Swiss Agency for Development and Cooperation (SDC)

HAP3: ASSESSMENT OF QUALITY OF CARE IN PRIMARY HEALTH CARE IN ALBANIA

2025 Survey

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Final Report

14 April 2026

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Financed by the Swiss Agency for Development and Cooperation

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Swiss Agency for Development and Cooperation SDC

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ABBREVIATIONS

HAP	Health for All Project
HC	Health Center
IPH	Institute of Public Health
LUHC	Local Units of Health Care
MoHSP	Ministry of Health and Social Protection
ODK	Open Data Kit
PHC	Primary Health Care
SARA	Service Availability and Readiness Assessment
SDC	Swiss Agency for Development and Cooperation
SCIH	Swiss Center for International Health
Swiss TPH	Swiss Tropical and Public Health Institute
QoC	Quality of Care
WHO	World Health Organization

EXECUTIVE SUMMARY

The “Health for All” (HAP) project in Albania was implemented in two initial phases (HAP1, 2015-2018, and HAP2, 2019-2023) in the pilot regions of Dibër and Fier, followed by the third phase (HAP3 Consolidation Phase), launched in April 2023 and running until December 2026. HAP3 has progressively expanded from the original two regions to additional regions, including Shkodër, Durrës, Tiranë, Elbasan, Korçë and Berat, and operates through 20 Local Units of Health Care (LUHCs) across these areas. While the earlier phases were geographically concentrated and enabled intensive, hands-on support including comprehensive training of all providers in targeted health centres (HCs) and rehabilitation of 30 HCs, HAP3 represents a shift toward a more decentralized model, with more distant supervision and follow-up by the central implementation team. The focus is on capacity building and peer learning, technical guidance and facilitation, and the systematic provision of essential primary health care equipment and selected supplies to intervention HCs, while implementation ownership rests primarily with the HCs and LUHCs. Importantly, direct, facility-wide training and infrastructure rehabilitation are not part of the expansion model.

In the framework of the HAP project, repeated cross-sectional, HC-based surveys were conducted to measure quality of care (QoC). The first survey was conducted in April/May 2015, at the beginning of HAP phase 1 (HAP1) and served as a baseline. The second survey was conducted in July/August 2018 and served, at the same time, as the endline of HAP1 and as the baseline for HAP2. The third survey conducted in October/November 2022 served as the HAP2 endline. The surveys were conducted in the HAP intervention regions, namely Fier and Dibër, and included the same 38 HC in all years, thereof 18 in Fier and 20 in Dibër. In 2025, a fourth QoC survey was conducted to assess the potential impact of HAP3 using a comparative design, including 24 HAP3-supported HCs (intervention) and 24 non-supported HCs (comparison), as well as a longitudinal assessment of QoC trends in Fier across 2015, 2018, 2022 and 2025.

In all surveys, data was collected on three dimensions of QoC in the selected HC:

1. Quality of doctor-patient interactions through doctor-patient observations
2. Patient satisfaction after consultation through patient exit interviews
3. Quality of the health centre infrastructure through a HC assessment tool

Scores were calculated to combine a number of indicators of an assessed topic and obtain an overall achievement score for the given topic. Five score categories were defined: (1) 0-19; (2) 20-39; (3) 40-59; (4) 60-79; and (5) 80-100. For example, if 31 items of ‘basic medical equipment‘ were assessed for availability in the surveyed HC and a HC had 5 items out of 31 items available, this translates to 16.1% of total possible items available. Thus, this HC would be in the score category 0-19. Or, if 22/31 items are available, the score is 71.0% and the category is (4) 60-79.

Importantly, a key limitation of this survey was that the distinction between intervention and comparison HCs was not clear-cut. Under HAP phase 3, support shifted from intensive, direct facility-level engagement to a broader system-level scale-up approach delivered mainly through LUHCs and Operators in different areas, meaning that effects at individual HC level may still be emerging and less immediately visible than under the earlier, more hands-on phases. At the same time, implementation intensity was not uniform across intervention HCs, as cascade training and dissemination of paper protocols were not consistently taken up in all facilities. Conversely, comparison HCs were not fully unexposed: some benefited indirectly from HAP-supported protocols, materials, peer-group activities, or LUHC-led dissemination, creating contamination of the comparison group. Together, these factors reduced the contrast between intervention and comparison HCs and limit causal attribution, which may partly explain why comparison facilities performed similarly to, or in some domains better than, intervention facilities. However, overall, intervention facilities have shown steady improvements over the 10-year period surveyed.

Considering these limitations, the main findings were:

Quality of the HC infrastructure measured through a health centre assessment tool (structural attributes):

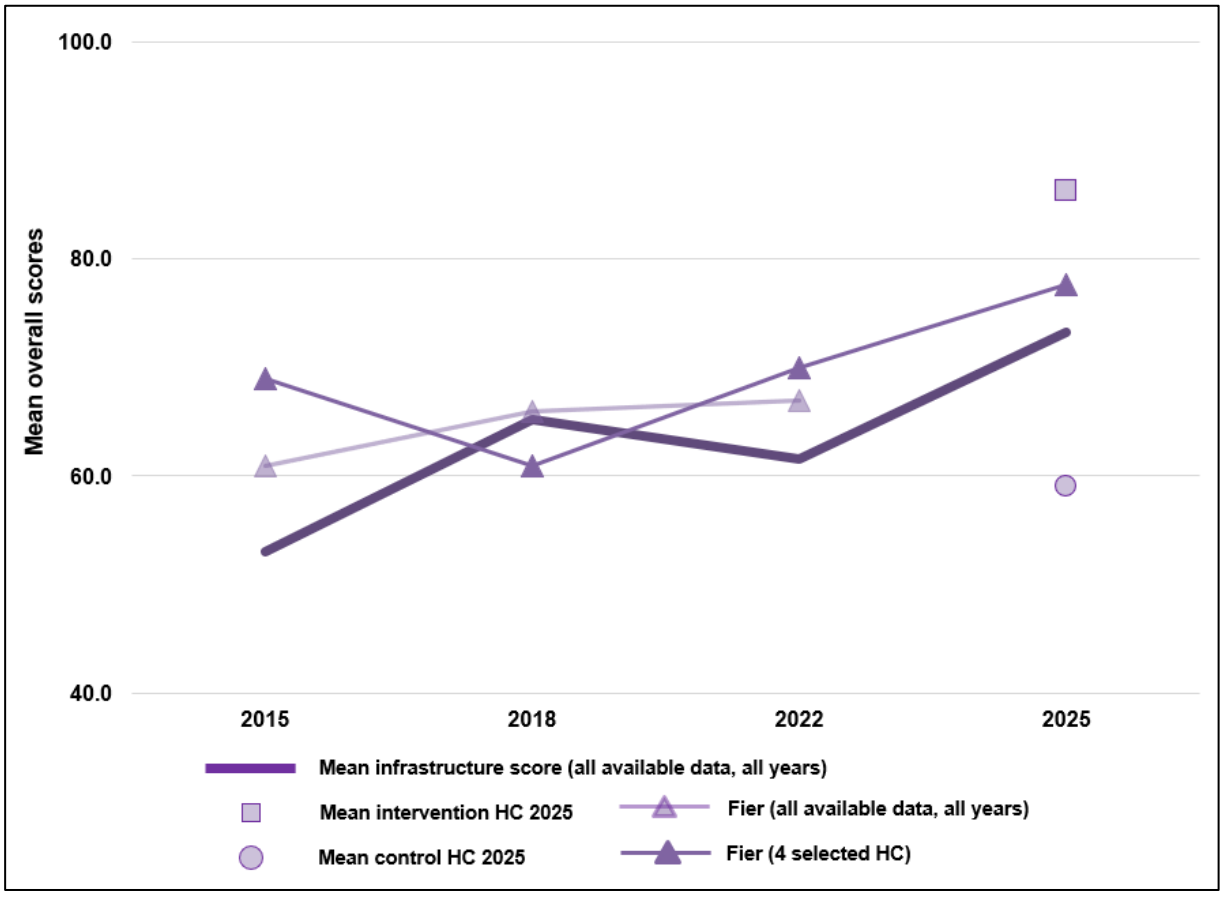
Quality of the infrastructure captured structural attributes such as facility cleanliness, maintenance, equipment functionality, and availability of essential utilities and materials in the surveyed HC between 2015 and 2025 (Figure 1). **Overall, a steady improvement in HC infrastructure quality was observed over the ten-year period**, with mean overall ("all-years-all-HC") scores rising from approximately 55 in 2015 to nearly 75 in 2025 (thick line). After minor fluctuations in 2018 and 2022, scores improved again in 2025, reaching the highest levels recorded.

In 2025, intervention HCs achieved the highest structural quality scores, exceeding 80 points, while comparison HCs scored lower (around 60), suggesting a clear effect of targeted support and infrastructure investments.

In Fier, scores for all HCs show gradual improvement (2015-2022), with the four selected Fier HCs outperforming the broader regional average by 2022 and still improving thereafter until 2025.

These overall results indicate notable progress in facility conditions and equipment standards, especially in supported HCs, reflecting the impact of continued investments in physical infrastructure and health system strengthening.

Figure 1: Summary scores for infrastructure



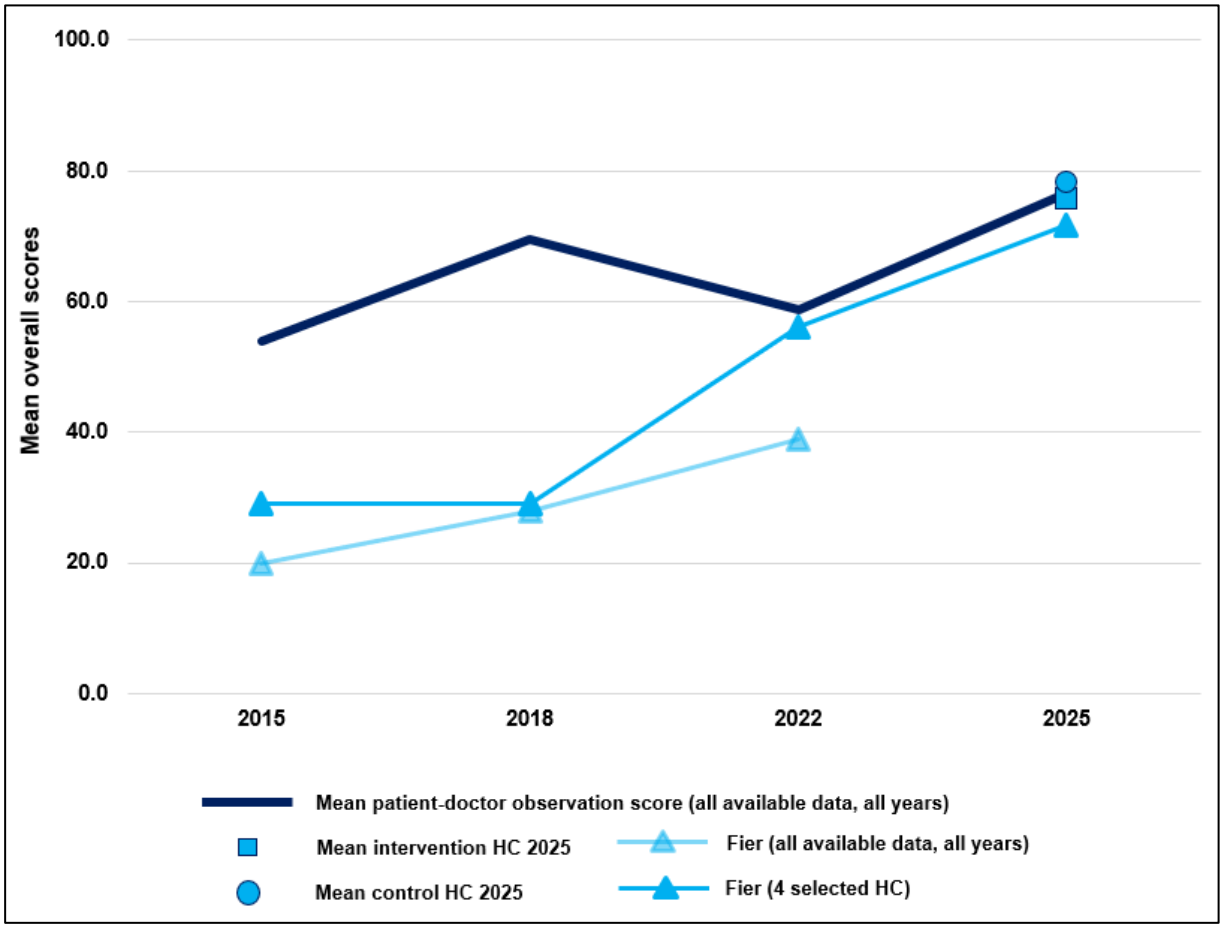
Quality of doctor-patient interactions measured through doctor-patient observations (process attributes):

Overall, a steady improvement in consultation quality (patient-doctor observation scores) over the ten-year period (2015-2025) was observed, with mean "all-years-all-HC" scores rising from around 55 in 2015 to nearly 80 in 2025 (dark blue line) was observed (Figure 2). After a moderate decline in 2022, the upward trend resumed sharply by 2025, reaching the highest recorded levels.

Both intervention and comparison HCs in 2025 achieved comparably high mean scores, suggesting that consultation quality has improved across the primary care network, not only in supported HC. Overall, the findings highlight sustained progress in patient-centred care and clinical practice quality, reflecting continued capacity building and institutional learning over successive years of implementation.

In Fier, patient-doctor observation scores followed a similar but more gradual trajectory, starting from a lower baseline and improving substantially over time. The four selected Fier HCs in 2025 had already achieved higher scores than the regional average by 2022 and have shown further improvement by 2025, reaching parity with other surveyed intervention and comparison HCs.

Figure 2: Summary scores for quality of doctor-patient interactions



Patient satisfaction measured by exit interviews after consultation (outcome attributes):

Overall, patient satisfaction levels measured between 2015 and 2025 through patient exit interviews remained consistently high throughout the ten-year period, with mean "all-years-all-HC" scores staying around or above 85% (thick dark red line) (Figure 3). Following a rise from

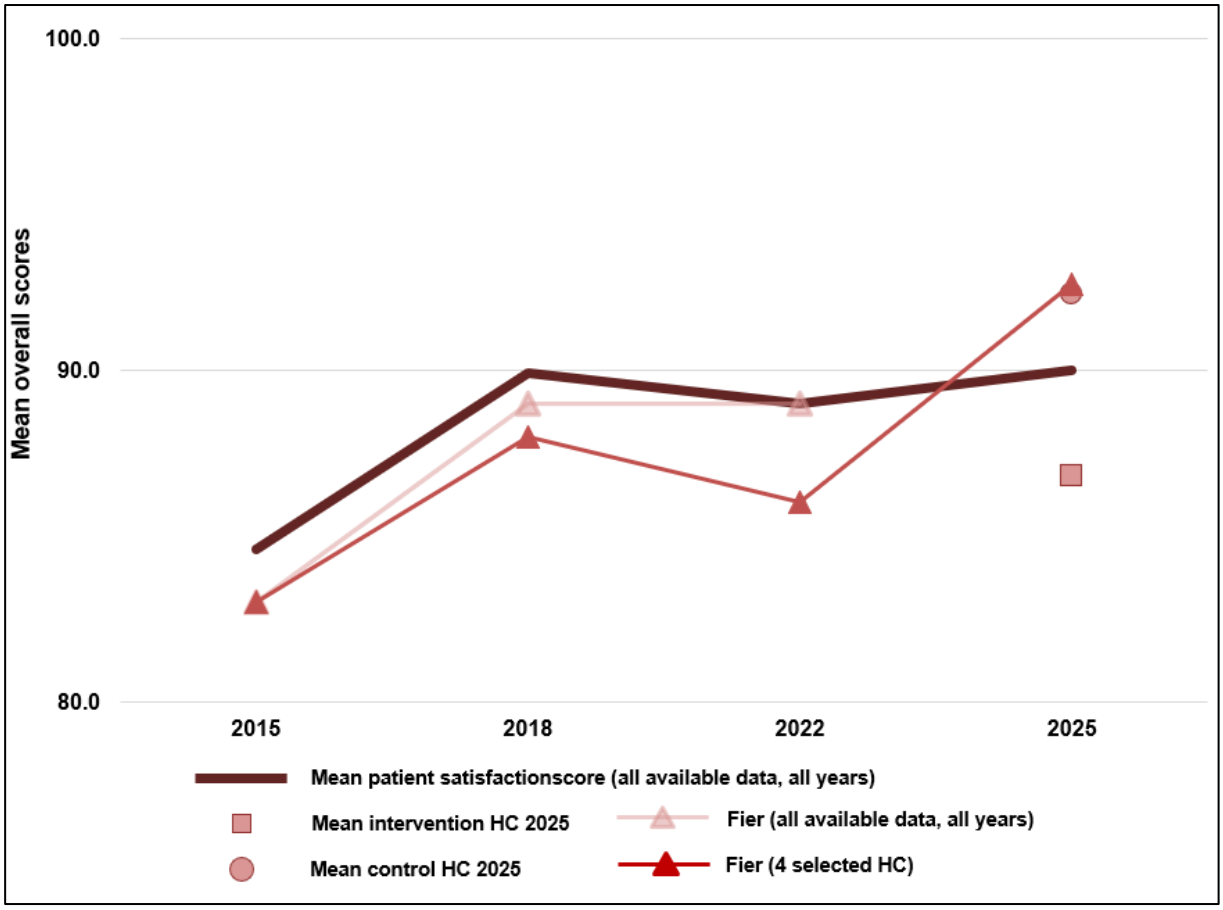
2015 to 2018, a slight dip in 2022 was observed, before scores improved again by 2025, reaching the highest recorded levels.

In 2025, both intervention and comparison HCs achieved similarly high mean satisfaction scores, although slightly higher in comparison HC. This indicates that patients generally report positive experiences with care across the primary care services, regardless of intervention status.

In Fier, satisfaction scores followed a similar upward trend. The four selected Fier HCs showed a marked improvement by 2025, performing on par with 2025 averages for comparison HC.

These results reflect sustained progress in patient-centred service delivery, with consistently strong patient perceptions of care quality and responsiveness across facilities.

Figure 3: Summary scores for patient satisfaction



The survey results indicate that, in 2025, in several QoC domains, comparison HCs performed similarly to or better than intervention HCs, a finding that requires careful interpretation. Unlike earlier phases, which relied on intensive, direct facility-level support, HAP3 adopted a scale-up approach focused on geographic expansion and system-level capacity building through LUHCs and a cascade training model. While this strategy has strengthened structures and introduced new services in more regions, its effects at individual HC level may take more time to become visible. In addition, the distinction between intervention and comparison HCs is not absolute, as comparison HCs were also indirectly exposed to HAP-supported protocols and guidance, leading to some diffusion of practices. The findings should therefore be understood in light of the transition to a decentralised implementation model and the partial overlap between the surveyed groups.

1 BACKGROUND

1.1 The Health for All Project

The Swiss Agency for Development and Cooperation (SDC) launched the first and second phase of the "Health for All" (HAP) project in Albania in 2015 and 2019 in two assigned pilot regions, namely Dibër and Fier. The third phase (also called HAP3 Consolidation Phase) was launched in April 2023, lasts until March 2027, and focusses on 20 Local Units of Health Care (LUHC) in 10 regions. The overall goal of HAP3 was that the Albanian population benefits from better health thanks to improved and inclusive primary health care services.

Expected outcomes of the project are:

- The National Health Institutions steer and manage more effectively and efficiently PHC and home care services.
- The citizens have access and use effectively primary health care and home care of better quality.

HAP adopted a results-oriented reporting system in the three phases of project implementation, focusing on outcome monitoring with reference to the Logical Framework, work plans and the respective budget. The achievements, progress and outcomes of the project are measured against defined indicators which are listed at the level of logframe.

The project included also facility-based surveys on quality of care (QoC). These were conducted in 2015, 2018, and 2022, respectively. In the HAP3 consolidation phase, the project continues to emphasise on activities that aim at improving primary health care services, and a cross-sectional survey assessing QoC in 17 HAP3-supported LUHC was deemed beneficial and necessary.

1.2 HAP consolidation phase 3

Since 2023 and the launch of Phase 3, HAP has progressively expanded its geographical coverage from two regions (Dibër and Fier) to nineadditional regions: Shkodër, Durrës, Tiranë, Elbasan, Korçë, Berat, Vlorë, Kukës and Lezhë. Compared to earlier phases, which were geographically concentrated and allowed for intensive, hands-on support, this scale-up required important adaptations in the implementation approach.

The expansion implied a shift towards a more decentralized model with more distant supervision and follow-up by the central implementation team. Implementation increasingly relied on close collaboration with the Operator and its local entities, the LUHCs, which have taken on a stronger operational role. HAP's role evolved towards technical support, capacity building and system strengthening rather than direct facility-level implementation.

Under phase 3, HAP has:

- Supported LUHCs in strengthening advanced nursing care for home-bound patients and elderly people through the expansion of Home Care Services.
- Contributed to the roll-out of clinical guidelines and protocols into routine primary health care practice.
- Expanded Home Care Services to 140 health centres by September 2025 (representing approximately 42% of all health centres in Albania).
- Supported the training and mobilization of nurses, including 1,018 primary health care (PHC) nurse trainers and 52 LUHC-based professionals (2022-2025).
- Trained 30.5% of family physicians and 31.2% of family nurses nationwide on non-communicable disease (NCD) protocols (2021-2025).
- Facilitated the expansion of peer groups in primary health care, with 10.8% of PHC providers currently participating in a peer group.

However, the intensity and depth of intervention in the newly covered regions differs from the earlier, more focused engagement in Fier and Dibër. In those two regions, HAP provided comprehensive, direct support, including training of all providers within targeted facilities and the rehabilitation of 30 health centres and health posts. In contrast, in the expansion regions HAP applied a cascade model. Typically, two representatives per HC were trained, with the expectation that they would subsequently transfer knowledge to colleagues through peer groups. HAP provided technical guidance and facilitation, while implementation ownership rested primarily with the health centres and LUHCs. Direct, facility-wide training and infrastructure rehabilitation were not part of the expansion model. In addition, regarding the scope of support it should be noted that (i) HAP 3 did not intervene in structural infrastructure issues such as water supply, electricity provision, or waste management systems in the supported health centres, and (ii) HAP systematically supplied intervention health centres with most essential basic PHC equipment and selected supplies necessary for service delivery.

1.3 Overview on Quality of Care

According to the definition of Donabedian (1988, 1990) [1, 2], QoC is characterized by three dimensions: structural attributes, the attributes associated with the process and attributes related to the outcomes. Therein, process attributes are often further sub-divided to technical and inter-personal dimensions.

The following definitions apply:

- Structural attributes: These attributes relate to the environment of the health service delivery. They understand the structural organization (medical personnel, internal organization and patient's payment for health services), human resources (qualified staff), and physical resources (infrastructure, equipment and drugs). In addition, the structure includes the technical performance and judgment of health personnel on patient's health situation for the provision of patient care.
- Process-related attributes: These attributes relate to the interaction between patient and health care provider, considering the interpersonal aspects and technical aspects. Potential benchmarks of process of care may include examination behaviours, preventive and treatment approaches or the ethical conduct of health workers. The definition of quality should be based and measured on local standards and local protocols and guidelines.
- Outcome attributes: Outcomes are considered a consequence of the quality of care, as for example survival and recovery of a patient or, more indirectly, patient satisfaction.

2 GOAL AND OBJECTIVES OF THE STUDY

The overall goal was to measure the QoC related to structural and process-related attributes as well as selected service quality outcomes in selected HCs in HAP3-supported LUHCs in Albania. To assess potential HAP3 impact, a comparative study design between HAP3-supported HC and HC not supported by HAP3 was applied [3, 4]. In addition, in Fier, changes over time (2015, 2018, 2022) in the various aspects related to QoC will be assessed.

The specific objectives of this study were to:

- Assess the QoC provided by providers to patients for PHC services, including the compliance with the NCD protocols introduced through HAP2 and HAP3.
- Assess patient satisfaction after medical consultation.
- Assess the capacities and readiness of the health facilities in terms of cleanliness, maintenance, and equipment related to protocol implementation and home based care implementation.
- Compare the QoC of PHC HC assisted by HAP with PHC HC not assisted by HAP.

- In selected HC in Fier, compare key findings to previous measurements from 2015, 2018 and 2022.
- Inform selected indicators from the projects' logical framework (logframe).
- Interpret the findings in the context of the HAP3 activities and the broader activities in the Albanian health system.

3 METHODS

3.1 Study design

A cross-sectional, facility-based survey was conducted. The survey assessed the three dimensions of QoC in health centers:

(i) quality of the facility capacity and readiness (structural attributes);
(ii) quality of provider-patient interactions (process attributes); and
(iii) patient satisfaction after consultation (outcomes).

To cover these three dimensions, data was collected at three different levels through the following approaches:

(i) the health centre through a health centre assessment tool;
(ii) the health care provider through provider-client observations; and
(iii) the patient satisfaction through exit interviews.

A summary of key study design parameters is shown in Table 1 and completed in the detailed sections below.

Table 1: Study design summary

	Quality of the infrastructure	Quality of doctor-patient interaction	Patient satisfaction
Target unit, population, respondent	Health centre (respondent(s): appointed by the health centre manager)	• Doctors (family and general medicine)	Patients
Consultation type	n/a	• Hypertension • Diabetes • Any kind of health consultation*	• Hypertension • Diabetes • Asthma • COPD • Dyslipidaemia • Mental health • Geriatric conditions (e.g. incontinence, frailty, dementia) • Any other kind of health consultation
Provider type	n/a	• Doctors (family and general medicine)	• Any health care provider (doctors, nurses, midwifes)
Tool	Health centre assessment tool	Observational tool	Exit interview questionnaire tool
Sample size target	52 HCs (24 assisted by HAP + 24 not assisted by HAP + 4 from Fier)	620 doctors	620 patients
Sampling	Exhaustive (all selected health centers)	Random sampling of doctors (1-3 per facility,	Exhaustive during visit in the health centre,

		proportional to size of facility)	depending on the capacity of the data collectors

3.2 Study area and target population

The 2025 QoC survey was conducted in selected LUHCs covered by HAP3 as well as in Fier LUHC, and those LUHC and HC not covered by HAP3, as comparison. Target population of the three different dimensions assessed are shown in Table 1 above. In addition:

(i) For the health centre assessment, the respondent(s) to the questionnaire was determined with the facility manager.
(ii) For the doctor-patient interaction, consultations for any kind of PHC services were observed but the health care providers under assessment were only doctors (family and general medicine).
(iii) similarly, exit interviews were conducted with patients that came for any kinds of PHC services.

3.3 Sample size

The sample size calculation is described in detail in the study protocol. In each group, i.e. intervention and non-intervention, 310 patients were to be observed for 'doctor's adherence to protocol guidelines for hypertension/diabetes' as the primary survey outcome. Based on findings from previous surveys in Fier and Diber, on average, 13 patients would be interviewed per HC. Thus, the number of HC per group (intervention vs. non-intervention) was 24 (310 / 13 = 24). This sample size calculation provides a representative sample of HC and patients, allowing to detect for a 15% increase in protocol adherence with 80% power and a 5% significance level.

3.4 Sampling

3.4.1 *Sampling of primary health care facilities*

A two stage sampling approach was used for the selection of the HAP intervention and non-intervention HC. A simple random sampling approach was applied for the selection of HC.

In a first stage, simple random sampling using STATA random sampling code with the health center as sampling unit was used to select 25 HAP intervention HC (Table 2).

In a second stage, non-intervention health centers were selected to match the sampled intervention facilities based on the number of outpatient visits in 2024. Using a matching procedure in Stata, 19 suitable matches were automatically identified. For the remaining 5 intervention centers, manual matching was conducted by selecting the closest available non-intervention health centers based on the same outpatient visit criterion.

In addition, HC from **Fier LUHC** were purposively selected for comparison to previous QoC surveys in HAP1 and HAP2 project phases.

Table 2: Selected health centers for the 2025 QoC survey

HAP3 intervention				Non-intervention			
No.	LUHC	Health center	No. of outpatients in 2024	No.	LUHC	Health center	No. of outpatients in 2024
1	Berat	Otllak	13176	1	Malesi e	Gruemire	13105

HAP3 intervention				Non-intervention			
No.	**LUHC**	**Health center**	**No. of outpatients in 2024**	**No.**	**LUHC**	**Health center**	**No. of outpatients in 2024**
					Madhe		
2	Bulqize	Shupenze	6437	2	Pogradec	Trebinje	6401
3	Durres	Rashbull	38032	3	Vlore	QSH Nr 5	21060
4	Elbasan	No. 1 Elbasan	51510	4	Gjirokaster	Pol.Gjirokaster	51926
5	Elbasan	No. 3 Elbasan	34708	5	Vlore	QSH Nr 1	33173
6	Elbasan	No. 4 Elbasan	47437	6	Vlore	QSH Nr 2	48180
7	Elbasan	Gjergjan	5905	7	Elbasan	Krekan	5897
8	Kavaje	Rrogozhin	16379	8	Tirane	Baldushk	16383
9	Kavaje	Synej	11706	9	Lezhe	Zejmen	11811
10	Kavaje	Lekaj	8489	10	Kukes	Bicaj	8527
11	Korce	Libonik	13370	11	Korce	Pirg	13338
12	Korce	No. 4 Korce	45061	12	Kruje	Q.Sh. Fush-Kruje	39553
13	Kukes	Kukës	52905	13	Durres	HC Sukth	26380
14	Mirdite	Poliklinika Rreshen	22687	14	Sarande	Sarande	22612
15	Mirdite	Rubik	11592	15	Teplene	Polik.Tepelene + Kuvelesh	11481
16	Peshkopi	Peshkopi	27229	16	Durres	Katund i Ri	27996
17	Pogradec	Bucimas	32505	17	Kruje	Q.Sh. Kruje + Cudhi	32201
18	Pogradec	Poliklinika Pogradec	51583	18	Kurbin	Mamurras	26283
19	Shkoder	Dajc	7878	19	Kukes	Shtiqen	8400
20	Shkoder	No. 3 Shkoder	44661	20	Kurbin	Polik.Laç	25729
21	Tirane	Vore	42724	21	Kucove	Q Sh Kucova	42840
22	Tirane	Shkoze	49968	22	Kruje	QSH Thumane	21967
23	Tirane	Bregu Lumit	29523	23	Vlore	QSH Nr 4	29881
24	Tirane	Bathore	43859	24	Vlore	QSH Nr 3	39094
Total outpatients 2024			**709,324**	**Total outpatients 2024**			**584,218**
HAP1 & HAP2 2015, 2018 and 2022 surveys: Fier							
1	Fier	No. 3 Fier			n/a; results in Fier will be compared to 2015, 2018 and 2022 surveys		
2		Zharrez					
3		Libofshe					
4		Patos					

3.4.2 *Sampling of health care providers for doctor-patient observations*

The inclusion criteria for doctors to be included in the doctor-patient observations were:

- Working in one of the selected HC;
- Practicing general or family medicine;
- Ability and willingness of the doctor to participate and provide written informed consent; and
- Ability and willingness of the patient 18 years or older (or her/his's legal representative for patients younger than 18 years) to participate and provide written informed consent.

All doctor–patient consultations that took place during the data collection day at each health

center were observed, within the limits of the data collectors' capacity. Depending on the number of doctors working in the facility and the flow of patients per doctor, the practice of one or more doctors could be observed.

A complete list of doctors working in the selected facilities was obtained prior to the survey. The doctors to be observed were selected randomly, and a 'replacement' order of the remaining doctors was also established, in case of absence, refusal or similar.

3.4.3 *Sampling of patients for exit interviews*

Inclusion criteria for patients receiving a consultation and exiting a HC were:

- Being a patient 18 years or older receiving a consultation from a health care provider (doctor, nurse, midwife) in one of the selected HC;
- Being a patient younger than 18 years accompanied by a legal representative (e.g. mother/father/caretaker) receiving a consultation from a health care provider (doctor, nurse, midwife) in one of the selected HC;
- Ability and willingness of the patient (or her/his's legal representative in case of patients <18 years of age, or unwilling to take decisions for him/her self) to participate and provide written informed consent.

The following was an exclusion criteria from study inclusion:

- Being a patient 18 years or older, lacking mental capacities for decision making (e.g. due to dementia, mental disability), receiving a consultation from a health care provider (doctor, nurse, midwife) in a the selected HC;
- Non willingness to provide consent for study participation.

For the exit interviews, all patients that received care at the facility on the day of data collection in a HC were invited to participate in the study, depending on the capacity of the data collectors. The patients for exit interviews could have been but did not necessarily have to be the same as for the doctor-patient observation.

3.5 Questionnaire tools

The survey included three questionnaire tools that assess the three different dimensions of QoC. Details are given in the study protocol. An overview on the different dimensions of QoC covered in the survey tools is displayed in Table 3. The full survey tools are available upon request with the authors (available in English & Albanian). The following table gives an overview on the different dimensions of QoC covered in the survey tools.

Table 3: Topics covered in the survey tools

Dimension	Sub-dimension/ operationalization	Level of data collection
Structure: Infrastructure		
Facility infrastructure, overall cleanliness and maintenance	• Facility – overall cleanliness (facility, yard, waiting area) • Facility – maintenance of floors and walls (painted, cracks) • Water – general availability of water • Practice room – water and soap, alcohol or antiseptic lotions, privacy of examination • Availability of electricity, heating, telecommunications	Health centre
Hygiene and safety standards	• Toilets - availability, water, soap, cleanliness	Health centre

Basic/essential medical equipment and supplies	• Availability and functionality of medical equipment and supplies (according to Basic Service Package) with a focus on the equipment provided by HAP such as medical bag content and home care equipment.	Health centre
Availability of guidelines	• Relevant guidelines related to NCDs (5 NCDs, Mental Health and Manual for Elderly Care) is available at the facility and can be easily retrieved	Health centre
Processes: Doctor-patient interaction		
General aspects on adherence on principles of clinical history and physical examination	• Makes a patient comfortable, e.g. greeting, seat offered • Interaction and welcoming • Privacy	Provider; all patients
Application of infection prevention and comparison measures	• Hand-washing practices • Procedures for disinfection	Provider; all patients
Observations on treatment of patients with arterial hypertension and diabetes	Anamnesis: • Asks questions relevant for the illness Physical examination: • Conducts relevant physical examinations correctly Explanations / advise: • Gives relevant and comprehensive explanations	Provider; patients with known/or newly diagnosed arterial hypertension and diabetes
Outcomes: Exit interviews for patient satisfaction		
Satisfaction with privacy		All patients
Satisfaction with doctor-patient interactions	• Respectful treatment • Doctors communication and explanations	All patients
Socio-demographic and economic aspects	• Socio-demographic aspects • Beneficiary from public social program • Insurance situation • Payment for services in PHC	All patients

3.6 Data collection

In a HC, the data collection process was conducted as follows:

1) Introduction of purpose and procedures of the survey to the health care providers to be targeted (medical doctors for general and family medicine)
2) Data collection:
    i. First, the doctor-patient observations;
    ii. Second, or in parallel, the exit interviews with patients; and
    iii. Third, health centre assessment after patient consultation hours (in the afternoon).

Data collection was carried out electronically using ODK software. The tools were administered on tablets.

3.7 Data management and analysis

Once data was transferred to the server of the Swiss TPH, regular data checks were conducted for quality assurance. Completeness and the logical structure of the obtained questionnaires was checked regularly. Feedback from the analysis was immediately given to the study coordinator.

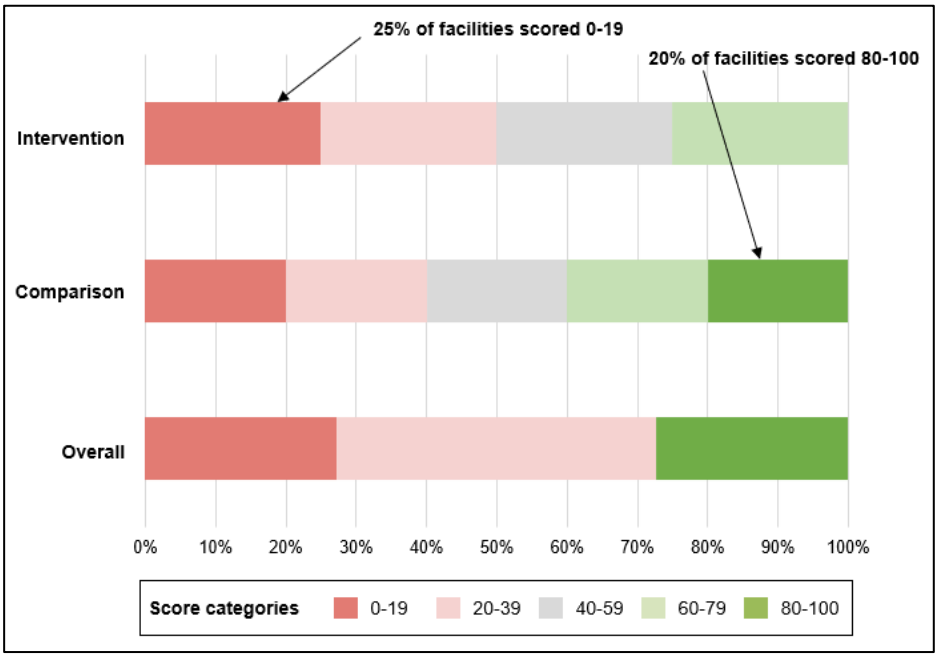
Following the survey design, data were analysed separately for (i) the 2025 survey, including a comparative analysis of the 24 intervention and 24 comparison HC and (ii) the overall indicators for Fier for 2025, including a comparison with previous survey years (2015, 2018 and 2021). Thus, findings are provided in separate sections 4 and 5, respectively.

Data was analysed using Stata Statistical Software and R statistical software. Scores were calculated to combine a number of indicators of an assessed umbrella topic and obtain an overall achievement score. Five score categories are defined: (1) 0-19; (2) 20-39; (3) 40-59; (4) 60-79; and (5) 80-100 (see Figure 4). HC are then categorized in these five categories depending on what score they achieved.

For example, 35 items of 'general medical equipment' were assessed for availability in the surveyed HC. If a HC has 5 items out of 35 items available, this translates to 14.3% of total possible items available. Thus, this HC would be in the score category 0-19. Or, if 25/35 items are available, the score is 71.4% and the category is (4) or 60-79.

The following example is not based on survey data, but it is only a hypothetical example to illustrate the presentation the results. As exemplified in Figure 4, 25% of HC in the intervention HC scored between 0-19, as opposed to 20% in comparison HC in the same year. Or, 0% of intervention HC scored between 80-100, but 20% of comparison HC scored 80-100. Across all results, the colour code implies that more green is more positive and more red is more negative.

Figure 4: Score categorization and example



3.8 Ethical considerations & clearance

This study was approved by the ethics committee of MoHSP in Albania (Nr. 208/75; date 02.07.2025 see annex 8.1).

All the study participants were given detailed information about the purpose and the activities of the study as well as the extent of their involvement. Importantly, participants were informed that (a) their participation is voluntary, (b) they can withdraw from participation at any time, (c) non-participation will not have any negative effects.

Written informed consent was obtained from all the participants respectively parents/legal guardians in case of participants below 18 years of age.

4 FINDINGS

The 2025 survey was implemented between 1 and 13 August 2025. A total of 48 HC were visited, thereof 24 intervention and 24 comparison HC (Table 4). In these HC, 292 and 307 doctor-patient consultation observations were conducted, respectively. In addition, a total of 747 exit interviews were conducted (357 in intervention, 390 in comparison).

In addition, in Fier, 4 HC were visited, resulting in 49 doctor-patient consultation observations and 81 patient exit interviews.

Table 4: Survey sample (2025)

	Intervention	Comparison	Total	Fier
Health centres	24	24	**48**	4
Observed consultations	292	307	**599**	**49**
Patients interviewed	357	390	**747**	**81**

Importantly, the following results sections (sections 4.1, 4.2 and 4.3) present results from the 2025 survey, including a comparative analysis of the 24 intervention and 24 comparison HC.

Results for selected overall indicators for Fier for 2025, including a comparison with previous survey years (2015, 2018 and 2021), are presented as a separate section 5.

Finally, the summary (section 6) presents overall indicators for infrastructure, doctor-patient consultations and patient exit interviews across the different survey years, intervention groups and regions for comparison.

4.1 Infrastructure survey

Importantly, as mentioned in section 1.2, HAP 3 did not intervene in structural infrastructure issues such as water supply, electricity provision, or waste management systems in the supported health centres.

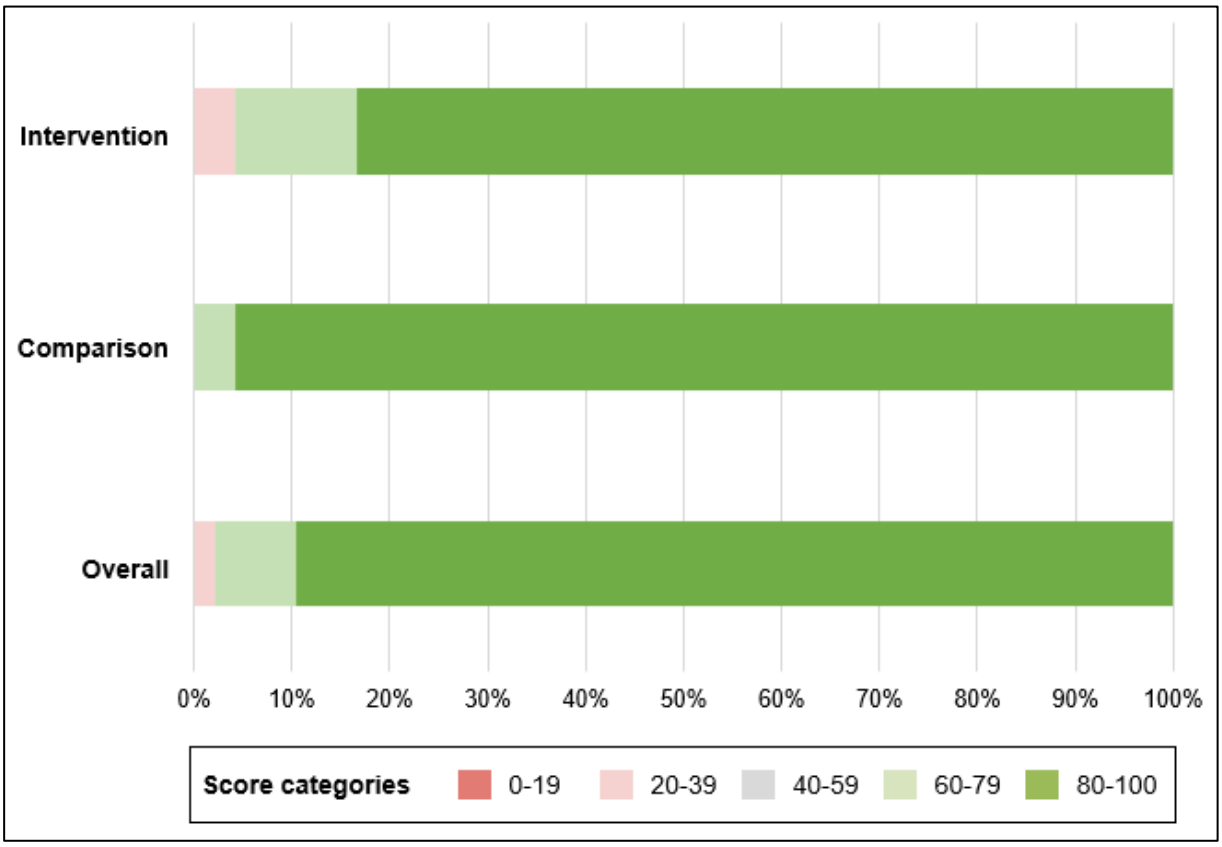
4.1.1 *Cleanliness of the HC*

Figure 5 shows scores for cleanliness in the HC, including the following indicators (yes/no):

- The HC and immediate surroundings (HC yard, waiting area outside) are free from long grass, paper debris and solid waste.
- The current waiting area is mopped, free of dust, trash; dirt, spider webs, and generally tidy.
- All examination rooms are mopped, free of dust, trash; dirt, spider webs, and the rooms are generally tidy.

Overall, high cleanliness standards were observed across both intervention and comparison HC. As shown in Figure 5, the vast majority of HC scored within the highest category (80–100%), with only a few scoring slightly lower (60–79%) and very few falling into the low ranges. The results indicate that cleanliness is consistently maintained and prioritised, regardless of intervention status, reflecting strong adherence to hygiene and maintenance practices at the HC level.

Figure 5: Scores on HC cleanliness



4.1.2 *Medical and hazardous waste disposal*

Figure 6 shows scores for medical and hazardous waste management in the HC, including the following indicators (yes/no):

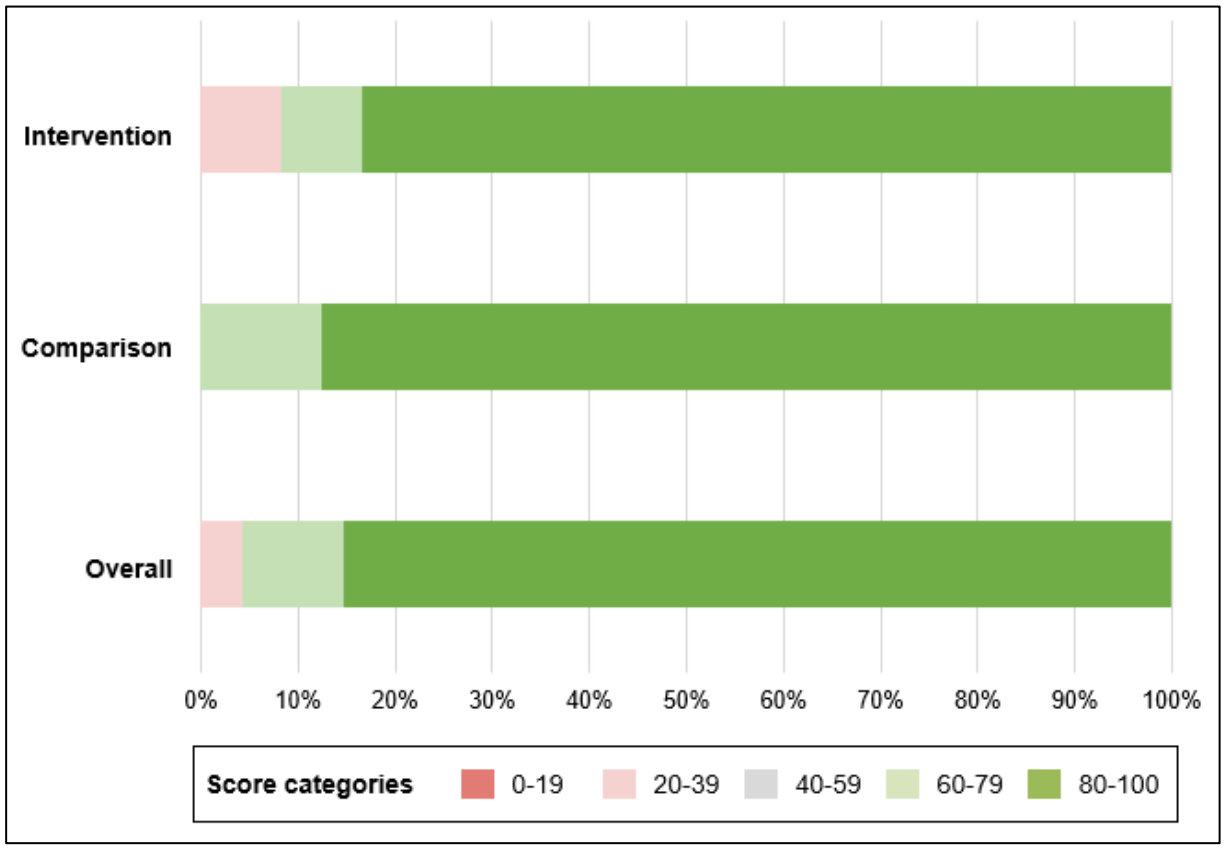
- Labelled containers for medical waste disposal are available in all required areas (e.g. examination rooms).
- The HC has adequate and safe disposal of sharps (sharps box/container).
- The HC has adequate and safe disposal of infectious waste (box/container).

In Albania, the waste disposal in HC is done by private companies that collect the waste at the HC and dispose it safely.

The survey found that in the majority of both intervention and comparison HCs, medical and hazardous waste disposal systems were in place and functioning appropriately. As shown in Figure 6, most HCs achieved very high scores (80–100%), reflecting overall good compliance with waste management standards.

Despite these isolated cases, the overall performance demonstrates that waste disposal systems are generally well established and consistently applied across HC, contributing to safe infection prevention and comparison practices.

Figure 6: Scores on medical and hazardous waste disposal



4.1.3 *Waiting rooms and privacy*

Table 5 shows proportions for available waiting rooms and privacy of examination/consultation rooms. All HC had designated waiting rooms/areas for their patients and the vast majority of HC (22/24 of intervention and 23/24 of comparison HC) had examination rooms that ensured sufficient privacy.

Table 5: Waiting rooms and privacy

	Intervention		Comparison		Overall	
	N	%	n	%	n	%
There is a designated waiting room/areas for patients	24	100.0	24	100.0	48	100.0
All examination room(s) ensure(s) privacy/confidentiality (door, window blind, curtain)	22	91.7	23	95.8	45	93.8

4.1.4 *Availability of electricity and lighting*

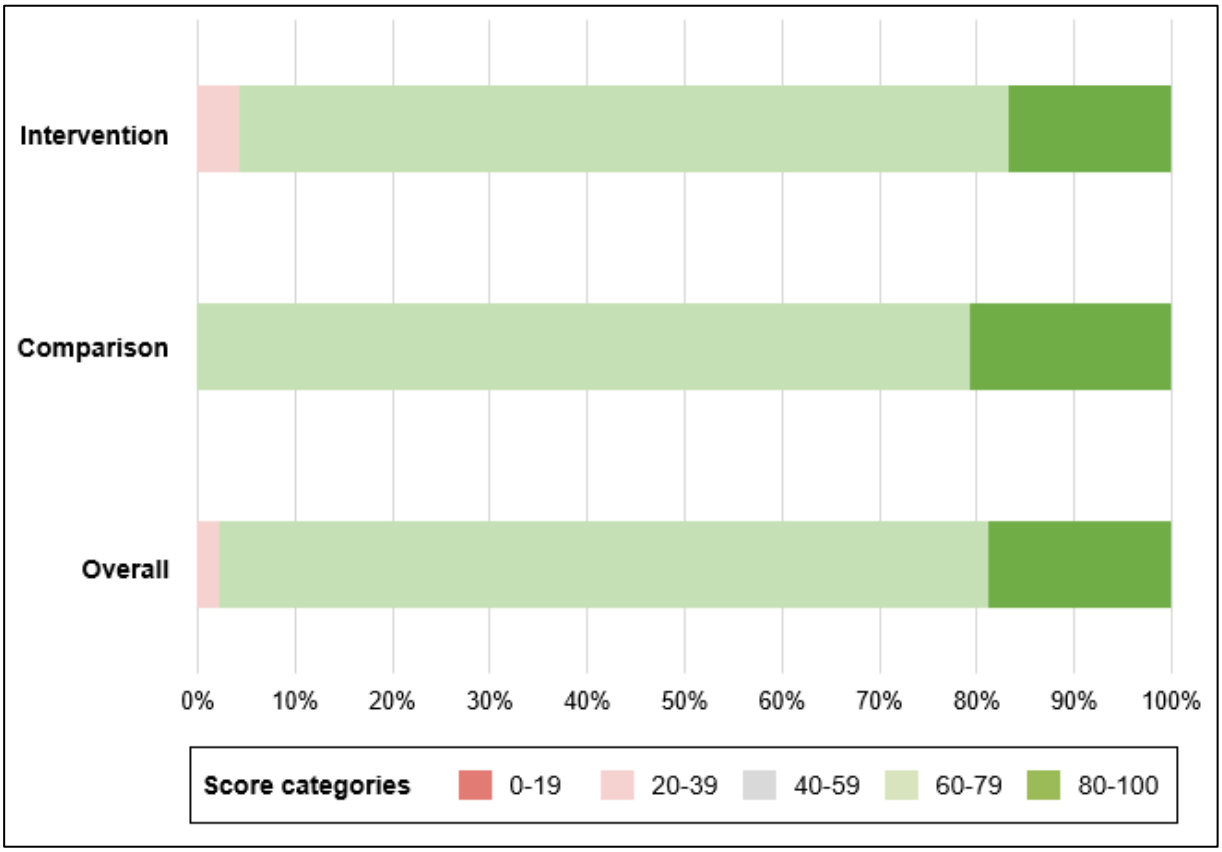
Figure 7 shows scores for the availability of electricity and lighting infrastructure in the HC, including the following indicators (yes/no):

- All examination rooms are well illuminated.
- The HC has electricity.
- During the past 7 working days, there was no power cut of more than 1 hour during opening hours.

Overall, high scores were recorded across both intervention and comparison HCs, indicating that electricity supply and lighting conditions are generally adequate and stable. As shown in Figure 7, nearly all HC reached the 60–100% score range.

Only one facility, namely HC Bregu Lumit, reported a (temporary) power supply issue, reflected in a lower score. Apart from this isolated case, the availability of electricity and lighting infrastructure was consistent across all sites, ensuring favourable conditions for service provision and patient care.

Figure 7: Scores on availability of electricity and lighting infrastructure



4.1.5 *Water and sanitation*

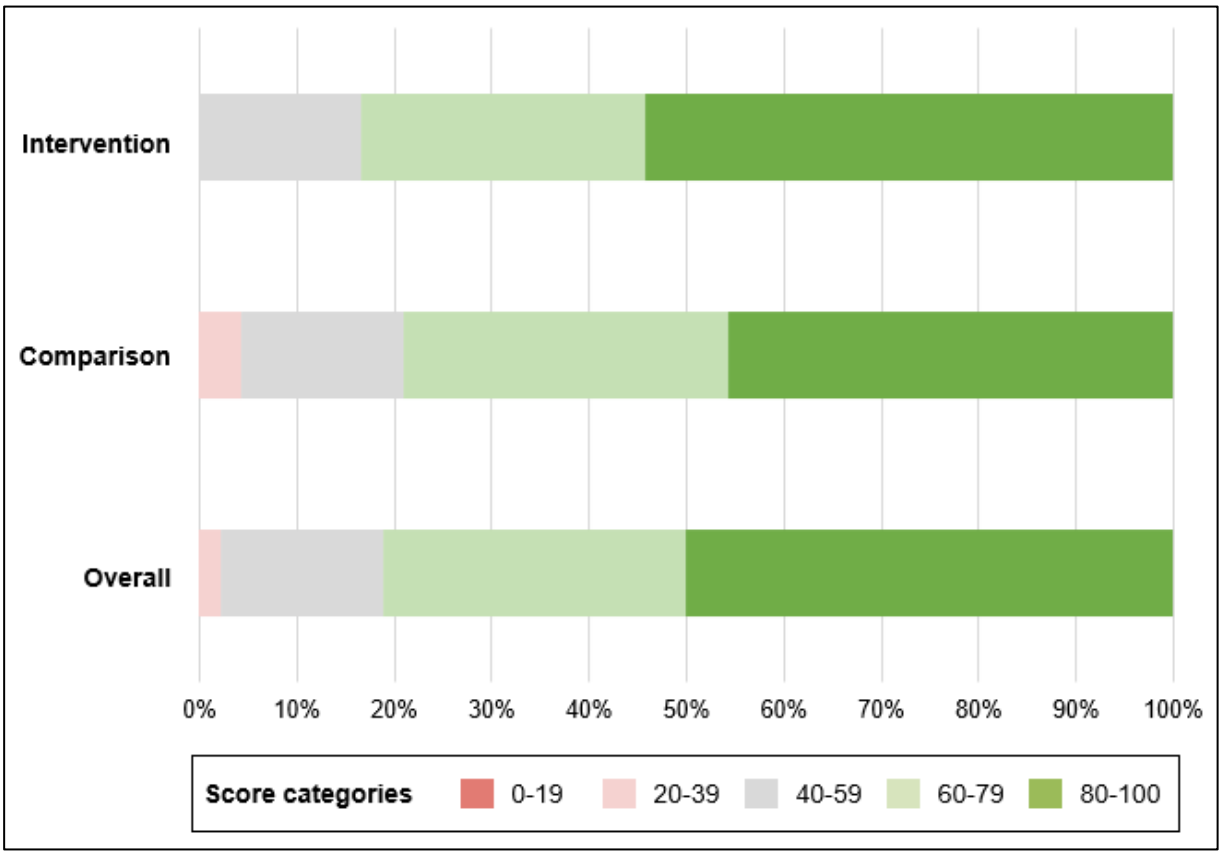
Figure 8 shows scores for the water and sanitation situation in the HC, including the following indicators (yes/no):

- There is running water in the HC (out of the tap).
- Functional washing points exist in examination rooms and/or entrance hall, and soap or hand disinfectants and water are available.
- The HC has at least one accessible and functional toilet for patients.
- Soap and water are available at the washing point near toilet or latrine.

Most HC achieved high water and sanitation scores, with the majority of both intervention and comparison HC scoring above 60%. The findings show no substantial difference between intervention and comparison HC, suggesting that access to water and sanitation is largely adequate across the surveyed HCs. Only one facility, namely HC Zejmen in the comparison group, reported insufficient water and sanitation infrastructure, resulting in a lower score.

Overall, these results indicate that basic water access, handwashing facilities, and patient toilets are generally available and functional.

Figure 8: Scores on water and sanitation



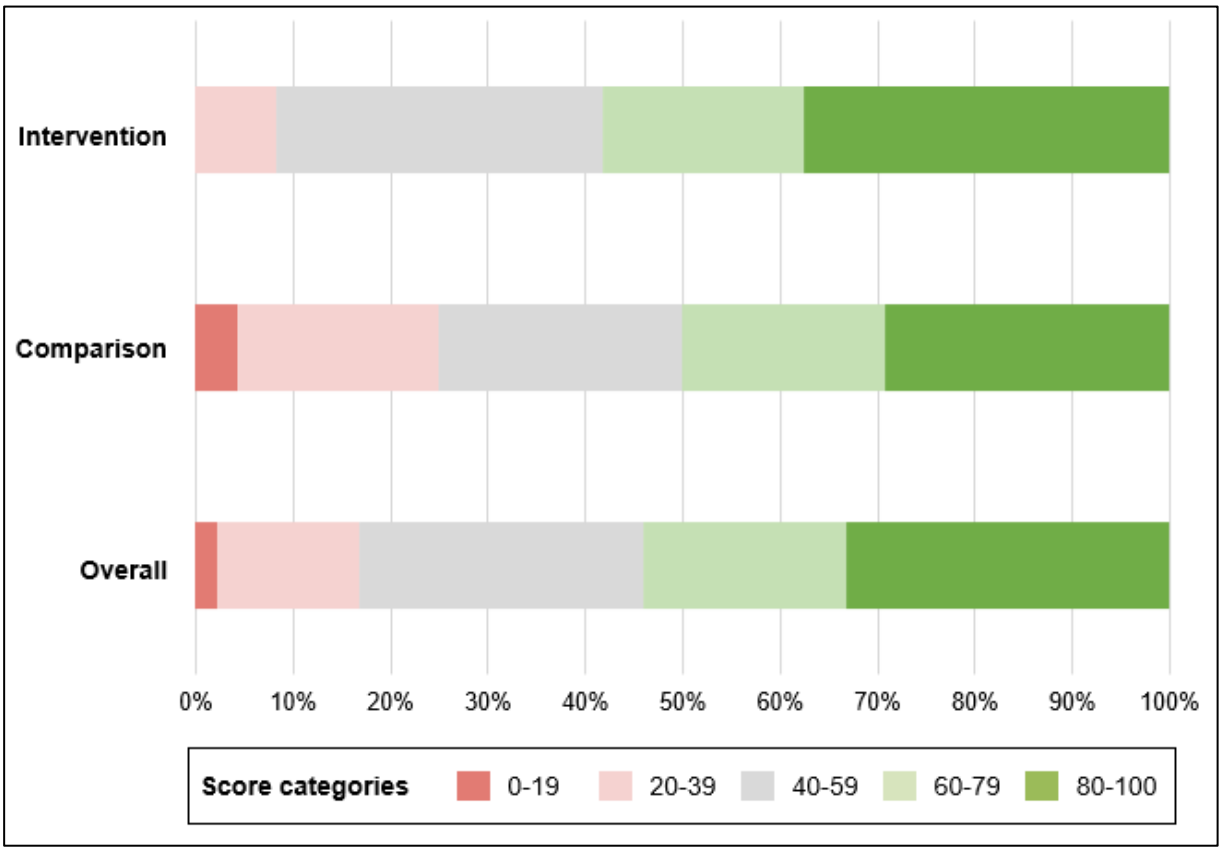
4.1.6 *Display and visibility of HC information and health information materials*

Figure 9 shows scores for the display and visibility of HC information and health information materials in the HC, including the following indicators (yes/no):

- The HC opening hours visibly displayed to the public.
- The tariffs are visibly displayed to the public/patients (note: tariffs for medical reports to attest fitness for driving licence, fitness for work, own a gun and to issue a health card).
- Awareness materials (posters, leaflets) (when counselling) based on standard package info (children, adults, women and reproductive health, seniors, mental health) are visibly displayed to patients.
- Leaflet on diabetes, HTA, Posters for signs of diabetes; Posters for causes of diabetes; Poster for patient's rights; Poster for `setting up a doctor's visit

Overall, the display and visibility of HC information and educational materials was moderate across the surveyed HC. About half of the facilities reached medium-level scores (40–59%), while fewer than one in four achieved good or very good visibility (≥60%).

Figure 9: Scores on display and visibility of HC information and health information materials



4.1.7 *Availability of printed copies of guidelines*

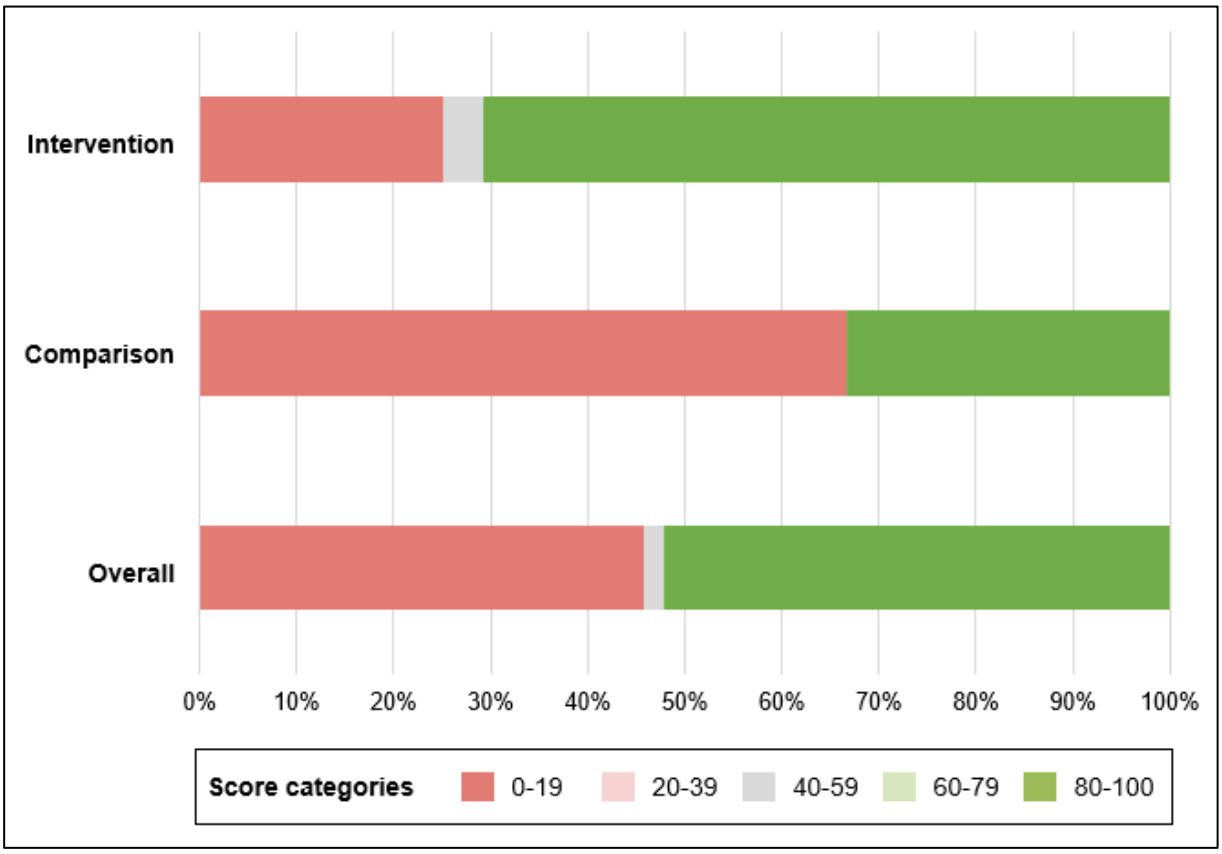
Figure 10 shows scores for the physical presence of medical guidelines in the HC, including the following indicators (yes/no):

- The Clinical Guideline/Protocols for PHC "Treatment Protocol and Clinical Guideline for Primary Health Care: Diabete, Dyslipidemia, Hypertension" (2022)
- The Clinical Guideline/Protocols for PHC "Treatment Protocol and Clinical Guideline for Primary Health Care: Asthma, COPD (2022)
- The Manual of Clinical Practice of family medicine on "Health Care for Elderly People in PHC" (2022)
- The Manual of Clinical Practice of family medicine on "Management of Mental Health Disorders in PHC" (2022)

The results reveal a polarized pattern across the surveyed HC. HCs either lack printed guidelines altogether (scoring 0–19%) or, conversely, have nearly all required guidelines available (scoring 80–100%). Only very few intervention HCs fall in-between. In addition, intervention HCs generally performed markedly better, with a larger share in the highest score category, whereas most comparison HCs had none of the assessed printed materials.

This “all-or-nothing” distribution suggests significant variation in the dissemination and management of printed guideline materials, reflecting uneven implementation and distribution systems whereby some facilities are well equipped with updated reference materials while others remain without access to essential clinical guidance for primary care.

Figure 10: Scores on availability of printed copies of guidelines



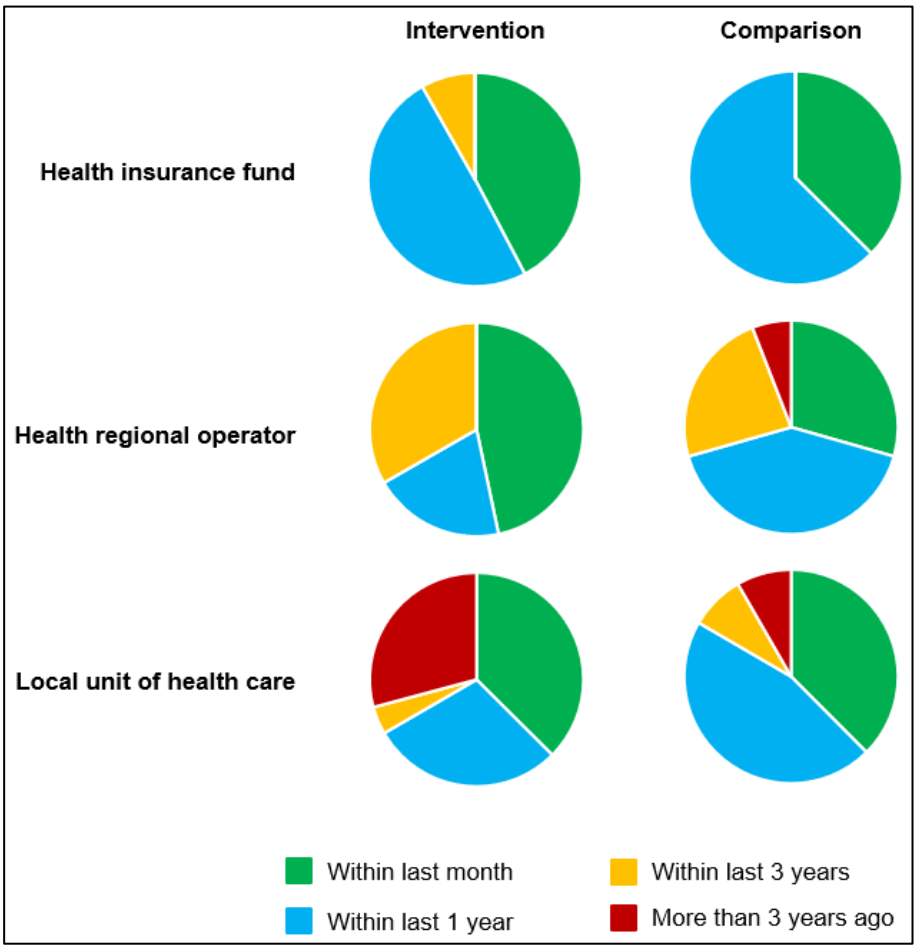
4.1.8 *Monitoring and supervision*

Table 6 displays, if the surveyed HC have ever received a monitoring visit by different agencies, namely the health insurance fund, the health regional operator or the LUHC. All HC (n=48; 100.0%) reported that they have ever received a monitoring visit by the health insurance fund.

Table 6: Monitoring visits carried out by different agencies

HC ever received a monitoring visit by…	Intervention		Comparison		Overall	
	n	%	n	%	n	%
… health insurance fund	24	100.0	24	100.0	48	100.0
… health regional operator	15	62.9	17	70.8	32	66.7
… local unit of health care	21	87.5	22	95.7	43	91.5

Figure 11: Duration since last monitoring visit carried out by different agencies



For those having received a monitoring visit by the LUHC, in 70.8% (17/24) of intervention HC and in 83.3% (20/24) of comparison HC, documentation of the last monitoring visit was available.

In the intervention HC, 70.8% of monitoring visits by the LUHC were from the 'Primary health care service and quality assessment and promotion'-unit/department and 16.7% from the 'Epidemiology service and environmental health'-unit/department. 12.5% of HC could not precise which unit/department of the LUHC did the last monitoring unit.

In the comparison HC, 87.5% of monitoring visits by the LUHC were from the 'Primary health care service and quality assessment and promotion'-unit/department and 12.5% from the 'Epidemiology service and environmental health'-unit/department.

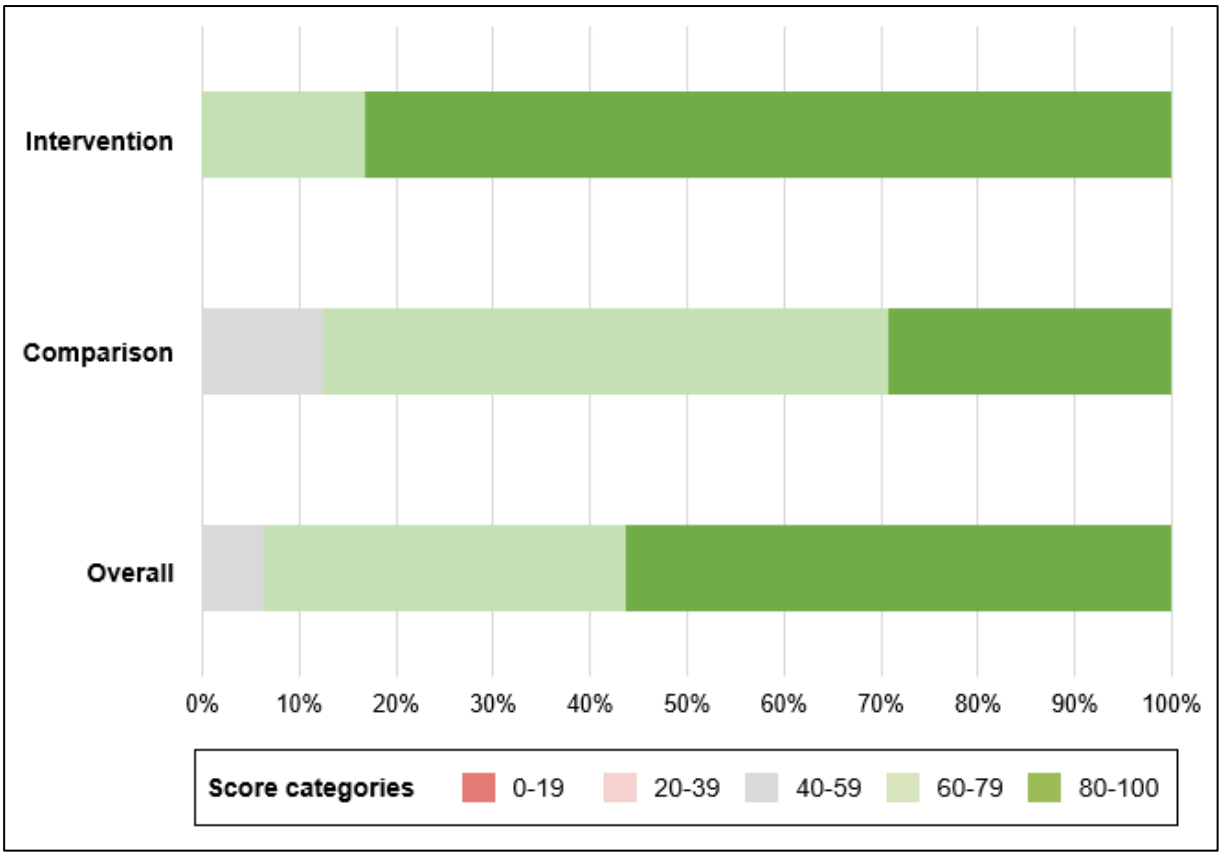
4.1.9 *Basic and essential medical equipment*

A list of 31 items of basic medical equipment – according to the 'Basic Service Package' – was assessed, for availability and functionality. The full list is shown in Table 20 in annex 8.2. For score calculation, equipment that was available but not functional was classified as not available.

As shown in Figure 12, the availability of basic and essential medical equipment was generally good across both intervention and comparison HC, with the majority of HC reaching scores of 60–100%. Intervention sites performed slightly better, with nearly all falling within the top two score categories (60–79% and 80–100%), while comparison facilities showed somewhat greater variation, with a few scoring lower (40–59%).

Overall, this suggests that most health centres are adequately equipped with essential tools required for the provision of basic primary health care services, though minor gaps remain in some comparison sites, likely related to maintenance, replacement, or redistribution of specific items.

Figure 12: Scores on availability of basic medical equipment



4.1.10 *Availability of doctors' and nurses' bags*

In addition to the basic medical equipment, HAP distributed medical tool bags for family doctors including 17 items of medical equipment[1] that fulfil the requirements of the list of medical equipment of the Basic Package of Services. Similarly, bags for nurses including 15-16 items of medical equipment[2] were also provided.

As shown in Table 7, the availability of both doctors' and nurses' bags followed a clear intervention-comparison pattern. Among intervention health centres, almost all doctors (87.5%) and nurses (91.7%) had a complete and functional bag, while in comparison HC, these were largely absent (only 4.2% of doctors' bags available and none for nurses). A small proportion of intervention HCs reported incomplete sets (8.3%), suggesting minor losses or missing items rather than a lack of distribution.

[1] Includes: adult, pediatric and fetal stethoscope, an adult, obese and paediatric sphygmomanometer, otoscope, ophthalmoscope, peak flow meter, oximeter, neurological hammer, pregnancy wheel, digital thermometer, measuring tape, pocket light, BMI wheel, resuscitation mask. For medical doctors working in woman consultancy rooms fetal doppler.

[2] Includes: adult and pediatric stethoscope, fetal doppler, an adult, obese and paediatric sphygmomanometer, otoscope, oximeter, pregnancy wheel, BMI wheel, digital thermometer and normal one, pocket light, head circumferences measure, common scissors, haemostatic lac, ear lavage kit.

Overall, these findings indicate that the provision of doctors' and nurses' bags was achieved almost exclusively in intervention HCs, demonstrating effective distribution under HAP support, but also highlighting the absence of equivalent equipment in comparison HC, which may affect the capacity of health workers to provide comprehensive care at the point of service.

Table 7: Availability of doctor's and nurses' bags

	Intervention		Comparison		Overall	
	n	%	n	%	n	%
Doctor's bag						
Available, complete	21	87.5	1	4.2	22	45.8
Available, incomplete	2	8.3	3	12.5	5	10.4
Not available	1	4.2	20	83.3	21	43.8
Nurse's bag						
Available, complete	22	91.7	0	0.0	22	45.8
Available, incomplete	2	8.3	0	0.0	2	4.2
Not available	0	0.0	24	100.0	24	50.0

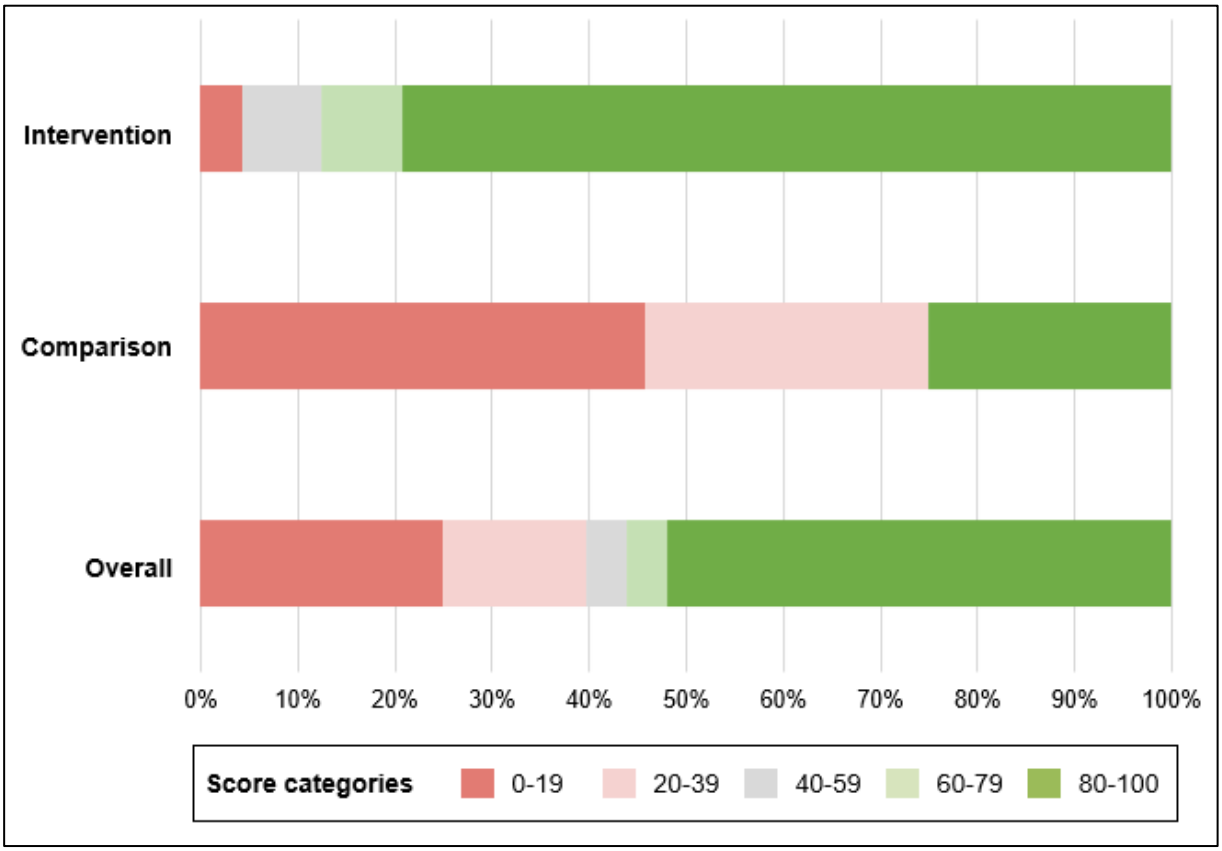
4.1.11 *Homecare para-medical equipment*

A list of 10 basic medical equipment and consumables was assessed for availability. The full list is shown in Table 21 in annex 8.2.

As shown in Figure 13, the availability of homecare equipment followed a similar pattern to that observed for doctors' and nurses' bags. Most intervention HCs achieved high scores (80–100%), indicating that nearly all required items were available at the time of the survey, while the majority of comparison HCs scored very low (0–39%), reflecting the absence of such materials.

Overall, this reveals a marked contrast between intervention and comparison HC, demonstrating that the provision of homecare para-medical equipment was largely limited to intervention HC supported under HAP. The results underline the added value of targeted equipment support in strengthening community and home-based service delivery capacities within the PHC system.

Figure 13: Scores on availability of homecare equipment



4.1.12 *Overall infrastructure scores*

The overall infrastructure score was calculated by combining all scores calculated in 4.1.1-4.1.11. Importantly, HAP did not intervene on all infrastructure aspects (e.g. water, electricity, waste management) but – as a reminder – HAP activities are outlined in detail in section 1.2.

As shown in Figure 14, the overall infrastructure conditions were good across both intervention and comparison HC, with the majority of facilities achieving scores above 60%. Intervention HCs performed particularly well, with most scoring within the highest category (80–100%), indicating that infrastructure standards were met for most assessed components.

Comparison HCs displayed slightly more variability, with several falling into the mid-range categories (40–79%), but still demonstrating generally acceptable infrastructure conditions. This reflects the consistent investment and maintenance of basic infrastructure across HC, while intervention sites show an additional level of improvement likely linked to targeted HAP support.

Overall, the findings suggest that infrastructure across the surveyed HCs provides a solid foundation for quality primary health care delivery, with minor differences between groups primarily reflecting the extent of external support and recent improvements.

Figure 14: Overall scores on infrastructure

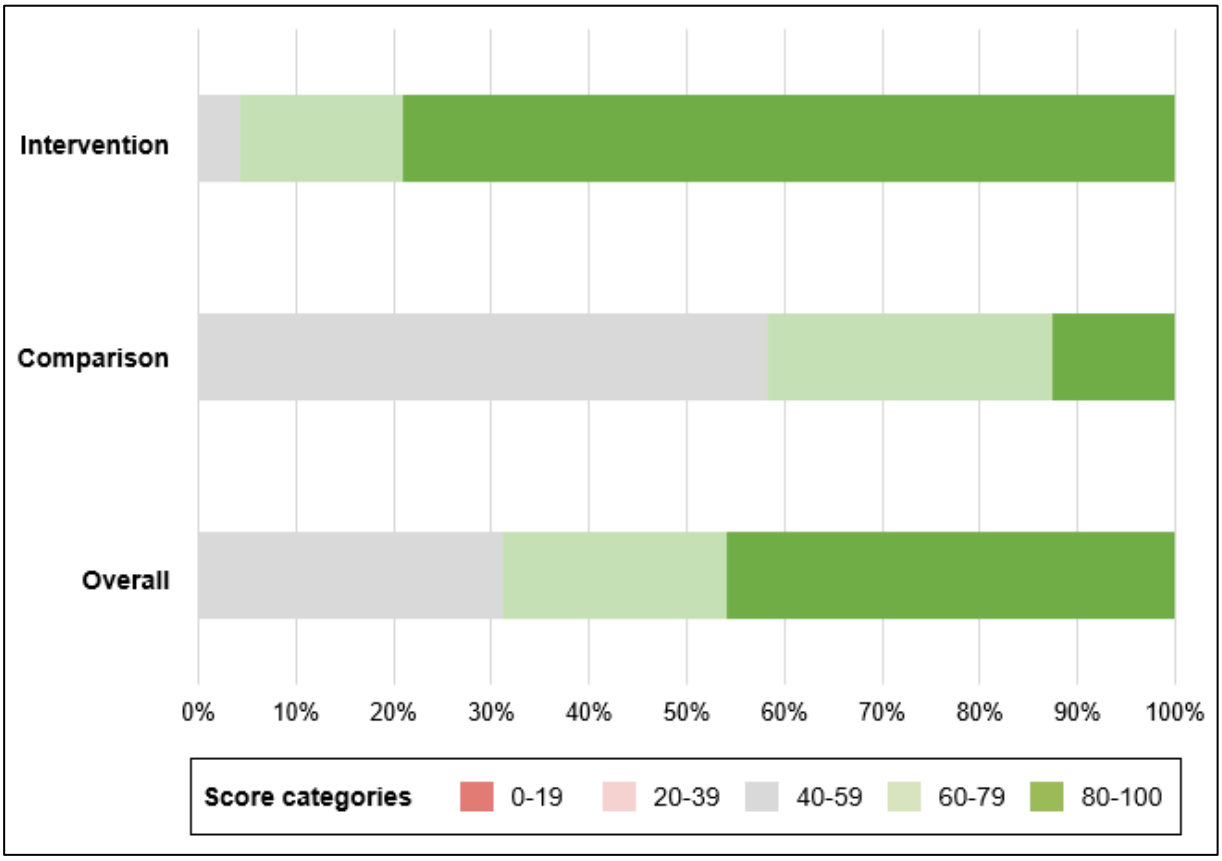


Table 8: Overall infrastructure scores by HC

Score	Intervention	Comparison
40-59	• Peshkopi	• Madhe Gruemire • Trebinje • QSH Nr 5 • Pol Gjirokaster • Baldushk • Bicaj • Pirg • QSH Fush-Kruje • QSH Kruje + Cudhi • Shtiqen • Cucova • Vlore QSH Nr 1 • Vlore QSH Nr 3 • Vlore QSH Nr 4
60-79	• Elbasan Nr 1 • Shkoder Nr 3 • Shkoze • Bregu Lumit	• Vlore QSH Nr 2 • Krekan • Zejmen • Sarande • Polik. Tepelene + Kuve • Mamurras • Thumane
80-100	• Otllak • Shupenze • Rashbull	• Sukth • Katund I Ri • Poliklinika Lac

	• Elbasan Nr 3 • Elbasan Nr 4 • Gjergjan • Rrogozhin • Syney • Lekaj • Libonik • Korce Nr 4 • Kukes • Poliklinika Rreshen • Mirdite Peshkopi • Bucimas • Poliklinika Pogradec • Dajc • Vore • Bathore	

4.2 Doctor-patient observations

The following numbers of observations were attained in the HC:

- 47 HC overall:
  - 23 intervention HC; no observations were conducted in Peshkopia (an intervention HC) because on the survey day, a Saturday, no patient has visited the HC (3rd of August);
  - 24 comparison HC;
- 84 doctors overall:
  - 41 doctors in intervention HC;
  - 43 doctors in comparison HC;
- 599 patient-doctor interactions overall:
  - 292 observations in intervention HC;
  - 307 observations in comparison HC.

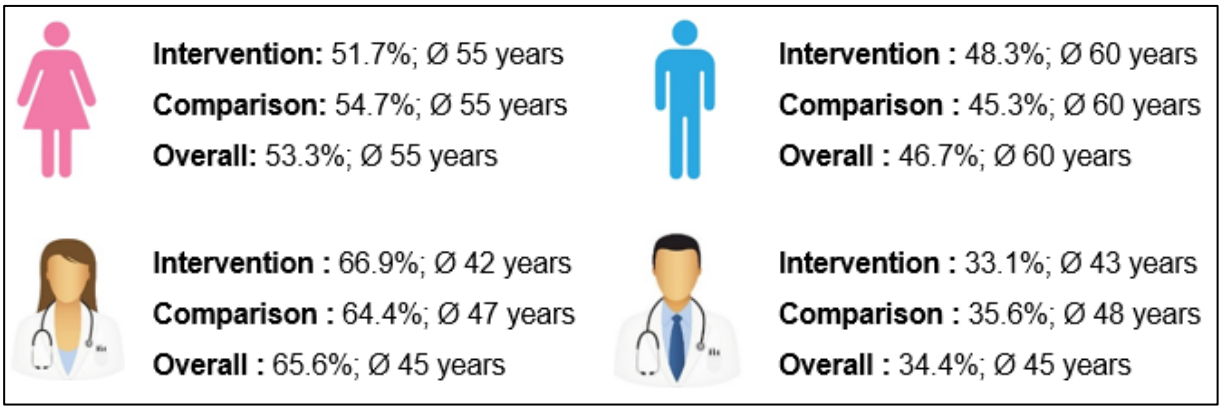
Thus, in both the intervention and comparison HC, the average number of observations per HC was 13 and the average number of observations per doctor was 7.

4.2.1 *Characteristics of patients and doctors*

Patient characteristics assessed, namely gender and age, were similar for the intervention and comparison groups. Slightly more than half were female patients (51.7% in intervention and 54.7% in comparison HC), the average age was 55 years in both groups.

About two thirds of doctors were female (65.6% overall). The average age of doctors was 45 years for both male and female doctors overall.

Figure 15: Patient and doctor gender and age



In both the intervention and comparison HC, the majority of doctors observed were general practitioners (87.6% vs. 97.0%, respectively). Only 5.5% in intervention and 2.6% in comparison HC were family doctors[3], and only very few (n=20, 6.9% vs. n=1, 0.3%, respectively) were specialist doctors.

4.2.2 *Medical visit*

Reasons for the patient's medical visits are shown in Table 9. About a quarter of all consultations were with patients who sought health care for arterial hypertension, which was 25.7% in intervention and 23.8% in comparison HC. This was followed by those who sought

[3] Doctors described themselves as family doctors. As the number of generalists trained in the specialization of family medicines is very low, the self-classification is thus more likely relating to general doctors being contracted as family doctors.

care for diabetes (9.9% in intervention and 8.1% in comparison HC). Only a small proportion of observations was for geriatric issues (6.3% overall) or mental health issues (1.3% overall).

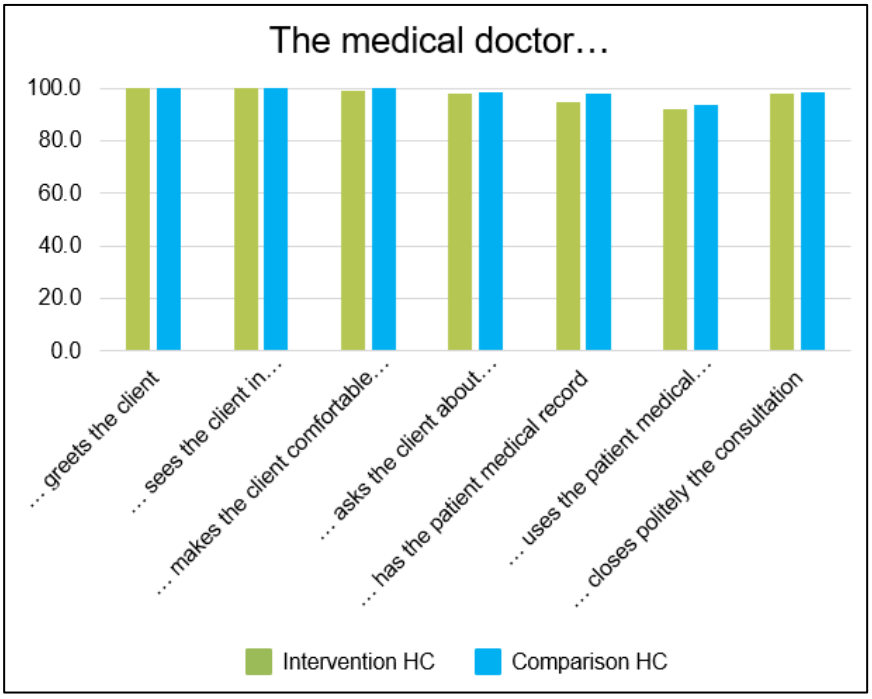
Table 9: Reason for medical visit

	Intervention		Comparison		Overall	
	n	%	n	%	n	%
Arterial hypertension	75	25.7	73	23.8	148	24.7
Diabetes	29	9.9	25	8.1	54	9.0
Asthma	5	1.7	4	1.3	9	1.5
COPD	6	2.0	4	1.3	10	1.7
Dyslipidaemia	3	1.0	4	1.3	7	1.2
Other chronic condition	27	9.3	28	9.1	55	9.2
Other non-chronic condition	127	43.5	143	46.6	270	45.1
Mental health issues	5	1.7	3	1.0	8	1.3
Geriatric conditions	15	5.1	23	7.5	38	6.3

4.2.3 *Adherence to principles of clinical practice*

In both the intervention and comparison HC, there were high levels of 'adherence to principles of clinical practice' achieved by doctors (Figure 16). There were no marked differences between the intervention and the comparison HC. The use of patient medical records (paper or digital) was the category with the lowest values: at 92.1% in the intervention and 93.8% in the comparison group.

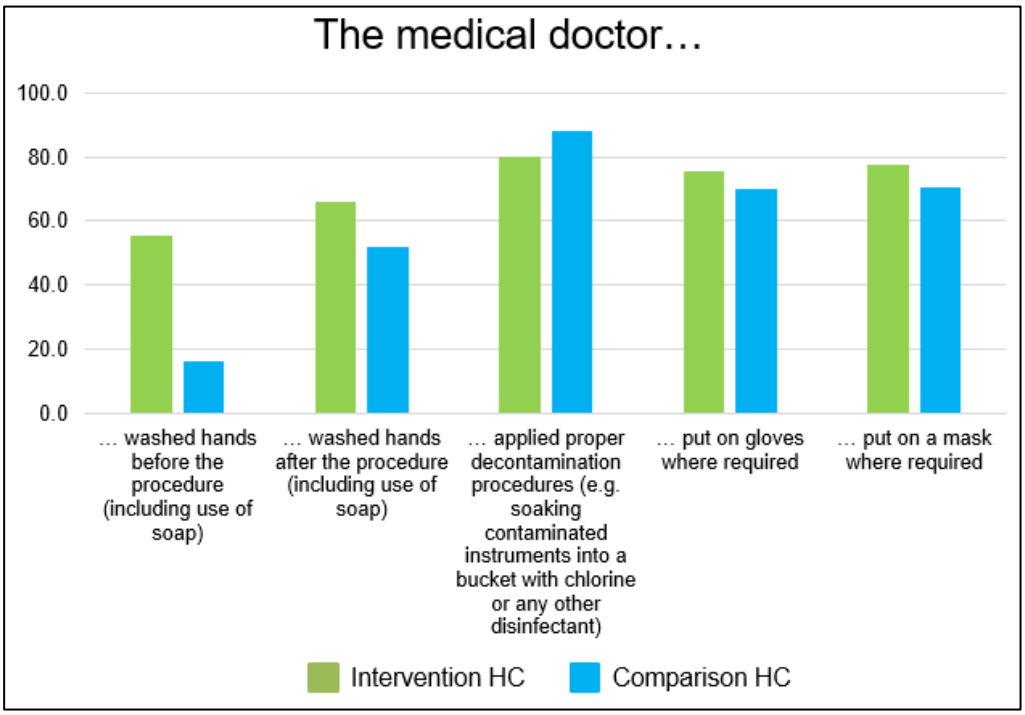
Figure 16: Adherence to principles clinical practice



4.2.4 *Practices on infection prevention and comparison*

Figure 17 shows indicators for doctor's behaviours towards infection prevention and comparison. More than half of the health care providers in the intervention group washed their hands with soap before (55.4%) and after (66.1%) the patient consultation. Where required, >60% of health care providers in both the intervention and comparison groups have applied contamination procedures for equipment and put on gloves or masks.

Figure 17: Infection prevention and comparison



4.2.5 *Practices in diabetes consultations*

As shown in Table 9, 9.9% (n=29) and 8.1% (n=25) of all patients in the intervention and comparison group, respectively, consulted for diabetes.

The 36 indicators assessed for diabetes consultations with regard to adherence to the diabetes treatment guidelines of the Albanian MoHSP are displayed in Table 17 in section 8.1, and combined scores were calculated for the following sub-categories:

- Anamnesis (10 indicators)
- Examination (8 indicators)
- Advice (18 indicators)
- Overall (combining all the above; 36 indicators)

Figure 18 to Figure 21 display the scores for the sub-categories. The following conclusions can be derived from these results:

Scores were on average highest for the advices given to diabetes patients (Figure 18).

- Scores categories were similar in the intervention and comparison groups.
- The scores for the examination were lowest for both groups. However, this might also be influenced to the negative because a proportion of patients came for routine or check-up visits where no examination was required (Figure 19). This finding was also in line with previous surveys in Fier and Diber (2015, 2018 and 2022). However, the fact that in about 65% of overall consultations physicians did not examine the patients or only perform a limited number or medical gestures is worrisome. A more in-depth examination is needed as to why this happens. In addition, this finding may an under-use of medical equipment provided by HAP.

Figure 18: Diabetes consultations: anamnesis scores

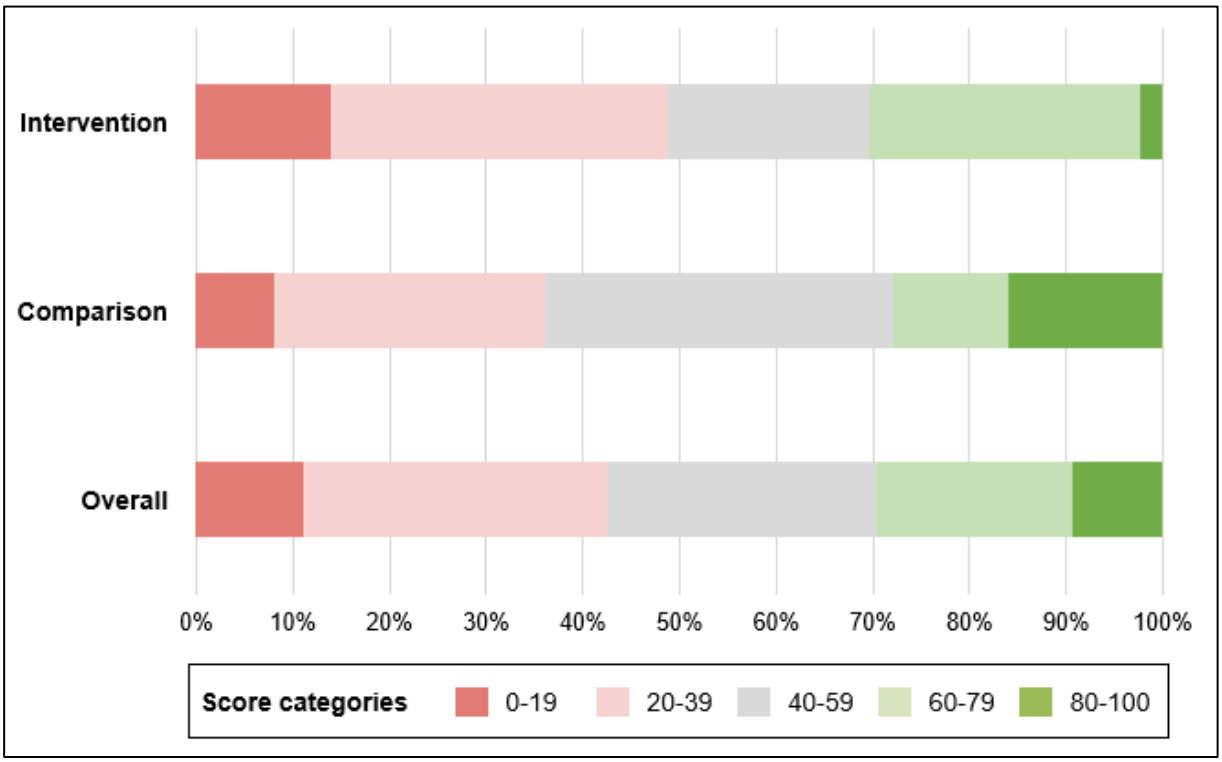


Figure 19: Diabetes consultations: examination scores

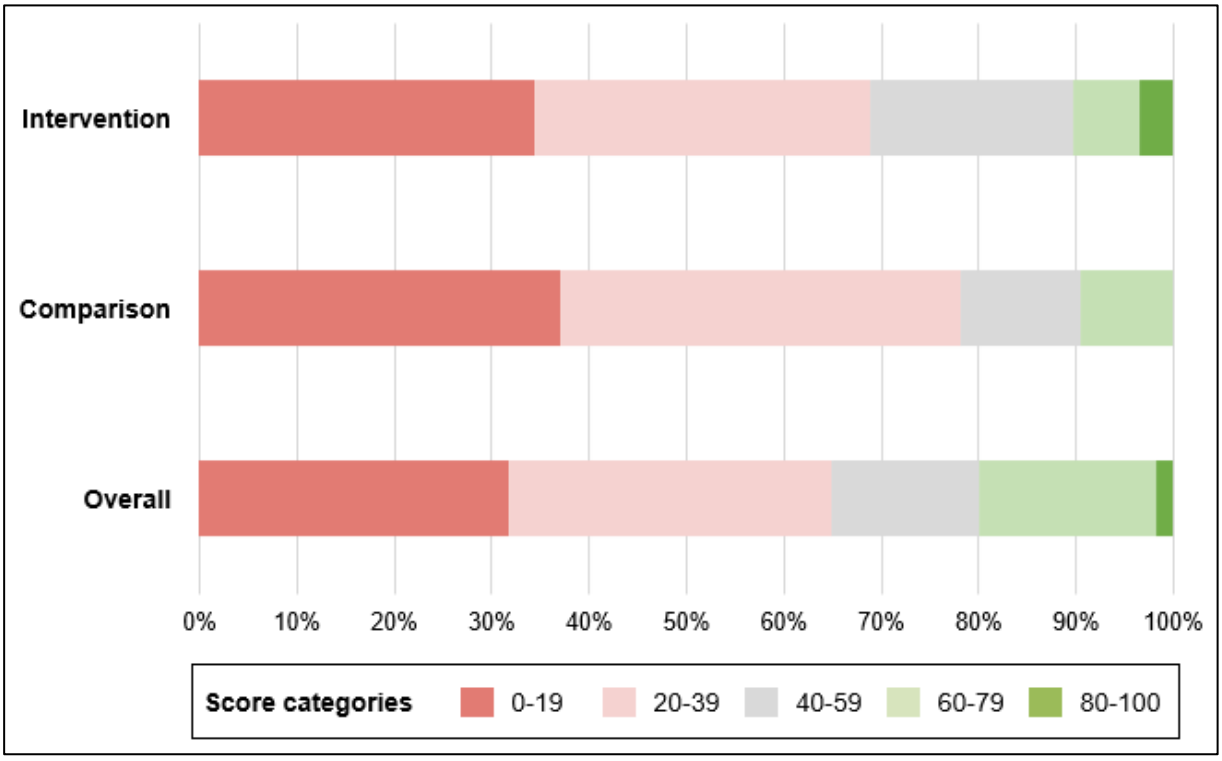


Figure 20: Diabetes consultations: advice scores

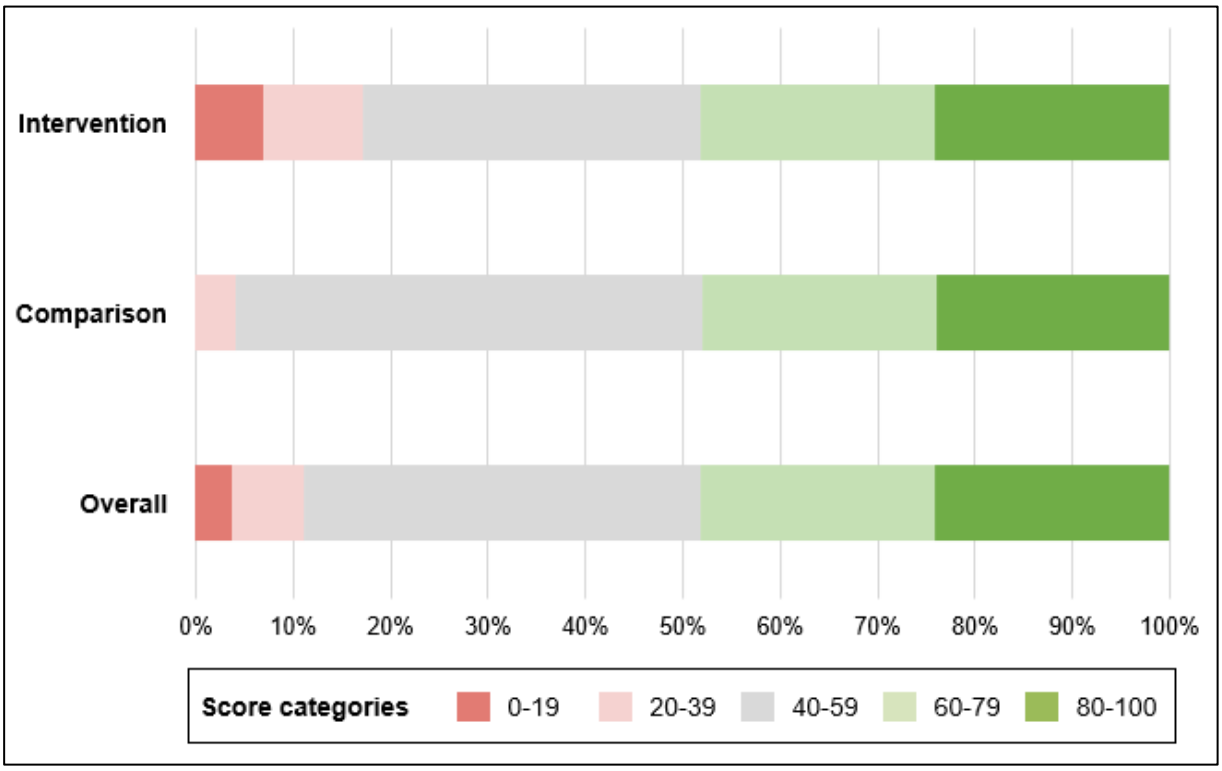
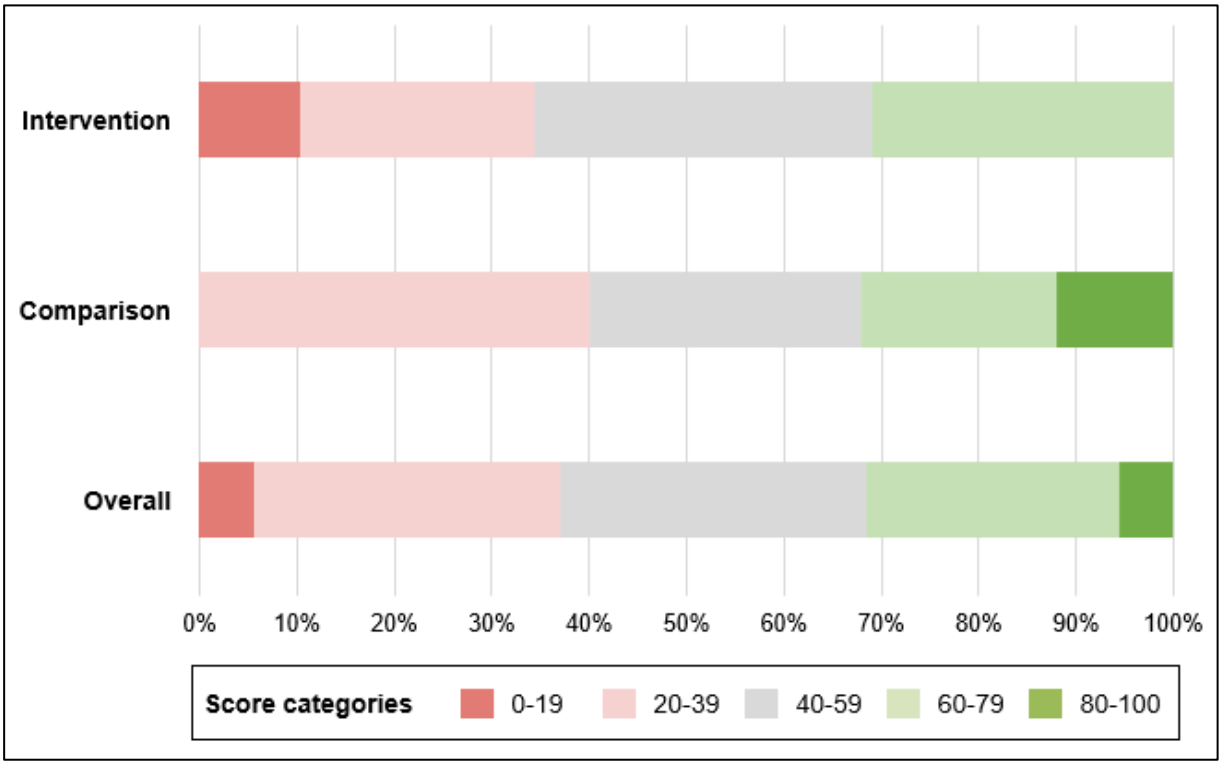


Figure 21: Diabetes consultations: overall scores



Among the 53 diabetes patients included in the study sample, the frequency of routine monitoring tests varied between intervention and comparison groups (Table 10), however, all results need to be interpreted with care, as sample size, especially also in stratified groups, were relatively small.

Substantially more patients had a fasting glucose test on the day of the survey in the intervention group (31.0%) compared to the comparison group (12.0%). Fasting glucose tests were most often conducted within the month before the survey (42.6% overall), though almost one in five patients reported their last test more than three months ago, and 3.7% could not recall or had never been tested.

For HbA1c testing, only 3.7% of patients had been tested on the day of the survey, and just over a fifth (22.2%) within the past month, while more than a third had their last HbA1c over three months ago. Notably, 11.1% reported never having had an HbA1c test or being unable to provide the information. Patterns were comparable in intervention and comparison groups.

For urine microalbuminuria testing, which is critical for monitoring diabetic complications, the overall coverage was low: more than a third (34.0%) had never been tested or did not know if/when they were tested, and less than 20% had been tested in the last month.

Common blood analyses were somewhat more regularly performed, but still nearly half of patients (47.2%) had their last test more than three months ago, with an additional 9.4% never or of unknown date.

Overall, the findings suggest that while fasting glucose testing is relatively frequent, essential routine monitoring tests such as HbA1c and urine microalbuminuria may be underutilized, particularly in comparison sites, highlighting gaps in the continuity and quality of diabetes care. However, it is important to note that HbA1c and urine microalbuminuria are laboratory-based investigations often performed in private laboratories or clinics. Although some of these tests are formally covered by public health insurance, the number of reimbursed beneficiaries is limited due to funding constraints. Therefore, the available data do not allow us to determine whether the low testing rates are primarily attributable to gaps in clinical practice (e.g., lack of prescription by physicians), patient-level barriers (e.g., OOP costs), or a combination of both. Financial barriers may discourage patients from completing recommended investigations, even when prescribed. Conversely, providers may adapt their prescribing behaviour to perceived affordability constraints. This situation reflects broader structural limitations within the Albanian health system, including restricted financial coverage and limited availability of certain diagnostic services in public primary care settings.

Table 10: Frequency of routine monitoring tests performed in diabetes patients (n=53)

	Intervention		Comparison		Overall	
	n	%	n	%	n	%
Last fasting glucose test						
Day of the survey	9	31.0	3	12.0	12	22.2
Within last month	12	41.4	11	44.0	23	42.6
Within last 3 months	3	10.3	4	16.0	7	13.0
More than 3 months	4	13.8	6	24.0	10	18.5
Never, unknown	1	3.5	1	4.0	1	3.7
Last HbAc1 test						
Day of the survey	2	6.9	0	0.0	2	3.7
Within last month	5	17.2	7	28.0	12	22.2
Within last 3 months	7	24.1	8	32.0	15	27.8
More than 3 months	10	34.5	9	36.0	19	35.2
Never, unknown	5	17.2	1	4.0	6	11.1
Last urine (microalbuminuria) test						
Day of the survey	2	6.9	0	0.0	2	3.8
Within last month	4	13.8	6	25.0	10	18.9
Within last 3 months	4	13.8	4	16.7	8	15.1
More than 3 months	4	13.8	11	45.8	15	28.3
Never, unknown	15	51.7	3	12.5	18	34.0

Last common blood analysis						
Day of the survey	2	6.9	0	0.0	2	3.8
Within last month	5	17.2	7	29.2	12	22.6
Within last 3 months	5	17.2	4	16.7	9	17.0
More than 3 months	14	48.3	11	45.8	25	47.2
Never, unknown	3	10.3	2	8.3	5	9.4

4.2.6 *Practices in hypertension consultations*

As shown in Table 9, about a quarter of all patients (24.7%; n=148) of all patients consulted for hypertension (25.7% in the intervention and 23.8% in the comparison group, respectively).

The 35 indicators assessed for hypertension consultations with regard to adherence to the hypertension treatment guidelines of the Albanian MoHSP are displayed in Table 18 in section 8.1, and combined scores were calculated for the following sub-categories:

- Anamnesis (11 indicators)
- Examination (10 indicators)
- Advice (13 indicators)
- Overall (combining all the above; 35 indicators)

Figure 22 to Figure 25 display the scores for the hypertension consultations for the four sub-categories. The following conclusions can be derived from these results:

- Scores were on average highest for the advice given to hypertension patients (Figure 24). Scores categories were similar in the intervention and comparison groups.
- The scores for the hypertension examination were lowest for both groups (Figure 23).
- Overall scores for hypertension consultations showed very similar patterns in the intervention and comparison groups: between 20-30% scored in the two lowest categories and between 35-45% in the two highest categories (Figure 25).

Figure 22: Hypertension consultations: anamnesis scores

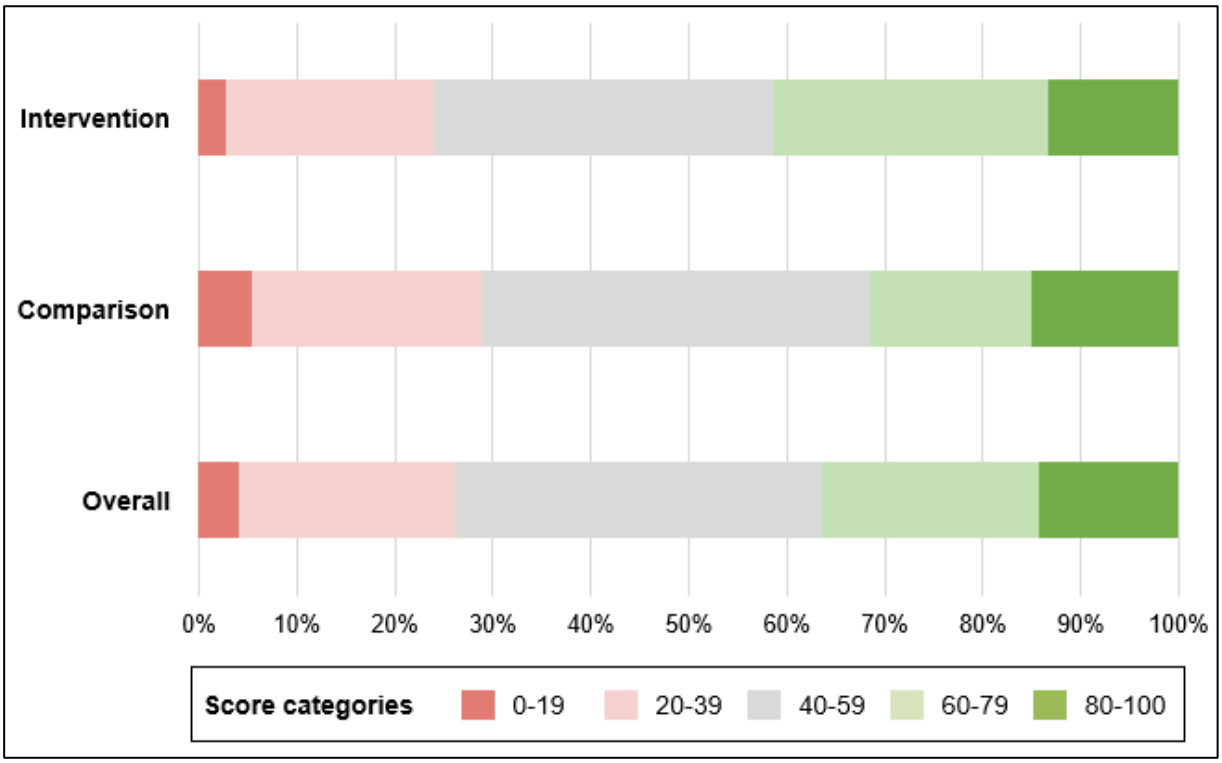


Figure 23: Hypertension consultations: examination scores

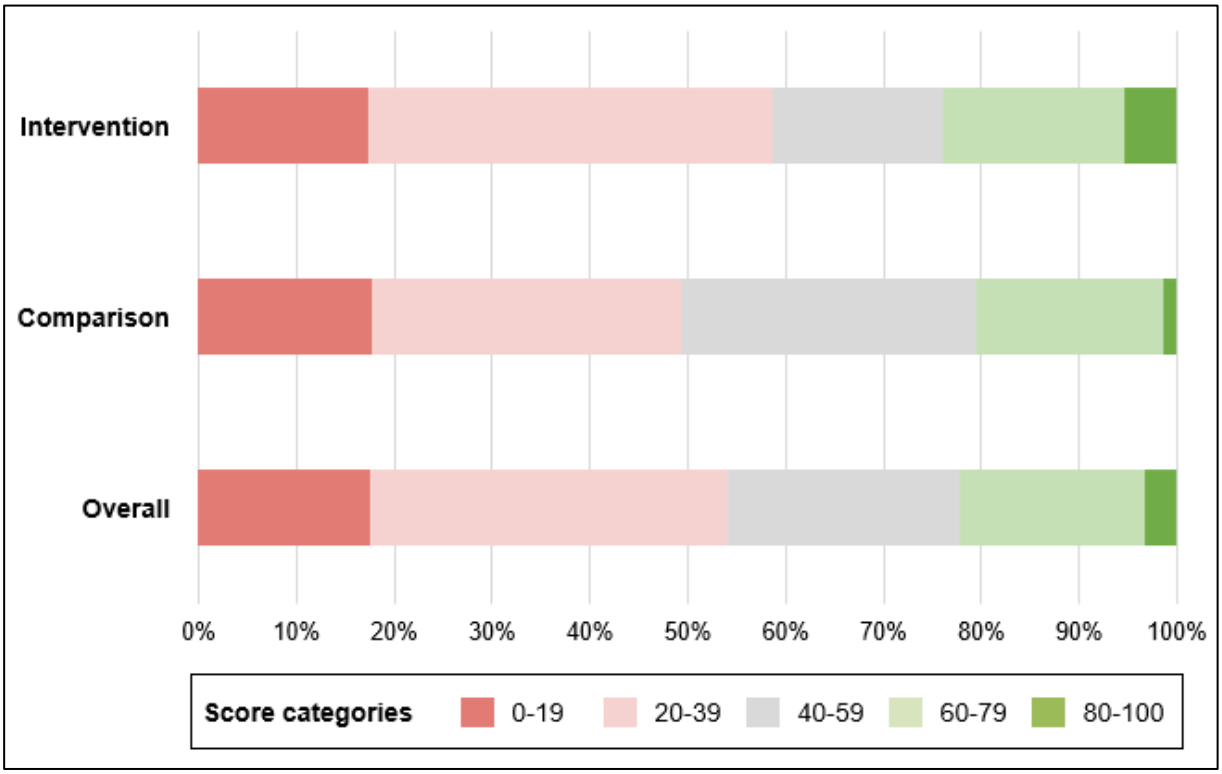


Figure 24: Hypertension consultations: advice scores

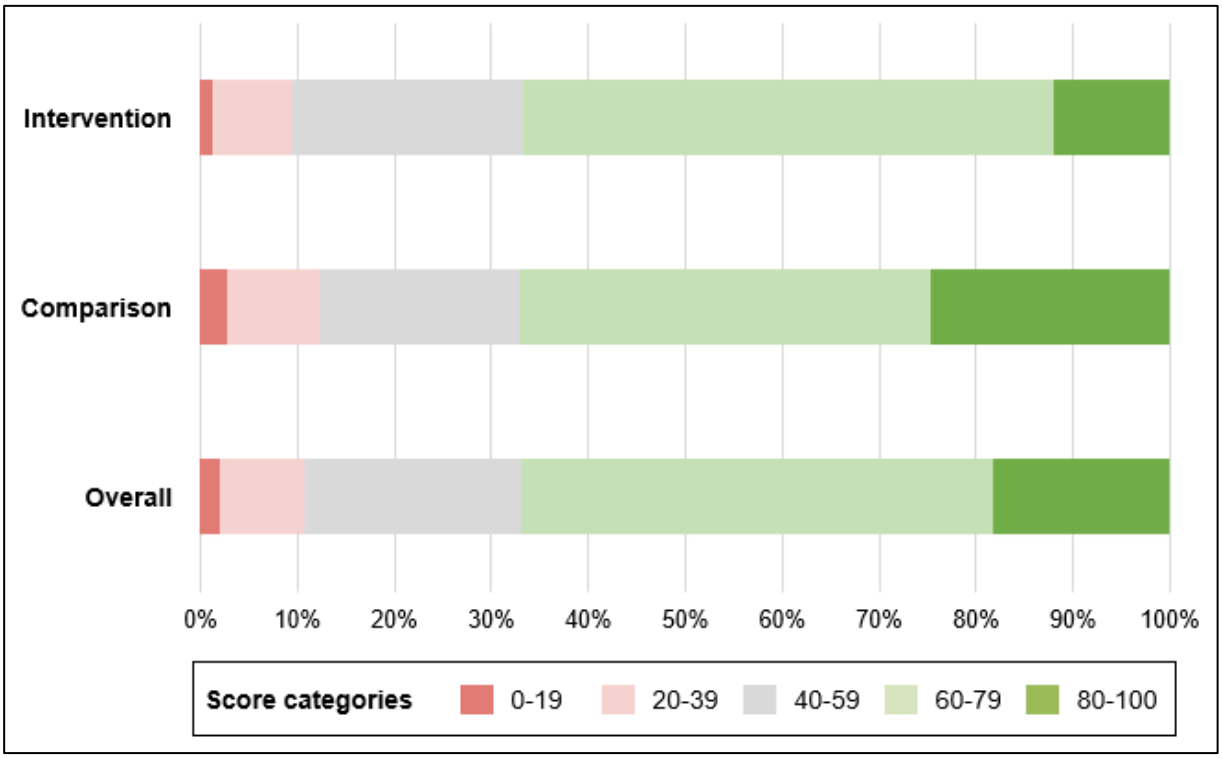
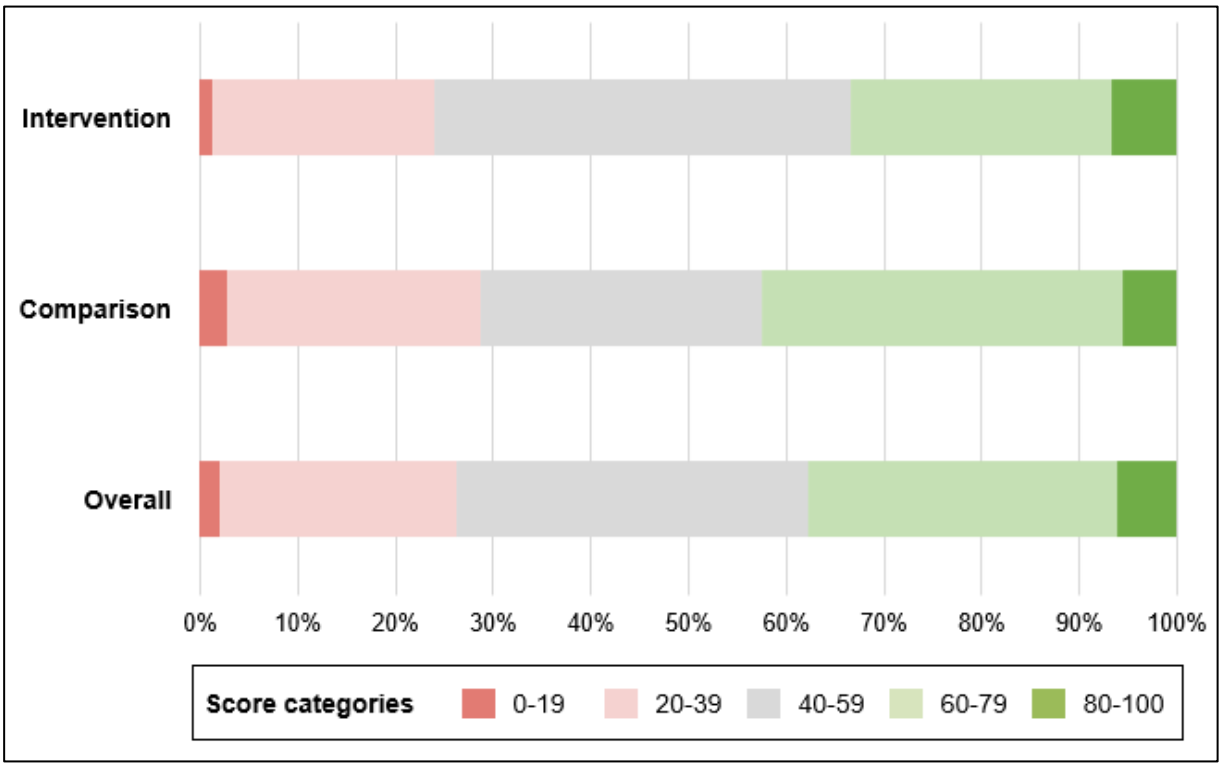


Figure 25: Hypertension consultations: overall scores



4.2.7 *Practices in consultations for conditions other than diabetes or hypertension*

As shown in Table 9, about 66.4% (n=430), respectively two thirds, of all patients consulted for diseases and conditions other than diabetes or hypertension.

The 14 indicators assessed for consultations for conditions other than diabetes and hypertension are displayed in Table 19 in section 8.1, and combined scores were calculated for the following sub-categories:

- Anamnesis (4 indicators)
- Examination (2 indicators)
- Advice (8 indicators)
- Overall (combining all the above; 14 indicators, thus, fewer indicators as for diabetes and hypertension which were the focus of the survey and analysis)

Figure 26 to Figure 29 display the scores for the consultations for conditions other than diabetes and hypertension for these four sub-categories. The following conclusions can be derived from these results albeit fewer indicators than for diabetes and hypertensions consultation:

- Proportions of >70% in the highest category (80-100 score points) were attained for all sub-categories (anamnesis, examination and advice). Thus, the scores were markedly higher than for diabetes and hypertension consultations.
- However, similarly to diabetes and hypertensions, lower scores were attained for examinations compared to anamneses and advice giving.

Figure 26: Consultations for other conditions: anamnesis scores

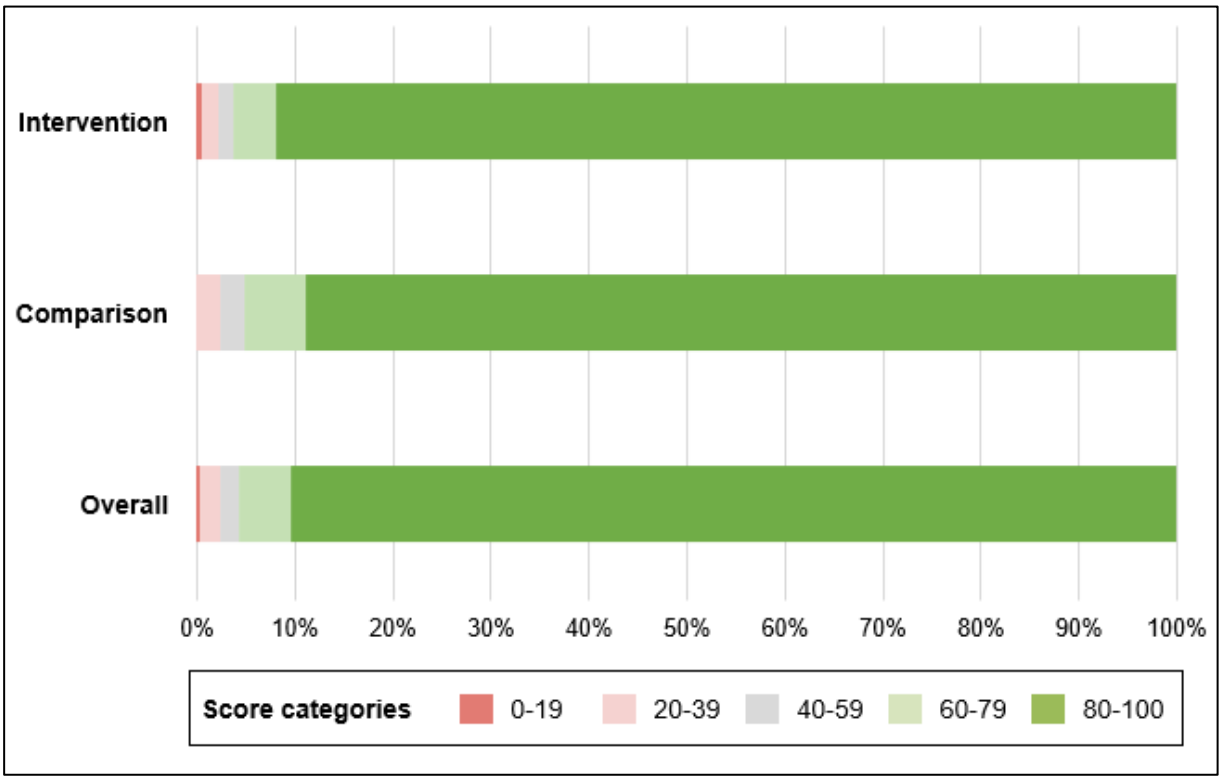


Figure 27: Consultations for other conditions: examination scores

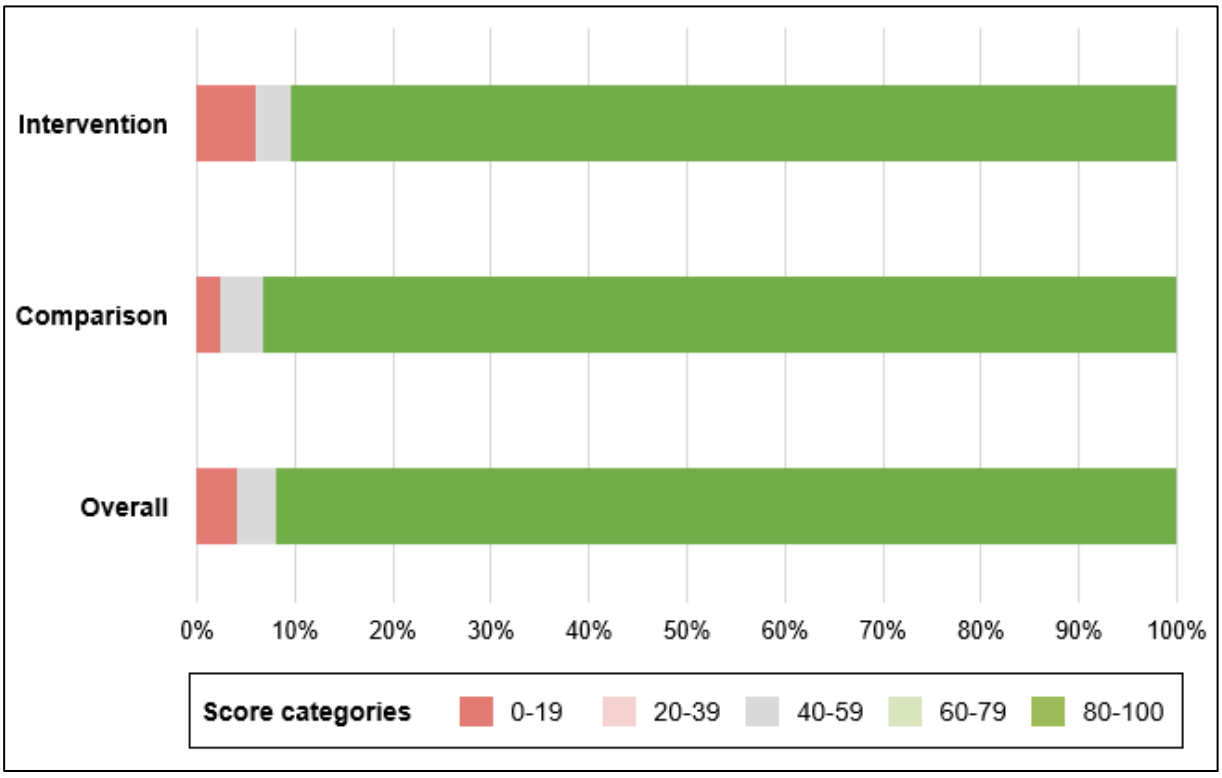


Figure 28: Consultations for other conditions: advice scores

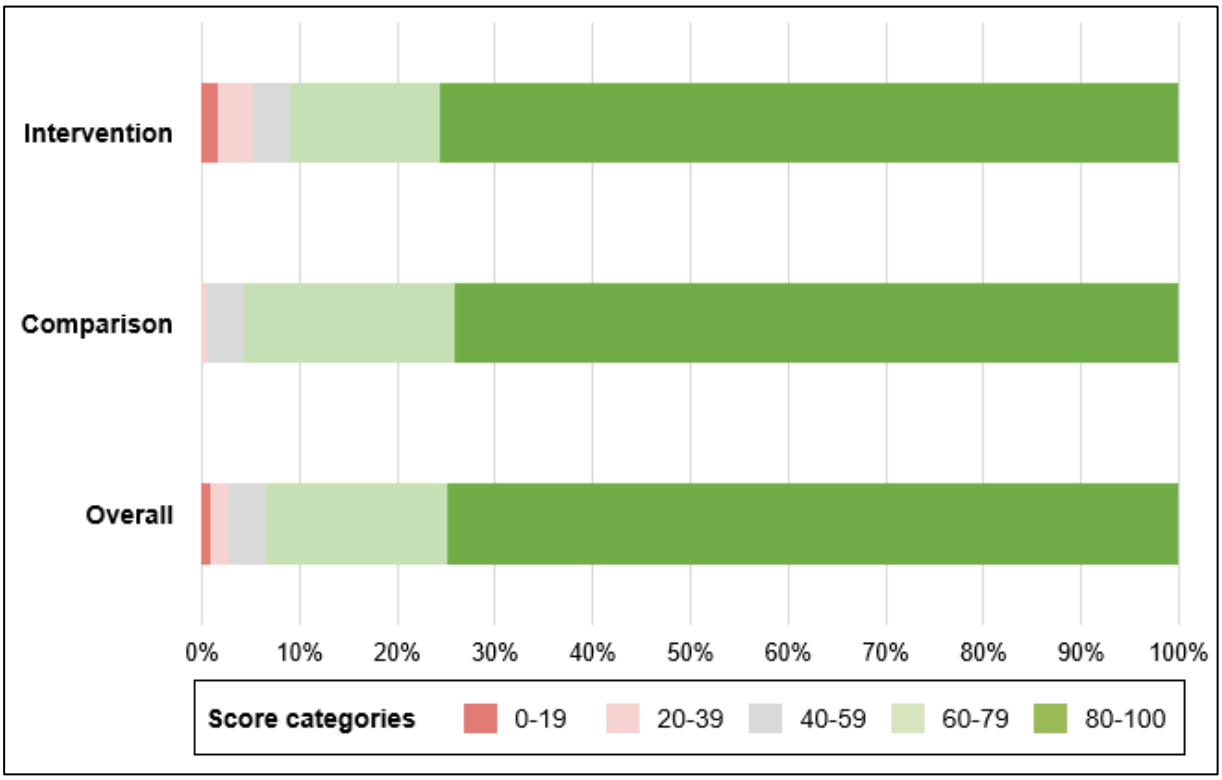
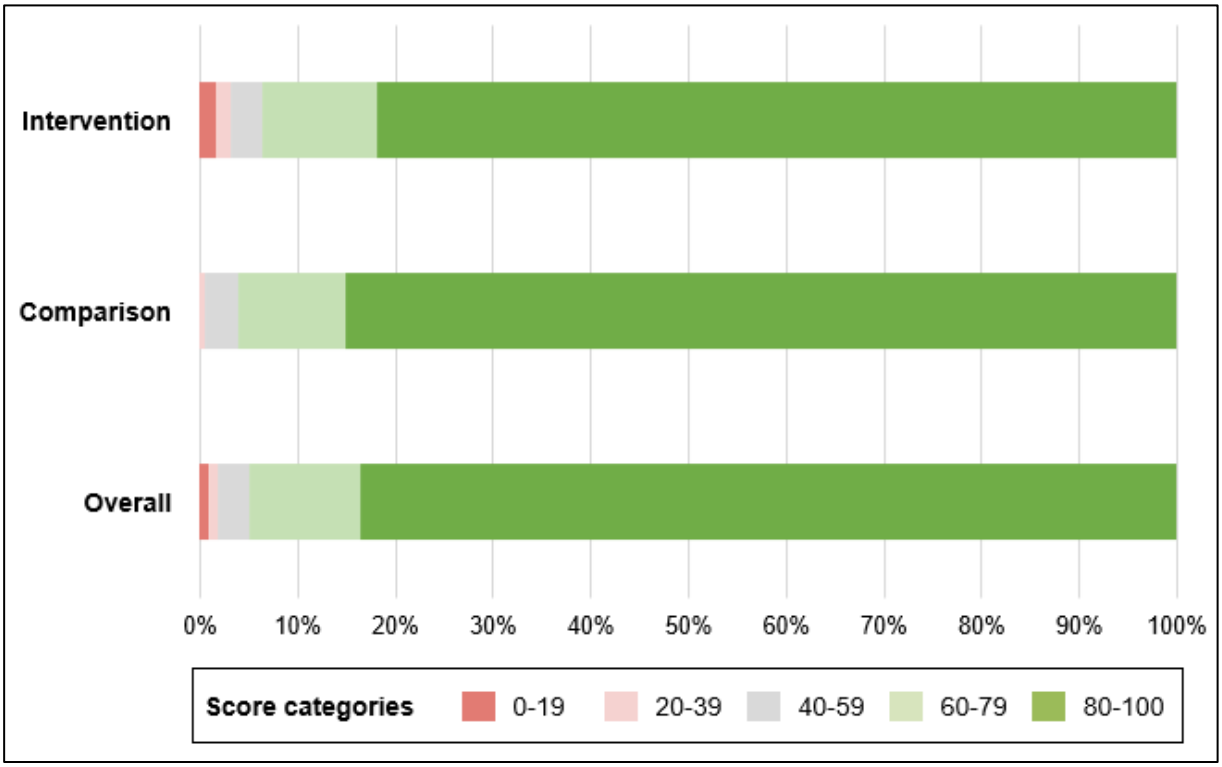


Figure 29: Consultations for other conditions: overall scores



4.2.8 *Overall patient-doctor consultation scores*

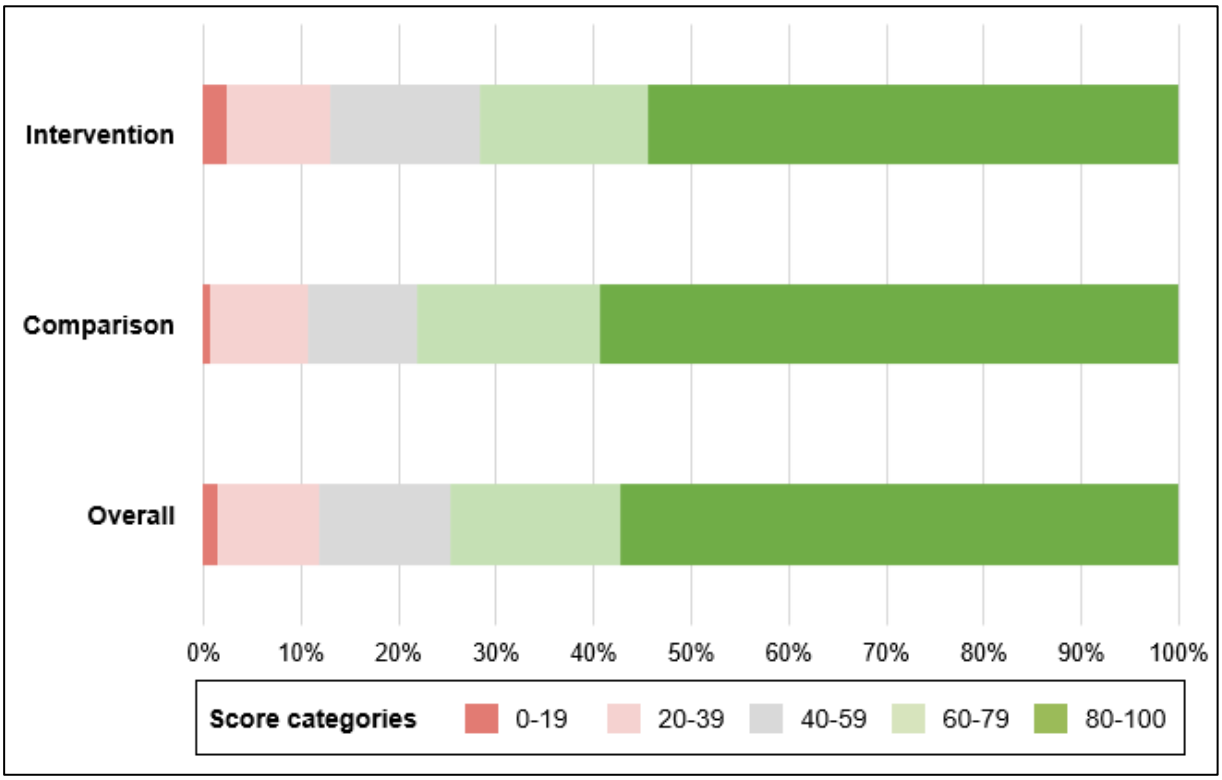
The overall score on patient-doctor consultations resulting from the observations combines the above presented dimensions, namely:

- Principles of clinical history
- Practices in diabetes consultations
- Practices in hypertension consultations
- Practices in consultations for conditions other than diabetes and hypertension

Figure 30 displays the overall scores for the patient-doctor consultations. The following conclusions can be derived from these results:

- In both groups, slightly more than 50% of doctor-patient consultations (54.5% in intervention and 59.9% in comparison group, respectively) scored overall between 80-100 score points.
- Score categories were similarly distributed between intervention and comparison groups.

Figure 30: Overall clinical observation score



4.3 Patient exit interviews

In 2025, 747 exit interviews were conducted in 47 HC, thereof 357 in the intervention and 390 in the comparison HC. Of note, no exit interviews were conducted in Peshkopia (an intervention HC) because on the survey day (Saturday 3rd of August), no patients showed up at the HC. On average, 16 exit interviews per HC were conducted both in the intervention and comparison HC.

4.3.1 *Characteristics of patients*

Patient characteristics assessed are presented in Table 11. Overall, the distribution of gender, age and age groups, were similar for respondents from the intervention and comparison groups. Median age was 59 years in the intervention and 62 years in the comparison group. In the intervention group, 50.7% of respondents were female whilst in the comparison group, 54.6% were female. Educational attainment levels of exit interview respondents were similar between the comparison and intervention groups. The majority in both groups have completed compulsory school (44.0% in the intervention and 39.3% in the comparison group, respectively). Furthermore, most respondents were pensioners, whereby the proportion of pensioners was higher in the comparison (51.2%) compared to the intervention (43.3%) group. About 6% of patients reported to be from an ethnic or linguistic minority.

Table 11: Patient age groups, median age and gender

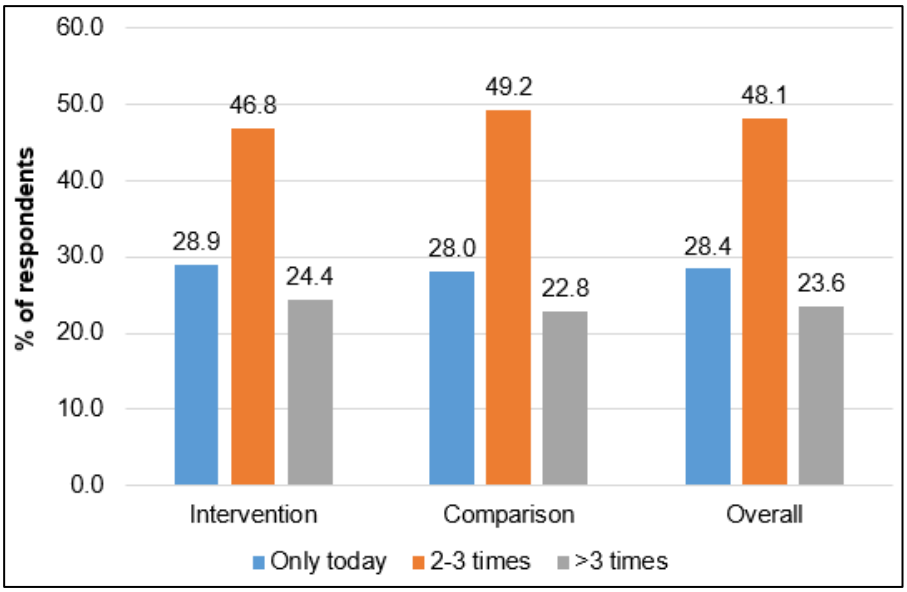
	Intervention		Comparison		Overall	
	N	%	n	%	n	%
Age groups						
<1 year	8	2.2	16	4.1	24	3.2
1-5 years	5	1.4	12	3.1	17	2.3
6-18 years	23	6.4	17	4.4	40	5.4
19-49 years	79	22.1	73	18.7	152	20.4
>49 years	242	67.8	272	69.7	514	68.8
Median age in years	**59**		**62**		**61**	
Gender						
Male	176	49.3	177	45.4	353	47.3
Female	181	50.7	213	54.6	394	52.7
Educational attainment						
Never attended school	3	0.9	3	0.9	6	0.9
Completed primary school (max 5 years)	20	6.2	20	5.8	40	6.0
Completed compulsory school (8/9 years)	142	44.0	136	39.3	278	41.6
Completed high school (12 years)	123	38.1	128	37.0	251	37.5
Completed college/university	35	10.8	59	17.1	94	14.1
Occupation						
Farmer	4	1.2	11	3.2	15	2.2
Employed	62	19.2	63	18.2	125	18.7
Self-employed	10	3.1	7	2.0	17	2.5
Housewife	20	6.2	17	4.9	37	5.5
Governmental employee	10	3.1	8	2.3	18	2.7
Unemployed	50	15.5	51	14.7	101	15.1
Pensioner	140	43.3	177	51.2	317	47.4

Other	27	8.4	12	3.5	39	5.8
Member of an ethnic or linguistic minority	**21**	**5.9**	**24**	**6.2**	**45**	**6.0**

4.3.2 *Use of health care services*

Most respondents visited the HC between 2-3 times over the course of the 3 months preceding the survey, in both the intervention group (46.8%) and the comparison group (49.2%) (Figure 31). On average, respondents visited the HC 3.5 times in the 3 months preceding the survey (3.5 times in the intervention and 3.6 times in the comparison group).

Figure 31: Frequency of visits to health centre in the 3 months preceding the survey



4.3.3 *Reason and type of consultation*

The most common reason for the consultation to the HC at the day of the survey among the exit interview respondents were chronic conditions (Table 12). Therein, most came for (not assessed) other chronic conditions (15.7% overall), and 13.7% (overall) came for arterial hypertension, followed by 7.6% for diabetes.

Table 12: Reasons for health centre consultation on survey day

	Intervention		Comparison		Overall	
	n	%	n	%	n	%
Arterial hypertension	44	12.3	58	14.9	102	13.7
Diabetes	27	7.6	30	7.7	57	7.6
Asthma	7	2.0	7	1.8	14	1.9
COPD	2	0.6	1	0.3	3	0.4
Dyslipidaemia	1	0.3	2	0.5	3	0.4
Other chronic conditions	57	16.0	60	15.4	117	15.7
Geriatric conditions	20	5.6	10	2.6	30	4.0
Mental health issues	4	1.1	5	1.3	9	1.2
Other non-chronic condition	45	12.6	96	24.6	141	18.9
Mother and child health	32	9.0	39	10.0	71	9.5
Other	118	33.1	82	21.0	200	26.8

Respondents were asked which type of consultations they sought on the day of the survey, whereby multiple answers were possible (Table 13). In both the intervention and comparison group, most patients reported to have consulted the HC on the survey day to conduct an examination (52.4% and 62.2%, respectively). In addition, 31.4% and 40.4% have received a prescription. Less than 20% in both groups were further referred to a specialist doctor or additional testing/examinations.

Table 13: Type of consultation on survey day

	Intervention		Comparison		Overall	
	n	%	n	%	n	%
Conduct an examination	187	52.4	242	62.2	429	57.5
Receive a prescription	112	31.4	157	40.4	269	36.1
Referral to specialist doctor	63	17.7	63	16.2	126	16.9
Referral for further testing/examinations	44	12.3	61	15.7	105	14.1
Other type of consultation	117	32.8	71	18.3	188	25.2

4.3.4 *Health care providers*

Respondents were asked what type of health professional they attended on the day of the survey, whereby multiple answers were possible (Table 14). Most patients were consulted a family doctor, which was 47.6% in the intervention and 64.8% in the comparison group. The proportion of those attended to by a general doctor was slightly higher in the intervention group (27.7% vs. 19.3%) than in the comparison group. Similarly for the category 'Other', which included nurses, x and y (24.7% vs. 14.7%, respectively).

Table 14: Health care provider on survey day

	Intervention		Comparison		Overall	
	n	%	n	%	n	%
Family doctor	170	47.6	252	64.8	422	56.6
General doctor	99	27.7	75	19.3	174	23.3
Specialist doctor	14	3.9	17	4.4	31	4.2
Other	88	24.7	57	14.7	145	19.4

4.3.5 *Satisfaction with health services*

When patients were asked about their overall satisfaction with the services received, in the intervention HC, 17.4% of respondents were satisfied and 81.8% were very satisfied (Table 15).

The high satisfaction with PHC services in Albania is potentially explained through several factors: (i) low knowledge of users' rights and what they can demand from the PHC services; (ii) low expectations to the PHC in general; (iii) satisfaction when the doctor is (a) referring them directly to a specialist or (b) is prescribing them medicines; (iv) in remote areas, access to services is challenging, so users tend to be satisfied with whatever is offered to them.

Table 15: Satisfaction with health services received, by intervention group

	Intervention		Comparison		Overall	
	n	%	n	%	n	%
Very unsatisfied	0	0.0	1	0.3	1	0.1
Unsatisfied	3	0.8	1	0.3	4	0.5
Satisfied	62	17.4	35	9.0	97	13.0
Very satisfied	292	81.8	352	90.5	644	86.3

The disaggregation of satisfaction levels by gender is shown in Table 16. In the intervention group, a higher proportion of women reported being 'very satisfied' compared to men (86.7% vs. 76.7%), whereas in the comparison group the pattern was reversed, with men reporting slightly higher levels of satisfaction than women (92.1% vs. 89.2%).

Table 16: Satisfaction with health services received, by gender

	Intervention				Comparison			
	Women		Men		Women		Men	
	n	%	n	%	n	%	n	%
Very unsatisfied	0	0.0	0	0.0	0	0.0	1	0.6
Unsatisfied	1	0.6	2	1.1	0	0.0	1	0.6
Satisfied	23	12.7	39	22.2	23	10.9	12	6.8
Very satisfied	157	86.7	135	76.7	189	89.2	163	92.1

4.3.6 *Perceived health care providers' behaviours*

Figure 32 and Figure 33 display 14 different indicators on health care providers' behaviours during the consultation from the patients' perspectives. The following results stand out:

- The patients largely reported overall 'positive' behaviours of the health care providers, as for all but two indicators, approval rates for the behaviours considered 'as should' were all above 80%. The two exceptions were (Figure 33):
  - In 75.8% of consultations (intervention group) did the doctor clearly explain the intake of the prescribed medicines to the patient. This is at least partly explained by the fact that typically, medication is prescribed by the doctor but intake is explained in detail by the pharmacist. In addition, it is possible that part of these are routine visits and thus, the patients are already well informed about the medicine intake, without a need for repetition.
  - In both the intervention and comparison groups, 77.6% and 64.4% of consultations, respectively, did the health care provider ask for any other current prescribed medicines. However, again, it might be that the health care provider is already informed about these.

Figure 32: Indicators on doctor's behaviours' during the consultation (part 1)

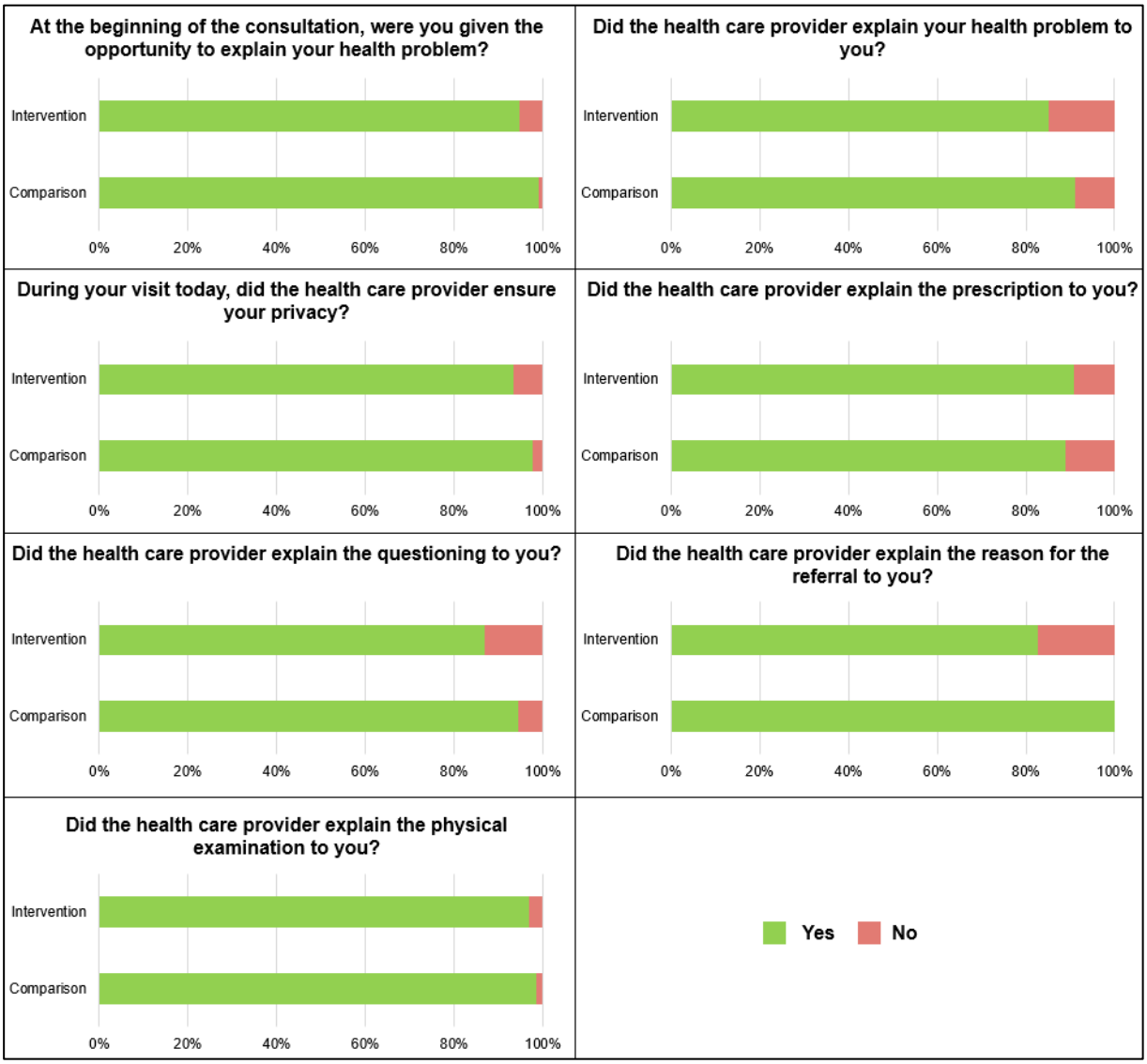
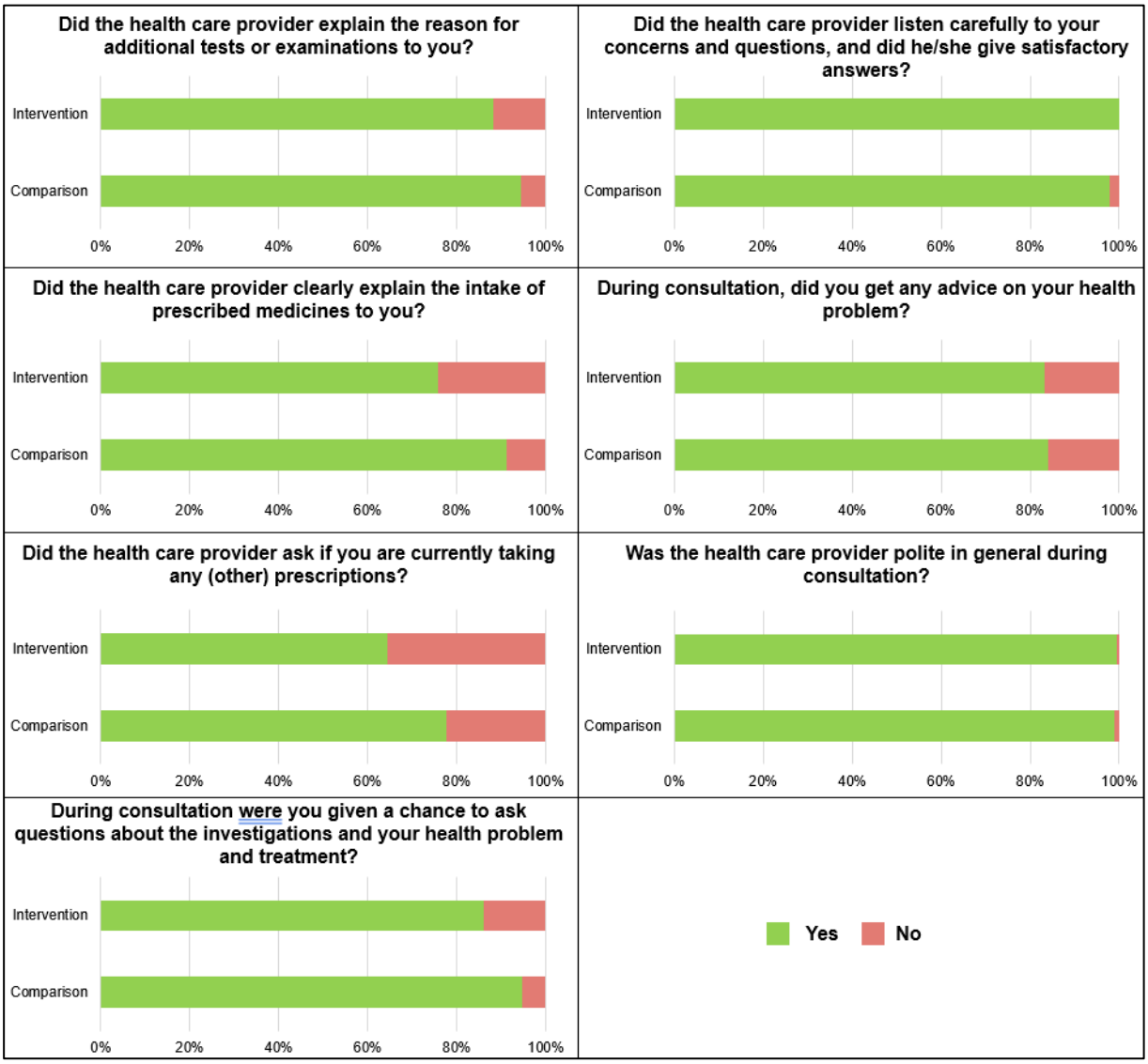


Figure 33: Indicators on perception of doctor's behaviours' during the consultation (part 2)



4.3.7 *Overall patient satisfaction scores*

A combined health care provider behaviour score for the 14 indicators shown above was calculated, calculating the number of services the patient was satisfied with out of the total number of services the patient could have been satisfied with. Different stratifications were made for analysis and the following findings stood out:

- Overall health care provider behaviours were similar in intervention HC and comparison HC (Figure 34).
- Health care provider behaviours were scored markedly higher for medical doctors (incl. family, general and specialist doctors) than for the other types of providers (Figure 35).
- Health care provider behaviours scored highest when patients consulted for diabetes, followed by hypertension (Figure 36). For other chronic conditions, higher proportions of scores <60% were found. Sample sizes for asthma (n=14), COPD (n=3) and dyslipidaemia (n=3) were too small to make meaningful interpretation.
- For mental health issues – even though sample size was small (n=9) – the proportion of scores in the 20-39 points was highest (Figure 37), and thus, there is some observed

limitations of health care providers with regard to mental health compared with other conditions.

Figure 34: Overall health care provider behaviour score as perceived by the patients, all consultations, by intervention group

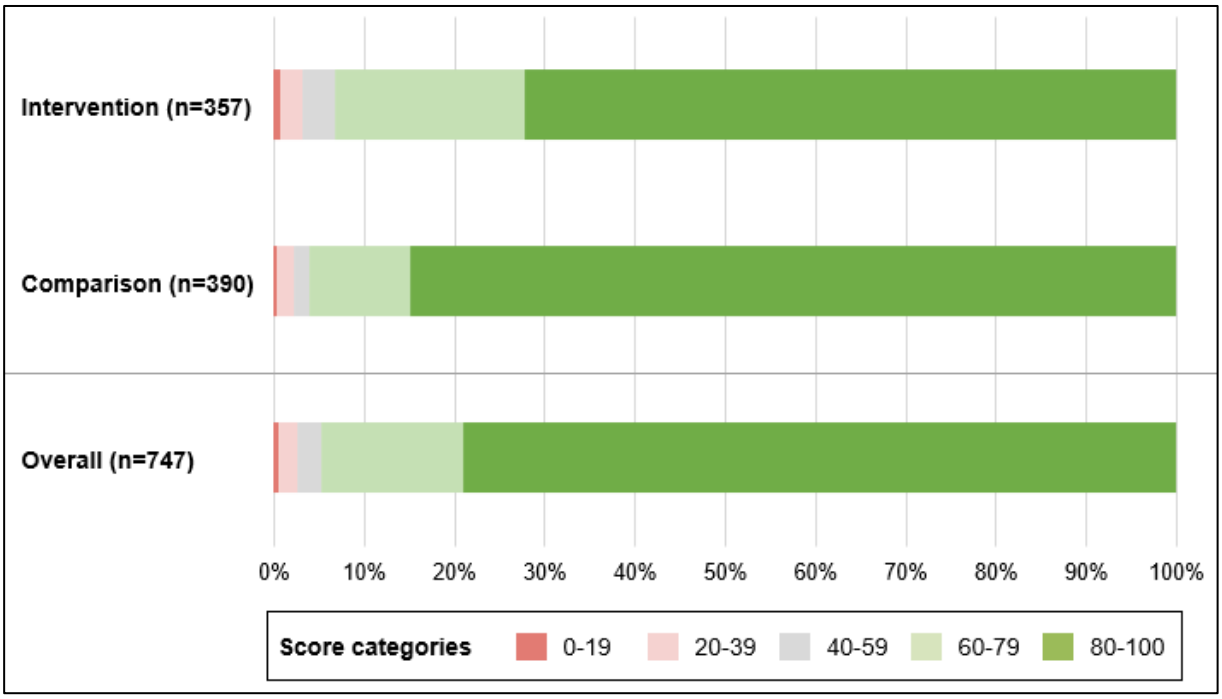


Figure 35: Overall health care provider behaviour score, all HC, by health care provider

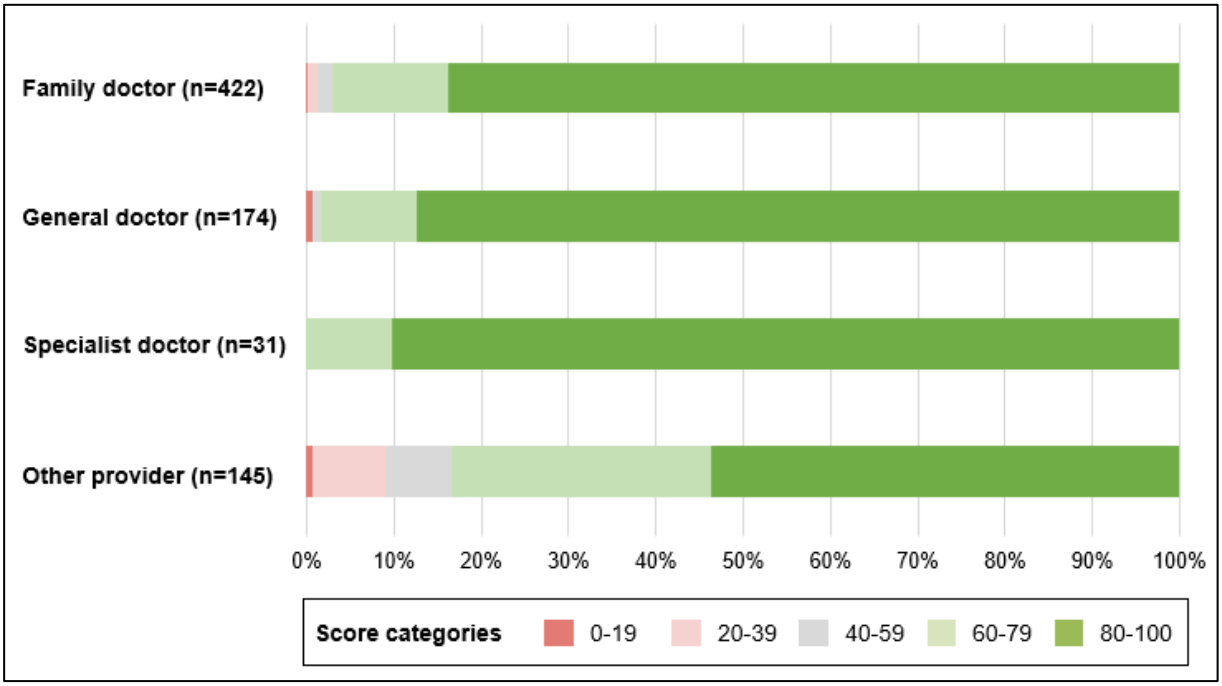


Figure 36: Overall health care provider behaviour score, all HC, by chronic conditions

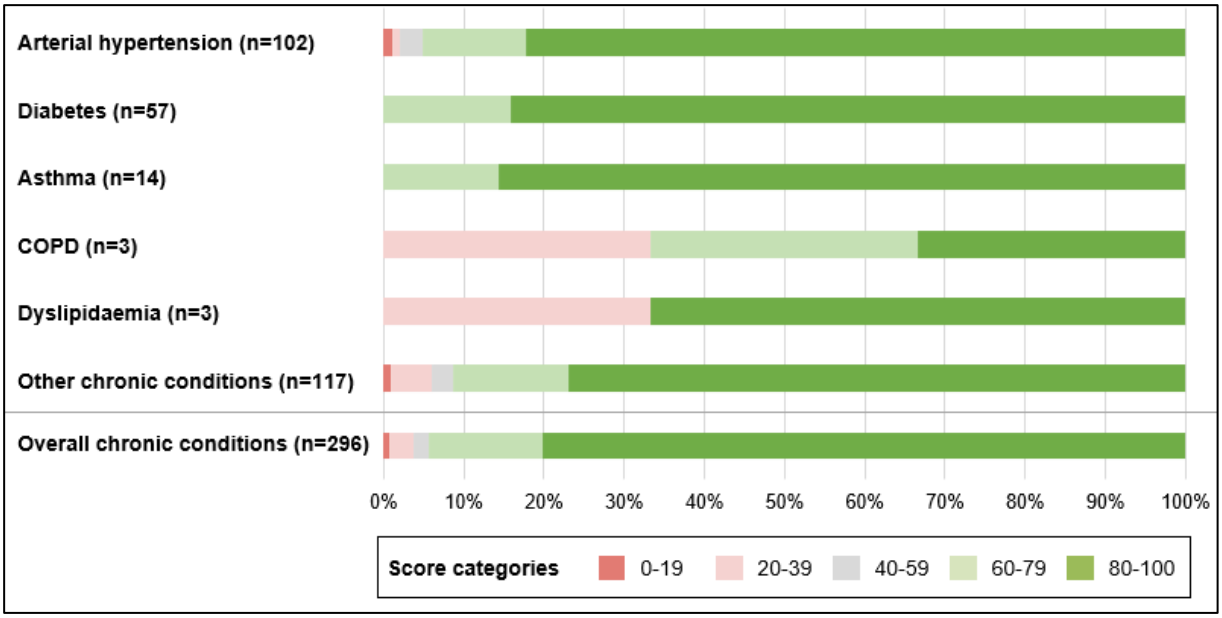


Figure 37: Overall health care provider behaviour score, all HC, by condition groups

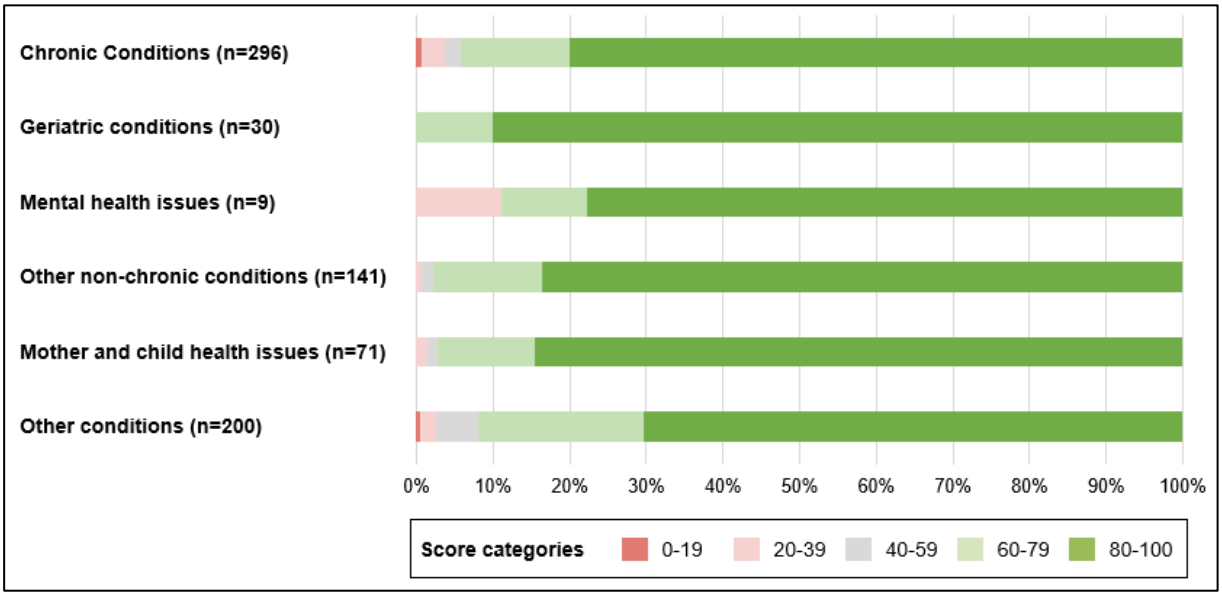
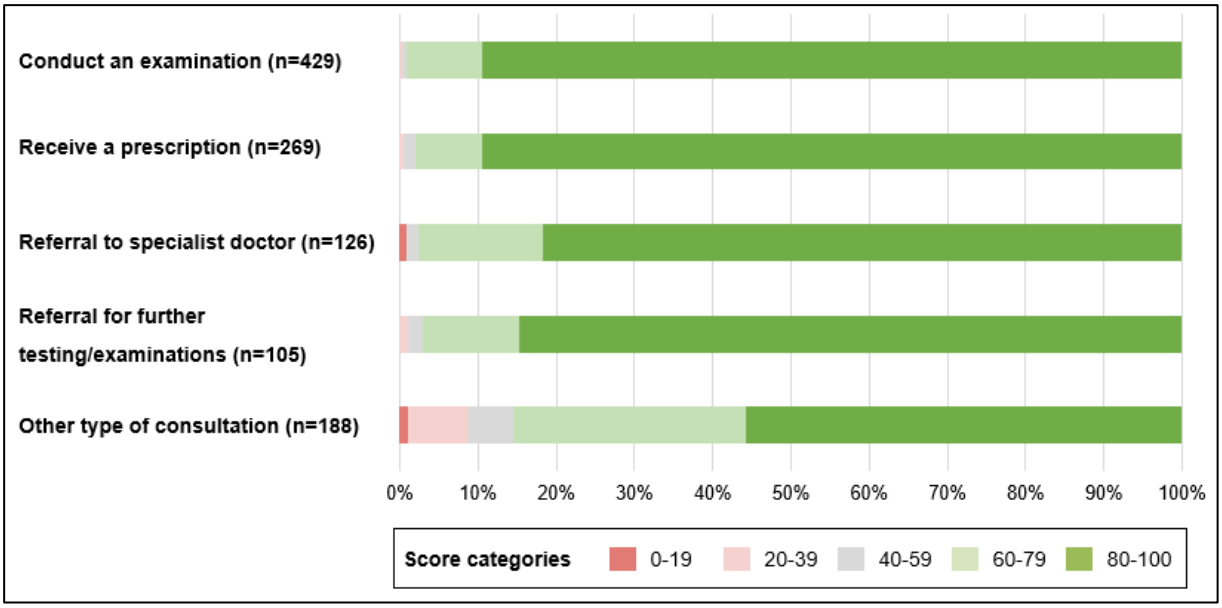
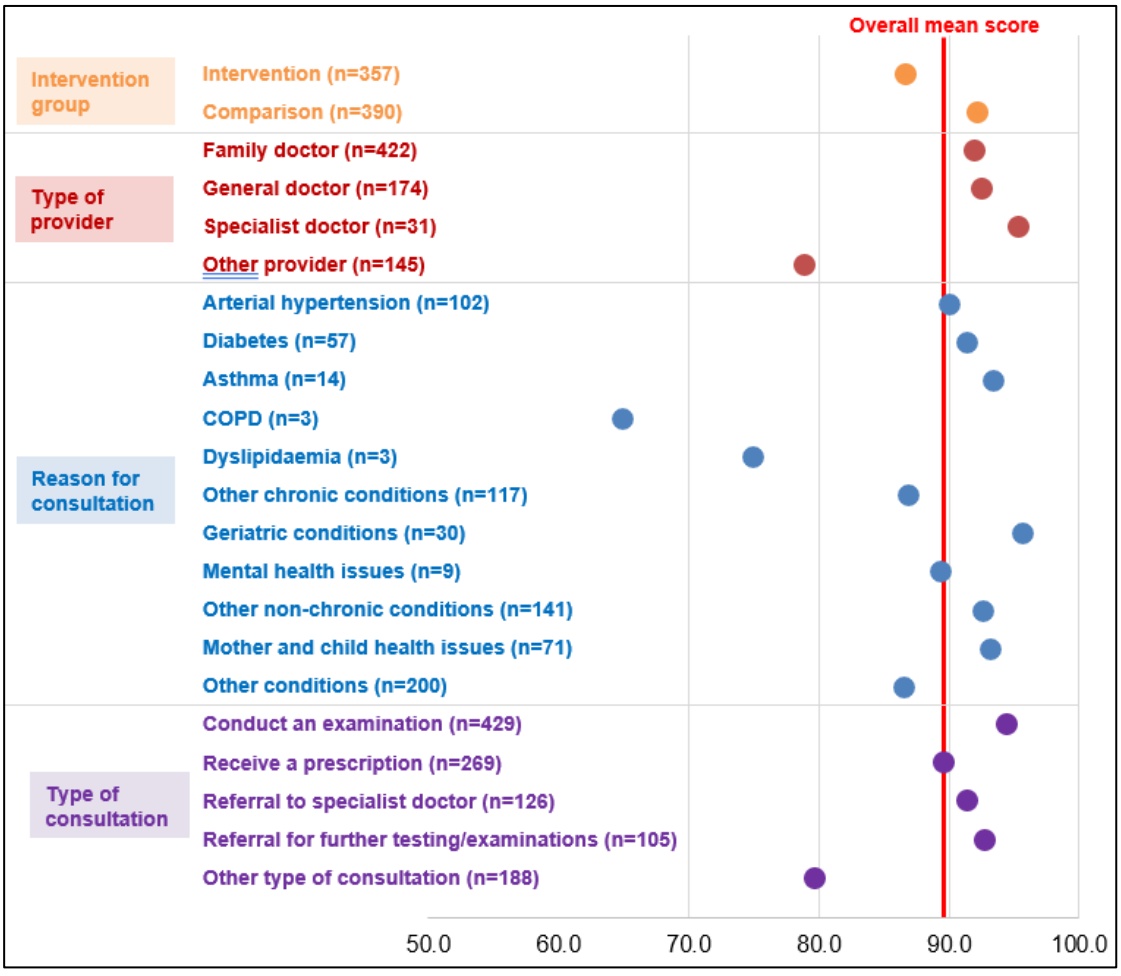


Figure 38: Overall health care provider behaviour score, all HC, by type of consultation



Mean behaviour scores are shown in Figure 39.

Figure 39: Mean health care provider behaviour scores



4.3.8 *Health spending and health insurance*

Among all respondents, only three individuals reported to have paid for their consultation on the day of the survey. At the same time, 72.0% of respondents from the intervention HCs and 73.0% of respondents from the comparison HCs reported to hold a valid insurance card. This is reflecting the fact that the MoHSP is providing all primary health care services for free, irrespectively whether individuals have a health insurance, thus, relativizing the need for the health insurance card. Only few services, e.g. health check for renewal of driving licence or documents demonstrating the person ability to work, require payments.

Overall, 12.9% (intervention) and 11.3% (comparison) reported to benefit from an economic or social aid scheme.

5 FINDINGS: FIER

This section presents the results for the overall indicators in Fier, focusing on the four selected HC with data available for all four survey rounds (2015, 2018, 2023, and 2025), thus covering a 10-year period.

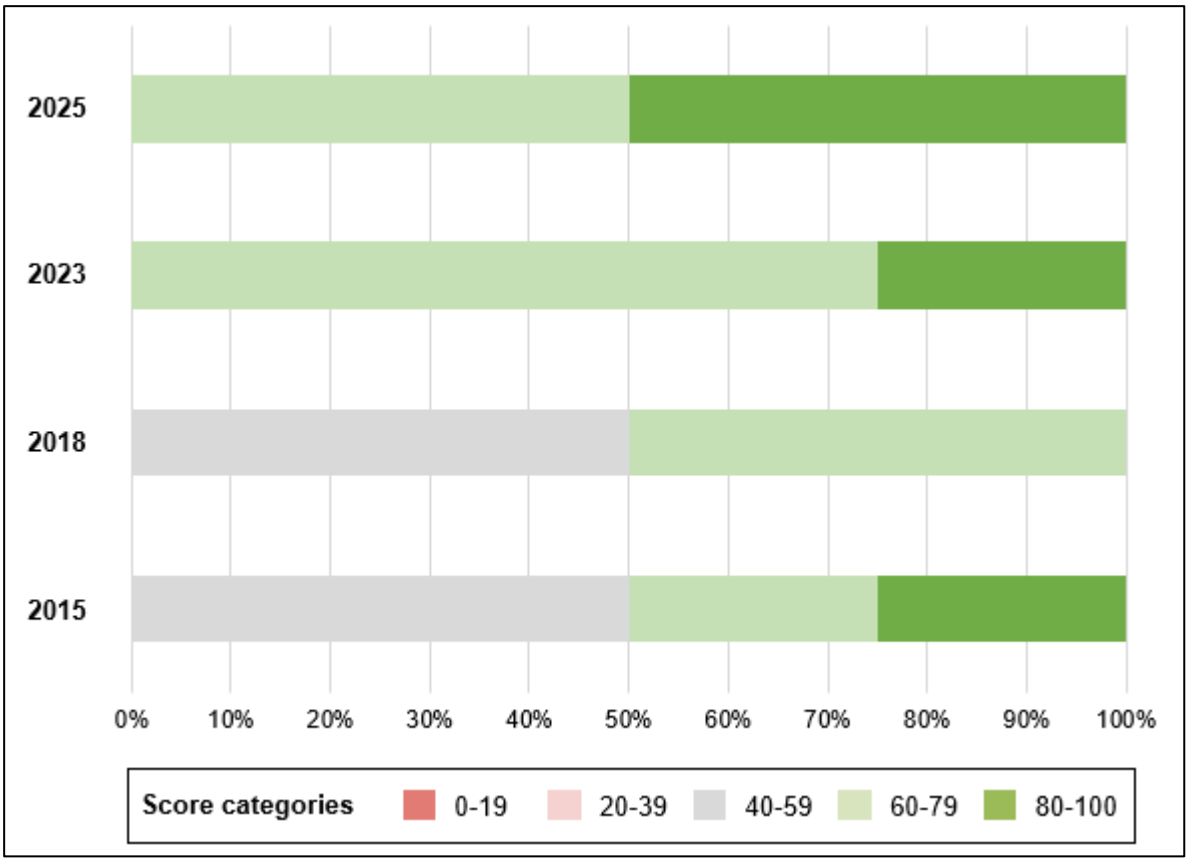
5.1.1 *Overall infrastructure scores*

Figure 40 shows the evolution of overall infrastructure scores for the four selected HCs in Fier over the ten-year period from 2015 to 2025. The scores reflect the combined performance across multiple structural domains, including cleanliness, water and sanitation, equipment availability, electricity and lighting, display of health information, and other facility-related aspects.

Overall, the results indicate steady improvement in HC infrastructure quality over time. In 2015 and 2018, most facilities fell within the mid-range score categories (40–79%), reflecting moderate but incomplete infrastructure readiness. From 2023 onwards, a clear shift toward higher performance levels is visible: all facilities achieved scores above 60%, and by 2025, over half reached the highest category (80–100%).

This upward trend demonstrates progressive strengthening of facility infrastructure and maintenance standards across the four HCs in Fier. The consistent improvements suggest the sustained impact of investments and support measures, contributing to enhanced readiness of primary health care facilities to deliver quality services.

Figure 40: Overall scores on infrastructure, Fier

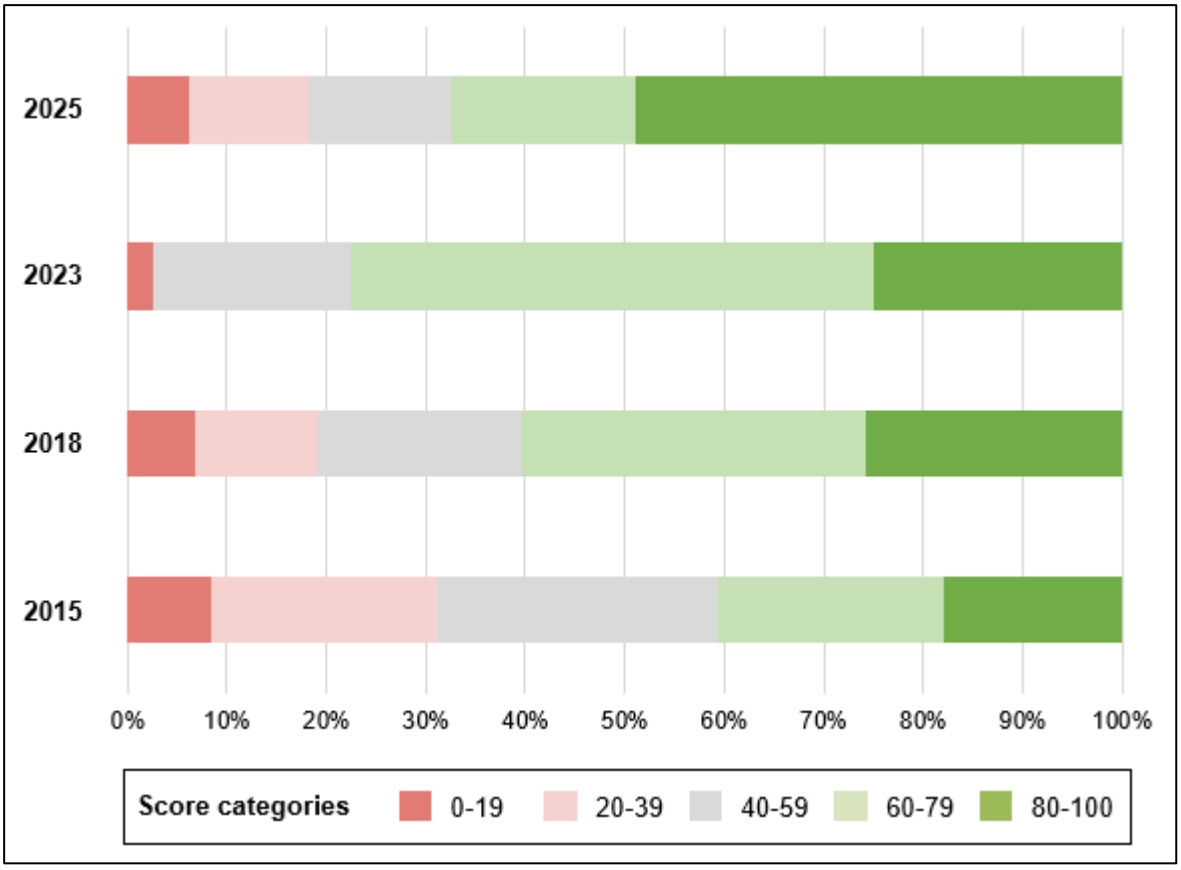


5.1.2 *Overall patient-doctor consultation scores*

The results of the overall score on patient-doctor consultations resulting from the observations show a steady and continuous improvement in consultation quality over time (Figure 41). In 2015 and 2018, most consultations fell within the lower and mid-range categories (0–59%), reflecting limited adherence to good clinical practice standards at the time. From 2023 onwards, there was a marked upward shift, with the majority of observations reaching the higher categories (60–100%). By 2025, more than half of all consultations achieved scores in the highest category (80–100%), indicating progress in clinical performance and patient management.

Overall, these findings demonstrate consistent strengthening of clinical practice and consultation quality in the four Fier HCs over the past decade. The trend suggests that ongoing professional training, supervision, and the integration of standardised clinical guidelines have effectively contributed to better-structured, more comprehensive, and patient-centred consultations.

Figure 41: Overall clinical observation score, Fier



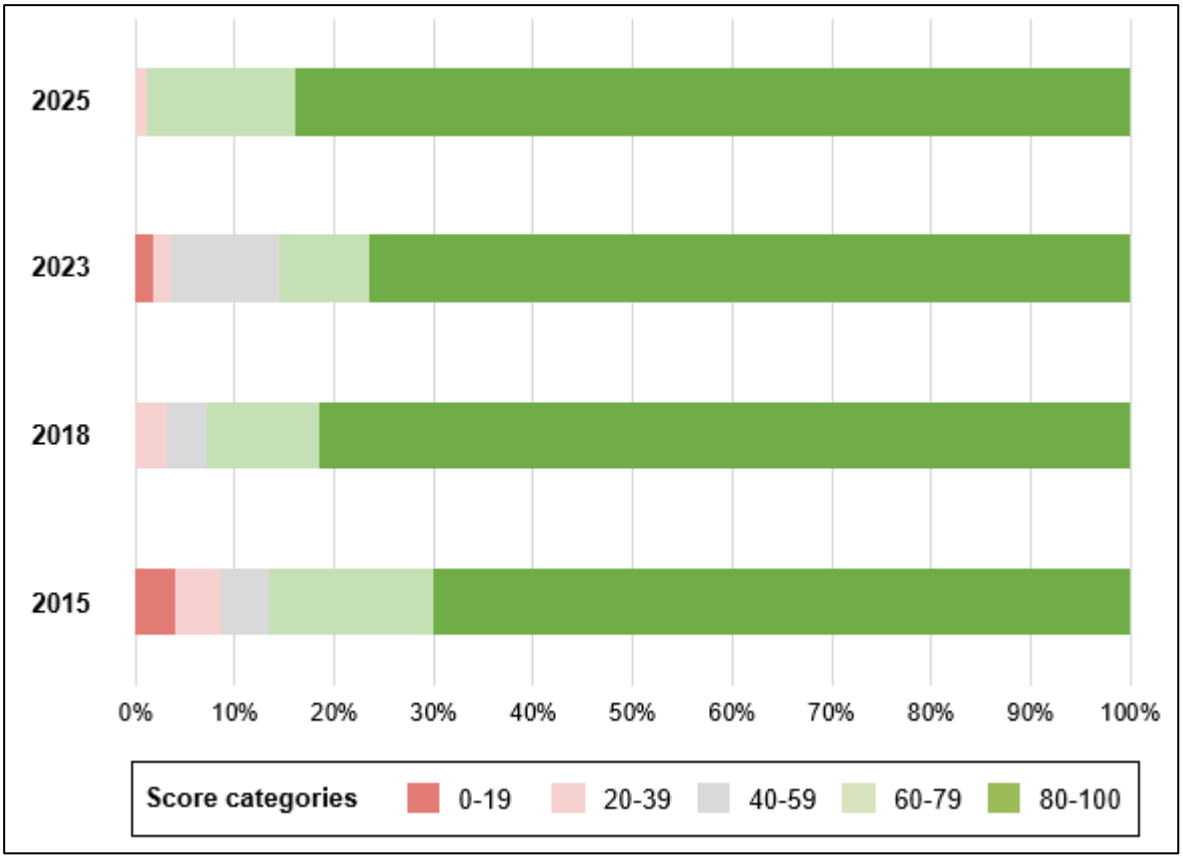
5.1.3 *Overall patient satisfaction scores*

The combined patient satisfaction score on health care provider behaviour calculated the number of services the patient was satisfied with out of the total number of services the patient could have been satisfied with. Figure 42 presents the evolution of the overall patient satisfaction scores on health care provider behaviour in the four selected HCs in Fier from 2015 to 2025.

Across all four survey rounds, patient satisfaction levels remained high, with the majority of patients consistently reporting positive experiences with provider behaviour. In 2015, satisfaction scores were already strong, with most ratings falling in the 60–100% range, and this positive trend continued throughout subsequent years.

By 2025, almost all patients reported satisfaction in the highest category (80–100%), indicating very high and stable levels of perceived care quality and provider responsiveness. Only minimal proportions of lower scores were observed, suggesting that patients in the surveyed HCs perceive their interactions with health care providers as respectful, attentive, and supportive.

Figure 42: Overall patient satisfaction score on health care provider behaviours, Fier



6 SUMMARY & CONCLUSIONS

The survey findings show that, in several analysed QoC domains, comparison HCs achieved equal or even higher scores than intervention HCs. This pattern requires contextual interpretation.

As outlined in section 1.2, HAP phase 3 (2022-2025) has operated in 11 regions of Albania, reaching approximately 150 HCs. However, the implementation model of phase 3 differed substantially from phases 1 and 2 (2015-2023). During the earlier phases, HAP intervened directly in around 80 HCs over eight years. Activities included comprehensive on-site training of physicians and nurses, provision of medical and nursing bags (with hands-on training for their use), rehabilitation of infrastructure in 30 facilities, and direct supply of additional equipment. This intensive and facility-focused engagement likely contributed to stronger and more immediate improvements at the HC level.

In contrast, phase 3 adopted a scale-up strategy aligned with the priorities of the Ministry of Health and Social Protection and agreed upon with stakeholders. Rather than directly supporting each HC, HAP operated primarily through the LUHCs and the Operators. A cascade training model was introduced: two representatives per HC were trained as trainers and supported to organize peer groups and disseminate knowledge within their facilities. HAP also developed NCD and home care monitoring manuals and trained LUHC and Operator representatives to oversee and facilitate implementation. With the exception of supplying medical and nursing bags, direct operational involvement at facility level was limited.

This strategic shift prioritized geographic expansion and institutional capacity-building over intensive, facility-level implementation. The survey results suggest that this approach has contributed to introducing new services and procedures and strengthening structures at system level. However, the effects at individual HC level may require more time to materialise. The current findings may therefore reflect an early stage of implementation, where foundations have been laid but measurable quality improvements are still emerging.

Additionally, the distinction between intervention and comparison HCs is not absolute. Comparison HCs have also been indirectly exposed to HAP-supported materials and guidance, including NCD protocols disseminated through LUHCs and the Operator. Some may also have received similar documents from other sources. This represents a degree of “contamination” of the comparison group which methodologically relevant, as it indicates diffusion of improved practices beyond formally supported sites yet it is positive from a health system perspective.

Overall, the findings should therefore be interpreted in light of (i) the transition from intensive, direct support to a system-level scale-up model, and (ii) the partial diffusion of interventions to comparison HC. Over time, stronger differentiation in implementation quality may become more visible as phase 3 interventions consolidate at facility level.

Quality of the HC infrastructure measured through a health centre assessment tool (structural attributes):

Figure 43 presents the evolution of mean infrastructure quality scores between 2015 and 2025, capturing structural attributes such as facility cleanliness, maintenance, equipment functionality, and availability of essential utilities and materials. The data compare overall averages (all years, all HCs, thick purple line), intervention and comparison HCs in 2025, data from Fier region (all years, all HCs in Fier), and the four selected Fier HCs only (2015-2025).

Overall, steady improvement in HC infrastructure quality was observed over the ten-year period, with mean overall (“all-years-all-HC”) scores rising from approximately 55 in 2015 to

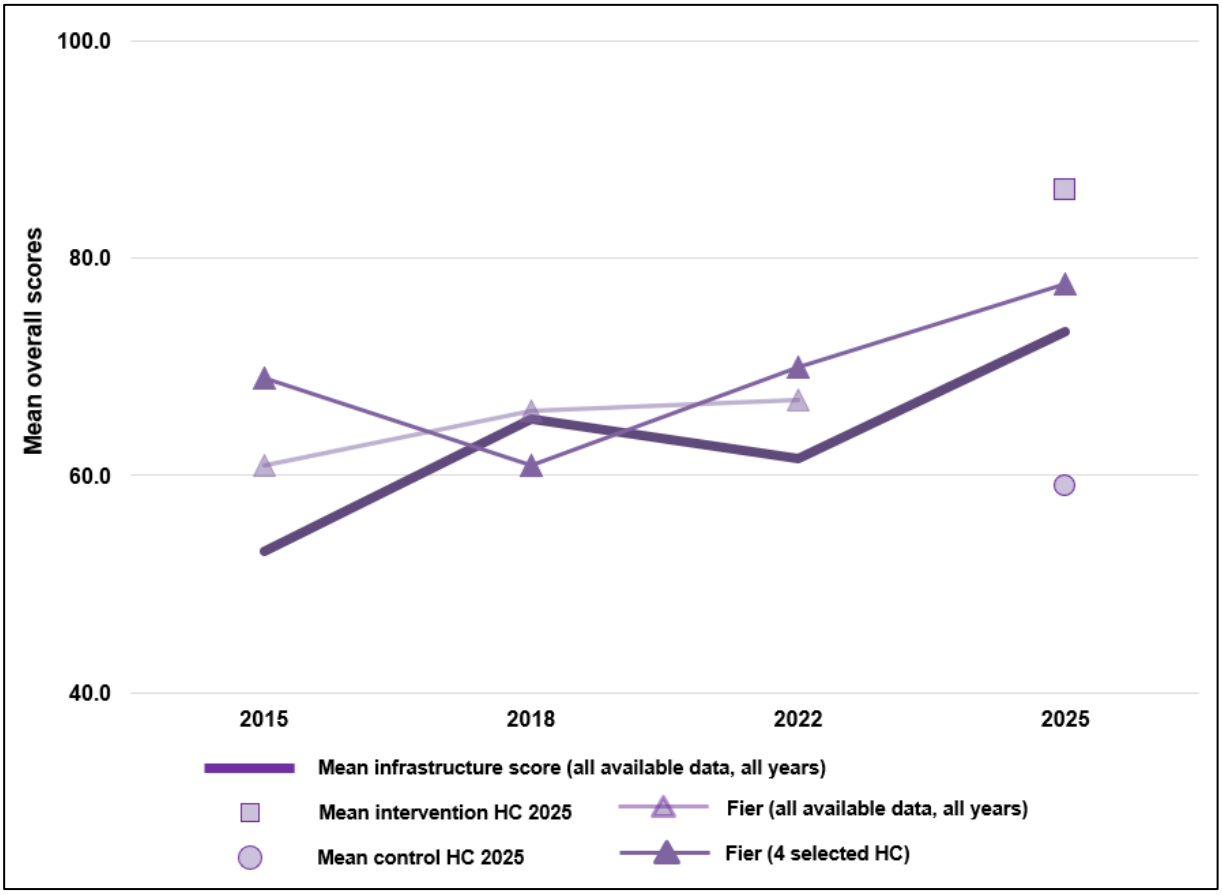
nearly 75 in 2025 (thick line). After minor fluctuations in 2018 and 2022, scores improved again in 2025, reaching the highest levels recorded.

In 2025, intervention HCs achieved the highest structural quality scores, exceeding 80 points, while comparison HCs scored lower (around 60), suggesting a clear effect of targeted support and infrastructure investments.

In Fier, scores for all HCs show gradual improvement (2015-2022), with the four selected Fier HCs outperforming the broader regional average by 2022 and still improving thereafter until 2025.

These overall results indicate notable progress in facility conditions and equipment standards, especially in supported HCs, reflecting the impact of continued investments in physical infrastructure and health system strengthening.

Figure 43: Summary scores for infrastructure



Quality of doctor-patient interactions measured through doctor-patient observations (process attributes):

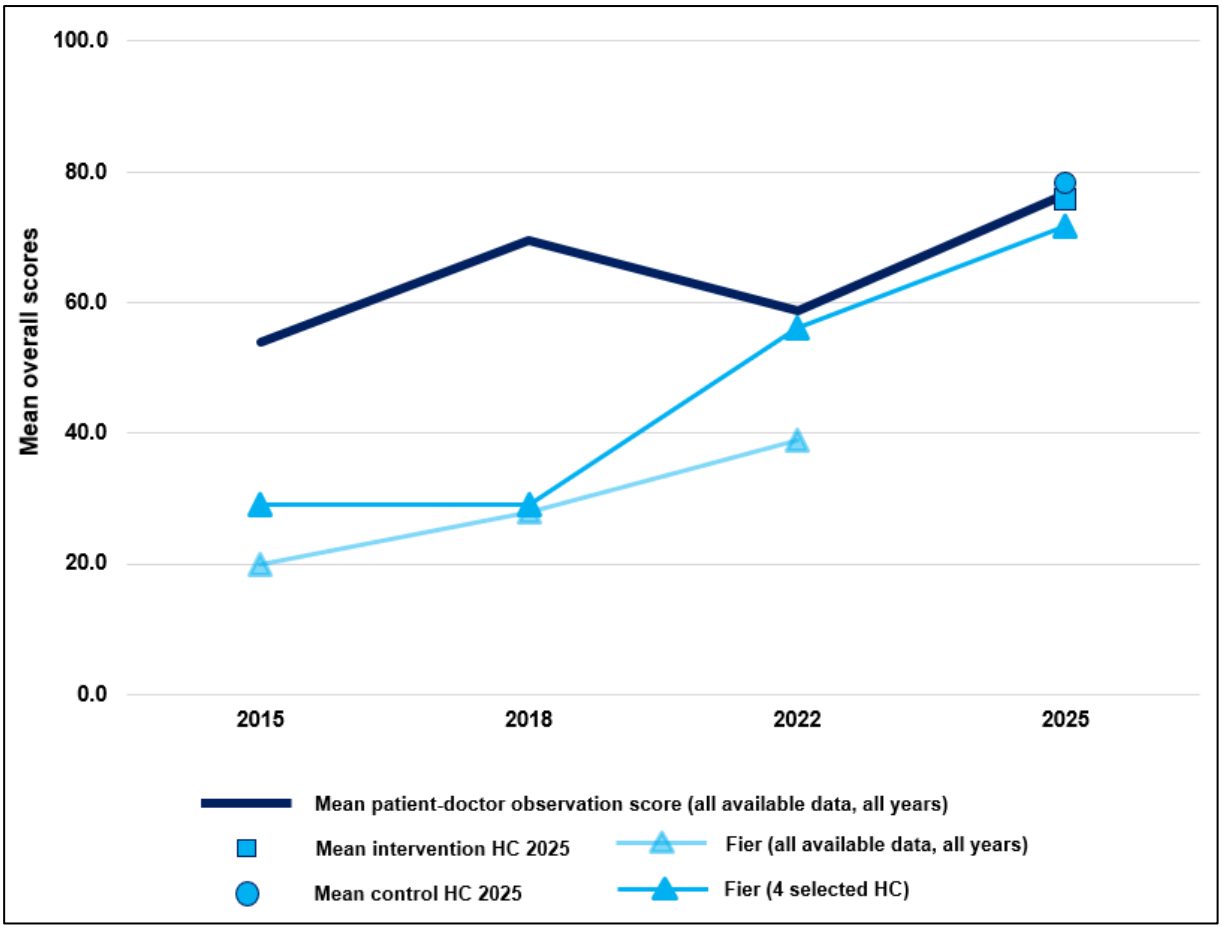
Figure 44 illustrates the evolution of mean patient-doctor observation scores between 2015 and 2025, comparing all available data (all years, all HC for every survey year), intervention and comparison HCs in 2025, data from Fier region (all years, all HC in Fier for every survey year), and data for only the 4 selected HC in Fier in 2025 (all years, only 4 selected HC).

The results show a steady overall improvement in consultation quality over the ten-year period, with mean “all-years-all-HC” scores rising from around 55 in 2015 to nearly 80 in 2025 (dark blue line). After a moderate decline in 2022, the upward trend resumed sharply by 2025, reaching the highest recorded levels.

Both intervention and comparison HCs in 2025 achieved comparably high mean scores, suggesting that consultation quality has improved across the primary care network, not only in supported HC. Overall, the findings highlight sustained progress in patient-centred care and clinical practice quality, reflecting continued capacity building and institutional learning over successive years of implementation.

In Fier, patient-doctor observation scores followed a similar but more gradual trajectory, starting from a lower baseline and improving substantially over time. The four selected Fier HCs in 2025 had already achieved higher scores than the regional average by 2022 and have shown further improvement by 2025, reaching parity with other surveyed intervention and comparison HCs.

Figure 44: Summary scores for quality of doctor-patient interactions



Patient satisfaction measured by exit interviews after consultation (outcome attributes):

Figure 45 presents the evolution of mean patient satisfaction scores between 2015 and 2025, based on exit interview data collected across all available survey years. The figure compares overall averages (all years, all HCs, thick dark red line), intervention and comparison HC in 2025, data from Fier region (all years, all HCs), and data from the four selected HCs in Fier (2015-2025)

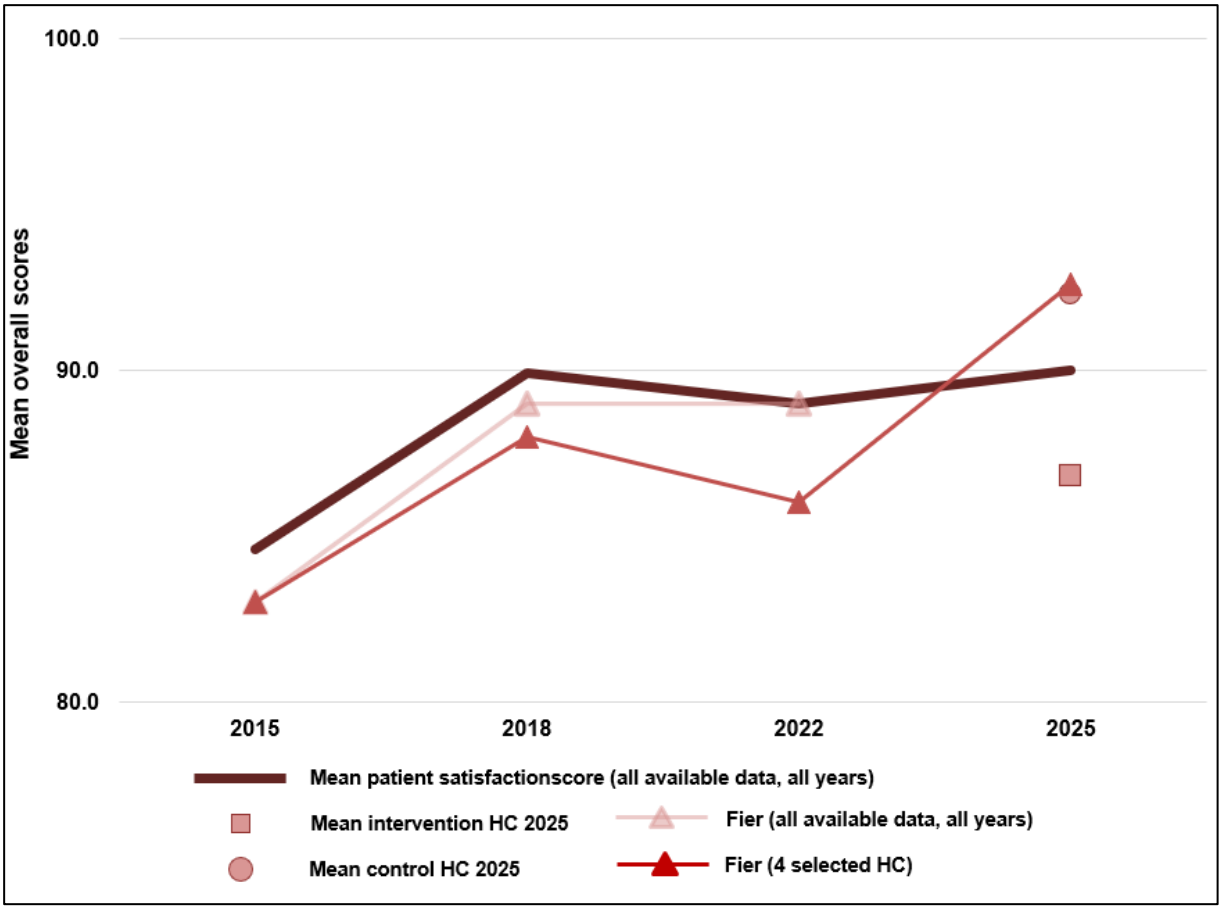
Overall, patient satisfaction levels remained consistently high throughout the ten-year period, with mean “all-years-all-HC” scores staying around or above 85% (thick dark red line). Following a rise from 2015 to 2018, a slight dip in 2022 was observed, before scores improved again by 2025, reaching the highest recorded levels.

In 2025, both intervention and comparison HCs achieved similarly high mean satisfaction scores, although slightly higher in comparison HC. This indicates that patients generally report positive experiences with care across the primary care services, regardless of intervention status.

In Fier, satisfaction scores followed a similar upward trend. The four selected Fier HCs showed a marked improvement by 2025, performing on par with 2025 averages for comparison HC.

These results reflect sustained progress in patient-centred service delivery, with consistently strong patient perceptions of care quality and responsiveness across facilities.

Figure 45: Summary scores for patient satisfaction



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2. Donabedian, A., *The seven pillars of quality.* Arch Pathol Lab Med, 1990. **114**(11): p. 1115-8.
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4. Gabrani, J., C. Schindler, and K. Wyss, *Perspectives of Public and Private Primary Healthcare Users in Two Regions of Albania on Non-Clinical Quality of Care.* J Prim Care Community Health, 2020. **11**: p. 2150132720970350.
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6. Braithwaite, J., *Quality of care in the COVID-19 era: a global perspective.* IJOHC Communications, 2021. **1**(1): p. 1-3.

8 ANNEXES

8.1 Ethical approval

REPUBLIKA E SHQIPËRISË
MINISTRIA E SHËNDETËSISË DHE MBROJTJES SOCIALE
KOMITETI I ETIKËS

Nr. 208/75 Prot. Tiranë, më 02.07 2025

Lënda: Shqyrtimi dhe miratimi i studimit

Dr. Besim Nuri
Menaxher i Projektit HAP
Rr: "Themisokli Germenji", Pall. Helios, Ap.2/2 Tiranë

Komiteti i Etikës, në mbledhjen e datës 27.06.2025, mori në shqyrtim kërkesën dhe dokumentacionin e paraqitur nga Dr. Besim Nuri, menaxher i projektit "Shëndet për të gjithë" (HAP 3), si dhe në cilësinë e investiguesit kryesor për studimin me titull: "Vlerësimi i cilësisë së shërbimit në Kujdesin Shëndetësor Parësor në Shqipëri 2025, faza e konsolidimit".

Anëtarët e Komitetit të Etikës shqyrtuan dokumentacionin nr. 208/48 prot., datë 14.05.2025 për studimin me titull: "Vlerësimi i cilësisë së shërbimit në Kujdesin Shëndetësor Parësor në Shqipëri 2025, faza e konsolidimit", të cilët theksuan se ky studim do të zbatojë një anketë mbi vlerësimin e cilësisë së shërbimit në Kujdesin Parësor.
Prof. Jovan Basho shpjegoi se anketa do të vlerësojë tre dimensionet e cilësisë së kujdesit në Kujdesin Shëndetësor Parësor në Qendrat Shëndetësore:
- cilësinë e infrastrukturës së Qendrës Shëndetësore (atributet strukturore);
- cilësinë e ndërveprimeve ofrues-pacient (atributet e procesit); dhe
- kënaqësinë e pacientit pas konsultimit (rezultatet).

Anëtarët e Komitetit të Etikës në takimin e datës 27.06.2025, konstantuan se janë përmbushur të gjitha kushtet për lëshimin e miratimin e studimit dhe votuan unanimisht **Pro** për studim me titull: "Vlerësimi i cilësisë së shërbimit në Kujdesin Shëndetësor Parësor në Shqipëri 2025, faza e konsolidimit" dhe mbështetur në nenin 22 e vijues të Ligjit nr. 105/2014 "Për barnat dhe shërbimin farmaceutik" të ndryshuar, dhe në Udhëzimin të Ministrisë së Shëndetësisë nr. 226, datë 08.03.2018 "Për provat klinike", vendosi si më poshtë:

MIRATIMI I STUDIMIT

T'i jepet miratimi porositësit të studimit me titull: "Vlerësimi i cilësisë së shërbimit në Kujdesin Shëndetësor Parësor në Shqipëri 2025, faza e konsolidimit", për fillimin e studimit sipas kushteve të paraqitura në protokollin përkatës.

Adresa: Rruga e Kavajës Nr. 1001, Tirana, Albania. Tel: +355 42376178/ext 72125, www.shendetesia.gov.al

Titulli i protokollit: "Vlerësimi i cilësisë së shërbimit në Kujdesin Shëndetësor Parësor në Shqipëri 2025, faza e konsolidimit".

Kompania e autorizuar në Republikën e Shqipërisë: Projekti "Shëndet për të gjithë" dhe financohet nga Agjencia Zvicerane për Zhvillim dhe Bashkëpunim.

Numri i qendrave në Republikën e Shqipërisë: Në 17 Njësi Vendore të Kujdesit Shëndetësor (NJVKSH) në 10 rajone.

Studimi/ prova klinike duhet të kryhet në pajtim me Deklaratën e Helsinkit mbi të drejtat e personave të përfshirë në studim dhe në përputhje me legjislacioniet në fuqi.

Udhëzohet porositësi i studimit që në përfundim të studimit të njoftojë me shkrim Komitetin e Etikës dhe të paraqesë një raport me rezultatin e studimit.

Komiteti i Etikës duke dhënë miratimin gjithashtu rezervon të drejtën që pas informimit paraprak të investigatorit kryesor, mund të inspektojë, monitorojë studimin në të gjitha hallkat e tij.

Kryetari i Komitetit të Etikës

Prof. MIRA RAKACOLLI

Adresa: Rruga e Kavajës Nr. 1001, Tirana, Albania. Tel: +355 42376178/ext 72125. www.shendetesia.gov.al

8.2 Score indicators

Table 17: Indicators on diabetes consultations

Anamnesis: The doctor asks questions about…	
1	… any specific health complaints
2	... general weakness
3	... urine discharge
4	… appetite
5	... eye-sight
6	… visit to ophthalmologist
7	... alcohol
8	... smoking
9	... using other medicine
10	… sedentary way of life
11	… adherence with diabetes treatment
1-11	Combined score on 'Anamnesis' (11 indicators in total)
Examination: The doctor conducts examination…	
12	… checks blood pressure
13	… weight measurement / calculation of body-mass index
14	… of skin, mucus membranes, nodes of lymph, ears, nose, thyroid glands
15	... of eyes
16	... of chest, auscultation of lungs
17	… auscultation of heart in 5 points
18	... of abdomen, palpation of liver and signs of percussion
19	... perfusion of legs (veins and feeling of legs)
20	… and gives clear explanations to the client concerning the purpose of tests and procedures
12-20	Combined score on 'Examination' (9 indicators in total)
Examination: The doctor advices about…	
21	… results of examinations
22	... the situation and diagnosis
23	... the prognosis
24	… about needed examinations
25	… nutrition, i.e. food intake
26	… on the prevention and treatment of hypoglycaemia and other acute and chronic complications of diabetes
27	… on self-monitoring - glycaemia comparison and prevention of hypoglycaemia
28	… about alcohol
29	… about smoking
30	… about physical exercise
31	... right ways of care of legs
32	… potential complication of the illness
33	… potential risks if illness is not treated
34	… importance of adherence to treatment
35	... about follow-up visit
36	… about the referral
37	… on prescribed medicines/treatment
21-37	Combined score on 'Examination' (14 indicators in total)
1-37	**Overall score on 'Diabetes consultation' (37 in total)**

Table 18: Indicators on hypertension consultations

Anamnesis: The doctor asks questions about…	
1	… any specific health complaints
2	… headache
3	… the use of medicine other than for hypertension
4	... the use of contraceptives
5	... eye-sight
6	… visit to ophthalmologist
7	... alcohol
8	... smoking

9	... using other medicine
10	… sedentary way of life
11	… high blood pressure
12	… adherence with hypertension treatment
1-12	Combined score on ‘Anamnesis’ (12 indicators in total)
Examination: The doctor conducts examination…	
13	… checks blood pressure
14	… weight measurement / calculation of body-mass index
15	… of skin, mucus membranes, nodes of lymph, ears, nose, thyroid glands
16	... of eyes
17	... of chest, auscultation of lungs
18	… auscultation of heart in 5 points
19	... of abdomen, palpation of liver and signs of percussion
20	... perfusion of legs (pulse and perfusion of legs)
21	… and gives clear explanations to the client concerning the purpose of tests and procedures.
13-21	Combined score on ‘Examination’ (9 indicators in total)
Examination: The doctor advices about…	
22	… results of examinations
23	... the situation and diagnosis
24	... the prognosis
25	… about needed examinations
26	… nutrition, i.e. food intake
27	… about alcohol
28	… about smoking
29	… about physical exercise
30	… about oral contraceptives
31	… potential complication of the illness
32	… potential risks if illness is not treated
33	… importance of adherence to treatment
34	... about follow-up visit
35	… about the referral
36	… on prescribed medicines/treatment
21-36	Combined score on ‘Examination’ (15 indicators in total)
1-36	**Overall score on ‘Diabetes consultation’ (36 in total)**

Table 19: Indicators for consultations other than diabetes and hypertension

Anamnesis: The doctor …	
1	… takes patient history (general history, specific to disease)
2	… asks open ended questions during history taking
3	… asks about any prescriptions the client is currently taking
4	… listens to the client and responds to client questions
1-4	Combined score on ‘Anamnesis’ (4 indicators in total)
Examination: The doctor …	
5	… performs medical examinations and other investigations as individually required
6	… gives clear explanations to the client concerning the purpose of tests and procedures
5-6	Combined score on ‘Examination’ (2 indicators in total)
Examination: The doctor advices about…	
7	… results of examinations
8	... the situation and diagnosis
9	... the prognosis
10	… needed examinations
11	… about follow-up visit
12	… about the referral
13	… on prescribed medicines/treatment
14	… on risks factors/health education
7-14	Combined score on ‘Examination’ (8 indicators in total)
1-14	**Overall score on ‘Diabetes consultation’ (14 in total)**

Table 20: Indicators for basic essential medical equipment (available and functional)

1	Sterilization equipment and anti-septic protocol
2	Ambu mask
3	Weight scale for children (over 2 years old)
4	Weight scale for infants and toddlers (up to 2 yers old)
5	Stadiometer for children (over 2 years old)
6	Stadiometer for infants and toddlers (up to 2 years old)
7	Ophtalmoscope
8	Pregnancy calendar
9	Table for vision testing
10	Hemostatic lac
11	Strong source of light in good condition (portable)
12	Nasal speculum
13	Otoscope
14	Glucometer
15	Peak flow meter for adult and pediatric
16	Pen light / Pocket type light
17	Neurological hammer
18	Pulse oximeter
19	Weight scale for adults
20	Stadiometer for adults
21	BMI Calendar
22	Measuring tape / Pelvimeter
23	Sphygmomanometer for children
24	Sphygmomanometer for adults
25	Stethoscope for children
26	Stethoscope for adults
27	Manual blood pressure cuff (Pediatrik, Adult, Obez)
28	Thermometer
29	Tuning fork
30	Scissors
31	Timer
1-31	**Overall score on 'General medical equipment' (31 in total)**

Table 21: Indicators for the homecare para-medical equipment

1	Shower Commode Chair With Wheels
2	Elbow crutches
3	Alternating air pressure anti decubitus mattress with electric pump
4	Bedpan with lid
5	Urinals for male patients
6	Zimmer frame walker
7	Sling for transfering the patient
8	Donut inflatable cushion seat
9	Toenail and fingernail clippers set
10	Microsurgery kit
11	Duoderm extra thin dressings 10x10 cm (pack of 10)
12	Nebulizer for adults for home use with nebulizer mask
13	Urine Rapid Test Strips
14	IV- Intra venous catheter
15	Breathing exercise device
16	Silicon Foley catheter nr 10 Fr, 12 Fr, 14 Fr, 16 Fr
17	Nazogastric Levine (NG)
18	Wheelchair
19	Enema bag
20	Sterile Gauzes
21	Wound Measuring Ruler

22	Lymph-edema treatment pump suplied with Arm Compression Pad and one Full Leg Compression Pad.Lymph-edema treatment pump with:
23	ECG Machine
24	Ear lavage kit
25	Portable oxygen concentrator
26	Laptop or desktop to facilitat HBC
27	Shower Commode Chair With Wheels
1-27	**Overall score on 'Homecare para-medical equipment' (27 in total)**