Compendium of the Roadmap for Health and Well-being in the Western Balkans (2021–2025)

ABSTRACT

This compendium is a supplementary document that accompanies the Roadmap for Health and Well-being in the Western Balkans (2021–2025) [hereinafter, Roadmap], which scopes the following countries and area [All references to “area” in this document should be understood as Kosovo]: Republic of Albania, Bosnia and Herzegovina, Montenegro, Republic of North Macedonia, Republic of Serbia, and Kosovo [All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999)] – hereinafter, the Western Balkans (WBs). The Roadmap builds on the individual health goals and priorities of the WBs through the lens of the European Programme of Work (2020–2025) – “United Action for Better Health” (EPW), and it identifies shared priorities and potential synergistic actions across the subregion. The Roadmap aligns efforts and fosters cooperation with regional, subregional and country/area partners to implement political, investment and technical objectives that deliver on the core priorities of the EPW.

This compendium is comprised of two sections. The first section contains two supporting tables for the Roadmap, which outline: 1) the health and sustainable development gap between WBs and the European Union and 2) priority actions for health and sustainable development at the country/area-level in the WBs. The second section contains six country/area briefs, which were completed to identify and centre the health and sustainable development priorities of the WBs in the Roadmap’s formation. Each brief is presented independently to grant easy access to country/area relevant information.

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¹ All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).
Abbreviations

AMR  Antimicrobial resistance
ART  Antiretroviral therapy
ANHS 2020  Albanian National Health Strategy 2016–2020
BCA  Biennial Collaborative Agreement
BI  Behavioural insight
BoP  Balance of Payments
CCA  Comparative Country Analysis
CGH  Common Goods for Health
CHIF  Compulsory health insurance fund (Republic of Albania)
COVAX  COVID-19 Vaccines Global Access
COVID-19  Coronavirus disease 2019
DALY  Disability-adjusted life year
DG NEAR  Directorate-General for European Neighbourhood Policy and Enlargement Negotiations
DTP3  Three doses of diphtheria tetanus toxoid and pertussis vaccine
EPW  European Programme of Work (2020-2025) – “United Action for Better Health in Europe”
EHR  Electronic health record
EC  European Commission
EU  European Union
GDP  Gross Domestic Product
GOARN  Global Outbreak Alert and Response Network
HCH  Human capital for health
HDI  Human Development Index
HEP  Health Emergency Protection
HiAP  Health in All Policies
HPOP  Healthier Populations
IA  Immunization Agenda
IHR  International Health Regulations (2005)
ILO  International Labour Organization
ITN  Insecticide-treated net
LGBTQIA+  Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and other marginalized sexual identities
MMR  Measles, mumps, rubella
MoHSP  Ministry of Health and Social Protection (Republic of Albania)
NATO  North Atlantic Treaty Organization
NCD  Noncommunicable disease
NSDI-II  National Strategy for Development and Integration 2014–2020 (Republic of Albania)
OOP  Out-of-pocket
PHC  Primary health care
PPE  Personal protective equipment
PTSD  Post-traumatic stress disorder
PPP  Purchasing power parity
RCCE  Risk communication and community engagement
SEEHN  South-eastern Europe Health Network
SDG  Sustainable Development Goals
SDC  Sustainable Development Council [Kosovo]
SPAR  States Parties Annual Report
TB  Tuberculosis
UHC  Universal health coverage
UN  United Nations
UNKT  United Nations Kosovo Team
UNSDCF  United Nations Sustainable Development Cooperation Framework
USD  United States Dollar
VAP  Vaccination action plan
WB  Western Balkans [Republic of Albania, Bosnia and Herzegovina, Montenegro, Republic of North Macedonia, Republic of Serbia and Kosovo]

\* All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).
Section 1.
Supporting tables for the Roadmap: Presenting the health and sustainable development gap in the Western Balkans (WBs) and country/area priorities
Table 1. The health and development gap in the WBs

Select indicators have been compiled to represent the health and sustainable development statuses of the WBs, European Union (EU), and WHO European Region (Table 1). This data is intended to be used for population-based comparisons to assess the health and development gap between the WBs and the EU and WHO European Region. Data from United Nations (UN) and WHO sources were relied upon wherever possible; however, other sources were used if their data were either more recent or unavailable in UN or WHO databases.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Albania</th>
<th>Bosnia and Herzegovina</th>
<th>Montenegro</th>
<th>North Macedonia</th>
<th>Serbia</th>
<th>Kosovo</th>
<th>EU</th>
<th>WHO European Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (millions) (2019)</td>
<td>2.85</td>
<td>3.30</td>
<td>0.62</td>
<td>2.08</td>
<td>6.94</td>
<td>1.79</td>
<td>447.58</td>
<td>918.8 (2018)</td>
</tr>
<tr>
<td>Population growth (annual %) (2019)</td>
<td>-0.4</td>
<td>-0.7</td>
<td>0.0</td>
<td>0.0</td>
<td>-0.5</td>
<td>-0.5</td>
<td>0.2</td>
<td>N/A</td>
</tr>
<tr>
<td>Population ages 65 and above (% of total population) (2019)</td>
<td>14</td>
<td>17</td>
<td>15</td>
<td>14</td>
<td>19</td>
<td>N/A</td>
<td>20</td>
<td>N/A</td>
</tr>
<tr>
<td>GDP (current USD, millions) (2019)</td>
<td>15 279.18</td>
<td>20 164.19</td>
<td>5542.58</td>
<td>12 547.04</td>
<td>51 475.02</td>
<td>7926.13</td>
<td>15 626 448.48</td>
<td>N/A</td>
</tr>
<tr>
<td>GDP per capita (PPP current international $) (2019)</td>
<td>14 648.30</td>
<td>16 288.80</td>
<td>24 035.90</td>
<td>18 107.80</td>
<td>19 495.10</td>
<td>11 906.40</td>
<td>47 827.70</td>
<td>N/A</td>
</tr>
<tr>
<td>GDP annual growth rate (%) (2019)</td>
<td>2.2</td>
<td>2.7</td>
<td>4.1</td>
<td>3.2</td>
<td>4.2</td>
<td>4.2</td>
<td>1.6</td>
<td>N/A</td>
</tr>
<tr>
<td>Foreign Direct Investment (BoP, current USD, millions) (2019)</td>
<td>-1161.05</td>
<td>-399.86</td>
<td>-342.12</td>
<td>-403.97</td>
<td>-3972.93</td>
<td>-211 142.87</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Unemployment rate (% of total labour force) (modelled ILO estimate) (2020)</td>
<td>11.7</td>
<td>16.9</td>
<td>15.9</td>
<td>18.4</td>
<td>9.1</td>
<td>N/A</td>
<td>7.4</td>
<td>6.8 (2019)</td>
</tr>
</tbody>
</table>

* All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).
Table 1 contd

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Albania</th>
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<th>Montenegro</th>
<th>North Macedonia</th>
<th>Serbia</th>
<th>Kosovo</th>
<th>EU (2015)</th>
<th>WHO European Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Development Index (2019)</td>
<td>0.795</td>
<td>0.780</td>
<td>0.829</td>
<td>0.774</td>
<td>0.806</td>
<td>N/A</td>
<td>0.87 (2015)</td>
<td>0.83 (2015)</td>
</tr>
<tr>
<td>Poverty headcount ratio at country/area poverty lines (% of population) (2018)</td>
<td>14.3 (2012)</td>
<td>16.9 (2015)</td>
<td>24.5</td>
<td>21.6</td>
<td>23.2</td>
<td>17.6</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Public spending on health (% of GDP) (2018)</td>
<td>2.84</td>
<td>6.21</td>
<td>5.06</td>
<td>3.77</td>
<td>5.07</td>
<td>2.5 (2016)</td>
<td>5.9</td>
<td>4.87</td>
</tr>
<tr>
<td>Public spending on health (% general government expenditure) (2018)</td>
<td>9.71</td>
<td>15.14</td>
<td>10.60</td>
<td>12.41</td>
<td>12.45</td>
<td>N/A</td>
<td>13.8</td>
<td>12.48</td>
</tr>
<tr>
<td>Out-of-pocket payments (% of current health expenditure) (2018)</td>
<td>44.58</td>
<td>29.33</td>
<td>39.61</td>
<td>42.11</td>
<td>38.31</td>
<td>N/A</td>
<td>21.6</td>
<td>29.82</td>
</tr>
<tr>
<td>Life expectancy at birth, female (years) (2019)</td>
<td>79.91</td>
<td>79.09</td>
<td>78.65</td>
<td>76.87</td>
<td>78.28</td>
<td>74.8 (1)</td>
<td>83.82 (1)</td>
<td>81.29</td>
</tr>
<tr>
<td>Life expectancy at birth, male (years) (2019)</td>
<td>76.25</td>
<td>74.38</td>
<td>73.15</td>
<td>72.84</td>
<td>73.46</td>
<td>70.3 (1)</td>
<td>78.45 (1)</td>
<td>75.09</td>
</tr>
<tr>
<td>Infant mortality rate (2019) (per 1000 live births)</td>
<td>5.06</td>
<td>2.04</td>
<td>5.34</td>
<td>4.63</td>
<td>N/A</td>
<td>3.32 (1)</td>
<td>7.00</td>
<td></td>
</tr>
<tr>
<td>Under-five mortality rate (per 1000 live births)</td>
<td>5.27</td>
<td>2.18</td>
<td>5.71</td>
<td>4.79</td>
<td>N/A</td>
<td>3.95 (1)</td>
<td>8.00</td>
<td></td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100 000 live births) (2019)</td>
<td>10.00</td>
<td>6.00</td>
<td>7.00</td>
<td>12.00</td>
<td>0.00 (2018)</td>
<td>6.00 (2017)</td>
<td>13.00</td>
<td></td>
</tr>
</tbody>
</table>

4 All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).

5 Infant, under-five and maternal mortality data are under review by the Albanian Ministry of Health and Social Protection due to differences in methodologies used.
### Table 1 contd

<table>
<thead>
<tr>
<th>Indicator*</th>
<th>Albania</th>
<th>Bosnia and Herzegovina</th>
<th>Montenegro</th>
<th>North Macedonia</th>
<th>Serbia</th>
<th>Kosovo†</th>
<th>EU*</th>
<th>WHO European Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHC Service Coverage Index (2017)⑨</td>
<td>—</td>
<td>61.0</td>
<td>68.0</td>
<td>72.0</td>
<td>65.0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Health Emergencies Protection Index (2019)⑨</td>
<td>79.5</td>
<td>52.7</td>
<td>60.0</td>
<td>71.7</td>
<td>80.5</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>IHR capacity and health emergency preparedness (2019)⑨</td>
<td>62.0</td>
<td>35.0</td>
<td>56.0</td>
<td>60.0</td>
<td>69.0</td>
<td>N/A</td>
<td>N/A</td>
<td>75</td>
</tr>
<tr>
<td>Vaccine coverage of at-risk groups for epidemic or pandemic prone diseases (%) (2018)⑨</td>
<td>96.5</td>
<td>70.5</td>
<td>72.5</td>
<td>87.0</td>
<td>94.0</td>
<td>N/A</td>
<td>N/A</td>
<td>93.4</td>
</tr>
<tr>
<td>Proportion of the target population with access to DTP3 (2019)⑨</td>
<td>99.0</td>
<td>73.0</td>
<td>86.0</td>
<td>92.0</td>
<td>97.0</td>
<td>N/A</td>
<td>N/A</td>
<td>95.0</td>
</tr>
<tr>
<td>Cause of death, by NCDs (% of total) (2019)①</td>
<td>93.94</td>
<td>94.42</td>
<td>94.11</td>
<td>96.13</td>
<td>94.92</td>
<td>N/A</td>
<td>N/A</td>
<td>89.82</td>
</tr>
<tr>
<td>Percentage of DALYs attributable to NCDs (2019)⑩</td>
<td>82.47</td>
<td>86.70</td>
<td>86.32</td>
<td>87.45</td>
<td>88.21</td>
<td>N/A</td>
<td>N/A</td>
<td>87.55</td>
</tr>
<tr>
<td>Probability (%) of dying aged 30–70 from any of cardiovascular disease, cancer, diabetes, or chronic respiratory disease (2019)⑥</td>
<td>11.40</td>
<td>18.72</td>
<td>22.30</td>
<td>22.73</td>
<td>21.95</td>
<td>N/A</td>
<td>N/A</td>
<td>16.32</td>
</tr>
</tbody>
</table>

---

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† UHC Service Coverage Index data is under review by the Albanian Ministry of Health and Social Protection due to differences in methodologies used.
## Table 1 contd

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Albania</th>
<th>Bosnia and Herzegovina</th>
<th>Montenegro</th>
<th>North Macedonia</th>
<th>Serbia</th>
<th>Kosovo*</th>
<th>EU*</th>
<th>WHO European Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol, total per capita (15+) consumption (in litres of pure alcohol)</td>
<td>7.17</td>
<td>7.15</td>
<td>11.47</td>
<td>6.16</td>
<td>8.75</td>
<td>N/A</td>
<td>N/A</td>
<td>9.73</td>
</tr>
<tr>
<td>Prevalence of tobacco use in adults aged 15+ (age-standardized)</td>
<td>29.20</td>
<td>38.30</td>
<td>N/A</td>
<td>N/A</td>
<td>40.60</td>
<td>N/A</td>
<td>N/A</td>
<td>26.32</td>
</tr>
<tr>
<td>Age-standardized mortality rate attributed to household and ambient air</td>
<td>67.99</td>
<td>79.76</td>
<td>78.65</td>
<td>82.17</td>
<td>62.50</td>
<td>N/A</td>
<td>N/A</td>
<td>30.00</td>
</tr>
<tr>
<td>Proportion of people living with HIV receiving ART (2019)</td>
<td>43.0</td>
<td>N/A</td>
<td>49.0</td>
<td>N/A</td>
<td>66.0</td>
<td>N/A</td>
<td>N/A</td>
<td>58.0</td>
</tr>
<tr>
<td>Suicide rate estimates, age-standardized (deaths per 100,000 population)</td>
<td>3.72</td>
<td>8.25</td>
<td>16.22</td>
<td>7.15</td>
<td>7.86</td>
<td>N/A</td>
<td>N/A</td>
<td>10.50</td>
</tr>
</tbody>
</table>

Notes. ART: Antiretroviral therapy; BoP: Balance of Payments; DTP3: Three doses of diphtheria tetanus toxoid and pertussis vaccine; DALY: Disability-adjusted life year; EU: European Union; GDP: Gross domestic product; IHR: International Health Regulations (2005); ILD: International Labour Organisation; NCDs: noncommunicable diseases; PPP: Purchasing Power Parity; USD: United States Dollar; UHC: Universal health coverage; WBs: Western Balkans.

* All data is provided to two decimal places, except where the data source lacked that degree of specificity.

† Dates and references for each row of data are provided in parentheses in the Indicator column, unless specified next to the data point.

‡ When possible, EU27 data was used instead of EU28 data.

§ N/A indicates the data is not available.

‖ Total value.

¶ This data is derived from a national source in Albania, which, while it is more up to date, it is not internationally comparable because it was not submitted via an official, subregion-wide data collection.

* All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).
References


* All online references were accessed on 23 June 2021.
Table 2. Health and sustainable development priorities in the WBs

After the country/area briefs (Section 2) were completed, a summary of health and sustainable development priorities across the WBs was compiled (Table 2). As shown, this exercise revealed a high degree of overlap of priorities among the countries/areas of the WBs. This summary, alongside the country/area briefs, was used to identify areas for united subregional action and formulate the Roadmap’s High Impact Action Areas and Reform Initiatives.

Table 2. Priority actions for health and sustainable development in the countries/areas of the WBs

<table>
<thead>
<tr>
<th>EPW Core Priorities</th>
<th>Albania</th>
<th>Bosnia and Herzegovina</th>
<th>Montenegro</th>
<th>North Macedonia</th>
<th>Serbia</th>
<th>Kosovo¹⁰</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Priority 1: Moving towards UHC</td>
<td>• Strengthen PHC • Increase health workforce • Reduce burden of NCDs • Improve health governance and evaluation/monitoring of essential services • Address financial hardship associated with use of health care, including medicines</td>
<td>• Strengthen PHC through the development of integrated patient-centred services • Improve health governance and evaluation/monitoring of essential services • Improve access to services, medicines and medical supplies • Address financial hardship associated with use of health care, including medicines</td>
<td>• Strengthen PHC through greater investment in prevention • Restore public trust in the health-care system • Address shortages in alternative care settings • Address financial hardship associated with use of health care, including medicines • Foster innovation in research and development</td>
<td>• Strengthen PHC • Increase health workforce • Improve procurement of medical supplies • Address financial hardship associated with use of health care, including medicines</td>
<td>• Strengthen PHC • Increase health workforce • Reduce burden of NCDs • Address financial hardship associated with use of health care, including medicines</td>
<td>• Improve public health data and information systems • Strengthen PHC • Increase health workforce • Reduce burden of NCDs • Address financial hardship associated with use of health care, including medicines • Combat discrimination and refusal of care</td>
</tr>
</tbody>
</table>

¹⁰ All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).
### Flagship Initiative 1: The Mental Health Coalition

**Albania**
- Deinstitutionalize services and foster community care models

**Bosnia and Herzegovina**
- Deinstitutionalize services and foster community care models

**Montenegro**
- Deinstitutionalize services and foster community care models

**North Macedonia**
- Deinstitutionalize services and foster community care models

**Serbia**
- Increase investment in prevention and improvement of social determinants of mental health
- Facilitate the implementation of the National Health Strategy
- Deinstitutionalize services and foster community care models

**Kosovo[^1]**
- Deinstitutionalize services and foster community care models
- Address post-war rates of mental health disorders, such as depression, PTSD, etc.

### Flagship Initiative 2: Empowerment through Digital Health

**Albania**
- Improve and integrate digital health information systems

**Bosnia and Herzegovina**
- Develop digital health information systems to facilitate the monitoring of service delivery and provider performance, and improve financial sustainability

**Montenegro**
- Develop digital health information systems to enhance the capacities of PHC, mental health, and management of chronic diseases

**North Macedonia**
- Improve and integrate digital health information systems to improve home-based care and prevention activities
- Develop specific regiments for chronic diseases and the elderly

**Serbia**
- Improve digital health information systems for data collection and epidemiological surveillance
- Increase digital health information systems in PHC to increase capacity

**Kosovo[^1]**
- Improve and integrate digital health information systems
- Develop systems to track and monitor health data and SDG progress

[^1]: All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).
### Core Priority 2: Protecting against health emergencies

<table>
<thead>
<tr>
<th>EPW Core Priorities</th>
<th>Albania</th>
<th>Bosnia and Herzegovina</th>
<th>Montenegro</th>
<th>North Macedonia</th>
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<td><strong>Kosovo</strong></td>
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<td><strong>Country/Area-level Priorities</strong></td>
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<tr>
<td>Increase the availability of medical supplies and equipment</td>
<td>Increase the availability of medical supplies and equipment</td>
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<tr>
<td>Improve IHR capacities to improve emergency risk communication and develop simulation programs to train for health emergencies</td>
<td>Improve IHR capacities to improve emergency risk communication and develop simulation programs to train for health emergencies</td>
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<tr>
<td>Improve PHC to guarantee the maintenance of essential services during crises</td>
<td>Improve PHC to guarantee the maintenance of essential services during crises</td>
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<td>Improve PHC to guarantee the maintenance of essential services during crises</td>
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<tr>
<td>Train health workforce to deal with crises</td>
<td>Train health workforce to deal with crises</td>
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<td>Train health workforce to deal with crises</td>
<td>Train health workforce to deal with crises</td>
<td>Train health workforce to deal with crises</td>
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<tr>
<td>Improve digital health infrastructure to support essential services during emergencies</td>
<td>Improve digital health infrastructure to support essential services during emergencies</td>
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<td>Improve digital health infrastructure to support essential services during emergencies</td>
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<tr>
<td>Build resilience of health-care facilities to climate change and natural disasters, while improving environmental sustainability</td>
<td>Build resilience of health-care facilities to climate change and natural disasters, while improving environmental sustainability</td>
<td>Build resilience of health-care facilities to climate change and natural disasters, while improving environmental sustainability</td>
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<td>Build resilience of health-care facilities to climate change and natural disasters, while improving environmental sustainability</td>
<td>Build resilience of health-care facilities to climate change and natural disasters, while improving environmental sustainability</td>
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<tr>
<td>Develop a formal review of the Region’s response to recent health emergencies</td>
<td>Develop a formal review of the Region’s response to recent health emergencies</td>
<td>Develop a formal review of the Region’s response to recent health emergencies</td>
<td>Develop a formal review of the Region’s response to recent health emergencies</td>
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<td>Develop a formal review of the Region’s response to recent health emergencies</td>
<td>Develop a formal review of the Region’s response to recent health emergencies</td>
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</tbody>
</table>

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### Notes

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<table>
<thead>
<tr>
<th>EPW Core Priorities</th>
<th>Albania</th>
<th>Bosnia and Herzegovina</th>
<th>Country/Area-level Priorities</th>
<th>Montenegro</th>
<th>North Macedonia</th>
<th>Serbia</th>
<th>Kosovo¹³</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core Priority 3:</strong> Promoting health and well-being</td>
<td>Address risk factors for NCDs</td>
<td>Address risk factors for NCDs</td>
<td>Address risk factors for NCDs</td>
<td>Address risk factors for NCDs</td>
<td>Address risk factors for NCDs</td>
<td>Address risk factors for NCDs</td>
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<tr>
<td></td>
<td>Respond to unmet care needs of an ageing population</td>
<td>Respond to unmet care needs of an ageing population</td>
<td>Respond to unmet care needs of an ageing population</td>
<td>Respond to unmet care needs of an ageing population</td>
<td>Respond to unmet care needs of an ageing population</td>
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<td>Combat AMR</td>
<td>Combat AMR</td>
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<tr>
<td></td>
<td>Improve environmental health</td>
<td>Improve environmental health</td>
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<td>Improve environmental health</td>
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<tr>
<td></td>
<td>Support local living environments with the HiAP approach</td>
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</tr>
<tr>
<td><strong>Flagship Initiative 3:</strong> European Immunization Agenda 2030</td>
<td>Develop and implement plan to target unvaccinated population</td>
<td>Develop and implement plan to target unvaccinated population (especially for DTP3)</td>
<td>Develop and implement plan to target unvaccinated population (especially for DTP3)</td>
<td>Develop and implement plan to target unvaccinated population (especially for DTP3)</td>
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<td>Develop and implement plan to target unvaccinated population (especially for DTP3)</td>
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<td>Increase public confidence in vaccination programmes</td>
<td>Increase public confidence in vaccination programmes</td>
<td>Increase public confidence in vaccination programmes</td>
<td>Increase public confidence in vaccination programmes</td>
<td>Increase public confidence in vaccination programmes</td>
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<td>Increase public confidence in vaccination programmes</td>
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<tr>
<td><strong>Flagship Initiative 4:</strong> Healthier Behaviours</td>
<td>Develop programmes to protect the most vulnerable groups from poverty and social exclusion</td>
<td>Develop programmes to protect the most vulnerable groups from poverty and social exclusion</td>
<td>Develop programmes to protect the most vulnerable groups from poverty and social exclusion</td>
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<td>Develop programmes to protect the most vulnerable groups from poverty and social exclusion</td>
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<td></td>
<td>Invest in outreach programmes particularly to target early childhood development and substance abuse</td>
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Section 2.
Country/area briefs: Identifying and centring the health and sustainable development priorities of the WBs
Introducing the Country/Area Briefs

In this section, six country/area briefs were prepared to identify the health and sustainable development priorities of the WBs. As a testament to multilateralism, the Roadmap is a subregional policy for the WBs that was constructed with a bottom-up approach. It began by centring the health and sustainable development priorities of individual countries/area, then it identified shared priorities for united subregional action in the WBs. Therefore, these country/area briefs are the core of the Roadmap’s foundation, and they have been used to develop the Roadmap’s High Impact Action Areas and Reform Initiatives.

Each brief contains an overview of health and sustainable development progress and trajectories, lessons learned from the COVID-19 pandemic, and an outline of country/area-level health and sustainable development priorities viewed through the lens of the Sustainable Development Goals [SDGs] (1) and the European Programme of Work [2020-2025] – “United Action for Better Health” (EPW) (2). More specifically, priorities are outlined in relation to selected targets of SDG 3, to ensure healthy lives and promote well-being for all at all ages, and across the three core priorities of the EPW, which include: 1) Moving towards universal health coverage; 2) Protecting against health emergencies; and 3) Promoting health and well-being.

For further information regarding each country/area’s health and sustainable development priorities, please consult the references used to assemble each brief. For all numerical references in Section 2, please see each country/area’s individual reference section immediately following their brief. Each brief is presented independently to grant easy access to country/area relevant information.

References


Republic of Albania

This country brief provides an overview of the Republic of Albania’s health and sustainable development priorities that informed the Roadmap’s formation. While this brief does not seek to be exhaustive or prescriptive, it identifies key issues and areas where Albania may benefit from and contribute to united action for better health in the Western Balkans (WBs).

Health and sustainable development progress in Albania

As outlined in Albania’s National Strategy for Development and Integration 2014–2020 (NSDI-II) [1], European Union (EU) accession is its overarching strategic priority. In 2018 and 2019, the European Commission agreed to open accession negotiations with Albania after the European Council granted Albania candidate status in 2014. In the European Commission’s Enlargement Strategy, five EU integration priority conditions were identified for opening accession negotiations: 1) public administration reform, stable institutions and a modern, professional and depoliticized civil service; 2) strengthening the independence, efficiency and accountability of judicial institutions; 3) increasing the fight against corruption; 4) increasing the fight against organized crime; and 5) ensuring the protection of human rights, including of Roma people, in antidiscrimination policies, property rights, etc. [2].

The goals set under each of the EU integration priority conditions relate to the achievement of the Sustainable Development Goals (SDGs) and their targets: more specifically, the EU accession process covers nearly two-thirds of the SDG targets (109 out of 169 targets). Overall, governance reforms have been prioritized and are at the centre of the EU accession process. The EU, United Nations (UN) and other development partners have provided support in the areas of public administration and judiciary reforms, including efforts to reduce corruption and strengthen the rule of law [3].

Albania’s economy has, on average, grown by 2.4% per year over the last decade, which has led to improvements in labour market patterns and contributed towards improved living standards and reducing poverty and social exclusion [4].

Albania’s human development index (HDI) increased from 0.745 to 0.795 between 2010 and 2019. This represents an average HDI growth of 0.72%, which is near Europe and Central Asia’s average of 0.76% during the same period [6]. Embedded in Albania’s HDI is their steady increase of life expectancy over the past decade: between 2010 and 2019, life expectancy increased by 1.60 years to 79.91 for females and by 2.02 years to 76.25 for males [7]. However, these figures are still significantly below the EU’s average of 83.82 for females and 78.45 for males [5]. During the same period, Albania’s population size decreased by 0.25% per year on average and the percentage of the population aged 65 years or older increased from 10.65% to 14.20% [5].

Major service gaps and investments in areas of health, education, social care and protection systems remain. Particularly, to ensure further gains in health and well-being, neonatal mortality and malnutrition need to be addressed. Roma women, Egyptian women, and women living in rural and remote areas in Albania, continue to have limited access to primary health care (PHC) and sexual and reproductive health-care services [4]. Building back better and leaving no one behind after the COVID-19 pandemic will be imperative to sustain the progress on health and sustainable development that Albania was making prior to the pandemic.
Looking forward: the health and sustainable development trajectory

The 2020–21 Biennial Collaborative Agreement (BCA) between the WHO Regional Office for Europe and Albania’s Ministry of Health and Social Protection (MoHSP) outlines the country’s health and sustainable development trajectory that will help it address the European Programme of Work (2020-2025) – “United Action for Better Health” (EPW)’s priorities and achieve the Sustainable Development Goals (SDGs) [8].

To maximize the opportunities for promoting population health and reducing health inequities, Albania’s BCA calls for the adoption of an intersectoral, Health-in-All-Policies (HiAP) approach that involves the whole of society and government [8]. This recognition emphasizes the need to improve overall governance and cooperation for health; therefore, the Roadmap will advance progress on the BCA’s priorities and support the international and national strategic frameworks it outlines as accelerators.

WHO is supporting the MoHSP’s review of the Albanian National Health Strategy 2016–2020 (ANHS 2020) to help develop the Albanian National Health Strategy 2021–2030, which WHO and other key partners have already committed to providing technical assistance and support. The ANHS 2020 had four strategic priorities: 1) Investing in people’s health throughout the life cycle; 2) Providing universal health coverage (UHC) for everyone; 3) Strengthening health systems by placing people in the centre; and 4) Improving governance and cross-sectoral cooperation on health.

SDG 3 Progress: Ensure healthy lives and promote well-being for all at all ages

SDG 3 aims to ensure healthy lives and promote well-being for all at all ages. Tracking Albania’s progress towards achieving the targets of SDG 3 provides an overview of where health and sustainable development have progressed well and where challenges remain (Table 4).
### Table 3. Selected targets and indicators to track Albania’s progress on SDG 3 achievement.

<table>
<thead>
<tr>
<th>SDG 3 Target</th>
<th>Status</th>
<th>Description</th>
<th>Indicator(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Target achieved</td>
<td>By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.</td>
<td><strong>3.1.1:</strong> Maternal mortality ratio: N/A&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>3.2</td>
<td>Target achieved</td>
<td>By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-five mortality to at least as low as 25 per 1000 live births.</td>
<td><strong>3.2.1:</strong> Children under-five mortality rate: N/A&lt;sup&gt;c&lt;/sup&gt;; <strong>3.2.2:</strong> Neonatal mortality rate: N/A&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>3.4</td>
<td>Challenges remain</td>
<td>By 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being.</td>
<td><strong>3.4.1:</strong> Risk of dying between the ages of 30 and 70 from one of four main NCDs (cardiovascular disease, cancer, diabetes, or chronic respiratory disease): Decreased from 18.7% to 11.4% between 2000 and 2019.; <strong>3.4.2:</strong> Suicide mortality rate: Decreased from 5.2 to 3.7 deaths per 1000 population between 2000 and 2019.</td>
</tr>
<tr>
<td>3.5</td>
<td>Challenges remain</td>
<td>Strengthen the prevention and treatment of substance abuse.</td>
<td><strong>3.5.2:</strong> Alcohol consumption per capita among population aged 15 years and older: Increased from 6.6 to 7.2 litres of pure alcohol between 2000 and 2018.</td>
</tr>
<tr>
<td>3.6</td>
<td>Significant challenges remain</td>
<td>By 2020, halve the number of global deaths and injuries from road traffic accidents.</td>
<td><strong>3.6.1:</strong> Death rate due to road traffic injuries: Decreased from 14.4 to 11.7 deaths per 100,000 population between 2000 and 2016.</td>
</tr>
<tr>
<td>3.7</td>
<td>Major challenges remain</td>
<td>By 2030, ensure universal access to sexual and reproductive health-care services.</td>
<td><strong>3.7.1:</strong> Proportion of women of reproductive age with their needs met for family planning with modern methods: Decreased from 16.7% to 9.3% between 2000 and 2020.; <strong>3.7.2:</strong> Adolescent birth rate: Decreased from 17.2 to 14.2 per 1000 women age 15-19 years between 2000 and 2019.</td>
</tr>
<tr>
<td>3.8</td>
<td>Major challenges remain</td>
<td>Achieve UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.</td>
<td><strong>3.8.1:</strong> Service coverage index&lt;sup&gt;d&lt;/sup&gt;: Increased from 44.0 to 59.0 between 2000 and 2017.; <strong>3.8.2:</strong> Regional indicators show that the share of households with catastrophic health spending increased from 11.9% in 2009 to 12.5% in 2015.</td>
</tr>
<tr>
<td>3.9</td>
<td>Challenges remain</td>
<td>By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.</td>
<td><strong>3.9.1:</strong> Age-standardized mortality rate attributed to household air pollution: 31.0 deaths per 100,000 population in 2016.; <strong>3.9.2:</strong> Age-standardized mortality rate attributed to ambient air pollution: 41.0 deaths per 100,000 population in 2016.; <strong>3.9.2:</strong> Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene: 0.2 deaths per 100,000 population in 2016.; <strong>3.9.3:</strong> Mortality rate attributed to unintentional poisonings: Decreased from 1.0 to 0.4 deaths per 100,000 population between 2000 and 2016.</td>
</tr>
<tr>
<td>3.a</td>
<td>Major challenges remain</td>
<td>Strengthen the implementation of the WHO Framework Convention on Tobacco Control.</td>
<td><strong>3.3.1:</strong> Age-standardized prevalence of current tobacco use among persons aged 15 years and older: Decreased from 34.2% to 29.2% between 2000 and 2018.</td>
</tr>
</tbody>
</table>

Notes. NCDs: noncommunicable diseases; SDGs: Sustainable Development Goals; UHC: Universal health coverage.

<sup>a</sup> For brevity, some SDG 3 targets and indicators were excluded when the health issues they addressed were not relatively high priorities or needs in Albania’s context (for example, tropical diseases, etc.) or if there was no data available for their indicators.

<sup>b</sup> The status assigned to each target was determined by an analysis carried out by the Sustainable Development Report (10), and the indicators selected for this table represent some of the many indicators that were considered when these assessments were made.

<sup>c</sup> Maternal, children under-five and neonatal mortality data are under review by the Albanian Ministry of Health and Social Protection due to differences in methodologies used.

<sup>d</sup> There are significant limitations associated with this measure of service coverage.

Source: Adapted from (7, 9, 10, 11).
Lessons learned from the COVID-19 pandemic in Albania

The COVID-19 pandemic and the 2019 earthquake disaster have exposed systemic weaknesses in Albania’s health and social systems, and they have disproportionately affected poor and vulnerable households who are less resilient in the face of social and economic shocks due to having less savings, for example. Consequently, these events have prompted policy responses and, in some cases, substantive changes in Albania. The government, supported by United Nation (UN) agencies and other development partners, focused attention towards its emergency response and supported interventions to improve people centred PHC, integrate health and social care at the community level, and sustain investments in the infrastructure of health facilities. To address immediate needs, WHO, in close collaboration and partnership with the MoHSP and other partners, played a substantial role in Albania’s COVID-19 coordination, risk communication and community engagement. WHO supported case management, surveillance, laboratory testing, infection prevention and control, vaccination, continuity of essential health services and other important interventions.

Now, to incorporate the lessons learned from these activities, WHO is assisting with the evaluation of the ANHS 2020 as the basis for starting the development of the Albanian National Health Strategy 2021–2030.

The COVID-19 pandemic has largely affected people who were already marginalized by exacerbating pre-existing vulnerabilities. Therefore, Albania doubled the amount of cash assistance per recipient in its COVID-19 mitigation measures and expanded the pool of eligible persons. Following the declaration of a state of emergency, food and other support items were delivered to approximately 600 000 individuals identified by local governments as vulnerable. The government provided financial compensation for the self-employed, and subsidies were provided to small businesses to pay their employees. Enhancing the quality of health care and education and strengthening social protection, with a particular focus on the most vulnerable, can help to prepare for future health emergencies and reduce their negative impact on health and the health system.

Despite the difficulties Albania faced during the outbreak, national authorities were very active and demonstrated strong governance and coordinating ability to collaboratively provide various mitigation measures. For example, protocols were developed for the safe return of children to school in collaboration with WHO, the United Nations Educational, Scientific and Cultural Organization, the United Nations Children’s Fund (UNICEF), and the World Bank, and frontline professionals were trained in different disciplines in mental health and psychological support during emergencies with assistance from UNICEF and WHO. Additionally, the Albanian Government also successfully mobilized COVID-19 vaccines through COVAX and other bilateral agreements. These successes have demonstrated the importance of further strengthening governance and administration mechanisms across Albanian health and social systems to reduce bureaucratic burden and increase resilience, collaboration, and the adaptability of national systems to shocks and challenges.

Closing the Health Gap: aligning Albania’s priorities with the EPW

Albania’s current country-level health priorities and gaps are discussed below in context of the EPW’s core priorities and flagship initiatives.

Core Priority 1: Moving towards UHC

Moving towards UHC is a high priority for Albania. As an initial step towards UHC, free access to preventative services for the entire population, including for the uninsured, was introduced in January 2017. More recently, the Government of Albania is planning additional investments to develop and implement new PHC models of care that consider the needs of rural and urban populations.

Progress towards UHC is monitored in two dimensions: the coverage of essential health services and financial hardship. Each is covered further in the context of Albania below.
Coverage of essential health services

In 2019, 27,100 fewer people in Albania (0.95% of the population) were covered by essential health services than in 2018. However, by 2023, Albania anticipates there will be 166,200 more people (5.8% of the population) covered (16). Coverage of essential health services is defined as the average coverage of the 14 SDG 3.8.1 tracer interventions. Of these 14 indicators, positive progress is projected for nine of them in Albania by 2023 (Table 5).

Table 4. Projected percentage point changes in normalized values across the 14 SDG 3.8.1 tracer interventions for service coverage between 2018 and 2023 in Albania.

<table>
<thead>
<tr>
<th>Service Coverage Indicator</th>
<th>2018 value (%)</th>
<th>Projected 2023 value (%)</th>
<th>Projected change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic sanitation</td>
<td>98.0</td>
<td>98.9</td>
<td>+0.9</td>
</tr>
<tr>
<td>Care seeking for pneumonia (children under 5)</td>
<td>81.8</td>
<td>77.7</td>
<td>-4.1</td>
</tr>
<tr>
<td>DTP3 immunisation</td>
<td>99.0</td>
<td>98.8</td>
<td>-0.2</td>
</tr>
<tr>
<td>Health worker density</td>
<td>68.7</td>
<td>90.2</td>
<td>+21.6</td>
</tr>
<tr>
<td>Hospital bed density</td>
<td>100.0</td>
<td>100.0</td>
<td>0.0</td>
</tr>
<tr>
<td>IHR core capacity index</td>
<td>49.9</td>
<td>93.7</td>
<td>+43.8</td>
</tr>
<tr>
<td>ITN use</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Mean fasting blood glucose</td>
<td>100.0</td>
<td>99.6</td>
<td>-0.4</td>
</tr>
<tr>
<td>Need met for family planning</td>
<td>7.7</td>
<td>11.4</td>
<td>+3.7</td>
</tr>
<tr>
<td>Non-elevated blood pressure</td>
<td>43.3</td>
<td>45.5</td>
<td>+2.2</td>
</tr>
<tr>
<td>People living with HIV receiving ART</td>
<td>41.9</td>
<td>47.3</td>
<td>+5.4</td>
</tr>
<tr>
<td>TB cases treated</td>
<td>87.0</td>
<td>87.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Tobacco non-use</td>
<td>70.8</td>
<td>72.0</td>
<td>+1.2</td>
</tr>
<tr>
<td>Women who received antenatal care visits 4+ times</td>
<td>71.1</td>
<td>71.2</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Notes. ART: Antiretroviral therapy; DTP3: Three doses of diphtheria tetanus toxoid and pertussis vaccine; IHR: International Health Regulations (2005); ITN use: Insecticide-treated bed net use among people at-risk of malaria; TB: Tuberculosis.

There are significant limitations associated with this method of measuring service coverage.

Source: Adapted from (16).

The main concern regarding the health workforce is that fewer young people are entering the medical profession, and those who do tend to migrate abroad, leading to a skill shortage in the country (17). Consequently, Albania’s BCA identifies developing policies that retain health workers, with a special emphasis on the new generation, as a high priority (8).

The key public health problem in Albania is the burden of noncommunicable diseases (NCDs). In 2019, the percentages of deaths and disability-adjusted life-years (DALYs) attributable to NCDs in Albania were 93.94% (5) and 82.47% (18), respectively. A more systematic, high quality health information system that improves the monitoring of service delivery for NCDs, progresses sustainable health financing policies, and enhances the assessment of providers’ performance is needed to improve the health system and tackle Albania’s burden of NCDs.

Therefore, as outlined in their BCA, Albania is committed to achieving a PHC system that is accessible, equitable, integrated, and community-oriented and one that includes support for mental health, NCD screening and early detection, and COVID-19 prevention (8). Developing an integrated, patient-centred package of care and social protection will also help increase capacity for Albania to manage HIV, tuberculosis, and hepatitis. To achieve these goals, Albania would
benefit from subregional cooperation to strengthen the government’s capacity to monitor and evaluate access and utilization of essential services and to develop an evaluation mechanism for the best practices of fighting and reporting corruption.

Financial hardship

Ensuring everyone can access high-quality health services without facing financial hardship is a key target of the EPW and SDGs. In 2015, 12.5% of households experienced catastrophic out-of-pocket (OOP) payments in Albania (11). Health services within primary and hospital care are purchased by the Compulsory Health Insurance Fund (CHIF) (17). The health insurance scheme is based on the single payer model: CHIF manages the scheme in accordance with national health-care policies. Although Albania has been working to increase public spending on health, in 2018, it was only 2.84% of GDP (compared to an EU average of 5.9%) and OOP payments accounted for approximately 44.58% of current health spending, more than double the EU average of 21.6% (19).

To reduce the number of people suffering financial hardship from health spending, Albania’s BCA has identified capacity building as a high priority to adopt the WHO recommended standards in recording, tracking and reporting financial protection (8). Furthermore, the WHO Barcelona Office for Health Systems Financing has published an in-depth analysis of financial protection in Albania (11), which will be updated as part of the Directorate-General for Neighbourhood and Enlargement Negotiations [DG NEAR] project.

Medicines are the main driver of OOP spending, therefore, improving access to essential medicines and medical supplies is required. To do so, Albania’s BCA has identified the following priorities: update and optimize the procedure for the reimbursement of drugs and medical devices; provide assistance for conducting Health Technology Assessments; strengthen the capacity of the National Agency of Drugs and Medical Equipment to converge with EU regulations and accreditation; increase capacity for inspections and pharmacovigilance; and employ WHO technical support to draft and implement Standard Operating Procedures for laboratories (8). Albania would benefit from subregional cooperation to progress each of these priorities.

Flagship Initiative 1: The Mental Health Coalition

Albania is committed to continuing to facilitate the implementation of the Action Plan for the Development of Mental Health Services in Albania 2013–2022 (20). The aim of this strategy is to protect the rights of those with mental health disorders and fight against social exclusion and discrimination by employing an integrated network of mental health services treatment, rehabilitation and social reintegration. Its two major strategic objectives are: 1) to decentralize mental health services through network expansion and the enhancement of existing services and 2) to deinstitutionalize mental health-care delivery by controlling the number of psychiatric beds and strengthening community mental health services.

Flagship Initiative 2: Empowerment through Digital Health

Albania recognizes the opportunities of digital technologies to promote health and social change and strengthen service provider accountability that ensures human-centred development and leaves no one behind. Furthermore, Albania is dedicated to paying special attention to increasing digitalization in the health-care sector to integrate health information systems and, thereby, improve data collection and epidemiological surveillance (8).

Expanding access to PHC can be achieved with improvements in digital technologies and telemedicine, and digitization can reduce the stress on the health system in future health emergencies by facilitating the maintenance of essential services for chronic conditions, mental health, maternal health, and beyond. Albania would benefit from technical and financial support from WHO and subregional cooperation to advance digital health.
Core Priority 2: Protecting against health emergencies

Albania is a World Health Emergencies Priority Country. In 2019, Albania had 359,900 more people (12.6% of the population) better protected from health emergencies than in 2018. By 2023, it is projected that number will increase to 1.36 million people (47.6% of the population). In 2019, Albania scored 79.5% in the Health Emergency Protection (HEP) Index, which is calculated based on three sub-indicators: 1) preparedness; 2) prevention; and 3) detection and response (16).

Preparedness

In 2019, Albania scored relatively low at 62.0% in the preparedness sub-indicator. This sub-indicator assesses emergency preparedness by averaging the scores of all 13 International Health Regulations (2005) (IHR) core capacities at the country level, which are reported through the States Parties Annual Report (SPAR) tool (16). The 2019 earthquake disaster in Albania exposed some pre-existing preparedness challenges in the country, such as the readiness of the health system to provide emergency care. Remaining challenges include procuring adequate supplies of lifesaving medical equipment, training the health workforce, and ensuring the resilience of the health system and communities to better manage future disasters and health risks. Fortunately, addressing these vulnerabilities can produce the greatest return on investment (21).

Prevention

In 2019, Albania fared best at 97.0% in the prevention sub-indicator, which assesses efforts to prevent health emergencies through routine and targeted vaccine campaign efforts. This sub-indicator includes vaccination coverage for five major infectious diseases: measles, polio, meningococcal meningitis A, yellow fever, and cholera (16). Albania’s health system still faces challenges in ensuring compliance with prevention and control practices in health-care settings, including the triage, isolation, and management of patients (22).

Detection and response

In 2020, Albania also performed well at 93.3% in the detection and response sub-indicator, which assesses the appropriateness of a country’s reaction to an event of potential public health concern. The indicator averages the time from a public health event’s start to detection, notification and response to provide an overall measure of timeliness (16). Albania’s development of a National Action Plan for Health Security is in progress. The MoHSP’s General Platform of Risk and Disaster Management synchronizes the response activity of its subordinate structures at the central, regional, and local levels with the National Civil Protection Structures. Regional Health Authorities are in the process of setting up their own Incident Management System, which should be completed with WHO’s technical support (23).

During the COVID-19 pandemic, essential services were disrupted, such as the monitoring and evaluation of chronic conditions, due to Albania lacking sufficient supplies to protect health-care personnel and patients (14). A key lesson learned from the COVID-19 pandemic related to health emergency preparedness is that Albania must prioritize improving its health system’s capacity to provide immediate access to the medical supplies, protective equipment, and digital infrastructure required to maintain essential services and protect health care personnel and patients.

To address the aforementioned areas of improvement, Albania’s BCA has identified the following priorities: to strengthen the capacity of the MoHSP in IHR implementation, emergency preparedness, and coordination and management of the health consequences of public health events and emergencies at all levels of the health-care system; to improve emergency risk communication in the health sector through an integrated and multisectoral approach; to support the MoHSP to develop a monitoring and evaluation simulation exercise programme to test the functional capabilities of health emergency systems; to strengthen the capacity of the MoHSP to conduct surveillance of high-threat infectious pathogens and to conduct rapid needs assessments and follow-up response activities; and to strengthen Albania’s strategic role in the fight against COVID-19 and the process of building back better (8).
Core Priority 3: Promoting health and well-being

In 2019, 26,600 more people in Albania (0.93% of the population) enjoyed better health and well-being than in 2018. By 2023, that number is projected to reach 133,800 more people (4.7% of the population) (16). The healthier populations (HPOP) index uses 16 outcome indicators related to social, environmental, and behavioural risks to assess the number of people whose lives have become healthier. In Albania, improvements in seven of the 16 indicators are projected between 2018 and 2023 (Table 6).

Table 5. Projected percentage point changes in normalized values across the 16 outcome indicators related to the HPOP index between 2018 and 2023 in Albania.

<table>
<thead>
<tr>
<th>HPOP Indicator</th>
<th>2018 value (%)</th>
<th>Projected 2023 value (%)</th>
<th>Projected change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to safely managed drinking water sources</td>
<td>70.0</td>
<td>70.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Access to safely managed sanitation services</td>
<td>39.9</td>
<td>39.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Adults not obese</td>
<td>76.5</td>
<td>73.5</td>
<td>-3.0</td>
</tr>
<tr>
<td>Ambient air quality</td>
<td>82.8</td>
<td>85.4</td>
<td>+2.6</td>
</tr>
<tr>
<td>Best practice policy implemented for healthy fats production</td>
<td>85.7</td>
<td>85.7</td>
<td>0.0</td>
</tr>
<tr>
<td>Child development</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Children not obese</td>
<td>92.2</td>
<td>90.4</td>
<td>-1.8</td>
</tr>
<tr>
<td>Children not overweight</td>
<td>84.3</td>
<td>87.4</td>
<td>+3.1</td>
</tr>
<tr>
<td>Children not stunted</td>
<td>88.6</td>
<td>92.3</td>
<td>+3.7</td>
</tr>
<tr>
<td>Children not wasted</td>
<td>98.7</td>
<td>99.6</td>
<td>+0.9</td>
</tr>
<tr>
<td>Primary reliance on clean household fuels</td>
<td>79.7</td>
<td>83.2</td>
<td>+3.5</td>
</tr>
<tr>
<td>Reduced alcohol use</td>
<td>72.7</td>
<td>72.7</td>
<td>0.0</td>
</tr>
<tr>
<td>Reduced child violence</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Reduced partner violence</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Reduced road traffic mortality</td>
<td>97.2</td>
<td>97.5</td>
<td>+0.3</td>
</tr>
<tr>
<td>Reduced suicide attempts</td>
<td>99.5</td>
<td>99.6</td>
<td>+0.1</td>
</tr>
<tr>
<td>Tobacco non-use</td>
<td>70.6</td>
<td>71.4</td>
<td>+0.8</td>
</tr>
</tbody>
</table>

Notes. HPOP: healthier populations.

Some indicators in this chart have been transformed to have values between 0 and 100 (0 worst–100 best).
N/A indicates the data is not available.
Further information regarding the indicators can be found at (16).
Source: Adapted from (16).

To address the social determinants of health across the life course, Albania’s BCA details its commitment to coordinate with UN agencies to propose and implement interventions for social protection and health improvement for people, especially women and children, who face health inequities (8).

Promoting health and well-being will require Albania to address the consequences of its ageing population and its high burden of NCDs. Overall, Albania’s negative population growth and ageing population jeopardizes the financial
sustainability of retirement and disability benefits and is projected to put further financial strain on Albania’s health insurance system (4).

Tackling Albania’s persistently high burden of NCDs will require intensive focus on prevention of common risk factors, especially in relation to Albania’s high smoking prevalence of 29.2% in adults aged 15 years or older (16). While Albania has made progress in this regard, significant work remains to fully implement the WHO Framework Convention of Tobacco Control. Reducing Albania’s persistently high burden of NCDs will require a sustained increase in investment to strengthen monitoring, treatment, evaluation and prevention at the PHC level. It will also require supporting efforts that can reduce the burden of NCDs, such as initiatives for nutrition, alcohol, tobacco, and obesity. Albania’s BCA identifies a core priority of utilizing an intersectoral approach to halt and reverse childhood obesity and diminish salt consumption through policy advocacy, developing and enforcing laws (such as taxation), labelling processed foods, and promoting healthy lifestyles in schools (8).

Albania is also committed to addressing antimicrobial resistance through strengthened surveillance systems, increased laboratory capacity, infection prevention and control, awareness raising and evidence-based policies and practices (8). Environmental health challenges, particularly industrial pollution, occupational exposures to health hazards (particularly in the mining industry), and extreme weather events are also significant concerns. For example, the mortality rate attributed to household and ambient air pollution is high at 67.99 per 100 000 population in 2016 (24). Concerted efforts are being made to integrate environmental considerations into Albania’s policies in the transport, energy and industry sectors (25). Albania’s BCA also calls for initiatives to combat vector-borne diseases by strengthening vector-control programmes (an act that will increase climate change resiliency) and sharing best practices through the European Healthy Cities Network to promote smart and sustainable transportation in urban settings and to support the implementation of national policies to improve air quality (8).

Flagship Initiative 3: The European Immunization Agenda 2030

Since achieving measles elimination in 2015, Albania has reported sporadic imported cases. The 2017–2018 measles outbreak caused health authorities to review immunization registries and perform catch-up immunizations targeting children with immunization delays as well as some adults and vulnerable people. More than 10 000 doses of the measles, mumps, and rubella (MMR) vaccine were administered. The schedule of the national immunization programme has been temporarily modified to allow the use of the MMR vaccine for children aged 9–12 months as a “zero dose” (22). Additionally, Albania’s BCA specifically calls for developing and implementing a multi-year plan to provide authoritative guidance and standards on quality, safety and efficacy of health products, with a special emphasis on micro-planning for immunization and targeting under-vaccinated and unvaccinated populations (8).

Flagship Initiative 4: Healthier Behaviours: incorporating behavioural and cultural insights

Safeguarding and, where possible, increasing social spending in areas such as health, social and child protection and education is a priority to protect Albania’s most vulnerable groups from poverty and social exclusion in Albania. This requires improved planning, budgeting, allocation and monitoring of public finances and increasing the effectiveness and efficiency of social spending, including better targeting of and outreach to the most vulnerable groups. There is also a need to explore alternative, innovative funding sources and to prioritize spending on areas that maximize return on investments (for example, early childhood development). This aligns with the EPW’s intent to develop an investment case for developing a knowledge and evidence base in this area of work.
References


*All online references were accessed on 23 June 2021.*


Bosnia and Herzegovina

Bosnia and Herzegovina administratively consists of two Entities: the Federation of Bosnia and Herzegovina [further devolved into ten cantons] and Republika Srpska, as well as the Brčko District of Bosnia and Herzegovina. This country brief provides an overview of health and sustainable development priorities in Bosnia and Herzegovina that informed the Roadmap’s formation. While this brief does not seek to be exhaustive or prescriptive, it identifies key issues and areas where Bosnia and Herzegovina may benefit from and contribute to united action for better health in the Western Balkans (WBs).

Health and sustainable development progress in Bosnia and Herzegovina

Bosnia and Herzegovina was identified as a potential candidate for European Union (EU) membership during the Thessaloniki European Council summit in 2003. Since then, agreements between the EU and Bosnia and Herzegovina have included visa facilitation and re-admission agreements (2008); the Interim Agreement on Trade and Trade-related issues (2008); and the Stabilisation and Association Agreement (2015). In 2016, Bosnia and Herzegovina applied for EU membership and in 2019, the European Commission adopted its Opinion, which the EU Council also endorsed in the same year, on Bosnia and Herzegovina’s application, identifying 14 key priorities for the country to fulfil in view of opening EU accession negotiations. The Opinion constitutes a comprehensive roadmap for deep reforms in the areas of democracy/functionality, the rule of law, fundamental rights and public administration reform (1). Aligning with EU norms and standards has become even more important for economic integration and sustainable development in Bosnia and Herzegovina, especially given how the EU accession process covers nearly two-thirds of the Sustainable Development Goal (SDG) targets (109 out of 169 targets).

Bosnia and Herzegovina’s economy has, on average, grown by 2.0% per year over the last decade, yet, despite stable economic growth, a high unemployment rate persists; 16.9% of the total labour force was unemployed in 2019 (2). Bosnia and Herzegovina’s human development index (HDI) increased from 0.721 to 0.780 between 2010 and 2019. This represents an average HDI growth of 0.88%, which is higher than Europe and Central Asia’s average of 0.76% during the same period (3). Embedded in Bosnia and Herzegovina’s HDI is the steady increase of life expectancy over the past decade: between 2010 and 2019, life expectancy increased by 0.62 years, to 79.09 for females and 0.53 years to 74.38 for males (4). These figures are still significantly below the EU’s average of 83.82 for females and 78.45 for males (2). During the same period, Bosnia and Herzegovina’s population size decreased by 1.24%, per year on average and the percentage of the population aged 65 years or older increased from 13.96% to 17.20% (2).

As a result of continuous health sector reforms and investments in strengthening primary health care (PHC), a slight shift in deployment of trained health workforce towards PHC has been observed, with an increase in trained family medicine specialists over the past decade (5). However, compared to the EU, Bosnia and Herzegovina continuously demonstrates lower rates of deployed health professionals. The EU has nearly twice as many physicians per 100 000 population: there were 351 in 2014 compared to 188 in 2013 in Bosnia and Herzegovina (6). The reasons for such low levels are multi-dimensional, but the emigration of the skilled health workforce in recent years to the EU is a matter of concern, especially in the context of the rising health-care demand of the ageing population.
Looking forward: the health and sustainable development trajectory

Bosnia and Herzegovina is committed to advancing a health and sustainable development trajectory that will help it address the European Programme of Work (2020-2025) – “United Action for Better Health” (EPW)’s priorities and achieve the Sustainable Development Goals (SDGs). In the Federation of Bosnia and Herzegovina, the Strategic Plan for Health Care Development in the Federation of Bosnia and Herzegovina between 2008 and 2018 was the last overarching health policy document endorsed by the Government of the Federation of Bosnia and Herzegovina (7). The Governmental Development Strategy of the Federation of Bosnia and Herzegovina 2021–2027, with an explicit health priority on improving health system outcomes, was sent to the Parliament of the Federation of Bosnia and Herzegovina for endorsement by the end of February 2021 (8). In the Republika Srpska, the Policy for Improvement of Health of the Population in the Republic of Srpska by the year 2020 was built upon Health 2020 and the European Action Plan for Strengthening Public Health Capacities and Services and EU Regulation to promote alignment with international strategies, guidelines and regulations, and it was endorsed by the Government of the Republika Srpska (9). The latest health policy frameworks developed and enforced by respective authorities and governments in Bosnia and Herzegovina were the Action Plan for the Prevention and Control of Chronic Non-Communicable Diseases of the Federation of Bosnia and Herzegovina 2019-2025 (10) endorsed by the Ministry of Health of the Federation of BiH and the Action Plan for the Prevention and Control of Non-Communicable Diseases of the Republika Srpska 2019-2026 (11) endorsed by the Government of the Republika Srpska.

In 2019, as a continuation of the 2015–2018 Joint Reform Agenda proposed by the EU, the International Monetary Fund and the World Bank, the governments of the Republika Srpska and the Federation of Bosnia and Herzegovina endorsed the Joint Socio-Economic Reforms for the Period 2019–2022 in Bosnia and Herzegovina. Major health sector reforms, with a focus on achieving sustainable health financing and optimization of health-care service delivery were envisaged, with significant financial support anticipated from the World Bank. In March 2021, the Bosnia and Herzegovina and the United Nations Sustainable Development Cooperation Framework 2021–2025 – a Partnership for Sustainable Development (UNSDCF) was developed and endorsed. Quality, accessible and inclusive education, as well as health and social protection, have been explicitly recognized as the key strategic priorities for cooperation in Bosnia and Herzegovina. The Framework’s targets are aligned with the 2030 Agenda for Sustainable Development, and the selected health priorities for cooperation and investment in health in Bosnia and Herzegovina are aligned with three core priorities of the EPW. Therefore, the Roadmap will also directly accelerate Bosnia and Herzegovina’s progress on its pre-existing global and country-level strategic frameworks.

SDG 3 Progress: Ensure healthy lives and promote well-being for all at all ages

SDG 3 aims to ensure healthy lives and promote well-being for all at all ages. Tracking progress in Bosnia and Herzegovina towards achieving the targets of SDG 3 provides an overview of where health and sustainable development has progressed well and where challenges remain [Table 7].
Table 6. Selected targets and indicators to track the progress of Bosnia and Herzegovina on SDG 3 achievement.

<table>
<thead>
<tr>
<th>SDG 3 Targeta</th>
<th>Statusb</th>
<th>Description</th>
<th>Indicator(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Target achieved</td>
<td>By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births.</td>
<td>• 3.1.1: Maternal mortality ratio: Decreased from 27.0 to 10.0 per 100 000 live births between 2000 and 2017.</td>
</tr>
<tr>
<td>3.2</td>
<td>Target achieved</td>
<td>By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-five mortality to at least as low as 25 per 1000 live births.</td>
<td>• 3.2.1: Children under-five mortality rate: Decreased from 9.8 to 5.8 deaths per 1000 live births between 2000 and 2018. • 3.2.2: Neonatal mortality rate: Decreased from 6.8 to 4.1 deaths per 1000 live births between 2000 to 2018.</td>
</tr>
<tr>
<td>3.4</td>
<td>Challenges remain</td>
<td>By 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being.</td>
<td>• 3.4.1: Risk of dying between the ages of 30 and 70 from one of four main NCDs (cardiovascular disease, cancer, diabetes, or chronic respiratory disease): Decreased from 22.0% to 18.7% between 2000 and 2019. • 3.4.2: Suicide mortality rate: Increased from 8.1 to 8.3 deaths per 1000 population between 2000 and 2019.</td>
</tr>
<tr>
<td>3.5</td>
<td>Challenges remain</td>
<td>Strengthen the prevention and treatment of substance abuse.</td>
<td>• 3.5.2: Alcohol consumption per capita among population aged 15 years and older: Increased from 6.4 to 7.1 litres of pure alcohol between 2000 and 2018.</td>
</tr>
<tr>
<td>3.6</td>
<td>Significant challenges remain</td>
<td>By 2020, halve the number of global deaths and injuries from road traffic accidents.</td>
<td>• 3.6.1: Death rate due to road traffic injuries: Decreased from 19.0 to 13.5 deaths per 100 000 population between 2000 and 2019.</td>
</tr>
<tr>
<td>3.7</td>
<td>Major challenges remain</td>
<td>By 2030, ensure universal access to sexual and reproductive health-care services.</td>
<td>• 3.7.1: Proportion of women of reproductive age with their needs met for family planning with modern methods: Increased from 22.4% to 37.3% between 2000 and 2020. • 3.7.2: Adolescent birth rate: Decreased from 16.6 to 11.0 per 1000 young women aged 15–19 years between 2000 and 2016.</td>
</tr>
<tr>
<td>3.8</td>
<td>Significant challenges remain</td>
<td>Achieve UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.</td>
<td>• 3.8.1: Service coverage index: Increased from 39.0 to 61.0 between 2000 and 2017. • 3.8.2: The EPW uses regional indicators of financial protection, which will be produced by the WHO Barcelona Office for Bosnia and Herzegovina as a country report under the DG NEAR project.</td>
</tr>
<tr>
<td>3.9</td>
<td>Challenges remain</td>
<td>By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.</td>
<td>• 3.9.1: Age-standardized mortality rate attributed to household air pollution: 43.0 deaths per 100 000 population in 2016. • 3.9.2: Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene: 0.1 deaths per 100 000 population in 2016. • 3.9.3: Mortality rate attributed to unintentional poisonings: Decreased from 1.2 to 0.5 deaths per 100 000 population between 2000 and 2016.</td>
</tr>
<tr>
<td>3.a</td>
<td>Major challenges remain</td>
<td>Strengthen the implementation of the WHO Framework Convention on Tobacco Control.</td>
<td>• 3.6.1: Age-standardized prevalence of current tobacco use among persons aged 15 years and older: Decreased from 46.3% to 38.3% between 2000 and 2018.</td>
</tr>
</tbody>
</table>

Notes. DG NEAR: Directorate-General for Neighbourhood and Enlargement Negotiations; NCDs: noncommunicable diseases; SDGs: Sustainable Development Goals; UHC: Universal health coverage.

a For brevity, some SDG 3 targets and indicators were excluded when the health issues they addressed were not relatively high priorities or needs in the context of Bosnia and Herzegovina (for example, tropical diseases, etc.) or if there was no data available for their indicators.

b The status assigned to each target was determined by an analysis carried out by the Sustainable Development Report [13], and the indicators selected for this table represent some of the many indicators that were considered when these assessments were made.

c There are significant limitations associated with this measure of service coverage.

Source. Adapted from [4, 12, 13].
Lessons learned from the COVID-19 pandemic in Bosnia and Herzegovina

The COVID-19 pandemic universally exposed systemic weaknesses in health and social systems, and it has largely affected people who were already marginalized by exacerbating pre-existing vulnerabilities. In Bosnia and Herzegovina, COVID-19-related health services were made available to all, irrespective of insurance coverage status or ability to pay. Daily coordination and functioning of International Health Regulations (2005) (IHR) Commission in Bosnia and Herzegovina were commendable, especially in terms of daily IHR case reporting and a quick confirmation of community transmission in Bosnia and Herzegovina. With the crisis unfolding, and especially in times of intensified transmission, managers at the facility-level were continuously challenged to efficiently repurpose scarce human and material resources and ensure maximum standards of infection prevention and control. Initially, the governing bodies at all levels faced considerable legal and practical challenges in supply chain management and emergency procurement in unstable international markets for medical and personal protective equipment, so they increasingly relied on international aid and outsourcing. Especially in the Federation of Bosnia and Herzegovina, emergency procurement function was outsourced to multilateral international partners with capacities and a good procurement track record.

With a return to a ‘new normal’ over the summer of 2020, a severe, negative socioeconomic impact was increasingly felt, and the governments of the Federation of Bosnia and Herzegovina and the Republika Srpska were hard-pressed into re-budgeting, concluding agreements on short-term financial support with international financial institutions, and passing stabilization and recovery laws under lex specialis rule to mitigate the consequences of the crisis on the economy and society.

Despite the difficulties faced, health authorities in Bosnia and Herzegovina closely followed global COVID-19 vaccine developments, regularly reported their preparedness for vaccine deployment, and developed COVID-19 vaccine roll-out plans in alignment with WHO recommendations. Governments of the Federation of Bosnia and Herzegovina and the Republika Srpska pooled the financial resources for a joint emergency procurement and through the Ministry of Civil Affairs, Bosnia and Herzegovina committed itself to participate as a self-financing country in the COVAX facility for vaccine procurement and distribution alongside the EU’s negotiated and approved financial support for vaccine procurement in the WBs (14). After navigating obstacles such as vaccine delivery delays, new and complex legally binding conditionalities from manufacturers and internal regulatory frameworks that had not been adjusted for swift emergency-use authorization of new vaccines, vaccines were supplied in Bosnia and Herzegovina via COVAX and EU4Health mechanisms, bilateral donations and direct procurement by the governments of Bosnia and Herzegovina and the Republika Srpska. Among the countries that helped Bosnia and Herzegovina bridge its supply gap, Serbia was the first and most generous with vaccine donation with its first batched delivered on 2 March 2021. Notably, however, the first COVAX shipment of vaccines did not arrive in Bosnia and Herzegovina until 25 March 2021. These experiences demonstrate the importance of strengthening governance and administration mechanisms across Bosnia and Herzegovina’s health and social systems to increase resilience, collaboration, and the adaptability of country-level systems to shocks and challenges.

Within the intricate administrative framework of Bosnia and Herzegovina, the COVID-19 pandemic demonstrated that major health systems reforms are required to improve financial management and ensure financial sustainability. In addition to securing predictable and sustainable financing, the health systems in Bosnia and Herzegovina need to be reoriented towards efficiency, equity and quality gains in service provision. Health systems in Bosnia and Herzegovina need to be developed to emphasize community-oriented and family medicine-based PHC, and they need to be reconfigured to provide more accessible and effective preventive and chronic disease management services to an ageing population. Consequently, improving the integration of people-centred, preventive and socially protective services at the community level is a priority.

Furthermore, the lessons learned from the reorganization and repurposing of hospital capacities during the COVID-19 pandemic response may be particularly valuable for informing forthcoming hospital sector reforms focused on improved performance management. Reprofiling the health workforce and creating high quality jobs in health systems remain imperative, especially in context of the increasing emigration from Bosnia and Herzegovina. Additionally, enhancing the quality of PHC, education and social protection, with a particular focus on the most vulnerable, can help to prepare for future health emergencies and reduce their negative impact on health and the health systems (15).
Closing the Health Gap: aligning Bosnia and Herzegovina’s priorities with the EPW

Current health priorities and gaps in Bosnia and Herzegovina are discussed below in context of the EPW’s core priorities and flagship initiatives.

Core Priority 1: Moving towards universal health coverage (UHC)

Moving towards UHC is a high priority for Bosnia and Herzegovina. To close the UHC gap in the country, policies need to be informed from the supply side perspective (for example, access-enabling initiatives), and complemented with better understanding of barriers for access, such as unmet needs and demands for health services. Additionally, under the Directorate-General for Neighbourhood and Enlargement Negotiations (DG NEAR) project, the WHO Barcelona Office will publish a study on financial protection in Bosnia and Herzegovina.

Progress towards UHC is monitored in two dimensions: the coverage of essential health services and financial hardship. Each is covered further in the context of Bosnia and Herzegovina below.

Coverage of essential health services

In 2019, 52,100 more people in Bosnia and Herzegovina (1.6% of the population) were covered by essential health services than in 2018. By 2023, that number is projected to increase to 128,800 people (4.0% of the population) (16). Coverage of essential health services is defined as the average coverage of the 14 SDG 3.8.1 tracer interventions. Of these 14 indicators, positive progress is projected for eight of them in Bosnia and Herzegovina by 2023 (Table 8).

Table 7. Projected percentage point changes in normalized values across the 14 SDG 3.8.1 tracer interventions for service coverage between 2018 and 2023 in Bosnia and Herzegovina.

<table>
<thead>
<tr>
<th>Service Coverage Indicator</th>
<th>2018 value (%)</th>
<th>Projected 2023 value (%)</th>
<th>Projected change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic sanitation</td>
<td>95.4</td>
<td>95.5</td>
<td>+0.1</td>
</tr>
<tr>
<td>Care seeking for pneumonia (children under 5)</td>
<td>89.1</td>
<td>89.4</td>
<td>+0.3</td>
</tr>
<tr>
<td>DTP3 immunisation</td>
<td>73.0</td>
<td>74.8</td>
<td>+1.8</td>
</tr>
<tr>
<td>Health worker density</td>
<td>37.1</td>
<td>56.8</td>
<td>+19.8</td>
</tr>
<tr>
<td>Hospital bed density</td>
<td>100.0</td>
<td>100.0</td>
<td>0.0</td>
</tr>
<tr>
<td>IHR core capacity index</td>
<td>33.0</td>
<td>43.3</td>
<td>+10.3</td>
</tr>
<tr>
<td>ITN use</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Mean fasting blood glucose</td>
<td>98.4</td>
<td>97.8</td>
<td>-0.6</td>
</tr>
<tr>
<td>Need met for family planning</td>
<td>35.2</td>
<td>40.6</td>
<td>+5.4</td>
</tr>
<tr>
<td>Non-elevated blood pressure</td>
<td>38.3</td>
<td>38.1</td>
<td>-0.2</td>
</tr>
<tr>
<td>People living with HIV receiving ART</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>TB cases treated</td>
<td>80.0</td>
<td>80.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Tobacco non-use</td>
<td>61.7</td>
<td>63.2</td>
<td>+1.5</td>
</tr>
<tr>
<td>Women who received antenatal care visits 4+ times</td>
<td>89.8</td>
<td>90.9</td>
<td>+1.1</td>
</tr>
</tbody>
</table>

Notes. ART: Antiretroviral therapy; DTP3: Three doses of diphtheria tetanus toxoid and pertussis vaccine; IHR: International Health Regulations (2005); ITN use: Insecticide-treated bed net use among people at-risk of malaria; TB: Tuberculosis.

1 Some indicators in this chart have been transformed to have values between 0 and 100 (0 worst–100 best). Further information regarding the indicators can be found at (16).
2 There are significant limitations associated with this method of measuring service coverage.
3 N/A indicates the data is not available.
Source: Adapted from (16).
The key public health problem in Bosnia and Herzegovina is the burden of noncommunicable diseases (NCDs). In 2019, the percentages of deaths and disability-adjusted life-years (DALYs) attributable to NCDs in Bosnia and Herzegovina were 94.42% [2] and 86.70% [17], respectively. More systematic, high quality health information systems that improve the monitoring of service delivery, progress sustainable health financing policies, and enhance the assessment of providers’ performance are needed to improve the country’s health systems.

Health authorities are committed to enabling three PHC systems across the governments of Bosnia and Herzegovina that are accessible, affordable, equitable, integrated and community oriented. To do so will require systems that include strengthened support for mental health, NCD screening and early detection and COVID-19 prevention. Developing an integrated, patient-centred package of care and social protection will help build back better and leave no one behind. To achieve these goals, health authorities in Bosnia and Herzegovina would benefit from subregional cooperation to strengthen capacities to monitor and evaluate access and utilization of essential services. Additionally, the governments of Bosnia and Herzegovina would benefit from developing an evaluation mechanism on the best practices for how to fight and report corruption.

Financial hardship

Ensuring everyone has access to high-quality health services without facing financial hardship is a key target of the EPW and SDGs. The governments of the Federation of Bosnia and Herzegovina and the Republic of Srpska have been working to reduce out-of-pocket (OOP) payments. In 2018, OOP payments accounted for approximately 29.33% of current health spending, which is still considerably higher than the EU average of 21.6% [18].

Experiences with COVID-19 crisis management have identified important systemic issues for health systems in Bosnia and Herzegovina, including, but not limited to, the following: legal framework obstacles related to public procurement and regulation of medicines and medical devices; needs-based deployment and redeployment of human and material resources; and enforcement of effective but restrictive public health and social measures. Additionally, medicines are the main driver of out-of-pocket spending; therefore, improving access to essential medicines and medical supplies is required. Overall, Bosnia and Herzegovina would benefit from subregional cooperation to progress each of the aforementioned priorities.

Flagship Initiative 1: The Mental Health Coalition

Governments of the Federation of Bosnia and Herzegovina and the Republika Srpska are committed to expanding the availability of community-based mental health centres for mental health-care provision. Promotion of mutual best practices and past subregional developments through the South-eastern Europe Health Network (SEEHN), such as community-based mental health care under the lead and coordination of Bosnia and Herzegovina, needs reinforcement, alignment, and inclusion into regional flagship initiatives, such as the Mental Health Coalition of the EPW.

Flagship Initiative 2: Empowerment through Digital Health

At the health systems level, increased use of digital technologies to provide effective, efficient and personalized health services is needed in Bosnia and Herzegovina. Currently, health systems do not provide comprehensive and sufficiently disaggregated information regarding the distribution of health service utilization and quality, which can partially be attributed to the incomplete digitalization of health information systems in Bosnia and Herzegovina. Digitalized health information that improves performance management in the health sector carries significant potential for the timely development of information that can be used to design and implement effective policies and interventions that are tailored to remedying existing inequities in coverage and rooted in the principles of proportionate universalism and leaving no one behind.

Expanding access to PHC can be achieved with higher adoption of information and communication technologies fortifying telemedicine, as digitization can reduce the stress on the health system in future health emergencies by continuing to provide people with critical links to services for chronic conditions, mental health, maternal health, and beyond. To advance digital health, Bosnia and Herzegovina would benefit from technical and financial support from WHO.
Core Priority 2: Protecting against health emergencies

In 2019, Bosnia and Herzegovina had 64,700 more people (2.0% of the population) better protected from health emergencies than in 2018. By 2023, that number is projected to be 246,500 people (7.6% of the population). Despite this progress, Bosnia and Herzegovina scored poorly at 52.7% in the Health Emergency Protection (HEP) Index in 2019, which is calculated based on three sub-indicators: 1) preparedness; 2) prevention; and 3) detection and response. 

Preparedness

In 2019, Bosnia and Herzegovina scored poorly at 35.0% in the preparedness sub-indicator. This sub-indicator assesses emergency preparedness by averaging the scores of all 13 IHR core capacities at the country level, which are reported through the States Parties Annual Report (SPAR) tool.

Prevention

In 2019, Bosnia and Herzegovina scored 70.5% (down from 92.0% in 2013) in the prevention sub-indicator, which assesses efforts to prevent health emergencies through routine and targeted vaccine campaign efforts. This sub-indicator includes vaccination coverage for five major infectious diseases: measles, polio, meningococcal meningitis A, yellow fever, and cholera.

Detection and response

In 2020, Bosnia and Herzegovina performed well at 86.6% in the detection and response sub-indicator, which assesses the appropriateness of a country’s reaction to an event of potential public health concern. The indicator averages the time from a public health event’s start to detection, notification and response to provide an overall measure of timeliness.

During the COVID-19 pandemic, essential services were disrupted, such as the monitoring and evaluation of chronic conditions, due to lacking sufficient supplies to protect health-care personnel and patients. A key lesson learned from the COVID-19 pandemic related to health emergency preparedness is that health authorities in Bosnia and Herzegovina must prioritize improving the capacities of its health systems to provide immediate access to the medical supplies, protective equipment, and digital infrastructure required to maintain essential services and protect health-care personnel and patients.

Amidst the COVID-19 pandemic crisis, the Ministry of Civil Affairs and health authorities in the Federation of Bosnia and Herzegovina, Republika Srpska and Brcko District made commitments towards their first formal review of emergency preparedness and response capacities through the Joint External Evaluation of IHR Core Capacities. The main lessons learned from the crisis management and response in Bosnia and Herzegovina resonate well with subregional experiences and should be translated into well-designed and coordinated actions in the WBs. To re-build crisis-resilient health systems, emergency preparedness capacities need to be strongly reinforced, especially in terms of better forecasting, contingency modelling and planning and identifying and addressing legal and regulatory obstacles and barriers for a more effective and efficient emergency management. In particular, differing regulatory procedures and practices for approval and emergency-use authorization for new health technologies might be streamlined and standardized across the subregion, and economies of scope and scale further exploited by agreeing on and setting up joint emergency health procurement mechanisms and practices in the WBs. If explored from an economic perspective, agreed upon and embedded in country-level legal and regulatory frameworks, such arrangements may reap significant benefits for participating economies and may be extended to strengthen public procurement of prioritized medicines and health technologies in non-emergency contexts.

Core Priority 3: Promoting health and well-being

In 2019, there were 54,600 more people in Bosnia and Herzegovina (1.7% of the population) enjoying better health and well-being than in 2018. By 2023, this number is projected to increase to 238,400 (7.4% of the population). The healthier populations (HPOP) index uses 16 outcome indicators related to social, environmental, and behavioural risks.
to assess the number of people whose lives have become healthier. In Bosnia and Herzegovina, improvements in seven of the 16 indicators are projected between 2018 and 2023 (Table 9).

Table 8. Projected percentage point changes in normalized values\(^a\) across the 16 outcome indicators related to the HPOP index between 2018 and 2023 in Bosnia and Herzegovina.

<table>
<thead>
<tr>
<th>HPOP Indicator</th>
<th>2018 value (%)</th>
<th>Projected 2023 value (%)</th>
<th>Projected change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to safely managed drinking water sources</td>
<td>88.9</td>
<td>88.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Access to safely managed sanitation services</td>
<td>21.9</td>
<td>23.5</td>
<td>+1.6</td>
</tr>
<tr>
<td>Adults not obese</td>
<td>80.0</td>
<td>78.2</td>
<td>-1.8</td>
</tr>
<tr>
<td>Ambient air quality</td>
<td>72.8</td>
<td>76.4</td>
<td>+3.6</td>
</tr>
<tr>
<td>Best practice policy implemented for healthy fats production</td>
<td>85.7</td>
<td>85.7</td>
<td>0.0</td>
</tr>
<tr>
<td>Child development</td>
<td>N/A(^a)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Children not obese</td>
<td>94.4</td>
<td>93.2</td>
<td>-1.2</td>
</tr>
<tr>
<td>Children not overweight</td>
<td>86.4</td>
<td>88.9</td>
<td>+2.5</td>
</tr>
<tr>
<td>Children not stunted</td>
<td>90.9</td>
<td>91.2</td>
<td>+0.3</td>
</tr>
<tr>
<td>Children not wasted</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Primary reliance on clean household fuels</td>
<td>44.9</td>
<td>46.6</td>
<td>+1.7</td>
</tr>
<tr>
<td>Reduced alcohol use</td>
<td>68.7</td>
<td>68.7</td>
<td>0.0</td>
</tr>
<tr>
<td>Reduced child violence</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Reduced partner violence</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Reduced road traffic mortality</td>
<td>95.6</td>
<td>96.6</td>
<td>+1.0</td>
</tr>
<tr>
<td>Reduced suicide attempts</td>
<td>98.9</td>
<td>98.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Tobacco non-use</td>
<td>62.8</td>
<td>64.3</td>
<td>+1.5</td>
</tr>
</tbody>
</table>

Notes. HPOP: healthier populations.
\(^a\) Some indicators in this chart have been transformed to have values between 0 and 100 (0 worst, 100 best).
\(^b\) N/A indicates the data is not available
Further information regarding the indicators can be found at (16).
Source: Adapted from (16).

While progress was made in the area of tobacco control, significant work remains to fully implement the WHO Framework Convention of Tobacco Control and reduce Bosnia and Herzegovina’s high prevalence of smoking, which stands at 38.30% of adults aged 15 years or older (16).

Promoting health and well-being will require health authorities in Bosnia and Herzegovina to address the consequences of its ageing population and high burden of NCDs. Overall, Bosnia and Herzegovina’s negative population growth and ageing population jeopardize the financial sustainability of retirement and disability benefits, and they are projected to put further financial strain on Bosnia and Herzegovina’s health insurance system.

NCDs, including mental health conditions, have been recognized as socially transmitted conditions, which place a huge burden on health sector resources, the economy and society. Reducing Bosnia and Herzegovina’s persistently high burden of NCDs will require a sustained increase in investment to strengthen monitoring, treatment, evaluation and prevention at the PHC level. It will also require supporting efforts that can reduce the burden of NCDs, such as initiatives for nutrition, alcohol, tobacco, and obesity. Recent efforts of health authorities in Bosnia and Herzegovina to improve
the governance of and investment in population health should be further strengthened, and well-designed packages of ‘best-buy’ interventions should be implemented to tackle the major causes and consequences of ill-health effectively and efficiently. To achieve the desired health gain for the population, comprehensive approaches remain critical. Improvements in clinical management of disease consequences should run in parallel with strong preventive efforts that tackle major population health risks and behaviours, such as tobacco smoking, imbalanced dietary habits, and inadequate levels of physical activity. Without developing and implementing targeted policies and regulatory frameworks that effectively address social and commercial determinants of health, the expected impact on population health will remain suboptimal.

Health authorities in Bosnia and Herzegovina are committed to addressing antimicrobial resistance through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness raising and evidence-based policies and practices. Additionally, environmental health challenges are a pressing issue in Bosnia and Herzegovina; for example, the mortality rate attributed to household and ambient air pollution is high, with 79.76 deaths per 100,000 population in 2016 (19). Bosnia and Herzegovina health authorities are committed to advocating for and championing efforts such as the European Healthy Cities Network to build climate resiliency, promote smart and sustainable transportation in urban settings, and support the implementation of country-level policies to improve air quality.

Flagship Initiative 3: The European Immunization Agenda 2030

The lessons learned from the roll-out and integration of new technologies and COVID-19 vaccines in Bosnia and Herzegovina during the COVID-19 pandemic should encourage the revisiting of routine immunization programmes in Bosnia and Herzegovina. There have been decreasing coverage trends over the last decade, and the country is in a need of a boost and alignment with the European Immunization Agenda 2030. Attention should not be solely focused on addressing vaccine supply, procurement and deployment. Rather, to revitalize immunization programmes, better understanding of the social, cultural and behavioural aspects regarding vaccine acceptance or hesitancy is required, and effective communication strategies need to be developed to influence the knowledge, attitudes and practices of people and drive behaviour change at the population-level.

Flagship Initiative 4: Healthier Behaviours: incorporating behavioural and cultural insights

Safeguarding and, where possible, increasing social spending in areas such as health, social and child protection and education is a priority to protect the most vulnerable groups from poverty and social exclusion in Bosnia and Herzegovina. This requires improved planning, budgeting, allocation and monitoring of public finances and increasing the effectiveness and efficiency of social spending, including better targeting of and outreach to the most vulnerable groups. There is also a need to explore alternative, innovative funding sources and to prioritize spending on areas that maximize return on investments (for example, early childhood development). This aligns with the EPW’s intent to develop an investment case for developing a knowledge and evidence base in this area of work.
References


All online references were accessed on 23 June 2021.


Health and sustainable development progress in Montenegro

Montenegro has made remarkable progress towards European Union (EU) accession by opening all chapters of the EU acquis Communautaire and closing three of them [1]. Aligning with EU norms and standards has become even more important for economic integration and sustainable development in Montenegro, especially given how the EU accession process covers nearly two-thirds of the Sustainable Development Goal (SDG) targets [109 out of 169 targets].

Prior to the COVID-19 pandemic, Montenegro’s economy grew, on average, by 2.9% per year over the last decade. Despite stable economic growth, a high unemployment rate persisted: 15.9% of the total labour force was unemployed in 2019. However, in 2020, Montenegro experienced an alarming recession of -15.2% [2]. Building back better and leaving no one behind will be imperative to sustain the progress on health and sustainable development that Montenegro was making prior to the pandemic.

Montenegro’s human development index (HDI) increased from 0.802 to 0.829 between 2010 and 2019. This represents an average HDI growth of 0.37%, which is lower than Europe and Central Asia’s average of 0.76% during the same period [3]. Embedded in Montenegro’s HDI is their steady increase of life expectancy over the past decade, which can largely be attributed to the country’s strengthening of UHC and increase in government spending on health. Between 2010 and 2019, life expectancy increased by 1.53 years to 78.65 for females and 0.88 years to 73.15 for males [4]. However, these figures are still significantly below the EU’s average of 83.82 for females and 78.45 for males [2]. During the same period, Montenegro’s population size remained nearly constant, and the percentage of the population aged 65 years or older increased from 12.97% to 15.39% [2].

Looking forward: the health and sustainable development trajectory

At present, the COVID-19 pandemic presents the greatest challenge to Montenegro achieving the Sustainable Development Goals (SDGs) and aligning itself with the European Programme of Work (2020-2025) – “United Action for Better Health” (EPW)’s core priorities. Within this context, Montenegro’s 2021 Comparative Country Analysis (CCA) identified six bottlenecks that must be overcome to achieve the SDGs: 1) an unfinished transition to a market economy as part of the EU accession process; 2) insufficient multisectoral cooperation; 3) an ageing population; 4) an inefficient and ineffective use of finance; 5) attitudes and social norms that negatively impact the realization of rights for vulnerable groups; and 6) insufficient data and evidence to formulate policies and evaluate programmes [5].

To accelerate and sustain health and sustainable development progress, Montenegro must focus on multidimensional pathways that put people at the centre and target vulnerable segments of the population. To do this, Montenegro’s CCA identified three priority areas to accelerate work [5]:

- Inclusive economic development and environmental sustainability
  - Notably, greater tax revenue will be reinvested in social and health services, and climate change adaptation is key to build resiliency and protect health.
• Human capital development, poverty reduction and social inclusion
  — Safeguarding and, where possible, increasing social spending in areas such as health, social and child protection is crucial to protect the most vulnerable groups from social exclusion and/or poverty.

• Governance, institutions, and social cohesion
  — Notably, improving coordination among multiple agencies with due attention to building national capacities for implementation and data generation and use, as well as monitoring and evaluation, should be prioritized.

SDG 3 Progress: Ensure healthy lives and promote well-being for all at all ages

SDG 3 aims to ensure healthy lives and promote well-being for all at all ages. Tracking Montenegro’s progress towards achieving the targets of SDG 3 provides an overview of where health and sustainable development has progressed well and where challenges remain (Table 10).

Table 9. Selected targets and indicators to track Montenegro’s progress on SDG 3 achievement.

<table>
<thead>
<tr>
<th>SDG 3 Target</th>
<th>Status</th>
<th>Description</th>
<th>Indicator(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Target achieved</td>
<td>By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.</td>
<td>3.1.1: Maternal mortality ratio: Decreased from 12.0 to 6.0 per 100,000 live births between 2000 and 2017.</td>
</tr>
<tr>
<td>3.2</td>
<td>Target achieved</td>
<td>By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-five mortality to at least as low as 25 per 1000 live births.</td>
<td>3.2.1: Children under-five mortality rate: Decreased from 14.2 to 2.5 deaths per 1000 live births between 2000 and 2018. 3.2.2: Neonatal mortality rate: Decreased from 9.0 to 1.7 deaths per 1000 live births, between 2000 to 2018.</td>
</tr>
<tr>
<td>3.4</td>
<td>Significant challenges remain</td>
<td>By 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being.</td>
<td>3.4.1: Risk of dying between the ages of 30 and 70 from one of four main NCDs (cardiovascular disease, cancer, diabetes, or chronic respiratory disease): Decreased from 24.8% to 22.3% between 2000 and 2019. 3.4.2: Suicide mortality rate: Decreased from 18.9 to 16.2 deaths per 1000 population between 2000 and 2019.</td>
</tr>
<tr>
<td>3.5</td>
<td>Challenges remain</td>
<td>Strengthen the prevention and treatment of substance abuse.</td>
<td>3.5.1: Alcohol consumption per capita among population aged 15 years and older: 11.5 litres of pure alcohol in 2018.</td>
</tr>
<tr>
<td>3.6</td>
<td>Challenges remain</td>
<td>By 2020, halve the number of global deaths and injuries from road traffic accidents.</td>
<td>3.6.1: Death rate due to road traffic injuries: Decreased from 14.2 to 7.6 deaths per 100,000 population between 2000 and 2019.</td>
</tr>
<tr>
<td>3.7</td>
<td>Major challenges remain</td>
<td>By 2030, ensure universal access to sexual and reproductive health-care services.</td>
<td>3.7.1: Proportion of women of reproductive age with their needs met for family planning with modern methods: Increased from 38.2% to 42.5% between 2000 and 2020. 3.7.2: Adolescent birth rate: Decreased from 22.9 to 10.0 per 1000 women aged 15–19 years between 2000 and 2018.</td>
</tr>
<tr>
<td>3.8</td>
<td>Significant challenges remain</td>
<td>Achieve UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.</td>
<td>3.8.1: Service coverage index: Increased from 52.0 to 68.0 between 2000 and 2017. 3.8.2: The EPW uses regional indicators of financial protection, which will be produced by the WHO Barcelona Office for Montenegro as a country report under the DG NEAR project.</td>
</tr>
</tbody>
</table>
### Lessons learned from the COVID-19 pandemic in Montenegro

The COVID-19 pandemic has exposed systemic weaknesses in health and social systems, prompting policy responses and, in some cases, substantive changes. In Montenegro, one of the key lessons learned is that health emergency responses are only as strong as the primary health care (PHC) system. To address each of the EPW’s core priorities, investments need to be made to strengthen PHC.

The COVID-19 pandemic has largely affected people who were already marginalized, and it has increased the number of Montenegrins experiencing vulnerability; leaving them less resilient in the face of social and economic shocks. Enhancing the quality of health care and education and strengthening social protection, with a particular focus on the most vulnerable, can help to prepare for future health emergencies and reduce their negative impact on health and the health system.

There is also a need to strengthen governance and administration mechanisms across Montenegrin health and social systems to reduce bureaucratic burden and increase resilience, collaboration, and the adaptability of national systems to shocks and challenges. Digital technologies can improve the efficiency and accountability of service providers to the people as well as improve the interface between people and health services, health system performance, and critical public health functions.

### Closing the Health Gap: aligning Montenegro’s priorities with the EPW

Montenegro’s current country-level health priorities and gaps are discussed below in context of the EPW’s core priorities and flagship initiatives.

#### Core Priority 1: Moving towards universal health coverage (UHC)

As reflected in its national health strategies since 2003, Montenegro is committed to and has made progress towards UHC. Despite this, key challenges remain regarding strengthening PHC, caring for the health and social care needs of...
the elderly population and subsequent shortage of alternative care settings, ensuring equitable access to quality and safe medicines and medical supplies, and improving financial protection (5).

Progress towards UHC is monitored in two dimensions: the coverage of essential health services and financial hardship. Each is covered further in the context of Montenegro below.

Coverage of essential health services

In 2019, 6300 more people in Montenegro (1.0% of the population) were covered by essential health services than in 2018. By 2023, Montenegro anticipates there will be 32 300 more people (5.1% of the population) covered (10). Coverage of essential health services is defined as the average coverage of the 14 SDG 3.8.1 tracer interventions. Of these 14 indicators, positive progress is projected for nine of them in Montenegro by 2023 (Table 11).

Table 10. Projected percentage point changes in normalized values for service coverage between 2018 and 2023 in Montenegro.

<table>
<thead>
<tr>
<th>Service Coverage Indicator</th>
<th>2018 value (%)</th>
<th>Projected 2023 value (%)</th>
<th>Projected change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic sanitation</td>
<td>98.3</td>
<td>99.3</td>
<td>+1.0</td>
</tr>
<tr>
<td>Care seeking for pneumonia (children under 5 years)</td>
<td>91.9</td>
<td>92.1</td>
<td>+0.3</td>
</tr>
<tr>
<td>DTP3 immunisation</td>
<td>86.0</td>
<td>87.0</td>
<td>+1.0</td>
</tr>
<tr>
<td>Health worker density</td>
<td>51.6</td>
<td>55.1</td>
<td>+3.5</td>
</tr>
<tr>
<td>Hospital bed density</td>
<td>100.0</td>
<td>100.0</td>
<td>0.0</td>
</tr>
<tr>
<td>IHR core capacity index</td>
<td>47.0</td>
<td>85.4</td>
<td>+38.4</td>
</tr>
<tr>
<td>ITN use</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Mean fasting blood glucose</td>
<td>99.3</td>
<td>98.9</td>
<td>-0.4</td>
</tr>
<tr>
<td>Need met for family planning</td>
<td>38.3</td>
<td>41.8</td>
<td>+3.5</td>
</tr>
<tr>
<td>Non-elevated blood pressure</td>
<td>43.5</td>
<td>46.3</td>
<td>+2.8</td>
</tr>
<tr>
<td>People living with HIV receiving ART</td>
<td>47.6</td>
<td>61.0</td>
<td>+13.4</td>
</tr>
<tr>
<td>TB cases treated</td>
<td>87.0</td>
<td>87.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Tobacco non-use</td>
<td>71.8</td>
<td>73.0</td>
<td>+1.2</td>
</tr>
<tr>
<td>Women who received antenatal care visits 4+ times</td>
<td>81.3</td>
<td>80.0</td>
<td>-1.3</td>
</tr>
</tbody>
</table>

Notes. ART: Antiretroviral therapy; DTP3: Three doses of diphtheria tetanus toxoid and pertussis vaccine; IHR: International Health Regulations (2005); ITN use: Insecticide-treated bed net use among people at-risk of malaria; TB: Tuberculosis.

* Some indicators in this chart have been transformed to have values between 0 and 100 (0 worst–100 best). Further information regarding the indicators can be found at (10).

* There are significant limitations associated with this method of measuring service coverage.

Source: Adapted from (10).

Focusing on PHC is essential because investments in secondary and tertiary care have historically outstripped prevention, which inhibits the provision of effective and efficient means to address the main risk factors of poor health, thus exacerbating health inequities. To move towards UHC, investment must be secured for PHC to ensure health workers and facilities have the resources they need to provide people with affordable, accessible and high-quality care.
With the onset of the COVID-19 pandemic, Montenegro immediately began to rethink its model of PHC service delivery and the need to target investment accordingly. Emergency response measures and services, including treatment, testing and contact tracing, heavily rely on health professionals earning the trust of their communities. Prioritizing investment in PHC, including community engagement for health and well-being, can build and maintain trust and confidence in the health system and in health authorities during the pandemic and beyond.

Montenegrin society is ageing rapidly, which has placed significant pressure on social services. Older persons who need long-term care due to severe health conditions lack appropriate facilities. A shortage of alternative care settings has also meant that people with mental health care needs and/or intellectual and/or psychosocial disabilities are often placed in psychiatric clinics. People living in more remote, rural, or northern areas face higher vulnerability as services are further away, and they often have increased transportation costs and delays in reaching necessary support.

Financial hardship

Ensuring people can access high-quality health services without facing financial hardship is a key target of the EPW and the SDGs. It is a high priority for Montenegro to reduce out-of-pocket (OOP) payments. In 2018, OOP payments accounted for approximately 39.61% of current health spending, which is considerably higher than the EU average of 21.6%. Strengthening financial protection is imperative to ensure that no one is left behind, and it will be undertaken as part of the Directorate-General for European Neighbourhood Policy and Enlargement Negotiations (DG NEAR) project.

Medicines are the main driver of OOP spending; therefore, improving access to essential medicines and medical supplies is required. To do so, Montenegro would benefit from subregional cooperation to expand access and improve procurement. Equitable access to quality and safe medicines and medical supplies is a critical issue for both improving health outcomes and strengthening trust and confidence in the health system. This issue must be addressed in a manner that ensures the sustainability of Montenegro’s health system but does not disincentivize the pharmaceutical industry from investing in research and development.

Flagship Initiative 1: The Mental Health Coalition

Montenegro has adopted a Strategy for the Improvement of Mental Health (2019–2023); however, implementation remains a challenge. Mental health services remain fragmented and institutionalized, with few opportunities for people to access treatment in community-based or general health-care settings. Montenegro is committed to expanding access to mental health care in community-based settings.

Flagship Initiative 2: Empowerment through Digital Health

Montenegro recognizes the opportunities of digital technologies to promote health and social change and strengthen service provider accountability that ensures human-centred development and leaves no one behind. However, existing information systems in the health sector are incomplete, fragmented and insufficiently interoperable to provide satisfactory data for the efficient management of the health system.

Montenegro has prioritized exploring innovative ways to deliver and expand access to PHC by exploiting the potential of digital technologies and telemedicine. Additionally, digitization can reduce the stress on the health system in future health emergencies by continuing to provide people with critical links to services for chronic conditions, mental health, maternal health, and beyond.
Core Priority 2: Protecting against health emergencies

In 2019, Montenegro had 53,400 more people (8.6% of the population) better protected from health emergencies than in 2018. By 2023, that number is projected to be 163,600 people (26.0% of the population). Despite this progress, Montenegro scored poorly at 60.0% in the Health Emergency Protection (HEP) Index in 2019, which is calculated based on three sub-indicators: 1) preparedness; 2) prevention; and 3) detection and response (10).

Preparedness

In 2019, Montenegro scored 56.0% in the preparedness sub-indicator. This sub-indicator assesses emergency preparedness by averaging the scores of all 13 International Health Regulations (2005) (IHR) core capacities at the country level, which are reported through the States Parties Annual Report (SPAR) tool (10).

Prevention

In 2019, Montenegro scored 64.0% (down from 88.0% in 2013) in the prevention sub-indicator, which assesses efforts to prevent health emergencies through routine and targeted vaccine campaign efforts. This sub-indicator includes vaccination coverage for five major infectious diseases: measles, polio, meningococcal meningitis A, yellow fever, and cholera (10).

Detection and response

In 2020, Montenegro performed well at 93.3% in the detection and response sub-indicator, which assesses the appropriateness of a country’s reaction to an event of potential public health concern. The indicator averages the time from a public health event’s start to detection, notification and response to provide an overall measure of timeliness (10).

To achieve long-term resilience to health emergencies, investments must prioritize strengthening existing policies and planning for health security. According to the Montenegrin Law on Health Protection, all insured citizens, as well as migrants, are entitled to free health services (5). However, for uninsured citizens, treatments for non-life-threatening conditions must be reimbursed to the state. During the COVID-19 pandemic, only COVID-19 related acute respiratory distress syndrome (ARDS) was considered life-threatening. Therefore, the public health system asked uninsured patients for reimbursement for all other COVID-19 related care. As this shows, achieving UHC will improve response capacity by ensuring all people have access to treatment for the entire range of conditions that may arise from a future health emergency.

Montenegro had sufficient hospital beds and health-care personnel to respond to the COVID-19 pandemic; however, one area for future improvement is its access of medical supplies and personal protective equipment (PPE), which will require enhanced health emergency governance at every level. PPE was purchased by the government of Montenegro, but donations of ventilators, X-rays machines and additional PPE highly assisted Montenegro’s response. Additionally, access to COVID-19 treatments, tests, and vaccines was facilitated by significant international help (14). Moving forward, Montenegro recognizes the need to strengthen collaboration for health emergencies at all levels to more efficiently produce the public goods required to manage crises.

In the early stages of the COVID-19 pandemic, the maintenance of essential services, such as the monitoring and evaluation of chronic conditions, was disrupted due to lacking supplies and infrastructure to protect health-care personnel and patients (14). It is a high priority for Montenegro to develop systems for future health emergencies that will provide immediate access to the medical supplies, protective equipment, and digital infrastructure required to maintain essential services.
Core Priority 3: Promoting health and well-being

In 2019, there were 2100 fewer people in Montenegro (0.3% of the population) experiencing good health and well-being than in 2018. By 2023, it is projected that this number will worsen to 5300 fewer people (0.8% of the population). The healthier populations (HPOP) index uses 16 outcome indicators related to social, environmental, and behavioural risks to assess the number of people whose lives have become healthier. In Montenegro, improvements in six of the 16 indicators are projected between 2018 and 2023 (Table 12).

Table 11. Projected percentage point changes in normalized values across the 16 outcome indicators related to the HPOP index between 2018 and 2023 in Montenegro.

<table>
<thead>
<tr>
<th>HPOP Indicator</th>
<th>2018 value (%)</th>
<th>Projected 2023 value (%)</th>
<th>Projected change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to safely managed drinking water sources</td>
<td>94.1</td>
<td>96.2</td>
<td>+2.1</td>
</tr>
<tr>
<td>Access to safely managed sanitation services</td>
<td>29.6</td>
<td>28.9</td>
<td>-0.7</td>
</tr>
<tr>
<td>Adults not obese</td>
<td>74.0</td>
<td>71.5</td>
<td>-2.5</td>
</tr>
<tr>
<td>Ambient air quality</td>
<td>80.7</td>
<td>84.0</td>
<td>+3.3</td>
</tr>
<tr>
<td>Best practice policy implemented for healthy fats production</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Child development</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Children not obese</td>
<td>92.0</td>
<td>90.5</td>
<td>-1.5</td>
</tr>
<tr>
<td>Children not overweight</td>
<td>89.1</td>
<td>91.2</td>
<td>+2.1</td>
</tr>
<tr>
<td>Children not stunted</td>
<td>91.9</td>
<td>92.0</td>
<td>+0.1</td>
</tr>
<tr>
<td>Children not wasted</td>
<td>97.8</td>
<td>98.3</td>
<td>+0.5</td>
</tr>
<tr>
<td>Primary reliance on clean household fuels production</td>
<td>55.5</td>
<td>51.2</td>
<td>-4.3</td>
</tr>
<tr>
<td>Reduced alcohol use</td>
<td>51.0</td>
<td>51.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Reduced child violence</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Reduced partner violence</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Reduced road traffic mortality</td>
<td>96.4</td>
<td>97.2</td>
<td>+0.8</td>
</tr>
<tr>
<td>Reduced suicide attempts</td>
<td>97.9</td>
<td>97.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Tobacco non-use</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Notes. HPOP: healthier populations.
* Some indicators in this chart have been transformed to have values between 0 and 100 (0 worst–100 best). Further information regarding the indicators can be found at (10).
Source: Adapted from (10).

The COVID-19 pandemic has resulted in the suspension of many essential services, and a subsequent pandemic of chronic conditions cannot be afforded. In 2019, the percentages of deaths and disability-adjusted life-years (DALYs) attributable to noncommunicable diseases (NCDs) were 94.11% (2) and 86.32% (15), respectively. In the short-term, increasing the availability of screenings for common NCDs requires urgent action and collaboration. In the mid- to long-term, reducing Montenegro’s persistently high burden of NCDs will require a sustained increase in investment to strengthen monitoring, treatment, evaluation and prevention at the PHC level. It will also require supporting efforts that can reduce the burden of NCDs, such as initiatives for nutrition, alcohol, tobacco, and obesity.

Montenegro also recognizes the need to increase the resilience of health-care facilities to climate change and natural disasters, while improving environmental sustainability. This includes expanding climate-resilient access to safe water,
sanitation, and hygiene for schools and health facilities and addressing environmental health hazards that climate change may exacerbate. For example, Montenegro’s mortality rate attributed to household and ambient air pollution is already high at 78.65 deaths per 100,000 population in 2016 [16].

Montenegro has also prioritized improving patient safety, tackling antimicrobial resistance, and developing strategic intelligence on levels and inequalities of health and well-being. Relatedly, to better include vulnerable groups and create a more inclusive society, behaviours and attitudes will need to be changed. A high priority for Montenegro is to continue promoting social change by challenging and countering negative attitudes, behaviours, and practices that foster the social exclusion of vulnerable groups. Montenegro recognizes and seeks to ameliorate the exclusion and deprivation experienced by the Roma and Egyptian communities, persons with disabilities, child victims of violence, children without parental care, children living in poverty, older persons, refugees and asylum seekers, informal workers, victims of trafficking, LGBTQIA+ persons, and homeless persons [5].

**Flagship Initiative 3: The European Immunization Agenda 2030**

Montenegro’s 2019 program of compulsory immunization of the population against certain infectious diseases was implemented [5], however, Montenegro is still faced with critically low, declining immunization rates. This is especially apparent in its vaccination coverage rate for the first dose of measles-containing vaccine (MCV1) among one-year-olds, which was critically low at 42% in 2019 [4]. It remains a priority for Montenegro to expand immunization coverage.

**Flagship Initiative 4: Healthier Behaviours: incorporating behavioural and cultural insights**

Safeguarding and, where possible, increasing social spending in areas such as health, social and child protection, and education is a priority to protect the most vulnerable groups from poverty and social exclusion in Montenegro. This requires improved planning, budgeting, allocation and monitoring of public finances and increasing the effectiveness and efficiency of social spending, including better targeting of and outreach to the most vulnerable groups. There is also a need to explore alternative, innovative funding sources and to prioritize spending on areas that maximize return on investments (for example, early childhood development). This aligns with the EPW’s intent to develop an investment case for developing a knowledge and evidence base in this area of work.

**References**


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16 All online references were accessed on 23 June 2021.


Republic of North Macedonia

This country brief provides an overview of the Republic of North Macedonia’s health and sustainable development priorities that informed the Roadmap’s formation. While this brief does not seek to be exhaustive or prescriptive, it identifies key issues and areas where North Macedonia may benefit from and contribute to united action for better health in the Western Balkans (WBs).

Health and sustainable development progress in North Macedonia

North Macedonia is on its way to start negotiations towards European Union (EU) accession (1), and the country has recently joined the North Atlantic Treaty Organization (NATO). North Macedonia is using the EU accession process to complete its transition to a well-functioning market economy, strengthen its institutions and the rule of law, and enhance service delivery and the needed infrastructure. Furthermore, aligning with EU norms and standards has become even more important for economic integration and sustainable development in North Macedonia, especially given how the EU accession process covers nearly two-thirds of the Sustainable Development Goal (SDG) targets (109 out of 169 targets).

Over the past two decades, North Macedonia’s economic growth has been the most stable among the Western Balkans (WBs); its income per capita has more than doubled and the country moved from low-middle- to upper-middle-income status. Furthermore, North Macedonia’s economy has, on average, grown by 2.6% per year over the last decade. Despite this stable economic growth, a high unemployment rate persists: in 2019, 18.4% of the total labour force was unemployed (2). Nonetheless, North Macedonia’s strategic geographic location is a major asset given the largely untapped export potential of its agriculture and services sectors (3).

North Macedonia’s economic transition is not yet complete. The declining productivity of local firms, the underfunding of public institutions, and the deficiencies in competition, investment policy and business regulation continue to pose serious structural challenges. These challenges are addressed in North Macedonia’s most recent reform agenda, which also includes a social protection reform targeting the most vulnerable. However, the success of the country’s reform agenda remains doubtful as the pace of reforms in social, health and other related development sectors appear to be slower than the country’s recent economic progress and the country’s public spending on health remains one of the lowest in the WHO European Region (3). Furthermore, despite its economic growth, North Macedonia has not been able to accelerate convergence to EU standards. Gross domestic product (GDP) per capita persists at only one-third of the average level of the EU (2), and the country remains in demographic and epidemiological transition (3).

In relation to health, North Macedonia’s human development index (HDI) increased from 0.743 to 0.774 between 2010 and 2019. This represents an average HDI growth of 0.46%, which is lower than Europe and Central Asia’s average of 0.76% during the same period (4). Embedded in North Macedonia’s HDI is their steady increase of life expectancy over the past decade: between 2010 and 2019, life expectancy increased by 1.47 years to 76.87 years for females and by 1.92 years to 72.84 years for males (5), but these figures are still significantly below the EU’s average of 83.82 years for females and 78.45 years for males (2). During the same period, North Macedonia’s population size remained nearly constant, yet the percentage of the population aged 65 years or older increased from 11.60% to 14.09% (2). The combination of this, plus a sub-replacement fertility level and increasing rates of emigration of working-age people (including physicians and nurses), is expected to put pressure on the country’s social protection systems, including health (3).
Looking forward: the health and sustainable development trajectory

The 2020–2021 Biennial Collaborative Agreement (BCA) between the WHO Regional Office for Europe and North Macedonia’s Ministry of Health outlines the country’s health and sustainable development trajectory that will help it address the European Programme of Work (2020-2025) – “United Action for Better Health” (EPW)’s priorities and achieve the SDGs (3).

To promote population health and reduce health inequities, North Macedonia’s BCA calls for the adoption of an intersectoral, Health-in-All-Policies (HiAP) approach that involves all of society and the government to improve health governance and cooperation. Consequently, supporting the Roadmap will directly accelerate North Macedonia’s action on the BCA’s priorities, and it will progress the international and national strategic frameworks the BCA outlines as accelerators (3).

Improving national efforts to strengthen health service delivery and reorganize the health system’s levels of care will help North Macedonia achieve more of the SDG targets related to health by 2030. To achieve the SDGs, it is imperative that the health sector promotes multisectoral collaboration to maximize efficiency and generate transformative change. This could include, but not be limited to, working with the financial sector to promote taxation for health, the environmental sector to mitigate the effects of air pollution and other environmental hazards, the educational sector to promote healthy lifestyles and health literacy, the labour sector to improve the retention of the health workforce, and the social policy sector to further integrate care for vulnerable populations (3).

Numerous changes are required to create an environment in North Macedonia more conducive for health progress. As outlined in North Macedonia’s BCA, four priority actions include to (3):

1. develop a functioning HiAP platform stewarded by the Ministry of Health to address the wider vision of health and the interrelated nature of the SDGs;

2. tap into the potential of communities and non-governmental organizations for better health literacy and mobilization;

3. improve national efforts for health resource allocation; and

4. address the migration and loss of the health workforce to other European countries, which threatens the development of the health system and implementation of the reform’s plans.

SDG 3 Progress: Ensure healthy lives and promote well-being for all at all ages

SDG 3 aims to ensure healthy lives and promote well-being for all at all ages. Tracking North Macedonia’s progress towards achieving the targets of SDG 3 provides an overview of where health and sustainable development has progressed well and where challenges remain (Table 13).
Table 12. Selected targets and indicators to track North Macedonia’s progress on SDG 3 achievement.

<table>
<thead>
<tr>
<th>SDG 3 Target*</th>
<th>Status*</th>
<th>Description</th>
<th>Indicator(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Target achieved</td>
<td>By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births.</td>
<td>• 3.1.1: Maternal mortality ratio: Decreased from 13.0 to 7.0 per 100 000 live births between 2000 and 2017.</td>
</tr>
<tr>
<td>3.2</td>
<td>Target achieved</td>
<td>By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-five mortality to at least as low as 25 per 1000 live births.</td>
<td>• 3.2.1: Children under-five mortality rate: Decreased from 43.0 to 30.6 deaths per 1000 live births between 2000 and 2017.</td>
</tr>
<tr>
<td>3.4</td>
<td>Challenges remain</td>
<td>By 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being.</td>
<td>• 3.4.1: Risk of dying between the ages of 30 and 70 from one of four main NCDs (cardiovascular disease, cancer, diabetes, or chronic respiratory disease): Decreased from 30.2% to 22.7% between 2000 and 2019.</td>
</tr>
<tr>
<td>3.5</td>
<td>Challenges remain</td>
<td>Strengthen the prevention and treatment of substance abuse.</td>
<td>• 3.5.2: Alcohol consumption per capita among population aged 15 years and older: Decreased from 15.8 to 9.9 deaths per 1000 live births between 2000 and 2017.</td>
</tr>
<tr>
<td>3.6</td>
<td>Target achieved</td>
<td>By 2020, halve the number of global deaths and injuries from road traffic accidents.</td>
<td>• 3.6.1: Death rate due to road traffic injuries: Decreased from 8.2 to 5.2 deaths per 100 000 population between 2000 and 2019.</td>
</tr>
<tr>
<td>3.7</td>
<td>Major challenges remain</td>
<td>By 2030, ensure universal access to sexual and reproductive health-care services.</td>
<td>• 3.7.1: Proportion of women of reproductive age with their needs met for family planning with modern methods: Increased from 18.2% to 26.8% between 2000 and 2017.</td>
</tr>
<tr>
<td>3.8</td>
<td>Significant challenges remain</td>
<td>Achieve UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.</td>
<td>• 3.8.1: Service coverage index: Increased from 54.0 to 72.0 between 2000 and 2017.</td>
</tr>
<tr>
<td>3.9</td>
<td>Challenges remain</td>
<td>By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.</td>
<td>• 3.9.1: Age-standardized mortality rate attributed to household air pollution: 43.0 deaths per 100 000 population in 2016.</td>
</tr>
</tbody>
</table>

Notes. DG NEAR: Directorate-General for Neighbourhood and Enlargement Negotiations; NCDs: noncommunicable diseases; SDGs: Sustainable Development Goals; UHC: Universal health coverage.

* For brevity, some SDG 3 targets and indicators were excluded when the health issues they addressed were not relatively high priorities or needs in North Macedonia’s context (for example, tropical diseases, etc.) or if there was no data available for their indicators.

* The status assigned to each target was determined by an analysis carried out by the Sustainable Development Report (7), and the indicators selected for this table represent some of the many indicators that were considered when these assessments were made.

* There are significant limitations associated with this measure of service coverage.

Source. Adapted from (5, 6, 7).
Lessons learned from the COVID-19 pandemic in North Macedonia

The COVID-19 pandemic has exposed systemic weaknesses in health and social systems, prompting policy responses and, in some cases, substantive changes in North Macedonia. North Macedonia’s government was very proactive in taking action to control the pandemic, issuing a formal declaration of emergency on 18 March 2020 to combat the spread of COVID-19. The government has not hesitated to take strong action when it felt it was needed.

The National Response included vigorous risk communication campaigns on social media, TV and other media, which benefited from strong support from other international agencies including WHO. The government also launched a dedicated web portal for sharing communication materials on COVID-19 to be regularly updated with ongoing support from WHO and UNICEF. To fight fake news and boost social listening, HealthBuddy+, a UNICEF/WHO multilingual interactive digital solution was implemented to provide easy access to trusted information on COVID-19, tailor local information, and support the dissemination of truthful information in both Macedonian and Albanian. With support from WHO, risk communication campaigns were guided by periodic behavioural insight studies on COVID-19 vaccine uptake among health workers to help understand vaccine hesitancy and the barriers to widespread immunization coverage.

The COVID-19 pandemic has largely affected people who were already marginalized by exacerbating pre-existing vulnerabilities. Despite the significant reduction in poverty over the past years in North Macedonia, a large share of the population that lives above the poverty line remains vulnerable. Moreover, as previously noted, unemployment is stubbornly high in North Macedonia, particularly among young people, with a large share of the unemployed population having been actively seeking work for more than a year. Low labour force participation, as well as high unemployment and informal work have resulted in a significant waste of working years. It is estimated that the average Macedonian worker loses about 25 years of productive employment during the average worker lifecycle. The economic impacts of the COVID-19 pandemic have exacerbated vulnerabilities and pushed more people into poverty. The most affected are among the following groups of the population: informal workers, the self-employed, the working poor, those with modest incomes working in sectors such as manufacturing, construction, tourism and services, and other vulnerable groups (the Roma population, the elderly, the young, and women).

Consequently, the government underwent a set of actions to strengthen the public health sector’s preparedness and the social safety net, particularly regarding employment and financial support for businesses. The Government and Ministry of Labour and Social Policy defined rapid response measures, such as increasing social assistance coverage and providing emergency packages of food and hygienic products. North Macedonia has a well-regulated unemployment insurance policy that was adapted to provide a significant source of income support during the crisis. Provision of this emergency support relied on existing social assistance and unemployment insurance schemes and their delivery mechanisms.

North Macedonia became a COVAX self-financing country, and WHO supported the country in its national COVID-19 vaccination deployment plan and operational readiness for allocations of COVAX vaccines. However, North Macedonia struggled to receive vaccines from sources beyond COVAX, such as through direct procurement with manufacturers, so vaccine deployment was delayed and posed many challenges. These developments demonstrate the importance of further strengthening governance and administration mechanisms across North Macedonian health and social systems to reduce bureaucratic burden and increase resilience, collaboration, and the adaptability of national systems to shocks and challenges. Additionally, enhancing the quality of primary health care (PHC) and education and strengthening social protection, with a particular focus on the most vulnerable, can help to prepare for future health emergencies and reduce their negative impact on health and the health system [8].
Closing the Health Gap: aligning North Macedonia’s priorities with the EPW

North Macedonia’s current country-level health priorities and gaps are discussed below in context of the EPW’s core priorities and flagship initiatives.

Core Priority 1: Moving towards universal health coverage (UHC)

Moving towards UHC is a high priority for North Macedonia. In 2019, the Minister of Health declared a reform of the PHC system, in line with the Astana declaration, to be the basis for an overall health reform aiming at moving towards UHC. WHO is supporting this vision, which is essential because this task requires a multisectoral, Health-in-All-Policies (HiAP) approach. Despite this, the success of the initiative remains uncertain as North Macedonia has a low level of public spending on health and very heavy reliance on out-of-pocket payments [see below](9). To close North Macedonia’s UHC gap, policies need to be informed by a better understanding of access barriers and financial hardship.

Progress towards UHC is monitored in two dimensions: the coverage of essential health services and financial hardship. Each is covered further in the context of North Macedonia below.

Coverage of essential health services

In 2019, 6300 more people in North Macedonia (0.3% of the population) were covered by essential health services than in 2018. By 2023, North Macedonia anticipates there will be 31 300 more people (1.5% of the population) covered [10]. Coverage of essential health services is defined as the average coverage of the 14 SDG 3.8.1 tracer interventions. Of these 14 indicators, positive progress is projected for seven of them in North Macedonia by 2023 (Table 14).

Table 13. Projected percentage point changes in normalized values across the 14 SDG 3.8.1 tracer interventions for service coverage between 2018 and 2023 in North Macedonia.

<table>
<thead>
<tr>
<th>Service Coverage Indicator</th>
<th>2018 value (%)</th>
<th>Projected 2023 value (%)</th>
<th>Projected change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic sanitation</td>
<td>99.3</td>
<td>99.8</td>
<td>+0.5</td>
</tr>
<tr>
<td>Care seeking for pneumonia (children under 5)</td>
<td>94.3</td>
<td>95.1</td>
<td>+0.8</td>
</tr>
<tr>
<td>DTP3 immunisation</td>
<td>92.0</td>
<td>92.6</td>
<td>+0.6</td>
</tr>
<tr>
<td>Health worker density</td>
<td>43.1</td>
<td>47.5</td>
<td>+4.4</td>
</tr>
<tr>
<td>Hospital bed density</td>
<td>100.0</td>
<td>100.0</td>
<td>0.0</td>
</tr>
<tr>
<td>IHR core capacity index</td>
<td>63.0</td>
<td>47.5</td>
<td>-15.5</td>
</tr>
<tr>
<td>ITN use</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Mean fasting blood glucose</td>
<td>96.6</td>
<td>94.4</td>
<td>-2.2</td>
</tr>
<tr>
<td>Need met for family planning</td>
<td>33.1</td>
<td>38.3</td>
<td>+5.2</td>
</tr>
<tr>
<td>Non-elevated blood pressure</td>
<td>44.3</td>
<td>46.0</td>
<td>+1.7</td>
</tr>
<tr>
<td>People living with HIV receiving ART</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>TB cases treated</td>
<td>80.0</td>
<td>80.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Tobacco non-use</td>
<td>71.8</td>
<td>73.0</td>
<td>+1.2</td>
</tr>
<tr>
<td>Women who received antenatal care visits 4+ times</td>
<td>94.9</td>
<td>94.3</td>
<td>-0.6</td>
</tr>
</tbody>
</table>

Notes. ART: Antiretroviral therapy; DTP3: Three doses of diphtheria tetanus toxoid and pertussis vaccine; IHR: International Health Regulations (2005); ITN use: Insecticide-treated bed net use among people at-risk of malaria; TB: Tuberculosis.

* Some indicators in this chart have been transformed to have values between 0 and 100 (0 worst–100 best). Further information regarding the indicators can be found in [10].

* There are significant limitations associated with this method of measuring service coverage.

Source: Adapted from [10].
The key public health problem in North Macedonia is the burden of noncommunicable diseases (NDCs). Currently, the percentages of deaths and disability-adjusted life-years (DALYs) attributable to NCDs in North Macedonia are 96.13% (2) and 87.45% (11), respectively. A more systematic, high quality health information system that improves the monitoring of service delivery for NCDs, progresses sustainable health financing policies, and enhances the assessment of providers’ performance is needed to improve the health system and tackle North Macedonia’s burden of NCDs.

Unfortunately, PHC reform comes with a major challenge regarding the health workforce. Only about one third of total physicians in the country are primary care practitioners and many of them are leaving the country (3).

Financial hardship

Providing accessible, high-quality health services without facing financial hardship is a key target of the EPW and SDGs. It is a priority for North Macedonia to increase public spending on health and reduce out-of-pocket (OOP) payments. In 2018, public spending on health in North Macedonia was only 3.77% of GDP (compared to an EU average of 5.9%) and OOP payments accounted for 42.11% of current spending on health (close to double the EU average of 21.6%) (9). Furthermore, medicines are the main driver of OOP spending; therefore, improving access to essential medicines and medical supplies is required. To progress each of these priorities, North Macedonia would benefit from the subregional cooperation facilitated through the Roadmap.

Health financing policy must be strengthened and public spending on health scaled up to build back better and leave no one behind. To achieve these goals, the following actions should be prioritized (3):

1. Funding should be prioritized for common goods for health (CGH) for population-based functions, such as comprehensive surveillance (including laboratories), data and information systems, regulation, and communication and information campaigns. Funding CGH helps ensure that public health functions are adequately prepared to respond to crises and reviewing the essential functions during a health-care emergency can guide the development of improved payment rates and methods for the health-care workers involved in front-line emergency responses.

2. The potential financial barriers to ensure no one faces financial barriers to health visits, diagnostic tests, treatment (including medicines), care or emergency transport should be assessed and mitigated. This is particularly important regarding informal payments.

3. Investment in health system purchasing and employment is required to produce an immense, positive impact on social and economic recovery and resilience at the local and national levels. Research in North Macedonia on the economic footprint of health on the national economy has demonstrated that its health system plays a key role as one of the most important top ten domestic sectors for fiscal stability and GDP in times of crisis.

4. A rapid, organized response to the COVID-19 pandemic’s recovery should be facilitated by targeting health financing measures. More specifically, the health financing response must support scale-up and deliver appropriate population-based and individual services, strengthen social safety nets, and encourage the private sector to contribute to recovery in line with national COVID-19 pandemic recovery priorities.

Flagship Initiative 1: The Mental Health Coalition

North Macedonia is committed to expanding the availability of community-based mental health centres for mental health-care provision. Promotion of mutual best practices and past subregional developments through the South-eastern Europe Health Network (SEEHN) network, such as community-based mental health care, needs reinforcement, alignment, and inclusion into regional flagship initiatives, such as the Mental Health Coalition of the EPW.
Flagship Initiative 2: Empowerment through Digital Health

There was significant progress improving health information systems in North Macedonia in 2020, with enhancements to the national digital health and electronic health record system (MojTermin). However, while progress has been made, further action is still required to accelerate digitalization and mobile health to strengthen supply chains for continuity of established treatment regimens for key chronic diseases, which will help reduce the need for provider encounters and minimize unscheduled attendance at emergency departments. Additionally, the use of digital platforms and telemedicine should be considered, when feasible, to aid in the deinstitutionalization of services for the elderly, people with disabilities and people with mental illnesses to promote home-based care and preventive activities.

Core Priority 2: Protecting against health emergencies

In 2019, North Macedonia had 52,000 fewer people (2.5% of the population) protected from health emergencies than in 2018. By 2023, that number is projected to worsen to 621,800 fewer people (29.9% of the population). Despite this, North Macedonia scored fairly at 71.7% in the Health Emergency Protection (HEP) Index in 2019, which is calculated based on three sub-indicators: 1) preparedness; 2) prevention; and 3) detection and response (10).

Preparedness

In 2019, North Macedonia scored 60.0% in the preparedness sub-indicator. This sub-indicator assesses emergency preparedness by averaging the scores of all 13 International Health Regulations (2005) (IHR) core capacities at the country level, which are reported through the States Parties Annual Report (SPAR) tool (10).

Prevention

In 2019, North Macedonia scored 83.5% (down from 96.0% in 2013) in the prevention sub-indicator, which assesses efforts to prevent health emergencies through routine and targeted vaccine campaign efforts. This sub-indicator includes vaccination coverage for five major infectious diseases: measles, polio, meningococcal meningitis A, yellow fever, and cholera (10).

Detection and response

In 2020, North Macedonia performed perfectly at 100.0% in the detection and response sub-indicator, which assesses the appropriateness of a country’s reaction to an event of potential public health concern. The indicator averages the time from a public health event’s start to detection, notification and response to provide an overall measure of timeliness (10).

Essential services were disrupted during the COVID-19 pandemic, such as the monitoring and evaluation of chronic conditions, due to North Macedonia lacking sufficient supplies to protect health-care personnel and patients. A key lesson learned in relation to health emergency preparedness is that, moving forward, it will be a high priority for North Macedonia to develop systems for future health emergencies that provide immediate access to the medical supplies, protective equipment, and digital infrastructure required to maintain essential services. This can be done by: 1) ensuring the initial reformation plans for the national PHC model align with lessons learned; 2) reviewing guidelines, algorithms and protocols in PHC; and 3) boosting capacities in essential areas such as maternal, child and antenatal care.

Another high priority for North Macedonia is to improve the health system’s capacity to maintain emergency risk communication and public health measures during crises. This should include the establishment of specific communication protocols for the protection of vulnerable groups, such as migrant workers and victims of domestic violence, and the maintenance of mental health strategies and crisis hotlines.
North Macedonia completed a joint external evaluation of the implementation of IHR core capacities in March 2019 (12), and it found numerous areas that required further attention, including biosafety and biosecurity, information systems, health workforce training and capacity, multisectoral collaboration and national coordination. Subsequent responses should include to (3):

- increase national capacity for monitoring and risk assessment and management;
- regularly assess health services and system access and impact;
- strengthen public health training, surveillance, and implementation of IHR core functions at national and regional levels;
- upgrade and reinforce laboratories;
- strengthen capacities of North Macedonia’s Institute for Public Health and public health centres to complete digitalization of the early warning system, investigations, and response and testing in case of communicable disease outbreaks;
- reinforce national public health response capacity related to COVID-19 and other respiratory public health threats, such as influenza or measles, by increasing the number of trained health professionals and expanding national testing capacity; and
- introduce digitalized robust information and response performance management systems for assessing vulnerability and risk.

Core Priority 3: Promoting health and well-being

In 2019, there were 15 500 fewer people in North Macedonia (0.7% of the population) experiencing good health and well-being than in 2018. By 2023, it is projected that this number will worsen to 84 200 fewer people (4.0% of the population) (10). The healthier populations (HPOP) index uses 16 outcome indicators related to social, environmental, and behavioural risks to assess the number of people whose lives have become healthier. In North Macedonia, improvements in five of the 16 indicators are projected between 2018 and 2023 (Table 15).
Table 14. Projected percentage point changes in normalized values of the HPOP index between 2018 and 2023 in North Macedonia.

<table>
<thead>
<tr>
<th>HPOP Indicator</th>
<th>2018 value (%)</th>
<th>Projected 2023 value (%)</th>
<th>Projected change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to safely managed drinking water sources</td>
<td>79.7</td>
<td>72.8</td>
<td>-6.9</td>
</tr>
<tr>
<td>Access to safely managed sanitation services</td>
<td>16.8</td>
<td>17.8</td>
<td>+1.0</td>
</tr>
<tr>
<td>Adults not obese</td>
<td>75.7</td>
<td>73.8</td>
<td>-1.9</td>
</tr>
<tr>
<td>Ambient air quality</td>
<td>72.1</td>
<td>77.2</td>
<td>+5.1</td>
</tr>
<tr>
<td>Best practice policy implemented for healthy fats production</td>
<td>85.7</td>
<td>85.7</td>
<td>0.0</td>
</tr>
<tr>
<td>Child development</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Children not obese</td>
<td>90.5</td>
<td>88.9</td>
<td>-1.6</td>
</tr>
<tr>
<td>Children not overweight</td>
<td>89.6</td>
<td>91.1</td>
<td>+1.5</td>
</tr>
<tr>
<td>Children not stunted</td>
<td>95.6</td>
<td>96.5</td>
<td>+0.9</td>
</tr>
<tr>
<td>Children not wasted</td>
<td>96.9</td>
<td>95.3</td>
<td>-1.6</td>
</tr>
<tr>
<td>Primary reliance on clean household fuels</td>
<td>64.6</td>
<td>62.6</td>
<td>-2.0</td>
</tr>
<tr>
<td>Reduced alcohol use</td>
<td>74.3</td>
<td>74.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Reduced child violence</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Reduced partner violence</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Reduced road traffic mortality</td>
<td>98.1</td>
<td>98.5</td>
<td>+0.4</td>
</tr>
<tr>
<td>Reduced suicide attempts</td>
<td>99.1</td>
<td>99.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Tobacco non-use</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Notes. HPOP: healthier populations.

* Some indicators in this chart have been transformed to have values between 0 and 100 (0 worst–100 best).

* N/A indicates the data is not available

Further information regarding the indicators can be found at [10].

Source: Adapted from [10].

Promoting health and well-being will require North Macedonia to address the consequences of its ageing population and its high burden of NCDs. North Macedonia’s ageing population and negative population growth jeopardize the financial sustainability of retirement and disability benefits, and they are projected to put further financial strain on the country’s health insurance system. Additionally, older people in rural areas tend to report worse health compared to older people living in cities, towns and suburbs. There is a higher concentration of unmet need for the medical examination of older people living in rural areas as a result of the health system’s structure; PHC services are lacking in rural areas, and people living in these areas are particularly affected by risk of poverty or social exclusion.

Reducing North Macedonia’s persistently high burden of NCDs will require a sustained increase in investment to strengthen monitoring, treatment, evaluation and prevention of NCDs at the PHC level. Healthy lifestyle promotion, health literacy and preventive public services are under-resourced. Improvements in this regard could involve reviewing national guidelines on essential preventive and community health interventions; expanding access to NCD screenings; improving guidance on supporting an inclusive health response to people with disabilities or those vulnerable and marginalized; strengthening services for migrants; and promoting infection control and preventive measures for workers in health facilities. Additionally, North Macedonia’s BCA calls for technical packages to address risk factors of NCDs through multisectoral action on tobacco, fat and sugary drinks taxation, trans fat elimination and salt reduction.

North Macedonia is committed to addressing antimicrobial resistance through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness raising and evidence-based policies and practices.
Additionally, environmental health challenges are a pressing issue in North Macedonia. The country is highly vulnerable to natural disasters, such as floods, earthquakes, heat waves and forest fires; however, health emergency preparedness and risk management, though improving, remain to be strengthened. In 2016, the age-standardized mortality rate attributed to household and ambient air pollution was high at 82.17 deaths per 100,000 population. Environmental health challenges, especially, air pollution, are critical for the country and limited improvements have been measured in recent years. North Macedonia is committed to advocating for and championing efforts such as the European Healthy Cities Network to build climate resiliency, promote smart and sustainable transportation in urban settings, and support the implementation of national policies to improve air quality.

Flagship Initiative 3: The European Immunization Agenda 2030

Decreasing coverage trends in immunization over the last decade are in need of a boost and alignment with the objectives of the European Immunization Agenda 2030. This is not just a matter of fixing vaccine supply, procurement and deployment. To revitalize immunization programmes, a better understanding of the social, cultural and behavioural aspects behind popular vaccine acceptance or hesitancy, and effective communication strategies need to be developed in order to influence the knowledge, attitudes, and practices of people and drive behaviour change at the population-level in a socially desirable direction. For example, large measles outbreaks and related fatalities were reported in 2018 and 2019, which the Ministry of Health contained with targeted vaccination campaigns and efforts to strengthen vaccine confidence in communities.

Flagship Initiative 4: Healthier Behaviours: incorporating behavioural and cultural insights

Safeguarding and, where possible, increasing social spending in areas such as health, social and child protection and education is a priority to protect the most vulnerable groups from poverty and social exclusion in North Macedonia. This requires improved planning, budgeting, allocation and monitoring of public finances and increasing the effectiveness and efficiency of social spending, including better targeting of and outreach to the most vulnerable groups. There is also a need to explore alternative, innovative funding sources and to prioritize spending on areas that maximize return on investments (for example, early childhood development). This aligns with the EPW’s intent to develop an investment case for developing a knowledge and evidence base in this area of work.

References


All online references were accessed on 23 June 2021.


Republic of Serbia

This country brief provides an overview of Serbia’s health and sustainable development priorities that informed the Roadmap’s formation. While this brief does not seek to be exhaustive or prescriptive, it identifies key issues and areas where Serbia may benefit from and contribute to united action for better health in the Western Balkans (WBs).

Health and sustainable development progress in Serbia

Serbia has firmly embedded itself in the European Union (EU) accession process by opening 18 of the 35 chapters of the EU acquis Communautaire. Key among them are the chapters on judiciary and fundamental rights, justice and security, education, and procurement, which are all critical for the country’s reform agenda. Chapter 28 on consumer and health protection has yet to be opened [1].

Serbia’s economy has, on average, grown by 1.9% per year over the last decade. Prior to the COVID-19 pandemic, Serbia’s GDP growth rate exceeded 4.0% for two consecutive years; however, the country experienced a recession of 1.0% in 2020 [2]. In 2019, 9.1% of the total labour force in Serbia was unemployed [2]; a figure that has been exacerbated by the pandemic. Building back better and leaving no one behind will be imperative to sustain the progress on health and sustainable development that Serbia was making prior to the pandemic.

Serbia’s human development index (HDI) increased from 0.766 to 0.806 between 2010 and 2019. This represents an average HDI growth of 0.57%, which is lower than Europe and Central Asia’s average of 0.76% during the same period [3]. Embedded in Serbia’s HDI is their steady increase of life expectancy over the past decade: between 2010 and 2019, life expectancy increased by 1.45 years to 78.28 for females and by 1.83 years to 73.46 for males [4]. These figures are still significantly below the EU’s average of 83.82 for females and 78.45 for males [2]. During the same period Serbia’s population size decreased, on average, by 0.53% per year, and the percentage of the population aged 65 years or older increased from 14.74% to 18.74% [2].

Looking forward: the health and sustainable development trajectory

The 2020–21 Biennial Collaborative Agreement (BCA) between the WHO Regional Office for Europe and Serbia’s Ministry of Health [5] outlines the country’s health and sustainable development trajectory that will help it address the European Programme of Work (2020-2025) – “United Action for Better Health” (EPW)’s priorities and achieve the Sustainable Development Goals (SDGs).

To maximize the opportunities for promoting population health and reducing health inequities, Serbia’s BCA calls for the adoption of an intersectoral, Health-in-All-Policies approach (HiAP) that involves the whole of society and government [5]. This recognition emphasizes the need to improve overall governance and cooperation for health; therefore, supporting the Roadmap will directly accelerate progress on the BCA’s priorities and support Serbia’s pre-existing international and national strategic frameworks.

These frameworks include the National Health Strategy, the National Programme for the Adoption of the EU Acquis (2014–2018), the Tobacco Control Strategy, as well as the national programmes on the prevention of obesity, cardiovascular diseases, type 2 diabetes, sexual and reproductive health, cancer control and prevention, and antimicrobial resistance (AMR) control. Furthermore, Serbia has formed a multisectoral working group for the implementation of the 2030 Agenda for Sustainable Development to provide further support to meet health-related goals and reduce fragmentation in the process [5].
SDG 3 Progress: Ensure healthy lives and promote well-being for all at all ages

SDG 3 aims to ensure healthy lives and promote well-being for all at all ages. Tracking Serbia’s progress towards achieving the targets of SDG 3 provides an overview of where health and sustainable development has progressed well and where challenges remain (Table 16).

Table 15. Selected targets and indicators to track Serbia’s progress on SDG 3 achievement.

<table>
<thead>
<tr>
<th>SDG 3 Target*</th>
<th>Status*</th>
<th>Description</th>
<th>Indicator(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Target achieved</td>
<td>By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births.</td>
<td>• 3.1.1: Maternal mortality ratio: Decreased from 13.0 to 12.0 per 100 000 live births between 2000 and 2017.</td>
</tr>
<tr>
<td>3.2</td>
<td>Target achieved</td>
<td>By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-five mortality to at least as low as 25 per 1000 live births.</td>
<td>• 3.2.1: Children under-five mortality rate: Decreased from 12.7 to 5.5 deaths per 1000 live births between 2000 and 2018. • 3.2.2: Neonatal mortality rate: Decreased from 7.8 to 3.4 deaths per 1000 live births between 2000 to 2018.</td>
</tr>
<tr>
<td>3.4</td>
<td>Challenges remain</td>
<td>By 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being.</td>
<td>• 3.4.1: Risk of dying between the ages of 30 and 70 from one of four main NCDs (cardiovascular disease, cancer, diabetes, or chronic respiratory disease): Decreased from 29.5% to 22.0% between 2000 and 2019. • 3.4.2: Suicide mortality rate: Decreased from 18.9 to 7.9 deaths per 1000 population between 2000 and 2019.</td>
</tr>
<tr>
<td>3.5</td>
<td>Challenges remain</td>
<td>Strengthen the prevention and treatment of substance abuse.</td>
<td>• 3.5.2: Alcohol consumption per capita among population aged 15 years and older: 8.7 litres of pure alcohol in 2018.</td>
</tr>
<tr>
<td>3.6</td>
<td>Target achieved</td>
<td>By 2020, halve the number of global deaths and injuries from road traffic accidents.</td>
<td>• 3.6.1: Death rate due to road traffic injuries: Decreased from 10.9 to 7.5 deaths per 100 000 between 2000 and 2019.</td>
</tr>
<tr>
<td>3.7</td>
<td>Major challenges remain</td>
<td>By 2030, ensure universal access to sexual and reproductive health-care services.</td>
<td>• 3.7.1: Proportion of women of reproductive age with their needs met for family planning with modern methods: Increased from 40.8% to 54.8% between 2000 and 2020. • 3.7.2: Adolescent birth rate: Decreased from 41.4 to 15.2 per 1000 women aged 15–19 years between 2000 and 2017.</td>
</tr>
<tr>
<td>3.8</td>
<td>Significant challenges remain</td>
<td>Achieve UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.</td>
<td>• 3.8.1: Service coverage index: Increased from 38.0 to 65.0 between 2000 and 2017. • 3.8.2: The EPW uses regional indicators of financial protection, which will be produced by the WHO Barcelona Office for Serbia as a country report under the Directorate-General for Neighbourhood and Enlargement Negotiations (DG NEAR) project.</td>
</tr>
<tr>
<td>3.9</td>
<td>Challenges remain</td>
<td>By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.</td>
<td>• 3.9.1: Age-standardized mortality rate attributed to household air pollution: 29.0 deaths per 100 000 population in 2016. • 3.9.1: Age-standardized mortality rate attributed to ambient air pollution: 39.0 deaths per 100 000 population in 2016. • 3.9.2: Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene: 0.7 deaths per 100 000 population in 2016. • 3.9.3: Mortality rate attributed to unintentional poisonings: Decreased from 0.7 to 0.3 deaths per 100 000 population between 2000 and 2016.</td>
</tr>
<tr>
<td>3.10</td>
<td>Major challenges remain</td>
<td>Strengthen the implementation of the WHO Framework Convention on Tobacco Control.</td>
<td>• 3.10.1: Age-standardized prevalence of current tobacco use among persons aged 15 years and older: Decreased from 45.9% to 40.6% between 2000 and 2018.</td>
</tr>
</tbody>
</table>

Notes. DG NEAR: Directorate-General for Neighbourhood and Enlargement Negotiations; NCDs: noncommunicable diseases; SDGs: Sustainable Development Goals; UHC: Universal health coverage.

a For brevity, some SDG 3 targets and indicators were excluded when the health issues they addressed were not relatively high priorities or needs in Serbia’s context (for example, tropical diseases, etc.) or if there was no data available for their indicators.

b The status assigned to each target was determined by an analysis carried out by the Sustainable Development Report (7), and the indicators selected for this table represent some of the many indicators that were considered when these assessments were made.

c There are significant limitations associated with this measure of service coverage.

Source: Adapted from [4, 6, 7].
Lessons learned from the COVID-19 pandemic in Serbia

The COVID-19 pandemic has exposed systemic weaknesses in health and social systems, prompting policy responses and, in some cases, substantive changes. For example, pockets of the Serbian population without health insurance were at risk of high out-of-pocket [OOP] health spending in the case of COVID-19 infection, which highlights the need to improve Serbia’s universal health coverage (UHC) index and reduce the percentage of OOP payments spent on health expenditure. This will require greater investment to strengthen the country’s primary health care (PHC) system, which will also help Serbia address each of the EPW’s core priorities.

The COVID-19 pandemic has largely affected people who were already marginalized, and the informal employment sector in Serbia has been the hardest hit by the pandemic. This has disproportionately affected poor and vulnerable households, who have fewer savings and depend more on self-employment or these informal, less secure jobs that make them less resilient in the face of social and economic shocks. Enhancing the quality of health care, education and social protection, with a particular focus on the most vulnerable, can help prepare for future health emergencies and reduce their negative impact on health and the health system (8).

Despite the difficulties Serbia faced during the outbreak, national authorities were very active and demonstrated strong leadership and negotiating ability to procure COVID-19 vaccines. With a proactive approach and good cooperation with the COVAX programme, various manufacturers and other stakeholders from different countries and regions, Serbia facilitated a strong mechanism for vaccine procurement. Serbia’s relative success in vaccine procurement allowed them to bilaterally donate vaccines across the WBs. This demonstration of subregional cooperation illustrates the importance of further strengthening governance and administration mechanisms across health and social systems in the WBs to reduce bureaucratic burden and increase resilience, collaboration, and the adaptability of health systems in the WBs to shocks and challenges. Additionally, Serbia has prioritized digitalization in its pandemic response, leading to the successful establishment of an online platform for mass vaccination. This success has demonstrated the importance of advancing the digitalization of health in Serbia to improve health system performance and the interface between people and health services (9).

Closing the Health Gap: aligning Serbia’s priorities with the EPW

Serbia’s current country-level health priorities and gaps will be addressed below in context of the EPW’s core priorities and flagship initiatives.

Core Priority 1: Moving towards UHC

The right to health is guaranteed in Serbia’s constitution, and the Health Insurance Fund (HIF) organizes the financing and distribution of such services to ensure every Serbian citizen has access to basic health coverage. Despite this, Serbia’s OOP payment share of current spending on health is 38.31%, which is much higher than the EU average of 21.6%. Additionally, in the past decade, Serbia’s public spending on health has decreased from 5.8% of GDP to 5.1% (10). Serbia’s BCA outlines three priorities for progress towards UHC: improving access to quality essential health services; reducing the number of people suffering financial hardship; and improving the availability of essential medicines, vaccines, diagnostics and devices for PHC (5).

Progress towards UHC is monitored in two dimensions: the coverage of essential health services and financial hardship. Each is covered further in the context of Serbia below.
Coverage of essential health services

In 2019, 34,100 more people in Serbia (0.5% of the population) were covered by essential health services than in 2018. By 2023, that number is projected to increase to 275,700 more people (3.2% of the population) (11). Coverage of essential health services is defined as the average coverage of the 14 SDG 3.8.1 tracer interventions. Of these 14 indicators, positive progress is projected for seven of them in Serbia by 2023 (Table 17).

Table 16. Projected percentage point changes in normalised values\(^a\) across the 14 SDG 3.8.1 tracer interventions\(^b\) for service coverage between 2018 and 2023 in Serbia.

<table>
<thead>
<tr>
<th>Service Coverage Indicator</th>
<th>2018 value (%)</th>
<th>Projected 2023 value (%)</th>
<th>Projected change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic sanitation</td>
<td>97.8</td>
<td>98.4</td>
<td>+0.6</td>
</tr>
<tr>
<td>Care seeking for pneumonia (children under 5)</td>
<td>93.2</td>
<td>93.2</td>
<td>0.0</td>
</tr>
<tr>
<td>DTP3 immunisation</td>
<td>96.0</td>
<td>95.5</td>
<td>-0.5</td>
</tr>
<tr>
<td>Health worker density</td>
<td>59.4</td>
<td>66.3</td>
<td>+6.9</td>
</tr>
<tr>
<td>Hospital bed density</td>
<td>100.0</td>
<td>100.0</td>
<td>0.0</td>
</tr>
<tr>
<td>IHR core capacity index</td>
<td>69.0</td>
<td>74.3</td>
<td>+5.3</td>
</tr>
<tr>
<td>ITN use</td>
<td>N/A(^c)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Mean fasting blood glucose</td>
<td>95.9</td>
<td>92.4</td>
<td>-3.6</td>
</tr>
<tr>
<td>Need met for family planning</td>
<td>49.1</td>
<td>53.7</td>
<td>+4.6</td>
</tr>
<tr>
<td>Non-elevated blood pressure</td>
<td>42.9</td>
<td>46.0</td>
<td>+3.1</td>
</tr>
<tr>
<td>People living with HIV receiving ART</td>
<td>65.8</td>
<td>77.2</td>
<td>+11.5</td>
</tr>
<tr>
<td>TB cases treated</td>
<td>87.0</td>
<td>87.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Tobacco non-use</td>
<td>59.4</td>
<td>60.3</td>
<td>+0.9</td>
</tr>
<tr>
<td>Women who received antenatal care visits 4+ times</td>
<td>96.6</td>
<td>95.5</td>
<td>-1.1</td>
</tr>
</tbody>
</table>

Notes. ART: Antiretroviral therapy; DTP3: Three doses of diphtheria tetanus toxoid and pertussis vaccine; IHR: International Health Regulations (2005); ITN use: Insecticide-treated bed net use among people at-risk of malaria; TB: Tuberculosis.

\(^a\) Some indicators in this chart have been transformed to have values between 0 and 100 (0 worst–100 best). Further information regarding the indicators can be found at (11).

\(^b\) There are significant limitations associated with this method of measuring service coverage.

\(^c\) N/A indicates the data is not available.

Source: Adapted from (11).

The key public health problem in Serbia is the burden of noncommunicable diseases (NCDs). Currently, the percentages of deaths and disability-adjusted life-years (DALYs) attributable to NCDs in Serbia are 94.92% (2) and 88.21% (12), respectively. Considering how public spending on health in Serbia has decreased in the last decade, improvements are needed to increase health expenditure and address how efficiently it is spent, identify health gaps, and tackle the increasing rates of mortality and morbidity from chronic NCDs. A more systematic, high quality health information system that monitors service delivery better, progresses sustainable health financing policies, and enhances the assessment of providers’ performance is needed to improve Serbia’s health system.

There are insufficient financial resources for tackling some of the major risk factors for common NCDs, which limits the implementation of activities for NCD prevention. Additionally, there are insufficient human resources, and Serbia is still missing a comprehensive health workforce strategy (5). Therefore, Serbia is committed to strengthening the capacity of PHC in NCD prevention and management with an improved quality of care and tailored human resources for the health workforce. These commitments will also include assisting stakeholders to support a multisectoral response on NCDs.
Financial hardship

Ensuring everyone can access high-quality health services without facing financial hardship is a key target of the EPW and SDGs. Financial protection will be monitored using regional indicators as part of the Directorate-General for Neighbourhood and Enlargement Negotiations (DG NEAR) project. To reduce the number of people suffering financial hardship from health spending, Serbia’s BCA has prioritized capacity building and institution development for better pricing negotiation and advancing procurement policies. Medicines are the main driver of OOP spending; therefore, it would be beneficial to advance equitable access to health products through global market shaping and help Serbia monitor and ensure efficient and transparent procurement and supply systems (5).

Flagship Initiative 1: The Mental Health Coalition

Serbia is committed to fostering intense development in preventive services that address the social determinants of health, including mental health care. One strategy for achieving this is continuing to facilitate the implementation of the country’s National Mental Health Strategy, which includes the continuation of the Project on Adults with Mental Disabilities – Living in Institutions in the European Region (13).

Flagship Initiative 2: Empowerment through Digital Health

Serbia recognizes the opportunities of digital technologies to promote health and social change and strengthen service provider accountability that ensures human-centred development and leaves no one behind. Furthermore, Serbia is dedicated to paying special attention to increasing digitalization in the health-care sector to integrate health information systems and, thereby, improve data collection and epidemiological surveillance.

Expanding access to PHC can be achieved with improvements in digital technologies and telemedicine, and digitization can reduce the stress on the health system in future health emergencies by continuing to provide people with critical links to services for chronic conditions, mental health, maternal health, and beyond. To progress digital health, Serbia would benefit from technical and financial support.

Core Priority 2: Protecting against health emergencies

In 2019, Serbia had 172 100 fewer people (2.5% of the population) protected from health emergencies than in 2018. However, by 2023, it is projected that 704 100 more people in Serbia will be better protected from health emergencies than in 2018 (8.2% of the population). Serbia scored well at 80.5% in the Health Emergency Protection (HEP) Index in 2019, which is calculated based on three sub-indicators: 1) preparedness; 2) prevention; and 3) detection and response (11).

Preparedness

In 2019, Serbia scored 69.0% in the preparedness sub-indicator. This sub-indicator assesses emergency preparedness by averaging the scores of all 13 International Health Regulations (2005) (IHR) core capacities at the country level, which are reported through the States Parties Annual Report (SPAR) tool (11).

Prevention

From 2013 to 2019, Serbia has consistently scored near 92.0% in the prevention sub-indicator, which assesses efforts to prevent health emergencies through routine and targeted vaccine campaign efforts. This sub-indicator includes vaccination coverage for five major infectious diseases: measles, polio, meningococcal meningitis A, yellow fever, and cholera (11).

Detection and response

In 2020, Serbia scored 86.6% in the detection and response sub-indicator, which assesses the appropriateness of a country’s reaction to an event of potential public health concern. The indicator averages the time from a public health event’s start to detection, notification and response to provide an overall measure of timeliness (11).
Serbia has identified several strategies to achieve long-term resilience to health emergencies. In the medium to long term, the priority should be to strengthen human, institutional, and physical resources in the health sector, including by building new hospitals and biosafety level laboratories, integrating public health emergency management into academic curricula, and upgrading the capacity for medical waste management by hospital and health-care providers. In the longer term, broader structural reforms will make the health system more resilient for any future emergency. This should include advancing UHC and addressing relevant topics such as health financing; high OOP expenditure during the COVID-19 pandemic and beyond; equitable access to health services for all; the development of a health-care workforce strategy; and health technology assessments.

The WHO Country Office in Serbia hosts one of the three emergency hubs in the WHO European Region, which provides support to Serbia and selected other countries/area in emergencies. Serbia’s BCA outlines three main desired outcomes to protect against health emergencies: strengthening of country health emergency preparedness; preventing the emergence of high-threat infectious hazards; and rapidly detecting and responding to health emergencies. To achieve these outcomes, Serbia identifies several priorities, including to:

1) assist in the drafting and endorsing of disease-specific epidemic and pandemic plans;

2) Strengthen capacity for high-threat pathogen detection and strengthening prevention and control;

3) improve capacity for early detection of events through early warning, alert, and response (EWAR) systems; and

4) coordinate rapid responses to all hazard types of emergencies, including chemical, biological, radiological and nuclear defence, and cyber security threats, by supporting the public health emergency operations centre in Serbia and further developing the emergency workforce.

The COVID-19 pandemic disrupted essential services, such as the monitoring and evaluation of chronic conditions, due to Serbia lacking supplies to protect health-care personnel and patients. A key lesson learned from the COVID-19 pandemic related to health emergency preparedness is that Serbia must prioritize improving its health system’s capacity to provide immediate access to the medical supplies, protective equipment, and digital infrastructure required to maintain essential services and protect health-care personnel and patients.

Core Priority 3: Promoting health and well-being

In 2019, there were 66,800 more people in Serbia (1.0% of the population) enjoying better health and well-being than in 2018. By 2023, this number is projected to increase to 255,800 more people (3.0% of the population). The Healthier Populations (HPOP) index uses 16 outcome indicators related to social, environmental, and behavioural risks to assess the number of people whose lives have become healthier. In Serbia, improvements in nine of the 16 indicators are projected between 2018 and 2023 (Table 18).
Table 17. Projected percentage point changes in normalised values\textsuperscript{a} across the 16 outcome indicators related to the HPOP index between 2018 and 2023 in Serbia.

<table>
<thead>
<tr>
<th>HPOP Indicator</th>
<th>2018 value (%)</th>
<th>Projected 2023 value (%)</th>
<th>Projected change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to safely managed drinking water sources</td>
<td>74.7</td>
<td>74.8</td>
<td>+0.1</td>
</tr>
<tr>
<td>Access to safely managed sanitation services</td>
<td>24.9</td>
<td>25.7</td>
<td>+0.8</td>
</tr>
<tr>
<td>Adults not obese</td>
<td>75.8</td>
<td>73.5</td>
<td>-2.3</td>
</tr>
<tr>
<td>Ambient air quality</td>
<td>76.1</td>
<td>79.3</td>
<td>+3.2</td>
</tr>
<tr>
<td>Best practice policy implemented for healthy fats production</td>
<td>N/A\textsuperscript{b}</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Child development</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Children not obese</td>
<td>89.8</td>
<td>87.9</td>
<td>-1.9</td>
</tr>
<tr>
<td>Children not overweight</td>
<td>88.7</td>
<td>90.6</td>
<td>+1.9</td>
</tr>
<tr>
<td>Children not stunted</td>
<td>94.3</td>
<td>95.0</td>
<td>+0.7</td>
</tr>
<tr>
<td>Children not wasted</td>
<td>97.2</td>
<td>97.7</td>
<td>+0.5</td>
</tr>
<tr>
<td>Primary reliance on clean household fuels</td>
<td>66.0</td>
<td>65.2</td>
<td>-0.8</td>
</tr>
<tr>
<td>Reduced alcohol use</td>
<td>64.0</td>
<td>64.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Reduced child violence</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Reduced partner violence</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Reduced road traffic mortality</td>
<td>97.0</td>
<td>97.3</td>
<td>+0.3</td>
</tr>
<tr>
<td>Reduced suicide attempts</td>
<td>98.9</td>
<td>99.4</td>
<td>+0.5</td>
</tr>
<tr>
<td>Tobacco non-use</td>
<td>62.4</td>
<td>63.7</td>
<td>+1.3</td>
</tr>
</tbody>
</table>

Notes. HPOP: healthier populations.
\textsuperscript{a} Some indicators in this chart have been transformed to have values between 0 and 100 (0 worst–100 best). Further information regarding the indicators can be found at [11].

Source: Adapted from [11].

To promote health and well-being, Serbia’s BCA has identified three priority areas for work, which include: support local living environments with HiAP policies that enable health and well-being; develop and implement technical packages to address risk factors through multisectoral action; and address environmental determinants of health, including climate change [5].

Promoting health and well-being will require Serbia to address the consequences of its ageing population and its high burden of NCDs. The ageing Serbian population is increasing health spending, which is exacerbating the poor financial situation of the HIF alongside the growing burden of NCDs and declining population levels. Tackling Serbia’s persistently high burden of NCDs will require a sustained increase in investment to strengthen monitoring, treatment, evaluation and prevention at the PHC level. It will also require supporting the prevention of common risk factors, such as initiatives for nutrition, alcohol, tobacco, and obesity. While Serbia’s alcoholism and drug-abuse mortality are relatively low, Serbian citizens tend to have unhealthy lifestyles, with low engagement in sport and recreation [5]. While Serbia has made progress in the area of tobacco control, much work remains in order to fully implement the WHO Framework Convention of Tobacco Control and reduce Serbia’s high prevalence of tobacco use in adults aged 15 years or older, which was 40.60% in 2018 [11].
Serbia is committed to addressing AMR through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness raising and evidence-based policies and practices. Specifically, this will require Serbia to strengthen national programmes and policies, and their implementation, to combat AMR [5]. Serbia also recognizes the need to increase the resilience of health-care facilities to climate change and natural disasters, while improving environmental sustainability. This is a pressing issue in Serbia; for example, the mortality rate attributed to household and ambient air pollution in 2016 was high at 62.50 deaths per 100 000 population [14]. Initiatives to address the environmental determinants of health include expanding climate-resilient access to safe water, sanitation, and hygiene for schools and health facilities and supporting the implementation of the Ostrava declaration and the protocol on water and health [5].

Flagship Initiative 3: The European Immunization Agenda 2030

Over the last thirty years, Serbia has significantly invested in the prevention of communicable diseases. However, war and consequent challenges in post-war recovery have resulted in sub-optimal vaccine coverage. For example, Serbia is still faced with critically low, declining immunization rates, which is especially apparent in its vaccination coverage rate for the first dose of measles-containing vaccine among one-year olds, which was low at 87% in 2019 [4]. Serbia has expressed a strong commitment to this flagship initiative: it co-drafted the resolution on the European Immunization Agenda 2030 for the 71st session of the WHO Regional Office for Europe’s Regional Committee.

Flagship Initiative 4: Healthier Behaviours: incorporating behavioural and cultural insights

Safeguarding and, where possible, increasing social spending in areas such as health, social and child protection and education is a priority to protect the most vulnerable groups from poverty and social exclusion. This requires improved planning, budgeting, allocation and monitoring of public finances and increasing the effectiveness and efficiency of social spending, including better targeting of and outreach to the most vulnerable groups. There is also a need to explore alternative, innovative funding sources and to prioritize spending on areas that maximize return on investments [for example, early childhood development]. This aligns with the EPW’s intent to develop an investment case for developing a knowledge and evidence base in this area of work. Finally, several behavioural insight studies have been conducted during the COVID-19 pandemic in Serbia, and more work is planned in the areas of risk communication and community engagement related to the COVID-19 pandemic that will be informed by the results of these and any additional studies.

References [18]


All online references were accessed on 23 June 2021.


Kosovo

This brief provides an overview of the priorities in Kosovo for health and sustainable development priorities that informed the Roadmap’s formation. While this brief does not seek to be exhaustive or prescriptive, it identifies key issues and areas where Kosovo may benefit from and contribute to united action for better health in the Western Balkans (WBs).

Health and sustainable development progress in Kosovo

Health authorities in Kosovo are focused on accelerating the achievement of the Sustainable Development Goals (SDGs) and meeting the expectations of the global 2030 Agenda for Sustainable Development. This framework is outlined in the United Nations Kosovo Team (UNKT)’s United Nations Sustainable Development Cooperation Framework 2021–2025 (1).

Kosovo has a critically low GDP per capita of 11,906.40 (Purchasing Power Parity (PPP) current international $) (2). Prior to the COVID-19 pandemic, stable economic growth persisted in Kosovo at 3.63% per year on average between 2010 and 2019. However, the COVID-19 pandemic incurred a -6.89% recession in 2020 (2). Furthermore, economic growth in the past decade has not coincided with robust job creation. The labour market is characterized by low employment, with just 28.8% of working-age people (15–64 years) employed in 2019 and the widest gender gap in the WBs. In 2019, only 21.1% of women participated in the labour force, compared to 59.7% of men (1). Several systemic barriers have contributed to women’s low economic participation including deep-rooted gender stereotypes and a rigid understanding of gender roles which have exacerbated women’s unpaid care burden and affected their access to resources, property, and assets. Although the average age in Kosovo is 29.5 years, youth unemployment (aged 15–24 years) is 49.4%, whereas unemployment among women is 60.3% and 44.1% among men. These high unemployment rates among youth and women undermine Kosovo’s potential for economic growth and sustainable development (1).

Access to health services is unequal, and Kosovo generally has poor health outcomes compared to the WHO European Region. Life expectancies at birth for females and males in Kosovo were 74.8 and 70.3 years, respectively, in 2019 (Table 1). These values are significantly lower than those of the WHO European Region, which were 81.29 years for females and 75.09 years for males in 2019 (2). Despite progress in maternal and child health indicators, significant challenges also remain for neonatal deaths in Kosovo (1).

Kosovo’s commitment to the 2030 Agenda for Sustainable Development was evidenced in the unanimous endorsement by the Kosovo Assembly of the Resolution on the SDGs (2018) and operationalization of the Sustainable Development Council (SDC) (1). Limited data coupled with the slow uptake of monitoring tasks by Kosovo’s SDC makes it difficult to obtain a detailed review of Kosovo’s progress on each SDG. A UNKT data mapping exercise revealed that data was available on 33% of the SDG global indicators, no data was available for 42% of them, and a further 25% were deemed irrelevant to the context of Kosovo (1). Data is not routinely collected, lacks time series for comparison, and is rarely disaggregated, which hinders identification of equity gaps. Not only is Kosovo’s development framework lacking alignment with half of its SDG targets, but the implementation of development strategies aligned with the SDGs is hampered by a lack of adequate financing for planned activities and a lack of data to monitor progress (1). The World Bank’s SDG Atlas presents data from the World Development Indicators and offers some data, albeit not official indicators for SDG monitoring, on Kosovo (2), and Eurostat’s SDG indicators tracks the progress of Kosovo regarding SDGs 1 (no poverty), 3 (good health), 7 (energy), 8 (decent work) and 17 (partnerships) (3). The SDG progress tracked by these indicators is detailed below.

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(1) All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).
Looking forward: the health and sustainable development trajectory

The United Nations Western Balkans Action Plan, a system-wide initiative developed in 2019 under the Secretary-General’s prevention platform, commits the United Nations Secretariat and agencies, funds, and programmes to support the WBs in the areas of dialogue, trust-building and reconciliation through concrete and coherent actions and partnerships at subregional and country/area levels [1]. Through the United Nations Integrated Strategic Framework on Kosovo (ISF), the UNKT has agreed to create closer synergies between its development and its peace and security pillars in the pursuit of mutually agreed objectives in the areas of intercommunity trust-building as well as justice, rule of law and human rights [1]. Relatedly, the Roadmap can help Kosovo explore synergies in areas of gender equality, quality education for all, green and inclusive economic development, and reconciliation and social cohesion with a focus on the youth.

Forecasts for potential SDG finance sources in Kosovo are suboptimal due to the COVID-19 pandemic. However, multilateral development financing has grown, and multilateral development banks have begun to strengthen their collaboration. Integrated reporting on the environmental, social and governance impacts of their lending would support ongoing efforts to mainstream SDG considerations in all operations. Unfortunately, the global economic recession and financial turmoil from the COVID-19 pandemic are derailing achievement of the SDGs and implementation of the 2015 Addis Ababa Action Agenda, which provides a global framework to finance sustainable development. Kosovo needs a more forward-looking, comprehensive SDG financial approach with longer-term objectives and public financial planning [4].

The 2020 Common Kosovo Analysis (CKA) consultation process revealed several root causes (outlined below) that significantly hamper sustainable development progress [4]:

- lack of accountability
- unequal and limited access to, and quality of, health and social services
- insufficient skills development as an impediment to both development and social inclusion
- low level of economic competitiveness and use of green economy
- social trust deficit
- limited political resolve to work on environmental protection
- lack of qualitative, timely and disaggregated data.

To address these issues, a system-wide approach is required. Consequently, the Cooperative Framework outlined priority areas for work, including deliverable projects, outcomes, and theories of change to assist Kosovo and its partners in linking their priorities to the SDGs. These priority areas include [1]:

- **Accountable governance**
  - Ensure that public institutions at all levels are more transparent, meritocratic, inclusive, gender-responsive, and capable and effective in designing public policies, administering services, holding those in power accountable, delivering justice and ensuring equality and participation for all.

- **Inclusive and non-discriminatory social policies and services**
  - Ensure that social services such as health care, education and social protection services are more accessible, qualitative, and effective, especially for vulnerable and excluded groups.

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20 All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).
• Resilient, sustainable, and inclusive economic development
  — Ensure that economic development is associated with policies aiming to promote environmental sustainability and mitigate adverse impacts on the environment, and green business practices that are more environmentally sustainable and resilient, as well as labour markets that are more inclusive and respective of gender equality and human rights.

• Social cohesion
  — Ensure a higher degree of trust among ethnic groups as well as between the population and institutions and focus on engagement and empowerment of excluded and vulnerable groups as agents of change in advancing trust and social cohesion with public institutions and authorities.

• Cross-cutting theme: Increased gender equality and rights-holders’ participation, empowerment, and civic engagement
  — Ensure all women and men in Kosovo, particularly young people, vulnerable groups, communities, and displaced persons increasingly claim their rights and fulfil their civic responsibilities.

SDG 3 Progress: Ensure healthy lives and promote well-being for all at all ages

SDG 3 aims to ensure healthy lives and promote well-being for all at all ages. Tracking progress in Kosovo towards achieving the targets of SDG 3 provides an overview of where health and sustainable development have progressed well and where challenges remain. The CKA provides the following updates (8):

• only 3.3% of GDP is invested in the health sector, resulting in low-quality health care;
• overall health conditions in Kosovo are reportedly poorer compared to those in the WHO European Region;
• infant mortality (12 deaths per 1000 live births) is nearly three times that of EU countries;
• there is limited implementation of laws and policies, poor coordination between sectors and health authorities and severe limitations in data collection, reporting and accuracy;
• people living in rural areas have limited access to health care;
• people tend to bypass family medicine centres and directly seek out specialists for sexual and reproductive health care;
• there is weak monitoring and accountability, including of illegal practices (such as clandestine abortion), and there is limited implementation of related policies;
• health-care services for women and girls with disabilities are poor, and health professionals are rarely educated on how to provide this type of care;
• data is not available on the achievement of SDG 3 indicators, including SDG target 3.1, where current data on maternal deaths make it difficult to assess the maternal mortality rate; SDG 3.8, which is not measurable due to the lack of a law on universal health coverage (UHC); and SDG 3.9, which is addressed through the Law on Tobacco that lacks an effective monitoring mechanism.

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21 All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).
EUROSTAT’s 2020 report found that Kosovo had a maternal mortality ratio of zero in 2018 (3). In contrast, the report also found that the incidence of tuberculosis in Kosovo of 43 cases per 100,000 inhabitants in 2018 was the highest among the countries/area considered. This was a significantly greater incidence than anywhere else: the next highest rates were recorded in Albania and Montenegro, where there were 15 cases per 100,000 inhabitants in each country in 2018. Additionally, Kosovo recorded the second highest incidence of hepatitis B at 3.7 cases per 100,000 inhabitants in 2018 (3).

### Lessons learned from the COVID-19 pandemic in Kosovo

The COVID-19 pandemic has exposed systemic weaknesses in health and social systems, prompting policy responses and, in some cases, substantive changes. For example, there are severe deficiencies related to access to and quality of health and education in Kosovo, and the COVID-19 pandemic is exposing and exacerbating these challenges and weaknesses in the system (5). Marginalized populations in Kosovo have been made more vulnerable, and acute care services have been severely disrupted due to a diversion of resources and containment measures that have reduced access for all, but especially for those most vulnerable. Additionally, community members have reported being denied access to health facilities based on their ethnicity and perceived heightened exposure. Measures taken to address the pandemic will need to include maintenance of basic services and the principle of non-discrimination (4). To improve access and combat the exacerbation of vulnerability for marginalized groups, greater investments in the primary health care (PHC) system are required to help Kosovo build back better and leave no one behind.

Effective management of the COVID-19 pandemic response and recovery efforts is crucial to Kosovo’s achievement of the SDGs. In June 2020, UNKT presented a two-year socioeconomic response plan to mitigate the effects of the COVID-19 pandemic and inform the responses of health authorities (5). The UNKT Socio-Economic Response Plan to COVID-19 (SERP) aims to mitigate the impacts of the pandemic and offer a comprehensive framework to guide efforts to save lives, protect people, and build back better. Developed concurrently with the CKA and based on rapid assessments that have also been integrated into the CKA, the SERP laid the foundations to formulate the Cooperation Framework’s outcomes, and it is an integral part of the Cooperation Framework through joint working protocols and regular monitoring and reporting. Its implementation is anchored around leaving no one behind and targeting people who have been most affected by the pandemic, and it offers opportunities to build resilience in all programmatic interventions over the next 24 months (5).

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22 All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).
Closing the Health Gap: aligning Kosovo’s priorities with the EPW

Kosovo’s current health priorities and gaps will be further addressed below in context of the EPW’s core priorities and flagship initiatives.

Core Priority 1: Moving towards UHC

Kosovo has significant progress to make before UHC is fully achieved. A 2019 rapid assessment of Kosovo’s PHC system by the WHO Regional Office for Europe delivered recommendations for improving PHC. Some of those recommendations are included below:

- **Improve the reporting and feedback system to manage population health and measure PHC performance, including to:**
  - revise the PHC data reporting and feedback cycle to better inform the health needs related to noncommunicable diseases (NCDs);
  - enhance the role of regional public health institutes in providing methodological support to municipalities and family medicine centres in assessing health needs and setting priorities; and
  - include more output and outcomes measures in PHC performance measurement and to integrate them into the reporting and accountability system.

- **Improve patient choices and clinical governance to optimize patient pathways, including to:**
  - use population awareness campaigns for promoting the benefits of coordinated and person-centred PHC;
  - develop and implement clinical guidelines and protocols for the main clinical conditions with clear referral criteria; and
  - introduce shared care plans for patients with multiple conditions and complex health needs.

- **Strengthen a people-centred approach in PHC services, including to:**
  - develop standards and criteria for accrediting family medicine centres;
  - redefine the model of cooperation with public health to strengthen proactive people-centred care;
  - address gaps related to specializing in family medicine, migration, and the unequal distribution of health workforce; and
  - introduce mobile diagnostic services that can be provided at remote family medicine centres through rotation.

- **Strengthen governance, revise payment schemes, and align other health system enablers to sustain PHC development, including to:**
  - strengthen PHC governance capacity; and
  - revise payment schemes for family medicine centres, introducing incentives for improved performance.

In the absence of UHC, only very basic services are free of charge. Around 20% of people in Kosovo have no access to health services due to extreme poverty. High levels of out-of-pocket spending, which is estimated at 40% of total

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medical costs, results in around a third of people not having easy access to health-care services due to a lack of funds, which causes around 18% of people to not seek medical services in the event of illness. Furthermore, this suggests that the most vulnerable groups are disproportionately affected. Roma and Ashkali communities in Kosovo face exacerbated difficulties in accessing health services due to their difficult socioeconomic conditions. There are still concerns about discrimination in health services and some people still face difficulties with civil documentation and personal identity documents, often linked to return or repatriation. Additionally, Kosovo needs to introduce measures and systemic solutions to address the problem of unregistered births in these abovementioned communities.

Kosovo is committed to allocating more financial resources to health to allow implementation of health sector reforms, including further roll-out of the electronic public health information system and to meet overall recommendations for health system financing. Public spending on health should be further increased. In January 2019, it was estimated that only 65% of annual public health-care needs were covered. Furthermore, the allocated funds are primarily used to cover fixed costs, which leaves less opportunity to cover direct patient costs, such as diagnosis, treatment and prevention. Health financing continues to be predominantly based on historical expenditure and institutional accountability has not increased. Consequently, no incentives have been introduced to improve productivity, efficiency and quality in the health sector.

Flagship Initiative 1: The Mental Health Coalition

The prevalence of mental health disorders, especially depression and post-traumatic stress disorder (PTSD), remain high in Kosovo as remnants of recent war and conflict. Kosovo is committed to fostering intense development in treatment and preventive services for mental health care. The most recent Mental Health Strategy (2014–2020) in Kosovo was focused on expanding mental health services and promoting community-based care.

Flagship Initiative 2: Empowerment through Digital Health

For Kosovo, the generation of data, notably the availability of reliable and accurate disaggregated data, remains a challenge due to a lack of collection mechanisms and of a central repository for monitoring; weak coordination; and insufficient human and financial resources to support evidence-based policy development. Shortcomings in data collection weaken evidence-based policymaking and impede acceleration of progress towards the SDGs and the measurement of policy impact. However, the CKA revealed notable progress in the capacity of health authorities for collection, analysis, dissemination of disaggregated data, although, improving exchange among various entities and increasing data utilization in policy development should be strengthened. Furthermore, Kosovo is dedicated to paying special attention to increasing digitalization in the health-care sector to integrate health information systems and thereby, improve data collection, epidemiological surveillance, and management of future health crises.

Core Priority 2: Protecting against health emergencies

The European Commission’s Kosovo 2020 report identified that Kosovo has not made any progress regarding serious cross-border health threats, including for communicable diseases. Therefore, Kosovo would benefit from subregional action to establish cross-border health emergency teams and services, as well as establish robust and well-integrated emergency management systems across public health functions.

The COVID-19 pandemic has revealed priority areas where Kosovo can develop its health system to prepare for future health emergencies. These priorities are identified in UNKT’s socio-economic response plan to COVID-19 (5), and they include to:

- strengthen PHC, especially promoting the empowerment of PHC and community empowerment programmes to shift commodity distribution from clinical settings to the community;
- improve data collection and epidemiological surveillance;

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• improve risk communication and community engagement protocols;
• provide access to continuous education and child support services during times of health crises;
• prioritize social protection, especially regarding food and nutrition, education, water and sanitation, gender-based violence, social services, and shelter interventions;
• promote subregional joint procurement for medicines and medical supplies, as the overall capacities of the health system in Kosovo are weak and health authorities faced serious challenges in securing supplies of personal protective equipment;
• maintain essential services during future health emergencies, with the COVID-19 response having endangered the maintenance of essential health services. This is especially pertinent for sexual and reproductive health services, with special attention to pregnant women and vulnerable populations, such as people with disabilities, people living in poverty, people living with HIV, the Roma, Ashkali and Egyptian communities, refugees and other minority groups.

Core Priority 3: Promoting health and well-being

In the European Commission’s Kosovo 2020 report [7], the following updates were noted regarding Kosovo’s progress towards promoting health and well-being:

• Health promotion regarding NCDs remains weak.
• A 2014-2020 cancer program was implemented; however, registration of cancer-related deaths is incomplete due to gaps in the legal framework and deficiencies in administrative procedures. Funding for systematic cancer screening is inadequate and there is an overall lack of reliable data on cancerous diseases.
• There is no specific legislation on nutrition and physical activity.
• The comprehensive law on tobacco control is still not enforced because of a lack of political will and poor implementation due to health authorities being under resourced.
• No updated antimicrobial resistance (AMR) action plan has been adopted, and control on the prescription of antibiotics to prevent AMR has not improved.
• The European Centre for Disease Prevention and Control conducted an expert assessment mission in Kosovo in October 2018 in the field of communicable diseases, which noted weak implementation of primary legislation and an absence of secondary legislation.
• Little progress has been made on the rights of persons with disabilities, and their integration into society remains a challenge due to limited support, inadequate health services and poor access to existing services.
• Kosovo is at an early stage of preparation for action on environmental protection and climate change mitigation. However, some progress has been achieved, notably through the adoption of the relevant strategies. Despite this, serious environmental problems continue to impact people’s livelihoods and health.
• Air quality continues to pose a major threat to human health and efforts should be made to adopt measures that improve it. Notably, the emission reduction plan, which was adopted in 2018 as Kosovo’s strategy for air quality, is not enforced.
• Urgent measures and permanent solutions are needed to reduce household reliance on lignite and wood heating.

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• Some progress has been noted on water safety and sanitation, most especially through the adoption of the Kosovo national water strategy, which includes an investment action plan. Urgent efforts are required to address how no drinking water quality reports have been published since 2015 and to ensure that the river basin authority, which was established in July 2017, is operational and prepares management plans.

• The transport system still faces several challenges, including road safety, inadequate road maintenance and weak administrative capacity of regulatory institutions.

To address some of the issues listed above, Kosovo would benefit from support to implement a more systematic, high-quality health information system that improves the monitoring of service delivery, progresses sustainable health financing policies and enhances the assessment of providers’ performance. Additionally, there are shortages of medical staff at all levels of health care, which needs to be addressed. Therefore, Kosovo is committed to strengthening the capacity of PHC in NCD prevention and management with an improved quality of care and tailored human resources for the health workforce. These commitments will also include assisting stakeholders to support a multisectoral response on NCDs. Additionally, nearly all issues listed above could be addressed with a robust implementation of the Roadmap in Kosovo.

Flagship Initiative 3: The European Immunization Agenda 2030

Immunization rates are lower in Kosovo than in previous years. Vaccination rates among school-age children are reported to vary between 95% and 98%. The Roma and Ashkali communities particularly, remain a concern with regards to immunization. The distribution of information on public services and the incidence of discrimination have not improved and this has a negative impact on access to health services. Additionally, action must be taken to address Kosovo’s high rates of tuberculosis and hepatitis B.

Flagship Initiative 4: Healthier Behaviours: incorporating behavioural and cultural insights

UNKT’s CKA revealed widespread discrimination and inequality in policy, programme and social norms that result in marginalized groups, especially people with intersectional marginalized identities, being left furthest behind. At the intersection of factors related to discrimination, geography, vulnerability to shocks, governance and socioeconomic status, marginalized people face multiple, reinforcing sources of deprivation and inequalities, which makes them more likely to be left behind across multiple dimensions of well-being.

Poverty has a higher adverse effect on children, youth, and women. Gender discrimination, patriarchal norms and harmful traditions hinder women’s access to economic, political, and social opportunities, impacting women and girls from non-majority communities, victims of sexual and gender-based violence, older women, migrant women, and women with disabilities the most. Persons with disabilities, in particular children, remain excluded with poor access to public spaces, education and health services. People with disabilities also face hindered access to employment and livelihood opportunities. Non-majority communities, especially Roma, Ashkali and Egyptian communities, face disproportionately higher rates of mortality and malnutrition, late birth registration and lack of documents, less access to education and employment, and more violence. Their increased vulnerability is, in part, due to limited implementation of language legislation. Migrants, internally displaced persons, and returnees are considerably disadvantaged in their access to opportunities and are, therefore, also more vulnerable to shocks. Rural residents, especially those from mountainous settlements, have limited or no access to communication means and unequal access to public utilities, higher rates of poverty and more vulnerability to environmental risks, including climate change. Climate change compounds existing vulnerabilities due to the limited prioritization to tackle it and the low capacity to mitigate greenhouse gases and adapt to the changing climate. Foreseen changes in the frequency and intensity of extreme weather events, including floods and drought, pose risks to livelihoods and further increase inequities.

All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).
References


27 All online references were accessed on 23 June 2021.

28 All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).
The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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