Swiss Agency for Development and Cooperation (SDC)

HAP2: ASSESSMENT OF QUALITY OF CARE IN PRIMARY HEALTH CARE HC IN DIBËR AND FIER REGIONS OF ALBANIA

2022 Phase 2 Endline Survey

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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

In the framework of the Health for All (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 Diber, and included the same 38 health centers (HC) in all years, thereof 18 in Fier and 20 in Diber.

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, 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) 60-79.

The main findings were:

In 2022 in general, there was a marked decrease of number of observations and exit interviews (-50.7% and -43.1%, respectively). Of note, data from the Health Insurance Fund show that the total number of consultations in PHC has decreased in the two years preceding the survey. The potential reasons include:

- Some family doctors continue to perform consultations by phones as a practice they acquired during the Covid-19 pandemic.
- The practice of doing e-prescription might lower the consultations in HC because (i) the digital literate patient can go directly to the pharmacy and take the drugs (once the e-prescription is done the patient gets a message into e-Albania platform that his recipe is ready in the pharmacy) and (2) the family nurse can send via WhatsApp the code of the e-prescription to the patient who then can go directly to the pharmacy. In addition, there are cases when family members come to receive prescriptions for the patient, and no interaction happens if the patient is not present.
- There are cases when family members come to receive prescriptions for the NCD patient, and no interaction happens if the patient is not present.
- The lack of family doctors in northern areas mostly, where one family doctor covers 2 or 3 health centres, may create difficulties in accessing the health service.

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

- The infrastructure score remained relatively stable in 2022 at 61.6 mean score points, indicating an only slight decrease since 2018.
- The infrastructure score showed marked improvement between 2015 and 2018, certainly partly due to HAP investments in infrastructure (e.g. 12 HC were rehabilitated).
- HC in Fier consistently achieved higher mean scores than in Diber, especially though in 2015 and 2022 (67.2 mean score in Fier vs 56.6 mean score in Diber for the latter).

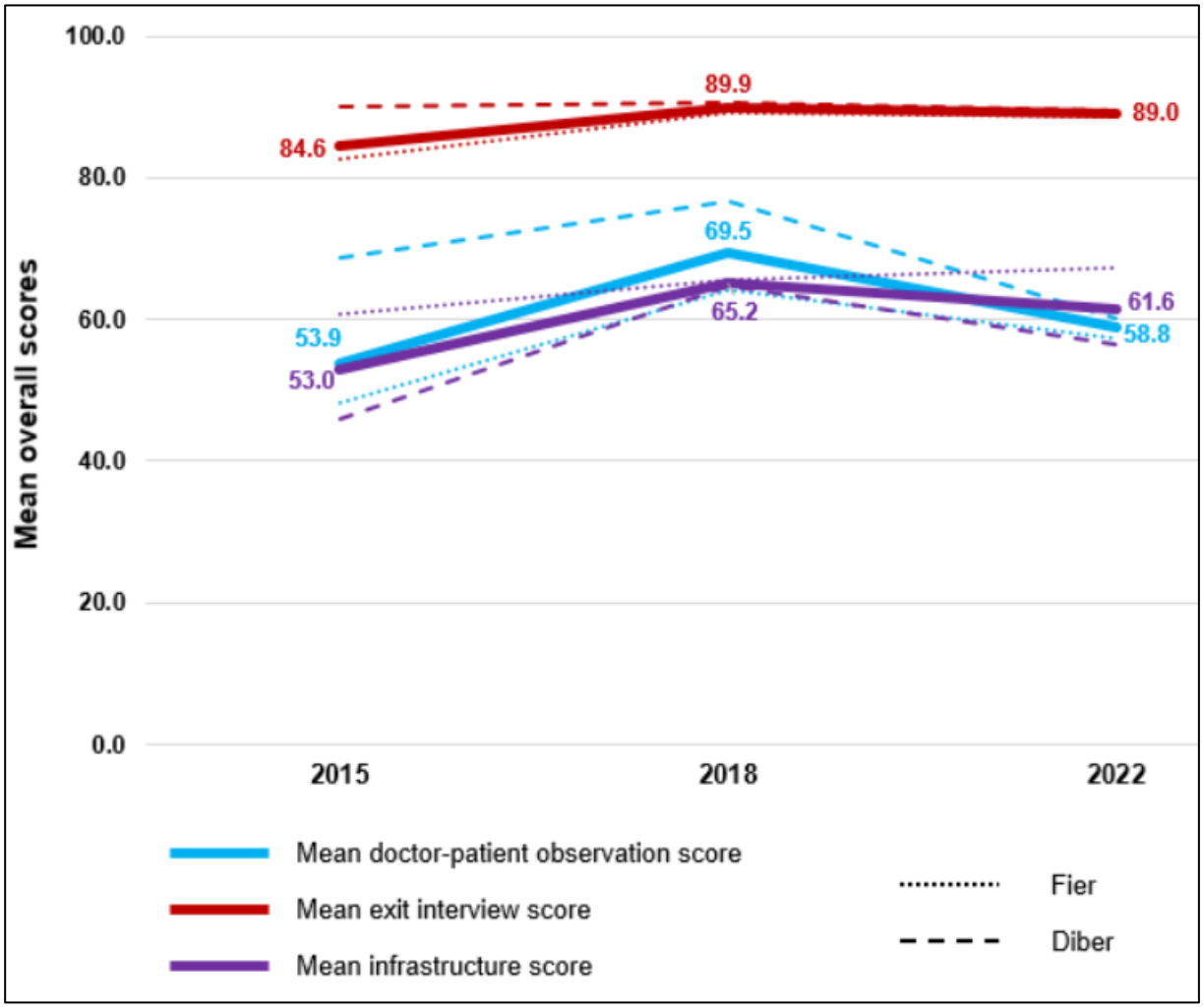
Quality of doctor-patient interactions measured through doctor-patient observations (process attributes):

- The quality of the doctor-patient interaction increased markedly between 2015 (mean score: 53.9) and 2018 (mean score: 69.5). However, in 2022, a decrease of the quality of this interaction was observed (mean score: 58.8), although remaining higher than 2015 levels.
- The quality of the doctor-patient interaction was markedly higher in Diber than in Fier in 2015 and 2018. In 2022 however, the quality of this interaction seem to have decreased as well.

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

- The patient satisfaction score was the highest achieving score, compared to the doctor-patient observation and the infrastructure score, across all years and both regions.
- Between 2015 and 2018, patient satisfaction has slightly increased from 84.6 score points to 89.9 score points, and remained at 89.0 points in 2022.
- Regional differences were only found in 2015, where satisfaction was higher in Diber than in Fier.

The mean overall scores for each dimensions of QoC by year and by region are summarized in the below figure.



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. A second phase of HAP implementation (called HAP2) is implemented between March 2019 – March 2023. The overall goal of HAP2 is that the Albanian population benefits from better health due to improved primary health care services.

Expected outcomes of HAP 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. A baseline and endline survey were conducted at the beginning and end of phase 1 (HAP1; 2015 and 2018) [1, 2]. The project implementation second phase (HAP2) started in March 2019. Thus, the 2018 endline survey was used at the same time as the baseline for HAP2. The assessments included two primary data collection activities:

(1) a HC-based survey on 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 QoC 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 quality of care and population access to services. The 2022 survey was aligned with the two previous surveys, thus allowing to measure changes over time and to stratify results along different regions and HC.

1.2 Overview on Quality of Care

For our surveys, we considered an operational definition of the QoC of health care services based on Donabedian (1988, 1990) [3, 4], which was also used in similar studies [5, 6]. According to this definition, the 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 basic idea to separate three parts is based on the assumption that the three dimensions are connected in terms of service quality: good structure increases the likelihood of good processes and good process increases the likelihood of good outcomes, though outcomes are a consequence rather than a component of the quality of services.

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 provider, considering the interpersonal aspects and technical aspects. Potential benchmarks of process of care may include inputs, referral from PHC HC for laboratory examinations, preventive and treatment approaches or the ethical conduct of health workers. The definition of quality should be based and measured on local standards.
- 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.

1.3 Activities within the HAP project to improve Quality of Care

Since the start of the HAP project in 2015 a number of activities were implemented with the objectives to positively influence and impact the provided QoC. Specifically, the following activities of project HAP1 and HAP2 might be relevant:

- Partial or full rehabilitation of selected HCs;
- Introducing additional continuous medical education measures for doctors and nurses namely the peer groups and in complement providing specific trainings;
- Supplying medical tools and instruments through the doctors' and nurses' bags;
- Development of PHC non-communicable diseases (NCDs) protocols for prevention, management, and control of five NCDs in PHC (diabetes, high blood pressure, asthma, dyslipidaemia, and chronic obstructive pulmonary disease (COPD)) and their implementation in selected regions;
- Increase quality of health services, through meeting accreditation standards of PHC services;
- Empowering nurses: defining and implementing new roles of nurses;
- Implementing new home-based care services for selected populations; and
- Supporting PHC centres in emergency situations, such as prevention, control, and management of COVID-19.

1.4 Quality of care in Fier and Dibër regions

Between the 2015 and 2018 surveys, it was found that the changes observed in the 38 PHC HC in the two regions were overall positive with improvements seen at all three levels assessed, e.g. infrastructure, service provision and patient satisfaction [1]. Whilst infrastructure scores especially improved in rural health centers, cleanliness, hygiene and basic/essential medical equipment and supplies improved overall. However, no significant changes were registered with regard to the use of guidelines and informational materials. Meanwhile, new management protocols for 5 non-communicable diseases, including for hypertension and diabetes, were introduced between February 2021 and January 2023, including accompanying training for health staff.

2 GOAL AND OBJECTIVES OF THE STUDY

The overall goal of the present study was to measure the QoC related to structural and procedural aspects as well as selected outcomes in HC in the two pilot regions of the HAP2 project in Albania and to indicate changes over time in the various aspects related to QoC since the baseline study in 2015 and the endline study in 2018 [1, 2].

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.
- Assess patient satisfaction after medical consultation.
- Assess the capacities and readiness of the health centers in terms of infrastructure, cleanliness, maintenance, protocols and selected equipment and consumables.
- Compare key findings to previous measurements from the 2015 and the 2018 surveys.
- Inform selected indicators from the projects' logical framework (logframe) to monitor the improvement of health care delivery over the course of HAP.
- Interpret the findings in the context of the HAP1 and HAP2 activities thereby taking into account possible effects of the Covid-19 pandemic on routine health service delivery.

3 METHODOS

3.1 Study design

In order to achieve the above-mentioned objectives, a cross-sectional, HC-based survey was conducted. The methodology employed for this 2022 endline survey phase 2 was the same as in the 2015 baseline and the 2018 endline surveys in order to allow for comparison of findings.

The survey assessed the three dimensions of QoC in HC:

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

3.2 Study area and target population

The 2022 QoC endline survey phase 2 was conducted in the two regions covered by HAP2 (Dibër and Fier). It targets the same public HC in urban and rural as during the 2015 and the 2018 survey.

Target population of the three different dimensions were:

(i) For the health centre assessment, the respondent(s) to the questionnaire were determined with the HC 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. **Excluded** were patients who consult for administrative reasons, like: renewal of driving licence and procedures conducted, issuing the permission for hunting guns, and "able to work" letters.

3.3 Sample size

Sample size calculation remained unchanged for the 2022 endline survey phase 2. Details are given in the study protocol but the expected sample size was 540 patients in both regions combined.

3.4 Sampling

3.4.1 *Sampling of health centers*

The sampling frame was built from all eligible HC which represented the primary sampling units. The following eligibility and inclusion criteria applied for the HC:

- covered by HAP2 project activities in the two HAP2 regions;
- at least one medical doctor working at the HC; and
- provision of care and prevention related to chronic diseases (e.g. diabetes mellitus, hypertension)

Thus, 80 HC were considered eligible. Sample HC were selected among all eligible HC employing a probability proportional to size (PPS) sampling approach, based on the number of visits per HC received, as notified in regional insurance directorates [7]. It was assumed that PPS took care of the urban / rural stratification at the same time.

Table 1: Number of health centers selected by region and setting

	Dibër	Fier	Total
Urban	4	7	11
Rural	16	11	27
Total	**20**	**18**	**38**

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

The inclusion criteria for doctors for 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 occuring during data collection in a HC (i.e. one day) were observed, depending on the capacity of the data collectors. Thus, the same doctor could have been observed repeatedly.

A complete list of doctors working in the selected HC was obtained. The doctors to be observed were selected randomly, and a 'replacement' order of the remaining doctors was also established, in case of absences, refusals 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) to participate and provide written informed consent.

For the exit interviews, all patients that received care at the HC on the day of data collection in a HC were invited to participate in the study, depending on the capacity of the data collectors.

3.5 Questionnaire tools

The survey includes three questionnaires that assess the three different dimensions of QoC. Details are given in the study protocol.

3.6 Data collection

In a HC, the data collection process is 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, and in parallel, the exit interviews with patients; and
    iii. Third, health centre assessment after patient consultation hours (in the afternoon).

Data collection was done 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 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.

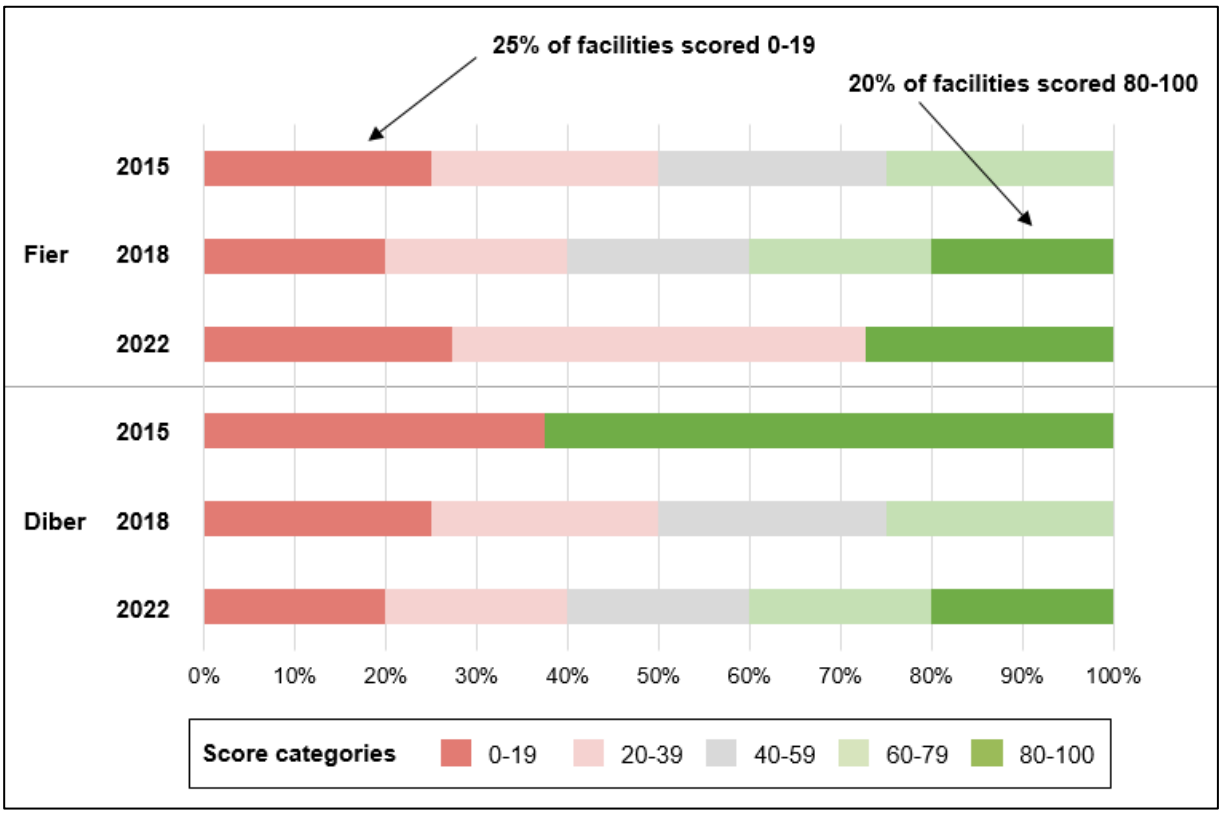
Data was analysed using Stata Statistical Software and R statistical software. Scores were calculated to combine a number of indicators of an assessed umbrella topic and obtain an overall achievement score. Five score categories are defined: (1) 0-19; (2) 20-39; (3) 40-59; (4) 60-79; and (5) 80-100 (see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

As exemplified in Figure 1, 25% of HC in Fier in 2015 scored between 0-19, as opposed to 20% in Diber in the same year. Or 0% of HC scored between 80-100 in 2015 in Fier, but 20% of HC in Diber scored 80-100 in 2015.

Across all results, the colour code implies that more green is more positive and more red is more negative.

Figure 1: Score categorization and example



3.8 Ethical considerations & clearance

This study was approved by the ethics committee of the MoHSP in Albania (Nr. 131/43; see annex 7.1).

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 and parents/legal guardians.

4 FINDINGS

The 2022 survey was implemented between 18 October and 1 November 2022. A total of 38 health centers were visited, thereof 20 in Diber and 18 in Fier region (Table 2). In these HC, 198 and 217 doctor-patient consultation observations were conducted in Diber and Fier, respectively. In addition, a total of 445 exit interviews were conducted (196 in Diber, 249 in Fier).

Table 2: Survey sample (2022)

	Dibër	Fier	Total
Health centers	20	18	**38**
Observed consultations	198	217	**415**
Patients interviewed	196	249	**445**

4.1 Infrastructure survey

In 2022, 38 HC were visited to conduct an infrastructure assessment, thereof 20 in Diber and 18 in Fier region. These were the exact same HC as in 2015 and in 2018. Over the course of the HAP1 and HAP2 implementation period (2015-2022), the project has invested in the overall infrastructure of the HC. Table 3 lists all HC surveyed including the status and year of rehabilitation. In total, 12 HC were rehabilitated, thereof 7 in Fier and 5 in Diber.

Table 3: Rehabilitation status and year of surveyed HC

No	Name health centre	HAP rehabilitation	Year of rehabilitation
Fier			
1	Cakran	1	2017
2	Dërmënas		
3	Kuman	1	
4	Libofshë	1	2017
5	Nr. 1 Fier (HC 1)		
6	Nr. 2 Fier (HC 1)		
7	Nr. 3 Fier		
8	Patos	1	2018
9	Ruzhdie	1	2022
10	Zharrëz		
11	Divjakë		
12	Dushk		
13	Grabian		
14	Karbunare		
15	Nr. 1 Lushnje	1	2019
16	Nr. 2 Lushnje	1	2019
17	Tërbuf		
18	Dukas		
Dibër			
1	Peshkopi - Bashki (municipality)		
2	Arras		
3	Kastriot	1	2018
4	Lure		
5	Maqellarë	1	2018
6	Melan		
7	Sllove		
8	Tomin (qender) health center		
9	Zall Dardhe/Rec (combined)		
10	Burrel- Bashki - HC 1 “Drita”		
11	Derjan		
12	Klos- Bashki (Municipality) - HC 1	1	2018
13	Komsi (qender)	1	2018

14	Lis	1	2022
15	Suç		
16	Xiber		
17	Bulqize- Bashki - “Minatori”		
18	Fushë Bulqizë		
19	Martanesh		
20	Zerqan		

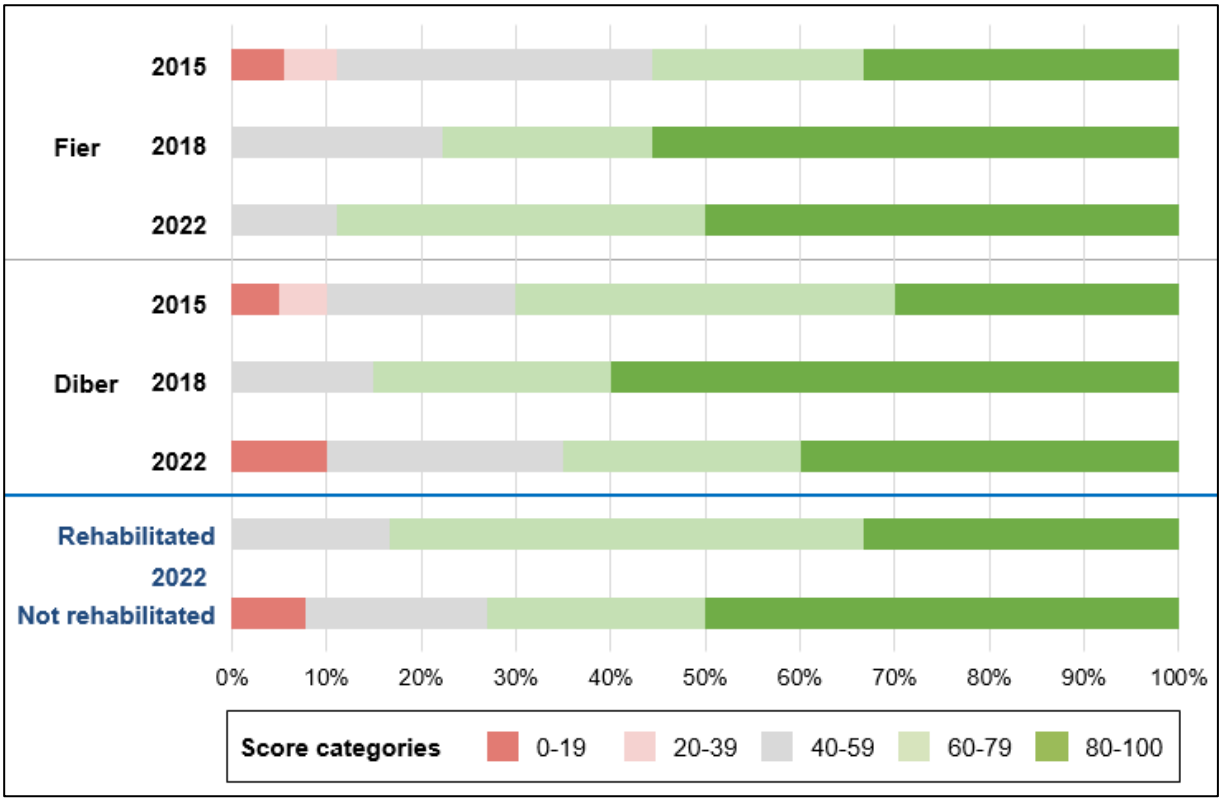
4.1.1 *Cleanliness of the HC*

Figure 2 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 HC has a rubbish bin which is properly used and not overflowing.
- 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.

Improvements regarding cleanliness were mainly achieved between 2015 and 2018. In Fier, more HC achieved a score of 60 and higher in 2022 than in 2018, which was the opposite in Diber. In Diber, two HC showed very low cleanliness scores in 2022 (namely Tomin and Sllove). HAP-rehabilitated HC in 2022 showed better cleanliness scores than non-rehabilitated HC.

Figure 2: Scores on HC cleanliness



4.1.2 *Medical and hazardous waste disposal*

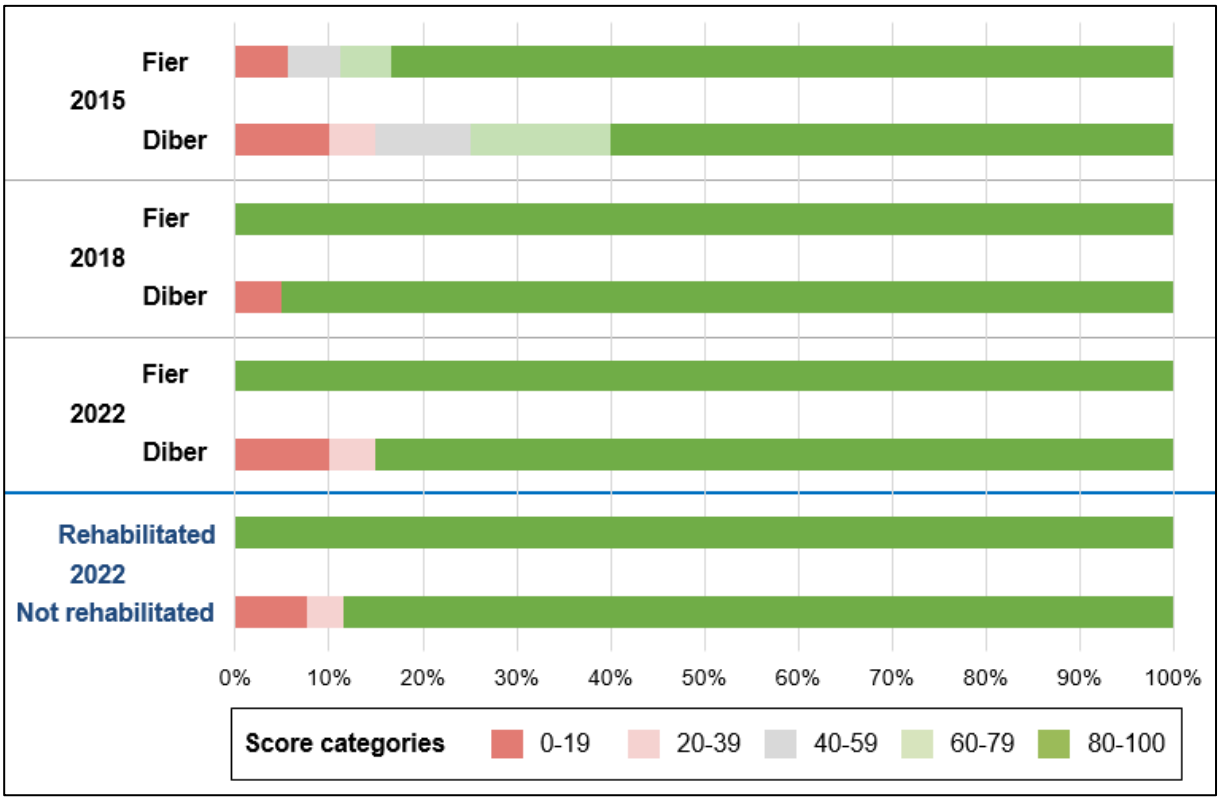
Figure 3 shows scores for medical and hazardous waste management in the HC, including the following indicators (yes/no):

- 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).
- Infectious waste is temporary stored at a protected place.
- Sharps waste is temporary stored at a protected place.
- There is regular and appropriate collection for infectious waste.
- There is regular and appropriate collection for sharps waste.
- The HC has essential disinfectants and antiseptics.
- The HC has chlorine solution or other disinfectants to disinfect contaminated instruments in all required areas (e.g. in examination rooms).

In Albania, the waste disposal in HC is done by private companies that collect the waste at the HC and dispose it safely. Whilst in HC in Fier, medical waste disposal is done appropriately since 2018 (all scores 80-100), in Diber, there remain three HC, where disposal of medical and hazardous waste is inappropriate, which are at the same time non-rehabilitated HC (namely Lure, Arras and Zall Dardhe/Rec). These three HC are located in remote, difficult-to-reach areas and the inappropriate waste disposal practices are likely to be linked to these logistical challenges. Medical waste disposal is done appropriately in all rehabilitated HC.

Figure 3: Scores on medical and hazardous waste disposal



4.1.3 *Available consultation space and privacy*

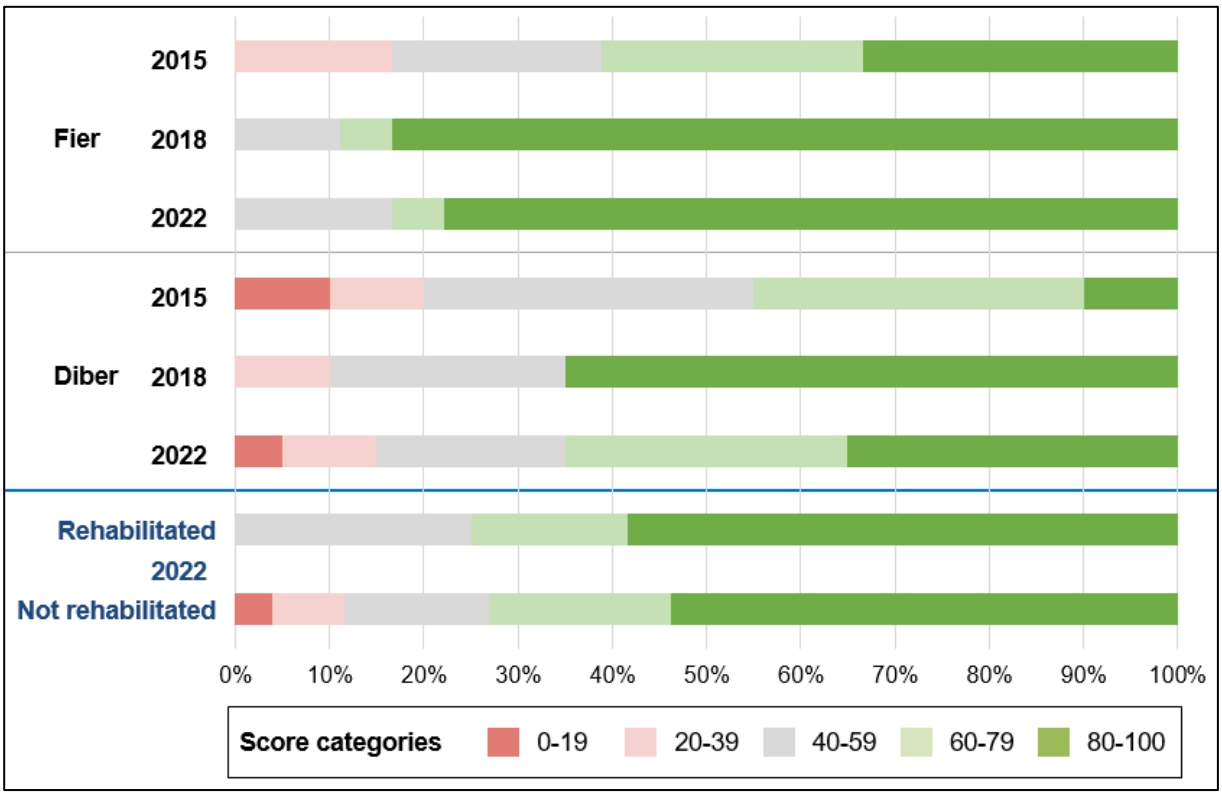
Figure 4 shows scores for available consultation space and privacy thereof in the HC, including the following indicators (yes/no):

- There is a designated waiting room for patients.
- There is at least one designated consulting room for women.
- There is at least one designated consulting room for children.
- All examination room(s) ensure(s) privacy/confidentiality (door, window blind, curtain).

Between 2015 and 2018, an improvement regarding available consultation space and consultation privacy was observed. However, in Diber, these improvements partly rolled back until 2022 but scores remained better than at baseline in 2015. Distribution of scores >60 in

2022 was similar for rehabilitated and non-rehabilitated HC, but there remain three HC in Diber with low scores (namely Lure, Arras and Martanesh).

Figure 4: Scores on available consultation space and privacy



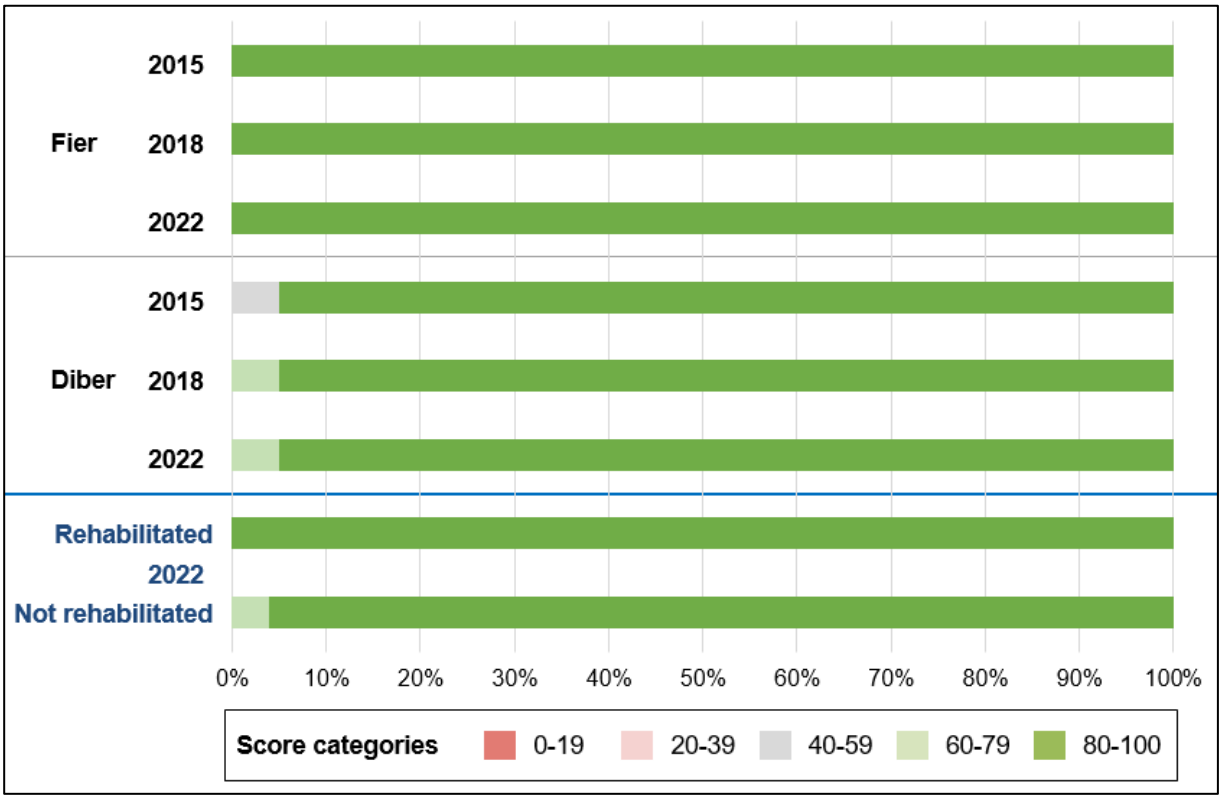
4.1.4 *Availability of electricity and telecommunication infrastructure*

Figure 5 shows scores for the availability of electricity and telecommunication infrastructure (i.e. computers, printers and internet) 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.
- There is not routinely a time of year when this HC has a severe shortage or lack of power.
- The HC has a functional generator.
- Fuel available today for the generator.
- The HC has a functional heating system.
- The HC has functional communication equipment (functional landline telephone or cell phone) available (either private phone or HC phone)?
- The HC has functional computer.
- The HC has a functional printer.
- The HC has internet access.
- During the past 7 working days the HC had internet for at least 1 hour every day.

The overall scores for availability of power and telecommunication infrastructure were high, across all survey years, regions and rehabilitation status. Only in Lure, there seems to be lack of electricity, incl. a generator, as well as no IT system with a computer, printer and internet.

Figure 5: Scores on availability of electricity and telecommunication infrastructure



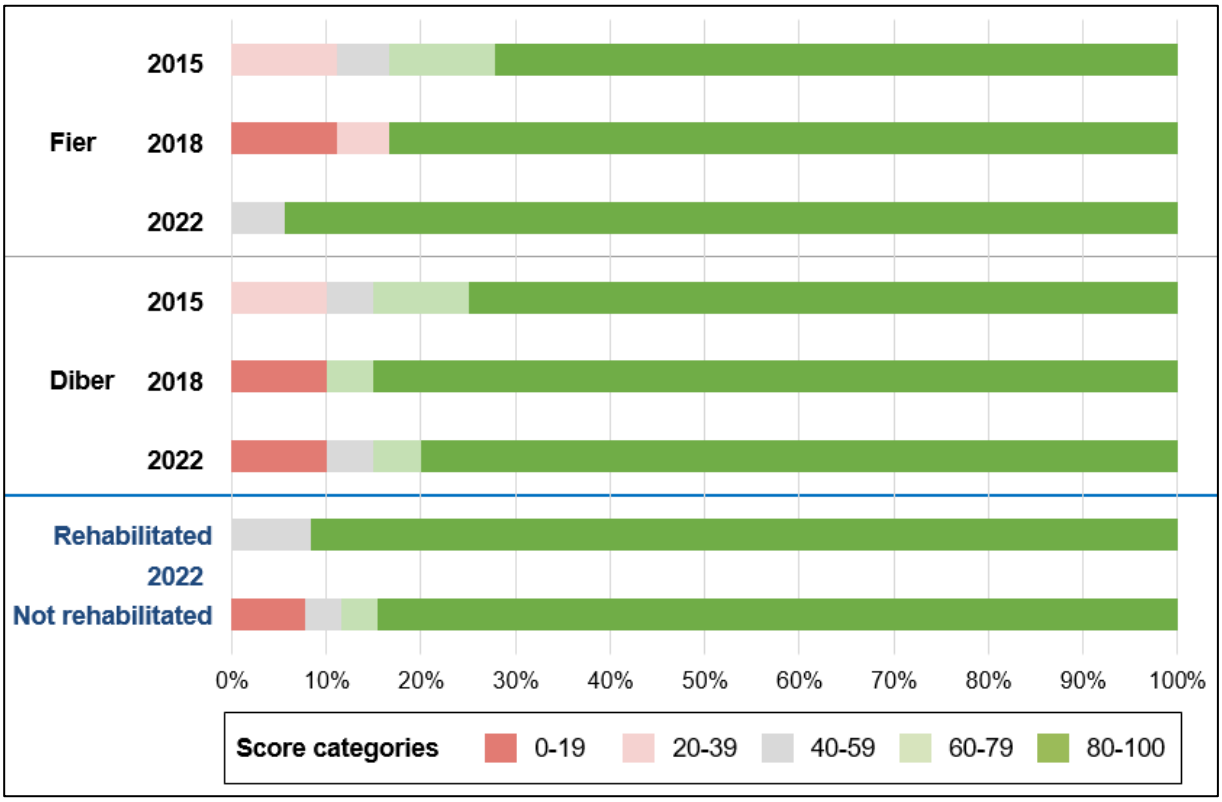
4.1.5 *Water and sanitation*

Figure 6 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).
- There is warm water available (out of the tap).
- There is not routinely a time of year when this HC has a severe shortage or lack of water (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.
- The HC has at least one accessible and functional toilet for staff.
- The toilet(s) or latrine is clean.
- A washing point is available near the toilet or latrine.
- Soap and water are available at the washing point near toilet or latrine.

There were steady improvements achieved with regard to the water and sanitation situation in the HC over the surveyed years in both regions. The exception remain the HC in Derjan and Xiber in 2022 (whilst in 2018 it was the HC in Zerqan and Xiber).

Figure 6: Scores on water and sanitation



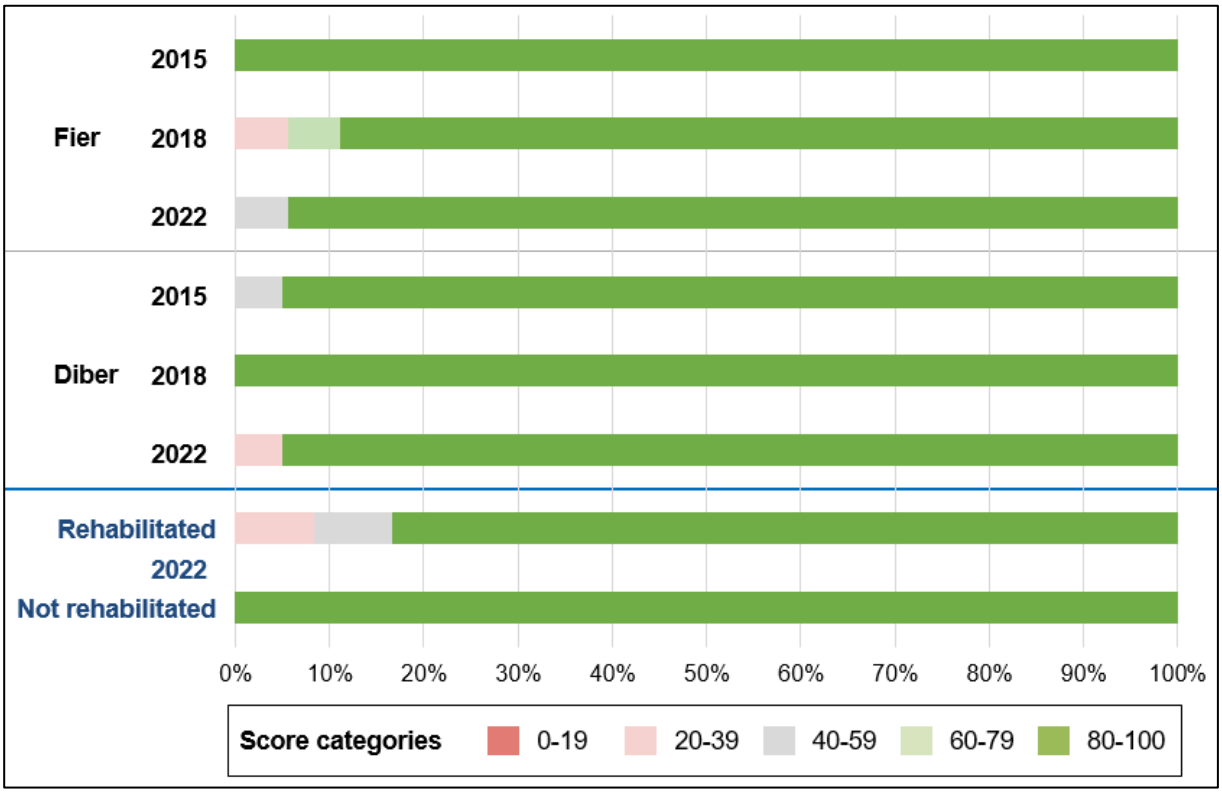
4.1.6 *Display and visibility of HC information and health information materials*

Figure 7 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 location visibly displayed in public.
- The HC opening hours visibly displayed to the public.
- A contact phone number visibly displayed to the public.
- The tariffs are visibly displayed to the public/patients.
- Information leaflets of the MoHSP complaining mechanism for citizens available at the heath HC.
- The green numbers to denounce corruption visibly displayed to the public.
- Information on the violation of law against tobacco and/or the movement "Albania says no to tobacco" visibly displayed to the public.
- Information on the "Basic check-up for the population 35-70 years old" is visibly displayed to the public.
- The "Albanian Charter of Patient's Rights" is visibly displayed to the public.
- The leaflets/posters at the HC have no logo/trademark from a pharmaceutical company.
- The Calendar of health promotion developed by MoHSP or IPH is visibly displayed to patients.
- The Calendar of Vaccination/Immunization is visibly displayed to patients.
- 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.

The majority of HC scored high (80-100) on the display and visibility of HC information and health information materials.

Figure 7: Scores on display and visibility of HC information and health information materials



4.1.7 *Availability of printed copies of guidelines*

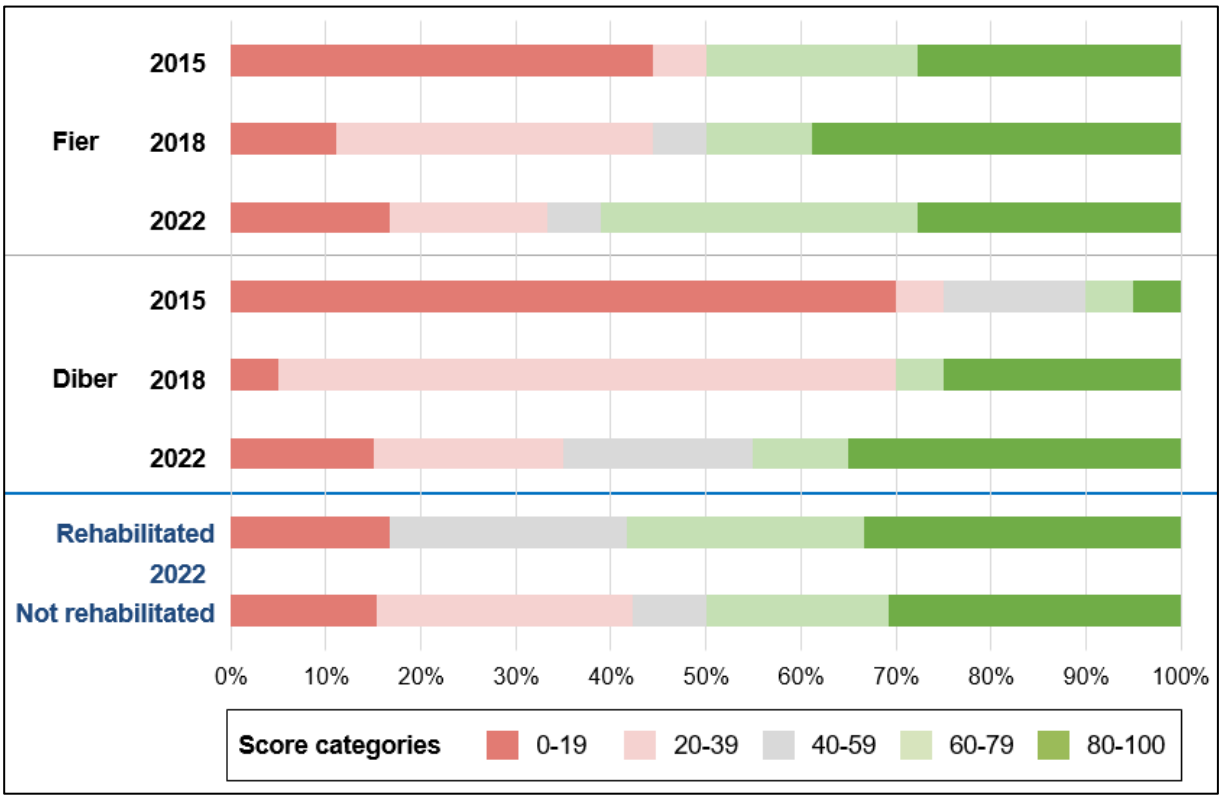
One specific objective of the 2022 survey was to assess the compliance with the new protocols on diabetes and hypertension management introduced through HAP2 in February 2021 up to January 2023.

Figure 8 shows scores for the physical presence of medical guidelines in the HC, including the following indicators (yes/no):

- The Clinical Guideline/Protocols for PHC: Diabetes Mellitus 2 (2020)
- The Clinical Guideline/Protocols for PHC: on Hypertension (2020)
- Guideline of Clinical Practice “Antenatal Care in primary health care” (June 2014)
- Guideline of Clinical Practice “Postnatal Care in primary health care – For mothers and newborns” (June 2014)
- Protocols of Clinical Practice on Postnatal Care in primary health care (June 2014)
- Guideline of Clinical Practice “Growth & Development of Children 0-6 age in the primary health care” (June 2014)
- Guideline of Clinical Practice “Nutrition of Pregnant Woman, infant and little child in primary health care” (June 2014)
- Protocols of Clinical Practice of family medicine based on the guidelines for Seniors
- “List of Medication and medical equipment in the Health Centre”, as part of Basic Package of Services (June 2018)

The availability of physical copies of guidelines in the HC has somehow improved between 2018 and 2022 as more HC are in the >60 score category in both Fier and Diber. In Fier, the percentage of HC in the 80-100 score category decreased from 38.9% to 27.8%, but in Diber, this percentage increased from 25.0% to 35.0%. Overall, since 2015, a strong improvement was observed but the availability of printed copies of guidelines in the HC remains insufficient in both regions, with still around a third of HC with a score <40. Thus, the introduction of the new protocols, including accompanying training for health staff, would still benefit from reinforcement. However, non-availability of printed copies of the guidelines does not automatically mean that they are not adhered to in practice by the doctors.

Figure 8: Scores on availability of printed copies of guidelines



4.1.8 *Quality assurance and control*

In 2022, 63.2% (24 out of 38) HC had a box/book to get public opinion on the quality of services, which was considerably higher than the previous years (36.8% in 2015 and 26.3% in 2018).

In 2018 and 2022, for most HC, the most recent visit by the public health directorate was within the past year before the survey (median number of months since visit: 3.0 in 2015, 11.0 in 2022). However, in 2022, documentation of such visits were only available in 25.7% of HC (44.7% in 2018).

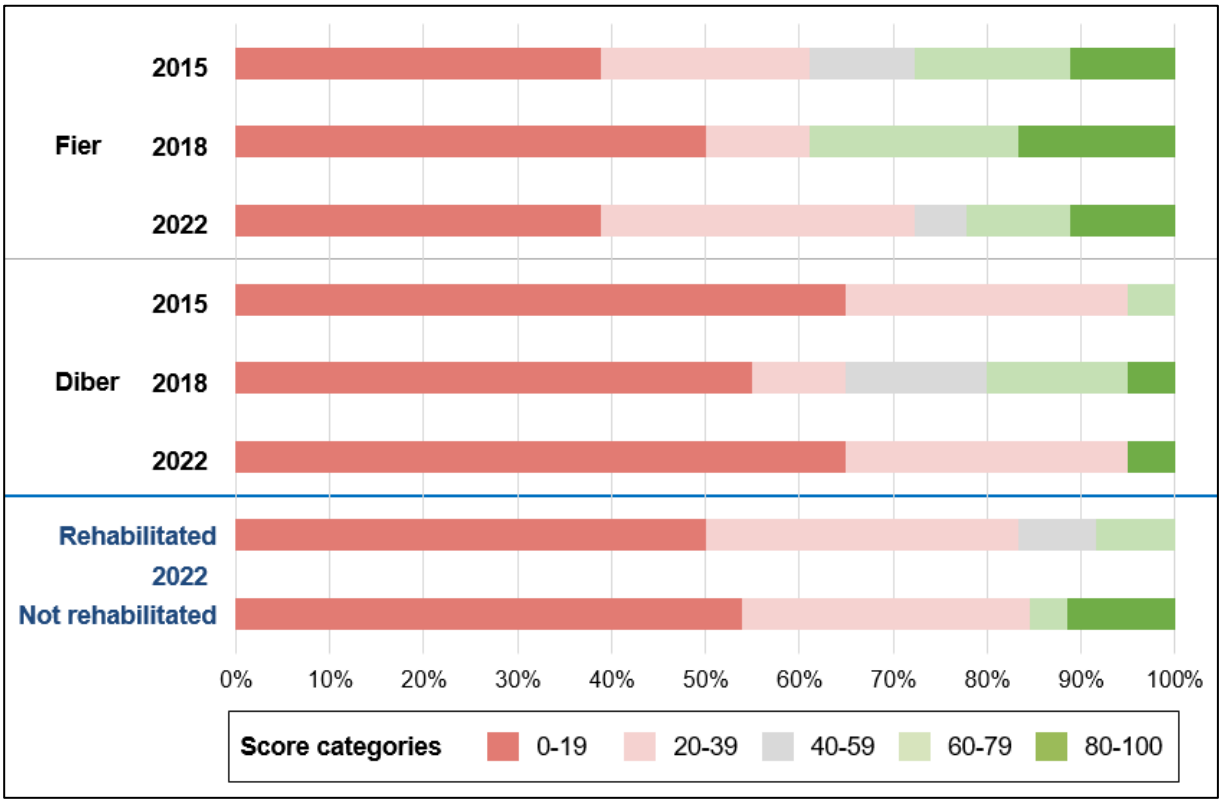
The median number of months since the last supervision by the national health insurance fund visit at the health center was 5.4 months in 2015 (range: 1-64 months), 2.8 months in 2018 (range: 1-17 months), and 6 months in 2022 (range: 2-35 months).

4.1.9 *General medical equipment (available and functional)*

A list of 35 items of basic medical equipment – according to the 'Basic Service Package' – was assessed, for availability and functionality. The full list is shown in Table 16 in annex 7.2. For score calculation, equipment that was available but not functional was classified as not available.

Figure 9 shows scores on availability of medical equipment by region, year and rehabilitation status of the HC. Major improvements were achieved between 2015 and 2018. Until 2022, scores of above 60 could be maintained for all HC in Fier and for 80% of HC in Diber. This was mirrored in the scores by rehabilitation status of the HC, as the underperforming HC in Diber were non-rehabilitated HC at the same time (both in 2022).

Figure 9: Scores on availability of general medical equipment



In addition to the basic medical equipment, HAP distributed medical tool bags to 223 family doctors in two project regions Dibër and Fier over the course of 2016 and 2017. The doctors' bag includes 17 items of medical equipment[1] that fulfil the requirements of the list of medical equipment of the Basic Package of Services. Similarly, in 2018, HAP distributed 1,180 bags for nurses in two project regions Dibër and Fier, including 15-16 items of medical equipment[2].

After distribution in 2016/17, most HC (94.7%) had functional doctor's bags available as assessed in the 2018 survey (Table 4). This percentage dropped to 84.2% in 2022, as a couple of bags or equipment became non-functional, potentially indicating neglected maintenance of the bags. In 2022, 30 HC (79.0%) had nurse's bags, whilst in 4 HC, these were no longer functional and in 4 HC they were not available altogether (both 10.5% each).

Table 4: Availability of doctor's and nurses' bags with essential medical equipment (2015, 2018, 2022)

	2015		2018		2022	
	n	%	n	%	n	%
Doctor's bag						
Available, functional	0	0.0	36	94.7	32	84.2
Available, not functional	0	0.0	2	5.3	4	10.5
Not available	38	100.0	0	0.0	2	5.3
Nurse's bag						
Available, functional	0	0.0	0	0.0	30	79.0
Available, not functional	0	0.0	0	0.0	4	10.5
Not available	0	0.0	38	100.0	4	10.5

[1] Includes: adult, pediatric and fetal stethoscope, an adult and pediatric sphygmomanometer, otoscope, ophthalmoscope, peak flow meter, oximeter, neurological hammer, glucometer including strips, pregnancy wheel, digital thermometer, measuring tape, pocket light, tourniquet and resuscitation mask.

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

Availability and functionality of four items of more advanced medical equipment was also assessed (Table 5). The availability of EKG machines, autoclaves and centrifuges was significantly higher in 2022 than previous survey years. However, only one HC in 2022 compared to four HC in 2018 had a photometer. It should be noted that these four equipment items are only required in HC in the capital and a few other bigger cities [8].

Table 5: Availability of advanced medical equipment (2015, 2018, 2022)

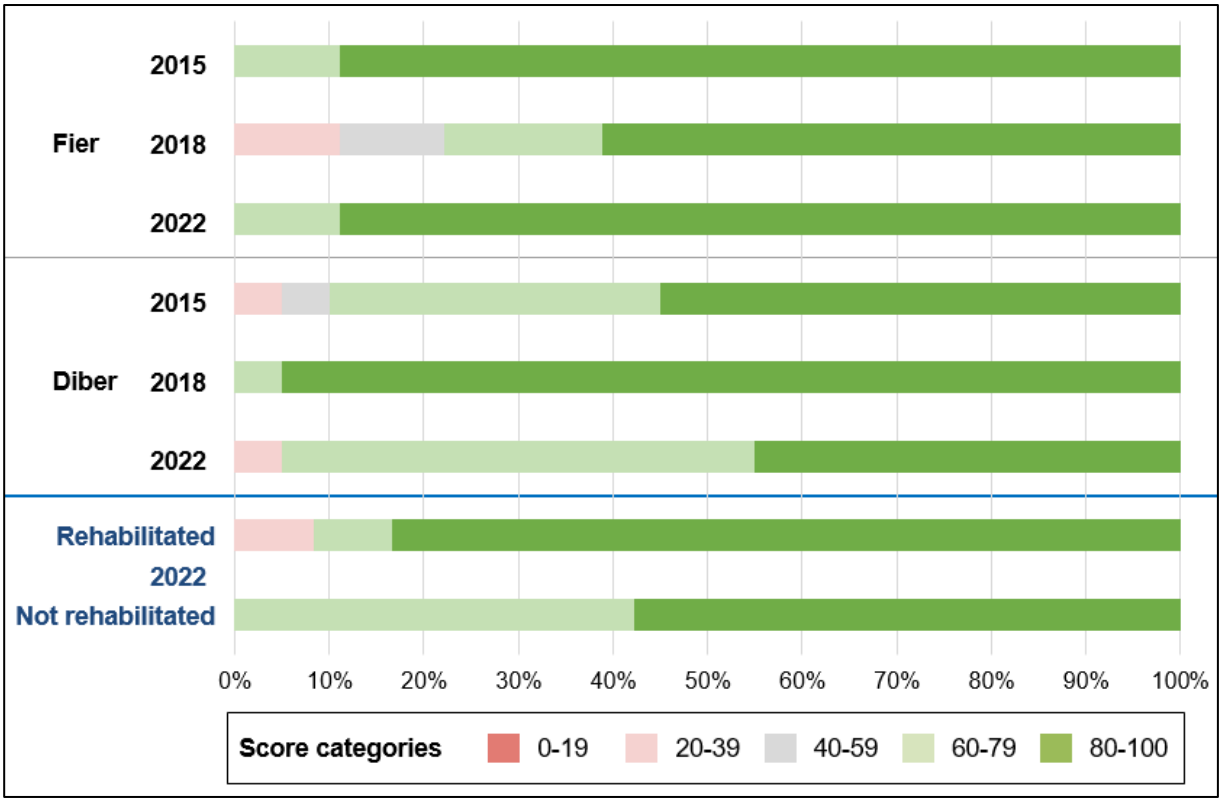
	2015		2018		2022	
	n	%	n	%	n	%
Advanced medical equipment						
EKG machine	1	2.6	9	23.7	28	73.6
Autoclave	3	7.9	6	15.8	20	52.6
Photometer	0	0.0	4	10.5	1	2.6
Centrifuge	1	2.6	6	15.8	14	36.8

4.1.10 *Basic medical consumables*

A list of 10 basic medical consumables was assessed for availability. The full list is shown in Table 17 in annex 7.2.

Figure 10 shows scores on availability of medical consumables by region, year and rehabilitation status of the HC. Generally, relatively high scores (60 and higher) were observed for medical consumables, with somewhat higher scores in Fier than Diber in 2022.

Figure 10: Scores on availability of basic medical consumables (2015, 2018, 2022)



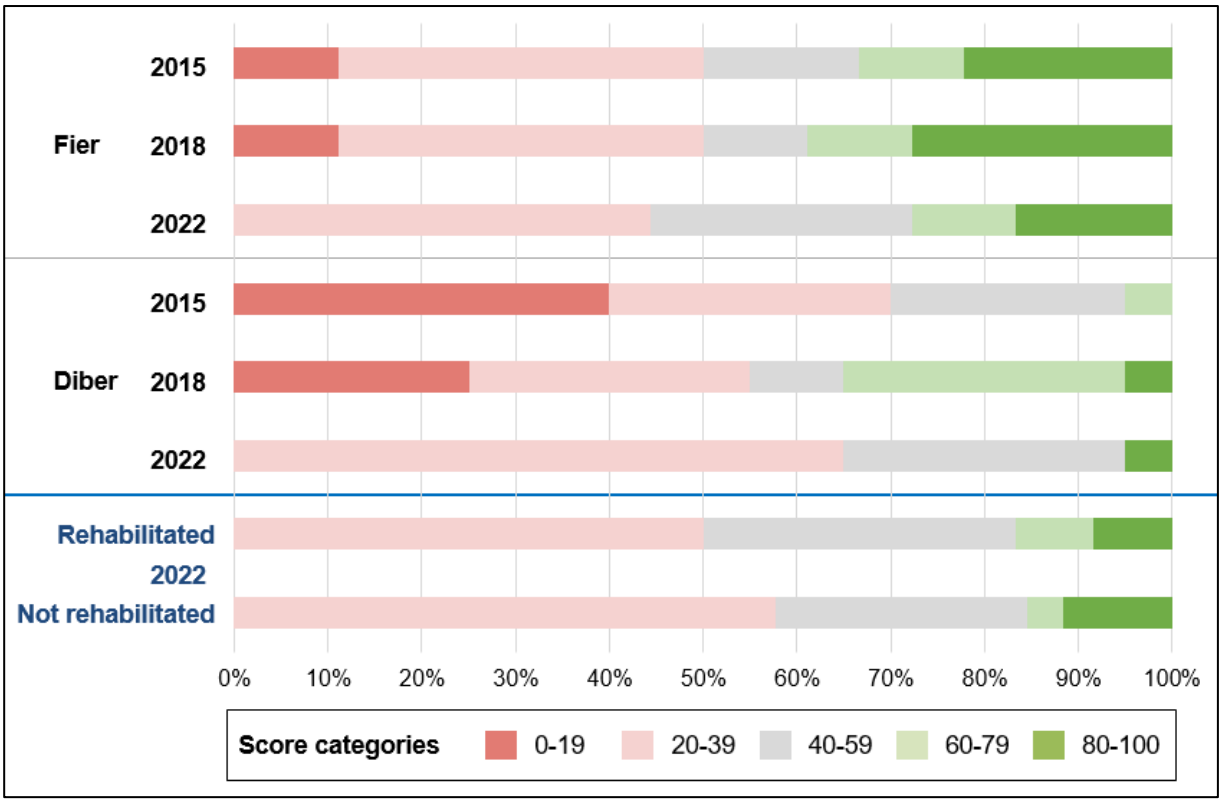
4.1.11 *Gynaecological and obstetrical services equipment*

A list of 8 items of gynaecological services equipment was assessed, for availability and functionality. The full list is shown in Table 18 in annex 7.2. For score calculation, equipment that was available but not functional was classified as not available.

Importantly, none of the selected HC are mandated to deliver gynaecological and obstetric services anymore [8]. Mother and child health care services are limited to verbal consultations and advices, anything beyond this is referred to specialist doctors.

Figure 11 shows scores on availability of gynecological services equipment by region, year and rehabilitation status of the HC. Across all years, a minority of HC had scores >60 for this equipment, but scores were consistently higher in Fier than Diber.

Figure 11: Scores on availability of gynaecological services equipment



Whether or not a delivery set is needed in the HC is decided by the director of the HC and based on the accessibility of the nearest obstetrical HC/hospital. Thus, for two thirds (68.4%) of HC (all years), the availability of a delivery set was not indicated. For the remaining 12 HC – thus considering the sample – the availability of these delivery sets dropped markedly from 66.7% in 2015 (n=8), to 58.3% in 2018 (n=7), to 16.7% in 2022 (n=2), likely due to the above-mentioned fact that these services are no longer offered in HC. In 2022, the available two sets were wrapped and sterile.

4.1.12 *Equipment to assess and monitor child development*

A list of 10 items of equipment to assess and monitor child development was assessed, for availability and functionality. The full list is shown in Table 19 in annex 7.2. For score calculation, equipment that was available but not functional was classified as not available.

Figure 12 shows scores on child development equipment by region, year and rehabilitation status of the HC. Very low availability of these items were observed in all survey years.

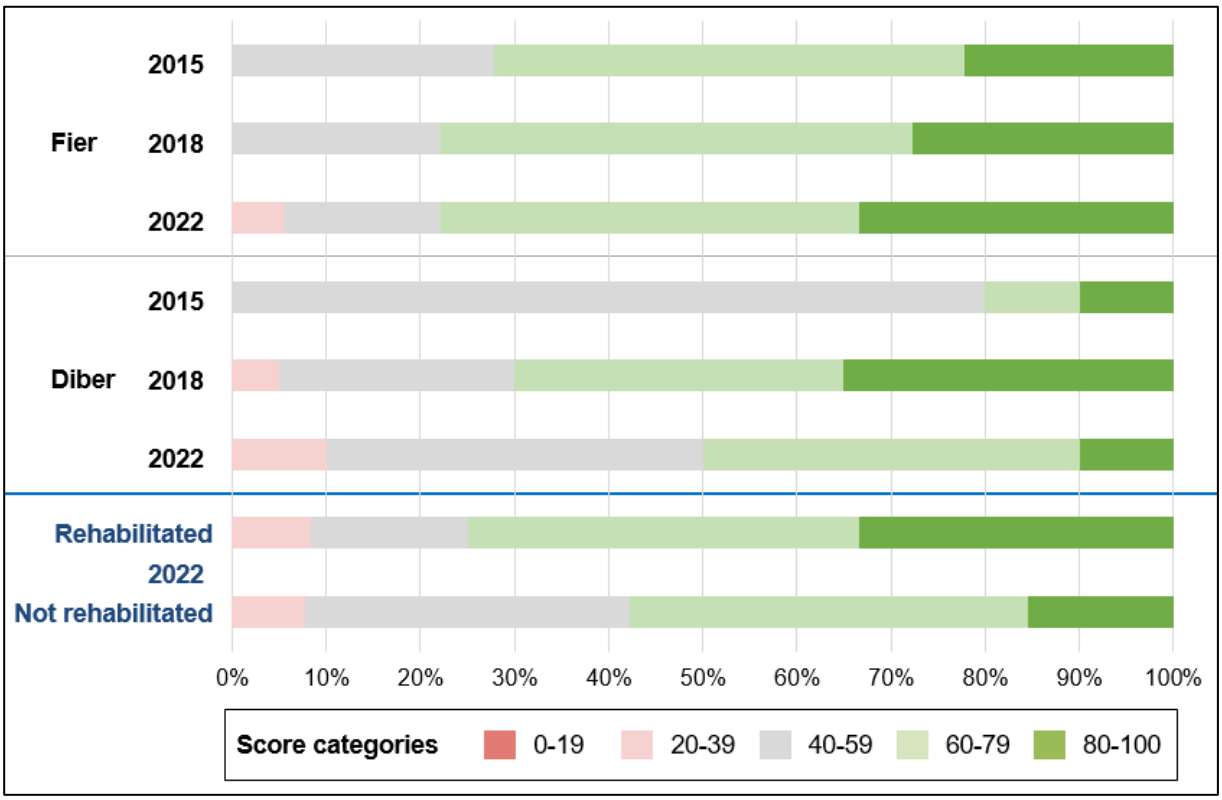
Figure 12: Scores on availability of equipment to assess and monitor child development

4.1.13 *Availability of drugs*

A list of 48 drugs was assessed for availability. The full list is shown in Table 20 in annex 7.2. In Albania, drugs prescribed by the doctors in the HC but are then purchased by the patients directly in the pharmacies. Hence, they are basically not given or sold in the HC. However, the HC must have a certain quantity of essential drugs that are needed mostly for emergency services or other health care provided at the center (e.g. microsurgery). Thus, the results should be interpreted with this limitation.

Figure 13 shows scores on availability of drug by region, year and rehabilitation status of the HC. Fluctuations were observed between regions and years but generally, most HC were moderately or well equipped with these essential drugs (score >60). However, in 2022, three HC (namely Bulqize “Minatori”, Fier Nr. 2 and Kastriot) had rather low scores.

Figure 13: Scores on availability of drugs



4.1.14 *Overall infrastructure scores*

The overall infrastructure score was calculated by combining all scores calculated in 4.1.1-4.1.13. In 2022, most HC in Fier (88.9%) achieved a score of 60 or higher. In Diber, 35% of HC achieved a score of 60 or higher but the majority (60%) were in the 40-59 score category. Klos and Libofshë, both HAP-rehabilitated HC, achieved highest scores (80-100), and Arras was the only HC in the 20-39 score category (Table 6). Arras and Xiber HCs are facilities where former class rooms were repurposed as health facility rooms, where potentially not all infrastructure standards are met.

Figure 14: Overall scores on infrastructure

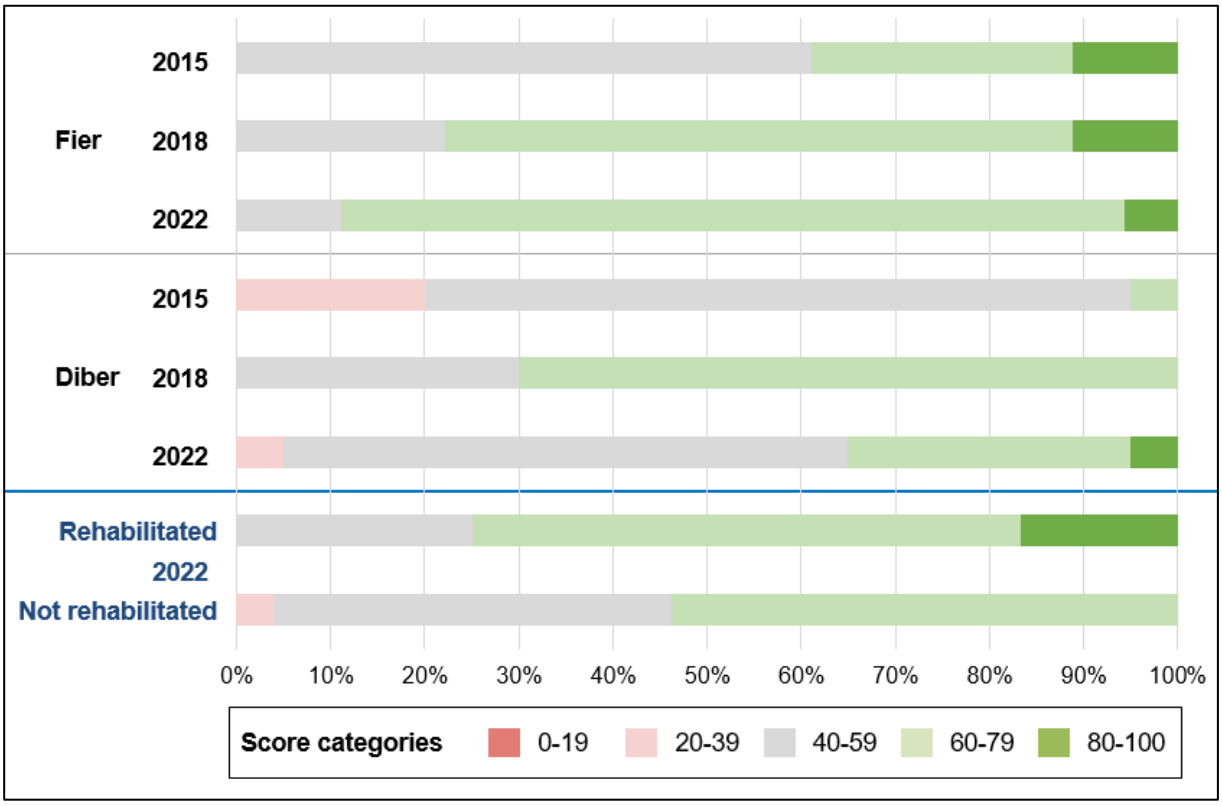


Table 6: Overall infrastructure scores by HC (2022)

Score	Name of HC	
20-39	• Arras	
40-59	• Derjan • **Lis** • Burrel Nr. 1 • Xiber • **Ruzhdie** • Bulqize 'Minatori' • Martanesh	• Lure • Fier Nr. 2 • Sllove • Tomin (qender) • Peshkopi • **Kastriot** • Zall Dardhe/Rec
60-79	• Divjakë • **Komsi** • Tërbuf • Grabia • Zharrëz • Fushë Bulqizë • Suc • Dukas • **Cakran** • **Patos** • Fier Nr. 1	• Fier Nr. 3 • Zerqan • **Maqellarë** • Dërmënas • Melan • **Kuman** • Karbunare • **Lushnje Nr. 1** • **Lushnje Nr. 2** • Dushk
80-100	• **Klos Nr. 1**	• **Libofshë**

In bold are HC that were rehabilitated by HAP

4.1.15 *Effects of the Covid-19 pandemic*

Respondents to the infrastructure questionnaire (i.e. health staff) were also asked on potential effects of the Covid-19 pandemic on the service provision in their HC. In all but one HC, it was reported that more services were offered since the Covid-19 pandemic (97.4%; Table 7). However, 11.1% of HC in Fier and 30.0% of HC in Diber also reported that some services were no longer offered. More respondents in both regions perceived that the waiting times for consultations were longer rather than shorter (38.9% vs. 16.7% in Fier, 50.0% vs. 20.0% in

Diber). Only two respondents felt that the health care providers in their facility have more time for consultations (5.3% overall), but 16.7% in Fier and 35.0% in Diber felt that they have less time for consultations. No changes regarding the service costs were reported, which is largely concordant with what the patients reported (Table 12).

In Fier, 38.9% of health staff reported that they perceive the health care providers to be less friendly / more stressed, and 22.2% thought the opposite (more friendly / less stressed). In Diber, there was mainly the perception that health care providers are less friendly / more stressed (45.0%) and no respondent felt the opposite. These findings are not concordant with what was perceived by the patients as the patients perceived the friendliness of the staff as increasing markedly.

Table 7: Effects of Covid-19 on the availability of services offered according to health care providers (2022)

	Fier		Diber		Total	
	n	%	n	%	N	%
(Some) services were no longer offered	2	11.1	6	30.0	8	21.1
Additional services were offered	17	94.4	20	100.0	37	97.4
Waiting times for consultation (longer)	7	38.9	10	50.0	17	44.7
Waiting times for consultation (shorter)	3	16.7	4	20.0	7	18.4
Health care providers have less time for consultations	3	16.7	7	35.0	10	26.3
Health care providers have more time for consultations	1	5.6	1	5.0	2	5.3
Health care services are more expensive	0	0.0	0	0.0	0	0.0
Health care services are less expensive	0	0.0	0	0.0	0	0.0
Health care providers are less friendly / more stressed	7	38.9	9	45.0	16	42.1
Health care providers are more friendly / less stressed	4	22.2	0	0.0	4	10.5

11.1% (n=2) of health staff in Fier and 35.0% (n=7) of respondents in Diber reported that patients have complained about the availability of medical staff at the HC since the beginning of the Covid-19 pandemic.

In all but one HC (namely in Burrel), health staff respondents have reported that patient pathways have changed due to the pandemic. For the 37 HC where something has changed, 17 (45.9%) reported that consultations were offered by phone or videophone, 12 (32.4%) reported that consultations were also done at home and 4 (10.8%) reported that prescriptions could be obtained online. Consequently, all HC reported that digitalisation was accelerated in the HC due to the pandemic. Importantly though, the ‘digitalisation’ reported referred all to phone/videophone consultations. Other digitalisation processes, e.g. digital patient dossiers or similar, were not reported.

4.2 Doctor-patient observations

In 2022, 415 patient-doctor interactions were observed from 69 doctors in 35 HC (Figure 15). Hence, in 3 HC visited (see Table 2), no patient-doctor observations were conducted because no patient visited the HC on the day of data collection as consultations were apparently done over the phone. The HC with no patients' visits on the day of data collection, are in very remote areas in Diber. The numbers were evenly distributed between the regions. In 2022, therefore, there was a marked decrease of number of observations (-50.7% compared to 2018) and, hence, the average number of observations per HC and doctor was lower in 2022 than in previous years. Of note, data from the Health Insurance Fund show that the total number of consultations in PHC has decreased in the two years preceding the survey. The potential reasons include:

- Some family doctors continue to perform consultations by phones as a practice they acquired during the Covid-19 pandemic.
- The practice of doing e-prescription might lower the consultations in HC because (i) the digital literate patient can go directly to the pharmacy and take the drugs (once the e-prescription is done the patient gets a message into e-Albania platform that his recipe is ready in the pharmacy) and (2) the family nurse can send via WhatsApp the code of the e-prescription to the patient who then can go directly to the pharmacy. In addition, there are cases when family members come to receive prescriptions for the patient, and no interaction happens if the patient is not present.
- There are cases when family members come to receive prescriptions for the NCD patient, and no interaction happens if the patient is not present.
- The lack of family doctors in northern areas mostly, where one family doctor covers 2 or 3 health centres, may create difficulties in accessing the health service.

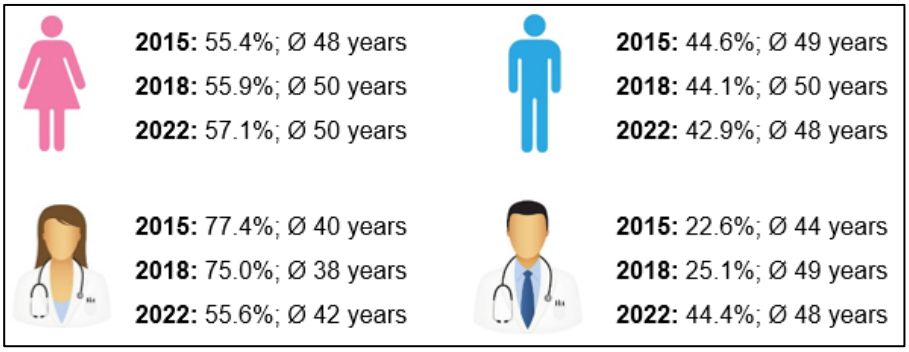
Figure 15: Number of HC, observations and observed doctors (2015, 2018, 2022)

4.2.1 *Characteristics of patients and doctors*

Patient characteristics assessed, namely gender and age, were similar for all three surveys. Every survey year, about 55% were female and for both females and males, the average age was around 50 years. Patient age groups are shown in Table 21 in annex 7.3.

The majority of doctors was female in all survey years, but the percentage of female doctors observed was lower in 2022 than in previous years. The average age of doctors remained similar over the years.

Figure 16: Patient and doctor gender and age (2015, 2018, 2022)



In 2022, 51.0% of doctors observed were general doctors (2015: 90.1%; 2018: 55.7%), 46.8% were family doctors[3] (2015: 6.1%; 2018: 44.4%), and 2.2% were specialist doctors (2015: 3.8%; 2018: 0.0%).

4.2.2 *Medical visit*

Reasons for the patient's medical visits are shown in Table 8. Across all years, between 22.6% and 29.0% sought health care for arterial hypertension and between 5.9% and 7.3% sought health care for diabetes. Thus, the percentage of patients seeking care for these health issues remained stable over the surveyed years. In 2022, a distinction was made between consultations for other chronic and other non-chronic conditions and overall, slightly more than half of all patients attended care for non-chronic health conditions.

Table 8: Reason for medical visit (2015, 2018, 2022)

	2015		2018		2022	
	n	%	n	%	n	%
Arterial hypertension	182	29.0	231	27.4	93	22.6
Diabetes	43	6.9	50	5.9	30	7.3
Other chronic condition	403	64.2	561	66.6	75	18.2
Other non-chronic condition					214	51.9

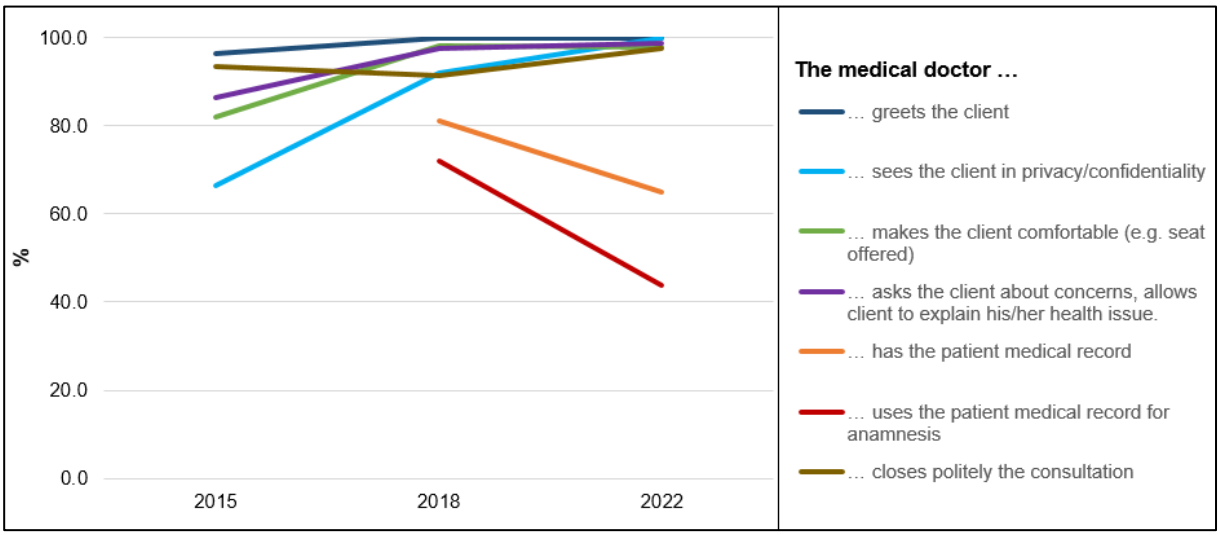
4.2.3 *Adherence to principles of clinical practice*

Between 2015 and 2018, there was a marked improvement of 'adherence to principles of clinical practice' achieved by doctors (indicators shown in Figure 17 and Table 22 in section 7.3), which remained high in 2022. Moreover, in 2022, the patient was more often seen in privacy as compared to previous years.

In 2018 and 2022, it was also observed if the doctors are in possession of the patient medical record (paper-based) during the consultation and whether they use the patient medical record during the anamnesis. As shown in Figure 17, the possession and use of medical records has decreased markedly between the two surveys, from 81.2% to 64.9% and 72.0% to 43.7%, respectively.

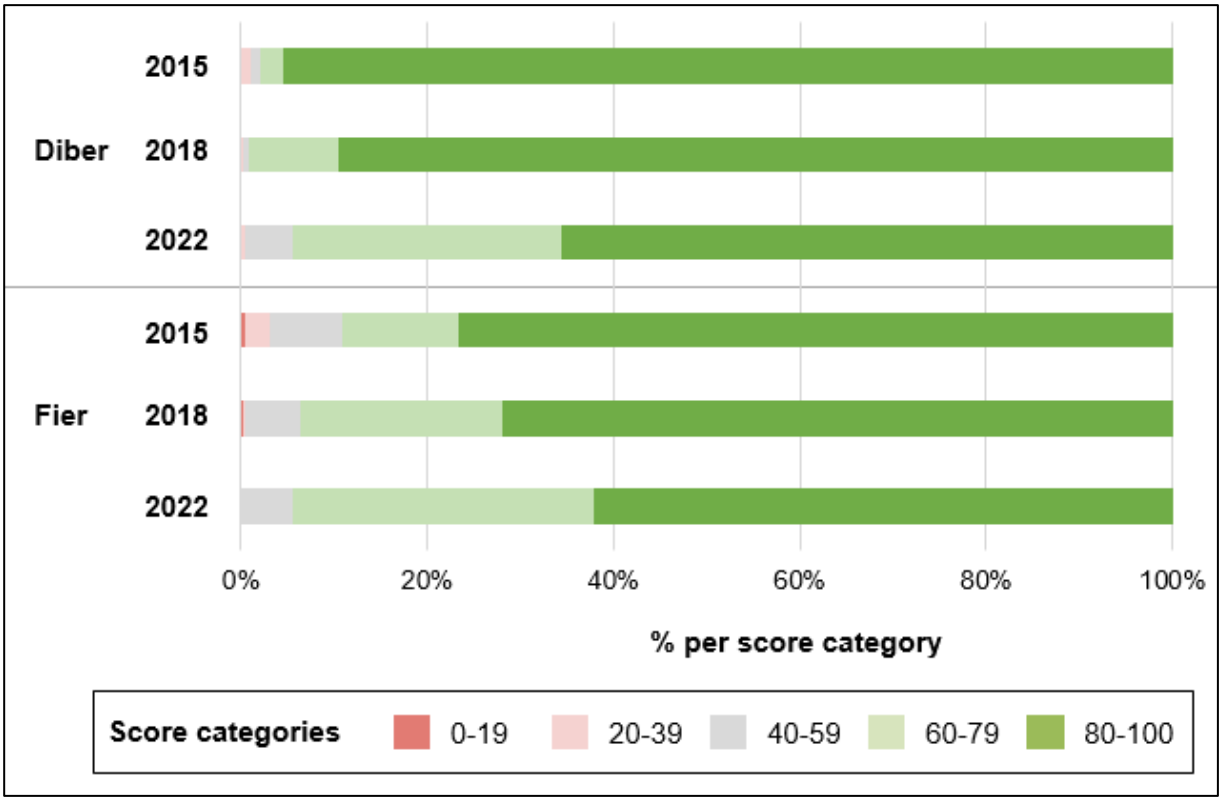
[3] Doctors described themselves as family doctors. As the number of generalists trained in the specialization of family medicines is very low, the self-classification is thus more likely relating to general doctors being contracted as family doctors.

Figure 17: Adherence to principles clinical practice (2015, 2018, 2022)



Taking together the five (2015) and seven (2018, 2022) indicators on 'adherence to principles of clinical practice', Figure 18 displays the percentage of doctors per score category (see score calculation and interpretation is described in section 3.7). In 2022, the majority of doctors in both Fier and Diber regions (>60%) had a score of >80, meaning they adhered to all principles 'adherence to principles of clinical practice'. This was slightly less than in 2018, which is due to the decreases in the possession and use of medical records. In 2022, the majority of doctors (>90%) achieved scores of >60 (light green and dark green together), which is an overall positive finding.

Figure 18: Scores on adherence to principles of clinical practice (2015, 2018, 2022)

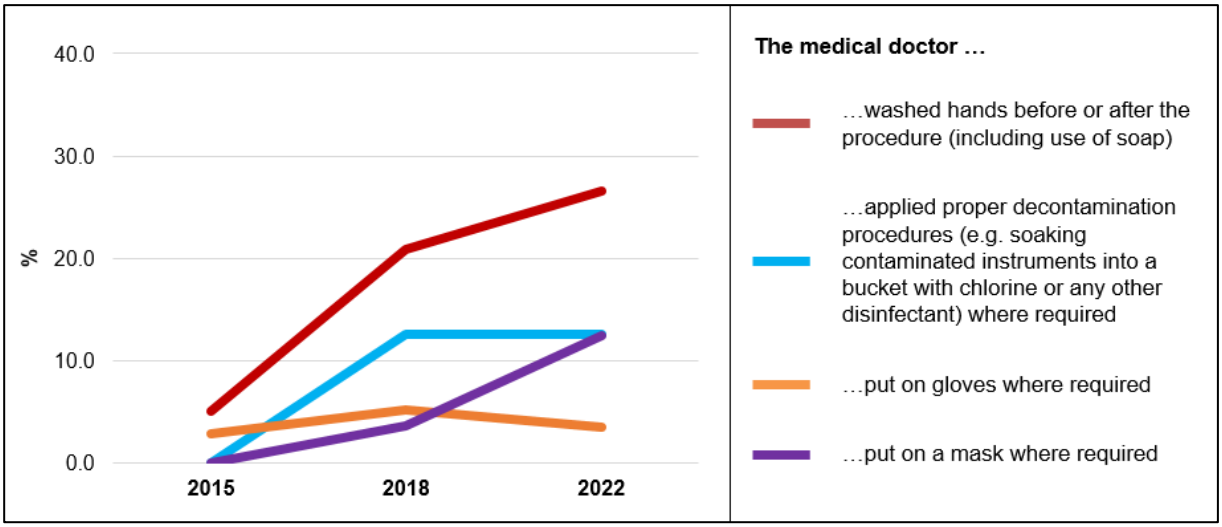


4.2.4 *Practices on infection prevention and control*

Figure 19 shows indicators for doctor's behaviours towards infection prevention and control. Over the years, an improvement was observed but these practices remain low as less than

30% of doctors practice them. Hand washing has improved from 5.0% in 2015, to 20.9% in 2018, to 26.6% in 2022. Of note, it should be noted that there were inconsistencies of data collection over the years, as in 2015, only washing hands 'before' the procedure was noted. Another marked increase was found for the wearing of masks, which is most likely explained by the generally increased used of masks due to the Covid-19 pandemic.

Figure 19: Infection prevention and control (2015, 2018, 2022)



4.2.5 *Practices in diabetes consultations*

As shown in Table 8, about 7.3% (n=30) of all patients in 2022 consulted for diabetes (6.9% in 2015 and 5.9% in 2018). Thus, there is a relatively limited number of patient-doctor observations for diabetes consultations across all years.

The 37 indicators assessed for diabetes consultations with regard to adherence to the diabetes treatment guidelines of the Albanian MoHSP are displayed in Table 13 in section 7.1, and combined scores were calculated for the following sub-categories:

- Anamnesis (11 indicators)
- Examination (9 indicators)
- Advice (17 indicators)
- Overall (combining all the above; 37 indicators)

Figure 20 to Figure 23 display the scores for the sub-categories. The following conclusions can be derived from these results:

- In Fier, results were improving steadily over the years.
- In 2022, the overall scores were still somewhat better in Diber than in Fier region.
- Most scores were best in 2018, especially in Diber region in 2018. Whilst most successes were achieved between 2015 and 2018, there was still a residual effect observed in 2022 as 2022 scores were mostly better than 2015 scores.
- In 2022, highest scores were achieved for 'advice'.
- 'Examination' scores were lowest, in all three survey years.

Figure 20: Diabetes consultations: anamnesis scores

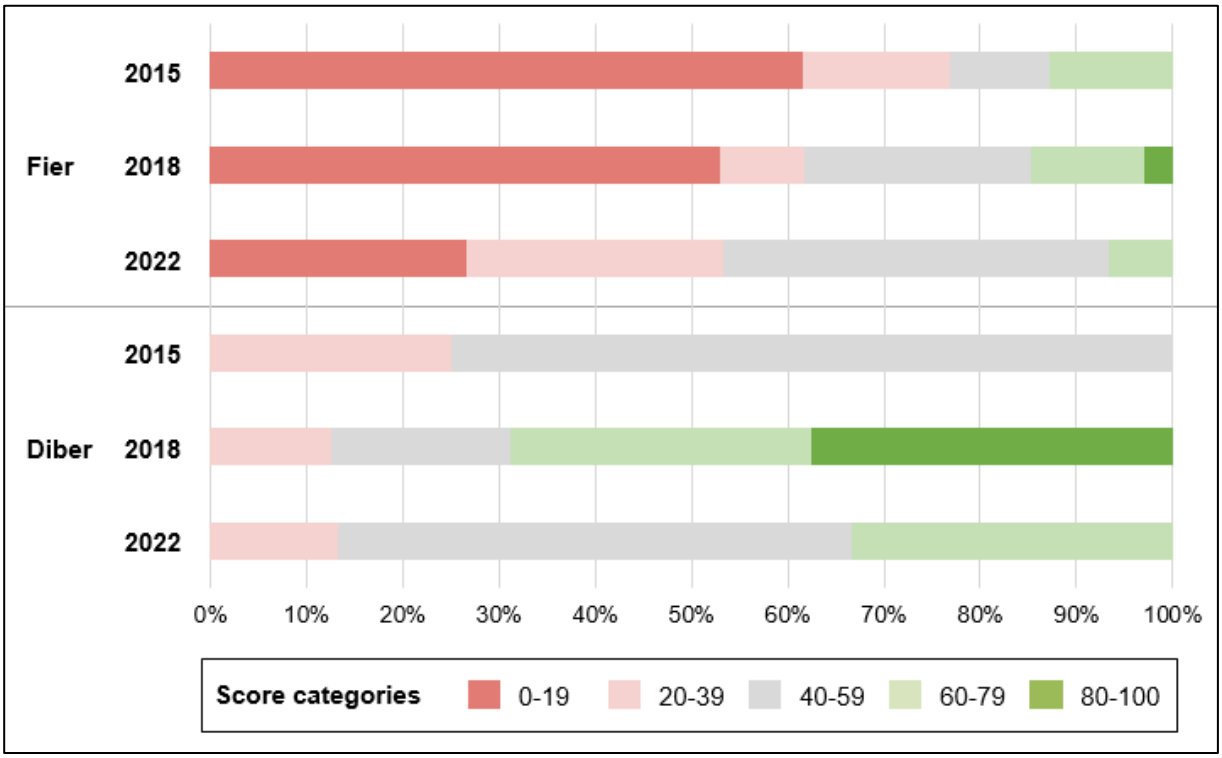


Figure 21: Diabetes consultations: examination scores

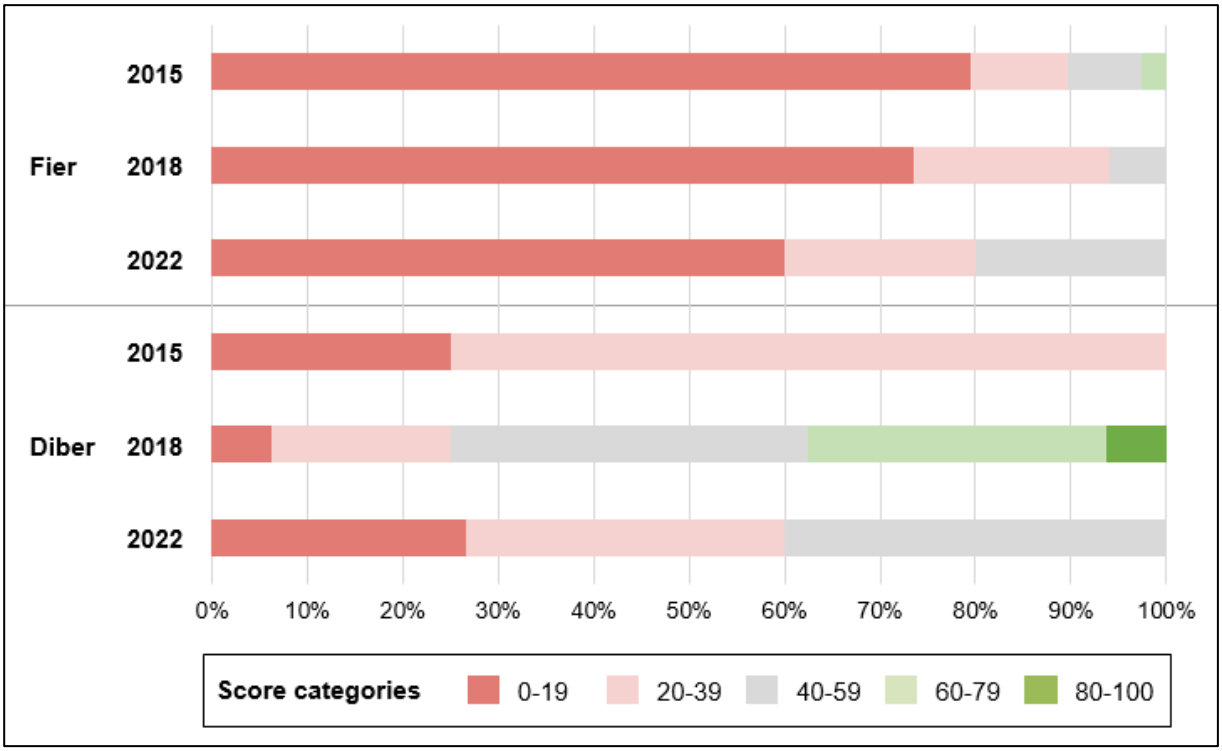


Figure 22: Diabetes consultations: advice scores

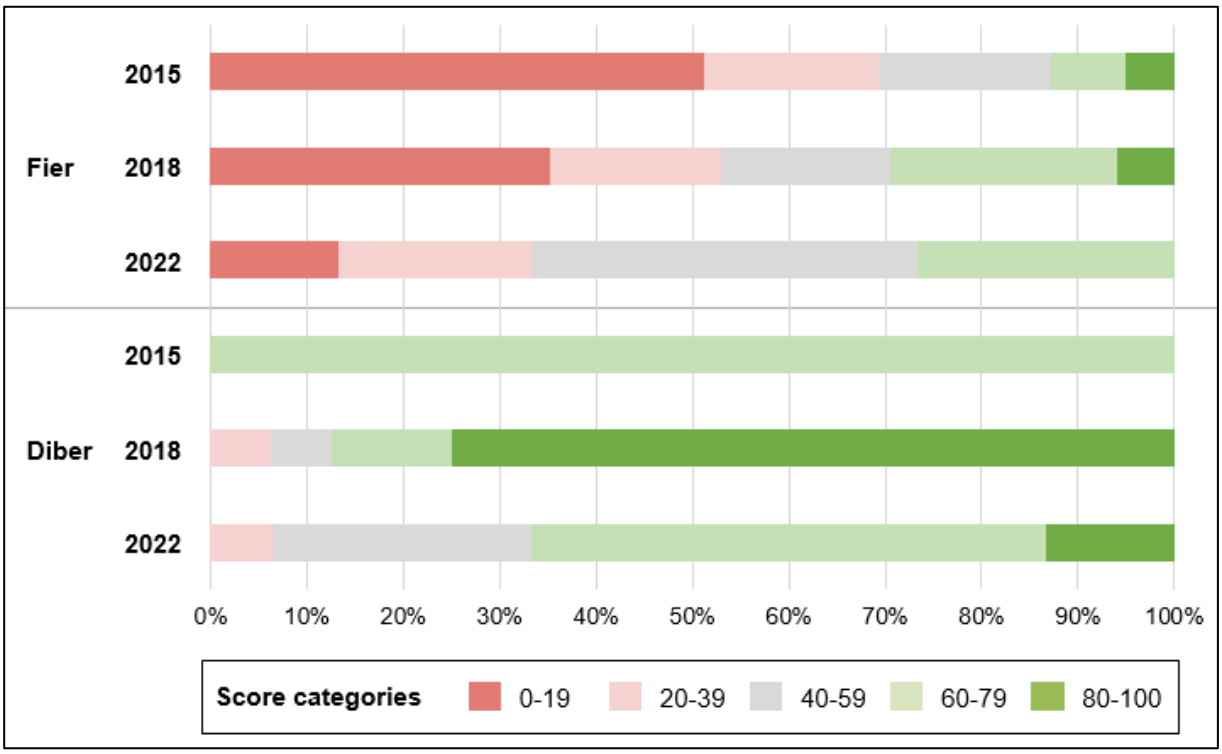
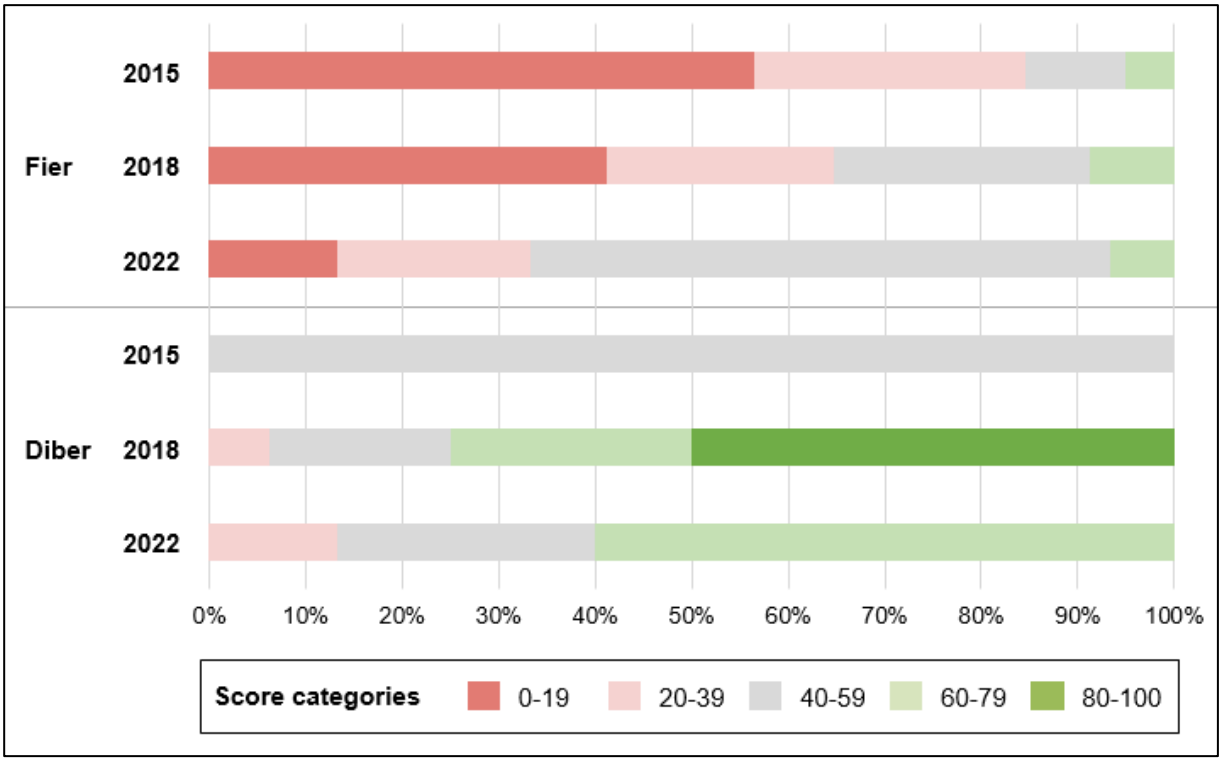


Figure 23: Diabetes consultations: overall scores



4.2.6 *Practices in hypertension consultations*

As shown in Table 8, about 22.6% (n=30) of all patients in 2022 consulted for hypertension (29.0% in 2015 and 27.4% in 2018). Thus, around a quarter of all consultations in all survey years.

The 36 indicators assessed for hypertension consultations with regard to adherence to the hypertension treatment guidelines of the Albanian MoHSP are displayed in Table 14 in section 7.1, and combined scores were calculated for the following sub-categories:

- Anamnesis (12 indicators)
- Examination (9 indicators)
- Advice (15 indicators)
- Overall (combining all the above; 36 indicators)

Figure 24 to Figure 27 display the scores for the hypertension consultations for the four sub-categories. The following conclusions can be derived from these results:

- Most scores were best in 2018, especially in Diber region in 2018. Whilst most successes were achieved between 2015 and 2018, there was still a residual effect observed in 2022 as 2022 scores were mostly better than 2015 scores.
- In both regions, the percentage of consultations with scores <40 decreased steadily over the surveyed years.
- 'Examination' scores were lowest, in all three survey years.
- In 2022, the overall scores were somewhat better in Diber than in Fier region.
- In 2022, highest scores were achieved for 'advice'.

Figure 24: Hypertension consultations: anamnesis scores

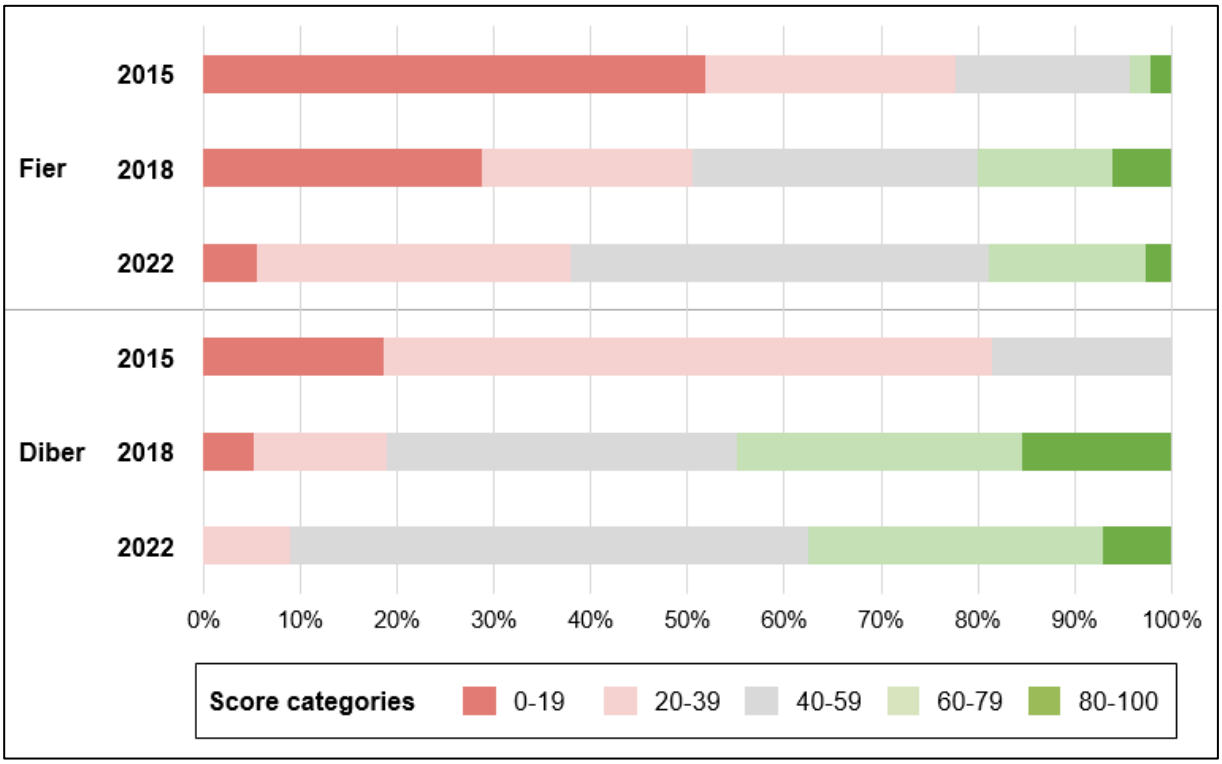


Figure 25: Hypertension consultations: examination scores

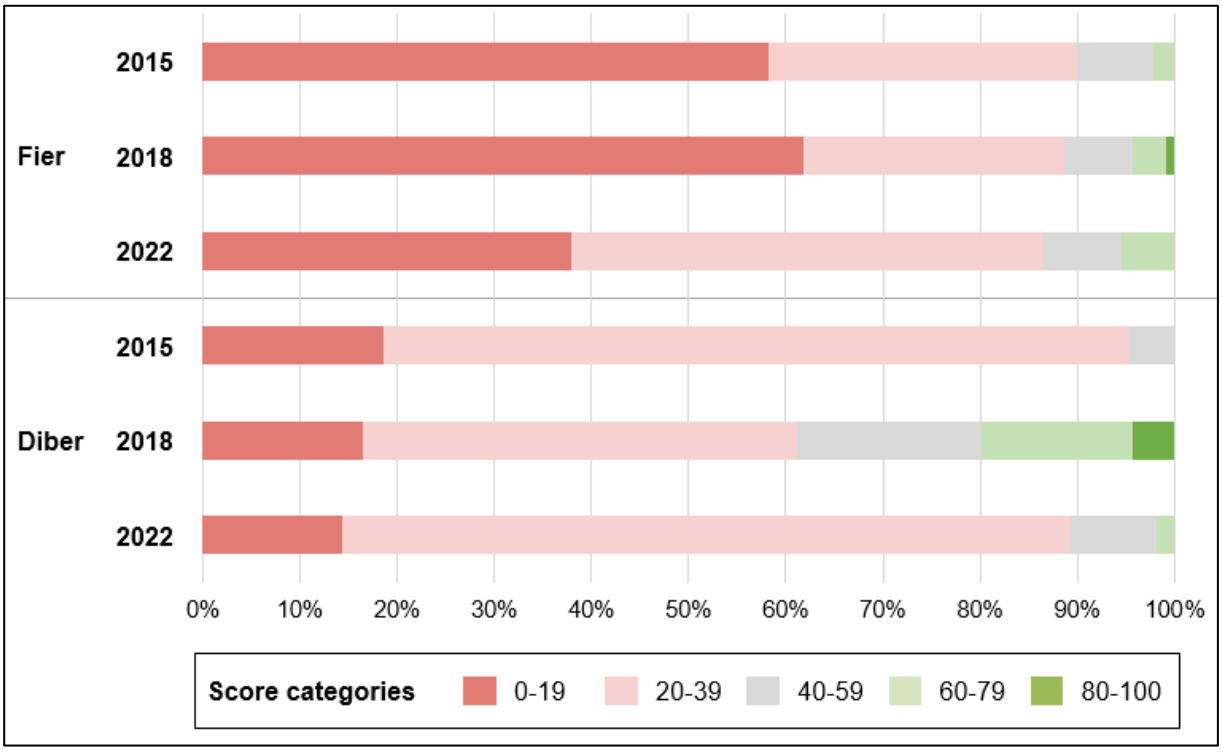
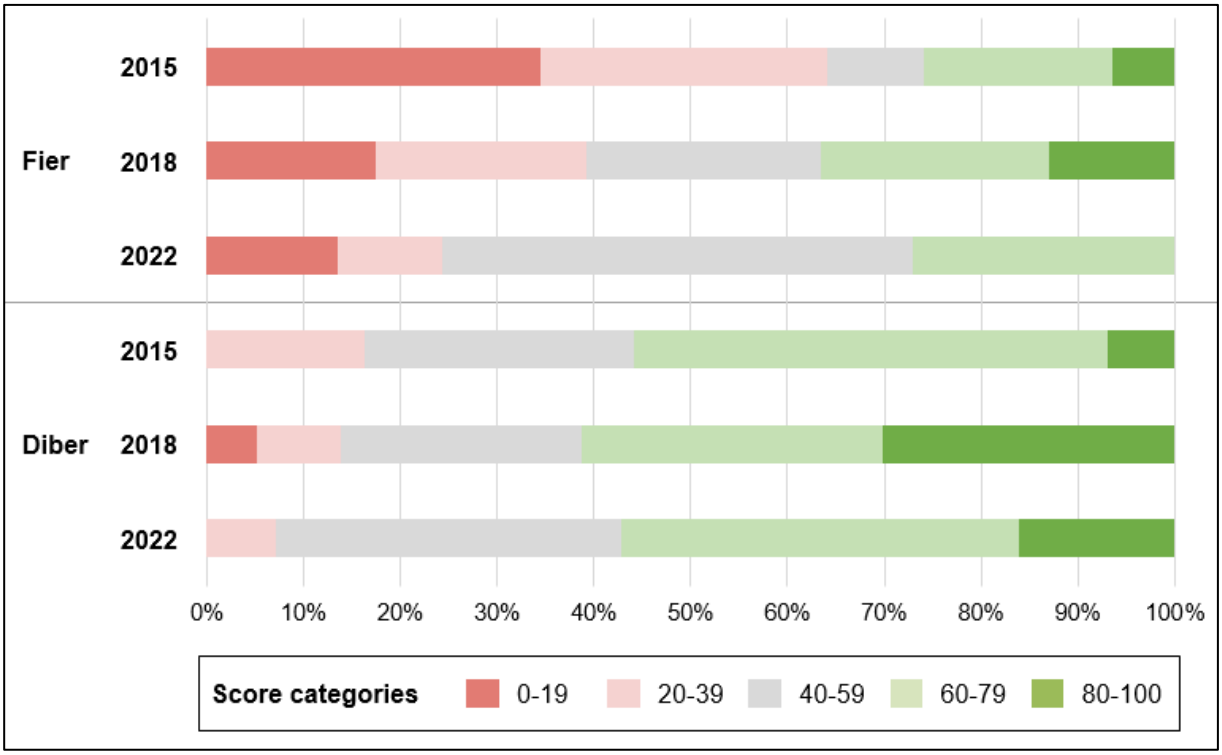
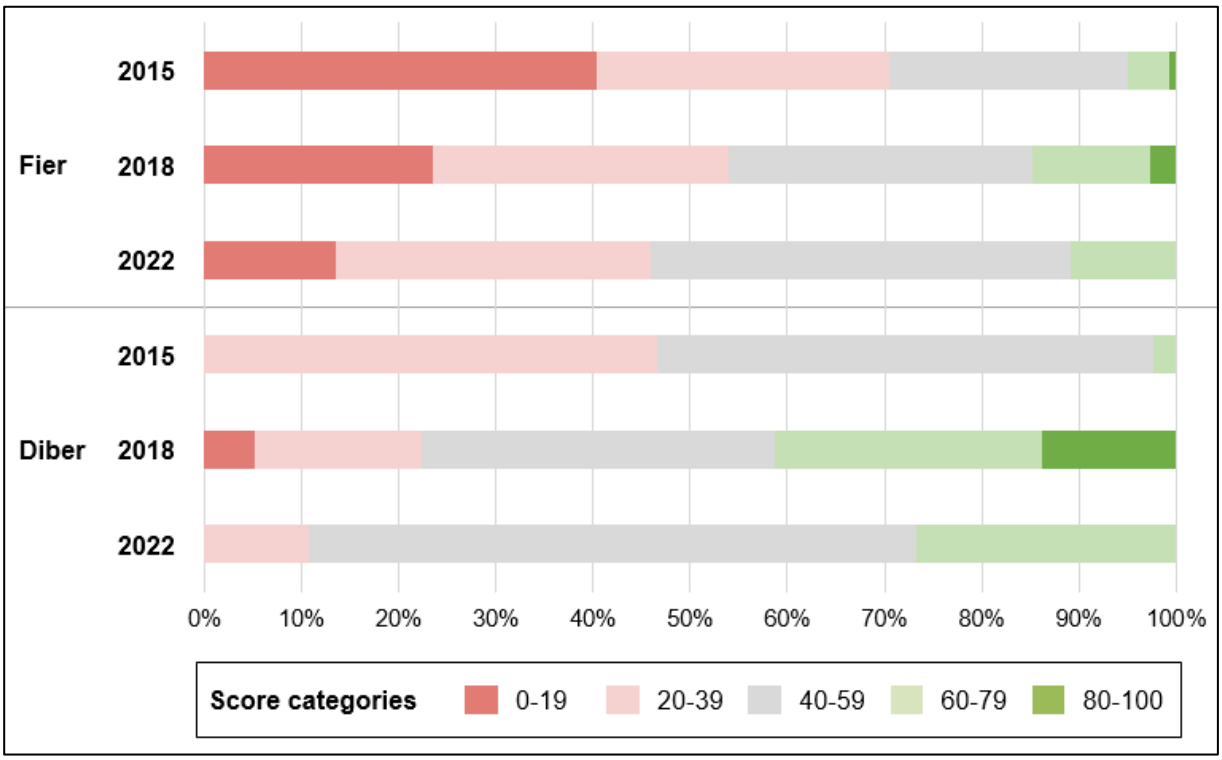


Figure 26: Hypertension consultations: advice scores



In 2022, 44.1% of hypertension patients were advised/instructed for referral, which was comparable to 2018 (47.5%) and considerably higher than at baseline in 2015 (23.7%).

Figure 27: Hypertension consultations: overall scores



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

As shown in Table 8, about 70.1% (n=289) of all patients in 2022 consulted for diseases other than diabetes or hypertension (64.2% in 2015 and 66.6% in 2018). Thus, around two thirds of all consultations across all years fell in this category.

The 14 indicators assessed for consultations for conditions other than diabetes and hypertension are displayed in Table 15 in section 7.1, 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)

Figure 28 to Figure 31 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:

- Most scores were best in 2022, especially in Diber region in 2022.
- A constant improvement was observed for all dimensions (anamnesis, examination, advice) from 2015, to 2018, to 2022 in both regions.
- In 2022, there remains a small percentage of doctors in Fier that have very low scores, i.e. adhere very poorly to standards for the three dimensions (anamnesis, examination, advice).
- In 2022, the lowest scores were found for ‘examinations’ in Fier.
- Overall, consultations for diseases other than diabetes and hypertension achieve significantly higher scores than for diabetes and hypertension consultations, across all years and both regions.

Importantly, the protocols for other NCDs than diabetes and hypertension have been introduced only in 2021 and the implementation process is still ongoing. Therefore, the results are expected to improve beyond this survey.

Figure 28: Consultations for other conditions: anamnesis scores

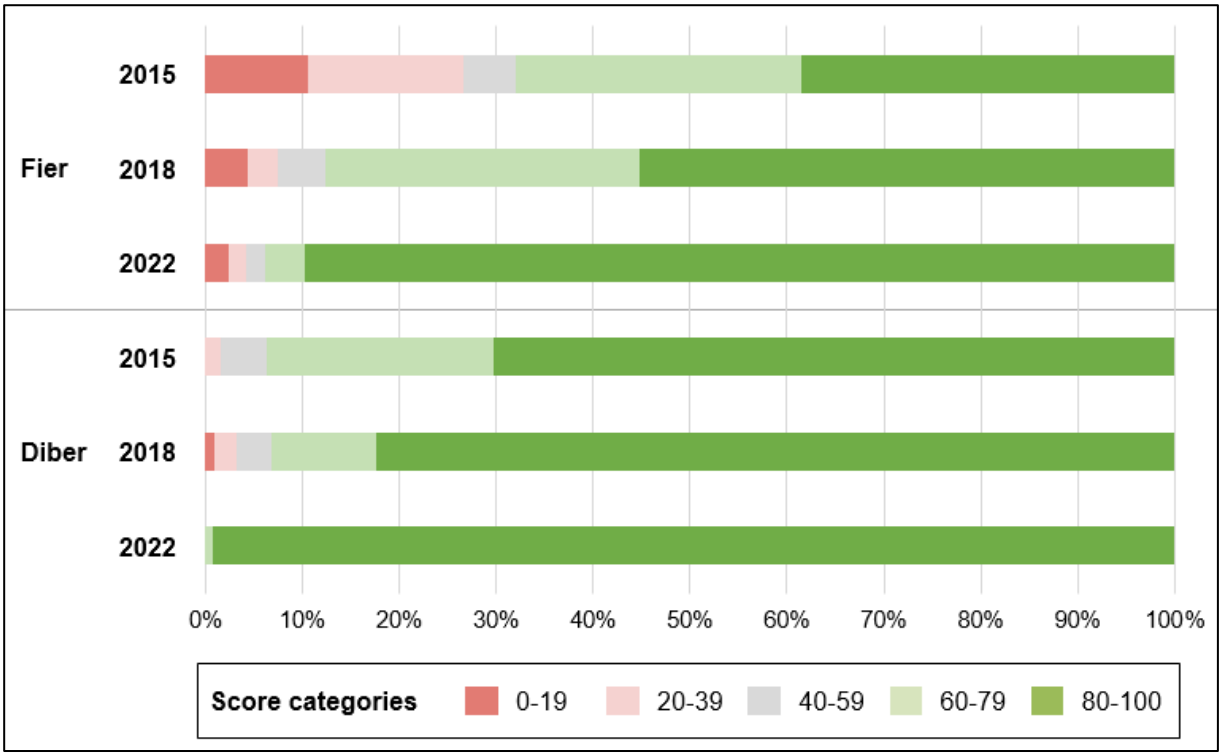


Figure 29: Consultations for other conditions: examination scores

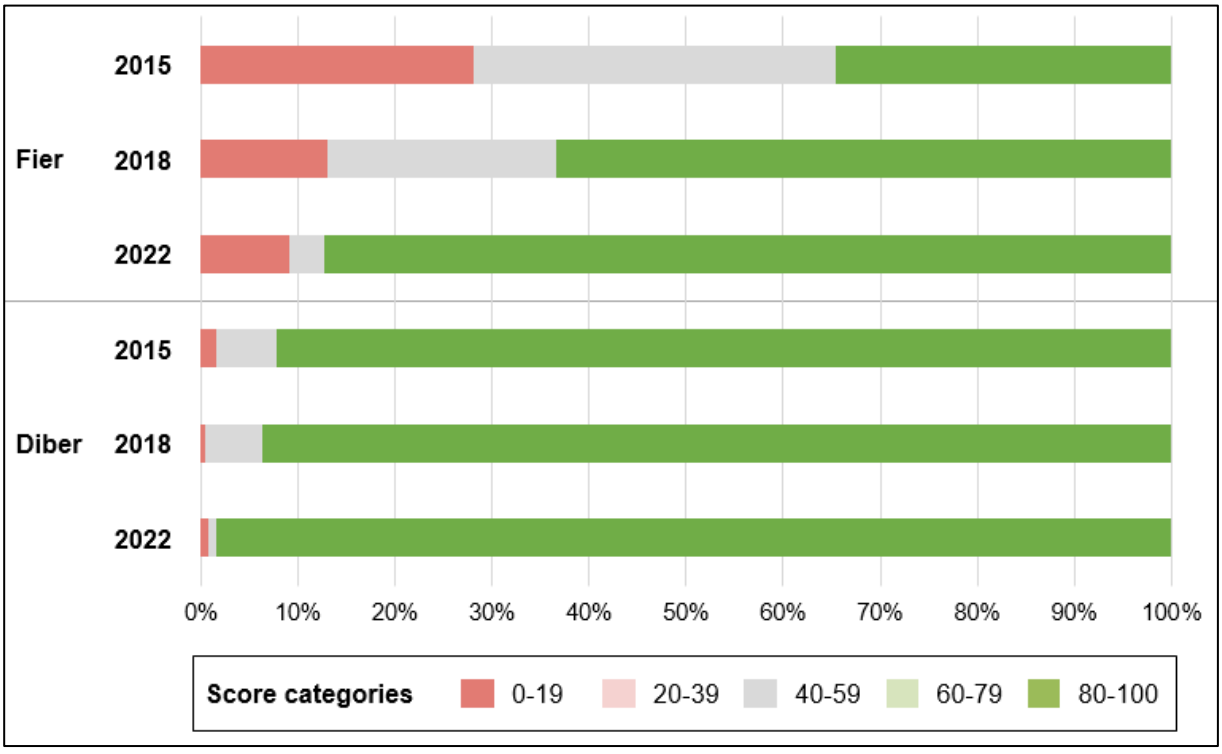


Figure 30: Consultations for other conditions: advice scores

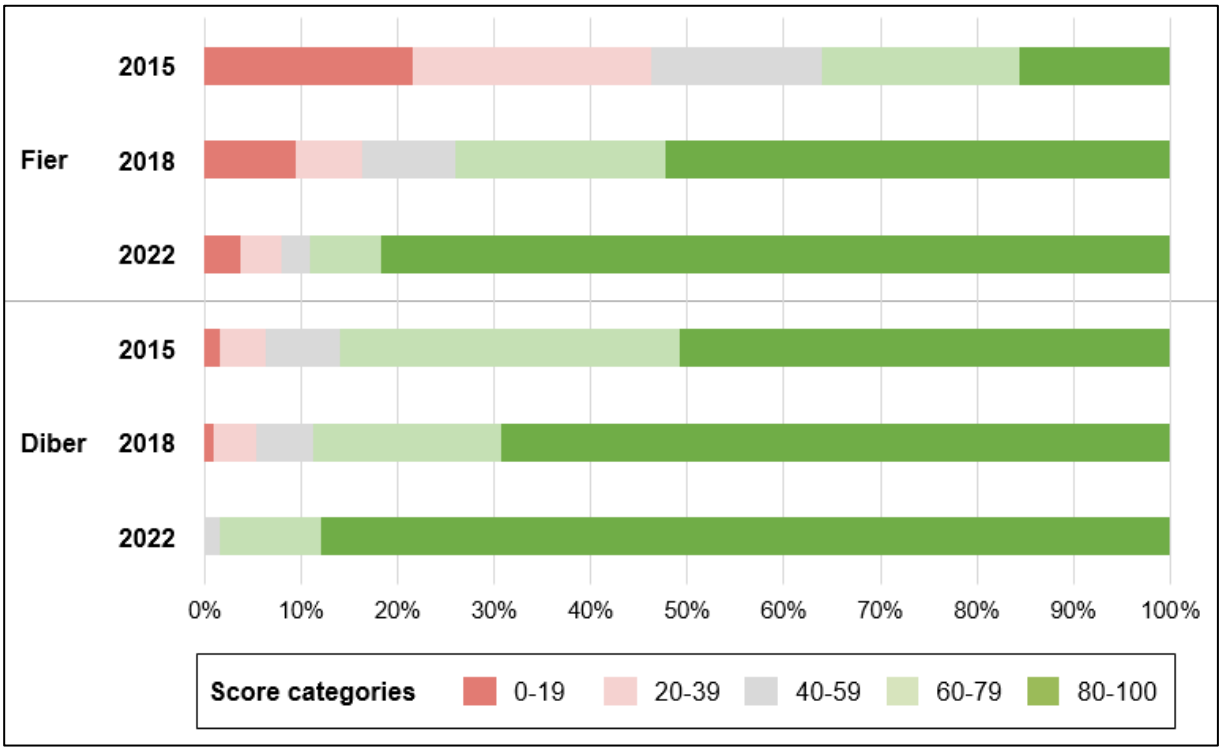
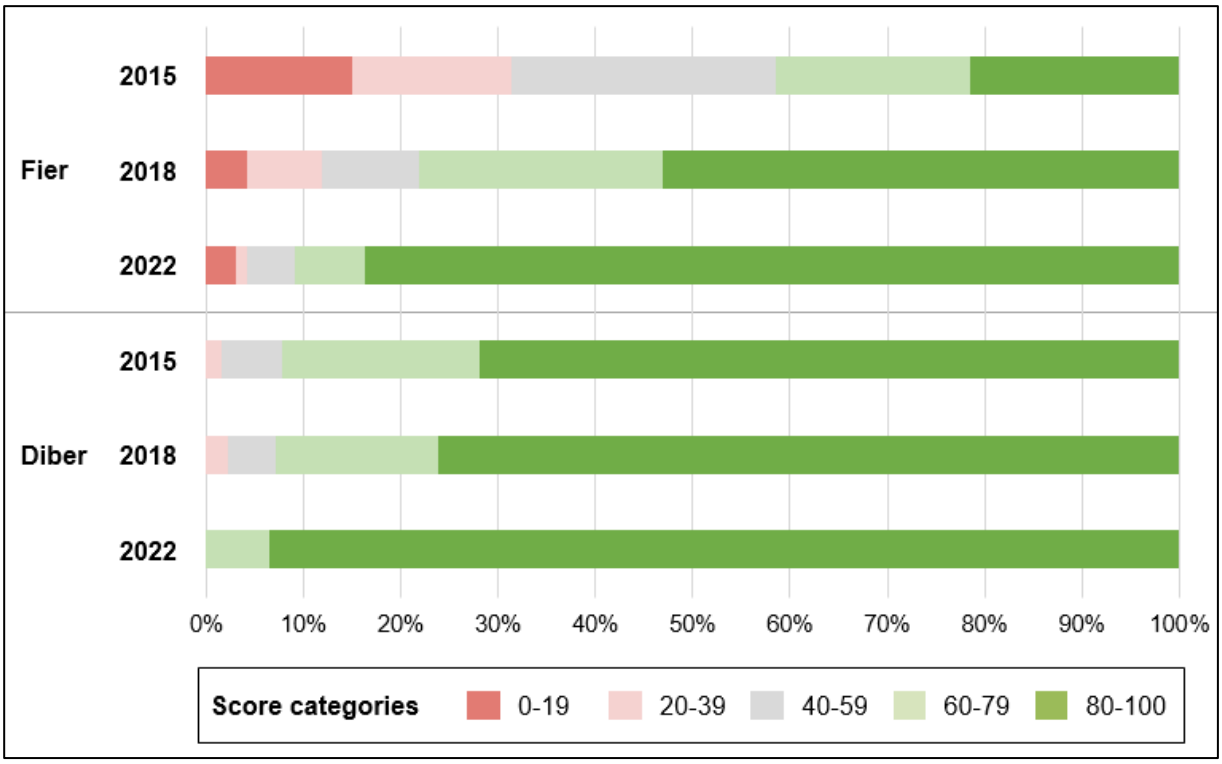


Figure 31: Consultations for other conditions: overall scores



4.2.8 *Overall scores on patient-doctor consultations*

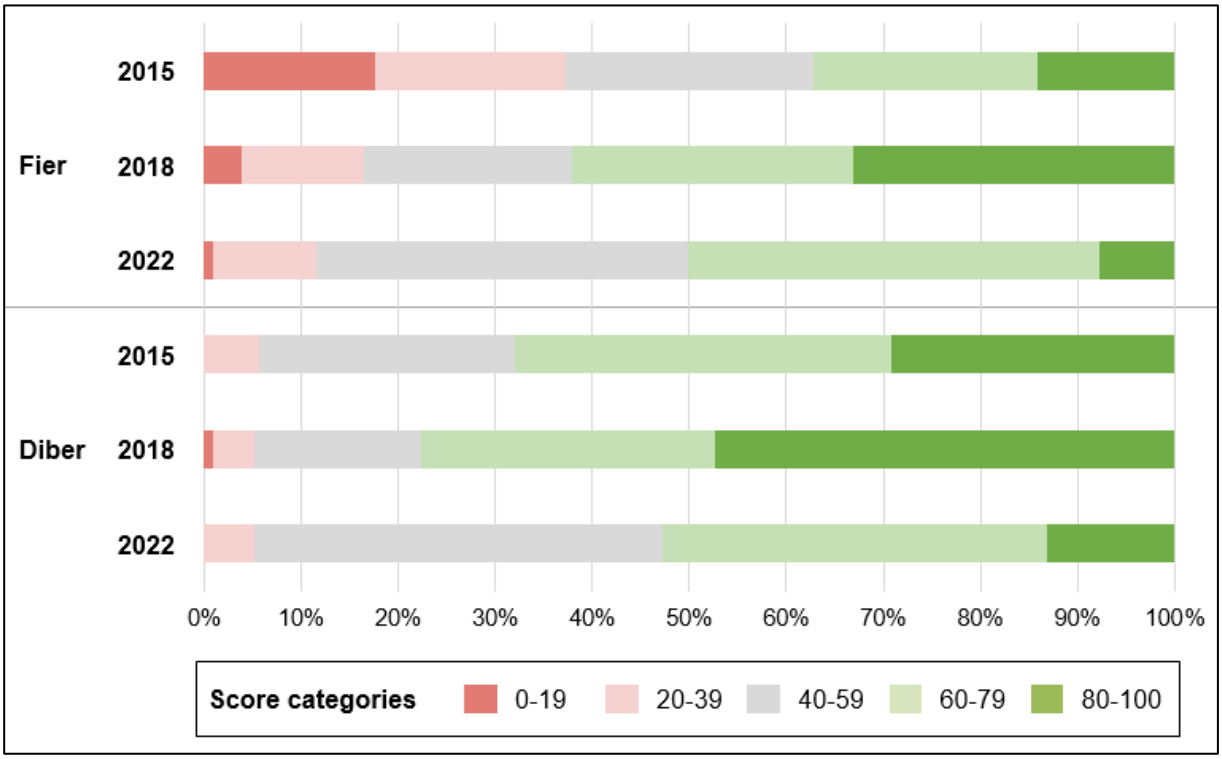
The overall score on patient-doctor consultations resulting from the observations combines the above presented dimensions, namely:

- Principles of clinical history
- Practices on infection prevention and control
- Practices in diabetes consultations
- Practices in hypertension consultations
- Practices in consultations for conditions other than diabetes and hypertension

Figure 32 displays the overall scores for the patient-doctor consultations. The following conclusions can be derived from these results:

- Most scores were best in 2018 with substantial improvements observed in the period 2015 to 2018. There was still a residual effect observed in 2022.
- All surveyed years, doctors in Diber scored better than doctors Fier.
- In 2022, the share of very low scores (i.e. <40) was lower as compared to 2015 and 2018 in all regions.

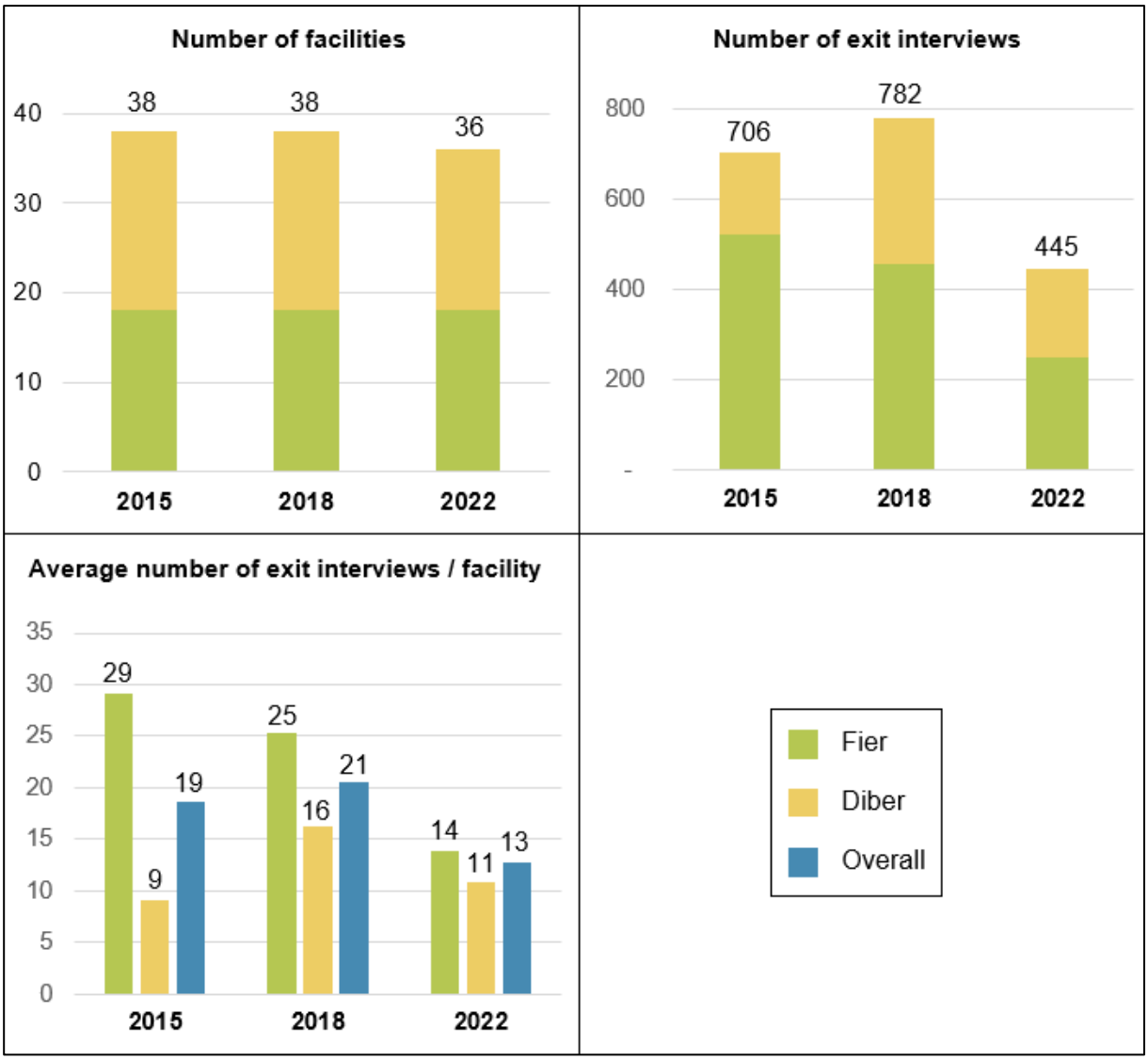
Figure 32: Overall clinical observation score (2015, 2018, 2022)



4.3 Patient exit interviews

In 2022, 445 exit interviews were conducted in 36 HC (Figure 33). The numbers were evenly distributed between the regions. In 2022, therefore, there was a marked decrease of number of exit interviews (-43.1% compared to 2018) and hence, the average number of exit interviews per HC and doctor was lower in 2022 than in previous years. The potential reasons remain the same as described in section 4.1.

Figure 33: Number of HC and exit interviews (2015, 2018, 2022)



4.3.1 *Characteristics of patients*

Patient characteristics assessed, namely gender and age, were similar for all three surveys (Table 9). Every survey year, between 56-60% of exit interview respondents were female. Median age ranged between 52 in 2015 to 59 in 2022.

Educational attainment levels of exit interview respondents improved between 2015 and 2018 and then remained at similar levels in 2022. In 2022, about 40% completed 8-9 years of school, another 40% completed 12 years of school and 10% completed university. In all survey years, pensioners represented the biggest respondent group (2015: 33.2%; 2018: 40.5%; 2022: 44.8%).

In 2022, 3.8% of respondents reported to belong to an ethnic or linguistic minority, hence, comparable to 3.0% in 2015 and 4.3% in 2018.

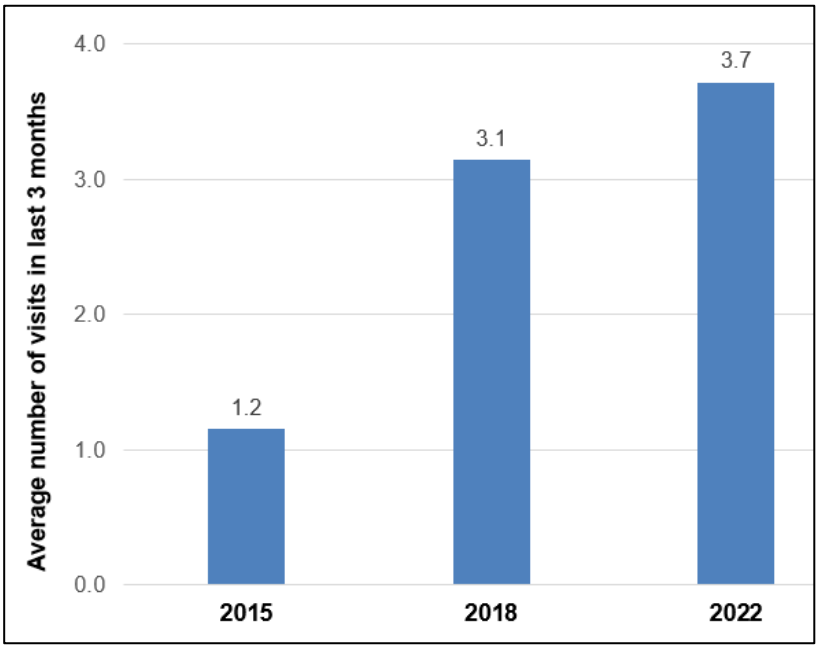
Table 9: Patient age groups, median age and gender (2015, 2018, 2022)

	2015		2018		2022	
	N	%	n	%	n	%
Age groups						
<1 year	56	7.9	14	1.8	13	2.9
1-5 years	47	6.7	17	2.2	23	5.2
6-18 years	72	10.2	31	4.0	28	6.3
19-49 years	148	21.0	227	29.3	92	20.7
>49 years	382	54.2	485	62.7	289	64.9
Median age in years	**52**		**56**		**59**	
Gender						
Male	309	43.8	337	43.4	178	40.0
Female	397	56.2	439	56.6	267	60.0
Educational attainment						
Never attended school	100	14.2	22	3.8	1	0.3
Completed primary school (max 5 years)	85	12.1	61	10.5	34	8.9
Completed compulsory school (8/9 years)	210	29.8	240	41.2	154	40.3
Completed high school (12 years)	199	28.3	189	32.5	149	39.0
Completed college/university	51	7.2	62	10.7	38	10.0
Other	59	8.4	8	1.4	6	1.6
Occupation						
Farmer	25	3.6	31	4.6	16	4.2
Employed	35	5.0	81	12.1	54	14.1
Self-employed	18	2.6	18	2.7	15	3.9
Governmental employee	18	2.6	16	2.4	7	1.8
Housewife	82	11.6	106	15.8	58	15.2
Unemployed	87	12.3	119	17.8	44	11.5
Pensioner	234	33.2	271	40.5	171	44.8
Belonging to an ethnic or linguistic minority	**21**	**3.0**	**33**	**4.3**	**17**	**3.8**

4.3.2 *Use of health care services*

As in previous survey years, the majority of the patients (66.7%) in the 2022 survey had visited the health center for 1-3 times in the past three months (2015: 55.5%; 2018: 75.0%). In 2022, more patients visited the HC more than 3 times (33.3% compared to 24.5% in 2018 and 29.9% in 2015). On average, respondents visited the HC 3.7 times in the 3 months preceding the survey, compared to 3.1 times in 2018 and 1.2 in 2015. Thus, even though there seem to be less visits the the health centers (see section 4.2), there was a steady increase of the number of consultations per individual observed over the surveyed period.

Figure 34: Average number of visits of exit interview respondents in the 3 months preceding the survey (2015, 2018, 2022)



The most common reason for the visit to the health center at the day of the survey among the exit interview respondents were chronic conditions (42.6% in 2015; 48.5% in 2018; 41.4% in 2022; Table 10). This was followed by 'other reasons', where routine medical check-ups are included.

Table 10: Reasons for health center visits on survey day (2015, 2018, 2022)

	2015		2018		2022	
	n	%	n	%	n	%
Chronic condition	301	42.6	376	48.5	184	41.4
Antenatal care	15	2.1	22	2.8	7	1.6
Child Health	136	19.3	60	7.7	52	11.7
Vaccination (excluding Covid-19)	29	4.1	16	2.1	32	7.2
Other	225	31.9	302	38.9	170	38.2

4.3.3 *Satisfaction with health services*

When patients were asked about their overall satisfaction with the services received, in 2022, 73.6% stated they were very satisfied and 23.5% were satisfied (Table 11). This was comparable to 2018 (68.4% were very satisfied and 26.0% satisfied; indicator was not assessed in 2015).

HAP has conducted at least three measurements (2015, 2018, and 2022) in relation to patients' satisfaction with PHC services, and the findings do not fluctuate a lot. 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 (e.g. in some parts of Diber), access to services is challenging, so users tend to be satisfied with whatever is offered to them. In addition, the Covid-19 pandemic might also have influenced this satisfaction (see section 4.3.5), as patients perceived that more services are offered, including home-based care and telephone-consultations, and that staff was more friendly.

Table 11: Satisfaction with health services received (2018, 2022)

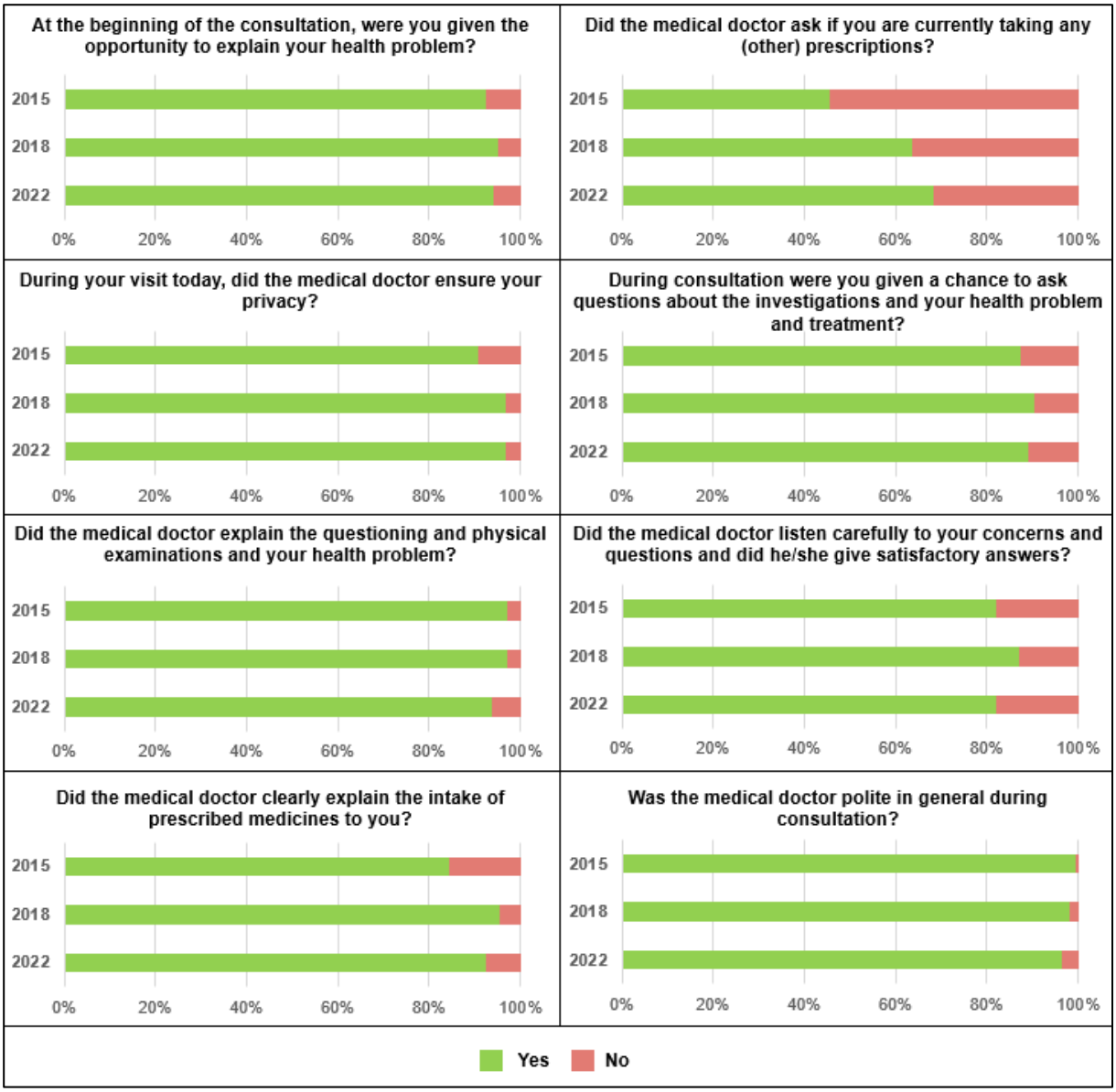
	2018	2022

	n	%	n	%
Very unsatisfied	37	4.8	6	1.4
Unsatisfied	6	0.8	7	1.6
Satisfied	202	26.0	104	23.5
Very satisfied	531	68.4	326	73.6

Figure 35 displays eight different indicators on doctor's behaviours' during the consultation from the patients' perspectives and their evolution over the surveyed years. The following results stand out when comparing over the years:

- The patients largely reported overall 'positive' behaviours of the doctors, as in 2022, approval rates for the behaviours considered 'as should' are all 60% and above.
- The most marked improvements were registered with regard to medications: whether or not a patient is taking medication was asked more frequently and the intake of prescribed medicines was explained more often.
- Ensuring of privacy by the doctor has increased over the years and was 90.8% in 2022.
- The politeness of the medical doctors' showed a negative trend over the surveyed years.

Figure 35: Indicators on doctor's behaviours' during the consultation (2015, 2018, 2022)



A combined satisfaction score for the eight 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 (Figure 36). Mirroring the above results for the individual indicators, overall:

- Satisfaction in exit interviews was high in both regions and was higher than in the 2015 baseline.
- Satisfaction was constantly slightly higher in Diber than in Fier with similar patterns in 2018 and 2022.
- When only looking at the patients that consulted the HC for chronic conditions (Figure 37), there is a tendency that satisfaction is even higher than for all consultations.

Figure 36: Overall satisfaction score, all consultations (2015, 2018, 2022)

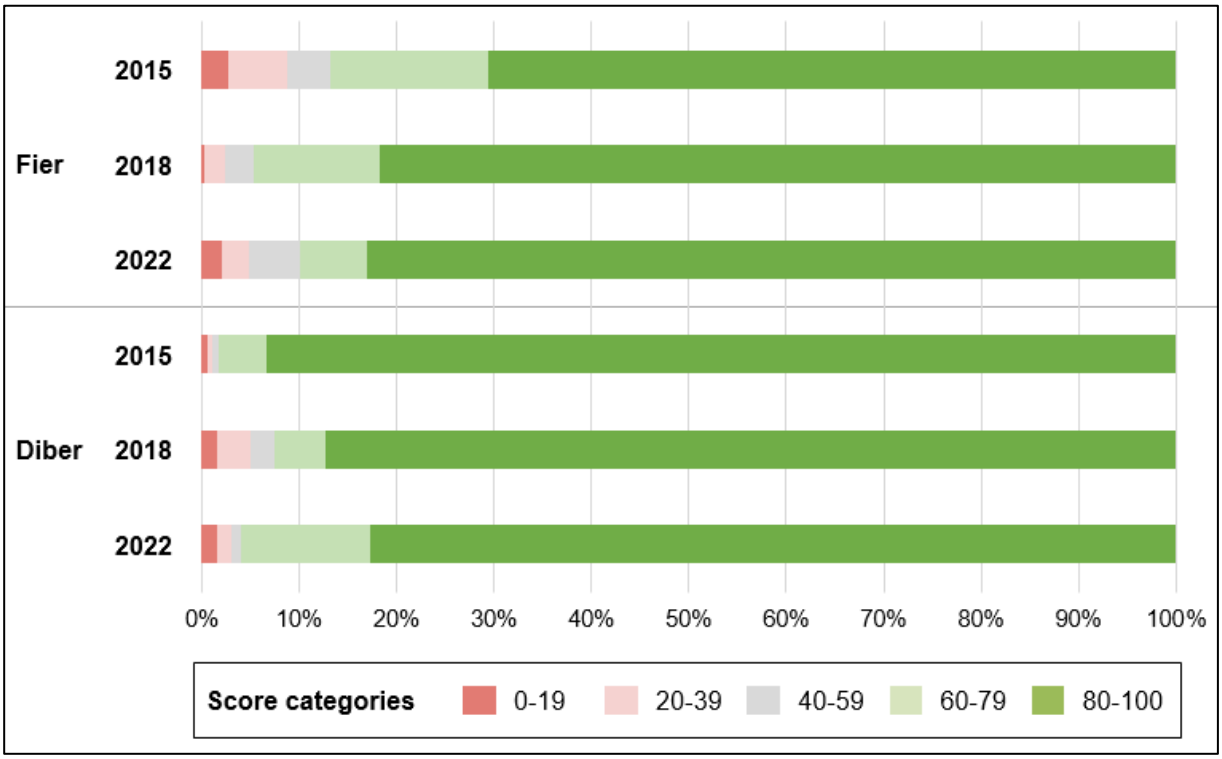
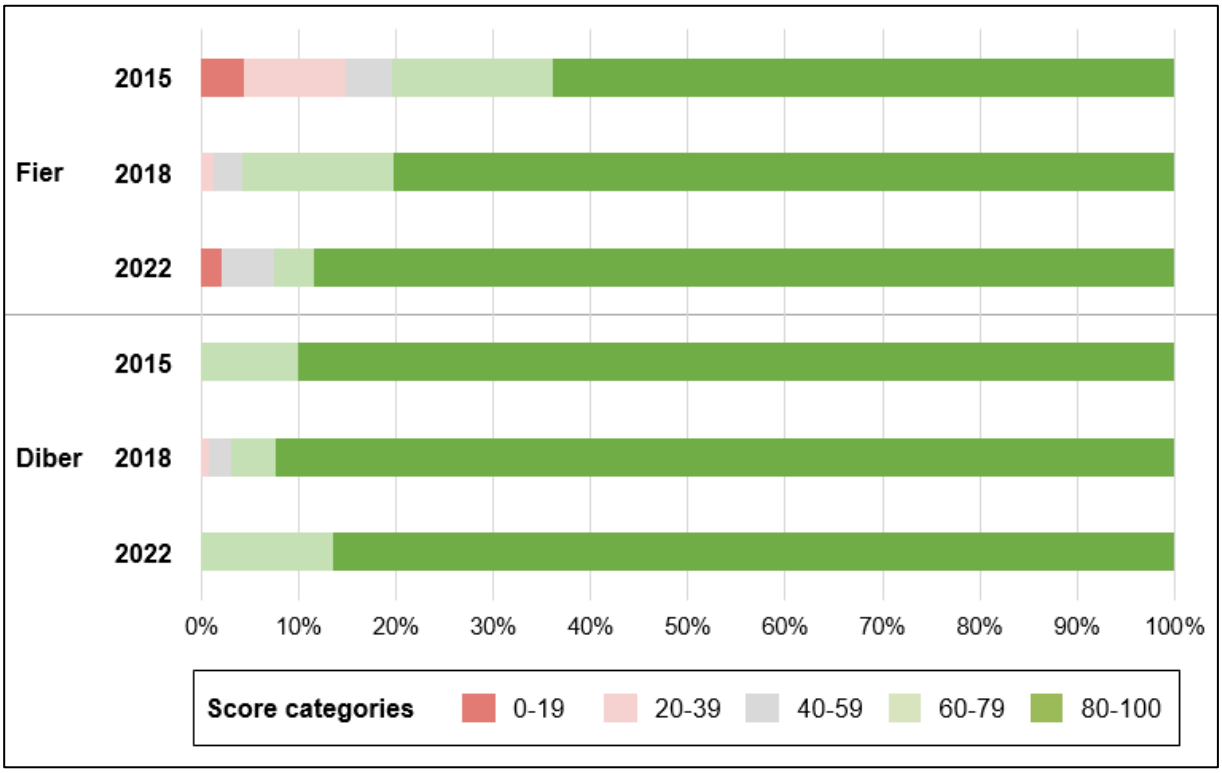


Figure 37: Overall satisfaction score, consultations for chronic conditions (2015, 2018, 2022)



4.3.4 *Health spending and health insurance*

Across all survey years, a very small percentage reported to have paid for their consultation on the day of the survey: 1.8% in 2015, 0.3% in 2018 and 2.0% in 2022. At the same time, 91.1% (2015), 84.3% (2018) and 81.3% (2022) 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, 15.2% (2015), 24.0% (2018) and 18.1% (2022) reported to benefit from an economic or social aid scheme.

4.3.5 *Effects of the Covid-19 pandemic*

The Covid-19 pandemic, which started in late 2019 / early 2020, had an immense effect on the health systems and service provision worldwide [9]. 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 HC were focusing their efforts on service provisions 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.

Results shown in Table 12 suggest that Covid-19 had different effects in the two regions. In Fier, health care providers were perceived to have more time for consultations (19.0%) and also to be friendlier / less stressed (44.9%). The latter was also perceived by 20.4% in Diber. There was between a forth and a fifth of patients in Fier that agreed that waiting times for consultations were longer or shorter, respectively, while in Diber, there was no noticeable change in the waiting times. In Diber, there was a strong perception that more services were offered (56.6%), which is likely due to the home visits done during the pandemic. This was less accentuated in Fier (14.6%). Few patients in Fier perceived that service costs have changed, whilst this was not at all noticed in Diber.

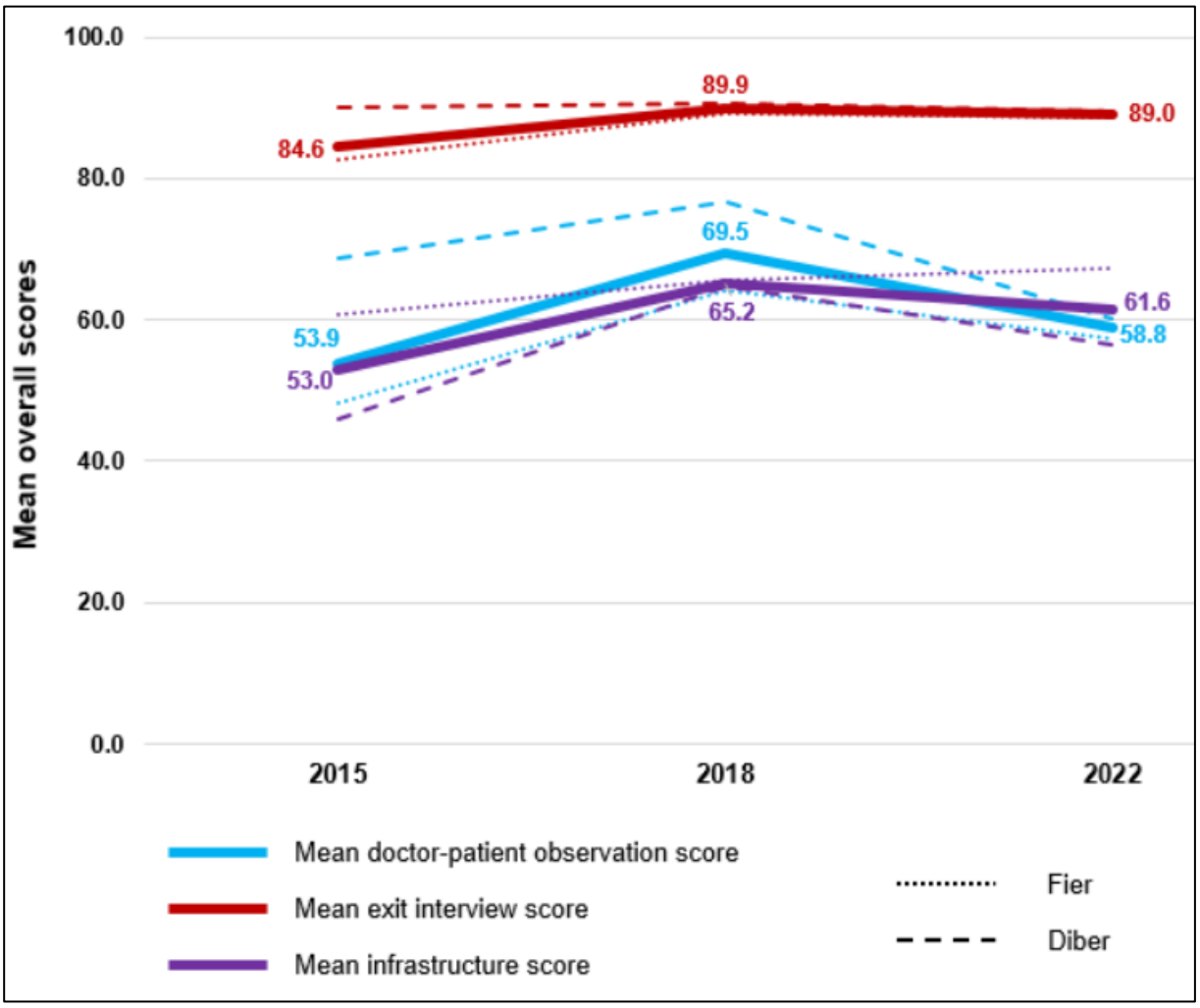
Table 12: Effects of Covid-19 on the availability of services offered according to patients (2022)

	Fier		Diber		Total	
	n	%	n	%	n	%
(Some) services were no longer offered	2	0.8	5	2.6	7	1.6
Additional services were offered	36	14.6	111	56.6	147	33.2
Waiting times for consultation (longer)	62	25.1	7	3.6	69	15.6
Waiting times for consultation (shorter)	80	32.4	8	4.1	88	19.9
Health care providers have less time for consultations	9	3.6	18	9.2	27	6.1
Health care providers have more time for consultations	47	19.0	2	1.0	49	11.1
Health care services are more expensive	3	1.2	0	0.0	3	0.7
Health care services are less expensive	8	3.2	0	0.0	8	1.8
Health care providers are less friendly / more stressed	6	2.4	3	1.5	9	2.0
Health care providers are more friendly / less stressed	111	44.9	40	20.4	151	34.1

5 CONCLUSIONS

The mean overall scores for each dimensions of QoC by year and by region are summarized in Figure 38.

Figure 38: Mean overall scores by year and region



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

- The quality of the doctor-patient interaction increased markedly between 2015 (mean score: 53.9) and 2018 (mean score: 69.5). However, in 2022, a decrease of the quality of this interaction was observed (mean score: 58.8), although remaining higher than 2015 levels.
- The quality of the doctor-patient interaction was markedly higher in Diber than in Fier in 2015 and 2018. In 2022 however, the quality of this interaction seem to have decreased as well.

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

- The patient satisfaction score was the highest achieving score, compared to the doctor-patient observation and the infrastructure score, across all years and both regions.
- Between 2015 and 2018, patient satisfaction has slightly increased from 84.6 score points to 89.9 score points, and remained at 89.0 points in 2022.
- Regional differences were only found in 2015, where satisfaction was higher in Diber than in Fier.

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

- The infrastructure score showed marked improvement between 2015 and 2018, certainly partly due to HAP investments in infrastructure (e.g. 12 HC were rehabilitated).
- The infrastructure score remained relatively stable in 2022 at 61.6 mean score points, indicating an only slight decrease since 2018.
- HC in Fier consistently achieved higher mean scores than in Diber, especially though in 2015 and 2022 (67.2 mean score in Fier vs 56.6 mean score in Diber for the latter).

The findings of this 2022 survey reveal dimensions or topics of the current QoC in HC that would benefit from further investments, interventions, or reinforcement.

6 REFERENCES

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7 ANNEXES

7.1 Ethical approval

REPUBLIKA E SHQIPËRISË
MINISTRIA E SHËNDETËSISË
DHE MBROJTJES SOCIALE

KOMITETI I ETIKËS

Nr. 131/43 Prot Tiranë, më 18 08 2022

Lënda: Shqyrtim dhe miratimi i studimit

Dr. Besim Nuri

Menaxher i projektit HAP

Rruga:' Themistokli Gërmenji"

Pallati Helios, Ap 2/1

Tiranë

Komiteti i Etikës, në mbledhjen e datës 23 Korrik 2022, mori në shqyrtim kërkesën dhe dokumentacionin e paraqitur nga Dr. Besim Nuri, Menaxher i projektit HAP, në cilësinë e Investiguesit Kryesor për studimin me titull: "Anketa për vlerësimin e cilësisë së shërbimit në Kujdesin Parësor në rajonin Fier, Dibër, Shqipëri 2022 ".

Komiteti i Etikës shqyrtoi dokumentacionin me nr. 131/ 33 prot., datë 13.07.2022 për studimin me titull : " Anketa për vlerësimin e cilësisë së shërbimit në Kujdesin Parësor në rajonin Fier, Dibër, Shqipëri 2022 ". Qëllimi është realizimi i indeksit të kënaqësisë së pacientit në qarkun Dibër dhe Fier.

Anëtarët e Komitetit të Etikës në takimin e datës 23 Korrik 2022, konstantuan se janë përmbushur të gjitha kushtet për lëshimin e miratimin e studimit dhe votuan unanimisht **Pro** për studimin me titull: Anketa për vlerësimin e cilësisë së shërbimit në Kujdesin Parësor në rajonin Fier, Dibër, 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 studimit me titull: "Anketa për vlerësimin e cilësisë së shërbimit në Kujdesin Parësor në rajonin Fier, Dibër, Shqipëri 2022 " për fillimin e studimit sipas kushteve të paraqitura në protokollin përkatës.

7.2 Score indicators

Table 13: 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 control 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 14: 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 15: 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 16: Indicators for general medical equipment (available and functional)

1	Microsurgery
2	Nebulizer
3	Ambu mask
4	Strong source of light in good condition (portable)
5	Nasal speculum
6	Otoscope
7	Ophtalmoscope
8	Glucometer
9	Peak flow meter
10	Pen light
11	Neurological hammer
12	Weight scale for adults
13	Weight scale for children (over 2 years old)
14	Weight scale for infants and toddlers (up to 2 years old)
15	Stadiometer for grown up children
16	Sphygmomanometer for children
17	Sphygmomanometer for adults
18	Stethoscope for children
19	Stethoscope for adults
20	Obstetrical stethoscope
21	Sterilization equipment and anti-septical protocol
22	Refrigerator
23	Vaccine refrigerator/portable
24	Height meter board for children (up to two years old)
25	Meter for height measuring (children over two years of age)
26	Thermometer
27	Tuning fork
28	Table for vision testing
29	Ear syringe
30	Scissors
31	Timer
32	Pelvimeter
33	Children growth chart
34	Fracture rods
35	Tongue depressor
1-35	**Overall score on 'General medical equipment' (35 in total)**

Table 17: Indicators for basic medical consumables

1	Surgical cotton (100% hydrophilic cotton, pack 100g)
2	Plastic perfusion system
3	Plastic syringes +2 needles 3ml
4	Plastic syringes +2 needle 5ml
5	Plastic syringes +2 needle 10ml
6	Thread for stitching wounds
7	Surgical gloves
8	Bandages 10cm x 10m (100% absorbed cotton, density 24x20)
9	Adhesive bandages 10cm x 15m (Non-flowable porous, elastic piece. Adhesive side covered with detachable paper)
10	Gauze 91cm x 100m (100% absorbed cotton, density 24x20)
1-10	**Overall score on 'Basic medical consumables' (10 in total)**

Table 18: Indicators for gynaecological services equipment (available and functional)

1	Gynaecological bed
2	Gynaecological instruments

3	Oxygen tank (tube)
4	Inhalator for salbutamol with the mask and the appropriate dosage instrument
5	Vaginal speculum, small size
6	Vaginal speculum, medium size
7	Vaginal speculum, large size
8	Pap smear materials: (brush, spatula, holder)
1-8	**Overall score on 'Gynaecological services equipment' (35 in total)**

Table 19: Indicators for equipment to assess and monitor child development (available and functional)

1	Box of blocks in different colors
2	Rattle, small red ball hung in a piece of thread
3	Book with simple illustrations or some sheets of colour paper with illustrations, i.e. a flower, a girl, a car, a cat, etc.
4	Large and thin pencils, sheets of paper for drawings
5	Doll
6	Hairbrush
7	Small plate and spoon
8	Cups
9	Simple puzzles with 2-3 pieces
10	Sheet with stripes and shapes
1-10	**Overall score on 'Equipment to assess and monitor child development (10 in total)**

Table 20: Indicators for the availability of drugs

1	Water for injections - 2 ml
2	Atropin sulphat 0.1% - (1 mg / 1ml)
3	Glucose (Solution for infusion 5% - 500 ml)
4	Glucose (Solution for injection 4g/10ml-10ml)
5	Diazepam (Solution for injection 10mg/2ml - 2ml)
6	Adrenaline (Solution for injection 1 mg/ml - 1 ml)
7	Furosemid (Solution for injection 20 mg/2 ml - 2ml)
8	Sodium Chloride (Solution for injection 85mg/10ml)
9	Sodium Chloride (Solution for infusion 9g/1000ml - 500ml)
10	Magnesium Sulphate (Solution for injection 2.5g/10ml - 10ml)
11	Nitroglycerin (0.3mg/tab)
12	Phytomenadione (Vitamin K) (Solution for injection 1% - 1ml)
13	Dexamethasone sodium phosphate (Solution 4mg/ml - 1ml)
14	Prednisolon (25mg/2ml)
15	Aminophylin (250mg/10ml)
16	Serum antitetanous (Human tetanus immunoglobulin) (Solution for injection 250 IU/1ml)
17	Viper venom antiserum (Solution for injection glass vial X 5ml)
18	Haloperidol (Solution for injection 5mg/ml - 1ml)
19	Metoclopramide hydrochloride (Solution for injection 10mg/2ml - 2ml)
20	Metoclopramide hydrochloride (Solution for injection 10mg/2ml - 2ml)
21	Acetylsalicylic acid (500mg/tab)
22	Morphine hydrochloride (Solution for injection 10mg/ml - 1ml)
23	Tramadol hydrochloride (Solution for injection X 100mg/2ml - 2ml)
24	Diclofenac sodium (Solution for injection 75mg/3ml)
25	Salbutamiol (as Salbutamol sulphate micronised) (Suspension inhalues i presuar 100µg/actuation - 200 doses)
26	Dihidroergotamine (1mg/ml)
27	Papaverin hydrochloride (Solution for injection 40mg/ml - 1ml)
28	Oxytocine (Solucion për I.M./I.V. injection 10 IU/1ml)
29	Alcohol ethilic (70%-100 ml/1000ml)
30	Providone Iodine (Solucion cutan 10g/100ml)

31	Chlorpheniramine Maleate (4mg/tab)
32	Silver sulphadiazine (Krem 10mg/g - 50 mg)
33	
34	Hidrokortizon (1% - 10mg/g - 30g)
35	Acetaminophen (Paracetamol) (500mg/tab)
36	Acetaminophen (Paracetamol) (100 mg/suppost)
37	Magnesium Hydroxide+Aluminum Hydroxide (400mg+400mg/tab)
38	Ranitidine hydrochloride (Solution for injection 50mg/2ml - 2ml)
39	Silver Nitrate (Nitrat Argjendi)
40	Atenolol (100 mg/tab)
41	Nifedipin (10 mg/tab)
42	Hyoscine butylbromide (Solution for injection 20mg/ml - 1ml)
43	Lanatoside C (Solution for injection 0.4mg/2ml - 2ml)
44	Amiodaron hydrochloride (200 mg/tab)
45	Folic Acid (5mg/tab)
46	Hydrogen peroxide 3% (Solution 30mg/ml - 100ml)
47	Oxygen tank
48	Nebulizer or volume pump
1-48	**Overall score on 'Availability of drugs' (48 in total)**

7.3 Additional tables

Table 21: Patient age groups

Age group	2015		2018		2022	
	Fier	Dibër	Fier	Dibër	Fier	Dibër
<5	8.0% (36)	16.6% (29)	7.6% (37)	7.3% (26)		
5-18	7.1% (32)	11.4% (20)	4.7% (23)	8.2% (29)		
19-49	17.3% (78)	25.7% (45)	21.7% (106)	26.8% (95)		
50-65	25.6% (160)	26.3% (46)	34.8% (170)	30.8% (109)		
>65	32.0% (144)	20.0% (35)	31.2% (152)	26.8% (95)		

Table 22: Adherence to principles of history and physical examination (2015, 2018, 2022)

The medical doctor…	2015		2018		2022	
	n	%	n	%	n	%
… greets the client	604	96.3	841	99.9	413	99.8
… sees the client in privacy/confidentiality.	440	66.4	780	91.9	413	99.8
… makes the client comfortable (e.g. seat offered)	528	82.0	828	98.1	403	97.8
… asks the client about concerns, allows client to explain his/her health issue.	553	86.3	822	97.5	406	98.8
… has the patient medical record	n/a	n/a	684	81.2	268	64.9
… uses the patient medical record for anamnesis	n/a	n/a	606	72.0	179	43.7
… closes politely the consultation	586	93.3	768	91.2	404	97.6

Table 23: Scores on adherence to principles of history and physical examination (2015, 2018, 2022)

Score	2015		2018		2022	
	Fier	Diber	Fier	Diber	Fier	Diber
0	2.7	0.6	0.0	0.0	0.0	0.0
25	6.8	0.6	1.0	0.3	0.0	0.5
50	11.5	2.9	1.6	0.0	0.5	0.5
75	22.7	6.9	10.7	3.1	6.0	4.6
100	56.3	89.1	86.7	96.6	93.6	94.4

Table 24: Infection prevention and control practices

The medical doctor…	2015		2018		2022	
	n	%	n	%	n	%
… washed hands before or after the procedure (including use of soap)	30	6.0	131	15.6	110	26.6
… applied proper decontamination procedures (e.g. soaking contaminated instruments into a bucket with chlorine or any other disinfectant)	0	0.0	44	10.6	47	11.4
… put on gloves where required	3	3.9	13	4.6	13	3.1
… put on a mask where required	0	0.0	9	3.9	50	12.1