PLAN OF MONITORING NCD IN ALBANIA

FRAMEWORK OF INDICATORS AND THEIR METADATA

2018

Alban Ylli

Eduard Kakarriqi

1. INTRODUCTION: DEFINITION AND TERMINOLOGY. CHRONIC DISEASES OR NON INFECTIOUS DISEASES

The most frequent diseases, which started to massively affect the health of Albanians during the end of 20th century and that now, in the new century, are the major threat to public health, have been traditionally called ‘chronic diseases’ or even ‘degenerative diseases’
These terms had their limits in describing the group of diseases of interest here, with tuberculosi, syphilis or AIDS showing a ’chronic’ development, while heart attack or stroke being ’acute’ manifestations of the continuum of blood circulation diseases. Furthermore, the term ’degenerative diseases’ is too broad and missleading, with its underlying conotation of the unstopable process of human body geting old and frail
’Non infective diseases’ (NCD) is the term most widely accepted as the appropriate name for the group of diseases which dont get typically trasmited by means of direct contact or by various vectors. It is not the ideal term for diseases which have a infective agent at the basis of their pathogenesis, such as rheumatismal heart disease or cancer of cervix, but it is generally efective for describing together in a category, from a public health point of view, health problems such as ischemic heart diseases, hypertension, cerebrovascular diseases, tumors, diabetes, chronic obstructive lung diseases etc. Although, these diseases have important specifics and diferences among them, their control strategies, or the organisation of an health system for them have a lot in common.

2. MONITORING/SURVEILLANCE OF NCDS AND THEIR RISK FACTORS

The monitoring process or the survveillance of NCDs would be the systematic and continous collection of data and their analyses for providing the due insight on their time and space distribution, their health impact and burden in society, as well as their risk factors and socio economic determinats.
NCD monitoring should also provide information on health system capacities and efectiveness in facing them. NCD monitoring is indinspensable in setting up health programs, developing health-related policies and documenting potential progress in NCD prevention and control.
The NCD monitoring system in Albania should have three principal components:

1. Monitoring for exposure to risk factors

2. Monitoring health outcomes (NCD related mortality and morbidity rates)

3. Evaluation of NCD-related health system response capacities

The following table gives a general model and few details to be followed during the process of developing a NCD monitoring or surveillance system

Table 1. Dimensions of NCD control and monitoring/surveillance approaches

1	Exposures
	Risk factors related to lifestyle: smoking, unhealthy diet, insuficient physical activitiy, alcohol abuse. Metabolic risk factors: hypertension, overweight/obezity, high blood cholesterol high blood sugar. Social determinants: education, income, acess to health services.
2	Health outcomes
	Mortality rate: diseases specific mortality rate. Morbidity: incidence and/or prevalence of morbidity rates for specific NCDs
3	Evaluation of health system capacities
	Assesing interventions and capacities: Infrastructure and resources, polcies and programs, access and coverage with essencial services for early detection, treatment or emergencies.

2.1 Categories of indicators for NCDs in Albania. Potentials and limits

Categories of NCD indicators as mentioned before, differ from each other in many aspects, including validity, practicity, timeliness, costs etc.

a. Mortality rates

Mortality rate shows the proportion of deaths from a specific cause as defined by the international system for classification of diseases (ICD) in the given population and in the given year.

This indicator has some advantages compared to the others:

- In theory is the most complete in terms of time and space

- It is not influenced by changes in service utilisation or health seeking behaviour in the population.
- It is based upon a legally and traditionally strong system; the death certificate reporting.

Mortality data analyses allows for insights on the NCD time and space trends in the past. There are noted, nonetheless, many practical problems related to completeness of the information and its quality. Some international reports consider quite poorly the quality of information received from death certificates in Albania for some NCD, such as cancer.

b. Morbidity rates

Morbidity rate is the proportion of specific diseases as classified by ICD in the population which has produced those diseases in a given time.
Morbidity rate could be estimated in some different ways depending on resources and service utilisation profile;

b.1.1. Aggregated data on hospitalized cases. In Albania, the aggregated data (total cases per year classified by disease, sex, standardised age groups and urban/rural) are traditionally reported by each hospital to Ministry of Health. It is based on ICD9. Its main aim is to gather information for more effective and more efficient hospital management. Nevertheless the data produced by this information system have been used and could still be used for monitoring also disease frequency, being cautious in their interpretation.
Main advantage of this indicator is its timely description of trends and situations on NCD cases in hospitals, as well as its relative diagnosis accuracy, because of the human and infrastructure potentials existing in hospitals for diagnoses.
Nonetheless, this category of indicators has some serious problems which significantly reduce its validity;

- It is enormously affected by utilisation of health care profile; in many cases diseases aren't reported simply because many persons don't go and see a doctor when they have a symptom or some don't go to the public hospital when they are referred to, by primary health care professionals. This profile is different for different diseases and it is affected by gravity of disease or existence of disease-specific appropriate services

- Health information systems producing these indicators focus on hospital management and not population health; aggregated data don't allow identification of individual cases which are hospitalized many times, in the same hospital or in different hospitals in different levels of the health system. In addition, new cases of disease can't be distinguished from existing cases.

b.1.2. A similar category of indicators is that based on information system which monitors the utilisation of primary health care services. Although the utilisation of these services are considered to be higher compared to hospitals and its access better, the data aggregation problems remain while the difficulties for diagnoses in primary health care makes this sub-category of indicators even less valid in NCD monitoring.

b.1.3. The new model of primary health care based 'check-up' services (for people 40-65 years) and its specific monitoring system could provide another opportunity for exploring some NCD or NCD related risk factors, if it succeeds in reaching a good population coverage for these services. Only in case of massive population coverage, this system would provide benefits for estimating the NCD risk factors prevalence such as unhealthy lifestyles or metabolic factors in specific age groups (high blood cholesterol, glycaemia or hypertension).

2.1.4 Another information system with importance for NCD monitoring is being built in Albania, staring from last year (2014); Case based reporting of four groups of NCD are regulated with a decision of Albanian Government. Traditionally case-based surveillance has existed in Albania only for infectious diseases. Now the system is expanded for NCDs, such as tumours, cerebro-vascular diseases (stroke), ischemic heart diseases and diabetes. This model of receiving detailed data from all health institutions with capacities for diagnoses and care for the requested diseases, will contribute in effective identification of new cases and their characteristics. It, nonetheless, wont fully avoid service utilisation variability for some cases of cancers, some ischemic heart diseases and especially for diabetes.

b.2.1. Population based morbidity rate, is the number of disease cases identified in population and usually needs application of a special survey on a population sample.
This indicator would give in theory the most accurate reflection of disease frequency in population, but it has limits as well;

- A good diagnosis needs typically, professional skills, examinations and time. It is hard to be achieved outside specialised clinical settings. It is very hard to apply complicated procedures for diagnosing specific diseases with only structured questionnaires or rapid tests.
- It adds to other logistical difficulties and costs related to population surveys; sending trained investigators to contact selected individuals in their households in community is always a tricky and challenging enterprise.

b.2.2. The introduction into survey questionnaires of structured questions asking for diseases 'diagnosed by a doctor' is a compromise which solves partially the diagnoses validity problem, but it adds, on the other hand, the problem of health care seeking behaviour. Consequently, the survey could produce valid information about disease diagnoses, but with the expected loos of many cases since many people in community are not contacting their doctors.

c. Prevalence of Risk Factors

For a number of NCDs, such as ischemic heart diseases, stroke or lung cancer, there is good knowledge of causal risk factors, which virtually permits the projection of disease in the future.

Therefore, we can use information on distribution of exposure to lifestyle and metabolic risk factors for estimating future trends for selected NCDs as well as planning for health services. Indicators based on risk factors are also extremely valuable in a time when focus of NCD control policies in Albania is oriented toward risk factors control, through promotion of healthy a life style and early detection of high risk groups.

All the same, this group of indicators has its own disadvantages because:

- Gives little information on the burden of NCDs at the moment of analyses. In addition like the above described indicator,
- Requires implementation population surveys which in some cases (metabolic factors) are quite technologically sophisticated and demanding.

3. A SHORT INSIGHT ON EXISITING INFORMATION SYSTEMS RELATED TO NCDs IN ALBANIA.

A scheme of institutions and the flow of health information related to NCDs in Albania is presented in annexes.

3.1. INSTAT

Institute of Statistic (INSTAT), which is legally the main institution about statistics in Albania, collects information of causes of deaths through death certificates, a document to be completed from hospital doctors if death occurs at the hospital settings or by family doctor if death occurs at home.

Instat analyses the data and prepares reports about the causes of deaths for 17 groups of diseases. Mortality rates are given for 100 000 inhabitants, based on population projections, calculated from Instat itself. Mortality rates could be disaggregated according to sex, age and region.

Death causes are still classified after ICD9, whereas the introduction of the new system of ICD10 is still in process.

3.2. Institute of Public Health

Institute of Public Health gets the information about causes of death from the reports published by Instat, and doesn't have access on the detailed databases. Although in theory Institute of Public Health should be involved in deciding about the format and structure of data presentation, it is not consulted and often information about causes of death is presented in a way which doesn't permit estimation of specific important NCDs (no breast cancer or no cervical cancer for example) Instituti i

Instat has made some correction on the total mortality rate estimations during last 5 years, changing some 'ad posteriori' historical data.

Hospital morbidity data are systematically collected by statistical offices of every hospital before being sent aggregated to Ministry of Health. Institute of Public Health analyses these information and has access in detailed data. The hospital based data have information on diseases classified according to ICD9, and allow disaggregation for sex, some fixed age groups, region and rural/urban.

Health care utilisation is registered at primary health care also and there are data on chronic patients. Approved forms are reported periodically at the Fund for financing health care and could be used by Institute of Public Health. Classification is done in rough groups of diseases and not according to ICD9, making difficult any comparative analyses.

A decision of Council of Ministers of the year 2014 has introduced into Albanian health care the services of 'check up' for people 40-65 years old. Its information system is based on reporting the activity in approved forms. The aggregated information allows the analyses of positive cases of a number of metabolic factors (high blood cholesterol, glycaemia or hypertension) according to health centers, sex and age.

Another decision of Council of Ministers of the year 2014 laid the bases for setting up 4 new information systems on NCDs in the form of case-based disease registries. Cancers, ischemic heart diseases, strokes, and diabetes must be reported every 6 months to Institute of Public Health by every relevant health service provider. The requested forms are detailed enough to permit disaggregation according person characteristics, diagnoses, place of living, treatment and they avoid the case duplications.

Apart of monitoring diseases in health services, Institute of Public Health carries out surveys for systematic monitoring of a number of risk factors in general population or selected population groups (health behaviour or metabolic related factors). Among those studied factors, most relevant for NCDs are overweight, physical inactivity, smoking, alcohol abuse, high blood pressure etc.

Important recent studies include Demographic and Health Survey (2009), Substance Abuse in General Population Survey (2014), Youth Risky Behaviour (2005,2009) Health Behaviour in School Children (2014) European School Survey Project on Alcohol and other Drugs (2011, 2015), and other small surveys in limited samples and age groups.

Another information system in process at Institute of Public Health is monitoring the screening activities (breast, cervix and colorectal). More information about services and indicators to be gathered at Institute of Public Health is presented in annexes.

4. FRAMEWORKS OF INDICATORS REVIEWED AND HARMONIZATION WITH ESSENTIAL NCD INDICATORS TO BE USED IN COUNTRIES OF THE REGION

During the work for selecting the set of essential indicators included in this report we reviewed a number of frameworks and models developed recently at international level. The most important among them is Global Monitoring Framework (GMF) for NCD monitoring adopted by 66th World Health Organization in May 2013. GMF encompassed a set of indicators which could applied in different countries of regions of the world to monitor NCD trends and the progress made towards achievement of objectives for NCD control.

Two other relevant instruments analyzed are the European Core Health indicators – ECHI, and H2020 Monitoring Framework, an instrument for monitoring global strategic objectives to be achieved within 2020.

It has been reviewed targets, core indicators, additional indicators, outcome indicators and process indicators. It has been seen 88 indicators of Health For All database (HFA), including 67 indicators of mortality database (MDB) in Europe etc.

Additionally, the work has been harmonized with Regional Health Development Centre for NCD-RHDC NCD at Montenegro, in joint efforts to develop a minimal NCD indicators frame for South European Countries.

It has been kept in mind to include the most appropriate and relevant indicators, those which could make possible a realistic insight about NCD related health status, health system and risk factors, without excessively increasing the workload for Albanian health information systems while permitting international comparative analyses with countries in our region. Social determinants have been also considered and some of them have been included in the proposed structure of indicators.

5. METADATA FOR INDICATORS INCLUDED IN THIS REPORT

For each of the indicators are described definition, specifications, desegregations, information sources, periodicity, and potential limitations.

For definitions or specifications of each indicators details about numerator and denominator are included in metadata.

Disaggregation, which would serve for measuring differences or inequalities, includes sex, geography and socio-economic status if it possible.

Socio-economic status is an difficult dimension of health information which is collected by routine reports of health institutions. It would substantially increase workload of those who fill the medical records and spending more time on extra data without increasing the rewards could demotivate professionals in completing at all the essential indicators itself. During the recent workshops organized with representatives from hospitals it has been suggested that even a minimal disaggregation about education or employment would double the workload needed for completing forms. On the other hand it would be much easier and practical inclusion of questions about social determinants in population surveys; they are carried out rarely and have dedicated financial resources.

Systems of information to be used for providing data for indicator calculation are given as well. Routine information systems and surveys are included; civil statistics systems, health services information systems, case based registries, administrative and financial reporting, school surveys or population surveys.

For most indicators validity, costs, practicality or other problems and limits are given along. Periodicity of reporting is considered as a key factor influencing the information burden. It is rationalized as much as possible. Some indicators could be reported every year, while some others because of their costs and logistical problems can't be calculated more often than once in 5 years.

Rationalization and refining of NCD indicators in Albania should be considered a continuing process; their future further adjustment is indispensable. It is linked to future plans, policies and interventions to be undertaken in the NCD prevention and control field in the country. This is especially true for process indicators, which should be adapted in accordance with specific program objectives and targets to be decided in the near future.

6. OBJECTIVES

Objectives of proposed NCD indicators framework are:

- To measure progress done in Albania on NCD control
- To enhance the monitoring and evaluation capacity in Albania in the field of NCDs
- To promote and enable the development of NCD related evidence-based policies in Albania
- To enable the harmonization and the exchange of information about NCD indicators with other countries in the region.

The indicators and monitoring system described in this report would support in its work the recently formed National Committee for prevention and control of NCDs. More details on the functions of this committee are presented in Annex.

7. AREAS COVERED AND CRITERIA FOR SELECTION OF INDICATORS

The framework of indicators covers the four pillars of NCD control and three areas of indicators mentioned above in this report.

Four components of control and prevention for NCDs are:

• Health policies addressing risk factors and determinants of health
• Prevention programs primarily focused on the reduction of NCD risk factors
• Early detection (eg screening programs)
• Effective and efficient treatment.

7.1. Three areas covered by indicators

• Health determinants - life style related characteristics and other categories of possible inequalities (geography, residence, socio-economic position, etc.)
• Health systems: financial resources for the control and prevention of NCDs (imputes indicators) and the coverage with health care services for NCDs (outcome indicators)
• Health status : mortality, morbidity and disability (impact indicator).

7.2. Criteria for the selection of indicators

• Compliance with international frameworks of indicators and WHO standards
• The existence of practicalities (legal basis, institutional bases and resources) to collect valid data for the proposed indicator.
• List of indicators should reflect in a balanced way all policy areas relevant to NCDs
• The final number of basic indicators should be kept limited considering that in the future other indicators may be added, especially indicators of process for specific NCD intervention programs.
• Some indicators can serve for more than one objective or may cover more than one area of NCD prevention.

7.3. Selected NCDs

The vast majority of Albanian citizens die from:

• cardiovascular diseases,
• Cancers,

• Chronic respiratory diseases, and
• Diabetes

It is proposed to monitor morbidity and mortality for these four groups of NCDs. These would be the impact indicators that measure improvements in the longer term on the first two objectives outlined earlier in this report. For all these diseases there are already laid the bases of information system in health services.

7.4. Selected risk factors

For most NCDs there are the four main risk factors related to lifestyle or behavior; unhealthy diet, tobacco smoking, alcohol abuse and lack of physical activity. Health policies or various health strategies, have placed these factors among priorities and propose specific interventions for their control. It is therefore important to monitor these risk factors in population, in order to measure progress in the short to medium term. It is proposed to monitor these risk factors through the following indicators:

- ***The prevalence of smoking*** a) among young people b) in adults

- ***Unhealthy diet*** a) overweight/obesity among young people b) overweight/obesity in adults c) low consumption of fruits and vegetables and **optionally** d) salt consumption e) consumption of saturated fats

- ***The prevalence of alcohol consumption*** a) consumption per capita in adults b) harmful alcohol consumption among young people

- ***Lack of physical activity*** a) insufficient physical activity among young people and **optional** b) insufficient physical activity in adults.

With the exception of alcohol consumption per capita which can be provided by trade data and national production, other indicators require population studies, (for youth through relatively simpler studies among school youth). These data are classified within the first and

the second step or phase in the STEPS instrument proposed by the WHO for NCD surveillance in the general population (the questionnaire and physical measurements). The consumption of salt and somehow saturated fat consumption are proposed to be optional because of the complexity of their measurement (to measure the salt consumption is required measurement of sodium excreted in urine and there aren't any studies yet in Albania in this field).

There are three major metabolic risk factors for cardiovascular diseases and other NCDs. And three are the indicators proposed to be measured;

- High blood pressure,
- high cholesterol in blood (optional) and
- High blood glucose (optional).

For the measurement of the last two metabolic factors, there are needed relatively complicated studies in the population and the involvement of laboratory biochemical measurements (third phase of the STEPS instrument proposed by the WHO for the surveillance of NCDs in the population). It is proposed that high blood pressure to be included into essential indicators, for two reasons: some studies in Albania have demonstrated that high blood pressure is very high and poorly managed. Also it has been part of national population studies and can be relatively easily applied (second phase of STEPS). Hypercholesterolemia and hyperglycemia are proposed to be included among additional indicators.

7.5. Health system capacities

Health system includes not only health services for the prevention, diagnosis and treatment of non-communicable diseases, but also instruments and policies about the strategic control of the roots of these diseases as well about monitoring of progress made. For this reason in the framework of the basic indicators are included in addition to four indicators that help to monitor essential services, three other indicators of policies and coordination at the level of decision making;

- Therapy and counseling for the prevention of cardiovascular accidents,
- Medicines and basic equipment for NCD clinical management,

• Palliative care,
• Screening for cervical cancer

• Regulations for marketing of unhealthy foods to children,
• The elimination of trans-fatty acids
• National Board of NCDs.

7.6. NCD related health disparities

For the measurement and monitoring of NCD related health inequalities, it is necessary the disaggregation or the distribution of data according to socio-economic variables such as geographical area or place of residence, education and income. Given that limited opportunities for these variables to be included into routine information systems of health services, it is proposed to follow a gradual approach for measuring them; to plan in advance the inclusion of the variables related to socio-economic determinants in studies to be carried out in the future. In addition, it can be planned also the extension of routine statistics in the longer term with data that will help the analyses of the health situation distributed to socioeconomic categories mentioned above.

8. INDICATORS FRAMEWORK AND THEIR DETAILED DESCRIPTION

8.1. Category: Health outcomes

a. Premature NCD Mortality

Indicator	**Premature cardiovascular Mortality**
Definition	Probability of dying between the ages 30 and 70 years from cardiovascular diseases, based on the ICD codes: I00-I99
Calculation	Rate of deaths ICD10 (I00-I99) in age group 30-70 years old based on estimated population 30-70 years per year, per 100000
Information source	Death certificates reporting
Disaggregation	Sex, age, residence
Periodicity	Each year
Limitations	Incompleteness of death certificates, problems with reporting

Indicator	**Premature cancer mortality**
Definition	Probability of dying between the ages 30 and 70 years from neoplasm's diseases, based on the ICD codes:C00-C97
Calculation	Rate of deaths ICD10 (C00-C97) in age group 30-70 years old based on estimated population 30-70 years per year, per 100000
Information source	Death certificates reporting
Disaggregation	Sex, age, residence
Periodicity	Each year
Limitations	Incompleteness of death certificates, problems with reporting

Indicator	**Premature chronic pulmonary mortality**
Definition	Probability of dying between the ages 30 and 70 years from chronic pulmonary diseases, based on the ICD codes: J30-J98
Calculation	Rate of deaths ICD10 (J30-J98) in age group 30-70 years old based on estimated population 30-70 years per year, per 100000
Information source	Death certificates reporting
Disaggregation	Sex, age, residence
Periodicity	Each year
Limitations	Incompleteness of death certificates, problems with reporting

Indicator	**Premature diabetes mortality**
Definition	Probability of dying between the ages 30 and 70 years from diabetes, based on the ICD codes: E10-E14
Calculation	Rate of deaths ICD10 (E10-E14) in age group 30-70 years old based on estimated population 30-70 years per year, per 100000
Information source	Death certificates reporting
Disaggregation	Sex, age, residence
Periodicity	Each year
Limitations	Incompleteness of death certificates, problems with reporting

b. Hospital based NCD morbidity

Indicator	**Infarctus of myocardium**
Definition	Number of new cases diagnosed with acute infarctus of myocardium in a specialised health centre, expressed as cases per 100 000 inhabitants.
Calculation	Numerator: number of new cases diagnosed with acute infarcts of myocardium in a specialised health centre in a given year Denominator: At-risk population (in this case, practically all population)
Information source	Reporting from hospitals. Ischemic heart diseases registry
Disaggregation	Sex, age, residence
Periodicity	Each year
Limitations	Incompleteness of individual forms, lack of reporting from hospitals

Indicator	**Cerebral-vascular accidents or stroke**
Definition	Number of new cases diagnosed with cerebral-vascular accidents in a specialised health centre, expressed as cases per 100 000 inhabitants.
Calculation	Numerator: number of new cases diagnosed with cerebral-vascular accidents in a specialised health centre in a given year Denominator: At-risk population (in this case, practically all population)
Information source	Reporting from hospitals, Cerebral-vascular accidents registry
Disaggregation	Sex, age, residence
Periodicity	Each year
Limitations	Incompleteness of individual forms, lack of reporting from hospitals

Indicator	**Cancers incidence**
Definition	Number of new cases diagnosed with each type of cancer in a specialised health centre, expressed as cases per 100 000 inhabitants
Calculation	Numerator: number of new cases diagnosed with cancer (each cancer type) in a specialised health centre in a given year. The type of cancer means the site of origin and not the metastases. Reappearance of cancer is not included Denominator: At-risk population for the specific cancer type. For cancer types affecting only one sex, it is used only sex-specific population (e.g. only males for prostate cancer)
Information source	Hospitals. Cancer registry. Data from GLOBOCAN could be used also, especially until population based national registry is fully functional
Disaggregation	Sex, age, residence
Periodicity	Each year
Limitations	Incompleteness of individual forms, partial coverage with reporting of national territory

Indicator	**Diabetes from hospitals**
Definition	Number of new cases diagnosed with diagnosed diabetes in a specialised health centre, expressed as cases per 100 000 inhabitants.
Calculation	Numerator: number of new cases diagnosed with diabetes in a specialised health centre in a given year Denominator: At-risk population (in this case, practically all population)
Information source	Reporting from hospitals. diabetes registry
Disaggregation	Sex, age, residence
Periodicity	Each year
Limitations	Incompleteness of individual forms, lack of reporting from hospitals

8.2. Category: exposure to risk factors

a. Lifestyle

Indicator	**Tobacco use at adults**
Definition	Age specific prevalence of adult persons who smoke tobacco or use tobacco products
Calculation	Numerator: number of adults over 18 years old, who smoke daily or less than daily Denominator: all survey respondents
Information source	Population surveys (preferably nationally representative) Albanian demographic and health survey, Substance use in general population survey, probably a STEPS survey
Disaggregation	Age, sex, residence and other data related to socioeconomic position of family if possible
Periodicity	Every 5 years
Limitations	Representativeness of selected samples, bias through different survey instruments etc

Indicator	**Tobacco use at adults**
Definition	Prevalence of adolescents who smoke tobacco or use tobacco products
Calculation	Numerator: number of adolescents 10-19 years oldwho smoke daily or less than daily Denominator: all adolescents respondents of the survey
Information source	Country wide school based surveys ESPAD Albania, GYTS Albania, YRBS Albania HBSC Albania,
Disaggregation	Age, sex, residence and other data related to socioeconomic position of family if possible
Periodicity	At least every 5 years
Limitations	Bias through self report, limited validity of survey instruments

Indicator	**Harmful use of alcohol: Adult Per Capita Consumption**
Definition	Total alcohol per capita (APC) (15+ years old) consumption within a calendar year in litres of pure alcohol
Calculation	Nominator: sum of recorded and unrecorded alcohol consumption a population during a year, in litres Denominator: midyear population aged 15+ for that year.
Information source	Data on total consumption of alcohol could be based on official statistics for sales of alcohol beverages, import and export of alcohol in different beverage categories. Data from producers' surveys on unregistered alcohol consumption could be used as well. Another relevant source is Food and Agriculture Organization of the United Nations statistical database (FAOSTAT)
Disaggregation	Age, sex if possible
Periodicity	Each year
Limitations	Incompleteness in official data Survey biases, mal-estimations

Indicator	**Harmful use of alcohol: heavy episodic drinking**
Definition	Heavy episodic drinking among adults is defined as those who report drinking 6 (60 grams) or more standard drinks in a single drinking occasion
Calculation	Nominator: Number of persons reporting consuming 60 grams or more of pure alcohol on at least one occasion monthly Denominator: all survey respondents Prevalence expressed in %
Information source	Population surveys (preferably nationally representative) Albanian demographic and health survey, Substance use in general population survey, probably a STEPS survey
Disaggregation	Age, sex, residence and other data related to

	socioeconomic position of family if possible
Periodicity	Every 5 years
Limitations	Representativeness of selected samples, bias through different survey instruments

Indicator	**Physical inactivity in adolescents**
Definition	Percentage of adolescents participating in less than 60 minutes of moderate to vigorous intensity physical activity daily
Calculation	Numerator: number of adelescents respondents for whom the number of days per week with > 60 minutes of physical activity is < 7 days Denominator: Number of survey respondents Expressed in %
Information source	Country wide school based surveys YRBS Albania, HBSC Albania,
Disaggregation	Age, sex, residence and other data related to socioeconomic position of family if possible
Periodicity	At least every 5 years
Limitations	Bias through self report, limited validity of survey instruments

Indicator	**Low fruit and vegetable consumption**
Definition	Age-standardized prevalence of persons aged 18+ years consuming less than five total servings (400 grams) of fruit and vegetables per day. A serving of fruit and vegetables is equivalent to 80 grams
Calculation	Nominator: Number of respondents aged 18+ years eating less than 5 servings of fruit and/or vegetables per day Denominator: All respondents of the survey aged 18+ years

Information source	Self-reporting in population surveys (preferably nationally representative) Albanian demographic and health survey, probably a STEPS survey, probably a specific nutrition survey
Disaggregation	Age, sex, residence and other data related to socioeconomic position of family if possible
Periodicity	Every 5 years
Limitations	Representativeness of selected samples, bias through different survey instruments etc

8.3. Category: exposure to risk factors

b. Metabolic factors

Indicator	**Overweight and obesity in adolescents**
Definition	Percentage of adolescents overweight or obese according to the WHO growth reference for school-aged children and adolescents, overweight – one standard deviation body mass index (BMI)for age and sex, and obese – two standard deviations body mass index for age and sex. >= 1 DS equivalent to BMI >= 25 kg/m2 at 19 years and >= 2DS equivalent to BMI >=30 kg/m2 at 19 years
Calculation	Nominator : a) Participants 10-19 years old in survey who are overweight b) Participants 10-19 years old in survey who are obese Denominator: all adolescents participant in the survey Expressed in %
Information source	Country wide school based surveys Adapted YRBS Albania, specific school based nutrition surveys
Disaggregation	Age, sex, residence and other data related to socioeconomic position of family if possible
Periodicity	Every 5 years
Limitations	Bias through physical measurements, limited validity of survey instruments

Indicator	**Overweight and obesity in adults**
Definition	Age standardised prevalence of overweight or obese among adults over 18 years old. BMI >= 25 kg/m2 for overweight , and BMI >=30 kg/m2 for
Calculation	Nominator :

	c) Participants over 18 years old in survey who are overweight d) Participants over 18 years old in survey who are obese Denominator: all participant over 18 years old in the survey. Expressed in %
Information source	Population surveys Albanian demographic and health survey, probably a STEPS survey, probably a specific nutrition survey
Disaggregation	Age, sex, residence and other data related to socioeconomic position of family if possible
Periodicity	Every 5 years
Limitations	Bias through physical measurements, limited validity of survey instruments, representativeness of the sample

Indicator	**Raised blood pressure**
Definition	Systolic blood pressure ≥140 and/or diastolic blood pressure ≥90 among persons aged 18+ years.
Calculation	Nominator : Number of respondents with systolic blood pressure ≥140mmHg or diastolic blood pressure ≥90mmHg. Denominator: All respondents of the survey aged 18+ years. Expressed in %
Information source	Population surveys where blood pressure is measured, not self reported Albanian demographic and health survey, probably a STEPS survey,
Disaggregation	Age, sex, residence and other data related to socioeconomic position of family if possible
Periodicity	Every 5 years
Limitations	Bias through pressure measurements, representativeness of the sample

8.4. **Category: NCD related health system**

Indicator	**Drug therapy and counselling to prevent cardiovascular accidents**
Definition	Percentage of persons aged 40 years and older with a 10-year cardiovascular disease risk ≥30%,including those with existing CVD receiving drug therapy and counseling to prevent heart attacks and strokes. • Drug therapy is defined as taking medication for raised blood glucose/diabetes, raised total cholesterol, or raised blood pressure, or taking aspirin or statins to prevent or treat heart disease. • Counseling is defined as receiving advice from a doctor or other health worker to quit using tobacco, reduce salt in diet, eat at least five servings of fruit and/or vegetables per day, reduce fat in diet, start or do more physical activity, maintain a healthy body weight or lose weight.
Calculation	Nominator: number of eligible survey respondents who are receiving drug therapy and counselling Denominator: number of eligible survey participants Expressed in %
Information source	a) Community based surveys with participants self-reporting. b) An alternative approach would be analyses of information from check up services for population 40-65 about the utilisation of these services.
Disaggregation	Age, sex, residence and other data related to socioeconomic position of family if possible
Periodicity	a) Every 5 years b) Each year
Limitations	a) Representativeness of survey samples, validity of instruments b) Difficulties to estimate the eligible population

Indicator	**Essential medicines and technologies for NCD**
Definition	Percentage of primary health care facilities who have all of the following available: Medicines - at least aspirin, a statin, an angiotensin converting enzyme inhibitor, thiazide diuretic, a long acting calcium channel blocker, metformin, insulin, a bronchodilator and a steroid inhalant Technologies - at least a blood pressure measurement device, a weighing scale, blood sugar and blood cholesterol measurement, devices with strips and urine strips for albumin assay
Calculation	Nominator: Number of facilities that have available during assessment the minimum list of essential medicines and basic technologies. Denominator: Number of surveyed facilities. Expressed in %
Information source	Nationally-representative health facility assessment
Disaggregation	Public and private facilities, urban rural etc
Periodicity	Every 5 years
Limitations	Incompleteness of reporting from health centers

Indicator	**Palliative care**
Definition	Access to palliative care assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer. Morphine- equivalent is a method of standardizing and combining volumes of opioids with differing potencies and is used as a measure of opioid consumption, which is used as the indicator for access to pain and palliation
Calculation	Nominator: Population-level consumption of morphine-equivalent strong opioid analgesics for a given time period.

	Denominator: Number of cancers deaths occurring in the population over the same time period Morphine-equivalent volumes are calculated as: (1*morphine)+(83.3*fentanyl)+(5*hydromorphone)+(1.33 *oxycodone)+ (0.25*pethidine) Expressed as a ratio
Information source	Levels of consumption of opioid medicines in kilograms or grams (for Fentanyl) are calculated by the International Narcotic Control Board (INCB) on the basis of statistics on manufacture and trade provided by Governments Death data are taken from death certificates
Disaggregation	-
Periodicity	Each year
Limitations	Incompleteness of death certificates, problems with reporting

Indicator	**Cervical cancer screening**
Definition	Proportion of women aged 30 - 49 who report they were screened once or more often for cervical cancer using pap smear or Human Papillomavirus (HPV) test.
Calculation	-
Information source	a) Population surveys. ADHS b) Health services based reporting. Information from screening centers reported to IPH
Disaggregation	a) Age, residence b) Age, residence and other data related to socioeconomic position of family if possible
Periodicity	a) Every 5 years b) Every two years 2 years
Limitations	a) Representativeness of sample, memory bias b) Incompleteness of reporting from health centers

Indicator	**Marketing to children unhealthy foods**
Definition	Existence of a policy to reduce the impact on children of marketing of foods and nonalcoholic beverages high in saturated fats, trans-fatty acids, free sugars, or salt
Information source	Experts opinions when ccompleting WHO NCD Country Capacity Survey
Periodicity	Every 2 years
Limitations	Bias through self-report, misunderstanding/misinterpretation

Indicator	**Elimination of trans-fats**
Definition	Adoption of a policy to limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply.
Information source	Experts opinions when ccompleting WHO NCD Country Capacity Survey
Periodicity	Every 2 years
Limitations	misunderstanding/misinterpretation of existing policies or lacking of them

Indicator	**NCD control national board**
Definition	Effective functioning of a board of committee with multi-disciplinary representation approved at ministerial or higher level
Information source	Experts opinions when ccompleting WHO NCD Country Capacity Survey
Periodicity	Every 2 years
Limitations	Misinterpretation over the role or the position of the Board

8.5. Additional/optional indicators

Indicator	**Salt intake**
Definition	Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years
Calculation	Numerator: Sum of sodium excretion in urine samples from all respondents aged 18+years. The gold standard for estimating salt intake is through 24-hour urine collection, however other methods such as spot urines and food frequency surveys may be more feasible to administer at the population level. Denominator: All respondents of the survey aged 18+ years Expressed as arithmetic mean
Information source	Population based surveys. No one is carried out to this date in Albania. IPH piloting in small samples
Disaggregation	Age, sex, residence and other data related to socioeconomic position of family if possible
Periodicity	Every 5 years
Limitations	Representativeness of samples, bias related to sodium measurement ect

Indicator	**Physical inactivity in adults**
Definition	Age-standardized prevalence of insufficiently physically active persons aged 18+ years; not meeting any of the following criteria: – 150 minutes of moderate-intensity physical activity per week – 75 minutes of vigorous-intensity physical activity per week – an equivalent combination of moderate- and vigorous-intensity physical activity accumulating at least 600 MET-minutes per week

	MET refers to metabolic equivalent. It is the ratio of a person's working metabolic rate relative to the resting metabolic rate. One MET is defined as the energy cost of sitting quietly, and is equivalent to a caloric consumption of 1 kcal/kg/hour. Physical activities are frequently classified by their intensity, using the MET as a reference. Minutes of physical activity can be accumulated over the course of a week but must be of a duration of at least 10 minutes.
Calculation	Numerator: Number of respondents aged 18+ years where none of 3 above listed criteria is true. Denominator: All respondents of the survey aged 18+ years
Information source	Population based surveys. Adapted ADHS in the future
Disaggregation	Age, sex, residence and other data related to socioeconomic position of family if possible
Periodicity	Every 5 years
Limitations	Representativeness of samples, bias related misinterpretations of physical activity

Indicator	**Saturated fat**
Definition	Age-standardized mean proportion of total energy intake from saturated fatty acids (SFA) in persons aged 18+ years
Calculation	Numerator: Sum of proportion of SFA of total energy intake from all participants aged 18+years. For each participant, divide the saturated fatty acid intake by the total energy intake to get the proportion of total energy from SFA Denominator: All respondents of the survey aged 18+ years.

	Expressed as %
Information source	Population-based survey using questionnaires An alternative way for estimating it can be FAO National Food Balance Sheets
Disaggregation	Age, sex, residence and other data related to socioeconomic position of family if possible
Periodicity	Every 5 years
Limitations	Representativeness of samples, bias related misinterpretations of consumption and nutrition related questions

Indicator	**Raised blood glucose/diabetes**
Definition	Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years or on medication for raised blood glucose. Fasting plasma glucose value ≥7.0 mmol/L (126 mg/dl) is considered positive for raised blood glucose
Calculation	Numerator: Number of respondents aged 18+ years with fasting plasma glucose value ≥7.0 mmol/L (126 mg/dl) or on medication for raised blood glucose. Fasting blood glucose must be measured, not self-reported, and measurements must be taken after the person has fasted for at least eight hours. Are considered diabetes positive people who have not high blood glucose at the measurement moment, but report to be on medication for raised blood glucose Denominator: All respondents of the survey aged 18+ years Expressed in %
Information source	Population-based (preferably nationally representative) survey. There are two main blood chemistry screening

	methods, dry and wet chemistry. Dry chemistry uses capillary blood taken from a finger and used in a rapid diagnostic test. Wet chemistry uses a venous blood sample with a laboratory based test. Either method is acceptable. Only small scale, not representative of general population surveys have been carried out
Disaggregation	Age, sex, residence and other data related to socioeconomic position of family if possible
Periodicity	Every 5 years
Limitations	Representativeness of samples, bias related to measurement techniques, lack of fasting status ect

Indicator	**Raised total cholesterol**
Definition	Age-standardized prevalence of raised total cholesterol among persons aged 18+ years Total cholesterol ≥5.0 mmol/L (190 mg/dl) is considered positive or high
Calculation	Numerator: Number of respondents aged 18+ years with total cholesterol value ≥ 5.0 mmol/L (190 mg/dl). Denominator: All respondents of the survey aged 18+ years. Expressed in %
Information source	Population-based survey in which cholesterol was measured, not self-reported. There are two main blood chemistry screening methods, dry and wet chemistry. Dry chemistry uses capillary blood taken from a finger and used in a rapid diagnostic test. Wet chemistry uses a venous blood sample with a laboratory based test. Either method is acceptable. Only small scale, not representative of general population surveys have been carried out
Disaggregation	Age, sex, residence and other data related to

	socioeconomic position of family if possible
Periodicity	Every 5 years
Limitations	Representativeness of samples, bias related to measurement techniques, ect

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NJE PLAN I MONITORIMIT TE SEMUNDJEVE JO INFEKTIVE DHE PERPARIMIT NE KONTROLLIN E TYRE NE SHQIPERI

KORNIZA E INDIKATOREVE BAZE DHE METADATA PER TO

2017

Autore te raportit :

Alban Ylli

Eduard Kakarriqi

Kontribuan per raportin:
Genc Burazeri, Bajram Dedja, Enver Roshi, Sonela Xinxo, Ervin Toci, Besjan Elezi, Arjan Bregu, ect.

10. HYRJE: PERKUFIZIMI DHE TERMINOLOGJIA. SEMUNDJET KRONIKE APO JO INFEKTIVE

Semundjet apo problemet shendetsore qe filluan te kercenojne ne menyre masive shendetin e shqiptareve gjate fundit te shekullit te 20-te dhe jane shnderuar ne problemin kryesor shendetsor te fillimshekullit te ri jane quajtur per nje kohe te gjate ”semundje kronike ” apo edhe ”semundje degjenerative”.
Keto emertime kane problemet e tyre pasi u mungon aftesia per te ndare ne menyre mjaftueshmerisht te sakte grupet e semundjeve me natyra te ndryshme dhe me strategji te ndryshme kontrolli. Keshtu tuberkulozi apo sifilizi, dhe aq me teper HIV/AIDS-i mund te konsiderohen ”semundje kronike ”, nderkohe qe infarkti i miokardit apo insulti cerebro-vaskular mund te konsideroheshin fare mire si ”semundje akute”. Po keshtu termi ”semundje degjenerative” eshte teper i gjere dhe shpesh mund te jete keq-orientues duke nenkuptuar proceset e pashmangshme te plakjes se indeve dhe organeve.

Emertimi ”semundje jo-infektive” eshte nje emertim i trete qe duket se eshte pranuar gjeresisht si me i pershtatshem per te grupuar problemet shendetesore me te rendeshme nga pikepamja e barres ne shoqeri dhe prioritetit aktual per shendetin publik. Edhe ky term nuk eshte ideal pasi mund te shkaktoje konfuzion per probleme te tilla si semundja reumatizmale e zemres (e cila ka ne baze nje shkaktar infektiv, nje streptokok beta-hemolitik) apo kancerin e qafes se mitres (i cili shkaktohet nga disa grupe virusesh te quajtur papillomavirus). Megjithate pavaresisht kesaj, ky emertim pranohet si me i pershtateshmi per te grupuar nga pikepamja e shendetit publik, probleme te tilla shendetsore si hipertensionin, semundjet e koronareve, semundjet cerebrovaskulare, tumoret apo neoplazite, diabetin, semundjet jo infektive te mushkerive dhe problemet me te shpeshta neurologjike apo te shendetit mendor.

Megjithese semundjet e mesiperme kane mjaft specifika dhe ndryshime te rendesishme, eshte pranuar se strategjite e parandalimit apo organizimi i sherbimeve lidhur me to kane shpesh karakteristika te ngjashme, pasi kane te perbashket disa faktore rreziku, nderkohe qe disa nga keto semundje mund te sherbejne si faktore risku per te tjerat e anasjelltas. Shembull

klasik eshte duhanpirja, parandalimi i se ciles do te pakesonte jo vetem kancerin e mushkerive e disa kancere te tjere, por edhe shume semundje kardiovaskulare. Po ashtu menyra e ushqyerjes lidhet si me semundjen e koronareve te zemres ashtu edhe me kancerin e kolonit. Konsumi i alkoholit ndikon jo vetem ne shendetin mendor por edhe tek dhe tek semundjet kardiovaskulare apo edhe tek disa kancere te trajtit digjestiv

11. MONITORIMI/SURVEJANCA E SEMUNDJEVE JO INFEKTIVE DHE FAKTOREVE TE TYRE TE RISKUT

Monitorimi apo survejanca e semundjeve jo infektive do te ishte mbledhja e vazhdueshme dhe sistematike e te dhenave si dhe analiza e tyre me qellim prodhimin e informacionit te pershtatshem, mbi barren e semundjeve jo infektive, te shperndare ne kohe dhe ne hapesire ne menyre te tille qe te lejoje vleresime mbi vdekshmerine, semundshmerine, faktoret risk dhe determinantet socio-ekonomike.
Monitorimi duhet te lejoje gjithashtu informimin mbi kapacitetet e sistemit shendetsor per te perballuar problemet lidhur keto semundje. Ky dimension i fundit do te ndihmonte procesin e monitorimit te mundesoje edhe vleresimin e barres ekonomike te semundjeve jo infektive.
Monitorimi i semundjeve jo infektive eshte i domosdoshem per te mundesuar ndertimin e programeve dhe politikave te pershtatshme shendetsore si dhe per te monitoruar perparimet e bera.

Nje sistem monitorimi i semundjeve jo infektive ne Shqiperi duhet te kete tre komponente kryesore;

4. Monitorimin e ekspozimeve apo te faktoreve risk,
5. Monitorimin e pasojave shendetsore (semundshmerine dhe vdekshmerine specifike)
6. Vleresimin e kapacitetit te sistemit shendetsor ne pergjigjen ndaj ketyre semundjeve

Tabela e meposhteme jep nje model te pergjithshem dhe disa detaje per tu ndjekur ne procesin e ndertimit te nje sistemi te survejances

Tabela 1. Dimensionet e kontrollit te semundjeve jo infektive dhe qasjet e survejances

1	Ekspozime
	Faktore risku te lidhur me sjelljen: duhanpirja, dieta e pashendetshme, sedentarizmi dhe abuzimi me alkoolin. Faktore risku fiziologjike dhe metabolike: hipertensioni, mbipesha/obeziteti, hiperkolesterolemia apo yndyrna e larta ne gjak, glukoza e rritur ne gjak Determinante sociale: niveli i arsimimit, te ardhurat per fryme dhe aksesi ne sherbimet shendetsore.
2	Pasojat shendetsore
	Vdekshmeria: vdekshmeria specifike per semundjet kryesore jo infektive ne vend. Semundshmeria: incidenca dhe/ose prevalenca e semundjeve kryesore jo infektive
3	Vleresimi i kapacitetit te sistemit shendetsor
	Vlersimi i nderhyrjeve dhe i kapaciteteve: infrastruktura dhe burimet, politikat dhe programet, aksesi dhe mbulimi me sherbime baze te kapjes se hereshme, te trajtimit apo urgjences

2.1 Kategorite e indikatoreve per semundjet jo infektive ne Shqiperi. Potencialet dhe kufizimet e tyre

Indikatoret qe do te ndihmonin per te kryer analizen e situates sipas dimensioneve te permendura me siper do te grupoheshin ne disa kategori kryesore dhe nenkategori te cilat dallojne si nga qasjet apo sistemet e sigurimit te informacionit ashtu edhe nga kendveshtrimet e ndryshme qe ofrojne ne interpretimin e situates lidhur me shperndarjet dhe prirjet e semundjeve jo infektive.

d. Nivelet e Vdekshmerise

Vdekshmeria ose mortaliteti shpreh proporcionin e vdekjeve nga nje shkak specific i parashikuar nga sistemi nderkombetar i klasifikimit te semundjeve, me popullaten ne vitin qe kryhet analiza.
Ky eshte nje indikator qe ka disa perparesi krahasuar me te tjeret:

- Eshte teorikisht me i ploti nga pikepamja e hapesires dhe kohes
- Nuk ndikohet nga prirjet shfrytezimit te sherbimeve dhe
- Bazohet ne nje sistem te aprovuar me ligj sic eshte raportimi i skedes se vdekjes.

Nepermjet analizes se vdekshmerise mund te verehen prirje ne kohe te semundjeve jo infektive, te cilat shprehin situaten lidhur me keto semundje per periudhen duke filluar nga koha ne te cilen kryhet analiza si dhe per nje kohe disa vjecare ne te shkuaren.

Megjithate perparesite e kesaj kategorie indikatoresh ngelen teorike nderkohe qe verehen shume problem praktike ne vendin tone lidhur me saktesine e informacionit, plotesine e tij (te shkaktuara gjate plotesimit dhe raportimit te skedave te vdekjeve) si dhe problem te tjera te lidhura me nivelin e detajimit apo koheduhushmerine (te lidhura me analizen e te dhenave, dhe marredheniet nderinstitucionale). Ka raporte nderkombetare qe e vleresojne te ulet vlefshmerine e informacionit te marre nga skedat e vdekjes ne Shqiperi.

e. Nivelet e Semundshmerise

Semundshmeria ose morboziteti shpreh proporcionin e semundjeve specifike te parashikuara nga sistemi nderkombetar i klasifikimit te semundjeve me popullaten qe i ka prodhuar ato ne kohen ne te cilen kryhet analiza.

Semundshmeria mund te matet ne disa menyra ne varesi te burimeve ne dispozicion dhe te modelit te shfrytezimit te sherbimeve;

b.1.1. Te dhenat e agreguara te semundjeve ne spitale, qe eshte nje indikator i prodhuar nga numri i vizitave lidhur me semundje specifike ne spital apo qendra shendetsore. Ne Shqiperi

funksionon tradicionalisht raportimi i te dhenave te agreguara mbi semundshmerine nga spitalet. Ky raportim kryhet ne menyre te pervitshme dhe perdor sistemin ICD9 per klasifikimin e semundjeve. Praktikisht ky sistem ka si qellim kryesor grumbullimin e informacionit per menaxhimin me te mire te spitaleve, perfshi matjen e eficiences, por te dhenat jane perdorur dhe mund te vijojne te perdoren edhe per monitorimin e shpeshtesise se semundjeve, gjithmone duke i interpretuar ato me kujdes.

Perparesia kryesore e ketij indikatore eshte pasqyrimi ne kohe i situates lidhur me semundjet jo infektive, nderkohe qe ofrohet saktesia me e madhe e mundeshme lidhur me diagnozen per arsye te mjeteve relativisht te pershtatshme qe ekzistojne ne spitale ne specialiste dhe teknologji.
Megjithate kjo kategori indikatoresh ka disa probleme serioze qe ia reduktojne mjaft vlefshmerine ne interpretim;

- Ndikohet shume nga profili i shfrytezimit te sherbimeve shendetesore nga ana e popullates. Keshtu qe shume raste te semundjes nuk kapen dot sepse shume persona nuk kerkojne ndihme shendetesore ne sherbimet publike. Ky profil eshte i ndryshem per semundje te ndryshme dhe lidhet mes te tjerash me llojin e semundjes apo ekzistencen e sherbimeve te pershtatshme per to.
- Sistemet e informimit shendetesor lidhur me kete indikator kane ne fokus menaxhimin e spitaleve dhe jo shendetin e popullates. Per kete arsye te dhenat jane te agreguara dhe nuk lejojne identifikimin e rasteve te perseritura ne te njejtin spital apo ne spitale te ndryshme. Gjithashtu nuk mund te identifikohen qarte rastet e reja.

b.1.2. Kategori indikatoresh e ngjashme me kete eshte edhe ajo e bazuar ne sistemin e informacionit mbi shfrytezimin e sherbimeve te kujdesit paresor. Megjithese problemet e aksesit ne kete rast do te ishin me te vogla per arsye te pragut te ulet te sherbimeve te kujdesit paresor, problemt e lidhura me agregimin e te dhenave dhe sidomos problemet e lidhura me veshtiresite e diagnozes e bejne kete nenkategori indikatoresh dhe sistemin e informacionit ku ajo bazohet me me pak vlere ne monitorimin e semundjeve jo infektive.

b.1.3. Modeli i ri i sherbimeve te kontrollit baze shendetesor prane sherbimeve te kujdesit paresor dhe sistemi i tij specifik i monitorimit do te ofronte nje mundesi me te mire per te

vleresuar disa semundje apo disa faktore risku me natyre jo infektive (pa u shmangur gjithsesi problemet e lidhura me dinamiken e perdorimit te ketyre sherbimeve baze nga popullata). Gjithsesi nje pjese e mire e ketij informacioni do te ndihmonte per kategorine e 3-te te indikatoreve te permendur me poshte; prevalencen e faktoreve risk te semundjeve jo infektive, pasi pjesa me e madhe e kontrollit baze sherben per te kapur heret menyrat e pashendeteshme te jeteses dhe faktoret metabolike (te tille si kolesteroli apo shqeri i i larte ne gjak, hipertensioni etj).

2.1.4 Sistemet e regjistrave te bazuar ne rastin (case-based) jane nje mundesi tjeter qe ka filluar te zbatohet ne Shqiperi edhe per disa semundje jo infektive si kanceret, semundjet cerebrovaskulare, semundjet ishemike te zemres dhe diabetin. Tradicionalisht ne Shqiperi jane grumbulluar te dhena te bazuara ne rastin vetem per semundjet infektive. Ky model i grumbullimit te te dhenave nga spitalet dhe qendrat e tjera ku vendoset diagnoza do te ndihmoje ne identifkimin e sakte te rasteve te reja te ketyre semundjeve po nuk do te shmange luhatjet ne perdorimin e sherbimeve per disa lloje kanceresh, disa lloje semundjesh ishemike te zemres dhe per diabetin.

b.2.1. Semundshmeria bazuar ne popullate, qe eshte numri i rasteve te identifikuara ne popullate, zakonisht nepermjet kryerjes se nje studimi ne kampione te kufizuara te popullates. Ky ne teori do te ishte indikatori me i sakte i semundshmerise, por kufizohet nga disa faktore;

- Veshtiresia per vendosjen e diagnozes, eshte nje aspekt thelbesor qe nuk lejon perdorimin e ketij grupi indikatoresh. Kerkohet aplikimi i procedurave te nderlikuara per vendosjen e diagnozes, jashte mjediseve tradicionale mjekesore (p.sh. diagnostikimi i angina pectoris me EKG ne popullate).
- Veshtiresia e kontaktimit te personave per tu studiuar eshte nje aspekt tjeter problematik pasi perftimi i ketyre indikatoreve eshte i lidhur me kryerjen e studimeve apo depistimeve te organizuara ne popullate dhe gjithe problemet logjistike dhe financiare te lidhura me to.

b.2.2. Nje kompromis qe zgjidh pjeserisht problemine vendosjes se diagnozes, por qe shton problemin e lidhur me aksesin ne sherbime eshte perdorimi ne pyetesoret e studimeve ne popullate i pyetjeve mbi semundjet e diagnostikuara nga nje mjek. Keshtu do te kishim

mundesi per te dhena mbi diagnoza relativisht te sakta, por me humbjet e priteshme te rasteve si pasoje e mosperdorimit te sherbimeve shendetesore nga nje pjese e mire e popullates.

f. Prevalenca e faktoreve risk

Per nje sere semundjesh jo infektive , si p.sh. semundjet ishemike te zemres, semundjet cerebrovaskulare, kanceri i mushkerive etj jane percaktuar qarte faktoret e riskut, ne nje mase te tille sa mund te parashikohet ne menyre te arsyeshme shpeshtesia e semundjes ne te ardhmen.

Ky grup indikatoresh eshte i vlefshem sidomos per vleresimin e situates se pritshme lidhur me semundjet jo infektive si dhe per planifikimin e sherbimeve ne te ardhmen. Gjithashtu eshte me mjaft vlere ne nje kohe kur fokusi i strategjive dhe kontrollit et semundjeve jo infektive eshte drejtuar kah kontrollit te faktoreve risk nepermjet ndryshimit te stilit te jeteses dhe kapjes se hereshme.

Megjithate edhe ky grup indikatoresh ka kufizime ne perdorim pasi:

- Jep pak informacion per barren e semundjeve jo infektive ne momentin e kryerjes se analizes dhe per me teper ashtu si indikatori me siper,
- Kerkon kryerjen e studimeve apo depistimeve specifike ne popullate me kostot dhe problemet logjistike te lidhura me to.

12. ANALIZE E SISTEMEVE EKZISTUESE TE INFORMACIONIT LIDHUR ME SEMUNDJET JO INFEKTIVE NE SHQIPERI

Nje skeme e institucioneve dhe rrjedhes se informacionit shendetsor lidhur me semundjet jo infektive ne Shqiperi eshte paraqitur ne aneks.

12.1. INSTAT

INSTAT, i cili me ligj eshte institucioni themelor ne Shqiperi lidhur me statistikat, eshte pergjegjes per mbledhjen e te dhenave mbi shkaqet e vdekjeve permes certifikatave te

vdekjes, nje dokument i detyrueshem per tu plotesuar nga spitali nese vdekja ndodh ne spital dhe nga mjeku i familjes ne se vdekja ndodh ne shtepi. Instat analizon te dhenat dhe pergatit raporte mbi shkaqet e vdekjeve sipas 17 grupeve. Nivelet e vdekshmerise paraqiten per 100 000 banore bazuar ne projeksionet e popullates te kalkuluar nga vete INSTAT. Nivelet e vdekshmerise mund te disagregohen sipas gjinise, moshes dhe qarkut.
Shkaqet e vdekjeve klasifikohen sipas ICD9, nderkohe qe eshte ne proces adoptimi sistemi i ri ICD10.

12.2. Instituti i Shendetit Publik

Instituti i Shendetit Publik merr informacion mbi shkaqet e vdekjeve sipas grupeve te paraqitura ne raporte por nuk ka akses ne te dhenat me te detajuara. Megjithese ne teori Instituti i shendetit puiblik duhet te perfshihet ne procesin a percaktimit te formatit te prezantimit te te dhenave, kjo shpesh nuk ndodh dhe informacioni mbi shkaqet e vdekjeve ne raportet e publikuara nuk lejon vleresimin e problemeve te rendesishme te shendetit publik te tilla si kanceri i gjirit apo kanceri i qafes se mitres.
INSTAT ka bere disa korrektime te niveleve totale te vdekshmerise gjate 5 viteve te fundit, duke ndryshuar disa te dhena historike

Te dhenat mbi semundshmerine spitalore grumbullohen sistematikisht nga zyrat e statistikave te cdo spitali dhe dergohen ne format te agreguar ne Ministrine e Shendetesise. Instituti i shendetit Publik i analizon keto te dhena dhe ka akses ne nivel detaji. Te dhenat permbajne informacion mbi semundjet te klasifikuara sipas ICD9, si dhe lejojne disagregimin sipas gjinise, disa grup moshave fikse, qarkut dhe vendbanimit urban/rural.

Perdorimi i sherbimeve shendetesore regjistrohet edhe ne nivel te sherbimeve te kujdesit shendetesor paresor, ku gjenden te dhena mbi pacientet kronike. Keto te dhena raportohen periodikisht ne Fondin e sigurimeve shendetsore dhe mund te perdoren edhe nga Instituti i Shendetit Publik. Klasifikimi behet sipas grup semundjesh jo infektive dhe jo sipas ICD9 duke veshtiresuar analizen e detajuar.

Mbi nje vendim te Keshillit te Ministrave te vitit 2014 eshte mbeshtetur ngritja e sherbimeve te kontrollit te baze te popullates 40-65 vjec sebashku me sistemin e informimit mbi aktivitetin. Informacioni sipas skedave te aprovuara eshte i agreguar dhe lejon analize te

rasteve pozitive me faktore risku (te tille si hipertension, hiperglicemi, hiperkolesterolemi etj) sipas qendrave shendetsore, gjinise, dhe moshes.

Nje tjeter vendim i Keshillit te Ministrave i vitit 2014 percakton mes te tjerash edhe ngritjen e 4 sistemeve te reja te informacionit mbi semundjet jo infektive ne formen e regjistrave te bazuar ne rast. Semundjet ishemike te zemres, semundjet cerebrovaskulare, diabeti dhe kanceret duhet te raportohen nga cdo ofrues sherbimesh relevant, sipas skedave te detajuara te aprovuara cdo 6 muaj ne Institutin e Shendetit Publik. Formati i informacionit sipas skedave lejon disagregim te detajuar sipas personit, diagnozes, vendbanimit, trajtimit dhe shmang dublikimin e rasteve. Formati i skedave te aprovuara te raportimit eshte ne aneks.

Vec monitorimit te semundjeve ne sherbimet shendetsore, Instituti i shendetit publik kryen studime edhe per vleresimin sistematik te nje sere faktoresh risk ne popullaten e pergjitheshme (te lidhur me sjelljen ose edhe metabolike apo biologjike). Nder ata faktore qe do te kishin rendesi per semundjet jo infektive jane mbipesha, aktiviteti fizik, duhanpirja, abuzimi me alkolin, tensioni i larte gjakut, etj.
Studime te rendesishem ne popullate te koheve te fundit jane Demographic and Health Survey (2009), Substance Abuse in General Population Survey (2014), Youth Risky Behaviour (2005,2009) Health Behaviour in School Children (2014) European School Survey Project on Alcohol and other Drugs (2011, 2015), si dhe studime te tjera me te vogla ne kappione te kufizuara ne mosha te caktuara

Nje tjeter aktivitet qe sapo ka filluar eshte edhe monitorimi i mbulimit me sherbime te depistimit (per kancer gjiri, cerviksi dhe kolorektal). Me shume informacion mbi sherbimet dhe indikatoret e ISHP gjendet ne aneks.

13. KORNIZAT E INDIKATOREVE TE ANALIZUAR DHE HARMONIZIMI ME INDIKATORET BAZE TE SEMUNDJEVE JO INFEKTIVE TE PERDORUR NE VENDE TE RAJONIT.

Puna per identifikimin e setit te indikatoreve baze te perfshire ne kete raport eshte ndertuar mbi vleresimin e disa kornizave dhe modeleve te zhvilluara kohet e fundit ne rang nderkombetar. Keshtu ne maj 2013, asambleja e 66te e organizates boterore te shendetesise adoptoi kornizen e pergjitheshme globale (Global Monitoring Framework - GMF) per

monitorimin e semundjeve jo infektive. GMF perfshinte nje set indikatoresh qe mund et aplikohen ne rajone apo vende te ndryshme te botes me qellim monitorimin e prirjeve dhe perparimeve te bera ne zbatimin e planeve per kontrollin e semundjeve jo infektive.

Nje instrument tjeter i rendesishem i analizuar eshte edhe korniza e indikatoreve baze europiane te shendetit (European Core Health indikator s - ECHI) si dhe H2020 Monitoring Framework, nje instrument per monitorimin e e objektivave strategjike per tu arritur brenda vitit 2020.

Jane analizuar targetet, indikatoret baze (ose 'core'), indikatoret shtese apo plotesues, indikatoret e pasojave si dhe ata te procesit. Jane analizuar gjithashtu, 88 indikatoret e database shendet per te gjithe (Health For All database – HFA), perfshire 67 indikatoret e database te mortalitetit MDB ne Europe etj.
Gjithashtu eshte harmonizuar puna me qendren rajonale te shendetit per semundjet jo infektive ne Mal te Zi (Regional Health Development Centre for NCD-RHDC NCD) ne perpjekjet e perbashketa per ndertimin e kornizes minimale te indikatoreve te semundjeve jo infektive ne vendet e Europes Juglindore.

Eshte pasur parasysh qe te perfshihen indikatoret me te pershtatshem dhe relevante, qe do te mundesonin nje pamje realiste lidhur me gjendjen shendetsore, sistemet shendetsore dhe faktoret risk lidhur me semundjet jo infektive, pa shtuar ne menyre te tepruar barren e sistemeve te informacionit, dhe duke lejuar ne te njejten kohe krahasime nderkombetare ne rajonin tone. Eshte pasur parasysh qe te perfshihen ne strukturen e indikatoreve edhe disa determinante sociale te perzgjedhur.

14. METADATA PER INDIKATORET E PERFSHIRE NE KETE RAPORT.

Per secilin indikator jane dhene Perkufizimet, specifikimet, disagregimet, burimet e informacionit, publikimet, periodiciteti dhe kufizimet potenciale.

Keshtu lidhur me specifikimet apo perkufizimin e indikatorit jane perfshire ne metadata te dhena mbi numeruesin dhe emeruesin.

Disagregrimi qe do te sherbente per matjen e diferencave apo pabarazive perfshin elemente te tille si seksi, gjeografia apo edhe elemente te statusit socioekonomik nese eshte e mundur. Eshte pasur parasysh fakti se statusi socioekonomik eshte vashtire te perfshihet ne indikatoret te cilet mblidhen nga te dhenat e prodhuara nga institucionet shendetsore. Kjo do te shtonte mjaft barren e punes mbi to dhe mund te kercenonte sigurimin e plotesise se vete indikatoreit baze (nje disagregim minimal mbi arsimin apo punesimin do te dyfishonte punen e profesionisteve shendetsore ne plotesimin e formulareve). Ne te kundert do te ishte me e lehte dhe nje barre me e vogel perfshirja e variablave mbi determinantet sociale ne studimet ne popullate te cilet kryhen rralle dhe kane burime financiare te dedikuara.

Sistemet e informacion qe prodhojne te dhenat per kalkulimin e indikatorit jane dhene gjithashtu, perfshire sistemet rutine apo studimet (sistemet e statistikave civile, studimet e bazuar ne popullate, te dhenat nga sherbimet shendetesore, perfshi regjistrat, te dhenat me natyre administrative e financiare etj).
Nje shikim kritik i vlefshmerise apo problemeve lidhur me kostot eshte dhene per shume indikatore.

Periodiciteti i raportimit eshte nje faktor tjeter kyc qe do te ndikonte ne barren e raportimit dhe eshte racionalizuar aq sa eshte e mundur. Disa indikatore mund te raportohen cdo vit, nderkohe qe disda te tjere per arsye te kostove dhe problemeve logjistike nuk mund te kalkulohen me shpesh se cdo 5 vjet.

Duhet pasur parasysh se racionalizimi i indikatoreve per semundjet jo infektive do te duhet te vijoje ne kohe dhe pershtatja e metejshme e tyre eshte e domosdoshme dhe e lidhur me planet dhe nderhyrjet ne fushen e semundjeve infektive ne Shqiperi. Kjo vlen edhe per indikatore te procesit te cilet do te vijojne te hartohen ne perputhje me strategjite apo programet specifike te kontrollit te ketyre semundjeve

15. OBJEKTIVAT

Objektivat e kornizes se indikatoreve baze dhe sistemit te propozuar jane

- Te masin perparimin e kryer ne Shqiperi ne kontrollin e semundjeve jo infektive dhe problemeve te lidhura me to.

- Te rrise kapacitetet monitoruese dhe vleresuese ne Shqiperi ne fushen e semundjeve jo infektive.
- Te promovoje dhe mundesoje ndertimin e politikave te bazuara ne fakte ne Shqiperi
- Te mundesoje harmonizimin e shkembimit te indikatoreve mbi semundjet jo infektive me vende te tjera te rajonit.

Sistemi i monitorimit permes indikatoreve do te mbeshteste mjaft ne punen e tij Komitetin kombetar te parandalimit dhe kontrollit te semundjeve kronike, i sapo miratuar. Me shume detaje mbi funksionet e ketij komiteti jane paraqitur ne aneks.

16. FUSHAT E MBULUARA DHE KRITERET PER PERZGJEDHJEN E INDIKATOREVE

Korniza e indikatoreve mbulon te kater kolonat e kontrollit te semundjeve jo infektive dhe tre fushat e indikatoreve te permendura me siper ne kete raport.

Kater kolonat kontrollit dhe parandalimit te semundjeve jo infektive

- Politika shendetsore qe adresojne faktoret risk dhe determinantet e shendetit
- Programme te parandalimit te semundjeve te lidhur kryesisht me reduktimin e faktoreve risk te semundjeve jo infektive.
- Kapje e hereshme (programme depistimi psh)
- Trajtim efektiv dhe eficient.

16.1. Tre fushat e indikatoreve

- Determinantet e shendetit – sjellje te lidhura me stilin e jeteses dhe kategori te lidhura me pabarazite e mundeshme (gjeografi, vendbanim, pozicion socio ekonomik etj).
- Sistemet shendetesore : burimet financiare per kontrollin dhe parandalimin e semundjeve jo infektive (indikator i imput-it ne sistemin shendetesor), mbulimi me sherbime te kujdesit shendetesor per semundjet jo infektive (indikator i outcome –it te sistemit shendetesor.

- Gjendja shendetsore: vdekshmeria, semundshmeria dhe disabiliteti (indikator i impact-it ne popullate).

16.2. Kriteret per perzgjedhjen e indikatoreve

- Perputhja me kornizat nderkombetare te indikatoreve dhe standartet e OBSH
- Ekzistenca e mundesive praktike (baza ligjore, institucionale dhe burimet) per mbledhjen e te dhenave valide per indikatorin.
- Lista e indikatoreve duhet te pasqyroje ne menyre te balancuar gjithe fushat relevante te politikave qe adresojne semundjet jo infektive.
- Numri final i indikatoreve baze duhet te mbahet i kufizuar duke pasur parasysh ne te ardhmen mund te shtohen indikatore te tjere sidomos indikatore te procesit te detyrueshem prej programeve specifike ne fushen e semundjeve jo infektive.
- Disa indikatore mund te sherbejne per me shume se nje objektiv apo mund te mbulojne me shume se nje fushe te parandalimit te semundjeve jo infektive.

16.3. Semundjet jo infektive te perzgjedhura

Shumica dermuese e qytetareve te Shqiperise vdesin nga:

- Semundjet kardiovaskulare,
- Kanceret,
- Semundjet kronike respiratore dhe
- Diabeti

Propozohet qe te monitorohet semundshmeria dhe vdekshmeria per keto kater semundje joinfektive. Keto do te ishin indikatoret e impact-it qe masin permiresimet ne terma afatgjate per dy objektivat e par ate permendura me lart ne kete raport. Per te gjitha keto semundje jane ngritur tashme bazat e sistemit te informacionit te bazuar ne rastin nga sherbimet shendetsore.

16.4. Faktoret risk te perzgjedhur

Per shumicen e semundjeve jo infektive kater jane faktoret kryesore te riskut te lidhur me sjelljen; dieta e pashendeteshme, perdorimi i duhanit, abuzimi me alkoolin dhe sedentarizmi ose mungesa e aktivitetit fizik. Politikat shendetsore apo nderhyrjet e ndryshme ne shendetesi, te parashikuara nga disa strategji kombetare pergjithesisht i kane renditur keta faktore mes prioriteteve dhe propozojne nderhyrje specifike per kontrollin e tyre. Eshte pra e rendesishme qe te monitorohen keto faktore risk me qellim matjen e progresit ne terma afatmesem. Propozimi eshte qe te monitorohen keto faktore risk permes indikatoreve te meposhtem:

- Prevalenca e duhanpirjes a) tek te rinjte b) tek adultet
- Dieta e pashendetshme a) mbipesha tek te rinjte b) mbipesha tek adultet c) konsumi i ulet i fruta perimeve dhe **opsionale** d) konsumi i kripes dhe e) konsumi i yndyrnave te saturuara
- Prevalenca e konsumit te alkoolit a) konsumi per kapita tek adultet b) konsumi i demshem i alkoolit tek te rinjte
- Sedentarizmi a) Ianktiviteti fizik tek te rinjte dhe **opsional** b) inaktiviteti fizik tek adultet.

Me perjashtim te konsumit per kapita te alkoolit i cili mund te sigurohet nga te dhena te tregetise dhe te prodhimit kombetar, indikatoret e tjere kerkojne kryerjen e studimeve ne popullate, (per te rinjte permes studimeve me te thjeshta dhe te shpejta tek te rinjte e shkollave). Keto mund te konsiderohen si hapi apo faza e pare dhe e dyte tek instrumenti STEPS i propozuara nga OBSH per survejancen e semundjeve jo infektive ne popullate (pyetesori dhe matjet fizike). Konsumi i kripes dhe deri diku konsumi i yndyrnave te saturura jane propozuar te jene opsionale per arsye te kompleksitetit te matjes (per kripen kerkohet matje e natriumit te ekskretuar ne urine dhe ende nuk ka asnje studim ne popullate ne vendin tone).

Tre jane faktoret risk metabolike me te rendesishem per semundjet kardiovaskulare apo edhe per semundje te tjera jo infective dhe tre jane indikatoret e propozuar per tu matur :

- tensioni i larte i gjakut,

- yndyrnat e larta ne gjak (**opsional**) dhe
- glukoza e larte ne gjak (**opsional**).

Per matjen e dy faktoreve te fundit metabolike kerkohen studime relativisht te komplikuara ne popullate me perfshirje e matjeve biokimike (faza e trete tek instrumenti STEPS i propozuara nga OBSH per survejancen e semundjeve jo infektive ne popullate). Propozohet qe presioni i rritur i gjakut te jete indikator baze, per dy arsye: disa studime ne Shqiperi kane deshmuar qe hipertensioni eshte mjaft i larte dhe i menaxhuar keq ne sherbimet shendetsore. Gjithashtu hipertensioni ka qene pjese e studimeve kombetare ne popullate dhe mund te aplikohet relativisht lehte (faza apo hapi i dyte i STEPS). Kolesterolemia e larte dhe glicemia e larte propozohet te jene indikatore shtese.

16.5. Kapacitetet ne sistemin shendetsor

Sistemi shendetsor perfshin jo vetem sherbimet shendetsore per parandalim, diagnoze dhe trajtim te semundjeve jo infektive, por edhe instrumenta dhe politika te cilat ndikojne ne kontrollin strategjik te rrenjeve te ketyre semundjeve si dhe ne mbikqyrjen e perparimeve te bera. Per kete arsye ne kornizen e indikatoreve baze jane perfshire vec 4 indikatoreve qe ndihmojne per monitorimin e sherbimeve esenciale edhe tre indikatore politikash dhe koordinimi ne nivel vendimmarrje;

- Terapia dhe keshillimi per parandalimin e aksidenteve kardiovaskulare,
- Barnat dhe pajisjet baze per menaxhimin klinik te semundjeve jo infektive,
- Kujdesi paliativ,
- Depistimi per kancerin e qafes se mitres

- Regullimi I marketingut tek femijet i ushqimeve te pashendetshme,
- Eliminimi i acideve trans-yndyrore
- Bordi kombetar i semundjeve jo infective.

16.6. Pabarazite shendetsore te lidhura me semundjet jo infektive

Per matjen dhe monitorimin e pabarazive shendetesore lidhur me semundjet jo infektive eshte i nevojshem disagregimi apo shperndarja e te dhenave sipas disa variablave me ndikim te mundshem si zona gjeografike apo vendbanimi, arsimi apo te ardhurat. Duke qene se mundesite jane te kufizuara per t'u perfshire keto variabla ne sistemet e informacionit rutine nga sherbimet shendetesore, propozohet te ndiqet nje qasje graduale e matjes se tyre; planifikimi i perfshirjes se variableve lidhur me determinate socio ekonomike ne studimet qe do te kryhen ne te ardhmen dhe zgjerimi ne terma afatgjate i statistikave rutine (pas forcimit te funksionimit te tyre) me te dhena qe do te ndihmonin shperndarje te situates shendetsore sipas kategorive socioekonomike te permendura me siper.

17. KORNIZA E INDIKATOREVE DHE DETAJE TE LIDHURA ME TA

17.1. Kategoria : pasoja shendetsore

c. Vdekshmeria e parakoheshme nga semundjet jo infektive

Indikatori	**Vdekshmeria e parakoheshme nga semundjet kardiovaskulare**
Perkufizimi	Probabiliteti i vdekjes ne moshat 30-70 vjec nga semundjet kardiovaskulare, te klasifikuara ne ICD10 ne kodet I00-I99
Matja	Proporcioni i vdekjeve ICD10 (I00-I99) ne moshat 30-70 vjec me popullaten e vleresuar 30-70 vjec i shprehur per 100000
Burimi i informacionit	Raportimi i skedave te vdekjes
Disagregimi	Seks, moshe, vendbanim,
Periodiciteti	Cdo vit
Kufizime	Paplotshmeri e skedave te vdekjes, mungesa ne raportim

Indikatori	**Vdekshmeria e parakoheshme nga semundjet neoplazike ose kanceret**
Perkufizimi	Probabiliteti i vdekjes ne moshat 30-70 vjec nga semundjet neoplazike, te klasifikuara ne ICD10 ne kodet C00-IC97
Matja	Proporcioni i vdekjeve ICD10 (C00-C97) ne moshat 30-70 vjec me popullaten e vleresuar 30-70 vjec i shprehur per 100000
Burimi i informacionit	Raportimi i skedave te vdekjes
Disagregimi	Seks, moshe, vendbanim,
Periodiciteti	Cdo vit
Kufizime	Paplotshmeri e skedave te vdekjes, mungesa ne raportim

Indikatori	**Vdekshmeria e parakoheshme nga semundjet kronike respiratore**
Perkufizimi	Probabiliteti i vdekjes ne moshat 30-70 vjec nga semundjet kronike respiratore, te klasifikuara ne ICD10 ne kodet J30-J98
Matja	Proporcioni i vdekjeve ICD10 (J30-J98) ne moshat 30-70 vjec me popullaten e vleresuar 30-70 vjec i shprehur per 100000
Burimi i informacionit	Raportimi i skedave te vdekjes
Disagregimi	Seks, moshe, vendbanim,
Periodiciteti	Cdo vit
Kufizime	Paplotshmeri e skedave te vdekjes, mungesa ne raportim

Indikatori	**Vdekshmeria e parakoheshme nga diabeti**
Perkufizimi	Probabiliteti i vdekjes ne moshat 30-70 vjec nga diabeti, te klasifikuara ne ICD10 ne kodet E10-E14
Matja	Proporcioni i vdekjeve ICD10 (E10-E14) ne moshat 30-70 vjec me popullaten e vleresuar 30-70 vjec i shprehur per 100000
Burimi i informacionit	Raportimi i skedave te vdekjes
Disagregimi	Seks, moshe, vendbanim,
Periodiciteti	Cdo vit
Kufizime	Paplotshmeri e skedave te vdekjes, mungesa ne raportim

d. Semundshmeria spitalore nga semundjet jo infektive

Indikatori	**Incidenca e infarktit te miokardit**
Perkufizimi	Numri i rasteve te reja te diagnostikuar me infarkt akut miokardi nga nje qender e specializuar i shprehur si raste per 100 000 banore
Matja	Numeruesi : Numri i rasteve te reja te diagnostikuar me infarkt akut miokardi nga nje qender e specializuar ne nje vit te dhene Emeruesi : popullata ne risk (praktikisht gjithe popullata e vleresuar e vendit)
Burimi i informacionit	Spitalet. Regjistri i semundjeve ishemike te zemres
Disagregimi	Seks, moshe, vendbanim,
Periodiciteti	Cdo vit
Kufizime	Paplotshmeri e skedave individuale, mungesa ne raportim nga spitalet

Indikatori	**Incidenca e aksideneteve cerebro vaskulare**
Perkufizimi	Numri i rasteve te reja te diagnostikuar me insulte cerbrovaskulare nga nje qender e specializuar i shprehur si raste per 100 000 banore
Matja	Numeruesi : Numri i rasteve te reja te diagnostikuar me insulte cerebrovaskulare nga nje qender e specializuar ne nje vit te dhene Emeruesi : popullata ne risk (praktikisht gjithe popullata e vleresuar e vendit)
Burimi i informacionit	Spitalet. Regjistri i aksideneteve cerebrovaskulare
Disagregimi	Seks, moshe, vendbanim,
Periodiciteti	Cdo vit
Kufizime	Paplotshmeri e skedave individuale, mungesa ne raportim nga spitalet

Indikatori	**Incidenca e kancereve**
Perkufizimi	Numri i rasteve te reja te diagnostikuar me kancer sipas tipeve nga nje qender e specializuar i shprehur si raste per 100 000 banore
Matja	Numeruesi : Numri i rasteve te reja te diagnostikuar me kancer sipas tipit nga nje qender e specializuar ne nje vit te dhene. Tipi i kancerit nenkupton vendin e origjines dhe jo metastazat. Nuk perfshihet rishfaqja e kancerit Emeruesi : popullata ne risk per tipin e kancerit. Per tipet e kancereve qe ndodhin vetem ne njerin seks, vetem popullata seks-specifike perdoret (psh vetem meshkujt per kancerin e prostates etj)
Burimi i informacionit	Spitalet. Regjistri kancerit. Por mund te sigurohen te dhena edhe nga vleresimet e GLOBOCAN
Disagregimi	Seks, moshe, vendbanim,
Periodiciteti	Cdo vit
Kufizime	Paplotshmeri e skedave individuale, mbulesa jo e plote me raportim nga gjithe territori i vendit.

Indikatori	**Incidenca e diabetit te diagnostikuar**
Perkufizimi	Numri i rasteve te reja te diagnostikuar me diabet nga sistemi shendetesor i shprehur si raste per 100 000 banore
Matja	Numeruesi : Numri i rasteve te reja te diagnostikuar me diabet nga sistemi shendetsor ne nje vit te dhene Emeruesi : popullata ne risk (praktikisht gjithe popullata e vleresuar e vendit)
Burimi i informacionit	Spitalet. Regjistri i diabetit
Disagregimi	Seks, moshe, vendbanim,
Periodiciteti	Cdo vit
Kufizime	Paplotshmeri e skedave individuale, mungesa ne raportim nga spitalet

17.2. Kategoria : Ekspozim ndaj faktoreve risk

c. Stili i jeteses

Indikatori	**Duhanpirja tek adultet**
Perkufizimi	Prevalenca ne perqindje sipas moshes e personave te rritur qe pijne duhan ose konsumojne produkte te duhanit
Matja	Numeruesi : numri i adulteve mbi 18 vjec qe pijne duhan perdite ose me edhe rralle Emeruesi : gjithe personat e perfshire ne studim
Burimi i informacionit	Studime ne popullate (mundesisht kampion i popullates se gjithe vendit)
Disagregimi	Mosha, seksi, vendbanimi dhe te dhena te tjera lidhur me pozicionin socio ekonomik te familjes nese eshte e mundur. ADHS, Studimi substance use in general population, ndoshta nje studim STEPS
Periodiciteti	Cdo 5 vjet
Kufizime	Perfaqesueshmeri e kampioneve te zgjedhur, gabime sistematike te lidhur me pyetesoret etj

Indikatori	**Duhanpirja tek te rinjte**
Perkufizimi	Perqindja e adoleshenteve qe pijne duhan ose konsumojne produkte te duhanit
Matja	Numeruesi : adoleshentet e moshave nga 10 ne 19 vjec qe pijne duhan perdite ose me edhe rralle Emeruesi : gjithe adoleshentet e perfshirene studim
Burimi i informacionit	Studime ne shkolla me kampione te te gjithe vendit. ESPAD Albania, GYTS Albania, YRBS Albania HBSC Albania
Disagregimi	Mosha, seksi, vendbanimi dhe te dhena te tjera lidhur me pozicionin socio ekonomik te familjes nese eshte e mundur
Periodiciteti	Te pakten cdo 5 vjet
Kufizime	Perfaqesueshmeri e kampioneve te zgjedhur, gabime sistematike te lidhur me pyetesoret veteraportues etj

Indikatori	**Perdorimi demshem i alkoolit : konsumi per kapita mes adulteve**
Perkufizimi	Konsumi total per kapita i alkoolit te paster ne vit i matur ne litra (tek personat mbi 15 vjec)
Matja	Numeruesi : sasia totale e alkoolit te konsumuar (te rregjistruar dhe te parregjistruar) nga popullate gjate nje viti kalendarik, ne litra Emeruesi : popullata mbi 15 vjec e vleresuar ne mes te vitit
Burimi i informacionit	Te dheant mbi konsumin total te alkoolit mund te bazohen ne statistikat zyrtare te shitjeve te pijeve alkoolike, improt eksporti sipas katogorive e ndryshme te pijeve alkoolike. Duhen marre parasysh edhe te dhenat e studimeve nga prodhuesit mbi alkoolin e paregjistruar qe qarkullon apo te dhenat e paraqitura nga Organizata Boterore e Bujqesise dhe Ushqimit (FAO). Per vleresuim mun dte perdoren edhe studime te perdorimit te alkoolit nga popullata
Disagregimi	Mosha, seksi nese eshte e mundur
Periodiciteti	Cdo vit
Kufizime	Paplotesi ne statistikat zyrtare biase te lidhura me studimet, keqvleresimet e eksperteve

Indikatori	**Perdorimi demshem i alkoolit: konsumi i rende episodik**
Perkufizimi	Konsumi i rende episodik eshte konsumi i 60 gr (6 gota pije) ose me shume alkool te paster ne nje episod
Matja	Numeruesi : numri i pjesemarresve ne studim qe raportojne te kene konsumuar 60 g ose me shume alkool te paster, te pakten nje here ne muaj Emeruesi : numri i pjesemarresve ne studim

	Prevalence shprehet ne perqindje
Burimi i informacionit	Studim ne popullate, mundesisht me kampion te popullates se vendit. ADHS, Studimi substance use in general population, ndoshta nje studim STEPS
Disagregimi	Mosha, seksi vendbanimi dhe faktore te tjere socio ekonomike nese eshte e mundur
Periodiciteti	Cdo 5 vjet
Kufizime	Gabime systematike te lidhura me studimet, validitet i ulet i pyetjeve, keqinterpretim i sasise se pijes etj

Indikatori	**Inaktiviteti fizik tek te rinjte**
Perkufizimi	Perqindja e adoleshenteve qe marrin pjese ne me pak se 60 minuta aktivitet fizik intensiv apo te moderuar ne dite
Matja	Numeruesi : pjesemarresit ne studim te moshave nga 10 ne 19 vjec per te cilet numri i diteve me mbi 60 minuta aktivitet fizik si me siper, eshte me pak se 7 ne jave Emeruesi : gjithe adoleshentet e perfshirene studim Shprehet ne perqindje
Burimi i informacionit	Studime ne shkolla me kampione te te gjithe vendit. YRBS Albania, HBSC Albania,
Disagregimi	Mosha, seksi, vendbanimi dhe te dhena te tjera lidhur me pozicionin socio ekonomik te familjes nese eshte e mundur
Periodiciteti	Te pakten cdo 5 vjet
Kufizime	Perfaqesueshmeri e kampioneve te zgjedhur, gabime sistematike te lidhur me pyetesoret, keqkuptim i pyetjeve mbi volumin e aktivitetit fizik etj

Indikatori	**Konsumi i ulet i fruta perimeve**
Perkufizimi	Prevalenca ne perqindje sipas moshes e personave te rritur qe konsumojne mesdatarisht me pak se 5 fruta ose perime (nen 400 gr) ne dite. Nje frute ose perime vleresohet 80 gram

Matja	Numeruesi : numri i pjesemarresve mbi 18 vjec qe konsumojne me pak se 5 fruta ose perime ne dite Emeruesi : gjithe personat mbi 18 vjec te perfshire ne studim
Burimi i informacionit	Studime me veteraportim ne popullate (mundesisht kampion i popullates se gjithe vendit). ADHS, ndoshta nje studim STEPS, ndoshta nje studim specific mbi ushqyerjen
Disagregimi	Mosha, seksi, vendbanimi dhe te dhena te tjera lidhur me pozicionin socio ekonomik te familjes nese eshte e mundur
Periodiciteti	Cdo 5 vjet
Kufizime	Perfaqesueshmeri e kampioneve te zgjedhur, gabime sistematike te lidhur me veteraportimin etj

8.2. Kategoria : Ekspozim ndaj faktoreve risk

d. Faktoret metabolike

Indikatori	**Mbipesha dhe obeziteti tek te rinjte**
Perkufizimi	Perqindja e adoleshenteve mbipeshe apo obeze sipas standarteve te rritjes te OBSH per femijet e shkolles dhe adoleshentet ; mbipeshe 1 deviacion standard te indeksit te mases trupore (BMI) sipas seksit dhe moshes, dhe obez 2 deviacione standard >= 1 DS eshte ekuivalent e >= 25 kg/m2 ne 19 vjec dhe >= 2DS ekuivalent e >=30 kg/m2 ne 19 vjec
Matja	Numeruesi : e) pjesemarresit mbi peshe 10-19 vjec ne studim f) pjesemarresit obeze 10-19 vjec ne studim Emeruesi: gjithe adoleshentet e perfshire ne studim Shprehet ne perqindje
Burimi i informacionit	Studime ne shkolla me kampione te te gjithe vendit. Nje YRBS i adaptuar. Ndoshta nje studim specifik mbi

	ushqyerjen ne shkolla
Disagregimi	Mosha, seksi, vendbanimi dhe te dhena te tjera lidhur me pozicionin socio ekonomik te familjes nese eshte e mundur
Periodiciteti	Te pakten cdo 5 vjet
Kufizime	Perfaqesueshmeri e kampioneve te zgjedhur, gabime sistematike te lidhur me matjet fizike

Indikatori	**Mbipesha dhe obeziteti tek adultet**
Perkufizimi	Prevalenca ne perqindje e personave adulte mbi 18 vjec mbipeshe apo obeze mbipeshe >= 25 kg/m2 e indeksit te mases trupore (BMI) obezitet >=30 kg/m2 e indeksit te mases trupore (BMI)
Matja	Numeruesi : a) pjesemarresit mbi 18 vjec mbi peshe ne studim b) pjesemarresit mbi 18 vjec obeze ne studim Emeruesi: gjithe pjesemarresit mbi 18 vjec ne studim Shprehet ne perqindje
Burimi i informacionit	Studime ne popullate me kampione te te gjithe vendit. ADHS, ndoshta nje studim STEPS, ndoshta nje studim specifik mbi ushqyerjen ne popullate
Disagregimi	Mosha, seksi, vendbanimi dhe te dhena te tjera lidhur me pozicionin socio ekonomik te familjes nese eshte e mundur
Periodiciteti	Cdo 5 vjet
Kufizime	Perfaqesueshmeri e kampioneve te zgjedhur, gabime sistematike te lidhur me matjet fizike

Indikatori	**Tensioni i larte i gjakut**
Perkufizimi	Presioni sistolik >=140 mmHg dhe/ose diastolik >= 90 mmHg tek personat mbi 18 vjec.
Matja	Numeruesi : numri i pjesemarresve mbi 18 vjec me tension sistolik >=140 dhe/ose diastolik >= 90 Emeruesi: gjithe pjesemarresit mbi 18 vjec ne studim Shprehet ne perqindje
Burimi i informacionit	Studime ne popullate me kampione te te gjithe vendit, ku tensioni i gjakut matet jo veteraportohet. ADHS, ndoshta nje studim STEPS,
Disagregimi	Mosha, seksi, vendbanimi dhe te dhena te tjera lidhur me pozicionin socio ekonomik te familjes nese eshte e mundur
Periodiciteti	Cdo 5 vjet
Kufizime	Perfaqesueshmeri e kampioneve te zgjedhur, gabime sistematike te lidhur me matjen e tensionit te gjakut

8.3. Kategoria : sistemi shendetesor per semundjet jo infektive

Indikatori	**Terapia dhe keshillimi per parandalimin e aksidenteve kardiovaskulare**
Perkufizimi	Proporcioni i personave mbi 40 vjec me nje risk 10 vjecar kardiovaskular >=30% (perfshi ata te diagnostikuar me semundje kardiovaskulare) qe marrin terapi dhe keshillim per parandalimin e aksidenteve kardiovaskulare. • Terapia nenkupton marrjen e barnave per kontrollin e huiperglicemise, hiperkolesterolemise apo hipertensionit , si dhe marrjen e aspirines dhe statinave per parandalim te problemeve kardiovaskulare • Keshillimi nenkupton marrjen e informacionit nga nje mjek apo profesionist tjeter shendetsor per lenien e duhanit, uljen e kripes ne ushqim, marrjen e 5 fruta perimeve ne dite, uljen e yndyrnave ne ushqim, fillimin e aktivitetit fizik, kontrollin e peshes trupore etj
Matja	Numeruesi : numri i personave ne nevoje (sic eshte pershkruar me lart) qe marrin terapi ose keshillim Emeruesi: numri total i personave ne nevoje (sic eshte pershkruar me lart) Shprehet ne perqindje
Burimi i informacionit	c) Studime ne po pullate me veteraportim nga pjesemaresit. d) Nje menyre alternative do te ishte perdorimi i informacionit nga sherbimet baze shendetesore oper popullaten 40-65 vjec, lidhur me perdorimin e ketyre sherbimeve
Disagregimi	Mosha, seksi, vendbanimi dhe te dhena te tjera lidhur me pozicionin socio ekonomik te familjes nese eshte e mundur

Periodiciteti	c) Cdo 5 vjet d) Cdo vit
Kufizime	c) Kufizime te lidhura me perfaqesueshmerine e kampioneve te zgjedhur, validitetin e pyetesoreve d) Veshtiresi per te vleresuar emeruesin apo popullaten ne nevoje

Indikatori	**Barnat dhe pajisjet baze per semundjet jo infektive**
Perkufizimi	Proporcioni i qendrave shendetesore dhe poliklinikave te cilat i kane gjitha barnat dhe pajisjet e meposhteme : • Barnat – aspirin, nje statine, nje bllokues enzime (ACEI), nje diuretik tiazid, nje kalci-bllokues, metformine, insuline, nje bronkodilatator dhe nje inhalant steroid • Pajisjet – aparat per matjen e tensionit, peshore, teste te shpejta per glicemine, kolesterolemine dhe albuminurine
Matja	Numeruesi: qendrat shendetsore te pajisura me gjithe barnat dhe pajisjet e listura ne listen me siper Emeruesi: numri i gjithe qendrave te vleresuara Shprehet ne perqindje
Burimi i informacionit	Studim mbi nje numer perfaqesues qendrash shendetsore te vendit
Disagregimi	Publike dhe private, fshat dhe qytet etj
Periodiciteti	Cdo 5 vjet
Kufizime	Paplotesia e raportimit nga qendrat shendestore

Indikatori	**Kujdesi paliativ**
Perkufizimi	Aksesi ne kujdesin paliativ i matur me konsumin e e analgjezikeve te forte ne ekuivalente te morfines (perjashtuar metadonin) per cdo vdekje nga kanceri
Matja	Numeruesi: konsumi ne nivel popullate i analgjezikeve te forte ne ekuivalente te morfines ne nje periudhe te caktuar Emeruesi: numri i vdekjeve nga kanceri pergjate se njejtes periudhe Volumet morfine –ekuivalente perllogariten si: (1*morfine)+(83.3*fentanyl)+(5*hydromorphone)+(1.33*oxycodone)+(0.25*pethidine) Shprehet ne formen e nje raporti
Burimi i informacionit	Informacioni mbi konsumin merret nga raportet vjetore mbi konsumin e narkotikeve te Bordit nderkombetar te kontrollit te narkotikeve (INCB) Te dhenat mbi vdekjet nga kanceret nga skedat e vdekjes
Periodiciteti	Cdo vit
Kufizime	Paplotesia e skedave te vdekjeve dhe mangesite ne raportimin e vdekjeve

Indikatori	**Depistimi per kancerin e qafes se mitres**
Perkufizimi	Proporcioni i grave 30-49 vjec te testuara per kancer cervikal te pakten nje here ose me shpesh me pap test ose me testin HPV
Burimi i informacionit	a) Studime ne popullate. ADHS b) Informacion nga sherbimet shendetesore. Raportimi ne ISHP nga qendrat e depistimit
Disagregimi	a) Mosha seksi, vendbanimi dhe pozicioni socioekonomik nese eshte e mundur
Periodiciteti	a) Cdo 5 vjet b) Cdo 2 vjet
Kufizime	Perfaqesueshmeri e kampioneve te zgjedhur, probleme me veteraportimin etj

Indikatori	**Marketing tek femijet i ushqimeve te pashendetshme**
Perkufizimi	Politika qe ulin pasojat e marketingut te ushqimeve me permbajtje te larte te sheqernave, yndyrnave te saturuara, acideve trans-yndyrore dhe kripes
Burimi i informacionit	Permes plotesimit te pyetesorit sistematik te OBSH mbi kapacitetet e vendit per semundjet jo infektive
Periodiciteti	Cdo dy vjet
Kufizime	Keq interpretime te politikave ekzistuese apo te mungeses se tyre

Indikatori	**Eliminimi i acideve trans-yndyrore**
Perkufizimi	Adoptimi i politikave qe kufizojne acidet trans-yndyroredhe qe praktikisht eliminojne vajrat vegjetale pjeserisht te hidrogjenizuara ne produktet ushqimore
Burimi i informacionit	Permes plotesimit te pyetesorit sistematik te OBSH mbi kapacitetet e vendit per semundjet jo infektive
Periodiciteti	Cdo dy vjet
Kufizime	Keq interpretime te politikave ekzistuese apo te mungeses se tyre

Indikatori	**Bordi kombetar per kontrollin e semundjeve jo infektive**
Perkufizimi	Funksionimi i nje bordi ose komiteti per perfaqesim multidisiplinar i miratuar ne nivel ministerial ose me te larte
Burimi i informacionit	Permes plotesimit te pyetesorit sistematik te OBSH mbi kapacitetet e vendit per semundjet jo infektive
Periodiciteti	Cdo dy vjet
Kufizime	Keq interpretime mbi rolin e bordit ose mbi multidisiplinaritetin

8.4. Indikatore shtese ose opsionale

Indikatori	**Konsumi i kripes**
Perkufizimi	Mesatarja e konsumit ditor te kripes (NaCl) sipas moshes e personave te rritur (mbi 18 vjec) ne grame
Matja	Emeruesi: totali i natriumit te eksktretuar ne urine nga personat e perfshire ne studim. Standarti arte eshte urina 24 oreshe por per arsye te veshtiresise, mund te perdoren edhe studime te tjera relativisht me te thjeshta (si matja e sasise se kripes permes pyetesoreve te ushqyerjes) Emeruesi: gjithe pjesemarresit ne studim Shprehet me mesatare artimetike
Burimi i informacionit	Studime ne popullate
Disagregimi	Mosha, seksi, vendbanimi dhe te dhena te tjera lidhur me pozicionin socio ekonomik te familjes nese eshte e mundur
Periodiciteti	Te pakten cdo 5 vjet
Kufizime	Perfaqesueshmeri e kampioneve te zgjedhur, gabime sistematike te lidhura me matjen e natriumit

Indikatori	**Inaktivitet fizik tek adultet**
Perkufizimi	Prevalenca ne perqindje sipas moshes e personave te rritur qe nuk jane fizikisht aktive ne menyre adekuate, cka do te thote qe nuk permbushin asnje nga kriteret e meposhtem : • 150 minuta aktivitet fizik i moderuar ne jave • 75 minuta aktivitet fizik intensiv ne jave • Cdo aktivitet fizik i kombinuar te pakten 600 MET minuta ne jave MET eshte Ekuivalenti Metabolik. Shpreh raportin e nivelit metabolik ne pune me nivelin metabolik ne qetesi te nje personi. Nje MET eshte kosto energjitike e te qendruarit ulur dhe eshte ekuivalente e konsumit kalorik prej 1 Kcal/Kg/Ore. MET shpesh perdoret si reference per klasifikimin e intensitetit te aktivitetit fizik.

	Minutat e aktivitetit fizik mund te akumulohen pergjate javes, por duhet te zgjasin te pakten 10 minuta ne nje episod
Matja	Numeruesi : numri i pjesemarresve ne studim (mbi 18 vjec) qe nuk permbush asnje nga kriteret e lartpermendur mbi aktivitetin fizik adekuat. Emeruesi: gjithe personat e perfshire ne studim mbi 18 vjec
Burimi i informacionit	Studime ne popullate (mundesisht kampion i popullates se gjithe vendit)
Disagregimi	Mosha, seksi, vendbanimi dhe te dhena te tjera lidhur me pozicionin socio ekonomik te familjes nese eshte e mundur
Periodiciteti	Cdo 5 vjet
Kufizime	Perfaqesueshmeri e kampioneve te zgjedhur, gabime sistematike te lidhur me pyetesoret, keqinterpretime te volumit te aktivitetit fizik etj

Indikatori	**Yndyrnat e saturuara**
Perkufizimi	Proporcioni mesatar i energjive te marra prej acideve yndyrore te saturuara (AYS) sipas moshes te personat e rritur (mbi 18 vjec)
Matja	Numeruesi: shuma e proporcioneve te AYS ne totalin e energjive te marra nga cdo pjesemarres i rritur ne studim Emeruesi: gjithe pjesemarresit mbi 18 vjec ne studim Shprehet perqindje
Burimi i informacionit	Studime me pyetesore ushqimore ne popullate. Por mund te sigurohen vleresime nga statistikat e FAO mbi balancat ushqimore kombetare
Disagregimi	Mosha, seksi, vendbanimi dhe te dhena te tjera lidhur me pozicionin socio ekonomik te familjes nese eshte e mundur
Periodiciteti	Te pakten cdo 5 vjet

Kufizime	Perfaqesueshmeri e kampioneve te zgjedhur, gabime sistematike te lidhura me keqinterpretime ne veteraportimin e ushqyerjes

Indikatori	**Hiperglicemia/ diabeti**
Perkufizimi	Prevalenca sipas moshes e sheqerit te rritur ne gjak / diabetit tek personat mbi 18 vjec. Konsiderohet e rritur vlera >= 7mmol/L (126 mg/dl) e glukozes ne plazme esell.
Matja	Numeruesi : numri i pjesemarresve mbi 18 vjec me vlera te glukozes ne plazme esell >= 7mm/L (126 mg/dl). Konsiderohen me diabet edhe personat qe nuk e kane glukozen e rritur ne momentin e matjes, por marrin mjekim per te. Emeruesi: gjithe pjesemarresit mbi 18 vjec ne studim Shprehet ne perqindje
Burimi i informacionit	Studime ne popullate me kampione te te gjithe vendit, ku behet e mundur matja e glukozes ne gjak (konsiderohen te vlefshme edhe testi i shpejte me gjak kapilar edhe testi laboratori me gjak venoz)
Disagregimi	Mosha, seksi, vendbanimi dhe te dhena te tjera lidhur me pozicionin socio ekonomik te familjes nese eshte e mundur
Periodiciteti	Cdo 5 vjet
Kufizime	Perfaqesueshmeri e kampioneve te zgjedhur, gabime sistematike te lidhur me matjen, validiteti i instrumentit, mos ruajtja e statusit esell etj

Indikatori	**Kolesteroli total i rritur ne gjak**
Perkufizimi	Prevalenca sipas moshes e kolesterolit total te rritur ne tek personat mbi 18 vjec. Konsiderohet e rritur vlera >= 5 mmol/L (190 mg/dl) e kolesterolit total ne plazme.
Matja	Numeruesi : numri i pjesemarresve mbi 18 vjec me vlera vlera >= 5 mmol/L (190 mg/dl) te kolesterolit total ne plazme. Emeruesi: gjithe pjesemarresit mbi 18 vjec ne studim Shprehet ne perqindje
Burimi i informacionit	Studime ne popullate me kampione te te gjithe vendit, ku behet e mundur matja e kolesterolit ne gjak (konsiderohen te vlefshme edhe testi i shpejte me gjak kapilar edhe testi laboratori me gjak venoz)
Disagregimi	Mosha, seksi, vendbanimi dhe te dhena te tjera lidhur me pozicionin socio ekonomik te familjes nese eshte e mundur
Periodiciteti	Cdo 5 vjet
Kufizime	Perfaqesueshmeri e kampioneve te zgjedhur, gabime sistematike te lidhur me matjen, validiteti i instrumentit, etj

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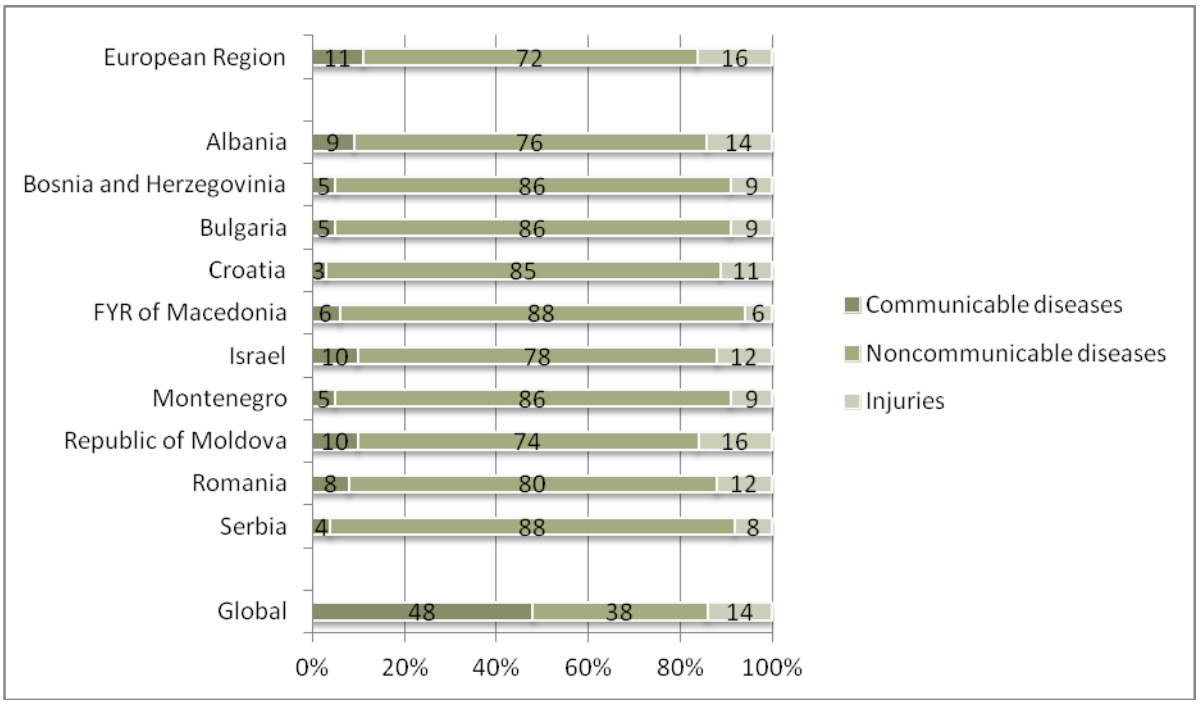
Aneks 1

Grupet e semundjeve jo infektive dhe barra e tyre ne shendet. Ne bote, rajon dhe Shqiperi

Barra e semundjeve dhe e vdekjeve prej semundjeve kronike ne Rajonin Europian te OBSH, sipas shkaqeve (2010)

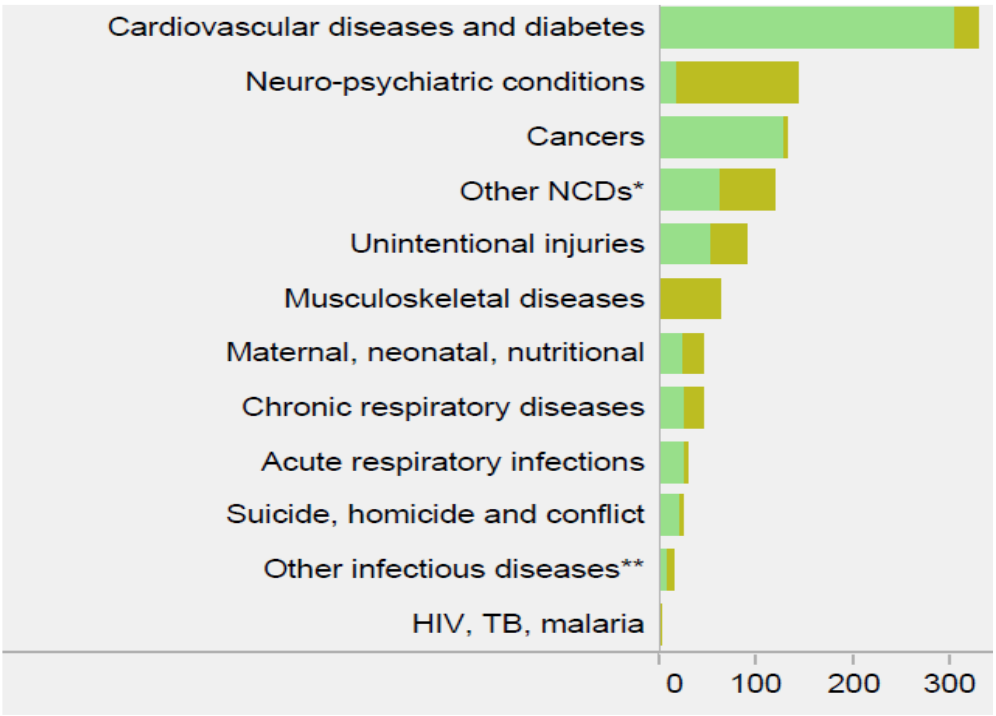
Grupet e semundjeve	Barra e semundjeve		Vdekjet	
	DALY (ne milione)	Proporcioni mbi gjithe shkaqet (%)	Numri (ne milione)	Proporcioni mbi te gjitha shkaqet (%)
Semundjet kardiovaskulare	34.4	23	5.1	52
Semundjet neuropsikiatrike	29.4	20	0.3	3
Kanceret (neoplazmat malinje)	17.1	11	1.9	19
Semundjet respiratore	6.8	5	0.4	4
Semundjet digjestive	7.1	5	0.4	4
Semundjet muskuloskeletike	5.8	4	0.03	0
Diabeti	2.3	2	0.15	2
Gjithe semundjet kronike	115.3	77	8.2	86
Gjithe shkaqet	150.3	100	9.6	100

Proporcioni i viteve te humbura te jetes dedikuar semundjeve jo infektive ne vende te Europes Juglindore (World Health Statistics, 2011)



Barra e semundjet ne Shqiperi. 2012

DALY, YLL dhe YLD (ne 000) sipas kategorive te semundjeve



Aneks 2

Faktoret risk te semundjeve jo infektive

Profili i barres se semundjeve kronike ne te ardhmen mund te projektohet duke u bazuar ne te dhenat mbi faktoret risk. Faktoret risk kryesore ne rang boteror per semundjet kronike jane hipertensioni, perdorimi i duhanit, kolesteroli i larte, dieta e varfer me fruta perime, mbipesha, jeta sedentare dhe abuzimi me alkoolin.

Keto shkaqe shprehen nepermjet faktereve risk te ndermjetem te tille si hipertensioni, hiperglicemia, nivelet anormale te yndyrnave ne gjak (sidomos lipoproteinat me densitet te ulet – kolesteroli LDL), dhe mbipesha/obeziteti (indeksi i mases trupore mbi 25 apo mbi 30)

Faktoret risk te modifikueshem sebashku me faktoret risk te pamodifikueshem te tille si mosha dhe trashegimia shpjegojne situaten epidemiolgjike lidhur me semundjet ishemike te zemres, semundjet cerebrovaskulare, semundjet kronike respiratore dhe disa kancere. Menyra se si faktoret risk sjellin semundjet kronike kryesore eshte e ngjashme ne te gjitha vendet e botes, pavaresisht disa perpjekjeve per te demostruar diferenca ne gravitetin e shfaqjes se shenjave te disa semundjeve.

Faktore socioekonomike Kulturore, politike dhe determinante mjedisore -Globalizimi -Urbanizimi -Plakja e popullates	**Faktore risk te modifikueshem** -Diete e gabuar -Inaktivitet fizik - Perdorim duhani - Abuzim alkooli **Faktore te pamodifikueshem** -Mosha -Trashegimia	**Faktore risk te ndermjetem** -Hipertensioni -Hiperglicemia -Yndyrna anormale ne gjak -Mbipesha/obeziteti	**Semundjet kryesore kronike** -Semundja ishemike e zemres -Cerebrovaskulare -Kanceri -Semundjet respiratore kronike -Diabeti

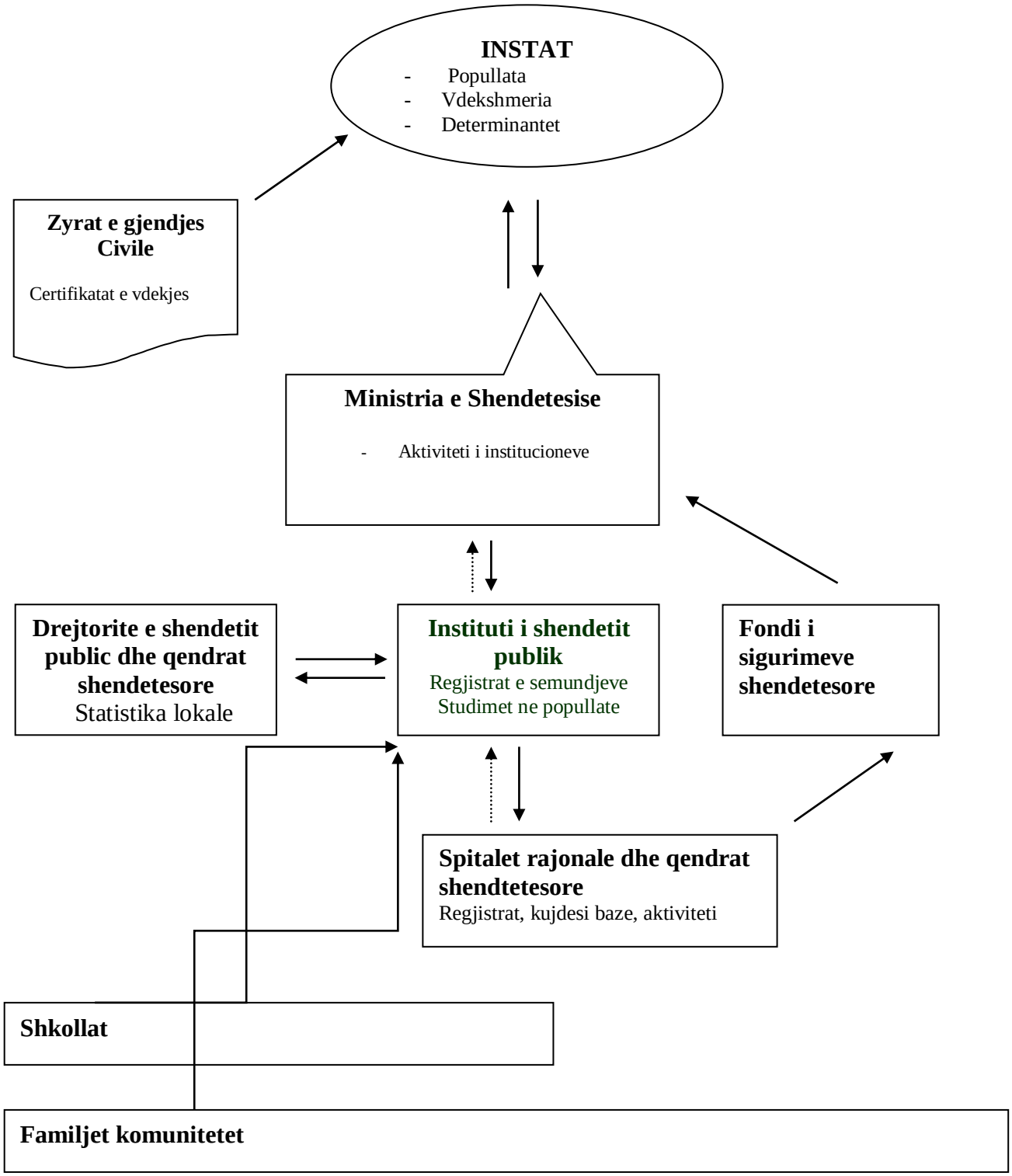
Duhanpirja vazhdon te ngelet shkaku i menjanueshem me i rendesishem i vdekjeve ne vendet e industrializuara. Ne Europe prevalenca e duhanpiresve ka rene qe prej fundit te viteve 70 nga 45% ne 30%. Gjithsesi ne Europen Lindore, duhanpirja ka vijuar te rritet sidomos mes te rinjve dhe grave.

Mbipesha e perkufizuar si BMI mbi 25 haset ne rreth nje te treten e banoreve te Europes. Te te moshuarit (70-79 vjec) prevalenca shkon deri ne 57%. Gjithashtu ky fenomen verehet gjithnje e me shpesh mes femijeve . 18% e femijeve ne Europe konsiderohen mbipeshe.

Vdekjet dhe barra e semundjes atribuar faktoreve risk kryesore ne numra absolute dhe perqindje e te gjitha vdekjeve / DALY , sipas kontributit qe kane dhene ne vdekjet totale ne bote. (2001)

Faktoret risk te lidhur me semundjet jo-infektive	Te ardhura te uleta/te mesme		Te ardhura te larta		Gjithe bota	
	Vdekjet (milione)	DALY (milione)	Vdekjet (milione)	DALY (milione)	Vdekjet (milione)	DALY (milione)
Presioni i larte e gjakut	6.2 (12.9%)	78.1 (5.6%)	1.4 (17.6%)	13.9 (9.3%)	7.6 (13.5%)	92.0 (6.0%)
Duhanpirja	3.3 (6.9%)	54.0 (3.9)	1.5 (18.5%)	18.9 (12.7%)	4.8 (8.5%)	72.9 (4.7%)
Kolesteroli i larte	3.1 (6.3%)	42.8 (3.1%)	0.8 (10.7%)	9.4 (6.3%)	3.9 (6.9%)	52.3 (3.4%)
Diete e varfer me fruta perime	2.3 (4.8%)	32.8 (2.4%)	0.3 (4.2%)	4.0 (2.7%)	2.6 (4.7%)	36.8 (2.4%)
Mbipesha dhe obeziteti	1.8 (3.6%)	31.5 (2.3%)	0.6 (7.8%)	10.7 (7.2%)	2.4 (4.2%)	42.3 (2.8%)
Sedentarizmi	1.6 (3.2%)	22.7 (1.6%)	0.4 (4.8%)	4.7 (3.2%)	1.9 (3.4)	27.4 (1.8%)

Aneks 3. Institucionet dhe marredheniet ne fushen e shkembimit te informacionit shendetsor



Aneks 4. Roli specifik i Institutit te Shendetit Publik lidhur me monitorimin e semundjeve jo infektive ne Shqiperi

Instituti i Shendetit Publik bazuar ne ligjin e Shendetit Publik te vitit 2009 eshte institucion publik, buxhetor, ne varesi administrative te Ministrit te Shendetesise, qe sherben si qender e kerkimit shkencor, qender reference e sherbimeve ne fushen e shendetit publik, qender universitare dhe qender informacioni.

Instituti i Shendetit Publik eshte pergjegjes per: 1. Informimin, keshillimin dhe mbeshtetjen e Ministrise se Shendetesise ne hartimin e politikave dhe te strategjive ne fushen e shendetit publik. 2. Sigurimin e ekspertizave. 3. Realizimin e studimeve te pavarura dhe prodhimin e informacioneve, bazuar ne fakte. 4. Pjesemarrjen ne formimin e burimeve njerezore ne shendet publik.

Sherbime/produkte te ISHP

- Analiza laboratorike reference (nga serologjia tek biologjia molekulare) me qellim konfirmimin e diagnozes se nje numri te madh semundjesh infektive
- Analiza laboratorike me validitet te larte me qellim sigurimin e cilesise ne laboratoret e shendetit publik ne rajone te vendit
- Analiza mikrobiologjike, fizike dhe kimike me qellim monitorimin e ndotjes se mjedisit (uje i pijshem, ujera siperfaqesore, ajer, ushqime, mjedise publike,banesa etj) nga agjente biologjike, kimike e fizike
- Ekspertiza sanitare me qellim vleresimin e rezikut ne shendet dhe propozimin/marrjen e masave per kontrollin e tyre
- Hetime epidemiologjike me qellim identifikimin e burimeve/shkaqeve te shperthimeve epidemike dhe propozimin/marrjen e masave per izolimin e tyre.
- Sigurim i sherbimeve te imunizimit per nje sere vaksinash dhe antigjenesh, ne koordinim me kujdesin shendetsor paresor. Sigurimi i logjistikes, kontrollit te cilesise dhe sistemeve te informacionit ne programin e vaksinimit
- Sigurim i sherbimeve te kontrollit (perfshire testet e identifikimit te hershem, kontrollin e sigurise se gjakut, aktivitetet e uljes se demit tek droge-perdoruesit dhe

informimin) per HIV/AIDS ne koordinim me kujdesin shendetesor paresor dhe institucione te tjera shendetsore.

- Sigurim i sherbimeve te levizeshme te kapjes se hereshme per kancerin e gjirit ne koordinim me sherbimet rajonale te shendetit publik dhe kujdesin shendetsor paresor.
- Sistemet e informacionit lidhur me survejancen e 70 semundjeve infektive dhe 7 sindromave infektive prodhimi i raporteve javore dhe vjetore lidhur me to
- Sistemet e informacionit lidhur me regjistrat e disa semundjeve kronike me rendesi te vecante per shendetin publik (infarkti i miokardit, aksidentet cerebrovaskulare, kanceret, diabeti. Ne proces
- Sistemi i informacionit mbi abortet dhe defektet e lindura si dhe prodhimi i raporteve vjetore
- Sistemi i monitorimit kombetar te cilesise se ujit te pijshem dhe prodhimi i raportit vjetor
- Sistemi i monitorimit ne qytete te perzgjedhura i ndotjes se ajrit dhe prodhimi i raportit vjetor
- Sistemi i monitorimit te ujerave siperfaqesore bregdetare dhe prodhimi i raportit vjetor
- Sistemi i informacionit kombetar mbi drogat dhe prodhimi i raportit vjetor
- Kurse te akredituara te trajnimit ne fusha te ndryshme te shendetit public per mjeket e kujdesit paresor, infermieret dhe punonjesit e shendetit publik
- Rekomandime mbi politikat shendetesore per ministrine e shendetesise bazuar mbi analizen e eksperiences nderkombetare, dhe eksperiencen nga studimet dhe nderhyrjet ne vendin tone (ligje, strategji, udhezues, standarte, praktika, organizim, sisteme, teknologji etj)
- Studime ne popullate me qellim vleresimin e situatave shendetesore te vecanta, sjelljeve te rrezikshme dhe faktoreve risk. Prodhimi i raporteve perkates
- Pilotim nderhyrjesh shendetesore parandaluese me qellim verifikimin e kushteve per shtrirjen e tyre ne plan te gjere
- Fushata te edukimit dhe ndergjegjesimit shendetsor te grupeve te ndryshme te popullates, ne bashkepunim me autoritetet shendetore rajonale
- Materiale informative per publikun dhe profesionistet e shendetesise fletepalosje, broshura, manual, udhezues etj)

- Periodike shkencore dhe operative ne fushen e shendetesise; Albanian Medical Journal (ne anglisht -4 numra ne vit) dhe Buletini i Institutit te Shendetit Publik (shqip dhe anglisht – 4 numra ne vit)

Indikatore shendetsore

- Vdekshmeria foshnjore ,feminore dhe perinatale
- Prevalenca e aborteve dhe e difekteve te lindura te regjistruara nga sherbimet
- Insidenca javore sindromike e semundjeve infektive te perzgjedhura dhe incidenca vjetore e gjithe semundjeve infektive te regjistruara nga sherbimet
- Incidenca vjetore e infarktit te miokardit, aksideneteve cerebrobvaskulare, kancereve, diabetit, semundjeve obstruktive kronike te mushkerive dhe aksidetenteve te regjistruara nga sherbimet
- Prevalenca e depresionit, tentativaves per vetevrasje, dhimbjes,etj te matura ne popullate ne grup mosha te perzgjedhura
- Shendeti total i vete vleresuar dhe semundjet totale te vete vleresuara ne grup mosha te perzgjedhura
- Prevalenca e kufizimeve ne aktivitetet e perditeshme dhe autonomi e matur ne grupmosha te perzgjedhura.
- Prevalenca e disa faktoreve risk te matur ne popullate ne grupmosha te perzgjedhura :

  mbulesa vaksinale,
  mbipesha dhe nenpesha,
  anemia,
  tensioni i larte gjakut,
  kequshqyerja,
  aktiviteti fizik
  duhanpirja,
  abuzimi me alkolin,
  konsumimi i drogave te paligjshme,
  risqe te lidhura me punen
  ekspozimi ndaj pluhurit ne ajer (PM10)
  ekspozimi ndaj ujit te pijshem me cilesi te demtuar
  mbulimi me sherbime te depistimit (per kancer gjiri, cerviksi dhe kolorektal)
  mungese te njohurive baze lidhur me shendetin.

Aneks 5.

Funksionet e Komitetit kombetar te semundjeve jo infektive i ngritur me urdher Ministri 163 dt 07/04.2015

- Komiteti Kombetar per Parandalimin dhe Kontrollin e Semundjeve kronike bazon aktivitetin e tij ne parimet e meposhtme:

  a. Mbrojtja dhe promovimi i shendetit
  b. Mbulimi universal me sherbime shendetesore
  c. Qasja ne te gjitha etapat e jetes
  d. Efikasiteti shkencor i nderhyrjeve shendetsore
  d. Sistem i integruar shendetesor
  f. Multisektorialiteti i nderhyrjeve per adresimin e shkaqeve baze

- Funksionet kryesore te Komitetit Kombetar per Parandalimin dhe Kontrollin e semundjeve kronike jane:

  a. Komiteti kombetar ka funksione keshilluese, vleresuese dhe koordinuese ne nivelin e politikave shendetesore dhe planifikimit strategjik.

  b. Komiteti identifikon mungesa, nevoja dhe kapacitete ekzistuese duke perdorur instrumenta efektive te vleresimit te situates ne fushen e kontrolit te semundjeve kronike

  c. Komiteti koordinon punen mes institucioneve shteterore, partnereve nderkombetare, komiteteve te tjera dhe shoqatave te profesionisteve me qellim hartimin e nderhyrjeve strategjike dhe planeve operacionale.

  d. Komiteti harmonizon prioritetet kombetare ne fushen e semundjeve kronike me strategjite rajonale te OBSH dhe prioritetet e integrimit ne BE

  d. Komisioni propozon nderhyrjet prioritare kosto-efektive te bazuara ne praktikat me te mira te identifikuara nga OBSH dhe vleresimin e situates ne vendin tone. Mbi te njejtat arsye, Komisioni propozon targete te arritshme dhe te matshme ne terma te mesem dhe te gjate.

f. Komiteti shqyrton dhe propozon rishikimin e funksioneve, ndërveprimit, komunikimin e agjencive dhe aktoreve të shëndetit publik në fushën e informimit, edukimit dhe promovimin e shëndetit.

g. Komiteti propozon ndryshime të nevojshme strukturore dhe organizative në sistemin shëndetësor, forcim apo rishpërndarjen e burimeve njerëzore, si dhe të burimeve financiare.

h. Komiteti nxit dhe ndihmon në gjenerimin e fondeve shtesë për programe të kontrollit të semundjeve kronike.

i. Komiteti informohet mbi progresin dhe vlerëson punën e kryer në lidhje me programet e kontrollit të semundjeve kronike dhe sistemet e informimit.