REVIEW REPORT

ACTION PLAN ON NON-COMMUNICABLE DISEASES ALBANIA 2016-2020

APRIL, 2021

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EXECUTIVE SUMMARY

PURPOSE

The "Action Plan on Non-Communicable Diseases [NCDs] 2016-2020" entails a comprehensive approach by: integrating policy and action to reduce inequalities in health and tackling the toll of NCDs by introducing health promotion and preventive programs at a population level; actively targeting sub-groups and individuals at a particularly high risk, and; maximizing population coverage with effective health care services. The aim of this report is to provide a comprehensive review the "Action Plan on NCDs, Albania 2016-2020". This review report will include operational and specific recommendations which will eventually support the development of the new "Action Plan on NCDs, Albania 2021-2030".

METHODOLOGY

The methodology of this review report consisted of consultative meetings, a desk review, key informant interviews and a consolidated final review report. Consultative meetings with key stakeholders and the team of the project "Shkollat për Shëndetin" were carried out. Desk review consists of a detailed assessment of all interventions and activities conducted in the framework of implementation of the current action plan on NCDs in relation to the anticipated objectives, targets and indicators. The detailed evaluation matrix for each block of activities envisioned in the "Action Plan on NCDs 2010-2020" is presented in Appendix 2. The interviews with key informant include representatives of different institutions at central and local level. Overall, 20 (twenty) key informant interviews are conducted including representatives from central level and regional/local level institutions from different sectors involved in NCDs activities and programs. A consolidated report summarizes findings emerging from the key informant interviews which are incorporated into the final draft of the "Review Report" regarding the implementation of the "Action Plan on NCDs, Albania 2016-2020".

CONCLUSIONS AND RECOMMENDATIONS

The NCD program processes took place in a supportive political atmosphere and were not mere products of technical analyses. Its development was preceded by a number of important policies, and interventions, including check-up program. The new NCD strategy was build upon those interventions or provided a roadmap to assure their sustainability. NCD Program has been developed with assistance of WHO and has taken ideas from WHO European NCD strategy. It aims at reducing health inequality, and tackles NCDs at three levels: population level health promotion, high risk categories, and treatment for all. On the other hand, priorities and actions of

the strategy were developed after analyzing the existing evidence in the field of NCD and their risk factors. In addition to estimations about NCDs burden, there were used original data from Institute of Public Health studies. 83% of key informants included in the review of the Program, reported that priorities and objectives were based on local evidence.

Only one third of informants thought that the resources dedicated to the measures and actions in the Program were enough. It raises the concern for more resources to be dedicated to the NCD control in the next strategic cycle. Representatives of some of the most important stakeholders, such as local governments or food industry, were absent during the process of strategy development. Additionally, the involvement of most of the other stakeholders (other ministries, civil society etc.,) remained small to insignificant. Although there was a formal consultation process, the approval of strategy was not followed by an organized campaign of promoting the new vision, targets and actions, to involve all potential actors and to raise their awareness about the challenges and opportunities. Also, the document and the actions it envisages were not made known to all those responsible for implementing it. More than 34% of informants, especially those at local level were not aware about it, or haven use the program document during their work. The document is not explicitly linked with other national health strategies covering NCD field, such as National Cancer Control Program. In total there are 75% of key informants who believe that the right actions and measures planned in the Program document are implemented.

Prevention and control of NCDs in health care settings have been progressing significantly during the lifespan of NCD Program. Albanian adults have easy access to basic health services about early identification of NCD risk factors, including metabolic factors and life style factors. New clinical guidelines were developed and approved and workforce has been trained. Data show that tens of thousands of people who were not aware about their hypertension or diabetes are now receiving advice and care. Also, new cancer screening programs such as colo-rectal, cervical and breast cancer screening programs are approved by government and for most of them there are dedicated funds and resources. Treatment centres and resources for coronary heart disease and cancer have increased substantially. At health system level there is more to be done for better monitoring quality of care and rational use of technology, as well as geographical distribution of human resources. Specific issues such as patient education need more efforts.

Population prevention has shown some progress especially with reorganisation of health inspectorate and improving its efficacy in the war against tobacco smoking in public places. Systematic activities targeting children and youth remain challenging. More efforts are needed to address obesity, unhealthy diets, and controlling marketing pressure. Issues such as alcoholic beverages, high fat, trans-fat, sugar or salt processed food targeting children and youth, should receive more attention. Teachers, parents and social media are still to be more systematically involved in NCD prevention actions. Health and social workers based at school settings need to be supported with NCD related competencies, curricula and training.

While there are some, though still inconsistent, data showing improvement in relation to hypertension awareness and treatment at primary health care, this NCD risk factor remains a major problem in Albania and needs to be addressed, along with diabetes, obesity and tobacco smoking, at population level.

It took a long time and advocacy efforts to finally appoint NCD focal points at some levels of health system. Still, they remain an temporary or ad hoc organisation and should be transformed into permanent NCD control units within Regional Operator of Health Care structures. They need to be provided with clear competency framework and properly trained. Additionally, involvement of relevant stakeholders and the public in various areas of NCDs remains challenging and need to be addressed in the new strategy.

The monitoring of NCD in Albania has been transformed since the approval of NCD program. There have been developed new NCD national framework of indicators, new systems of health care based NCD registries and new national reports about NCDs. Although NCD were included for the first time in the ADHS 2018, data from population remain scarce. WHO STEPwise approach to Surveillance (STEPS) need to be introduced in Albania, in order to better monitor progress in health outcomes. Also, NCD risk surveillance measurements at schools can provide essential information to monitor policies. Existing models such as Health Behaviour at School Study (HBSC), European School Survey Project on Alcohol and Other Drugs (ESPAD), European Childhood Obesity Surveillance Initiative (COSI) and Youth Risky Behaviour (YRB) need to be further supported to become systematic instruments for policy information.

On the other hand, the death and disease registration in Albania needs to be improved. Introduction of the ICD10 model can be an opportunity for improving the NCD monitoring system.

The review demonstrates that the overall mortality rate among Albanian adults aged 30-69 years not only hasn't continued its increase observed during the first decade of 2000, but has started to slightly decrease, especially during the last 5 years. This seems to be mainly due to a decline in the number of deaths from chronic respiratory disease and, to a lesser extent, ischemic heart disease and strokes (in males). The cancer mortality rate in this age group has also shown some signs of decrease during these years. The main driver of the higher mortality rate (and shorter life expectancy) among men is their higher cancer mortality rate, particularly given that men's lung cancer mortality rate is five times higher than that for women. Also, the significantly higher cardiovascular preventable death rate in men aged 30-69 years is only reversed in old age, particularly by the increasing stroke risk among women aged 70+ years. This profile points to the necessity of insisting on a smoking control policy and other NCD related risk behavior control policies.

While there are some, though still inconsistent, data showing improvement in relation to hypertension awareness and treatment at primary health care, this NCD risk factor remains a

major problem in Albania and needs to be addressed, along with diabetes, obesity and tobacco smoking, at population level.

INTRODUCTION

Closely aligned with the "Albanian National Health Strategy 2016-2020", the "Action Plan on Non-Communicable Diseases [NCDs] 2016-2020" entails a comprehensive approach by:

- integrating policy and action to reduce inequalities in health and tackling the toll of NCDs by introducing health promotion and preventive programs at a population level;
- actively targeting sub-groups and individuals at a particularly high risk, and;
- maximizing population coverage with effective health care services.

The priority activities are organized within four strategic objectives including governance, prevention, health system and surveillance. With a commitment and vision to provide Universal Health Coverage and quality and timely health services for all Albanian residents, the Albanian Programme for the prevention and control of NCDs aims at avoiding premature death and significantly reducing the NCD burden.

The NCD action plan envisages concrete efforts and activities with the aim of strengthening of the continuum of care for the management of NCDs. Ultimately, combining and integrating the efforts of a wide range of stakeholders from both governmental and non-governmental sector will help Albania to achieve the NCD targets in line with the WHO "NCD Global Monitoring Framework".

The Action Plan on NCDs is based on positive developments and progress of Albania in general and reforms in the health sector in particular. The Action Plan takes into consideration the updated legislation and the regulatory framework adopted in Albania during the last decade, in close cooperation and with the technical assistance of various partner organizations and international agencies.

The Action Plan on NCDs addresses the current public health challenges and the priorities defined by the Albanian government, focusing especially on the major NCDs including cardiovascular diseases, cancer, diabetes and chronic respiratory diseases.

However, as the "Action Plan on NCDs 2016-2020" has already expired, there is a need to conduct a comprehensive review of its implementation and thereby provide useful information which will support the development of the new "Action Plan on NCDs, Albania 2021-2030".

In this context, this review report concerning the "Action Plan on NCDs 2016-2020" will generate the necessary evidence for improving the interventions and programs which will be eventually envisioned in the upcoming "Action Plan on NCDs, Albania 2021-2030".

PURPOSE AND OBJECTIVES

The **aim** of this report is to provide a comprehensive review the "Action Plan on NCDs, Albania 2016-2020". This review report will include operational and specific recommendations which will eventually support the development of the new "Action Plan on NCDs, Albania 2021-2030".

The **specific objectives** of this review report are as follows:

- To evaluate the degree of accomplishments and achievements of the expected objectives of the "Action Plan on NCDs, Albania 2016-2020".
- To evaluate the degree of implementation of the anticipated interventions and activities envisioned in the "Action Plan on NCDs, Albania 2016-2020".
- To provide evidence on the strengths and weaknesses in the implementation of the "Action Plan on NCDs, Albania 2016-2020".
- To evaluate the expenditures and cost related to the implementation of activities of the "Action Plan on NCDs, Albania 2016-2020".
- To evaluate the achievements regarding the implementation of school-based health education programs aiming at control and prevention of NCDs.
- To evaluate the degree of achievements and success regarding the enabling of supportive environments in schools regarding health education programs aiming at ultimately controlling and preventing the NCDs.
- To evaluate the degree of achievements/success regarding the capacity building activities (training and continuous professional development) for the teachers and especially local health personnel on NCD control and prevention.
- To evaluate the degree of outreach and coverage of all Albanian families and communities at large, including the vulnerable and marginalized population categories.
- To evaluate the level of participation and contribution of the general population and specific groups in the implementation of interventions aiming at control and prevention of NCDs.
- To identify, formulate and recommend specific and concrete actions and interventions for the new "Action Plan on NCDs, Albania 2021-2030".
- To identify, formulate and recommend specific and concrete school-based health promotion interventions and health education programs for the new "Action Plan on NCDs, Albania 2021-2030".

METHODOLOGY

The methodology of this review report consisted of the following approaches:

1) Consultative meetings
2) Desk review (preliminary review report)
3) Key informant interviews
4) Consolidated draft (final review report)

Each of these methodological steps is described in detail below.

1) ***Consultative meetings:*** with key stakeholders and the team of the project "Shkollat për Shëndetin"[1]. The approach for the review of the action plan on NCDs was shared and agreed upon with selected relevant NCD experts mainly working at the national Institute of Public Health.

   Subsequently, the proposed methodology for the desk review of the action plan on NCDs was endorsed by the team of the project "Shkollat për Shëndetin".

2) ***Desk review (preliminary review report):*** consisting of a detailed assessment of all interventions and activities conducted in the framework of implementation of the current action plan on NCDs in relation to the anticipated objectives, targets and indicators. In addition, the expenditures and costs related to the implementation of activities of the action plan were also assessed, based on the availability of the information/data.

   The detailed evaluation matrix for each block of activities envisioned in the "Action Plan on NCDs 2010-2020" is presented in Table 1.

TABLE 1. REPORTING FORM REGARDING THE IMPLEMENTATION OF ACTIVITIES ENVISIONED IN THE "ACTION PLAN ON NCDs, 2016-2020"

STRATEGIC OBJECTIVES	SPECIFIC OBJECTIVES	TARGET	ACTIVITIES	INDICATORS	ACHIEVED	COMMENTS	COST
STRATEGIC OBJECTIVE 1:	**Specific objective 1.1:**						

[1] This is a Swiss project implemented in Albania by Save the Children.

Based on the information generated from the desk review, an initial draft of the "Review Report" of the current action plan on NCDs was developed.

3) ***Key informant interviews:*** feedback from stakeholders was sought by interviewing a range of key informants including representatives of different institutions at central and local level.

The aim of key informant interviewing was to generate valuable information for obtaining a better insight into the main achievements, indicators of success, concrete examples of useful practices and, most importantly, to identify bottlenecks, obstacles and challenges which may have hindered the timely and/or efficient implementation of selected interventions envisaged in the action plan on NCDs, especially the activities targeting schoolchildren and their families.

Key informant interviews included experts and professionals from the following institutions:

i) central level: major health sector institutions and organizations including the Ministry of Health and Social Protection (MoHSP), the Institute of Public Health (IPH), the General Directorate of the Health Care Service Operator (GDHCSO), and the Compulsory Health Care Insurance Fund (CHCIF);

ii) r*egional and local level*: including the Regional Directorates of the Health Care Service Operator (RDHCSO) and the related Local Health Care Units (LHCU).

More specifically, overall, **20 (twenty) key informant interviews were conducted** including representatives from the following institutions and organizations:

- *Central* level (10 key informant interviews):
  - MoHSP (3 key informants)
  - IPH (4 key informants)
  - GDHCSO (2 key informants)
  - CHCIF (1 key informant)
- *Regional* and *local* level (10 key informant interviews):
  - RDHCSO (4 key informants)
  - LHCUs (6 key informants)

The detailed list of key informants interviewed is presented in Annex 1.

The interview guide used for key informants at central and regional level is presented in Table 2.

TABLE 2. INTERVIEW GUIDE FOR KEY INFORMANTS AT CENTRAL AND LOCAL LEVELS (N=20)
General characteristics: age; gender; diploma/degree; work position; job profile; years in the current position; overall working experience.
Can you please describe shortly your main duties/tasks/responsibilities?
Can you please describe shortly the mandate, mission, scope of work and services provided by your institution regarding the implementation of the action plan on NCDs 2016-2020?
In your opinion, was there enough data to set priorities for the anticipated main aim (of the action plan)?
Were appropriate measures proposed to achieve the overall goal?
Have the approved measures and interventions been implemented? If not, please mention the main interventions and activities which have not been implemented and the respective reasons (according to your opinion).
Were social inequalities addressed by the proposed measures and interventions? Please mention at least one relevant example.
Were sufficient financial resources provided for implementation of the action plan? If not, please specify.
In your opinion, what were the main obstacles and challenges for the implementation of all the envisaged activities of the action plan on NCDs 2016-2020?
What would be your main recommendations for the upcoming action plan on NCDs?
Additional questions for key informants at local level (NCD specialists)
How many NCD-related activities have you carried out with your team in the past year?
In the course of your work, do you and/or any of your team members make reference to the national action plan on NCDs 2016-2020?
What are the concrete obstacles you encounter in your work?
What should be done to make NCD interventions more effective in your community?
What advice can you give to the team that will draft the new action plan on NCDs?
What other information would you like to share about your experience working in NCD control and prevention?

Of note, the interview guide with key informants was developed with and endorsed by relevant stakeholders and the Project Team of Save the Children during the initial consultative meetings.

4) ***Consolidated draft (final report):*** findings emerging from the key informant interviews were summarized and incorporated into the final draft of the "Review Report" regarding the implementation of the "Action Plan on NCDs, Albania 2016-2020".

RESULTS

1. The process of strategy development

Information included in this section is made possible by analyses of opinions and experiences received during key informant's interviews.

For the first time in 2016 Government of Albania developed a comprehensive strategy addressing Non-Communicable Diseases as a health priority. It was formally named National Program on Prevention and Control of NCDs in Albania 2016-2020 and included an Action Plan. Both documents were approved by an order of Minister of Health (No 4963, Dt. 03/10/2016), which set responsibilities for implementation upon various departments within Ministry of Health.

Factors which influenced the development of the strategy.

The strategy processes took place in a supportive political atmosphere and were not mere products of technical analyses. Its development was preceded by a number of policies, decisions, and interventions such as;

- NCDs and universal care were part of the 2013 election campaign and were included in the new government program.
- NCD control and Universal Care were major justifications for the new Check-Up Program which kicked off one year before.
- A national Committee for NCDs Prevention and Control was set up with an order of Minister of Health during first half of 2015 (No 1719, Dt. 07.04.2015). Although under Ministry of Health, that Committee had some interdisciplinary nature, including 5 representatives from other ministries and civil society.
- The National Report on Health prepared for the first time in 2014 by Institute of Public Health provided detailed information on NCD burden on Albanian population and health priorities in the country.
- A decision of Council of Ministers issued in 2014 to regulate health information system included 4 new models of case based disease registries on NCDs, namely cancers, heart attack, stroke and diabetes (VKM No 327, dt 28.05.2014 'About defining the format and the ways of collecting health information').

The new NCD strategy was built upon those interventions or provided a roadmap to assure their sustainability.

NCD Strategy was developed in the same time with the National Health Strategy and Health Promotion Strategy. NCDs were included in both national documents as health priorities.

The working group responsible for writing of document was composed by experts of Ministry of Health, Institute of Public Health and University Hospital. There were involved other experts, from Primary Health Care, Civil Society and other Ministries, but their role was marginal and mostly consultative as participants in the meetings. Nevertheless, during the consultative activities a significant number of participants were involved.

A key support was provided by WHO office in Tirana and WHO Europe experts in Copenhagen. The first blueprint was conceived in a meeting of Albanian experts and WHO experts in Copenhagen, using as a guide the WHO Strategy on NCDs. Strategy is based on a comprehensive approach, which aims at reducing health inequality, and tackles NCDs at three levels: population level health promotion, high risk categories, and treatment for all. Also the main priority areas were designed according to a WHO proposed structure: Governance, Prevention, Health Systems and Surveillance.

The priorities and actions of the strategy were developed after analyzing the existing evidence in the field of NCD and their risk factors. In addition to estimations about NCDs burden, there were used original data from Institute of Public Health studies. Those data served to establish some main trends at the bases of the strategy:
Tobacco smoking remained high among males and tends to increase among females.
Overweight and obesity have been increasing along with lack of physical activity.
Control of high blood pressure and diabetes remained a key problem, with majority of population unaware about them.

More specifically, around 83% of key informants included in the review of the Program, reported that priorities and objectives were based on local evidence. The same proportion of them agreed that the proposed measures were aproporiate to acheive the overall aim of the Program. 75% of key informants thought that social inqualities ware also appropriately adressed in the Program. On the other hand, only one third (33.3%) of informants thought that the resources dedicated to the measures and actions in the Program were enough.
The document and the actions its envisages were not made known to all those responsible for implementing it. More than 34% of informants declared that they were not aware about it, or didnt use the program document during their work.

TABLE 3. STRUCTURED OPINIONES OF KEY INFORMANTS ABOUT THE PROGRAM	
Priorities and objectives of the NCD Program were based upon local data and studies.	Totally agree 41.7% Agree 41.7% Neutral 16.7%
There were proposed the right measures for achieving the overall aim of the NCD Program.	Totally agree 16.7% Agree 66.7% Neutral 16.7%
Social inequalities were appropriately addressed through measures and actions.	Totally agree 8.3% Agree 66.7% Neutral 25.0%
There were dedicated appropriate resources to the implementation of the NCD Program.	Agree 33.3% Neutral 50.0% Don't agree 16.7%
During the work, I or members of my team have consulted the NCD Program document.	Totally agree 8.3% Agree 58.3% Neutral 25.0% Don't agree 8.3%

Issues concerning strategy developing process and its structure

- The strategy is meant to be an interdisciplinary program, with many actions falling beyond the boundaries of traditional health system or outside the institutions governed by Ministry of Health. Yet, representatives of some of the most important stakeholders, such as local governments or food industry, were absent during the process of strategy development. Additionally, the involvement of most of the other stakeholders (other ministries, civil society etc) remained small to insignificant.
- The decisions about the NCD national Committee and the Strategy approval are actions undertaken only by the Minister of Health and don't involve actively other partners in government.

- There was a formal consultation process, but the approval of strategy was not followed by an organized campaign of promoting the new vision, targets and actions, to involve all potential actors and to raise their awareness about the challenges and opportunities.
- The document doesn't make clear reference to other strategies in the field of NCDs, such as Cancer Control Strategy or Reduction of Harmful Use of Alcohol. Also, the document doesn't cover some NCD related issues such as chronic respiratory diseases, oral health or other rare diseases (policies about the last category are specifically required in the process of EU integration).
- Although well structured, the strategy and its action plan are not fully compatible with the new format approved by Council of Ministers for national policy documents. The new format allows detailed cross-referencing with other government policies as well as structured monitoring of indicators.

2. Implementation of activities envisaged in the action plan

The priority action areas of the action plan of non-communicable diseases 2016-2020 were organized within 4 strategic objectives: governance, prevention, health system and surveillance. The review follows those areas in its analyses of implementation. A more structured review following each objective and activity is presented in a specially designated matrix, (annex 2 of this report).

In total there are 75% of key informants who believe that the right actions and measures planned in the Program document are implemented.

I. *Governance: strengthening and expanding cross-sector cooperation and partnership for NCDs*

With regard to this strategic objective there were envisaged 14 (fourteen) activities, out of which 9 (nine) were fully achieved and 5 (five) were partially achieved.

A careful assessment of the activities intended to achieve the *governance* related objectives revealed that the key *success* features of fully achieved activities included:

- establishment of IC, focal points etc. is achievable;
- development of recommendations, strategies, including NCDs in various programs or strategies etc. is achievable;
- high political priority (for example PPPs);
- reviewing, updating, changing, adapting of legislation and regulations is achievable;
- identification of targets, responsibilities, steps is achievable, and
- carrying out of feasibility reports is achievable.

In other words it seems that fully achieved activities are those requiring mainly theoretical review and reasoning; otherwise a strong political priority is necessary for the success and implementation of the relevant activities.

The key *impeding* features of partially achieved activities included:

- difficulties to stick to the scheduled regular meetings;
- the inter-sectorial collaboration towards prevention and control of NCDs is challenging;
- the implementation of recommendations is challenging;
- involvement of relevant stakeholders and the public in various areas of NCDs is challenging;
- increasing human resource dedicated to NCDs is rather difficult.

Partially achieved activities seem those who require actual implementation in the field (i.e. turn theory into action or “getting things done”).

II. *Prevention: Scaling up equity-sensitive population interventions to address risk factors and their underlying social determinants*

With regard to this strategic objective there were envisaged 42 (forty-two) activities, out of which 20 (twenty) were fully achieved, 10 (ten) were partially achieved and 12 (twelve) were not achieved.

A careful assessment of the activities intended to achieve the *prevention* related objectives revealed that the key *success* features of fully achieved activities included:

- increasing human resources and infrastructure dedicated to health inspectorate workforce is achievable
- political will to introduce taxes
- development of protocols, guidelines, regulatory frameworks on alcohol and tobacco etc. is achievable
- training and campaigns against alcohol, tobacco, physical activity and nutrition are achievable
- high political priority to implement certain prevention programs (check-up)

In other words the prevention activities most likely to succeed are those dealing with setting up the human resources and infrastructure to enforce the health inspectorate, introducing taxes and implementing high political priorities as well as those needing theoretical review and reasoning. Training of primary health care staff on various prevention subjects is also achievable.

The key *impeding* features of partially achieved activities in this domain included:

- evaluating the impact of interventions is challenging
- reviewing the existing regulations/initiatives related to reducing marketing pressure of food and non-alcoholic beverage to children is challenging
- organizing of round tables to revise the regulations related to reducing marketing pressure of food to children is challenging
- increasing human resources dedicated to particular prevention activities is challenging
- the inter- and intra-sectorial collaboration towards prevention and control of NCDs is challenging
- training of school health staff on the physical activity and diet is challenging

In other words, activities dealing with evaluation of the impact of interventions, those affected by market pressures, those requiring collaboration among stakeholders are likely to be only partly achieved.

The key *failing* features of not achieved activities included:

- adding nicotine replacement treatment (NRT) in the list of reimbursable drugs
- establishing new infrastructure to support various prevention activities
- physical activity and nutrition seemingly less important than alcohol and tobacco, i.e. not receiving a similar attention
- going against market mainstream (i.e., trans-fat, salt reduction);

In summary, prevention activities that require substantial financial resources, those perceived as counteracting food industry interests on certain products and those not considered as a priority are very likely to fail.

III. *Health Systems: Strengthen integration, accountability and rational use of services for improved management of NCDs*

With regard to this strategic objective were envisaged 30 (thirty) activities, out of which 20 (twenty) were fully achieved and 10 (ten) were partially achieved.

A careful assessment of the activities falling under the *health systems* related objectives revealed that the key *success* features of fully achieved activities included:

- development of health system assessment, clinical guidelines and pathways, monitoring reports, etc. is achievable
- training the health staff and emergency care staff is achievable
- organizing of conferences to present results of interventions is achievable
- increasing the number of chemotherapy centres is achievable
- high political priority (i.e. emergency care and network, expanding universal coverage, check-up package, incentives in order to cover areas underserved with NCD services, recertification system for doctors and nurses, CHCIF covering private hospital care, implementation of findings and recommendations from the pilot population-based cervical cancer screening, drugs' track and trace system, etc.).

In other words, activities that are bound to theoretical reasoning and reviewing and high political priority are likely to succeed.

The key *impeding* features of partially achieved activities in this domain included:

- adding new monitoring indicators on quality of care is challenging
- producing reports assessing quality of care and rational use of technology is challenging adding a product in the list of reimbursable drugs is challenging
- creating models and establishing cabinets for patient education is challenging
- expansion of palliative care services and training primary health care staff on this issue is challenging
- balancing the distribution of health professionals related to NCDs is challenging

In summary, activities related to quality of care monitoring and assessment, those involving financial demands and practical allocation of humans resources related to NCDs are more likely to be only partially achieved.

IV. *Surveillance-Research (HIA): Establish a comprehensive and coordinated national NCD surveillance system*

With regard to this strategic objective were envisaged 22 (twenty-two) activities, out of which 12 (twelve) were fully achieved, 8 (eight) were partially achieved and 2 (two) were not achieved.

A careful assessment of the activities intended to achieve the *surveillance-research* related objectives revealed that the key *success* features of fully achieved activities included:

- High political will and priority (under 5-child nutrition surveillance scaling up establishing national registers of NCDs, e-Health system
- Developing of manuals, reports, publications, conferences, disaggregated analysis
- Standardizing national surveys to comply with international indicators.

It can be concluded that fully achieved activities falling under this domain are those requiring mainly theoretical review and reasoning; otherwise a strong political will is necessary for the success and implementation of the relevant activities.

The key *impeding* features of partially achieved activities in this domain included:

- finishing up or completing the planned activities is challenging (i.e., implementing ICD-10, check-up quality indicators) is challenging
- carrying out of periodic nationwide surveys is challenging (i.e., HBSC, COSI, GYTS, ESPAD, YRBS, GPS, etc.)
- data disaggregation for service utility data is challenging
- increasing the number of experts trained on health impact assessment is challenging.

In other words, periodic surveys and those activities dealing with sensitive elements are likely to be only partially achieved.

The key *failing* features of not achieved activities included:

- The coordination mechanism for the management of updates and adaption of health information according to ICD 10 is not established
- Establish an exchange program with European Centre

In summary, activities depending on elements that would impact NCDs (for example, NCD health information) and those requiring cooperation among stakeholders are likely to fail.

3. Progress towards achievement of NCD related health targets and strengthening the system response

The national program of prevention and control of NCDs should have influenced directly or indirectly changes in health outcomes, as well as health system indicators.

There have been many monitoring processes and instruments developed during the lifespan covered by strategy and under its direct influence. They are valuable for measuring the progress in terms of NCD related health outcomes. They may also be useful in providing evidence about effectiveness of some of the implemented actions.

The monitoring instruments developed and processes carried out included:

- The plan of monitoring NCDs and the progress in their control in Albania produced a framework of indicators and their metadata. It helped to standardize the monitoring at many layers;

Exposures	
	Risk factors related to lifestyle: smoking, unhealthy diet, insuficient physical activitiy, alcohol abuse. Metabolic risk factors: hypertension, overweight/obezity, high blood cholesterol high blood sugar. Social determinants: education, income, acess to health services.
Health outcomes	
	Mortality rate: diseases specific mortality rate. Morbidity: incidence and/or prevalence of morbidity rates for specific NCDs
Evaluation of health system capacities	
	Assesing interventions and capacities: Infrastructure and resources, polcies and programs, access and coverage with essencial services for early detection, treatment or emergencies.

- Based on the above framework a national report on NCDs was prepared by Institute of Public Health, for the first time in the country[2].

- As planned in the NCD strategy, a new module on NCDs was included in the Albanian Demographic and Health Survey of 2018[3].

- A national forum on NCDs was organized by Ministry of Health and Social Protection in collaboration with Institute of Public Health in 2019. The forum served also as a proxy for a mid-term evaluation of the NCD strategy[4].

[2] Instituti i Shëndetit Publik. Raporti Kombëtar mbi Sëmundjet Jo Të Transmetueshme. Vdekshmëria, Sëmundshmëria dhe Faktorët e Riskut. 2018

[3] Institute of Statistics, Institute of Public Health, and ICF. 2018. Albania Demographic and Health Survey 2017-18. Tirana, Albania: Institute of Statistics, Institute of Public Health, and ICF

- A bulletin about check up program was developed by Institute of Public Health in 2018 and a forum about it was organized under the auspices of Ministry of Health and Social Protection[5].

- A National report on demographic and health challenges in Albania in the 21st Century was prepared in 2020 by a team of national experts and with support of UNFPA. The report included for the first time a comprehensive analyses of NCD related health outcomes and risk factors[6].

- Faculty of Medicine and Ministry of Health and Social Protection with the support of WHO, analysed the progress towards SDG. NCDs and the related risk factors were presented in an extended report.

All the indicators and trends analysed in the aforementioned reports allow for some progress evaluation in terms of NCD health outcomes. In this section they are reviewed according to the 'Overall targets' as they are listed in the NCD Strategy;

- ***Target 1. Halt the rise of premature mortality from NCD. Unconditional probability of dying between the ages of 30 and 70 from CVDs, cancer, diabetes or chronic respiratory disease***.

The Review demonstrates that the overall mortality rate among Albanian adults aged 30-69 years not only hasn't continued its increase observed during the first decade of 2000, but has started to slightly decrease, especially during the last 5 years. This seems to be mainly due to a decline in the number of deaths from chronic respiratory disease and, to a lesser extent, ischemic heart disease and strokes (in males). The cancer mortality rate in this age group has also shown some signs of decrease during these years.

Ischemic heart disease alone showed a decline in males (about 82 deaths in 2014 compared with 67 deaths per 100,000 people in 2018), but less so in females (29 vs. 28 deaths per 100,000people, respectively). Similarly, the mortality rate from strokes among those aged 30-69 years declined in males but remained unchanged in females.

The mortality rate from all neoplasms among those aged 30-69 years in both sexes has shown signs of decline since 2014. Still, the mortality rate from lung cancer has not been significantly affected in the past years; in 2018, it was almost five times higher in males than in females (about 50 and 11 deaths per 100,000 people, respectively). In 2018, the death rate from breast cancer among Albanian females aged 30-69 years was 23.6 per 100,000 people, with a negligible decline compared with the year 2014 (24.7 deaths per 100,000 people).

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The mortality rate from diabetes in 2018 was 5.6 and 4.2 deaths per 100,000 people in men and women aged 30-69 years, respectively and hasn't significantly changed during last 5 years.
For both sexes, the death rate from chronic respiratory disease appears to have declined in the past seven years of reporting,

The main driver of the higher mortality rate (and shorter life expectancy) among men is their higher cancer mortality rate, particularly given that men's lung cancer mortality rate is five times higher than that for women. Also, the significantly higher cardiovascular preventable death rate in men aged 30-69 years is only reversed in old age, particularly by the increasing stroke risk among women aged 70+ years. This profile points to the necessity of insisting on a smoking control policy and other risk behavior control policies.

TABLE 4. OVERALL AND SPECIFIC MORTALITY RATES FOR SELECTED DISEASES 2012-2018 AMONG THE ALBANIAN POPULATION AGED 30-69 YEARS

All causes (number of deaths per 100,000 population)								Trend
	2012	2013	2014	2015	2016	2017	2018	
Total	404.4	396.1	395.4	401.5	385.8	393.8	384.9	Slight decline
Cardiovascular disease (number of deaths per 100,000 population)								
	2012	2013	2014	2015	2016	2017	2018	
Males	214.1	206.7	211.3	216.6	210.9	215.6	209.5	
Females	104.5	108.6	102.1	109.9	108.1	115.7	112.9	
Total	158.5	157.1	156.2	162.9	159.3	165.3	160.8	Stable
Ischemic heart disease (number of deaths per 100,000 population)								
	2012	2013	2014	2015	2016	2017	2018	
Males	87.6	78.0	82.4	80.5	63.0	80.1	67.3	
Females	31.4	31.5	28.6	27.1	24.8	31.3	27.6	
Total	59.1	54.5	55.2	53.7	43.8	55.6	47.3	Slight decline
Strokes (number of deaths per 100,000 population)								
	2012	2013	2014	2015	2016	2017	2018	
Males	47.1	44.8	47.6	45.6	42.9	39.6	34.3	
Females	29.3	32.7	28.0	31.3	27.5	33.6	28.7	
Total	38.1	38.7	37.7	38.4	35.2	36.5	31.5	Slight decline
Neoplasms (number of deaths per 100,000 population)								
	2012	2013	2014	2015	2016	2017	2018	
Males	169.2	167.6	169.1	166.0	151.9	154.4	160.1	
Females	107.6	99.7	108.2	104.7	102.9	101.9	101.2	
Total	137.9	133.3	138.4	135.2	127.3	128.0	130.4	Slight decline
Lung cancer (number of deaths per 100,000 population)								
	2012	2013	2014	2015	2016	2017	2018	

Males	49.3	54.0	48.5	50.6	44.5	47.4	49.6	
Females	9.2	9.8	11.6	11.0	11.6	10.9	10.9	
Total	29.0	31.6	29.9	30.6	28.0	29.1	30.1	Stable
Breast cancer (number of deaths per 100,000 population)								
	2012	2013	2014	2015	2016	2017	2018	
Males	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Females	27.1	22.3	24.7	23.1	20.5	23.9	23.6	
Total	13.8	11.3	12.4	11.6	10.3	12.0	11.9	Stable
Diabetes (number of deaths per 100,000 population)								
	2012	2013	2014	2015	2016	2017	2018	
Males	6.1	6.0	4.4	5.1	4.6	4.4	5.6	
Females	4.3	4.2	3.9	7.1	4.6	3.8	4.2	
Total	5.1	5.1	4.2	6.1	4.6	4.1	4.9	Stable
Chronic respiratory diseases (number of deaths per 100,000 population)								
	2012	2013	2014	2015	2016	2017	2018	
Males	5.3	4.0	3.7	6.4	4.9	4.2	3.7	
Females	1.8	1.8	1.0	2.6	2.0	1.8	0.8	
Total	3.5	2.9	2.3	4.5	3.5	3.0	2.3	Slight decline

Analyses based in data from INSTAT.

According to the Global Burden of Disease estimates the age-standardized rate, in Albania (deaths from all NCDs per 100,000 population, standardized for age) has shown a strong declining trend, especially during the 2 first years covered by the Strategy. This trend is observed after an increase which continued through first decade of 2000. This is an indicator of the influence the changing of the age structure has in NCD mortality trends.

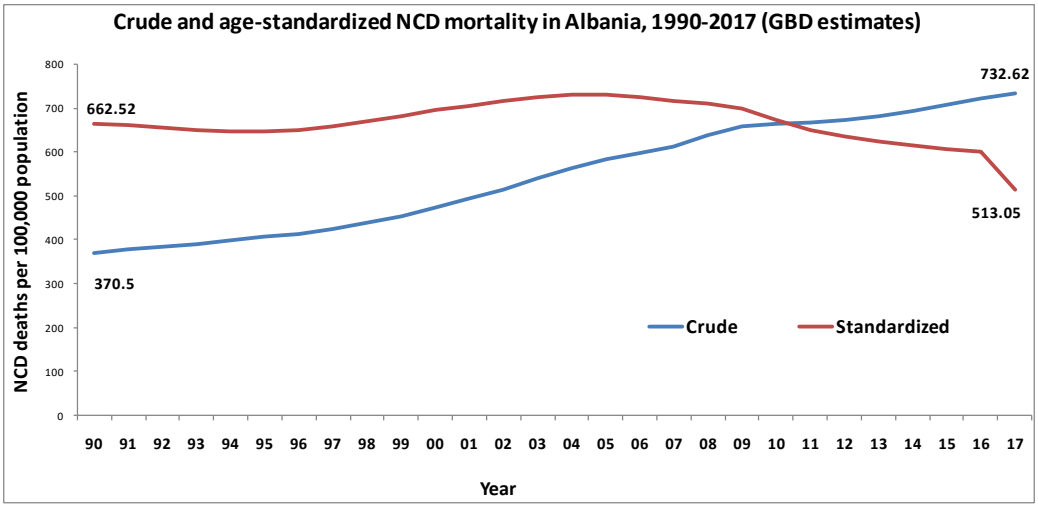

Figure 1. The Crude and Standardized NCD Death Rate in Albania, 1990-2017

- ***Target 2. Alcohol. Halt the rise among women. Reduce consumption among men. Halt the rise of binge drinking among adolescents.***

Unfortunately, data about alcohol use in Albania are relatively incomplete. While tobacco use is somehow documented in a standardized way during the last 2 decades, recent data on harmful alcohol use are largely lacking, especially for the indicator 'binge drinking'.

Time trends based on national data (ADHS, RHS) show a decline in prevalence of drinking ≥5 days per week during last year among persons aged 15-49, while the prevalence of drinking among women remains stable.

There is also a decrease in the prevalence of *lifetime drunkenness among children as demonstrated* in the HBSC 2018 compared with the HBSC 2013/14. Hence, in the HBSC 2013/14, 13.6% of young people reported a lifetime episode of drunkenness compared with 9.8% of those in HBSC 2017/18; 4.7% reported 2-3 episodes of drunkenness in 2013/14 vs. 3.4% in 2017/18.

TABLE 5. TRENDS OF HARMFUL ALCOHOL USE IN ALBANIA, BY VARIOUS NATIONAL SOURCES

Survey name/data source	Indicator	Age	Sex	Indicator value (and year)			Trend
ADHS, 2008-09, 2017-18, RHS 2002	Prevalence (%) of drinking ≥5 days per week during last year	15-49	Male	41.1% (2002)	16.3 (2008)	6.4 (2018)	Strong decline
		15-49 (15-44 in RHS)	Female	4.8 (2002)	0.8 (2008)	0.8 (2018)	Decline
Healthy Behaviour School Survey, 2013-14, 2019	Percentage (%) reporting lifetime drunkenness	11, 13, 15	Both		19.5% (2014)	14.2% (2018)	Decline

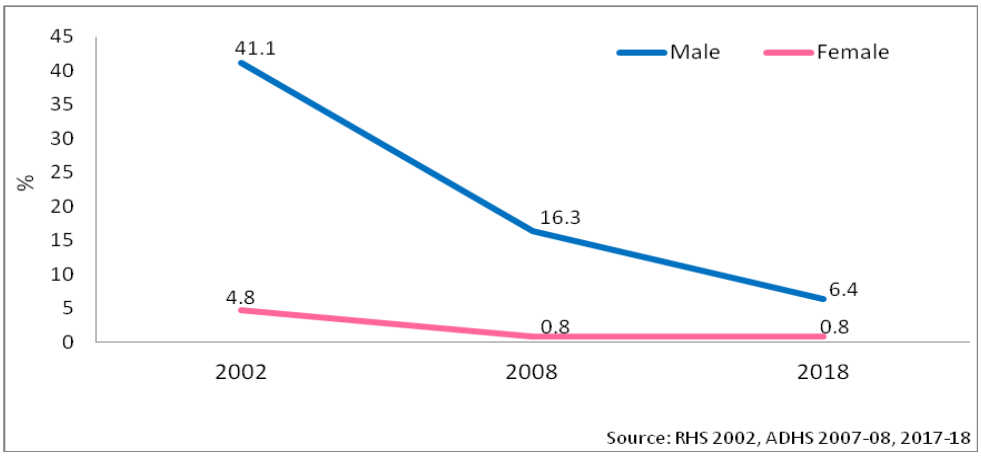

Figure 2. Prevalence (%) of drinking ≥5 days per week during last year

- ***Target 3. Tobacco. Reduce prevalence of tobacco use among adolescents. Halt the rise among women. Reduce prevalence among the adult population***

The information on smoking in Albania is based on periodic population-based surveys that included different age-categories. Comparing the three large surveys employing the same methodology, namely the Reproductive Health Survey (RHS) and the two ADHS rounds, there is evidence of a gradual decrease in smoking prevalence in men aged 15-49 years (from 46% in 2002 to 36% in 2018), but a slight gradual increase in women (from 3% in 2002 to 5% in 2018). Still, compared to GPS 2014 data, even the trend among women is showing signs of stalling.

On the other hand, two rounds of Healthy Behaviour School Survey, 2013-14 and 2019 show that prevalence of smoking among children has remained unchanged.

TABLE 6. TRENDS OF TOBACCO USE IN ALBANIA, BY VARIOUS INTERNATIONAL AND NATIONAL SOURCES

Survey name/data source	Indicator	Age	Sex	Indicator value (and year)				Trend
Institute for Health Metrics and Evaluation (IHME)	Prevalence of daily smoking %	10+	Both	48.3 (1990)	52.2 (2000)	51.2 (2010)	52.8 (2018)	Stable
ADHS, 2008-09, 2017-18, RHS 2002	Prevalence (%) of current	15-49	Male		46.3 (2002)	42.5 (2008)	35.3 (2018)	Strong decline
		15-49	Female		3.0	4.2	5.0	Increase

	smoking				(2002)	(2008)	(2018)	
	Among smokers, % of smoking 10+ cigarettes during past 24 hours	15-49	Male			92.8 (2008)	89.7 (2018)	Slight decline
			Female			61.0 (2008)	54.5 (2018)	Moderate decline
Healthy Behaviour School Survey, 2013-14, 2018	Percentage (%) reporting smoking last month	11, 13, 15	Both			4.4 (2014)	4.5 (2018)	Stable
			Male			6.8 (2014)	6.7 (2018)	Stable
			Female			2.2 (2014)	2.7 (2018)	Slight increase

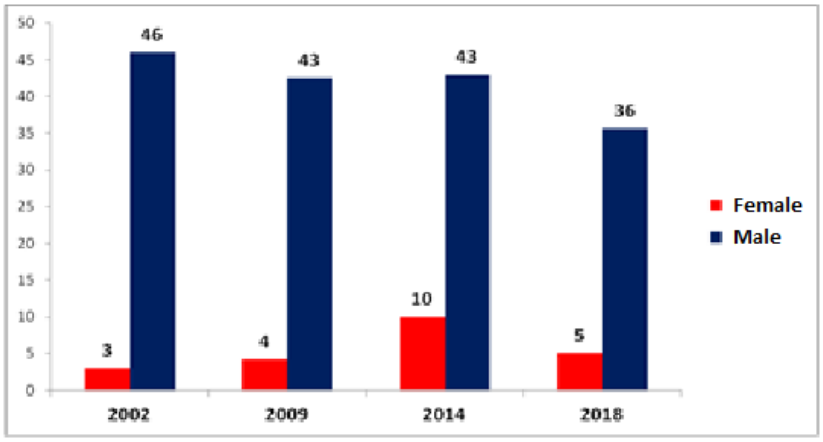

Figure 3. Tobacco smoking trends. National Population surveys

- ***Target 4. Physical activity. Reduce physical inactivity among school aged children by 10%***

Unfortunately physical inactivity has not been monitored systematically among different age groups of Albanian population. In general population it is measured for the first time only by ADHS 2018 and a survey among older people in 2017. The only survey allowing time trend analyses is Healthy Behavior School Survey, which original 2013-14 round was followed by a second round in 2019. The comparison shows some improvement in terms of prevalence of physical activity in bother girls and boys.

TABLE 7. TRENDS OF PHYSICAL ACTIVITY BY VARIOUS NATIONAL SOURCES						
Survey name/data source	**Indicator**	**Age**	**Sex**	**Indicator value (and year)**		**Trend**
ADHS, 2017-18	Prevalence (%) of usual weekly practice of exercises that increase breathing and heart rate	15-49	Male		24.4 (2018)	NA
			Female		18.4 (2018)	NA
MOSHA 2016-2017	Prevalence (%) of those who have done a specific physical activity or sport during last year.	>65	Male	17.9 2017		NA
		>65	Female	10.9 2017		NA
Healthy Behaviour School Survey, 2013-14, 2018	Prevalence (%) of engaging In physical activity for ≥3 days per week Prevalence (%) of sedentary lifestyle on weekends (watching TV or using electronic devices for ≥2 hours per day)	11, 13, 15	Both	74.2 (2013)	77.4 (2018)	Increase (improvement)
			Male	82.0 (2013)	86.8 (2019)	Increase (improvement)
			Female	70.0 (2013)	73.8 (2019)	Increase (improvement)
		11, 13, 15	Both	74.6 (2103)		NA

- ***Target 5. Hypertension. Relative reduction of the prevalence of HBP by 10%***

While there are various sources providing data about hypertension, there is a lack of continuity of standardized data. The reported hospitalizations and cases registered at primary health care are affected by utilization of health care and doesn't truly reflect the prevalence of the problem in population. The time trend analyses about hypertension in health care, show that while registered have been increasing in primary health care, they remain stable or even decreasing in hospitals. This profile may reflect a better management of hypertension at primary health care centres after the introduction of check up program. This finding is corroborated by another study among older people, which demonstrated that severe high blood pressure has been almost halved (29.2% to 14.8%) in Tirana primary health care settings. The May Measurement Month (MMM) surveys of 2018 and 2019 show an increase in the level of awareness (from 52% to 65%)

On the other hand to correctly monitor the NCD strategy target 5, population studies are needed. They are rare and far between. Also, the methods they use may differ substantially. Anyhow data consistently show very high levels of prevalence in adult populations in Albania.
Also high blood pressure was again in 2018 ranked first among risk factors, in terms of attributable deaths.

TABLE 8. TRENDS OF HYPERTENSION BY VARIOUS SOURCES

SOURCE	YEAR					Trend
	2015	2016	2017	2018	2019	
Hospital discharges(registered incident episodes, all ages)	118 cases per 100,000	115 cases per 100,000	112 cases per 100,000	109 cases per 100,000		Slight decrease
Registered cumulative prevalent cases, all ages (PHC)	267,280 cases	269,077 cases	281,857 cases			Increase
Vulnerability study, self-reported, PHC users (≥18 years)				51.9%		NA
MOSHA study, self-reported, general population (≥60 years)			43.1%			NA
Check-up, measured, PHC users (35-70 years)		46.5%				NA
ADHS 2017-8, measured, general population sample: 40-44 years 45-49 years 50-59 years			53.8% in men; 36.1% in women 60.4% in men; 52.0% in women 65.1% in men; 68.8% in women			NA
MMM, measured, general population sample (≥18 years)				37.2%	38.6%	Slight increase
IMIAS 2016, measured, PHC users in Tirana (69-79 years)		56.6%				NA

- ***Target 6. Diabetes and obesity. Halt the rise of obesity and overweight***

According to national surveys on children (COSI) and adults in Albania (ADHS), the prevalence of overweight is on decline among both children and adults and the latest figures show achievement of the NCD strategy targets in this field.
Nevertheless, while total overweight prevalence has been on decrease during the time span under strategy, obesity has increased.

TABLE 9. TRENDS OF DIABETES AND OBESITY BY VARIOUS NATIONAL SOURCES						
Survey name/data source	**Indicator**	**Age**	**Sex**	**Indicator Value (and year)**		**Trend**
ADHS, 2008-09, 2017-18,	Prevalence (%) of overweight (defined as BMI = 25-29.9 kg/m2)	15-49	Male	44.8 (2008)	39.7 (2018)	Slight decline
			Female	29.6 (2008)	28.8 (2018)	Slight decline
	Prevalence (%) of obesity (defined as BMI ≥30 kg/m2)	15-49	Male	8.5 (2008)	13.4 (2018)	Strong increase
			Female	9.7 (2008)	16.4 (2018)	Strong increase
Childhood Obesity Survey Initiative (COSI), 2013, 2016	Prevalence (%) of overweight	8.0-8.99	Both	14.5 (2013)	12.5 (2016)	Slight decline
			Male	15.0 (2013)	12.9 (2016)	Slight decline
			Female	14.1 (2013)	12.2 (2016)	Slight decline
	Prevalence (%) of obesity	8.0-8.99	Both	7.9 (2013)	9.2 (2016)	Slight increase
			Male	9.9 (2013)	12.3 (2016)	Slight increase
			Female	5.9 (2013)	5.8 (2016)	Stable
Healthy Behaviour School Survey, 2013-14	Prevalence (%) of overweight (self-reported)	11, 13, 15	Male		17.1 (2013)	**NA**
			Female		7.5 (2013)	**NA**
	Prevalence (%) of obesity (self-reported)	11, 13, 15	Male		5.5 (2103)	**NA**
			Female		1.6 (2013)	**NA**

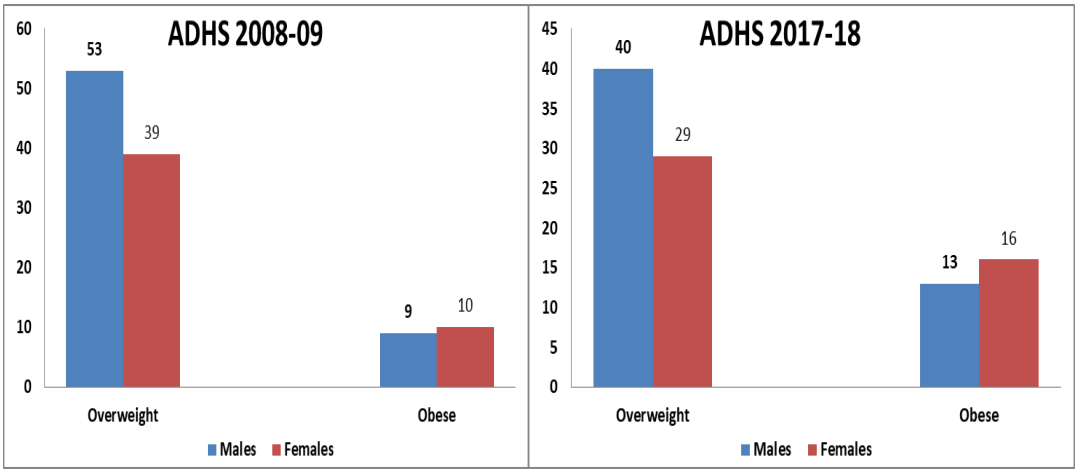

Figure 4. Overweight and obesity trends

- ***Target 7. Health system response: At least 50% of eligible at-risk population undergoes the appropriate therapy. Improve access to essential medicines required to treat major NCDs (by 25%)***

While there are identifiable actions taken by Ministry of Health and Social protection to improve access to proper care for all those who need it, data are no systematic about progress in outcomes. There are, nevertheless, a number of studies which have explored access to health care in high risk population group; the health vulnerability study of 2018, MOSHA study of 2017, evaluation of the first year of the cervical cancer screening program, etc.

Those studies demonstrate that from 75% to 95% of those who needed care/treatment, or were advised to undergo further examinations, were able to do that in public sector. The access is lower among high vulnerability groups (poor individuals, unemployed, Roma communities etc) and in some specific categories falls even under the NCD Strategy target of 50%.

75%-80% of individuals have reported to receive the essential medicines when they were prescribed. One study among older people showed significant progress related to access to medicines. Compared to the 2008 round, the 2017 study among older people confirmed significant improvement in the access to essential medicines; there were 75% of those who could easely access the prescribed medicines in 2017, from only around 40% in 2008.

Another way to estimate achievement of health care access targets is the analyses of time trends of hospitalizations for selected NCDs which need expensive treatment. Cancer treatment budget is especially increased after the introduction of the NCD Strategy. And the access seems to have improved considerably. For example, while the incidence of breast cancer during last 5 years has remained relatively stable at around 700 new cases per year, the hospitalizations have steadily

increased from 4669 cases in 2015 to 6571 in 2017. This profile demonstrates an increase in contacts with specialised health care for those who need treatment.

CONCLUSIONS AND RECOMMENDATIONS

The NCD program processes took place in a supportive political atmosphere and were not mere products of technical analyses. Its development was preceded by a number of important policies, and interventions, including check-up program. The new NCD strategy was built upon those interventions or provided a roadmap to assure their sustainability.

NCD Program has been developed with assistance of WHO and has taken ideas from WHO European NCD strategy. It aims at reducing health inequality, and tackles NCDs at three levels: population level health promotion, high risk categories, and treatment for all. On the other hand, priorities and actions of the strategy were developed after analyzing the existing evidence in the field of NCD and their risk factors. In addition to estimations about NCDs burden, there were used original data from Institute of Public Health studies. 83% of key informants included in the review of the Program, reported that priorities and objectives were based on local evidence.

Only one third of informants thought that the resources dedicated to the measures and actions in the Program were enough. It raises the concern for more resources to be dedicated to the NCD control in the next strategic cycle.

Representatives of some of the most important stakeholders, such as local governments or food industry, were absent during the process of strategy development. Additionally, the involvement of most of the other stakeholders (other ministries, civil society etc.,) remained small to insignificant.

Although there was a formal consultation process, the approval of strategy was not followed by an organized campaign of promoting the new vision, targets and actions, to involve all potential actors and to raise their awareness about the challenges and opportunities. Also, the document and the actions it envisages were not made known to all those responsible for implementing it. More than 34% of informants, especially those at local level were not aware about it, or haven use the program document during their work. The document is not explicitly linked with other national health strategies covering NCD field, such as National Cancer Control Program.

In total there are 75% of key informants who believe that the right actions and measures planned in the Program document are implemented.

Prevention and control of NCDs in health care settings have been progressing significantly during the lifespan of NCD Program. Albanian adults have easy access to basic health services about early identification of NCD risk factors, including metabolic factors and life style factors. New clinical guidelines were developed and approved and workforce has been trained. Data show that tens of thousands of people who were not aware about their hypertension or diabetes are now receiving advice and care. Also, new cancer screening programs such as colo-rectal,

cervical and breast cancer screening programs are approved by government and for most of them there are dedicated funds and resources. Treatment centres and resources for coronary heart disease and cancer have increased substantially. At health system level there is more to be done for better monitoring quality of care and rational use of technology, as well as geographical distribution of human resources. Specific issues such as patient education need more efforts.

Population prevention has shown some progress especially with reorganisation of health inspectorate and improving its efficacy in the war against tobacco smoking in public places. Systematic activities targeting children and youth remain challenging. More efforts are needed to address obesity, unhealthy diets, and controlling marketing pressure. Issues such as alcoholic beverages, high fat, trans-fat, sugar or salt processed food targeting children and youth, should receive more attention. Teachers, parents and social media are still to be more systematically involved in NCD prevention actions. Health and social workers based at school settings need to be supported with NCD related competencies, curricula and training.

While there are some, though still inconsistent, data showing improvement in relation to hypertension awareness and treatment at primary health care, this NCD risk factor remains a major problem in Albania and needs to be addressed, along with diabetes, obesity and tobacco smoking, at population level.

It took a long time and advocacy efforts to finally appoint NCD focal points at some levels of health system. Still, they remain an temporary or ad hoc organisation and should be transformed into permanent NCD control units within Regional Operator of Health Care structures. They need to be provided with clear competency framework and properly trained. Additionally, involvement of relevant stakeholders and the public in various areas of NCDs remains challenging and need to be addressed in the new strategy.

The monitoring of NCD in Albania has been transformed since the approval of NCD program. There have been developed new NCD national framework of indicators, new systems of health care based NCD registries and new national reports about NCDs. Although NCD were included for the first time in the ADHS 2018, data from population remain scarce. WHO STEP-wise approach to Surveillance (STEPS) need to be introduced in Albania, in order to better monitor progress in health outcomes. Also, NCD risk surveillance measurements at schools can provide essential information to monitor policies. Existing models such as Health Behaviour at School Study (HBSC), European School Survey Project on Alcohol and Other Drugs (ESPAD), European Childhood Obesity Surveillance Initiative (COSI) and Youth Risky Behaviour (YRB) need to be further supported to become systematic instruments for policy information.

On the other hand, the death and disease registration in Albania needs to be improved. Introduction of the ICD10 model can be an opportunity for improving the NCD monitoring system.

The review demonstrates that the overall mortality rate among Albanian adults aged 30-69 years not only hasn't continued its increase observed during the first decade of 2000, but has started to slightly decrease, especially during the last 5 years. This seems to be mainly due to a decline in the number of deaths from chronic respiratory disease and, to a lesser extent, ischemic heart disease and strokes (in males). The cancer mortality rate in this age group has also shown some signs of decrease during these years.

The main driver of the higher mortality rate (and shorter life expectancy) among men is their higher cancer mortality rate, particularly given that men's lung cancer mortality rate is five times higher than that for women. Also, the significantly higher cardiovascular preventable death rate in men aged 30-69 years is only reversed in old age, particularly by the increasing stroke risk among women aged 70+ years. This profile points to the necessity of insisting on a smoking control policy and other NCD related risk behavior control policies.

While there are some, though still inconsistent, data showing improvement in relation to hypertension awareness and treatment at primary health care, this NCD risk factor remains a major problem in Albania and needs to be addressed, along with diabetes, obesity and tobacco smoking, at population level.

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26. Law No. 74/2018 for some amendments and additions to law no. 9518, dated 18.4.2006, "On the protection of minors from alcohol use"

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33. Health Behaviour in School-aged Children (HBSC 2017-18 and HBSC 2013-2014)

34. Law "On promotion and protection of breastfeeding" updated in 2019

35. Clinical guidelines for prevention, diagnosis and control of several chronic diseases (for cardiovascular diseases, diabetes, hypertension, cancer, chronic pulmonary disease including asthma, mental conditions, elderly people, etc.), were updated in 2019

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38. NCDs report, Institute of Public Health. 2018

39. 2019 NCD country capacity assessment for Albania, WHO

ANNEX 1. LIST OF KEY INFORMANTS

The full list of key informants interviewed representing different institutions and organizations at central and local level is presented in the table below:

NO.	NAME	INSTITUTION	POSITION
1	Merita Xhafaj	Ministry of Health and Social Protection	General Director of Health and Social Policies
2	Erol Çomo	Ministry of Health and Social Protection	Specialist of Public Health and Health Promotion
3	Ilsa Dede	Ministry of Health and Social Protection	Specialist of Social Policies
4	Albana Fico	Institute of Public Health	General Director
5	Gentiana Qirjako	Institute of Public Health	Head of Health Promotion Sector
6	Enver Roshi	Albanian Parliament	Chair of Commission on Labor, Social Affairs and Health
7	Alban Ylli	Institute of Public Health	Head of Public Health Performance and Chronic Diseases Department
8	Mirela Cami	General Directorate of Health Care Services Operator	Director
9	Naum Sinani	General Directorate of Health Care Services Operator	Head of the Health Services Provider Sector
10	Albana Adhami	Compulsory Health Care Insurance Fund	Director
11	Areti Beruka	State Health Inspectorate	Chief Health Inspector of Tirana Region
12	Lindita Haxhia	Regional Directorate of Health Care Services Operator, Shkodër	Director of Local Health Care Unit (LHCU), Shkodër
13	Ervin Hoxha	Regional Directorate of Health Care Services Operator, Vlorë	Director of Local Health Care Unit (LCHU), Vlorë
14	Xhevair Budani	Regional Directorate of Health Care Services Operator, Elbasan	Director
15	Bora Salaj	Regional Directorate of Health Care Services Operator, Tiranë	Director of LCHU, Tiranë

16	Mikel Llogori	Local Health Care Unit (LHCU), Korçë	Director LHCU Korçë
17	Ariela Malaj	Local Health Care Unit (LHCU), Tiranë	Head of Primary Health Care, LHCU, Tiranë
18	Megi Bilali	Local Health Care Unit (LHCU), Shkodër	Head of Primary Health Care, LHCU, Shkodër
19	Majlinda Gjika	Local Health Care Unit (LHCU), Vlorë	Head of Primary Health Care, LHCU, Vlorë
20	Eriona Petro	Local Health Care Unit (LHCU), Durrës	Head of Primary Health Care, LHCU, Durrës

ANEX 2. DETAILED RESULTS FROM KEY INFORMANTS INTERVIEWES

Evaluation of the National Action Plan on Non-Communicable Diseases 2016-2020, in the context of the preparation work for the new Action Plan for the next 5 years.

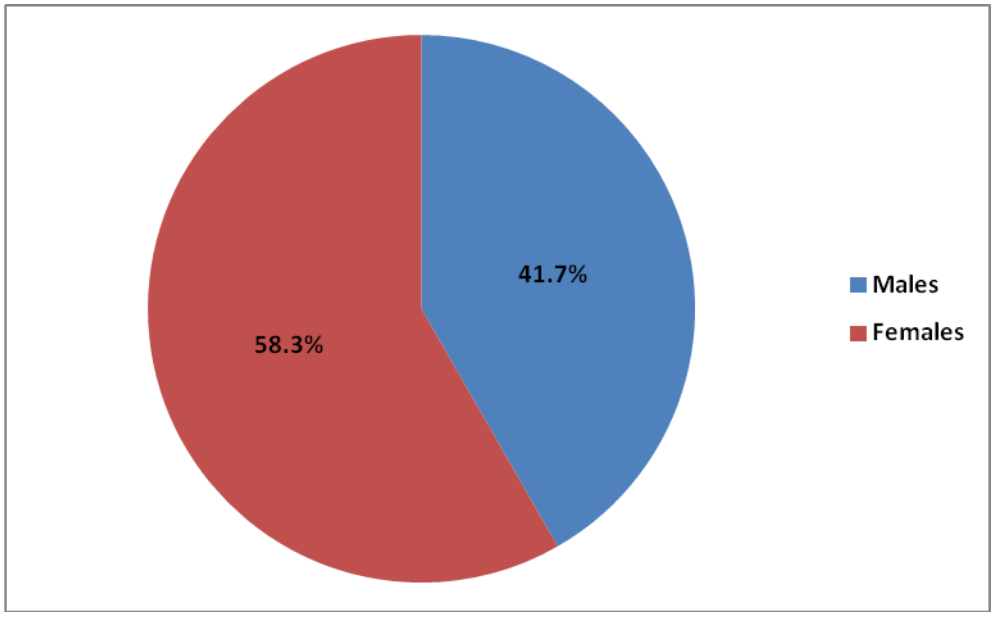

Figure 5. Gender distribution of interview participants

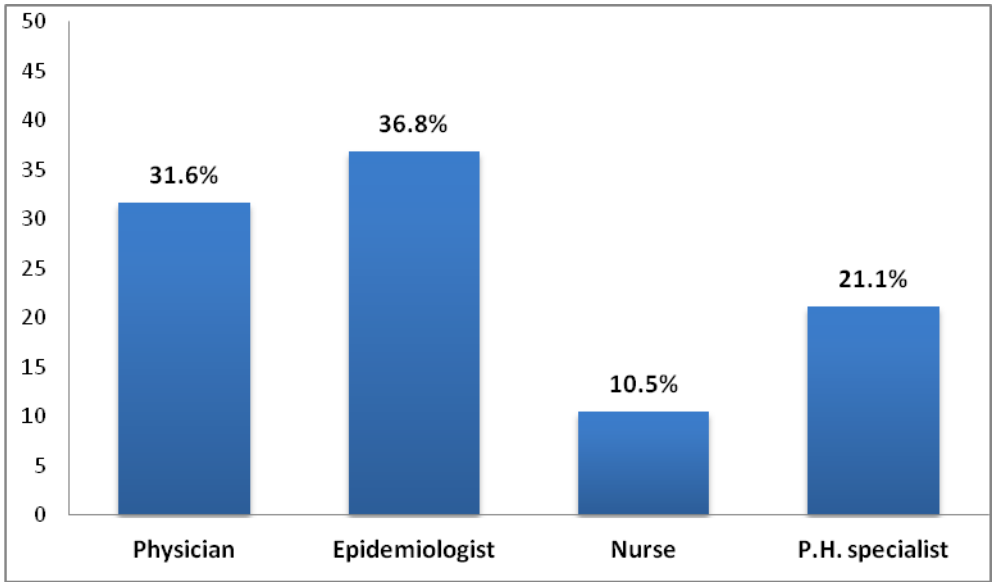

Figure 6. Distribution of the interview participants profession

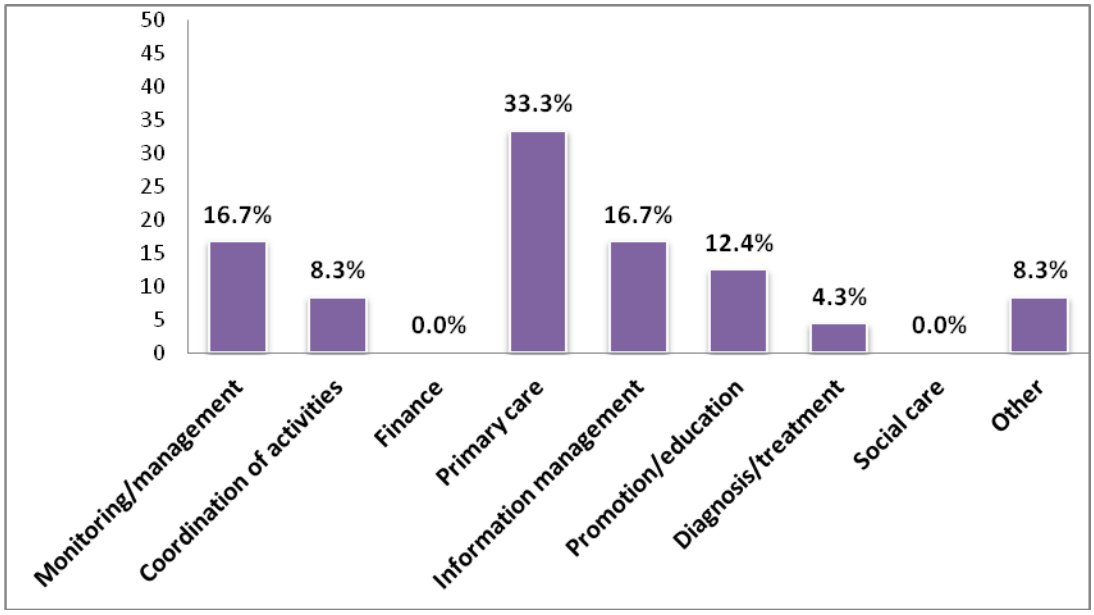

Figure 7. Distribution of job position of interview participants

The main opinions of the most important actors regarding the National Action Plan on Non-Communicable Diseases 2016-2020 are shown below.

Issues discussed on the NCDs National Action Plan	Opinions of the key informants of the NCDs National Action Plan
The priorities and objectives of the NCDs Plan were based on national data and studies.	➢ National studies, progress reports, reports to international agencies (United Nations Agencies, European Commission, etc.,). ➢ Somewhat because there were some shortcomings and some reports were relatively old. Data from ADHS 2009, primary health care services, and data from INSTAT, data from the Ministry of Health and Social Protection, etc. were used. ➢ The priorities and objectives of the NCDs Plan, in addition to national studies are also based on data collected from the registers and surveillance of chronic diseases, screening programs (check-up, breast cancer, cervical cancer), and data from other institutions such as the Compulsory Health Care Insurance Fund, INSTAT, etc.,.
Appropriate measures were proposed to achieve the overall goal.	➢ The proposed measures were discussed in several meetings with national and foreign experts. ➢ Some activities carried out have been in function of achieving the objectives of the NCDs Plan (breast cancer, cervical screening, check-up, education and promotion of NCDs risk factors, etc.,). ➢ In general, some of the appropriate measures have been

	proposed and implemented to achieve the overall goal of the NCDs Plan, which is to avoid premature death for some of the chronic diseases, including some types of cancer; reduced alcohol and smoking use according to national studies among adults and young people; decreased prevalence of obesity in both men and women; the number of medicaments on the list of reimbursement has increased; implementation of national screening programs, etc.,.
Approved measures and interventions have been implemented.	➢ Some of the measures have been properly implemented, some have not. ➢ A number of measures have been implemented inspired or supported by the strategy. This includes in particular a range of activities, programs and policies that improve access to health care for early detection of NCDs and risk factors, as well as their treatment, such as the check-up program, universal health care policies, new centers of coronary angiography diagnosis, policies of distribution of bypass operations in publicly funded private hospitals, screening program for Ca cervix and Ca of the colon, enlargement of the list of reimbursable drugs and substantial increase of funding for drugs about the cancer`s treatment, etc.,. Also, some measures have been implemented regarding the proper monitoring of NCDs, such as preparation of standardized indicators, set up of registers for Ca, cardiovascular diseases and diabetes, etc.,. The first national reports in this area (NCDs national report, bi-annual NCDs system evaluation reports, studies on the elderly, etc.,.), are an indicator of progress. Also, in principle ICD 10 was adopted and is awaiting final implementation. There has been less progress in the area of primary prevention or behavior control. The report on reducing salt consumption is a step in this direction. However, there have been efforts in the right direction, including initiatives by some local governments to promote active living, alternative transport (bicycles, etc..,) and healthy school nutrition (bread on bag). Cross-sectoral cooperation has been strengthened in terms of control and prevention of NCDs in our country. The Health Inspectorate has been strengthened and have been taken measures to increase the excise tax on tobacco products, alcohol, energy drinks and with added sugar. Family physicians in primary health care have been trained in counseling about the health effects of alcohol, tobacco products, unhealthy nutrition, physical inactivity, etc.,. Physical activity hours in schools have been increased. But there is a need to strengthen the role of schools in promoting a healthy lifestyle to students and also there is a need for promotional and educational activities for the general population. On the other hand there is a need to

	strengthen the capacity of primary health care physicians to educate the population about a healthy lifestyle.
Social inequalities were addressed by the proposed measures and interventions.	➢ Check-up Program 35-70 years old; Universal access to family doctor. ➢ Universal care measures have aimed to improve access for less-favoured groups; those with lower incomes, those living in the village, etc. The results of the first evaluation of the check-up program and the screening program for Ca of cervix, are a good proof of this. ➢ Breast and cervical Ca screening, check-up, for example, are provided for all, regardless of solvency, reducing social inequalities in access to these services. ➢ All population has free access to health care services, especially when the referral system is followed. More specifically in the cervical cancer screening program, the family doctor invites and contacts every woman of the target age to perform the screening with the HPV test, regardless of her economic opportunities and place of residence, also the same procedure is followed by check-up.
Sufficient financial resources were provided for implementation of the NCDs Action Plan.	➢ The non-implementation of activities is partly related to the lack of coordination and monitoring of the implementation of the NCDs Plan, partly to the non-allocation of the necessary funds. ➢ I am not very aware of the financial resources dedicated to the implementation of the NCDs Action Plan, but despite the successes and achievements so far, there is a need for more financial resources in terms of screening programs and other programs related to primary prevention of NCDs. ➢ More financial resources are needed to implement the NCDs Action Plan.
In your opinion, what were the main obstacles and challenges for the implementation of all the envisaged activities of the action plan on NCDs 2016-2020?	➢ Lack of a functional structure in the MoHSP to coordinate and monitor the implementation of the NCDs Action Plan. ➢ The establishment of the Health Care Operator, has been a challenge related to the determining of tasks/responsibilities in this field, at national and local level. The determination of district`s focal points was carried out late, despite constant requests and reports from the IPH. ➢ The pandemic has created a major problem in accessing services and shifting attention and resources over the past year. There is an unpublished report regarding the measures and consequences of the pandemic.
What advice can you give to the team that will draft the new action plan on NCDs?	➢ A comprehensive consultative process. ➢ More preventive measures and also related to better work organization should be involved. Focal point training curricula and other public health professionals (school doctors, social workers, etc.) should be considered. ➢ School programs should be included. ➢ Social media should be included in awareness raising programs. ➢ STEPS must replace ADHS.

What would be your main recommendations for the upcoming action plan on NCDs?	➢ Focus on strengthening coordination and monitoring structures. ➢ More professional human ressources. ➢ Focal points in districts need to determine specific competencies/skills and tasks. ➢ Strengthening cross-sectorial cooperation towards design and implementation of preventive policies of NCDs in our country. ➢ The Action Plan should be based on two main standards: the check-up program and the vulnerability report in the Primary Health Care Service. ➢ Increased investments in infrastructure and logistics for H.C.

ANEX 3. THE FULL EVALUATION MATRIX

The full evaluation matrix is available in the following Excel document (please CTRL+ Click): Final - Reporting Form Review of NCDs Action Plan.xls