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Original Article

Albanian Health Promotion Model: a health perspective for Western Balkan countries

Eni Tresa[1,2], Thora Jónsdóttir[3], Albano Alia[1], Rafn M. Jónsson[4] and Genc Burazeri[1,2,5]

Abstract: This article proposes a mixed-blended model adapted for Western Balkan countries, advancing the connections between the Icelandic Model of Health Promotion and the assets models for health improvement through the whole school approach and non-formal education methodology. The need to reshape health promotion interventions in Western Balkan countries is urgent, and requires explicit synergies so that a more coherent approach can be taken in their utilization. To this end, we propose a new Albanian Health Promotion Model that integrates key concepts that are associated with the involvement of schoolchildren; parents/caregivers, grandparents, communities, and religious leaders; teachers and school staff; involvement of central and local governments; engagement of the private sector; involvement of non-governmental and civil society organizations; and, importantly, enables the development of supportive environments. The proposed model aims to contribute to a more in-depth theoretical understanding of health and development through integration of the key elements of various models, methods, approaches, and tools employed in health promotion practice. Making the theory of the Icelandic model more feasible for non-Nordic cultures could better contextualize the ideas in public health policy and practice. The Albanian Health Promotion Model may also support interventions to maximize their results in vulnerable communities that have specific requirements and, as a result, could be extrapolated to similar countries in the region and beyond.

Keywords: health promotion, Albanian Health Promotion Model, Western Balkans, health-promoting schools

Introduction to the challenge

Albania has experienced economic growth and wide-ranging reforms in recent years, transitioning from 'one of Europe's poorest countries to an upper middle-income country' (1). However, the country is currently facing an epidemiologic transition, and non-communicable diseases (NCDs) constitute about 93% of overall deaths and 56% of morbidity in Albania (2). The NCD burden in Albania is primarily due to high blood pressure, nutritional-related risks, smoking, overweight and obesity, high plasma sugar levels, and physical inactivity (3). Of note is the evidence of a considerable increase in the

1. 'Schools for Health', a project of the Swiss Development and Cooperation Agency, Tirana, Albania.
2. Department of Public Health, Faculty of Medicine, University of Medicine of Tirana, Tirana, Albania.
3. Save the Children Iceland, Department of Domestic Program, Reykjavík, Iceland.
4. Directorate of Health, Public Health Department, Reykjavík, Iceland.
5. Department of International Health, School CAPHRI, Care and Public Health Research Institute, Maastricht University, Maastricht, The Netherlands.

Correspondence to: Eni Tresa, Faculty of Medicine, University of Medicine of Tirana, Rr. 'Dibres', No. 371, Tirana, 1004, Albania. Email: eni_tresa@hotmail.com

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prevalence of obesity in both men and women in the past few years (28% increase overall) (4). Unhealthy behavioral practices and lifestyle patterns, such as smoking, excessive alcohol intake, being overweight, and obesity, pose a significant challenge for transitional Albania. Focusing on the prevention of NCDs among children and youth is therefore crucial, as their exposure to behavioral practices in childhood, both positive and negative, is likely to influence their health outcomes in adult life (3). An integrated approach to the prevention and control of NCDs, involving all sectors and stakeholders, is thus urgently needed.

Response to the challenge: Albanian Health Promotion Model

The Albanian Health Promotion Model (AHPM) is based on several successful models, including the whole school approach (WSA), World Health Organization's (WHO) health-promoting schools (HPS) Framework, and the Icelandic Model of Health Promotion (IMHP). The WSA promotes healthy school policies, schools' physical and social environments, individual health skills, action competencies, and community links (5). The HPS Framework helps schools to empower students by creating an environment of friendliness, care, and trust, allowing interpersonal relationships and self-esteem to develop. The IMHP is a 'community collaborative approach that has demonstrated remarkable effectiveness in reducing substance use initiation among youth in Iceland over the past 20 years'(6).

The AHPM has adapted these three models to fit the Albanian context to best approach children, parents/caregivers, grandparents, community and religious leaders, teachers, and school staff (Figure 1). Overall, any city that embraces the AHPM can become a 'healthy city' as defined by the WHO/Europe: 'it continually creates and improves its physical and social environments and expands the community resources that enable people to mutually support each other in performing all the functions of life and developing to their maximum potential' (7).

Involvement of children

Children's participation is likely to empower children and youth to embrace critical thinking and decision-making and provide them with the skills and confidence to make their voices heard. This can be achieved through the practice of democracy within schools and the inclusion of human rights education in schools' curricula (8). As stated by WHO's general director, 'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'(9). Non-formal education, including peer to peer, is a very effective tool in the human rights education of children in relation to health promotion activities, and helps to create a safe environment for young people to reflect on their behavior (10).

Parents/caregivers, grandparents, community, and religious leaders

The Albanian Health Promotion Model emphasizes the importance of community- and parental engagement and collaboration in preventing, for example, adolescent substance abuse. Parents, as role models for their children, are fundamental to the success of such initiatives (11). For example, parents who consume the recommended daily serving of fruit and vegetables are 10 times more likely to have children who also do so (12). Equally, the use of tobacco and alcohol among children is positively associated with parental models of using such substances (13).

In non-Western societies, senior women, some of them grandmothers, play a crucial role in child-rearing (14). Religious leaders, whose authority is influenced by their faith, may influence community health (15). The Icelandic model is mandatory: school associations must be established and run in all elementary schools, which helps ensure that all parents are reached and important information is shared with them (16).

Teachers and other school staff

The school is widely recognized as an ideal setting in which to promote health and well-being among young people (17). Those who feel connected to their school are less likely to engage in risky behaviors such as early sexual initiation, alcohol, tobacco, other drug use, and violence (18).

In schools, children form social connections and

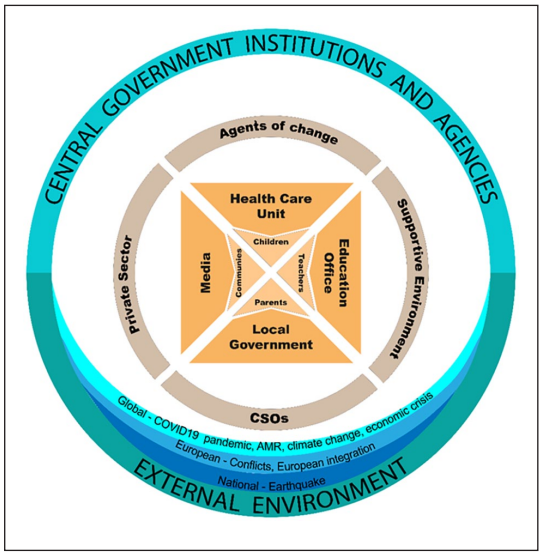

Figure 1. Albanian Health Promotion Model.
Note. The model recognizes central government institutions and agencies and the external environment have an influence on population health (at a national level: earthquakes; at a European level: conflicts, European integration; and at a global level: COVID-19, antibiotic resistance, climate change, or economic crises).

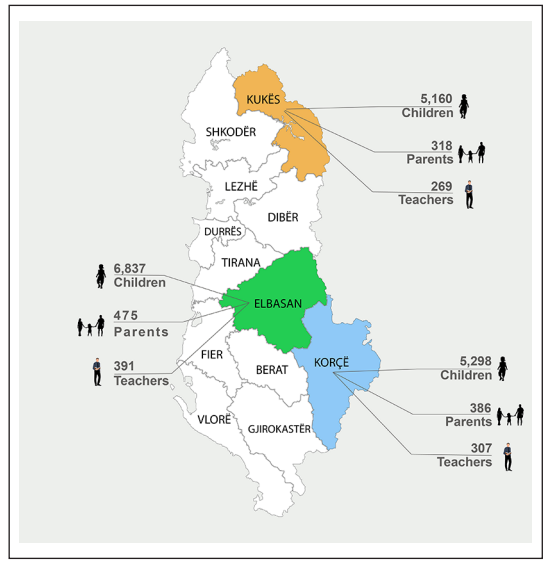

Figure 2. Data from Piloting Albanian Health Promotion Model covering the period of 1 March 2021 to 28 February 2022.

learn from professionally trained staff. Teachers perceive health promotion in schools as integral to their role (19). Therefore, teachers and school staff should be trained in strategies to raise students' motivation to live healthy/sustainable lifestyles, and to model for their students the most innovative participatory methodologies, both to effectively convey health knowledge to the young people, while at the same time, fostering their critical thinking about the harmful consequences of risky behaviors (17).

Health professionals (e.g., school doctors, nurses, or health promotion specialists) have an essential role in health promotion and prevention. They have the knowledge to educate on health and should have the time and resources to instruct the youngsters on different topics within health promotion and prevention (20). Successful collaboration between the health and education sectors can help to improve children's health (20). Based on the IMHP, in addition to general health care, school health staff have the opportunity to have a dialog with children on an individual level through the annual health interviews. The interviews aim to strengthen students' awareness of their lifestyle and well-being and enable them to take action if they feel unwell or worried (6).

Involvement of the central and local governments

According to the WHO, governments have a key role to play in HPSs (21). Central governments (CGs) can influence legislation, for example, in determining the availability of alcohol. It is feasible to limit access to alcohol and tobacco by setting a minimum purchasing age: at least 18 or 20 years of age (22). In addition, outlets should be restricted from selling such products, at least those located close to schools, and a ban on all marketing of alcohol and tobacco should be enforced on social media, and in relation to sports and leisure activities (23).

Local governments (LGs) can play an important role in mobilizing and responding to the public to promote sustainable health outcomes (24). The example of the National Youth Law in Iceland shows that municipal councils set their own rules on the support to be provided for independent youth activities (25). Conversely, in Albania, health

promotion is within the mandate of local health care units and the service is regulated through the Council of Ministers (Decision no. 417, 2018).

Inclusion of private sector and local non-governmental organizations

Scientific literature favors health promotion partnerships between government and industry (26), however, non-governmental organizations (NGOs) are known for 'their ability to maintain institutional independence and political neutrality'. NGOs have shown leadership in promoting sustainable community development, and are good at reaching out to the poor and to remote communities and mobilizing these populations (27).

Enabling supportive environments

Based on the Health Asset Model, the AHPM has fostered the creation of supportive environments that help to promote health, enhance the ability of individuals and communities to maintain and sustain health and well-being, and that help to reduce health inequalities (28). Other possible events might be adequate coverage of lighting in places where young people hang out or are probable places for the distribution of illegal drugs.

The case study of Albania

Schools for Health (S4H) is a Swiss Development and Cooperation Agency project, implemented by Save the Children in Albania during the period 2021–2025 (http://shkollatpershendetin.al/en/). The project aims to induce positive behavioral change in the Albanian population, with a particular focus on schoolchildren aged 6–15 years and their respective parents/caregivers. The project works on site in selected schools and communities of Albania through a wide array of interventions targeting children and their parents/caregivers. It operates at a national level through online interventions, using digital applications aimed at promoting a wide range of healthy behaviors/lifestyle practices.

In the course of the S4H project, a health promotion model has been suggested for adaptation to the context of Albania, which considers the specific needs, circumstances, environment, existing structures, capacities, and available resources in the country.

The Schools for Health project adopted this model following a large-scale consultation with interested parties; the round table included education offices, representatives of the health sector, beneficiaries, and the involvement of CGs and LGs, the private sector, and NGOs. After consolidation, the model was discussed with the project advisory board, which included senior experts in education, health, sports, civil society, and the NGO sector. The model was piloted in 30 schools, in the regions of Kukes (north Albania: 16 communities), Korce (south: 20 communities), and Elbasan (central Albania: 24 communities). Overall, 19,437 persons were reached through health education sessions furing the first year of implementation. Figure 2 shows the data from the piloting phase of the "Schools for Health" project in Albania.

Involvement of children

All the activities involving children were aimed at increasing the necessary skills and knowledge to avoid behavioral risk factors for NCDs and cope with health emergencies such as COVID-19. All the interventions were shaped according to the needs of each community based on an assessment conducted at the beginning of the first year of project implementation. After reviewing the teaching curricula for schoolchildren aged 6–16 years in relation to healthy behaviors/lifestyle practices (e.g., nutrition, physical activity, substance use, mental health, sexual and reproductive health) and identifying the potential learning inequalities among children, extracurricular activities on the same topics were proposed to school children so they could learn more about their health.

Empowerment among the children was achieved through peer to peer education sessions, the engagement of a children's government within participating schools, the organization of children's parliaments, and school-based learning activities (e.g., competitions, cooking classes).

Parents/caregivers, grandparents, community, and religious leaders

The AHPM also proposes parent-targeted activities as a method of engagement such walks, 'joined family time', informative sessions specifically for parents, and participation in organized activities

(e.g., watching sports events or concerts). Parents can also be reached through parents' associations such as the Parents' Association of Children with a Disability or through parents sitting on the school board. The pilot activities were found to benefit from promoting positive partnerships between parents and children as an important precondition for fostering sustainable healthy lifestyle practices. Overall, 104 activities were carried out in urban and rural areas of the three regions, targeting parents and community members, promoting positive parenting, as well as increasing their level of knowledge and skills regarding engagement in healthy behaviors. Overall, parents were satisfied with the targeted interventions: 97% of the parents interviewed (sample: $n = 690$) reported appreciating the project activities.

Teachers and other school staff

The AHPM proposes activities for teachers and health promotion staff, such as training modules on healthy lifestyle, a Knowledge Portal; integration of healthy lifestyle activities in the curricula, improvement of the university curricula for teacher training, and an e-learning platform for teachers.

In addition to being part of the process, teachers are encouraged, trained, and equipped with the knowledge and materials to take the lead in this process and perform independent activities in relation to healthy lifestyles for children during classes.

Overall, the project has eight accredited training modules for teachers. After the training (through online and on-site means), teachers reported liking the training topics and requested ongoing training on health issues. The pre–post test results showed that teachers increased their knowledge by an average of 36%. This value varied from 27% on topics related to mental health to 54% on topics related to healthy nutrition.

Through the online platforms we aim to reach all teachers in Albania, to train and inform them accordingly. The e-learning platform, that already has several developed training modules uploaded, was established to offer online training for all interested parties who have the authority to access it. Teachers and other school staff can access the online library, and the Knowledge Portal offers updated professional information on health issues.

Involvement of the central and local governments

During the piloting phase, S4H worked with the stakeholders in each project location to build effective and sustainable partnerships with LGs and respective agencies such as the education office, the local agriculture directory, the local health care unit, and other agencies at a municipal level. S4H aimed to strengthen the multi-sectoral collaboration and inter-sectoral cooperation among local stakeholders, and strengthening the capacities of LGs and affiliated agencies. Local staff as key professionals at the municipal level were also trained, including the child protection unit, and health promotion specialists of local health care units. The pre–post-test showed that 70% of the participants had increased their knowledge and skills on the promotion of healthy lifestyle habits among children 6–16 years old and appreciated having gained the necessary knowledge to approach vulnerable groups about health-related topics in a way that prevented prejudice and stigma.

Involvement of the LG facilitated the support of schools with the necessary infrastructure and equipment/materials—the basic prerequisites for creating appropriate environments for health promotion interventions.

Inclusion of private sector and local non-governmental organizations

The prospect of close coordination and partnerships with LGs may be attractive to local farmers and other relevant businesses. All project interventions were aimed at strengthening collaboration with key agents of change at the local level including those in the NGO sector. This type of intervention was deemed vital to identify successes, build on existing good practices at the community level, and as an effective way to reach out to large audiences of children, including those with disabilities, and their respective families. Hence, project cooperation with local NGOs and civil society organizations that provide services especially for marginalized and vulnerable population groups is essential.

Enabling supportive environments

As per the Icelandic and Spanish experiences, first we identified the health assets (protective factors) in each school and municipality, mapped the resources, and made a start-up plan. Schools were supported to build school gardens and playgrounds where children could grow their own vegetables and engage in physical activities to help maintain their health (28).Overall, six cooperation agreements were signed between representative farmers and schools. The activities were attended by 75 participants (37 men and 38 women).

Conclusion

In conclusion, the AHPM focuses on the promotion of health among children, parents, teachers, and the wider community. The interventions also include professionals from relevant sectors, such as the health care unit, education office, LG, and the media. At the environmental level, the model engages the private sector, agents of change, civil society organizations, and creates supportive environments.

Contribution to health promotion

The AHPM is a new theoretical model that facilitates the practice of community health workers and health promotors in reaching the most vulnerable, in empowering them, and raising their awareness of the importance of participating in health promotion activities. The AHPM is based on the engagement of all sectors and stakeholders related to health (e.g., school children, parents, grandparents, the wider community, religious leaders, teachers, the wider school staff, involvement of CGs and LGs, the engagement of the private sector and local NGOs) to facilitate the creation of supportive environments.

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ORCID iD

Eni Tresa https://orcid.org/0000-0003-4559-5506

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