Access to Health Services in Diber and Fier Regions

Baseline Evaluation Report – Health for all Project

Sabine Kiefer

30 September 2016

Financed by the Swiss Agency for Development and Cooperation

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Swiss Agency for Development and Cooperation SDC

Contacts

Health for All Project (HAP)
Project implementation Unit
Themistokli Germenji St.
Tirana, Albania

Dr. Joao Costa
Project manager

Joao.costa@swisstph.org

Swiss Tropical and Public Health Institute
Socinstrasse 57
4002 Basel, Switzerland

Website: www.swisstph.ch

Prof. Dr. Kaspar Wyss
Senior Public Health Specialist
Head of Department
Swiss Centre for International Health

Tel: +41 61 284 81 40

kaspar.wyss@unibas.ch

Terre des hommes
Avenue de Montchoisi 15
1006 Lausanne, Switzerland

Website : www.Tdh.ch

Mr. Thierry Agagliate
Program Manager

Tel : + 41 58 611 06 31
thierry.agagliate@Tdh.ch

Save the Children Schweiz
Sihlquai 253
8005 Zürich, Switzerland

www.savethechildren.ch

Ms Martina Frank
Senior Health Programme Officer

Tel: + 41 44 267 74 89
martina.frank@savethechildren.ch

Acknowledgements

The report was developed under the guidance and inputs of several people: Kaspar Wyss, Besnik Kadesha, Ardita Kongjonaj, Joao Costa and Ehad Mersini. We would further like to acknowledge the previous work of Barbara Matthys on the knowledge and behaviour on chronic conditions on which one component of the data collection heavily draws. Further Ms. Emira Galanxhi, Social Statistics Director of INSTAT, Albania provided valuable comments that have improved the design of the study.

The data collection was done by EUNACAL Institute. Particularly we would like to highlight the commitment and professionalism of Alban Nelaj, as national supervisor and coordinator. We are further indebted to our interviewers and the regional supervisors (Corbin Kappler - Diber & Klodiana Tosuni - Fier) who have been working day by day in the field. Without the dedication of interviewers and supervisors this survey would not have been possible. They all have been supported by a number of staff, including drivers and technical staff to whom we would also like to express our thanks.

Lastly we would greatly like to thank all participants in the study who patiently answered our questionnaire and who have been welcoming and friendly to our interviewers.

Disclaimer

Although this study has been commissioned by the Swiss TPH, Terres des hommes and Save the Children under a contract with the Swiss Agency for Development and Cooperation, these entities bear no responsibility for, and are not in any way, committed to the views and recommendations expressed herein, which are the responsibility of the author of this report.

Table of Contents

List of Tables

List of Figures

Executive Summary

Background

The Health for All Project (HAP) aims to increase the health of the Albanian population, including the most vulnerable, by improving primary care services and health promotion activities. The project was launched in 2015 and the implementation period is foreseen for four years.

To track the project outputs and outcomes a baseline measurement was conducted to inform the log-frame. A household survey was part of this baseline assessment. The survey was conducted with the aim to assess a) the health situation and management of chronic diseases and acute illnesses of those affected in Diber and Fier region; b) health seeking behaviour and access barriers to health care for chronic diseases and acute illnesses; and c) knowledge, attitude and practice on diabetes, hypertension and child development.

Methods

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

Key results

The Albanian household survey collected information from 1'275 households and 5'188 individuals living in those households. Detailed information was obtained from 1'096 individuals with at least one chronic disease, and 175 persons who had in the four weeks prior to the survey been suffering from an acute health problem. Information on mother and child care was obtained from 161 mothers of children under 5 years.

Households & household members

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

Chronic and acute conditions

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

- Satisfaction with health services among individuals with chronic conditions was higher than for among individuals with acute conditions (20% vs. 32% were slightly unsatisfied or satisfied).
- Total median expenses for chronic conditions in the past four weeks were 25 Euros and therewith almost twice as high as for acute conditions (14 Euros). In both cases expenditures for drugs was the most important cost driver (72% for chronic conditions and 70% for acute conditions). The median treatment or admission costs were in both cases zero, but proportionally they ranged between 12% for chronic conditions and 19% for acute conditions. Median transport costs were for chronic conditions higher than for acute conditions.
- Total median costs for patients with chronic or acute conditions varied depending on the health insurance status of the person. Having a health insurance card reduced the associated costs for chronic and acutely ill patients substantially.

Mother & child health

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

Knowledge, attitude and practice

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

Conclusion

The household survey provides a comprehensive data collection that once more emphasises the importance of the public health sector in Albania. Even more so, should challenges, barriers and difficulties for accessing the services or trusting the services be actively addressed. A main focus should thereby be given to financial barriers, the quality of services and the coverage of health insurance.

1 Background and objectives

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

Expected outcomes of the project are:

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

HAP has adopted a results-oriented reporting system focusing on outcome monitoring with reference to the Logical Framework, work plans and respective budget. The achievements, progress and outcomes of the project shall be measured against defined indicators. As the project implementation phase started in January 2015, a baseline measurement was conducted against which the progress - at the end of the implementation period in 2018 - can be measured. The baseline assessment included data from secondary data sources (e.g. from the Health Insurance Fund) but also entailed specific primary data collections: a study on quality of care and a household survey to estimate family access to healthcare.

This report presents the results of the baseline household survey of family access to health care in the two regions covered by HAP, Fier and Diber. The approach of the study allows (a) to measure changes over time, (b) to stratify results along different regions and socio-demographic groups and (c) to provide detailed information to the HAP implementation unit.

The aim of the survey of family access to health care was to conduct and establish a baseline measurement on key activities of the HAP project against which the success can be measured at the end of the implementation phase (2018) at population level.

Specific objectives of the survey were to assess:

- Health situation and management of chronic diseases and acute illnesses of those affected in Diber and Fier region
- Health seeking behaviour and access barriers to health care for chronic diseases and acute illnesses
- Knowledge, attitude and practice on diabetes, hypertension and child development

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

2 Methodology

2.1 Study area and design

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

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

Figure 1: Territorial administrative map of Qarks of Albania

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

Source: Ministry of Local Affairs

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

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

2.2 Target population and sample size

The design of the sample size built on a representative probability sample allowing for analysis of indicators of access and barriers to health care services. We applied a disproportionate stratified random sampling procedure at the level of the two regions Diber and Fier by sampling the same number of clusters from each stratum independent of its demographic size. The number of clusters was calculated using the equation of Bennett et al. (1991).

For the calculation of the sample size several assumption were made:

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

Hence the study targeted 1'268 chronically ill or who have been acutely ill respondents (634 per region) and respective households. Assuming an average size of 4 individuals living in a household, we expected to obtain information of about 5'072 individuals (including personal and proxy answers). 53 clusters were thus selected from each region, applying a proportional to size random sample within each region (see also Annex D).

2.3 Questionnaire development

Questionnaires were designed to provide relevant indicators of health patterns and health seeking behaviour as well as of barriers to access care to fulfil the requirements

from the HAP log-frame, requirements specified by HAP team members and standards and experiences from other data collections (e.g. DHS).

Overall three electronic data collection forms were developed that contain different questionnaire sections:

ODK Form 1: Household questionnaire covered the following areas:

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

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

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

ODK Form 3: Individual questionnaire for mothers' questionnaire (section 7)

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

The study protocol and draft questionnaires received ethically clearance from the Ministry of Health on the 3rd of September 2015 (see also Annex B: Approval letter from MoH).

To assure the accuracy of the translation, questionnaires were translated into Albanian and back-translated. All instruments have been pre-tested and adapted according to the experience collected during training and pilot testing (20/21 and 23 October 2015).

2.4 Sampling Procedure and Field Data Collection

Data collection was carried out between the 27 October and 8 November 2015. In total 20 interviewers were organized in 5 teams. Each team was headed by one team leader who was responsible for the organization of the team and quality assurance.

An interviewer training was held over a course of two days (20/21 October 2015). Interviewers were trained on good research practice including how to handle informed consent and confidentiality, objectives of the study, selection principles of households

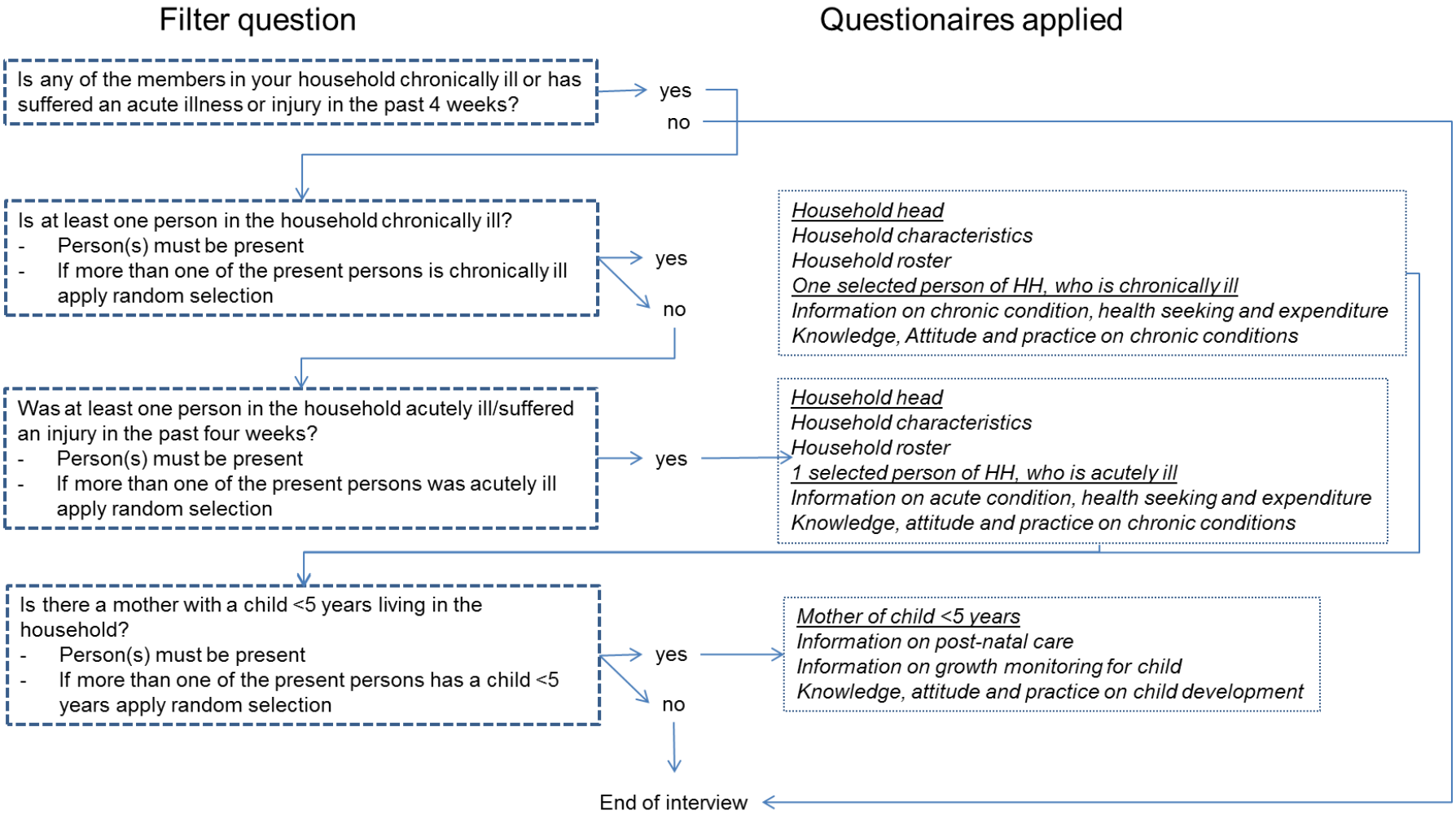
and patients with a chronic or acute condition within the household and the questionnaires. On 23 October 2015 a pre-test was conducted.

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

Once a household contact was successful established, interviewers went through a cascade of filter question that determined which questionnaire forms were relevant for the specific household (see Figure 2).

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

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


Filter question
Questionaires applied
Is any of the members in your household chronically ill or has suffered an acute illness or injury in the past 4 weeks?
yes
no
Is at least one person in the household chronically ill?
- Person(s) must be present
- If more than one of the present persons is chronically ill apply random selection
yes
no
Household head
Household characteristics
Household roster
One selected person of HH, who is chronically ill
Information on chronic condition, health seeking and expenditure
Knowledge, Attitude and practice on chronic conditions
Was at least one person in the household acutely ill/suffered an injury in the past four weeks?
- Person(s) must be present
- If more than one of the present persons was acutely ill apply random selection
yes
Household head
Household characteristics
Household roster
1 selected person of HH, who is acutely ill
Information on acute condition, health seeking and expenditure
Knowledge, attitude and practice on chronic conditions
Is there a mother with a child <5 years living in the household?
- Person(s) must be present
- If more than one of the present persons has a child <5 years apply random selection
yes
no
Mother of child <5 years
Information on post-natal care
Information on growth monitoring for child
Knowledge, attitude and practice on child development
End of interview

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

To answer questions on health (seeking) behaviour for chronic or acute conditions and possible barriers the interviewers selected one member recently acutely ill or chronically ill. In case more than one member was eligible priority was given to the one with the chronic condition. If more than one member living in the household had a chronic condition and was present, a random selection was applied by the interviewer, according to the last birthday method. This person was also the one answering the knowledge, attitude and practice questions on chronic conditions.

In case the household had also a mother with a child 5 years or younger, she was questioned on mother and child health.

The fieldwork (30 October–8 November 2015) was organised and carried out independently from each team according to the work schedule (see Annex D).

Field monitoring was conducted on a daily basis by field supervisors. After the fieldwork, interviewers together with their supervisors submitted the questionnaires to the server using WiFi connections.

2.5 Data analysis

Data collection was done with tablets using ODK software. Hence filters, skips and validity of answers were built into the questionnaire making data cleaning easier. For data analysis we merged the datasets of the different forms according to the birth date of the answering person. The birth date was though prone to error and some manual checks and matching had to be done.

For data analysis we calculated regional and combined estimates and weighted estimates of the two regions for household characteristics and the household roster. The weighting was done according to the population demographic weight of each region.

Socio-economic status was calculated as an index of assets using principal component analysis (PCA). The sample was then stratified along the percentiles over the total sample population.

Data analysis was carried out with STATA. Beyond those uni- and bivariate analyses, tests of significance between the regions were conducted in some instances.

2.6 Ethical considerations

Ethical clearance and authorization was obtained prior to the study from the Albanian Ministry of Health on 3rd September 2015 (see Annex B: Approval letter from MoH).

Oral informed consent was obtained from all respondents at the beginning of the interview. It was pointed out that participation was voluntary and that the respondents could withdraw the participation at any time. The head of the household was also provided with an information letter on the objective and the purpose of the survey and aspects relating to the confidentiality of information.

3 Results

Overall 1'528 households were contacted in the regions Diber and Fier (see Table 1). Interviewers were able to establish a household contact with 91% of households (n=1'387). Of established contacts we experienced a 5% refusal rate, i.e. households were not willing to provide any information to the interviewer. Another 39 households did not fulfil the inclusion criteria (no household member chronically or in the past four weeks acutely ill). Hence we obtained information for 1'275 households and their respective household members (response rate 92%).

Table 1: Overview on sampling of households

	Diber	Fier	Total	Rates
HH contacted	782	746	1'528	
thereof not at homes/no contact	74	67	141	
Established contacts with HH	**708**	**679**	**1'387**	**91%**
thereof No consent obtained	39	34	73	
thereof not eligible or target person not available	27	12	39	
HH Eligible & available households that participate who have at least 1 person chronically or acutely ill	**642**	**633**	**1'275**	**92%**

In total, 5'188 persons lived in these 1'275 households (see Table 2). Within each household, we obtained information from the household head, or his/her closest available representative, on characteristics of the household and socio-demographic information on each household member.

In a next step, we then randomly selected one individual either chronically or acutely ill in the past four weeks to obtain information on access to care patterns, whereby priority was given to those chronically ill (see also section 2.4, Figure 2). Hence in total 1'096 individuals with chronic conditions and 175 individuals with an acute condition in the past four weeks before data collection were included and asked about their type of illness and diagnosis, health seeking behaviour and expenditures for health.

In addition, for questions on knowledge, attitude and practice related to chronic conditions we obtained information from 1,264 individuals as the chronic or acutely ill person answered the interview.

In case a mother of a child under 5 years lived in the household and was available at the time of the interview, we also questioned her on the experienced post-natal care and her health seeking behaviour for child health & development. We thus were able to conduct interviews with 161 mothers of children under 5 years. Mothers also were questioned on their knowledge, attitude and practice related to child growth and development. The following table outlines the specific numbers, stratified by the regions.

Table 2: Denominators and definitions

Questionnaire[3]	Topic	Denominator definition	Diber	Fier	Total
Form 1					
HH Questionnaire	Information on HH characteristics & HH access to care	Households	642	633	1'275
	Information on socio-demographics & characteristics of HH members	Individuals (household roster)	2'968	2'220	5'188
Form 2					
Information on chronic conditions	Type of illness & diagnosis Health seeking & access (barriers) to care Health expenditures	Selected individual reporting a chronic condition	522	574	1'096
Information on acute conditions	Type of illness & diagnosis Health seeking & access (barriers) to care Health expenditures	Selected individual reporting an acute condition in the past 4 weeks	117	58	175
KAP chronic conditions	Knowledge of risk factors Chronic disease knowledge	Individuals chronically or acutely ill	636	628	1,264
Form 3					
Information on mothers & child	Post-natal care Health seeking behaviour for child health & development	Mother with a child <5 years	109	52	161
KAP Mother &Child	Knowledge on child development	Mother with a child <5 years	109	52	161

3.1 Characteristics of households and individuals

We included information on household composition as well as some socio-demographic factors, health and insurance status from 1'275 households (see Table 3) respectively

[3] See also section 2.3 and Figure 2.

5'188 individuals living in those households, thereof 2'968 (57%) in Diber and 2'220 (43%) in Fier (see Table 4). The average number of household members was 4 persons (SD: 1.9) with a minimum of 1 and a maximum of 12 persons listed for a household. Average household size in Diber was higher (4.5; SD: 2.0) than in Fier (3.5; SD: 1.7).

65% (825 of 1'275) of households included in the study where located in rural areas (Diber: 67% (433 of 642); Fier: 62% (392 of 633)). In rural areas household size was slightly higher with an average size of 4.2 (SD: 1.9) compared to urban areas (3.6; SD: 1.7).

More than half of the households receive governmental pensions (56%) followed by income from farming/livestock (40%), salary in Albania (23%) and social aid (22%), despite farming livestock being highly relevant in rural settings and social aid being much more common in Diber than Fier. Remittances are a source of income for about 18% of study households. In Diber there were more households where at least one member benefitted from social or economic aid (Diber: 34%; Fier: 11%). The proportion of those household was also slightly higher in rural areas (rural: 25%; urban: 19%).

Only about 2% of households had family members that belonged to an ethnic or linguistic minority. These households were mostly located in Fier (2%) compared to Diber (1%) and more often in urban (3%) than rural (1%) settings.

Table 3: Socio-economic household characteristics

	Diber	Fier	Rural	Urban	Total
HH level					
Number of HH	642	633	825	448	1275
Average HH size (SD)	4.5 (2.0)	3.5 (1.7)	4.2 (1.9)	3.6 (1.7)	4.0 (1.9)
Rural location %	67	62	-	-	65
Household income					
Private business in Albania	10	7	6	13	9*
Salary in Albania	25	20	15	37	23*
Pension	54	59	57	57	56*
Social aid	31	10	23	17	22*
Farming/livestock	41	39	58	5	40*
Remittances	19	18	21	14	18*
Other	3	4	3	4	3*
% of HH where at least one person benefits from social-/economic aid	34	11	25	19	24*
% of HH where at least one person belongs to an ethnic or linguistic minority	2	1	1	3	2*

*weighted total by district

Table 4 outlines the socio-demographic characteristics of household members. Average age of household members was 38 years (median: 38). Sampled men were younger (n=

2,549; median age: 34) than sampled women (n= 2,635, median age: 40). Most household members were between 18 and 49 years (39%) or above (22% between 49<65 and 16% were 65 or older).

About half of the individuals were married (56%) and more than one third was single (38%). 45% had finished secondary grade (grade 5-12) and another 28% had a high school degree.

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

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

* weighted by district

3.1.1 Relative wealth of study households

Relative wealth of the household was calculated using Principal Component Analysis (PCA) for a list of assets (improved water source for drinking water; improved water

source for other water (e.g. hand washing); improved toilet facilities; household assets (cumulative index); mobility assets (cumulative index); owning agricultural land, owning livestock). The resulting index score was then used to split the study households according to wealth quintiles. The following Table 5 provides an overview on the mean socio-economic quintile scores. It seems that in Diber and rural areas individuals are slightly better off than in Fier and urban settlements with the exception of the second quintile.

Detailed information on each of the asset household variables stratified by district and urban vs. rural is available in Annex C.

Table 5 Mean socio-economic score by quintile

	Diber	Fier	Rural	Urban	Total
Q1 – Poorest	-1.88	-2.23	-1.99	-2.11	-2.09
Q2 – Second	-0.69	-0.75	-0.68	-0.74	-0.72
Q3 – Middle	0.35	0.22	0.31	0.22	0.30
Q4 – Fourth	1.09	1.08	1.09	1.02	1.08
Q5 – Richest	1.55	1.51	1.54	1.43	1.53

3.1.2 Households' geographical distance to next health facilities

Overall, households use public health providers for their first consultation (96%), most commonly governmental health centres, governmental hospitals and health posts. General household access to policlinics is slightly higher in Fier and in urban areas.

The most important factor for choosing a health provider over another is proximity. For 63% of the households this is a relevant factor, followed by costs, health insurance coverage and quality of services.

80% of households are located less than five kilometres from the next PHC facility. Households in Fier tend to be even closer to the next PHC facility (64% of households located less than 1 kilometer away from the facility). The proportion of households that have only remote access to PHC facilities (>20 kilometer) is in both districts with 2% relatively low. In comparison, policlinics are in both regions less accessible as access seems to depend on proximity to urban areas.

Table 6: Preferred health providers

	Diber (n=642)	Fier (n=633)	Rural (n=825)	Urban (n=448)	Total*
% using public facilities for first consultation	97	95	97	96	96
Thereof: Type of public health facility					
Gov. hospital	38	22	34	23	31
Gov. policlinic	1	5	2	5	3
Gov. health centre	49	58	53	54	53
Health Post	12	15	11	18	13
Other public	0.2	0.2	0.3	0	0.2
Reasons for choosing this health providers					
Geographical proximity	60	68	60	70	63
Familiarity with the staff	17	19	17	18	18
Good services	23	20	22	21	22
fast appointments	14	13	13	13	13
no need for appointment	7	9	8	8	8
covered by my insurance	19	20	15	28	19
does not cost much	25	24	21	30	24
good quality	14	14	14	13	14
good services	12	10	13	6	11
Distance to next PHC facility					
Less than 1 km	57	64	48	83	60
1 - 4.9 km	23	27	31	15	25
5 - 9.9 km	14	6	15	1	11
10 - 14.9 km	2	1	3	0	2
15 - 19.9 km	2	1	2	0	2
20+ km	2	0	2	0.2	1
Distance to next policlinic					
Less than 1 km	26	20	5	55	23
1 - 4.9 km	12	22	10	30	16
5 - 9.9 km	13	19	21	7	15
10 - 14.9 km	15	11	20	0.2	13
15 - 19.9 km	10	13	17	2	11
20+ km	25	16	28	6	21

* weighted by district

3.1.3 Health status and insurance coverage of all household members

56% of all household members have no chronic or acute illness (see Figure 3). 25% of individuals reported to suffer from a chronic condition, though the proportion of persons reporting a chronic condition is higher in Fier (33%) than in Diber (20%). 11% of persons living in the study households report an acute condition in the past four weeks and another 8% indicate that they have been affected by a chronic and acute condition in the past four weeks.

Of those reporting a chronic condition or a chronic and acute condition, 60% are female. Acute illnesses are equally shared between men and women (around 50% each).

Children <5 years have been mostly affected with acute conditions (approximately 20%) but there are also 12% of infants (<1 year) for whom chronic conditions have been reported. One can see that the proportion of acute illness decreases with age whilst the proportion of chronic conditions rises with age with a drastic increase from 49 years onwards (49>65 years: 44% and 65 years or older: 58%). Also the proportion of those affected with acute and chronic condition increases from 49 years old or older.

Figure 3: Health status of household members (n=5,188)

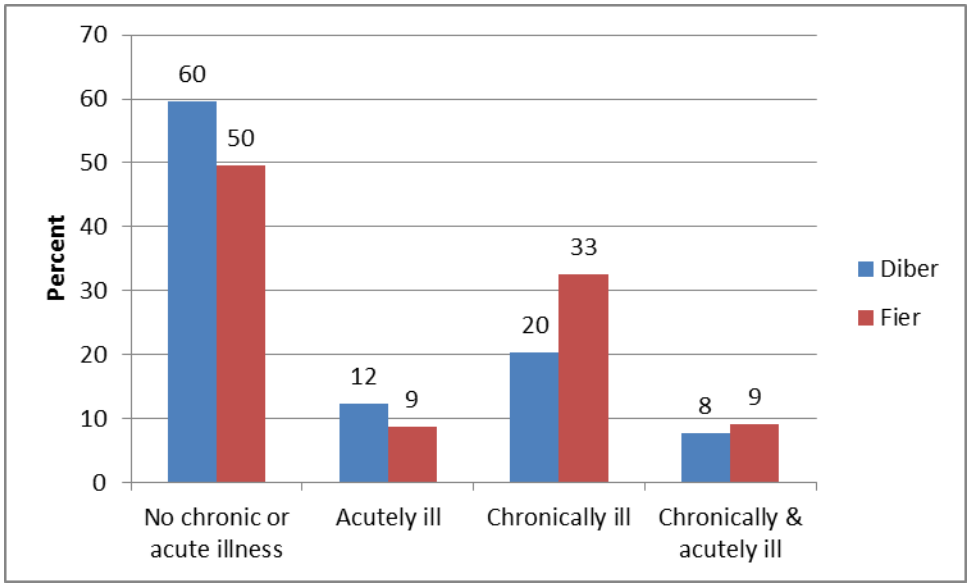
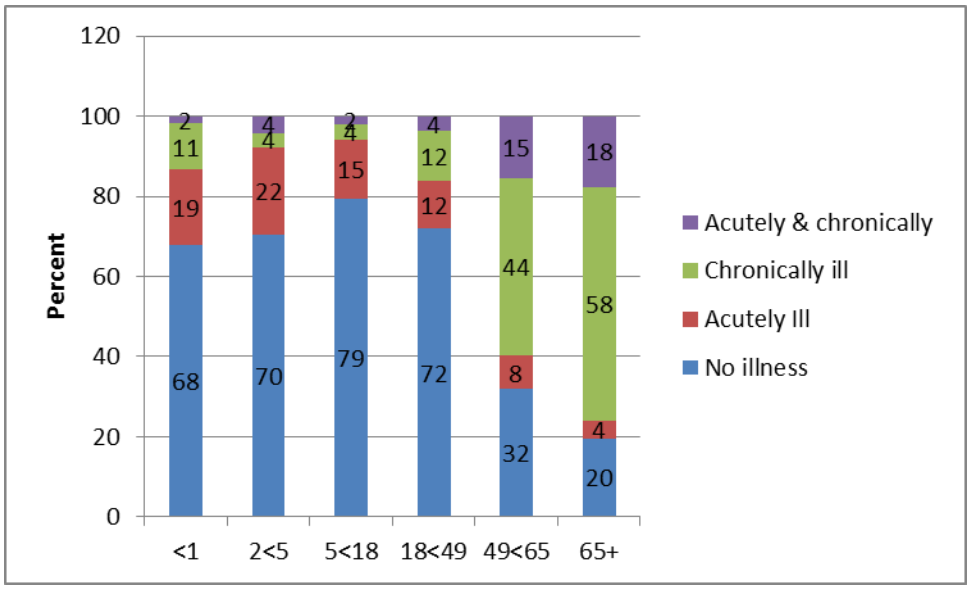
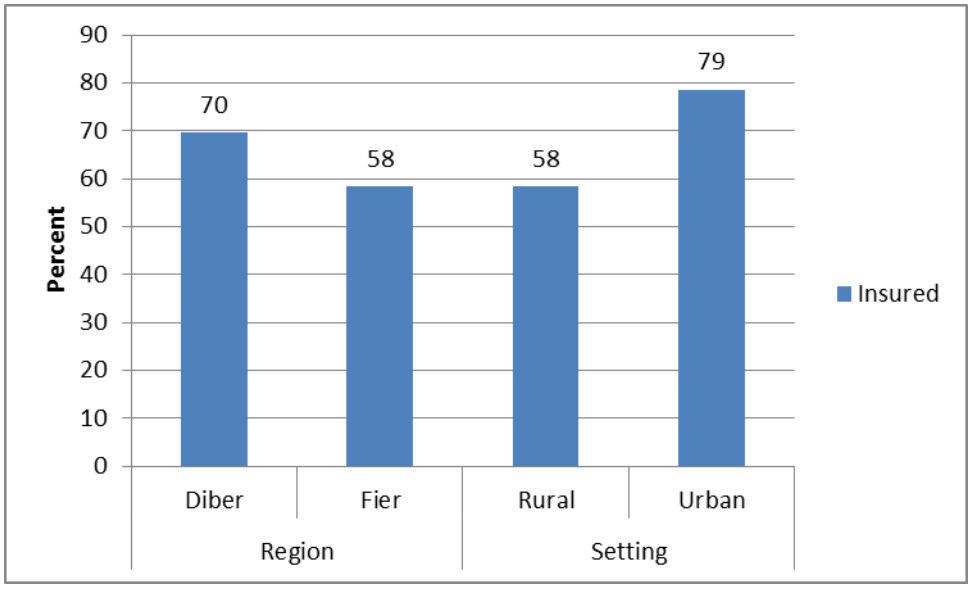


Figure 4: Health status of household members by age group (n=5,184)



Health insurance coverage for all household members is overall 66%, but higher in Diber than in Fier (70% vs. 58% respectively) and higher in urban than rural settings (78% vs. 58%) (see also Figure 5). Health insurance coverage among males and females is almost the same (63% vs. 67% respectively). 34% (n=1,827) individuals had at the time of the interview no valid health insurance card.

Figure 5: Health insurance status of household members (district level, n=5,188; setting level: n=5,184)

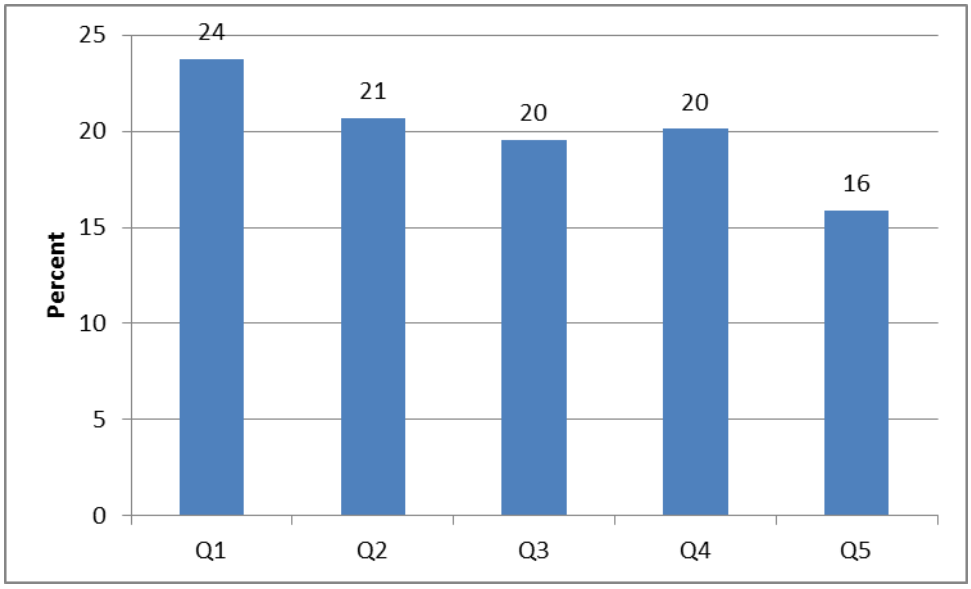


The proportion of people with health insurance coverage, who live in household where at least one member of the household benefits from a social or economic aid scheme, is 70% (Diber: 70%; Fier: 66%). No differences in gender coverage could be identified for this subgroup (males: 70%; female: 69%).

The health insurance card coverage is not influenced by household wealth, but the wealthier the household the lesser do individuals have a valid health insurance card (see

Figure 6). Possible reasons for this pattern could be the ability of households to pay the required costs or household members having less time to renew their health insurance cards. Or the poorer households being in a higher need for partial coverage by health insurance

Figure 6: Coverage of health insurance status by wealth quintile (n=5,070)



We also questioned the 1,827 individuals who did not have a valid health insurance card at the time of the interview about the reasons why they had no valid health insurance card. Table 7 outlines the given reasons. Almost half of those not insured indicated that this was because they did not renew their health insurance card (49%), because the person thought that s/he did not need the health insurance (19%) or because the person did not pay contributions/is not eligible (15%).

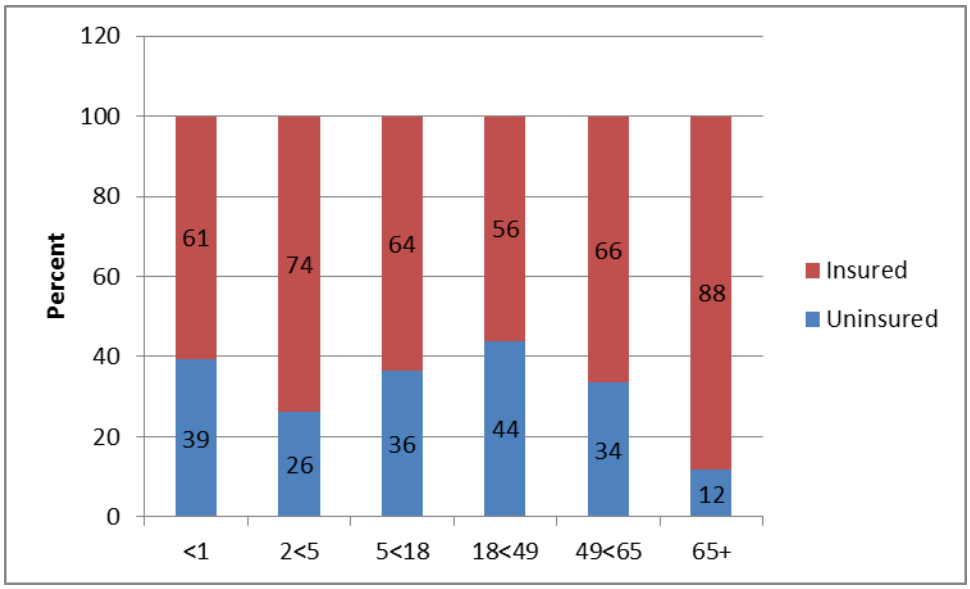
Table 7: Reasons for not having a valid health insurance card

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

*weighted by district

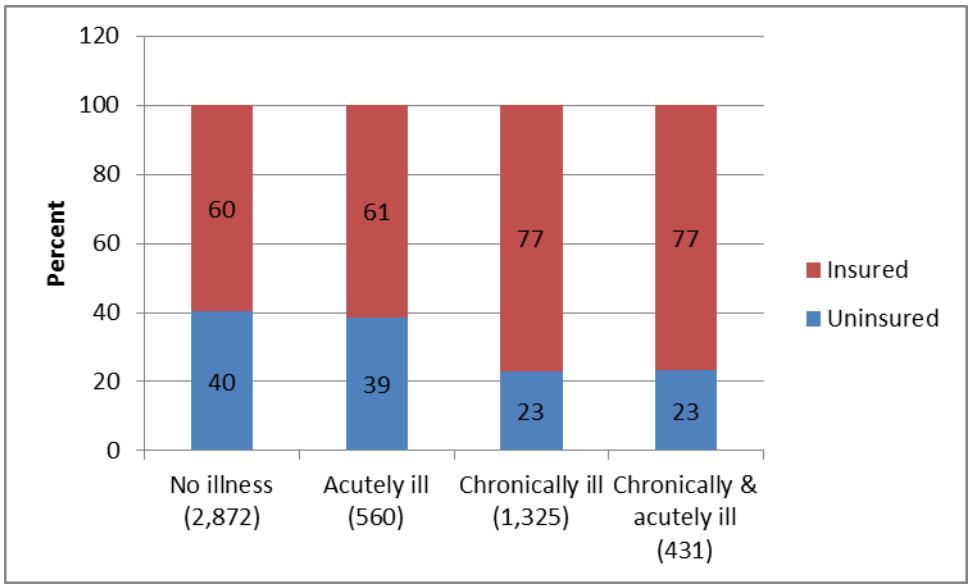
Of those insured are about 50% are women. Of those insured about 30% are between 18-49 years old, followed by those between 49 and 65 years and those 65 years and older. One can also see that with increasing age a higher proportion of the age group gets health insurance coverage. Of those 65 or older, almost 90% report having a valid health insurance card compared to only 60% of children younger than one year.

Figure 7: Health insurance coverage of household members by age group (n=5,184)



Of those insured 50% have no specific condition but almost 30% of those insured report a chronic condition. In return almost 90% of those who report having a chronic condition or a chronic and acute condition have a valid insurance card.

Figure 8: Health insurance coverage of household members by health status (n=5,188)



3.2 Selected patients with chronic condition

3.2.1 Profile of interviewees

Of the interviewees[4] included in the sample and willing to provide more detailed information on their chronic condition(s), 71% were female, with an average age of 59 years (SD: 15; median: 61). Of participants, 16% were between 18 to 49 years (16%), 41% between 49<65 and another 40% 65+. For children below 18 years questions were answered by an adult/caretaker.

Table 8: Demographic profile of chronic disease patients included in the sample

	Diber	Fier	Rural	Urban	Total
n	522	574	715	380	1096
% female in HH	68	75	72	72	72
Average age (SD)	58 (17)	61 (15)	59 (16)	60 (15)	59 (16)
% by age cat:					
<1	0.8	0	0.2	0.5	0.4
2<5	0.6	0.7	0.6	0.8	0.6
5<18	2	2	2	2	2
18<49	20	14	18	13	16
49<65	43	40	40	43	41
65+	35	44	39	41	40

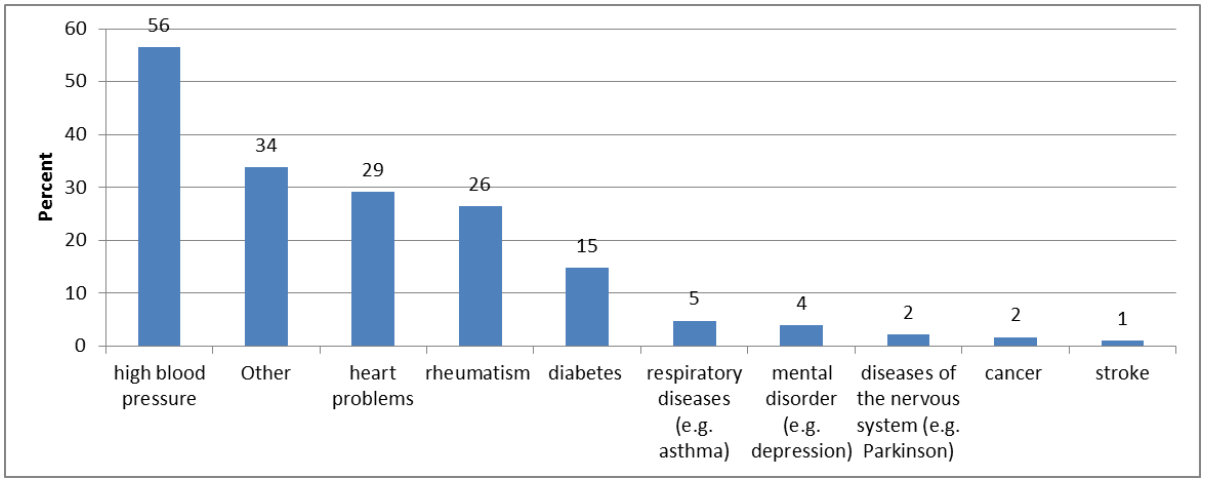
3.2.2 Situation of chronic disease patients: Illness patterns

Most common was hypertension (56%), heart problems (29%), rheumatism (26%), followed by diabetes (15%) and respiratory diseases (5%) and mental disorders (4%). Diseases of the nervous system were reported by 2% and stroke and cancer were mentioned by about 1% of the interviewees, respectively.

The proportion of women indicating suffering from a chronic condition was typically higher with the exception of "having a stroke", whereby 64% of those who declared having had a stroke were men. Differences between the regions and rural or urban setting have not been found.

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

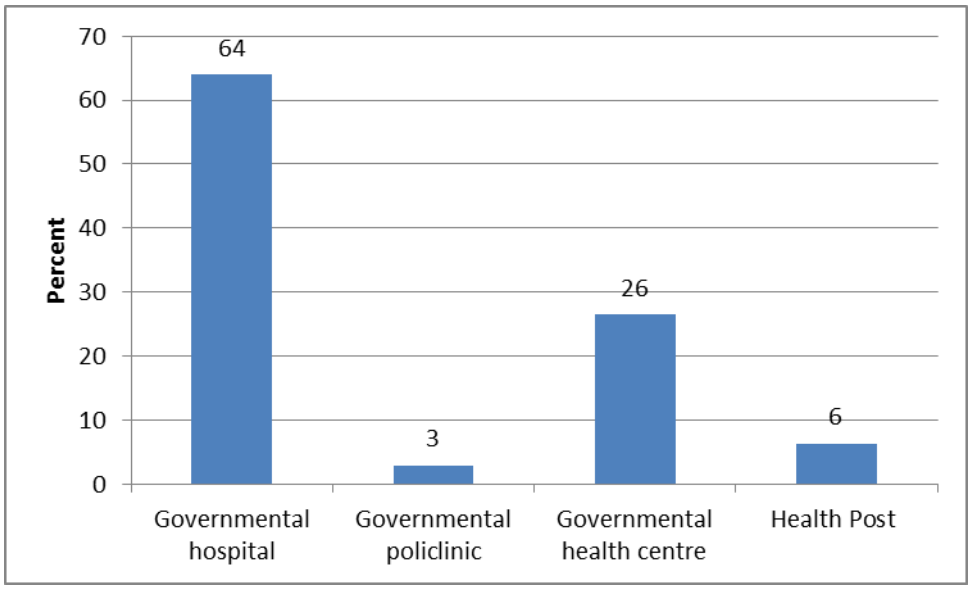
Figure 9: Self-reported chronic conditions (n= 1,096)



However, about half of interviewees reported having more than one chronic condition: 32 % had two conditions, 15% indicated having three conditions and 4% mentioned that they suffer from four or more chronic conditions. Conditions that have typically been reported together were high blood pressure and heart problems.

94% of interviewees received their diagnosis through a public sector health provider, most commonly hospitals (64%) followed by health centres (26%). Only 6% declared that they were diagnosed through private providers, typically by a private hospital or clinic (87%).

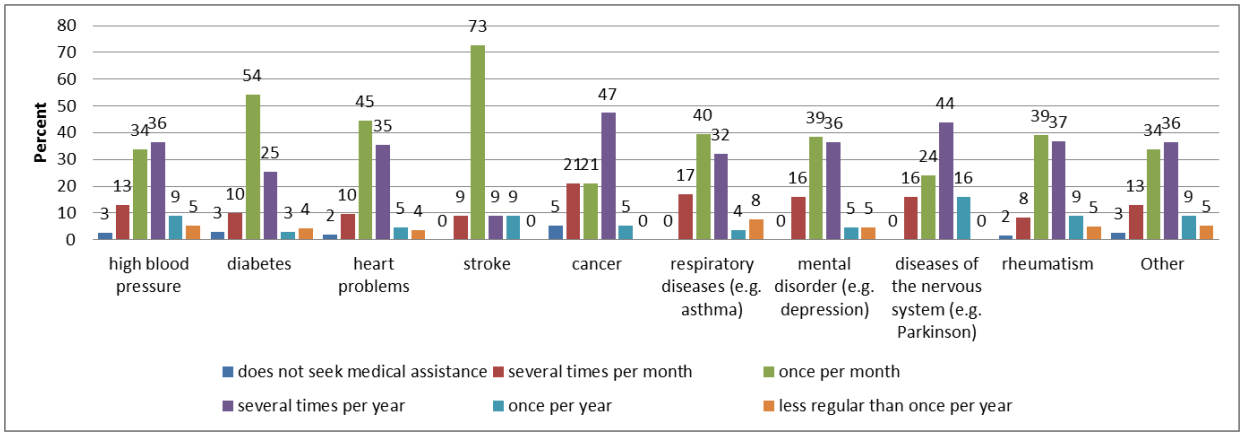
Figure 10: Provider establishing the diagnosis of a chronic condition (n=1,027)



3.2.3 Health seeking behaviour & barriers

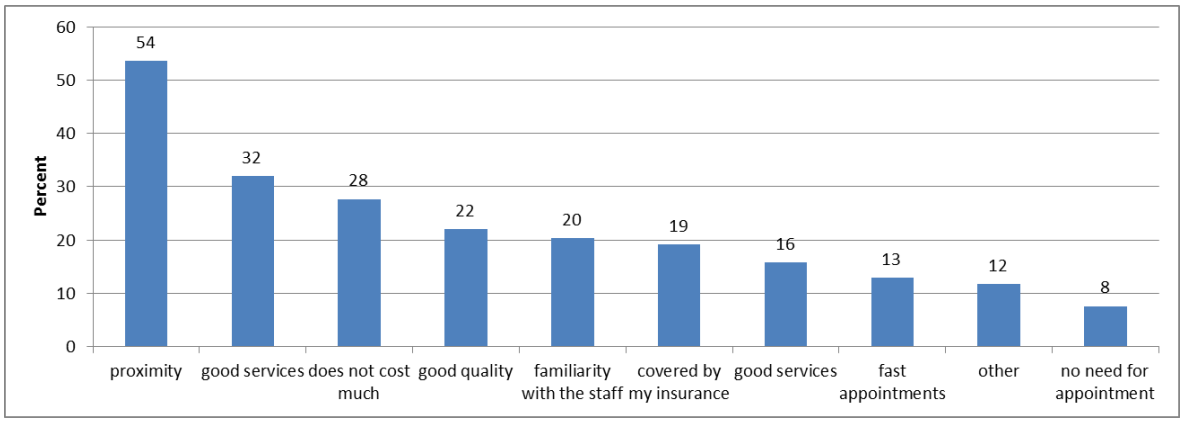
We tried to establish the regularity with which patients seek care for their chronic condition distinguishing in decreasing order from several times per month (e.g. weekly), once per month (e.g. monthly), several times per year (e.g. 6 times a year), once per year (e.g. annually), less regular (e.g. once every two years) or not seeking care at all. Health seeking for chronic conditions varies depending on the specific condition. 72% of stroke patients visited a health provider once per month, compared to 54% of diabetes patients, 45% of persons with heart problems and 40% with respiratory diseases. Patients with high blood pressure visited mostly either monthly or several times per year. Similar patterns were also identified for mental disorders, rheumatism and other chronic conditions. For 'disease of the nervous system' visits were typically 'several times per year' and monthly visits were less common.

Figure 11: Regularity of health seeking behaviour for chronic condition (n= 1,096)



Out of 1,096 participants declaring having a chronic condition 53% reported seeking care in the past four weeks. Another 17% had sought care in the past eight weeks. This adds up to 767 individuals who actually sought care in the past four to eight weeks. Medical care was sought at the hospital and health centre. Patients were most commonly treated by a doctor (82%) or a doctor and a nurse together (11%). When choosing a provider geographical proximity to the health provider is for chronic disease partients the most important factor. This observation is independent from the region (Fier or Diber) but more important for those living in urban settings (see Annex C).

Figure 12: Reasons for choosing a health provider by persons suffering from a chronic condition (n=767)



However, many interviewees in both regions seem to live in good reach (50%-60% live less than 5 kilometres away from the health provider) although in Diber the distances are bigger (see Figure 13). About 20% of the chronic patients live 20 kilometres or more from the health provider. The proximity to health providers is particularly high for those living in urban areas: 64% of patients live less than 1 km away from the health provider compared to 25% of patients living in rural areas. Similarly, 24% of rural patients have to travel more than 20km to the health provider compared to 11% in urban areas (see Figure 14).

Figure 13: Distance to health provider among persons with a chronic condition by location (n=767; Diber: n=363; Fier: n= 404)

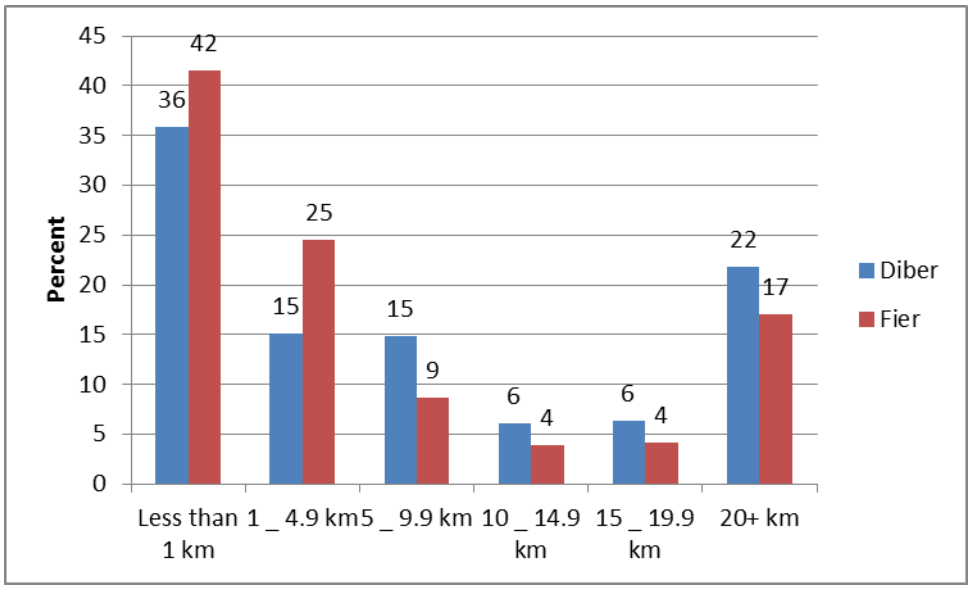
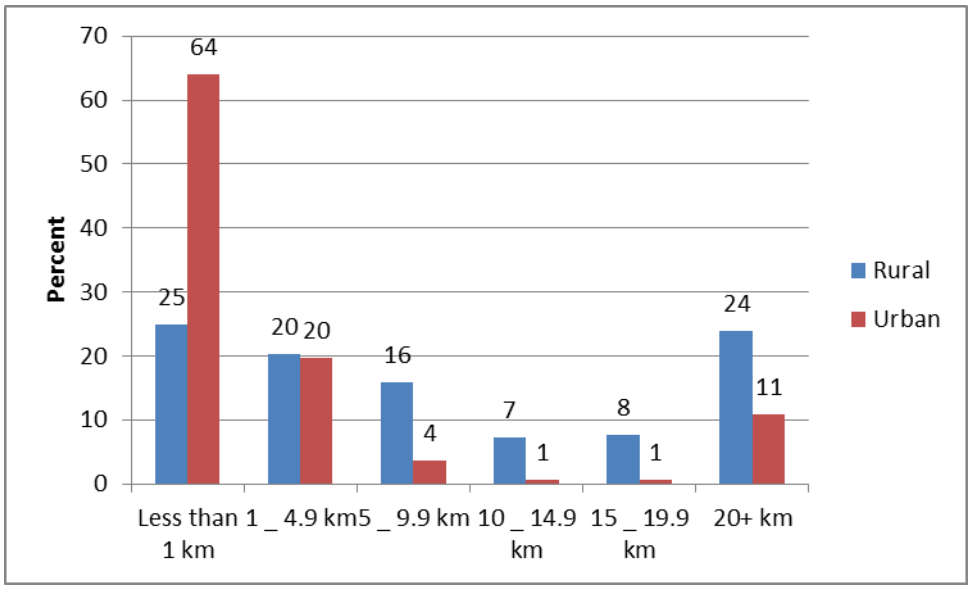


Figure 14: Distance to health provider among persons with a chronic condition by area of residence (n=767, rural: n= 494; urban: n= 273)



The most common reasons why patients visited not only PHC facilities but also a hospital were that they had been referred (21%) or that tests (20%) or services (16%) had not been offered at the level of the PHC provider. Specifically in rural areas, referral was more common than in urban areas (24% vs. 14%). The tests and services were more readily available in urban areas compared to rural regions (22% vs. 16% for test and 18% vs. 14% for services). The quality of services and the perceived competence of the doctors were for 6% of the chronic patients' reasons for consulting also other than the PHC physician.

Figure 15: Reasons for visits other than PHC among persons suffering from a chronic condition (n=767)

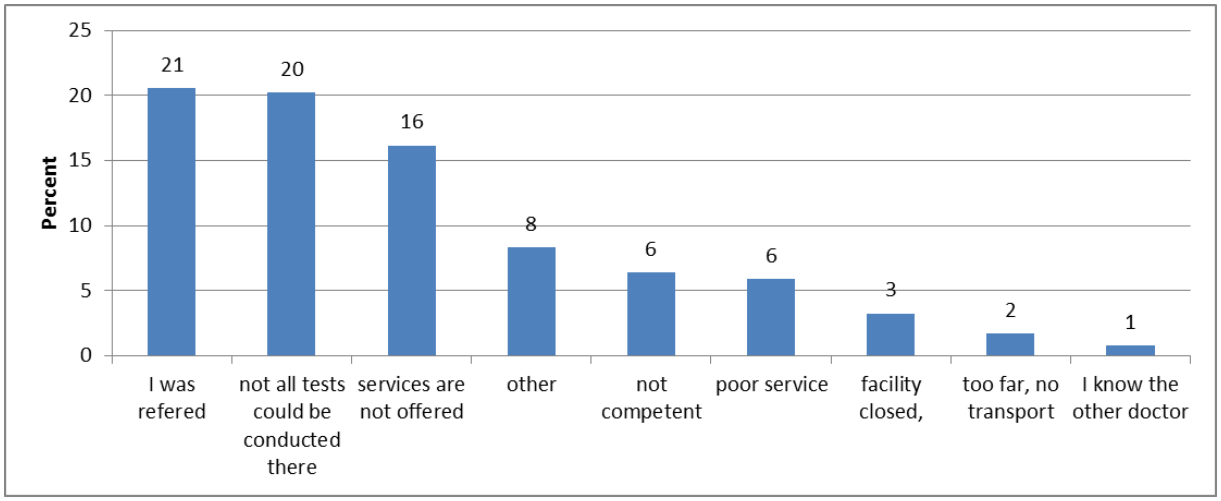
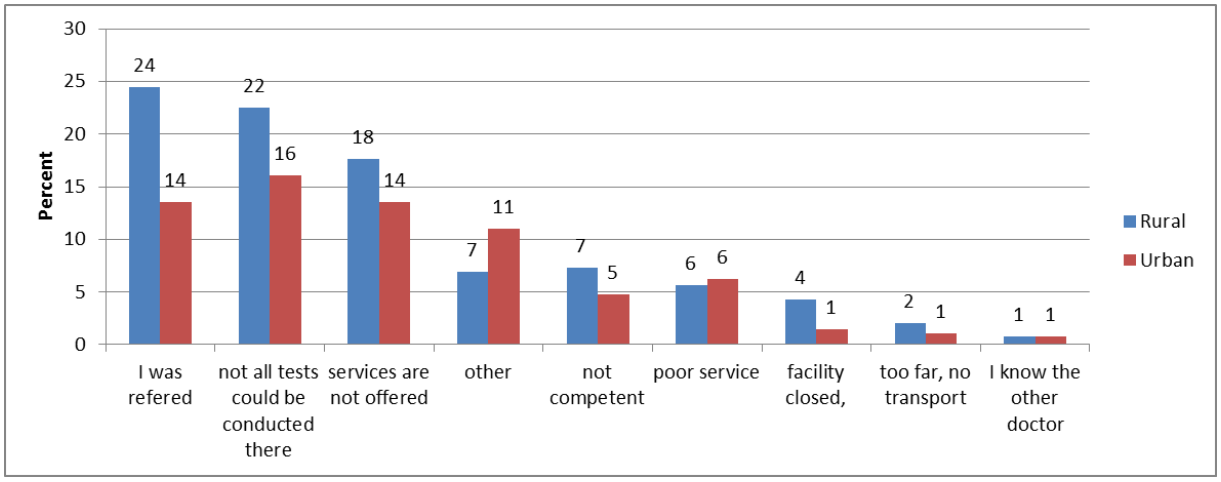


Figure 16: Reasons for visits other than PHC by area of residency among persons suffering from a chronic condition (n=767; rural: n= 494; urban: n= 273)



Despite more than half of chronic disease patients accessing care in the past four to eight weeks, 30% of interviewees reported that they face difficulties in regularly consulting a health service provider and 26% reported that obtaining care for their chronic condition was at times difficult. In both situations it was mainly related to situation of financial hardship. Also transport was an issue, specifically in Diber and/or rural areas. Also not having a valid health insurance card has been mentioned in Fier and/or rural areas.

Figure 17: Difficulties for seeking care among persons with a chronic condition (n= 328)

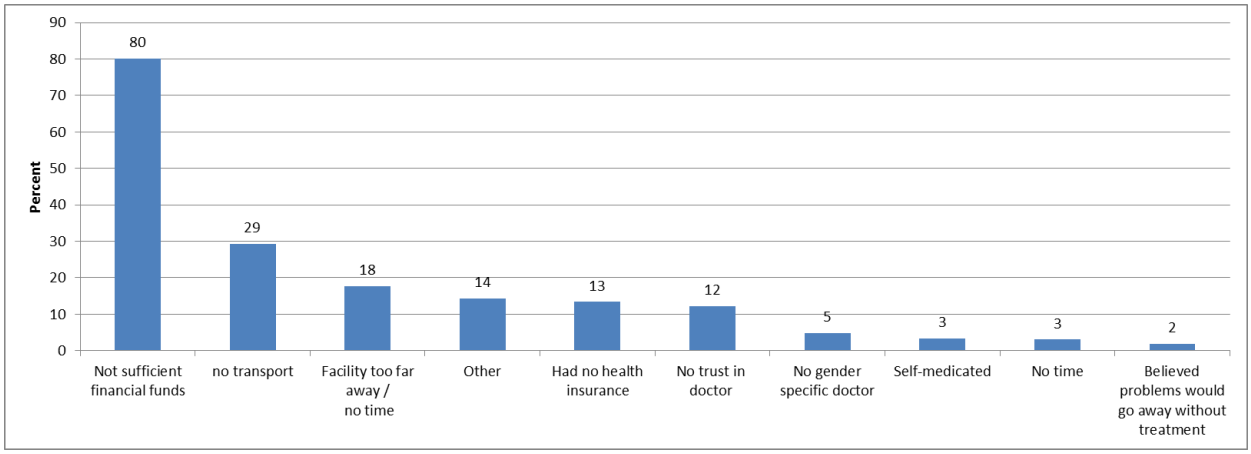


Figure 18: Difficulties for seeking care among persons with a chronic condition by region (n= 328; Diber: n= 140; Fier: n=188)

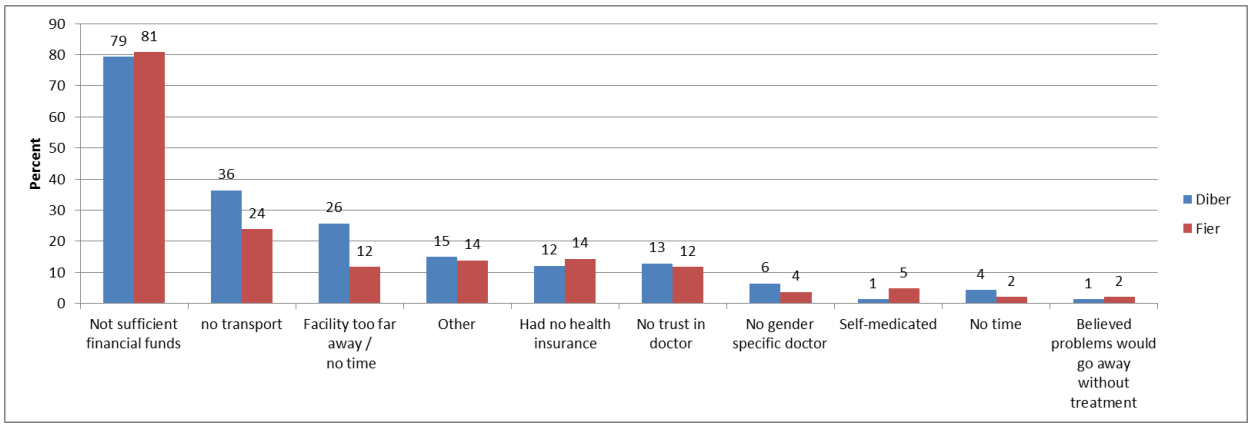
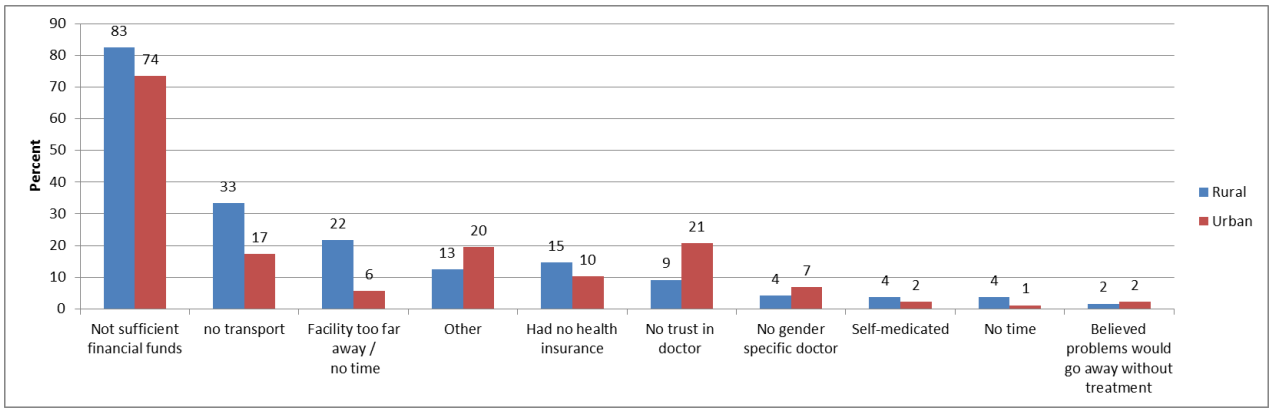


Figure 19: Difficulties for seeking care among persons with a chronic condition by area of residency (n=327; rural: n=240, urban: n=87)



Chronic disease patients were also asked if they ever encountered difficulties in obtaining care (e.g. treatment, medicine) and 26% (n= 284) indicated so. A main barrier was here that people felt they could not afford the care (74%), followed by varied other reasons including the lack of a valid health insurance card (12%), the doctor did not have time/appointment was unavailable (10%) and 7% had in the past been refused. Also the opening of the facility was a barrier though less so in Fier than in Diber (1% vs. 7%; see Figure 20 and Figure 21).

Figure 20: Difficulties among persons with a chronic condition for obtaining health services by region (n= 284; Diber: n=112; Fier: n=172)

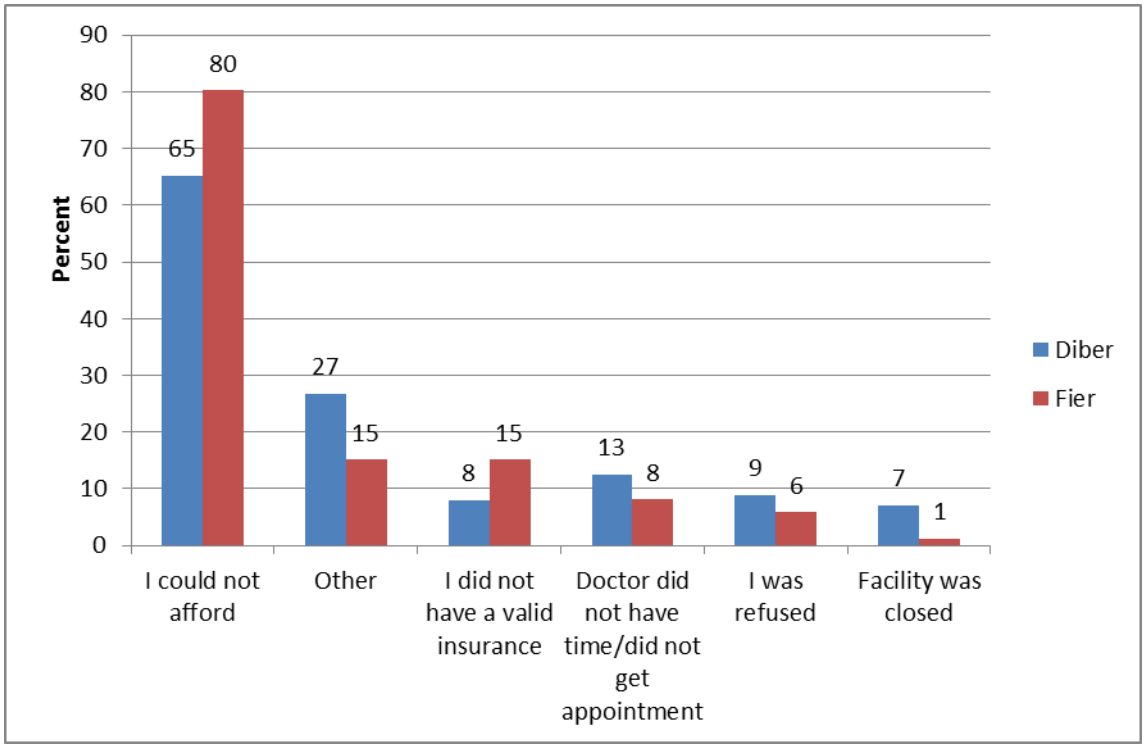
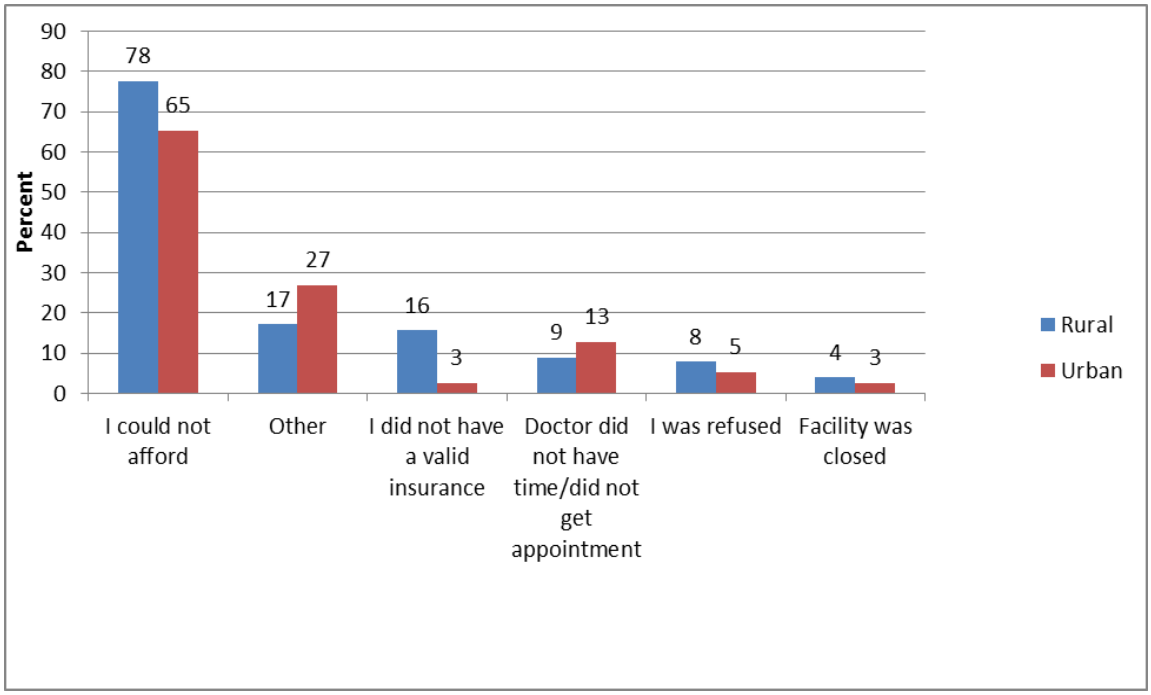


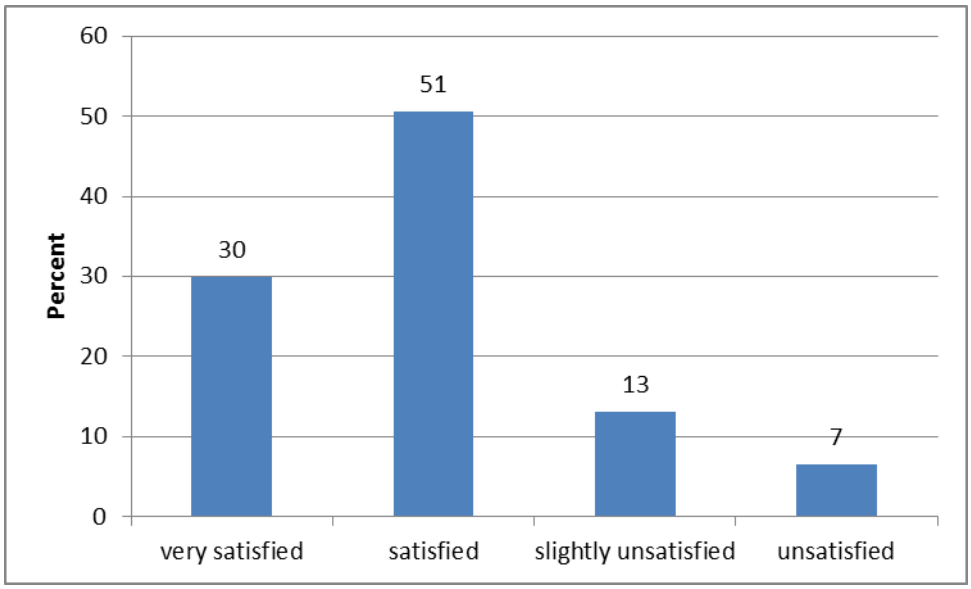
Figure 21: Difficulties among persons with a chronic condition for receiving health services by area of residency (n=283; rural: n=205; urban: n=78)



3.2.4 Satisfaction with services for chronic conditions

Satisfaction among those who used a health service was overall good. 30% were very satisfied, 51% satisfied, 13% slightly unsatisfied and another 6% unsatisfied (see Figure 22), with some more being slightly unsatisfied or unsatisfied in rural areas (see Annex C). Despite the dissatisfaction only 20% were aware that there is a patient complaint system.

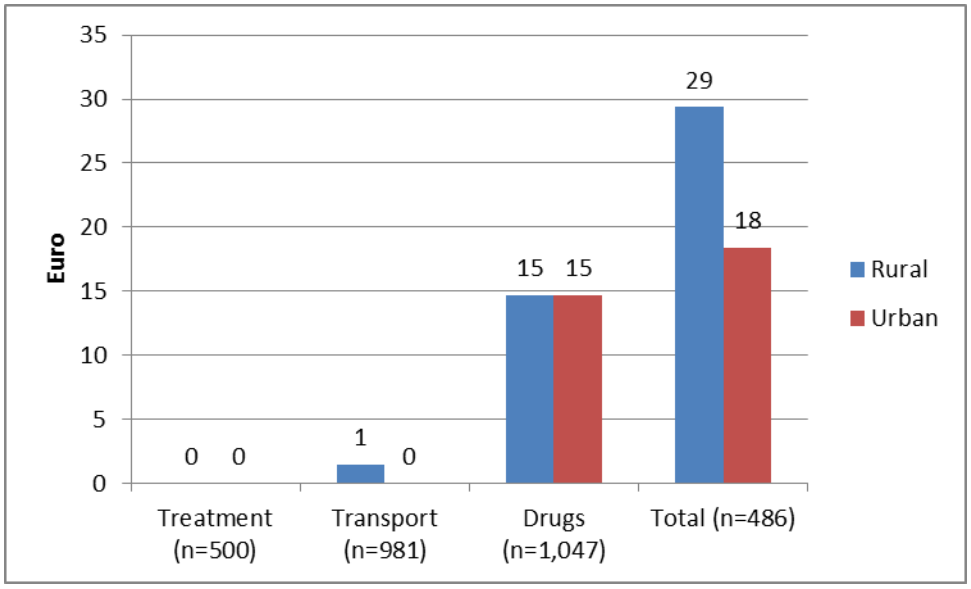
Figure 22: Satisfaction with health service among persons with a chronic condition who consulted a health service provider (n=767)



3.2.5 Health expenditures for chronic conditions

The median total costs for health seeking for chronic conditions in the past four weeks was 25 Euros (Diber: 24 Euros; Fier: 29 Euros) and were substantially higher in rural settings compared to urban settings (rural: 29 Euros, urban: 18 Euros).

Figure 23: Median costs for chronic condition in the past four weeks by location



The median admission costs were zero in both regions (see Annex C) and independent from the setting (see Figure 23).

Despite the differences in proximity to the health facilities we did not identify any substantial cost differences for transport; the median cost was 1 Euro. The highest expenditure in the past four weeks for the chronic condition was related to purchasing

drugs and/or conducting tests. 50% of all chronic disease patients pay here up to 15 Euros (median Diber: 13 Euros; median Fier: 18 Euros), the other 50% s have higher expenditures.

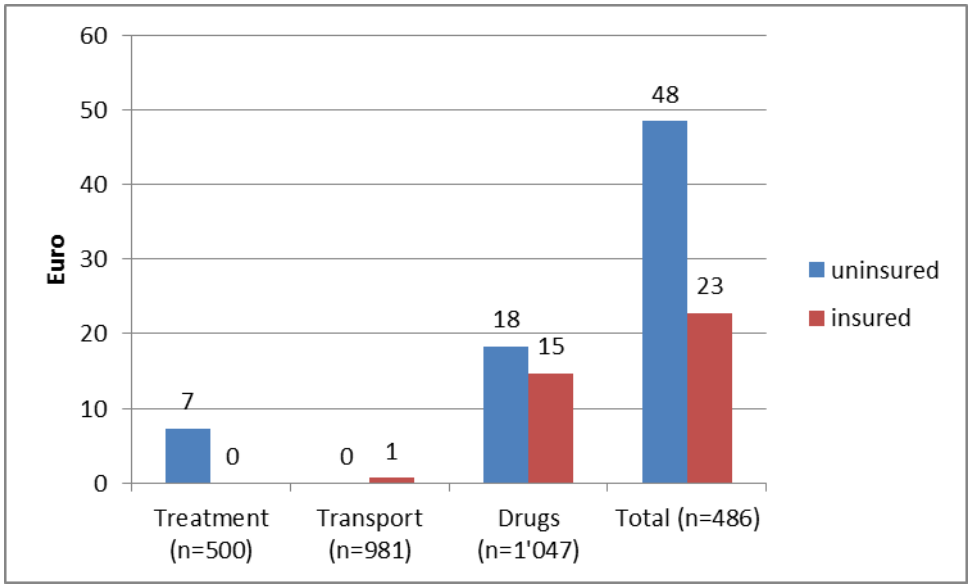
The average proportion of the different cost types out of the total costs is outlined in Table 9**Error! Reference source not found.**. Attributing the costs, we see that admission makes on average only 12% of the total costs, followed by transport who proportionally account for 16% on average. By far the largest proportion of total cost can be attributed to drugs (72%).

Table 9: Proportion of total costs in the past four weeks for chronic conditions

Admission	Transport	Drugs	Total
12%	16%	72%	100%

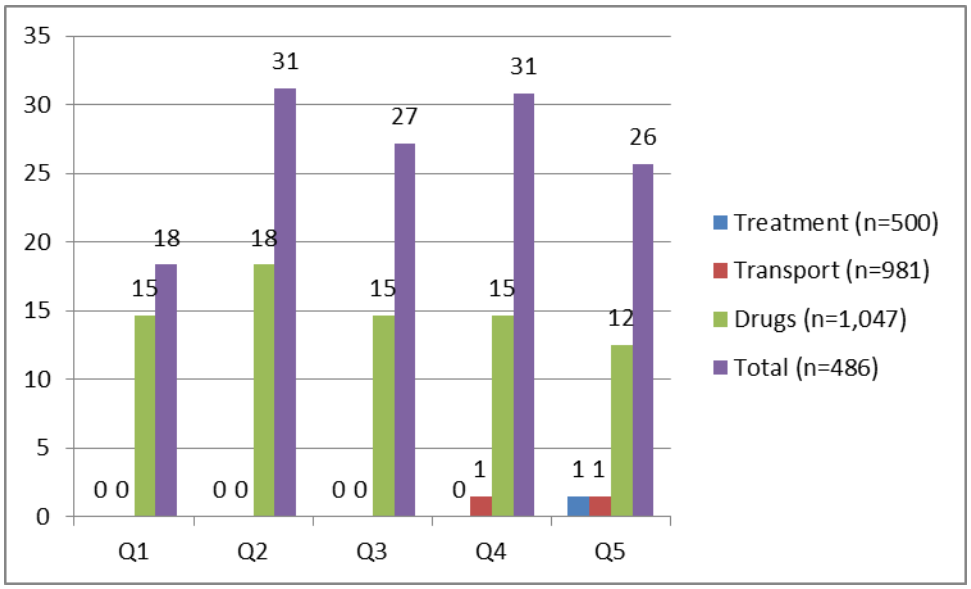
Despite these general patterns we also identified differences between those insured vs. uninsured and for some specific conditions. Very clear are the differences between the insured vs. uninsured: the total median costs for uninsured were 48 Euros, more than double the total median costs of the insured (23 Euros). A difference can also be found regarding the median treatment costs (see Figure 24). From another perspective: the 68 uninsured persons for whom we can estimate total costs paid a total of 6868 Euros, averaging 101 Euros per person. In comparison: the 418 insured persons paid total costs of 20'466 Euros, averaging only 49 Euros per person.

Figure 24: Median costs among people with a chronic condition in the past four weeks by insurance status



Median payments did not were lowest for the lowest wealth quintile but increased thereafter in a non-systematic way. Highest expenses were in all wealth quintiles for drugs with very few variations between the quintiles (see Figure 25).

Figure 25: Median costs among people with a chronic condition in the past four weeks by wealth quintile



Total costs for some specific conditions appear also very high (see Annex C), specifically cancer (62 Euro) and diseases of the nervous system (110 Euro). It is worthwhile noting that the higher the median costs on the different categories the higher is also the dissatisfaction of the patient (see Annex C).

Non-monetary gifts/payments to healthcare providers were not common; only 6% of the patients reported having done that in the previous four weeks.

3.3 Selected patients with an acute health problem

3.3.1 Profile of interviewees

Overall 175 patients[5] provided information relating to an acute health problem, thereof 117 (67%) from Diber and 58 (33%) from Fier. Overall more of the interviewees were females (68%), specifically in Fier (74%). Average age was 34 years, though people in Fier were slightly older (41%).

Table 10: Demographic characteristics of interviewees with an acute health problem

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

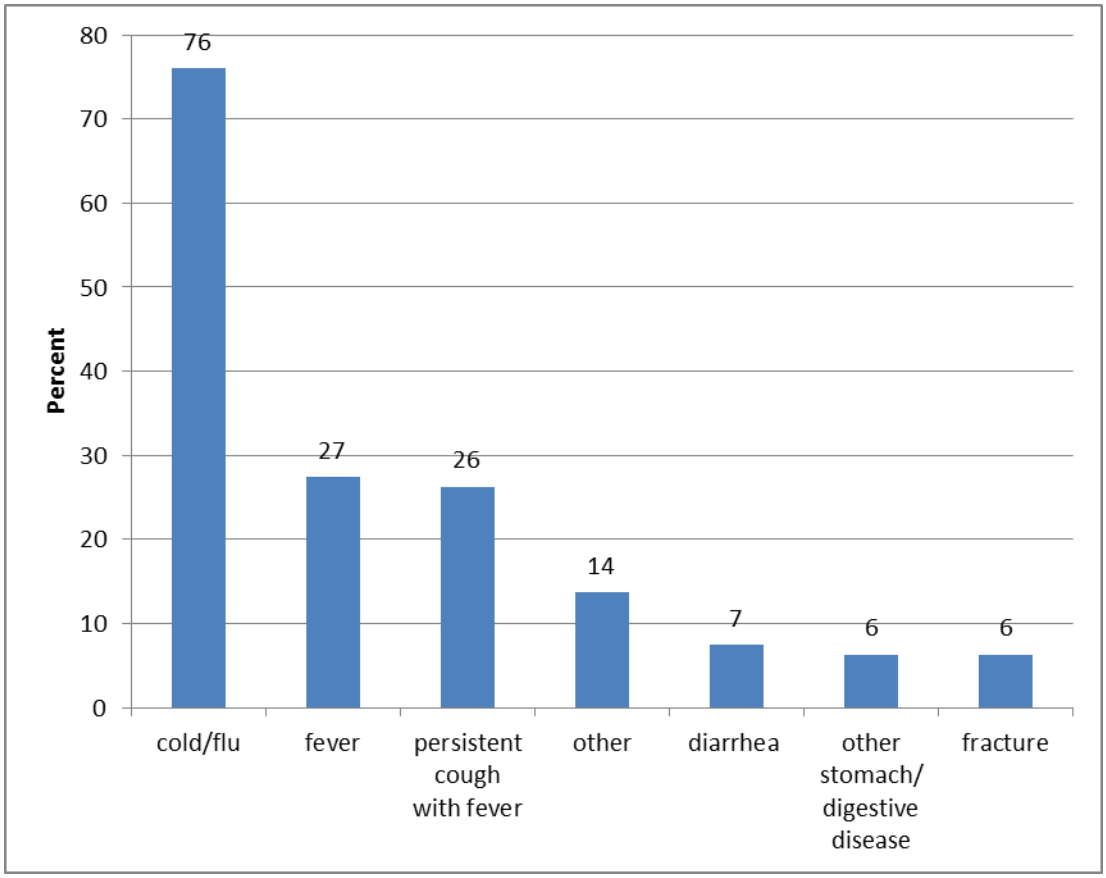
	Diber	Fier	Rural	Urban	Total
n	117	58	107	67	175
% female in HH	66	74	67	70	68
Average age (SD)	32 (20)	41 (18)	35 (20)	35 (19)	35 (20)
% by age cat:					
<1	3	0	1	5	2
2<5	12	3	9	9	9
5<18	11	9	11	9	10
18<49	55	52	53	54	54
49<65	15	24	17	21	18
65+	3	12	8	3	6

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

Cold/flu, fever and persistent cough with fever were the most common mentioned illnesses/symptoms (see

Figure 26). All other diseases were far less common (e.g. stomach/digestive issues), which can be explained by the season of data collection (October/November). The pattern was the same for rural and urban settings.

Figure 26: Self-reported acute health problems (n=175)

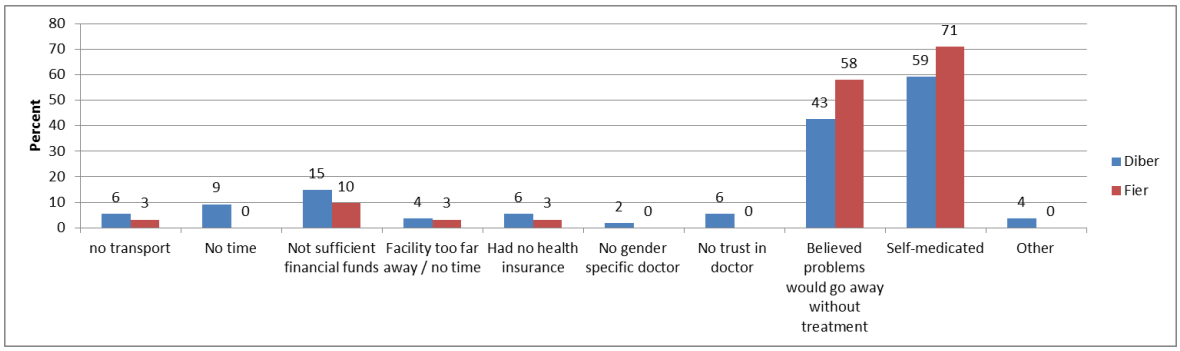


3.3.3 Health seeking behaviour & barriers

About 51% sought care for acute condition (Diber: 54%, Fier: 47%; rural: 53%, urban: 49%). Of those not seeking care (n=85) most self-medicated (64%) and believed that the health problem would go away without medical treatment (48%). Lack of financial funds was another aspect that patients had mentioned as well as the lack of time (see Figure 27). Those not seeking professional care suffered mostly from a cold/flu (86%), persistent cough with fever (28%), fever (19%) and/or diarrhoea (12%)[6].

Figure 27: Reasons for not seeking care among persons with an acute health problem by region (n=85, Diber: n=54, Fier=n=31)

[6] Multiple answers were possible.



Of those seeking care more than 80% indicated that they sought assistance in the first three days, typically men went immediately on the same or first day and women on the first or second day after onset of symptoms. 63% sought care once in the past four weeks and another 23% visited the health provider twice.

97% sought care in public facilities, although this was more common in Diber (98%) than Fier (93%). Hence only 3% of respondents declared that they used a private health provider.

In both regions and settings governmental health centres and governmental hospitals were most frequently visited. In those facilities 67% were taken care of by the doctor and another 14.44% by the nurse and doctor. In 6.67% the nurse administered the treatment by herself. Also the pharmacist was partly involved.

Reasons why patients had also consulted non-PHC facilities were that the services required were not offered at PHC (27%), that not all tests could be conducted at PHC (19%) or the facility closed (23%). Specifically in Fier, PHC facilities were not able to perform all required tests, and in Diber a main problem was the closure of the facility (see Figure 28). Poor service was considered a particular issue in urban areas (16%) and the competence of staff mentioned in urban settings (10%) (see

Figure 29).

Figure 28: Reasons among persons with an acute health problem for not using a PHC service by region (n=48; Diber: n=33; Fier: n=15)

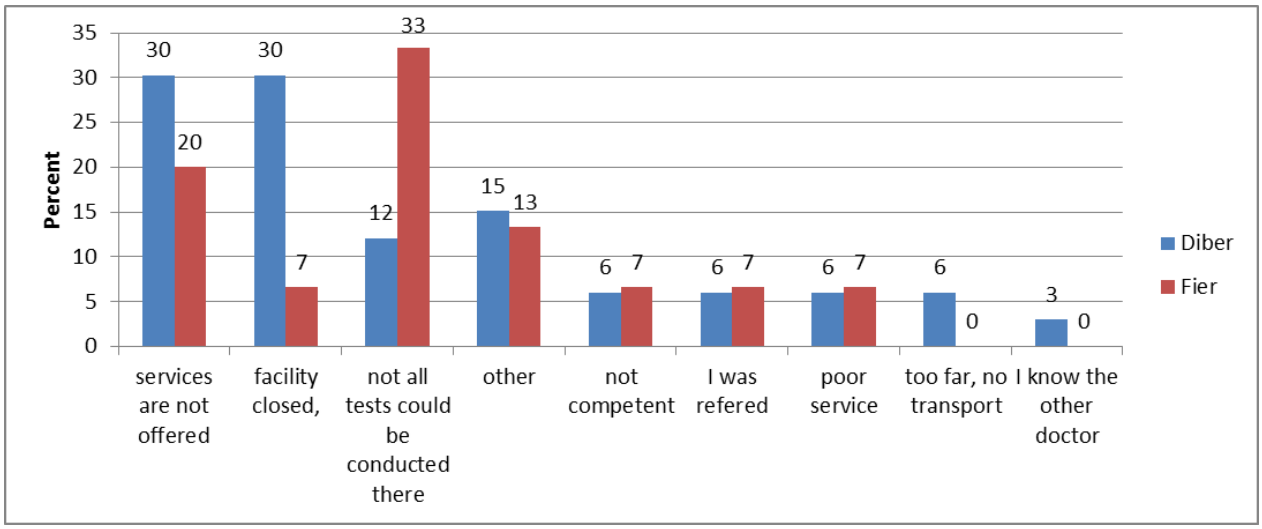
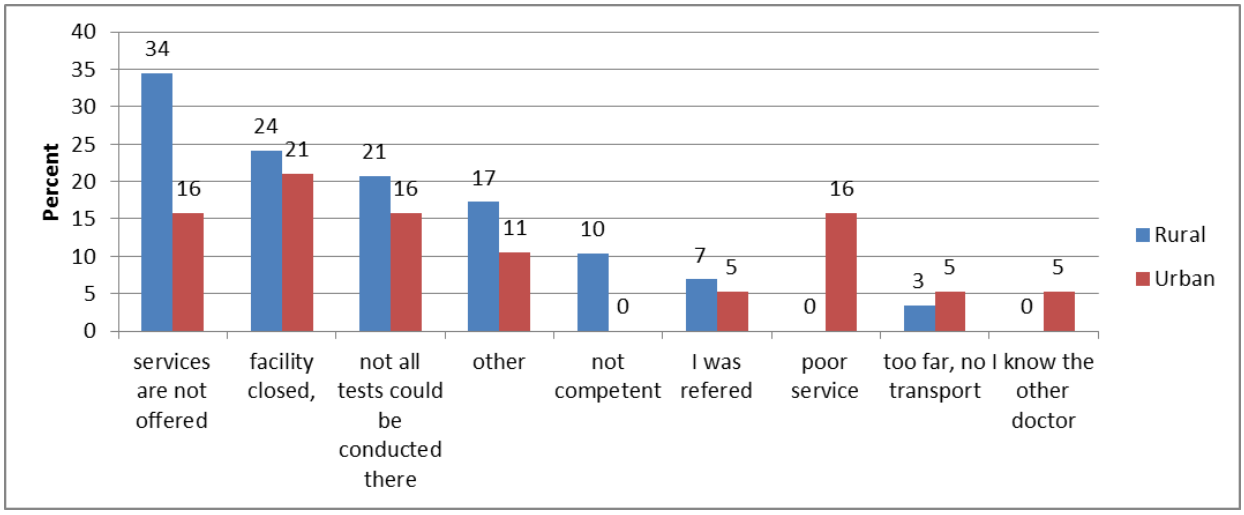


Figure 29: Reasons among persons with an acute health problem for not using a PHC service by area of residency (n=48; rural: n=29; urban: n=19)



Hence 24% indicated that they encountered difficulties in seeking care and 17% indicated that they experienced challenges in obtaining care. The lack of sufficient funds was a main barrier, specifically mentioned in Fier and in rural areas followed by insufficient transport. The lack of trust in the doctor was particularly high in urban areas (up to 50%) followed by issues related to the gender of the doctor. There were also persons who self-medicated or believed that also the symptoms would disappear without treatment.

The affordability of health services was yet the same issue participants mentioned for obtaining care. In rural areas not having a valid health insurance card was an issue mentioned by about 30% of participants.

Figure 30: Main problems among persons with an acute health problem in seeking care (n=90)

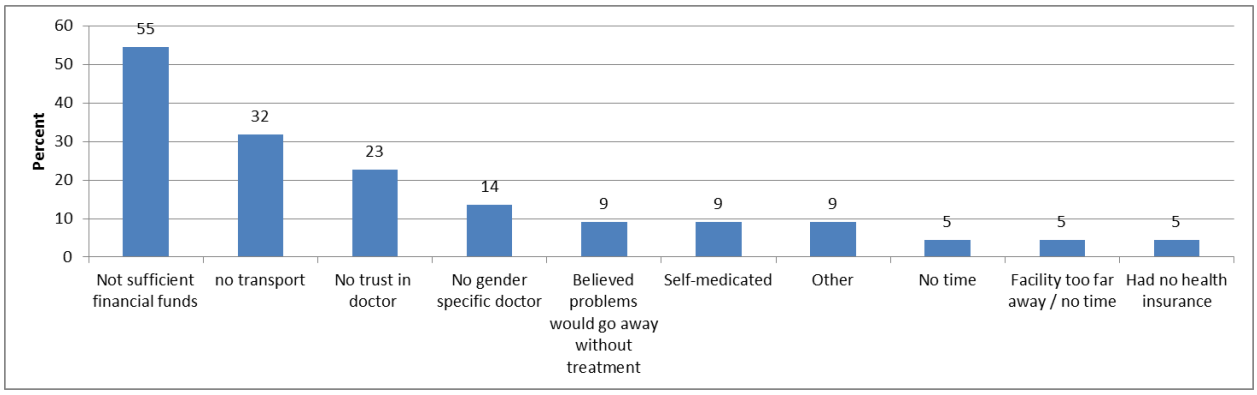


Figure 31: Challenges among persons with an acute health problem in seeking care by region (n=90, Diber: n=63; Fier: n=27)

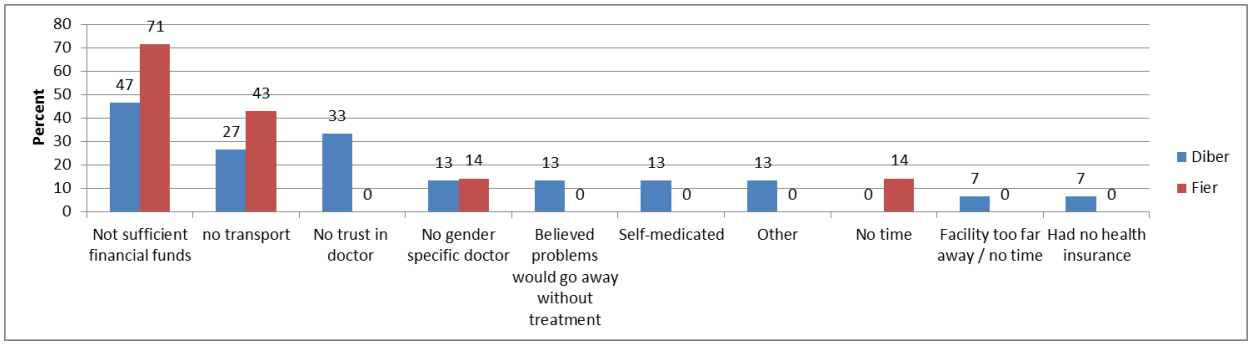
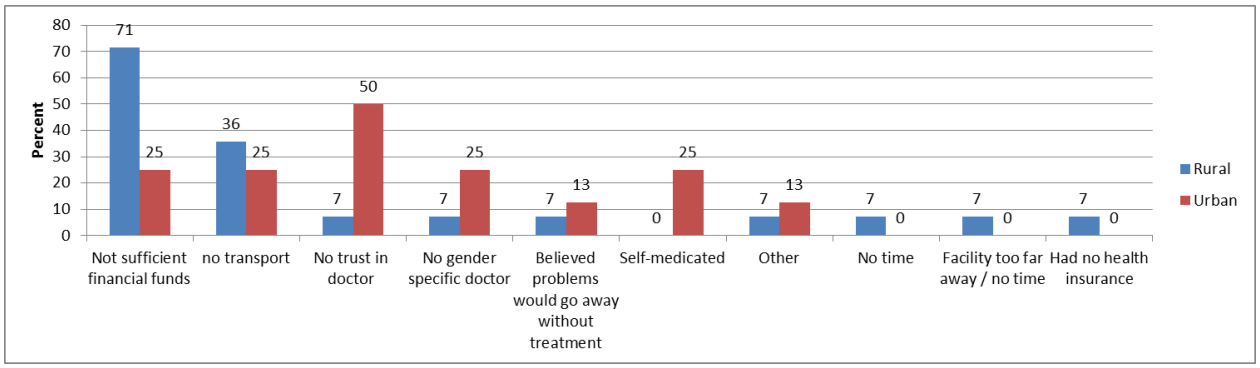


Figure 32: Challenges among persons with an acute health problem in seeking care by area of residency (n=22; rural: n=57; urban: n=33)

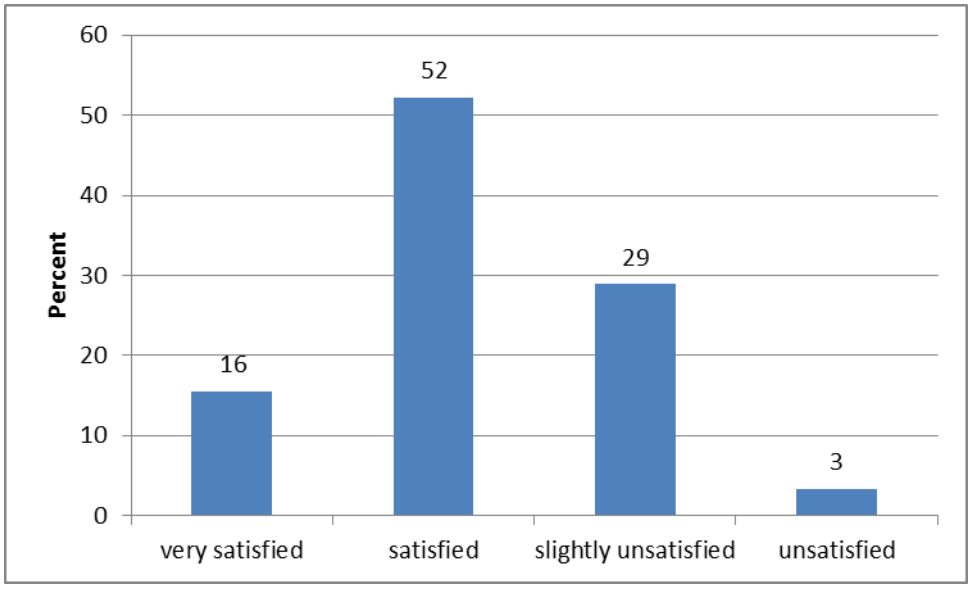


3.3.4 Satisfaction with services for acute health problem

Satisfaction (very satisfied and satisfied: 68%) among those suffering from an acute health problem was high; on the other hand a total of 29% (Diber: 25%; Fier: 37%) declared they were slightly unsatisfied and 3% unsatisfied with the services they received. The proportion of unsatisfied acute disease patients (1/3rd) is higher than those unsatisfied for chronic disease services (see section 3.2.4).

In urban settings, respondents showed less extremes, i.e. less 'very satisfied', but also less 'slightly unsatisfied' (see also Annex C).

Figure 33: Satisfaction among persons with an acute health problem with health service received (n=90)



3.3.5 Health expenditures for acute health problem

Total median costs were in both regions around 14 Euros whereby costs for drugs were the most important cost driver. Total median costs in rural settings were higher (16 Euros) compared to urban settings (12 Euros). In case patients were not insured total median costs were almost doubled compared to those of the insured, mainly because additional costs for treatment were necessary (see

Figure 35). Splitting the costs according to the acute illness: those with fracture (21 Euros) or digestive stomach problems (29 Euros) or diseases not specified in the questionnaire ("other"; 37 Euros) had the highest costs (see Annex C).

Figure 34: Median costs among persons with an acute health problem in the past four weeks by area of residency

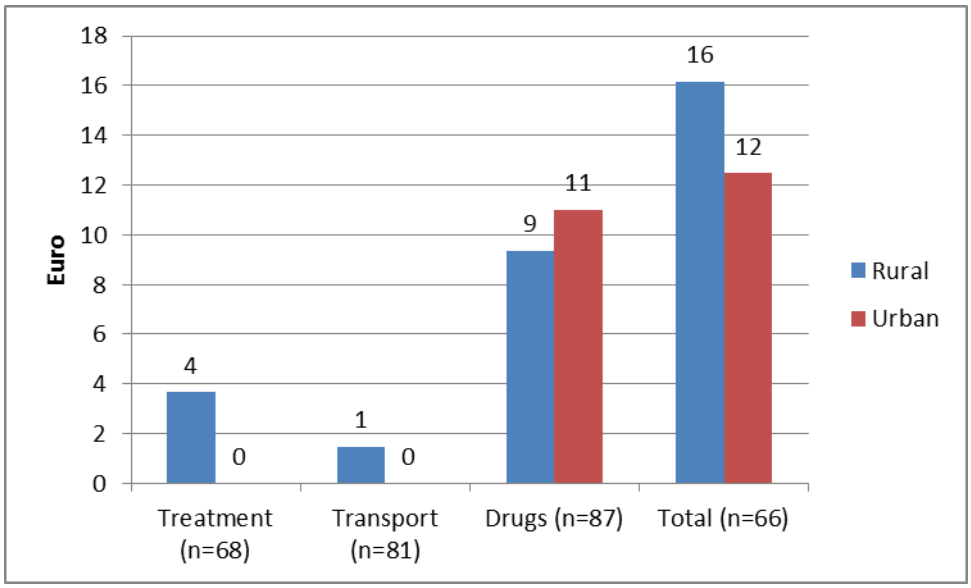
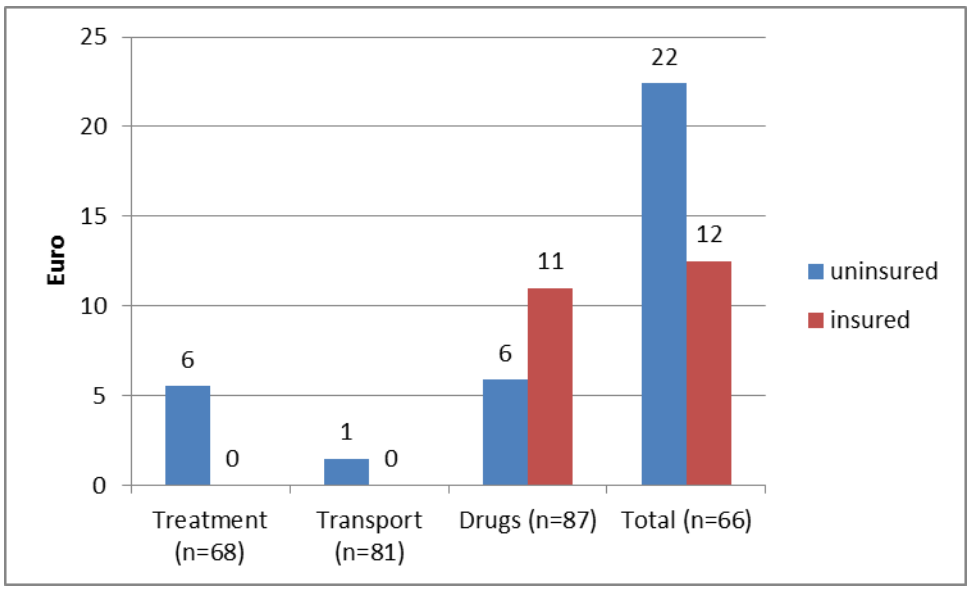


Figure 35: Median costs among persons with an acute health problem in the past four weeks by insurance status



Overall do the total costs for acute conditions split on average into 19% costs for admission, 11% for transport and 70% for drugs.

Table 11: Proportion of total costs in the past four weeks for acute conditions

Admission	Transport	Drugs	Total
19%	11%	70%	100%

A weak link could be detected between the satisfaction and the cost incurred: those unsatisfied or slightly unsatisfied had to bear the highest total median costs. 13% provided non-monetary gifts to the health provider although this seemed to be more common in Fier (Diber: 11%, Fier: 19%).

3.4 Mother and child health

3.4.1 Profile of interviewees

Overall 161 mothers of children under 5 years were interviewed, thereof most from Diber (68%, n=109) and from rural areas (73%; n=118). The average age of mothers was 28 years (median: 27 years).

Table 12: Demographic characteristics of mothers interviewed

	Diber	Fier	Rural	Urban	Total
n	109	52	118	53	161
Average age (SD)	28 (6)	28 (6)	28 (6)	29 (5)	28 (6)

3.4.2 Postnatal care

The majority of women had left the hospital after two to three days (55%). More than 90% of women had left the hospital within a week. The longest stay noted was 120 days.

62% of women had someone checking of their health conditions after being discharged from hospital, typically within the first week after discharge (78%). In most cases, this was carried out either by the nurse or midwife (56%) or a doctor (38%). However, in 2/3rd of cases this contact took place at the hospital rather than at home (1/3rd). Specifically, if the contact was with the doctor, this was more commonly taking place at the public health facility - hospital (79%) or the health centre (19%).

Seventy four percent (74%) of the mothers reported that a health provider checked the baby's health (Diber 71%; Fier 79%) after discharge from the hospital. Most commonly this was done by the nurse or midwife (48%), a paediatrician (31%) or a general doctor (21%). We identified regional differences between Diber and Fier; the checks being conducted more commonly by paediatricians in Diber (36%), whilst in Fier this seemed to be rather captured in 32% of cases by doctors (e.g. general doctors). T check was done in the first 7 days (55%). After 14 days the coverage among those who had received a check was 79%.[7]

As with maternal care, most health checks took place at public facilities, commonly governmental hospitals (53%) or governmental health centres (33%), and to a much smaller extent at health posts (10%) or other public facilities. Specifically paediatricians or doctors are conducting the checks in public hospitals (paediatricians: 89%, doctors: 63%) or health centres (paediatricians: 9%, doctors: 29%). About 4% of doctors' check-ups also take place at health posts. In comparison, nurses and midwifes practice the check-ups at the health centre (50%), public hospitals (27%) but also at health posts (20%).

[7] The proportion of all babies (including those who eventually did not receive a check) checked in the first two weeks after release from the hospital was 55% (see also Annex F).

Table 13: Mother & child health: Provision of postnatal care

	Diber	Fier	Rural	Urban	Total
Maternal health					
Time at hospital (days)	(n=105)	(n=52)	(n=116)	(n=41)	(n=157)
Average	6	5	6	4	5
Median	3	4	3	3	3
Check on maternal health conducted (in %)	(n=105)	(n=52)	(n=116)	(n=41)	(n=157)
	62	63	63	61	62
If maternal health check conducted: Time of check after discharge (days)	(n=65)	(n=33)	(n=73)	(n=25)	(n=98)
	7				
Average	6.5	7	7	7	7
Median		5	7	5	7
If maternal health check conducted: Health provider overseeing check (in %)	(n=65)	(n=33)	(n=73)	(n=25)	(n=98)
	34		37	40	38
Doctor	3	46	3	4	3
Paediatrician	60	3	58	52	56
Nurse / Midwife	0	49	1	0	1
Traditional doctor	2	3	1	0	1
Other	2	0	0	4	1
Don't know		0			
Child's health					
Check on child health (in %)	(n=105)	(n=52)	(n=116)	(n=41)	(n=157)
	71	79	73	76	74
Time after discharge (days)	(n=73)	(n=39)	(n=83)	(n=29)	(n=112)
Average	15	12	14	14	14
Median	7	7	7	7	7
Health provider overseeing child check-up (in %)	(n=75)	(n=41)	(n=85)	(n=31)	(n=116)
Doctor	15	32	20	23	21
Paediatrician	36	22	29	36	31
Nurse / Midwife	49	46	51	42	48

3.4.3 Child monitoring, development & growth check-up

Decision making for child growth monitoring and checks for the child is mainly done by the mother or mother in law (77%) and/or the husband (39%) with a partial overlap when decisions are taken jointly. Other relatives take relatively minor roles in this decision process.

The majority of mothers declared that the child's last check-up had taken place either in the last month before the interview (31%) or to 2-6 months ago (32%). Asking about

specifics of the growth and development check-up the most common was "checking the vaccination card" (89%); see Table 14. Questions on development progress or the nutritional habits were only done by about 2/3rd of the doctors. Of the checks conducted most common was the weight measurement (81%) and to a smaller extent head measurement (51%) and height measurement (57%). Information on disease prevention was only provided by 43% of health providers in the frame of the last check-up.

It appears that in Fier development and growth check-ups are conducted more rigorously as, compared with all items in the list of services, the performance was better. No systematic difference could be found in how health providers conducting growth and development checks.

Table 14: Growth and development check: questions asked and procedures provided in percent

	Diber (n=105)	Fier (n=52)	Rural (n=116)	Urban (n=41)	Total (n=157)
Mother asked about…					
… development progress	62	65	63	63	63
…child diet and eating habits	62	67	62	68	64
… vaccination card and revised it	91	87	90	88	89
Health provider conducted…					
…head measurement	42	69	48	59	51
… height measurement	50	73	53	71	57
… weight measurement	77	89	79	88	81
Provided…					
..information on how to prevent diseases	41	48	40	54	43
Average of activities performed during visit	4	5	4	5	5

About 20% of mothers reported having ever received information material in form of leaflets, booklets, brochures, Dvd's (Diber: 23%, Fier: 15%).

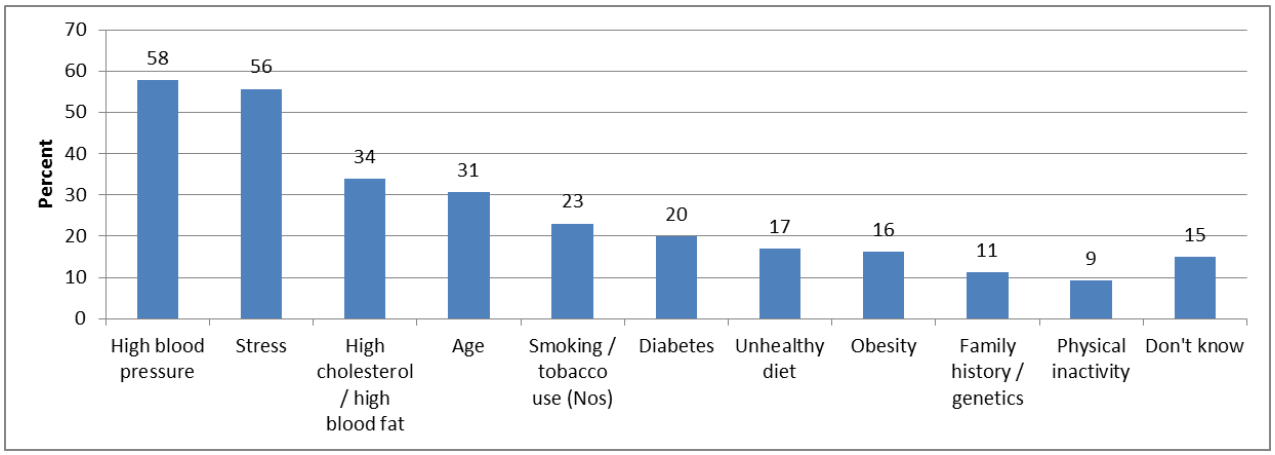
3.5 Knowledge, Attitude and Practice

3.5.1 Cardiovascular disease, diabetes, obesity & health beliefs

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

Participants correctly identified between 0 to 10 risk factors. Most of the interviewees cited two (22 %), three (19 %), one (15%) or four (12%) risk factors. 18% were able to cite more than four risk factors. 18 individuals mentioned ten risk factors. 14% of interviewees did not know any risk factor for cardiovascular disease. Figure 36 shows the cited risk factors for cardiovascular disease. High blood pressure and stress were mentioned by more than 50% of respondents. High cholesterol and age were known by approximately 1/3rd of respondents, followed by smoking, diabetes, unhealthy diet and obesity. Family history and physical inactivity were least commonly mentioned.

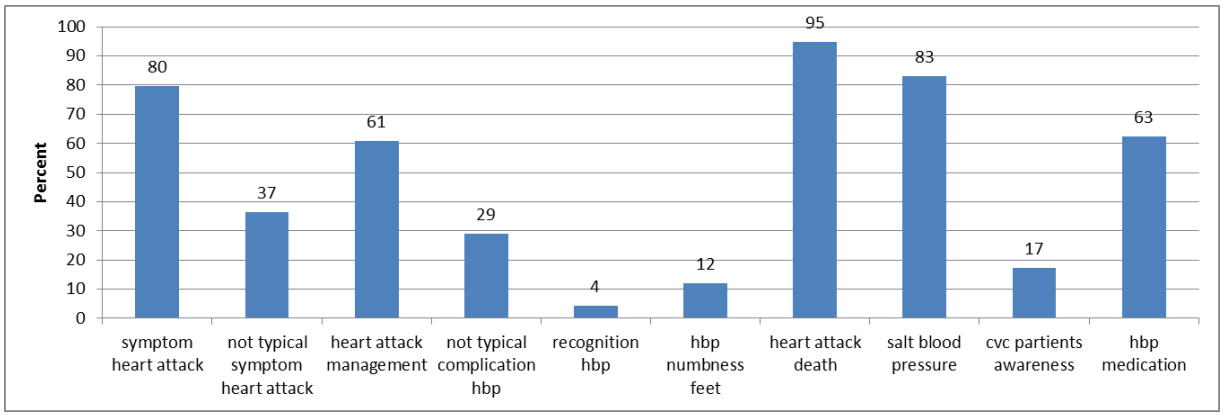
Figure 36: Identified risk factors by selected participants with a chronic or acute condition for cardiovascular disease (n= 1,264)



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

Figure 37 illustrates the knowledge on cardiovascular diseases. The question 'Heart attack is a frequent cause of death' was correctly answered by a large majority (95%), followed by 'Eating less salt can have a good effect on blood pressure" (83%), 'typical symptoms of a heart attack' (80%). More difficult questions 'High blood pressure can cause a feeling of numbness in the feet' and 'Patients easily recognise high blood pressure because of the symptoms' were correctly answered only by a minority of the study participants (12% and 4%, respectively).

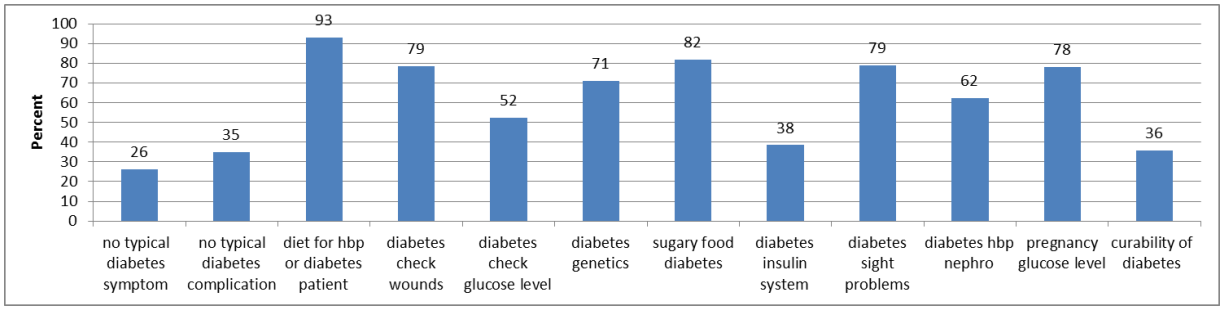
Figure 37: Overall percentage of correct answers for knowledge questions on cardiovascular disease by selected participants with a chronic or acute condition (n= 1,264)



A high knowledge was observed for the questions on 'Healthiest food for a person with diabetes or high blood pressure' (93%), 'Consuming too much sugary foods can be a cause of diabetes' (82%) followed by 'Patients with diabetes should regularly check their feet wounds which do not heal' (79%), 'diabetes is a common cause of problems with seeing' (79%) and 'Women have to check their blood sugar levels during pregnancy' (78%).

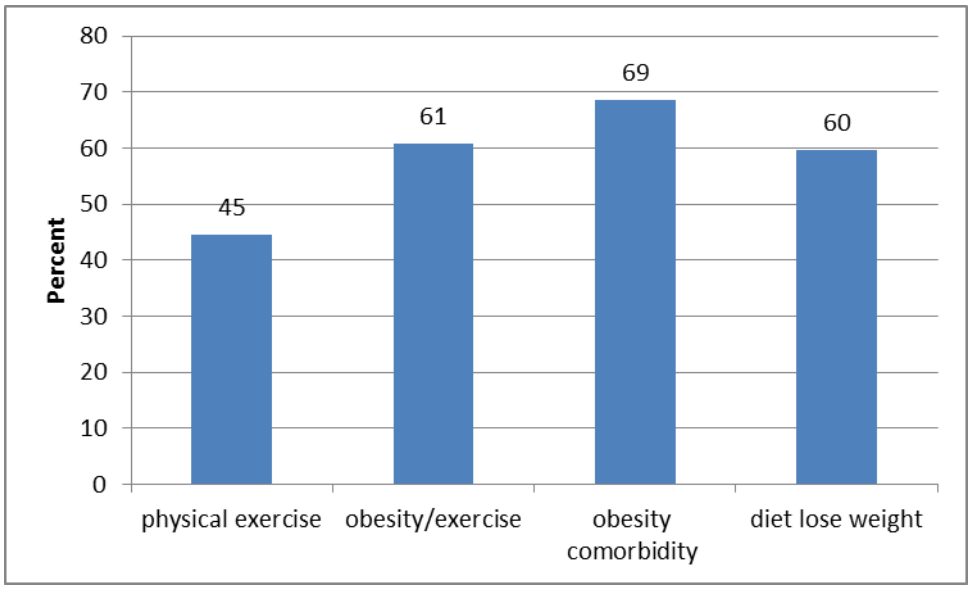
A low percentage of correct answers was found for 'not a typical diabetes symptoms (26%)', 'not typical a complication of diabetes' (35%), 'Diabetes can be cured' (36%) and 'In diabetes patients, the insulin system works normally' (38%).

Figure 38: Overall percentage of correct answers for knowledge questions on diabetes by selected participants with a chronic or acute condition (n= 1,264)



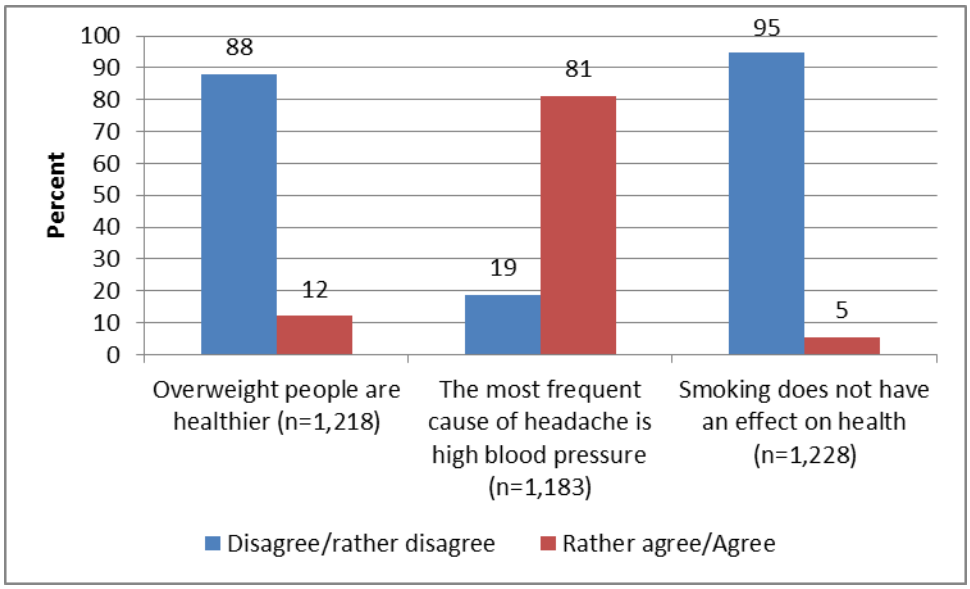
The knowledge on obesity showed a consistent relative positive picture with between 60-70% of respondents knowing the correct answers. It is noteworthy that only 45% of interviewees correctly answered the question on 'how often should you do physical exercise'.

Figure 39: Overall percentage of correct answers for knowledge questions on obesity by selected participants with a chronic or acute condition (n= 1,264)



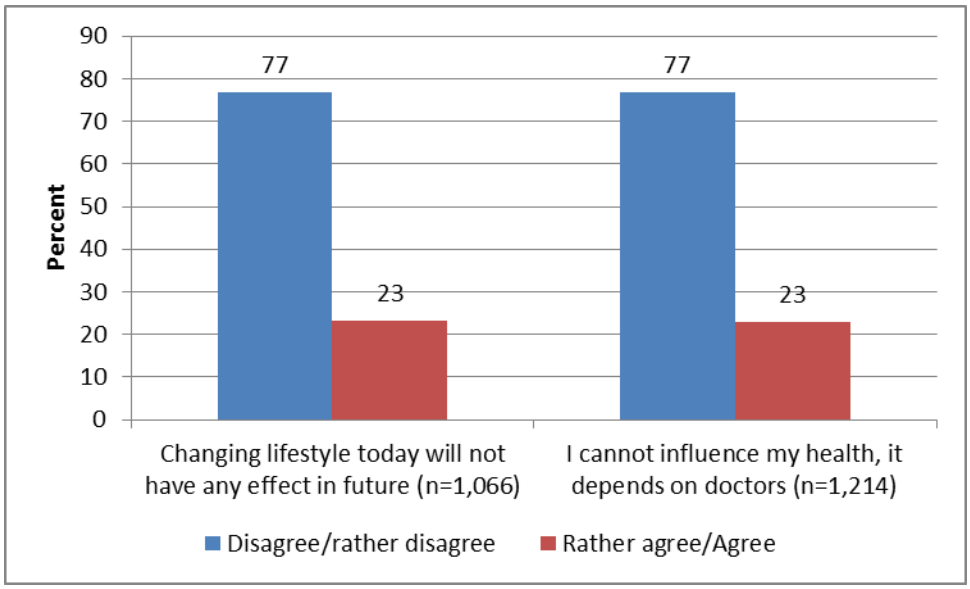
Health beliefs of the interviewees on general statements and of the own health are illustrated in Figure 40 and Figure 41. The findings overall indicate a rather good knowledge.

Figure 40: Opinions of selected participants with a chronic or acute condition on the general health



Beliefs on influencing, and, to a certain degree, controlling the own health showed that the majority of interviewees considered their own health as a status that can heavily be influenced by todays behaviour. However about 20% of interviewees see their health as a given status which can be influenced only to a limited extent.

Figure 41: Opinions among selected participants with a chronic or acute condition on the own health



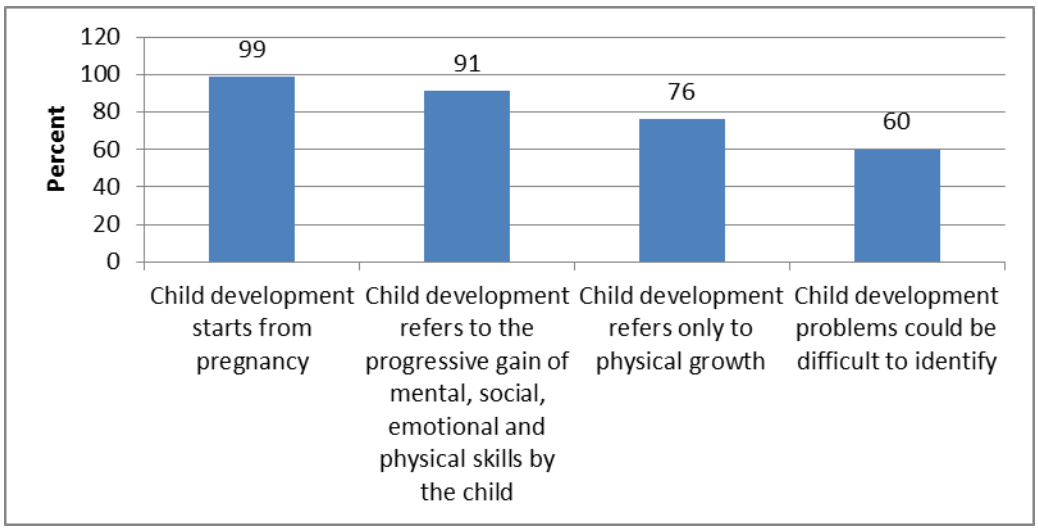
3.5.2 Child health

The following graphs (Figure 42 to

Figure 44) show the knowledge of mothers about child development and risk factors for children's growth and development. The anticipated answers are listed in Annex E.2

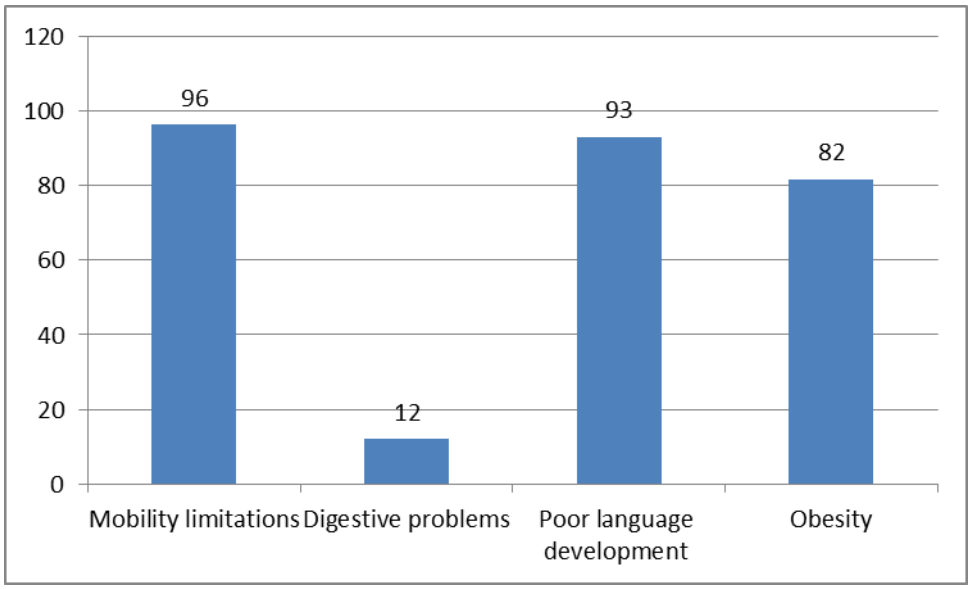
There is a very high awareness amongst mothers that child development starts already from pregnancy and that it encompasses mental, social, emotional, and physical skills. Contradictory though, 76% of women also claim that it only refers to physical growth. Only 60% of women are aware that development problems could be difficulty to identify (see Figure 42).

Figure 42: Percentage of correct answers among mothers regarding children's development (n=157)



The manifestations of growth and development problems are well known (between 82% and 96% of correct answers), though only 12% identified digestive problems as not directly related to growth and development (see Figure 43).

Figure 43: Percentage of correct answers among mothers of manifestations of growth and development problems in children (n=157)



The overall knowledge on risk factors for child growth and development are well known (see Figure 44). In 9 of the 11 listed risk factors correct answers were given for more than 90% of questioned women. But again we experienced low knowledge rates for items that are not a risk for child development, e.g. 'occasional colds during childhood' are only seen by 23% not as risk factor (see Figure 45).

Figure 44: Percentage of correct answers among mothers of risk factors for children's growth and development (n=157)

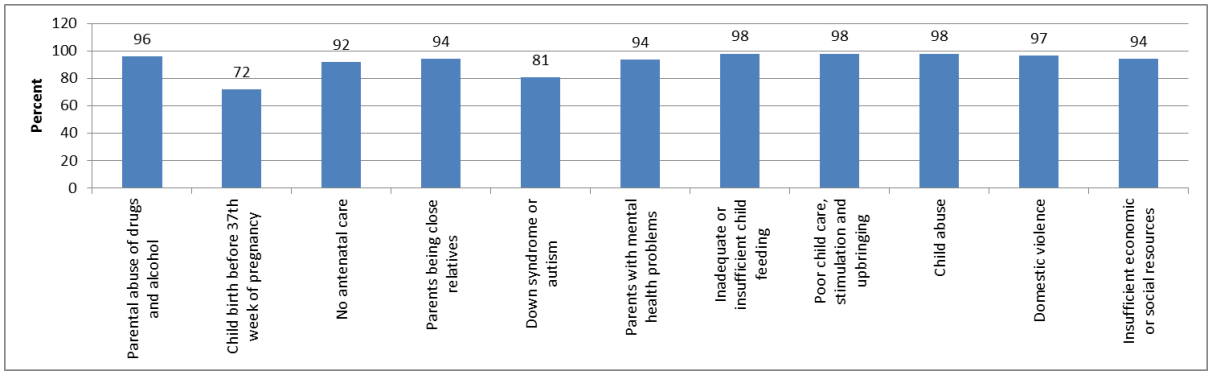
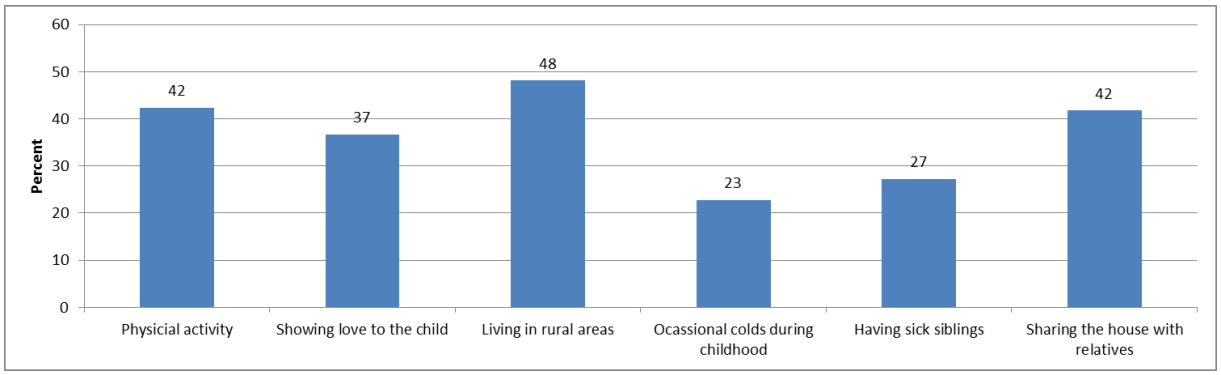


Figure 45: Percentage of correct answers for among mothers of factors that are not a risk for children's growth and development (n=157)



The identification of growth and development problems in children up to 1 year, between 1 and 4 years and consequences of child development problems achieved overall very high knowledge scores with a few exceptions, related to negative items (e.g. child <1 not defecating regularly, genetic disorders as a complication of development problems). 77% of mothers knew that a child should sit by him/herself at the age of 3 to 9 months and 93% could indicate that a child should walk between 9 and 18 months. However, only 29% of mothers could identify that a child should be reacting to noises between the 3rd and 9th month.

4 Study limitations and bias

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

Contact and response rates are very high and the very limited number of household that were not successfully contacted or who had no chronic or acute ill patient was low. The two possible explanations are that either interviewer's had not recorded all contacts as their targets were the successful conducted interviews or that the inclusion criteria were framed in such a way that almost each household was eligible. Comparing the age distribution of the survey to the census 2011, we discover that the younger age categories are underrepresented and older age groups (49-65; 65+) are overrepresented (Table 15). The overrepresentation of elderly individuals might explain the relatively high proportion of chronic conditions in the sample and indicate a possible selection bias.

Table 15: Comparison of age distribution between household survey and census 2011

	Diber		Fier	
	HH-Survey	Census 2011	HH-Survey	Census 2011
<5	8%	7%	5%	12%
5<18	19%	30%	13%	18%
18<49	41%	41%	35%	39%
49<65	20%	14%	25%	19%
65+	12%	9%	22%	12%

- Due to the sampling procedures no prevalence estimates for chronic respectively acute conditions in the whole of the population can be estimated.
- The data collection was carried out in October/November 2015 which is typically a time where an increased number of acute infections are being observed.
- The various sections of the questionnaire were merged according to the birthdate of the respective person, e.g. the recorded birthdate of the person who answered the questions on the chronic conditions was compared to the birthdate of the household roster. This way we could merge the household and socio-demographic variables to the respondent. The birthdate was though prone to error and thus some manual corrections needed to be conducted (e.g. month and day interchanged) to be able to merge the different questionnaire sections.
- Due to the technical limitations it was not possible to generate an automated random selection within the household of chronic or acute patients. Hence interviewers were instructed to prioritise chronic disease patients over acute patients and in case more than one patient was available within the household to apply the last birthday method. Given the age distribution of selected chronic disease patients a higher number of elderly people in the sample of selected could have been expected. Hence it could be possible that no random selection according to the last birthday method was applied within the household. Also likely is that some household members refused participation (e.g. older individuals) and thus other/younger household members were prioritised.
- The PCA approach provides a statistical methodology to reduce data complexity and to create a new variable that is labelled as “wealth index”. Indeed, asset indicators are combined and the assumption that assets can typically be translated in monetary values can be questioned. Hence the terminology as “wealth index” can be misleading and should possibly be interpreted also as a “asset index”
- The differentiation between high blood pressure and heart problems may have led to some confusion in the way lay persons use concepts of circulatory problem (high blood pressure) and cardiac/heart problem (ischemia for instance.
- The estimation of costs for chronic conditions may be impeded by a new regulation of the Health Insurance Fund that advises doctors to prescribe reimbursable drugs to chronically ill people once in two months. Hence whilst patients are recommended to check their health status on a monthly basis the cost for drugs, are only incurred on a bi-monthly basis.
- Mothers of children under 5 years often answered negative items incorrectly, i.e. only a small proportion of mothers identified the items as being wrong. This

pattern could indicate that they – by tendency – agreed to the items independent from the content.

-

5 Discussion and recommendations

The household survey is a comprehensive data collection that captures information on 1'275 households and 5'188 individuals living in those households. For each individual household member we collected basic information on the person's background and the health and insurance status. Further detailed information was obtained from 1'096 persons who indicated to suffer from a chronic disease, and 175 persons who had in the four weeks prior to the survey been affected by an acute health problem. Here we asked about access to health services, barriers for accessing care, health expenditures and the person's knowledge, attitude and practice in relation to chronic conditions. Lastly we obtained information on mother and child care from 161 mothers of children under 5 years and also checked their knowledge, attitude and practice on child growth and development.

HOUSEHOLDS & HOUSEHOLDS MEMBERS

The majority (96%) of households reported that their priority health providers are public PHC providers. The main reason for this choice is proximity. About 80% live less than 5 kilometres from the next PHC facility. Only 2% of households in Diber, a mountainous region, live about 20 kilometres from the closest by PHC facility. Hence physical access should not be considered as a major barrier. Respondents stated also that costs, coverage through health insurance and good services are relevant aspects. However, there are hardly any private primary care providers in the regions and the Albanian Health Insurance Fund (HIF) contracts only public PHC providers. Thus patients have very limited alternatives to the public PHC providers. From this perspective it is of utmost importance that the PHC facilities provide high quality of care and that patients have faith and trust in the health provider.

Regarding the health situation in households one can say that the majority of household members is healthy. In the past four weeks there were about 11% of all household members acutely ill, mostly children. About 25% of household members are chronically ill and 9% are chronically and acutely ill. As expected, the proportion of those with chronic conditions increases among those 50 years old and above.

More than half of household members had at the time of the interview a valid health insurance card, whereby availability was better in Diber than in Fier and better in urban than in rural areas. The obligation to renew the health insurance card every six month was the main obstacle for those who were uninsured at the time of the interview. The reason for the obligation to regularly renew the card is that the Health Insurance Fund has an opportunity to penalise unpaid contributions. However, the percentage of

those actually paying their own contributions (i.e. persons who are in paid work in Albania) is relatively low in comparison to the overall number of insured persons. Hence one could argue that the costs for renewing the card on patient side (e.g. transport but also opportunity costs) are exceeding the benefit of the health insurance fund for identifying users with unpaid contributions. In the future could also the introduction of an increasingly electronic management of the payments of the Health Insurance Fund (since 2016 being tested with plans for scaling up) provide an opportunity to electronically block insurance cards of users who did not pay their contribution and thus allow a permanent card without expiry date. This would limit the burden on patients, but also the administrative burden of the Health Insurance Fund would be substantially lowered. Lastly, there are on-going discussions on switching to a national paid insurance scheme. This would also allow handing out time unlimited insurance cards. However, there were also about 20% of household members who thought that they do not need a health insurance card and about 15% indicated that they do not pay contributions or are not eligible.

The introduction of Universal Health Coverage (UHC) in 2016 is likely to increase the amount of those uninsured as treatment is also free of charge for the uninsured. However the expenses for drugs are a main cost driver when seeking care and these are not covered with UHC. Hence it will be important to increase awareness of the population on the potential risks of having no health insurance and to counterbalance already existing tendencies that those in need of regular drugs (e.g. chronically ill) will have health insurance coverage.

CHRONIC & ACUTE CONDITIONS

The selected chronic disease patients mostly suffered of high blood pressure, heart problems, rheumatism and diabetes. The diagnosis was mostly given at a governmental hospital or a governmental health centre again emphasising the important role of the public health sector. 70% of the interviewees had sought care in the previous four to eight weeks. Health seeking patterns reflected the requirements of the disease (e.g. monthly checks on diabetes vs. several times per year for cancer) and likely the policy of the Health Insurance Fund (prescription of drugs for two months). When choosing the health provider what mattered most for persons with a chronic condition was the geographical proximity to the health provider, followed by the quality of services and the costs.

Selected patients, who had an acute health problem in the past four weeks were mainly affected by cold/flu, fever and persistent cough with fever. About half of the patients had sought care at public health facilities. This highlights again the importance of the public health sector in Albania for primary care. Patients consulted also other providers beyond the PHC facility mainly because services were not offered, the facility was closed or not all tests could be performed. The reasons indicated that despite a far-reaching availability of facilities, the services provided and possibly the required infrastructure is not sufficient to provide the services required for acute care.

The two biggest difficulties for seeking care for chronic patients were the unavailability of financial funds to cover related health costs and costs of transport to the health provider. The situation was the same for those suffering from an acute health problem. However, in acute situations, patients also indicated their lack of trust in the doctor, that no gender specific doctor was available and the belief that problems would go away without treatment or through self-medication. These aspects were for chronic patients of rather low relevance which might yet again show that chronic disease patients had more time to orientate themselves and to choose over a longer time their preferred health provider. The specific mistrust of acute patients towards doctors in urban settings and the issue of a lack of financial fund in rural areas should receive some specific attention.

Satisfaction among patients with chronic conditions was higher than for those with an acute health problem (20% vs. 32% slightly unsatisfied or unsatisfied). The reasons could be that either chronic disease patients receive repeatedly similar treatments and thus their expectations are more in line with what they receive or chronic disease patients have already selected the doctors they are most satisfied with, whilst acute patients need to take the doctor which is in their acute situation available. It is also possible that patients with a chronic condition are older and tend to be less critical.

Total median expenses for chronic conditions in the past four weeks were 25 Euros and therewith almost twice as high as for acute conditions (14 Euros). In both cases were expenses for drugs the biggest cost driver (72% for chronic conditions and 70% for acute conditions). This finding is quite surprising as the drugs for the insured should mainly be covered by the Health Insurance Fund. The relatively high costs could either indicate that patients insist on having specific drugs which are not listed by the health insurance fund and thus co-payments are required or that patients also purchase drugs without specific prescriptions. The median costs for admission were in both cases zero, but proportionally they ranged between 12% for chronic conditions and 19% for acute conditions. Median transport costs were for patients with chronic conditions higher than for those with an acute health problem, which can possibly be related to choosing also other than PHC facilities as health provider. Total median costs varied for those with a chronic condition respectively an acute health problem with the health insurance status. Hence having a health insurance card reduces costs by a substantial proportion. Overall costs were double as high for those uninsured compared to those insured. In-kind payments have further possible effects on both equity and access to care and policymakers should address this issue to discourage such practices.

MOTHER & CHILD HEALTH

Post-natal care consultations were typically provided within the first week after discharge from the hospital. Most of consultations to women and children were provided by a nurse/midwife (56% and 48% respectively) followed by a doctor and for children also by a paediatrician.

Child monitoring and development check-up also appear to be routinely conducted, although the comprehensiveness of the checks is a bit questionable. The check of the vaccination cards is thereby given a high priority as well as weight measurement. Other physical examinations or questions on development progress are still checked in the majority of cases (approx. 55%-60%) but this must be considered as too low. Also information on preventing diseases or other information on child health is insufficiently distributed. This finding is consistent with the analysis of the Quality of Care Survey conducted by Project HAP in spring 2015. There it was found that only one of the health facilities surveyed had all tools for monitoring child development (psycho-motor/cognitive skills).

KNOWLEDGE, ATTITUDE AND PRACTICE

Respondents, who were in-depth questioned about their chronic or acute condition, were also questioned on their knowledge, attitude and practice related to cardiovascular disease. The number of risk factors for cardiovascular diseases that can be cited by respondents is relatively mixed. There are about 18% who could cite more than four risk factors but there were also 14% of interviewees who could not think of any risk factors. Commonly known were two to three risk factors. The knowledge on cardiovascular disease and diabetes showed that "easy" items obtained a high proportion of correct answers among respondents, whilst more challenging questions, that required a deeper understanding of the diseases and the causes, were only recognised by a smaller number of the respondents. Typical questions that were more difficult were question on signs and symptoms and even more so what would not be a sign and symptom. This could indicate that respondents are sensitised towards changes in their body but that they cannot relate them or differentiate them to the different possible diseases. For obesity general knowledge was lower than for cardiovascular or diabetes. Specifically the question on physical exercise had relatively low scores. The result could indicate that more information on lifestyle related factors and particular sensitisation on obesity could be needed.

Very high levels of knowledge on child health and development were observed among mothers. Risk factors for development and also aspects relating to child development were generally well known. The progress of a child and its exact ordering into chronology was for some mothers difficult, specifically for when a child should react to noise. However, these are also orientation marks and thus the results should be treated with care.

Out of the above the following brief recommendations are derived:

Table 16: Recommendations and next steps

Finding	Recommendation
PHC facilities are the main provider for chronic	It is of utmost importance that the PHC facilities are further strengthened in providing high quality of clinical care, which also

and acute conditions	includes infrastructure and equipment.
A main issue for lacking health insurance coverage is the obligation to renew the health insurance card every 6 months	HAP should consider supporting technical advancements but also policy initiatives to reduce the burden for patients to renew their health insurance card every 6 months. This should be done in view of avoiding free-riders but at the same time in the light of the newly introduced UHC and already on-going discussions on a fully state financed insurance system.
The costs for uninsured are substantially higher	Increase awareness of the population on the potential risks of having no health insurance. Monitor and possibly counterbalance tendencies of decreasing health insurance coverage due to the UHC introduction, specifically as costs for drugs are not covered.
Referrals, unavailability of services, tests and closure of the facility were reasons why not only PHC services were accessed	HAP should work towards addressing infrastructural deficiencies and thus contribute towards better services and availability of services.
Persons with an acute health problem faced the following concerns: lack of trust in the doctor, unavailability of doctors of the same sex ; so that their satisfaction was relatively low	Acute health situations seem not to be adequately covered at PHC facilities. The project should evaluate whether this could relate to a) a lack of procedures and guidelines; b) lack of knowledge at health staff level on how to treat patients, c) reimbursement mechanisms or else, d) lack of the required equipment, consumables, medicines and other materials
Most post-natal care, including children and mothers, checks were done facility based.	Evaluate possibilities of home-based services and their cost-effectiveness.
Checks on child development were not covering all various aspects	Develop protocols and checklists for checks on child development and update the knowledge of health providers accordingly.
Overall good knowledge but lack of specific disease knowledge on diabetes and obesity	Increase the awareness of signs and symptoms for diabetes and specifically also awareness of lifestyle factors related to obesity.

6 Conclusion

The household survey provides a comprehensive data collection that once more emphasises the importance of the public health sector in Albania. Even more so, the challenges, barriers and difficulties should be actively addressed for accessing the

services or trusting the services. A main focus should thereby be given to financial barriers, the quality of services and the coverage of health insurance. In addressing these issues attention should be given to differences between the region but more so between urban and rural health facilities. The knowledge of the population on cardiovascular disease and child development seems good, but there is room for improving the knowledge on a more fundamental level, thereby giving specific attention to lifestyle related factors.

Annex

Annex A: Abbreviations

HAP	Health for All Project
HH	Household
HIF	Health Insurance Fund
KAP	Knowledge, Attitude and Practice
MoH	Ministry of Health in Albania
n	Sample size
ODK	Open Data Kit
PCA	Principal Component Analysis
PHC	Primary Health Care
Q	Quintile
SCIH	Swiss Centre for International Health
SDC	Swiss Development Cooperation
Swiss TPH	Swiss Tropical and Public Health Institute
UHC	Universal Health Coverage

Annex B: Approval letter from MoH

REPUBLIKA E SHQIPËRISË
MINISTRIA E SHËNDETËSISË

Nr. 1559 Prot
4

Tiranë, më 07.09 2015

Drejtuar: **Projektit "SHËNDET PËR TË GJITHË"**

Për Dijeni: **Drejtorive të Shëndetit Publik: Fier, Lushnje, Mallakastër, Peshkopi, Bulqizë, Mat**

Bashkive: Fier, Lushnje, Mallakaster, Divjakë, Roskovec, Patos, Dibër, Mat, Bulqizë, Klos

Lënda: **Miratim dhe Informim për kryerjen e studimit "Aksesi i Familjes në Kujdesin Parësor Shëndetësor" në qarqet Dibër dhe Fier.**

Projekti "Shëndet për të Gjithë" 2015 - 2018 i financuar nga Agjencia Zvicerane për Zhvillim dhe Bashkëpunim i cili zbatohet ne qarqet Dibër dhe Fier do të kryejë studimin "Aksesi i Familjes në Kujdesin Parësor Shëndetësor" gjatë muajve Shtator – Tetor 2015 në nivel familje në këto dy qarqe. Ky studim është pjesë e planit të aktiviteteve të projektit për 2015, i miratuar nga Ministria e Shëndetësisë.
Protokolli i studimit së bashku me pyetësorët përkatës janë shqyrtuar dhe miratuar nga Ministria e Shëndetësisë.
Me qëllim kryerjen me sukses të këtij studimi, kërkohet ndihmesa e DSHP-ve dhe organeve të pushtetit lokal në mbarëvajtjen e procesit të mbledhjes së të dhënave.

Ju falëminderit,

ZËVENDËSMINISTËR
Milva EKONOMI

Adresa: Bulevardi "Bajram Curri" Nr 1, Tirana, Albania. Tel: +355 4 23646 22 www.shendetesia.gov.al

Annex C: Additional tables & graphs

Household level

Table 17: Overview on household assets

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

Question	Answer categories	Diber (n= 642)	Fier (n= 633)	Urban (n= 448)	Rural (n=825)
	Strain through a cloth	4	9	8	3
	Use water filter	8	10	6	13
	Let it stand and settle	0	3	0	3
What kind of toilet facility do the dwellers in your dwelling/apartment usually use?	Flush or pour flush toilet	68	64	62	72
	Pit latrine	13	16	18	6
	Composting toilet	3	4	5	0
	Bucket toilet	3	4	3	5
	Hanging toilet/hanging latrine	14	13	12	17
	No facility /bush / field	1	0	0	1
Do you share this toilet facility with other dwellings/apartments?	Yes	13	8	9	15
Assets 1					
Does your dwelling/apartment have:	Radio	12	11	10	15
	Television	99	100	99	100
	Telefone	89	88	86	92
	Landline phone	11	13	5	25
	Internet access	33	25	24	40
	DVD Player	20	17	19	19
	CD Player	7	3	3	8
	Refrigerator	93	97	95	95
	Freezer	10	8	9	10
	Washing machine	84	88	84	92
	Dishwasher	22	24	22	24
	Mircowave	13	16	10	24
	Sofa	96	98	97	96
	Electric radiator	12	13	8	21
	Generator	2	1	2	2
	Sewing kitt/machine	16	17	13	23
	Air conditioner	4	8	3	11
	Water boiler	50	67	54	67
	Computer	17	12	10	22
	Laptop	18	12	11	22

Question	Answer categories	Diber (n= 642)	Fier (n= 633)	Urban (n= 448)	Rural (n=825)
	Satellite Dish or cable receiver	64	72	65	74
What type of fuel is mainly used for cooking in your dwelling/apartment?	Electricity	5	8	3	13
	Liquid Propane Gas	14	48	25	42
	Natural Gas	8	27	16	21
	Charcoal	1	0	0	0
	Wood	72	17	57	23
How many rooms in this dwelling/apartment are used for sleeping?	1	24	27	22	32
	2	50	50	52	46
	3	20	20	22	18
	4	5	2	4	3
	5	0	1	1	0
Assets 2					
Does any member in this dwelling/apartment own	a watch	92	87	89	91
	a bicycle	13	23	17	19
	a motorcycle or scooter	4	13	10	6
	an animal-drawn cart	6	6	9	1
	a car or truck	27	25	25	29
	a tractor	3	2	4	1
	a boat with a motor	1	0	1	0
Does any dweller in this dwelling/apartment own agricultural land?	Yes	75	70	94	32
Do the dwellers in this dwelling/apartment own any livestock, herds, other farm animals or poultry?	Yes	62	48	79	10
How many of the following animals do the dwellers in this dwelling own?	milk cows or bulls	92	53	76	57
	horses, donkeys or mules	27	20	25	4
	goats	8	12	10	15
	sheep	15	12	14	9
	chickens	65	86	74	72
	pigs	2	1	2	2

Question	Answer categories	Diber (n= 642)	Fier (n= 633)	Urban (n= 448)	Rural (n=825)
Does any dweller in this dwelling/apartment have a bank account?	Yes	28	21	20	34
Does your household have regular internet access?	Yes	35	25	23	42
Does your household have at least one mobile phone?	yes	99	97	98	97

Table 18: Ownership of assets and household characteristics by wealth quintiles

	Total (n=1'275)				
Household Asset Variable	Q1	Q2	Q3	Q4	Q5
Improved water source for drinking water	17	20	20	24	19
Improved water source for other water (e.g. hand washing)	20	23	20	20	16
Improved toilet facilities	17	22	19	23	19
Household assets (cumulative index) Mean	10	8	8	7	5
Does the member of apartment own (cumulative index)	2	2	2	2	1
Own agricultural land	9	18	26	26	22
Own livestock	3	11	23	34	29

Figure 46: Health Status by location (rural (n= 3,535) vs. urban (n=1,649))

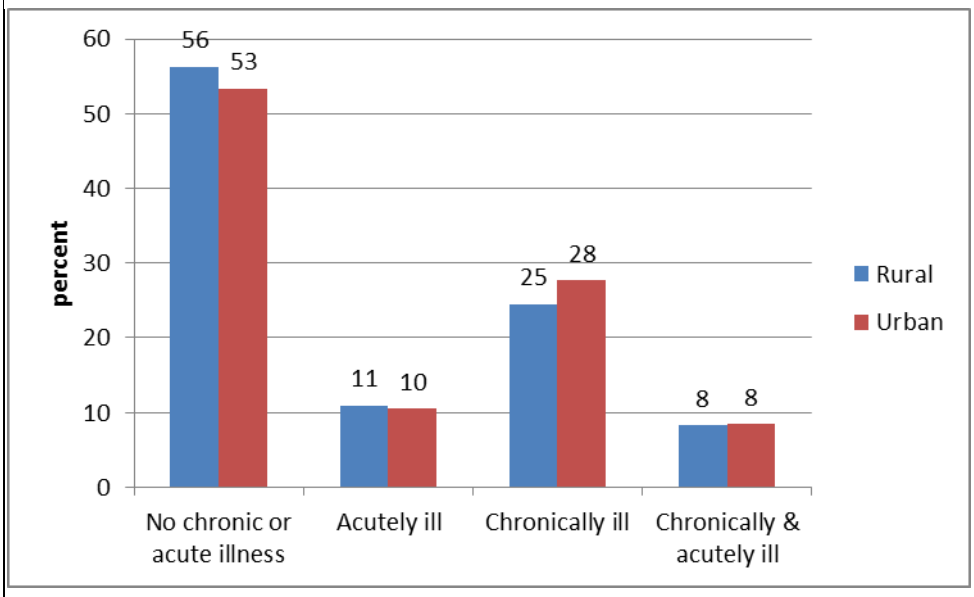


Figure 47: Health status and age groups

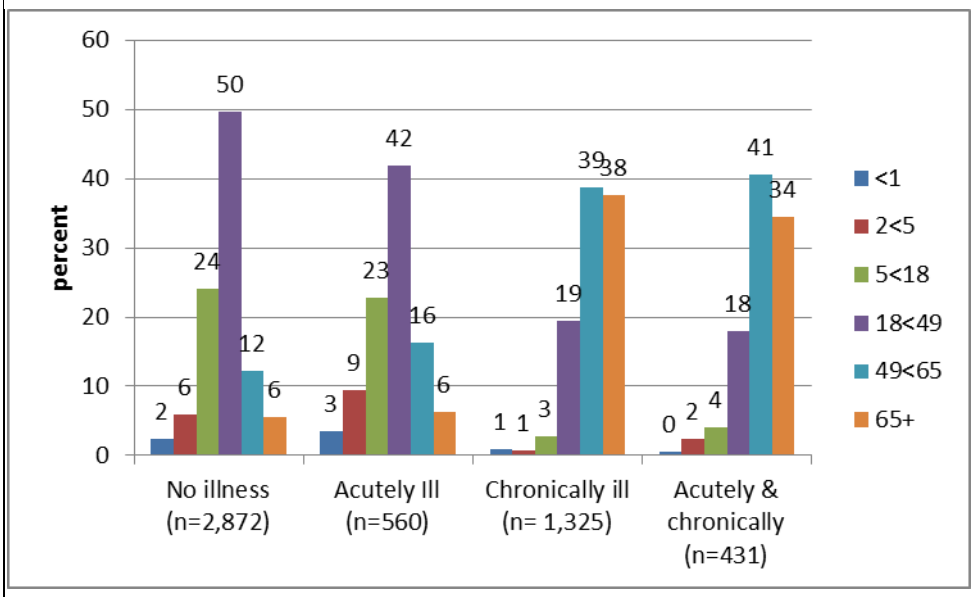


Figure 48: Reasons for not having health insurance (n=902)

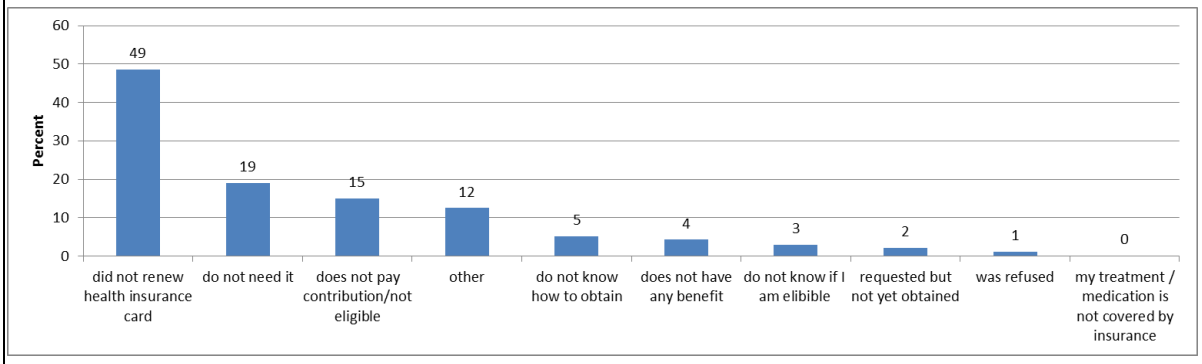


Figure 49: Insurance status and age groups

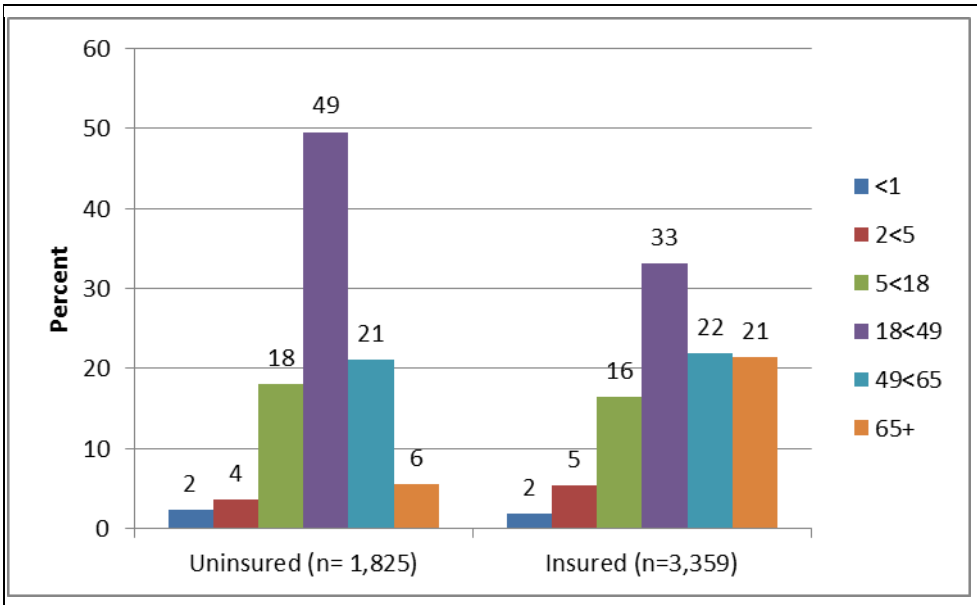
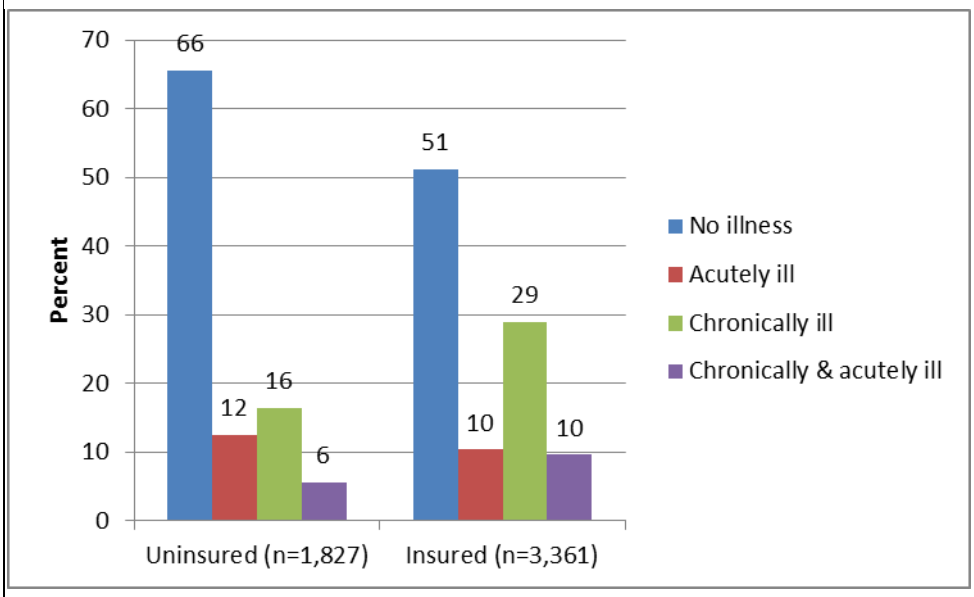


Figure 50: Insurance status and health status



Chronic conditions

Figure 51: Chronic conditions: Diber (n=522) vs. Fier (n=574)

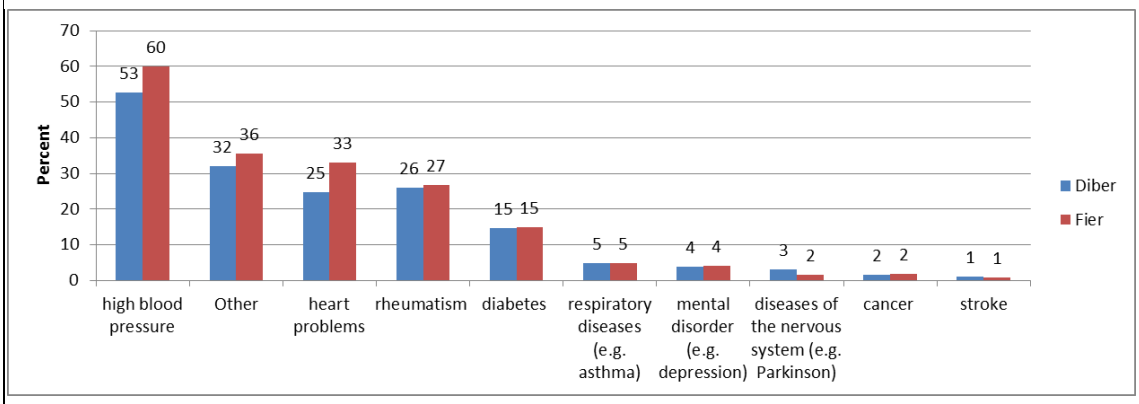


Figure 52: Chronic conditions: Rural (n=715) vs. Urban (n=380)

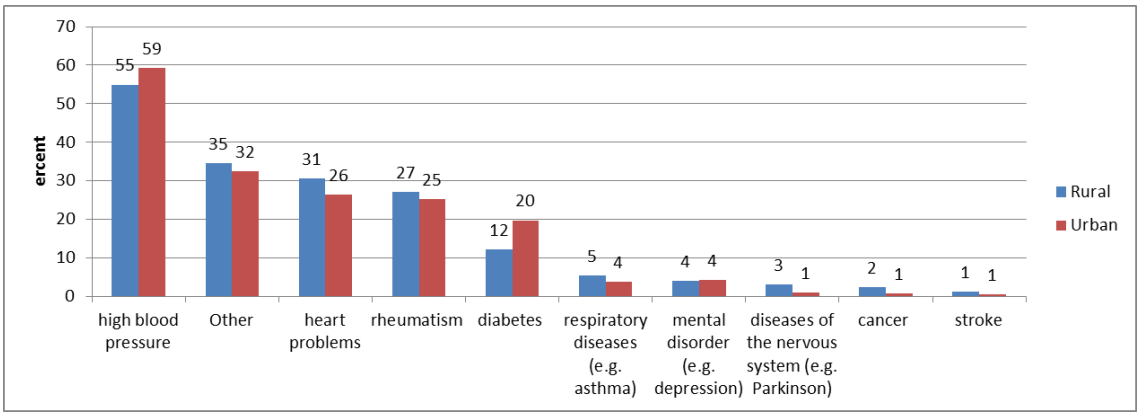


Figure 53: Public facility of diagnosis: Diber (n=522) vs. Fier (n=574)

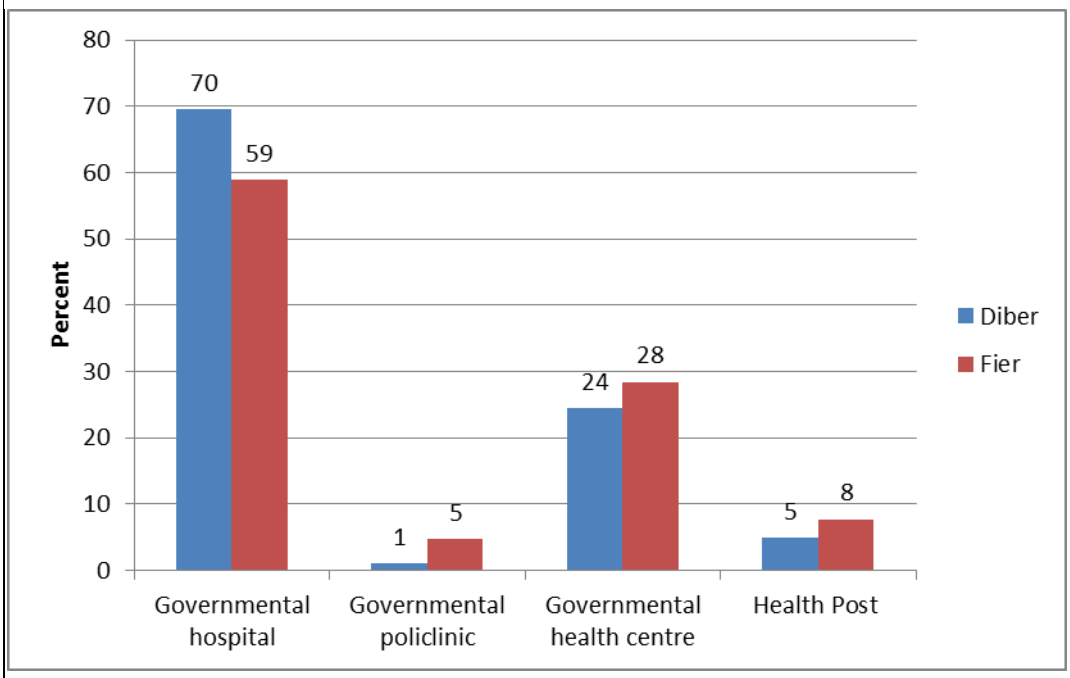


Figure 54: Public facility of diagnosis: Rural (n=715) vs. Urban (n=380)

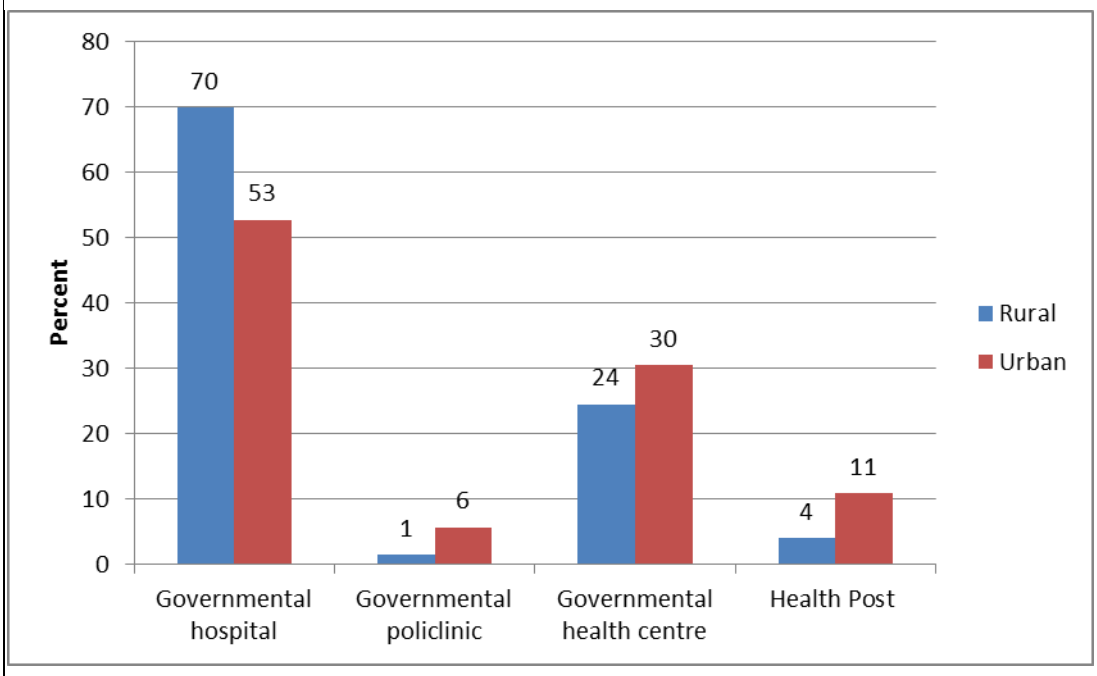


Figure 55: Aspects relevant for choosing a health provider: Diber (n=363) vs. Fier (n=404)

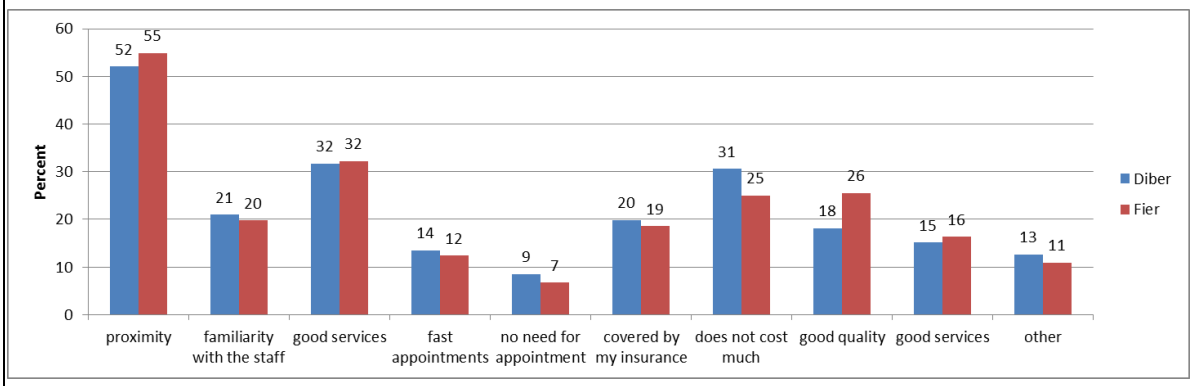


Figure 56: Aspects relevant for choosing a health provider: rural (n=494) vs.urban (n=273)

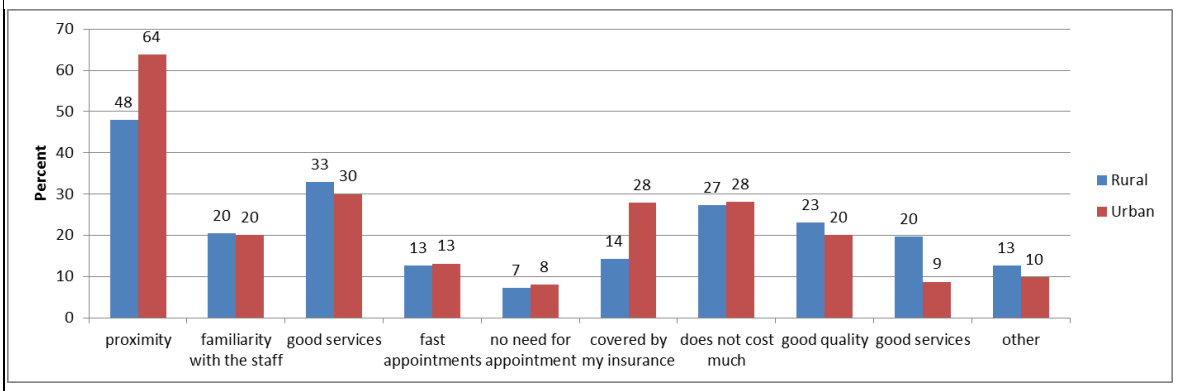


Figure 57: Distance to health provider for chronic condition (n=767)

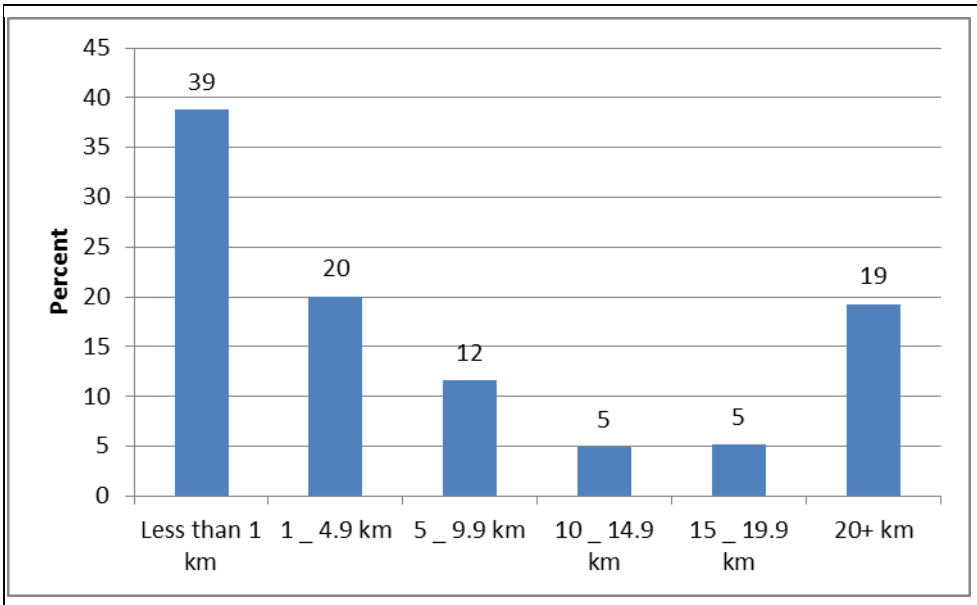


Figure 58: Why not only PHC: Diber (n=363) vs. Fier (n=404)

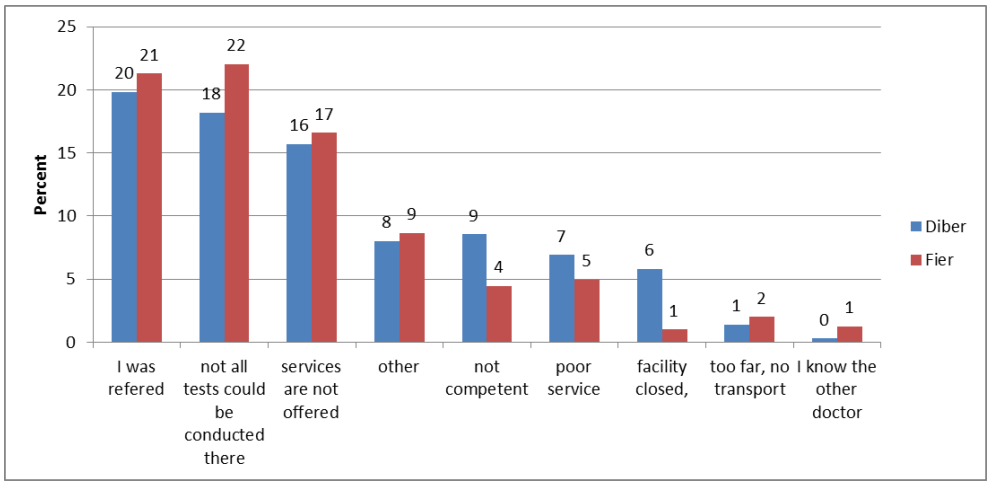


Figure 59: Satisfaction: Diber (n=363) vs. Fier (n=404)

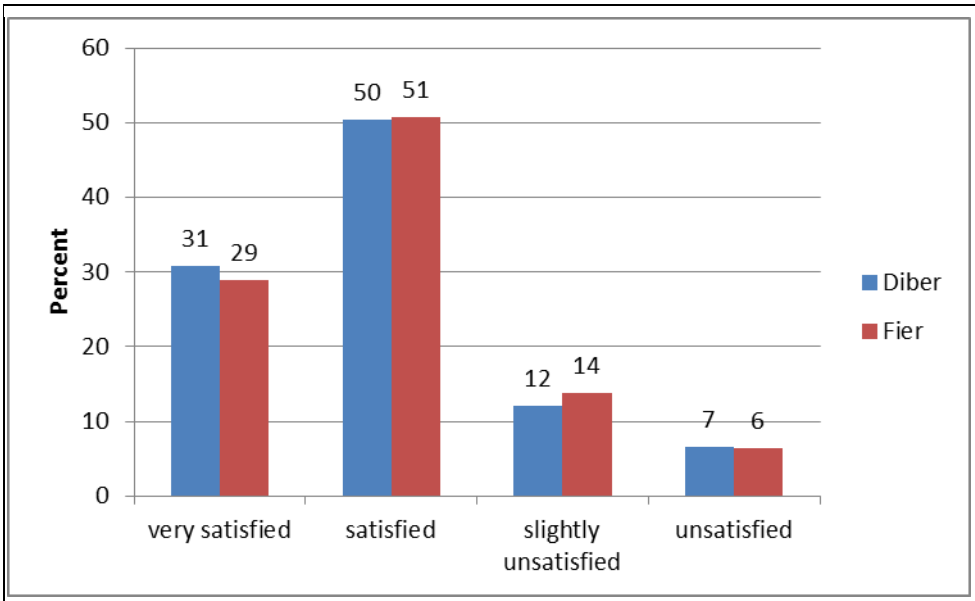


Figure 60: Median Costs (Euro) for Chronic Conditions in past 4 weeks: Diber vs. Fier

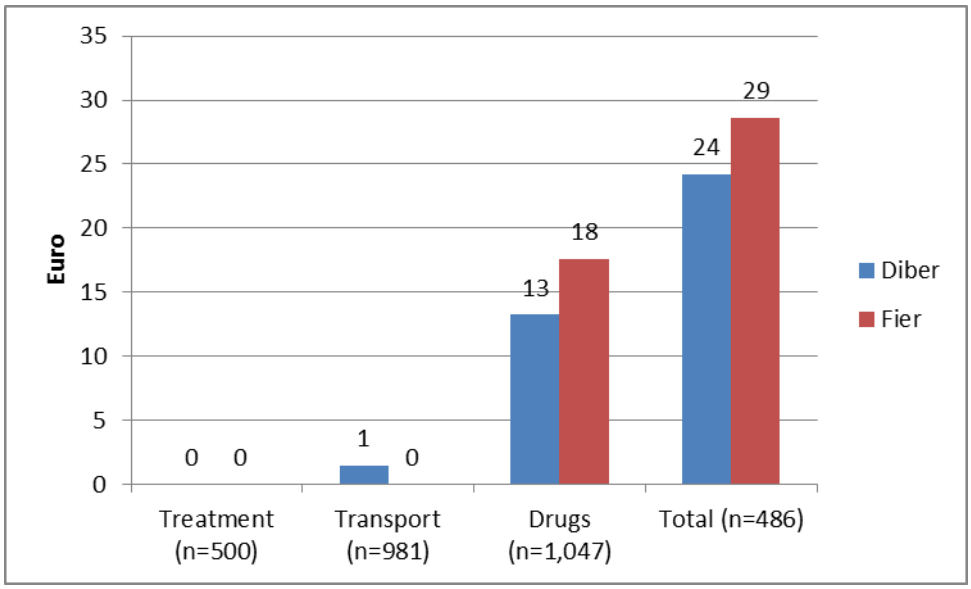


Figure 61: Median Costs (Euro) for Chronic Conditions in past 4 weeks and level of satisfaction with services received

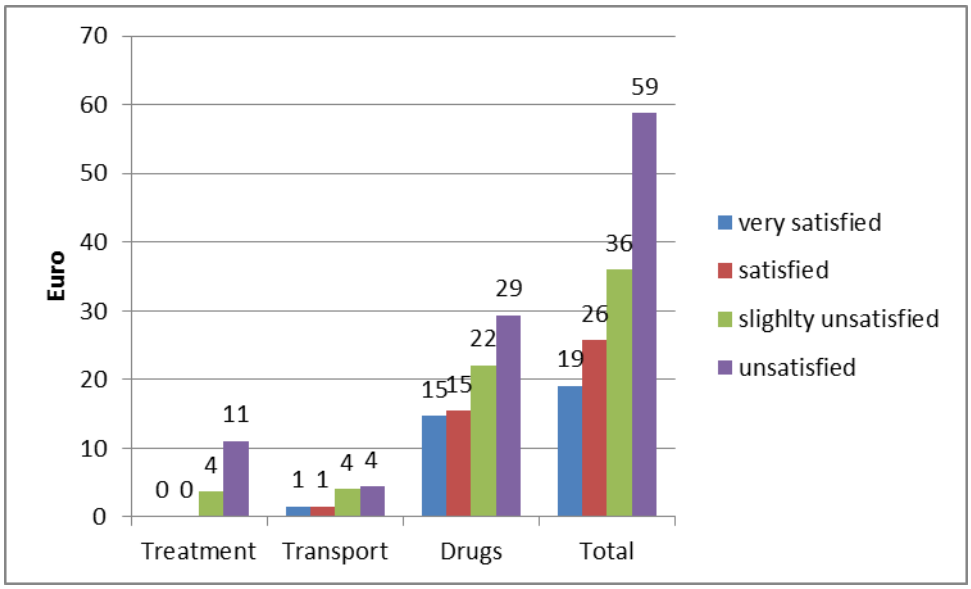
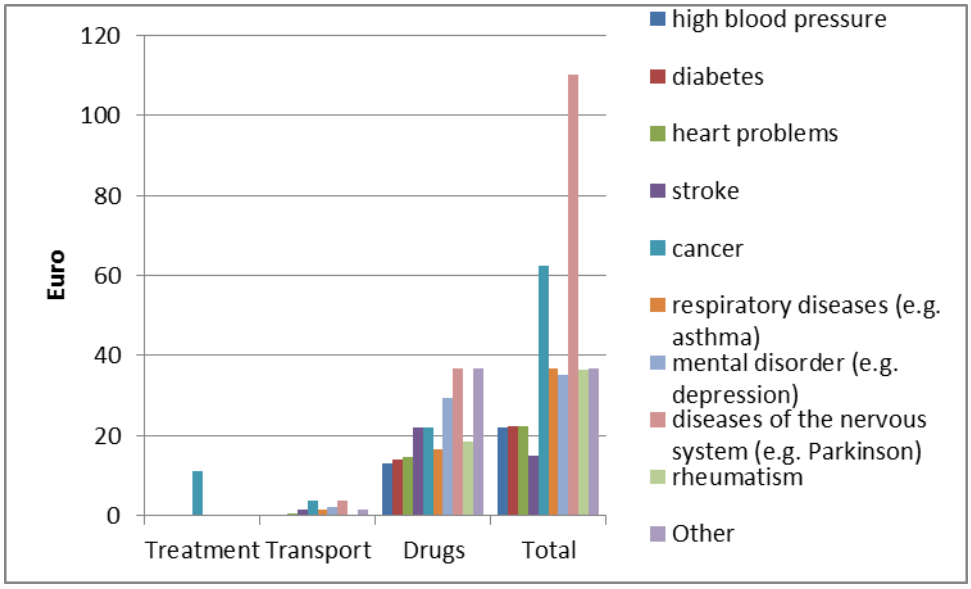


Figure 62: Median Costs (Euro) for Chronic Conditions in past 4 weeks and type of chronic condition



Acute conditions

Figure 63: Acute conditions: Diber (n=117) vs. Fier (n=58)

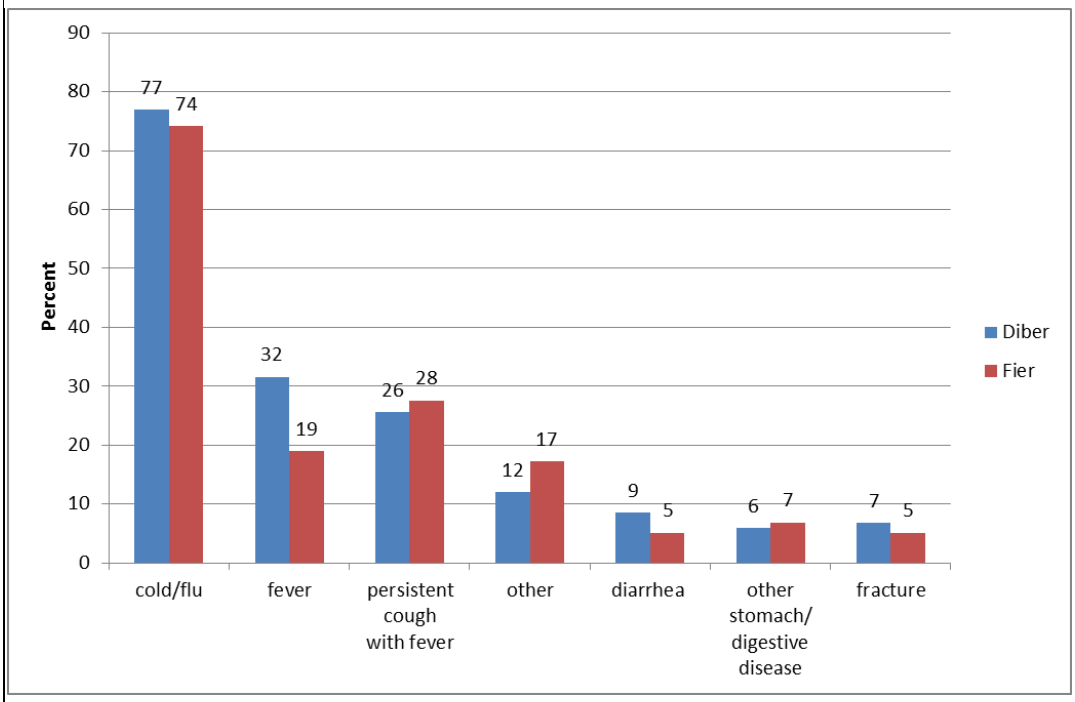


Figure 64: Acute conditions: Rural (n=107) vs. Urban (n=67)

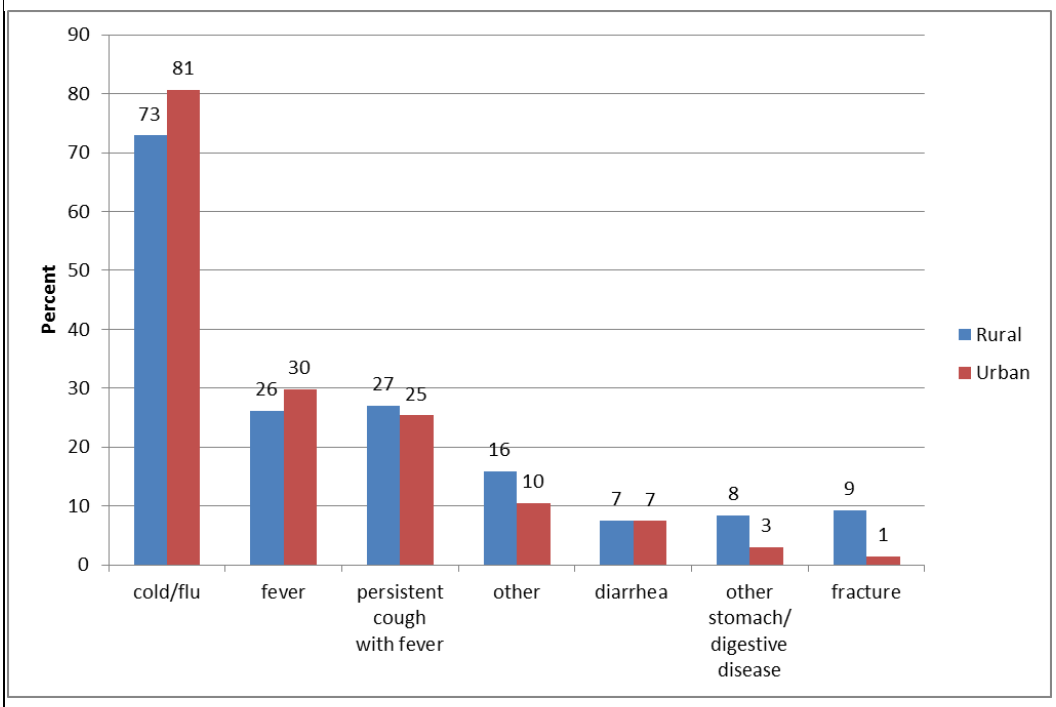


Figure 65: Public health providers: Diber (n=62) vs. Fier (n=25)

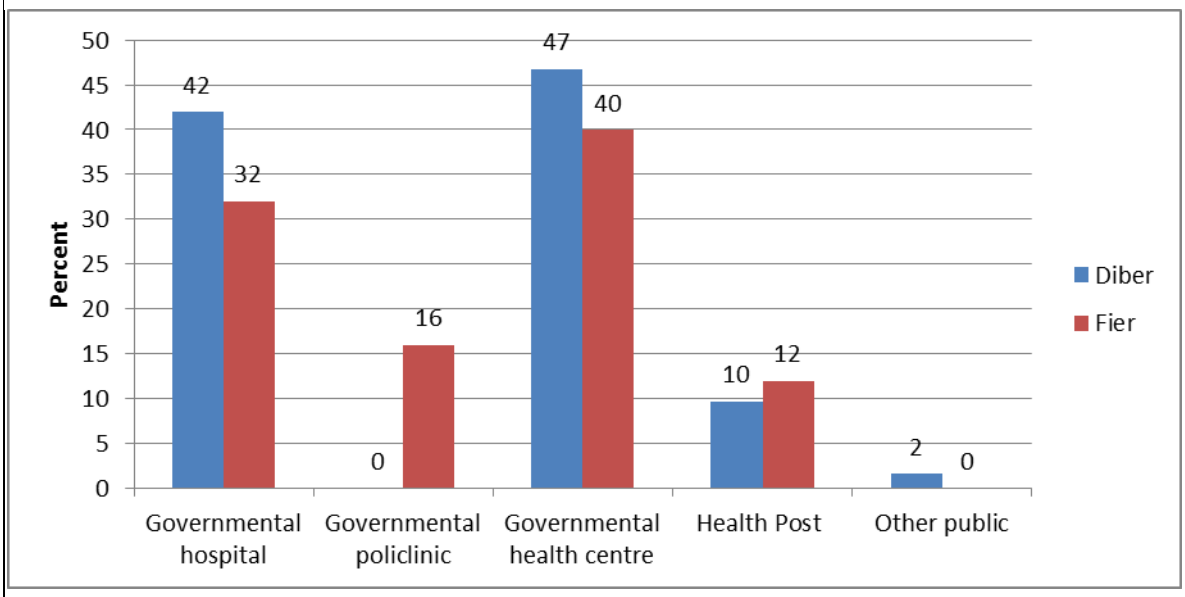


Figure 66: Public health providers: Rural (n=55) vs. Urban (n=32)

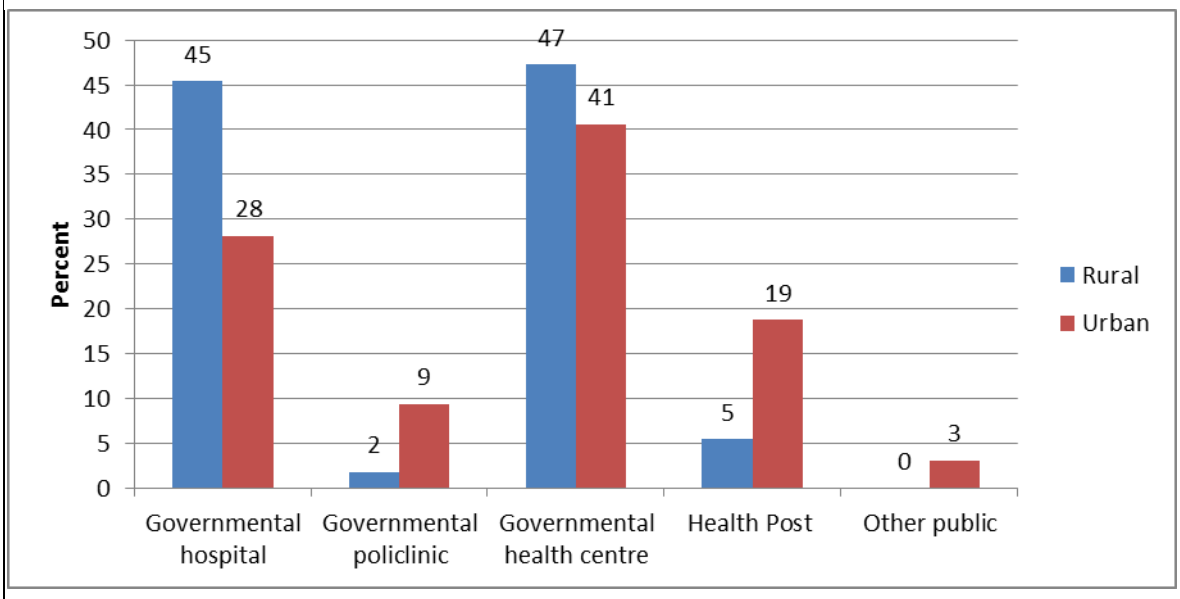


Figure 67: Why did you not seek care for your acute condition: urban (n=50) vs. rural (n=34)

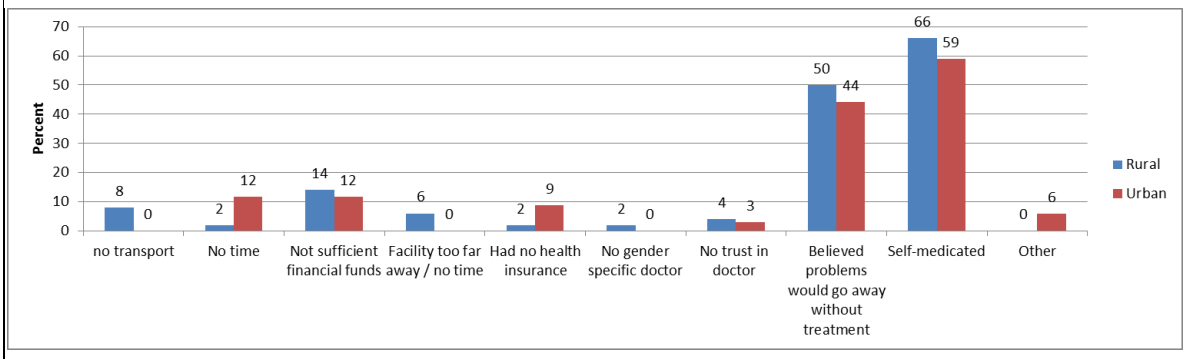


Figure 68: Difficulties for obtaining care for acute conditions: Diber (n=12) vs. Fier (n=3)

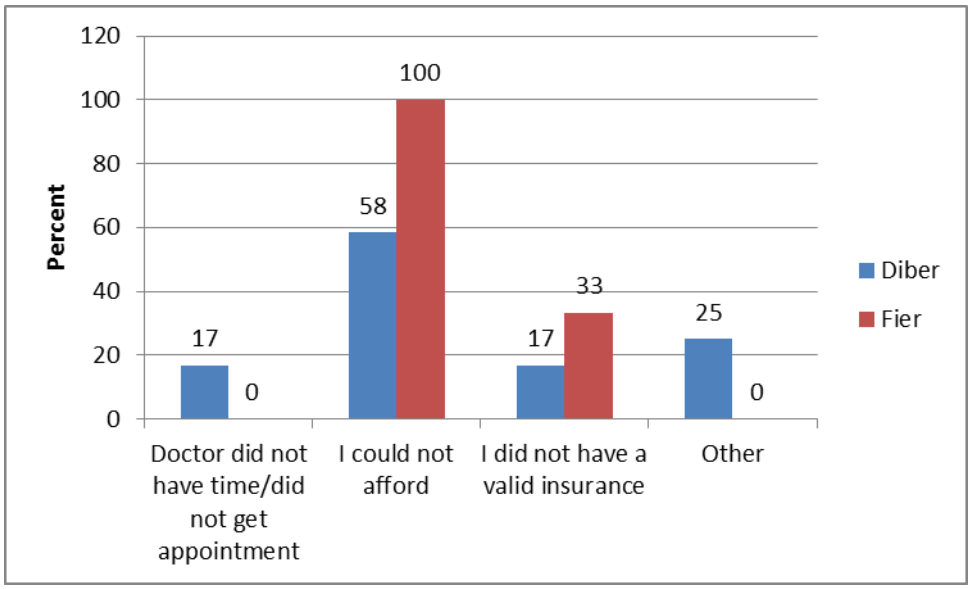


Figure 69: Difficulties for obtaining care: Rural (n=10) vs. Urban (n=5)

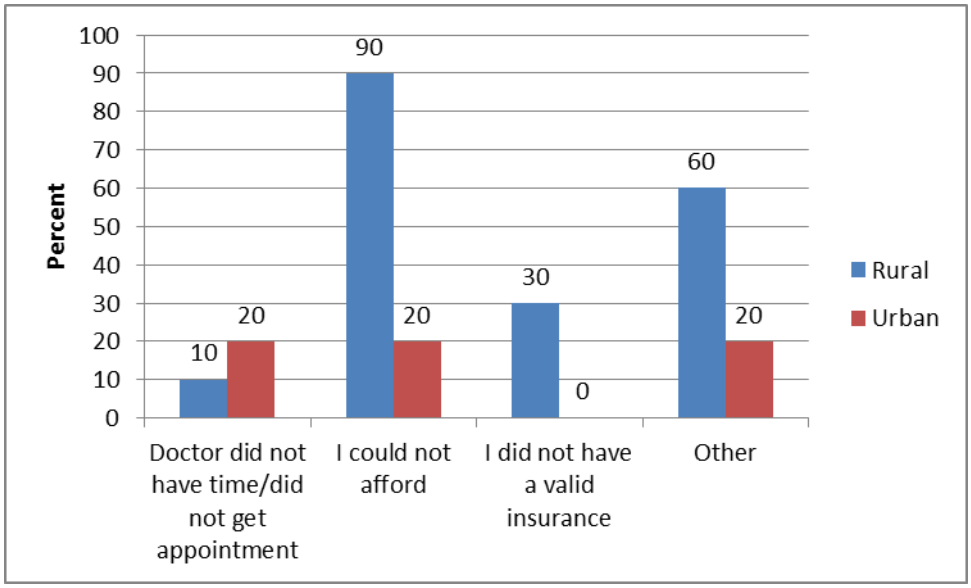


Figure 70: Satisfaction for acute conditions: Diber (n=63) vs. Fier (n=27)

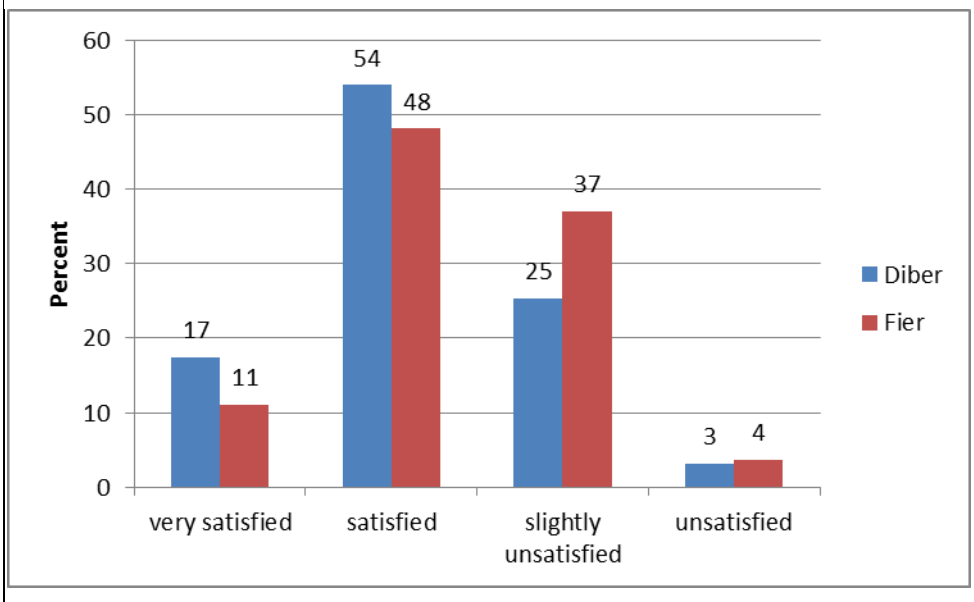


Figure 71: Satisfaction: Rural (n=57) vs. Urban (n=33)

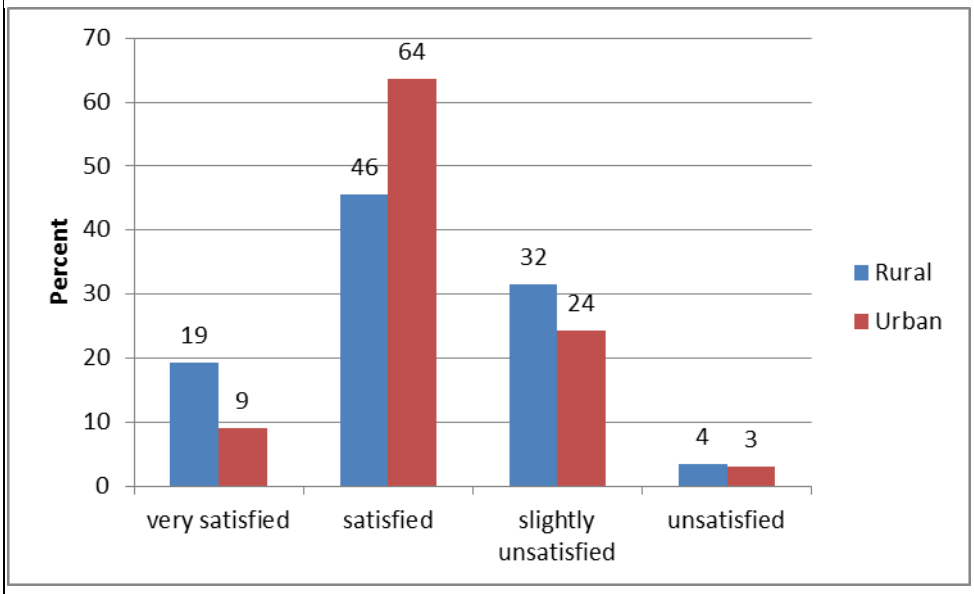


Figure 72: Median Costs (Euro) for Acute Conditions in past 4 weeks: Diber vs. Fier

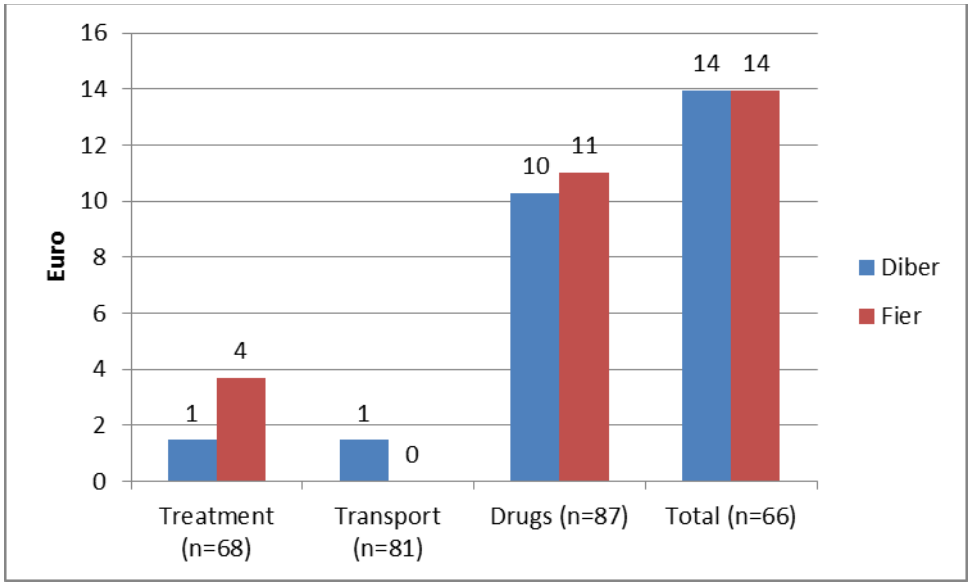


Figure 73: Median Costs (Euro) for Acute Conditions in past 4 weeks and level of satisfaction with services received

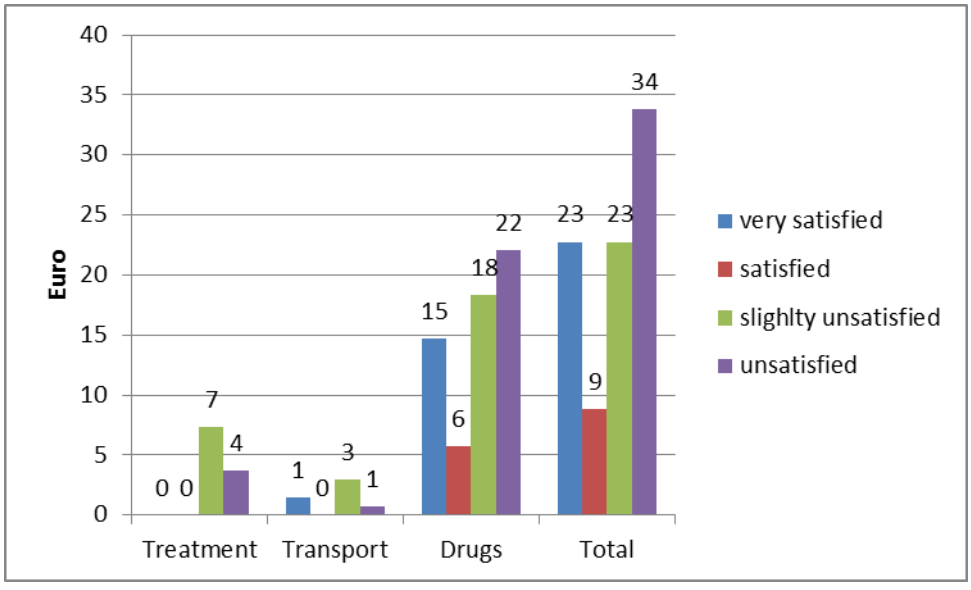
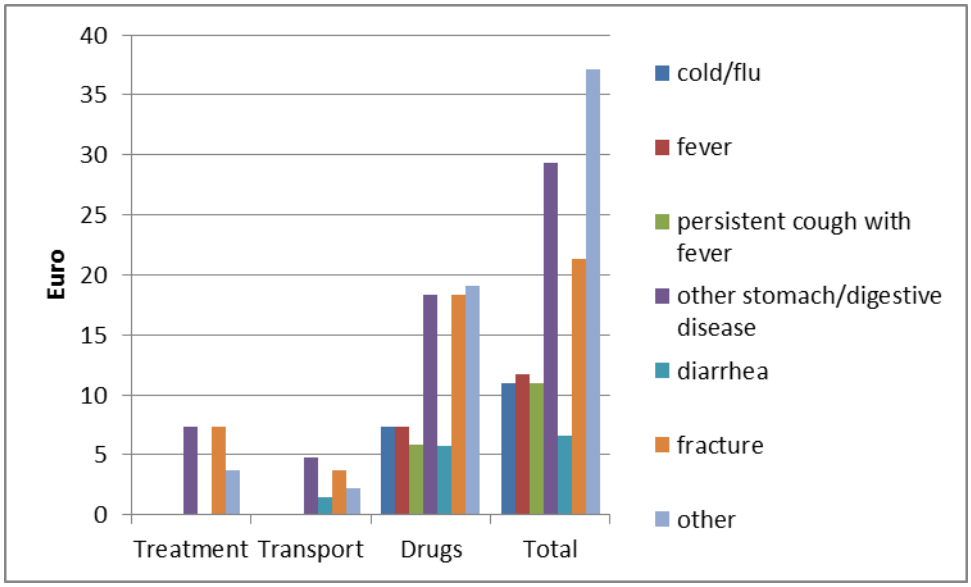
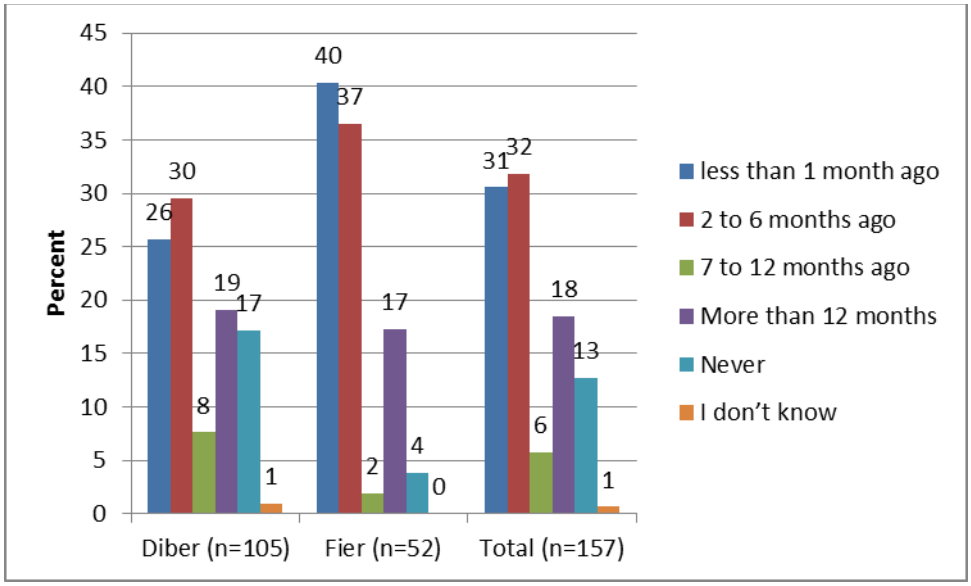


Figure 74: Median Costs (Euro) for Acute Conditions in past 4 weeks and type of acute condition



Mother and Child Health

Figure 75: Last growth and development check-up



Knowledge, Attitude and Practice – Child Health

Figure 76: Manifestations of growth and development problems in children (n=158) (percentage of correct answer)

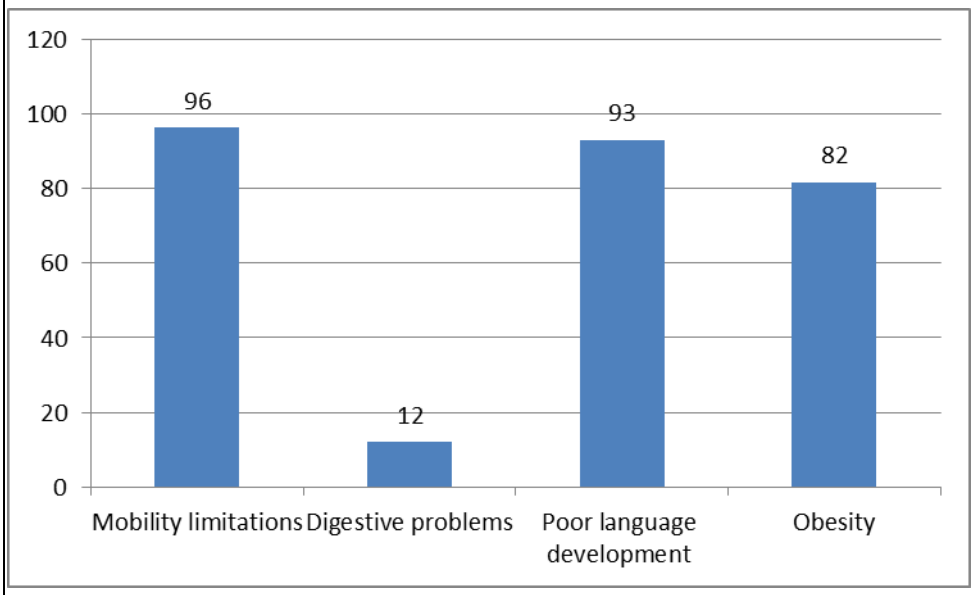


Figure 77: Growth or development problems in a child up to 1 year old (n=158) (percentage of correct answer)

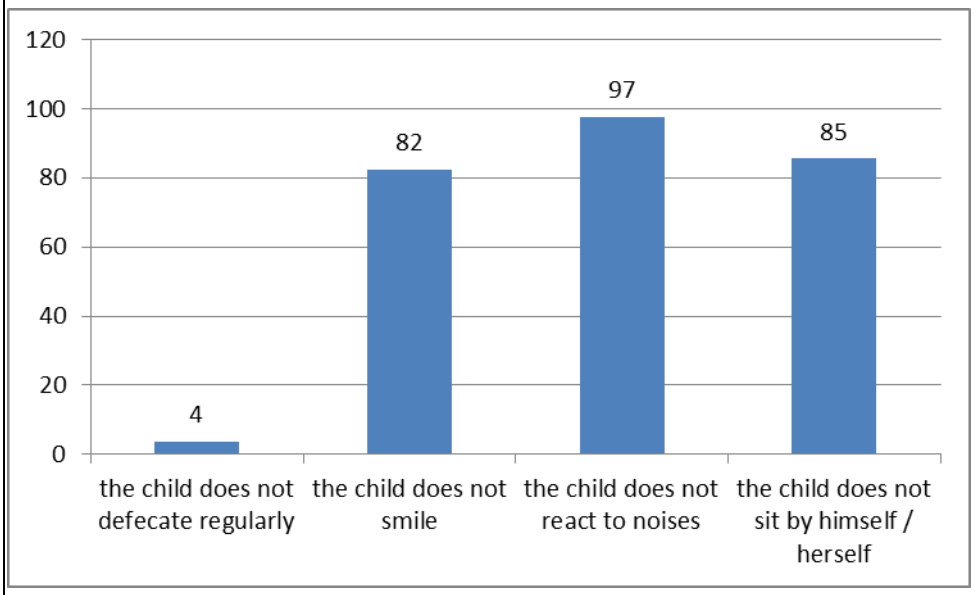


Figure 78: Identification of growth and development problems in children between 1 and 4 years old (n=158) (percentage of correct answer)

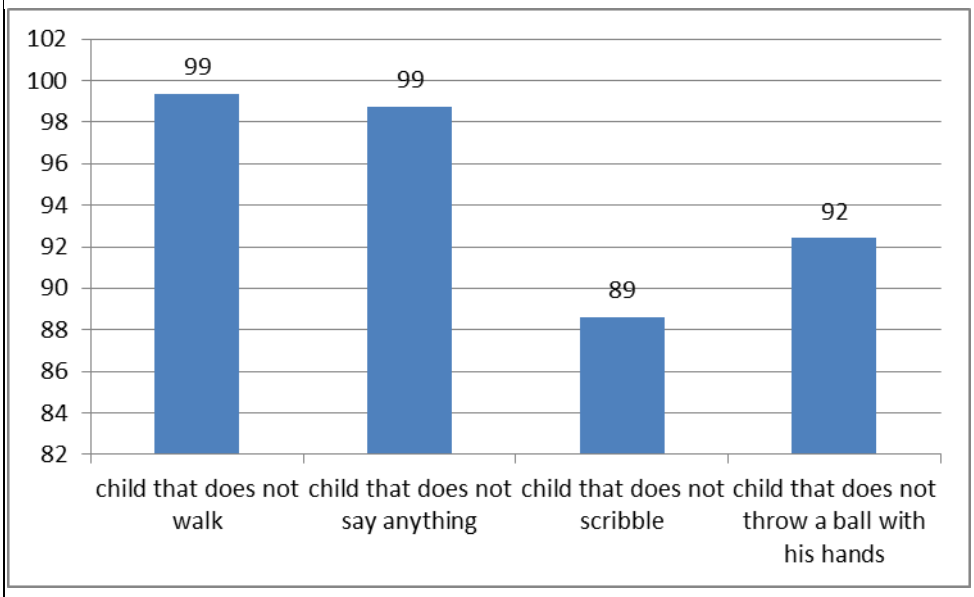
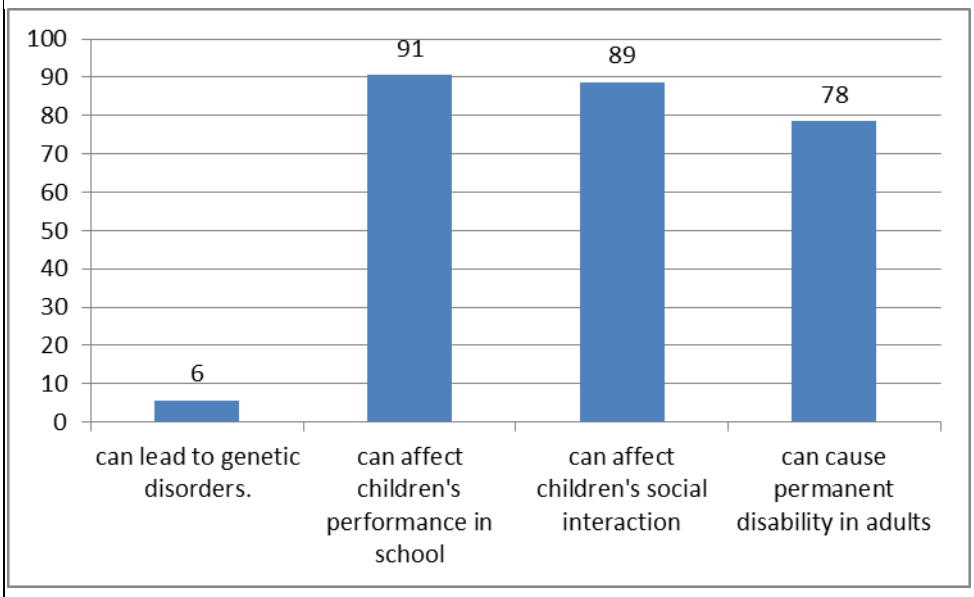


Figure 79: Consequences of growth and development problems during childhood (n=158) (percentage of correct answer)



Annex D: Sampled clusters and data collection schedule

Municipality	Location	Village	Team	Data collection day
DIBER				
Bulqize	Rural	Dushaj,	T1	01/11/2015
Diber	Rural	Pilafe,	T8	01/11/2015
Mat	Rural	Prell	T4	01/11/2015
Diber	Rural	Trepç, Shkolla	T7	01/11/2015
Bulqize	Urban	Bulqize- city	T1	27/10/2015
Bulqize	Urban	Bulqize- city	T2	27/10/2015
Bulqize	Urban	Bulqize- city	T3	27/10/2015
Mat	Urban	Burrel- city	T4	27/10/2015
Mat	Urban	Burrel- city	T5	27/10/2015
Mat	Urban	Burrel- city	T6	27/10/2015
Diber (Peshkopi)	urban	Peshkopi- city	T7	27/10/2015
Diber (Peshkopi)	urban	Peshkopi- city	T8	27/10/2015
Diber (Peshkopi)	urban	Peshkopi- city	T9	27/10/2015
Diber (Peshkopi)	urban	Peshkopi- city	T10	27/10/2015
Diber	Rural	Borovjan,	T8	28/10/2015
Bulqize	Urban	Bulqize- city	T2	28/10/2015
Mat	Urban	Burrel- city	T5	28/10/2015
Diber	Rural	Hotesh ,	T10	28/10/2015
Klos	Rural	Skënderaj	T6	28/10/2015
Bulqize	Rural	Sopot,	T3	28/10/2015
Klos	Rural	Suç	T4	28/10/2015
Diber	Rural	Ushtelenxe ,	T9	28/10/2015
Diber	Rural	Vranjt	T7	28/10/2015
Bulqize	Rural	Zerqan,	T1	28/10/2015
Diber	Rural	Bllat e Siperm,	T7	29/10/2015
Mat	Urban	Burrel- city	T5	29/10/2015
Diber	Rural	Fushe-Muhurr,	T8	29/10/2015
Bulqize	Rural	Gjorice e Poshtme,	T1	29/10/2015
Bulqize	Rural	Godvi,	T2	29/10/2015
Klos	Rural	Gurre e vogel	T6	29/10/2015
Diber	Rural	Kllobçisht,	T9	29/10/2015
Klos	Urban	Klos- town	T3	29/10/2015
Diber	Rural	Rret Kale,	T10	29/10/2015
Klos	Rural	Shulbater	T4	29/10/2015
Mat	Rural	Batër e Vogël,	T5	30/10/2015
Bulqize	Rural	Çerenc i Siperem,	T2	30/10/2015
Mat	Rural	Karice,	T4	30/10/2015
Diber	Rural	Katund i Vogel,	T10	30/10/2015

Municipality	Location	Village	Team	Data collection day
Klos	Urban	Klos- town	T6	30/10/2015
Klos	Urban	Klos- town	T3	30/10/2015
Bulqize	Rural	Llodomirice,	T1	30/10/2015
Diber	Rural	Maqellare,	T9	30/10/2015
Diber	Rural	Muhurr,	T7	30/10/2015
Diber	Rural	Seliste E siperme,	T8	30/10/2015
Diber	Rural	Burim,	T10	31/10/2015
Klos	Rural	Dom	T4	31/10/2015
Mat	Rural	Frankth,	T5	31/10/2015
Bulqize	Rural	Kraste,	T1	31/10/2015
Diber	Rural	Laçes,	T8	31/10/2015
Bulqize	Rural	Okshatine,	T9	31/10/2015
Bulqize	Rural	Peshk,	T2	31/10/2015
Diber (Peshkopi)	urban	Peshkopi- city	T6	31/10/2015
Diber	Rural	Zall-Rec,	T7	31/10/2015
FIER				
Mallakaster	Urban	Ballsh - town	T1	03.11.2015
Fier	urban	Fier City	T10	03.11.2015
Lushnje	Urban	Lushnje - city	T2	03.11.2015
Fier	urban	Fier City	T3	03.11.2015
Lushnje	Urban	Lushnje - city	T4	03.11.2015
Lushnje	Urban	Lushnje - city	T5	03.11.2015
Lushnje	Urban	Lushnje - city	T6	03.11.2015
Fier	urban	Fier City	T7	03.11.2015
Fier	urban	Fier City	T8	03.11.2015
Mallakaster	Urban	Ballsh - town	T9	03.11.2015
Mallakaster	Rural	Klos,	T1	04.11.2015
Fier	urban	Fier City	T10	04.11.2015
Divjakë	Rural	Remas,	T2	04.11.2015
Fier	urban	Fier City	T3	04.11.2015
Divjakë	urban	Divjakë	T4	04.11.2015
Lushnje	Rural	Dushk, Shkolla e mesme	T5	04.11.2015
Lushnje	Rural	Gramsh,	T6	04.11.2015
Fier	urban	Fier City	T7	04.11.2015
Fier	urban	Fier City	T8	04.11.2015
Mallakaster	Rural	Qafa e Vidhit,	T9	04.11.2015
Mallakaster	Rural	Drenove Fushe,	T1	05.11.2015
Fier	Rural	Mbrostar Q. Shendetsore	T10	05.11.2015
Divjakë	Rural	Cerme Sektor, Shkolla	T2	05.11.2015
Fier	Rural	Hoxhare,	T3	05.11.2015
Divjakë	Rural	Sulzotaj,	T4	05.11.2015
Lushnje	Rural	Gjaz,	T5	05.11.2015

Municipality	Location	Village	Team	Data collection day
Lushnje	Rural	Zhelizhan,	T6	05.11.2015
Fier	Rural	Ambulanca Metaj	T7	05.11.2015
Fier	Rural	Daullas,	T8	05.11.2015
Mallakaster	Rural	Visoke,	T9	05.11.2015
Fier	Rural	Levan,	T1	06.11.2015
Fier	Rural	Peshtan Bregas,	T10	06.11.2015
Lushnje	Rural	Shakuj,	T2	06.11.2015
Fier	Rural	Kreshpan,	T3	06.11.2015
Divjakë	Rural	Spolate,	T4	06.11.2015
Lushnje	Rural	Plug, Shkolla 9 vjeçare	T5	06.11.2015
Lushnje	Rural	Bicakaj ,	T6	06.11.2015
Fier	urban	Fier City	T7	06.11.2015
Fier	Rural	Frakull e madhe,	T8	06.11.2015
Fier	urban	Fier City	T9	06.11.2015
Roskovec	urban	Roskovec - town	T10	07.11.2015
Lushnje	Rural	Kamçisht,	T2	07.11.2015
Patos	urban	Patos -city/town	T3+T1	07.11.2015
Lushnje	Rural	Cinar,	T4	07.11.2015
Lushnje	Urban	Lushnje - city	T5	07.11.2015
Lushnje	Rural	Lumth,	T6	07.11.2015
Roskovec	Rural	Kurjan	T7	07.11.2015
Fier	Rural	Cakran I ri,	T8	07.11.2015
Fier	Rural	Varibop,	T9	07.11.2015
Fier	Rural	Gorishove,	T10	08.11.2015
Patos	urban	Patos -city/town	T1	08.11.2015
Mallakaster	Rural	Malas,	T7	08.11.2015
Roskovec	Rural	Ngjeqar,	T9+T5	08.11.2015

Annex E: Knowledge, Attitude and Practice – Questionnaire

Annex E.1: Cardiovascular, diabetes & obesity

Question	Answers	correct	Category
Which risk factors for cardiovascular disease do you know? (do not read responses)	Diabetes High blood pressure Obesity Smoking / tobacco use (Nos) High cholesterol / high blood fat Unhealthy diet Physical inactivity Family history / genetics Age Stress Other None	(1-9)	Knowledge
Cardiovascular knowledge			
Which of the following is a typical symptom of a heart attack?	a) Left-sided chest pain b) Headache c) Feeling thirsty d) Pain in the legs	a	Knowledge
Which of the following is not a typical symptom of heart attack?	a) Difficulty breathing b) Left-sided chest pain c) Headache d) Loss of consciousness	c	Knowledge
What should you do, if someone suddenly experienced strong pain on the left side of the chest, which is irradiating into the left arm?	a) Wait for the symptoms to go away b) Give pain killers c) Go immediately to the hospital, or if not available to the doctor d) Go to the doctor if the symptoms last longer than 2 days	c	Knowledge
Which of the following is not a complication of high blood pressure?	a) Heart disease b) Stroke (brain infarct) c) Muscle weakness d) Problems with seeing	c	Knowledge

Question	Answers	correct	Category
Patients easily recognize high blood pressure because of the symptoms.	Yes / No / Don't know	No	Knowledge
High blood pressure can cause a feeling of numbness in the feet.	Yes / No / Don't know	No	Knowledge
Heart attack is a frequent cause of death.	Yes / No / Don't know	Yes	Knowledge
Eating less salt can have a good effect on blood pressure.	Yes / No / Don't know	Yes	Knowledge
Most people with cardiovascular disease know that they are sick.	Yes / No / Don't know	No	Knowledge
People with high blood pressure only have to take medication when the blood pressure is high.	Yes / No / Don't know	No	Knowledge
Diabetes and high blood pressure can cause kidney disease.	Yes / No / Don't know	Yes	Knowledge
Diabetes knowledge			
Which of the following is not a typical symptom caused by diabetes?	a) Frequent need to urinate b) Lower back pain c) Tiredness d) Unexplained weight loss	b	Knowledge
Which of the following is not a complication of diabetes?	a) Problems with breathing b) Problems with seeing c) Slow wound healing d) Foot numbness	a	Knowledge
Which of the following foods is the healthiest for a person with diabetes or high blood pressure?	a) Fruits and Vegetables b) Bread c) Fatty meat d) Fried food	a	Knowledge
Patients with diabetes should regularly check their feet for wounds which do not heal.	Yes / No / Don't know	Yes	Knowledge
Patients with diabetes regularly taking medication don't have to check their blood sugar levels regularly.	Yes / No / Don't know	No	Knowledge
Consuming too much sugary foods can be a cause of diabetes.	Yes / No / Don't know	Yes	Knowledge

Question	Answers	correct	Category
In diabetes patients, the insulin system works normally.	Yes / No / Don't know	No	Knowledge
Diabetes is a common cause of problems with seeing.	Yes / No / Don't know	Yes	Knowledge
Women have to check their blood sugar levels during pregnancy.	Yes / No / Don't know	Yes	Knowledge
Diabetes can be cured.	Yes / No / Don't know	No	Knowledge
Children of persons with diabetes are more likely to get the disease than children from healthy families.	Yes / No / Don't know	Yes	Knowledge
Obesity knowledge			
How often should you do physical exercise to stay healthy?	a) 10 minutes per day on 3 days per week b) 2 hours once in a week c) 2 hours every day d) 30 minutes every day	d	Knowledge
Which of the following statements is not true?	a) Overweight people have a higher risk of getting diabetes. b) Regular physical exercise has a good effect on blood sugar levels. c) Gaining weight increases the risk of getting high blood pressure. d) Regular physical exercise increases the risk of getting high blood pressure.	d	Knowledge
Obese people often also have high blood pressure.	Yes / No / Don't know	Yes	Knowledge
Eating little sugar and fat does not help to reduce weight.	Yes / No / Don't know	No	Knowledge
Health Beliefs			
How much do you agree with the following statement: "Overweight people are healthier."?	Disagree / Rather disagree /Rather agree / Agree		Health Belief

Question	Answers	correct	Category
How much do you agree with the following statement: "The most frequent cause of headache is a high blood pressure."?	Disagree / Rather disagree /Rather agree / Agree		Health Belief
How much do you agree with the following statement: "Smoking or taking nos does not have an effect on health."?	Disagree / Rather disagree /Rather agree / Agree		Health Belief
How much do you agree with the following statement: "I think that changing my lifestyle today will not have any effect on my health later in life."?	Disagree / Rather disagree /Rather agree / Agree		Health Belief
How much do you agree with the following statement: "I cannot influence my health because it depends on the doctors."?	Disagree / Rather disagree /Rather agree / Agree		Health Belief

Annex E.2: Child health & development

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

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

Which of the following cases is a growth or development problem in a child between 1 and 4 years old?			
child that does not walk	Yes / No / Don't know	yes	Knowledge
child that does not say anything	Yes / No / Don't know	yes	Knowledge
child that does not scribble	Yes / No / Don't know	yes	Knowledge
child that does not throw a ball with his hands	Yes / No / Don't know	yes	Knowledge
Consequences of growth and development problems during childhood			
What are consequence of development problems during childhood?			
Development problems can lead to genetic disorders.	Yes / No / Don't know	No	Knowledge
Development problems can affect children's performance in school	Yes / No / Don't know	Yes	Knowledge
Development problems can affect children's social interaction	Yes / No / Don't know	Yes	Knowledge
Development problems can cause permanent disability in adults	Yes / No / Don't know	Yes	Knowledge
Knowledge on children			
At which age should a child sit by himself?	up to 3 months 3 to 9 months 9 to 12 months Don't know	3 to 9 months	Knowledge
At which age should a child react to noises?	up to 3 months 3 to 9 months 9 to 12 months Don't know	3 to 9 months	Knowledge
At which age should a child walk?	up to 9 months between 9 and 18 months 18 - 24 months Don't know	between 9 and 18 months	Knowledge

Annex F: Log-frame indicators informed by HH survey

Indicator	Indicator definition	Source and means of verification	Frequency of data collection	Baseline value	Progress up to 31 December 2015
Overall goal: The Albanian population, including the most vulnerable, benefit from better health thanks to improved primary health care services and health promotion activities					
Household expenditure for health care (as proxy for access to health services)	- Out of pocket expenditure for medicine - Out of pocket expenditure for travel to providers - Out of pocket payment to health providers	Household survey	Baseline and end of phase	<u>Expenditures of patients with a chronic condition:</u> Treatment: Median: 0 LEK/ 0 Euro Transport: Median: 60 LEK / 0.5 Euro Drugs: Median 2000 LEK / 14 Euro <u>Expenditures of patients with an acute condition:</u> Treatment: Median: 500 LEK/ 4 Euro Transport: Median: 100 LEK / 0.7 Euro Drugs: Median 1500 LEK / 11 Euro	
Outcome 1. Central government, donors and other relevant actors' engagement in the health system reform leads to better management and provision of services through qualified health professionals.					

Indicator	Indicator definition	Source and means of verification	Frequency of data collection	Baseline value	Progress up to 31 December 2015
% of persons who possess a valid health insurance card stratified by gender	Numerator: Number of males and females with health insurance cards in Qarks covered by the project Denominator: Total number of males and females in Qarks covered by the project	Household survey	Baseline and end of phase	Overall: 65% Diber: 70% Fier: 58% % of male with valid insurance card: 63% % of female with valid insurance card: 67%	
% of persons living in households receiving social or economic aid possessing a valid health insurance card stratified by gender	Numerator: Number of males and females living in households receiving social or economic aid covered with health insurance Denominator: Total number of males and females living in households receiving social or economic aid	Household survey	Baseline and end of phase	Overall 70% Diber: 70% Fier: 66% % of male with health card: 70% % of female with health card: 69%	
Outcome 2. Citizens in target regions, especially the marginalized and vulnerable groups, have increased access to more decentralized, affordable, quality primary health services. More health conscious citizens contribute through increased participation towards an accountable and responsive health system.					
% of female and male infants who received post-natal care by PHC nurse/doctor subsequent to delivery	Numerator: Number of male and female infants receiving post-natal care by PHC nurse/doctor subsequent to delivery Denominator: Number of male and female infants in Qarks covered by the project	HH Survey findings	Baseline and end of phase	74% 56% (in the first 14 days when being at home)	

Indicator	Indicator definition	Source and means of verification	Frequency of data collection	Baseline value	Progress up to 31 December 2015
% of HH receiving social or economic aid using PHC in first instance	Numerator: HH receiving social or econmic aid and using PHC in first instance Denominator: HH receiving social or econmic aid	HH Survey findings	Baseline and end of phase	67% (70% of all households receive social or economic aid)	
% of population reached through media information campaigns	Numerator: Number of adult population reached through media information campaigns Denominator: Citizens in Diber and Fier 20 years and older	Household survey	Baseline and end of phase	0%	
Output 1 for outcome 1 Core reforms such as professional development/CME, health governance and financing are supported and carried forward.					
Output 2 for outcome 1 Decentralised management functions are promoted and strengthened					
Output 3 for outcome 1 Health Management training activities within Faculty of Public health is operational and fully equipped and teachers at faculty of public health have been trained.					
Output 4 for outcome 1 Key managers of the health system have been trained in health management, governance and financing issues.					
Output 5 for outcome 2 Capacities of health professionals at the primary level are increased through CME, thereby emphasising family medicine teams and nurses.					

Indicator	Indicator definition	Source and means of verification	Frequency of data collection	Baseline value	Progress up to 31 December 2015
% of patients being referred from PHC level to hospitals	Numerator: Number of patients consulting outpatient hospital services who first have consulted a PHC services Denominator: Number of patients consulting outpatient hospital services	Household survey	Baseline and end of phase	Patients with chronic condition: 38% followed-up at PHC 44% at hospital level 17% both PHC and hospital 1% other Patients with an acute condition: 61% first contact with PHC 39% first contact with hospital	
Output 6 for outcome 2 Primary health infrastructure is available and equipped.					
Output 7 for outcome 2 Development of management capacities at the primary level are supported in order to foster the autonomy of local government units (including efficient resource corruption prevention).					
Output 8 for outcome 2 Health promotion activities targeting PHC staff as well as communities, Civil Society actors, service users and disadvantaged groups are introduced					
Output 9 for outcome 2 Citizens' interaction with health institutions to enhance transparency and accountability mechanisms are fostered and increased.					
% of citizens informed or aware of patient complaint system	Numerator: Number of adult citizens informed on patient complaint system Denominator: Number of adult citizens in areas covered by the project (population 20 years old and older)	Household survey	End of phase survey	0%	