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Report on Access to Health Services in Diber and Fier Regions

Health for All Project – Albania (HAP)

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Abbreviations

ADHS	Albania Demographic and Health Survey
CME	Continuous Medical Education
HAP	Health for All Project
HC	Health Centre
HIF	Health Insurance Fund
HTA	Mat Month of Measurement
IPH	Institute of Public Health
MoHSP	Ministry of Health and Social Protection
NCD	Non-communicable disease
ODK	Open Data Kit
PH directorate	Public Health directorate
PHC	Primary Health Care
QoC	Quality of Care
SARA	Service Availability and Readiness Assessment
SCIH	Swiss Centre for International Health
SDC	Swiss Development Cooperation
SSV	Supportive supervision
Swiss TPH	Swiss Tropical and Public Health Institute
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women

Executive Summary

Background

The Swiss Agency for Development and Cooperation launched in 2015 the “Health for All” (HAP) project in Albania in two assigned pilot regions/qarks (Diber and Fier). The overall goal of the project is that the Albanian population, benefit from better health due to improved primary health care services and health promotion activities.

To track the project success and impact over the implementation period, a baseline measurement was conducted to inform the log-frame. A household survey was part of this baseline assessment which was now at the end of the project phase repeated. The survey was conducted with the aim to measure changes over time and to assess a) the health situation and management of chronic diseases and acute illnesses of those affected in Diber and Fier region; b) health seeking behaviour and access barriers to health care for chronic diseases and acute illnesses; and c) knowledge, attitude and practice on diabetes, hypertension and child development.

Methods

We repeated the cross-sectional survey from October/November 2015 in December 2018 in the HAP pilot districts (Diber & Fier). The sampling was done using clustered randomised sampling. Within each cluster we then sampled households. Households were included if at least one person in the household suffers from a chronic condition or was acutely ill in the past four weeks. Within each household we asked the household head about characteristics of the household and the background of each household member, including the health and insurance status. We then randomly selected one person from those in the household who suffered a chronic or/and one person suffering from an acute condition and asked them about their access to health services, barriers to access care, health expenditures and their knowledge, attitude and practice in respect to cardiovascular diseases. If a mother with a child less than 5 years was living in the household she was interviewed on aspects of postnatal care, child development checks and her knowledge on child health & development. The methodology used during the endline was the same as during the baseline.

Key results

This report of the household surveys for project HAP covers two comprehensive data collections: the baseline information on 1’275 households and 5’188 individuals living in those households and endline information on 1’289 households and 4’749 persons living in those households. Further detailed information was obtained from 2’231 persons (endline 1’135, baseline 1’096 persons) who indicated to suffer from a chronic disease, and 730 persons (endline 555, baseline 175 persons) who had in the four weeks prior to the survey been affected by an acute health problem. Information on mother and child care was obtained from 316 (endline 157, baseline 161 mothers) of children under 5 years.

Households & household members

- During the base- and endline survey, households first choice for a health provider are governmental PHC facilities. The main reason for this choice is geographical proximity.
- Respondents stated that costs, health insurance coverage and quality of services are relevant aspects when choosing a health provider.

- We observe an increase in self-reported chronic conditions from 25% to 31% whilst approximately the same proportions report having an acute condition or both.
- We observe an overall increase in the availability of valid health insurance cards, whereby coverage was – as during the baseline - higher in Diber than in Fier.
- Whilst during the baseline the obligation to renew the health insurance card every six month was considered as a principle obstacle for those who were uninsured the main reason given during the endline was that non-insured considered that they did not need insurance.

Chronic and acute conditions

- As during the baseline was the most common reported chronic conditions high blood pressure. Other commonly mentioned conditions were in both surveys heart problems, rheumatism and diabetes.
- Of the interviewees 84% had sought care in the past four to eight weeks (baseline 70%). When choosing the health provider what mattered most for persons with a chronic condition was the geographical proximity to the health provider, followed by the quality of services and the costs. This remained unchanged from base- to endline).
- Also the patterns for selected acutely ill patients remained unchanged during base- to endline: individuals were commonly affected by cold/flu, fever and persistent cough with fever.
- Patients consulting also other providers above the PHC facility (e.g. policlinics, specialists) did this mainly because they were referred, not all tests were available or services were not offered (baseline services were not offered, the facility closed or not all tests could be performed).
- As during the baseline: The two biggest difficulties for seeking care for chronic and acute patients were the unavailability of financial funds related to health costs and transport.
- Overall satisfaction was high. Satisfaction with health services remained higher among individuals with chronic conditions than with acute conditions.
- Total inflation adjusted median expenses for chronic conditions in the past four weeks were 24 Euros compared to 21 Euros for acute conditions. As during the baseline expenditures for drugs was the most important cost driver (62% for chronic conditions and 69% for acute conditions). The median treatment or admission costs were in both cases zero, but proportionally accounted for 12% of the total costs for chronic and acute conditions.

Mother & child health

- Postnatal care consultations and check-ups for children were in the majority of cases conductedwithin the first week after release from the hospital. Most of consultations to women and children were provided by a nurse/midwife followed by a doctor and for children also by a paediatrician.
- Child monitoring and development check-up app ear to be routinely conducted. The check of the vaccination cards is thereby given a high priority as well as weight measurement. Other physical examinations (e.g. head or height measurements) or questions on development progress are not as consistently applied.

Knowledge, attitude and practice

- About 23% (baseline 18%) could cite more than four risk factors for cardiovascular disease; also we observe that the number of interviewees that could not think of risk factors decreased from 14% to 5% of interviewees.
- Level of knowledge on child health and development remained at very high levels among mothers. Risk factors for development and also aspects relating to child development were generally well known.

Conclusion

The household survey emphasises the importance of the public health sector in Albania. Whilst various aspects remain largely unchanged, e.g. disease patterns, the results of the surveys show also that Albania experienced measurable positive progress on the accessibility of public health services. Also aspects related to mother and child health have measurably improved as did the general knowledge on cardiovascular diseases.

Still, access and treatment costs remain a concern for many households and patients. Hence, reducing this access barriers further and also addressing issues of high costs of drugs will be important to increase the population health. At the same time it will be important that the quality the PHC system is strengthened and that the system is capable of managing this increased demand. It will also be necessary to further improve awareness and knowledge on risks and risk factors at community level specifically for chronic conditions which are a major burden in Albania.

1 Background and objectives

The Swiss Agency for Development and Cooperation launched in 2015 the “Health for All” (HAP) project in Albania in two assigned pilot regions/qarks (Diber and Fier). The overall goal of the project is that the Albanian population, benefit from better health due to improved primary health care services and health promotion activities.

The two main expected outcomes of the project are:

- Central government, donors and other relevant actors’ engagement in the health system reform leads to better management and provision of services through qualified health professionals
- Citizens in target regions have increased access to more decentralized, affordable, quality primary health services. More health-conscious citizens contribute through increased participation towards an accountable and responsive health system

The project started implementation in 2015 and the current phase ended in April 2019. To assess the success and impact of the HAP project over the implementation period, key indicators are compared at the end of this project phase against indicator values at the beginning of the project.

To inform the logframe two primary data collections were conducted at base- and endline: (1) a study on quality of care (QoC) and (2) a household survey.

This report summarises the findings of the household endline survey and compares the findings with the baseline household survey of family access to health care in the two regions covered by HAP, Fier and Diber. The approach of the study allows (a) to measure changes over time, (b) to stratify results along different regions and socio-demographic groups and (c) to provide detailed information to the HAP implementation unit. At the same time it allows – with certain methodological limitations – the comparison to Albanian Demographic and Health Survey 2017 – 2018[1] funded by the Swiss Agency for Development and Cooperation (SDC), the United Nations Population Fund (UNFPA), the United Nations Children’s Fund (UNICEF) and United Nations Entity for Gender Equality and the Empowerment of Women (UN Women).

Specific objectives of the survey were to assess:

Health situation and management of chronic diseases and acute illnesses of those affected in Diber and Fier region

- Health seeking behaviour and access barriers to health care for chronic diseases and acute illnesses
- Knowledge, attitude and practice on diabetes, hypertension and child development

Chapter 2 outlines the methodology. In chapter 3 we present the results which are structured along characteristics of the household and individuals living in the households (chapter 3.1), selected chronic disease patients (chapter 3.2), selected acute disease patients (chapter 3.3), mother and child health (chapter 3.4) and knowledge, attitude and practice for chronic conditions and child health (chapter 3.5). The report concludes with a discussion and recommendations section.

1.1 Findings from the baseline household survey 2015

Key results

The Albanian household survey collected information from 1’275 households and 5’188 individuals living in those households. Detailed information was obtained from 1’096 individuals with at least one chronic disease, and 175 persons who had in the four weeks prior

to the survey been suffering from an acute health problem. Information on mother and child care was obtained from 161 mothers of children under 5 years.

Households & household members

- The majority (96%) of households reported that their first choice for a health provider is governmental primary health care (PHC) facilities. The main reason for this choice is geographical proximity, regardless of whether the household is located in a rural or urban area.
- Respondents stated that costs, health insurance coverage and quality of services are relevant aspects when choosing a health provider.
- The majority of household members were healthy, but 25% of household members reported a chronic condition, 9% both a chronic and acute condition in the past four weeks and 11% were affected by an acute condition.
- More than half of household members had at the time of the interview a valid health insurance card, whereby coverage was higher in Diber than in Fier and better in urban than in rural areas.
- The obligation to renew the health insurance card every six month is considered as a principle obstacle for those who were uninsured at the time of the interview. Another 20% of household members who were not insured thought that they do not need a health insurance card and about 15% indicated that they do not pay contributions or are not eligible.

Chronic and acute conditions

- Most common chronic conditions reported by the interviewees were high blood pressure, heart problems, rheumatism and diabetes. The diagnosis was mostly established at a governmental hospital or a governmental health centre.
- 70% of the interviewees had sought care in the past four to eight weeks. When choosing the health provider what mattered most for persons with a chronic condition was the geographical proximity to the health provider, followed by the quality of services and the costs.
- Selected patients, who were acutely ill in the past four weeks were mainly affected by cold/flu, fever and persistent cough with fever.
- About half of the chronically or acutely ill patients had sought care, typically at public health facilities. Patients also consulted other providers above the PHC facility (e.g. policlinics, specialists) mainly because services were not offered, the facility was closed or not all tests could be performed.
- The two biggest difficulties for seeking care for chronic patients were the unavailability of financial funds related to health costs and transport. This was the same for acute conditions. However, patients suffering from an acute problem also indicated their lack of trust in the doctor, the absence of an adequate provider in terms of gender and the belief that problems would go away without treatment or with self-medication.
- Satisfaction with health services among individuals with chronic conditions was higher than for among individuals with acute conditions (20% vs. 32% were slightly unsatisfied or satisfied).

- Total median expenses for chronic conditions in the past four weeks were 25 Euros and therewith almost twice as high as for acute conditions (14 Euros). In both cases expenditures for drugs was the most important cost driver (72% for chronic conditions and 70% for acute conditions). The median treatment or admission costs were in both cases zero, but proportionally they ranged between 12% for chronic conditions and 19% for acute conditions. Median transport costs were for chronic conditions higher than for acute conditions.
- Total median costs for patients with chronic or acute conditions varied depending on the health insurance status of the person. Having a health insurance card reduced the associated costs for chronic and acutely ill patients substantially.

Mother & child health

- Postnatal care consultations were typically within the first week after release from the hospital. Most consultations to women and children were provided by a nurse/midwife (56% and 48% respectively) followed by a doctor and for children also by a paediatrician. Care was for the majority of women and children provided in public health facilities, specifically governmental hospitals and health centres.
- Child monitoring and development check-ups appear to be routinely conducted. Checking of the vaccination cards is thereby given a high priority as well as weight measurement. Other physical examinations (e.g. head or height measurements) or questions on development progress are not consistently applied.

Knowledge, attitude and practice

- About 18% of respondents could cite more than four risk factors for cardiovascular disease; however, 14% of interviewees could not think of any risk factors. Commonly known were two to three risk factors.
- Questions that appeared more difficult for respondents were related to signs and symptoms and even more so, questions on what would not be a typical sign and symptom.
- For obesity, general knowledge and awareness was lower than for cardiovascular disease or diabetes.
- Very high levels of knowledge on child health and development were observed among mothers. Risk factors for development and also aspects relating to child development were generally well known.

1.2 Activities of project HAP relating to access to care and knowledge, attitude and practice & major policy changes in Albania

During the first phase, the Health for All Project (HAP) has implemented different activities on increase of primary health care service quality, which directly or indirectly influence the access to health care, and population access to a qualitative PHC. These activities relate to:

(1) health promotion activities on prevention and treatment of non-communicable diseases (NCDs). One of the main health promotion activities implemented by HAP has been PerSHENDETje Campaign a community-based activity on NCD prevention, and risks awareness. School based activities on promotion of healthy schools,

increasing physical activity, healthy eating and reduction of smoke and alcohol consumption. Community campaigns on Diabetes, HTA (Mat Month of Measurement), and many other health promotion activities organised by health centre staff and cabinets of health promotion in region areas during these 4 years.

(2) intensive continuous medical education (CME) activities for family doctors and nurses in a Peer Group format. This forms a newly national recognised mean of CME at the work place and other formal CME organised activities to increase knowledge skills and competences of the PHC providers, focusing mainly on prevention and treatment of NCDs and mother and child services.

(3) infrastructure improvement of 14 health centres in Fier and Diber. Equipping 80 health centres with doctors and nurses' bags containing medical equipment, and providing child and mother scales and measuring devices, for monitoring mother and child health, as factors of increasing quality of PHC health services.

(4) increasing transparency and accountability toward PHC including a better informed population on patients' rights and improvement of complaining mechanisms.

Further important to the topics investigated here in this household survey there are two main Ministerial Orders that have likely led to important changes:

- Order of Minister of Health and Social Protection, No. 576 date 16.12.2017 "On referral system and tariffs within the public health service".
- Order of Minister on "Approval of the list of chronic diseases", Nr. 37, date 25.01.2017.

Based in these two orders, all the patients are eligible to have free medical care at family physician – PHC – if they have a personal ID. They are also eligible to a first diagnosis at the specialist in case they are assumed chronic disease patients and follow the referral system from PHC onwards. Also first choice treatments, which are ordered by the specialist and prescribed by the family doctor at PHC, are free. Hence the costs for treatment are likely to have decreased for the population and the need for an insurance card is mainly related to obtain additional tests/treatment options at the level of PHC and/or specialties services.

2 Methodology

2.1 Study area and design

The study was carried out in the two pilot regions of the HAP: Diber and Fier. Fier is located 98 km south-west of Albania with access to the seaside. Diber is a mountainous region within Albania, located 212 km north-east of Tirana. Each region is structured into three sub-regions. Fier has 6 municipalities: (Fier, Lushnje, Mallakaster, Patos, Roskovec, Divjake) compared to 4 municipalities in Diber (Diber, Mat, Klos, Bulqize)[1].

The census 2011 registered 447'263 persons living in the two regions (310'277 in Fier living in 87'605 households and 137'036 in Diber living in 33'204 households). The regions therefore cover approximately 16% of the total population of Albania.

[1] http://www.reformaterritoriale.al/en/home/draft-maps

Figure 1: Territorial administrative map of Qarks of Albania

Source: Ministry of Local Affairs

The endline data collection for the HAP project was – just like the baseline survey – conducted as a cross-sectional face-to-face survey at household level in the two pilot regions Diber and Fier.

Inclusion criteria for households were that at least one household member, who lives in the household, is chronically ill or was acutely ill in the past four weeks. The ill-person also needed to be present during the data collection. Data collection was done using electronic data capture with tablets. The software used was Open Data Kit.

2.2 Target population and sample size

The sample of clusters was identical to the baseline, i.e. no new sampling of clusters was conducted. For the baseline we applied a disproportionate stratified random sampling procedure at the level of the two regions Diber and Fier by sampling the same number of clusters from each stratum independent of its demographic size. The number of clusters was calculated using the equation of Bennett et al. (1991).

For the calculation of the sample size at baseline several assumptions were made:

- Proportion estimate considering the most relevant indicator at 10% (based on percentage of women (15-45) reporting no chronic illness or disability: 86%; percentage of men (15-45) reporting no chronic illness or disability: 93%; percentage of women and men (15-45) reporting no acute illness or injury: 80%
- A cluster size of 12 dwellings/apartments is used. This corresponded to the workload of one team, i.e. four interviewers, during half a day.
- The design effect was set at 1.5 because of the size of a cluster (12 dwellings).
- Response rates for the Demographic and Health Survey (DHS) in 2011 were very high (around 96%) independent of urban or rural areas. We therefore assume a maximum of 10% non-response.

Based on these assumptions both studies (base- and endline) targeted 1'268 chronically ill or who have been acutely ill respondents (634 per region) and respective households. Assuming an average size of 4 individuals living in a household, we expected to obtain information of about 5'072 individuals (including personal and proxy answers). 53 clusters were thus selected from each region, applying a proportional to size random sample within each region (see also Annex C). However, within each cluster interviewers conducted a random walk that was likely different to the baseline so that with a high probability other households have been sampled within each cluster than during the baseline survey.

2.3 Questionnaire development

Questionnaires were designed to provide relevant indicators of health patterns and health seeking behaviour as well as of barriers to access care to fulfil the requirements from the HAP log-frame, requirements specified by HAP team members and standards and experiences from other data collections (e.g. DHS).

The questionnaires were the same as during the baseline though a few modifications were introduced: (1) few questions omitted as information was captured several times, (2) answer categories merged and added as baseline had shown some needs for that.

The electronic data collection form contained different questionnaire sections:

ODK Form 1: Household questionnaire covered the following areas:

- General questions, distances to health facilities and services at community level
- Household characteristics
- Financial aspects
- Questions on each household member (**household roster**)

ODK Form 2: Individual questionnaire for persons with a chronic condition and/or an acute illness

- Disease patterns
- Health seeking behaviour and access barriers for health seeking
- Knowledge and practice/behaviour on diabetes and hypertension
- Satisfaction with services offered
- Health expenditures

ODK Form 3: Individual questionnaire for mothers' questionnaire

- Postnatal care
- Care seeking behaviour the child and growth & development monitoring
- Knowledge and practice/behaviour on child development (milestones)

2.4 Sampling Procedure and Field Data Collection

Data collection was carried out between the 7-20 December 2018. 16 interviewers were organized in four teams. Each team was headed by one supervisor who was responsible for the organization of the team and quality assurance of the data collection process.

Before data collection, interviewer and supervisor training were held over a two and a half days course (2-4 December 2018), including a pretest. Interviewers and supervisors were

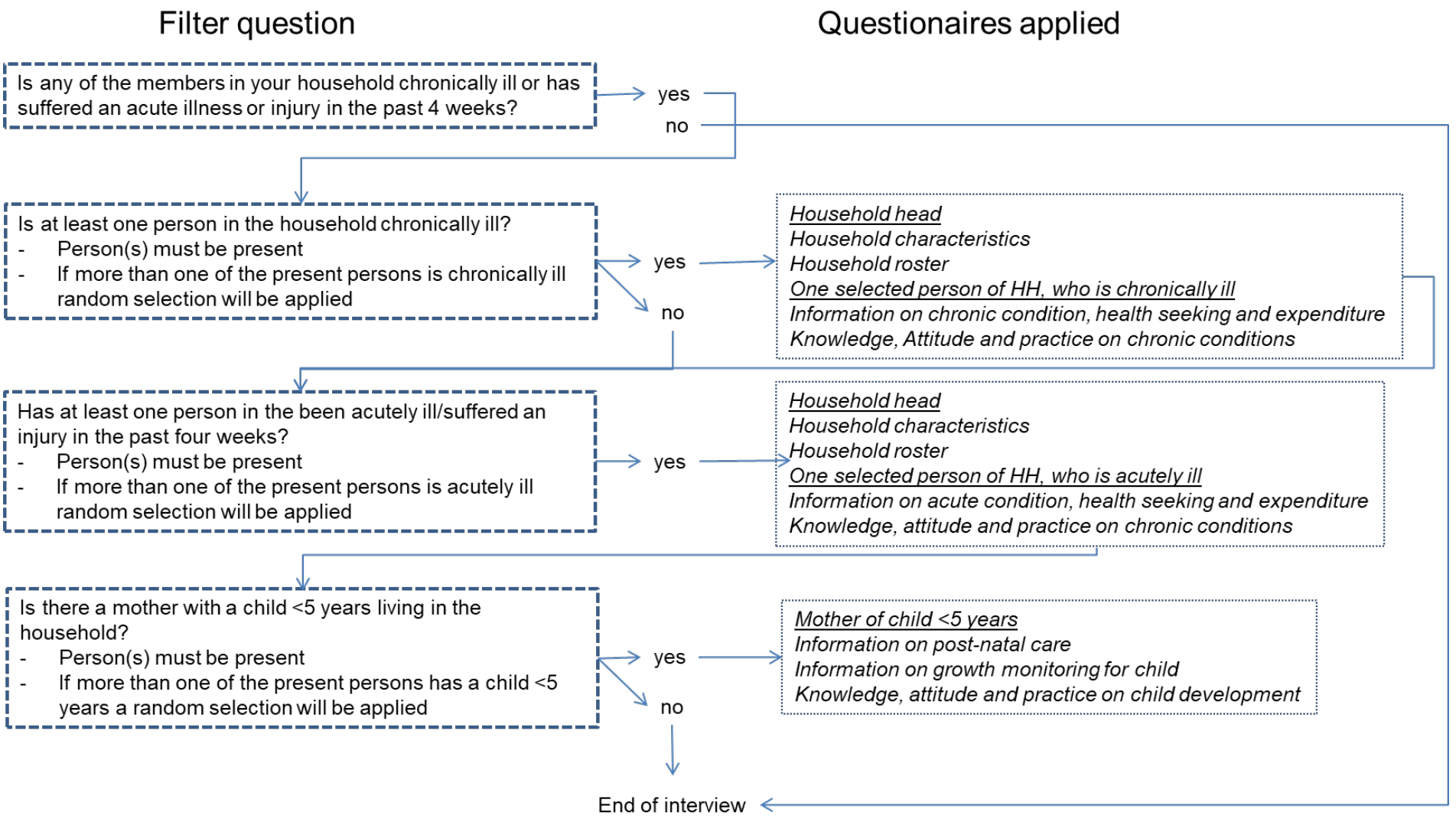
trained on good research practice, including how to handle confidentiality, obtaining consent, objectives of the study, selection principles of households and patients with a chronic or acute condition within the household and the questionnaires. Interviewers also received a detailed training on the different sections of the questionnaire and the handling of the electronic data collection tool. In addition, the training also included a specific session for the supervisors, on quality assurance, ensuring safety and security of the data collectors in the area, relationships with the local representatives, management of tablets and transferring electronic data. On 3 December 2018 a pretest was conducted in Fier region to practice the learned skills and provide feedback on the next day about any questions on the data collection procedure and questionnaire.

During data collection households were identified using a random-walk procedure, i.e. a common place was selected within a cluster (village/town) and all interviewers walked off in different directions[2]. Interviewers were instructed to select every 3rd household and record all contact attempts (e.g. independently of the availability or eligibility of the household).

Once a household contact was successful established, an information letter on the study was delivered, and after obtaining the oral consent of the household head the interviewers went through a cascade of filter question that then automatically determined which sections of the questionnaire were relevant for the specific household (see Figure 2).

[2] The random walk instructions were specified as follows: (1) In the appointed village – select the place from where the walking starts (schools / commune / religious institution / post office etc.); (2) In the appointed city – select the place from where the walking starts (center - to the suburb and vice versa); (3) Each interviewer moves/walks towards a different direction from each other to / different way; accessing both sides of the road and contacts 1 in every three households; (4) Each interviewer - will perform six interviews (families) per day (12 families = 1 team); (5) Each family contacted (with or without approval to proceed) will be recorded; (6) If in a particular village will not be contacted a certain minimum of the study group continued – it will continue to the next (neighbouring) village.

Figure 2: Sampling of respondents within households for the different questionnaire forms/sections



Questions on household characteristics as well as the household roster were answered by the household head or its closest available representative: To identify all members' interviewers asked for dwelling head or its closest representative and then listed all members who cook/eat at one cooking place/kitchen and permanently live in the households. Members who live and work abroad were counted as family members if they lived in the past 12 months in the family/dwelling or if they only work temporarily abroad (leaving the family for 3-6 months).

To answer questions on health (seeking) behaviour for chronic or acute conditions we applied a slightly different approach than during the baseline to increase the sample size. During the baseline interviewers selected one member recently acutely ill or chronically ill. In case more than one member was eligible priority was given to the one with the chronic condition. For the endline this approach was changed: interviewers selected one person of those chronically ill in the household and also one acutely ill if available in the household. In other words: if a household had chronically and acutely ill persons we filled both questionnaire sections during the endline but had only filled one – typically the chronically ill - during the baseline.

If more than one member living in the household had a chronic and acute condition and was present, an automated random selection was applied for the chronic and acute ill patient. The knowledge, attitude and practice questions on chronic conditions were then answered either by the person responding to his/her chronic illness (preferred) or the person responding to his/her acute illness. In case the household had also a mother with a child 5 years or younger, she was questioned on mother and child health. The fieldwork (7-20 December 2018) was organised and carried out independently from each team according to the work schedule (see Annex C).

Field monitoring was conducted on a daily basis by field supervisors. The questionnaires were submitted to the server immediately after being filled out. The interviewer consulted the field supervisor in case of any questions or uncertainty. Daily feedback was provided from the study technical advisor and data collection company managers. The national M&E expert of the HAP team was directly involved on data collection supervision.

2.5 Data analysis

Data analysis followed the analysis of the baseline survey. Datasets of the household roster and all other sections were first merged on the basis of a unique identifier and then separated according to the different questionnaire sections. For data analysis we calculated regional and combined estimates and weighted estimates of the two regions for household characteristics and the household roster. The weighting was done according to the population demographic weight of each region. For financial data we discounted the inflation rate based on Worldbank estimates[2] (Source: World Bank - World Development Indicators) and applied then the same exchange rate to Euro as during the baseline. Data analysis was carried out with STATA. Beyond those uni- and bivariate analyses, tests of significance between the regions were conducted in some instances.

2.6 Ethical considerations

The study protocol and draft questionnaires received ethical clearance from the Ministry of Health and Social Protection (MoHSP) on the 8th of October 2018 (see also Annex A: Approval letter from MoHSP). Oral informed consent was obtained from all respondents at the beginning of the interview. It was pointed out that participation was voluntary and that the respondents could withdraw the participation at any time. The head of the household was also provided with an information letter on the objective and the purpose of the survey and aspects relating to the confidentiality of information.

3 Results & Discussion

Overall 2'567 households were contacted in the regions Diber and Fier (see Table 1). During the endline survey and therewith approximately 1'000 households more than during the baseline (n=1'528 households) Interviewers were able to establish a household contact with 67% of households and thus substantially less than during the baseline (91% of households). Whilst the refusal rate remained between the end- and baseline survey stable (approx. 5%) a substantially higher number of households (n=360) were not eligible or the target person was not at home compared to the baseline (n=39). Hence the response rate dropped from 92% during the baseline to 74% during the endline though the overall total number of households remained almost the same. In other words: the interviewers needed to contact more households during the endline to obtain the targeted sample size of chronically and/or acutely ill patients. This might either relate to the time of the year the data collection was done or a systematic difference in how non-eligible households were recorded by the interviewers.

Table 1: Overview on sampling of households

	Baseline				**Endline**			
	Diber	**Fier**	**Total**	**Rates**	**Diber**	**Fier**	**Total**	**Rates**
HH contacted	782	746	1'528		1'085	1'482	2'567	
thereof not at homes/no contact	74	67	141		295	541	836	
Established contacts with HH	**708**	**679**	**1'387**	**91%**	**790**	**941**	**1'731**	**67%**
thereof No consent obtained	39	34	73		21	61	82	
thereof not eligible or target person not available	27	12	39		126	234	360	
HH Eligible & available households that participate who have at least 1 person chronically or acutely ill	**642**	**633**	**1'275**	**92%**	**643**	**646**	**1'289**	**74%**

In total, 4'749 individuals lived in these 1'289 households (see Table 2). Within each household, we obtained information from the household head, or his/her closest available representative, on characteristics of the household and socio-demographic information on each household member.

In a next step, we then randomly selected one individual either chronically and/or one member acutely ill in the past four weeks to obtain information on access to care patterns, (see also section 2.4, Figure 2). Hence in total 1'135 individuals with chronic conditions and 555 individuals with an acute condition in the four weeks prior to data collection were included and asked about their type of illness and diagnosis, health seeking behaviour and expenditures for health. The increases in sample size for acutely ill patients (baseline n=175) are reflecting a slight methodological change on the inclusion criteria (see chapter 2.4).

In addition, for questions on knowledge, attitude and practice related to chronic conditions we obtained information from 1'125 individuals as the chronic or acutely ill person answered the interview.

In case a mother of a child under 5 years lived in the household and was available at the time of the interview, we also questioned her on the experienced post-natal care and her health seeking behaviour for child health & development. We thus were able to conduct interviews with 157 mothers of children under 5 years. Mothers also were questioned on their knowledge,

attitude and practice related to child growth and development. The following table outlines the specific numbers, stratified by the regions.

Table 2: Denominators and definitions

			Baseline			Endline		
Questionnaire[3]	**Topic**	**Denominator definition**	**Diber**	**Fier**	**Total**	**Diber**	**Fier**	**Total**
Form 1								
HH Questionnaire	Information on HH characteristics & HH access to care	Households	642	633	1'275	643	646	1'289
	Information on socio-demographics & characteristics of HH members (living in HH with at least one chronically or acutely ill person)	Individuals (household roster)	2'968	2'220	5'188	2,578	2,171	4'749
Form 2								
Information on chronic conditions	Type of illness & diagnosis Health seeking & access (barriers) to care Health expenditures	Selected individual reporting a chronic condition	522	574	1'096	525	610	1'135
Information on acute conditions	Type of illness & diagnosis Health seeking & access (barriers) to care Health expenditures	Selected individual reporting an acute condition in the past 4 weeks	117	58	175	323	232	555[4]
KAP chronic conditions	Knowledge of risk factors Chronic disease knowledge	Individuals chronically or acutely ill	636	628	1,264	608	517	1'125
Form 3								
Information on mothers & child	Post-natal care Health seeking behaviour for child health & development	Mother with a child <5 years	109	52	161	102	55	157
KAP Mother &Child	Knowledge on child development	Mother with a child <5 years	109	52	161	102	55	157

[3] See also section 2.3 and Figure 2.

[4] The increases in sample size for acutely ill patients from base- to endline are reflecting a slight methodological change on the inclusion criteria (see chapter 2.4).

3.1 Characteristics of households and individuals

We included information on household composition as well as some socio-demographic factors, health and insurance status from 1'289 households (see Table 3) respectively 4749 individuals living in those households, thereof 2'578 (54%) in Diber and 2'171 (46%) in Fier (see Table 4). The average number of household members was 3.4 persons (SD 1.8) and thus slightly lower than during the baseline (average 4.0). Average household size in Diber was higher (4.0; SD 1.8) than in Fier (3.4; SD 1.7). A similar proportion of households compared to the baseline were located in rural areas (baseline 65%; endline 64%). In rural areas household size was slightly higher with an average size of 3.9 persons (SD 1.9) compared to urban areas 3.3 (SD 1.5).

The income structure of households also remained similar with only a few changes to the baseline: the most common income were governmental pensions (endline 59%, baseline 56%) followed by income from farming/livestock (endline 33%, baseline 40%), remittances (endline 27%, baseline 18%), salary in Albania (endline 26%, baseline 23%), social aid (endline 20, baseline 22%) and private business in Albania (endline 13%, baseline 9%). Naturally income from farming/livestock is more common in rural than urban areas (rural 50%, urban 3%). Differences between the regions are observed for pension (being more common in Fier) and social aid (being more common in Diber) but otherwise are similar.

The proportion of households where at least one person benefits from social or economic aid remains largely stable at overall 24% with higher proportions being observed in Diber (endline: Diber 33%, Fier 12%; Baseline: Diber 34%, Fier 11%). The proportion of those households was also slightly higher in rural areas (rural 25%, urban 19%).

The proportion of households where at least one household member belongs to an ethnic or linguistic minority has doubled from 2% in the baseline to 4% during the endline. Among urban households this was most commonly the case (5%).

Table 3: Socio-economic household characteristics

	Baseline					Endline				
	Diber	**Fier**	**Rural**	**Urban**	**Total**	**Diber**	**Fier**	**Rural**	**Urban**	**Total**
HH level										
Number of HH	642	633	825	448	1'275	643	646	820	469	1'289
Average HH size (SD)	4.5 (2.0)	3.5 (1.7)	4.2 (1.9)	3.6 (1.7)	4.0 (1.9)	4.0 (1.8)	3.4 (1.7)	3.9 (1.9)	3.3 (1.5)	3.7 (1.8)
Rural location %	67	62	-	-	65	66	61	-	-	64
Household income % *(Multiple answers)*										
Private business in Albania	10	7	6	13	9*	14	12	9	20	13*
Salary in Albania	25	20	15	37	23*	27	24	18	39	26*
Pension	54	59	57	57	56*	51	68	60	59	59*
Social aid	31	10	23	17	22*	28	10	22	15	20*
Farming/livestock	41	39	58	5	40*	34	32	50	3	33*
Remittances	19	18	21	14	18*	26	29	30	23	27*
Other	3	4	3	4	3*	3	5	4	5	4*
% of HH where at least one person benefits from social-/economic aid	34	11	25	19	24*	33	12	26	17	24*
% of HH where at least one person belongs to an ethnic or linguistic minority	2	1	1	3	2*	4	4	4	5	4*

*weighted total by district

Table 4 outlines the socio-demographic characteristics of household members which largely remain similar to the baseline. Average age of household members was 41 years. Most household members were between 18 and 49 years (38%) or above (23% between 49<65 and 20% were 65 or older).

More than half of the individuals were married (58%) and more than one third were single (34%). The most common educational degree obtained was 43% for finishing secondary grade (grade 6-9 years) and another 30% had a high school degree (10-12 years).

Table 4: Socio-demographic characteristics of individuals living in households

	Baseline					Endline				
	Diber	**Fier**	**Rural**	**Urban**	**Total***	**Diber**	**Fier**	**Rural**	**Urban**	**Total***
Individual level										
Total number of people living in HH	2'968	2'220	3'535	1'649	5'188	2'578	2'171	3'191	1'558	4'749
% female in HH	51	51	50	52	51	50	50	49	52	50
Average age (SD)	35 (23)	43 (23)	38 (23)	40 (23)	38 (29)	38 (23)	46 (23)	41 (25)	44 (23)	41 (28)
% by age cat:										
<1	3	1	2	2	2	1	1	1	1	1
2<5	5	4	5	5	5	5	3	5	3	4
5<18	19	13	18	15	17	17	11	15	13	15
18<49	41	35	39	38	39	41	33	38	37	38
49<65	20	25	21	23	22	22	26	23	24	23
65+	12	22	16	18	16	15	26	19	22	20
Marital status										
married	51	62	55	56	55	55	62	58	58	58
divorced	0.4	0.8	0.4	1	0.6	0	1	0	1	1
separated	0.2	0.1	0.1	0.2	0.1	0	0	0	0	0
widow/er	6	6	6	7	6	6	8	6	8	7
single	42	31	39	35	38	39	28	35	33	34
other	0.6	0.2	0.4	0.6	0.5	0	0	0	0	0
Highest Education achieved										
none	0.5	0.6	0.6	0.3	0.5	1	0	1	0	1
pre-school/ kindergarten	2	2	2	3	2	2	3	2	2	2
primary (grade 1-5)	14	14	16	11	14	15	15	15	13	15
secondary grade (grade 6-9)	47	41	48	35	45	45	39	49	29	43
high school (10-12)	26	32	25	35	28	29	32	26	39	30
college/technical school (10-12)	3	3	2	3	3	1	2	1	2	1
university	8	8	6	12	8	8	10	6	15	9
Don't know	0.1	0.2	0.1	0.3	0.2	n/a	n/a	n/a	n/a	n/a

* weighted by district

3.1.1 Households' geographical distance to next health facilities

Overall, households use public health providers for their first consultation (97%), most commonly governmental health centres, governmental hospitals and health posts. Households in Diber prefer to access governmental hospitals as their preferred provider (47%) with much smaller proportions in Fier (18%). In Fier households preferred provider are

governmental health centres (67%). No major differences were identified for location of households. Also the overall access patterns remain stable between base- and endline.

The reasons why households address to specific providers are: geographical proximity (62%), does not cost much (39%), good services (27%), familiarity with the staff (25%) and covered by the insurance (23%). Various other aspects (e.g. qualified staff, waiting times) remained around 10%. Almost 60% of households were located in close proximity (<1km) to the next PHC facility in both districts and another 25% of households in 1 - 4.9 km distance. Households being further away than 20km from next PHC facility are very few (2%). The distance to the next policlinic is further away: 41% of households being in distance of less than 5km but 23% being more than 20km away from next policlinic.

Table 5: Preferred health providers

	Baseline					Endline				
	Diber (n=642)	**Fier (n=633)**	**Rural (n=825)**	**Urban (n=448)**	**Total***	**Diber (n=642)**	**Fier (n=633)**	**Rural (n=825)**	**Urban (n=448)**	**Total***
Use public facilities for first consultation	97	95	97	96	96	99	95	97	97	97
Thereof: Type of public health facility										
Gov. hospital	38	22	34	23	31	47	18	33	31	34
Gov. policlinic	1	5	2	5	3	1	3	1	4	2
Gov. health centre	49	58	53	54	53	41	67	52	58	53
Health Post	12	15	11	18	13	11	12	14	7	11
Other public	0.2	0.2	0.3	0	0.2	0	0	0	0	0
Reasons for choosing this health providers (multiple answers)										
Geographical proximity	60	68	60	70	63	68	55	60	64	62
Familiarity with the staff	17	19	17	18	18	30	19	22	30	25
Good services	23	20	22	21	22	38	13	25	26	27
Fast appointments	14	13	13	13	13	11	5	7	10	8
No need for appointment	7	9	8	8	8	14	5	9	10	10
Covered by my insurance	19	20	15	28	19	19	28	19	30	23
Does not cost much	25	24	21	30	24	37	41	39	39	39
Good quality	14	14	14	13	14	n/a	n/a	n/a	n/a	n/a
Good services	12	10	13	6	11	n/a	n/a	n/a	n/a	n/a
Qualified health staff	n/a	n/a	n/a	n/a	n/a	7	8	7	7	7
Short waiting times	n/a	n/a	n/a	n/a	n/a	14	6	9	12	10
Modern medical devices	n/a	n/a	n/a	n/a	n/a	2	4	3	4	3
Laboratory tests	n/a	n/a	n/a	n/a	n/a	5	5	5	4	5
I need to get referral	n/a	n/a	n/a	n/a	n/a	3	0	2	1	2
Other	n/a	n/a	n/a	n/a	n/a	9	19	15	12	13
Distance to next PHC facility										
Less than 1 km	57	64	48	83	60	52	66	46	83	59
1 - 4.9 km	23	27	31	15	25	29	23	32	16	26
5 - 9.9 km	14	6	15	1	11	10	9	14	0	9
10 - 14.9 km	2	1	3	0	2	4	1	4	0	2
15 - 19.9 km	2	1	2	0	2	2	0	2	0	1
20+ km	2	0	2	0.2	1	3	1	3	1	2
Distance to next policlinic										
Less than 1 km	26	20	5	55	23	21	18	6	43	19
1 - 4.9 km	12	22	10	30	16	22	22	14	36	22
5 - 9.9 km	13	19	21	7	15	10	14	17	4	12
10 - 14.9 km	15	11	20	0.2	13	10	14	18	1	12
15 - 19.9 km	10	13	17	2	11	14	10	17	2	12
20+ km	25	16	28	6	21	24	22	29	13	23

* weighted by district

3.1.2 Health status of all household members

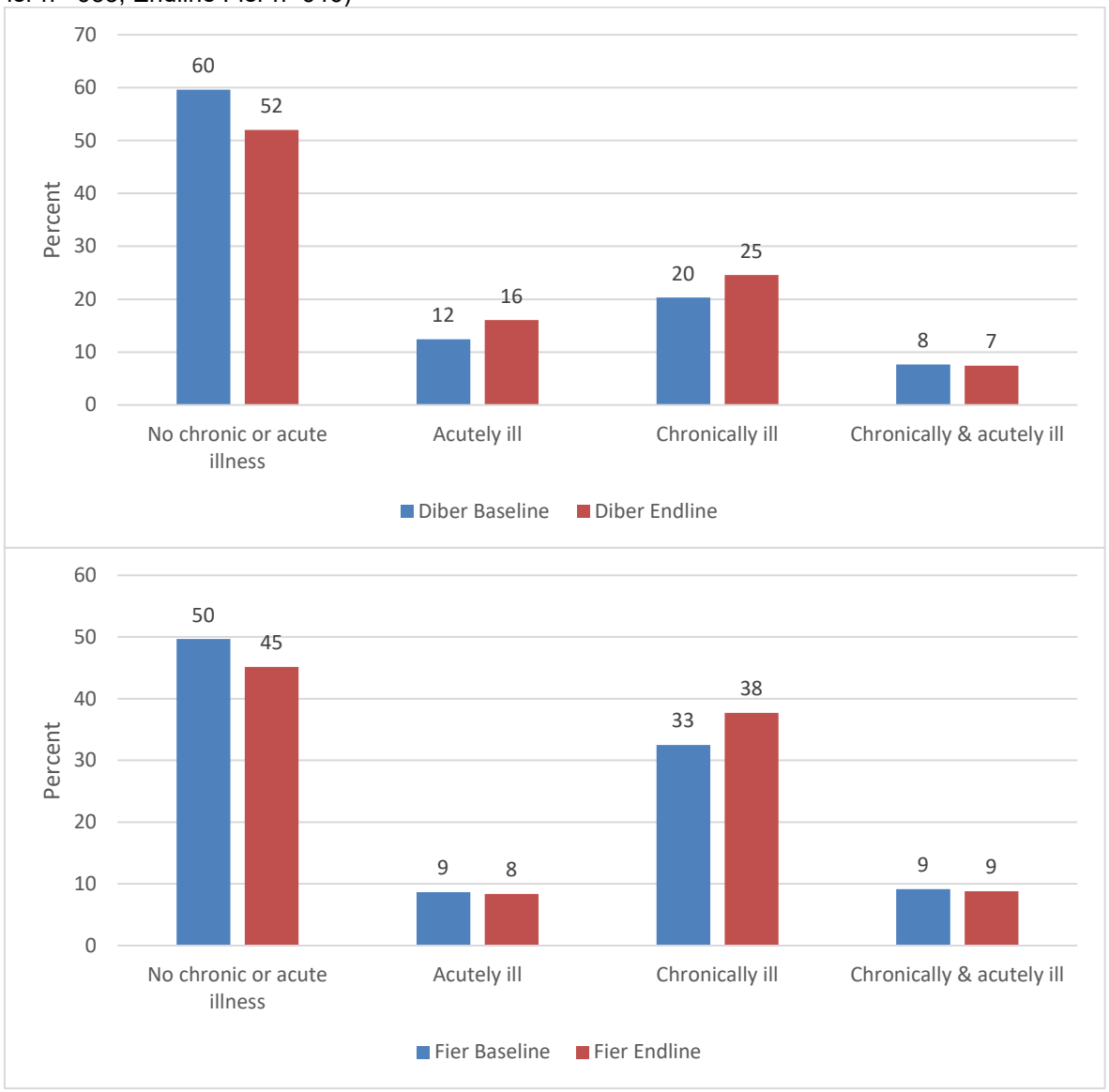
Overall 49% of all household members have no chronic or acute illness, thereof 52% in Diber and 45% in Fier (see Figure 3). Most common conditions among household members were chronic conditions. As during the baseline the proportion of household members with chronic conditions in Fier (endline 38%, baseline 33%) was substantially higher than in Diber (endline 25%, baseline 20%). The data also shows some increases since the baseline in both regions.

13% of persons living in the study households report an acute condition in the past four weeks with the proportions being the same in Fier (endline 9%, baseline 8%) as during the baseline, but slight increases in Diber since then (endline 16%, baseline 12%).

This regional difference might reflect a seasonal effect as conditions in Diber tend to be harsher in winter than in Fier or a general difference in hygienic conditions. The percentage of those affected by an acute and chronic condition remains largely stable at 8%.

Of those reporting a chronic condition or a chronic and acute condition, 60% are female. Acute illnesses are equally shared between men and women (female: 51%).

Figure 3: Health status of household members (Baseline Diber n=642, Endline Diber n=643; Baseline Fier n= 633, Endline Fier n=646)

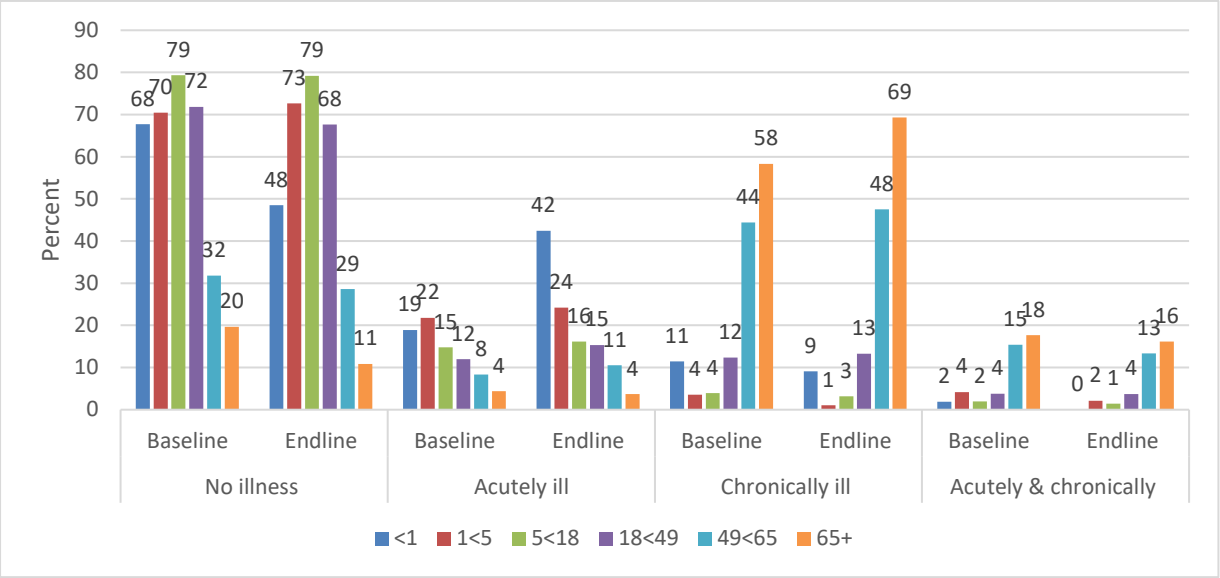


Infants <1 years have been mostly affected with acute conditions and substantially more than during the baseline (endline 42%, baseline 19%). Similarly were children <5 most commonly reported with acute illness (endline 24%, baseline 22%). As during the baseline we had another approx. 10% of infants (<1 year) for whom chronic conditions have been reported.

One can see that the proportion of acute illness decreases with age whilst the proportion of chronic conditions rises with age with a drastic increase from 49 years onwards (49>65 years: endline 48%, baseline 44%; 65 years or older: endline 69%, baseline 58%). Also, the proportion of those affected with acute and chronic conditions increases from 49 years old or older. The age pattern is also reflected with those not suffering from any chronic or acute illness or injury in the past four weeks: the proportions substantially decrease from 49 years onwards.

The increase in chronic conditions between base- and endline might also reflect the effect of the annual check-up introduced in 2015 for people 35-70 years. It is possible that "silent" chronic conditions have been detected. This could be considered as a positive result for the early detection and eventually medical care.

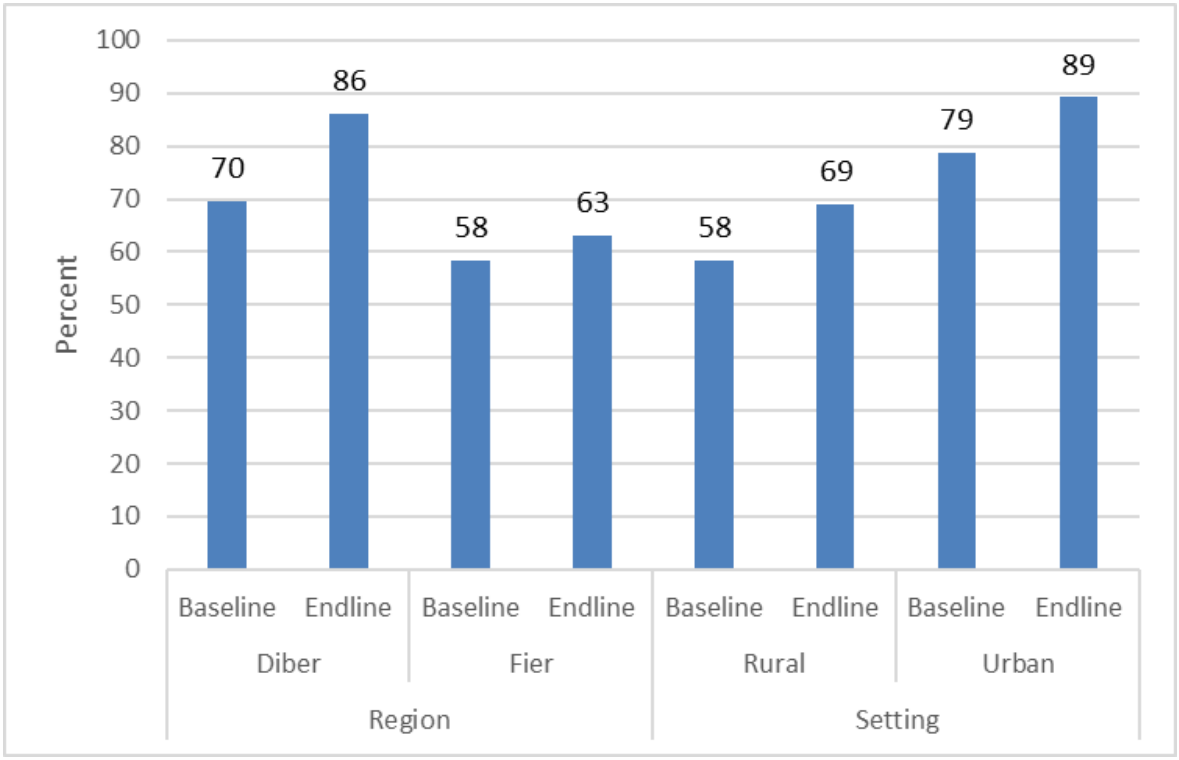
Figure 4: Health status of household members by age group (Baseline: n=5,184, Endline n=4,749)



3.1.3 Insurance cover of all household members

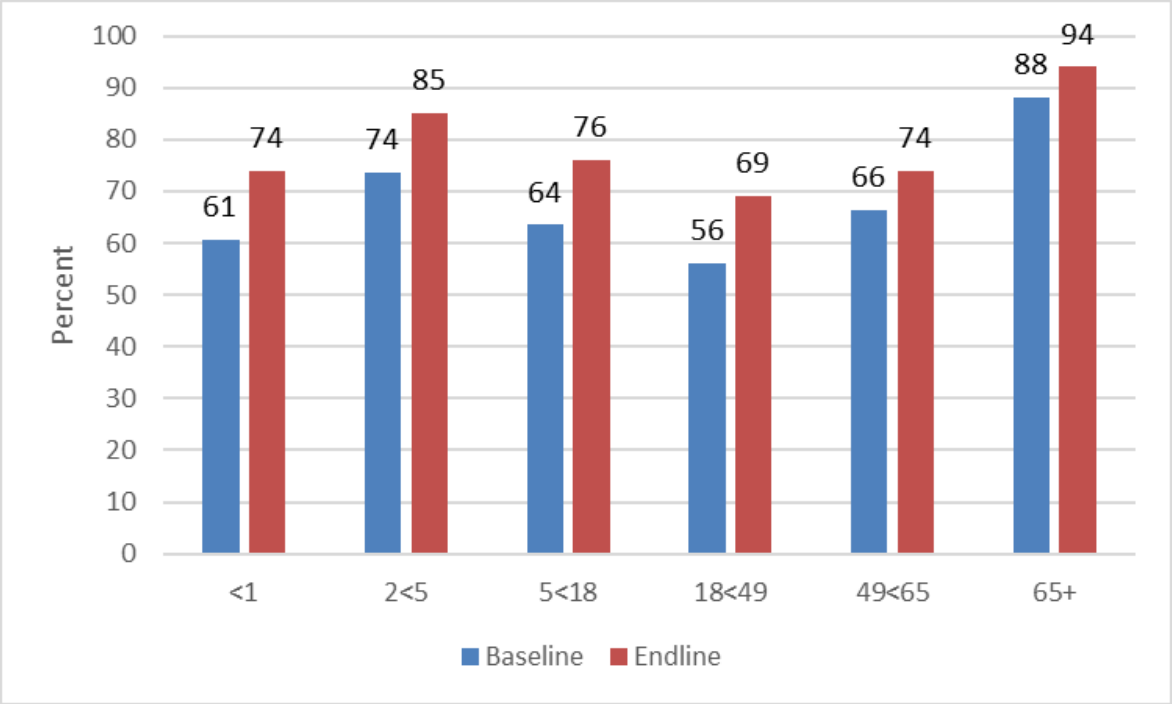
Health insurance coverage for all household members is overall 76%, but higher in Diber than in Fier (86% vs. 63% respectively) and higher in urban than rural settings (89% vs. 69%) (see also Annex B.1: Household level). Health insurance coverage among males and females is almost the same (males 74%, females 77% respectively). Interestingly, the health insurance status of household members increases across all stratifications since the baseline measurement. The reasons for these increases remain somewhat unclear: it might have to do with changes of the concept of health insurance since 2016 when the government decided to provide free PHC services for all including the specialist consultations for patients with chronic conditions / reimbursement of essential drugs. It might also reflect, that obtaining and renewing the health insurance was simplified through electronic processes.

Figure 5: Health insurance status of household members (Baseline: n=5’184, Endline n=4’749)



Of those insured about 51% are women. Health insurance coverage is highest among those 65 years and older (94%) and among children 1<5 years (85%) followed by children and adolescents 5<18 years (76%). Infants (<1 year) and adults (49<65) both had 74% coverage while Adults (18<49 years) had the lowest insurance coverage (69%). Over time we thus observe slight increases in the insurance status.

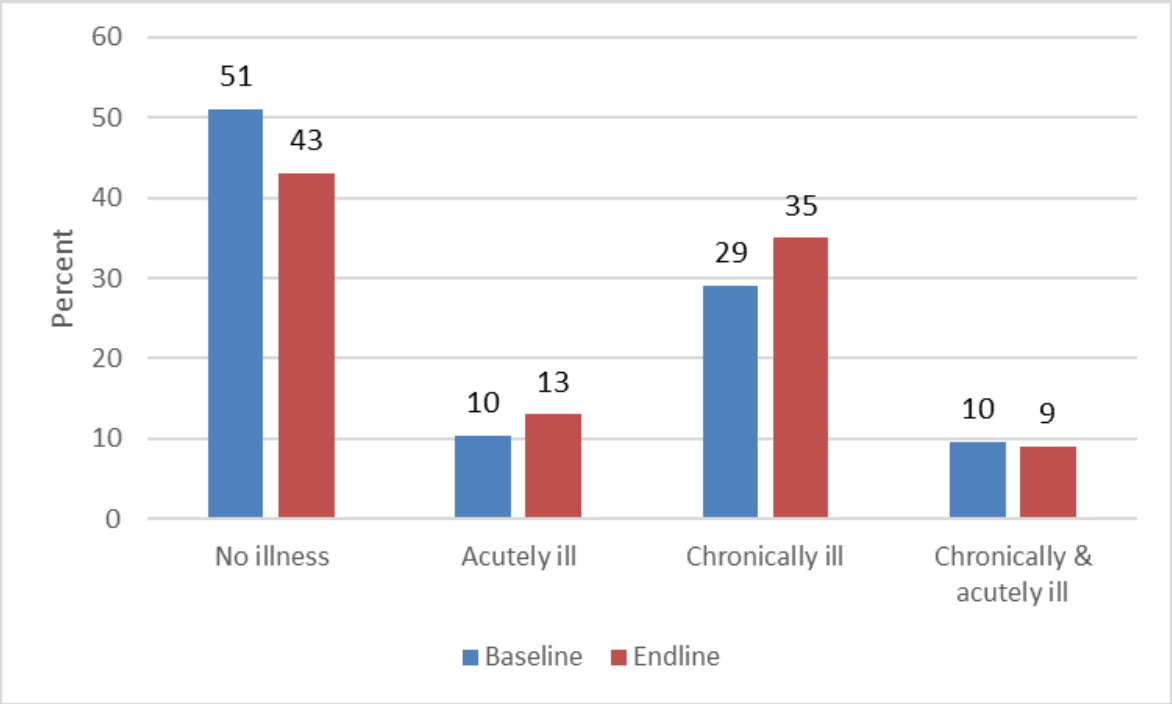
Figure 6: Health insurance coverage of household members by age group (Baseline: n=5'184, Endline n=4'749)



Of those insured 43% have no specific condition but 35% of those insured reported a chronic condition, 13% an acute condition and approx. 9% have both. In return 86% of those who reported having a chronic condition are insured. Also 78% of those acutely ill are insured. The proportion of those suffering from a chronic and acute condition who have a health insurance card is 84%.

The proportion of people with health insurance coverage, who live in households where at least one member of the household benefits from a social or economic aid scheme, is 81% (Diber: 86%; Fier: 66%) compared to those living in households without socio-economic aid (74%). No differences in gender coverage could be identified for this subgroup (males: 80%; female: 82%).

Figure 7: Health insurance coverage of household members by health status (Baseline: n=5'184, Endline n=4'749)



We also questioned the 1'158 (baseline 1'827) individuals who did not have a valid health insurance card at the time of the interview about the reasons why they had no valid health insurance card. Table 6 outlines the given reasons. During the endline respondents indicated most commonly that they did not need it (endline 36%; baseline 19%) or that they did not pay contributions/were not eligible (endline: 36%, baseline 15%). 14% (baseline 4%) considered it did not have an any benefit and another 11% (baseline 49%) declared that they did not renew their health insurance card. This reflects the perceptions of people on insurance coverage and indicates that a lot more information and education is needed on their rights and the mechanisms how to better access services.

Table 6: Reasons for not having a valid health insurance card – *multiple answers*

	Baseline					Endline				
	Diber (n=902)	**Fier (n= 925)**	**Rural (n=1'473)**	**Urban (n=352)**	**Total (n=1'827)***	**Diber (n=357)**	**Fier (n=801)**	**Rural (n=990)**	**Urban (n=168)**	**Total (n=1'158)***
did not renew health insurance card	60	34	45	52	49	11	11	10	16	11
do not need it	21	16	18	22	19	48	30	35	36	36
does not pay contribution/not eligible	5	28	18	10	15	8	51	38	40	36
other	11	15	13	11	12	18	8	11	8	11
do not know how to obtain	4	6	5	5	5	16	2	7	2	7
does not have any benefit	5	4	4	7	4	16	12	13	18	14
do not know if I am eligible	3	3	3	5	3	5	3	4	2	4
requested but not yet obtained	2	3	2	1	2	5	2	3	5	3
was refused	1	2	1	2	1	4	0	2	1	2
my treatment/ medication is not covered by insurance	0	0	0	0	0	2	0	1	0	1

*weighted by district

3.2 Selected patients with chronic condition

3.2.1 Profile of interviewees

Of the interviewees[5] included in the sample and willing to provide more detailed information on their chronic condition(s), with an average age of 62 years (SD: 15; median: 63), 63% were female. Of participants, 14% were between 18 to 49 years (baseline: 16%), 38% between 49<65 (baseline 41%) and another 46% 65+ (baseline 40%). For children below 18 years questions were answered by an adult/caretaker.

Table 7: Demographic profile of chronic disease patients included in the sample

	Diber	Fier	Rural	Urban	Total	Diber	Fier	Rural	Urban	Total
n	522	574	715	380	1'096	525	610	725	410	1'135
% female in HH	68	75	72	72	72	62	64	63	63	63
Average age (SD)	58 (17)	61 (15)	59 (16)	60 (15)	59 (16)	59 (17)	63 (14)	62 (16)	61 (15)	62 (15)
% by age cat:										
<1	0.8	0	0.2	0.5	0.4	0.2	0.2	0.3	0.0	0.2
2<5	0.6	0.7	0.6	0.8	0.6	0.8	0	0.4	0.2	0.4
5<18	2	2	2	2	2	2	0.5	0.8	1	1
18<49	20	14	18	13	16	18	11	13	16	14
49<65	43	40	40	43	41	39	38	39	37	38
65+	35	44	39	41	40	41	50	46	45	46

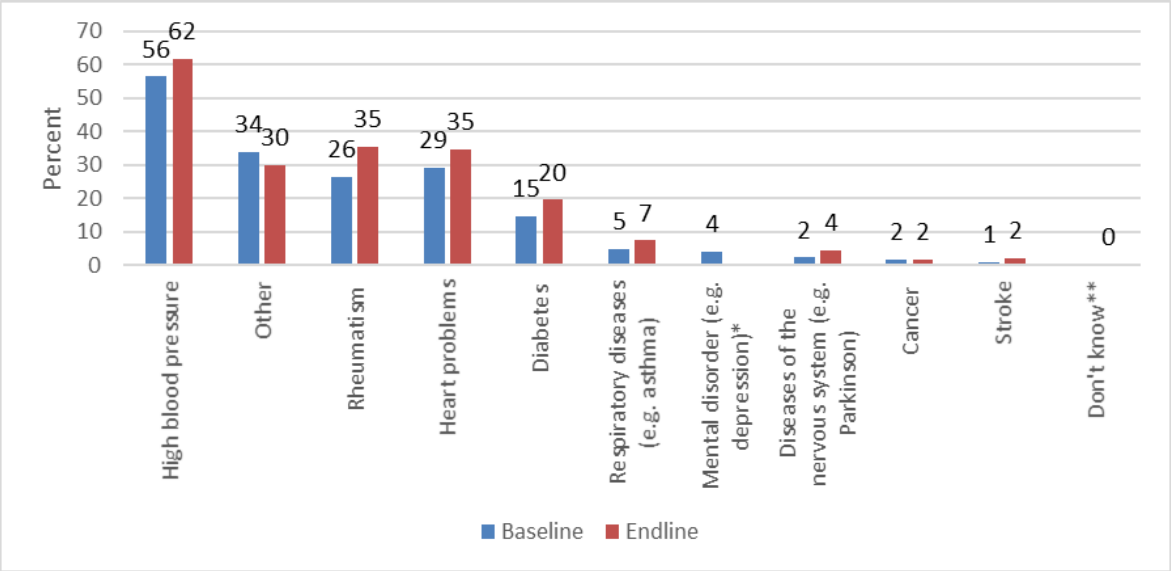
3.2.2 Situation of chronic disease patients: Illness patterns

Disease patterns remained at large stable between the base- and endline though we have reported increases for almost all conditions: hypertension (endline 62%, baseline 56%), heart problems (endline 35%, baseline 29%), rheumatism (endline 35%, baseline 26%), followed by diabetes (endline 20% baseline 15%) and respiratory diseases (endline 7%, baseline 5%) and diseases of the nervous system (endline 4%, baseline 2%). Stroke and cancer were mentioned by about 1-2% of the interviewees, respectively.

We identified no substantial gender issues for the various chronic conditions though more women than men reported being affected by rheumatism (63%) and high blood pressure (69%). High blood pressure was also more common in Fier than Diber (69% vs. 53% respectively).

[5] These numbers do not present prevalence estimates as only one person from each household was selected to provide detailed information about his/her chronic conditions (see also chapter 2.4).

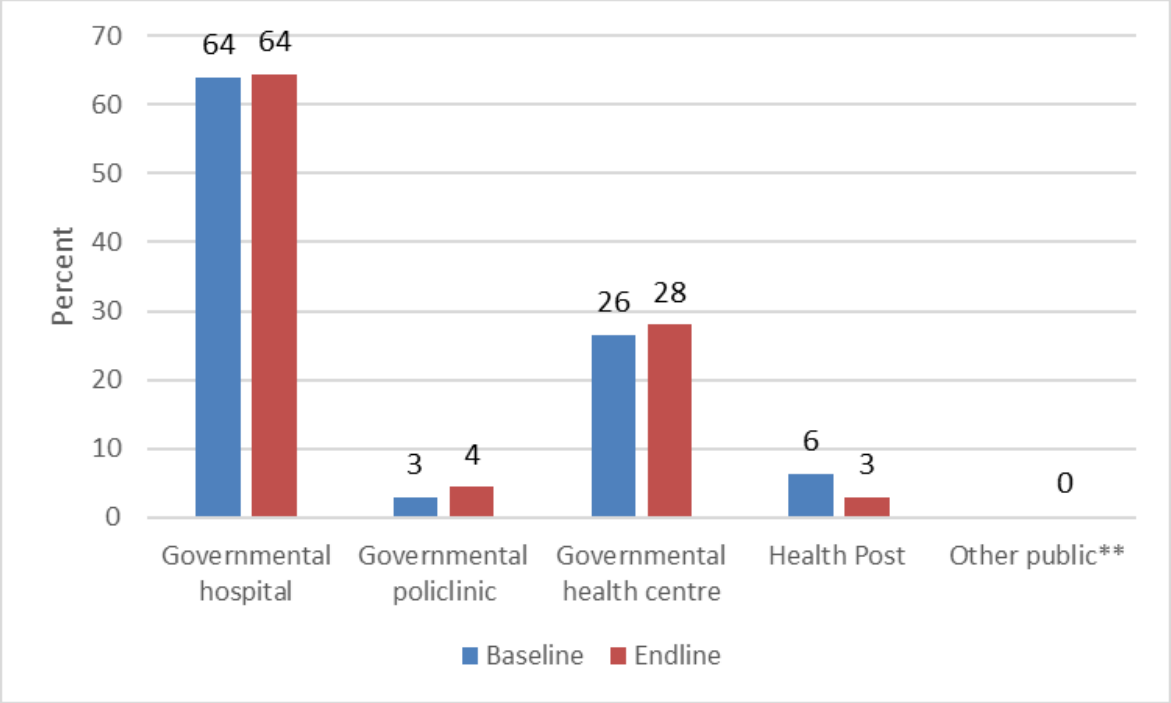
Figure 8: Self-reported chronic conditions (Baseline n= 1'096; Endline n='1135) – *multiple answers*



*Baseline only. **Endline only

95% of interviewees received their diagnosis through a public sector health provider, most commonly hospitals (64%) followed by health centres (28%). Only 5% declared that they were diagnosed through private providers, typically by a private hospital or clinic (75%).

Figure 9: Provider establishing the diagnosis of a chronic condition (Baseline n=1'027; Endline n=1'075).



**Endline only.

The increase of some NCDs such as hypertension, diabetes, heart problems etc. during the end-line survey compared to baseline might be explained by the implementation of the annual check-up. However, many respondents reported diagnosis occurred in public hospitals rather than PHC facilities, where annual check-ups take place. It is possible, that when a problem is

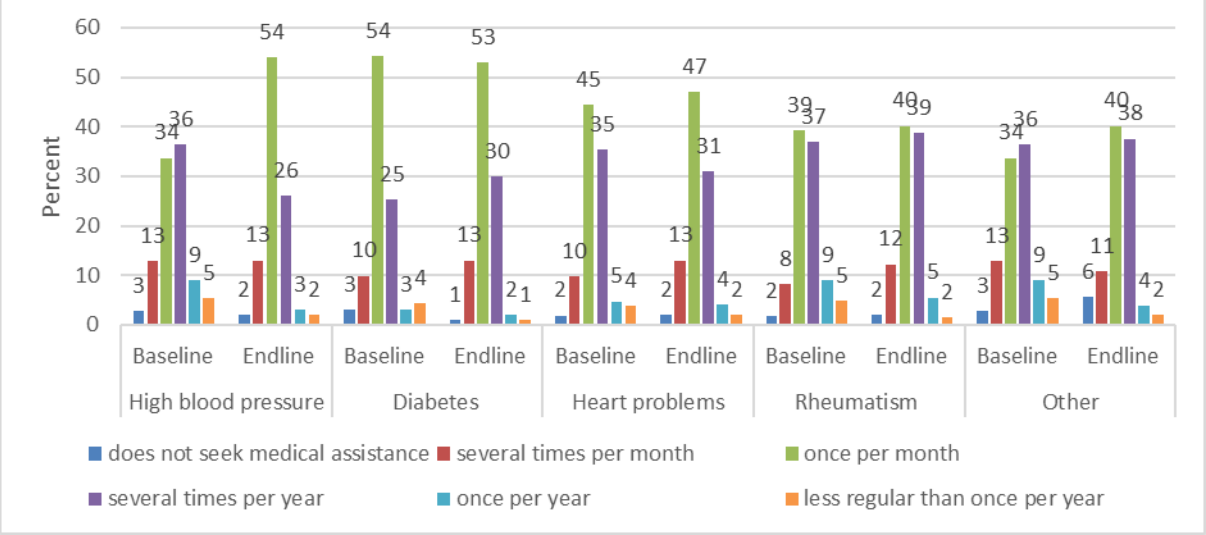
detected by the check-up, people are sent to the specialist physician where a diagnosis is confirmed.

3.2.3 Health seeking behaviour & barriers

We tried to establish the regularity with which patients seek care for their chronic condition distinguishing in decreasing order from several times per month (e.g. weekly), once per month (e.g. monthly), several times per year (e.g. 6 times a year), once per year (e.g. annually), less regular (e.g. once every two years) or not seeking care at all. 97% of patients seek care for their chronic condition, most commonly once per month (44%) or several times per year (36%). Figure 10 shows the health seeking pattern for the most common diseases. During the endline we could not distinguish major differences between the different conditions as patients most commonly seek care once per month or several times per year. Patients visited particularly once per month for the following conditions: high blood pressure (endline 54%, baseline 34%), diabetes (endline 53%, baseline 54%), heart problems (endline 47%, baseline 45%). For rheumatism and other conditions approximately 40% of patients visited once per month. Overall it seems that health seeking behaviour for the most common chronic conditions has either remained stable or significantly improved possibly showing an increased risk awareness.

Differences compared to the baseline were identified for disease of the nervous system shifting from more commonly visiting several times per year during the baseline (baseline 44%, endline 24%) to once per month during the endline (baseline 24%, endline 44%). The situation is similar for stroke patients. This might indicate difficulties related to services provided to the stroke patients: absence of rehabilitation services, lack of home-based care, challenges related to transport of stroke patients etc.. However, it needs to be taken into account that also the patient numbers for disease of the nervous system and stroke were relatively low (n=51 and n=25 respectively).

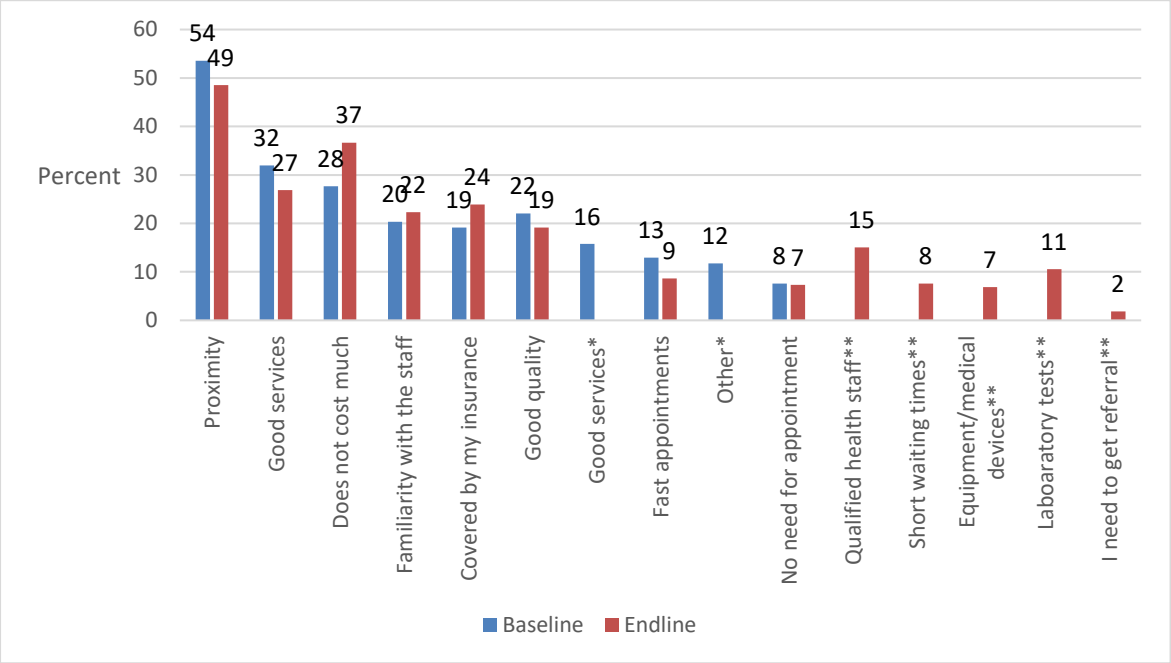
Figure 10: Regularity of health seeking behaviour for chronic condition (Baseline: n= 1’096; Endline 1’135)



Out of 1,135 participants declaring to have a chronic condition 58% (n=640) reported seeking care in the past four weeks. Another 26% (n=289) had sought care in the past eight weeks. This adds up to 929 individuals who actually sought care in the past four to eight weeks. Medical care was sought at the public sector (87%) at hospital and health centre. Patients were most commonly treated by a doctor and/or a nurse. When choosing a provider, a similar pattern appears as during the baseline. Most important factors are geographical proximity to

the health provider (49%), low costs (37%), good services (27%), covered by insurance (24%), familiarity with the staff (22%), good quality (19%) and qualified staff (15%).

Figure 11: Reasons for choosing a health provider by persons suffering from a chronic condition (Baseline: n=767; Endline 1'135) – *multiple answers*



*Baseline only; **Endline only

The most common reasons why patients visited not only PHC facilities but also a hospital was that they had been referred (30%) or that tests (26%) or services (18%) had not been offered at the level of the PHC provider. The quality of services and the perceived competence of the doctors were in less than 10% of the chronic patients' reasons for consulting at a facility other than the PHC physician.

Whilst during the baseline we identified that referrals were more common in rural than urban areas (21% vs. 14%) this effect can no longer be shown during the endline (rural 31%, urban 30%). Also, the other factors, e.g. 'not all tests or services were offered at PHC' no longer show such differences between rural and urban areas. In other words: the availability of tests was more limited in urban settings during the endline than during the baseline, indicating that the situation in urban PHC centres became more problematic over time (see Figure 12).

Figure 12: Reasons for visits other than PHC among persons suffering from a chronic condition (Baseline n=767; Endline 1'135) – *multiple answers*

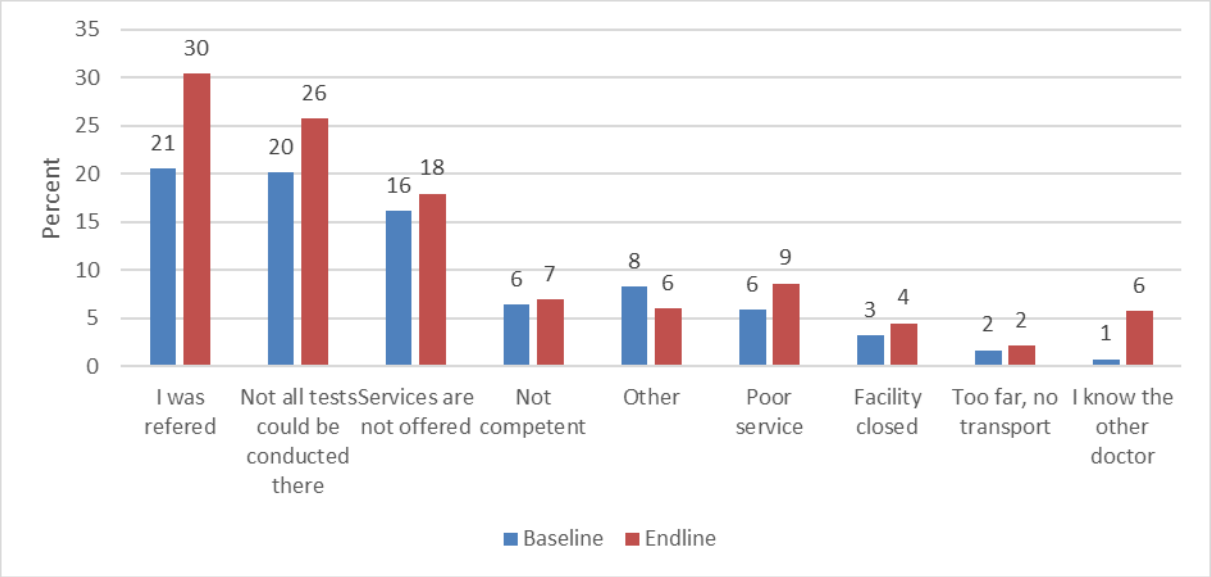
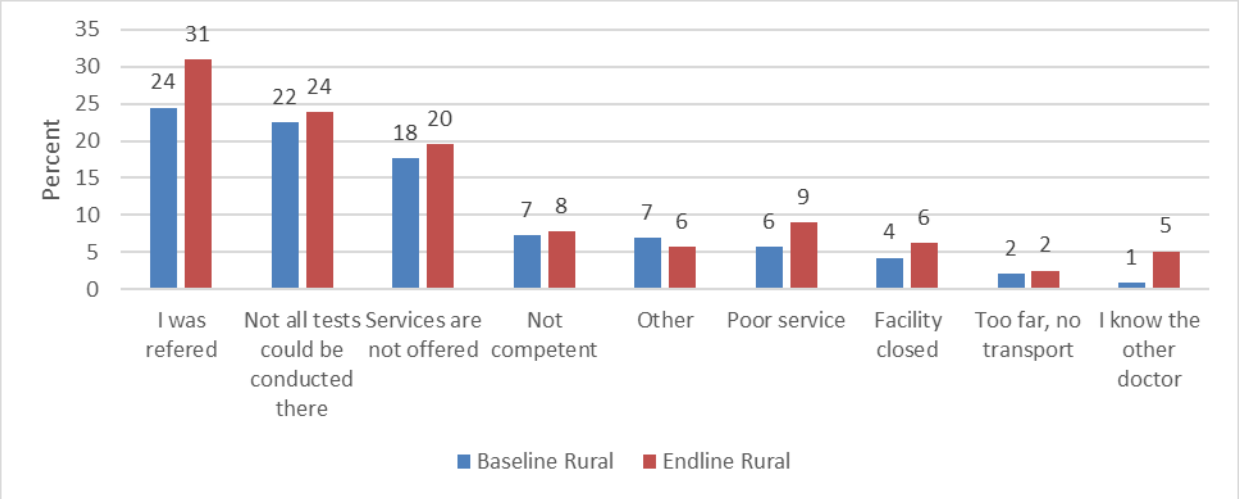
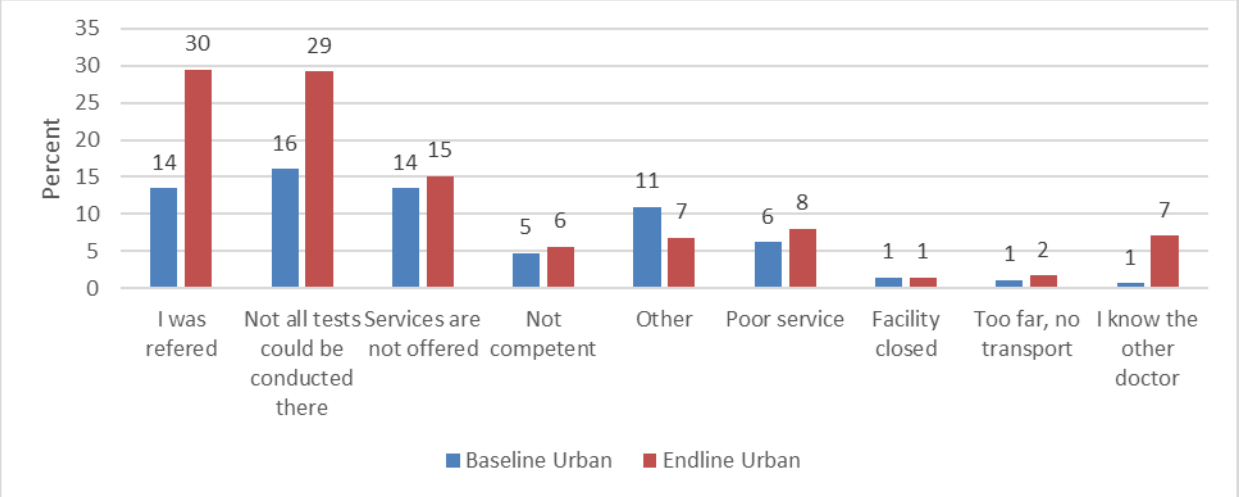


Figure 13: Reasons for visits other than PHC by area of residency among persons suffering from a chronic condition (Baseline rural n= 494, Endline rural n= 725; Baseline urban n= 273, Endline urban n=410) – *multiple answers*



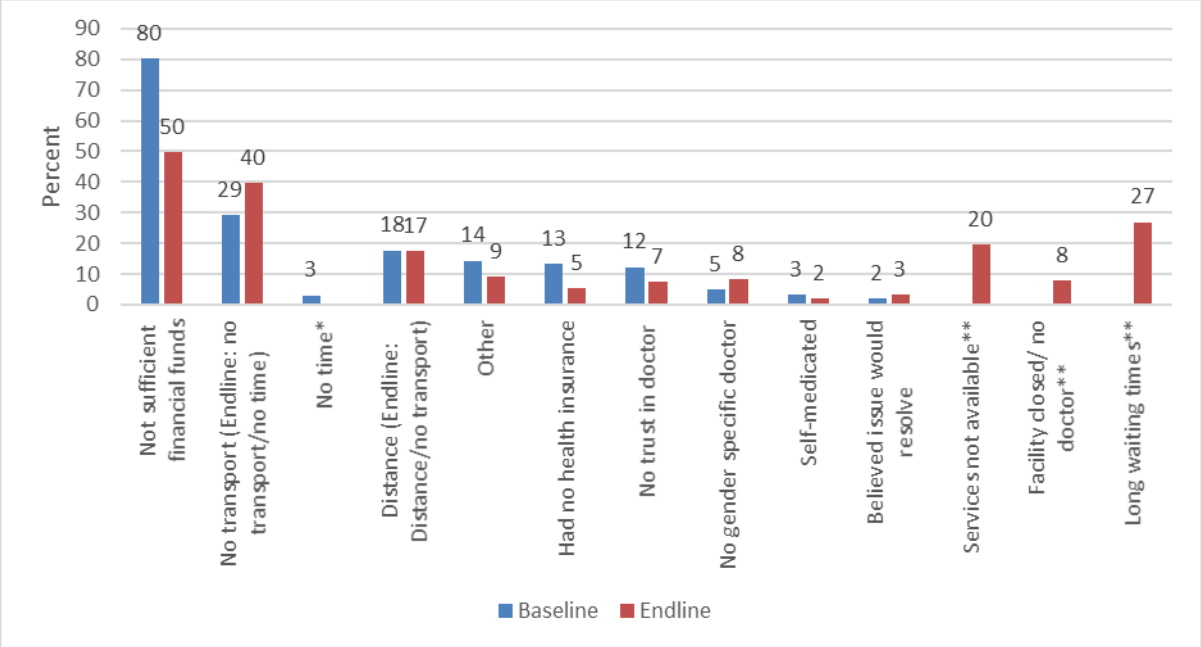


Despite more than half of chronic disease patients accessing care in the past four to eight weeks, 20% of interviewees reported that they face difficulties in regularly seeking care from a health service provider (baseline 30%) and 10% reported that obtaining care for their chronic condition was at times difficult (baseline 26%). For seeking care, financial hardship was still the main factor (see Figure 14 though we observe that this barrier has steeply decreased and only 50% of respondents name it a continued barrier (baseline 80%). Lack of transport/time was another main factor why patients had difficulties seeking care (endline 40%, baseline 29%). During the endline we also explored some additional items that show as being important: long waiting times (27%) and services being not available (20%). For the other factors the patterns and relative percentages remain the same as during the baseline.

The patterns remained between the two regions almost the same. Differences were identified for mainly four items: Had no health insurance (Diber 10%, Fier 3%), no gender specific doctor available (Diber 21%, Fier 3%); facility closed/ no doctor (Diber 11%, Fier 6%) and long waiting times (Diber 14%, Fier 33%).

Hence it might be valid to assume that while financial accessibility has improved transport, services not available and long waiting times are becoming more problematic during end-line. It is possible, that long-waiting times are becoming more problematic with the introduction of the electronic referral system because patients perceive they wait longer before they can consult a specialist physician.

Figure 14: Difficulties for seeking care among persons with a chronic condition (Baseline n= 328; Endline n=219) – *multiple answers*



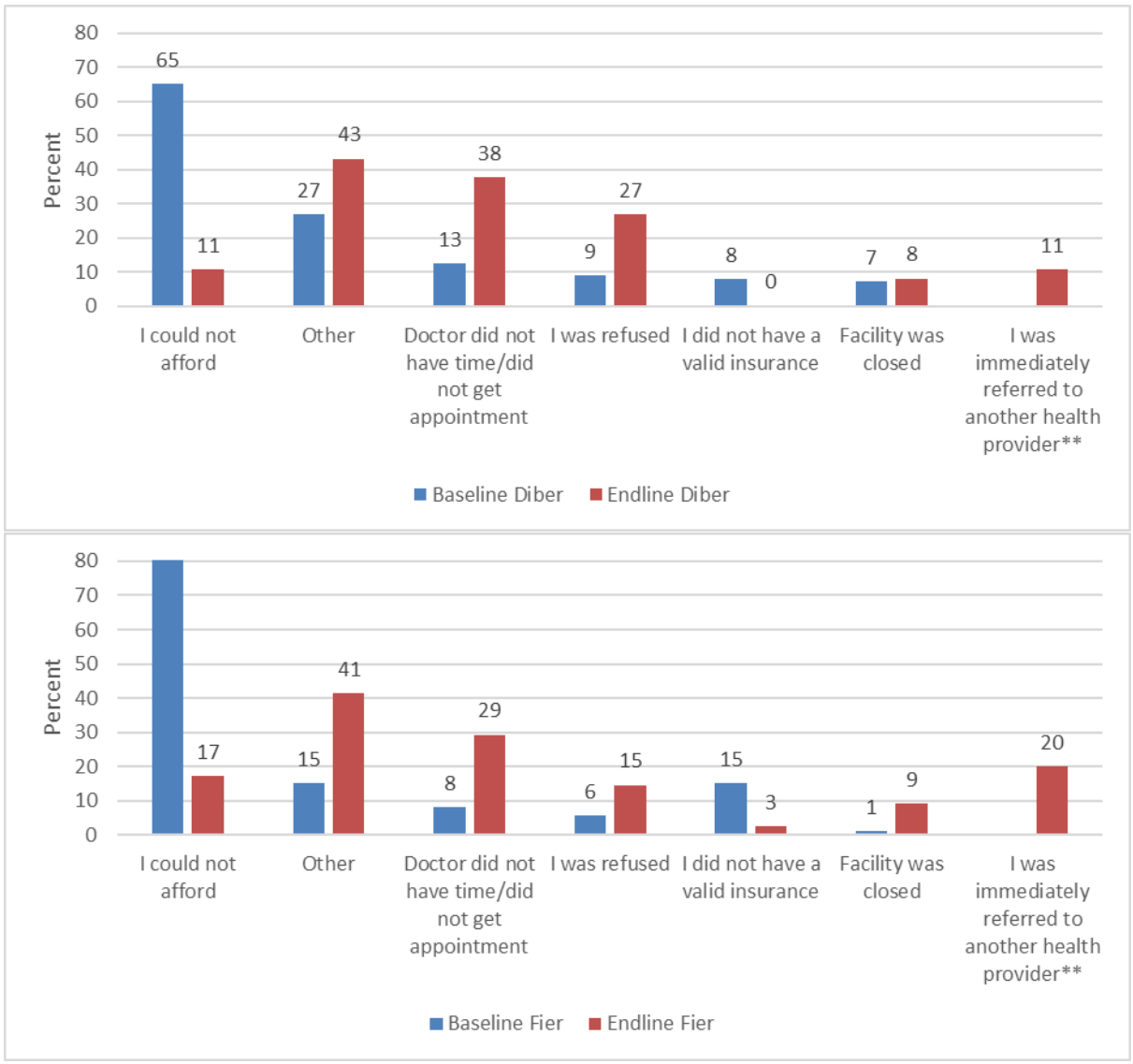
*Baseline only; **Endline only

Chronic disease patients were also asked if they ever encountered difficulties in obtaining care (e.g. treatment, medicine) and 10% indicated this to be the case. A main barrier was that people experienced that the doctor did not have time/did not get appointment (baseline 10%, endline 32%) and that patients were instantly referred to another health provider (endline 17%). Respondents indicated that the problems for obtaining care due to limited financial funds have substantially decreased though 15% respondents still had issues herewith (baseline 74%).

Doctors not having time and patients being refused seem more common in Diber than in Fier, whilst instant referrals are more common in Fier than in Diber (see Figure 15). We did not find any systematic differences between rural and urban settings with the exception of referral. Patients in urban settings were more often instantly referred to another health provider (rural 14%, urban 24%).

Whilst the underlying reasons for these developments are unclear one can speculate that the main problems of accessibility in Diber are related to availability, workload and motivation of health care providers. Whilst "immediate referral" shows (more in Fier) perhaps deficiencies in general practitioners capacities and/or reflects issues related to the regulatory framework of the referral system.

Figure 15: Difficulties among persons with a chronic condition for obtaining health services by region (Baseline Diber n=112, Endline Diber n=37; Baseline Fier n=172; Endline, Fier n=75) – *multiple answers*

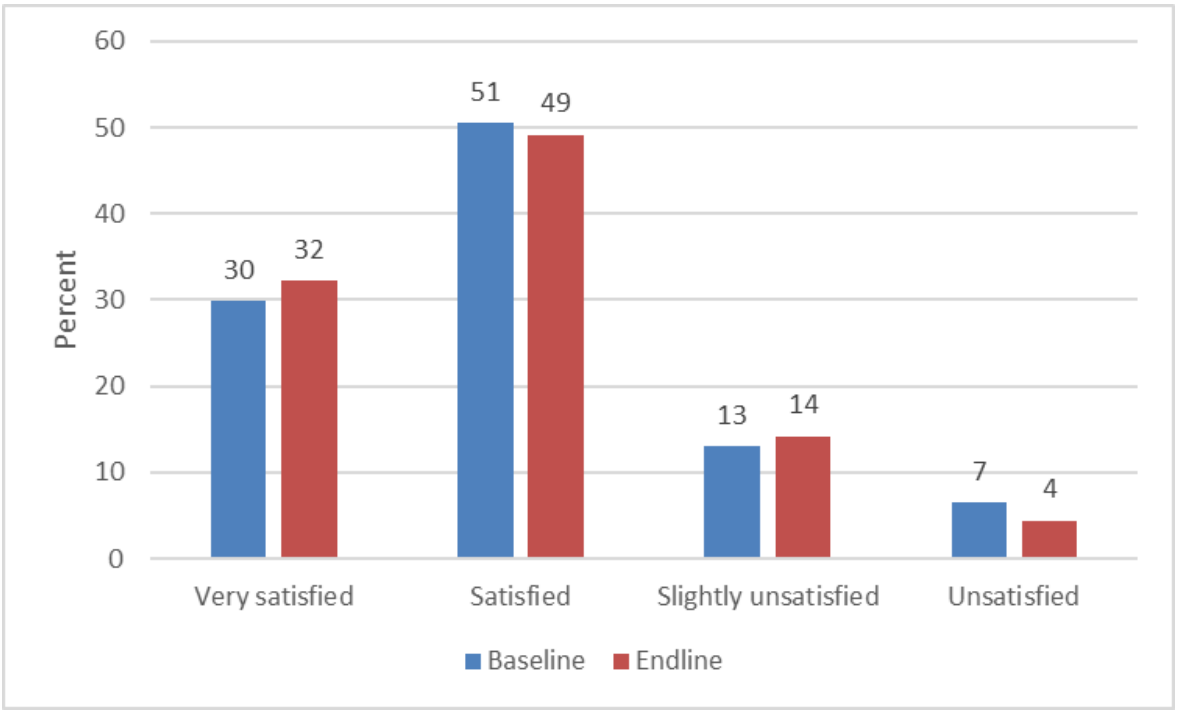


**Endline only.

3.2.4 Satisfaction with services for chronic conditions

Satisfaction among those who used a health service was overall good. 32% were very satisfied (baseline 30%), 49% satisfied (baseline 51%), 14% slightly unsatisfied (baseline 13%) and another 4% unsatisfied (baseline 7%; see Figure 16), with those in rural areas being slightly less satisfied (see Annex B). As during the baseline only 20% were aware that there is a patient complaint system.

Figure 16: Satisfaction with health service among persons with a chronic condition who consulted a health service provider (Baseline n=767; Endline n=929)

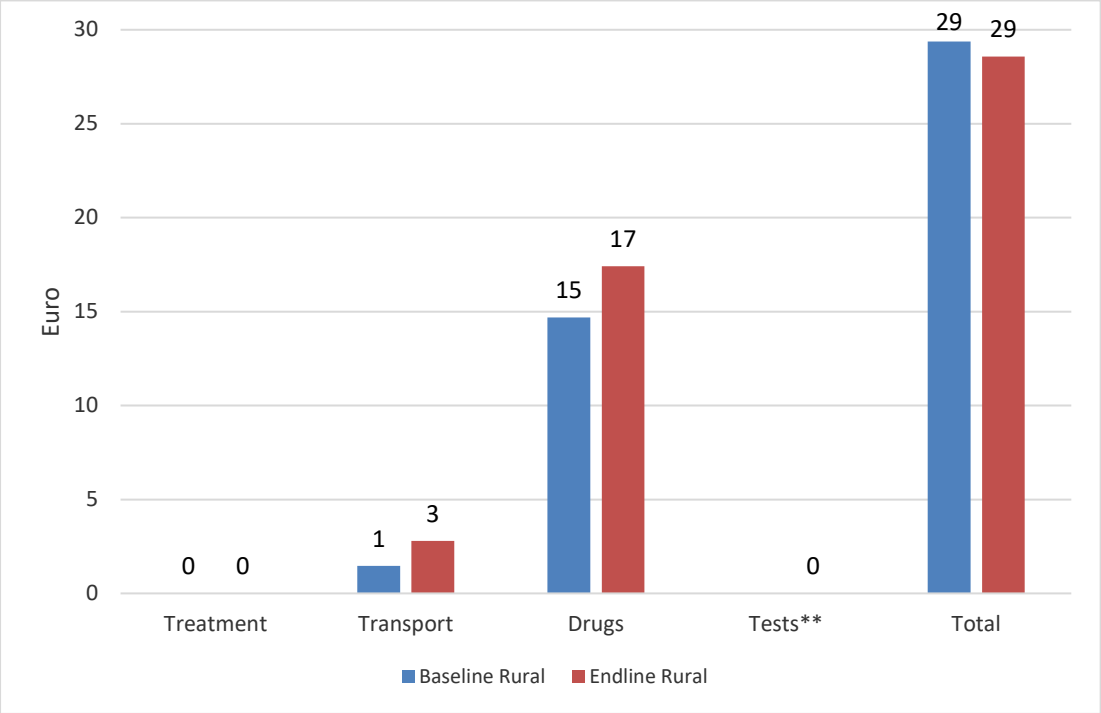


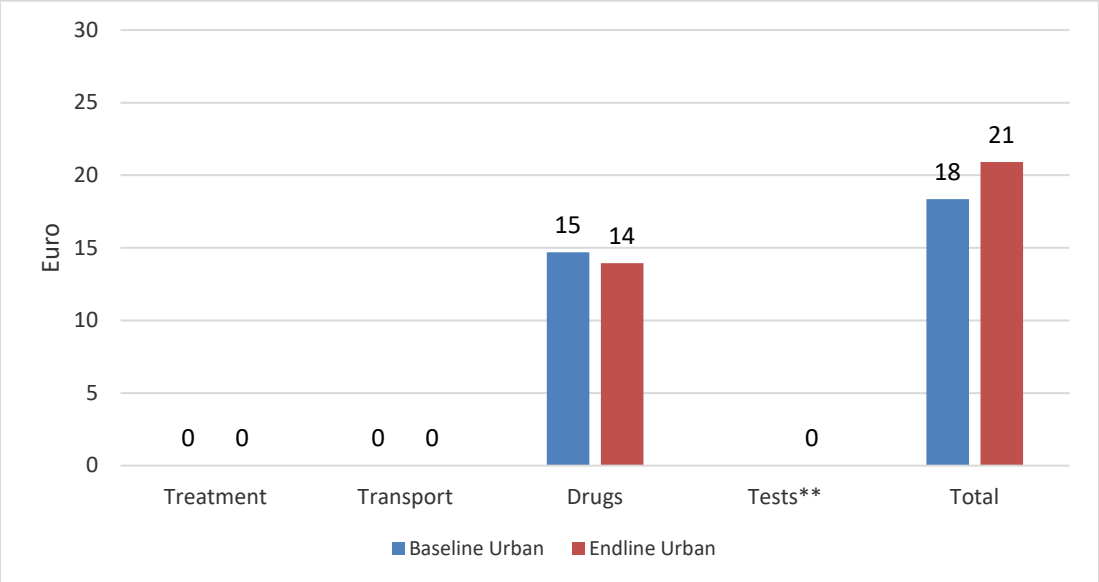
3.2.5 Health expenditures for chronic conditions

The inflation adjusted median total costs for health seeking for chronic conditions in the past four weeks was similar to the baseline, 24 Euros (Diber: 22 Euros; Fier: 28 Euros) and were substantially higher in rural settings compared to urban settings (rural: 29 Euros, urban: 21 Euros)[6].

[6] Using current exchange rates without inflation adjustment the following costs are calculated: 29 Euros (Diber: 25 Euros; Fier: 33 Euros; rural: 34 Euros, urban: 25 Euros).

Figure 17: Median costs for chronic condition in the past four weeks by location (endline estimates adjusted for inflation)





**Endline only.

The median treatment costs were zero in both regions (see Annex B) and independent from the setting (see Figure 17). Median costs for tests were also zero during the endline. Inflation adjusted median transport costs have increased from 1 to 3 Euros from base-to endline in rural areas but remain stable at 0 Euros in urban settings. The highest expenditure in the past four weeks for the chronic condition was related to purchasing drugs. 50% of all chronic disease patients pay here up to inflation adjusted 17 Euros (median Diber: 14 Euros; median Fier: 17 Euros), the other 50% have higher expenditures. Of note: during the endline we separated the costs of drugs and tests, although this did not have an actual effect on the median estimates.

The average proportion of the different cost types out of the total costs is outlined in Table 8. The costs categories account largely for the same proportions as during the baseline. By far the largest proportion of total cost can be attributed to drugs (baseline 72%) or drugs and tests respectively (endline 62% and 11%). Transport costs proportionally account on average for 16% of all costs followed by treatment costs around 12%

Table 8: Proportion of total costs in the past four weeks for chronic conditions

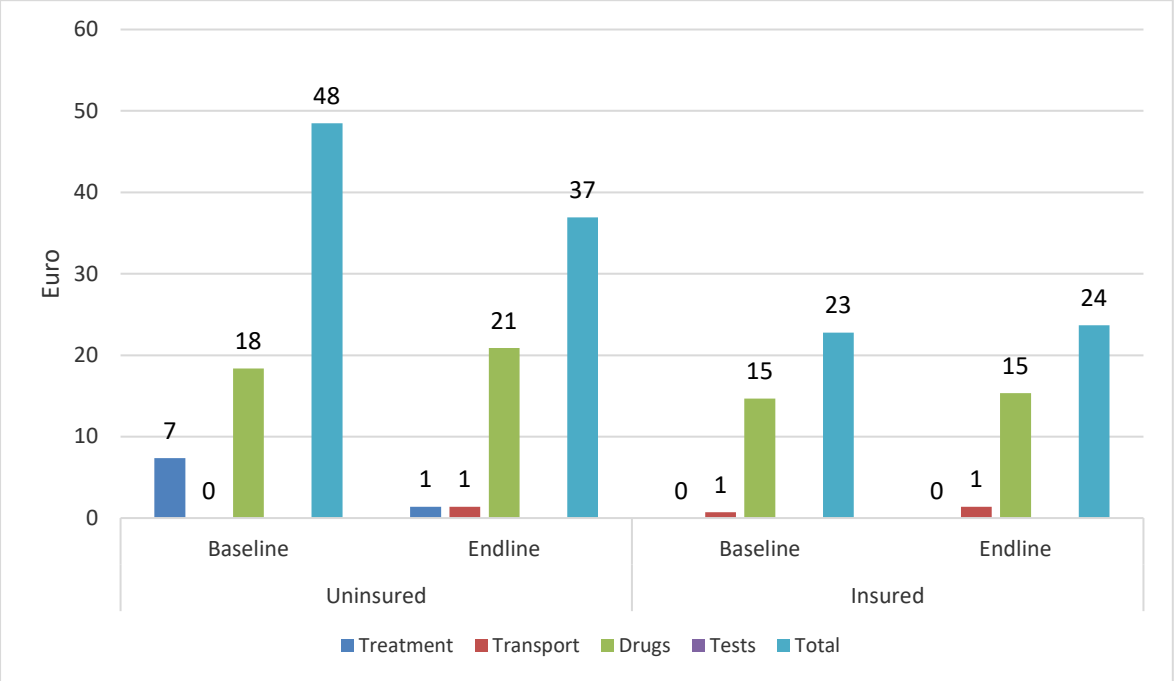
Baseline				Endline*				
Treatment	**Transport**	**Drugs**	**Total**	**Treatment**	**Transport**	**Tests**	**Drugs**	**Total**
12%	16%	72%	100%	12%	15%	11%	62%	100%

* inflation adjusted

Despite these general patterns we identified differences between those insured vs. uninsured and for some specific conditions. The inflation adjusted total median costs for uninsured were 37 Euros (baseline: 48 Euros) and thus still 13 Euros more expensive than the total median costs of the insured (endline 24 Euros, baseline 23 Euros). However, we also observe a drop of the median costs for those without insurance of 11 Euros. The drop is largely due to the drop of median admission costs from 7 Euros during the baseline to 1 Euro during the endline (see Figure 18) which is related to the ongoing reforms on free access to Primary Care Services in Albania.

Total costs for some specific conditions appear very high (see Annex B), specifically cancer (endline 54 Euros and baseline 62 Euros) and stroke (endline 65 Euros, baseline 15 Euros). Also, the correlation between costs and satisfaction remains: the higher the costs, the higher the dissatisfaction of the patient (see Annex B). Non-monetary gifts/payments to healthcare providers were not common; only 6% of the patients reported having done that in the previous four weeks.

Figure 18: Median costs among people with a chronic condition in the past four weeks by insurance status (endline estimates adjusted for inflation)



3.3 Selected patients with an acute health problem

3.3.1 Profile of interviewees

Overall 555 patients[7] provided information relating to an acute health problem, thereof 323 (58%) from Diber and 232 (42%) from Fier. Overall more of the interviewees were females (59%). The average age was with 48 years substantially higher than during the baseline (35 years). Respondents were on average in Fier (53 years) older than in Diber (44 years).

Table 9: Demographic characteristics of interviewees with an acute health problem

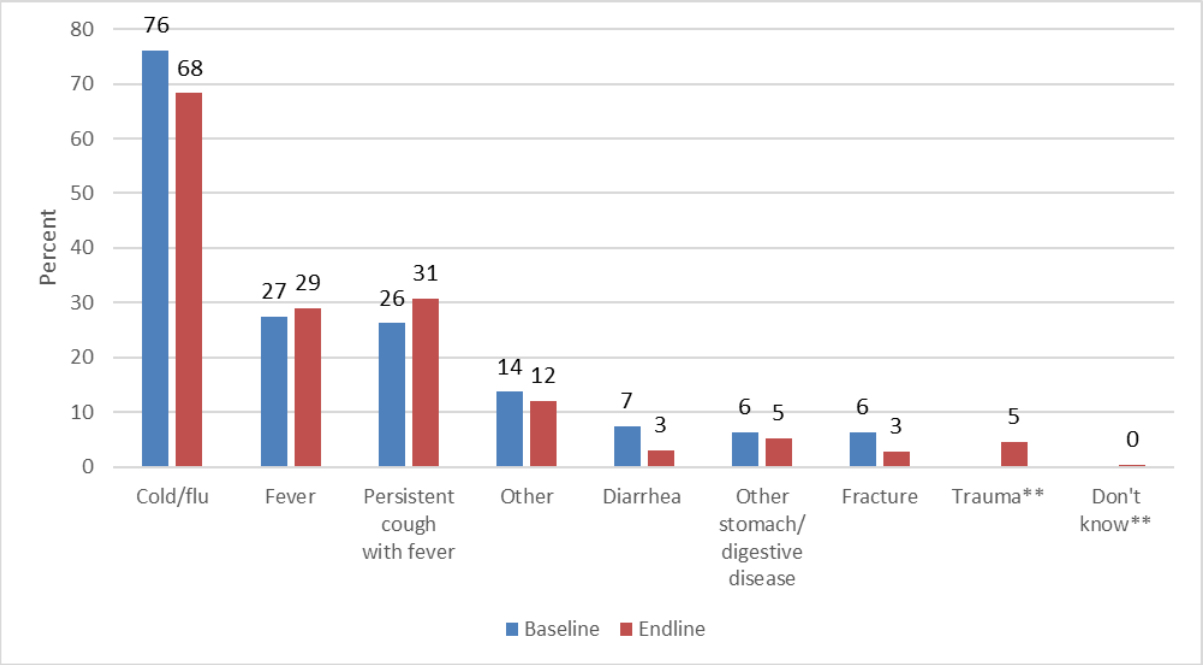
	Baseline					Endline				
	Diber	**Fier**	**Rural**	**Urban**	**Total**	**Diber**	**Fier**	**Rural**	**Urban**	**Total**
n	117	58	107	67	175	323	232	365	190	555
% female in HH	66	74	67	70	68	57	62	59	58	59
Average age (SD)	32 (20)	41 (18)	35 (20)	35 (19)	35 (20)	44 (23)	53 (21)	49 (22)	46 (23)	48 (22)
% by age cat:										
<1	3	0	1	5	2	2	0	2	2	2
2<5	12	3	9	9	9	6	4	5	5	5
5<18	11	9	11	9	10	8	4	6	7	6
18<49	55	52	53	54	54	35	24	29	33	31
49<65	15	24	17	21	18	30	36	34	29	32
65+	3	12	8	3	6	19	31	24	24	24

3.3.2 Situation of patients with an acute health problem: Illness patterns

Illness patterns remained largely the same as during the baseline: cold/flu, fever and persistent cough with fever were the most common mentioned illnesses/symptoms (see Figure 19). All other diseases were far less common (e.g. stomach/digestive issues), which could be explained by the season of data collection (endline December, baseline October/November). The pattern was the same for rural and urban settings.

[7] These numbers do not present prevalence estimates as only one person from each household with an acute illness was selected to provide detailed information (see also chapter 2.4).

Figure 19: Self-reported acute health problems (Baseline n=175; Endline n=555) – *multiple answers*

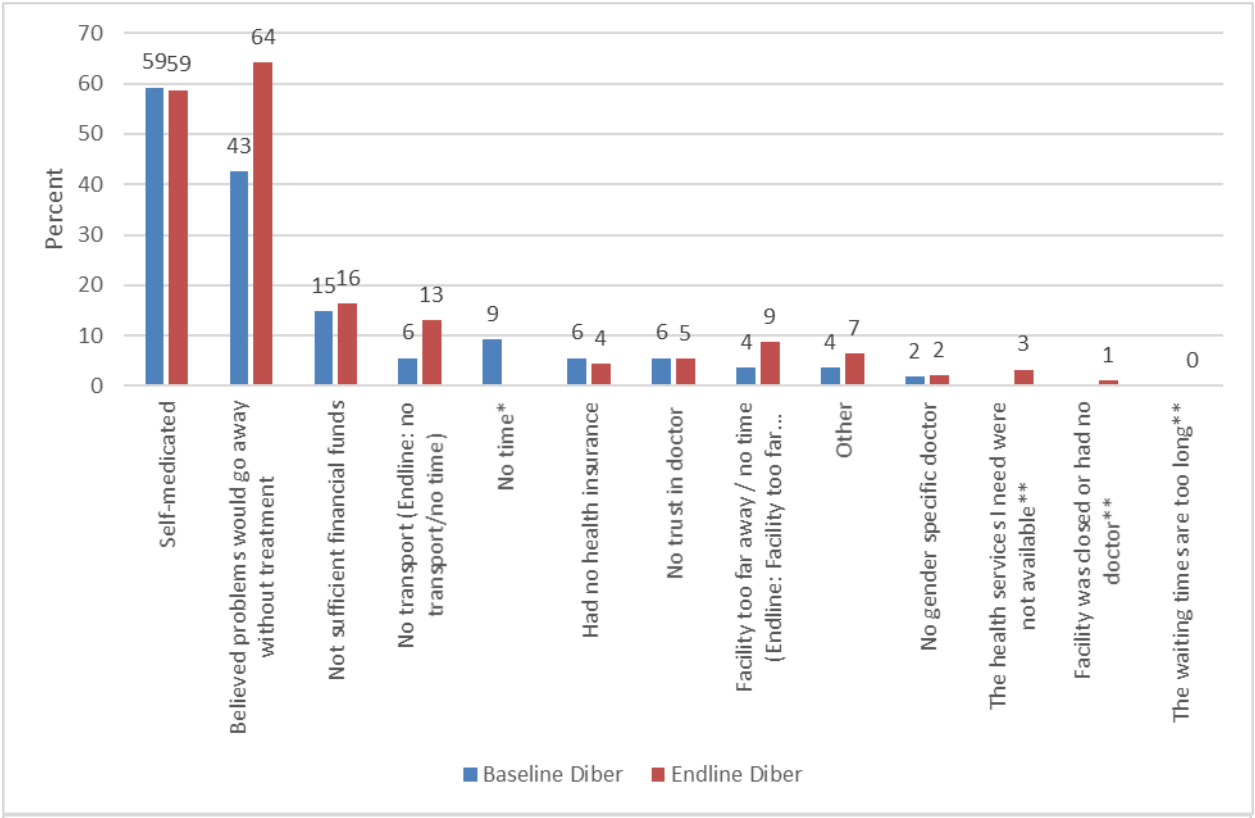


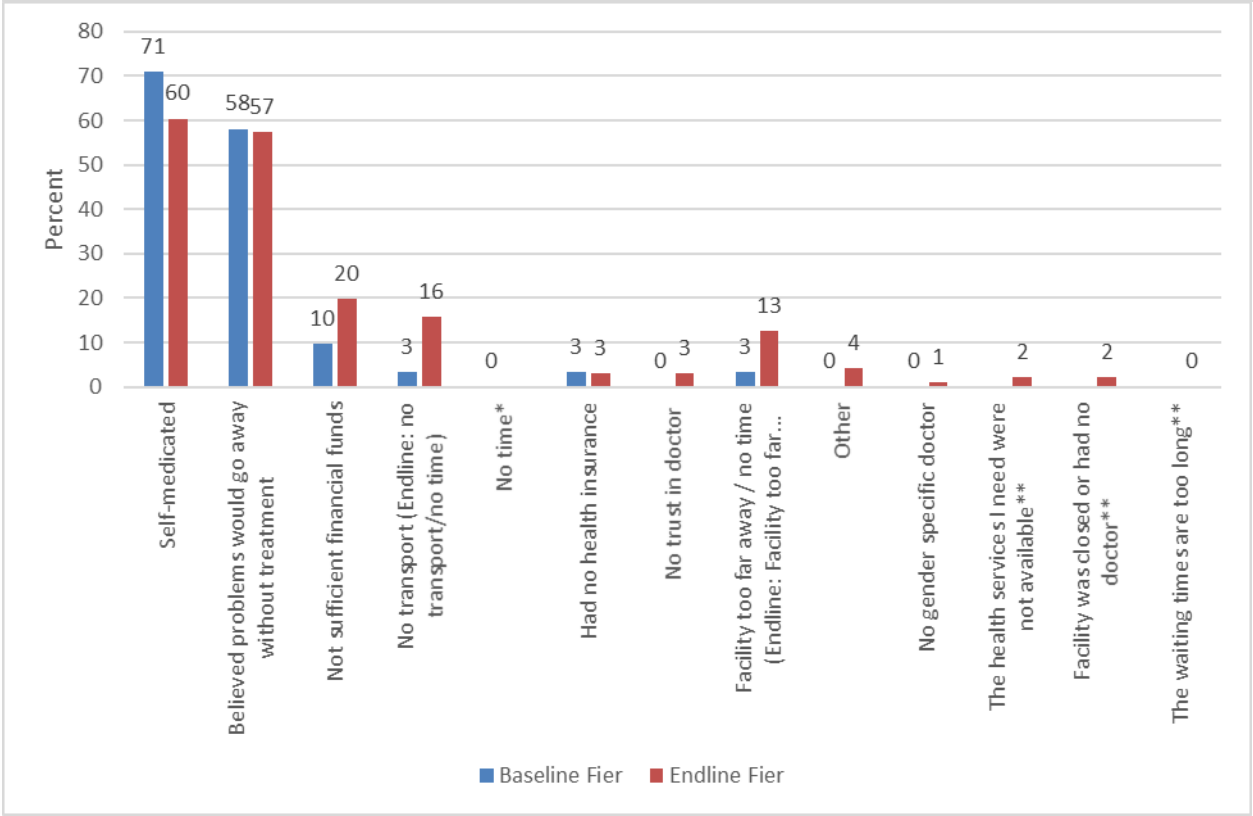
**Endline only.

3.3.3 Health seeking behaviour & barriers

About 66% sought care for acute condition (Diber: 72%, Fier: 59 %; rural: 66%, urban: 66%). Of those not seeking care (n= 188) most self-medicated (60%) and believed that the health problem would go away without medical treatment (61%). Lack of financial funds was another aspect that patients had mentioned as well as the lack of time/transport (see Figure 20).

Figure 20: Reasons for not seeking care among persons with an acute health problem by region (Baseline Diber n=54, Endline Diber n=323, Baseline Fier n=31, Endline Fier n=232). – *multiple answers*





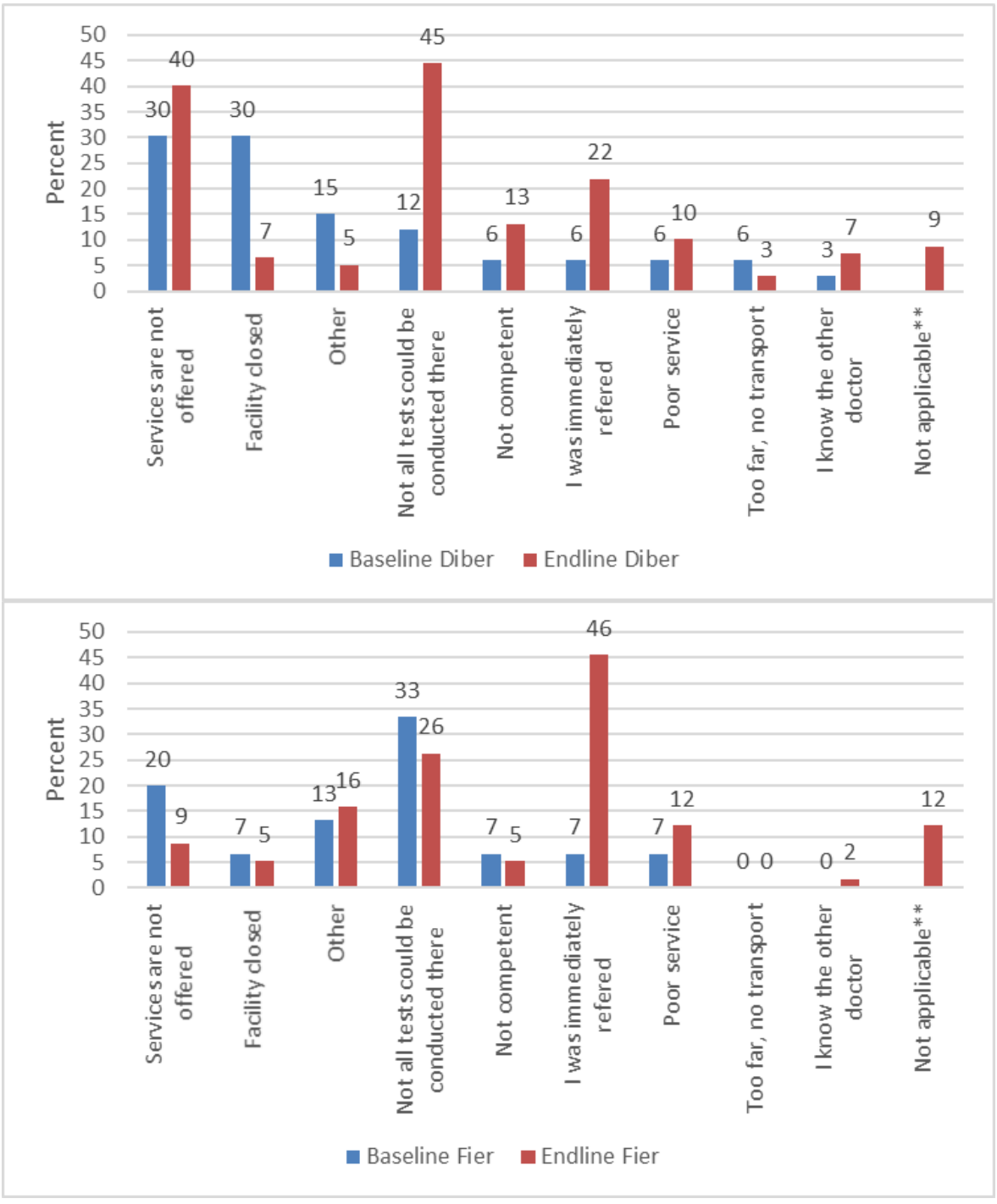
*Baseline only. **Endline only

Of those seeking care (n=367) more than 72% indicated that they sought assistance in the first three days after the illness occurred. Typically patients addressed facilities for the acute condition once in the past four weeks (71%) and another 19% indicated to have been there twice.

98% sought care in public facilities, although this was slightly more common in Diber (99%) than Fier (96%). Hence only 2% of respondents declared that they used a private health provider. In both regions and settings governmental health centres and governmental hospitals were most frequently visited. However, respondents in Diber (55%) addressed hospitals much more often than respondents in Fier (33%), which again might reflect problems of PHC in Diber and/or perceptions of consumers about PHC in that region.Patients were typically taken care of by the doctor (94%) and/or the nurse (50%).

Reasons why patients had also consulted non-PHC facilities were different to the baseline. During the baseline most common reasons given were that the services required were not offered at PHC (27%), that not all tests could be conducted at PHC (19%) or the facility was closed (23%). During the endline the most common reason was that not all tests could be conducted at the PHC facility (see Figure 21).

Figure 21: Reasons among persons with an acute health problem for not using a PHC service by region (Baseline Diber n=33, Endline Diber n=137; Baseline Fier n=15; Endline , Fier n=57). – *multiple answers*

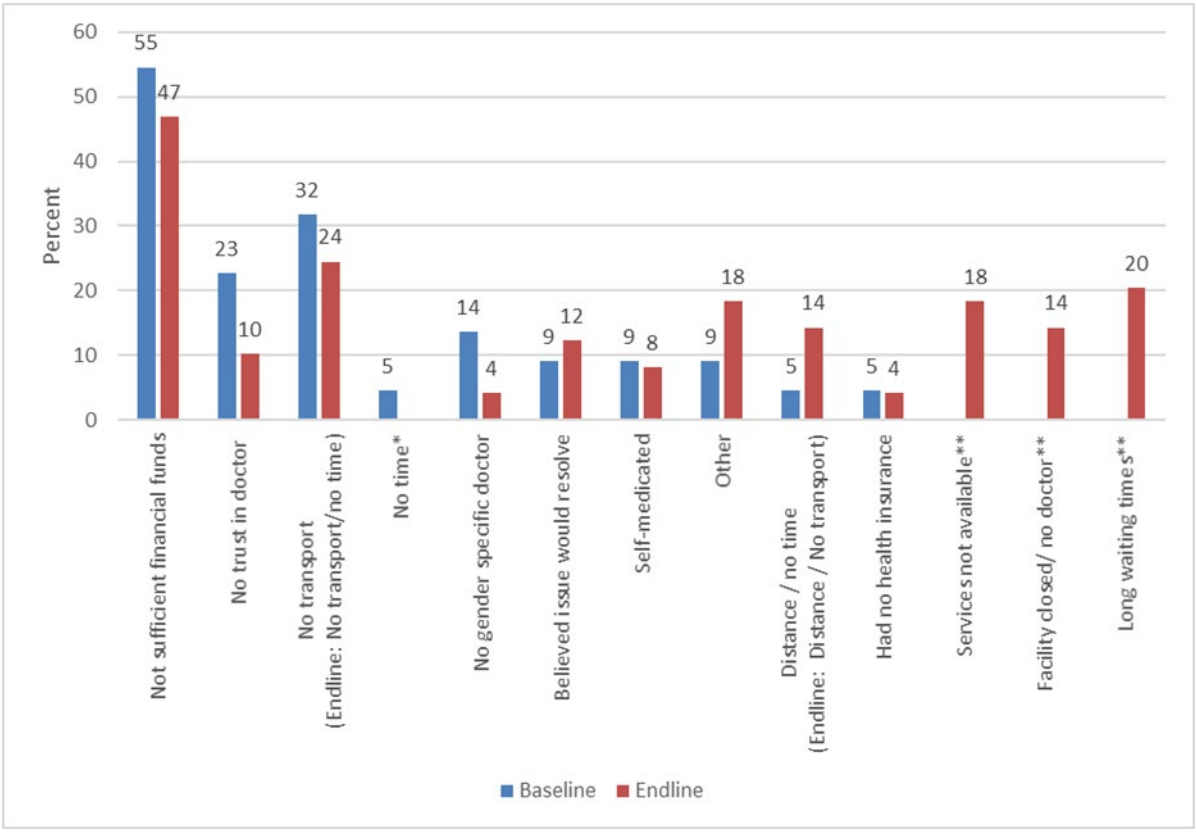


**Endline only.

Hence 13% (baseline 24%) indicated that they encountered difficulties in seeking care and 9% (baseline 17%) indicated that they experienced challenges in obtaining care.

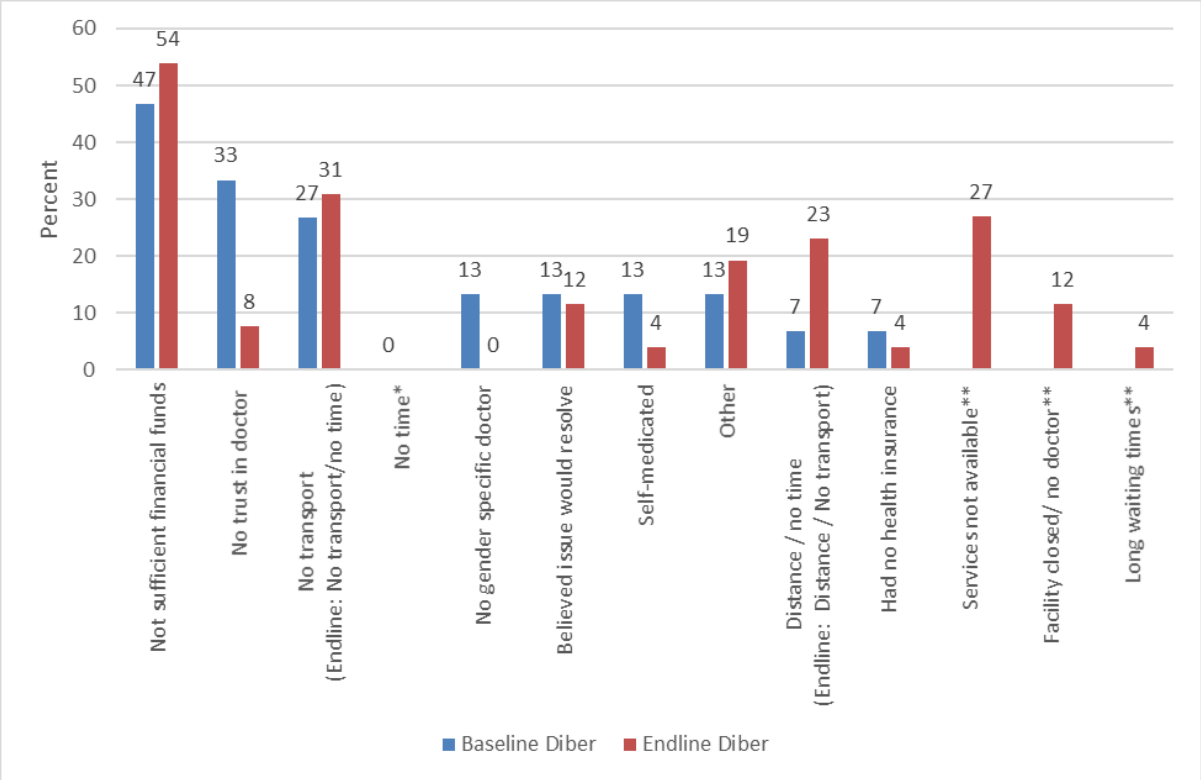
The lack of sufficient funds remains a main barrier for seeking care (endline 47%, baseline 55%) followed by the lack of transport or time (endline 24%, baseline 32%). Other important factors are the long waiting times or services not being available. The trust in doctors seems to have increased from base- to endline (see also Figure 22). Hence the overall situation of accessibility to PHC services has improved. However, the range of perceived problems is still there.

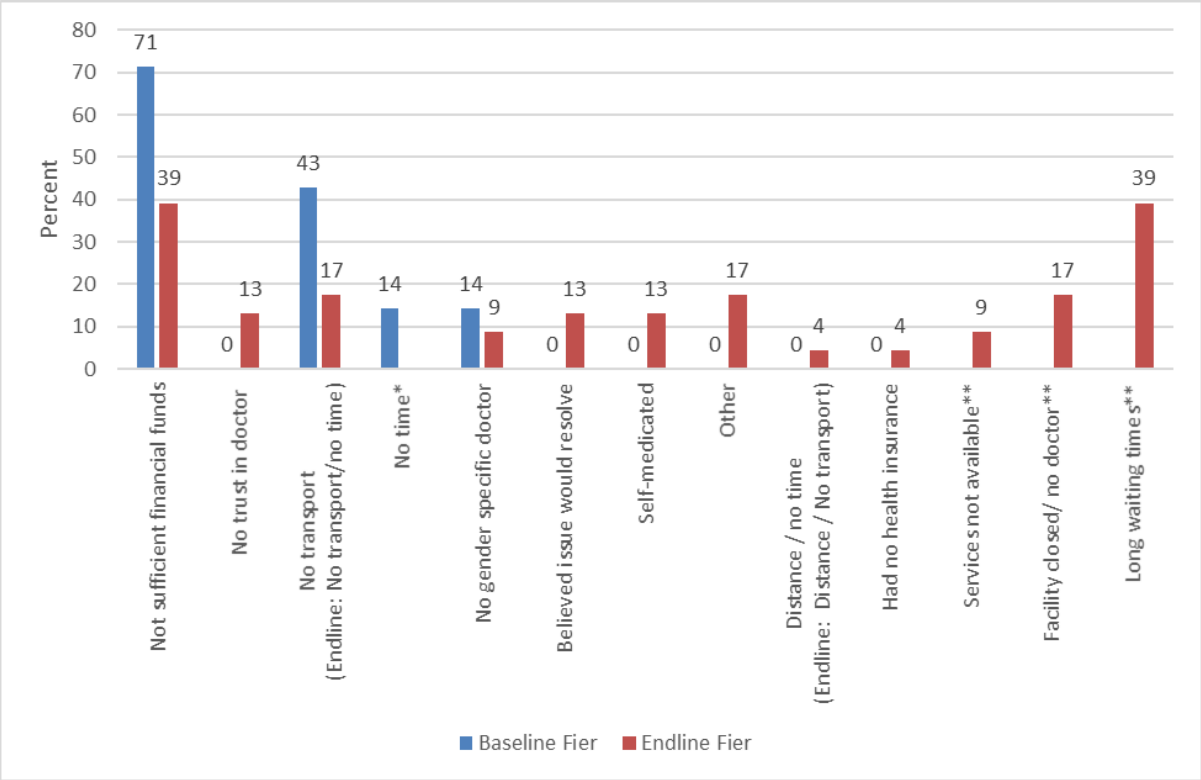
Figure 22: Main problems among persons with an acute health problem in seeking care (Baseline: n=90; Endline n=49). – *multiple answers*



*Baseline only. **Endline only.

Figure 23: Challenges among persons with an acute health problem in seeking care by region (Baseline Diber n=63, Endline Diber n=26; Baseline Fier n=27; Endline Fier n=23). – *multiple answers*



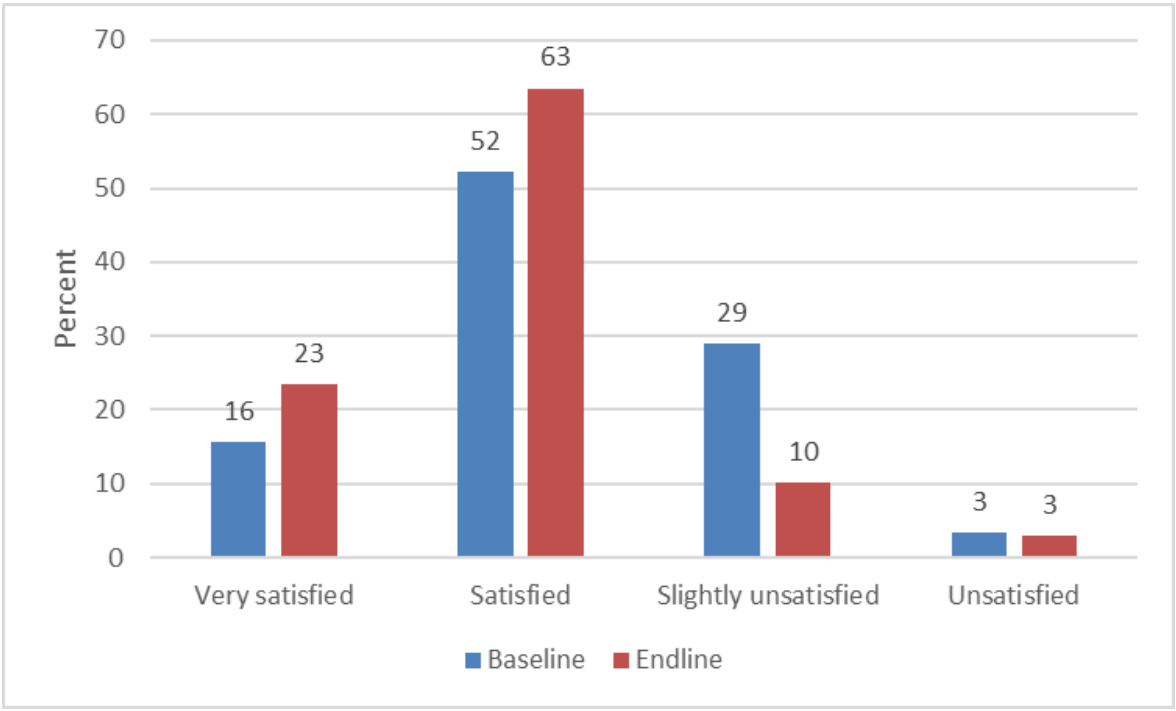


*Baseline only. **Endline only.

3.3.4 Satisfaction with services for acute health problem

Satisfaction (very satisfied and satisfied: 68%) among those suffering from an acute health problem was generally high; although a total of 29% (Diber: 25%; Fier: 37%) declared they were slightly unsatisfied and 3% unsatisfied with the services they received. The proportion of unsatisfied acute disease patients (1/3rd) is higher than those unsatisfied for chronic disease services (see section 3.2.4). In urban settings, respondents showed less extremes, i.e. less 'very satisfied', but also less 'slightly unsatisfied' (see also Annex B).

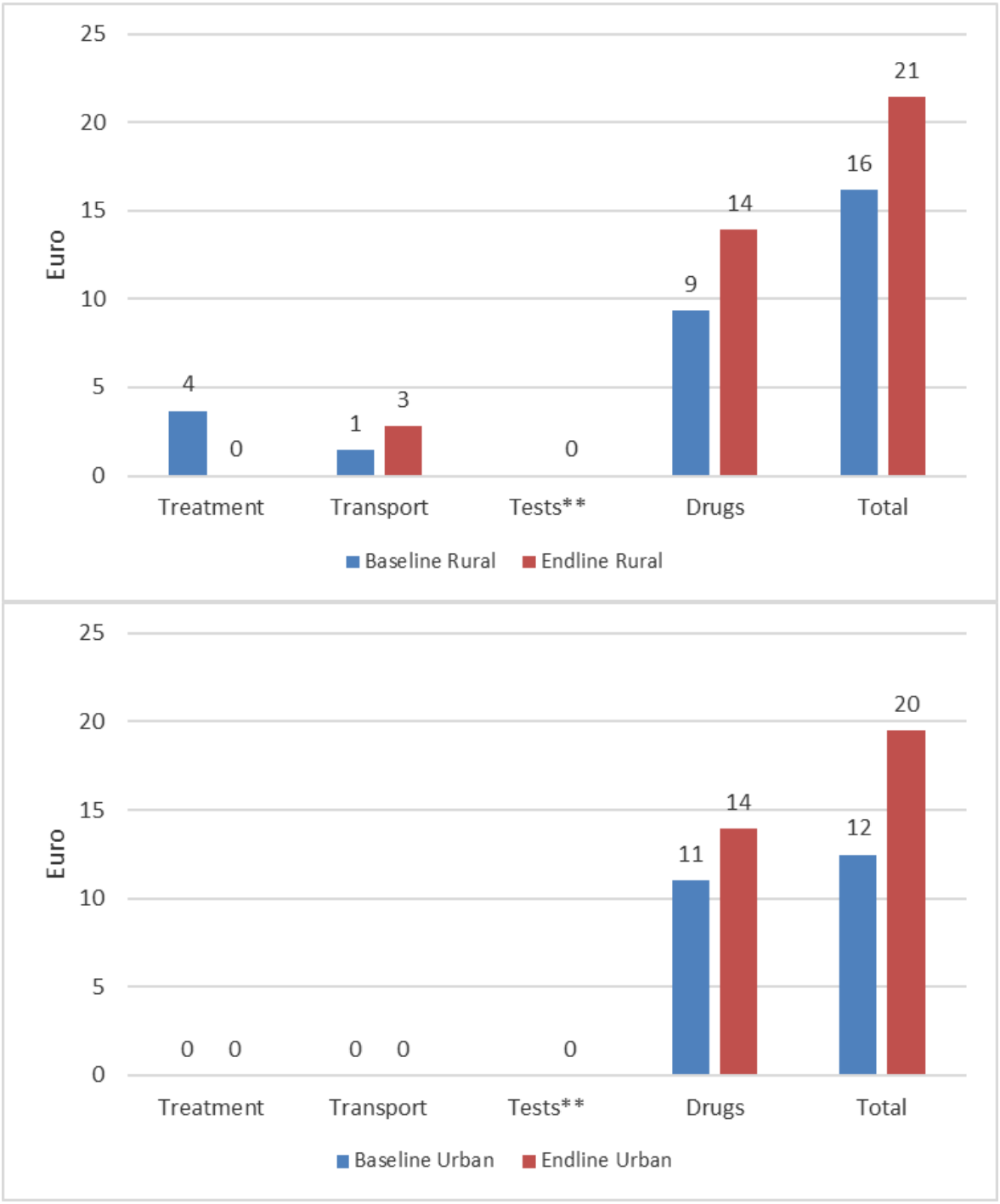
Figure 24: Satisfaction among persons with an acute health problem with health service received (Baseline n=90; Endline n=367)



3.3.5 Health expenditures for acute health problem

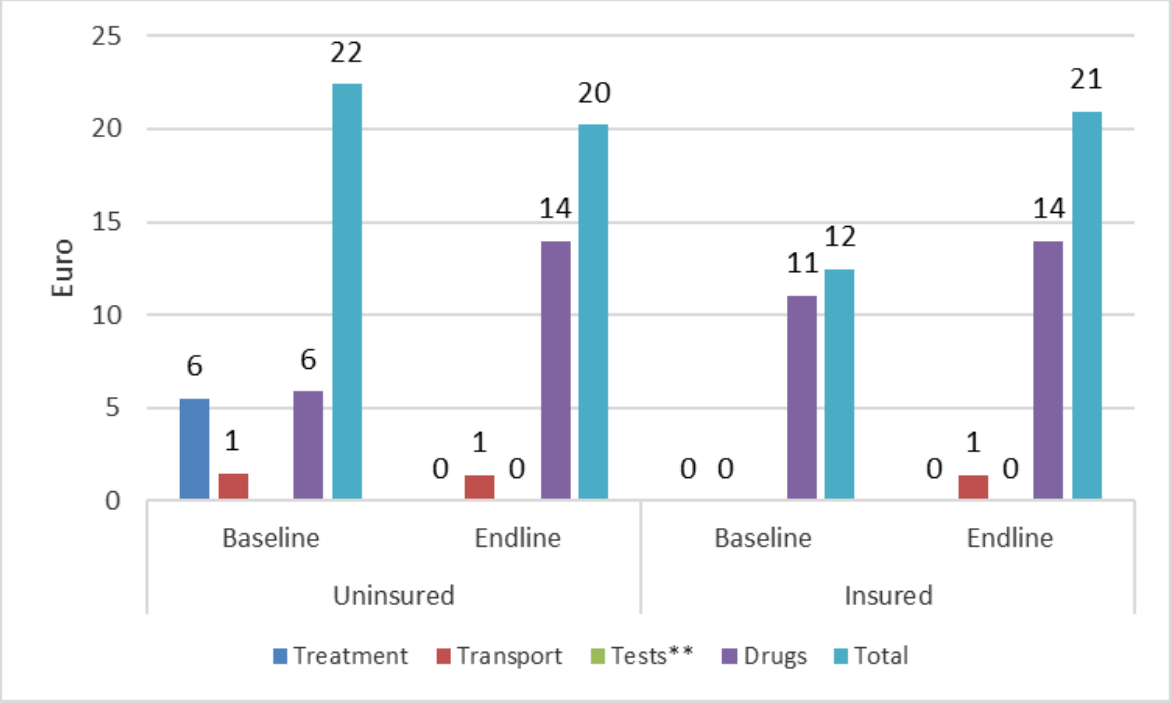
Total inflation adjusted median costs in both regions were 20-21 Euros whereby costs for drugs were the most important cost driver (14 Euros). Total median costs in rural settings were slightly higher (21 Euros) compared to urban settings (20 Euros) which is related to transport costs. In contrary to the baseline we no longer identify differences between patients insured or not insured. Total median costs were 21 Euros and 20 Euros respectively (see Figure 26). Depending on the type of acute illness median costs vary: those with fracture pay the highest median total costs (31 Euros) whilst those with diarrhoea pay the least median total cost (14 Euros). Across all diseases the main cost driver are drugs whilst median treatment costs are 0 Euros – with the exception of diarrhoea (2 Euros) and other stomach/digestive diseases (7 Euros) – (see Annex B).

Figure 25: Median costs among persons with an acute health problem in the past four weeks by area of residency (endline estimates adjusted for inflation)



**Endline only

Figure 26: Median costs among persons with an acute health problem in the past four weeks by insurance status (endline estimates adjusted for inflation)



**Endline only

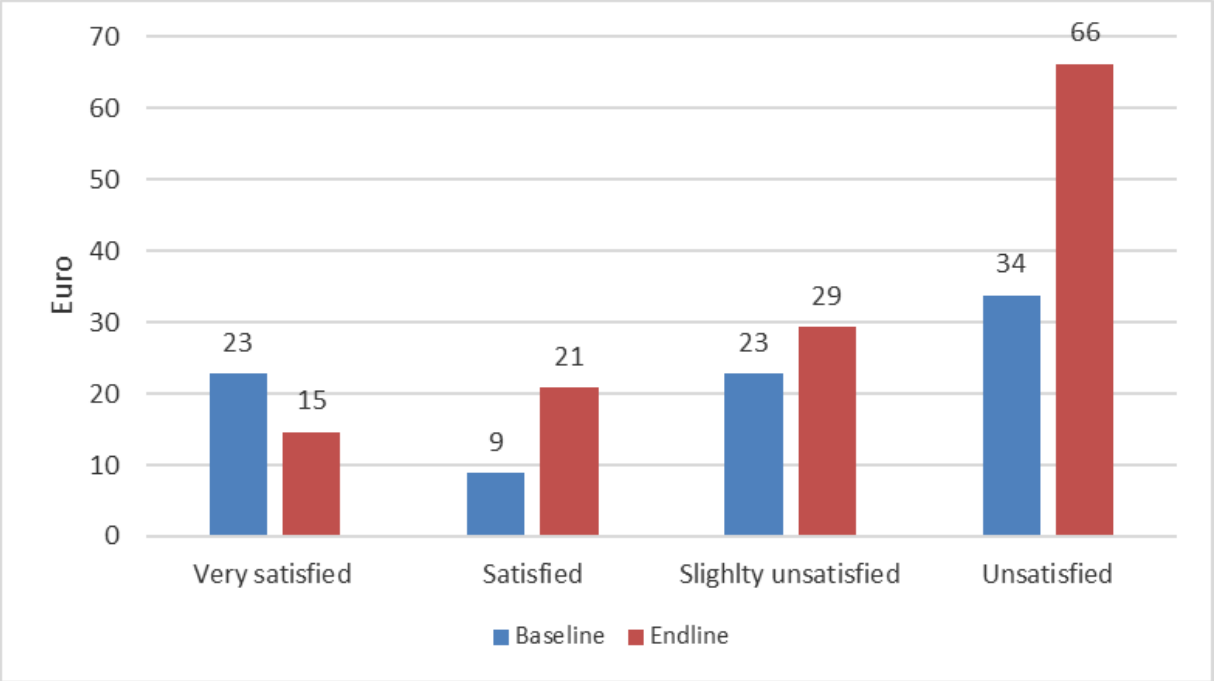
Overall the total costs for acute conditions split on average into 12% costs for admission, 13% for transport, 6% for tests and another 69% for drugs.

Table 10: Proportion of total costs in the past four weeks for acute conditions

Baseline				Endline				
Treat-ment	**Trans-port**	**Drugs**	**Total**	**Treat-ment**	**Trans-port**	**Tests**	**Drugs**	**Total**
19%	11%	70%	100%	12%	13%	6%	69%	100%

As for chronic conditions, we identified a strong link between the satisfaction and the cost incurred: specifically, those unsatisfied had to bear the highest total inflation adjusted median costs (66 Euros). Patients very satisfied accrued total median costs of 15 Euros. 11% provided non-monetary gifts to the health provider although this seemed to be more common in Fier (Diber: 15%, Fier: 5%).

Figure 27: Satisfaction with health service among persons with an acute condition who consulted a health service provider (Baseline n=90; Endline n=367)



3.4 Mother and child health

3.4.1 Profile of interviewees

Overall 318 (baseline n=161; endline n=157) mothers of children under 5 years were interviewed, thereof most from Diber (baseline 68%, n=109; endline 64%, n=102) and from rural areas (baseline 73%, n=118; endline 76%, n=120). The average age of mothers was 28 years (median: 27 years) during the baseline and 30 years during the endline (median: 29 years).

Table 11: Demographic characteristics of mothers interviewed

	Baseline					Endline				
	Diber	**Fier**	**Rural**	**Urban**	**Total**	**Diber**	**Fier**	**Rural**	**Urban**	**Total**
n	109	52	118	53	161	102	55	120	37	157
Average age (SD)	28 (6)	28 (6)	28 (6)	29 (5)	28 (6)	30 (6)	29 (5)	29 (6)	32 (4)	30 (6)

3.4.2 Postnatal care

The majority of women had left the hospital after two to three days (endline 72%, baseline 55%). More than 90% of women had left the hospital within a week. Two people stayed 20 days or more.

69% (baseline 62%) of women had someone checking of their health conditions after being discharged from hospital, typically within the first week after discharge (endline 82%, baseline

78%). In most cases, this was carried out either by the nurse or midwife (endline 66% baseline 56%) or a doctor (endline 27%, baseline 38%). In 60% of cases this contact took place at home, specifically with the nurse or midwife (88%). If not at home, women's health was commonly checked at the public health facility - hospital (61%) or the health centre (18%). Hence postnatal care patterns remain overall similar to the baseline survey.

More women reported during the endline that a health provider checked the baby's health after discharge from the hospital (endline 80%, baseline 74%). Checks on the child health were highest in urban areas (95%) and similar between Diber and Fier. The check was done in the first 7 days (endline 77%, baseline 55%). After 14 days the coverage among those who had received a check was 87% (baseline 79%). Most commonly this was done by the nurse or midwife (56%), a paediatrician (25%) or a general doctor (17%). Differences between Diber and Fier prevail in this regard, with checks being more commonly conducted in Diber by nurses and midwifes (Diber 66%, Fier 43%).

Most health checks took place at public facilities, commonly governmental health centres (39%), governmental hospitals (29%) or at health posts (22%) or other public facilities. In this regard the pattern has changed as during the baseline most respondents reported this check being conducted at governmental hospitals.

Table 12: Mother & child health: Provision of postnatal care

	Baseline					Endline				
	Diber	**Fier**	**Rural**	**Urban**	**Total**	**Diber**	**Fier**	**Rural**	**Urban**	**Total**
Maternal health										
Time at hospital (days)	n=105	n=52	n=116	n=41	n=157	n=102	n=55	n=120	n=37	n=157
Average	6	5	6	4	5	4	4	4	4	4
Median	3	4	3	3	3	3	3	3	3	3
Check on maternal health conducted (in %)	n=105	n=52	n=116	n=41	n=157	n=102	n=55	n=120	n=37	n=157
	62	63	63	61	62	74	60	66	78	69
If maternal health check conducted: Time of check after discharge (days)	n=65	n=33	n=73	n=25	n=98	n=75	n=33	n=79	n=29	n=106
Average	7	7	7	7	7	6	4	6	4	6
Median	6.5	5	7	5	7	5	2	3	5	4
If maternal health check conducted: Health provider overseeing check (in %)	n=65	n=33	n=73	n=25	n=98	n=75	n=33	n=79	n=29	n=108
Doctor	34	46	37	40	38	27	27	28	24	27
Paediatrician	3	3	3	4	3	9	3	5	14	7
Nurse / Midwife	60	49	58	52	56	64	70	67	62	66
Traditional doctor	0	3	1	0	1	n/a	n/a	n/a	n/a	n/a
Other	2	0	1	0	1	n/a	n/a	n/a	n/a	n/a
Don't know	2	0	0	4	1	n/a	n/a	n/a	n/a	n/a
Child's health										
Check on child health (in %)	n=105	n=52	n=116	n=41	n=157	n=102	n=55	n=120	n=37	n=157
	71	79	73	76	74	80	80	76	95	80
Time after discharge (days)	n=73	n=39	n=83	n=29	n=112	n=82	n=44	n=91	n=35	n=126
Average	15	12	14	14	14	8	8	8	8	8
Median	7	7	7	7	7	6	3	5	6	5
Health provider overseeing child check-up (in %)	n=75	n=41	n=85	n=31	n=116	n=82	n=44	n=91	n=35	n=126
Doctor	15	32	20	23	21	15	20	16	17	17
Paediatrician	36	22	29	36	31	20	36	22	34	25
Nurse / Midwife	49	46	51	42	48	66	43	62	49	56

3.4.3 Child monitoring, development & growth check-up

99% of parents seek care at public sector providers for their children, typically governmental hospitals (45%) or governmental health centres (43%). The majority of mothers declared that the child's last check-up had taken place either in the last month before the interview (37%) or to 2-6 months ago (34%).

Asking about specifics of the growth and development check-up the most common was "checking the vaccination card" (92%); though we also see increases for questions on development progress or the nutritional habits in comparison to the baseline; see Table 13. Of the checks conducted most common was the weight measurement (85%) and to a smaller extent head measurement (71%) and height measurement (75%), whereby specifically the later two have again improved since the baseline. More mothers reported that they were

provided with information on disease prevention (endline 63; baseline 43%) in the frame of the last check-up.

From the data it appears that growth and development check-ups are conducted most rigorously in urban settings. Differences between Diber and Fier are not apparent for the endline data.

Table 13: Growth and development check: questions asked and procedures provided in percent

	Baseline					Endline				
	Diber (n=105)	**Fier (n=52)**	**Rural (n=116)**	**Urban (n=41)**	**Total (n=157)**	**Diber (n=102)**	**Fier (n=55)**	**Rural (n=120)**	**Urban (n=37)**	**Total (n=157)**
Mother asked about…										
… development progress	62	65	63	63	63	84	75	78	92	81
…child diet and eating habits	62	67	62	68	64	72	75	68	86	73
… vaccination card and revised it	91	87	90	88	89	91	93	90	97	92
Health provider conducted…										
…head measurement	42	69	48	59	51	73	69	64	95	71
… height measurement	50	73	53	71	57	76	71	69	92	75
… weight measurement	77	89	79	88	81	87	82	83	92	85
Provided…										
..information on how to prevent diseases	41	48	40	54	43	67	56	58	78	63
Average of activities performed during visit	4	5	4	5	5	6	5	5	6	5

3.5 Knowledge, Attitude and Practice

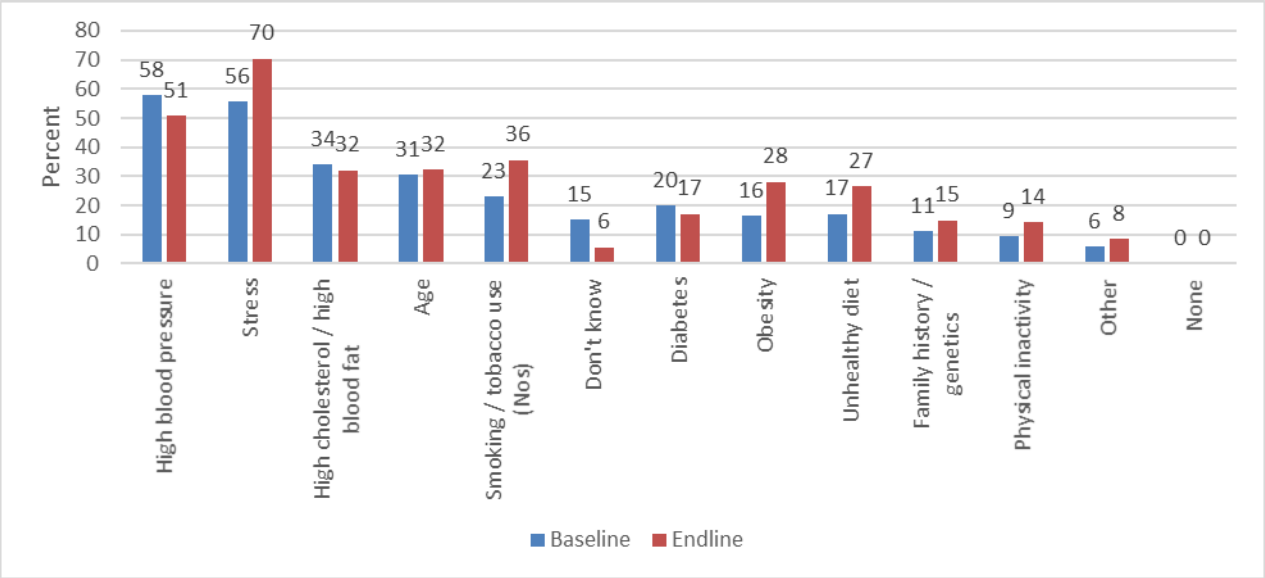
3.5.1 Cardiovascular disease, diabetes, obesity & health beliefs

Respondents, who were in-depth questioned about their chronic or acute condition, were questioned on their knowledge, attitude and practice related to cardiovascular disease. Overall 1125 (baseline 1,264) individuals participated in this part of the survey.

We observe generally positive tendencies related to the knowledge on cardiovascular disease. Participants correctly identified between 0 to 10 risk factors. Most of the interviewees cited two (endline 27%, baseline 22%), three (endline 21%, baseline 19%), one (endline 13%, baseline 15%) or four (endline 12%, baseline 12%) risk factors. 23% (baseline 18%) were able to cite

more than four risk factors. 10 individuals mentioned ten risk factors. 5% (baseline 14%) of interviewees did not know any risk factor for cardiovascular disease. Figure 28 shows the cited risk factors for cardiovascular disease. Stress and high blood pressure were mentioned by more than 50% of respondents. High cholesterol, age and smoking were known by approximately 1/3rd of respondents, followed by obesity and unhealthy diet. Family history and physical inactivity were least commonly mentioned.

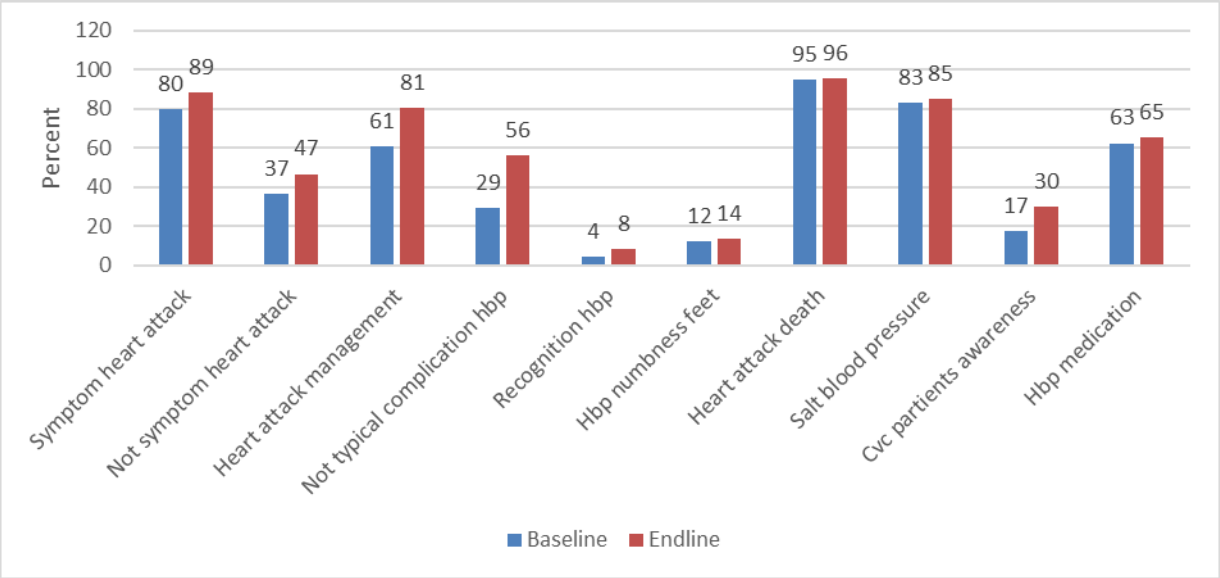
Figure 28: Identified risk factors by selected participants with a chronic or acute condition for cardiovascular disease (Baseline n= 1'264; Endline n=1'125)



A total of 26 questions pertained to the knowledge on diabetes (12), cardiovascular diseases (10) and obesity (4). Answers to the relevant knowledge questions can be inferred from Annex D.1.

Figure 29 illustrates the knowledge on cardiovascular diseases. The patterns remain at large similar to the baseline results. The question 'Heart attack is a frequent cause of death' was once more correctly answered by a large majority (96%), followed by 'Eating less salt can have a good effect on blood pressure" (85%), 'typical symptoms of a heart attack' (89%). More difficult questions 'High blood pressure can cause a feeling of numbness in the feet' and 'Patients easily recognise high blood pressure because of the symptoms' were correctly answered only by a minority of the study participants (14% and 8%, respectively).

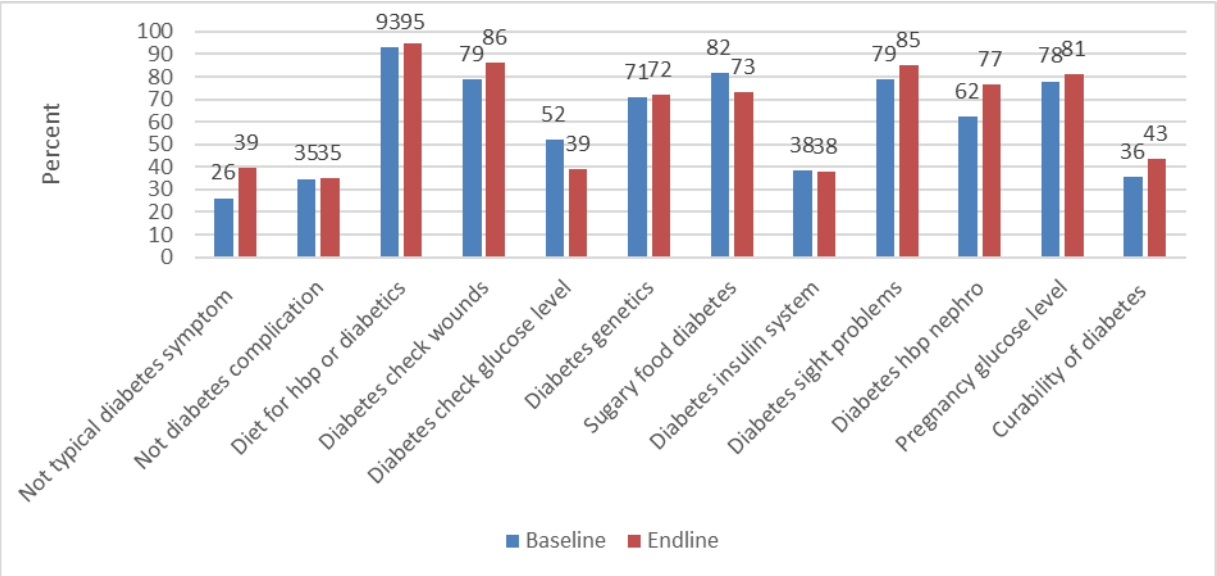
Figure 29: Overall percentage of correct answers for knowledge questions on cardiovascular disease by selected participants with a chronic or acute condition (Baseline n= 1'264; Endline n=1'125)



A high knowledge was observed for the questions on 'Healthiest food for a person with diabetes or high blood pressure' (95%), followed by 'Patients with diabetes should regularly check their feet wounds which do not heal' (86%), diabetes is a common cause of problems with seeing' (85%) and 'Women have to check their blood sugar levels during pregnancy' (81%).

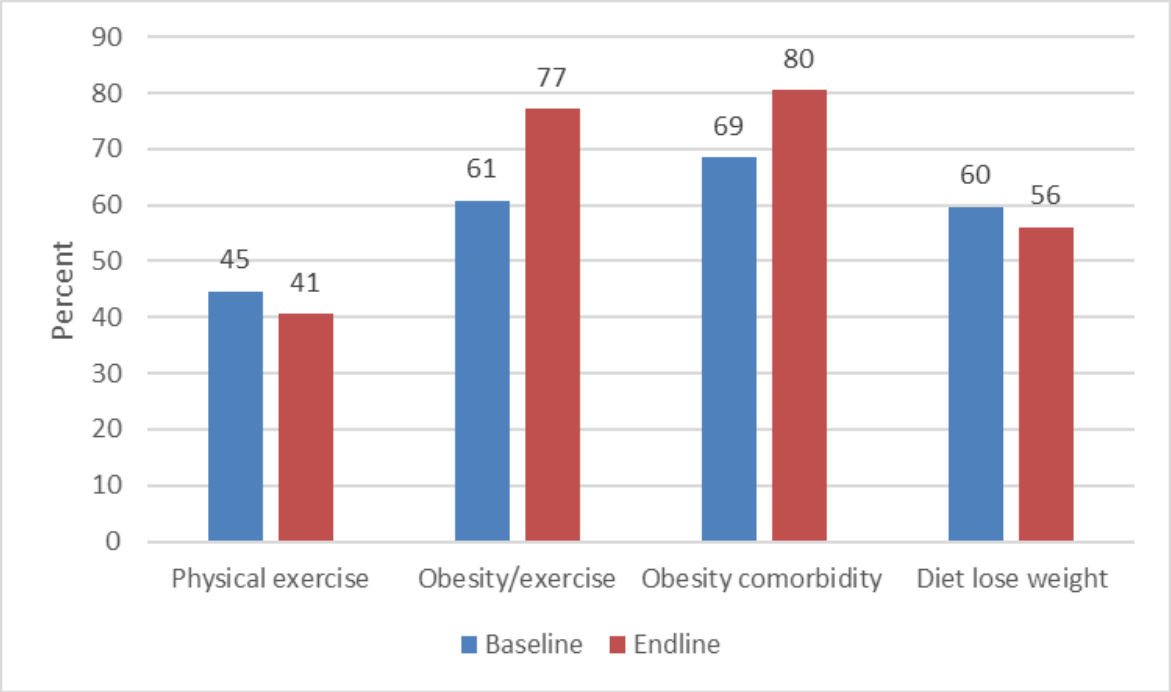
A low percentage of correct answers was found for 'not a typical diabetes symptoms (39%)', 'not typical a complication of diabetes' (35%), 'Diabetes can be cured' (43%) and 'In diabetes patients, the insulin system works normally' (38%). A drop of correct answers was observed for whether patients still need to check their glucose levels (baseline 52%, endline 39%) and whether consumption of sugary foods can be a cause for diabetes (baseline 82%, endline 73%).

Figure 30: Overall percentage of correct answers for knowledge questions on diabetes by selected participants with a chronic or acute condition (Baseline n= 1'264; Endline n=1'125)



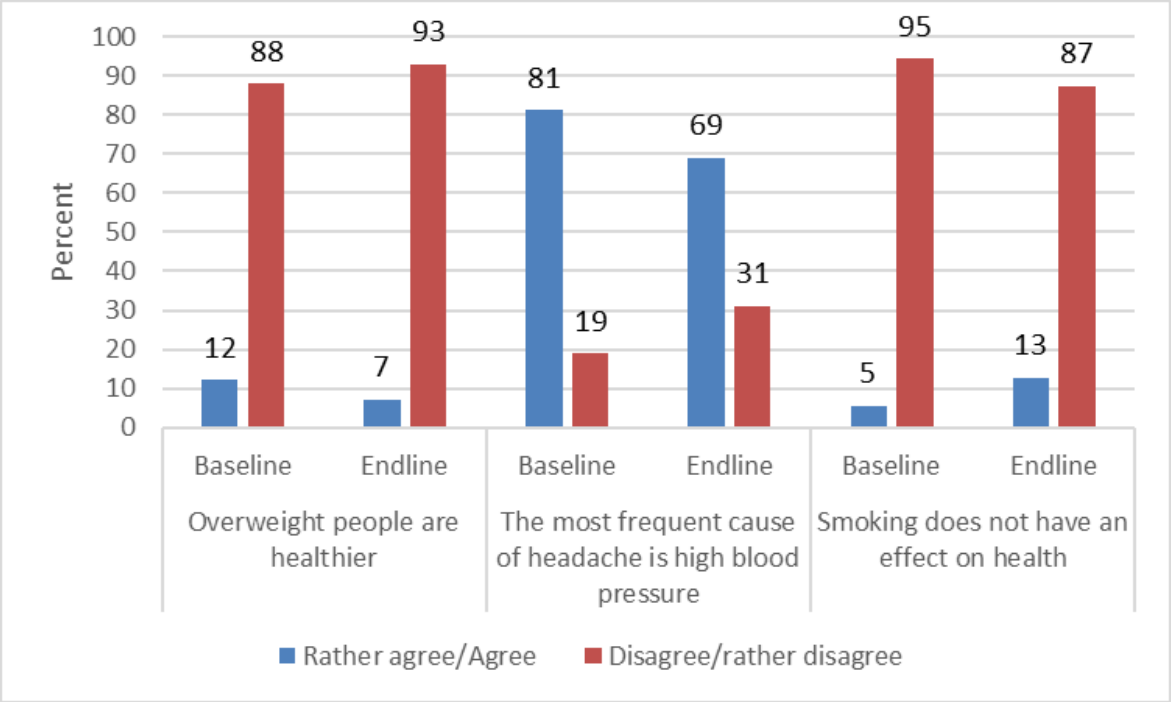
The knowledge on obesity showed a consistent relative positive picture between 55-70% of respondents knowing the correct answers. It is noteworthy that only 41% (baseline 45%) of interviewees correctly answered the question on 'how often should you do physical exercise'.

Figure 31: Overall percentage of correct answers for knowledge questions on obesity by selected participants with a chronic or acute condition (Baseline n= 1'264; Endline n=1'125)



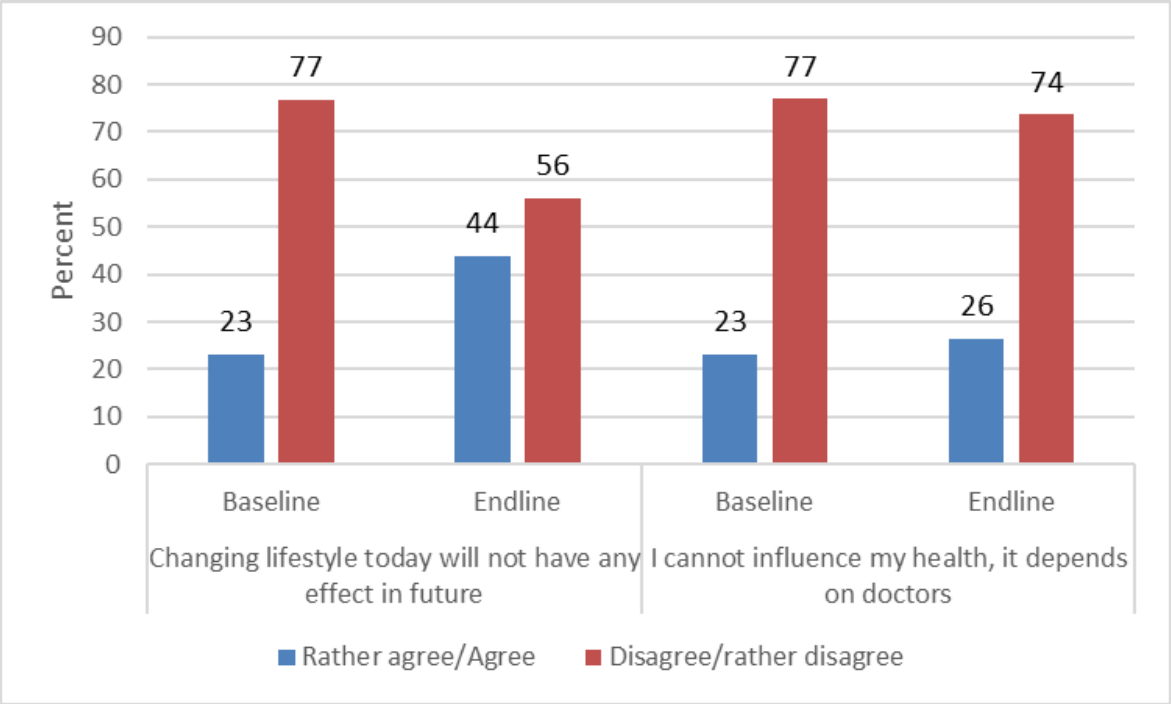
Health beliefs of the interviewees on general statements and of the own health are illustrated in Figure 32 and Figure 33.

Figure 32: Opinions of selected participants with a chronic or acute condition on the general health (Baseline n=1'264, Endline n=1'125)



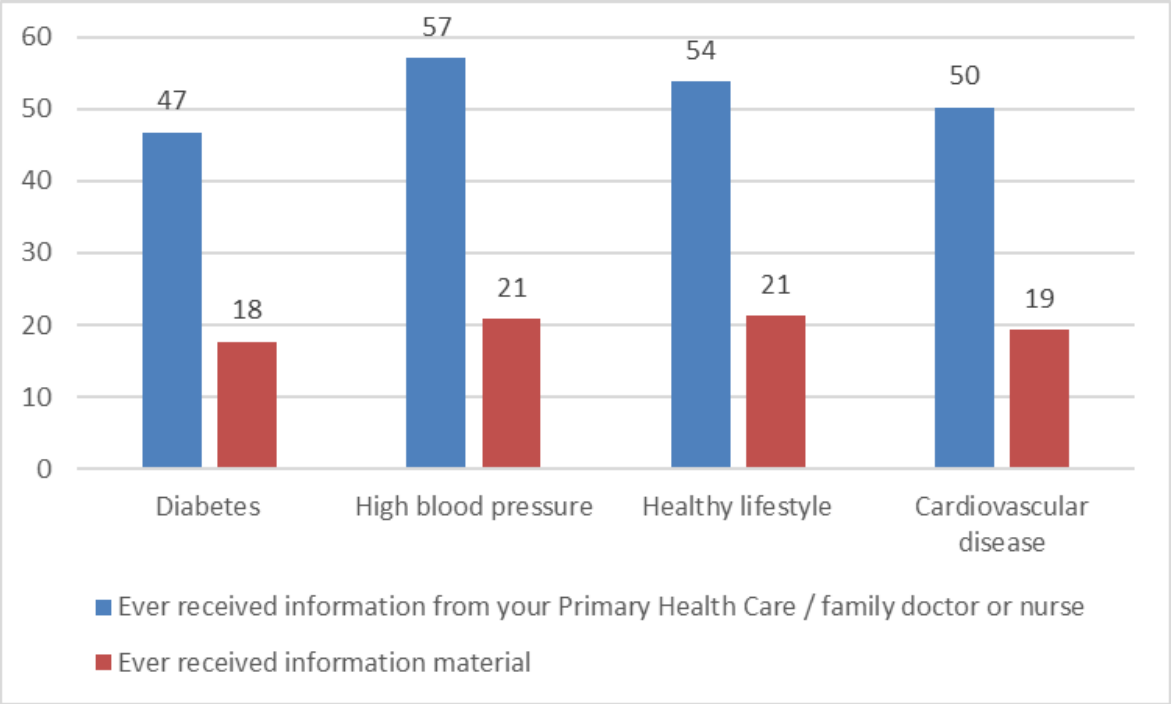
Beliefs on influencing, and, to a certain degree, controlling the own health showed that the majority of interviewees considered their own health as a status that can heavily be influenced by todays behaviour. However, the percentage decreased from the base- to endline (baseline 77%, endline 56%). As during the baseline about 20% of interviewees see their health as a given status which can be influenced only to a limited extent.

Figure 33: Opinions among selected participants with a chronic or acute condition on the own health (Baseline n=1'264, Endline n=1'125)



During the endline we further questioned respondents whether they have seen any TV spots on (a) diabetes and (b) on family medicine. 27% of respondents were aware of such TV spot on diabetes (Diber: 20%, Fier: 34%) and 9% on a spot about family medicine (Diber 4%, Fier 16%). About 50% of respondents further indicated receiving information on various diseases and conditions from their family doctor/nurse whilst only about 20% received actual printed or other information material.

Figure 34: Respondents receiving information from family doctor/nurse and ever (n=1'125)

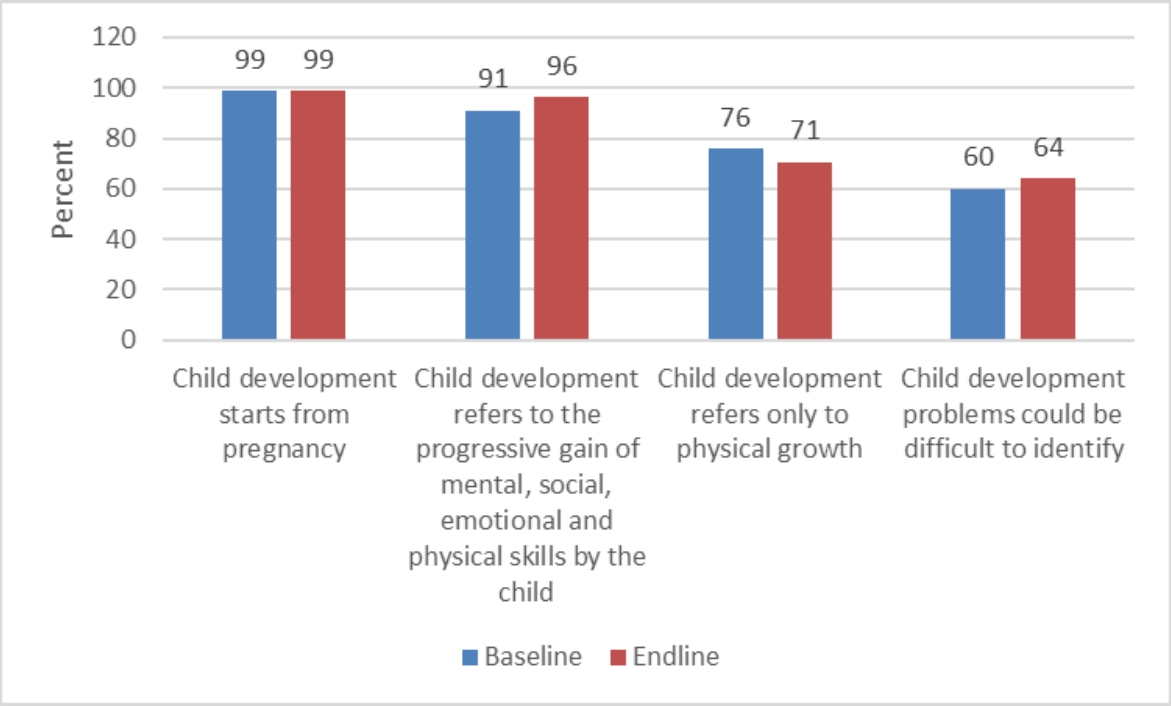


3.5.2 Child health

The following graphs (Figure 35 to Figure 38) show the knowledge of mothers about child development and risk factors for children's growth and development. The anticipated answers are listed in Annex D.2

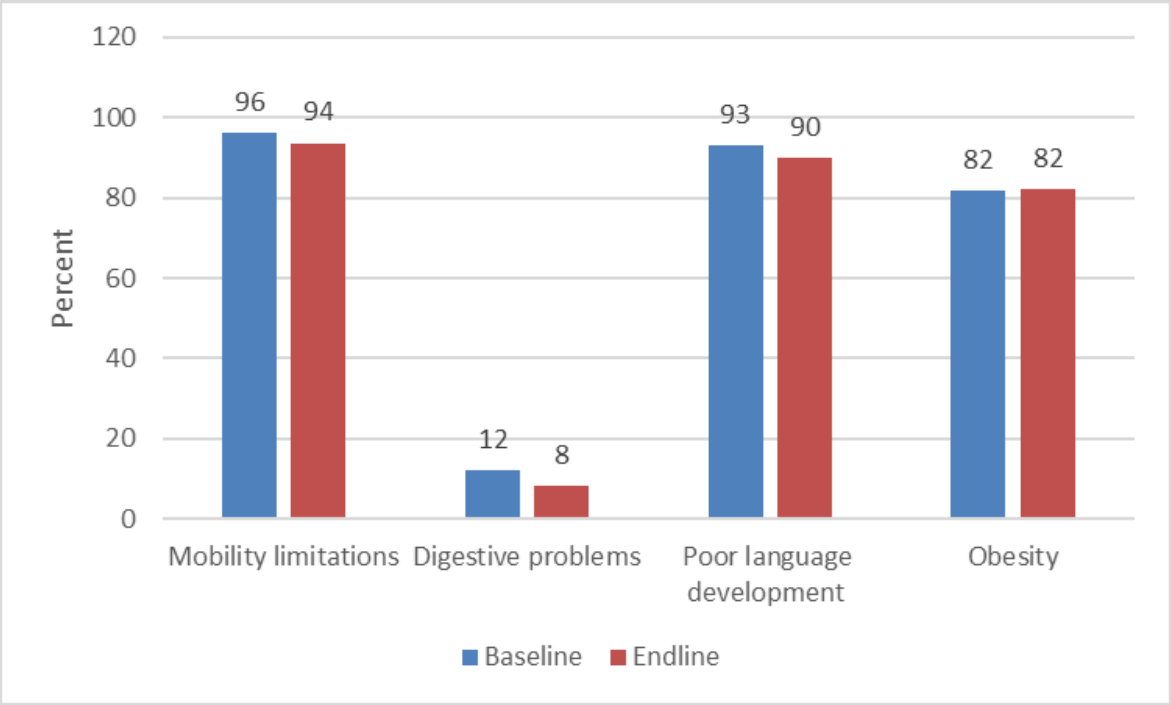
There is a very high awareness amongst mothers that child development starts already from pregnancy and that it encompasses mental, social, emotional, and physical skills. Contradictory though, 71% (baseline 76%) of women also claim that it only refers to physical growth. 64% of women are aware that development problems could be challenging to identify (see Figure 35).

Figure 35: Percentage of correct answers among mothers regarding children's development (Baseline n=157; Endline n=157)



The manifestations of growth and development problems are well known (between 82% and 96% of correct answers), though only 8% (baseline 12%) identified digestive problems as not directly related to growth and development (see Figure 36).

Figure 36: Percentage of correct answers among mothers of manifestations of growth and development problems in children (Baseline n=157; Endline n=157)



The overall knowledge on risk factors for child growth and development are well known (see Figure 37). 10 of the 11 listed risk factors received correct answers from more than 90% of

questioned women. Only the risks of a birth before the 37th week of pregnancy was not as often identified. However we experienced relatively low knowledge rates for items that are not a risk for child development, e.g. 'occasional colds during childhood' are only seen by 17% (baseline 23%) not as risk factor (see Figure 38), although this might be attributable to some methodological issues (see also chapter 4).

Figure 37: Percentage of correct answers among mothers of risk factors for children's growth and development (Baseline n=157; Endline n=157)

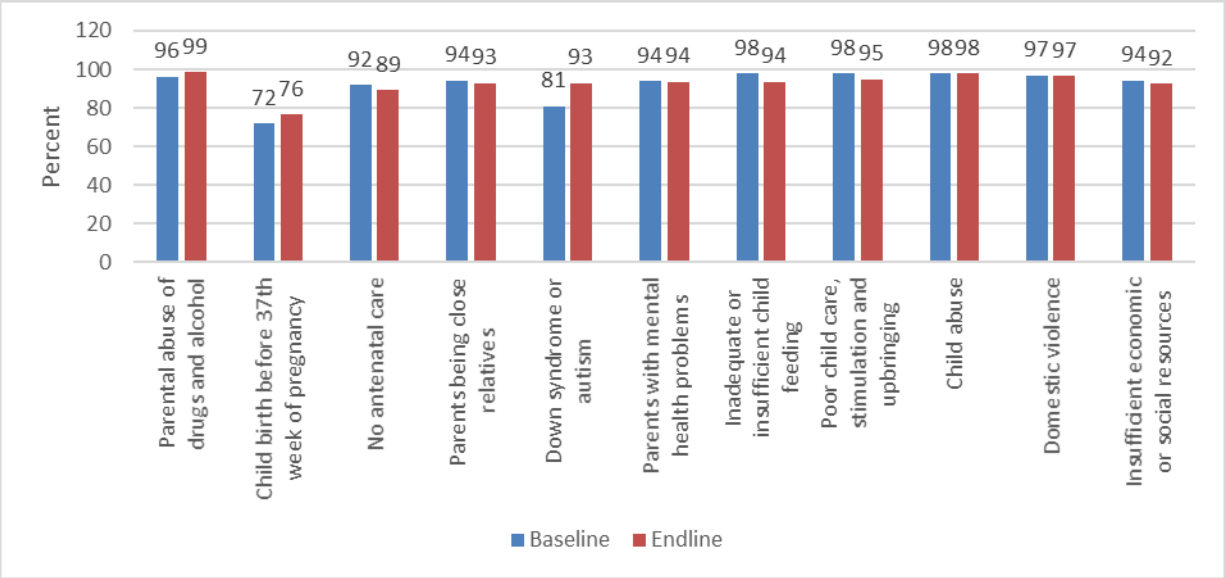
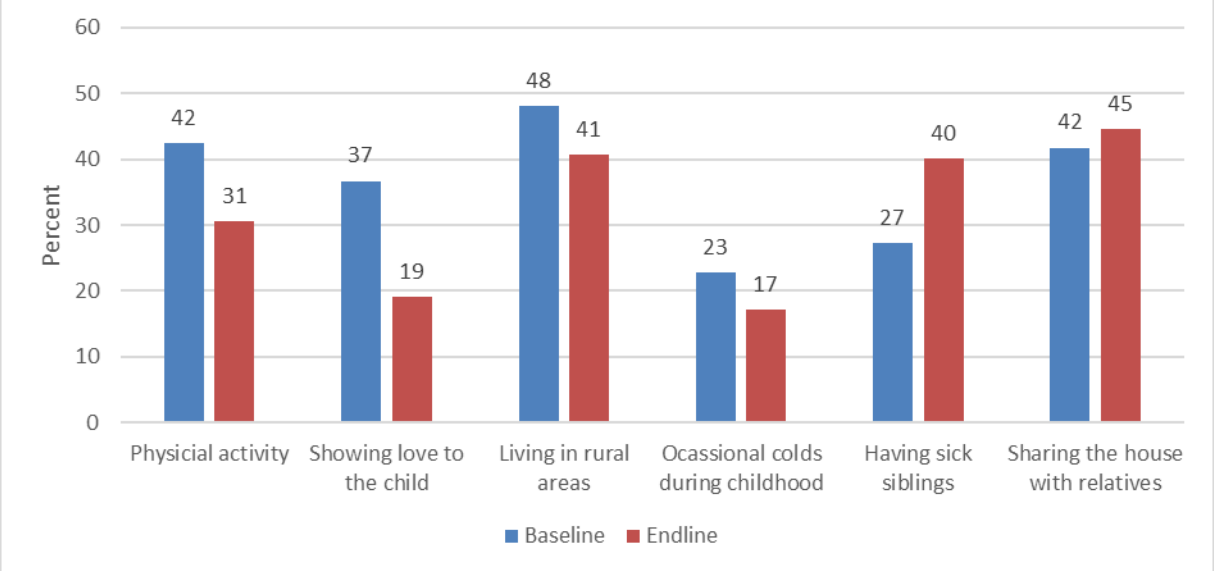


Figure 38: Percentage of correct answers among mothers identifying aspects that are not risk for children's growth and development (Baseline n=157; Endline n=157)



Just like during the baseline the identification of growth and development problems in children up to 1 year, between 1 and 4 years and consequences of child development problems achieved overall very high knowledge scores with a few exceptions, related to negative items (e.g. child <1 not defecating regularly, genetic disorders as a complication of development problems). 50% (baseline 77%) of mothers knew that a child should sit by him/herself at the

age of 3 to 9 months and 83% (baseline 93%) could indicate that a child should walk between 9 and 18 months. However, only 38% (baseline 29%) of mothers could identify that a child should be reacting to noises between the 3rd and 9th month.

4 Study limitations and bias

The data collection was closely supervised by field supervisors but a few limitations and potential sources of error should be taken into consideration also when comparing base- and endline data:

4.1 Factors limiting time comparisons

- During the baseline contact and response rates were very high and the very limited number of households that were not successfully contacted or who had no chronic or acute ill patient was low. This data was much more realistic during the endline survey indicating that during the baseline survey interviewers had not recorded all contacts as their targets were the successfully conducted interviews. Due to the sampling procedures no prevalence estimates for chronic or acute conditions in the whole population can be estimated.
- Further it should be considered that various aspects, e.g. behaviour change or epidemiologic patterns, are typically occurring over a long time perspective. Hence the time that elapsed since the baseline might not yet be sufficient to observe changes.
- Since the baseline various interventions and policy changes were initiated. Major changes are the introduction and implementation of the check-up initiative and the changes in the insurance scheme/free access to Primary Health Care. Both aspects are likely important for interpreting results of the survey though the extent to which these changes truly influenced cannot be estimated here and thus is speculative. However, direct comparisons between base- and endline must take these changes into account.

4.2 Factors influencing data quality

- The data collection was carried out in October/November 2015 and December 2018 which is possibly a time where an increased number of acute infections are being observed.
- For the baseline data the various sections of the questionnaire were merged according to the birthdate of the respective person, e.g. the recorded birthdate of the person who answered the questions on the chronic conditions was compared to the birthdate of the household roster. The birthdate was though prone to error and thus some manual corrections needed to be conducted (e.g. month and day interchanged) to be able to merge the different questionnaire sections. This was an automated process during the endline survey
- During the endline we were able to generate an automated random selection within the household of chronic or acute patients. However, during the baseline interviewers were instructed to (a) prioritise chronic disease patients over acute patients and (b) in case more than one patient was available within the household to apply the last birthday method. The differences in the random selection procedure might have introduced some interviewer bias.
- The Health Insurance Fund that advises doctors to prescribe reimbursable drugs for chronic conditions typically every two months, whilst patients are recommended to check their health status on a monthly basis. There are also various other rules for

self-contributions to drugs (e.g. if deviating from reimbursable drugs). Hence the estimation of costs for chronic conditions may be impeded by the various regulation of the Health Insurance Fund which should be taken into account for interpretation.

Inverted knowledge and attitude questions for mothers of children under 5 years but also chronic and acute patients were often answered incorrectly, i.e. relatively small proportion identified the items as being wrong. This pattern could indicate that they – by tendency – agreed to the items independent from the content or that inverted/negative items were difficult to understand.

5 Comparison of Results

This report of the household surveys for project HAP cover two comprehensive data collections. During the baseline information on 1'275 households and 5'188 individuals living in those households was collected. During the endline we collected information on 1'289 households and 4'749 persons living in those households. For each individual household member we collected basic information on the person's background and the health and insurance status. Further detailed information was obtained from 2'231 persons (endline 1'135, baseline 1'096 persons) who indicated to suffer from a chronic disease, and 730 persons (endline 555, baseline 175 persons) who had in the four weeks prior to the survey been affected by an acute health problem. Here we asked about access to health services, barriers for accessing care, health expenditures and the person's knowledge, attitude and practice in relation to chronic and acute conditions. Lastly, we obtained information on mother and child care from 316 (endline 157, baseline 161 mothers) of children under 5 years and also checked their knowledge, attitude and practice on child growth and development.

5.1 Comparing key findings from the baseline household survey 2015 to the endline survey 2018

HOUSEHOLDS & HOUSEHOLDS MEMBERS

Characteristics of households and socio-demographic characteristics of household members are largely the same as during the baseline survey indicating comparable samples.

As before the most important provider for health are public providers, preferably health cerntres followed by hospitals and health posts. However, in Diber governmental hospitals continue to play a more important role than in Fier. The main reason for choosing public providers is proximity. About 85% live less than 5 kilometres from the next PHC facility. Only 2% of households indicate to live about 20 kilometres from the closest by PHC facility. As during the baseline costs remain an important factor for choosing the health provider. Given that the public sector is the most important provider for health in Albania working on improving quality of services and care continues to be of high importance.

Regarding the health situation in households one can say that half of the household members indicated to be healthy during the endline. This is a decrease since the baseline where at the time 56% had indicated to be neither acutely nor chronically ill. The main increases are seen with those chronically ill where an increase from 25% to 31% whilst the proportion of those acutely ill and those suffering from acute and chronically ill conditions stayed relatively the same (11% to 13% and 8% respectively). One could hypothesise that the eased access to PHC has led to a higher number of diagnosis as a main access barrier, i.e. insurance card, payments for health, were removed. In addition, the check-up intervention introduced in 2015 possibly led to detect unknown health problems (hypertension, diabetes etc.).

We continue to see main differences between the regions: Fier has a much higher number of chronically ill diagnosed patients. As expected, the proportion of those with chronic conditions increases among those 50 years old and above. The proportion of household members with a valid health insurance card increased from 70% during the baseline to 86% during the endline. Lowest insurance coverage is seen in people between 18 and 49 years, whilst those 65 years and older have highest coverage. The obligation to renew the health insurance card every six month was the main obstacle during the baseline for those who were uninsured at the time of the interview. This pattern has changed for the endline: patients were most commonly not insured because they considered they would not need it or that they did not pay contributions/were not eligible. Opposite to expectations the introduction of Universal Health Coverage (UHC) in 2017 did not increase the amount of those uninsured. Also the overall increased proportion of insurance card holders might reflect the introduction of the electronic management of health insurance cards. Nowadays, card holders can electronically extend the validity of the health insurance card (given that contributions have been paid).

As such, the reasons have changed as to why a person may not have a health insurance card. Hence it remains important to increase awareness of the population on the potential risks of having no health insurance and raise awareness on the benefits of having such.

Baseline	**Endline**
Households & household members	
The majority (96%) of households indicate governmental PHC facilities their first choice provider. T	97% use public facilities first. Of which 53% use governmental health centres and a further 34% use government hospitals.
The main reason for this choice is geographical proximity. Further important factors: costs, health insurance coverage and quality of services.	The primary factor for choosing health services is proximity (62%), followed by costs (39%), good quality (27%), familiarity with staff (25%) and covered by insurance (23%).
25% of household members reported a chronic condition, 9% both a chronic and acute condition in the past four weeks and 11% were affected by an acute condition.	13% acutely ill 31% chronically ill 8% chronically and acutely ill
More than half of household members had at the time of the interview a valid health insurance card, whereby coverage was higher in Diber than in Fier.	75.62% had insurance 86.15% in Diber 63.1% in Fier
The obligation to renew the health insurance card every six month is considered as a principle obstacle for those who were uninsured at the time of the interview. Another 20% of household members who were not insured thought that they do not need a health insurance card and about 15% indicated that they do not pay contributions or are not eligible.	Main reasons given at 36% each ‘Do not need it’ and ‘Does not pay contribution/not eligible’. Followed by ‘Does not have any benefit’ with 14% and ‘Did not renew health insurance card’ at 11%.

CHRONIC & ACUTE CONDITIONS

Illness patterns for chronic and acute conditions between base- and endline have not changed. The selected chronic disease patients mostly suffered of high blood pressure, heart problems, rheumatism and diabetes, though we also identified gender and regional differences in the occurrence of diseases.

The diagnosis was mostly given at a governmental hospital or a governmental health centre again emphasising the important role of the public health sector. 84% of the interviewees had sought care in the previous four to eight weeks indicating a higher proportion than during the baseline (70%). Health seeking patterns reflected the requirements of the disease (e.g. monthly checks high blood pressure).

Selected patients, who had an acute health problem in the past four weeks were mainly affected by cold/flu, fever and persistent cough with fever. About 66% of the patients had sought care at facilities, thereof 98% public health facilities.

The proportion of patients indicating challenges in seeking care were 20% (baseline 30%) for chronic patients and 13% (baseline 24%) for acute conditions, indicating in both situations a decrease of difficulties. For acute and chronic conditions the two biggest difficulties for chronic patients for seeking care remain financial hardship and lack of transport. However, also long waiting times and services not being available are deterrents for seeking care. However, specifically for financial barriers we also identified a steep decrease for chronic patients from 80% during the baseline to 50% during the endline survey and to a lesser extend also for acute conditions (endline 24%, baseline 32%). Satisfaction among patients with chronic conditions remains very high at 81% being very satisfied or satisfied and for acute conditions satisfactions has also improved since the baseline (very satisfied and satisfied: 68%). Satisfaction for both varies with payments made: the more patients had to pay the less satisfied were they. Hence the costs associated with the illnesses might be contributing to the observed differences.

Total inflation adjusted median expenses for chronic conditions in the past four weeks were 24 Euros compared to 21 Euros for acute conditions. As during the baseline expenditures for drugs was the most important cost driver (62% for chronic conditions and 69% for acute conditions). The median treatment or admission costs were in both cases zero, but proportionally accounted for 12% of the total costs for chronic and acute conditions. Total median costs varied for those with a chronic condition with the health insurance status. Having a health insurance card continues to reduced costs for chronic conditions by a substantial proportion. For chronic conditions median total costs were still 13 Euros higher for the uninsured than the insured.

Baseline	Endline
Chronic and acute conditions	
Most common chronic conditions reported by the interviewees were high blood pressure, heart problems, rheumatism and diabetes. The diagnosis was mostly established at a governmental hospital or a governmental health centre.	Most common chronic conditions were high blood pressure, diabetes, heart problems and rheumatism.
70% of the interviewees had sought care in the past four to eight weeks. When choosing the health provider what mattered most for persons with a chronic condition was the geographical proximity to the health provider, followed by the quality of services and the costs.	58% sought care in the past four weeks 26% sough care in the past 8 weeks Most important factors are geographical proximity to the health provider (49%), low costs (37%), good services (27%), covered by insurance (24%), familiarity with the staff (22%), good quality (19%) and qualified staff (15%)
Selected patients, who were acutely ill in the past four weeks were mainly affected by cold/flu, fever and persistent cough with fever.	Selected patients, who were acutely ill in the past four weeks were mainly affected by cold/flu, persistent cough with fever and fever.
About half of the chronically or acutely ill patients had sought care, typically at public health facilities. Patients consulted also other providers above the PHC facility (e.g. policlinics, specialists) mainly because services were not offered, the facility was closed or not all tests could be performed.	The majority of patients sought care at public facilities. Patients with both chronic conditions and acute illnesses consulted also other providers above the PHC facility (e.g. policlinics, specialists) mainly because they were referred, not all tests were available or services were not offered.
The two biggest difficulties for seeking care for chronic patients were the unavailability of financial funds related to health costs and transport. This was the same for acute conditions. Patients suffering from an acute problem also indicated their lack of trust in the doctor, the absence of an adequate provider in terms of gender and the belief that problems would go away without treatment or with self-medication.	The two biggest difficulties for seeking care for chronic patients were the unavailability of financial funds related to health costs (50%) and transport (40%), followed by long waiting times (27%) and services not available (20%). Patients with acute illnesses had similar difficulties: health costs (47%), transport (24%), long waiting times (20%) and services not available (18%).
Satisfaction with health services among individuals with chronic conditions was higher than for among individuals with acute conditions (20% vs. 32% were slightly unsatisfied or satisfied).	Chronic: 32% very satisfied, 49% satisfied, 14% slightly unsatisfied, 4% unsatisfied. Acute: 23% very satisfied, 63% satisfied, 10% slightly unsatisfied, 3% unsatisfied
Total median expenses for chronic conditions in the past four weeks were 25 Euros and therewith almost twice as high as for acute conditions (14 Euros). In both cases expenditures for drugs was the most	Chronic: Total 24 Euro; Drugs 17 Euro, transport 1 Euro Acute: Total 21 Euro; Drugs 14 Euros, transport 1 Euro

important cost driver (72% for chronic conditions and 70% for acute conditions). The median treatment or admission costs were in both cases zero, but proportionally they ranged between 12% for chronic conditions and 19% for acute conditions. Median transport costs were for chronic conditions higher than for acute conditions.	Inflation adjusted admission costs were proportionally 12% for both chronic conditions and acute conditions. Drugs accounted for 62% for chronic conditions and 69% for acute conditions. Median transport costs were for chronic conditions slightly (15%) higher than for acute conditions (13%).
Total median costs for patients with chronic or acute conditions varied depending on the health insurance status of the person. Having a health insurance card reduced the associated costs for chronic and acutely ill patients substantially.	The total inflation adjusted median costs for uninsured patients with chronic conditions were 37 Euros (insured 24 euros). The total median costs for uninsured patients with acute conditions were 20 Euros (insured 21 euros).

MOTHER & CHILD HEALTH

Post-natal care consultations were typically provided within the first week after discharge from the hospital. Most of consultations to women and children were provided by a nurse/midwife (66% and 56% respectively) followed by a doctor and for children also by a paediatrician. Depending on the provider checks were more common at home (e.g. nurse) or at the hospital (e.g. doctors).

Child monitoring and development check-up also appear to be routinely conducted and the comprehensiveness of the checks appears to have improved since the baseline. The check of the vaccination cards is thereby given a high priority as well as weight measurement. However, other physical examinations or questions on development progress – though improved – can still be further strengthened. In addition, information on preventing diseases or other information on child health is insufficiently distributed.

Baseline	Endline
Mother & child health	
Postnatal care consultations were typically within the first week after release from the hospital. Most consultations to women and children were provided by a nurse/midwife (56% and 48% respectively) followed by a doctor and for children also by a paediatrician. Care was for the majority of women and children provided in public health facilities, specifically governmental hospitals and health centres.	69% of women received a post-natal check up in the first week after leaving the hospital. Most often the check-up was performed by a nurse or midwife (66%) or doctor (27%). 77% of check-ups for the children were performed in the first 7 days, generally by a nurse or midwife (56%), paediatrician (25%) or general doctor (17%). Most health checks took place at public facilities, commonly governmental health centres (39%), governmental hospitals (29%) or at health posts (22%) or other public facilities
Child monitoring and development check-up appear to be routinely conducted. The check of the vaccination cards is thereby given a high priority as well as weight measurement. Other physical examinations (e.g. head or height measurements) or questions on development progress are not consistently applied.	The majority of last child's check-up were in the past month (37%) or 2-6 months ago (34%). The most common check was checking the vaccination card (92%) followed by weight measurement (85%), height measurement (75%) and head measurement (71%)

KNOWLEDGE, ATTITUDE AND PRACTICE

Respondents, who were in-depth questioned about their chronic or acute condition, were also questioned on their knowledge, attitude and practice related to cardiovascular disease. The number of risk factors for cardiovascular diseases that can be cited by respondents is relatively mixed. There are about 23% (baseline 18%) who could cite more than four risk factors and also the number of interviewees not knowing any has decreased since the baseline (endline 5%, baseline 14%) of interviewees who could not think of any risk factors. As during the baseline interviewees were able to cite between two to three risk factors. As during the baseline, the knowledge on cardiovascular disease and diabetes showed that "easy" items obtained a high proportion of correct answers among respondents, whilst more challenging questions, that required a deeper understanding of the diseases and the causes, were only recognised by a smaller number of the respondents. Typical questions that were more difficult were question on signs and symptoms and even more so what would not be a sign and symptom. The later could though be an effect of the inverted item that might have been difficult to understand in the interview situation.

For obesity general knowledge was lower than for cardiovascular or diabetes although we also observed here improvements from base- to endline. Specifically the question on physical exercise had relatively low scores. The result could indicate that more information on lifestyle related factors and particular sensitisation on obesity could be needed.

Very high levels of knowledge on child health and development were observed among mothers. Risk factors for development and also aspects relating to child development were generally well known. The progress of a child and its exact ordering into chronology was for

some mothers difficult, specifically for when a child should react to noise. However, these are also orientation marks and thus the results should be treated with care.

Baseline	Endline
Knowledge, attitude and practice	
About 18% could cite more than four risk factors for cardiovascular disease; however, 14% of interviewees could not think of any risk factors. Commonly known were two to three risk factors.	About 23% could cite more than four risk factors for cardiovascular disease; 5% of interviewees could not think of any risk factors. Commonly known were two (27%) to three (21%) risk factors.
Very high levels of knowledge on child health and development were observed among mothers. Risk factors for development and also aspects relating to child development were generally well known.	There is high awareness amongst mothers about child development, growth and development problems and risk factors. 10 of the 11 risk factors were correctly identified by over 90% of mothers interviewed.

5.2 Comparing key findings from the 2017-2018 ADHS survey to the HAP endline survey 2018

The following congruencies and differences were identified for key aspects between the two surveys. Of note: differences between the surveys possibly reflect different methodologies or analysis strategies. For instance, the HAP survey analysed data only for household in which a chronically or acutely ill person lives is. This might influence the general insurance coverage in the household as awareness might be higher among household members or maybe doing the process for one or all household members is the same. Also the ADHS limits several analysis to subgroups, e.g. age groups or gender. This might also limit the direct comparability.

ADHS	HAP Endline
Insurance status	
Between 2008-09 and 2017-18, there was an increase in the proportion of persons covered by insurance. The proportion of women protected by state insurance or social security increased significantly, from 26% to 46%, while for men the increase was only modest, from 34% to 37%.	We observed also an increase in health insurance coverage though at substantially higher coverage levels and with no gender differences.
Chronic and acute conditions	
Self-reported noncommunicable diseases: The prevalence of noncommunicable disease (NCD) is higher among women (20% compared with 8% among men) and, as one would expect, increases with age, from 4% among women age 15-29 to 41% among women age 50-59, and from 3% among men age 15-29 to 16% among men age 50-59. **Focusing on the age group 50-59:** Hypertension is the most common NCD followed by diabetes, diseases related to bones and ligaments and heart disease.	As during the baseline the proportion of household members with chronic conditions in Fier (endline 38%, baseline 33%) was substantially higher than in Diber (endline 25%, baseline 20%). As in the ADHS reporting chronic conditions was more common among females than men. **Randomly selected chronically ill respondents** indicated that their most common chronic conditions were high blood pressure, diabetes, heart problems and rheumatism. Hence, the relative importance of conditions is the same as in the ADHS.
Recent injuries and ailments in the past 2 weeks Influenza and the common cold were the most frequently mentioned illnesses, reported by 12% of women and 7% of men.	13% of persons living in the study households report an acute condition in the past **four weeks**. Patients were mainly affected by cold/flu, persistent cough with fever and fever. However we did not identify any gender differences.
Mother & Child health	
Postnatal care for women: For the **most recent births in the past 2 years**, 88% of women and 86% of newborns received a postnatal check **within 2 days of delivery**. Only 6% of mothers did not receive any form of postnatal check. women received a postnatal check within 2 days of their most recent birth from the obstetrician/gynecologist (60%), 26% from the nurse/midwife, and 2% from the family doctor	69% (baseline 62%) of women who had **given birth in the last 5 years** had someone checking of their health conditions **after being discharged from hospital**, typically within the first week after discharge. In most cases, this was carried out either by the nurse or midwife (endline 66% baseline 56%) or a doctor (endline 27%, baseline 38%).

Postnatal care for newborns: 86% of newborns had a postnatal check within the **first 2 days after birth**. Only 8.2% of newborns did not receive a postnatal check within the first 2 days. Slightly more than half (51%) were checked by a nurse or midwife, 30% by an obstetrician or gynecologist, and 5% by a family doctor.	In 80% of cases, a health provider checked the baby's health **after discharge from the hospital** (baseline 74%). Most commonly this was done by the nurse or midwife (56%), a paediatrician (25%) or a general doctor (17%).

6 Recommendations

Based on key findings of the baseline survey recommendations were derived. The following table provides an overview on whether key findings and recommendations from the baseline are still valid and/or if progress has been achieved. In addition to the recommendations that are still valid from the baseline there are a few additional recommendations. Of note: recommendations on population health and access to health are a task and responsibility for all, including the MoHSP and its implementation subordinated institutions (national and regional ones), the Health Insurance Fund (HIF), as well as other stakeholders intervening in the health domain.

Table 14: Recommendations and next steps

Finding Baseline	Recommendation from Baseline	Finding & Recommendations Endline
PHC facilities are the main provider for chronic and acute conditions	It is of utmost importance that the PHC facilities are further strengthened in providing high quality of clinical care, which also includes infrastructure and equipment.	The finding and recommendation from baseline remains valid.
A main issue for lacking health insurance coverage is the obligation to renew the health insurance card every 6 months	HAP should consider supporting technical advancements but also policy initiatives to reduce the burden for patients to renew their health insurance card every 6 months. This should be done in view of avoiding free-riders but at the same time in the light of the newly introduced UHC and already on-going discussions on a fully state financed insurance system.	With the policy changes introduced in 2017 making PHC visits free of cost a substantial milestone was achieved, that is also mirrored by the results of the endline survey (reduction of costs and costs as barrier being less often mention). Also the user-friendliness of renewing the insurance card has improved which might also be reflected in the increased number of persons with an insurance card. Nevertheless, costs remain a concern also because specific services, drugs, etc. are not exempted and thus might still be a burden for many people.
The costs for uninsured are substantially higher	Increase awareness of the population on the potential risks of having no health insurance. Monitor and possibly counterbalance tendencies of decreasing health insurance coverage due to the UHC introduction, specifically as costs for drugs are not covered.	The finding remains valid though the costs have decreased also for those uninsured with a chronic condition. Costs are indistinguishable for insured and uninsured for acute conditions. Main cost drivers are the costs for drugs which are partly covered by the health insurance fund.

Referrals, unavailability of services, tests and closure of the facility were reasons why not only PHC services were accessed	HAP should work towards addressing infrastructural deficiencies and thus contribute towards better services and availability of services.	The finding remains valid and actually the tendency has increased also for urban facilities. Hence it should be carefully assessed why the tendency that specific tests are not offered by PHC are actually increasing rather than strengthening the PHC system.
Persons with an acute health problem faced the following concerns: lack of trust in the doctor, unavailability of doctors of the same sex ; so that their satisfaction was relatively low	Acute health situations seem not to be adequately covered at PHC facilities. The project should evaluate whether this could relate to a) a lack of procedures and guidelines; b) lack of knowledge at health staff level on how to treat patients, c) reimbursement mechanisms or else, d) lack of the required equipment, consumables, medicines and other materials	Satisfaction with health services for acute conditions increased. Also, the trust in doctors seems to have increased. At service level are the long waiting times or services not being available main deterrents. ,
Most post-natal care, including children and mothers, checks were done facility based.	Evaluate possibilities of home-based services and their cost-effectiveness.	Post-natal care at home has increased since the baseline though still a substantial proportion is being done at hospital level. The provider delivering the care seems to be a main determinant on whether this is done at home or at a facility (e.g. nurses/midwife = largely at home).
Checks on child development were not covering all various aspects	Develop protocols and checklists for checks on child development and update the knowledge of health providers accordingly.	The coverage of the various aspects has improved since the baseline though there is more room for improvement.
Overall good knowledge but lack of specific disease knowledge on diabetes and obesity	Increase the awareness of signs and symptoms for diabetes and specifically also awareness of lifestyle factors related to obesity.	Overall an improvement of knowledge has been observed. However, specifically related to lifestyle related factors further improvements are needed.

7 Conclusion

The household survey provides a comprehensive data collection that once more emphasises the importance of the public health sector in Albania. Whilst various aspects remain largely unchanged, e.g. disease patterns, the results of the surveys show that Albania experienced measurable positive progress on the accessibility of public health services. This is likely attributable to the policy changes introduced in 2017 and which ensure for several conditions and situations free of charge services at PHC. This is an important achievement in strengthening the PHC system and to remove important access barriers. Also aspects related to mother and child health have measurably improved as did the general knowledge on cardiovascular diseases.

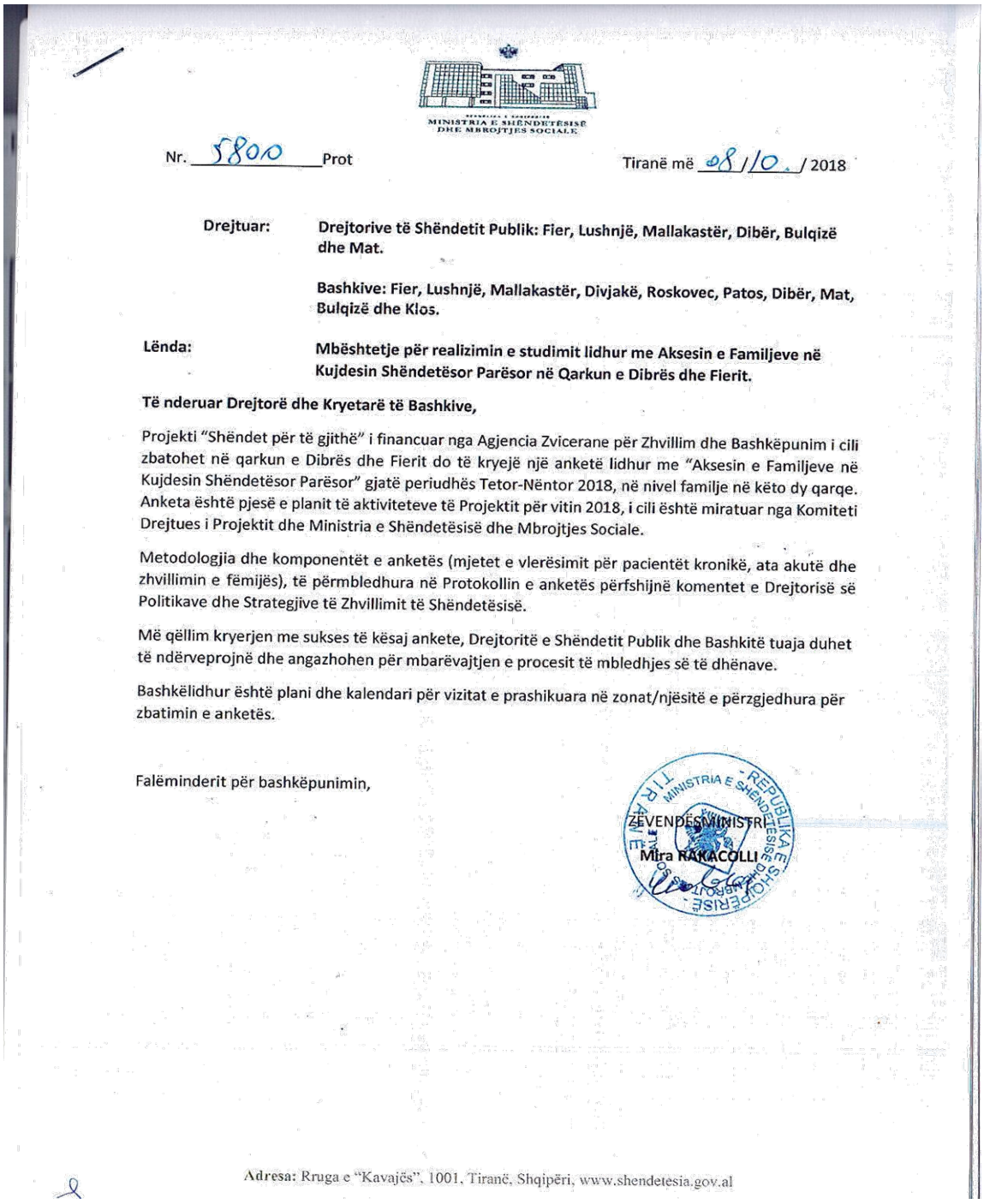
Notably, access and treatment costs remain a concern for many households and patients. Hence, reducing this access barriers further and also addressing issues of high costs of drugs will be important to increase the population health. At the same time it will be important that the quality the PHC system is strengthened and that the system is capable of managing this increased demand. Investments into the infrastructure but also into the capacity of Human Resources must be prioritised. It will be necessary to further improve awareness and knowledge on risks and risk factors at community level specifically for chronic conditions which are a major burden in Albania.

8 References

1. *Albania Demographic and Health Survey, 2017 - 2018*. 2018, Institute of Statistics.
2. The World Bank. *Albania*. DataBank: World Development Indicators 2019 [cited 2019 16 June]; Available from: https://databank.worldbank.org/reports.aspx?source=2&country=ALB.

Annex

Annex A: Approval letter from MoHSP



MINISTRIA E SHËNDETËSISË DHE MBROJTJES SOCIALE

Nr. 5800 Prot Tiranë më 08/10/2018

Drejtuar: **Drejtorive të Shëndetit Publik: Fier, Lushnjë, Mallakastër, Dibër, Bulqizë dhe Mat.**

Bashkive: Fier, Lushnjë, Mallakastër, Divjakë, Roskovec, Patos, Dibër, Mat, Bulqizë dhe Klos.

Lënda: **Mbështetje për realizimin e studimit lidhur me Aksesin e Familjeve në Kujdesin Shëndetësor Parësor në Qarkun e Dibrës dhe Fierit.**

Të nderuar Drejtorë dhe Kryetarë të Bashkive,

Projekti "Shëndet për të gjithë" i financuar nga Agjencia Zvicerane për Zhvillim dhe Bashkëpunim i cili zbatohet në qarkun e Dibrës dhe Fierit do të kryejë një anketë lidhur me "Aksesin e Familjeve në Kujdesin Shëndetësor Parësor" gjatë periudhës Tetor-Nëntor 2018, në nivel familje në këto dy qarqe. Anketa është pjesë e planit të aktiviteteve të Projektit për vitin 2018, i cili është miratuar nga Komiteti Drejtues i Projektit dhe Ministria e Shëndetësisë dhe Mbrojtjes Sociale.

Metodologjia dhe komponentët e anketës (mjetet e vlerësimit për pacientët kronikë, ata akutë dhe zhvillimin e fëmijës), të përmbledhura në Protokollin e anketës përfshijnë komentet e Drejtorisë së Politikave dhe Strategjive të Zhvillimit të Shëndetësisë.

Më qëllim kryerjen me sukses të kësaj ankete, Drejtoritë e Shëndetit Publik dhe Bashkitë tuaja duhet të ndërveprojnë dhe angazhohen për mbarëvajtjen e procesit të mbledhjes së të dhënave.

Bashkëlidhur është plani dhe kalendari për vizitat e prashikuara në zonat/njësitë e përzgjedhura për zbatimin e anketës.

Falëminderit për bashkëpunimin,

REPUBLIKA E SHQIPËRISË - MINISTRIA E SHËNDETËSISË DHE MBROJTJES SOCIALE - TIRANË

ZËVENDËSMINISTRI

Mira RAKACOLLI

Adresa: Rruga e "Kavajës", 1001, Tiranë, Shqipëri, www.shendetesia.gov.al

Annex B: Additional tables & graphs

Annex B.1: Household level

Table 15: Overview on household assets

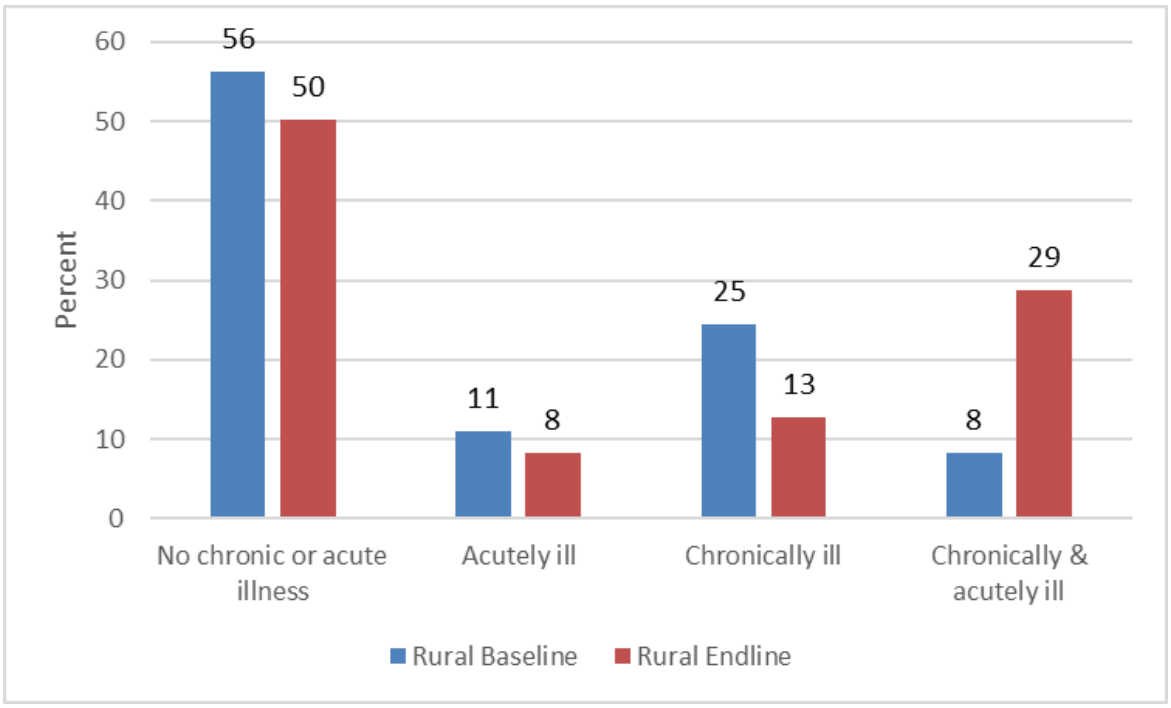
		Baseline				Endline			
Question	Answer categories	Diber (n=642)	Fier (n=633)	Urban(n=448)	Rural (n=825)	Diber (n=643)	Fier (n=646)	Urban (n=469)	Rural (n=820)
What is the main source of drinking water for the dwellers in your dwelling/apartment?	Piped Water	64	20	34	57	68	24	59	39
	Tube well or borehole	1	6	5	1	2	6	0	6
	Dug well	8	7	11	0	6	4	0	8
	Water from spring	25	12	27	4	24	7	1	23
	Tanker truck	0	36	18	18	0	44	23	21
	Cart with small tank	0	1	1	1	0	1	0	1
	Surface water (river, dam, lake, ponds, stream, canal, irrigation channel)	1	1	1	0	0	0	0	0
	Bottled water	1	18	4	19	0	14	16	2
	Other	0	0	0	0	*	*		
What is the main source of water used in your dwelling/apartment for other purposes such as cooking and hand washing?	Piped Water	68	54	48	86	69	70	93	56
	Tube well or borehole	1	12	9	2	2	11	1	9
	Dug well	10	13	18	0	6	9	1	11
	Water from spring	19	8	20	2	22	3	0	19
	Tanker truck	0	8	3	5	0	5	2	3
	Cart with small tank	0	1	0	1	0	0	0	0
	Surface water (river, dam, lake, ponds, stream, canal, irrigation channel)	1	1	1	0	0	0	0	0
	Bottled water	0	4	1	4	0	3	2	1
	Other	0	0	0	0	0	0	0	0
Do you do anything to make the water safer to drink?	Yes	13	11	11	14	11	13	13	11
What do you usually do to make the water safer to drink?	Boil	75	44	47	80	58	22	53	30
	Add bleach/chlorine	14	34	39	0	13	33	5	36

		Baseline				Endline			
Question	Answer categories	Diber (n=642)	Fier (n=633)	Urban(n=448)	Rural (n=825)	Diber (n=643)	Fier (n=646)	Urban (n=469)	Rural (n=820)
	Strain through a cloth	4	9	8	3	1	14	3	11
	Use water filter	8	10	6	13	25	28	34	22
	Let it stand and settle	0	3	0	3	0	2	2	1
	Solar disinfection					3	0	3	0
What kind of toilet facility do the dwellers in your dwelling/apartment usually use?	Flush or pour flush toilet	68	64	62	72	73	14	34	48
	Pit latrine	13	16	18	6	2	3	0	4
	Composting toilet	3	4	5	0	0	1	0	0
	Bucket toilet	3	4	3	5	0	0	0	0
	Hanging toilet/hanging latrine	14	13	12	17	25	83	65	47
	No facility /bush / field	1	0	0	1	0	0	0	0
Do you share this toilet facility with other dwellings/apartments?	Yes	13	8	9	15	20	13	17	17
Assets 1									
Does your dwelling/apartment have: (*multiple answers*)	Radio	12	11	10	15	12	23	21	15
	Television	99	100	99	100	98	98	99	97
	Telefone	89	88	86	92	N/A	N/A	N/A	N/A
	Telephone/Cell phone/Landline phone	99	97	98	97	97	96	97	96
	Landline phone	11	13	5	25	N/A	N/A	N/A	N/A
	Internet access	33	25	24	40	55	55	64	50
	DVD Player	20	17	19	19	17	19	24	15
	CD Player	7	3	3	8	9	14	16	9
	Refrigerator	93	97	95	95	93	95	97	92
	Freezer	10	8	9	10	14	8	10	11
	Washing machine	84	88	84	92	87	90	96	84
	Dishwasher	22	24	22	24	5	13	15	6
	Mircowave	13	16	10	24	19	24	34	14
	Sofa	96	98	97	96	96	96	96	96
	Electric radiator	12	13	8	21	14	22	31	11
	Generator	2	1	2	2	2	7	6	4

		Baseline				Endline			
Question	Answer categories	Diber (n=642)	Fier (n=633)	Urban(n=448)	Rural (n=825)	Diber (n=643)	Fier (n=646)	Urban (n=469)	Rural (n=820)
	Sewing kitt/machine	16	17	13	23	7	20	18	11
	Air conditioner	4	8	3	11	4	18	22	5
	Water boiler	50	67	54	67	74	74	82	69
	Computer	17	12	10	22	N/A	N/A	N/A	N/A
	Laptop	18	12	11	22	N/A	N/A	N/A	N/A
	Computer/Laptop	N/A	N/A	N/A	N/A	30	25	41	20
	Satellite Dish or cable receiver	64	72	65	74	80	72	78	75
What type of fuel is mainly used for cooking in your dwelling/apartment?	Electricity	5	8	3	13	3	14	18	4
	Liquid Propane Gas	14	48	25	42	N/A	N/A	N/A	N/A
	Natural Gas	8	27	16	21	N/A	N/A	N/A	N/A
	Gas	N/A	N/A	N/A	N/A	30	55	46	41
	Charcoal	1	0	0	0	2	0	0	2
	Wood	72	17	57	23	48	15	12	43
	No food cooked	N/A	N/A	N/A	N/A	0	0	0	0
	Electricity and gas	N/A	N/A	N/A	N/A	16	15	23	11
How many rooms in this dwelling/apartment are used for sleeping?	1	24	27	22	32	27	26	30	25
	2	50	50	52	46	58	52	57	54
	3	20	20	22	18	13	17	10	18
	4	5	2	4	3	2	4	2	3
	5	0	1	1	0	0	1	1	0
	6	N/A	N/A	N/A	N/A	0	0	0	0
Assets 2									
Does any member in this dwelling/apartment own (*multiple answers*)	a watch	92	87	89	91	85	60	80	68
	a bicycle	13	23	17	19	8	34	23	20
	a motorcycle or scooter	4	13	10	6	3	20	7	14
	an animal-drawn cart	6	6	9	1	7	5	0	9
	a car or truck	27	25	25	29	29	32	36	28
	a tractor	3	2	4	1	2	5	1	5
	a boat with a motor	1	0	1	0	0	0	0	0
Does any dweller in this	Yes	75	70	94	32	64	66	23	89

		Baseline				Endline			
Question	Answer categories	Diber (n=642)	Fier (n=633)	Urban(n=448)	Rural (n=825)	Diber (n=643)	Fier (n=646)	Urban (n=469)	Rural (n=820)
dwelling/apartment own agricultural land?									
Do the dwellers in this dwelling/apartment own any livestock, herds, other farm animals or poultry?	Yes	62	48	79	10	59	44	8	77
How many of the following animals do the dwellers in this dwelling own? (*multiple answers*)	milk cows or bulls	92	53	76	57	87	44	22	71
	horses, donkeys or mules	27	20	25	4	74	85	8	22
	goats	8	12	10	15	6	13	11	9
	sheep	15	12	14	9	11	12	0	12
	chickens	65	86	74	72	78	86	77	82
	pigs	2	1	2	2	1	10	3	5
Does any dweller in this dwelling/apartment have a bank account?	Yes	28	21	20	34	29	32	43	23
Does your household have regular internet access?	Yes	35	25	23	42				

Figure 39: Health Status by location (Baseline: rural (n= 3,535), urban (n=1,649); Endline: rural (n=820), urban (n=469))



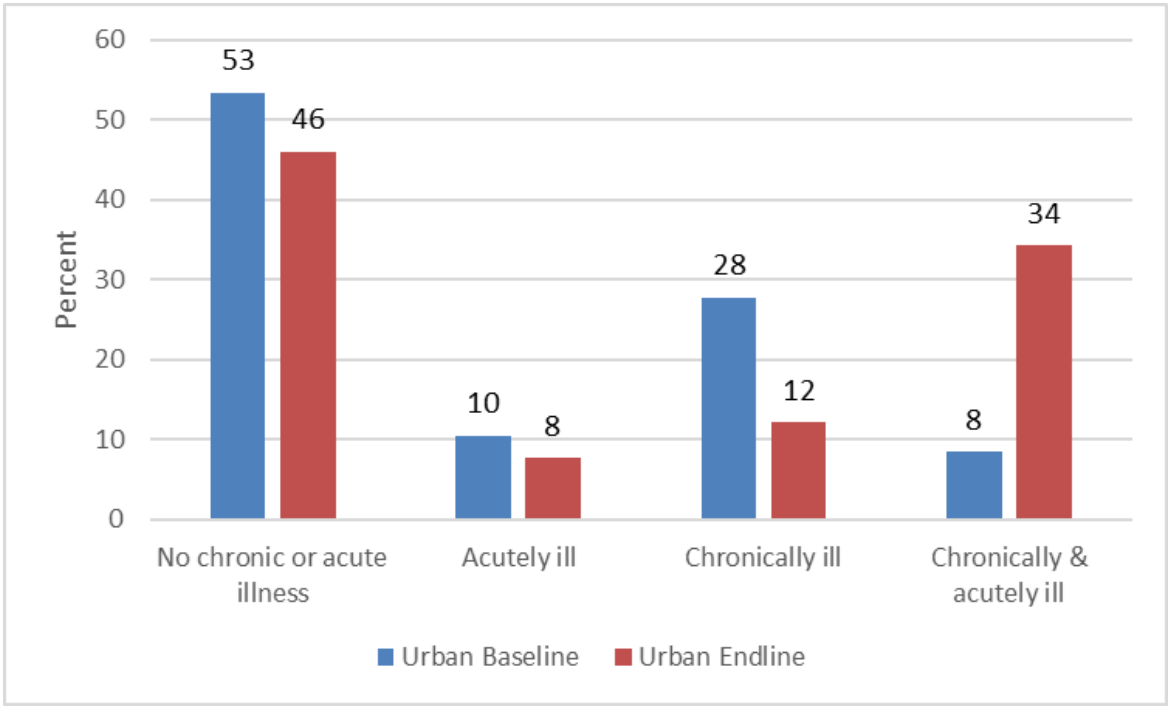


Figure 40: Health status and age groups

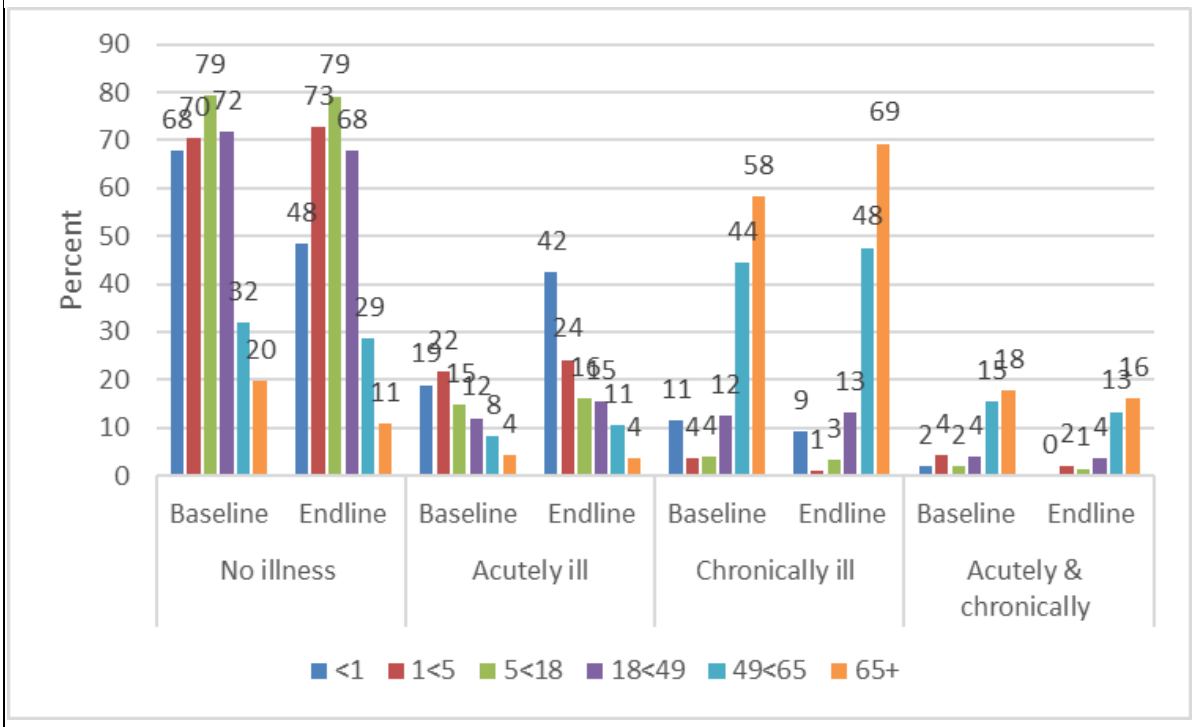


Figure 41: Reasons for not having health insurance (Baseline: n=902; Endline: n=4749)

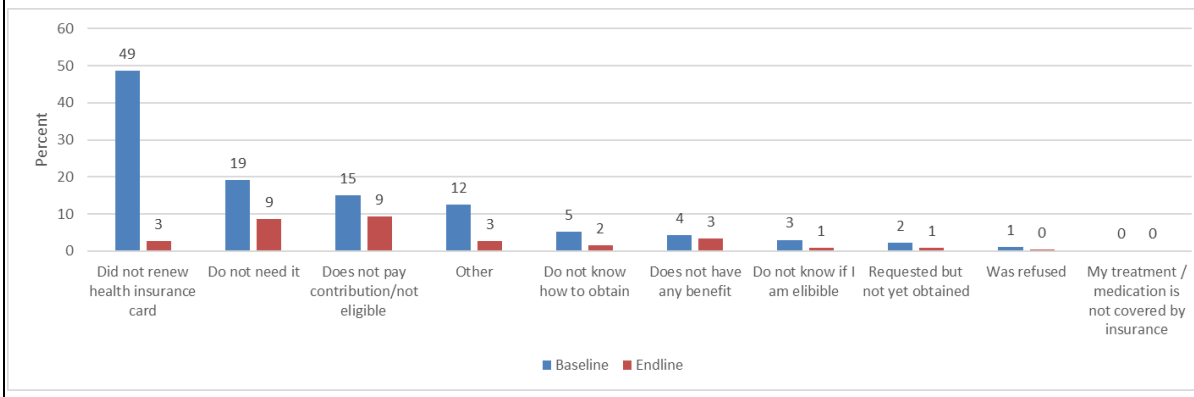


Figure 42: Insurance status and age groups

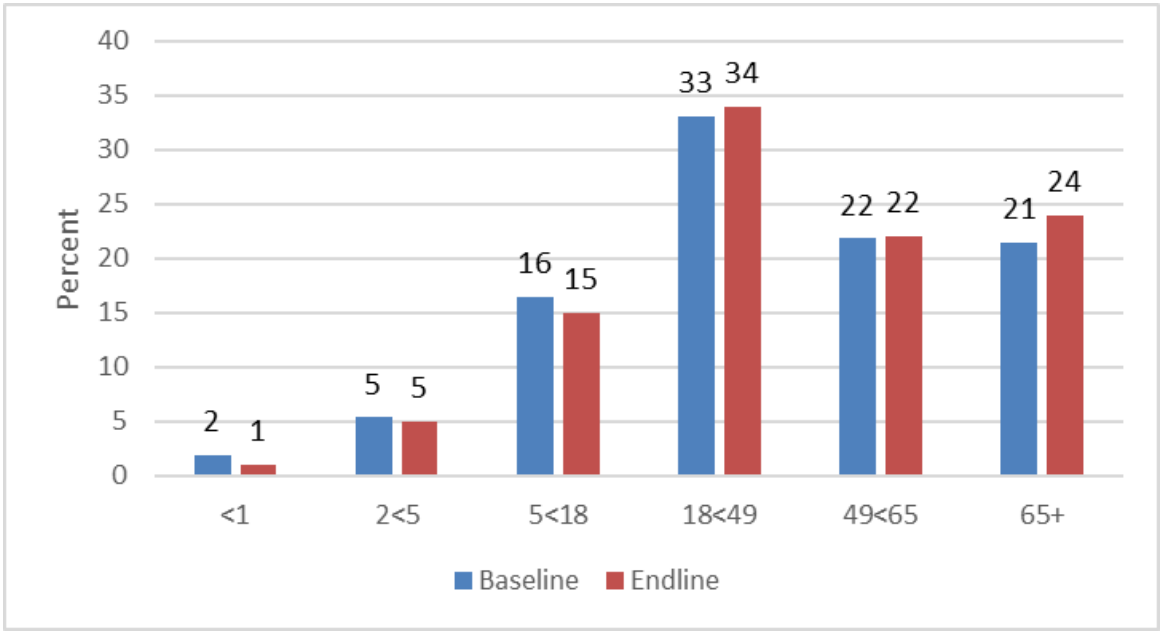
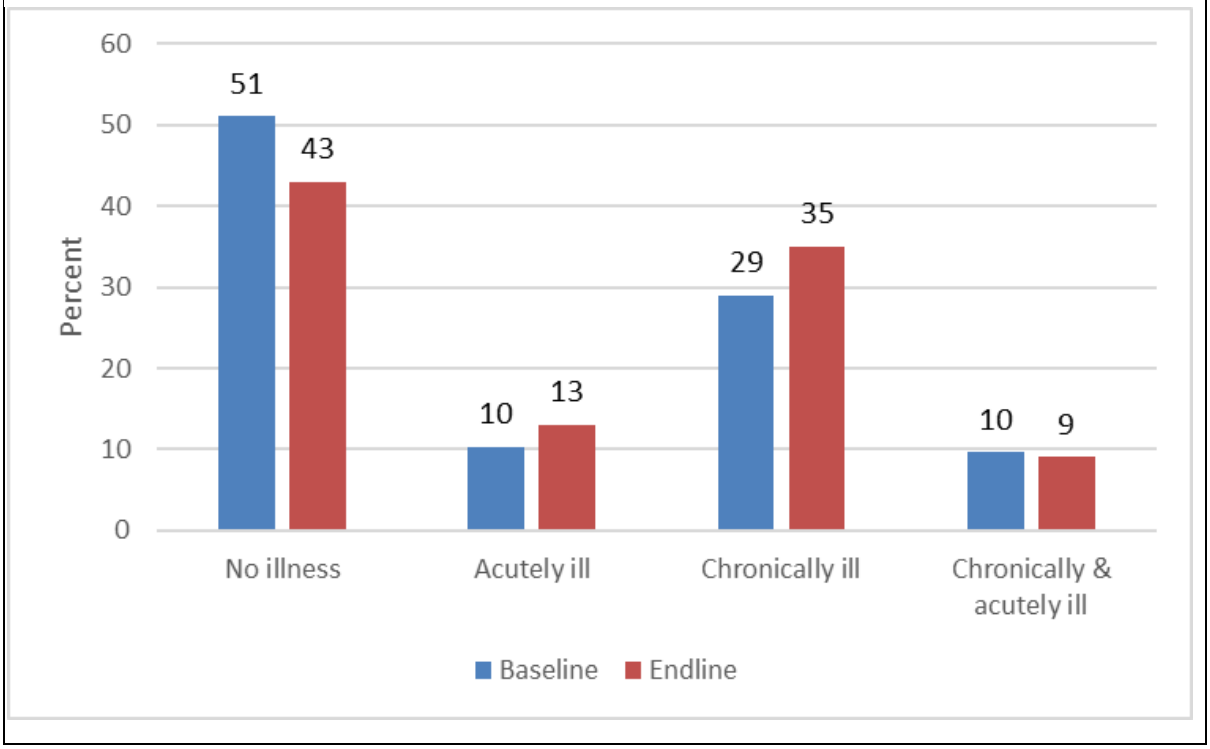
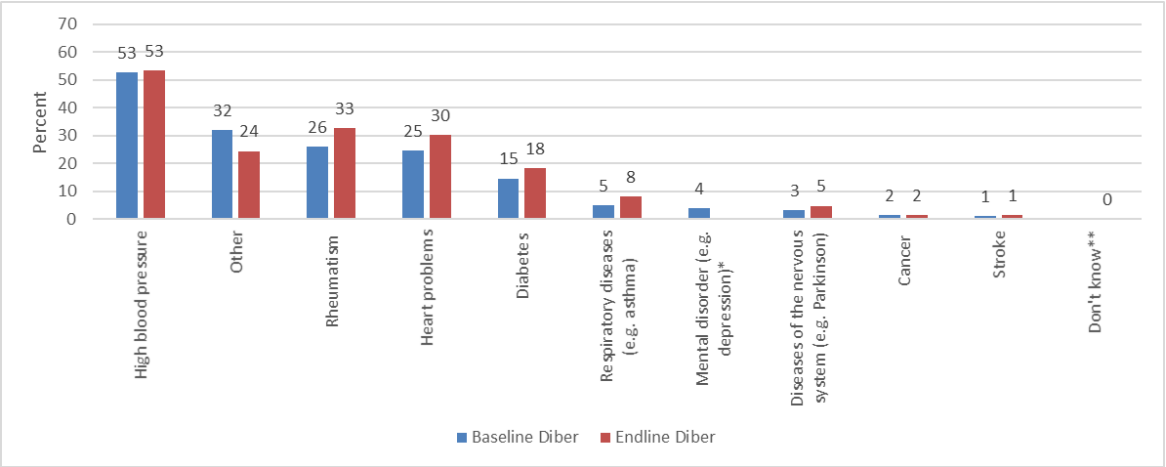


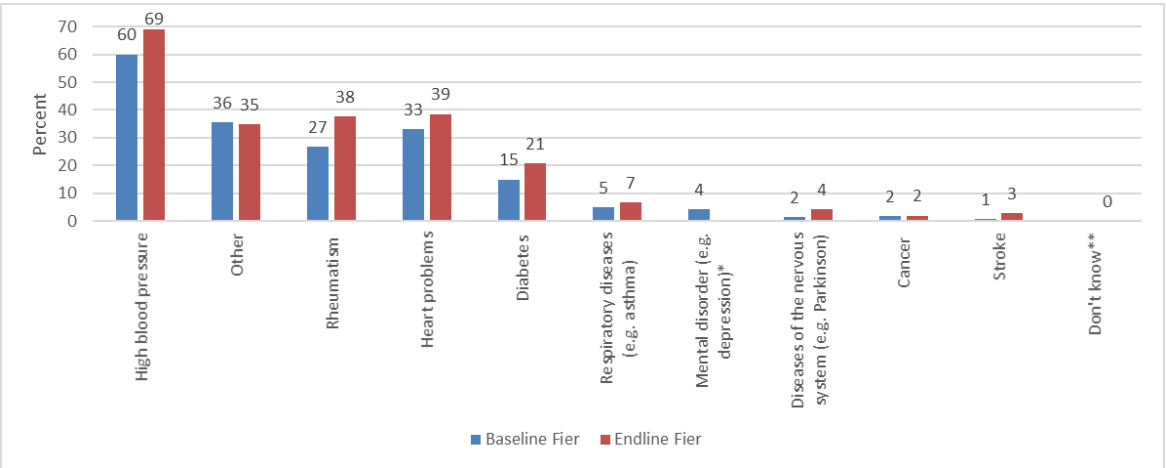
Figure 43: Insurance status and health status



Annex B.2: Chronic conditions

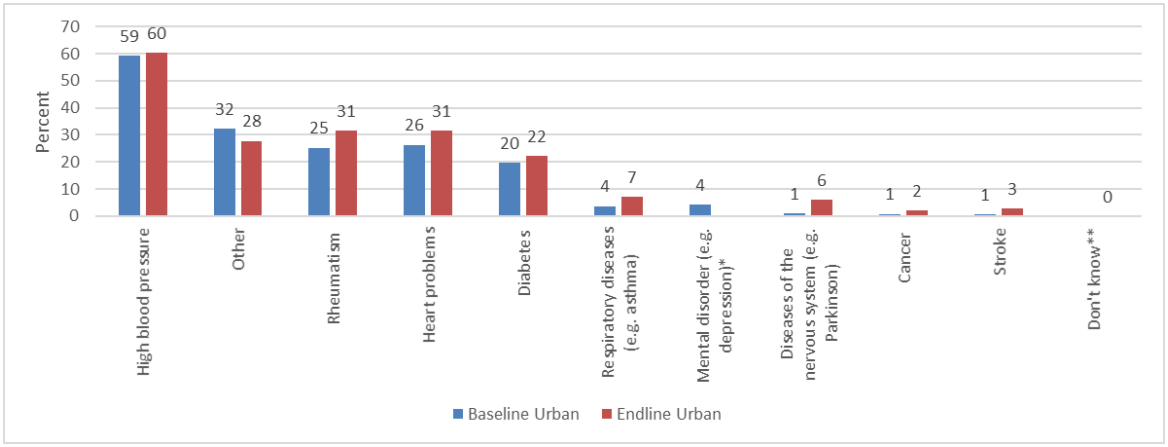
Figure 44: Chronic conditions: Baseline Diber (n=522), Fier (n=574); Endline Diber (n=525), Fier (n=610) – *multiple answers*

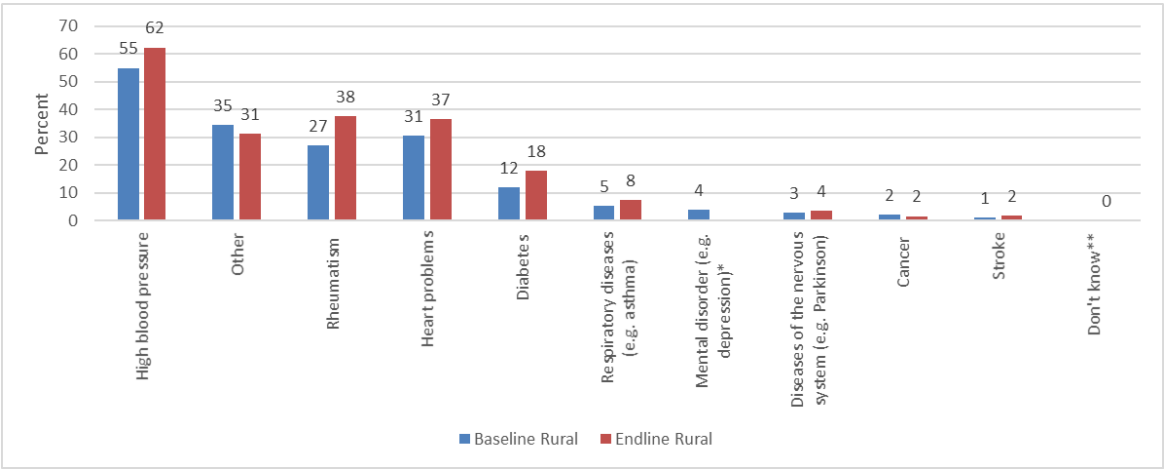




**Endline only

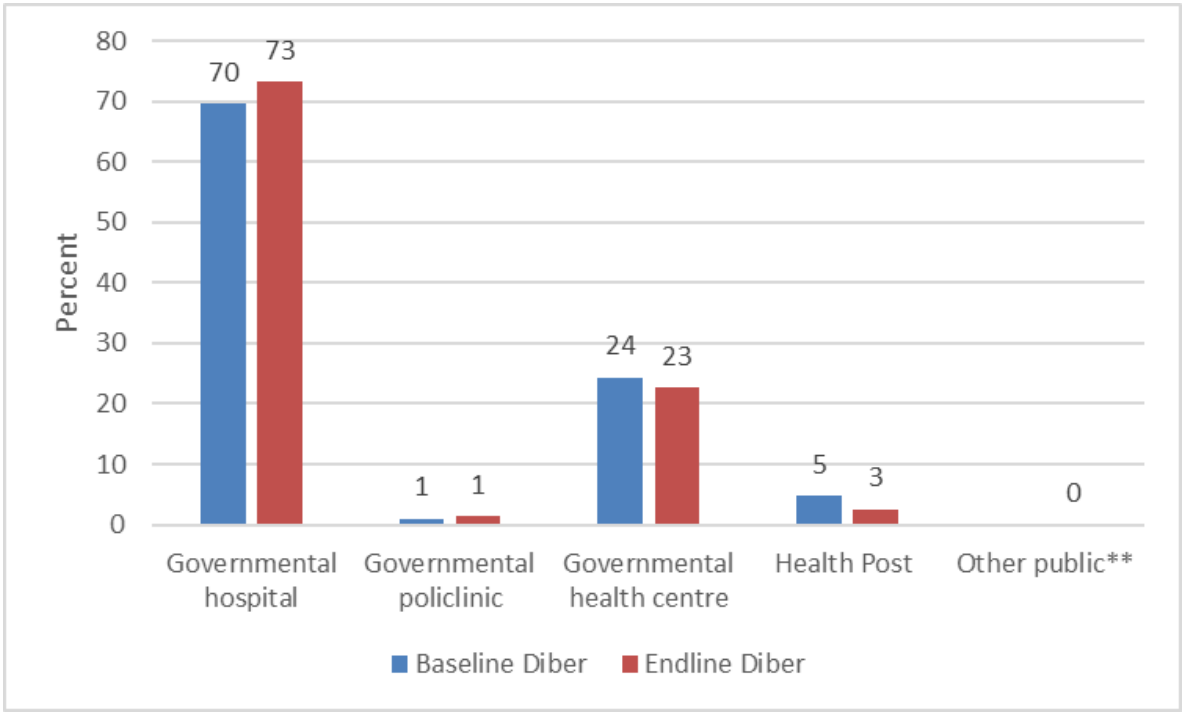
Figure 45: Chronic conditions: Baseline Rural (n=715), Urban (n=380); Endline Rural (n=725), Urban (n=410) – *multiple answers*

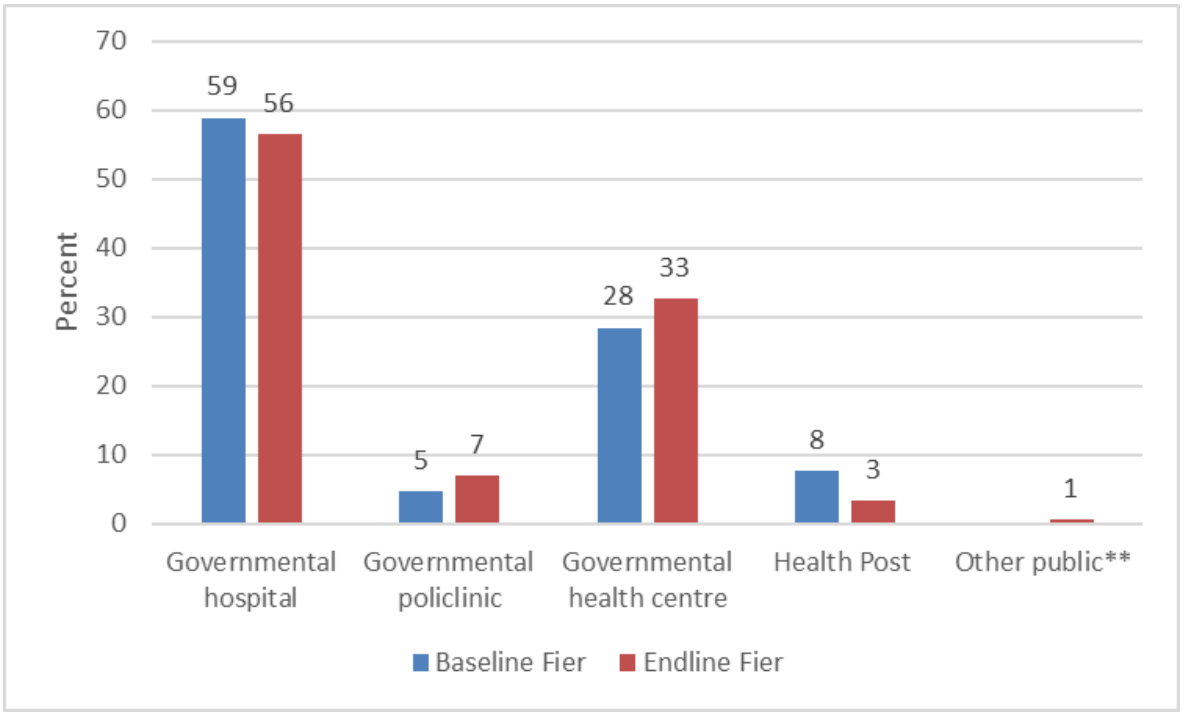




**Endline only

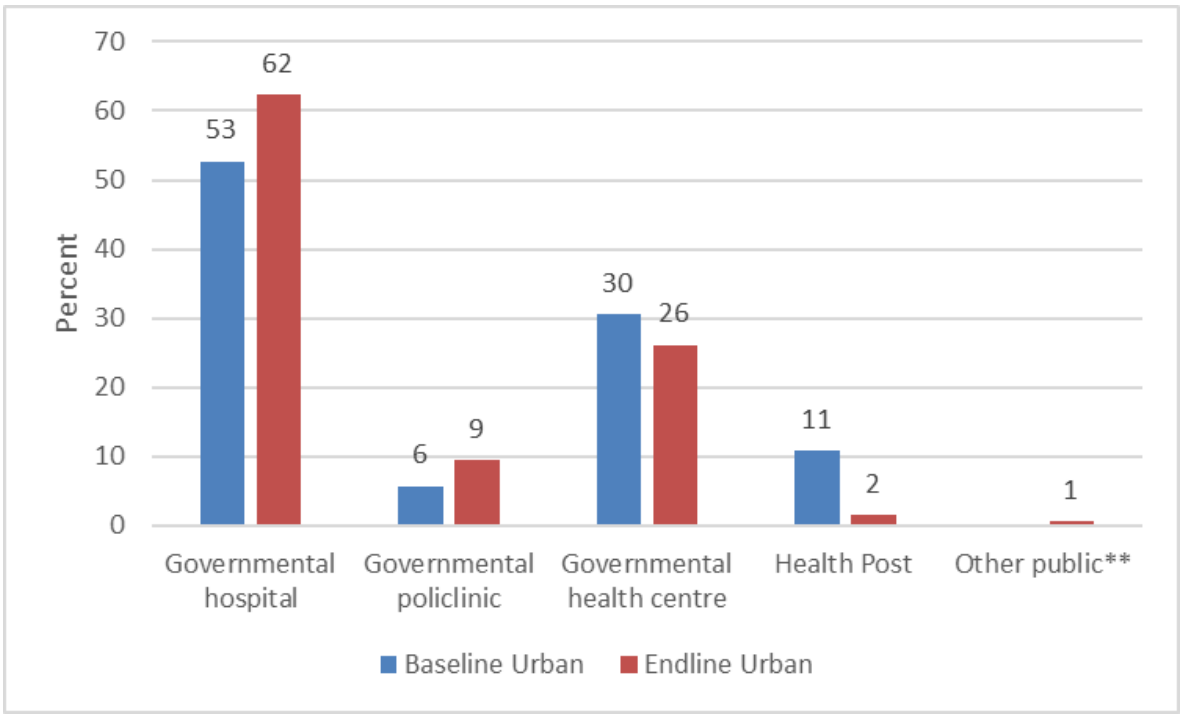
Figure 46: Public facility of diagnosis: Baseline Diber (n=522), Fier (n=574); Endline Diber (n=525), Fier (n=610)

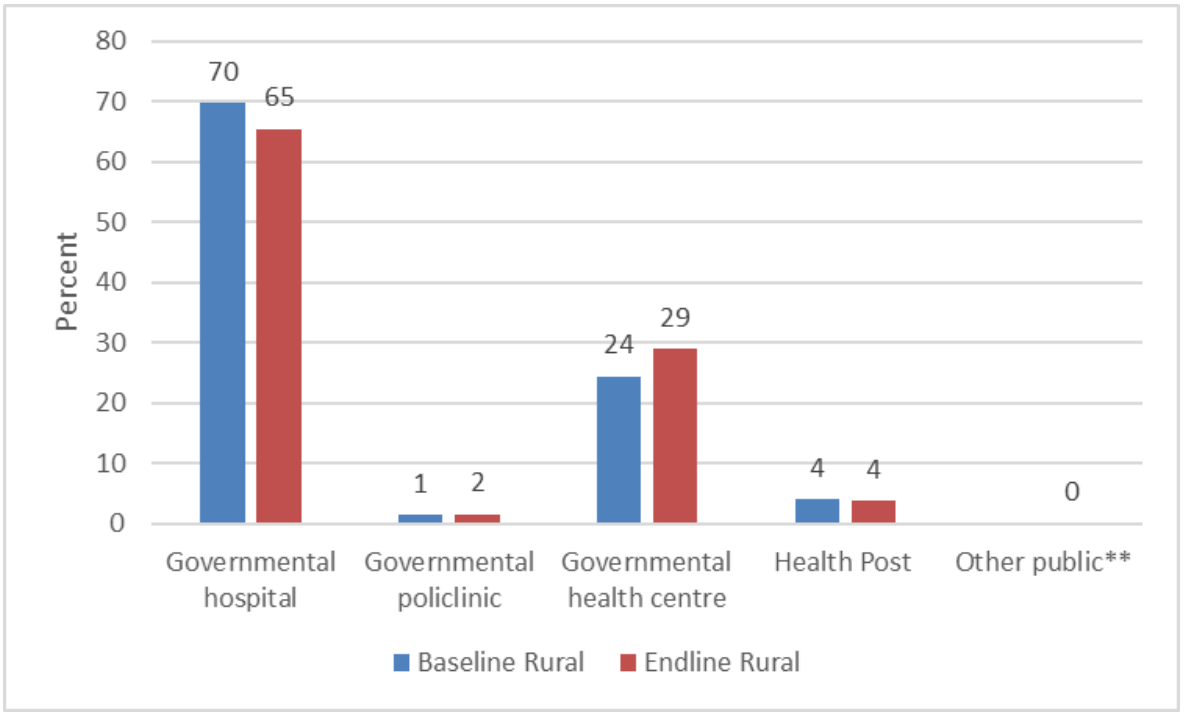




**Endline only

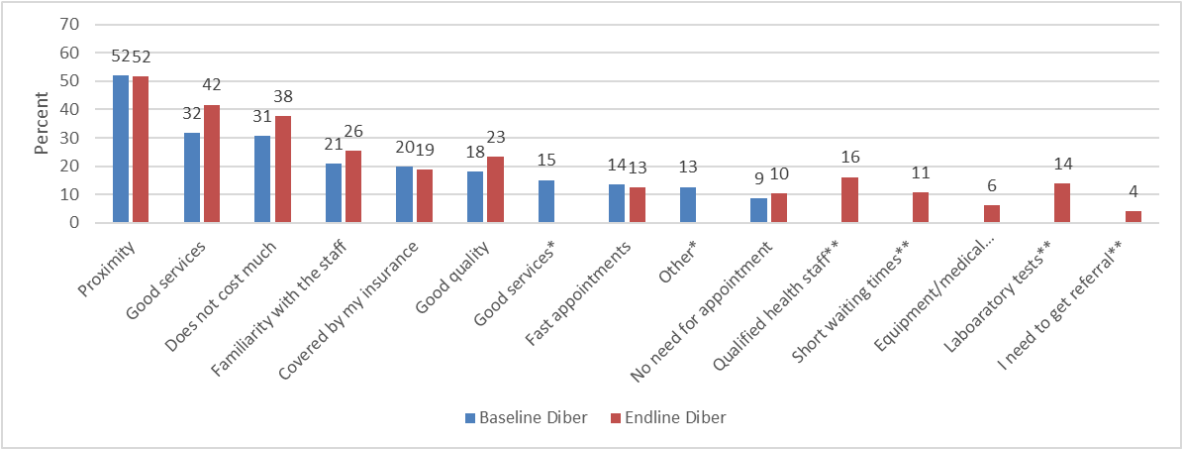
Figure 47: Public facility of diagnosis: Baseline Rural (n=715), Urban (n=380); Endline Rural (n=725), Urban (n=410)

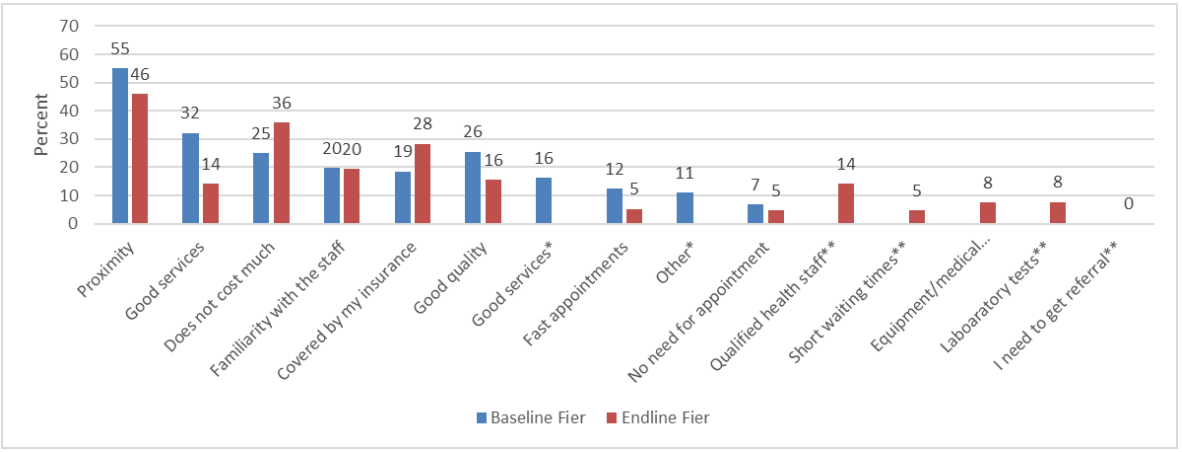




**Endline only

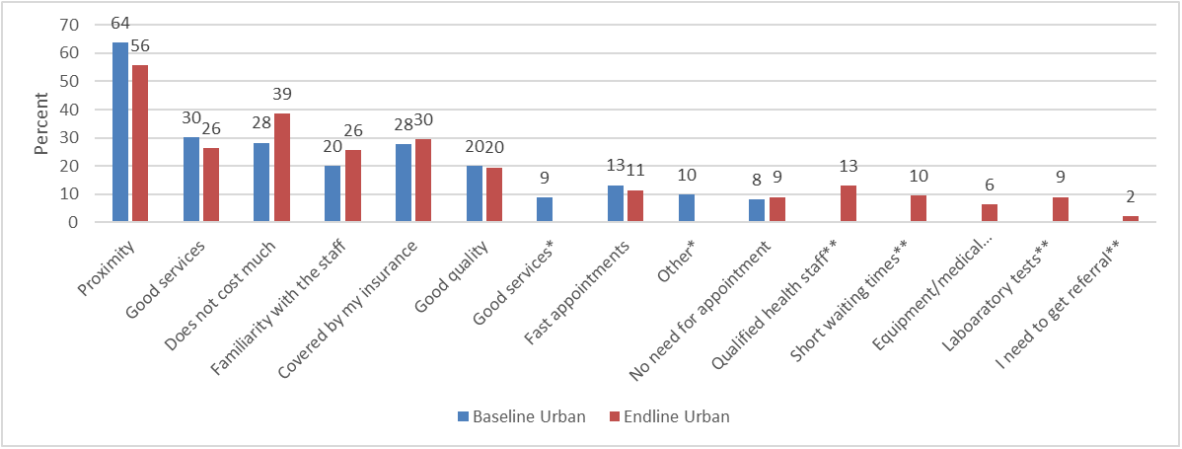
Figure 48: Aspects relevant for choosing a health provider: Baseline, Diber (n=363), Fier (n=404); Endline Diber (n=525), Fier (n=610) – *multiple answers*

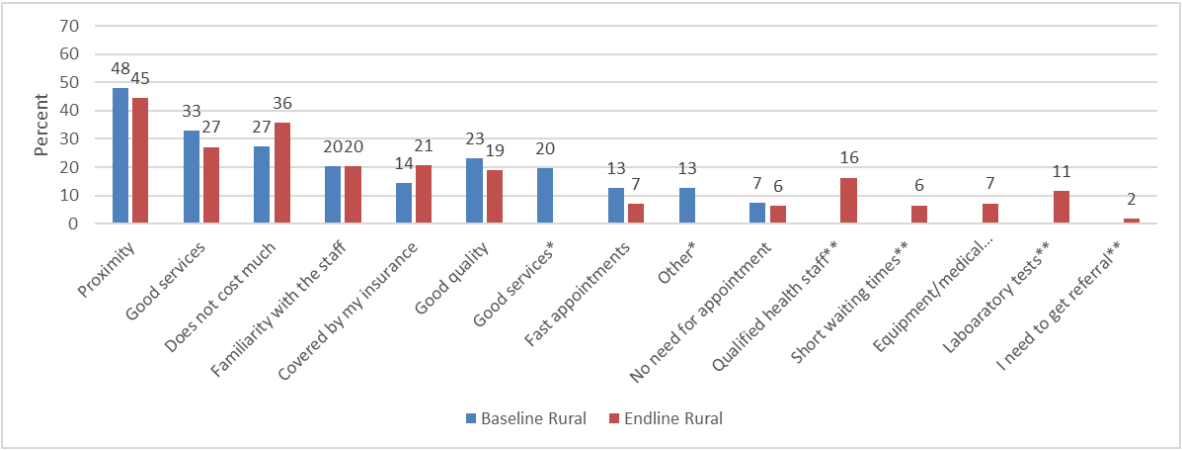




*Baseline only. **Endline only

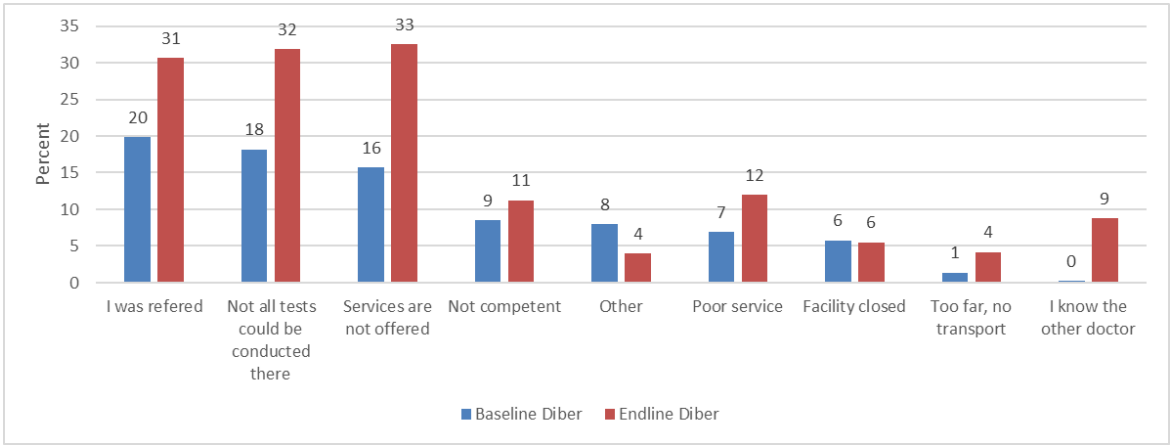
Figure 49: Aspects relevant for choosing a health provider: Baseline Rural (n=494), Urban (n=273); Endline Rural (n=725), Urban (n=410) – *multiple answers*





*Baseline only. **Endline only

Figure 50: Why not only PHC: Baseline, Diber (n=363), Fier (n=404); Endline Diber (n=525), Fier (n=610) – *multiple answers*



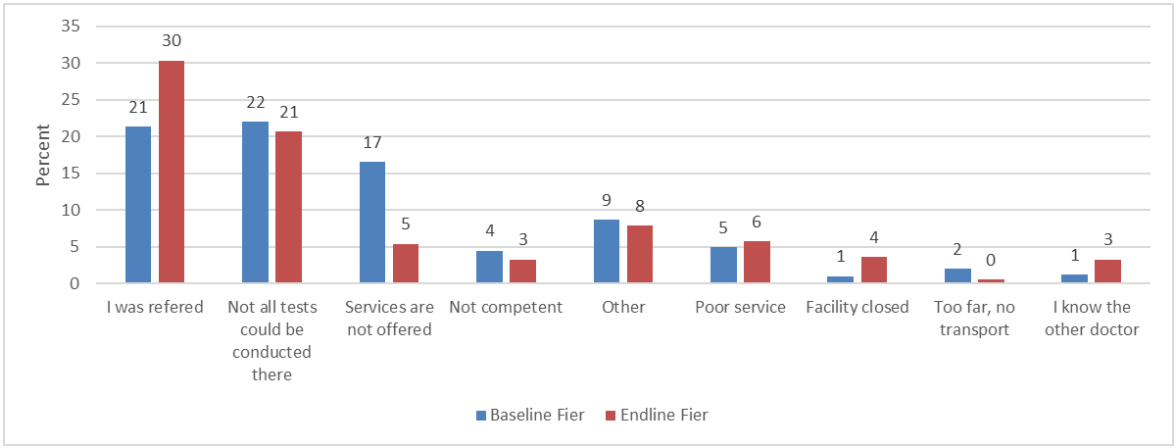
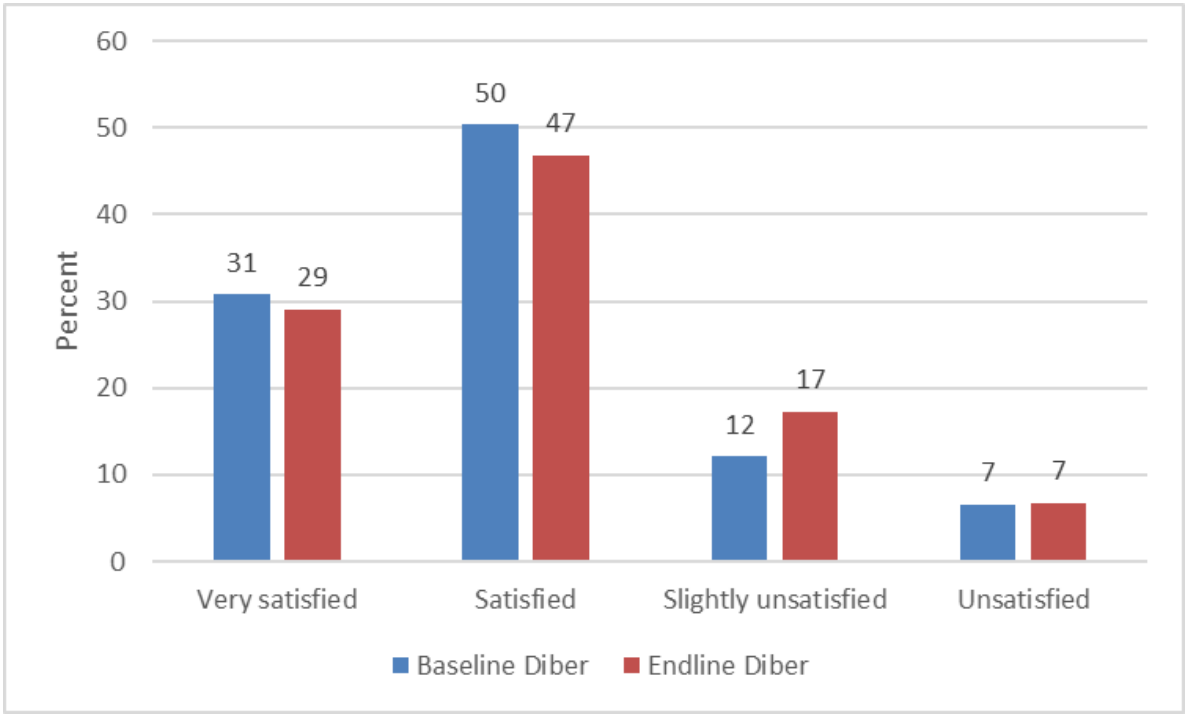


Figure 51: Satisfaction : Baseline, Diber (n=363), Fier (n=404); Endline Diber (n=457), Fier (n=472)



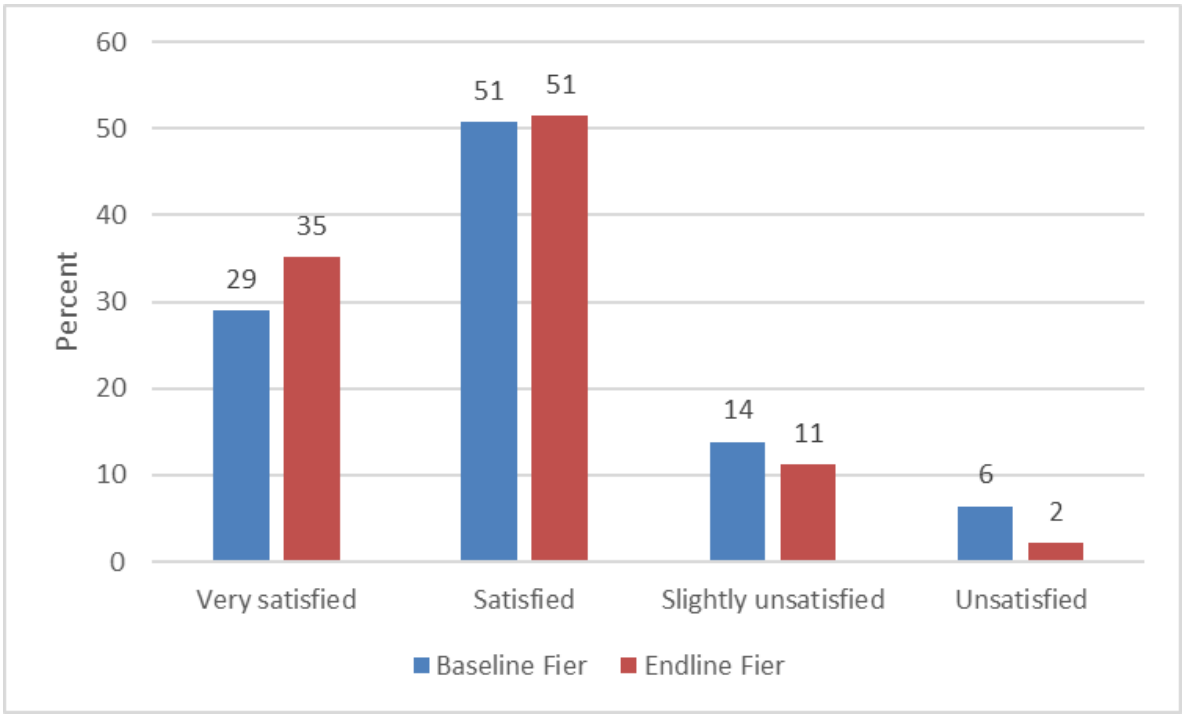
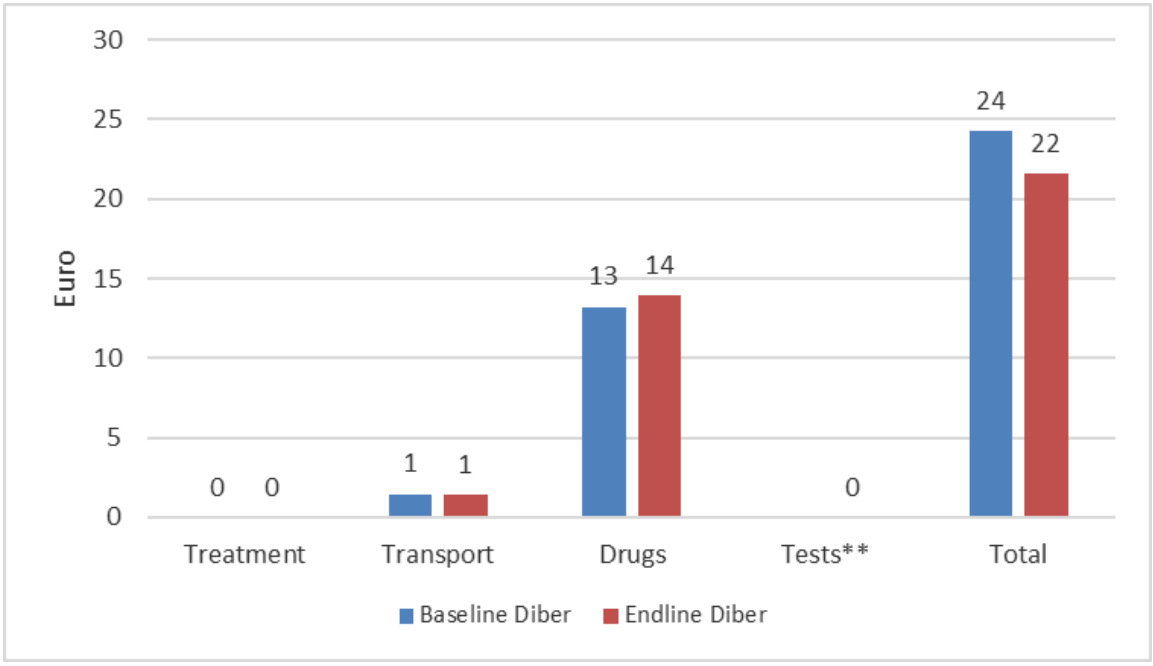
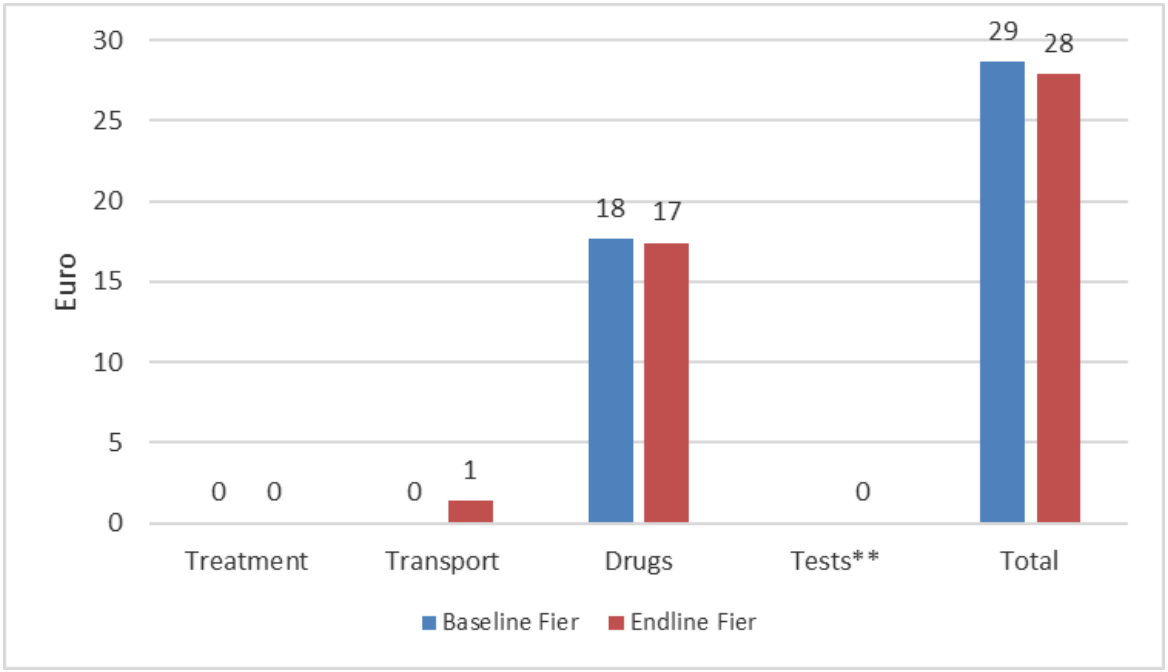


Figure 52: Median Costs (Euro) for Chronic Conditions in past 4 weeks: Diber vs. Fier





**Endline only

Figure 53: Median Costs (Euro) for Chronic Conditions in past 4 weeks and level of satisfaction with services received

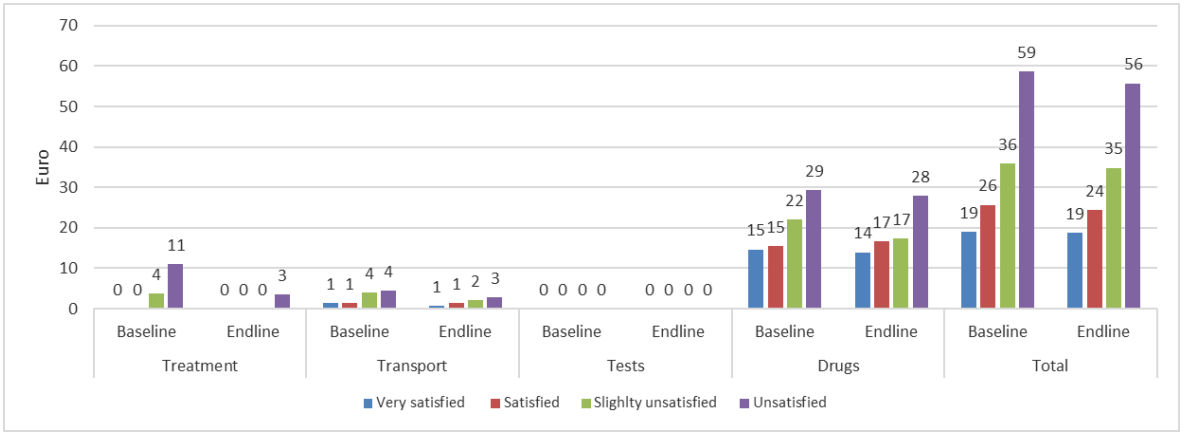
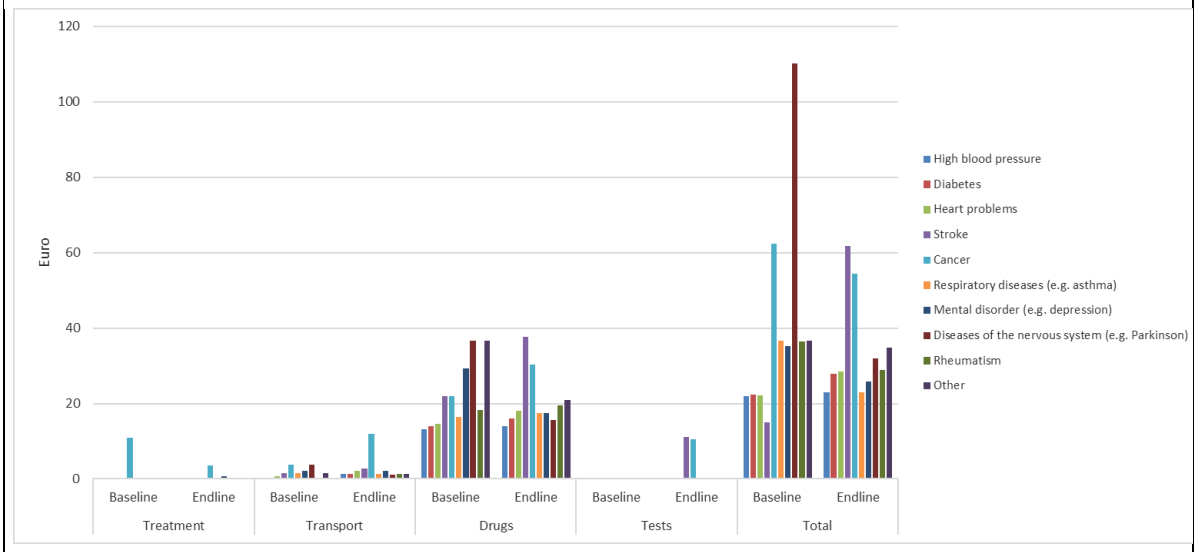
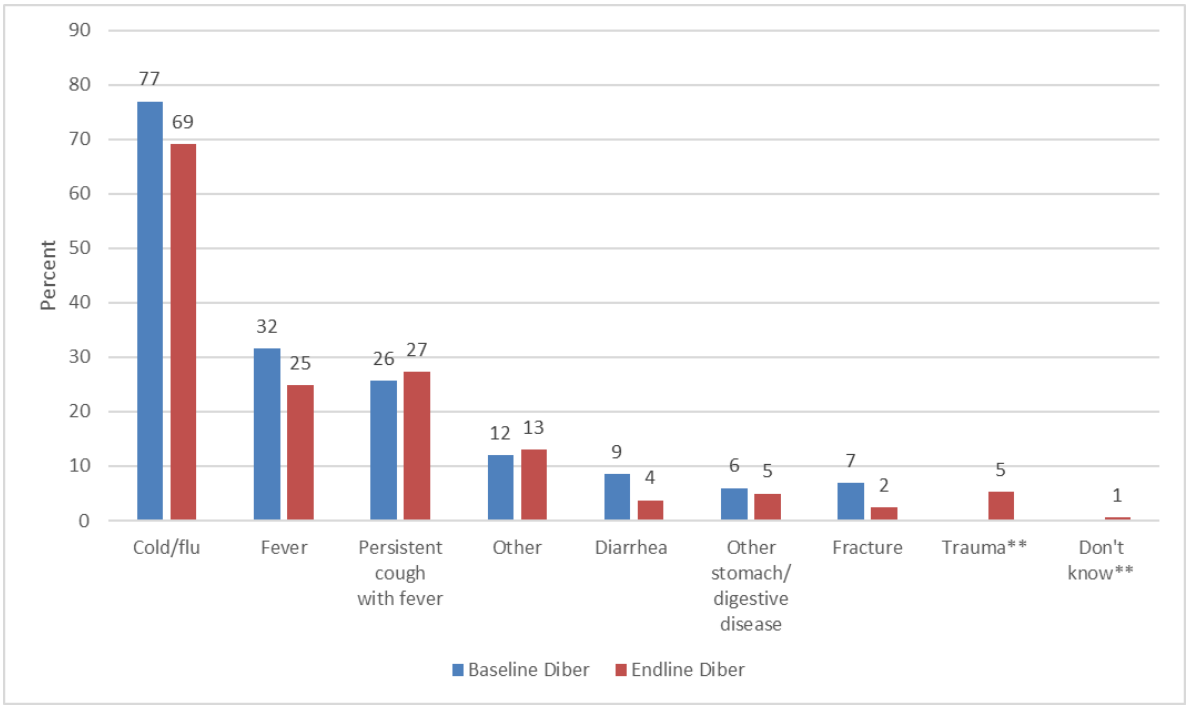


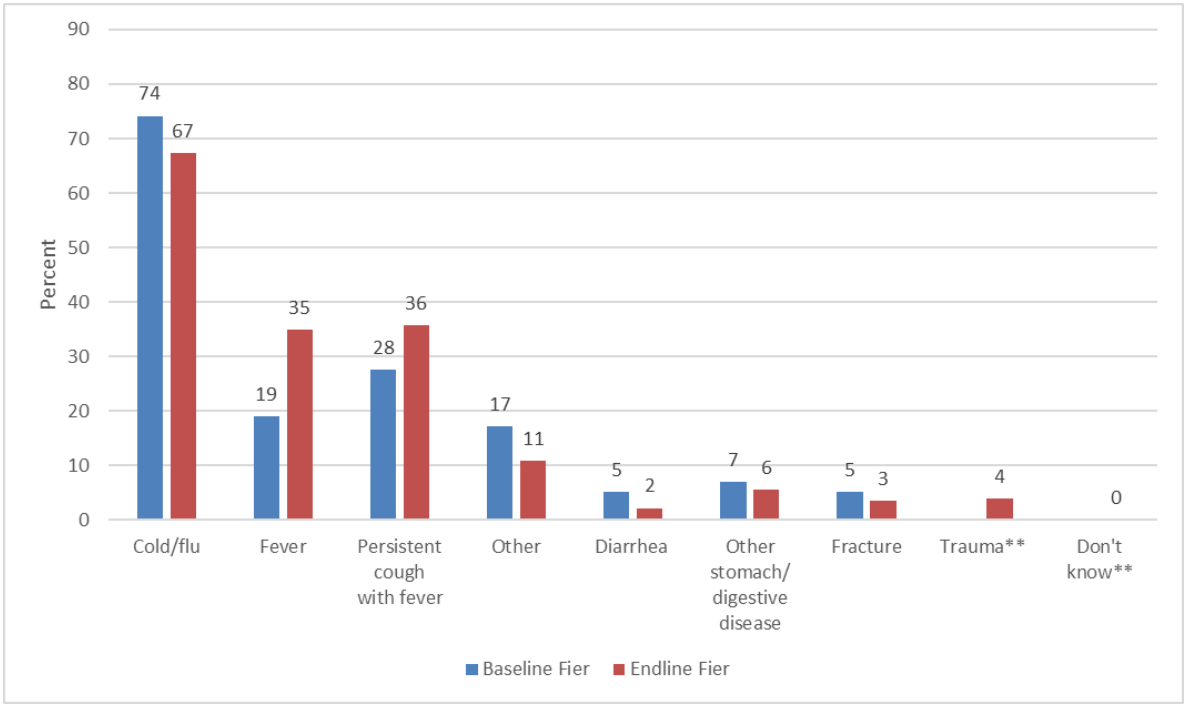
Figure 54: Median Costs (Euro) for Chronic Conditions in past 4 weeks and type of chronic condition



Annex B.3: Acute conditions

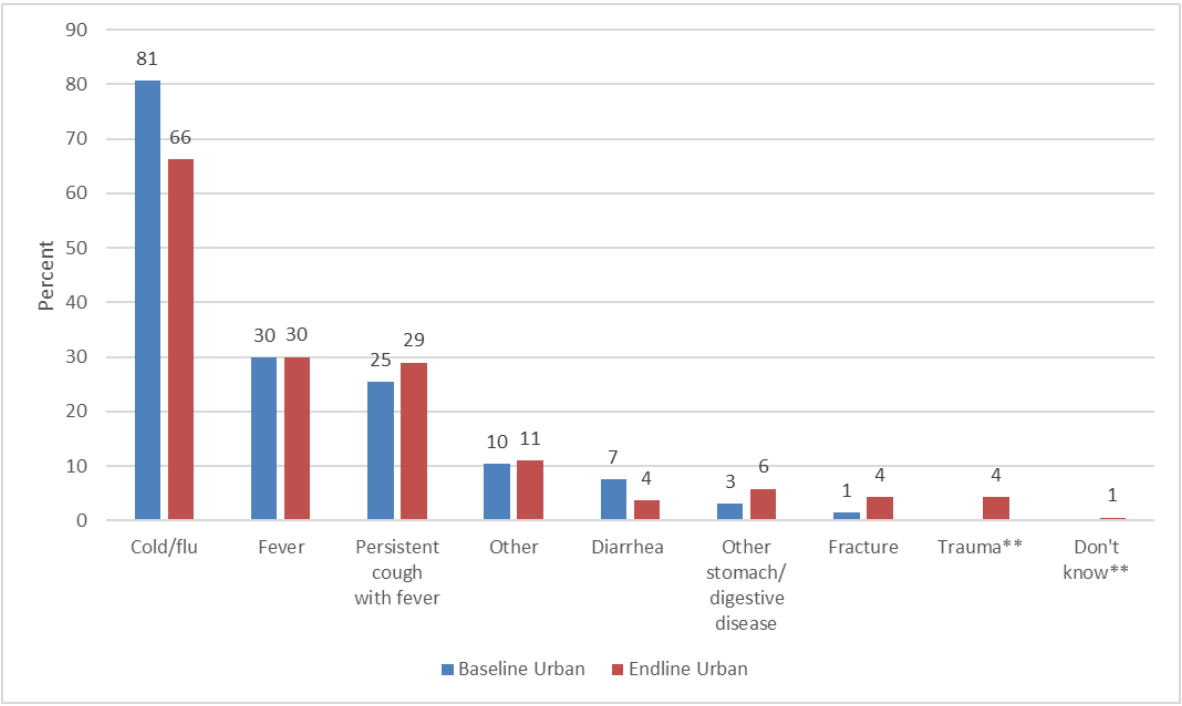
Figure 55: Acute conditions: Baseline Diber (n=117), Fier (n=58); Endline Diber (n=323), Fier (n=232) – *multiple answers*

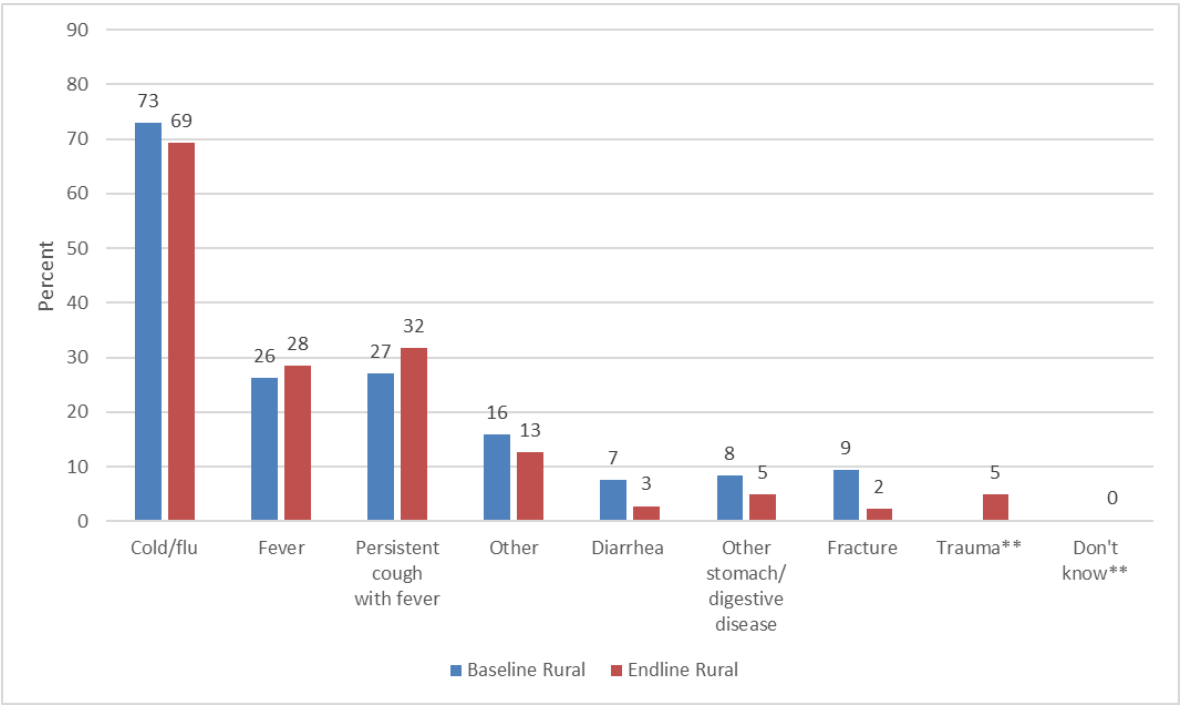




*Endline only

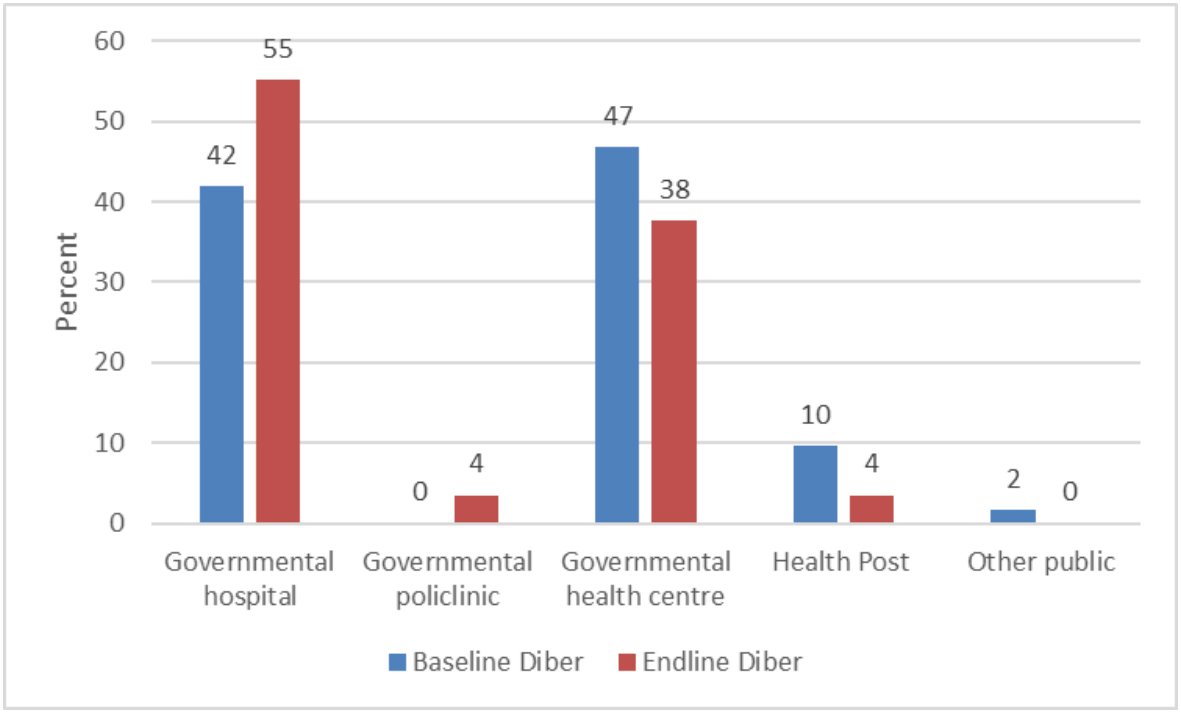
Figure 56: Acute conditions: Baseline Rural (n=107), Urban (n=67); Endline Rural (n=365), Urban (n=190) – *multiple answers*





**Endline only

Figure 57: Public health providers: Baseline Diber (n=62),Fier (n=25); Endline Diber (n=228), Fier (n=131)



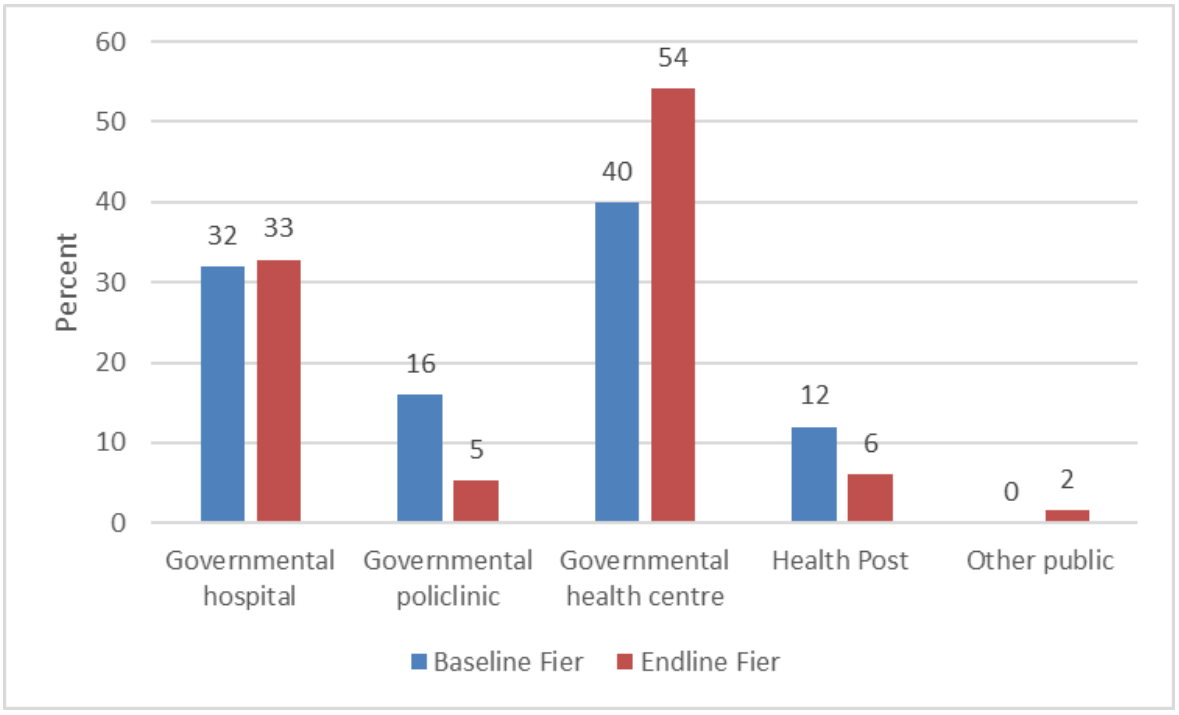
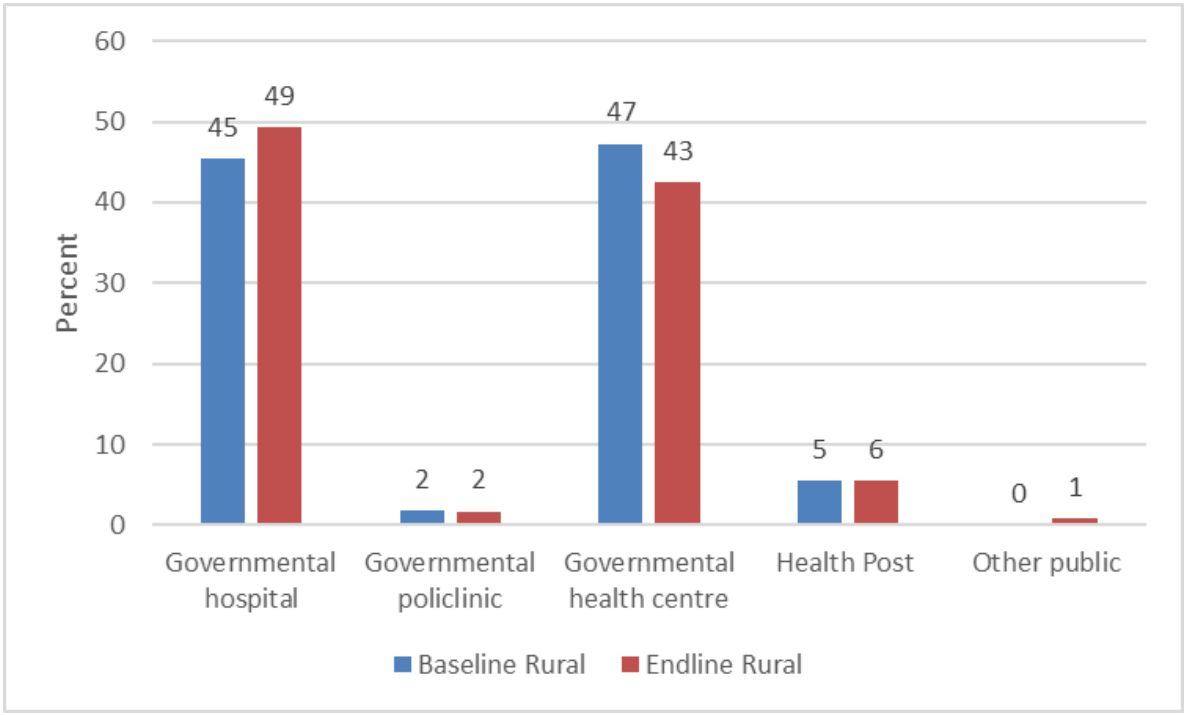


Figure 58: Public health providers: Baseline Rural (n=55), Urban (n=32); Endline Rural (n=235), Urban (n=124)



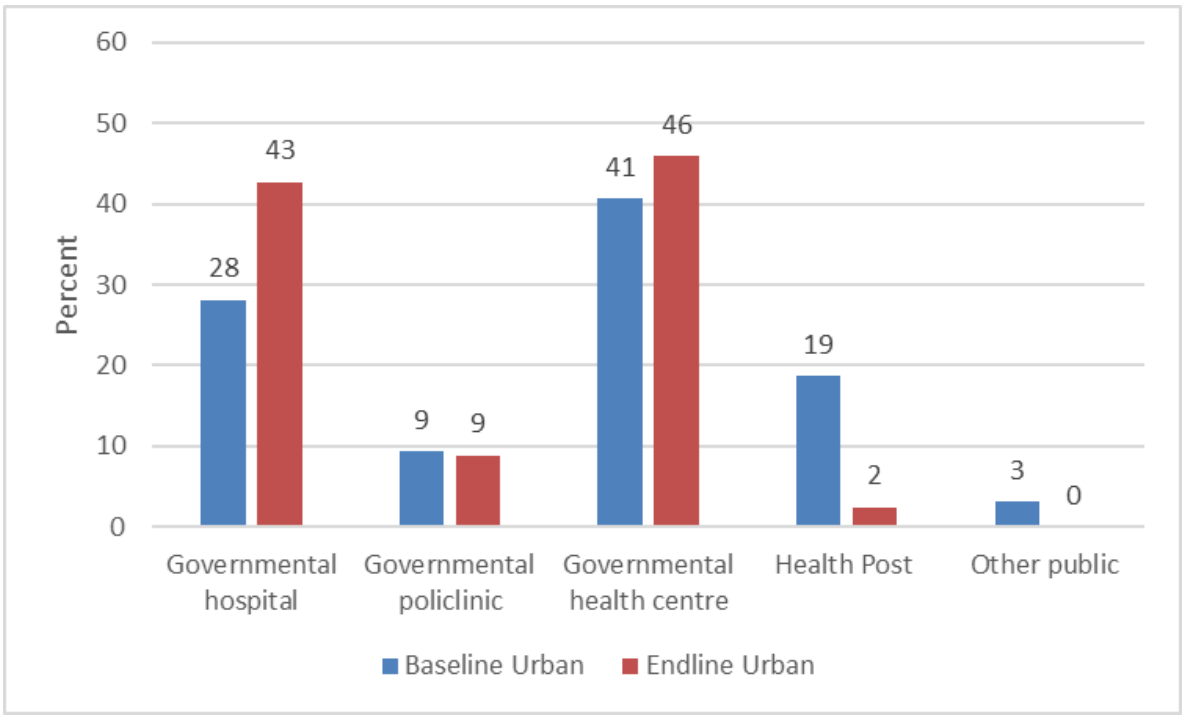
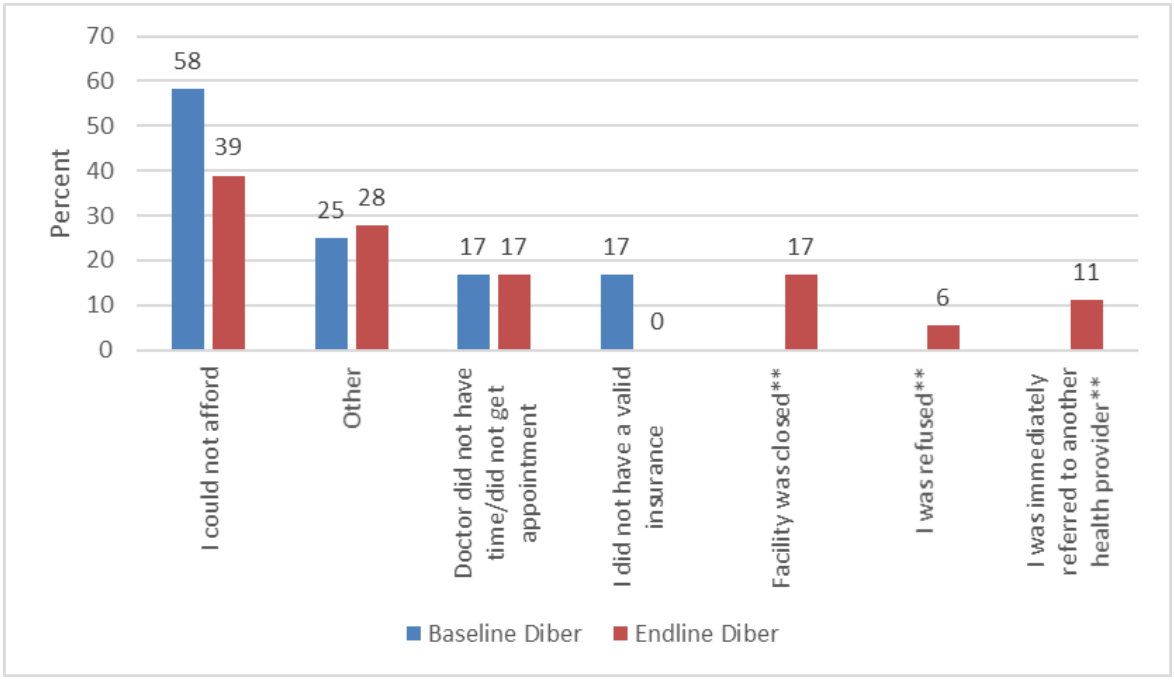
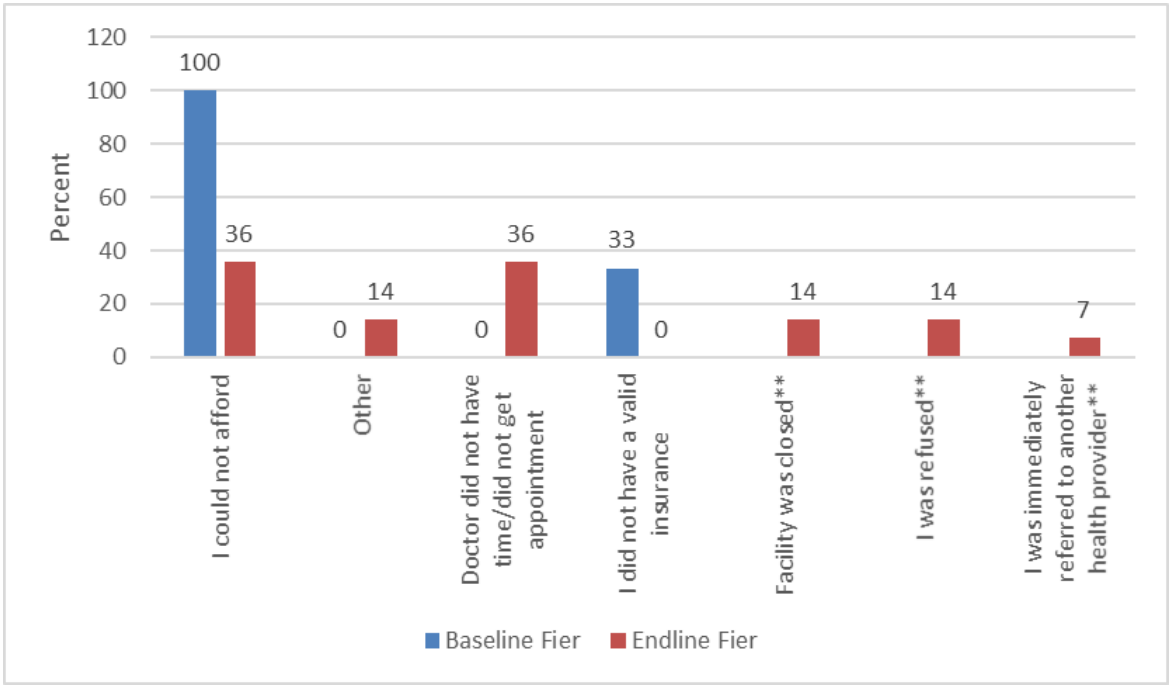


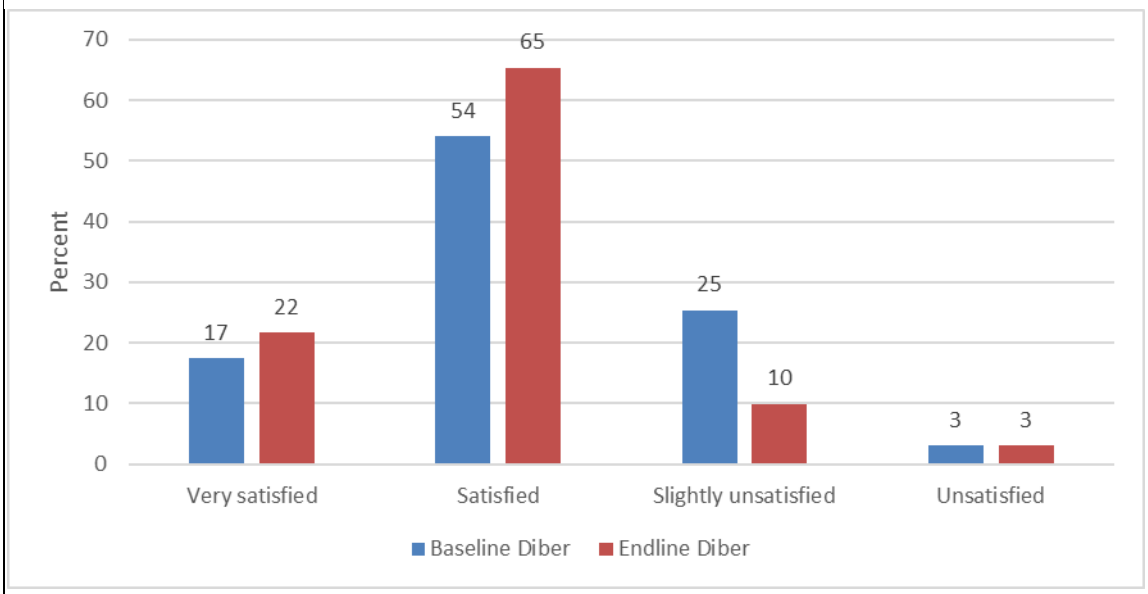
Figure 59: Difficulties for obtaining care for acute conditions: Baseline Diber (n=12), Fier (n=3); Endline Diber (n=323), Fier (n=232) – *multiple answers*





**Endline only

Figure 60: Satisfaction for acute conditions: Baseline Diber (n=63), Fier (n=27); Endline Diber (n=231), Fier (n=136)



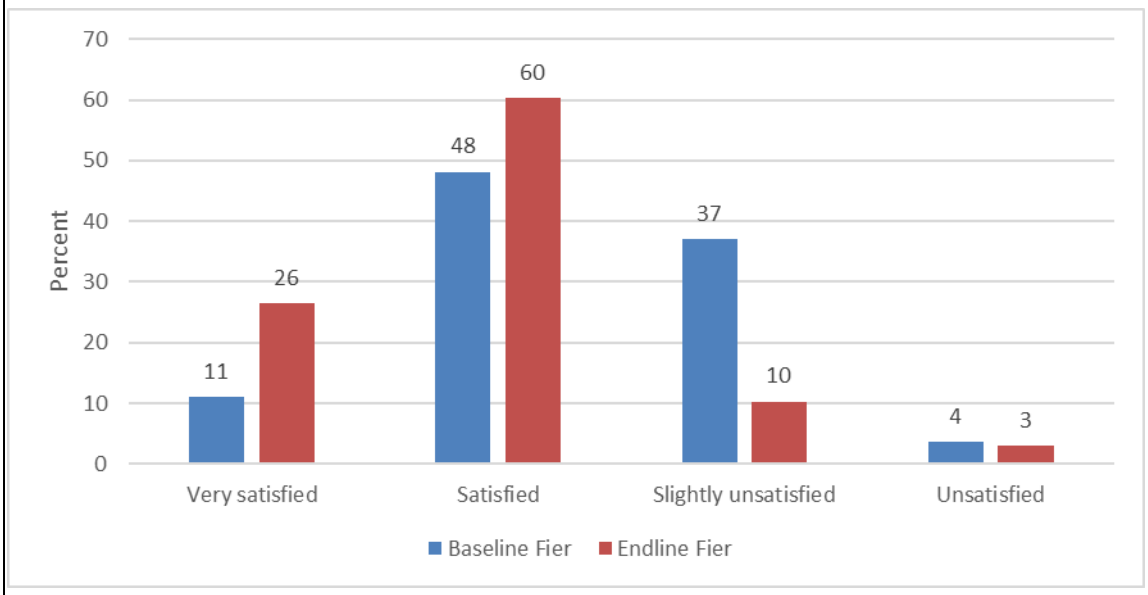
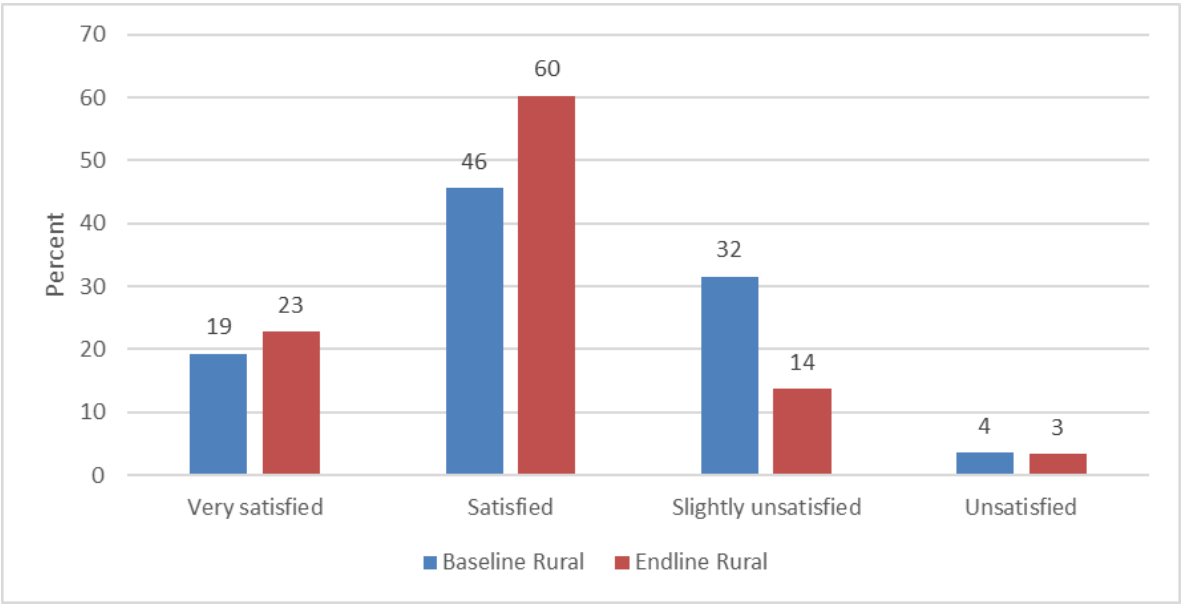


Figure 61: Satisfaction: Baseline Rural (n=57), Urban (n=33); Endline Rural (n=242), Urban (n=125)



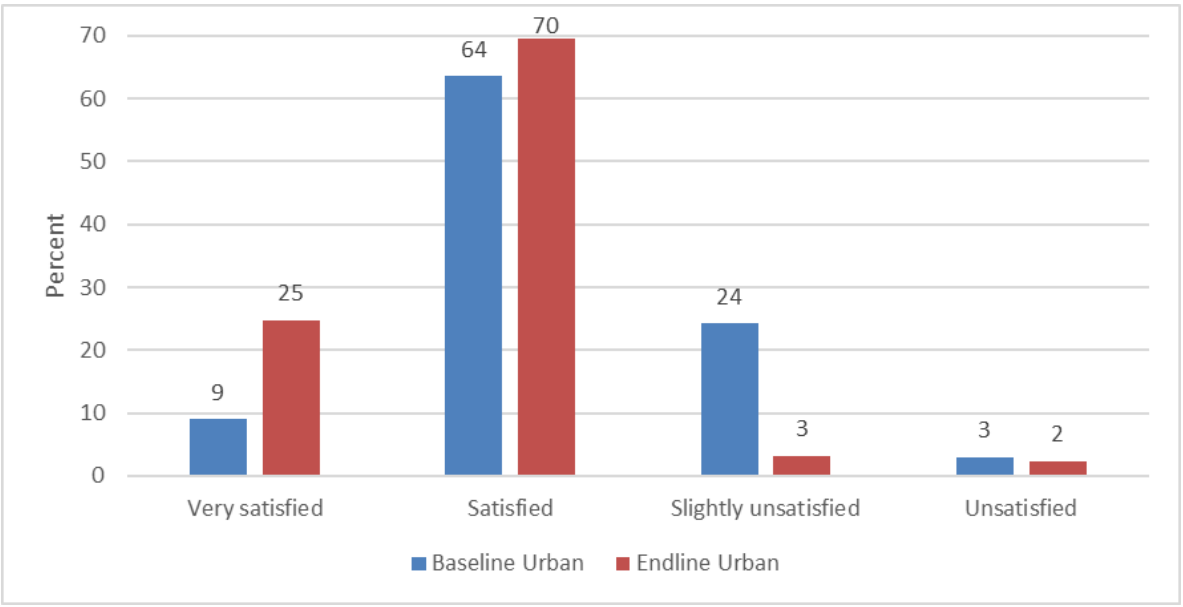
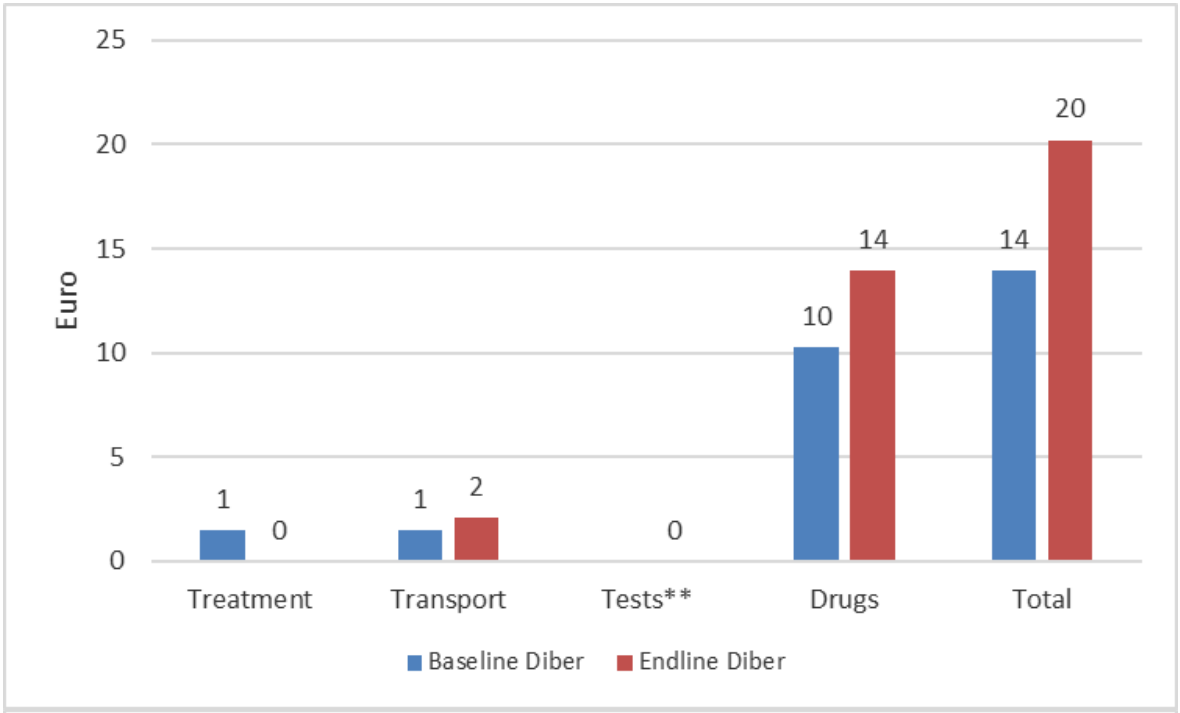
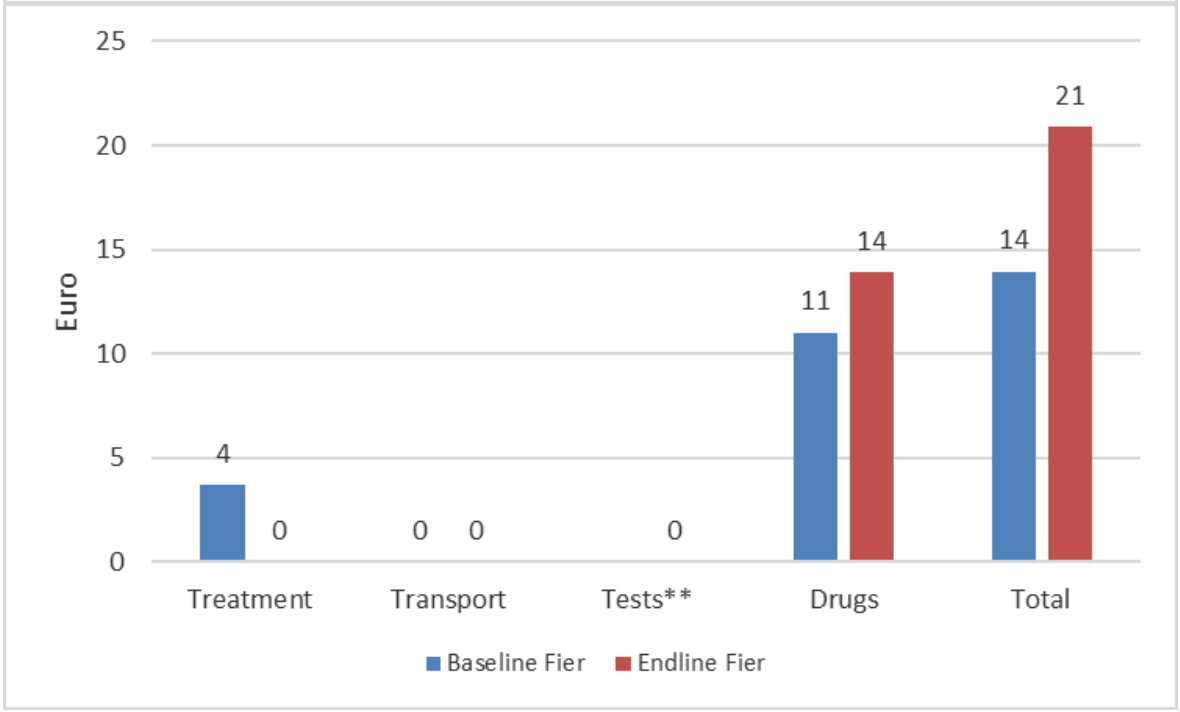


Figure 62: Median Costs (Euro) for Acute Conditions in past 4 weeks: Diber vs. Fier





**Endline only

Figure 63: Median Costs (Euro) for Acute Conditions in past 4 weeks and level of satisfaction with services received

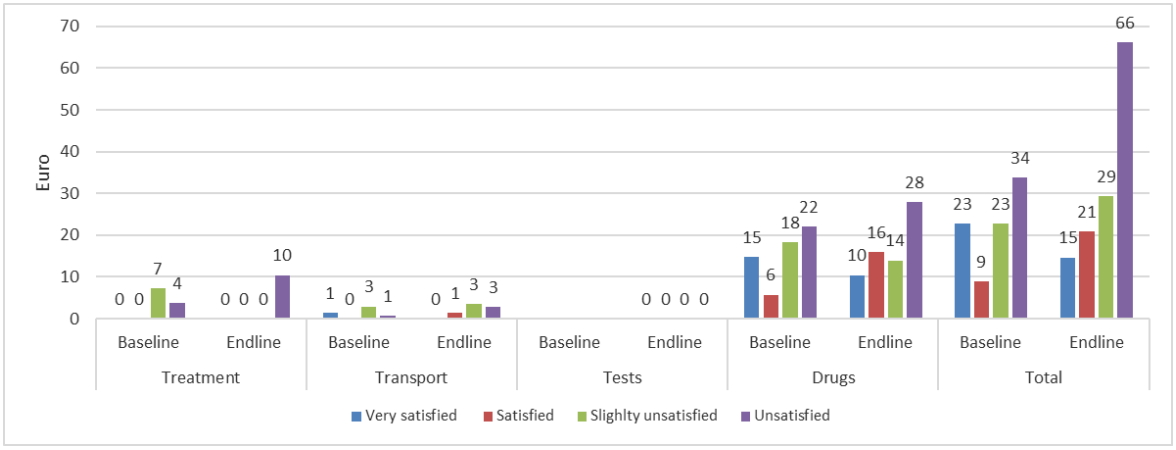
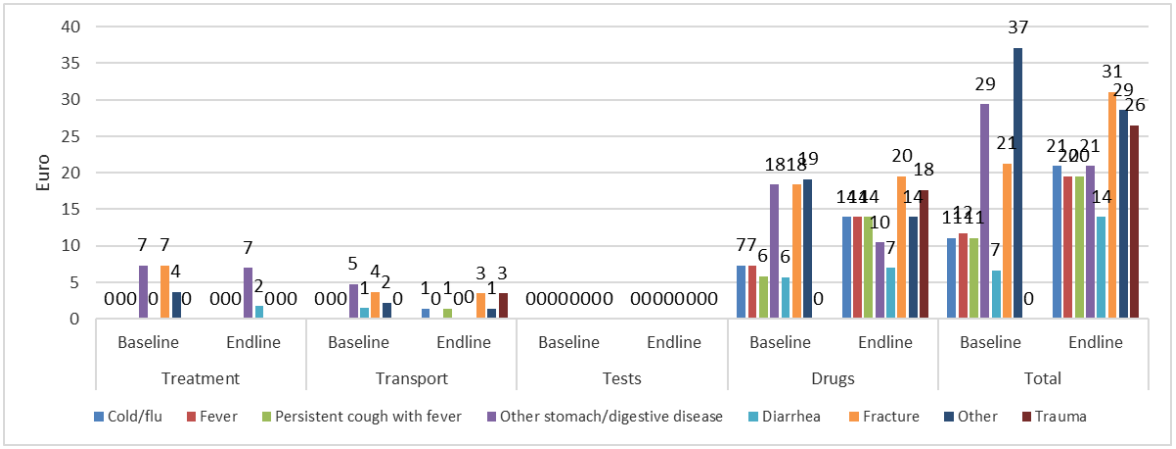
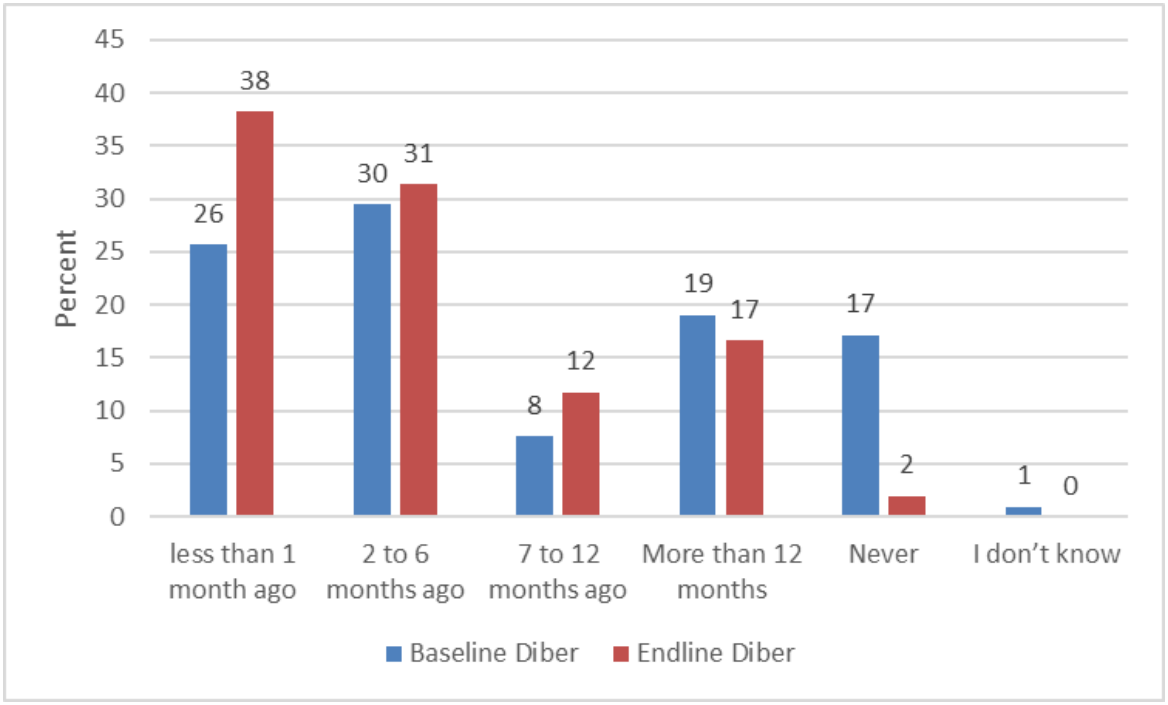


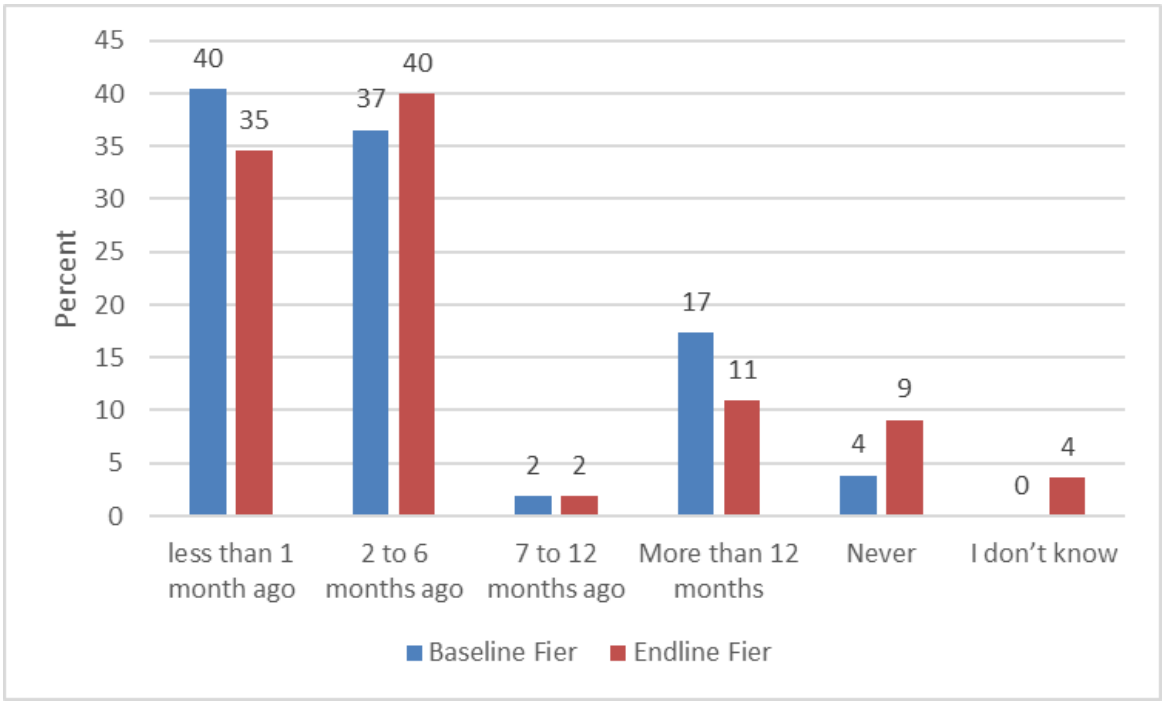
Figure 64: Median Costs (Euro) for Acute Conditions in past 4 weeks and type of acute condition



Annex B.4: Mother and Child Health

Figure 65: Last growth and development check-up





Annex B.5: Knowledge, Attitude and Practice – Child Health

Figure 66: Manifestations of growth and development problems in children (Baseline n=158; Endline n=157) (percentage of correct answer)

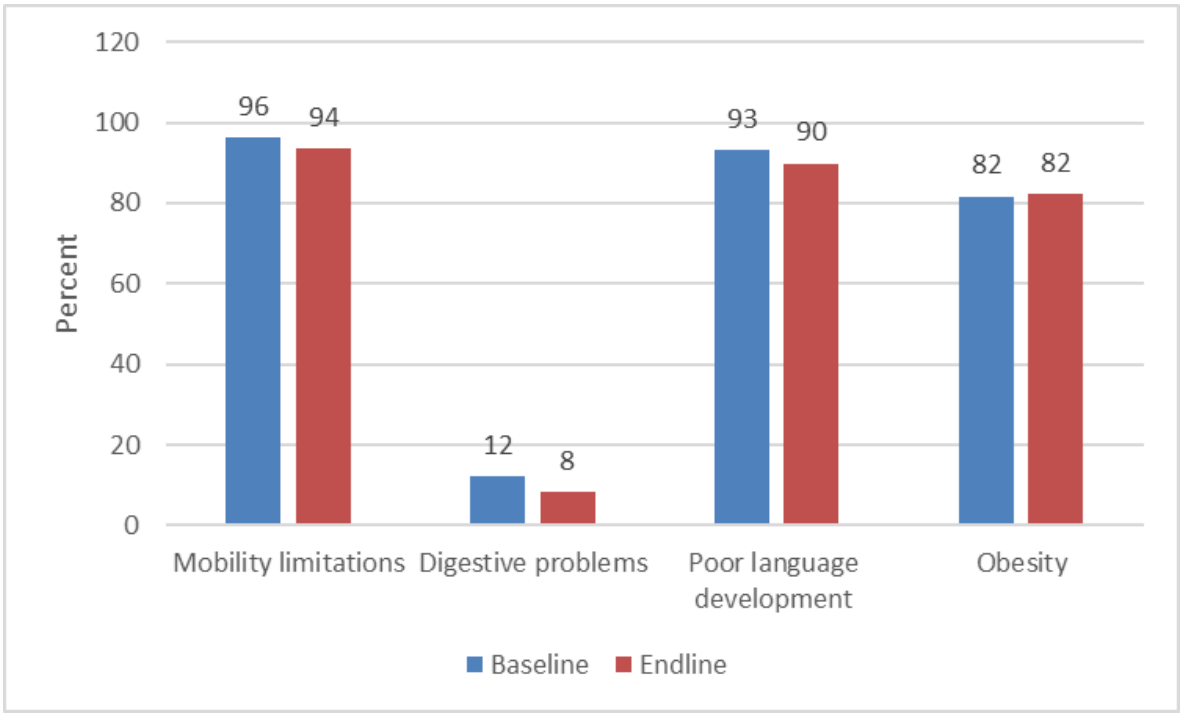


Figure 67: Growth or development problems in a child up to 1 year old (Baseline n=158; Endline n=157) (percentage of correct answer)

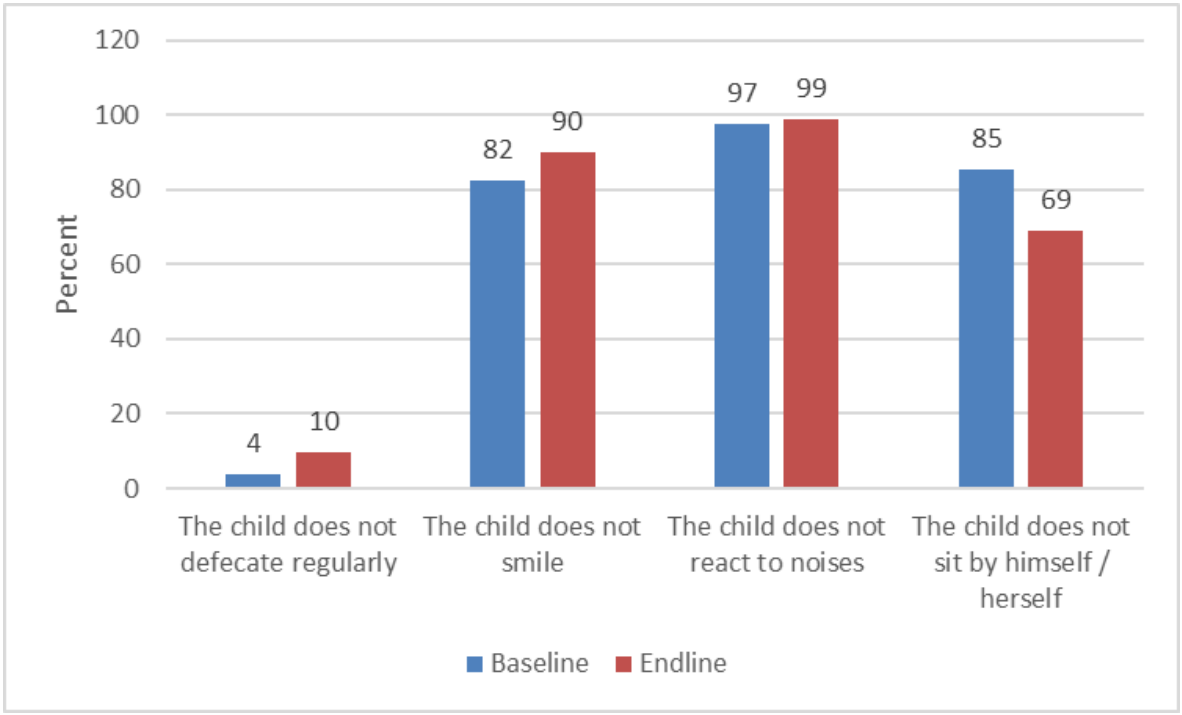


Figure 68: Identification of growth and development problems in children between 1 and 4 years old (Baseline n=158; Endline n=157) (percentage of correct answer)

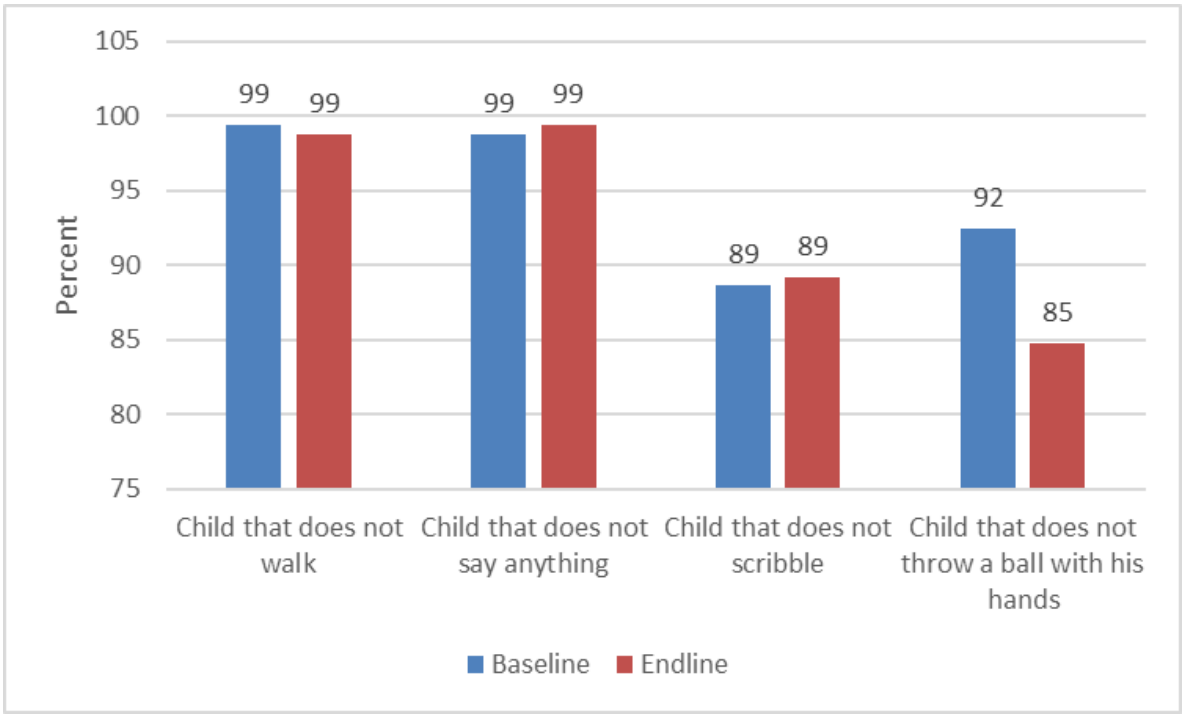
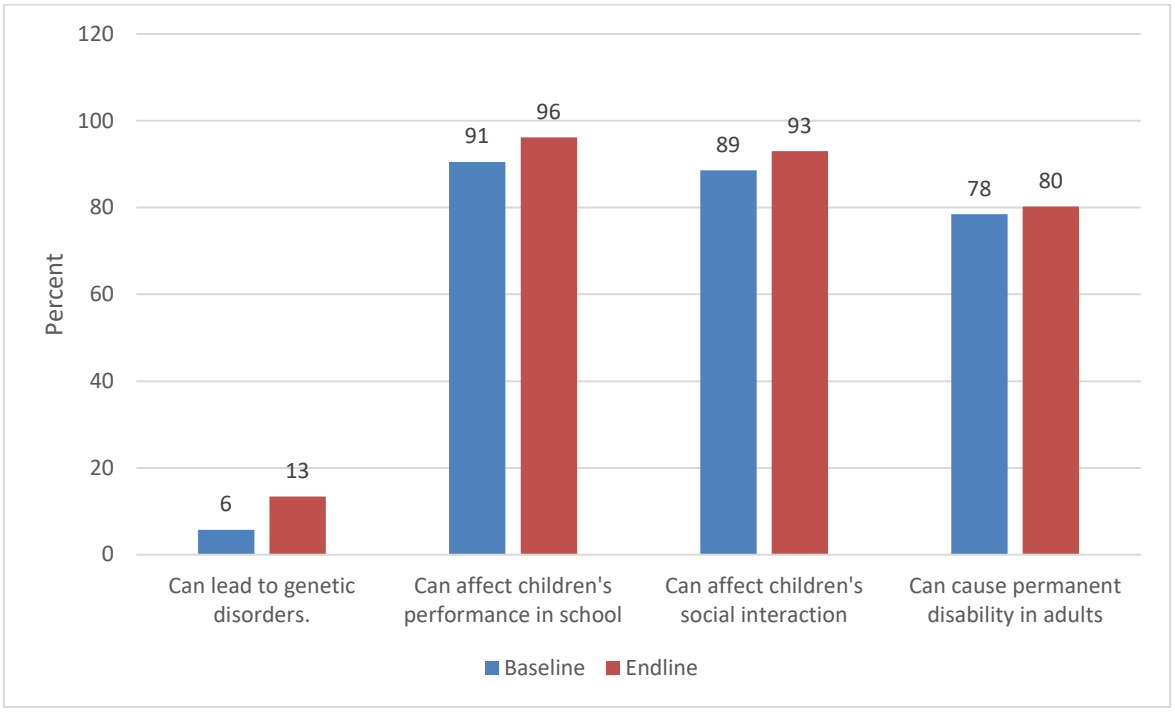


Figure 69: Consequences of growth and development problems during childhood (Baseline n=158; Endline n=157) (percentage of correct answer)



Annex C: Sampled clusters and data collection schedule

No.	Municipality	Location	Village	Team	Data collection day
FIER REGION SAMPLED CLUSTERS					
1	Fier	Urban	Fier Qytet	T1	07/12/2018
2	Fier	Urban	Fier Qytet	T1	07/12/2018
3	Fier	Rural	Peshtan Bregas	T1	08/12/2018
4	Fier	Rural	Kreshpan	T1	08/12/2018
5	Fier	Rural	Cakran i ri	T1	09/12/2018
6	Fier	Rural	Varibop	T1	09/12/2018
7	Fier	Urban	Fier Qytet	T1	10/12/2018
8	Fier	Urban	Fier Qytet	T1	10/12/2018
9	Mallakaster	Rural	Klos	T1	11/12/2018
10	Fier	Rural	Gorishove	T1	11/12/2018
11	Fier	Urban	Fier Qytet	T1	12/12/2018
12	Fier	Urban	Fier Qytet	T1	12/12/2018
13	Mallakaster	Rural	Drenove Fushe	T1	13/12/2018
14	Mallakaster	Rural	Visoke	T1	13/12/2018
15	Fier	Rural	Frakull e madhe	T1	14/12/2018
16	Mallakaster	Rural	Malas	T1	14/12/2018
17	Mallakaster	Urban	Ballsh	T1	15/12/2018
18	Mallakaster	Rural	Qafa e Vidhit	T1	15/12/2018
19	Fier	Rural	Daullas	T1	16/12/2018
20	Fier	Rural	Hoxhare	T1	16/12/2018
21	Fier	Rural	Levan	T1	17/12/2018
22	Fier	Urban	Fier Qytet	T1	17/12/2018
23	Mallakaster	Urban	Ballsh	T1	18/12/2018
24	Fier	Urban	Fier Qytet	T1	18/12/2018
25	Fier	Urban	Fier Qytet	T1	19/12/2018
26	Fier	Urban	Fier Qytet	T1	19/12/2018
27	Lushnje	Urban	Lushnje	T2	07/12/2018
28	Lushnje	Urban	Lushnje	T2	07/12/2018
29	Divjakë	Rural	Spolate	T2	08/12/2018
30	Divjakë	Rural	Remas	T2	08/12/2018
31	Divjakë	Rural	Sulzotaj,	T2	09/12/2018
32	Divjakë	Urban	Divjakë	T2	09/12/2018
33	Lushnje	Urban	Lushnje	T2	10/12/2018

34	Lushnje	Rural	Kamçisht	T2	10/12/2018
35	Lushnje	Rural	Gramsh,	T2	11/12/2018
36	Divjakë	Rural	Cerme Sektor	T2	11/12/2018
37	Lushnje	Rural	Cinar	T2	12/12/2018
38	Lushnje	Rural	Bicakaj	T2	12/12/2018
39	Fier	Rural	Ambulanca Metaj	T2	13/12/2018
40	Fier	Rural	Mbrostar	T2	13/12/2018
41	Lushnje	Urban	Lushnje	T2	14/12/2018
42	Lushnje	Urban	Lushnje	T2	14/12/2018
43	Roskovec	Rural	Kurjan	T2	15/12/2018
44	Roskovec	Rural	Ngjeqar	T2	15/12/2018
45	Lushnje	Rural	Gjaz	T2	16/12/2018
46	Lushnje	Rural	Zhelizhan	T2	16/12/2018
47	Lushnje	Rural	Shakuj	T2	17/12/2018
48	Lushnje	Rural	Lumth	T2	17/12/2018
49	Lushnje	Rural	Dushk	T2	18/12/2018
50	Lushnje	Rural	Plug	T2	18/12/2018
51	Roskovec	Urban	Roskovec	T2	19/12/2018
52	Patos	Urban	Patos	T2	19/12/2018
53	Patos	Urban	Patos	T2	20/12/2018
DIBER REGION SAMPLED CLUSTERS					
No.	**Municipality**	**Location**	**Village**	**Team**	**Data collection day**
1	Peshkopi	Urban	Peshkopi	T3	07/12/2018
2	Peshkopi	Urban	Peshkopi	T3	07/12/2018
3	Diber	Rural	Zall-Rec	T3	08/12/2018
4	Diber	Rural	Laçes	T3	08/12/2018
5	Diber	Rural	Rreth Kale	T3	09/12/2018
6	Diber	Rural	Seliste E siperme	T3	09/12/2018
7	Diber	Rural	Maqellare	T3	10/12/2018
8	Diber	Rural	Burim	T3	10/12/2018
9	Diber	Rural	Pilafe	T3	11/12/2018
10	Diber	Rural	Ushtelenxe	T3	11/12/2018
11	Diber	Rural	Hotesh	T3	12/12/2018
12	Peshkopi	Urban	Peshkopi	T3	12/12/2018
13	Diber	Rural	Trepç	T3	13/12/2018
14	Diber	Rural	Katund i Vogel	T3	13/12/2018

15	Diber	Rural	Borovjan	T3	14/12/2018
16	Diber	Rural	Vranjt	T3	14/12/2018
17	Diber	Rural	Kllobçisht	T3	15/12/2018
18	Diber	Rural	Bllat e Siperm	T3	15/12/2018
19	Diber	Rural	Fushe-Muhurr	T3	16/12/2018
20	Diber	Rural	Muhurr	T3	16/12/2018
21	Peshkopi	Urban	Peshkopi	T3	17/12/2018
22	Peshkopi	Urban	Peshkopi	T3	17/12/2018
23	Bulqize	Urban	Bulqizë	T3	18/12/2018
24	Bulqize	Urban	Bulqizë	T3	18/12/2018
25	Bulqize	Urban	Bulqizë	T3	19/12/2018
26	Bulqize	Urban	Bulqizë	T3	19/12/2018
27	Mat	Urban	Burrel	T4	07/12/2018
28	Mat	Urban	Burrel	T4	07/12/2018
29	Bulqize	Rural	Peshk	T4	08/12/2018
30	Bulqize	Rural	Kraste	T4	08/12/2018
31	Bulqize	Rural	Çerenc i Siperem	T4	09/12/2018
32	Bulqize	Rural	Llodomirice	T4	09/12/2018
33	Mat	Rural	Prell	T4	10/12/2018
34	Mat	Urban	Burrel	T4	10/12/2018
35	Bulqize	Rural	Gjorice e Poshtme	T4	11/12/2018
36	Bulqize	Rural	Okshatine	T4	11/12/2018
37	Bulqize	Rural	Sopot	T4	12/12/2018
38	Bulqize	Rural	Zerqan	T4	12/12/2018
39	Klos	Rural	Dom	T4	13/12/2018
40	Klos	Urban	Klos	T4	13/12/2018
41	Bulqize	Rural	Dushaj	T4	14/12/2018
42	Bulqize	Rural	Godvi	T4	14/12/2018
43	Mat	Rural	Karice	T4	15/12/2018
44	Mat	Urban	Burrel	T4	15/12/2018
45	Klos	Rural	Skënderaj	T4	16/12/2018
46	Klos	Rural	Suç	T4	16/12/2018
47	Mat	Rural	Batër e Vogël	T4	17/12/2018
48	Mat	Rural	Frankth	T4	17/12/2018
49	Klos	Rural	Gurre e vogel	T4	18/12/2018
50	Klos	Rural	Shulbater	T4	18/12/2018

51	Klos	Urban	Klos	T4	19/12/2018
52	Klos	Urban	Klos	T4	19/12/2018
53	Mat	Urban	Burrel	T4	20/12/2018

Annex D: Knowledge, Attitude and Practice – Questionnaire

Annex D.1: Cardiovascular, diabetes & obesity

Question	Answers	correct	Category
Which risk factors for cardiovascular disease do you know? (do not read responses)	Diabetes High blood pressure Obesity Smoking / tobacco use (Nos) High cholesterol / high blood fat Unhealthy diet Physical inactivity Family history / genetics Age Stress Other None	(1-9)	Knowledge
Cardiovascular knowledge			
Which of the following is a typical symptom of a heart attack?	a) Left-sided chest pain b) Headache c) Feeling thirsty d) Pain in the legs	a	Knowledge
Which of the following is not a typical symptom of heart attack?	a) Difficulty breathing b) Left-sided chest pain c) Headache d) Loss of consciousness	c	Knowledge
What should you do, if someone suddenly experienced strong pain on the left side of the chest, which is irradiating into the left arm?	a) Wait for the symptoms to go away b) Give pain killers c) Go immediately to the hospital, or if not available to the doctor d) Go to the doctor if the symptoms last longer than 2 days	c	Knowledge
Which of the following is not a complication of high blood pressure?	a) Heart disease b) Stroke (brain infarct) c) Muscle weakness d) Problems with seeing	c	Knowledge
Patients easily recognize high blood pressure because of the symptoms.	Yes / No / Don't know	No	Knowledge
High blood pressure can cause a feeling of numbness in the feet.	Yes / No / Don't know	No	Knowledge
Heart attack is a frequent cause of death.	Yes / No / Don't know	Yes	Knowledge
Eating less salt can have a good effect on blood pressure.	Yes / No / Don't know	Yes	Knowledge
Most people with cardiovascular disease know that they are sick.	Yes / No / Don't know	No	Knowledge
People with high blood pressure only have to take medication when the blood pressure is high.	Yes / No / Don't know	No	Knowledge
Diabetes and high blood pressure can cause kidney disease.	Yes / No / Don't know	Yes	Knowledge

Question	Answers	correct	Category
Diabetes knowledge			
Which of the following is not a typical symptom caused by diabetes?	a) Frequent need to urinate b) Lower back pain c) Tiredness d) Unexplained weight loss	b	Knowledge
Which of the following is not a complication of diabetes?	a) Problems with breathing b) Problems with seeing c) Slow wound healing d) Foot numbness	a	Knowledge
Which of the following foods is the healthiest for a person with diabetes or high blood pressure?	a) Fruits and Vegetables b) Bread c) Fatty meat d) Fried food	a	Knowledge
Patients with diabetes should regularly check their feet for wounds which do not heal.	Yes / No / Don't know	Yes	Knowledge
Patients with diabetes regularly taking medication don't have to check their blood sugar levels regularly.	Yes / No / Don't know	No	Knowledge
Consuming too much sugary foods can be a cause of diabetes.	Yes / No / Don't know	Yes	Knowledge
In diabetes patients, the insulin system works normally.	Yes / No / Don't know	No	Knowledge
Diabetes is a common cause of problems with seeing.	Yes / No / Don't know	Yes	Knowledge
Women have to check their blood sugar levels during pregnancy.	Yes / No / Don't know	Yes	Knowledge
Diabetes can be cured.	Yes / No / Don't know	No	Knowledge
Children of persons with diabetes are more likely to get the disease than children from healthy families.	Yes / No / Don't know	Yes	Knowledge
Obesity knowledge			
How often should you do physical exercise to stay healthy?	a) 10 minutes per day on 3 days per week b) 2 hours once in a week c) 2 hours every day d) 30 minutes every day	d	Knowledge
Which of the following statements is not true?	a) Overweight people have a higher risk of getting diabetes. b) Regular physical exercise has a good effect on blood sugar levels. c) Gaining weight increases the risk of getting high blood pressure. d) Regular physical exercise increases the risk of getting high blood pressure.	d	Knowledge

Question	Answers	correct	Category
Obese people often also have high blood pressure.	Yes / No / Don't know	Yes	Knowledge
Eating little sugar and fat does not help to reduce weight.	Yes / No / Don't know	No	Knowledge
Health Beliefs			
How much do you agree with the following statement: "Overweight people are healthier."?	Disagree / Rather disagree /Rather agree / Agree		Health Belief
How much do you agree with the following statement: "The most frequent cause of headache is a high blood pressure."?	Disagree / Rather disagree /Rather agree / Agree		Health Belief
How much do you agree with the following statement: "Smoking or taking nos does not have an effect on health."?	Disagree / Rather disagree /Rather agree / Agree		Health Belief
How much do you agree with the following statement: "I think that changing my lifestyle today will not have any effect on my health later in life."?	Disagree / Rather disagree /Rather agree / Agree		Health Belief
How much do you agree with the following statement: "I cannot influence my health because it depends on the doctors."?	Disagree / Rather disagree /Rather agree / Agree		Health Belief

Annex D.2: Child health & development

Questions/Items	Answer categories	Correct	Dimension
Which of the following statements is correct regarding children's development?			
Child development starts from pregnancy	Yes / No / Don’t know	Yes	Knowledge
Child development refers to the progressive gain of mental, social, emotional and physical skills by the child	Yes / No / Don’t know	Yes	Knowledge
Child development refers only to physical growth	Yes / No / Don’t know	No	Knowledge
Child development problems could be difficult to identify	Yes / No / Don’t know	Yes	Knowledge
Growth and development problems in children			
Which of the following can be manifestations of growth and development problems in children?			

Mobility limitations	Yes / No / Don't know	Yes	Knowledge
Digestive problems	Yes / No / Don't know	No	Knowledge
Poor language development	Yes / No / Don't know	Yes	Knowledge
Obesity	Yes / No / Don't know	Yes	Knowledge
Growth and development risk factors in children			
Please state whether or not the following conditions are risk factors for children's growth and development?			
Parental abuse of drugs and alcohol	Yes / No / Don't know	Yes	Knowledge
Physical activity	Yes / No / Don't know	No	Knowledge
Lack or late enrolment of mothers in antenatal care during pregnancy	Yes / No / Don't know	Yes	Knowledge
Showing love to the child	Yes / No / Don't know	No	Knowledge
Child birth before 37th week of pregnancy	Yes / No / Don't know	Yes	Knowledge
Living in rural areas	Yes / No / Don't know	No	Knowledge
Parents being close relatives	Yes / No / Don't know	Yes	Knowledge
Down syndrome or autism	Yes / No / Don't know	Yes	Knowledge
Occasional colds during childhood	Yes / No / Don't know	No	Knowledge
Parents with mental health problems	Yes / No / Don't know	Yes	Knowledge
Inadequate or insufficient child feeding	Yes / No / Don't know	Yes	Knowledge
Poor child care, stimulation and upbringing	Yes / No / Don't know	Yes	Knowledge
Child abuse	Yes / No / Don't know	Yes	Knowledge
Domestic violence	Yes / No / Don't know	Yes	Knowledge
Insufficient economic or social resources	Yes / No / Don't know	Yes	Knowledge
Having sick siblings	Yes / No / Don't know	No	Knowledge
Sharing the house with relatives	Yes / No / Don't know	No	Knowledge
Identification of growth and development problems in children up to 1 year old			
Which of the following cases is a growth or development problem in a child up to 1 year old?			
the child does not defecate regularly	Yes / No / Don't know	No	Knowledge
the child does not smile	Yes / No / Don't know	Yes	Knowledge
the child does not react to noises	Yes / No / Don't know	Yes	Knowledge
the child does not sit by himself / herself	Yes / No / Don't know	Yes	Knowledge
Identification of growth and development problems in children between 1 and 4 years old			
Which of the following cases is a growth or development problem in a child between 1 and 4 years old?			
child that does not walk	Yes / No / Don't know	yes	Knowledge
child that does not say anything	Yes / No / Don't know	yes	Knowledge

child that does not scribble	Yes / No / Don’t know	yes	Knowledge
child that does not throw a ball with his hands	Yes / No / Don’t know	yes	Knowledge
Consequences of growth and development problems during childhood			
What are consequence of development problems during childhood?			
Development problems can lead to genetic disorders.	Yes / No / Don’t know	No	Knowledge
Development problems can affect children's performance in school	Yes / No / Don’t know	Yes	Knowledge
Development problems can affect children's social interaction	Yes / No / Don’t know	Yes	Knowledge
Development problems can cause permanent disability in adults	Yes / No / Don’t know	Yes	Knowledge
Knowledge on children			
At which age should a child sit by himself?	up to 3 months 3 to 9 months 9 to 12 months Don't know	3 to 9 months	Knowledge
At which age should a child react to noises?	up to 3 months 3 to 9 months 9 to 12 months Don't know	3 to 9 months	Knowledge
At which age should a child walk?	up to 9 months between 9 and 18 months 18 - 24 months Don't know	between 9 and 18 months	Knowledge

Annex E: Log-frame indicators informed by HH survey

Indicator	Indicator definition	Datasource and means of verification	Frequency of data collection	Baseline value	Endline value
Overall goal: The Albanian population benefit from better health thanks to improved primary health care services and health promotion activities					
Outcome 2: Citizens in target regions have increased access to decentralized, quality primary health services. More health conscious citizens contribute through increased participation towards an accountable and responsive health system					
% of infants who received post-natal care with 2 days of childbirth	Numerator: Number of infants receiving post-natal care by PHC nurse/doctor subsequent to delivery within 2 days Denominator: Number of infants of mothers registered in Qarks covered by the project	HH Survey Study Health information system DHS 2017-2018	Baseline and end phase study	74% 56% (in the first 14 days when being at home)	80% 87% (in the first 14 days when being at home)
% of population (measured at household level) are well informed about chronic conditions and maternal and child health.	Numerator: Number of correct answers (define the well informed concept) Denominator: Number of interviewer taking part in the HH Survey	HH survey	Baseline & Endline Phase 1	22% of interviewees could cite at least 2 risk factors for chronic conditions; 81.5% of mothers state correct answers related to children's development	27% of interviewees could cite at least 2 risk factors for chronic conditions; another 21% three risk factors; 82.5% of mothers state correct answers related to children's development
% increase or decrease in household health expenditure by type of expenses (transportation, medicines, fees, etc.) in comparison with the findings of the HH survey.	as defined in the HH survey protocol • Out of pocket expenditure for medicine • Out of pocket expenditure for travel to providers • Out of pocket payment to health providers	HH survey	Baseline & Endline Phase 2	Expenditures of patients with a chronic condition: Treatment: Median: 0 LEK/ 0 Euro Transport: Median: 60 LEK / 0.5 Euro Drugs: Median 2000 LEK / 14 Euro Expenditures of patients with an acute condition: Treatment: Median: 500 LEK/ 4 Euro Transport: Median: 100 LEK / 0.7 Euro Drugs: Median 1500 LEK / 11 Euro	Expenditures of patients with a chronic condition (inflation adjusted): Treatment: Median: 0 LEK/ 0 Euro Transport: Median: 190 LEK / 1 Euro Drugs: Median 2277 LEK / 17 Euro Tests: Median 0 LEK / 0 Euro Expenditures of patients with an acute condition (inflation adjusted): Treatment: Median: 0 LEK/ 0 Euro Transport: Median: 190 LEK / 1 Euro Drugs: Median 1898 LEK / 14 Euro Test: Median 0 LEK/ 0 Euro