Socio-demographic statistics in Albania: selected topics and future developments

Tiranë, 2010

Preface and acknowledgments

This publication based on thematic research presents an important moment in the strengthening of the social statistics in INSTAT through the three-year programme Developing Demographic and Social Statistics in Albania (DESSA). It contains a collection of articles pertaining to most topical issues of social and demographic change in Albania today. Thus, it represents a significant instrument for policy makers and other stakeholders alike: it provides essential information for monitoring the national policies and strategies related to the developments in demography, education and health.

Different statistical sources, administrative and survey ones, such as Living Standard Measurement Survey (LSMS 2005, LSMS 2008) and Demographic and Health Survey (ADHS 2008/09) were used as the main data sources for analyzing phenomena during the last decade. The information collected also pertained to issues related to demographic information system, the description of education trends through main standard education indicators, health needs and characteristics of access to health care, regional dynamics and territorial classification in Albania.

The portfolio, produced in the frame of the partnership between Albanian and Swiss institutions in the field of social statistics, displays the common product of the expertise belonging to the National Institute of Statistics (INSTAT), the Swiss Federal Statistical Office (SFSO) and international academia field. The activities were financed by the Swiss Cooperation Agency in Albania (SCO-A), and involved apart from the project directors of SFSO a large number of experts from various Universities in Switzerland and Italy. Besides making this publication possible, the programme made a substantial financial contribution to the implementation of the ADHS and to the build-up of a comprehensive GIS infrastructure, which will be used, among other purposes for the preparation of the 2011 Census.

INSTAT and SFSO would like to take this opportunity to thank particularly to all the international and national staff and experts, for the devoted work and commitment in the implementation of this project and for producing valuable outputs. All the contributors to this project, which comes to his end through this publication, are presented in a distinct form at the beginning of the report.

Thanks are extended to all those involved directly or indirectly in jointing our efforts, while acknowledging responsibility for generating valuable outcome.

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Abbreviation list:

ADHS	Albanian Demographic and Health Survey
AIDS	Acquired Immunodeficiency Syndrome
ALUIZNI	Agency for the Legalization, Urbanization, and Integration of the Informal Zones/Buildings
BMI	Body Mass Index
BP	Blood Preassure
CARDS	Community Assistance for Reconstruction, Development and Stabilization
CEAT	Communauté d'études pour l'aménagement du territoire, EPFL
CI	Confidence Interval
CSO	Civil Status Offices
DESSA	Developing Demographic and Social Statistics in Albania
DFLE	Disability-Free Life Expectancy
EA	Enumeration Area
ECHIS	European Core Health Interview Survey
EPFL	Ecole Polytechnique Fédérale de Lausanne
EU	European Union
EUROSTAT	Statistical Office of the European Community
GDP	Gross Domestic Product
GIS	Geographic Information System
HALE	Healthy Life Expectancy
HFA	Health for all
HU	Housing Unit
ICD	International Classification of Diseases
ICF	International Classification of Functioning and Disability
IHCI	Institute of Health Care Insurance
INSTAT	Albanian National Institute of Statistics
IPH	Institute of Public Health
IOM	International Organization for Migration
ISCED 97	International Standard Classification of Education
LSMS	Living Standard Measurement Survey
MICS	Multiple Indicator Cluster Survey
MEHM	Minimal European Health Module
MoH	Ministry of Health
NACE	Nomenclature of Economic Activities in the European Union
NORAD	Norwegian Agency for Development Co-Operation
NUREC	Network on Urban Research in the European Community
NUTS 2 ,3	Nomenclature of Units for Territorial Statistics
OECD	Organization for Economic Co-operation and Development
OR	Odds Ratio
PHC	Primary Health Care

PSU	Primary Sampling Unit
PPS	Proportion Probability of Size
RHS	Reproductive Health Survey
SCO-A	Swiss Cooperation Office in Al
SFM	Swiss Forum for Migration and Population Studies, University of Neuchâtel
SFSO	Swiss Federal Statistical Office
SSU	Secondary sampling unit
TFR	Total Fertility Rate
TRHA	Tirana Regional Health Authority
UNO	United Nations Organization
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Population Fund (formerly United Nations Fund for Population Activities)
USAID	United States Agency for International Development
WEI	World Education Indicator
WHO	World Health Organization

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INTRODUCTION

Lantona Sado, Ilka Steiner, Denise Efionayi[1], September 2010

Background

According to the UN[2], there were an estimated 3.14 million people living in Albania in 2008, at an average density of 109.3 inhabitants per square kilometre. The total average annual growth rate of the population between 2005 and 2010 was 0.4 per cent, and although the population size in rural areas decreased by 0.6 per cent that in urban areas increased by 1.9 per cent. In 2005, 58.5 per cent of the active population was employed in the agricultural sector, 28 per cent in services and 13.5 per cent in industry. In 2008, 18.5 per cent[3] of the population was living below the poverty line and the official unemployment rate was 13.8 per cent. A major source of income for Albania, a country with one of the lowest levels of GDP per capita in Europe (USD 4,174 in 2008), is remittances from abroad, representing about 12.2 per cent of GDP per capita[4], sent mostly by emigrants living in Greece or Italy.

Albania's agricultural and economic centres are situated along the coastal alluvial plain, in the west of the country. The major urban agglomerations comprise the capital city of Tirana and the main sea port city of Durrës on the Adriatic Sea. The mainly rural mountainous and often scarcely accessible interior constitutes about 70 per cent of the country's total surface area.

After the death of the country's Communist ruler, in April 1985, measures towards liberalization and freedom to travel (including abroad) were introduced by the new government. Even though the elections in early 1991 reinstated the party in power, a multi-party cabinet was formed following a general strike and urban opposition. The elections of March 1992 eventually ended the Communist regime after 46 years of stark rule, and in 1998 Albania became defined by a renewed constitution as a parliamentary republic.

As in other eastern European countries, collapse of Communism caused in Albania not only political but also drastic social, economic and demographic changes. The political openness in the early 1990s permitted people to move freely within Albania's twelve counties (prefectures) and also to emigrate. Therefore, an overwhelmingly rural society, completely isolated by the communist regime, came into contact with other norms and values. As a result, new demographic behaviour, e.g. a drop in total fertility rate (from around 6 to 1.6 children per woman) and major internal and international migrations, were observed.

The health care system, modelled under the communist regime on the Soviet *Semashko* system of universal health care coverage, was restructured and new measures were adopted in order to reduce expenditure and improve availability, quality and use of the system. Currently, the health system is mainly public and the state the major provider of health services, health promotion, sickness prevention, diagnosis and treatment, though there is a rapidly developing private sector. A health insurance system has been introduced, interventions have been undertaken to strengthen primary health care in the country with introduction of family medicine delivered by general practitioners and reliance on out-of-pocket payments (both formal and informal) has increased.

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[2] For all data mentioned in this paragraph see: http://data.un.org/CountryProfile.aspx?crName=Albania#Summary, consulted on 25.08.2010

[3] See World Bank data: http://data.worldbank.org/country/albania, 25.08.2010

[4] Idem

Albania's public educational system has also been modernized and has been adapting itself to the Bologna reform since 1990. In fact, the system in place in 1990 was itself the result of major reform started in the 1950s, focusing on a drive against illiteracy, achievement of universal education and promotion of gender equality in education (Falkingham, 2001). Today, with addition of private institutions to Albania's education system the opportunities for its citizens are widening.

While the demographic behaviour of a population is a major foundation of a society, its educational level and state of health represent important components of the human capital available for its economy and development in general. However, demography, education and health are closely linked factors and mutually influence each other. For example, promotion of gender equality in education plays an important role in influencing demographic behaviour: according to Falkingham (2001) gender equality has been a major factor in fertility transition in Albania.

Strategic priorities established in National Strategy for Development and Integration (NSDI)

In order to pursue and eventually achieve sustained social and economic development, as well as NATO and European integration, democratization and rule of law, the Albanian government approved in 2007 a strategic framework: the National Strategy for Development and Integration (NSDI). As a continuation of the National Strategy for Socio-Economic Development (NSSED), in place until 2006, it establishes government's medium to long-term goals (2007–2013) for all sectors, based on a national vision. In addition to the 22-sectoral strategies covering all ministries, NSDI comprises 15 crosscutting strategies such as gender equality, social inclusion, migration and youth. The strategy translates the Millennium Development Goals (MDGs) into national priorities and links with the Stabilization and Association Agreement (SAA), which was signed by Albania on June 12 2006.

Table 1. Summary of revised MDGs (1–6) regarding social and demographic *indicators*

1	Eradicate extreme poverty and reduce the risk of social exclusion "Risk of social exclusion" has been added in order to take into account the EU's social inclusion policy.
2	Achieve high quality basic universal education The target of universal enrolment in basic education has been altered to take into consideration the legal obligation of nine years duration of basic education. Moreover, the target of an increase in spending for basic education to the level of new EU member states has been introduced to express Albania's aspiration to become an EU member state.
3	Promote gender equality and empower women Newly introduced targets are related to preventing and combating violence against women and eliminating gender disparity in employment and payment.
4	Reduce child mortality (practically unchanged)
5	Improve maternal health The target has been reworded to become more ambitious and to express Albania's ambition to become an EU member state. Furthermore, given that maternal mortality tends to be higher in rural areas, this indicator has been disaggregated into rural and urban indicators.
6	Combat HIV/AIDS and Tuberculosis The newly added indicators aim at monitoring groups at risk, including new mothers and persons taking drugs. Additionally, the indicator of Adult HIV prevalence rate has been disaggregated by gender and age.

Since Albania reached a more developed stage of social and economic development by 2008 and its government aspires it to become an EU member state in the foreseeable future, the Department of Strategy and Donor Coordination (DSDC) organized an MDG target and indicator revision process. "The revision process was amongst others supposed to clarify institutional responsibility in terms of target setting and monitoring in order to build a functional and unbiased monitoring system."[5] Table 1 summarizes the revised MDGs regarding social and demographic aspects. The adjustments account for three trends and intentions. First of all, indicators of almost all goals have been adjusted, either by setting more ambitious or realistic levels or by introducing new, or removing old, ones. Furthermore, since Albania has submitted its application to obtain status of an EU candidate country, its targets have been aligned in order to meet the EU system of social inclusion indicators. At last, several targets have been disaggregated by region (rural/urban), gender or age, resulting in more accurate monitoring since social and demographic behaviour vary due to these attributes.

Within the NSDI framework, yearly reporting on policy outcomes and impacts is undertaken alongside other reporting mechanisms focused on budgeting and planning. Monitoring of implementation of the sector and crosscutting strategies is based on a list of indicators defined for each strategy. Tracking of monitoring indicators will be supported by implementation of a national five-year programme for official statistics.

Developing Demographic and Social Statistics in Albania (DESSA)

The social and demographic indicators used for monitoring NSDI are primarily provided by INSTAT, Albania's Institute for Statistics, which is charged with producing timely, relevant and transparent statistics for government departments and for public consumption. For development of the country and its international integration, continuing improvements of INSTAT and the statistical system overall is therefore essential.

INSTAT is supported in part by a network of multilateral and bilateral donors. The European Union (EU) is financing, through CARDS, improvement of Gross National Product statistics and has special interest in regionalization of the country's economic data. Swedish International Development Assistance (SIDA) is supporting business statistics and INSTAT's computing system.

As a topically complementary programme Developing Demographic and Social Statistics in Albania (DESSA) is focusing on durability and synergies among various projects, building on long-term collaboration. Between 1999 and 2002, Swiss–Albanian cooperation concentrated on preparation and conducting of a General Population and Housing Census of Albania. Between 2003 and 2005, it was mainly devoted to analysis and presentation of census and survey results, including topics such as gender, youth and migration, serving policy makers and other stakeholders in a democratic society. The present DESSA project has, over the period 2007–10, been building on these assets and the experiences of the cooperation between INSTAT, Swiss Agency for Development and Cooperation (SDC) and Swiss Federal Statistical Office (SFSO). The project pursued four objectives:

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[5] DSDS, NSDI Progress Report 2008, p. 68: see pages 70–83 for the exact goals and indicators

- development of operational strategies to improve periodicity, quality, reliability and comparability of data and indicators on demography, health and education

- re-enforcement of the geographical–statistical support in the country in order to improve the quality of sampling, support the conducting of censuses and synchronization of results with reference territories

- further development of indicators and data analysis on important social issues that concern policy makers both nationally and internationally, as well as improvement of dissemination of indicators and accessibility of data

- improvement of performance of INSTAT in terms of project management, data collection and cooperation with ministries and other institutions, as well as with the regions.

DESSA has been a two stage project. An initial phase of assessment of the situation and the needs in terms of statistics and resources (human capital, training, infrastructure, procedures, etc.) required the production of relevant data. This took place from September 2007 to March 2008. For each information system—demography, health, education and geography—an assessment report was produced that included analysis of the situation and a package of recommendations. The assessment also considered the needs for monitoring of processes that have to be tracked with relevant indicators, especially progress in implementation of NSDI, realisation of the MDGs and progress with the SAA.

The goal of this first phase was to elaborate an operational plan that considered the current state of affairs and was built upon a realistic and durable development of the national statistical system particularly with regard to social and demographic statistics, with special focus on regionalization of indicators and the perspective of gender. The second phase began in April 2008 and was devoted to implementation of the action plan.

Content of the publication

The present portfolio of articles contains a series of stand-alone articles based on in-depth social and demographic analysis and on description of methodological issues covering DESSA activities and domains. Special focus on gender, regionalisation and migration has been integrated across all contributions. All programme components were involved and the articles written by INSTAT staff and collaborators under supervision of international experts, following in-depth discussions during the common workshops. In most cases, the contribution of national experts was directly linked to on-the-job training experiences performed within the framework of DESSA. The results of the analysis include an overview of the present situation with regard to statistics and recommendations for future activities and possible improvements in statistical production and dissemination. Alongside the information provided on topical issues (demographic change, access to health, migration, etc.), the publication serves pragmatically as a document that sums up the major outcomes and experiences of the programme that should serve future developments in the field of statistical production.

In order to gain an overview of the different sources of demographic information presently available for measurement of demographic and social trends, Wanner, Lerch and Galanxhi describe the Albanian Demographic Information System (ADIS). In their article the authors present the findings of the last population census and of various household surveys recently undertaken in Albania. They go on to discuss demographic indicators and suggest some ways to improve the current ADIS and usage of the civil registration system for statistical purposes.

Taking as a starting point the 1989 Census, and estimating reproductive behaviour and population movements in 2001 in order to provide longitudinal perspective to recent estimates, Lerch, Subashi, Nesturi, Galanxhi and Wanner discuss recent demographic patterns and the dynamics observed in the different regions of Albania since 1989. After presenting the effects on age structure of two components——migration and fertility——the authors summarize the main regional trends and highlight some future population issues.

Gabadinho, Kasneci and Toro, using data from the Living Standards Measurement Survey (LSMS) of 2005 and of 2008, monitor trends in educational participation and attainment. By taking into account the personal attributes of gender, social origin and spatial location, the article analyses potential sources of inequalities in the field of education. When durable socio-economic development is targeted, it is essential to focus on education because conditions in early childhood determine to a very large extent individual personal and professional development. The authors conclude that educational strategies are not only an effective, but also an efficient investment compared to other types of social policies.

Since educational achievement and living standards, the latter dependent in part on the former, have an important impact on a person's state of health, Weiss, Çaushi, Pupuleku, Abazi and Bici, based on LSMS 2008 and Demographic and Health Survey (DHS, 2008–2009), discuss the health status, behaviour and service utilization in Albania.

One factor affecting negatively health care services access, equity, efficiency and utilization is informal payments. Abazi, Domenighetti, Tomada, Bici, Çaushi and Pupuleku, using the same data sources as Weiss et al. (LSMS, DHS), analyze access to health care services between 2005 and 2008 and the changes in informal payments. The authors discuss barriers in accessing care and identify barrier differences between men and women and among regions of residence.

The aforementioned articles using LSMS data for their analysis classified Albania into four regions——Mountain, Coastal and Central Areas, and Tirana city——as designed in the survey.

DESSA has also made a substantial contribution towards the development of a Geographical Information System (GIS) at INSTAT. This system will be used for implementation of the 2011 Albanian population and housing census, and for development of a new sampling framework for future household surveys. The cartography theme was a major component in the last article of the present portfolio. Authored by Schuler, Jarne, Shameti and Seferkolli it proposes a typology of communes and a definition of agglomerations for Albania, using the 2001 Population and Housing Census results. This new classification provides an example for territorial analyses and policy evaluation, as well as for urban and regional planning.

1 Albanian Demographic Information System: A description

Philippe Wanner, Mathias Lerch, Emira Galanxhi[6]

Abstract

This chapter presents and describes the current Albanian demographic information system (ADIS), which is based on population censuses, population registers and surveys and monitored by the Institute of Statistics of Albania in Tirana. In a context of impressive demographic changes, including international emigration, increase in life expectancy and decrease in birth rates especially in urban areas, new observatory tools should be developed in order to measure demographic behaviours and provide accurate information for policy makers. Current and future developments in statistical infrastructure are then discussed in this chapter.

Introduction

Albania has undergone impressive demographic changes since the 1960s and particularly during the years following the end of the Communist Regime, marked as they were by economic and political transition. During the last five decades, the overall fertility rate has dropped from more than six to around 1.6 children per woman. Simultaneously, major internal and international population movements have taken place, creating challenges for the government's economic and social policies.

In this context, an adequate Albanian Demographic Information System (ADIS) is required for the measurement of population trends and demographic changes and for the development of policy responses that are adapted to the demographic situation at any particular time. The present document provides an overview of the different sources of demographic information presently available for the measurement of demographic trends. It presents in the first part a census, and in the second part the main surveys recently undertaken in Albania. A third part deals with new improvements in data (in particular population registers). Finally, this document also suggests some ways to improve the current ADIS.

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Population census

In Albania, a Population Census is conducted every ten years by the Institute of Statistics of Albania (INSTAT), the last one being held in 2001 and the next one scheduled to take place in 2011. A census is a major source of statistical information, not only in respect of demography, but also with regard to economy, education, infrastructure, etc. As a basis for survey sampling, it plays a significant role in ADIS.

The census undertaken in Albania is exhaustive, with all households required to answer questions. A census agent is devoted to all census work in an area and in charge of collection of the questionnaires. The census is organized within the framework of international recommendations (UN, 2006) and is also adapted to the social situation in the country.

The census questionnaire generally covers 1) the building (number of floors, type of building, etc.), 2) dwelling (bathing facilities, kitchen, etc.), 3) household members (list of names), including persons temporary present and members of the household that live abroad, 4) household (ownership, etc.), 5) agriculture (including land ownership), 6) socio-economic and demographic information on each person in the household (age, place of birth, civil status, education completed, activity, etc.).

The census data permit the computation of traditional demographic tables (population characteristics that include age, household size, social status, etc.) at the prefecture and district levels (see INSTAT, 2002). They also provide useful information on births and fertility (computed by using information on children living in households and by indirect demographic methods), infant mortality and migration. The questionnaire applied in Albania allows estimation of migration, as questions regarding place of birth and place of residence at the time of the last census are useful for describing internal migration and understanding underlying factors.

Information on the ethnic and religion composition of the population was absent from the 2001 Census. Surveys (e.g. LSMS), however, do record this information. As far as we know, some such questions were integrated into a preliminary version of the 2011 questionnaire.

Due to the complexity of a census, it is important to assess its quality and that of the answers given using, for example, a post-enumeration survey. In the absence of such a survey, no precise appraisal of the quality of the 2001 census is possible. The quality was assessed by INSTAT (Ekonomi et al., 2003) as being "fairly good", though during another assessment undertaken inside the country, several interviewees outside INSTAT announced they had some reservations regarding the completeness of the data (Lerch and Wanner, 2008). Nevertheless, putting aside the question of exhaustiveness, experts seem to be rather confident about the quality of the census declarations. The main problem that emerged concerns definition of the relationship between household members and a reference person (Ekonomi et al., 2003). The way in which this definition should be applied was not clear in the case of extended Albanian families. The resulting errors and missing values were resolved during the phase of data validation using a deterministic approach.

Household surveys

Several household surveys have been undertaken over the last decade, and these provide information that proves to be very valuable for description of the underlying factors of demographic trends (see Table 1).

The Multiple Indicator Cluster Survey (MICS, 2002 and 2005), led by UNICEF in collaboration with INSTAT, focused on child health, and also provided information on fertility determinants. The Reproductive Health Survey (RHS, 2002), conducted by the Institute of Public Health (IPH) and INSTAT and supported by international organizations such as USAID, UNFPA, UNICEF and CDC, was the first national information source on family planning and reproductive health issues. RHS has been updated by means of regional surveys (PRO project) and was followed by a Demographic and Health Survey (DHS) organized in 2008–9 (Lerch and al, 2008). Finally, the Living Standards Measurement Survey (LSMS), undertaken by INSTAT (in 2002, 2005 and 2008) with the support of the World Bank, is the main national survey to study and measure internal and international migration. Socio-economic determinants of fertility and child mortality can also be investigated on the basis of this survey. The latest LSMS was undertaken in 2008 (see Lerch et al., this book). The International Organisation of Migration (IOM) and the Centre for Economic and Social Studies (CESS) in Tirana have also organized several small scale or regional surveys on migration and remittances.

Table 1: Overview of population based surveys, Albania

Survey	Sample size and age (years)	Regional representativeness	Respondent selection in household	Response rate (%)
MICS, 2000	4,821 women (15–49) 1,452 children (0–4)	urban, rural	all women	97
RHS, 2002	5,697 women (15–44) 1,740 men (15–49)	metro Tirana, other urban, rural	random selection of one eligible woman	94
LSMS, 2002 (panel 2003–4) (survey 2005)	5,775 women (≥15) 4,070 women (15–49)	mountain, coastal, central areas and Tirana; urban and rural	all women	unknown
MICS, 2005	5,091 women (15–49) 1,093 children (0-4)	urban, rural	all women	96
LSMS, 2008	3,839 women (15–49)	mountain, coastal, central areas and Tirana; urban and rural	all women	unknown
DHS, 2008	7,584 women 3,144 men (15–49)	mountain, coastal, central areas and Tirana; urban and rural	all women	98

Surveys are of particular interest as they gather extensive information about individual characteristics, living standards, etc. In general, surveys in transition countries are characterized by a low non-response rate level (less than 5%), which reinforces their capacity to describe correctly the demographic and social situation in those countries. However, the size of the samples sometimes does not allow precise computation of indicators referring to events with a low incident rate, e.g. deaths or births. For this reason, surveys should be regarded as a complement, rather than an alternative, to other demographic data sources.

RHS is one of the most relevant databases available for any attempt to understand questions concerning fertility, including reproductive health. The sample size (5,697 women and 1,740 men) included in this 2002 survey was large enough to allow for an analysis of

fertility issues. A RHS final report was subsequently published (Morris et al., 2005). According to our information, no other such demographic analysis has been undertaken and published based on these data. The sample of the DHS survey in 2008-9 is larger and provides richer information, especially what internal and international migration is concerned.

Other internationally standardized surveys also provide demographic information, but their sample sizes are less important statistically: as mentioned above LSMS has been organized three times and an additional panel was followed during the years 2002 to 2004. These data have been used extensively to analyse international migration (Carletto et al., 2004), as well as fertility patterns (Gjonca et al., 2008).

Albania recently organized a second demographic survey, DHS, implemented by INSTAT and IPH with technical assistance from ICF Macro and funding from UNICEF, USAID, MEASURE DHS, Swiss Agency for Cooperation and Development (SCD), UNFPA and WHO. The survey updates the trends identified earlier with a larger sample representative both at the urban and rural level and at the regional level.

Civil registration system

The civil register is a third source of demographic data. As in other countries, the civil register is in charge of the production of civil acts and also the collection of vital statistics. It includes births, marriages and deaths, registered in 408 Civil Status Offices (CSOs). Civil registration also includes a "Fundamental Register", a handwritten book recording every family and their legal residence in the locality. The definition of the family refers to that of a household, with some singularities: in particular, members of a family are defined according to filiation, marriage and adoption. Additional individuals may belong to the family if some conditions are respected. Finally, and more precisely, the size of place of residence in Albania should offer at least 4m^2 per person (Civil Status Law 8950, Art. 4).

A family can only transfer its legal place of residence after at least twelve months of residence in a new locality. Transfer of place of residence for one part of a family is possible only if there is official separation of one part or creation of another family (Civil Status Law 8950, Art. 2). According to the interviewees, these rules are interpreted in different ways by civil status officers. In particular, young adults are often registered in their parental household even if they live elsewhere.

Each vital event such as birth has to be registered in the municipality of *legal residence* (the place where the individual is registered in the Fundamental Register). Each event is recorded three times: in the Fundamental Register, in the specific register (birth, death or marriage) and in a questionnaire expressly set up for INSTAT for processing vital statistics. This questionnaire furnishes additional information for statistical purposes. Questionnaires are collected at each head CSO at the district level and are sent to INSTAT headquarters, where the data are computed (see Figure 1).

Modernization of the Civil Registration System is still in progress. One project for its modernization was initiated by Statistics Norway in 1999. The project proposal released in 2001 included a pilot project funded by the Norwegian Ministry of Foreign Affairs and the Norwegian Agency for Development Cooperation (NORAD). Meanwhile, a new package of laws (Civil Status Law, ID-Number Law and ID-Documents Law) was approved by the Albanian Parliament in 2002 and represents the legal basis for the project. Funding and technical assistance for the project are provided by a delegation of the European Commission through the CARDS programme, while its implementation is a responsibility of OSCE. A memorandum
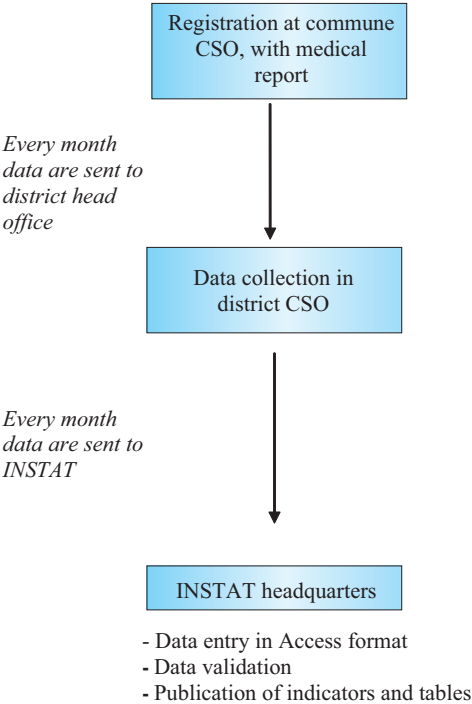
of understanding was signed in 2007 between OSCE and the Albanian Ministry of Interior.

The main objectives of this modernization are (1) to obtain an accurate list of voters for elections and (2) to elaborate a civil status registration system of "one registration and multiple uses". The main modifications to the system lie in geographical referencing of civil status data and a registration based on individuals rather than on families.

Additionally, all civil status and events books have been computerized and a new electronically centralized system is currently under organization with direct access for CSOs and specific access for data users in governmental institutions (not yet defined).

Albania faces difficulties in achieving exhaustiveness in regard of declaration of vital events. Some births are not registered, especially in rural regions and among young mothers (of age less than 20 years), but the main problem concerns registration of a death. The level of underestimation is high but varies among prefectures. Reasons for not registering a death include little knowledge of such an obligation, time required to do so and the immediate requirement to arrange the funeral rather than to undertake administrative procedures. Sometimes the reason is an attempt to continue to receive the pension benefit. Moreover, even if a cause of death is recorded on the register, the validity of the stated declaration is sometimes questionable, especially when the death occurs outside of hospital.

Figure 1: Vital statistics data-gathering procedure

Every month data are sent to district head office

Every month data are sent to INSTAT

Registration at commune CSO, with medical report

Data collection in district CSO

INSTAT headquarters

- Data entry in Access format
- Data validation
- Publication of indicators and tables

Such limitations in vital statistics lead to difficulty in computing life expectancies.

Demographic indicators

ADIS provides most of the data necessary for computation of relevant demographic indicators, even if the quality of data is not always optimal. Nevertheless, a gap exists between the information that is available and the computation of demographic indicators, which remains poor, as reported in Table 2.

The main reason for this gap is the absence of data regarding the yearly population living in Albania that are required in order to compute standardized indicators. Population by age and gender have not until now been computed on an annual basis. Population prospects established by INSTAT in collaboration with the Institut national d'études démographiques (INED) provided estimates for such structuring, but based upon hypothetically derived estimates of fertility, mortality and migration that are not always verified.

Due to the absence of yearly population structure, most published indicators are not standardized, hindering international and regional comparisons. Moreover, the infrastructure necessary for construction of indicators is poor (see Chapter 5).

Another problem arises from the absence of regional indicators, even if there is growing interest in the regionalization of demographic indicators (as our interviews suggest).

Table 2 lists the main demographic indicators, based upon the compendium of Eurostat Statistical requirements and the indicators published by the Council of Europe in their Demographic Yearbook. For each indicator, the data that are available in Albania are identified. The final column provides information on whether or not the indicator is regularly published in Albania. As can be seen, most of the data needed to compute indicators are available, but they are often not specifically published.

Annual population estimates

Two sources, the Census and the Civil Status Population Register, provide information on the size and structure of the population. The 2001 Census provides a precise description of the population and is a basis for population prospects (INSTAT, 2005), which reflect population trends according to different indicators.

The Fundamental Register provides annual information on the size of the population and the distribution according to gender. The estimate based on this register provides a different picture from the one offered by the last census. This can be explained by the difference in the definition of legal or de facto population. For instance, the size of Tirana (city) on 31 December 2001 was 43 per cent higher than the figure based on the 2001 (1 April) Census (Brunborg et al., 2004).

For the estimation of population trends, INSTAT refers to a hybrid method mixing population movements based on *legal residence* and population stock based on *usual* or *observed residence*. These population statistics refer to the handwritten information (population by gender, change of place of residence, births, deaths) sent by the local CSO to the district branch at the beginning of the month. Information is aggregated at the district level and sent to INSTAT headquarters each month. Based upon the population statistics at the date of Census, INSTAT uses the numbers of migrations, births and deaths in order to estimate the yearly population statistics by gender.

Therefore, the first step in the production of yearly population statistics consists in adding to Census-based populations the movement statistics forwarded by CSO, with both summarized at the regional level. The resulting figures are then compared with the regional population projections established by INSTAT (based on the 2001 Census and INSTAT, 2005) for the relevant year. If the difference is less than 15,000 inhabitants (representing the annual projected net migration), the computed number is considered as the international migration component of the balance. If the difference is higher, international migration is considered to be 15,000 persons and estimated population figures are consequently adapted. By gender only the yearly total population is available at both regional and national levels. Estimates by age cannot be computed with current internal migration data obtained from CSOs. INSTAT therefore relies on population projections for computation of age-standardized indicators.

Table 2: Availability of Demographic Indicators in Albania

Indicator	Data source	Published (yearbook)
Population (at national, NUTS 2 and NUTS 3 levels)		
Total population by gender and age (on 1st January)	Information only available from population forecasts estimated from 2001 Census	No
Total population by marital status, gender and age	Information available in 2001 Census	No
Fertility		
Total fertility rate (and fertility rate by parity)	Vital statistics Surveys also allow computation of TFR : RHS 2002 (national and urban/rural) and LSMS 2002–04, 05 (national and regional level)	National TFR only
Mean age at first birth or childbearing	Vital statistics Surveys also allow computation of mean ages: RHS 2002 (national and urban/rural) and LSMS 2002–04, 05 (national and regional level)	No
Completed fertility of cohorts	Census 2001, LSMS 2002 provide estimates of completed fertility	No
Mean age at first birth or childbearing of cohorts	RHS 2002 and LSMS 2002 provide estimates of mean age at birth, according to cohort	No
Proportion of births outside of marriage	RHS 2002	No
Prevalence of contraception	RHS 2002 provide estimates of prevalence of contraception	No
Legally induced abortions by age of mother	RHS 2002	No
Marriage and divorce		
Mean age at age of leaving parental home	LSMS 2002 allow computation of this indicator	No
Total (first) marriage rate	Vital statistics RHS 2002	No
Mean age at first marriage (rate-based)	Vital statistics RHS 2002	No
Proportion of ever-married by age 50	Census, various surveys	No

Mean age at first marriage in female cohorts	No	No
Total divorce rate, divorce by duration of marriage	RHS, Census	No
Mortality		
Age specific mortality rates and life expectancy (e^0)	Vital statistics	Only national e^0
Infant and child mortality rates	Vital statistics Information also available in surveys: LSMS 2002–04 (national, regional level and urban/rural), MICS 2005 (national and urban/rural), RHS 2002 (national and urban/rural)	Yes, national
Late foetal deaths by age of mother	RHS (still births)	No
Cause-specific mortality rates	Vital statistics	In numbers but not standardized
Migration		
Internal migration	2001 Census. LSMS 2002–04, 05 (national and regional level and urban/rural). LSMS 2008	No
Emigration	2001 Census. LSMS 2002–04, 05 (national and regional level and urban/rural)	No
Immigration	No	No
Immigration, emigration and net migration rate	No	No

Fertility rates

Total Fertility Rate (TFR) is calculated by INSTAT at the national level using vital statistics and the projected female population by age (INSTAT, 2005). Relevant indicators related to the calendar of fertility are not published, nor are the TFRs by parity. Data do not allow for estimation of fertility rates at the regional level.

Birth histories based on survey data complete these indicators by estimating period and cohort fertility under certain assumptions. LSMS 2002, and RHS 2002 and DHS 2008-9 record the entire fertility history of all women in selected households. The LSMS panel surveys carried out in 2003 and 2004 update the information on births, but the sample of women is too small to provide accurate estimates, especially at the prefecture level.

Mortality rates and life expectancy

Mortality rates and life expectancies at the national level are computed every year by INSTAT using vital statistics and projected population size by gender and age (from INSTAT, 2005). Only the number of cause-specific deaths is published. However, the quality of the declaration is unknown. No information about the cause of death is published, even if vital statistics would permit it.

LSMS 2002, RHS 2002, DHS 2008-9 and MICS surveys inform on infant deaths at the national and urban or rural level. Based on birth histories, infant and child mortality can be directly estimated.

Marriage and divorce statistics

INSTAT publishes every year the crude marriage rate and the mean age at marriage at the national level, based on vital statistics and yearly total population estimation. Total marriage rates are not computed, even if the necessary data are available (age at marriage and projected population by age and gender). Divorces are only published in terms of a figure giving the total number of divorces recorded.

Migration

Direct and indirect estimates for internal and international migration before 2001 can only be computed using the Census or LSMS 2002. For the period after the Census, LSMS 2005 provides extensive information on internal and international movements. The internal and international migration history of all present and former (children) household members, as well as of other family members, is documented. Furthermore, the socio-economic profile and legal situation of migrants abroad were also recorded. The census data have been extensively analysed with regard to migration (INSTAT, 2004), but no indicators on migration have been published by INSTAT since 2001.

How to improve ADIS

Albania currently faces a wide range of social and economic challenges, and requires valuable indicators to plan the needs of the population in terms of health care, education, etc. This is also true regarding demography, with huge changes in behaviour regarding family composition, fertility and migration. In this context of change, demographic indicators may help to understand demographic behaviours of the population and to monitor social and economic challenges.

A number of tasks with regard to ADIS has to be done in the next few years to construct a most informative demographic information system.

Improving the vital statistic register

First of all, INSTAT has to adapt its statistical system to bring it into line with the improvement of the fundamental register and registers of civil events.

Improvements include adaptation of the statistical form: for instance, during registration of a birth it would be useful to record the marital status of the mother, instead of only reporting the year of marriage. Moreover, place of birth (abroad or in Albania) should be recorded, as is currently the case for recording a death. Questions concerning economic status of the parents could also be reformulated in order to avoid misunderstanding.

Information on divorces should also be integrated into the statistical civil status system. This implies that information from the tribunals should be made accessible to INSTAT. Finally, contrary to other countries, data on foetal deaths are completely absent in Albania. It may be useful to gauge the possibility of gathering such data using information from the hospitals (see also health assessment).

Apart from the development and improvement of civil status registers, it is also important to check the quality of the declaration. In the context of assessment of ADIS (Lerch and Wanner, 2008), we had the opportunity to check data quality and identify some problems

regarding completeness of registration for each item, and quality of declaration of, for instance, cause of death. Our results indicated that there is incomplete declaration of deaths at both infant and old age in the northern and southern regions and of births to teenage women. An understanding of the factors that have led to this situation should also lead to an improvement in the quality of declarations. Information on the importance to register should be distributed among Albania's regions, where completeness is not observed, and among the social classes that do not register. It would probably be useful to check whether cooperation between Civil registration offices and the maternity hospitals, religious leaders and medical doctors could improve the registration, as has been observed for instance in Kosovo (Wanner and Lerch, 2009).

Finally, information allowing for harmonization of definition of the population (legal versus de facto) with other data sources should be an objective. Collaboration between INSTAT and the CSOs is therefore important in order to develop adequate solutions.

Developing migration statistics

In the 1990s, international migration involved at a minimum one in five Albanians, and the waves caught by surprise those in charge of statistics. Now, almost 20 years after the beginning of international migration, we still lack instruments to measure, and indicators of, migration. However, the 2001 Census provided some indicators of internal migration, mostly based upon place of residence twelve years before or one year before, indicators that underestimate international migration. Based upon census data, the numbers of Albanians abroad have been estimated (Ekonomi et al., 2004). However, prior to 2001, only surveys could provide realistic information on international migration, and more particularly on the Albanian diaspora. A measure of monthly or yearly flow is still missing.

Building capacities of analyses

INSTAT should also face the challenges of building a new demographic information system in the context of economic transition. Such a context leads to rapid staff turnover and competition between public and private sectors to hire the best statisticians, a challenge characteristic of all countries in transition. For these reasons, there is need for continuous demographic training.

Additional demographic data will shortly be collected. A Census is about to be organized and other surveys will also take place. INSTAT should participate actively in these surveys, not only in terms of organization of field work and sampling, but also in design of the questionnaire and valorisation of the data.

Analysing existing surveys and computing new sets of demographic indicators

Finally, there is a lack of analysis of demographic information, be it because surveys are not analysed in depth, or because indicators are not integrated into descriptive studies. This is particularly the case when one turns to focus on regions and their diversity. Moreover, some important demographic indicators (e.g. standardized fertility by parity) in the Albanian context are not computed, while age standardization in general could be developed systematically (i.e. relying on projections is better than having no standardization at all) in order to provide comparable estimates at the international level.

For this reason, it is necessary to develop analysis capacity. INSTAT itself is not in a position to be a leader in demographic research. What would probably be useful in this context is guarantee or reinforcement of collaboration between INSTAT and identified external experts (universities in Albania, European statistical offices, researchers outside Albania). This could be achieved by, for example, proposing grants for analyses. This approach will improve not only the scientific capacity of INSTAT but also, probably, the available indicators.

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Annex 1:
Definitions used in Albania

Concept	Data Source	Definition
Family	Vital statistics	Group of people related by blood, marriage or adoption who are registered—according to law—together in the fundamental register. Membership is based on legal residence.
	Census	Close family members (father, mother and direct descendants). Membership is based on usual residence.
Household	Vital statistics	Idem to family
	Census	Group of people living together in one dwelling and sharing a joint economy. Membership is based on usual residence. Members absent for less than 12 months who are expected to come back are also part of the household.
	Survey	Group of people living together in one dwelling and sharing a joint economy. Membership is based on usual residence. Absent members who were present during the last 12 months are also part of the household.
Birth	Vital statistics	Product of conception emergence from mothers body, independently from the period of gestation.
Live birth	Vital statistics	Complete emergence from mother's body, independently of the period of gestation, of the product of conception, which *respires* or manifests *other signs of life.*
Foetus death	Vital statistics	Complete extraction of a product of conception from mother's body, independently from the period of gestation, which—after this extraction—no longer breathes or manifests any other signs of life. A live birth is, however, considered as a foetal death if the weight of the foetus is less than 500 g, or (if information not available) its period of gestation was less than 22 weeks, or it measures less than 25 cm.

Source: INSTAT, 1996; INSTAT, 2001; survey documents

Annex 2:
Available variables in Albanian vital statistics

	Birth data	Death data
Place of marriage District, commune / municipality, town / village	**Place of registration** District, commune / municipality, town / village	**Place of registration** District, commune / municipality, town / village
Personal data of men and women	**General data about birth**	**Personal data**
Birth date	Birth date	Birth data
Place of legal residence (district, commune / municipality, town / village)	Gender of child	Date of death
Main income source (none, public, private, both or other)	Type of birth place (health institute, at home with / without medical assistance, other with / without medical assistance)	Gender
Level of education (in four levels according to number of school years)	Nationality	Age
Nationality	Type of birth (unique, twin, …)	Country of occurrence (Albania, abroad)
Civil status before marriage (single, widow, divorced)	Duration of pregnancy (in weeks)	Nationality
Marriage order	Weight at birth	Civil status
	Birth order	Level of education (in four levels according to number of school years)
		Main income source (none, public, private, both or other)
		Permanent usual residence
Data on the married couple	**Data on parents**	**Medical data**
Date of marriage	Date of birth	Place of death (at home, medical institute, other)
Place of legal residence of the new couple a) District, commune / municipality, town / village, or b) abroad	Level of education (in four levels according to number of school years)	Medical treatment before death (yes, no)
Number of children from earlier marriage	Main income source (none, public, private, both or other)	Primary, external and secondary cause of death
	Permanent usual residence of couple, or, if not married, of mother	
	Years of marriage of the mother	

2 Regional demographic dynamics in Albania

Mathias Lerch, Blerina Subashi, Majlinda Nesturi, Emira Galanxhi and Philippe Wanner[7]

Abstract

Albania experienced fast demographic changes during its political and economic transition. This chapter investigates regional differences in fertility and migration during the last twenty years and discusses their impact on population structures. In 1989, population mobility was very low while fertility as well as child mortality was highest in remote rural areas. Woman in the north-east had 4 children on average, whereas urban dwellers had less than three, particularly in the capital Tirana. Similarly to the 1980s, declining fertility during the 1990s was concentrated in peripheral regions because it still concerned higher order births. The first demographic transition has been completed around 1989 in Tirana, around 2001 in coastal and central regions and only recently in the north-east. Fertility further declined to subreplacement levels throughout the country in 2009. The one-child family model, as well as an emergent postponement of motherhood, seems to be diffused down the urban hierarchy, leading to very low fertility in cities. Child mortality declined by half between 1989 and 2005-9 but is still highest in European comparison and remains contrasted at the regional level. High international emigration since 1989 continued at a fast pace until 2009, particularly from the coast, and increasingly concerned the poorest regions as well. Whereas demographic profiles of the migrant stocks indicate the dominance of survival migrants from remote parts of the country, opportunity-seeking migration seem more prevalent in coastal and urban regions. Combined with low fertility, the emigration of young adults initiated a fast population ageing since 2001. However, the significant rural exodus replaced international emigrants and significantly inflated demographic reproduction in cities. Retained urbanisation under communism has therefore been caught up within the last two decades.

1 Introduction

The former communist countries in Central and Eastern Europe experienced rapid demographic changes during the decade prior to and, especially, after the fall of the Berlin Wall. Fertility collapsed in many countries to very low levels and the societies experienced a health crisis. Economic hardship and political unrest also led to unprecedented internal

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and international migration. In this regional context, Albania can be attributed a particular status both before and during its political and economic transition. During communism, the overwhelmingly rural society was completely isolated and maintained specific demographic behaviours. However, after the fall of the regime in 1990, demographic changes found elsewhere in the region were very pronounced in Albania.

Despite its small size, Albania's geography is diverse. Three million one hundred thousand people live in 28,748 square metres. In the west lies a coastal alluvial plain, containing the country's main agricultural and economic centres. The major urban agglomeration comprises the capital Tirana, located in the middle of the country, and the main sea port city of Durres on the Adriatic coast. In the hinterland, the mainly rural, mountainous and often with difficulty accessible terrain represent 70 per cent of the total area (this region is here referred to as the Centre). In the north-east, the mountains reach more than 2,000m above sea level. The physical, economic and political legacy have integrated specific territories into the remaining part of the country but isolated others. As a consequence, demographic behaviours have diverged among regions.

Socio-economic development was not only unevenly distributed in the past, but regional inequalities increased following the fall of communism. Population trends might therefore have become increasingly polarized. However, after more than 40 years of isolation, not only were Albanians granted the right to move freely, but also the formerly isolated regions came into contact with modern norms and values. Family behaviours may have changed and regional specificities disappeared.

Given Albania's geographic position, as a neighbour of the EU and part of the Balkans, international influences are diverse. To the north-east, the population of Kosovo and the Albanian minority in Macedonia share the same ethnic background, as well as similarities in long-term demographic trends, namely high fertility leading to demographic pressure. The Western Balkans also experienced considerable emigration after 1989. Across the Adriatic Sea and over the south-eastern mountains, Albanians went to Italy and Greece, the country's major commercial partners since 1989. Because they experienced lowest–low fertility levels in the 1990s (i.e. less than 1.3 per woman), these European Union member countries face a different problem, namely advanced population ageing.

The aim of this chapter is to investigate to what extent Albanian regions have differed in their demographic profile and behaviours since 1989. We take the 1989 Census as a starting point and estimate reproductive behaviours (Section 3) and population movements (Section 4) in 2001 and 2008 in order to provide a longitudinal perspective to recent estimates provided by INSTAT et al. (2010). These two components of demographic change—migration and fertility—strongly modified the age structure in the regions, presented in the following Section. Finally, the main regional trends are summarized and put in the transitional context. Some specific population issues are also highlighted.

For the purpose of comparability with the most recent available data, districts are regrouped into the four domains of survey estimates: urban Tirana (with 350,000 residents in 2001) and the coast (950,000) are distinguished from the north-eastern rural and mountainous region (350,000) and the remaining area, referred to as the centre (1.4 million; see Appendix). Estimates are also presented by prefecture as well as for urban and rural areas. Besides urban Tirana, the level of urbanisation is highest on the coast (43% in 2001), followed by the centre (33%) and the north-east (21%).

2. Regional population structures, the legacy of past demographic dynamics

The population pyramid discussed here is an essential tool for defining social and economic policies. Knowing the age and sex structure of regional populations is important for estimating and predicting their needs in terms of social services (schooling and day-care infrastructure, health institutions, etc.). Population pyramids also illustrate the share of dependent people that the working age groups have to support, and hence the demographic potential for socio-economic development. The larger the relative importance of working age groups in a population, the more income can theoretically be generated per inhabitant. If children and retirees make up a small share of the total population, income can be invested in production and used to increase the quality of social services (education, health, pensions) rather than to adjust their quantity.

Beside its importance for planning issues, the pyramid also traces the history of all birth generations composing a population. It has been affected by multiple historical events, leading to demographic changes that transformed the regional age and sex structure presented here. The underlying demographic dynamics are discussed in depth in the later sections.

Regarding the general shape of the pyramids prior to 2001, the four Albanian regions represent different schematic stages in the demographic transition (Figure 1). The age structure of a pre-transitional population, in which people have many children and die earlier, is indeed changing with the modernisation process. Consequently to increasing living standards and health conditions, deaths are postponed to older ages, broadening the pyramid through prolonged survival. Compared to this earlier mortality decline, fertility decline tends to lag over time as family behaviours have a social inertia. During this demographic transitional phase, the combination of high fertility and low (infant) mortality leads to population growth and widens the base of the age pyramid. The age structure then has a pyramidal shape. Once fertility decreases towards the replacement level for a certain period (i.e. each couple reproduces itself numerically in having 2.1 children), the base of the pyramid of the post-transitional population narrows and the overall form becomes more regular in successive decades. The north-eastern Albania and the Tirana-city populations stand, respectively, for these two extremes regarding age structure in this universal and secular process, if we consider the year 1989. The coastal and central populations can be placed in the last stage.

The population structure in the north-eastern mountains maintained a clear triangular shape until 2001 (Figure 1), indicating the persistence of high birth rates during the 20th Century. Even if the number of children declined considerably among women born after Wold War II, decreasing infant mortality sustained the effect of relatively high fertility in increasing the number of survivors at older ages. The population is consequently very young with more than a third aged less than 15 in 2001 (against a fifth in Tirana).

The earlier fertility decline in urban Tirana, and to a lesser extend in coastal–central regions, explains the more regular shape of the pyramid until 2001. If one ignores the hollows discussed later on, the recent birth cohorts are hardly more numerous than the older ones. However, the combination of sharply declining fertility in recent years together with persistently high international emigration levels transformed the age-sex structure until 2008–9.

A first hollow is hardly visible at the top of the population pyramids (Figure 1). There is a sex imbalance with more women than men at older ages. While differential mortality according to sex is clearly a determinant factor (on average men die earlier than women), the

male cohort born in 1920–25 also suffered excess mortality during the Second World War. The second hollow, among the generation born during World War II, aged 55 to 59 in 2001, was a typical birth deficit due to disruption or postponement of childbearing among the preceding generations (aged 70–90 in 2001) and can be explained by the civil disorder at that time. Indeed, the subsequent widening of the pyramid at lower ages illustrates the recuperation of the delayed births. Falkingham and Gjonca (2001) highlighted that in no other European country has the post-war baby boom began from such a high fertility level (i.e. 6.1 children per woman in 1950).

Another major hollow is due to the absence of young emigrant adults in all regions. Since the outflow concerned primarily men, they became less represented among people aged 15 to 39 years (on average 91 per 100 women in 2001, compared to a ratio of 106 at birth). The imbalance between the sexes is more marked in Tirana (91) and the coast (88), compared to the central (97) and the north-eastern region (99; see Figure 2). This can be explained by higher internal immigration of women, accentuating the females' overrepresentation due to the emigration of men abroad. Despite the high levels of emigration during the 1990s, the old age dependency ratio stayed relatively constant until 2001, because fertility was so high in the past that numerous child cohorts continuously entered the labour market.

Figure 1: Age and sex structure of the regional populations in Albania, 1989, 2001, 2008–9
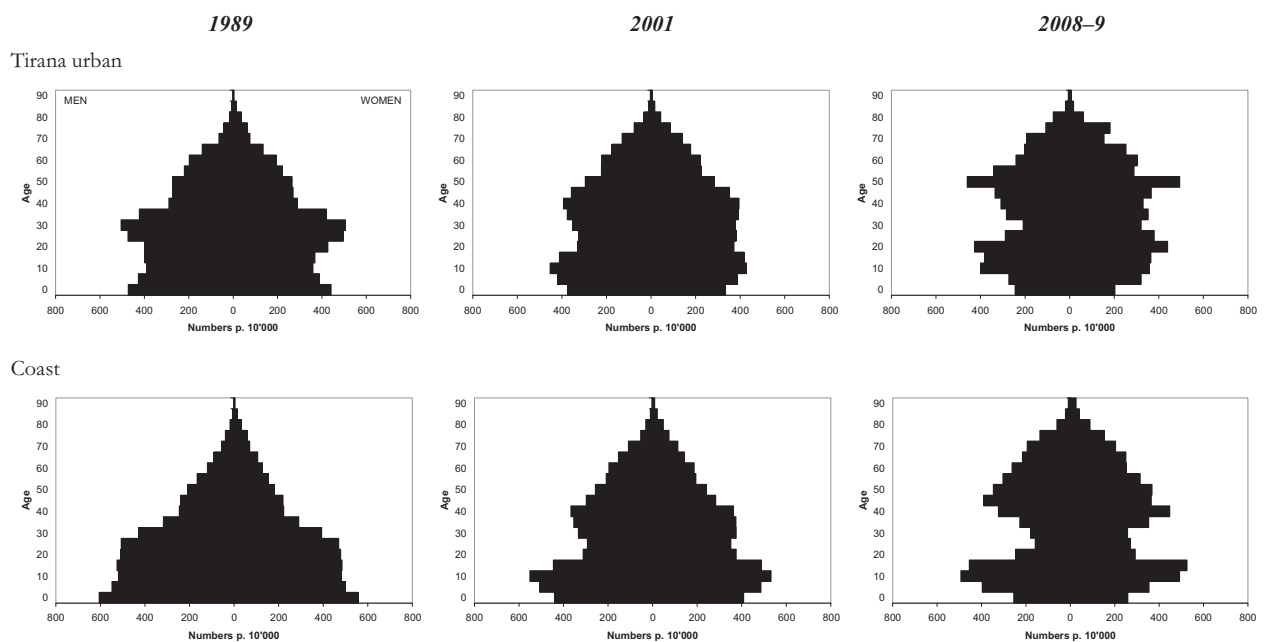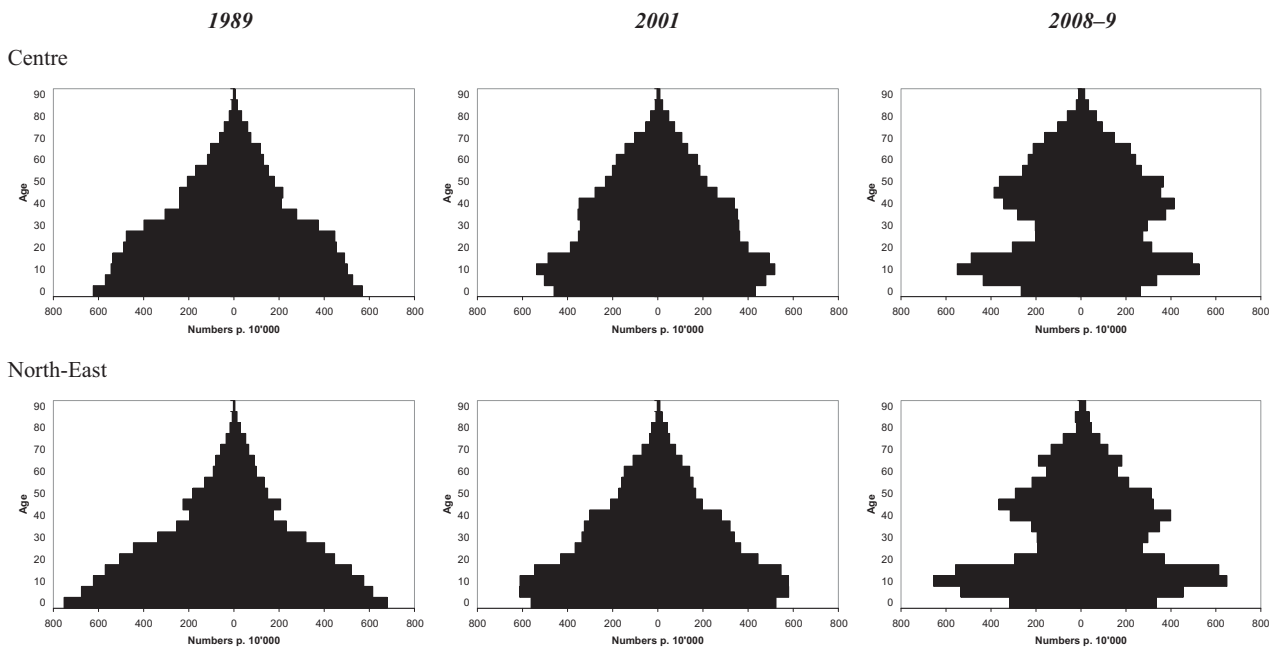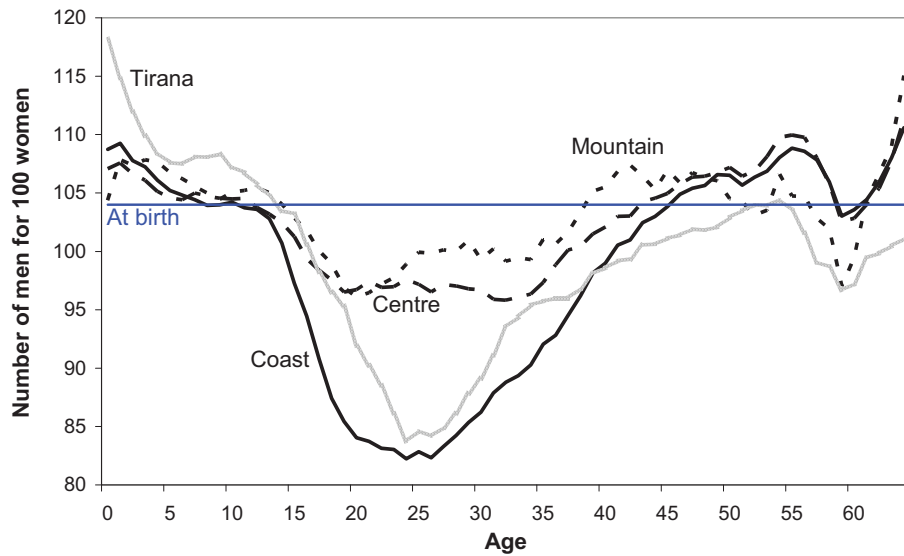

Figure 1 (cont.): Age and sex structure of the regional populations in Albania, 1989, 2001, 2008–9

Centre

North-East

Source: Population Census, 1989, 2001; DHS, 2008–9 (weighted numbers).

Figure 2: **Sex-ratio of Albanian regional populations by age, 2001**

Source: Census, 2001.

    With the continuing international outflow, the hollows among the young adult cohorts strongly deepened between 2001 and 2008–9. Meanwhile, the pyramids become wider on the top as more numerous birth cohorts, who benefited from declining adult mortality during communism, reach retirement age. Old age dependency increased consequently between 1989 and 2008-9 from one to two individuals per ten Albanians in working age (see also Table 1). The coast experienced the most critical situation in this regard: emigration was so

high[8], that an individual aged 65 years and over could only be supported economically by five individuals of working age in 2008–9.

Table 1: Regional indicators of the age-structures, 1989, 2001, 2008–9

		Coast	**Centre**	**North-East**	**Tirana**	**Total**
Population	1989	1,058,250	1,465,082	411,278	247,807	3,182,417
	2001	957,493	1,411,004	348,197	352,581	3,069,275
Young age	1989	0.51	0.55	0.70	0.36	0.54
dependency	2001	0.46	0.46	0.58	0.36	0.46
(0–14 / 15–64)	2008–9	0.35	0.37	0.48	0.26	0.36
Old age	1989	0.08	0.09	0.08	0.09	0.09
dependency	2001	0.12	0.12	0.10	0.13	0.12
(65+ / 15–64)	2008–9	0.22	0.18	0.15	0.18	0.19
Labour force	1989	2.12	2.04	2.29	1.60	2.05
renewal	2001	1.43	1.60	2.08	1.26	1.54
(15–39 / 40–64)	2008–9	0.88	1.00	1.22	0.99	0.98

Source: Census, 1989, 2001; DHS, 2008–9

In contrast, the dependency of children declined strongly in all regions because of the recent fertility decline under the replacement level. Departure of young adults further contracted recent birth cohorts, since a certain number of children have been born outside of Albania or joined their parents abroad. Whereas children were half as numerous compared to adults in coastal and central regions in 1989, they represented just a third in 2008–9. Young age dependency has always been lower in Tirana because of its historically lower fertility level.

Another effect of international emigration is the ageing of the work force. Young adults were twice as numerous as those aged 40 to 64 in 1989. After 20 years of emigration these two working age groups are about of equal size; the latter even outnumbers the former along the coast.

3. Regional reproductive behaviours during the last stage of Albania's fertility transition

Compared to the rest of the European continent, including the Balkans, Albania's fertility transition—i.e. the shift from a high to a low number of children—is lagging behind by 15 years (see Sardon, 2000). Between 1938 and 1945 demographic reproduction was close to the biological level (i.e. in the absence of birth control) and limited by high mortality among pregnant women and particularly their children (Dumani, 1995, citing Misja et al., 1987). If the average number of children per woman was persistently higher than in Europe until 2001, the decline was impressive during the second half of the 20th century (see Figure 3). After an initial post-war rise to a maximum value of 6.8 children per woman in 1960, fertility steadily decreased to three births on the eve of the political and economic transition in 1990 (Falkingham and Gjonca, 2001).

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[8] And mortality perhaps relatively lower compared to other regions.

Figure 3: National period fertility (TFR) and mean number of children ever born to female cohorts enumerated in 2001 (by region)

Birth cohort & approximate year when reached mean childbearing age
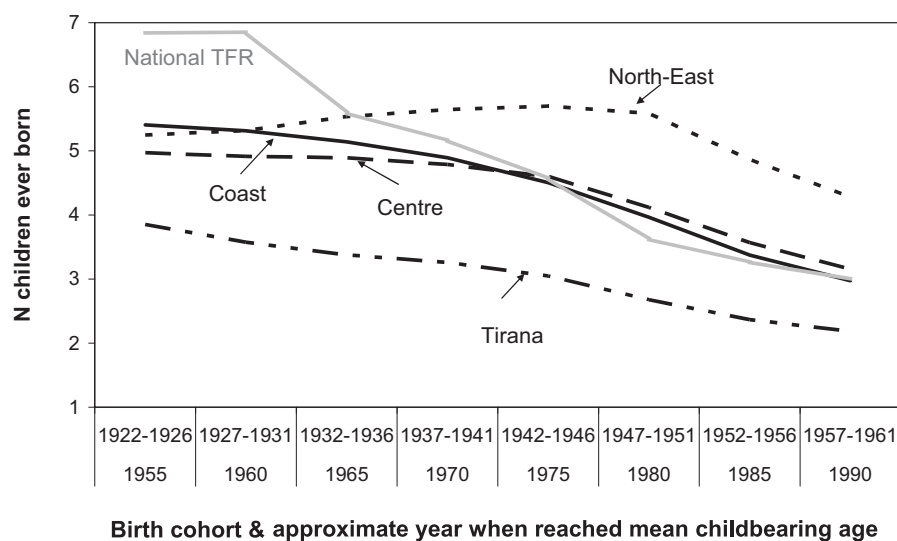
Source: Census, 2001; Falkingham and Gjonca, 2001

The most recent census provide some insights into regional fertility regimes of the past, approximated here by completed fertility of successive birth generations enumerated in 2001 (Figure 3). Women born in 1922–26 were in their main childbearing age in 1955 when period fertility was highest (6.8 children per woman), while the last cohort born in 1957–61 reached this stage in 1990 when women only had three children on average. Regional fertility differences are insignificant in the 1922–26 generation (about five children per woman), except for women in Tirana who had one child less by the end of their reproductive life. The decline started several decades earlier than in the remainder of Albania, exemplifying the pioneering role of the capital in the decennial fertility transition. It continued however at a similar pace compared to other regions. If the 1945 and subsequent generations in Tirana had fewer than three children at age 40, this threshold has not yet been attained in the rest of Albania. Cohort fertility declined last in the north-east. The last birth generation, which is about to reach the end of its reproductive age span at the time of the census, still counts more than four children per woman against three in coastal and central regions.

The decline in the number of children during communism resulted from a "stopping behaviour" without modern contraceptive means. Females limited the number of children once they had a desired family size, leading to a compression in childbearing within a restricted age interval (between 20 and 29 years). It has to be underlined, that this evolution occurred in a pro-natalist environment, characterized by several indirect measures favouring childbearing, including maternity leave, free clothing and health services for children, and specialised infant and child care (Gjonca et al., 2008).

The spectacular increase in female education—and more generally the improved female status[9]—under communism was one of the principal factors behind Albania's fertility transition (Falkingham and Gjonca, 2001). The proportion of higher skilled women increased from four per cent among women born in the mid-1920s to two-fifths among those born around 1960 (Figure 4). Moreover, whereas cohort fertility decreased substantially among low-skilled

[9] The communist regime indeed implemented policies aiming to break up the traditional patriarchal family structures in emancipating women among others (Dumani, 1995).

women born after 1945 (from 5 to 3.5 children), those holding a post-obligatory diploma were characterized for several decades by a fertility level near to replacement. Thus, the historical fertility decline in Albania was achieved by evolution in both the spread of education and the decline in the number of children born to women who remained less skilled.

This explains why the fertility decline during the 1980s was particularly important in rural areas (Dumani, 1995). However, it occurred essentially within marriage as Albania is characterized by early union formation and near universal entry into motherhood. Cultural marriage patterns were historically different between Western and Eastern Europe: people married late and definitive celibacy was high on the West of Hajnal's fictive line St. Petersbourg–Trieste, while on the eastern side union formation occurred early and concerned almost everybody. Whereas socialist policies sustained these divergent patterns by housing allocation policies and incentives for childbearing, different social phenomena led to a continuing increase of age at first marriage in Western Europe since the mid-1960s: individualisation, aspiration for self-realisation, and other major factors of the so-called second demographic transition. Labour market constraints also encouraged later family formation.

During the economic and political hardship in the transition years, fertility limitation at higher parities (e.g. number of children already born) was generalized among Albanian couples. Nevertheless, marriage remained early (at age 23 years) and universal, and was immediately followed by the first birth (Gjonca et al., 2008). The Balkan region did not experience a significant postponement of marriages and first births observed since the 1990s in the more developed CEE countries (Hungary, Slovakia, Czech Republic, Poland; Sobotka, 2003). The Albanian fertility rate nevertheless dropped from 3 to 2.3 children between 1989 and 2000–1. Last estimates from the Demographic and Health Survey (DHS) indicate an on-going trend as the mean number of children per woman fell below replacement level (1.6) in 2006–9.

Figure 4: Cohort fertility according to educational attainment & proportion of higher skilled females in different birth cohorts
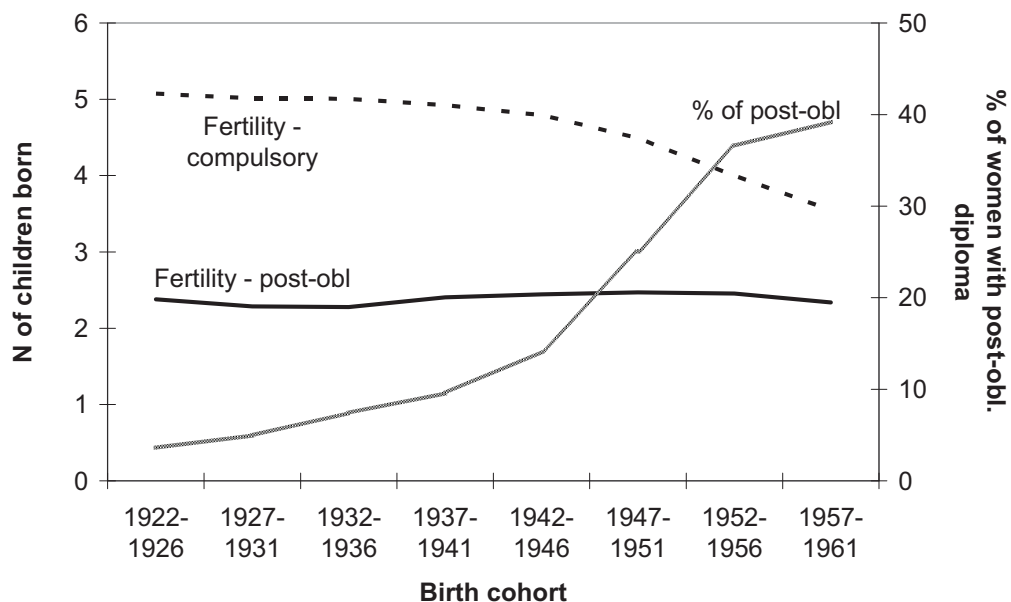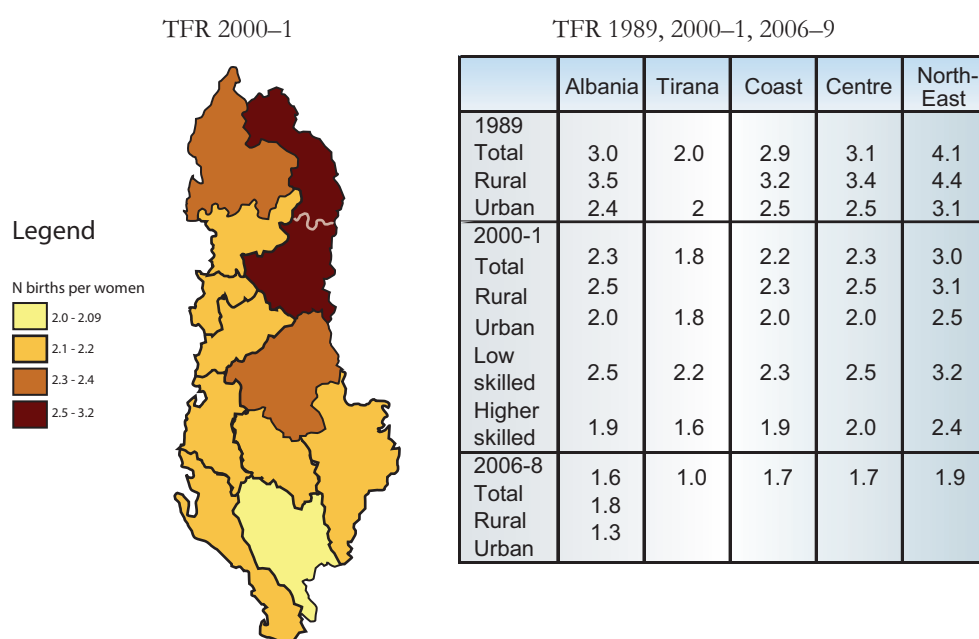

Source: Census, 2001.

The next Section investigates the most recent stage of the Albanian fertility transition (1989–2009) from a period and regional perspective.

Different family sizes but similar regional calendars of family formation

Period fertility by region is estimated here indirectly from the 1989 Census using the national rate and regional child-female ratios, and from the womens' own children at the 2001 census (see Cho et al., 1986)[10]. After 20 years of economic and political transition, the spatial fertility gradient has not changed, though it is less marked (see Table-Figure 1).

Table-Figure 1: Total fertility rate according to place of residence and educational attainment in the regions of Albania, selected years.

TFR 2000–1

TFR 1989, 2000–1, 2006–9

	Albania	Tirana	Coast	Centre	North-East
1989 Total	3.0	2.0	2.9	3.1	4.1
Rural	3.5		3.2	3.4	4.4
Urban	2.4	2	2.5	2.5	3.1
2000-1 Total	2.3	1.8	2.2	2.3	3.0
Rural	2.5		2.3	2.5	3.1
Urban	2.0	1.8	2.0	2.0	2.5
Low skilled	2.5	2.2	2.3	2.5	3.2
Higher skilled	1.9	1.6	1.9	2.0	2.4
2006-8 Total	1.6	1.0	1.7	1.7	1.9
Rural	1.8				
Urban	1.3				

Legend

N births per women

- 2.0 - 2.09
- 2.1 - 2.2
- 2.3 - 2.4
- 2.5 - 3.2

Source: Census 1989, distribution of national TFR in prorate of regional child–woman ratio; Census 2001, own children; INSTAT, 2010, for 2006–8

Whereas the number of children was historically highest in the north-east (more than four children per woman in 1989), this region experienced the sharpest fertility decline during transition. As with Kosovarian and Albanian women in Macedonia (SOK and UNFPA, 2005; Brunnbauer, 2010), women had on average three children in 2000–1. Similarly to the 1980s, the decline was stronger in rural Albania, as women had 1.3 children fewer in 2000–1 than they had twelve years before. The average number declined further to less than two children in 2006–9.

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[10] Whereas regional estimates for 1989 have been obtained by distributing the national fertility level in prorate to the child–woman ratio, estimates for 2000–01 are based on the women's own children (Cho et al., 1986). They have been matched to their mothers present in the same household and family nucleus in 2001. By providing the age of the mother at the time of birth, conventional total fertility rates can be calculated—i.e. births by age of mother divided by the number of females by age. The numbers of births during the year previous to the census and females at mid-year have been estimated by reversed survival based on life tables from WHO for 2000. Fertility differentials may, however, be underestimated since the same infant and adult mortalities have been applied across all regions. Some specific bias may further result from the fact that Albania has experienced high levels of emigration. Children whose mother is not in the household at enumeration may therefore be matched to the wrong woman in the household. Furthermore, there was some confusion about the concept of household during census enumeration, and this may also impact on the reliability of the information regarding "family nucleus". We control these potential biases in adapting the matching algorithm (use of information on relationship to household head, parity and age) and in limiting analysis to the twelve-month period prior to the survey.

The situation was different in the rest of the country. From three children in 1989, couples were just replacing themselves in 2000–1 (2.2 children), and under-replacement levels were already observed in urban areas. The population in the capital experienced the lowest fertility for decades. Starting from only two children per woman in 1989, the level stayed almost constant until 2000–1. Immigration of women from peripheral regions, characterized by a higher fertility level, explains this surprising stability (Lerch 2010, see also Section 3). More recently, however, Tirana women have become characterized by similar lowest–low fertility levels observed elsewhere on the European continent form the 1990s on (1 child in 2006–9). Fertility also dropped under the remplacement level in southern Albania, especially in the historical cities of Korçë and Gjirokastër, where women benefit traditionally from higher levels of education and infants from lower mortality.

Whereas fertility decline in rural areas between 1989 and 2001 was double that in cities, the number of children fell to the same extent in both areas during the subsequent decade. The first decade was indeed characterized by a drop in higher order birth rates, which were more prevalent in rural than urban areas. In the last decade, however, the postponement of family formation might also have played a role, as the widespread drop in fertility to subreplacement levels indicates for rural and urban areas alike (respectively 1.8 and 1.3 children in 2006–9). When women delay births, traditional measures of age-specific period fertility can indeed drop temporarily to very low levels, but may rise later on when births are recuperated at older ages. Low fertility seems to have been diffused along the urban hierarchy until 2006–9.

A significant fertility differential also exists with regard to educational attainment, as evinced between women who have at best completed two years of secondary school and those with a higher diploma (four years of secondary school or more). Whereas the former had 2.5 children in 2000–1, the latter had only 1.9. This educational gradient is similar across regions, except in the north-east where it is more pronounced (0.8 children). Thus, whatever the educational level, a similar regional gradient just described is still apparent, with highest fertility in the north-east, followed by lower rates in central and coastal regions, and finally Tirana. The low fertility of higher educated women in the capital in 2000–1 (1.6 children) illustrates their pioneering role in the Albanian fertility transition.

Regional fertility by birth order

Differentials in regional fertility do not concern all birth orders, as evinced by true period parity transition ratios[11] in 2000–1 (Table 2). The life-time probability of entry into motherhood does neither significantly differ across regions (85%), nor between urban and rural areas. This may point to an important influence of social or cultural norms valorising motherhood throughout Albania. Compared to 1990, when motherhood still was universal, the country seems either to be experiencing a retreat from universal marriage or a postponement of the entry into motherhood, leading to depressed first birth intensities during the observation period.

Regional disparities become important at higher parities. The probability of having a third and fourth birth declined respectively by about 10 and more than 20 percentage points compared to 1990 (see Falkingham and Gjonca, 2001). Interestingly, the one-child family model was diffused in the capital as early as 2000–1: only 38 per cent of women having already one child enlarged their family with a second one compared to two-thirds across the whole country.

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[11] Period parity progression ratios estimate, under current fertility patterns, the probability of transition from one parity to the next, i.e. the probability of having a first child for women without children (the probability of having the second one for women of parity one, etc.). It is obtained here as the ratio of successive age-parity specific birth probabilities and measures the importance of family enlargements conditional on the number of children already born.

This low fertility seems to prevail to a lesser extent in all urban areas (48%). Transition rates from the second to the third birth, as well as from the third to the fourth, are also lower in the capital (respectively, 24% and 20%, against 44% and 29% at national level) and other urban places in the south. Indeed, a mother's double burden that results from childrearing and employment may be particularly high in economically more developed regions. Employment in the private sector is more frequent, but provides lesser social benefits than in the public sector: e.g. maternity leave of six months is not always guaranteed. Furthermore, western influence from Italy and Greece—where the one-child model has prevailed since 1990—may be strongest in central places of the Albanian economy.

Table 2: Period parity progression ratios by region, 2000–01

PPPR	Total	Rural	Urban	Coast	Centre	North-East	Tirana
parity 1	0.85	0.86	0.84	0.84	0.86	0.87	0.84
parity 2	0.62	0.73	0.48	0.61	0.62	0.85	0.38
parity 3	0.44	0.54	0.32	0.43	0.43	0.71	0.24
parity 4	0.29	0.31	0.22	0.24	0.29	0.45	0.20

Source: Census 2001, own children. Note: based on age-parity specific birth probabilities

North-eastern Albania illustrates another contrasting situation, as the two- and three-child family model remained widespread until 2000–1: 85 per cent and 71 per cent of women having had, respectively, one and two children further enlarged their family. Traditions and family-oriented gender roles that valorise high fertility are historically more prevalent in the north-eastern mountains. Furthermore, the north is the poorest region in Albania though regional disparities have declined since 2002 (World Bank, 2007). A larger number of children may represent an increased demand for family workforce on a household's agricultural plot, as well as financial security in older age. Similarly to past fertility trends, coastal and central regions still lay between the two extremes in 2000–1.

Standardized timing of family events across regions

If regions differ in the average number of children couples have, the timing of these family events is surprisingly homogenous across the country, with childbearing beginning relatively early (at age 24; Table 3). Interestingly, the timing of the first birth did not change significantly following the end of communism: between 1950 and 1989, the age at first birth rose slightly, to 24.5 years (Falkingham and Gjonca, 2001). The onset of motherhood occurs on average one year later in Tirana and other urban places (at age 25), and the postponement of family formation may begin to diffuse from these central places in Albanian society.

Contrary to early first births, second births are significantly postponed in 2000–1, occurring on average five years after the first one (at 29 years of age) against three years in 1989. Third and fourth births are born at a 3- and 1.5-year interval, respectively. The high regional standardization of the family events calendar could indicate the importance of social norms in regulating family formation and enlargement in Albania.

Table 3: Mean age at marriage and birth by order, women 2000–01

Mean age at birth	2001							1989*
	Total	Rural	Urban	Coast	Centre	North-East	Tirana	Total
parity 1	24.1	23.7	24.7	24.3	23.9	24.2	25.0	24.5
parity 2	29.0	29.1	29.5	29.4	29.1	28.5	29.7	27.2
parity 3	31.7	32.1	32.0	32.2	31.8	31.3	32.1	29.6
parity 4	33.3	33.5	33.5	33.7	33.5	32.7	33.6	31.4

Source: Census 2001, own children; Falkingham and Gjonca, 2001, for 1989. Note: based on birth probabilities by parity and age

Persistent regional infant mortality disparities

Albania experienced a major health transition during communism. Characterized by the lowest average duration of life (life expectancy) in Central and Eastern Europe in 1950, the country performed among the best in adult survival in 1989. The progress, however, has not been linear. After major improvements during the 1950s, when malaria was eradicated and the country benefited from technical and sanitary assistance from the USSR and Eastern European countries, progress slowed with increasing isolation, particularly during the 1980s (Meksi and Dalla Zuanna, 1994). The Mediterranean diet and a healthy life style due, paradoxically, to material deprivation, have been advanced as determinants for the good health of the Albanians (Gjonca et al., 1997).
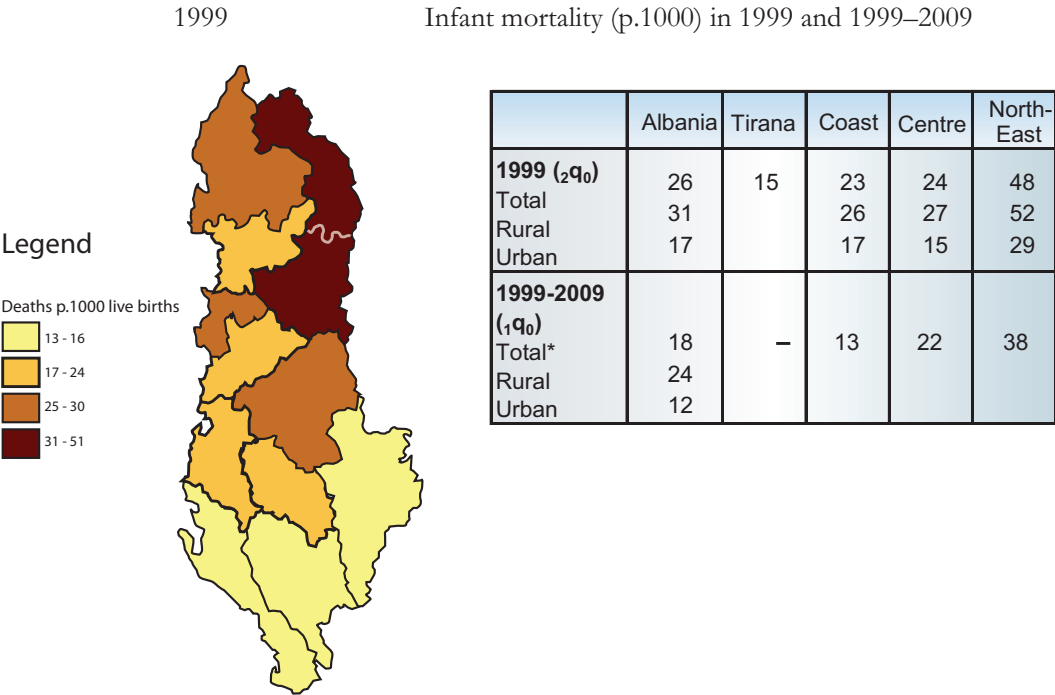
During the years of transition, adult mortality temporarily increased for men and stayed constant for women. According to INSTAT, life expectancy reached 72 years for men and 79 for women in 2001–5. Thus, Albania fared well compared to other transition countries characterized by increasing mortality during the 1990s. Indeed, adults aged 45 years and older had a similar mortality level to those in Italy, despite the gap in socio-economic development between these two countries (INSTAT, 2004b). However, the transition period changed the way of life, with the spread of new unhealthy and risky behaviours, including increased smoking among women, introduction of motorized vehicles, etc. From almost non-existent during communism, accidental death represented eleven per cent of all causes of mortality in 1997[12]. Albania is now increasingly characterized by a Western mortality pattern, with 70 per cent of deaths due to man-made degenerative diseases in older age (cancers and cardiovascular diseases). The increase in concentration of mortality in this age group is a challenge for a mainly primary health care system. It does not yet meet the new needs of an ageing population and lacks the necessary funds to update the medical technology (Gjonca, 2001, 2007).

An important achievement under communist rule was the diminution of child mortality by a factor of three throughout the country. The change was particularly marked in the north-east, where mortality is historically highest: in 1960, in Kukës and Tropojë, more than one child in three died before their fifth birthday against one in twenty in 1989 (Gjonca, 2001). Even if large improvements have been achieved, infant and child health are still the worst by Balkan or European standards. Nevertheless, the decline to two per cent by 2005–9 is important.

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[12] Mainly car accidents and homicides during the political turmoil.

We limit our regional analysis to infant mortality, estimated here indirectly from the last Census (using Brass's method[13]: UN, 1983). The estimated risk of dying before the 2nd birthday in 1999 was very close to infant mortality rates derived from survey data gathered in 2000 and 2002, but is higher than official figures from MOH for 2001[14]. Since the survey estimates refer to a long period characterized by a sharply declining infant mortality, the real rate may be somewhere in between.

Table-Figure 2: Probability of dying before 2nd birthday in 1999 and infant mortality during 1999–2009, Albanian prefectures and regions.

1999 Infant mortality (p.1000) in 1999 and 1999–2009

Legend

Deaths p.1000 live births
- 13 - 16
- 17 - 24
- 25 - 30
- 31 - 51

	Albania	Tirana	Coast	Centre	North-East
1999 ($_2q_0$) Total Rural Urban	26 31 17	15	23 26 17	24 27 15	48 52 29
1999-2009 ($_1q_0$) Total* Rural Urban	18 24 12	–	13	22	38

*Source: Census 2001; INSTAT et al., 2010, for 1999–2009. Note: 1999 indirect estimate using Brass's method (implied from Coale-Demeny South Model) based on children ever born and surviving to women aged 20–24; * refers to the period 2005–9*

According to the estimates from the Census, regional differentials in child survival have not changed since 1945 (see Gjonca, 2001; Table-Figure 2). Even if the overall level is much lower, prefectures in the south count fewer than 20 deaths per 1,000 live births, while the highest levels (more than 30 deaths before age 2) are exclusively found in north-eastern Albania. As with fertility, Kosovo is characterized by a similar infant mortality in 2003 (SOK and UNFPA, 2005).

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[13] The indirect estimation is based on the necessary relation between the mean number of children ever born to a woman and those surviving until enumeration. The difference must be a function of the level of and exposure time to mortality. Since exposure time can be approximated by the mother's age and a model fertility schedule, the level of mortality can be estimated from the reported numbers of children born and surviving. The method assumes however that mortality was constant during the years immediately preceding the Census. Since Albania experienced a steady decline, the indirect estimates may therefore overestimate infant mortality in 1999.

[14] The national estimate from the Census is 26 deaths per 1,000 live births against 26 from RHS, 28 from MICS and 16 from the Ministry of Health.

The 2001 census do not provide the necessary data for the estimation of mortality by sex, but estimates based on adjusted vital statistics in 1997 indicate a gender differential (28 per 1,000 male, and 35 per 1,000 female, births died before age one; Gjonca, 2001).

Results from the Living Standards Measurement Survey (LSMS, 2002) confirm this regional gradient in health condition: people in the north-east more often reported being in a poor or very poor physical condition. The pattern of illness is typical in situations of material deprivation, with respiratory diseases representing an abnormally high proportion (INSTAT, 2004c). Furthermore, the distribution of primary health practitioners revealed a certain inequality across districts, especially after controlling for the population's needs and consultation rates (Gini index of 0.30 in 2000; Thedorakis et al., 2005).

From the above it appears that living in cities has a beneficial impact on child survival, though inequalities may exist. Mortality is lowest in Tirana (15 per 1,000) followed by central and coastal towns (under 20 per 1,000). The threshold of 30 deaths before the 2nd birthday is only exceeded in rural north-eastern areas (see Table-Figure 2). Child health has further increased over the past decade, particularly in rural areas (falling from 31 to 24 per 1,000 births).

Population mobility from and between Albanian regions

During the transition from communism to democracy and a market economy, population mobility increased strongly as it represented a major reaction of the Albanians to the free but changing and insecure environment. The sudden openness of both district and national borders provided the Albanians the incentives and opportunity to move from village to city or to neighbouring European member countries. Employment opportunities and living standards are higher in these locations and the attraction of foreign countries had already been formed during communism: the idea to migrate may have arisen through watching Italian and Greek television, which though illegal was technically possible at that time. After almost 20 years of transition, two fifths of Albanian households have at least one former member living abroad and one fifth count a former member in another place within Albania (INSTAT et al., 2010).

The factors driving emigration were probably similar for both types of geographic mobility: limited access to basic needs, a situation which is compounded in rural areas facing high demographic pressure. Additional to material conditions, increasing isolation in the countryside when compared to the communist period, may have further given a push to migrate (Darques, 2004). Under central planning, income was redistributed within the country, economic linkages between urban and rural areas were more developed and city dwellers had to undertake stays in the countryside. With the opening of borders and Albania's integration into the international community, however, urban locations became the prime focus of economic activity, especially the Tirana–Durres urban corridor. Isolation also has its own dynamic: depletion of professional services in rural areas encouraged more emigration into cities, traditionally associated with a higher status in the Albanian psyche (Pojani, 2009).

The next section summarizes the existing knowledge of internal and international population movements within and from Albania. The age and sex structure of different types of migrant stocks are then estimated for 2001 and 2008. This additional information provides insights into not only the social dynamics underlying either type of population mobility, but also their impact on regional population structures. Whereas population mobility during the 1990s was estimated using the inter-census residual method, the relative stock of migrants in 2008 was provided by the most recent LSMS. Estimates for the latter period should therefore be confirmed by the next Census.

Internal population redistribution

In the initial years of communist industrialisation and restructuring in the 1950s, internal migration increased sharply. The dominant movements originated from the peripheral north-eastern and south-eastern highlands and headed towards Tirana and the coastal lowlands. But urbanisation stagnated in 1965, in parallel with improved living conditions and the benefits of social policies in rural areas (e.g. extension of pension schemes, school and day-care centres; Sjorberg, 1989). Indeed, interregional allocation of the labour force by the government, as well as restrictions by means of a domestic passport and residence permit, controlled and limited rural exodus. Despite a zero urban-growth policy, unregulated migration nevertheless existed and significantly contributed to the growth of the urban population, especially during the 1980s. Because of higher natural growth in rural areas, however, the urbanisation rate remained stable between 1960 and 1990 (30–36%[15]). Moreover, some rural–urban migration was diverted to surrounding agricultural areas, as illegal immigrants had restricted access to ration books and housing in cities (Sjorberg, 1992, 1994).

During the transition years, internal population mobility dramatically increased: a quarter of Albanians aged 15 years and more lived in a different commune in 2001 than they did twelve years before and more than half of them crossed district borders. Migration peaked in periods of political turmoil and economic crisis, as during the first democratic elections in 1991–2 and the 1997 financial crisis (World Bank, 2007). Interestingly, the geography of the migration flows after communism resembles the patterns prior to 1990. Young people left the predominantly rural highlands in the inner part of the country and increased the working population in the cities, as well as their immediate rural territories, mainly around the capital and on the west coast. Interregional flows were dominated by females (73 men per 100 women in the last census), as in the 1980s: the overrepresentation of women in cities has been attributed to regional allocation of the female work force and marriage migration, traditionally undertaken by a bride re-joining her husband and his family (Sjoberg, 1994).

As a consequence of the population redistribution during transition, half of Albanians lived in urban areas in 2008 according to latest LSMS estimates. The population of the major urban agglomeration, Tirana, almost doubled between 1989 and 2001 and represents twelve per cent of the Albanians (INSTAT, 2004). Urban primacy became one of the strongest in the Balkan region: there is no secondary city in the national urban hierarchy, but several much smaller urban places (Arvanitidis and Petrakos, 2008).

The ascendency of Tirana in the national urban system, as well as its attraction for internal migrants, is due to several factors. In the initial years of independence and central planning after WWII, the country's political capital was transferred from Durres to Tirana, at that time a small village located in the centre of the country. If the geographical shift was motivated by public health concerns (presence of malaria infested marshes), it also represented a political affirmation of nationhood since Durres was considered a symbol of former Italian dominance over the country. Later on, with the closure of Albania's borders and the interruption of cross-border activities over 30 years, the historical cities Korçë and Shkodër (located respectively near the south-eastern and north-western borders) found themselves in a peripheral position unfavourable for development (Sivignon, 1975). Moreover, cross-border relations and economic activity in the Balkan area has remained limited following the fall of communism (except in the south of Albania, where a significant Greek minority live). Since 1989, Tirana and the coast has attracted the majority of enterprises and foreign direct investments in the country.

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[15] During communism, every place with (new) administrative or industrial infrastructure was defined as an urban location (Darques, 2004). Even where an urban status reflected the demographic reality prior to 1989, the important depopulation of peripheral regions during the 1990s challenges the classification and asks for a reassessment of the definition in Albania (see the last article in this volume).

Contrary to many developing countries, housing conditions of immigrants in peri-urban and rural adjacent zones are relatively comfortable, though this situation has really improved in the end of the 1990s. The new houses are often larger and better built than the old buildings in the city. But they were poorly equipped with urban infrastructure. Internal immigrants settled near urban centres and had no choice other than to construct informally. The vacant urban parcels were either state land or open to claims for property restitution. Agricultural land, however, has been distributed among the population and transferred by private owners to the informal occupants. Given that these areas were for agriculture purpose, the municipalities did not allocate them urban infrastructure (roads, transport networks, waste water channels, etc.) until 1997, when the formalization of informal constructions began (World Bank, 2007).

International migration from Albania

Whereas labour migration was permitted in former Yugoslavia, leaving the country was considered a crime and punished by the death sentence in communist Albania. Hardly anyone moved out between 1945 and 1989. With the political change in 1990, the Albanians were granted a passport as well as the freedom to move freely, while the economic crisis drove a major part to emigrate in order to find a new livelihood.

Various attempts have been made to estimate the emigrant stock since 1989. They converge on a fifth of the population having left the country between 1989 and 2001 (see Carella et al., 2004 for a comparison of estimates). Similar to internal movements, the major loss is concentrated among young adults, aged 15–45 years (INSTAT, 2004). Whereas the outflow was initially dominated by men, it became more gender balanced at the end of the 1990s: four men left per woman in 1992, a ratio that fell to 2.4 in 1999. The strong male dominance in the initial years can be explained by the fact that most movements were undertaken illegally and were physically arduous and dangerous (by foot over the mountains to Greece or by boat across the Adriatic Sea to Italy; Gjonca, 2000). Following the male emigrants' settlement abroad, family reunifications increased and today represent a major part of the flow to these countries. This evolution is linked to progressive regularization of illegal immigrants in Italy and Greece at the end of the 1990s.

Regarding the regional selection of migration, Zezza et al. (2005) provide total stock estimates of international and internal migrants by district using a simple balancing equation between estimated deaths, births and internal net migration over the inter-census period 1989–2001. Once these demographic events are added to and subtracted from the district populations enumerated in 1989, the resulting "closed" population (since international migration is not considered) can be compared to the observed population at the 2001 Census. The difference provides an estimate of the international net migration stock. The mountains and rural north-east were particularly affected by internal movements and many people headed directly to the Tirana–Durres area, while the coast is the major international emigration zone. Agorastakis et al. (2007) used a more refined method for backward projecting the 2001 population (aged 12 years and more) and compared the aggregated results with the enumerated total in 1989, the residual being the emigrant stock. Those authors show a more homogenous geography of international outflows, with somewhat higher shares in the extreme south (including urban districts such as Korçë) and the coast. Moreover, some northern districts not only experienced high internal but also high international emigration (Figure 5).

Figure 5: Relative internal and international emigration and internal immigration by district (in % of 1989 population), 1989–2001

International emigration (%)   Internal emigration (%)   Internal immigration (%)
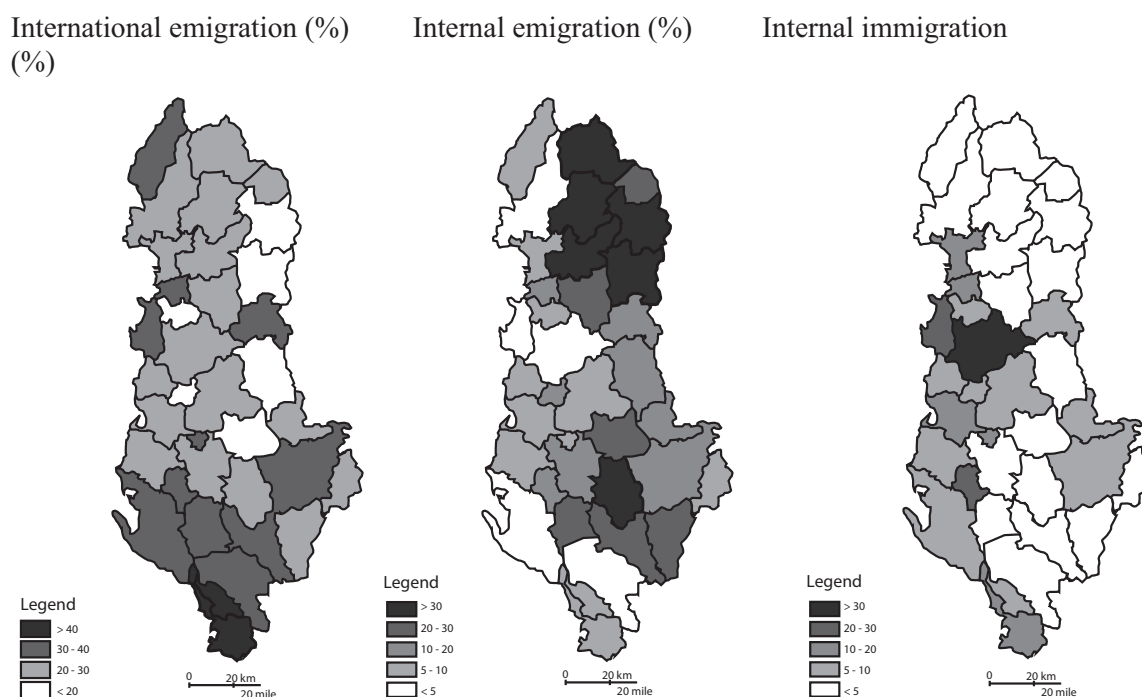
Source: Agorastakis et al., 2007

However, available information concerning the timing of the above-mentioned phenomenon is contradictory. Azzari and Carletto (2009) estimated annual emigration of children and spouses reported by surviving family members who participated in the 2005 LSMS[16]. These figures indicate a record flow in 1997, followed by a subsequent decline. However, comparisons of different indirect stock estimates for the 1990s provide a different trend (see Carella et al., 2004): between 1989 and 1992 alone, 220,000 Albanians left the country. During the period 1995–1999, an estimated 140,000 Albanians moved abroad, indicating a decline before the 1997 banking crisis and a subsequent recovery in the late 1990s. It is, difficult to assess time trends with these stock estimates, as well, since an important share of migrants departed and returned to Albania several times throughout this time.

Regional migrant stocks by age and sex and their impact on population structures

The population pyramids in Figure 6 illustrate our estimates of migrant stocks by age and sex in 2001. We adopted for each region a similar method to the one used at the national level (INSTAT, 2004a), but consider both international and internal mobility from and between regions.
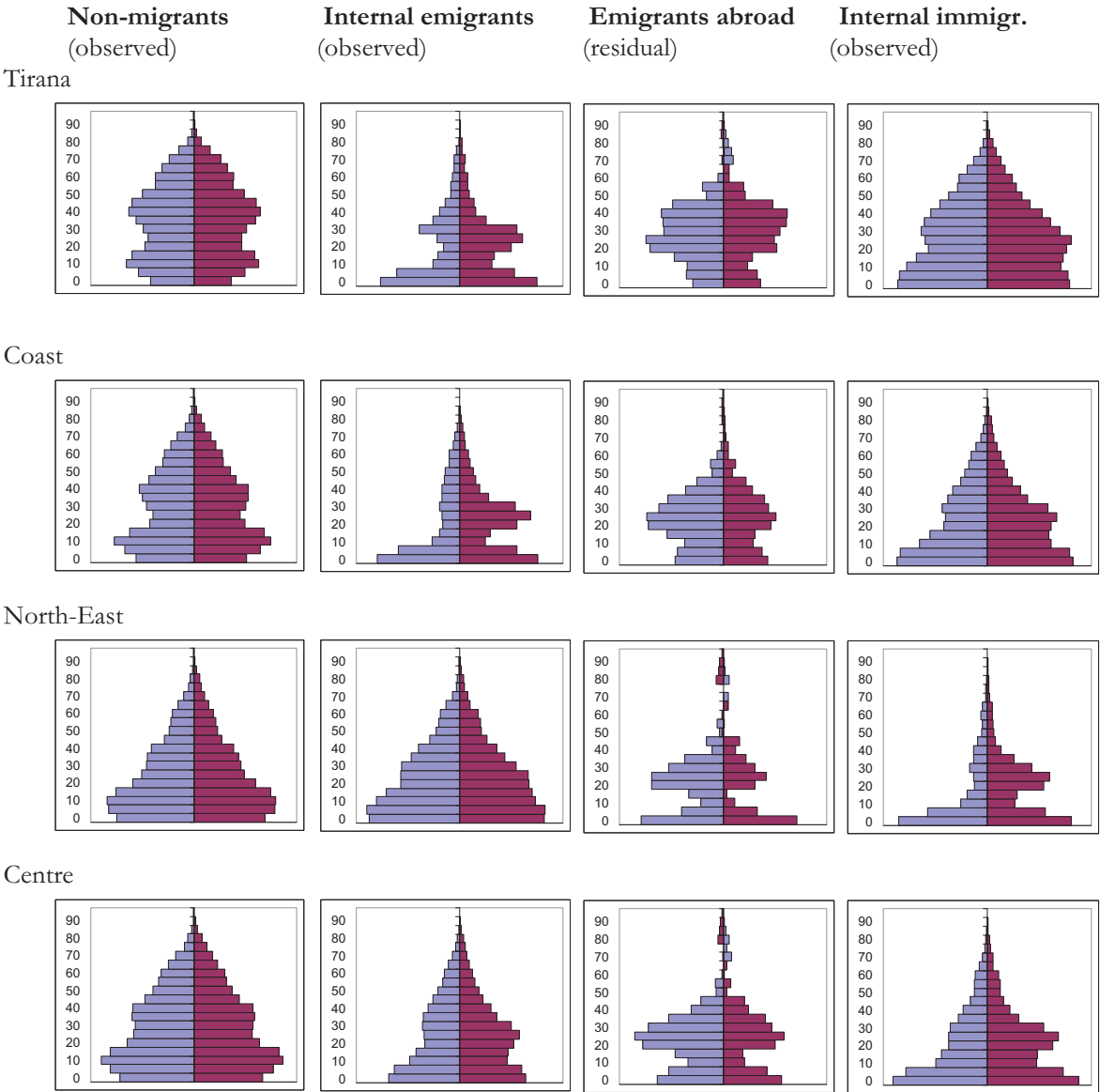
Table 4 reports the share of internal and international migrants among the population that originated from a given region—i.e. all (children of) individuals who lived there in 1989—and would have been present in 2001 had there been no mobility during the inter-census period.

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[16] This estimate, based on the absentee approach, is susceptible to bias, particularly when computed from proxy-information provided by parents without correction for the prevalence of orphans. Parents of emigrants may have died following the departure of their children and in several cases there might be nobody left to report the absence of a former household member (particularly when whole families have left). See also the note in the appendix for more discussion on LSMS survey estimates.

This reference population is estimated in forward projecting the 1989 population under the hypothesis of sealed regional borders, as well as specific assumptions regarding mortality and fertility trends between 1989 and 2001 (see Appendix). The residual between this projected "closed" population and the observed number of both non-migrants and internal emigrants (enumerated at the last census) represents the net outflow abroad. Internal immigrant stocks were enumerated at the census and are expressed here in per cent of the same reference population in order to analyse replacement effects. Similar stock estimates of movers between 2001 and 2008 are provided by the last LSMS survey (Table 5; see also Appendix).

The estimates for 2001 confirm the high prevalence of internal emigration from north-eastern Albania, representing more than a quarter of the population aged less than 65 who originate from this region. Comparatively, international emigration "only" concerned ten per cent. The departure to other places within Albania concerned whole families, as evinced by a relatively equal participation of both sexes, as well as of different age groups. The high poverty level in this area drove whole families to leave. The broad base of the pyramid also indicates high fertility among these internal movers. International flows, in contrast, were largely dominated by males, particularly among young adults (2 men per woman). The form of their population pyramid indicates a departure of large families as well, even if the broad base could be due to the projections' hypotheses that may overestimate fertility among international migrants. Internal inflow from other Albanian regions is negligible, but the high overrepresentation of women and very young children point to traditional Albanian marriage patterns: the bride is re-joining her husband to found a family. Whereas recent internal moves seem less important, compared to the preceding decade (only 8% between 2001 and 2008), the survey data indicate a continuing trend of international emigration (8% of young adults). However, northern regions seem to have become more attractive than in the past, since immigration of individuals aged 15–34 years - almost absent during the 1990s - increased to seven per cent after 2001. This inflow may be composed of returning migrants.

Figure 6: Estimated age and sex structure of non-migrant, internal and international emigrant and internal immigrant stocks in 2001, by region

	Non-migrants (observed)	Internal emigrants (observed)	Emigrants abroad (residual)	Internal immigr. (observed)

Tirana

Coast

North-East

Centre

Source: Censuses 1989 and 2001. Note: age is plotted on the vertical axis, males on the left (blue), females on the right (red).

Table 4: Inter-census (1989–2001) migrant stocks in Albanian regions, 2001

Age group (years)	Relative migrant stocks by age (in % of total internal and international emigrants and non-migrants)				Sex-ratio of migrants (number of men per 100 women)			
	Coast	Centre	North-East	Tirana	Coast	Centre	North-East	Tirana
Internal emigration								
0–14	5	10	26	5	106	106	108	103
15–34	3	9	26	3	35	71	94	49
35–54	2	8	26	1	81	105	108	105
54–64	2	8	27	1	111	114	102	102
International emigration								
0–14	27	16	11	14	116	125	121	107
15–34	40	22	14	22	152	161	209	135
35–54	28	14	9	18	127	125	139	95
54–64	16	4	2	8	105	99		97
Internal immigration								
0–14	13	7	2	70	106	105	104	109
15–34	10	5	1	56	74	66	34	83
35–54	7	3	1	36	104	99	80	106
54–64	7	3	1	35	115	101	105	108

Source: Census 1989 and 2001

Table 5: 2001–2008 migrant stocks in Albanian regions, 2008

Age group (years)	Relative migrant stocks by age (in % of total internal and international emigrants and non-migrants)			
	Coast	Centre	North-East	Tirana
Internal emigration				
15–34	0	3	8	1
35–54	2	2	7	0
55–64	2	6	2	0
International emigration				
15–34	22	16	8	9
35–54	3	3	2	2
55–64	0	0	0	0
Internal immigration				
15–34	14	11	7	19
35–54	5	3	3	12
55–64	2	0	2	13

Source: LSMS, 2008. Note: direct declaration of internal migration (n = 191 aged 15–64 years), proxy declaration of international migrants by household heads

A similar gender and family pattern in population mobility is also found in the centre of Albania. Internal emigration concerned entire families, but represents a smaller part

(10%) of the population than would have been found in 2001 had regional borders remained closed during the 1990s. As in the north-east, women were also more represented among the movers within Albania (7 men per 10 women). In contrast, international emigrants are mainly composed of men (16 per 10 women), though less strongly than in the north-east. They headed towards Greece and were selected among young adults. A fifth of those aged 15–34 years were estimated to be living abroad in 2001. Population mobility continued to be important among young adults until 2008, especially to foreign destinations (16% went abroad since 2001).

As expected, the most important losses due to international outflows are found on the coast, where the selection according to age was strongest: around two fifths of the population aged 15 to 34 who originate from this region lived abroad in 2001 (mainly in Italy). And the outflow seems not to have ceased, as another fifth of young adults left between 2001 and 2008. The emigration stock is dominated by males to a lesser extent than in the more rural and remote regions discussed above (15 per 10 women in 2001). The coast is also an attractive destination for internal migrants, representing ten per cent of the young adults in 2001 who originate from that area. The inflow apparently intensified in recent years (14% among young adults). As exemplified by the triangular shape of the immigrant population pyramids in 2001 and 2008 alike (see Figure 6 and 7), the new residents came with their families and had a much higher number of children compared to those who always lived along the coast. Internal immigration thus inflates birth rates along the coast. The counter-flow to places outside the coastal region was almost negligible and mainly concerned females characterized by a high number of children. This again indicates a specific interaction of migration and marriage patterns leading to traditionally large families.

While international emigration from Tirana was similar to that from central regions, the capital stands out as the main internal migration magnet. Arrivals from other regions account for more than half of the population aged 15 to 34 in 2001 that would have lived there if regional borders had been closed. Contrary to other regions, internal inflow not only replaced the out-migrants, but led to a strong population increase in Tirana. Recent estimates indicate an on-going trend in internal inflows as well as international outflows until 2008, representing respectively 19 per cent and nine per cent of the hypothetically closed population since 2001. Moreover, the immigrants' offspring make up 70 per cent of all children born to individuals who originate from the capital. Thus, the same phenomenon found at the coast is particularly pronounced in Tirana: whereas non-migrants are characterized by very low fertility (as evinced by the sharply shrinking base of their age pyramid in Figure 6), highly fertile women coming from other regions settled in the country's main city and inflated birth rates. However, the demographic profile of the internal immigrants seems to have changed in recent years. As indicated by the similarly broad base of the non-migrants and immigrants age-pyramids in 2008 (plotted in Figure 7), they indeed seem now to have a fewer number of children compared to migrants who preceded them during the 1990s.

Coast   Tirana
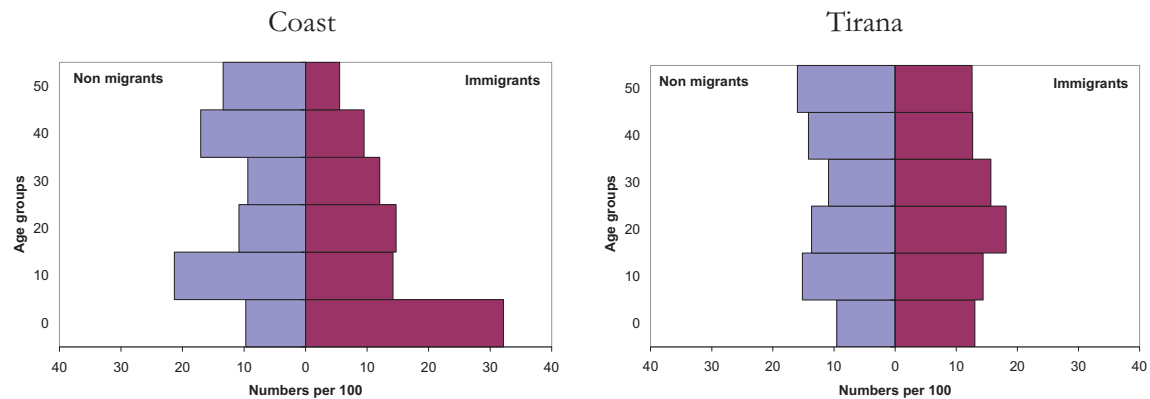
Another similarity to migratory dynamics at the coast is the strong selection of international migration according to age: more than a fifth of young adults originating from the capital were estimated to be abroad against less than 15 per cent among other age groups. Interestingly, the share of women was highest compared to the rest of Albania (135 men per 100 women), while children have a much lower emigration rate, too. International outflows from Tirana may therefore concern more couples or single men and women.

Several conclusions can be drawn from these estimates. In remote areas, emigration was a major security valve during transition as indicated by the traditional male-bread-winner migrations abroad and the movements of either highly fertile women or whole families within Albania. Since the share of the elderly among the origin population is low, the effect was neutral in terms of demographic dependency: adults departed and their numerous children were born and now live in the destination regions. The internal movers headed towards urban centres, where fertility is traditionally lower. Immigrants inflated the lower birth rates in these regions, especially in Tirana, where immigrants clearly outnumbered international emigrants, and at the coast (see Lerch 2010). Thus, internal migration seems to redistribute not only the labour force but also demographic reproduction within the country, and therefore contributed in a direct and indirect manner to the fast urbanisation in transitional Albania. International outflows, in contrast, have been more selective, particularly from central places in the Albanian economy. The movers' profiles point to an ''opportunity seeking emigration'' related to educational and working opportunities abroad, rather than to a ''survival migration'' involving whole families pushed by economic hardship as in the north-east and centre.

Recent trends indicate an on-going international outflow, especially from the coast, as well as a higher participation of the remote north-eastern region in the phenomenon. The internal migrants' destinations have also diversified, a phenomenon already observed in 2000-1 (INSTAT, 2004a). Besides the traditional migration magnet Tirana, the coast progressively seems to attract recent movers and therefore experiences similar direct and indirect effects found during the 1990s in the capital, i.e. the replacement of those who left for abroad and the inflation of regional birth rates. But since these last estimates are based on a survey (i.e. the number of internal migrants is small), they should be confirmed with the next census.

Summary and conclusions

On the eve of its political and economic transition, Albania was characterized by contrasting demographic regimes at the regional level. The mean number of children per woman was consistently highest and health conditions worst in the remote and mountainous north-east. Because of the late onset of the fertility transition at the end of the 1970s, the population's age structure had a triangular shape with high potential for future demographic growth. In more urbanized regions, however, the historical fertility decline started in the middle of the 1960s, or even well before in the case of the capital Tirana. The young birth generations became less numerous and the age-sex structure had a more regular shape in 1989.

With the fall of one of the most extreme forms of socialism, the country entered a new arena of demographic change. The Albanian exception, exemplified by the highest fertility level on the European continent for more than half a century, ceased. Fertility declined over the last 50 years due to the spread of education and the declining number of children among women who remained poorly skilled. The country completed its first demographic transition at the beginning of the 21st Century and now seems to follow, at a fast pace, the European trend, leading to lowest–low fertility levels. The decline to 1.6 children per woman in 2008–9 had indeed been anticipated for 2021 (INSTAT, 2004b). Decennial trends in infant mortality also continued with a sharp decline to half the 1989 level.

With the opening of regional and national borders, unprecedented population mobility developed especially among men. Since women and families made up an increasing share of recent flows, Albanian emigration seems to have followed a common pattern of labour migration found in the 1960s to 1980s in other southern European countries (Bonifazi, 2004), but once again at an accelerated pace. The retained urbanisation under communism has also been catched up as half of the population was estimated to be living in cities in 2008, compared to only one third in 1989. The pace of this rural exodus, as well as its strong focus towards the capital, is comparable to the Greek experience in the 1950s (Darques, 2004).

The last twenty years, during which these changes took place, may be schematically separated into two distinct phases, similar to other CEE countries (see Philipov and Dorbitz, 2003). During the 1990s, the fall of the former system led to an economic and institutional crisis, exacerbated in Albania by riots against the governmental infrastructure, political unrest and a financial crisis in 1997. Major segments of the population were impoverished and regional inequalities increased. Half of rural households had no running water or sanitation inside the house against a majority with such services in urban areas in 2002. Poverty rates, as well as the poverty gap, were twice as high in the north-east compared to central and coastal regions, and particularly the city of Tirana (World Bank, 2003). Fertility decline and emigration provided in this context a Malthusian check and security valve in lowering demographic pressure on scarce resources and in providing to the remaining population better living conditions through remittances. The money sent by Albanians abroad indeed represented up to a fifth of annual GDP during the 1990s. However, demographic responses seem to have been relatively contrasted at the regional level in the first decade of political and economic transition.

Similarly to the 1980s, fertility decline was more important in rural areas and particularly the mountainous north-east because it concerned primarily higher order births. Birth limitation was probably associated with material constraints. Moreover, the north-east contributed to a lesser extent to the outflow abroad until 2001, because households may not afford international mobility (Zezza et al., 2005). When emigration was affordable, however, men

were in the overwhelming majority to move and, later on, managed to reunify their families. But most northern families moved within Albania. Population movements from central regions were characterized by a similar gender and family pattern, indicating their importance for the survival of the family. Zezza et al (2005) argue that internal movements relocated poverty within the country, particularly in or near to main urban centres.

The geographical position of the more urbanised coast, as well as of the districts on the southern border, predisposed these areas to be the main contributor to emigration abroad. These regions also benefited intensively most from remittances (Lerch and Wanner, 2006). Contrary to predominantly rural regions, emigration from urban areas concerned mainly young men and women without families. The equal gender participation was particularly pronounced in the outflows from Tirana, probably indicating a greater importance of pull factors. Young city dwellers may have been more attracted by pull factors, such as educational and professional opportunities, than pushed by severe poverty. The estimation of demographic profiles of migrant stocks by educational level would provide more evidence on this issue. The capital and the cities of Korçë and Gjirokastër were also the first places in Albania where fertility behaviour observed in the neighbouring European Union countries emerged. Since 2000-1, the one-child family model started to be diffused and women waited somewhat longer before having their first child. More developed educational and professional opportunities probably explain the vanguard position of these urban areas in the trend towards postponed and lowest-low fertility. Furthermore, extensive transnational ties with emigrants may also have played a role in the transformation of family behaviours (Lerch 2009).

On the eve of the 21th century, Albania entered a second transitional phase of political and economic consolidation. The percentage of households living under the poverty line was half as high in 2008 (12%) compared to 2002. The country experienced a regional convergence of living standards, though much of this evolution is attributed to an increasing inflow of migrant remittances into poor areas (World Bank, 2007). Transport infrastructure has been developed and now links remote regions to central places of the Albanian economy and society.

Concomitant to these changes, regional differences in demographic behaviours weakened and may vanish in the future. The last decade has been characterized by a relative homogenisation in fertility and infant mortality levels, with similar declines in urban and rural areas alike. Very low fertility is now observed in all cities and may spread in the future to peripheral rural regions. Indeed, the north-east experienced a fast catching up of its delayed fertility transition, as the average number of children declined to 1.9 in 2006–9. The inhabitants of this region have also participated increasingly in international emigration, which has become as important as internal departures since 2001. Recent estimates indicate an on-going pace of international outflows at the national level as well, particularly from the coast.

These demographic trends have strongly affected the age and sex structure of the regional populations in Albania, as they have in other Western Balkan countries (Mrdjen and Penev, 2003). Besides the rapid ageing of the work force, Albania shifted from a critical situation—characterized by young age population pressure—into a new area of population ageing since 2001. Old age dependency strongly increased, but an even larger number of individuals will progressively reach retirement age in the next ten to 20 years. The elderly have until now been prevented from falling into poverty, because they have benefited from remittances. However, current lowest–low fertility does not assure the reproduction of already depleted cohorts of working age, questioning the sustainability of the ageing process. The situation is most critical in urban areas, though internal inflows of young adults have partly attenuated the trend. Immigrants not only fill the gaps due to departures among the urban work force, but also have a larger number of children than non-migrants. They have consequently inflated urban fertility rates and, therefore, contributed indirectly to the fast urbanisation in Albania.

While the present analysis has provided a snapshot of demographic changes in Albania's regions, it raises several questions that remain unanswered. We have not considered adult mortality trends here because of data limitations, though they will become increasingly important for regional age structures in the future. Furthermore, the percentage of women who enter motherhood declined to a similar lower rate across all regions between 1989 and 2000–1. Is there a widespread adoption of fertility postponement under way? The absence of regional differences raises questions of whether the motives could differ according to the social group, i.e. economic uncertainty against new opportunities and value change. The recent change in internal migration patterns is also worth further investigation. We have observed an increase in the attractiveness of the coast, experiencing a similar inflation of births rates found in Tirana during the 1990s. The profile of immigrants into the capital, however, seems to have changed, with highly fertile women and entire families being less represented. Do "survival" migrants increasingly favour secondary cities on the coast, whereas the primary city now mainly selects movers looking for new educational and economic opportunities? This destination shift could also indicate increasing step-wise migrations before leaving the country (see King and Vullnetari 2003).

Despite the importance of the living context (urban–rural) and educational attainment in shaping fertility behaviours, the same regional gradient persists among social sub-groups, even if it has become much less marked compared to the past. In particular, the population in the north-east appeared less advanced in its demographic transition up until 2001, as in neighbouring Kosovo as well as in the Albanian minority in Macedonia. Do cultural factors play a role? Deslondes (2004) favours a historical explanation in arguing that socialist policies aiming to redistribute economic activity and income between regions failed to integrate the North in the national economy. Northern districts were also traditionally opposed to the centralized regimes perceived as foreign dominance. With the restrictions on internal migration, the population was further isolated in the county's topography and maintained specific demographic behaviours. The lower living standards in the region may have also increased the importance of large family structures that favours reproduction. More traditional gender roles—combated by the communist regime—also play a role, as they not only were more developed in the past in that region but also re-emerged during transition (Fischer, 1999). Recent estimates confirm, however, the coming to an end of regional peculiarities.

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Appendix

Domains of estimation (LSMS and DHS Regions): districts and major cities in the domains of estimation.

Region	Districts in the region	Major cities	Other urban cities
Region 1 Coastal area	Lezhë, Kurbin, Kavajë, Mallakastër, Lushnjë, Delvinë, Sarandë, Durrës, Fier, Vlorë	Durrës, Fier, Vlorë	Lezhë, Kurbin, Kavajë, Mallakastër, Lushnjë, Delvinë, Sarandë, Durrës
Region 2 Central area	Devoll, Kolonjë, Pogradec, Mirditë, Pukë, Malesi e Madhe, Mat, Kuçovë, Skrapar, Krujë, Peqin, Gjirokastër, Permet, Tepelenë, Shkodër, Elbasan, Berat, Korçë, Tirana (rural)	Shkodër, Elbasan, Berat, Korçë	Devoll, Kolonjë, Pogradec, Mirditë, Pukë, Malesi e Madhe, Mat, Kuçovë, Skrapar, Krujë, Peqin, Gjirokastër, Përmet, Tepelenë
Region 3 Mountain area	Kukës, Has, Tropojë, Bulqizë, Dibër	no major cities	Kukës, Has, Tropojë, Bulqizë, Dibër
Region 4 Tirana	Tirana urban, Tirana other urban		

Methodological note on the estimation of internal and international migration stock in 2001 and 2008

Internal out- and in-migration stocks at the end of the inter-census period (1989–2001) can readily be estimated from the 2001 Census. For children born during this period, the migration status of their mother is imputed. International emigration is estimated by forward projecting the 1989 populations by age and sex until 2001 in assuming sealed regional borders (no in- and out-migration[17]). For the stake of simplicity, we assume a linear evolution in mortality, identical across regions (the national trend according to WHO life tables), but different fertility trends. Total fertility by region is supposed to follow a linear trend between the 1989 level and the one observed among non-movers at the last census using the own-children method[18]. International migration is defined as the residual between these projected populations and the individuals who either never moved or left for another region within Albania until enumeration in 2001 (i.e. the stayers and the internal emigrants). We limit the presentation of our results to the population stock aged less than 65 years in 2001, not only because of the very unlikely hypothesis of spatially homogenous mortality, but also because of the dubitative quality of mortality data for older ages.

The aforementioned hypotheses are susceptible to bias the stock estimates of international emigrants. In assuming constant mortality throughout the country we overestimate the residual (i.e. the international emigration component) in areas characterized by high mortality levels, but underestimate it where mortality is low. Moreover, we assume that the Albanians abroad are characterized by the same fertility and mortality level as those who have not left their region of residence since 1989, and that all female migrants move with their children (in the case they have some) or found the family at destination. This was indeed the case for internal migrants who were strongly selected among newly married people leaving for

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[17]   The population in five-year age groups (published by the Statistical Committee (1991)) was decomposed according to a) person-years lived under age five from the 1989 national life table, and b) with a moving average at ages above four years.

[18]   We consider only non-migrants for regional fertility estimates in 2001 because internal migrants are characterized by a considerably higher fertility level. For example, interregional immigrants represented 40% of women aged 15 to 49 years in Tirana and had 2.4 children per woman against 1.4 among non-migrants in 2000–1 (Lerch, 2010).

an urban centre to find work and found a family (Lerch, 2010). As far as international flows are concerned, Carletto et al. (2005) observed from LSMS 2002 data that emigration either concerns unmarried men or entire families. Moreover, the proportion of mono-parental households headed by a woman is small in Albania (4% of the total; INSTAT, 2005) and only few women indicated the absence of their husband in the surveys (LSMS and RHS). Thus, most of the families separated through international migration may have been reunified by 2001. In 2008–9, twelve per cent of households with former members abroad cared for at least one child left behind (INSTAT et al., 2010).

Recent estimates of migrant stocks are based on the LSMS 2008 and concern movements during the period between 2001 and 2008. Internal migrants are identified based on a direct declaration at the survey (the mothers migration status was imputed for their children aged less than 15 years). The number of international emigrants is estimated from proxy information provided by the household head. Since not only their children, but also their spouses have been enumerated as migrants, there is a risk of double counting an international emigrant (once by the parents and once by the spouse, if they do not live in the same household). We therefore only considered international emigrants who were aged at least 15 years less than the proxy informant. The survey does not provide estimates of numbers of children emigrated.

3

Insights into the Albanian education system: trends in attainment and participation.

Alexis Gabhadino, Anila Kasneci, Bora Toro[19]

Abstract

This article is the outcome of collaboration between members of the Albanian Institute of Statistics and international experts. The aim of the project was to train collaborators in understanding and utilizing survey data. Using data from the Living Standards Measurement Surveys carried out in 2005 and 2008, standard educational indicators were calculated to monitor the trends in educational attainment and participation in Albania. The key variables used for stratification were gender, age/cohort, region and educational level of the parents.

Indicators of educational attainment by age groups (cohorts) monitor the outcomes of the educational system over a long period. They reflect important changes in the educational system and in the participation of the population consecutive to major political events. Of particular interest was the attainment of cohorts that were possibly enrolled during and after the fall of the communist regime in 1990. Indicators of participation (enrolment ratios) monitor the current characteristics of the educational system and the individual and family decisions about education.

International comparison of the indicators shows an important gap between Albania and countries with more advanced educational systems. Whereas literacy and completion of compulsory basic education is almost universal, an important proportion of the population does not complete a second degree, neither vocational or general. School life expectancy, based on current enrolment rates, is also low in international comparison. The number of private schools and universities in the country is rapidly increasing.

The results show an important stratification of educational attainment by region, with the capital, Tirana, concentrating the most educated population and most of the youngsters enrolled in tertiary education. A marked stratification according to social origin, as measured by father's educational attainment, was also observed. The results of early promotion of gender equality in education can be seen in the comparable achievement of women and men in the cohorts aged 50 to 54 years (at survey time) onwards. Both the attainment of the cohorts that recently left the education system and the current enrolment rates show a new trend toward better educational achievement among women.

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1. Introduction

As a result of major political events over the past two decades, Albania's educational system has experienced important changes that are still on-going. The educational system that was in place before the end of the communist system in 1990 was the result of a major reform that started in the 1950s and that was focused on a drive against illiteracy, achievement of universal education and promotion of gender equality in education (Falkingham and Gjonça, 2001). Reorganization of the public education system began in 1990, aimed at modernizing the curriculum and, later on, adapting it to the 1999 Bologna declaration. Over this period, the number of private institutions in Albania has rapidly increased, widening the educational opportunities.

Concurrent with these important changes in education supply (provision of opportunities), important changes are also expected to take place in demand (family decisions about education), leading to new patterns in educational attainment and participation. The educational level of the population influences the evolution of a society in many aspects. For example, the promotion of gender equality in education referred to above is regarded as one of the most important factors explaining the transition of fertility in Albania (Falkingham and Gjonça, 2001). The reform of the education system initiated by the communist regime formed also the basis for the health transition in Albania (Gjonca et al, 1997). Education attainment of the population is also an indicator of the stock of human capital available to influence economic development.

In this article we use data from the Living Standards Measurement Survey (LSMS) carried out in 2005 and 2008 to monitor trends in educational participation and attainment. Using standard indicators, we focus on some potential sources of inequalities in this domain: gender, social origin and spatial location. When possible we compare also the indicators obtained from the 2008 survey with those obtained from other sources so as to validate the results.

The article is organized as follows. In Section 2, we present a recent history of the Albanian educational system and its current structure. This information is necessary to understand and interpret the results that will be presented later in the document. In Section 3 we report on the data used to produce the results and consider some aspects of the methodology used. Section 4 is devoted to educational attainment of the adult population, focusing on a comparison between generations, gender, region and educational level of parents. Section 5 reports the results of participation in education at survey time. Section 6 is devoted to concluding remarks.

2. Albanian educational system Recent history

The important political changes that took place in Albania during and after the 1990s have led to changes in the economic and social life of the country. These changes have had a significant impact on the education system, which has faced many challenges. The availability of efficient infrastructure in the education sector is regarded as an important aspect during transition to a market economy. The internal and international migration, rapid urbanization and lack of security had a negative impact on the educational infrastructure. These factors led to decline in participation of the school age population, especially in pre-university education. Secondary education was affected most by this decline. For example, secondary enrolment dropped by 50 per cent between 1989 and 1995 (Hazans and Trapeznikova, 2006). As a result of the political crisis of 1997, a significant share of schools below university level were ransacked (one third according to Picard and Wollf, 2008) and some school buildings were even razed.

In the last twenty years, the Albanian educational system has been thus constrained to adapt to new political and economic conditions, as well as to improve accordance with international agreements. Education in Albania is a national priority with the aim of offering the population equal rights to obtain education at all levels regardless of social status, gender, nationality, religion, etc.

The construction of new buildings for obligatory schools, as well as reconstruction and modernization of the rest of the infrastructure, began after 1990. Transformation of curricula began with elimination of political and ideological aspects, replacing them with other subjects, including civic society, health education, human rights and informatics. Another direction was modernization of teaching methodologies and qualification of teachers with new concepts, focusing on pupil and development of individual creative thinking (Pango, 1996).

From the academic year 2004–2005 onwards the structure of compulsory education changed. The duration of the first cycle, belonging to level 1 as(ISCED-1997., increased from four to five years, changing the duration of compulsory education from eight to nine years of schooling. In 2003, university education officially entered a process of structural reform, on the basis of the Bologna Declaration.

Today, Albania's education system is still experiencing continuous reform. The fact that human capital formation through education is one of the main obligations a developed society has to ensure its future is expressed in some important documents, the most important of which are National Strategies for development and legal documents designed to regulate the functioning of pre-university and university education.

Public education is financed by the government budget, through funds allocated for each year and by some international organization in the form of grants for important projects monitored by them. The budget allocated by government for public education has gradually increased from year to year. At the same time, the number of private schools in the country has been rapidly increasing, expanding possibilities for pupils and students to participate in the growing demand for education. However, it is obvious through the number of Albanian students continuing their university studies abroad that the demand for education cannot be satisfied entirely by the educational opportunities offered in Albania. The number of students leaving Albania to attend universities abroad is estimated at 2,000 to 4,000 each year. This figure represents five to ten per cent of students enrolled in public higher education institutions (Germenji and Gedeshi, 2008).

Current structure

The Albanian educational system is organized into two main parts: pre-university and university. Its structure and correspondence with the levels of International Standard Classification of Education (ISCED-1997) is detailed below.

Pre-university education includes:
- pre-primary education, starting at age three years and finishing at age six (corresponds to level 0 of ISCED- 97)

- basic education, compulsory for children aged six to 15 years, realized in two cycles:

1. lower or primary cycle (corresponds to ISCED level 1)

2. upper level or lower secondary (corresponds ISCED level 2)

- upper secondary education runs in two major directions, *general* and *technical-vocational*:

    1. general secondary education is structured around two types: secondary *oriented* education with *natural sciences* and *social sciences* profiles; and secondary *general* profile

    2. secondary technical-vocational education is organized on the basis of a common three years and one or two years with subjects of specialities or profiles.

Notice that ISCED level 4 post-secondary––not tertiary––, is not applied so far in the Albanian educational system.

Since the 2004–2005 academic year, the structure of pre-university education is structured in "5+4+3". Primary education has an increased duration of five years, starting when children are six years old, while lower secondary level is four years, as before, but postponed by one year, i.e. from age 11 to 15 years. During the 2003–04 academic year, basic or compulsory education operated on the basis of the previous "4+4" structure.

University or tertiary studies correspond to ISCED levels 5 and 6. All institutions registered as universities and higher schools, as well as other institutions offering programmes at these levels, are included in this category. The first stage of university studies is organized for full- or part-time attendance, both in public and private institutions.

Before compliance with the Bologna Declaration was implemented in the Albanian educational system, university studies were organized in two stages. Studies performed at the first stage, lasting 4 years, were considered finished, with students gaining a university diploma. The second stage belonged to research, advanced and scientific programmes of study.

After compliance with the Bologna Declaration, the programme is divided into three stages. The first two cycles have a duration of three and two years, corresponding, respectively, to Bachelor and Master degrees. Such a curriculum was implemented for the first time in Albania by the Polytechnic University of Tirana. The third cycle corresponds to doctoral studies and is run by designated high quality universities, with completion taking from three to five full years.

Most of the universities in the country are public, but in recent years the number of private universities has grown rapidly. As of March 2010, 34 private institutions of higher education were licensed. The first private university, which opened in 2002, is named New York University of Tirana and is a branch of University of New York. Most Albanian private universities are located in Tirana, though there are three licensed universities for the academic year 2009–2010 outside of Tirana, situated in Burrel, Pogradec (yet to begin activity) and Vlora.

3. Data and methods

For the present article data from the Living Standards Measurement Survey (LSMS) carried out in 2008 by the Albanian Institute of Statistics (INSTAT) was used mostly, with data from LSMS 2005 included, as well as some administrative data for comparison purposes.

LSMS includes a module devoted to education. This survey is thus a powerful tool for monitoring of trends in educational attainment and participation, allowing one to measure a

variety of outcomes in this domain. Moreover, some indicators can be compared with other sources, allowing cross validation of results. For example, calculation of age-specific enrolment rates using administrative data on the number of pupils and students requires estimates of the total population of each age. These estimates are based on previous censuses and statistics of population movements and their precision is difficult to assess, particularly when then last census was so long ago (2001). Nevertheless, enrolment rates can be computed directly from LSMS data allowing calibration of the results.

Rich individual information available from other data sources allows a deeper study of the determinants of educational attainment and participation. It is possible, for example, to link educational characteristics of the individuals surveyed to other characteristics, including household characteristics or parental educational attainment.

Nonetheless, some precautions are required when computing and interpreting indicators obtained from survey data based on a stratified random sample, as is the case with LSMS. First, weights are to be used in order to obtain figures representative of the whole population. All the results stemming from LSMS are weighted using standard weights that come with the data. Second, obtained indicators are to be considered as estimators of the real figures in the whole population, within a confidence interval representing precision of the measure. Precision decreases when the indicators are stratified by gender, region or age, due to a reduced numbers of people surveyed in each category.

The present article is an outcome of collaboration between members of INSTAT and international experts. The aim of the project was to train collaborators in understanding and utilizing survey data. The methodology used here is rather simple: only standard educational indicators are used. The key variables used for stratification are gender, age/cohort, region and educational level of the parents. Two types of indicators are used. Indicators of education attained measure the outcome of the process of human capital formation. They apply mainly to generations that have finished their schooling, and reflect the outcomes of the previous educational system and have thus to be interpreted by considering the situation of the educational system at the time where each cohort was enrolled. Indicators of participation in education (e.g. enrolment ratios) are transversal, instantaneous measures of the current participation of a cohort in educational activities. This information can be used to monitor the expected educational achievement of the generations currently participating in education.

Finally, one important point to keep in mind when analysing the educational attainment and participation of the population in education is the important internal and international migration flows characterising the Albanian context (INSTAT 2004, Carletto et al., 2006). According to recent estimates, since 1990, one third of the Albanian population has emigrated (cited in Germenji 2008). As stressed by Germenji and Gedeshi (2008), emigrants include substantial outflows of highly skilled Albanians from the country's universities and science and arts institutions. Albania has currently one of the highest emigration rates of highly skilled workers in the Balkan region, with nearly 50 per cent of lecturers and researchers having left the country since 1990. Moreover, emigration of young individuals seeking better educational opportunities abroad is also high. The result of this selective emigration of highly educated persons is to decrease the overall educational attainment of the resident population.

4. Educational attainment of the population

In this section we consider indicators of the educational attainment of the population. The educational attainment of the adult population reflects the amount of knowledge and skills at the disposal of the economy and the society (UNESCO 2005; Barro and Lee, 1993) and is therefore used by economists as an indicator of the available stock of human capital.

There are several ways of looking at the educational attainment of the population. The illiteracy rate is a first simple indicator measuring elementary skills. It can be considered as an alternative way of measuring the fraction of the population who have no school attainment. We can also measure the educational attainment as the fraction of the population who have achieved a given educational level. We consider therefore four main levels (primary, lower secondary, upper secondary and tertiary education).

We compare here the attainment between genders and generations, as well as between regions, and make some international comparisons. Notice that when comparing results between generations or countries, measures of school attainment do not adjust for the level of knowledge. This is an important point since, for example, a given educational level achieved during or after the communist period may not represent the same skills and knowledge. The programe of education nowadays are more wide and away from ideological aspect.

Notice also that education is still on-going for the youngest surveyed individuals and their educational attainment can still evolve. Thus, the distribution of educational level can be considered as more or less fixed in time only from age 25 onward.

Overview of educational attainment in the population Literacy

Literacy is supposed to be a basic achievement of primary education. According to definition provided by the UNESCO, illiteracy is one's in/ability to both read and write with understanding a short simple statement on his or her everyday life.

**Figure 1: Illiteracy rate by age and gender (LSMS 2008)**
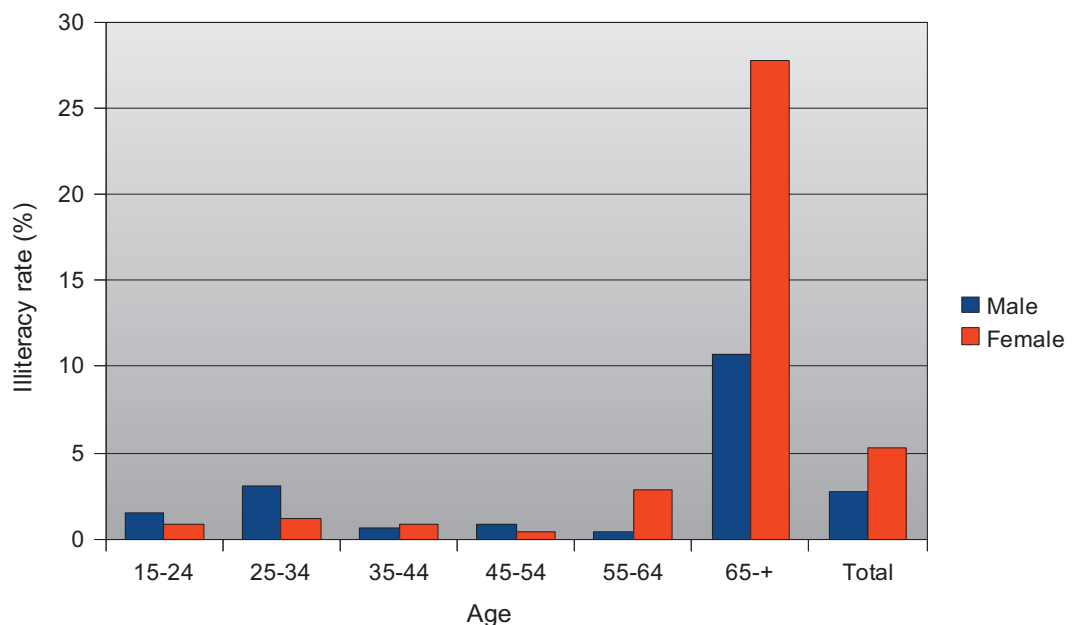
The following questions about literacy in the LSMS questionnaire were used to build the illiteracy rate considered here:

Can you read the newspaper?
Can you write a one page personal letter?

One goal of the Educational Reform Law of 1946 was to eliminate illiteracy and gender inequalities in education, and by 1956, illiteracy was deemed to have been eliminated. Indeed the figures obtained from the 2008 LSMS survey perfectly match this assumption.

The illiteracy rate is significantly higher for individuals aged 65 years and above, that is generations that were eligible to attend primary school before the reform. Moreover, one can see from Figures 1 and 2 that the gender inequalities in education were important in this age group, the illiteracy rate being much higher for women (28%) than for men (11%).

Figure 2: Highest diploma obtained by gender (LSMS, 2008)
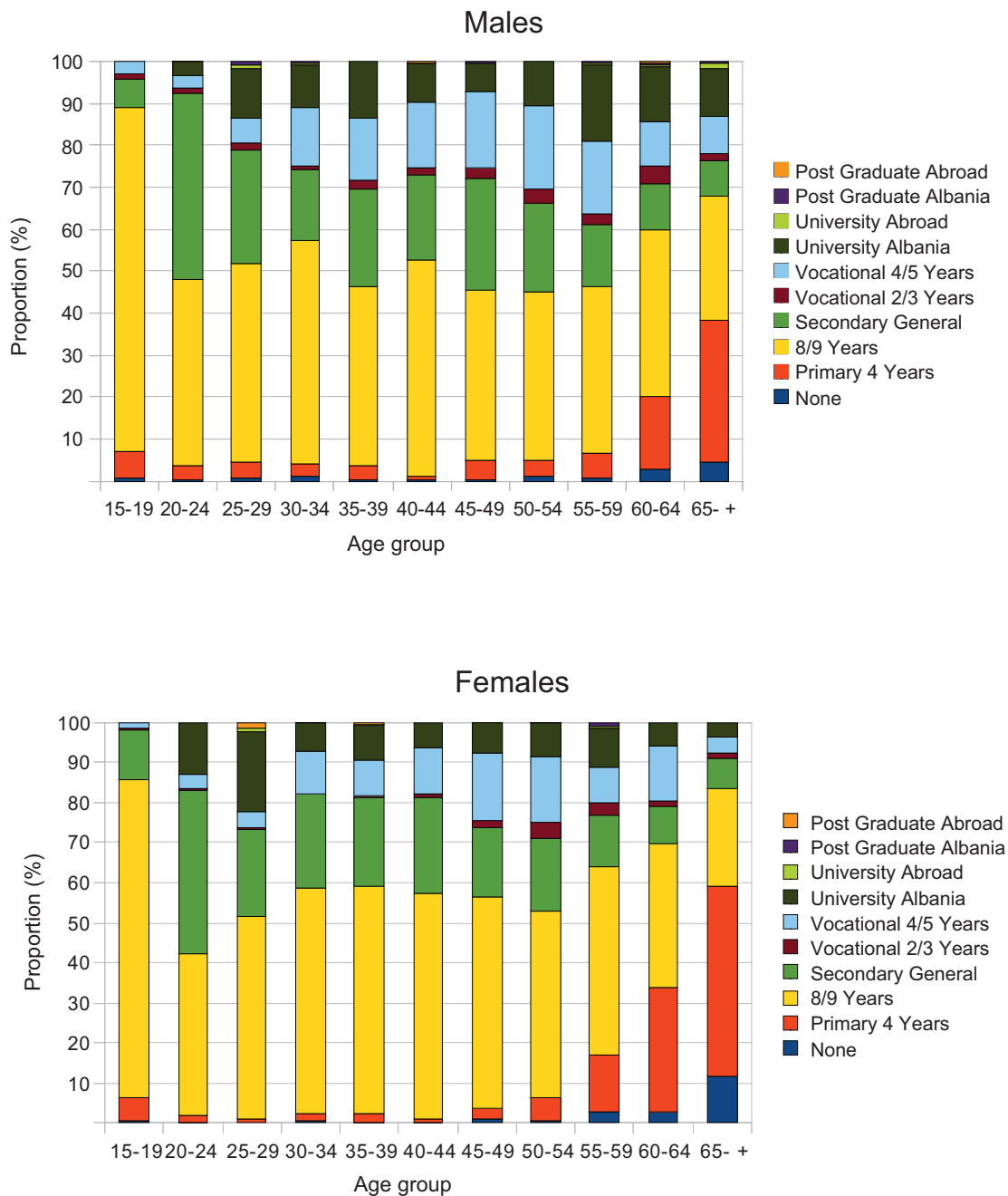
Basic education

The completion of the first cycle of basic education is universal (99%) among the population aged 25–64 years, and almost universal (96%) for the male population aged 65 years and more (Figure 3). However, for this late age group, the proportion of women having completed the first cycle of basic education is lower than for men, at 88 per cent.

**Figure 3: Educational attainment by age group (LSMS, 2008)**

Male

Females
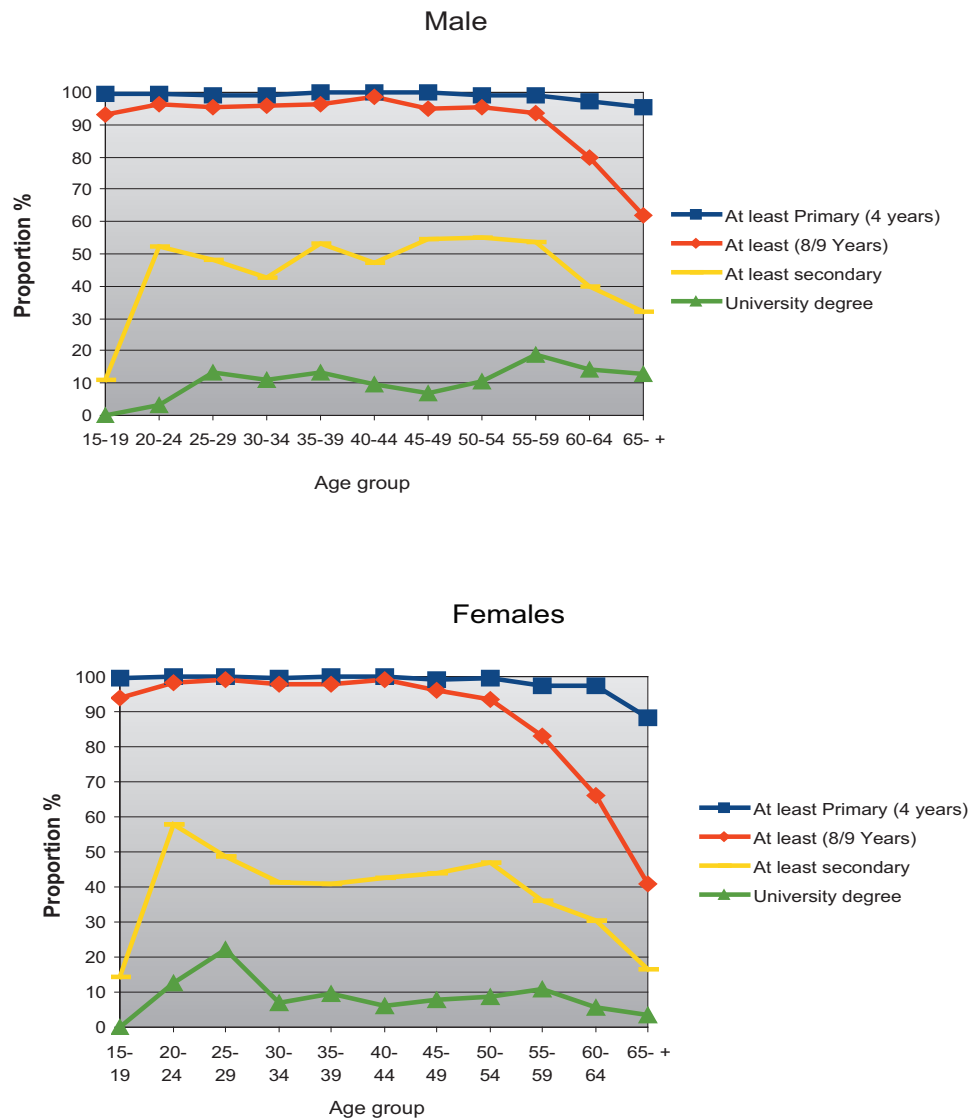
Completion of the second cycle of basic education is almost universal in Albania, at least for the generations born after 1950. Only a reduced and constant fraction of pupils (5% or less) leave the educational system with only the first four years of primary education completed. In Figure 3 the dramatic effects of the 1946 Educational Reform Law, which made primary school attendance compulsory, are seen. Nevertheless, a gender gap is also apparent, with universal primary education achieved later for women than for men.

About 93 per cent of the population aged 25–64 years completed the whole primary education program. From this point of view, Albania has attained the level observed in OECD countries and compares favourably with many other countries: for example, in the countries

of the World Education Indicators (WEI) programmer (UNESCO, 2005), on average 23 per cent of women and 18 per cent of men had not completed primary education.

Figure 4: **Fraction of population with secondary education as highest diploma, by type (LSMS, 2008)**

Males

Females
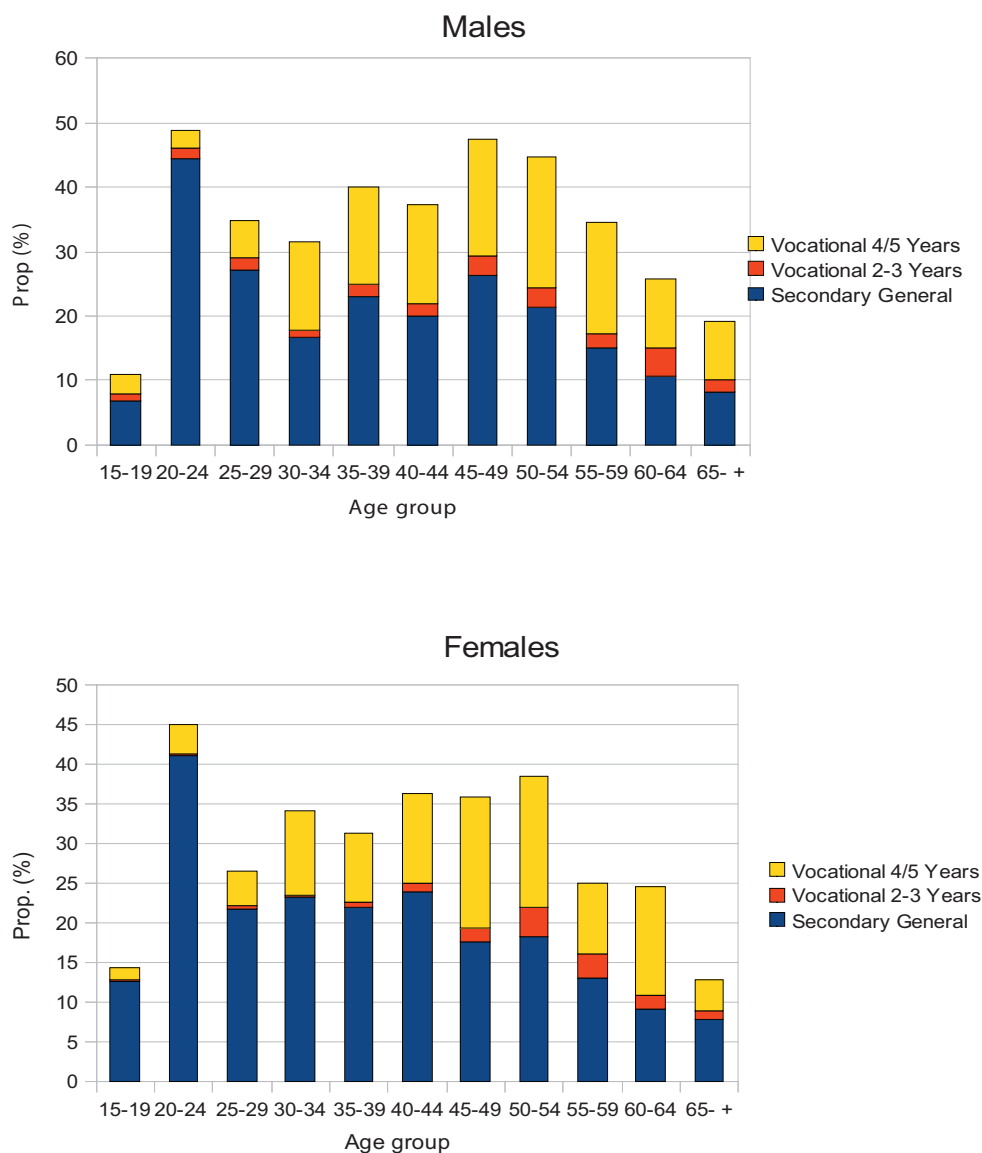
The proportion of older women who had completed basic education is significantly lower than for men (41% versus 62% for the age group 65+, and 66% versus 80% for 60–64-year-olds). In contrast, for those younger than 40 years, the proportion is always higher by about two per cent for women than for men.

Secondary education

Completion of secondary education, either vocational or general, is far less common than completion of primary education. Albania compares unfavourably with many other countries in this regard. Indeed attainment is equal or higher than upper secondary for less than half the population aged 25 to 29 years. In 2007, the mean for the OECD countries was near 80 per cent for the population aged 25 to 34 years.

Since only nearly half of children complete more than primary education, secondary education is regarded as a key educational level distinguishing children in Albania and the determinants of access to secondary education is an important topic where LSMS data has been analysed in two papers (Picard and Wollf, 2008; Hazans and Trapeznikova, 2006). The proportion of a generation who achieved at least secondary education is lower for individuals aged 30 to 34 years than for those aged 50 to 54 years. This corresponds to the major political changes that occurred in the 1990s, which led to a drop of 50 per cent in secondary enrolment rates between 1989 and 1995 (Hazans and Trapeznikova, 2006). Indeed, people of 30 to 34 years of age in 2008 were eligible to participate in secondary education during this period.

For the newest generations the proportion of youngsters who completed upper secondary education is increasing. This proportion is 51 per cent for males aged 20 to 24 years in 2008 and 58 per cent for females of the same age. Hence the salient gender differences in educational attainment that characterize the oldest generations have now disappeared and an opposite gender gap is appearing (however we compare here only broad education levels without accounting for type of secondary education).

The share of a cohort leaving the educational system with a brief vocational education is indeed low (only a small percentage) and does not vary much among cohorts. In the oldest cohorts, aged 50 and above (born before ~1955), long (4 to 5 years) vocational and secondary general education was equally common. However long vocational studies have become much less common in younger cohorts.

In the last cohort for which figures can be considered as stable, aged 25–29 years when surveyed, only six per cent of males and four per cent of females hold a diploma, while 22 per cent of women and 27 per cent of men achieved general secondary level. In the next cohort, aged 20 to 24 years, more than 40 per cent of females and males completed general secondary education as the highest diploma but part of them may engage in tertiary education and the proportion will thus decrease.

University level

The percentage of the adult population completing tertiary education is slightly more than ten per cent. The figure compares less favourably to other countries. For instance, the OECD mean is 24 per cent, and the figure for countries of the WEI programmer is 15 per cent. However, the observed level may be low due to international migration of the well-educated population.

The proportion of women holding a university degree is significantly lower than for men in the older cohorts, as observed with primary education. On the contrary, in the youngest cohort for which the figure can be considered as reliable, aged 25–29 years, the proportion of women holding a university degree is nearly double that of men.

Regional variations

There are important regional variations in educational attainment of the population. The proportion of the adult (25 to 64 years) population who have achieved secondary education (vocational or general) is three quarters in Tirana but less than 40 per cent in the central and mountain regions (Figure 5). The difference between females and males is more noticeable in the regions outside Tirana, with females having achieved secondary education being less numerous.

At least one part of these spatial inequalities is due to differences in educational opportunities: availability of secondary schools in the community has been identified as a determinant of school participation (Hazans and Trapeznikova, 2006).

Figure 5: Proportion of population aged 25–64 years who completed at least secondary education (LSMS, 2008)
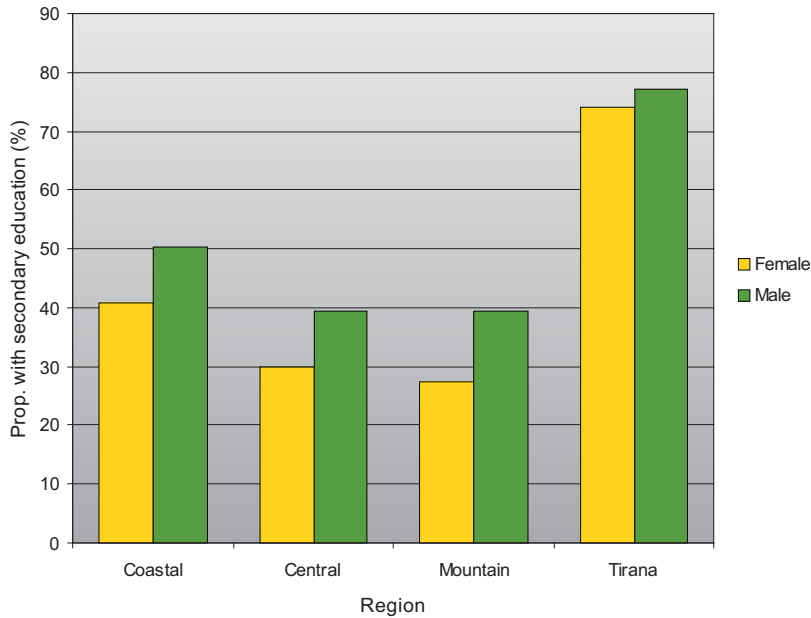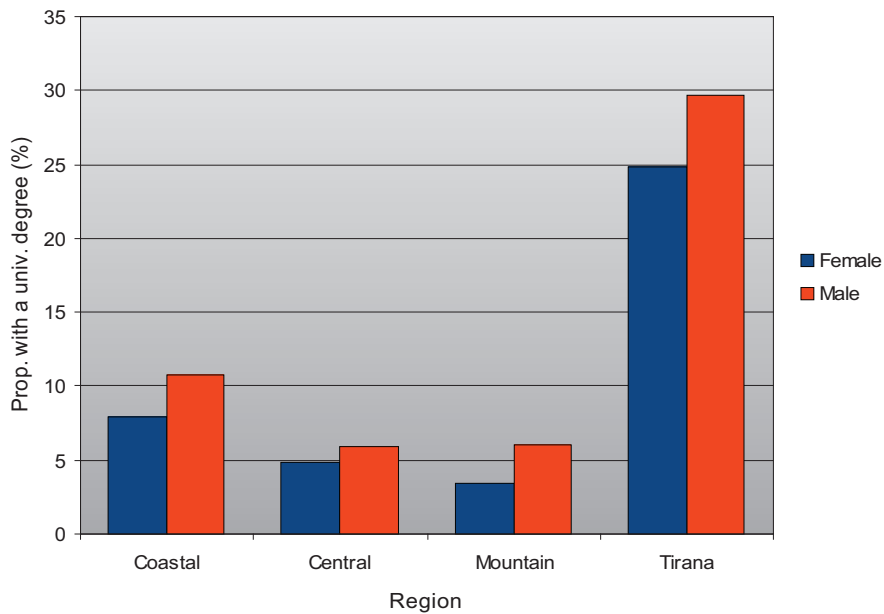

Figure 6: Proportion of 25-64 year-olds having university degree (LSMS 2008)

Regional variations are more pronounced for tertiary than for secondary education. The most educated individuals are clearly concentrated in the Tirana region. In this region, nearly one quarter of women and 30 per cent of men hold a tertiary diploma. In the central and mountain region, this proportion is six per cent for males and three to five per cent for females (Figure 6).
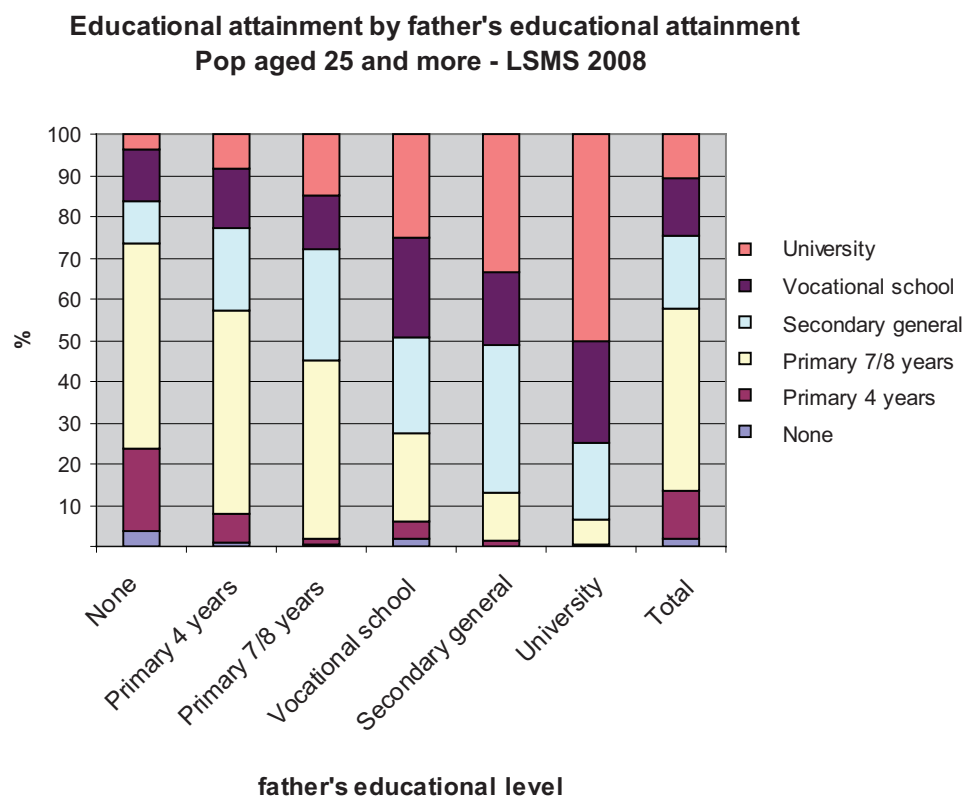
Educational mobility

LSMS data contains information on the educational level of parents, collected either by interview with the parent, if they live in the same household, or by means of a specific question about the educational attainment of the father and the mother of the interviewee (notice that the classification is not the same for the two sources of information and we had thus to make a compatible classification).

This information allows study of educational mobility, defined as change in educational status from parent to child, over generations. The degree to which attainment of social position or educational level is associated with social origin is regarded as a measure of a society's openness (Breen and Jonsson 2005). We computed here simple mobility tables, which compare the educational attainment of the interviewees with their father's attainment.

Figure 7 shows a regular gradient linking educational level attained with the attainment of the parents. The higher the educational level of the father, the higher the educational level of the daughter or son. In the population aged 25 years and more, half of the individuals whose father achieved a university diploma also achieved tertiary education. The proportion is only about 15 per cent for individuals whose father completed only primary school.

Figure 7: Attained educational level by father's educational level - aged 25 years and above (LSMS, 2008)

Educational attainment by father's educational attainment
Pop aged 25 and more - LSMS 2008

father's educational level

Mobility does not increase, rather it decreases, when considering only individuals aged 25 to 34 years at the time of the survey. Among this age group, more than 60 per cent of individuals whose father had attained lower secondary as their highest diploma left the education system with the same diploma (Figure 8). In the 45 to 54 year age group this share is less than 25 per cent (Figure 9).

Educational attainment, by father's educational attainment - Pop aged 25 to 34 - LSMS 2008

Father's educational attainment

Educational attainment by father's educational attainment - Pop aged 45 to 54


Father's educational level

5. Participation in education

While education attained by a cohort is the outcome of a process, enrolment is an instantaneous measure of participation of a cohort in educational activities. We computed age-specific enrolment rates, which are the proportion of interviewees of a given age who were enrolled at the time of the survey. By summing age-specific enrolment rates we obtain school life expectancy, an indicator of the number of schooling years a child can expect given the current observed participation.

Age specific enrolment rates

Rates computed from LSMS 2008 show that enrolment in basic education is almost universal from age seven to fourteen years, since nine out of ten children in this age group range attend school (Figure 10). However, enrolment at age seven years is complete only in Tirana (Figure 11) being slightly less in other regions (especially in the mountain region) and is also slightly unbalanced between men and women. In mountain and coastal regions the rate is ten per cent lower for women. At age eleven years we see a significant decrease in enrolment rate in Tirana, which remains to be explained by use of the characteristics of children collected by LSMS.

Figure 10: **Age specific enrolment rates, by gender (LSMS, 2008)**
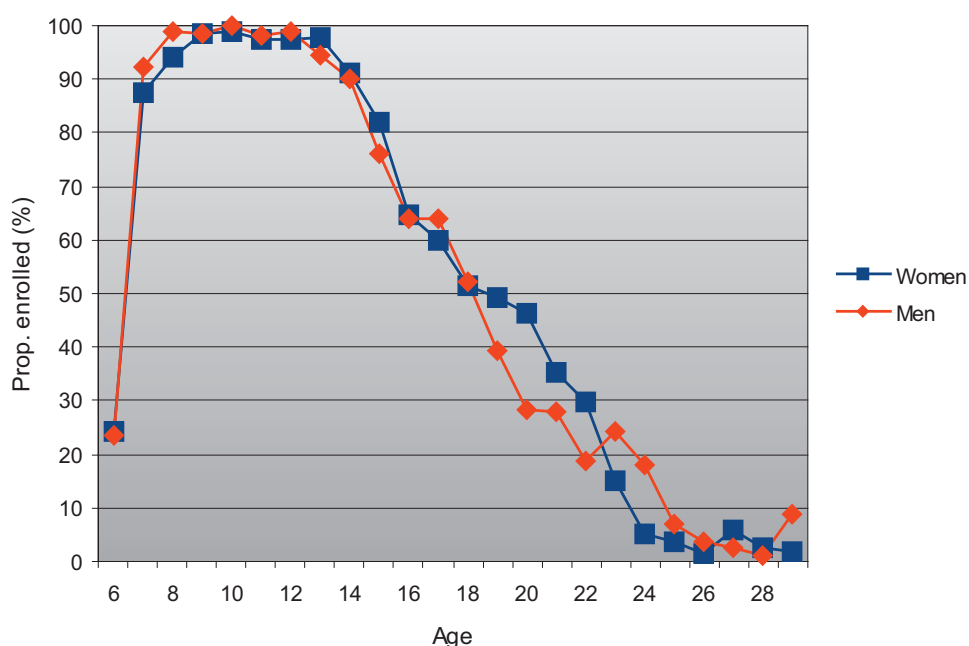

Enrolment is at its highest (94% and more) for both sexes between ages eight and thirteen years, and starts decreasing afterwards. Age fourteen corresponds to the end of eight to nine year compulsory education for the most precocious pupils. The enrolment rate starts to decrease at age 14 years and more significantly at age 15. At age 18 years, nearly one teenager out of two is no longer enrolled in the education system.

As already observed with educational attainment, enrolment in secondary education in Albania is low compared to other countries including neighbouring countries. For example, enrolment exceeds 90 per cent for ten specific ages in Greece and for at least fourteen specific ages in many OECD countries. With only seven age-specific enrolment rates exceeding 90 per

cent, Albania is close to the lowest observed figures, e.g. the figure is six in Turkey. Indeed, while in OECD countries the major decrease in enrolment rates is observed at the end of secondary level the decrease starts immediately after basic level in Albania.

Enrolment rates from age 19 to 22 years, that measure mainly participation in tertiary education, are higher for females than for males (Figure 10). At age 19 years the difference is as high as ten per cent (49% versus 39%). Indeed, administrative data show that female students are more numerous than males students at the beginning of university studies (56% of students are females). However, we observe a gap in the opposite direction from age 23 years onwards, the age range that corresponds to higher cycles of tertiary education.

Figure 11: School life expectancy, by gender and stratum (LSMS, 2008)
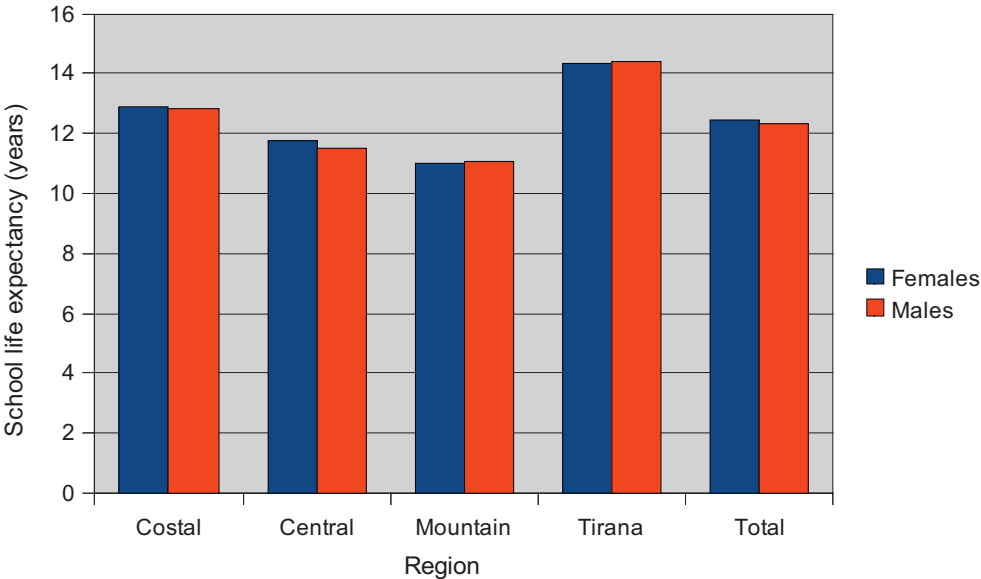
Based upon enrolment rates calculated from LSMS 2008, an Albanian child can expect on average slightly more than twelve years of schooling. On an international scale school life expectancy in Albania is rather low, less than the WEI average of 13.5 years and considerably less than the figure for OECD countries, above 17 years (UNESCO, 2005).

Whereas we have seen in the previous Section school attainment is significantly higher for females than for males in the youngest cohorts, the gender difference in school life expectancy is barely different (12.4 versus 12.3 years). However, one must bear in mind that school attainment measures degrees obtained, not participation, and that more females graduate than do males.
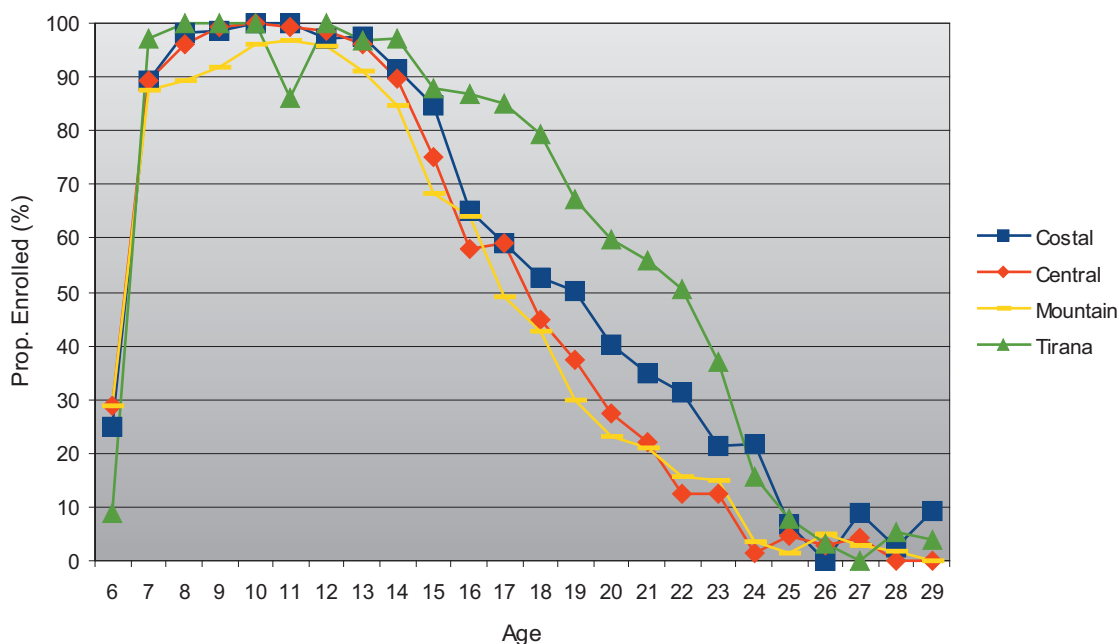
Regional variations

In Albania, access (distance) to a secondary school is, along with parental education and household structure (Hazans and Trapeznikova, 2006; Picard and Wolff, 2008), an important determinant of school enrolment after primary school. Moreover, in rural areas children may be requested to help their parents with agricultural work.

Figure 12 shows that the decrease in enrolment after compulsory education is much more significant in the mountain and central rural areas, and in the coastal region. At age 18 years, enrolment is still close to 80 per cent in Tirana but near to or less than 50 per cent in the other parts of the country. A further difference can be seen from age 18 years onwards between the coastal region on one side and the mountain and central regions on the other, where enrolment rates decrease more rapidly. As a result, school life expectancy is higher by more than two years in Tirana than in the central and mountain rural areas and thus the figure for the capital is higher than the average of WEI countries.

Trends in enrolment rates

There is a trend toward an increase in enrolment rates in both secondary and tertiary education for females, when comparing the results for 2005 and 2008 (Figure 13). There is also an increase in the rate for males, though less so and only in an age range corresponding to tertiary education. These trends lead to an increase in school life expectancy between 2005 and 2008 that is more significant for women (from 11.7 to 12.4) than for men (from 12.0 to 12.3).

Males

Male
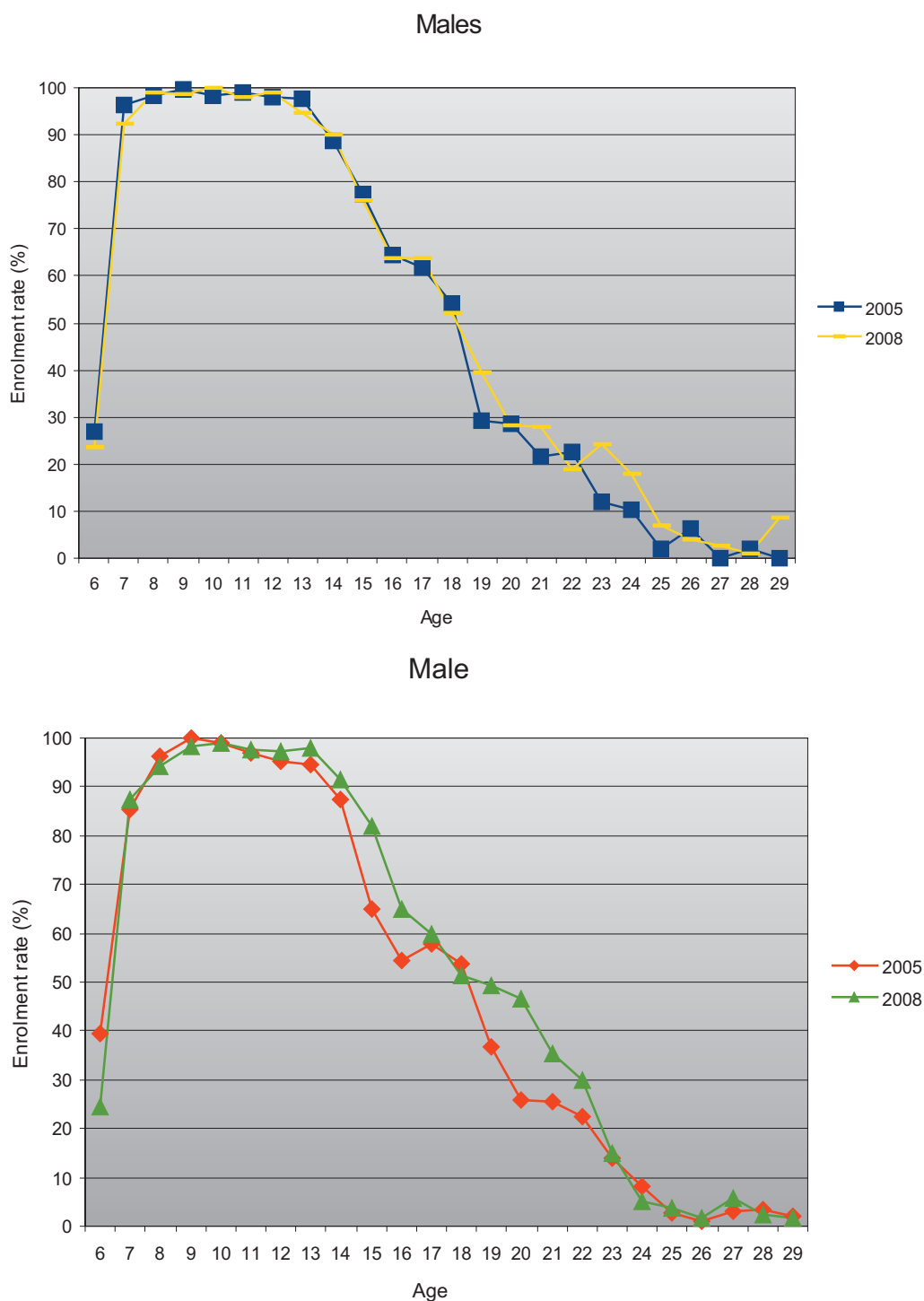
## Enrolment in public and private institutions

LSMS contains questions about the type of institution (public or private) in which respondents were enrolled. Educational institutions are defined as private institutions that are controlled and managed by non-governmental organization (e.g. an enterprise, association, religious group, etc.). In Albania, the private educational institutions are licensed by the Ministry

of Education and Science and accredited by the Public Agency for Accreditation of Higher Education. The first school of this kind was opened in 1992. There are currently 326 private schools in Albania, including pre-schools, primary and lower secondary schools, and upper secondary and tertiary institutions.

Figure 14: Number of private institutions, by educational level (administrative data)

### Private Educational Institutions
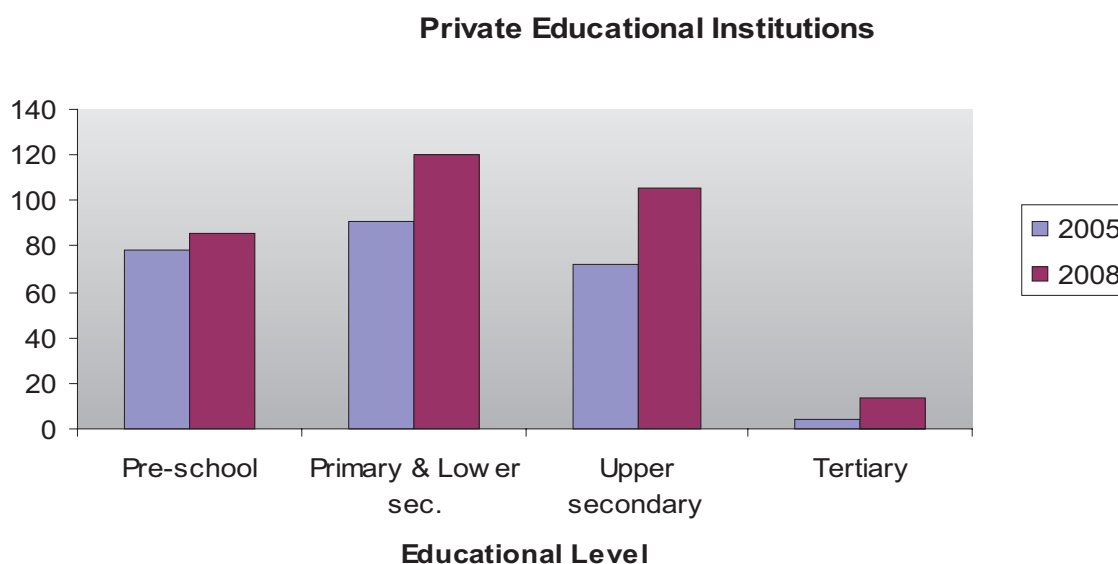
Private education providers may play a significant role in absorbing the growing number of new students and in meeting demand, especially at higher levels of education. As Figure 14 shows, the number of private educational institutions is increasing year by year. Such evolution can also be seen for higher educational levels: there were 15 tertiary institutions in 2005 and 25 in 2008, an increase of more than 66 per cent. The increase number of private institutions widens the choice for pupils and students and contributes to meeting the demand for quality tertiary

The increase in the number of private institutions shows up in the participation of students in such schools or universities. Enrolment in the private sector is highest for the secondary level general, but barely exceeds ten per cent (Figure 15). The average for the OECD countries for the first and second cycle of secondary education was, respectively, 85 per cent and 83 per cent in 2009.

More than nine out of ten students in Albanian universities are enrolled in public institutions (Figure 15). At this level the private sector is less developed than in many other countries. In OECD countries for example, private institutions host between 20 per cent and 30 per cent of students depending on the cycle.

Figure 15: Enrolment, by type of institution (LSMS, 2008)
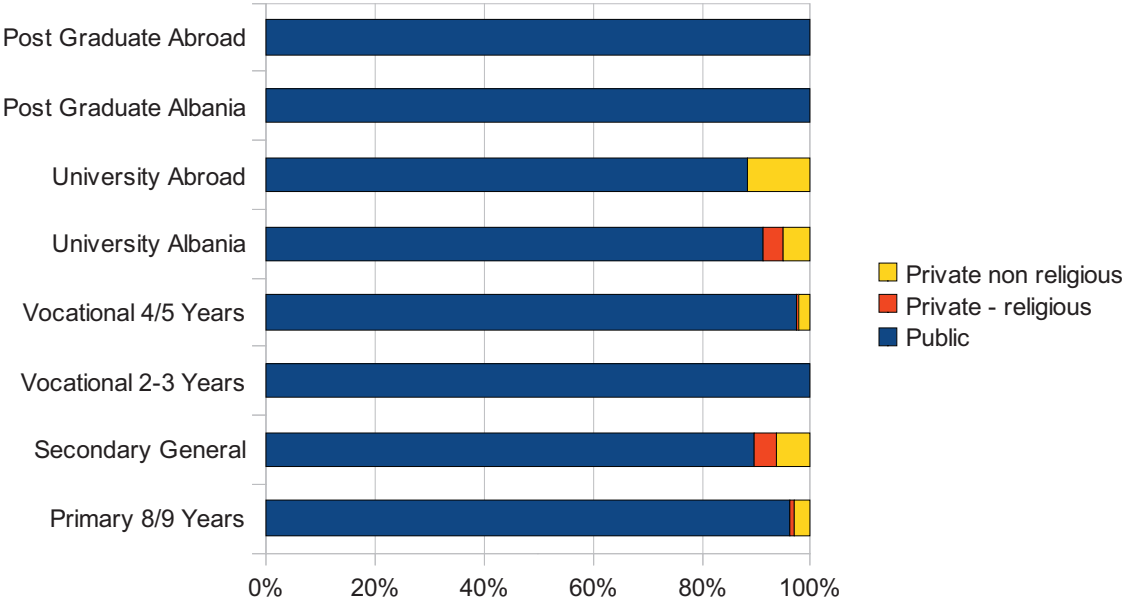
6. Conclusions

Both the educational attainment of the adult population in Albania and the current trends in participation show an important gap between this country and those with more advanced education systems. While literacy and completion of compulsory basic education is almost universal, an important proportion of the population does not complete a second degree, neither vocational nor general. Of course, indicators of completed education do not take into account the proportion of a cohort entering secondary education and leaving it without achieving a degree. But the enrolment rates decrease quite early after the end of compulsory education, meaning that many children drop out early from the education system.

At a lower scale we observe important regional variations in the indicators. The capital Tirana clearly concentrates the most educated population, while the levels of overall attainment and participation are lowest in the mountain and central regions, with the coastal region having an intermediate profile. Differences in educational opportunities (notably in availability of secondary schools in the community) partly explain these regional variations. However, part of the explanation lies in the fact that in rural areas, youngsters have to leave the educational system early to work for a small family business or farm run by their parents.

We observe also an important stratification according to social origin as measured by the father's educational attainment. Nevertheless, such spatial and social inequalities in educational opportunities exist in most countries. Comparing the level of these inequalities with other countries would be very interesting.

Concerning gender stratification, LSMS data show how the situation has evolved over time. Prior to 1950, women were clearly disadvantaged in a strongly patriarchal society. The communist regime achieved gender equality in education, though the situation took longer time to evolve in central and mountain regions than in Tirana. By comparing LSMS data from 2005 and 2008 we observe a trend toward an increase in enrolment rates for women.

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4

Health and Health-Related Needs in Albania: Monitoring health by means of population surveys

Walter Weiss, Nurije Çaushi, Fatjona Pupuleku, Ruzhdije Bici, Ornela Abazi [20]

Abstract

This article is based on health data collected in two interview surveys undertaken in Albania: the Living Standards Measurement Survey 2008 of the general population, and the Demographic and Health Survey 2008–09 of the population of reproductive age (15–49 years). Basic indicators, including self-perceived health and prevalence of lasting health problems (chronic disease, disability), reveal a high burden of disease among the elderly compared to the younger Albanian population, reflected also in hospitalization rates. The findings are discussed in the context of the frequency and distribution of health risks resulting from hypertension, overweight and obesity, smoking and alcohol consumption. The conclusion is that high morbidity of older generations in Albania is due mainly to traditional lifestyle patterns combined with a cohort effect. Further analysis focused on health determinants that include educational achievement and groups at particular health risk, e.g. people living in one-person households and without strong social ties. This life condition, particularly frequent in older women living in urban areas, is likely to become more frequent with the process of internal migration and demographic change. The prevalence of this condition should be monitored in order to set up in a timely fashion the infrastructure necessary to satisfy their health care needs and the social support resulting from them. Finally, the possibilities to establish a regular process of monitoring health, health determinants and health-related needs in Albania by means of population surveys are discussed, followed by recommendations for initialization of this process.

Introduction

In the history of health statistics, health information was for a long time mostly derived from demographic data, i.e. vital statistics on mortality, life expectancy or causes of death. Although this information is still useful for public health policy, e.g. for identifying and

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preventing causes of premature mortality, it has lost most of its value for monitoring a population's health. Since acute illness due to infectious disease is no longer the principal cause of death, life expectancy has increased tremendously. In parallel, chronic degenerative diseases from which people often suffer long years before dying, have become frequent[19]. If this kind of illness is registered as the cause of death, almost no information regarding the health status and other conditions of the deceased person can be derived from these causes. Therefore, evaluating a population's health in order to assess the needs of health care or to define possible measures for preventing illness and promote health requires a large range of new information, including the following:

- disabling effects of lasting health problems
- individual capacity and environmental facilitators to cope with chronic disease
- behavioural factors that increase or, to the contrary, reduce risks of becoming ill
- exposure to potentially health-damaging factors in the physical and social context.

In developed countries in recent decades, collecting this type of new data by means of health interview surveys has become the method of choice. Interview surveys among representative samples of a population provide individual data covering a large range of topics. As the data are collected in a methodologically standardized way, they can be used for epidemiological description, etiological analysis and comparison of different groups of the population. Such analysis are of particular interest if they are based on internationally comparative data, collected with questionnaires elaborated by international (World Health Organization, World Bank) or supranational (Eurostat) organizations, thus allowing assessment of a country's situation against other countries[21].

Since the beginning of the last decade, health related information has been collected in Albania by means of population survey. Whereas some of these focus on specific topics, e.g. maternal and child health (MICS3, 2005) or sexual and reproductive health (RHS, 2002), more general information about health status, morbidity or use and accessibility of health services is available in the Living Standards Measurement Survey (LSMS, 2005, 2008) and the Albanian Demographic and Health Survey (ADHS, 2008).

In this article, the most pertinent data from surveys conducted in 2008 (LSMS and ADHS) were used to demonstrate the utility of a few exemplary health indicators for monitoring the Albanian population's health. Starting with a presentation of health status measures, the available indicators concerning health related behaviour, and the use of health care services are described, followed by a discussion of the effects of health determinants, including educational achievement and level of social integration. Finally, the question of how to improve health information in Albania by routinely collected survey data is addressed.

Database

The most recent information on the health situation of the Albanian population was collected in LSMS 2008 and ADHS 2008–2009. Data from these sources are exclusively used in the present analysis, which is reported below.

LSMS 2008

LSMS was established to improve the scope and quality of household data collection in developing countries for the purpose of increasing the use of such information in policy making.

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[21] This procces of changing patterns of deseases is called epidemiological transition

Information was collected with four questionnaires: a household questionnaire, a diary for recording household food consumption, a community questionnaire and a price questionnaire. The household questionnaire included a health module and other core modules as defined in Groshand and Glewwe (2001), as well as additional modules on migration, fertility, subjective poverty, agriculture, non-farm enterprises and social capital.

The choice of employing these modules was aimed at matching as much as possible the specificity of Albania in terms of data needs, driven by pressing policy questions. Design (e.g. questions asked, their sequence, units and time-frames used) was also adapted to fit the Albanian reality.

The 2008 LSMS final sample consisted of 3,600 households (response rate, 85.4%). Sampling design was strictly based upon the one used previously, in 2005: a stratified two-stage cluster sampling design in which the Primary Sampling Units (PSUs) were represented by the Census Enumeration Areas (EA) while the Second Stage Units (SSUs) were the households. The selection of EA within each stratum was carried out by means of a Probability Proportional to Size (PPS) design. The second stage units were selected by means of systematic probability sampling. As far as Tirana city was concerned the PSUs were selected by means of a systematic sampling procedure: prior to selection the EAs were ordered according to their socio-economic characteristics. The EAs were stratified according to the following geographic criteria:

i)   large geographic areas: mountain, coastal, and central
ii)   whether the areas were urban (big towns), other (small towns) or rural
iii)   Tirana city was considered as a separate stratum.

Household membership is defined as the individual concerned being away from the household for less than six months. Deceased individuals, lodgers, hired workers and servants are never considered household members. Guests who stay with the household for six months or more, infants of less than six months and new arrivals are considered household members. The head of household is always considered a member of the household irrespective of the time she or he has spent away from it.

Details of stratification (number of PPUs and HU per stratum) are reported in Table 1 in the Appendix, while the composition of the crude and the population-weighted samples, according to age, gender, region and urban or rural residence is reported in Table 2.

Demographic and Health Survey

The Albanian DHS was designed to provide data to monitor the population and health situation in Albania. Specifically, ADHS 2008–09 collected information on fertility levels, marriage, sexual activity, fertility preferences, knowledge and use of family planning methods, breastfeeding practices, nutritional status of women and young children, childhood mortality, maternal and child health, awareness and behaviour regarding AIDS and other sexually transmitted infections. Additional features of the survey included the collection of information on migration (out-migration, returning migrants and internal migration), haemoglobin testing to detect the presence of anaemia, blood pressure (BP) measurements among the adult population, and questions related to accessibility and affordability of health services. The information was collected by means of three questionnaires: a household questionnaire, a women's and a men's questionnaire.

The information collected in ADHS 2008–09 provides updated estimates of an array of demographic and health indicators that can be used for developing appropriate policies and programmes to address the most important health issues in Albania.

A representative probability sample of almost 9,000 households (response rate 98%) was selected in such a manner as to allow separate urban and rural, as well as regional, level estimates for key population and health indicators, e.g. fertility, contraceptive prevalence, and infant mortality (children under five years of age). All women aged 15–49 years in the total sample of households, and all men aged 15–49 years in a sub-sample of one-half of households, who were either a usual resident of a household in the ADHS sample or a visitor present in the night preceding the interview were eligible for interview. Additionally, all children under five years of age and eligible women and men aged 15–49 years were weighed and measured to assess their nutritional status. Finally, BP was measured for eligible women and men in the households selected for the men's interview to estimate the prevalence of hypertension among the adult population in the country.

A two-stage sample design was used for the Albanian DHS. The first stage consisted of selecting a sample of PSUs as used for LSMS 2008. In total, 450 PSUs were selected for ADHS, including 245 urban and 205 rural PSUs, covering four geographic domains—mountains, central and coastal Albania, and urban Tirana. A listing of each of the selected PSUs was carried out in preparation for LSMS. The ADHS survey selected 20 households from the updated household listing in each PSU, excluding households selected for LSMS.

Health status

Dimensions and measurement of health

Historically, medical practice and scientific research into health was mainly concerned with deficient states of health, i.e. the different forms and stages of disease or trauma and their consequences (e.g. disability). In the second half of the last century, risk factors for ill health also became the object of medical activities. More recently, psychological and sociological approaches (Antonovsky, 1990; McDowell and Newell, 1996) referred to lay-concepts of health that traditionally stress the positive aspects of health, such as self-perceived physical, psychological and social well-being or functioning in everyday life, work performance and social integration.

Different concepts of health and illness go along with different methods of evaluating and measuring health: in clinical approaches, measurement consists in allocating cases (patients) to an appropriate classification. The World Health Organization (WHO) developed and maintains such systems in particular for classifying diseases (the International Classification of Diseases, ICD) or impairments and disabilities (the International Classification of Functioning, ICF). In psychological and sociological approaches, a person's current health status can be represented by a point or position on a continuum between the extremes of good health and illness. A frequent method to define this position is to ask a person to rate him or herself on a scale showing several values. In the case of the general indicator for the subjectively perceived health status (question: *How is your health in general?*), the values may be "very good", "good", "fair", "bad" or "very bad". More sophisticated indicators are based on a battery of items, compiled in an index, measuring for instance level of psychosocial strain and stress or of psychological distress, depression, etc.

Questionnaires for health interview surveys, such as those designed by WHO and Eurostat, present a variety of indicators and indices allowing measurement of different dimensions and components of health in order to produce population health profiles. These profiles can be used to describe a country's overall health situation or to compare its subpopulations defined by gender and age, socio-economic conditions, educational status, geographical area and so on.

Perceived health

In LSMS 2008 the question that is asked to obtain a very general assessment of a person's self-perceived health status is worded "How would you rate your health condition: very good, good, poor, very poor?" This widely used indicator proved to be a fairly good predictor of hospitalization and subsequent mortality (Idler and Beniamini, 1997), explained by the fact that people in general have an adequate appreciation of their health based on experience with ill health and disability, and comparison with that of other people in the same age group.

Chart 1: Perceived health by gender and age
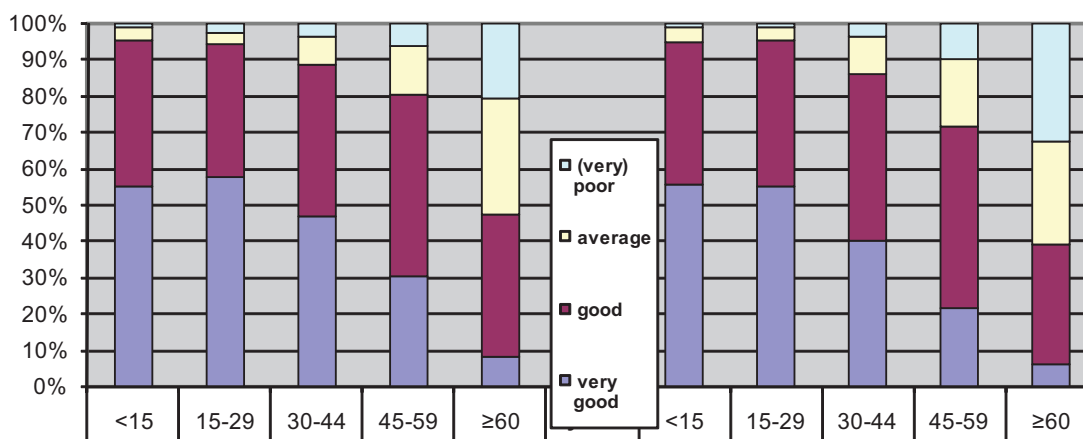
LSMS, 2008

Among the Albanian population aged 15 years and more about four out of every five people assess their health as very good or good (83% of men and 79% of women), while six per cent of men and nine per cent of women declare being in poor or very poor health. People living in rural areas rate their health as slightly poorer than do those living in an urban environment, but this difference has no clear equivalent in the four regions, where the variations of perceived health are slight for both men and women. As expected, the proportion of people in good health diminishes with age, while poor health becomes more frequent. More surprisingly, this decline in health is very prominent after the age of 60 years. As Chart 1 shows, fewer than 50 per cent of such men and 40 per cent of such women assess their health as very good or good, while those in poor or very poor health rise dramatically to, respectively, 31 per cent and 43 per cent.

Chronic disease and disability

The prevalence of chronic health problems is not yet well documented in Albania. Therefore, the following analysis is limited to lasting health problems reported in LSMS 2008 and to hypertension as measured in the course of ADHS 2008–09.

Chronic health problems

Information on chronic disease and disability was collected through the question: "Have you suffered from a chronic disease or disability that has lasted more than 3 months (including severe depression)?". Fourteen per cent of the population aged 15 years and over reported suffering from such a condition. As expected this proportion rises with age, and after the age of 45 years the rate of chronic disease and disability is higher among women than men. The prevalence is highest in the Tirana region, followed by the costal and central regions.

Chart 2: Share of population with a lasting (chronic) health problem

Age (Years)
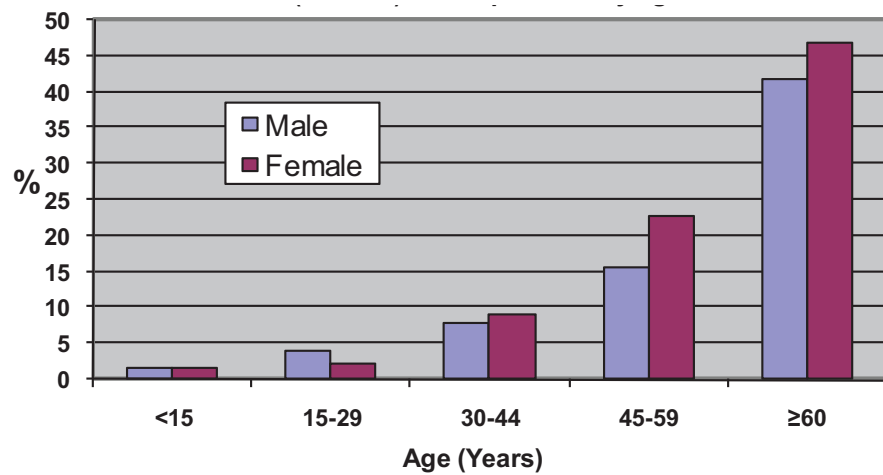
While the proportion of people affected by chronic health problems is comparatively low among the young (Chart 2), it increases exponentially to reach a very high level in the group aged above 60 years (44%), corresponding to what was reported with respect to perceived health.
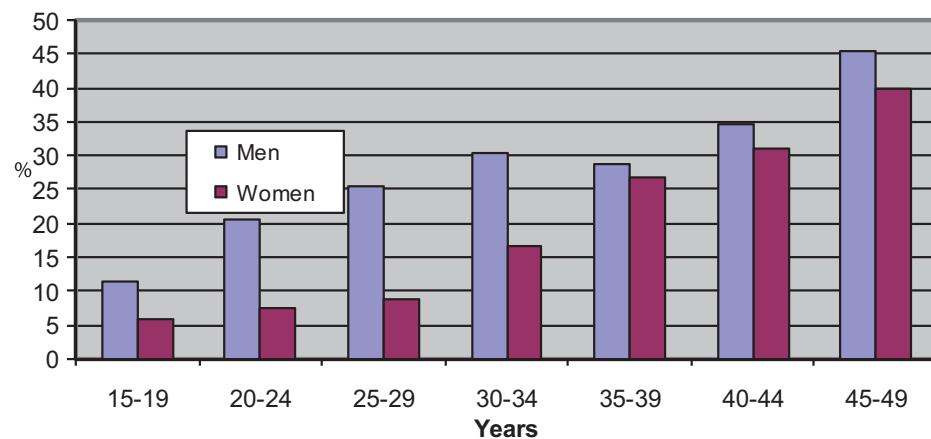
Hypertension

High blood pressure (hypertension) is known to be a contributing factor to a wide range of health problems, in particular heart disease, stroke and kidney disease. One objective of ADHS 2008–09 was to provide information on cardiovascular risk factors (hypertension, smoking and nutritional status), based on population-based data rather than clinical data. In accordance with WHO (1999) guidelines, individuals were classified as hypertensive if their systolic blood pressure exceeded 140 mmHg or if their diastolic blood pressure exceeded 90 mmHg. Three measurements of systolic and diastolic blood pressure were taken during the survey interview, at approximately ten-minute intervals between measurements. The average of the second and third measurements was used to classify individuals as described. BP measurements were successfully taken from 96 per cent of women and 94 per cent of men. Following internationally recommended guidelines, respondents were regarded as hypertensive if they had normal BP but who were taking medication to lower it. This was the case of one per cent of interviewed women and less than one per cent of men.

**Chart 3: Proportions of men and women with hypertension**

Years

Chart 3 shows that in all age groups for whom data are available, men have a higher prevalence of hypertension than women, the difference being particularly prominent in younger ages, up to 35 years. Also, hypertension is positively associated with age. Thus in Albania, 40 per cent of women and 45 per cent of men aged 45–49 years have hypertension. Given that hypertension increases with age, the finding indicates that this condition presents a serious health problem for older Albanians. It also helps to understand the observed poor health of the Albanian elderly population, in particular regarding the prevalence of chronic illness.

Acute illness and temporary impairment

Chronic disease, acute illness and the possible impairment caused by them influence a person's well-being and functioning in everyday life. Interviewees were asked if they had had any sudden illness or injury, e.g. flu, diarrhoea, fracture, etc. during the four weeks preceding the interview. If this was the case, the impact of this illness or injury on everyday life was assessed through the following question: "How many days during the last four weeks have you been unable to carry out usual activities because of this sudden illness or injury?"

**Chart 4: Share of men and women with acute illness within 4 weeks by age**
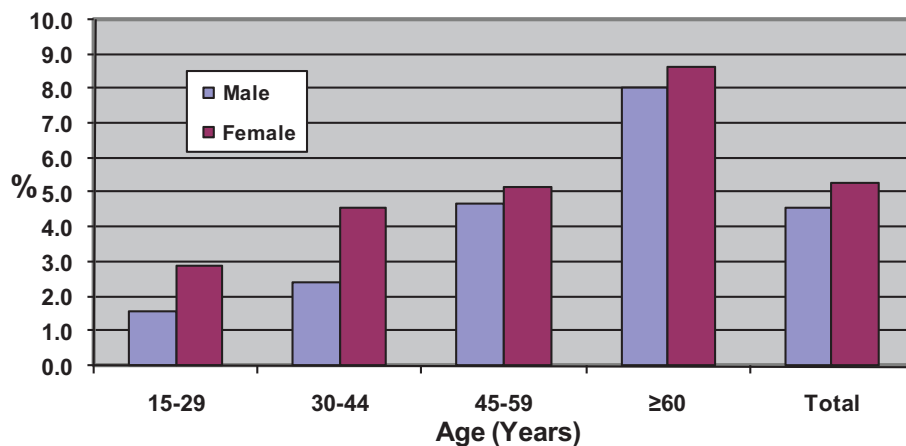
LSMS,2008

Chart 4 shows that acute illness is more frequent in women than in men, particularly among those of reproductive age. The occurrence also increases with age, and after the age of 60 years some eight per cent of men and women are affected by a sudden health problem.

Chart 5: Duration of temporary impairment by gender and age
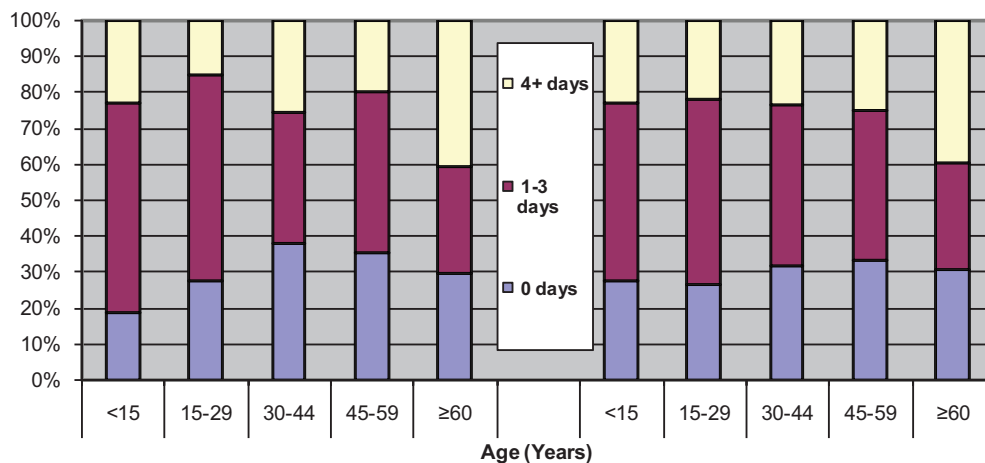
LSMS,2008

Over all ages, the share of women reporting four or more days of temporary impairment is slightly higher than that of men (Chart 5). This corresponds to the fact that women in general have higher morbidity. Across all age groups and for both sexes, in about 30 per cent of cases acute illness has no major impact on everyday life and functioning, as no days of impairment are reported. Up to the age of 60 years around 20 per cent of men and women report more severe consequences with at least four days impairment. As observed on the basis of other indicators, the health situation markedly deteriorates after the age of 60 years, with four out of ten men and women with acute illness reporting having been impaired for at least four days.

There is little geographical variation in the pattern of impairment of work, though the rural population reports slightly more days of temporary impairment than does the urban population. A comparison at the regional level reveals only a marked difference for Tirana, with the highest proportion of people without temporary impairment (48%) and the lowest proportion with more than three days impaired (19%). This can most probably be explained by the general life and work conditions of urban Tirana, on average less physically demanding than those in rural areas.

4. Health behaviour and health risks

Albania, like other countries in epidemiological transition (see Introduction, footnote 19), is facing an increase in non-communicable diseases associated with urbanization and a modern, less active lifestyle, in particular changed nutritional patterns resulting in overweight and obesity, and other behaviour detrimental to health, including smoking or excessive alcohol drinking. In ADHS 2008–09 information on such behavioural patterns is available, allowing estimates to be made of the prevalence of corresponding health risks among the population aged 15 to 49 years.

Body mass index

Body mass index (BMI) is a composite measure based on a person's height and weight, more precisely the ratio of weight (in kilograms) divided by height (in metres) squared (kg/m^2). These measurements were taken for all subjects during interview. Women who were pregnant at the time of interview or who gave birth during the two months preceding it were excluded from the sample. A cut-off point of 18.5 is used to define under-nutrition while a BMI of 25 defines over-nutrition (overweight) and 30 defines obesity.

Chart 6: Shares of men and women with overweight or obesity by age
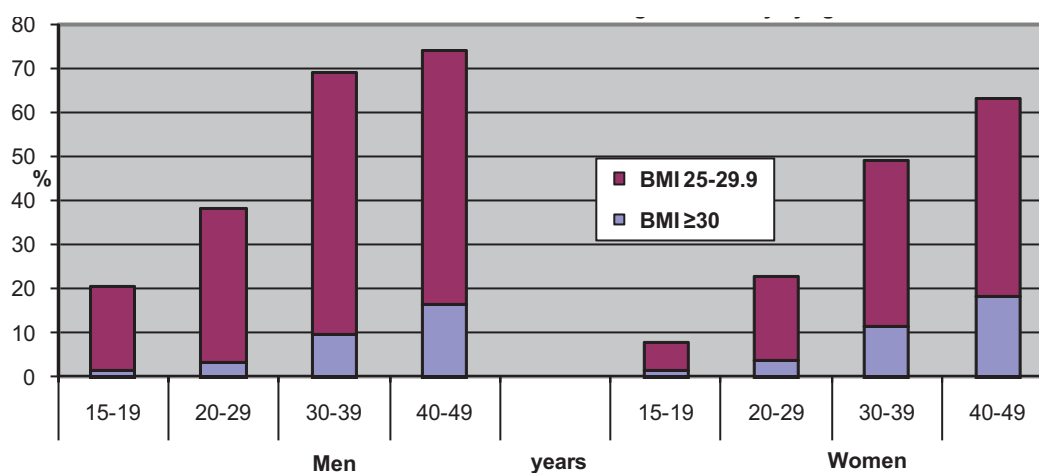
ADHS, 2008–09

In the Albanian population aged 15 to 49 years, only 46 per cent of men and 58 per cent of women have a BMI within the normal range of 18.5–24, while at all ages under study obesity is about as prevalent in men as in women, though overweight is markedly more frequent among men (Chart 6). The proportions of both overweight and obese people increase strongly with age to the extent that in their forties three out of four men and almost two out of three women are overweight or obese.

In both sexes overweight and obesity are about as frequent in the urban and rural context, while there is some variation between the regions, but only among women: levels of overweight and obesity are highest in the coastal region, while women living in the mountain region and, particularly, in Tirana show substantially lower levels.

Overweightness and obesity are positively correlated to hypertension. Almost half of obese women (47%) and men (45%) are hypertensive. As with hypertension, being overweight becomes even more frequent at older ages, confirming the critical health situation of the elderly generation of Albania.

Tobacco smoking

Smoking has a strong negative impact on a population's health. Smoking is a known risk factor for cardiovascular disease, and causes lung, and other forms of, cancer, and contributes to the severity of pneumonia, emphysema and chronic bronchitis. It may also have an impact on individuals who are exposed to second-hand smoke. Because smoking is an acquired behaviour, all morbidity and mortality caused by smoking is preventable.

As Chart 7 shows, smoking is still mainly a behavioural pattern of men. The male smoker rate increases rapidly with age to reach a peak of 56 per cent at age 30–34 years, after which it decreases slightly. This pattern suggests that cigarette smoking among men has not changed substantially over the past few years. In contrast, smoking among women is a relatively recent phenomenon, as ten per cent of women aged 25–29 years smoke cigarettes, compared to three to four per cent in the older age groups. Also, the female smoker rate is by far the highest in urban Tirana (14%) and among those with a university degree or higher education (15%). In contrast, the male smoker rates are lowest in these same groups.

Chart 7: Smoker rate by gender and age
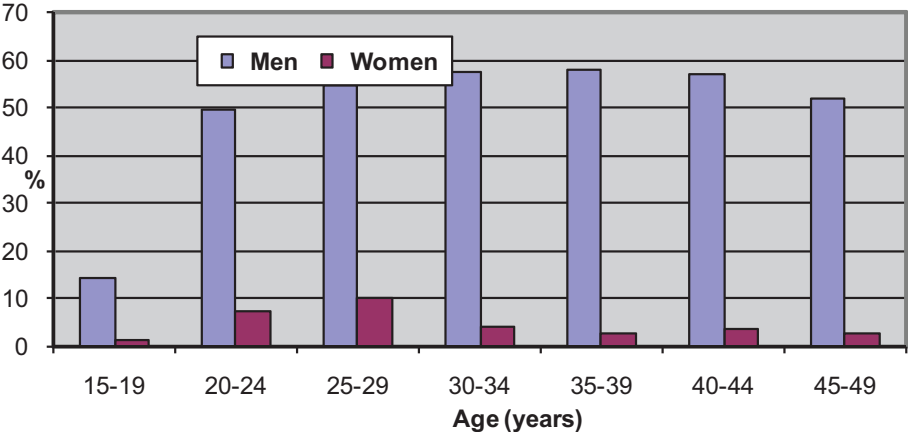
ADHS, 2008–09

With respect to the prevention or reduction of health risks due to smoking, two facts are of particular interest: age when smoking begins, and the potential of smokers who want to quit.

The onset of smoking has a major effect on health because people who start smoking early have, on average, a longer period of exposure to the hazardous products of smoke. Overall, the age at which women and men start smoking is declining in Albania. For example, the median age at which men start smoking has dropped by more than two years, from 20.4 years among men aged 45–49 years to 18.2 years among those aged 20–24 years. As to those who want to quit smoking, three in five female (60%) and two-thirds of male (67%) smokers tried to stop smoking in the year preceding interview. For women, those living in urban areas and in Tirana, and those with a university degree or higher education are least likely to try to stop smoking. On the other hand, men with the same characteristics are more likely to try to stop smoking than other male smokers.

Alcohol consumption

Excessive alcohol consumption is a serious problem in many European countries. Europe has the highest level of alcohol consumption in the world, and alcohol abuse is considered to be the third highest risk factor for death and disability, after tobacco use and hypertension. Potential consequences of chronic alcohol abuse include increased risk of cirrhosis, hypertension, psychological illnesses and congenital malformations. Moreover, acute alcohol intoxication leads to domestic violence and other family, social and employment problems, accidents, criminal behaviour, homicide and suicide.

Chart 8: Rate of all and frequent alcohol consumers by gender and age
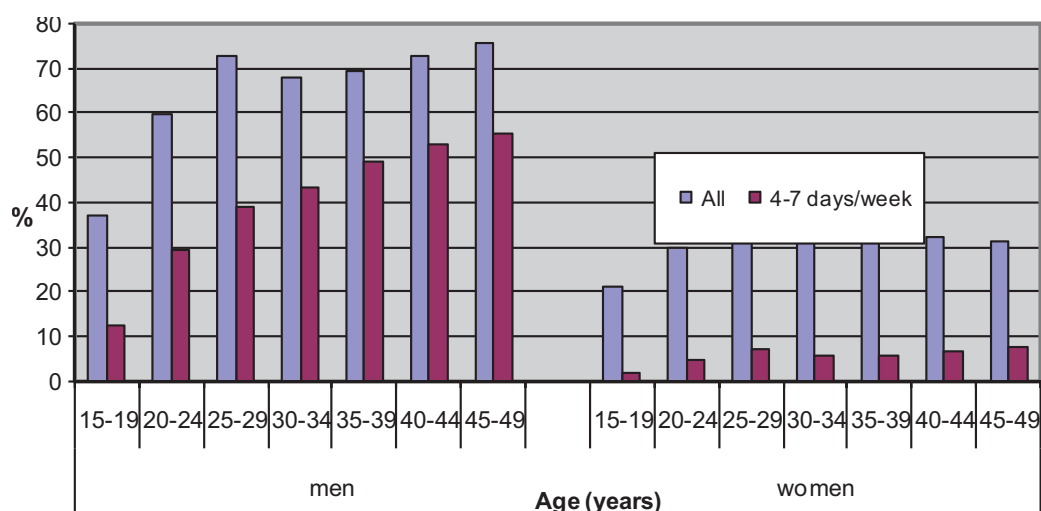
ADHS, 2008–09

As with smoking, consumption of alcoholic beverages is mainly a male behaviour. Between the ages of 25 and 50 years, some 70 per cent of men, compared with some 30 per cent of women, drank alcohol in the twelve months preceding the interview. More importantly, while up to three quarters of male alcohol consumers drink alcoholic beverages at from four to seven days a week, this is only the case for just one quarter of female consumers (Chart 8).

Alcohol consumption among women is highest in urban areas (36%), in urban Tirana and central regions (33% each). The proportion of women who drink alcohol increases with level of education. Thus, 18 per cent of women with no, or only primary four-year, education reported drinking alcohol in the past twelve months, compared with 47 per cent of women with a university degree or higher education. In contrast, alcohol consumption among men is highest in rural areas (65%) and in the coastal region (72%), and among those with primary eight-year education only (65%).

Health service utilization

Information on the utilization of health services is important to planners at the national and local levels because it allows assessment of the coverage of a population's health-related needs and utilization of health care facilities and other services at the various levels of the Albanian health system. As this system has seen several reforms and restructuring in recent years, administrative data do not yet cover a representative segment of activities and patients, particularly because of the presence of public and private services for both outpatient and inpatient care. Therefore, the following analysis are based on the few data collected on hospital care among the Albanian population in the framework of LSMS 2008.

In the LSMS respondents were asked: "During the past 12 months have you stayed in a hospital or maternity hospital or private clinic in Albania or abroad?" Across all ages, 2.2 per cent of men and 3.4 per cent of women are hospitalized at least once a year. Whereas the hospitalization rates of women of reproductive age are much higher than those of men, marking a first peak at age 30–44 years, the male rates rise sharply with increasing age, to reach more than six per cent among those aged more than 60 years, against five per cent among women of the same age (Chart 9).

Chart 9: **Shares of population with at least 1 hospitalization over 12 months by gender and age**
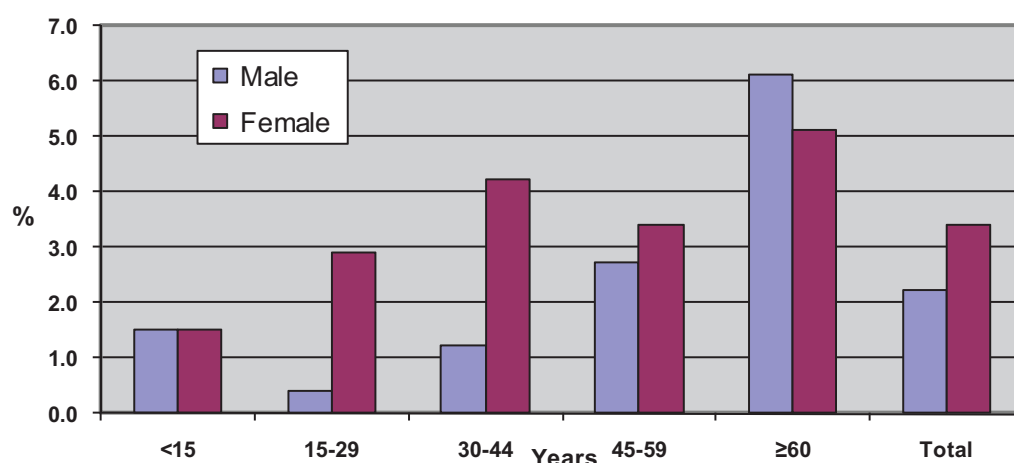
LSMS, 2008

For both sexes the hospitalization rates are higher in rural than in urban areas. As a consequence, on the regional level the hospitalization rate is the highest in the centre (3.3%) and lowest in Tirana (1.4%). This might reflect differences in the density of health services, in particular for outpatient care, making hospitalization less necessary in urban areas.

Interviewees who had at least one treatment in hospital in the course of the year were asked for how many days they had stayed in hospital. As the number of days reported might cover more than one hospitalization, this figure cannot be used to calculate the average length of stay but rather the mean number of hospital days per patient per year. As Chart 10 shows, a person hospitalized at least once spent on average thirteen days in hospital over one year. People more than 60 years of age are close to this average, while the youngest and those aged 45–59 years have the highest values, probably because of often more severe disease.

Chart 10: Mean hospitalization days per patient and year
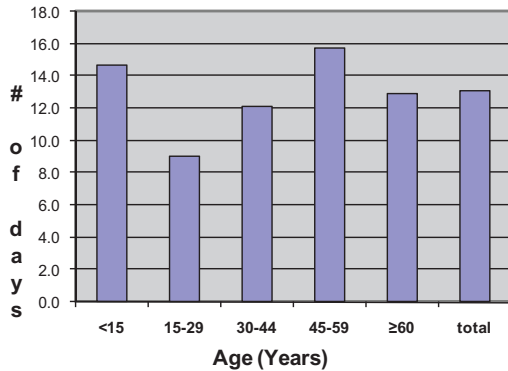
LSMS, 2008

Chart 11: Annual hospitalization days per inhabitant
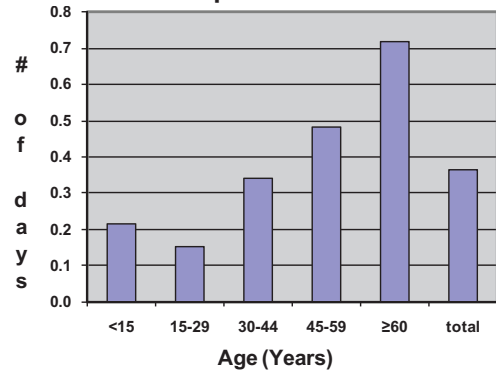
LSMS, 2008

In Chart 11, the total number of annual hospitalization days per age group is divided by the total population size of this age. These figures represent the mean number of days each inhabitant spends in hospital per year, reflecting basic hospitalization rates "corrected" by the average number of hospitalization days. They allow estimates of future needs for hospital beds as a function of demographic structure and evolution assuming that the current morbidity patterns remain by and large unchanged. Not surprisingly, the group over 60 years of age has the highest value, but the difference from the next younger age group is smaller than in the hospitalization rates. Also, the two younger age groups show comparatively low values.

Health determinants

Educational achievement

A large and persistent association between education and health has been well documented in many countries and time periods and for a wide variety of health measures, including mortality. Cutler and Lleras-Muney (2008) tried to explain the association between health and education through three mechanisms: firstly, that poor health leads to lower levels of schooling; secondly, that additional factors, such as family background or individual differences, both increase schooling and improve health; and thirdly, that increased education directly improves health. According to those authors the relationship between health and education is a complicated one, with a range of potential mechanisms shaping their connection.

In fact, education influences health by two major strands. On the one hand, knowledge and behavioural competencies acquired through education allow avoidance of health risks, coping effectively with strains and stresses in everyday life, and utilising resources in the social and physical environment that have a positive effect on health. On the other hand, the probability of access to higher positions in working life increases substantially with educational status. Higher work positions mean not only better income, but also lower exposure to health risks (noxious agents, work accidents, etc.), and—even more importantly—they are often accompanied by a higher degree of autonomy and control over the working situation. These factors allow a person to, for instance, regulate their workload and avoid or at least reduce stress and its negative impact on health (Zimmermann and Weiss, 2004).

As a person's educational status usually is acquired at a young age, the question arises as to whether education has a lasting effect on later life and is, therefore, positively related to health up to old age, or whether the educational effect fades over time. Studies (e.g.

Ross and Wu, 1996) show that there is much more evidence for the first hypothesis: that the positive effects of education on health tend to increase and to accumulate during life rather than fade out.

Hereafter, we will explore if and how in Albania education is related to the few health indicators used above. As final educational status often is attained by age 25 to 30 years, at least by those who have access to higher education, the following analysis are limited to the part of the population older than 29 years. Moreover, educational achievement is not equally distributed in the Albanian population. Thus, in the oldest age group, the proportion of people having only primary education is much higher than among the younger generations. We therefore have to control for this confounding effect of age when looking for any impact of educational achievement on health.

Chart 12 shows perceived health separately for five levels of educational attainment among three age groups. As expected, among 30–44 and 45–59 year-olds a clear gradient appears: the proportion of those rating their health as very good or good increases continuously with educational level, while the share of people with very poor or poor health decreases proportionally.

Chart 12: **Perceived health by educational achievement and 3 age groups**
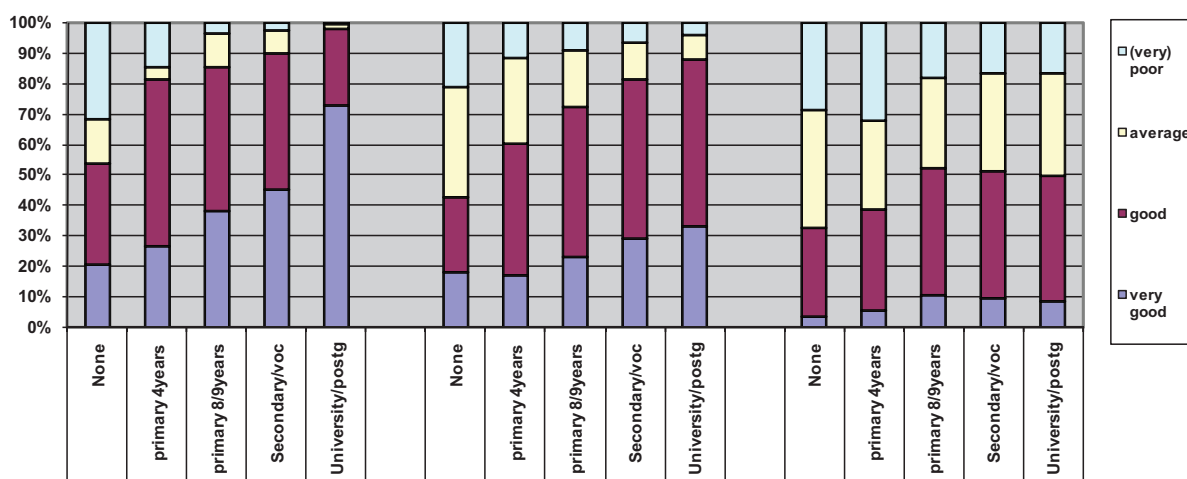
LSMS, 2008

Surprisingly the trend levels off somewhat in 60 years and older age group, where only a small gap, of some ten per cent, distinguishes those who did not go to school or only for four years from those who achieved a higher level (Chart 12). This result is confirmed by an almost identical picture with respect to prevalence of a chronic health problem or a disability: whereas up to the age of 59 years a linear decrease in the prevalence rate is observed with increasing educational level, the prevalence in the group aged 60 years and above shows only slight differences, from 40 to 50 per cent, in percentage of chronic health problems and educational level. Contrary to the result with perceived health, the prevalence of a lasting problem is no higher among groups with a very low educational level (Chart 13).

Chart 13: Percentage of lasting (chronic) problem, by age and educational achievement
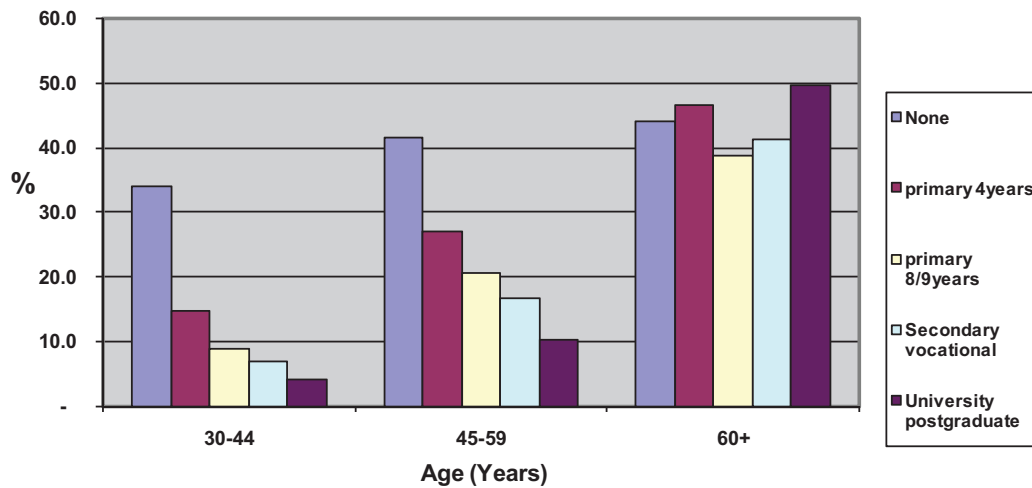
This result sheds some light on the unexplained tremendous jump in the prevalence rates of chronic health problems from those aged up to 59 years to those who are older. Obviously, for this cohort of people, level of educational achievement did not affect the occurrence of health problems. In the past, they either were exposed to difficult life conditions, which uniformly had a negative impact on health, and a health system with poor performance with respect to both prevention of chronic health problems and their treatment.

Chart 14: Share of population with acute illness in previous 4-week period, by age and educational achievement
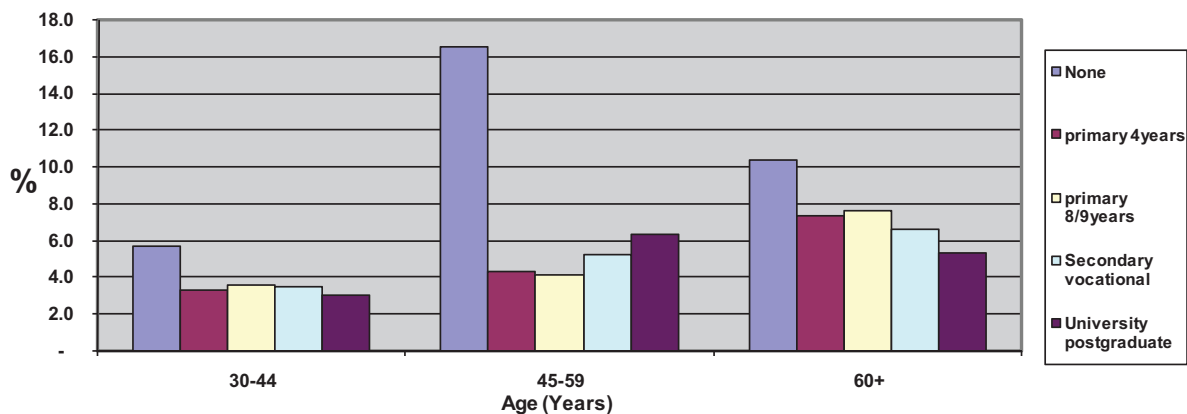
This interpretation is supported by analysis of occurrence of acute illness. Chart 14 shows that among people aged 60 years and above the rate of those with an acute illness in the four-week reference period varies as expected, i.e. according to educational status. Moreover, with increasing educational status not only does the rate of those becoming ill decrease, but also the proportion of those who, despite that illness, are not impaired in their daily activities increases markedly (Chart 15). This observation seems to indicate that although people with higher educational achievement could not take advantage of it in the past, they currently do better in either avoiding acute illness or coping with it.

Chart 15: Percentage of acute ill without impairment, by age and educational achievement
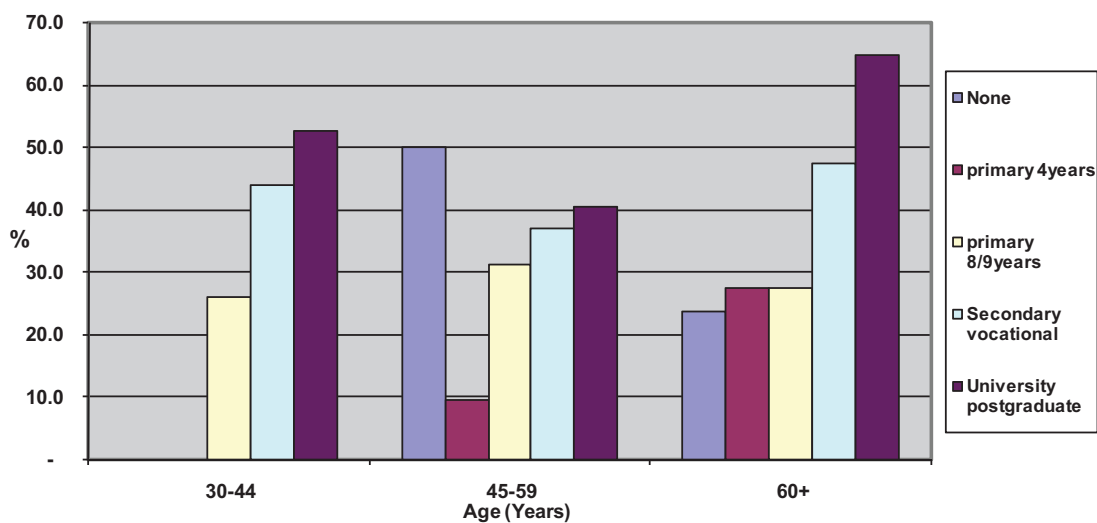
LSMS, 2008

The percentage of people admitted to hospital during a given period, e.g. one year, can be used as a measure of the severity of morbidity. Chart 16 shows for three age groups a general tendency is observed in the expected direction, i.e. that the proportion decreases markedly with rising educational status.

Chart 16: Hospitalization rate (12 months), by age and educational achievement
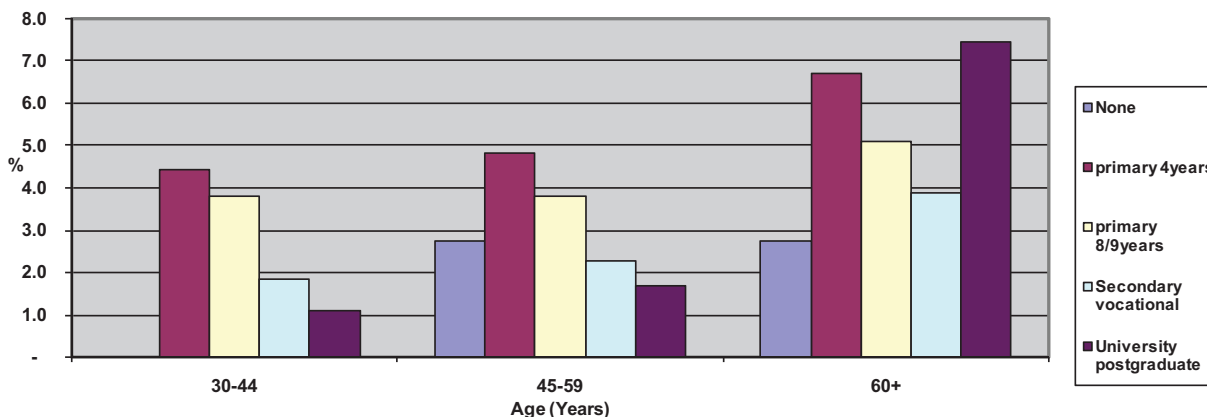
LSMS, 2008

Whereas these results confirm those reported above, i.e. a negative association between educational achievement and morbidity, Chart 16 also reveals some exceptions. Those who did not attend school or did so for four years or less and who proved to be the least healthy are among those with the lowest hospitalization rates. In contrast, the highest hospitalization rate is found among the oldest with the highest educational level. As these observations are in sharp contradiction with the reported findings of our study and the empirical evidence documented in a large body of scientific work (Stamm and Lamprecht, 2008), they cannot be explained by health status. Alternatively, the findings could reflect a main effect of educational status or, more generally, the socio-economic status linked to it, resulting in unequal access to health services and particularly to hospital care. It is in fact conceivable that elderly people with a high socio-economic status have easy access to hospital care, while those from the lowest socio-economic groups cannot afford to seek this type of care.

Life conditions

Beside social status (as measured by level of educational achievement and financial situation, or income), many other conditions of a person's life influence their health. Such determinants reside in their housing situation, employment status, physical environment for leisure activities or the social environment and support, to mention but a few. So far, information about these factors is rather scarce in Albania. Nevertheless, data on two indicators have been collected within the framework of LSMS 2008, shedding light on the socio-emotional situation of the interviewee. First, information was obtained on the household size, i.e. whether a person lives alone or shares a household with one or more other persons. Second, the interviewee was asked whether they have at least one close friend, a so-called confidant[22]. Based on this information we created a new indicator with three values, calling it Social Integration. *Poor* social integration applies for a person living alone without a confidant, *medium* for someone who either lives alone but has a close friend or does not have a close friend but does not live alone. Finally, *high* social integration means that a person does not live alone and can count at least on one close friend.

As mentioned above, lack of social integration not only is a stress factor in itself, but also creates a state of vulnerability because socially isolated people cannot count on necessary socio-emotional support if they encounter difficulties or any other stressful situation in their life. There is ample empirical evidence in the scientific literature for such vulnerability and the health problems arising from it (House et al., 1988). Monitoring health therefore means also monitoring the prevalence of such states of vulnerability.

Compared to countries with larger segments of elderly people, poor social integration seems not yet to be a large problem in Albania, with some two per cent of the population affected. Nevertheless, whereas this condition is non-existent among younger people, it becomes more frequent in middle age and among the elderly, particularly among women. As Chart 17 shows, nine per cent of women aged 45–59 years and one out of five women aged 60 years and older are poorly integrated. Moreover, while around 80 per cent of the male population in these age groups shows a high degree of social integration, this is the case only for, respectively, 54 per cent and 37 per cent of women. Although this condition is found throughout the country, it is more frequent in the urban contexts of Tirana and the coastal region.

Chart 17: Level of social integration by gender and age groups
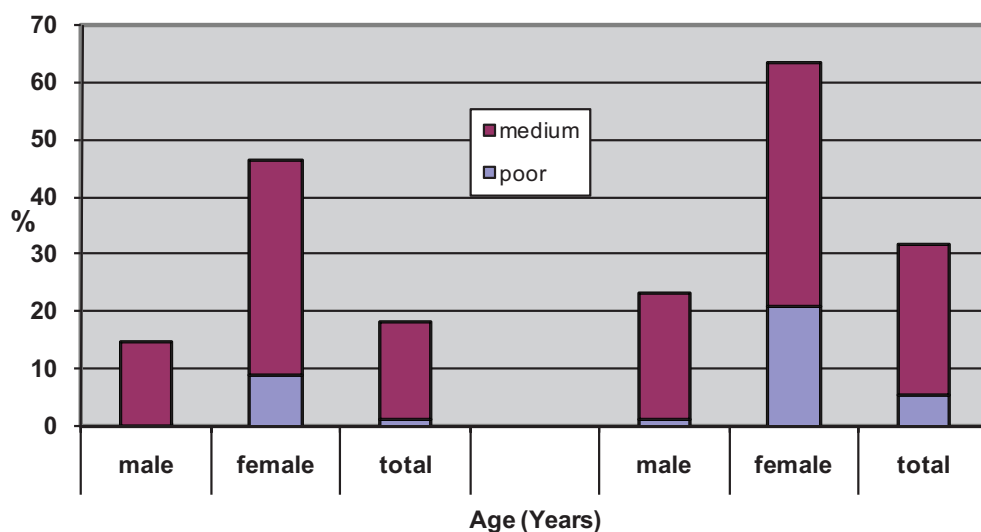
LSMS, 2008

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[22] This question was addressed to the heads of households only

Consistent with what can be expected theoretically, the few health indicators that are available highlight the precarious health situation of this segment of the population. Thus, among those with poor social integration, more than 40 per cent perceive their health as poor or very poor, with less than 30 per cent thinking it good or very good. Chart 18 shows that this situation is in sharpest contrast to those who are better integrated.

Chart 18: Perceived health by level of social intergration
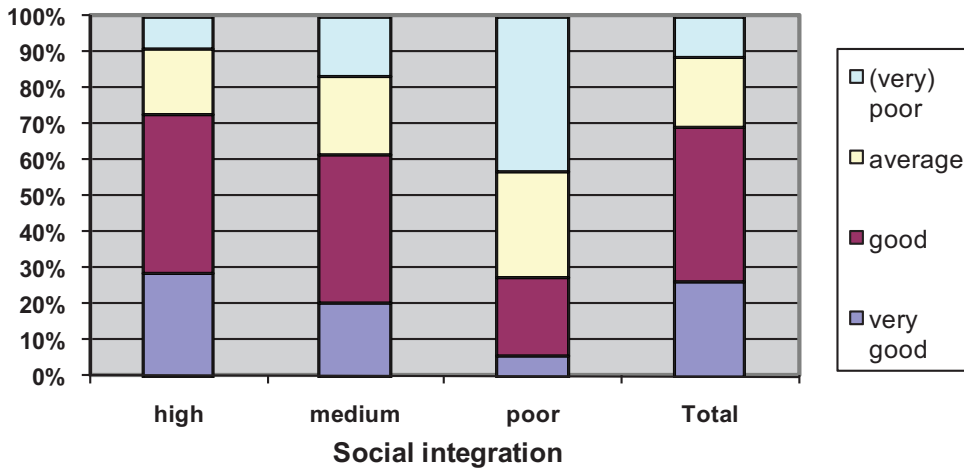
LSMS, 2008

This association of poor social integration and poor health is even stronger with respect to chronic health problems and disabilities (Chart 19): among the poorly integrated population almost 60 per cent has a long lasting health problem. Although this figure reflects to some extent an effect of age (more than 40% of men and women in the oldest age group have such a problem), the finding is of interest given the disabling effects of these problems and the needs of support which might result from them.

The same holds true with regard to the level of hospitalization (6%) (Chart 20), which is about 50 per cent higher than the average of the Albanian population, and slightly higher compared to the population aged 60 years and over. This can probably be explained by the observation from other countries that people who cannot count on informal care and help from their entourage are more likely to be hospitalized than others with the same level of morbidity.

Chart 19: Share of population with a chronic health problem by level of social integration
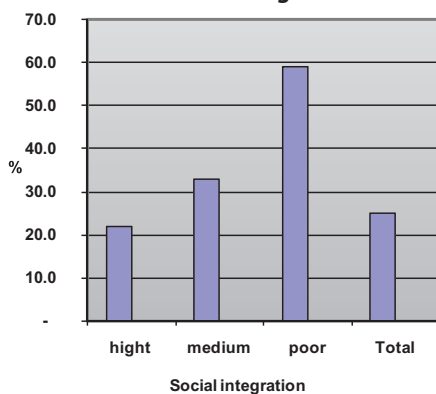
Chart 20: Hospitalization rate by level o social integration
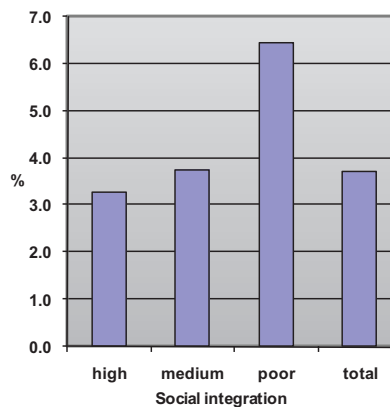
LSMS, 2008

Discussion

Monitoring health and health-related needs of the Albanian population is one of the major reasons for collecting health data in the framework of recent population surveys in Albania. The process of monitoring health is based on various dimensions, particularly the following:

- health status (physical, psychological, socio-emotional)
- morbidity, i.e. prevalence of disease and disability
- health risks in terms of potentially health-damaging behaviour, agents and situations
- health determinants that include income, education, work position and other socio-economic factors.

The few examples of health status and morbidity measures described in the present article highlight that some major traits of the health situation in Albania are largely comparable to those of other European countries, i.e. that health status is systematically poorer in women than in men and that in both sexes it declines steadily over age. This is the case for both the perception of a person's health in general and the prevalence of a lasting health problem—a chronic illness or disability. Surprisingly, both indicators show a steep decline after the age of 60 years. Moreover, the share of people restricted in their usual activities because of an acute health problem for more than three days in one month strongly increases between the groups aged 45–59 years and 60+ years, and even doubles in men.

These observations deserve further investigation as they may indicate a relatively rapid deterioration of health in the aging process. Alternative to such a longitudinal interpretation of cross-sectional data, the observed health gap could reflect, at least partially, a cohort effect. In other words, people in the age group 60 years and older might have been exposed to life conditions that have a stronger negative impact on health than those of younger generations, including a less effective health system or restricted access to health services and goods. This interpretation is supported by the observed effects of educational achievement as one of the strongest health determinants. Whereas good health is positively correlated with educational status in the Albanian population up to 60 years of age, this is not the case in older generations: the prevalence of poor perceived health and chronic health problems is almost equally distributed among groups with different levels of educational achievement. This result is in contradiction to large empirical evidence showing that the effects of education on health do not fade with age, but rather tend to cumulate (Ross and Wu, 1996). In conclusion, the generation in question probably was not only exposed in the past to life conditions detrimental to health, but also to a social situation where higher educational status did not represent a noticeable advantage with respect to health.

Further evidence for understanding the health situation of the older Albanians can be derived from the observed health risks. Given the high proportion of people with hypertension, or who are overweight or obese, or both, by the age of 50, it is expected that these factors are not only more prevalent in older age but have a particularly negative impact on health. This situation adds more evidence of the factors still in force, e.g. traditional nutritional patterns, are the major causes of the high burden of disease in older age. Other lifestyle patterns, e.g. smoking and (heavy) alcohol consumption, highly prevalent in the male population, may also contribute to the observed health problems of the elderly. These observations indicate that at present traditional lifestyle has still a stronger negative impact on health than new lifestyle patterns symbolizing emancipation and modern urban life.

Monitoring health-related needs is aimed at identifying people who have specific needs for maintaining health, recovering from illness or coping with disease or disability. Such needs may relate to a wide variety of activities, including the following:

- prevention of health risks and health promotion
- treatment and nursing care
- health counselling and social support.

Moreover, the process of monitoring needs has to be linked to the monitoring of accessibility to health services and goods for all people concerned. Accessibility can be restricted for economic reasons, e.g. the cost of treatment or request for an informal payment (Abazi et al., this volume), for geographical reasons (distance to nearest health facility) or for socio-cultural reasons, such as lack of familiarity with, or confidence in, a health professional or institution.

So far, information on the utilization of health services is relatively scarce in Albania. The need for hospital care, measured by the proportion of the population undergoing hospital treatment in the course of one year, shows a distribution similar to that in comparable countries. Thus, women of reproductive age have markedly higher hospitalization rates than do men from the same age group, but both men and women aged 60 years and above have the highest hospitalization rates. Whereas hospitalization rates are rather low compared to European countries with developed health services[23], the mean number of hospitalization days per patient per year is relatively high, in particular in the age group 45 to 59 years. These observations indicate either that hospital care is mainly reserved for people with relatively severe disease, or that accessibility of hospital care is generally limited, or both.

There is ample empirical evidence that social exclusion creates a state of vulnerability to health problems (House et al., 1988). Beside the fact that the lack itself of social ties and integration causes psycho-social stress, people in this situation are likely to miss the buffering effect of social support if they are exposed to stress caused by illness or other adverse life conditions. The few data available on the socio-emotional situation of the Albanian population reveal that 2.2 per cent of the people are in the unfavourable condition of living alone, in a one-person household, and missing any close (confidential) relationship. As can be expected, this segment of the population suffers from particularly bad health, often accumulating the effects of older age and poor educational status. Thus, the proportion of people who perceive their health as poor, or very poor, and suffering from chronic illness and disability are extremely high in this group. Consequently, the needs of those people in terms of health care and help in everyday life might be particularly high, especially if they cannot depend on informal care and assistance from their entourage.

If at present the absolute number of people in this situation is limited, some 17,500 individuals, with most of them living in the urban context of Tirana and the coastal region, the situation might change rapidly with evolution of demographic factors such as longer life expectancy and weakening family ties. If the health system is to adapt to the imminent health-related needs of this population group, periodic evaluation of the health situation in terms of both health status and independence (with regard to basic daily activities—mobility, getting dressed, eating and personal hygiene, etc.) is of great importance.

Monitoring the health needs of the population as a whole and of specific segments provides an informational basis for efficient development and organization of the health system. Thus, in the case of people with weak social ties, the proportion of whom will probably increase rapidly as discussed above, timely provision of home care services and institutions for long-term care will help reduce bed utilization in hospitals, leaving space for acute care and reducing the high costs.

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[23] Cf. WHO–HFA database: http://data.euro.who.int/hfadb/

Recommendations

Keeping control over the evolution of health care costs, i.e. cost containment, has become one of the major concerns of health policy throughout the world, regardless of whether a country's health system follows the model of a public health service (as for instance in England or Denmark) or that of social security (e.g. Germany and France). Nevertheless, fast and regularly increasing health budgets do not necessarily lead to an improvement of the health situation of the whole population, nor do they guarantee more equity in health. As the WHO pointed out in its programmatic policy approach, Health for All (HFA), health is not only the result of good and accessible health services but also influenced by many other sectors of public policy and legislation, including social policy, taxation, environment and education. Periodic evaluation of the population's overall health allows assessment of the general impact of public policies on health.

For the purpose of assessing the general health status of populations, several summary measures have been developed in recent decades. In the case of indices such as Health Adjusted Life Expectancy (HALE) or Disability Free Life Expectancy (DFLE), the method consists in differentiating the number of years lived in good health from total life expectancy, the aim of public health policies being not only to increase life expectancy but also to improve health-related quality of life over the lifespan. The so-called Minimum European Health Module (MEHM) is the instrument currently most in use for collecting data and computing DFLE in Europe. Developed by Eurostat, a short questionnaire composed of three items (Cox et al, 2009) can be inserted in thematic interview surveys. EU Member States are supposed to collect the data annually within the framework of their Labour Force Survey.

A more comprehensive approach to monitoring health, health risks and health-related needs as discussed in the present article, requires periodic collection of data on a larger basis. Within the framework of the EU Health Monitoring Programme (Kramers, 2009), a comprehensive list of health indicators to be collected by means of health interview surveys (HIS) was established. On the basis of this list, a questionnaire was developed in cooperation with international agencies and member states. With this instrument, European Core Health Interview Survey (ECHIS), EU Member States collected a first series of data since 2007. These data are used by member states and non-members such as Switzerland for production of national health monitoring reports and by Eurostat for the process of monitoring at the Community level.

If the Albanian authorities were to decide to set up a programme for monitoring health at the population level, we strongly recommend a stepwise implementation of the principal elements of the health interview survey programme developed by Eurostat. These elements, MEHM and ECHIS, represent validated and standardized instruments that can be readily adapted and translated for use in all other European countries. This is not only of interest in terms of saving time and money, but above all for taking advantage of the large know-how that has been developed along with data collection procedures, data analysis, diffusion and utilization.

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Appendix

Table 1. Distribution of PSUs and Housing Units in the Sampling Frame for LSMS 2008 (based on 2001 Census) and Sample Allocation by Stratum.

Geographic area	Stratum	No. PSUs in frame	No. sample PSUs	No. sample HUs
Central	1, Shkoder	278	10	80
	2, Elbasan	220	10	80
	3, Berat	123	10	80
	4, Korce	179	10	80
	5, other urban	573	20	160
	6, rural	2,485	65	520
	Sub-total	3,858	125	1,000
Coastal	7, Durres	306	10	80
	8, Fier	168	10	80
	9, Vlore	241	10	80
	10, other urban	510	30	240
	11, rural	1,479	65	520
	Sub-total	2,704	125	1,000
Mountain	12, other urban	172	50	400
	13, rural	658	75	600
	Sub-total	830	125	1,000
Tirana	14, low	268	17	136
	15, medium	452	31	248
	16, high	359	27	216
	Sub-total	1,079	75	600
Albania	Total	8,471	450	3,600

LSMS, 2008

Table 2. Distribution of Sample and Population (weighted) for LSMS 2008, by background characteristic.

Background characteristic	Sample		Population (weighted)	
	N	%	N	%
Age group (years)				
<15	3,230	21.7	655,439	20.7
15–29	3,790	25.5	777,425	24.5
30–44	2,760	18.6	594,158	18.8
45–59	2,868	19.3	632,366	20.0
>60	2,226	15.0	508,895	16.1
Gender				
Male	7,490	50.4	1,600,157	50.5
Female	7,384	49.6	1,568,126	49.5
Region				
Costal	3,897	26.2	991,068	31.3
Central	4,086	27.5	1,361,453	43.0
Mountain	4,779	32.1	259,913	8.2
Tirana	2,107	14.2	555,848	17.5
	(missing 5)			
Residence				
Urban	7,402	49.8	1,541,480	48.7
Rural	7,467	50.2	1,626,803	51.3
	(missing 5)			

LSMS, 2008

5 Informal Payment and Access to Health Care in Albania

Ornela Abazi, Gianfranco Domenighetti, Angelo Tomada, Nurije Çaushi, Ruzhdije Bici, Fatjona Pupuleku, [24]

Abstract

Background

Research carried out in transitional economies in Central and South-eastern Europe on informal payments has found that such payments can create several negative effects on health system performance. Informal payment can have implications in governance of a health system and negatively affect access, equity, efficiency and utilization of health care services.

Methods

Data in the Living Standards Measurement Survey (LSMS) conducted in Albania in 2005 and 2008 were analysed and informal payment and access to health care services compared, in order to find out how the situation had changed over this three-year period. Furthermore, data from Demographic and Health Survey (DHS) 2008–09 were used to analyse barriers to access to care for rural and urban residents, and among four regions. For each variable of interest we first calculated crude prevalence rates in univariate analysis. Then, in order to have a standardized comparison of informal payments and access to care between the two sample sets (LSMS 2005 and 2008) and to compare differences in access for men and women, and by region of residence, odds-ratios were derived from a multivariate logistic regression model using as covariates gender, age, education, household size, urban or rural status, whether suffering from chronic illness, and subjective health status.

Results

At the macro level, analysis identified that in 2005 and 2008 the prevalence of patients making informal payments in various health settings varied between about 18 per cent and 53 per cent, the highest prevalence being in the hospital care setting. For both years, informal payments were mostly requested or expected in the hospital setting (68% and 61%, respectively), followed by hospital outpatient visits (63%, 54%) and ambulatory visits (60, 48%). The value of the gift (voluntary or expected) made to medical staff was in two

thirds of cases less than 500 leke for ambulatory and outpatient visits and 2,000 leke for hospital care.

Over the period between 2005 and 2008, the only statistically significant crude prevalence was a decrease in informal payments requested in the ambulatory care visit setting (60.4% to 47.5%) though the difference was not significant in logistic regression analysis when taking into account confounding factors. This means that the level of informal payment did not vary significantly over the study period.

Access to health care appears also to be unchanged. In particular, the prevalence of people declaring difficulties to find money to pay for health care is relatively high (about 30%). Of those, 66 per cent had to borrow money or sell valuables, including animals, in order to be able to pay for health care. About 15 per cent of respondents considered that this issue caused a consequent decline in their health status. Relevant differences in infrastructural facilities between urban and rural areas were also a source of significant disadvantages and inequities in access to care for rural residents, in particular in terms of availability of supplies and drugs, health care equipment, transport facilities and distance to health providers (see Table 10). The prevalence of perceived factors (finance, transport type, distance to health facilities, not wanting to go alone) preventing people from obtaining medical advice or treatment according to four regions (Tirana, coastal, central and mountain) systematically worsened for men and women through a gradient that declined from urban to mountain areas. The main problem was obtaining money for treatment, with a prevalence that increased from 35–44 per cent in Tirana to 70–74 per cent in central–mountain areas.

Conclusions

The high prevalence of informal payments and the differences among urban and rural areas and different regions in access to health care services continue to persist. The above mentioned results highlight the need for policy actions that can create equal access to health care, regardless of differences in ability to pay for both them and residency. There is a need to continue to study how the phenomena of informal payment and access to health care will evolve in the coming years in order to provide evidence for policy makers. Periodical population-based surveys, such as LSMS, offer a great opportunity to monitor the situation. Policy makers need to take these results into consideration when evaluating health sector reform interventions undertaken up to now in order to improve the situation, as well as when preparing new interventions.

1. Introduction

Before the fall of the communist regime, the health system in Albania was modelled on the Soviet *Semashko* system of universal health care coverage, with a virtually exclusive role for the state in financing and delivery (Nuri, 2002). In the last two decades, the Albanian health system has undergone several changes. Measures were adopted in order to reduce expenditure including downsizing of health facilities and staff, separation of purchaser and provider roles, introduction of new mechanisms of provider payment, and introduction and creation of a private health sector. A health insurance system has been introduced. Interventions have been undertaken to strengthen primary health care with the introduction of family medicine delivered by general practitioners but reliance on out-of-pocket payments (both formal and informal) has increased. A number of alternative health sector reform strategies, to improve the availability, quality and use of health care services, have taken place.

All the organizational and budgetary changes that have been undertaken were aimed at fragmenting the funding and administration of primary and hospital health care services that had previously been the exclusive responsibility of the Ministry of Health (MOH). Within this framework the role of the Health Insurance Institute (HII) in financing health care services has been extended. HII is becoming the main purchaser of health services, paying the salaries of primary care physicians, hospital health care, prescription drugs, in accordance with the list of drugs approved by the MOH, and high-end diagnostics. Meanwhile, MOH continues to pay non-physician salaries, other operating costs for primary care, and all the public health services.

In 2006, Albania spent 6.5 per cent of GDP on health care, while the share of private expenditure amounted to 62.7 per cent of that figure. Out-of-pocket expenditures account for almost 94.7 per cent of private expenditure on health (World Health Organization, 2009). The high share of private out-of-pocket funding creates serious inequities in access, has a considerable poverty impact and limits the effectiveness of government sectoral stewardship (World Bank, 2006).

There is evidence that informal payments made by patients for health care services that are officially free have increased since the fall of the communist regime. Informal payments are defined as direct payments by patients for services they are entitled to for free, usually in a public health system. They range from the ex ante cash payment to the ex post gift-in-kind (Allin et al., 2006).

According to an MOH study conducted in 2000 (Ministry of Health 2000), 80 per cent of patients reported making informal payments in primary care settings. Results of LSMS 2002 indicated that 43 per cent of people giving gifts during a hospital stay (60% of all cases) and 40 per cent of those going to public ambulatories said gifts were required or expected (World Bank 2003).

Analysis of a three-province survey showed that out-of-pocket payments were widespread and extensive within the study area, and a substantial share of these payments were informal payments which appear to be particularly severe for inpatient care (Vian et al., 2004). A qualitative study conducted in 2003 found that informal payments were not being used to improve equipment or supplies, but to supplement the providers' personal income. Also, many providers viewed informal payments as voluntary and as having no effect on the quality of care given, while members of the general public often saw informal payments as a requirement to gain access to treatment (Burak and Vian, 2007).

Requiring payment from patients restricts access to health care to those who can pay, makes payment levels and terms arbitrary, and can render essential services unaffordable. One of the primary reasons for government involvement in financing health care is to pool the risk of illness across the population and thus pool resources to ensure equity across both the healthy and the sick and among those who cannot afford health care. Equity in delivery and distribution of health care does not, per se, guarantee equality in health and survival. However, access to health services without economic barriers that could prevent people from purchasing the care they need is an important determinant of health and a cornerstone in the long road to social justice. Improvement of health system financing and increase in access to health care services are among the main priorities stated in the National Strategy for Health, 2007–2013 (Ministry of Health, 2004).

Through our study we aim to determine the prevalence of Albanian citizens making informal payments in order to obtain health care services in the years 2005 and 2008, to explore how this phenomenon has changed over the study period and to investigate how ability to pay

has influenced access to health care services, analysing in doing so urban, rural and regional disparities.

2. Methodology

The source of information was data contained in the two main cross-sectional national surveys: Living Standards Measurement Survey (LSMS), and Albanian Demographic and Health Survey (ADHS).

LSMS

Data from LSMS, a cross-sectional population study, nationally representative, were accessed in order to explore the phenomena of informal payment, access to health services and to find out how these have changed between 2005 and 2008. LSMS was established by the World Bank in 1980 in order to explore ways of improving the type and quality of household data collected by government statistical offices in developing countries.

Albanian Institute of National Statistics (INSTAT) was the national implementer of this study in Albania, assisted technically and supported financially by the World Bank and United Nations Development Program (UNDP).

LSMS is implemented every three years, the first in 1995 (Grosh and Glewwe, 1995) and the most recent in 2008. It is a multi-topic survey, designed to permit four types of analysis: simple descriptive statistics on living standards, monitoring of poverty and living standards over time, description of the incidence and coverage of government programmes, and measurement of the impact of policies and programmes on household behaviour and welfare (Grosh et al., 2000).

Our analysis refers to the LSMS data collected in 2005 and 2008. Representative sample sizes (n) were, respectively, 3,640 (response rate: 91.7%) and 3,600 households (response rate: 85.4%). The sampling design for LSMS carried out in Albania in 2008 was strictly related to the one used in 2005. Sampling of LSMS 2005 was a stratified, two-stage cluster design in which the Primary Sampling Units (PSUs) were represented by the census Enumeration Areas (EAs), while the Second Stage Units (SSUs) were the households. The selection of EAs within each stratum was carried out by means of a Probability Proportional to Size (PPS) design, and the measure was represented by the number of households living within each EA. The SSUs were selected by means of systematic sampling. Members of household included all persons that had been away for less than twelve months. Deceased individuals, lodgers, hired workers and servants were never considered household members. Guests who stayed with the household for six months or more, infants of less than six months and new arrivals were considered household members. The head of household was always considered a member of the household irrespective of the time she or he spent away from it.

The household questionnaire forms the heart of LSMS. A health module is included in the questionnaire and is divided into two parts: Part A, which collects information on general health status, and Part B, which covers access to health care. Both parts include self-reported questions. Part A was answered individually by every household member aged 15 years and older; for household members younger than 15 years a parent or guardian answered on their behalf. In total, 15,547 individuals in 2005 and 14,210 in 2008 answered this part of the questionnaire. Part B was answered only by the most knowledgeable person in the family, and their total number was equal to the number of households included in both surveys (N = 3,640 for 2005, and N = 3,600 for 2008).

For Part A, data collected on informal payments pertaining for both years concerning public ambulatory visits, hospital outpatient care, hospital care and private doctor visits were analysed. The results are reported in Tables 1 to 4 and shown in Figures 1 to 3.

For Part B, data on access to health care collected through questions of the Health module Part B for years 2005 and 2008 of the LSMS questionnaires were also analysed. The results are shown in Tables 5 to 10.

ADHS

The Albanian DHS is designed to provide data that facilitates monitoring of the population and health situation in Albania. The questions analysed here form part of a questionnaire for women and men. Specifically, the 2008–09 ADHS collected information on fertility levels, marriage, sexual activity, fertility preferences, knowledge and use of family planning methods, breastfeeding practices, nutritional status of women and young children, childhood mortality, maternal and child health, and awareness and behaviour regarding AIDS and other sexually transmitted infections (INSTAT,ISHP, ICF Macro Calverton 2010). Additional features include the collection of information on migration (out-migration, returning migrants, and internal migration), haemoglobin testing to detect the presence of anaemia, blood pressure (BP) measurements among the adult population, and questions related to accessibility and affordability of health services. Three questionnaires were used to collect the information: Household Questionnaire, Women's Questionnaire and Men's Questionnaire.

A two-stage sample design was used for ADHS, the first of which involved selection of a sample of PSUs as used for LSMS 2008. In total, 450 PSUs were selected for the ADHS sample, including 245 urban PSUs and 205 rural PSUs, covering four geographic domains—mountains, central Albania, coastal Albania and urban Tirana. A listing of each of the selected PSUs was carried out in preparation for LSMS. The ADHS survey selected 20 households from the updated household listing in each PSU, excluding those selected for LSMS.

A representative probability sample of almost 9,000 households (response rate 98%) was selected in such a manner as to allow separate urban and rural, as well as regional, level estimates for key population and health indicators, e.g. fertility, contraceptive prevalence, and infant mortality for children under five. All women aged 15–49 years (n = 7,584) in the total sample of households, and all men aged 15–49 years (n = 3,013) in a sub-sample of one-half of households, who were either usual residents of, or visitors to, the household on the night before the survey was undertaken were eligible for interview.

Statistical analysis

In order to explore, on the basis of LSMS questionnaires, how the informal payment phenomenon and access to health care evolved from 2005 to 2008, we tested for differences with the chi-square test (significance level set at $p < 0.05$) crude prevalence rates for each question and year under investigation. Since the two sample sets, even if statistically representative, were not composed of the same individuals, we performed logistic regression analysis using the 2005 sample as the reference group, including as potential confounding factors gender, age, education, household size, urban or rural setting, whether suffering from chronic illness, and subjective health status. Differences in crude prevalence rates were therefore confirmed only when the 95 per cent confidence interval referring to a specific Odds Ratio (OR) did not include the value 1 (OR and confidence interval being all below or over 1).

Since in Part B of the LSMS health module, questions regarding all family members were answered by the most knowledgeable person, we decided to include in the logistic regression

models only those covariates that could characterize the family socio-economic situation (gender, age and education level of the respondent, household size, rural or urban).

For data drawn from the ADHS questionnaire, the same statistical procedures set out above (crude prevalence rates and logistic regression analysis) were used to perform comparative analysis between men and women in rural and urban settings. The 95 per cent confidence intervals (CIs) were calculated for each OR.

3. Results

Part A: Informal payments

Table 1. Ambulatory visits: Prevalence

"During the past 4 weeks did you visit any public ambulatory to obtain outpatient health care?"					
Answer	Crude Prevalence Rate N (%)			Odds Ratio*	95% CI (min-max)
	2005 n = 15,547	2008 n = 14,210	P value (chi-square)		
Yes	1,463 (9.4)	1,151 (8.1)	<0.001	1.233	1.038–1.463
No	14,084 (90.6)	13,059 (91.9)			

LSMS 2005, LSMS 2008

*OR includes terms of gender, age group, household size, education, urban/rural, whether suffering from chronic illness, subjective health status

Although Table 1 reports a slight decrease in the crude prevalence rate in public ambulatory visits, after controlling for confounding factors (gender, age group, household size, etc.), we found that between 2005 and 2008 there had been a statistically significant increase in the prevalence of people declaring they had visited an ambulatory to obtain outpatient healthcare (OR: 1.233; CI: 1.038–1.463).

Table 1.1. Ambulatory visits: Prevalence of patients making informal payments

"Have you ever given any gift (money, food, service) to the medical staff of a public ambulatory during the past 4 weeks?"					
Answer	Crude Prevalence Rate N (%)			Odds Ratio*	95% CI (min-max)
	2005 n = 1,463	2008 n = 1,151	P value (chi-square)		
Yes	285 (19.5)	204 (17.7)	0.253	1.031	0.704–1.511
No	1,178 (80.5)	947 (82.3)			

LSMS 2005, LSMS 2008

*OR includes terms of gender, age group, household size, education, urban/rural, whether suffering from chronic illness, subjective health status

Table 1.1 reports that the prevalence of individuals who made informal payments to obtain an outpatient health care visit in a public ambulatory did not change significantly between 2005 and 2008 (OR: 1.031; CI: 0.704–1.511). In 2008, about 18 per cent of patients making an ambulatory visit gave a gift to the medical staff.

Table 1.2. **Ambulatory visits: Value of informal payment**

"What was the value of any gift (money, food, service) made to medical staff of a public ambulatory during the past 4 weeks?"			
Amount (leke)	Crude prevalence rate N (%)		P value (chi-square)
	2005 n = 285	2008 n = 204	
Up to 500	250 (87.7)	181 (88.7)	0.884
501–1,000	22 (7.7)	17 (8.3)	
1,001–2,000	9 (3.2)	4 (2.0)	
> 2,000	4 (1.4)	2 (1.0)	

LSMS 2005, LSMS 2008

The value of informal payment made to the medical staff of a public ambulatory did not change significantly between 2005 and 2008 (Table 1.2; p = 0.884). The majority of people making informal payments paid up to 500 Leke (about 88%), while a few individuals (less than 5%) gave a gift whose value was more than 1,000 Leke.

Table 1.3. **Ambulatory visits: Modality of informal payments**

"Was the gift requested or expected, or voluntary?"					
Answer	Crude Prevalence Rate N (%)			Odds Ratio*	95% CI (min-max)
	2005 n = 283	2008 n = 204	P value (chi-square)		
Requested or expected	172 (60.4)	97 (47.5)	0.005	0.551	0.244–1.244
Voluntary	113 (39.6)	107 (52.5)		1.575	0.687–3.609

LSMS 2005, LSMS 2008

*OR includes terms of gender, age group, household size, education, urban/rural, whether suffering from chronic illness, subjective health status

Although between 2005 and 2008 there was a decrease (from 60.4% to 47.5%) in the prevalence of people stating that the informal payment was explicitly requested or expected by the medical staff of a public ambulatory, the difference was not significant in logistic regression analysis when taking into account confounding factors (OR: 0.551; 95% CI 0.244–1.244). Conversely, there was an important increase in the prevalence of those individuals who declared having paid voluntarily for an outpatient ambulatory health care visit from 39.6% in 2005 to 52.5% in 2008.

Table 2. Hospital outpatient visits: Prevalence

"During the past 4 weeks did you visit any hospital to obtain outpatient health care?"					
Answer	Crude Prevalence Rate N (%)			Odds Ratio*	95% CI (min-max)
	2005 n = 15,547	2008 n = 14,210	P value (chi-square)		
Yes	635 (4.1)	415 (2.9)	<0.001	1.055	0.836–1.333
No	14,912 (95.9)	13,795 (97.1)			

*OR includes terms of gender, age group, household size, education, urban/rural, whether suffering from chronic illness, subjective health status

Table 2 reports that in Albania there was an important decrease in the prevalence of hospital outpatient visits between 2005 (4.1%) and 2008 (2.9%) though it is not statistical significant if confounding factors are taken into account (OR:1.055; CI: 0.836–1.333).

Table 2.1. Hospital outpatient visits: Prevalence of patients making informal payments

"Have you ever given any gift (money, food, service) to the medical staff of hospital during the past 4 weeks?"					
Answer	Crude Prevalence Rate N (%)			Odds Ratio*	95% CI (min-max)
	2005 n = 635	2008 n = 415	P value (chi-square)		
Yes	194 (30.6)	155 (37.3)	0.022	1.451	0.915–2.301
No	441 (69.4)	260 (62.7)			

LSMS 2005, LSMS 2008

*OR includes terms of gender, age group, household size, education, urban/rural, whether suffering from chronic illness, subjective health status

Although Table 2 reports a decrease in the prevalence of hospital outpatient visits the proportion of individuals stating they had made informal payments for an outpatient health care visit in a hospital (Table 2.1) did not change significantly between 2005 and 2008 (OR: 1.451; CI: 0.915–2.301).

Table 2.2. Hospital outpatient visits: Value of informal payment

"What was the value of any gift (money, food, service) made to the medical staff of hospital during the past 4 weeks?"			
Amount (leke)	Crude prevalence rate N (%)		P value (chi-square)
	2005 n = 194	2008 n = 155	
Up to 500t	128 (66.0)	109 (70.3)	2.688
501–1,000	38 (19.6)	22 (14.2)	
1,001–2,000	13 (6.7)	8 (5.2)	
>2,000	15 (7.7)	16 (10.3)	

LSMS 2005, LSMS 2008

The value of informal payments made to the medical staff in a hospital outpatient visit did not vary significantly between 2005 and 2008 (Table 2.2; p = 2.688). The majority of people making informal payments paid up to 500 Leke (about 70%), while about 15 per cent gave a gift whose value was greater than 1,000 Leke.

Table 2.3. Hospital outpatient visits: Modality of informal payments

"Was the gift requested or expected, or voluntary?"					
Answer	Crude Prevalence Rate N (%)			Odds Ratio*	95% CI (min-max)
	2005 n = 194	2008 n = 155	P value (chi-square)		
Requested or expected	123 (63.4)	83 (53.5)	0.063	0.631	0.287–1.390
Voluntary	71 (36.6)	72 (46.5)		1.621	0.737–3.564

*OR includes terms of gender, age group, household size, education, urban/rural, whether suffering from chronic illness, subjective health status

Requested or expected informal payments decreased between 2005 and 2008 (from 63.4% to 53.5%), while voluntary payments increased by the same proportion. Nevertheless, these changes were not significant after taking into account the confounding factors included in the logistic regression analysis (OR 0.631; CI 0.287–1.390). Nevertheless, in both years, the majority of people declared that the gift was requested or expected by the medical staff.

Table 3. Hospital care: Prevalence

"During the past 12 months, have you stayed in a hospital or maternity hospital or a private clinic, in Albania or abroad?"					
Answer	Crude Prevalence Rate N (%)			Odds Ratio*	95% CI (min-max)
	2005 n = 15,547	2008 n = 14,210	P value (chi-square)		
Yes	677 (4.4)	377 (2.7)	<0.001	0.743	0.576–0.958
No	14,870 (95.6)	13,833 (97.3)			

LSMS 2005, LSMS 2008

*OR includes terms of gender, age group, household size, education, urban/rural, whether suffering from chronic illness, subjective health status

Between 2005 and 2008, the prevalence of stays in hospitals or private clinics in Albania or abroad decreased significantly, from 4.4 per cent to 2.7 per cent (Table 3; OR: 0.743; 95% CI: 0.576–0.958).

Table 3.1. Hospital care: Prevalence of patients making informal payments

"Have you ever given any gift (money, food, service) to the hospital staff during the past 12 months?"					
Answer	Crude Prevalence Rate N (%)			Odds Ratio*	95% CI (min-max)
	2005 n = 677	2008 n = 377	P value (chi-square)		
Yes	360 (53.2)	165 (43.8)	0.003	0.768	0.583–1.011
No	317 (46.8)	212 (56.2)			

LSMS 2005, LSMS 2008

*OR includes terms of gender, age group, household size, education, urban/rural, whether suffering from chronic illness, subjective health status

Although the prevalence of individuals declaring they had made informal payments during their stay in hospital or private clinic in Albania or abroad decreased between 2005 and 2008 (Table 3.1; from about 53% to 44%) the difference is not statistically significant in logistic regression analysis (OR: 0.768; 95% CI: 0.583–1.011): about half of individuals answered that they had given some gift to staff in order to obtain hospital care.

Table 3.2. Hospital care: Value of informal payment

"What was the value of any gift (money, food, service) made to the hospital staff during the past 4 weeks?"			
Amount (leke)	Crude prevalence rate N (%)		P value (chi-square)
	2005 n = 360	2008 n = 165	
Up to 500	19 (5.3)	10 (6.1)	0.410
501–1,000	41 (11.4)	19 (11.5)	
1,001–2,000	57 (15.8)	23 (13.9)	
>2,000	243 (67.5)	113 (68.5)	

LSMS 2005, LSMS 2008

The value of informal payments made to hospital staff did not change significantly between 2005 and 2008 (p = 0.410). The majority of people (about 70%) declared having paid more than 2,000 Leke, while only about six per cent paid 500 Leke or less, contrary to payments made in the ambulatory setting, where about 70% of patients gave a gift of value less than 500 Leke.

Table 3.3. Hospital care: Modality of informal payments

"Was the gift requested or expected, or voluntary?"					
	Crude Prevalence Rate N (%)			Odds Ratio*	95% CI (min-max)
Answer	2005 n = 360	2008 n = 165	P value (chi-square)		
Requested or expected	246 (68.1)	101 (61.2)	0.120	0.663	0.306–1.439
Voluntary	114 (31.9)	64 (38.8)		1.468	0.692–3.116

LSMS 2005, LSMS 2008

*OR includes terms of gender, age group, household size, education, urban/rural, whether suffering from chronic illness, subjective health status

Table 3.3 reports that there has been no significant change in the modality of informal payments between 2005 and 2008; the majority of people declared that the gift was regularly requested or expected by the hospital staff.

Table 4. Private doctor visits: Prevalence

"During the past 4 weeks did you visit any private doctor to obtain outpatient health care?"					
	Crude Prevalence Rate N (%)			Odds Ratio*	95% CI (min-max)
Answer	2005 n = 15,547	2008 n = 14,210	P value (chi-square)		
Yes	193 (1.2)	116 (0.8)	<0.001	0.428	0.367–0.499
No	15,354 (98.7)	14,094 (99.2)			

LSMS 2005, LSMS 2008

*OR includes terms of gender, age group, household size, education, urban/rural, whether suffering from chronic illness, subjective health status

The prevalence of private medical visits was, as expected, very low compared to those made to public ambulatories (Table 1). Table 4 shows that in Albania there was a slight but significant decrease in the prevalence of such visits between 2005 (1.2%) and 2008 (0.8%) (OR: 0.428; 95% CI: 0.367–0.499).

Table 4.1. Private doctor visits: Prevalence of patients making informal payments

"Have you ever given any gift (money, food, service) to private doctor and staff during the past 4 weeks?"					
Answer	Crude Prevalence Rate N (%)			Odds Ratio*	95% CI (min-max)
	2005 n = 193	2008 n = 116	P value (chi-square)		
Yes	9 (4.7)	8 (6.9)	0.404	3.298	0.648–16.785
No	184 (95.3)	108 (93.1)			

LSMS 2005, LSMS 2008

*OR includes terms of gender, age group, household size, education, urban/rural, whether suffering from chronic illness, subjective health status

As expected, the prevalence of individuals declaring they had made informal payments to a private doctor was very low (compared to that in the public care setting) and did not change significantly between 2005 and 2008 (OR: 3.298; 95% CI: 0.648–16.785).

Figure 1. Prevalence of patients having made informal payments in various health settings
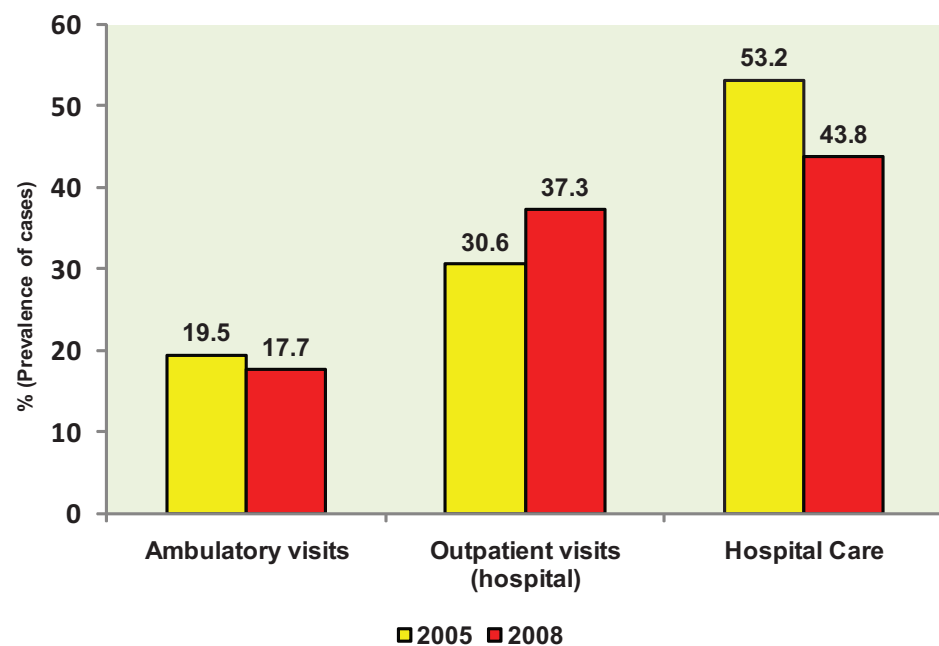
Figure 2. Value (leke) of informal payments (2008)
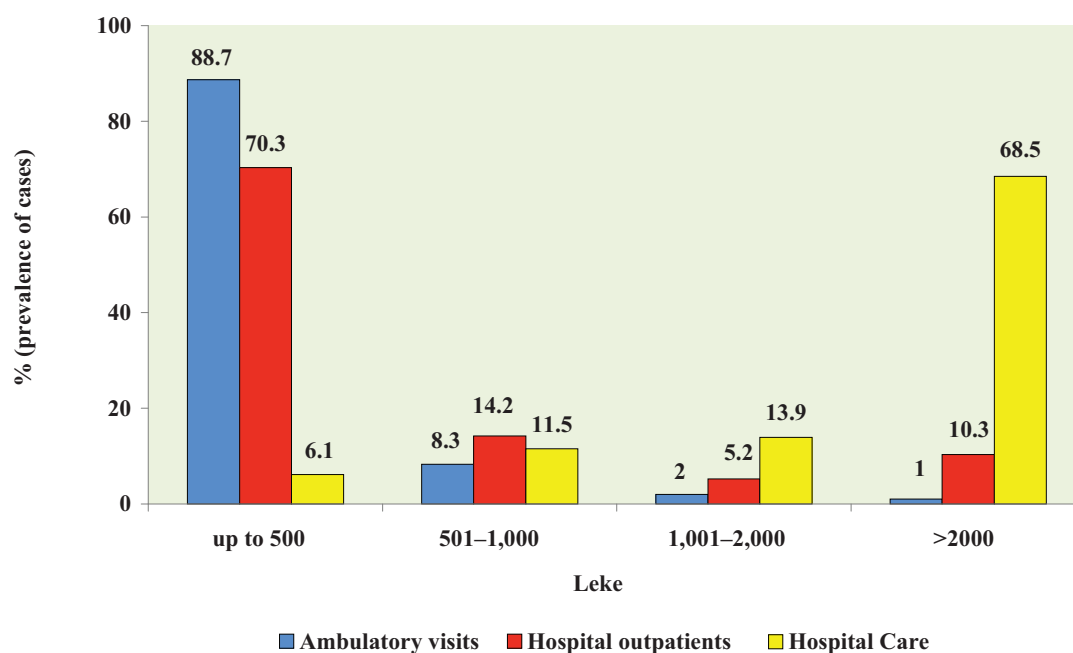
Figure 3. Modality of informal payments (2008)
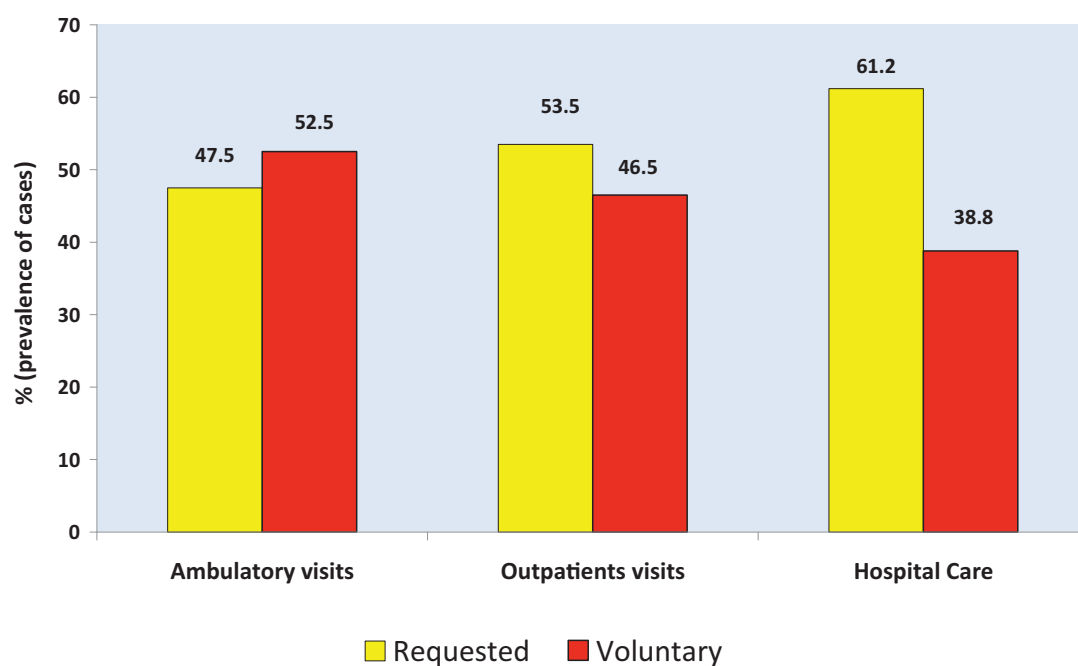
Comments to figures

Figure 1

Figure 1 shows a comparison of the prevalence of patients having made informal payments in different settings. The highest prevalence of informal payments concerns hospital care, where the percentage of patients declaring they had made some gift to hospital staff was 53.2% in 2005 and 43.8% in 2008. On the contrary, over the same period, the prevalence of informal payments regarding hospital outpatient visits increased from 30.6% to 37.3%, while

the situation remained statistically unchanged (p = 0.253) for public ambulatory visits, where less than 20% of patients made informal payments.

Figure 2

Figure 2 compares the value in Leke of informal payments made in the three main health care settings for 2008. A relevant and significant difference (p < 0.001) emerges between ambulatory and hospital outpatient visits on the one side, and hospital care on the other. Whereas in the first case the majority of people spent up to 500 Leke for informal payments (respectively, 88.7% in ambulatory visits and 70.3% as hospital outpatients), in the hospital care setting 68.5% of patients gave a gift whose value was more than 2,000 Leke.

Figure 3

Figure 3 compares the modalities of informal payments in the three health settings in 2008. Although significant differences exist among these settings, it is important to underline the large percentage of people who were requested to make some gift. In the hospital care setting, 61.2% of patients declared that the informal payment was explicitly requested by medical staff, while for ambulatory and outpatient visits the prevalence was respectively 53.5% and 47.5%.

Part B: Access to Health Care

Table 5. Difficulties in finding money to pay for health care

<table>
<tr><th colspan="6">"During the last 12 months finding the money to pay for health care for the members of your family has been:"</th></tr>
<tr><th rowspan="2">Answer</th><th colspan="3">Crude Prevalence Rate N (%)</th><th rowspan="2">Odds Ratio</th><th rowspan="2">95% CI (min-max)</th></tr>
<tr><th>2005
n = 3,640</th><th>2008
n = 3,600</th><th>P value
(chi-square)</th></tr>
<tr><td>Very difficult
Difficult</td><td>1,223
(33.6)</td><td>1,002
(27.8)</td><td rowspan="3"><0.001</td><td>0.754</td><td>0.678–0.837</td></tr>
<tr><td>Not difficult</td><td>2,055
(56.5)</td><td>2,030
(56.4)</td><td></td><td></td></tr>
<tr><td>No-one has needed any health care</td><td>362
(9.94)</td><td>568
(15.8)</td><td></td><td></td></tr>
</table>

LSMS 2005, LSMS 2008

*OR includes terms of gender, age group, household size, education, urban/rural

Table 5 reports that the coverage of health costs remains a problem for one third of the Albanian population. Over the reference period, the prevalence of individuals who declared that finding money to pay for health care for their family members was particularly difficult has only slightly decreased, from 33.6% to 27.8%. Since, over this period, the prevalence of people declaring not to have any difficulty in finding money for covering health costs has not changed, the slight decrease in the percentage of individuals with financial problems is presumably a result of the increase in the prevalence of people stating they did not need health care.

Table6. Need to raise money in order to pay for health care

"Over the last year has it been necessary to do any of the following in order to raise money to pay for health care for members of your family? • Borrow money • Sell farm animals • Sell products • Sell valuables • Others (specify)"					
Answer	Crude Prevalence Rate N (%)			Odds Ratio	95% CI (min-max)
	2005 n = 1,223	2008 n = 1,002	P value (chi-square)		
Yes	806 (65.9)	660 (65.9)	0.986	1.027	0.855–1.233
No	417 (34.1)	342 (34.1)			

LSMS 2005, LSMS 2008

*OR includes terms of gender, age group, household size, education, urban/rural

Table 6 underlines and confirms the permanent existence of financial difficulties in paying for health care services. About two third of Albanian families declared that they had had to borrow money, sell farms animals or products, etc., in order to cover family health costs.

Table 7. Referred to hospital but not undertaken visit

"In the past 12 months how many times has someone in your household been referred to the hospital but not gone?"					
Answer	Crude Prevalence Rate N (%)			Odds Ratio	95% CI (min-max)
	2005 n = 3,278	2008 n = 3,031	P value (chi-square)		
Once and more	175 (5.3)	204 (6.7)	0.020	1.337	1.072–1.667
None	3103 (94.7)	2827 (93.3)			

LSMS 2005, LSMS 2008

*OR includes terms of gender, age group, household size, education, urban/rural

Table 7 shows that between 2005 and 2008 there has been a slight but statistically significant increase in the prevalence of people declaring that a family member had rejected hospital care at least once in the last twelve months (from 5.3% to 6.7%).

Table 8. Refused health services

"Has anyone in your household ever been refused health services?"					
Answer	Crude Prevalence Rate N (%)			Odds Ratio*	95% CI (min-max)
	2005 n = 3,640	2008 n = 3,600	P value (chi-square)		
Yes	135 (3.7)	215 (6.0)	<0.001	1.614	1.281–2.035
No	3,505 (96.3)	3,384 (94.0)			

LSMS 2005, LSMS 2008

*OR includes terms of gender, age group, household size, education, urban/rural

Table 8 reports a significant increase in the percentage of stated cases (from 3.7% to 6.0%) where someone in the household had been refused health services (OR: 1.614; 95% CI: 1.281–2.035).

Table 9. Reason for refusal

"What was the reason for this refusal?"					
Answer	Crude Prevalence Rate N (%)			Odds Ratio	95% CI (min-max)
	2005 n =135	2008 n = 215	P value (chi-square)		
Could not afford to pay	78 (57.8)	95 (44.2)	0.013	0.528	0.332–0.838
Unable to get to where services were available; Services only provided to residents of particular regions; Unable to get referral for specialty services; Other	57 (42.2)	120 (55.8)			

LSMS 2005, LSMS 2008

*OR includes terms of gender, age group, household size, education, urban/rural

Table 9 reports that in 2005 the main reason of rejection to hospital care was related to financial problems (57.8%), while 42.2 per cent of respondents mentioned other functional factors, such as impossibility of getting to where such services were available, or to get referral for specialist services, etc. In 2008, although a significant decrease, the percentage of those declaring they could not afford to pay for health care services was still relatively high (44.2%), showing that the coverage of health care costs remains a relevant problem as well as a source of social inequity for many families in Albania.

Table10. Factors preventing people from accessing health care

"Many different factors can prevent people from getting medical advice or treatment for themselves. When you are sick and want to get medical advice or treatment, is each of the following a big problem or not?"									
Answer: "It is a big problem"	Men N (%)	Women N (%)	P value	Men			Women		
				Town N (%)	Countryside N (%)	P value	Town N (%)	Countryside N (%)	P value
Getting money needed for treatment	1,875 (62.2)	4,391 (56.3)	<0.001	951 (56.5)	924 (67.1)	<0.001	1,913 (47.4)	2,477 (63.4)	<0.001
The distance to the health facility	912 (30.1)	2,316 (30.0)	0.600	267 (16.4)	645 (41.9)	<0.001	460 (13.1)	1,856 (43.6)	<0.001
Having to take transport	945 (30.8)	2,494 (32.3)	<0.001	310 (18.6)	635 (41.3)	<0.001	604 (16.2)	1,889 (45.2)	<0.001
Not wanting to go alone	478 (15.1)	3,188 (39.1)	<0.001	189 (10.9)	289 (18.7)	<0.001	1,005 (22.9)	2,183 (52.1)	<0.001
Concern that there may not be any health provider	1,352 (45.3)	3,666 (49.5)	<0.001	658 (39.4)	694 (50.3)	<0.001	1,538 (41.3)	2,126 (56.1)	<0.001
Concern that there may be no drugs available	1,497 (52.2)	4,048 (54.0)	<0.001	774 (47.4)	723 (56.4)	<0.001	1,843 (47.2)	2,203 (59.4)	<0.001
Concern that there may be no supplies or equipment available	1,617 (54.9)	4,763 (62.5)	<0.001	835 (50.1)	782 (59.0)	<0.001	2,210 (57.2)	2,551 (66.8)	<0.001
Getting permission to go (only for women)		1,388 (16.7)					330 (7.9)	1,058 (23.8)	<0.001
Concern that there may not be a female health provider (only for women)		1,476 (19.4)					539 (13.2)	937 (24.3)	<0.001

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Figure 4

"Many different factors can prevent people from getting medical advice or treatment for themselves. When you are sick and want to get medical advice or treatment, is each of the following a big problem or not?" (answer: "It is a big problem")

Legend:
- Concern that there may not be a female health provider (only for women)
- Getting permission to go (only for women)
- Getting money needed for treatment
- Concern that there may be no supplies or equipment available
- Concern that there may be no drugs available
- Concern that there may not be any health provider
- Having to take transport
- The distance to the health facility
- Not wanting to go alone
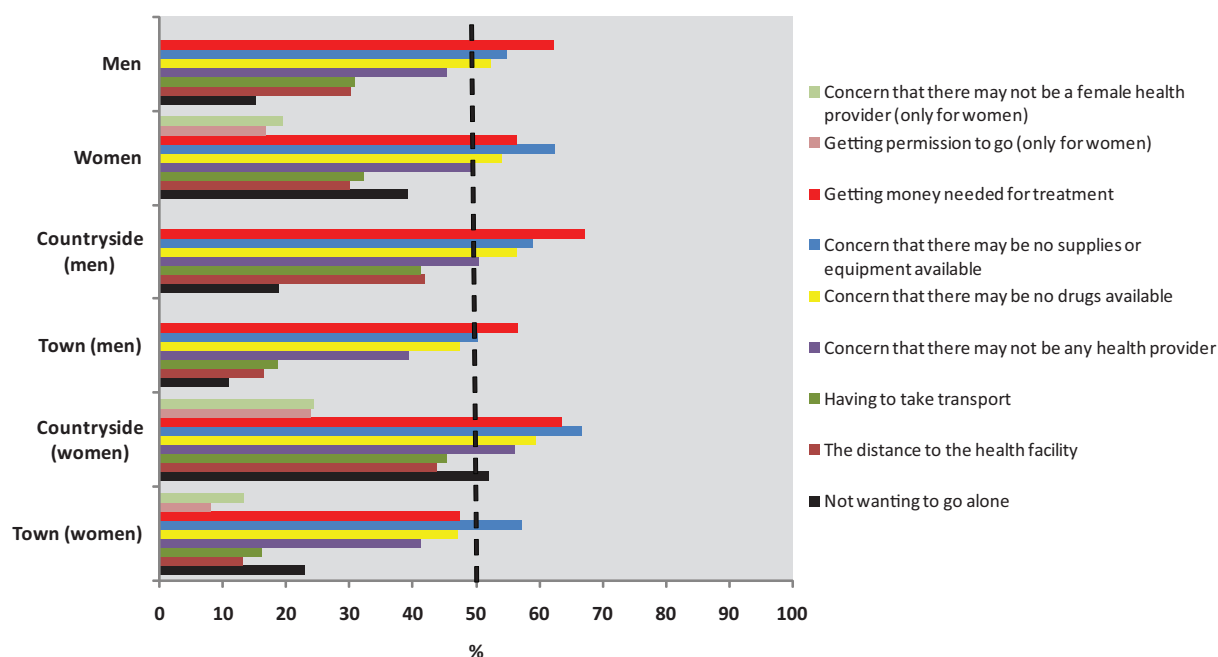
ADHS 2008-09

Table 10 and Figure 4 show that, in general, accessing the money required for medical treatment represents the main factor preventing people from accessing medical care, followed by availability of drugs, lack of health care providers and availability of equipment and, only for women "not wanting to go alone". Furthermore, for all the factors mentioned in Table 10 and Figure 4, people living in the countryside declare huge unfavourable conditions to gain access to health care compared to citizens living in urban areas. Table 10 and Figure 4 also underline specific female concerns, more frequently mentioned among rural residents, and probably associated with cultural and psychological factors. In particular, women respondents living in rural areas pointed out the importance of having the choice of consulting a female health care provider (24.% versus 13.2% in urban areas), and of getting permission to visit a health provider (23.8% versus 7.9%), not wanting to go alone to the doctor (52.1% versus 22.9%), and infrastructural problems related to the distances involved (43.6% versus 13.1%).

Table 11. Health condition belief among men

Men: "Do you believe that during the last 12 months your health has declined due to problems in paying for medical care?"					
Answer	Crude prevalence rate N (%)			Odds Ratio*	95% CI (min-max)
	town n = 1,278	countryside n = 1,175	P value (chi-squared test)		
Yes, very much	17 (1.3)	35 (2.7)	<0.001	1.975	1.495–2.583
Yes, some	87 (6.2)	167 (14.7)	<0.001	1.861	1.656–2.091
Yes, a little	97 (7.9)	118 (9.5)	<0.001	1.075	0.980–1.178
Not at all	1,074 (84.2)	840 (72.0)	<0.001	0.765	0.704–0.830
Did not remember / refused	3 (0.3)	15 (1.2)	<0.001	-	-

ADHS 2008-09

*OR include terms for age, having a private health insurance, subjective health status, suffering from chronic disease, educational level; town = reference group

Table 11 reports that, following the barriers to access mentioned above, the prevalence of men believing that during the last twelve months their health had declined (somewhat or very much) due to problems in paying for medical care had more than doubled in the countryside compared with those living in urban areas (17.4% versus 7.5%).

Table 12. Health condition belief among women

Women: "Do you believe that during the last 12 months your health has declined due to problems in paying for medical care?"					
Answer	Crude prevalence rate N (%)			Odds Ratio*	95% CI (min-max)
	Town n = 3,843	Countryside n = 3,739	P value (chi-squared test)		
Yes, very much	56 (1.1)	102 (2.8)	<0.001	1.232	1.083–1.400
Yes, some	302 (7.5)	456 (12.8)	<0.001	1.255	1.187–1.327
Yes, a little	443 (11.8)	549 (16.1)	<0.001	1.088	1.039–1.138
Not at all	3,028 (79.2)	2,606 (67.9)	<0.001	0.936	0.899–0.974
Did not remember / refused	14 (0.3)	26 (0.5)	<0.001	-	-

ADHS 2008-09

*OR include terms for age, having a private health insurance, subjective health status, suffering from chronic disease, educational level; town = reference group

Table 12 reports that the same is true for the female population: 15.6% of women living in rural areas believed that during the previous twelve months their health had declined due to problems in paying for medical care, while in urban areas the prevalence had decreased to 8.6%.

Table 13 and Figures 5 and 6 show the prevalence of perceived factors preventing people from accessing medical advice or treatment by region (Tirana, coastal, central and mountain). The proportion of people considering that relevant factors are "a big problem" (getting money, distance to health facilities, having to take transport, not wanting to go alone) was systematically less for men and women from urban Tirana than for those in mountain areas. A main issue was obtaining money for treatment, with a prevalence increasing from 35 per cent and 44 per cent, respectively, for women and men in Tirana, to 70 per cent and 74 per cent, respectively, in central and mountain areas. However, the biggest difference among regions concerned problems with transportation and the distances involved and, for women, "not wanting to go alone". Lack of health providers, medicines and equipment are perceived as big problems by a similar consistent part of the population in all regions, though some gender differences exist, in particular regarding the perception of scarcity of health providers (men: 45.9%; women: 26.3%)

Table13. Factors preventing access to health care

Question: "Many different factors can prevent people from getting medical advice or treatment for themselves. When you are sick and want to get medical advice or treatment, is each of the following a big problem or not?" (answer: "It is a big problem")										
	Men* (N=3013)					Women* (N=7584)				
	Tirana urban (N=520) %	Coastal (N=753) %	Central (N=874) %	Mountain (N=866) %	P value	Tirana urban (N=1142) %	Coastal (N=1961) %	Central (N=2115) %	Mountain (N=2366) %	P value
Getting money needed for treatment	43.9	56.5	74.0	68.8	<0.001	34.7	51.9	63.4	69.6	<0.001
The distance to the health facility	6.9	31.8	33.5	48.7	<0.001	9.1	24.6	36.0	49.8	<0.001
Having to take transport	10.7	29.6	35.0	47.9	<0.001	9.5	31.8	36.6	49.0	<0.001
Not wanting to go alone	10.7	12.8	16.4	22.5	<0.001	15.4	38.8	42.4	61.5	<0.001
Concern that there may not be any health provider	45.9	39.4	47.7	48.6	<0.001	26.3	49.5	57.1	51.5	<0.001
Concern that there may be no drugs available	53.8	46.9	56.5	42.7	<0.001	40.8	56.0	57.4	53.0	<0.001
Concern that there may be no supplies or equipment available	60.9	47.2	57.7	51.8	<0.001	46.9	65.3	65.5	66.0	<0.001
Getting permission to go (only for women)	-	-	-	-	-	5.6	15.5	18.1	30.5	<0.001
Concern that there may not be a female health provider (only for women)	--	-	-	-	-	9.8	13.6	25.0	25.2	<0.001

*weighted percentages

ADHS 2008-09

Two specific problems for women living in central and mountain regions are concern that there may be a lack of female health providers and obtaining permission to undertake a medical examination.

Figure 5

> **Many different factors can prevent people from getting medical advice or treatment for themselves. When you are sick and want to get medical advice or treatment, is each of the following a big problem or not? (MEN: Answer: "It is a big problem")**

Categories (top to bottom):
- Concern that there may be no supplies or equipment available
- Concern that there may be no drugs available
- Concern that there may not be any health provider
- Not wanting to go alone
- Having to take transport
- The distance to the health facility
- Getting money needed for treatment

Legend: ■ Tirana urban ■ Coastal ■ Central ■ Mountain
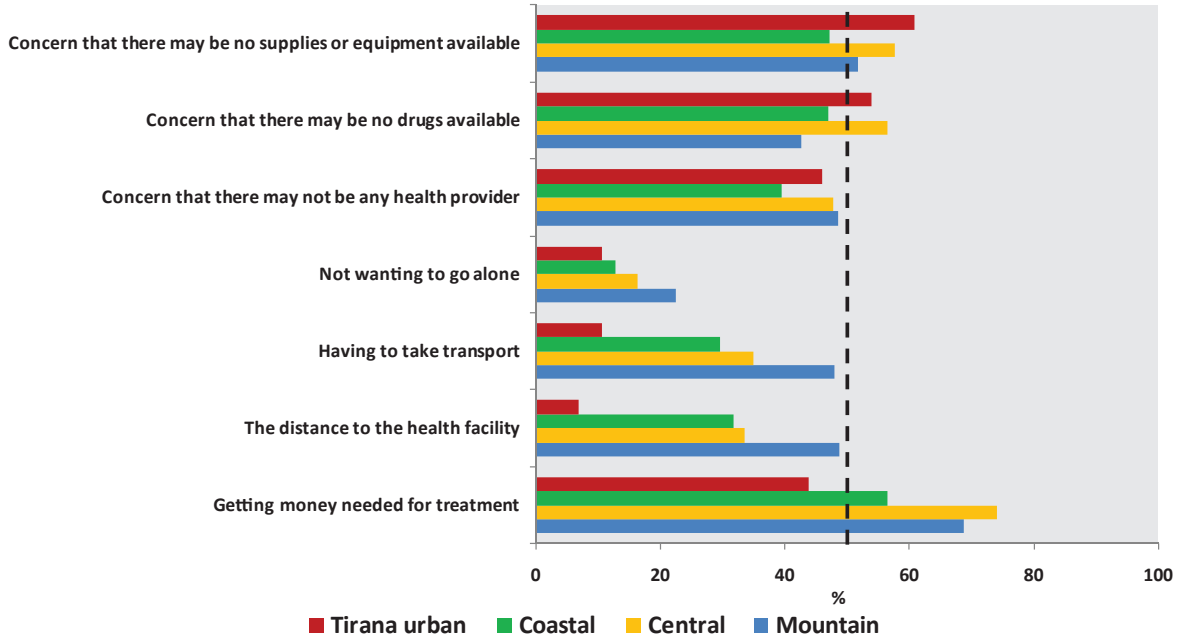
Figure 6

> **Many different factors can prevent people from getting medical advice or treatment for themselves. When you are sick and want to get medical advice or treatment, is each of the following a big problem or not?" (WOMEN: answer: "It is a big problem")**

Categories (top to bottom):
- Concern that there may not be a female health provider (only for women)
- Getting permission to go (only for women)
- Concern that there may be no supplies or equipment available
- Concern that there may be no drugs available
- Concern that there may not be any health provider
- Not wanting to go alone
- Having to take transport
- The distance to the health facility
- Getting money needed for treatment

Legend: ■ Tirana urban ■ Coastal ■ Central ■ Mountain

4. Discussion

In Albania, several measures introduced in the health care system at the country level have not contributed to any change or improvement of the situation concerning reduction of informal payments over the period 2005 to 2008.

Introducing and raising official fees as a substitute for under-the-table payments has had a positive effect on reducing informal payments in some countries. In Albania, within the framework of the Health Care Reform the Ministry of Health has introduced formal payments as a measure to formalize under-the-table payments, as well as to increase resources. Charges have been introduced in the primary, secondary and tertiary health care services since 1991. Unfortunately, such interventions undertaken during the period 2005 to 2008 have not eliminated informal payments: informal payment continues to exist in parallel in ambulatory, hospital outpatient and inpatient health care services, and lack of financial resources continues to create barriers to access to health care.

As results of other studies have suggested, informal payments in Albania are influenced by factors such as the low salaries of health staff, a belief that health is extremely important and worth any price, a desire to obtain better quality care, fear of being denied treatment or missing the opportunity to get the best possible outcome, and a tradition of giving a gift to express gratitude.

On the other hand, the informal payment phenomenon is very much related to the modality of funding and management of health care services. The health care sector in Albania is mostly publicly owned, and MOH is the major provider of services. The private sector is not yet consolidated and most of the private outpatient, inpatient practices and diagnostic centres are located in urban areas, especially Tirana. MOH owns and administers all health care services through its district directorates, with the exception of the Tirana region where all administration responsibilities for primary health care and public health are delegated to the Tirana Regional Health Authority (TRHA).

The health system is mostly funded through budget allocations, though in 1995 HII was established to secure additional source of finance to the system. The Institute is funded through payroll taxes and by budget transfers for vulnerable groups of the population, but since a large proportion of the Albanian population is involved in informal activities, this scheme does not represent a significant source of funding.

Primary Health Care (PHC) is provided by health care centres and health posts in rural areas; in addition to health centres, PHC in urban areas is also provided by large polyclinics offering specialized outpatient care. Secondary and tertiary care is offered by public hospitals and clinics.

Poor quality of services, lack of equipment and drugs and poor infrastructure are some of the reasons why people prefer to skip primary health care and look for outpatient services in the secondary and tertiary health care settings.

In 2006, out-of-pocket expenditures accounted for almost 95 per cent of private expenditure for health. This trend has resulted in inequalities in access to health care services and a lack of financial protection of the population against catastrophic health expenditure.

Out-of-pocket payments are a regressive form of health financing and data suggest that very high levels of such payments are accompanied by higher proportions of people reporting they do not seek health care when they ought because of the associated costs. These costs include three main categories: official user fees charged by health services, payments for drugs or medical supplies and under-the-table payments to service. The distinction between official and unofficial payments is often unclear.

Informal payments are a serious concern for the country and have become central to the debate about equity in access to health care in Albania, and the problems of access to health care did not change over the three-year period under study. Inequalities in access to health care exist also between regions, particularly between rural and urban areas, through differences in availability of supplies and drugs, health care equipment, state of infrastructure, distance to health provider and transport.

Policy actions that can create equal access to health care, regardless of the differences in ability to pay and residency, are needed. Periodical population-based surveys such as LSMS offer a great opportunity to provide evidence and monitor informal payments and access to health care across the country. Policy makers need to take these results into consideration when evaluating the interventions in health sector reform undertaken up to now to reduce informal payments and increase access to health services, as well as when preparing new interventions. Some useful policy recommendations, already proposed by Babalanova and McKee (2002), include the following:

- Government should formulate a coherent, explicit policy on informal payments.

- Government must address specifically the issue of payments expected for medical treatment and that are viewed as a bribe. It is argued that these sustain social inequalities and are damaging to the health sector and society. Cultural gratuity payments should also be addressed in the long run, as they create tolerance towards direct user payment.

- As the current health sector reform process is intended to increase accountability, informal payments should be debated publicly and consensus sought.

- Government should consider setting up official channels for private contributions, such as user fees for some users, sponsorships and donations, to stop some of the informal payments. These should be well regulated and benefit the facilities as a whole rather than individual practitioners.

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6 Typology of Communes and Definition of Agglomerations in Albania

**Martin Schuler, Alain Jarne,
Ervin Shameti, Ledjo Seferkolli**[25]

Introduction

1.1   Proposal for a classification of communes

This paper proposes a classification methodology for Albanian communes[26], based on 2001 *Population and Housing Census* results. This classification provides a tool for territorial analyses and policy evaluation, as well as for urban and regional planning. This classification might also be used as an instrument for structuring sampling frames for surveys. The results might provide the basis for a working classification built on 2011 Census data.

This classification of communes will focus on two main outputs: first, a typology of Albanian towns, as well as rural types of communes, and second—since delimitation of urban areas is part of this classification process—a definition of Albanian agglomerations consisting in central towns and their suburban communes. Special attention will be given to the Tirana–Durrës metropolitan area.

These territorial classifications have been developed as part of Swiss–Albanian Statistical cooperation (DESSA). The research was carried out by Swiss researchers experienced in the field and Albanian statisticians at INSTAT with good knowledge of statistical information and GIS methods. The authors would like to express their gratitude to D. Efionayi-Mäder, I. Nurja and L. Sado for their efficient support during the project and to Marco Buscher for his helpful suggestions and comments.

1.2 Methods

Various methods may be used to create a classification, or typology, of communes. The first family of approaches is based mainly on theoretical assumptions that are confronted with specific data, the observation of which confirms or rejects the validity of a model. This may be called a top-down or deductive approach. Another family, inductive approaches, moves from an observation to broader generalization and theory. One example of a deductive approach is the *Swiss Typology of Communes (Schuler et al 2005)* developed by the Federal Statistical Office (FSO), while an example of an inductive approach is the British Census-based Area Classification[27]. In the first case, the relevant variables for classification are chosen according to a pre-existing theory or model of spatial organization, a hierarchy is then established and thresholds are fixed. The second method reduces the wide data set by using statistical methods (elimination of highly correlated variables, etc.), and then clustering techniques are used. The FSO methodology will provide a general framework to build the Albanian classification that will be adapted as much as possible to the Albanian specific spatial, social and economic context, according to data availability.

1.3 Current spatial classifications in Albania

1.3.1 Urban–rural

At the time of the last Census in 2001, Albania was institutionally divided into twelve counties (prefectures), 36 districts and 374 communes, thereof 65 towns. In communist times, the numbers of prefectures (10) and districts (12) were stable, though the number of communes increased from 203 in 1958 to 539 in 1990. In 1997, a new institutional structure was set in place with twelve prefectures, 36 districts and 357 communes (of which 313 were rural and 44 urban). By 2001, the year of the last Census, the number of communes had increased to 374 (309 rural communes and 65 towns).

In Albania, as in all other countries, there is a tradition of distinction between urban and rural communes. In fact, the designation of a municipality as a town was a political act with strong implications for the political status of the local administration. According to Aliaj[28], under communism, the three main criteria for urban centres to receive the status of town were as follows:

- activity, including dominance of the industrial labour market, and location of local administration or authorities in the inhabited centre

- size of the settlement, expressed as number of inhabitants, e.g. the population size of the area must exceed the official limit, which ranged from 2,000 to 5,000 inhabitants

- impact on the surroundings (the labour market) and on the social dimension (urban life-style).

When discussing the urban–rural distinction at the commune level in Albania, we have to consider not only the size and structure of the communes, but also the administrative delimitations. As in many other countries, Albanian local boundaries are often drawn in a way that reduces the surface of an urban municipality to the urbanized area and to that which will shortly be urbanized. In consequence, rural municipalities usually have an extensive surface

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[27] Vickers, Daniel and Phil Rees 2006. op. cit.

[28] Aliaj, Besnik. 1999. op. cit., p. 27.

area that includes territories situated near the neighbouring centre. During urban planning under the communist regime, urban extension occurred nearby existing towns on the territory of the urban municipality, or by integrating neighbouring territories.

The liberal urbanization that followed after 1991 has created a widespread structure of settlements, which is why the urban sprawl of a city often touches the neighbouring commune, even if it might affect only a small part of a large rural area.

1.3.2 LSMS Regions

The Living Standards Measurement Survey (LSMS)[29] is a random survey of living conditions of the Albanian population. In this survey, a regional typology including different types of centres is used. It has been carried out using Enumeration Areas (EAs), stratified according to geographical criteria on three levels: a) large geographic areas (Mountain Area, Coastal Area and Central Area), b) the Urban areas (big towns) and Other Urban areas (small towns) included in the large geographic areas, and c) Tirana city (i.e. Tirana Municipality and its suburbs, Kamëz, Vorë), which was considered as a separate stratum[30].

The distinction between the three main geographic areas follows the delimitation of the 36 districts (Map 1), attributing seven districts to the mountain area, 19 to the central area, and 10 to the coastal area. The central area is not only by far the biggest, but also encloses Shkodër, Tirana and the plain of Korcë.

The urban distinction follows the official, institutional delimitation of Albania, by adopting the distinction between big cities and others (besides Tirana). Elbasan, Shkodër, Korcë and Berat are the four big cities in the central area, and Durrës, Fier and Vlorë are the three big cities in the coastal area. There is no big city in the mountain area. The threshold of 40,000 inhabitants has been chosen to separate big cities from other cities. Among the other cities, eleven are in the central area, seven in the coastal area and six in the mountain area. They all are institutional units as district capitals.

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[29] LSMS, 2002, 2005 and 2009.
[30] *Albania, Living Standard Measurement Survey 2005, op. cit.*, p. 7–8.

Map 1: LSMS regions of Albania

Legend — LSMS categories:
- Tirana
- Big cities
- Other cities
- Coastal area
- Central area
- Mountain area

Montenegro

Kosovo

Kopliku

Bajram Curri

Shkodër

Krumë

Pukë

Kukës

Lezhë

Rrëshen

Burrel

Peshkopi

Laç

Krujë

Bulqizë

Durrës

Tiranë

Macedonia

Librazhd

JKavajë

Elbasan

Peqin

Llushnjë

Pogradec

Gramsh

Kuçovë

Fier

Korçë

Bilisht

Ballsh

Çorovodë

Ersekë

Vlorë

Tepelenë

Përmet

Gjirokastër

Greece

Delvinë

Sarandë

A d r i a t i c   S e a

Source: INSTAT

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1.4 Context: Albania, a fast changing territory (population size in thousands)

Census	Albania		Tirana			Other urban			Other urban > 5,000		
	Pop.	% growth	Pop.	% Albania	% growth	Pop.	% Albania	% growth	Pop.	% Albania	% growth
1923	804		11	1.3		117	14.5		87	10.8	
1938	1,040	1.73	25	2.4	5.75	135	13.0	0.97	105	10.1	1.30
1945	1,122	1.09	60	5.3	13.24	179	15.9	4.11	150	13.4	5.20
1955	1,391	2.18	108	7.8	6.09	275	19.8	4.39	224	16.1	4.07
1960	1,626	3.17	119	7.3	1.92	383	23.6	6.88	250	15.4	2.21
1969	2,063	2.68	153	7.4	2.81	498	24.1	2.95	418	20.3	5.91
1979	2,595	2.32	189	7.3	2.16	677	26.1	3.12	594	22.9	3.57
1989	3,182	2.06	238	7.5	2.34	892	28.0	2.79	829	26.1	3.39
2001	3,064	-0.32	341	11.1	3.05	1,123	36.7	1.94	1,103	36.0	2.41

Table 1: Population of Albania, for Tirana, towns and rural communities, 1923–2001

Some important developments of Albania in the 20th Century are summarised below:

- 1923–1938: Country is mainly poor and rural, with only 10–15% of population urban; towns have only administrative and commercial functions

- 1938–1945: Population is pushed into towns for security reasons, but after the war, people go ba ck to the countryside

- 1946–1959: Industrialization, creation of new cities and increase in urban population size

- 1960–1969: Period of strong population increase, essentially in smaller towns

- 1969–1979: Period of high natural population increase, but of low internal mobility rate; equal population growth rates in all parts of the country

- 1979–1989: Decreasing, but still high, population growth rate; urban growth higher than rural

- 1989–2001: Decrease in global population, higher growth in Tirana, lower growth in other cities, and decrease in southern cities

- 1990: Demise of the Communist regime: end of isolation

- 1991: First democratic elections, mass emigration to Greece and Italy

- 1993–1996: Economic growth, political stability, steady emigration rates, rising internal migration to Tirana area

- 1997: Collapse of pyramid schemes[31] and high losses of numerous households, new waves of exodus

- 2000–2010: Toward a stable economic and political situation, controlled emigration, continued urbanization (Tirana–Durrës area) and increase in regional disparities.

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[31] A pyramid scheme is a non-sustainable business model that involves the exchange of money primarily for en-rolling other people into the scheme, without any product or service being delivered. During 1996–97, Albania was convulsed by the dramatic rise and collapse of several huge financial pyramid schemes.

2. Building the classification

2.1 General principles

This typological approach distinguishes—at the first level—between urban and rural communities, i.e. between communes situated in agglomerations and others, situated outside the urbanized areas. At this level, there will be a definition proposed for urban agglomeration.

Within the two entities, i.e. within the agglomerations as well as within the rural parts of the country, the structure of communes can be highly differentiated. Within agglomerations, the typology proposes a distinction between centres and communes in the fringe area (suburban communes), which can be distinguished according to morphological or functional criteria. In consequence, there must be an approach of defining centres by size, function or institutional role. Albania has been using such definitions for a long time. For defining agglomerations, a minimum size of the unit should be defined, as well as criteria that allow (or prevent) the attribution of a neighbouring commune to an agglomeration. Within the agglomerations, the distinction of urban communes can be done by applying various morphological or social criteria, such as density and type of settlements, or social and income groups.

Outside of the agglomerations, communes are defined essentially on the grounds of their economic structure. Since commuting in rural areas in Albania is not a dominant phenomenon, the structure of the active population corresponds quite well to employment patterns. The economic structure can be of a quite different nature: communes with predominantly agricultural activities, those with an important industrial component, or those with tertiary activities. In addition, rural communes may also show combinations between the three sectors. Since most of the Albanian communities with a dominant tertiary sector are defined by centrality, not many rural communes have a large amount of tertiary activity. Empirical analysis shows that, for Albania, only some very specific types of tertiary branches are located outside the agglomerations: tourism, electricity supply and some sectors of public administration, such as defence or health. Within the secondary sector, mining is very often located in rural areas and defines a very specific economical pattern.

2.2 Hierarchy of urban centres

The first step of our proposal for the classification of Albanian municipalities concerns the definition of a centre. We propose to consider three groups of urban measurement:

(i)   **Administrative status**: capitals of prefectures and district capitals. On the other hand, we do not refer, in a first step, to the administrative definition of town (urban municipality)

(ii)   **Size**: population according to Census 2001

(iii)   **Economic centrality**: Davies index.

Administrative status is defined by the regional context. Each region has a capital and some administrative functions. The smallest capitals may have fewer than 5,000 inhabitants and would not dispose of all functions linked to this status. In this case, they may be situated largely behind other towns that dispose of central functions but do not possess the status of capital. Thus it is important to analyse the group of the smallest capitals and to compare them to other towns.

Size expressed by number of inhabitants is not, in itself, a sufficient criterion to define urbanity. In fact, many Albanian rural communes are quite highly populated since they cover a large territory. In combining administrative status and size, we will obtain an approximation, especially in combination with the third criterion, centrality.

Economic centrality can be defined as spatial economic specialization. According to the concept of *advantages of agglomeration*, specialized services are concentrated in some central places, where the proximity of other services increases the added value of an enterprise. Rarity of services (especially of services with higher added value) and specialization of services addressed to a great public show strong spatial concentration. For our purposes, we classify all Albanian municipalities in function of their employment structure in 2001 on the basis of European NACE classification[32]. These figures allow an index of centrality to be calculated for all ten NACE groups.

Davies centrality index is the measurement—for each spatial unit—of a value corresponding to the sum of workers in each tertiary group, where each group has been weighted by the inverse of its total frequency across all spatial units.

$$C_i = \Sigma_j(N_i * (1/N_j))$$

i = spatial unit (here: communes)
*j = economic activity (NACE groups of tertiary sector)*
N_j = total number of jobs in activity j for all Albania
N_i = number of jobs in activity j for spatial unit i

Graphic 1 indicates on its x-axis the size of the commune by its percentage of the total Albanian population. The y-axis gives the percentage of Albanian tertiary centrality. The different colours indicate the institutional status of the municipalities (capitals of prefecture or districts in dark or light blue, respectively, other municipalities as a function of the number of their inhabitants as red, orange or yellow in order of decreasing size). Tirana alone accounted for eleven per cent of the total Albanian population in 2001, and 41 per cent of the overall centrality of the country.

In fact, there is a high positive correlation between the institutional and the economic centrality of municipalities. At a given size, a town with capital functions shows a higher degree of service than a municipality without this attribute. On the other hand, urban municipalities without capital functions usually show a higher centrality than rural communes.

[32] Statistical Classification of Economic Activities in the European Community (in French: Nomenclature statistique des activités économiques dans la Communauté européenne), commonly referred to as NACE, is a European activity standard classification system.
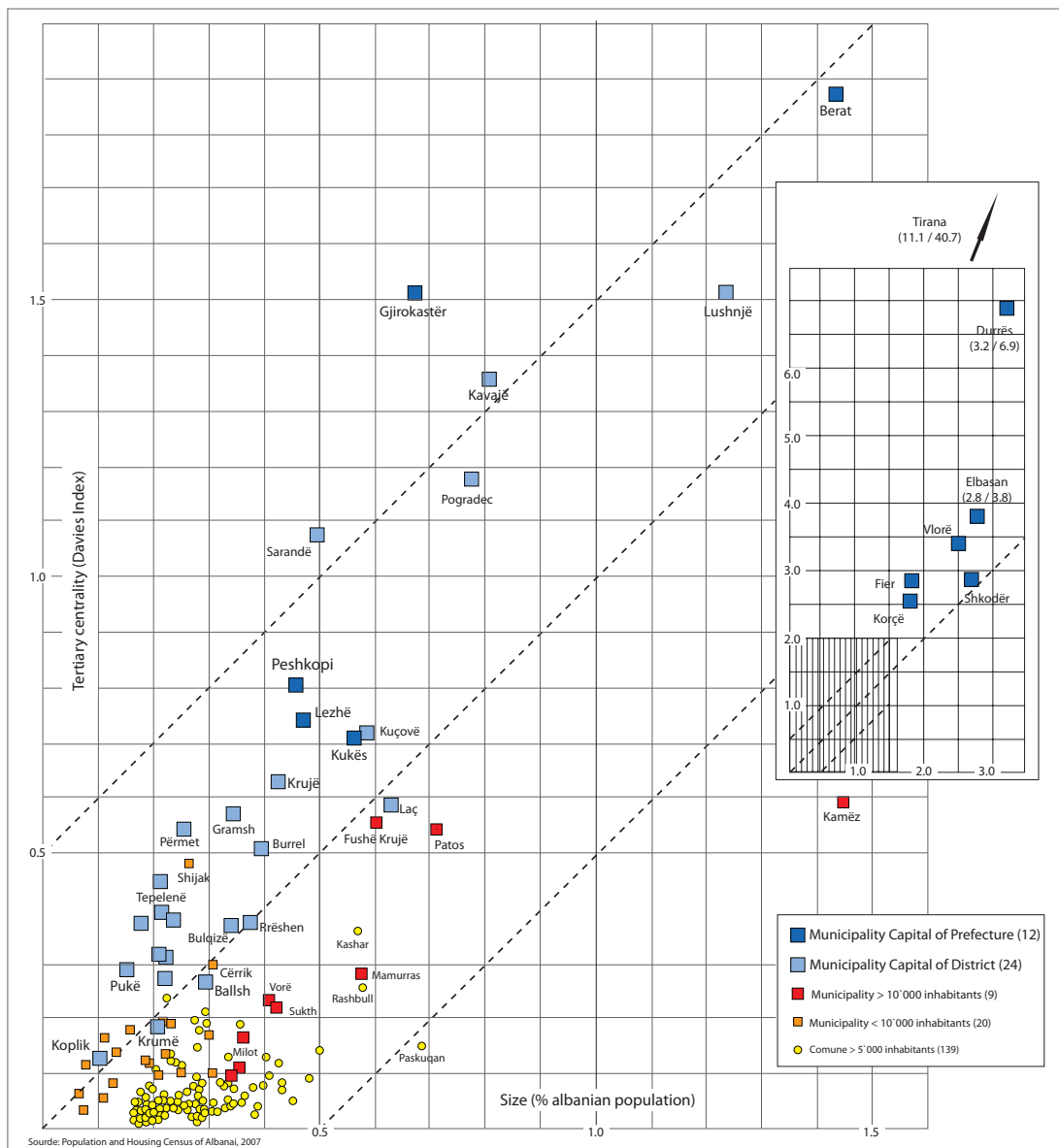
Graphic 1: Comparison of population size, institutional status and economic centrality (Davies index) in Albanian communes and municipalities

Durrës for example, has a high Davies index. Thus, the Tirana–Durrës corridor concentrates half of Albanian "central functions". Centrality is also slightly higher than population in most of the capitals of prefectures: Elbasan, Vlorë, Fier, Korçë and Berat. The only big city with more than 40,000 inhabitants with a ratio of index of centrality to index of population close to 1 is Shkodër, where industry remains quite important, but where the tertiary sector is underdeveloped. Some medium-sized cities are characterized by a large range of services (especially public administration). Several capital towns of rural southern prefectures belong to this group. These towns (Gjirokastër, Sarandë, Përmet or Tepelenë) are located outside the network of large centres.

Municipality with capital functions	Prefecture capital	District capital	Urban	Population 2001	% Albanian population	% Albanian tertiary centrality	% centrality / % population	% agriculture	% industry	% services
Tiranë	X	X	X	341,453	11.12	40.72	3.66	0.1	21.2	78.6
Durrës	X	X	X	98,792	3.22	6.93	2.15	0.8	24.9	74.2
Elbasan	X	X	X	86,148	2.81	3.82	1.36	0.2	27.9	71.9
Shkodër	X	X	X	83,274	2.71	2.85	1.05	1.4	34.2	64.4
Vlorë	X	X	X	77,652	2.53	3.41	1.35	0.7	26.5	72.9
Fier	X	X	X	56,164	1.83	2.85	1.56	6.6	29.6	63.7
Korçë	X	X	X	55,017	1.79	2.56	1.43	0.9	34.1	65.0
Berat	X	X	X	44,040	1.43	1.87	1.30	8.9	22.5	68.6
Gjirokastër	X	X	X	20,601	0.67	1.51	2.25	0.6	18.0	81.4
Kukës	X	X	X	17,157	0.56	0.71	1.27	2.4	32.9	64.7
Lezhë	X	X	X	14,420	0.47	0.74	1.58	0.8	21.8	77.4
Peshkopi	X	X	X	14,017	0.46	0.80	1.76	0.6	20.8	78.7
Lushnjë		X	X	37,860	1.23	1.51	1.22	16.3	21.1	62.6
Kavajë		X	X	24,776	0.81	1.35	1.68	1.6	19.3	79.0
Pogradec		X	X	23,762	0.77	1.17	1.51	0.6	25.5	73.9
Laç		X	X	19,424	0.63	0.59	0.92	12.5	20.6	66.9
Kuçovë		X	X	18,038	0.59	0.72	1.22	0.4	45.2	54.4
Sarandë		X	X	15,247	0.50	1.07	2.15	10.7	19.2	70.2
Kruje		X	X	13,075	0.43	0.63	1.47	4.7	30.2	65.1
Burrel		X	X	12,123	0.39	0.51	1.29	0.8	32.4	66.7
Rrëshen		X	X	11,447	0.37	0.37	1.00	41.3	17.3	41.4
Gramsh		X	X	10,533	0.34	0.57	1.66	0.8	38.8	60.4
Bulqizë		X	X	10,454	0.34	0.37	1.08	14.0	42.8	43.2
Ballsh		X	X	9,154	0.30	0.27	0.89	2.7	40.5	56.8
Përmet		X	X	7,726	0.25	0.54	2.14	2.5	22.1	75.4
Peqin		X	X	7,267	0.24	0.38	1.61	1.5	25.8	72.7
Librazhd		X	X	7,216	0.24	0.38	1.61	0.9	21.9	77.1
Çorovodë		X	X	6,755	0.22	0.31	1.41	2.7	27.7	69.6
Bilisht		X	X	6,729	0.22	0.28	1.26	4.7	37.3	53.7
Bajram Curri		X	X	6,546	0.21	0.39	1.85	0.6	34.1	65.3
Tepelenë		X	X	6,539	0.21	0.45	2.09	1.3	16.8	82.0
Delvinë		X	X	6,421	0.21	0.31	1.50	23.4	21.5	55.1
Krumë		X	X	6,378	0.21	0.19	0.89	34.2	20.3	45.5
Ersekë		X	X	5,499	0.18	0.37	2.08	3.7	24.1	72.2
Pukë		X	X	4,579	0.15	0.29	1.94	15.9	17.6	66.4
Koplik		X	X	3,126	0.10	0.13	1.28	1.8	17.1	81.2

Table 2: Centres, their population size, institutional status, economic activity, centrality and typology

In contrast, a few towns show lower centrality. These are cities with a large portion of industrial activity (such as Ballsh—extraction and refining of oil—and Bulqizë) or agricultural activity (Rrëshen, Krumë) and sometimes mixed (Laç, industrial city—metallurgy, chemistry—located in an agricultural plain).

Graphic 1 points out some special cases, such as for instance Shijak near Durrës, which, although it does not possess administrative privileges, has a strong centrality due to a very large concentration of hotels, restaurants and retail businesses (1/3 of employment).

On the other hand, there are big cities like Kamëz (45,000 inhabitants in 2001) that show a very low centrality. The low index value reflects the situation of residential suburbs of Tirana, recently populated by immigrants coming mainly from the North. The biggest commune of Albania—Paskuqan—is in a similar situation.

In our typology, four different types of urban centres are defined:

- a distinct category for **Tirana (type 11)**

- a second class including the **other centres of national importance (type 12):** province capitals of more than 40,000 inhabitants—Durrës, Elbasan, Shkodër, Vlorë, Fier, Korcë, Berat and Gjirokastër.

Two groups are distinguished within the smaller capitals of prefectures and the district capitals (with more than 5,000 inhabitants). Thus, the condition to be part of these groups is the population size (between 5,000 and 40,000 inhabitants):

- The first group is composed of 17 **capitals with tertiary structure (type 13)** (<30% of industrial employment). These towns are essentially located in the coastal regions and in the southern part of the country.

- The second group of prefecture or district capitals is defined by high **industrial employment (type 14)** (>30%). Nine towns belong to the group: Kuçovë, Kukës, Krujë, Burrel, Gramsh, Bulquizë, Ballsh, Bilisht and Barjam Curri. These towns are essentially situated in mountain areas.

Only two district capitals are not included in groups 13 and 14, since they have fewer than 5,000 inhabitants: Pukë and Koplik, both situated in the prefecture of Shkodër.

2.3 Definition of Urban areas

2.3.1 Concepts and methodology

The process of urban expansion is inherent to urban growth. In Albania, urban sprawl has been on the decrease for some time. **Suburbanization** occurred from the 1950s onwards, essentially due to the construction of large industrial plants. Until 1991, the morphological pattern of Albanian towns was quite regular: more or less densely occupied urban zones with a clear continuum of a built up area, but with scattered settlements along the road axes. **Peri-urbanisation** (also known as ex-urbanisation in an Anglo-Saxon context) is quite a recent process in Albania. It is defined by the emergence of a not necessarily continuous built-up urban area. This process has been made possible by partial abandonment of the former urban planning system under a very strong population increase in urban areas. Both

immigrants coming from rural areas and the urban elite able to invest in housing are settling in municipalities outside of the traditional centres. Communes located in the urban fringe may be differentiated by social groups: lower income groups in suburban areas along the main transport axes, as well as in (former) industrial areas and higher income groups in communes with better living conditions, on the coast or on hillsides.

Agglomerations are urban areas composed of a single centre or several centres with surrounding communes in strong connection to the centre(s). The intensity of the connection can be defined by different concepts of urbanization and measured by different types of indicators. Definitions of agglomerations use more than one type of indicator, since the phenomena of urbanization is complex. In fact, many different formulae have been developed in the past in different countries, corresponding to national concepts of urbanization, availability of data and institutional pattern. In two ESPON (**European Spatial Planning Observation Network**) projects a definition for "Morphological Urban Area" and one for "Functional Urban Area" have been developed[33]. The morphological approach has been adapted on an international scale by defining a density of 650 inhabitants/km² for delimiting an urban area, the functional approach was developed referring to data on commuting, but in the end no common definition was found.

Defining urban for Albania requires reference to the following criteria:

- **Morphology**: Several approaches for classifying types of settlement are in use, the three most important being: proportion of **multi-storey houses** compared to individual houses, various measures for **density**, or an indicator of a **continuously built-up area**.

- **Function**: Interaction between agents from the centre and the surrounding communes. The indicator most used in this field is **commuting** from domicile to work. Migration flows or social interaction can also be of some use.

- **Structure**: At least historically, urban and non-urban populations are involved in very different economic activities. This situation is still predominant in Albania, since **agriculture** is the main economic activity in rural areas, but is less important in towns.

- **Urban dynamics:** Criteria of **dynamism**, **intensity, urban diversity** or **spatial differentiation**, which reflects intensity and the combination of different functions in a given space. Urbanity can be defined as characterizing places in which degree of interaction is particularly high. Usually, intensity is strongly linked to growth and change.

- **Institution**: Political and administrative attribution of central function to a settlement. In this case, towns dispose of specific and enlarged competences in comparison to rural municipalities. In some countries, towns may have a status comparable to a region, but in Albania they are incorporated in the structure of prefectures and districts. (This indicator has already been introduced in Section 1.3.1.)

Currently, there is no official definition of agglomeration in Albania.

In the following sections, the different concepts of urbanity are discussed and transformed into indicators. Later, we suggest adopting a mixed method for delimitation of urban agglomerations, i.e. a combination between a morphological criterion, a functional criterion and a structural one.

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[33] ESPON, Potentials for polycentric development in Europe. Final Report of Project 1.1.1, Nordregio Stockholm, 2005 and ESPON, Study in Urban Functions. Final Report of Project 1.4.3., IGEAT, Brussels, 2007.

2.3.2 Morphological criteria: density and continuity

Population density is one of the most common criteria used in territorial analysis, operational since the 19th century when the local population was counted regularly and the surface of the territories measured. The base indicator refers to the number of inhabitants on a total surface area, but population can also be measured against productive land, agricultural land or a built up area.

Map 2 shows the population density per km^2 of the total area of each Albanian commune. The map indicates high values in most of the district capitals, a phenomenon reinforced by the fact that urban municipalities in Albania only have small territories. Besides the capital, high density is frequent in the fertile plains of central Albania.
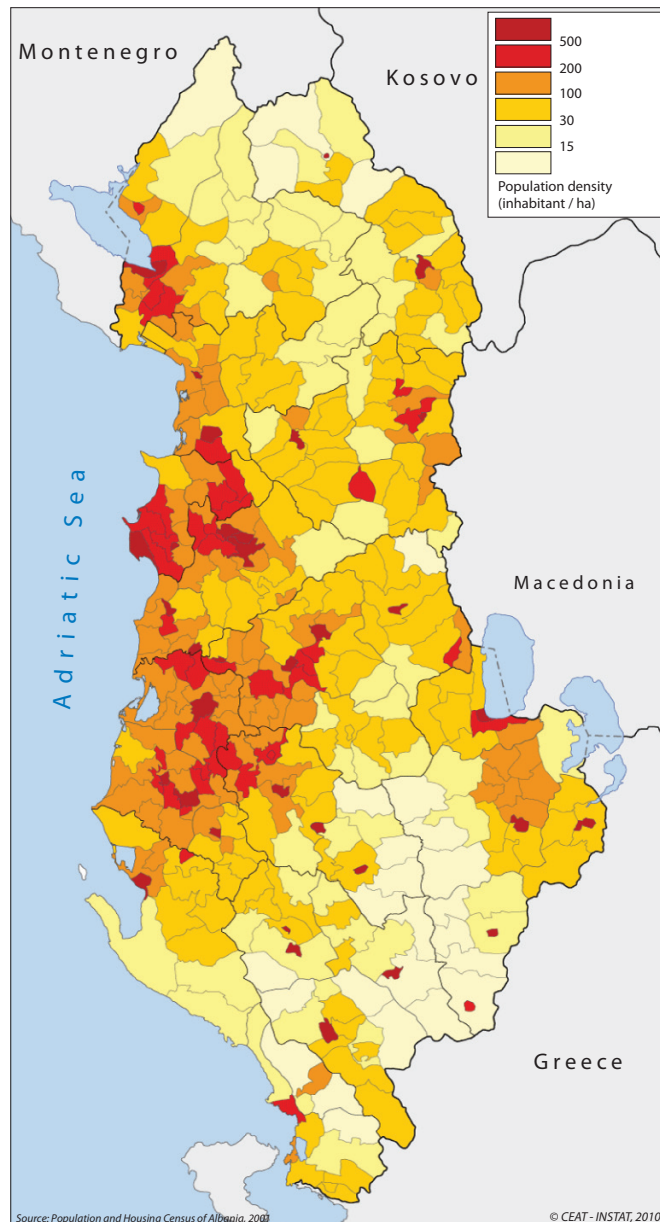

Map 2: Population density, 2001

The continuation of a built up area is the most widely used criterion for defining agglomerations. Developed at the end of the 19th century, this criterion has been made

operational with low-scale mapping. A second period of development of this indicator was made possible by aerial photographs taken from planes or balloons. Finally, a third period has been initiated by the availability of satellite photos. The European NUREC project[34] has applied this method since 1994 to most European countries.

For a few years, Albania has had orthophotographs covering the whole country in a very detailed manner.[35] They make digitalization and use of GIS data possible at the building level. Digitalization is now in process at INSTAT. This will allow calculation of accurate built-up zones extension, and definition of exact thresholds that distinguish urbanized zones and neighbouring communes. In the meantime, a less sophisticated way has had to be adopted to define the indicator. In accordance with international approaches (NUREC, UN recommendations, Urban Audit, Eurostat), we suggest a threshold of 200 metres between two buildings (or another urban type of land use, such as sports fields, depositories, etc.).

2.3.3 Functional criterion: commuting
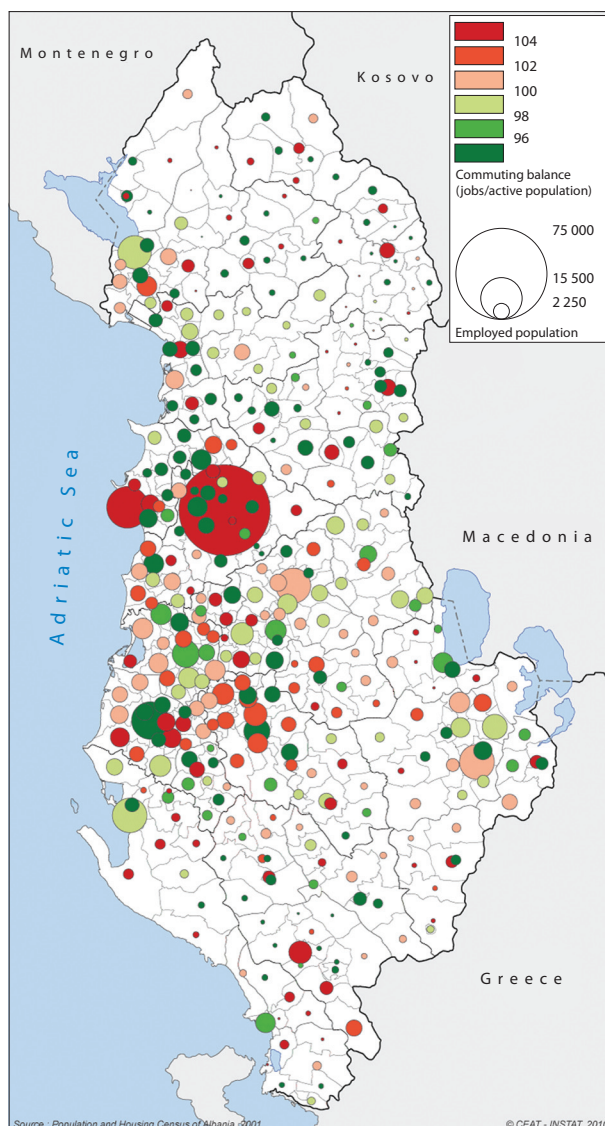
Map 3: Commuting balance of Albanian communes, 2001
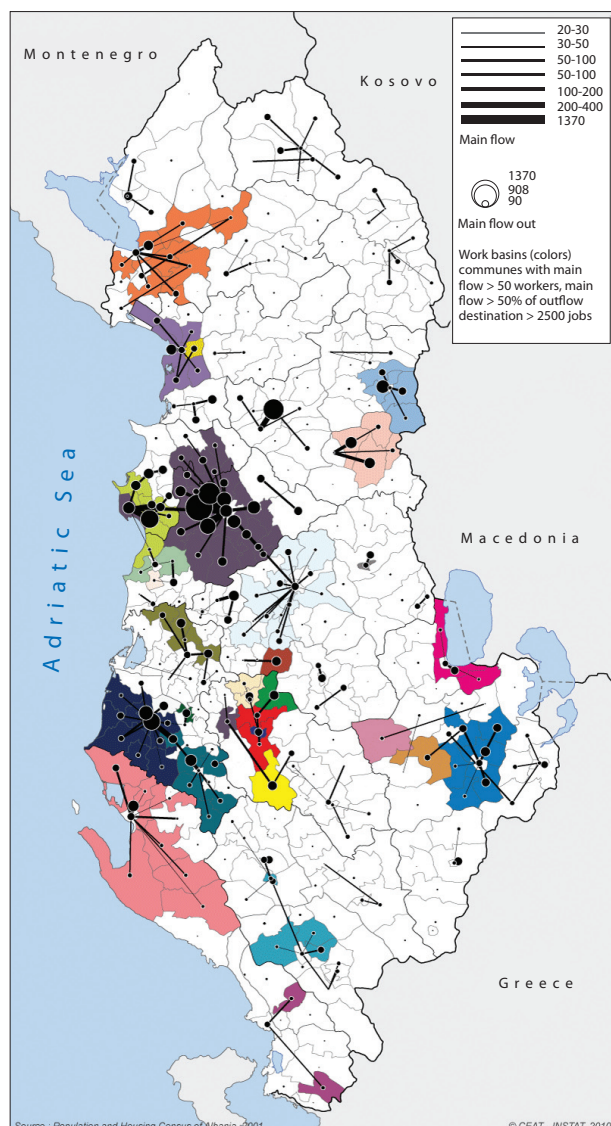
Map 4: Employment basins, out-commuting and intensity of the main flow, by Albanian commune, 2001

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[34] NUREC, Atlas of Agglomerations in the European Union, Volumes I to V., Duisburg, 1994.
[35] ALUIZNI, Agjencia e Legalizimit, Urbanizimit dhe Integrimit te Zonave/Ndertimeve Informale.

Daily commuting is by far the most common indicator used to measure intensity of interaction between inhabitants of different communes. Commuter balance is calculated as the difference between the number of jobs in a commune and the number of active persons. In Map 3, communes in red have a surplus of jobs over active persons, while those in green have a deficit of jobs[36]. At the national level, the balance is zero, if we set aside commuters crossing the national border. Such flows hardly exist in Albania and they were not included in the 2001 Census.

The region of Tirana shows a very clear commuting pattern (see Maps 3 and 4), with a high positive balance for the centre and negative balance for about 20 communes in its surroundings. Durrës shows a similar trend as do smaller centres, including Gjirokastër, Kukës and Korçë. On the other hand, there are some important local capitals—e.g. Shkodër and Lushnjë—that show a negative commuting balance. In some urban regions, industrial plants or some types of tertiary functions have been established outside of the province or district capital in a commune belonging to the agglomeration. In our classification, it is important either to consider such communes as part of the agglomeration or to define them in accordance with their economic function.

In the 2001 Census, out of a total of 623,000 active persons, 47,500 were working in a commune other than that of their domicile, corresponding to 7.6 per cent, while in Switzerland 57.3 per cent of active persons are working in another commune. The Albania percentage of inter-communal commuters is low for several reasons, including the following:

on average, Albanian municipalities are large (8,400 inhabitants per commune, in comparison to 2,400 in Switzerland)
transportation networks are scarce and out-dated, and in 2001, few Albanians had private vehicles
during the transition period, lack of employment opportunities has caused residential migration.

There might also be some data errors in the commuting figures linked to fuzziness of boundaries around cities.

In Map 4, the colour scheme indicates extension of some employment basins. A basin is composed of all communes having i) their main out-commuting flow bigger than 50 workers and 50 per cent of out-commuting flows, and ii) this main out-commuting flow directed to a centre with at least 3,000 jobs. The intensity of the flows is indicated by the thickness of the line (only flows > 20 persons are marked). This map gives an idea of how agglomerations would look if only functional criteria were used.
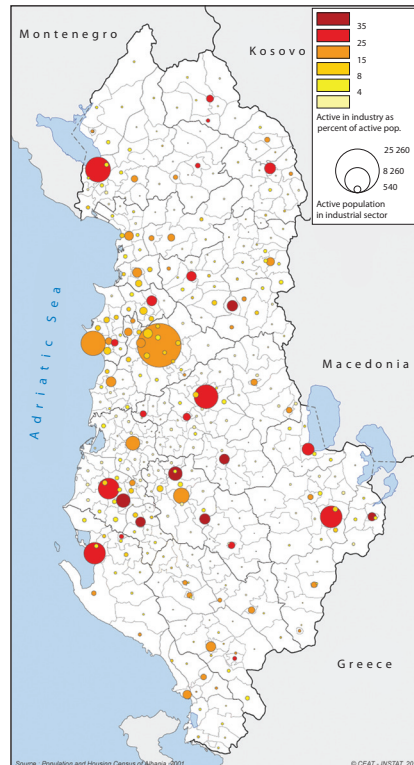
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[36] This indicator is based on differences between domicile and place of work as declared in the 2001 Population and Housing Census.
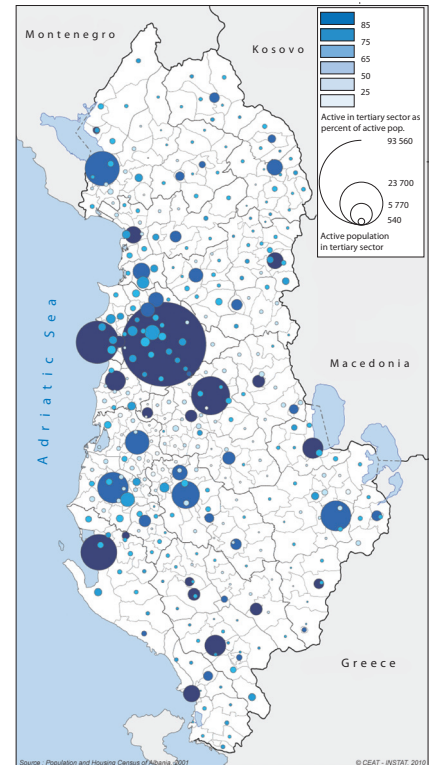
2.3.4 Structural criterion: economic activity

Maps 5, 6 and 7 show the spatial repartition of employment of three economic sectors (agriculture, industry and services) for all Albanian communes, both in absolute figures (corresponding to the symbol size) and in relative figures (in colour intensity).
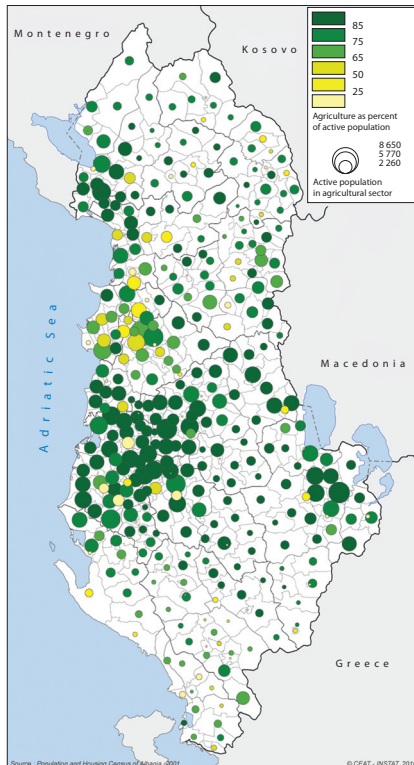
Map 5: Agricultural sector, 2001   **Map 6:** Industrial sector, 2001   **Map 6:** Industrial sector, 2001

The agriculture sector is dominant in a large majority of communes (Map 5), with 85 per cent of communes having more than 50 per cent of people working in the sector. In absolute figures, agriculture is dominant in the lowlands, both in the coastal plains in central and northern Albania, and in the plain of Korçë. A low percentage of workers in agriculture is found in the Tirana–Durrës area, as well as in towns and in the southernmost part of the country.

Industrial economic activity (Map 6) is concentrated in specific areas, mostly in smaller towns. One town, Poliçan, is a commune with more than 50 per cent of its activity industrial, with twelve others between 30 and 50 per cent. However, employment in this sector has undergone a drastic decline since 1991, especially in large metallurgy, chemistry and machine construction plants.

The services sector has become very important in all urban municipalities, with relative maxima in Durrës, Vlorë and Gjirokastër. Many suburban communes have also high percentages of active persons in this sector, probably often commuters to a neighbouring centre.

In our typology, the sector structure will be of importance to establish a distinction between centres and to delimit communes in agglomerations. The economic activity criteria will also be used to differentiate non-urban communes (see 2.5).
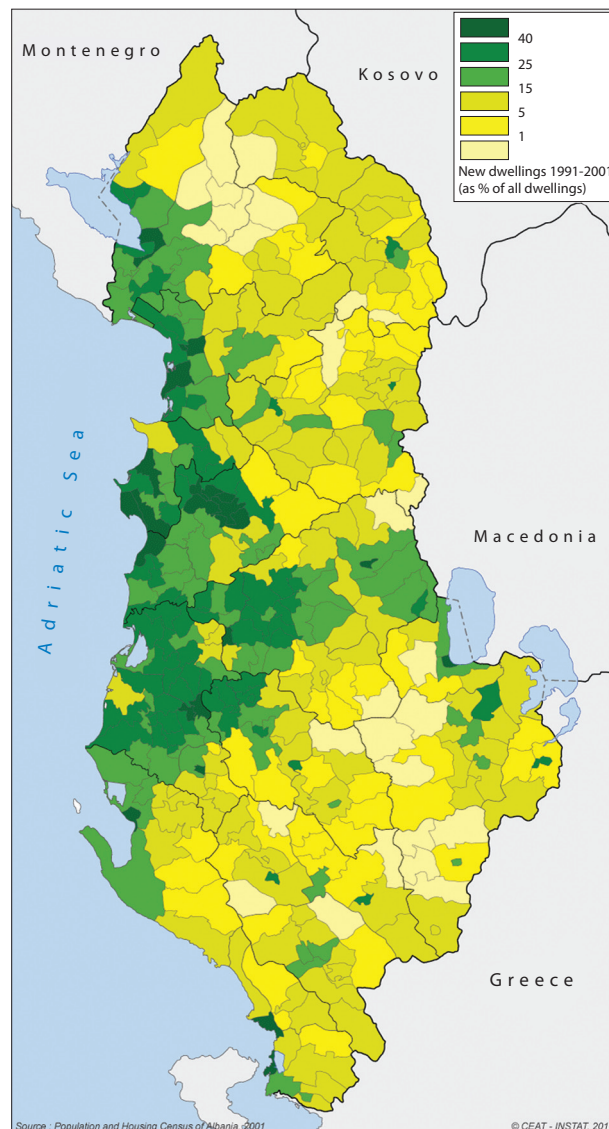
Map 8: Percentage of newly built dwellings

The process of urbanization is a dynamic one. The intensity of changes can be used as a constitutional factor of urbanization. Since we do not dispose of an indicator of population growth at the local level, we propose an alternative indicator: the proportion of dwellings in newly built houses in the total stock of dwellings. Map 8 shows the distribution of this percentage for dwellings built after 1991, with a concentration in the greater Tirana area and in most district capitals and communes with a strong agricultural activity located in the plains.

2.3.6 Communes on the fringe of agglomerations

A classic distinction is often made between suburban and peri-urban communes on the fringe of agglomerations. In most cases, *suburban* areas are primarily made up of large flats, while *peri-urban* areas consist of single-family houses and small buildings. But this distinction does not seem to be efficient in the context of Albania. In fact,

prior to 1990, all urban development, including the majority of large apartment blocks, took place inside the "yellow line"[37], while communes immediately next to Tirana were rural. The development after 1990 was very fast and often not administrated, and consisted mainly in one- or two-dwelling private houses. This is the reason why the proposed typology makes a distinction based on social and economic conditions.

As an indicator of income was not available, educational attainment was considered. Map 9 shows the distribution of percentage of active persons with higher education (university and secondary level). The territorial pattern is markedly uneven across the country, though highest in most towns and other places of economic specialization. Within the area of Tirana, communes situated in the southern and eastern regions have a higher percentage of people with higher education qualifications than do those in the north and west.
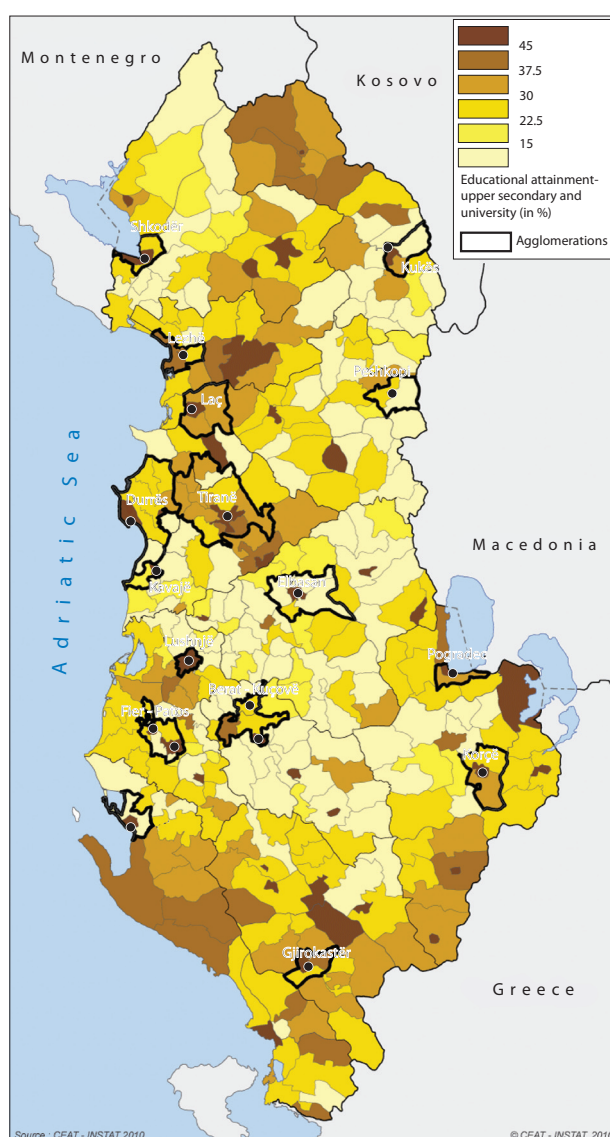
Map 9: Distribution of percentage of active persons with higher education qualifications (agglomeration boundaries: see 2.3.7)

[37] In order to establish control over urban growth, town borders—so-called yellow lines—were introduced around cities during the communist period. Town borders constituted a division between rural and urban territory, and urban expansion was not allowed beyond this line. See Aliaj, Besnik (1999), op. cit., p. 27.

2.3.7 Albanian agglomerations in 2001

A formula defining agglomeration will be presented in Section 3, and its application in Table 3. According to this proposal, Albania comprises 16 agglomerations with more than 20,000 inhabitants, grouping 64 communes with 1,517 million inhabitants. All the larger towns form an agglomeration numbering at least two communes, and even five for Elbasan, nine for Durrës and thirteen for Tiranë. Although Lushnjë appears in Table 3, with the selected indicators and thresholds no other commune is integrated into this agglomeration. Two specific cases are noteworthy: Berat–Kuçovë and Fier–Patos agglomerations, each of which includes two important connected centres of comparable size (where ratio of the number of inhabitants between the two centres is lower than 2.5:1). Such cases are called *bipolar agglomerations*.

Agglomerations of more than 20,000 inhabitants			
Code	Agglomeration	No. of communes	Population size, 2001
3414	Tiranë	13	506,245
601	Durrës	9	177,778
704	Elbasan	5	118,591
803	Fier–Patos	5	102,100
3212	Shkodër	2	98,611
101	Berat–Kuçovë	5	94,238
3611	Vlorë	2	88,148
1403	Korçë	3	71,082
1802	Laç	3	48,263
2114	Lushnjë	1	37,860
2804	Pogradec	2	37,084
1204	Kavajë	2	31,421
509	Peshkopi	3	29,755
1906	Lezhë	3	26,170
1705	Kukës	3	24,990
1005	Gjirokastër	3	24,980
	Albania	64	1,517,316

Table 3: Agglomerations of more than 20,000 inhabitants, number of communes and population size, 2001
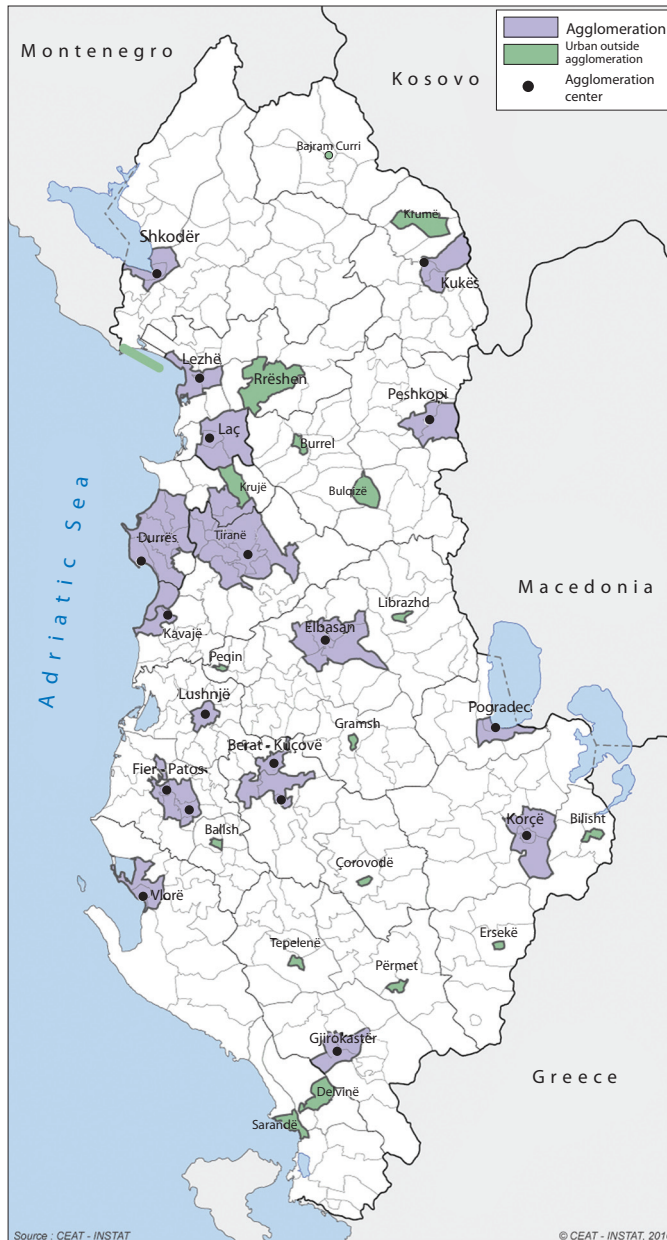
Map 10: Agglomeration and cities outside agglomerations

2.4 Metropolitan area definition

Metropolises are large urban areas composed of several interconnected urban agglomerations. They may be defined by size (typically with more than one million inhabitants), economic specialization and national and international significance. Currently, there is no official definition of metropolis in Albania, but the Tirana–Durrës corridor is very often assimilated as a metropolis. The larger capital region of Albania is obviously the only urban area showing a strong dynamic in the direction of an international concept of metropolis.

The thirteen communes of the Tiranë agglomeration, the nine of the Durrës agglomeration and the two of Kavajë form what is called the **Tirana–Durrës Metropolitan Area**. According to the proposed definition, contiguity of the three existing urban agglomerations is a criterion. These areas demonstrate quite strong commuting flows between the agglomeration centres.

The Metropolitan Area of Tirana–Durrës comprised 715,000 inhabitants in the 2001 Census, while other urban areas recorded 951,000 and rural areas about 1,403,000.

Tirana Metropolitan Artea

Agglomerations

500`000

125`000

25`000

Totla population 2001

Source : Population and Housing Census, 2001

© CEAT - INSTAT, 2010

Map 11: Agglomerations and Tirana–Durrës Metropolitan Area population cartogram (size of communes proportional to the population)

The cartogram represented in Map 11 shows the territory of the Albanian communes as a function of their population size and not, as is usually the case, as a function of the surface area. This cartographic method is also called anamorphosis. The maps include the 16 Albanian agglomerations, thereof the three agglomerations of the Tirana–Durrës Metropolitan Area, composed of the agglomerations of Tirana, Durrës and Kavajë.

2.5 Non-urban communes

2.5.1 Economic structure
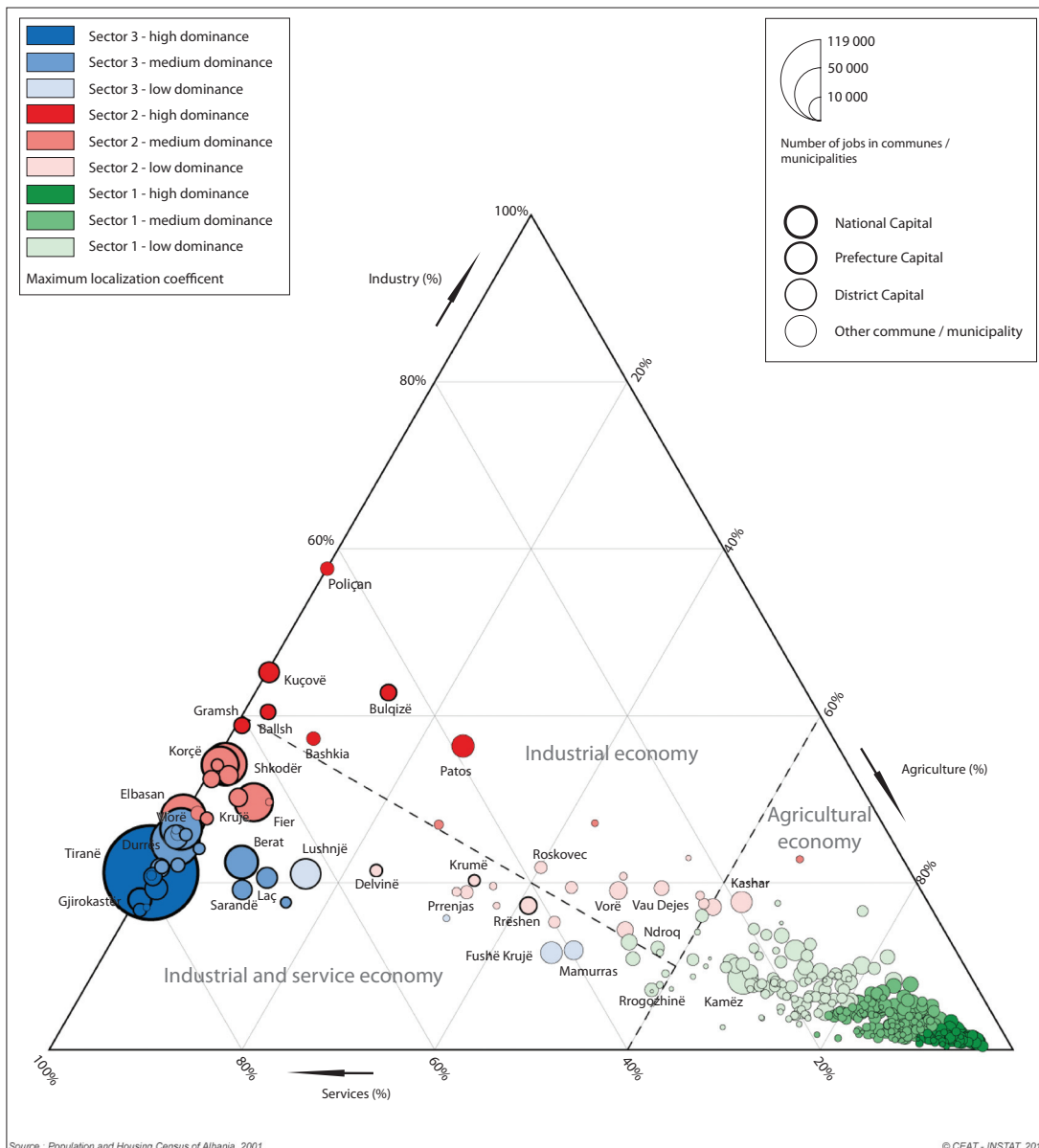
Graphic 2: Share of employment in the three economic sectors, by commune, 2001

Rural communes are defined by their economy structure. Graphic 2 shows a triangular structure that represents the parts of the agricultural, industrial and service sectors in the active population of each commune. It shows a very clear separation between numerous very rural and agricultural communes (mostly very small in size) and some important communes with an industrial or tertiary dominance. The three colours correspond to the highest localization coefficient in each commune. The intensity of colour indicates the dominance of the index. The three sectors in the graphics delimited by interrupted lines correspond to thresholds used to define non-urban communes in the classification. In fact, the classification defines non-urban communal types by either dominance in agriculture, in industry or in a mixed tertiary and industrial structure. Two specific types complete the chosen approach.

2.5.2 Specific economic types

Within the group of non-agricultural rural communes, we distinguish between an industrial type and another combining industry and tertiary sector. Outside this combination, there could be a series of types of communes based on tertiary specialization. The typology could distinguish between tourism communes, as well as a type of commune specialized in health or in education. For Albania, we assess that tourism could create a classic type of non-urban commune with tertiary specialization. On the other hand, most schools, hospitals and other institutions of the social sector are situated within centres and not in rural areas. Also, some Albanian communes are clearly dominated by state institutions, such as for energy production, the army and mining. Our proposal contains two types of economic specialization: tourism on the one hand, and energy and mining, taken together, on the other.

2.5.3 Agricultural communes and subtypes

We separate agricultural communes into two groups, distinguished first by a class with a more or less exclusive presence of this sector and another by different agriculture type (*agricultural* vs. *deep agricultural*). The distinction should take into account different types of agriculture production, irrigation system, cattle stock, or agriculture products. Because of lack of available data, our proposal is a substitution solution.

The distinction should take into account the conditions of agriculture in mountain areas and those in plains. The criterion of altitude is not optimal: the Korçë area, for example, is situated at a high altitude but the conditions for agriculture production are those of a plain. In consequence, a mean slope was chosen estimated on the basis of a numerical model[38].

Map 12: **Mean slope by commune**

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[38] Mean slope was calculated using a Digital Elevation Model (DEM), which is a digital representation of ground surface topography. Source: Shuttle Radar Topography Mission (SRTM).

3. Fourteen types of commune

3.1 List of criteria

The typology comprises four main groups of communes: the centres, communes situated in the fringe of urban agglomerations, rural industrial and service communes, and agricultural communes. Centres and communes in the urban fringe form the urban part of Albania, industrial, service and agricultural communes form the rural part of the country.

3.1.1 Group 1: Centres

A centre is defined by its institutional function as capital of a prefecture or of a district. Four types of centres are proposed; the main distinction follows the size, but there is a secondary criterion applied for smaller centres, which distinguishes between service-oriented and industrial capitals. The attribution of a centre dominates all other attributions.

Type	Name	Definition
11	National capital	National capital
12	Capitals of national importance	Prefecture capital, > 40,000 inhabitants
13	Capitals of service economy	Capital between 5,000 and 20,000 inhabitants
		Part of industry in activity < 30%
14	Capitals of industrial economy	Capital between 5,000 and 40,000 inhabitants
		Part of industry in activity > 30%

3.1.2 Group 2: Communes on the fringe of agglomerations

A commune of agglomeration fringe is define by its proximity and high interaction with an urban centre. The definition is based on a combination of five indicators expressing different aspects of urbanity: a continuously built up area (with interruptions of less than 200 m), a population density higher than 250 inhabitants per km^2, a percentage of agricultural employment of less than 85 per cent, a percentage of new built dwellings (after 1991) higher than 30 per cent and an intensity of out-commuting actives of more than 20 per cent. To be introduced into an agglomeration, a commune has to fulfil the first criterion (built up area),

Within the group of urban communes outside the centres we distinguish two sub-types (suburban and peri-urban) taking into account the socio-economic differentiation, especially in the Tirana area (south-east versus north-west). The chosen indicator (educational level) allows one to distinguish between the lower status of suburban communes and the higher status of peri-urban communes. The attribution of a commune to an agglomeration dominates all other attributions (beside that of a centre).

Type	Name	Definition
Urban		Continuity of built up area (breaks < 200 m) between the centre and the main village of the commune
		At least one of the following criteria has to be given:
		- population density > 250 inhabitants per km^2 - agriculture employment < 85%
		- newly built dwellings (1989 to 2001) > 30%
		- intensity of commuting out-flows > 20%
21	Suburban	Part of higher education < 30%
22	Peri-urban	Part of higher education > 30%

3.1.3 Group 3: Rural industrial and service communes

Communes not belonging to the group of capitals with more than 5,000 inhabitants or to a commune of an agglomeration are defined by their economic structure. Non-agrarian communes count less than 60 per cent of actives in agriculture or a high percentage of actives in selected tertiary branches.

Types 1 and 2 dominate group 3, which dominates group 4. Within the types of group 3, the following hierarchy is observed: 32 > 34 > 31 / 33.

Type	Name	Definition
31	Industrial communes	Agriculture employment < 60%; (industry+5%) > (tertiary-5%)
32	Mining and energy communes	Mining or energy employment > 5%
33	Industrial and service economy communes	Agriculture employment < 60%; (industry+5%) < (tertiary-5%)
34	Tourism communes	Employment in hotels and restaurants > 5%

3.1.4 Group 4: Agricultural communes

Agrarian or mostly agrarian communes are divided into four types, distinguished by the percentage of agrarian activity and the steepness of communal territory. The threshold for a deep agrarian commune is 80 per cent agrarian actives; a (mixed) agrarian commune accounts for between 65 per cent and 80 per cent agrarian actives. The threshold between communes in plains and communes in mountainous regions is given by a mean slope greater than 13.5 degrees (see Map 12).

Type	Name	Definition
41	Agricultural communes of plains	Agriculture from 65–80%; mean slope < 13.5
42	Agricultural communes of mountainous areas	Agriculture from 65–80%; mean slope > 13.5
43	Deep agricultural communes of plains	Agriculture > 80%; mean slope < 13.5
44	Deep agricultural communes of mountainous areas	Agriculture > 80%; mean slope > 13.5

3.2 Map of the 14 types

Legend:

- 11 - National Capital
- 12 - Capitals of National Importance
- 13 - Capitals of Service Economy
- 14 - Capitals of Industrial Economy
- 21 - Suburban
- 22 - Periurban
- 31 - Industrial Communes
- 32 - Mining and Energy Communes
- 33 - Industrial and Service Economy Communes
- 34 - Touristic Communes
- 41 - Agricultural Communes of Plains
- 42 - Agricultural Communes of Mountainous Areas
- 43 - Deep Agricultural Communes of Plains
- 44 - Deep Agricultural Communes of Mountainous Areas

Montenegro

Kosovo

Adriatic Sea

Macedonia

Greece

Source : CEAT - INSTAT

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Map 13: Communes by type

Graphic 3: Hierarchy of types

- Urban
  - 1 - Central
    - 11 - National Capital
    - 12 - Capitals of National Importance
    - 13 - Capitals of Service Economy
    - 14 - Capitals of Industrial Economy
  - 2 - Suburban
    - 21 - Lower Status Suburban
    - 22 - Higher Status Suburban
- Rural
  - 3 - Specific types
    - 31 - Industrial Communes
    - 32 - Mining and Energy Communes
    - 33 - Industrial and Service Economy Communes
    - 34 - Touristic Communes
  - 4 - Agricultural
    - 41 - Agricultural Communes of Plains
    - 42 - Agricultural Communes of Moutainous Areas
    - 43 - Deep Agricultural Communes of Plains
    - 44 - Deep Agricultural Communes of Moutaious Areas

Typology of Communes of Albania						
	Name	Code	Abbr.	No. comm.	Pop. 2001	% pop. alb
Centres (capitals)	National capital	11	TIRANA	1	341,453	11.12
	Capitals of national importance	12	CAPNAT	7	501,087	16.33
	Capitals of service economy	13	CAPSERV	10	110,564	3.60
	Capitals of industrial economy	14	CAPIND	16	228,600	7.45
Fringe of agglomerations	Suburban	21	SUBURB	28	261,623	8.52
	Peri-urban	22	PERIBURB	19	223,098	7.27
Industrial and service economy	Industrial communes	31	INDUSTR	6	35,004	1.14
	Mining and energy communes	32	MINING	12	53,929	1.76
	Industrial and service economy communes	33	MIXT	8	27,042	0.88
	Tourism communes	34	TOURIST	9	43,442	1.42
Agriculture economy	Agricultural communes of plains	41	AGRPLAIN	40	238,831	7.78
	Agricultural communes of mountainous areas	42	AGRMOUNT	71	266,268	8.68
	Deep agricultural communes of plains	43	DAGRPLAIN	74	481,631	15.69
	Deep agricultural communes of mountainous areas	44	DAGRMOUNT	73	256,703	8.36
	Total Albania			**374**	**3,069,275**	**100.00**

Table 4a: **Classification of fourteen types of Albanian commune, number of communes, by type and population size, 2001**

Aggregated Typology of Albanian Communes						
	Name	Code	Abbr.	Nb. com.	Pop. 2001	% pop. alb
Centres	National centres (11, 12)	10	NATCENTER	8	842,540	27.45
	Regional centres (13, 14)	15	REGCENTER	26	339,164	11.05
Agglomerations	Suburban communes (21, 22)	20	SUBURB	47	484,721	15.79
Industrial and service economy	Industrial and service economy (31, 32, 33, 34)	30	INSUSTRSERV	35	159,417	5.19
Agriculture economy	Agriculture communes of plains (41, 43)	40	AGRIPLAIN	114	720,462	23.47
	Agriculture communes of mountainous areas (42, 44)	45	AGRIMOUNT	144	522,971	17.04
	Total Albania			374	3,069,275	100.00

Table 4b: **Classification of six aggregated types of Albanian commune, number of communes by type and population size, 2001**

For empirical reasons it might be useful to dispose of an aggregated classification. Table 4b reports six classes of an aggregated typology, where the upper level has been maintained.

4. Testing the classification

4.1 Tests on some independent demographic variables by type of commune

| Code	Types of commune	% males	% children	% 60 years and over	% immigrants	% actives
11	National capital	49.5	23.8	13.6	30.5	34.8
12	Capitals of national importance	49.3	25.8	12.7	12.4	31.6
13	Capitals of service economy	49.6	30.7	9.1	7.6	32.2
14	Capitals of industrial economy	49.5	28.3	11.1	10.1	31.8
21	Suburban	49.8	31.6	9.8	18.8	35.1
22	Peri-urban	50.3	31.2	9.5	26.1	31.6
31	Industrial communes	49.8	30.8	10.7	5.1	31.7
32	Mining and energy communes	49.8	31.3	11.2	7.3	31.9
33	Industrial and service economy communes	49.6	30.1	14.0	6.5	28.8
34	Tourism communes	49.9	28.6	11.0	5.6	30.8
41	Agricultural communes of plains	49.7	30.7	11.6	9.0	33.3
42	Agricultural communes of mountainous areas	50.4	32.0	11.5	2.8	27.8
43	Deep agricultural communes of plains	49.9	31.0	10.2	7.6	40.4
44	Deep agricultural communes of mountainous areas	51.0	31.8	10.4	2.4	37.5
	Albania	49.9	29.3	11.2	12.7	33.9

Table 5: **Mean values of six independent demographic variables, by the 14 classes of the typology**

The empirical value of the typology can be tested by improving the values of independent variables, i.e. variables which do not constitute the typology itself. For our purpose, five variables have been tested: the percentage of the male population, of children and elderly people, the proportion of immigrants in the population of 2001 and the activity rate.

Four out of the five tested variables show a clearly differentiated structure by the fourteen classes of the typology; centres count fewer children, but also fewer elderly people than do suburban communes and within the rural part of the country, the most agricultural types have higher percentages of both groups. Activity rate is highest in Tirana, but also in suburban communes and in agricultural communes located in plains. Finally, the percentage of immigrants in the population depends very heavily on the typology: between Tirana and the other types of capitals, between suburban communes, and also between plains and mountains.

It is obvious that the value of the typology should be tested using other variables, and most importantly using more up-to-date figures.

12.5 Test of housing structure by type of commune
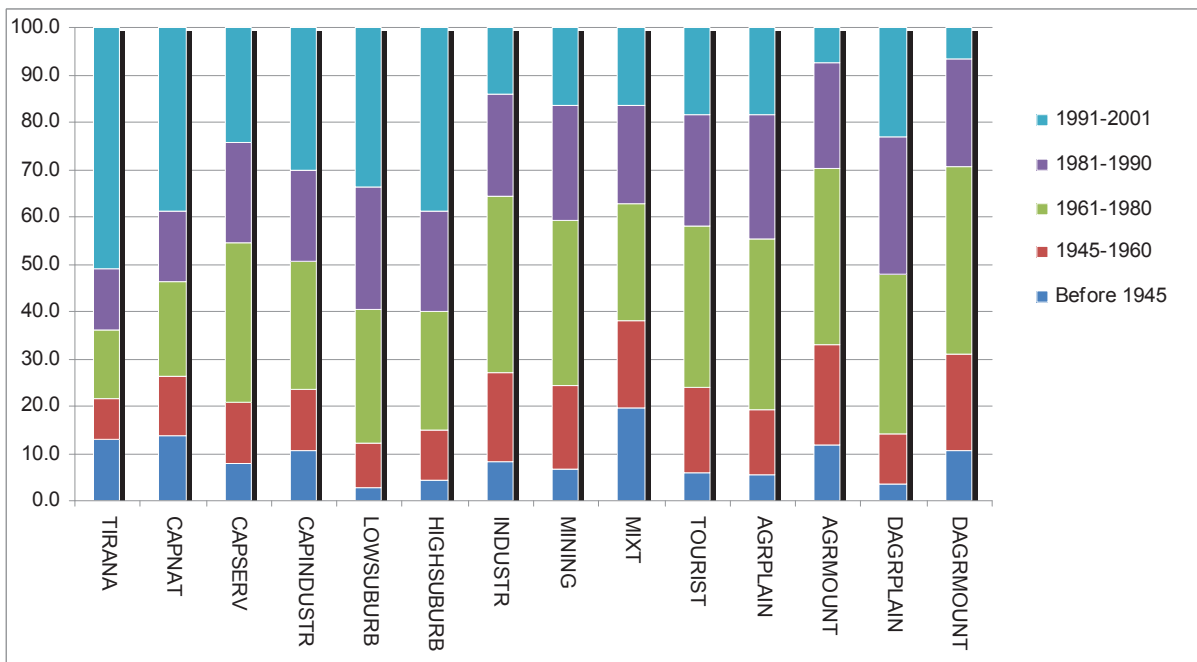
Graphic 4: Housing structure by period of construction, by the fourteen classes of typology
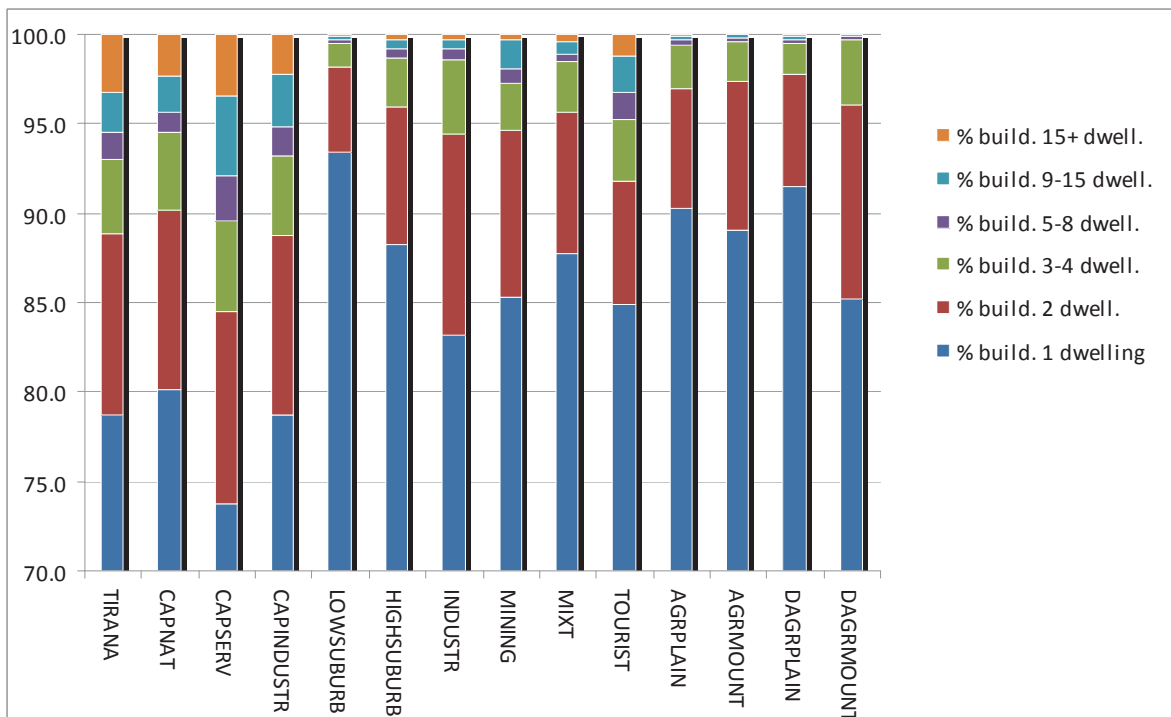
Graphic 5: Housing structure by size of building, by the fourteen classes of the typology

Both the indicator of the period of housing construction and that of the size of the houses show clear distinctions among the fourteen types. Graphic 4 shows the proportion of existing dwellings in 2001 by period of construction. The new buildings are concentrated in Tirana, in big capitals and in suburban and peri-urban areas. In smaller capitals, more than 50 per cent of dwellings are more than 20 years old, in Tirana, 36 per cent, in peri- and sub-urban areas, 40 per cent. The graphic also highlights the difference between agricultural communes in plains

and in mountains. The housing renewal is higher in plains: about 15 per cent old dwellings (before 1960) and 50 per cent new ones (after 1980). In mountainous areas, the proportion of old and new dwellings is similar (30%).

Graphic 5 shows that capitals of the service economy have the lowest proportion of individual houses. In comparison with other types of capitals, these places developed mainly during the communist period and later underwent less development. It also shows that housing in suburban and peri-urban areas still has rural characteristics. Other tests could be carried out, for example with regard to internal migration.

5. Conclusion

5.1 Challenges and prospects

In the present article, the authors develop two territorial classifications, a typology of the Albanian communes and a definition of urban agglomerations. The year of reference of these classifications is 2001, the year of the last census. Demographic and socio-economic population data are available at the level of commune, village, quarter and Census areas. Data on flow of commuters and migrants between all communes is also available. Moreover, the quality of orthophotographs has become very high, allowing information of land use and settlement structure to be exploited in a very detailed way.

The combination of different data sources has allowed us to build up a coherent definition of the Albanian agglomerations and a classification of communal types that distinguish between different types of centre, communes on the fringe of an agglomeration, industrial and service-oriented communes and also agricultural communes. The typology makes the distinction between fourteen classes defined by a hierarchy and separated by thresholds.

These classifications can be put to very different uses. First, they are an analytical tool which allows interpretation of spatial structures and developments for specialists in planning, administration and science. Secondly, the classification can be used for the purpose of data sampling in surveys or in international comparisons. Finally, they may be of value for some administrative and political purposes, but should retain the status of a statistical instrument. It is not suggested that political action be linked directly to these classifications, as in the case of the official distinction between capital and urban communes.

Data from the 2011 Census will allow typology of the demographic, economic and social context to be adapted over the subsequent ten years. We estimate that the typology will still be valuable, but that the thresholds should be adapted in order to reflect the changing economic and demographic conditions, such as the diminishing role of agriculture, the increase in flows of commuters and fluctuating patterns within the agglomerations.

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Conclusions and recommendations

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Marco Pecoraro[39], September 2010**

As stated in the Introduction, this portfolio of contributions stems from a series of analytical activities carried out in a collaborative programme named Developing Demographic and Social Statistics in Albania (DESSA), supported since 2007 by Swiss Cooperation (SDC) through the Federal Statistical Office (SFSO) and implemented at the Albanian Institute of Statistics (INSTAT). The articles not only highlight various facets of demographic change that have taken place in Albania since 1990, with focus on educational and health issues as major components of human capital in a transition economy, but additionally give insight into the socio-demographic information system in place.

Before summarizing a few results of current importance, the conclusions address some methodological findings and institutional issues drawn from the articles or from the detailed assessments undertaken prior to implementation of the DESSA action plan.[40] Special attention is paid to the development of a Geographic Information System (GIS), the largest programme component, which encompassed training, large-scale field activities and infrastructure investments. Analytical outcomes and practical observations related to various activities within DESSA led to some overall final considerations about the future development of statistical production in Albania and the role of INSTAT, all of which are considered below.

Methodological issues to be addressed

In several Albanian socio-demographic areas, a relative variety and abundance of basic statistics drawn from administrative and survey data exist, but not all administrative data collected are useful for analytical purposes and, in some cases, multiplicity of sources even creates confusion. However, it was observed throughout DESSA collaboration that the data available on demography, health and education in Albania are, at least in part, of good quality, while significant information also exists (from surveys) on migration and gender. Nevertheless, it was also noted that improvement was necessary with regard to methodological documentation and systematic quality control. Need for action in this area had already been recognised and begun to be addressed in 2006 by Swedish–Albanian statistics partnership, with focus on development of a central metadata repository and a public database. Starting with economic data, this initiative will progressively be extended to cover all statistics provided by INSTAT.

Potential for improvement had also been observed with regard to production of indicators—in many cases significant indicators are absent, though the basic data necessary for their production are available. Modernisation of the civil registry system is expected to resolve some of these shortcomings but will require institutionalized collaboration between INSTAT and the local civil status offices in order to find an adequate solution.

When the DESSA programme started, appropriate weighting and standardisation techniques (or ratios) were not used, due to insufficient expertise. Consequently, life expectancy, fertility

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by parity, infant mortality, etc., could not be computed, and gender and regional disaggregation, crucial to many types of analysis, was insufficient. Given the fact that sound analytical expertise is a prerequisite for development and adequate use of relevant indicators, the implementing partners decided to concentrate activities on needs-oriented capacity building through internships, practical trainings and lectures related to various topics.

Development of new data sources and policy monitoring

Until recently, most social statistics in Albania were based solely on individual and household data of the Living Standards Measurement Survey (LSMS) supported by the World Bank. However, during the last three years, other data sources—Labour Force Survey (LFS), Household Budget Survey (HBS), Albanian Demographic and Health Survey (ADHS)—have become available, undertaken by INSTAT. Simultaneously, the use of administrative data sources became maximised. Swiss–Albanian partnership substantially supported ADHS 2008 through DESSA, both financially and with expertise in the fields of health and migration statistics. However, the planned elaboration of a new basis for reporting data on social protection issues was abandoned given that reliable data in this area are still largely lacking.

Many of the indicators used in demography, education and health relate to the cross-cutting strategies on social inclusion, poverty reduction, gender equality, youth and migration developed within the framework of the Albanian government's Integrated Planning System. The underlying information system was put in place to monitor policy outcomes and impacts under the National Strategy for Development and Integration (NSDI) 2007–2013 (see Introduction). In spite of the improvements mentioned in the present report, policy monitoring[41] still faces considerable challenges, as awareness of the relation between policy planning and statistical production in Albania is still insufficient at various levels of governance and policy implementation.

Although the new integrated information system is closely linked to strategic planning and budgeting of government, and supported by the national five-year programme for official statistics, utilisation of these statistics has still to be improved in terms of responsibilities, efficiency and accuracy, hampering evidence-based policy making. The mere numbers of sector strategies (21) and cross-cutting strategies (17) and relevant actors does not facilitate the coordination and establishment of priorities.

Challenges related to institutional development

INSTAT is in principle a central actor in policy monitoring and reporting on NSDI, with a threefold role: it is part of a group that defines high level indicators on NSDI and is also one of the agencies—if not the most important one—supplying the status of the indicators for the NSDI progress reports. Thirdly, it has to review the sector strategies and propose additional tables, text or indicators. However, the Institute does not always have the resources to play an active role in conformance with the requirements of European Union and United Nations principles on collection and coordination of data.

INSTAT recently faced many internal and external challenges due to major changes and constraints in the political and institutional context of Albania: organisational reforms, cuts in statistical agencies of line ministries, modernisation of local registration systems and school

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[41] understood as assessment of the functioning of policy, and the results achieved: see Marco Segone, (ed., 2008) Bridging the gap: The role of monitoring and evaluation in evidence-based policy making in partnership Unicef, Geneva

registration, etc. These developments have sometimes complicated the collaboration with government agencies, line ministries and other, external, partners. Challenges related to this issue were experienced within all programme components, and the need for support aiming at strengthening INSTAT's capacity to address the institutional environment was expressed on several occasions (and foreseen in the initial project plan). To give an example, the designing of a memorandum of understanding in order to facilitate exchange of statistical information with the Ministry of Health was begun, but due to institutional restructuring within the Ministry this initiative had to be interrupted. Considering this and other experiences and INSTAT's priorities, as well as the capacities of the programme, in terms of available human and financial resources, INSTAT and SFSO decided to abstain from a more proactive involvement in terms of support for cooperation with other national institutions, as well as with the regions.

Support provided to cartography and GIS

It is worth highlighting again that the largest component of the DESSA programme is the support provided for cartography and GIS tools for statistical use (creation of sampling frames for household surveys, mapping for censuses and dissemination of regional and small area data). The project was directed by Roberto Bianchini and included not only, as in all other components, a prior assessment, technical assistance and training, but also support for fieldwork activities and office work, as well as acquisition of equipment and consumables. Thus, the following results were achieved at the conclusion of the project:

- definition of a sound and sustainable strategy, and plans for introduction and use of geospatial technologies at INSTAT, as experienced in other European Statistical Offices

- support provided for establishment of a functioning management and technical structure at INSTAT in the field of GIS and cartography

- technical support provided to define the implementation approach, data models, IT infrastructure and the materials used for fieldwork activities and office work (digitalization and data analysis for the area of Tirana and for improvement of spatial data on administrative boundaries). About 1,500 A0 format maps at a scale of between 1:500 and 1:1,000 were updated, and about 100 local surveyors and supervisors were recruited and trained

- support for development of institutional cooperation with other Albanian authorities dealing with mapping services and products, as well as thematic analysis of the cartography component, which proposes a typology of communes and a definition of agglomerations for Albania, based on the 2001 Population and Housing Census results. This new classification provides an example for territorial analysis and policy evaluation, as well as for urban and regional planning. Urban sprawl replaces urban concentration and debate on new definitions of agglomerations and metropolitan areas allows this evolution to be taken into account (cf. contribution of Schuler, Jarne, Shameti and Seferkolli in this publication).

The experts involved with the DESSA project have also succeeded in coordinating activities with other projects and donors providing assistance and funds for continuation of the work begun here in this specific field. To this regard, it is important to mention the following:

- support that is being provided by UNFPA Albania at INSTAT for enlargement to other areas of the country of the spatial data model implemented by DESSA in the area of Tirana, and for acquisition of equipment and training activities

- support provided by the EU-funded project *Technical Assistance to the National Statistics Office (INSTAT) and its Regional Offices, Albania* in the field of digitalization procedures and geocoding.

In April 2011, another Population and Housing Census will be launched in Albania. The data collected will permit computation of demographic tables at the prefecture and district levels. The technical assistance and advice, training, support for fieldwork activities and office work, as well as the acquisition of equipment, provided through DESSA has enabled the process of updating the digital maps. Thus, the GIS infrastructure put in place and the know-how elaborated within the DESSA framework will be an important contribution to the implementation of the 2011 Census activities. In terms of analysis, data from the Census will allow use of the developed typology, which may have to be adapted in order to reflect the changing economic and demographic conditions, such as the diminishing role of agriculture, increase in flows of commuters and fluctuating patterns within the agglomerations.

The above-mentioned achievements concern only some of the outputs and outcomes of the three-year activities within the DESSA programme. Others are directly reflected through the articles devoted to selected topics, which we hope will be deepened in future analysis. They most interestingly disclose significant socio-demographic developments and change in Albania that we briefly address below.

Rapid and contrasting socio-demographic change

Although pertaining to very different issues, all the articles of this publication illustrate the rapid socio-economic changes that have taken place in Albania over a relatively short period of its transition. This transformation concerns structural conditions (health and education system) and behaviour alike. The drastic decline in the fertility rate and increase in internal and international mobility are only two striking examples. With regard to internal mobility, more than a quarter of the Albanians have moved elsewhere within the country, contributing to urbanisation at an unprecedented pace: half of the population was estimated to be living in cities in 2008 compared to only one third in 1989.

In contrast, there is good evidence of an increase in worsening developments and cumulative social exclusion mechanisms affecting in particular elderly people with low educational and socio-economic background, who are residing in remote rural regions. This phenomenon was found to be even worse among elderly people over 60 years of age who experience a rapid deterioration in health status and who have limited access to medical care, not only because of lack of health facilities in rural areas, but also because of insufficient financial means for making informal payments. This holds particularly true for inpatient treatment; indeed two thirds of hospitalized patients are reported to expect or even be required to make informal payments. Whereas more than 70 per cent of respondents in ADHS reported to have difficulties paying for medical advice or treatment in rural areas, this proportion drops by almost half in Tirana.

Impoverishment of whole segments of the population goes hand in hand with substantially increased incomes for others who may, for instance, benefit from remittances from family members living abroad. While some regional inequalities persist, other differences in demographic behaviour have obviously weakened during the past ten years compared to the 1990s. According to ADHS, overall infant and child mortality declined significantly over the five years preceding the survey. Nevertheless, even though almost all women receive antenatal or obstetric care, the nutritional status of children, despite an improving trend, remains a public health concern.

Wide regional differences also exist in the level of schooling attained, though participation in primary education remains high across the whole country since Albania almost eradicated illiteracy under the communist system and guaranteed a relatively equal access for both

gender groups. The results of that policy are reflected in the comparable achievement of women and men in the cohorts above 50 years of age. Nevertheless, most people enrolled in tertiary education live in the capital, while the majority of the population in other regions do not complete a secondary degree, neither vocational nor general. The relatively limited tertiary education attainment may be explained partially by international brain drain (emigration of highly skilled individuals).

Meanwhile on-going emigration and the trend toward low fertility may bring about rapid demographic aging in the future. In the light of internal migration, the size of the elderly population, particularly women with limited social integration living in agglomerations, is likely to grow. These people will need support and adequate health care if an increase in health inequities and social inequalities is to be avoided.

As stated earlier, health and education are critical to human capital and thus influential factors in the economic and democratic progress of a country. A comprehensive approach to monitoring health and educational needs, as well as social and minority development situations, must be based on quality indicators serving evidence-based policy making. Regional, gender and socio-economic disaggregation is absolutely key in this context.

To ensure production of technically sound statistics and to enable politically relevant monitoring, continuous dialogue between producers, suppliers and users of evidence should be promoted. For this reason, the available data have to be made accessible to a wider public, through user-friendly dissemination, documentation and valorisation. Hence, we hope that in the present publication, besides highlighting recent socio-economic development, the articles shed light on the availability of various datasets in the Albanian context that are worthy of further analysis and debate.