TOWARDS A HEALTHY COUNTRY WITH HEALTHY PEOPLE

PUBLIC HEALTH AND HEALTH PROMOTION STRATEGY

Contents

. Preface

The public health and health promotion strategy is a document that after a broad consultation it was approved by the Ministry of Health.

The strategy responds to Albania"s public health challenges, but also uses the strengths of the health system of the country and seeks to preserve its positive aspects. A major effort will be needed to prevent current trends from making the health experience of Albanians worse, and it will take an even greater effort to make improvements.

The strategy is modelled on the WHO European regional strategy for Health for All in the 21st Century, *Health21*[1]. The strategy outlines the various component policy areas that collectively contribute towards population health, and provides the rationale for engagement and analysis of the current situation and trends in Albania. The analysis is found particularly in section 7, „Mechanisms for Improving Health in Albania".

The initial reference document was consulted on widely, which led to the production of practical and realisable short- to medium-term recommendations and targets. These are given in section 6, „General Recommendations for Improving the Public Health System ".

This strategy is until 2010. Many indicators are not well defined in Albania due to a lack of complete information, so the document focuses on what is achievable in the short and medium term from 2002–10, and is open for changes in the long run according to data available in the future. It will be monitored, reviewed and updated after five years, in 2007, in order to adapt it to policy changes

Also an action plan has been produced from the recommendations and targets

2. Albania's Social, Economic and Health Context

Albania is located in the Balkan peninsula in south-eastern Europe, bordered by Montenegro and Kosovo in the North, the former Yugoslav Republic of Macedonia in the east, and Greece in the south-east. To the west the country faces the Adriatic and Ionian seas, beyond which is Italy. The country covers an area of 28 750 square kilometres, and is mainly mountainous apart from its western flat coastline. The population was 3 087 000 at the last census (2001).

Before the 1990s an estimated two-thirds of the Albanian population lived in rural areas. Since restrictions on movement were lifted there has been an unprecedented internal rural–urban migration: now 58% live in rural areas and 42% in urban ones[2]. This rapid influx into the main cities, especially Tirana and Durres, has put considerable strain on their infrastructure and health services.

In recent years many people have left the country, emigrating legally or illegally to western countries, mainly neighbouring Greece and Italy. Around 600 000 people are calculated to

have left Albania between 1990 and 2000[3]. On the other hand, in 1999 there was a large-scale immigration of 750 000 people from Kosovo due to the war in the former Yugoslavia, which were returned back after NATO intervention.

About 97% of the Albanian population are ethnic Albanians, and fewer than 2% are Greek minorities. The unified form of the Albanian language has been used since 1970.

The country is divided into 12 prefectures and 36 districts, which are further divided into communes with elected local authorities. All local governments have tax-raising powers, a system which is improving recently, but still most receive almost all their annual revenue from central government.

One of the priorities of the actual government is the decentralisation of power towards the local governments in certain areas such as health (primary health care, including the public health services at local level), education, ownership over pastures, forests, etc. The local governments are responsible for the maintenance and provision of equipment to the Health Centres, but the appointment of doctors and other medical staff is done by the Directories of Public Health at district level, while the payment of doctors is done by the Health Insurance Institute while for the other staff from the above mentioned directories.

Albania is still one of the poorest countries in Europe. Its GDP is difficult to calculate due to the extensive informal economy, The 1997 crisis brought an increase in the demand for cash assistance under the social insurance scheme. However, due to the growing number of families in need and a high rate of inflation, the social insurance scheme is allocating less benefit in real terms.

Albania shows the signs of demographic transition, however it still has high rates of infant and maternal mortality and morbidity: anyway there is a decrease in birth rate. Chronic diseases and cardiovascular diseases are on the increase and are the main cause of mortality; cancer and accidents are also important contributors to mortality. Even people's diet is changing, but vegetables and fruit are still part of the traditional diet. Tobacco consumption is increasing, as well as that of alcohol, especially among females – but consumption is lower than in other East European countries.

Vaccine-preventable diseases have decreased dramatically due to the improvement of vaccination programmes. Family planning is offered in primary health care facilities, and numbers of abortions are decreasing.

Despite isolation from the USSR, the health care system was developed based on the Semashko model. Sanitary–epidemiological or hygiene stations were set up in every district. Health services were organised and controlled from the centre in vertical programmes administered at district level through separate directorates responsible for medical care. After the 1990s, the system was reorganised and more autonomy was given to the districts. Also, primary care services were offering more services but still demand exceeded supply, and the hospitals still carry a heavy burden. The so called "classical" services of public health – hygiene and epidemiology – are included in the primary health

care services, together with health education and promotion. A new system – that of Regional Health Authority – is being implemented in Tirana and the Directory of Public Health functions as a separate entity, divided from the Directory of Primary Health Care.

General practitioners are paid by Institute of Health Insurance per capita, and they also carry out many public health duties included in their contract. The public health services are going through a reform, and the main Institute of Public Health is undergoing changes, including the development of surveillance and preventative programmes for infectious diseases, other chronic diseases and non-communicable diseases. Importance is being given to programs in the field of health education and promotion, as well as to programs of monitoring and evaluation.

The information system needs to be updated; often information is not used for action purposes but is considered as a statistical exercise. Training in management, administration and modern public health is under way, but is not offered regularly, and there is no School of Public Health in the country.

The Faculty of Medicine, which offers training in medicine and postgraduate training in specialist areas, has had very little contribution to either health care reform or continuous education.

A credit system is not established within the Ministry of Health. Recently, the Order of Physicians has taken the very first steps in this direction.

After the failure of pyramid schemes and the consequent widespread violence, many health facilities and hospitals were destroyed and looted, and health care services were reduced to emergency care only. From 1999 onwards, most were rehabilitated and the number of hospitals and hospital beds was reduced according to a well-planned strategy. Some advanced technologies have been introduced into the health care system, and efforts to improve the quality of care are being felt all over the country. The struggle to cope with the massive humanitarian disaster in 1999 has focused the strengths and operating forces within the country, leading to many development initiatives in the field of public health.

3. The Need for a Public Health Strategy in Albania and its Guiding Principles

3.1 Background

The Albanian Government is committed to the right of every Albanian to enjoy the highest attainable standard of health. Part Two, Chapter V of the Constitution provides for the state to support a high standard of physical and mental health and a healthy environment for the citizens of Albania[4]. As well as being a fundamental human right, individual health is also a precondition for personal and family well-being and quality of life. As such, it is a major long-term resource for the functioning of society as a whole. All these factors justify long-term investment by Albanian society at all levels to sustain and improve the health of Albanians.

As well as being strongly influenced by individual genotype, personal health is greatly affected by factors that affect society as a whole. These are social and economic conditions, and environmental and behavioural factors. Their total effect determines the overall state of health of a society. This is usually referred to as the „state of public health". Thus public health is an important indicator of a society"s social cohesion and inclusiveness; of its wealth and poverty, and their distribution; and of its environmental conditions and cultural norms. It follows that many different sectors of society need to be involved in efforts to sustain and improve public health.

Sustained and ethical economic and social development are necessary for good public health. Conversely, good public health is necessary for sustainable economic and social development. Moreover, the formulation and systematic implementation of policies that improve public health status (for example, by reducing injuries, diseases and long-term disabilities) leads to reduced need for some social and medical care services, and thus provides greater flexibility for decision-makers about national and local government expenditure.

These are critical issues for Albania"s future, and will become increasingly important as Albania seeks accession to the EU in the future. In particular, Article 152 of the Treaty of Amsterdam requires health impact analysis of all social and economic policies of the Union and of EU member states, thus accounting for the impact on public health of policies in all other fields will be an inescapable requirement of EU membership.

Improving public health status requires planned, coordinated and sustained actions, based on science and directed at populations, to promote health, prevent disease and prolong life, through the systematically organised efforts of society. The principal functions of contemporary public health practice are set out in Appendix III.

3.2 Life expectancy statistics

Despite living in one of the most underdeveloped countries of Europe and having suffered from social isolation, many Albanians have enjoyed relatively good health compared with other low-income societies, or even compared with some high-income western countries. However, high infant and maternal mortality, increasing tobacco and drug use, increasing trend of road accidents in the recent years; and incomplete non-communicable disease control mean the state of public health in Albania gives cause for concern. Expectation of life at birth has for many years provided a good summary statistic of the state of public health in a population, and a basis for comparison between countries. Very recently, new statistics have become available that take disability into account, also providing a measure of the quality of life expectancy. While Albanians live longer, and live longer without disability, than people in other countries with similar gross national income (GNI), on both measures Albania is still behind some other countries in the World Health Organization (WHO) European Region.

Compared with the 15 European Union member states and the 13 states negotiating

accession to the EU, data from 1998 place Albania in 19th position for average unadjusted life expectancy at birth (75 years in, a year below the EU average of 76)[5], and, with more recent data, in 26th place for Healthy Life Expectancy (HALE) a new WHO measure of life expectancy with an adjustment for years spent in poor health, (59.4 years in 2000, ten years below the EU average of 69.8 years)[6]. The difference between the average unadjusted life expectancy and the HALE highlights the need to improve the health of the population.

The averages mask an inequality of about years between female and male unadjusted life expectancy at birth (72.9 and 64.3 years, respectively, in 2000)[7]. Despite slight downturns in 1994–96[8], trends for both genders have shown a steady increase since the late 1980s.

3.3 Incidence of health problems

Albania"s relatively high life expectancy appears to be the result of a protective Mediterranean way of life, including healthy nutrition and physically active lifestyles, plus a low incidence of automobile and industrial trauma. Total morbidity patterns conform with the low-income country pattern, with communicable diseases occupy a high ranking. On the other hand, mortality in Albania mirrors that of higher-income countries where cardiovascular disease, chronic pulmonary disease, cancer and accidents outrank communicable diseases as main causes of death[9]. The top three causes of death in 1999 and 2000 were circulatory system diseases; cancer; and external causes from trauma, poisonings and accidents. Death rates from circulatory system diseases and cancer have increased since 1997, while deaths from accidents and injuries decreased[10], after a rise in 1997 when civil unrest and violence gripped the country.

As countries develop, they often experience a mortality transition due to changes in lifestyle, resources and infrastructure. Many countries see a significant overall decrease in communicable diseases and an increase in diseases of „affluence", such as cancer and heart disease. Albania appears to be following a slightly different transition, like other Mediterranean countries, with a fall in mortality from most infectious diseases and a relatively small increase in diseases of affluence[11]. However, standardised death rates reveal that Albania is still faring worse than most Western European countries, though somewhat better than some other transitional countries. For example, according to the WHO[12], in 1998 Albania"s standardised death rates:

> for cardiovascular diseases in both sexes were approximately 55% higher than those of the United Kingdom and 153% above France, but 22% below Estonia or Hungary – far higher than other Mediterranean countries such as Spain, Italy and Greece
> for cancers in males were approximately 26% below those of the United Kingdom, 35% below France and 42% below Estonia; these values are slightly lower than Greece and much lower than Croatia; females are doing even better with standardised death rate for cancer approximately 57% below those of the United Kingdom, 41% below France and 51% below Estonia
> for accidents, injuries and poisonings were 40% higher in females and 178% higher in

Comment [GHW1]: These figures have not changed, just a maths error – sorry! - GHW

males than in the United Kingdom and 62% lower in females and 55% lower in males than in Estonia or lower than Macedonia or Romania
for diseases of the respiratory system were 117% higher than Austria and 71% higher than Estonia
for infectious and parasitic diseases were half those of Bulgaria, only a third of those in Estonia, and comparable to Greece and the United Kingdom, but slightly higher than Czech Republic.

Despite the low death rates for cancer and cardiovascular diseases, as compared to the other European countries, rates for both of these causes of death have increased steeply since 1994. Between 1957 and 1987, increases in cardiovascular disease shaved three years off life expectancy. In addition, the major changes in the country since the early 1990s have allowed more people to own their own cars. During that period there has been an increase in accidents and injuries, which may continue[13]. If the current trajectory continues, Albania could lose its advantage within three to four years.

3.4 The main determinants of health

Research has shown that, although deficiencies in medical care may play a part in differences in mortality, morbidity, disability and self assessment of health, for most specific diseases and injuries this plays a small – albeit important – part[14]. The excesses in mortality are largely due to the higher incidences of the diseases and injuries in the first place, and the higher incidences are due to a small number of determinants (underlying, causative factors). Most determinants can be significantly and positively influenced by social, economic and public health policies, strategies and practices.

Those determinants are:

risk conditions, especially social and economic inequalities, prolonged or recurrent unemployment, poverty and social exclusion
harmful psychological, biological, chemical or physical factors, which are in fact often linked with social and economic risk conditions
lifestyle *risk factors*, such as smoking, alcohol and narcotics use, physical inactivity, poor nutrition and unsafe sexual behaviour, which are likewise linked with social and economic risk conditions.

3.5 Levels of action

Clearly, such a broad range and depth of determinants necessitates actions in many different areas of society, from individual to governmental, in order to maintain and improve public health. Given the nature of the determinants, such actions need to engage:

the highest policy levels of government (for example in battling against poverty or limiting industrial damage to the environment), many individual government sectors and local government

much of business and industry, and differing professional and other interest groups
citizens themselves and their communities, and the non-governmental sector (for example in promoting healthier eating or controlling tobacco).

3.6 Planning for action

For the success of actions of such scope and complexity, it is axiomatic that there is:

understanding of public health, and commitment, at the highest levels of government and state administration, to policies across sectors to improve public health
clear definition, systematic organisation, leadership, coordination and performance management of overall public health functions and practices
a public health strategy, based on problem identification and analysis, which sets out feasible measures of proven effectiveness
an implementation plan for the strategy, properly resourced with finances and personnel.

A major implication for the planning and deployment of resources is to ensure that the public health strategy, whose aims are necessarily long term, should be based on the investment of health approach and receives long-term sustainable financing. This requires the coordination of policies; practical cooperation of public health with other social and medical services; and, where necessary, the reallocation of resources from short-term to long-term uses. Also, the strategy must focus on what is achievable in the short and medium term from 2002–12.

4. The Basis for Prioritising Goals and Criteria for Including Priorities and Actions

4.1 Improving human freedom from the consequences of ill health

The humanistic view of mankind considers that all people have equal value, and that while we should strive to take account of individual needs, we should also take responsibility for the common good. Almost all changes in Albanian society have been inspired by these views (although they have not always been respected), and have avoided the deterministic view of man as controlled purely by fate, genetic conditions and social circumstances. Based on this view, everyone should have an equal opportunity to develop and to participate fully in the progress made.

Introducing this concept to health policy, we understand the importance of people's health and their ability to choose and influence their environment. So the consequences of ill health, measured in terms of premature death and handicaps, should be addressed first. Ill health creates obstacles between people's functions and the environment limiting their freedom, thus creating handicaps.

Developing the health of Albania will require action to formulate policies and programmes focused on the causes of ill health, not individual illnesses, and stressing the link between

the promotion of health and the absence of long-term health risk factors. The principle of a common risk factor has been taken into account, where exposure to a risk factor is often a contributory cause of several different diseases and/or injury. It is easier to focus on the determining factors than on individual diseases.

The determining factors can be chosen on the basis of their significance for the distribution and the consequences of ill health. These factors are often experienced in several sectors of society. Prioritisation must emerge from a choice of determining factors based on clear principles.

4.2 Minimising ill health for the most seriously ill

In the Albanian health policy from 1945–90, human health was first and foremost for the benefit of the State. It was important to have healthy soldiers, farmers and workers. The pronatalist policy was based on the view that size and health of the population were decisive factors for the nation"s survival and progress.

Welfare policies were introduced after the 1990s on the principle that welfare is equally valuable irrespective of who possesses it. The same principle is being applied when talking about health policies. But this is unacceptable to the principle of human worth and the needs and solidarity principle, which requires that the most seriously ill should receive preferential treatment.

Many health indicators measure health for the entire population, and a pattern is often created. Our national health–political efforts, which in practice favour many people, should focus the improvement on the groups with the poorest health.

4.3 Equality and efficiency

Achieving equality in health is not easy, as genetics and age influence the health of individuals. Health differences are unjust if it is possible to change them, and if they are a result of basic social structures which create wealth and good for many, but poverty and ill health for others. According to the work division in society, it is our responsibility to remove the unjust effects of such a structure. Responsibility for individual health is divided between the individual and society, while responsibility for injustices in health distribution among groups is primarily a matter for society.

Some of the circumstances that create ill health and mark people from birth and throughout their development, in work and dwellings, for example, can be unjust. It is necessary for each determining factor to decide whether it is possible to reduce or remove this factor without jeopardising the basic conditions necessary to ensure welfare for the groups affected.

We use the word 'vulnerability' to express the situation that, as a result of genetic factors, family or social background, or behaviour, some individuals or groups are more sensitive than others to the effects of given determining factors. Newborn babies, children, older

people, female sex workers, people migrating from poorer areas, inhabitants of rural areas, etc., need special health measures.

In certain sectors, life is changing and demands are greatly increasing, without corresponding to an increase in control. This interplay between determining factors is also becoming an important criterion for priorities and choices between the determining factors and target groups. Some measures to meet the needs of especially vulnerable groups have been addressed in special strategies.

Many determining factors are not just causes of illness, but also influence the progression and consequences of a disease.

Our criteria for prioritisation and special actions in this strategic document are based on:

the burden of diseases and their impact on morbidity and mortality
the disease trend – if there is a growing threat of worse health
preventability
plausible actions based on evidence.

Actions can be led by the Ministry of Health or Institute of Public Health; or these institutions can be instrumental in assisting other government departments or ministries in taking the action forward if a different government department has the lead and action is already under way, or action is covered by a separate strategy, for example, drugs, HIV/AIDS and vaccine preventable diseases, mental health .

Depending on the actions that are being taken by other government departments, the Minister for Health should take the initiative and provide the lead while the other ministers should provide backing as their departments affect health, and *vice versa*. Mention also needs to be made of links with all other government strategies and mechanisms for cooperation (see recommendations regarding the establishment of a Public Health Forum and Institute-led health development working groups with each ministry, section 6). Important areas for development include putting a good immunisation system in place, health care service development; and the system of health insurance.

Other development areas with an impact on health, but not included in the strategy, are:

transport infrastructure
communications infrastructure
security – internal and external
housing
food/agriculture
water sanitation
legal – ownership of business, legislation, law

education
social development
energy – power
migration – both to and from (threat of brain drain out of Albania)
youth, culture and sport.

All these areas have an impact on health, and all need their strategies to include health when they are written.

5. Overall Goals, and Equity and Solidarity in Health

5.1 Overall goals

This strategy is intended to help advance the health of the people of Albania towards the best in Europe as quickly as possible. Given the current situation, it is important to set realistic overall goals. According to the burden of disease, the key health problems faced in Albania are:

1. **cardiovascular heart disease/cancer**
2. **accidents – home, work, traffic**
3. **reproductive health/sexual health – cervical cancer, HIV, AIDS**
4. **respiratory diseases**
5. **mental health – social changes, suicides, drug abuse**
6. **diarrhoeal diseases.**

The country has shown remarkable ability to change and adapt to new situations in the past, including responding to the Kosovar refugees and the rapid economic turnaround following the 1997 collapse. As of 2000, Albania ranks fourth out of 27 for percentage change in GDP among Eastern European countries, and has one of the highest GDPs in the region after a decade of instability[15]. There is reason for hope.

The goal for the first five years is :

to preserve the present level of life expectancy and health experience at the 2001 level, and

And the overall goal is:

to achieve year-on-year improvements in life expectancy and health experience

5.2 Equity and solidarity

Social and economic deprivation, including major inequalities, severe poverty and social exclusion, are the largest single determinant of ill health, and a major destroyer of social

cohesion in all societies. Such deprivation is associated with higher rates of tobacco, alcohol and narcotics use, depression, suicide, antisocial behaviour and violence, increased risk of under-nutrition, a wide range of physical conditions, and severely curtailed life expectancy at all ages. Fortunately, none of these problems is inevitable – policies directed at enhancing social solidarity among income, gender, ethnic and age groups, and reducing the inequalities among them, do actually work.

Analysis of the Albanian situation

Albania is the poorest country in Europe with a GNI (purchasing power parity; PPP) per capita in 1999 of US$3240 versus US$6770 for all of Eastern Europe[16]. Following the 1997 collapse of fraudulent pyramid schemes, in which many citizens lost their life savings, the government has successfully reversed negative economic trends. However, one-third of Albanian families have only one income source, averaging US$64 per month – the lowest in Europe[17].

Albania also has nearly the lowest human development index in all of Europe, only the Republic of Moldova is lower, and has dropped slightly since 1999[18]. Recent indicators suggest a standard of living that needs improvement: 45% of the Albanians have running water inside the house and only 16.4% need to take water from public faucets. The number of fixed phones seem to be improving as from 2000 to 2001 more than 30,000 new residential telephone lines were in place[19].

Poverty is not evenly distributed across Albania: 15% of urban dwellers are considered poor, while twice as many (30%) of rural Albanians are poor[20]. Overall, 24% of Albanians fall below the official poverty line; 36% of these are families headed by a single mother. From 1998 to 1999, real wages rose by 10%, though average family income is still low (about $300 per month)[21].

Official unemployment in 2000 was the lowest it had been since 1996, at 16.8% in 2000[22]. In March 2001, it fell one-fifth compared with a year before, and in June 2001 the rate was 14.3%. Most increased employment has been in the urban private sector, with public sector and rural employment remaining level[23]. While these trends show an improvement, rates are still among the highest in the region, with Greece at 10% and the Czech Republic at 5% in 1999[24]. As of 2000, there was also a gender gap with a slightly higher proportion of woman (19%) than men (15%) being registered for unemployment. And, younger people are significantly more likely to be unemployed with those between 16 and 34 making up nearly 60% of the registered unemployed[25]. Underemployment is also a significant problem, especially in rural areas[26]. A survey conducted in 2000 revealed that 33% of Albanian adults are only partially employed[27].

A state welfare system established in the early 1990s has provided a small benefit for unemployed and those officially below the poverty line. However, the benefits are meagre (the basic benefit per month is about $18) and the administration of the programme inconsistent and unequal[28]. There are limited social services or financial provision for

people who are more vulnerable such as those identified by the World Bank: street children, children in orphanages, women who are victims of abuse, women as objects of human trafficking and prostitution, dug addicted youths, other youth engaged in high risk behaviours, and lonely or abandoned elderly people[29].

These high levels of poverty and unemployment undoubtedly play a major part in Albania"s low position in European health comparisons, and are almost certainly associated with a steep health gradient within Albania: worldwide experience shows that better-off people live several years longer and have fewer illnesses, injuries and disabilities than poorer people. Unfortunately, insufficient Albanian data are collected routinely to demonstrate this and to show trends over time. However, a recent survey of reproductive and family health issues has demonstrated a gradient across Albanian society, with better educated people tending to report better personal health, better health knowledge, and a higher percentage of healthier behaviours than less well educated people at the opposite end of the scale[30].

The available data do not reveal if there are any significant differences in poverty or health status among Albania"s ethnic groups. The country appears to be fairly homogeneous, however, with the latest available data from the 1989 census showing that less than 5% of the population were Greek or other minority groups such as Vlachs, Gypsies, Serbs, and Bulgarians and the rest Albanian[31,32].

Regional differences in infrastructure and poverty contribute to inequality. Mountainous areas in the north and east are home to poorer peasants who farm land that is prone to erosion and lower productivity. Those in the southern areas of the country benefit from richer farm land, more productive industry, and better infrastructure[33]. There is evidence for lower utilisation of health facilities by people in rural areas and those with lower levels of educational attainment. For example, only 45% of rural respondents to a survey conducted in 2000 were registered at a health centre, and half did not have a family doctor. For some the nearest health centre was 20 km away, and 39% said there was no pharmacy near enough to their home[34]. Although nearly 70% of the general population were covered by basic health insurance, only 3% of farmers (who comprise about a quarter of the population) were covered. Many children, women and older people were also not covered[35]. But even so, they are covered by the state health structures to receive basic health care. Infant mortality, especially post-neonatal mortality, showed a gradient in 1995 from 11.8 per 1000 live births in urban areas to 22.6 in rural areas[36] – this figure has now reached fewer than 20 per 100 000, whereas in Tropoje, Has and Kukes, rates are still much higher.

Health care inequalities are not limited to rural areas – even in Tirana, 21% are not registered at a health centre and some do not have a family doctor[37]. Unfortunately, a lack of data conceals the extent of such inequalities; but the problem is almost certainly widespread and significant across most health care and public health services.

Homelessness is a also serious problem following the 1997 crisis, when many people sold

their homes to invest in the pyramid schemes, although data are not available showing the numbers of such people. Many have since been housed in vacated emergency dwellings erected for Kosovar refugees, or in some new accommodation built with external funding[38]. Recent changes in the economy show that the construction sector has increased and now contributes the most to GDP: 18% in 2000 up from only 7% in 1992[39]. Much of this represents residential construction and in the first six months of 2001, more than 700,000 m^2 of new housing was built[40].

In the mid-1990s, the government initiated health system reform measures which legalised health insurance and aimed to improve the quality of care as well as patient and doctor satisfaction[41]. In 1995, the Health Insurance Institute was founded, with a unique financing scheme sensitive to the extreme levels of poverty among the population[42]. Unfortunately, the economic and civil crisis of 1997, and the formidable nature of reforming a system that was so fragmented and inefficient, meant that the reform measures have still not fully taken hold. Anyway, after 1997 the services of public health are included in the personal contract that family doctors have with the Health Insurance Institute. Shortly after things had begun to settle down following the 1997 crisis, nearly half a million Kosovar refugees entered the country in 1999. This put a huge strain on the already weakened social services infrastructure[43].

In addition to lack of access and poor conditions in hospitals and health centres, the health care system also has the problem of illegal payments. More than two-thirds of the population (80%) have admitted to paying an illegal fee to a doctor or other health care worker for treatment.[44] Illegal fee payment can partly be attributed to a culture of such payment and a belief among patients that they must pay, and it is the rural and less well educated people who end up paying these illegal fees more often. In the same study, seventy-five per cent of respondents agreed that the health system needs to be managed more effectively.

In 2000, UNICEF developed a rough measure of social exclusion measuring poverty, infant mortality and school drop-out rate. This index revealed a geographic pattern with higher levels of social exclusion in the north and east with improvements heading south and west. It is believed that many of the southern-most districts may be better off due to remittances from abroad, as those areas are closer to Greece and Italy, the primary magnets for economic emigration[45].

Practical implications

Achieving these targets will require action as follows:

- a much higher profile in Albanian public and political life for health status, why it is vital for Albania"s social and economic success, and how it can be improved
- the adoption and implementation of this proposed strategy
- the development and application of skills in assessing the impact on health of policies in other sectors, and modifying such policies where necessary, in keeping with the

Amsterdam Treaty of the European Union (Article 152)
regular expert reports by the government, prepared for parliamentary and public discussion, debate and decision, on the health status of the people of Albania, and the efficacy of current health improvement measures
significant and sustained economic improvement and social development in Albania, including the formulation, adoption and implementation of measures designed to reduce poverty, economic inequality and social exclusion, based on the poverty reduction strategy being formulated with the assistance of the World Bank
concerted action across all sectors of society, at national and local levels, to identify and meet the needs of the worst-off
sustained prioritisation of the needs of the least advantaged people in the implementation of the measures proposed in this public health strategy
major improvements in public health information systems to:
- supply baseline data for target-setting
- allow progress towards the target to be monitored
- provide a well managed and sufficient database for regular; comprehensive reporting on the health status of the population
- enable health impact analysis to be undertaken.

6. General Recommendations for Improving the Public Health System

6.1 Introduction

Set out below are the short- and medium-term actions required to improve the public health system. These will require broad consultation, refinement in the light of responses to consultation, and then preparation of detailed implementation plans and budgets, before final approval by the Ministry of Health.

By 2003	Institute of Public Health to issue licences to Public Health Specialists to enable them to practice.
By 2003	The Institute of Public Health to prepare annual national public health report for the Minister of Health.
By 2003	Institute of Public Health to be responsible for effective communication systems between Public Health Directors of each District and the Institute on all issues of public health.
By 2004	Director of Public Health and each District to produce an annual health report.
By 2004	Within each district, employ one Health Promotion Coordinators thus establishing a strong network of trained health education specialists. The Health Promotion and Education should also occupy an important part of the everyday practice of the family doctor.
By 2004	A District Public Health strategy bazen on the national strategy to prioritise to District needs.
By 2004	Establish a national training programme for the health education and promotion specialists.
By 2004	Establish an ongoing post-basic training programme for doctors, nurses and health education specialists in public health.
By 2004	Each Ministry works with the Ministry of Health and the Institute of Public Health regarding its Department"s contribution to health, by establishing health development group.

By 2005	Common training for public health specialists and more flexible training, including part-time and full-time, and academic with field work, by 2005. Specialist public health training needs to be reviewed through collaboration between the Public Health Institute and the Faculty of Medicine. This will result in high-quality training that includes fieldwork placements and academic training, and is linked to ongoing training and accreditation by the Institute.
By 2005	Establishment of the School of Public Health
By 2005	Establish a national public health forum to include NGOs, district departments, other government departments, professional associations and groups. The forum will advocate, share information, and help coordinate action.
By 2005	Improve the status of public health specialists. Public health specialists should be moved into a higher salary bracket.
By 2005	Introduce a credit system of points for training courses attended – the more points, the higher the salary.
By 2005	Establish a comprehensive public health information service within the Institute.
By 2005	Undertake feasibility study of establishing screening programs for protecting the women's health (breast and cervical cancer screening)
By 2006	Start health education training for all nurses and family doctors as part of their basic training.
By 2006	To establish a network of community health workers in the rural area
By 2006	To include all school in the network of Health Promoting Schools
By 2008	Increase the number of trained specialists from 110 partly trained (2002) to 130 fully trained specialists.

6.2 Targets and actions

The health of Albania and the Albanian people is affected by many complex factors which defy simplistic solutions. Section 7 of this strategy provides a situational analysis of the state of the health of Albania. It highlights areas of development which will need to be frequently revisited and provides holistic models such as the WHO Investment for Health approach which can help thinking on whole systems solutions.

The situational analysis makes it clear that real improvements in health and well being are linked to many interrelated factors:

1. Social and economic factors of which poverty and inequalities play a large part.
2. Government policy and spending decisions across sectors including; education, agriculture, the environment, transport, employment and health.
3. Infrastructures which support health across the above areas, but including systems for the effective delivery of public health, health care and health promotion.
4. Lifestyle risk factors that are linked to social-economic factors and include behaviours such as smoking, physical inactivity, use of alcohol and narcotics, poor nutrition and unsafe sexual behaviour.

The complexity of theses issues means that they cannot be addressed by one sector alone and effective intervention will require actions on many levels including: governmental, professional, community and the individual.

Section 7 provides information on the areas that need attention in order for Albania to become a healthy country with healthy people. It also makes the connections between many of the differing priority areas. The comprehensive approach, which respects the interdependencies of work on differing topics, should underpin a developing work programme. However, acknowledging that everything cannot be done at once, an expert group in Albania have set targets and outlined actions in specific areas that they consider to be of priority. Based on this, an outline work plan has been developed which suggests the funding implications. Once funding has been achieved, a detailed project plan will be developed which will not only detail inputs, but which will clarify outputs, outcomes and evaluations methods.

Smoking has been identified as a major cause of ill health and death and is an area amenable to public health and health promotion interventions. It has, therefore, been the subject of extensive and separate strategic development (see appendix 1). However, that work is reflected in this strategy and work plan.

It cannot be stressed enough that while the work programme must be achievable and reflect what is possible within available resources, actions in priority areas must be seen in the wider context of the need for political stability and economic and social development for a fair and equal society.

Specific targets for short and medium term actions

1. Priority action area: Coronary heart disease and cancer

Coronary heart disease and cancer are the two main causes of death in Albania. A major contributory factor to these is smoking cigarettes, being responsible for the death of one in five males under 70 years of age. With the exception of Hungary, Albania has the highest smoking rate in Europe and rates have increased since 1990 from 29% in that year to 39% in 2001.

This is clearly a priority area for public health and health promotion action and a separate strategy paper has been produced to cover tobacco related issues in more detail. The findings of this paper are reflected in the actives given below. However, other issues also contribute to coronary heart disease and cancer and targets have also been set in the areas of physical activity and healthy eating. In addition, socio-economic factors can impact upon smoking rates and health promotion activities should be located within the broader development agenda.

(see page 59)

1.i Targets on tobacco use

To stop the present increase in smoking in men and effect a 2% year on year reduction in this level.

To stop the increase in smoking in women and effect a 20% reduction on the 1999 figure by the year 2010.

1.ii Actions

(*This section should be read in conjunction with the tobacco control in Albania report located at appendix 1.*)

Implement the tobacco control strategy in the following areas:

Infrastructure and tobacco control

- Improve the infrastructure for tobacco control.
- Adopt a tobacco control law.
- Increase the capacity of experts and professionals in the statutory and NGO sectors.

Research

- Publish research findings.
- Conduct bi-annual surveys.
- Develop international links to import expertise and provide funding.

Price and tax measures

- Develop a formal taxation system.
- Increase tobacco tax.
- Hypothecate taxation.
- Undertake economic analysis of tax policies.

Cessation and prevention

- Facilitate pilot projects.
- Provide nicotine replacement therapy.
- Provide smoking advice at the GP/Primary care level.

- Initiate health promotion projects to provide information and support for those who have not started to smoke and those wishing to stop. This to include the development of smoke free environments.

2. Targets for Healthy eating

From 2000 to 2001, the Albanian consumer price indices (CPI) for tobacco, oils and fats has fallen whilst the CPI for fruits, vegetables, bread, cereals and medical care has risen. If the relative cost of healthy items increases, people are more likely to make unhealthy choices. However, price is not the only reason that people may not eat a healthy diet, there being a range of factors relating to societal change and individual circumstance, *(see page 56)*. While it is essential to ensure that all Albanians have an adequate and nutritious diet, it is also import to ensure that changes away from a traditional "Mediterranean`" diet do not contribute to an increase in coronary heart disease.

2i Target

To promote and preserve healthy eating within the whole population, but with specific attention to the worst off in society, and to reduce under nourishment to negligible levels by the year 2010.

2ii Actions

To compile an educational program in schools starting from the low grades.
Produce educational materials on healthy eating.
Provide targeted interventions on infant nutrition, e.g: breast feeding programmes food supplements and education for parents, carers and food providers.
Facilitate a GP nutritional advice training programme.

3. Targets on Physical Activity

Adequate levels of physical activity not only help to prevent heart disease and aid weight control, it can also help in the prevention of non-insulin dependent diabetes and osteoporosis.

(see page 58)

3.i Target

To establish the current level of activity and ensure that those who are able, have 30 minutes of moderate exercise per day.

3.ii. Actions

Collect base line data on current types and levels of activity.

Establish collaboration between the Institute of Public Health and the Ministry of Youth, Culture and Sport to develop an action plan based upon the data.

4. Targets for Reproductive Health

4.a HIV/AIDS

Reported cases of HIV infection have risen from 10 by 1994 to 72 by 2001. These rates are the lowest in Europe. However, there is reason to believe that there is considerable unreporting as the lack of treatments such as retroviral drugs means that people are

unlikely to come forward for testing until they need treatment for a secondary infection

A national strategy inter-dicaseterial and multi-sectoral is being prepared by the Institute of Public Health for HIV/AIDS and STIs. Only some of the main activities are included in this document.

(see page 43)

4.a.i. Target

To maintain low the level of incidence of HIV infection

4.a.ii. Actions

Expanding the sentinel surveillance among the groups at risk for acquiring HIV infection

and once incidence has been established

Provide appropriately targeted prevention and health promotion services with particular stress on school attending youth

Provide effective treatment and counselling regimes for those affected by HIV.

4.b. Sexually transmitted infections (STI's)

While levels of STI"s seem to be low, there has been a tenfold increase in the rate of syphilis since 1997 and there is also a possibility of under-reporting of other infections.

(see page 44)

4.b.i Target

To halt the current increase in the incidence of STI"s and maintain low levels of infection.

To reduce the incidence of syphilis by a factor of 10 by 2010.

4.b.ii. Actions

Determine surveillance systems for reporting of STIs

Provide adequate treatment and prevention services.

Provide targeted health promotion in a range of settings.

Introducing the concept of youth-friendly services in the Primary Health Care settings

4.c. Unwanted pregnancies

Since abortion became legal in 1991, the rate has risen to 40 per 1000. In addition only 60% of women have access to family planning services.

(see page 39)

4.c.i. Target

To reduce the rate of unwanted pregnancies by making contraception services accessible to all women by 2010.

4.c.ii Actions

Initiate research on access to appropriate services across Albania.

Increase and enhance service provision and accessibility across Albania.

4.d. Breast and cervical cancer

Fewer than half of Albanian women surveyed in 2000 had ever had a gynaecological examination. Most of those women who had been examined were from Tirana or Durres. The possibility for early detection and effective treatment of cervical cancer is, therefore, limited and it is proposed that work should be undertaken to address this.

(see page 39)

4.d.i. Target

To assess the feasibility of breast and cervical screening and report by 2004

4.d.ii. Actions

Conduct a feasibility study of breast and cervical cancer screening.

and then

Role out appropriate service provision base on the findings of the study in collaboration with the obstetric and gynaecologic university clinic and primary health care.

5. Respiratory disease

Albania has a high rate of diseases of the respiratory system (71% higher than Estonia for example). Measures to address smoking will have an impact upon this rate, but actions to address diseases such as TB may also be needed. In addition, measures in the National Environmental Health Action Plan to improve the quality of air should be linked to work in this area.

(see pages 8, 42 and 46)

5.i. Targets

Chronic and acute respiratory diseases: To decrease the present upward trends in chronic respiratory disease and control outbreaks of acute respiratory disease especially in children.

5.ii. Actions

Strengthen and make effective the monitoring and surveillance systems.
Establish quality indicators for reporting.
Expand air quality monitoring to all urban areas.
Monitoring the indoor air pollution in the super-populated areas (Tirana and Durres)
Finalise local NEHAPs and implement them

6. Mental Health, alcohol and drug use

Political and social factors are known to impact on the mental health of populations and treating the individual without addressing the wider issues is likely to have limited impact. The rate of people dying as a result of „mental disorders" has increased since 1997, while there is thought to be in excess of 20,000 drug users in Albania. Alcohol remains a problem for Albania and its misuse is estimated to cost the country up to 5% of its gross national product.

A particular strategy is also being elaborated in the field of mental health; Ministry of Health is also in posses of a draft strategy for drug-demand reduction.

(see pages 39, 40, 41 and 59)

6.i. Targets

To develop comprehensive base line data in all areas which relate to mental health and to put in place a mechanism for updating and using this data in a systematic way. This will provide information for the further refinement of the targets:

a. To promote social change and enhance the well being of the population of Albania.
b. To increase the uptake of primary mental health care services and reduce the uptake of acute mental health care services.
c. To decrease the number of suicides.
d. To reduce illegal psychoactive drug use and resulting harm and mortality.
e. To maintain alcohol use at the low 2001 level of consumption across the whole county.

6.ii. Actions

Initiate systematic data collection across all areas relating to mental health and further define the targets and actions based upon this information.

Social Change

- Develop a set of population well-being indicators.
- Increase awareness of professionals and members of the public of ways to prevent and recognise mental illness.

Suicide

- Set up a pilot school counselling scheme in 10 high schools.
- Set up a pilot community nurse counselling scheme in 4 areas (2 rural and 2

urban)

Alcohol

- Initiate an alcohol awareness programme with a special emphasis on drink driving.

Drugs

- Collect data on the prevalence of drug misuse

and then

- Develop appropriate health promotion, prevention and treatment services.

7. Accident prevention

The incidence and perception of violence in Albania is a contributory factor to mental health problems, and social change initiatives in that area should take this into account. The accident rate in Albania is still relatively low as compared to other countries in the region. However, there may well be under-reporting, as a systematic method of collecting data is not in place. It is known that external causes are the main reason for death between the ages of 4 and 45. There is also a comparably high fatality rate in relation to road traffic accidents. It is important to stress out that the violence as well as the domestic violence has increased since 1997.

(see page 55)

7.i. Target

To set meaningful targets based on systematically collected data by 2004

7.ii. Actions

Put in place a mechanism for data collection and analysis as far as accidents and violence are concerned.

Adopt a multi-sectoral approach to improve roads, driver training, traffic legislation and the enforcement of laws.

Facilitate a Road Safety Education programme in elementary schools.

Facilitate particular school education programs and programs oriented towards groups at risk for violence prevention

8. Diarrhoeal diseases

There has been a very slight decrease in diarrhoeal diseases (1999 –1,602.7 to 1,598.1 per 1000,000 in 2001). However, there is still considerable scope for improvement and work in this area should be linked to the NEHAP and the Water Strategy, both of which remain in initial phase.

(see page 44)

8.i. Target

To reduce the incidence of diarrhoeal disease by 20% by the year 2010 and maintain a year on year improvement on this.

8.ii Actions

Improve waste management systems.

Produce quarterly water quality reports at the District level.

Train District epidemiologists to report and manage outbreaks.

Raise awareness of personal and public hygiene issues in schools and at the District level.

Improve food safety measures

7. Mechanisms for Improving Health in Albania

7.1 A healthy start in life

Life transitions and health

Throughout the course of human life there are critical transitions, including birth itself, the emotional and physical changes of early childhood, starting school, changing schools, starting work, leaving home, setting up a family, changing or losing employment, retirement, bereavement. Each of these changes can affect health, and each needs to be positively managed if damage to health is to be avoided. Adopting a life-course approach to developing policies for health recognises the complex interactions between such life events, risk conditions and risk factors.

Babies and young children

Giving children a healthy start in life must be a priority for Albania. Investing in health protection early pays off later. Two kinds of policy are therefore required:

social policies that create a supportive environment for good parenting
health policies that promote reproductive health and well-being; high-quality health care in pregnancy, childbirth and early life; and high-quality developmental and preventative services.

Analysis of the Albanian situation

The health and well-being of Albanian babies and young children is significantly below European standards. After rising slightly from 1988 to 1992, infant mortality is in decline from a peak of 34 per 1000 live births in 1992. However, reports of current rates of infant mortality ranged from 12.2 to 20 in 1999 across various reliable data sources[46]. Using an average of this range, and comparing it with WHO reports for the rest of Europe, this rate of infant mortality is very high. Compared with EU member countries it is over four times as high, and compared with those applying for membership it is almost twice as high[47]. According to official Albanian health statistics, 31% of infant mortality was attributable to pulmonary diseases in 1997 and 1998[48], while diarrhoeal disease was the third leading cause of infant death[49].

A report from the Ministry of Health estimates that 23% of pregnant women suffer from anaemia, down from a reported 53% in 1990 though still high[50]. In a country with a very young age structure, such as Albania, ante-natal care is very important. Despite the poor infrastructure, which may be influencing infant mortality trends, many women are reportedly receiving antenatal care: in 2000, 95% of women received antenatal care from a skilled professional at least once during pregnancy[51]. However, a single visit does not ensure a healthy pregnancy – only 18% of women sought antenatal care in their first trimester, 45% waited until the second trimester, and 37% delayed consulting a health professional until the last three months of pregnancy. Not surprisingly, these data correlate

with education level: more women with higher levels of education are seeking antenatal care earlier[52]. Data are not available to indicate how many made early, regular visits to a health care professional to ensure a healthy pregnancy and birth.

Trends in perinatal mortality have been similar to infant mortality: they have been improving since the early 1990s. But they seem to have levelled off since 1994, and still compare unfavourably with other European states: the average post-neonatal mortality rate in 1998 was 14.1 deaths per 1000 live births[53], placing Albania in last place in Europe on this key measure of child health[54]. Perinatal mortality tends to reflect service provision and quality of antenatal care services.

Low birth weight – a significant risk factor for later physical and intellectual development – affects between 3 and 8% of all births[55,56]. Breast feeding, which is a major protective factor against infections and allergies and contributes greatly to physical, mental and emotional development, is falling: in 1998 only 70% of six-month-olds were breast fed, down from a high of 87% in 1996. One household survey, taken in 2000, showed that only 9% of children under four months were exclusively breast fed, and only 24% of six- to nine-month-olds were breast fed in combination with other foods[57]. A separate survey, also carried out during 2000, indicated that 84% of women breast fed for six months or more, and that breast-feeding behaviour correlated with a higher educational level of the mother[58]. It will be important to track this behaviour carefully to ensure that Albania does not fall below other European countries with which it is currently comparable.

Although the International Medical Corps spoke in 1999 about malnutrition as a serious problem for children, several reports – even at the beginning of governmental democratic changes – did not show any severe malnutrition in Albania, including the poorer areas. But, iodine deficiency was cited as a particular challenge, with 794 cases in one district[59]. In 2000, 44% of households did not have adequately iodised salt[60]. Food supplementation to prevent vitamin A, D and iodine deficiency is patchy and the maximum coverage is 21% in one district. Many districts do not have any supplementation programmes in place[61]. Meanwhile, the Ministry of Health in collaboration with UNICEF have undertaken a program for preventing the iodine deficiency.

Data from the 2000 UNICEF Multiple Indicator Cluster Survey (MICS) indicate that 4% of children aged under five are too thin for their age; 17% are stunted; and 4% are wasted, a sign of recent malnutrition and under-nutrition[62]. Malnutrition is somewhat worse for Albanian male infants: at one year, 28% were stunted and 14% showed signs of moderate or severe wasting. This is compared to 24 and 11%, respectively, for one-year-old girls. At the same time, however, between 1996 and 1998 nearly 11% of Albanian children aged under five were more than two standard deviations *above* normal weight for height measures, suggesting that some children are showing early signs of obesity[63].

WHO data show that immunisation rates, after falling in the early 1990s due to upheaval during the transition, are now satisfactory by international standards. In June 2002, Europe was declared polio-free by the European Regional Commission for the

Certification of Poliomyelitis Eradication. This significant achievement depended a great deal on Albania because of an outbreak in 1996 which threatened to spread out of control[64]. Successful efforts to control this disease in Albania are testament to the potential for a well-organised and effective health system. But some diseases, such as mumps, are still a cause for concern[65,66]. Rubella, in particular, has shown a sharp increase, to 1752 cases in 2000 from only 15 cases in 1999[67]; but after a successful immunisation campaign, by the end of 2000 numbers reduced to only 18 cases in 2001. The indigenous transmission of measles seems to have been interrupted following the national immunisation campaign, which had a coverage estimate of 95% in 2001 according to the WHO[68]. However the distribution of vaccination cards is still low and sometimes creates confusion. In 2000, the UNICEF MICS collected information from vaccination cards showing that only 61% had received measles vaccine, and only 57% polio[69]. In order to remedy these problems the Ministry of Health has developed a National Plan of Action for Immunisation, aiming to improve the levels of immunisation, as well as surveillance and monitoring of vaccine-preventable diseases, by the year 2005[70].

Data from the Albanian Ministry of Health for 1998 show that for babies and toddlers up to age of four, the leading cause of death is respiratory diseases. However, after age four most young children die from injuries and accidents[71].

*7.2 Health of children and young peop*le

Through their school years, children and young people develop from almost complete social dependency to taking up their full responsibilities in society. As well as intellectual and physical development, this period of their lives should provide the fullest possible opportunity for the development of personal, social and health skills. At the same time, they need the advice, support and protection of their families, schools and society at large, to help them cope with the many social and emotional challenges they will face before their own skills have fully developed. Some of these challenges may seriously threaten their physical or mental health. A significant minority of children and young people unfortunately suffer physical, emotional or sexual abuse from people responsible for protecting them – orphanages, boarding schools, and sometimes even members of their own families.

Three kinds of policy are therefore required:

- social policies that sustain a supportive environment for good parenting throughout childhood and adolescence, and that detect and deal with abuse quickly, humanely and effectively
- educational policies that foster mutual respect among teachers, parents and students, and that provide a healthy school environment and the opportunity at all stages of education to develop relevant health skills
- effective health policies that are based on the properly assessed mental and physical needs of children and young people, and that are sensitively provided to meet those needs in the most acceptable ways.

Analysis of the Albanian situation

Compared with other European countries, Albania has a very young population: 33% were under 15 in 2000[72], as compared with 16% in Bulgaria and 19% in the United Kingdom[73]. The average age in Albania is only 28.6, and fully half the population are under 25 years old[74]. This is a result of the very high total fertility rate, the second highest compared with EU members and applicants in 1999, although fertility has been decreasing since the early 1980s[75]. While the percentage of young people has been gradually declining since the 1970s, and the proportion of people over 65 has been slowly rising, the country must be prepared to deal with a large adolescent and young adult population now and in the coming years. Albania would pay a heavy social and economic price in future if it failed to promote and protect the health of young people in this decade.

Information about the health of children and young people in Albania is patchy and incomplete. Given the age profile of the population, a lack of data on adolescents and young adults represents a significant blind spot for assessing the health status of the country. However, the available data show some disturbing trends.

Accident and injury are the leading causes of death among young people[76]. In 1998, death rates from suicide among Albanians under 25 years old were six times higher than in Greece, though slightly lower than in Austria[77]. Young people represent about 10% of all convicted criminals including violent crimes[78], yet there is no coordinated juvenile justice system and few alternatives to imprisonment (i.e. community-based programmes). A review of the existing provisions for young offenders in 2000 notes that the Albanian Minister of Justice wishes to implement effective change in this area consistent with the UN Convention on the Rights of the Child and other international standards[79].

Young people are not well informed about the health care system, including health insurance offered by the government[80]. In addition, young Albanians say that they want to be better informed about reproductive health issues, and that this should take place in school as well as in the family[81]. A survey reported by the Ministry of Health shows that 86% of parents and 95% of teachers are in favour of including sexual education in the school curriculum[82]. A recent UNICEF project, *Rapid Assessment and Response on HIV/AIDS Among Especially Vulnerable Young People,* showed some alarmingly low levels of awareness among young drug users and sex workers who were surveyed. The majority do not use condoms every time they have sex and a quarter of drug users between 10 and 24 in Shkodra had no HIV/STI information. Most report obtaining the information they do have from the media or peers[83]. With rising HIV incidence, these young people will be a greater and greater risk of infection without improved education and prevention measures. Unintended pregnancy is also a risk for the ill-informed young person: government figures for 2000 showed that among girls between 15 and 19 years old, 62% did not use any method of contraception[84].

Many Albanian children are at risk. In 2000, UNICEF reported that 2 800 children were living or working on the streets, of whom more than half had never gone to school and

two-thirds came from the very small Roma minority group[85]. A report by the Albanian government states that approximately 5 000 children are victims of criminal networks in child exploitation and trafficking[86]. Some official estimates show that 70% of Albanians who claim disability benefits are young people under the age of 18 and the number of social orphans is rising (children from families in crisis, abandoned by their parents, etc.) – 15,000 children have been abandoned by one or both parents since the transition began [87].

Twenty-three per cent of all drug users are aged between 15 and 19. Among school-aged youth surveyed in 1997–98, the prevalence of drug use was between 10% and 12%. The most popular drug for this age group was marijuana, accounting for 60–65% of use, with heroin and cocaine at 10–25% and 10–12%, respectively[88]. With drug use trends on the increase since the early 1990s, these figures are likely to be higher today.

In 1991, 26% of males and 3% of females between 15 and 24 years old reported smoking[89]. There is no more recent data for this age group, though statistics for Albanian adults show a pronounced increase in rates of smoking since the early 1990s[90].

An opinion poll conducted by UNICEF in early 2001 provides some more recent data about attitudes and experiences of 9 to 17 year olds throughout Europe. Data on Albanian youth show that 59% have seen violence at home, 31% do not feel safe in their neighbourhoods, 11% have been victims of violence and 50% report that they have little or no information about HIV/AIDS. More than a third say they have a friend who smokes cigarettes and 1 in 10 have friends who drink alcohol. Despite the fact that two thirds think Albania will be a better place to live in the future, nearly half plan to emigrate to Western Europe or the USA[91]. This survey did not ask about the youths own behaviour with respect to health risks, but the results do shed some light on the outlook of young people in Albania today.

Education for this age group is vitally important for their future health and contribution to society. The news is mixed: during the violence in 1990 to 1992 many school buildings were destroyed and looted and 90% of primary school teachers are not university trained[92]. Between 1993 and 1995 only 35% of 14–18-year-olds attended school[93], and only 22% of all university students were studying science, maths or engineering[94]. Education for young people with disabilities is almost non-existent with no access to special education[95] and some children are prevented from going to school entirely because of bloods feuds[96]. But school enrolment for primary school is close to 100%, and the literacy rate for those aged between 15 and 24 in 1999 was 97.8% – higher than the adult literacy rate of only 84%[97].

UNICEF in collaboration with the Institute of Public Health has recently begun providing life skills, peer education, and is establishing "youth friendly" health services for young people at risk of sexually transmitted infections in Tirana and three other districts. There is currently very limited access to such services and support[98]. A social business project led by UNICEF and local private businesses, YAPS (Youth Albania Parcel Service), is employing orphans, migrant youth, youth with disabilities and Roma as a mail delivery service providing jobs to the disadvantaged youth as well as assisting with

communications[99100]. Young people have also been represented for the first time as part of a government delegation by a Youth Parliament member at the UN Special Session on Children held in May 2002[101].

7.3 Health in adulthood and healthy ageing

As in all European societies, Albanian adults carry a set of demanding social responsibilities for which the utmost emotional and physical fitness is required. People will be able to face future challenges more effectively if their personal and family relationships become far more stable than is currently the case. Such stability would have its greatest benefit in the future health and well-being of our children. But parents themselves would also benefit – physically as well as emotionally.

As workers in an economy which needs substantial modernisation and radical transformation, adult Albanians can expect many changes in their careers, with constant personal challenges to learn, adapt and re-learn skills and work practices throughout their working lives.

By the demands they make on the workforce, such economy-driven changes are likely to challenge long-established patterns of families caring for older relatives, and the corresponding roles of grandparents towards their grandchildren, which remain vital in Albania.

Albania is only a gradually ageing society, but this trend will continue. Between 1990 and 2000, the proportion of the population over 60 years of age rose from 7.9% to 10.4% and official statistics predict it will reach 12.2% by 2010[102.] A 1993 estimate projected that the proportion of older people would double over the next 35 years[103]. Coupled with falling birth rates[104] and increasing life expectancy, this will eventually reduce the economically active proportion of the population. At the same time, high levels of chronic illness, a huge burden of avoidable disability, economic deprivation and lack of social opportunities mean that most people struggle to survive in old age, rather then enjoying the personal and social possibilities common in many other European countries. Society as a whole is thus deprived of much of the contribution it could gain from the experience of its older citizens, and in addition pays an avoidable price in social and medical care.

The policy challenges are far-reaching:

1. a very long-term commitment to developing better personal, family, social and workplace relationships
2. the provision of opportunities for lifelong learning and personal development
3. enabling people to live healthier lives, survive longer, and stay fitter throughout their old age
4. the alleviation of economic hardship and social deprivation from the lives of older people, helping to sustain their existing roles in family life, and giving them the possibility of creating new social opportunities, as happens in many other countries.

Analysis of the Albanian situation

Information about the health of the adult population of Albania is patchy and incomplete. However, the available data show many serious problems. From age 45 onwards, the leading causes of death are circulatory system diseases and cancer[105]. This early onset and disease burden in middle and old age is due, in part, to risk factors such as poor diet and nutrition, insufficient physical activity, alcohol, smoking and injuries, and the underlying determinants – especially poverty, and social and economic inequalities – which promote these risk factors.

According to a survey of knowledge, attitudes, behaviours and skills carried out in 2000, only 6% of Albanian women reported that they smoke[106]. However, other data suggest that the rate may be as high a 18%, up dramatically from only 8% of all women in 1990. Rates for men have also increased, although more slowly, from 50% in 1990 to 60% in 2000[107]. In addition, each smoker is smoking more. In 1975, annual consumption was about 725 cigarettes per person. By 1999, this figure had risen to about 960 – a 32% increase[108]. These trends are in contrast to those that have been occurring in EU countries for many years.

Owing largely to economic pressures, many Albanian adults are forced to seek work far from home. With a net migration rate of 10.36 per 1000 people and 352 000 migrant workers abroad[109] (20% of the labour force[110]), Albania has very high residential instability, among the highest in the region. Adults who leave the country in search of employment have remitted approximately US$400 million per year, or 20–22% of the GDP[111]. Of the nearly 600 000 people who have left Albania in total, nearly 70% are males between 16 and 30 years old[112]. Some of these workers are women entering the commercial sex trade in neighbouring countries, thus exposing themselves and their partners to increased risk of infection with HIV and other sexually transmitted diseases[113]. According to UNICEF, there are as many as 30 000 Albanian women and girl sex workers in European cities, some as young as 14 years old[114]. Most of the children at risk for trafficking for labour and prostitution are members of ethnic minority groups[115] and are increasingly from rural areas[116]. In Italy and Greece, Albanian sex workers occupy the lowest social rung among an already marginalised group: most are street workers rather than massage-parlour workers or call-girls[117].

Some of the migration is within the country, with the urban population growing rapidly while rural areas are losing people. The percentage of urban population in 2001 was 42% compared with 58% in rural areas[118]. These figures are expected to change over the next 25 years to 54% urban, 46% rural[119]. Between 1991 and 1998 the population of Tirana swelled by 30%[120] and by 2001, 11% of the countries residents lived in Tirana[121]. Numbers like these makes it impossible for an already weak infrastructure to provide services to all the city's residents. Furthermore, many of the urban migrants come to the cities and set up temporary dwellings in the outskirts where there is no infrastructure, they are not registered legally for health services, education, etc. and the quality of life is overall very poor[122].

High maternal mortality and poor reproductive health are serious concerns for the country, especially given the young population profile. Fewer than half of Albanian women surveyed in 2000 had ever had a gynaecological examination, and only 23% of young women had ever heard of breast examination. Of these, most were from Tirana or Durres; among rural women levels of awareness were much lower[123]. Abortion was illegal until 1991 and, while that has meant a lower rate of maternal deaths due to abortion[124], the number of abortions has risen since that time to 40 per 1000[125]. Few health services offer alternative methods of birth control[126], and only 60% of women have any access at all to family planning services[127]. Until recently, men made most decisions concerning family planning, such as how many children and how many years apart[128]. Maternal mortality from all causes has declined, from a high in 1989 of 45 per 1000 to 15 in 1998, but remains one of the highest in the region[129]. This is likely to be due to poverty, poor antenatal and perinatal care (see section 5.2), and difficulties in gaining access to care over poor roads and in mountainous regions.

Data on the health, well-being and social welfare of people over 65 years old are scant. It is known that there are few residential homes for older people, no long-term care hospitals, and that most older people are cared for by relatives[130]. Official data on social protection programmes from 2000 reveal a total of 5 elderly centres providing for about 230 older Albanians[131].

Suicide rates among older people have been climbing, from a low of only one per 100 000 in 1992 to 14 per 100 000 in 1998[132]. This suggests increasing personal distress about their life circumstances, poor mental and emotional health, and inadequate diagnosis, treatment and care among this group. In addition, estimates of annual primary care visits for older adults are very low by European standards: 1.66 visits per person per year[133].

Although more recent data are not available, in 1990 69% of all 65 to 74-year-old Albanians had no remaining teeth[134]. While this reflects poorly on the state of oral care during the lifetimes of these people (many years ago), it also affects their health today, reducing their ability to consume sufficient nutrition on a daily basis. Data on the nutritional status of older adults in Albania are not available, but even in wealthier nations some older adults frequently have an inadequate diet[135], and this is likely to be a serious problem in Albania.

Increasing rates of heart disease and cancer, especially of the lung and breast[136], among the over-65 age group, due to rising tobacco use among adults, will place a growing burden on older Albanians and on the health care infrastructure.

7.4 Improving mental health

Mental health problems are now assessed to be one of the main causes of illness and disability throughout the world[137]. Unipolar major depression was estimated to be the leading cause of disability globally in 1990, and the burden of disease it causes is continuing to increase worldwide. Albania"s suicide rate is increasing, and contributes to

the leading cause of death (accident and injury) for 15–19 year olds. Suicides can be sharply reduced by early detection and effective treatment of depression. Alcohol use is also estimated to be a major cause of the disease burden, particularly for adult men, among whom it is the leading cause of disability in industrialised countries.

Well designed living and working environments can help people maintain a sense of personal value and harmony with society, and sustain mutually supportive social relations that enable them to cope with stressful situations and events. On the other hand, unemployment, social exclusion and poverty all contribute to mental health problems.

The policy challenges are to:

create living and working environments that help to promote better mental health
introduce modern mental health services, with an emphasis on early detection and appropriate treatment
meet the needs of young people, who are especially vulnerable to late diagnosis, misdiagnosis and inadequate treatment
destigmatise mental health problems so that people are not discouraged from seeking and receiving treatment and care.

Analysis of the Albanian situation

Information about mental health in Albania is extremely patchy and incomplete. Apart from suicide mortality data, which show increases in all age groups[138], plus data on alcohol and narcotic use, where increases are also seen, there appears to be very little information. There appear to be no data about health and well-being.

In 1998 the standardised death rate for mental disorder and diseases of the nervous system was 24 per 100 000, down from a peak of 33 in 1994, but increasing since 1997. The rates were slightly higher for men, with 29 per 100 000 dying from a mental disorder and only 20 per 100 000 females. These rates are twice those in Bulgaria and Estonia for the same year[139].

Of special concern in Albania is the relatively recent unrest and civil disorder that resulted in many people losing their life savings, jobs and homes in 1997, and the huge refugee crisis of 1999. These are likely to have raised stress levels among the population and may have contributed to the increased suicide rates. Undoubtedly other mental health problems, such as depression and anxiety, may also have been triggered by a lack of economic and political stability. Similarly, the high levels of population instability and migration in Albania cited in section 7.3 can have a detrimental effect on protective social bonds, as families are separated and children are moved from friendship groups.

Facilities for mental health care are few and far between. With only four psychiatric hospitals, very few psychologists, and only 90 psychiatrists, access to mental health care has historically been difficult[140]. Conditions in these hospitals are historically very poor

with inadequate or missing heat, sanitation, and other aspects of physical living conditions. Regard for patient"s rights is very low and modern medical practices such a maintenance of patient files and outpatient rehabilitation are recent innovations to the system, where they have been implemented. Mental health care has not had a place in the medical curriculum and psychiatric nurses have been generally lacking in professional skills and knowledge[141].

Ministry of Health, based on the recommendations of WHO, has recently expanded the concept of mental health in the structures of the primary health care. Early in 2000 the government created the Albanian Development Centre for Mental Health with a multi-disciplinary approach to addressing mental health issues nationwide. New mental health legislation also promises to raise the profile of mental health and protect the rights of the mentally ill. In December 2000, a pilot community mental heath centre was opened in Tirana and other centres are opened in Elbasan, Diber, etc. Given that the WHO describes the current state of mental health in Albania as an „almost emergency situation", these plans are encouraging[142].

*7.5 Reducing communicable disease*s

Nowadays, communicable diseases make a relatively smaller contribution to the total burden of disease and disability, but disproportionately affect poorer people. Control over them has largely been achieved, but sustained efforts are required to:

control epidemics through case-finding and effective treatment of individuals, plus effective population measures including information and education, immunisation where appropriate, and other appropriate methods
identify outbreaks, through good surveillance, and institute effective outbreak control measures
ensure that immunisation programmes achieve and maintain recommended population coverage
introduce and sustain new immunisation measures, according to need
address the underlying social and economic determinants such as poverty and inequalities.

The main current policy challenge in this area is to raise standards in Albania to the levels of European best practice in epidemic control and outbreak management.

Analysis of the Albanian situation

The control of some communicable diseases in Albania appears to be satisfactory. Drainage of marshes has eliminated malaria, and endemic syphilis has also been eradicated[143]. In 1999 there were no cases of poliomyelitis or neonatal tetanus[144]. And, as of 21 June 2002, Europe was declared polio-free. After Albania"s polio outbreak in 1996, this is an important achievement and could not have been obtained without a strong response to the outbreak by Albania[145]. Incidence of pulmonary tuberculosis is remaining

stable[146], although it still accounts for about one-fifth of all deaths from communicable diseases[147]. Measles and rubella are part of the national immunisation calendar, while mumps will be introduced in 2004 according to the National Immunisation Strategy. As of 2000, catch-up vaccination campaigns for children, as well as women of child-bearing age, marked the first steps toward elimination of rubella and of congenital rubella syndrome. Other plans include pregnancy counselling for women of child-bearing age[148]. Despite these improvements, the following aspects require consideration.

Pertussis cases have been on an increase until 2001 when a slight drop suggests and improving situation (36 in 2001[149], down from 86 in 2000, compared with 29 in 1999[150]) and the annual incidence of mumps (50/100 000 in 2000, down slightly compared with the average of 64 for the period 1991–2000, but up from 35 in 1999[151]). Mumps is endemic in Albania, with epidemic peaks every two to four years. Between 1990 and 2000, the average annual incidence rate has been 63 reported cases per 100 000 people, with epidemic peaks between 95 and 127 per 100 000. Most of these cases (66–89%) have been among people under 15, and half of all cases strike those between five and 14 years old[152].

An increase in incidence of HIV (ten cumulative cases in 1994, rising to 72 by 2001) and AIDS (at 0.010 cases per 100 000 in 2000, up from zero in 1993) means that this formerly isolated country is being affected by opening up relations with the rest of the world. Although rates are still the lowest in Europe, trends indicate this may not remain the case[153]. There are low levels of awareness of how to prevent HIV/AIDS: in 2000, 40% of women did not know a single effective way to prevent infection; 87% believed HIV can be spread by mosquito bites; 77% did not know where to get tested for infection with the virus; and only 0.7% have actually been tested[154]. And, while 82% of men know what condoms are, only 33% say they have ever used them, and only 9% of men say they used a condom the last time they had had sex[155].

As of 1998, epidemiological data had ruled out intravenous drug use as a cause in any confirmed cases of HIV/AIDS. But intravenous drug use is increasing in prevalence[156]. A UNICEF report from 2001 estimates that there are 10 000 drug addicts in Albania with 8 000 in Tirana alone (and this is only half of the number estimated by government sources[157]). The report also listed one case of HIV infection transmitted from mother to child and four from infected blood. The primary mode of transmission, at least with the data available, remains heterosexual (72.7% of all infections). Very little data exists on men who had sex with men, partly because of the strong social stigma attached. Eighty percent of all HIV report having contracted the infection while outside of Albania, highlighting the impact of migration on this growing epidemic[158].

A recent UNICEF project in the region, *Rapid Assessment and Response on Especially Vulnerable Young People* highlights some worrying information about HIV risk behaviours in Albania and the South Eastern European region. For example, among drug users in Shkodra between 10 and 24 years old, only 3% use condoms every time they have sex. This is significantly lower than the regional estimate of 27%. Nearly two-thirds of injecting drug users reported sharing needles and 25% said that

Comment [GHW2]: This figure has been changed from what I originally submitted (which was 42 according to Health for All). The source has not been changed or updated and I cannot confirm the number 72 with anything I have access to. The most accurate numbers I can find now is 15 AIDS cases as of Oct 2001 and 53 confirmd and 15 unconfirmed cases of HIV infection as of July 2001. I leave it to you to decide which figures to use.

The sources for the numbers I list here are (respectively): UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance (2002) *Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections – Albania*, United Nations/WHO:Geneva, Switzerland.
And
UNICEF (2001) *HIV/AIDS in South Eastern Europe*, UNICEF Area Office for the Balkans: Belgrade, The Federal Republic of Yugoslavia.

had no information about HIV/AIDS/STI. In Tirana, 32% of drug users have had between 2 and 5 sexual partners in the past year, only slightly lower than the regional proportion (42%). And, among sex workers in Vlora, more than half had over 100 partners per month and only 10% use condoms every time. Not surprisingly, 74% of them reported having had an STI in the last 12 months[159], [160].

HIV/AIDS testing is offered anonymously and free of charge, but there are only three sites in Tirana and only blood banks provide the service outside the city. Counseling is only available at one the three sites in Tirana and nowhere outside. The Ministry of Health approved some funding to provide anti-retroviral treatment in 2001[161]. There is no data yet on the impact of this step.

While the levels of other sexually transmitted diseases appear low (gonorrhea, six cases in 2000[162]; syphilis, 10 cases in 1999[163]), there has been a tenfold increase in the rate of new syphilis infections since 1997 after its virtual absence prior to 1995. Gonorrhea incidence, on the other hand, appears to have been in continuous fall from the peak of 230 cases in 1982[164]. There is strong evidence to suggest that not only are gonorrhea rates higher than reported, but that there is general under-reporting of STIs. Higher rates would be expected given the elements of social change occurring in the population, such as high migration, increases in prostitution, and the young age structure of the population[165].

High prevalence of hepatitis among drug users: in 2000, 65% had hepatitis C[166]; and in 1998, 18% had hepatitis B antigens, the highest level among 10 countries studied[167]. By the year 2000, however, prevalence rates for hepatitis A, B and C antibodies among the healthy population were comparable with other European countries (11, 18 and 1.5%, respectively)[168]. Rates have been steadily declining since the mid-1980s, especially after 1995 with the introduction of the vaccine. Most people sick with some form of hepatitis have type B[169] and, in the year 2000, there were 93 cases per 100 000[170].

There have been high rates of food-borne and other gastrointestinal infections per 100 000 population: in 2000 there were 18.2 cases of shigellosis; 9.5 cases of salmonellosis; 45.8 cases of other food-borne infections; and 1239 cases of gastroenteritis of unknown cause[171]. In 1998 there were 523 cases of brucellosis and high rates of this disease led the public health authorities to implement a special surveillance system[172]. Food-borne infection rates have been steadily decreasing in recent years, but concern is raised over the level of infections reported.

Figures for Albania are compared below with other European countries[173].

Hepatitis incidence is six times higher than in Austria (93 versus 15 per 100 000).

Pertussis is twice that in Austria and Bulgaria, but less than half the rate in Italy (Albania, 2.41 per 100 000; Austria, 1.27; Bulgaria, 1.29; Italy, 6.59).

Mumps incidence is somewhat higher than in Bulgaria and somewhat lower than in Italy (Albania, 51 cases per 100,000; Bulgaria, 29; Italy, 70).

AIDS is among the lowest rates when compared with EU members and applicants to the EU. In 2000, the incidence of new AIDS cases in Albania was only 0.1 per

100 000 population. This was 4.6% of the average among EU members, and 18.8% of the average among applicants. Many of the applicant countries had very low rates owing to a similarly isolated past. Given that AIDS incidence in Greece and Italy, where many Albanians have emigrated for work, are 1.25 and 3.16 per 100 000, respectively, Albania may see sharp increases in coming years as workers travel between these countries.

Gonorrhoea and syphilis rates are similar to Italy, but much lower than in Austria (gonorrhoea: Italy, 0.42 cases per 100 000; Austria, 5.36; Albania, 0.33; syphilis: Italy, 0.56 cases per 100 000, Austria, 2.27; Albania, 0.89).

Measures to detect and control outbreaks of communicable diseases are in place. In the 1990s, 30 out of 37 districts experienced epidemics of cholera, typhoid and poliomyelitis[174]. Outbreaks and sporadic cases of endemic haemorrhagic fever have occurred each year since 1986, especially in the area surrounding Kukes[175].

There is a weekly system of reporting syndromic infectious diseases, and also a hospital-based system of reporting. Albania has been promoted as a success among other East European countries in developing such system, and Albania is part of a network operating in this field. But further changes are needed to catch up to EU standards.

The Albanian Institute of Public Health National Enterovirus Laboratory is accredited by WHO.

7.6 A healthy and safe physical environment

The Constitution addresses the physical environment, ensuring that citizens have the right to be informed of the status and protection of the environment, as well as providing for rational exploitation of natural resources following principles of sustainable development[176]. In early 2000, Albania joined other South-Eastern European countries to develop a Regional Environmental Reconstruction Programme for South Eastern Europe (REReP). As part of the Stability Pact framework for the region, the REReP identifies several priority areas:

institutional strengthening and policy development
civil society development
rehabilitation of environmental damage from the wars in the region
projects with a regional cooperation dimension, including participation in existing international instruments and programmes
support to priority national and local projects[177].

A political commitment to action on the environment and health was achieved with the adoption of the European Charter on Environment and Health in Frankfurt in 1989; the 1994 Helsinki Declaration on Action for Environment and Health in Europe; and the

establishment of the European Environment and Health Committee. Resulting from the Helsinki Declaration, the Environmental Health Action Plan for Europe was drawn up, and individual states formulated national environment and health action plans (NEHAPs), among them Albania, although the plan remains in draft form[178].

The main current policy challenge in this area in Albania is to finalise and implement the NEHAP.

Analysis of the Albanian situation

Although recent measurements of air, water and land pollution are within allowed norms, and many parts of Albania are clean[179], concern has been expressed about the state of the physical environment[180][181]. Current environmental issues include air and water pollution, waste management, deforestation and soil erosion, and the country is party to international agreements concerning biodiversity, climate change, hazardous waste, ozone layer protection and wetlands[182].

The decline in many of Albania"s industries that contributed to air pollution (chromium smelting, steel metallurgy, etc.) has meant cleaner air. Oil extraction and refining, heating, cement production and uncontrolled solid waste incineration are the main sources of air pollution today[183]. Over the past decade, however, increasing numbers of people have come to own their own cars, many of which are not in good condition and use poor quality fuel. Between 1994 and 2000, the number of cars on the road increased from 68 000 to 150 000[184][185], though even in 2000 there were only 30 cars per 1 000 people[186]. Retail trade indices from the second quarter of 2001 show rising levels of the sale and repair of motor vehicles, up more than 300% since 1999 and the number of automobiles in the road is certainly increasing[187]. A large number of these cars are driven into Tirana every day, causing a great deal of traffic pollution. In 1998, 5.7 tonnes of gases and soot were released into the atmosphere in Tirana. When pollution from cars is combined with other sources of air pollution (burning of wood and oil, industrial activity, construction, bare soil, lack of green areas), the levels of solid particles in the air far exceed the safe limit of 200 mg^2/day: Tirana had 513 mg^2/day and Elbasan 533 mg^2/day[188].

Water pollution is also a problem for the country: between 1997 and 1998 3350 tonnes of solid waste and 12 450 tonnes of liquid waste were dumped into the rivers, lakes and sea around Albania. Some rivers still show good water-quality indicators while others, such as the Tirana River, have pollution levels higher than national and European standards[189]. Because there are no wastewater treatment plants in the country, wastewater is dumped directly into rivers, lakes and the sea[190]. There is also no systematic monitoring of water quality and, as of 2000, the national water strategy (drafted in 1996) had not been implemented[191].

The rapid movement of the rural population into the cities exacerbates the problems caused by lack of services and infrastructure, and only 55% of citizens have access to solid waste-removal services. There are no managed dumpsites or incinerators.: when not

removed, waste is left on streets where it attracts insects and animals[192] – vectors of communicable diseases – or it is burned, contributing to air pollution[193]. Urban waste in Tirana increased 8–10% in the year from 1999 to 2000. The opening of the economy has caused an influx of packaged consumer goods, increasing pressure on the already weak waste management system[194].

An environmental assessment conducted by the United Nations Environment Programme in 2000 highlighted some specific hot spots within Albania that it recommended be addressed promptly by the international community for the immediate health and safety of Albanians and the long term preservation of the natural environment. Among these were a chemical plant in Durres, a fertiliser plant in Vlore, an oil refinery in Ballsh, oil fields in Patos and a solid waste dump site in Sharra[195]. A recent news article following an EU symposium on pollution held in Durres, criticised the Albanian government for failing to address the Durres site in particular. Its vast swathe of toxic chromium VI has not been cleaned up and is contaminating washing and drinking water for an estimated 10 000 people. Lack of funds was cited by the government as the reason for failure to address the hot spot two years after the UNEP report[196]. This case is evidence for the fact that there is no system for industrial waste management[197].

A specific type of waste particularly hazardous to health is health care waste. National estimates place the daily production of health care waste at 7.2 tonnes, most of which is in Tirana. This waste poses a risk to people in the health care setting and to those in the vicinity if it is not disposed of effectively. A 1997 study revealed that hazardous waste was not being adequately treated before disposal, and that treatment facilities were not functioning satisfactorily. Waste stored in and around hospitals before pick-up is kept in open containers, and animals have been reported foraging in heaps of waste. In addition, the report stated that there was no regulatory framework for health care waste management. In the spring of 2001, the government developed a strategic plan to remedy these problems[198].

Soil erosion is also a major problem, and parts of Albania are experiencing erosion at rates 100–1000 times higher than other European countries. Some areas of the country are suffering from desertification. There are natural and man-made reasons for this problem, and some recent events, such as the privatisation of land which makes owners want to protect their soil, are helping to reduce the problem. However, legislation and monitoring to protect the soil are lacking[199].

Biodiversity reduction, a problem the world over, is particularly apparent in Albania with one of the highest rates of loss of biodiversity in Europe. All of the above described sources of pollution are damaging habitat and state monitoring and protection measures are inadequate to stop the large amount of illegal hunting, fishing, and wood collecting (for fuel). A World Bank project for 2002 plans to bring 40% of Albania"s forest into communal management systems and the 1992 Forest Act is bring strengthened[200].

Nearly all the country"s electricity (97%) is generated by hydropower. This means that the

country is dependent on full, free-flowing rivers. Drought, or excessive silting caused by soil erosion, can lead to blackouts that affect most of the country[201]. Even when electrical power is being generated, less than half the population are connected to the grid[202] and more than 40% of electricity generated is not paid for, either through defects in the system or illegal consumption[203], causing the power company to be in dire financial straits. As a result, there were serious shortages and daily power cuts during the cold winter months of 2000–01[204].

Although 97% of the population have access to safe drinking water, according to the UNICEF MICS, in the year 2000 less than half the population had drinking water piped directly into their home. Twenty per cent had water piped into their yard, and 16% had to obtain it from a public tap. Of course, this varies greatly between urban and rural dwellings: 90% of people in urban areas have water piped into their home, whereas only 20% have such an arrangement in the rural areas. In fact, a quarter of rural Albanians must travel to a public tap for water that is safe enough to drink[205]. Of all water produced in Albania, 64% is lost due to inefficient management and crumbling infrastructure[206]. Even the water that is available is frequently not properly disinfected, especially in rural areas[207], and low pressure and damage to the pipes lead to dangerous contamination from parallel sewage pipes. Of the 15 plants built to chlorinate and disinfect water, only five are operating as of 2001[208]. In France and Italy, 95% of the rural population have access to safe water in their homes[209].

Ten per cent of all Albanians live in households without a sanitary method of disposing of human waste. The situation is even worse in rural areas, where 14% use pit latrines[210]. Illegal construction of homes and businesses in the cities and their outskirts damages the sewage system, increasing the risk that sewage will contaminate the water supply and cause epidemics of water-borne infections[211]. It is estimated that in Tirana alone there are 24 000 connections between clean water pipes and wastewater pipes, due to breaks in the pipes[212].

The relatively recent unrest also affected the physical environment by making it decidedly less safe for the public. During the 1997 civil unrest, 600 000 weapons were released into the hands of civilians and most have not been recovered. In addition, there are more than 100 000 tonnes of surplus, non-serviceable ammunition needing to be destroyed – posing a serious threat to both the population and the environment. Weapons collection and ammunition disposal plans are in place and are being carried out, though progress is slow due to funding and staff shortages[213].

There are corruption problems among the police, who are charged with carrying out weapons collections and other civil safety efforts. The government is taking anti-corruption measures across the board that are slow, but seem to be working, and Albania ratified the European Civil Convention on Corruption in 2000[214]. Anti-corruption and public image efforts within the police department and Ministry of Public Order led to the dismissal of 368 people in the year 1999–2000[215]. However, there are concerns that the police force cannot stand up to the armed militias and gangs in the country. Clan networks

exert significant power and control in rural areas[216].

Like other countries in the region, Albania is home to a large number of land mines. While the number of anti-personnel mines in Albania is lower than neighbouring nations, during the Kosovo crisis the Serb military forces left behind mines over an area of approximately 1400 hectares. As of March 2001, 19 Albanians had died, 124 had been injured, and only 11.4 hectares had been cleared[217].

The government has recently started taking more action on the environmental front, and some other social and political changes are improving the environment. With help from the Organization for Security and Co-operation in Europe (OSCE), a Ministry of the Environment is being established, an environmental workshop was scheduled for April 2001, and regional round tables were held at the beginning of September 2001 to improve and localise the water system[218]. Albania has also signed international conventions on improving water quality[219]. As a measure to control logging, which will also help prevent soil erosion and silting up of rivers, the Minister of State has recently strengthened the forestry police against illegal logging[220]. New technologies are being adopted, both in industry and agriculture, and increasing privatisation is said to provide a better situation for protection of the environment[221].

Steps towards implementing the REReP and Stability Pact priorities have begun, with work being funded for water supply and sewage treatment projects (27 million Euros) regional environment reconstruction plan (8.93 million Euros), post-conflict environmental assessment (600 000 Euros), and humanitarian de-mining (510 000 Euros)[222].

In 1999, a major new environmental project began with funding from Italy totalling US$300 million. Funds managed by the World Bank will be directed at destroying pesticides, controlling logging, removing illegal buildings from the coast, improving drinking water and sewage systems, monitoring and controlling urban pollution, addressing numerous car-wreck sites, and restoring green space[223].

The NEHAP[224], drafted in 1998 and not yet finalised, reviews and analyses the situation in Albania, and identifies measures that must be taken in order to improve the status of environmental health and safety. Key among these are intersectoral collaboration across the government; improved health and environment information systems that will allow tracking and linking of environmental and health changes, with a focus on collecting data on vulnerable subgroups of the population; establishing a legal framework and standards for environmental protection and health; building local capacity for monitoring and implementing environmental health policy and programmes; and ensuring public participation in decision-making and access to information about the environment. Specific environmental risks addressed include water, air, noise and land pollution; food safety; radiation safety; and natural disasters and industrial accidents. The plan also includes specific action steps to be taken in urban and rural settlements and in the workplace. Finally, it targets different parts of the economy with specific tasks for improvement, including industry (factories and mining), energy, transport, agriculture and tourism.

NEHAP implementation is seen as a shared responsibility between the Ministry of Health and the National Environmental Agency because they carry the main governmental responsibilities for environmental health. Working together in an Inter-sectoral Committee, their remit is to coordinate their work, involve other ministries as necessary, and monitor the progress of implementation.

Not surprisingly, this public health strategy addresses many areas that are also covered by the NEHAP. The health situation in Albania has evolved somewhat since the NEHAP was drafted, but the fundamentals remain the same and where they address the same areas the proposals have much in common. It will be important to ensure that the Public Health Implementation Plan, which will be drawn up for the implementation of the Public Health Strategy, complements, and does not duplicate, the tasks needed for NEHAP implementation.

7.7 Multisectoral responsibility and mobilising partners for better public health

Investment for health

Economic and social development depend to a significant extent on effective measures to promote and sustain the health of the population. A healthier population is collectively and individually more contented, and socially and economically more productive. Effective promotion of health is thus an investment in future social and economic development, whereas the costs of sickness treatment, and the associated social costs, are equally clearly expenditures.

However, in most industrialised countries the increasing emphasis of the health sector for much of the past 50 years has been on diagnosing and treating the sick. In general, this has entailed the development of ever more sophisticated technologies. In many instances this approach has achieved relatively small improvements in health for steadily increasing costs. It is widely accepted that, overall, sickness treatment makes a minor contribution to the health status of the population, the major contributors being social, economic and environmental conditions, and the social and personal behaviours that derive from them. The health sector therefore stands in need of a new vision that recognises and acts on these facts.

While acknowledging the vital importance of health care services, the new vision recognises that the origins of most health problems lie much deeper in society, and must be tackled through a very broadly based health-promotion strategy. The WHO Ottawa Charter for Health Promotion, 1986 (reproduced in Appendix I) states that the fundamental conditions for health are:

> peace, safe and sound shelter, education, wholesome food, sufficient income, a stable ecosystem, sustainable resources, social justice and equity.

In 1998 the 51 countries of WHO's European Region agreed a new health policy, Health

21 – 21 objectives for the 21st century. This addresses these fundamental conditions through activities in five key areas:

> building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and re-orienting health services.

The Ottawa Charter on Health Promotion made clear the links that connect broad social and economic factors with health, and it underpins the current WHO strategy.

Health 21 places new emphasis on the concept of health development, namely that health contributes to social and economic development and, conversely, that development needs to proceed in a way that enhances health. Against this background, the WHO Regional Office for Europe's new programme Investment for Health offers a pragmatic approach to linking health improvement to the development of economic and social infrastructure.

Introduction to the Investment for Health concept

Throughout history, the greatest improvements in people's health have come not from health services, but from health-promoting social and economic changes. Policy areas such as education, income maintenance, workplace regulation, housing, transport, agriculture and communications, as well as private initiatives, have a profound influence on health. Consequently, their impact on health needs to be considered in making investment decisions. The Investment for Health approach aims to address this – both by building social and economic strength, and by bringing about health improvement for the population.

The Investment for Health approach identifies investments which can improve health by attacking the main causes of ill-health in a credible, effective and ethical manner. This means developing strategies that are focused on the key social and economic determinants of health, and involve diverse policy areas.

For these principles to be effectively applied, traditional policy-making approaches need to be revised. In particular, a collaborative approach across government needs to be developed that recognises the complex interrelationship of the factors determining the health of a population.

These issues have been taken up through the Investment for Health programme by many countries, including Romania, Slovenia, Hungary and Malta, as well as regions of Italy, Germany and the United Kingdom.

The real challenge for any country adopting the Investment for Health approach is to apply theory into practice in society. Societies invariably have political priorities, such as fiscal soundness, economic regeneration and stability, educational excellence and social cohesion. Policies and public institutions are directed towards achieving those priorities. Specifically, the challenge is to find ways of reinforcing such priorities through the

effective deployment of Investment for Health and, conversely, of enhancing people's health – equitably and sustainably – through the medium of social and economic development.

Multisectoral responsibility and mobilising partners for better public health

For public health to be effectively promoted and healthy environments to be created it is necessary to mobilise many different sectors of society. Correspondingly, many different actions in pursuit of the legitimate interests of many different sectors are capable of inadvertently undermining public health. Therefore all sectors need to be aware of three fundamental issues:

1. the benefits to their own work, and to the wider society, of contributing to and investing in the protection and promotion of public health
2. how they can best contribute to and invest in the protection and promotion of public health
3. the need to be accountable for any adverse impact on health resulting from their policies and programmes.

This emphasis on the roles of other sectors highlights the need for leadership and coordination of public health practice at all levels of society:

1. to advocate and build alliances for policies that protect and promote public health
2. to ensure that there are structures and processes to facilitate and harmonise multisectoral collaboration for better public health
3. to establish a mechanism for health impact assessment to help ensure that all sectors become accountable for the effects on public health of their policies and actions.

Analysis of the Albanian situation

The preparation of the National Environmental Health Action Plan for Albania (1998) was an important step in recognising the impact on public health of actions in other sectors of society. The decision to prepare this Public Health Strategy and the proposed Public Health Action Plan for its implementation are further important steps, which have been emphasised by the creation of an Inter-Sector Co-ordinating Commission to oversee these tasks.

More routinely, alliances for health have been slowly developing across Albania for a number of years, to promote healthier living and combat threats to health. However, most of what is needed to establish systematic and reliable structures and processes at national and local levels has yet to be put in place, nor is there yet any mechanism for health impact assessment.

7.8 Reducing non-communicable diseases

Non-communicable diseases cause the greatest burden of disease and disability in all European countries. As indicated in section 3.3, Albania"s situation in this respect is better than that of some of its Eastern European neighbours and, in some cases, better than parts of Western Europe: research has shown that Albania"s lower mortality is largely due to relatively healthy nutrition, physically active lifestyles, and a low incidence of automobile and industrial trauma. There is, however, scope to make a significant and positive impact on some worrying trends through public health policy, strategy and practice.

The determinants that can be influenced by public health policy, strategy and practice are:

risk conditions, especially social and economic deprivation – major inequality, severe poverty and social exclusion
lifestyle *risk factors*, such as smoking, alcohol and narcotics use, physical inactivity, poor nutrition and unsafe sexual behaviour, which are linked with social and economic status
environmental factors – social, biological, physical or radiological.

Collectively, the identification of these determinants offers the opportunity for an integrated approach which can contribute to the reduction of several of the major diseases contributing to Albania"s burden of disease and disability: cardiovascular diseases, certain cancers, chronic obstructive pulmonary diseases, mental health problems, and violence and injuries.

The knowledge exists to prevent many cases of these non-communicable diseases. In addition, screening and case-finding strategies allow for the detection, diagnosis and effective treatment of some diseases at a pre-symptomatic stage. Treatment has also become increasingly effective for some, such as coronary artery disease and breast cancer, and in most cases rehabilitation is an important part of case management.

Other countries have demonstrated that, by taking a strategic approach to these diseases, it is possible to achieve huge successes within a single generation. For example, it is possible to reduce mortality among men under 65 years of age due to cardiovascular diseases by 70–75% within a 25-year period[225]. As other countries invest increasingly in such strategies, the policy implications of losing ground would be profound for Albania, having an impact on social and economic development as well as health.

Analysis of the Albanian situation

The Albanian situation is generally favourable in comparison with other South-Eastern European countries, and unfavourable compared with Western Europe. The low level of non-communicable diseases in Albania has been attributed to the 'Mediterranean effect' of a diet high in fruits and vegetables and low in saturated fats[226]. Although information is

less complete than in other European countries, some statistics show a clear picture of Albania's age-standardised death rates:

- circulatory system diseases in both sexes in 1998 were more than double the rates in Italy (1997) and France (1997), but only about half the rates in Estonia (1999) and Romania (1999)[227]
- overall cancer rates in 1998 in both men and women were lower than for the rest of Europe, although rates in males were more than double those for females[228]; but trachea, bronchus, and lung cancer exceeded rates in France, Italy, Bulgaria, Macedonia and Romania[229].

However, a key indicator of the overall trend of non-communicable diseases in Albania is the fact that, for all the conditions listed above, standardised death rates have been increasing steadily since the mid-1990s[230]. A recent study shows a rapid increase in Type II diabetes mellitus in Albania with an overall prevalence of 6.3% with a peak of 8.3% among 55-64 year olds – these are double the figures for 1980 and exceed rates in England[231].

7.9 Reducing injury from violence and accidents

Intentional and unintentional violence leads to huge personal, social and economic costs and is a major cause of death. Alcohol use is a major risk factor for all forms of violence and accidents. Other important factors are poverty, unemployment, poor housing and urban decay. In Albania, external causes of death are the main killers of children and adults up to middle age[232].

While serious public violence usually attracts the attention of the police, violence at home (almost always against women, children or older people), and the abuse of people in institutions, often goes unreported and uncorrected.

Accidents occur in all human situations – at work, home, school and leisure. Occupational accidents cause a serious burden of disease and disability and are largely preventable. The toll from road trauma is very much larger, and is also largely preventable given sufficient determination and single-mindedness to enforce seat-belt wearing; to improve road and vehicle quality; to set and enforce sufficiently low speed regulations; and to clamp down severely on driving while under the influence of alcohol.

Analysis of the Albanian situation

External causes are the main cause of death between ages four and 45[233]. These include road traffic accidents, drowning, suicide and other highly preventable external causes of death.

Although high within Albania, external causes of death are relatively low when compared to most neighbouring countries, although data are patchy and incomplete. The death rate from accidents, injuries and poisonings in 1998 was less than half the rate in Estonia

(1999), but more than double that in Italy (1997). The standardised death rate from motor vehicle accidents was 7.49 per 100 000 population in 1998, compared to 16.78 in Estonia and 12.29 in France; the United Kingdom, at 5.48 deaths per 100 000, was slightly safer[234]. However, Albania has a very high fatality rate (0.68 deaths per accident[235]) due primarily to poor roads, reckless driving, and lack of emergency medical services[236]. In 1998 there were only 46 ambulances per 1000 people[237]. Considered the worst in Europe, 75% of all roads are in very poor condition[238] and fewer than 30% of the roadways are paved[239].

Domestic violence is a major problem for women. A 1996 study reported that 64% of women in the study had been physically or psychologically abused by their partner or other family members. As with other quality-of-life measures, research indicates that domestic violence is disproportionately worse in rural areas, and affects women with lower levels of education. Women's choices are few: there is only one shelter for women and children in the country, located in Tirana, and – with no provision for domestic violence in Albanian law – only 5% of cases are brought to the courts[240]. A report from the National Committee on Women and Family in late 2000 shows that little has changed, attributes 80% of the cases to alcoholism and documents an increase over the past decade, though this may be due to increased reporting as women begin to feel more comfortable coming forward. The resurgence of the medieval code of Kanun in some areas, which places women as objects, has not improved matters[241]. UNICEF is beginning to increase awareness and improve responses to domestic violence with training of health care staff as well as lawyers and police. UNICEF also plans to support NGOs to reinforce existing services and provide new ones[242].

Recent years have seen an increase in blood feuds among families especially in Northern Albania. The blood feud is an element of the Kanun, a system of laws from the middle ages in which revenge for an offence requires killing the offender. Because of the resurgence of these blood feuds, hundreds of families are confining themselves to their homes, including preventing children from attending school, in order to protect themselves from this type of violence[243].

As described in section 7.6, weapons and ammunition left over from earlier regional conflicts also threaten people's safety. Unless land mines are removed and weapons are taken out of general circulation, accidents and injuries will continue to mount. The country has embarked on efforts to address both problems[244].

7.10 Healthier living

Good, clear information about health is necessary to enable people to make healthy choices, but it is not sufficient. The evidence shows that choices made by individuals, families and communities – including decisions to adopt health-enhancing behaviours – usually depend on their cultural, social, economic and physical environments. It is also

evident that the behaviours most harmful to health are most frequent among the poorest social groups; for example, inadequate incomes, poor education, and job insecurity or unemployment raise their levels of stress and promote greater alcohol consumption, drug use and nicotine dependence.

Moreover, better educated and more socially advantaged people are better placed to understand and act on health messages. This risks further widening health differences, and increasing the marginalisation of vulnerable groups of people.

It follows that, if poor people are to become better able to adopt healthier lifestyles, emphasis will need to be given to:

improving participation in democratic processes
improving their cultural, social, economic and physical environments
designing health information and education programmes to meet their particular needs
helping them to become confident and competent to make choices about their health.

To successfully combat the major epidemics of non-communicable diseases, which are creating an increasing burden of disease, disability and early mortality, attention will need to be focused on:

improving eating habits, physical activity and sexual health (addressed in this section)
reducing tobacco and alcohol use (addressed in section 7.11, along with drugs).

Analysis of the Albanian situation

Healthy eating concerns food and nutrition policies, food security, food safety, micronutrient deficiencies, and food and health choices. Albania has maintained many traditional foods of the Mediterranean region, and therefore benefits from a varied diet that is high in fruits and vegetables[245]. In 1992, Albania endorsed the World Declaration and Plan of Action for Nutrition, and these provide a strategic framework for national food and nutrition policies and action plans. In addition, agriculture is improving and local production is gradually replacing exports, which means higher quality and lower prices for Albanians. Vegetable production has not improved as much as livestock products, however, partly because only about half of the greenhouses built during the communist period are in use[246].

Data from WHO and others illustrate the situation.

The traditional Mediterranean diet is being replaced by processed, western foods higher in salt and saturated fats[247].
Some traditional customs persist, however, including those that give male family members higher quality food and do not allow women and children to sit at the table or eat until the men have finished, according to a recent government report[248].
Many Albanians eat the internationally recommended minimum intake of over 400 g of

fruits and vegetables (in addition to potatoes) per day, which prevent deficiencies of micronutrients (anti-oxidants, flavonoids and phyto-oestrogens) and help to prevent non-communicable diseases. But most do not reach the recommended 600 g per day. The median intake was only 490 g per day in 1995[249], and is probably lower now following the 1997 crisis and subsequent dramatic increases in poverty.

In 2000, Albanians consumed an average of 2 864 calories per day[250]. This is just above the recommended minimum from the Food and Agriculture Organization of 2770 calories to improve GDP significantly[251]. But, it is the one of the lowest compared with other European countries. The 1999 average for EU members was 3472 calories per day, and for applicants was 3172[252]. Since 1994, Albanian's median caloric intake has been 2 802, suggesting that increased vigilance in food availability is necessary to prevent further declines in this important measure of food security and nutrition[253].

Official statistics show that in 1993 Albanian households spent an average of 67.7% of their income on food. This figure had dropped to only 49.2% as of 2000 suggesting greater levels of food security as well as a higher standard of living as more income is freed up to spend on clothing, education, health care, and transport, all of which have increased significantly during the same period[254].

In section 7.1, iodine deficiency was noted as a considerable problem. Data from 1997 showed the rate of goitre among school children to be 40%, ranging from 92% in areas with iodine-free drinking water to 15% in areas with iodine in the drinking water. In Bulgaria, the highest level of goitre in this age group is 20%[255]. More recent information about salt iodisation efforts suggest that, as privatisation continues and salt operations are improved, increased iodisation will follow[256]. Health data from a study conducted in 2000 revealed that nearly a third of newborn children from a North Eastern area were severely iodine deficient[257]. UNICEF is taking some steps in concert with the government to address this problem including the social marketing of iodized salt, and building the capacity for salt iodization[258].

Mean fat intake of 27% of dietary energy compares well with other countries and with current international recommendations (15–30%), Fat intake per capita per day increased from 79 g in 1994 to 89.4 g in 1996. It has since fallen to 78.5 g in 1997, but is slowly coming back up, with 85.9 g in 2000[259]. These fluctuations mirror the civil situation in the country around the crisis in 1997.

Protein intake per capita per day, in grams, has fallen from a high of 103.4 in 1996 to 96.8 in 2000, although it is on the upswing from a low of 87.5 in 1998[260].

The consumer price indices (CPI) for various commodities can be an predictor for consumption. As numerous studies of tobacco control have demonstrated, price is a factor in people's decision to smoke. From 2000 to 2001, the Albanian CPI for tobacco, oils and fats has fallen while the CPI for fruits and vegetables, bread and cereal, medical care, and rent has risen[261]. If the relative costs of tobacco and other less healthy choices falls while that for healthy items rise, people may make increasingly unhealthy choices.

There are no data on overweight and obesity in the general population. As mentioned in section 7.1, some young children are showing early signs of overweight.

Taken together, these findings demonstrate the need for strategies that aim to:

- encourage maintenance of traditional lifestyle and food choices that have, so far, kept the population at relatively low risk for many non-communicable diseases
- replace the trend towards high-fat, energy-dense foods by greater use of foods rich in complex carbohydrates and dietary fibres (such as fruits and vegetables), thus reducing risks and increasing protection against non-communicable diseases, and improving energy balance
- prevent and control potential excess weight gain in the population as a whole, with prevention in young adults as a primary goal.

The health gains from moderate activity include enhanced mood and self-esteem; improved physical appearance and posture; and substantial reductions in obesity, hypertension, cardiovascular diseases, non-insulin-dependent diabetes and osteoporosis, and in the burden of avoidable disease, disability and mortality which these produce. Moreover, joint physical activity can strengthen family cohesion and other social networks (for example, among older people) and encourage respect for the environment. Recent guidelines recommend that all individuals who are not actively employed in physical labour should try to take at least 30 minutes of moderately intense exercise every day, such as brisk walking, cycling, dancing or swimming. Unfortunately, no data appear to exist on the levels or type of physical activity among the Albanian population.

A satisfying sex life is an important part of physical and mental health. Sexuality is an important resource for people; positive sexual experience and expression of sexuality contribute significantly to a sense of well-being and to the quality of life. However, many people suffer from different kinds of problems and disorders in their personal relationships and sex life, which may lead to loneliness, sexual dysfunction, psychosomatic symptoms and increased risks of illness. At the same time, many illnesses and treatments are known to affect sexuality and may reduce sexual desire, excitement or performance.

Unfortunately, apart from statistics already quoted on sexually transmitted diseases (section 7.5), youth health (section 7.2) and migration and the commercial sex trade (section 7.3), data on sexual knowledge, beliefs, attitudes and behaviours in Albania appear to be lacking. This makes it difficult to formulate a realistic and effective strategy.

7.11 Reducing harm from alcohol, drugs and tobacco

Tobacco smoking is the biggest threat to health in Albania. Fifty per cent of all regular smokers will die as a result of smoking, half in the most economically active period of life (middle age) and half in old age. A significant minority of non-smokers exposed to environmental tobacco smoke will suffer from tobacco-related diseases, disabilities or

death as a result. Tobacco smoke increases the risk of many cancers, cardiovascular heart disease, low birth weight, sudden infant death, allergies and many other health problems. Apart from the suffering this causes to individuals, families and friends, there are huge costs to the Albanian economy, primarily due to lost production and the costs of treating tobacco-related diseases. Determined countries have been successfully combating the tobacco-related burden of disease for many years. This has been achieved through an empirical combination of anti-tobacco policies, embodied in the 1988 Madrid Charter and Strategies for a Smoke-free Europe, whose effectiveness has been demonstrated in many countries.

Alcohol plays an unintrusive part in the lives of many people. However, alcohol consumption can have significant adverse effects on the physical, psychological and social health of individuals, families and communities. Its direct and indirect adverse effects are diffuse and costly, not confined to a minority of easily identified heavy drinkers, but extending across the whole population. It can adversely affect drinkers" health, happiness, home life, friendships, work, studies, employment opportunities and finances. Alcohol consumption is associated with unprotected sexual intercourse, and heavy drinking is associated with increased trauma of many kinds, including road traffic accidents, workplace accidents, family violence and violent behaviour towards others, including violent crimes such as robbery and rape, self-harm and suicide. Acute intoxication may cause sudden coronary death, while chronic overuse may result in liver cirrhosis, certain cancers, hypertension, stroke or congenital malformations. The harm done by alcohol imposes a significant burden on individuals, families and the economy as a whole, primarily due to lost production, the costs of treating alcohol-related injuries and diseases, and costs of fire and damage to property. According to WHO estimates for the region, the total cost of alcohol to Albanian society is likely to be of the order of 2–5% of GNP[262].

Illicit drugs increase the risk of poisoning, dependence, psychosis, suicide and crime. Drug use contributes significantly to the spread of HIV and hepatitis. There is clear evidence that providing an extensive network of services for drug users can reduce risky, health-damaging behaviour and limit antisocial and criminal activity among drug users.

Analysis of the Albanian situation

Based on data collected in 1999–2000 as part of a nationally representative survey of tobacco use and policy in Albania, smoking is responsible for the deaths of one in five males under 70 years. The overall proportions of the population aged 15 years and over in Albania who were regular smokers in the most recent survey were 60% male, 18% female[263]. Overall daily smoking rates have been increasing steadily during the 1990s: from 29% in 1990 to 39% in 2001. This is the second highest rate in comparison with EU members and applicants, with only Hungary home to more smokers (overall rates in Hungary, 42%)[264].

The 1999–2000 survey included some information about tobacco control policy in Albania[265]. While some steps have been taken, Albania remains without a strong anti-

tobacco climate across government and the private sector. Survey data provide the following information.

A draft tobacco law introduced to Parliament by the Minister for Health, including many recommended measures to control tobacco use, was not approved or enacted. At the same time, the Ministry of Agriculture introduced a bill to decrease the price of tobacco.

There is no law against selling or giving tobacco to anyone under a specific age.

Only partial restrictions that ban or restrict smoking in public are in place, and only in a few educational and health care facilities. There are no restrictions on tobacco advertising or requirements to place warnings on cigarette packets.

Cigarette taxes, based on quality measures, make up about one-third of the retail price. This is contrary to World Bank, EU and other recommendations whereby *all* tobacco should be taxed at about two-thirds of retail cost. Five per cent of tobacco tax revenue is earmarked to provide tobacco seeds to farmers. None is set aside for health-promotion efforts.

Despite WHO recommendations that smoking cessation services should be made available by governments, there are no such programmes in Albania.

Approximately US$260 000 000 per year is spent on retail sales of tobacco in Albania, compared with a total for all health expenditures in 1999 of about US$9 000 000[266].

Although there are no accurate data on tobacco smuggling, the NGO For a Tobacco-Free Albania estimates that about two-thirds of all cigarettes consumed are smuggled. The Minister of Finance has calculated that only 2000 tons of tobacco passed through customs, whereas annual consumption in 1999–2000 exceeded 6000 tons.

Approximately 40 000 families depend on the tobacco trade in rural areas, an inefficient use of the 5000 hectares currently dedicated to tobacco cultivation. While this represents a decrease from 25 000 hectares in the 1980s, the national strategy is to increase cultivation to 32 000 hectares. The same amount of land, if used to grow olive trees rather than tobacco, would yield seven times greater profits for farmers and help to alleviate rural poverty.

In Tirana alone there are more than 500 children between nine and 15 years selling tobacco on the street.

Despite the discouraging situation, a recent survey of attitudes to smoking revealed that between 71 and 93% of people believe smoking should be prohibited in a variety of public settings, including public transport, schools, offices and health facilities[267]. In addition, some efforts at tobacco control are under way, primarily carried out by the NGO For a Tobacco-Free Albania with support from the WHO and the Albanian Ministry of Health. A week-long event in October 2000; a celebration of World No Tobacco Day each year since 1999; and involvement in the WHO Health Promoting Schools network suggest that support is building for stronger anti-tobacco measures. A National Anti-Tobacco Conference is being planned to establish a National Anti-Tobacco Plan and identify sources of funding. In addition, Albania is a formal member of the Intergovernmental Negotiating Body of the WHO framework convention on tobacco control.

Being relatively specific to the alcohol problem, rates of chronic liver disease and cirrhosis are a good measure of its scale. Between 1987 and 1995, age-standardised death rates from these conditions dropped sharply, from 15 per 100 000 population to zero. Rates were up very slightly for females in 1998, which may or not suggest an increasing trend. These rates are significantly lower than those for other European countries in the region: Austria had 19.37 deaths per 100 000 in 1999 and Bulgaria had 15.44[268].

There are few data about actual consumption of alcohol, though the Ministry of Health reported in May 2001 that alcohol abuse is becoming more widespread[269]. Although standardised death rate data suggest there is not an alcohol use/abuse problem, from the increase in drug use presented in the following paragraphs it appears that substance abuse behaviours are on the rise. It will be important to collect and carefully monitor alcohol consumption in the coming years.

The use of illicit drugs is increasing. Prior to 1993 there was no discernible drug problem. A consequence of opening Albanian society after decades of severe isolation has been an increase in drug trafficking and use. Most drug users have been using drugs of any kind for less than three years[270]. Drug trafficking is also growing within Albania, as it is an increasingly active trans-shipment point for South-West Asian drugs including opium, hashish and cannabis, as well a more limited point for South American cocaine coming into Western Europe[271]. The Ministry of Public Order and Police has worked with the governments of neighbouring countries to launch a successful effort to combat illegal trafficking of drugs and people in the region. Such traffic between Albania and Italy has fallen 500% between 2000 and 2001[272].

Data on drug use in Albania is patchy and incomplete, but estimates from the Institute of Public Health and the Toxicological Clinic of University Hospital Centre[273], indicated that:

- there may have been as many as 20 000 drug users in the country in 1998, up from 5000 in 1995
- there is only one drug treatment centre in Albania, located in Tirana, and first treatment demand at this centre has increased steadily from 1995 (27 cases) to 2000 (907 cases)
- of people requesting treatment for the first time in the years 1995–99, 88% were between 15 and 29 years, with 23% between 15 and 19 years, and half between 20 and 24 years
- most of those seeking treatment are male; the ratio of males to females between 1995 and 1999 was about15 : 1 – this does not necessarily reflect the real pattern of drug use/abuse, however, because of social norms preventing females from seeking treatment
- between 1995 and 1999, about 65% of drug users seeking treatment had a medium to high educational level, most were unemployed or partially employed, and nearly all had stable living arrangements within a family setting; about one-third were users as well as traffickers, and 10% were married with children
- opiates, primarily heroin, account for 87% of all first treatment demands; cannabis and

cocaine came in second and third, with 4.4 and 1.8%, respectively; opium was the most popular drug in the early 1990s, but has been replaced by heroin since 1996; based on official, reliable data available in 2000, there are no hallucinogens, stimulants or volatile inhalants in use in Albania

during the period from 1995–99 smoking or chasing heroin was the preferred method of taking the drug, whereas injection has not been as popular, however, trend data suggest that injecting drug use is increasing in prevalence: in 1995 only eight cases presented for treatment having injected heroin; by 1999 that figure had increased to 163 cases; but there are no confirmed epidemiological data on intravenous drug use being linked to any hepatitis or HIV infections as of 1998.

7.12 Settings for health promotion

Several sections of this report have dealt with many behavioural issues related to health. This section addresses the fact that behavioural choices are made in the everyday settings of life – homes, schools, workplaces and local communities – and that many of the actions necessary to promote healthier behaviours can most effectively be achieved in and through these settings.

The home is the physical environment in which people spend most time, and which accommodates the primary unit of society, where family members can enact their own health policies such as a smoke-free and safe environment, and healthy eating. Primary health care professionals, especially those who make home visits, can be influential in promoting safer and healthier living. As the most frequent 'outside visitors' to most homes, the mass media also have an important part to play.

In pre-school settings and schools, young children can readily absorb and practise the basis of healthy living – good social interaction and teamwork – and can learn about personal hygiene, accident prevention, healthy eating and other basic health and safety issues.

WHO, the EU and the Council of Europe advocate the right of all children to be educated in a health-promoting school, in which education aims to provide the skills needed for healthy behaviour, not simply the transmission of knowledge. With the support of a comprehensive health education curriculum tailored to the needs of each year group, such schools require students, teachers and parents to be partners who together design, implement and evaluate programmes to promote basic life skills, enhance health values, promote healthy lifestyles and prevent accidents.

This three-way partnership also needs to embrace representatives of the local community, so as to reinforce all the main elements of the social networks that influence behaviour.

Employed adults spend at least one-third of their life at work, and the workplace has tremendous importance for their health. This is recognised in legislation and through inspection of the health and safety of workplaces. Furthermore, there is enormous

economic benefit to be gained from making working environments safe and healthy, not only by minimising exposure to risks, but also by increasing the participation of employers and employees to promote a safer and healthier working environment and to reduce stress. This requires the promotion of a work culture that favours teamwork and open debate, on the understanding that better social relationships at work contribute to higher staff morale and productivity, as well as to better health. Moreover, since the workplace is one of the few places where the adult population can be reached in a systematic manner, it provides great scope for effective, consistent health promotion sustained over long periods, for example smoke-free workplaces and healthy menu canteens.

Local communities – both urban and rural – are also a potentially powerful setting for promoting better health. Their power springs from their democratic base; from the services they provide which can improve living conditions, employment, social integration and individual care; from their position as a catalyst for building partnerships for health among local people and organisations representing different sectors of society; and from the health-promoting examples they can show in their public administrative functions.

Albanian situation and targets for improvement

The value of different settings for health promotion is recognised in Albania. However, most practice is still at an early stage, and much development will be needed to bring the extent and depth of Albanian experience up to the standards of many other European countries.

Albania is a member of the WHO Network for Health Promoting Schools where some anti-tobacco health promotion efforts have been implemented[274], as well as curricula addressing mental health, sexual and reproductive health, healthy behaviours and addictions. The collaboration with the Health Promoting Schools Network has also extended into the communities around the schools, linking parents and other community members into the school-based approach to improving the health of youth[275]. Peer education has also been identified as an effective method to convey health-promotion information both in schools and in the community at large[276].

The state news agency still officially controls all newspapers; freedom of the press, while improved since communist times, is still not complete[277]. Not surprisingly, a recent survey of the Albanian public's perception of their health care system showed that people have little trust in health-promotion information provided through media channels such as TV or the press. The highest level of trust was in information from family members and GPs, despite general criticism of the health care system[278]. Other data show that, although only 37% of the population have a television, 93% are able to watch it every day and report getting information about AIDS and family planning from television programmes. This same survey, in contrast to other reports, revealed that people believe television to be the best way to disseminate health information[279].

Community participation in improving the health care system is being encouraged by the

Ministry of Health, especially in the management and maintenance of local services[280]. As people become involved in making changes and improving the system, they will share in the responsibility for – and benefit from – a functioning health care system. This is another step toward a free and democratic society.

The International Medical Corps noted in 1999 that some health care providers were providing patient health education in lieu of standard medical treatment because supplies and equipment were lacking. It will be important to encourage the continuation of good health education and promotion practices even as facilities are better equipped[281].

7.13 Specific educational, preventive, diagnostic and clinical tasks

Medical care professionals have long had a major impact on public health through:

- educating their patients about healthy living and self-care
- carrying out immunisation and other disease prevention work as part of public health programmes
- screening and early diagnosis of disease which can be stopped at a pre-symptomatic stage
- effective long-term treatment of serious chronic illnesses.

They will be called on to contribute even more in future, especially in primary health care, as more evidence is accumulated about effective health promotion and disease prevention methods; as more screening programmes are introduced; and as effective treatment becomes available for more serious chronic illnesses.

Analysis of the Albanian situation

The reform of health care in Albania will present a major opportunity to bring primary health care"s contribution to better public health to the forefront of global practice. Major donor organisations are contributing resources and expertise to assist with improvement of a primary care system where half the population does not have a family doctor, and where some bypass primary care services to see specialists who offer incentives[282]. Other challenges that will have to be overcome are the grey market for medical care, where physicians receive special payments from patients for services; a crumbling infrastructure; and an emphasis on curative rather than preventive approaches to health care[283].

There are simply not the facilities in much of the country to provide good primary care. During the political changes in 1991 and 1992, and the violence and chaos that accompanied them, a quarter of city health centres and two-thirds of health posts in small villages were destroyed[284], and the number of functioning health care facilities fell to a low of 85 per 1000 in 1994. This decline, from 129 per 1000 in 1990, was due primarily to funding pressures following the fall of communism[285]. The subsequent violence in 1997 also caused severe damage to the health care system, as health centres and hospitals were

looted of drugs and other supplies, and one-third of medical staff abandoned their posts[286]. Health care personnel are underpaid, and many are leaving the country in search of better pay. Adding to inequality in access to primary care is a significant imbalance in the distribution of health care staff across the country, with variations up to 50% between some districts in the ratio of staff to population[287].

Since the civil crises, Albania has slowly begun to improve its primary health care system through a series of reforms, with help from UNICEF, WHO, the World Bank and the EU"s Phare programme, among other donors. The Minister of Health has identified increasing regional and local capacity, strengthening the Ministry of Health as a policy and regulatory body, increasing financing for health, and increasing privatisation of the health insurance system as the main priorities for health system improvements[288]. Primary health care has largely been decentralised, with local governments running primary health centres. The Health Insurance Institute is being introduced carefully and, in 1997, covered 70% of the general population (although some inequalities exist, as described in section 5.2), provided salary for primary care doctors, and covered some essential prescription medications. Gradual privatisation has also taken place, with many dentists and pharmacies now private. However, there is not yet a private insurance system[289].

7.14 Advocacy for better public health

The views of medical care professionals on health issues command public attention. This gives them a potentially influential role in advocating better public health. In many societies doctors have played this role with distinction, for example as leading advocates of better living conditions for the poor in the 19th and early 20th centuries; and, in recent decades, as leaders in the struggle to control the tobacco epidemic; and as outspoken critics of health inequalities, particularly through their professional associations. Such advocacy, when conducted in a professional manner without party political considerations, can be effective in its own right and also enhance the public esteem of the professions involved.

Analysis of the Albanian situation

Based on available data sources, there are no active professional associations of doctors, nurses or other health care professions in Albania that have so far become advocates for better public health.

7.15 Managing for quality in health development and public health practice

The rapid evolution of public health in recent decades has brought major challenges to public health practice in the form of new environmental hazards, the return of epidemics of 'old' communicable diseases, outbreaks and epidemics of emerging communicable diseases,

and major epidemics of non-communicable diseases. To the extent that it has been possible to meet these challenges, success has been achieved by developing and applying new skills, some refined from the epidemiological toolkit, and many borrowed or adapted from a range of other disciplines, especially from the behavioural, social and political sciences.

There is no reason to believe that, in this respect, the future is going to be very different. Public health practitioners around the world will need to have at their disposal a wide range of sophisticated diagnostic and operational skills, will want to share and compare learning about effective practices with other practitioners, and will need to access, adapt and swiftly apply evidence-based practice to their local problems.

To make this possible will require significant improvements in the design and management of public health systems.

Analysis of the Albanian situation

UNICEF reported in 2000 that many of the infant deaths could be attributed to poor sanitary conditions in the hospitals with such basics as gloves not widely available and antibiotics not distributed to all districts[290]. According to an International Medical Corps report in 1999 of five districts, lack of resources and poor facilities were widespread problems. No single facility visited had all the equipment it needed to and some lacked such basics as running water and electricity. For example, only 25% of facilities had received and distributed contraceptives and more than 40% had no running water. The IMC and UNICEF, in a separate report, attributed these problems not to a shortage of resources country-wide, but rather a need for improved management on how to organise and distribute the existing resources[291, 292]. The commitment to this public health strategy represents a significant commitment to change in Albania, but the major process of change lies in the future and will be very demanding.

7.16 Funding health development and the public health system

Public health services are funded from public finances and need to observe the basic principles of public financing – to achieve defined levels of service at optimum effectiveness and least cost. There are no international guidelines, and judgements about expenditure therefore need to be made empirically. As a newly emerging area, health promotion in many countries is often under-funded, and special arrangements often need to be made, for example by providing 0.5–1% of the health insurance fund, or a percentage of tobacco, alcohol or gambling taxes.

Analysis of the Albanian situation

A full review of current arrangements for health protection is proposed. This should consider the adequacy or otherwise of the current funding arrangements for health protection.

Health promotion has yet to be systematically financed in Albania, and has got by for a number of years on very little funding. Of the entire government budget, 7% is dedicated to health care[293], estimated to be only 45% of the total need. Much of this is made up for by foreign aid, increasingly so in recent years, which has supported more than 50% of all health expenses since 1997, an increase from 16% in 1995[294]. Allocation of these funds is controlled centrally with only 4% of community councils involved in preparing the budget for their community and are therefore unable to customise their services to meet local needs[295].

Public spending on health currently amounts to only 2.2% of GDP[296], compared to an EU average of about 8%[297]. This has been decreasing steadily since 1993 when 4.2% of the GDP was spent on health care[298]. In 1999, health expenditure per capita is the lowest in Europe at only US$36 (PPP) compared with US$62 in Bulgaria and US$2 697 in Germany[299]. Currently, 56% of health expenditure is provided by the Ministry of Finance; 26% by Albanian households; and only 4% by employers. The figure for household expenditure, however, may be an underestimate as it does not include illegal payments to doctors[300]. The establishment of a Health Insurance Institute in 1995, and a willingness to pay some amount for private care on the part of the Albanian population[301], mean that health care financing has hope for reform. The efficacy of the health insurance system will rely primarily on increasing the income of the general public and reducing widespread poverty[302].

Comment [GHW3]: This is MARKEDLY lower than 1998 -$116. I have checked and re-checked and am comparing apples to apples. Does this make sense to others who have more inside info? Bulgaria also dropped from $230. Germany went up slightly from 2 488.

In the framework of decentralisation process, the finances for public health services will be covered by the local governments, which are still unprepared and lack the proper level of awareness for the importance of these services. Funding of public health services is also at risk because they might be included in the bulk of curative services provided by the primary health care.

7.17 Human resources for health development and public health practice

Advanced postgraduate academic education, supervised development of practical skills in an approved public health service training post, and a demanding professional examination are the basis of high-quality European public health practice. Training usually takes three to five years.

Analysis of the Albanian situation

Current education and training arrangements for public health practice in Albania differ significantly from the above, but will need to be brought into line if the health system is to improve. Health care staff do not receive adequate training to perform their job and continuing professional development is non-existent for most. According to an IMC report, in Durres only 63% of all health facilities staff has been trained in diarrheal disease and acute respiratory infection (ARI) management. The situation was worse in other areas with only 18.75% in Elbasan having ARI training[303].

Staff are poorly paid and under-resourced, so are unable to provide the kind of care they would like to offer. There is also a serious lack of skilled health care managers, leading to inefficient allocation and management of resources, both human and capital[304]. This poor allocation of human resources results in an uneven distribution of physicians and other providers; some of the larger polyclinics have too many, while individual doctors in rural areas are expected to cover multiple villages - and this without an adequate transport infrastructure – they are "essentially abandoned"[305]. In addition, the physicians who are staffed in rural areas tend to be older, average age 40-50 and as younger doctors are not encouraged to work in poorly resourced rural areas the shortage of providers will only become more serious[306]. As mentioned in section 7.5, there is a need for qualified specialists in the field of public health. Although the Faculty of Medicine offers training courses in post-graduate level to MDs who want to specialize in the field of public health, their curriculum is poor in this regard. The Institute of Public Health in collaboration with the University of Montreal has established a 6-month training course for Public Health Management. Despite of this, there are deficiencies in both in basic and ongoing training in the field of public health, what is related to the lack of a School of Public Health. In fact, as specialists in emigrate[307], there is a need to train more and improve the working conditions for those who remain.

7.18 Research and knowledge for health development and public health practice

Effective public health practice has always depended on ready access to good routine information, high-quality special surveys and skilled research. In countries that possess them, good routine information, survey and research systems have taken many years to construct.

Analysis of the Albanian situation

This report has identified many deficiencies in the provision of routine information, surveys and research in public health in Albania. Repairing these deficiencies will take many years, but progress needs to be made as quickly as can be afforded, to minimise the extent of 'blind steering'.

After consultation, amendment and political endorsement of this strategy, it is intended that a transparently clear implementation plan for the period 2003–05 should be drawn up. This will contain proposals, progress and implementation of which will need to be monitored and evaluated, and regularly reported to government and parliament.

7.19 Implementation, monitoring and evaluation of the Public Health Strategy

Implementation of the Public Health Strategy should be regularly monitored and evaluated with high level inter-ministerial supervision, involving annual reports to government and parliament on progress with implementation.

APPENDIX I -TOBACCO CONTROL IN ALBANIA

1. Tobacco Control in Albania.

1.1 Challenges facing Albania

Albania remains the poorest country in Europe, with an estimated 20% of the three million population on an income of less than US$1 a day. It faces a daunting array of challenges. Public confidence and trust in the Government's ability to deliver public services need to be established. Corruption remains a major barrier to prosperity and public health. Public finance and taxation strategies are in relatively early stages of development.

1.2 The importance of tobacco control

Although there are many pressing needs facing the country, as in all low income countries (and much more so than in high income countries), the health and economic burden from the harm done by tobacco is a major deterrent to health, social and economic development. 1999 data show that 60% of men and 18% of women are cigarette smokers. If they continue to smoke, one half of all of these smokers will die from tobacco, one quarter in middle age. It can be estimated that tobacco will be responsible for approximately one fifth of all deaths of the total male population that occur before the age of 70 years.

1.3 The current lack of tobacco control

Although a draft tobacco control law has been prepared, it has yet to be approved by the parliament and enacted. Essentially, there are, at present, no tobacco control policies or strategies. Smuggling of cigarettes is widespread. There are no provisions to help cigarette smokers to quit. Implementation of effective tobacco control strategies represents one of the most cost effective investments for health gain in the country.

2. Infrastructure for Tobacco Control

2.1 Draft tobacco law

The Ministry of Health has prepared a draft law for tobacco control in Albania. The draft law should be reviewed, endorsed by key stakeholders and introduced to the next session of the parliament for adoption.

2.2 Nominated officer for tobacco control

An officer within the Centre for Health Promotion has the technical competence for advising on tobacco control in Albania and is the official counterpart for tobacco control with the World Health Organization. This post should be formally recognized as the full time technical post responsible for tobacco control policy in Albania, located within the Institute for Public Health.

2.3 Implementation of the tobacco control law

A structure needs to be formalized to monitor and ensure the implementation of the tobacco control law, once this has been passed by the parliament.

2.4 Non-governmental organizations

The NGO, „For a Tobacco – Free Albania" has played a prominent role in bringing the need for tobacco control into the public domain. The NGO will have a continuing role in reporting on the implementation of the tobacco control law, and should receive funding for this purpose. At present, the president of „For a Tobacco – Free Albania" is the same person as the officer within the Centre for Health Promotion that has technical competence for tobacco control. Once the „For a Tobacco – Free Albania" is financially secure, the President should give up his position of presidency to avoid potential conflicts of interest. „For a Tobacco – Free Albania" should affiliate itself with the European Network for Smoking Prevention.

2.5 Funding of tobacco control strategy

As is common practice in many countries, US States and municipalities, a proportion of tobacco taxes should be earmarked or hypothecated to fund all tobacco control strategies, including the provision of services for smoking cessation (treatment of tobacco dependence).

2.6 National tobacco control conference

In partnership with the World Health Organization, and with technical support from Peter Anderson, a national conference is being prepared by the Institute of Public Health for Monday 5 November 2001 to bring together key governmental and non governmental and public sector and private sector organizations to discuss and endorse the proposed tobacco law and tobacco control strategy for Albania.

3. Research

3.1 National surveys

A nationally representative survey on smoking of 4393 men and 4007 women was undertaken, using WHO standardized methodologies, during the end of 1999 and the beginning of 2000. The findings should be prepared for the national conference, due to take place on 5 November 2001. Regular surveys on smoking should continue on a two yearly basis.

3.2 Tobacco Health Research and Capacity Building Program

An application is being prepared by the Centre for Health Promotion, with the technical support of Peter Anderson for funding to the International Tobacco Health Research and Capacity Building Program of the National Institutes of Health of the United States. The deadline for a letter of intent is 4/9/01 and for the application itself of 26/10/01.

3.3 Case study analysis of the political economy of tobacco control

In association with the London School of Hygiene and Tropical Medicine, a case study analysis should be undertaken of the political economy of tobacco control in Albania. A research counterpart is being identified in Albania.

4. The framework convention on tobacco control of the World Health Organization

4.1 Intergovernmental Negotiating Body

Albania is a formal member of the Intergovernmental Negotiating Body (INB) of the framework convention on tobacco control of the World Health Organization, which is due for adoption at the World Health Assembly, May 2003. Albania was represented at the 2nd INB by the General Secretary of Health, who will attend the 3rd INB, 22-27 November 2001.

4.2 Negotiating position

The national conference, scheduled for 5 November will assist the Albanian delegation in its negotiating position at the 3rd INB.

5. Price and tax measures to reduce the demand for tobacco

5.1 Tobacco taxes

In all countries of the world, an increase in the price of tobacco through taxation is the most cost effective option to reduce demand for tobacco products and increase government revenue at the same time. The current system in Albania of basing excise tax on tobacco quality as measured by a commission through parameters such as smell and taste should be replaced by a taxation system, whereby tobacco taxes are increased form the current one third of the total retail cost to two-thirds of the total retail cost, as recommended by the World Bank.

5.2 Economic analysis

As a matter of urgency, the Ministry of Finance, with the support of the World Bank, should undertake thorough economic analyses of tobacco policy in Albania, within the framework of the World Bank publication, Tobacco Control in developing Countries.

5.3 Hypothecation of tobacco taxes

A proportion of the revenue from tobacco taxes should be used to fund all tobacco control activities, including smoking cessation services.

6. Non-price measures to reduce the demand for tobacco.

6.1 Non-price measures

Currently, there are no effective non-price measures in operation to reduce the demand for tobacco. Measures that deal with environmental tobacco smoke, regulation of contents of tobacco products, regulation of tobacco product disclosures, packaging and labelling, education, training and public awareness, and controls on advertising, promotion and sponsorship should be implemented that follow the recommendations of the World Health Organization, and the directives of the European Union, recognizing that many of these directives are minimal requirements, rather than optimal tobacco control strategies.

6.2 Measurement of tobacco constituents

The Ministry of Health itself should assign a laboratory to measure the constituents of tobacco products (including tar and nicotine), according to international standards. This laboratory should be independent of the laboratory assigned by the Ministry of Agriculture, to ensure verification of standards as required by public health.

7. Tobacco dependence and cessation.

7.1 Tobacco dependence as a recognized disorder

Tobacco dependence is a recognized disorder within the WHO classification of disorders. The WHO recommends that smoking cessation services (the treatment of tobacco dependence) should be funded and made available by Governments. The World Bank recommends that the treatment of tobacco dependence is a highly effective and cost effective intervention even for low income countries.

7.2 The development of cessation services

Currently there are no cessation services in Albania. The major pharmaceutical companies that manufacture treatment products do not market such products in Albania. As a matter of urgency, an application should be made by the Centre for Health Promotion, with the technical support of Peter Anderson, to the British Embassy"s small grants scheme under the auspices of the UK Department for International Development to mount pilot cessation services in four primary health care clinics in Tirana, Shkodra and Korca. Peter Anderson should request the European Divisions of the global pharmaceutical companies to donate sufficient supplies of nicotine replacement treatment products for the pilot clinics.

8. Measures related to the supply of tobacco.

8.1 Licensing system

A licensing system for retailers should be implemented. Measures should be implemented that both restrict the selling and the purchase of tobacco products by children and young people under the age of 18 years.

8.2 Smuggling of tobacco products

There are no accurate data on the extent of smuggling of tobacco products in Albania. Estimates by „For a Tobacco-Free Albania" would suggest that at least two thirds of cigarettes consumed in Albania are smuggled, representing a huge tax loss. International experience would demonstrate that it is the international tobacco industry that is both the main organizer and beneficiary of tobacco smuggling in Albania. As in all countries of the world, the price of tobacco products is less of a determinant of smuggling than the presence of corruption.

8.3 Firm action against smuggling

The government should immediately adopt firm action against smuggling as recommended by both the World Bank and the World Health Organization and which is included in the draft text of the framework convention on tobacco control. The international community could help in this respect by searching and reporting on the documents of the tobacco industries that are in the public domain on the extent of industry supported smuggling in Albania.

9. Government support for tobacco manufacturing and agriculture

9.1 Cultivation of tobacco – an inefficient option

Currently 5000 hectares of land are cultivated for growing tobacco crops for export, compared with 25,000 hectares of land cultivated for both domestic and export before the 1990s. A proportion of tobacco tax is used to support the expansion of cultivation, although it is government policy not to subsidize the agricultural sector. Cultivation of tobacco is an inefficient use of land for the estimated 40,000 families dependent on this trade in rural areas. The equivalent use of this land for growing olive trees, for which it is suitable, would yield profits to farmers some seven times that achieved by the tobacco crop.

9.2 Analysis of crop substitution

As a matter of urgency, economic and agricultural analysis should be undertaken by both the World Bank, and the Agricultural Service Project of Albania on crop substitution of tobacco crops with other more economic crops, such as olive trees. It would likely make greater economic sense if the tobacco taxes were used to enable farmers to shift to a more profitable product, rather than cultivate tobacco.

Silvia Bino, Director

Appendix II Ottawa Charter for Health Promotion

First International Conference on Health Promotion, Ottawa, Canada 17–21 November 1986

Health promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing.

Prerequisites for health

The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites.

Advocate

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

Enable

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to 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 cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

Mediate

The prerequisites and prospects for health cannot be ensured by the health sector alone.

More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by non-governmental and voluntary organizations, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

Health promotion action means

Build healthy public policy

Health promotion goes beyond health care. It puts health on the agenda of policy-makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy-makers as well.

Create supportive environments

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitute the basis for a socioecological approach to health. The overall guiding principle for the world, nations, regions and communities alike is the need to encourage reciprocal maintenance – to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanization – is essential and must be followed by action to ensure positive benefit to the health of the public. The

protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

Strengthen community action

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

Develop personal skills

Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

Reorient health services

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services, which refocuses on the total needs of the individual as a whole person.

Moving into the future

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

Commitment to health promotion

The participants in this Conference pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors
- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies
- to acknowledge people as the main health resource, to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and wellbeing
- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and most importantly with people themselves
- to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The Conference urges all concerned to join them in their commitment to a strong public health alliance.

Call for international action

The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, non-governmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the

moral and social values that form the basis of this CHARTER, health for all by the year 2000 will become a reality.

Appendix III The Functions of Contemporary Public Health Practice

Ensuring that overall social, economic and fiscal policies promote the health of the population and reduce inequalities in health

By influencing the Cabinet of Ministers to examine the impact on health of government policies in all sectors, and to adjust them accordingly [in keeping with Article 152 of the EU Treaty of Amsterdam] and, in particular, to base social and economic policies on the growing body of evidence that demonstrates that greater social and economic equity leads to better overall health, and that better overall health enhances social and economic development;

Ensuring leadership and coordination of overall public health functions and practices

By identifying one senior government official to be accountable for the sustained and systematic planning and development of health policy, for overall public health system coordination and management, and for monitoring the implementation of health policy;

Maintaining and applying comprehensive, active information about the health of the population

By collecting, collating, analysing, interpreting and presenting data for the purpose of (a) informing the public and influencing health policy-making; (b) aiding the design, amendment and monitoring of interventions to promote, maintain or restore health, to control disease outbreaks, and to prevent epidemics of communicable and non-communicable diseases; (c) assisting the assessment of needs for purchasing evidence-based effective health care;

Promoting positive health in populations

By enabling people to take greater control over the determinants of their physical and mental health and thereby improve their health;

Providing programmes to prevent specific diseases, injuries or disabilities in populations

By initiating, constantly developing, organising and effectively implementing long-term programmes designed to prevent specific diseases, injuries or disabilities in populations, including congenital disorders, immunisation-preventable diseases, other communicable diseases, oral and dental diseases, nutrition-related disorders, cardiovascular diseases, neoplasms, musculo-skeletal disorders and motor vehicle injuries;

Investigating and identifying the causes of outbreaks or epidemics of diseases or injuries in populations ***and formulating and implementing*** counter-measures of known or predictable effectiveness

By enforcing laws or regulations that protect and/or restore health and safety, by

informing, educating and mobilising people to take effective action, and by initiating or amending legislation or regulations;

Investigating, identifying and assessing possible threats to the health of populations from physical, biological, chemical, radiological, social or psychological causes, and from natural or man-made disasters, ***and formulating and implementing*** counter-measures of known or predictable effectiveness

By enforcing laws or regulations that protect and/or restore health and safety, by informing, educating and mobilising people to take effective action, and by initiating or amending legislation or regulations;

Ensuring and maintaining the efficiency, effectiveness, equity of access and quality of public health services

By monitoring and adapting services to meet assessed needs, by ensuring that all practice is based on reliable evidence of effectiveness, and by introducing and maintaining measures to enhance quality;

Monitoring and advising on effectiveness of, and equity of access to, personal medical services

Much variation from country to country: Albanian statutory requirements to be assessed.

Ensuring sufficient and appropriate research and development for effective public health practice

By establishing high level arrangements to set up, fund and run a public health research and development programme, which is based on identified priorities, is transparent, professional and efficient in its contractual operations, and is capable of holding its contractors properly accountable for their contracts.

Ensuring and contributing to education and training for competent public health professional practice and for high quality research and development

By designing a programme tailored to the public health functions which have to be performed, ensuring the competence of the academic teachers and service trainers, coordinating and managing the programme efficiently, and funding it sufficiently.

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