

# Empowering Health Care Consumers in Europe and Eurasia

## Final Report

October 7, 2008



This report is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of Agreement No. GPO-A-00-07-00004-00. The contents are the responsibility of the C-Change program, managed by AED, and do not necessarily reflect the views of USAID or the United States Government.

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## Acronyms and Abbreviations

ARI	Acute Respiratory Infections
BCC	Behavior Change Communication
BCG	Baccille Calmette Guerin (vaccine against Tuberculosis)
C-CHANGE	Communication for Change
C-IMCI	Community – Integrated Management of Childhood Illnesses
CME	Continuing Medical Education
CSO	Civil Society Organization
CVD	Cardiovascular Disease
DfID	Department for International Development, UK
DHS	Demographic and Health Survey
DPH	Department of Public Health
DPT	Diphtheria Pertussis Tetanus vaccine
E&E	Europe and Eurasia
FAP	Feldshar Accoushar Point (primary level health post)
FG	Focus Group
FETP	Field Epidemiology Training Program
GDP	Gross Domestic Product
GNI	Gross National Income
HepB	Hepatitis B vaccine
HP	Health Promotion
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IPC	Interpersonal Communication
IPH	Institute of Public Health
KAPs	Knowledge, Attitudes, and Practices
MCH	Maternal and Child Health
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
NGO	Non-Governmental Organization
OSI	Open Society Institute
PHCR	Primary Health Care Reform
SES	Sanitary Epidemiologic Surveillance
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNICEF	United Nations Children’s Education Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
WHO	World Health Organization

## I. Executive Summary

### Background

In spring 2008, the U.S. Agency for International Development (USAID) Bureau for Europe and Eurasia (E&E) asked the Communication for Change program (C-Change)<sup>1</sup> to: a) examine the region's experience with motivating health care consumers to take more responsibility for their health and b) determine how USAID and other donors can increase the effectiveness of their assistance in this area.

Prior to the early 1990's under the Soviet system, each person or "consumer" was registered with a local clinic and received services free of charge. Health reforms in most E&E countries now enable consumers to participate in selecting providers and seeking care. Since the 1990s the profile of illnesses has changed from those related to infectious diseases to chronic (non-communicable) illnesses (e.g. diabetes, cancer, and heart disease) that are related to lifestyle choices such as alcohol, smoking, physical activity and diet.

While infectious diseases remain a threat in many countries, the primary causes of adult mortality – the probability of dying between the ages of 15 and 60 – in the E&E region are non-communicable diseases and injuries<sup>2</sup> and account for more than 85 percent of all deaths annually, with males being disproportionately affected. This contributes to a gender gap in adult mortality that is the largest in the world (USAID 2007; WHO, 2006.) Specifically, according to the World Health Organization (WHO), in 2002, 95 percent of deaths in Armenia, 91.86 percent in Albania; and in 82.5 percent in Kyrgyzstan resulted from non-communicable diseases and injuries. The high prevalence of smoking among adult males in these countries (over 60 percent) presents an even more foreboding future for consumer health and the health care system.

### Health Promotion Framework and C-Change Approach

WHO's 1986 "Ottawa Charter for Health Promotion"<sup>3</sup> and subsequent charters addressing the topic served as the framework for C-Change's analysis of health care consumer empowerment. *Health promotion, as defined by the Charter, is the process of enabling people to increase control over, and to improve, their health by developing personal skills, embracing community action, and fostering appropriate public policies, health services and supportive environments.* Health promotion represents a comprehensive social and political process, embracing actions directed at strengthening the skills and capabilities of individuals, families and communities and changing social, environmental and economic conditions to alleviate their impact on public and individual health.

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<sup>1</sup> The Communication for Change Program (C-Change) is a worldwide, cross-sector communication program funded by USAID and launched in September of 2007. The five-year cooperative agreement provides communication assistance to programs in health, the environment, and democracy and governance.

<sup>2</sup> Injuries include intentional and unintentional injuries such as poisonings, drownings, falls, fires, vehicle collisions, violence, war and self-inflicted injuries.

<sup>3</sup> More information on the WHO Ottawa Charter for Health Promotion (Geneva, 1986) can be found at <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index.html>

The Ottawa Charter identifies three basic strategies for health promotion including *advocating* for health to create the essential conditions indicated above; *enabling* all people to achieve their full health potential; and *mediating* between the different interests in society in the pursuit of health. In the E&E region, five priority action areas support the strategies outlined above:

- **Building healthy public policy** by combining diverse but complementary approaches such as legislation, fiscal measures, taxation and organizational change to ensure safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.
- **Creating supportive environments** that include safe, stimulating, satisfying and enjoyable living and working conditions.
- **Strengthening community actions** to set priorities, make decisions, plan strategies and implement them to achieve better health. At the heart of the process is empowering communities.
- **Developing personal skills** through providing information and enhancing life skills that allow people to exercise more control over their own health and environments.
- **Reorienting health services** to move beyond the role of clinical and curative services through collaboration among individuals, community groups, health professionals, health service institutions and governments to create an integrated health care system.

WHO's 2005 "Bangkok Charter for Health Promotion"<sup>4</sup> provided a revised direction for health promotion, highlighting the changing context of global health and challenges, including the growing burden of chronic diseases.

Building on this framework, C-Change supports a systems approach to changing individual behaviors and social norms that aims at achieving long-term change. This assessment draws from these approaches with a particular focus on change in social norms, social networks and social systems. For a health consumer to be "empowered" multiple factors come into play. This assessment compiles perspectives and observations from health care providers, consumers, government officials, NGOs and media to reach its recommendations.

### Methodology

This assessment focused on three countries representing distinct geographical regions within E&E – Kyrgyzstan, Albania and Armenia – and consisted of four components:

- **A literature review** of the state of health promotion and primary health care in E&E countries;
- **Pre-assessment surveys and conference calls** with USAID missions;
- **Country visits** to conduct in-depth interviews and to visit active USAID-funded projects and health facilities in rural sites, and
- **Focus groups with health consumers** in each country.

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<sup>4</sup> More information on the WHO The Bangkok Charter for Health Promotion in a Globalized World (11 August 2005) can be found at [http://www.who.int/healthpromotion/conferences/6gchp/bangkok\\_charter/en/index.html](http://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/index.html)

The three member team carrying out this assessment had specialties in communication, public health, and sociology and experience in countries of the Europe and Eurasia region.

### Key Findings

#### **Government institutions are making efforts to address health promotion and disease prevention, though resources and staffing are limited.**

Currently, the responsibility for health promotion, which was under the Sanitary and Epidemiologic Service (SES) in the Soviet system, is performed by varied entities in each country. Of the countries visited, Kyrgyzstan has the most developed approach with a separate health promotion unit operating under the Ministry of Health (MoH) with staff, budget and a health promotion strategy that guides national efforts. Health promotion in Albania is bifurcated between two MoH structures, the Institute of Public Health (IPH) and the Department of Public Health (DPH). The IPH establishes policy while the DPH maintains an operational and technical role. The SES and the central MoH both conduct health promotion activities in Armenia, depending on the initiative and donor funding. Efforts to address consumer involvement and health promotion have increased in recent years, but funding and support for efforts addressing chronic diseases is still limited. While the countries visited have existing national health promotion strategies, government agencies addressing health promotion do not appear to have the resources and staffing to implement these strategies fully.

#### **Consumer-oriented health programs in the region are growing.**

Most national health programs are still disease or topic specific (e.g. HIV, TB and family planning) as they are usually donor supported and related to the donor's development agenda. However, efforts in the region are growing to empower health care consumers. These programs typically involve international NGOs in partnership with local groups. One promising intervention, community-based volunteer health groups, are operating in all three assessment countries to motivate consumers to participate in health planning and decision-making in their communities. Health care consumers involved in this intervention are more satisfied with services and programs that address the needs of communities, though in most countries only a small percentage of the population participate.

**Consumers generally feel negatively about the care they receive in public clinics,** reporting that they do not trust the skills of providers and they feel service quality is poor. Some consumers pay for the services of private physicians or go directly to pharmacists to obtain medicine for health problems. Young mothers are the exception; they feel they receive good care from public facilities for maternal and child health services (i.e. prenatal, delivery and immunizations). In addition, consumers who are involved in community-based volunteer programs report that the services and care they receive are satisfactory.

#### **Consumers are interested in preventive health and eager for information.**

In all communities visited and during focus group discussions, consumers expressed a desire for information and education on nutrition, exercise and chronic disease prevention. Consumers typically obtain health information from their providers (both public and private) and some seek information from pharmacists. Consumers also indicated that they get information on health from television and newspapers. Several long-established programs on television address health issues and are popular with consumers. These programs tend to follow a traditional

public affairs format and report on various aspects of health care and specific health and disease topics.

**Civil society organizations are increasingly active in health consumer activities.**

Several civil society organizations in all three assessment countries are starting to promote patient rights, patient information and consumer protection, aided by new legislation on public health. These advocacy efforts provide a supportive environment for health promotion efforts to develop. For example, in Kyrgyzstan the Finnish Lung Health Project, in conjunction with the Ministry of Health (MoH) Tobacco Control Office, has been working on tobacco control legislation. Active patient advocacy groups for diabetes, hypertension and asthma are also functioning. In Albania, the human rights organization Mjaft, (which translates to “Enough” in English) has targeted health, in particular improving health services and quality of care, as its next initiative. The Albanian Center for Population and Development is an NGO active in lobbying for reproductive and sexual health rights. In Armenia, the Open Society Institute (OSI) is active in building legal capacity for improving human rights concerning health and social protection.

Recommendations

Empowering health care consumers to take more responsibility for their own and their family’s health will not be achieved by a single intervention alone, but through adequate reforms and long-term behavior change communication interventions supported by legislation and legal actions. Many efforts already underway in the E&E region are beginning to follow this approach; however, more needs to be done.

To initiate and sustain empowered health care consumers and more effectively address chronic diseases, C-Change recommends working with governments to develop an overarching health promotion strategy that is based on behavioral research and the epidemiology of each country. Individual behavior change related to healthy lifestyles must be supported by a “conducive environment” that reinforces the change through structures, programs and policies to create a new social norm of empowered consumers who are ready and willing to take responsibility for their own health and that of their families. Under a common health promotion strategy, a plan for empowering consumers would involve multi-dimensional interventions involving:

- Governments
- Health Care Providers and Pharmacists
- Communities
- Private Sector
- Media
- Civil Society
- Research

Representatives of all major stakeholders should be involved in developing the health promotion strategy for greater ownership of messages and more informed action. The assessment team recommends the following for governments and development organizations to consider:

**Support government structures, programs and policies that address health promotion, using the WHO’s guidance and framework for health promotion.**

This assessment found that health promotion planning is underway through various government structures, yet more is needed to ensure that these organizations have the resources and “vision” to develop sustainable programs. Donors can be advocates to ensure that government health programs address emerging health problems that countries in this region face. They also can ensure that these structures have adequate resources (both finances and staffing) to function. Donors can also support an effective and efficient structure for health promotion and behavior change and communication (BCC) within a MoH.

Roles and responsibilities for health promotion units should be clearly defined and include the ability to:

- Develop a health promotion strategic plan that can guide the work of all stakeholders.
- Create print, online and broadcast educational materials or have the expertise to work with a communications agency to develop needed materials.
- Work with stakeholders such as media, NGOs, regional and community leaders, health care providers, private sector groups and other organizations to ensure their support and provide them with trusted and relevant communication messages, information and materials.
- Work with the health sector to ensure services actively promote health.
- Develop and support policies that promote health.

Donors can support meetings to bring stakeholders together and to monitor program implementation. Donors can also support the planning efforts of these units to develop evidence-based health promotion and disease prevention policies and plans by conducting appropriate research, behavioral surveys and studies.

**Reorient existing health programs to address health promotion and disease prevention, including chronic diseases.**

In addition to structural changes, health promotion should address both infectious and chronic diseases within the current context of health facilities and community level programs. The public health sector should include training and capacity building for health care providers to inform and counsel their patients on the causes of health and of disease. For example, research in tobacco control indicates that a counseling session between the provider and patient is one effective tool for helping smokers quit. As many consumers go directly to pharmacists for health information and counseling, pharmacists should participate in training and capacity building efforts. Media programs that focus on health are logical targets for increasing attention to health promotion messages for consumers. Donors also can expand efforts to engage journalists and television producers in health promotion and educate them about disease prevention.

Risk assessment programs can be developed to use volunteer-based health groups in schools, universities, and youth organizations to address the younger generation. Efforts could include developing risk assessment tools that relate to lifestyle choices followed by a series of onsite interventions – such as health fairs and screenings – that target key positive health behaviors and stimulate community dialogue and discussion. Based on specific risk behavior research, key positive health behaviors can be modeled through the media, such as presenting physically

fit, active, engaged non-smoking and non-drinking young people as cool, positive role models who receive social acceptance and social rewards.

**Engage and support the private sector and NGOs to provide products and services directly to the consumer by supporting market development.**

Various health programs have demonstrated that involving the private sector has contributed positively to changing health behaviors through consumer education and delivery of quality products and services. Donor financing can help to develop the market for local companies to make their products available to consumers (e.g. in family planning, smoking cessation, and hypertensive drugs) and support product marketing. Supporting “Direct-to-Consumer” health promotion creates a more informed consumer who then puts pressure on health providers for better quality, more choices, respect and accountability. For example, it is possible to improve the social norms around acceptability of modern contraceptives through advertising and sales promotions.

A key element in empowering health care consumers is supporting the growth of NGO advocacy efforts; building capacity through media training and developing an agenda to advance health promotion. Tobacco and alcohol control is one example: by advocating for increased taxation, smoking bans, and regulation of product advertising and promotion, studies have shown that countries can decrease the incidence of several major cancers, including lung, esophageal and liver (Disease Control Priorities Project 2006). USAID can consider supporting NGOs that advocate for health promotion issues in several ways: tap the vibrant international tobacco control network to provide support and capacity strengthening for these NGO efforts; capture and share the regional examples of NGO success in promoting a positive health agenda; enable NGOs to monitor and help reinforce health policies and programs in the region to support long-term, sustainable programs.

## **II. Background**

In this report, “health care consumers” are defined as “the end users and purchasers of health care services. They include individuals and families; men, women and children; and vulnerable groups such as the elderly, disabled, dislocated and those living in poverty. Collectively, they represent the ‘demand side’ of the health care equation in contrast to the ‘supply-side’ that includes health care providers and their supporting infrastructure.”<sup>5</sup>

Health care consumers exercised few health care rights, responsibilities and protections in the former Soviet Union. In many countries, individuals could not choose their providers and received little, if any, patient counseling or health promotion information from providers or through mass media. Civic organizations to advocate for or monitor health care and codes of patients’ rights did not exist.

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<sup>5</sup> Statement of Work, “Assessment of Europe and Eurasia experiences in empowering health care consumers.” USAID 2008.

When USAID and other donors began assisting countries to strengthen their health care systems in the E&E region in the early 1990s, in many countries, the systems were:

- severely under-funded;
- overbuilt with too many hospitals;
- staffed with too many specialists and too few primary care physicians;
- of poor clinical quality not subject to evidence-based medicine standards;
- disease driven rather than health driven; and
- not attentive to consumers' changing health-seeking behaviors.

E&E countries and donors have consistently focused assistance more on the health care provider rather than on the consumer. While much has been accomplished, far fewer investments have been made to change the behavior of individuals and families to assume greater responsibility for their health. The findings and recommendations outlined in this report address the benefits of focusing efforts on consumers and specific methods and channels of outreach.

The E&E Bureau at USAID charged the C-Change project with a) examining the region's experience in motivating health care consumers to take more responsibility for their health, and b) determining how USAID and other donors can make their assistance more effective in this area. To provide a representative overview of such a vast geographical area within the relatively brief three-week time period, the E&E Bureau in collaboration with USAID Missions in the region selected three countries to visit that represented distinct geographical regions: Kyrgyzstan (Central Asia), Albania (Eastern Europe) and Armenia (Caucasus).

### Assessment Team

The core review team consisted of three specialists: (1) a public health expert specializing in consumer and health system linkages; (2) C-Change Communication Officer; and (3) a sociologist and doctoral candidate specializing in Russian, East European and Eurasian Studies. All three assessment team members have extensive experience working in the region on health and development projects. One team member has worked in former Soviet countries since 1996 and as a consultant to the USAID ZdravPlus project in Kyrgyzstan for two years. Another served as a Peace Corps volunteer in Armenia for two years; and another did her pre-dissertation field work on health and domestic violence in Kyrgyzstan and Tajikistan, and worked at a maternal and infant training and research center in Russia.

### Objectives

The objectives of the assessment were to:

1. Document the experience of E&E countries and donors in empowering health care consumers to take more responsibility for their health and that of their families.
2. Identify the most cost-effective interventions for empowering health care consumers.
3. Provide recommendations to USAID Missions on how to assist E&E countries to empower health care consumers more effectively.

### Health Promotion Framework

As a first step in designing this assessment, the C-Change and E&E Bureau staff agreed on a framework for health promotion. According to the World Health Organization's (WHO) Ottawa Charter for Health Promotion<sup>6</sup>, health promotion is "the process of enabling people to increase control over the root causes of health in order to improve it."

Health promotion represents a comprehensive social and political process. This includes embracing actions directed at strengthening the skills and capabilities of individuals, families and communities as well as changing social, environmental and economic conditions to alleviate their impact on public and individual health.

The Ottawa Charter identifies three basic strategies for health promotion: *advocating* to create the essential conditions needed for health; *enabling* all people to achieve their full health potential; and *mediating* between the different interests in society in the pursuit of health.

#### **Advocate**

Good health is a major resource for social, economic and personal development and an important dimension in quality of life. Political, economic, social, cultural, environmental, behavioral and biological factors can either support positive health outcomes or hinder them. Health promotion action aims at making these conditions favorable through advocacy for health such as tobacco control legislation and taxation.

#### **Enable**

Health promotion also focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources so all people can achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People will achieve their fullest health potential when they take control of the root causes, or determinants, of both health and disease.

These root causes include a range of personal, social, economic and environmental factors that determine the health status of individuals or populations. Health promotion is concerned with addressing not only those factors related to the actions of individuals, but also income and social status, education, employment and working conditions, access to appropriate health services, and physical environments. In combination, these factors create different living conditions that have an impact on health and disease.

#### **Mediate**

Health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organizations, by local authorities, by industry and by the media. Professional and social groups and health personnel have a major responsibility to mediate between differing interests.

Five priority action areas support the strategies outlined above:

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<sup>6</sup> More information on the WHO Ottawa Charter for Health Promotion (Geneva, 1986) can be found at <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index.html>

- **Building healthy public policy** by combining diverse but complementary approaches such as legislation, fiscal measures, taxation and organizational change to ensure safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments. For example, studies show that every 10 percent increase in the price of cigarettes will reduce youth smoking by about seven percent and overall cigarette consumption by about four percent<sup>7</sup> (Campaign for Tobacco-Free Kids).
- **Creating supportive environments** such as safe, stimulating, satisfying and enjoyable living and working conditions. For example, ensuring that fresh fruits and vegetables are available at local markets constitutes a supportive environment.
- **Strengthening community actions** to set priorities, make decisions, plan strategies and implement them to achieve better health. Empowered communities are at the heart of the process. One example includes engaging community members in community-based volunteer health committees to determine health priorities and engage in activities such as renovating their local health clinic.
- **Developing personal skills** through providing information and enhancing life skills that allow people to exercise more control over their own health and environments. Health fairs with screenings and surveys would help individuals to assess their risk of disease.
- **Reorienting health services** to move beyond clinical and curative services through collaboration among individuals, community groups, health professionals, health service institutions and governments to create a health care system. For example, a public health action committee consisting of local elected officials, public health experts, hospital administrators, school and other community leaders could set a local health promotion strategy for their community.

The Jakarta Declaration on Leading Health Promotion into the 21st Century developed in July 1997 confirmed that these strategies and action areas are relevant for all countries. It further emphasized that:

- Comprehensive approaches (that use combinations of the five strategies) to health development are more effective than single-track approaches.
- Settings for health offer practical opportunities to implement comprehensive strategies.
- Participation is essential to sustain efforts. When people are at the center of health promotion action and decision-making processes they are effective.
- Health literacy/health learning fosters participation. Access to education and information is essential to achieving effective participation and empowering people and communities.
- Priorities for health promotion in the 21st century include promoting *social responsibility* for health and increasing *investments* for health development. In addition, expanding *partnerships*, securing an *infrastructure* for health promotion and *empowering* the individual are essential.

WHO's 2005 Bangkok Charter for Health Promotion highlighted the changing context of global health and challenges, including the growing burden of chronic diseases. The Bangkok Charter provided a revised direction to health promotion by calling for policy coherence, investment and partnering across governments, international organizations, civil society and the private sector

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<sup>7</sup> More information can be found at <http://www.tobaccofreekids.org/research/factsheets/pdf/0146.pdf>.

to work towards four key commitments—that health promotion is 1) central to the global development agenda, 2) a core responsibility of all governments, 3) part of good corporate practice, and 4) focuses on community and civil society initiatives.

Building upon this framework, C-Change supports a systems approach to changing individual behaviors as well as social norms and aims at achieving long-term change, emphasizing the expansion of:

- **Objectives** – from change not only in individuals, but in social norms, social networks and social systems that reach beyond and influence the individual.
- **Audiences** – from high-risk populations and their influencers to a wide range of stakeholders including journalists, policymakers and the private sector.
- **Messages** – from vertical “do this” messages to horizontal communication among organizational networks and interpersonal networks.
- **Channels** – from media as channels to media as partners – and from traditional broadcasting to inclusion of new media technologies.
- **Management** – from capacity building of a few organizations, to strengthening networks of many organizations in multiple regions, as well as expanding skills training of middle managers to include leadership, business management, and new management models for large-scale programs.

This assessment draws from these approaches with a particular focus on change in social norms, social networks and social systems. For a health consumer to be “empowered” there are multiple factors that come into play. Therefore, the assessment will compile perspectives and observations from health care providers, consumers, government officials, NGOs and media to draw its recommendations.

#### Definition of Health Care Consumer Empowerment

As part of this assessment, the C-Change and E&E Bureau staff also agreed on a multi-component definition of health consumer empowerment that parallels WHO’s definition:

*Empowerment is a process through which people gain greater control over decisions and actions affecting their health.*

Empowerment may be a social, cultural, psychological or political process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve political, social and cultural action to meet those needs. Individual empowerment refers primarily to an individuals’ ability to make decisions and have control over his or her life. Community empowerment involves individuals acting collectively to gain greater influence and control over the root causes of health and quality of life in their community. The assessment team’s findings indicate that community members who are empowered in one area, such as health, are more likely to mobilize and remain active in their communities in other areas such as education or agriculture, than their underpowered counterparts.

### III. Methodology

This assessment consisted of four components:

- A literature review of reports and studies in the E&E countries concerning health promotion, primary health care and family health (attached in Appendix 3)
- Pre-assessment surveys of USAID Mission staff (template attached in Appendix 4)
- Visits to three E&E countries to conduct in-depth interviews with stakeholders and rural site visits to active programs and health facilities
- Twenty focus groups with health care consumers
  - Four in Kyrgyzstan (two rural, two urban)
  - Eight in Albania (four rural, four urban)
  - Eight in Armenia (four rural, four urban)

#### Literature Review

The literature review for this assessment identifies the current state of consumer empowerment activities within the E&E region. It includes published reports and unpublished documents available from organizations working within the region, including multilateral aid agencies (e.g. United Nations agencies), bilateral agencies (e.g. USAID), and NGOs (e.g. Project HOPE). To provide comprehensive coverage, the review examined documents on programs with any clearly identified consumer-focused element. To restrict this review to a reasonable length, only projects taking place or reporting on activities within the last five years and only programs with technical or other reports are included. Therefore, more recent interventions that have no written documentation may not be included.

#### In-Depth Interviews

This assessment includes 82 in-depth interviews and roundtable sessions with government, donors, cooperating agencies, NGOs, health care providers, pharmacists, media and health care consumers. In total, the team obtained insight from approximately 140 individuals representing a broad range of society in Kyrgyzstan, Albania and Armenia. A list of the persons and organizations can be found in Appendix 1. A standardized assessment tool (attached in Appendix 2) was used to collect information and elicit perspectives on empowering consumers. The tool focused on three areas: (1) current programs, projects, and practices focusing on health care consumers, (2) health care providers, and (3) the media. In most cases, the three-member team participated in interviews together with one member responsible for recording notes during each session.

#### Pre-Assessment and Field Visits

Prior to their visit, the team contacted USAID Missions in each of the three countries for information on USAID health-related projects and for suggestions on people and projects to interview and/or visit. The team spent two days in each country visiting projects in rural areas that use volunteers to provide health information to their communities. Rural sites were selected in collaboration with USAID project staff (e.g. Village Health Committees implemented by the ZdravPlus Project and the Swiss Red Cross in Kyrgyzstan; Village Health Teams implemented by Proshendetit and the American/Albanian Red Cross in Albania; and Health Action or Activist Groups implemented by Project NOVA and the Primary Health Care Reform Project in Armenia). In addition to meeting with project staff and community groups, the team also

interviewed local Sanitary and Epidemiologic Service (SES) officials and staff in local health facilities such as Family Medical Centers, Family Group Practices and the frontline health facility for consumers, the FAP (Feldshar Accoucher Point). During field visits, the team met with local MoH health promotion officers in Albania and Kyrgyzstan (the MoH in Armenia does not have a specific health promotion unit). The list of project sites and health facility visits can be found in Appendix 1.

### Focus Groups

To gather independent information from consumers, local researchers were contracted to conduct focus group discussions in each country prior to the team's arrival. Focus group areas chosen provided a representative view of consumers throughout the country and did not include groups from donor project areas. During the country visits, the assessment team also spoke to health care consumers in all three countries where donor projects were active. The results of these discussions presented a contrast to the focus group findings and are outlined in detail in Appendix 6. Time and budget constraints limited the number of focus group interviews. Initially, the methodology called for four focus groups per country. However, eight focus groups were conducted in Albania and Armenia as the assessment team knew less about consumers in these countries. The focus group topic guide can be found in Appendix 5.

Focus group participants were separated by gender and selected according to the following criteria:

- People who have used the health care system during the last year;
- Public users and private users;
- Urban/rural; and
- Sex and age variables

Thus, four types of groups were interviewed:

- a. 1 male group - urban - ages 20-40, 40+
- b. 1 female group - urban - ages 20-40, 40+
- c. 1 male group - rural - ages 20-40, 40+
- d. 1 female group - rural - ages 20-40, 40+

In Albania and Armenia, researchers interviewed two of each type; in Kyrgyzstan only one.

General information collected from the focus groups included:

- Where participants access health care
- Main medical reasons to access care/services
- Satisfaction with care/services
- Concerns/issues with care and providers/services
- The most important attributes of "good quality services"

### Limitations

As a qualitative assessment, information contained in this report represents a point in time with regard to knowledge, attitudes and practices. The focus groups conducted represent a small sample size, and to obtain more thorough information a more rigorous study would be desirable. For example, the latter would have permitted a more in-depth investigation into whether

consumers held different perspectives in areas where donor projects were active. In addition, the assessment team had limited time in each country for in-depth interviews and field visits. However, as one team member has a long-term association with Kyrgyzstan, this review contains a more in-depth perspective for that country. The literature review provides an overview of projects and initiatives in the E&E region that involve empowering consumers, but represents only written reports and other written information the team could gather during the assessment. Therefore, undocumented NGO experiences could have been missed.

#### **IV. Brief Overview of Assessment Countries**

A detailed overview of health status for the assessment countries is found in Appendix 7.

##### General Information

The countries included in this assessment – Kyrgyzstan, Armenia and Albania – span a geographical range of 3,000 miles, from the mountainous border with China to the Adriatic Sea, and involve many different ethnic groups and languages. All three countries are relatively similar in size and population. Kyrgyzstan ranks as the largest among them, approximately the size of South Dakota with 5.4 million people. Albania and Armenia are each nearly equivalent to Maryland in size with populations of 3.6 and 2.9 million respectively.

##### Non-Communicable Diseases

Although health status has traditionally been measured primarily by infectious disease morbidity and mortality, communicable diseases are no longer the only threat. Because of lifestyle and diet changes along with rapidly aging populations in developing countries, major non-communicable diseases such as circulatory system diseases, cancer, diabetes, psychiatric disorders, and chronic respiratory diseases now contribute to the worldwide burden of disease (Disease Control Priorities Project 2006).

In fact, the primary causes of adult mortality – the probability of dying between the ages of 15 and 60 – in the E&E region are non-communicable diseases and injuries<sup>8</sup>. Requests from health care consumers regarding chronic diseases during the assessment trip validated this finding. While some diseases are linked to genetic attributes, most stem from lifestyle choices, particularly related to alcohol, smoking, diet and exercise. It is estimated that non-communicable diseases and injuries account for more than 85 percent of all deaths annually, with males being disproportionately affected. This contributes to a gender gap in adult mortality that is the largest in the world (USAID 2007; WHO, 2006). Specifically, according to WHO, in 2002, 95 percent of deaths in Armenia, 91.86 percent in Albania, and 82.5 percent in Kyrgyzstan were due to non-communicable diseases and injuries. The percentage is an increase from 2000, when according to WHO, 55 percent of deaths in E&E were attributed directly to lifestyle diseases versus 40

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<sup>8</sup> Injuries include intentional and unintentional injuries such as poisonings, drownings, falls, fires, vehicle collisions, violence, war and self-inflicted injuries.

percent in the EU-15<sup>9</sup>. In contrast, only 5 percent of E&E deaths were due to infectious, parasitic, maternal and perinatal conditions (Demography and Health in E&E, USAID 2005).

According to WHO, chronic disease is becoming “globalized” and cancer is predicted to be a leading chronic disease burden in the emerging world in the next few decades. By 2020, a 73 percent increase in new cases of cancer is anticipated in developing countries compared with 23 percent in developed nations. Seven types of cancers account for approximately 60 percent of all newly diagnosed cancer cases and cancer deaths in developing countries: cervical, liver, stomach, esophageal, lung, colorectal and breast (Disease Control Priorities Project 2006). WHO estimates that knowledge currently available could prevent up to 1/3 of new cancers and increase survival for another 1/3 of cancers detected at an early stage.

While cardiovascular disease (CVD) was once largely confined to high-income countries, it is now the number one cause of death worldwide. In fact, 80 percent of the world’s 13 million annual CVD deaths occur in low- and middle-income countries.

Tobacco use accounts for a substantial and avoidable percent of CVD and cancers (Disease Control Priorities Project 2006). In all three countries visited, WHO data showed smoking prevalence among adult males is over half (60-65 percent). Smoking among boys ranges from 10 to 15 percent. A survey by the MoH in Kyrgyzstan revealed that 50 percent of physicians smoke. The gender disparity in smoking is much greater in the transition countries than in Western Europe. Males in the E&E region smoke more than Western European men while females in the E&E region smoke much less than Western European females. In E&E, 46 percent of males smoked in 1999-2001 vs. 16 percent of females, contrasting with European countries such as UK (29 percent of males and 25 percent of females), France (33 percent and 21 percent), and Denmark (32 percent and 29 percent).

Despite lower estimates of alcohol consumption in the E&E region compared to the EU-15, deaths in 2000 directly related to alcohol such as cirrhosis were notably higher in E&E countries (24 alcohol-related deaths per 100,000) than in the EU-15 (15 per 100,000) or in the U.S. (9 per 100,000) (Demography and Health in E&E, USAID 2005).

The World Bank’s *Albania Health Sector Note* (2006) states, “Albania’s health care system is ill prepared to face the growing incidence of non-communicable diseases and other new health risks.” It also notes that, “Concerted efforts are also required to improve Albania’s health promotion capacity, so as to inform the population about the new risk factors and ways to avert them.”

#### Health Care System Structure

All three assessment countries are extensively involved in reforming their health care systems. Kyrgyzstan has the most experience, with their health reform process beginning more than 10

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<sup>9</sup> EU-15 refers to the 15 countries in the European Union before the expansion on 1 May 2004, when eight central and eastern European countries as well as Cyprus and Malta joined the organization. They include Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and the United Kingdom.

years ago. Health care reform in these countries has generally centered on health care financing and on reconfiguring curative health services and doctors into a Family Medicine model with less emphasis on the structure of the MoH. At a glance, the MoH retains its structure from the Soviet era, though Albania, never under the Soviet system, is unique. Under the Soviet structure, the SES was the preventive arm of the MoH, responsible for health promotion. The SES' primary role is sanitary protection, disease control and epidemiologic surveillance. The SES is highly focused on data collection and highly centralized, but has offices at each district (or *oblast*) level and sub-district (or *rayon*) level. The SES performs food, water, occupational and environmental protection inspections and maintains population-based disease control efforts. The SES also investigates disease outbreaks and other public health problems and maintains an extensive surveillance system which primarily monitors long-term incidence trends by *oblast* and *rayon* levels.

In former Soviet countries, efforts have been undertaken to modify and strengthen the SES around a public health model. Thus far, SES reform has focused mainly on central level restructuring and on conforming to international regulations and standards and less on public health services aimed at the consumer.

In Armenia since 1990, SES and the central MoH have engaged in health promotion activities depending on the initiative and donor funding. For example, the SES organized health promotion immunization campaigns while the central MoH has led other health promotion activities such as IMCI. Although Armenia is restructuring its MOH, the new public health policy and structure was not yet public when the team visited. Interviews with the Armenian SES suggest that the new public health strategy will give the SES greater authority to undertake health promotion.

In Kyrgyzstan, initial efforts to reform the SES after 1990 were not successful so a separate Health Promotion Unit was created under the MoH's preventive services office, as part of a DfID initiative to strengthen health promotion. The Health Promotion Unit is now supported by USAID's ZdravPlus project, which is trying to develop a more consumer-focused public health service at the *rayon* SES level.

In Albania, health promotion has been bifurcated between two MoH structures, the Institute of Public Health (IPH) and the Department of Public Health (DPH). The DPH (with only one staff member and very little budget) maintains an operational role while the IPH establishes policy and works to pass legislation.

### Civil Society

The entire E&E region is developing NGOs, though ample room for growth exists. According to USAID's NGO Sustainability Index (2000), Albania, Kyrgyzstan and Armenia were between 4.6 and 5 on a 7 point scale (where 7 indicates a low or poor level of development and 1 indicates a very advanced NGO sector.) While all three countries show progress in civil society development, problems still exist with building local capacity. Further, NGOs tend to be located in urban areas and do not extend into rural areas. External factors also hamper NGO development such as highly centralized governance structure; a controlled or reactionary media; and a low level of capacity, will, or interest on the part of the NGO community.

### Media and Literacy

With regard to media, television is widely available and ownership of TV sets remains at nearly 100 percent. Albania has 65 television stations (three national and 62 local) and two cable networks. Armenia has 48 television stations, including two public stations, and Kyrgyzstan has two national and 6 regional (*oblast*) stations (World Resources Institute 2007). Programming from Russia and foreign films are frequently broadcast in Armenia and Kyrgyzstan. However, in-depth interviews showed that both countries are moving toward more local programming in their national language.

Literacy is at nearly 100 percent in all three countries (CIA World Factbook 2008). While Internet use is increasing among young urban populations, it is still low compared to developed countries. In 2006, Albania reported 471,200 Internet users (13.1 percent of the population); Armenia reported 172,800 users (1.7 percent of the population); and Kyrgyzstan reported 298,100 users (5.5 percent of the population) (Internet World Stats 2008).

### Economic Status

Kyrgyzstan is the poorest of the three countries assessed with a Gross National Income (GNI) of \$590. It ranked 175<sup>th</sup> for GNI of the 209 countries rated by the World Bank (2007). Armenia progressed economically in recent years, but still ranks as 123 out of 209, with a GNI per capita of \$2,640. Albania has the highest reported GNI among these three countries, but is still one of the poorest countries in Europe with a GNI per capita of \$3,290<sup>10</sup>.

Although the capital cities of Bishkek, Tirana and Yerevan have experienced considerable commercial development, the recent surge in food and transportation costs greatly affects consumers in these countries. For example, the cost of local bread in Bishkek increased by 80 percent this year and local transportation by 60 percent. This excessive inflation reduces purchasing power for health care, increases stress and decreases time to attend to health care needs.

## **V. Summary of Literature Review**

The assessment team, with assistance from USAID's Knowledge Service Center, collected technical reports and documents from multilateral aid organizations, bilateral donor agencies, and international NGOs, as well as available program assessments in academic literature, prior to the assessment trip. While in the field, the team collected additional reports and literature. Thus, the literature review incorporated new material during the assessment visits. The final review includes a combination of materials obtained electronically and directly from project representatives. We restricted the review to projects operating within the past 5 years and to those countries with newly democratic governments from 1990. The full text of the literature review can be found in Appendix 3.

Findings from the literature support many of the conclusions reached during the assessment trip. Highlights of important findings include:

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<sup>10</sup> There are several sources with varying rates for the indicators presented in this report. For consistency of comparison among the three countries, the CIA World Factbook is used, unless otherwise noted in the text.

- “Empowerment” is a concept of growing importance to donors, program designers and managers.
- Though most projects to date have not included empowerment as a specific outcome goal, the region provides numerous examples of programs that contribute to the empowerment of health consumers, including health promotion, education and community mobilization campaigns. Particularly notable projects include health education campaigns within the Central Asia regional campaign ZdravPlus and efforts to support and spread Village Health Committees (with support from USAID and the Swiss Red Cross) in Kyrgyzstan; the Proshendetit primary health care reform project and the American and Albanian Red Cross cooperative project on integrated management of childhood diseases in Albania; Project NOVA and the Primary Health Care Reform Project in Armenia; and the American International Health Alliance Health Partnerships programs in several countries in Europe and Eurasia. Despite disparate country contexts, one common theme among all these projects is that their social mobilization efforts include working in both urban and rural communities to involve individuals in the health of themselves, their families and their communities.
- While few reliable studies on cost effectiveness exist, those available suggest that media interventions (which we categorize as empowerment interventions) seem to be cost-effective methods for improving health, as most research shows that such interventions are effective, and often at a low cost per participant (in the case of media interventions).
- Media advocacy, in addition to providing issue or campaign-specific information, works to shape the public discourse about health. This may be an important complement to individual behavior change interventions which, to date, have predominated in the region.
- Several health promotion programs in the E&E region have focused on maternal and child health, nutrition and family planning. While additional research is needed to gauge the cost-effectiveness of consumer-focused health interventions in this region, they have certainly had impact. A growing body of empirical evidence demonstrates that communication strategies are effective in changing behaviors in ways that contribute to positive health outcomes.
- Several consumer efforts related to health care system reform in the region have resulted in more provider interaction with patients and better consumer understanding of health topics, services offered, and service delivery. It is not clear, however, how these efforts have affected service utilization rates, quality of care and consumer satisfaction with health services.
- Few programs have advocated for better access to services for consumers and consumer rights. Some efforts have involved communities in health care reform, but have not directly advocated for consumer rights. While programs that contain an element of consumer-focus are common, consumer empowerment as an explicit goal remains rare.
- Numerous programs combine some successful components, yet few include all desirable elements. Overall, programs tend to be particularly strong when using multiple approaches to reach consumers as part of an overall health strategy, making success

and behavior change more likely. Common weaknesses are insufficient attention to long-term strategies for sustainability and a research base that is not clearly articulated in program documentation.

## VI. Key Findings – Perception and Practices of Key Stakeholders

The findings reflect the perceptions and practices of health care consumers, government, donors, NGOs, health care providers, and media from both focus groups and assessment team interviews.

Overall, perceptions and practices during this assessment were consistent throughout all three countries. Findings related to specific countries are noted in the text.

### Consumers

**Consumers generally feel negatively about the care they receive in public clinics**, reporting that they do not trust provider skills, they are pressured to make informal payments to providers and they feel service quality is poor. Significant barriers exist such as time spent waiting in line and completing paperwork, distance from a health facility, the cost of health care, poor quality of services and conditions of facilities.



Focus groups revealed that health care consumers in Albania, Armenia and Kyrgyzstan seek health care primarily when they are seriously ill or after an accident. Where consumers go for their health care depends on availability of services and, most notably, their income. According to focus group participants, those in the cities who can afford it prefer the more comfortable environment and shorter waiting time of a private doctor.<sup>11</sup> In any case, private or public, people prefer to go where they personally know the medical staff. Many consumers report going directly to pharmacists to obtain medicine for health problems. The exceptions are young mothers who feel that they receive good care from public facilities for maternal and child health services (i.e. prenatal, delivery and immunizations). The other exception is consumers who are involved in community-based volunteer programs who report that the services and care they receive are satisfactory. Relationships between Feldshar Accoushar Point (FAP) staff and the community seem to be positive where community-based volunteer groups have been established and include a FAP staff member. In Kyrgyzstan, community-based volunteer groups work in approximately 96 percent of villages across seven *oblasts* or regions.

<sup>11</sup> In low income countries, the 'private' doctor is often the public doctor, only after hours.

**Consumers are interested in preventive health and eager for information.**

In general, consumers are very interested in health promotion and disease prevention. In all communities visited and during focus group discussions, consumers expressed a desire for information and education on nutrition, exercise and chronic disease prevention. Consumers typically obtain health information from their providers (both public and private). A survey in rural Kyrgyzstan in 2007 (ADB) found that 78 percent of those surveyed reported getting health information from the local health facility. Many also seek information primarily from pharmacists, largely because this advice is free and easy to obtain. Interestingly, despite the continuous production of pamphlets, leaflets and posters on various diseases and health programs, few focus group participants mentioned these materials as influential information sources with the exception of short-lived campaigns such as for immunization or HIV. A more rigorous examination of KAPs on this topic would be ideal.

Consumers also indicated that they get information on health from television programs and newspapers. Television has the widest reach of mass media in all three countries and ownership of TV sets remains at nearly 100 percent. Several long-established programs on television address health issues and are popular with consumers. These programs tend to follow a traditional public affairs format and report on various aspects of health care and specific health and disease topics.

Government

**Government institutions are making efforts to address health promotion and disease prevention, though resources and staffing are limited.**

Currently, the responsibility for health promotion, which was under the Sanitary and Epidemiologic Service (SES) in the Soviet system, is performed by different entities in each country. Of the countries visited, Kyrgyzstan has the most developed approach with a separate health promotion unit operating under the Ministry of Health (MoH) with staff, budget and a health promotion strategy that guides national efforts. Health promotion in Albania is bifurcated between two MoH structures, the Institute of Public Health (IPH) and the Department of Public Health (DPH). The IPH establishes policy while the DPH maintains an operational and technical role. The SES and the central MoH both conduct health promotion activities in Armenia, depending on the initiative and donor funding. Although Albania does not have an SES per se, it has an equivalent entity with the same role. Efforts to address consumer involvement and health promotion have increased in recent years, but funding and support for efforts addressing chronic diseases is still limited. While the countries visited have existing national health promotion strategies, government agencies addressing health promotion do not appear to have the resources and staffing to implement these strategies fully.

**SES officials at *rayon* levels seem open to change.**

The SES offices at the local *rayon* or sub-district level seem open to change. For example, in Kyrgyzstan, the ZdravPlus project is promoting collaboration among the *rayon* SES, curative services, health promotion unit and the local administration. However, national SES officials seem more focused on the central structure and traditional roles rather than a consumer-oriented public health service.

### **MoH Press Offices are forging a better relationship with the media.**

Health promotion messages are often released by different offices within the MoH, and this has confused the media and the public. Though more coordination is necessary, each country did have a MoH Press Office that is cultivating the relationship between the media and the MoH. As journalists interviewed commented, MoH press offices (especially in Armenia and Kyrgyzstan) have had a positive impact on health issue coverage and accuracy of reported information because they are responsive to the media and meet media timelines. These press offices must also identify and train media spokespersons who are health specialists to represent the MoH to the public. The long-term future of the Armenian MoH press office seems somewhat secure, while Kyrgyzstan's MoH press office still appears dependent on USAID funding. The team did not collect as much information on the press office in Albania.

### Donors

#### **Donor-funded consumer-oriented health programs are growing in the region.**

Most national health programs are still disease or topic specific (e.g. HIV, TB and family planning) as they are usually donor supported and related to the donor's development agenda. However, efforts in the region are growing to empower health care consumers. These programs typically involve international NGOs in partnership with local groups. One promising intervention, community-based volunteer health groups, are operating in all three assessment countries to motivate consumers to participate in health planning and decision-making in their communities. Health care consumers involved in this intervention are more satisfied with services and programs that address the needs of communities, though only a small percentage of the population participate. In fact, the assessment team noticed a huge disparity between the positive, more empowered attitudes of consumers toward health care in areas with community-based volunteer groups compared to the negative, underempowered attitudes of focus group participants in areas where no community-based volunteer groups operated.

### NGOs

#### **Civil society organizations are becoming active in health consumer activities.**

Previously, NGOs in this region were focused primarily on democracy and governance, but this trend seems to be changing as donor support changes. Several civil society organizations in all three assessment countries are starting to promote patient rights, patient information and consumer protection, aided by new legislation on public health. These advocacy efforts provide a supportive environment for health promotion efforts to develop. For example, in Kyrgyzstan the Finnish Lung Health Project, in conjunction with the MoH Tobacco Control Office, has been working on tobacco control legislation. Active patient advocacy groups for diabetes, hypertension and asthma are also functioning. In Albania, the human rights organization Mjaft, (which translates to "Enough" in English) has targeted health, in particular improving health services and quality of care, as its next initiative. The Albanian Center for Population and Development is an NGO active in lobbying for reproductive and sexual health rights. In Armenia, the Open Society Institute (OSI) is active in building legal capacity for improving human rights concerning health and social protection. Community-level NGOs are also involved in health planning committees with local leaders. For example, in Armenia, Project NOVA is building the capacity of local NGOs to train and supervise community-based volunteer groups.

### Health Care Providers (including Pharmacists)

#### **Health system reform and perceived low income has increased the health care provider workload.**

Health care providers consider low pay as a huge barrier that causes many to seek jobs in neighboring countries where pay is higher. It also seems to be the catalyst for many to seek additional “under the table” payments from patients. In Kyrgyzstan, a government family doctor earns about \$40 per month; as a result, many doctors have migrated to Russia and Kazakhstan.

Health workers also view health system reform as more burdensome; providers see an increased number of patients and have less time for counseling. Many feel that the reduction of specialists and the consolidated Family Medicine specialty have resulted in more tasks and more patients for fewer staff. MoH officials and health personnel indicate that providers are aware of the importance of patient rights and the need for improved counseling skills, however, widespread dissatisfaction among health workers over low pay, large case loads, and lack of adequate medical equipment override their ability to provide additional counseling.

#### **Pharmacists are an important source of health information for consumers but under-utilized as a communication channel.**

The focus groups indicated that pharmacists are a source of health information for many, but the vast majority of pharmacists are not trained to counsel consumers and are generally not being adequately used as a potential source to distribute legitimate health information to the public.

### Media

#### **News reporting is largely reactionary.**

In general, news reporting about health is largely reactionary or based on newsworthy stories when they occur, such as disease outbreaks or poor hospital conditions. Investigative journalism exists in a nascent stage—rural health facilities in Kyrgyzstan, and hospitals in Albania have been examined. A few health-specific TV programs and newspaper columns provide consumers with information on health services and disease prevention.

#### **Members of the media are highly interested in training on disease-related issues.**

Journalists in all three countries expressed interest in disease-driven issues and have occasionally received training on topics such as HIV or TB, primarily through the local NGOs or donor programs. Both the media and health personnel tend to focus on disease-related issues while ignoring health-driven issues.

## **VII. Key Findings – Catalysts for Health Care Consumer Empowerment**

The assessment team identified three catalysts for consumer empowerment:

- 1. Community-based volunteer groups that involve consumers directly in health service delivery and health issues affecting the community**
- 2. Mass media or specifically, television programs dedicated to health issues**
- 3. NGOs that advocate support for health promotion legislation**

### Community-Based Volunteer Groups

The assessment team considered community-based volunteer groups as the intervention with the most potential for empowering consumers, though the program was at different stages of development in each country. While the population in each country generally had a negative view of the health care system and did not feel empowered, the small percentage of the population engaged with community-based volunteer groups did feel empowered as health care consumers and had a greater feeling of ownership of their own health care as well as of the health facilities in their communities. The assessment team's findings indicate that community members who are empowered in one area, such as health, are more likely to mobilize and remain active in their communities in other areas such as education or agriculture, than their underpowered counterparts. For example, once volunteer groups in Armenia refurbished their local health facilities, several groups decided to create additional change in their villages by developing irrigation systems and/or building a kindergarten.

The intervention model in each country visited differed depending on the cooperating agency or NGO implementing the program.

<b>Country</b>	<b>Name of Intervention</b>	<b>Implementing Agency</b>
Kyrgyzstan	Village Health Committees	<ul style="list-style-type: none"><li>• Swiss Red Cross</li><li>• ZdravPlus</li></ul>
Albania	Village Health Teams	<ul style="list-style-type: none"><li>• Proshendetit</li><li>• American/Albanian Red Cross</li></ul>
Armenia	Health Action Groups	<ul style="list-style-type: none"><li>• Project NOVA</li><li>• Primary Health Care Reform (PHCR) Project</li></ul>

Each model follows a similar process. The first step involves project and local health promotion staff conducting a participatory appraisal with a community to reach consensus on health problems. The problems are then ranked in terms of priority and capacity to achieve results. For the first time, many health care consumers participate in the problem-solving and decision-making process in their communities.

Common factors across all models include:

- Communities decide together on priorities, which are largely disease-driven, and then obtain training from donor projects on specific health issues and how to communicate with their friends and neighbors.
- Campaigns are carried out by the community; outreach includes door-to-door visits, assemblies at schools and town hall meetings.
- Most volunteers observed were already trusted members of their communities (village teachers, community leaders, etc.). In several communities in Kyrgyzstan and Albania, the head of the student council participated in the community-based volunteer group to bring the youth perspective.
- The health teams always include one health care provider (doctor or nurse) from the community so that volunteers work very closely with the local health facility.

- Health information campaigns conducted by volunteer groups usually are assessed by the volunteers themselves, based on information recall collected by questionnaires soon after each campaign has ended. Typically, very high knowledge rates are found.

There were some distinctions between each country in terms of models, focus, stage of development and level of sustainability.

#### ❖ *Kyrgyzstan*

Kyrgyzstan has more experience with volunteer-based groups than other assessed countries; more groups existed involving a greater proportion of the population (mostly because interventions have been implemented for a longer period of time). This program serves as a model. Community-based volunteer groups work in approximately 96 percent of villages across seven *oblasts*. The MoH has adopted a singular community volunteer model and now requires all community volunteer projects to be approved by the health promotion unit. The model was first developed by the Swiss Red Cross in 2003 and is now being scaled nationwide through a joint effort by the Swiss Red Cross and USAID ZdravPlus.

Volunteers under this model are elected by their communities and it was observed that they feel a personal responsibility for the job. The assessment team met volunteers in Kyrgyzstan who had been continuously active for four years, demonstrating a sense of dedication and pride associated with the committees.

Since each community decides on their own priorities, campaign topics varied. However, iodine deficiency, anemia, brucellosis, childhood illnesses (such as diarrhea), smoking and alcohol abuse are examples of topics chosen by communities in Kyrgyzstan. Communities conduct informational campaigns and many support the focus areas with civic enforcements. For example, one village health committee in rural Kyrgyzstan conducted an alcohol abuse prevention campaign. Afterward, the community decided not to sell any alcoholic beverages to children under the age of 18 and to close shops at 7 p.m. because a survey found people often buy alcohol at night.

The team observed a richer sense of ownership in terms of sustainability. Many communities conducted their own fundraising initiatives, such as local concerts and health fairs, to raise money for transport to visit families in more remote areas and to buy supplies. Though not yet completely sustainable, these programs are making progress.

#### ❖ *Albania*

In Albania, village health teams operate projects similar to those in Kyrgyzstan in 16 districts (in 5 of 12 regions) with funding from Proshendetit. The focus of the American/Albanian Red Cross is on child survival and family planning in 183 community-based volunteer groups. In communities visited, volunteers reported that people in the community dialogue more about health after the groups have been active. Nurses and doctors also confirmed that people are asking more questions now about health services and prevention.

## ❖ Armenia

In Armenia, health action groups decide their own priorities in the Primary Health Care Reform (PHCR) project while family planning/maternal and child health are the priorities of Project NOVA. Community-based volunteer groups are still largely in pilot mode and cover a relatively small population nationwide. However, in communities where the groups have been active, the team observed changes in the villagers' mentality. Some villages have taken the action groups to a new level by forming sub-committees on other issues such as building irrigation systems or kindergartens, which was noted in several communities as reported by Project NOVA.

### *Barriers*

With regard to community-based volunteer groups, barriers include:

- 1. Sustainability.** The sustainability of volunteer groups is a major concern of both the project staff and the volunteers themselves, since initiatives are nearly entirely donor driven. Various techniques are being applied to promote self sustainability, such as local income generation, training volunteers to apply for grants, and concurrently establishing a local NGO to take over coordination and training when the donor project ends.
- 2. Limited Local Capacity.** The capacity of health department staff at the *rayon* level to design, develop and implement programs and materials is limited. In most projects, technical assistance is given by donor project staff or subsidized by donor funds.
- 3. Limited National Capacity.** Although national policy makers are well informed and supportive of donor projects, they lack the skills to promote volunteer groups, to maintain, monitor and establish new volunteer groups and to develop new communication initiatives.
- 4. Small Scale of Community Interventions.** Most programs are conducted in rural areas and therefore affect only a small percentage of the population in each country.
- 5. Little Data on Results/Cost Effectiveness.** Reports concerning cost effectiveness of community-based volunteer projects were not available, either from the literature or country visits. Most projects reviewed are still relatively new, so evaluating either their impact or cost effectiveness is still premature. In addition, most monitoring and evaluation done by volunteer groups is by self-assessment and somewhat superficial.

### *Mass Media*

The second catalyst for health care consumer empowerment is mass media, which is an important means to create high visibility for health issues. Media advocacy, in addition to providing issue or campaign-specific information, works to shape the public discourse about health and can also increase audiences for news outlets.

As previously noted, television is widely available, even in remote areas, and is regularly used to obtain visibility for MoH and donor campaigns. Some television programs that are widely watched include:

Country	Program	Details
Kyrgyzstan	<ul style="list-style-type: none"> <li>UNICEF cartoon</li> </ul>	<ul style="list-style-type: none"> <li>This 3-5 minute program broadcast in schools and occasionally on national television has wide popularity and recall.</li> </ul>
Albania	<ul style="list-style-type: none"> <li>“The Body and Health”</li> <li>“Fiks Fare”</li> </ul>	<ul style="list-style-type: none"> <li>This half-hour show, the longest running program on television (30 years), is broadcast weekly to a national audience and features a doctor answering health questions.</li> <li>This daily program broadcast to a national audience exposes corruption and “under the table” payments to doctors with hidden cameras and has a humorous bent.</li> </ul>
Armenia	<ul style="list-style-type: none"> <li>“Health”</li> <li>“Your Right to Healthcare”</li> </ul>	<ul style="list-style-type: none"> <li>These two-hour MoH productions air twice weekly to a national audience.</li> </ul>

Although each MoH mentioned developing an entertaining health series with a health theme as a long-term goal, currently no program exists such as the soap opera about IMCI that was produced by ZdravPlus in Uzbekistan with USAID support.

### *Barriers*

With regard to media, barriers include:

**1. Cost.** Airtime for media messages is extremely expensive. While donor projects and governments have successfully negotiated with television stations in the past, it seems to be increasingly difficult.

**2. Politics.** While efforts exist in these countries to adopt legislation to require stations to allow free or discounted airtime for public health messages; legislation has not yet passed. In at least two of the countries it was mentioned that the legislation has not passed because members of parliament own many of the private stations.

### NGO Advocacy

The third catalyst observed during the assessment visit was the swell of NGOs that promote health issues, health care reform and health service delivery can create an enabling environment for health consumerism.

Existing NGOs that have traditionally focused on other issues are now focusing on health. Examples of promising advocacy projects in each country include:

Country	Details
Kyrgyzstan	<ul style="list-style-type: none"> <li>• The Finnish Lung Health Project, in conjunction with the MoH Tobacco Control Office, has been working on tobacco control legislation.</li> <li>• Patient advocacy groups exist for diabetes, hypertension and asthma.</li> </ul>
Albania	<ul style="list-style-type: none"> <li>• Mjaft, a human rights organization has targeted health, in particular, improving health services and quality of care, as its next initiative.</li> <li>• The Albanian Center for Population and Development is an NGO active in lobbying for reproductive and sexual health rights.</li> </ul>
Armenia	<ul style="list-style-type: none"> <li>• The Open Society Institute (OSI) is building legal capacity for improving human rights concerning health and social protection.</li> </ul>

Although progress has been slow and results are mixed, the concept of using legislation to protect health consumers has been established in all three countries. New public health and pharmaceutical laws being developed include health consumer protection and patient rights. Legislation to protect consumers against tobacco in Kyrgyzstan has been bold, but not yet successful. In the other two countries, laws limiting smoking areas have passed, but are not entirely successful because enforcement is inadequate.

In Armenia, OSI has been building legal capacity for improving human rights around health and social protection. In 2001, OSI developed modules for improving long-term care accommodations and rehabilitating state institutions, including the prison system. OSI works to promote the rights and legal protection for marginalized populations, such as drug users, particularly around reducing HIV transmission risk. They have also worked with the American University in Armenia on tobacco control. OSI builds institutional and national capacity by developing and incorporating legal issues and consumer protection into medical and law school curricula. They provide fellowships for law and health specialists and plan to train local NGOs and lawyers on law and health issues. Currently, OSI is developing a legal guidebook on patient rights that should be available through the OSI website in September 2008. They will advocate for including human rights protection in the new Public Health Law being developed and will promote proper monitoring of health institutions and facilities.

Mjaft serves as a local government watchdog in Albania and has been involved with reforming the education sector. Currently, they are preparing a campaign to raise awareness about the poor quality of health services. Mjaft recently conducted research into health system issues that revealed three main problems: (1) access, (2) service and infrastructure, and (3) finance and administration. According to Mjaft, health is not a government priority. They noted that many hospitals and primary health centers in rural areas do not even function. Consequently, many people with illnesses go directly to hospitals in the larger cities. The Mjaft report also highlighted the informal payment system for health care. Although reportedly 3 percent of government expenditures is allocated to health, adding informal (or out of pocket) payments could increase

actual expenditure to as high as 6 percent. Mjaft wants to find a way to include informal payments as part of the health care system. They “bombard” the media with prepared articles on human rights issues and also organize street demonstrations.

## VIII. Conclusions

**In general, especially in areas where USAID-funded projects are not underway, health consumers lack “power” in terms of their own health care, the services rendered to them in public facilities and in the basic relationship of doctor to patient.** There is a common lack of trust in the system, services and providers. Having to pay extra for free services that are low quality was particularly vexing to consumers and detracts from consumer empowerment.

**Donors have been addressing important health issues in the region through targeted campaigns.** Two out of the three assessment countries’ MoHs have been addressing health issues through their public information efforts in the media. However, traditionally, these efforts tend to be focused on particular disease topics (i.e. HIV and AIDS or TB) or a calendar of monthly health issues.

**More recently, however, a newer wave of programs in all of the countries visited and throughout the region has begun to focus on health promotion, consumer empowerment and health policy changes. Consumers are reacting positively to these interventions, but more needs to be done.**

- Various projects are empowering consumers with information to make decisions related to select disease prevention and health care issues, ranging from avian influenza, to HIV and AIDS, to family planning.
- Television programs and newspaper stories are being used to inform and educate consumers about health promotion issues, consumer rights and specific health topics.
- NGOs are taking on health issues in their advocacy agendas.
- Pilot programs designed to involve the consumer in health care agenda setting and delivery are emerging as promising interventions in all three countries and in the region.
- Health care consumers are demonstrating that they can be effective agents and advocates for improving their individual health and that of their family. They need not be passive consumers relying solely on the health system to take care of their health. On the contrary, they have the power to assume much more of this responsibility themselves.

**Currently, there are no sustained efforts that address the long-term health issues related to chronic diseases which are the health issues affecting most consumers.** Health reports from the region forecast a wave of chronic diseases related to lifestyle (e.g. high smoking rates, poor diet, and lack of exercise). Most efforts to date have been sporadic at best. Consumers in the region are hungry for information and education on these topics. It appears that now is the time for addressing these issues in a long-term, systematic way.

**To affect behaviors related to chronic disease requires a long-term commitment to interventions that address the individual, the community and decision makers, as well as laws and policies related to high-risk behaviors** (e.g. smoking restrictions). To be sustainable, it will also require support by the private sector, government, donors and civil society.

## **IX. Recommendations**

Empowering health care consumers to take more responsibility for their own and their family's health will not be achieved by a single intervention alone, but through adequate reforms and long-term behavior change communication interventions supported by legislation and legal actions. Many efforts already underway in the E&E region are beginning to follow this approach; however, more needs to be done.

To initiate and sustain empowered health care consumers and more effectively address chronic diseases, C-Change recommends working with governments to develop an overarching health promotion strategy that is based on behavioral research and the epidemiology of each country. Individual behavior change related to healthy lifestyles must be supported by a “conducive environment” that reinforces the change through structures, programs and policies to create a new social norm of empowered consumers who are ready and willing to take responsibility for their own health and that of their families. Under a common health promotion strategy, a plan for empowering consumers would involve multi-dimensional interventions involving:

- Governments
- Health Care Providers and Pharmacists
- Communities
- Private Sector
- Media
- Civil Society
- Research

Representatives of all major stakeholders should be involved in developing the health promotion strategy for greater ownership of messages and more informed action.

Following are specific recommendations to consider in each area to be developed under a common strategic plan.

### *Governments*

#### **Support government structures, programs and policies that address health promotion.**

This assessment found that health promotion planning is underway through various government structures, yet more is needed to ensure that these organizations have the resources and “vision” to develop sustainable health promotion programs to empower consumers. Donors can be advocates to ensure that government health programs address emerging health problems that countries in this region face. They also can ensure that these structures have adequate resources (both finances and staffing) to function. Donors can also support an effective and efficient structure for health promotion and behavior change communication (BCC) within a MoH.

Roles and responsibilities for health promotion units should be clearly defined and include the ability to:

- Develop a health promotion strategic plan that can guide the work of all stakeholders.
- Create print, online and broadcast educational materials or have the expertise to work with a communications agency to develop needed materials.
- Work with stakeholders such as media, NGOs, regional and community leaders, health care providers, private sector groups and other organizations to ensure their support and provide them with trusted and relevant communication messages, information and materials.
- Work with the health sector to ensure services actively promote health.
- Develop and support policies that promote health and empowerment of consumers.

Donors can support meetings to bring stakeholders together and to monitor program implementation. Donors can also support the planning efforts of these units to develop evidence-based health promotion and disease prevention policies and plans by conducting appropriate research, behavioral surveys and studies.

#### **Collaborate with local SES for community data collection.**

More reliable consumer-focused targeting and monitoring of health promotion initiatives could be achieved by realigning the SES from providing broad-scale incidence rates to more community-oriented information and analysis. This does not require training specialists, but rather refocusing on the fundamentals of public health epidemiology. Although U.S. government assistance trains epidemiologic specialists (i.e. the field epidemiology training program [FETP] course in Almaty, Kazakhstan), the impact of this training does not reach the consumer level. In fact, MoH officials in Kyrgyzstan mentioned that few who receive this advanced epidemiologic training return to government service. USAID's ZdravPlus project in Kyrgyzstan has made considerable progress promoting evidence-based health promotion by developing an epidemiologist training manual for *rayon*-level (sub-district) epidemiologists, based on the CDC FETP course.

#### Health Care Providers and Pharmacists

##### **Build the capacity of health care providers and pharmacists to participate in educating consumers.**

In addition to structural changes, health promotion should address both infectious and chronic diseases within the current context of health facilities. The public health sector should include training and capacity building for health care providers to inform and counsel their patients on the causes of health and of disease to help them make more informed choices. For example, research in tobacco control indicates that a counseling session between the provider and patient is one effective tool for helping smokers quit.

As economies continue to grow in the E&E region, the public is turning more often to the private sector. Pharmacists, who largely operate privately, are more frequently sources for advice about health problems and, owing to the rapidly increasing cost of living and health care, for primary treatment of illness, particularly in urban areas. Pharmacists are an underused avenue for disseminating health messages and should participate in training and capacity building efforts.

Health care providers and pharmacists should also be active participants in developing a strategy for health promotion creating greater buy-in and action for key messages and activities.

Successful programs in Finland, Singapore and other high-income countries suggest strongly that reducing identified, modifiable dietary and lifestyle risk factors could prevent most cases of CVD, diabetes and many cancers among populations in developing countries. This includes changing behaviors related to smoking, physical activity and diet. In addition, investments in education, food policies and urban physical infrastructure are needed to support and encourage these changes (Disease Control Priorities Project 2006).

### Communities

#### **Take community-based volunteer groups to scale.**

Developing community initiatives should be a key component of a health promotion strategy. Health care consumers involved in community problem solving and decision-making processes report having more say and “power” in their health care and service delivery. Communities with volunteer groups discuss health care more often and question health workers about preventing disease and available services. The assessment team observed that the momentum from empowered consumers carries over into other aspects of community welfare. For example, once volunteer groups in Armenia refurbished their local health facilities, several groups decided to create additional change in their villages by developing irrigation systems and/or building a kindergarten.

These initiatives also link the health system with the community by including local physicians and nurses or midwives in the volunteer group. This approach both improves the effectiveness of outreach communication and improves the communication and relationship between the community and the health provider, a critical factor for empowering consumers.

Maintaining the momentum of these community programs and enhancing the systems, structures and tools they have developed is critical. Next these community-based volunteer interventions should be taken to scale to achieve greater impact by affecting greater numbers of consumers. Risk assessment programs can be developed to use volunteer-based health groups in schools, universities, and youth organizations to address the younger generation. Efforts could include developing risk assessment tools that relate to lifestyle choices followed by a series of onsite interventions – such as health fairs and screenings – that target key positive health behaviors and stimulate community dialogue and discussion on health behaviors. Media interventions can help educate consumers about the programs and the changes that consumers are making through their own efforts. These messages reinforce important empowerment themes and help create interest and involvement in these activities. Civil society can ensure that these programs are coordinated nationally with established standards and have the support and commitment of decision makers and the government.

### Private Sector

#### **Engage the private sector to provide products and services directly to the consumer by supporting market development.**

Various health programs have demonstrated that involving the private sector has contributed positively to changing health behaviors through consumer education and delivery of quality products and services. Donor financing can help to develop the market for local companies to make their products available to consumers (e.g. in family planning, smoking cessation, and hypertensive drugs) and support product marketing. Supporting “Direct-to-Consumer” health promotion creates a more informed consumer who then puts pressure on health providers for better quality, more choices, respect, and accountability. For example, it is possible to improve the social norms around acceptability of modern contraceptives through advertising and sales promotions, spurring consumers to make more informed decisions.

#### **Encourage employers to take the lead in promoting positive lifestyles and health promotion programs for employees.**

Public/private sector collaboration on health promotion and disease prevention can start in the workplace. Private sector organizations will be greatly impacted by the loss of productivity related to chronic diseases. Internationally, private sector companies have supported successful health promotion programs for employees and their families which can be captured and adapted for companies in the region. Large private sector organizations (such as Azerbaijan International Operating Company, Albanian Petroleum Investment and Grand Candy in Armenia) can take leadership roles in developing and implementing workplace health promotion programs for their employees, resulting in a more informed and empowered workforce.

### Media

#### **Engage media in health promotion issues and expose them to programs that are making a difference.**

To ensure factual information in the press, journalists must be trained on health-related issues. Given their very limited budgets, journalists are eager for additional training and the opportunity to travel to remote areas to interview health care providers, project staff and volunteers, or local officials. Training journalists on health-related issues and providing them with opportunities to speak with those involved in local initiatives helps to foster long-term relationships with the press and ensures increased coverage and more accurate reporting.

#### **Seek collaboration with MoH Press Offices to engage media in promoting health.**

MoH Press Offices are a key partner for USAID in distributing health messages and guiding health promotion efforts in each country. Developing or supporting current MoH press offices will build a positive relationship between the media and the government and increase frequency and accuracy of coverage. For example, conversations with media and NGOs in Kyrgyzstan suggest that the MoH Press Office (supported by ZdravPlus) has built a more trusting relationship with reporters, leading to more cooperation and increased health messaging in the media. Examples of additional activities to support BCC messaging in the media include identifying and training MoH media spokespersons, working with advertising and marketing agencies to improve BCC programming, and engaging university communication departments to strengthen in-country capacity for health journalism.

### **Develop television formats that engage, educate and activate the consumer.**

Media programs that focus on health are logical targets for engaging consumers and increasing their attention to health promotion messages. These messages, which are ideally reinforced from other sources, help create a dialogue among social networks about health issues and drive consumer action. Since television has the widest reach of any medium in the region, we recommend that USAID invest in longer-term television programs that can address health promotion issues over time and in-depth. Based on specific risk behavior research, key positive health behaviors can be modeled through the media, such as presenting physically fit, active, engaged non-smoking and non-drinking young people as cool, positive role models who receive social acceptance and social rewards. For example, a national or regional soap opera in each country could be linked to communication activities. Countries in Africa and Central Asia have introduced such programming and have shown successes in changing community norms and individual behaviors around a series of issues such as IMCI, domestic violence, and STIs. As part of the “Stop Diarrhea” campaign in Uzbekistan, ZdravPlus created a soap opera that coincided with community activities including health fairs and live theater performances. The campaign also went hand-in-hand with clinical training for doctors and nurses.

### Civil Society

#### **Energize NGOs to focus on legal and structural issues that hinder health promotion and empowerment programs.**

A key element in empowering health care consumers is supporting the growth of NGO advocacy efforts; building capacity through media training and developing an agenda to advance health promotion. Tobacco and alcohol control is one example: by advocating for increased taxation, smoking bans, and regulation of product advertising and promotion, studies have shown that countries can decrease the incidence of several major cancers, including lung, esophageal and liver (Disease Control Priorities Project 2006). USAID can consider supporting NGOs that advocate for health promotion issues in several ways: tap the vibrant international tobacco control network to provide support and capacity strengthening for these NGO efforts; capture and share regional examples of NGO success in promoting a positive health agenda; and enable NGOs to monitor and help reinforce health policies and programs in the region to support long-term, sustainable programs.

### Research

#### **Invest in research that supports and strengthens health promotion and empowerment programs.**

To support the activities recommended above, C-Change suggests conducting research that includes:

- Evaluating the impact of community interventions using data from several countries.
- Identifying critical individual and social determinants that impact high risk behaviors.
- Examining the effect of combining interventions on health consumerism.
- Carrying out more in-depth sociological, quantitative research with consumers in both rural and urban areas to define cultural barriers and to determine what the consumers believe will empower them to make their own health decisions.

- Collaborating with national and local health promotion structures to gather baseline data about health behaviors for planning evidence-based programs for consumers. No behavioral data exist in any country visited on which to base health promotion programs. If programs are developed to address consumer empowerment and health promotion, surveys and other behavioral studies will be important to validate the programs and help measure change over time. Donors that support health promotion efforts can support such studies.

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**Appendix 1A – Final E&E Assessment Team Interview List  
Kyrgyzstan  
June 4 – 12, 2008**

**June 5-7, 2008: Site Visit to Issyk-Kul Oblast, Ton Rayon (Rural Kyrgyzstan)**

**Friday, June 6**

- 9:00 a.m. – Public Health Coordinator, Ton Rayon, ZdravPlus
- 10:00 a.m. – Deputy Head of Administration, Ton Rayon Administration – Turabik Tumenbaev
- 11:15 a.m. - Director of FMC (Family Medical Center) – J.A. Sansyzbaeva
- 12:15 p.m. – Chief Doctor of Ton Rayon Hospital
- 3:45 p.m. – FGP (Family Group Practice) in Burkut Village – Armira Alybaeva, Doctor, and Rosa Chekirov, Nurse

**Saturday, June 7**

- 9:30 a.m. – SES Director – Omurbek Abykeev
- 10:30 a.m. – Health Promotion Unit Specialists – Elmira Duschaeva and Altani Okunova
- 11:30 a.m. – Visit to Village Health Committees (VHCs) in Tort-Kul Village
- 12:30 p.m. – Visit to VHCs in Ak-Cay Village

**June 9–12, 2008: Interviews in Bishkek**

**Monday, June 9**

- 9:30 a.m. – Department of Public Health, Director – A.S. Sydykanov
- 11:00 a.m. – World Bank, Health Programs Specialist – Asel Sargaldakova
- 2:00 p.m. – Health Promotion Center - Gulmira Aitmurzaeva, Director, and team
- 3:30 p.m. – Tobacco Control - Chinara Bekbosarova, National Coordinator

**Tuesday, June 10**

- 9:00 a.m. – Health of Licensing and Medical Care Department, MoH – Dinara Sagymbaeva
- 10:00 a.m. – ZdravPlus – Greg Garrett, Country Manager
- 11:00 a.m. – UNFPA – Cholpon Asanbaeva, National Programme Officer on Reproductive Health
- 1:30 p.m. – Swiss Red Cross – Tobias Schuth
- 3: 00 p.m. – Family Group Practice Association – Syumjan Mukeeva, Director
- 4:00 p.m. – CAPACITY – Nurgul Kinderbaeva, Director
- 5:15 p.m. – Internews – Mariya Rasner, Country Director, and journalist team

**Wednesday, June 11**

- 9:30 a.m. – MoH Press Center - Elena Bayalinova, Director
- 11:00 a.m. – USAID Mission Representative, Health Specialist – Damira Bibosunova
- 1:00 p.m. – Republican SES – Ludmila Davydova, Deputy Director
- 3:00 p.m. – UNICEF - Cholpon Imanalieva, Programme Officer, and Farhad Imambakiyev, Project Officer, Communications

- 4:00 p.m. – Asia Development Bank, Asel Chyngysheva, Project Officer
- 5:00 p.m. – Pharmacist

**Thursday, June 12**

- 9:00 a.m. – Finnish Lung Health Project – Lilia Niemi
- 10:00 a.m. – Hospital Association – Kubanichbek Jemuratov
- 11:30 a.m. – DFID – Melitta Jakob
- 2:00 p.m. – MoH Continuing Education Center (ZdravPlus) – Barton Smith
- 4:30 p.m. – MIR TV – Evgenia Lim, Health Reporter
- 5:30 p.m. – Pharmacist in Bishkek

**Appendix 1B – Final E&E Assessment Team Interview List  
Albania  
June 16 – 19, 2008**

**Monday, June 16**

- 9:00 a.m. – USAID Mission – Zhaneta Shatri
- 11:00 a.m. – MJAFT (Human Rights Organization) – Elisa Spiropali, Policy Officer
- 1:30 p.m. – Access-FP – Galina Stolarsky, Country Coordinator, Altina Peshkatari, BCC Program and Enriquito Lu, Director of Family Planning/Reproductive Health, Jhpiego
- 3:00 p.m. – URC Proshendetit – Paul Richardson, Chief of Party and Dorina Tocaj, Health Promotion and BCC Specialist
- 5:15 p.m. – American Red Cross – Anila Gjoni, Operations Manager and Manuela Murthi, Consultant with ARC

**Tuesday, June 17 – Site Visit to Burrel (Rural District in Northern Albania)**

- 9:00 a.m. – American Red Cross – Sanie Meta, Local Coordinator
- 10:00 a.m. – Burrel District Public Health Director – Gani Korsita
- 12:00 p.m. – Useful Help For Albanian Women NGO Director – Natasha Ballabani
- 1:00 p.m. – Village Health Team in Komcemuzhak Village
- 3:15 p.m. – Head of Media Association and Local TV Station – Luftim Vani
- 4:30 p.m. – Health Promotion Unit in Burrel

**Wednesday, June 18**

- 9:00 a.m. – UNICEF – Dr. Marianna Bulki, Health Officer, and Alketa Zazo, Youth Officer
- 10:00 a.m. – Albanian Red Cross – Zamir Muca, General Secretary
- 11:30 a.m. – Institute of Public Health – Jeta Lakrori, Head of Promotion Department
- 3:00 p.m. – MoH – Gazmend Bejtja, Director of Public Health Unit and Eda Pullumbi, Health Promotion Unit
- 4:15 p.m. – Albanian Center for Population and Development (ACPD) – Dr. Elona Gjebrea
- 4:15 p.m. – World Bank – Lorina Kostallari, Operations Officer
- 5:15 p.m. – Nesmark (Social Marketing) – Ardian Paravani, Executive Director
- 6:00 p.m. – SHQIP Newspaper – Lorina Mixha, Reporter on Mother Theresa Hospital in Tirana
- 7:00 p.m. – Health Insurance Institute – Gazment Koduzi, Director of Doctors Directory

**Thursday, June 19 – Site Visit to Lezhe (Northern Coastal District)**

- 9:00 a.m. – URC Proshendetit – Aferdita Gjoni, Local Coordinator
- 10:00 a.m. – Health Promotion Unit – Mirela Ndoi and Flora Koldodaj, Nurses
- 12:00 p.m. – Manati Village Health Team in Kolsh Commune – Age Deti, Nurse and Adevie Pergjini, Volunteer plus Marinela Leka, Local Doctor
- 2:00 p.m. – Pharmacist in Tirana
- 4:00 p.m. – Pharmacist in Tirana

**Appendix 1C – Final E&E Assessment Team Interview List  
Armenia  
June 22 – 27, 2008**

**Sunday, June 22 – Site Visit to Charenstavan in Kotayk Marz, Central Armenia**

- 4:00 p.m. – Charentsavan City Hospital – Artur Danilchenko, Family Doctor

**Monday, June 23**

- 9:00 a.m. – Project NOVA – Inna Sacci, Chief of Party
- 10:30 a.m. – AUA Center for Health Sciences Research – Varduhi Petrosyan, Director
- 12:00 p.m. – USAID Mission Social Reform Office – Karen Nahapetyan, Project Management Assistant
- 2:40 p.m. – Internews (Local NGO) – Nune Sargsyan, Director

**Tuesday, June 24**

- 9:30 a.m. – SES – Artavazd Vanyan, Director
- 9:30 a.m. – MoH Press Office – Ruzlana Gevorgyan, Press Secretary
- 9:30 a.m. – Primary Health Care Reform (PHCR) Project – Rick Yoder, Chief of Party, and Ruzanna Melyan, Public Education Team Leader
- 11:00 a.m. – WHO – Tigran Avagyan, Country Program Coordinator, and Team
- 11:30 a.m. – MoH Primary Health Care Division – Ruzanna Yuzbashyan, Director
- 4:00 p.m. – USAID Implementing Partners Roundtable

**Wednesday, June 25 - Site Visit to Armavir City and Araks Village in Armavir Marz (Western Armenia near border with Turkey)**

- 10:00 a.m. – Armavir Development Center NGO – Naira Arakelyan, Director
- 11:30 a.m. – Focus Group Discussion with 15 Villagers including the Village Mayor, Doctor, Nurses and those involved in Project NOVA's Health Action Group
- 1:00 p.m. – Focus Group Discussion with Community Nurses attending Project NOVA's Safe Motherhood Clinical Skills training and Trainer
- 2:00 p.m. – Focus Group Discussion with OB/GYNs and nurses attending Project NOVA's Family Planning/Reproductive Health Counseling Training
- 5:00 p.m. – Roundtable Discussion with Project NOVA implementing NGOs including Aragatsotn Marz NGO Forum, Ararat Reproductive Health NGO and Armavir (Marz) Development Center

**Thursday, June 26 – Site Visit to Kotayk Marz in Central Armenia**

- 11:00 a.m. – Focus Group Discussion with Community Health Committees
- 1:00 p.m. – Pharmacist in Yerevan
- 2:00 p.m. – Pharmacist in Yerevan
- 3:00 p.m. – USAID Armenia Social Protection Systems Strengthening Project (SPSSP) – Christopher Hartwell, Deputy Chief of Party

**Friday, June 27**

- 9:00 a.m. – Ani and Narod Memorial Foundation – Mara Arshakovna and Zaruhi Beglaryan, ANMF

- 10:00 a.m. – TV Program “Healthcare” and “Your Right to Healthcare” – Shushan Hunyanyan, Reporter
- 10:30 a.m. – Open Society Institute – David Amiryan, Health Program Coordinator, and Anahit Papikyan, External Education
- 2:00 p.m. – UNICEF – Lianna Hovakimyan, Health Programs Coordinator, and Sheldon Yett, UNICEF Representative, Armenia

## Appendix 2 – Assessment Tool for C-Change E&E Assessment

(This tool will be used for in-person interviews only)

This tool will be used to conduct a rapid, focused consultation with key stakeholders in Kyrgyzstan, Albania and Armenia at multiple levels to elicit their perspectives on empowering health care consumers in Europe and Eurasia.

It is intended as a tool to generate discussion rather than as an interview that strictly follows a given format. The guide will be used to identify interventions that are considered best practices within behavior change communication as well as suggestions for innovations in program design within and across sectors. It will ultimately help us develop recommendations for USAID on empowering health care consumers in the region.

To gain a comprehensive view, the inquiry will be aimed at stakeholders working in or influencing the national level in organizations and companies, as well as those working in, influencing or representing the local/community level.

### **I. Health Care Consumers (To develop profiles of consumer and consumer provider audiences and identify any formative research or surveys and verify information we obtain from consumer research)**

1. What is the current relationship of the consumer to the health care system? Positive   
Negative
- a. What contributes to this relationship?
- b. Do you see any group where the relationship is changing?
- c. Are there aspects of health care that are more consumer-focused?

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2. What are the perceived strengths of consumers regarding health services?

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3. What are the perceived barriers that consumers face which hinder them from accessing health services?

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4. Is there consumer interest in public health services, preventive health services, and family health services?

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5. How can we increase consumer awareness in (country) related to health care and public health services?

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6. Within the general public, which specific audiences or groups should we target (e.g. mothers, older people, youth, etc)?

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## **II. Current Programs/Services for Health Care Consumers (To obtain information about current efforts that target health care consumers)**

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1. What are the services available for health care consumers?

- a. Have there been any initiatives to help individuals access health care?
  - b. Are services subsidized? If so, does subsidized health care influence health consumers' access to health services?
  - c. Are there any consumer materials, campaigns, or hotlines in urban and rural areas?
  - d. If a consumer has a complaint about a service or provider is there any recourse he/she can take?
  - e. Is there any participation by consumers or consumer groups at either national or local levels for influencing health services or policies?
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2. What type of programs or interventions currently promote family health services and public health?

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3. Are there any interventions/programs that focus on health care consumers? (Consumer education programs about the health care system, services, etc.)

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4. Do the media play a role in consumer awareness of curative and/or preventive health care services ?

- a. Are there health programs on TV and radio? If so, which audiences do they target and who sponsors them, both financially and with program content?
- b. Is there popular programming (such as country-specific soap operas, etc.) that incorporate health issues into the story line?
- c. Are there newspaper articles or advice columns? If so, what is the MOH's level of participation in these news media articles?
- d. Does web-based information play any role in informing health care consumers? If so, who is the target audience and what are the health topics?
- e. What is the frequency between paid placement versus investigative reporting?
- f. Are there any differences between state and independent media reporting on health issues either in the technical content or frequency of reporting?
- g. Are there examples of health and development programs in the region that have worked closely with the media? If so, which media channels did they use?

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5. Is civil society involved in promoting consumer interest in health care services?

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6. Do government ministries produce health campaigns about any specific topics, or are health campaigns generally driven by donor projects? Does the MoH have the capacity to do this?

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### **III. Health Care Providers**

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1. Have there been any initiatives within the MoH promoting consumer awareness about access, availability of services, or cost of government health services?

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2. Is there any ongoing training or continuing education for health care staff concerning patient and provider relationships? If so, are these activities primarily donor supported?

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3. Do government Health Promotion activities also promote consumer empowerment and awareness of health services, or only awareness about disease and prevention?

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4. What special initiatives has the SES (Sanitary and Epidemiologic Services) initiated to promote consumer awareness?

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5. What is the perceived role of the consumer in prevention and health care according to SES officials?

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6. Are there any civil society organizations or NGO's which have an active role with the MoH at the national level?

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7. Have the MoH or other government sectors attempted to introduce any legislation or laws which promote consumer empowerment and/or protection? Have any consumer groups or NGOs attempted to influence the government on introducing laws or legislation advocating consumer empowerment and/or protection?

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### **III. Possible Approaches/Recommendations**

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1. What are the key issues (messages) we need to address to educate consumers about primary health care and consumer empowerment? (Alternatively, what behaviors do we want consumers to initiate, change, reinforce?) (REMEMBER: this is a multi-year effort so we can weave in a number of messages over the course of the project.)

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2. Are there specific segments of consumers that we should try to address with the messages?

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3. Who do we need to involve in a communication effort for consumer education (i.e. who are the stakeholders, including the government, who have an interest in consumers?)

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4. What approaches/interventions do you recommend to educate consumers about primary health care and consumer empowerment? (Which are most cost effective and trusted strategies by specific audiences?)

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## **Appendix 3 - Empowering Health Care Consumers in the Europe and Eurasia (E&E) Region Literature Review**

### **Introduction**

For almost two decades, the US Agency for International Development (USAID) and other bilateral and multilateral aid organizations have been committed to improving health systems and the health of populations in the Europe and Eurasia region. These reform efforts have demonstrated many successes, strengthening the primary health care sector and health financing in many countries of the region.

Prior to the early 1990s, in many countries of the region, the government provided health care and decisions about health care were centralized. Individuals did not bear much responsibility for their own health and were also deprived of the right to choose where and from whom to receive care. Donor organizations have increasingly recognized that reform efforts must include interventions that will inform and empower health care consumers to take a more active role in the health of themselves and their communities. The rationale for increasing the focus on consumers is multifold, but some important points are:

- 1) Introduction of consumer choice is closely tied to the reorganization of the primary care system;
- 2) Informed consumers are more likely to become active consumers who hold providers accountable and thus play a role in improving the quality and efficiency of health care;
- 3) Increased power in decision making about health care can contribute to the desire for more democratic participation in other parts of society; and,
- 4) The population needs to take more responsibility for their health status to engage in healthier lifestyles (Borowitz et al 1999).

The Communication for Change Program (C-Change) is a worldwide, cross-sector communication program funded by USAID and launched in September of 2007. With funding from the Europe and Eurasia (E&E) Bureau of USAID, C-CHANGE has undertaken an assessment of programs, campaigns, and interventions targeted at health communications, community mobilization and consumer empowerment in the Europe and Eurasia region. This assessment includes a review of the literature on consumer-focused programs as well as site visits to three countries within the E&E region. Albania, Armenia and the Kyrgyz Republic were chosen to represent three areas of the E&E region in which donors were and continue to be particularly needed and active: Southeastern Europe, the Caucasus and Central Asia.

The purpose of this project is to:

1. Document the experiences of E&E countries and donors in empowering health care consumers to take more responsibility for their health and their families;
2. Identify the most cost effective interventions for empowering health care consumers; and
3. Provide recommendations to USAID Missions on how they can more effectively assist E&E countries to empower health care consumers.

## **Methodology for Literature Review**

We include in this literature review documents available from organizations working within the region including multilateral aid agencies (e.g. United Nations agencies), bilateral agencies (e.g. USAID), and non-governmental organizations (e.g. Project HOPE). To provide comprehensive coverage, we examined documents on programs with any clearly identified consumer-focused element. To restrict this review to a reasonable length, we include only projects taking place or completing and reporting on activities within the last 5 years (from 2003 on)<sup>14</sup>. We include only programs for which technical or other reports are available, meaning that new and on-going interventions may not be included due to insufficient data. Nevertheless, this review identifies the current state of consumer empowerment activities within the E&E region.

For the purposes of this assessment, we limit the E&E region to post-socialist states,<sup>15</sup> focusing on those regions which, due to widespread poverty and other factors, are likely to continue to need active engagement with donors to reform their health systems and improve the health of their populations. The countries of Southeastern Europe (including Albania), the Caucasus (including Armenia), and Central Asia (including the Kyrgyz Republic) are therefore the focus of this assessment.

As the programs we identified did not state empowerment as a specific goal but did so indirectly, the works referenced in this text and the reference section reflect our best efforts to define programs as “empowering” based on other characteristics. In addition, the peer-reviewed literature on this topic is almost non-existent, meaning that our primary sources are project documents, including technical, mid-term, and final reports. While these are useful for learning about what projects have been done, without evaluation from independent observers, it can be difficult to accurately gauge the success of interventions.

In researching the cost-effectiveness of interventions, we discovered there was little research available on the topic and thus, included all countries in the developing world in our review.

## **Empowerment and Behavior Change Communication**

As the first step in our analysis, the C-Change and E&E Bureau staff also agreed on a multi-component definition of health consumer empowerment that parallels the World Health Organization’s (WHO) definition relating to health promotion:

*Empowerment is a process through which people gain greater control over decisions and actions affecting their health.*

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<sup>14</sup> This time frame is somewhat approximate: to ensure the review is as comprehensive as possible we include programs for which activities ended before 2003 but which produced reports or evaluations in 2003. We also include some 2002 references for projects that are especially relevant for our purpose.

<sup>15</sup> This excludes Turkey and Macedonia and limits the assessment to Russia, Ukraine, Belarus, Estonia, Latvia, Lithuania, Hungary, Poland, Czech Republic, Slovak Republic, Slovenia, Romania, Bulgaria, Croatia, Bosnia and Herzegovina, Albania, Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan.

Empowerment may be a social, cultural, psychological or political process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve political, social and cultural action to meet those needs. Individual empowerment refers primarily to an individuals' ability to make decisions and have control over his or her life. Community empowerment involves individuals acting collectively to gain greater influence and control over the root causes of health and quality of life in their community.

The following section is a brief review of Behavior Change Communication (BCC) "best practices" that we use to guide our assessment and analysis.

AED uses communication as the key tool for behavior change across programs. AED defines BCC as:

The strategic use of communication to promote positive health outcomes, based on proven theories and models of behavior change. BCC employs a systematic process beginning with formative research and behavior analysis, followed by communication planning, implementation, and monitoring and evaluation. Audiences are carefully segmented, messages and materials are pre-tested, and both mass media and interpersonal channels are used to achieve defined behavioral objectives (AED 2008).

The past few decades have seen a quiet but dramatic revolution in health communication programs with a change from simply informing target audiences to a focus on influencing behaviors – which are specific, measurable and have a direct link to a health outcome – of communities and individuals, recognizing them as participants and as consumers. BCC programs are also closely linked to health care service delivery, supplies and behaviors of health care providers (Roberts et al 1995). They are thus simultaneously more complex than mere presentation of information and offer the possibility of measurable change in behaviors that affect health outcomes, benefits that move beyond those gained when the focus is solely on increasing awareness and knowledge. The challenge moving forward is to design and carry out effective BCC programs to specifically engage consumers of health care to participate in the decision-making process.

BCC campaigns and consumer-focused interventions in general rely on the interest and needs of consumers to be effective. AED (Orleans and Phillips 2007) has identified six steps to build demand for effective health programming: 1) View the target population as consumers and look at the health behavior from consumers' perspectives; 2) Re-design evidence-based products and services to better meet the needs and wants of consumers; 3) Market and promote products and services in ways that reach consumers (particularly underserved consumers) where they are; 4) Use policy changes as opportunities to reach consumers and encourage the desired result; 5) Systematically measure, track, report and study the health behavior and use of the intervention to identify opportunities for and successes of the program; and 6) Combine and integrate as many of these strategies as possible to maximize impact.

In addition to campaigns and interventions focused on individual behaviors and specific health issues, media advocacy is an important component of any overall effort to improve population

and public health. Media advocacy harnesses the power of the media to spread beneficial social messages and focuses on the social conditions helping to create health problems rather than individual behavior change. In contrast to the more individually-targeted messages of social marketing, media advocacy is a participatory approach that recognizes the need for communities to engage in shaping social and health conditions (Communication Initiative Network 2001). As such, media advocacy can be an important tool for empowerment of individuals and communities and its effects can extend far beyond the media sphere.

### **Consumer Empowerment and Cost Effectiveness**

While few reliable studies on cost effectiveness exist, those that do suggest that health promotion and education interventions (which we categorize as empowerment interventions) are cost-effective methods for improving health (Hutchinson & Wheeler 2006).

We recognize that empowerment can include structural changes and transfers of power as well as the more conventional components of traditional BCC programs such as community mobilization, peer education, and health promotion materials. A comparison of HIV prevention interventions among sex workers in Puerto Rico and the Dominican Republic demonstrates that while both are relatively low cost per HIV case averted, the one that includes policy and regulatory changes in addition to BCC campaign components is more cost-effective (Sweat et al 2006). In addition to the effectiveness of intensive BCC programs, mass media campaigns have been shown to be both effective and cost-effective in some contexts even when not paired with other communication channels (Hutchinson et al 2006).

With regard to chronic diseases – representing the majority of deaths in the E&E region (Demography and Health in E&E, USAID 2005) – a number of specific interventions have proven to be cost-effective in developing countries:

- Controlling tobacco and alcohol consumption, through increased taxation, smoking bans and regulation of advertising and promotion has decreased the incidence of several major cancers including lung, esophageal and liver.
- To reduce the risk factors for cancer and cardiovascular disease (CVD) associated with certain foods and obesity, governments such as Poland have conducted school and public education campaigns on diet and also work with the food and agricultural sectors.
- Diabetes education for both patients and providers – which reduced the cost of drugs by 62 percent in one study of 10 Latin American countries – is also an essential intervention (Disease Control Priorities Project 2006).

While additional research needs to be done to gauge the cost-effectiveness of consumer-focused health interventions in the E&E region, there is little doubt about their effectiveness. There is a growing body of empirical evidence that demonstrates that communication strategies have proven to be effective in changing behaviors in ways that contribute to positive health outcomes. (Noar 2006; Bertrand et al 2006; Gordon et al 2006; Grilli et al 2002).

### **Consumer Empowerment and Corruption**

The role of under-the-table and informal payments in health care is an important topic of study in the E&E region, where corruption and informal payments for health remain widespread. A thorough treatment of this topic is outside the parameters of this review, but we note that there

is considerable evidence suggesting that informal payments and provider or system corruption harms consumers and inhibits their access to health care and health information (see, e.g., Allin et al 2005; Pereira et al 2005; Vian et al 2006).

### **Consumer Empowerment in the Europe and Eurasia Region<sup>16</sup>**

This section of the document explores the existing literature on consumer empowerment in the E&E region and serves as a record of current knowledge on effective consumer-oriented programs in the region. We provide a brief overview of the more notable projects in the region, and then delve into greater detail on several of them.

Campaigns to educate the public about nutrition, especially the need to consume iodized salt have been successful in the Caucasus and Central Asia. In Azerbaijan, as a result of implemented activities, the consumption of iodized salt at households increased from 44 percent (2002) to 70 percent in 2003 and selling of iodized salt at the market increased from 30 percent (2002) to 68 percent in 2003. In addition, 89.1 percent of salt tested in the markets was iodized, 60.9 percent of families used iodized salt regularly, 25 percent use iodized salt occasionally, 86.2 percent of families said that iodized salt was available at their local market, 65 percent of families interviewed could explain the need for using iodized salt and 66 percent knew how to keep iodized salt and the best way to use iodized salt so that its iodine content was kept to the maximum. (Gleason 2004; UNICEF 2005; UNICEF 2006) In Kyrgyzstan, the ZdravPlus project provided consumers with the materials to test salt at home and in stores, which not only raised the proportion of houses with iodized salt, but it also empowered consumers to be able to ensure their nutritional needs were met and held sellers accountable for providing iodized salt (Schuth 2007).

An evaluation of health reform in Azerbaijan explicitly calls for creation of a national plan for health promotion and education as well as community-based efforts to involve individuals and families in their own health (Rogosh et al 2005). A UNESCO report on the socio-cultural aspects of HIV/AIDS in the Caucasus advocates for more educational outreach to young adults and adolescents, particularly through schools and peer mentoring efforts (Buckley 2005).

A common feature of all of the health reform activities in the Europe and Eurasia region has been greater emphasis on primary health care. In Romania, for example, the focus on primary health care (PHC) resulted in a greater sense of community involvement in public health (URC 2007b). The BCC program which focused on promotion of family planning was well-integrated into the overall primary health care reform project, but the links between communication and specific behavior changes remain unclear. One suggestion for future programs is to better link communications to service provision (Jones et al 2004), rather than relying on improved quality of care or increased health knowledge alone to change behavior and empower consumers. An evaluation of the introduction of family medicine-centered PHC in Bosnia and Herzegovina found that successful diffusion relied on the perceived benefits of the innovation to key

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<sup>16</sup> This section functions as an overview of programs in countries of the region other than the assessment countries. We do not discuss all programs in detail in the body of the text but have rather selected examples that highlight both successes and opportunities for further efforts. The reference section of this report includes program documents not cited in the body of the text to demonstrate the range of documents are website and database searches revealed.

stakeholders. The authors reported that innovations in the health care system were empowering to both providers and users of health care, and that communication between those promoting change and those adopting it was crucial to success (Atun et al 2007).

#### *Child Survival Project—Azerbaijan*

Numerous country-specific programs have led to important changes to health services and population health in the Caucasus. One example is an innovative child survival program in rural districts of Azerbaijan that led to the creation of Village Health Committees in 79 villages. This community mobilization has both increased the participation and role of women in public life and better equipped men to address health issues of importance for women and children. The program has provided health education and behavior change communication for the VHCs and the general public, participating in health fairs and other health promotion activities (Wilcox & Moseley 2006). Again, program reports reflect the difficulty of linking changes in health behavior to specific interventions within a short timeframe. Thus far, evaluation attempts have measured the formation of VHCs rather than associated health outcomes (Wilcox & Moseley 2006). Future research should evaluate the ways in which the existence of VHCs and participation in VHCs may directly and indirectly influence health behaviors and outcomes and should pay particular attention to the mechanisms through which community mobilization in VHCs can affect consumers.

#### *Healthy Women in Georgia*

Healthy Women in Georgia is another program in the Caucasus region with an explicit focus on creating informed and pro-active health consumers. Activities designed to promote this goal included a Parents' School for expecting parents, a breast health conference and educational sessions, Healthy Lifestyles courses to teach adolescents about health issues, community events to allow members to discuss and share health information, and a mass media campaign involving television ads, billboards, a hotline and an award-winning website (Healthy Women in Georgia 2006). A mid-term evaluation of this project found that it was very successful in increasing health knowledge, though as expected, health behaviors are slow to change. The hotline was well-known but little-used, suggesting that there might be important barriers to use health resources even when they are nominally available. Evaluation of the Healthy Lifestyles component demonstrated that radio is a particularly effective way to reach youth in Georgia, though other forms of mass media follow closely in importance (Dersham 2006a).

#### *Children's Tolerance Education Project (CTEP)—South Caucasus*

Implemented by Save the Children and co-funded by USAID and the Swiss Development Agency, CTEP was designed to promote tolerance, compassion and cooperation as important values among children in Azerbaijan, Armenia and Georgia. The mass media campaign broadcast educational and entertaining children's puppet shows through local television stations, using a common curriculum across the region.

The 2004-2005 campaign was the first effort ever to use children's puppet shows to spread information in the region, making evaluation of the results of particular interest to the implementing organization. Using a pre-test/post-test format in selected schools which screened

the shows, researchers found that on three of the four topics studied (out of 12 tolerance topics included in the curriculum), children's KAP (knowledge, attitudes and practices) scores increased significantly, with no differences by age, gender or country. The majority of children described the programs as good and would recommend them to a friend. Approximately half reported discussing the programs positively outside of the school setting (Dershem 2006b).

While a pre-test/post-test design is not ideal for studying the effectiveness of a program, the results of the evaluation suggest that innovative communication techniques, such as the use of "edutainment" programs, may be effective in the context of the South Caucasus.

#### *Romanian Health Care Reform Program—Romania*

While none of the primary components of the Romanian Health Care Reform Program or any of the measurement indicators used to evaluate success were explicitly consumer-oriented, the project included potentially empowering characteristics. The program worked to build capacity at the local level while educating consumers about what services were available and how to use them. One specific challenge that arose was the inappropriate use of new emergency services for minor medical events. The project worked on educating consumers to take responsibility for their own care and the use of accessible services (URC 2007). The successes of the Romanian case may be attributed to stakeholders' commitment to PHC, which led to community involvement with and responsibility for public health in the pilot regions. Ongoing mentoring and monitoring were the components that allowed the participation of stakeholders and the involvement of different groups from the grassroots up (URC 2007).

#### *Romanian Family Health Initiative—Romania*

The Romanian Family Health Initiative is a collaborative project with JSI Research and Training Institute, the Romanian Ministry of Health and USAID/Romania. The initiative is a response to a health system focused on curative care and in which health care personnel were not being used to their full capacity to deal with family and reproductive health issues. BCC efforts are very well integrated into RFHI programs, but production and stocking of BCC materials is problematic, and health centers are often left without BCC materials to share with patients. RFHI focuses both on improving interpersonal skills of providers for disseminating information, but also relies on mass media channels. (Jones et al 2004). Lessons from the RFHI include the importance of investing in health promotion and BCC at the individual level and through mass campaigns, as both were important and neither would have been successful alone in the Romanian case.

#### *ZdravPlus—Central Asian Region*

One of the most comprehensive and effective efforts to reform healthcare in post-transitions country is USAID's series of reform initiatives in Central Asia called ZdravReform. ZdravReform initiated restructuring of the healthcare system in Kazakhstan, the Kyrgyz Republic, Tajikistan, Turkmenistan and Uzbekistan, and the ongoing ZdravPlus program continues to support important changes to health infrastructure, quality, service delivery, financing and health communication. Consumer education and empowerment are one important component of ZdravPlus's overall health strategy. Research on ZdravPlus's activities on reducing hypertension showed in pilot areas that increased provider training, training on interpersonal

communication and patient education can have clinically measurable health benefits (Nugmanova et al 2008). We include some specific examples of ways in which education and empowerment programs have been integrated into the ZdravPlus program thus far.

Consumer empowerment was accomplished through the following ways under the umbrella of the larger ZdravPlus program:

- The Healthy Communities Grants Programs provides small grants to organizations throughout the region, and by 2004 had awarded grants to over 80 organizations for health and community action. Community action grants were most often used for access to safe water and sanitation, while health grants allowed groups to cover topics such as reproductive health, prevention of infectious diseases and prevention and treatment of chronic diseases such as diabetes and hypertension (ZdravPlus 2005).
- The ZdravPlus program provided training on interpersonal communication for NGO and community leaders as well as health care personnel, allowing more effective partnerships between organizations and stronger outreach to communities. One important outcome is a better relationship between health care providers and consumers at the primary health care level due to better communication (ZdravPlus 2005).
- A ZdravPlus project in Zhezkazgan, Kazakhstan, as part of a Safe Motherhood pilot program, trained women and their families on what to expect during pregnancy and delivery as well as information on self-care during pregnancy. Program coordinators produced informational materials, including brochures and booklets, adapted video clips, and trained health care providers to better interact with and educate consumers. Women reported satisfaction with the information they were given and an increased level of respect from health care personnel (Kenney et al 2005). While this intervention succeeded in increasing patient knowledge and attitudes toward health providers, it did not measure any link between these activities and health behaviors among users of health care.
- An example of progressive programming occurred during the 2001-2002 ZdravPlus pilot of an educational program on child health in the Ferghana Oblast of Uzbekistan. The program promoted Integrated Management of Childhood Illnesses (IMCI) through a combination of mass media and interpersonal communications. The program first assessed the state of knowledge in the region through research and then produced a wide array of informational materials, including brochures, newspaper articles, radio spots, TV advertisements and TV soap operas. The mass media messages also formed the basis for many interpersonal communications, and ZdravPlus worked with providers to increase the efficacy of their communications with consumers. The project included three 6-week campaigns. The first was on nutrition and anemia, the second on acute respiratory infections (ARIs) and the 3<sup>rd</sup> on diarrhea disease and hygiene (Ibragimov et al 2003). While evaluators describe the campaign as successful, they acknowledge the difficulties inherent in efforts to evaluate behavior changes within a short time-frame, a problem that is common to research on BCC and other interventions designed to affect health behaviors.

- In 2004 ZdravPlus began an initiative to work within the *mahalla* (neighborhood association) structure for health promotion in Uzbekistan. Based on this and their previous work, ZdravPlus staff suggested a six-step model for effective health promotion in the region that involved the community in each step of the process<sup>17</sup>. They include: 1). Identify community access points (*mahalla* committees, official health promotion centers, etc.) and assess what kinds of health education is already conducted and what can be added; 2). Demonstrate health promotion and education options, to excite and draw in potential community health educators; 3). Identify appropriate activities in collaboration with the community access point; 4). Work at both the top and grass-roots levels to ensure official support and community buy-in; 5). Hold orientation trainings before implementation of programs to contribute to a smooth implementation process; and 6). Evaluate programs and outcomes (Pavin et al 2004). This report explains the important roles monitoring and evaluation play in health interventions in the region, and in general, more recent documents show more attention to rigorous evaluation. The growing emphasis on empowerment in consumer-oriented health orientations represents a challenge to rigorous evaluations, as “empowerment” can be a difficult concept to successfully operationalize.

In Uzbekistan, ZdravPlus created a soap opera as part of their “Stop Diarrhea” campaign in conjunction with parallel opening ceremonies including health fairs and live theater performances. The campaign also went hand-in-hand with clinical training for doctors and nurses.

*American International Health Alliance Health Partnership Program Healthy Communities—Central and Eastern Europe*

Between 1994 and 2006, AIHA participated in over 30 health partnerships in 9 countries of Central and Eastern Europe. These partnerships covered a wide range of issues, including hospital quality improvements and building educational capacity in health management, but a number focused specifically on empowering activities such as community mobilization. Among the many changes participants and evaluators have attributed to the programs include broad social changes in mindset about health, increased attention on the individual and personal responsibility, and strengthened communities able to work together across diverse backgrounds to build better health.

In 1995, AIHA adapted the Healthy Communities approach, a strategy and methodology for involving and empowering communities, to the CEE region. Recognizing that development of local leadership capacity is essential to this strategy, AIHA engaged in 18-24 month programs of workshops and professional exchanges. AIHA instituted seven of these partnerships, in cities in Slovakia, Romania, Hungary, and Latvia (most recently in 2001). The partnerships mobilized communities to take action for their health, and engaged in locally-specific needs assessments. US and CEE partners worked to build capacity and sustainable programs through building connections with other organizations. The healthy communities programs had effects beyond the borders of the communities themselves, through providing examples of successful programs for replication or advocating for change at the regional and national level (AIHA 2006).

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<sup>17</sup> The “*mahalla*” unit only exists in Uzbekistan.

### *AIHA Primary Health Care Reform in the Newly Independent States*

AIHA's projects designed to improve primary health care reform in the NIS from 1998-2006 provide an important example of empowerment as a secondary benefit from programs without an explicitly empowering agenda. Most of the activities focused on the provider and institutional sides of health care services, and evaluators explicitly stated that the locus of control remained with physicians and other health care providers. Simultaneously, however, interventions led to less paternalistic attitudes among health workers, increased emphasis on personal responsibility for health, higher levels of individual and community involvement in health issues, and increased demand for services. The successes of these programs highlight that even unintentionally empowering interventions can have important and far-reaching consequences for participants (Paterson and Telyukov 2007).

### *Nationwide Physical Activity Campaign—Poland*

The review, in general, does not include countries of Eastern Europe, as their level of economic development has allowed them to address issues such as population health more comprehensively than the countries under consideration here. Most no longer receive funding from organizations such as USAID and many have already become part of the European Union. We do, however, include one example from Poland, as the countries of Eastern Europe face some of the same health problems as the countries we cover in this review and may provide examples of successful programs in the future.

The Polish Nationwide Physical Activity Campaign is one of several efforts started in Poland to improve cardiovascular health through promoting exercise and healthy lifestyles. The campaign took place from 2001-2003 in 3 month cycles each year, using a combination of TV, radio, newspapers and the Internet to promote education on the benefits of physical activity. The campaign also included local programs such as organized sports activities, as well as national-level competitions for the physically active. Evaluation of the campaign showed that not only did it increase knowledge on benefits of exercise and the minimum level of physical activity necessary, it encouraged thousands of individuals to become more physically active. The campaign has been successfully adapted to neighboring Eastern European countries, and an Australian group of experts included it in a list of programs using best practices for encouraging physical activity in developing countries (Drygas et al 2008).

### **The Kyrgyz Republic**

Kyrgyzstan is a mountainous country in Central Asia with a population of close to 5.4 million people. Fertility remains above replacement rate, with a TFR of close to 2.7. Approximately 40 percent of the population lives below the poverty line, and unemployment is high at 18 percent. Kyrgyzstan is ethnically and linguistically heterogeneous (only approximately 65 percent of the population are ethnic Kyrgyz, with sizeable Uzbek, Russian, Tajik and other minorities), which contributes to the challenge of effective communication interventions (CIA 2008).

The Kyrgyz Republic is widely lauded as an example of successful reform in a low-income context.

### *Manas Taalimi Health Care Reform*

Kyrgyzstan's Manas Taalimi National Program of Health Care Reform (1996—ongoing) is an integrated approach to health care reform with widespread donor support. It is currently the setting for a Sector Wide Approach (SWAp), allowing multiple development organizations to collaborate to achieve sustainable and lasting health care reform. The Joint Country Support Strategy calls for the Asia Development Bank, Swiss Cooperation, Department for International Development (DfID), World Bank Group, and UN Agencies to collaborate on community mobilization and empowerment as ways to promote health reforms (World Bank 2007). To date, the World Bank's support for health in the Kyrgyz Republic has been closely connected to its support for community driven development focusing on issues such as sanitation and water supply. The community driven projects that are already underway have been evaluated as successful and future programs need to empower communities to decide on health programming at the local level (World Bank 2007).

### *Village Health Committees (Community Action for Health)*

One specific example of how community mobilization is working in Kyrgyzstan may be found in Village Health Committees. Creation of these committees, which assess local health needs and design health actions to meet these needs, began in 2002 in Naryn oblast and as of 2005 has become part of the Ministry of Health's national reform strategy, Manas Taalimi.

With funding from USAID, the Swiss Agency for International Development and Cooperation, and the Swedish International Development Agency, the government plans to scale up these community-based interventions to the national level by 2010 (USAID 2006).

The goals of the Community Action for Health (CAH) strategy in Kyrgyzstan are to enable rural communities to take a role in improving their own health and to enable the health system to work in partnership with communities toward common health goals. A striking feature of Kyrgyzstan's VHCs is that they work in partnership with the MOH and are mirrored at the rayon level with health committees registered as NGOs. At the village level, VHCs work with local health facilities (FGPs/FAPs) and health promotion units, with guidance from the Republican Centre for Health Promotion at the national level (Joint Mid-term Review 2008)

VHCs are involved in disseminating information on a broad array of health topics, including nutrition/anemia, infectious diseases, reproductive tract infections, brucellosis, alcohol abuse, hypertension and CVD, malaria, hygiene, and childhood diseases. Additional health topics are planned for inclusion in the future, and as VHCs mature, many go on to initiate their own activities, such as tree planting and village clean-up events. Many have also started to apply for small grants for activities such as FAP restoration and ensuring clean water supplies (Joint Mid-term Review 2008).

While Kyrgyzstan is in many ways a pioneer in consumer empowerment in the health field, programs designed to empower consumers remain new and relatively untested. We expect that within the next few years, the literature on consumer-oriented health programs, in Kyrgyzstan and other countries of the E&E region will continue to grow.

## **Albania**

Albania is a country of slightly more than 3.6 million in Southeastern Europe. While life expectancy is on par with other European nations, Albania remains under-developed economically. Approximately 25 percent of the population lives below the poverty line, and unemployment is extremely high, with estimates ranging from 13-30 percent of the population (CIA 2008; USAID 2007). As in the other countries included in our assessment, social, economic, and political instability in recent decades have negatively affected both population health and provision of services, leading in turn to donor efforts to reform health systems and improve population health.

The major donor-sponsored projects in Albania have important lessons for future efforts to empower consumers. Here we discuss two past projects (the Partners for Health ReformPlus Project and the Albanian Family Planning Activity through JSI) and three ongoing projects (the Albanian Child Survival Project, Proshendetit primary health care reform project, and the ACCESS-FP project on postpartum and post-abortion family planning).

### *Partners for Health ReformPlus*

Efforts in Albania to build an improved primary health care system from the ground up have had important implications for consumers. The Partners for Healthcare ReformPlus PHC pilot project provided training to over 200 health professionals to allow them to be better health educators, direct education for over 2600 local women, and school-based programs for youth.

Recommendations from this pilot recommended further community-focused efforts, including assessments of community-defined needs (Cook et al 2005).

In addition to information and education programs, the pilot project aimed to provide necessary equipment to clinics, train providers in utilization of clinical guidelines, improve outreach to the community, and reform health financing. While the project was not able to reach its goals on health financing, outcomes include a higher rate of contraceptive use, higher rates of PHC facilities, and lower rates of bypassing PHC facilities for higher-level care facilities in the pilot region (Hotchkiss et al 2005).

### *Albanian Family Planning Activity*

The Albania Family Planning Activity focused exclusively on reproductive health-related efforts. The BCC component of the Albania Family Planning Activity was a notable success according to the final technical report for the project (Cappa 2007), which uses measures related to recognizing the ads and materials (not use of family planning methods). While almost 80 percent of program targets (married women of reproductive age) could report remembering at least one campaign advertisement or message, further research is necessary to determine whether the program has influenced contraceptive behaviors as well as knowledge. Television ads and sequential campaigns resulted in measurably higher levels of knowledge on available reproductive health services among consumers. The success of the campaign is encouraging but also highlighted needs for further education campaigns, particularly those with empowerment of users of family planning services as a goal (Cappa 2007). In addition, future programs should use indicators of behavior change, rather than simply memory of materials, to better gauge the effectiveness of communication programs targeted toward behavior change.

### *Proshendetit*

The Proshendetit health care reform project works at the district level to train health promotion workers who can, in turn, train teams to work at the community level. An explicit goal of the program is the promotion of links between the national health care system and community members. Rather than seeing communities solely as consumers of care, the project urges health officials to take advantage of the resources available from involving communities in their own care. The health promotion component of Proshendetit is based on research specifically conducted to guide development of materials, and involves training of community health promoters as well as media campaigns (URC 2005).

Proshendetit and the earlier Partners for Health ReformPlus project between them covered seven administrative districts in Albania. Both projects demonstrated a commitment to evaluating pilot efforts to enhance scaling-up of programs to the national level and, along with the Albania Family Planning Activity, also demonstrated the importance of baseline research for program planning (e.g., the Manoff Group 2005).

### *Albanian Child Survival Project*

A project to improve child health and survival in three districts of Albania provides further evidence of the benefits of consumer-oriented interventions. The American Red Cross and the Albanian Red Cross collaborative Albanian Child Survival Project is an initiative to increase community involvement in healthcare, and improve access to and quality of key healthcare services. A central component of the project is training village nurse-midwives (VHNs) and village health educators (VHEs) to work as village health teams (VHTs), greatly expanding the availability of health information on maternal and child health topics in these regions. The initial successes have led to recommendations for expanding the types of communications VHTs use, including men more actively in discussions of reproductive health, and reaching out to rural families who may experience barriers to access (Fullerton 2005). Again, further research should assess links among VHTs, increased health knowledge, and specific outcomes, including community empowerment. While VHTs include both community educators and nurses, it is unclear whether services are provided in the format of the teams, or whether the VHTs are exclusively designed for health education and promotion.

### *ACCESS-FP*

ACCESS-FP is working in Albania with the Ministry of Health to integrate family planning (particularly IUD adoption) into postpartum and post-abortion care, as well as to increase the acceptance of modern contraception in Albania (ACCESS-FP 2008). The ACCESS-FP project is an example of a new project with potential for consumer empowerment, but as activities are just commencing, no results are currently available.

## Armenia

Armenia is located in the Southern Caucasus and has a population of approximately 3 million. The population growth rate is very low (close to no growth). The Total Fertility Rate in 2005 was 1.3, down from 2.8 in 1990 and well below the replacement level of 2.1 (USAID 2007). HIV prevalence is low (at or below 0.1 percent of the population), but rates are expected to climb and reported rates may capture only a small proportion of those actually infected (Buckley 2005). Approximately 43 percent of the population lives below the poverty line (USAID 2007). Armenia is the most ethnically homogenous of the countries of the Caucasus, which has important implications for health communication and consumer empowerment interventions (Buckley 2005).

UNICEF has conducted a successful information campaign in Armenia (see the anemia campaign referenced above, although current results are limited to expansion of education efforts UNICEF 2005), but the two major health programs with consumer-focused components we discovered prior to the assessment trip are the PRIME II project, a two-year comprehensive primary care reform project with an emphasis on improving maternal health services, and the Green Path Campaign, a 2000 effort to promote greater awareness, knowledge, acceptance, and adoption of modern contraception through encouraging utilization of pre-existing counseling and related services (Thompson and Harutyunyan 2001; Thompson and Harutyunyan 2006; Topçuo\_lu 2005)<sup>18</sup>. While in the field, we learned about the currently ongoing Project NOVA and Primary Health Care Reform project, also discussed below.

### *PRIME II*

The PRIME II project worked extensively to promote the role of rural nurses and midwives in service provision in isolated health facilities through increased training and providing a supportive supervision. The program focused on approximately 60 primary health care facilities in one rural, Northern region. On specific outcomes related to consumers, PRIME II was partially successful. Assessors rated the goal of community involvement as fully accomplished (though the measurement of community involvement remained unclear). The more complicated goal of increasing patient satisfaction due to better performing services was only partially accomplished, and the authors of the final report acknowledge that opportunities remain to better serve consumers. In addition, the goal of increasing the use of services due to greater patient satisfaction was not at all accomplished (Topçuo\_lu 2005). The failure of the PRIME II project to achieve some of its consumer-related goals may reflect the programmatic emphasis on the service provider, rather than users of services.

### *Green Path Campaign*

The Green Path campaign was a multimedia health campaign launched in June 2000. The campaign worked to increase contraceptive knowledge and acceptance using available but underutilized Family Planning Bureaus. Despite the short (less than one year) duration of the program clear successes resulted, not only in knowledge increases but in health behavior

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<sup>18</sup> Both the PRIME II and Green Path programs took place prior to the timeframe we focus on for this review. We include them, however, because they are the best available examples of past programs with a consumer-focused element in Armenia.

changes as well. The post-intervention survey measured significant increases in factors associated with contraceptive behavior change, including knowledge, favorable attitude toward modern methods, favorable attitude toward family planning services, and information seeking and utilization of existing services. New visits to family planning sites increased by 84 percent and the use of contraceptive methods increased by 4.6 percent, a statistically and practically meaningful change (and a 50 percent greater change than program designers expected) (Thompson & Harutyunyan 2006). The multi-media campaign offers a successful model for interventions in other countries of the Europe and Eurasia region.

### *Primary Health Care Reform Project*

The Primary Health Care Reform Project grew out of the earlier Armenia Social Transition Project and is currently ongoing. The project works on continuing reform of the health system, public education on open enrollment for primary care, improving quality of care, and fostering more individual involvement in healthcare through community mobilization, outreach and health promotion. Documents evaluating the success of the program in empowering consumers are not yet available, but the project has initiated several interventions, including supporting Village Health Groups that are currently in pilot-mode and that are likely to have increased empowering effects in the future.

### *Project NOVA*

Project NOVA is an ongoing project designed to improve access to and the quality of reproductive care in rural areas of Armenia. During its initial stages, (October 2004-September 2006), the project worked in five northern provinces. After completing its interventions in the north, the project moved to southern marzes (districts.) Project NOVA works to improve health facility infrastructure, train health promotion nurses to improve their ability to provide quality care and health information, and to improve relations between health facility staff and the communities they serve (Sacci et al 2008 DRAFT NOT FOR DISTRIBUTION).

Because Project NOVA is ongoing, documents assessing the effectiveness of intervention components are not yet available. While it is too early to judge the long-term success of its efforts, the project has included consumer-focused activities since its inception. Among the main goals of the project is increased consumer demand generated through community mobilization and education (Pereira et al 2005).

Armenia also offers cautionary examples of less successful campaigns. The World Bank-supported Armenian Social Investment Fund (ASIF) project is an example of efforts to include community-driven, bottom-up approaches in building local capacity and promoting community involvement, while accomplishing development goals. Babajanian (2005a; 2005b) found that within communities, local leaders often became the leaders of the new development programs as well, and broader community involvement remained nominal at best. The involvement of well-informed, connected locals in leadership roles (e.g. local mayors often took part in efforts) often had positive implications for the development outcome in question. Unfortunately, however, the community empowerment focus was unsuccessful, as the efforts served to reinforce local structures and institutions rather than empowering new participants.

Efforts to fight domestic violence also faced difficulties when introduced in Armenia. The issue of domestic violence was seen as one imposed by Western funding agencies. Of the six local NGOs awarded grants to combat domestic violence, only two had an earlier focus on the issue, leading community members to view the NGOs as merely chasing grants. The campaign did do a great deal to bring the problem of domestic violence into the public sphere, but despite some evidence on what interventions might be acceptable to locals, donor organizations encouraged a reliance on hotlines and shelters that proved unsuccessful in this context (Ishkanian 2007).

## Conclusions

- “Empowerment” is a concept of growing importance to donors, program designers and managers.
- Though most projects to date have not included empowerment as a specific outcome goal, the region provides numerous examples of programs that contribute to the empowerment of health consumers, including health promotion, education and community mobilization campaigns. Particularly notable projects include health education campaigns within the Central Asia regional campaign ZdravPlus and efforts to support and spread Village Health Committees (with support from USAID and the Swiss Red Cross) in Kyrgyzstan; the Proshendetit primary health care reform project and the American and Albanian Red Cross cooperative project on integrated management of childhood diseases in Albania; and Project NOVA and the Primary Health Care Reform Project in Armenia. Despite disparate country contexts, one common theme among all these projects is that their social mobilization efforts include working in both urban and rural communities to involve individuals in the health of themselves, their families and their communities.
- While few reliable studies on cost effectiveness exist, those available suggest that media interventions (which we categorize as empowerment interventions) seem to be cost-effective methods for improving health, as most research shows that such interventions are effective, and often at a low cost per participant (in the case of media interventions).
- Media advocacy, in addition to providing issue or campaign-specific information, works to shape the public discourse about health. This may be an important complement to individual behavior change interventions which, to date, have predominated in the region.
- There have been a number of health promotion programs in the E&E region focusing on maternal and child health, nutrition and family planning. While additional research needs to be done to gauge the cost-effectiveness of consumer-focused health interventions in the E&E region, there is little doubt about their impact. There is a growing body of empirical evidence that demonstrates that communication strategies have proven to be effective in changing behaviors in ways that contribute to positive health outcomes.
- There have been few programs that advocate for better access to services for consumers and consumer rights. Some efforts have worked to involve communities in health care reform but they have not directly advocated for consumer rights. While programs that contain an element of consumer-focus are common, consumer empowerment as an explicit goal remains rare.

- While numerous programs combine some successful components, few include all desirable elements. Overall, programs tend to be particularly strong if using multiple approaches to reach consumers as part of an overall health strategy, making success and behavior change more likely. Common weaknesses are insufficient attention to long-term strategies for sustainability and a research base that is not clearly articulated in documents describing the programs.

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<sup>20</sup> This section includes documents that provided background information for this review and may be of interest for further reading, but were not directly cited in the text.

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## Appendix 4 – Pre-Assessment Questions for USAID Missions

Please answer any or all of the questions below regarding programs in your country targeted toward health care consumers (i.e. anyone who is the end-user of health care services such as individuals, families, and vulnerable groups including the elderly, disabled, dislocated and those living in poverty.)

The survey should take 10-15 minutes of your time. Thank you in advance for your knowledge and insight.

1. Have there been any health care consumer programs or campaigns in [country] in the past 5 years? If yes, please list the names of these programs and the general goal(s) of the program.
2. Were these programs funded by USAID or other donors? If USAID, which cooperating agency implemented the program?
3. Are there any reports or evaluations of this program or campaign that you can share with us? Or, is there someone else that you suggest we contact for the information?
4. Are you aware of any other consumer-focused research related to utilization of health services, health promotion, or health education?
5. In your opinion, what issues are the most important to health care consumers in your country?

## Appendix 5 - Focus Group Discussion Topic Guide

### Introductions and Purpose

- Introduction of the moderator
- Purpose of the discussion: This discussion is a part of a review being conducted by USAID in three countries: Kyrgyzstan, Albania, and Armenia. The purpose of this review is to determine ways in which USAID can help the government and other countries to promote better awareness about health care, prevention and the health services which are available.
- Format for the discussion: informal and confidential.
- Length: Approximately one hour to an hour and a half.
- Participant introductions: Ask participants to introduce themselves, including any information about their family, work, or role in their community.
- Obtain general information about the village or neighbourhood from a member of the group. If this is an established group, ask them to describe their current and past activities.

### Discussion Questions

*Please note that the questions below are illustrative only and the consumer empowerment activities the assessment team is examining in each country will influence the specific questions asked.*

- Where do they usually go when they need health care? (Explore all possibilities: pharmacies, government services, private, relative, etc.) Is there a consensus in the group or varied sources for health care?
- What are their main reasons for seeking health care?
- Are they satisfied with their health services? If so, what are some of the reasons why they are satisfied? If not, what are some of the reasons why they are not satisfied? (For example: quality of services, treatment by providers, wait for treatment, results of treatment?)
- Where do they usually get advice about how to be healthy? On what topics do they receive or hear information concerning good health? Where do they get this information?
- What changes have they noticed over the past two years concerning their access to health services? (For example, is it better or worse and why?) Have they made any changes on where they go for health care during the past two years?
- What changes have they noticed in the quality of health services over the past two years?
- Have they made any changes over the past two years on where they go for advice about their health?
- What do they consider to be good quality health services?

- Do they feel that they can do anything to improve or make any changes in the quality of health services? In other words, do they feel “empowered” as health consumers? If so, how do they advocate for better health care? If not, why not?
- Has health communications or health education influenced their health-seeking behavior? In what way?
- Are there any final comments or anything someone wants to add concerning this discussion?

### **Focus Group Discussion – Report Outline**

#### **Location**

Oblast \_\_\_\_\_ Rayon \_\_\_\_\_ Village/City \_\_\_\_\_

**Moderator** \_\_\_\_\_ Date of Discussion: \_\_\_\_\_

Length of session: \_\_\_\_\_ Name of group (if established): \_\_\_\_\_

#### **Background**

1. Describe the number and characteristics of the group (gender, approximate ages, approximate education, employment, etc.)
2. Describe the characteristics of the discussion (lively, active participation by all, restricted to few respondents, guarded, etc.)

#### **Key Findings and Observations**

1. Describe where the participants go for health care (government, private, pharmacy, etc.)
2. Describe the reasons for seeking health care.
3. Describe the level of satisfaction with the health care services which they are using.
4. Describe where they receive information about being healthy, topics and sources of information.
5. Describe what the group believes would be good quality health services.
6. What is the group’s reaction to being able to make any change in the existing health services?
7. Do health consumers feel “empowered?” Why or why not?
8. How have health communications or health education influenced their health-seeking behavior?
9. What other interesting points were brought out during the discussion, even those not contained in the Topic Guide?

10. Summary of the discussion: Did the group appear to find this discussion to be an important issue?

### **Report Requirements**

Approximate length for each group: 4 pages outlining major findings as bullet points.

## Appendix 6 – Summary of Focus Group Findings

This summary contains highlights of focus group findings in Kyrgyzstan, Albania and Armenia. Qualitative research with consumers focused on four distinct audiences in the three countries that were stratified by age, sex and geographic location. They include:

- Urban:
  - Males 20-40
  - Males 40+
  - Females 20-40
  - Females 40+
  
- Rural:
  - Males 20-40
  - Males 40+
  - Females 20-40
  - Females 40+

The research examined their main reasons for seeking health care, type of providers they use, attitudes about current health care services, relations with providers, feeling of empowerment related to their own health and health care, understanding of health promotion and areas that interest them.

The common issues raised in all groups are summarized in the following paragraphs.

There were varying degrees of satisfaction with the services provided by physicians in the public health system. Overall, there was a general dissatisfaction with the health services people received at public clinics. Many participants complained that the providers were not qualified while the equipment and tests used were old and dated. Most lacked trust in their providers. Older participants had more experience with the health care system and had a regular doctor they visit. They tended to have more positive attitudes about their care. Young participants who use the system less often and, only when necessary, were less satisfied with the care they receive. Satisfaction with service delivery varied with the type of service provided. Primary care for children and mothers was considered good. Participants reported problems with secondary and tertiary care, however.

*“...I apply to a doctor only in severe cases. I do not trust doctors. Imagine I had visited gynecologist twelve years ago when I had my last delivery. Of course this is not normal, but I do not trust them, there is a threat to be infected during the examination.”*

There was also concern about having to pay “extra” for services that should be, according to the system, provided free of charge. This issue was raised in all groups and was an overriding reason for the lack of trust participants felt about their providers and the health system.

*“I went to the health care facility where I was referred for diagnosis and the doctor was not carefully examining me, because I was free of charge patient. I knew that I was eligible for free*

*care, but I paid her in order to be examined more accurately. When you do not pay to a provider, you receive unpleasant attitude.”*

Many participants in all three countries prefer the services and care of private physicians and clinics when they can afford it. They are more confident in the level of care and diagnostics. Rural women in Armenia mentioned that sometimes they prefer private facilities for specialized care since they end up paying the same amount as in a public facility but receive better care. They reported that they can negotiate the price in a private facility and still get quality services. Participants also expressed positive opinions about physicians' attitudes toward patients in private facilities as well as superior physical conditions.

In most groups, the pharmacist was a trusted source of information on health. Many participants described going to the pharmacist with questions about health conditions that were originally diagnosed by physicians. Some participants said they diagnose and treat themselves and then go to the pharmacy for medicine.

*“We go to health provider only when we have a serious health problem. We can't think of going for prevention or to get information on being healthy.”*

When asked what constitutes “good quality health services” participants reported high professionalism; experience of doctors; a serious approach to making a diagnosis (through counseling, consulting other physicians, and advice); responsibility and conscientiousness among doctors. Others discussed the importance of a high quality doctor/patient interaction, based on mutual respect and care for the patient. The qualification of doctors and his/her personal characteristics are very important. Some also mentioned the importance of clean and friendly facilities. There were some mixed feelings about changes in the health system with some respondents reporting that changes in quality are not taking place while others said that changes are visible with more new laboratories and an increase in the level of physician qualification during the past few years.

Almost all participants in the three countries felt disempowered in relation to the health care system and their own health. They do not believe that there is a place in the system where they would be heard. A common sentiment was that people did not feel like “they had a say” in their health care or the services provided. All consumers felt they have no power in making any change to get the quality of service they want. Service providers have the most power and patients have little say.

*“Who has money has the power.”*

However, most agreed that public organizations need to play a role in advocating for improved health system performance.

There was a great interest expressed by participants regarding obtaining information on health, disease prevention and health promotion. All groups mentioned this as important to them. Women, in particular, confirmed that they need disease prevention information.

*“The only power we have is to ourselves and our children, to take care for not getting sick”.*

Topics that respondents were interested in varied by groups and countries and included:

- Nutrition and food additives
- How to breast feed and care for a baby
- Where to go for cancer and pap tests
- Overall information on their health status
- Psychological health (urban young)
- Healthy lifestyle
- Reproductive health
- Sports and physical activity
- Allergy
- Old age health
- Cancer
- Influenza
- Obesity
- Women's health
- Cardiovascular disease

Participants in all countries said they get very little information on health promotion or health information from their providers. Most stated they get what they need from conversations with family members (i.e. mothers and mothers-in-law). Newspapers, TV, brochures from health facilities, pharmacists and village health workers (e.g. nurses) and local NGOs were also cited as sources of health information.

*"I am becoming doctor of myself by getting/searching for information by myself through different sources about my disease (ulcer). The information I have been looking for has been what should I eat, what is harmful and what's healthy."*

#### Country-Specific Focus Groups Findings

The following highlights unique findings of the focus groups by country. Please note that the focus groups were conducted in areas without USAID donor projects. The findings presented below contrast the attitudes and perceptions that the assessment team encountered during in-depth interviews with health care consumers in areas with donor projects.

#### ❖ *Albania*

In Albania, focus group participants noted that service providers lack both effective communication skills and respectful attitudes. For example, one participant stated that the doctor should first speak with the patient before the examination. It appears that health consumers seek private sector doctors for more serious illnesses. With the exception of young mothers seeking MCH services, younger consumers tend to prefer the private sector, whereas older consumers tend to use public services more often. Although most participants felt powerless to effect any change, one young mother provided her own example of an empowered consumer:

*"I reacted to a doctor who was smoking when I brought my daughter for a check up."*

*I told him to put out the cigarette before I would enter with my baby. And he did so.”*

As noted above, despite the perceived poor quality of health facilities, young mothers still tend to prefer government health services because they are familiar with them. People seemed more satisfied with primary-level services, especially MCH services, than with secondary and tertiary levels.

#### ❖ Armenia

Urban focus groups in Armenia expressed mixed levels of trust regarding public and private health services. Virtually all rural women participants appeared satisfied with the quality of care in rural ambulatory facilities. However, consumers are increasingly seeking medical advice from pharmacists because the advice is free and, in some cases, better advice than from doctors, especially in urban areas. No focus group participant mentioned health care facilities as a significant source for information on how to prevent diseases, although rural men mentioned family doctors as a source.

Despite government initiatives in health care reform, such as “free” primary health care and free choice for selecting family doctors, participants mentioned that health care services have become more expensive and less affordable during the past two years. Information concerning the availability of services seems to be poorly communicated. As one participant stated:

*“People do not have information on which services should be provided for free and which should not. And when a doctor asks for payment, we pay without knowing whether that service was supposed to be free of charge or not.”*

#### ❖ Kyrgyzstan

Most consumers in both Bishkek (urban) and Jalalabad (rural) stated that they seek health care from government facilities. Bishkek residents are concerned with the quality of air and market produce. In Jalalabad, a more rural area in the south, consumers preferred government health services over private physicians. Consumers suspect that private sector doctors are more concerned about profit than the patient. Private pharmacies are flourishing and many consumers seek self-diagnosis rather than spend the time and money to visit a medical facility. Still, clients are suspicious of the quality and the authenticity of the drugs being sold.

One focus group participant stated how people can be more responsible for their health:

*“To start changes first of all from ourselves; from changes in the minds of our children through educating among them honesty, kindness, and responsibility.”*

While health consumers in Kyrgyzstan expressed considerable dissatisfaction over the quality of health services, they felt the quality of services for children was much better than health services for adults.

## Appendix 7 – Overview of Assessment Countries

### General Information<sup>21</sup>

The countries included in this assessment span a geographical range of 3,000 miles, from the mountainous border of China to the Adriatic Sea, and involve many different ethnic groups and languages. All three countries are relatively similar in size and population. Kyrgyzstan ranks as the largest among them, approximately the size of South Dakota with 5.36 million people. Albania and Armenia are each nearly equivalent to Maryland in size with populations of 3.62 and 2.97 million respectively. Estimated population growth rates for 2008 range from a negative rate for Armenia at -0.077 percent, to 0.538 percent in Albania, and 1.38 percent in Kyrgyzstan. 2008 Estimated fertility rates follow a similar distribution. In Armenia, 1.35 children are born per woman. In Albania, the rate is 2.02 and, in Kyrgyzstan, it is 2.67. In both Armenia and Albania, abortion is widely practiced.

### Health Status

All three countries have high infant mortality rates (IMR) relative to European and Eurasian countries. The highest reported IMR is in Kyrgyzstan with 32.3 per 1,000 live births, while Albania and Armenia have IMRs of 19.3 and 20.9, respectively (CIA World Factbook 2008). According to UNICEF, maternal mortality is much higher than for industrialized nations; in Albania it is at 92/100,000; in Armenia at 76/100,000 and in Kyrgyzstan considerably higher at 150/100,000. Moderate to severe malnutrition in Albania is at 7.5 percent, Armenia at 4.0 percent, and Kyrgyzstan at 3.4 percent (CIA World Factbook 2008).

According to UNAIDS data for 2007, there are an estimated 2,800 people living with HIV in Armenia and 4,000 in Kyrgyzstan. WHO estimates only 255 HIV infected persons in Albania. However, labor migration in all three countries increases risk for cross-border disease transmission, particularly for HIV and AIDS and STIs.

Despite these trends, life expectancy for all three of the assessment countries has increased since 1990. According to WHO and the CIA World Factbook, since 1990 Kyrgyzstan's average (combined male and female) life expectancy has increased only slightly from 65 to 69.12 (the lowest of the three). In Armenia, it has gone from 65 to 72.4 and in Albania, it has steadily increased from 67 to 77.78. The highest life expectancy gender gaps in the world are found in the E&E region where, in former Soviet countries, males on average live 12 years less than females (Demography and Health in E&E, USAID 2005).

Immunization coverage rates for Baccille Calmette Guérin (BCG) vaccine and first dose Diphtheria Toxoid, Tetanus Toxoid and Pertussis (DPT) vaccine are regarded as a fundamental indicator for access to health services. According to WHO, reported immunization coverage in 2007 for BCG is nearly 100 percent in all three countries: Albania is at 98 percent, Armenia is at 94 percent and Kyrgyzstan is at 98 percent. As these coverage rates were achieved through routine health services, this shows very high access to these services.

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<sup>21</sup> There are several sources with varying rates for the indicators presented in this report. For consistency of comparison among the three countries, the CIA World Factbook is used, unless otherwise noted in the text.

The following coverage for three doses of DPT for infants was achieved in 2007: Albania 98 percent, Armenia 88 percent and Kyrgyzstan 94 percent. In Albania, these high immunization coverage rates have been maintained with little variation over the past eight years (2000-2007). Armenia has more variable immunization coverage reported over the past eight years. Third dose Hepatitis B declined from 91 percent to 78 percent between 2005 and 2006, but increased to 85 percent in 2007. Measles vaccine coverage in Armenia declined slightly from 94 percent to 92 percent between 2005 and 2006. Measles coverage data for Armenia are not yet available for 2007 (WHO). In Kyrgyzstan, third dose DPT and Hepatitis B coverage have dropped slightly from 99 percent in 2004 to 94 percent in 2007. First dose DPT and Hepatitis B have remained consistently high, between 96 percent to 99 percent since 2000. These differing coverage rates between first and third doses of DPT and Hepatitis B show a slight, yet certainly not desirable, increasing drop out trend for completing the required immunization schedule.

As in other former communist countries, most infants are born in the hospital. According to UNICEF, 98 percent of deliveries occur in the hospital in Albania, 97 percent in Armenia and 97 percent in Kyrgyzstan. Also, most consumers in urban areas reportedly have access to clean water, reported by WHO as between 98 to 99 percent in the three countries. However, access to clean water in rural areas is lower in Armenia (80 percent) and in Kyrgyzstan (66 percent). In terms of overall health system performance, out of the 190 countries ranked by WHO, Albania comes in 55<sup>th</sup>, Armenia is 104<sup>th</sup> and Kyrgyzstan ranks 151<sup>st</sup>.<sup>22</sup>

Household and Community Components of the Integrated Management of Childhood Illness (C-IMCI) indicators serve as a good measure of both consumer empowerment to take care of their own health, as well as provider capability and readiness to meet consumer demand. C-IMCI focuses on changing behaviors around key family practices, and involving the community to achieve this change. 2006 C-IMCI assessment data from UNICEF reveals that considerable progress is still needed before health consumers and providers in these three countries are best prepared to take care of common childhood illnesses, such as acute respiratory infections (ARI) and diarrhea. In Albania, for example, only 45 percent of children under age 5 with suspected pneumonia were found to be appropriately referred for treatment. In Armenia, only 36 percent were referred appropriately and in Kyrgyzstan, it was only 62 percent. In terms of providing the basic essentials for children with diarrhea (oral rehydration and continued feeding), just half of children under age 5 with diarrhea were found to have been treated properly in Albania, 59 percent in Armenia, and only 22 percent in Kyrgyzstan.

Although health status has traditionally been measured primarily by infectious disease morbidity and mortality, communicable diseases are no longer the only threat. Because of lifestyle and diet changes along with rapidly aging populations in developing countries, major non-communicable diseases such as circulatory system diseases, cancer, diabetes, psychiatric disorders, and chronic respiratory diseases now contribute to the worldwide burden of disease (Disease Control Priorities Project 2006).

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<sup>22</sup> These rankings by WHO are based on the following indicators: overall health of population, responsiveness of the health care system, fairness in financial contribution, goal attainment, health expenditure per capita (\$), and performance. France ranks first; the USA 37<sup>th</sup> <http://www.photius.com/rankings/healthranks.html> .

In fact, the primary causes of adult mortality – the probability of dying between the ages of 15 and 60 – in the E&E region are non-communicable diseases and injuries<sup>23</sup>. Requests from health care consumers regarding chronic diseases during the assessment trip validated this finding. While some diseases are linked to genetic attributes, most stem from lifestyle choices, particularly related to alcohol, smoking, diet and exercise. It is estimated that non-communicable diseases and injuries account for more than 85 percent of all deaths annually, with males being disproportionately affected. This contributes to a gender gap in adult mortality that is the largest in the world. (USAID 2007; WHO, 2006). Specifically, according to WHO, in 2002, 95 percent of deaths in Armenia, 91.86 percent in Albania, and 82.5 percent in Kyrgyzstan were due to non-communicable diseases and injuries. The percentage is an increase from 2000, when according to WHO, 55 percent of deaths in E&E were attributed directly to lifestyle diseases versus 40 percent in the EU-15<sup>24</sup>. In contrast, only 5 percent of E&E deaths were due to infectious, parasitic, maternal and perinatal conditions (Demography and Health in E&E, USAID 2005).

According to WHO, chronic disease is becoming “globalized”, and cancer is predicted to be one of the leading chronic disease burdens in the emerging world in the next few decades. By 2020, a 73 percent increase in new cases of cancer is anticipated in developing countries compared with 23 percent in developed nations. Seven types of cancers account for approximately 60 percent of all newly diagnosed cancer cases and cancer deaths in developing countries: cervical, liver, stomach, esophageal, lung, colorectal and breast (Disease Control Priorities Project 2006). WHO estimates that knowledge currently available could prevent up to 1/3 of new cancers and increase survival for another 1/3 of cancers detected at an early stage.

While cardiovascular disease (CVD) was once largely confined to high-income countries, it is now the number one cause of death worldwide, with 80 percent of the world’s 13 million annual CVD deaths occurring in the middle- and low-income countries.

Tobacco use accounts for a substantial and avoidable percent of CVD and cancers (Disease Control Priorities Project 2006). In all three countries visited, WHO data showed smoking prevalence among adult males is between 60 to 65 percent. Smoking among boys ranges from 10 percent to 15 percent. A survey by the MoH in Kyrgyzstan revealed that 50 percent of physicians smoke. The gender disparity in smoking is much greater in the transition countries than it is in Western Europe. Males in the E&E region smoke more than Western European men, whereas females in the E&E region smoke much less than Western European females. In E&E, 46 percent of males smoked in 1999-2001 vs. 16 percent of females. Contrast this with the UK (29 percent of males and 25 percent of females), France (33 percent and 21 percent), and Denmark (32 percent and 29 percent.)

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<sup>23</sup> Injuries include intentional and unintentional injuries such as poisonings, drownings, falls, fires, vehicle collisions, violence, war and self-inflicted injuries.

<sup>24</sup> EU-15 refers to the 15 countries in the European Union before the expansion on 1 May 2004, when eight central and eastern European countries as well as Cyprus and Malta joined the organization. They include Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and the United Kingdom.

Despite lower estimates of alcohol consumption in the E&E region compared to the EU-15, deaths in 2000 directly related to alcohol, such as cirrhosis, were notably higher in E&E countries (24 alcohol-related deaths per 100,000) than in the EU-15 (15 per 100,000) or in the U.S. (9 per 100,000) (Demography and Health in E&E, USAID 2005).

The World Bank's *Albania Health Sector Note* (2006) states, "Albania's health care system is ill-prepared to face the growing incidence of non-communicable diseases and other new health risks." It also notes that "Concerted efforts are also required to improve Albania's health promotion capacity, so as to inform the population about the new risk factors and ways to avert them."

### Health Care System Structure

All three assessment countries are extensively involved in reforming their health care systems. Kyrgyzstan has the most experience, with their health reform process beginning more than 10 years ago. Health care reform in these countries has generally centered on health care financing and on reconfiguring curative health services and doctors into a Family Medicine model with less emphasis on the structure of the MoH. At a glance, the MoH retains its structure from the Soviet era, though Albania, never under the Soviet system, is unique. Under the Soviet structure, the SES was the preventive arm of the MoH, responsible for health promotion. The SES' primary role is sanitary protection, disease control and epidemiologic surveillance. The SES is highly focused on data collection and highly centralized, but has offices at each district (or *oblast*) level and sub-district (or *rayon*) level. The SES performs food, water, occupational and environmental protection inspections and maintains population-based disease control efforts. The SES also investigates disease outbreaks and other public health problems and maintains an extensive surveillance system which primarily monitors long-term incidence trends by *oblast* and *rayon* levels.

In former Soviet countries, efforts have been undertaken to modify and strengthen the SES around a public health model. Thus far, SES reform has focused mainly on central level restructuring and on conforming to international regulations and standards and less on public health services aimed at the consumer.

In Armenia since 1990, SES and the central MoH have engaged in health promotion activities depending on the initiative and donor funding. For example, the SES organized health promotion immunization campaigns while the central MoH has led other health promotion activities such as IMCI. Although Armenia is restructuring its MOH, the new public health policy and structure was not yet public when the team visited. Interviews with the Armenian SES suggest that the new public health strategy will give the SES greater authority to undertake health promotion.

In Kyrgyzstan, initial efforts to reform the SES after 1990 were not successful so a separate Health Promotion Unit was created under the MoH's preventive services office, as part of a DfID initiative to strengthen health promotion. The Health Promotion Unit is now supported by USAID's ZdravPlus project, which is trying to develop a more consumer-focused public health service at the *rayon* SES level.

In Albania, health promotion has been bifurcated between two MoH structures, the Institute of Public Health (IPH) and the Department of Public Health (DPH). The DPH (with only one staff member and very little budget) maintains an operational role while the IPH establishes policy and works to pass legislation.

### Civil Society

The entire E&E region is developing NGOs, though ample room for growth exists. According to USAID's NGO Sustainability Index (2000), Albania, Kyrgyzstan and Armenia were between 4.6 and 5 on a 7 point scale (where 7 indicates a low or poor level of development and 1 indicates a very advanced NGO sector.) While all three countries show progress in civil society development, problems still exist with building local capacity. Further, NGOs tend to be located in urban areas and do not extend into rural areas. External factors also hamper NGO development such as highly centralized governance structure; a controlled or reactionary media; and a low level of capacity, will, or interest on the part of the NGO community.

### Media and Literacy

With regard to media, television is widely available and ownership of TV sets remains at nearly 100 percent. Albania has 65 television stations (three national and 62 local) and two cable networks. Armenia has 48 television stations, including two public stations, and Kyrgyzstan has two national and 6 regional (*oblast*) stations (World Resources Institute 2007). Programming from Russia and foreign films are frequently broadcast in Armenia and Kyrgyzstan. However, in-depth interviews showed that both countries are moving toward more local programming in their national language.

Literacy is at nearly 100 percent in all three countries (CIA World Factbook 2008). While Internet use is increasing among young urban populations, it is still low compared to developed countries. In 2006, Albania reported 471,200 Internet users (13.1 percent of the population); Armenia reported 172,800 users (1.7 percent of the population); and Kyrgyzstan reported 298,100 users (5.5 percent of the population) (Internet World Stats 2008).

### Economic Status

Kyrgyzstan is the poorest of the three countries assessed with a Gross National Income (GNI) of \$590. It ranked 175<sup>th</sup> for GNI of the 209 countries rated by the World Bank (2007). Armenia progressed economically in recent years, but still ranks as 123 out of 209, with a GNI per capita of \$2,640. Albania has the highest reported GNI among these three countries, but is still one of the poorest countries in Europe with a GNI per capita of \$3,290 (CIA World Factbook 2008).

Although the capital cities of Bishkek, Tirana and Yerevan have experienced considerable commercial development, the recent surge in food and transportation costs greatly affects consumers in these countries. For example, the cost of local bread in Bishkek increased by 80 percent this year and local transportation by 60 percent. This excessive inflation reduces purchasing power for health care, increases stress and decreases time to attend to health care needs.