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Research on Identifying and Analyzing Needs and Barriers of Implementation of Palliative Care in Albania

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Glossary

Acute pain - Pain that has a known cause and occurs for a limited time. It usually responds to analgesic medications and treatment of the cause of the pain.

Addiction - A commonly used term describing a pattern of drug use that indicates physical or mental dependence. It is not a diagnostic term and is no longer used by the World Health Organization (WHO).

Advance medical directives - Used to give other people, including health care providers, information about a patient's own wishes for medical care. Advance directives are important in the event patients are not physically or mentally able to speak for themselves and make their wishes known. The most common types of advance directives are the living will and the durable power of attorney for health care. A Do Not Resuscitate (DNR) is also a form of an Advance Medical Directive.

Analgesic medications - Medications used to prevent or treat pain. Palliative care is the active holistic care of individuals across all ages with serious health-related suffering due to severe illness, and especially of those near the end of life. It aims to improve the quality of life of patients, their families and their caregivers¹.

Caregiver - Any person who provides care for the physical, emotional, or spiritual needs of a family member or friend.

Chronic pain - Pain that occurs for more than one month after an injury has healed, that occurs repeatedly over months, or is due to a lesion that is not expected to heal.

Community based care - Medical and social service care often provided by volunteer trained members of the community.

Dignity - The quality of being worthy, honored, or esteemed. Human rights are based on inherent human dignity and aim to protect and promote it.

End-of-life care - Doctors and caregivers provide care to patients approaching the end of life that is focused on comfort, support for the family, and treatment of psychological and spiritual concerns.

Essential medicines - medicines that satisfy the priority health care needs of the population. Essential medicines are intended to be available at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price the individual and the community can afford.

Ethics - a system of moral principles and rules that are used as standards for professional conduct. Many hospitals and other health care facilities have ethics committees that can help doctors, other healthcare providers, patients, and family members in making difficult decisions regarding medical care. This may vary with religious and cultural backgrounds.

Grief - the normal process of reacting to a loss. The loss may be physical (such as a death), social (such as divorce), or occupational (such as a job). Emotional reactions of grief can include anger, guilt, anxiety, sadness, and despair. Physical reactions of grief can include sleeping problems, changes in appetite, physical problems, or illness.

¹ <https://hospicecare.com/what-we-do/projects/consensus-based-definition-of-palliative-care/definition/>

Home based care - Medical and social care provided by trained health care professionals or volunteers in a person's home.

Hospice - A care program that provides a centralized program of palliative and supportive services to dying persons and their families, in the form of physical, psychological, social, and spiritual care; such services are provided by an interdisciplinary team of professionals and volunteers who are available at home and in specialized inpatient settings.

Hospice care - Care designed to give support to people in the final phase of a terminal illness, and focused on comfort and quality of life, rather than a cure. The goal is to enable patients to be comfortable and free of pain so that they live each day as fully as possible. Aggressive methods of pain control may be used. Hospice programs generally are home-based, but they sometimes provide services away from home -- in freestanding facilities, in nursing homes, or within hospitals. The philosophy of hospice is to treat the whole person by providing support for the patient's emotional, social, and spiritual needs, as well as addressing medical symptoms.

Life-limiting illness - An illness with a prognosis of a year or less to live.

Life-threatening illness - An illness serious enough that a patient may die.

Multidisciplinary team - A group of individuals representing different medical disciplines who work together to care for a patient and family.

Nursing home - A residential facility for persons with chronic illness or disability, particularly older people who have mobility and eating problems. This is also called a convalescent home or long-term care facility.

Opioid - A type of medication related to opium. Opioids are analgesics used in acute and chronic pain. Opioids include morphine, codeine, and a large number of synthetic (man-made) drugs like methadone and fentanyl.

Pain - An unpleasant feeling that may or may not be related to an injury, illness, or other bodily trauma. Pain is complex and differs from person to person, as related to the individual's pain threshold.

Palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual².

Palliative care standards - Standards reflecting the level of care a patient and family can expect to receive when dealing with a diagnosis of a life-limiting illness.

Holistic care, Is a form of healing that considers the whole person -- body, mind, spirit, and emotions -- in the quest for optimal wellness. The principles of palliative care are framed

² <https://www.who.int/news-room/fact-sheets/detail/palliative-care>

around holistic care and the interdependent physical, social, emotional, cultural and spiritual aspects.³

Psychosocial care - Care given to meet a constellation of social, mental health, and emotional needs.

Quality of life. An individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment.⁴

Spiritual care - Providing the necessary resources to address and support people's values and beliefs, provided these values and beliefs place no individuals at risk. It is based on treating each person with respect and dignity, promoting love, hope, faith, and helping vulnerable people to find the strength to cope at times of life crises when overcome by despair, grief, and confusion.

Suffering - Absence of any power to control or to meaningfully influence a perceived process of one's own disintegration.

Symptom management -Care given to improve the quality of life of patients who have a serious or life-threatening disease. The goal of symptom management is to prevent or treat as early as possible the symptoms of the disease, side effects caused by treatment of the disease, and psychological, social, and spiritual problems related to the disease or its treatment. Also called palliative care, comfort care, and supportive care.

Severe illness - is understood as any acute or chronic illness and/or condition that causes significant impairment, and may lead to long-term impairment, disability and/or death⁵.

Terminal - A progressive disease that is expected to cause death.

Terminal illness - refers to an illness or disease process that is not responsive to curative medical treatment and which will worsen and eventually cause death.⁶

Terminally ill - a person who suffers from a terminal illness is said to be terminally ill, and although it is difficult to predict exactly how long a terminally ill person will live it is often assumed that a terminal illness will result in death in 6 months or less. This timeframe is most applicable to illnesses with somewhat predicable trajectories, such as cancer. In

³ Ref: IAHPC Pallipedia. Internet. Accessed on November 7, 2018. Available at <http://pallipedia.org/holistic/>

⁴ From World Health Organization <https://www.who.int/healthinfo/survey/whoqol-qualityoflife/en/>

⁵ Ref: IAHPC Pallipedia. Internet. Accessed on November 7, 2018. Available at <http://pallipedia.org/serious-illness/>

⁶ https://link.springer.com/referenceworkentry/10.1007%2F978-0-387-79061-9_2889

contrast, some other common conditions such as Alzheimer's disease, organ system failure, lung disease, and AIDS, for example, may exhibit much less predictable disease trajectories and may not result in death for many months or even years. Consequently, the predictability of when an illness has reached the terminal stage can vary significantly⁷

Withholding care - Not offering a specific treatment to a patient.

⁷ Lorenz, K. A., Lynn, J., Dy, S. M., Shugarman, L. R., Wilkinson, A., Mularski, R. A., et al. (2008). Evidence for improving palliative care at the end of life: A systematic review. *Annals of Internal Medicine*, 148(2), 147–159.

Abbreviations

ALOS	Average length of stay
CAT	Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment
CAT - OP	Optional Protocol of the Convention against Torture CAT - OP
CCPR	International Covenant on Civil and Political Rights
CCPR - OP2 - DP	Second Optional Protocol to the International Covenant on Civil and Political Rights aiming to the abolition of the death penalty
CED	Convention for the Protection of All Persons from Enforced Disappearance
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CERD	International Convention on the Elimination of All Forms of Racial Discrimination
CESCR	International Covenant on Economic, Social and Cultural Rights
CMV	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families
CRC	Convention on the Rights of the Child
CRC - OP - AC	Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict
CRC - OP - SC	Optional Protocol to the Convention on the Rights of the Child on the sale of children child prostitution and child pornography
CRPD -	Convention on the Rights of Persons with Disabilities
ECHR	European Convention of Human Rights
ICCPR	International Covenant on Civil and Political Rights
LLOS	Lifelong length of stay
MHCIF	Mandatory Health Care Insurance Fund
MoH	Ministry of Health
MD	Medical Doctor
NGO	Non-governmental organization
OHS	Oncological Home Service (Tirana)
PC	Palliative care
UDHR	Universal Declaration of Human Rights
WHO	World Health Organisation

1. Executive Summary

Palliative care in Albania is relatively new. The first palliative care service for terminal cancer patients was established in 1993 by Ryder Albania Association. The Albanian Association of Palliative Care was established in 2002 as a consortium to develop palliative care in the country.

Currently there are a limited number of associations and only one public service of palliative care that provide services to terminal cancer patients across the country. But these services cannot meet the high demand for palliative care. They can only cover 34% of needs which means that 66% of patients do not benefit from specialised palliative care services.

The diversification of the services is very limited and out-patient oriented, they don't reflect the holistic approach to address different needs of patients.

Meanwhile, there is no pain control unit in the public hospitals, or inpatient units for terminal cancer patients. Palliative care in the country is not yet a distinct specialty or sub-specialty in the medical field.

In general, palliative care services are sporadic and do receive financial support from the authorities and public health system. Also, it should be mentioned that palliative care is not integrated into the public health care system.

The study aims to explore the barriers and challenges for the provision of palliative care in the health care system in Albania. The objectives of the study are: *i*) to assess the policies and legal framework related to palliative care; *ii*) to analyse the implementation of palliative care law from the perspective of the palliative care stakeholders; *iii*) to identify the level of availability, accessibility and affordability of medications for palliative patients; *iv*) to identify the needs of health professionals for trainings in palliative care components. The methodology used for this study is qualitative method. Data was gathered through desk review and interviews with key informants in the field.

Some important conclusions drawn from the study are: *i*) Albania has made distinctive efforts to produce legislation, regulations and strategies for palliative care. But actually, there is no strategy in force due to the end of time period of the previous strategy (Strategy of Palliative Care in Albania 2010-2020). As result, there is no Plan of Action. There is an identified need to revise the standards and protocols of palliative care; *ii*) There is a situation of withhold care in terms of geographically differences of law implementation, drug availability, accessibility and affordability; *iii*) The system doesn't respond to the needs of patients in palliative care due to the organization of the system, lack of services, lack of resources; *iv*) The number of patients in need of palliative care in Albania is increasing and the projected number of patients/year will put the system in crises or will seriously endanger the access of patients for services; *v*) The patients with other diagnosis than cancer do not receive palliative care and are excluded de facto of the system.

Recommendations are addressed to institutions in regard to policy, drug availability, service provision and law implementation and education for health professionals in palliative care.

2. Introduction

Albania is a small country of almost 2.8 million inhabitants in the Balkan Peninsula. After 50 years under communist dictatorship, Albania became a democracy in 1991. The passage to a completely new system of government alongside other factors has made the last 30 years a long and difficult transition for the country's population.

Challenges persist especially in two fields of fundamental services for Albanian citizens' health care and education. The diagnostic and curative health services are organized on three levels: primary health care, secondary hospital service, and tertiary hospital service. Public health services and promotion are provided within the framework of the primary health care, supported and supervised from the Institute of Public Health. The health care system in Albania in the last 10 years has changed from mostly public to a growing private health care system of providers.

Palliative care and control for soothing cancer pain are amongst the still unresolved issues in Albania, a situation similar to that of public health systems in other Eastern European countries. Patients' access to palliative care services and quality of life in advanced and terminal stages of incurable diseases is less than convenient. Despite international experience in modern and cost-effective methods of treatment, health authorities pay little attention to this category of patients. WHO recommends that governments and health authorities promote new methods of pain control and palliative care principles in public health systems, to ensure a better quality of life for the terminal cancer patients.

Palliative care in Albania is relatively new. The first palliative care service for terminal cancer patients was established in 1993 by Ryder Albania Association. The Albanian Association of Palliative Care was established in 2002 as a consortium to develop palliative care in the country. Currently there are a limited number of associations and only one public service of palliative care that provide services to terminal cancer patients across the country. But these services cannot meet the high demand for palliative care. They can only cover 34% of needs which means that 66% of patients do not benefit from specialised palliative care services. Meanwhile, there is no pain control unit in the public hospitals, or inpatient units for terminal cancer patients. It should be emphasized that palliative care in the country is not yet a distinct specialty or sub-specialty in the medical field.

In general, palliative care services are sporadic and do receive financial support from the authorities and public health system. Also, it should be mentioned that palliative care is not integrated into the public health care system. The objective of our country is to establish palliative care for all those in need, starting with cancer patients. In general, basic measures of WHO regarding education and training policies, drugs' availability and palliative care institutionalization should be undertaken in Albania.

In Albania there are about 17.800 deaths annually. It is estimated that about 60% of deaths in Albania (over 10.000 deaths) would need palliative care and pain soothing services by provision of an opioid analgesic such as morphine. With at least two family members taking care of their terminally ill relative, there would be at least 30.000 individuals annually who would have their quality of life much improved if palliative care support is offered. Most

people, about 95%, die at home and this is preferable by both patients and their family members.

It can be concluded that, the way of death is still not institutionalized in Albania and should be avoided by strengthening of in-house services, better care in the future, as well as strengthening cultural and medical services. WHO recommends including pain soothing and palliative care services in existing institutions of health care, in palliative health care services. Self-standing institutions of care such as hospitals could be examples of what it can be done, but would not be sufficient to meet all the needs.

Based on the age structure in Albania it is estimated that there are over 4.000 new cancer cases each year. With the ageing of the young generation and population ageing tendency, it is expected that cancer incidence will increase significantly in the future. A high number, over 2/3 of patients, are diagnosed in an advanced and incurable stage of the disease.

Therefore, for the majority of those suffering from cancer, pain soothing and palliative care is the more realist and appropriate therapy to be provided. Based on existing asylum data it is calculated that there should be around 500 people, mainly cancer patients, who receive some form of palliative care. Those most in need of palliative care services are amongst elderlies on the verge of death. On the other hand, the prevalence rate of HIV/AIDS and its related deaths is not yet well known.

2.1 Purpose and objectives

The study aims to explore the barriers and challenges for the provision of palliative care in the health care system in Albania.

The objectives of the study are:

- To assess the policies and legal framework related to palliative care
- To analyse the implementation of palliative care law from the perspective of the palliative care stakeholders
- To identify the level of availability, accessibility and affordability of medications for palliative patients.
- To identify the needs of health professionals for trainings in palliative care components.

2.2 Methodology

The methodology used for this study is qualitative method: to collect qualitative data to ensure reliable, accurate and valid information. The following data collection methods were used:

a) Desk review: review of policies, legislation, standards and protocols, research, relevant reports/analysis on the situation of palliative care in Albania;

b) Face to face and online semi-structured key informants interviews with the representatives of the following categories of stakeholders (Annex 1);

- Policy makers representatives at central level;

- Representatives of service providers related to palliative care;
- Family doctors;
- Oncologic specialists;
- Pharmacists;
- Social workers working in the field;
- Social administrators at the local government.

The study was carried out during the period May-July, 2021. The period May-June was used for data collection in Tirana, Durrës, Fier, Elbasan and Korçë according to Plan of Interviews (Annex 1), data analysis and report writing was carried out during the period June-July 2021. Interviews with all stakeholders were organized in close cooperation with Ryder Albania staff.

3. Country context

3.1 Determining needs for palliative care.

Palliative care is required for a wide range of diseases as cardiovascular diseases, cancer, chronic respiratory diseases, AIDS and diabetes. Many other conditions may require palliative care, including kidney failure, chronic liver disease, multiple sclerosis, Parkinson's disease, rheumatoid arthritis, neurological disease, dementia, congenital anomalies and drug-resistant tuberculosis⁸.

To improve access to palliative care, it is important to investigate and understand the level of need in the population⁹. Current population needs for palliative care have been estimated in several countries using different methods for its measurement¹⁰, based on patient diagnoses¹¹, symptom prevalence, population surveys and percentage of the death rates^{12, 13}. Most of these methods produce broadly similar results in terms of how many people are estimated to need palliative care although additional data sources can increase sensitivity.

For the estimation of patients in need of palliative care in Albania we are using the population based approach recommended by Gomez and Stjernsward calculating 60% of the total mortality as the need for palliative care. Due to the fact that death rate in 2020 is significantly affected from Covid 19, for a realistic calculation we are referring the statistics of 2019. Although, it is important to stress palliative care must be integrated with effective infection control that prioritizes those at greatest risk¹⁴.

⁸ <https://www.who.int/news-room/fact-sheets/detail/palliative-care>

⁹ Etkind et al.. How many people will need palliative care in 2040? Past trends, future projections and implications for services. *BMC Medicine* (2017) 15:102 DOI 10.1186/s12916-017-0860-2

¹⁰ Morin L, Aubry R, Frova L, MacLeod R, Wilson DM, Loucka M, Csikos A, Ruiz-Ramos M, Cardenas-Turanza M, Rhee Y, et al. Estimating the need for palliative care at the population level: a cross-national study in 12 countries. *Palliat Med.* 2017;31(6):526–36. doi:10.1177/0269216316671280.

¹¹ Murtagh FE, Bausewein C, Verne J, Groeneveld EI, Kaloki YE, Higginson IJ. How many people need palliative care? A study developing and comparing methods for population-based estimates. *Palliat Med.* 2014;28:49–58.

¹² Gómez-Batiste X, Martínez-Muñoz M, Blay C, Amblàs J, Vila L, Costa X, Espauella J, Espinosa J, Constante C, Mitchell GK. Prevalence and characteristics of patients with advanced chronic conditions in need of palliative care in the general

¹³ Higginson I. Health care needs assessment: palliative and terminal care. In: Stevens A, Raftery J, editors. *Health care needs assessment*. Oxford: Radcliffe Medical Press; 1997. p. 1–28.

population: a cross-sectional study. *Palliat Med.* 2014;28:302–11.

¹⁴ <http://www.thewhpc.org/resources/global-atlas-on-end-of-life-care>

In 2019, the number of deaths registered in Albania is 21,937¹⁵. The crude mortality rate for 2019 is 768.6 deaths per 100 thousand populations and 8.08 deaths per 1,000 inhabitants. Referring to the causes of death, the largest proportion, 94.1 % is due to “natural causes”, followed by “accidents” with 2.4 %. During these years, deaths from the "Circulatory system diseases" account for 53.4 % of the total deaths. This group of diseases continues to be the main cause of death, with a mortality rate of 410.0 per 100 thousand populations. Deaths from cancer account for 16.3 % of total deaths or 3,583 deaths, ranking as the second major group referring to the number of related deaths. The mortality rate from these diseases is 125.5 per 100 thousand population. In the cancer group, the highest proportion is occupied by cancer of the digestive system" with 34.2 %, and respiratory system" with 25.9 %.

Based in the total death rates 21,937 and the calculation methodology by Gomez and Stjernsward for palliative care we can project a total of 13,162 patients (21,937*60%) annually needing palliative care.

The average long of stay (ALOS) is useful to calculate the number of the patients in need of palliative care per day. Different countries have various figures in the calculations of ALOS, for example in the USA the average Lifelong Length of Stay (LLOS) for Medicare patients enrolled in hospice in 2018 was 89.6 days.¹⁶ Another study in 2014 from Marie Curie Hospice for cancer patient's result to be 18 days¹⁷.

The current ALOS in the country for cancer patients is 44 days¹⁸, so we project a daily census of about 1.586 patients including all the patients in need of palliative care. In addition there are usually two or more family members directly involved in care for each patient, therefore care would be given to at least 39.500 persons annually.

3.2 Palliative care and Human Rights

Palliative care and human rights are based on principles of the dignity of the individual and the principles of universality and non-discrimination. Palliative care is already articulated as a human right within the international bill of rights¹⁹.

The human right approach to advancing palliative care development serves to coalesce a broad medical, moral, and legal imperative – that care of patients with life – threatening illness is a fundamental responsibility of governments, societies and health professionals²⁰.

In the last edited Atlas of global palliative care and in the Health and Human Rights Resource Guide is emphasised and explained that under international law, there are two main sources for this right: the right to health and the right to be free from cruel, inhuman and degrading treatment. The main statement of the right to health is contained in the International Covenant on Economic, Social and Cultural Rights (ICESCR) Article 12.1 (1966), Health care includes palliative care. This covenant is ratified and accessed from Albania in October 1991²¹.

¹⁵ <http://www.instat.gov.al/en/themes/social-condition/health/publications/2020/causes-of-deaths-2019/>

¹⁶ <https://www.nhpco.org/hospice-facts-figures/>

¹⁷ Mary-Ann McCann et.al 2014. Audit of average length of stay in Marie curie hospice Belfast
https://spcare.bmj.com/content/bmjspcare/4/Suppl_1/A96.2.full.pdf.

¹⁸ This figure is assure from the reports of the different organization that provide palliative care service in Albania.

¹⁹ <https://www.sciencedirect.com/science/article/pii/S0885392409006472>

²⁰ https://paliativossinfronteras.org/wp-content/uploads/Palliative_Care_as_a_Human_Right_2009.pdf

²¹ https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4

In the same documents is highlighted that the UN Committee on Economic, Social and Cultural Rights stated that it is critical to provide “attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity”.

Also, the WHO has stated that access to Essential Medicines is part of a nation’s human rights obligations. Many international organizations and bodies have called for the provision of palliative care as an essential component of the right to health care including the Canadian Senate (2000)⁹, the European Committee of Ministers (2003)¹⁰, the European School of Oncology (2004)¹¹, the Worldwide Palliative Care Alliance (2005)¹², the IAHPC (2008)¹³, UN Special Rapporteurs (2008, 2009)^{14 15}, the International Narcotics Control Board (2011)¹⁶ and the World Health Assembly (2014)²². These initiatives are essential and useful to be considered from stakeholders to advocate for the palliative care as a human right.

The following table demonstrate the international and European conventions, which also are ratified from Albania government and are related with health and human rights for palliative care as the right to freedom, torture and cruel, inhuman, and degrading treatment.

Ratification Status for Albania²³			
Treaty Description	Treaty Name	Signature Date	Ratification Date, Accession(a), Succession(d) Date
CAT - Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment - CAT	CAT		11 May 1994 (a)
CAT - OP - Optional Protocol of the Convention against Torture CAT - OP	CAT-OP		01 Oct 2003 (a)
CCPR - International Covenant on Civil and Political Rights	CCPR		04 Oct 1991 (a)
CCPR - OP2 - DP Second Optional Protocol to the International Covenant on Civil and Political Rights aiming to the abolition of the death penalty	CCPR-OP2-DP		17 Oct 2007 (a)
CED - Convention for the Protection of All Persons from Enforced Disappearance	CED	06-Feb-07	08-Nov-07
CED - ART.32. - Interstate communication procedure under the International Convention for the Protection of All Persons from Enforced Disappearance	CED, Art.32		
CEDAW - Convention on the Elimination of All Forms of Discrimination against Women	CEDAW		11 May 1994 (a)
CERD - International Convention on the Elimination of All Forms of Racial Discrimination	CERD		11 May 1994 (a)
CESCR - International Covenant on Economic, Social and Cultural Rights	CESCR		04 Oct 1991 (a)

²² WHPCA_Global_Atlas_DIGITAL_Compress.pdf

²³ https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=2&Lang=EN

CMV - International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	CMW		05 Jun 2007 (a)
CRC - Convention on the Rights of the Child	CRC	26-Jan-90	27-Feb-92
CRC - OP - AC Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict	CRC-OP-AC		09 Dec 2008 (a)
CRC - OP - SC Optional Protocol to the Convention on the Rights of the Child on the sale of children child prostitution and child pornography	CRC-OP-SC		05 Feb 2008 (a)
CRPD - Convention on the Rights of Persons with Disabilities	CRPD	22-Dec-09	11-Feb-13

Note: Declarations and reservations are not reflected in the table.

Table 1: International conventions ratified from Albania with relation to the right to health.

General comment 14²⁴ describes the normative content of article 12 of the ICESCR²⁵ and distinguishes between the right to health and the right to be healthy.

Four essential elements to the right to health are availability, accessibility, acceptability and quality. In the context of palliative care these elements are elaborated as following:

Availability, palliative care should be available in sufficient quantities within a country's public health facilities and other health care facilities including children's homes and care homes for the elderly. This includes health care professionals and other health care workers trained in palliative care and availability of essential palliative care medicines. It should be integrated into mainstream health care so that psychosocial support and symptom control are available from the time of diagnosis.

Accessibility is described in terms of "four overlapping dimensions": *non-discrimination*, including minority groups, to prisoners and other marginalized populations. It should be available to children, to older people, to people with disabilities, to people living with HIV; *physical accessibility*, in terms of the diversification of the services based on the patients' needs as home care, health care facilities, and communities in both urban and rural areas; *economic accessibility* (affordability), there is uncertain funding of palliative care services. In some countries palliative care is fully funded by the state and NGOs also receive state funding. In many developing countries palliative care is funded through donations from communities or corporate donations with little contribution from the state; and *information accessibility*, patients and their families should have sufficient access to information about palliative care services and the option of palliative care. Ideally, palliative care should be a well-publicized service within communities.

Acceptability, palliative care services should be respectful of medical ethics and, indeed, palliative care training includes strong emphasis on bio-ethics as there is often challenging

²⁴ <https://www.refworld.org/pdfid/4538838d0.pdf>

²⁵ *Ibid*

decisions to be made about end-of-life care. Palliative care services should be respectful of culture, gender and age; respecting confidentiality and aiming to improve quality of life of patients and family members.

Quality, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. They should follow minimum standards that are appropriate to the individual country's resources.

Human rights law is an evolving field, and existing legal standards and precedents do not directly address many human rights violations. Through ongoing documentation and advocacy, advocates can build a stronger body of jurisprudence on human rights and palliative care.

The following tables (Table 2 and Table 3) show international human rights instruments and protected rights and fundamental freedoms ratified from Albania government. The tables provide information about specific articles of human rights related to health that can be used as legal referral in addressing violations of the rights of terminally-ill patients. These legal tools assist in framing common health or legal issues as human rights issues, and in approaching them with proper intervention strategies.

International conventions ratified by Albania and articles related to health	UDHR²⁶	ICCPR²⁷	ICESC R²⁸	CEDAW²⁹	ICERD³⁰	CRC³¹
Year	1998	1991	1991	1993	1994	1992
Torture or Cruel, Inhuman or Degrading Treatment*	Art. 5	Art. 7				Art. 37(a)
Life	Art. 3	Art. 6.1				Art. 6.1
Health	Art. 25		Art. 12	Art. 12	Art. 5(e) (iv)	Art. 24
Expression and Information	Art. 19	Art. 19(2)				Art. 13,
Art. 17						
Non-discrimination and Equality	Art. 1, Art. 2	Art. 2(1), Art. 3	Art. 2(2), 3	Art. 2, All	Art. 2, Art. 5, All	Art. 2

Table 2. Specific articles related to the right to health at international level ratified conventions by Albania

²⁶ Universal Declaration of Human Rights (UDHR)

²⁷ International Covenant on Civil and Political Rights (ICCPR)

²⁸ International Covenant on Economic, Social, and Cultural Rights (ICESCR)

²⁹ Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

³⁰ International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)

³¹ Convention on the Rights of the Child (CRC)

European Conventions ratified by Albania and articles related to health	Europe: ECHR³²	Europe: ESC³³
Torture or Cruel, Inhuman or Degrading Treatment	Art. 3	
Life	Art. 2	
Health		Art. 11, Art. 13
Expression and Information	Art. 10	
Non-Discrimination and Equality	Art. 14	Art. E

Table 3. Specific articles related to the right to health at European level ratified conventions by Albania

3.3 Policy developments

WHO and other international organizations as IAHPIC, EAPC and WPCA have undertaken initiatives and developed number of valuable documents and guidelines to integrate and develop palliative care in public health care system. Specifically, WHO since years has design a public health strategy that recommend governments to establish and integrate palliative care in the country's health care system. The WHO strategy consists in four pillars respectively policy development; drug availability; education of policy makers, health professionals and wide public; and implementing palliative care in primary, secondary and tertiary care levels. This strategy and the signatory of the human rights conventions are important interventions to create the appropriate climate for availability, accessibility, acceptability and quality of palliative care.

Policies that support the provision of palliative care are essential for development of palliative care. Types of policies needed include: laws that acknowledge and define that palliative care is part of the health-care system; national standards defining how palliative care programs must operate; clinical guidelines for the delivery of palliative care services; establishment of palliative care as a recognized medical specialty/sub-specialty; regulations that establish palliative care as a recognized type of health-care provider with accompanying licensing provisions; a national strategy on palliative care implementation³⁴.

Although palliative care service is provided since in 1993, its became part of the Albanian Ministry of Health's (MoH) agenda in 2011 when the MoH signed the implementation of the National Cancer Control Plan.³⁵ The plan was designed for 10 years and palliative care was one of the four pillars alongside with prevention, diagnose and treatment (Ministry of Health; 2011). To address the needs of palliative care integration and development was create a five years (2011 – 2015) action plan, which was conceptualised based in who strategy

³² European] Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR)

³³ 1996 Revised European Social Charter (ESC)

³⁴ <http://www.thewhpc.org/resources/global-atlas-on-end-of-life-care>

³⁵ [https://www.jpsmjjournal.com/article/S0885-3924\(17\)30401-3/fulltext](https://www.jpsmjjournal.com/article/S0885-3924(17)30401-3/fulltext)

recommendations, and the most challenging objective was to create the legal framework available for the palliative care service provision and medicaments availability.

The first palliative care action plan was an excellent result, but being part of the national cancer control plan created the perception of a service only for cancer patients. During implementation, stakeholders made efforts to include other patients in need of palliative care in various policy documents, few results were available on paper but the implementation remains a challenge. In 2014, the Albanian Parliament approved the law on palliative care, which was developed with the contributions of all palliative care stakeholders in country, including Ministry of Health. The new law assures that palliative care is considered a basic human right and is a multidisciplinary service, the law seeks to increase the amount of opioids available in the country, it urges that extensive specialization and education on palliative care be provided, and it seeks to include palliative care in the state's welfare scheme.

Although these accomplishments are important, the most challenging work is yet to come, the implementation of the law. In 2015, the NAPC undertook the initiative to work with a group of professionals on drawing by-laws to make the palliative care law applicable. In the beginning of 2016, the by-law documents were drafted and approved by the Council of Ministers and the Ministry of Health. The by-laws call for social and economic support for patients and their families in the terminal phase of illness. However, the by-laws have been postponed because of the high cost assessed by the Ministry of Social Welfare.

In 2011, the palliative care working group developed National Palliative Care Standards. The same year, those standards were approved by the MoH. Although approved, applying the standards continues to be a challenge.

In 2012, the Palliative Care Clinical Guidelines for Children and Adults were developed and approved by the MoH, and in 2014, medical protocols were developed based on these guidelines. These protocols are still under consideration by the MoH and even if their application will continue to be a challenge because of limited resources.

Actually, there is not any palliative care action plan which is useful for setting the pillars and roadmap how to integrate and develop in coordinate and efficient way palliative care in the country.

3.4 Service provision

Public health policy must acknowledge people's right to high-quality palliative care whatever the nature of the disease they suffer from and this should not depend on the financial abilities of patients or their informal caregivers³⁶.

To reach the huge numbers of people with palliative care needs that are not receiving the appropriate palliative care services they need, will require further integration into existing health care systems, including primary care and long-term care. Home based care is especially important and should be prioritised over creating new facilities. Some inpatient

³⁶Beek et al. Comparison of legislation, regulations and national health strategies for palliative care in seven European countries (Results from the European Research Group): a descriptive study. BMC Health Services Research 2013, 13:275. <http://www.biomedcentral.com/1472-6963/13/275>

care is needed but the vast majority of palliative care services can be delivered in the places people call home³⁷.

In Albania palliative care service is provided for the first time in 1993 from non-profit organizations. Still, they play a vital role in the provision of home care service, lobbying and advocacy, and capacity building activities for health professionals. The first government palliative care service for cancer patients was created in Tirana in 2001, and for more than 10 years has been the only government provider of palliative care.

Currently palliative care service in Albania is provided from public and non-public sector only for cancer patients.

In the public sector palliative care is provided from one Oncology Home Service (OHS) in Tirana and from 9 palliative care units in the regional hospitals created in 2012.

OHS is established in 90s as a non-profit service with funds from Italy and in 2001 it was the first governmental funding service in the country. OHS is home care based for cancer patients composed by medical doctors, nurses and one social worker. The patients are referred from the National Oncology Centre and family doctors in Tirana.

Palliative care units in regional hospitals. In 2012, plans for development of palliative care units in all the regional hospitals were projected to reallocate the resources of the hospital with no additional costs from the Mandatory Health Care Insurance Fund (MHCIF). It was made possible to establish palliative care in all regional hospitals. Each region has at least two main cities. The palliative care units provide home care only for the cities where the hospital is and day hospital service for whole region. Each unit for the day hospital has a room with two beds, but mostly the service is designed for home care service. Each palliative care team has a part-time physician, two full-time nurses, and one part-time social worker who have been trained with a theory and practise approach. Regulatory documents have been developed for administrators and managers of palliative care units. Several regional palliative care units are not functioning based on what was conceptualised in the very beginning. Actually, majority of the regional palliative care units are functioning as consultancy centres for terminal cancer patients and day hospital and very few as home care service.

Non-profit sector provide palliative care through two organizations Ryder Albania Association and Mary Potter Association. Few years back Caritas Albania was providing home palliative care in three cities of the country, but they was closed due to the project funds ending. The current organization are funded from project based and also the respective doctors working in the two organizations has the contract with Regional Mandatory Health Insurance Funds to prescribe reimbursed medicaments for terminal cancer patients.

Ryder Albania Association (RAA) founded in 1993 was the first palliative care provider in Albania. RAA has two multidisciplinary mobile home care teams one in Tirana the capital city and one in Durres the bigger sea port city in the country. Each day the two home care teams take care for about 65 – 70 terminal cancer patients. From 2003 – 2008 RAA has run the first and the only 10 – bed inpatients hospice in the country, which was closed due to a lack of funding.

Mary Potter (Family Health Care) Association (MPA) is established in early 90s and its main focus is home palliative care provision and training of health professionals. The MPA

³⁷ <http://www.thewhpc.org/resources/global-atlas-on-end-of-life-care>

program is led by a nurse with physician support. The organization is located in Korca city, one of the biggest city in the southeast area of the country.

In Albania, there are no specialized paediatric palliative care inpatient units; however, the paediatric hemo-oncology ward at the National Oncology Centre provides some inpatient palliative care consultation. More work is needed to establish children's palliative care in Albania.³⁸

Palliative care for non-cancer patients including elderly are not yet regulated and do not benefit by specialized palliative care units. The patients are getting services from various specialist or family doctors but not a palliative care approach.

Actually in the country there is not any inpatient hospice or hospital service dedicated to palliative care service for the all wide range of diseases, although many international convention emphasise the right for health services based on patients' needs and attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity".³⁹

3.5 Drug Availability

An important component of palliative care is access to essential drugs to alleviate pain. For many with terminal illnesses, pain and suffering caused by the illness is debilitating but can be easily treated with opioid analgesics⁴⁰.

WHO has developed two lists of medicines that it considers essential for satisfying the priority health care needs of the population. They are called the Model List of Essential Medicines and the Model List of Essential Medicines for Children, and they serve as a guide for national and institutional essential medicines lists.

The Committee on Economic, Social and Cultural Rights established in General Comment 14 that states are obligated to provide "essential medicines as defined by the WHO Action Programme on Essential Drugs" as part of the minimum core obligations to realize the right to health.⁴¹

Access to Opioids Opioid availability remains a challenge in Albania. WHO recommends an essential list with 33 drugs for palliative care, from which 32 are available for palliative care, in the country. Meanwhile 16 (or 48%) out of 33 medicaments are reimbursed from the health insurance schema. 20% of this group of drugs (reimbursed for palliative care) has limitations on their use and quantity. More specifically, there are pharmaceutical forms from the reimbursement list that are missing or not included in the reimbursement schema. For example the oral solution morphine or the 20, 30, 60 mg morphine; fentanyl 100 mcg; haloperidol 5mg/ml; oxycodone 5 mg, 20 mg etc., are not available in the country and even are not foreseen in the reimbursement list.

The medicaments from the essential list which are not reimbursed are available in the pharmacy, but expensive to be afforded for the majority of the patients and families. For example the oral morphine solution cost about 8 euro one flacon. One patient might need

³⁸

³⁹

⁴⁰ <https://www.who.int/news-room/fact-sheets/detail/palliative-care>

⁴¹ Health and Human Rights Resource Guide

from 1 to 3 flacons in a week (despite other medicaments and facilities) which means from 8 – 24 euro per week. For more details the list of the reimbursed and not reimbursed medicaments is available at Annex 2 of the report.

Only a small number of terminal patients are able to access these medications because of the lack of knowledge of all physicians. For many years, morphine was only available in 10 mg injection and in 10 mg slow-release tablets. Recently, two crucial palliative medicines have become available respectively oxycodone and oral morphine solution.

Methadone is only available for injecting drug users as part of the HIV program. Pethidine (not recommended for palliative care) is very rarely used. Injection morphine is now produced in Albania by a local company. The length of a prescription has been limited to seven days, but because of the new law, it has been expanded to 28 days maximum. However, local physicians still apply the previous restrictions. All GPs can prescribe opioids but only based on the oncologist's recommendation. The authority for prescribing opioids is limited to palliative care physicians (as mentioned earlier) and oncologists. As in other studies in Albania one of the factors affecting the availability of opioids for medical need is related with concerns about addiction, reluctance to prescribe, insufficient training for professionals, law restricting activities, administrative burden cost, difficulties in distribution⁴²

3.6 Education and training

The growing demand for palliative care in international and national levels means that health professionals are expected to provide palliative care as a core part of their practice⁴³.

The vast majority of health professionals worldwide including Albania have little or no knowledge of the principles and practices of palliative care.

Strategies for improving palliative care education include a national undergraduate curriculum for palliative care, expanded training opportunities for generalist practitioners, and further recognition for the role of practitioners of specialist palliative care and associated curriculum development. Addition to professionals, there is also a need to carry out community education and awareness campaigns about palliative care at the same time as services are established. When services are delivered patients and families also need extensive training on how to provide care including personal care, body mechanics, and symptoms to expect and how to manage, along with signs/symptoms of impending death and so forth.

Volunteers also play an important role in hospice and palliative care and bring the community dimension into compassionate care.

Training in the practice of palliative care is a recent addition to undergraduate and postgraduate medical and other healthcare curricula, and several initiatives are under way to promote palliative care principles and practice in healthcare training. The challenge that we all face is how to develop these skills in the face of multiple demands on our time.

⁴² WHPCA_Global_Atlas_DIGITAL_Compress.pdf

⁴³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4332140/>

In Albania in the last decade there are made several and significant efforts for improving the curricula of university programs for physicians, nurses, and social workers.

In the program of the Faculty of Medicine, palliative care is slightly integrated in the oncology subject. In the specialization curriculum of the oncology palliative care is integrated as a module, but in the curricula of the specialization of family doctors palliative care is quite missing, meanwhile in the work practise family doctors is expected to provide palliative care. Although there were undertaken a lot of activities to establish a specialization in palliative care in medicine faculty it was not realised.

There are several public and non-public university programs for nurses, in most of these programs, palliative care is an elective or compulsory subject. While in other nursing programs palliative care is integrated into the curricula of various subjects. In 2018, the Ryder Albania Association, in close cooperation with the Public Faculty of Nursing in Tirana, designed a master program in palliative care and in the academic year 2019 - 2020, the first master program in palliative care was opened with limited number student enrolled. In 2020 the first palliative care nurses was graduated in the country.

In the Faculty of Social Sciences, in social work program, palliative care is included with a chapter in the syllabus of the subject “Social work in health care” and in the master of arts in social work, palliative care is wider included in the program.

Literature is very important for education and training, and it is widely available in English language, nonetheless several essential books on palliative care are translated and published in Albanian and are available for students and professionals, respectively “Hospice and Palliative Care”, The essential guide; The Hospice Companion; Symptom Relief in Terminal Illness, and Cancer Pain Relief, with a Guide to Opioid Availability etc.

Another essential issue for the education and training in palliative care is the qualification of the health care personnel, which is of poor quality⁴⁴. The education and training of the in-service health professionals is realised through “Centre for Continuous Education”, whose main aim is providing necessary courses and trainings, but because of limited resources the majority of the training, including palliative care topics, are done on project based and from different organizations. By regulations physicians must gain 120 credits of continuing medical education over four years and the nurses must gain 40 credits. If they have not accomplished these criteria they cannot be licensed. Two main providers of palliative care training in the country are RAA and the Mary Potter Centre. Every year, both organizations are involved in capacity building initiatives for general practitioners (GPs) and other nursing staff in the palliative care services in several cities in Albania. However, the planning and organization of the trainings are completely dependent on donor funding; therefore, the delivery of training is a challenge every year for RAA and Mary Potter⁴⁵. In 2013, about 40 GPs and nurses received the Educating in the End of Life Nursing Education Consortium (ELNEC) certificate. The training was organized in country, and the full ELNEC module is now available in the Albanian language since 2013,

Relating the education of the wider public which is crucial in palliative care there are initiatives undertaken years before, meanwhile the current ones are sporadically and mainly

⁴⁴ https://www.osfa.al/sites/default/files/vleresimi_i_nevojave_per_kujdes_paliativ_ne_rang_kombetar.pdf

⁴⁵ Ibid

in the international day/week/month of palliative care. In 2013, Open Society Foundation in Albania (OSFA) produced three TV spots aiming to increase public awareness regarding palliative care in Albania. The materials for preparation have been extrapolated from the “Life before death” series produced by Moonshine Agency (supported by the Open Society Foundation’s International Palliative Care Initiative). A major part of the series has been translated and subtitled in Albanian and distributed to the main palliative care stakeholders in country that are involved in capacity building to use as resource and advocacy⁴⁶.

4. Main Findings

4.1 Policy development

A package of policy and legislation documents is available for palliative care in Albania. The policy documents are oriented only to cancer patients and exclude the patients with other diagnoses in need of palliative care.

These documents aren’t well known by all the actors in the field, less known it’s their content and issues that they address. As result, there are differences in the level of knowledge and the ways of responding to the problems that professionals face during service provision.

Even though there have been distinctive developments, there are still gaps not addressed, especially in the service provision ‘responsibilities and the types of services. So, the guidelines for family doctors, define the roles in counseling and informing palliative patients, but don’t specifies their role in treatment and home visits. Professionals lack a comprehensive knowledge of the guidelines about primary service. There is unclarity and confusion in family doctors regarding roles and functions for the service provision at primary service.

The palliative care standards of palliative care service are approved in 2011, but very few professionals know and are informed about, as result they are not implemented. The experts of the area reports the need to review, update and introduce based on an effective strategy to all stakeholders.

“We have come till here step by step. In the beginning it was done the need assessment for palliative care, after that, there were developed the standards of palliative care, treatment protocols, both approved by Ministry of Health. At the end, it was approved the law “On Palliative Care in Republic of Albania”, which was a big step for us, as not many countries have that”.

Oncologist MD, Tirane

Even though the law “On palliative care in Republic of Albania” foresees the care of a caregiver for palliative patients, this is never applied, no concrete actions have been taken to provide regulation at central level. The experts identify the need for social care and the lack of it as an important issue to be addressed. Social administrators reported that in principle the terminally-ill patients are treated as persons with disability and have the right to have caregivers if they fulfilled certain criteria ruled in legislation.

⁴⁶ <https://pubmed.ncbi.nlm.nih.gov/28807704/>

“The law on palliative care guarantee the right of patient to have a caregiver when it’s needed, but till now there is no concrete initiative from Ministry of Finance to formulate the criteria and modes of applications”.

Ocologist MD, Tirane

“Although we apply the Council of Minister Decision Nr.722, 2019 for the caregiver in any case of disability, it’s especially difficult to terminally ill patients to access this right due to the need to be presented physically in many services and the process itself takes time”.

Social administrator, Tirane

There is no approved reimbursed package that includes not only medicaments but also equipment and medical supplies for patients of palliative care, which in experts’ opinions would facilitate the services to these patients by reimbursing costs they are facing during the illness.

“We offer medical and psychological assistance to patients and their families, but we offer that without having an evaluation costs for these services. It’s responsibility of Ministry of Finance together with Ministry of Health and Social Protection and Mandatory Health Care Insurance Fund to define the costs and to provide reimbursement for some of the costs”.

Oncologist MD, Tirane

Stakeholders still identify palliative care with cancer diagnose, which is an important gap resulting mainly due to missed actions from policymakers to recognize and integrate within palliative care other diagnosis than only cancer.

“Palliative care begun in Albania as symptomatic treatment of patients with cancer. But there are other diagnosis that need the same treatment about the symptoms such as degenerative illnesses, other life-risk illness such as diabetes, etc that need to be included in palliative treatment”.

Oncologist MD, Tirane

“The law itself doesn’t speak only for cancer patients, speaks about palliative care. So it’s important that Ministry of Health and Social Protection, MHCIF, Regional Directorates of MHCIF to begin to act in the spirit of the law”.

Oncologist MD, Tirane

4.2 Service provision - Implementation

4.2.1 Territorial and service coverage

The palliative care service in Albania is not unified and it is provided differently in different regions. It’s a different picture in Tirana, Durrës and Korça where the system of palliative care consists, from many years now, of: primary service, OHS (Oncological

Home Service), tertiary service (University Hospital Centre “Mother Teresa”) and non-profit service providers such as Sue Ryder Albania and Mary Potter in Korça. The other regions present a different situation with lack of services for palliative care and the service is provided only by family doctors and oncologists specialists at the secondary service.

The territorial coverage with palliative care units is achieved by establishing 11 regional units in regional hospitals in Albania, but not every unit has functioned well.

“In my opinion, palliative care units in Durrës, Vlora have functioned well, less well units in Shkodër, Berat, Lezha, Kukës, and in a limited way unit of Elbasan”.

Oncologist MD, Tirane

Other forms of palliative care service as inpatients hospice, respite care, day care centers and do not exist in territory. There are no inpatient units or services dedicated and specialized for palliative care service in Albania. The palliative patients could be hospitalized in emergency situations, but there are not dedicated beds, rooms or units with proper infrastructure resources and holistic approach. Majority of the palliative patients access services by contacting privately medical doctors, paying directly, and receiving service by non-specialized medical staff.

There are only tertiary services for children, located only in Tirana. The other regions lack services for children this due to the low rate of children in palliative care in Albania.

4.2.2 Family doctors as the core of palliative care

According to legislative framework the provision of palliative care is responsibility of family doctors and palliative care units in hospitals. The family doctors are overloaded and in the majority of the cases can't offer home visits. On the other side palliative care units are established only in the regional hospitals that cover approximately two – four municipalities, so they can't respond properly to all the needs and also do not possess the appropriate resources.

The caseload for family doctors is high and they state that they face long working hours in Albania. From the interviews there are evidences that in some regions the rate is more than doubled than the rate regulated in standards in Albania, which is 1 family doctor/2500 inhabitants⁴⁷.

“We should offer home treatment for all patients that can't come at the Center. We don't have a car to provide this service, but we rely on familiars of the patients”.

⁴⁷ The Package about Services in Primary Health Care Services, Ministry of Health and Social Protection, reviewed 2018 https://shendetesia.gov.al/wp-content/uploads/2018/02/Paketa_e_rishikuar_e_miratuar.pdf

Family Doctor, Fier

“Sometimes, I work overtime to do home visits, cause it’s impossible to finish everything during the regular working hours”.

Family doctor, Durres

“I have in my care 5300 patients”.

Family doctor, Durres

4.2.3 The model of palliative care team

Palliative care service in Albania is outpatient and medical oriented. The model of multidisciplinary team is present only in services such as SOB, Sue Ryder Albania and Mary Potter. This model, even though exists in paper in those hospitals that have palliative care units, practically doesn’t function due to the lack of resources.

The only public service provider that offers home care for cancer patients according to a medical-psycho model is located in Tirana. SOB (Home Care Oncological Service of Tirana) is configured and is functioning as a multidisciplinary service and its team consists of 7 doctors, 8 nurses and 1 social worker. SOB serves to a big population and a big territory and can’t cover all the needs of Tirana Municipality. SOB offered services to 1300 patients during 2018 and is facing an increasing number of patients.

“The only public palliative service provider is Oncological Home Service (OHS) in Tirana. This service is defined to offer services in a more medical-psycho model for patients. The problem I see with this service is that it responds to a big population needs and lacks resources”.

Oncologist MD, Tirane

4.2.4 The palliative care as a right

The access of population to palliative care services is very low because all the services are located in Tirana. Palliative care units are suffering lack of resources and they are not doing home visits anymore, and there are regions that have no palliative care units at all. The rural population and the people with limited financial resources are the ones who are almost without access due to the distant services which are located in cities.

The interviewed medical doctors reported that they know very little about the patients’ rights and even though in their understanding there is a linkage between the palliative care system and Human Rights, they don’t see the palliative care system to reflect it.

Covid 19 pandemic situation

Covid 19 pandemic situation affected the services offered to palliative patients, especially during lockdown period March-June 2020, but the situation was improved using mobile medicine and face to face visits after June 2020.

“Palliative care is not a privilege, it’s a right, so everyone in need of that should have access, despite of the place, economic or social situation. This doesn’t happen here, not everyone have access in such services”.

Oncologist MD, Tirane

“For the moment, we have a patient that is in chemotherapy and is taking the treatment at Oncologic Hospital in Tirana, but we check his general state once a week”.

Family doctor, Fier

Covid 19 situation affected the situation of the services because the request was higher than prior. We offered the consults over mobile at the beginning of the pandemic, but we continued after the first months with family visits”.

Family doctor/Fier

4.2.5 The nature of services-medical oriented

In the primary care service, except of SOB established in Tirana, the public service are medical oriented services, composed only by nurses and medical doctors. The family doctors service consist in the prescription of the medicaments (reimburse or not), informing and instructing the patients relating disease and medicaments and in rare cases perform home care service. The family nurse by regulations should do home care service for palliative patients, but in reality the number of home visits is limited.

“The palliative patients have many needs, that I can’t say that we can met actually. Some of them are living alone, or they are elderly, or they have children, so they need somebody to help or assist them. Some of them need transport, some of them need assistance to get the medicines, that aren’t always available, and they need to go to hospital more than once”.

Family doctor, Elbasan

4.2.6 Palliative care units in regional hospitals

Secondary care, in the regional hospitals since many years are established the palliative care units with two – four beds capacity. They aim to provide day care and home care service to palliative patients. In the very begging there were several efforts which resulted in creating a model and provision of home care with day care service. Actually these units are functioning mainly as day centers for a number of limited patients.

“No, no, the service is not as it was previously. We have no real possibility to offer home care, we face an increased number of patients, also a lot of other responsibilities are added. Sometimes we hospitalized few patients at pathology unit, few days...”.

Palliative Care Unit, MD

The regional hospitals in Albania have one social worker or psychologist who is responsible for all units, but mostly they are engaged in the pediatric and maternity care. Therefore the palliative care services lack the presence of these professionals, even is supposed to be a multidisciplinary team.

“The service is needed to be multidisciplinary, the basic staff is nurse, medical doctor and social worker. But there is also need for psychologist, dietolog”.

Oncologist MD, Tirane

“Social worker is responsible for all hospital’units, she comes if we ask for her, but usually she stays at pediatric unit, where seems to need her more...”.

Paliative Care Unit, MD

Health staff recognizes the complexity of patients; needs and they ask for collaboration and support by social care services of municipalities.

“The idea is that our patients need also other services, for example from local government and social workers there. There are some patients who have received wheel chairs and other aids from local government and Red Cross”.

Family doctor, Fier

“We have many difficulties with palliative patients, they need not only medical care but also psychological assistance. Their familiars also need to be educated and assisted. Maybe a better collaboration with local government and social services there could be of help”.

Family doctor/Fier

“Cancer patients are faced with many difficulties, stigma and fear are very much present”.

Family doctor,Durres

4.2.7 Referral System

Referral system is working according to the services available in the region, anyway the referral system consists of: family doctor (primary), oncologist specialist (secondary),

Oncologic Hospital (Tirane, tertiary). Wherever is available, family doctors refer the patients and/or familiars to home care services offered by public or non-profit service providers (Tirana, Durres, Korce).

“We refer the patients to the Regional Hospital. The mammography is functional again so there are diagnostic equipment available there. They schedule to make some diagnostic visits in different villages of Fier according to a plan”.

Family doctor, Fier

“I had a patient recently that I referred to Ryder/Durres and he got home services from them. He passed away as he was at the terminal phase”.

Family doctor, Durres

4.2.8 Protocols in palliative care

Although there are protocols in palliative care, very few family doctors know about them and they follow the general protocol to ask advice from specialist doctors.

“As far that I know there is no protocol for palliative care. It’s the specialist that decide on diagnosis and the treatment and we just follow the case”.

Family doctor, Fier

“We don’t have protocols for palliative patients, we follow the instructions given by oncologists”.

Family doctor/Durres

4.2.9 Prescription process

Prescription process is limited by some rules coming from MHCIF that aims to control the level of expenditures on reimbursed medicaments. The patients are always obliged to go to specialists for recommendations even in cases of pain control medicaments. Family doctors do not exercise their competence to prescribe all the medicaments that patients need (financial limitations) and especially some medicaments that are prejudged such as morphine.

“I have no right to prescribe. My prescription is always based on that of the specialist”.

Family doctor/Durres

“It’s the oncologist specialist that prescribe the pain killers and I just execute the prescription according to the system, which in itself has some limitations”.

Family doctor/Elbasan

4.2.10 Diversification of services

Limited diversification of the services is verified. The main services are counseling services and geographic limited home care service. There are present day hospital

services. The palliative care units that were established at the regional hospitals (at the beginning they were offering home care services) nowadays are operating as day hospital services due to the different understanding about palliative care of hospital managers and they are not offering anymore home visits.

“No, no, the service is not as it was previously. We have no real possibility to offer home care, we face an increased number of patients, also a lot of other responsibilities are added. Sometimes we hospitalized few patients at pathology unit, few days...”

The patients are asking for home care visits in the informal ways, and they are getting it from not qualified health staff and not through the system. Majority of the patients or their familiars get the service by direct payment or using acquaintances' networking.

“Quite often patients or their familiars find privately doctors to follow them. It's something that happens and we accept it”

Family doctor/Tirane

There is a lack of inpatient services for terminally ill patients or number of beds in hospitals for palliative care. The rate for availability of beds in hospitals is 2/1000⁴⁸ inhabitants in Albania. The interviewed health staff stated the lack of beds for palliative care in years in Albania.

“The need for hospital beds in palliative care is high and our system doesn't offer this care to many patients. The situation is worsen with the increase of the number of terminally-ill patients”

Medical doctor/Tirane

4.3 Drug availability, accessibility, and affordability

4.3.1 Drug availability

The list of reimbursed medicaments contains 16 out of 33 medicaments recommended by WHO. It's verified that, even though the medical doctors allover Albania can prescribe the same medicaments from the list, the situation is not presented the same. There are big differences in implementation of the list of reimbursed medicaments from the medical doctors in Tirana with what is evident in other parts of Albania. The family doctors, out of Tirana don't prescribe many of medicaments of the list, not guarantying in this way needed treatment to the patients. The list of reimbursed medicaments is approved each year at national level, but it's not applied in the unified way due to the different rules implemented by Regional Directorates of MHCIF.

⁴⁸ INSTAT, Health Care Indicators, 2018 <http://www.instat.gov.al/media/6116/treguesit-e-shendetit-publik-2018.pdf>

Reimbursed medicaments are available in all pharmacies, except of morphine that is only available in pharmacies, which are contracted by MHCIF.

“The reimbursed medicines about palliative care are increased and the situation is improved much, in comparison with years ago”.

Oncologist MD, Tirane

“There is a different situation in implementation of the List of Reimbursed Medicine in Tirana in comparison to other regions of Albania. Patients living in Tirana and benefiting from our services, either public or non-profit, have access to any medicine listed as reimbursed. This is not happening in other parts of Albania, even though family doctors have the right to prescribe, but they don't feel confident to do it or they don't have the proper knowledge about palliative care medicine”.

Oncologist MD, Tirane

“The situation of medicaments availability is different in Tirana, Durres and Korca from the other parts of Albania. Regarding the opioids, the medical doctors have almost the same availability, but this doesn't happen for other medicines”

Oncologist MD, Tirane

“If we consider the list of medicines recommended by WHO, we can prescribe 25 out of 33 in Tirana. It's not the same situation in other regions”.

Oncologist MD, Tirane

The practices of prescriptions differ a lot in different parts of Albania. There are no unified practices. Fund for Health Insurance and Care has the responsibility to handle this”.

Oncologist MD, Tirane

4.3.2 Drug accessibility

Although, the drug availability is not considered an issue of concern, the drug access is a problem. Because of the limitations of reimbursed prescriptions by family doctors, the access of medicaments is not the same for patients living in different parts of Albania as the practices of prescriptions resulted to be quite different.

FHIC is operating differently in different regions and Regional Directorate of FHIC exerts administrative checks to family doctors about the quantity of reimbursed medicaments they prescribe, so they are very careful not to exceed the amount (in Lekw) they are allowed to. This creates a situation of withhold care where patients are not accessing the medicaments, especially in regions other than Tirana.

The system is oriented first towards the cheapest medicaments, which prevent the doctors to prescribe according to the needs and the stage of the patients.

“The problem is about the limit I have to prescribe reimbursed medicines. There are controls to make sure that we as family doctors don’t overpass the limits. There is no written rule how many prescription I can do of reimbursed medicines, but non officially it’s been said to be careful”.

Family doctor/Durres

“Family doctors has all the right to prescribe out of what the specialist has recommended but there are some barriers coming from their knowledge, not unified rules, agency barriers that are impeding family doctors to prescribe some very needed medicine for patients”.

Oncologist MD, Tirane

‘According to the system we first should prescribe the cheapest medicine, which is not always good and effective for the patients, because the treatment should apply to the diagnosis and the stage of the disease’.

Family doctor/Durres

The medical equipment’s or other supplies are not reimbursed, although they are very needed, and not provided from primary or secondary services. The patients or their familiars are obliged to pay for the equipment and supplies they need.

“There are also other equipment and supplies that are needed for different diagnosis at the terminal stage that are not reimbursed”.

Oncological Doctor/Tirane

4.3.3 Drug affordability

The palliative patients with other diagnosis than cancer can’t have prescribed reimbursed painkiller medicaments, due to no regulations issued on this and, they have to pay for painkillers.

“There are medicaments that are not included in the list of reimbursed medicines, that patients can access those by paying, but those are expensive, such as Oxycodone, Fentanyl or Oral Morphine”.

Oncologist MD, Tirane

“I haven’t had patients with other diagnosis than cancer that needed pain treatment, but in that case they would need to cover financially the medicines by themselves”.

Family doctor/Fier

The reimbursement medicines are in relation with diagnosis. I can say that about 78% of cancer patients receive reimbursement medicines, the others pay for the needed medicines”.

Family doctor/Fier

4.3.4 Pain treatment

The situation regarding pain treatment has changed a lot in Albania regarding the mentality of medical doctors and patients. The medical doctors are prescribing more morphine even for the fact that is included in the list of reimbursed medicaments.

Family doctors still have barriers to prescribe morphine and they do not issue prescriptions by themselves, they wait and follow the prescription by the specialist doctor. This create problems in terms of access for the patients as they need to go for unnecessary visits to specialist doctors and sometimes they don't get that treatment for various reasons when they need it.

The system limits the medicaments and their dosage that family doctors can prescribe, which results in fewer access and no proper treatment of pain for many patients according to their stage of illness and their need.

The morphine is allowed by the system only for cancer patients which put the patients with other diagnosis in the situation either to pay by themselves or not to get pain treatment at all. All other diagnosis that are in the palliative umbrella and have palliative stage are excluded from the pain treatment in Albania.

“There is a progress now in Albania regarding pain treatment, especially for cancer patients because morphine is in the list of reimbursed medicaments. But it's not the same situation for patients with other diagnosis that need pain treatment as the morphine is only dedicated to cancer patients. So, there is a need to recognize and address the needs for pain treatment for other diagnosis patients, so palliative patient is an umbrella term that can be used in this regard”.

Oncologist MD, Tirane

“We tried to introduce practices of prescription of morphine at least at regional hospitals, but the situation still presents challenges for patients that need that treatment, as very few doctors (only surgeons or anesthetists) can prescribe it and only for cancer patients”

Oncologist MD, Tirane

“I don't do pain treatment. I try to refer the cases, cause it's not my competence to treat pain”.

Family doctor, Durres

“I have no right to prescribe morphine, oxycodone or other opioids for palliative patients, cancer patients or other diagnosis, these are medicines that should be prescribed by specialist”.

Family doctor, Durres

“The system we use to execute the prescription has limitations regarding the drugs and the quantity”.

Family doctor, Durres

“We have tramadol and morphine in the list of emergency medicines that we can prescribe. I have prescribed morphine only on cancer patients and with the approval of oncologist specialist, I wouldn’t prescribe that by myself”.

Family doctor/Fier

“We administrate here in the Health Center some pain killers such as diclofenac, voltaren, tramadol and we can prescribe these medicines, but we can’t prescribe morphine without a diagnose and the approval of oncologist specialist”.

“I haven’t had patients with other diagnosis than cancer that needed pain treatment, but in that case they would need to cover financially the medicines by themselves”.

Family doctor/Fier

4.4 Education

4.4.1 University education

The education system for medical doctors and nurses lacks a consolidated and structured knowledge for palliative care. There are few lectures that are given integrated in different courses.

Medicine Program has few hours in palliative care, which is considered not to meet all the needs of future medical doctors for knowledge in this field. There is the specialization in Oncology for medical doctors that is focused more in cancer treatment clinically-wised.

Faculty of Medical-Technical Sciences (in Tirana) which is the main university for nurse education has included palliative care lectures in different courses in Bachelor program. There is a special Master of Arts program (1 year) for nurses in palliative care.

There have been some efforts to translate from English literature in the field of palliative care from organizations such as Sue Ryder Albania, which is available at the Faculty of Medicine library and Faculty of Medical-Technical Sciences library. This literature is limited in themes and in quantity.

“There are few hours dedicated to oncology in Medicine Program, but those aren’t enough. Palliative Care should be as a specific course”.

Oncologist MD, Tirane

“Some years ago, it was an initiative to establish a Master Degree Program for medical doctors in palliative care, but due to the bureaucracy reasons, failed to opened it. For the moment, there is a specialization in Oncology for medical doctors, which is still running”.

Oncologist MD, Tirane

“During my studies, the information about terminally-ill patients and palliative care has been limited, then in practice as family doctor I’m faced with all categories of patients, including terminally-ill patients”.

Family doctor, Durres

“I have no information about the specialists that offer services for palliative patients”.

Family doctor, Durres

“There is not much literature in Albanian for palliative care, Ryder Albania contributed with some translated books that helped in providing literature in Albanian, but there is a need for more”.

Oncologist MD, Tirane

4.4.2 Education on job

There is a lack of education on job for medical doctors and nurses regarding palliative care. The internship time (3-6 months) is not enough to learn about all the diagnosis family doctors will meet. They were not introduced with different/new/updated protocols about different diagnosis that are considered to have a palliative stage. They stated that had no information about legislation in the field of palliative care, but also no information about patients ‘rights.

The trainings that are provided had in focus administrative responsibilities and especially the recommendation and reimbursement process.

Family doctors presented the need for guidance/supervision during the first years of their work as they were faced with different challenges, especially in terms of the area, patients, diagnosis, roles and responsibilities.

“Family doctors must conclude an internship of 3-6 month at regional hospitals before the licensing process. We have received training about the recommendation/reimbursement procedures but not a specific training about the practical work”.

Family doctor, Fier

“There are new protocols for diabetes, hyper pressure of blood, that are the most spread diagnosis in the population, but we haven’t received training about this”.

Family doctor, Fier

“I don’t have information about legislation in the field of palliative care or about the rights of patients, I’m on duty only from 1 year”.

Family doctor, Durres

“We need training on palliative care cases. There is a project on-going (Health for All) in collaboration with HAP, which is assisting us with family visits, we received some training

about home visits, preparation, medical equipment needed, etc. This training can help also about palliative care cases”.

Family doctor, Fier

“I have no information if there are protocols in palliative care”.

Family doctor, Durres

“It’s really difficult to be a young family doctor, harder than I thought. I didn’t know the patients, the area, I had many challenges been without a direction in my work”.

Family doctor, Durres

5. Conclusions and Recommendations

Palliative care is an approach that improves the quality of life of patients and their families and is related deeply with the actions made by state to guarantee and respect Human Rights of the patients. Albania has made distinctive efforts to produce legislation, regulations and strategies for palliative care. Actually, there is no strategy in force due to the end of time period of the previous strategy (Strategy of Palliative Care in Albania 2010-2020). As result, there is no Plan of Action. There is an identified need to revise the standards and protocols of palliative care.

Palliative care is not fully recognised under the human right to health. There is a situation of withhold care in terms of geographically differences of law implementation, drug availability, accessibility and affordability.

The system doesn’t respond to the needs of patients in palliative care due to the organization of the system, lack of services, lack of resources. The number of patients in need of palliative care in Albania is increasing and the projected number of patients/year will put the system in crises or will seriously endanger the access of patients for services.

The patients with other diagnosis than cancer do not receive palliative care and are excluded de facto of the system.

There is a limited typology of services, which affects the right to health services and especially the inpatient services result in a very low availability of beds in all regions.

Palliative care services are out patient oriented, the situation is not responded with more home and community services, but the main burden is of patients and families. Inpatient services present lack of beds and lack of access of hospital palliative care in many regions.

Palliative care in Albania is not provided as an integrated health services, the public services are mainly medical oriented. Medical needs are more in focus and less psychosocial needs of patients.

The multidisciplinary team approach is not present everywhere to address practical needs and provide different services. But there is an articulated need from all professionals to work as a team and they recognize other professionals' contribution to the needs of the patients.

The patients are benefiting only drug reimbursement treatment and completely lacking the medical equipment and supplies/facilities, which is covered by patients and their families and is considered as a expensive service to be paid privately.

Palliative care in Albania is more identified with cancer diagnosis and less with other diagnosis as chronic diseases, AIDS, diabetes, kidney failure, chronic liver diseases, multiple sclerosis, Parkinson's disease, rheumatoid arthritis, neurological disease, dementia, congenital anomalies and drug-resistant tuberculosis, etc.

Pain treatment has changed a lot in Albania regarding the mentality of medical doctors and patients. The family doctors are prescribing more opioids but they still have barriers to prescribe them, which creates problems in terms of access the right for a life without pain and respect to person's dignity.

Although there are no evident problems with drug availability, it's verified insufficient accessibility and affordability which are related with the different implementation of the law in territory, limited access to prescribe opioids from family doctors, lack of human resources and lack of staff training in palliative care.

Palliative care is frequently delivered by non-specialists or other specialist doctors from different disciplines than oncology or palliative care, contacted based on private acquaintances/referral or by direct payment due to the limited home care services in country.

Recommendations

Policy

1. A new Strategy on Palliative Care and a Plan of Action is needed to be established. These documents will ensure all the future steps of governmental institutions in responding to the needs of palliative care system.
2. The new Strategy and Action Plan should be based on a careful and overall need assessment of terminally-ill patients about different services to respond to different needs at different stages of illness.
3. The new Strategy and Action Plan should reflect the approach of Human Rights based on the most recent guidelines of WHO on palliative care as a Human Right.

4. The new strategy should expand the scope of palliative care to include non-cancer palliative care provision.
5. National standards on palliative care and protocols of palliative care need to be revised, update and respond to a more integrated palliative health care system.
6. A reconceptualization of palliative care units in regional hospitals is needed in order to regain the mission they had at the beginning of their establishment.

Drug Availability

1. Policy on the provision of opioids and other essential palliative care medicaments needs to be clarified and give to family doctors the right to prescribe in order to improve the access to opioids and appropriate pain treatment.
2. Prescriptive procedures and the limitations in place need to be improved. Prescriptive procedures should be unified and implemented the same way in all regions. Family doctors need to be trained in pain treatment and prescriptive procedures.
3. More medicaments that are on the WHO list should be included in list of Reimbursed Medicaments and equipment and medical supplies should be added to the list.

Service provision-Implementation

1. Immediate steps should be taken to unify the implementation of the law on palliative care which asks for accessibility of services everywhere in territory. The patients should access the same the services, irrespective of region where they're living, income, disease type or age.
2. Inpatient services should be increased in order to respond to the needs of palliative patients about hospitalization.
3. Home care services should be increased targeting palliative care patients in order to guarantee health care to these patients.
4. The teams should be established with a holistic approach regarding the needs of patients including professionals as medical doctors, nurses, social workers in all services.
5. The HOS (Home Oncological Service) should be supported with staff and resources to respond to the needs of Tirana population.

Education

1. Palliative care curricula need to be introduced into the education program for physicians as a separate course.
2. A program for teaching palliative care is needed for continuing family doctors education.

ANEKS I Lista e personave te intervistuar

Ofruesit e shërbimeve

1. INTERVISTAT (mund te kete me shume se nje person nga çdo institucion)

INSTITUCIONI	POZICIONI	DATA
SOB	Drejtor	03.06, 2021
Sue RYDER-Alb	Drejtor	18.06.2021
Mary Potter/Korca	Drejtoreshë	25.06.2021
Drejtoria e Shërbimeve Sociale/BT	Përgjegjëse Sektori	25.06.2021

Mjekët onkologë

1. INTERVISTAT (mund te kete me shume se nje person nga çdo institucion)

Qytetet	POZICIONI	DATA
Tiranë	Mjek onkolog	22.06.2021
Tiranë	Mjek onkolog	18.06.2021
Tiranë	Mjek onkolog	22.06.2021
Tiranë	Mjek onkolog	22.06.2021
Durrës	Mjek onkolog	08.06.2021

Mjekët e familjes

1. INTERVISTAT (mund te kete me shume se nje person nga çdo institucion)

Qytetet	POZICIONI	DATA
Fier	Mjeke familje	16.06.2021
Durrës	Mjeke familje	08.06.2021
Elbasan	Mjeke familje	10.06.2021
Tiranë	Mjeke familje	03.06.2021

Punonjësit social dhe administratorët socialë

INTERVISTAT (mund te kete me shume se nje person nga çdo institucion)

Qytetet	POZICIONI	DATA
Tiranë	Punonjëse Sociale/SOB	17.06.2021
Tiranë	Punonjëse Sociale/Sue Ryder Alb	17.06.2021
Elbasan	Administratore Sociale	17.06.2021

Institucionet e Edukimit

1. INTERVISTAT (mund te kete me shume se nje person nga çdo institucion)

INSTITUCIONI	POZICIONI	DATA
FSHTM (Fakulteti i Shkencave Teknike Mjekesore)	Pedagog ne MP ne Infermieri	23.06.2021
Fakulteti i Shkencave Sociale/UT	Pedagoge ne MP ne Shendetesi	25.06.2021

Aneks II Lista e medikamenteve te rimbursueshme

	Medikamenti	Doza
1	Amitriptyline	25 mg
2	Carbamazepine	100-200 mg
3	Codeine phosphate	15 mg
4	Dexamethasone	4 mg/ml 0,5 mg
5	Diazepam	10 mg 5 mg/ml
6	Diclofenac	50 mg
7	Fentanyl(patch transdermal)	25 microgram/hr 50 microgram/hr
8	Gabapentin	300 -400 mg
9	Haloperidol	0.5-5 mg me pika
10	Hyoscine butylbromide	10 mg
11	Ibuprofen	400 mg
12	Lorazepam	1 mg 2,5 mg
13	Megestrol acetate	160 mg
13	Metoclopramide	10 mg 10 mg/2 ml
14	Morphine	10 mg 10 mg/ml
15	Oxycodone	10 mg
16	Tramadol	50 mg 100mg/2ml

Aneks III Lista e medikamenteve te parimbursueshme

	Medikamenti	Doza	Cmimi
1	Amitriptyline	50-150 mg	
2	Bisacodyl	10 mg tab 10 mg rectal suppositories	100 lek/cp
3	Citalopram	20 mg tab 10mg/5 ml oral sol 20-40 mg inj	380 lek/cp
4	Dexamethasone	4 mg tab	
5	Diazepam	2.5 mg 10 mg rectal suppository	
6	Diclofenac	25 mg 50- 75 mg/3ml	46 lek/amp
7	Diphenhydramine	25 mg 50mg/ml	
8	Haloperidol	0.5-5 mg 0.5-5mg/ml inj	470lek/amp
9	Hyoscine butylbromide	20 mg/1 ml oral sol 10 mg/ml inj	
10	Ibuprofen	200 mg	13.5 lek/cp
11	Levomepromazine	5- 50mg tab 25 mg/ml inj	
12	Loperamide	2 mg	11.2 lek/cp
13	Lorazepam	2 mg/ml drops 2-4 mg/ml inj	
14	Megestrol acetate	160mg tab 40mg/ml sol	
15	Methadone	5 mg tab 1mg/ml oral sol	
16	Metoclopramide	5 mg/ml inj	
17	Midazolam	1-5 mg/ml inj	
18	Mineral oil enema		
19	Mirtazapine	15-30 mg tab 7.5-15 mg/ml inj	122.6 lek/cp
20	Morphine	10-60 mg tab 10mg/5ml oral sol 30 mg tab	129.9 lek/cp
21	Octreotide	100 mcg/ml inj	
22	Oral rehydration salts		
23	Oxycodone	5 mg tab	
24	Prednisolone	5 mg tab	8.3 lek/cp
25	Senna	8.6 mg tab	
26	Tramadol	50 mg/ml	51 lek/cp
27	Trazodone	25-75 mg tab 50 mg inj	
28	Zolpidem	5 -40 mg tab	20 lek/cp