



Highlights on health in Albania 2005

Highlights on health give an overview of a country's health status, describing recent data on mortality, morbidity and exposure to key risk factors along with trends over time. The reports link country findings to public health policy considerations developed by the WHO Regional Office for Europe and by other relevant agencies. *Highlights on health* are developed in collaboration with Member States and do not constitute a formal statistical publication.

Each report also compares a country, when possible, to a reference group. This report uses the 25 countries with low child mortality and low or high adult mortality, designated Eur-B+C by WHO, as the reference group. Eur-B+C comprises Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Poland, Republic of Moldova, Romania, Russian Federation, Serbia and Montenegro, Slovakia, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine and Uzbekistan.

To make the comparisons as valid as possible, data, as a rule, are taken from one source to ensure that they have been harmonized in a reasonably consistent way. Unless otherwise noted, the source of data in the reports is the European health for all database of the WHO Regional Office for Europe. Other data and information are referenced accordingly.

Keywords

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Summary: findings and policy considerations

Life expectancy

WHO estimates that a person born in Albania in 2002 can expect to live 70.4 years on average, some two years longer than average life expectancy (LE) in Eur-B+C countries, but more than eight years shorter than the Eur-A average. Female LE in 2002 was 74.1 years; for males, it was 67.3 years. About 12% (9 years) of the average life span in Albania is spent with illness.

As the length of life increases, older people can respond with lifestyle changes that can increase healthy years of life. Correspondingly, health care systems need to shift towards more geriatric care, the prevention and management of chronic diseases and more formal long-term care. Since people are living longer, measures to improve health and prevent disease need to focus on people of working age.

Ageing and employment policies (OECD, 2004)

What are the main risk factors for disability in old age and how can disability be prevented? (Health Evidence Network, 2003a)

Infant mortality

WHO/UNICEF estimate Albania's infant mortality rate to have been 23 per 1000 live births in 2000. The official national rate for the same year was 12 per 1000, and 8.4 in 2003.

Antenatal care is one of the most important services in health care. Nevertheless, it can be expensive, and interventions may be excessive, unneeded and unproven. A simplified model of antenatal care, based on evidence of benefit, is available.

Managing newborn problems: a guide for doctors, nurses and midwives (WHO, 2003a)

What is the efficacy/effectiveness of antenatal care? (Health Evidence Network, 2003b)

The WHO reproductive health library, version 6 (WHO, 2003b)

Main causes of death

Mortality rates for males and females in Albania are higher than Eur-A averages, but lower than Eur-B+C averages. In 2003, selected main noncommunicable diseases accounted for about 76% of all deaths in Albania (52% of all deaths were caused by diseases of the circulatory system and 14% by cancer). External causes claimed about 5% of total deaths and communicable diseases, around 0.5%.

Preventive care, delivered through a country's primary care system, can reduce all-cause mortality and premature mortality, particularly from CVD.

A strategy to prevent chronic disease in Europe: a focus on public health action: the CINDI vision (WHO Regional Office for Europe, 2004a)

Towards a European strategy on noncommunicable diseases (WHO Regional Office for Europe, 2004b)

What are the advantages and disadvantages of restructuring a health care system to be more focused on primary health care services? (Health Evidence Network, 2004)

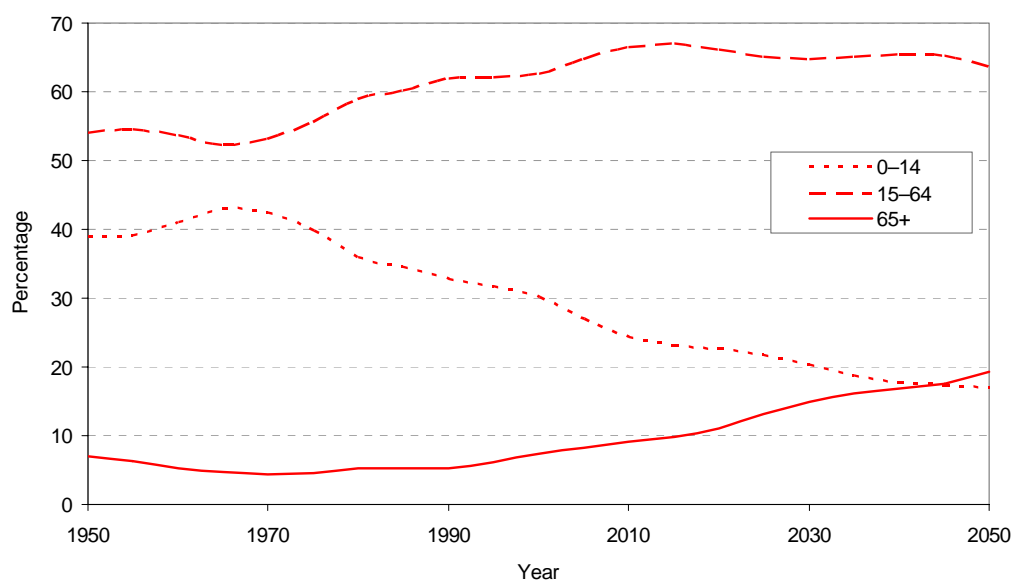
Selected demographic and socioeconomic information

Population profile

Albania's population was 3.1 million in mid-2003. Compared to averages for Eur-B+C countries, Albania has a relatively high proportion of young people 0 to 14 years of age and a low proportion of people over 65. Its birth rate is high compared to the average for Eur-B+C countries and is falling.

Since 1992, emigration from Albania has been significant. In 2001, the national Institute of Statistics (INSTAT, 2005) estimated that more than 300 000 people had left the country, including 40% of the population aged 19–40. In 1996, 93% of Albanian emigrants were aged 19–40, many of whom had high levels of education. Though the data from different sources have to be taken with caution, it appears that the emigration process had not slowed by 2004, and Albanians were still leaving both legally and illegally. By 2030, the percentage of the population from 0 to 14 is expected to fall to about 20% from 28% in 2003. At the same time, by 2030, the percentage of people 65 and over is predicted to double. (*Annex. Age pyramid*) Natural population growth is much higher in Albania than the average in Eur-B+C countries.

Percentage of the population aged 0–14, 15–64 and 65+ years, Albania, 1950 to 2050 (projected)



Source: United Nations (2005).

The free and uncontrolled movement of the population allowed since 1990 has also changed the urban/rural population ratio. In 1989, at the last population census, 36% of the Albanian population lived in urban areas (WHO Regional Office for Europe, 2005). In 2002, this figure was 43%. Nevertheless, Albania's population is still less urban than that of Eur-B+C countries.

Selected demographic indicators in Albania and Eur-B+C
2003 or latest available year

Indicators	Albania	Eur-B+C		
	Value	Average	Minimum	Maximum
Population (in 1000s)	3102.8	–	–	–
0–14 years (%)	28.1	–	–	–
15–64 years (%)	64.1	–	–	–
65+ years (%)	7.9	–	–	–
Urban population (%) ^a	43.2	63.7	25.0	73.3
Live births (per 1000)	15.2	12.8	8.6	27.1
Natural population growth (per 1000)	9.4	0.8	–7.5	23.0
Net migration (per 1000) ^b	–4.9	1.8	–6.6	2.1

^a2002; ^b2000.

Sources: Council of Europe (2005), WHO Regional Office for Europe (2005).

Socioeconomic indicators

Health outcomes are influenced by various factors that operate at individual, household and community levels. Obvious factors are, for example, diet, health behaviour, access to clean water, sanitation and health services. However, underlying health determinants of a socioeconomic nature also play a role in causing vulnerability to health risks. Here, the key factors are income, education and employment. Though moderately correlated and interdependent, each of these three determinants captures distinctive aspects of the socioeconomic background of a population and they are not interchangeable. Various indicators represent the key socioeconomic determinants of health.

Income: absolute poverty, relative poverty and income distribution

There is an income gradient affecting health: the poor generally suffer worse health and die younger than people with higher incomes. For instance, the latter are better able to afford the goods and services that contribute to health, for example, better food and living conditions.

People are considered to be in absolute poverty if their incomes are not sufficient to purchase very minimal goods and services. The World Bank currently uses an absolute poverty line of US\$ 2.15 and US\$ 4.30 income per capita per day to measure poverty in low- and middle-income countries of the WHO European Region (using 1993 international prices adjusted for purchasing power parity). While there is no certainty that the poverty lines measure the same degree of need across countries, the World Bank uses them as a constant to permit comparison. Many countries in the Region calculate their national poverty lines on the basis of a minimum consumption basket selected and priced according to the specific circumstances of the country.

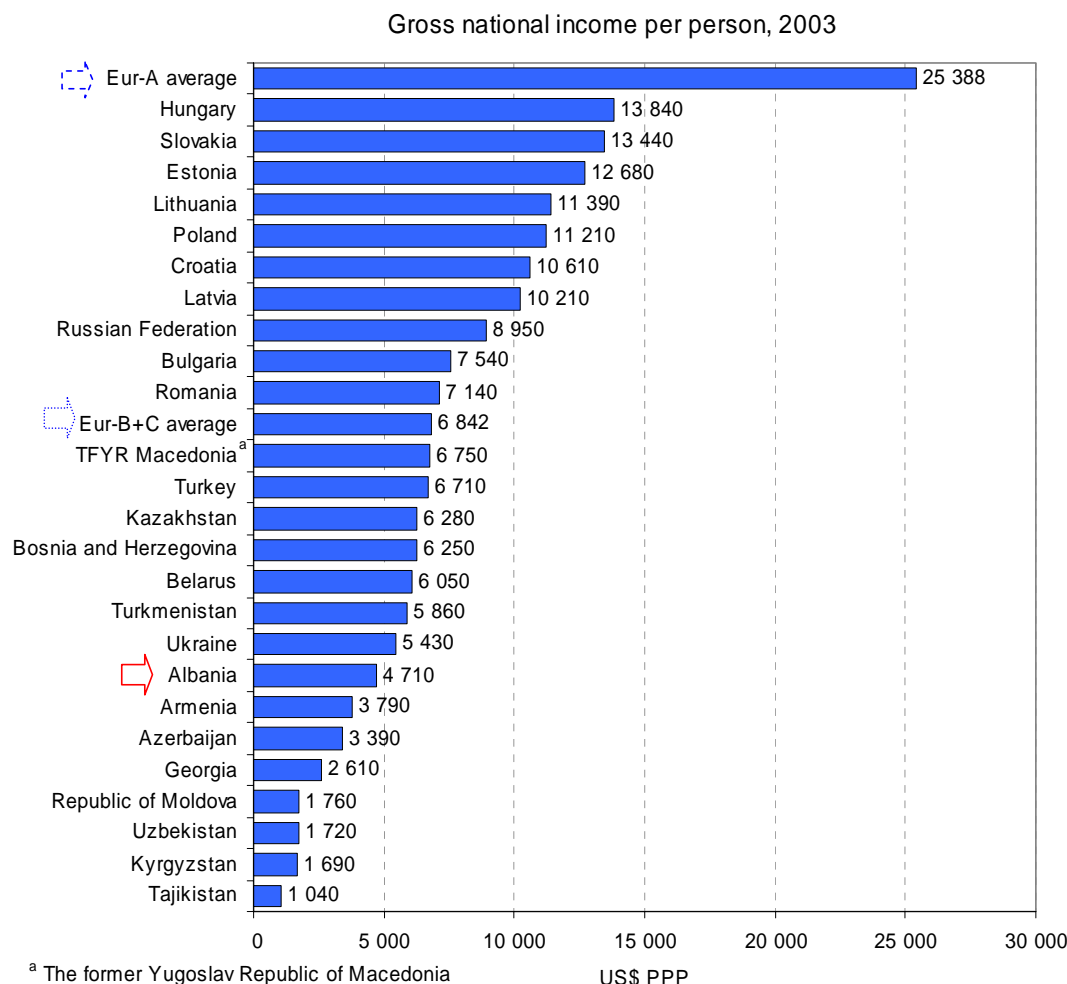
Albanian per capita gross national income in US dollars, adjusted for purchasing power parity, was \$4710 in 2003, below the Eur-B+C average of \$6842.

Relative poverty is an indicator of income level below a given proportion (typically 50%) of the average national income. In high-income countries, there are far more pockets of relative poverty than of absolute poverty.

In 2002, referring to a national poverty line, 25% of Albania's population lived in poverty. Using the World Bank's recommended benchmarks to measure absolute poverty in Europe, household surveys in Albania found in late 1996 that almost 23% of people lived on US\$ 2.15 per day or less. A 2002 survey found the rate to have dropped to about 12%. If the US\$ 4.30 poverty line is applied, the 1996 survey found almost 71% of the population living in absolute poverty by definition. The 2002 survey established the rate at 58% (World Bank, 2005).

Another measure of relative poverty in terms of income is the Gini index. This presents the extent to which the distribution of income (or, in some cases, consumption expenditure) among individuals or households within an economy deviates from a perfectly equal distribution. A Gini index of 0 represents perfect equality, while an index of 100 implies perfect inequality.

At the same time, the Gini indices for Albania for 1996 and 2002 were relatively low, consistent with the pervasiveness of poverty. In 1996 the Gini index for Albania was 29.1 and in 2002, it was 28.1. The Gini indices for 15 Eur-B+C countries for 2000 to 2002 range from 26.1 for Bosnia and Herzegovina (2001) to 45.6 for the Russian Federation (2000) (World Bank, 2005).



Source: World Bank (2005).

Education

Education tends to enhance an individual's job opportunities. In so doing, it can improve income, which in turn affects health positively. Education can also give more access to knowledge about healthy behaviour and increase the tendency to seek treatment when needed. A lower level of education – independent of individual income – is correlated with the inability to cope with stress, with depression and hostility and with adverse effects on health.

School enrolment is an indicator of access to education. The secondary school net enrolment represents the percentage of the total population of official school age (defined nationally) that is enrolled in secondary schools.

Net secondary school enrolment in Albania in 2000 was 73.9% of the school age population compared to a 81.2% average for Eur-B+C countries in the same year. The average net enrolment in Eur-A countries that year was 88.5%. (UNESCO, 2005)

Employment

Being employed tends to be better for health than being unemployed, except in circumstances where employment exposes the individual to physical injury or psychological stress. National unemployment

rates and rates for particular sub-populations are monitored to assess the extent to which people have or lack access to opportunities that would enable them to earn an income and feel secure. Vulnerability to health risk is increased by long-term unemployment, that is, continuous periods without work, usually for a year or longer; the socioeconomic status of an individual and of his/her dependents can slide as the period of unemployment increases.

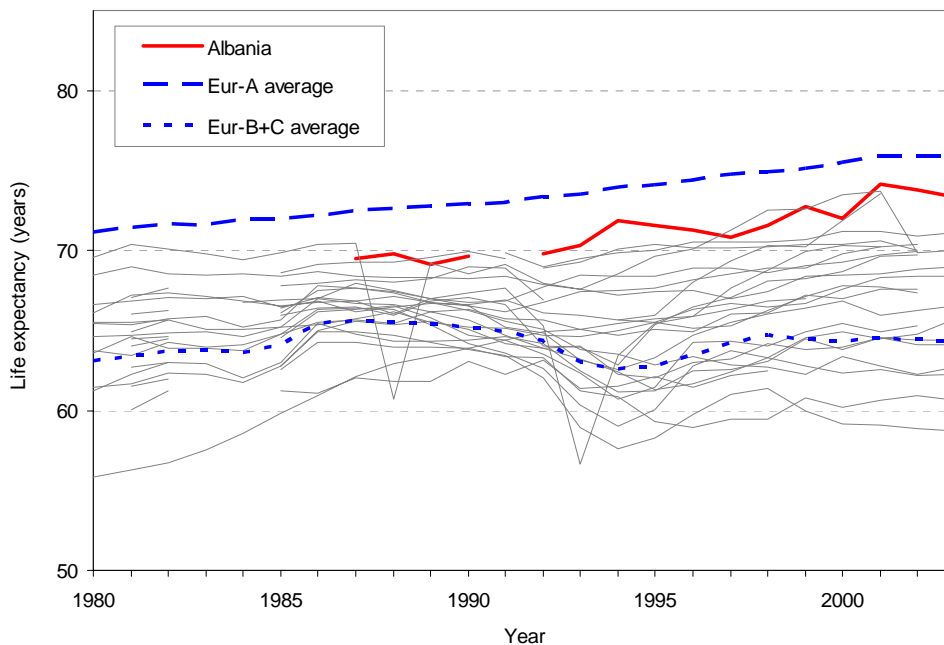
Below is a profile of the key socioeconomic indicators for Albania along with averages, where relevant, to permit comparison with a reference group of countries.

In 2001, total unemployment in Albania was 22.7% compared to a Eur-B+C average of 12.9% that year, keeping in mind that national rates are based on estimates of people available and seeking employment, and that countries have different definitions of the labour force and unemployment. (ILO, 2005)

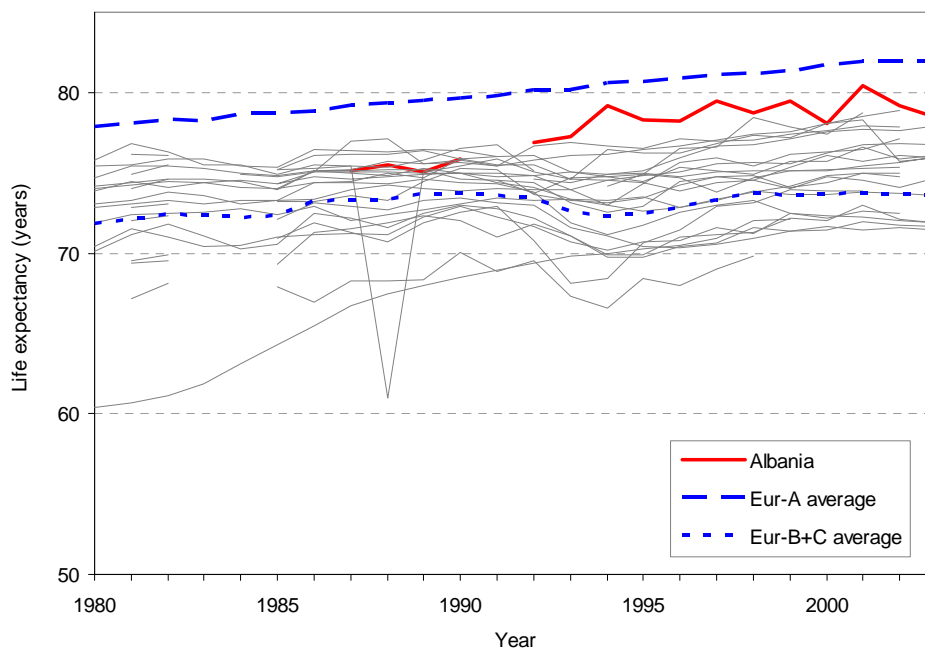
Life expectancy (LE) and healthy life expectancy (HALE)

According to WHO (2003c) estimates, a person born in Albania in 2002 can expect to live 70.4 years on average: 74.1 years if female and 67.3 years if male. This estimate is two years longer than the Eur-B+C average, but more than eight years shorter than the Eur-A average. In 2002 the national mortality statistics, on which the official life expectancy (LE) figure is based, gave estimates six years higher at birth than the WHO estimate. Underreporting of deaths and difficulties gathering population statistics most likely explain these differences. According to the national figures, the Albanian people gained about 3.6 years in LE between 1987 and 2003. This gain was slightly greater for men (3.8 years) than women (3.3 years).

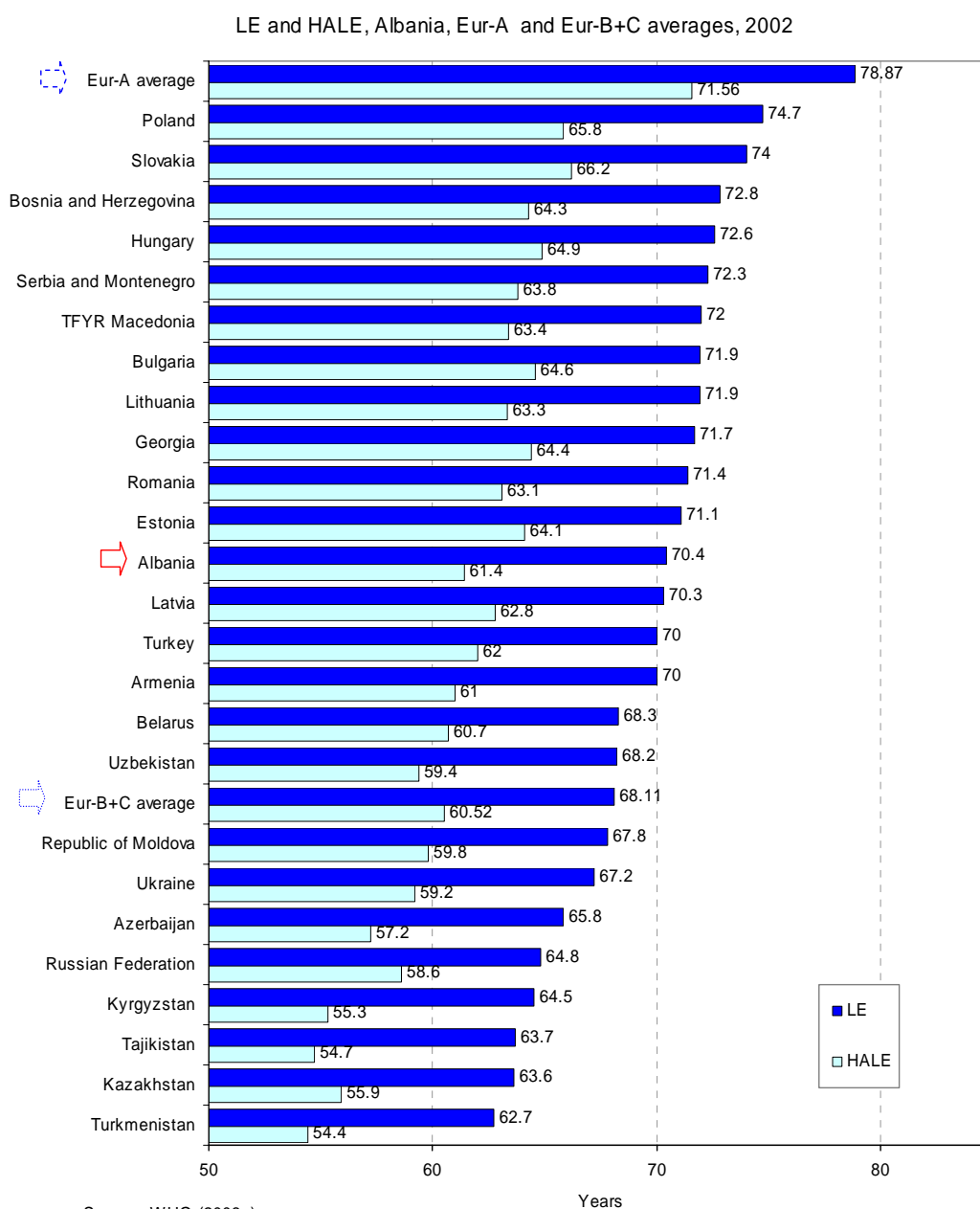
Life expectancy at birth for males, Albania, Eur-A and Eur-B+C averages, 1980 to latest available year



Life expectancy at birth for females, Albania, Eur-A and Eur-B+C averages, 1980 to latest available year



In addition to LE, it is increasingly important to know the expected length of life spent in good health. WHO uses a relatively new indicator for this purpose – healthy life expectancy (HALE), subtracting estimated years of life spent with illness and disability from estimated LE. For Albania, WHO (2003c) estimates that people can expect to be healthy for about 87% of their lives. They lose an average of 9.0 years to illness – the difference between LE and HALE. This loss is larger than the Eur-A average (7.3 years) and the Eur-B+C average (7.6 years).



Since women live longer and since the possibility of deteriorating health increases with age, women lose more healthy years of life (10.8 years) than men (7.8 years). Nevertheless, women in Albania have 3.8 more years of healthy life expectancy. Also among people 60 years old, females live more than three years longer healthy compared with males (13.9 versus 10.5 years) according to the WHO estimates (2003c).

Burden of disease

The burden of disease in a population can be viewed as the gap between current health status and an ideal situation in which everyone lives into old age, free of disease and disability. Causing the gap are premature mortality, disability and certain risk factors that contribute to illness. The analysis that follows elaborates on the burden of disease in the population. The disability-adjusted life-year (DALY) is a summary measure that combines the impact of illness, disability and mortality on population health.

Main conditions

The table below shows the top 10 conditions, in descending order, that account for approximately 90% of the burden of disease among males and females in Albania. Unintentional injuries among males and cardiovascular diseases and neuropsychiatric conditions among both males and females account for the highest burden of disease. Because mortality from neuropsychiatric conditions is minor, disability in daily living comprises the bulk of their burden on the population's health.

Ten leading disability groups as percentages of total DALYs for both sexes in Albania (2002)

Rank	Males		Females	
	Disability groups	Total DALYs (%)	Disability groups	Total DALYs (%)
1	Unintentional injuries	22.1	Neuropsychiatric conditions	24.1
2	Cardiovascular diseases	19.3	Cardiovascular diseases	19.6
3	Neuropsychiatric conditions	16.5	Malignant neoplasms	9.0
4	Malignant neoplasms	9.0	Unintentional injuries	7.0
5	Perinatal conditions	4.4	Musculoskeletal diseases	5.8
6	Respiratory infections	3.9	Sense organ diseases	4.3
7	Digestive diseases	3.7	Perinatal conditions	4.1
8	Musculoskeletal diseases	3.4	Respiratory infections	4.0
9	Sense organ diseases	3.1	Nutritional deficiencies	3.5
10	Intentional injuries	2.7	Digestive diseases	2.9

Source: Background data from WHO (2003).

Main risk factors

The table below shows the top 10 risk factors with their relative contributions, in descending order, to the burden of disease in the male and female populations of Albania. According to DALYs, tobacco, alcohol and high blood pressure comprise the greatest burden of disease on Albanian men, and high blood pressure and high BMI on women.

Ten leading risk factors as causes of disease burden measured in DALYs in Albania (2002)

Rank	Males		Females	
	Risk factors	Total DALYs (%)	Risk factors	Total DALYs (%)
1	Tobacco	12.6	High blood pressure	7.2
2	Alcohol	10.4	High BMI	6.0
3	High blood pressure	7.7	Tobacco	4.9
4	High cholesterol	4.7	High cholesterol	4.0
5	High BMI	4.5	Low fruit and vegetable intake	2.2
6	Low fruit and vegetable intake	2.7	Physical inactivity	2.2
7	Physical inactivity	2.2	Unsafe sex	1.9
8	Occupational risk factors for injuries	1.8	Indoor smoke from solid fuels	1.6
9	Lead	1.4	Alcohol	1.5
10	Indoor smoke from solid fuels	1.4	Childhood and maternal underweight	1.4

Source: Background data from WHO (2003).

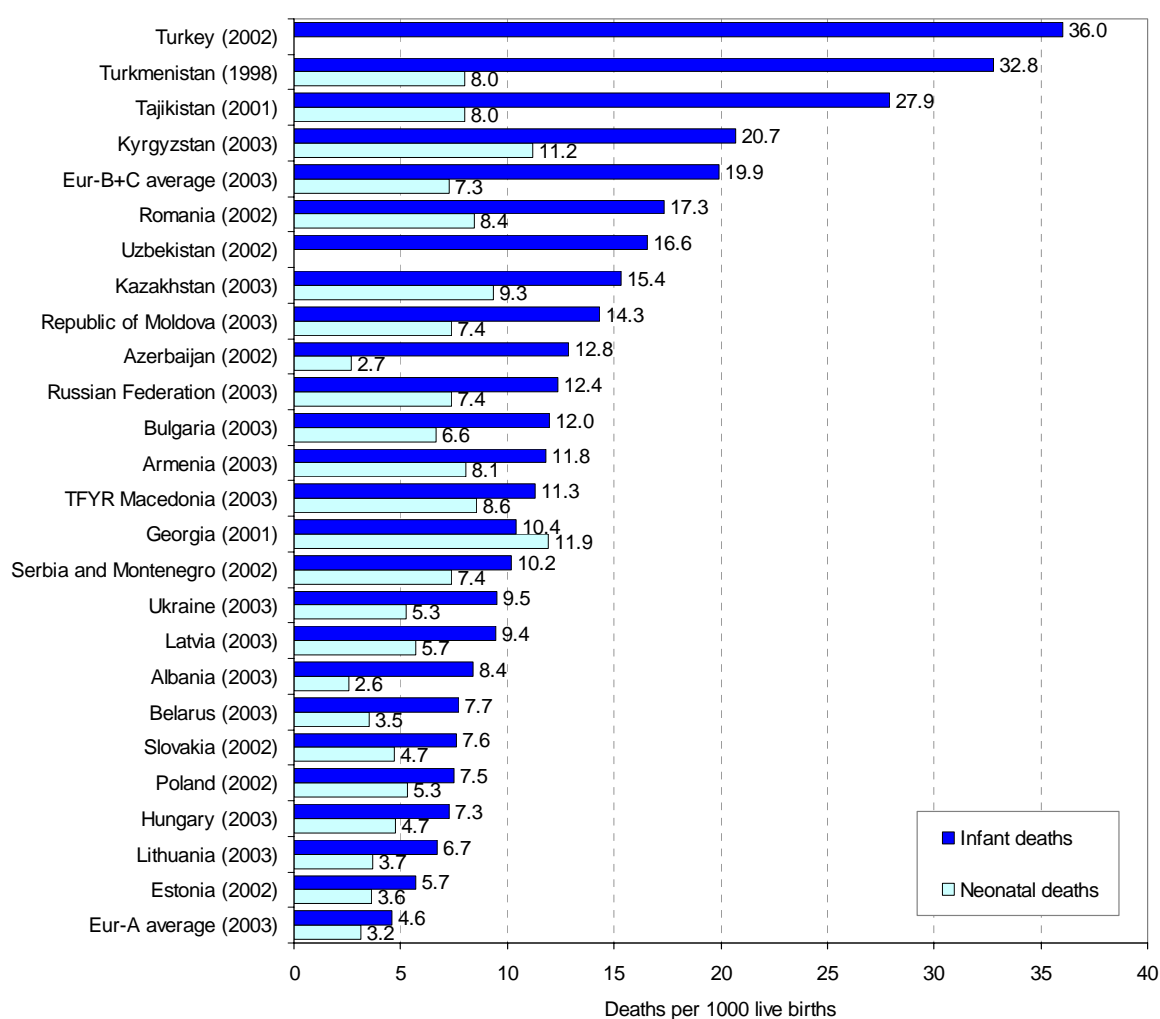
Mortality

Infant, neonatal and child mortality

Both infant and neonatal mortality rate in Albania are below the Eur-B+C average. The WHO/UNICEF estimate for infant mortality (23/1000 live births in 2000), however, is double the national rate for the same year (12/1000), which suggests a significant under-reporting of deaths during the first year of life (WHO, 2004). In 2003, the officially reported figure for infant mortality was 8.4 deaths per 1000 live births. For neonatal mortality in 2003, the national Institute of Statistics reported 2.6 deaths per 1000 live births (INSTAT, 2005), while the Ministry of Health reported 9.8 per 1000.

Based on nationally reported deaths and births in 2002, there is a probability that out of every 1000 live births in Albania, about 16 children will die before age 5 (the Millennium Development Goal [MDG] for the under-5 mortality rate for Europe and central Asia is 15 deaths per 1000 live births by 2015). Adjusting for the known biases in national data (under-reporting of vital statistics), WHO estimates Albania's latest probability to be 21 deaths under-5 per 1000 live births (2003). Whether Albania will reach the MDG goal by 2015 is uncertain as extrapolation of the current WHO estimates is not valid. The lowest WHO estimates for the Eur-B+C countries are for Estonia and Slovakia, each at 8 deaths per 1000 live births.

Infant deaths and neonatal deaths per 1000 live births,
Albania, Eur-A and Eur-B+C averages, latest available year



Maternal mortality

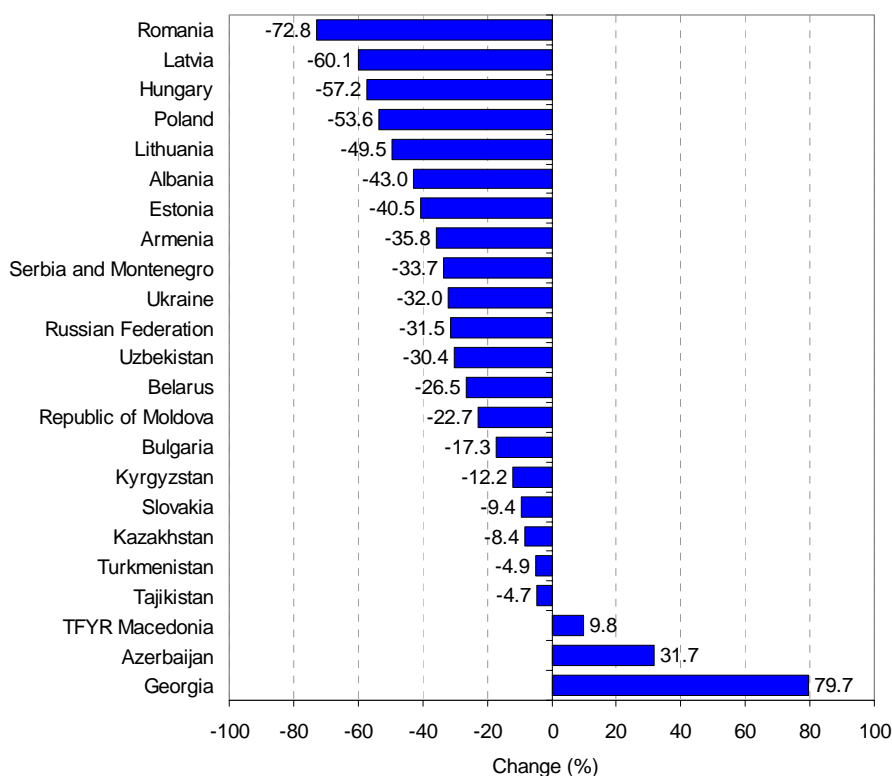
Maternal mortality rates (MMR) and the Millennium Development Goal (MDG)

Despite the difficulties in accurately measuring MMR, nationally reported figures are accepted at face value relative to the MDG to improve maternal health – to reduce the MMR by 75% between 1990 and 2015. In some countries, the 2015 target may be equal to or lower than the average current MMR for high income countries in the European Region (the Eur-A 2001 average of five maternal deaths per 100 000 live births). Countries with 2015 targets lower than the current Eur-A average can be judged as having achieved or being likely to achieve the MDG (World Bank, 2004).

However, in some countries, MMR were higher in 2002 than they had been in 1990. Applying the 75% reduction to the 1990 baseline in these countries creates, in some cases, a 2015 MDG target that requires dramatic reductions in MMR before 2015. In these cases, more important than reaching maternal mortality targets is taking concrete action to provide women with access to adequate care during pregnancy and childbirth, initiatives that have proven to bring down MMR.

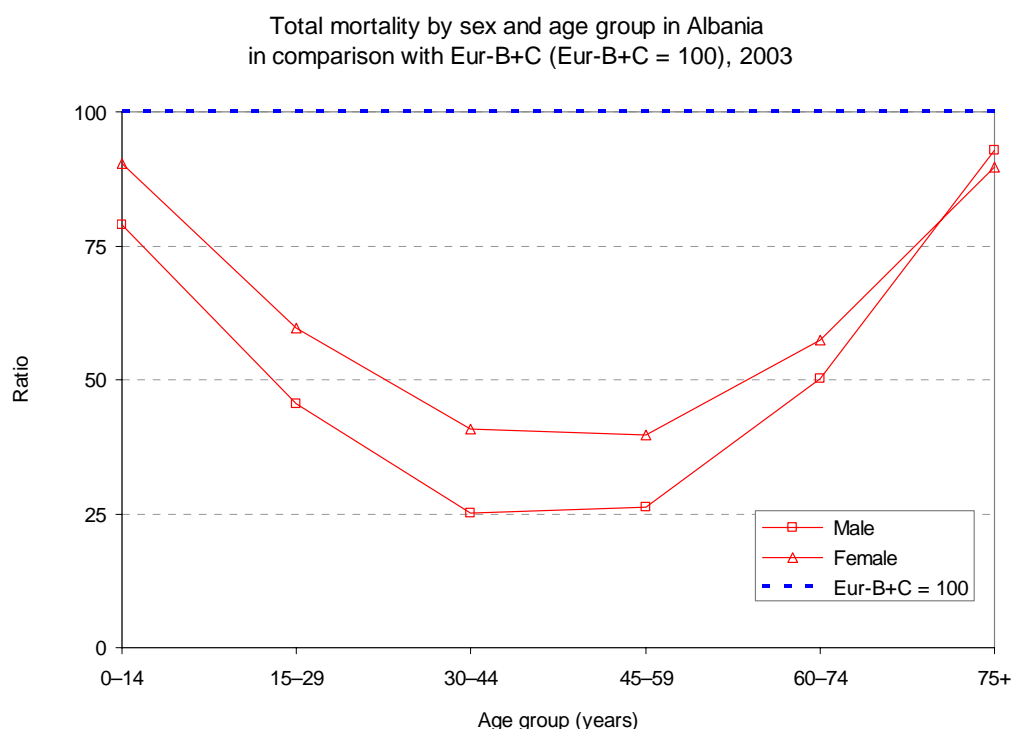
The official maternal mortality ratio – approximately 20 per 100 000 live births – is below the Eur-B+C average, but no information is available on possible under-reporting. From 1999 to 2003, 6 out of 51 maternal deaths were due to induced or spontaneous abortion (including ectopic pregnancies). The rate (12%) could be reduced by improving health care practices in abortion procedures and follow-up. However, according to the Ministry of Health, only deaths were abortion-related (excluding ectopic pregnancies) from 1999 to 2003 (MOH/IPH/INSTAT, 2002). Between 1990 and 2002, Albania's MMR fell by 43%. By 2015, the rate would have to fall to 9 deaths per 100 000 live births for Albania to achieve the MDG target, a 56% drop in the MMR over 13 years.

Per cent change for maternal mortality (3-year moving averages),
1990 to 2002 or latest available year



Excess mortality

In general, mortality rates for males and females in Albania are higher than the Eur-A average, but lower than the Eur-B+C average for all age groups for both genders.



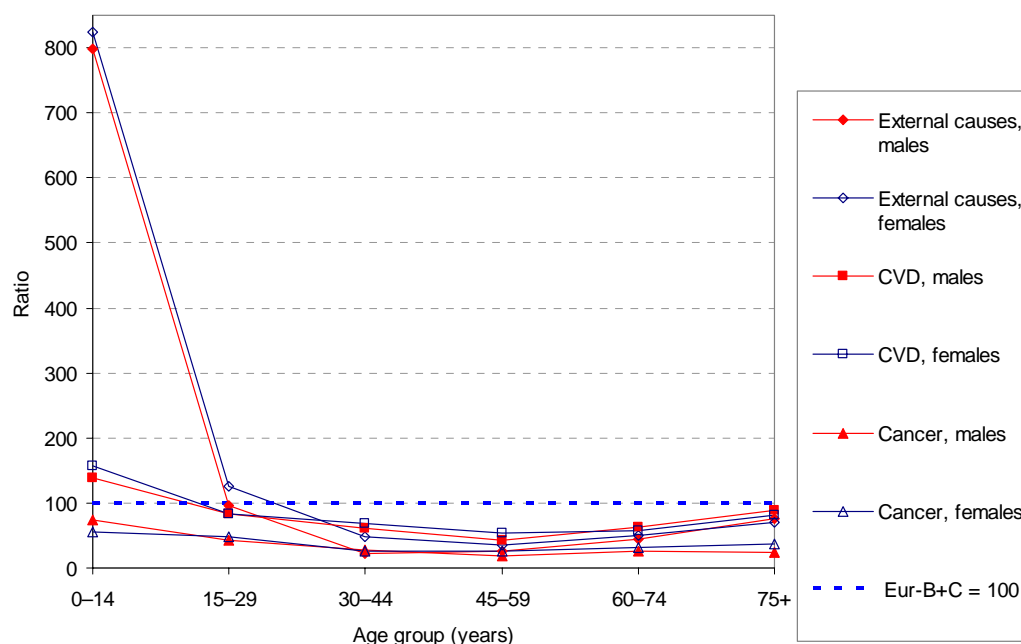
Main causes of death

In 2003, selected main noncommunicable diseases accounted for about 76% of all deaths in Albania, external causes for about 5% and communicable diseases for about 0.5%. In total 52% of all deaths were caused by diseases of the circulatory system and 14% by cancer. Ill-defined causes – main cause of death classified under symptoms, signs, abnormal findings, etc. – accounted for 13.5% of all deaths in Albania in 2003, thus hampering international comparisons of cause-of-death statistics, especially for cardiovascular diseases. (*Annex. Selected mortality. Annex. Mortality data*)

Albanian people are at lower risk of dying from CVDs than the Eur-B+C average, excluding males under 15 years old and females under 30. For children and adolescents, the excess risk for dying of CVDs is eight times the Eur-B+C average, and Albania – together with Turkmenistan – has the highest death rate in this age group. This may, however, be at least partly explained by differences in classification and registration of causes of death.

The risk for cancer death is lower for all men and women aged 15 years or more. According to these national figures, Albanians have also a low death risk for external causes and poisonings in all age groups and for both sexes compared to the Eur-B+C average.

Main causes of mortality by sex and age group in Albania
in comparison with Eur-B+C (Eur-B+C = 100), 2003



CVD

Cardiovascular diseases cause more than half of all deaths in Albania. The biggest single killers are cerebrovascular diseases (18.7% of all deaths in 2003), ischaemic heart disease (15.1%) and diseases of pulmonary circulation and other heart diseases (12.5%).

Mortality for CVD has increased both for the young and middle-aged (under 45 years old) and for the elderly (75 and over), while a declining trend can be observed in the remaining age groups. The development is similar for both sexes and for ischemic heart disease and cerebrovascular diseases.

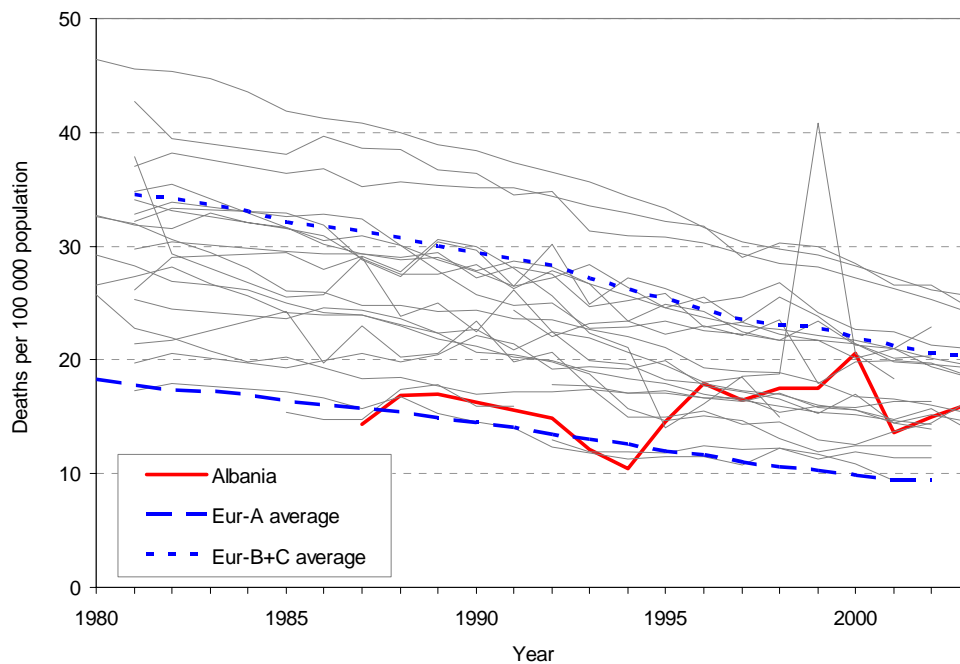
Cancer

Cancer causes only every seventh death in Albania. Mortality below 30 years old is declining and following the Eur-B+C average. Males 30–74 years old also have declining death rates, significantly below the Eur-B+C average. Elderly males have an increasing risk for dying from cancer, equal to the Eur-B+C average. Female cancer death rates are increasing, but they are still below the Eur-B+C average.

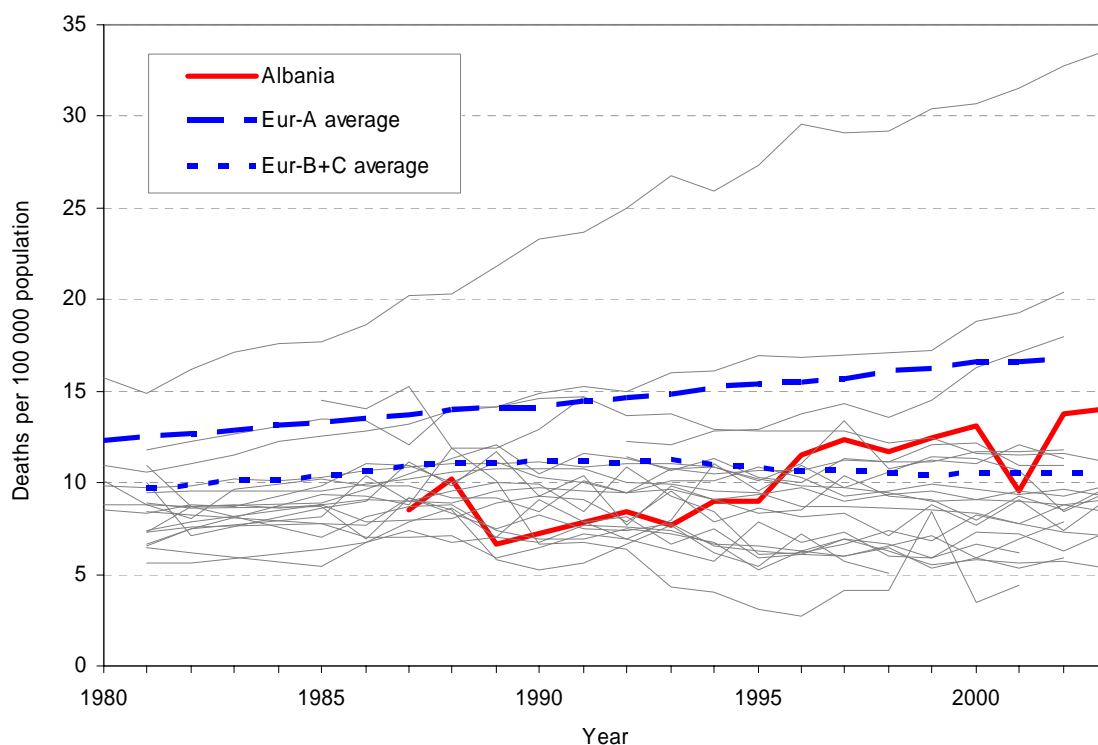
As for general cancer mortality, cause-specific death rates in Albania are low compared to the Eur-B+C levels, and are either decreasing (lip cancer, bladder cancer, cancer of oesophagus, skin cancer, uterine and ovarian cancer) or stagnating (colorectal cancer and cancer of lymphoid and haematopoietic tissue). The death rates from pancreatic, breast and cervical cancers are low, but show an increasing trend. Stomach cancer mortality is declining both in Eur-A and Eur-B+C countries on average, while the Albanian rate has stagnated since the late 1980s. Prostate cancer is increasing both in Albania and in the Eur-B+C region on average, but the Albanian rate is higher than the average in the reference group. Since 1998, the death rate from liver cancer has been from two to three times the Eur-A and Eur-B+C averages. This difference may, however, be explained by coding practice, since the deaths from chronic liver diseases and cirrhosis have practically disappeared from the mortality statistics.

Mortality developments for cancers of the larynx, trachea, bronchia and lungs is different for men and women. For men, the death rate remains stable, and below the declining Eur-A and Eur-B+C averages. For women, it is increasing at the same rate as the Eur-A average, and it has already passed the Eur-B+C average. These mortality patterns reflect the previous trends in smoking, which became more common in Albania between 1990 and 2000. According to the most current data, 60% of males and 18% of females 15 years old and over are regular daily smokers.

Standardized death rate for stomach cancer in people of all ages, Albania, Eur-A and Eur-B+C averages, 1980 to latest available year



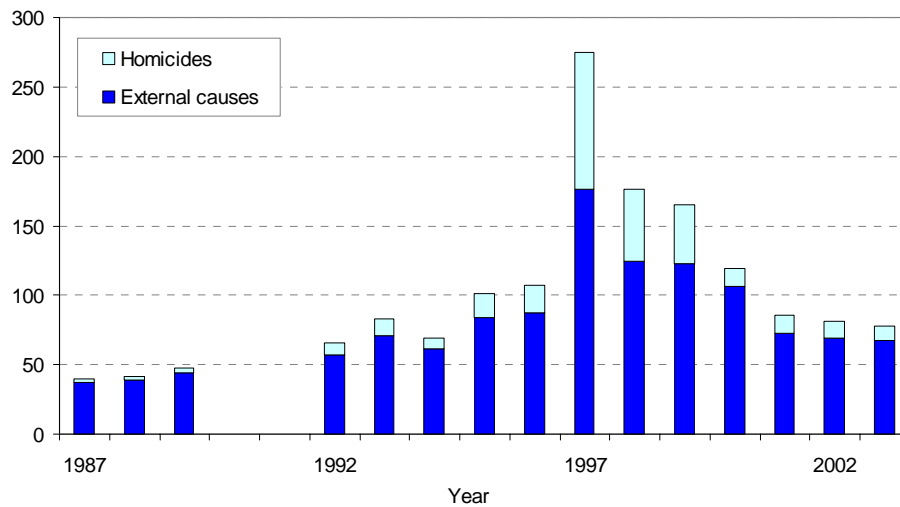
SDR for larynx, trachea, bronchus and lung cancer in females, all ages, Albania, Eur-A and Eur-B+C averages, 1980 to latest available year



External causes

Mortality from external causes has been significantly below the Eur-B+C average, and until the mid-1990s was even below the Eur-A average. After a significant peak in 1998 – caused by increase in homicide and assault deaths among men – the Albanian rate has halved, to somewhat above the Eur-A average.

SDR for homicides and assaults and for other external causes
in males of all ages, Albania



According to national statistics, the death rates from accidents, motor vehicle transport accidents, accidental drowning, exposure to smoke, fire and flames, and accidental poisoning have been comparable to the Eur-A averages, and those from motor vehicle transport accidents and accidental falls are even below them. The suicide rates are also low, but higher than in the early 1990s.

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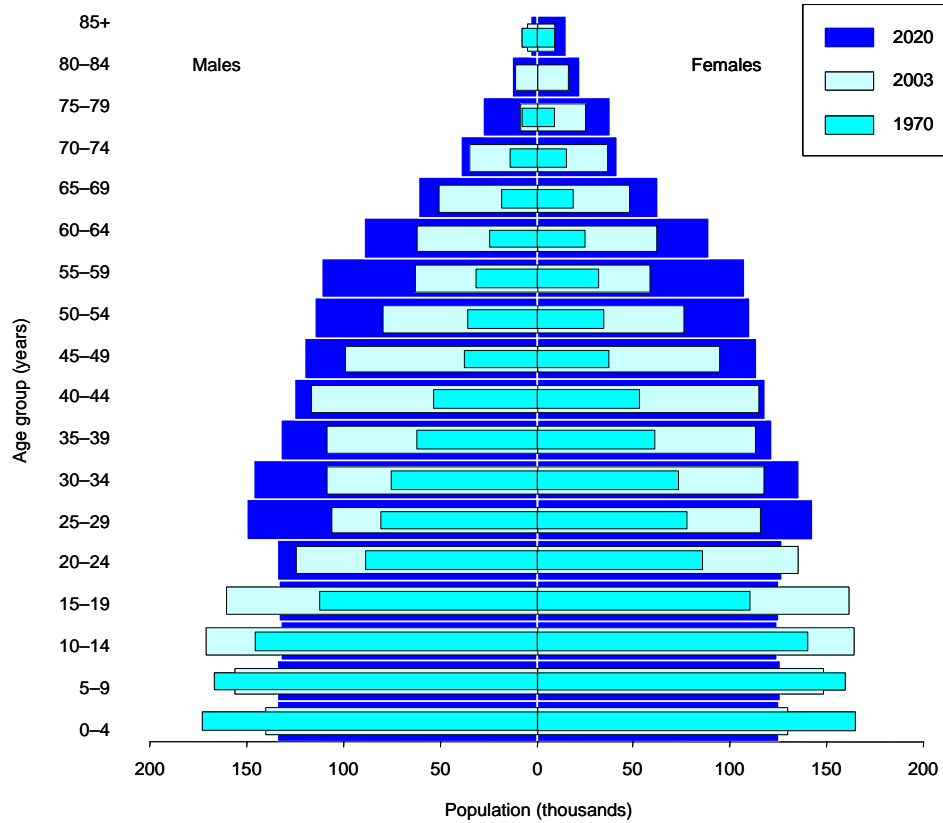
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Annexes

Annex. Age Pyramid

AGE PYRAMID FOR ALBANIA, 1970, 2001 AND 2020 (PROJECTED)



Sources: WHO Regional Office for Europe (2005) and United Nations (2005).

Annex. Selected mortality

SELECTED MORTALITY IN ALBANIA COMPARED WITH EUR-A OR EUR-B+C AVERAGE

Selected mortality in Albania compared with Eur-B+C averages

Condition	SDR per 100 000		Excess mortality in Albania (%)	Total deaths in Albania (%)	Total deaths in Eur-B+C (%)	Eur-A average	Excess Albania to Eur-A (%)	Total deaths in Eur-A (%)
	Albania (2003)	Eur-B+C average (2003)						
Selected non-communicable conditions	646.5	1044.9	-38.1	76.3	79.6	533.8	21.1	82.4
<i>Cardiovascular diseases</i>	439.8	741.8	-40.7	51.9	56.5	243.4	80.7	37.6
Ischaemic heart disease	127.8	362.7	-64.8	15.1	27.6	95.9	33.3	14.8
Cerebrovascular diseases	158.8	221.7	-28.4	18.7	16.9	61.1	159.9	9.4
Diseases of pulmonary circulation and other heart disease	106.2	68.9	54.1	12.5	5.3	56.6	87.6	8.7
<i>Malignant neoplasms</i>	121.1	172.0	-29.6	14.3	13.1	181.5	-33.3	28.0
Trachea/bronchus/lung	29.4	33.9	-13.3	3.5	2.6	37.1	-20.8	5.7
Female breast	11.3	22.1	-48.9	1.3	1.7	27.0	-58.1	4.2
Colon/rectal/anal	5.0	19.0	-73.7	0.6	1.4	20.7	-75.8	3.2
Prostate	16.7	14.3	16.8	2.0	1.1	25.1	-33.5	3.9
<i>Respiratory diseases</i>	47.2	63.1	-25.2	5.6	4.8	47.8	-1.3	7.4
Chronic lower respiratory diseases	18.1	31.2	-42.0	2.1	2.4	20.2	-10.4	3.1
Pneumonia	22.4	23.6	-5.1	2.6	1.8	16.2	38.3	2.5
<i>Digestive diseases</i>	14.1	52.3	-73.0	1.7	4.0	30.8	-54.2	4.8
Chronic liver disease and cirrhosis	0.0	32.0	-100.0	0.0	2.4	12.6	-100.0	1.9
<i>Neuropsychiatric disorders</i>	24.2	15.7	54.1	2.9	1.2	30.3	-20.1	4.7
Communicable conditions	4.4	20.8	-78.8	0.5	1.6	8.4	-47.6	1.3
AIDS/HIV	0.0	0.8	-100.0	0.0	0.1	1.1	-100.0	0.2
External causes	43.0	139.6	-69.2	5.1	10.6	40.3	6.7	6.2
<i>Selected unintentional causes</i>	33.0	102.2	-67.7	3.9	7.8	28.7	15.0	4.4
Motor vehicle traffic injuries	9.3	14.7	-36.7	1.1	1.1	9.9	-6.1	1.5
Falls	2.1	7.5	-72.0	0.2	0.6	6.1	-65.6	0.9
<i>Selected intentional causes</i>	9.9	37.4	-73.5	1.2	2.9	11.6	-14.7	1.8
Self-inflicted (suicide)	4.4	23.2	-81.0	0.5	1.8	10.6	-58.5	1.6
Violence (homicide)	5.5	14.2	-61.3	0.6	1.1	1.0	450.0	0.2
Ill-defined conditions	114.2	64.0	78.4	13.5	4.9	20.9	446.4	3.2
All causes	847.2	1312.2	-35.4	100.0	100.0	647.8	30.8	100.0

Annex. Mortality data

Mortality data

Table 1. Selected mortality for the group 0–14 years by sex in Albania and Eur-B+C:
SDR per 100 000 population and percentage changes from 1995 to latest available year

Causes of death	Sex	Albania (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
All causes	Both	127.1	-6.7	49.4	-2.4	151.7	-3.8
	M	134.6	-6.8	55.3	-2.5	170.5	-3.9
	F	119.0	-6.6	43.3	-2.4	131.9	-3.8
<i>Infectious and parasitic diseases</i>	M	3.6	-7.4	1.4	-1.1	10.9	-7.0
	F	3.4	-5.9	1.1	-3.0	9.5	-6.6
Intestinal infectious diseases	M	0.3	-11.2	0.2	-0.7	5.1	-8.2
	F	0.0	-12.5	0.1	-7.3	4.7	-7.9
<i>Malignant neoplasms</i>	M	7.1	8.5	3.3	-1.8	5.1	-1.9
	F	6.6	32.8	2.6	-1.8	4.2	-1.9
<i>Cardiovascular diseases</i>	M	26.3	0.3	1.4	-3.1	3.3	1.1
	F	21.4	2.4	1.3	-2.5	2.6	0.1
<i>Respiratory diseases</i>	M	26.0	-9.3	1.4	-4.3	35.9	-5.0
	F	25.2	-9.4	1.0	-4.2	30.7	-5.0
Pneumonia	M	16.5	-9.9	0.5	-6.0	20.9	-4.9
	F	19.6	-9.6	0.4	-5.1	17.9	-4.7
<i>Certain conditions originating in perinatal period</i>	M	179.5	-6.3	255.3	-2.1	607.6	-2.7
	F	189.5	-3.1	202.3	-1.6	427.5	-2.7
Congenital malformations and chromosomal abnormalities	M	6.4	-7.1	11.6	-2.9	24.2	-2.8
	F	7.5	-4.5	10.0	-3.3	21.0	-2.6
<i>Ill-defined causes</i>	M	10.7	-7.9	5.0	-3.9	5.6	-0.6
	F	13.1	-6.1	3.4	-4.2	4.6	-1.0
<i>External causes of injury and poisoning</i>	M	21.4	-3.8	7.0	-4.0	29.0	-3.4
	F	10.0	-7.0	4.6	-3.2	18.1	-3.1
Motor vehicle traffic injuries	M	3.5	2.0	2.5	-4.5	4.7	-2.6
	F	0.4	-9.2	1.7	-4.8	3.0	-1.6

Mortality data contd

Table 2. Selected mortality for the group 15–29 years by sex in Albania and Eur-B+C:
SDR per 100 000 population and percentage changes from 1995 to latest available year

Causes of death	Sex	Albania (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
All causes	Both	77.4	-2.9	56.0	-2.3	161.0	-0.9
	M	109.8	-4.1	82.0	-2.3	241.7	-1.0
	F	47.1	-0.8	29.3	-2.2	79.0	-0.6
<i>Infectious and parasitic diseases</i>	M	0.8	-1.5	1.2	1.5	12.3	3.0
	F	0.3	-4.7	0.8	1.9	5.1	2.5
Malignant neoplasms	M	7.3	-5.9	6.2	-1.0	8.8	-1.9
	F	6.4	-1.1	4.7	-1.4	7.7	-1.9
<i>Cardiovascular diseases</i>	M	17.0	0.5	4.1	-2.4	17.6	0.0
	F	9.2	5.9	2.3	-2.0	7.3	-0.9
<i>Respiratory diseases</i>	M	1.8	-5.6	1.4	-3.6	6.9	0.2
	F	0.9	-9.1	0.9	-2.7	3.8	-1.1
<i>Digestive diseases</i>	M	0.8	-8.3	0.9	-3.5	8.0	3.0
	F	0.5	-8.5	0.5	-3.8	3.7	3.1
Ill-defined causes	M	4.7	-7.1	4.0	-3.1	11.6	7.1
	F	5.1	8.2	1.4	-1.3	3.3	5.8
<i>External causes</i>	M	68.5	-4.1	58.3	-1.4	162.4	-1.6
	F	17.4	0.0	14.4	-1.6	36.9	-0.2
Motor vehicle traffic injuries	M	17.5	9.4	28.5	-1.3	27.8	-1.5
	F	2.0	7.8	7.3	-1.4	8.0	0.3
Accidental drowning	M	4.4	-8.1	1.3	-2.2	10.8	-3.9
	F	1.2	-7.3	0.2	-2.1	1.9	-2.2
Accidental poisoning	M	4.4	4.6	2.8	0.0	19.1	3.3
	F	1.8	-1.1	0.7	0.8	4.4	2.5
Suicide	M	5.8	0.4	12.7	-1.8	36.8	0.0
	F	4.6	0.6	3.1	-2.2	5.8	-1.3

Mortality data contd

Table 3. Selected mortality for the group 30–44 years by sex in Albania and Eur-B+C:
SDR per 100 000 population and percentage changes from 1995 to latest available year

Causes of death	Sex	Albania (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
All causes	Both	131.2	0.9	120.3	-2.5	453.8	-0.7
	M	175.8	1.3	161.6	-2.6	700.0	-0.8
	F	87.9	0.4	78.5	-2.1	215.6	-0.2
<i>Malignant neoplasms</i>	M	24.2	-1.9	27.6	-2.3	40.2	-2.8
	F	29.8	1.6	31.3	-2.0	43.8	-1.4
Trachea/bronchus/lung cancer	M	2.8	-3.6	5.0	-3.4	7.3	-4.2
Female breast cancer	F	2.7	0.0	2.8	-0.6	2.2	-1.0
<i>Cardiovascular diseases</i>	F	9.1	1.0	10.0	-2.6	10.0	-2.3
	M	35.2	4.2	26.1	-2.5	158.6	-0.4
Ischaemic heart disease	F	21.8	4.1	10.4	-2.1	45.3	0.0
	M	15.6	6.1	11.8	-3.1	73.7	-2.2
Cerebrovascular diseases	F	6.9	45.3	2.4	-2.7	14.4	-1.3
	M	10.1	5.3	4.4	-3.2	24.6	-0.4
<i>Respiratory diseases</i>	F	6.4	2.1	3.6	-2.5	10.6	-1.3
	M	2.8	-5.4	3.9	-3.5	34.3	0.9
<i>Digestive diseases</i>	F	1.2	-4.8	2.2	-2.0	9.8	0.8
	M	5.3	3.8	12.6	-2.4	50.2	1.4
<i>External causes</i>	F	0.6	-10.9	5.4	-1.7	19.4	4.1
	M	81.9	1.8	58.8	-1.2	299.5	-1.9
Motor vehicle traffic injuries	F	15.1	-0.3	15.1	-1.8	58.9	-1.0
	M	20.0	14.6	16.0	-0.5	31.4	-1.7
Suicide	F	2.7	0.7	3.9	-2.0	7.1	-0.5
	M	4.4	5.3	21.2	-1.5	54.9	-2.4
	F	3.6	7.7	5.8	-2.2	7.9	-2.5

Mortality data contd

Table 4. Selected mortality for the group 45–59 years by sex in Albania and Eur-B+C:
SDR per 100 000 population and percentage changes from 1995 to latest available year

Causes of death	Sex	Albania (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
All causes	Both	402.0	1.4	435.6	-1.3	1294.9	-0.6
	M	518.9	1.2	580.1	-1.4	1981.7	-0.6
	F	277.9	1.9	293.3	-1.0	698.9	-0.5
<i>Malignant neoplasms</i>	M	139.6	1.4	218.2	-1.2	323.2	-1.9
	F	101.0	5.5	155.0	-1.0	186.1	-0.5
Trachea/bronchus/lung cancer	M	34.3	1.0	65.9	-1.5	101.4	-2.9
Female breast cancer	F	13.1	9.1	21.8	3.4	15.4	1.0
<i>Cardiovascular diseases</i>	F	21.9	5.1	44.0	-2.2	45.3	0.1
	M	203.7	1.4	156.4	-2.6	793.1	-0.1
Ischaemic heart disease	F	92.9	-0.6	50.9	-2.5	271.7	-0.6
	M	102.6	3.3	86.2	-3.3	435.3	-0.7
Cerebrovascular diseases	F	33.7	5.3	17.8	-3.4	111.1	-0.6
	M	42.9	0.5	23.7	-2.6	168.6	-0.9
<i>Respiratory diseases</i>	F	24.5	-4.2	14.5	-2.1	88.4	-1.4
	M	16.1	-2.7	20.3	-1.7	108.7	-1.4
<i>Digestive diseases</i>	F	6.7	-6.1	10.2	-1.3	24.5	-0.7
	M	18.7	-1.0	49.6	-0.8	129.7	0.7
<i>External causes</i>	F	8.3	3.4	20.3	-0.7	57.3	1.9
	M	75.9	1.0	62.8	-1.0	409.2	-0.9
Motor vehicle traffic injuries	F	23.0	4.3	20.9	-0.9	89.1	-1.1
	M	16.8	7.1	13.0	-1.3	28.5	-1.8
Suicide	F	3.6	17.4	4.1	-2.1	7.5	-1.4
	M	9.5	7.1	23.1	-1.1	68.1	-2.4
	F	3.6	16.6	8.5	-1.2	10.2	-3.4

Mortality data contd

Table 5. Selected mortality for the group 60–74 years by sex in Albania and Eur-B+C:
SDR per 100 000 population and percentage changes from 1995 to latest available year

Causes of death	Sex	Albania (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
All causes	Both	1927.8	0.8	1570.9	-1.9	3411.7	-0.1
	M	2514.5	-0.4	2156.9	-2.1	4996.4	0.1
	F	1341.3	2.4	1069.2	-1.9	2339.0	-0.6
<i>Malignant neoplasms</i>	M	630.7	-0.1	851.3	-1.4	1002.5	-0.8
	F	254.7	5.7	439.8	-1.1	438.9	-0.7
Trachea/bronchus/lung cancer	M	210.7	-1.6	261.8	-1.9	321.7	-1.5
Female breast cancer	F	39.5	3.2	59.0	0.2	37.1	-1.4
<i>Cardiovascular diseases</i>	F	29.3	19.6	79.7	-1.6	68.7	1.3
	M	1292.2	-0.4	744.9	-3.6	2903.0	0.6
	F	756.6	1.8	335.7	-3.9	1507.8	-0.3
Ischaemic heart disease	M	497.5	3.5	381.3	-4.2	1582.2	1.2
Cerebrovascular diseases	F	234.2	8.5	133.5	-4.6	731.4	0.5
<i>Respiratory diseases</i>	M	397.3	-0.8	143.3	-3.7	833.7	0.2
	F	300.8	1.3	86.7	-4.1	528.9	-0.8
<i>Digestive diseases</i>	M	114.7	-5.3	144.0	-3.5	303.0	-2.4
	F	54.6	-2.9	62.5	-2.4	68.6	-3.6
<i>External causes</i>	M	52.6	-5.8	111.6	-1.6	193.0	0.1
	F	30.8	-1.8	54.1	-1.7	94.2	0.2
Motor vehicle traffic injuries	M	84.5	1.8	79.3	-1.4	320.0	1.0
	F	27.2	3.5	32.1	-2.1	88.7	-0.5
	M	20.8	11.7	14.8	-3.0	24.3	-1.5
Suicide	F	6.5	37.5	5.9	-3.4	9.5	-1.0
	M	7.1	14.8	24.5	-1.6	60.5	-0.8
	F	5.0	62.0	8.7	-2.6	12.7	-3.1

Mortality data contd

Table 6. Selected mortality for the group 75+ years by sex in Albania and Eur-B+C:
SDR per 100 000 population and percentage changes from 1995 to latest available year

Causes of death	Sex	Albania (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
All causes	Both	11592.5	0.7	8059.6	-1.0	12338.8	0.0
	M	13780.8	-0.3	9832.0	-1.1	14838.0	0.1
	F	10246.2	1.5	7112.5	-0.9	11421.7	0.0
<i>Malignant neoplasms</i>	M	1330.9	0.5	2231.1	-0.4	1489.3	1.2
	F	589.0	3.0	1136.2	-0.4	721.7	0.8
Trachea/bronchus/lung cancer	M	398.1	1.8	457.1	-0.7	323.5	1.0
Female breast cancer	F	102.4	9.5	102.7	1.5	55.6	0.5
<i>Cardiovascular diseases</i>	F	36.4	6.9	159.6	-0.4	92.0	3.1
	M	7808.6	0.4	4356.2	-2.1	10221.2	0.4
	F	6213.2	2.0	3577.9	-1.9	8805.6	0.4
Ischaemic heart disease	M	2045.9	6.1	1708.0	-2.2	4925.6	1.4
Cerebrovascular diseases	F	1385.4	9.8	1150.0	-2.2	4028.6	1.2
<i>Respiratory diseases</i>	M	2864.8	1.6	1119.8	-2.5	3004.4	0.7
	F	2547.4	3.8	1026.9	-2.4	2967.6	0.5
<i>Digestive diseases</i>	M	906.2	-5.3	1156.5	-2.4	824.1	-2.1
	F	583.8	-4.0	591.9	-2.1	302.3	-3.2
<i>External causes</i>	M	138.7	-7.5	340.3	-1.1	270.4	0.3
	F	120.3	-3.2	279.8	-0.4	175.0	1.1
Motor vehicle traffic injuries	M	149.9	-8.2	275.0	-0.6	604.2	0.1
	F	65.0	-1.3	187.8	-1.2	172.4	-1.2
Suicide	M	38.4	-7.9	28.1	-2.2	34.6	-3.1
	F	10.1	4.6	10.0	-3.1	14.7	-1.7
	M	2.8	-11.3	49.5	-1.6	86.6	-1.1
	F	11.8	22.0	11.8	-3.2	22.4	-1.9

Technical notes

Calculation of averages

Averages for the reference group, when based on data in the European health for all database of the WHO Regional Office for Europe, are weighted by population. Some countries with insufficient data may be excluded from the calculation of averages. Otherwise, for data from other sources, simple averages have been calculated where required.

To smooth out fluctuations in annual rates caused by small numbers, three-year averages have been used, as appropriate. For example, maternal mortality, usually a small number, has three-year moving averages calculated for all countries. When extreme fluctuations are known to be due to population anomalies, data have been deleted, as appropriate.

Data sources

To make the comparisons as valid as possible, data for each indicator have, as a rule, been taken from one source to ensure that they have been harmonized in a reasonably consistent way. Unless otherwise noted, the source of data for figures and tables in this report is the January 2005 version of the European health for all database of the WHO Regional Office for Europe. The health for all database acknowledges the various primary sources of the data.

In cases where current census data for national population are unavailable, coupled with ongoing migrations of people in and out of countries, UN estimates or provisional figures supplied by the country are used to approximate national population. Such population figures create uncertainty in standardized death rates.

Disease coding

Case ascertainment, recording and classification practices (using the ninth and tenth revisions of the International Statistical Classification of Diseases and Related Health Problems: ICD-9 and ICD-10, respectively), along with culture and language, can influence data and therefore comparability across countries.

Healthy life expectancy (HALE) and disability-adjusted-life-years (DALYs)

HALE and DALYs are summary measures of population health that combine information on mortality and non-fatal health outcomes to represent population health in a single number. They complement mortality indicators by estimating the relative contributions of different causes to overall loss of health in populations.

DALYs are based on cause-of-death information for each WHO region and on regional assessments of the epidemiology of major disabling conditions. The regional estimates have been disaggregated to Member State level for the highlights reports.

National estimates of HALE are based on the life tables for each Member State, population representative sample surveys assessing physical and cognitive disability and general health status, and on detailed information on the epidemiology of major disabling conditions in each country.

More explanation is provided in the statistical annex and explanatory notes of *The world health report 2003*¹.

Limitations of national-level data

National-level averages, particularly when they indicate relatively good positions or trends in health status, as is the case in most developed countries, hide pockets of problems. Unless the health status of a small population is so dramatically different from the norm that it influences a national indicator, health risks and poorer health outcomes for small groups will only become evident through subnational data.

¹ WHO (2003). *The world health report 2003 – Shaping the future*. Geneva, World Health Organization (<http://www.who.int/whr/2003/en>, accessed 10 June 2005).

Reference groups for comparison

When possible, international comparisons are used as one means of assessing a country's comparative strengths and weaknesses and to provide a summary assessment of what has been achieved so far and what could be improved in the future. Differences between countries and average values allow the formulation of hypotheses of causation or imply links or remedies that encourage further investigation.

The country groups¹ used for comparison are called reference groups and comprise:

- countries with similar health and socioeconomic trends or development; and/or
- geopolitical groups.

The 27 countries with very low child mortality and very low adult mortality are designated Eur-A by WHO. Eur-A comprises Andorra, Austria, Belgium, Croatia, Cyprus, the Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, the Netherlands, Norway, Portugal, San Marino, Slovenia, Spain, Sweden, Switzerland and the United Kingdom. However, data for most indicators are unavailable for two of the 27 countries: Andorra and Monaco. Therefore, unless otherwise indicated, Eur-A and averages for Eur-A refer to the 25 countries for which data are available.

The 25 countries with low child mortality and low or high adult mortality are designated Eur-B+C by WHO. Eur-B+C comprises Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Poland, Republic of Moldova, Romania, Russian Federation, Serbia and Montenegro, Slovakia, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, and Uzbekistan. Unless otherwise indicated, Eur-B+C and averages for Eur-B+C refer to these countries.

Comparisons should preferably refer to the same point in time, but the countries' latest available data are not all for the same year. This should be kept in mind as a country's position may change when more up-to-date data become available.

Graphs have usually been used to show time trends from 1980 onwards. These graphs present the trends for all the reference countries as appropriate. Only the country in focus and the group average are highlighted and identified in the legend. This enables the country's trends to be followed in relation to those of all the reference countries, and performance in relation to observable clusters and/or the main trend or average to be recognized more easily.

¹ WHO (2004). *The world health report 2004 – Changing history*. Geneva, World Health Organization (<http://www.who.int/whr/2004/en>, accessed 26 August 2004).

Glossary

Causes of death

	ICD-10 code
Cerebrovascular diseases	I60–I69
Chronic liver disease and cirrhosis	K70, K73, K74, K76
Chronic obstructive pulmonary disease	J40–J47
Colon/rectal/anal cancer	C18–C21
Diseases of pulmonary circulation and other heart disease	I26–I51
Falls	W00–W19
Female breast cancer	C50
Ischaemic heart disease	I20–I25
Pneumonia	J12–J18
Prostate cancer	C61
Neuropsychiatric disorders	F00–99, G00–99, H00–95
Road traffic injuries	V02–V04, V09, V12–V14, V19–V79, V82–V87, V89
Self-inflicted (suicide)	X60–X84
Trachea/bronchus/lung cancer	C33–C34
Violence	X85–Y09

Technical terminology

Disability-adjusted life-year (DALY)	The DALY combines in one measure the time lived with disability and the time lost owing to premature mortality. One DALY can be thought of as one lost year of healthy life.
GINI index	The GINI index measures inequality over the entire distribution of income or consumption. A value of 0 represents perfect equality; a value of 100, perfect inequality. Low levels in the WHO European Region range from 23 to 25; high levels range from 35 to 36 ¹ .
Healthy life expectancy (HALE)	HALE summarizes total life expectancy into equivalent years of full health by taking account of years lived in less than full health due to diseases and injuries.
Income poverty line (50% of median income)	The percentage of the population living below a specified poverty line: in this case, with less than 50% of median income.
Life expectancy at birth	The average number of years a newborn infant would live if prevailing patterns of mortality at the time of birth were to continue throughout the child's life.
Natural population growth	The birth rate less the death rate.
Neuropsychiatric conditions	Mental, neurological and substance-use disorders.
Population growth	(The birth rate less the death rate) + (immigration less emigration).
Standardized death rate (SDR)	The age-standardized death rate calculated using the direct method: that is, it represents what the crude rate would have been if the population had the same age distribution as the standard European population.

¹ WHO Regional Office for Europe (2002). *The European health report 2002*. Copenhagen, WHO Regional Office for Europe:156 (<http://www.euro.who.int/europeanhealthreport>, accessed 28 May 2004).