Commentary

Public health in the Balkan region: one school’s experience

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Europe and the Balkans

Major improvements in European health status occurred throughout the 20th century. These gains were less evident in the Balkans. At the beginning of the 21st century, most of the countries in the region are lacking in reforms and their health sectors demonstrate dysfunction. The disease profile is a complex blend of a repetitious past, diseases of development, and the consequences of socio-economic upheaval and disasters. The opportunity to achieve ‘health for all’ is largely absent. Health data reveal growing disparity within the region and significantly higher vulnerability than in Europe. They lag behind Europe in economic development and political stability but unevenly so, with low GNP, limited modernization, corruption, unemployment, and poverty.1–4

Working in the Balkans

The first activities (1989) were training for health professionals in Balkan Public Health identified opportunities for action, circa 1988, from which a modest regional policy emerged and funding materialized. It has enabled the cultivation of inter-country relations, contacts, and connections with various actors, which were facilitated through good relations with the Federation of International Cooperation of Health Services and Systems Research Centers (FICOSSER), the Association of Schools of Public Health in the European Region (ASPHER, www.aspher.org), WHO, Council of Europe (CE), and most recently with the PH-SEE Network (www.snz.hr/ph-see). Engagement with Ministries of Health, public health structures, and NGOs were loosely structured. The first activities (1989) were training for health professionals in Balkan Public Health (ASPHER’s 14th General Assembly, 1992) and ASPHER expert consultations within the context of the Greek Presidency of the European Union (EU)5 (1994). A programme, Neighbours in the Balkans: Initiating a Dialogue for Health, was conducted in collaboration with WHOEURO (1999),6 which was later utilized by the CE as a lead in to vulnerability reduction in SEE (Balkan region). Two additional workshops, Health in the Balkans and Health in Conflict and Disaster were transacted (FICOSSER, 2002).7

A PHARE programme and Greek Technical Aid programme targeted connectivity between the School, the Institute of Public Health, Tirana and Albanian NGOs. Visits by Albanian colleagues to observe ASPHER activities were sponsored, and a bilateral agreement initiated by the respective Ministries of Health and scholarships from the Onassis Foundation facilitated study of Albanian students in Athens. PHARE support was given to the establishment of the I-JPHE (ASPHER) and for a Centre for Balkan Public Health (Athens School).

INTERREG II was implemented for infrastructure development along Greece’s northern border and cross-border public health activities with Albania8–14 and Bulgaria.15 It became a focal point for inter-country relations and a means of developing a considerable amount of published material in several languages (books, studies, brochures, pamphlets). Many Development Assistance Committee (DAC-OECD) programmes supported training activities for the entire Balkan and Black Sea regions, leading to memoranda of understanding, new relationships, and unexpected collaborations. Numerous individuals played a role in the Balkan activities of the Athens School. Of note were the contributions of Ulrich Laaser (Germany), Franco Cavallo (Italy), Lenhart Kohler (Sweden), Patrick Vaughan (UK), Jacque Bury (ASPHER), Bui Dang Ha Doan (FICOSSER), and Anna Ritsetakis (WHOEURO).

The first writer participated in several deliberations on the developments of Schools of Public Health in the European Region (ASPHER, 1994) got underway, the region had entered a so-called transition. Poor health was the result of low levels of social and economic development. Reform emphasized the environment to a background of a contained cholera epidemic in Albania. Safe drinking water was not ensured and sewage and water pipes were frequently found side by side. In regions where mining once existed and around metallurgical sites, respiratory diseases were prevalent especially in children. Diarrhoeal disease was significant.

In Bulgaria the foetal death rate was on the increase and rural infant mortality was high, but less than that in Albania. Infectious diseases were on the rise (TB, hepatitis, dysentery, and enterocolitis of unknown aetiology). Zoonoses were becoming more common as a result of privatization of animal husbandry and uncontrolled meat production. Significant dental problems existed in both countries.

Activity backdrop

As PHARE [Albania had a PHARE office in the MoH, which promoted initiatives on the reconstruction of networking public health laboratories (France and Denmark), training for hospital management (France), retraining of nurses and midwives (Greece and Denmark), rehabilitation of health centres, retraining general practitioners, and development of family medicine and primary health care (Germany).] and INTERREG (circa 1994) got underway, the region had entered a so-called transition. Poor health was the result of low levels of social and economic development. Reform emphasized the environment to a background of a contained cholera epidemic in Albania. Safe drinking water was not ensured and sewage and water pipes were frequently found side by side. In regions where mining once existed and around metallurgical sites, respiratory diseases were prevalent especially in children. Diarrhoeal disease was significant.

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A general lack of access to adequate health care services is a common Balkan problem. Mental diseases have emerged as a significant problem for the entire region. In continuum, Greece has emphasized mental health problems resulting from war and the considerable traumatization of children while the region has passed through various disasters (natural and man-made).15–20

Regional comparisons and issues

INTERREG in the Balkans and BRIMHEALTH in the Baltics21 were similar. Both targeted public health development through partnership,22 each was lead by a SPH (Athens, Gottenberg).
Common experience suggested that a Balkan–Baltic comparison for population health development through the prism of the transition process would be useful. Such a study was not undertaken. WHO EURO established a formal unit for public health training research and development for the Baltic region. There was no such initiative in the Balkans. Other proposals that never came to fruition were to establish an ASPHER in the Balkans (BASPHE) and to conduct an annual Forum for Balkan Public Health. The SEE–PH Network (2000), the Association of Public Health Institutes in SEE (Sarajevo 2003), and the currently terminating ASPHER-Open Society Institute (OSI) link (2001–05) are filling in for this idea. OSI has supported SPH in both the Balkans and the Baltics while the Network funded through Germany and the Stability Pact has established a consortium of interacting Balkan SPH and an Internet platform of educational material. Two new Schools (Belgrade, Skopje) have become members of ASPHER (Yerevan, 2005). Cross Border Public Health Stations established between Albania and Bulgaria have not yet realized their strategic objectives to improve epidemiological surveillance and bring about an integration of inter-border areas. The deployment of such centres and improved informational systems take on greater importance when the Eastern Balkan Peninsula and the Aegean Sea are upgraded as nodal regions for peace and development. They are part of a wider infrastructure and ‘sanitation shield’ for Europe.

Schools of Public Health within the Balkans require redirection and they have to claim a higher priority on the political agenda, especially as national educational systems interface more and more with Europe (Bologna process). Regional autonomy and interdependence of its constituent parts must be augmented and inter-regional decision making for public health has to be more symmetrical. Top–down reform hierarchies should be supplemented by ‘bottom up’ and grassroots initiatives with responsibility and accountability.

**Future engagement**

Maintenance of momentum for public health action is necessary for Balkan development. Consequently, the Athens School continues to accumulate experience and develop new relationships with institutions and health professionals throughout the region [INTERREG III kick-off meeting with representatives from FYROM, Kilkis, Northern Greek frontier, 2005]. New activities include building solidarity with Turkey, in the areas of primary health care, disaster management, and public health, and with Egypt, in health management. The first writer is participating in a Tolerance and Reconciliation Agenda, especially as national educational systems interface more and more with Europe (Bologna process). Regional autonomy and interdependence of its constituent parts must be augmented and inter-regional decision making for public health has to be more symmetrical. Top–down reform hierarchies should be supplemented by ‘bottom up’ and grassroots initiatives with responsibility and accountability.

**Conclusions**

The Athens School has made a small contribution to Balkan public health and it has stimulated others to enter this difficult European byway. Inherent in the symbolism of its work is to view public health as a peace builder and a useful instrument to forge a community of Schools, working for the common good (community and institution building for health) without the impediment of borders (frontiers falling). (A recent phrase ‘border breaking, community making’ in the EU by Tony Judt is appropriate.) However, without adequate socio-economic management, population vulnerability can potentiate susceptibility to disease and a creeping social disaster is possible. Health hazards are present and the risks are significant.

**References**


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