Swiss Agency for Development and Cooperation (SDC)

HAP2: HOUSEHOLD ACCESS TO HEALTH CARE IN DIBËR AND FIER REGIONS OF ALBANIA

2023 Phase 2 Endline Survey

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Final survey report

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ABBREVIATIONS

HAP	Health for All Project
HSB	Health Seeking Behaviour
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
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

1 BACKGROUND

1.1 The 'Health for All Project' Phase 2

The Swiss Agency for Development and Cooperation launched the first phase of the "Health for All" (HAP) project in Albania in 2015 in two assigned pilot regions, namely Dibër and Fier, and the second phase in 2019, in the same settings. This document will focus on second phase of HAP (also called HAP2), implemented between March 2019 – March 2023, with reference to first phase for specific comparatives of indicators.

The overall goal of HAP2 was that the Albanian population benefits from better health due to improved primary health care services.

Expected outcomes of the project are:

- The Ministry of Health and Social Protection (MoHSP) and its regional entities manage more effectively and efficiently primary health care (PHC) services;
- The citizens in target regions have access to better quality PHC services.

HAP adopted a results-oriented reporting system in both phases of project implementation, focusing on outcome monitoring with reference to the Logical Framework, work plans and respective budget. The achievements, progress and outcomes of the project are measured against defined indicators which are listed at the level of logframe. Albeit the phase 2 logframe does not include any longer a population based indicator, the present household survey provides essential information to track population based trends over time. A baseline and endline survey were conducted at the beginning and end of phase 1 (HAP1; 2015 and 2018) [1, 2]. The implementation of the project' second phase (HAP2) started in March 2019. Thus, the 2018 endline survey was used at the same time as the baseline for 2018. However, for the sake of clarity, it remains called endline. The baseline and endline assessments included two primary data collection activities:

(1) a facility-based survey on PHC quality of care (QoC); and

(2) a household survey related to access to PHC services, health insurance coverage and health literacy of chronic conditions and child development.

As health care service improvement activities continue to be implemented within HAP2, a continuation of repeated, cross-sectional monitoring of access to PHC services through a survey was deemed beneficial and necessary. At the same time the Covid-19 pandemic resulted in major disruption in health services delivery with mostly undocumented positive and negative effects on population access to services.

Thus, the present document provides a detailed study report of the 2022 endline survey phase 2 on access to PHC services, health insurance coverage and health literacy of chronic conditions and child development. The proposed survey is aligned with the two previous surveys, thus allowing to measure changes and trends over time.

1.2 Covid-19 pandemic

The Covid-19 pandemic, which started in early 2020, had an immense effect on the health systems and service provision worldwide [3]. Health systems were at the same time required to deal with the pandemic and to continue to provide safe and high-quality health care. This holds true for Albania. For example: overwhelmed health centers were focusing their efforts on service provisions in 2020 and 2021 around Covid-19, restricted person movements on the access and use of PHC services, or patients hesitated to visit health centers because of fear of infection.

Whilst a comprehensive assessment of the effect of the pandemic on Albania's health system is not an objective of this study, the repetitive surveys (2015, 2018, 2023) nevertheless give some indications on these effects and the results have to be interpreted under this lens. In this regard, brief sections have been added to the survey tools assessing the potential effects of the pandemic on access to PHC in Albania.

2 GOAL AND OBJECTIVES OF THE STUDY

The goal of the survey on family access to healthcare is to conduct and to establish an updated measurement on key activities of the HAP2 project. This, to assess key information on population health and service access at the end of the implementation phase (March 2023). Additionally, the collected information is to inform the project phase 3 (HAP3) to plan and prioritise population level activities.

Specific objectives of the survey were to assess:

- Health situation and health management of chronic diseases and acute illnesses;
- Health seeking behaviour (HSB) and access barriers to health care for chronic diseases and acute illnesses;
- Out-of-pocket expenditures for health care of chronic diseases and acute illnesses;
- Knowledge, attitude and practice (KAP) on diabetes, hypertension, obesity and child development; and
- Effects of the Covid-19 pandemic on the availability and use of health services.

3 METHODS

3.1 Study design

To achieve the above-mentioned objectives, a cross-sectional, household-based survey was conducted. The methodology employed for this 2023 endline survey phase 2 was the same as in the 2015 baseline and the 2018 endline surveys to allow for comparison of findings. Hence, the study design was (repeated) cross-sectional surveys allow to measure trends and changes over time.

The surveys were conducted in October/November 2015, December 2018, and February 2023.

3.2 Study area and target population

The 2023 endline survey phase 2 was conducted in the two regions covered by HAP2 (Dibër and Fier). It targeted the same clusters as during the 2015 baseline survey and the 2018 endline survey.

The detailed sampling strategy, described in the study protocol, was the same as in the previous survey and is briefly summarized here. A three-stage sampling strategy was applied:

1. In a first stage, 53 study clusters per region with a probability of selection proportional to population size within the region were randomly selected. The selected clusters are shown in Table 23 in annex 8.2.
2. In a second stage, 12 households were randomly selected within a cluster, through a random walk procedure starting from a common/central place. Selected households were contacted and checked for inclusion criteria and eligibility. The household inclusion criteria area:
    - At least 1 person living in the household who is chronically ill

OR
- At least 1 person living in the household who has recently been acutely ill (<4 weeks)
  AND
- Written informed consent of all interviewed participants.

3. In a third stage, within a selected, eligible household, the following household members aged 18 years or older were administered a questionnaire interview:
   - Household head or representative → Housing conditions, socio-demographic information of the household
   - Individuals recently acutely ill or chronically ill → health situation and management, HSB, access to health care, expenditures, insurance, KAP
   - Mother with a child <5 years of age → health situation and management, HSB, access to health care, expenditures, insurance, KAP (incl. child development)

3.3 Questionnaire tool

The questionnaire for the 2023 was largely identical to the previous surveys so to assure consistency with the past. Table 1 gives an overview on the topics covered and the target respondents for each topic. The full survey tool is shown in Annex 1 in sections 8.1 (available in English & Albanian).

Table 1: Topics covered in the survey tool

Topic	Details	Target respondent
Housing conditions	• Location of household • Housing characteristics (e.g. electricity, toilet, etc.)	Household head or representative or other household member
Socio-demographic information	• Household socio- demographics • Household member socio-demographics	Household head or representative or other household member
Health situation, health and management	• Prevalence of acute conditions • Prevalence of chronic conditions • Management of acute and chronic conditions • Management of diabetes, hypertension and child development	Household head or representative or other household member
HSB, health care access, household health expenditures, health insurance	• HSB for acute and chronic conditions and child development • Health care access • Household health expenditures stratified by categories (consultation, transport, drugs) for chronic and acute conditions and child development • Health insurance coverage	Individuals acutely or chronically ill[1]
KAP related to diabetes and hypertension	• KAP related to diabetes, hypertension, obesity	Individuals acutely or chronically ill[2]
KAP related to child development	• KAP related to child development	Mother with a child <5 years of age[3]

[1]Administered to one household member selected randomly within each household among those who are acutely or chronically ill (or both)
[2]Administered to one individual selected randomly (if multiple individuals acutely or chronically ill in a household)
[3]Administred to the mother selected randomly (if multiple mothers with a child <5 years of age)

3.4 Data collection

In a household, the data collection process was as follows:

1) Introduction of purpose and procedures of the survey to the household members to be targeted

2) Informed consent administration (see section 3.6 below)
3) Data collection:
    i. First, interview with the household head or representative or other household member;
    ii. Second, interview with individual acutely and/or chronically ill; and
    iii. Third, interview with mother with a child <5 years of age (if present).

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

3.5 Data management and analysis

Once data was transferred to the server of the Swiss TPH regular data checks was 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.

Data was analysed using Stata Statistical Software and R statistical software and Excel. Summary cross-tables outline differences between the two regions and between survey years of 2015, 2018 and 2023.

3.6 Ethical considerations

Ethical approval for this study was received from the Ethic Committee of MoHSP in Albania on 13 December 2022 (Nr. 131/59; 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. Informed consent was obtained from all the participants.

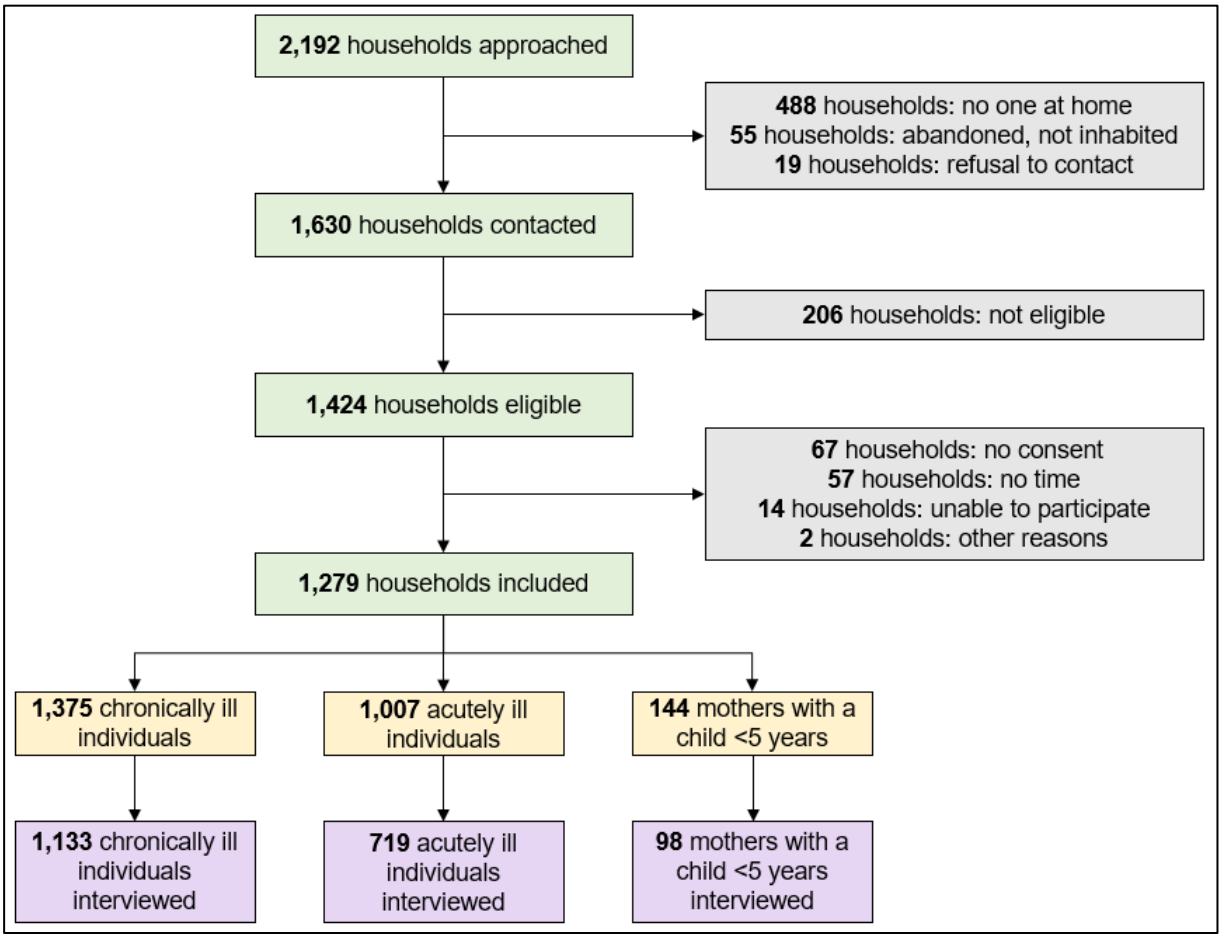
4 FINDINGS

4.1 Survey participation

Data collection was conducted between 14 and 26 February 2023. In total, 2,192 households were approached in 53 clusters (Figure 1). Thereof, 1,057 (48.2%) in Diber and 1,135 (51.8%) in Fier. 1,630 (74.4% of 2,192) were contacted and of these, 206 (12.6% of 1,480 were not eligible, i.e. no chronically or acutely ill person in the household). The remaining 1,424 (87.4% of 1,630) households were eligible, meaning they had at least one person with a chronic or an acute illness. 140 households dropped out because they did not consent, had no time, respondents were not able to participate (e.g. too sick) or other reasons (9.8% of 1,424). Thus, finally, 1,279 households were included resulting in an 89.8% inclusion rate among eligible households.

Within the participating households, 1,357 members were chronically ill and 1,007 were acutely ill. In addition, there were 144 mothers. Out of these eligible individuals, one per respondent group (chronically ill, acutely ill or mother) and per household was selected to be interviewed further at random.

Figure 1: Participation and respondent flow chart (2023)



In 2015 and 2018, a comparable number of households was included (1,275 in 2015 and 1,289 in 2018, and 1,279 in 2023) and inclusion rates among eligible households ranged between 90% and 95% across years (Table 2). Further, in 2023, a total of 3,951 individuals were living in the included households, compared to 5,188 in 2015 and 4,749 in 2018. Indeed, the average number of household members decreased from 4.0 in 2015, to 3.4 in 2018, to 3.1 in 2023. Consequently, respondent numbers in 2023 were slightly lower than in previous survey years.

Interestingly, the number of acutely ill individuals interviewed has increased markedly over the years. This could be due to timing of the surveys (2015: October/November; 2018: December; 2023: February) and the seasonality of diseases, especially also the common cold / flu, which was the most commonly reported acute illness in 2023.

Table 2: Survey samples (2015, 2018, 2023)

	2015	2018	2023
Households approached	1,528	2,567	2,192
Households contacted	1,387	1,731	1,630
Households contact rate (among approached)	91%	67%	74%
Households eligible	1,348	1,371	1,424
Household eligibility rate (among contacted)	97%	79%	87%
Households included	1,275	1,289	1,279
Household inclusion rate (among eligible)	95%	94%	90%
Individuals living in included households	5,188	4,749	3,959
Average no. of individuals per household	4.0	3.4	3.1
Individuals chronically ill (interviewed)	1,096	1,135	1,133
Individuals acutely ill (interviewed)	175	555	719
Mother with a child <5 years of age (interviewed)	161	157	95
Respondents to the knowledge, attitudes and practice questionnaire part	1,264	1,125	1,279

4.2 Characteristics of households and individuals

The income structure of households across the survey years and regions is shown in Table 3. **The main income source for surveyed households in both regions remains pensions (57% in Diber and 60% in Fier).** This is partly explained by the fact that the eligibility criteria skew the sample towards elderly people (i.e. "chronically ill") and indeed, in 2023, 47% of household members in Diber and 61% of household members in Fier were aged above 49.

Second income source was 'farming and livestock gearing activities' which gained importance in both regions over the years as an income source. In Fier, the proportion of households that have salaries as income source decrease whilst this remained stable in Diber. Interestingly, the proportion of households that rely on remittances has decreased in Fier in 2023 compared to 2018.

Table 3: Household income structure (2015, 2018, 2023)

	Diber (%)			Fier (%)		
	2015	2018	2023	2015	2018	2023
Pension	54	51	57	59	68	60
Farming / livestock	41	34	27	39	32	21
Social aid	31	28	25	10	10	7
Salary	25	27	25	20	24	30
Remittances	19	26	26	18	29	23
Private businesses	10	14	11	7	12	14
Other	3	3	1	4	5	2

In 2023, 28% in Diber and 9% in Fier reported that at least one household member is benefitting from an economic or social aid scheme. This compared to 23% and 11% in 2015 and 33% and 2% in 2018, respectively.

Table 4 outlines the socio-demographic characteristics of household members which largely remain similar in the three survey years. In 2023, the average age of household members was 41 years. Most household members were between 18 and 49 years in both regions and survey years except for Fier in 2023 which had slightly more household members in the 65+ group.

In 2023, more than half of the individuals were married (63%) and less than one third were single (27%). However, in Fier, there were more married and less single household members compared to previous years. The most common educational degree obtained was finishing secondary grade (grade 6-9 years) with 43% overall in 2023. In Fier, the percentage of household members with a university degree increased from 10% to 12%.

Table 4: Socio-demographic characteristic of household members (2015, 2018, 2023)

	Diber (%)			Fier (%)		
	2015	2018	2023	2015	2018	2023
Age groups						
<1	3	1	0[a]	1	1	0[a]
2 - <5	5	5	4	4	3	2
5 - <18	19	17	14	13	11	9
18 - <49	41	41	34	35	33	29
49 - <65	20	22	25	25	26	27
65+	12	15	22	22	26	34
Marital status						
Married	51	55	60	62	62	66
Divorced	<1	0	<1	<1	1	<1
Separated	<1	0	<1	<1	0	<1
Widow/er	6	6	7	6	8	9
Single	42	39	31	31	28	22
Other	<1	0	<1	<1	0	<1
Educational attainment						
None	<1	1	<1	<1	0	<1
Pre-school	2	2	<1	2	3	<1
Primary (grade 1-5)	14	15	14	14	15	10
Secondary (grade 6-9)	47	45	46	41	39	38
High school (grade 10-12)	26	29	26	32	32	37
College/technical school (grade 10-12)	3	1	3	3	2	2
University	8	8	9	8	10	12
Unknown	<1	0	<1	0	0	<1

[a] In 2023, due to digital recording of only the year of birth, a differentiation between <1 year and 1 year of age could not be made.

4.2.1 *Households' health seeking indicators*

For the vast majority of households, public health facilities are the first location for health care seeking: 97% of households in Diber and 84% in Fier, respectively, in 2023 (Table 5). In Diber, this was similar to previous surveys. In Fier, however, this percentage decreased markedly to 84% in 2023 which in turn meant that more people turned to private health facilities as first location of care seeking. Also to note that in June 2021, a new Regional Hospital opened in Fier. Although it is a public hospital following the national referral system, it is also accessible directly. However, in cases where the referral system is bypassed, services have to be paid for out-of-pocket according to official pricing lists. This could partially explain this change.

Table 5: First location of health care seeking (2015, 2018, 2023)

	Diber (%)			Fier (%)		
	2015	2018	2023	2015	2018	2023
Public health facility	**97**	**99**	**97**	**95**	**95**	**84**
Hospital	38	47	34	22	18	25
Polyclinic	1	1	1	5	3	15
Health center	49	41	55	58	67	54
Health post	12	11	10	15	12	7
Other public	<1	0	0	<1	0	0
Private health facility	**3**	**1**	**3**	**5**	**5**	**16**

Private hospital/clinic	-	-	78	-	-	72
Pharmacy	-	-	6	-	-	10
Private doctor	-	-	11	-	-	14
Other private	-	-	5	-	-	4

The main decisive factor for the choice of the health care facility in 2023 could be geographical proximity in both regions (67% for Diber households and 65% for Fier households, respectively; Table 6). This was followed by the perception of good services with 49% in Diber and 38% in Fier region. It is noteworthy that the notions of 'good quality' (overall) and the 'qualified health staff' have gained importance in respondent's perspectives.

Table 6: Health care seeking: decisive factors (2015, 2018, 2023)

	Diber (%)			Fier (%)		
	2015	2018	2023	2015	2018	2023
Geographical proximity	60	68	67	68	55	65
Familiarity with the staff	17	30	28	19	19	26
Good services	23	38	49	20	13	38
Fast appointments	14	11	8	13	5	12
No need for appointment	7	14	12	9	5	8
Covered by insurance	19	19	21	20	28	33
Does not cost much	25	37	30	24	41	21
Good quality	14	n/a	24	14	n/a	31
Qualified health staff	n/a	7	14	n/a	8	30
Short waiting times	n/a	14	15	n/a	6	15
Modern medical devices	n/a	2	5	n/a	4	17
Laboratory tests	n/a	5	8	n/a	5	29
I need to get referral	n/a	3	0	n/a	0	0
Other	n/a	9	4	n/a	19	11

For the 2023 questionnaire, respondents with a chronic condition or disability were asked "How far away from your home are the health providers from whom you obtained medical assistance for your chronic condition or disability located?". In Diber, 36% lived less than 1km away from a health provider where in Fier on 23% lived within 1km of a health provider (Table 7).

Table 7: Distance from a health care provider for people with a chronic condition (2023)

Distance in km	Diber (%)	Fier (%)
<1	36	23
1 - 4.9	32	33
5 - 9.9	14	12
10 - 14.9	10	12
15 - 19.9	4	6
20+	5	12

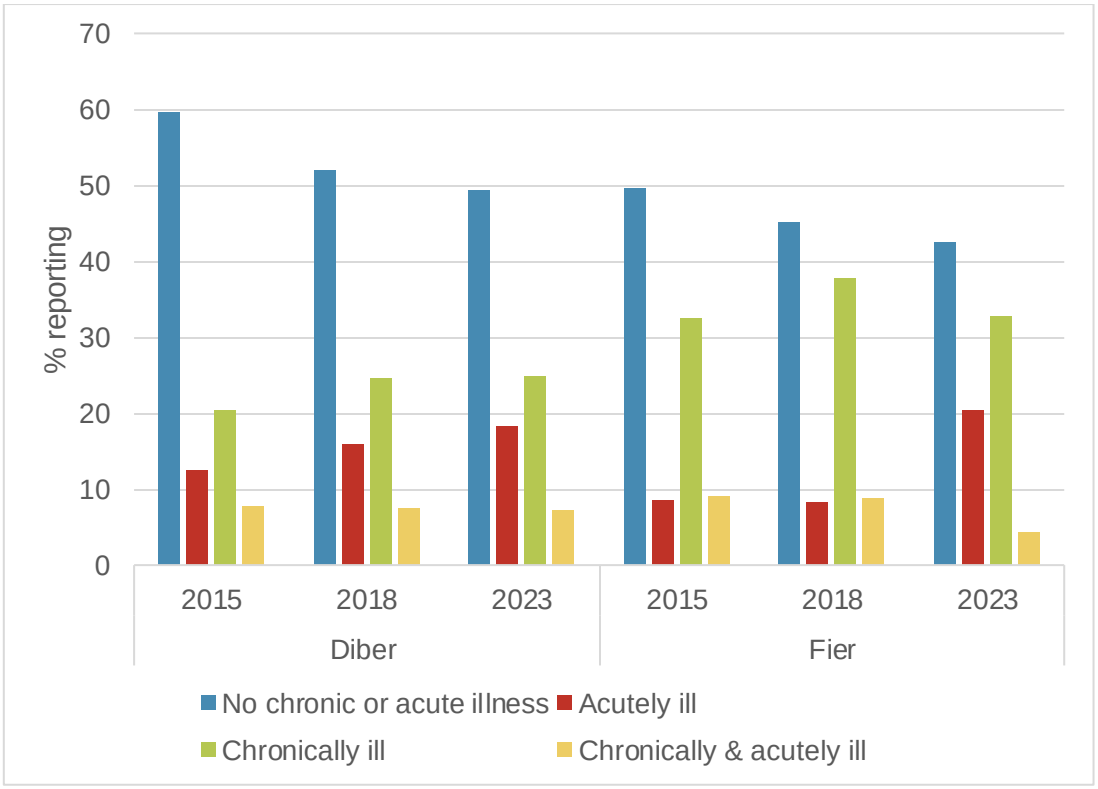
4.2.2 *Health status of all household members*

In 2023, 50% and 41% of all household members in Diber and Fier reported no chronic or acute illness, respectively (Figure 3). In all years, the prevalence of chronic illness is greater in Fier compared to Diber. Acute illness was also more prevalent in Fier in 2023 compared to Diber in previous years. The general increase in acute illnesses (see also Table 2) could be explained by the timing of the surveys (2015: October/November; 2018: December; 2023: February) and the seasonality of diseases such as the common cold. Acute illnesses are equally shared between men and women (female: 51%).

The percentage of those affected by both an acute and chronic condition simultaneously remained largely stable at around 7% in Diber but decreased in Fier slightly from 9% to 4%.

Of those reporting a chronic condition or a chronic and acute condition, 60% are female, which could indicate increased health seeking in women compared to men.

Figure 2: Health status of household members



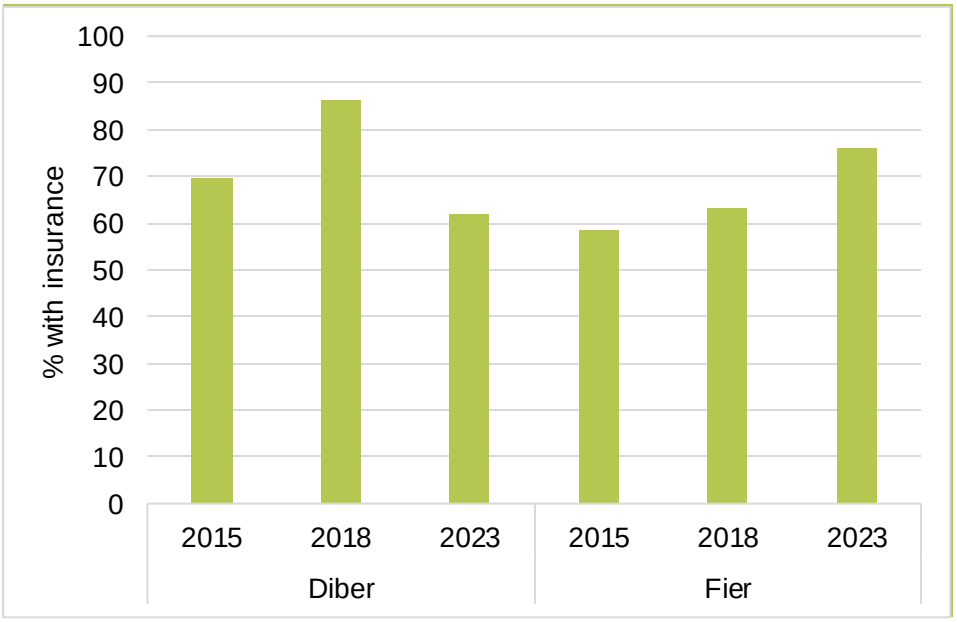
Main results for health conditions by age groups were:

- Children under 5 years of age have been most affected with acute conditions, increasing between 2015 (41%) and 2023 (56%).
- Chronic disease in the under 5's has decreased over the survey years (from 15% in 2015, to 10% in 2018 and 0% in 2023).
- The proportion of acute illness decreased with age whilst the proportion of chronic conditions rises with age with a strong increase from 49 years onwards (49>65 years: 2015: 44%, 2018: 48%, 2023: 35%; 65 years or older: 2015: 58%, 2018: 69%, 2023: 60%).
- The proportion of those affected with both acute and chronic conditions increases from 49 years old or older.
- The 5-18 and 18-49 age groups have the lowest prevalence of acute or chronic disease.

4.2.3 *Insurance cover of all household members*

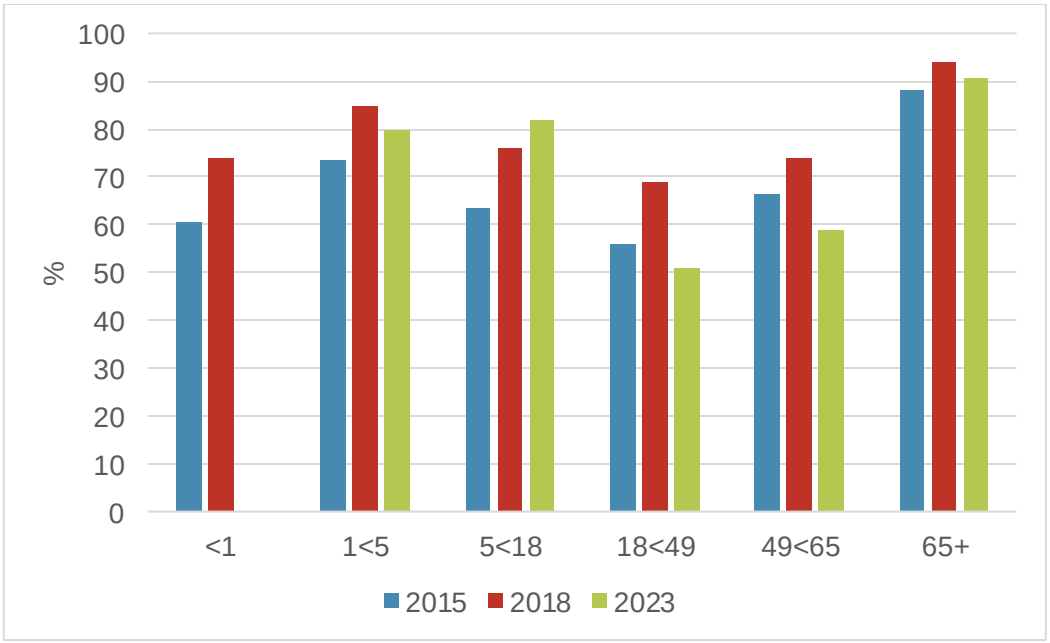
Health insurance coverage for all household members reduced in Diber in 2023 to 62% compared to 86% in 2018 (Figure 3). In contrast, in Fier health insurance coverage was 76% in 2023, an increase from 63% in 2018.

Figure 3: Proportion of household members with health insurance, by region (2015, 2018, 2023)



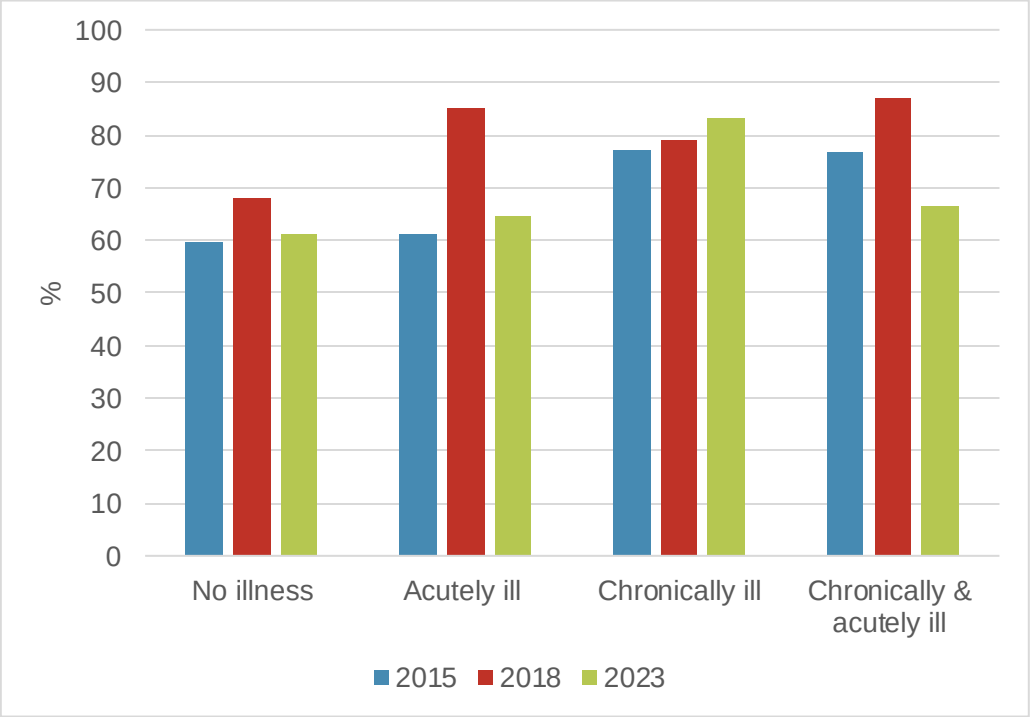
Health insurance coverage is highest among those 65 years and older in all survey years (Figure 4). Adults aged 18 and 65 years had the lowest insurance coverage, also in 2023. However, in children and adolescents, insurance coverage increased from 64% in 2015 to 82% in 2023. Of note, in Albania, by law, all individuals aged 0-18 years are ensured and eligible for free health care.

Figure 4: Proportion of household members with health insurance, by age group (2015, 2018, 2023)



Of those with no illness about 60% are insured. Insurance coverage was higher in those with chronic disease and those with both chronic and acute disease (Figure 5).

Figure 5: Proportion of household members with health insurance, by health status (2015, 2018, 2023)



4.3 Indicators in individuals with chronic conditions

When interpreting findings for individuals with chronic conditions, it should be kept in mind that between the 2018 and 2023 surveys, the Covid-19 pandemic has caused most deaths in elderly individuals and individuals with existing health conditions. Thus, this excess mortality in the target population might have influenced the findings presented in this section.

4.3.1 *Respondent characteristics*

Of the interviewees[1] included in the sample and willing to provide more detailed information on their chronic condition(s), in 2023, there were 590 eligible respondents in Diber and 534 in Fier with 189 respondents with both acute and chronic condition (

Table 8). The average age in 2023 was 63 in Diber, and 67 in Fier. Women represented 62% of the respondents interviewed about their chronic condition in Diber and 57% in Diber. For children below 18 years questions were answered by an adult/caretaker.

[1] These numbers do not present prevalence estimates as only one person from each household was selected to provide detailed information about his/her chronic conditions (see also chapter **Error! Reference source not found.**).

Table 8: Demographic profile of chronic disease patients interviewed (2015, 2018, 2023)

	Diber			Fier		
	2015	2018	2023	2015	2018	2023
n	522	525	590	574	610	534
% female in HH	68	62	62	75	64	57
Average age (SD)	58 (17)	59 (17)	63 (16)	61 (15)	63 (14)	67 (13)
Age groups						
<1	0.8	0.2	n/a[a]	0	0.2	n/a[a]
2<5	0.6	0.8	0.3	0.7	0	0
5<18	2	2	2	2	0.5	1
18<49	20	18	11	14	11	7
49<65	43	39	35	40	38	30
65+	35	41	52	44	50	62

[a] In 2023, due to digital recording of only the year of birth, a differentiation between <1 year and 1 year of age could not be made.

4.3.2 *Chronic conditions patterns*

Whilst the illness patterns remained similar, interestingly, there were marked decreases of the main chronic conditions between 2018 and 2023 (Figure 6 and Table 9; the overall totals are higher than 100% as individuals could be affected by multiple conditions). This is interesting and reasons for this decrease could include: a selection or reporting bias, a decreased diagnosis of chronic conditions even though they are prevalent, an actual decrease in chronic conditions, or other, and could be investigated in more depth.

However, in all years and in both regions, high blood pressure (40%), heart problems (23%), rheumatism (17%) and diabetes (16%) remain the top four chronic conditions.

Figure 6: Self-reported chronic conditions (2015, 2018, 2023)

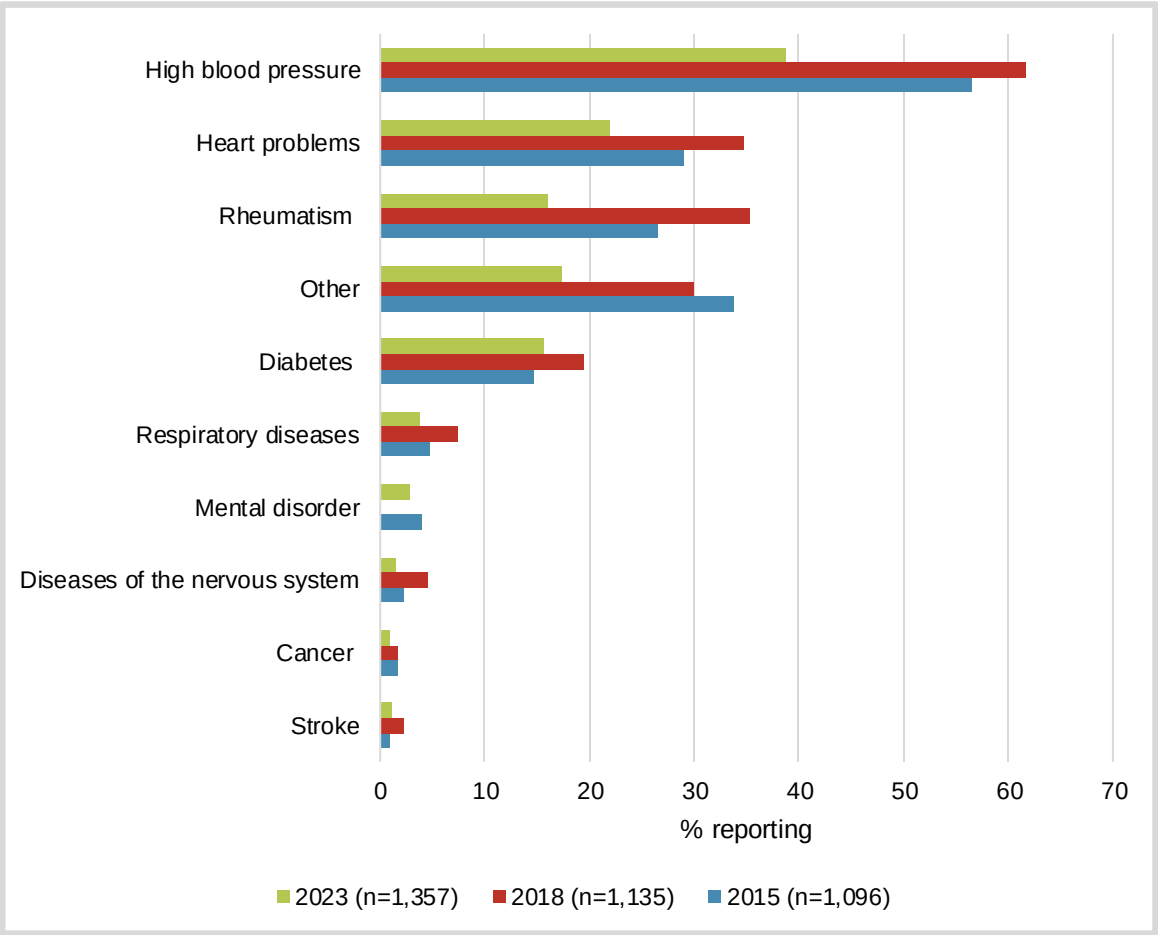


Table 9 shows the self-reported chronic conditions by region and year. In both regions, in all years, high blood pressure was the most frequent self-reported health condition. In Fier, the frequency of self-reporting of chronic conditions decreased significantly in 2023 compared to previous years (Figure 2) but the relative frequency of the conditions remained stable (Table 9). In Diber, the relative frequency of heart problems increased while rheumatism decreased.

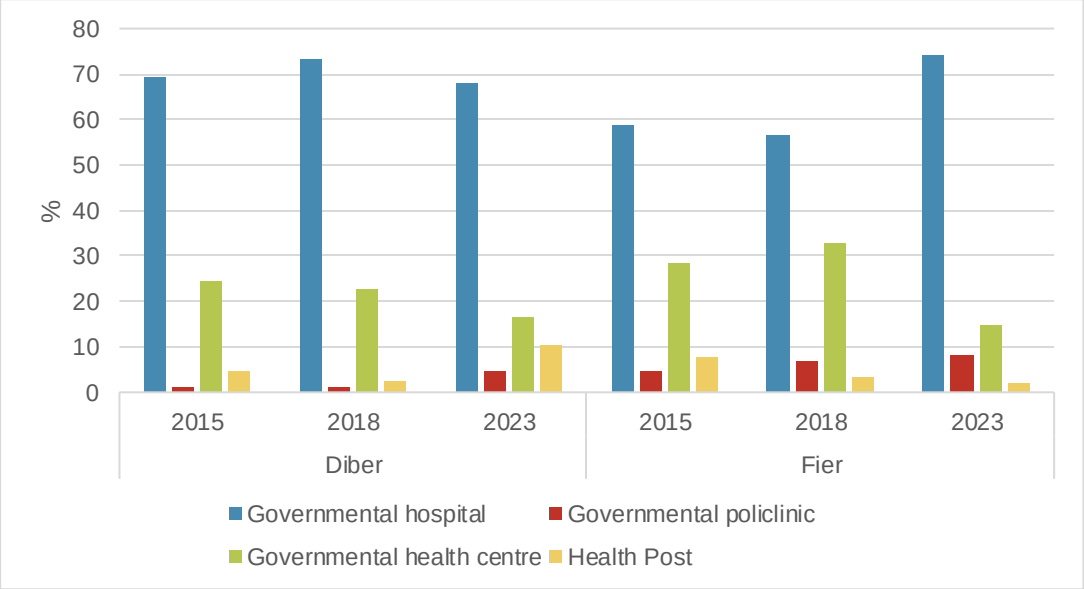
Table 9: Self-reported chronic conditions, by region (2015, 2018, 2023)

	Diber (%)			Fier (%)		
	2023	2018	2015	2023	2018	2015
High blood pressure	43.2	53.3	52.7	34.0	68.9	59.9
Other	16.3	24.4	32.0	18.7	34.9	35.5
Rheumatism	13.9	32.8	26.1	19.0	37.5	26.8
Heart problems	24.8	30.3	24.7	18.4	38.5	33.1
Diabetes	15.8	18.3	14.6	15.5	20.7	15.0
Respiratory diseases (e.g. asthma)	4.5	8.2	4.8	2.9	6.7	4.9
Mental disorder (e.g. depression)*	3.1	-	3.8	2.3	-	4.2
Diseases of the nervous system (e.g. Parkinson)	1.8	4.8	3.1	1.4	4.3	1.6
Cancer	0.9	1.5	1.5	1.1	2.0	1.9
Stroke	0.9	1.3	1.2	1.7	3.0	0.9

95% of interviewees received their diagnosis through a public sector health provider, most commonly hospitals (~60%) in both regions for all survey years, followed by health centres (~25%). In Fier in 2023, diagnosis in governmental polyclinics was more common compared to previous years. Typically, no diagnoses are made in health posts because they are not staffed with doctors. However, the nurses in the health posts still seem to play an important

role in the diagnosis of chronic condition as in Diber, diagnosis in health posts has increased over the years. Their initial assessment (e.g. verbal anamnesis, strip diabetes test, measuring of blood pressure) could lead to referral and confirmation of diagnosis in another facility and be perceived by the patients as the point of diagnosis.

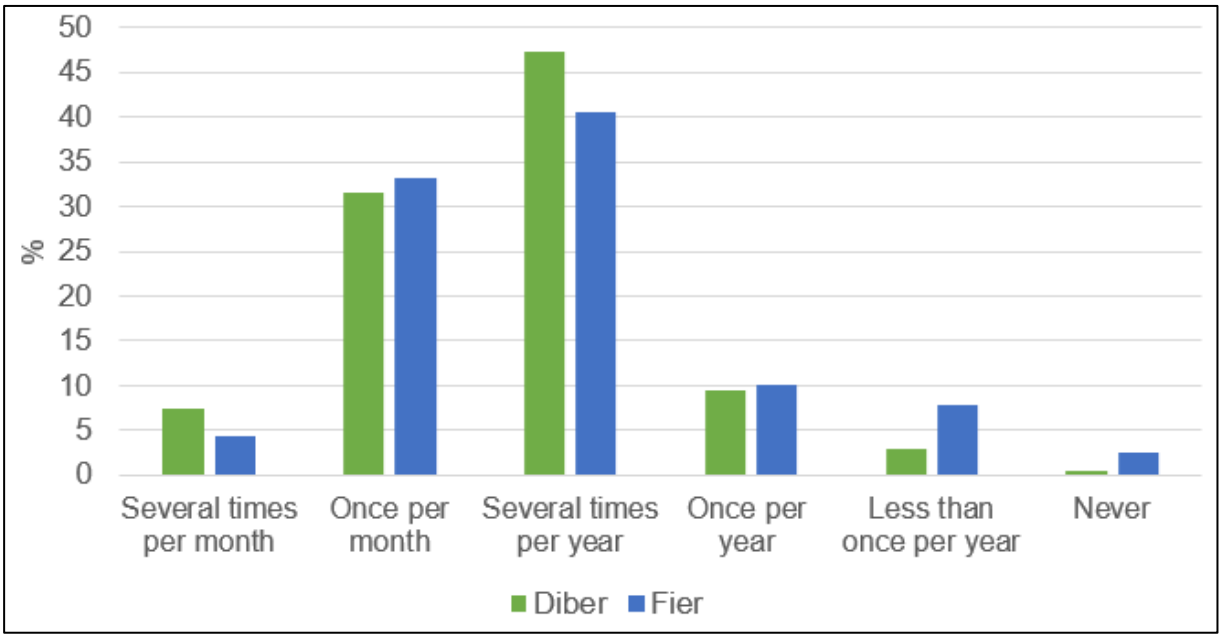
Figure 7: Provider establishing the diagnosis of a chronic condition (2015, 2018, 2023)



4.3.3 *Health seeking behaviour & barriers*

The regularity with which patients seek care for their chronic condition was assessed (Figure 8 and Figure 9). In 2023, most chronic patients seek health care several times per year (47% in Diber and 41% in Fier, respectively). About a third of patients in both Diber and Fier seek health care once per month (32% and 33%, respectively).

Figure 8: Regularity of health seeking behaviour for chronic illness (2023)



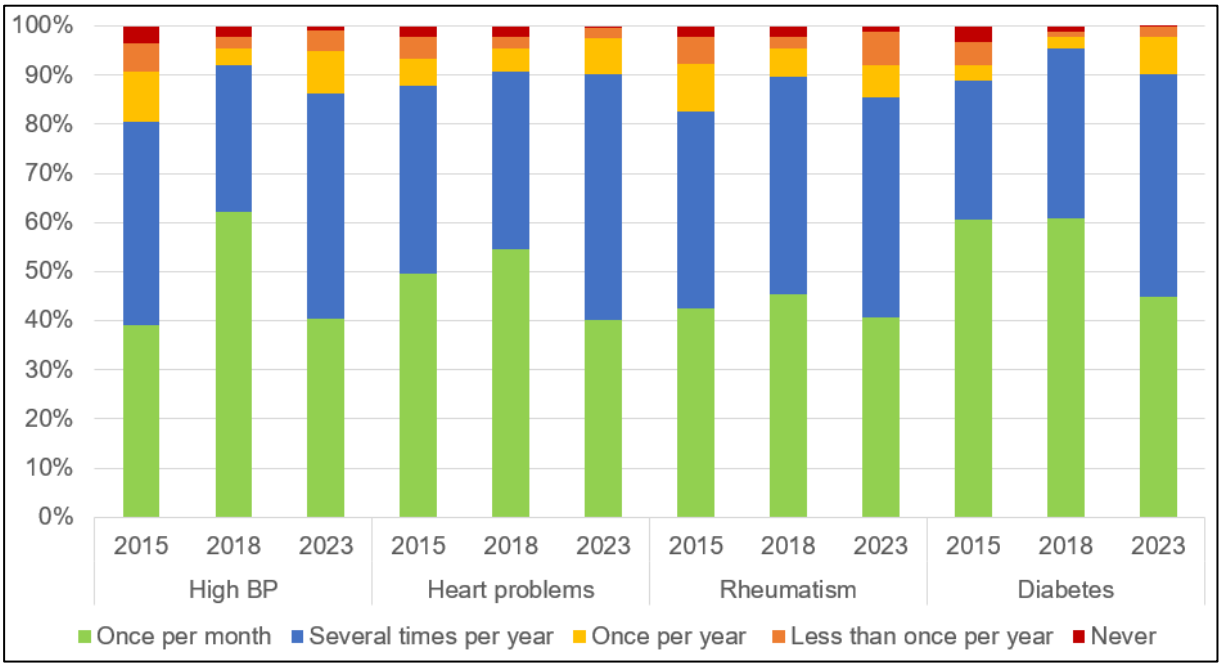
Health seeking patterns for the most common diseases is shown in Figure 9. Main findings were:

- For high blood pressure, health seeking increased between 2015 and 2018 but became again less frequent in 2023.

- For heart problems, health seeking frequency also decreased slightly between 2018 and 2023.
- For rheumatisms, the proportion of those seeking health care once a month remained relatively stable.
- For diabetes, there was a marked decrease for those seeking health care once per month.

Importantly, due to the Covid-19 pandemic, Albania has introduced that for patients with a stable and manageable chronic conduction, the family doctor gives the medication for two to six months, with no need for the patient to come and see the doctor if she/he is feeling well managed. However, the patients are still obliged to come at least once in six months. This could have decreased the frequency of medical visits as observed in Figure 9.

Figure 9: Regularity of health seeking by condition, by chronic condition (2015, 2018, 2023)



Out of 1,135 participants declaring to have a chronic condition 58% (n=640) reported seeking care in the four weeks preceding the 2023 survey. Another 26% (n=289) had sought care in the eight weeks preceding the survey. This adds up to 929 individuals (81.9%) who actually sought care in the four to eight weeks preceding the survey.

Medical care was sought at the public sector (87%) at hospital and health centre. Patients were most commonly treated by a doctor and/or a nurse. The most important factor for choosing a specific health care provider across all years was the geographical proximity to the health provider in both regions (38% in Diber and 39% in Fier; Table 10). In 2023, this was followed by 'good services' (37% in Diber and 26% in Fier). Interestingly, the 'low costs' became less important in 2023, compared to previous survey years (20% in Diber compared to 38% in 2018 and 13% in Fier compared to 36% in 2018.).

Table 10: Reasons for choosing a health care provider by persons suffering from a chronic condition (2015, 2018, 2023)

	Diber (%)			Fier (%)		
	2015	2018	2023	2015	2018	2023
Proximity	52	52	38	55	46	39
Good services	32	42	37	32	14	26
Does not cost much	31	38	20	25	36	13
Familiarity with the staff	21	26	16	20	20	17
Covered by my insurance	20	19	19	19	28	28
Good quality	18	23	21	26	16	22
Fast appointments	14	13	7	12	5	7
No need for appointment	9	10	7	7	5	5
Qualified health staff	-	16	17	-	14	24
Short waiting times	-	11	6	-	5	10
Equipment/medical devices	-	6	7	-	8	17
Laboratory tests	-	14	14	-	8	24
Other	13	-	6	11	-	5

In both regions in 2023, the most common reason for visiting not only PHC facilities but also a hospital was that they had been referred (17% in Diber and 16% in Fier, respectively) (Table 11). 'Not all tests could be conducted' in the PHC was second most frequent in Diber (14%) and third in Fier (11%), whilst for 'services not offered' it was the inverse (13% in Diber and 12% in Fier).

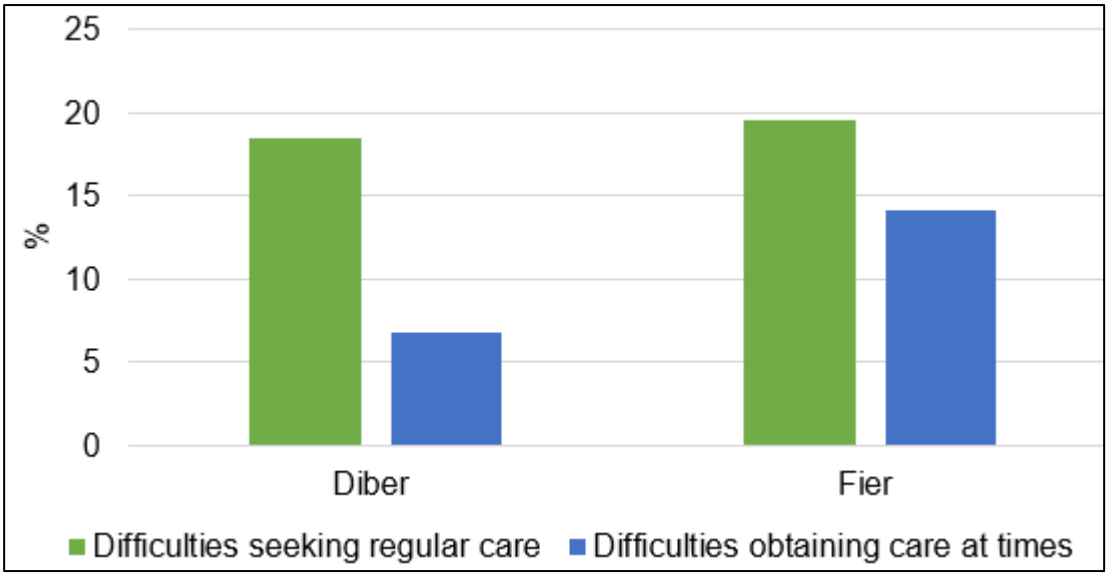
Table 11: Reasons for visits other than PHC among persons suffering from a chronic condition (2015, 2018, 2023)

	Diber (%)			Fier (%)		
	2015	2018	2023	2015	2018	2023
Proximity	52	52	38	55	46	39
Good services	32	42	37	32	14	26
Does not cost much	31	38	20	25	36	13
Familiarity with the staff	21	26	16	20	20	17
Covered by my insurance	20	19	19	19	28	28
Good quality	18	23	21	26	16	22
Fast appointments	14	13	7	12	5	7
No need for appointment	9	10	7	7	5	5
Qualified health staff	-	16	17	-	14	24
Short waiting times	-	11	6	-	5	10
Equipment/medical devices	-	6	7	-	8	17
Laboratory tests	-	14	14	-	8	24
Other	13	-	6	11	-	5

Despite more than half of chronic disease patients accessing care in the preceding four to eight weeks, nearly a fifth of interviewees reported that they do face difficulties in regularly seeking

care from a health service provider (18% in Diber and 20% in Fier) (Figure 10). Importantly, this has decreased form overall 30% in 2015.

Figure 10: Difficulties in seeking and obtaining health care (2023)



In 2023, affordability was no longer the main barrier in seeking health care as previously in 2015 and 2018, in both regions (Table 12). Instead, transportation was the main barrier in both regions, followed by distance, whereby this also included a transportation component. Similarly, the affordability could also apply to transportation cost. **Thus, overall, the significant limitation was indeed geographical access and the challenge to overcome this both logistically (i.e. transportation means) and financially (i.e. paying for transportation).** Importantly, both these factors have increased and thus worsened compared to 2018.

Other factors that were limiting in 2023 were that 'services were not available' in the PHC, and in Fier, 'long waiting times', whilst in Diber it was rather 'no health insurance' which plays into affordability as well as 'no trust in doctor'.

Table 12: Difficulties in seeking care among persons with a chronic condition (2015, 2018, 2023)

	% of people in Diber			% of people in Fier		
	2015	2018	2023	2015	2018	2023
Affordability	79	51	48	81	49	58
No transport	36	39	52	24	40	63
Distance (Endline: distance/no transport)	4	14	29	12	19	25
Other	15	13	16	14	7	12
Had no health insurance	12	10	9	14	3	9
No trust in doctor	13	8	15	12	7	5
No gender specific doctor	6	21	16	4	2	3
Self-medicated	1	4	5	5	1	7
Believed issue would resolve	1	7	6	2	1	9
Services not available**	-	-	19	-	18	19
Facility closed/ no doctor**	-	11	12	-	6	8
Long waiting times**	8	14	8	-	33	14

*2015 only; **2018 and 2023 only

Chronic disease patients were also asked if they ever encountered difficulties in obtaining care (e.g. treatment, medicine, availability of the health care provider, opening times of the facility, referred to another service or service provider, etc.) once at the health facility. In 2023, 10% indicated this to be the case. This was comparable to 2018, where also 10% indicated ever having encountered difficulties. Table 13 displays the types of difficulties encountered.

In 2023, in both regions, affordability was again the most important single factor for obtaining care for patients that were at the health facility (27% in Diber and 45% in Fier). This could include affordability to pay for the services or for prescribed drugs. This was similar to 2015 (65% in Diber and 80% in Fier) but was not the case in 2018. In 2018, the main barrier was that the doctor did not have time/did not get appointment (10% overall in 2015, 32% overall in 2018).

In Diber, other difficulties were reported at similar frequency (around 15%) but in Fier, an immediate referral to another health facility was another important reason why patients did not obtain health care at the facility (21%), which was comparable to 2018 (20%). This proportion increased also in Diber from 11% to 16% between 2018 and 2023.

Table 13: Difficulties in obtaining health services at the health facility among persons with a chronic condition (2015, 2018, 2023)

	Diber			Fier		
	2015	2018	2023	2015	2018	2023
I could not afford	65.2	10.8	26.7	80.2	17.3	45.2
Doctor did not have time/did not get appointment	12.5	37.8	16.4	8.1	29.3	14.9
I was refused	8.9	27.0	11.2	5.8	14.7	13.1
I did not have a valid insurance	8.0	0.0	15.5	15.1	2.7	5.4
Facility was closed	7.1	8.1	14.7	1.2	9.3	9.5
I was immediately referred to another health provider**		10.8	16.4		20.0	20.8
Other	26.8	43.2	37.0	15.1	41.3	22.0

**2018 and 2023 only

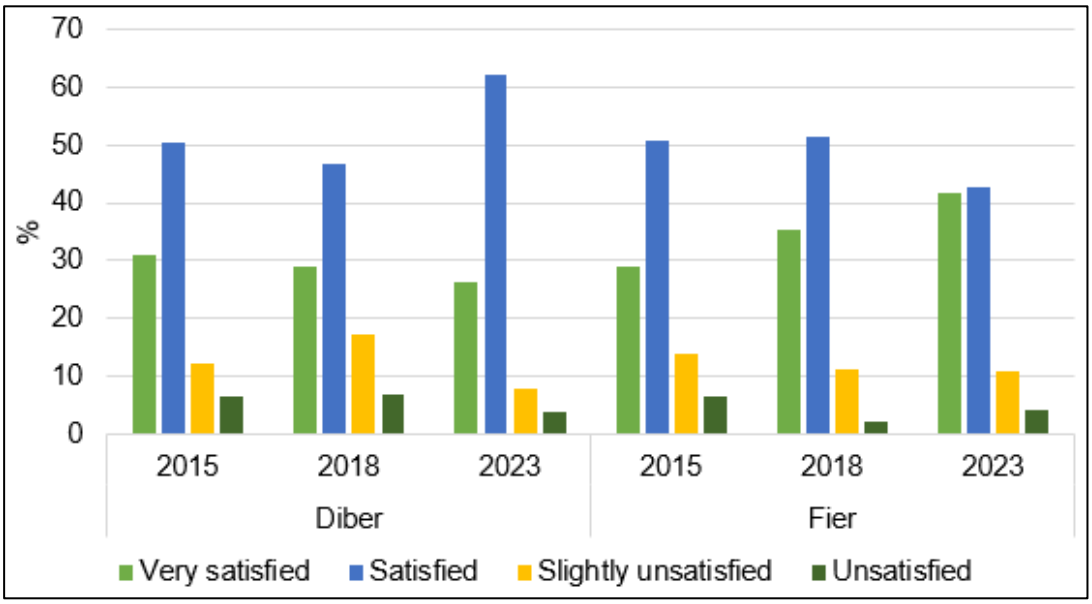
4.3.4 *Satisfaction with services for chronic conditions*

Satisfaction among those who used a health service remained overall good.

- In Diber, the proportion of patients ‘very satisfied’ or ‘satisfied’ was 81% in 2015, 76% in 2018 and increased to 88% in 2023.
- In Fier, the proportion of patients ‘very satisfied’ or ‘satisfied’ was 80% in 2015, 87% in 2018 and 84% in 2023.

Figure 11 shows the satisfaction levels by year and region.

Figure 11: Satisfaction with health service among persons with a chronic condition who consulted a health service provider (2015, 2018, 2023)



4.3.5 *Health expenditures for chronic conditions*

Household expenditures on health care for the chronic patient were assessed. The average cost – instead of the median cost – was assessed as many people did not pay anything (which would skew the median calculation). **Overall, 89.9% of chronic patients reported to have paid something (i.e. reported as >0 LEK) in 2023 for at least one of the factors assessed (i.e. transport, testing, care and drugs).** This was comparable to previous years (97.9% in 2018 and 97.8% in 2015).

Inflation was considered as follows: 2023 was taken as the reference value; and inflation rates considered were 5.2% depreciation between 2015 and 2018 and 20.4% depreciation between 2015 and 2023.[2]

Figure 12 displays the average health expenditures for patients with chronic conditions in the 4 weeks preceding the survey for: care and treatment; transport, tests and drugs. **In both regions, costs have increased since 2018 overall and drugs were the main cost driver in 2023.**

[2] https://www.worlddata.info/europe/albania/inflation-rates.php#:~:text=The%20inflation%20rate%20for%20consumer,the%20price%20increase%20was%202%2C474.13%25

Figure 12: Average health expenditures (in LEK) for chronic conditions in the four weeks preceding the survey (2015, 2018, 2023) – with inflation adjustment & 2023 as reference value

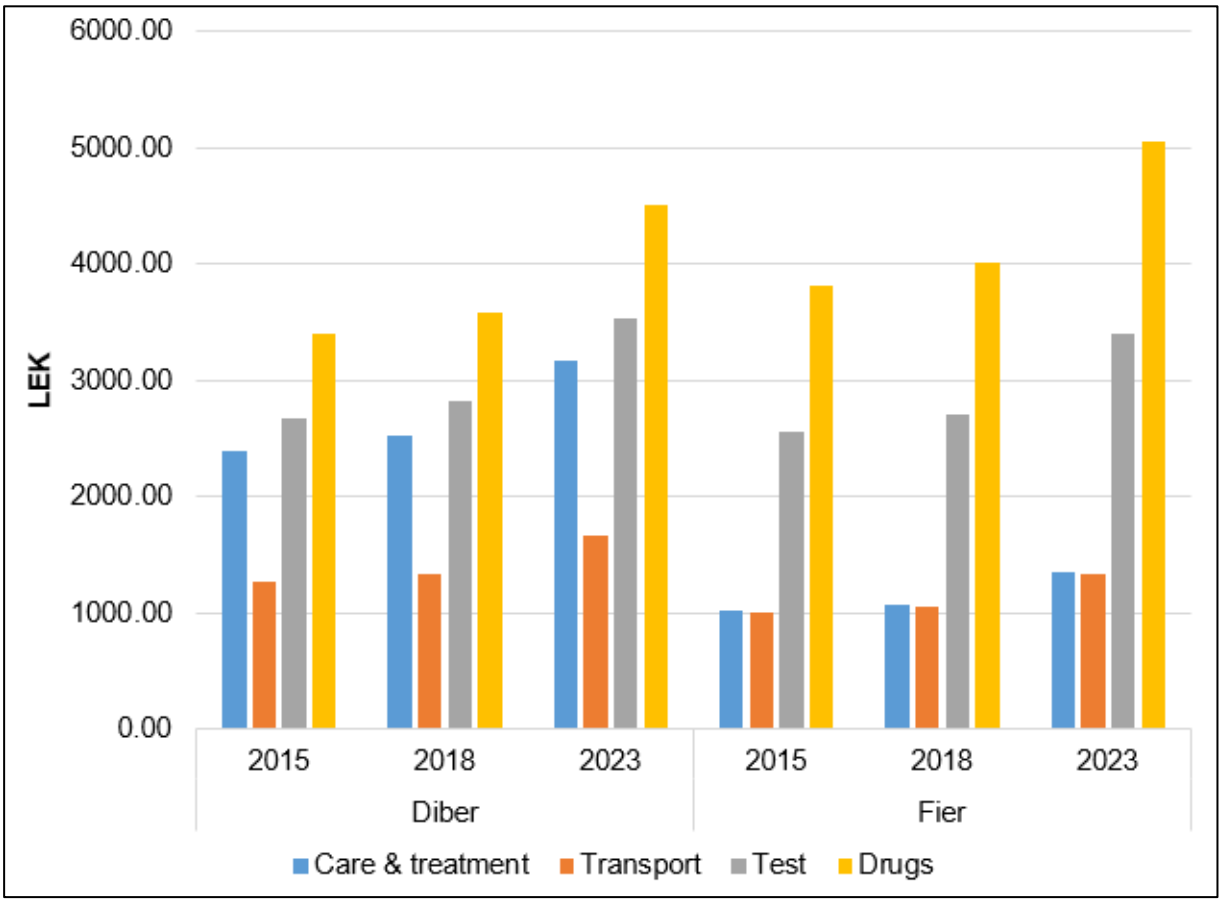
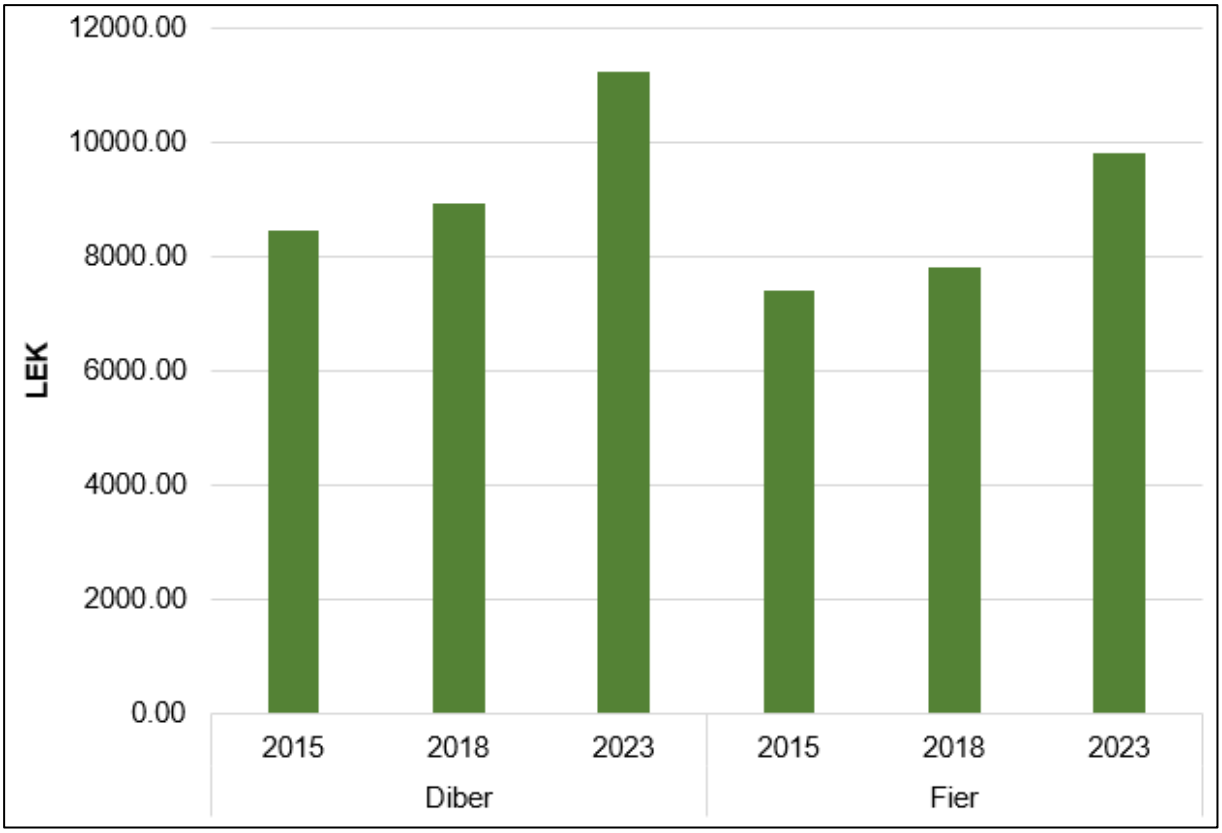


Figure 13 shows the average total health expenditures for all costs combined, excluding transportation costs. Similar to Figure 12, an increasing trend for mean costs were observed in both regions.

Figure 13: Average total health expenditures excluding transport costs (in LEK) for chronic conditions in the four weeks preceding the survey (2015, 2018, 2023) – with inflation adjustment & 2023 as reference value



Graphs for expenditures without consideration of inflation are shown in annex 8.2.

4.4 Indicators in individuals with an acute health issue

4.4.1 *Profile of interviewees*

In 2023, 573 respondents from Diber and 421 from Fier were selected for disease specific interviews (Table 14).

Table 14: Demographic characteristics of interviewees with an acute health problem

	Diber			Fier		
	2015	2018	2023	2015	2018	2023
N	117	323	573	58	232	421
% female	66	57	53	74	62	51.07
Average age (SD)	32 (20)	44 (23)	43 (23)	41 (18)	53 (21)	42 (23)
Age group						
<1	3	2	-	0	0	-
1<5	12	6	5	3	4	3
5<18	11	8	17	9	4	9
18<49	55	35	57	52	24	33
49<65	15	30	30	24	36	31
65+	3	19	17	12	31	25

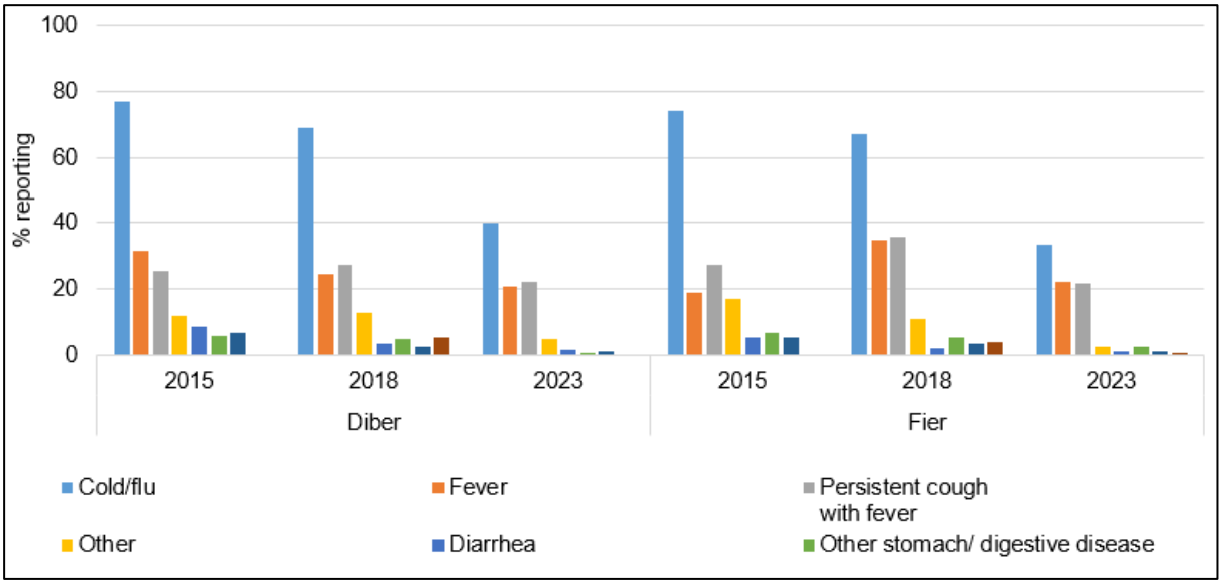
[a] In 2023, due to digital recording of only the year of birth, a differentiation between <1 year and 1 year of age could not be made.

4.4.2 *Acute illness patterns*

Patterns of self-reported acute illnesses remained similar over all survey years (Figure 14). Flu and colds remained the most frequent health issue followed by fever and chough with fevers.

All other diseases were far less common, especially so in 2023, which could be explained by the season of data collection (December 2015, October/November 2018, and February 2023).

Figure 14: Self-reported acute health problems



4.4.3 *Health seeking behaviour & barriers*

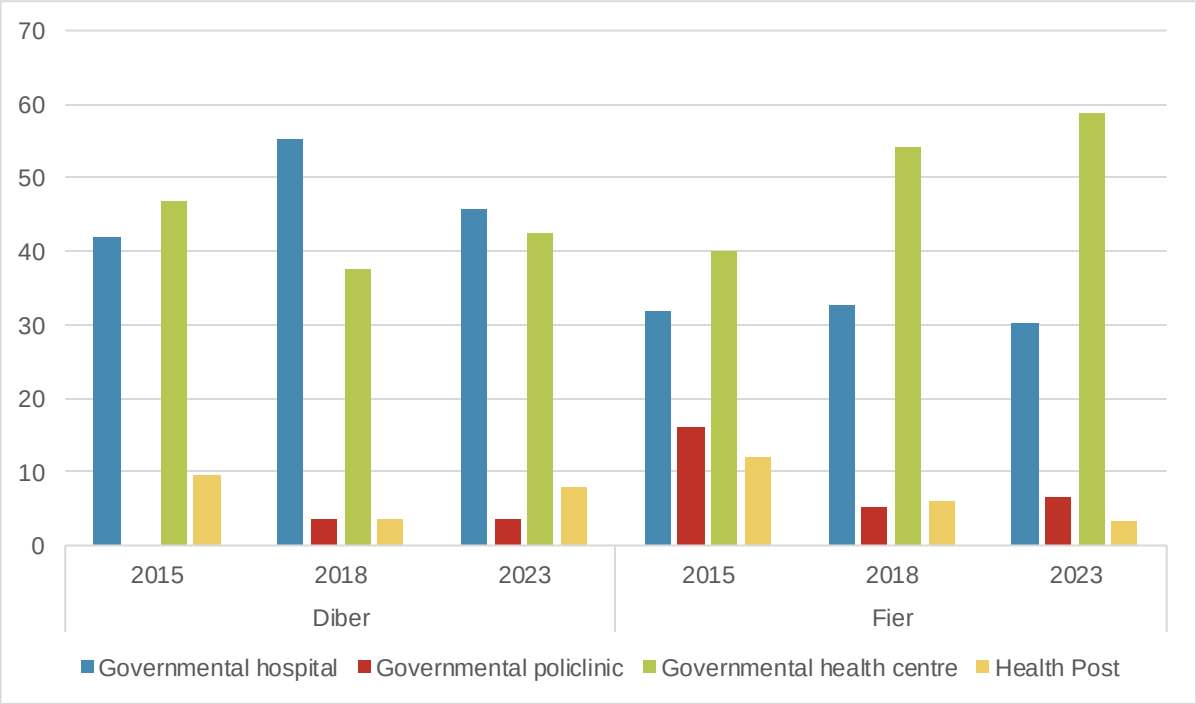
In 2023, about half (51%) have sought health care for their acute illness (54% in Diber and 45% in Fier). This equal to 51% in 2015 (54% in Diber and 47% in Fier), and compared to 66% in 2018 (72% in Diber and 59% in Fier). Of those seeking care, the median number of days people waited to seek care was 2 days in both regions and 81% indicated that they sought assistance in the first three days after the illness started.

Among those seeking care for acute illnesses, in 2023, 87% went to the public health facilities (94% in Diber and 73% in Fier). In 2018, 98% sought care in public facilities (99% in Diber and 96% in Fier). Thus, the proportion of people using the private sector services increased overall (13% in 2023), and especially in Fier (27% in 2023 as compared to 6% in Diber).

For those seeking care in public health facilities in Fier, a marked preference or necessicity for health centers was found in all years (Figure 15). In Diber, the majority went still to governmental hospitals as compared to health centers but this difference grew smaller in 2023 as compared to 2018. More generally, for both regions the use of health centres was an important place for help seeking. This is a positive finding as primary health care seeeking should start at the level of the health center and health posts, rather than hospitals and polyclinics.

For those seeking care in the private sectors, the majority mentioned going to pharmacies (67%), which is in line with findings presented in Table 18 (see below), indicating a strong tendency to self-medication for mostly self-limiting, mild illnesses.

Figure 15: Type of government facility attended when ill with acute illness (2015, 2018, 2023)



Of those not seeking health care at public primary health care facilities, reasons as to why are displayed in

Table 15. In 2015, most common reasons were that the services required were not offered at PHC (27%), that not all tests could be conducted at PHC (19%) or the facility was closed (23%). In 2018, the most common reason was that not all tests could be conducted at the PHC facility. In 2023, in both regions, the most common reasons were that the services were not offered and that the patients were immediately referred. In Diber, 'services not offered' was equally important.

Table 15: Reasons among persons with an acute health problem for not using PHC services (2015, 2018, 2023)

	Diber (%)			Fier (%)		
	2015	2018	2023	2015	2018	2023
Services are not offered	30	17	3	20	2	2
Facility closed	30	3	1	7	1	1
Other	15	2	4	13	4	1
Not all tests could be conducted there	12	19	3	33	6	1
Not competent	6	6	0	7	1	0
I was immediately referred	6	9	3	7	11	2
Poor service	6	4	1	7	3	1
Too far, no transport	6	1	0	0	0	1
I know the other doctor	3	3	1	0	0	0

Respondents were asked on difficulties in seeking care for an acute health problem (Table 16) as well as difficulties in obtaining care once arrived at the health facility (Table 17).

In 2023, the lack of a gender-specific doctor was the main barrier in seeking health care in Fier. In 2015 and 2018, the main barrier was affordability. In Diber, the main barrier also used to be affordability in previous years but in 2023, the belief that the issue would resolve, and self-medication were the main reason for not consulting a service. Importantly, the proportion of respondents stating 'no trust in doctor' has decreased significantly in Diber from 33% in 2015 to less than 1% in the following survey years.

Table 16: Difficulties seeking care among persons with an acute health problem (2015, 2018, 2023)

	Diber (%)			Fier (%)		
	2015	2018	2023 (n=157)	2015	2018	2023 (n=264)
Not sufficient financial funds	47	4	5	71	4	0
No trust in doctor	33	1	<1	0	1	<1
No transport	27	2	1	43	2	0
No time*	0	-	-	14	-	-
No gender specific doctor	13	0	0	14	1	1
Believed issue would resolve	13	1	9	0	1	0
Self-medicated	13	0	7	0	1	0
Other	13	2	<1	0	2	<1
Distance	7	2	1	0	0	0
Had no health insurance	7	0	-	0	0	-
Services not available**	-	2	0	-	1	1
Facility closed/ no doctor**	-	1	<1	-	2	<1
Long waiting times**	-	0	<1	-	4	0

*2015 only; **2018 and 2023 only

Once at the health facility, there remain barriers in obtaining care (Table 17). In all years and both regions, 'affordability' remained the single most important barrier to obtain health care (includes potentially paying for services and medication). However, this decreased drastically since 2015. In Diber, another important challenge was that the health care provider did not have time and/or it was impossible to get an appointment with a family doctor. In Diber, some family doctors work on rotations in a facility and not on a regular basis.

Table 17: Difficulties in obtaining health services at the health facility among persons with an acute illness (2015, 2018, 2023)

	Diber (%)			Fier (%)		
	2015	2018	2023 (n=64)	2015	2018	2023 (n=19)
I could not afford	58	39	31	100	36	58
Other	25	28	36	0	14	11
Doctor did not have time/did not get appointment	17	17	27	0	36	0
I did not have a valid insurance	17	0	20	33	0	11
Facility was closed**	-	17	11	-	14	32
I was refused**	-	6	6	-	14	0
I was immediately referred to another health provider**	-	11	3	-	7	0

*2015 only; **2018 and 2023 only

Of those not seeking care, reasons were asked and the following was found over the years (Table 18):

- Most of the self-reported acute illnesses seemed to be mild and self-limiting, because:
  - In Fier in 2023, the most important reason was that people opted for self-medication, which indicates that treatments were probably available over the counter. This was also found in the previous survey years. The second reason was the 'belief that problems would go away without treatment'.

  - In Diber in 2023, the 'belief that problems would go away without treatment' was actually the most important reason for not seeking care. This was followed by self-medication, which used to be the main reason in 2015.
- Other reasons are much less important, with less than 20% mentioning them.
  - In Diber, affordability was third important (all years).
  - In Fier, 'no trust in doctor' gained importance, which is concerning, potentially also beyond the study area.

Table 18: Reasons for not seeking care among persons with an acute health problem by region (2015, 2018, 2023)

	Diber (%)			Fier (%)		
	2015	2018	2023	2015	2018	2023
Self-medicated	59	59	43	71	60	75
Believed problems would go away without treatment	43	64	72	58	57	67
Not sufficient financial funds	15	16	14	10	20	3
No transport	6	13	11	3	16	3
No time	9	-	-	0	-	-
Had no health insurance	6	4	2	3	3	1
No trust in doctor	6	5	1	0	3	6
Facility too far away	4	9	5	3	13	1
Other	4	7	2	0	4	5
No gender specific doctor	2	2	0	0	1	1
The health services I need were not available		3	1		2	1
Facility was closed or had no doctor		1	1		2	2

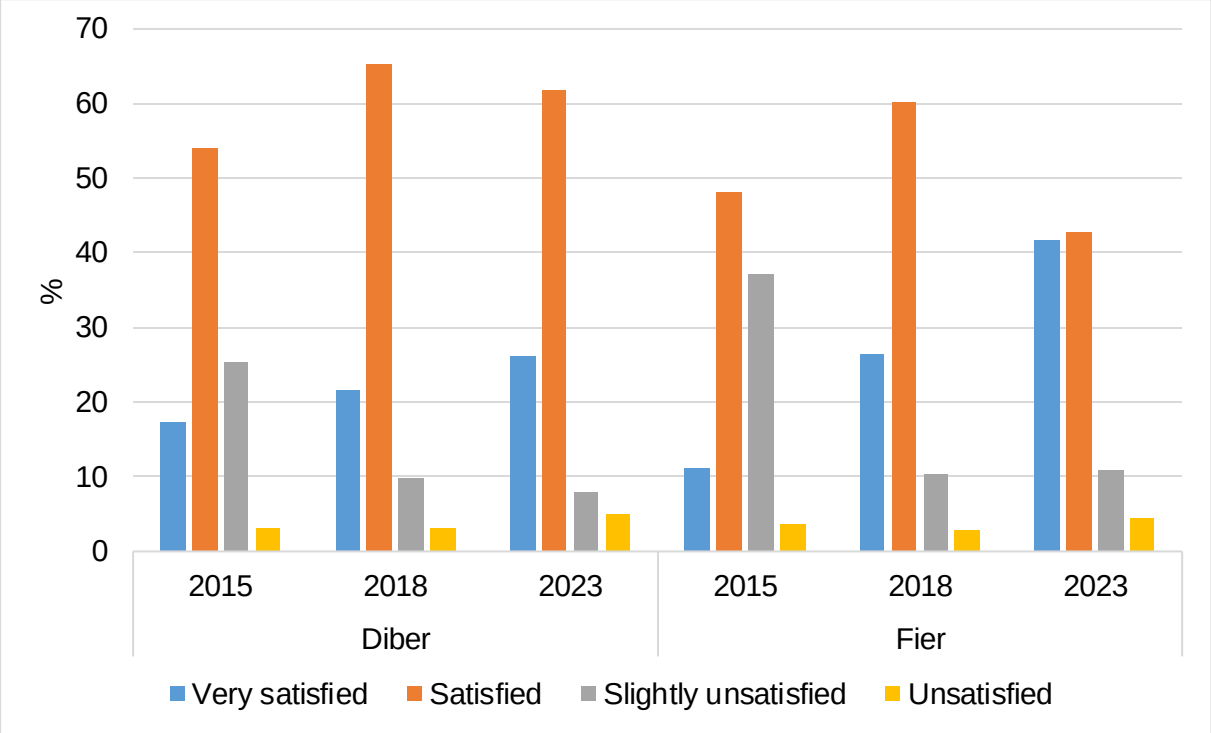
4.4.4 *Satisfaction with services for acute health problem*

Satisfaction among those who used a health service reached was very similar as in respondents with a chronic condition in 2023. The satisfaction levels evolved as follows:

- In Diber, the proportion of patients 'very satisfied' or 'satisfied' was 71% in 2015, 87% in 2018 and increased to 88% in 2023.
- In Fier, the proportion of patients 'very satisfied' or 'satisfied' was 59% in 2015, 87% in 2018 and decreased slightly to 84% in 2023.

Figure 16 shows the satisfaction levels by year and region.

Figure 16: Satisfaction with health service among persons with an acute health problem who consulted a health service provider (2015, 2018, 2023)



4.4.5 *Health expenditures for acute health problems*

Household expenditures on health care for the acute patient were assessed. **Overall, 99.5% of acutely ill patients reported to have paid something (i.e. reported as >0 LEK) in 2023 for at least one of the factors assessed (i.e. transport, testing, care and drugs).** This was comparable to previous years (99.8% in 2018 and 99.9% in 2015).

Inflation was considered as follows: 2023 was taken as the reference value; and inflation rates considered were 5.2% depreciation between 2015 and 2018 and 20.4% depreciation between 2015 and 2023.[3]

Figure 17 displays the average health expenditures for patients with acute conditions in the 4 weeks preceding the survey for: care and treatment; transport, tests and drugs. **As for patients with chronic conditions, in both regions, costs have increased since 2018 overall and drugs were the main cost driver in 2023.**

[3] https://www.worlddata.info/europe/albania/inflation-rates.php#:~:text=The%20inflation%20rate%20for%20consumer,the%20price%20increase%20was%202%2C474.13%25

Figure 17: Average health expenditures (in LEK) for persons with an acute health problem in the past four weeks – with inflation adjustment & 2023 as reference value

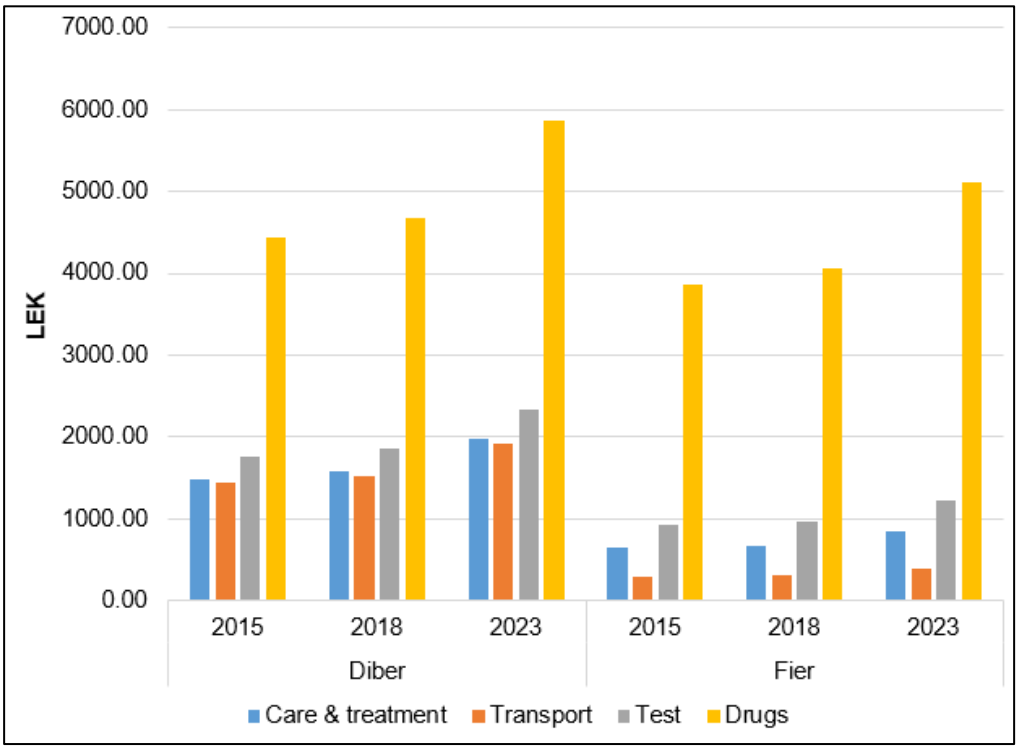
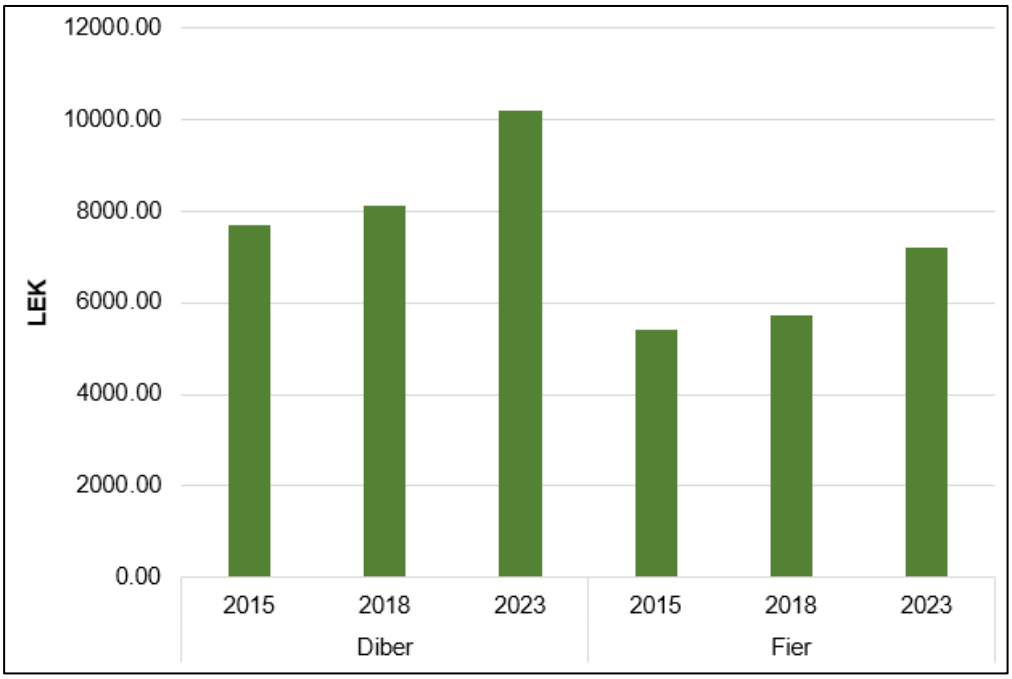


Figure 18 shows the average total health expenditures for all costs combined, excluding transportation costs. Similar to Figure 17, an increasing trend for mean costs were observed.

Figure 18: Average total health expenditures excluding transport costs (in LEK) for chronic conditions in the four weeks preceding the survey (2015, 2018, 2023) – with inflation adjustment & 2023 as reference value



Graphs for expenditures without consideration of inflation are shown in annex 8.2.

4.5 Indicators on mother and child health

4.5.1 *Profile of interviewees*

Overall, in 2023, 90 mothers of children under 5 years were interviewed (out of 95 eligible). As in previous years, more mother respondents were recruited in Diber (68% in 2015, 64% in 2018, 70% in 2023). The mean age of mothers was around 30 years in Diber and Fier in 2018 but this increased to 32 and 35 years, respectively, in 2023.

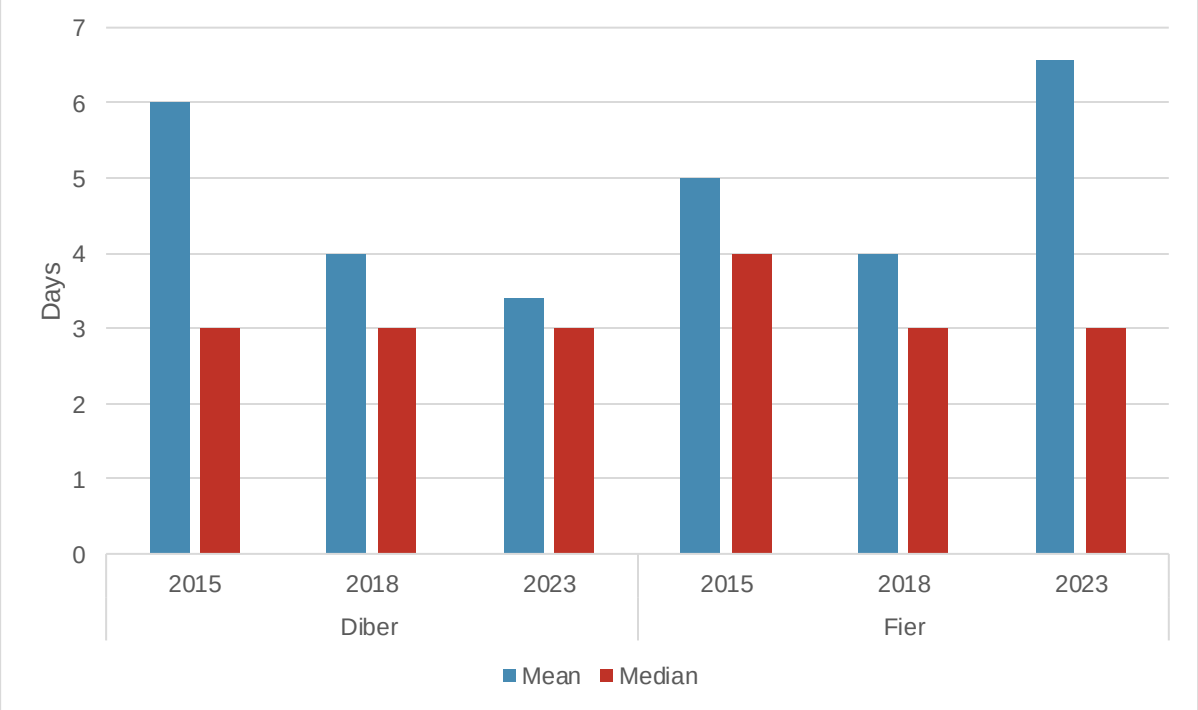
Table 19: Demographic characteristics of mothers interviewed

	Diber			Fier		
	2015	2018	2023	2015	2018	2023
n	109	102	70	52	55	20
Mean age (SD)	28 (6)	30 (6)	32(6)	28 (6)	29 (5)	35(6)

4.5.2 *Postnatal care*

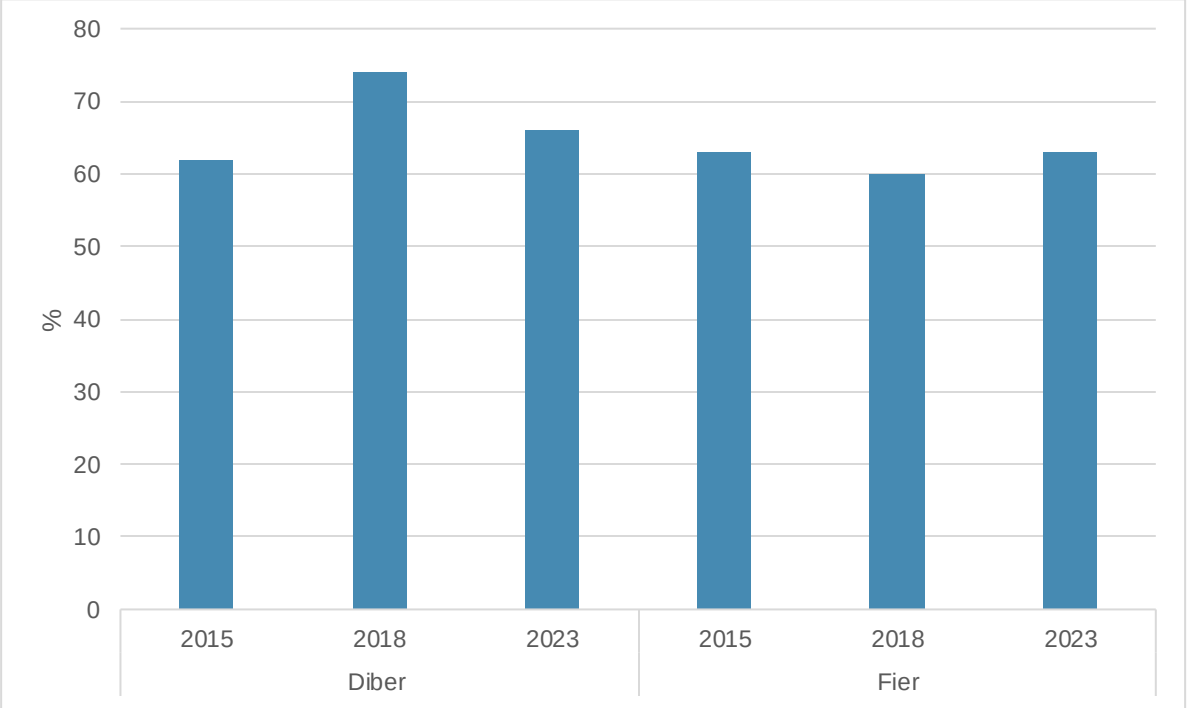
In all survey years, the majority of women had left the hospital after three days in both Diber and Fier (Figure 19).

Figure 19: Mean and median time spent in hospital after birth, by region (2015, 2018, 2023)



The proportion of women reporting having had a health check after maternity discharged remained relatively stable in Fier (slightly above 50%) (Figure 20). In Diber, the proportion dropped from 74% in 2018 to 66% in 2023 but remained thus still higher than at baseline in 2015 (62%).

Figure 20: Proportion of women having had a health check after maternity discharge, by region (2015, 2018, 2023)



In 2023, the mean number of days mothers waited for a health check after discharge was 6.8 days in Diber and 6.5 days in Fier (Figure 21). This ranged between 1 and 60 days in Diber and 1 and 40 days in Fier, thus, the median is also meaningful and was 3 days in Diber and 4 days in Fier. In Diber, this has improved by 2 days since 2015, where mothers waited 5 days. In Fier, the delay was shorter in 2018 with 2 days.

Figure 21: Time to health check after maternal discharge

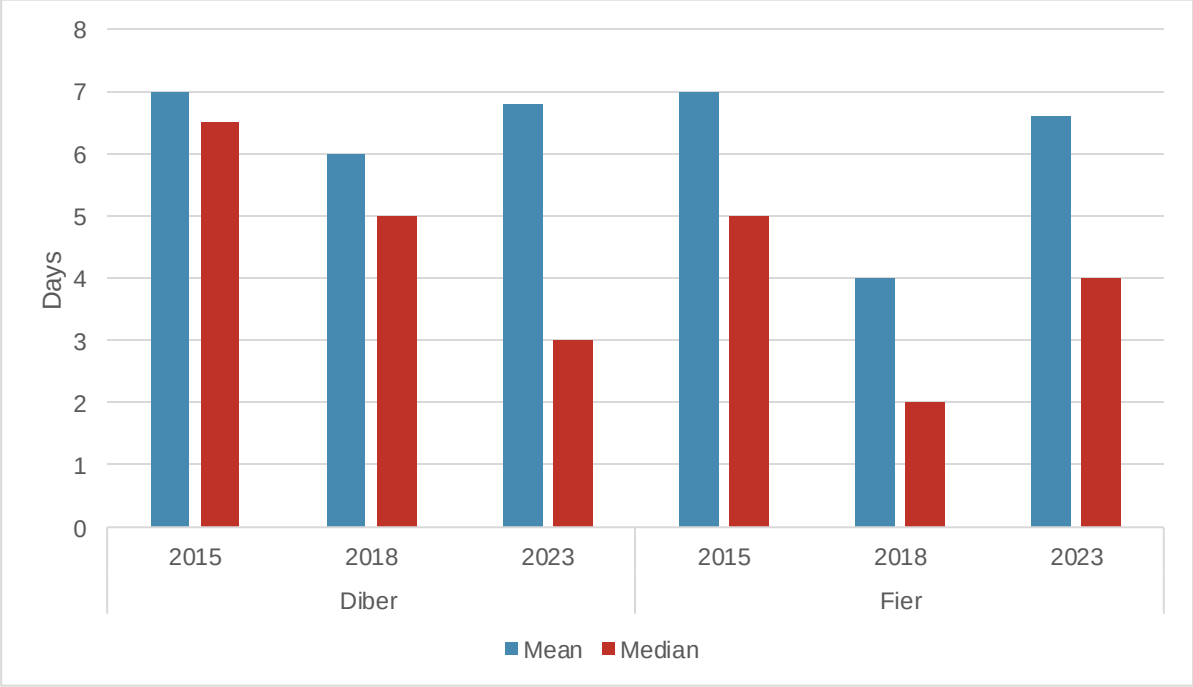
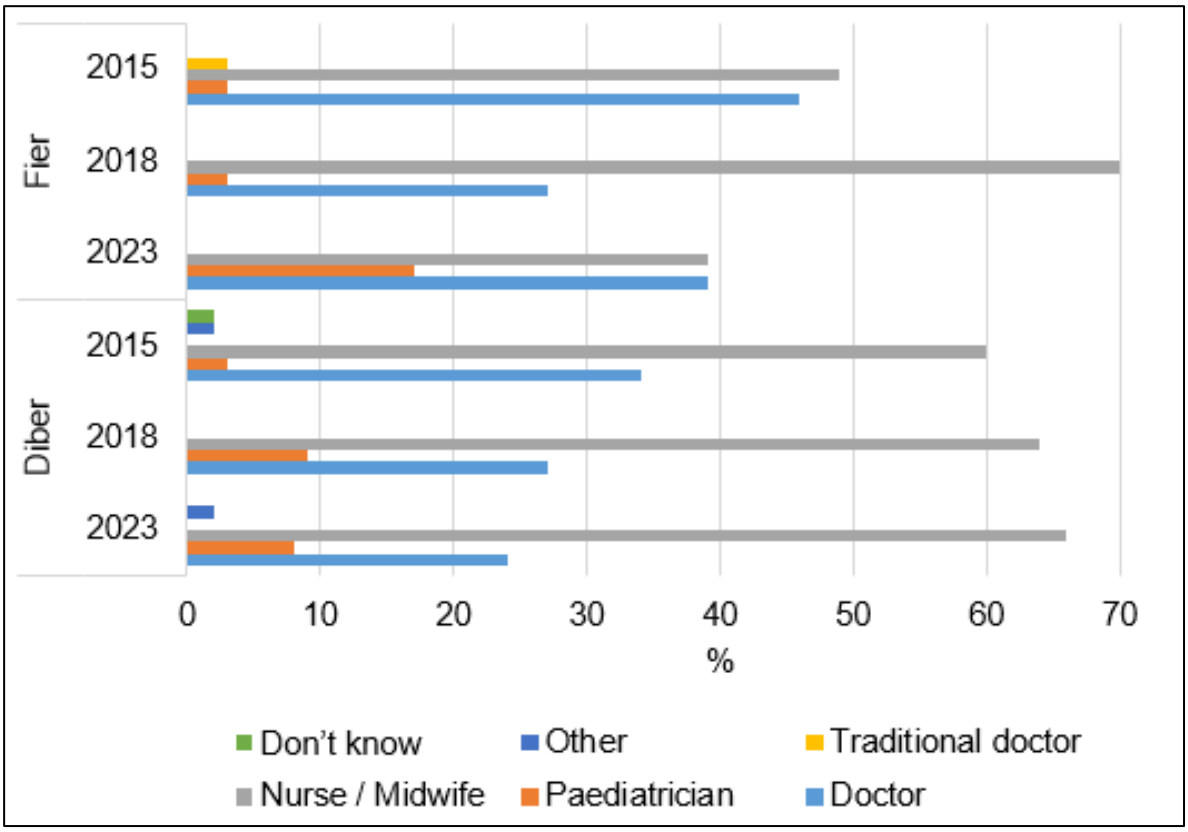


Figure 22 shows the type of health care provider who was performing the maternal check-up. In the majority of cases, it was a nurse or a midwife, in both regions. However, in Fier in 2023, there was an equal proportion of mothers who reported that a medical doctor did the check-up

(39%). In Diber, the proportion for nurses and midwives increased steadily while the proportion of doctors decreased steadily, probably indicating that nurses and midwives have taken over certain roles and tasks of doctors in this regard.

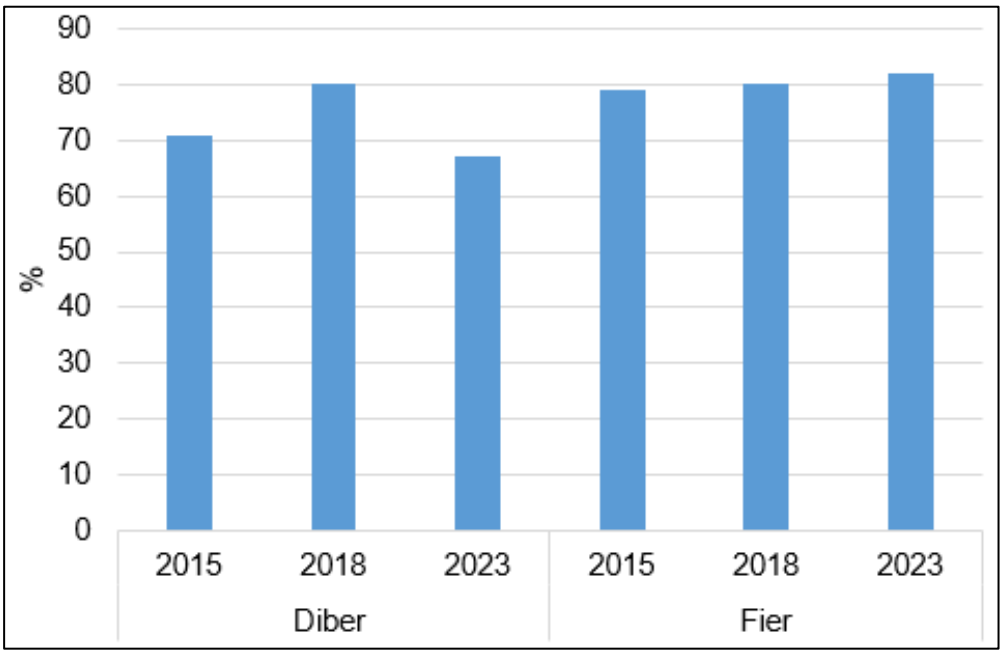
Figure 22: Type of health care provider performing maternal check (2015, 2018, 2023)



4.5.3 *Child monitoring, development & growth check-up*

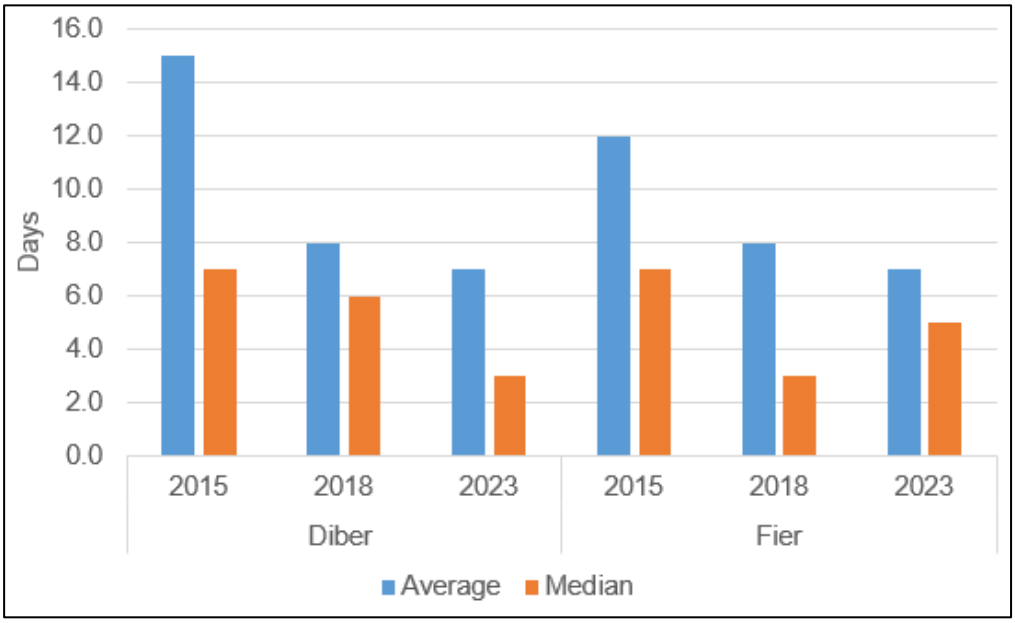
Over all child health checks were reported by 80% of mothers in both Diber and Fier in all survey years (Figure 23). This is slightly higher than the reported proportion of women having had a health check after maternity discharge (Figure 20 above).

Figure 23: Child health check after birth (2015, 2018, 2023)



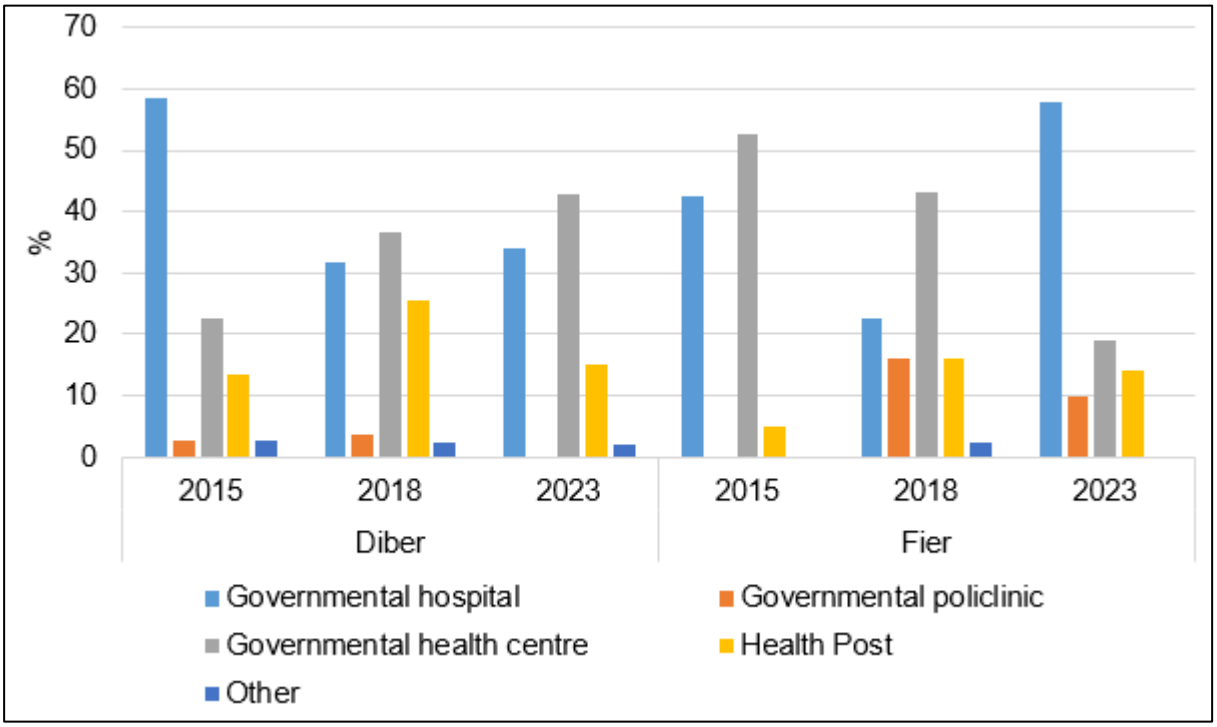
The majority of mothers declared that their child received a check 6 days after birth in 2023, this is reduction from 14 days in Diber and 12 days in Fier in 2015 (Figure 24). The patterns were similar to that for the maternal check-ups: in Diber, the delay decreased steadily from a median of 7 days to 3 days and in Fier, there was a decrease from 7 days to 3 days between 2015 and 2018 but then it increased slightly again to 5 days in 2023.

Figure 24: Time of child health check after birth discharge (2015, 2018, 2023)



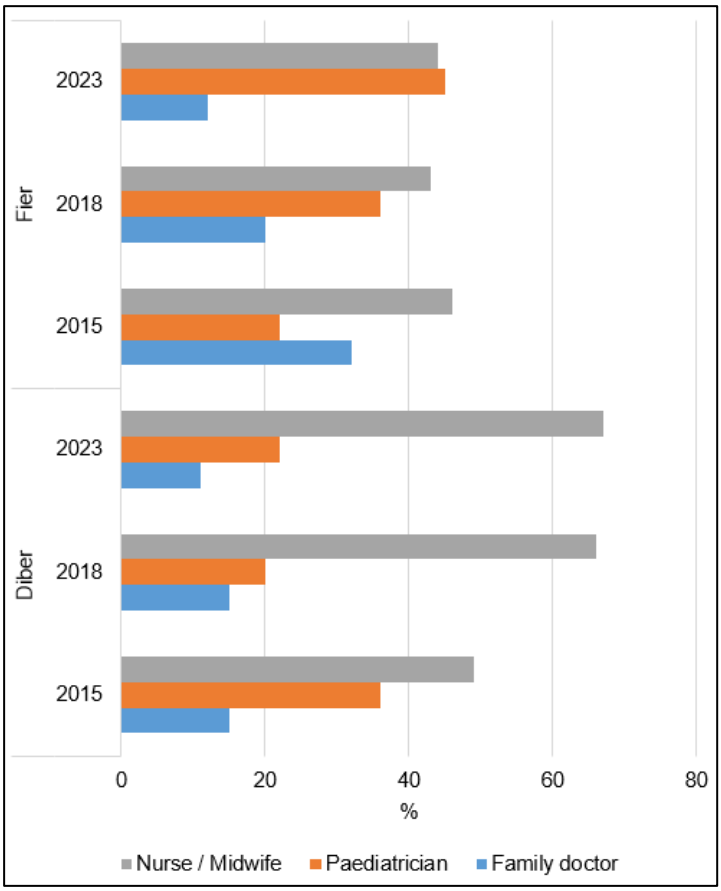
In 2023, 83% of mothers reported that they were doing the health check for their children in a public health facility, which was 85% in Diber and 76% in Fier (Figure 25). For those using the public health sector, most visited a governmental health center (most used in Diber with 43%) or a hospital (most used in Fier with 58%).

Figure 25: Health facility for child health check (2015, 2018, 2023)



As shown in Figure 26, in 2023 in Fier, in the majority of cases, the check-ups were done by a medical doctor (either a paediatrician or a family doctor). This was similar to 2018. However, in Diber, the majority of check-ups are still done by a nurse/midwife.

Figure 26: Health professional conducting child health check



Practices from health care providers during the health check-ups for children are shown in Table 20. Overall, in 2023, the proportion of mothers reporting to have been asked certain questions and that the health care provider conducted certain examinations was higher than previous years (for most indicators), in both regions. The lowest proportion was found for 'measuring the head circumference' in Diber with 63%.

Table 20: Growth and development in children: questions asked and procedures provided (%)

	Diber (%)			Fier (%)		
	2015	2018	2023	2015	2018	2023
Mother asked about:						
Development progress	62	84	84	65	75	97
Child diet and eating habits	62	72	85	67	75	97
Vaccination card and revised it	91	91	96	87	93	96
The health provider conducted:						
Head measurement	42	73	63	69	69	89
Height measurement	50	76	70	73	71	89
Weight measurement	77	87	93	89	82	100
Information on how to prevent diseases	41	67	63	48	56	81

4.6 Knowledge, Attitude and Practice

4.6.1 *Cardiovascular disease, diabetes, obesity & health KAP in adults*

Respondents, who were in-depth questioned about their chronic or acute condition, were questioned on their knowledge, attitude and practice related to cardiovascular disease. Overall, there were 1,264 respondents in 2015, 1,125 respondents in 2018 and 1,279 respondents in 2023 for this part of the survey.

Respondents were asked about risk factors for cardiovascular diseases, whereby no responses or options were prompted. Risk factors for cardiovascular diseases known to more than 40% of respondents in 2023 were 'stress', 'high blood pressure' and 'high cholesterol' in Diber and Fier, and 'smoking' additionally in Diber (Table 21). Therefore, especially in Fier, more people were aware of potential risk factors as in previous years, in other words, health literacy has increase over the years. As compared to previous years, there was significantly more awareness on 'unhealthy diet' and 'physical inactivity'.

Table 21: Known reported, non-prompted cardiovascular disease risk factors (2015, 2018, 2023)

	Diber (%)			Fier (%)		
	2015	2018	2023	2015	2018	2023
High blood pressure	54	62	48	62	38	45
Stress	50	63	51	62	79	66
High cholesterol / high blood fat	32	40	52	36	23	45
Age	31	40	32	30	24	37
Smoking / tobacco use	24	50	49	22	18	40
Don't know	19	7	5	11	4	11
Diabetes	18	23	27	22	11	18
Obesity	16	42	28	17	12	33
Unhealthy diet	13	34	34	22	18	35
Family history / genetics	11	20	16	12	9	19
Physical inactivity	9	21	29	10	7	34
Other	5	8	2	7	9	4
None	0	0	0	0	0	0

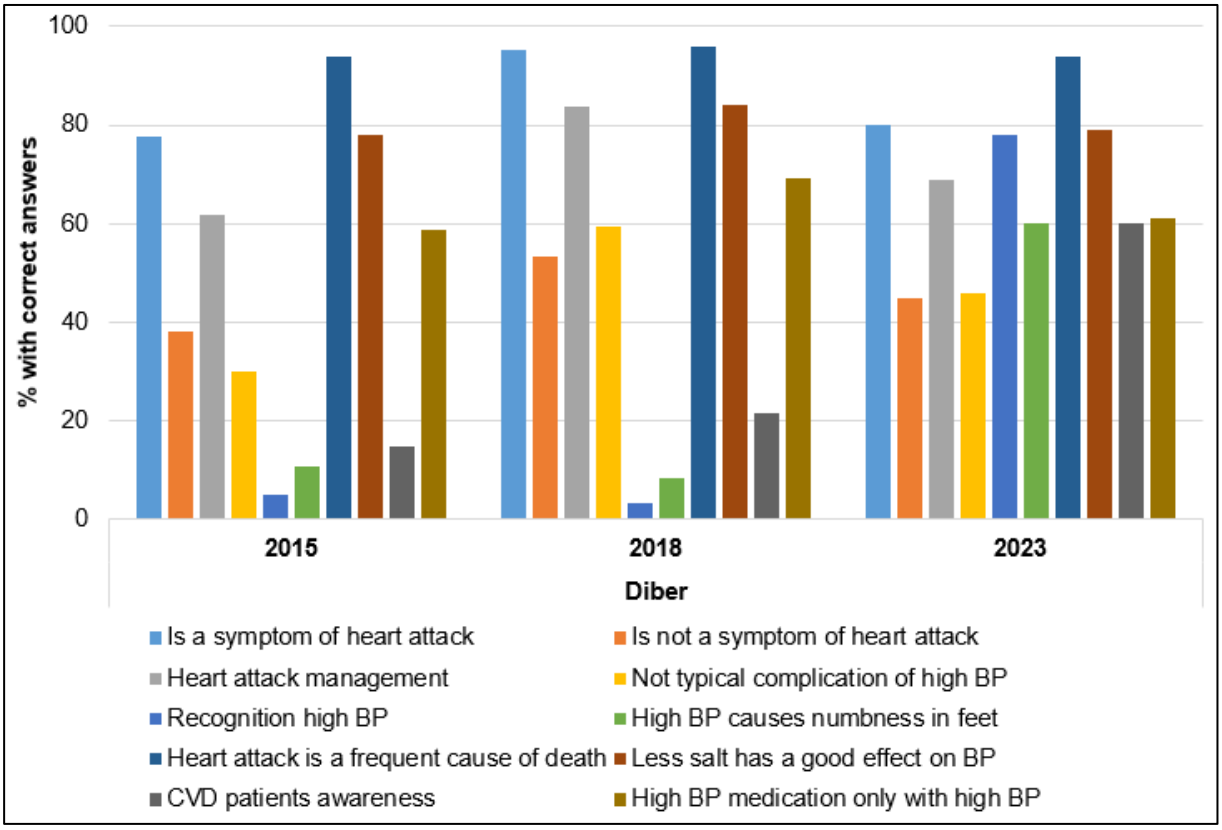
A total of 26 questions pertained to the knowledge on CVDs (n=10) diabetes (n=12), and obesity (n=4).

For CVDs, respondents were asked the below list of questions and statements and Figure 27 and Figure 28 show the proportion of respondents with correct answers in Diber and Fier, respectively. The questions were:

1. Which of the following is a typical symptom of a heart attack?
2. Which of the following is not a typical symptom of heart attack?
3. What should you do, if someone suddenly experienced strong pain on the left side of the chest, which is irradiating into the left arm?
4. Which of the following is not a complication of high blood pressure?
5. Patients easily recognize high blood pressure because of the symptoms.
6. High blood pressure can cause a feeling of numbness in the feet.
7. Heart attack is a frequent cause of death.
8. Eating less salt can have a good effect on blood pressure.
9. Most people with cardiovascular disease know that they are sick.
10. People with high blood pressure only have to take medication when the blood pressure is high.

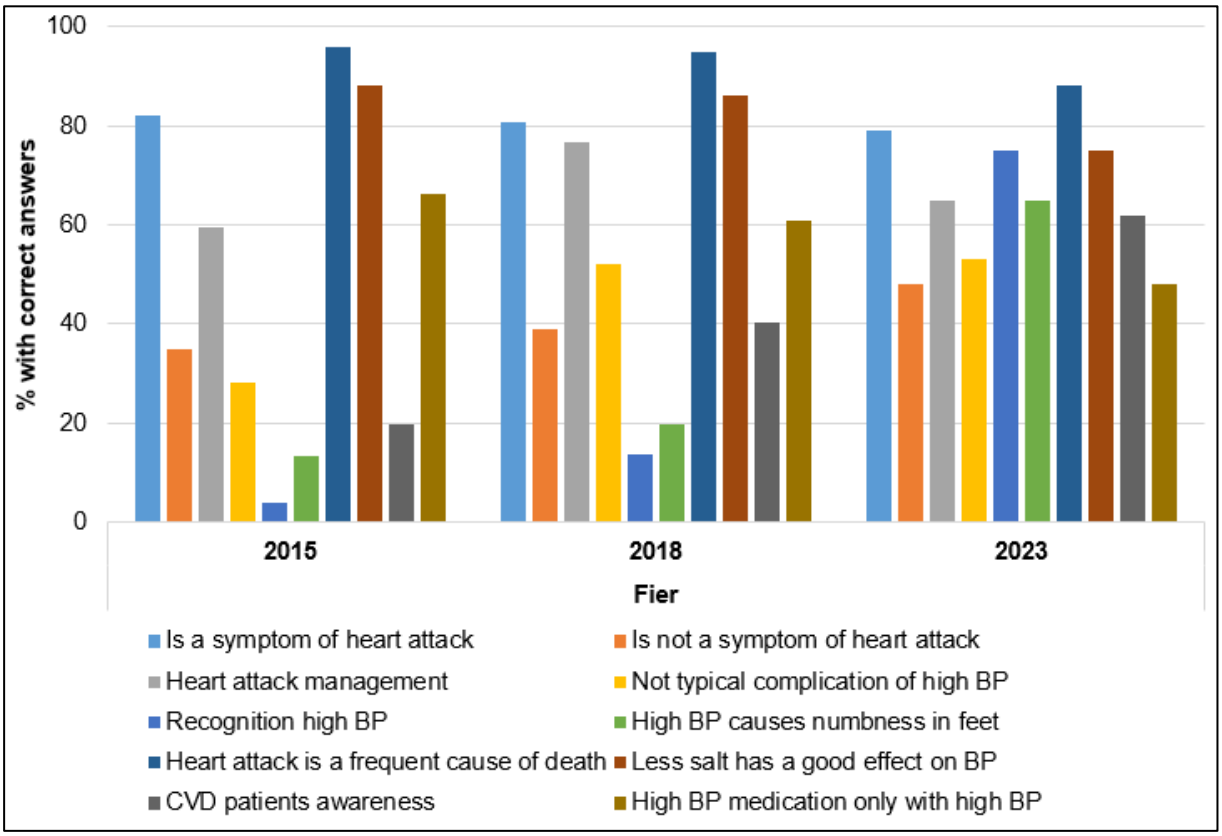
In Diber, the graph shows an overall increase of correct answers related to CVDs. As in 2018, in 2023, people are very aware that heart attack is a frequent cause of death and that lower salt intake has a positive effect on the blood pressure.

Figure 27: Proportion of respondents with correct answers on questions related to CVDs, in Diber (2015, 2018, 2023)



In Fier, there was a similar positive trend as more respondents had more correct answers in 2023 compared to previous years. Especially knowledge related to BP has increased.

Figure 28: Proportion of respondents with correct answers on questions related to CVDs, in Fier (2015, 2018, 2023)



For diabetes, the following questions or statements were asked:

1. Which of the following is not a typical symptom caused by diabetes?
2. Which of the following is not a complication of diabetes?
3. Which of the following foods is the healthiest for a person with diabetes or high blood pressure?
4. Patients with diabetes should regularly check their feet for wounds which do not heal.
5. Patients with diabetes regularly taking medication don't have to check their blood sugar levels regularly
6. Children of persons with diabetes are more likely to get the disease than children from healthy families.
7. Consuming too much sugary foods can be a cause of diabetes.
8. In diabetes patients, the insulin system works normally.
9. Diabetes is a common cause of problems with seeing.
10. Diabetes and high blood pressure can cause kidney disease.
11. Women have to check their blood sugar levels during pregnancy.
12. Diabetes can be cured.

In both Diber (Figure 29) and Fier (Figure 30), the knowledge patters with regard to diabetes have remained relatively stable over the surveyed years. Moreover, they are also similar between the regions, with slightly higher knowledge levels in Fier compared to Diber in 2023. Highest knowledge was found for the ‘healthy diets’, followed by ‘checking for wounds at the feed that do not heal’ in both regions. ‘Sight problems’, ‘checking blood glucose levels during pregnancy’ and ‘sugary food can cause diabetes’ were also correctly answered by a majority of respondents (~above 80%).

Figure 29: Proportion of respondents with correct answers on questions related to diabetes, in Diber (2015, 2018, 2023)

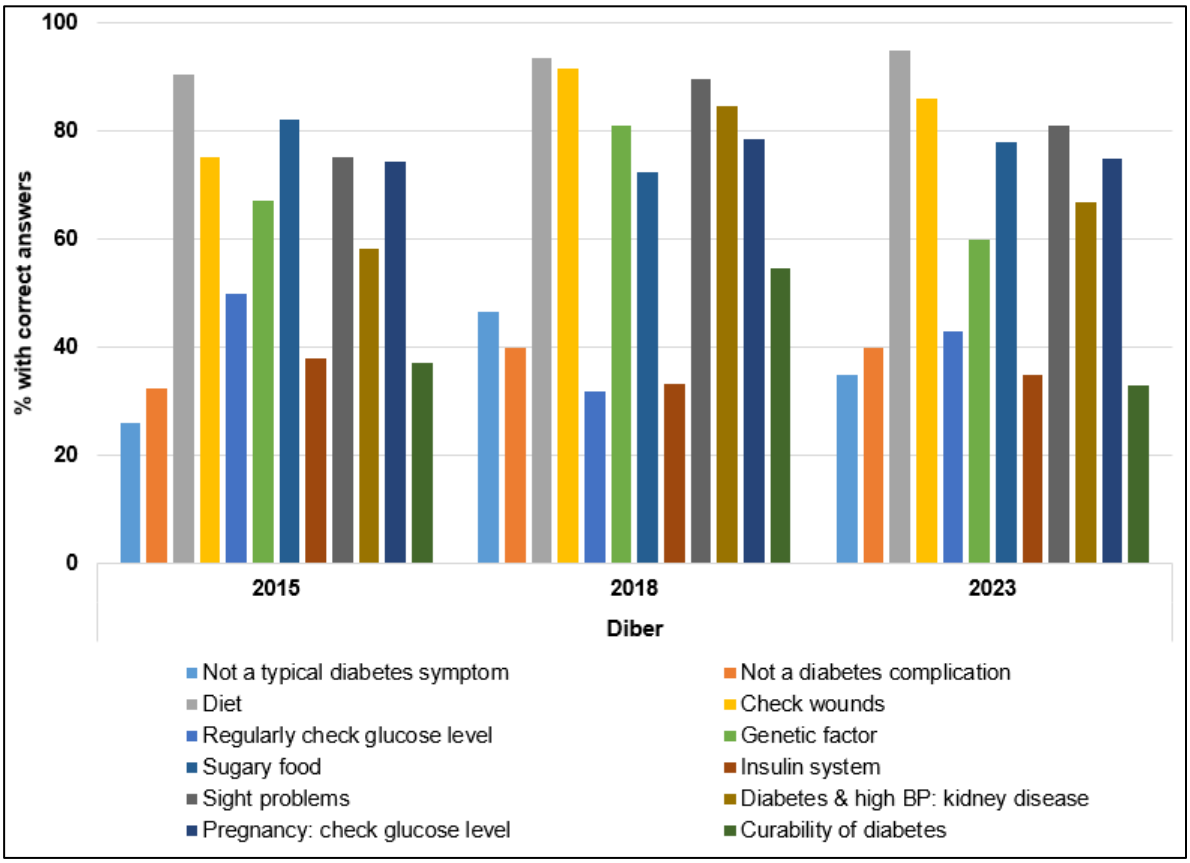
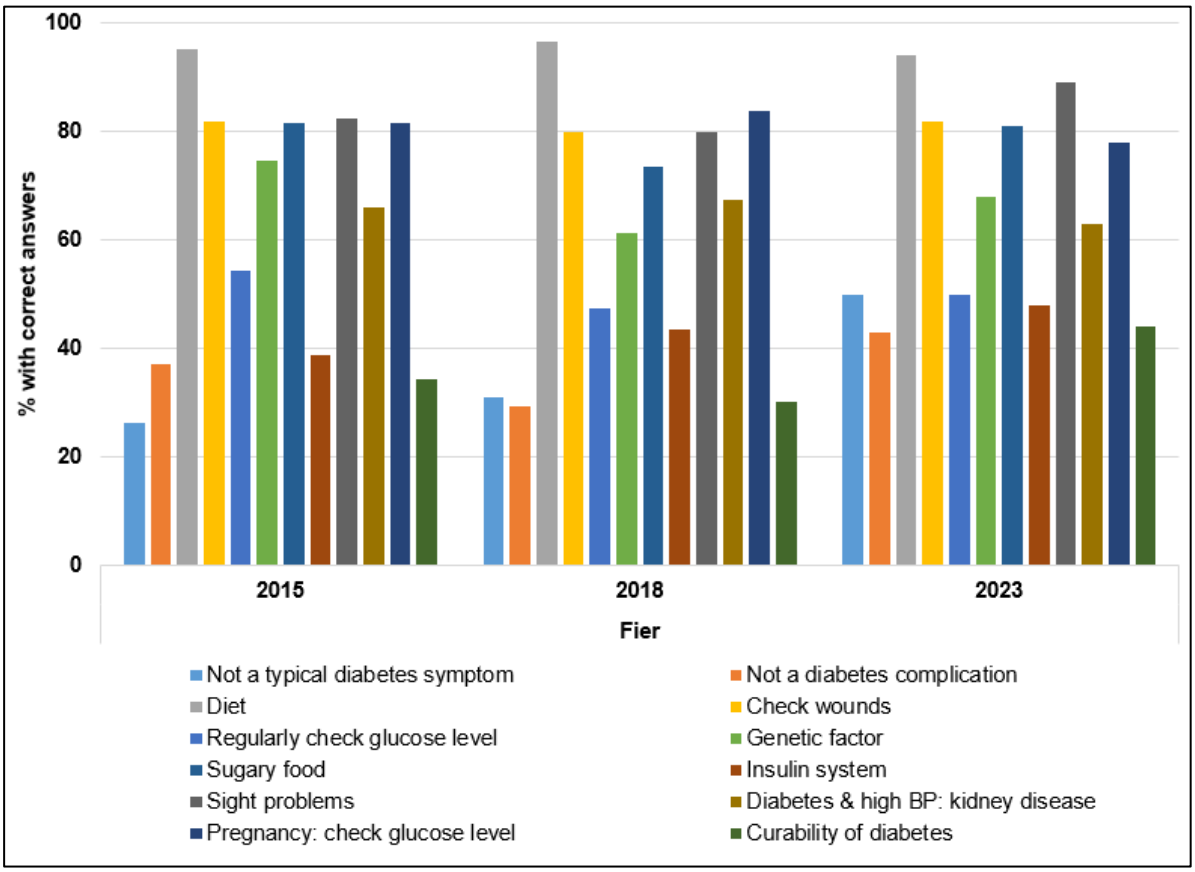


Figure 30: Proportion of respondents with correct answers on questions related to diabetes, in Fier (2015, 2018, 2023)

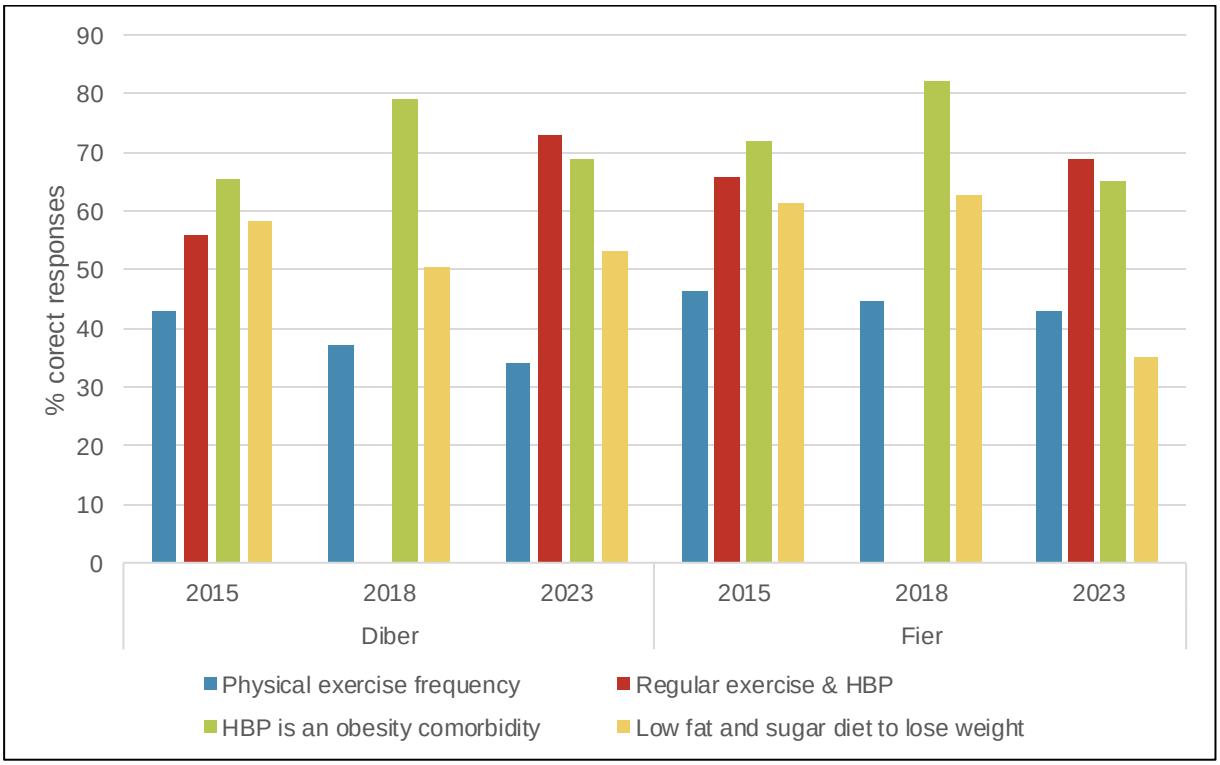


For obesity, the following questions or statements were asked:

1. How often should you do physical exercise to stay healthy?
2. Which of the following four statements were false:
   - Overweight people have a higher risk of getting diabetes.
   - Regular physical exercise has a good effect on blood sugar levels.
   - Gaining weight increases the risk of getting high blood pressure.
   - Regular physical exercise increases the risk of getting high blood pressure.
3. Obese people often also have high blood pressure.
4. Eating little sugar and fat does not help to reduce weight.

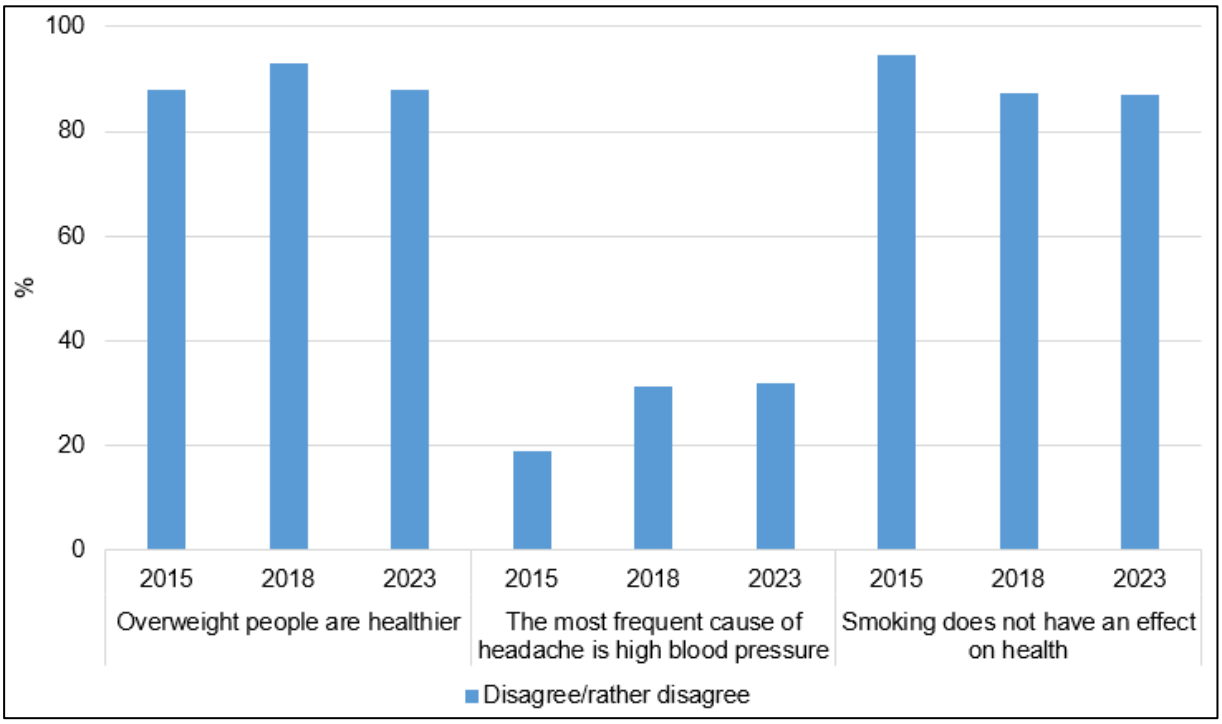
In 2023, the knowledge on obesity showed that between 60% and 80% of respondents were aware that high blood pressure is a comorbidity associated with obesity (Figure 31). Many were aware that regular exercise was not associated with high blood pressure but the contrary. The knowledge that low fat and sugar diets were effective for weight loss decreased in 2023 compared to previous years. Knowledge of the frequency of exercise required to remain healthy (30 minutes per day) was quite low, around 50%.

Figure 31: Proportion of respondents with correct answers on questions related to obesity (2015, 2018, 2023)



The majority of respondents (>80%) across all survey years did not agree that 'overweight people are healthier' or that 'smoking has no effect on health' (Figure 32). However, disagreement with 'the most frequent cause of headache is blood pressure' was just above 30% in 2023, similar to 2018.

Figure 32: Attitudes to general health for both chronic and acute disease respondents (2015, 2018, 2023)



Beliefs on influencing, and, to a certain degree, controlling the own health showed that the majority of interviewees considered their own health as a status that can heavily be influenced by present-day behaviour (Figure 33). However, the percentage agreeing decreased from 2015 to 2023.

Figure 33: Attitude towards own health (2015, 2018, 2023)

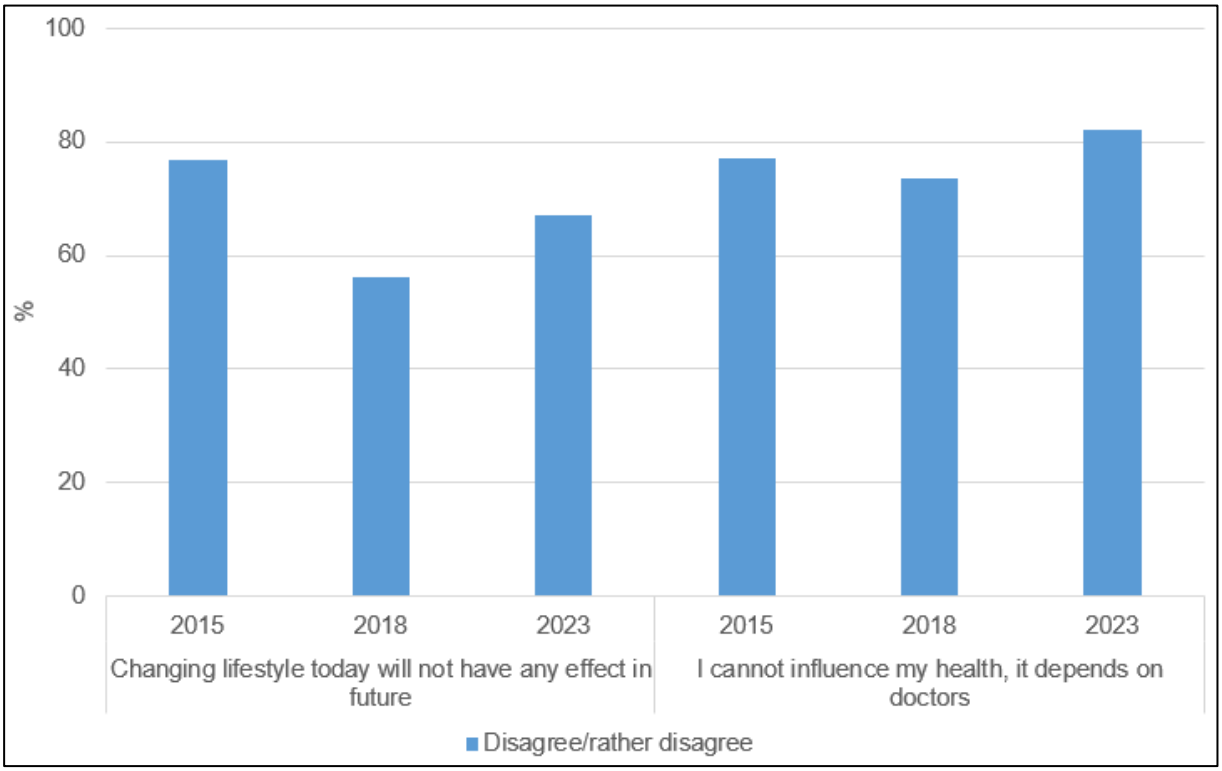
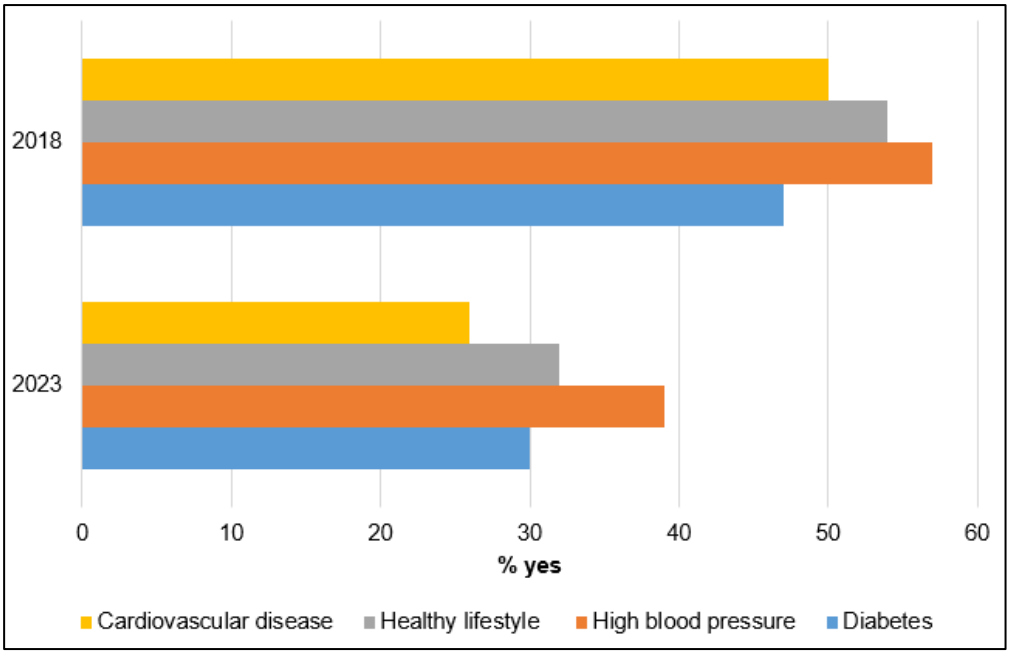


Figure 34 shows the proportion of respondents who have ever received any health information from the PHC facility. The proportion decreased for all the four health issues, namely CVDs,

healthy lifestyles, high BP and diabetes. In essence, less than 40% of the respondents reported to have received information on these health issues in 2023.

Figure 34: Health information received (2015, 2018, 2023)



4.6.2 *Knowledge on child health*

Table 22 shows the knowledge of mothers about child development and risk factors for children's growth and development. There is a very high awareness amongst mothers that child development starts already from pregnancy and that it encompasses mental, social, emotional, and physical skills. However, the perception that child health encompasses only physical health was believed by ~30% of mothers with around 40% not being aware that development problems could be difficult to identify.

Table 22: Percentage of correct answers amongst mothers regarding children's development (2015, 2018, 2023)

	2015	2018	2023
Child development (% giving correct answers)			
Child development starts from pregnancy	99	99	96
Child development refers to the progressive gain of mental, social, emotional and physical skills by the child	91	96	94
Child development refers only to physical growth	76	71	69
Child development problems could be difficult to identify	60	64	55
Child development problems (% giving correct answers)			
Mobility limitations	96	94	88
Digestive problems	12	8	16
Poor language development	93	90	94
Obesity	82	82	78
Risk factors for growth and development (% answered 'No')			
Physical activity	42	31	39
Showing love to the child	37	19	38
Living in rural areas	48	41	62
Ocassional colds during childhood	23	17	29
Having sick siblings	27	40	38
Sharing the house with relatives	42	45	51
Risk factors for growth and development (% answered 'Yes')			
Parental abuse of drugs and alcohol	96	99	94
Child birth before 37th week of pregnancy	72	76	70
Late or no antenatal care	92	89	79
Parents being close relatives	94	93	85

Down syndrome or autism	81	93	91
Parents with mental health problems	94	94	90
Inadequate or insufficient child feeding	98	94	87
Poor child care, stimulation and upbringing	98	95	84
Child abuse	98	98	92
Domestic violence	97	97	93
Insufficient economic or social resources	94	92	77

5 STUDY LIMITATIONS

The following limitations are associated with the study and its findings:

- During the 2015 survey, contact and response rates were very high and the very limited number of households that were not successfully contacted or who had no chronic or acute ill patient was low (Table 2). This data was much more realistic during the 2018 and 2023 survey indicating that during the 2015 survey interviewers had not recorded all contacts as their targets were the successfully conducted interviews.
- The different timing of the surveys (2015: October/November 2018: December 2023: February) might have influenced the number of acute infections are being observed, especially considering that these were mostly flus.
- Since the first survey in 2015 various interventions and policy changes were initiated.
    - Between 2015 and 2018, major changes are the introduction and implementation of the check-up initiative and the changes in the insurance scheme/free access to primary health care. Both aspects are likely important for interpreting results of the survey though the extent to which these changes truly influenced cannot be estimated here and thus is speculative. However, direct comparisons must take these changes into account.
    - Increase of hospital/private services opportunity offered, such as the new Regional Hospital in Fier. The increase of types of health and diagnostic services, presence of specialised doctors may impact the access of health services and selection of facility in the region.
- In the 2018 and 2023 surveys, the selection of the respondents for the different questionnaire sections was random whilst in 2015, interviewers were instructed to (a) prioritise chronic disease patients over acute patients and (b) in case more than one patient was available within the household to apply the last birthday method. The differences in the random selection procedure might have introduced some interviewer bias.
- Inverted knowledge and attitude questions for mothers of children under 5 years but also chronic and acute patients were often answered incorrectly, i.e. relatively small proportion identified the items as being wrong. This pattern could indicate that they – by tendency – agreed to the items independent from the content or that inverted/negative items were difficult to understand.
- The Health Insurance Fund that advises doctors to prescribe reimbursable drugs for chronic conditions typically every two months, whilst patients are recommended to check their health status on a monthly basis. There are also various other rules for self-contributions to drugs (e.g. if deviating from reimbursable drugs). Hence, the estimation of costs for chronic conditions may be impeded by the various regulation of the Health Insurance Fund which should be taken into account for interpretation.

6 CONCLUSION

The 2023 study included 1,279 households with an inclusion rate of 90% among eligible households. The proportion of household members 49 years and older grew constantly over the years (from 38% in 2015 to 43% in 2018 to 53% in 2023). The surveyed population has seen a demographic shift towards being older and having fewer mothers with a child less than 5 years of age. Pensions remained the primary income source for surveyed households.

In 2023, high blood pressure (40%), heart problems (23%), rheumatism (17%), and diabetes (16%) remained the most prevalent conditions in chronically ill patients (same pattern as previous years). The most common acute health issues were flu/cold (37%), persistent cough

with fever (22%), and fever (21%). The overall reporting of acute illnesses was higher than previous years likely due to timing of the survey.

Public health facilities remained the first choice for healthcare for the majority of households (2015: 94% in chronic and 97% in acute patients; 2018: 87% in chronic and 98% in acute patients; 2023: 90% in chronic and 86% in acute patients). However, private sector healthcare usage increased from 6% in 2015, 13% in 2018 to 9% in 2023 (for chronic patients), indicating a shift in healthcare-seeking behaviour, especially in Fier. The same pattern was observed for acutely ill patients.

Similar to previous years, geographic proximity was the most important factor when choosing a certain health care facility for chronically ill persons (38% in Diber and 39% in Fier in 2023). In line with that finding, distance and transportation were the main challenges in seeking health care. These translate also into affordability, which was, in previous years, identified as the main barrier. At the same time, both chronic and acute patients reported increased out of pocket healthcare costs in 2023 compared to previous years. Drug expenses were the main cost driver.

Overall, satisfaction with healthcare services remained high in chronically ill patients (in Diber: 81% in 2015, 76% in 2018 and increased to 88% in 2023; in Fier: 80% in 2015, 87% in 2018, 84% in 2023) as well as in acutely ill patients (in Diber: 71% in 2015, 87% in 2018, 88% in 2023; in Fier: 59% in 2015, 87% in 2018, 84% in 2023).

In 2023, 90 mothers of children under 5 were interviewed, with a slight increase in maternal age in both regions. The mean age of mothers in Diber and Fier rose to 32 and 35 years, respectively (from 28 in both in 2015, and 30 and 29, respectively, in 2018). Regarding postnatal care, the majority of women left the hospital after three days consistently across the years. However, the proportion of women reporting a health check after discharge dropped in Diber from 74% in 2018 to 66% in 2023 but remained higher than in 2015 (62%). Child health checks were reported by 80% of mothers in both regions, with the majority receiving a check 6 days after birth in 2023, showing a reduction from previous years.

Awareness of risk factors for cardiovascular diseases among respondents in 2023 was highest for 'stress' (Diber: 51%, Fier: 66%; decreases since 2018), 'high blood pressure' (Diber: 48%, Fier: 45%; decrease in Diber, increase in Fier since 2018), and 'high cholesterol' (Diber: 52%, Fier: 45%; increases since 2018). Knowledge about 'unhealthy diet' and 'physical inactivity' also increased markedly. Knowledge related to CVDs saw an overall increase in both regions, with people being more aware of heart attack symptoms and the benefits of lower salt intake. Knowledge related to diabetes remained relatively stable but slightly higher in Fier compared to Diber in 2023. In terms of obesity, respondents understood the association with high blood pressure and the benefits of regular exercise, although awareness of the effectiveness of low-fat and low-sugar diets for weight loss decreased.

Impact of the household survey results on HAP interventions:

1. As a result of the dramatic demographic changes in the country, HAP is supporting PHC services in Albania with a particular focus on care of the elderly. Thus, the elaboration and support for implementation of the "Manual on elderly people care in PHC", and of the guidelines and protocols of NCDs that affect mostly elderly people are some of the contributions of HAP in this regard. In the future, HAP will collaborate with the Faculty of Medicine for strengthening teaching capacities in geriatrics and gerontology. Finally, the education of elderly for prevention of the most important syndromes and risk situation related to their age will be in the focus of HAP in the next years.

2. The early detection of NCDs and the constant health education of patients and their family members remains a priority for the health system in Albania. In this regard, HAP has elaborated a Manual of Health education with a focus on prevention on NCDs and targeting the health care providers and users of PHC services. HAP will support implementation of the health education manual in PHC services of the regions targeted by the project, in close collaboration with LUHCs and the Operator.

3. According to people's perceptions, affordability, and cost of transport are the two most important factors that hamper to a certain extent the accessibility to PHC services. In this regard, HAP will provide a strong support to improve accessibility of services through the extension of home care provided by family nurses. HAP will support the upscaling of these services in 6 regions of Albania targeting approximately 100 health PHC facilities. Enforcing the role of nurses in management and control of NCDs will extend options for the population. This approach may help reach people and address their problems, to prevent and better manage NCDs and other chronic conditions.

4. The upscaling of the new services supported by HAP requires the enhancement of capacities (technical, managerial and leadership) of local health authorities (Operator and LUHC). Despite the positive results in the last two years, the steering challenges in this regard remain serious due to: a) limited financial resources; b) over-centralized and over-politicized environment of the health administration (central, regional, and local); c) limited autonomy and weak technical capacities of LUHC. HAP will continue providing support to these structures and will collaborate with them to overcome some of their weaknesses and limitations. HAP will work especially towards strengthening the monitoring capacities of LUHC and the Operator in order to make sure that the new services will continue being provided.

5. Many indicators that improved in the period 2015-2019 have slightly worsened in the subsequent phase 2019-2022. This is mostly due to the difficult situation created by the pandemic of COVID-19 and the consequences on the health system and services. These data show that HAP achievements are fragile, and a lot of efforts are needed to maintain and bring forwards the good results introduced by the project.

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8 ANNEXES

8.1 Ethical clearance

REPUBLIKA E SHQIPËRISË
MINISTRIA E SHËNDETËSISË
DHE MBROJTJES SOCIALE

KOMITETI I ETIKËS

Nr. 131/59 Prot Tiranë, më 13.12.2022

Lënda: Shqyrtim 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 25 Nëntor, 2022, mori në shqyrtim kërkesën dhe dokumentacionin e paraqitur nga Dr. Besim Nuri, Menaxher i projektit Hap në cilësinë e investiguesit kryesor dhe aplikues projekti "Shëndet për të gjithë" (HAP 2) për studimin me titull: " Aksesi i familjeve në kujdesin Shëndetësor në qarqet Dibër dhe Fier, Shqipëri 2022".

Komiteti i Etikës shqyrtoi dokumentacionin me numër.131/54 prot, datë14.11.2022, studimin me titull: "Aksesi i familjeve në kujdesin Shëndetësor në qarqet Dibër dhe Fier, Shqipëri 2022 " (projekti HAP2). Qëllimi i anketës është kryerja e një matjeje të përditësuar mbi aktivitetet kyçe të shëndetit të popullsisë në qarqet Dibër dhe Fier për menaxhin shëndetësor të sëmundjeve kronike dhe akute.

Anëtarët e Komitetit të Etikës në takimin e datës 25 Nëntor 2022, konstantuan se janë përmbushur të gjitha kushtet për lëshimin e miratimin e studimit dhe votuan unanimisht *Pro* për studimin me titull: "Aksesi i familjeve në kujdesin Shëndetësor në qarqet Dibër dhe Fier, Shqipëri 2022 " dhe mbështetur në nenin 22 e vijues të Ligjit nr. 105/2014 "Për barnat dhe shërbimin farmaceutik" dhe në Udhëzimin të Ministrisë së Shëndetësisë nr. 226, datë 08.03.2018" Për provat klinike: vendosi sa më poshtë:

MIRATIMI I STUDIMIT

T'i jepet miratimi porositësit të provës klinike/ studimi me titull: "Aksesi i familjeve në kujdesin Shëndetësor në qarqet Dibër dhe Fier, Shqipëri 2022 " për fillimin e studimit sipas kushteve të paraqitura në protokollin përkatës.

Titulli i protokollkit: "Aksesi i familjeve në kujdesin Shëndetësor në qarqet Dibër dhe Fier "

Sponsor: Projekti " Shëndet për të gjithë"

Numri i qendrave në Republikën e Shqipërisë : Në studim përfshihen 51 (pesëdhjetëenjë) qendra shëndetësore të qarqeve Fier dhe Dibër.

Mosha e pacientëve: mbi 18 – vjeç dhe synohet 1271 pjesëmarrës nga komuniteti i qarqeve Fier dhe Dibër.

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.

8.2 Additional tables

Table 23: Sampled clusters, Dibër and Fier regions, Albania, 2023

No.	Municipality	Location	Village / Neighbourhood
Fier region			
1	Fier	Urban	Fier Qytet
2	Fier	Urban	Fier Qytet
3	Fier	Rural	Peshtan Bregas
4	Fier	Rural	Kreshpan
5	Fier	Rural	Cakran i ri
6	Fier	Rural	Varibop
7	Fier	Urban	Fier Qytet
8	Fier	Urban	Fier Qytet
9	Mallakaster	Rural	Klos
10	Fier	Rural	Gorishove
11	Fier	Urban	Fier Qytet
12	Fier	Urban	Fier Qytet
13	Mallakaster	Rural	Drenove Fushe
14	Mallakaster	Rural	Visoke
15	Fier	Rural	Frakull e madhe
16	Mallakaster	Rural	Malas
17	Mallakaster	Urban	Ballsh
18	Mallakaster	Rural	Qafa e Vidhit
19	Fier	Rural	Daullas
20	Fier	Rural	Hoxhare
21	Fier	Rural	Levan
22	Fier	Urban	Fier Qytet
23	Mallakaster	Urban	Ballsh
24	Fier	Urban	Fier Qytet
25	Fier	Urban	Fier Qytet
26	Fier	Urban	Fier Qytet
27	Lushnje	Urban	Lushnje
28	Lushnje	Urban	Lushnje
29	Divjakë	Rural	Spolate
30	Divjakë	Rural	Remas
31	Divjakë	Rural	Sulzotaj,
32	Divjakë	Urban	Divjakë
33	Lushnje	Urban	Lushnje
34	Lushnje	Rural	Kamçisht
35	Lushnje	Rural	Gramsh,
36	Divjakë	Rural	Cerme Sektor
37	Lushnje	Rural	Cinar
38	Lushnje	Rural	Bicakaj
39	Fier	Rural	Ambulanca Metaj
40	Fier	Rural	Mbrostar
41	Lushnje	Urban	Lushnje
42	Lushnje	Urban	Lushnje
43	Roskovec	Rural	Kurjan
44	Roskovec	Rural	Ngjeqar
45	Lushnje	Rural	Gjaz
46	Lushnje	Rural	Zhelizhan
47	Lushnje	Rural	Shakuj
48	Lushnje	Rural	Lumth
49	Lushnje	Rural	Dushk
50	Lushnje	Rural	Plug
51	Roskovec	Urban	Roskovec

52	Patos	Urban	Patos
53	Patos	Urban	Patos
Diber			
54	Peshkopi	Urban	Peshkopi
55	Peshkopi	Urban	Peshkopi
56	Diber	Rural	Zall-Rec
57	Diber	Rural	Laçes
58	Diber	Rural	Rreth Kale
59	Diber	Rural	Seliste E siperme
60	Diber	Rural	Maqellare
61	Diber	Rural	Burim
62	Diber	Rural	Pilafe
63	Diber	Rural	Ushtelenxe
64	Diber	Rural	Hotesh
65	Peshkopi	Urban	Peshkopi
66	Diber	Rural	Trepç
67	Diber	Rural	Katund i Vogel
68	Diber	Rural	Borovjan
69	Diber	Rural	Vranjt
70	Diber	Rural	Kllobçisht
71	Diber	Rural	Bllat e Siperm
72	Diber	Rural	Fushe-Muhurr
73	Diber	Rural	Muhurr
74	Peshkopi	Urban	Peshkopi
75	Peshkopi	Urban	Peshkopi
76	Bulqize	Urban	Bulqizë
77	Bulqize	Urban	Bulqizë
78	Bulqize	Urban	Bulqizë
79	Bulqize	Urban	Bulqizë
80	Mat	Urban	Burrel
81	Mat	Urban	Burrel
82	Bulqize	Rural	Peshk
83	Bulqize	Rural	Kraste
84	Bulqize	Rural	Çerenc i Siperem
85	Bulqize	Rural	Llodomirice
86	Mat	Rural	Prell
87	Mat	Urban	Burrel
88	Bulqize	Rural	Gjorice e Poshtme
89	Bulqize	Rural	Okshatine
90	Bulqize	Rural	Sopot
91	Bulqize	Rural	Zerqan
92	Klos	Rural	Dom
93	Klos	Urban	Klos
94	Bulqize	Rural	Dushaj
95	Bulqize	Rural	Godvi
96	Mat	Rural	Karice
97	Mat	Urban	Burrel
98	Klos	Rural	Skënderaj
99	Klos	Rural	Suç
100	Mat	Rural	Batër e Vogël
101	Mat	Rural	Frankth
102	Klos	Rural	Gurre e vogel
103	Klos	Rural	Shulbater
104	Klos	Urban	Klos
105	Klos	Urban	Klos

106	Mat	Urban	Burrel

Table 24: Household income sources (2015, 2018, 2023)

Percentage of households with income source	2015		2018		2023	
	Diber	Fier	Diber	Fier	Diber	Fier
Private business	10	7	14	12	11	14
Salary	25	20	27	24	25	30
Pension	54	59	51	68	57	60
Social aid	31	10	28	10	25	7
Farming / livestock	41	39	34	32	27	21
Remittances	19	18	26	29	26	23
Other	3	4	3	5	1	2

Figure 35: Average health expenditures for chronic conditions in the four weeks preceding the survey (2015, 2018, 2023) – without inflation adjustment

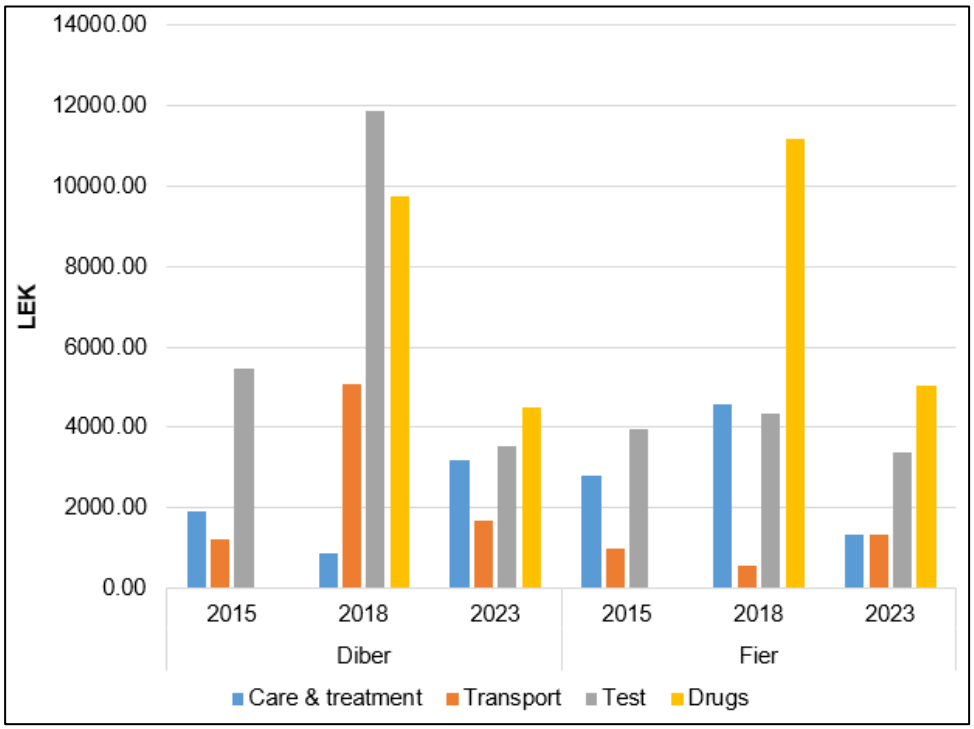

Figure 36: Average health expenditures for acute conditions in the four weeks preceding the survey (2015, 2018, 2023) – without inflation adjustment