Swiss Agency for Development and Cooperation (SDC)

Accessible Quality Healthcare Project:
Assessment of the Quality of Care in Primary Health Care Facilities

2016-2018-2023

AQH Accessible Quality Healthcare
Kujdesi Shëndetësor i Qasshëm dhe Cilësor
Pristupačna i Kvalitetna Zdravstvena Zaštita

SDC project implemented by Swiss TPH

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Accessible Quality Healthcare Project:
Assessment of the Quality of Care in Primary Health Care Facilities

2016-2018-2023

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Survey Report
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1. Background

Since the 1990s, Kosovo has struggled with an under-performing health system, which does not adequately meet the needs of Kosovar citizens for health and health services. As a result, the country has some of the worst health indicators in South Eastern Europe and ranks below neighbouring countries. The health status of vulnerable population sub-groups is a concern as financial and social barriers prevent them from accessing appropriate healthcare services.

In May 2015, the Ministry of Health (MoH) of Kosovo and Swiss Agency for Development and Cooperation (SDC) signed a cooperation agreement regarding the "Accessible Quality Healthcare" (AQH) project. The overall goal of the AQH project is to ensure that the health of the population of Kosovo has improved, with strengthened healthcare providers and managers able to meet the needs of the patients (especially vulnerable groups), who are more aware of their rights and needs.

The AQH project in Kosovo is a SDC project and implemented by Swiss Tropical and Public Health Institute (Swiss TPH).

The objective of the study is to measure the quality of care related to structural and procedural aspects, as well as selected outcomes, in Primary Health Care (PHC) in 20 project partner municipalities in Kosovo.

The specific objectives of this study are to provide PHC service providers with information to:

- Assess the quality of health services provided in several PHC centres in each municipality, including specific structural and procedural aspects.

- Allow comparison of different aspects of quality of care between 20 project municipalities.

- Determine to what degree health providers have infrastructure and consumables available as outlined in the national PHC norms or, where these are unavailable, those outlined in WHO standards.

- Assess patient satisfaction with the services provided at PHC centres.

The project has the following expected outcomes:

- **Outcome 1 -** Primary Health Care providers deliver quality services for NCDs to informed citizens

- **Outcome 2 -** Health managers ensure delivery of quality PHC services that respond to communities' needs.

- **Outcome 3 -** The population improves its health literacy and demands better access to high quality care.

AQH I was implemented in 2016-2019 in 12 municipalities in Kosovo. In 2020, the AQH project entered phase two (2020-2023) and expanded its support to 20 municipalities (out of 38 municipalities in Kosovo).
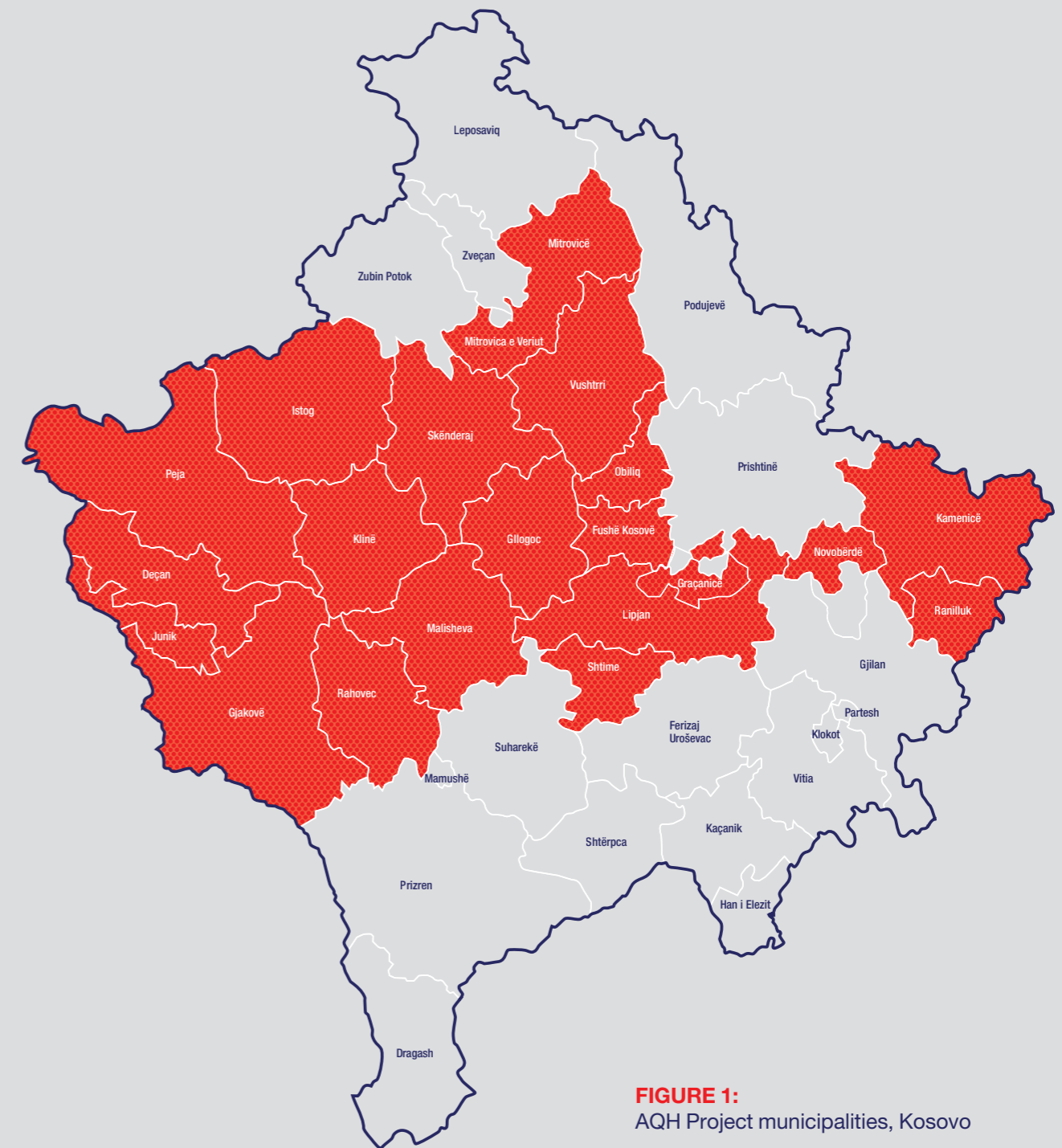

FIGURE 1:
AQH Project municipalities, Kosovo

A baseline and midline survey were conducted before (2016) and at the end (2018) of AQH I. The project implementation phase II started in early 2020.In 2023, the endline survey of phase II of the AQH project was conducted.

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

The present document provides a detailed report of the 2023 endline survey phase II on QoC. The survey was aligned with the two previous surveys, thus allowing to measure changes over time and to stratify results along different types of facilities.

1.1 Overview on Quality of Care

For our surveys, we consider an operational definition of the QoC of health care services based on Donabedian (1988, 1990) [1, 2], which was also used in similar studies [3, 4]. According to this definition, the QoC is characterized by three dimensions: structural attributes, the attributes associated with the process and attributes related to the outcomes. Therein, process attributes are often further sub-divided to technical and inter-personal dimensions.

The basic idea to separate three parts is based on the assumption that the three dimensions are connected in terms of service quality: good structure increases the likelihood of good processes and good process increases the likelihood of good outcomes, though outcomes are a consequence rather than a component of the quality of services.

The following definitions apply:

- Structural attributes: These attributes relate to the environment of the health service delivery. They understand the structural organization (medical personnel, internal organization and patient's payment for health services), human resources (qualified staff), and physical resources (infrastructure, equipment and drugs). In addition, the structure includes the technical performance and judgment of health personnel on patient's health situation for the provision of patient care.

- Process-related attributes: These attributes relate to the interaction between patient and provider, considering the interpersonal aspects and technical aspects. Potential benchmarks of process of care may include inputs, referral from PHC facilities for laboratory examinations, preventive and treatment approaches or the ethical conduct of health workers. The definition of quality should be based and measured on local standards.

- Outcome attributes: Outcomes are considered a consequence of the quality of care, as for example survival and recovery of a patient or, more indirectly, patient satisfaction.

2. Goal and Objectives

The overall goal of the present study is to measure the QoC related to structural and procedural aspects as well as selected outcomes in PHC in 20 municipalities of the AQH in Kosovo and to indicate changes over time in the various aspects related to QoC since the baseline study in 2016 and midline study in 2018.

The specific objectives of this study are:

- Assess the QoC provided by providers to patients for PHC services, including the compliance with the NCD protocols introduced through AQH II

- Assess the capacities and readiness of the health facilities in terms of infrastructure, cleanliness, maintenance, protocols and selected equipment and consumables.

- Assess patient satisfaction after medical consultation.

- Make meaningful comparisons, e.g. urban vs. rural, regions or facilities that have benefitted from rehabilitation and those not.

- Compare findings to previous measurements from the 2016 baseline and the 2018 midline surveys. (However, results are mainly compared to the 2018 results, which served as a baseline for the phase II of the project.)

- Inform selected indicators from the projects' logical framework (logframe) to monitor the improvement of health care delivery over the course of AQH.

- Interpret the findings in the context of the AQH I and AQH II activities thereby considering possible effects of the Covid-19 pandemic on routine health service delivery.

3. Methods

3.1 Study design

The methodology employed for this 2023 endline survey phase II was the same as in the 2016 baseline and the 2018 midline surveys in order to allow for comparison of findings. Hence, the study design was a (repeated) cross-sectional survey design.

The survey assessed the three dimensions of QoC in health facilities:

i   quality of the facility infrastructure (structural attributes);

ii   quality of provider-patient interactions (process attributes); and

iii   patient satisfaction after consultation (outcomes).

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

i   the health centre through a health centre assessment tool;

ii   the health care provider through provider-client observations; and

iii   the patient satisfaction through exit interviews.

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

TABLE 1: Study design summary

	Quality of the infrastructure	Quality of doctor-patient interaction	Patient satisfaction
Target population	Health centre (respondent: appointed by the health centre manager)	• Doctors (family and general medicine) • Patient	Patient
Consultation type	n/a	• Hypertension • Diabetes • Any kind of health consultation*	• Hypertension • Diabetes • Any kind of health consultation*
Provider type	n/a	• Doctors (family and general medicine doctors)	• Any health care provider (doctors, nurses, midwifes)
Tool	Health centre assessment for selected indicators	Observational tool	Exit interview questionnaire
Sample size 2023	55	1,727	948
Sample size 2018	57	1119	628
Sample size 2016	40	1013	716
Sampling	Exhaustive	Random sampling of doctors (1-3 per facility, proportional to size of facility)	Exhaustive during visit in the health centre, depending on the capacity of the data collectors

*See section 3.2 for more details

3.2 Study area & target population

The 2023 QoC endline survey was conducted in the 20 municipalities covered by AQH II.

Target population of the three different dimensions assessed are shown in Table 1 above. In addition:

i   For the infrastructure assessment, the respondent(s) to the questionnaire were determined with the facility manager.

ii   For the doctor-patient interaction, consultations for any kind of PHC services were observed but the health care providers under assessment were only doctors (family and general medicine).

iii   Similarly, exit interviews was conducted with patients that came for any kinds of PHC services. Excluded were patients who consult for administrative reasons, like: renewal of driving licence and procedures conducted, issuing the permission for hunting guns, and "able to work" letters

3.3 Sample size

The design of the sample size built on a representative probability sample allowing analysing indicators for the quality of health care provided and the satisfaction of the patient. The sample was stratified according to the two domains of facilities in the study: MFMC and FMC.

The number of clusters was calculated using the equation of Bennett, Woods et al. ("A simplified general method for cluster-sample surveys of health in developing countries." World Health Stat Q, 1991, 44(3): 98-106).

$$c = p \times \frac{(1-P) \cdot D}{s^2 \cdot b}$$

Where p (or t) is the estimation of the proportion; D the design effect; s the standard error and b the average number of responses to the item per cluster. The equation was modified and adapted to the present survey using the equation:

c = (((t² x p(1-p)) / m²) x D) / nc + 10%.

Where:

c = required number of cluster

t = confidence level at 95% (standard value of 1.96)

p = estimated proportion of patients being unsatisfied 20%

m = margin of error at 5%

D = design effect at 1.0

nc = number of patients per cluster

10% sample loss

Assumptions

- We assumed a proportion of 20% of patients are unsatisfied with the facility.
- For the cluster size we made differentiated assumptions: for MFMC we assumed a minimum number of patients per doctor per day of 12 whilst we assumed a minimum number of patients per doctor per day of 8 for FMC.
- A relative low refusal rate (approx. 10%).
- The design effect was set at 1.0 because of the clustering (between 8-12 patients/facility).

Table 2 gives the estimation of patients for different estimations of the proportion with 10% sample loss (safety margin), using the modified equation. The number of patients is estimated for each domain.

TABLE 2: Estimation of patients included in the survey for different estimations of the proportion (p) with 10% safety margin

CI	Proportion
	2.5%	5.0%	7.5%	10.0%	15.0%	20.0%	30.0%	35.0%	50.0%
2.0%	258	502	733	951	1'347	1'690	2'219	2'403	2'641
2.5%	165	321	469	609	862	1'082	1'420	1'538	1'690
3.0%	114	223	326	423	599	751	986	1'068	1'174
5.0%		80	117	152	216	270	355	385	423
6.5%		69	90	128	160	210	228	250
10.0%			38	54	68	89	96	106

We observed variations in the number of patients accessing the facilities depending on the domain and based on the number of doctors (family medicine and general doctors) working there.

Hence, we estimated the number of clusters per domain, assuming an average of 12 number of patients per doctor per MFMC and an average of 8 patients per doctor per FMC.

TABLE 3: Estimation of the number of clusters (c) per stratum (here MFMC) for different estimations of the proportion with 10% safety margin

CI	Proportion
	2.5%	5.0%	7.5%	10.0%	15.0%	20.0%	30.0%	35.0%	50.0%
2.0%	21	42	61	79	112	141	185	200	220
2.5%	14	27	39	51	72	90	118	128	141
3.0%	10	19	27	35	50	63	82	89	98
5.0%	0	7	10	13	18	23	30	32	35
6.5%	0	0	6	8	11	13	18	19	21
10.0%	0	0	0	3	4	6	7	8	9

TABLE 4: Estimation of the number of clusters (c) per stratum (here FMC) for different estimations of the proportion with 10% safety margin

CI	Proportion
	2.5%	5.0%	7.5%	10.0%	15.0%	20.0%	30.0%	35.0%	50.0%
2.0%	32	63	92	119	168	211	277	300	330
2.5%	21	40	59	76	108	135	177	192	211
3.0%	14	28	41	53	75	94	123	134	147
5.0%	0	10	15	19	27	34	44	48	53
6.5%	0	0	9	11	16	20	26	28	31
10.0%	0	0	0	5	7	8	11	12	13

Thus, we assumed that the following sample sizes needs to be attained:

- Information on infrastructure from all 55 health facilities
- 270 provider-patient interactions of which we assume that approximately 50% might be related to chronic conditions per facility type, thus, 540 in total
- 270 patient exit interviews per facility type, thus, 540 in total

3.4 Sampling

3.4.1 Sampling of health facilities

The sampling frame was built from all eligible health facilities (i.e. MFMC or FMC) which represented the primary sampling units. The following eligibility and inclusion criteria applied for the health facilities:

- covered by AQH II project activities in the 20 AQH II municipalities;
- at least one medical doctor working at the health facilities; and

- provision of care and prevention related to chronic diseases (e.g. diabetes mellitus, hypertension)

Thus, 20 MFMCs and 99 FMCs health facilities were considered eligible. Sample health facilities were selected among all eligible health facilities employing a probability proportional to size (PPS) sampling approach, based on the number of visits per health facility received, as notified in regional insurance directorates [5]. It was assumed that PPS took care of the urban / rural stratification at the same time.

A list of the selected facilities is given in Table 5.

TABLE 5: Selected health facilities

No.	Municipality	Name of facility	Type of facility
1	Deçan	MFMC - Deçan	MFMC
2	Deçan	FMC- Strellc	FMC
3	Fushë Kosovë	MFMC - "Dr.Fatmir Krasniqi"	MFMC
4	Fushë Kosovë	FMC Bardh i Madh	FMC
5	Fushë Kosovë	FMC Miradi e Poshtme	FMC
6	Gjakovë	MFMC- Gjakovë	MFMC
7	Gjakovë	FMC 4 Orize	FMC
8	Gjakovë	FMC 5 Ereniku	FMC
9	Gjakovë	FMC 6 Ponoshec	FMC
10	Gjakovë	FMC 9 Rogove	FMC
11	Gllogoc/Drenas	MFMC - "Dr.Hafir Shala" Drenas	MFMC
12	Gllogoc/Drenas	FMC-Terstenik	FMC
13	Gllogoc/Drenas	FMC-Komoran	FMC
14	Graqanica*	Health Centre Gracanica	PHC Center
15	Gracanica*	Health Centre Gusterica	PHC Center
16	Istog	MFMC	MFMC
17	Istog	FMC	FMC
18	Junik	MFMC " Dr Ali Hoxha" Junik	MFMC
19	Kamenica	MFMC Dardanë	MFMC
20	Kamenica	FMC	FMC
21	Klinë	MFMC Klinë	MFMC
22	Klinë	FMC	FMC
23	Lipjan	MFMC-Lipjan	MFMC
24	Lipjan	FMa -Kraishte	FMA
25	Lipjan	FMC -Gadime	FMC
26	Lipjan	FMC -Magurë	FMC
27	Lipjan	FMC -Janjevë	FMC
28	Malishevë	MFMC - "Dr.Shpëtim Robaj" Malishevë	MFMC

No.	Municipality	Name of facility	Type of facility
29	Malishevë	FMC Bellanicë	FMC
30	Malishevë	FMC Drenovc	FMC
31	Mitrovicë	MFMC - "Dr.Nexhat Çuni " Mitrovicë	MFMC
32	Mitrovicë	FMC "Ura e Gjakut"	FMC
33	Mitrovicë	FMC "Ilirida"	FMC
34	Mitrovicë	FMC "Bair"	FMC
35	Mitrovicë	FMC "Tuneli i Parë"	FMC
36	Mitrovicë	FMC "Shupkovc"	FMC
37	Novo Brdo*	Ambulanta Novo Brdo	PHC Center
38	Novo Brdo*	FMC Llabjan	PHC Center
39	Obiliq	MFMC - Obiliq	MFMC
40	Obiliq	FMC Millosheve	FMC
41	Peja	MFMC Peja	MFMC
42	Peja	FMC IV	FMC
43	Peja	FMC	FMC
44	Rahovec	MFMC Dr.Fahredin Hoti"	MFMC
45	Rahovec	FMC	FMC
46	Rahovec	FMC	FMC
47	Skenderaj	MFMC- Skenderaj	MFMC
48	Skenderaj	FMC-1	FMC
49	Skenderaj	FMC-3	FMC
50	Vushtrri	MFMC- Vushtrri	MFMC
51	Vushtrri	FMC- 1	FMC
52	Vushtrri	FMC - Lumi i Madh	FMC
53	Ranilug*	Ambulanta Ranilug	PHC Center
54	Shtime	MFMC - Shtime	MFMC
55	Shtime	FMC -Muzeqinë	FMC

*Serbian-speaking municipalities

3.4.2 Sampling of providers for provider-client observations

The inclusion criteria for doctors for doctor-patient observations were:

- Working in one of the selected health facilities for at least 3 years or have been exposed to AQH interventions previously;
- Medical doctors that are providing primary health care services;
- Ability and willingness of the doctor to participate and provide written informed consent; and
- Ability and willingness of the patient 18 years or older (or her/his's legal representative for patients younger than 18 years) to participate and provide written informed consent.

The doctors to be observed were selected randomly. In case, there was more than one doctor fulfilling the eligibility criteria, the respondent/participant doctor was randomly selected.

All doctor-patient consultations occuring during data collection in a health facility (i.e. one day) were observed, depending on the capacity of the data collectors. Thus, the same doctor was observed repeatedly.

3.4.3 Sampling of patients for exit interviews

Inclusion criteria for patients receiving a consultation and exiting a health facility were:

- Being a patient 18 years or older receiving a consultation from a health care provider (doctor, nurse, midwife) in one of the selected health facilities;
- Being a patient younger than 18 years accompanied by a legal representative (e.g. mother/father/caretaker) receiving a consultation from a health care provider

(doctor, nurse, midwife) in one of the selected health facilities;
- Ability and willingness of the patient (or her/his's legal representative in case of patients <18 years of age) to participate and provide written informed consent.

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

3.5 Questionnaire tools

The survey included three questionnaires that assess the three different dimensions of QoC.

The questionnaires for the 2023 survey were largely identical to the baseline and midline surveys in 2016 and 2018. These were generally based on previous studies on QoC in Tajikistan, in Chad and in Albania [4, 6]. All studies considered a mix of indicators from WHO Service Availability and Readiness Assessment (SARA) and the "Tool to Improve Quality of Health Care" within the "ACCESS" program supported by the Novartis Foundation for Sustainable Development (2014) [7, 8]. The modules were adapted to the Kosovo local context thereby taking into consideration the national PHC norms or, where these are unavailable, the WHO norms established in the Package of Essential NCD Interventions.

The full survey tools are shown in Annex 1 (available in English, Albanian and Serbian). The following table gives an overview on the different dimensions of QoC covered in the survey tools.

TABLE 6: Topics covered in the survey tools

Dimension	Sub-dimension/ operationalization	Level of data collection
Structure: Infrastructure		
Facility infrastructure, overall cleanliness and maintenance	• Facility – overall cleanliness (facility, yard, waiting area) • Facility – maintenance of floors and walls (painted, cracks) • Water – general availability of water • Practice room – water and soap, privacy of examination • Availability of electricity, heating, telecommunications	Health facilities
Hygiene and safety standards	• Toilets -- availability, water, soap, cleanliness	Health facilities
Basic/essential medical equipment and supplies	• Availability and functionality of medical equipment and supplies (according to Basic Service Package)	Health facilities
Aspects of accountability	• Public display of key information (opening hours, tariffs, contact, complaint box)	Health facilities
Availability of guidelines and health promotion material	• Relevant guidelines and health promotion material is available at the facility and can be easily retrieved	Health facilities
Availability of consumables	• Availability and quantity of consumables (according to Updated list of Medications and Consumables, 12.06.2018))	Health facilities
Processes: Doctor-patient interaction		
General aspects on adherence on principles of clinical history and physical examination	• Makes a patient comfortable, e.g. greeting, seat offered • Interaction and welcoming • Privacy • Relevant explanations are given	Provider; all patients
Application of infection prevention and control measures	• Hand-washing practices • Procedures for disinfection	Provider; all patients
Observations on management of patients with arterial hypertension and diabetes	Anamnesis • Asks questions relevant for the illness • Physical examination • Conducts relevant physical examinations correctly • Explanations • Gives relevant and comprehensive explanations	Provider; patients with known/ or newly diagnosed arterial hypertension and diabetes
Outcomes: Exit interviews for patient satisfaction		
Satisfaction with privacy		All patients
Satisfaction with doctor-patient interactions	• Respectful treatment • Doctors' communication and explanations	All patients
Satisfaction with the quality of the facility	• Secrecy of medical and personal information • Ability to choose doctor • Prompt attention • Decision involvement in healing options • Clean surroundings	All patients
Socio-demographic and economic aspects	• Socio-demographic aspects • Beneficiary from public social program • Insurance situation	All patients

For the observations of the doctor-patient interactions as well as the exit interviews, the tools had three disease-specific blocks depending on the patient's disease:

- Patients with diabetes;
- Patients with hypertension;
- Patients with a condition other than diabetes or hypertension (referred to as 'other disease').

3.6 Data management and analysis

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

Data was analysed using Stata Statistical Software and R statistical software.

For each domain (infrastructure, clinical consultation and exit interview), an overall score was calculated where the denominator was 'total number of questions' and the nominator was 'number of correctly answered questions'. The latter could refer to availability and/or functionality of infrastructure, equipment or drugs in the infrastructure assessment; correct behaviours of the doctors according to good practice and protocols for the doctor-patient observations; and satisfying/positive answers with regards to quality of care from the exiting patients in the exit interviews.

In addition, summary scores of sub-categories within the different domains (see Table 6 above) were calculated using the same approach.

Scores are typically stratified per municipality and year.

3.7 Ethical considerations & clearance

Ethical approval for this study was sought from the Kosovo Doctors Chamber (Ref No. 66/2023, date. 24.04.2023).

Before data collection relevant authorities, specifically the Municipal Department of Health and Social Welfare (DHSW) of 20 project municipalities were informed about the study by MoH Division of PHC, its purpose and when the data collection will take place. Contacts with DHSW were established through the study coordinator from AQH. The DHSW directorate managers in turn informed the selected health facilities on the survey.

The ethical approval letter is shown in Annex 1.

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

4. Findings

4.1 Overall assessment of municipalities

Table 7 provides an overview on the overall scores per municipality for each domain (infrastructure, clinical consultation and exit interview). It is apparent that municipality specific aspects dominate, with several improvements but also some aspects that have rather declined.

TABLE 7: Overall scores of municipalities in Kosovo (2016, 2018, 2023)

Municipalities	No of facilities	Infrastructure Score (%)			Clinical Consultation Score (%)			Exit Interview Score (%)		
		2016	2018	2023	2016	2018	2023	2016	2018	2023
Decan	2	n/a	49	67	n/a	41	63	n/a	95	82
Fushë Kosovë	3	61	64	75	74	70	69	98	84	73
Gjakovë	5	67	62	70	80	46	72	95	89	75
Gllogovc/Drenas	3	53	55	72	62	63	70	95	91	80
Gracanica*	3 (2)	70	65	71	58	55	n/a*	89	79	74
Istog	2	n/a	65	70	n/a	78	64	n/a	97	86
Junik	1	62	61	76	73	42	77	96	88	89
Kamenica	2	n/a	62	72	n/a	79	76	n/a	93	91
Klinë	1	n/a	56	75	n/a	79	65	n/a	92	96
Lipjan	5	44	49	67	59	70	82	91	86	89
Malishevë	3	44	53	58	54	63	34	83	91	83
Mitrovicë	6	54	64	68	75	81	86	97	87	81
Novo Brdo	2	n/a	60	55	n/a	75	64	n/a	77	97
Obiliq	2	59	63	66	71	83	76	97	85	96
Peja	3	n/a	62	66	n/a	72	75	n/a	94	90

Municipalities	No of facilities	Infrastructure Score (%)			Clinical Consultation Score (%)			Exit Interview Score (%)		
		2016	2018	2023	2016	2018	2023	2016	2018	2023
Rahovec	3	58	62	71	70	52	62	95	93	86
Ranilug	1	n/a	60	62	n/a	75	69	n/a	86	87
Shtime	2	n/a	60	68	n/a	74	74	n/a	89	93
Skenderaj	3	52	57	66	62	80	72	93	94	91
Vushtrri	3	60	55	79	65	59	82	97	74	82
Overall	**55**	**55.5**	**58.6**	**68.0**	**61.8**	**67.1**	**69.6**	**92.5**	**88.8**	**83.1**

*Upon request, in 2023, only facility infrastructure was assessed and exit interviews were performed.

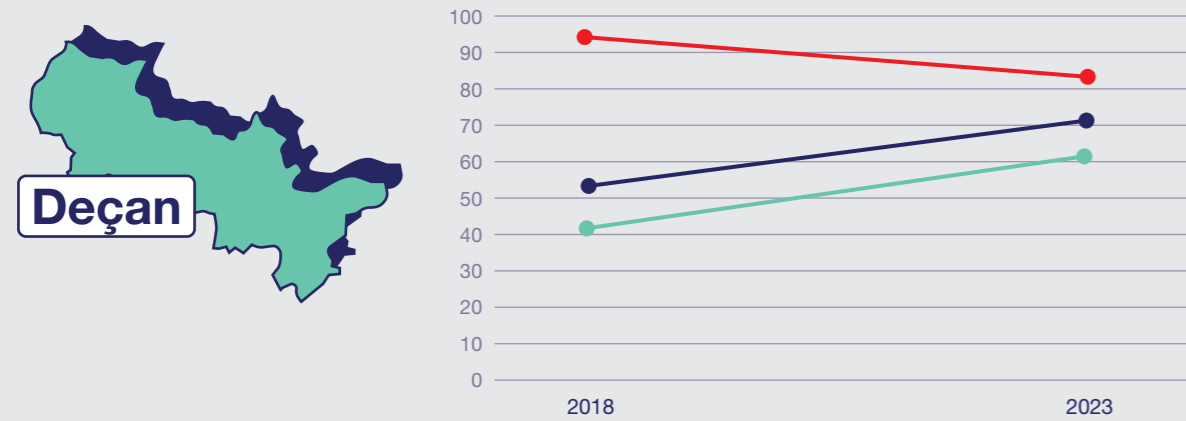**Key findings on overall scores by domain (see also 3.6):**

- **Infrastructure assessment:** In all municipalities except Novo Brdo the overall infrastructure score increased between 2018 and 2023. Looking at changes the 12 municipalities that were included from 2016 on, the score increased in all of them between 2016 and 2023, but four experienced a slight dip at the intermediary survey in 2018. In its two phases, AQH had supported all municipalities with infrastructure investments and basic medical equipment at MFMC and FMC level.

- **Doctor-patient observations:** Results from the clinical observations show a very diverse picture. Many municipalities show increasing overall score trends but there are several municipalities where the score has decreased either from 2018 to 2023 or overall, which could be a result of a general shortage of medical staff at facility level, a high turn-over of staff including the new posting of young doctors (e.g. Malisheve).

- **Exit interviews:** With few exceptions, the trend from the exit interviews is mostly negative. In six municipalities, the decrease from 2018 to 2023 is statistically significant while only Novo Brdo has a significant positive increase. The overall negative trend in patient satisfaction can be attributable to the intense efforts of MoH with the support of AQH in patient rights awareness rising with the intensified national annual campaigns since 2017. In addition, the implementation of Community Score Cards in each Municipality on questions related to quality health care might also have resulted in a more critical appreciation of patients on health services in municipalities.
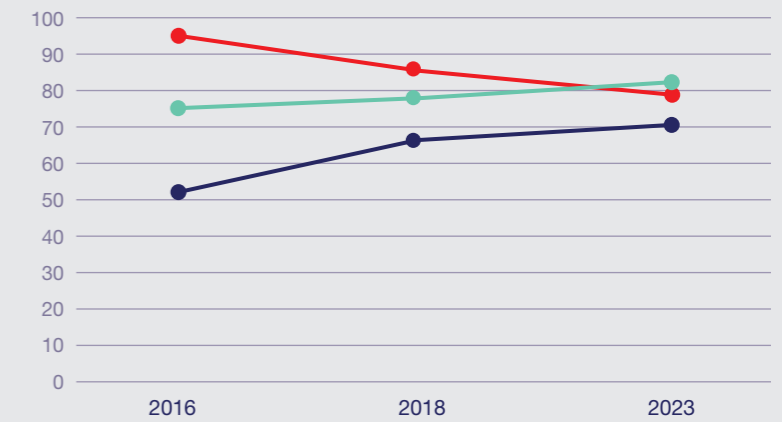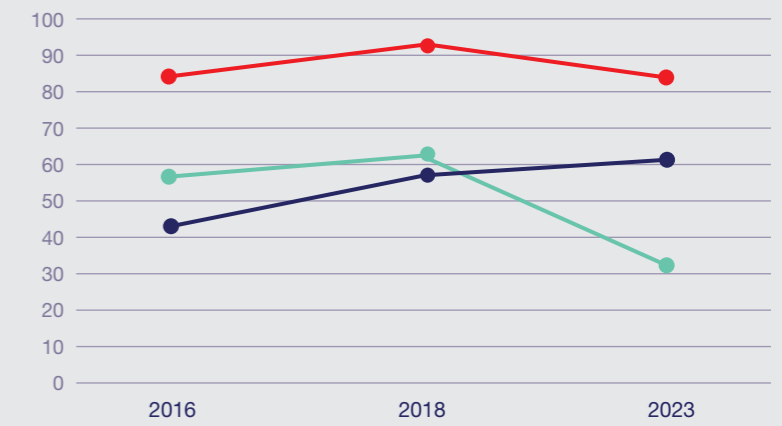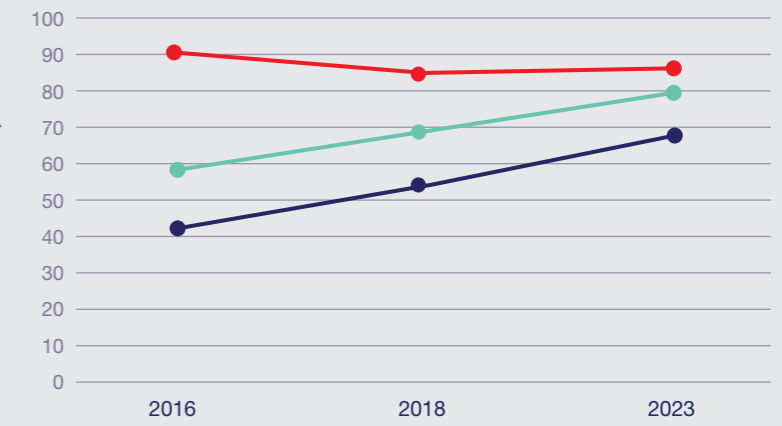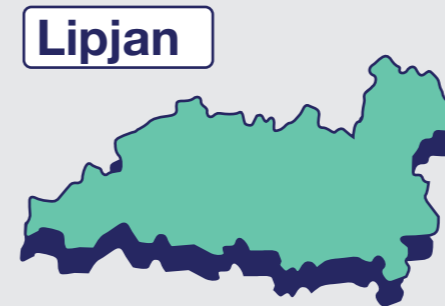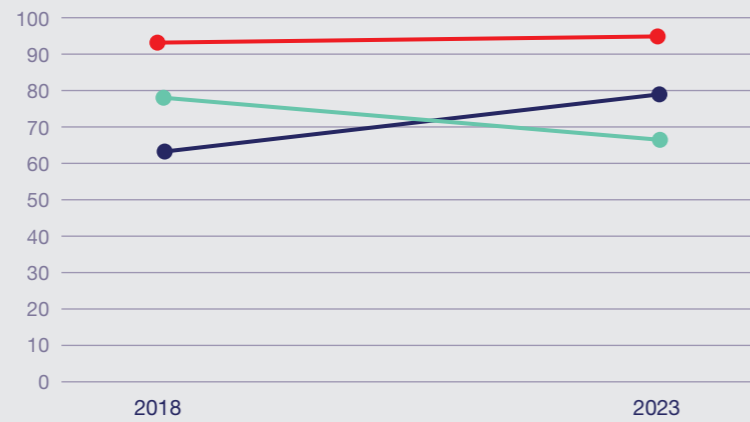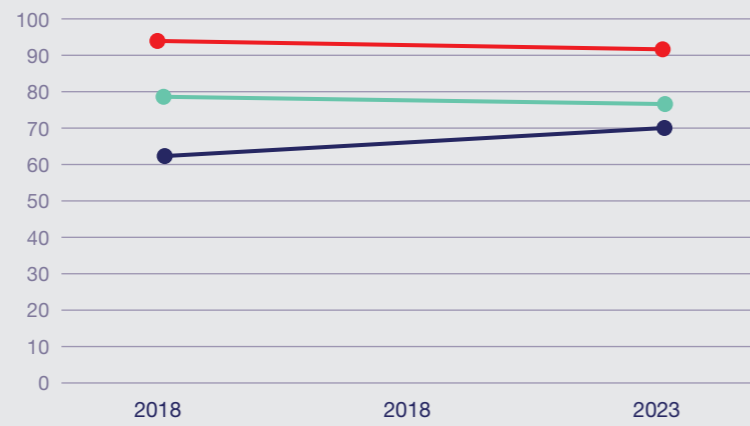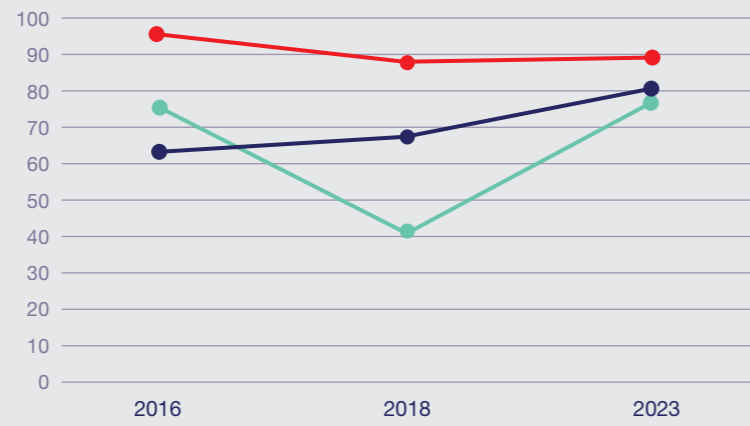
Figure 2 shows the summary scores for each domain for each municipalities.

FIGURE 2: Infrastructure, clinical consultation and exit interview scores per municipality for each data collection phase (2016, 2018, 2023)
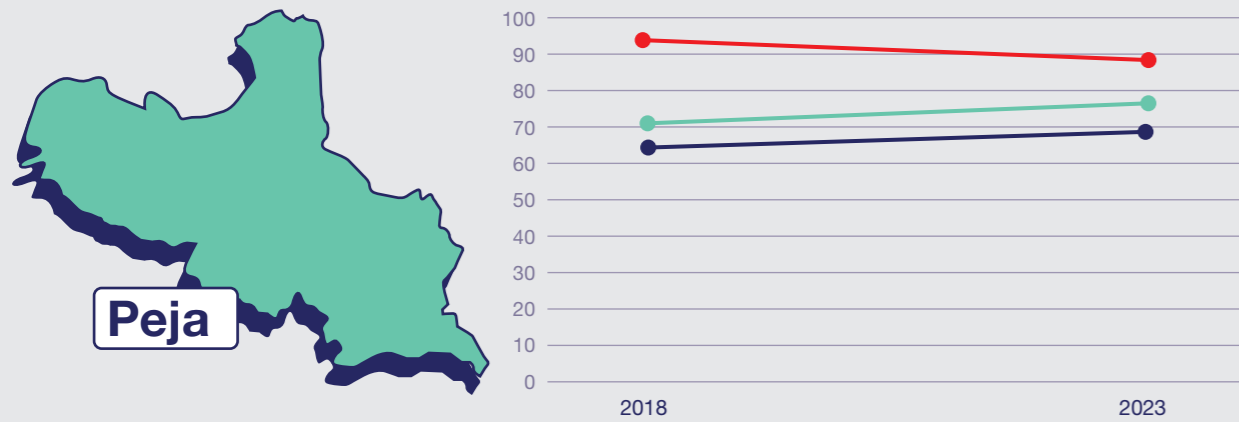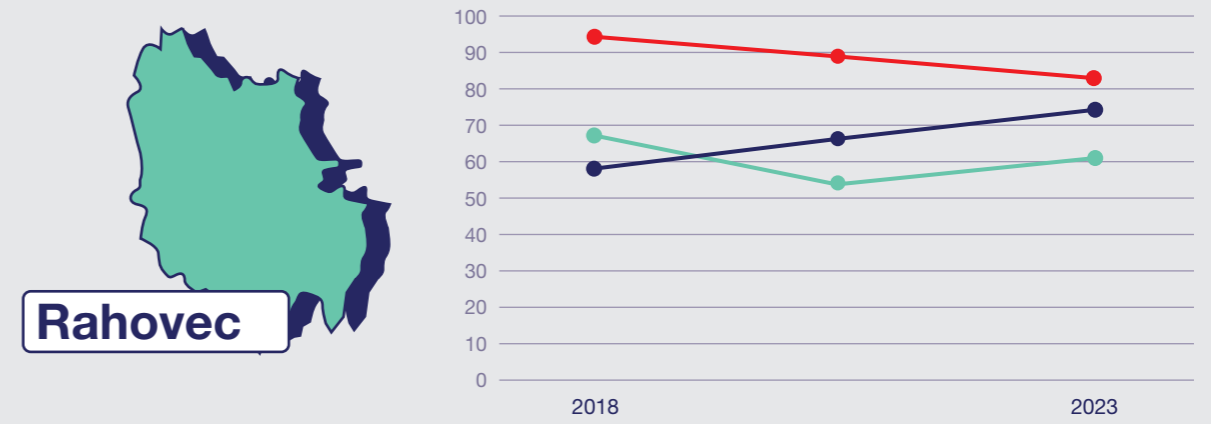

- Exit Interview Score (%)
- Infrastructure Score (%)
- Clinical Consultation Score (%)
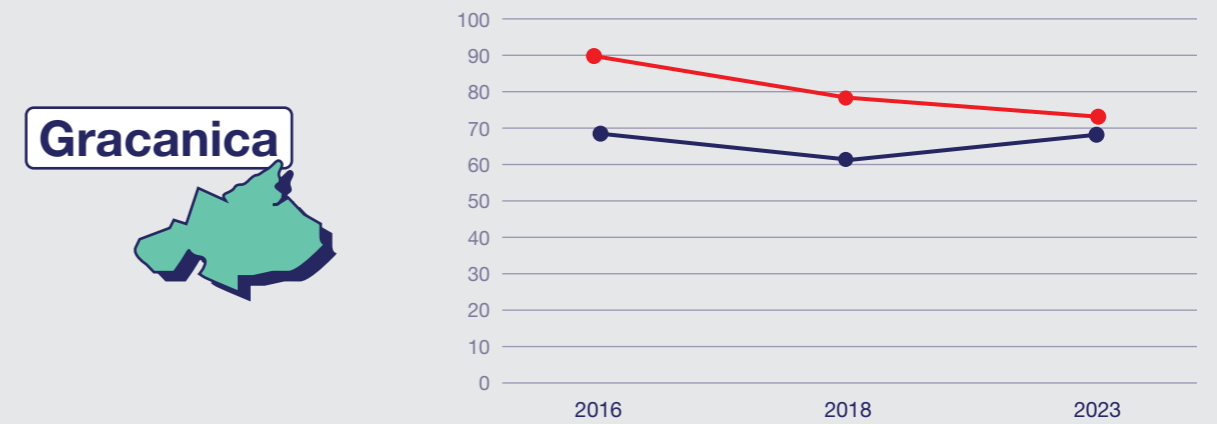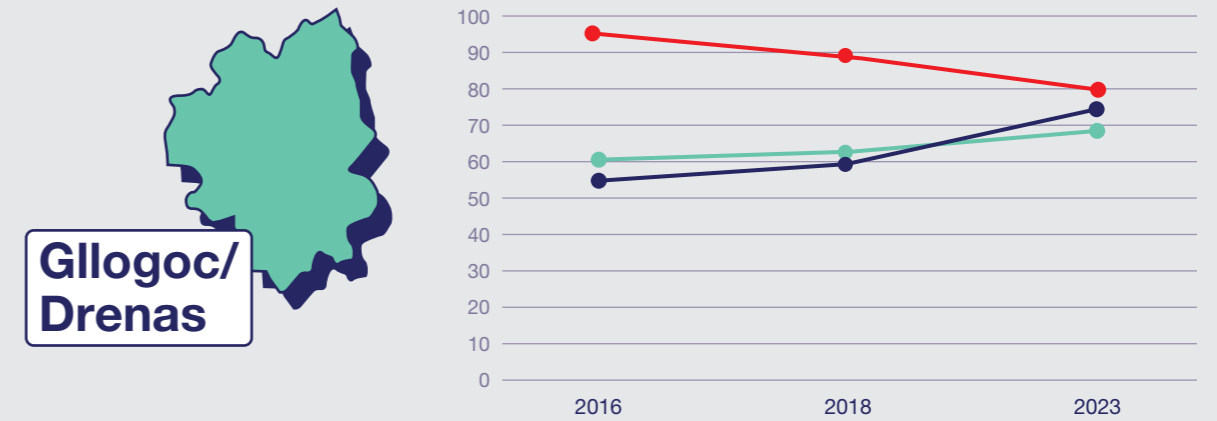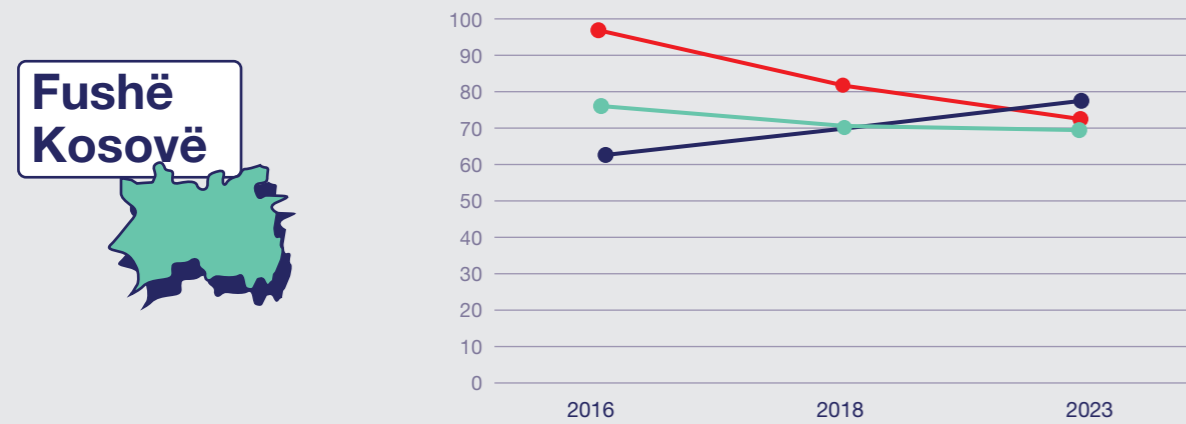
Deçan

Fushë Kosovë

Gjakovë

Gllogoc/Drenas

Gracanica

Istog

● Exit Interview Score (%)   ● Infrastructure Score (%)   ● Clinical Consultation Score (%)

Junik

Kamenica

Klinë

Lipjan

Malishevë

Mitrovicë

● Exit Interview Score (%)   ● Infrastructure Score (%)   ● Clinical Consultation Score (%)

Novo Brdo

Obiliq

Peja

Rahovec

Ranilug

Shtime

● Exit Interview Score (%)   ● Infrastructure Score (%)   ● Clinical Consultation Score (%)

Skenderaj
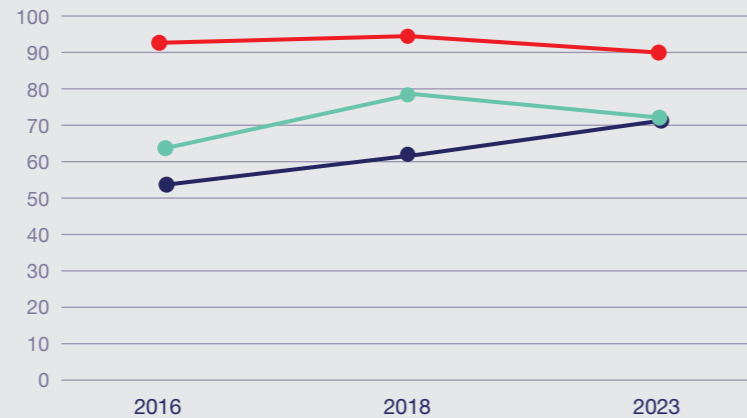
Vushtrri
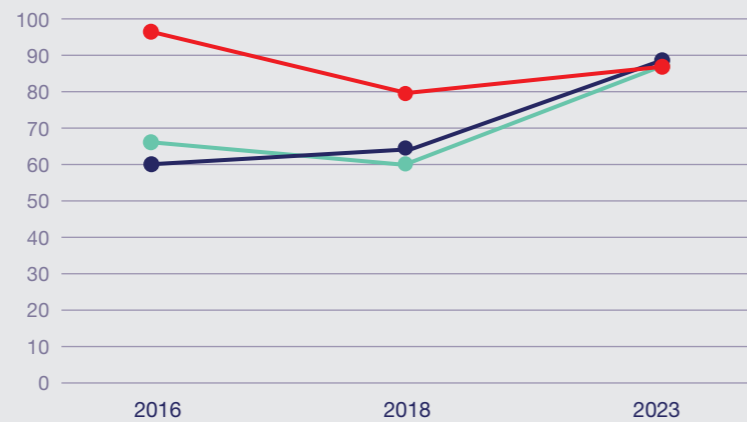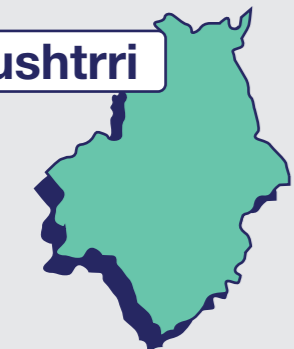
4.2 Infrastructure

The following Table 8 and graphs in Figure 2 show the achieved scores for 2016, 2018 and 2023 in all municipalities from the infrastructure interviews. The overall trend is positive in almost all municipalities with values ranging from 49 (Lipjan) to 65 (Graçanicë) in 2018 and from 55 (NovoBrdo) to 79 (Vushtrri) in 2023. As in 2018, values in MFMCs are higher in 2023 compared to FMCs.

It is important to note that observed differences are influenced by a variety of factors, including the general health politics, the facility situation at the day of the survey, AQH investments, other project-based investments and methodological aspects.

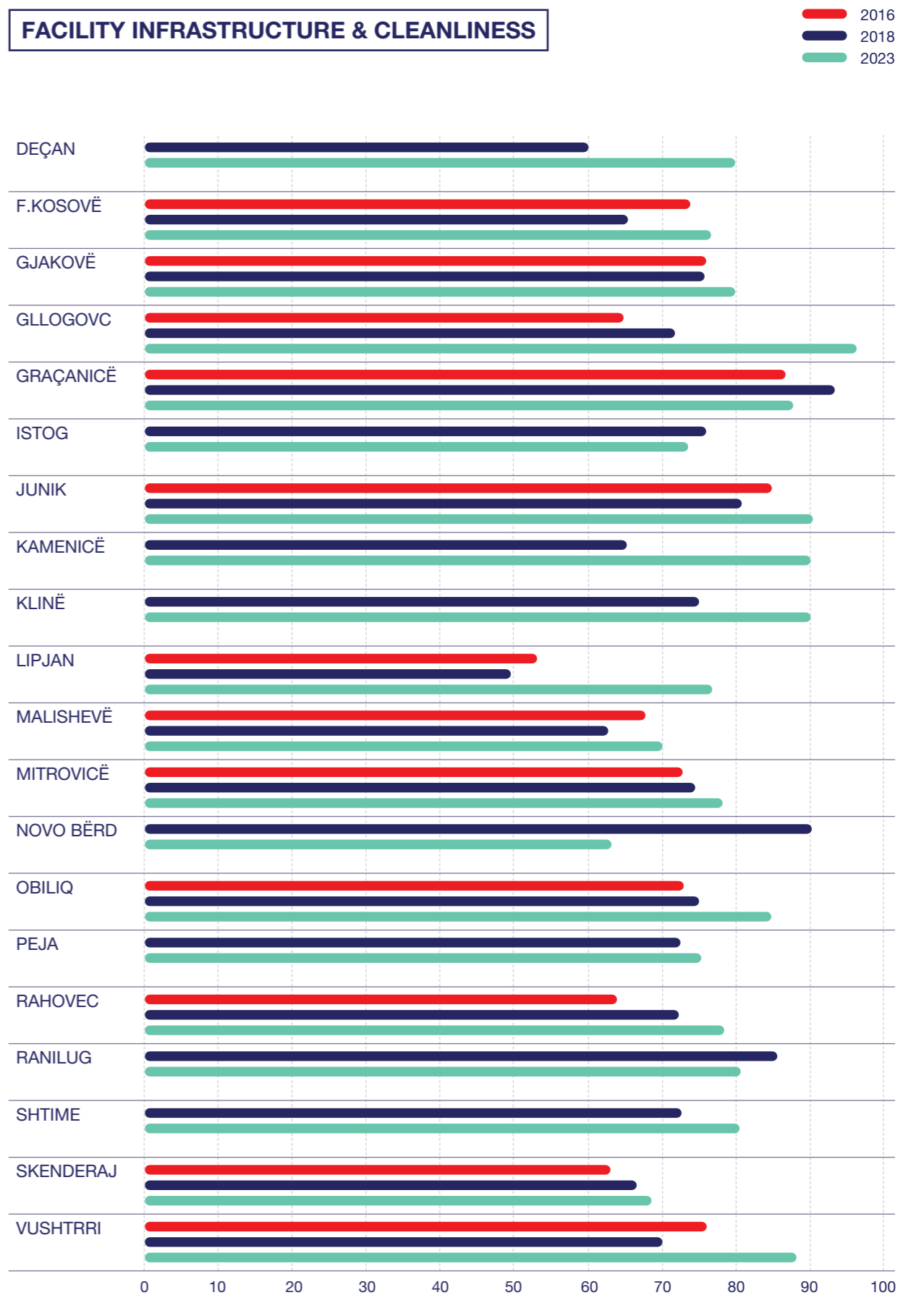**TABLE 8:** Infrastructure scores by facility type (2016, 2018, 2023)

	MFMC (mean, range)			FMC (mean, range)		
	2016 (n=11)	2018 (n=19)	2023 (n=18)	2016 (n=11)	2018 (n=35)	2023 (n=34)
Overall infrastructure	71 (48-90)	70 (59-86)	80 (59-89)	51 (32-72)	60 (39-75)	69 (51-88)
Facility Infrastructure & Cleanliness	88 (80-100)	85 (67-100)	90 (71-100)	64 (40-95)	62 (30-95)	74 (50-100)
Hygiene	83 (61-100)	79 (33-100)	92 (67-100)	73 (31-100)	68 (33-100)	93 (78-100)
Public Accountability[1]	83 (45-100)	87 (36-100)	89 (45-100)	64 (18-91)	71 (18-100)	66 (9-100)
Guidelines & Material	89 (60-100)	68 (20-100)	89 (20-100)	49 (0-100)	56 (0-100)	78 (20-100)
General Medical Equipment	69 (41-97)	65 (26-97)	82 (55-92)	45 (0-84)	60 (24-82)	72 (42-89)
Availability of Medicines	69 (29-100)	61 (36-80)	65 (39-82)	55 (44-69)	53 (36-71)	54 (30-73)

FIGURE 3: Infrastructure scores by municipality (2016, 2018, 2023)

- 2016
- 2018
- 2023

OVERALL INFRASTRUCTURE

FACILITY INFRASTRUCTURE & CLEANLINESS

- 2016
- 2018
- 2023

HYGIENE

PUBLIC ACCOUNTABILITY

GUIDELINES & MATERIALS

Legend:
- 2016
- 2018
- 2023

Chart categories: DEÇAN, F.KOSOVË, GJAKOVË, GLLOGOVC, GRAÇANICË, ISTOG, JUNIK, KAMENICË, KLINË, LIPJAN, MALISHEVË, MITROVICË, NOVO BËRD, OBILIQ, PEJA, RAHOVEC, RANILUG, SHTIME, SKENDERAJ, VUSHTRRI

GENERAL MEDICAL EQUIPMENT

Legend:
- 2016
- 2018
- 2023

Chart categories: DEÇAN, F.KOSOVË, GJAKOVË, GLLOGOVC, GRAÇANICË, ISTOG, JUNIK, KAMENICË, KLINË, LIPJAN, MALISHEVË, MITROVICË, NOVO BËRD, OBILIQ, PEJA, RAHOVEC, RANILUG, SHTIME, SKENDERAJ, VUSHTRRI

AVAILABILITY OF MEDICINES

Legend: ● 2016 ● 2018 ● 2023

Municipalities (top to bottom): DEÇAN, F.KOSOVË, GJAKOVË, GLLOGOVC, GRAÇANICË, ISTOG, JUNIK, KAMENICË, KLINË, LIPJAN, MALISHEVË, MITROVICË, NOVO BËRD, OBILIQ, PEJA, RAHOVEC, RANILUG, SHTIME, SKENDERAJ, VUSHTRRI

X-axis: 0 10 20 30 40 50 60 70 80 90 100

Key findings:

● The overall infrastructure score in MFMCs has remained stable between 2016 (71) and 2018 (70), but has increased to 80 in 2023. In FMCs, there was a steady increase over the surveyed years from 51 in 2015, to 60 in 2018, to 69 in 2023.

● Regarding facility infrastructure and cleanliness, trends are mostly positive and values generally quite high.

● Hygiene standards have dramatically increased overall. Interestingly, they were higher in 2016 than 2018, but improved then again in 2023. This may be related to AQH support in maintenance corners, and the training module on infection prevention and control measures offered by the AQH project since 2017 as well as an after effect of COVID-19.

● Public accountability[1] had various results depending on the items assessed. In regards to visibility of the contact phone number displayed to the public, there was an increase from 33 (2016) to 50 (2023). In addition there was an increase from 46 (2016) to 87 (2023) on the availability at the facility of the information leaflets about the Ministry of Health helpline for citizens' complaints. Whereas for display of posters from pharmaceutical companies there was a decrease from 80 (2016) to 17 (2023).

● The availability of guidelines and material has improved in most municipalities and is very high in some of them. This high trend could be attributed to the support of AQH to the Ministry of Health in developing CPG and in supporting municipalities with the provision of material and training.

● Through the support of AQH, the availability of general medical equipment has improved in most municipalities over the survey years.

● The availability of medicines has worsened in about half of the municipalities and is rather low compared to other indicators. In addition, in MFMCs, the availability of medicines was lower in 2023 than in the 2016 baseline. AQH could not influence on the improvement of the availability of medicines since the project does not have the mandate to support this sector.

4.3 Clinical Observations

The following graphs display the achieved scores from the clinical observations for 2018 and 2023 in the 20 municipalities that were surveyed in both years (Figure 3). Findings are shown in five categories. Disease-specific results on patients with diabetes, hypertension and 'other illnesses' are further divided into sub-categories on whether the medical doctor asks questions about the illness (questions/anamnesis), conducts the examination appropriately (examination) and advices and explains results, diagnosis and further steps sufficiently (advice). The results on the sub-categories are shown for the entire study population (Figure 4). Taken together, they form the 'overall' score on clinical observations.

1 Measured through indicators such as accessibility of complaint mechanisms, visible display of the Charter of Patient's Rights and Responsibilities, display of posters from pharmaceutical companies

FIGURE 4: Clinical observation scores by municipality (2016, 2018, 2023)

- 2016
- 2018
- 2023

INFECTION PREVENTION AND CONTROL

DOCTORS KNOWLEDGE AND COMPLIANCE
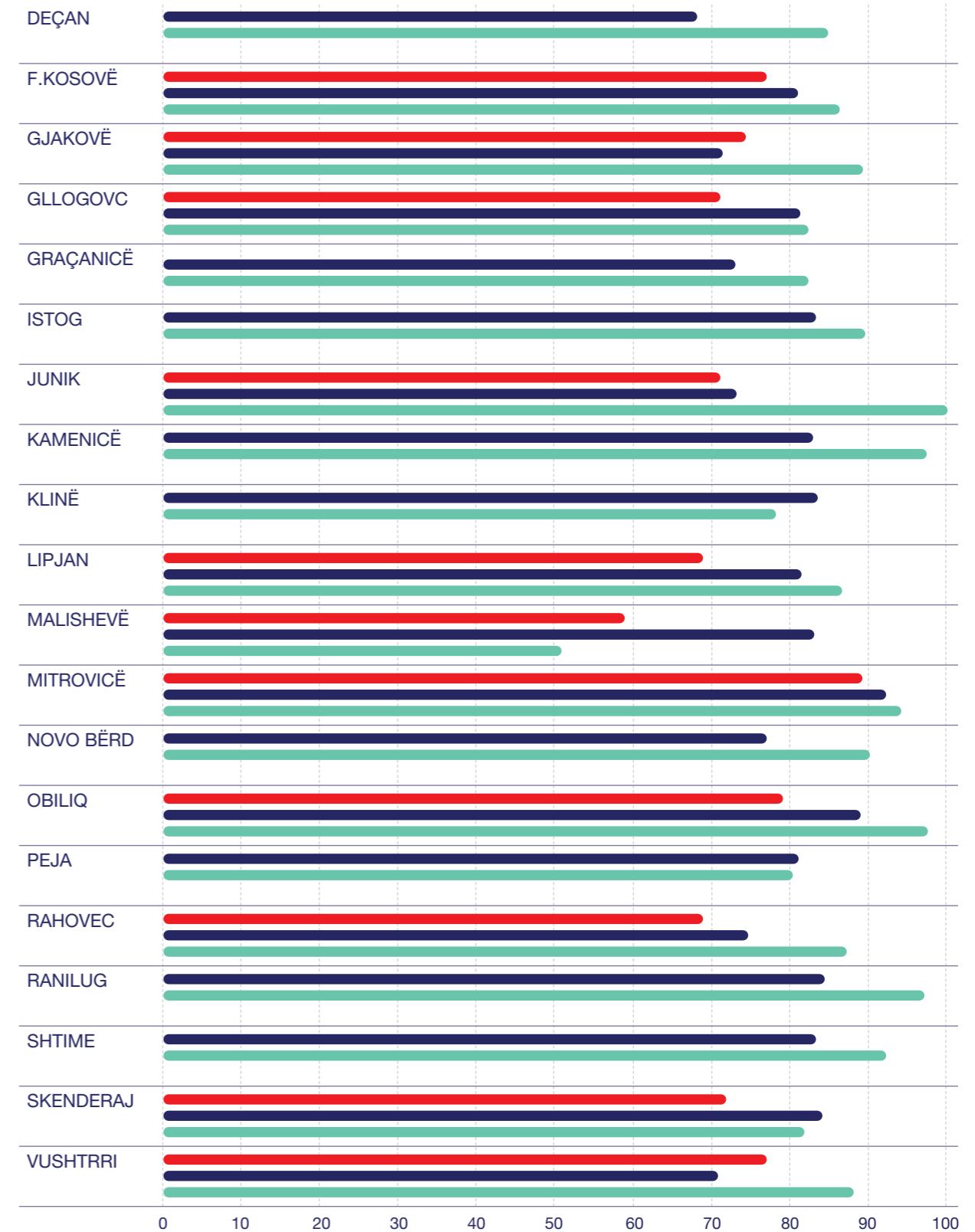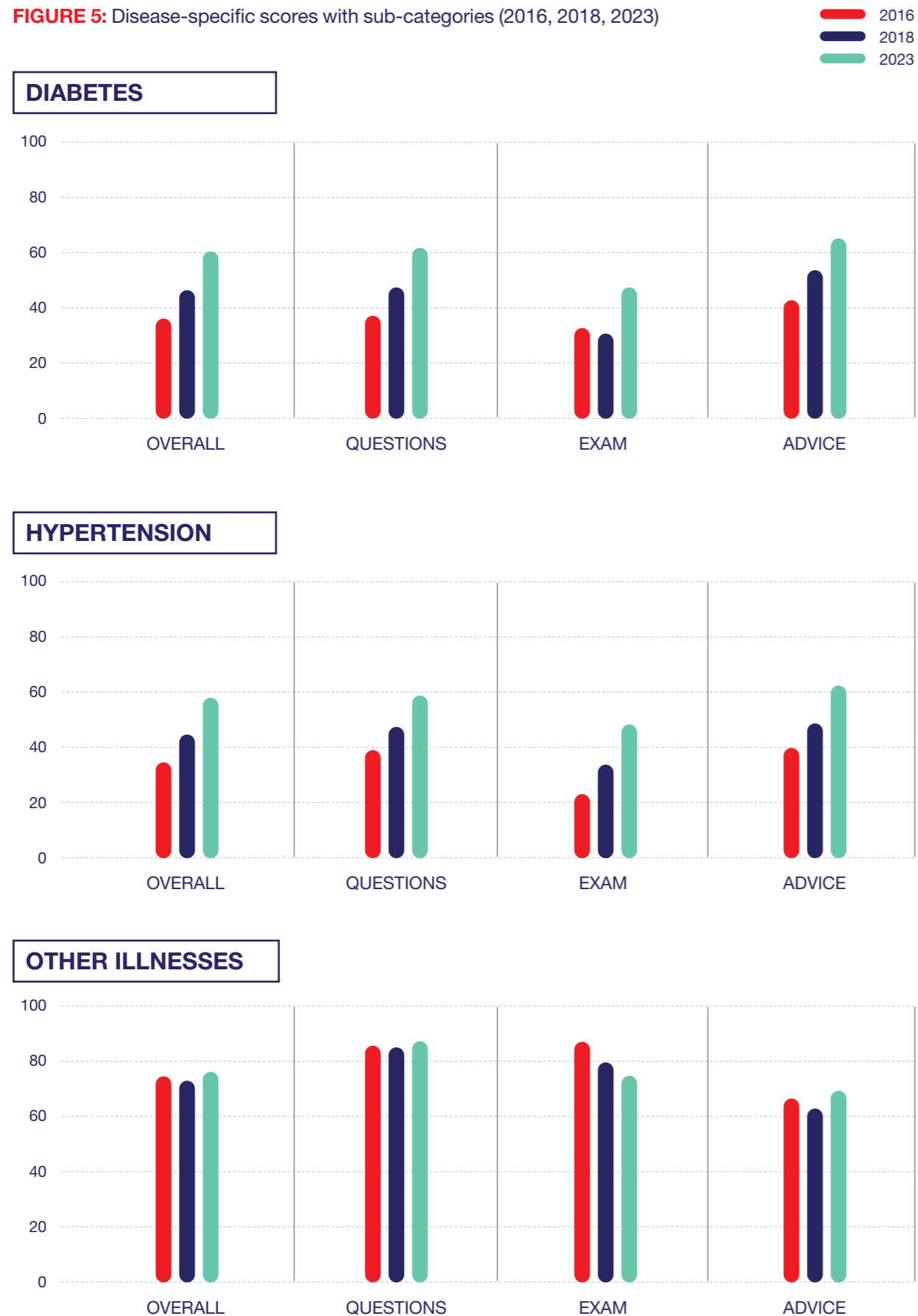
- 2016
- 2018
- 2023

FIGURE 5: Disease-specific scores with sub-categories (2016, 2018, 2023)

As mentioned above, 'other illnesses' refers to patients with illnesses other than diabetes and hypertension.

Key findings:

- Results on the doctor's knowledge and compliance with principles of clinical history and physical examination show significant increases in almost all municipalities. Only in Malishevë a substantial decrease from 83 to 52 can be observed. The overall increase in compliance with clinical guidelines can be attributed to the AQH support to MoH on the trainings and roll-out of CPGs for treatment of diabetes and hypertension.

- When it comes to the doctor's adherence to infection prevention and control measures, values have significantly increased in 14 municipalities but remain low in many of them. The increase in adherence to handwashing practices might be related to COVID-19 hygiene measures, and the AQH supported continuous medical education on infection prevention.

- Regarding diabetes, the overall score (including the anamnesis, examination and advice) has increased by 30%. The strongest increase was observed in how the doctors perform the examination (52%). However, the overall number of patients observed is relatively low (n=81).

- The hypertension score increased by 29% with the largest increase also in the examination sub-score (41%) (n=242). The positive trends in adherence to guidelines related to diabetes and hypertension can be attributed to the support of AQH to municipal partners.

- The score on other illnesses (than diabetes or hypertension) increased by 4%. The examination sub-score decreased by 6% but the sample in this sub-category are lower than in the other sub-categories and the overall sample (n=1462 vs. n=1727).

4.4 Exit Interviews

In 2023, 948 exit interviews were conducted, compared to 629 in 2018 and 716 in 2016. In 2023, 33% have reported to not have visited the health center in the 3 months preceding the survey, thus similar to 2018 (33%) and higher than in 2016 (21%).
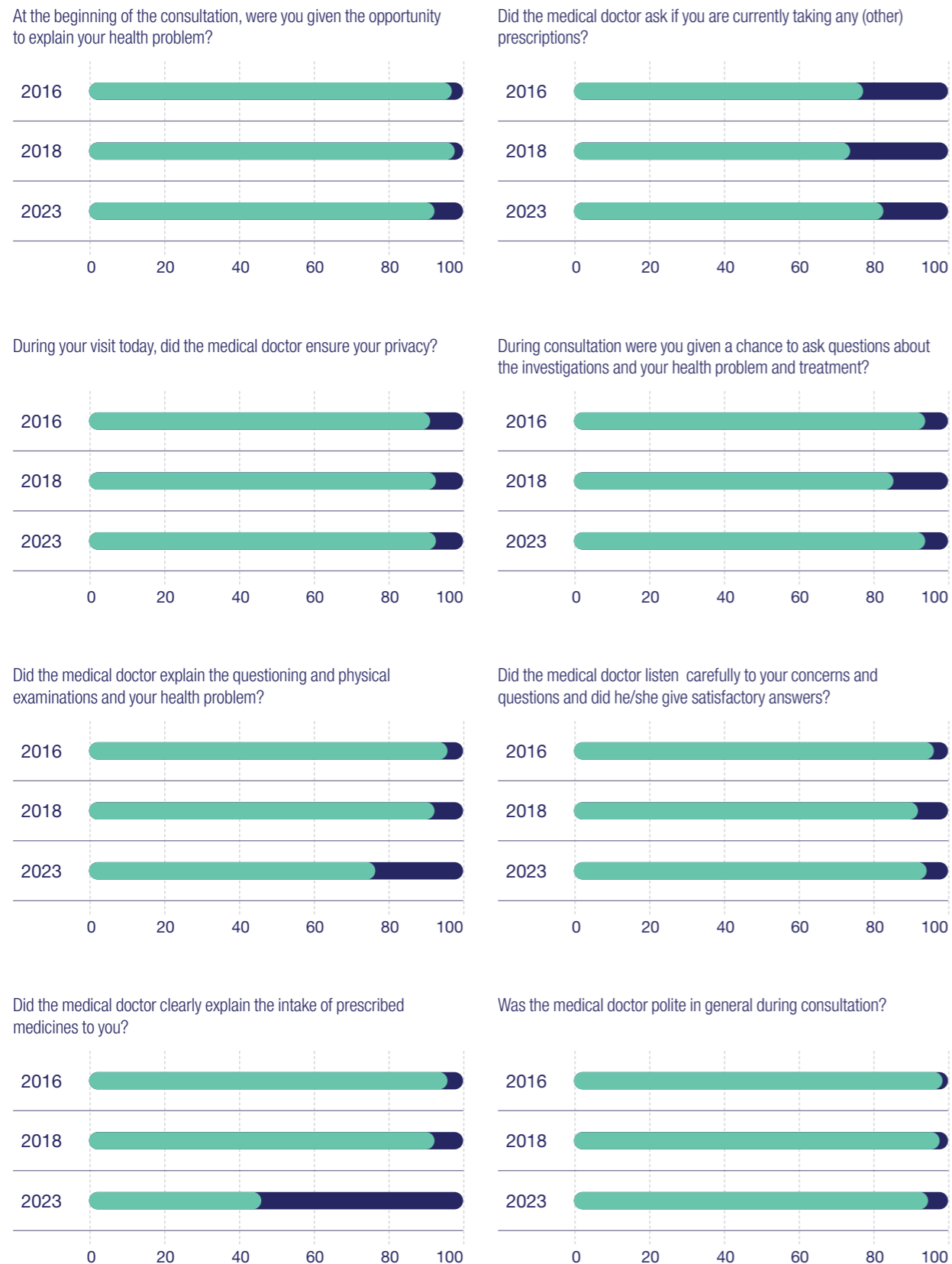
The main results on the overall satisfaction of patients exiting the facility were:

- Across municipalities, patients were mostly satisfied or very satisfied with the health services. In comparison to 2018, the ratio of very satisfied patients vs. satisfied patients increased in 2023.

- The overall patients service score significantly decreased in seven municipalities (F. Kosove, Gjakove, Gllogovc/Drenas, Malisheve, Rahovec, Decan, Istoq A significant positive change could only be observed in Novo Brdo.

Figure 6 displays eight different indicators on doctor's behaviours' during the consultation from the patients' perspectives and their evolution over the surveyed years. The following results stand out when comparing over the years:

- The patients largely reported overall 'positive/skilled' behaviours of the doctors (green colour), as in 2022, approval rates for the behaviours considered 'as should' are all 60% and above, with one exception (see following point).

- The most significant (negative) change was observed regarding the explanation of the intake of prescribed medicines (-47.6%). Another marked negative change was the explanations given by the doctor regarding the questioning and physical examination (-15.9% between 2018 and 2023).

- Improvements between 2018 and 2023 were observed for "doctor asking on current (other) prescriptions" and "patient was given chance to ask questions".

- The politeness of the medical doctors' showed a slight negative trend over the surveyed years.

FIGURE 6: Indicators on doctor's behaviours' during the consultation (2016, 2018, 2023)   ● YES   ● NO

At the beginning of the consultation, were you given the opportunity to explain your health problem?

Did the medical doctor ask if you are currently taking any (other) prescriptions?

During your visit today, did the medical doctor ensure your privacy?

During consultation were you given a chance to ask questions about the investigations and your health problem and treatment?

Did the medical doctor explain the questioning and physical examinations and your health problem?

Did the medical doctor listen carefully to your concerns and questions and did he/she give satisfactory answers?

Did the medical doctor clearly explain the intake of prescribed medicines to you?

Was the medical doctor polite in general during consultation?

Looking in more detail at the various aspects regarding the consultation that have been reported by exiting patients we identified the following positive and negative changes between 2018 and 2023 in the different facilities (see Table 9).

TABLE 9: Overview on significant changes in patients exiting facilities between 2018 and 2023 at municipality level

Municipality	Positive Changes	Negative Changes
Gjakovë	• n/a as no data was collected in 2023	• n/a as no data was collected in 2023
Gllogovc/Drenas	• Patient got advice on health problem	• Doctor did not explain the intake of prescribed medicine • Doctor did not ask if patient currently takes prescriptions
Gracanica	• Patient got advice on health problem	• Doctor did not explain the intake of prescribed medicine • Medical doctor was not polite during consultation
Mitrovicë	• Patient was given chance to ask questions about the investigation, health problem and treatment • Doctor listened carefully to patients concerns and questions and gave satisfactory answer	• Patient was not given the opportunity to explain the health problem • Doctor did not explain the intake of prescribed medicine
Junik		• Doctor did not explain the intake of prescribed medicine
Lipjan	• Doctor asked if patient currently takes prescriptions • Patient was given chance to ask questions about the investigation, health problem and treatment • Patient got advice on health problem	• Patient was not given the opportunity to explain the health problem
Malishevë	• Patient was given chance to ask questions about the investigation, health problem and treatment • Doctor listened carefully to patients concerns and questions and gave satisfactory answer • Patient got advice on health problem	• Doctor did not explain the questioning and physical examinations and the health problem • Doctor did not explain the intake of prescribed medicine • Doctor did not ask if patient currently takes prescriptions
Obiliq	• Patient was given chance to ask questions about the investigation, health problem and treatment	
Fushë Kosovë	• Patient got advice on health problem	• Doctor did not explain the questioning and physical examinations and the health problem • Doctor did not explain the intake of prescribed medicine
Rahovec		• Doctor did not explain the intake of prescribed medicine

Municipality	Positive Changes	Negative Changes
Skenderaj	• Doctor asked if patient currently takes prescriptions	• Doctor did not explain the questioning and physical examinations and the health problem • Doctor did not explain the intake of prescribed medicine
Vushtrri	• Patient's privacy was ensured • Doctor asked if patient currently takes prescriptions • Patient was given chance to ask questions about the investigation, health problem and treatment • Doctor listened carefully to patients concerns and questions and gave satisfactory answer • Patient got advice on health problem • Medical doctor was polite during consultation	• Doctor did not explain the intake of prescribed medicine
Kamenica		• Doctor did not explain the questioning and physical examinations and the health problem • Doctor did not explain the intake of prescribed medicine
Decan	• Patient's privacy was ensured • Patient got advice on health problem	• Doctor did not explain the intake of prescribed medicine
Istog		• Doctor did not explain the questioning and physical examinations and the health problem • Doctor did not explain the intake of prescribed medicine
Klinë		
Peja	• Patient got advice on health problem	
Shtime	• Patient got advice on health problem	
Novo Brdo	• Doctor asked if patient currently takes prescriptions	
Ranilug		

5.
Conclusion

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

Importantly, the indicators included to calculate the overall scores might slightly vary between the years as some questions/indicators had to be adjusted, updated, removed or added. Nonetheless, the overall scores do reflect the status of the three dimensions against the standard of care in any given survey year.

FIGURE 7: Mean overall scores by year

● Mean exit interview score   ● Mean exit interview score   ● Mean infrastructure score
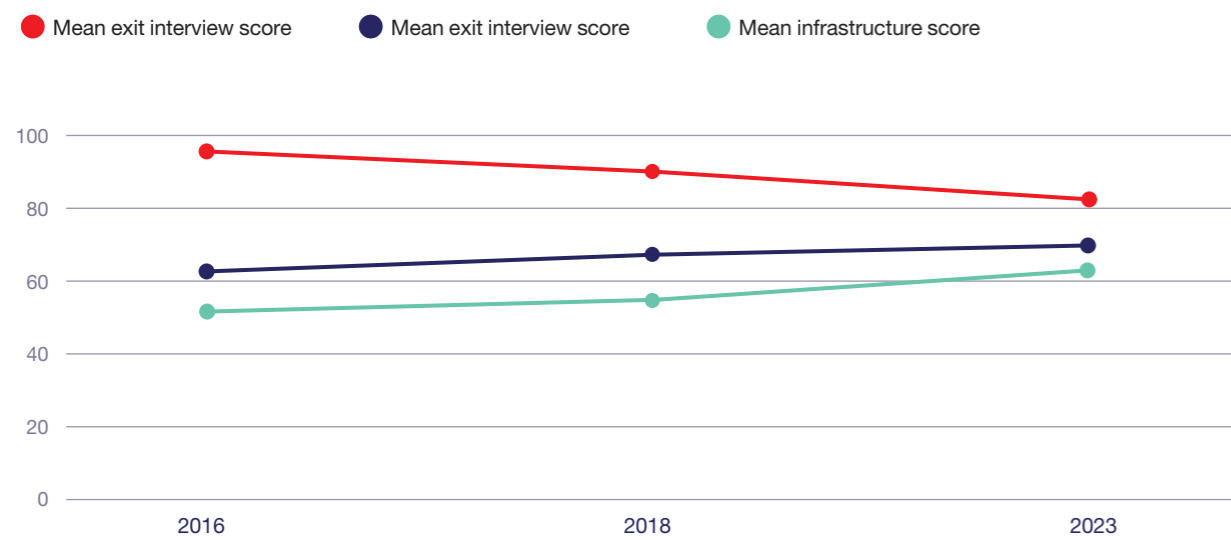
Quality of the HC infrastructure measured through a health centre assessment tool (structural attributes):

● The infrastructure score showed slight improvement between 2016 and 2018 and then a marked improvement between 2018 and 2023. This improvement in infrastructure can be attributed to AQH project interventions including: provision of basic medical equipment, refurbishment of PHC centers, as well as renovation of PHC centers through Quality Improvement Projects (QIPs).

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

● The quality of the doctor-patient interaction increased slightly but steadily increased over 2016, 2018 and 2023. This steady increase could be due to the fact that AQH project in collaboration with MoH organized continuous trainings on the management of diabetes and hypertension and encouraged the implementation of CPGs among primary healthcare providers.

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

● The patient satisfaction score has decreased significantly over the years. This decrease could be due to increased knowledge about quality healthcare services among the PHC users. Since 2016, AQH project in collaboration with national stakeholders have developed several initiatives to improve population knowledge on disease risks as well as empower to demand the right to quality services.

6.
Recommendations

Overall the findings of this 2023 survey reveal dimensions or topics of the current Quality of Care in Primary Health Care facilities, that would benefit from further investments, interventions, or reinforcement. The following Table 10 indicates remaining key findings since 2016 through to 2018 and 2023, and provides recommendations for 2024 and beyond.

Table 10: Overview of key findings and recommendations

Key findings	Recommendation(s) and Relevance for 2024 and beyond
Infrastructure	
● Frequent power-cuts and only half of the surveyed facilities had a generator ● Functional heating systems unavailable in 2/3 of the facilities ● Frequent water supply shortages / 18% of facilities do not have access to tap water	The key findings and recommendation remain, though structural improvements have also been observed. ● Ensure the availability of basic amenities in PHC facilities (power, water, heating) according to national standards

● Variation in the range of equipment available at facilities
● Basic equipment not available in some facilities
● Lack of standards for some categories of equipment (e.g. gynaecological equipment)
● Lack of equipment to assess and monitor child growth
	The equipment situation has improved for most facilities. The lack of equipment to assess and monitor child growth remains a main issue. The availability of drugs is more variable in 2023 compared to 2016.
	
	● Revise equipment standards for PHC and ensure provision and maintenance of equipment[2]:
	  - Identify critical aspects that hinder the inadequate availability of the equipment, material and drugs
	  - Provide basic equipment
	  - Elaborate a step wise strategy/plan for health technology/equipment management, eventually addressing both levels PHC and SHC

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2   As based on the equipment standards of the Administrative Instruction - 04/2020

Key findings	Recommendation(s) and Relevance for 2024 and beyond

• Disinfectant for instruments often not available in the necessary places
• Washing points/soap not available near all toilets
• Cleanliness of toilets could be improved
• Storage and collection of infectious waste could be improved
	Soap has been more available near all toilets in 2023 compared to 2916, but the cleanliness of the toilets have not improved across all municipalities.
	Progress has been identified for the storage of waste although the collection remains an issue.
	
	• Ensure hygiene standards and enforce infection prevention and control measures:
	  – Functional washing points must be close to toilets
	  – Functional washing points must be in the consultation rooms
	  – Re-enforce "washing hands" protocol with periodic refreshment training for all professionals in PHC
	  – Include "washing hands" topic in health education measures for patients
	  – Ensure, that water and soap are constantly available at all washing points
	  – Ensure that chlorine solutions or other disinfectants for instruments are available
	  – Regular cleaning

Clinical consultations	

• Very low adherence to infection prevention and control measures during consultations	Hygiene practices and infection prevention remain a significant problem in clinical practice. Hence recommendations remain valid.
	
	• Ensure hygiene standards and enforce infection prevention and control measures:
	  – Raise awareness and remind health staff on infection prevention measures
	  – Re-enforce "infection prevention and control" protocol with periodic refreshment training for all professionals in PHC

• Very low adherence to general diabetes treatment guidelines • Very low adherence to general hypertension treatment guidelines • Variable adherence to principles of good clinical practice and physical examination	Adherence to hypertension treatment has overall improved though it is still variable between municipalities & facilities. However, there is still sufficient space for further improvements. • Review and revise relevant national CPGs, add new relevant CPGs including patient pathways • Distribute relevant national CPGs to the health facilities and ensure online access • Continue to train health professionals on CPGs • Promote/implement existing relevant national CPGs • Develop tools to monitor implementation of CPGs, such as CPGs related clinical audits
Other observations	
• Feedback mechanism missing in 20% of facilities	Feedback mechanisms have improved. • Support the development of patient/provider interaction on quality of care, through feedback mechanisms
• Referral mechanisms could be improved	Finding and recommendation remains valid. • Support the referral of patients between levels of care

7.
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1   Donabedian, A., *The quality of care. How can it be assessed?* JAMA, 1988. **260**(12): p. 1743-8.

2   Donabedian, A., *The seven pillars of quality.* Arch Pathol Lab Med, 1990. **114**(11): p. 1115-8.

3   Boller, C., et al., *Quality and comparison of antenatal care in public and private providers in the United Republic of Tanzania.* Bull World Health Organ, 2003. **81**(2): p. 116-22.

4   Matthys, B., *Assessment of quality of care in primary health care facilities in two pilot rayons of project Sino. Study report.* 2013, Swiss Tropical and Public Health Institute: Basel.

5   Levy, S. and S. Lemeshow, *Sampling of populations. Methods and applications*. 4 ed. 2008, John Wiley & Sons.

6   Lechthaler, F., *Study Protocol on the Quality of Care Study in Chad*. 2015, Swiss Tropical and Public Health Institute: Basel.

7   Novartis Foundation, *Quality as the missing link between access to healthcare and improved patient outcomes. Express Newsletter 3/14.* 2014, Novartis Foundation: Basel.

8   WHO, *Service Availability and Readiness Assessment (SARA)*. 2011, World Health Organization: Geneva.

8. Annexes

Annex 1: Ethical approval

Albanian (Original version)

Engl

![Emblem of Kosovo Doctors Chamber]

ODA E MJEKEVE TE KOSOVES
KOSOVO DOCTORS CHAMBER · LEKARSKA KOMORA KOSOVA

COMMISSION ON ETHICAL ISSUES

REF. NO: 66 /2023

DATE:	24	04	2023

COMMISSION ON ETHICAL MATTERS, in support of Article 9, paragraph 1, sub-paragraph 1.6, Article 35, paragraph 1, sub-paragraph 1.1 and Article 36 of Law No. 04/L-150 on Chambers of Healthcare Professionals, Article 47, paragraph 1, sub-paragraph 1.1 and Article 49 of the Statute of KDC and Article 10 paragraph 1, Article 12 and Article 13 paragraph 4, sub-paragraph 4.1 of the Regulation on the Scope and Competencies of the Commission on Ethical Matters, the Commission on Ethical Matters, on 24 April 2023, issues the following:

PERMISSION
FOR BIO-MEDICAL RESEARCH

Based on the request of Ariana Bytyçi Katanolli - in the capacity of the bearer of the research project, with the address [Neighbourhood MATI 1 Trade Buildings Ent.8 No. 36, 10000 Prishtina, Republic of Kosovo, for the conduction of the research "Assessment of the Quality of Health Care in Primary Health Care Institutions", based on the documentation submitted to the Commission and being covered in Article 10 paragraph 1, Article 12 and Article 13 paragraph 4 sub-paragraph 4.1 of the Regulation on the Scope and Competencies of the Commission on Ethical Matters, on 24 April 2023, the Commission estimates that:

The applicant Ariana Bytyçi Katanolli - in the capacity of the research project, is permitted to collect, use and process the data of the respondents-patients in the MFMCs and the FMCs in: Deçan, Drenas, Fushe Kosova, Gjakova, Graçanica, Istog, Junik, Kamenica, Klina, Lipjan, Malisheva, Mitrovica, Novoberda, Obiliq, Peja, Rahovec, Skenderaj, Vushtrri, Rranillug and Shtime, municipalities in the Republic of Kosovo, with the aim of implementing a prospective-qualitative research entitled: "Assessment of the Quality of Health Care in Primary Health Care Institutions", carried out in the time period from 24 April 2023 to 23 April 2024, these data will be used only as a project for the implementation of this innovation, and not for other purposes of the applicant or third parties involved in this research.

With this act of permission, it is confirmed that the applicant has met the criteria assessed by the Commission on Ethical Matters to carry out the research permitted according to the request submitted by the applicant.

The entity that implements the research permitted according to this permission act, is obliged to submit the report in written form related to the research implemented according to the permission to the Commission on Ethical Matters within 30 (thirty) days after the end of the research.

Përkthyes Gjyqësor për Gjuhë Angleze
Court Translator for English Language
Sudski Prevodilac za Engleski jezik
Prof. Bekim Kastrati
No. ___01___ Dt. 03/04/2023
GJILAN

Place	Date	Chairperson of the Commission on Ethical Matters
Prishtina	24 April 2023	Prof. dr. Shaip Krasniqi

Legal advice: Regarding this act, the dissatisfied party can submit a complaint within 15 (fifteen) days from the day of its acceptance. The complaint must be submitted through the Committee on Ethical Affairs of the OMC to the Governing Council of the OMC.