

# “SHADOW” REPORT



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



February 2016



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# **“SHADOW” REPORT**

## **HEALTHCARE FIELD - CASE OF ALBANIA**

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

February 2016

## 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 (CLCI)
- 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

# PART ONE

## A. ACKNOWLEDGEMENTS

This Shadow Report (hereinafter referred to as the “SHR”) regarding the protection of women’s rights in the area of health against CEDAW standards was prepared by the Albanian Centre for Population and Development (ACPD) in cooperation with 20 non-profit organizations, a full list of which is found in Annex 1.

We would like to thank all the non-profit organizations that responded positively to this initiative and contributed to the collection of the necessary information by filling in the questionnaires, conducting interviews, participating in consultations, etc.

ACPD would like to thank the UNFPA for the financial support in drafting this Shadow Report on CEDAW standards and their de facto and de jure status in Albania.

In addition, we would also like to thank the Commissioner for Protection from Discrimination, Ms. Irma Baraku, who met with the team of experts, gave her opinions and made relevant comments.

We would also like to thank all the people, representatives of central and local institutions, representatives of various communities and interest groups who cooperated by providing information and opinions about the areas covered in this report.

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This study would have not been possible without the valuable contribution of the ACPD staff, who worked during the entire time under the guidance of experts to collect primary data and prepare the information, based on which the analysis of the report is made.

## B. METHODOLOGY

1. *The Structure:* The SHR is made of two parts: Part One, which contains introductory and summary information, including the recommendations of the report, and Part Two, which dwells on the analysis of healthcare non-discrimination standards in the legal and factual field. Apart from the legal analysis, the most dynamic parts of the SHR are the facts obtained on women’s health situation and the discrimination against them. By legal basis we do not just mean the law, but also the international documents ratified, by-laws, strategic documents, protocols and so on, that impose obligations.
2. *The axis of analysis:* The working group has carefully analysed CEDAW’s Article 12 components, and the meaning given in the General Recommendation 24 of the CEDAW Committee to confirm the achievements and address the needs for improvement. The main aim of all methodological techniques was to identify critical issues based on the progress achieved following the “Concluding Observation on Albania” of the CEDAW Committee in July 2010. The main question arising is whether the legal framework and the factual situation is in accordance with

Article 12 of the CEDAW Convention.

3. *The Method*: Information provided in this SHR covers a period of approximately 5 years, running from July 2010 to December 2015. Experts used information about health issues contained in reports, studies, analysis of statistics *publicised*, publications of state institutions, international organizations, NPOs, etc. Initially, the work focused on the study and analysis related to the legislation, as well as its changes and evolution. The prepared questionnaires and responses received, contributed to a high degree, to test the first findings obtained from the research work on the legislation and studies. Meetings with NPOs, key stakeholders working in the field of health, experts and important institutions within the country enabled us to obtain first-hand information on the legislation, in particular, on its implementation in practice. In the acknowledgment section we have mentioned all the contributors, who have “given” the SHR a wide number of authors. The Report, presents identified problems as inherent and comprehensively accepted.

## C. INTRODUCTION

1. Albania ratified the CEDAW Convention in 1993 (Law No. 1769/09.11.1993) and its Optional Protocol (Law 9052/17.04.2003) in 2003, adopted by the General Assembly on 6 October 1999, that entered into force on 22 December 2000. The official text of CEDAW was published for the first time in the Official Gazette 15 years after its ratification.
2. According to the Constitution of the Republic of Albania (Article 122/1), “Any international agreement that has been ratified constitutes part of the internal juridical system *upon its publication in the Official Gazette of the Republic of Albania*”.
3. Pursuant to Article 18 of CEDAW Convention, Albania has approved and submitted the first, second and third periodic report under CEDAW<sup>1</sup> and has currently approved the 4th national periodic report<sup>2</sup>. In every report, as in the present one, attempts were made to reflect the legislative, judicial, administrative or other measures undertaken by the state in the implementation of the Convention, as well as all factors that positively influenced or hindered the approach towards CEDAW standards.
4. Ratification, acknowledgment and implementation of the CEDAW Convention have contributed to the significant progress of the legal and substantive equality between women and men. However, it should be noted that the implementation in practice of these instruments in Albania is still limited.
5. In this SHR while we have highlighted the results achieved by the Albanian government, we have also focused on what the civil society considers to still 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. Some of the achievements and shortcomings are linked to the fact that development and progress are a never-ending process which extends itself to merits and responsibilities. Some failings are related to the inadequate measures taken by the government. Others are associated with features of stereotypes that still “enjoy” solid ground in the Albanian setting. Eliminating them will require more time and money. Some failings

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1 Report on Albania of 23 May 2002, considered as a combined report of the first and second report- Reference No. CEDAW/C/ALB/1-2. It was reviewed by the CEDAW Committee at its 28th session in January 2003); The third report was adopted by the Decision of the Council of Ministers (DCM) 1082/ 07.23.2008. This report was reviewed by the CEDAW Committee in its 46th session, July 2010.

2 Fourth Periodic Report adopted by DCM. 806/26.11.2014.

could be eliminated if the civil society were to be more consistent and aware, exerting pressure on the government.

6. 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.
7. Although the Civil Society has played an active role in eliminating discrimination against women and promoting gender equality as an integral part of the state and society, it also feels responsible for not achieving the required standards. The conclusions and recommendations are of a constructive, rational and comprehensive *nature*, and some of them are directed at and pay greater attention to the civil society in the country. The SHR analyses the active and well/badly addressed roles of NPOs operating in this field.
8. Tackling in reality the CEDAW standards is a long struggle. They often are challenging even for countries with consolidated democracies. In the recommendations we have dared to suggest, we have endeavoured to rely on the possibilities and prospects of Albania in the most realistic and not a utopian way. Thus, while the principles and standards are unique, the discretion of measures taken is diverse – in order to suit particular countries and societies. For this reason, the Convention itself has left some of these “measures” in the hands of the states.

## D. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

1. Article 12, states “Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure that women have equal access to health care services. This includes the obligation of states to provide health services only needed by women”<sup>3</sup>. Hence, the following findings and recommendations relate simply to women’s health.
2. Notwithstanding the provisions of Paragraph I of Article 12, Member States shall ensure to women appropriate services in connection to pregnancy, birth and the post-natal period, granting them free services where necessary, as well as adequate nutrition during pregnancy and breastfeeding.
3. The obligations are immediate, because under Article 12 (2) the verb “shall ensure” is used<sup>4</sup>. These obligations could be, for example, prevention of some diseases, such as maternal mortality and tuberculosis<sup>5</sup>. Obligations may be more gradual in approving a therapeutic drug as safe and effective, but that is initially more costly for distribution to the public. Article 12 requires member states to ensure access to specific services “related to family planning” and appropriate services for the pregnancy, the post-natal period and the appropriate nutrition during pregnancy and breastfeeding. However, Article 12 (2) is also specific in terms of free provision of services when necessary<sup>6</sup>. Article 12 (1) includes no specific obligations, as Member States may choose for themselves measures they deem necessary to guarantee equal access to health services, although these measures are monitored by the CEDAW Committee<sup>7</sup>.
4. *SHR highlights that Albania has a new and/or improved legal framework, whereby the approximation with CEDAW and other standards in relevant documents is evident.* Some of these documents are: Law No. 10221/04.02.2010, “On Protection against Discrimination”; Ratification of the UN Convention “On the Rights of People with Disabilities”, Law No. 108/2012; The framework

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3 General Recommendation 24, 14, Commentary, p. 329.

4 Commentary, page 329.

5 General Recommendation 24, para. 17.

6 Commentary, page 329-330.

7 General Recommendation 24 para. 9.

Law No. 93/2014 “On the Inclusion and Accessibility for Disabled People”; The ratification in 2012 of the Council of Europe Convention “On Preventing and Combating Violence against Women and Domestic Violence”<sup>8</sup>; amendments to specific provisions in 2012 and 2013 of the Criminal Code offences related to domestic violence and gender-based violence; Amendments to the Law 9669/18.12.2006, “On Measures Against Domestic Violence” in 2010. Progress has been made in terms of commitment for the establishment of a national centre for social care services for victims of domestic violence, protection of confidentiality of the data, personal information of victims and improvement of protection orders; Ratification of the Convention of the International Labour Organization “Health and Safety in Construction”, 1988, adopted by Law No. 5/30.01.2014, and “Promotional Framework of Health and Safety at Work”, 2006, with the adoption of Law No. 4/30.01.2014. More information about the legal framework is found further in this Shadow Report.

5. This SHR acknowledges and dwells on the results achieved by the Albanian government. In the main, however, we have focused on what the civil society considers as problems and shortcomings which still affect the equality standards enabling in this way discrimination against women in health matters.
6. Problems outlined in this report represent the need for improvement/review of the legal framework in relation to sexual and reproductive health, protection of breastfeeding, recognition of gender identity, screening and preventative examinations related to pregnancy, mental health, screening of women for cancers of the reproductive system, etc., the need to reform the healthcare in order to provide quality and comprehensive services, etc.
7. The SHR emphasizes the need for structural improvements, training of human resources, budget increases to a sufficient and realistic level to implement the laws, strategies and policies that focus on the health of the mother and child.
8. The SHR reiterates in particular the health of vulnerable women, who have a much lower access to obtaining health services and need a different approach to services.

## The SHR reaches the following conclusions and recommendations:

### 1. General 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 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 by Law No.51/14.02.2013, to provide free service 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

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<sup>8</sup> Law No.104/11.08.2012 “Ratification of the Council of Europe Convention on “Preventing and Combating Violence against Women and Domestic Violence”.

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.
3. *Financing strategies that are considered underfunded.* Such an example is the reproductive health strategy, where, among other things, women's health is not a separate item, making the medium-term planning and long-term interventions in the sector difficult.

## 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 healthcare 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.
2. Arrangements for integrated sexual and reproductive health service provisions in primary health care level as per the basic service package of the approved PHC.
3. 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.
4. *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.
5. *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.

6. *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 this population.
7. *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 throughout interventions. Strengthening the cooperation and supporting NPOs and local communities in implementing information and educational activities and changing behaviours regarding contraception for vulnerable groups.
8. *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.
9. *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.
10. *Preparation of a national study* on the access of women and girls to the health system.

### 3. Voluntary termination of pregnancy

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 set up for the 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 the 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 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 medicated 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: Sexually transmitted infections (STIs) and HIV/AIDS

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 develop 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 improve 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 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.
2. *The information obtained from the current cancer registry is incomplete and often unreliable due to the lack of oncology health services across the country, "loss of cases", demographic movements, lack of a unique identification code for cases with tumour diseases, lack of capacity among health personnel to data collection, lack of following-up cases of cancer, lack of access to death certificates, and their non-quality completion.*

#### 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.

### *General recommendations*

1. Inclusion, in particular, of issues related to vulnerable women, in the legislation and protocols of healthcare workers work.
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.

*The following measures are recommended:*

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 an 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) with target 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 the violence.

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

*Conclusions:* Data from the Strategy Against Human Trafficking 2014-2020 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.

*The following measures are recommended*

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

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 infrastructure<sup>9</sup>, and long distances to access health centres<sup>10</sup>.
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)

1. *Legal*: Inclusion, in particular, of issues of women with disabilities in the labour legislation and health workers protocols. Women with disabilities to be actively involved in developing and implementing programs, policies and protocols related to health and social issues. Determination of 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 abilities 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

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

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<sup>9</sup> SOROS 2011. Access to health care services by vulnerable groups

<sup>10</sup> Hazizaj A., Elezi P., Ballo M., National Evaluation 2014: Roma Children Access to Early Childhood Services, UNICEF/CRCA/YWCA/Observatory, Tirana 2014.

## 12. The health of LGBTI and women LBT

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.
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 Discrimination<sup>11</sup>. 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

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

1. *Monitoring*: Continuous monitoring and control by public institutions on private institutions to ensure compliance with the health rights of women in 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*

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<sup>11</sup> CPD, 2014. Annual Report.

*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 the health field

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

## 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. *Introduction:* According to the requirement of Article 12 of the CEDAW Convention and the General Recommendation No. 28 of the CEDAW Committee, while states have the right to select measures to achieve equality in the field of health care, it is the Committee that eventually decides, if the State has adopted all the appropriate measures<sup>12</sup>. Therefore, we shall pause briefly in this SHR on health legislation, plans and policies undertaken by the Albanian government, whether they are based on scientific research and assessments of the health status, needs of women, whether they are based on indicators of health and whether women's health services are monitored, ensuring that they are suitable and affordable<sup>13</sup>.
2. *The Albanian legislation in general* provides specific support and special healthcare services for mothers and children.
3. *Constitutional standards:* The right of the mother and child to healthcare is defined in the Constitution of the Republic of Albania (1998, amended). Article 55 of the Constitution states that "citizens enjoy equally the right to healthcare from the state, and everyone is entitled to healthcare insurance." This commitment is based on the constitutional principles of comprehensive quality health services provided for in the Law No. 8876/04.04.2002, "Reproductive Health", (amended), Law No. 10138/11.5.2009, "Public Health", etc.
4. *Work relations:* The Work Code and Law No. 10237/18.2.2010, "Health and Safety at Work", contain a number of provisions related to particularly difficult or harmful for the health jobs, and have special stipulations for the protection of the health of mothers and children, that clearly define working conditions for pregnant women<sup>14</sup>. In 2014, two International Labour Organization (ILO) Conventions were ratified namely "Health and Safety in Construction" (Law No.5/30.01.2014 for C167), and "Promotional Framework for Occupational Safety and Health" (Law No.4/30.01.2014 for C187).
5. 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. In general, the

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12 General Recommendation 28 para. 23.

13 General Recommendation 24, 29, paragraph 29 and 31 (d).

14 Article 104/6 of Law No. 7961/12.07.1995, "Labour Code of the Republic of Albania", as amended in 2015, stipulates as follows: The Council of Ministers determines the non-exhaustive list of factors, processes and working conditions affecting the safety or the health of the mother and/or child, as well as specific rules on working conditions for pregnant women, women who have recently given birth and those breastfeeding children".

law provides for a series of measures for a safe motherhood, such as the right of every woman to receive the care they need in order to enjoy good health during pregnancy through to childbirth. The law foresees the right that all pregnant women should benefit from free periodic medical follow-up during pregnancy, birth and post-partum, in particular the mandatory pre and post-partum examinations, as defined by decision of the Minister of Health. “The law provides for healthcare during childhood and adolescence. It also defines the basic principles of health care during the reproductive years for women and men, and above all respects the principle of non-discrimination enshrined in the Constitution and important international documents. The by-laws issued by the Ministry of Health (MoH) complete the legal framework in force<sup>15</sup>. *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 mechanisms for the monitoring of the quality and the enforcement of the law, both in the public and in private sector, and administrative measures to be imposed when the law is not implemented.*

6. Law No. 10107/30.03.2009, on “On Healthcare”, as amended by Law No. 51/14.2.2013, foresees free [healthcare] services for children (0-14 years old). However, according to the UN Convention “On the Rights of the Child” and the Law “On the Protection of Children’s Rights in Albania”, the definition of the concept “child” includes ages 0-18.
7. The Law “On the Promotion and Protection of breastfeeding”<sup>16</sup> intends primarily to support breastfeeding as against formula milk (when not determined by specific circumstances), and to regulate and control the marketing of breast milk substitutes for the healthy feeding of children. It must be said that despite the amendments, the Law 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.*
8. The Law “On Termination of Pregnancy”, as amended by Law No. 57/14.02.2013: The changes made have not impaired the essence of the law, but they highlight the role of the inspectorate responsible for public health. The law guarantees the respect towards every human being from the beginning of life, a principle that should not be breached unless it is necessary and under the conditions specified in the law. This law is permeated by the principle that “Every woman has the right to accurate information and counselling before terminating the pregnancy”. In this context, the health personnel plays an important role in informing women about the health risks related to the termination of pregnancy and the rights provided in the law on the family, mother and children. In cases of underage girls up to 16 years, the law stipulates that, in addition to consent of the girl herself, the consent of her parent or legal guardian is required. This law determines specific administrative measures and fines in cases when these principles are violated. *The law 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.*
9. Law No. 9952/14.07.2008, on the “Prevention and Control of HIV/AIDS” addresses the most

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15 Directive issued by the Minister of Health, namely Directive No. 146 / 04.11.2003 , based on the law on “Reproductive health”, in point 1, states that: all public and private institutions offering primary health care to mothers and children shall implement the regulation on reproductive health. Points 3 and 4 of this Directive specify that pregnant women should be provided with free healthcare during pregnancy (including free ultrasound scans), during birth and after the birth in healthcare institutions for mothers and children.

16 Law No. 8528/23.9.1999, amended by Law No. 58/2013: “Promoting and Protecting Breastfeeding”.

important legal aspects of HIV/AIDS, including discrimination, the right to privacy at the workplace, 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. The law provides for the treatment and care, support for prevention and control of transmission from mother to child and opportunities for further research studies in the field of HIV/AIDS. This law establishes the rules for the prevention and control measures against HIV/AIDS, as well as the care, treatment and support for people living with HIV/AIDS. By-laws deriving from this law, such as the Decision of the Council of Ministers No. 113/17.02.2011<sup>17</sup>, support the principles of equality, non-discrimination and confidentiality of health status of people infected with HIV/AIDS. The decision focuses on the prevention and control of HIV/AIDS in the education system, social, healthcare and correctional institutions. In relation to other STIs, an order was issued in 2011 by the Minister of Health<sup>18</sup>, the purpose of which is to strengthen the etiological supervision against STIs.

10. *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”<sup>19</sup>. 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. The Law on “Social Assistance and Services” was amended in 2011 by adding provisions concerning the rights of domestic violence victims to obtain economic assistance if issued with a Protection Order (PO). The Law on “Legal Aid”<sup>20</sup> was amended to include the establishment and operation of national legal clinics. The National Strategy “On gender equality, reduction of gender-based violence and domestic violence 2011-2015” was drafted and implementation started. Decision No. 334/17.02.2011, on the “Mechanism for the coordination of work on the referral of cases of domestic violence and the manner of its processing procedure”, defines the local government as the main authority that shall chair the steering committee, the composition of the interdisciplinary technical team and the role of the local coordinator. Municipalities through their structures handle cases of domestic violence by awarding them, amongst others, economic assistance<sup>21</sup>. Order No. 36/18.03.2011 of the Prime Minister, set up the first National Centre for the treatment of victims domestic violence”<sup>22</sup>.
11. *Women with disabilities*: Albania ratified the UN Convention “On the Rights of Persons with Disabilities”, with the Law No. 108/2012 and the framework Law No. 93/2014 “For the inclusion and accessibility of disabled people”, which introduces measures to ensure the inclusion and accessibility of all disabled people to the maximum level permitted by resources, without prejudice to the acquired rights, which are in accordance with the UN Convention on the Rights of Persons with Disabilities. The Convention contains a special section for women

17 DCM No. 113 /17.02.2011, “On the prevention and care of people living with HIV/AIDS”.

18 Order No. 199/17.05.2011, “On the laboratory reporting of sexually transmitted infections”, pursuant to Law No. 7761/19.10.1993, as amended.

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

20 Law No. 143/2013 , “On some amendments to Law No. 10039/22.12.2008, “On legal assistance”.

21 Research Institute Data Centrum 2012. The base study report on Domestic Violence and the Albanian State Police.

22 The Centre has operated since 25.04.2011 and aims at the rehabilitation of women, girls and children (up to 16), victims of domestic violence; it provides social assistance and qualitative, sustainable and modern services to promote independence, inclusion, dignity as well as their integration into normal life. The establishment of the centre was supported by UNDP under the framework of “One UN”.

with disabilities according to which women and girls with disabilities are subject to multiple discriminations and member states should take measures to guarantee their rights.

12. *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. The legal and institutional framework against discrimination in Albania has improved significantly. Almost all the main concepts against discrimination developed by the EU Directive on Racial Equality<sup>23</sup>, are included in the Albanian Constitution and the relevant legislation. In 2010, Law No. 10221/04.02.2010, "On Protection from Discrimination" was adopted, in full compliance with the relevant four main European Directives. The immediate positive result- following the adoption of this law- was the establishment of the Office of the Commissioner for Protection from Discrimination.
13. *LGBTI*: Law No. 10221/04.02.2010, "On Protection from Discrimination" prohibits discrimination relating to gender, gender identity, sexual orientation, genetic predispositions. Article 20 prohibits discrimination by means of refusing to provide a person or a group of people goods or services, amongst others, because of sexual orientation and gender identity. 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.
14. *Important strategies and bylaws in the field of women's health*: In support of the legal framework and health policies for meeting the needs of every individual, in particular the needs of women and children for appropriate, high quality and financially affordable services- in order to improve their health conditions - a number of strategies are being implemented such as: The Reproductive Health Strategy and Action Plan 2009-2015; The Maternal Health Action Plan 2009-2015<sup>24</sup>; The Children's Health Action Plan 2012-2015<sup>25</sup>, and the National Strategy for the Prevention and Control of HIV/AIDS 2010-2014, with emphasis on preventing possible outbreaks of epidemics amongst risk groups such as homosexuals, injecting drug users, sex workers, etc. *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-disaggregated data collected by the MoH, their quantity and quality is insufficient to support the drafting health policies, planning budgeting programs and interventions related to women's health.
15. The first National Strategy on Securing Contraceptives 2003-2010<sup>26</sup>, which aims, in the main, to achieve independence in the provision of modern contraceptives by 2010, has been replaced by the second National Strategy on Securing Contraceptives, which covers the period 2012-2016<sup>27</sup>. This strategy aims to improve the access and the quality of family planning services and reproductive health, to increase the use of modern family planning methods, to reduce the number of abortions and to improve the health of mothers and children in Albania. According to this Strategy, providing national coverage to meet the needs for contraceptives includes two phases: the first phase (2012-2013) provides free provision of the full range of modern contraceptives to the entire population in need, through the public health service, and the second stage (2014-2016) provides free delivery of modern contraceptives only to the most vulnerable groups of the population. The second phase of the Strategy was considered premature for the

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23 Council Directive 2000/43/CE.

24 <http://www.shendetesia.gov.al/al/baza-ligjore/dokumenta-strategjike>

25 [http://www.unicef.org/albania/Action\\_Plan\\_Shqip13.pdf](http://www.unicef.org/albania/Action_Plan_Shqip13.pdf)

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

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

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 the needs for modern contraception<sup>28</sup>.

16. 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. Adoption of guidelines and protocols on the care and nutrition of mothers and children define the best standards of healthcare and practices offered<sup>29</sup>. In the context of improving peri-natal care, the International Protocol to evaluate the quality of care to mothers and new-borns in the maternity ward was adopted for the first time. This is a unified tool to assess the quality of care services for births and new-borns based on the international standards. The National Accreditation and Quality Centre drafted and accredited 15 national clinical protocols on obstetrics and neonatology, as well as 27 clinical protocols on paediatrics. These protocols are based on scientific medical evidence and are tailored to the national context.
17. 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, which is based on international norms and standards and provides standardized information about the effectiveness and use of modern contraceptive methods, as well as advising clients as per their specific needs. The MoH predicts that by the end of 2015 it shall complete the drafting of Family Planning (FP) guidelines and update the FP protocol.
18. In the context of improving the regulatory framework on abortion, in early 2015 a working group was set up to draft guidelines for the termination of pregnancy. Approval of clinical practice guidelines on abortion<sup>30</sup>, developed in collaboration with ACPD, aims to reduce the number of unwanted pregnancies and provision of adequate healthcare for a safe abortion. The guidelines describe: the standard and contemporary methods for performing abortions based on scientific evidence, including for the first time the medical abortion and the procedure for taking drugs for its performance; follow-up and monitoring of women after abortion, and providing information on the use of modern family planning methods.
19. In its endeavours to prevent vertical transmission of HIV, the MoH in cooperation with PHI and supported by UNFPA, has started putting together the Programme for the Prevention of Transmission of HIV from mother to child. Drafting the guidelines for testing pregnant women for some infectious agents such as HIV, syphilis, hepatitis B and measles, and approval for the inclusion in the basic package of PHC services, has marked the first achievement toward meeting the goal.
20. In addition, there are a number of other important laws and bylaws adopted such as Law No. 138/2014 "On Palliative Care in the Republic of Albania"; Order of the Minister of Health on provision of free health care for patients with tumour diseases<sup>31</sup>, including women with tumours of the reproductive system; The National Strategy for cancer control and the Action Plan 2011-2020, setting out concrete steps and activities for each of the main pillars of the national control cancer program (NCCP): 1) primary prevention; avoidance of risk factors; 2) secondary prevention, early detection; 3) tertiary prevention, effective treatment; 4) quaternary prevention, palliative care; and 5) cancer registry based on population.

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

29 Ministry of Health, Order No. 62/18.02.2014 and 157/26.04.2014.

30 Ministry of Health, Order No. 491/11.17.2015, "On the approval of the Clinical Practice Guidelines for safe abortion, information sheets and consent of the patient in hospital for surgical abortion, curettage and medical abortion."

31 Order No. 528, dated 01.10.2013, "On the exemption from the application of fees for medical services provided to patients with tumour diseases and pregnant women"

21. Legislation related to THB has seen some achievements: Law No. 141/2014 has been amended by Law 10383/02.24.2001, "On Compulsory Health Care Insurance in the Republic of Albania" defining compulsory health care for victims of trafficking as economically inactive people and covering the payment contributions from the state budget or other resources defined by DCM No. 762/12.11.2014 on the "Method of Organization and Delivery of Mental Health Care for Persons who are in Residential Care Institutions", enables the victims of trafficking to receive mental health care. Council of Ministers' Decision No. 582/27.07.2011, on the "Approval of Standard Operating Procedures for the Identification and Referral of VT/PVT", serves to identify the victims of trafficking by specially trained professionals (police officers, social workers, work inspectors, physicians, providers support services, etc.). Necessary measures have ensured the obligation to approximate the Council of Europe Convention "On Measures Against Trafficking of Human Beings", ratified by Law No. 9642/20.11.2006. The Strategy for combating trafficking of people and the Action Plan 2014-2020 include obligations for public health workers and ensure the provision of psycho-social, legal, health and adequate support for VT/PVT, as well as their reintegration in the society. The Cooperation Agreement on the Functioning of the National Referral Mechanism for VT/PVT, first signed in 2005, was further expanded with the participation of other members (15.06.2012), such as several ministries, including the Ministry Health and several NPOs.

*Legal problems reported by NPOs interviewed regarding the legal framework:*

22. Focusing on the analysis of the legal framework, NPOs stated that the "laws are almost sufficient, but the problem remains in their implementation". This is the assessment of 10 out of 19 NPOs interviewed. 13 of the 21 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 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.

## **B. Administrative structures at central and local level regarding 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. At the primary level (PHC), these services in urban areas are provided through mother and child clinics, family planning centres and women's centres in maternity wards, while in rural areas they are provided through healthcare centres and ambulatory clinics in villages by family doctors, nurses and midwives/nurses. In secondary health care, reproductive health care services are provided in maternity and paediatric services at district level. Reproductive health care inspectors working within the Public Health Departments in the districts are responsible for the management and monitoring of sexual and reproductive health care services in PHC.
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 Health<sup>32</sup>. Duties and services provided are based on the basic package of PHC services reviewed by the DCM. No. 101/04.02.2015 (following the one adopted in 2008), as per the amendments to Chapters on child health care, women's health care and reproductive health. As provided in the basic package of services, PHC institutions are responsible for offering key services for the prevention and control of diseases and health promotion, including sexual and reproductive health care, prenatal and postnatal maternal and child health, nutrition, growth monitoring, psycho-motor development, as well as child immunization.

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 government<sup>33</sup>. In this program, particular attention is paid to reducing inequalities and increasing the quality of health care services, making substantial changes to financing in order to cover the full cost and reducing the financial burden on citizens, especially those who come from socially excluded groups. Continued protection and improvement of the health of mother and child, *although not treated as a separate component of health reform undertaken*, is considered a priority of the public health care policy. For 2013, the financing of primary health care, by comparison to 2012 increased by 4.4%<sup>34</sup>.
4. During the period covered by this report, 3 new maternity hospitals were certified as "child-friendly hospitals", thus bringing the total number to 9 nationwide. Breastfeeding indicators are already part of the nutritional surveillance of children, drafted by the Institute of Public Health and approved by the Ministry of Health in 2013. During 2011-2012, the maternity wards in 16 districts of the country were equipped with modern medical equipment, which significantly improved their infrastructure and direct impact on improving the health of the mother and child.
5. Based on the findings and specific needs, the medical staff in 6 regional maternity hospitals underwent training on effective antenatal and new-born care. Approved instruments for assessing the quality were used during 2013-2014 in two maternity hospitals of the country and were followed by training of health personnel, and drafting of intervention plans in these institutions<sup>35</sup>.

#### *Institutions collecting statistics on services and logistics information on contraceptives*

6. 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, collecting 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 PF.

#### *The main structures for the implementation of the fight against HIV/AIDS*

7. 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 performance of all activities under approved national policies and standards. The National Program, involving a multidisciplinary team of dedicated doctors, epidemiologists, psychologists and social workers, is the national reference centre in

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32 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", amended.

33 Government Health Program, 2013-2017.

34 Equivalent to 278.6 million ALL. SOROS 2014. Annual Report 2013.

35 As a result of this, Kukes implemented the rooming technique, i.e. putting the baby onto skin to skin contact with the mother immediately after birth, and set up individual maternity rooms. A local protocol was implemented for the hospital as an example on how to adapt national protocols. In Durres, all management steps were improved in relation to normal newborns partogram.

relation to the prevention, diagnosis, counselling and psycho-social support to people living with HIV/AIDS and cooperates closely with the National Reference Laboratory at the Institute of Public Health, which is responsible for the diagnosis of HIV and other STIs. 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.

8. The prevention program is coordinated by the MoH and includes the line ministries<sup>36</sup>. The Inter-Ministerial Committee on HIV/AIDS established in 2003, has given a negligible contribution and been accused of lack of initiative<sup>37</sup>. This structure was replaced by the Country Coordination Mechanism, which was resized in 2012, including representatives from state institutions, NPOs and individuals living with HIV/AIDS and tuberculosis.
9. The biological control and risky behaviours system for vulnerable STI groups intends to implement a second generation surveillance and it 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, provide follow-up on diagnosed cases, assess the size of the most vulnerable groups and monitor the quality of services provided to people living with HIV/AIDS.*

#### *Cancer diagnostics and treatment services*

1. There is only one public centre for the diagnostics and treatment of cancers<sup>38</sup>. Palliative care services are provided by the Oncology Service Centre at home (funded by the state budget), Ryder Albania Organisation, Mary Potter Organisation, and Caritas. The family doctor in PHC offers counselling, breast screening and referral of cases for examination by the specialist.
2. The National Committee for Cancer Control, reorganized in 2011, is the body responsible for the fight against cancer and also runs a national program to control cancer (NCCP). NCCP was aligned in 2011 with the technical expertise and the support from international agencies. This program was developed in accordance with the WHO recommendations for the implementation in stages (also known as the “steps” model) through the identification and implementation of first and foremost, urgent activities that yield the greatest possible benefits<sup>39</sup>. So far the first two stages have been completed: the involvement of main national stakeholders, followed by the international technical agencies and financing institutions.
3. The operation and the regulation of the NCCP’s activity are based on the relevant laws<sup>40</sup>, the National Strategy for Cancer Control and the 10 year Action Plan.
4. The computerization of cancer data began in 2008, and records are received from the University Hospital Centre (UHC) “Mother Teresa”, and data are collected from 36 districts in the country. Cancer observations and risk factors are based on institutional cooperation between the UHC and the PHI. 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.*

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36 Ministry of Justice, Ministry of Interior, Ministry of Education and Science and the Ministry of Labour, Social Affairs and Equal Opportunities (currently MoSWY).

37 WHO Regional Office for Europe (2015). HIV in Albania: A national programme report.

38 National Oncology Service at the University Hospital Centre “Mother Teresa”.

39 Ministry of Health (2011)

40 Laws “On Health Care in the Republic of Albania”; “On Public Health”; “On Compulsory Insurance of Health Care in the Republic of Albania”.

### *Structures associated with the care of VT/PVT*

10. The Inclusion of the Ministry of Health as part of the State Committee against Trafficking of Persons and in the Responsible Authority has enabled a more active involvement of the health sector in the identification and protection of VT/PVT.
11. It is reported that the National Anti-Trafficking Coordinator's Office, was awarded an annual budget for the first time. The National Referral Mechanism has been revived with the establishment of a task force and the intensification of activities for the prevention and awareness. Three mobile units were set up in Tirana, Vloora and Elbasan, resulting in the increased identification of victims and potential victims<sup>41</sup>.

### *Structures related to domestic violence*

12. According to the Decision No. 334/17.02.2011, "On the Mechanism for Coordination the work on the referral of cases of domestic violence and the manner of its functioning procedure", the local government is the main authority for managing the steering committee, the technical interdisciplinary team and appointing the local coordinator. The Municipalities through their structures support cases of domestic violence with economic assistance<sup>42</sup>. 37 municipalities and 23 communes have had their social administrators appointed, the job description of whom includes issues of prevention of domestic violence and treatment of its victims<sup>43</sup>.
13. Provision of *services for perpetrators* thanks to the cooperation of the MoSWY with the Counselling Line for men and boys (an NPO providing services to perpetrators since 2013), have enabled specialized assistance and counselling for abusers through certified consultants certified since September 2014<sup>44</sup>.

## C. The role of NPOs

### *What is revealed by NPOs 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. Some of the services offered by them are awareness campaigns, research, training and few offer medical services for vulnerable groups. There are NPOs that have contributed and continue to contribute to discussions on laws, drafting of protocols, guidelines and training manuals, serving as support to state institutions.
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. STOP AIDS, Action Plus, National Association for the prevention and rehabilitation, and APRAD, implement damage limitation programs for drug users in Tirana. ACPD, NAPH, New Age, FHA and PCEC work with Roma communities in Tirana, Durrës, Elbasan, Lezha, Shkodra, Fier and Vloora. LGBTI associations have begun to organize prevention activities for their community (SGA and ALGA). Association of people living with HIV/AIDS (PLWHA) has been active in addressing and meeting the needs of people affected by HIV/AIDS. Albanian Association of Infectionists has also worked in supporting people living with HIV/AIDS. Involvement of

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41 European Commission (2014). Albania Progress Report.

42 Research Institute Data Centrum (2012). The base study report on domestic violence and the Albanian state police.

43 National Strategy for Gender Equality and Reduction of Gender Based Violence and Domestic Violence, 2011-2015.

44 The Project of Counselling Centre for Women and Girls supported by the IAMAMAN Foundation. For the standardisation of counselling practices, the National Line for Men and Boys cooperates with the Probations Service (for alternative sentencing), the Courts, police and local structures dealing with gender issues for the referral of cases and specialised assistance support of the abusers.

NPOs has been effective in activities organized within the global campaign of the fight against AIDS.

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. Amongst the information and awareness activities of NPOs working in the field of tumours of the reproductive system, is the awareness mass walk in the boulevard of Tirana, organized for the past 5 years by the Albanian Women's Christian Association/YWCA, with the participation of women and girls from all around Albania. These events are preceded by information and awareness activities in the field, providing information about the ways of detecting and preventing breast cancer, along with physical and ultrasound examination of the breast by doctors.
4. *Focus on the capital city*: Several local NPOs such as STOP AIDS, Action Plus, ACPD, ALGA, ACA, etc., mainly covering the protection of reproductive health amongst vulnerable groups, prevention of unplanned pregnancies, reduction of the number of abortions or prevention of STIs, including HIV, are supported by UNFPA in their projects. Their activity is limited mainly in Tirana, and mostly covers urban areas. Among the most active NPOs are ACPD, supported by the International Planned Parenthood Federation, which has provided services in the field of family planning in urban and rural areas of the country for about two decades; ACA - Albania Community Assist, which is supported by UNFPA (2011-2014) in its project to improve access to health services for vulnerable population groups such as the Roma and Egyptian communities, people with disabilities and migrants, internal urban and rural areas in Berat and Kucova, Lezha, Shkodra, Elbasan, Fier, Durrës and Fushë-Krujë. 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 increasing 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, NPOs and state structures*: NPOs report that there is need for improvements in their work, for instance, increased cooperation between organizations working in the health field. 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 are reports on the need to improve the work of NPOs in terms of better cooperation with local authorities and relevant structures. There is an unquestionable need to strengthen the cooperation and the support of NPOs and local communities for the implementation of information and educational activities and changing behaviours regarding contraception in groups at risks. *There is a need for cooperation/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. Greater financial support is needed for NPOs working in the women's health sector. Since 2012 the sector of NPOs working in the field of HIV/AIDS has been in a critical state in terms of funding. Currently there are only two organizations (STOP AIDS and Action Plus), funded mainly by UNFPA and that work with injecting drug users, men who have sex with men, sex workers, and prisoners. Meanwhile the ACA, has been working since 2011 with the Roma and Egyptian communities and vulnerable

women in rural areas.

7. *The need for consultation with NPOs in drafting legislations, policies and plans of action:* There is a need to develop education and advocacy programs, and provide services focusing on women and their rights, as well as all factors/stakeholders that promote/help discrimination of women and their disadvantaged position in the society in general. These programs must have at their foundation sustainable strategies and must be well coordinated with other social stakeholders, the civil society, the community, the media, the government, etc. There should be legal and policy improvements lobbying and advocacy for free access to health services for all women and girls. Medical staff should be trained to fight discrimination against women from vulnerable groups. Consultations should be held with women in the community to find out about their health needs and discriminations they are faced with. Needs should be assessed at country, regional and local level and services should be provided based on the identified needs and specific characteristics of the groups that will use these services.

# 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:* Changes that occurred over the past two decades, among which the demographic transition (in 2014, 12% of the population was over 65 years old), have led to a clear epidemiological transition, with a considerable drop in infectious diseases and a huge increase in chronic diseases. Chronic diseases are reported to be the cause of about 90% of deaths in women, of which heart diseases are the leading cause for 61% of deaths<sup>45</sup>. The level of mortality has fluctuated between 2001-2014, with an average of about 20,000 deaths annually.
2. *Neoplastic diseases:* These diseases takes second place in the total number of diseases. There is evidence of gradual growth in the level of mortality and the load 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 activity<sup>46</sup>.
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 disease load among women, compared with 8.8% in men<sup>47</sup>.
4. *Number of births:* Births have undergone a significant decrease of 32% for the period 2001-2014<sup>48</sup>. Meanwhile, General Fertility Rate has fallen from 2.31 children per women in 2001 to 1.78 - far below the replacement level of 2.1 - in 2014. The highest levels of fertility are seen among women of age groups 25-29 and 20-24, and women in rural areas. The urban-rural difference can be attributed to the greater number of births of younger women in rural areas, compared to urban areas<sup>49</sup>. It was a surprise to see the phenomenon of the continued growth of fertility in adolescents. Fertility at ages under 20 years old has increased from 0.016 in 1989 to 0.018 in 2001 and 0.020 in 2011<sup>50</sup>. *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 (75.5 years

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45 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.

46 Same as 43.

47 Same as 43.

48 INSTAT (2015): Women and men in Albania: From 53,000 births recorded in 2001, about 35,000 births in late 2014.

49 INSTAT (2014): Births to women aged 15-19 living in rural areas are twice as high as those in urban areas (21 vs. 10 births per 1000 women 15-19 years).

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

for males and 79.7 years for females in 2012). 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. *NPOs operating in the field of health, report some of the most important problems facing the Albanian women in the field of health are: a) Prejudices and cultural barriers of women and the society itself prohibits their access to reproductive health services and do not allow women to exercise their rights to services and information, such as those on abortion, contraception, HIV testing and counselling, screenings for tumours of the reproductive system, etc.; b) Limited access to health services mainly for vulnerable groups (Roma women, LGBTI, women living in rural areas, women with disabilities, abused women, etc.). Access to services is related to the geographical distance, the lack of specialized services, lack of necessary infrastructure, the quality of services provided, the unprofessional attitudes and behaviour of the health personnel, biased and discriminatory attitudes from the staff at health centres<sup>51</sup>.*
2. *Women are not aware of the services:* Information on the rights and access to health services is limited. When interviewed ACPD stated that “although family planning services are provided free for insured women, often women and girls do not use this right, but use paid services in the private sector or prefer not to receive these services 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 seem to have little or no knowledge of the health legal framework and their rights to access health services.* All NPOs interviewed report/conclude that women and girls in general, in particular women from vulnerable groups (such as women with disabilities, women living in rural areas, LGBTI, women of the Roma population, etc.), have limited or no knowledge about their health rights and do not know the laws. 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 work on data about the low access to health services by certain groups, such as Roma women, more than half of which are without health insurance cards, while 10% of Roma children are not inoculated. Experts and NPOs interviewed stated that there is a need to provide information without prejudice and without discrimination for all women.
4. *Lack of services that should be provided by the state:* On a PHC level there is a lack of integrated provision of certain services for integrated sexual and reproductive health, as determined in the basic service package approved 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.*

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51 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.

### 3. Health and nutrition for mothers and children

#### *Actual situation and the problems identified by NPOs*

1. *1. Maternal mortality has seen a sustainable drop.* According to official sources, in the last two decades, the level of maternal mortality has halved<sup>52</sup>. This downward trend can be explained by the improvement of socio-economic status and living conditions of the population, and improvements in the quality of health care services. The major causes remain bleeding, infections after birth, pre-eclampsia/eclampsia during pregnancy and unsafe abortion.
2. *2. Infant and child mortality has reduced, but the level is still high by comparison to the region:* In the recent decades, mortality of children under 5 years old decreased gradually (8.9 deaths per 1000 live births in 2013)<sup>53</sup>. In 2013, the infant mortality rate was 13 deaths per 1000 live births (UNICEF 2014). This is one of the highest levels in the region and is much higher compared to the official national reports, according to which this indicator is 7.8 deaths per 1000 live births<sup>54</sup>. Although neonatal mortality has decreased, its share in the infant mortality rate has increased (from 48% in 1990 to 54% in 2013). The main causes of infant mortality are respiratory diseases, peri-natal causes, followed by congenital abnormalities. On the other hand, child mortality fell more than the infant mortality. The main factors contributing to this change are thought to be the reduction of fertility, maternal education, HIV/AIDS, economic, and long-term trends<sup>55</sup>.
3. *3. Physical development and maternal and child nutrition:* The situation of nutrition and physical development of children has gradually improved over the past decade<sup>56</sup>. *Albania, however, still faces the double burden of malnutrition.* Delayed growth 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. *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 abode. 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 educated to higher educational level is associated with a lower mortality in early childhood<sup>57</sup>.
5. *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 Albania<sup>58</sup>.
6. *6. Lack of periodic demographic and 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, many of the specific reproductive health data covering these years make it difficult to evaluate the current situation and interventions in this field.

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

53 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).

54 INSTAT (2014):

55 Wang H. and co-author (2014). Global, regional, and national levels of neonatal, infant, and under 5 mortality during 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet* 384:957-79.

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

57 PHI (2014). National Health Report.

58 PHI (2014). National Health Report.

7. *Access to health care appears varied for pregnant women and small children:* More than 99% of pregnant women give birth in the presence of qualified medical staff. The majority of them (97%) have made at least one prenatal visit, while 67% have made at least four visits. In 2013, total vaccination coverage was 98% for measles, DTP3, HepB3 and Hib3. In the same period, 83% of new-borns underwent a postnatal visit within two days after birth<sup>59</sup>.

## 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. Lack of integrated services results in critical health gaps that limit the effectiveness of programs to SRH and compromise human health and fuel the stigma and discrimination against vulnerable groups. For instance, women in rural areas, but also other vulnerable groups, lack the information and have limited access to sexual health services and reproductive health.
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 "pulling out method" (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%)*<sup>60</sup>.
4. *Covering the needs:* Family planning services are part of the health services package and modern contraceptive methods are offered free to the public health services at subsidized prices through social marketing, but at market prices for the private pharmaceutical network and the non-traditional sales outlets. *The public sector is the main source of supplying modern contraceptives, followed by the private pharmaceutical sector at about 39%.* The public sector and social marketing is believed to cover the needs of middle and low income groups, while the private market covers those on higher incomes. The only program of social marketing in the country is facing many difficulties, such as finding financial resources for its continuity and securing contraceptives to supply - on the main - the market with emergency contraception.
5. *Distribution of modern methods of contraceptive* is regulated by the directive of the MoH, whereby the public sector provides tablets, injections, Intrauterine Devices and condoms. Methods that require a more specialized service, such as intrauterine devices and female sterilization, are only offered at centres with obstetricians and gynaecologists.
6. *Knowledge about contraception and their use:* Knowledge on contraception is almost complete and in general women, especially married women, have more knowledge and information than men about these methods<sup>61</sup>. However, the use of modern contraceptive methods of 11% is considered as one of the lowest in Europe<sup>62</sup>. About 59% of women aged 15-49 use the natural method

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59 Same as 56

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

61 PHI (2012).

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

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%.

7. *Factors influencing the behaviour on family planning* are age, marital status, level of education, abode, number of children, information on family planning and the time needed to reach the health centre<sup>63</sup>. 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 is associated with the increased use of contraceptive methods.
8. *Unmet needs for family planning* (mainly counselling) are estimated at an average of 13% for the period 2006 to 2012<sup>64</sup>. The greatest 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.
9. *Modern contraception coverage*: The National Information and Logistics Management System at PHI collects statistics on FP services and information on contraceptive logistics. Data from this system enable the MoH to estimate national needs for modern contraceptives, to monitor the national family planning program and the extent of their use nationwide. One positive achievement is undoubtedly the provision of the public sector by the Albanian Government from 2010 onwards with modern contraceptives, independent of donor support. In addition, the MoH<sup>65</sup> Order No. 570/21.11.2014 changed the stipulations for the second phase relating to the provision of contraceptives. Between 2014-2016 they will be 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.

## 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. More than 431 health facilities nationwide, including hospitals, polyclinics, health centres and several village clinics, provide information and counselling on FP and offer free modern contraceptives like the pill, condoms and injections. Since 2009, intrauterine devices have been offered not only in maternity hospitals, but also in health centres by obstetricians and gynaecologists professionals trained in programs supported by international donors (USAID). Female sterilization is provided free of charge 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 organizations<sup>66</sup> who focus on improving the structure, the service quality and increasing demand for the use of

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

64 PHI. National Health Report, 2014

65 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".

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

modern contraceptive methods<sup>67</sup>. The successful cooperation between the MoH, the Institute of Public Health and partners like UNFPA has provided support for various projects and strategies in the field of reproductive health and family planning.

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 services sensitive to PF and bringing them closer to the population. 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 such as 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 2013<sup>68</sup>. Abortion remains an urban phenomenon<sup>69</sup>, 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 abortions<sup>70</sup>.
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 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 2013<sup>71</sup>. PHI claims that it has reason to doubt the validity of this growth 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 efficiencies 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 in Tirana (the capital and largest city in the country) and Lezha, reports that “*medical*

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67 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).

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

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

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

71 Same as 68.

*personnel was acting within the legal framework.* The information and treatment of patient seemed standardised and the same for both institutions, ranging from a preliminary visit to become a mother, and then proceeding with having consultations, giving the necessary information regarding risks during or after the abortion, benefits of pregnancy, family law, etc.”. Monitors noticed that abortion by married women 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 *Misoprostol* is widely used, which is not registered by the National Drug Control for this purpose, but is easily found in pharmacies or private clinics<sup>72</sup>. 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*: Expert researchers explain that Albania is part of those countries where the selection of the sex prior to birth has spread fast after the lowering of the fertility rate<sup>73</sup>. 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 his ACPD, in collaboration with partner organizations and institutions, with the support of UNFPA, has planned a number of activities and awareness of the population about the existence of the phenomenon and its consequences, based on a communication strategy and Action Plan (2015-2017) which shall be piloted in Tirana, Lezha, Dibra, Kukës and Fier.
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 too<sup>74</sup>. In a cooperation with INSTAT, the new abortion form has been prepared along with the guidelines for data reporting from all public and private health services. The computer program allows the entry of data on abortions and the electronic reporting of the information is done every 3 months. *However, only 13 districts can report electronically. Problems are failure to report in time by all districts and the quality of reporting, raising the need to revise the program and continuously train 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 doubled<sup>75</sup>. 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.

<sup>72</sup> [http://www.respond-project.org/pages/files/6\\_pubs/research-reports/Study12-Albania-Report-July2013-FINAL.pdf](http://www.respond-project.org/pages/files/6_pubs/research-reports/Study12-Albania-Report-July2013-FINAL.pdf)

<sup>73</sup> World Vision, UNFPA (2012). Unbalanced ratio of births between sexes in Albania.

<sup>74</sup> INSTAT (2012): Abortion surveillance system in Albania.

<sup>75</sup> PHI (2013). HIV/AIDS in Albania (1993-2013)

2. *The distribution by sex, age and transmission group:* The HIV epidemic is concentrated in the capital, Tirana. The male-female ratio at diognostication is 2:1. About 2/3 of those infected belong to the age group 25-45 years. The main route of transmission is the heterosexual way(83%), followed by the homosexual way (10%) and vertical transmission from mother to child (3.4%). Three quarters of new cases are diagnosed in the late stage of infection, leading to an increase in the percentage of deaths.
3. *Knowledge by age group:* 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 transmission of HIV/AIDS is higher among women than men (28% versus 20%).
4. *Voluntary testing of women remains at very low levels.* Testing for the HIV infection is done in voluntary testing centres, “recommended” by health professionals. Testing is required 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 population<sup>76</sup>. 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 the centres of voluntary counselling and testing under the MoH in 12 prefectures nationwide and include voluntary testing, and counselling before and after testing. Counselling for pregnant mothers is provided at the FP medical centres and maternity hospitals. Treatment and care for people with HIV/AIDS is available at the UHC, in the infectious diseases and paediatrics wards. Medical care services provided to those affected include anti-retroviral therapy (ARV), diagnosis and management of infections and other associated diseases, as well as psycho-social 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 identification and 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 latter stages, creating large gaps 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 measuring and 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.

<sup>76</sup> PHI (2011). The study of biological control of behaviour.

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 from financial obligations to these services, 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 positive 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 users<sup>77</sup>. 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.<sup>78</sup>. 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, whom 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 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 LGBTI young 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

<sup>77</sup> 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].

<sup>78</sup> PHI (2013). BIO-BSS. Final Report.

infected with HIV/AIDS. Centres have been set up for voluntary counselling and testing for HIV/AIDS 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.<sup>79</sup>.

#### *Problems identified by NPOs about vulnerable groups*

1. *The figures of voluntary testing remain 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 support<sup>80</sup>.
4. *Psychosocial support services for people infected with HIV 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*

1. *Some of the achievements are:* adoption by the Council of Ministers of the fund to purchase a linear accelerator, which will provide a contemporary treatment and less risk for patients with tumour disease; operation and management by IPH of two mobile mammography devices to support the program of breast cancer screening in areas and population groups with low access to health services; provision of financial support from the UNFPA program for early detection of cervical cancer.
2. *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 Albania<sup>81</sup>. The number of women affected has grown every year. In addition, there is a trend of younger women being affected by these diseases. This concerning situation is confirmed too by the data from international sources. In 2012 in Albania, the incidence (per 100,000 cases) and mortality (deaths per 100,000) for breast cancer was estimated to have been 69.4 and 21.8, and for cancer of the cervix, respectively 6.2 and 2.4.<sup>82</sup>
3. *Incomplete registration of cases:* Meanwhile, the incidence of (registered) breast cancer and cervical

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

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

81 Ministry of Health (2014).

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

cancer in Albania is lower than in other European countries.<sup>83</sup> It is believed this is because of problems related to incomplete registration by the oncology service not mirroring the factual situation.

4. Awareness about preventive practices such as smear tests and mammograms, are reported respectively at 49% and 77%.<sup>84</sup> According to NPOs, 75% of women affected by breast cancer and more than half of cervical cancer cases diagnosed are at an advanced stage of the disease.<sup>85</sup>
5. *Prevention identifies certain problems* such as: 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 only performed by specialists in the maternity ward, and cytological examination is offered only at UHC and specialized private clinics; lack of a national registry of tumours, 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 women<sup>86</sup>. INSTAT<sup>87</sup> 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). It showed that 53.7% of women were “currently” facing domestic violence. Compared to 2014, reported cases of domestic violence have increased by 30%; and there is a 12% rise in the cases of domestic violence ending in deaths. For as long as sexual violence will continue to be a taboo, (police) reporting statistics will not change, therefore the analysis of the phenomenon, its causes, consequences and effectiveness of the implementation of planned measures should be extended.
2. *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.* Of the 94 cases recorded in 2005, only for the period from January to September 2015, this number is about 3,000 cases. There is a significant increase in the identification of these cases, especially after the amendments made to the Criminal Code in 2012 and 2013, where domestic violence is considered a crime and punished like any other crime. In 2014, there was an increase of about 30% of recorded cases and an increase of more than 35% of the number of requests and lawsuits filed for EPO/EP<sup>88</sup>.
3. *Forms of violence and overlapping of health problems:* 23.7% of women 18 to 55 years ((N = 646.879), have experienced physical violence in a marriage/relationship “during their life”, and 14.7% experience physical violence “currently” (within the 12 months preceding the interview). 58.2% of women have experienced physical violence in their marriage/intimate relationships “during their life”, and 52.8% of women are “currently” experiencing psychological violence (within 12 months prior to the interview). 7.9% of women aged 18 to 55 said they had experienced sexual violence “during their life” in a marriage/intimate relationship, and 5% were “currently” experiencing sexual violence (within 12 months prior to the interview)<sup>89</sup>. Injuries and bruises caused by physical violence of battered women are real, and women often try to cover and hide

83 PHI (2014). National Health Report.

84 PHI (2012).

85 Albanian Women's Christian Association/YWCA

86 INSTAT (2015): Women and men in Albania: The number of women affected by the criminal offence of Domestic Violence in 2014 was 3,090. In 2014, there was a huge gap between men and women victims of sexual crimes, where 90.8% of the victims were women and 9.2% were men. In relation to minors (under 18) victim of sexual crimes, both women and men are victims of sexual violence, while adults (over 18) are victims as sexual violence and sexual exploitation.

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

88 Alimadhi, S (2015). Representative of the Ministry of Interior. 8 October 2015.

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

the physical signs of injury because they are ashamed. However, physical abuse and physical injuries related to it often overlap and lead to other short and long-term physical health problems for women. In rural areas and regions, where the emergency medical services either do not exist or are not available immediately, abused women are more at risk of permanent injuries and disability, or even lose their lives from their injuries.<sup>90</sup>

4. *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. Most abused women in Albania continue to suffer in silence despite continuing efforts to increase public awareness on domestic violence issues and legislative and social services recently created for victims of domestic violence. Thus, abused women are not receiving protection, support services and access to justice, which is their legal and a human right. Most “lifelong” and “currently” abused women who sought help, did so from their families (respectively 91.8% and 89.5%) and/or the family of the spouse/partner (respectively 60.9% and 58.7%). A large number of “lifelong” and “currently” abused women have also sought help from friends (respectively 29.0% and 27.5%). Only a small percentage of “lifelong” and “currently” abuse women have sought help from a doctor/healthcare employee (respectively 14.8% and 15.6%), police (respectively 16.8% and 14.1%), lawyer (respectively 14.8% and 7.8%), or the court (respectively 11.2% and 6.2%)<sup>91</sup>. The main problem that women and girls - victims of domestic violence - face today is related to home ownership issues. 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<sup>92</sup>.
5. In parallel with the work of NPOs that provide counselling services for different vulnerable groups, it is necessary to extend the work and establish a national advisory service to address violence against women.
6. *Accommodation at the National Centre for the Treatment of Victims of Domestic Violence* started on 25.04.2011. It shows that: a) for 2011-2012<sup>93</sup>, 63 beneficiaries were accommodated, of whom 25 women and 39 children<sup>94</sup>; b) for the year 2012-2013, 63 beneficiaries were accommodated, of whom 34 women and 28 children<sup>95</sup>. The age of abused women accommodated at the centre ranges from 19 years to 51 years, and the majority are women from rural with a ratio of 70% - 30%.
7. *Increasing the knowledge of health personnel and the community*: The PHI in cooperation with the Department of Public Health in 10 districts of Albania has organized health promotion activities with the staff, community and schools to increase awareness of domestic violence against women and children<sup>96</sup>. Findings from the national intervention evaluation of health personnel capacity building to address gender-based violence, shows that: GBV training received has significantly improved the capacity (knowledge, attitudes and practices) of service providers; the training as an innovation in content and in the organization, has laid the foundations of GBV services in primary health care<sup>97</sup>.

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90 Haarr, R.N. & M. Dhamo (2009). Domestic violence in Albania: National population-based survey. Tirana, Albania: UNDP.

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

92 Given the need for counselling, shelter, legal aid, social services, and relevant information on the rights of women victims of domestic violence, the Counselling Line for Women and Girls in the coming year will start to provide 24-hours assistance to this category of vulnerable women and girls.

93 MoSWY (2014): Specifically for the period 08.07.2011-20.11.2012

94 Of which 3 are children unaccompanied by the mother.

95 MoSWY (2014):

96 Ministry of Health (2014).

97 Assessment “Building the capacity of health personnel to address gender-based violence”, dated 17.04.2014, organized by UNFPA, the National Centre for Social Studies, in cooperation with the Ministry of Health.

8. *Failure to report cases of violence by health employees:* No cases of domestic violence are reported by the healthcare staff<sup>98</sup>. 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. NPOs claim that doctors do not report cases of domestic violence and in addition very few complete victim forms. Although the legal framework for domestic violence is complete and training has been organized by the Ministry of Health and various non-profit organizations, the health centres continue the non-performance of their obligations under the law or bylaws. The monitoring of protection orders/immediate protection issued during 2014 by the District Court of Tirana, show that there were no written healthcare reports issued by health institutions submitted before the court<sup>99</sup>. One of the doctors interviewed during the evaluation<sup>100</sup> stated: *“There is no reason for us as doctors to deal with the [domestic] violence. It is it our duty, and has not been required of us. This should be done by the police and psychologists. These women do not come to us and tell us about the violence, and this shows that we are not suitable.*
9. *Shortfalls associated with the psychosocial service:* The Ministry of Health Order No. 410/12.07.2010 has stimulated the reorganization of health and psychosocial services to provide assistance at any time for persons subjected to domestic violence. Practice shows a timely provision of first aid, but there is a lack of psychosocial services at health centres.
10. *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 %). In addition, sexually abused women (47.0%) were twice as likely to say their husband/partner knew when they used contraceptives, compared to women who were not sexually abused (21.2%). 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.<sup>101</sup>
11. *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. Most women who sought help from medical and/or legal services about domestic violence, paid less than 100 ALL (<1 USD). A large number of women who sought help from doctors and lawyers paid 100 to 1,000 ALL (1-10 USD), and 18.7% of victims of domestic violence who had sought

### Specific case referred by Vatra Psychosocial Centre

5. from a southern Albania town was physically abused by her husband, she had cuts in the eyebrow and broken teeth. The woman was taken by her mother to the district hospital for medical assistance. She said: “I have nowhere to go, my father does not accept me home, and my mother does not have the power to convince him to accept me”. The duty doctor having treated her, told her to go to the police and seek protection...

In this case, the doctor just carried out the treatment and told her to go to the police. Pursuant to the Law “On measures against domestic violence”, the duty doctor could have informed the woman of her right to receive PO/EPO, and along with her, draft the request for an EPO and lodge it with the Court District. Likewise, the doctor himself could have cooperated with the victim to seek the assistance of law enforcements, and ensure that the woman was accommodated in a safe place, at the nearest shelter until the EPO would be issued, or longer depending on the particular situation.

98 Same as 100.

99 Human Rights in Democracy Centre (2014) Monitoring Report of the Tirana District Court for the period January to December 2014.

100 Same as 100.

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

help from judges and 21.3% who had sought help from lawyers paid 11,000 to 30,000 ALL (11-30 USD). 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.<sup>102</sup>

12. *Statistics*: Central and local authorities, have a legal obligation to collect data on domestic violence and gender-based violence. MoSWY has taken a number of concrete steps in connection with the cases treated at the local level, by assigning local coordinators (where applicable) to deal with this task. In addition, a request has been made to collect periodic data by line ministries. In order to collect accurate data, starting from 2013, MoSWY in cooperation with UNDP is working on an on-line system for the collection of domestic violence data, dealt with at the local level by the Referral Mechanisms. The system is set up and some local coordinators have been trained. The functioning of this system is a short-term priority of the MoSWY.
9. *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.
10. *Raising public awareness*<sup>103</sup> still needs improvement. The One UN Programme 2012-2016 has played an important role. The National Action Plan for Engaging Men and Boys as Partners of Women and Girls for Gender Equality and Prevention of Gender Based Violence and Domestic Violence (for the period 2014-2019) is a milestone in this regard<sup>104</sup>. 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.
11. *There is a lack of a functioning and well-coordinated system for the prevention, treatment and reintegration of domestic violence cases*. This has often caused unjust resolutions to situations, by accentuating further gender inequality. It can often be seen that people experiencing domestic violence do not have confidence in the state institutions<sup>105</sup>. Specific sectors focused on domestic violence set up by local government under various departments (the Department of Social Services, Department of Economic Assistance, the Department of Culture and Sport) based on the internal organization of each municipality, only have one expert who deals with domestic violence and gender equality. Until the local elections in May 2011<sup>106</sup>, only 14 municipalities (out of 65) had appointed violence/gender equality experts. The contributions of these experts are not always taken into consideration by the Local Government Units. 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:*

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

103 DCM. 404/13.05.2015 “On approval of the plan for the European integration” 2015-2020.

104 A very important policy document was drafted in 2013 by MoSWY in collaboration with UN Women, UNDP and UNFPA. It stipulates concrete actions for the creation of a national youth movement for gender equality; capacity building of professionals and community leaders to address issues of gender equality and domestic violence, education of families and citizens as drivers of change, etc.

105 According to the National Survey on Domestic Violence 2013 (p. 55-56): “Abused women are often reluctant to seek help on domestic violence. Only 8.4% of women who had experienced “lifelong” domestic violence, and 7.1% of those who are “currently” experiencing domestic violence had ever sought help for violence in a marriage/intimate relationship. These figures shows that the majority of abused women in Albania continue to suffer in silence, despite constant efforts to raise public awareness on domestic violence issues and the legislative and social services recently established for victims of domestic violence”: <http://www.instat.gov.al/en/publications/books/2013/domestic-violence-in-albania-2013.aspx>

106 UN Albania, 2012. Gender equality and local government.

A representative of the civil society in Kukës reports that there is still no clear understanding of the phenomenon of trafficking and several member institutions of the Regional Anti-Trafficking Committee (RAC), associate trafficking with only one type of exploitation, that for sexual purposes. Moreover, police or Social Services do not consider domestic trafficking as a phenomenon that exists in Albania. Thus, cases that can be identified as VT/PVT inside the country, or who may have been exploited in other ways, are not included in technical anti-trafficking discussion.

*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”<sup>107</sup>. When victims of domestic violence, - upon reporting the violence - cannot return to their houses due to fearing for their life, the police struggles to find temporary housing for them. Even with the improvements made by the DCM, there are still problems due to the limited capacity, or other problems.*

12. *Services not covering the full geographical extent and not with the same quality:* Despite the positive model of the National Centre for victims of domestic violence, as well as the state cooperation with NPOs that provide shelters, the availability of support services for women victims of GBV and DV is not the same in the entire country and not for all victims of GBV. 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 support services<sup>108</sup>.
13. Based on the data collected<sup>109</sup> 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

According to the CEDAW Committee concluding observations of 2010 ‘CO/29 “Victims of trafficking suffering from serious health problems, including post-traumatic stress disorder, must have access to adequate healthcare.”

*The actual situation and the problems identified by NPOs*

1. *The progression of people trafficking:* Data from the strategy against people trafficking for 2014-20 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

<sup>107</sup> 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.

<sup>108</sup> Women centres that support in particular survivors of domestic violence or victims of trafficking have been set up in Tirana, Shkodra, Pogradec, Elbasan, Durrës, Berat, Vlora, Gjirokastra and Kukes. Source: 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.

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

<sup>109</sup> Council of Europe and UN Women (2015). Albania final report: Mapping support services against violence towards women and girls.

trafficked for sexual exploitation and/or begging. During 2014, 125 VT/PVT were identified and assisted, compared to 95 in 2013, with 63 adult against 52 in 2013; 62 children against 43 in 2013<sup>110</sup>. Proactive mobile units, set up in 2013 have identified more cases. Only during the period June 2013 - July 2014, these mobile units identified 85 PVT, a figure close to the total number of VT/PVT identified during 2011-2013.

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 deceitful marriages, work, and a new trend observed recently, recruiting via social networks, like Facebook<sup>111</sup>. The case law to date has identified these recruitment methods<sup>112</sup>.
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 Kosovo<sup>113</sup>.
4. *The national referral mechanism of people trafficking has improved* and coordination of the relevant authorities and stakeholders involved locally<sup>114</sup> has increased, but there is still much room for improvement. According to a representative of a civil society organization in Durrës, “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”. Similarly, members of the civil society in Shkodra, report that RAC annual action plan does not contain detailed actions relating to the relevant budget in connection to the provision of assistance for victims as well as prevention activities undertaken by these units<sup>115</sup>. According to civil society organizations in Durrës, Shkodra, Lezha and Kukës, these [discussion] tables have not been effective. They are focused mainly on descriptive reports rather than case management. 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. Government institutions should be more active in finding solutions, and not just focus on bureaucratic solution, or exchange reports and information<sup>116</sup>. Representatives of the Red Cross and World Vision in Lezha, - members of the Anti-Trafficking Technical Roundtable (ATTR) -, report that, despite some members who show goodwill, direct assistance for VT/PVT is really low. In Lezha, civil society organizations are very active in this area as the focus of these organizations covers various social fields. Their main assistance consists of sporadic humanitarian services, provided when requested by ATTR<sup>117</sup>.
5. *Provision of VTs with Health Cards and free healthcare*: Over 120 victims of trafficking in the country have been provided with health cards, which has enabled all those with a VT status to attend health centres or hospitals and get free healthcare service<sup>118</sup>.
6. *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

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110 Report on the implementation of the strategy for combating people trafficking and Action Plan 2014 - 2017, from January to December 2014.

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

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

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

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

115 Caritas Albania (2015). Baseline final report.

116 Same as 118

117 Same as 118

118 <http://www.punetebrendshme.gov.al/k-k-a-t/aktivitete-te-njesise-antitrafik/karta-shendetesore-falas-per-viktimat-e-trafikimit>

services, long-term rehabilitation and reintegration of VTs/ PVTs. There are four shelters (three private ones) for VTs/PVTs. They offer multi-disciplinary services like housing, psychosocial counselling and legal representation in courts, treatment of health needs, vocational training, etc., for local or foreign victims, children or adults, male or female. These are: the “National Reception Centre for Victims of Trafficking” (NRCpublic centre), “Different and Equal” (Tirana), “Another Vision” (Elbasan) and “Hearth” (Vlora). NPOs continued to mediate health services for VT/PMT during 2014. Beneficiaries were supported by being accompanied to specialist doctors for health visits, purchasing medicines as prescribed by doctors, and support during admissions into hospitals. STIs, HIV/AIDS tests were also carried out. They were assisted and supported with medications for mental health problems during their stay in the shelter<sup>119</sup>. Some of the cases are supported while undergoing routine medical tests. Pregnant women are supported with proper medical assistance necessary during this period. Organisations working with VT/PVT that have cooperated with the “Population and Development Centre” that offers medical services such as: counselling, HIV/AIDS and STI testing, gynaecological examinations. In addition, the centre has worked together with the *Albanian University, School of Dentistry* to secure free dental services to beneficiaries of the program, the “Community Mental Health Centre No. 2” and the PHI<sup>120</sup>.

7. *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 problems. Organizations also report cases where *VT have been refused service from the psychiatric institution*. Cases with mental health problems, in particular those with schizophrenia, often become a risk to other beneficiaries or the shelter staff, making the need for more specialized treatment imminent. In addition, adequate sanitation conditions are still far from the standards. This is a concern as interviews by police investigators take place in only one purpose built room, which lacks sanitation services, and VT/PVT have to stay in these conditions at times, for long hours. Apparently, funds allocated are insufficient or absent.<sup>121</sup>

## 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%)<sup>122</sup>.

119 Report on the implementation of the strategy for combating people trafficking and Action Plan 2014 - 2017, from January to December 2014.

120 Report on the implementation of the strategy for combating people trafficking and Action Plan 2014 - 2017, January-December 2014.

121 Interviews conducted by Caritas with four victims of trafficking in 2015, who were originally from Kukes, Lezha, Shkodra and Durres, found that none of them was aware of their rights as VT or the interviewing and referral procedures. Any police action was taken for granted and no explanation was given for the consecutive action. The four cases state that they were taken to police stations and kept for long hours, from 6 to 12 and there was no basic provisions (food, personal hygiene items, etc.). Reception conditions were not good, and in most cases they were forced to sit on a chair. In three cases, the police did not introduce themselves to the victim, and there were police officers who entered and left the room, making them feel uncomfortable. With the exception of one case where the victim reported that she felt insulted by the police, three other cases claim that the police conduct was within the norms required. In all cases, a female police was present during the interview and the referral.

122 PHI (2014). National Health Report.

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 barriers<sup>123</sup> 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. Challenges are related to the provision of healthcare services and the pressure on the services from the general population. The physical infrastructure is lacking, therefore it presents a significant problem to rural women and their communities. Because of the lack of investment, a significant proportion of health facilities, mainly in rural areas and especially in remote rural areas of the country, leave much to be desired, e.g. access to social services, health and medical services, security services, action lines, etc.
6. *There is a distinct lack of information on risks, health care and services offered*. The low level of information impacts on the delayed finding and diagnostication; 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 traumas<sup>124</sup>.
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 most<sup>125</sup>.
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<sup>126</sup>. Documents show that about 80% of men and 80% of women from rural areas say they have no health insurance at all<sup>127</sup>.

## 13. Women with disabilities

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

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

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

126 Women centres that support mainly survivors of domestic violence or victims of trafficking are set up in Tirana, Shkodra, Pogradec, Elbasan, Durres, Berat, Vlora, Gjirokastra and Kukës. Source: 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.

[www.un.org.al/editorfiles/file/Roadmap%20%20Costing%20of%20the%20coe%20Convention.pdf](http://www.un.org.al/editorfiles/file/Roadmap%20%20Costing%20of%20the%20coe%20Convention.pdf)

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

*A global and regional problem:* The Council of Europe warns that “the rate of abuse and violence committed against persons with disabilities is considerably higher than the rate for general population, and higher in women with disabilities, particularly women with severe disabilities, where the percentages of abuse far exceed those of non-disabled women”<sup>128</sup>.

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

1. *Disabled people (DP) have limited access to most health services, therefore their needs for service and health care remain unmet.*<sup>129</sup> 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 population<sup>130</sup>.
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. In addition, women with disabilities may be reluctant to report abuse if they are dependent on the abuser, who is their carer.
3. There are huge gaps in policies and the legislation in relation to women with disabilities<sup>131</sup>. NPOs point out that although there have been efforts to improve the legislation, and harmonise it with the CRPD, CEDAW and other relevant recommendations, 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. The rights of women and girls with disabilities are protected by the Albanian Legal Framework under the general term of “women and girls”, while persons with disabilities benefit specific support as a special category. The legislation and the regulating by-laws on special conditions and specifics for this category are insufficient. The Albanian Helsinki Committee, states “*Work is slow for the implementation of standards determined by the Convention “On the Rights of Persons with Disabilities” to guarantee in practice the rights of persons with disabilities, including “... delays of payments this community is entitled to. In particular in remote areas of the country there are problems with the education of these citizens, the provision of medical and rehabilitation services for them, employment etc.*”<sup>132</sup>.
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 bylaws<sup>133</sup>.
5. One of the most pressing issues for health centres, requiring serious and fast investment, is the reasonable adjustments for patients with disabilities<sup>134</sup>. The implementation of the new framework requires substantial improvements in infrastructure and equal access to services, and this was underlined by the European Commission Progress Report on Albania in 2014.

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128 Council of Europe. Action Plan to promote the rights and full participation of people with disabilities in society: Improving the Quality of Life for People with Disabilities in Europe, 2006-2015, Line of action No. 13: Protection against violence and abuse, p. 27, in: [http://www.coe.int/t/e/social\\_cohesion/soc-sp/Rec\\_2006\\_5%20Disability%20Action%20Plan.pdf](http://www.coe.int/t/e/social_cohesion/soc-sp/Rec_2006_5%20Disability%20Action%20Plan.pdf)

129 [http://www.ishp.gov.al/multimedia/Kalendari\\_2013/Dita%20Boterore%20%20e%20Personave%20me%20Aftesi%20te%20Kufizuar.pdf](http://www.ishp.gov.al/multimedia/Kalendari_2013/Dita%20Boterore%20%20e%20Personave%20me%20Aftesi%20te%20Kufizuar.pdf)

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

131 ADRF (2010). “Women with disabilities in Albania, included or forgotten?”

132 Albanian Helsinki Committee (2014) Report on the situation of human rights in Albania in 2014.

133 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.

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

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. Equality between disabled men and women, is one of the basic principles on which this document has been drafted. 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.
9. *There is a lack of health information in formats appropriate for blind women, and access to adapted websites is non-existent.*

## 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, with 34% of this population younger than 15 years old (Egyptians 27% and Albanians 20%)<sup>135</sup>.
2. *More diseases:* Chronic diseases such as cardio-vascular diseases, rheumatism, diabetes and neurological and psychiatric diseases are significantly common among the Roma<sup>136</sup> population, based on the empirical data. Roma women are more 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 disabilities<sup>137</sup>. Besides the socio-economic and cultural factors, this situation is largely due to inadequate access to health care, related in particular to the quality and financial non-affordability of health care services<sup>138</sup>.
3. *Discrimination of the Roma population is relatively high:* According to reports, there is discrimination while using health care services. 43%<sup>139</sup> of the Roma respondents feel openly discriminated by health care providers<sup>140</sup>. Their concerns relate not only to bribing doctors or nurses, but also in numerous examples, to direct or indirect discrimination related to inappropriate treatment by health care providers, communication barriers, and violation of rights to health care. All of these factors make the health system and healthcare centres unfriendly places for them.
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. The same study states, 37% of Roma and 20% of Egyptians say they do not know where to get health cards and are not aware of the procedures<sup>141</sup>.

<sup>135</sup> INSTAT (2015): Roma and Egyptians in Albania: Socio-demographic profile and economic development based on the 2011 Census.

<sup>136</sup> UNDP (2012). Needs assessment study on Roma and Egyptian communities in Albania.

<sup>137</sup> Same as 138.

<sup>138</sup> RAA (2013). Civil Society Monitoring of the Implementation of the National Strategy and Action Plan of the Decade in 2012 in Albania.

<sup>139</sup> INSTAT (2015): Roma and Egyptians in Albania: Socio-demographic profile and economic development, based on the 2011 Census.

<sup>140</sup> Same as 137.

<sup>141</sup> UNDP (2014). Needs assessment study on Roma and Egyptian communities in Albania.

5. *Contraceptives*: The majority has no knowledge on reproductive health<sup>142</sup>, pregnancy, childbirth and childcare. In 2011, the number of Roma and Egyptian individuals using contraceptives doubled (23% to 20% Roma and Egyptians), compared to 2003<sup>143</sup>. Knowledge on contraception received by the Roma and Egyptian girls is mainly from informal sources. Data shows that 85% of Roma and 80% of Egyptian girls obtain this information from “female relatives”, while around 10% of Roma and 11% of Egyptian girls learn about it from their female friends<sup>144</sup>.
6. *Health of pregnant women*: The number of medical examinations during pregnancy or after birth is lower than the one recommended. About 12% of Roma women aged 15 to 30 years, do not undergo any medical visit during pregnancy, while 35% undergo up to three visits. The same thing happens after birth. Data shows that 51% of Roma mothers and 25.8% of Egyptian mothers undergo no afterbirth checks at all<sup>145</sup>. Consequently, many Roma and Egyptian women are affected by various infections. According to the data collected, 19.2% of Roma and 10.9% of Egyptian respondents lost a child after birth. One of the reasons, along with socio-economic factors, is scarce health care.
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 more<sup>146</sup>.
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. 40% of Roma mothers and 19% of Egyptian mothers aged 13-40 years old, have become mothers aged 13 to 16 years, while still being just children. 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. Many of them do not use health services because they are not aware that they and their children’s health require medical treatment<sup>147</sup>.
10. *Lack of data*: There is still a lack of comprehensive data in Albania regarding Roma and Egyptians women’s health and child mortality. It is difficult to find official data on the health status of the Roma community.
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. Roma and Egyptians are among the most vulnerable subgroups in terms of health. This is mainly due to malnutrition, poor living conditions, and lack of prenatal and preventative health care, low educational level, marriages and births at a very young age.
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

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142 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.

143 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.

144 UNDP (2014). Needs assessment study on Roma and Egyptian communities in Albania.

145 Same as 142.

146 Same as 142.

147 UNDP (2014). Needs assessment study of Roma and Egyptian communities in Albania.

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.

13. *Physical and cultural distances to health services* tend to be greater for Roma, due to their locations and there is a lack of services in the neighbourhoods where they are concentrated. Physical distance is made worse by the cultural distance and the idea of negative interactions with the health services, and the fear of discrimination.
14. *Costs and corruption*: Although health costs can be covered when using health cards, informal payments due to corruption increase the cost and the respondents in the Needs Assessment Study stated that this was one of the reasons why they do not seek medical assistance.

## 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 does not exist just in the school or working environments, but also in the provision of public services such as health, education, etc. Discrimination against LGBTI people is connected to their external appearance or behaviour. 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. Some of them are victims of hate crime and are not protected when attacked in the street by other citizens.
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 services<sup>148</sup>.
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 study<sup>149</sup>, 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 not provision of specific assistance related to gender change or other treatments associated with their special needs. Moreover, Albanian surgical services do not perform the respective medical interventions. The law "On Reproductive Health" has a legal provision that guarantees the right of same-sex couples to have children through assisted medical reproduction techniques. According to the Alliance Against LGBT Discrimination representative, Article 17 of the Law stating: "Every individual has the right to defend his/her reproductive ability, by complaining against the actions, decisions and injuries by third parties, when the rights related to reproductive health are violated" should be further interpreted regarding medical interventions that include intersex people.
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 community<sup>150</sup>. The general perception among respondents was that health professionals do not have knowledge on the specific health needs of LGBTI people, and the

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

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

150 Pink Embassy, Activity Report, June 2013 - December 2014, to: <http://www.pinkembassy.al/sites/default/files/uploade/Raporti%20Vjetor%20i%20Pink%202014.pdf>

necessary skills needed to manage these needs in clinical practice<sup>151</sup>.

5. *Health care for LBT women in the country does not exist*: Current data<sup>152</sup> indicate that LBT women are invisible 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 limits contact with patients and does not enable open communication between them. They do not have knowledge on the special needs of LBT people and cannot offer affordable and quality care. This makes the LBT people to have no faith in the health services and health professionals.

## 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 1979, Albania had 76,500 people, 65 and older. In 2011, the number of people 65 and older has increased more than 4 times to 318,000. This is a high percentage of the population. Further growth in the number of elderly is projected for the next five decades, reaching 667,000 in 2060. In 2011, among people 65 or older there were 91 males for every 100 females. For elderly 80 and older, there were 66 men for every 100 women. In 2014, women on average lived longer than men by 3.9 years<sup>153</sup>.
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. Specific requirements for appropriate caregivers for the elderly are not taken into consideration. Wrong treatments even abuses of the elderly in nursing homes are a recurring theme repeating itself<sup>154</sup>. 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 persons<sup>155</sup>.
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 elderly<sup>156</sup>.
4. 27% of respondents interviewed stated that *"Healthcare for the elderly is not available when they need it"*. The main reasons for this, are difficulties to cover the medical treatment (20 percent), to a lesser extent, the distance to health care services (4 percent) and particularly difficult disease, which make it impossible for the elderly to go to the doctor (3 percent)<sup>157</sup>. Here is what an elderly Roma woman<sup>158</sup> from the Kinostudio area of Tirana said: *"I am old and sick and suffer from many*

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

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

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

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

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

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

157 Ylli, A. (2010). Health and social conditions of elderly people in Albania: Baseline data from a national survey. Public Health Reviews, Vol . 32, No. 2, f. 549-560.

158SOROS (2011). Access to health services by vulnerable groups.

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. Older women tend to suffer more of disabilities than older men. To some extent, this is the consequence of the higher number of elderly women, however it may not be the full explanation, because the rate of disability for women at a specific age is consistently higher. Also, gender roles which make women responsible for most household chores can be a factor, because disabilities would affect women more severely than men<sup>159</sup>.
6. There is lack of structures and NPOs to address the needs of the elderly and in particular the needs for health services. The “Albanian Society for All Ages”, which supports the elderly, has no financial support for activities, while there is no health infrastructure for older people. “The interpretation of health parameters cannot be the same for the young and the elderly, there is no gerontology<sup>160</sup>”
7. NPOs for the elderly report that not even the Agency for the Support of Civil Society (ASCS) has a focus group for the elderly. There is a lack of projects and donations for the elderly. The CSSA Annual Report for 2014 does not include any projects that address the needs of 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 sentence<sup>161</sup>. Law No. 8328/16.4.1998, “On the Rights and Treatment of Prisoners and Detainees”, amended by Law 40/2014, provides for medical treatment of women prisoners and detainees, which includes a full screening to determine primary healthcare needs namely: sexually transmitted diseases or blood borne diseases; mental health care needs, including the treatment of Post-Traumatic Stress Disorder, risk of suicide or self-harm; history of reproductive health; drug addiction; sexual abuse and other forms of violence that women may have suffered before being sent to the institution.
2. The Ombudsman<sup>162</sup> 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 with a

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

160 Information from representatives of the Association “Albanian Society for All Ages”, November 2015.

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

162 Ombudsman’s Report, 2014

court order for “obligatory medication” and “temporary admission” has not been implemented. The treatment of this category in IEVPs, while they have no psychiatrists and access to psychiatric counselling at regional psychiatric hospitals is difficult, or in the Prisons’ Special Health Institution for cases with acute episodes remains illegal, reflecting overall the problem of overcrowding<sup>163</sup>.

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 detained claiming health problems; delays of visits by the specialist doctor of lack of periodic visits in cases of diseases that can deteriorate (neurologist); and lack of a special food diet for cases with particular health problems<sup>164</sup>.

## 18. Work relations and specific issues of women’s health

*The actual situation and problems identified by NPOs*

1. *Low level of employment and pay affects healthcare:* In 2014<sup>165</sup>, employees aged 15-64 years old constituted 50.5% of the working age population. The employment rate for men is 58% and for women 43.4%. Among the self-employed and salaried employees, men dominate with 57.2% and 70.5% respectively. 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. The gender wage gap is 10%. This means that men have an average gross monthly salary 10% higher than women. *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 role*<sup>166</sup>.
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 children<sup>167</sup>. The census shows that differences in employment participation are higher among men and women in rural areas, compared with those in urban areas. Of those employed in urban areas, women make up only a share of 40 percent. In rural areas, the gender gap is greater, with women making up 30 percent of employees. These differences may be due to different gender roles between urban and rural areas, and lack of opportunities for rural women<sup>168</sup>.
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 reproduction<sup>169</sup>.
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

163 Ombudsman’s Report, 2014

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

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

166 GAD (2010). Work rights for women in Albania.

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

168 Same as 167.

169 Same as 169.

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”, that determines the State Inspectorate, covering the area of work, and Health Inspectorate, covering the area of health, as the state authorities responsible for the enforcement of this Law and the Regulation approved by Decision No. 634/15.07.2015 “On the Introduction of Health and Safety at Work for Pregnant Women and New Mothers”, which defines detailed rules on health safety at work for pregnant women and new mothers.
6. *Very few NPOs work in the field of occupational diseases.* There are no statistic or monitoring of their impacts on women’s health. The Decision of the Council of Ministers No. 594/07.01.2015, “On the Approval of the List of Occupational Diseases”, is not known by women and NPOs.

## 19. The role of education and school curricula related to health and health services

### *The actual situation*

1. *School curriculum:* Pupils in grades 1-9 of basic education, are introduced to nutrition education curricula, developed by the Public Health Institute and the Institute of Education Development. This education is part of the “cross-curricula” module. These modules were piloted in 20 schools in Kukës, Shkodër, Durrës and Tirana. In relation to the Comprehensive Sexuality Education in schools text books have been prepared that focus on “Life skills and sex education training” that was piloted in some schools<sup>170</sup>.
2. *Training sessions for teachers and health employees:* There were 300 open education sessions as well as 10 events that were organised with the participation of teachers, students and parent, during 2013-2014. Application of these modules is expected in all schools in the country<sup>171</sup>. The Anti-Trafficking Unit in cooperation with the Ministry of Health, has identified the need for training on people trafficking for the public health staff. In 2014<sup>172</sup>, they organised a series of trainings. The JTIP project, funded by the US State Department, conducted training sessions with health workers in Shkodër, Vlora and Tirana.
3. *Accredited modules:* Based on the approved regulatory framework<sup>173</sup> accredited training modules were developed for service providers to monitor growth and nutrition. Child nutrition, breast feeding, and growth and development trainings for the health personnel has been completed in several districts. All in all, just for the period March 2013-March 2014, 600 family doctors, nurses and midwives were trained<sup>174</sup>.

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170Information from the Centre for Population and Development in Albania”.

171 MoSWY (2014): National report on the situation of children’s rights in Albania 2013-2014.

172Trainings were organised in Shkodra by the Office for Monitoring and Combating People Trafficking, in Vlora by Vatra Centre and in Tirana by the organisation “Different and Equal”.

173Decision No. 101/04.02. 2015. The package of health care services in primary health care (as amended).

174MoH (2015):

# ANNEXES

## Annex 1

### List of NPOs that cooperated



Albanian Centre for Population and Development (ACPD)



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 LGBT Discrimination



Association "Acli-Ipsia in Albania"



Center for Legal Civic Initiatives, CLCI



Children's Human Rights Centre of Albania CRCA,



Community Development Center Today for the Future" (CDC-TFF)



Counselling Line For Women and Girls



Gender Alliance for Development Centre (GADC)



Human Rights in Democracy Centre (HRDC)



National Centre for Social Studies (NCSS)



Psycho-Social Centre "Vatra", Vlorë ("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

## Annex 2

### Part Three: Questionnaire

1. The organization you represent?
2. What are the issues/aspects related to the health and rights of women that you cover:
3. What is the level of knowledge of your staff about CEDAW and the General Recommendations affecting the field of women's health?
  - a) Full knowledge
  - b) A little knowledge
  - c) No knowledge
4. Does your organization work for the recognition of CEDAW Conventions by the community; NPOs; professionals of the justice system?
  - a) Yes it has worked with primary care physicians regarding this Convention
  - b) No
5. Do you cooperate with other NPOs:
  - a) Who have the same field of activities as your organization? Yes/No  
If so, which are they:
  - b) Dealing with other matters? Yes/No  
If so, which are they:
  - c) At regional level (including international organizations): Yes/No  
If so, which are they:
  - d) At local level (NPOs within the country): Yes/No  
If so, which are they:
6. In your opinion, what are the most important problems of discrimination faced by the Albanian women in the field of health? Please list them based on your expertise.
7. Based on your expertise, do you believe that applicable laws are generally sufficient and fully protect women's rights in the field of health? Yes/No  
If not, list your suggestions/recommendations about the shortcomings of the legal framework.
8. Do you think the state authorities exercise due diligence regarding the rights of women in the field of health? What do you think is the most active state structure?
  - a) List authorities with which you cooperate positively.
  - b) List authorities with which communities you deal with, have problems in accessing services
9. Do you think that health services, in particular reproductive health services are accessible? According to you, what is the extent of women's access to health services, referring to the information/preventative, remedial/advisory level?
10. What do you think **government stakeholders** could do more to protect women's rights about their health?
11. Have you complained to the Office of the Ombudsman about the protection from discrimination of women for issues related to the inactivity of the administrative authorities?

12. Do you think the media has a role to eradicate gender stereotypes or do you think the **media** in certain cases reinforces these stereotypes?
13. Do you think the health rights of women prisoners and detainees in the penitentiary institutions are respected?
14. Do you think that NPOs recognize women's health issues, or do they need to improve their work, and if so, in what ways?
15. Do you think women are aware of the content and the opportunities of the law on health rights? How did you reach this conclusion?
16. Have you had cases or you know of cases where the violation of a women's health is reported to the police, prosecutors or the court?
17. Which do you think are the **state provided services that are missing** in order to protect the health of women (including reproductive health)?
18. Which are the **NPO provided services that are missing** in order to protect the health of women (including reproductive health)?
19. What do you think should be done for the **NPOs to be supported by the government stakeholders** and vice-versa in the field of women's health?
20. Do you think that human trafficking and women trafficking remains a significant problem for our country and there health problems of these women that are not addressed appropriately?
21. What is the **economic situation of women** (given the knowledge/data you have on the situation where you live/work) and does this affects the access to health services?
22. Is the appropriate level of health protection for women in work relations? Are **health services** in general in conformity with the requirements/needs of women?
23. What can you recommend for improving the healthcare of women in work relations?
24. Is the level of awareness regarding the protection of women's health, family planning and reproductive health the right one? Please enter the data (statistics, etc.) that you have available.
25. In your opinion, how does the level of education of women relates to their health?
26. According to you, what is the degree of vulnerability of women toward HIV/AIDS and STIs?
27. What can you suggest for improving the situation of women's health, including reproductive health?
28. How can you briefly describe the real situation of women in rural areas in terms of health care (express yourself in terms of knowledge/data you have)?
29. What can you recommend for improving the health of women in rural areas.
30. Do you think the real situation of women about their rights within the family has a direct impact on their health situation?

## Part Four: Necessary suggestions and recommendations

1. What could be the areas that need to be carefully looked at, in a report prepared by NPOs to CEDAW regarding women's health?
2. What remains the most pressing issue in Albania in terms of discrimination against women in the field of health?
3. If you would be the person who will recommend to NPOs what to do against discrimination against women in the field of health, what issues would you highlight?
4. If you would be the person who will recommend what to do the Albanian state on discrimination against women in the field of health, what issue would you highlight to them as the most important?
5. If you would be the person who will recommend what to do to the international partners on the discrimination against women in Albania in the field of health, what issue would you highlight?
6. Do you think the process of reviewing the internal legislation has been completed, and there is no longer need for stipulations against the discrimination of women in the health field? Are there any suggestion/recommendation specific to a matter which should be regulated by law?
7. Do you think women have an effective legal protection against discrimination in the field of health? What are the reasons why women rarely use existing laws to protect against discrimination in the field of health?

## Annex 3

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