

Healing the Crisis



A Prescription for Public Health Action in South Eastern Europe

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South Eastern Europe

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Executive Summary

In all countries and territories of South Eastern Europe, there is an urgent need for action in public health. The recommendations set out by this report reinforce the priorities identified by the ministers of health of South Eastern Europe in the 2001 Dubrovnik pledge. Success will depend on political and financial commitment at regional and national levels and increased and better harmonised donor support. The recommendations focus on four key areas of activity:

- ▶ Building capacity to identify and respond to the threats to population health at national, district, and local levels, including the development of effective surveillance, information, and training systems to enable appropriate identification and analysis of problems.
- ▶ Investing in appropriate health care financing and delivery systems that ensure quality and access, especially for vulnerable populations.
- ▶ Developing mechanisms for practical cooperation and sharing of best practices within the region. Better documentation of activities is also essential for governments and civil society organisations working in the region to learn from each other.
- ▶ Encouraging increased commitment and coordination by donors and international financial institutions to support nationally led strategies to implement these recommendations.

The countries and territories of South Eastern Europe urgently need to tackle problems created by the near collapse of health systems. Good health for the people living in this region will be crucial to ensure enduring peace, economic growth, and stability.

The Urgent Need to Improve Public Health

South Eastern Europe—Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Former Yugoslav Republic of Macedonia,* Moldova, Romania, Serbia and Montenegro, and the UN-administered province of Kosovo—is emerging from a decade of wrenching transition from planned to market economies; from authoritarian to democratic regimes; and, in some cases, from peace to war and back to a fragile peace. Nowhere has transition been more painful than in the countries and territories that once comprised Yugoslavia.**

Despite the recent, tumultuous past, the prospects for success in the region have never been better. For the first time in history, all of the countries and territories in South Eastern Europe enjoy democratically elected governments. They are open to reforms to overcome the challenges they face. Poverty reduction and development strategies have been or are being developed in Albania, Serbia and Montenegro, Bosnia and Herzegovina, Moldova, and Romania. The

*Officially recognized as the Former Yugoslav Republic of Macedonia, henceforth will be referred to as Macedonia.

**Slovenia, which was once part of the former Yugoslavia, is about to join the European Union, and has not been included in this review.

countries and territories that make up the region are eager to reintegrate with the rest of Europe and are exploring ways to cooperate in areas of mutual interest. Public health* must be recognized as a critical issue that requires and compels sustained regional cooperation.

The countries and territories of South Eastern Europe urgently need to tackle problems created by the near collapse of health systems. Good health for the people living in this region will be crucial to ensure enduring peace, economic growth, and stability.

Despite being part of the Stability Pact for South Eastern Europe, a regional network designed to increase cooperation in areas of common interest, there are few examples of regional cooperation in the area of health. Yet the region's multiple common health concerns provide a unique opportunity for governments and civil society to work together to share best practice and lessons learned.

This report draws attention to the challenges and opportunities to addressing common public health problems in South Eastern Europe. It focuses on key issues related to population health and the provision of basic health services. The report does not examine the different elements of the health care system, such as secondary or tertiary care, or the challenges posed by the new and largely unregulated private sector. It is based on the findings of a review of available sources of information on health in South Eastern Europe, including published studies, health statistics, and reports from governments, development agencies, research institutes, and nongovernmental organisations (NGOs). To provide further information and detail, this report is accompanied by a database of all identified documents, including bibliographic information and annotations; an in-depth review of the information in the reference documents; and summary profiles of each country. These documents are available online at: <http://www.lshtm.ac.uk/ecohost/see>. The examples in this report are drawn from throughout the region. However, differences in the numbers of examples from various countries and territories reflect differences in available information. Further details can be obtained from the information review on the website.**

The Context

While the countries and territories covered in this report have unique and varied histories and face distinct challenges in overcoming the past, they also share common problems that each has combated with varying degrees of success. Bulgaria and Romania, candidates to join the European Union, were not included in the current round of accession. Moldova, which enjoys close linguistic and cultural ties with Romania, is still reeling from the collapse of the Soviet Union,

*Public health is defined as the promotion of health and prevention of disease through the organised efforts of government and society.

**References referring to the data presented in this paper are listed at the end of the document. Additional references can be found in the information review and the online database.

the breakdown of trade with the former republics, and a violent conflict in the Transdnier region. Albania's economy has yet to recover from the collapse of pyramid investment schemes in 1997. Bosnia and Herzegovina remains internally divided. Kosovo is operating under the administration of the United Nations. The prospect of an all-out war has receded in Macedonia, but the country has yet to implement the agreed terms of co-existence between the Macedonian majority and the Albanian minority. Serbia, after the assassination of Prime Minister Zoran Djindjic, is trying to push through reforms while breaking the hold of organised crime. The Republic of Montenegro continues to adapt to the uncertainties of its relationship with the Republic of Serbia.

War and instability have exacted a huge toll on the region as a whole. In addition to killing hundreds of thousands of people, disabling tens of thousands, and displacing millions, the wars plunged millions more into poverty. Families were divided across frontlines. Transportation, housing, education, and health care systems were damaged or, in some places, destroyed. Industries and established patterns of trade were interrupted and abandoned. The region was set back decades economically. Those countries fortunate to escape a war on their territory, such as Bulgaria and Romania, suffered from the disruption of trading routes. Organised crime and corruption proliferated. There was a steep rise in the trafficking of drugs and people. Each country or territory saw the mass emigration of young people and trained professionals.

In the aftermath of war, borders are now open between former warring territories and across the region. Although the relative freedom of movement will ease regional cooperation, it will also necessitate increased collaboration to ensure that the benefits outweigh the potential problems.

Growing Poverty and Social Exclusion

Many in South Eastern Europe live on the margins of society. Information on the scale of poverty is complicated by problems of data comparability and availability, but existing information clearly shows that poverty is widespread and social inequalities are on the rise.* Surveys show that up to 30 percent of Albanians lived below the national poverty line in 1998 [1]. In Serbia and Montenegro 33 percent of the population lived on less than U.S. \$2 per day in 1999 [2]. In Moldova, the scale of poverty is even greater. Up to 66 percent of the population lived below the national poverty line in 1999 [3]. The situation is often worse in many rural areas, where traditional forms of support and employment have disappeared.

*The UN Committee on Economic, Social and Cultural Rights defines poverty as including sustained or chronic deprivation of the resources, capabilities, choices, security, and power necessary for the enjoyment of an adequate standard of living and other fundamental civil, cultural, economic, political, and social rights. For the purposes of this review, however, poverty levels have been proxied through income poverty.

Unemployment

One of the main reasons for the mounting poverty, particularly in the former Yugoslavia, is the great increase in unemployment. This has been compounded by the disruption of social protection systems. In Bosnia and Herzegovina, an official unemployment rate of 40 percent was recorded in 2001, while in Macedonia it was 30.5 percent. Falling wages have accompanied the rising unemployment. Throughout the region, real wages plummeted after 1989 and have not yet returned to pre-transition levels (Table 1).

TABLE 1 Real Wages for Selected South Eastern European Countries

(index, base year = 100)	1989	1999
Bulgaria (a) (b)	100	52.2
Macedonia	100	53
Moldova (a)	100	35.1
Romania (c)	100	62.3

Source: UNICEF 2001: *A Decade of Transition* [4].

Note: (a) based on gross wages; (b) public sector only; (c) based on net wages.

The collapse of the former systems helped a small minority get rich. But the vast majority became poor and throughout the region income inequalities increased considerably. A stark reminder of the growing inequality is increasing levels of malnutrition, which has particularly grave consequences for children.

The nutritional status of children generally reflects the socio-economic fortunes of their parents. Undernutrition is most common among children from poorer families. The effects of poverty are especially serious for children as poor health services, nutrition, and lack of access to early childhood programs can permanently affect their development.

Discrimination

The most vulnerable in these societies are those unable to participate in a modern market economy, whether because of lack of skills, age, or discrimination. The impact of discrimination is especially pernicious for displaced persons and for members of minority populations. The largest such minority group is the Roma, who have been subject to increasing discrimination throughout Central and Eastern Europe since 1990. In many parts of the region they live on the margins of society, often in shockingly substandard housing and with limited access to health facilities or schooling.

Opportunities for employment are few and life expectancy is lower than it is among majority populations. A UNDP-sponsored survey in Macedonia in 2000 found that more than four out of five Roma could not afford to buy sufficient food [5]. In 2002, UNDP reported that just over half of Roma in Bulgaria had health insurance; the proportion was only slightly higher in Romania [6], despite a formal commitment to universal coverage in both countries.

Refugees and internally displaced people face particular risk of impaired mental and physical health. Many have experienced traumatic events in the process of displacement and are viewed with suspicion in their new places of residence. Often lacking appropriate documentation, these populations are frequently denied access to any form of health or social insurance and receive limited—if any—social support.

Other vulnerable populations have also fared badly in the past decade. Elderly people, especially in rural areas, have seen the collapse of social support. High levels of emigration mean that many are now physically isolated from their families. Their outlook is worsened by the almost complete absence of community care schemes.

People with disabilities have suffered considerably. Disabled children in Moldova experience death rates 10 times higher than those of able-bodied children [3]. In Serbia and Montenegro only a tiny fraction—10 percent of the estimated 143,000 children with disabilities—is believed to receive any formal social support [7].

Limited Access to Health Services

The social costs of transition have had a direct and indirect impact on the publicly funded health sector. Access to services has diminished as health care systems have suffered from lack of investment in infrastructure, erosion of the real value of health sector salaries, a shift of health care expenditure to households both formally and informally, and neglect of public health services. At the same time demand has increased, as the population's health status has suffered due to deteriorating housing, nutrition, and changes in lifestyle. This creates a vicious cycle as ill health is a predisposing factor for poverty.

The current performance of the health sector is rooted in a legacy of war and civil strife, chronic fiscal deficits, the dissolution of the previous social safety network, and changes in societal values. It also reflects the legacy of a system that emphasised a medical, rather than a public health model, focusing on treatment rather than prevention and on institutions and professionals rather than the people they served. These institutions, previously part of a planned economy, are plagued by problems of weak management, duplication of services, and a focus on specialised hospital care rather than basic primary care. Further, where new states have been created, each must now develop its own national frameworks for disease prevention and control, and build capacity to monitor and implement these plans.

Shifting the burden of health care to the poor

A major feature of economic transition and reform in many countries and territories has been a shift in the burden of health care costs from the state to families and individuals, and in particular to those whose needs are greatest—the poor and ill. This has happened formally, through introduction of co-payments for health services and drugs, and informally, by informal, out-of-pocket payments. Both formal and informal payments have increased dramatically. For example, in Moldova in 2001, official payments by individuals receiving care made up almost 40 percent of the overall health care budget, placing a huge burden on families. And despite policies to discourage informal, out-of-pocket payments, the practice is widespread in many countries. As illness is concentrated among the poor, this inevitably impacts already vulnerable populations. The withdrawal of subsidies for drugs has hit many people hard, particularly those prevented from working by chronic diseases.

Structural reforms are not completed, while day-to-day problems are plaguing service delivery and access to health care. This adds to the social costs of transition and prevents the establishment of an equitable and efficient system. In response, a largely unregulated private health provider system is developing, with profound implications for the poor and ill.

Throughout the region, reduced access to health care has been especially great in rural areas, where the migration of health professionals to cities, coupled with inadequate investment in equipment and facilities, has led to the loss or deterioration of services.

The reasons for poor health in South Eastern Europe are numerous, but some are particularly significant. One factor is smoking, which is expected to increase due to aggressive marketing by tobacco companies and weak policy responses from governments so far.

The State of Health in the Region

The Challenges of Assessing Health

Any attempt to assess the health of populations in South Eastern Europe faces major obstacles: data are often unreliable or simply absent. Until recently it was nearly impossible to find accurate population estimates, as wars, conflict, and economic decline have triggered large-scale population movements across the region. In 2001, the population of Bosnia and Herzegovina was estimated to be between 3,365,000 and 3,759,000 [8]. Estimates of the population in Kosovo in 2001 ranged from 1.61 million to 1.96 million people [9]. As population data provide the basis for calculating rates, there is considerable uncertainty about the accuracy of health or economic indicators.

Lack of reliable data and information

Censuses conducted in 2001 in Albania, Bulgaria, and Croatia, and, in 2002 in Macedonia and the Republic of Serbia, however, are helping health professionals gain more accurate insights into population health. Once fully analysed, they will provide a better understanding of what has happened to health in these countries. However, a significant number of people are not captured by censuses—including refugees, minorities, and those without papers, citizenship, or homes.

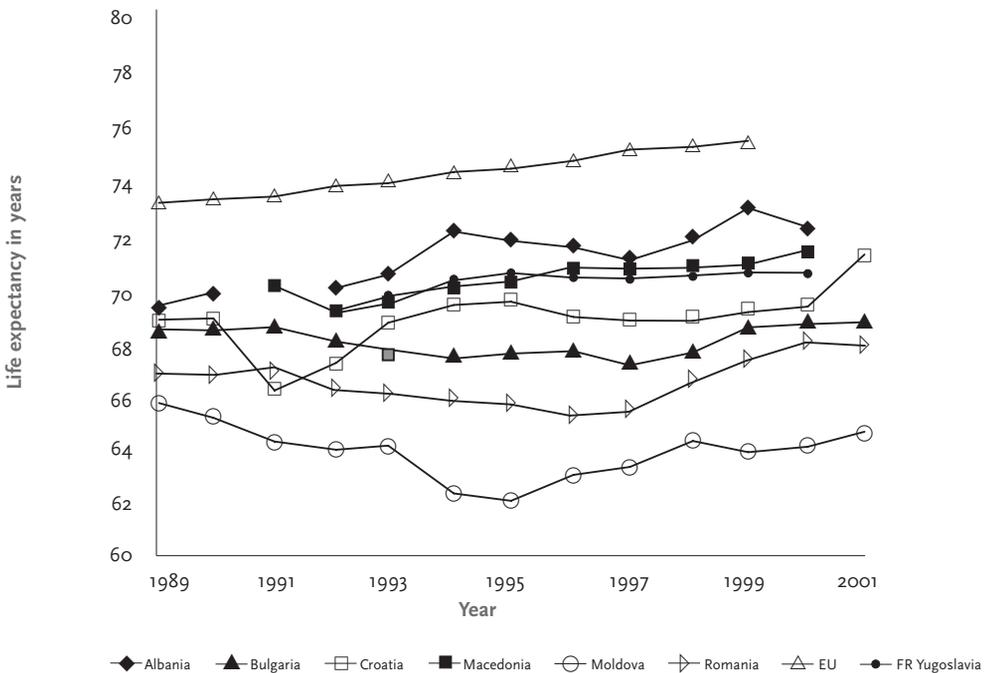
Another challenge in assessing population health is the fragmentation of previous health information systems over the past decade as a consequence of economic transition and politi-

cal turmoil. Data on nonfatal diseases are especially problematic. Data for Bosnia and Herzegovina and Serbia and Montenegro are often unavailable. Data for Kosovo are either missing or considered highly problematic [10] and there is little reliable information from the semi-autonomous region in Moldova [11].

In certain areas, health information is available from nongovernmental sources. Multilateral and bilateral donor organisations, as well as national and international NGOs, have undertaken a number of studies looking at health and socio-economic conditions. These provide important, if incomplete, pictures. However, very little is yet known about the most vulnerable groups of the population. In 1999–2000, Bosnia and Herzegovina, the then Federal Republic of Yugoslavia, Macedonia, Moldova, and Albania undertook cluster surveys of families and children to measure progress against end of decade goals for children. These surveys established comparative data useful for policymakers at the country level—in some cases they are the first such data for 10 years. The data are available at <http://www.childinfo.org/index2.htm>.

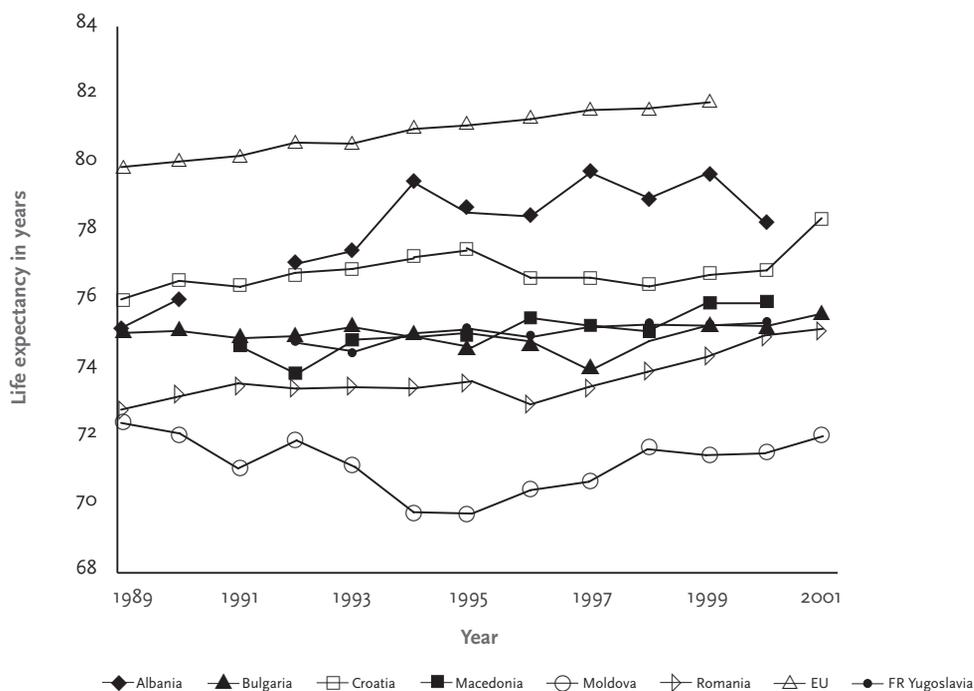
The Burden of Premature Death and Disability

FIGURE 1 Life Expectancy at Birth for Males*



Source: WHO HFA database, January 2003 [12].

FIGURE 2 Life Expectancy at Birth for Females



Source: WHO, HFA database, January 2003 [12].

Life expectancy

Although caution is needed in interpreting the data, Figure 1 and Figure 2 indicate that estimated life expectancy in most countries of the region did not improve significantly in the 1990s. In contrast, life expectancy in the countries of the European Union has moved steadily upward for both sexes. Consequently, the gap in life expectancy between South Eastern Europe and the EU has increased for both men and women. At the most extreme, people in Moldova can expect to live 10 years less than their counterparts in the EU. Many of these deaths are among the young

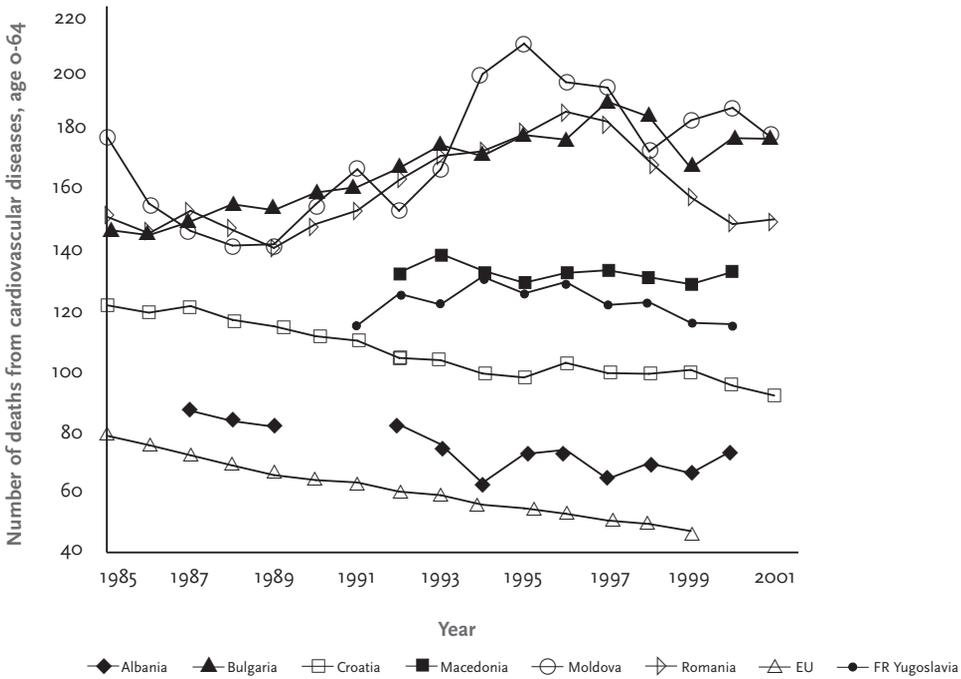
*In all figures using the WHO HFA database, data for FR Yugoslavia include Serbia, Montenegro, and Kosovo. Since 1999, data collection in Kosovo is no longer undertaken by the FR Yugoslavia but by the United Nations Interim Administration Mission in Kosovo (UNMIK). Bosnia and Herzegovina has not made data available to WHO since 1992. Line breaks in the figures indicate periods of missing data.

or middle-aged, the groups that are supporting families and can contribute substantially to the reconstruction of their countries. Women everywhere can expect to live longer than men, but it is disturbing that female life expectancy showed only a moderate increase in most countries during the 1990s.

Causes of death

The main causes of death in the region include heart disease, with death rates in several countries more than three times those in the EU, and cancer, where the gap is not as large, but is growing. Figure 3 shows that in all countries of the region the burden of premature mortality due to cardiovascular diseases is higher than in the European Union.

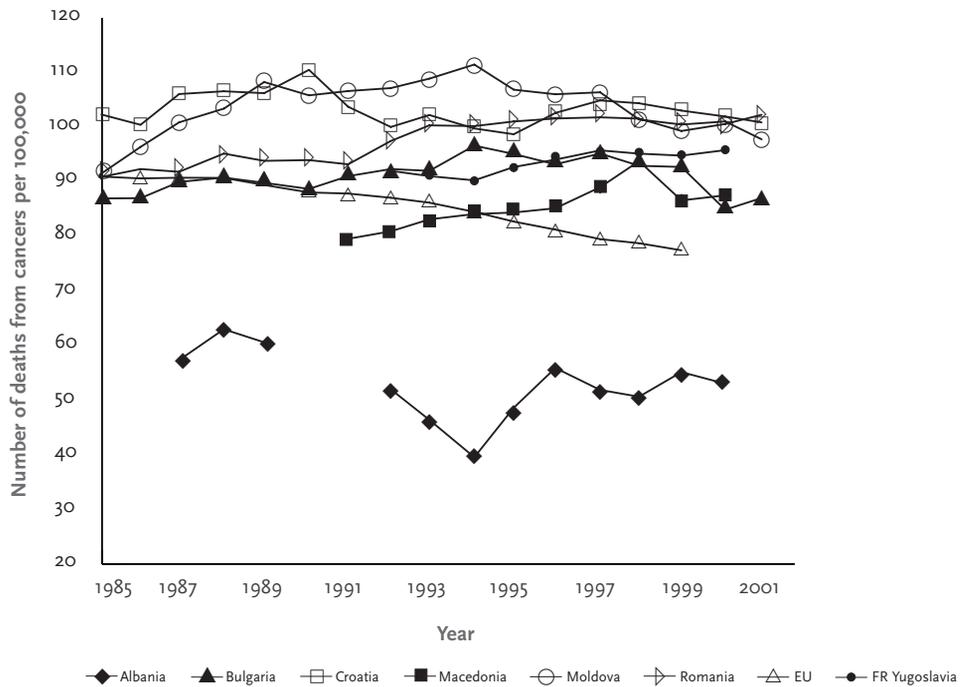
FIGURE 3 Age Standardised Death Rate from Cardiovascular Diseases, per 100,000, age 0-64



Source: WHO, HFA Database, January 2003 [13].

Figure 4 shows the cancer mortality gap between the EU and South Eastern Europe, where many more people die before the age of 64 than in the European Union. The one exception is Albania, where a Mediterranean diet rich in fresh fruits, vegetables, and olive oil seems to have protected the population [14,15].

FIGURE 4 Age Standardised Death Rate from Cancers, per 100,000 population, age 0-64



Source: WHO, HFA Database, January 2003 [13].

Reasons for poor health

The reasons for poor health in South Eastern Europe are numerous, but some are particularly significant. One factor is tobacco smoking, which is expected to increase due to aggressive marketing by tobacco companies and weak policy responses from governments so far. It is now widely accepted that about half of all regular smokers will die from tobacco-related diseases. Fifty percent of these deaths will be among people who are below retirement age.

Another reason for poor health is a diet high in fat and, in some countries, low in fresh fruits and vegetables, especially in winter when they are out of season.

Inadequate health care is a third factor. For example, many people with high blood pressure remain undiagnosed. Of those whose condition is known, many are treated inadequately. Deaths due to cervical cancer are largely preventable, and screening programs in Western countries have had great success. In South Eastern Europe, however, death rates remain very high, reflecting not only high levels of the sexually transmitted infection that increases the risk of developing cervical cancer but also a failure to provide comprehensive, quality-controlled screening programs. In 1999, death rates from cervical cancer in Bulgaria, FR Yugoslavia, and Moldova were three times higher than the EU average. In Romania, the death rates were six times higher than in the EU. In most countries of the region, cervical cancer rates are still on the rise [13].

Although cancer rates are increasing, palliative care for those dying from this disease is not integrated into national health care policies and is not funded by national or private health insurance systems. Effective drugs, in particular opiates needed for pain relief are often not available. Medications for symptom control and treatment of opportunistic infections are difficult to obtain.

Death rates from injuries and violence are particularly high throughout South Eastern Europe (Figure 5). These deaths disproportionately affect the young and have multiple causes. Road traffic accidents are often due to poor road conditions and inadequate enforcement of driving regulations—allowing for drunk driving, speeding, and lack of seat belt use. Homicides and suicides are facilitated by easy access to firearms left over from the wars of the 1990s. A study in Croatia in the mid-1990s found that up to a third of children had access to small arms or explosives in their own homes [38]. Even in those countries and territories spared conflict, rates of homicide are at least 2.7 times higher than in the European Union [13]. Rates of domestic violence are also high and a major though underreported source of morbidity in women, children, and vulnerable elders.

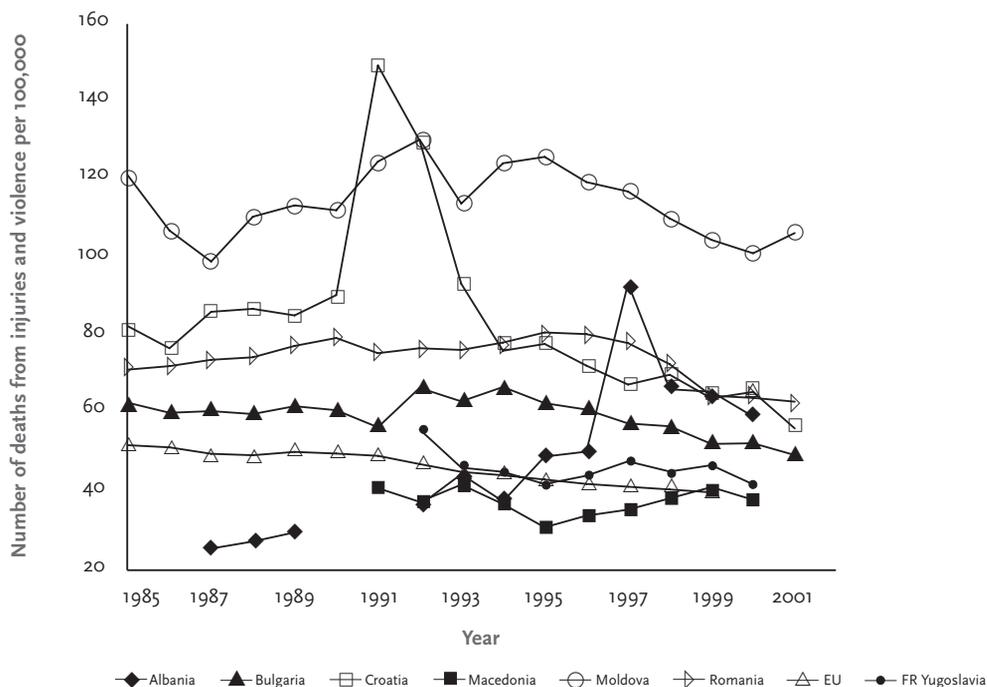
Disability

Health is measured not only in premature death; it also includes long-term disability. Physical disability may be war-related, in particular as a consequence of the many landmines yet to be cleared. It can also result from inadequately treated chronic disorders, such as diabetes-related amputations or chronic heart or lung disease. Disabilities can also be the consequences of poverty and poor health in early childhood.

Mental disability, although often less visible, can be equally incapacitating. The wars and conflicts in former Yugoslavia, Albania, and Moldova had traumatic effects on the population, the consequences of which may be seen for generations to come. Though relatively little systematic information is available about the mental health of people in South Eastern Europe, reported rates of psychiatric symptoms have increased. High levels of post-traumatic stress disorder have also been reported. Throughout the region (with the exception of Bosnia and Herzegovina and, to a lesser degree, Croatia), mental health services are underdeveloped and largely institutional, with few community-based support services [39]. Amnesty International,

UNHCHR, UNICEF, and WHO have documented that people with mental or physical disabilities, or children without parental care or in conflict with the law are often relegated by official policies to residential care and conditions that violate basic human rights. The slow pace of improvement and the overall lack of community-based services are striking and due to shortages of funds, low official priority, and limited foreign assistance. There are also significant, enduring legal and policy barriers to the full integration of people with mental disabilities into society.

FIGURE 5 Age Standardised Death Rates from Injuries and Violence, per 100,000, all ages



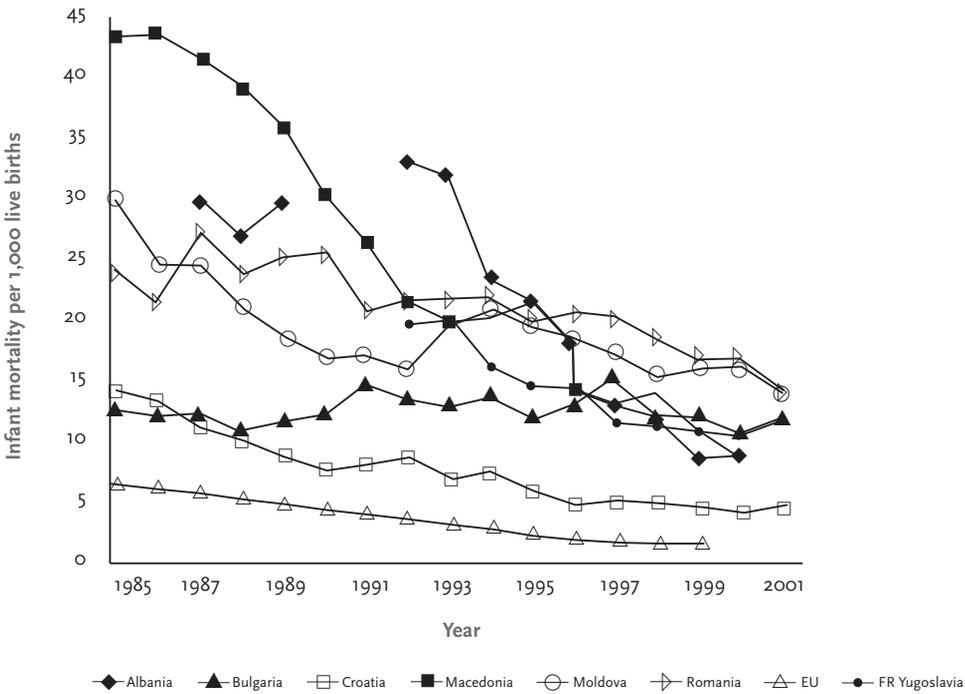
Source: WHO HFA database, January 2003 [13].

Health from Infancy to Adulthood

Infants and children

The first three years of life are crucial for children. Lack of access to basic health rights and care during this period can permanently damage a child and impair further development. The crippling effects of poverty, poor nutrition, and lack of health protection are affecting more and more children in South Eastern Europe. The systems in place before 1990 had many failings but they did do much to improve the health and welfare of children. Since 1990, many of these systems have suffered, either from destruction of facilities and loss of skilled staff, or from the economic collapse that has accompanied transition.

FIGURE 6 Infant Mortality per 1,000 Live Births



Sources: WHO HFA database, January 2003 [13].

Comparable data on children's health are scarce. One measure of child health, infant mortality rates, however, do have the advantage of being widely reported and can provide a basis for comparison. Infant mortality rates in the 1990s in South Eastern Europe did not decline nearly as rapidly as in the countries of the EU. In 1999, the rates remained almost three times higher than in the European Union (Figure 6).

There are alarming data from UNICEF's Multiple Indicator Cluster Surveys (MICS) on childhood malnutrition. Two important measures, low height for age (stunting) and low weight for height (wasting) reveal that a substantial proportion of children in the region are undernourished. Several studies in the region also show that the majority of children are not exclusively breast-fed for six months, as recommended by WHO.

Many other easily preventable nutritional disorders persist. Iodine deficiency is easily prevented by adding iodine to salt. Yet surveys in Albania, Moldova, and FR Yugoslavia showed that many households do not have access to iodised salt. In 2000, less than three-quarters of salt in the FR Yugoslavia was adequately iodised. In Albania it was less than half. In Moldova one third was iodised with only 13 percent iodisation in the semi-autonomous Transdnier region [3,17,18].

Perhaps the most dramatic sign of the worsening status of many children is the growing number living on the streets. In the late 1990s, an estimated 5,000 children were living on the streets of Romania and 3,000 on the streets in Albania [40,41]. Thousands more are placed in institutions. There has been some improvement from the almost medieval conditions seen in Romanian "orphanages" in the early 1990s. But much remains to be done to develop foster care and community and family support programs.

Adolescents

One of the best ways to gauge the future health of a population is to look at the health of its adolescents. Adolescents must make many lifestyle choices. Unfortunately, many of these choices can lead to premature death in adulthood.

A survey of school children aged 15 in Belgrade found that 20 percent had been drunk at least once in their lives [10]. In Croatia, in 1999, more than 50 percent of school children aged 15-19 were regular smokers [42]. Most alarmingly, the number of young drug users in Albania is estimated to have doubled every two years during the 1990s. In Albania 10-12 percent of school children aged 13-14 have used illicit drugs. Among urban adolescents aged 14-18 in Bulgaria, the figure rises to 30 percent [19,20]. Cannabis is the most widely used illicit drug, but opiates are becoming more common. In Bulgaria, the number of heroin users is estimated to have increased from 1,500 in the beginning of the 1990s to 25,000-30,000 by the end of the decade, with young people the majority of users. The average age of people seeking treatment for heroin addiction in Bulgaria has decreased from 24.7 in 1995 to 21.5 in 1999 [21].

Rates of sexually transmitted infections and HIV/AIDS are on the increase in South Eastern Europe and young people are among those most at risk. Sex education is poorly developed,

knowledge about HIV/AIDS and sexually transmitted infections insufficient, and access to cheap, quality condoms is limited. Surveys among adolescents show widespread and increasing unsafe sexual behaviour. Just one in eight adolescents in Moldova reported using a condom during their first sexual encounter [3]. In Romania, a 1996 survey found that only 15 percent of unmarried women aged 15–24 used contraceptives when they first had intercourse [22]. Such low condom use not only increases the risk of sexually transmitted infections and HIV, but also contributes to high adolescent pregnancy rates. In Bulgaria, the rate of pregnancy for adolescents aged 15–19 years declined from 75 per 1,000 in 1989 to 48 per 1,000 in 1999. Yet this was still six times higher than the EU average and occurred in the context of an overall decline in Bulgarian birth rates [23,24].

Men and women

The consequences of rapid transition and civil conflict have affected both men and women. In many parts of the region, death rates for men increased and life expectancy declined in the first half of the 1990s. Men in the region are more likely to suffer from heart disease, injuries, and violence. Women are vulnerable in other ways. During the transition, many women have become unemployed and now face discrimination in finding new employment.

Maternal mortality rates have generally declined over the last 20 years and most of the countries and territories in the region have achieved the WHO target for Europe. However, in Albania, Romania, and Moldova these rates remain above the target. More troublesome is the fact that available data from all countries and territories in the region suggest large variations between population groups and geographical areas. In addition, nonfatal complications from childbirth remain common, often reflecting poor care at the time of birth.

Despite some improvements over the last 10 years, increasing access to family planning services has been slow in SEE and the region is marked by a low awareness and use of modern contraception. There is a high reliance on termination of pregnancy for family spacing. The only country where termination rates are below the EU average is Croatia. Rates in Romania remain above the number of live births. Complications from termination are one of the leading causes of maternal mortality in the region.

War and poverty have contributed to widespread violence. In the war in Bosnia and Herzegovina, an estimated 20,000 to 50,000 women were raped. Children and men were also victims of sexual violence. While the scale of domestic violence is significant, the problem is often covered by a “blanket of silence,” and legal and social protection of victims is underdeveloped [25]. The long-term mental health consequences from this abuse remain unclear, but are likely to be severe.

Young women and children have been the major victims of the organised crime groups that have flourished with the breakdown of governments and the opening of borders. Up to 20,000 Bulgarian women are thought to have been forced into prostitution in Bulgaria and abroad [26,27]. The problem is even more severe in Macedonia, Moldova, and Albania. Moldova

is a primary country of origin for human trafficking, and an estimated 30,000 Albanian women and girls are believed to have worked as sex workers in EU countries over the past 10 years [20]. An estimated 10 percent of those trafficked for the sex trade are minors, many of whom are also trafficked for use as beggars and menial laborers [28].

Despite the dearth of information on risk factors, much can be done to give people the knowledge and power to make choices that are in the best interests of their health.

Promoting Healthy Societies

The Risk Factors

A comprehensive view of the state of health in South Eastern Europe requires an examination of the levels of exposure to the risk factors that contribute to future levels of disease.

There are no established national surveillance systems tracking risk factors for chronic diseases. However, the available data show that the levels of many traditional risk factors are very high in South Eastern Europe. The impact of these risk factors is exacerbated, as access to preventive health services is limited.

Despite the dearth of information on risk factors, some general concerns can be illustrated by looking at areas where information is available. These examples represent areas where there are proven interventions to avoid or minimise the health risks that confront South Eastern Europe. Much can be done to give people the knowledge and power to make choices that are in the best interests of their health.

The following paragraphs examine risk factors that lead to premature death and disease. While there are many risk factors that determine the health of given populations at various times, the examples below illustrate some of the specific health challenges facing South Eastern Europe at the beginning of the 21st century.

Tobacco

The role of tobacco in South Eastern Europe is complex and has adversely affected health in a variety of ways. Several countries grow tobacco, and some governments, despite limited finances, continue to subsidise its production, effectively transferring scarce resources to a wealthy multinational industry that is profiting from the premature deaths of many of their citizens. The region is also at the center of an extensive tobacco smuggling industry. Those directly involved in tobacco smuggling are often the same people that smuggle sex workers, illicit drugs, and weapons.

The greatest impact of tobacco on the people of this region, however, will come from the increasing ranks of young smokers. Faced with declining markets in EU countries and North America, international tobacco companies are aggressively marketing their products in markets where they face fewer restrictions. A particular target is young women. Lung cancer rates, a clear indicator of historical patterns of smoking, are already rising among women and are certain to increase further unless effective action is taken soon.

Alcohol

Alcohol is a major avoidable risk factor for disease and premature deaths in the region. It contributes to death from cardiovascular disease and cancer, and is the leading cause of intentional and unintentional injuries. Although the acute effects of alcohol consumption are less apparent in South Eastern Europe than in the former Soviet Union, deaths from liver cirrhosis are extremely frequent in some countries of the region. Accurate information on consumption of alcohol is difficult to obtain, because of high levels of unrecorded production and consumption. What studies do exist indicate high levels of consumption, particularly among men. An especially worrying trend is the increase of adolescent alcohol consumption. Various sources suggest high levels of drinking among youth in South Eastern Europe, starting from a very young age.

Drug use and HIV/AIDS

So far, South Eastern Europe has been spared the explosive increases in HIV/AIDS seen in many parts of the former Soviet Union. But there are many signs that this could change in the near future. Rates of injecting drug use are increasing throughout the region, especially among the young, and high-risk behavior is common. A rapid assessment focusing on HIV/AIDS among especially vulnerable young people in South Eastern Europe showed that 90 percent of injecting drug users interviewed had sex while under the influence of drugs, but only 14 percent used condoms regularly. More than 9 out of 10 sex workers had sex while under the influence of drugs, but only 47 percent used condoms regularly. Almost two-thirds of injecting drug users shared needles and syringes [29]. Adequate sex education is lacking in most schools and access to condoms is limited.

Tuberculosis

Tuberculosis re-emerged in South Eastern Europe during the 1990s after 40 years of steady decline. It is a disease of the poor and hits hardest those living in crowded conditions, refugee camps, or institutions such as prisons—people who also are the most likely to experience difficulties in accessing health services. Appropriate drugs and standardised treatment regimens have been lacking and the proportion of cases that are resistant to the standard drugs (multi-drug resistant tuberculosis) has increased. It is believed that official data underestimate the actual number of cases—partly due to the strong social stigma attached to the disease. While the countries of the EU experienced a steady decline in new cases, tuberculosis is becoming increasingly frequent in parts of the region, with significant increases noted in Kosovo, Moldova, and Romania. According to official data, the incidence in Romania in 2001 was 12 times the EU average [13]. Prisons are breeding grounds for the disease and epidemics within the prison system are common. In Moldova, for example, the incidence in prisons in 1999 was 6,000 per 100,000, over 40 times higher than the national average [30].

Nutrition

Accessibility of a balanced range of fresh foods, especially to vulnerable groups, is a major problem. Food and nutrition policies are central to the prevention of many noncommunicable diseases. The general population and many health officials in the region have insufficient knowledge about healthy nutrition, control of body weight, and the importance of breastfeeding.

Evidence from other countries in transition suggests that there will be rising levels of many of the chronic diseases associated with poor nutrition. Unfortunately, efforts to further address these impending problems are undermined by inadequate data. The data that are available, however, are troubling. In Albania, for example, the frequency of diabetes among the adult population increased by a factor of four between 1980 and 2001 [31]. In Macedonia, adult onset diabetes has increased from 5,000 in 1992 to 37,000 in 1998 [32].

Environment

The WHO has estimated that environmental factors contribute to 25 to 33 percent of the world's premature deaths and diseases [12]. In South Eastern Europe, industrialisation policies by previous regimes placed little priority on protecting against the negative environmental and health effects of development. At the beginning of transition, falls in industrial output led to reductions in emissions of some pollutants, but as economic recovery occurs, it will be essential to strengthen systems of environmental protection. Threats include poor air quality from obsolete industrial plants and motor vehicles using leaded petrol and lacking catalytic converters, low quality household and industrial fuels, high dust and heavy metal emissions, and inadequate water treatment and waste disposal facilities. There is also widespread use of pesticides in food products and a significant problem of microbiological contamination of food. Finally, in Kosovo and Serbia and Montenegro there is a persistent hazard from the residue of depleted uranium munitions.

Unfortunately earlier systems for environmental monitoring were ill-suited to meet these challenges and in many places new policies have yet to be implemented. Even where policies exist, funding is often insufficient, regulation is weak, and public awareness of environmental threats is low. Most countries have adopted National Environmental and Health Action Plans but progress in implementing them has been uneven.

The Challenges for Health Policy

All countries and territories in South Eastern Europe have engaged in health sector reform programs, which are both technically and politically challenging. Each is trying to raise sustainable levels of resources for health care, in ways that distribute the costs across society. Shrinking economies and a growing informal sector, however, have reduced the public revenues available for health sector reforms. States and territories in the region also face the challenge of paying for present levels of activity while making up for sustained underinvestment in the past. In some countries and territories the challenge is exacerbated by the need for reconstruction of war-damaged infrastructure and the loss of skilled professionals through emigration. And all face the challenge of providing basic services for poor and excluded groups, which are at increased risk of poor health.

There is also an increasing recognition of the need for coordinated action across sectors. Investment in education or housing must accompany investment in the health sector to achieve maximum health gain. Yet these reforms have often been hampered by entrenched divisions between ministries. In practice, reforms have frequently had more success at the local level.

The serious public health issues facing South Eastern Europe are a clear, compelling reason for communities, governments, and donors to work together to find solutions that will benefit individual countries and territories, the region as a whole, and, ultimately, Europe.

Steps to Improve Public Health

As the recent report by the WHO Commission on Macroeconomics and Health has argued, targeted and sustained investment is needed to reverse negative trends in health. The health sector in South Eastern Europe is too often ignored. Many donors have now turned to other parts of the world such as Afghanistan or Iraq that have recently been devastated by conflict. Yet South Eastern Europe should not be forgotten. With sustained support and attention from states in the region and targeted assistance from the outside, substantial improvement can be made in the field of public health. Without a healthy population, the countries and territories of South Eastern Europe cannot move forward. Improving public health will help ensure that South Eastern Europe becomes a vital contributor to Europe.

Ultimately, it is up to the people of the countries and territories of South Eastern Europe, through their governments and increasingly through civil society organizations, to shape the policies and practices that will help the region's next generation lead longer and healthier lives.

The situation in South Eastern Europe is by no means hopeless. There have been many successes and, in some places, levels of life expectancy that had long stagnated or even declined have begun to recover. Modern systems of disease surveillance are being built up, and health care and health policy are increasingly based on evidence. But this kind of progress can only continue and expand as long as national and international resources are pooled and local ownership is ensured.

The serious public health issues facing South Eastern Europe are a clear, compelling reason for communities, governments, and donors to work together to find solutions that will benefit individual countries and territories, the region as whole, and, ultimately, Europe.

Recommendations and Best Practices

Each of the countries and territories included in this study are signatories to the main UN conventions assigning states the responsibilities to protect, promote, and empower people to realise their rights. Although many of the problems identified must ultimately be addressed at the national level, the common history and common challenges allow for a unique opportunity to develop common approaches for moving forward. A focus on equity is key as an underlying principle, as is human resource development, especially in public health.

In all of the countries and territories of South Eastern Europe, there is an urgent need for action. The recommendations set out by this report reinforce the priorities identified by the ministers of health of South Eastern Europe in the 2001 Dubrovnik pledge. Success will depend on political and financial commitment at the regional and national levels and increased and better harmonized donor support. The recommendations lie within four areas and examples of best practice for each are presented below.*

1. Building capacity to identify and respond to the threats to population health at the national, district, and local levels, including the development of effective surveillance, information, and training systems to enable appropriate analysis of problems.

Fostering a multisectoral approach

A key part of developing a multisectoral approach to health is to involve a variety of stakeholders in policy development and planning. This includes ministries of health, education, transport, environment, agriculture, and social welfare, as well as other relevant stakeholders in the private sector and among nongovernmental organisations.

► *Local Health Plans*

The Andrija Stampar School of Public Health in Croatia, in collaboration with local governments, the Ministry of Health, and the Centers for Disease Control and Prevention, Atlanta, has implemented a program to create county-level public health plans. These plans, presented for funding to the central government, are developed by multidisciplinary teams that include civil society organizations. An adaptation of the program involv-

*More detailed information about each of these projects can be found online in the information review.

ing current partners and the Faculty of Medicine of St. Cyril and Methodius University, Skopje, is currently underway in Macedonia and planned for the Republic of Serbia.

Reorienting training

One of the main challenges to the public health system in the last decade has been moving from a medical-or-disease oriented model to a preventive approach toward public health. This has meant retraining the workforce to better understand population-oriented approaches and the role of socio-economic determinants of health.

► *Postgraduate Training Programs in Public Health*

In collaboration with the Association of Schools of Public Health in the European Region (ASPHER), the Romanian National Institute for Research and Development in Health has successfully established itself, gaining joint recognition by the Ministry of Health and Family and the Ministry of Education to train a future generation of public health professionals. Similar efforts are underway in Albania, Bulgaria, Croatia, Macedonia, and Moldova.

Investing in people

At a time of rapid growth in medical knowledge, continuing training and access to information is crucial. Efforts aimed to ensure that South Eastern European health professionals and policymakers have access to information are vital to the quality of care in the region.

► *Continuous Medical Education (CME)*

CME became compulsory in Romania in 1999 as a requirement for physicians to renew their right to practice. Macedonia has also developed a CME program, aimed at providing life-long learning in primary care. Initially begun as a pilot project, the program was adopted by the government and fully integrated in the system of medical education.

Implementing reliable surveillance/health information systems

There are still many gaps in knowledge of the health status of the people living in South Eastern Europe. The establishment of national and regional health information systems with age- and sex-disaggregated data helps determine where policy responses are most needed. These systems are also key for monitoring and evaluating the overall health of the populations and any interventions designed to improve it.

► *Developing Health Information Systems in Moldova*

In 2000 and 2001, as part of the National Health Reform Strategy, two districts adopted pilot projects on health information systems in the fields of primary care and hospital management. The resulting ability to develop district health profiles in 2001 allowed for the integration of information about emergency, primary, and secondary care, aiding key local

stakeholders in their decision-making. In the same year, a corresponding insurance information system was created in conjunction with the formation of the National Insurance Company. The success of these pilot projects led the Ministry of Health to adopt a national Integrated Health Information System.

Targeting health promotion efforts

Empowering the public to participate in setting the agenda and making decisions on matters related to health is a key component of health promotion efforts. There is an urgent need for programs that will give people the necessary information to make healthy choices.

► *Prevention of Smoking in Croatia*

In March 2003, the first national no-smoking day in Croatia was launched on the first day of Lent. The initiative in this predominantly Catholic country was supported by the Croatian archbishop, who instructed priests to introduce the topic in their Sunday sermons, as well as by leaders of the other religious denominations [33,34].

2. Investing in appropriate health care financing and delivery systems that ensure quality and access, especially for vulnerable populations.

Improving health care delivery systems

Sustained improvement in the health sector requires investment in many areas. A key component is the expansion of primary health care to ensure that the entire population has access to basic health services.

► *Reducing Perinatal Mortality in Macedonia*

The perinatal project in Macedonia introduced innovations in medical training, trained trainers, provided equipment, and developed a national database for perinatal and neonatal data. Fifty percent of the doctors and 25 percent of the nurses who care for neonates successfully completed this training. This program can take much of the credit for a 21 percent reduction in perinatal mortality and for a reduction of early neonatal deaths by 36 percent. Increased investment would allow for further reductions in perinatal mortality [35,36].

► *Baby Friendly Hospitals*

All the countries and territories of the region have created WHO/UNICEF Baby Friendly Hospitals. This follows 10 basic steps to promotion of breastfeeding by removing harmful practices and ensuring mother and child are not separated. The many health professionals now trained and supported by ministries of health ensure that it is sustainable and continues to

develop, with countries supporting each other. The program is a good example of bilateral and regional collaboration. Building on the work done to date, the countries and territories of the region will now strive to make maternity services more family and woman friendly.

▶ ***Primary Health Care in Bulgaria***

The primary health care component of Bulgaria's health sector restructuring project rehabilitated facilities and provided equipment for 1,784 general practices, with a focus on remote and rural areas of the country. The program also provided training for over 1,000 general practitioners.

Investing in appropriate, accessible services for the most vulnerable

Old ways of doing business must give way to new, evidence-based methods of protecting and promoting health. People with mental disabilities should no longer be institutionalized. Successful and feasible community-based alternatives exist. Drug users must have access to HIV prevention services. A number of innovative pilot programs for these and other vulnerable populations have led to national policy changes.

▶ ***Mental Disabilities***

The Child Development Centre in Albania was the first development centre to use a multidisciplinary approach to mental disabilities. The Centre is now fully funded by the Ministry of Health. Projects to introduce community-based services are underway in Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Macedonia, and Moldova with the hope that these will lead to nationwide reform.

▶ ***HIV Prevention for Drug Users***

In Bulgaria, the Initiative for Health Foundation is a small NGO that provides harm reduction services to commercial sex workers and approximately 35 percent of injection drug users in Sofia. Between 1998 and 2001, it contacted more than 1,800 injection drug users. On average, the NGO distributes 10–12,000 needles and syringes per month [37]. Similar projects are underway in Croatia, Moldova, Romania, and the Republic of Serbia. In Albania, a pilot harm reduction project in Tirana prompted the government to adopt and implement a national strategy on harm reduction.

▶ ***Palliative Care in Romania***

Romania serves as an excellent model for palliative care development. It has a resource training centre in Brasov and a recognized postgraduate certificate program in palliative care. Romania also has a network of home-based care programs and a number of inpatient hospice units and is also the only country in the region to have partial funding from

national insurance for palliative care services. As with other countries in the region, however, access to opioid medications for pain management is still limited.

► *Visiting Nurses in Serbia*

The Institute of Public Health in the Republic of Serbia instituted a continuing education program for visiting nurses, and supplied them with nursing kits. The project demonstrated that visiting nurses play a key role in community-based health services as well as with assisting families to deal with violence, unemployment, poor housing, and other health determinants that usually lie outside of the traditional health delivery system.

3. Developing mechanisms for practical cooperation and sharing of best practices within the region. Better documentation of activities is also essential for governments and civil society organisations working in the region to learn from each other.

Greater movement of people means greater need for collaboration across borders. This is especially important in the area of infectious disease control, not only to monitor emerging trends in disease but also as a means of fostering regional collaboration and good will.

► *Joint TB Control Program in Albania, Macedonia, and Kosovo*

Over the past few years a number of countries and territories have been working together in the area of TB control to make sure that patients can receive directly observed treatment (DOTS) even as they cross borders between countries and territories. Cross-border collaboration in the subregion began with the development of the “Balkan Initiative,” a yearly meeting of national tuberculosis managers from the region that provides an open platform for discussion and collaboration. In addition to organizing reciprocal cross-country site visits to National Tuberculosis Programs (NTP) in Macedonia, Kosovo, and Albania, each team traveled to Romania to learn from its national TB program. As a result of this increased communication, the Macedonian National Reference Laboratory helped to develop the Albanian National Laboratory Network, and the NTP manager from Albania took part as a lecturer in the DOTS training program in Kosovo. Similarly, a team from Belgrade will train Serbian doctors from Kosovo in DOTS. During the conflict in Macedonia’s Tetovo region, Albanian TB patients were treated in neighboring Kosovo, with both Macedonian and Kosovar TB dispensaries in close contact.

► *South Eastern European Public Health Network*

Under the auspices of the Stability Pact for South Eastern Europe, a network of public health faculty have been established and a common postgraduate curriculum in public

health has been developed. The project is led by the Andrija Stampar School of Public Health in Zagreb and the Faculty of Health Sciences of the University of Bielefeld, and includes Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Macedonia, Moldova, Romania, Serbia and Montenegro, and Slovenia.

▶ ***Rapid Assessment and Response***

Little data in South Eastern Europe exist on HIV and AIDS, especially on risk behaviour and practices. For this reason, several countries implemented “rapid assessment and response”—a methodology designed to quickly assess a current vulnerable situation and use the information to make informal decisions about the development of interventions. Rapid assessment and response methodology has allowed for the development of cross-border collaboration in designing programs to reach the most vulnerable populations (intravenous drug users, commercial sex workers, men who have sex with men). One finding consistent across the region was that if HIV testing was made anonymous, free, and accessible, many more people would choose to be tested.

▶ ***Tobacco Control Among Youth***

Early in 2003, the Global Youth Tobacco Survey was carried out in Bosnia and Herzegovina, Croatia, Macedonia, and Serbia and Montenegro, and it will also be conducted in Albania, Kosovo, Moldova, and Romania by the end of the year. The survey, carried out in over 100 countries around the world, gathers information on smoking prevalence among teens, their knowledge and attitudes toward smoking, and how smoking is addressed in the media and school curricula. This information will strengthen the capacity of governments to develop youth-specific tobacco control strategies and programs to monitor the impact of health promotion campaigns on smoking behaviour.

▶ ***Stability Pact Projects***

Under the auspices of a Stability Pact for South Eastern Europe initiative, four health projects are currently being implemented. These projects bring together professionals from the region to develop common frameworks for different issues, ranging from food safety, to mental health legislation, to improving epidemiological surveillance for communicable diseases as a tool for better decision-making. There is also a project establishing a South Eastern European public health network (described above).

4. Encouraging increased commitment and coordination by donors and international financial institutions to support nationally led strategies to achieve these goals.

Much of the external assistance in the region in recent years has been delivered as humanitarian aid in times of crisis, when there was often little thought given to longer term issues or to national ownership and participation in the design of programs. After the crisis ended, with the exception of the World Bank, donor funding for health-related issues in the region decreased significantly. Donor commitment to support national efforts and strengthen the rebuilding process has never been so critical. Many of the examples given above evidence a commitment by donors to support nationally led strategies. But much more remains to be done, including improved harmonisation of donor support.

► ***Fostering collaboration by developing Poverty Reduction Strategy Papers***

In addition to investing in basic health services and disease prevention efforts, governments have either developed or are developing overall Poverty Reduction Strategies Papers (PRSP) in Albania, Bosnia and Herzegovina, Moldova, Romania, and Serbia and Montenegro. The PRSP process attempts to bring together all stakeholders, including government officials and civil society representatives from a variety of fields in an effort to design a unified plan of action. This process provides a key opportunity to address the root causes of health inequity as well as offering a formal mechanism for representatives from different sectors to analyse causes and propose solutions for poverty.

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London School of Hygiene & Tropical Medicine (LSHTM)

The mission of the London School of Hygiene & Tropical Medicine is to contribute to the improvement of health worldwide through the pursuit of excellence in research, postgraduate teaching, advanced training, and consultancy in international public health and tropical medicine. To achieve this mission LSHTM serves as Britain's national school of public health and a leading institution in Europe for research and postgraduate education in public health and tropical medicine as well as an international centre of excellence in public health and medicine in developing countries.

Open Society Institute (OSI)

The Open Society Institute, a private operating and grantmaking foundation based in New York City, implements a range of initiatives to promote open society by shaping government policy and supporting education, media, public health, and human and women's rights, as well as social, legal, and economic reform. OSI's Network Public Health Programs promote sustainable improvement in public health by supporting graduate and continuing education for the public health workforce and information systems that generate reliable data; initiatives that improve the quality of health care; activities that ensure the participation of vulnerable populations in health programs and policymaking; and health policy reforms based on evidence and best practice.

The Department for International Development (DFID)

DFID is the UK government department responsible for promoting sustainable development and reducing poverty. DFID's central focus is a commitment to the Millennium Development Goals for 2015 to eradicate extreme poverty and hunger; achieve universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria, and other diseases; ensure environmental sustainability; and develop global partnerships for development. DFID's assistance is concentrated in the poorest countries of sub-Saharan Africa and Asia, but also contributes to poverty reduction and sustainable development in middle-income countries, including those in Latin America and Eastern Europe.

United Nations Children's Fund (UNICEF)

UNICEF is guided by the Convention on the Rights of the Child and strives to establish children's rights as enduring ethical principles and international standards of behaviour toward children. By mobilizing political will and material resources, UNICEF helps countries, particularly developing countries, formulate policies and deliver services for children and their families. UNICEF is committed to ensuring special protection for the most disadvantaged children—victims of war, disasters, extreme poverty, all forms of violence and exploitation, and those with disabilities. UNICEF makes its unique facilities for rapid response available to its partners to relieve the suffering of children and those who provide their care. The Fund is nonpartisan and its cooperation is free of discrimination. Through its country programmes, UNICEF aims to promote the equal rights of women and girls and to support their full participation in the political, social, and economic development of their communities.

Public Health in South Eastern Europe
is ailing as a result of political and
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region's health problems. This report
prescribes targeted, sustained
investment programs by international
agencies to improve public health
and strengthen regional stability.



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