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NATIONAL REPORT

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**POPULATION DEVELOPMENT AND REPRODUCTIVE HEALTH
CURRENT SITUATION IN ALBANIA**

In Albania during this seven years of social and economic changes related with the changing of the regime passing from a communist dictatorship to a democratic system, are placing new and difficult challenges on population development and reproductive health Albania's, unique geographical and political position between countries of former Yugoslavia, Greece, Macedonian and less than an hour away from Italy by sea, makes it a critical country in the scheme of overall health and social development of the Mediterranean basin.

1. Demographic characteristics and projections

1.1 Population size and growth

According the official figures from the National Institute of Statistics (INSTAT)the population of Albania was reported during the last census in 1989, .as 3.182 000.
However during this last seven years , in Albania exists a mass migration, from one district to another, especially from the northern parts (which are the poorest) of the Country to the central and south parts, and also abroad of Albania, as a result of abolishing all restrictions on migration, thus leading to a rapid increase and overpopulation of urban areas.
Of all the former socialist countries of Central and Easter Europe, Albania's transition from a centralised government, to a free market and more developed system, has had also the most profound and disruptive impact. There is little of the Country's former institutional framework, that has not been badly affected by the economic difficulties which the country is facing and the repercussions on the social and health profile of the population have been and continue to be serious. One of the results of this is a growing pressure on people to leave rural areas and communities, and seek a different life in main cities of the country, or abroad. During the period of 1990-1995 it is estimated that the number of emigrants fluctuated between 300-350.000, representing 9-11 per cent of the total population in 1995. Most of this emigrants are young and highly educated thus, affecting both the reproductive capacity as well as the economic potential of Albania. Emigrants are mostly oriented towards neighbouring countries, primarily Greece and than Italy.
According also to INSTAT, the estimated mid year population for 1995 was 3,249 000 and the annual growth during the period 1990- 1995 was 0,23%, instead of 1,93 %-2% during the previous communist period 1980-1990.
The structure of the population is young , so 32,9 % were below 15 years of age in 1995 and around 9,2 % were 60 years older. The percentage of woman aged 15-49 years was 50,9 %.

1.2 Fertility and mortality

A significant decline in the level of fertility had occurred during this last 5 years.
According to the published data, from INSTAT the CBR(crude Birth Rate) is estimated to be 22,2 births per 1000 inhabitants in 1995, compered with 25,4 births during the period 1985-1990 (a decline of about 12,6 per cent). Similarly, the Total Fertility Rate (TFR) dropped over the period 1960-1995, from a high of 6,9 children per woman in 1960, to 3,1 children during the period 1985-1990 and to 2,7 children in 1990- 1995. This is mainly attributed to the transition of the Albanian society from agrarian to a more industrialised society and from traditional family patterns to more

modern ones. Moreover high levels of female literacy and female employment in the formal sector were also effective in realising this decline in fertility levels. This continuous decline is also supported by a modest increase in the average age at marriage, for women, from 21,8 years in 1950 to 23,0 years in 1990, although it stayed almost stable for men (around 27 years).

1.3 Population distribution and urbanisation

About 58 per cent of the estimated population for 1995 were living in rural areas (INSTAT), compared to around 64 per cent according to the 1989 census. Almost half of the estimated population for 1995 were living in 6 districts namely, Durres, Elbasan, Fier, Korúa, Shkodra and finally Tirana where according the last estimations the total population was around 500 000 inhabitants.

2. Health Situation of Women and Children

2.1 Woman's health

Woman's health is one of the great priorities of Albanian Society, in generally and of course for the health services. One important indicator for measuring the woman's health is the maternal mortality which although had decreased during the years (about half)1985 (56,7 per 100 000 live births) 1997,(27,5 per 100 000 live births), still remained one of the highest in Europe.
The major causes resulted from the maternal deaths are

1) bleeding during delivery
2) existing pathologies before pregnancies which are aggravated from the pregnancy
3) hypertension form pregnancy
4) sepsis puerperal.

There are significant differences in geographical distribution of maternal mortality, with the highest figures in mountain districts. As we mentioned before, the trend of national maternal mortality continued to decline but still remain one of the highest in Europe.
According MOH reports, until 1991 the main cause of maternal mortality was abortion, because it was not legally permitted. Following its legalisation in June 1991, abortion fell as a cause of maternal mortality from 50 % to 25 % in 1993, to 6%, in 1997 (In 1997 we had only one maternal death from abortion).
Actually in Albania exists a law, for the interruption of pregnancies approved in 1995, which admit the voluntary interruption of pregnancies till 12 weeks of gestation.
The ratio is approximately of 2,2 births per abortions or 358 abortions for every 1000 live births.
From a study conducted by INSTAT(Our National Institute of Statistics) resulted that a high percentage of abortion, 28%, is in 30-34 group of age, and 22.9% in 25-29 group of age. Regarding the degree of education's , 47.5% of women who did abortion have an elementary education and 44,3 % of them have secondary education.
Premature delivery rates are reported as 7,4 percent and low birth weight was about 12 %. The principal causes for premature births are related with the socio-economic causes and too frequent births with short intervals. Placental insufficiency (hypertension and toxaemia) antenatal cardiac diseases and anaemia, are among the main causes of low birth weight. Hypertension occurs in 4 to 5 % of pregnancies, with complications of preeclampsia/eclampsia occurring in 1,1 per cent.

2.2 Health Care services for women

The primary health care services for women are the Consulting Centres for women in cities, health centres and ambulances in the villages.
The secondary health care for woman include all the maternity wards in district hospitals. Also in villages were are the health centres, a number of them in each district had a delivery room, where a

doctor and midwife-nurses follow the pregnant woman. Also in all the villages there is a nurse-midwifes who controls all pregnant women of this village.
For the births at home in rural areas, the family comes fetch the midwifes, who travels to home either on foot or by a horse, because there is a lack of infrastructure.
Some of this delivery rooms are under primitive conditions. No electricity , no running water is typical at births site in some of them, and often exist a shortage of medical supplies and drugs.
One of the main problem of pregnant women is anómia form iron deficiencies.
In 1997 in Albania, 90,8% of all deliveries took place in health institutions and 9,1% took place at home, assisted by a health trained personnel. In major hospitals in districts delivered about 1/3 of women.
The maternity hospital in Tirana with 260 beds and 40 for premature births is the only tertiary health care which we have, and the number of annual deliveries is about 10% of all the annual births in Albania.
From the legislative aspects, after 1993, all the women after child birth have the permission to stay in their homes for one year and watch their children. The state pays 80% of their salary

2.3 New-born and child care
The average birth weight of an Albanian baby is 3,1 kg.
The *Perinatal Mortality* for the year 1997 was 15.2 per thousand live births. The leading causes of perinatal deaths are birth asphyxia, prematurity and low birth weight, congenital anomalies.
The *neonatal mortality*, during this last years is increased. So deaths of 0-28 days of live in 1991 were 8,6 and in 1997 10,5 per thousand live births.
The principal causes of increasing of this neonatal mortality are:
1) A better definition of WHO, regarding the still births and live births, more reliable statistical data
2) The continuous increasing of medicalization of deliveries. The incidences of sectio-cesarea is increased as a result of an increasing "monitoring" of deliveries",
3) The insufficiencies in materials and furniture's and in technical capacities of the staff who works in districts maternity hospitals.
4-A low access to antenatal care services, related with the quality of this services especially in rural zones and the low technical capacities of health personnel who works in this centres.In 1997 the average number of antenatal visits was: 5.1 (1996)
For this reason the MOH had started since 1996 a training program for neonatologists in all the districts, which will continue with the training of all the health staff who works in Reproductive health services according the needs of each district.
In Albania breastfeeding is a priority. We actually have good data for breastfeeding mothers. About 85% of all the mothers, breastfeed their children for the first four months of life *Baby friendly hospital* initiative is developed, and this year we have the certificate given by WHO/ UNICEF as Baby friendly Hospital, to one of the Albanian district maternity , which is the first baby friendly hospital also in Balkans peninsula Now the MOH is working, to prepare a draft law for breast milk substitutes based on international Code of breast milk substitutes .
Children health
Infantile mortality still remains one of the highest in Europe.
Compared with the year 1990, this indicator is decreased from 45 per 1000 live births to 22,5 per 1000 live births in 1997(according the data from Statistic's Office in MOH.)
About 39% of deaths of 0-1 years old occurred in home, (year 1997),. 55% of children 0-1 year died in maternity and 45% in hospitals. Infant mortality is higher 4% in rural zones.
The principal causes for infant mortality are
- Acute respiratory infections 30,9 %(1997)
- Neonatal diseases 22,6 %(1997)

- Diarrhoeal diseases 8 % (1997)
- Congenital anomalies 10,5 %(1997)

Malnutrition while not particularly severe- is widespread among children of Albania.

A three year long national survey, conducted by our Institute of Public Health, (IPH), in collaboration with UNICEF, had started two years before in 10 districts of Albania. The preliminary results showed that for the entire Tirana district, (capital of Albania), one fifth of the children were malnourished, and of these one out of five cases was moderately malnourished (second degree) and less than 0,3 percent of children showed severe third degree of malnutrition. (First degree is 10-20 percent below the 50th weight percentile, second degree of malnutrition is 20-40 percent below and third degree is more than 40 % below this percentile). The peak of the malnourished cases was between age 1-2 years(35% of this age group were malnourished).
Also in a study conducted in 1993 form the IPH, 63 % of children of 10-12 years old, had a severe form of iodine deficiencies.
Health services in primary health care for children starts from rural zones where are ambulances, and are working nurses midwifes, but under the control of the doctor who works in the health centre of this zone. In cities the primary health care for children is covered by Consulting Centres for children, which follow up the growth, development and immunisation of children from 0-6 years old. The total number of health structures for children in PHC for the year 1997 was 1986 in villages and 181 in cities.
For the secondary health care, in all the district hospitals exist the paediatric wards The total number of them in 1995 was 49. The number of paediatric beds in 1995 was 55,7 per 100 000 inhabitants

2.4 Family planning

Under 1991 the FP methods, according to a pronatalist communist policy were forbidden. Their application, effectiveness and safety were virtually unknown in Albania and their use claimed to cause cancer or permanent sterility. In 1991 was approved an Order of the Minister of Health concerning the performance of abortion and in Maj. 1992 was approved a decision of the Council of Ministers for the approval of FP activities in Albania,. In this context the first FP/ mother and child health (FP/MCH) project started in 1992, implemented by the Ministry of Health in collaboration with UNFPA. FP services , with basically trained personnel were integrated in to the existing MCH(mother and child health) services to all over the country. Even if their coverage is still uneven and the quality has to be improved, a good level of accessibility has been achieved. About 60% of women in reproductive age (WRA) have access to FP services for the first time in Albania. The first health care level is represented by 11 regional FP centres situated in the main towns and districts. Their purpose is to serve as referral centres for the surrounding FP service in the women`.s consulting rooms and health centres and ambulances in villages. Contraceptives provided by UNFPA have been distributed free of charge through the public FP facilities.. Information and training on FP and STD/AIDS has been made available to professionals and their knowledge about MCH was improved. New training techniques
in medical personnel and in counselling of clients have been introduced and contributed to a higher quality level of the relevant services, remembering always that before 1991 was nothing.
The prevalence contraceptive rate in 1996 was about 8% of the total population, or 5% of the married WRA. Contraceptive use still remained low to have a significant impact on the reduction of the abortion ratio. The unmet needs in family planning were first estimated in 1996 on the basis of several hypotheses and demonstrated that the contraceptive needs of about 40% of WRA are not met. Men are not sufficiently involved in RH and FP issues.

FP services which are normally situated in maternity hospitals and MCH services are not consulted by men. Only rarely couples come together to FP services for seeking counselling and advice. Even condoms are mostly procured by women, who then have to convince their partners to use them. FP services and other RH related services are unequally distributed between urban and rural areas with disadvantages for the rural population. Quality of services, including accessibility and availability, is lower in rural areas.

2.5 Adolescents RH

Although there are no legal barriers for adolescents to receive FP services, especially amongst the unmarried however may exist socio-cultural barriers. The analysis of individual client registers indicated that only 3% of them are of the risk group of early pregnancy (15-19 years of age). A girl under age of 18 , who wants abortion needs authorisation from her parents.. 16,4 Per cent of women undergoing induced abortion were under 25 years of age, 2,7 % under 20 years and 1% was from the age group 13-17 years (1994). Sexual education was introduced since 1995 in Albanian schools thanks to the joint activities of MOH, Ministry of Education , but the thematic is more oriented toward biomedical than to behavioural issues.

2.6 STD/AIDS

In Albania the first case of HIV infection was detected in 1993. The number of HIV cases is increasing slowly every year to a current number of 39 in 1997, and now we have 8 patients with AIDS disease. The epidemiological situation of STD, is not so clear and well reported, This data are collected by the Epidemiological Sector, the Sector of Statistics in MOH and the Institute of Public Health (IPH). But these are data service based and therefore not representative. Approximately from gonorrhoea were reported about 100-150 cases every year. But for the moment exists defects in their declaration. Now the national had elaborated a new declaration form which is anonymous (as they had done with AIDS).
In 1996 were registered 40 cases with syphilis's, after 30 years of eradication of it.

2.7 Resource availability

It is difficult to be precise about the budget of FP/MCH, because the health budget is separated in different institutions according the three levels of health care. Despite this can be assumed that estimations for 1996 including salaries, running costs and indirect costs resulted in a financial contribution for MTh/FP services about 60000 US$. Taking into account increasing expenditures, the MOH had invested about 200 000 US$ in F.P. during the last 4 years.

3.Population Policy and Objectives

3.1 Objectives for RH

The Ministry of Health (MOH) has formulated the following overall objectives related to RH, which must be reached by the year 2000. Some of this objectives are:
To reduce infantile mortality to less than 25 per 1000 live births
To increase the immunisation coverage of the children up to 95%
To reduce 50% the deaths of children under 5 years old caused by diarrhoeal diseases and to reduce 25 % the incidence of those diseases
To reduce 30% the number of deaths dues to acute respiratory infections in the children under 5 years of age
To reduce by 50 % the severe and moderate forms of malnutrition in children under 5 years old and to eliminate the disorder caused by the deficiency of Iodine and Vitamin A..

To reduce maternal mortality under 25 per 100 000 live births.
To increase the coverage of prenatal care by medical professionals to 90 %
To increase the prevalence rate of contraceptives to > 20 %
To increase the quality of delivery services through retrained medical staff and improved equipment.

3.2 Priorities and approaches for the future of RH services

Now a priority for the Albanian Government is the ensuring of equal access for the PHC services. This must be achieved through a more efficient utilisation of its limited resources through the restructuring of the health service. Special emphasis is put on the PHC services as the most cost effective means for achieving the health for all strategy. It will be focused on the improvement of the organisation and management services, procedures and treatment protocols, strengthening of human resources through training and retraining, and provision and availability of medical supplies, drugs and equipment's. An immediate need for better health education was identified to ensure that FP and nutrition information are widely disseminated.

3.3 Integration of RH services

The recently established sector of Rh (1996) is part of the Directorate of PHC in the MOH. For all the RH services are needed horizontal linkages between several services at the PHC, such are women and children consulting centres, laboratory services and vertical linkages to clinical services (as a part of a referral system), such are the maternity services, specialised laboratories for cancer screening and diagnostics of reproductive tract infections. At the present these services often operate separately.

3.4 Population policy directives

The socio economic and political changes during this transition period brought profound impact on the Governments principles toward population issues and policies. In June 1995 in Albania was held a National Conference on Population and development, as a follow up to the ICPD. The recommendations of the Conference, laid down the basis for formulating a strategic framework for the population situation in Albania.
The strategy for the national population policy include among others , emphasising the need for improving health care and its institutions, through setting up reproductive health centres, expanding F.P network within PHC relevant training programmes, devoting special care to teenager R.H., assisting priority to the health of pregnant women, , expand the role of midwifes and nurses in the field of R.H. especially in the areas of counselling and information services; the formulation of a national IEC program for RH issues, the role of family and the status of women including sexual education and other elements of family life in the school curricula.
For the future national policy on population development a number of strategic interventions are considered of vital importance as they are listed below:
Building national capacity at all the levels of government to identify priorities, formulate policies, implement programmes, monitor and evaluate its progress and impact.
Data collection and analysis in all the difference levels of government information and statistical systems in order to be able to integrate population factors into developments of policies and planning, as well as to identify needs and priorities
Donor co-ordination An increasing number of donor agencies national and international are involved in population and development activities, so there is a need to enhance their co-ordinationin order to avoid overlap and duplication of programme activities*Partnership with the civil society*, The establishment of an effective partnership with NGOs and other representatives of

civil society and the regular exchange of information will ensure the involvement of influential segments of society in the process of policy formulation and implementation.

3.5 Reproductive health policy and strategy

RH is a new concept for the Albanian health sector. At the present our Sector of RH in the MOH develops the strategy for the introduction of this concept to the relevant health services, particularly the existing PHC services. Now we are working to develop linkages between the services and to enlarge the perspectives of RH in various directions. Seven major orientations should contribute to this enlarged view of RH

1) People should be put in the centre of concern. RH should be concerned with women as women, with women needs before, during, and after the age of reproduction and not just mothers. RH should respond to sexual and RH needs of women, men and adolescents and should respond especially to the needs of the rural population, who is the majority of the population in Albania.
2) RH should be understood less as medical and more as an intersectorial approach, involving more relevant sectors such as education, labour and social affairs, non governmental and private organisations.
3) RH should create close collaboration between the different public health services. The horizontal co-operation between existing PHC services such as MCH, STD/AIDS prevention and IEC should be improved and also should develop vertical co-operation with the services at secondary level, such are maternity, laboratories for RTI diagnosis and services at tertiary level for counselling, treatment of infertility and post reproduction problems.
4) IEC must be strengthened and play an important role. By the means of IEC people should be enabled to make informed choices for their lifestyle and health.
5) Strengthening capacity building especially in management, intersectorial communication and collaboration. This includes active and continuous training, development of skills for team working and interpersonal communication
6) Improving the quality of RH services.
7) RH should be oriented towards and performed primarily by the first level of care. Services should be performed lessthrough medical specialists than through GP, midwifes and nurses and therefore contribute to a de medicalisation of RH and FP