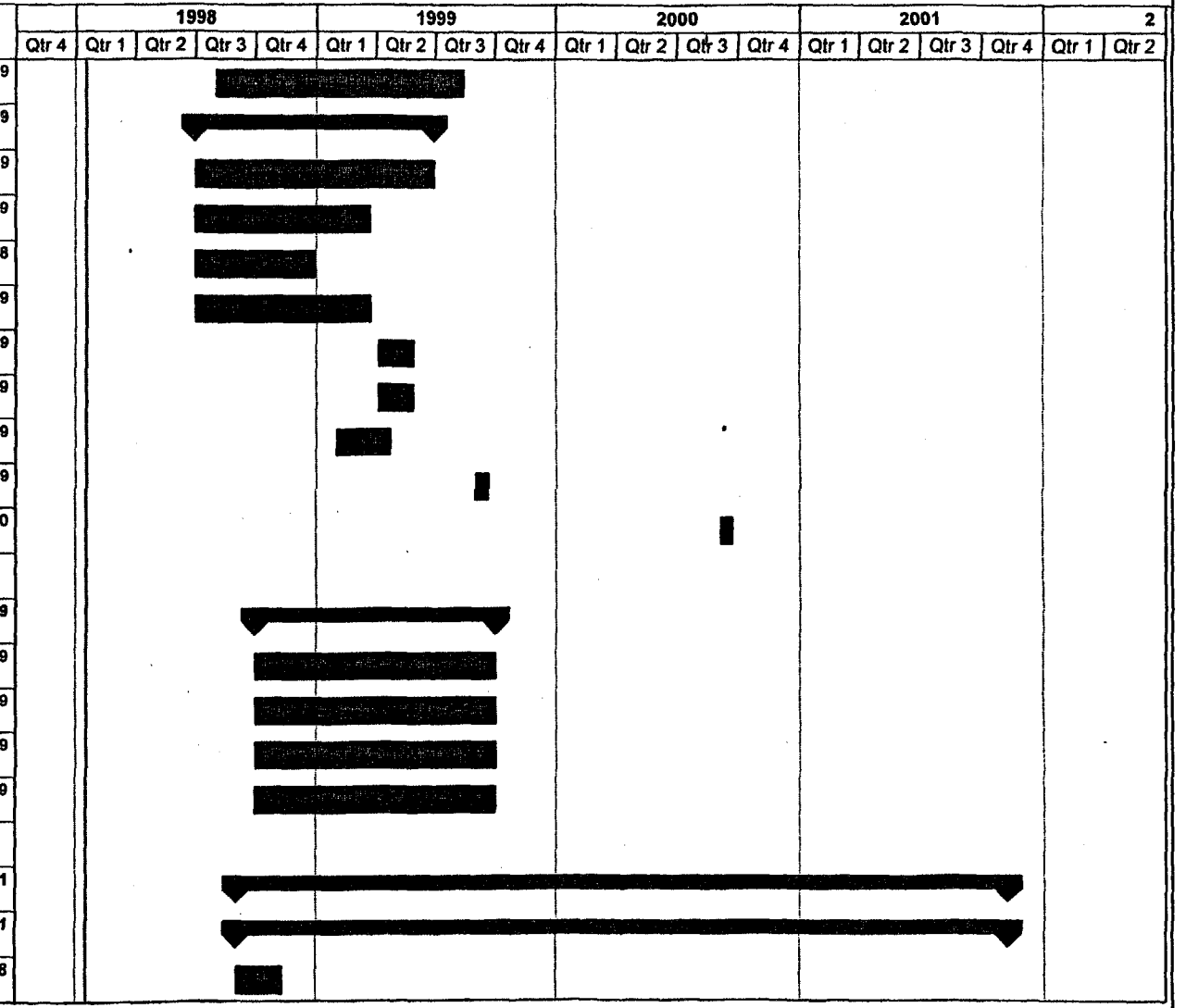
ALBANIA

Health System Recovery and Development Project

Detailed Implementation Schedule

Appendix 1

ID	Task Name	Start	Finish
43	Staff Fellowships	8/3/98	8/13/99
44	TA	7/1/98	6/29/99
45	Health Planning/Financ	7/1/98	6/29/99
46	HR Planning and Devel	7/1/98	3/23/99
47	Health Info Collection/A	7/1/98	12/29/98
48	Hospitals/Spec.Service	7/1/98	3/23/99
49	Office Equipment Procureme	4/5/99	5/28/99
50	Furniture Procurement	4/5/99	5/28/99
51	Staff Training-Health Plan/Fi	2/1/99	4/23/99
52	Study Tours	9/1/99	9/20/99
53	Study Tours	9/4/00	9/21/00
54			
55	Civil Works Rehabilitation	10/1/98	10/1/99
56	Rural PHCs	10/1/98	10/1/99
57	Urban PHCs	10/1/98	10/1/99
58	Tirana Hospital	10/1/98	10/1/99
59	Polyclinics	10/1/98	10/1/99
60			
61	Clinical Skills Mgt. and Training	9/3/98	11/8/01
62	TA- Management Contract	9/3/98	11/8/01
63	TA Selection Award	9/3/98	11/11/98



Project: Health Services Developmen
Date: 1/16/98

Task
Progress
Milestone
Summary
Rolled Up Task
Rolled Up Milestone
Rolled Up Progress

ALBANIA

Appendix 1

Health System Recovery and Development Project

Detailed Implementation Schedule

ID	Task Name	Start	Finish	1998				1999				2000				2001				2	
				Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2
64	TA Implementation	11/12/99	11/8/01																		

Project: Health Services Developmen
Date: 1/16/98

Task
Progress
Milestone
Summary
Rolled Up Task
Rolled Up Milestone
Rolled Up Progress

REPUBLIC OF ALBANIA

HEALTH SYSTEM RECOVERY AND DEVELOPMENT PROJECT

PROJECT IMPLEMENTATION PLAN: APPENDIX 2

Cost Tables

ALBANIA
Health System Recovery and Development Project
Table 1. Capacity Building - MOH
Detailed Costs

	Unit	Quantities 98/99	99/00	00/01	01/02	Total	Unit Cost (US$)	Totals Including Contingencies (US$ '000) 98/99	99/00	00/01	01/02	Total	Summary Divisions Component	Expenditure Account	The Government 98/99	99/00	00/01	01/02	Total	E 98/99	99/00
I. Investment Costs																					
A. Pharmaceuticals Policy Development																					
1. Office equipment																					
Computers	unit	3	-	-	-	3	2,500	8.3	-	-	-	8.3	CBMOH	OEQEA	-	-	-	-	-	-	-
Office materials	lumpsum							2.2	2.3	2.3	2.4	9.2	CBMOH	OEQEA	-	-	-	-	-	-	-
Subtotal Office equipment								10.6	2.3	2.3	2.4	17.6			-	-	-	-	-	-	-
2. Technical Assistance																					
Initial Assessment /a	mm	3	-	-	-	3	15,000	47.8	-	-	-	47.8	CBMOH	PDEA	-	-	-	-	-	-	-
Policy Development /b	mm	9	3	-	-	12	15,000	143.4	48.9	-	-	192.3	CBMOH	CBEA	-	-	-	-	-	-	-
Subtotal Technical Assistance								191.2	48.9	-	-	240.1			-	-	-	-	-	-	-
3. Staff training abroad /c	lumpsum							17.0	-	-	-	17.0	CBMOH	EXTREA	-	-	-	-	-	-	-
4. Pharmaceutical Inspectorate																					
Computers /d	unit	8	-	-	-	8	2,500	22.3	-	-	-	22.3	CBMOH	OEQEA	-	-	-	-	-	-	-
Printers /e	unit	8	-	-	-	8	1,500	13.4	-	-	-	13.4	CBMOH	OEQEA	-	-	-	-	-	-	-
Subtotal Pharmaceutical Inspectorate								35.6	-	-	-	35.6			-	-	-	-	-	-	-
Subtotal Pharmaceuticals Policy Development								254.3	51.2	2.3	2.4	310.2			-	-	-	-	-	-	-
B. Hospital Sector Policy Development																					
1. Technical Assistance /f	mm	2	2	-	-	4	15,000	31.9	32.6	-	-	64.5	CBMOH	PDEA	-	-	-	-	-	31.9	32.6
2. Materials and Supplies /g	lumpsum							6.2	-	-	-	6.2	CBMOH	OEQEA	-	-	-	-	-	6.2	-
Subtotal Hospital Sector Policy Development								38.1	32.6	-	-	70.7			-	-	-	-	-	38.1	32.6
C. Primary Health Care/Public Health Dept.																					
1. Technical Assistance /h	mm	6	3	-	-	9	15,000	95.6	48.9	-	-	144.5	CBMOH	CBEA	-	-	-	-	-	-	-
2. Workshops	ls							2.2	2.3	2.3	2.4	9.2	*CBMOH*	*LOTREA*	-	-	-	-	-	-	-
Subtotal Primary Health Care/Public Health Dept.								97.8	51.2	2.3	2.4	153.7			-	-	-	-	-	-	-
D. Directorate of Health Education																					
1. Technical Assistance /i	mm	3	9	-	-	12	15,000	47.8	146.7	-	-	194.5	CBMOH	PDEA	-	-	-	-	-	47.8	146.7
E. Economic Finance Dept.																					
1. Investment Unit																					
Fellowships /j	my	1	1	-	-	2	50,000	53.1	54.3	-	-	107.4	CBMOH	EXTREA	-	-	-	-	-	-	-
Technical Assistance for Investment Planning /k	mm	6	6	-	-	12	15,000	95.6	97.8	-	-	193.4	CBMOH	CBEA	-	-	-	-	-	-	-
Subtotal Investment Unit								148.7	152.1	-	-	300.8			-	-	-	-	-	-	-
2. Finance Unit																					
T.A. Info System Development & Accountability /l	mm	6	-	-	-	6	15,000	95.6	-	-	-	95.6	CBMOH	CBEA	-	-	-	-	-	-	-
Budgeting Procedures	mm	3	-	-	-	3	15,000	47.8	-	-	-	47.8	CBMOH	CBEA	-	-	-	-	-	-	-
Long Term Training /m	ls							53.1	-	-	-	53.1	CBMOH	EXTREA	-	-	-	-	-	-	-
Personal Computer	Unit	1	-	-	-	1	2,500	2.8	-	-	-	2.8	CBMOH	OEQEA	-	-	-	-	-	-	-
Printer	unit	1	-	-	-	1	1,500	1.7	-	-	-	1.7	CBMOH	OEQEA	-	-	-	-	-	-	-
Subtotal Finance Unit								200.9	-	-	-	200.9			-	-	-	-	-	-	-
Subtotal Economic Finance Dept.								349.6	152.1	-	-	501.7			-	-	-	-	-	-	-
Total								787.7	433.7	4.7	4.8	1,230.8			-	-	-	-	-	85.9	179.3

\a *Assess needs for policy formulation. Define next required in development of policy (draft TORs for further T.A.).*
\b 2 people for 6 months each for policy formulation.
\c 2 MOH staff for 3 months each abroad.
\d Computers for 7 branch offices plus 1 for Tirana
\e 7 printers for district offices, 1 for Tirana
\f Support development of minimum standards of health care.
\g For committee work.
\h Change strategy to guidelines for implementation.
\i 3 months on initial assessment of non-communicable diseases and injuries. 9 months on policy definition of NCD injuries prevention.
\j 2 persons for 1 year study
\k Two persons for six months each.
\l USAID will finance.
\m Focus on health finance planning and budgeting

Mon Apr 20 12:27:28 1998

ALBANIA
Health System Recovery and Development Project
Table 1. Capacity Building - MOH
Detailed Costs

Expenditures by Financiers (US$ '000)

IDA			USAID					Italian Government				
00/01	01/02	Total	98/99	99/00	00/01	01/02	Total	98/99	99/00	00/01	01/02	Total
-	-	-	-	-	-	-	-	8.3	-	-	-	8.3
-	-	-	-	-	-	-	-	2.2	2.3	2.3	2.4	9.2
-	-	-	-	-	-	-	-	10.6	2.3	2.3	2.4	17.6
-	-	-	-	-	-	-	-	47.8	-	-	-	47.8
-	-	-	-	-	-	-	-	143.4	48.9	-	-	192.3
-	-	-	-	-	-	-	-	191.2	48.9	-	-	240.1
-	-	-	-	-	-	-	-	17.0	-	-	-	17.0
-	-	-	-	-	-	-	-	22.3	-	-	-	22.3
-	-	-	-	-	-	-	-	13.4	-	-	-	13.4
-	-	-	-	-	-	-	-	35.6	-	-	-	35.6
-	-	-	-	-	-	-	-	254.3	51.2	2.3	2.4	310.2
-	-	64.5	-	-	-	-	-	-	-	-	-	-
-	-	6.2	-	-	-	-	-	-	-	-	-	-
-	-	70.7	-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	95.6	48.9	-	-	144.5
-	-	-	-	-	-	-	-	2.2	2.3	2.3	2.4	9.2
-	-	-	-	-	-	-	-	97.8	51.2	2.3	2.4	153.7
-	-	194.5	-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	53.1	54.3	-	-	107.4
-	-	-	-	-	-	-	-	95.6	97.8	-	-	193.4
-	-	-	-	-	-	-	-	148.7	152.1	-	-	300.8
-	-	-	95.6	-	-	-	95.6	-	-	-	-	-
-	-	-	-	-	-	-	-	47.8	-	-	-	47.8
-	-	-	-	-	-	-	-	53.1	-	-	-	53.1
-	-	-	-	-	-	-	-	2.8	-	-	-	2.8
-	-	-	-	-	-	-	-	1.7	-	-	-	1.7
-	-	-	95.6	-	-	-	95.6	105.3	-	-	-	105.3
-	-	-	95.6	-	-	-	95.6	254.0	152.1	-	-	406.1
-	-	265.2	95.6	-	-	-	95.6	606.2	254.4	4.7	4.8	870.1

ALBANIA
Health System Recovery and Development Project
Table 2. Capacity Building _ Health Insurance Institute
Detailed Costs

	Unit	Quantities 98/99	99/00	00/01	01/02	Total	Unit Cost (US$)	Totals Including Contingencies (US$ '000) 98/99	99/00	00/01	01/02	Total	Summary Divisions Component	Expenditure Account	Expenditures by Financiers (US$ '000) The Government 98/99	99/00	00/01	01/02	Total	IDA 98/99	99/00	00/01	01/02	Total	98/99
I. Investment Costs																									
A. Technical Assistance	mm	3	3	3	3	12	15,000	47.8	48.9	50.0	51.2	197.9	CBHII	CBEA	-	-	-	-	-	-	-	-	-	-	47.8
B. Equipment																									
1. Office Equipment																									
Server	unit	1	-	-	1	2	4,000	4.5	-	-	4.8	9.2	CBHII	OEQEA	0.0	-	-	0.0	0.1	4.4	-	-	4.7	9.1	-
Personal Computer /a	unit	32	18	-	-	50	2,485	88.5	50.9	-	-	139.4	CBHII	OEQEA	0.7	0.4	-	-	1.0	87.8	50.5	-	-	138.3	-
Printers	unit	23	20	-	-	43	2,000	51.2	45.5	-	-	96.7	CBHII	OEQEA	0.4	0.3	-	-	0.7	50.8	45.2	-	-	96.0	-
Software	lumpsum							5.6	3.4	5.8	-	14.8	CBHII	OEQEA	0.0	0.0	0.0	-	0.1	5.5	3.4	5.8	-	14.7	-
Computer Network	unit	2	5	-	-	7	6,000	13.4	34.1	-	-	47.5	CBHII	OEQEA	0.1	0.3	-	-	0.4	13.3	33.9	-	-	47.1	-
Computer Supplies /b	lumpsum							3.3	3.4	4.7	4.8	16.2	CBHII	OEQEA	0.0	0.0	0.0	0.0	0.1	3.3	3.4	4.6	4.7	16.1	-
Subtotal Office Equipment								166.4	137.4	10.5	9.5	323.8			1.2	1.0	0.1	0.1	2.4	165.1	136.4	10.4	9.5	321.4	-
C. Vehicle	unit	1	-	-	-	1	25,000	27.8	-	-	-	27.8	CBHII	OEQEA	0.2	-	-	-	0.2	27.6	-	-	-	27.6	-
D. Staff Training																									
1. Workshops	unit	1	-	-	-	1	2,000	2.2	-	-	-	2.2	CBHII	LOTREA	-	-	-	-	-	-	-	-	-	-	2.2
2. Seminars	unit	1	3	2	3	9	1,208	1.3	4.1	2.8	4.3	12.6	CBHII	LOTREA	-	-	-	-	-	-	-	-	-	-	1.3
3. Long Term Fellowships																									
Health Planning Fellowship /c	unit	1	-	-	-	1	50,000	53.1	-	-	-	53.1	CBHII	EXTREA	-	-	-	-	-	-	-	-	-	-	53.1
Health Finance Fellowship /d	unit	1	-	-	-	1	50,000	53.1	-	-	-	53.1	CBHII	EXTREA	-	-	-	-	-	-	-	-	-	-	53.1
Subtotal Long Term Fellowships								106.2	-	-	-	106.2			-	-	-	-	-	-	-	-	-	-	106.2
4. Training Materials	mm							2.2	1.1	2.3	1.2	6.9	CBHII	LOTREA	-	-	-	-	-	-	-	-	-	-	2.2
5. Short Term Fellowships /e	unit	2	2	2	2	8	10,000	21.2	21.7	22.2	22.7	87.9	CBHII	EXTREA	-	-	-	-	-	-	-	-	-	-	21.2
6. Study Tours /f	unit	2	2	2	2	8	4,000	8.5	8.7	8.9	9.1	35.2	CBHII	EXTREA	-	-	-	-	-	-	-	-	-	-	8.5
Subtotal Staff Training								141.7	35.7	36.3	37.3	251.0			-	-	-	-	-	-	-	-	-	-	141.7
Total Investment Costs								383.7	222.0	96.8	98.0	800.5			1.5	1.0	0.1	0.1	2.6	192.7	136.4	10.4	9.5	349.0	189.5
II. Recurrent Costs																									
A. Equipment O&M	ls							6.7	12.3	13.0	13.7	45.7	CBHII	OEOMEA	6.7	12.3	13.0	13.7	45.7	-	-	-	-	-	-
B. Office Expenditures	Annual Cost							5.6	5.7	5.8	6.0	23.0	CBHII	OTHEA	5.6	5.7	5.8	6.0	23.0	-	-	-	-	-	-
C. Vehicle Maintenance	Annual Cost							2.8	2.8	2.9	3.0	11.5	CBHII	VOMEA	2.8	2.8	2.9	3.0	11.5	-	-	-	-	-	-
Total Recurrent Costs								15.0	20.8	21.7	22.6	80.2			15.0	20.8	21.7	22.6	80.2	-	-	-	-	-	-
Total								398.7	242.8	118.5	120.7	880.7			16.5	21.9	21.8	22.7	82.8	192.7	136.4	10.4	9.5	349.0	189.5

\a year 1: 6 for central branch and 26 Tirana urban PHCs; year 2: 18 Tirana rural administrative PHCs.
\b *floppy disks, tape back-up, etc.*
\c for economist.
\d for economist.
\e For branch office staff. Assume a 2 and a half month course at $10T. ($4T/mo. for fellowship abroad)
\f $100/day assumption. For branch office staff.

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Health System Recovery and Development Project
Table 2. Capacity Building _ Health Insurance Institute
Detailed Costs

UK			
99/00	00/01	01/02	Total
48.9	50.0	51.2	197.9
-	-	-	-
-	-	-	-
-	-	-	-
-	-	-	-
-	-	-	-
-	-	-	-
-	-	-	-
-	-	-	-
-	-	-	2.2
4.1	2.8	4.3	12.6
-	-	-	53.1
-	-	-	53.1
-	-	-	106.2
1.1	2.3	1.2	6.9
21.7	22.2	22.7	87.9
8.7	8.9	9.1	35.2
35.7	36.3	37.3	251.0
84.6	86.3	88.5	448.9
-	-	-	-
-	-	-	-
-	-	-	-
-	-	-	-
84.6	86.3	88.5	448.9

ALBANIA
Health System Recovery and Development Project
Table 3. Tirana Region Health Management - Regional Health Authority
Detailed Costs

	Unit	Quantities 98/99	99/00	00/01	01/02	Total	Unit Cost (US$)	Totals Including Contingencies (US$ '000) 98/99	99/00	00/01	01/02	Total	Summary Divisions Component	Expenditure Account	Expenditures The Government 98/99	99/00	00/01	01/02	Total
I. Investment Costs																			
A. Civil Works																			
1. Reconstruction of existing HII and TRHA offices /a	completion %s		70	30		100		-	140.2	61.5	-	201.7	RHA	CWOTHEREA	-	14.0	6.1	-	20.2
B. Architectural/Engineering Services	Fee							7.0	3.6	1.2	-	11.9	RHA	A&EEA	-	-	-	-	-
C. Office Equipment																			
1. Personal Computers	unit	-	20	-	-	20	2,500	-	56.9	-	-	56.9	RHA	OEQEA	-	0.4	-	-	0.4
2. Laser Printers	unit	-	10	-	-	10	1,800	-	20.5	-	-	20.5	RHA	OEQEA	-	0.2	-	-	0.2
3. Photocopiers/facsimile machines	lumpsum							-	79.7	-	-	79.7	RHA	OEQEA	-	0.6	-	-	0.6
Subtotal Office Equipment								-	157.1	-	-	157.1			-	1.2	-	-	1.2
D. Vehicles	unit	2	-	-	-	2	25,000	55.6	-	-	-	55.6	RHA	OEQEA	0.4	-	-	-	0.4
E. Furniture																			
1. Office furniture	unit	-	40	-	-	40	600	-	27.3	-	-	27.3	RHA	FURNEA	-	0.6	-	-	0.6
2. Conference room	lumpsum							-	22.8	-	-	22.8	RHA	FURNEA	-	0.5	-	-	0.5
Subtotal Furniture								-	50.1	-	-	50.1			-	1.1	-	-	1.1
F. Technical Assistance /b	mm	6	10	6	5	27	15,000	95.6	163.0	100.0	85.3	443.9	RHA	CBEA	-	-	-	-	-
G. Training																			
1. Long Term Fellowships																			
Health Planning and Finance	lumpsum	1	-	-	-	1	50,000	53.1	-	-	-	53.1	RHA	EXTREA	-	-	-	-	-
Health Management	lumpsum	1	-	-	-	1	50,000	53.1	-	-	-	53.1	RHA	EXTREA	-	-	-	-	-
Public Health /c	lumpsum	1	1	-	-	2	50,000	53.1	54.3	-	-	107.4	RHA	EXTREA	-	-	-	-	-
Equipment Engineer /d	mm	-	12	-	-	12	3,300	-	43.0	-	-	43.0	RHA	PIEA	-	-	-	-	-
Subtotal Long Term Fellowships								159.3	97.4	-	-	256.7			-	-	-	-	-
2. Short Term Fellowships /e	lumpsum							10.6	10.9	16.7	11.4	49.5	RHA	EXTREA	-	-	-	-	-
3. Study Tours	lumpsum							-	21.7	11.1	-	32.8	RHA	EXTREA	-	-	-	-	-
4. Local Training	lumpsum							5.6	5.7	5.8	6.0	23.0	RHA	LOTREA	-	-	-	-	-
Subtotal Training								175.5	135.6	33.6	17.3	362.1			-	-	-	-	-
Total Investment Costs								333.8	649.6	196.4	102.6	1,282.3			0.4	16.3	6.1	-	22.9
II. Recurrent Costs																			
A. Building Maintenance	Annual Cost							-	2.8	4.1	4.2	11.1	RHA	BOMEA	-	2.6	3.9	4.0	10.5
B. Equipment O&M	Annual Cost							-	6.3	6.4	6.6	19.3	RHA	OEOMEA	-	5.1	5.6	5.8	16.5
C. Vehicle O&M	Annual Cost							5.6	5.7	5.8	6.0	23.0	RHA	VOMEA	4.2	4.6	5.1	5.2	19.1
Total Recurrent Costs								5.6	14.8	16.3	16.7	53.4			4.2	12.3	14.6	14.9	46.1
Total								339.3	664.4	212.7	119.3	1,335.7			4.6	28.7	20.8	14.9	68.9

\a Minor works contracts procured on basis of lowest cost of at least 3 quotations.
\b 4 people. develop structure and strategy of RHA (6 mm), health planning and finance (9 mm); human resources planning and dev. (6mm); health info. system (6 mm).
\c 2 persons for a one year, full-time MPH, one with concentration on infectious diseases, mother/child and family planning, and one with concentration of NCDs and injuries.
\d specialization in biomedical equipment standards and mgt. 2 persons for 6 months each
\e 10 people for 3 months each.

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ALBANIA
Health System Recovery and Development Project
Table 3. Tirana Region Health Management - Regional Health Authority
Detailed Costs

by Financiers (US$ '000)				
IDA				
98/99	99/00	00/01	01/02	Total
-	126.2	55.3	-	181.5
7.0	3.6	1.2	-	11.9
-	56.5	-	-	56.5
-	20.3	-	-	20.3
-	79.1	-	-	79.1
-	155.9	-	-	155.9
55.2	-	-	-	55.2
-	26.7	-	-	26.7
-	22.3	-	-	22.3
-	49.0	-	-	49.0
95.6	163.0	100.0	85.3	443.9
53.1	-	-	-	53.1
53.1	-	-	-	53.1
53.1	54.3	-	-	107.4
-	43.0	-	-	43.0
159.3	97.4	-	-	256.7
10.6	10.9	16.7	11.4	49.5
-	21.7	11.1	-	32.8
5.6	5.7	5.8	6.0	23.0
175.5	135.6	33.6	17.3	362.1
333.3	633.3	190.2	102.6	1,259.4
-	0.2	0.2	0.2	0.6
-	1.2	0.8	0.8	2.8
1.4	1.1	0.7	0.7	3.9
1.4	2.5	1.7	1.8	7.4
334.7	635.7	191.9	104.4	1,266.8

ALBANIA
Health System Recovery and Development Project
Table 4. Tirana Regional Health System Delivery - Rural Areas
Detailed Costs

	Unit	Quantities 98/99	99/00	00/01	01/02	Total	Unit Cost (US$)	Totals Including Contingencies (US$'000) 98/99	99/00	00/01	01/02	Total	Summary Divisions Component	Expenditure Account	Expendit The Government 98/99	99/00	00/01	01/02
I. Investment Costs																		
A. Construction/Rehabilitation of 27 Rural Health Centers																		
1. New PHC Centers																		
Type 1 Health Centers	completion %s		60	40		100		-	178.5	121.7	-	300.2	THSRUR	CWRHCEA	-	17.8	12.2	-
Type II Health Centers	completion %s		60	40		100		-	48.8	33.3	-	82.1	THSRUR	CWRHCEA	-	4.9	3.3	-
Subtotal New PHC Centers								-	227.3	155.0	-	382.4			-	22.7	15.5	-
2. Reconstruction of Health Centers																		
Type I Health Centers	completion %s		40	40	20	100		-	33.8	34.6	17.7	86.1	THSRUR	CWRHCEA	-	3.4	3.5	1.8
Type II Health Centers	completion %s		40	40	20	100		-	35.2	36.0	18.4	89.5	THSRUR	CWRHCEA	-	3.5	3.6	1.8
Type III Health Centers	completion %s		40	40	20	100		-	112.7	115.3	59.0	286.9	THSRUR	CWRHCEA	-	11.3	11.5	5.9
Subtotal Reconstruction of Health Centers								-	181.6	185.8	95.1	462.5			-	18.2	18.6	9.5
Subtotal Construction/Rehabilitation of 27 Rural Health Centers								-	409.0	340.9	95.1	844.9			-	40.9	34.1	9.5
B. Architectural/Engineering Services																		
1. New Rural Health Centers	Fee							11.1	6.8	4.7	-	22.6	THSRUR	A&EEA	-	-	-	-
2. Rehabilitation of Rural Health Centers	Fee							10.7	6.8	7.0	2.9	27.3	THSRUR	A&EEA	-	-	-	-
Subtotal Architectural/Engineering Services								21.8	13.6	11.6	2.9	49.9			-	-	-	-
C. Medical Equipment	lumpsum							74.1	-	-	-	74.1	THSRUR	MEQEA	0.6	-	-	-
D. Furniture for Exam Rooms/Clinics	completion %s		100			100		-	120.7	-	-	120.7	THSRUR	MEQEA	-	0.9	-	-
Total Investment Costs								95.9	543.3	352.5	97.9	1,089.5			0.6	41.8	34.1	9.5
II. Recurrent Costs																		
A. Building Maintenance																		
1. New Rural Health Centers	Annual Cost							-	4.5	7.8	7.9	20.2	THSRUR	BOMEA	-	4.2	7.4	7.5
2. Rehabilitated Rural Health Centers	Annual Cost							-	3.6	7.4	9.5	20.6	THSRUR	BOMEA	-	3.4	7.1	9.0
Subtotal Building Maintenance								-	8.2	15.2	17.4	40.8			-	7.6	14.4	16.6
B. Medical Equipment O&M	Annual Cost							3.0	3.0	3.1	3.2	12.3	THSRUR	MEOMEA	1.8	2.1	2.5	2.5
Total Recurrent Costs								3.0	11.2	18.3	20.6	53.1			1.8	9.7	16.9	19.1
Total								98.8	554.5	370.8	118.5	1,142.6			2.3	51.5	51.0	28.6

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Health System Recovery and Development Project
Table 4. Tirana Regional Health System Delivery - Rural Areas
Detailed Costs

ures by Financiers (US$ '000)

Total	IDA 98/99	IDA 99/00	IDA 00/01	IDA 01/02	IDA Total
30.0	-	160.6	109.6	-	270.2
8.2	-	43.9	30.0	-	73.9
38.2	-	204.6	139.5	-	344.1
8.6	-	30.4	31.1	15.9	77.5
9.0	-	31.6	32.4	16.6	80.6
28.7	-	101.4	103.7	53.1	258.2
46.3	-	163.5	167.2	85.5	416.3
84.5	-	368.1	306.8	85.5	760.4
-	11.1	6.8	4.7	-	22.6
-	10.7	6.8	7.0	2.9	27.3
-	21.8	13.6	11.6	2.9	49.9
0.6	73.5	-	-	-	73.5
0.9	-	119.7	-	-	119.7
85.9	95.3	501.5	318.4	88.4	1,003.6
19.1	-	0.3	0.4	0.4	1.1
19.5	-	0.3	0.4	0.5	1.1
38.6	-	0.6	0.8	0.9	2.2
8.9	1.2	0.9	0.6	0.6	3.4
47.5	1.2	1.5	1.4	1.5	5.6
133.4	96.5	503.0	319.8	89.9	1,009.2

ALBANIA
Health System Recovery and Development Project
Table 5. Tirana Regional Health System Delivery - Urban Areas
Detailed Costs

	Unit	Quantities 98/99	99/00	00/01	01/02	Total	Unit Cost (US$)	Totals Including Contingencies (US$ '000) 98/99	99/00	00/01	01/02	Total	Summary Divisions Component	Expenditure Account	Expendit The Government 98/99	99/00	00/01	01/02
I. Investment Costs																		
A. Construction/Rehabilitation of 10 Urban Health Centers																		
1. New Urban Health Centers	completion %s		60	40		100		-	315.5	215.2	-	530.7	THSUR	CWUHCEA	-	31.6	21.5	-
2. Rehabilitation of existing Centers	completion %s		40	30	30	100		-	501.8	385.0	393.9	1,280.7	THSUR	CWUHCEA	-	50.2	38.5	39.4
Subtotal Construction/Rehabilitation of 10 Urban Health Centers								-	817.3	600.2	393.9	1,811.4			-	81.7	60.0	39.4
B. Architectural/Engineering Services																		
1. New Urban Health Centers	Fee							15.4	9.5	6.5	-	31.3	THSUR	A&EEA	-	-	-	-
2. Rehabilitation of Urban Health Centers	Fee							29.4	15.1	15.4	15.8	75.6	THSUR	A&EEA	-	-	-	-
Subtotal Architectural/Engineering Services								44.9	24.5	21.9	15.8	107.0			-	-	-	-
C. Medical Equipment	completion %s		100			100		-	34.3	-	-	34.3	THSUR	MEQEA	-	-	-	-
D. Furniture for Exam Rooms/Clinics	completion %s		100			100		-	91.1	-	-	91.1	THSUR	MEQEA	-	-	-	-
Total Investment Costs								44.9	967.2	622.1	409.6	2,043.7			-	81.7	60.0	39.4
II. Recurrent Costs																		
A. Medical Equipment O&M	Annual Cost							-	1.4	1.4	1.4	4.2	THSUR	MEOMEA	-	1.4	1.4	1.4
B. Building Maintenance																		
1. New Urban Health Centers	Annual Cost							-	6.3	10.8	11.0	28.1	THSUR	BOMEA	-	6.3	10.8	11.0
2. Rehabilitated Urban Health Centers	Annual Cost							-	10.0	18.0	26.3	54.3	THSUR	BOMEA	-	10.0	18.0	26.3
Total Recurrent Costs								-	17.7	30.1	38.7	86.5			-	17.7	30.1	38.7
Total								44.9	984.9	652.2	448.3	2,130.3			-	99.5	90.2	78.1

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Health System Recovery and Development Project
Table 5. Tirana Regional Health System Delivery - Urban Areas
Detailed Costs

ures by Financiers (US$ '000)

Total	98/99	99/00	IDA 00/01	01/02	Total
53.1	-	284.0	193.7	-	477.6
128.1	-	451.6	346.5	354.5	1,152.7
181.1	-	735.6	540.2	354.5	1,630.3
-	15.4	9.5	6.5	-	31.3
-	29.4	15.1	15.4	15.8	75.6
-	44.9	24.5	21.9	15.8	107.0
-	-	34.3	-	-	34.3
-	-	91.1	-	-	91.1
181.1	44.9	885.5	562.0	370.2	1,862.6
4.2	-	-	-	-	-
28.1	-	-	-	-	-
54.3	-	-	-	-	-
86.5	-	-	-	-	-
267.7	44.9	885.5	562.0	370.2	1,862.6

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Health System Recovery and Development Project
Table 6. Tirana Regional Health System Delivery - Hospitals
Detailed Costs

	Unit	Quantities 98/99	99/00	00/01	01/02	Total	Unit Cost (US$)	Totals Including Contingencies (US$ '000) 98/99	99/00	00/01	01/02	Total	Summary Divisions Component	Expenditure Account	The 98/99	The 99/00
I. Investment Costs																
A. Rehabilitation of Tirana Regional Hospital																
1. New Construction	completion %s		30	40	30	100		-	1,618.2	2,207.2	1,693.5	5,518.8	HOS	CWHOSPEA	-	161.8
2. Rehabilitation of Priority Services/Infrastructure																
Morgue	completion %s		100			100		-	14.4	-	-	14.4	HOS	CWHOSPEA	-	1.4
Medical Gas System	completion %s		100			100		-	225.4	-	-	225.4	HOS	CWHOSPEA	-	22.5
Electrical System	completion %s		40	40	20	100		-	110.2	112.7	57.7	280.6	HOS	CWHOSPEA	-	11.0
Heating System	completion %s		40	40	20	100		-	150.2	153.7	78.6	382.6	HOS	CWHOSPEA	-	15.0
Roadscaping	lumpsum							293.7	-	-	-	293.7	HOS	CWHOSPEA	29.4	-
Subtotal Rehabilitation of Priority Services/Infrastructure								293.7	500.2	266.4	136.3	1,196.6			29.4	50.0
Subtotal Rehabilitation of Tirana Regional Hospital								293.7	2,118.4	2,473.6	1,829.7	6,715.4			29.4	211.8
B. Architectural/Engineering Services																
1. Equipment Specialist /a	mm	3	2	2	1	8	15,000	47.8	32.6	33.3	17.1	130.8	HOS	PIEA	-	-
2. New Construction	Fee							126.5	97.1	66.2	33.9	323.7	HOS	A&EEA	-	-
3. National Consultants /b	my	2	2	2	2	8	2,400	5.3	5.5	5.6	5.7	22.1	HOS	A&EEA	-	-
4. Hospital Planning Training /c	ls							5.3	-	-	-	5.3	HOS	EXTREA	-	-
Subtotal Architectural/Engineering Services								185.0	135.1	105.1	56.6	481.9			-	-
C. Equipment																
1. General Services Equipment																
Telecommunications Systems	lumpsum							222.5	-	-	-	222.5	HOS	MEQEA	1.7	-
Heating System	lumpsum							222.5	-	-	-	222.5	HOS	MEQEA	1.7	-
Electrical System	lumpsum							166.9	-	-	-	166.9	HOS	MEQEA	1.3	-
Morgue	lumpsum							27.8	-	-	-	27.8	HOS	MEQEA	0.2	-
Subtotal General Services Equipment								639.8	-	-	-	639.8			4.8	-
2. Medical Equipment for New Construction																
Diagnostic Services	ls							-	-	1,251.8	-	1,251.8	HOS	MEQEA	-	-
Intensive Care	ls							-	-	777.8	-	777.8	HOS	MEQEA	-	-
Laboratory Services	ls							-	-	770.8	-	770.8	HOS	MEQEA	-	-
Admissions	lumpsum							-	-	132.7	-	132.7	HOS	OEQEA	-	-
Subtotal Medical Equipment for New Construction								-	-	2,933.2	-	2,933.2			-	-
3. Medical Equipment for Rehabilitated Facilities /d																
Surgery	lumpsum							-	1,229.3	-	-	1,229.3	HOS	MEQEA	-	9.2
Sterilization	lumpsum							-	102.4	-	-	102.4	HOS	MEQEA	-	0.8
Subtotal Medical Equipment for Rehabilitated Facilities								-	1,331.7	-	-	1,331.7			-	10.0
Subtotal Equipment								639.8	1,331.7	2,933.2	-	4,904.7			4.8	10.0
D. Furniture																
1. For New Construction	completion %s			100		100		-	-	232.9	-	232.9	HOS	MEQEA	-	-
E. Support for Operational Expenditures /e																
1. Medical Supplies	ls							890.1	569.1	302.7	-	1,762.0	HOS	MEQEA	-	-
F. Mgt. Training - Hospital Administration /f																
Technical Advisor for MDs /g	mm	-	1.5	-	-	1.5	15,000	-	24.4	-	-	24.4	HOS	CBEA	-	-
Technical Advisor for Chief Nurses /h	mm	-	10	-	-	10	12,000	-	130.4	-	-	130.4	HOS	CBEA	-	-
Fellowships /i	course	-	1	1	-	2	7,500	-	8.1	8.3	-	16.5	HOS	EXTREA	-	-
Department heads training /j	COURSE	-	4	-	-	4	1,000	-	4.6	-	-	4.6	HOS	LOTREA	-	-
Chief Nurses Training /k	Course	-	4	-	-	4	2,000	-	9.1	-	-	9.1	HOS	LOTREA	-	-
Subtotal Mgt. Training - Hospital Administration								-	176.6	8.3	-	185.0			-	-
Total Investment Costs								2,008.6	4,331.0	6,055.9	1,886.4	14,281.9			34.2	221.8
II. Recurrent Costs																
A. Building Maintenance																
1. New Building	Annual Cost							-	32.4	77.3	112.9	222.5	HOS	BOMEA	-	29.9
2. Rehabilitated Infrastructure	Annual Cost							5.9	16.0	21.7	24.9	68.5	HOS	BOMEA	5.3	14.8
Subtotal Building Maintenance								5.9	48.4	99.0	137.8	291.0			5.3	44.7
B. Equipment Maintenance																
1. Medical Equipment for New Construction	Annual Cost							-	-	117.3	120.0	237.4	HOS	MEOMEA	-	-
2. Medical Equipment for Rehabilitated Infrastructure	Annual Cost							-	53.3	54.5	55.7	163.5	HOS	MEOMEA	-	37.3
Subtotal Equipment Maintenance								-	53.3	171.8	175.8	400.9			-	37.3
Total Recurrent Costs								5.9	101.6	270.8	313.6	691.9			5.3	82.0
Total								2,014.5	4,432.7	6,326.7	2,200.0	14,973.8			39.5	303.9

\a 4 months for general services (e.g., heating, medical gasses, communications) equipment, and 4 months for medical equipment.
\b Engineer and architect full time for 4 years.
\c Training course - 1 month in comparable hospital setting in Europe.
\d Surgery services area is being rehabilitated currently, using Govt. funding.
\e Possible ECHO Program financing (EU).
\f Possible USAID financing.
\g External TA to support development of course curriculum and run the course. Twinning possibity for financing.
\h Two TA to design curriculum and run courses. Twinning arrangement possible -- Swiss
\i Three month courses. Assume unit cost = $2500.00 per month inclusive. Specific areas of hospital management, including medical equipment specialization (engineer).
\j Two weeks training (in one week courses) for each department head. Assume 30 department heads split into two groups.
\k Assume 80 nurses, four courses, twenty in each. One month in length.

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ALBANIA
Health System Recovery and Development Project
Table 6. Tirana Regional Health System Delivery - Hospitals
Detailed Costs

Expenditures by Financiers (US$ '000)												
Government			IDA					Other				
00/01	01/02	Total	98/99	99/00	00/01	01/02	Total	98/99	99/00	00/01	01/02	Total
220.7	169.3	551.9	-	1,456.4	1,986.5	1,524.1	4,966.9	-	-	-	-	-
-	-	1.4	-	13.0	-	-	13.0	-	-	-	-	-
-	-	22.5	-	202.8	-	-	202.8	-	-	-	-	-
11.3	5.8	28.1	-	99.2	101.4	51.9	252.5	-	-	-	-	-
15.4	7.9	38.3	-	135.2	138.3	70.8	344.3	-	-	-	-	-
-	-	29.4	264.4	-	-	-	264.4	-	-	-	-	-
26.6	13.6	119.7	264.4	450.2	239.8	122.6	1,077.0	-	-	-	-	-
247.4	183.0	671.5	264.4	1,906.5	2,226.2	1,646.8	6,043.9	-	-	-	-	-
-	-	-	47.8	32.6	33.3	17.1	130.8	-	-	-	-	-
-	-	-	126.5	97.1	66.2	33.9	323.7	-	-	-	-	-
-	-	-	5.3	5.5	5.6	5.7	22.1	-	-	-	-	-
-	-	-	5.3	-	-	-	5.3	-	-	-	-	-
-	-	-	185.0	135.1	105.1	56.6	481.9	-	-	-	-	-
-	-	1.7	220.9	-	-	-	220.9	-	-	-	-	-
-	-	1.7	220.9	-	-	-	220.9	-	-	-	-	-
-	-	1.3	165.6	-	-	-	165.6	-	-	-	-	-
-	-	0.2	27.6	-	-	-	27.6	-	-	-	-	-
-	-	4.8	635.0	-	-	-	635.0	-	-	-	-	-
-	-	-	-	-	1,251.8	-	1,251.8	-	-	-	-	-
-	-	-	-	-	777.8	-	777.8	-	-	-	-	-
-	-	-	-	-	770.8	-	770.8	-	-	-	-	-
-	-	-	-	-	132.7	-	132.7	-	-	-	-	-
-	-	-	-	-	2,933.2	-	2,933.2	-	-	-	-	-
-	-	9.2	-	1,220.1	-	-	1,220.1	-	-	-	-	-
-	-	0.8	-	101.7	-	-	101.7	-	-	-	-	-
-	-	10.0	-	1,321.8	-	-	1,321.8	-	-	-	-	-
-	-	14.8	635.0	1,321.8	2,933.2	-	4,889.9	-	-	-	-	-
-	-	-	-	-	232.9	-	232.9	-	-	-	-	-
-	-	-	-	-	-	-	-	890.1	569.1	302.7	-	1,762.0
-	-	-	-	-	-	-	-	-	24.4	-	-	24.4
-	-	-	-	-	-	-	-	-	130.4	-	-	130.4
-	-	-	-	-	-	-	-	-	8.1	8.3	-	16.5
-	-	-	-	-	-	-	-	-	4.6	-	-	4.6
-	-	-	-	-	-	-	-	-	9.1	-	-	9.1
-	-	-	-	-	-	-	-	-	176.6	8.3	-	185.0
247.4	183.0	686.3	1,084.3	3,363.4	5,497.5	1,703.4	11,648.6	890.1	745.8	311.1	-	1,947.0
73.4	107.3	210.6	-	2.4	3.9	5.6	11.9	-	-	-	-	-
20.6	23.7	64.4	0.6	1.2	1.1	1.2	4.1	-	-	-	-	-
94.0	130.9	275.0	0.6	3.6	4.9	6.9	16.1	-	-	-	-	-
93.9	96.0	189.9	-	-	23.5	24.0	47.5	-	-	-	-	-
43.6	44.6	125.5	-	16.0	10.9	11.1	38.0	-	-	-	-	-
137.5	140.6	315.4	-	16.0	34.4	35.2	85.5	-	-	-	-	-
231.5	271.6	590.4	0.6	19.6	39.3	42.0	101.6	-	-	-	-	-
478.8	454.5	1,276.7	1,084.9	3,383.0	5,536.8	1,745.4	11,750.2	890.1	745.8	311.1	-	1,947.0

ALBANIA
Health System Recovery and Development Project
Table 7. Tirana Regional Health Service Delivery - Polyclinics
Detailed Costs

	Unit	Quantities 98/99	99/00	00/01	01/02	Total	Unit Cost (US$)	Totals Including Contingencies (US$ '000) 98/99	99/00	00/01	01/02	Total	Summary Divisions Component	Expenditure Account	Expenditures The Government 98/99	99/00	00/01	01/02	Total
I. Investment Costs																			
A. Medical Equipment																			
1. Radiology and Diagnostic	lumpsum	-	1	-	-	1	1,894,000	-	2,155.8	-	-	2,155.8	POL	MEQEA	-	-	-	-	-
2. Emergency and Gypsum Room /a	lumpsum	-	1	-	-	1	38,500	-	43.8	-	-	43.8	POL	MEQEA	-	-	-	-	-
3. Gynecology /b	lumpsum	-	1	-	-	1	13,600	-	15.5	-	-	15.5	POL	MEQEA	-	-	-	-	-
4. Otorhinoloringology (ORL)	lumpsum	-	1	-	-	1	67,800	-	77.2	-	-	77.2	POL	MEQEA	-	-	-	-	-
5. Physiotherapy	lumpsum	-	1	-	-	1	54,000	-	61.5	-	-	61.5	POL	MEQEA	-	-	-	-	-
6. Dermatology	lumpsum	-	1	-	-	1	27,000	-	30.7	-	-	30.7	POL	MEQEA	-	-	-	-	-
7. Sterilization	lumpsum	-	1	-	-	1	477,000	-	542.9	-	-	542.9	POL	MEQEA	-	-	-	-	-
8. Clinical Laboratory	lumpsum	-	1	-	-	1	394,400	-	448.9	-	-	448.9	POL	MEQEA	-	-	-	-	-
9. Opthamology	lumpsum	-	1	-	-	1	94,500	-	107.6	-	-	107.6	POL	MEQEA	-	-	-	-	-
Subtotal Medical Equipment								-	3,483.9	-	-	3,483.9			-	-	-	-	-
B. Furniture for Exam Rooms/Clinics	completion %s			100		100		-	-	87.3	-	87.3	POL	MEQEA	-	-	-	-	-
C. Support for Operational Expenditures																			
1. Medical Supplies	ls							166.9	113.8	46.6	-	327.3	POL	MEQEA	-	-	-	-	-
D. Rehabilitation of 3 Specialized Polyclinics																			
1. Polyclinic 1	completion %s		70	30		100		-	131.5	57.6	-	189.1	POL	CWPOLEA	-	12.0	5.2	-	17.2
2. Polyclinic 2	completion %s		70	30		100		-	131.5	57.6	-	189.1	POL	CWPOLEA	-	12.0	5.2	-	17.2
3. Polyclinic 3	completion %s		60	40		100		-	150.2	102.5	-	252.7	POL	CWPOLEA	-	13.7	9.3	-	23.0
Subtotal Rehabilitation of 3 Specialized Polyclinics								-	413.2	217.7	-	630.9			-	37.6	19.8	-	57.4
E. Architectural/Engineering Services	Fee							18.4	9.4	9.6	-	37.4	POL	A&EEA	-	-	-	-	-
Total Investment Costs								185.3	4,020.3	361.3	-	4,566.8			-	37.6	19.8	-	57.4
II. Recurrent Costs																			
A. Medical Equipment O&M	Annual Cost							-	139.4	142.6	145.8	427.8	POL	MEOMEA	-	139.4	142.6	145.8	427.8
B. Building Maintenance	Annual Cost							-	8.3	12.8	13.1	34.2	POL	BOMEA	-	8.3	12.8	13.1	34.2
Total Recurrent Costs								-	147.6	155.4	158.9	461.9			-	147.6	155.4	158.9	461.9
Total								185.3	4,167.9	516.6	158.9	5,028.8			-	185.2	175.2	158.9	519.3

\a to be supplied to only one polyclinic.
\b to be supplied to only one polyclinic.

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ALBANIA
Health System Recovery and Development Project
Table 7. Tirana Regional Health Service Delivery - Polyclinics
Detailed Costs

by Financiers (US$ '000)

Italian Government				
98/99	99/00	00/01	01/02	Total
-	2,155.8	-	-	2,155.8
-	43.8	-	-	43.8
-	15.5	-	-	15.5
-	77.2	-	-	77.2
-	61.5	-	-	61.5
-	30.7	-	-	30.7
-	542.9	-	-	542.9
-	448.9	-	-	448.9
-	107.6	-	-	107.6
-	3,483.9	-	-	3,483.9
-	-	87.3	-	87.3
166.9	113.8	46.6	-	327.3
-	119.5	52.4	-	171.9
-	119.5	52.4	-	171.9
-	136.6	93.2	-	229.7
-	375.6	198.0	-	573.6
18.4	9.4	9.6	-	37.4
185.3	3,982.8	341.5	-	4,509.5
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
185.3	3,982.8	341.5	-	4,509.5

ALBANIA
Health System Recovery and Development Project
Table 8. Upgrading Professional Skills
Detailed Costs

	Unit	Quantities 98/99	99/00	00/01	01/02	Total	Unit Cost (US$)	Totals Including Contingencies (US$ '000) 98/99	99/00	00/01	01/02	Total	Summary Divisions Component	Expenditure Account	Expenditures by Financiers (US$ '000) The Government 98/99	99/00	00/01	01/02	Total	Italian Government 98/99	99/00	00/01	01/02
I. Investment Costs																							
A. Staff Training Activities																							
1. GP Training Activities																							
Training the Trainers /a	mm	-	6	-	-	6	15,000	-	97.8	-	-	97.8	MCS	EXTREA	-	-	-	-	-	-	97.8	-	-
Didactic Equipment /b	lumpsum	4	-	-	-	4	4,000	17.8	-	-	-	17.8	MCS	OEQEA	-	-	-	-	-	17.8	-	-	-
Technical Documents and Materials /c	lumpsum							5.6	5.7	5.8	6.0	23.0	MCS	OEQEA	-	-	-	-	-	5.6	5.7	5.8	6.0
Trainer Per Diems /d	session	-	4	4	2	10	3,600	-	16.4	16.8	8.6	41.7	MCS	LOTREA	-	-	-	-	-	-	16.4	16.8	8.6
Trainee Per Diems /e	session	-	4	4	2	10	12,000	-	54.6	55.9	28.6	139.1	MCS	LOTREA	-	-	-	-	-	-	54.6	55.9	28.6
Subtotal GP Training Activities								23.4	174.5	78.5	43.1	319.5			-	-	-	-	-	23.4	174.5	78.5	43.1
2. Nurses Training Activities																							
Training the Trainers /f	mm	-	4	-	-	4	15,000	-	65.2	-	-	65.2	MCS	CBEA	-	-	-	-	-	-	65.2	-	-
Didactic Equipment /g	lumpsum	4	-	-	-	4	4,000	17.8	-	-	-	17.8	MCS	OEQEA	-	-	-	-	-	17.8	-	-	-
Technical Documents and Materials /h	ls							5.6	5.7	5.8	6.0	23.0	MCS	OEQEA	-	-	-	-	-	5.6	5.7	5.8	6.0
Trainer fees /i	fee							19.8	41.2	-	-	61.0	MCS	LOTREA	-	-	-	-	-	19.8	41.2	-	-
Trainee Fees /j	completion %s	33	67			100		79.3	164.7	-	-	244.0	MCS	LOTREA	-	-	-	-	-	79.3	164.7	-	-
Subtotal Nurses Training Activities								122.5	276.8	5.8	6.0	411.1			-	-	-	-	-	122.5	276.8	5.8	6.0
Total								145.9	451.3	84.3	49.1	730.5			-	-	-	-	-	145.9	451.3	84.3	49.1

\a 6 GPs for 6 months each @ $2,500/person/month. Cost includes round-trip fare, tuition, board and books. $15,000/person/overseas course.
\b AV Equipment, etc. for two training rooms.
\c Reproduction of EU PHARE materials already in use under their project.
\d $10/day x 20 = $200 x 3 mos. = $600/person/session. x6 = $3600. Yrs. 2, 3 and 4.
\e $8/day x 20 days = $160/person month. 250 MDs. 25/session. 10 sessions of 3 mo. each. $12,000/session. implementation in yrs. 2, 3 and 4.
\f 2 expatriate nurses to train 12 Albanian trainers for 2 months.
\g AV Equipment, etc. for four training rooms.
\h Will use EU PHARE materials already in use under their project. Reproduction necessary.
\i Training fee for 12 trainers @ $250/mo. x 18 months.
\j $8/day x 30 days x 900 nurses.

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ALBANIA
Health System Recovery and Development Project
Table 8. Upgrading Professional Skills
Detailed Costs

Total
97.8
17.8
23.0
41.7
139.1
319.5
65.2
17.8
23.0
61.0
244.0
411.1
730.5

ALBANIA
Health System Recovery and Development Project
Table 9. Project Management
Detailed Costs

	Unit	Quantities 98/99	99/00	00/01	01/02	Total	Unit Cost (US$)	Totals Including Contingencies (US$ '000) 98/99	99/00	00/01	01/02	Total	Summary Divisions Component	Expenditure Account	Expenditures by Financiers (US$ '000) The Government 98/99	99/00	00/01	01/02	Total	IDA 98/99	99/00	00/01	01/02	Total
I. Investment Costs																								
A. Office Equipment	lumpsum							38.9	-	-	-	38.9	PM	OEQEA	0.3	-	-	-	0.3	38.7	-	-	-	38.7
B. Office Furniture	lumpsum							27.8	-	-	-	27.8	PM	FURNEA	0.6	-	-	-	0.6	27.2	-	-	-	27.2
C. Vehicle	unit	1	-	-	-	1	25,000	27.8	-	-	-	27.8	PM	OEQEA	0.2	-	-	-	0.2	27.6	-	-	-	27.6
D. External TA																								
1. External Audit	mm	1	1	1	1	4	15,000	15.9	16.3	16.7	17.1	66.0	PM	PIEA	-	-	-	-	-	15.9	16.3	16.7	17.1	66.0
2. Management Advisory Support	mm	6	5	3	3	17	15,000	95.6	81.5	50.0	51.2	278.3	PM	PIEA	-	-	-	-	-	95.6	81.5	50.0	51.2	278.3
Subtotal External TA								111.5	97.8	66.7	68.2	344.2			-	-	-	-	-	111.5	97.8	66.7	68.2	344.2
E. Local Consultants																								
1. Project Director	mm	12	12	12	12	48	180	2.3	2.3	2.4	2.5	9.5	PM	PIEA	-	-	-	-	-	2.3	2.3	2.4	2.5	9.5
2. Procurement Specialists /a	mm	24	24	24	24	96	160	4.1	4.2	4.3	4.4	16.9	PM	PIEA	-	-	-	-	-	4.1	4.2	4.3	4.4	16.9
3. Accountant	mm	12	12	12	12	48	140	1.8	1.8	1.9	1.9	7.4	PM	PIEA	-	-	-	-	-	1.8	1.8	1.9	1.9	7.4
4. Civil Works Engineer	mm	12	12	12	12	48	160	2.0	2.1	2.1	2.2	8.4	PM	PIEA	-	-	-	-	-	2.0	2.1	2.1	2.2	8.4
5. Administrative Asst.	mm	12	12	12	12	48	90	1.1	1.2	1.2	1.2	4.7	PM	PIEA	-	-	-	-	-	1.1	1.2	1.2	1.2	4.7
Subtotal Local Consultants								11.3	11.6	11.9	12.1	47.0			-	-	-	-	-	11.3	11.6	11.9	12.1	47.0
F. Staff Training																								
1. Study Tours /b	lumpsum	2	1	1	1	5	5,500	11.7	6.0	6.1	6.3	30.0	PM	EXTREA	-	-	-	-	-	11.7	6.0	6.1	6.3	30.0
2. Workshops	course	2	2	2	2	8	2,500	5.6	5.7	5.8	6.0	23.0	PM	LOTREA	-	-	-	-	-	5.6	5.7	5.8	6.0	23.0
Subtotal Staff Training								17.2	11.7	11.9	12.2	53.1			-	-	-	-	-	17.2	11.7	11.9	12.2	53.1
Total Investment Costs								234.7	121.1	90.5	92.6	538.8			1.1	-	-	-	1.1	233.6	121.1	90.5	92.6	537.7
II. Recurrent Costs																								
A. Equipment O&M	Annual Cost							1.6	1.6	1.6	1.7	6.4	PM	OEOMEA	1.2	1.3	1.4	1.5	5.3	0.4	0.3	0.2	0.2	1.1
B. Vehicle O&M	Annual Cost							2.8	2.8	2.9	3.0	11.5	PM	VOMEA	2.1	2.3	2.5	2.6	9.6	0.7	0.5	0.4	0.4	2.0
C. Office supplies	ls							2.2	2.3	2.3	2.4	9.2	PM	OTHEA	1.6	1.8	2.0	2.0	7.3	0.7	0.5	0.3	0.4	1.9
Total Recurrent Costs								6.6	6.7	6.9	7.0	27.2			4.8	5.4	6.0	6.1	22.2	1.8	1.3	0.9	0.9	5.0
Total								241.2	127.8	97.4	99.6	566.0			5.9	5.4	6.0	6.1	23.4	235.3	122.4	91.4	93.5	542.6

\a One procurement specialist initially, with provision for a second, given major procurement work involved.
\b Study tours for project management staff.

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ALBANIA
Health System Recovery and Development Project
Procurement Arrangements
(US$ Million)

	Procurement Method						
	International Competitive Bidding	Local Competitive Bidding	International Shopping	Local Shopping	Consulting Services	N.B.F.	Total
A. Civil Works	8.5 (7.7)	0.8 (0.8)	-	0.2 (0.2)	-	0.6	10.2 (8.6)
B. Equipment	6.0 (5.9)	-	0.2 (0.2)	0.0 (0.0)	-	5.8	11.9 (6.2)
C. Pharmaceuticals	-	-	-	-	-	-	
D. Technical Assistance/Training	-	-	-	-	2.2 (2.2)	2.3	4.4 (2.2)
E. Recurrent Costs	-	-	-	0.0 (0.0)	-	1.4 (0.1)	1.5 (0.1)
Total	14.5 (13.6)	0.8 (0.8)	0.2 (0.2)	0.2 (0.2)	2.2 (2.2)	10.1 (0.1)	28.0 (17.0)

Note: Figures in parenthesis are the respective amounts financed by IDA

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REPUBLIC OF ALBANIA

HEALTH SYSTEM RECOVERY AND DEVELOPMENT PROJECT

PROJECT IMPLEMENTATION PLAN: APPENDIX 3

Equipment

ALBANIA: HEALTH SYSTEM DEVELOPMENT PROJECT

Standard List of Equipment to be Supplied in every Outpatient Polyclinic of the City of Tirana

Equipment	Unit Cost	Polyclinic 1		Polyclinic 2		Polyclinic 3		Total Cost	
	(US$000s)	Qnty	Cost	Qnty	Cost	Qnty	Cost	Qnty	Cost
1. Radiology and Diagnostic Units									
Ultrasound system general	65.0	1	65.0	1	65.0	1	65.0	3	195.0
Electroencephalograph	35.0					1	35.0	1	35.0
Blood vessels dopler with peripheric sond 7.5	8.0					1	8.0	1	8.0
Electrocardiograph 3 ch.	5.0	1	5.0	1	5.0	1	5.0	3	15.0
Upper fibro gastroscope	15.0	1	15.0	1	15.0	1	15.0	3	45.0
Fiberscopic table, trolley & suction	8.0	1	8.0	1	8.0	1	8.0	3	24.0
Fiberscopic Illuminator	4.0	1	4.0	1	4.0	1	4.0	3	12.0
Fiberscopic cleaning machine	15.0	1	15.0	1	15.0	1	15.0	3	45.0
X-ray system	100.0	1	100.0	1	100.0	1	100.0	3	300.0
Diagnostic TV system	150.0	1	150.0	1	150.0	1	150.0	3	450.0
Remote Control TV system	200.0	1	200.0	1	200.0	1	200.0	3	600.0
X-ray film viewer	1.0	2	2.0	2	2.0	2	2.0	6	6.0
X-ray film cassette set	3.0	2	6.0	2	6.0	2	6.0	6	18.0
Film Marker	3.0	2	6.0	2	6.0	2	6.0	6	18.0
Protective floor screen	3.0	2	6.0	2	6.0	2	6.0	6	18.0
Protective gloves, apron, goggles	1.0	4	4.0	4	4.0	4	4.0	12	12.0
Autodeveloper Table top	10.0	1	10.0	1	10.0	1	10.0	3	30.0
Autodeveloper	20.0	1	20.0	1	20.0	1	20.0	3	60.0
Manual development set	1.0	1	1.0	1	1.0	1	1.0	3	3.0
SUB-TOTAL			**617.0**		**617.0**		**660.0**		**1894.0**

Equipment	Unit Cost	Polyclinic 1		Polyclinic 2		Polyclinic 3		Total Cost	
	(US$000s)	Qnty	Cost	Qnty	Cost	Qnty	Cost	Qnty	Cost
2. Clinical Laboratory									
Medical Refrigerator	1.0	1	1.0	1	1.0	1	1.0	3	3.0
Microscope	8.0	2	16.0	2	16.0	2	16.0	6	48.0
Incubator	3.0	1	3.0	1	3.0	1	3.0	3	9.0
Heat Sterilizer	3.0	3	9.0	3	9.0	3	9.0	9	27.0
Steam sterilizer (vertical)	10.0	1	10.0	1	10.0	1	10.0	3	30.0
Water bath	1.0	2	2.0	2	2.0	2	2.0	6	6.0
Mixer	1.0	1	1.0	1	1.0	1	1.0	3	3.0
Rotator mixer	1.0	1	1.0	1	1.0	1	1.0	3	3.0
Blood sedimentation set	5.0	2	10.0	2	10.0	2	10.0	6	30.0
Hemoglobin meter	5.0	1	5.0	1	5.0	1	5.0	3	15.0
Coagulometer	20.0	1	20.0	1	20.0	1	20.0	3	60.0
Electrolyte Analyzer	10.0	1	10.0	1	10.0	1	10.0	3	30.0
Clinical Spectrophotometer	10.0	1	10.0	1	10.0	1	10.0	3	30.0
ph Meter	2.5	1	2.5	1	2.5	1	2.5	3	7.5
Bench Centrifuge	3.0	3	9.0	3	9.0	3	9.0	9	27.0
Hematocrite centrifuge	2.0	1	2.0	1	2.0	1	2.0	3	6.0
Water distillation system	3.5	1	3.5	1	3.5	1	3.5	3	10.5
Slide staining set & slide warmer	1.0	1	1.0	1	1.0	1	1.0	3	3.0
Slide rack	1.0	1	1.0	1	1.0	1	1.0	3	3.0
Laboratory Glass set	1.5	3	4.5	3	4.5	3	4.5	9	13.5
Electrophoresis	3.0	2	6.0	2	6.0	2	6.0	6	18.0
Automatic micropipette 5-50 (microliter)	0.4	3	1.2	3	1.2	3	1.2	9	3.6
Automatic micropipette 50-200 microliter	0.4	3	1.2	3	1.2	3	1.2	9	3.6
Automatic micropipette 200-1000 microliter	0.4	2	0.8	2	0.8	2	0.8	6	2.4
Electronic timer	0.3	3	0.8	3	0.8	3	0.8	9	2.3
SUBTOTAL			131.5		131.5		131.5		394.4
3. Ophthamology Unit									
Ophtalmometer with table	10.0	1	10.0	1	10.0	1	10.0	3	30.0
Slit lamp with table	10.0	1	10.0	1	10.0	1	10.0	3	30.0
Sight tester with table	0.5	1	0.5	1	0.5	1	0.5	3	1.5
Trial lens set	1.0	1	1.0	1	1.0	1	1.0	3	3.0
Fundus camera with table	2.0	1	2.0	1	2.0	1	2.0	3	6.0
Binocular Magnifier	8.0	1	8.0	1	8.0	1	8.0	3	24.0
SUBTOTAL			31.5		31.5		31.5		94.5

Equipment	Unit Cost	Polyclinic 1		Polyclinic 2		Polyclinic 3		Total Cost	
	(US$000s)	Qnty	Cost	Qnty	Cost	Qnty	Cost	Qnty	Cost
4. Ear, Nose and Throat (ORL)									
Head mirror	0.2	3	0.6	3	0.6	3	0.6	9	1.8
Oto-nasal scope set	0.5	1	0.5	1	0.5	1	0.5	3	1.5
ORL Treatment unit with chair	10.0	1	10.0	1	10.0	1	10.0	3	30.0
Suction pump	1.5	1	1.5	1	1.5	1	1.5	3	4.5
Laryngoscope set	2.0	5	10.0	5	10.0	5	10.0	15	30.0
SUBTOTAL			**22.6**		**22.6**		**22.6**		**67.8**
5. Physiotherapy Unit									
Hot pack warmer*	0.3	2	0.6	2	0.6	2	0.6	6	1.8
Hot pack set*	0.2	2	0.4	2	0.4	2	0.4	6	1.2
Low frequency therapy unit	5.0	1	5.0	1	5.0	1	5.0	3	15.0
Microwave therapy unit	5.0	1	5.0	1	5.0	1	5.0	3	15.0
Ultrasound therapy unit	4.0	1	4.0	1	4.0	1	4.0	3	12.0
Ultraviolet lamp unit	1.0	2	2.0	2	2.0	2	2.0	6	6.0
Infrared ray therapy unit	1.0	1	1.0	1	1.0	1	1.0	3	3.0
SUBTOTAL			**18.0**		**18.0**		**18.0**		**54.0**
6. Dermatology									
Electro radio cauter	3.0	1	3.0	1	3.0	1	3.0	3	9.0
Cryoskin	6.0	1	6.0	1	6.0	1	6.0	3	18.0
SUBTOTAL			**9.0**		**9.0**		**9.0**		**27.0**

Equipment	Unit Cost	Polyclinic 1		Polyclinic 2		Polyclinic 3		Total Cost	
	(US$000s)	Qnty	Cost	Qnty	Cost	Qnty	Cost	Qnty	Cost
7. Sterilization Unit									
Steam steriliser with generator	120.0	1	120.0	1	120.0	1	120.0	3	360.0
Steam steriliser table top	10.0	3	30.0	3	30.0	3	30.0	9	90.0
Hot air steriliser	3.0	3	9.0	3	9.0	3	9.0	9	27.0
SUBTOTAL			**159.0**		**159.0**		**159.0**		**477.0**
8. GYNECOLOGY									
Examination table	5.0					1	5.0	1	5.0
Colposcoope set	7.0					1	7.0	1	7.0
Gynecological examination unit	0.5					2	1.0	2	1.0
Cusco's vaginal speculum set	0.2					2	0.3	2	0.3
Kristeller's vaginal speculum set	0.2					2	0.3	2	0.3
SUBTOTAL							**13.6**		**13.6**
9. EMERGENCY AND GYPSUM ROOM									
Operation table	10.0					1	10.0	1	10.0
Plaster table	10.0					1	10.0	1	10.0
Operation lamp mobile with emergency unit	8.0					1	8.0	1	8.0
Emergency Room Instruments**	3.0					3	9.0	3	9.0
Suction pump	1.5					1	1.5	1	1.5
SUBTOTAL							**38.5**		**38.5**
GRAND TOTAL			**988.6**		**988.6**		**1083.7**		**3060.8**

* Prices are estimates

** Instruments include: Mosquito hemostatic forceps, scissors, small operation instrument set, standard operating scissors May dissecting scissors, Metzembaum scissors, dressing forceps, tissue forceps

REPUBLIC OF ALBANIA

HEALTH SYSTEM RECOVERY AND DEVELOPMENT PROJECT

PROJECT IMPLEMENTATION PLAN: APPENDIX 4

Implementation Responsibilities

REPUBLIC OF ALBANIA

HEALTH SYSTEM DEVELOPMENT PROJECT

Chart 1: IMPLEMENTATION RESPONSIBILITIES AND ADDITIONAL RESOURCE REQUIREMENTS

COMPONENT	ACTIVITY	IMPLEMENTING AGENCY	ADDITIONAL RESOURCE REQUIREMENTS
Component 1: NATIONAL CAPACITY BUILDING	Technical assistance Office Equipment Staff Training Limited civil works rehabilitation Training	MOH, NIPH, HII	Office Equipment MIS Technical Assistance Staff Training
Component 2: GOVERNANCE AND MANAGEMENT OF HEALTH SYSTEM IN TIRANA REGION	Establishment of Tirana Regional Health Authority (TRHA) Limited civil works rehabilitation Equipment and training	MOH, with increasing support from newly-established TRHA	2 professional staff Office Equipment Staff Training
Component 3: UPGRADING TIRANA HEALTH CARE DELIVERY SYSTEM	Civil works rehabilitation of and medical equipment for: Tirana Hospital, 3 polyclinics, primary health centers Technical Assistance	MOH	Technical Assistance Office Equipment and Materials Library Staff Training
Component 4: PROJECT MANAGEMENT	Implementation of Project Activities	MOH	1 Project Director 1 Procurement Specialist 1 Accountant 1 Engineer/Architect 1 Administrative Assistant 1 Driver Office Equipment Study tours/training for senior officers

F.T. - Full time staff P.S. - Permanent Staff

REPUBLIC OF ALBANIA

HEALTH SYSTEM RECOVERY AND DEVELOPMENT PROJECT

STAFF APPRAISAL REPORT

ANNEX 2

Tirana Regional Health Authority: Concept and Responsibilities

Tirana Regional Health Authority: Terms of Reference
(Draft of January 1998)

1. A Regional Health Authority would be established with responsibility for the planning and management of the health system in Tirana. Specifically, the TRHA would be responsible for the following in the Region:

a) Determining and updating the health service needs of the population on the basis of most recent estimates of population, morbidity, mortality and service utilization from the National Institute of Statistics, Institute of Public Health and Ministry of Health.

b) On the basis of policies formulated by the Ministry of Health, identifying priorities and prepare 3-year rolling investment and strategic plans.

c) Preparing annual budgets for the Tirana Regional Health System, on the basis of health service needs and strategic priorities defined in the investment plans. Operational guidelines would be mandated by the Ministry of Health and resources projected with the Health Insurance Institute (HII).

d) Managing institutions and personnel in Tirana Region.

e) Informing and educating health workers and the public on the roles and appropriateness of different levels and forms of health service delivery.

2. The TRHA would be constituted of four Operational Units. The head of each Unit would be a member of the Regional Health Management Team (RHMT) that would manage the TRHA on a day-to-day basis. The four Units would be the following:

a) Planning, Finance and Evaluation: Planning, overall coordination of resource management, supervision of health facilities and service providers, monitoring and evaluation. The Head of the Planning, Finance and Evaluation Unit would also be the Executive Director of the TRHA. He/She would be appointed by the Minister of Health;

b) Public Health: Health promotion and disease prevention: immunization against communicable diseases, environmental sanitation, food and water safety, and enforcement of waste disposal regulations; growth monitoring and nutrition, STD/HIV prevention, chronic disease prevention, prevention of drug and alcohol abuse and road safety promotion; disease surveillance and notification. The new

Public Health Unit would be formed out of the existing Directorate of Hygiene and Epidemiology, with input of current Directorate of Public Health for Urban Tirana, the Directorate of Public Health for Rural Tirana, and the Directorate of Stomatology;

c) Primary Health Care: Registration and supervision of the service delivery activities of GPs, nurses and midwives in primary health centers, individual practices and emergency services. This Unit would be developed partly from the existing Directorates of Public Health for Urban and Rural Tirana;

d) Hospital Services: Establishment of guidelines for hospital capacity relative to the population, in-patient and out-patient facilities, referrals from primary health centers and emergency services; specification of the relationships between secondary-level functions for the Region and tertiary-level functions of the CHU (in collaboration with the CHU management). This Unit would be developed out of existing Hospital management staff.

3. The Head of each Unit would have, as a minimum qualification, at least one year of relevant experience in a related field. Professional training requirements:

a) For the Planning and Evaluation Unit and the Public Health Unit: a Master's degree in Health Planning/Financing or Public Health.

b) For the Primary Health Care Unit and the Hospital Services Unit: a doctor with a Master's degree in Health Planning/Financing/Management or Public Health, preferably with training in General Practice in the case of Primary Health Care, and specialist training in the case of Hospital Services Unit.

4. Management Board

A Management Board would be established to ensure that the development of the Tirana Regional Health System is consistent with the national health strategy and financial resources. The Board would have the following responsibilities:

a) Review, amend and approve, as appropriate, the three-year rolling investment plan and strategic plans and the annual budgets of the TRHA, particularly major budgetary plans, institutional development and changes in personnel numbers;
b) Identify legislative and regulatory requirements to ensure effectiveness of the TRHA, and present these to relevant level of authority: MOH, Government, Parliament.

5. The Management Board would consist of the following members:

- The Minister of Health (who would also serve as the Chairperson of the Board);

- The Director of the Health Insurance Institute (who would also serve as the Deputy Chairperson);

- The Executive Director of the TRHA (who would also be the Secretary of the Management Board);

- a representative of the Ministry of Finance;

- The Chairperson of the City Council (Urban Tirana), or representative;

- The Chairperson of the District Council (Rural Tirana), or representative.

The Management Board would meet quarterly and/or on request from the Minister of Health or the Executive Director of the TRHA.

REPUBLIC OF ALBANIA

HEALTH SYSTEM RECOVERY AND DEVELOPMENT PROJECT

STAFF APPRAISAL REPORT

ANNEX 3

Letter of Intention from Ministry of Health

Republic of Albania
Ministry of Health and Environmental Protection

Mr. Carlos Elbirt
Resident Representative
The World Bank
Tirana, December 11, 1997

Dear Mr. Elbirt,

Health System Recovery and Development Project

I am pleased to confirm that the Ministry of Health and Environment Protection has completed technical consultations with the World Bank's team for the above mentioned Project. We are satisfied that the proposed Project addresses our strategic problems and will help us to achieve the goals of our health policy. Accordingly, we are prepared to proceed to formal Negotiations as soon as possible, perhaps during the month of January or February1998. We acknowledge the expressions of support for our health policy and the proposed Project by the major bilateral and multilateral agencies during a meeting in Tirana on December 3, 1997. We reached this stage of agreement on the strategic direction of our work with the assistance of a number of organizations. The relevant background documents include the following:

a) Health Care Reform in Albania. Background document 1: Situation Analysis: Background document 2: Policy Options Appraisal. This was produced with the assistance of the World Health Organization in April 1996.

b) Primary Health Care Policy. This was produced by our Ministry with the support of the EU-PHARE in 1995.

c) Master Plan for Tirana University Hospital. This was produced with the support of APHP.

In addition to the above, we have benefited enormously from collaboration with the World Bank (through the first health project), EU-Phare, the Government of Germany, Italy, Greece, the Netherlands, Switzerland and the United Kingdom, USAID, UNICEF UNFPA and WHO. On the basis of all the previous work, we have identified the following key issues and strategic solutions:

(a) A potential breakdown of basic clinical and public health services, due to shortages of pharmaceuticals, supplies and equipment . This will be addressed through

short-term relief and supplies, while developing adequate mechanisms to ensure an effective and affordable provision of these basic health inputs on a sustainable basis;

(b) Weak planning and management capacity. This which will be addressed through the implementation of a revised Policy and Governance Framework, both at the national level and the sub-national level, beginning in the area of Tirana.

(c) Low level of resources and inadequate financing and payment mechanisms. This will be addressed through a revised financing and provider payment system. We will build upon the initial successes of the Health Insurance Institute. We will also conduct feasibility studies for contracting specialist out-patient and in-patient services in hospitals, as well as general services such as catering and laundry, with the objective of a gradual shift to performance-based allocation of resources.

(d) A structural mismatch between health services provided and population needs. This will be addressed through increased emphasis on primary health care, essential hospital services, major public health services. This will include investments in equipment, rationalization and phased upgrading of buildings as necessary, as well as training to improve the skills of our doctors, nurses and other personnel.

My Ministry is prepared to proceed with the proposed Project. We look forward to your response.

Yours sincerely,

Leonard Solis
Minister of Health and Environment
Republic of Albania

REPUBLIC OF ALBANIA

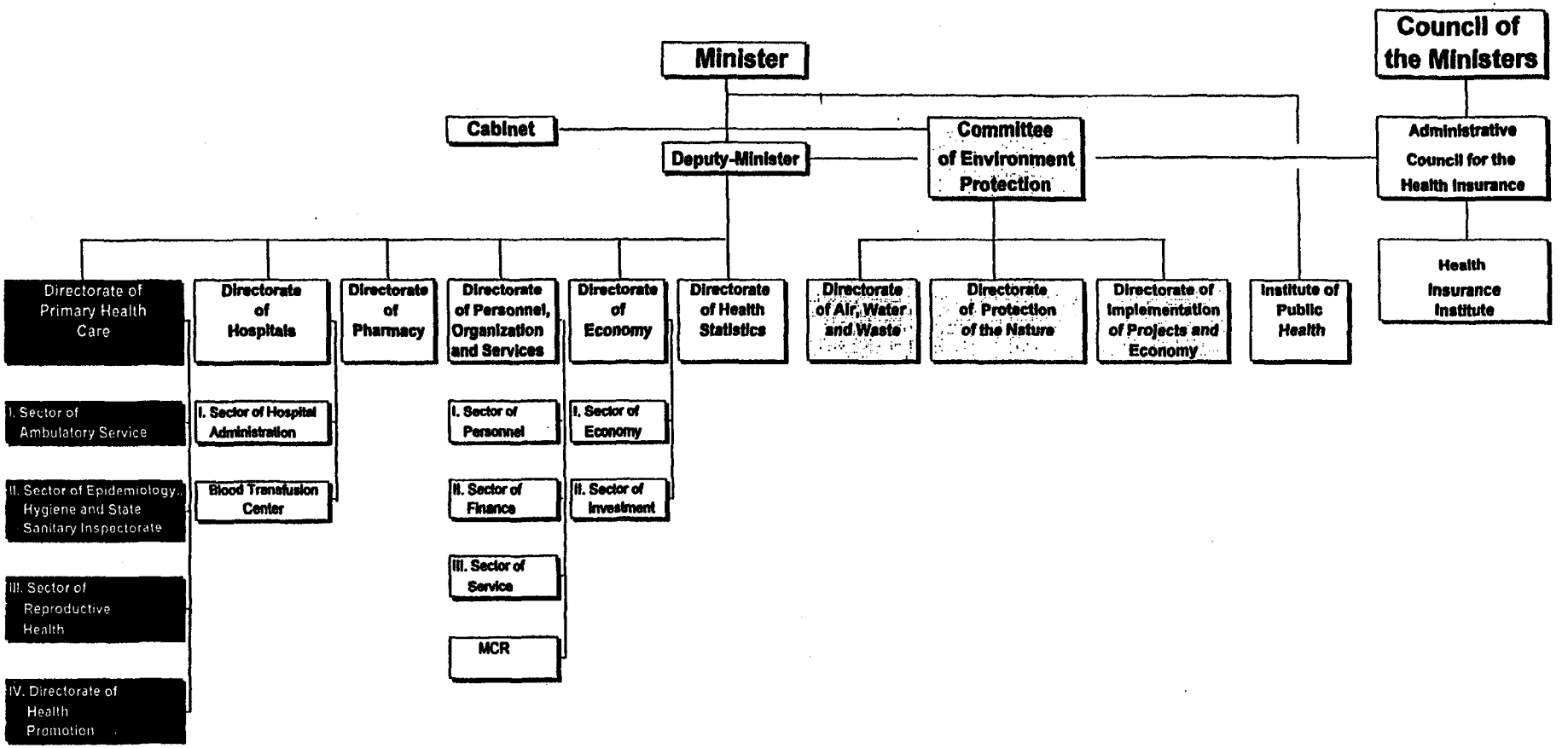
HEALTH SYSTEM RECOVERY AND DEVELOPMENT PROJECT

STAFF APPRAISAL REPORT

ANNEX 4

Ministry of Health and Environmental Protection: Organizational Chart

Organigram of the Ministry of the Health and Environment



Annex 4

REPUBLIC OF ALBANIA

HEALTH SYSTEM RECOVERY AND DEVELOPMENT PROJECT

ANNEX 5

Economic Analysis

ANNEX 5: ECONOMIC ANALYSIS

A. Introduction

A.1. The proposed Project combines multiple interventions to solve a number of existing and imminent problems in the health sector. Specifically, these are:

- a potential breakdown of basic clinical and public health services, to be addressed through short-term relief and supplies, while developing adequate mechanisms to ensure an effective and affordable provision of these basic health inputs on a sustainable basis;
- weak governance, planning and management capacity, to be addressed by implementing a revised Policy and Governance Framework, both at the national and regional levels;
- inadequate resources and reimbursement mechanisms, to be addressed through a revised financing and provider payment regime, in the context of the new macro-economic conditions resulting from the recent crisis; and
- a structural mismatch between health services provided and population health needs, to be addressed through immediate improvement of basic services and by restructuring and upgrading the health care delivery system.

A.2. The Project is designed to fulfill pre-conditions for sustained improvements in health services and long-run health status. This Annex presents the economic rationale for the Project, focusing on the potential impact of proposed interventions. It is based on guidelines provided by the Bank's Human Development Department (HDD)[1] and addresses the following issues: 1) linkages to Economic and Sector Work (section B); 2) analysis of alternatives (section C); 3) assessment of financial and fiscal impact (section D); 4) analysis of cost-effectiveness (section E); 5) risk analysis (section F); 6) analysis of institutional capacity (section G); 7) analysis of poverty alleviation impact (Section H); 8) analysis of environmental impact; 9) performance criteria for monitoring and evaluation (section I); and 10) overall coherence of analysis (section K). Quantitative estimates are used where available and appropriate. Elsewhere, emphasis is placed on basic principles and their relevance to the needs of Albania and the proposed interventions.

B. Linkages to Economic and Sector Work

B.1. Overview. The proposed Project is consistent with and guided by the Sector Recovery and Development Strategy of the Government. The sector development strategy stresses the concurrent development of (a) effective governance, policy formulation and management capacity, as well as (b) upgrades of the service delivery infrastructure to meet the needs of the population. Each of these is necessary and neither is sufficient by itself. The strategy was formulated through a careful and deliberative process involving major stakeholders in Albania's health sector, in consultation with foreign partners.

B.2. Specific Studies. The Project is grounded in a body of knowledge accumulated by a number of organizations working in Albania over the past five years. In addition, the Bank's study of the Social Challenges of Transition provided a valuable insight into the challenge of health sector development in the Region[2]. For the last four years, and with support of the donor community, the

[1] Preker, A., Brenzel L., Ratta, A. Economic Analysis in the Population, Health and Nutrition Sectors: A Conceptual Framework and Portfolio Review. Working Draft. September 26, 1996.

[2] Goldstein, E., Preker, A., Adeyi, O., Chellaraj, G. Trends In Health Status, Services and Finance: The Transition In Central And Eastern Europe. World Bank Technical Paper Number 241, 1996.

MOH has been developing the elements of an overall policy framework. Several policy and planning documents have been drafted that cover overall health care reform, the development of Primary Health Care, the country's hospital strategy and master plans for the rehabilitation and development of Tirana University Hospital and two regional hospitals in Shkodra and Vlora[3].

C. Analysis Of Alternatives

C.1. Overview: Overall, the alternatives to the proposed design of the project include the cessation of IDA's support for the health sector in Albania, a limitation of IDA support to non-lending services only, and alternative interventions as part of an IDA-funded project. A cessation of IDA support would have resulted in a decline in badly needed foreign aid and reduced the seriousness with which other major development agencies and NGOs regard the Albanian health sector. During project design and preparation, alternative interventions were examined with a view to making the most sensible professional judgment in a very needy and resource-poor setting. The choices made were influenced by the current status of Albania's health sector (see Section A above), the Project budget constraint, the political feasibility and local implementation capacity. The main alternatives considered are outlined and reasons for their rejection explained.

C.3. National Capacity Building

a) *No IDA support for further reform (status quo)*. This would result in delayed or stalled reform and lead to deterioration of health services and health status in Albania. Events in the latter stages of project preparation demonstrated the capacity of IDA to build a coalition in support of needed system reforms. In December 1997, following a series of consultations, major international agencies pledged their support for the Government's sector development strategy.

b) *Centralization in the MOH of decision making on health financing, service delivery and public health*: This option had the attraction of acceptance with the medical lobby. However, the Project sought to address systemic reform, which required concentrating MOH functions on policies, regulations and setting of standards, while delegating the management of sector finances to the Health Insurance Institute, the planning and supervision of public health interventions to the Institute of Public Health, and the management of health services to the regional/district levels.

c) *Immediate coverage of all health services by the Health Insurance Institute*: This would appear to have the attraction of comprehensive risk pooling, but is unrealistic in resource-poor Albania and carries major risks. One is that the income level is not sufficient to support, in the short term, the required premiums for a comprehensive health insurance system covering hospital services. A rush to include hospital among those covered by the HII would result in a cost explosion. In the face of political pressure from clinicians, without the benefit of capable managers; it could also result in uncritical acceptance of inappropriate provider reimbursement systems (for example the premature adoption of Diagnosis Related Groups -- DRGs -- for which Albania lacks the necessary database).

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[3] Health Care Reform in Albania. Background document 1: Situation Analysis; Background document 2: Policy Options Appraisal. Ministry of Health and Environment Protection - WHO/EURO. April 1996.
Primary Health Care Policy. Ministry of Health and Environment Protection. 1995
Hospital Policy In Albania. 1996-2001. Ministry of Health and Environment Protection - Assistance Publique Hopitaux de Paris (APHP). July 1996.
Master Plan for Tirana University Hospital. Ministry of Health and Environment Protection - Assistance Publique Hopitaux de Paris (APHP). 1996.

Given these considerations, it was judged appropriate to maintain the step-by-step approach taken so far, with continued technical assistance from the United Kingdom Know How Fund.

C. 4. Governance And Management Of Health System In Tirana Region.

a) *No IDA support for further reform (status quo).* This would result in an ineffective investment in civil works and equipment, without resolving a major constraint on productivity: the over-centralized and inappropriate management structure, as well as a weak management capacity in the Region of Tirana. Since decentralization involves a real or perceived loss of power by the central MOH, the "no decentralization" approach had the attraction of being politically easy. However, it would amount to doing more of what does not work, with the consequence of continued structural inefficiencies, poor planning and resource allocation.

b) *Establishment of a "Regional Level MOH" in the image of the national MOH.* In principle, this would result in a structure with which Albanians were more familiar. It would therefore engender less anxiety and perhaps less resistance to change. However, the Regional Health System requires a managerial focus, as distinct from the bureaucratic focus of the current central MOH. Consequently, its design and proposed staffing were based on the duties to be performed, rather than on historical precedents. The trial of a Regional Health Authority in Tirana would provide lessons in what works and what does not, for reasonable adaptation in other regions of the country.

C. 5. Upgrading of Tirana Regional Health System.

a) *No IDA support for upgrading the Tirana Regional Health System.* No donor is ready on its own to finance the required inputs and restructuring. Excluding salaries, personal health services accounted for an estimated 1.32% of Albania's GDP in 1994. IDA's willingness to support the reforms strengthened Government resolve to develop a strategic plan and co-financiers' willingness to fund aspects of the Regional Health System The implementation plan would be based on estimated health service needs and estimated health system revenues. The first phase would focus on restructuring and rehabilitation of core facilities in the health centers, polyclinics and the Tirana Hospital (general services, civil works and equipment for laboratory and diagnostic equipment, accidents and emergencies.

b) *Purchase of equipment and uncritical rehabilitation of buildings, unconstrained by consideration of health needs and prospects for sustainability.* This would have resulted in unsustainable additional recurrent cost burdens, and poor maintenance of equipment. Existing inadequacies in the system would have worsened. This would have resulted in: (i) continued structural inefficiencies; (ii) persistence of clinical services of poor quality; (iii) sub-optimal utilization of existing stock of buildings, equipment and personnel; and (iv) failure to pre-empt an epidemic of chronic, non-communicable diseases.

D. Assessment Of Financial And Fiscal Impact

D.1. It is estimated that most of the productivity gains would come from improvements in organization and management. The Project would yield efficiency gains from a restructured system at the National level and decentralization to the Regional (Tirana) levels. Given the extremely unwieldy state of the current bureaucracy, the potential for improvements is large and an estimated efficiency gain of 10% is reasonable. If the health sector expenditure (including foreign aid) remains

at 5% of GDP, the Project could result in a stream of productivity gains equivalent to 0.5% of GDP per year in the medium term.

D.2. The project is consistent with and supports the Bank's proposed economic strategy for Albania, i.e., the restoration of fiscal balance and an emphasis on medium-term sustainability and national capacity building.

E. Analysis of Cost-Effectiveness

E.1. What follows is not really about cost-effectiveness, but more on the benefits of the Project. The Project would support clinical and public health interventions of known cost-effectiveness. However, while improvements in health status constitute a major rationale for health system development, it is not realistic to expect significant and attributable improvements in aggregate health status during the life-span of a project focusing on system reforms and service delivery. Two considerations are central to the expected benefits from this component in the medium- to long-term:

(a) As a weak, under-equipped system with poor infrastructure, the health sector requires significant investments to meet the minimum criteria for a modern health care delivery system, even at Albania's level of income. For example, much of the stock of medical equipment is obsolete and surgical procedures are sometimes performed with rusted equipment. Starting from this low base, the potential for improvement is enormous.
(b) Once the structures are upgraded, and the management and clinical skills meet current standards of effectiveness, a platform would be established from which improvements in organization, accessibility, population coverage, service utilization and quality of care would result in significantly better health outcomes in the medium term. For example, a poorly trained physician, with duties limited to minor clinical procedures like incision and drainage of abscesses, is officially described as a "microsurgeon", and the use of modern clinical protocols for diagnosis and treatment is almost non-existent. Again, starting from this low base of technical skills, the potential for improvements is large.

E.2. The costs associated with poor quality would be reduced by doing things right the first time, thus avoiding the costs of needless complications and deaths. This conclusion is derived in part from a conceptual framework of quality assurance management methods, whereby quality can be measured on three levels: structure, process and outcome. Structure assesses the quality of health care through the setting in which care takes place. This includes the adequacy of facilities and equipment, administrative processes and the qualifications of medical staff. *The assumption is that without required inputs, good health care will not be achievable.* Process considers not only that equipment exists, but also whether what is currently thought to be proper health care is applied, including clinical history, physical examination, diagnostic tests, justification of diagnosis and therapy. *The assumption is that without proper procedures, good health outcomes will not be achievable.* Outcome considers whether a change in a person's current and future health status can be attributed to antecedent health care.

E.3. Given the multiple determinants of aggregate health status, Project elements are necessary for improved outcomes in the medium term, but are not sufficient by themselves. Sustained improvements in household and individual income (or, at least, no significant decreases in real income) are required for the Project activities to achieve medium-term improvements in aggregate health status. Assuming that the Project achieved the goals of upgrading medical equipment and institutionalizing the use of clinical protocols, clinical services in hospitals, polyclinics and health

centers would increase by about 20% by the end of the Project. This is based on contemporary literature on the benefits of improvements in the quality of care.[4] These and the planned improvements in management and governance structures, public health services could result in a modest 10% improvement in aggregate health status in Tirana Region by the end of the Project.

F. Risk Analysis

There are three major sets of risks to the Project. The first is that political and social upheavals could preclude the stability needed for effective implementation and institutional development. This risk will be mitigated by: (a) the benefits to major stakeholders of cooperation in all aspects of the recovery program, and (b) the emphasis on improving community ownership of, and involvement in, health service planning, organization and management. Specifically, Local Health Advisory Committees will be established at the commune level, with inputs into the local planning of health service delivery. Health Advisory Committees will be established at the Regional/District Levels, to work with District Health Management Teams and the proposed Tirana Regional Health Authority in health planning, service delivery and management, and to improve responsiveness of the health sector to local problems. Representatives of the NGO Forum will be encouraged to participate as members of the management teams for districts and hospitals. Further details are shown in the Health Sector Strategy Matrix (Annex 6, Section C). The second risk is that weak national capacity for implementation could hinder effective implementation. This risk would be mitigated by specifying responsibilities for implementation prior to project effectiveness and by appropriate use of external technical assistance. Prior agreement with the Government on the need for technical assistance for the Project Coordination Unit has been emphasized. Finally, fiscal instability could make it difficult for the Government to meet its counterpart financing commitments under the Project and to operate services effectively beyond the initial phase. This risk would be mitigated by limiting required counterpart funds to the most essential recurrent expenditures. Given the weaknesses of the Albanian economy and its recent history of political and social strife, expectations of local implementation capacity, counterpart funds and speed of implementation must remain realistic and modest.

G. Analysis of institutional capacity

G.1. At the national and regional/district levels, definitions of tasks are insufficiently specified and/or overlapping, while human resources capacities, though improving, still remain minimal. Responsibilities for planning, managing and implementation are not clearly delineated. This is particularly acute for the region of Tirana (covering two distinct administrative structures, the City and a rural district) which manages separate funds. In addition, other services are directly managed by the central MOH. At all levels of health facilities, information systems and modern resources management methods are still embryonic.

G.2. National capacity building for health system reform would support improvements in the economic efficiency of the health sector by strengthening the institutions responsible for governance and regulation, the MOH, the HII and the IPH. Efficiency gains in the sector are contingent upon the existence of accountability, clarity of managerial and administrative roles, and appropriate incentive

[4] See Adeyi, O., Morrow, R. "Essential Obstetric Care: Assessment and Determinants of Quality". Social Science and Medicine. 45 (11). 1997.

structures. Improvements in institutional capacity and governance would enhance the sustainability of the overall reform strategy and facilitate improvements in financing and delivery mechanisms.

G.3. Improvements in the governance and management of health system in Tirana would result in the actual decentralization of management and regulation of the health system to the most populated region of the country, where the full range of health services (although at a low quality level) exist and where the need for restructuring is the most acute. To that extent, the benefits could be the most visible in the quickest time. Rational decentralization will have a dual effect, enhancing systemic efficiency and cost-effectiveness, while improving accessibility of the health system to the population.

H. Poverty Alleviation Impact

According to the report "Albania: Growing Our Of Poverty (# 15698, 1996), although the orders of magnitude were imprecise, the evidence indicated that poverty was more pervasive among the rural population than the urban population, but, generally, poverty in the rural areas was less severe than in towns. The Poverty Analysis recommended an increased emphasis on interventions to combat the most common illnesses at the primary health care level, including: treatment of acute respiratory infections, diarrheal diseases, reproductive health problems. The Project would address these problems through the focus on improved access and service delivery at the primary and secondary levels of care, covering both urban Tirana and the surrounding rural districts. It would help to alleviate the burden of preventable illnesses and premature deaths as well as the associated loss of production and income.

I. Environmental Impact

This is a Category C Project: "No appreciable environmental impact." Upgrading of unsanitary hospital buildings would contribute to improved environmental safety, as would the replacement of old equipment -- radiology and laboratory -- that present health risks. Sanitary procedures would be introduced for dealing with waste management.

J. Performance criteria for monitoring and evaluation

This is presented in detail in Section IV of the Project Implementation Plan of the Staff Appraisal Report.

K. Overall Coherence Of Analysis

The Government's strategy stresses the concurrent development of (a) effective governance, policy formulation and management capacity, as well as (b) upgrades of the service delivery infrastructure to meet the needs of the population. Through a carefully designed combination of interventions, the proposed Project would fulfill requirements for achieving these objectives. All the issues presented above are recognized by the Government and the proposed interventions are part of the Government's pre-crisis sector strategy which has now been supplemented by an Emergency Aid Strategy and Program.

REPUBLIC OF ALBANIA

HEALTH SYSTEM RECOVERY AND DEVELOPMENT PROJECT

ANNEX 6

Health Sector Strategy Note

Republic of Albania: Health Sector Strategy Note.

Introduction

1. This annex presents the strategy to be supported by the proposed Health System Recovery and Development Project. During Negotiations in March, 1998, the Government re-confirmed its commitment to this strategy. It is being further elaborated by the Government and will be formally launched in the third quarter of 1998. This document (Annex 6) is organized as follows. After this introduction, the historical context of the health sector strategy is presented. This is followed by an examination of the major issues in the health sector and the development objectives to be pursued. For each development objective, the accompanying matrix provides details of strategic choices, progress indicators, Bank instruments (e.g. lending or non-lending), partner agencies, assumptions and risks.

Context: History And The Broader Health Sector Reform Program..

2. The development of this strategy dates back to 1992, when IDA started working with the Government of Albania (GOA). Details of the initial strategy are contained in the Report Number 10362-ALB, "Albania: Health Sector Reform During The Transition", dated March 23, 1992. This document was based upon several technical reports on specific aspects of the health sector. The strategy was reviewed and updated on the basis of experiences gained during the ongoing Health Services Rehabilitation Project (First Health Project), and consultations with partner agencies within and outside Albania. In the accompanying matrix, issues and choices that have remained the same since 1992 are marked "(a)". Those with some modifications are marked "(b)", and those that are much different from the 1992 scenario are marked "(c)".

3. The following are major technical reports that contributed to the health sector strategy (copies are available in project files):

Health Care Reform in Albania. Background document 1: Situation Analysis; Background document 2: Policy Options Appraisal. Ministry of Health and Environment Protection - WHO/EURO. April 1996.

Primary Health Care Policy. Ministry of Health and Environment Protection. 1995

1996-2001 Hospital Policy In Albania. Ministry of Health and Environment Protection - Assistance Publique Hopitaux de Paris (APHP). July 1996.

Master Plan for Tirana University Hospital. Ministry of Health and Environment Protection - Assistance Publique Hopitaux de Paris (APHP). 1996.

Albania: Growing Out of Poverty. World Bank. Report Number 15698. The World Bank. August, 1996.

Health, Nutrition and Population Sector Strategy. Human Development Network, World Bank. 1997.

European Health Care Reforms. World Health Organization. 1997.

Trends in Health Status, Services and Finance: The Transition In Central and Eastern Europe. Vols. I & II. World Bank, 1996.

4. The proposed project is a part of a broader Health System Recovery and Development Program, which was prepared in cooperation with the Government, Albanian professionals and health sector workers, and to which the international community pledged support at the Albania Donors' Conference in October 1997. The following table shows the estimated costs of the broader program, the proposed project, and sources of funds.

Program and Project Costs.

Description	**Costs (US$ '000)**
Total Program cost (i)	37,166.1
Of which Project cost (ii)	28,000
IDA (iii)	17,000
Government of Albania (iv)	2,400
Other financiers Project financing gap = (ii)-(iii)-(iv)	8,600

Major Issues And Development Objectives

5. The main issues and development objectives are sub-divided into four categories.

a) *Weak capacity for planning and management.* Routine, day-to-day decisions are still over-centralized in the central MOH. Responsibilites and tasks are poorly defined at the national and regional/district level, and management skills are weakly developed at all levels of the health care system. In response to this, the development objective is to restructure the health system, with an emphasis on improved capacity for policy making and management at the appropriate level. Health service management will be professionalized, a departure from the current situation whereby physicians with no management training and/or strong skills are in positions of management. Information systems will be developed to support these functions. Government will continue the trend toward greater private sector involvement in health service delivery.

b) *Inadequate resources and provider payment systems.* Albania's economy remains weak. Mainly as a result of this, resources are inadequate to provide essential health services for the entire population. In addition to this, the health system suffers from inefficiencies in resource utilization. The health sector strategy emphasizes the development of a larger and more predictable revenue base for health services, to the extent that is feasible in Albania's weak economy and without increasing the tax burden. Incentives will be introduced to increase productivity and the quality of care. Private sector involvement will be encouraged, including the "hotel functions" of hospitals, i.e., cleaning, catering, laundry and transportation.

c) *Poor fit between health services and major health problems.* Health services are concentrated in large institutions -- hospitals, whereas a majority of health problems could be effectively managed in health centers and out-patient polyclinics. The quality of health services is poor, due to a

combination of obsolete or lack of basic equipment, and poorly trained staff using inappropriate techniques. Although Albania faces a burden of non-communicable diseases, public health interventions -- health promotion and disease control -- are weak. There is little community ownership of, and participation in, health service planning, organization and management. The capacity for local leadership and action is limited, particularly in the more technically demanding areas of hospital administration and health system management. In response to these problems, the strategy emphasizes the development of a network of primary health centers, polyclinics and streamlined hospitals. The skills of doctors, nurses and para-medical staff will be upgraded and modern clinical protocols will be introduced to ensure improvements in the quality of care. Incentives will be introduced and/or strengthened to encourage good clinical practices and patient care. An aggressive program of non-communicable disease program will be developed on the basis of epidemiological, social and behavioral evidence. Effective partnerships will be established and/or strengthened with Non-Governmental Organizations and elected representatives of the population.

d) *A potential breakdown of basic clinical and public health services:* These services were further weakened by the disturbances of 1997. There are shortages of consumables and supplies for running clinical and public health laboratories, with risks of epidemics and needless complications of simple illnesses. In response to these problems, the clinical and public health laboratories will be restored to a functional status. Consumables and supplies will be provided to ensure that services are delivered as needed.

Republic of Albania: Health Sector Strategy Matrix.

A: DEVELOP PLANNING AND MANAGEMENT CAPACITY.						
Major Issues (a)	***Development Objectives (a)***	***Strategic Choices (b)***	***Progress Indicators (b)***	***Bank Instruments (b)***	***Other partners (b)***	***Assumptions and Risks (b)***
Over-centralization of day-to-day decision making. Poorly defined responsibilities and tasks at the national and regional/district levels. Limited capacity for policy formulation and strategic planning. Poor management skills at all levels.	Restructure health system to enhance policy making and effective management.	- Reduce and focus scope of work of MOH on policy making, standard setting, regulation and supervision. - Strengthen capacity and maintain semi-autonomous status of the Health Insurance Institute. - Improve technical and operational capacities of the Institute of Public Health. - Decentralize responsibilities for organization , planning and management of health services to the regional level. - Develop management skills at all levels, consistent	-MOH produces 3-year rolling plans with specific objectives, by end of CY99. - IPH develops National Policy For Control of Non-communicable Diseases and Injuries by end CY99. -Tirana Regional	*Lending:* HSRP (Health I), ongoing. HSRDP (Health II) FY98.	- Govt. of Italy (technical assistance to the Institute of Public Health) - Govt. of Switzerland. - U.K. Know How Fund (technical assistance to the Health Insurance Institute). - USAID, AIHA (technical assistance to the MOH). - Government of the Netherlands (potential, technical assistance for capacity building at the national and regional levels, pharmaceutical	- GOA maintains a commitment to restructure the health sector. - GOA and IDA are willing to experiment with needed changes and to learn in the context of Albania.

		with responsibilities.	Health Authority established & functioning according to its TORs.		reforms, hospital management and quality assurance). reform).	
Management systems and skills – personnel, planning, budgeting, monitoring and evaluation – are weak and scarce.	- Professionalize health services management. - Develop information systems suitable for an outcome-based management system. - Encourage gradual private sector involvement in health service delivery.	- Restructure management of health services, using incentives to increase productivity. - Start with primary care services, pharmacies, dental services.	- Trained managers in charge of regional health authorities by end CY00 and regional hospitals by end CY01. - Private sector involved in "hotel" services of hospitals, on a pilot basis, by end CY00.	*Lending:* HSRP, ongoing. HSRDP (Health II) FY98. *Non-lending:* Hospital Sector Mgt. Study. FY99.	- Government of the Netherlands (potential, technical assistance for capacity building at the national and regional levels, pharmaceutical reform, hospital management and quality assurance). reform). - U.K. Know How Fund (technical assistance to the Health Insurance Institute).	- Doctors and other health professionals support a slimmer and better equipped network of hospitals, polyclinics and health centers.

B: INCREASE RESOURCES AND IMPROVE PROVIDER PAYMENT SYSTEMS						
Major Issues (a)	***Development Objectives(a)***	***Strategic Choices(a)***	***Progress Indicators (a)***	***Bank Instruments (a)***	***Other partners (a)***	***Assumptions and Risks (a)***
Resources are inadequate to cover essential health services.	Develop a larger and more predictable revenue base for health services.	Expand contribution base, increase premiums in line with benefits. Tighten criteria for exemption from contributions. Protect budgetary allocations to health. Maximize quantity and efficiency of donor assistance; focus on sustainability.	- Health Insurance Institute remains financially solvent and semi-autonomous. - Heatlh Insurance Institute covers priamry health care by the end of CY02.	*Lending:* HSRP (Health I), ongoing. HSRDP (Health II) FY98. PER FY99/00	- U.K. Know How Fund (technical assistance to the Health Insurance Institute).	- Govt. maintains semi-autonomous status of Health Insurance Institute. - A weak economy constrains the revenue base of HII and the rate at which it can expand its coverage beyond primary care.
Use of resources is inefficient	Establish incentives to increase productivity. Encourage gradual private sector involvement in health service delivery.	- Develop capacity of Health Insurance Institute to contract (purchase) services at the primary and hospital levels. - Shift from salary-based to a mix of salary, capitation and fee-for services; avoid cost	-Output/ outcome-based incentives introduced at the hospital level by end CY00. - Slelective "hotel" services are out-sourced	HSRDP (Health II) FY98. *Non-lending:* Hospital Sector Mgt. Study. FY99	- U.K. Know How Fund (technical assistance to the Health Insurance Institute).	- Major stakeholders are involved in the process. - Potential losers (i.e. the workers who might be laid off, doctors who may lose administrative powers) do not block reform. -GOA and partners develop an effective approach to ensure success of necessary but unpopular measures.

		explosion. - Consider out-sourcing of laundry and catering services.	on a pilot basis by end CY00.			

C: IMPROVE THE FIT BETWEEN HEALTH SERVICES AND HEALTH PROBLEMS.						
Major Issues (b)	***Development Objectives (b)***	***Strategic Choices (b)***	***Progress Indicators (b)***	***Bank Instruments (b)***	***Other partners (b)***	***Assumptions and Risks (b)***
Services are excessively concentrated in large institutions.	Develop a streamlined service delivery system.	- Streamline health service pyramid: develop a network of regional hospitals, polyclinics and health centers.	% increasein populaiton with access to primary health care. % increase in service utilization rates. Selected hospital facilites, polycinics and health centers equipped as planned. Non-communicable disease control program lauchced by end of CY00. Injury	*Lending:* HSRP (Health I), ongoing. Covers Shkodra in the North, Vlora in the south. HSRDP (Health II) FY98. Would cover Tirana Region. *Non-lending:* Hospital Sector Mgt. Study. FY99	- Assistance Publique Hopitaux de Paris (APHP). Technical Assistance for hospital system plan. - Govt. of Italy (polyclinics and health centers in Tirana Region). - Govt. of Greece. -OPEC/Islamic Bank - Govt. of Kuwait - EU-PHARE - Govt. of Germany - Catholic Foundation	- GOA maintains commitment to restructure health sector. - Donors fulfill pledges.

			control program lauched by the end of CY00			
Health centers and polyclinics are staffed with poorly trained "specialists". There is a shortage of trained primary care doctors and nurses.	- Reorient the mix of skills in line with the health problems and services delivered at each level. - Increase the status of primary care through professional and financial incentives.	- Limit quantity, upgrade skills of health personnel. - Convert poorly trained "specialists" to well trained general practitioners. - Introduce specialization program for general practitioners. - Maintain capitation system for reimbursing general practitioners.	% eligible physicians "converted" to general practitioners % eligible population covered by general practitioners .	*Lending:* HSRP (Health I), ongoing. HSRDP (Health II) FY98	- EU-PHARE. - Govt. of Switzerland. - USAID	-Training programs are done according to good technical criteria. - Donors fulfill pledges.
The quality of health services is poor.	- Improve quality of care at the primary, polyclinic and hospital levels	- Update diagnostic and therapeutic equipment in health facilities. - Adapt and institutionalize modern protocols	% eligible staff trained in the use of modern clinical protocols. % eligible patients	*Lending:* HSRP (Health I), ongoing. Covers Shkodra in the North, Vlora in the south.	Got of Italy. Got of Netherlands (potential). UNICEF, WHO (e.g. protocols for Integrated Management of	- GOA and donors address all major determinants of quality: structures, processes and incentives. - Client satisfaction with quality of care

		for diagnosis and treatment. - Improve provision, distribution and use of pharmaceuticals. - Gradually introduce outcome-based remuneration, starting on an experimental basis.	benefiting from the use of modern clinical protocols. -Measurable increase in client satisfaction with the quality of care.	HSRDP (Health II) FY98. Would cover Tirana Region. *Non-lending:* Hospital Sector Mgt. Study. FY99	Childhood Illnesses). UNFPA (reproductive health services).	is interpreted with caution. Recongize that measurable improvements in clinical outcomes will take several years -- and sophisticated information systems. Focus on fulfilling the pre-conditions.
Health promotion and disease prevention are under-developed.	Realign health service priorities in line with the current and expected health problems.	Develop strategies for control of non-communicable diseases, injuries and accidents. Improve operational capacity of the Institute of Public Health. Strengthen epidemiological surveillance. Improve service delivery for control and treatment of vaccine-	Non-communicable disease control program lauchced by end of CY00. Injury control program lauched by the end of CY00.	*Lending:* HSRDP (Health II) FY98. *Non-lending:* Non-communicable disease control study. FY99/00	WHO (potential). UNICEF Govt. of Italy.	GOA and partners commit to public health interventions as effective tools for reducing premature illnesses, deaths, disabilities and lost productivity.

		preventable diseases.				
There is little community ownership of and participation in health service planning, organization and management. Limited capacity for locally inspired initiatives, leadership and action. Technical/management skills are very scarce at the community level. Local authorities have failed in some cases to fulfill contractual obligations to maintain rehabilitated health centers, due to resource constraints.	Establish effective partnerships with NGOs and elected representatives of the people.	Establish Local Health Advisory Committees at the commune level, with a say in planning of service delivery at the health centers. Develop District Health Advisory Committees to work with District Health Management Teams in planning district health services. Develop Regional Health Advisory Committee, starting with Tirana, to guide planning and organization. Encourage representation of the NGOs Forum on the District Health Mangt. Team and hospital mangt. teams.	Number of	*Lending:* HSRDP (Health II) FY98.	Health NGOs Forum Foreign NGOs. Individuals and elected representatives of the communes.	- A gradual approach is adopted and expectations are kept modest. - A disticntion is made between tasks suitable for direct community involement in service delivery (e.g. planning and mobilization for immunization, pre-natal care, family planning) and those suitable for a comunity advisory role (e.g. management of services in health facilties like hospitals and polyclinics). - IDA avoids the temptation to do things for which it does not the ground presence in Albania.

D: AVOID A BREAKDOWN OF BASIC CLINICAL AND PUBLIC HEALTH SERVICES						
Major Issues (C)	***Development Objectives(C)***	***Strategic Choices(C)***	***Progress Indicators (C)***	***Bank Instruments (C)***	***Other partners (C)***	***Assumptions and Risks (C)***
Civil disturbances ruptured some aspects of an already fragile system. Shortages of pharmaceuticals, laboratory reagents, spare parts and consumables for running simple clinical and public health functions. Risks of epidemics of communicable diseases if public health functions remain weak. Risk of increased loss of productivity due to avoidable illnesses, deaths and disabilities.	Restore adequate functioning of essential health services.	- Ensure adequate supplies of pharmaceuticals and consumables.		*Lending*: HSRDP (Health II) FY98. Ongoing "supervisio" and policy discussions.	NGOs UNICEF WHO ? ECHO	Donors fulfill pledges. GOA assumes responsibility for sustaining these basic functions.

MAP SECTION

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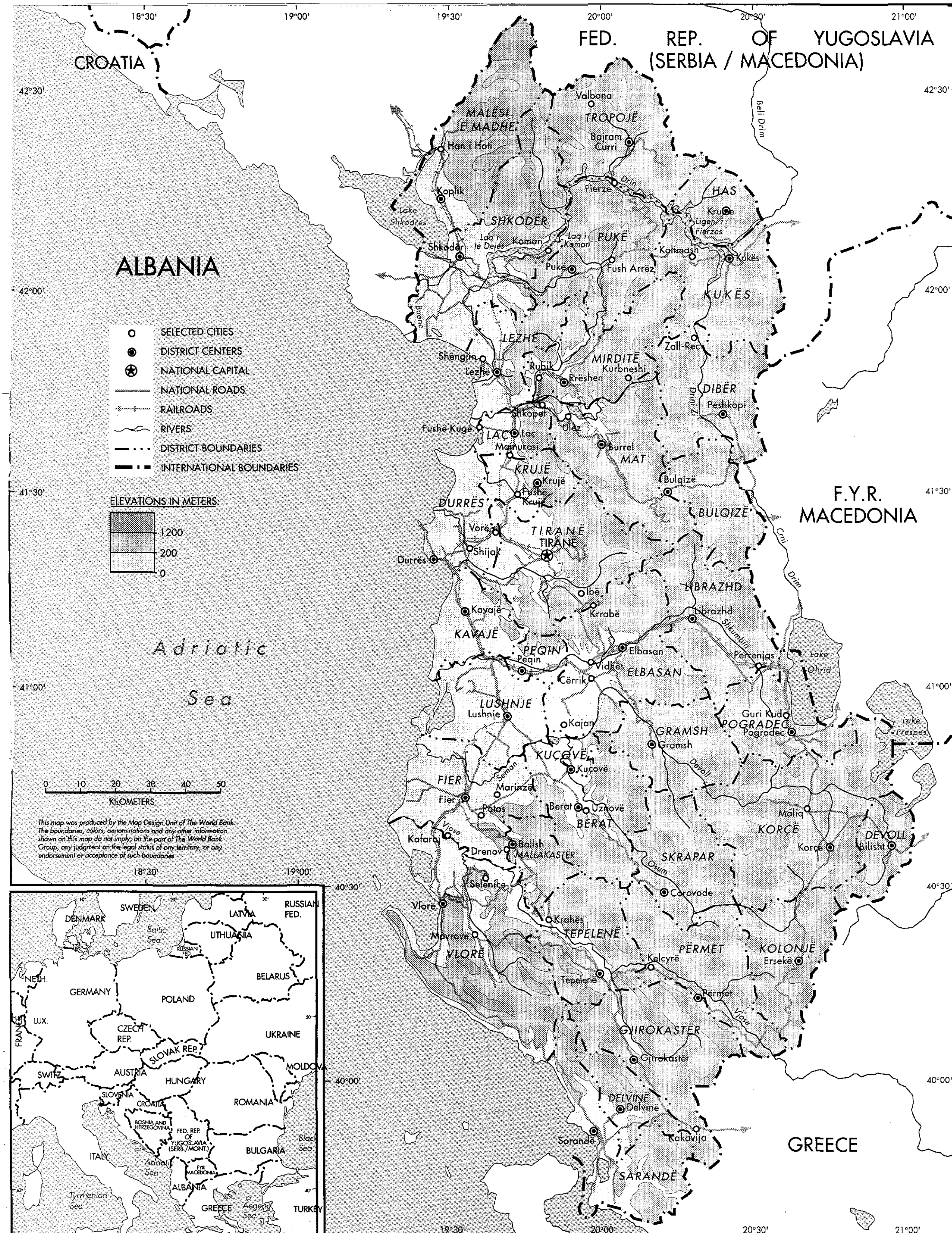

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