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Universal Periodic Review of Albania

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Joint Stakeholder Submission



Albania Center for Population and Development (ACPD)
Bulevardi "Gjergj Fishta", Kompleksi "Tirana 2000", Kulla 4, Tiranë
Tel: 04 253839 / 04 251475 E-mail: info@acpd.org.al Website: www.acpd.org.al

ACPD is a non-for-profit organization, established in January 1993, that works for improvement of policies, legislation, the right of information and services for issues concerning population and development, including reproductive health.



Albanian Association of People Living with HIV/AIDS

Rr. "Aleksander Moisiu ", Nr.80
Tirana, Albania
Mobile phone: 00355 69 24 81 657
Email: hoxhajolimbi@gmail.com



Roma Active Albania

Rr.Ylbere Bylykbashi; P. 25; Shk. 2; Ap 4;
Mobile phone +355692058782
Email: info@raa.al



Stop AIDS

Kahreman Ylli, Nd. 32, H 18, ap 45, Njesia Bashkiake nr. 4
Tirana, Albania
Telephone: +355 4 362662 Tel: +355 692066359
Mobile phone: +355 68 20 57 773 Email: gencaxionp@albmail.com
Email: arianboci@yahoo.com
stopaids_al@yahoo.it Web: www.aksionplus.net



Aksion Plus

Qendra e Shendetit Mendor Nr 1, Rr. Stavri Vinjau,
Prapa ambasadës amerikane,
Tirana, Albania
Tel: +355 692066359
Email: gencaxionp@albmail.com
Web: www.aksionplus.net



National Center for Community Services

Rr: Isa Boletini; Building "Planet X", P.O. Box 2390
Tirana, ALBANIA
Tel/fax: +355 4 2273247
E-mail: lilianadango@gmail.com.



Psicho-Social Center "Vatra"

Rr: "Nermin Vlora Falaski"
Pallati 13, Shkalla I, Kati I tretë
Tel & Fax: +35533 22407
E-Mail: info@qendravatra.org.al



Center Act for Society

Rruga "Blv. Zhanë D'ark" Nd.61, H.5, Ap.24
Tirana, Albania
Tel: +355 44507447,
E-mail: actforsocietyalbania@gmail.com
www.actforsocietycenter.org



Sexual Rights Initiative

Rue de Monthoux 25
Genève, Switzerland
www.sexualrightsinitiative.com
info@sexualrightsinitiative.com

Formed in 2006, the Sexual Rights Initiative (SRI) is a coalition of national and regional organisations including Action Canada for Sexual Health and Rights (Canada), Akahata (Argentina), CREA (India), Coalition of African Lesbians (South Africa), Egyptian Initiative for Personal Rights (Egypt) and the Federation for Women and Family Planning (Poland). The SRI partners advocate together for the advancement of human rights related to sexuality, gender and reproduction at UN Human Rights Council.



Key Words

Sexual and Reproductive Health and Rights

HIV/AIDS

Discrimination

Comprehensive Sexuality Education

The background is a stylized, flat-design illustration of a cityscape. It features several buildings: a tall, thin skyscraper on the right with horizontal window bands, a multi-story office building in the center-left with a grid of windows, and a smaller house in the foreground on the right with a dark roof and two chimneys. There are also several dark green, rounded trees scattered throughout the scene. The overall color palette is muted, with various shades of blue, grey, and green.

Executive Summary



1. The Republic of Albania is responsible for ensuring the fulfillment of international human rights treaty commitments. During the last review, Albania received 171 recommendations, 4 of which it noted. Concerningly, the noted recommendations related to increasing anti-discrimination protections on the grounds of nationality, ensuring the protection of minority rights, including by extending minority rights status to Egyptian persons. Albania did however accept five recommendations that called for strengthened efforts to improve access to housing, health services, education and employment, two of which specifically addressed this in relation to Roma and Egyptian persons. Albania received and accepted three recommendations relating to increasing its efforts at eliminating discrimination on the grounds of sexual orientation and gender identity, including through the full implementation of the Law on Protection from Discrimination.
2. Despite the commitments made by Albania during its last review and the positive developments outlined in this report, specific obstacles to the realization of the right to health and to sexual and reproductive health services by vulnerable groups persist throughout Albania.
3. This submission addresses three main barriers that restrict or prevent individuals from being able to exercise their sexual and reproductive rights: limited access to healthcare services, including sexual and reproductive healthcare for vulnerable groups; HIV/AIDS stigma, discrimination and access to services; and inconsistent policy and implementation of school-based comprehensive sexuality education.
4. Persons facing multiple and intersecting forms of oppression, particularly rural women, Roma and Egyptian persons, as well as persons with non-normative sexual orientation and gender identity and expression, sex workers (SW), men who have sex with men (MSM) and people who inject drug (PWID) experience limited access to healthcare services generally and sexual and reproductive health (SRH) services in particular. This is primarily due to unprofessional, biased and discriminatory attitudes from healthcare professionals, lack of SRHR information by service users and providers and unequal distribution and resourcing of healthcare facilities.
5. There is an urgent need to align laws with international human rights norms and standards. Laws that criminalise sex work and the transmission of HIV have a direct impact on the health-seeking behavior and quality of services received by affected persons.
6. HIV prevention and treatment remains a major challenge for the healthcare system. Protection gaps and key concerns

include lack of access to specialized STI/HIV and SRH services and discrimination by healthcare providers, and an increase in mother to child transmission of HIV/AIDS [UNCT Para 53].

7. Comprehensive Sexuality Education (CSE) programs do not extend to children or young people based in non-formal or out of school settings including those from the young key populations. Many young persons from key popula-

tions are not in school, often as a result of the discrimination they experience in schools, and are not reached by school-based programs. Despite a decade long partnership between the Albanian state and UNFPA and national civil society groups to institutionalize school-based CSE, and the current curriculum review process that is underway, widespread resistance to school-based sexuality education persists.



Barriers to access to healthcare services: violence and discrimination

Laws and policies

8. Fundamental rights and freedoms, principles of non-discrimination, equity and the right of special protection for 'children, the young, pregnant women and new mothers' are included in the Albanian Constitution.
9. The Law no.8876/2002 'On Reproductive Health'¹ amended recognizes and protects the reproductive rights of individuals to make decisions freely and without coercion about their reproductive lives, and stipulates a series of measures for maternal health.
10. Healthcare Law², "Reproductive Health Law and Public Health Law ³ does not provide any specific reference to sexual orientation, gender identity or LGBTI persons' rights or particular healthcare needs. For transgender persons, access to gender-confirming surgery is also limited. Conversely, intersex persons are often forced into unnecessary medical interventions. In-vitro fertilization (IVF) and assistive reproduction technology (ART) are not available to LGBTI persons. The Criminal Code does not criminalize forced sterilization.
11. Law no.8045/1995 'on Interruption of Pregnancy' amended, legalized abortion in 1995. Abortion can only be performed by obstetrician-gynecologists which reduces access to legal abortion, particularly for women in rural areas or from under-serviced communities. Abortion carries an age of consent of 16 years. The use of pre-natal screening to determine the sex of the fetus, in order to provide for sex-selective abortion is not permitted⁴.
12. The Anti-Discrimination Law no.10221/2010 includes sexual orientation and gender identity as prohibited grounds of discrimination. Same-sex relations and the expression of LGBTI identities are no longer a criminal offence.
13. The National Action Plan on LGBTI 2016-2020 is the main policy document addressing the problems and issues affecting the lives of LGBTI people and leading to inequalities and discrimination including in education, employment, health and housing.⁵
14. The Criminal Code criminalizes abortion without the consent of the pregnant woman.⁶Article 96 of the Criminal Code established criminal responsibility for HIV transmission "from partner to partner or among married couples if the HIV status is not disclosed". Article 113, 114 and 115 of the Criminal Code criminalise various aspects of sex work including

the selling, buying or living off the proceeds of sex work.

15. WHO has supported the inclusion of universal health care coverage into the National Strategy for Development and Integration 2020 and the process of developing the Albanian National Health Strategy 2016–2020⁷, as a means of achieving the Sustainable Development Goals (SDGs⁸). While specific attention is paid to women in the National Strat-

egy for Sexual and Reproductive Health 2016-2020, the National Health Strategy 2016-2020 does not include women's health and well-being as separate items, making it difficult to develop appropriate interventions for women and girls.

16. There is no national strategy in Albania for the prevention and control of viral hepatitis although interferon alpha is on the national essential medicines list for the treatment of hepatitis C.



Access to Available, Accessible, Acceptable and Quality healthcare services

17. It is more difficult for persons from vulnerable groups to access the healthcare and treatment they need. The Progress Report for Albania of the European Commission for 2018, highlighted that: 'reducing health inequalities, access to services needs to be strengthened for vulnerable populations, including women, Roma and Egyptian minorities, people with disabilities and populations in rural or remote areas'.
18. In practice, LGBTI persons lack full access to healthcare and experience poor service quality. Typically, doctors presume that patients are heterosexual, and thus, the specific health needs related to SOGI are not discussed⁹. Sexual orientation and gender identity are not recorded in the medical files besides in cases of voluntary HIV tests¹⁰. In the absence of statistics is difficult to design policy on issues related to LGBTI health. In 2015, Alliance LGBTI had thirteen cases of discrimination in accessing healthcare. In one case, it was not possible to access necessary healthcare services without the individual being accompanied by a representative from Alliance LGBT. LGBTI people reported being dis-

criminated against and they felt that the doctors were showing stigmatizing and negative attitudes towards them¹¹.

19. About 12% of Roma women aged 15 to 30 years, do not receive any medical care, including antenatal checkups, during pregnancy, while 35% undergo up to three healthcare checks during pregnancy. Data shows that 51% of Roma and 25.8% of Egyptian women who give birth do not receive post-natal health checks at all. Consequently, many Roma and Egyptian women are affected by various health problems. 19.2% of Roma and 10.9% of Egyptian respondents have experienced infant mortality. This is due to socio-economic factors and insufficient access to healthcare¹².

Corruption, and other financial barriers to healthcare services

20. Albania's government spending on healthcare is about 2.6% of the GDP. This is lower than that of countries with similar levels of income and the lowest in the SEE¹³. A recent study notes, "... there is a limited financial protection for the poor, with high out-of-pocket expenditure rates, estimated at 55 percent of total expenditures on health".

21. As stated by the OSF¹⁴ survey, 50% of Roma persons do not have health insurance cards, which reduce their access to free and reimbursed services. Even when a Roma person has a card, corrupt healthcare demand illicit payments, and survey respondents indicated this as a reason for not seeking medical care¹⁵. The Progress Report of the European Commission for 2018 clearly states that 'most unemployed Roma and Egyptians have difficulties accessing healthcare due to complicated procedures for obtaining health cards. In fact, overall

access to public services for Roma remains difficult, particularly in rural areas'.¹⁶

22. Access to antenatal care was considerably higher among higher-income individuals (91%) than those in the lower-income category (49%). In addition, there was a slight difference between income groups in the percentage of births attended by skilled healthcare personnel (95% in the worse-off subgroup vs. 100% in the better-off category).¹⁷



Discrimination

23. Access to services is impeded by unprofessional, biased and discriminatory attitudes and behaviour of personnel and staff at healthcare centers¹⁸. The Progress Report for Albania of the European Commission for 2016¹⁹ noted that 'Roma and Egyptians continued to face very difficult conditions and frequent discrimination, particularly on access to education, employment, housing, health and civil registration'. Other reports²⁰ also highlight the lack of implementation of laws against discrimination.²¹
24. There are specific factors that have a negative impact on Roma persons' sexual wellbeing and health-seeking behavior. Only 60 percent of Roma persons have received formal education and there is inadequate provision of non-school based education programs. They experience high levels of stigma, discrimination and exclusion by state and non-state actors, and are often subjected to open hostility from service providers.
25. Roma women and girls also have less access to comprehensive sexuality education and Sexual Reproductive Health services – including HIV and STI prevention programs. This increases Roma women and girls' vulnerability to STIs, including HIV.
26. Roma women and girls experience higher levels of sexual violence and coercion. According to the Integrated Biological and Behavioral Assessment report (IBBS) 2011, one in five Roma women are forced to have sex by their partners²².
27. Discrimination against LGBTI people persists. There is little awareness among civil servants, healthcare professionals and law enforcement officers about sexual orientation, gender identity and expression and the human rights of LGBTI persons. LGBTI persons frequently face discrimination by healthcare professionals because of their sexual orientation and gender identity and expression²³. In 2015, the People's Advocate report found that the medical services were insensitive and unfriendly to LGBTI persons^{24,25}. LGBT Alliance reports incidents where lesbian and gay persons did not receive proper treatment from healthcare professionals and the case of two transgender women who, after having been subjected to hate crimes, faced degrading and offensive treatment by healthcare staff, who initially refused to treat them²⁶.
28. A study among Young Key Populations from marginalized groups (such as MSM, IDU, LGBTI and Sex Workers)²⁷ shows that for the majority of participants the "first door" in receiving healthcare services and information about health problems is the pharmacist in

their neighborhood or their social network²⁸. A young respondent in the study, who was an injecting drug user, said, "... for every problem, first I go to the pharmacy which is close to where I live, and the pharmacist not only gives me [treatment], but also advises me how to use it. All in all, this is the place where we pray

and solve our health problems"²⁹. Family members and state and non-state healthcare services are their last option, for fear of being labeled as "people with deviant behaviors", or stigmatized and discriminated against by the community and their families as well.



Geographical barriers, gaps in public health personnel and equipment

29. There are shortfalls in the service provision infrastructure³⁰, long distances to access healthcare centers³¹ and lack of specialized services³², lack of access to specialized STI/HIV and SHR services are barriers to the realization of the right to health³³. Every year, hundreds of general practitioners and specialists leave Albania to work in other countries leaving significant human resource deficiencies in Albanian hospitals³⁴. The problem is more acute in rural areas which lack specialized healthcare personnel.
30. Emergency obstetrical services are limited or absent in small districts which cause the increasing maternal mortality rates. The distance to health services tend to be higher for Roma persons, due to the location and the lack of services of the neighborhoods where they are concentrated. The physical distance is aggravated by the anticipation of negative interactions with health services and fears of discrimination.
31. The Primary Health Care (PHC) centers have a considerable shortage of diagnostic and treatment equipment and no

standard list of equipment. One study³⁵ confirmed patients' poor access to laboratory services, especially in rural areas. Even for simple blood and urine analysis, patients have to go to polyclinics. The PHC centers are in charge of maintaining equipment. However, the outdated equipment, the lack of qualified specialists, especially at the local level, and the limited budget puts strains on ensuring equitable access in PHC.

Barriers and gaps in Sexual and Reproductive Services

32. SRH services and contraceptive supplies are available free of charge and without age restrictions. Emergency contraception is available without prescription. Abortion services were obtained in the majority of cases in state care health facilities. Anyone 18 or older has to pay for abortion services if they do not have health insurance. The cost is around USD 45. Post-abortion care is not always accessible – particularly for marginalized persons, for instance one study found that none of the sex workers interviewed who had abortions had received post-abortion care.³⁶
33. Condoms were mainly provided by

NGOs. Another source are pharmacies (drugstores) and supermarkets³⁷ or sexual partners/clients – particularly for sex workers, and MSM persons. Pharmacies were the only source for obtaining modern contraception methods, mainly emergency pills.

34. Lack of integrated services results in critical health gaps that limit the effectiveness of SRH programs and compromise the health, wellbeing of persons from vulnerable groups. Services

for SRH are centered mainly on family planning services and do not offer comprehensive and integrated services. For instance, women in rural areas and other vulnerable groups, lack SRH information and have limited access to SRH services³⁸. Significant gaps remain in addressing gender-based violence; providing mental health screening and screening for cancers of the reproductive system; and drafting of legislation that guarantees the rights of transgender men/women.



35. The viral hepatitis prevention and control program within the Department of Infection and Disease Control of the MoH does not target PWID, or any other key affected populations³⁹. A study conducted in 2014 found that Viral/Chronic Hepatitis cases had increased. Hepatitis C (anti HCV) prevalence among people who inject drugs increased from 8% in 2008 to 28.8% in 2014. Hepatitis B prevalence among PWID was 11.5% in 2014.⁴⁰ According to a WHO report ‘the government does not collaborate with in-country civil society groups to develop and implement its viral hepatitis prevention and control program’, although there is reportedly a national surveillance system for acute hepatitis A, B and C but not for any type of chronic hepatitis’⁴¹.
36. In order to address the absence of state provided youth-friendly SRH and HIV/AIDS services to persons from minority groups and key populations, the Albanian Center for Population and Development (ACPD), an IPPF Member Association, and a few other NGOs offer these services. The ACPD has established youth-friendly SRH standards in its two clinic centers, enabling stigma-free, rights-based and gender-sensitive services for young people, including young key populations. Young key populations are also reached through community-based mobile and outreach services for SRH and HIV. Currently the ACPD doesn’t receive any financial support

from the Albanian government to deliver these services.

Data-collection and monitoring difficulties

37. Health statistics are neither standardized, harmonized, nor sex-disaggregated. Efforts have so far been hindered by different collection methodologies and different standards used by key health actors such as the Albanian Institute of Statistics (INSTAT), the Ministry of Health, Institute of Public Health (IPH) hospitals, and other health institutions. This challenge negatively affects the quality, accuracy, and accessibility of administrative data. This has made the monitoring of the impact of national health policy and legislation on women and girls very difficult as the main health indicators are still to be established⁴². In order to remedy this situation, in late 2015, the MoH and the IPH started compiling a list of health indicators based on the European Core Health Indicators (ECHI) and a Manual of Core Health Indicators has been developed⁴³. Respective health indicators were piloted recently, while large-scale implementation has not yet begun.⁴⁴ Data at the IPH are more comprehensive. They include thematic data and information from the primary health care system as well as from (public) hospitals.

HIV/AIDS prevalence and concerns

38. Prevailing gender differentials, stigma and discrimination, and poverty impede access to appropriate services. Albania is a traditional and patriarchal society in which stigma and discrimination play a significant role in preventing members of key affected populations accessing HIV testing for earlier diagnosis and treatment of HIV infection.
39. Gender inequality, rigid gender norms and stereotypes, and restricted social

autonomy among women is directly linked to lower access to sexual health services, including HIV testing and treatment. Financial disparities and intimate partner violence in relationships often hinder the woman's ability to negotiate condom use and protect herself from HIV.

40. Too often young key populations are unable to benefit from the rights and privileges of the social system that are generally available to other people. There were 883 reported cases of persons testing positive for HIV by 2015. In 2017, 69 men and 25 women (2 of them were pregnant) were newly diagnosed



as HIV positive.⁴⁵ In 2016, 105 men and 23 women (3 were pregnant and 1 was between the ages of 0-17) tested positive for HIV⁴⁶. The UNAIDS online database shows an incidence-to-prevalence ratio in Albania of 0.07% for 2017⁴⁷.

41. The majority of persons living with HIV (PLHIV) in Albania are unaware of their HIV status and thus unlikely to be accessing treatment or care; or using prophylaxis against reinfection or transmitting the virus⁴⁸. Figures show that uptake of HIV tests in the country is very low (1.1/1000 population) and HIV-related deaths in the country is likely to be underestimated. High levels of discrimination or stigma towards LGBT and lack of capacities to provide quality SRH and HIV services for this community impede them to get the needed care.
42. HIV prevention programs in Albanian prisons are small in scale and rarely comprehensive. A pilot program supported by UNFPA in 2015 established five voluntary counselling and testing (VCT) centers in prisons (4 male and 1 female prison), and developed guidelines on HIV management and training prison health and security staff. A surveillance reporting system was also instituted⁴⁹. The study showed that early detection of HIV and other STIs, and access to services, improved in prisons with VCT.
43. In July 2015, the MoH in collaboration with UNFPA approved protocols for the

prevention of mother to child sexually transmitted infections (STIs) and HIV transmission⁵⁰. Antenatal services to screen pregnant women for HIV and facilitate early diagnosis, provision of counseling services in mother and child health centers, and free distribution of anti-retroviral medicines are envisaged in Strategic Document and Action Plan for Sexual Reproductive Health 2017-2021 and foreseen in the Basic Package of Primary Health Care Services.⁵¹

44. Beyond positive legal aspects, mother to child transmission is a growing concern, representing 31 or 3.5% of the total reported cases⁵². While in 2013, six cases of MTCT were reported. Assuming a HIV transmission rate of 25% among untreated HIV positive women⁵³; this means at least 24 HIV positive women were pregnant in Albania in 2013 and 16 others in 2014. This is likely to be a conservative estimate because most people are diagnosed late and other infants who acquired their infection vertically may not yet be symptomatic and presenting for HIV testing. Uptake of voluntary counseling and testing (VCT) remains low; VCT services involve the collection of blood samples and lengthy pre-test counseling which may deter those most at risk of HIV. To address this, "provider-initiated testing and counseling" in antenatal care settings across the country, which will be introduced through the Global Fund Program. Services will also be promoted for pregnant women

through campaigns, and efforts will be made to address stigma and discrimination⁵⁴.

45. Initial diagnosis is delayed until the late stages of disease. More than 70 percent of persons newly diagnosed are symptomatic and approximately half of patients newly enrolled in anti-retroviral treatment programs in 2014 present with CD4 counts below 200. Following a positive HIV diagnosis, patients are referred to a psychologist and referred to the University Hospital Centre Mother Teresa (UHCMT), for HIV treatment and care.

46. Excluding those who are reported to be deceased, as of the end of 2013, 58% of those ever diagnosed with HIV in the country receive HIV treatment and care⁵⁵. However, over a third of persons diagnosed are not accounted for in monitoring systems and patients who do not attend HIV care following their diagnosis are not actively followed up. This incurs an additional risk for reinfection, ongoing transmission, as well as increased morbidity and mortality. As of February 2015, 21 children and 339 adult patients with HIV were receiving ART in Albania; these treatments have been interrupted on a regular basis for



up to three months due to ARV drug stock-outs. Seventeen physicians provide medical services for these 360 patients in total, with uneven patient loads. Even though CSOs spoke up about this situation and addressed the issue to the responsible institutions much should be done to ensure timely and quality treatment for HIV people.

47. NPOs report that the main obstacle remains stigma and discrimination against PLHIV, which results in the delay in HIV testing, late diagnosis and access to care. Multisectoral, integrated and holistic services for PLHIV and their family members, including standardized healthcare, psycho-social, supportive, educational, legal and referral systems, information on illness, facilitating financial problems for families of children, handling of cases abandonment, end-of-life care, are almost completely absent and urgently needed.
48. HIV prevalence among people who inject drugs (PWID) appears to be low. Only 1% of diagnosis reports relating to injecting drug use⁵⁶. Nevertheless, methadone maintenance treatment (MMT) services currently prescribe less than the recommended 60-120 mg; not taking the recommended dose of methadone treatment might lead to heroin uptake/injection and might increase the risk for HIV transmission if needles and syringes are shared. Institute of Public Health (IPH), supported by the Joint

United Nations Program on AIDS (UNAIDS) carried out a population size estimate of the number of PWID using the multiplier and capture-recapture method. It was estimated that the number of PWID ranges from 4,000 to about 6,000⁵⁷. Among these, 32% are aged 24 years or under and the majority are unmarried (63%); and over 10% of PWID are without formal education and with limited access to information.

Discrimination

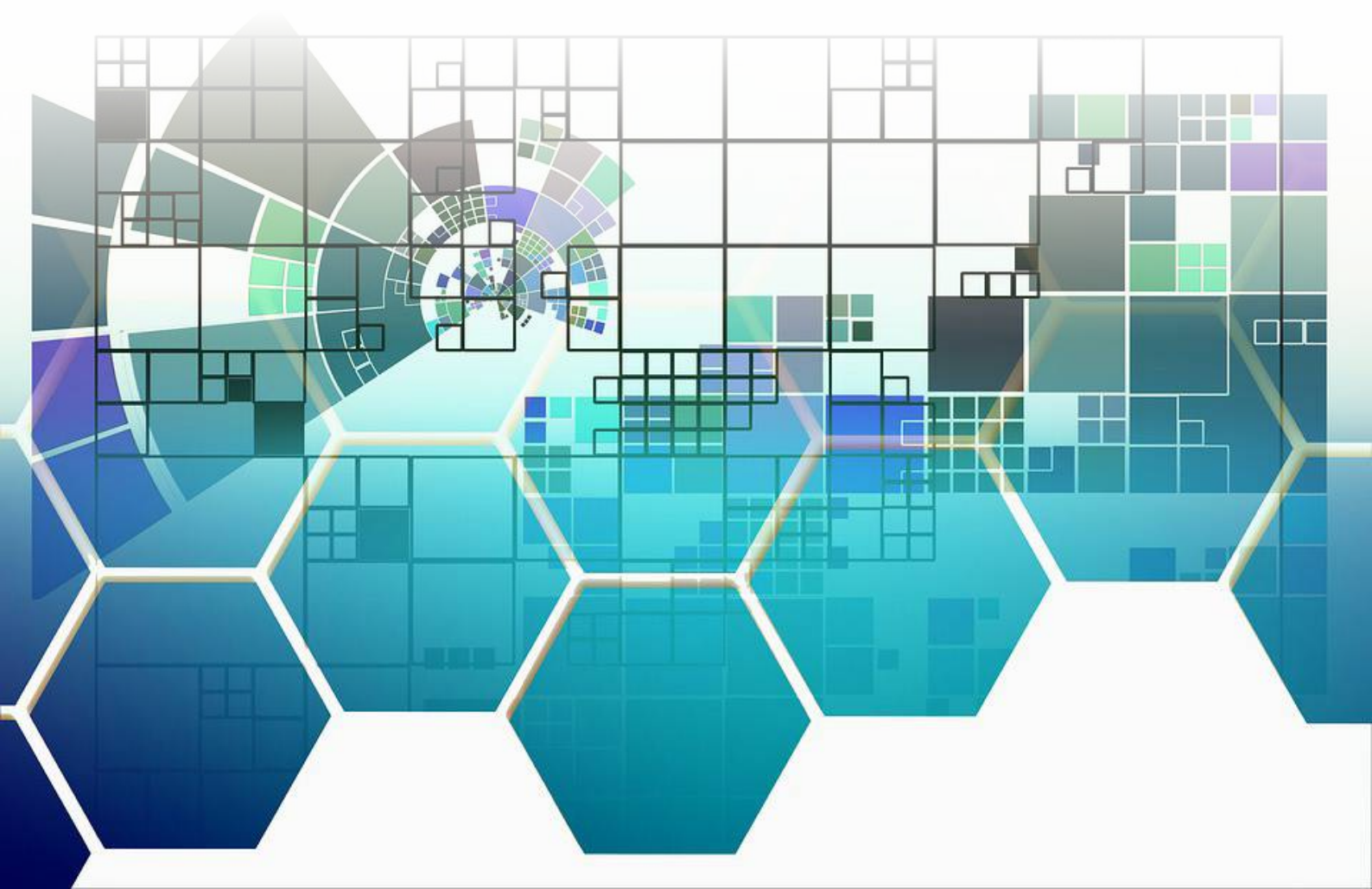
49. Health care workers and other professional service providers in the social sector have attitudes that negatively influence health seeking behaviors of key affected populations and PL HIV/AIDS⁵⁸. One of the NPO that works with PLHIV report: "The main obstacle remains stigma and discrimination against PLHIV, which affects the delay in HIV testing, late diagnosis and access to care. The majority of these issues remain the responsibility, burden and commitment of health institutions, social services and those of local government seeking solutions. In Albania, cases of abandonment, social isolation, stigma and discrimination for persons living with HIV/AIDS are evident".

Data and statistics

50. The continuum of care in Albania is hampered by the absence of data collected for several key measures. Clinical data is registered on paper charts. HIV/STI data-collection and reporting protocols exist, but most health-care providers do not systematically collect or report the required data. STI data are particularly unreliable, also due to lack of accountability and supervision of the private health sector. The overall HIS system is still weak and its rollout has been slow. As a result, available data is

fragmented and unreliable, while the available data is not systematically used for policy and program development.

51. Data are not available to perform a treatment/continuum of care cascade analysis for HIV in the country, and measurements of HIV RNA (viral load testing) are largely unavailable due to a lack of reagents⁵⁹. As a result, it is impossible to estimate the percentage of PLHIV who achieve suppression of viral load and no data is available regarding prevalence of antiviral resistance. Albania health system does not have a clinical management information system for HIV data tracking.



Men who have sex with men (MSM)

52. For fear of stigma, discrimination and isolation MSM are not open about their same sex conduct or sexual orientation. There is no estimation of the HIV prevalence regarding MSM. The latest IBBS survey (2011)⁶⁰ estimated HIV prevalence to range between 0.5 and 3.0% among MSM surveyed between 2005 and 2011. However, the IBBS sample size for each year is restricted to Tirana. This fact, combined with the unlikelihood of MSM self-identifying as homosexual, or non heterosexual, in a hetero-normative environment, limits the validity of this estimate. While most HIV cases are assumed to be acquired through opposite sex conduct, the 2 to 1 ratio of male to female diagnoses indicates that there may be substantial under-reporting of infections acquired through same sex conduct between men. Homosexual, bisexual men and other MSM remain a hidden and stigmatised population. Anecdotal evidence suggests that MSM are likely to be victims of verbal or physical abuse.
53. The vulnerability and stigmatization of MSM has several associated effects. The IBBS (2011) shows that up to 75% of MSM are in sexual relationships with wives or girlfriends with many men re-

porting sex with other men only when abroad. Approximately one quarter to a third of sexually active MSM report having four or more concurrent male partners. Over 75% of MSM report engaging in sexual conduct with female partners; only 14% of MSM report using condoms consistently. It is estimated that more than one-fifth of MSM inject drugs (21%). In Tirana, heroin is the most frequently injected drug for MSM. The low rates of condom use during sex mean MSM are particularly vulnerable to HIV, while a high level of stigma causes HIV testing services may be perceived as user-friendly. Only 24% of MSM report ever having an HIV test while sexual identity is not reported with HIV testing data. This fact, combined with the 2:1 ratio of male to female diagnoses suggests that HIV prevalence for MSM is likely to be underestimated; and such men are at risk of presenting late for diagnosis.

Sex workers (SW)

54. Sex work is illegal in Albania. It is considered a criminal act.⁶¹ Data on population size, and health status⁶² of sex workers is very limited. Two types of sex work can be distinguished: street-based and motel/hotel/apartment-based or 'indoor' sex work. Street-based sex work is most visible. Street based sex workers face daily threats of violence, discrimination and police action, while at

the same time lack access to adequate social and health services, including HIV prevention. IBBS study⁶³ (2011) found that about a third of respondents started engaging in SW around the age of 18. While most report using condoms, consistent condom use is limited, with approximately one-quarter not using condoms during their last sexual interaction with a client. In the SWAN study, SW reported police seizing or destroying their condoms. SW also recounted having experienced police using or threatening to use their condoms as “evidence of a crime”. Though less frequent than the seizure or destruction of condoms, the phenomenon of “condoms as evidence” was nonetheless reported at a high rate in Albania (50%). The SW have reported high levels of arrest, extortion, physical and sexual violence by police. “I am scared [to report police violence] because [the police] beat me. Worse, they can kill me.” (Roma trans woman, SW and drug user, Albania).⁶⁴

55. A quarter of SWs use drugs, with almost 8% having injected drugs at least once in the last 12 months. More than half of these women are of Roma descent. In addition to female SWs, there are a considerable number of male SWs, mainly selling sex to other men. A study of UNFPA⁶⁵ has identified challenges in gaining access and trust members of these groups.
56. SW are highly stigmatized and discriminated. It is difficult to reach them directly to offer information and services on SRHR. Some use mobile phones or Internet to get in contact with clients, while others work through brothel managers, pimps, taxi drivers. Non Governmental Organizations provide support for a small group of SW such as: peer to peer education, counseling, education session on HIV/AIDS, Sexually Transmitted Infections (STI).

Comprehensive sexuality education and youth empowerment

- Albania has made remarkable progress in developing and implementing comprehensive sexuality education at pre-university level⁶⁶. A 'Positioning Paper on Comprehensive Sexuality Education for Young People in Albania' is approved in 2012 and from 2015 Comprehensive Sexuality Education started to be implemented in schools. However, the SE program has not been developed to reach out to the children/young people from key populations in informal settings. Many young key populations are not in school and are not reached by school-based programs.
- There is widespread opposition to school SE in the country. Parents, caregivers, community members and teachers as well see SE as a factor leading to "early" sex. They argue that it runs against the Albanian culture, that schools should promote moral values instead of implementing SE. They feel that SE might be okay for young people but not for children and young people at young ages.⁶⁷
- Training of health-care providers should include a human rights based approach to addressing the needs of young persons from key populations. For example, one of the objectives of the MISP is reducing HIV transmission, and planning for comprehensive SRH care (integrated into primary health care where possible). Trainers can include information on young key populations into this topic in order to increase providers' capacity to offer stigma-free, respectful services and make them aware of the issues facing young sex workers, young MSM, young people who inject drugs, etc.⁶⁸
- In June 2017, UNFPA Albania launched the establishment of the "Media Platform on Sexual and Reproductive Health". This initiative is creating a network of journalists that collaborate on issues pertaining to SRH, including gender-based violence/harmful practices and healthy lifestyles, with a special focus on young people and to support one another to report on SRHR topics that receive less coverage, or are reported on in ways that reinforce stereotypes and discrimination. Through this SRH media platform, journalists will find support and opportunities to share ideas, news, stories, data and open debates in the media about comprehensive SE, family planning and use of modern contraceptives, STIs and HIV, unintended pregnancies, early/child marriages and harmful practices, teenage pregnancies and abortions and influence on education and well-being of young people, youth empowerment and youth participation in decision-making affecting their lives, fight against violence and gender inequalities and much more.

Recommendations for action

Barriers to access to health services. Violence and Discrimination

- Decriminalise all aspects of adult consensual sex work by repealing Articles 113, 114 and 115 of the Criminal Code.
- Develop and implement minimum standards for the effective participation of representatives of minority and marginalized groups, including persons from key populations, Roma and Egyptian persons, women and youth, in the design, implementation, monitoring and evaluation of policies, programs and health measures.
- Increase public health expenditure and establish an adequate budgetary allocation to health care in order to increase access to free or affordable health services for all, including marginalized persons and persons living in rural areas, and put in place anti-corruption measures.
- Accelerate efforts to develop programmes and policies that end all forms of discrimination, including son preference and gender-biased sex selection.

- Conduct regular national monitoring, through inter alia broad-based surveys of a robust set of sexual and reproductive health indicators disaggregated by relevant factors including gender identity, sexual orientation, age, location, race, ethnicity and others and use these to inform programs and services.

HIV and AIDS

- Decriminalize HIV transmission and review other laws and policies which deter persons from accessing HIV prevention and treatment services.
- Scale up HIV Prevention, Testing and Care Programs particularly for hard-to-reach communities and persons from key populations.

Comprehensive Sexuality Education

- Ensure the participation and views of youth, including out of school youth, from key populations and marginalized groups are actively sought out and included in the review of existing implementation of CSE in formal and informal settings, particularly in rural and underserved and marginalized communities, to strengthen the curriculum, implementation and impact of CSE.

Endnotes

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- 4 In 2011 the Parliamentary Assembly of the Council of Europe highlighted alarming levels of skewed sex ratio at birth in several Council of Europe member countries, including Albania, where the rate stood at 112 /100 compared to a normal sex ratio at birth of 102-106 males to 100 females. Several international human rights bodies have equated pre-natal sex-selection to an act of violence against women and called on states to enact legislation prohibiting such practice. A comparison between the results of demographic surveys would indicate improvements in this ratio over the last decades. However, stakeholders on the ground pointed to the need for more up-to-date data allowing for an accurate assessment of the situation Council of Europe, (2017). GREVIO's (Baseline) Evaluation Report on legislative and other measures giving effect to the provisions of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention) ALBANIA. INSTAT (2018). Women and men in Albania.
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