

“SHADOW” REPORT
HEALTH CARE FIELD -
CASE OF ALBANIA

Submitted to the United Nation’s Committee on the Convention on the Elimination of
All Forms of Discrimination Against Women

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Submitted by the Albanian Centre for Population and Development (ACPD) and the
following Non-Profit Organizations:

- **Action Plus**
- **Albanian Association of People Living with HIV/AIDS (PLWHA)**
- **Albanian Disability Rights Foundation (ADRF)**
- **Albanian Helsinki Committee (AHC)**
- **Albanian Society for All Ages/ASAG**
- **Albanian Women’s Christian Association/YWCA**
- **Alliance Against Discrimination of LGBT People**
- **Association “Acli-Ipsia in Albania**
- **Centre for Legal Civic Initiatives (CLC**
- **Children’s Human Rights Centre of Albania (CRCA)**
- **Community Development Centre “Today for the Future” (CDC- TFF**
- **Counselling Line For Women and Girls**
- **Gender Alliance for Development Centre (GADC**
- **Human Rights in Democracy Centre**
- **National Centre for Social Studies (NCSS)**
- **Psycho-Social Centre “Vatra” (“Vatra” P.S.C)**
- **Observatory for Children’s Rights (Observatory)**
- **PINK Embassy/LGBT Pro Albania**
- **Useful to Albanian Women (UAW)**
- **Women’s Forum of Elbasan**

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List of Abbreviations

CEDAW	Convention on the Elimination of Discrimination against Women
DV	Domestic Violence
PHI	State Labour Inspectorate/Public Health Institute
SHI	State Health Inspectorate
SII	Social Insurance Institute
INSTAT	Institute of Statistics
STI	Sexually Transmitted Infections
CC	Civil Code
LC	Labour Code
FC	Family Code
CPD	Commissioner for Protection from Discrimination
PHC	Primary Health Care
LGE	Law on Gender Equality in Society
LGBT	Lesbian, Gay, Bisexual, Transgender and Intersex
MoH	Ministry of Health
MoSWY	Ministry of Social Welfare and Youth
SAA	Stabilisation and Association Agreement with EU
NPO	Non-Profit Organization
ILO	International Labour Organization
WHO	World Health Organization
PWD	Persons with Disabilities
NCCP	National Program of Cancer Control
SHR	Shadow Report
RA	Republic of Albania
DHSA	Demographic and Health Survey in Albania

NSGEEDV	National Strategy for Gender Equality and Domestic Violence
NES	National Employment Service
RH	Reproductive Health
SRH	Sexual and Reproductive Health
SSS	State Social Service
THB	Trafficking of Human Beings
ATTT	Anti-Trafficking Technical Table
PO	Protection Order
UN Women	United Nations Entity for Gender Equality and the empowerment of women
DDM	Decision of the Council of Ministers
VT/PVT	Victims of Trafficking/Potential Victims of Trafficking

I. PART ONE

A. INTRODUCTION

1. Albania ratified the CEDAW Convention in 1993.
2. In this SHR while we have highlighted the results achieved by the Albanian government, we have also focused on what the civil society still considers to be problems and shortcomings that affect the standards of equality, creating the grounds for the discrimination against Albanian women's health issues in general and sexual and reproductive health in particular based on Articles 12/1, 14/1 of CEDAW.
3. In this SHR we shall only dwell on health issues. In this way, the analysis is more qualitative rather than quantitative and it is focused on issues of sexual and reproductive health, the health of violated and trafficked women, women with HIV/AIDS, women in rural areas, etc.

B. CONCLUSIONS AND RECOMMENDATIONS

The SHR reaches the following conclusions and recommendations:

1. General conclusions and recommendations on women's health legislation
1. In general, the Albanian legislation is complete and provides special support and health services, specific to women, mothers and children. The problems lie much more in the implementation of the law and not just in its content. In this SHR we have identified several issues related to the legal framework, such as: the need for Law No. 10107/ 30.03.2009, "On Health Care", amended in 2013, to provide free services for children up to 18 years old; the Law "On the Promotion and Protection of Breastfeeding" to provide support to mothers for breastfeeding, the Law "On Termination of Pregnancy", amended by Law No. 57/14.02.2013, to provide free healthcare, such as tests prior to abortion or follow-up procedures, a provision for the obligation of health institutions to report the number of abortions, although this has been regulated by other acts. It is necessary to improve the legislation in areas such as: screening and preventative examinations in early pregnancies, domestic violence and measures to prevent it, gender-based violence, mental health screening, screening of women for cancers of the reproduction system, etc. Likewise, we have

identified the need for drafting and adopting a law that guarantees recognition of gender identity, (Gender Recognition Law) and the right of trans [gender] women to recognize the gender identity. The need for reviews and improvements to the legal framework concerning health should be a continuous and a progressive process.

2. Laws need bylaws such as guidelines, protocols, orders, etc., in order to provide the required result. The legal framework should be accompanied by the corresponding budgets. Periodic amendments to legislation are necessary and should be made in accordance with the dynamic changes that come about as a result of new problems and the needs that arise in the field of women's health and consultations with stakeholders.

2. Sexual and reproductive health: Family planning and contraception

Conclusions: Women's health problems are obvious and affect their well-being and the potential to fulfil the right to health. The main causes of mortality among women are reported to be cardiovascular diseases and neoplasia. The insufficient awareness and [lack of] access for women to services are the main obstacles to receiving health care services. Despite the improvement of health and nutrition indicators of mothers' and children's health, there are inequalities linked to age, gender, mentality, socio-economic level, geographical area and place of residence. There is an evident lack of integrated services, resulting in critical health gaps that limit the effectiveness of SRH programs, compromise human health and fuel the stigma and discrimination against vulnerable groups. Despite the achievements, NPOs report as problematic a low level of use of modern contraceptive methods, particularly among adolescents/youths and other vulnerable groups. Unofficial sources indicate a higher number of abortions than those published.

Recommendations:

1. Improvement of the quality of mothers' and children's services through unified protocols and standards for monitoring the health of mother and child. Development of a national plan in consultation with stakeholders on the health of women and girls; Arrangements for integrated sexual and reproductive health service provisions in primary health care level as per the basic service package of the approved PHC; Distribution of clinical guidelines and treatment protocols at health centres, the development of training manuals and training of personnel and updating other service guideline documents in order to implement them in practice.
2. The budget: The presence and identification of disparities in the health and nursing of children require prioritising the most vulnerable mothers and children in the planning process for universal health care coverage. Provision of an adequate and realistic budget for the implementation of the reproductive health strategy, together with human and administrative resources. Improved health care policies for mothers and children, expressed through better allocation of more effective financial and human resources in the health sector, with a view to ensuring equal access to quality health services for all women and children, including women in rural areas and the Roma community. The budget must ensure the quality of services and provisions with quality technological equipment.
3. Personnel and Infrastructure: Increase in the level of knowledge and skills of the health personnel through continuous education. Equipping health centres and clinics with the required set of equipment, specified in the basic package of primary health care. Provision of family planning services closer to vulnerable

groups: at the workplace, as part of a package of health services offered in these places; at clinics in rural areas, in places that young people frequent, where Roma population live, etc. Expansion of friendly services that provide counselling and family planning services for the most vulnerable groups.

4. Access: Provision of free medical visits near settlements for women of vulnerable groups. Provision of these health services should be made according to an approach based on the specific needs of that population.
5. Awareness: Awareness of women about their rights in obtaining health care and benefits of particular services; awareness of the community. Strengthening the health and prevention promotion components using interventions that are innovative and effective when traditional methods have not yielded results. Developing appropriate communication strategies to address the needs of different population groups such as: youth, Roma women, women with disabilities, and so on, and recognising the importance of well-thought interventions. Strengthening the cooperation and supporting NPOs and local communities in implementing information and educational activities and changing behaviours regarding contraception for vulnerable groups.
6. Evaluation and Monitoring: Despite the significant decline in mother, child and infant mortality in recent years, their levels should be evaluated continuously by the state, comparing them to other countries of the region and different areas within the country. A system should be established to monitor and evaluate the quality of services provided. Performance monitoring system, supervision and quality assurance of the service is lacking, which is reflected in the absence of data and indicators. The implementation of laws, orders and protocols in the field of health should be monitored.
7. Statistics: Sex-disaggregated data on all issues of reproductive health should be collected. Capacity building of health personnel in the suburbs and at the MoH for the collection and reporting of quality data should be established.
8. Preparation of a national study on the access of women and girls to the health system.

3. Voluntary termination of pregnancy

Recommendations:

1. Legal: The legislation relating to the termination of pregnancy should be reviewed and improved in order to increase the safety in the performance of abortions and minimise complications with repercussions on the general and reproductive health of women. Unified protocols should be set up for safe abortion with the introduction of modern techniques and post-abortion care for all healthcare institutions that perform abortions. Consent by the woman in the terminating the pregnancy should be prioritised, and the consent of the husband should not become a necessity.
2. Reporting and monitoring: The monitoring system should be improved by strengthening administrative rules regarding reporting of abortions and imposing sanctions on institutions/health personnel that do not report them. These measures will significantly increase the quality of reporting of the number of abortions, especially those performed in the private sector, contributing to a more accurate assessment of the situation on abortions in the country and a better planning of interventions to improve the quality of care for safe abortion. Data collected on causes that drive women to abortion, their age and social status should be improved and in turn they will serve to the social prevention of such unwanted approaches.

The monitoring and evaluation system for the quality and performance of the public and private health services that do (carry out) abortions should be strengthened.

3. Measures should be taken for registering medications used for medical abortions, to improve the monitoring of their use and provide a real situation of the number of abortions that occur in the country.
4. Informing and educating the public [should take place] on the benefits and risks arising from the use of medications that are used to terminate the pregnancy.
5. Studies: An in-depth study should be undertaken to assess on a national level the phenomenon and the size of selective abortions in Albania. Obtaining this information will help policymakers to develop strategies on controlling and eliminating this phenomenon.

4. Women with HIV/AIDS

Recommendations:

1. Legal and political: The legal framework for the inclusion of new strategies such as risk mitigation services and their financing should be improved. A comprehensive strategy should be developed on a very broad level IEC/BCC that uses various communication channels to promote voluntary testing and counselling to prevent transmission of HIV from mother to child. Drafting and ensuring the implementation of policies and a regulatory framework that supports necessary activities and sustainable interventions for the elimination of vertical transmission of HIV from mother to child should also take place.
2. Administrative - advisory: Specific antenatal services should be set up for the HIV screening of pregnant women, and implementation of programs for HIV counselling and testing for all pregnant women in mother and child health service centres, as defined in the basic package of primary healthcare services. The number should increase and the capacity and quality of services provided by the centres of voluntary counselling and testing should be improved in addition to the provision of financial resources for their operation.
3. Prevention and access: There should be a supportive environment for girls and women, to identify, address and eliminate the barriers for the prevention programs and interventions to women of sexually active age.
4. Monitoring: The national protocol for the prevention of HIV from mother to child should be completed and monitored by a multidisciplinary team led by PHI. The system of biological control and risky behaviours for vulnerable groups for STIs has not been able to generate data about the prevalence and incidence of HIV, given the number of undiagnosed infected cases, or provide follow-up of newly diagnosed cases, to assess the size of the most vulnerable groups and to monitor the quality of services provided to people living with HIV/AIDS.
5. Awareness: There should be awareness programs among women of vulnerable groups to increase the likelihood of their identification.

5. Tumours of the reproductive system: Breast and cervix cancer

1. Emergencies: The Ministry of Health, along with other relevant institutions, should immediately start the implementation of the national program of cancer screening as per the priority interventions determined in the action plan.

6. Health of vulnerable women

Conclusion: In general, women from vulnerable groups are faced with social exclusion and lack of access to health services. We can mention women from various groups, such as women living in rural areas, women with disabilities, women living

with HIV/AIDS, women of the Roma and Egyptian community, LGBTI women, women serving a prison sentence, etc. Interventions in the existing legal framework must ensure better protection of vulnerable women's rights for full access to health services.

Recommendations:

1. Inclusion, in particular, of issues related to vulnerable women, in the legislation and work protocols of healthcare providers.
2. In-depth studies to better understand the needs of vulnerable women in the field of health.
3. Provision of health services in areas where they live and according to an approach based on the specific needs of these groups.

7. The health of women who are victims of domestic violence

Conclusion: The increase of violence against women seeking help from various state structures indicates the necessity for the implementation of a more efficient system to respond to the cases presented. Although the legal framework for domestic violence is complete, healthcare centres continue the non-performance of their obligations as stipulated by laws or bylaws.

Recommendations:

1. Administrative: Putting into operation progressively a more efficient and coordinated system to respond in a timely and effective manner to cases presented, as well as providing a range of supporting and rehabilitating services; implementation of a holistic approach in addressing violence, reviewing the structure of the HC (involvement of professionals such as social workers and psychologists), and initiating interventions (advocacy/coordination/awareness for the prevention) targeting stakeholders outside the health sector (governmental, non-governmental, private), and above all the local government and the community.
2. Directing/planning the GBV service as part of the public/primary health and issues of human rights.
3. Prioritising meeting the complex needs of the most vulnerable groups of the population through the recognition of these needs (groups), and intervention strategies.
4. Support for the GBV service through its integration in all other services of public/primary health and service planning using a 'holistic' approach to address issues of violence including it in the development of parallel programs.
5. Statistics: As long as sexual violence will continue to be a taboo, its reporting statistics will not change, therefore the analysis of the phenomenon, its causes, consequences and effectiveness of the implementation of planned measures must be further extended.
6. Prevention: Implementation of measures outlined in the political and legal documents of the institutions, to prevent and address cases of violence - for the victims and the community-, and addressing the factors/determinants of violence in various sector/cross sector strategies. Effective coordination of efforts at all levels and with all stakeholders to address violence.

8. Victims of trafficking (VT/PVT) and addressing their health problems

Conclusions: Data from the Strategy Against Human Trafficking 2014-2017 show an increase in internal trafficking of minors and adults, mainly in urban and tourist areas. The National Referral Mechanism for trafficked persons has improved and coordination of relevant authorities and stakeholders involved locally has increased, however, there is still much room for improvement. NPOs report problems such as

lack of community and residential services for victims of trafficking and violence who suffer mental health problems and require constant and specialised attention.

Recommendations:

1. Administrative: Improving the quality of mental health services available for VT/PVT. Increasing access to services in health centres where VT/PVTs live. Providing and ensuring social and psychological services, legal, health and suitable support to potential victims and trafficked groups/persons for their reintegration into society.
2. Prevention/Awareness: Empowerment of governmental and non-governmental actors working with groups "at risk", including public health workers, health professionals contributing to the identification, prevention, medical assistance and referral of VT/PVT, as well as customers/potential exploiters. Awareness and information of victims/potential victims of trafficking on healthcare issues, such as STIs, HIV/AIDS, reproductive health and family planning.

9. Healthcare for women in rural areas

Recommendations:

1. Administrative and access: Immediate provision of health services for women in rural areas at health centres near their homes. There is a lack of specialized healthcare personnel, especially in rural areas. Emergency obstetrical services are limited or absent in small districts in these areas, increasing maternal mortality rates. There are short-falls in the service provision infrastructure¹, and long distances to access health centres².
2. Monitoring: Qualitative assessments and community participation related to service delivery and health problems in rural areas with a particular focus on women living in these areas.
3. Awareness: Empowering women in rural areas to take the right decisions for their health and provide positive models of upbringing and child care.

10. Women with disabilities (PWD)

Recommendations:

1. Legal: Inclusion, in particular, of issues of women with disabilities in the labour legislation and healthcare providers' protocols. Women with disabilities to be actively involved in developing and implementing programs, policies and protocols related to health and social issues. Defining specific measures for the identification, treatment and protection that should be offered to women with disabilities who are at risk or have been victims of different abuses in families or institutions.
2. Access: Increased access to healthcare services for women with disabilities by assessing needs and accessibility, these women have to benefit from services.
3. Monitoring: Establishing a system of indicators based on gender and disability in order to monitor the implementation of all disability and gender equality strategies.
4. Studies: In-depth studies should be conducted to recognize the specific needs of women with disabilities in the field of health.

11. Women from Roma and Egyptian communities

Recommendations:

1. Legal: Inclusion of Roma community during the policy formulation and adoption of such measures for the needs of Roma community, and ensuring effective

¹ SOROS 2011. Access to health care services by vulnerable groups

² Hazizaj A., Elezi P., Ballo M., National Evaluation 2014: Roma Children Access to Early Childhood Services, UNICEF/CRCA/YWCA/Observatory, Tirana 2014.

participation of Roma community in drafting, implementation, monitoring and evaluating policies, programs and health measures.

2. Awareness: Health centres near Roma and Egyptian communities should promote family planning through training, information and free distribution of modern contraceptives. Special measures should be taken to educate and raise awareness of Roma communities on basic health issues targeting, in particular, parents, women and new mothers, as well as children in schools. Preparation of targeted information campaigns to increase the knowledge of women, girls, men and boys of Roma community on sexuality education, reproduction and protection from pregnancy.
3. Administrative: Arrangements for regular visits to Roma settlements and slums with mobile medical units providing health care services for children, pregnant women, new mothers and the elderly.

12. The health of LGBTI and women LBT

Recommendations:

1. Legal: There is a necessity for drafting the law on "Recognition of gender identity" to ensure full access of trans [gender] people to the state healthcare services, free and without discrimination. Policies should be drafted to respond to the health needs of LGBTI people for promotion, prevention and treatment. NPOs working with LGBT persons report that legal recognition of gender is and will remain a priority for the rights of trans[gender] people in Albania. Without such a law, health protection for trans[gender] people will not be possible for years. Comprehensive policies and action plans should be drafted for the LBT women and girls and inclusion of this component in every practice and policy where appropriate or required by the community of girls and women LBT, are indispensable.
2. Interventions in the existing legal framework should aim to protect the rights of LGBTI people to achieve an approximation of the existing legislation with the Law No. 10 221/4.2.2010 "Protection against discrimination", which would increase legal guarantees for the protection of the rights of the LGBTI community. This has also been requested by the Commissioner for Protection from Discrimination³. Even the EU Progress Report on Albania, 2013, -in relation to the rights of this of this community-, highlighted that "Albanian authorities should apply the existing legislation and draft new legislation in the area of anti-discrimination".
3. Access: Providing quality and ethical health care based on the sexual orientation and gender identity, as well as:
4. Education and awareness: Increased knowledge and change of attitudes of health professionals regarding the health needs of LGBTI people, through changes in the curriculum and training, which should focus not only on providing adequate medical information, but also on issues regarding respect for the rights of LGBTI people and improving their access to health services.
5. Training and capacity building of health professionals in all institutions where necessary and appropriate.
6. Empowerment of LBT women in relation to sexual education, protection from violence and abuse, protection from STIs, etc., as well as awareness of the impact and consequences of discrimination and violence on the health of LBT women and girls.

13. The health of older women

Recommendations:

³ CPD, 2014. Annual Report.

1. Administrative and access: Increasing the number of health and social services that focus on the special needs of elderly women.
2. Provision of free health services for senior citizens to enhance their quality of life.
3. Recognition of the International Plan of Action on Ageing, Madrid 2002, and its implementation, as life expectancy has increased and women live longer than men and suffer more from chronic diseases.

14. Work relations and specific issues of women's health

Recommendations:

1. Monitoring: Continuous monitoring and control by public institutions on private institutions to ensure compliance with the health rights of women at work.
2. Awareness: Awareness of women through the package of rights relating to health and safety at work.

15. Recommendations for NPOs operating in the field of health

1. Development of NPO programs that focus on women's health and with a particular approach towards the health of women from vulnerable groups. There are numerous urban and rural areas where there are no women's NPOs and health institutions do not provide information and awareness about women's health.
2. Information and empowerment of women and the communities where they live on the right to health.
3. Education programs, advocacy and provision of services aimed at women and their rights.
4. The need for collaboration/partnership in the implementation of joint projects between NPOs and state health institutions in terms of information, awareness and delivery of quality health care for women. There is a need for consultations with NPOs in drafting legislations, policies and action plans.

16. Recommendations for the international partners supporting health field

1. Call for proposals involving a multidisciplinary approach and involvement in the strategic plans of marginalized groups;
2. Advocacy and pressure to the Albanian government to take appropriate measures for the improvement of access for all women to free health service.
3. Provision of positive models, taken from experience of developed countries, to combat discrimination in health.

II. PART TWO: Analysis of non-discrimination standards in matters of health care

A. Legal approaches to the standards of CEDAW in the field of healthcare

1. The legal framework in force - the need for alignment with the standards of Article 12 et al of CEDAW
 1. The Albanian legislation in general provides specific support and special healthcare services for mothers and children.
 2. The Law on "Reproductive Health" recognizes and protects the reproductive rights of individuals and couples and ensures that these rights are protected in accordance with the national laws and policies as well as other internationally recognized principles. Directives issued by the MoH based on the law on "Reproductive health", are not clear as to whether the instruction that women are to be examined without charge during pregnancy, childbirth and post-natal is mandatory for the private

sector. This directive does not define the monitoring mechanisms and the quality of law enforcement, both in the public and in private sector, and administrative measures to be imposed when the law is not implemented.

3. The Law "On the Promotion and Protection of breastfeeding"⁴ contains few and insufficient provisions to guarantee the nutrition of the child with mother's breast milk. Most of the provisions refer to trading, advertising and sales of alternative milk and not measures to support mothers breastfeeding their children.
4. The Law "On Termination of Pregnancy", as amended by Law No. 57/14.02.2013: defines clearly that abortion should, under no circumstances, be considered as a method of family planning. The law does not foresee the provision of free healthcare, such as tests prior to the abortion, abortion procedures and follow-up visits. There is an absence of provisions for the obligation of health institutions to report the number of abortions. Although this has been regulated in legal documents, we believe that the inclusion in this law of this regulation would be appropriate.
5. Law No. 9952/14.07.2008, on the "Prevention and Control of HIV/AIDS" addresses the most important legal aspects of HIV/AIDS, including discrimination, the right to maintain the work post, consenting to information, protection of classified information, access to free treatment, creation of "safe places" where people have the opportunity to receive treatment that saves lives, as well as a mechanism for complaints.
6. Violence against women and domestic violence: In 2012, Albania ratified the Council of Europe Convention "On Preventing and Combating Violence against Women and Domestic Violence"⁵. In 2012 and 2013, the Criminal Code was amended with specific provisions for offences related to domestic violence and gender-based violence; in 2010, amendments were made to the Law No. 9669/18.12.2006, "On measures against domestic violence", committing to establish a national centre for social care services for victims of domestic violence, protection of confidentiality, protection of data and personal information of the victim and improvement of protection orders.
7. Women with disabilities: Albania ratified the UN Convention "On the Rights of Persons with Disabilities", and adopted the Law No. 108/2012 and the framework Law No. 93/2014 "For the inclusion and accessibility of disabled people".
8. Roma and Egyptian women: The main focus seems to be on certain development policies such as the Social Inclusion Strategy, the Strategy for Development and Integration and the National Action Plan for the Integration of Roma and Egyptians in Albania, 2015-2020. In 2010, Law No. 10221/04.02.2010, "On Protection from Discrimination" was adopted, in full compliance with the main relevant four European Directives.
9. LGBTI: Law No. 10221/04.02.2010, "On Protection from Discrimination" prohibits discrimination relating to gender, gender identity, sexual orientation, genetic predispositions. The government is working on finalizing the National Action Plan (NAP) for LGBTI people in Albania from 2015 to 2020, which aims to improve the quality of life for LGBTI people in Albania.
10. Important strategies and bylaws in the field of women's health: a number of strategies are being implemented. The Reproductive Health Strategy is underfunded. In addition, we would like to highlight as problematic the fact that in the health budget, women's health is not a separate item, creating difficulties for medium-term planning and long-term interventions in the sector. Although there are sex-

⁴ Law No. 8528/23.9.1999, amended by Law No. 58/2013: "Promoting and Protecting Breastfeeding".

⁵ Law No. 104/11.08.2012 "Ratification of the Council of Europe Convention on "Preventing and Combating Violence against Women and Domestic Violence".

disaggregated data collected by the MoH, their quantity and quality is insufficient to support the drafting of health policies, planning budgeting programs and interventions related to women's health.

11. The first National Strategy on Securing Contraceptives 2003-2010⁶, has been replaced by the second National Strategy on Securing Contraceptives, which covers the period 2012-2016⁷. The second phase of the Strategy envisioned that the contraceptive methods would be offered free of charge only to risk groups. This was considered premature for the conditions and the situation of RH and family planning in our country where the level of use of modern contraceptive methods is still low and a number of women, especially young people, are unable to cover their needs for modern contraception⁸.
12. One of the most important achievements during the period covered by this report, is the improvement of the regulatory framework for mother and child services in primary healthcare.
13. The National Family Planning Protocol, drafted in 2009 by the MoH, was distributed to all institutions and healthcare centres that provide reproductive health services and family planning. This is an important strategic document.

Legal problems reported by NPOs interviewed regarding the legal framework:

14. Focusing on the analysis of the legal framework, NPOs stated that the “laws are almost sufficient, but the problem remains in their implementation”. More than half of NPOs interviewed report that laws need additional by-laws, such as guidelines, protocols, orders, etc., in order to provide the required result. The legal framework should be accompanied by the corresponding budgets. Continued amendments to legislation should be made in accordance with the dynamic changes that come out as a result of new problems and needs that arise in the field of women's health, as well as consultations with stakeholders. It is necessary to make improvements to the legislation in areas such as: screening and preventative examinations in early pregnancies, domestic violence and measures to prevent it, as well as gender-based violence, mental health screening, screening of women for cancers of the reproduction system, etc. Likewise, the need for drafting and adopting a law that guarantees the recognition of gender identity (Gender Recognition Law) and the right of women to recognize trans gender identity has been identified.

2.Administrative structures at central and local level related to health care

Structures providing health care for women and children

1. Three levels of health care (primary, secondary and tertiary) provide health care to mothers and children as part of the reproductive health services.
2. The institutions of primary health care (PHC) are organized and function according to the laws in force and the provisions enforced by the Ministry of Health⁹.
3. Reforming the health care system in order to provide comprehensive quality services is one of the basic objectives of the new program of the current government¹⁰.

⁶ Ministry of Health (2002): National Strategy on Securing Contraception 2003-2010.

⁷ Ministry of Health (2011): National Strategy on Securing Contraception 2012-2016.

⁸ Albanian Centre for Population and Development (2013). Alternative Report of NPOs on the Situation in the Country Regarding the Components of Reproductive Health.

⁹ Law No. 10107/30.03.2009, "On Health Care in the Republic of Albania"; Law No. 10138/11.05.2009 "On Public Health"; Law No. 7870/13.10 1994 "On Health Insurance in the Republic of Albania", ammended.

¹⁰ Government Health Program, 2013-2017.

Continued protection and improvement of mother's and child's health, although not treated as a separate component of health reform undertaken, is considered a priority of the public health care policy.

Institutions collecting statistics on services and logistics information on contraceptives

4. A National System of Information and Logistic Management was established in 2006 under the Ministry of Health, operating as part of the Institute of Public Health and it collects statistics on services and logistics information on contraceptives. The data generated by this system helps in better planning activities to enhance the quality of service to Family Planning.

Structures for the implementation of the fight against HIV/AIDS

5. The national program for the prevention and control of HIV/AIDS at the Institute of Public Health is responsible for coordinating the activities of state structures, NPOs and international organizations, and guarantees the accomplishment of all activities under approved national policies and standards. Since 2012 the program as a whole and in particular preventive activities for the most vulnerable groups have been underfunded, increasing the chances of a disease outbreak amongst these groups of the population.
6. The biological control and risky behaviours system for vulnerable STI groups operates as a single system of monitoring and evaluation. This system has so far been unable to generate data about the prevalence and incidence of HIV, the number of undiagnosed infections, to provide follow-up on diagnosed cases, to assess the size of the most vulnerable groups and monitor the quality of services provided to people living with HIV/AIDS.

Cancer diagnostic and treatment services

1. There is only one public centre for the diagnostic and treatment of cancers¹¹.
2. The National Committee for Cancer Control, reorganized in 2011, is the body responsible for the fight against cancer and also runs the national program to control cancer (NCCP).
3. The current cancer registry covers about 80% of the cancer incidence in Albania. The information obtained from this system is incomplete and often unreliable and this is due to the lack of oncology health services across the country, "loss of cases" because the demographic movements of the population, the lack of a unique code to identify tumour cases, lack of capacity among health personnel to collect data, lack of follow-up on cases with cancer, lack of access to death certificates, and lack of accuracy in filling them in.

3. The role of NPOs in issues related to women's health

What NPOs tell about their role

1. The small number: The number of NPOs working in the health care field is low and the services they provide for sexual and reproductive health are limited.
2. Effectiveness in the fight against HIV/AIDS: There are about 18 NPOs that have focused their activities on HIV/AIDS, but there are many others which have in their programs activities aimed at preventing HIV/AIDS and the reduction of the harm it causes.

¹¹ National Oncology Service at the University Hospital Centre "Mother Teresa".

3. The establishment of the coalition in the fight against cervical cancer, consisting of a group of women and girls, representatives of the civil society and women parliamentarians is an indication of increased awareness of women about the importance of prevention and early screening for the cancer of the cervix.
4. Focus on the capital city: Their activity is limited mainly in Tirana, and mostly covers urban areas. There is a lack of NPOs working in particular with women in every district (and more so in rural areas). There are many urban and rural areas where there is no presence of women NPOs and health institutions do not carry out any information and awareness work on women's health. According to the Observatory for the Rights of Children in the regions of Korca, Kukës, Dibra and Shkodra, there is a huge need for information, awareness, and increase of access to health services for women in rural areas. A lack of information is reported by victims of domestic violence in matters of health care, such as STIs, HIV/AIDS, reproductive health and in particular family planning.
5. Coordination of efforts between NPOs and state structures: Although a coalition of reproductive health has been set up in Albania which can be considered successful, there is still much to be done in terms of joint initiatives and coordination of work. There is an unquestionable need to strengthen the cooperation and the support of NPOs and local communities by local authorities and relevant structures for the implementation of information and educational activities and changing behaviours regarding contraception in groups at risks. There is a need for partnership in the implementation of joint projects between NPOs and public health institutions in terms of information, awareness and delivery of quality services on women's health.
6. Lack of sufficient financial resources in the field of health creates fragmented services offered only in certain areas which are not sustainable.
7. The need for consultation with NPOs in drafting legislations, policies and plans of action.

B. Practical approaches to the standards of CEDAW in the field of health care

1. General information on women's health

1. Chronic diseases are the leading cause of mortality: Chronic diseases are reported to be the cause of about 90% of all deaths in women, of which heart diseases are the leading cause for 61% of deaths¹².
2. Neoplastic diseases: There is evidence of gradual growth in the level of mortality and the burden of disease from cancer for both sexes. In women this increase can be explained by engaging in non-healthy behaviour such as smoking, harmful consumption of alcohol, very high levels of obesity and lack of physical activity¹³.
3. Mental and behavioural disorders: These disorders show a trend of growth and higher incidence among females. In 2010, mental and behavioural disorders accounted for 13.4% of the total burden of disease among women, compared with 8.8% in men¹⁴.

¹² PHI (2014). National Health Report; INSTAT (2015). Women and men in Albania: Deaths of women constitute about 46% of total deaths for the years 2013 and 2014 and mainly focus on older age, where almost 50% of deaths occur after the age of 80, explaining the higher longevity.

¹³ Same as 43.

¹⁴ Same as 43.

4. Number of birth deliveries in adolescents: Number of birth deliveries at ages under 20 years old has increased from 0.016 in 1989 to 0.018 in 2001 and 0.020 in 2011¹⁵. Although the absolute number of births by teenagers is relatively small and is falling due to the declining numbers of women aged 15-19, the upward trend of teenage fertility requires the attention of health policy makers.
5. The sex ratio at birth: The number of males per 100 females is higher than its natural level. In 2014 this ratio was 109 males per 100 females.
6. Life expectancy has increased steadily over the past twenty years for both sexes. However, in the past ten years, life expectancy increased by 4.4 years for men, but only 3.1 years for women.

2. Access to services and awareness of women

Actual situation and the problems identified by NPOs

1. Limited access to health services: a) Prejudices and cultural barriers of women and the society itself prohibits their access to SRH services and do not allow women to exercise their rights to services and information, such as those on abortion, contraception, HIV testing and counselling, and screening for tumours of the reproductive system. b) Access to services is related to the geographical distance, the lack of specialized services, lack of infrastructure, the quality of services provided, the unprofessional attitudes and behaviour of the health personnel, biased and discriminatory attitudes from the staff at health centres¹⁶.
2. Women are not aware of the services: Information on the rights and access to SRH services is limited. ACPD stated that "although family planning services are provided free for insured women, often women and girls do not use this right for a variety of reasons, such as: they do not have information on them; fear possible bias by service providers; fear negative attitudes by the members of the community, do not consider it necessary or important, etc. "
3. Women and girls have little or no knowledge of the health legal framework and their rights to access health services. Some NPOs draw this conclusion based on direct contacts and meetings with women of communities in which they operate, focus groups and workshops organized. Others, like the "Human Rights in Democracy" centre, base their conclusions on data about the low access to health services by certain groups (more than half of Roma women are without health insurance cards, while 10% of Roma children are not vaccinated).
4. Lack of services provided by the state: On the PHC level there is a lack of integrated provision of certain SRH services, as determined in the basic service package approved by MoH in 2015. They include counselling before and after abortion, screening for cervical cancer and breast cancer, testing and counselling for HIV/AIDS, screening of pregnant women for HIV/AIDS, friendly services for adolescents and youth. Some of the above services are offered free of charge but are limited to certain areas and they are largely lacking for vulnerable women, but also for the rest of the population.

3. Health and nutrition for mothers and children

Actual situation and the problems identified by NPOs

¹⁵ INSTAT (2015): Young people in Albania: Challenges in changing times.

¹⁶ Arqimandriti M and co-author (2014). Monitoring of primary health care services in Albania; Albanian Helsinki Committee (AHC) (2014). Report "On the findings of the monitoring conducted in several institutions of public health": Among the problems identified in the report is the lack of an unified and effective mechanism for dealing with requests and complaints of patients in primary health care services/hospitals (including two maternity hospitals) monitored by it.

1. Maternal mortality has seen a sustainable drop. According to official sources, in the last two decades, the level of maternal mortality has halved¹⁷. The major causes remain bleeding, infections after birth, pre-eclampsia/eclampsia during pregnancy and unsafe abortion.
2. Infant and child mortality has reduced, but the level is still high by comparison to the region: In the past decades, mortality of children under 5 years old has gradually decreased (8.9 deaths per 1000 live births in 2013)¹⁸. In 2013, the infant mortality rate was 13 deaths per 1000 live births (UNICEF 2014), one of the highest rates in the region and much higher compared to the official national reports¹⁹.
3. Maternal and child nutrition: The situation of nutrition and physical development of children has gradually improved over the past decade²⁰. Albania, however, is facing the double burden of malnutrition. Stunting has decreased, but it is still a problem for the public health, and obesity in children has increased. The burden of obesity is shifting from urban children, belonging to mothers with secondary or higher education, living in the richer households, to children living in poor families in rural areas.
4. Disparities in maternal and child health: Despite the improvement of health and nutrition indicators, there are disparities associated with the age, gender, socioeconomic level, geographic areas and residence. The highest rates of infant mortality are observed in families with low income (40% higher than in children from families with high incomes), children in rural areas (two times higher than in urban areas) and in particular children in rural mountainous areas. In addition, mothers' higher educational level is associated with a lower mortality in early childhood²¹.
5. Serious discrepancies between different sources of data: When presenting indicators on the health of mother and child, we should point out that there is a serious problem of inconsistent data, including national (INSTAT and MOH) and between national and international agencies. Inconsistencies are associated not only with the different methodologies used, but also with the quality of recording health data in Albania²².
6. Lack of periodic health assessments: The Demographic and Health Survey (DHS) 2008-09, has not been followed in recent years by other assessments, in order to constantly have a clear picture of the health and nutrition indicators. On the other hand, lack of specific reproductive health data makes it difficult to evaluate the current situation and interventions in this field.

4. Sexual and reproductive health: Family planning and contraception

Actual situation and problems identified by NPOs

1. Lack of integrated services: Services for sexual and reproductive health are centred mainly on the provision of family planning services and not the provision of integrated services resulting in critical health gaps that limit the effectiveness of programs to SRH and fuel the stigma and discrimination against vulnerable groups.

¹⁷ Ministry of Health (2014): From 22.7 deaths in 1990 to 11.8 in 2013.

¹⁸ INSTAT (2014): In men, from 16.3 (2004) to 9.2 (2013), while in women it fell from 13.6 (2004) to 6.3 (2013).

¹⁹ INSTAT (2014): The infant mortality rate was 7.8 deaths per 1000 live births in 2013.

²⁰ UNICEF, WHO, World Bank group joint child malnutrition estimates (2015). Levels and trends in child malnutrition.

²¹ PHI (2014). National Health Report.

²² PHI (2014). National Health Report.

2. Lack of infrastructure and inappropriate health technology: Provision of integrated SRH services is based on the existing infrastructure and medical equipment (not modern standards) of health services.
3. Inappropriate level of awareness by woman in relation to sexual health and reproductive health because the lack of information. In addition, there are cultural and attitude barriers, a lack of necessary services and confidentiality by the health staff. ACPD reports some data from the study Knowledge, Attitudes and Practice, conducted in 2013 in the district of Tirana: Less than half of women and girls interviewed, either do not use modern contraception (36.3%) or believe in the withdrawal (40%) to prevent unwanted pregnancies. Among the reasons for not using family planning methods, was fear of side effects (19.2%) and the belief that they are harmful for the health (14.5%)²³.
4. Knowledge about contraception and its use: Knowledge on contraception is almost complete²⁴. However, the use of modern contraceptive methods of 11% is considered as one of the lowest in Europe²⁵. About 59% of women aged 15-49 use the natural method of withdrawal as a protective measure against pregnancy. The most used modern method is the condom for men (4%), followed by the female sterilization (3%) and the pill (2%). The use of all the other methods is less than 1%.
5. Factors influencing the behaviour on family planning are age, marital status, level of education, place of residence, number of children, information on family planning and the time needed to reach the health centre²⁶. The use of modern methods is higher among younger women and lowest among women living in rural areas. The younger married women are more likely to use a condom than the older women and less likely to use long-term or permanent methods such as intrauterine devices and sterilization. Sexually active unmarried women practice modern contraception significantly more than married women (29% versus 11%) and they also prefer condoms and pills. Long-term or permanent methods are only used by married women. The increased number of children and the level of education are associated with the increased use of contraceptive methods.
6. Unmet needs for family planning (mainly counselling) are estimated at an average of 13% for the period 2006 to 2012²⁷. The greatest unmet needs are observed in the young age group (25-29) and rural women. The preference for boys affects the behaviour on family planning. Women with unmet needs are more likely to have at least one son and live mainly in rural areas.
7. Modern contraception coverage: One positive achievement is undoubtedly the provision of the public sector by the Albanian Government from 2010 onwards with modern contraceptives, independent from donor support. In addition, the MoH Order²⁸ changed the stipulations for the second phase relating to the provision of contraceptives. Between 2015-2016 they are provided free of charge by the public sector for the entire population thanks to the successful advocacy of national and international actors supporting activities related to the FP in the country.

²³ Albanian Centre for Population and Development (2013). Sexual and reproductive health among young people in Albania.

²⁴ PHI (2012): In general women, especially married women, have more knowledge and information than men about these methods.

²⁵ WHO 2014. World health statistics. <http://www.who.int/gho/countries/alb/en/>

²⁶ Ismaili F and co-authors. Factors affecting the behaviour towards family planning in Albania. Tirana, 2011.

²⁷ PHI. National Health Report, 2014

²⁸ Ministry of Health, Order No. 570/21.11.2014, "On the provision of contraceptives to the population in need through the public sector for the years 2015-2016".

5. Provision of family planning services

The actual situation and the problems identified by NPOs

1. FP services are offered in all three levels of healthcare, integrated with other reproductive health. Since 2009, intrauterine devices (IUD) have been offered not only in maternity hospitals, but also in health centres by obstetricians and gynaecologists trained in programs supported by international donors (USAID). Female sterilization is provided free of charge only at maternity hospitals.
2. Increased access: We would like to highlight in this report that the geographic reach and service quality has improved significantly as a result of appropriate interventions in the field of family planning, supported by USAID and implemented by agencies and international organizations²⁹ who focus on improving the structure, the service quality and increasing demand for the use of modern contraceptive methods³⁰.
3. There is a low level of use of modern contraceptive methods in general and in particular amongst adolescents, young people and other vulnerable groups, while unwanted pregnancies, abortions and STIs continue to remain at high levels. There is evidence to show that young people use emergency contraceptive methods in the wrong way.
4. Low access to modern contraceptive methods among certain groups, such as women living in rural areas, adolescents, Roma women, is due to the lack of sensitive FP services and their provision far from their dwellings. Access by adolescents to modern contraceptive methods in the public sector is difficult, because young people do not attend services at clinics or maternity wards, and even less so health centres in rural areas. For this reason, provision of services closer to certain groups of women and girls, for example at the workplace, as part of a package of health services offered to these places, at clinics in rural areas, venues attended by youth, where Roma population live, remains a necessity.
5. Ensuring continuity of education for health personnel regarding interpersonal communication methods, contraception counselling skills and updating their knowledge regarding new methods of contraception remains a growing concern.

6. Voluntary termination of pregnancy

The actual situation and problems identified by NPOs

1. A higher “use” of abortion in rural areas: The number of abortions in the period 2004-2013 almost halved in absolute value. The number of abortions per 1000 live births has decreased from 257 in 2004 to 186 in 2013³¹. Abortion remains an urban phenomenon³², although for the period 2009-2013 there is a growing trend of abortions in rural areas.
2. Abortion in the public sector vs. the private sector: Most of the abortions are performed in the public sector, and only 10% of them are performed in private clinics or hospitals licensed to perform abortions³³.
3. Unreliable data on abortion: Unofficial sources indicate a higher number of abortions than those published. The causes can be underreporting, mainly by private entities, and abuses in diagnosis in the public sector, showing [abortions] as emergency

²⁹JSI/SEATS II/Albania dhe JSI/TASC I/Albania, URC/Pro Shëndeti, ACCESS-FP/Jpiegho, AED/Communication for Change (C-Change).

³⁰ Boci, A., Eichleay, M., and Searing, H. (2013). Factors influencing women’s reproductive health choices in Tirana, Albania. The RESPOND Project Study Series: Contributions to Global Knowledge - Report No. 12. New York: engenderhealth (The RESPOND Project).

³¹ INSTAT (2015): Women and men in Albania.

³² Same as 66: In 2013, 61% of abortions were done by women living in urban areas.

³³ PHI (2014). In 2013, 61% of abortions were done by women living in urban areas. 1, 2014.

hospitalizations, to avoid payment for the performance of abortion. On the other hand, the assessment of the data shows a significant and almost impossible increase in spontaneous abortions, whereby the percentage of abortions from 18% in 1996 increased to 67.2% in 2013³⁴. IPH claims that it has reason to doubt the validity of this increase and this requires a more detailed investigation. Given the great reliance on unreliable contraceptive methods, it is highly likely that in many cases abortion is used as a family planning method. These data indicated deficiencies in the health care system to provide couples with reliable means for planning and controlling pregnancies and childbirth.

4. Enforcement of the law: The Albanian Helsinki Committee, while monitoring the two maternity hospitals (one in Tirana and the other in Lezha), reports that "medical personnel was acting within the legal framework.. The information and treatment of patients seemed standardised and the same for both institutions, ranging from a preliminary examination of the woman, and then proceeding with counselling, giving the necessary information regarding risks during or after the abortion, benefits of pregnancy, family law, etc.". Monitors noticed that abortion by married women often required the consent of the spouse, while the law does not stipulate this.
5. The use of medical abortion is a method that means taking tablets to perform the abortion, mainly in the early stages of pregnancy. In Albania the drug misoprostol is widely used, which is not registered by the National Drug Control Agency for this purpose, but is easily found in pharmacies or private clinics³⁵. Unofficial data show that a large number of women perform unsafe abortions by taking tablets for uncontrolled termination of pregnancy. In some cases, these women return to maternity hospitals to complete the abortion after medical abortion fails.
6. Selective abortion for the selection of the sex of the child before birth: Researchers on this phenomenon explain that Albania is one of those countries where the selection of the sex prior to birth has spread fast after the lowering of the fertility rate³⁶. Analysis based on the INSTAT census show compelling evidence of sex selective abortions due to the preference for males. Increasing sex ratio at birth (160 boys to 100 girls for the first time births to 162 for the fourth time births) is a clear indicator of this practice. Factors affecting the existence of this phenomenon are numerous and mainly related to the mentality and our early tradition of having boys born first. This relates to issues of heritage (family name and ownership), the need to feel protected, the phenomenon of emigration and a number of other factors that tend to highlight gender stereotyping, emphasising the role of the male. Despite being a well-known fact, selective abortion continues to be neglected and fails to get the proper attention. In an effort to address this, ACPD in collaboration with partner organizations and institutions, planned a number of activities and awareness raising of the population about the existence of the phenomenon and its consequences, based on a Communication Strategy and Action Plan (2015-2017).
7. Reporting system: Every doctor who performs abortions is required to report to INSTAT by completing the abortion form, which respects the confidentiality of women. In an effort to control abortion, the abortion information system has been reviewed, including now not just public institutions but private ones too³⁷, and a new abortion form has been prepared along with the guidelines for data reporting. The computer program allows the entry of data on abortions and the electronic reporting

³⁴ Same as 68.

³⁵http://www.respond-project.org/pages/files/6_pubs/research-reports/Study12-Albania-Report-July2013-FINAL.pdf

³⁶ World Vision, UNFPA (2012). Unbalanced ratio of births between sexes in Albania.

³⁷ INSTAT (2012): Abortion surveillance system in Albania.

of the information is done every 3 months. However, only 13 districts can report electronically. Such problems as failure to report in time by all districts and the quality of reporting are raising the need to revise the program and to ensure continuous training for those responsible for reporting.

7. Sexually transmitted infections (STIs) and HIV/AIDS

Actual situation

1. Increased number of new cases: Although the data indicate that Albania remains a country with low prevalence (approximately 0.02%) of HIV/AIDS, the number of new cases diagnosed with HIV/AIDS for the period 2008- 2013 doubled³⁸. 2013 saw the highest number of new cases diagnosed for years (124 cases). By November 2014 there were 96 new HIV positive cases, of which 5 were children infected through mother to child transmission.
2. Time of diagnosis: Three quarters of new cases are diagnosed in the late stage of infection, leading to an increase in the percentage of deaths.
3. Knowledge of HIV/AIDS: The age group 15-24 years have more knowledge about HIV/ AIDS than the age group 24-49 years. However, only 36% of women and 22% of men aged 15-24 correctly know how to prevent HIV. Comprehensive knowledge on the HIV transmission is higher among women than men (28% versus 20%).
4. Testing for the HIV infection: Testing for the HIV infection is done in voluntary testing centres, "recommended" by health professionals. Testing is obligatory for all blood donors, volunteers or family members of patients undergoing surgery. The percentage of testing in the country is low, only 7.7% of the general population³⁹. Voluntary testing of women remains at very low levels. According to the data collected from the monitoring system, women infected in the majority of cases are diagnosed as a couple, following the epidemiological screening after the partner has been found to be HIV positive. The results of the study on the biological control of behaviour indicate that vulnerable groups (such as injecting drug users, men who have sex with men, sex workers and Roma population) have not only a low level of knowledge and testing, but are also involved in risky practices and behaviour in relation to HIV/AIDS or various STIs.
5. Preventive services and medical care: Preventive services are offered by 12 centres of voluntary counselling and testing under the MOH and include voluntary testing, and counselling before and after testing. Counselling for pregnant mothers is provided at the FP centres and maternity hospitals. Treatment and care for people with HIV/AIDS is available at the UHC in Tirana, and include anti-retroviral therapy (ARV), diagnosis and management of infections and other associated diseases, as well as psychosocial support for the people affected and their families. An outpatient clinic for people with HIV/AIDS at the University Hospital has been operating since 2007, which provides service and free care for ARV treatment and monitoring, psycho-social counselling and voluntary testing for HIV/STIs, tests for diagnosing tuberculosis (skin test) and prophylactic treatment.

Problems identified by NPOs

6. Late diagnosis of new cases shows the low level of voluntary testing, low access to testing and even lower level of knowledge about prevention ways, protection measures, and above all, the importance of voluntary testing. This means that HIV/AIDS is identified and diagnosed mainly in its later stages, creating large gaps

³⁸ PHI (2013). HIV/AIDS in Albania (1993-2013)

³⁹ PHI (2011). The study of biological control of behaviour.

in the prevention or early diagnosis of the infection and increasing the number of those infected. Therefore, the identification becomes even more difficult. The possible propagating effect that this situation carries, considering that each infected person may have several partners or be involved in different risky behaviours is very important and highlights the urgent need to diagnose the infection at its early stages.

7. The main obstacle remains the stigmatization and discrimination against persons with HIV/AIDS at all levels of society, which in turn affects the delay in HIV testing, diagnosis and access to care.
8. There are still no studies in Albania aimed at assessing the level of stigma and discrimination through a monitoring and evaluation system in priority areas such as health care, education, social support, employment, etc.
9. There is a lack of regulatory mechanisms that provide timely and continuing treatment with ARVs, their laboratory monitoring as per the proper protocol through diagnostic tests; early access to diagnostic testing and treatment of opportunistic and sexually transmitted infections as well as exemption of these services from financial obligations, as provided for by the HIV/AIDS law.
10. Lack of national management protocol for the care, treatment and follow-up of children living with HIV in Albania has created lingering and deficiencies in their treatment and health care, and late diagnosis with fatal consequences.
11. The lack of an outpatient clinic for the follow-up of children living with HIV brings delays in case management and treatment, reduces the quality of care and creates disadvantages for a multidisciplinary approach to them.
12. There is a lack of full prevention protocol for the HIV transmission from mother to child. Therefore, there are deficiencies in counselling and voluntary testing of pregnant women, and the system of referrals and treatment, if the mother is HIV positive.

8. Provision of service for vulnerable groups

Actual situation

1. Injecting drug users (IDU): There are about 60,000 drug users, of which 10%-15% are estimated to be injecting drug users⁴⁰. Continuous data collected from observations of biological behaviour show that IDUs engage in risky behaviour which can cause infections and transmission of HIV/AIDS or various STIs, as they reuse and share needles, have unprotected sex with more than one partner, do commercial sex work, etc.⁴¹. The spread of HIV infection amongst this population group is low, about 1%, but there is a significant increase of cases of hepatitis B (15%) and hepatitis C (30%), which exposes this possibly at risk group to potential epidemic outbreaks of HIV/AIDS or various STIs.
2. Transmission of HIV by victims of sexual exploitation to their customers and other groups remains generally unknown. Some of the factors significantly affecting the increased risk of HIV and STIs for victims of sexual exploitation are the stigma and the neglect, limited access to health, social and legal services, sexual exploitation and trafficking, exposure to violence and drug abuse. Around 25% of men infected with HIV are gay or bisexual. Details of biological behavioural surveillance (2013) point to a low use of condoms by men who have sex with men, who in turn engage in unsafe sexual practices with women. In addition, MSMs encounter difficulties in securing adequate condoms for anal sex and lubricants. The stigma and discrimination often

⁴⁰ European monitoring centre for drugs and drug addiction. Profile of Albania 2015, in: <http://www.emcdda.europa.eu/html.cfm/index211541sq.html> [accessed in October 2015].

⁴¹ PHI (2013). BIO-BSS. Final Report.

becomes an obstacle for this community to use existing services or organise themselves.

3. LGBTI have knowledge about HIV/AIDS but are less knowledgeable about STIs. Most of the young people who are LGBTI do not speak to relatives or health professionals about HIV/AIDS and STIs, as they link this to their sexual activity and very few of them receive information on STIs from public institutions. Most of them are afraid to reveal their orientation and sexual activity to public health specialists. There is a lot of prejudice, inaccuracies and myths amongst the young LGBTI people about sexual practices, safe sex, condoms, ways of becoming infected with HIV/AIDS and STIs. LGBTI young people have very little access to condoms for anal sex. They are not aware of public centres and health experts sympathetic towards them.
4. Persons serving a prison sentence: The epidemiological situation of HIV and STIs in prisons is not clear, but the data presented by the General Directorate of Prisons shows there are 4 people infected with HIV/AIDS. Centres for voluntary counselling and testing for HIV/AIDS have been set up in two prisons, with the support of UNFPA and "STOP AIDS" who is the implementing body. Details of a study carried out in some prisons in Albania show that the prisoners get involved in risky behaviour such as drug and alcohol use, unprotected sex, etc.⁴².

Problems identified by NPOs about groups at risk

1. The figures of voluntary testing remains very low. On the other hand strategic documents for the prevention and controlling HIV/AIDS, lack strategies in relation to the increase of voluntary testing. The number of centres of voluntary counselling and testing is insufficient and there is a lack of activities to access individuals or groups that can be affected by HIV. NPOs that can implement these activities are unfunded.
2. Non-comprehensive strategic documents: Strategic documents do not offer solutions to problems faced by groups at risk, in particular injecting drug users, who can become a source of an epidemic outbreak of HIV/AIDS in Albania. In addition, these documents focus more on primary prevention of infection and do not pay attention to the practices of harm reduction, which have been successful in controlling HIV/AIDS, and above all, are cost-effective as strategies.
3. Failure to reach the objectives: The HIV/AIDS control program has specific sex-disaggregated targets. However, their achievement so far for groups of women and girls at risk, such as injecting drug users (IDU), sex workers (SW) or trafficked women has been a challenge. For some of them, such as SWs, the current legislation itself prevents them from receiving or seeking health services and social support⁴³.
4. Psychosocial support services for people infected with HIV/AIDS are almost absent. Some of them operate with funds from external sources. The government has made no efforts to finance these services.

9. Tumours of the reproductive system: Breast and cervix cancer

The actual situation and problems identified by NPOs

⁴² ACPD (2013). Alternative Report of NPOs on the Situation in the Country Regarding the Components of Reproductive Health.

⁴³ RA Criminal Code, Chapter VIII, Article 113: Prostitution is punishable by a fine or imprisonment up to three years.

1. Concerns about the spread: Data from national sources indicate that breast and cervical cancers are today two of the most common cancers among women in Albania⁴⁴. The number of women affected has grown every year. In addition, there is a trend of younger women being affected by these diseases. In 2012, the incidence (per 100,000 cases) and mortality (deaths per 100,000) for breast cancer in Albania was estimated 69.4 and 21.8 respectively, and for the cervix cancer 6.2 and 2.4 respectively.⁴⁵
2. Incomplete registration of cases: Meanwhile, the incidence of (registered) breast cancer and cervical cancer in Albania is lower than in other European countries.⁴⁶ It is believed this is because of problems related to incomplete registration by the oncology service not mirroring the factual situation.
3. Awareness about preventive practices such as smear tests and mammograms, are reported respectively at 49% and 77%.⁴⁷ According to NPOs, 75% of women affected by breast cancer and more than half of cervical cancer cases are diagnosed at an advanced stage of the disease.⁴⁸
4. Other problems identified are: delays in the implementation of the national program for the early detection of breast cancer and cervical cancer; limited access to cervical cancer screening as the smear test is performed by specialists only in the maternity ward, and cytological examination is offered only at UHC and specialized private clinics; lack of a national registry of tumours, thus causing problems in planning, monitoring and evaluation of interventions as well as in achieving the objectives.

10. The health of women who are victims of domestic violence

The Actual situation

1. Increased number of abused women: Various sources and the situation in the country show an increase in the number of abused women⁴⁹. INSTAT⁵⁰ conducted in 2013 the second national survey on domestic violence in Albania. Data showed growth in the percentage of abused women 56.0% (2007), 59.4% (2013). There has been a progressive increase from year to year of the number of those reporting violence and other crimes that occur in family settings.
2. Abused women are often reluctant to seek help: 8.4% of women who had experienced "lifelong" domestic violence and 7.1% of those who are "currently" facing domestic violence had never sought help against violence in marriage/intimate relationships. In all cases where the Counselling Line for Women and Girls has intervened, it encountered flagrant cases where women report the need for shelter, while their legal issues are not conclusively resolved. Another very important service for women survivors of domestic violence, is counselling. Counselling should be immediate and available at all times, free and in different languages.
3. Failure to report cases of violence by health employees: No cases of domestic violence are reported by the healthcare staff⁵¹. In perceiving the GBV services in general as related only to police reporting, no effort has been made to monitor or assess other aspects of the service. One of the doctors interviewed during the

⁴⁴ Ministry of Health (2014).

⁴⁵ Ferlay et al (2013). Cancer incidence and mortality patterns in Europe: Estimates for 40 countries in 2012. *Europ J Canc*; 49: 1374-1403.

⁴⁶ PHI (2014). National Health Report.

⁴⁷ PHI (2012).

⁴⁸ Albanian Women's Christian Association/YWCA

⁴⁹ INSTAT (2015): Women and men in Albania: The number of women affected by the criminal offence of Domestic Violence in 2014 was 3,090.

⁵⁰ INSTAT (2013): Domestic violence in Albania. National population-based survey.

⁵¹ Same as 100.

evaluation⁵² stated: "There is no reason for us as doctors to deal with the [domestic] violence. It is not our duty, and has not been required of us. This should be done by the police and psychologists. As these women do not come to us and tell us about the violence, it implies that they do not see as as suitable.

4. Shortfalls associated with the psychosocial service: Practice shows a timely provision of first aid, but there is a lack of psychosocial services at health centres.
5. Contraceptives and raped women: Sexually abused women (15.7%) were almost 3 times more likely to say their husbands would not allow them to use contraceptives to avoid pregnancy, compared to women who were not sexually abused (5.8 %). 2.3% of sexually abused women and girls were concerned about the risk of acquiring STDs, including HIV/AIDS, while 43.5% of sexually abused women reported having SSTs.⁵³
6. Payments for receiving services: Victims of domestic violence who have sought the help of health services and/or legal services, have had to pay (even bribe) for some health/legal services offered. For many abused women, payments (bribes) for these services constitute a significant barrier for their ability to access health services, protection, support, and access to justice.⁵⁴
4. The role of the media: NPOs report that the media often misdirects, promoting unhealthy stereotypes in terms of formation or increasing prejudice to such matters. Publishing the data of the person whose rights have been violated, constitutes in itself a new violation of privacy, inciting prejudice in the community where the person in question works and resides.
5. Raising public awareness⁵⁵ still needs improvement. Some of the NPOs interviewed stated that victims of domestic violence do not have information on health care in general and STIs/HIV/AIDS, or reproductive health and family planning in particular.
6. There is a lack of a functioning and well-coordinated system for the prevention, treatment and reintegration of domestic violence cases. The monitoring of the Referral Mechanism work, conducted by the MLSA (today MoSWY) for 2012, showed that: "although this mechanism is functional and highly effective in several municipalities - where regular meetings of multidisciplinary teams are held and there is a good coordination among member institutions which provide legal assistance, counselling, psychological and vocational training, employment, housing and food assistance for cases they deal with - there is still much work to be done and many challenges to face. More resources are needed for full service delivery including: the establishment of a 24-hour telephone line, regional shelters, etc., which are some of the priorities where the work should be focused to strengthen these mechanisms, in parallel and by spreading them further across the country"⁵⁶.
7. Services not covering the full geographical extent and not with the same quality: Services are available mainly in the largest cities, for women victims of domestic violence or victims of trafficking, while women/girls from rural and remote areas, do not have access or have very limited access to direct supportive services⁵⁷.

⁵² Same as 100.

⁵³ INSTAT (2013): Domestic violence in Albania. National population-based survey.

⁵⁴ INSTAT (2013): Domestic violence in Albania. National population-based survey.

⁵⁵ DCM. 404/13.05.2015 "On approval of the plan for the European integration" 2015-2020.

⁵⁶ MoSWY/DPSBGJ (2012). Report on the establishment and effectiveness of the functioning of the National Referral Mechanism for cases of Domestic Violence at local level. December 2012.

⁵⁷ Guidelines for the implementation of the EC Convention on Preventing and Combating Violence against Women and Domestic Violence - Assessment of the current situation and the financial implications for the implementation of the Convention in Albania", with the support of UN Women, 2013.

8. Based on the data collected⁵⁸ in 3 shelters, there are constraints for women who suffer from mental health disorders or serious health problems that require hospitalization. In cases of extreme disabilities or severe mental health issues, shelters refer them to specialized services, because they do not have specialized staff to handle these cases.

11. Victims of trafficking (VT/PVT) and addressing health problems

The actual situation and the problems identified by NPOs

1. The progression of people trafficking: Data from the strategy against people trafficking for 2014-17 show an increase in internal trafficking of minors and adults, mainly in urban areas, as well as tourist areas, where we see more women trafficked for sexual exploitation and children trafficked for sexual exploitation and/or begging.
2. Women occupy the main place as VT/PVT: VTs are mostly women aged 15-24, who are used for prostitution within the country and abroad, in destination countries. Some of the ways used by traffickers to recruit are deceit for marriages, for offering a job, and a new trend observed recently, recruiting via social networks, like Facebook⁵⁹. The case law to date has identified these recruitment methods⁶⁰.
3. Albania is still a country of origin for trafficking: According to the latest study conducted by IOM on THB in the Western Balkans and the State Department report on people trafficking, Albania is identified mainly as a country of origin for victims of trafficking, who are exploited mainly for prostitution in EU countries such as: Italy, Belgium, Greece, United Kingdom, Germany and Kosovo⁶¹.
4. The national referral mechanism of people trafficking has improved and coordination of the relevant authorities and stakeholders involved locally⁶² has increased, but there is still much room for improvement. According to a representative of a civil society organization in Durres, “the organization has provided input for the drafting of the annual action plan. However, this has not been accompanied by a budget allocated for each activity, hence it is not clear if the plan is fully implemented or not”. According to them there is a need for a better coordination between all the members of the RAC, not only in emergency cases, but further to meet the needs of VT/PVT.
5. The role of NPOs in cases of people trafficking, including their medical assistance: NPOs have carried a significant weight and have played a prominent role in assisting and providing reception services, long-term rehabilitation and reintegration of VTs/PVTs.
6. Problems identified by NPOs: lack of community and residential services for victims of trafficking and violence who suffer of mental health problems and require constant specialised follow-up. NPOs express concern about the non-effective treatment for victims in mental health institutions and insufficient knowledge of their staff regarding PSV. Experts psychiatrist employed in mental health institutions, are untrained and inexperienced for the treatment of VT who display mental health

<http://www.un.org.al/editor-files/file/Roadmap%20of%20the%20coe%20Convention.pdf>

⁵⁸ Council of Europe and UN Women (2015). Albania final report: Mapping support services against violence towards women and girls.

⁵⁹ Different but equal (2014). Study on the issues of cooperation of victims of trafficking with law enforcement authorities.

⁶⁰ CRS & MB (2015). Training Module on human trafficking. Caritas Albania, 2015. Final baseline report.

⁶¹ US Department of State's Report on People Trafficking, June 2014;

⁶² IOM (2014) Needs Assessment: Human Trafficking in the Western Balkans.

problems. Organizations also report cases where VT have been refused service from the psychiatric institution.

12. Health care for women in rural areas

The actual situation and problems identified by NPOs

1. The PHI study shows that for antenatal care, the prevalence of at least four visits was substantially higher in urban areas (82%), compared with rural areas (57%). Similarly, it was significantly higher among the rich (91%), compared with the poor (49%)⁶³.
2. Lack of studies: There has been no recent study on health and demography in the country apart from the (NSGEDV 2008-2009), to appropriately compare using a scientific methodology.
3. There is a massive need to work with women living in rural areas on pre and post-natal education, because there are problems related to child growth, malnutrition, and neglect that come about as a result of the lack of information.
4. The health system continues to be under-funded particularly for primary health care and public health services, and is unable to meet the basic needs of the most vulnerable women and children, particularly in rural areas.
5. There is lack of services and in particular of quality services, and lack of access due to long distances. Geographical barriers⁶⁴ are a key factor, influencing the rural population's access to health services. According to the study, 43.8% of respondents in rural areas identified as key problems, obstacles or barriers to get to health services, the geographical distance and lack of transport facilities.
6. There is a distinct lack of information on risks, health care and services offered. The low level of information impacts on the delayed diagnosing; information on the benefits of health insurance coverage is incomplete; there is negligence by the women themselves to have periodic checks - constraints that come from the patriarchal culture and mentality, lack of access to health services due to economic difficulties, etc.; rural woman carry the burden of the problems faced by the family and as a consequence their suffer huge psychological traumas⁶⁵.
7. Informal Payment: Cash payments continue to remain a concern in the health sector and have a direct impact on poor households who are not aware they can receive the service and be excluded from health insurance payments. They are either forced to pay substantial sums directly to obtain services or choose to forgo the treatments they need the most⁶⁶.
8. Women and girls in rural areas are financially/economically dependent on the men. They are mostly involved in household work, and this affects their independence in taking decisions and accessing health services, including sexual and reproductive health.
9. Services are available mainly in big cities and for women victims of domestic violence or victims of trafficking, while women/girls from rural and remote areas do not have access or have very limited access to direct support services. Documents show that about 80% of men and 80% of women from rural areas say they have no health insurance at all⁶⁷.

13. Women with disabilities

The actual situation and problems identified by NPOs in relation to disabled women

⁶³ PHI (2014). National Health Report.

⁶⁴ SOROS (2011). Access to health services by vulnerable groups.

⁶⁵ CERAI (2010). Migration, the reality for women in rural areas.

⁶⁶ World Bank (2011). Albania Out-of-Pocket Payments in Albania's Health System. Report No. 64803-AL

⁶⁷ SOROS (2011). Access to health services by vulnerable groups.

1. Disabled people (DP) have limited access to most health services; therefore their needs for service and health care remain unmet.⁶⁸ Disabled women and girls are one of the most marginalized and subject to multiple discrimination. They are more likely to have more difficulties than men are. This gender gap is mainly due to the link between disability and aging, and the fact that women live longer and make up the majority of the elderly population⁶⁹.
2. Statistics on violence relating to DP: Women with disabilities represented 2% of the reported cases of domestic violence in 2014, compared to 1% in 2013. Some cases go unreported because of the stigma of domestic violence, lack of knowledge of available resources and limited protection, as well as the accommodation options for all victims of domestic violence.
3. There are huge gaps in policies and the legislation in relation to women with disabilities⁷⁰. NPOs point out that although there have been efforts to improve the legislation, the element of double discrimination against women with disabilities is neglected and overlooked, due to the disability and gender. In the field of health (legislation and policies) the disability issues in general and those related to women in particular are not mainstreamed.
4. The legal framework needs to be recognized and implemented by all responsible actors, but the law does not solve every problem. ADRF has raised the concern of financial support in the implementation of this Law and other bylaws⁷¹.
5. One of the most pressing issues for health centres, requiring serious and fast investment, is the reasonable adjustments for patients with disabilities⁷².
6. Reform of the current KMCAP commissions and establishment of multidisciplinary committees in accordance with the bio-psycho-social development model of the Convention on the Rights of PWD must be one of the priorities in implementing this law, as this can ensure that people with disabilities are not treated in a discriminatory manner.
7. Disabled women should be part of any strategy and action plan: The Action Plan of the Council of Europe for people with disabilities draws the attention to the specific needs of women with disabilities. In the area of health care, women with disabilities are still not part of the analysis on the reflection of gender in health policies, both in terms of acquiring health information, and provision of health care at all levels.
8. There is a lack of studies about the problems of women with disabilities. In various reports compiled by various organizations or institutions, women with disabilities are rarely mentioned.

14. Women from Roma and Egyptian communities

The actual situation and problems identified by NPOs

1. A young population: According to INSTAT, based on the 2011 census, the Roma population is younger than other groups.
2. More diseases: Chronic diseases such as cardio-vascular diseases, rheumatism, diabetes and neurological and psychiatric diseases are significantly common among the Roma⁷³ population, based on the empirical data. Roma women are more

⁶⁸http://www.ishp.gov.al/multimedia/Kalendari_2013/Dita%20Boterore%20%20e%20Personave%20me%20Aftesi%20te%20Kufizuar.pdf

⁶⁹ INSTAT, UNFPA, UN WOMEN (2014). Gender perspective in Albania. Gender analysis of the results of the 2011 Census of Population and Housing.

⁷⁰ ADRF (2010). "Women with disabilities in Albania, included or forgotten? "

⁷¹ ADRF (2014). The objectives of the government's program and disability plans. Survey report. Tirana 2014, page 23. This report was prepared with the support of Civil Rights Defenders.

⁷² CFFESD (2014). Monitoring of primary health care services in Albania.

⁷³ UNDP (2012). Needs assessment study on Roma and Egyptian communities in Albania.

susceptible to high blood pressure (26%) and long-term muscle and bone diseases (arthritis) 31%. Cases of tuberculosis, syphilis, hepatitis B and HIV/AIDS are more common among Roma than non-Roma population. In addition, a greater proportion of Roma families have members who suffer from disabilities⁷⁴.

3. Discrimination of the Roma population is relatively high: According to reports, there is discrimination while using health care services. 43%⁷⁵ of the Roma respondents feel openly discriminated by health care providers⁷⁶.
4. Health insurance and health cards: According to a UNDP study of 2014, 42% of Roma and 24% of Egyptians do not have health cards. Family poverty is one of the reasons. These families cannot pay for their health insurance.
5. Contraceptives: The majority has no knowledge on reproductive health⁷⁷, pregnancy, childbirth and childcare. In 2011, the number of Roma and Egyptian individuals using contraceptives doubled (23% to 20% Roma and Egyptians), compared to 2003⁷⁸. Knowledge on contraception received by the Roma and Egyptian girls is mainly from informal sources.
6. Health of pregnant women: The number of medical examinations during pregnancy or after birth is lower than the one recommended.
7. Termination of pregnancy: In the absence of family planning, the number of abortions for unwanted pregnancies remains high. This is shown in the survey done in the framework of the UNDP study. Almost 53% of Roma and 39% of Egyptian women have an abortion, while about 3/4 of them have two or more⁷⁹.
8. Marriages under 18 years old are another great concern. Roma girls marry at a younger age and become mothers sooner than other ethnic groups. The Family Code stipulates that the age of consent for marriage is 18 years old. The court may allow underage marriages only "for important reasons"(Article 7, Family Code).
9. Low level of educational of the Roma and Egyptian women: This is another factor that negatively impacts their and their children's healthcare. The average level of education is minimal, where 55% of women over 15 years old have never attended school and only 18% have completed at least one year in compulsory education.
10. Lack of data: There is still a lack of comprehensive data in Albania regarding Roma and Egyptians women's health and child mortality.
11. Poverty, etc.: The causes of this inadequate health situation are associated with the poverty, poor living conditions and lack of basic infrastructure, limited access to health services, low level of education and some forms of discrimination.
12. Barriers identified in receiving healthcare services: There is limited access to information, quality and continuous health services, as well as free and timely health services; there is a lack of healthcare services in the communities where the Roma live; there is low level of education of Roma mothers which directly influences the growth and health of children; there is a stigma/stigmatization and prejudice from medical staff faced by Roma women; and there is a patriarchal and conservative mentality of men in Roma families, who do not allow women to access health services.

⁷⁴ Same as 138.

⁷⁵ INSTAT (2015): Roma and Egyptians in Albania: Socio-demographic profile and economic development, based on the 2011 Census.

⁷⁶ Same as 137.

⁷⁷ Knowledge about sexual and reproductive health education is obtained in the higher grades of the 9-year education, but many Roma girls leave school as soon as they complete lower grades.

⁷⁸ De Soto, H., Beddies, S., Gëdeshi, I. (2005). Roma and Egyptians in Albania: From social exclusion to social inclusion, The World Bank, Washington D.C.

⁷⁹ Same as 142.

15. The health of LGBTI and women LBT

The actual situation and problems identified by NPOs

1. Homophobia and hatred: A 2014 report of Pink Embassy in Albania, homophobia exist not only in school or working environments, but also in the provision of public services such as health, education, etc. LGBTI people report that while receiving health services they face stigma and discrimination. It is reported that many people are stigmatized because of their sexual orientation or their gender identity and cannot fully enjoy universal human rights.
2. Discrimination against women: LBT Women face discrimination by medical staff because of their sexual orientation or gender identity, and lack of confidentiality, which in turn excludes the LBT women from the access to information and health services⁸⁰.
3. Problems of regulatory framework in the field of health: Despite positive changes achieved in various aspects, legal and social, a lot remains to be done in terms of respecting the rights of LGBTI people in the country. According to the study⁸¹, the regulatory framework in the field of health does not have any categorization for various population groups when referring to the protection of rights and the equal provision of health care. For transgender/intersex people there is no provision of specific assistance related to gender change or other treatments associated with their special needs.
4. Knowledge of medical staff for specific needs: LGBTI people suffer from poor medical and psychological services and the Albanian medical system is unprepared to address the needs and problems of this community⁸². The general perception among respondents was that health professionals do not have knowledge on the specific health needs of LGBTI people, and the necessary skills needed to manage these needs in clinical practice⁸³.
5. Health care for LBT women in the country does not exist: Current data⁸⁴ indicate that LBT women are not visible and their needs are not taken into account in the design of health policies, development of services and the provision of adequate health care. Health professionals have prejudices, which limit contact with patients and do not enable open communication between them.

16. The health of older women

Actual situation and problems identified by NPOs

1. The third age 'is growing': The results of the census conducted by INSTAT in 2011 show that the proportion of elderly in the population has increased significantly over the past 10 years due to low birth rates and high overseas immigration of the young. In 2014, women on average lived longer than men by 3.9 years⁸⁵.
2. Inappropriate treatment of the elderly and insufficient residential homes: Studies show that Albania does not offer acceptable medical and social treatment for the elderly. Wrong treatments even abuses of the elderly in nursing homes are a recurring

⁸⁰ Interviews with representatives of the association Pink Embassy/LGBT PRO Albania.

⁸¹ Voko K (2013). Technical Report - Access to services and quality of health care for LGBT people in Albania. Alliance against LGBT discrimination, December 2013.

⁸² Pink Embassy, Activity Report, June 2013 - December 2014, to:

<http://www.pinkembassy.al/sites/default/files/uploade/Raporti%20Vjetor%20i%20Pink%202014.pdf>

⁸³ Voko K (2013). Technical Report - Access to services and quality of health care for LGBT people in Albania. Alliance against LGBT discrimination, December 2013.

⁸⁴ Voko K (2013). Technical Report - Access to services and quality of health care for LGBT people in Albania. Alliance against LGBT discrimination, December 2013.

⁸⁵ INSTAT (2015): Aging population: The situation of the elderly in Albania.

theme repeating itself⁸⁶. ASAG (Albanian Society for All Ages) finds that standards are at a bare minimum, given that day care centres are limited in Albania. In addition, shelters are few in number and do not meet the requests of an overwhelming number of elderly, who are often abandoned or abused by relatives or other persons⁸⁷.

3. The elderly suffer from more than one chronic disease. They say they cannot afford to buy medicines and are often forced to take only a fraction of the medication, mainly reimbursed medication. On the other hand, the public healthcare system is unprepared to cope with the growing needs of the elderly⁸⁸.
4. 27% of respondents interviewed stated that "Healthcare for the elderly is not available when they need it". Here is what an elderly Roma woman⁸⁹ from the Kinostudio area of Tirana said: "I am old and sick and suffer from many diseases; I can hardly walk and I have no energy to go to the nearest clinic. I do not have money to pay the doctor cash, therefore I go to the nearest pharmacy, the pharmacist gives me the medication and I do not have to pay the 200 ALL to the doctor".
5. There is lack of structures and NPOs to address the needs of the elderly and in particular the needs for health services.
6. NPOs for the elderly report that even the Agency for the Support of Civil Society (ASCS) has never had the elderly in its focus. There is a lack of projects and donations for the elderly.

Groups in Need

17. Women serving a prison sentence

The actual situation and problems identified by NPOs

1. There is a lack of appropriate structures of professionals in some detention institutions, and as a consequence there is an absence of specialized services such as psychiatric, health, and psychosocial services, that are essential for the wellbeing and the human rights of people serving a prison sentence⁹⁰.
2. The Ombudsman⁹¹ following and inspection of the rights of persons deprived of their liberty reports a lack of psychiatrists to follow cases of the mentally ill and non-implementation of the legislation on the quality of service provided by social and health care staff.
3. NPOs report the case of a woman who was held in custody despite a request for her to serve the sentence at home due to a health condition. The woman was left for a long period in prison, and then released, which posed more of a risk for her health condition.
4. Agreements remain on paper only: The agreement between the Ministry of Justice and Ministry of Health to establish a Special Medical Institution, provided for in the Law No. 44/08.05.2012 "On Mental Health", aiming at housing and treatment of persons who have been issued a court order for "obligatory medication" and "temporary admission" has not been implemented.
5. There are a number of problems relating to the health of women serving a sentence such as lack of specialist doctors in the institutions and in particular gynaecologists; non-examination by doctors of cases when the detainee claims having health

⁸⁶ Friedrich-Ebert-Stiftung (2014). Care for the elderly.

⁸⁷ ASAG (2012). Aging, legislation assessment in Albania.

⁸⁸ UNFPA, NCSS (2015). Social profile of elderly people in Albania. Qualitative assessment.

⁸⁹ SOROS (2011). Access to health services by vulnerable groups.

⁹⁰ European Institute of Tirana: Protection of Human Rights in Albania: Monitoring Report 2011. On mental healthcare in the prison system, 2011.

⁹¹ Ombudsman's Report, 2014

problems; delays of examination by the specialist doctor or lack of periodic visits in cases of diseases that can deteriorate (neurologist); and lack of a special food diet for cases with particular health problems⁹².

18. Work relations and specific issues of women's health

The actual situation and problems identified by NPOs

1. Low level of employment and payment affects healthcare: Women are 1.3 times more likely than men to work as unpaid workers in a family business. Five out of ten employed women are engaged in agricultural activities. The second sector which accounts for the largest share of employed women after the agriculture sector is that of non-market services, including activities such as public administration, social services, and other service activities. Women face lower pay discrimination regardless of the executive position. The hierarchy of the enterprise and low access to career development opportunities play a significant role⁹³.
2. Sectors where women are concentrated, affect the salary and certain occupational diseases: Women tend to centre on certain types of work. Men are more likely to be employers or self-employed, and women are likely to be employed or to perform unpaid work in the family business. Women who do not have children have a higher level of economic activity. While the number of children increases, the economic activity usually falls, especially for women with four or more children⁹⁴.
3. The coverage of social protection for informal workers remains extremely limited. The study noted that female workers can be more vulnerable to social exclusion and face multiple risks because of their dual roles of production and reproduction⁹⁵.
4. Working conditions and the impact on health: Organizations interviewed report that many women work with chemicals, exposed to high levels of noise, dust, experience bad hygiene and sanitary conditions (2 bathrooms for 300 employees), and have no water, no minimum rest, and no canteens.
5. There is a lack of monitoring by the state to prevent and ensure the implementation of all stipulations defined by Law No. 161/2014, "On amendments and additions to Law No. 10237/18.02.2010, "On Health and Safety at Work". Very few NPOs work in the field of occupational diseases. There are no statistics or monitoring of their impacts on women's health.

⁹² HRDC monitoring the Prison detention block 325 for women, in Tirana.

⁹³GAD (2010). labour rights for women in Albania.

⁹⁴INSTAT, UNFPA (2014). Gender perspective in Albania: Gender analysis of the results of the 2011 Census of Population and Housing.

⁹⁵Same as 94.