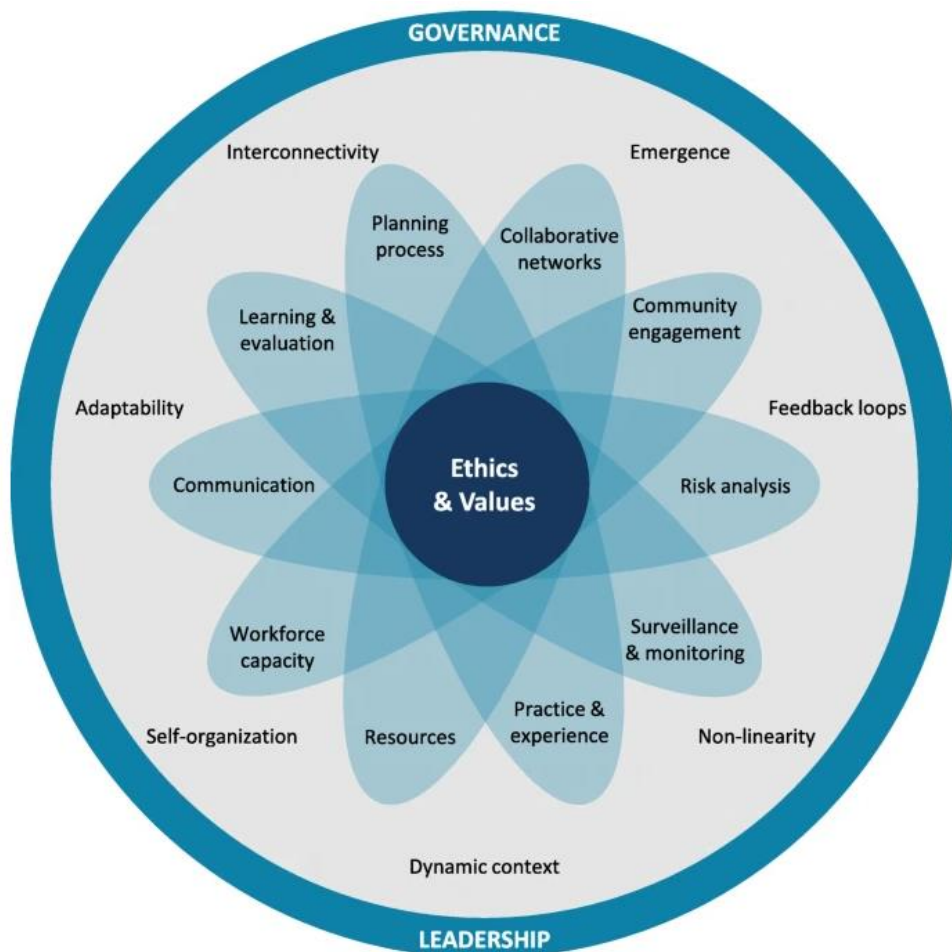


EMERGENCY PREPAREDNESS AND RESPONSE IN ALBANIA

Research Report



July 2023

Contents

1. EXECUTIVE SUMMARY	3
2. INTRODUCTION	14
2.1. Background	14
2.2. Context	14
3. AIM AND OBJECTIVES OF THE RESEARCH.....	15
3.1. Overall Aim	15
3.2. Specific Objectives	15
4. METHODOLOGY	17
4.1. Desk Review	17
4.2. Quantitative Study	17
4.3. Qualitative Research	20
5. RESULTS	25
5.1. Findings From Desk Review	25
5.2. Results from quantitative research.....	70
5.3. Results of Qualitative Research	90
5.3.1. Findings From Focus Group Discussions.....	90
5.3.2. Findings From Key Informant Interviews.....	101
6. CONCLUSIONS.....	112
7. RECOMMENDATIONS.....	115
ANNEX 1. INSTRUMENTS OF DATA COLLECTION	117
7.1. Interview Guide for Focus-Group Discussions	117
7.2. Interview Guide for Key Informants.....	122
7.3. Structured Questionnaire for the Quantitative Study	126
ANNEX 2: Detailed information on focus groups discussions.....	132
ANNEX 3: Detailed information of Key Informants Interviews	133

1. EXECUTIVE SUMMARY

1.1. Context

Albania is vulnerable to earthquakes, floods, forest fires, and landslides. Recent natural disasters (the 2019 earthquake) and the more recent COVID-19 pandemic have demonstrated the importance of ensuring accessibility to health and human services for everyone living in Albania. There are systematic issues that have impacted the health care system in Albania in decades, and more specifically its weaknesses in the health emergency preparedness and response that were very much exposed during the pandemic. The fragmentation and lack of clarity regarding mandates, responsibilities and lines of communication during emergency situations evidently requires a substantial and structural reform.

In this framework, the “Support to Health Emergency Service Preparedness” SDC project contracted an organization/company capable of conducting a formative research in terms of Knowledge, Attitude, Practices and Beliefs (KAPB) survey on vulnerable populations with respect to access and use of emergency services to inform the project strategy and effective activities towards emergency preparedness, as well as contribute in setting of a useful baseline regarding an informed, engaged and empowered civil society that will accelerate successful planned interventions in this area.

1.2. Aim and Objectives

The aim of this report was to identify and assess hindrances and obstacles of vulnerable populations with respect to accessing and using emergency care services in order to inform effective and evidence-based policies for reducing the risk of vulnerable population groups in Albania.

The main specific objectives consisted of exploration and assessment of the level of knowledge, attitudes and practices of vulnerable population groups regarding the access to emergency healthcare services.

1.3. Methodology

The current study consisted of two main components: desk review, and primary data collection (by use of both quantitative and qualitative methods, techniques, and instruments).

The desk review provided useful insights and information for informing decision-making, program planning, and policy development.

The quantitative component consisted of a cross-sectional including a representative sample of 500 vulnerable individuals of both genders (aged 18 years and above) pertinent to different regions of Albania.

The qualitative research consisted of two instruments: focus group discussions and key informant interviews. Overall, 15 focus group discussions and 20 key informant interviews were conducted in 4 (four) regions of Albania.

1.4. Findings from the Quantitative Research

About 28% of individuals included in the quantitative study were categorized as poor; around 14% were categorized as sick; 9% as disabled; around 11% were living in remote areas of the country; whereas the remaining 37% of participants had at least two characteristics of vulnerability (poor, sick, disabled, remote areas).

About 8% of individuals reported a very poor health condition and further 20% reported a poor health status. On the other hand, only 13% of individuals reported a very good health status in general. In addition, more than half of study participants (about 55%) reported the presence of at least condition/disease and almost one-fifth of study participants (19%) reported the presence of at least two conditions/diseases.

Emergency health services (individual level)

When asked whether they had sought services at the National Center of Medical Emergencies (NCME), 23% of participants reported that they had sought services many times near this center. Among those who answered positively regarding the call of number 127 (NCME), more than half (about 59%) of participants reported that they had always received a response from this number, whereas 17% of individuals had never received an answer. Half of participants reported that they were very satisfied with the services provided by NCME and further 31% of individuals reported that were satisfied with the services received from this center. On the other hand, about 3% of individuals were only a little satisfied and further 2% were not satisfied at all with the services provided by the NCME.

Almost three-quarters (73%) of participants agreed that the services provided by NCME were on a timely manner, whereas about 15% disagreed with this statement. Furthermore, more than two-thirds (67%) of individuals agreed that the ambulances were properly equipped, whereas 11% of participants disagreed with this statement. In addition, about 88% of participants agreed that the personnel providing emergency services was good, whereas only 3% disagreed with this statement. Also, three-quarters of participants agreed that their medical problems/issues were solved by the NCME, whereas 6% of individuals disagreed with this statement.

Among those who reported to have used emergency services regardless of calling the number 127 (pertinent to the NCME), about 24% of participants reported that they attended emergency services at their place of residence; around 52% received emergency services at the primary health care centers, whereas the remaining 23% of individuals received emergency services at the hospital. More than half (about 58%) of participants reported that they were very satisfied with the emergency services received and further 27% were satisfied with the emergency services received. Conversely, 1.9% of individuals were only a little satisfied and further 1.7% of participants were not satisfied at all with the emergency services received.

Among those who answered positively regarding the use of emergency services regardless of calling the number 127 (pertinent to NCME), three-quarters (76%) of participants agreed that the health facility providing emergency services is close to their respective place of residence, whereas about 22% of individuals disagreed with this statement. Furthermore, about 73% of individuals agreed that the health facilities providing emergency services were properly equipped, whereas 11% of participants disagreed with this statement. In addition, about 92%

of participants agreed that the personnel providing emergency services was good, whereas only 3.3% disagreed with this statement. Also, around 84% of participants agreed that their medical problems/issues were solved by the health facilities providing emergency services, whereas 6% of individuals disagreed with this statement. Of note, the absolute majority of study participants (about 93%) reported that they trusted their family physicians, whereas only 2% did not agree with this statement.

When asked whether, in the past year, individuals had been unable to receive emergency services when needed, almost one-third of participants reported that they were unable to receive emergency services when needed, whereas the remaining 68% reported that they were able to receive emergency services when needed (32%).

When asked about the reasons for not being able to receive emergency services when needed (during the past year), almost two-thirds (about 66%) of participants reported that negligence was the main reason for not receiving such services. The second main reason for the inability to receive emergency service when needed was the distance to health facilities providing emergency services which was reported by 52% of study participants who reported to have not been able in the past year to receive emergency services when needed. The third main reason for the inability to receive emergency services when needed consisted of financial constraints, which was reported by 43% of individuals who reported inability to receive emergency services when needed. The fourth reason for the inability to receive emergency services when needed concerned medical problems (sicknesses) which prohibited 41% of individuals from receiving emergency services when needed. The fifth reason involved stigma which was reported by about 35% of individuals who reported inability to receive emergency services during the past year when needed. The sixth reason was the lack of trust which was reported by 33% of individuals who reported inability to receive emergency services during the past year when needed. On the other hand, one out of four participants reported that they did not know where to go when they needed emergency services in the past year.

When asked about the communication of health personnel, about 41% of participants reported that they perceived as very good the communication of health professionals and further 40% perceived it as good. On the other hand, 3.6% of individuals reported a bad communication of health personnel and further 1.2% of participants reported a very bad communication style/manner of health personnel providing emergency services in different health facilities across Albania.

Health emergencies (population/community level)

When asked about the self-perceived safety of the living area, 27% of participants felt very unsafe and further 40% felt unsafe. Conversely, 28% felt safe and only 5% felt very safe with their respective living areas.

When asked about the self-perceived safety of the buildings where participants lived, 15% of them felt very unsafe and about 35% felt unsafe. On the other hand, about 43% of participants felt safe and about 7% felt very safe.

When asked about the self-perceived community impact in case of emergencies, about 18% of individuals perceived a high risk of negative impact at community level and further 58% of participants perceived risk of negative community impact. Conversely, about 4% did not

perceive any risk at all, whereas 21% did not perceive any significant risk of negative impact at community level in case of emergencies.

When asked about the self-perceived own family impact in case of emergencies, about 21% of individuals perceived a high risk of negative impact on their own families and further 57% of participants perceived risk of negative family impact. On the other hand, about 3% of individuals did not perceive any risk at all, whereas 20% did not perceive any significant risk of negative impact on their own families in case of emergencies.

Lack of local plans for preparation in case of emergencies was reported by almost 81% of participants, whereas the remaining 19% did not perceive this as a concern. Lack of information about proper and prompt preparation against emergencies was reported by about 78% of participants, whereas the remaining 22% of individuals did not perceive this as a serious issue. Lack of adequate support from local government in case of emergencies was reported by 73% of participants, whereas the remaining 27% of individuals did not perceive this as a challenge. Lack of prompt institutional reaction in cases of emergencies was reported by 74% of participants, whereas 26% of individuals did not perceive this as a serious barrier. Furthermore, about 21% of participants reported other concerns in cases of emergencies, including living alone, long distances, commuting difficulties, lack of community participation, lack of social cohesion, etc.

Overall, slightly more than half of participants (about 51%) reported that their families had been affected by emergencies/disasters, whereas the remaining 49% had never been affected by any emergencies/disasters.

On the whole, only 28% of participants reported that they were aware of emergency plans in their living areas, whereas the remaining 72% did not know about the existence of any emergency plans in their respective living areas. Even more importantly, only one participant (0.5% of valid responses) knew about the existing laws and regulations for effective management of emergencies/disasters in the Republic of Albania, whereas 99.5% of individuals were not aware of the existing laws and regulations about management of emergency situations. However, this question was answered by only 183 participants (36.6% of the total number of study participants). Also, only 16% of participants knew about the existence of local regulations for effective management of emergencies/disasters.

Overall, the most preferred source of information regarding the knowledge and awareness of emergency situations consisted of community discussions, which was reported by about 45% of participants. Television (national and/or local) was the second main preferred source of information which was reported by 31% of individuals. Municipal Council meetings consisted of the third most preferred source of information, which was reported by 11% of individuals. School discussions with pupils was the fourth most preferred source of information, which was reported by 6% of individuals. On the other hand, the least preferred source of information consisted of mobile applications, which was reported by 0.4% of individuals.

1.5. Findings from the Qualitative Research

Findings From Focus Group Discussions

Emergency health services (individual level)

Access to emergency health services faces several barriers, particularly affecting vulnerable groups such as low-income individuals, disabled people, and rural communities. These barriers include demographic, geographic, economic, and cultural factors that hinder their ability to reach emergency health services. Ensuring access to healthcare is essential for upholding basic human rights, including safety, quality, and equity.

Participants generally reported having access to emergency health services when needed. Local emergency health services were preferred, as they offered ease of access, established contacts with doctors and nurses, and facilitated faster service provision. Patients usually sought assistance directly from the emergency department or contacted doctors to request ambulance services.

However, some challenges were noted in accessing the National Center of Medical Emergencies (NCME) using the number 127. Delayed responses were attributed to traffic and limited address information, making it difficult for ambulances to locate patients promptly. Some participants were unaware of the national emergency service, leading them to seek emergency care independently.

Participants expressed a preference for receiving all health services near their residences. The lack of comprehensive services in some areas forced citizens to seek private healthcare or neglect regular visits, potentially leading to emergency situations.

During the COVID-19 pandemic, citizens reported positive experiences with the health service, which remained available 24/7. However, financial burdens were reported by some individuals, impacting their ability to afford treatment.

The study revealed that vulnerable individuals heavily rely on traditional medicines, particularly in emergency situations. Regardless of their socio-economic background, people turn to various traditional remedies, and only when the situation worsens do they consider seeking formal health care.

Factors influencing the health status of the population include poverty, which reduces opportunities for accessing paid services, especially those located far from their residential areas. In remote areas and small towns, a significant portion of the population consists of elderly individuals with an increased need for health services. Some elderly individuals live alone, making it even more challenging for them to manage emergency cases.

Distance to the health facility. The distance to health facilities emerged as a significant barrier to accessing health care.

Negligence. Many participants admitted that their negligence in seeking medical help constituted a significant barrier to receiving timely services. Lack of awareness about the importance of their health condition led them to believe that their health issues were transitory, resulting in delayed or avoided medical care.

Delay to response. Delayed response times were reported as another significant barrier. Ambulances sometimes took a long time to arrive at the scene, and there were cases where ambulances did not arrive at all.

Lack of information. Lack of knowledge to recognize danger signs and a preference for traditional approaches were mentioned as barriers by participants.

Insufficient medicines and equipment. In some cases, the participants reported that they had to purchase themselves some of the medications due to their absence at the time they requested the service.

Lack of human resources. Participants in the focus groups highlighted a significant barrier to accessing emergency health services, which is the lack of adequate health care providers and specialists, especially in small towns and rural areas. This shortage of medical professionals makes it challenging for individuals with chronic illnesses to access necessary healthcare services near their residences.

Quality of services. The public health system faces several challenges that directly impact the quality of services offered to citizens.

Need to better equip Health Centers. Wider coverage with services from health centers would reduce the number of cases that are referred and require services in other facilities.

Health emergencies (population/community level)

The findings identified that communities, both in rural and urban areas, face various hazardous events, including disasters, that directly impact their health. As front-line health workers and first responders play a crucial role during emergencies, it is essential to involve them in all phases of emergency risk management.

In civil emergency situations, such as non-pandemic emergencies, participants reported a lack of clear guidance and direction from health institutions. As a result, citizens often tried to manage the emergency themselves initially and later sought assistance from the municipality. To improve community disaster resilience, it is crucial for communities to receive adequate knowledge and skills through training and risk communication. Local stakeholders, including community leaders, play a vital role in identifying priorities and training the local workforce to respond efficiently to sudden disasters.

Citizens acknowledged the importance of civil society organizations, such as churches and the Red Cross, in providing crucial first aid and support during emergency situations.

However, during the experiences of the earthquake, participants reported that the response was not entirely positive. Families, especially those with chronically ill members, did not receive adequate follow-up and support. The lack of psycho-social services was a significant concern, as many individuals, including children and the elderly, faced trauma and fear after the earthquake.

During the COVID-19 pandemic, citizens faced a challenging and unprecedented situation, and they relied on information from various sources to understand and cope with the emergency. However, the most preferred and trusted method of communication about emergencies and preparedness was through official channels and health authorities. This indicates that people valued receiving information from reliable sources and trusted the guidance provided by health experts and authorities.

However, it's important to note that while citizens generally had positive experiences during the pandemic, there might still be some regional variations or specific challenges faced by

vulnerable groups that warrant further attention and improvement in the healthcare system. Ensuring continued access to quality healthcare and support for all communities, especially during emergencies like the COVID-19 pandemic, remains a critical aspect of emergency preparedness and response planning.

The option of receiving health care at home was highly appreciated by citizens, especially during the COVID-19 pandemic. Doctors and nurses provided in-home services to patients who were unable to visit healthcare facilities, ensuring that medical attention was accessible and convenient. This approach proved beneficial for managing mild COVID-19 cases, with individuals receiving telephonic guidance from doctors and healthcare personnel demonstrating a willingness to provide in-home services.

During the pandemic, citizens in small cities reported better health service experiences compared to large cities. In some large cities, access to health services became a challenge, with individuals having to pay for healthcare or manage their health situations themselves due to limited access to healthcare facilities. This disparity in access to health services had direct implications for patients, including postponed care, difficulties in obtaining follow-up visits, challenges reaching hospitals by ambulance due to resource constraints, and longer wait times. Throughout the COVID-19 pandemic, the emergency service number 127 received positive feedback from citizens, with quick ambulance response times reported in most cases. However, delays were occasionally experienced due to difficulties in locating addresses, especially in areas with inadequate road infrastructure.

Unfortunately, the pandemic also led to unfortunate deaths occurring within hospitals, which might have been a result of various factors such as the severity of the cases, resource constraints, or other challenges faced by the healthcare system during the crisis.

During the COVID-19 pandemic, citizens faced several obstacles and barriers in accessing health care services, which impacted their health-seeking behaviors and overall well-being.

- Financial Barriers: Participants reported spending significant amounts on health services for their families during the pandemic. This included expenses for buying oxygen bombs, medications, and healthy food.
- Negligence: Both citizens and medical personnel were suspected of showing negligence in seeking or providing medical help.
- Lack of Information and Awareness: Participants reported a lack of information and awareness about diseases, first aid measures, and when to seek medical help.
- Infrastructural/Geographical Barriers: Remote and deep rural areas faced challenges in accessing healthcare services due to poorly maintained road infrastructure.
- Communication Challenges: Physical distancing, personal protective equipment, and limited time spent with doctors during the pandemic made communication challenging for some citizens.

During emergency situations, particularly natural disasters like fires, earthquakes, etc., citizens reported positive experiences with the formation of volunteer groups mobilized to help. However, there were some challenges faced by these volunteers, such as a lack of necessary clothing and tools to support their efforts during emergencies.

In some cases, citizens considered approaching medical emergency services or their family doctor, but overall, healthcare facilities were not consistently mentioned as the first point of contact during emergencies. For disabled or chronically ill individuals, the movement during emergency situations, such as earthquakes or floods, posed significant difficulties.

During emergency situations, citizens in various municipalities reported limited engagement of civil society organizations in providing assistance. While some areas saw involvement from NGOs, such as the Red Cross, in providing aid and support to affected citizens, it was not consistently observed across all regions.

Religious institutions, particularly churches, were mentioned as being active in helping citizens during emergencies in certain regions.

Despite facing various emergency situations, participants reported that they lacked information on how to react or provide first aid effectively.

The most preferred method of obtaining information about emergencies and preparedness for responding to emergency situations was through community meetings organized by municipalities, local government institutions, and family doctors.

Overall, participants expressed a sense of lacking information about their rights regarding health emergencies. They emphasized the importance of having clear and accessible information on how to react in various emergency situations, provide first aid to themselves or family members, and know where to seek health services during emergencies.

Findings from Key Informant Interviews

Accessing emergency services poses significant challenges for vulnerable groups, primarily due to distance, difficult road conditions, and limited access to transportation, especially for the elderly and disabled residents.

Lack of awareness, economic limitations, and limited physical access create barriers for vulnerable individuals seeking emergency care. Social problems, poverty, and limited access to information further increase their vulnerability, leading to difficulties in managing chronic conditions and accessing support resources. Negative past experiences with social assistance or doctors may deter some residents from seeking medical care during emergencies.

Moreover, during emergencies, vulnerable groups face difficulties in accessing and receiving health services, compounding their vulnerability. Factors contributing to these challenges include inappropriate living conditions, poor house construction, neglect of diseases over time, and inadequate preventive measures. Additionally, the limited operating hours of health centers in remote areas pose challenges. In regions with floods, transportation becomes severely restricted, making it difficult to provide timely assistance.

Furthermore, facility and infrastructure challenges include a lack of functioning ambulances, a shortage of medical personnel, and inadequate emergency medications. Proper infrastructure and transportation options are crucial to ensure timely care for vulnerable groups during emergencies, and home visits may be necessary for those unable to reach health centers. Training and preparedness efforts should focus on addressing the specific needs of vulnerable groups, including specialized training for handling chronic patients, dementia, and mental

health disorders. Awareness campaigns targeting the younger population can improve emergency response.

In terms of training and preparedness, several key findings have emerged. Education and awareness campaigns targeting different age groups are essential, as some individuals, particularly the younger population, lack sufficient knowledge about emergency response. The need for specific training in emergency care and first aid is emphasized across various regions, including training for handling emergencies like COVID-19, earthquakes, fires, and floods.

Furthermore, specialized training for social workers and community center staff is essential to handle vulnerable groups effectively during emergencies. It is crucial to integrate gender perspectives and provide social support, counseling, and attention to health, nutrition, and hygiene during the rehabilitation phase.

Findings suggest that involving community members and civil society representatives in training and preparedness efforts is essential and highlights the importance of community participation and cooperation in building disaster resilience and effective emergency responses.

Concrete action plans, regular plan revisions, and simulation exercises are necessary for continuous improvement in disaster preparedness and response. To address the needs of vulnerable groups during health emergencies, the training should focus on providing first aid, handling chronic conditions, and coordinating with police and fire brigades. Training and preparedness efforts should be comprehensive, addressing the specific requirements of different communities and risk groups.

The research findings highlight the significance of disseminating timely and accurate information about emergency health services to vulnerable groups. Efforts have been made through various channels, including mass media, health personnel, administrators, and village heads. However, there are challenges in reaching specific vulnerable populations, such as the elderly and people with disabilities, who may prefer face-to-face meetings and encounter difficulties with new technologies.

Civil Society Organizations (CSOs) play a minimal role in informing vulnerable groups. In order to improve preparedness, awareness campaigns and sensitization projects have been effective in educating the community about emergency health services and their rights. Efforts have been made to raise awareness among specific interest groups, to protect property and health during emergencies. However, there is room for improvement, and continuous training and information sharing are needed to better serve vulnerable groups during crises.

Improving communication strategies and addressing the unique information needs of vulnerable populations will enhance their ability to access emergency services and make informed decisions during crises.

The various challenges faced by health centers and fire departments during natural disasters like earthquakes, floods, and landslides highlight the importance of investing in infrastructure and specialized vehicles to ensure efficient emergency response and support for vulnerable communities. Investment in medical equipment, transportation, and training for emergency personnel will contribute to better preparedness and resilience. Cooperation between authorities, NGOs, and other stakeholders is essential to address the challenges faced and ensure the availability of necessary resources during emergencies.

Collaboration and cooperation between various actors are essential for addressing the challenges faced by health centers and improving access to emergency services for vulnerable groups. Local and international organizations can play a vital role in providing training and medical resources to health centers, especially in areas with limited infrastructure. However, unmet infrastructure needs should be addressed to ensure efficient emergency response. Cooperation with the local government is crucial, and vulnerable groups should be encouraged to understand and cooperate during emergencies.

Civil society organizations (CSOs) are instrumental in providing aid and support during crises, supplying essential items, and raising awareness about emergency services. Engaging citizens and encouraging them to seek timely medical attention is vital, as delays in seeking help can lead to critical situations.

1.6. Conclusions and Recommendations

Conclusions

This study identified and assessed hindrances and obstacles of vulnerable populations with respect to accessing and using emergency care services in order to inform effective and evidence-based policies for reducing the risk of vulnerable population groups in Albania. More specifically, this study explored and assessed in-depth the level of knowledge, attitudes and practices of vulnerable population groups regarding the access to emergency healthcare services.

The current study assessing access to, and quality of individual and community health emergencies provides valuable evidence for guiding effective emergency responses, reducing disparities, and improving health outcomes for affected population groups in Albania. This study contributes to the development of a resilient and robust health system in Albania that can better withstand and respond to future emergencies.

Recommendations

Improving responses to individual and community health emergencies requires a comprehensive approach that involves various stakeholders, from government agencies to healthcare providers and the general public. In the context of Albania, an adequate preparedness and response to health emergencies requires the government and all relevant actors to: enhance emergency preparedness; strengthen healthcare infrastructure; improve early detection and surveillance; enhance access to healthcare services; engage and educate communities; strengthen the capacities of healthcare workers; coordinate and collaborate; conduct research and embrace innovation; and engage in continuous education and learning.

By implementing these recommendations, Albanian communities can enhance their capacities to respond effectively to individual and community health emergencies, saving lives and reducing the impact on public health and well-being of the Albanian population.

2. INTRODUCTION

2.1. Background

The Albanian Ministry of Health and Social Protection (MOHSP) has already endorsed the new National Health Strategy, Albania 2021-2030, which emphasizes the implementation of the Primary Health Care Strategy 2020-2025 with the main results focused on strengthening the PHC facilities network with appropriate infrastructure and equipment by 2025.

New strategic objectives of the new health strategy that show also the objectives of the government for the future of the health system in Albania are the Strategic Goal 4: Strengthen the system response to emergencies and Strategic Goal 5: Digital Health. Switzerland's International Cooperation Strategy 2021-2024 has put public service strengthening as a priority in its development cooperation, the Swiss country programme Albania 2022-2025 has formulated the improvement of strengthening the health systems resilience in emergencies as a priority objective.

Albania is vulnerable to earthquakes, floods, forest fires, and landslides. Recent natural disasters (the 2019 earthquake) and the more recent COVID-19 pandemic have demonstrated the importance of ensuring accessibility to health and human services for everyone living in Albania. There are systematic issues that have impacted the health care system in Albania in decades, and more specifically its weaknesses in the health emergency preparedness and response that were very much exposed during the pandemic. The fragmentation and lack of clarity regarding mandates, responsibilities and lines of communication during emergency situations evidently requires a substantial and structural reform.

The proposed implementation strategy is advised to take into account mainly the national health sector reform policies such as the draft National Health Strategy 2021-2030 and the Primary Health Care Strategy 2020-2025, but also the Action Plans on Health Promotion 2022-2030, the Action Plan on NCD Control and Prevention 2021-2030 and the Action Plan on Sexual and Reproductive Health 2022-2030. Also, the proposed implementation strategy should take into consideration the principles of "One Health" approach addressing simultaneously the joint health threats to humans, animals and the environment. The "One Health" approach is vital for ensuring effective control, prevention, early detection and prompt mitigation measures against local and global health threats including pandemics.

2.2. Context

In this context, the "Support to Health Emergency Service Preparedness" SDC project contracted an organization/company capable of conducting a formative research in terms of Knowledge, Attitude, Practices and Beliefs (KAPB) survey on vulnerable populations with respect to access and use of emergency services to inform the project strategy and effective activities towards emergency preparedness, as well as contribute in setting of a useful baseline regarding an informed, engaged and empowered civil society that will accelerate successful planned interventions in this area.

3. AIM AND OBJECTIVES OF THE RESEARCH

3.1. Overall Aim

The aim of this project was to conduct a formative research regarding Knowledge, Attitude, Practices and Beliefs (KAPB) survey on vulnerable populations with respect to access and use of emergency services to inform the project strategy and effective activities towards emergency preparedness, as well as contribute in setting of a useful baseline regarding an informed, engaged and empowered civil society that will accelerate successful planned interventions in this area.

The findings will be used also to develop citizen participation, health system responsiveness, responsibility, accountability, and transparency mechanisms, strengthen CSOs, citizens' associations and citizens' ability to advocate for emergency preparedness, and develop an evidence-informed strategic communication that leads to positive change among individuals, families, communities, and service providers.

The overall aim of this assignment is to identify and assess hindrances and obstacles of vulnerable populations with respect to accessing and using emergency care services in order to inform effective and evidence-based policies for reducing the risk of vulnerable population groups in Albania.

3.2. Specific Objectives

The specific objectives of this research work are as follows:

- Explore and assess respondents' level of knowledge (e.g., knowledge on where to access services, what to know about their rights, if they know their doctor) on emergency care services,
- Explore and assess the current knowledge levels, attitudes, practices and behaviors that facilitate or limit citizen participation and advocacy,
- Explore the individual, group (social) and structural (system) barriers to access and use of emergency services, at the PHC level or beyond,
- Explore what are the needs of vulnerable groups with regard to emergency medical care services,
- Explore and assess the current knowledge levels, attitudes, practices and behaviors of citizens that facilitate or limit creation of health system accountability and transparency mechanisms,
- Explore and assess the extent of knowledge on ways to report problems, mistreatments, lack of services (e.g., complain mechanisms),
- Explore and assess the degree to which respondents are familiar with the services, and service providers in their communities,
- Explore and assess their perceptions in relation to quality of care, when used the emergency care,
- Explore and assess the degree to which respondents currently use the health system, and emergency care,

- Explore the most popular media used by respondents and the trusted and popular sources of information related to emergency services, at the PHC level or beyond,
- Explore if the respondents understand that there can have a role when it comes to health care services in their communities,
- Explore the current levels of knowledge about the health emergency preparedness, policies governing the system, services provided, and patient rights,
- Describe and explore the social/cultural norms that surround health emergency service preparedness,
- Describe the types of education, advocacy, and system monitoring activities that would work best to increase civil society participation in health reform efforts,
- Explore and assess the role of the local CSOs that work in health care system strengthening and how they interact with the citizens and vulnerable communities,
- Describe the key agents of change at community level including individuals, groups of individuals and local civil society organizations which can/should increase participation in health reforms.

4. METHODOLOGY

The current study consisted of two main components: desk review, and primary data collection (by use of both quantitative and qualitative methods, techniques, and instruments).

4.1. Desk Review

Desk review is a research methodology that involves gathering and analyzing existing data and information from various sources, such as published literature, reports, and databases, without conducting primary data collection. It is also known as a literature review, document analysis, or secondary data analysis.

The desk review methodology is commonly used in the health services research field, where there is a need to synthesize existing knowledge on a particular topic or issue. The methodology is cost-effective and time-efficient as it relies on existing data rather than new data collection.

The following steps were involved in conducting the desk review in the current project:

- Defining the research question and objective: this step consisted of identifying the research question and objective that will guide the desk review.
- Identification of relevant sources: this step involved identification of relevant sources of information such as published literature, reports, databases, and other relevant documents.
- Screening and selection of sources: this step involved screening and selecting the most relevant sources that meet the research question and objectives.
- Data extraction and analysis: this step involved extracting relevant data from the selected sources and analyzing it to answer the research question and objectives.
- Synthesis of the findings: this step involved synthesizing the findings from the analyzed data to develop meaningful conclusions and recommendations.
- Documentation of the process and findings: this step involved documenting the process and findings of the desk review in the final report of the research work.

Overall, desk review was a valuable research methodology in the current project providing useful insights and information to inform decision-making, program planning, and policy development.

4.2. Quantitative Study

Study design

The quantitative component consisted of a cross-sectional study, which is the most appropriate study design for assessing the magnitude/extent/prevalence and distribution of health characteristics, risk factors and health outcomes at a population level.

Study population and sampling

The study population consisted of a representative sample of 500 vulnerable individuals of both genders (aged 18 years and above) pertinent to different regions of Albania.

Individuals were recruited with help of emergency care personnel, primary health care staff, as well as public health professionals in each district/area targeted for this research component.

The sample was recruited from the following areas:

- Region 1 (prefectures of Shkodra, Kukës, and Lezha) – overall, 92 participants were included in the sample in this region as follows:
 - Pukë (Fushë-Arrëz): 28
 - Shkodër (Dajç): 30
 - Lezhë (Shëngjin): 34
- Region 2 (prefectures of Dibra, Tirana, and Durrës) – overall, 205 participants were included in the sample in this region as follows:
 - Dibër (Klos): 29
 - Tirana: 104
 - Durrës (Shijak, Ishëm): 72
- Region 3 (prefectures of Elbasan, Korça, and Berat) – overall, 100 participants were included in the sample in this region as follows:
 - Elbasan (Belsh): 32
 - Gramsh 30
 - Kuçovë: 38
- Region 4 (prefectures of Fier, Gjirokastrë, and Vlorë) – overall, 103 participants were included in this region as follows:
 - Fier (Patos): 37
 - Përmet (Këlcyrë): 31
 - Vlorë (Novoselë): 35

Data collection

The data collection consisted of a semi-structured interviewer-administered questionnaire inquiring all participants about a wide range of characteristics related to the access, utilization, as well as other aspects pertinent to emergency health care services.

More specifically, the questionnaire covered the following dimensions:

- *Demographic factors:*
 - Age
 - Gender
 - Place of residence (urban, peri-urban rural)
- *Socio-economic characteristics:*
 - Employment status
 - Profession
 - Economic situation
 - Social status
- *Health status:*
 - Self-perceived general health status
 - Pre-existing conditions/diseases
 - Self-perceived quality of life
- *Health care utilization:*
 - Emergency services
 - Primary health care services

- Other health services (secondary, tertiary)
- *Barriers/obstacles to access and use emergency care:*
 - Cost
 - Lack of insurance
 - Geographical barriers
 - Transportation
 - Language and cultural barriers
 - Fear and mistrust
 - Stigma
- *Awareness and understanding of health rights:*
 - Health rights only apply to those insured
 - Health rights are only for serious illnesses
 - Healthcare is a privilege, not a right
 - Doctors and healthcare providers always know what is best
 - Health rights are only relevant in emergency situations
- *Knowledge and attitudes toward civil society advocacy approaches:*
 - Cultural and social context
 - Personal experiences
 - Education and awareness
 - Political climate
- *Current and future usage of emergency services, including lifestyle and cultural influencers and norms:*
 - Lifestyle factors
 - Cultural norms
 - Influencers
 - Hindering factors
- *Knowledge of attitudes toward health system transparency and accountability tools:*
 - Personal experiences
 - Cultural and social context
 - Education and awareness
 - Trust in the healthcare system
- *Access and perceived barriers to health services and motivating influences for seeking services during health emergency preparedness:*
 - Perceived barriers
 - Cultural factors
 - Motivating influences
 - Personal responsibility
- *Effective channels of communication regarding health emergency preparedness, including trusted sources:*
 - Mass media
 - Community outreach
 - Mobile messaging
 - Trusted sources
 - Printed materials

- *Identification of appropriate education, advocacy and system accountability measures to empower civil society:*
 - Education and training programs
 - Advocacy campaigns
 - Community-based M&E
 - Participatory decision-making
 - Health system transparency and accountability measures

Data analysis

Quantitative data analysis consisted of descriptive statistics and statistical inferences. The descriptive component consisted of reporting and presentation of appropriate summary measures depending on the type of variables (calculation of measures of central tendency and dispersion for numerical variables, and calculation of absolute values and their respective proportions/percentages for categorical variables).

Student's T-test (parametric test) and Mann-Whitney (non-parametric test) were used to compare mean values of two groups.

Conversely, ANOVA (parametric test) and Kruskal-Wallis (non-parametric test) were used for comparison of three or more groups.

Chi-square test and Fisher's exact test were used to compare potential differences in the proportions/percentages of categorical variables.

Pearson's and Spearman's correlation coefficients were used to assess the linear associations between numerical variables.

Regression analysis was conducted to assess independent correlates (predictor variables) of barriers/obstacles to access emergency care services (outcome variable) among vulnerable individuals.

Ethical considerations

All study participants were informed about the aim and procedures of the study and will be ensured about the anonymousness and confidentiality of the research work. Also, participants were informed that the findings will be presented aggregated thereby making impossible identification of personal information. Afterwards, all individuals were asked to give their oral consent for participation in this study. The study was approved by the Ethical Council at the University of Medicine, Tirana on the 30th of May 2023.

4.3. Qualitative Research

The qualitative research consisted of two instruments: focus group discussions and key informant interviews.

4.3.1. Methodology of Focus Group Discussions

General methodological considerations

Focus group discussions constitute a frequent research method in qualitative research. Currently, the use of focus groups method is widespread in the health sector because they

provide useful clues that complement individual (in-depth) interviews, or the direct observation of study participants.

Focus groups are group discussions which are conducted to explore certain issues and problems of interest. The group engages in a collective activity – which is the essence of this research technique – arguing and debating about a series of questions and sharing personal experiences. Focus group research is a generic term whose main feature consists of participants' interaction about a particular topic or issue of interest.

Focus groups constitute an effective method for exploring people's talks, ideas, experiences, opinions, prejudices, beliefs, wishes and concerns.

This research method is especially valuable for allowing study participants to generate their own questions and elaborate on their own ideas and concepts, as well as to express their own priorities, in their own words.

It has been convincingly argued that focus group research reveals important dimensions that otherwise would remain uncovered by the other conventional data collection methods. More specifically, in the health field, focus groups can be used to assess the satisfaction of participants with the quality of health care services; to develop and/or evaluate health education programs; or, to explore cultural and socioeconomic barriers regarding the utilization levels of health care services including emergency health services.

In particular, focus group research targeting certain minority groups, marginalized (vulnerable) population subgroups, or hard-to-reach population segments may provide valuable clues about the perceptions, beliefs and experiences of these population groups which constitute rather under-researched categories.

Several issues were carefully addressed for the focus group discussions in the current research including a detailed preparatory work and a careful reflection about all the ethical issues involved.

Number and regional distribution of focus groups in the current research

In the current project, overall, 15 focus group discussions were conducted in 4 (four) regions of Albania, as described below:

- Region 1 (including the following three prefectures: Shkodra, Kukës, and Lezha) – three focus groups were conducted in this region as follows:
 - One focus group in Pukë (Fushë-Arrëz)
 - One focus group in Shkodër (Dajç)
 - One focus group in Lezhë (Shëngjin)
- Region 2 (including the following three prefectures: Dibra, Tirana, and Durrës) – seven focus groups were conducted in this region as follows:
 - One focus group in Dibër (Klos)
 - Four focus groups in Tirana (2 in Tirana, Kamëz and Vora)
 - Two focus groups in Durrës (Shijak, Ishëm)
- Region 3 (including the following three prefectures: Elbasan, Korça, and Berat) – three focus groups were conducted in this region as follows:
 - One focus group in Elbasan (Belsh)
 - One focus group in Gramsh
 - One focus group in Kuçovë

- Region 4 (including the following three prefectures: Fier, Gjirokastrë, and Vlora) – three focus groups were conducted in this region as follows:
 - One focus group in Fier (Patos)
 - One focus group in Përmet (Këlcyrë)
 - One focus group in Vlora (Novoselë)

Description of the organization of focus group discussions

- Size: each focus-group consisted of about 8-10 individuals,
- Sampling: purposive samples of vulnerable people both users and non-users of emergency health care services,
- Composition: diverse composition of vulnerable people (in terms of gender, place of residence, ethnicity, and socioeconomic status) to maximize the exploratory power consisting of a wide range of perspectives within each focus group,
- Duration: each focus-group lasted, on average, 1.0-1.5 hours,
- Location: rented venue, easily accessible for participants,
- Incentives: financial coverage were provided for each participant (for the transport and/or other related costs).

Data analysis pertinent to focus group discussions

For the qualitative data analysis, the *thematic analysis* was employed, consisting of the model with six stages developed by Braun and Clarkeⁱ:

- The first stage consisted of *familiarization* with the data gathered from all focus group discussions. To fully understand and deepen the insight provided by the data, the audio recordings and text notes recorded during the discussions were heard by the researchers and read, respectively. Next, all the audio recordings and notes were *transcribed*.
- The second phase consisted of creation of *initial codes*. This process employed an interpretive approach that focuses on interpretations, perceptions and ways in which participants understood the topic of discussion. In this process, a word code or phrase that accurately describes the meaning of the entire text was assigned.
- The third stage consisted of the search for *potential topics*. After all the interviews were coded, these encodings were organized into broader-based themes and then adapted to different categories. Once the codes were categorized within these dimensions, they were transformed into *themes*.
- The fourth stage consisted of the revision of the topics, their subdivision or split into two or more *specific topics* as appropriate.
- The fifth stage consisted of *naming* of the topics, placing *titles* and *subtitles* for each topic, and determining the aspects of the data captured by each topic.
- The sixth stage included the *interpretation* of the findings. A list of the main findings was developed emerging from the categorization and classification process that was subsequently accompanied by *quotes* or descriptive examples to give “life” to the data obtained. Cases that deviated from the general patterns were analyzed and highlighted

ⁱ http://eprints.uwe.ac.uk/11735/2/thematic_analysis_revised_-_final.pdf.

in the final report. These included individuals who presented thoughts or ideas and experiences that were different from the majority of participants on a particular topic.

4.3.2. Methodology of Key Informant Interviews

General methodological considerations

Key informant interviewing (KII) is a research technique used in qualitative research to gather information and insights from individuals who possess unique and specialized knowledge on a particular subject/topic. These individuals are referred to as “key informants”.

KII involves conducting in-depth, semi-structured interviews with key informants to elicit their perspectives, experiences, and expertise on a specific topic or issue. The interviews are typically conducted one-on-one, and the questions are tailored to the informant’s expertise and knowledge.

KII is commonly used in the health services research field, where access to specialized knowledge is critical. The information gathered from key informants is used to inform policy and decision-making, program planning and evaluation, and to develop a deeper understanding of complex issues.

To conduct a successful KII in the current research, appropriate key informants were identified who have the necessary knowledge and expertise on the topic of emergency health care services.

A suitable rapport was established with each informant and a safe and comfortable environment for them to share their insights will be enabled.

Finally, the information gathered from key informants was adequately analysed and synthesized in order to develop meaningful conclusions and recommendations.

Number and regional distribution of key informant interviews

In the current project, 20 key informant interviews were conducted in 4 (four) regions of Albania, as described below:

- Region 1 (prefectures of Shkodra, Kukës, and Lezha) – four key informants will be interviewed as follows:
 - One in Pukë
 - Two in Shkodra
 - One in Lezhë
- Region 2 (prefectures of Dibra, Tirana, and Durrës) – ten key informants were interviewed as follows:
 - One in Dibër (Klos)
 - Ten in Tirana
 - One in Durrës
- Region 3 (prefectures of Elbasan, Korça, and Berat) – three key informants were interviewed as follows:
 - One in Elbasan (Belsh)
 - One in Gramsh
 - One in Kuçovë

- Region 4 (prefectures of Fier, Gjirokastrë, and Vlora) – three key informants were interviewed as follows:
 - One in Fier (Patos)
 - One in Përmet (Këlcyrë)
 - One in Vlora (Novoselë)

Description of the organization of key informant interviews

- Size: individual (one-on-one) interviews (n=20),
- Duration: 30-45 minutes each,
- Key informants: emergency services, primary health care, and representatives from key relevant institutions (at central, regional, and local level).

5. RESULTS

Findings from the current research are organized into the following sections: i) desk review; ii) quantitative study, and; iii) qualitative research. Each of these sections is comprehensively presented in the following sections and their respective subsections.

5.1. Findings From Desk Review

Initially, a clear distinction should be made between health emergencies which apply at a community level compared with those which apply at an individual level. From this perspective, health emergencies at a community or society level include a natural and/or human disaster situation, or an epidemic/pandemic situation (earthquake, fire, flood, mass accident, landslide, explosive explosion, storm, civil war, but also any epidemic outbreak, i.e., mass infection, etc.) which seriously endangers people's lives. On the other hand, health emergency at an individual level consists of an individual case with a health condition which is perceived and/or is objectively a risk to the patient's life if not acted upon immediately through emergency health care services.

Based on these considerations, findings from the desk review are organized into the following eight subsections (the first two involve health emergencies at a community/societal level, whereas the other six subsections concern individual health emergencies):

Community/societal level:

- i) general considerations about health disasters;
- ii) health emergency preparedness and response;

Individual level:

- iii) general considerations about vulnerable population groups;
- iv) categorization of vulnerable groups;
- v) access to healthcare services among vulnerable groups;
- vi) international experiences and practices in emergency healthcare services for vulnerable population groups;
- vii) vulnerable groups in Albania, and;
- viii) challenges and needs to address the emergency healthcare services in the Albanian vulnerable population groups.

Each of these eight subsections is presented in detail below.

1.1.1. General considerations about health disasters

A health disaster refers to a widespread event or situation that severely disrupts the normal functioning of healthcare systems and significantly impacts the health and well-being of a population. It involves a significant increase in the incidence and severity of illnesses, injuries, or deaths, overwhelming the available healthcare resources and response capacity¹.

The World Health Organization (WHO) definition of disaster is as follows: "*A disaster is an occurrence disrupting the normal conditions of existence and causing a level of suffering that exceeds the capacity of adjustment of the affected community*"².

United Nation Office for Disaster Risk Reduction (UNISDR) defines disasters as follows: “A serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human, material, economic and environmental losses and impacts”ⁱⁱ.

Conversely, Federal Emergency Management Agency (FEMA) defines disaster as “An occurrence that has resulted in property damage, deaths, and/or injuries to a community”. (FEMA 1990)ⁱⁱⁱ.

International Federation of Red Cross (IFRC) added another factor to the definition: “A disaster is a sudden, calamitous event that seriously disrupts the functioning of a community or society and causes human, material, and economic or environmental losses that exceed the community’s or society’s ability to cope using its own resources.” Though often caused by nature, disasters can have human origins^{iv}.

Health disasters can result from various causes, including infectious disease outbreaks (e.g., pandemics), natural disasters (e.g., hurricanes, earthquakes), industrial accidents, terrorism, or other large-scale emergencies¹.

In a health disaster, the affected population may face challenges such as inadequate access to medical care, shortage of essential supplies and resources, overwhelmed healthcare facilities, and strained public health infrastructure. These events can lead to increased morbidity and mortality rates, as well as the disruption of essential healthcare services, including routine medical care, emergency response, and disease surveillance³.

Efforts to manage and mitigate health disasters involve coordinated response and preparedness measures by healthcare providers, public health agencies, governments, and international organizations. These actions typically include emergency medical care, public health interventions (e.g., disease surveillance, contact tracing, vaccination campaigns), provision of essential supplies and resources, establishment of temporary healthcare facilities, and psychological support for affected individuals and communities⁴.

The role of health sector is an essential aspect of every emergency event whether it is caused by a naturally occurring hazard (hurricane, earthquake), an industrial accident, or a biological hazard. The human involvement in the challenge of the disaster will often lead to health-related impacts and negative health consequences. While the initial disaster might not have direct or obvious public health impacts, the complexity and multifaceted drivers of each disaster can often lead to detrimental impacts on public health either at local, regional, national or international levels⁵.

The increase in the rate of disasters obliges medical society to pay more and more attention to the disaster response. There are attempts to make the subject of disaster an independent specialty of medicine because it has unique focus in managing cases and it involves dealing with several issues other than direct medical treatment of patients.

Therefore, all in all, public health is a core function of emergency management, disaster risk reduction and disaster risk management.

ⁱⁱ <https://www.unisdr.org/we/inform/terminology>.

ⁱⁱⁱ <http://www.ifrc.org/en/what-we-do/disaster-management/about-disasters/what-is-a-disaster/>.

^{iv} [Disasters and Disaster Medicine | IntechOpen](#).

Key definitions

- **Hazard**: “A hazard is an agent which has the potential to cause harm to a vulnerable target”^v. In disaster medicine: “A Hazard is a potential source of harm or adverse health effect on a person or persons”^{vi}.
- **Risk**: “someone or something that creates or suggests a hazard”^{vii}. In disaster medicine, it is: “risk is the likelihood that a person may be harmed or suffers adverse health effects if exposed to a hazard”^{vi}.
- **Vulnerable**: “capable of or susceptible to being wounded or hurt”^{viii}. On the other hand, IFRC defines vulnerability as follows: “the diminished capacity of an individual or group to anticipate, cope with, resist and recover from the impact of a natural or man-made hazard”ⁱⁱⁱ.

The outcome of the triggering event by its effects on human and environment decides whether this is a disaster or not. The factors affecting the disaster outcome are: i) scope of the impact; ii) speed of the impact; iii) duration of the impact, and; iv) social preparedness of the community⁶.

Disaster stages

The time frame for a disaster is a principal factor in innovating methods for management of the disaster. Quarantelli in 1980 divided the time factor into three phases⁷:

- **Pre-impact phase**: In this phase, there is enough time for investigating choices, inventing ways to prevent or mitigate the disasters, and training communities on the methods. Strategic planners and leaders are involved in this phase by making the needed large-scale decisions and policy shifts intended to change people’s perception of risk.
- **Trans-impact phase**: This phase includes the period that is immediately before, during, and after event. Policymakers and operation leaders are involved and are under strong time pressure to deal with the effects of disasters.
- **Post-impact phase**: This phase includes two subphases, the early and late phases. In the early one, there is a need to restore pre-impact norm. In the late phase, there is a need to set new norms to prevent or mitigate future disasters.

1.1.2. Health emergency preparedness and response

The process of disaster management involves four phases: mitigation, preparedness, response, and recovery^{vi}.

- **Mitigation** is defined as: “The act of making a condition or consequence less severe”⁸. In the medical field, mitigation is defined as follows: “the effort to reduce loss of life

^v <https://en.wikipedia.org/wiki/Hazard>.

^{vi} Health and Safety Authority. <http://www.hsa.ie/eng/Topics/Hazards/>.

^{vii} <https://www.merriam-webster.com/dictionary/risk>.

^{viii} <http://www.dictionary.com/browse/vulnerable>.

and property by lessening the impact of disasters. It is most effective when implemented under a comprehensive, long-term mitigation plan”^{ix}.

The mitigation deals with the identification of the risks and trying to prevent them or decrease their effects. The fundamental steps in risk management are as follows:

- Risk identification,
 - Risk impact assessment,
 - Risk prioritization analysis,
 - Risk mitigation analysis.
- Preparedness is defined as: “the quality or state of being prepared; especially, a state of adequate preparation in case of disasters”^x. Conversely, IFRC defines preparedness as: “Disaster preparedness refers to measures taken to prepare for and reduce the effects of disasters; that is, to predict and, where possible, prevent disasters, mitigate their impact on vulnerable populations, and respond to and effectively cope with their consequences”⁹. It takes the results of mitigation and uses it to prepare the community on how to deal with them. The goal of preparedness is to raise the ability and readiness of a community, an organization, or a country to respond timely and efficiently to any disaster that may occur.

The basic components of disaster preparedness involve the following¹⁰:

- Identifying organizational resources,
 - Determining roles and responsibilities,
 - Developing policies and procedures and planning activities.
- Response: in disaster perspective, response encompasses the decisions and actions taken to deal with the immediate effects of an emergency^{xi}. Usually, it is for a short period of hours or days starting from the time of the impact or shortly before that if there are predicting signs like hurricanes. Response plan is best to be put with the preparedness and whole plan to make a complete coordinated plan rather than making a fragmented plan and there is difficulty in incorporating the different fragments together⁸.

Medical response during disaster deals with the following elements:

- Higher-management level and reaching the frontline staff in direct response to the disaster,
 - Surge of the resources to accommodate the increase in demands because of the disaster,
 - Dealing with victims, how to define and follow them in different places, and how to deliver treatment to the victims in different places.
- Recovery: in disaster medicine, recovery for hospitals is defined as: “The process by which a hospital minimizes the impact an emergency has made on its operations in an effort to resume normal operations or establish new norms for operations”¹¹.

Recovery can be divided into three stages^{iv}:

^{ix} Dictionary.com. <http://www.dictionary.com/browse/mitigation>.

^x <https://www.merriam-webster.com/dictionary/preparedness>.

^{xi} Disaster Response. Wikipedia. https://en.wikipedia.org/wiki/Disaster_response.

- *Early recovery*: in this stage, regaining the basic services and trying to work as normal as possible or having a new normal. As an example, early recovery may consist of working in an alternative place which becomes the new normal place.
- *Rehabilitation*: in this stage, save the undamaged issues, restore the restorable, and try to go back to pre-disaster condition. Referring to the example above, work to fix and rebuild the health-care facility is done in this stage.
- *Development*: this will be a long-lasting stage (maybe to the next disaster impact); it will intermingle with the mitigation plan, and in it, new standards are set in the building codes or electricity sources to decrease the harmful effects of disasters and go back to normality more rapidly with less damage or work with better efficiency. In the same example as discussed earlier, building or making modifications in other buildings to use them as alternative places will serve patients in time of disaster.

In summary, disasters, emergencies, or catastrophes involve unavoidably also the health sector and constitute special situations requiring different management styles and techniques. It is mainly the difference in number which exceeds the resources, and for a proper management there is a desperate need for planning to recall staff and surge space and stuff. There are situations which require the utilization of the entire country's resources (such as the case of earthquake in Albania in November 2019), whereas other situations may even necessitate international aid (such as the case of the recent examples of Haiti earthquakes, Iraq and Syrian mass immigration due to internal wars and, more recently, the Afghani refugee crisis and the ongoing war in Ukraine).

1.1.3. General considerations about vulnerable population groups

Vulnerable population groups are those who are at a higher risk of experiencing negative health outcomes, social marginalization, or economic disadvantage due to a combination of individual, social, and environmental factors. Vulnerable groups may face barriers to accessing healthcare, education, social services, and employment opportunities, which can further exacerbate their vulnerabilities. Vulnerable groups may require specific support and interventions to address their special needs and challenges and ensure their health and well-being.

The terms 'vulnerability' or 'vulnerable groups' are commonly used, but often with different meanings by different stakeholders and actors involved.

In particular, a clear distinction should be made between risk-related 'vulnerability' to different factors (with poverty being one of the main determinants) and 'vulnerable' groups whose persistent exposure to various determinants make them prone to particular susceptibility (e.g., individuals with "chronic" poverty who require specific attention and concrete measures to address their deficiencies)¹².

Vulnerable groups are physically, mentally, or socially disadvantaged persons who may be unable to meet their basic needs and may therefore require specific assistance. Persons exposed to and/or displaced by conflict or natural hazard may also be considered vulnerable <https://inee.org/eie-glossary/vulnerable-groups>¹³.

A vulnerable group can be defined as a “*population within a country that has specific characteristics that make it at a higher risk of needing humanitarian assistance than others or being excluded from financial and social services*”¹⁴.

Vulnerability is a complex and multidimensional concept that is influenced by various factors such as age, gender, race, ethnicity, disability status, socioeconomic status, geographic location, and more https://link.springer.com/chapter/10.1007/978-3-031-06998-7_1¹⁵.

The analysis of risk and vulnerability commonly involves two specific areas of consideration. On the one hand, vulnerability analysis focuses on the role of risk in the dynamics of vulnerability or susceptibility to a certain outcome (e.g., poverty, or lack of access to health care services) and the strategies and techniques that individuals and families should employ in order to address and ultimately mitigate the exposure to various sources of risks.

This is also applicable for healthcare services with e.g., risk mitigation in terms of exposure to e.g., catastrophic health expenditure, or other unfavorable outcomes pertinent to utilization and cost of medical care.

From this point of view, in the health services field, the focus should be on the impact of risk on access to and quality of services and care received, taking into consideration all the potential informal and formal mechanisms and instruments of risk reduction, mitigation and coping strategies available to individuals, particularly those with limited resources, conventionally referred to as vulnerable individuals. This is the core of risk and vulnerability analysis.

On the other hand, there is also a focus on specific vulnerable groups that are characterized by limited resilience to avoid susceptibility (e.g., poverty, or lack of access to health services) and have fewer opportunities compared to the general population to break away from persistent susceptibility (e.g., “chronic” poverty, or continuous lack of access to medical services, or attainment of inadequate medical care).

The analysis of risk and vulnerability in health involves systematic approaches to identifying hazards or risks that are most likely to have an impact on a healthcare facility and the surrounding community. Conducting a risk assessment/hazard vulnerability analysis (HVA) is also a requirement in the CMS Emergency Preparedness Rule^{xii}.

Vulnerability in health care, however, is a complex concept that has been defined in various ways. It is often used to describe the susceptibility of individuals or groups to harm or adverse outcomes¹⁶. Vulnerability can be influenced by various factors such as age, gender, race, ethnicity, socioeconomic status, geographic location, and more¹⁷.

In its 2000-2001 World Development Report, the World Bank has defined risk and vulnerability as follows¹⁸: “*Risk refers to uncertain events that can damage well-being – the risk of becoming ill, or the risk that a drought will occur. The uncertainty can pertain to the timing or the magnitude of the event. For example, the seasonal fluctuation of farm income is an event known in advance, but the severity is not always predictable. Vulnerability measures the resilience against a shock or stresses – the likelihood that a shock will result in a decline in well-being. [...] Vulnerability is primarily a function of a household’s asset endowments and insurance mechanisms – and of the characteristics (severity, frequency) of the shock.*”

^{xii} [Hazard Vulnerability/Risk Assessment | ASPR TRACIE \(hhs.gov\)](#).

Notwithstanding the fact that risk and its related negative effects are not necessarily of central importance when analyzing vulnerable population categories, there is a significant overlap in these two areas of concern, because the inadequate resilience and opportunities will make vulnerable groups particularly prone to further hardship and adversity in risky environments.

On the other hand, the OECD/DAC provides the following definitions¹⁹: “*Risk constitutes the likelihood and potential severity of occurrence of a particular and potentially adverse shock or stress, while vulnerability is the degree of exposure of households or individuals to shocks and stresses, and their ability to prevent, mitigate or cope with the event.*”

According to Devereux (2001), the following definition is provided about vulnerability²⁰: “*Vulnerability means a defenselessness, insecurity and exposure to risk, shocks and stress, and not simply a lack or a want. Vulnerability is the degree of exposure to risk, and the capacity of households or individuals to prevent, mitigate or cope with risks. Vulnerability is thus linked with levels of net assets (stocks) rather than flows of income or consumption, and combines exposure to a threat, with susceptibility or sensitivity to its adverse consequences.*”

Notwithstanding the fact that the aforementioned definition makes reference to vulnerability linked mainly to poverty, it may well apply in the realm of health status and health care services.

From this perspective, as far as the health status is concerned, health vulnerability can be thought of the risk exposure to different health threats and hazard and the related insecurity, lack of resources and weakness of certain susceptible individuals or even whole groups (conventionally referred to as ‘vulnerable individuals’ or ‘vulnerable categories’, respectively) for preventing, mitigating or dealing effectively with the health risks involved.

Likewise, concerning health care services, health vulnerability can be thought of the risk exposure to lack of access and/or poor quality of health care services received by vulnerable individuals and/or entire vulnerable groups, and the lack of resources to cope successfully with such situations and episodes.

Nonetheless, according to the literature, analysis of vulnerability should take into consideration not only the risks and threats involved, but also the *resilience* in resisting or recovering from the negative effects of risky situations and high-risk events. The instruments or resources of resistance or coping strategies constitute the assets, prerogatives and capabilities that different individuals, families and entire groups can mobilize and manage in the face of adversity and high-risk situations²¹. Of note, low levels of assets and entitlements constitute an important determinant of vulnerability.

In order to address risk and vulnerability issues the notion of “social protection” is gradually gaining prominence as a valuable approach. According to Slater et al. (2006): “*.....social protection includes ‘public actions taken in response to levels of vulnerability, risk and deprivation which are deemed socially unacceptable within a given polity or society’, and is mandated either by the state or by organizations such as NGOs claiming to operate in the public interest*”²².

The ‘Social Risk Management’ model, established by the World Bank, incorporates social protection by focusing on three strategies to deal with risks (*prevention, mitigation, coping*), three levels of formality of risk management (*informal, market-based, publicly managed*) and

a wide array of relevant stakeholders (individuals, families, communities, organizations, and governments)²³.

It should be pointed out that, social protection moves further than the ‘social sectors’ including the health sector, education, or the labor market. From this perspective, social protection includes also ‘social assistance’ for supporting the seriously vulnerable individuals and certain population categories²⁴.

Based on all the aforementioned considerations, it can be logically assumed that vulnerable people are basically much more exposed to risks and are the least protected category from the negative consequences of different risks involved²⁵.

This practical concept fully applies in the area of health care services, where vulnerable people have typically limited assets and resources and are generally less capable of dealing and coping with different risk exposures thereby experiencing serious negative health consequences.

From this standpoint, risk exposure has a direct negative impact on health and well-being of vulnerable individuals, leading to poor health including occurrence or exacerbation of a whole range of diseases, or worsening the health status in general.

It should be pointed out that health risks and their related negative impact may concern different components and dimensions of health status: health-seeking behavior, access to and utilization of preventive services, early detection of diseases, as well as treatment and rehabilitation services.

It is argued that the direction of causation can be both ways – poor health may lead to exposure to risks, e.g., sick individuals cannot access health care services due to their limited physical conditions, and exposure to risks may lead to poor health, e.g., lack of preventive services and/or early detection may lead to establishment of coronary heart disease, diabetes, or different types of cancer.

Therefore, interventions aiming at reducing risk exposure, e.g., provision of primary prevention services and/or secondary prevention services for early detection of diseases, may constitute a direct contribution to health improvement. This would be the remarkable case of medical check-up in Albania which includes all adult individuals of both sexes.

Hence, in order to achieve universal health coverage in Albania, there has been a firm political commitment since 2014 to conduct a nation-wide medical checkup program including all Albanian citizens of both sexes aged 40-65 years which was expanded in 2016 to the age-group of 35-70 years, consisting of 1.2 million Albanian citizens who benefit from this unique program on an annual basis. This type of medical checkup is quite unique for Albania and beyond because, to the best of knowledge, there has been no such exercise including the overall middle-aged population of a certain country to date. More than one thousand Albanian citizens a day benefit from this medical checkup which screens for a wide array of chronic conditions including cardiovascular disease, diabetes, chronic respiratory diseases and some types of cancer²⁶.

Furthermore, the checkup program aims to assess and provide counseling about the control and prevention of a range of risk factors such as smoking, harmful alcohol consumption, unhealthy dietary habits, and sedentary lifestyle. It should be pointed out that, in the framework of the medical check-up program targeting all Albanian individuals aged 35-70 years, there has been an increase of more than 75 thousand examinations per year from 2015 to 2017.

Another example of risk exposure reduction includes the successfully established national prevention and early detection programs of selected tumors and cardiovascular diseases in Albania, which is an initiative undertaken by the Ministry of Health and Social Protection in the past couple of years. Actually, in parallel with the medical checkup program, the mobile mammography devices provide services for over five thousand Albanian women a year, which is sparing the household budgets of overall 60 thousand Euros annually.

On the other hand, interventions towards restoring and improving health status (by e.g., effective treatment and adequate rehabilitation services) may allow individuals to recover promptly and return to the labor market, exert the expected family roles and engage in different social activities.

Effective approaches to deal with different health risks include *prevention* strategies, *mitigation* strategies and *coping* strategies. Prevention strategies aim to reduce the likelihood of a risk occurring in the first place. Mitigation strategies aim to reduce the impact of a risk if it does occur. Coping strategies aim to help individuals and communities deal with the aftermath of a risk.

Use of preventive health services and effective health-seeking behavior constitute remarkable examples of successful preventive strategies. In turn, migration to more resourceful areas with better health care services would be a sound mitigation strategy. Conversely, receiving treatment and rehabilitation services until full restoration and complete recovery would constitute a successful coping strategy.

Yet, as mentioned above, vulnerable individuals and even whole population categories (i.e., vulnerable groups) typically lack most of the prerequisites and the necessary resources for employment of these three types of strategies (prevention, mitigation and coping).

1.1.4. Categorization of vulnerable groups

First of all, a distinction should be made between vulnerabilities related to the *socioeconomic* status as opposed to vulnerabilities related to *individual* characteristics including also presence of diseases and other limiting conditions, as summarized below²⁷:

- Socioeconomic status (consisting of both absolute and relative poverty).
- Individual characteristics (including presence of diseases, disabilities/special needs, people living with HIV/AIDS, problematic drug users, LGBTQI community, sex workers, or prisoners).
- “Ecological” level (large groups consisting of women, children and the elderly, as well as smaller groups referred to as minorities including e.g., the Roma and Egyptian communities).

Thus, from a different viewpoint, the concept of vulnerability may apply at an “*ecological*” level including pretty wide and large population categories (such as women, children and the elderly), or smaller groups distinguished by ethnicity, race, or religious affiliation (all these are conventionally referred to as minority groups).

In the context of Albania and other Western Balkan countries, a remarkable minority group consists of Roma and Egyptian communities.

Regarding the socioeconomic status in *absolute* terms, its link with health status and health care are related to different degrees and levels of difficulties, hardship and limited access to food, shelter, and access to and utilization of healthcare services.

In *relative* terms, there is convincing evidence in the scientific literature about the extent to which income inequality affects the relationship between socioeconomic factors, personal situations, and health status of the individuals²⁸.

From this point of view, income inequality, which relates to the disproportion of distribution of income, is a key factor in the effect of socioeconomic status on health. Therefore, it is logical to assume that improvements in public health may be linked to a significant reduction of the negative effects on health of income inequality²⁹.

A robust study assessing the effect on income inequality and the changing gradient of socioeconomic status on physical functioning and limitations including the period 1984-2007, reported that, in an environment of greater income inequality, the positive effect on health of increased levels of income, being employed, having a college education, being married, being a woman and being white were more significant³⁰. On the other hand, these factors had less of an impact on health in the environment of smaller income inequality. Based on their findings, the authors argued that greater income inequality may reflect dwindling resources being devoted to human resources and social goods, including literacy and clean air³¹.

Another vigorous study consisted of a systematic analysis of long-term effects of income inequality³¹. According to the findings of this study, income inequality did not exert an immediate effect on mortality. On the other hand, income inequality affected mortality risk from 5-12 years later, with a peak observed after 7 years. The authors speculated that the time lag may have been due to the delay between the exposure to potential harm and the effects on health (Zheng, 2012).

All in all, this robust study suggests that the greater income inequality has a delayed effect of increased mortality, possibly due to the lag in effect of exposure to harm such as decreased investment in public infrastructure and the effects on health³².

A 2012 report from the World Health Organization (WHO) assessed equity in health between and within countries in the 53 states of the WHO European region³³. Of note, this report has significantly influenced health policy in Europe in the past five years. The report was commissioned because it was convincingly argued that “.....*systematic differences in health between social groups, that are avoidable by reasonable means, are unfair.*” (Marmot M et al., 2012).

The report determined that the conditions of daily life significantly affect health, and that these conditions are influenced by changeable factors such as economic arrangements, distribution of power, policy, and societal values. The effects on health of social determinants accumulate over a lifetime. The report focused on the process of healthcare inequities rather than just identification of vulnerable groups (Marmot M et al., 2012).

Overall, this thorough study defined many of the social determinants of health and suggested wide ranging recommendations to improve the health of citizens of 53 European states.

On the other hand, societies may overlook certain vulnerable populations. Such categories are often referred to as unrecognized vulnerable populations. A remarkable example in many

countries worldwide consists of immigrants who often constitute a forgotten or unrecognized vulnerable group.

Several factors driving forces have been indicated to increase susceptibility of immigrants including fear of deportation, inadequate insurance coverage, language barriers and unfair systems which affect the access of immigrants to healthcare services.

Hence, it has been quite recently reported that the immigrants in Texas, USA, underutilize healthcare services partly due to inadequate insurance coverage³⁴. Conversely, fear of deportation has been recently reported as the main reason for underutilization of health care services by immigrants in Toronto, Canada³⁵. Consistent findings have been also reported in the neighboring Italy³⁶.

Regarding individual characteristics including presence of diseases and other limiting conditions, health vulnerability may arise from a wide range of factors and circumstances.

In a narrow sense, presence of certain diseases and limiting conditions may directly affect individuals' ability to access health services and receive quality care. Hence, sick individuals, especially patients with chronic diseases and/or multimorbidity, constitute an important vulnerable group in all societies³⁷.

Some of the most commonly recognized vulnerable population groups include the following categories:

- *Elderly*: elderly people are typically defined as individuals aged 65 and older. Elderly people are often vulnerable due to their declining physical and cognitive abilities, as well as age-related health conditions and social circumstances. They may also face risks related to social isolation, financial insecurity, and abuse³⁸. One of the primary challenges faced by elderly people is their age-related decline in physical and cognitive function³⁹. This can lead to a range of health issues, including chronic diseases, mobility limitations, and increased risk of falls. According to the National Institute on Aging, elderly people may also be more susceptible to infections and illnesses and may have more difficulty recovering from health setbacks^{xiii}. In addition to health challenges, elderly people may also face social and economic vulnerability. Many elderly people live on fixed incomes, which can limit their ability to access resources such as healthcare, transportation, and housing. Elderly people may also experience social isolation and loneliness, particularly if they live alone or have limited social networks⁴⁰. Elderly people may also face discrimination and ageism, which can lead to negative health outcomes and reduced access to resources⁴¹. For example, some healthcare providers may be less likely to provide certain treatments or services to elderly patients, or may assume that certain health conditions are a normal part of aging and therefore not treatable⁴². It is important to recognize the specific challenges faced by elderly people and to work towards addressing them through policies and programs that promote healthy aging, social inclusion, and access to essential resources and services. This can involve addressing ageism and discrimination, promoting intergenerational activities and social networks, and providing specialized healthcare and other services tailored to the needs of elderly individuals.

^{xiii} National Institute on Aging. <https://www.nia.nih.gov/>.

- *Children and youth:* children and youth are particularly vulnerable due to their developing bodies and brains, and their lack of independence^{xiv}. They may also face risks related to poverty, abuse, neglect, and inadequate education^{xv}. Children and youth are considered vulnerable population groups due to their physical, emotional, and cognitive development, as well as their dependence on adults for care and protection⁴³. As convincingly indicated in several reports by WHO and/or UNICEF, one of the primary challenges faced by children and youth is their vulnerability to abuse, neglect, and exploitation. Children may experience physical, sexual, or emotional abuse within their families, communities, or institutions such as schools or residential care facilities⁴⁴. They may also be subjected to labour exploitation, trafficking, or other forms of violence. Neglect, which can involve a lack of food, shelter, or basic healthcare, can also have long-term consequences for children's health and development⁴⁵. In addition to these risks, children and youth may also face other challenges related to their development. For example, they may experience mental health problems such as anxiety or depression, or may have difficulty accessing education or healthcare services⁴⁶. Children and youth from marginalized or disadvantaged communities, such as those living in poverty or in conflict-affected areas, may be particularly vulnerable to these challenges⁴⁷. It is important to recognize the specific needs and challenges faced by children and youth and to work towards addressing them through policies and programs that promote child protection, education, and health. This can involve implementing laws and policies that prevent child abuse and exploitation, promoting access to quality education and healthcare, and providing support for children and families facing social or economic challenges. It is also important to involve children and youth in decision-making processes and to ensure their voices are heard and their rights are respected.
- *Women:* women may also comprise a vulnerable population group compared to men due to a range of factors including historical and systemic discrimination, gender-based violence, and unequal access to resources and opportunities⁴⁸. Women may also experience health disparities related to reproductive health, maternal mortality, and chronic diseases. In many societies, women may also face cultural and social barriers that limit their education, economic participation, and political representation. These barriers can lead to women being disproportionately affected by poverty, food insecurity, and lack of access to healthcare and other essential services⁴⁹. It is important to recognize the specific challenges and needs of women in order to address gender inequalities and promote gender equity. However, it is also important to recognize that women are a diverse group and may experience different levels of vulnerability depending on other factors such as age, race, ethnicity, socioeconomic status, and disability status.
- *Low-income individuals and families:* people who are living in poverty often face multiple challenges, including limited access to healthcare, food insecurity, and inadequate housing⁵⁰. They may also experience discrimination and social exclusion.

^{xiv} [More than 90% of the world's children breathe toxic air every day \(who.int\)](https://www.who.int/news-room/fact-sheets/detail/ambient-air-pollution-and-health-effects).

^{xv} [Fast Facts: Preventing Child Abuse & Neglect |Violence Prevention |Injury Center |CDC](https://www.cdc.gov/violenceprevention/fastfacts/index.html).

Indeed, low-income individuals and families are often considered vulnerable population groups due to their limited access to resources and opportunities, which can result in a range of challenges related to their health, education, and economic well-being⁵¹. One of the primary challenges faced by low-income individuals and families is poverty, which can lead to inadequate access to basic needs such as food, housing, and healthcare. Poverty can also lead to limited access to education and employment opportunities, which can have long-term consequences for individuals and families⁵². Low-income individuals and families may also face other challenges related to their economic circumstances, such as debt, financial insecurity, and difficulty accessing credit or other financial services. These challenges can create additional stress and negatively impact mental and physical health. In addition to economic challenges, low-income individuals and families may also face social and cultural barriers that limit their access to resources and opportunities⁵³. For example, they may face discrimination based on their race, ethnicity, gender, or other factors, which can limit their ability to access healthcare, education, or employment opportunities. It is important to recognize the specific needs and challenges faced by low-income individuals and families and to work towards addressing them through policies and programs that promote economic opportunity and social inclusion. This can involve implementing policies that support access to quality education and healthcare, promoting affordable housing, and providing support for families facing financial challenges. It is also important to address systemic inequalities and discrimination that contribute to poverty and social exclusion.

- *People with disabilities:* people with disabilities and special needs may face challenges related to physical accessibility, discrimination, and lack of access to healthcare and social services. They may also experience social isolation and financial insecurity⁵⁴. People with disabilities are considered a vulnerable population group due to their unique challenges related to their physical, cognitive, or sensory impairments⁵⁵. These challenges can impact their ability to access essential resources and services, participate in society, and achieve their full potential. One of the primary challenges faced by people with disabilities is accessibility. Many physical environments, transportation systems, and information and communication technologies are not designed to accommodate people with disabilities, which can limit their ability to access basic needs such as healthcare, education, and employment opportunities. This can also result in social isolation and exclusion from community activities and events. People with disabilities may also face discrimination and stigmatization, which can negatively impact their mental health and well-being⁵⁶. They may be excluded from social activities or denied access to resources and services based on their disability, or may face negative stereotypes and attitudes from others. In addition to these challenges, people with disabilities may also face additional health-related challenges related to their disability⁵⁷. For example, they may be at increased risk for certain health conditions or may require specialized healthcare services and accommodations. It is important to recognize the specific needs and challenges faced by people with disabilities and to work towards addressing them through policies and programs that promote accessibility, inclusion, and empowerment. This can involve implementing laws and policies that promote accessibility and non-discrimination, providing

specialized healthcare services and accommodations, promoting employment opportunities for people with disabilities, and raising awareness and understanding of disability rights and issues. It is also important to involve people with disabilities in decision-making processes and to ensure their voices are heard and their rights are respected.

- *Sick individuals:* sick individuals are considered a vulnerable population group due to the enormous challenges they face related to their health and well-being. This group includes individuals with acute or chronic illnesses, temporary disabilities, and mental health conditions. One of the primary challenges faced by sick individuals is the risk of physical and mental health complications⁵⁸. They may experience a range of symptoms, limitations, and functional impairments related to their condition, which can impact their daily activities, relationships, and quality of life. They may also experience stigmatization and discrimination related to their illness, which can further exacerbate their health and social challenges⁵⁹. Access to healthcare is a critical challenge faced by sick individuals. They may face barriers to accessing healthcare, including limited availability of medical personnel and equipment, inadequate training of staff, and limited availability of medications. Additionally, sick individuals may face financial barriers to accessing healthcare, such as high costs for medical treatment and medication⁶⁰. Sick individuals may also face challenges related to mental health and emotional well-being. They may experience depression, anxiety, and other mental health conditions related to their illness, which can further impact their physical health and quality of life⁶¹. They may also face social isolation and exclusion, as their condition may limit their ability to participate in social activities and connect with others. It is important to recognize the specific needs and challenges faced by sick individuals and to work towards addressing them through policies and programs that promote access to healthcare, education, and social support services, reduce stigma and discrimination, and provide support for mental health and well-being. This can involve implementing laws and policies that protect the rights of sick individuals, promoting education and awareness about their health and well-being, providing access to affordable and quality healthcare, and promoting social inclusion and support for sick individuals and their families. It is also important to involve sick individuals in decision-making processes and to ensure their voices are heard and their rights are respected.
- *Minorities:* minorities including Roma and Egyptian communities are often considered vulnerable populations due to a range of factors that can lead to social, economic, and health disparities compared to the general population. Roma communities, for example, are one of the largest ethnic minority groups in Europe and have historically faced discrimination, marginalization, and persecution⁶². Roma and/or Egyptian people may face barriers to education, employment, and healthcare, and are often subject to stereotypes and prejudice^{xvi}. As a result, they may experience poverty, social exclusion, poor health outcomes, several barriers (to education, employment, and political representation), and may also face violence and harassment. It is important to recognize

^{xvi} [EUR-Lex - 32021H0319\(01\) - EN - EUR-Lex \(europa.eu\)](#).

the specific challenges faced by these minority groups and to work towards addressing the underlying structural inequalities that contribute to their vulnerability. This can involve addressing discrimination and promoting social inclusion, as well as ensuring access to essential services such as healthcare, education, and employment opportunities.

- *People living in remote areas:* indigenous residing in rural areas, especially those pertinent to remote areas may face systemic discrimination, which can lead to health disparities, poverty, and social marginalization⁶³. They may also face challenges related to cultural preservation and other social issues. This may also be the case for certain population categories residing in remote (mountainous) areas in north Albania. People living in remote areas, such as rural or isolated regions, are often considered a vulnerable population group due to their limited access to resources and services compared to those living in urban or more developed areas⁶⁴. One of the primary challenges faced by people living in remote areas is limited access to healthcare and other essential services. They may have to travel long distances to access healthcare facilities, and may not have access to specialized services or technologies. This can result in delays in treatment and negatively impact health outcomes. In addition to healthcare, people living in remote areas may also face limited access to education, employment opportunities, and basic resources such as food and clean water. This can result in social and economic exclusion, and limit their ability to achieve their full potential^{xvii}. Infrastructure and transportation can also be a challenge in remote areas, with limited or poor road networks, transportation options, and communication technologies. This can impact access to emergency services, limit economic opportunities, and contribute to social isolation. People living in remote areas may also face environmental challenges, such as natural disasters, climate change, or exposure to pollution or hazardous materials. These environmental factors can impact health and well-being, and may have long-term consequences for individuals and communities^{xviii}. It is important to recognize the specific needs and challenges faced by people living in remote areas and to work towards addressing them through policies and programs that promote access to essential resources and services. This can involve investing in infrastructure and transportation networks, promoting access to healthcare and education services, supporting economic development, and addressing environmental concerns. It is also important to involve communities in decision-making processes and to ensure their voices are heard and their rights are respected.
- *Immigrants and refugees:* immigrants and refugees may face challenges related to language barriers, cultural differences, and lack of access to healthcare and social services⁶⁵. They may also experience discrimination and xenophobia. In addition to immigrants and refugees, there is the issue of internal migrants. Internal migrants, also known as domestic migrants, are people who move within a country to live and work in a different region or area. This was also the case of transitional Albania characterized by massive internal migration in early 1990s following the breakdown of the

^{xvii} [Chapter-VIIIndigenous-peoples-and-ethnic-minorities.pdf \(un.org\).](#)

^{xviii} <https://online.regiscollege.edu/blog/environmental-factors-that-affect-health/>.

communist regime, where many families moved mainly from the northern areas of the country to Tirana and Durres regions⁶⁶. Internal migrants are often considered a vulnerable population group due to their unique challenges related to migration and displacement^{xix}. One of the primary challenges faced by internal migrants is access to basic needs such as housing, healthcare, and education. They may face discrimination and barriers in accessing these resources and services due to their migrant status or lack of familiarity with their new location. Internal migrants may also face challenges related to their employment and economic situation. They may be employed in low-paying or precarious jobs, and may not have access to social protections or benefits. This can result in economic vulnerability and poverty, and limit their ability to access other resources and opportunities. In addition to these challenges, internal migrants may also face social and cultural barriers that limit their integration and participation in their new communities⁶⁷. They may face discrimination based on their ethnicity or language, or may struggle to adapt to cultural norms and practices in their new location. Internal migrants may also be at increased risk of exploitation, trafficking, or abuse due to their vulnerability and lack of social support networks. It is important to recognize the specific needs and challenges faced by internal migrants and to work towards addressing them through policies and programs that promote access to resources and services, social inclusion, and protection from exploitation and abuse. This can involve implementing laws and policies that protect the rights of migrants, providing support for housing, education, and healthcare, promoting employment opportunities and social protections, and addressing discrimination and social exclusion. It is also important to involve migrants in decision-making processes and to ensure their voices are heard and their rights are respected.

- *People living with HIV/AIDS*: people living with HIV/AIDS (PLWHA) are considered a vulnerable population group due to the unique challenges they face related to their HIV status and the associated stigma, discrimination, and health risks³². One of the primary challenges faced by PLWHA is access to healthcare and treatment. While effective treatments for HIV/AIDS are available, many PLWHA may face barriers to accessing them due to factors such as poverty, lack of health insurance, or discrimination based on their HIV status. This can result in delayed or inadequate treatment, which can negatively impact their health outcomes⁶⁹. PLWHA may also face social and cultural challenges related to the stigma and discrimination associated with HIV/AIDS. This can result in social exclusion, discrimination, and even violence. They may also face negative attitudes and beliefs from healthcare providers, which can impact their access to care and the quality of care they receive. In addition to these challenges, PLWHA may also face other health risks related to their HIV status, such as increased risk for opportunistic infections, cancers, or other health conditions^{xx}. They may also experience mental health challenges related to their HIV status, such as depression or anxiety⁶⁸. It is important to recognize the specific needs and challenges

^{xix} [Migration and displacement | International Committee of the Red Cross \(icrc.org\)](https://www.icrc.org/en/document/migration-displacement).

^{xx} <https://www.hiv.gov/hiv-basics/staying-in-hiv-care/other-related-health-issues/other-health-issues-of-special-concern-for-people-living-with-hiv/>.

faced by PLWHA and to work towards addressing them through policies and programs that promote access to healthcare and treatment, reduce stigma and discrimination, and provide support for mental health and well-being. This can involve implementing laws and policies that protect the rights of PLWHA, promoting education and awareness about HIV/AIDS, providing access to affordable and quality healthcare, and promoting social inclusion and support for PLWHA and their families. It is also important to involve PLWHA in decision-making processes and to ensure their voices are heard and their rights are respected.

- *Drug users:* drug users are considered a vulnerable population group due to the unique challenges they face related to their drug use and the associated health and social risks⁶⁹. One of the primary challenges faced by drug users is the risk of developing addiction and related health problems. Drug addiction can impact physical and mental health, leading to a range of negative health outcomes such as HIV/AIDS, hepatitis C, overdose, and other health complications⁷⁰. Additionally, drug use can also lead to social and economic challenges such as unemployment, homelessness, and social isolation. Drug users may also face social and legal consequences related to their drug use. They may experience discrimination, stigmatization, and criminalization, which can lead to further marginalization and difficulties accessing services and support⁷¹. Access to healthcare and harm reduction services is a critical challenge faced by drug users. They may face barriers to accessing healthcare, including discrimination from healthcare providers and lack of access to affordable and appropriate services⁷². Harm reduction services such as needle exchange programs, medication-assisted treatment, and overdose prevention interventions can also be limited or unavailable in many regions, further increasing the health risks faced by drug users. It is important to recognize the specific needs and challenges faced by drug users and to work towards addressing them through policies and programs that promote access to healthcare and harm reduction services, reduce stigma and discrimination, and provide support for mental health and well-being. This can involve implementing laws and policies that protect the rights of drug users, promoting education and awareness about drug use and addiction, providing access to affordable and quality healthcare, and promoting harm reduction services. It is also important to involve drug users in decision-making processes and to ensure their voices are heard and their rights are respected.
- *Prisoners:* prisoners are considered a vulnerable population group due to the distinctive challenges they face related to their incarceration, social exclusion, and the associated health and social risks⁷³. One of the primary challenges faced by prisoners is the risk of exposure to infectious diseases and poor living conditions. Prisons are often overcrowded, with inadequate ventilation, poor hygiene, and limited access to healthcare. This can lead to the spread of infectious diseases such as HIV/AIDS, tuberculosis, and COVID-19, as well as other health complications. Prisoners may also face social and economic challenges such as limited access to education and job training programs, discrimination, and social exclusion⁷⁴. These challenges can make it difficult for prisoners to reintegrate into society after their release and increase the likelihood of recidivism. Access to healthcare is a critical challenge faced by prisoners. They may

face barriers to accessing healthcare, including limited access to medical personnel and equipment, inadequate training of staff, and limited availability of medications⁷⁵. Additionally, prisoners may face stigma and discrimination related to their healthcare needs, leading to further barriers to accessing appropriate care. Prisoners may also face challenges related to mental health and substance use disorders. Incarceration can exacerbate pre-existing mental health conditions, leading to further health complications and difficulties accessing appropriate care. It is important to recognize the specific needs and challenges faced by prisoners and to work towards addressing them through policies and programs that promote access to healthcare, education, and job training programs, reduce stigma and discrimination, and provide support for mental health and well-being⁷⁶. This can involve implementing laws and policies that protect the rights of prisoners, promoting education and awareness about prisoner health and well-being, providing access to affordable and quality healthcare, and promoting social inclusion and support for prisoners and their families. It is also important to involve prisoners in decision-making processes and to ensure their voices are heard and their rights are respected.

- *Commercial sex workers*: commercial sex workers are considered a vulnerable population group due to the exceptional challenges they face related to their occupation, social exclusion, and the associated health and social risks⁷⁷. One of the primary challenges faced by commercial sex workers is the risk of exposure to infectious diseases such as HIV/AIDS, sexually transmitted infections (STIs), and other health complications⁷⁸. This is due to the nature of their work, which involves engaging in sexual activities with multiple partners, often without access to condoms or other protective measures. They may also face violence and abuse from clients or law enforcement⁷⁹. Commercial sex workers may also face social and economic challenges such as limited access to healthcare, education, and job training programs, discrimination, and social exclusion⁸⁰. These challenges can make it difficult for them to access appropriate healthcare and support services, and increase the likelihood of poverty and exploitation. Access to healthcare is a critical challenge faced by commercial sex workers. They may face barriers to accessing healthcare, including stigma and discrimination from healthcare providers, lack of access to appropriate services, and limited availability of healthcare resources⁸¹. Additionally, many commercial sex workers may not have legal status or may be afraid to seek healthcare due to fear of arrest or deportation. Commercial sex workers may also face challenges related to mental health and substance use disorders⁸². They may experience high levels of stress and trauma related to their work, leading to further health complications and difficulties accessing appropriate care. It is important to recognize the specific needs and challenges faced by commercial sex workers and to work towards addressing them through policies and programs that promote access to healthcare, education, and job training programs, reduce stigma and discrimination, and provide support for mental health and well-being. This can involve implementing laws and policies that protect the rights of commercial sex workers, promoting education and awareness about their health and well-being, providing access to affordable and quality healthcare, and promoting social inclusion and support for commercial sex workers and their families.

It is also important to involve commercial sex workers in decision-making processes and to ensure their voices are heard and their rights are respected.

- *LGBTQ+ individuals*: LGBTQ+ individuals may face discrimination and harassment based on their sexual orientation or gender identity, which can lead to negative health outcomes, including mental health problems and substance abuse⁸³. One of the primary challenges faced by LGBTQ+ individuals is the stigma and discrimination they may experience due to their sexual orientation or gender identity. This can lead to social exclusion, harassment, violence, and even discrimination in housing, employment, and healthcare⁸⁴. As a result, LGBTQ+ individuals may experience poorer mental and physical health outcomes, including higher rates of depression, anxiety, and suicide⁸⁵. Access to healthcare is also a critical challenge faced by LGBTQ+ individuals. They may face barriers to accessing healthcare, including discrimination from healthcare providers and lack of access to appropriate services³². They may also face legal and social barriers to accessing gender-affirming healthcare, including hormone therapy or gender confirmation surgery⁸⁶. LGBTQ+ individuals may also face unique challenges related to their identity, including discrimination in schools and workplaces, family rejection, and barriers to accessing resources and services⁸⁷. It is important to recognize the specific needs and challenges faced by LGBTQ+ individuals and to work towards addressing them through policies and programs that promote equality and social inclusion, reduce stigma and discrimination, and provide support for mental and physical health⁸⁸. This can involve implementing laws and policies that protect the rights of LGBTQ+ individuals, promoting education and awareness about LGBTQ+ identities and issues, providing access to affordable and quality healthcare, and promoting social inclusion and support for LGBTQ+ individuals and their families. It is also important to involve LGBTQ+ individuals in decision-making processes and to ensure their voices are heard and their rights are respected.

Figure 1 summarizes selected vulnerable population groups which may suffer from different types of discrimination (including practical, formal, or societal discrimination).

Figure 1. Selected vulnerable groups suffering from different types of discrimination
(source: <https://www.bsr.org/en/blog/respecting-the-rights-of-vulnerable-groups>)



1.1.5. Access to healthcare services among vulnerable groups

Characterization of specific vulnerable groups in health care is recently based on Levesque's et al. "access framework", which still constitutes the state-of-art instrument on this matter⁸⁹. Based on this practical framework, specific and important vulnerable groups are characterized in the transition economies and former communist countries including Albania.

Building on a comprehensive view of access articulated around factors pertaining to the healthcare system, individuals and context, Levesque et al. have integrated both supply- and demand-side dimensions into their access framework, allowing operationalization of access along the pathway of utilization of care from perception of need through the outcomes of health service use⁹⁰.

The framework consists of five dimensions of accessibility of care (approachability, acceptability, availability and accommodation, affordability, appropriateness) and five corresponding abilities of patients and populations to access care (ability to perceive, ability to seek, ability to reach, ability to pay, ability to engage).

These dimensions of access are considered as interdependent constructs. The framework is arranged in pairs: each supply-side dimension of accessibility of care is mirrored by a matching demand-side ability of patients or populations to access services.

The combination of a corresponding supply- and demand-side dimension is referred by the authors as "paired dimensions".

It has been reasonably argued that access to healthcare is central in the performance of health care systems in all countries of the world. As a matter of fact, the importance of service delivery for people has resulted in measurement of utilization and access having a prominent role in the health policy literature⁹¹.

Nevertheless, access to health care remains a complex notion as exemplified by the varying interpretations of the concept across different authors and different schools of thought⁹². The situation is much more complex in the case of vulnerable population subgroups, whose access to and utilization rates of health care services are considerably lower as compared to the general population.

In the health care realm, access is usually defined as: “...*access to a service, a provider or an institution, hence, defined as the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs.*”⁹³

Access has been conceptualized in numerous ways. Notwithstanding the fact that the term access is often used to describe factors or characteristics influencing the initial contact or use of services, there are differing opinions and considerations regarding specific aspects and components included within the ‘access’ to health care services and whether the emphasis and the focus should be placed more on describing characteristics of the providers, or the actual process of health care provision⁹⁴.

A strong primary healthcare system has been considered as vital in order to improve population health. However, primary health care services are not always readily accessible, especially by vulnerable population subgroups⁹⁵.

As a matter of fact, outstanding differences in health status and health utilization rates still exist within and between populations worldwide, and inequities in access to primary health care services continue and tend to affect the most vulnerable people in all societies, which are actually the groups with the most substantial and complex healthcare needs⁹⁶.

Sadly, on the face of it, individuals and even whole groups with the greatest need often have, paradoxically, the poorest utilization of healthcare services. From a human rights perspective: “*access to healthcare should be within reach of all, regardless of race, gender, culture, religion, political belief or socioeconomic condition.*”⁹⁷

Furthermore, a closely linked concept with access to healthcare is the notion of equity, which focuses on its foundation values of fairness and social justice⁹⁸. Improving access to primary health care services especially for the most vulnerable population categories is considered a priority of the global agenda and is integrated as a central component to many contemporary health agreements and translated into substantial health service reforms internationally. Yet, regardless of these efforts, there remains a considerable degree of inequitable access to healthcare services, which inevitably results in unmet healthcare needs and worse and inequitable health outcomes particularly among vulnerably population subgroups⁹⁹.

1.1.6. International experiences and practices in emergency healthcare services for vulnerable groups

Emergency healthcare services for vulnerable groups can vary widely across countries and regions, depending on factors such as political, economic, and social conditions, healthcare infrastructure, and cultural norms.

However, there are some international experiences and best practices that can inform emergency healthcare services for vulnerable groups, which are briefly summarized below:

- *Community-based interventions:* in many countries, community-based interventions have been effective in providing emergency healthcare services to vulnerable groups^{xxi}. These interventions involve working with community organizations and volunteers to provide outreach, education, and support to vulnerable individuals and families¹⁰⁰.

^{xxi} [scaling-up-the-community-based-health-workforce-for-emergencies.pdf \(who.int\)](#).

Community-based interventions can take many forms, depending on the specific needs of the population being served and the resources available. Some examples of community-based interventions for emergency healthcare services for vulnerable groups include¹⁰¹: i) mobile health clinics: these are vehicles equipped with medical equipment and staffed by healthcare providers who travel to underserved areas to provide medical care. They can be especially effective in reaching vulnerable populations who may have difficulty accessing traditional healthcare services; ii) health education and awareness campaigns: community-based organizations can organize health education and awareness campaigns to inform vulnerable populations about the risks of certain health conditions, the importance of preventative care, and the availability of emergency healthcare services; iii) volunteer networks: establishing volunteer networks can help to provide additional support to vulnerable populations during emergencies. Volunteers can provide a range of services, from distributing food and supplies to assisting with transportation to medical appointments; iv) partnerships with faith-based organizations: many vulnerable populations have strong connections to faith-based organizations, which can be leveraged to provide emergency healthcare services. Partnerships with these organizations can help to build trust and improve access to healthcare services; v) telemedicine: this involves using technology to provide healthcare services remotely. Telemedicine can be especially useful in reaching vulnerable populations who may have difficulty accessing traditional healthcare services due to physical or geographical barriers¹⁰². Community-based interventions for emergency healthcare services for vulnerable groups are often most effective when they involve close collaboration between healthcare providers, community-based organizations, and other local stakeholders¹⁰³. By working together, these stakeholders can ensure that vulnerable populations have access to the care and support they need during emergencies.

- *Targeted outreach*: emergency healthcare services for vulnerable groups can be improved by targeting outreach efforts to specific populations and locations where vulnerable groups are known to reside¹⁰⁴. This can involve collaborating with community-based organizations, faith-based groups, and other local stakeholders to identify and reach out to vulnerable individuals. The goal of targeted outreach is to ensure that vulnerable individuals and families are aware of the emergency healthcare services available to them and have access to them when needed. This may involve¹⁰⁵: i) identifying high-risk populations: targeted outreach efforts should focus on identifying populations that are at the highest risk of experiencing health emergencies, such as low-income families, homeless individuals, and elderly populations¹⁰⁶; ii) collaborating with community-based organizations: community-based organizations often have deep knowledge of the populations they serve and can be valuable partners in targeted outreach efforts. They can help to identify vulnerable individuals and families and provide information about emergency healthcare services¹⁰⁷; iii) using targeted messaging: effective targeted outreach efforts use messaging that is tailored to the specific needs and concerns of vulnerable populations. This may involve using language that is culturally and linguistically appropriate, as well as addressing any mistrust or scepticism that vulnerable populations may have towards traditional

healthcare services⁹⁸; iv) providing education and support: in addition to providing information about emergency healthcare services, targeted outreach efforts should also focus on providing education and support to vulnerable populations. This may involve providing information about preventive care, managing chronic conditions, and other health-related topics¹⁰³; v) establishing partnerships with local healthcare providers: targeted outreach efforts are more effective when they involve partnerships with local healthcare providers. Healthcare providers can help to identify vulnerable populations and provide information about emergency healthcare services¹⁰⁸. On the whole, targeted outreach for emergency healthcare services for vulnerable groups is an important strategy for ensuring that vulnerable individuals and families have access to the care and support they need during emergencies. By working with community-based organizations, local stakeholders, and healthcare providers, targeted outreach efforts can help to improve health outcomes for vulnerable populations.

- *Culturally competent care*: providing culturally competent care is essential for emergency healthcare services for vulnerable groups. This involves understanding and respecting cultural differences and ensuring that healthcare providers have the necessary skills and training to work effectively with diverse populations¹⁰⁹. From this point of view, culturally competent care for emergency healthcare services for vulnerable groups involves providing care that is respectful of and responsive to the cultural and linguistic needs of the individuals and families being served. This approach recognizes that culture plays an important role in shaping health beliefs and behaviours, and that healthcare providers must be able to understand and address these cultural factors in order to provide effective care¹¹⁰. Some key elements of culturally competent care for emergency healthcare services for vulnerable groups include: i) understanding cultural beliefs and practices: healthcare providers should take the time to understand the cultural beliefs and practices of the populations they serve. This may involve learning about traditional healing practices, religious beliefs, and other cultural factors that may impact health and healthcare¹¹¹; ii) providing language support¹¹²: language barriers can be a significant barrier to accessing healthcare services for vulnerable populations. Healthcare providers should ensure that interpretation services are available to patients who do not speak the “common” language; iii) addressing health disparities¹¹³: culturally competent care recognizes that health disparities often stem from social and economic factors that are deeply rooted in a community’s history and culture. Healthcare providers should work to address these disparities by advocating for policies that promote health equity and partnering with community-based organizations to address social determinants of health; iv) respecting individual preferences and needs^{xxii}: culturally competent care recognizes that individuals have unique needs and preferences that may be shaped by their cultural background. Healthcare providers should respect and accommodate these individual preferences whenever possible; v) building trust: building trust between healthcare providers and vulnerable populations is essential for providing effective care¹¹⁴. Healthcare providers should work to build relationships with the communities they serve by listening to their concerns, respecting

xxii [Culturally appropriate care - Care Quality Commission \(cqc.org.uk\)](https://www.cqc.org.uk).

their cultural beliefs and practices, and involving them in decision-making about their healthcare. Overall, providing culturally competent care for emergency healthcare services for vulnerable groups is an essential component of improving health outcomes for these populations. By understanding and addressing the cultural factors that impact health and healthcare, healthcare providers can ensure that vulnerable individuals and families receive the care and support they need during emergencies.

- *Access to medications and medical equipment:* vulnerable groups may face challenges in accessing necessary medications and medical equipment during emergencies¹¹⁵. Ensuring that these resources are available and accessible can improve health outcomes for vulnerable individuals. Access to medications and medical equipment is critical for providing emergency healthcare services to vulnerable groups¹⁰⁷. For many vulnerable populations, access to medications and medical equipment can be a significant barrier to obtaining necessary care during an emergency. This can include individuals who may not have health insurance or who may be living in poverty, as well as those with chronic conditions or disabilities. Some key strategies for improving access to medications and medical equipment for vulnerable groups during emergencies include¹⁰¹: i) stockpiling medications and medical equipment: healthcare providers can help ensure that vulnerable populations have access to necessary medications and medical equipment during emergencies by stockpiling supplies in advance. This may involve working with community partners to identify which medications and equipment are most needed and ensuring that an adequate supply is available in the event of an emergency; ii) providing financial assistance^{xxiii}: for many vulnerable populations, the cost of medications and medical equipment can be prohibitive. Healthcare providers can help address this barrier by providing financial assistance to help cover the cost of necessary supplies during an emergency; iii) leveraging Telemedicine¹¹⁶: this can be a powerful tool for improving access to medications and medical equipment for vulnerable populations during emergencies. By using video conferencing and other technologies, healthcare providers can remotely assess patients' needs and prescribe medications and equipment as needed; iv) partnering with community-based organizations¹¹⁷: healthcare providers can also improve access to medications and medical equipment for vulnerable populations by partnering with community-based organizations. These organizations may be able to provide assistance with transportation, translation services, and other support that can help individuals obtain necessary supplies during an emergency. On the whole, improving access to medications and medical equipment is an essential component of providing emergency healthcare services to vulnerable populations. By working to identify and address barriers to access, healthcare providers can help ensure that all individuals and families have the necessary resources to stay healthy and safe during emergencies.
- *Mental health support:* emergency healthcare services for vulnerable groups should also include mental health support, as vulnerable populations may experience heightened levels of stress and trauma during emergencies¹¹⁸. This can involve

^{xxiii}https://www.europarl.europa.eu/document/activities/cont/201302/20130208ATT60776/20130208ATT60776_EN.pdf.

providing counselling services, peer support, and other mental health resources. Mental health support is a critical component of emergency healthcare services for vulnerable groups, as emergencies can cause significant stress and anxiety that can exacerbate existing mental health conditions and lead to new ones¹¹⁹. Additionally, many vulnerable populations, such as those who are homeless, refugees, or survivors of domestic violence, may have experienced trauma that requires specialized mental health support. Some key strategies for providing mental health support to vulnerable populations during emergencies include¹²⁰: i) providing crisis counselling: healthcare providers can offer crisis counselling services to individuals and families during and after emergencies¹²¹. These services may involve individual counselling sessions, group therapy, or other forms of support that can help individuals cope with stress, anxiety, and trauma; ii) partnering with mental health organizations¹²²: healthcare providers can also partner with mental health organizations to provide specialized support to vulnerable populations during emergencies. For example, organizations that specialize in trauma-informed care or provide services to refugees and immigrants may be able to offer additional support to these populations; iii) training staff in trauma-informed care^{xxiv}: healthcare providers can improve their ability to provide mental health support to vulnerable populations by training staff in trauma-informed care. This involves understanding how trauma can impact individuals and tailoring care to meet the unique needs of each person; iv) addressing social determinants of health^{xxv}: addressing social determinants of health, such as poverty, lack of access to education, and discrimination, is critical for improving mental health outcomes among vulnerable populations. Healthcare providers can work with community partners to identify and address these underlying factors to support the mental health of vulnerable populations. Overall, providing mental health support is an essential component of emergency healthcare services for vulnerable populations. By offering specialized services, partnering with mental health organizations, and addressing social determinants of health, healthcare providers can help ensure that all individuals and families receive the support they need during and after emergencies.

- *Disaster preparedness*: investing in disaster preparedness and emergency planning can help to improve emergency healthcare services for vulnerable groups¹¹⁵. This can involve training healthcare providers, establishing emergency response protocols, and stockpiling necessary medications and medical equipment. Disaster preparedness is a critical aspect of emergency healthcare services for vulnerable groups. Effective disaster preparedness can help healthcare providers ensure that vulnerable populations receive timely and appropriate care during emergencies, as well as reduce the impact of emergencies on these populations¹²³. Some key strategies for disaster preparedness for vulnerable groups include: i) developing emergency plans: healthcare providers should develop emergency plans that specifically address the needs of vulnerable populations¹²⁴. This may include plans for evacuating individuals who are immobile or

^{xxiv} [Interagency Task Force on Trauma-Informed Care | SAMHSA](#).

^{xxv} <https://www.cdc.gov/about/sdoh/addressing-sdoh.html#:~:text=Addressing%20differences%20in%20SDOH%20makes,or%20access%20to%20healthcare%20services..>

have disabilities, plans for providing medications and medical equipment, and plans for providing mental health support; ii) establishing partnerships: healthcare providers should establish partnerships with community organizations and agencies that serve vulnerable populations, such as shelters, food banks, and social service agencies¹⁰⁰. These partnerships can help ensure that vulnerable populations receive timely and appropriate care during emergencies; iii) preparing staff: healthcare providers should prepare their staff to provide care to vulnerable populations during emergencies. This may include training staff in cultural competence, trauma-informed care, and the specific needs of vulnerable populations¹⁰⁶; iv) conducting drills and exercises: healthcare providers should conduct drills and exercises to test their emergency plans and ensure that staff are prepared to provide care to vulnerable populations during emergencies¹⁰¹; v) building resilience: healthcare providers should work with vulnerable populations to build resilience and help them prepare for emergencies. This may include providing education and training on emergency preparedness, providing access to resources such as emergency kits and supplies, and identifying and addressing underlying factors that may make vulnerable populations more susceptible to emergencies¹¹⁵. Overall, disaster preparedness is critical for ensuring that vulnerable populations receive timely and appropriate care during emergencies. By developing emergency plans, establishing partnerships, preparing staff, conducting drills and exercises, and building resilience, healthcare providers can help ensure that vulnerable populations are better able to withstand and recover from emergencies.

- *Inclusive policies*^{xxvi}: policies that promote inclusivity and reduce discrimination can help to improve emergency healthcare services for vulnerable groups. This can involve implementing laws and policies that protect the rights of vulnerable populations, promoting education and awareness about their health and well-being, and providing access to affordable and quality healthcare^{xxvii}. Inclusive policies are essential for ensuring that emergency healthcare services are accessible and effective for vulnerable groups. Inclusive policies can help to address disparities in healthcare access and outcomes, and ensure that vulnerable populations receive the care they need during emergencies. Some key strategies for developing inclusive policies for emergency healthcare services for vulnerable groups include¹³⁴: i) ensuring equitable access: inclusive policies should ensure that vulnerable populations have equitable access to emergency healthcare services. This may include ensuring that emergency services are located in areas that are accessible to vulnerable populations, such as low-income neighbourhoods or rural areas; ii) addressing language barriers¹²⁵: inclusive policies should address language barriers by providing language access services, such as interpretation and translation services, to ensure that vulnerable populations can communicate effectively with healthcare providers during emergencies; iii) incorporating cultural competence¹²⁶: inclusive policies should incorporate cultural competence by ensuring that healthcare providers are trained in the cultural practices

^{xxvi} <https://www.ohchr.org/sites/default/files/Documents/Issues/Disability/SDG-CRPD-Resource/policy-guideline-good-health.pdf>.

^{xxvii} <https://inclusivehealth.specialolympics.org/resources/tools/inclusive-health-principles-and-strategies>.

and beliefs of vulnerable populations. This can help to reduce disparities in healthcare access and outcomes and improve the quality of care for vulnerable populations; iv) providing financial assistance: inclusive policies should provide financial assistance to ensure that vulnerable populations can afford emergency healthcare services¹²⁷. This may include offering sliding scale fees or financial assistance programs to reduce the cost of emergency care for low-income individuals and families; v) addressing social determinants of health: inclusive policies should address social determinants of health, such as poverty, homelessness, and food insecurity, which can impact the health and wellbeing of vulnerable populations¹²⁸. This may include partnering with community organizations and agencies to address these underlying factors and ensure that vulnerable populations have access to resources and support during emergencies. On the whole, inclusive policies are essential for ensuring that emergency healthcare services are accessible and effective for vulnerable populations. By ensuring equitable access, addressing language barriers, incorporating cultural competence, providing financial assistance, and addressing social determinants of health, healthcare providers can help to reduce disparities in healthcare access and outcomes and ensure that vulnerable populations receive the care they need during emergencies.

1.1.7. Vulnerable groups in Albania

The most comprehensive report describing vulnerable population groups in Albania concerns a study conducted in 2018 (which was published in 2019) in the framework of the “Health for All Project” (HAP), which is a project of the Swiss Agency for Development and Cooperation (SDC)¹²⁹. This study provides a useful description of the general situation of the typical vulnerable groups based on a general identification and classification employed in most of the countries worldwide. In addition, this study provides a practical matrix (grid) for assessing and subsequently prioritizing the major vulnerable population groups in Albania especially based on their health needs and the related challenges.

Below are summarized the main findings from this study, which are nevertheless enriched with more recent evidence pertinent to the years 2019-2023.

Women and children in Albania

The total number of children under the age of 5 years in Albania is 138,491, out of a total population, 2,793,592 inhabitants (≈5%)¹³⁰. Conversely, the overall number of children 0-18 years in Albania is 639,285, constituting 23% of the overall population (INSTAT, 2023).

The pre-primary school gross enrolment ratio (GER)¹³¹ for 2018-2019 was 78.3%, whereas net enrolment ratio (NER) for the same year for this category was 71.9%^{xxviii}. In 2021-22, about 72,384 children were enrolled in kindergarten (INSTAT, 2022). The proportion of children of the age 3 or 4 years who attend an organized Early Childhood Education Program (ECEP) has increased over the past 10 years from 55% to 73%^{xxix}. Boys’ participation rates in ECEP is

^{xxviii} MoES, National Strategy for Education 2021-2026.

^{xxix} ADHS 2017-2018.

higher in urban areas (77%) compared with rural areas (68%) [ADHS, 2018]. About 79,942 children (3-6 years old) are enrolled in kindergartens, of whom 404 are children with disabilities, 910 are Roma children and 1,769 are Egyptian children (MoES, 2020).

Data from Eurostat - EU-SILC survey (2020) indicate that the share of children (aged 0-17 years) living in a household which is at risk of poverty and/or severely materially and socially deprived and/or a (quasi) jobless household has decreased by 2.9 percentage points in 2020 compared to 2019 data (51 % in 2020 and 53.9% in 2019) – or more than double compared to EU-27 (23.8%).

In Albania, there are no child or family benefits other than of a one-time bonus payment at birth and the “Ndihma Ekonomike” (cash assistance) programme targeting poor households.

Results of EU-SILC 2020 indicate that the age group of 0-17 years in Albania is the poorer (28.4%) compared to age group 18-64 years (21.6%). About 58% of Albanian children (aged less than 18 years) suffer from material and social deprivation, which is 4 times higher than in EU-27 (14.2%). Severe material and social deprivation is 5 times higher in Albania (42.4%) compared to EU-27 (8.2%) [EU-SILC, 2020].

Regarding women, the overall number of female individuals in Albania is 1,406,532 constituting 50.3% of the overall population (INSTAT, 2023). There are categories among women with high risk of vulnerability, especially those living in absolute poverty or those who are heads of family. According to ADHS 2017-18, about 17% of families in Albania have a woman as head of family (ADHS 2018). In addition, there are more head of family women among those living in absolute poverty compared to other, non-poor categories. Women living in absolute poverty have more children to take care of compared to other women; on average 1.9 children per women compared to 1.02 children per woman in non-poor category (LSMS, 2012). In addition, ADHS 2018 demonstrates that women with more children face more problems with accessing health care. The same is true for those women who are divorced or widowed.

In 2017, 12% of 82483 families which benefited from state economic aid were families with a woman as head of family (State Social Service).

Public provisioning of childcare services is important because private childcare options are not affordable for all, especially for poor families in Albania. There are no national quotas in Albania (with the exception of Tirana, the capital) set for the children coming from vulnerable families and is in the discretion of the municipalities to set these quotas. The absence of affordable public childcare service could also lead to a vicious cycle of poverty and vulnerability for women and children in these households¹³². The lack of childcare services has a negative impact on women access to the labour market. Having younger children in the household also increases the likelihood of mothers staying away from the labour market, especially when there is lack of child-care. Establishing eligibility criteria and quotas for enrolling children from families in need in public nurseries and kindergartens remains to be properly addressed, particularly in the large urban areas with higher demand¹³³.

Violence and abuse is another vulnerability driver among women. About 15% of Albanian women 18-55 years old reported last year physical violence (INSTAT 2013). Nevertheless, ADHS 2018 shows a positive trend related to violence against women in Albania; the proportion of women and men who agree with one or more justifications for wife beating has

declined over time from 30% of women and 36% of men in 2009, to 7% of women and 11% of men in 2018. Still, in 2018, 1% of women 15-49 years old report having injuries resulting from a recent violence. Since 2006, by law, every health centre is requested to screen women about violence and provide them medical assistance as needed.

Access to education for children from poorer backgrounds remains a challenge. Children who live in jobless households might be more likely to receive less education, or lower quality education, and also run the risk of being excluded later in their lives from the labour market, or being at a disadvantaged position (UNICEF, 2016). Data indicate that working poor live in larger households with an average of six people and have more small children aged 0-5 years, compared to non-poor (0.65 small children for the working poor vs 0.32 for the working “non poor”)¹³⁴. Findings from ADHS 2019, list a number of factors that impact participation in pre-school education such as: socioeconomic status of their parents; education level as well as the gender of the head of household. Only 11% (or 225) of the kindergartens provide meals to 28% (or 21,978) of the children attending kindergartens. Extending food programs to more kindergartens would increase the enrolment and target nutrition issues of children coming from low-income families.

Addressing the vulnerability of women and children in Albania requires a comprehensive approach. It includes promoting gender equality, combating gender-based violence, improving access to education, enhancing maternal and child healthcare services, strengthening child protection systems, and addressing the root causes of vulnerability through poverty reduction measures and social support programs. Collaboration between government agencies, civil society organizations, and international partners is essential to effectively address these challenges and ensure the well-being and rights of women and children in Albania.

Older people in Albania

Albania is one of the last countries in Europe to experience effects of population ageing. The proportion of the population over 65 years of age in Albania increased from 5% in the year 1990 to 11% in 2011 (this was the last census conducted in Albania by the national Institute of Statistics [INSTAT, 2011]).

As a matter of fact, the proportion of older population in Albania is steadily increasing and INSTAT’s projections for the year 2025 have estimated the ≥ 65 -year population at more than 17% (<http://instat.gov.al/>).

According to the most recent figures provided by INSTAT, in 2022, the overall number of older people in Albania (individuals aged 65 years and over) was 439,225, comprising 15.7% of the whole Albanian population.

According to the official figures, life expectancy at birth in Albania has increased steadily in both sexes. However, in the past ten years, life expectancy increased 4.4 years in males, but only 3.1 years in females (<http://instat.gov.al/>).

In absolute terms, there are currently more than 370,000 people over 65 years old in Albania compared to just above 230,000 in the year 2001. The rapid decrease of birth rates, coupled with the increase in life expectancy have accounted for this significant demographic transition of the Albanian population.

Emigration is another substantial factor, which is influential not only in boosting the ageing of the population, but weakening the traditional support nets provided by families as well. Of note, emigration of younger members of the family is particularly high in Albania.

International Mobility in Ageing Study (IMIAS, 2016) conducted in Tirana indicates that around 10% of older persons live totally alone, while 45% live only with their spouses¹³⁵. Nonetheless, younger generations, leaving earlier their home and working abroad remain a potential source of support for their older parents left alone, by sending remittances and, at the moment of serious health problems, by covering expensive medical interventions.

According to the Living Standard Measurement Survey (*LSMS, 2012*) data, an estimated 10% of the older population in Albania was poor and could not meet the basic standards of living. The ‘depth of poverty’ of the elderly poor was on average not very large and it implies that with limited means many poor elderly can be raised to a non-poor status.

Mobile phone has expanded massively during recent years in Albania with an overwhelming majority of older people owning one, but computers and Internet connection are not available to a large number of older individuals, which constrains adequate access to information and medical care. Similarly, although private cars’ ownership is on increase, only one in five older people possesses one (according to the current reports), which can be a constraint in terms of physical mobility in areas where public transport is scarce.

According to the available information, around 30% of Albanian older people live in apartment blocks, where a major mobility constraint for 80% of them is the lack of elevators. The large majority or 93% of older people has access to an improved type of sanitation, but only 76% have toilet inside the own dwellings. This situation is typical in rural areas (IMIAS, 2016).

The pension system in Albania, although virtually covers all older people, faces challenges related to demography and economy. There were only 1.1 contributors for 1 pension receiver in 2013. The old-age dependency ratio almost doubled from 8.6% in 1989 to 16.7% in 2011. According to reliable projections, in 2030, this ratio will have again doubled to 32.9%. In addition, only 58.4% of people at working age were contributors in 2012.

The recent law on pensions, which has introduced for the first time the social pensions, addresses some of these challenges as well (increased share of salary contribution to pension schemes and incentives for motivating contributions).

Economic growth of Albania came to almost a halt at 2012, but afterwards the economy has shown signs of recovery with a growth rate of about 2.8% in 2016. Unemployment of young people and informal economy remain a concern which can threaten the pension system and other social care schemes, although during the last few years formal employment is steadily increasing, albeit to a slow pace.

Family values and the importance of family members providing care for elderly people have traditionally been prominent in Albanian culture; however, in the absence of family caregivers, an increasing number of older people face significant physical problems and social isolation (Porrazzo et al., 2015).

Most of the elderly in Albania rely on their pensions and remittances from relatives living abroad to cover their living and medical expenses. However, families that have greater financial stability rely on informal care services, which in most cases are not provided by a trained workforce, but rather by unemployed women in search of a job. There are no data available

related to the informal workforce that is mobilized to help elderly people in need. Family care for elderly people remains unpaid work, with consequences for the living standards and wellbeing of the families concerned. However, the incidence of informal care within the family is fading, as the ‘care drain’ is becoming evident and a new ‘culture of distance’ is embracing the Albanian family¹³³.

Roma community in Albania

The socioeconomic status of the Roma community is poorer than the country’s general population in Albania. Due to the poverty, difficult conditions, lifestyle, low educational level, education, poor access to health services, and discrimination, the Roma have a higher morbidity incidence and are more vulnerable to communicable diseases in particular.

The number of those declared Roma or Egyptians in the last national census is 8301 and 3668 respectively¹³⁶. This is lower than previously reported proportions. E.g., according to the Council of Europe, for the same year (that is 2011), there were 115,000 Roma and/or Egyptian people living in Albania. Conversely, for the same year (in 2011), a UNICEF survey has reported 13,000 individuals pertinent to Roma and/or Egyptian communities (INSTAT, 2011). Based on these considerable discrepancies in the number of Roma/Egyptian people living in Albania, it has been speculated that this group constitutes a population hard-to-reach, characterized by distrust of administration, social exclusion, illiteracy, as well as assimilation through social mobility processes (INSTAT, 2011).

Roma people tend to cluster in specific areas in Albania, especially in cities. In areas where they live they make at least 32% of actual population (compared to less than 0.5% in national scale). In some quarters in Shkoder, Fier or Tirana, Roma people comprise more than 60% of the local population.

Education levels among Roma are many times lower than general population of Albania. While education among general population women education attainment is slightly higher, the contrary is true among Roma community (INSTAT, 2020).

ADHS 2018 shows a much higher proportion of Roma and Egyptians in population with around 3% of the sample reporting to belong one of those two ethnic communities.

The last census conducted in Albania in 2011 (INSTAT), shows clear findings about the marginalization of Roma and Egyptians in the Albanian society, with a gap which is widening in the market economy. Hence, actions should be taken to enhance access and participation to education and labor market of Roma/Egyptian people. In addition, housing and health are also major issues, as well as lack of resources from communities, but also institutional and social barriers to be alleviated (including stigmatization and discrimination) [INSTAT, 2011].

The Law on Social Housing¹³⁷ in Albania determines the eligibility criteria and prioritises 15 categories of people/households that can receive housing support including individuals pertinent to Roma and Egyptian communities. Yet, The Social Housing Strategy calls for coordinated action with other strategies and documents, particularly the cross-sectoral strategy for decentralisation and local governance, the national social protection strategy, and national action plans for the integration of vulnerable groups such as the Roma and Egyptian communities¹³⁴.

People living with HIV/AIDS in Albania

Albania has a National Strategy and Action Plan on HIV/AIDS 2015-2019 and the NSDI II 2016-2020, Pillar 3: Investing in People and Social Cohesion, component 11.2: A Stronger, More Accessible Health Care System, as well as the recently adopted National Strategy on Health address the concerns included in Target 3.3 (Objective 1.5 of the strategy – Securing access in preventive and community services and a specific program under public health).

Albania is a country with a low prevalence of HIV although the number of HIV diagnosed cases has steadily increased over time and estimates point to a relatively higher number of undiagnosed cases. Males (70.4% in 2014) and youths over 19 years (93.9% in 2014) dominate the HIV/AIDS diagnosed cases and the population at risk of infection^{xxx}.

Otherwise, the HIV prevalence in the general population in Albania is 0.1% and the incidence is 0.004% (based on the number of population according to the 2011 Census conducted in Albania).

Problematic drug users in Albania

Two most recent specialized surveys (General population survey of 2015 and problematic drugs survey of 2015) show that there should be roughly 3500-9000 problematic drug users in Albania. They are persons with serious addiction issues, and with increased risks for various health problems. In addition to health issues they have problems with the law as well. From the surveys it seems that those problematic drug users who have good access at the services have lower rates of police indictment or overdoses (GPS 2015, PDU 2015).

Poverty in Albania

In 2018 there were 53000 families receiving state economic assistance (including unemployment benefit and other forms of assistance for the poor). The figure was twice as high 5 years ago, but the important decrease is most probably caused by the social assistance reform rather than a change in the actual number of unemployed or poor in Albania. To be noted that the unemployment benefit is received by less than 10% of those who are looking for a job (INSTAT 2018). Among the total number of beneficiary families, only less than 2% are individuals (victims of violence, trafficking, or orphans).

Among 82483 families which received state economic assistance during 2017, 7455 were poor families with children under 18 years old, 11.6% were poor families with a woman as family head, and 8.8% were poor families caring for a person with special needs (State Social Service).

Latest LSMS showed that 14% of Albanian population lived in absolute poverty (consuming less than 4891 Leke per month per capita). 3% were considered extremely poor (unable to meet more than three basic needs, including those related to food). Analyses of all LSMS rounds data on poverty demonstrate a decrease of its prevalence in Albania, with a short reversed trend observed during the period 2008-2012, with a slight increase in poverty in urban areas.

^{xxx}Ministry of Health of the Republic of Albania. National Health Strategy: 2016-2020. Tirana; 2016.

The Gini coefficient, an indicator of distribution of wealth shows an evenly distribution of wealth in urban areas (0.05) compared with a less evenly distribution in rural (0.15). This coefficient decreased in a positive trend from 0.26 to 0.11 between 2009-2018. It may be explained by the fact that more household in the lower social strata have been able to acquire more assets over the past decade.

Interestingly, individuals living in relative poverty have a much lower rate of state health insurance or social security than other higher social categories (ADHS2018).

ADHS 2018 also shows that poorer women have an increased risk of encountering problems when seeking health care. Indeed, women of lowest wealth quintile face a more than 5 times higher risk of problems when seeking care, compared to women of highest quintile.

Nonetheless, since the reformed programme of social assistance was implemented in Albania in 2018, the number of poor households benefiting from the programme has been on the rise from a monthly average of 54,299 poor households in 2018 to 60,588 in 2019, 63,510 in 2020 and 68,247 beneficiaries for the year 2021.

In 2020 (the most recent data available for Albania), the percentage of the population living below the at-risk-of-poverty threshold in Albania was 21.8%, if social transfers (including pensions) are included in the household income (EU-27: 16.1%). It was 37.9% when these transfers are not included (EU-27: 43.2%).

People with disabilities and with special needs

139278 persons benefited from disability aid in 2017 (State Social Service). From this aid package were also paid 18633 carers for those with full disability. There were 6.2% of the total Albanian population over 15 years old, who reported to be persons with disabilities in the latest LSMS (2012). This would make a total of around 138000 individuals. In this category are included functional disabilities and the majority of the group have issues in mobility and eye sight. The rate is higher among women compared to men. The highest rate is observed in Gjirokastra and this is most likely related to a high proportion of people over 65 years old in that region. The region with the lowest prevalence is Tirana. The same survey shows there is a lower education level among people with disability in Albania demonstrating their vulnerability earlier in life. 24.3% of them never attended school, while only 3.3% have achieved a university education.

LGBTQ+ in Albania

There are no measurements of the size of this group in Albania. An estimation from an unpublished report of a WHO mission to the country puts it at around 3% of the general population.

Only a small minority of this group comes out openly about their sexual orientation and they are predominantly men and young. Institute of Public Health has explored their health vulnerability mostly in relation to men who have sex with men (MSM) and their increased risk of getting HIV/AIDS/IST. The prevalence of HIV and syphilis among them is higher than other population group (BioBSS).

1.1.8. Challenges of vulnerable groups for emergency health services and other healthcare services in Albania

In general, emergency healthcare services in Albania face challenges due to the increasing trend of traumatic emergencies, changes and diversity of medical emergencies, and increased mortality and post-traumatic morbidity. These challenges put pressure on medical emergency services by overloading hospital Emergency Departments and ambulance services¹³⁸.

In particular, vulnerable groups in Albania face several challenges when it comes to accessing emergency healthcare services. Some of the key challenges include:

- **Limited Access:** Vulnerable groups, such as the elderly, people with disabilities, and those living in remote or rural areas, often face barriers in accessing emergency healthcare services¹³⁹. Geographical limitations, lack of transportation options, and inadequate infrastructure can hinder their ability to reach healthcare facilities in a timely manner.
- **Financial Constraints¹⁴⁰:** Economic limitations can prevent vulnerable groups from seeking timely emergency healthcare. High out-of-pocket costs, especially for emergency medical services, can deter individuals from seeking the necessary care. This is particularly relevant for low-income individuals¹⁴¹.
- **Lack of Awareness:** A lack of awareness about available emergency healthcare services and how to access them can be a significant challenge for vulnerable groups. This can be due to limited education, language barriers, or insufficient dissemination of information¹⁴². As a result, people may not know where to go or who to contact during emergencies, delaying their access to timely care.
- **Language and Cultural Barriers:** Language barriers for certain minority groups in Albania (such as Roma and Egyptian communities) can impede effective communication between healthcare providers and vulnerable groups, hindering their understanding of the available services and their medical needs. Additionally, cultural differences may affect trust and willingness to seek emergency healthcare services.
- **Stigmatization and Discrimination:** Vulnerable groups, such as people living with HIV/AIDS, individuals from the LGBTQ+ community, or those with mental health conditions, may face stigmatization and discrimination when accessing emergency healthcare services in Albania too. Fear of judgment or mistreatment may prevent them from seeking timely care, potentially worsening their health conditions during emergencies⁸⁴.
- **Inadequate Healthcare Infrastructure:** Insufficient healthcare infrastructure, particularly in rural or remote areas, can limit the availability and quality of emergency healthcare services in Albania. Lack of well-equipped emergency departments, shortage of medical professionals, and limited resources can all contribute to delays in providing critical care to vulnerable groups¹⁵².
- **Limited Training and Preparedness:** Emergency healthcare providers may not always receive adequate training and preparedness to address the specific needs of vulnerable groups in Albania. This can include understanding and addressing cultural sensitivities,

providing accessible communication, and accommodating individuals with disabilities, among other considerations.

However, vulnerable population groups in Albania, similar to other countries worldwide, face a wide range of challenges and obstacles for accessing good-quality healthcare services at all levels including not only emergency care, but also primary and secondary healthcare services. The sections below describe in more detail the array of health-related problems and challenges faced by the main vulnerable groups in Albania.

Health challenges of women and children in Albania

Regarding health needs, while there is a higher measured risk for certain health conditions among men compared to women (cancers, heart diseases etc.), women self-report more diseases and disabilities. This most probably demonstrate a better utilization of health services and better awareness by women compared to men. For example, self-reported prevalence of hypertension is higher among women, in the same sample where measured prevalence of this condition is higher among men (ADHS 2018). This pattern is confirmed by utilization rates of primary health care-based program of essential health checkups; there is a significantly lower utilization rate of the check-up services by men, especially younger men (Check-up Bulletin, 2018).

In the context of Albania, communicable diseases, maternal, neonatal and nutritional disorders accounted for 30.5% of the total burden of disease in 1990, but only for 9.5% in 2010¹⁴³. Furthermore, there is currently evidence of a sharp and significant linear decrease in both mortality rate and burden of disease due to the combined toll of mother and child health conditions and nutritional deficiencies.

Nonetheless, regardless of the fact that the economic growth in Albania has improved food security and the overall nutritional status, malnutrition among children still persists and this is mainly visible in vulnerable population categories including particularly the Roma and Egyptian communities. Causes of micronutrient malnutrition in Albania include a combination of household food insecurity, poor infant and young child feeding and care practices and inadequate access to quality health services (IPH, 2014).

Stunting and other forms of under-nutrition reduce a child's chance of survival, hindering also optimal health and growth. On the other hand, overweight and obesity as manifestations of over-nutrition contribute significantly to diabetes and other NCDs in adulthood. As convincingly argued in the vast international scientific literature, both under and over nutrition have serious consequences on child survival, development, health outcomes in adulthood and economic productivity of individuals and whole communities.

Anemia is an important public health problem among children pertinent especially to vulnerable categories (in the Albanian context, this is particularly the case of ethnic minorities including Roma and Egyptian communities), and its consequences include increased morbidity and mortality, stunting, lower performance in school, cognitive delays, and apathy. Furthermore, anemia rates are higher in Albanian women pertinent to the Roma minority and this condition is associated with weakness and fatigue, lower productivity, and increased risk of maternal mortality from postpartum hemorrhage among women in this vulnerable group.

Inadequate infant and young child feeding practices including insufficient complementary feeding contribute also to child malnutrition and micronutrient deficiencies among Albanian children pertinent to different vulnerable groups which do not seek preventive services, advice and counseling (due to difficulties to access health care services).

Indeed, according to the first national health report, household food insecurity contributes to poor nutrition outcomes of the Albanian children and women (*IPH, 2014*).

Health challenges of older people in Albania

Previous research studies conducted in Albania (IMIAS) indicate comparatively high levels of chronic illness, depression and avoidable disability in older people of both sexes. LSMS and IMIAS studies confirm that disability, chronic diseases and depression are constantly higher among Albanian older women compared to men¹³⁶.

According to a fairly recent research report including a representative sample of about 1,000 older people of both sexes in Albania¹⁴⁴, overall, the prevalence of self-perceived poor general health status was about 36%. There were no significant sex-differences in the prevalence of self-perceived poor health, but a strong positive relationship with age.

Similarly, older people residing in urban areas exhibited a significantly lower prevalence of poor self-perceived general health (about 30%) compared with their counterparts from rural areas (around 46%) and particularly those from periurban areas (about 50%). Furthermore, poverty level was significantly higher among older people who perceived their health status as poor¹⁵⁹.

The prevalence of at least one chronic disease or condition was about 47%. Among older people who reported to have at least one chronic condition, the prevalence of cardiovascular diseases was 65.4%; the prevalence of diabetes was 24.6%; the prevalence of diseases of the stomach and/or the liver was 31.5%; and the prevalence of chronic lung diseases was 36.5%.

Overall, about 41% of older people reported some degree of visual impairment and about 24% of older people reported hearing problems. On the other hand, 52 individuals (5.3%) reported to be bed-bound (*MOSHA, 2018*).

On the other hand, applying the WHO-5 index, the prevalence of mental health problems in this overall sample of older men and women in Albania was about 70%. There was evidence of a highly significant relationship with the age of older people, but not with sex (*MOSHA, 2018*).

Health challenges faced by Roma and Egyptian communities

Several minorities in Albania (including particularly Roma and Egyptian communities) face a range of health challenges related to accessibility and affordability of healthcare services, a situation which is similar to most the countries worldwide.

Nonetheless, the Albanian Ministry of Health and Social Protection has supported many NGO initiatives to provide services for hard-to-reach and inaccessible communities including the Roma and Egyptian minorities. There are several NGOs supported also by the government which provide mental health services for these vulnerable ethnic minorities.

Also, the Ministry is currently extending the medical services at a community level with a particular focus on vulnerable and marginalized population categories including minority groups such as Roma community and Egyptians.

Also, provision of free-of-charge services also for the uninsured individuals (as of January 2017) and the checkup offered to all individuals aged 35-70 years regardless of their insurance status are measures which tend to ameliorate the situation and reduce the health inequity gap which is observed between the Roma and Egyptian communities compared to the general population (Si Je paper).

In addition, regarding the ethnic minorities, there are several NGOs being supported by the Albanian government which aim at reaching Roma and Egyptian communities all over the country.

Health challenges of poor people in Albania

ADHS 2018 also shows that poorer women have an increased risk of encountering problems when seeking health care. Indeed, women of lowest wealth quintile face a more than 5 times higher risk of problems when seeking care, compared to women of highest quintile.

At a more general note, poor people in Albania face various health challenges, primarily due to their socio-economic conditions and limited access to resources. Some key health challenges faced by the poor in Albania include¹⁴⁵: i) Limited Access to Healthcare: Poverty often leads to limited access to healthcare services. Poor individuals may struggle to afford medical consultations, diagnostic tests, medications, and other necessary treatments^{xxxi}. This can result in delayed or inadequate healthcare, leading to the progression of diseases and poorer health outcomes; ii) Higher Disease Burden: Poor living conditions, including inadequate housing, sanitation, and access to clean water, can contribute to a higher burden of communicable diseases among the poor. Lack of access to preventive measures and healthcare services increases their vulnerability to diseases such as respiratory infections, gastrointestinal illnesses, and vector-borne diseases; iii) Malnutrition: Poverty is often associated with malnutrition, both undernutrition and overnutrition^{xxxii}. Poor individuals may not have access to a balanced diet, resulting in deficiencies of essential nutrients. Malnutrition can lead to weakened immune systems, stunted growth in children, and increased susceptibility to diseases; iv) Mental Health Issues: Poverty is linked to higher rates of mental health issues such as depression, anxiety, and stress¹⁴⁶. Financial instability, limited access to mental health services, and the challenges associated with poverty can exacerbate mental health conditions. However, mental health services are often inaccessible or unaffordable for the poor in Albania; v) Limited Health Education: Lack of health education and awareness among the poor can contribute to unhealthy behaviors and poor health outcomes¹⁴⁷. Without proper knowledge about preventive measures, disease management, and healthy lifestyles, poor individuals may struggle to make informed decisions regarding their health; vi) Environmental Hazards: Poor communities often reside in areas with environmental hazards, such as pollution, inadequate waste management, or proximity to industrial sites¹⁴⁸. These conditions can lead to respiratory problems, skin diseases, and other health issues that disproportionately affect the poor; vii) Access to Clean

^{xxx} [Albania health system information \(who.int\)](http://who.int).

^{xxxii} [Albania's Economy – Challenges and Opportunities for Recovery from the Pandemic \(worldbank.org\)](http://worldbank.org).

Water and Sanitation: Poor individuals may lack access to clean drinking water and proper sanitation facilities. This increases the risk of waterborne diseases, such as diarrhea and parasitic infections, which can have severe health consequences, especially for children.

Addressing the health challenges of poor people in Albania requires a multi-faceted approach. It involves improving access to affordable healthcare services, including preventive care and essential treatments. Efforts should focus on providing health education and promoting healthy behaviors. Additionally, initiatives to alleviate poverty, improve living conditions, and address social determinants of health, such as access to clean water, sanitation, and nutrition, are essential to improving the overall health outcomes of the poor population in Albania.

Health challenges of people with disabilities and special needs in Albania

ADHS 2018 has measured the prevalence of all chronic disabilities in a relatively younger sample of Albanian population (15-59 years old). 3.1% of women and 2.3% of men at this age groups are chronically disabled. The data confirm a higher rate among women (35% higher). The risk increases with age reaching 6.2% and 4.6% for women and men respectively at the age 50-59 years old. The survey demonstrates also a strong association between disabilities with education and wealth status. Women and men with less than basic education (8 years) report a disability prevalence of 7.2% and 10.6% respectively. Among those with a university degree the rates are under 0.7% and 0.3%.

Health challenges of people living with HIV/AIDS in Albania

Of note, the experience of the past years has shown that the lack of timely planning of the needs of people living with HIV/AIDS and failure to reconcile patients' needs and demands with procurement procedures that require up to 6 months until the moment of drug delivery. This issue has brought major problems in the continuous provision and sometimes even interruption of therapies consisting of antiretroviral drugs, which bears serious negative health consequences for people living with HIV/AIDS.

Therapy and monitoring of the side effects of drug treatment against HIV/AIDS is done through routine controls, as well as various laboratory examinations. Nonetheless, it should be point out that there are deficiencies in monitoring and measuring the viral load (HIV-ARN), testing, which is recommended to be performed at least once a year for each patient based on the WHO guidelines and protocols (IPH, 2018).

Logistic and technical capacities are established at the Microbiology Service of the University Hospital Center (UHC) "Mother Teresa" in Tirana, although this Service does not currently perform routine testing for HIV/AIDS yet. This type of service was initiated for the first time by the Molecular Microbiology Laboratory at the national Institute of Public Health, which has been performing this service for several years, but with capacity building at the UHC, the services provided by the IPH are limited.

In any case, planning and procurement of the kits and reagents remains an issue of serious concern, as well as raising the awareness of the UHC management structures that this is an important and vital laboratory test for people living with HIV (IPH, 2018).

Furthermore, the clinical problems posing the patients with serious opportunistic infections and pathologies are in contrast with the limited diagnostic and therapeutic capabilities and services available and offered at the UHC in Tirana.

Primary and secondary treatment and prophylaxis of opportunistic infections is problematic due to the occasional absence of drugs and antibacterial, antiparasitic and antiviral preparations for hospital use (such as e.g., the lack of fluconazole, valganciclovir, peginterferon, penicillin benzathine, etc.). Due to skipping of receiving the clinical services from the family doctors, the application of long-term preventing therapies for opportunistic infections among outpatients is scarce (IPH, 2018).

Part of the follow-up protocols for people living with HIV/AIDS should also be the control and management of chronic, metabolic, neurological, patho-physiological, and HPV or pap test tests, application of special vaccination schemes, and so on. Interdisciplinary referral schemes need to be improved by re-emphasizing the importance of training and combating stigma and discrimination phenomena by non-infectious specialists and the health personnel operating at all levels (IPH, 2018).

Health challenges of LGBTQ+ individuals in Albania

The evidence on this vulnerable population category is scant for Albania. However, the report “Access to Health Services and Quality of Care for LGBTQ+ Persons in Albania” prepared by the office in Albania with support of UN agencies and LGBTQ+ civil organizations points at a lack of LGBTQ+-friendly healthcare facilities and services, coupled with immense pressures of discrimination, stigma, social exclusion and homophobia faced by LGBTQ+ people.

Health challenges of problematic drug users in Albania

Similar to the situation observed in many other countries, certain population subgroups in Albania, particularly people who inject drugs (PWID) are at increased risk of Hepatitis B virus (HBV) and HIV/AIDS infections, among other diseases.

On the whole, HBV incidence rate in Albania was 9 cases for 100,000 population in the year 2012 (recent data are scarce), whereas the incidence among PWID community is said to be considerably higher^{xxx}.

The prevention and treatment of narcotic drugs abuse and also harmful use of alcohol in Albania is reflected in the priorities of the national strategies, including the NSDI II 2016-2020, Pillar 3: Investing in People and Social Cohesion, component 11.2: A Stronger, More Accessible Health Care System, and the already adopted National Strategy on Health: Albania 2016-2020.

As a matter of fact, these issues related to such vulnerable groups comprising problematic drug users are included in specific objectives of the National Health Strategy and also in the Anti-drugs National Strategy 2017-2020 (draft) and the recently adopted Action Plan Against Cultivation and Trafficking of Cannabis in Albania.

All in all, progress has been achieved in Albania for addressing the needs of the communities affected by narcotics and harmful alcohol use, with a negative impact on the quality of life.

Geographical distribution of selected vulnerable groups in Albania¹⁴⁹

Below is presented the geographical distribution of selected vulnerable groups in Albania and a useful indicator of access to health care services based on the findings reported in the ADHS 2017-18.

Geographical distribution of selected vulnerable groups in Albania (% of population) and an indicator of access to basic health care (ADHS 2017-18, LSMS 2012, INSTAT)¹³⁰

DISTRICT	Absolute poverty*	Illiteracy[†]	Disabilities in >15 years	Roma or Egyptian	Children at risk[‡]	Elderly	Distance from HC[¶]
Tirana	14.2	2.2/15.3	5.1	2.8	13.6	12.2	16
Shkodra	15.7	2.2/23.7	7.9	4.3	9.8	14.4	18
Lezha	17.5	2.7/21.5	7.3	2.5	14.6	13.4	21
Kukesi	21.8	1.7/20.0	7.2	0.5	9.6	10.2	20
Korca	12.2	2.5/16.9	6.8	6.6	16.5	16.2	14
Gjirokastra	10.7	2.5/17.9	8.7	1.3	9.6	18.4	17
Fieri	17.5	3.4/18.1	7.0	4.3	20.5	14.1	20
Elbasani	10.7	4.9/20.4	7.6	4.0	20.7	12.2	19
Durresi	16.2	1.6/22.0	6	2.6	15.4	12.7	14
Dibra	13	2.8/24.6	6.3	1.2	17.1	11.1	20
Berati	12.7	2.1/20.7	7.8	1.8	23.8	14.1	14
Vlora	11.7	1.3/20.7	7.8	1.2	17.7	15.9	18

* Consuming less than 4891 Leke per month per capita.

[†]Not able to read/less than basic education.

[‡]Children under 18 years who live without at least one biological parents.

[¶]Average distance from the nearest health centre in minutes.

On the other hand, below is presented a matrix which summarizes the main criteria of at-risk groups for health vulnerability identified in the Albanian context in the framework of the “Health Vulnerability Study” conducted by the SDC project “Health for All” in 2018 (and subsequently published in 2019).

Health vulnerability categories (population subgroups) identified in the Albanian context¹⁶⁷

At-risk groups for health vulnerability identified in the Albanian context	Criteria	Most vulnerable sub-groups: at least one criterion
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i. Older people	• Aged 65years and above • Retired	• Social pension only • Living alone (including widowed) • Loss of functional abilities/lack of autonomy
ii. Disabled	• Under the disability assistance scheme	• Women • Living alone • Continuous need of assistance/care
iii. Sick people	• At least 2 diagnosed chronic conditions	• Unemployed • Homeless
iv. Poor people	• Under the social assistance scheme	• Homeless • Social assistance
v. Women	• Females aged >18 years	• Head of family • Unemployed • Homeless • Victims of violence/abuse • Victims of trafficking
vi. Children	• Age 0-18 years	• Orphans • Child labor • Victims of trafficking
vii. Roma and Egyptian community	• Self declared Roma and/or Egyptian ethnicity	• Roma/Egyptian • Women

Conversely, below is presented a gender-based analysis about health-related needs and access to care of some vulnerable groups in Albania, according to the same “Health Vulnerability Study” described above (the report of this study was published in 2019). The selected vulnerable categories in this analysis included the elderly, the poor, disabled individuals, Roma community, people living with HIV/AIDS, problematic drug users, as well as the LGBTQ+ community.

The prevalence of most chronic conditions is higher among older women than men, regardless of a lower life expectancy in men largely due to an excessive risk of some frequent types of cancers and cardiovascular diseases. Furthermore, the prevalence of unhealthy behavioral/lifestyle factors including smoking and alcohol consumption is higher in men than in women. Also, men display lower utilization rates of health care compared to women.

Regarding the poor, there are more head of family women among those living in absolute poverty. More importantly, women living in absolute poverty have more children to take care of. As a matter of fact, women in lowest wealth quintile experience much more frequent problems accessing health care, and are less aware about disease prevention programs.

Within the Roma community, education attainment among women is lower compared to men. In addition, there is a high prevalence of adolescent pregnancies among Roma women compared to the general population in Albania.

A gender-based analysis about health-related needs and access of some vulnerable groups in Albania¹⁶⁷

CATEGORY	WOMEN	MEN
Elderly	Prevalence of most chronic conditions is higher. Starting from lower rates in younger age tend to surpass men at older age Mobility is lower and life space is more limited Mental health issues including depression are more prevalent. Starting from lower rates in younger age tend to surpass men at older age Inability to pay for drugs is higher	Lower life expectancy (mostly because higher risk of some frequent cancers and heart diseases) Higher smoking and drinking rates Lower utilization rates of health care compared to women
The poor	There are more head of family women among those living in absolute poverty. Women living in absolute poverty have more children to take care of. Women in lowest wealth quintile report poorer perinatal care Women in lowest wealth quintile experience much more frequent problems accessing health care, including taking permission to go. Women in lowest wealth quintile are less aware about disease prevention programs	Similarly to women there is observed a higher prevalence of chronic diseases, disabilities and mental issues among men of lowest quintile. Lower needs for reproductive health care compared to women Lower utilization of health care compared to women. High pressure to secure employment and family income Alcohol abuse and smoking at much higher rates compared to women
Disabled	Reported disabilities are more frequent among women.	
Roma	Education attainment among Roma women is lower compared to Roma men The mobility disabilities are more frequent among Roman women compared to Roma men High prevalence of adolescent pregnancies Lower rates of antenatal and post natal care compared top general population of Albanian women.	
HIV/AIDS	Higher stigma about HIV/AIDs in women	Higher prevalence among men
Drug Users		Much higher prevalence among men.
LGBTQ+		Predominantly men. Higher risks of HIV and STI infections.

Prioritization of vulnerable groups in Albania

Based on the “Health Vulnerability Study” but also on the scientific literature review at an international scale and also the recent information from Albania, the Table below presents a practical matrix (grid) for prioritizing the major vulnerable population groups in Albania, especially based on their health needs and the related challenges.

The following vulnerable groups are identified which are relevant for Albania (in priority order):

- i) older people (especially old women, the poor, isolated, those with loss of autonomy, or with multimorbidity);
- ii) disabled individuals;
- iii) people with diseases (especially those with multimorbidity, or mental disorders);
- iv) women (particularly family heads, the poor, violated, or victims of traffic);
- v) children (especially from poor families, orphans, street children, or victims of traffic);
- vi) ethnic minorities (Roma and Egyptians);
- vii) people living with HIV/AIDS;
- viii) commercial sex workers;
- ix) problematic drug users;
- x) prisoners;
- xi) LGBTQ+ community.

Assessment form for prioritization of vulnerable groups in the health field in Albania¹⁶⁷

At-risk groups for health vulnerability identified in the Albanian context	Population size*	Degree of health needs*	Degree of vulnerability for accessing health services*	TOTAL*
viii. Older people	25	25	50	100
ix. Disabled	15	25	50	90
x. Sick people	20	25	40	85
xi. Women	25	20	40	85
xii. Children	15	20	40	75
xiii. Roma and Egyptian community	5	20	50	75
xiv. People living with HIV/AIDS	5	20	40	65
xv. Commercial sex workers	5	10	35	50
xvi. Problematic drug users	5	10	30	45
xvii. Prisoners	5	10	25	40
xviii. LGBT community	5	10	20	35

**A score from 1 to 25 was assigned for each of the first two columns (population size and degree of health needs), whereas a score from 1 to 50 was assigned for the third column (degree of vulnerability for accessing health services). Next, a summary (total) score was calculated referred to as “health vulnerability” score (last column in the table).*

Training of professionals for addressing health needs of vulnerable groups

According to a United Nations Population Fund (UNFPA), the training of health professionals in Albania is crucial for addressing the health needs of vulnerable groups¹⁵⁰. This report also emphasizes that the focus on the elderly should be a new agenda for health and social care, as Albanian population is aging at a very high rate. At the same time, the report does not leave aside focus on human rights and reproductive health rights (UNFPA, 2020).

Regarding the specific role of health personnel in Albania, while the evidence on the existing training gaps is scarce, it should be pointed out that, similar to other countries, health professionals in Albania require specific training to effectively address the health needs of vulnerable groups. Below are summarized some key training needs for health professionals in this regard, according to international recommendations:

- Cultural Competence^{xxxiii}: Health professionals need training to develop cultural competence, enabling them to understand and respect the diverse cultural backgrounds, beliefs, and values of vulnerable populations. This training should focus on promoting cultural sensitivity, effective communication, and addressing potential biases or stereotypes that may hinder the delivery of equitable and patient-centered care.
- Trauma-Informed Care^{xxxiv}: Vulnerable groups, such as survivors of violence or refugees, may have experienced trauma. Health professionals need training to understand the impact of trauma and develop skills to provide trauma-informed care. This includes creating a safe and supportive environment, recognizing trauma triggers, and employing appropriate communication and intervention strategies.

^{xxxiii} <https://hpi.georgetown.edu/cultural/>.

^{xxxiv} <https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/>.

- Health Literacy¹⁵¹: Many vulnerable groups have limited health literacy, which affects their understanding of health information and their ability to navigate healthcare systems. Health professionals should receive training on health literacy, ensuring they can communicate effectively, use plain language, and employ visual aids to enhance patient comprehension and engagement.
- Identifying Social Determinants of Health¹⁵²: Health professionals should be trained to identify and address the social determinants of health that contribute to vulnerability. This includes understanding the impact of factors such as poverty, housing instability, discrimination, and access to resources on health outcomes. Training can help professionals screen for social determinants, provide appropriate referrals, and advocate for policies that address these underlying causes.
- Trauma and Mental Health¹⁵³: Vulnerable groups often experience higher rates of mental health issues. Health professionals should receive training on trauma-informed approaches and evidence-based interventions for mental health conditions prevalent among these populations. This training can include techniques for screening, assessment, and referral to mental health services.
- Interdisciplinary Collaboration¹⁵⁴: Addressing the complex health needs of vulnerable groups often requires interdisciplinary collaboration. Health professionals should receive training on working effectively as part of a multidisciplinary team, including professionals from social work, psychology, public health, and other relevant fields. Training should focus on fostering effective communication, understanding different roles and perspectives, and coordinating care to ensure comprehensive support.
- Advocacy and Policy Engagement¹⁵⁵: Health professionals can play a crucial role in advocating for policy changes and initiatives that address the health needs of vulnerable groups. Training should equip them with knowledge and skills related to health policy, advocacy strategies, and community engagement. This can empower health professionals to actively participate in shaping policies and programs that promote equity and improve health outcomes for vulnerable populations.

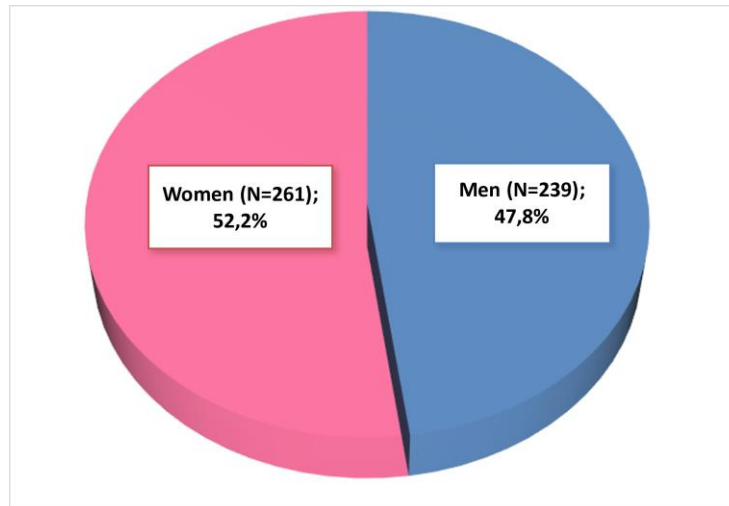
Continuous professional development and ongoing training opportunities are essential to keep health professionals updated on emerging best practices, research, and policies related to addressing the health needs of vulnerable groups. By investing in comprehensive training, health professionals can better serve and advocate for the well-being of these populations.

5.2. Results from quantitative research

Distribution of socio-demographic characteristics

Of 500 study participants, 239 (47.8%) were males and 261 (52.2%) were females (Figure 1).

Figure 1. Gender distribution of study participants



Overall, mean age of study participants was about 56.3 ± 15.2 years. Median age was 58.5 years (interquartile range: 48-67 years). The youngest individual was 18 years old, whereas the oldest participant was 87 years old (Table 1).

Table 1. Age distribution among study participants (N=500)

Number	Valid	500
	Missing	0
Mean		56.27
Std. Deviation		15.205
Minimum		18
Maximum		87
Percentiles	25	48.00
	50	58.50
	75	67.00

Regarding the place of residence, 109 (21.8%) of participants were from urban areas, whereas 242 (48.4%) individuals were from rural areas (Table 2).

Table 2. Distribution of study participants by place of residence

Place of residence	Frequency	Percent	Cumulative Percent
Urban	109	21.8	21.8
Rural	242	48.4	70.2
Periurban	149	29.8	100.0
Total	500	100.0	

As for the years of formal schooling (Table 3), overall, mean years of education among study participants was about 10.3 ± 3.6 years. Median years of education was 10 years (interquartile range: 8-12 years). The least educated participant had one year of formal schooling only, whereas the most educated individual had 23 years of formal education (Table 3).

Table 3. Distribution of years of formal schooling among study participants

Number	Valid	499
	Missing	1
Mean		10.31
Std. Deviation		3.620
Minimum		1
Maximum		23
Percentiles	25	8.00
	50	10.00
	75	12.00

Regarding the distribution of education categorized into low (0-8 years of formal schooling), middle (9-12 year) and high (≥ 13 years of formal schooling), on the whole, 45% of study participants were low educated, 36% had middle education, and only 19% reported a high educational level (Table 4).

Table 4. Distribution of education among study participants

Education	Frequency	Percent	Cumulative Percent
Low (0-8 years)	225	45.1	45.1
Middle (9-12 years)	179	35.9	81.0
High (≥ 13 years)	95	19.0	100.0
Total	499	100.0	

Concerning the distribution of employment status, overall, 34% of study participants were employed, 28% were unemployed, and the remaining 38% of individuals were retired (Table 5).

Table 5. Distribution of employment status among study participants

Employment	Frequency	Percent	Cumulative Percent
Employed	170	34.0	34.0
Unemployed	140	28.0	62.0
Retired	190	38.0	100.0
Total	500	100.0	

Regarding the distribution of marital status, the vast majority of study participants were married (about 77%), around 8% were single, and almost 13% were widowed (Table 5).

Table 6. Distribution of marital status among study participants

Marital status	Frequency	Percent	Cumulative Percent
Single	41	8.2	8.2
Married	386	77.2	85.4
Divorced	7	1.4	86.8
Widowed	63	12.6	99.4
Co-habiting	3	0.6	100.0
Total	500	100.0	

The absolute majority of study participants (almost 95%) were ethnic Albanians, whereas about 5% of individuals were pertinent to Roma and/or Egyptian communities (Table 7).

Table 7. Distribution of ethnicity among study participants

Ethnicity	Frequency	Percent	Cumulative Percent
Albanian	473	94.6	94.6
Roma/Egyptian	26	5.2	99.8
Other	1	0.2	100.0
Total	500	100.0	

Participants were asked a series of questions aiming at assessing their economic situation (or, poverty level). When asked about their self-perceived poverty level (Table 8), 16% of individuals reported to be very poor and further 36% reported to be poor. Conversely, only 7.8% of participants reported to be not poor.

Table 8. Distribution of self-perceived poverty among study participants

Self-perceived poverty	Frequency	Percent	Cumulative Percent
Very poor	80	16.0	16.0
Poor	177	35.5	51.5
Average	203	40.7	92.2
Not poor	25	5.0	97.2
Not poor at all	14	2.8	100.0
Total	499	100.0	

When asked to compare their economic situation with the average income in Albania (Table 9), about 38% of study participants reported to have a lower income than the average families in Albania and further 12% reported to have a much lower oncome than the national average. On the other hand, only 8% of individuals reported to have a higher income than the national average.

Table 9. Distribution of relative income among study participants

Relative income	Frequency	Percent	Cumulative Percent
Much higher	3	0.6	0.6
Higher	38	7.6	8.2
Almost the same	208	41.6	49.8
Lower	189	37.8	87.6
Much lower	62	12.4	100.0
Total	500	100.0	

As for the economic assistance (*“ndihma ekonomike”*), overall, about 19% of study participants received economic assistance from the government (Table 10).

Table 10. Distribution of economic assistance among study participants

Economic assistance	Frequency	Percent	Cumulative Percent
No	406	81.2	81.2
Yes	94	18.8	100.0
Total	500	100.0	

Regarding the categorization of study participants according to their vulnerability characteristics (Table 11), about 28% of individuals were categorized as poor, around 14% were categorized as sick, 9% as disabled, around 11% were living in remote areas of the country,

whereas the remaining 37% of participants had at least two of the aforementioned characteristics of vulnerability (poor, sick, disabled, remote areas).

Table 11. Categorization of study participants according to their vulnerability characteristics

Category	Frequency	Percent	Cumulative Percent
Poor	141	28.2	28.2
Sick	72	14.4	42.6
Disabled	45	9.0	51.6
Remote areas	57	11.4	63.0
At least two	185	37.0	100.0
Total	500	100.0	

General health status

Concerning the general health status (Table 12), about 8% of individuals reported a very poor health condition and further 20% reported a poor health status. On the other hand, only 13% of individuals reported a very good health status in general.

Table 12. Distribution of self-perceived health status among study participants

Health status	Frequency	Percent	Cumulative Percent
Very poor	38	7.6	7.6
Poor	101	20.2	27.8
Average	163	32.6	60.4
Good	132	26.4	86.8
Very good	66	13.2	100.0
Total	500	100.0	

Regarding the prevalence of existing diseases (Table 13), more than half of study participants (about 55%) reported the presence of at least condition/disease, whereas the remaining 45% did not have any diseases.

Table 13. Distribution of current diseases/conditions among study participants

Diseases	Frequency	Percent	Cumulative Percent
No	226	45.2	45.2
Yes	274	54.8	100.0
Total	500	100.0	

Cardiovascular diseases including hypertension included the most prevalent disease group (37%) among individuals who reported the presence of at least one disease, followed by neurological diseases and other mental health problems (28%), and next diabetes (17%).

Of note, almost one-fifth of study participants (19%) reported the presence of at least two conditions/diseases. Hence, the issue of multimorbidity was a serious concern in a non-trivial proportion of study participants.

Emergency health services (individual level)

When asked whether they had sought services at the National Center of Medical Emergencies (NCME), 23% of participants reported that they had sought services near this center for many times. Further 25% of individuals reported that they had received services at least once from this center. Conversely, almost half of individuals (about 49%) had never sought services from NCME (Table 14).

Table 14. Have you ever sought services at the National Center of Medical Emergencies (NCME)?

Services sought at NCME	Frequency	Percent	Cumulative Percent
Yes, many times	115	23.0	23.0
Yes, at least once	127	25.4	48.4
No	246	49.2	97.6
Don't know	12	2.4	100.0
Total	500	100.0	

When asked whether they had called the number 127 (pertinent to the NCME), about 16% of participants reported that they had called this number many times and further 25% of individuals reported that they had called this number at least once. On the other hand, more than half of individuals (about 55%) had never called the number of NCME (Table 15).

Table 15. Have you ever called the number 127 (pertinent to the NCME)?

Called 127 (NCME)	Frequency	Percent	Cumulative Percent
Yes, many times	81	16.2	16.2
Yes, at least once	127	25.4	41.6
No	277	55.4	97.0
Don't know	15	3.0	100.0
Total	500	100.0	

Among those who answered positively regarding the call of number 127 (NCME), more than half (about 59%) of participants reported that they had always received a response from this number and further 18% of individuals reported that they had received sometimes an answer from this number. On the other hand, about 17% of individuals had never received an answer from the number of NCME (Table 16).

Table 16. If you called the number 127 (NCME), did you receive an answer from them?

Answer from no. 127 (NCME)	Frequency	Percent	Cumulative Percent
Yes, always	161	58.5	58.5
Yes, sometimes	49	17.8	76.4
No	47	17.1	93.5
Don't know	18	6.5	100.0
Total	275	100.0	

Among those who answered positively regarding the services received from NCME, about half of participants (50%) reported that they were very satisfied with the services provided by NCME and further 31% of individuals reported that were satisfied with the services received from this center. On the other hand, about 3% of individuals were only a little satisfied and further 2% were not satisfied at all with the services provided by the NCME (Table 17).

Table 17. If you called the number 127 (NCME), were you satisfied with the services provided by the NCME?

Satisfied with NCME services	Frequency	Percent	Cumulative Percent
Very satisfied	114	50.4	50.4
Satisfied	70	31.0	81.4
Average	31	13.7	95.1
A little	6	2.7	97.8
Not satisfied at all	5	2.2	100.0
Total	226	100.0	

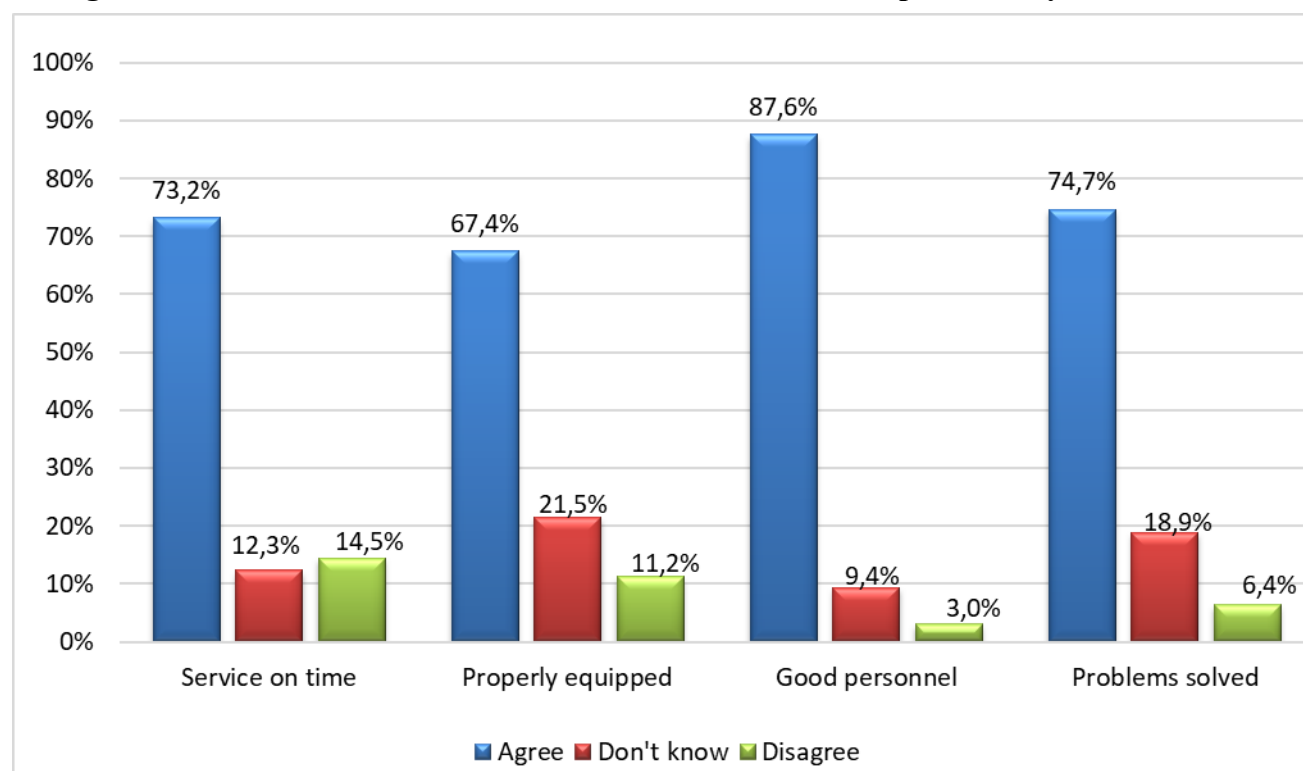
Among those who answered positively regarding the services received from NCME, almost three-quarters (73%) of participants agreed that the services provided by NCME were on a timely manner, whereas about 15% disagreed with this statement (Figure 2).

Furthermore, more than two-thirds (67%) of individuals agreed that the ambulances were properly equipped, whereas 11% of participants disagreed with this statement (Figure 2).

In addition, about 88% of participants agreed that the personnel providing emergency services was good, whereas only 3% disagreed with this statement (Figure 2).

Also, three-quarters of participants (75%) agreed that their medical problems/issues were solved by the NCME, whereas 6% of individuals disagreed with this statement (Figure 2).

Figure 2. Satisfaction with selected dimensions of the services provided by NCME



When asked whether they had received emergency services regardless of calling the number 127 (pertinent to the NCME), 87% of participants reported that they had received emergency services, whereas about 12% of individuals reported that they had never received emergency services (Table 18).

Table 18. Have you ever received emergency medical services, regardless of calling the number 127 (pertinent to the NCME)?

Received emergency services	Frequency	Percent	Cumulative Percent
No	57	12.3	12.3
Yes	402	87.0	99.4
Don't know	3	0.6	100.0
Total	462	100.0	

Among those who reported to have used emergency services regardless of calling the number 127 (pertinent to the NCME), about 24% of participants reported that they attended emergency

services at their place of residence; around 52% received emergency services at the primary health care centers, whereas the remaining 23% of individuals received emergency services at the hospital (Table 19).

Table 19. Where have you attended emergency services?

Place of receiving emergency services	Frequency	Percent	Cumulative Percent
Emergency services at place of residence	102	24.3	24.3
Health center	219	52.3	76.6
Hospital	98	23.4	100.0
Total	419	100.0	

Among those who reported to have used emergency services regardless of calling the number 127 (pertinent to the NCME), more than half (about 58%) of participants reported that they were very satisfied with the emergency services received and further 27% were satisfied with the emergency services received. Conversely, 1.9% of individuals were only a little satisfied and further 1.7% of participants were not satisfied at all with the emergency services received (Table 20).

Table 20. How satisfied were you with the services received?

Satisfaction with emergency services	Frequency	Percent	Cumulative Percent
Very satisfied	244	57.5	57.5
Satisfied	114	26.9	84.4
Average	51	12.0	96.5
A little	8	1.9	98.3
Not at all	7	1.7	100.0
Total	424	100.0	

Among those who answered positively regarding the use of emergency services regardless of calling the number 127 (pertinent to NCME), three-quarters (76%) of participants agreed that the health facility providing emergency services is close to their respective place of residence, whereas about 22% of individuals disagreed with this statement (Figure 3).

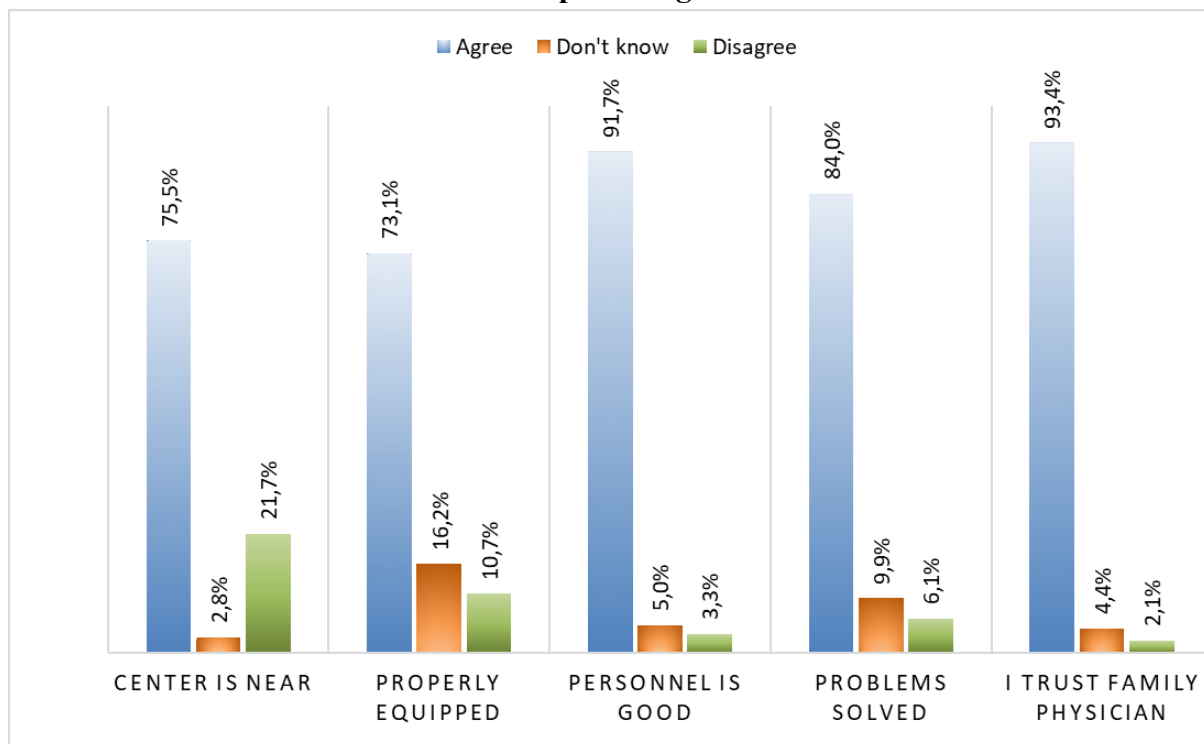
Furthermore, about 73% of individuals agreed that the health facilities providing emergency services were properly equipped, whereas 11% of participants disagreed with this statement (Figure 3).

In addition, about 92% of participants agreed that the personnel providing emergency services was good, whereas only 3.3% disagreed with this statement (Figure 3).

Also, around 84% of participants agreed that their medical problems/issues were solved by the health facilities providing emergency services, whereas 6% of individuals disagreed with this statement (Figure 3).

Of note, the absolute majority of study participants (about 93%) reported that they trusted their family physicians, whereas only 2% did not agree with this statement (Figure 3).

Figure 3. Satisfaction with selected dimensions of the emergency services at different health facilities providing such services



When asked whether, in the past year, individuals had been unable to receive emergency services when needed, almost one-third of participants reported that they were unable to receive emergency services when needed, whereas the remaining 68% reported that they were able to receive emergency services when needed (32%) (Table 21).

Table 21. In the past year, have you been unable to receive emergency services when needed?

Unable to receive emergency services	Frequency	Percent	Cumulative Percent
No	336	67.7	67.7
Yes	160	32.3	100.0
Total	496	100.0	

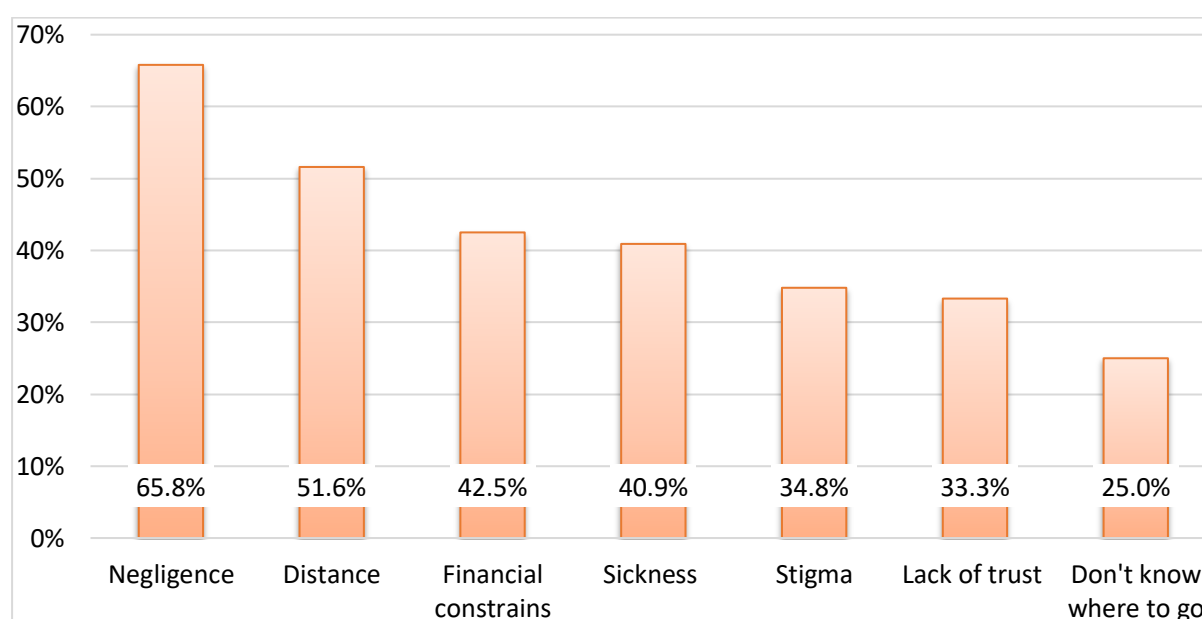
When asked about the reasons for not being able to receive emergency services when needed (during the past year), almost two-thirds (about 66%) of participants reported that negligence was the main reason for not receiving such services (Figure 4).

The second main reason for the inability to receive emergency service when needed was the distance to health facilities providing emergency services which was reported by 52% of study participants who reported to have not been able in the past year to receive emergency services when needed (Figure 4).

The third main reason for the inability to receive emergency services when needed consisted of financial constraints, which was reported by 43% of individuals who reported inability to receive emergency services when needed (Figure 4).

The fourth reason for the inability to receive emergency services when needed concerned medical problems (sicknesses) which prohibited 41% of individuals from receiving emergency services when needed (Figure 4).

Figure 4. Reasons for not being able to receive emergency services in the past year when needed



The fifth reason involved stigma which was reported by about 35% of individuals who reported inability to receive emergency services during the past year when needed (Figure 4).

The sixth reason was the lack of trust which was reported by 33% of individuals who reported inability to receive emergency services during the past year when needed (Figure 4).

On the other hand, one out of four participants (25%) reported that they did not know where to go when they needed emergency services in the past year (Figure 4).

When asked about the communication of health personnel (Table 22), about 41% of participants reported that they perceived as very good the communication of health professionals and further 40% perceived it as good. On the other hand, 3.6% of individuals reported a bad communication of health personnel and further 1.2% of participants reported a very bad communication style/manner of health personnel providing emergency services in different health facilities across Albania.

Table 22. How do you consider the communication of health personnel?

Communication of health personnel	Frequency	Percent	Cumulative Percent
Very good	206	41.2	41.2
Good	199	39.8	81.0
Average	71	14.2	95.2
Bad	18	3.6	98.8
Very bad	6	1.2	100.0
Total	500	100.0	

Health emergencies (population/community level)

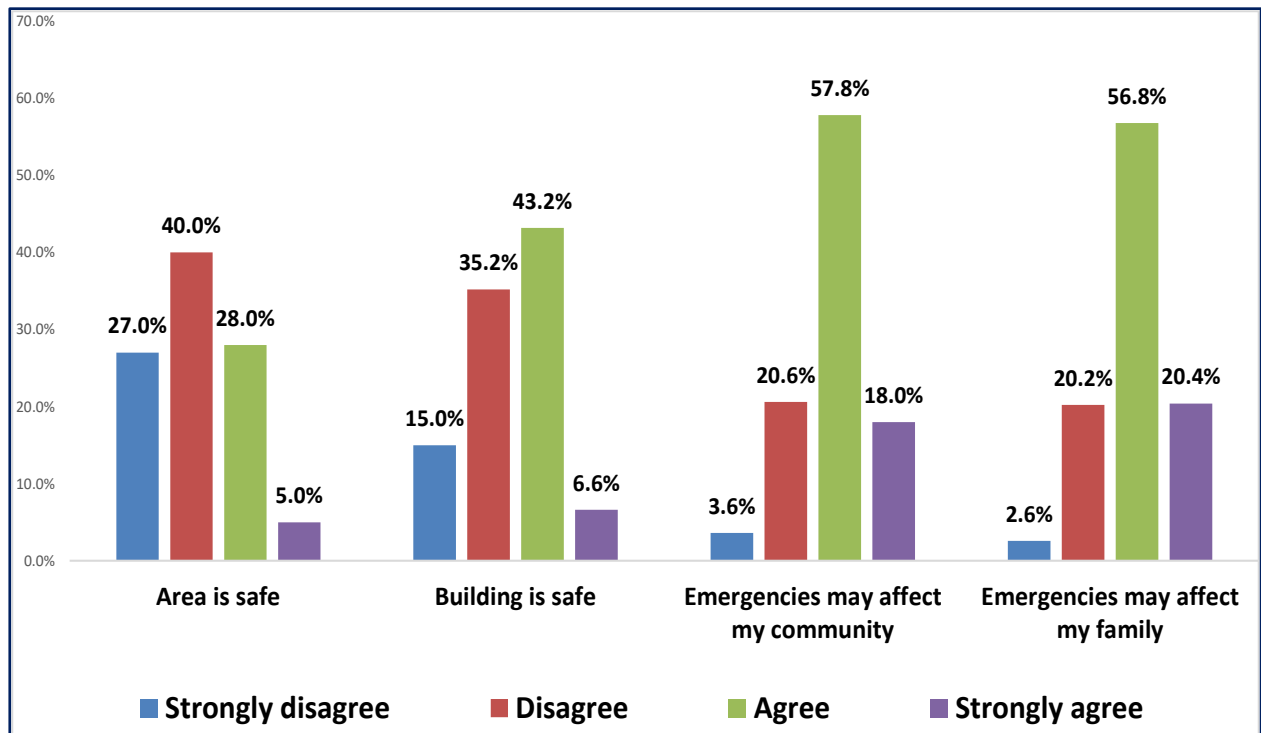
Subsequently, all study participants were asked a series of questions regarding health emergencies at a community or society level. These include a natural and/or human disaster situation, or an epidemic/pandemic situation (earthquake, fire, flood, mass accident, landslide, explosive explosion, storm, civil war, but also any epidemic outbreak, i.e., mass infection, etc.) which seriously endangers people's lives.

Four questions were asked about self-perceived risk in cases of such community emergencies: i) one about perceived safety of the area where participants resided/lived; ii) perceived safety of the building where participants lived; iii) perceived risk of community impact in case of emergencies; iv) perceived risk of own family impact in case of emergencies. Findings from self-reported perceived risk regarding these four dimensions are presented in Figure 5.

When asked about the self-perceived safety of the living area, 27% of participants felt very unsafe and further 40% felt unsafe. Conversely, 28% felt safe and only 5% felt very safe with their respective living areas (Figure 5).

When asked about the self-perceived safety of the buildings where participants lived, 15% of them felt very unsafe and about 35% felt unsafe. On the other hand, about 43% of participants felt safe and about 7% felt very safe (Figure 5).

Figure 5. Self-perceived risk in cases of community emergencies (disasters)

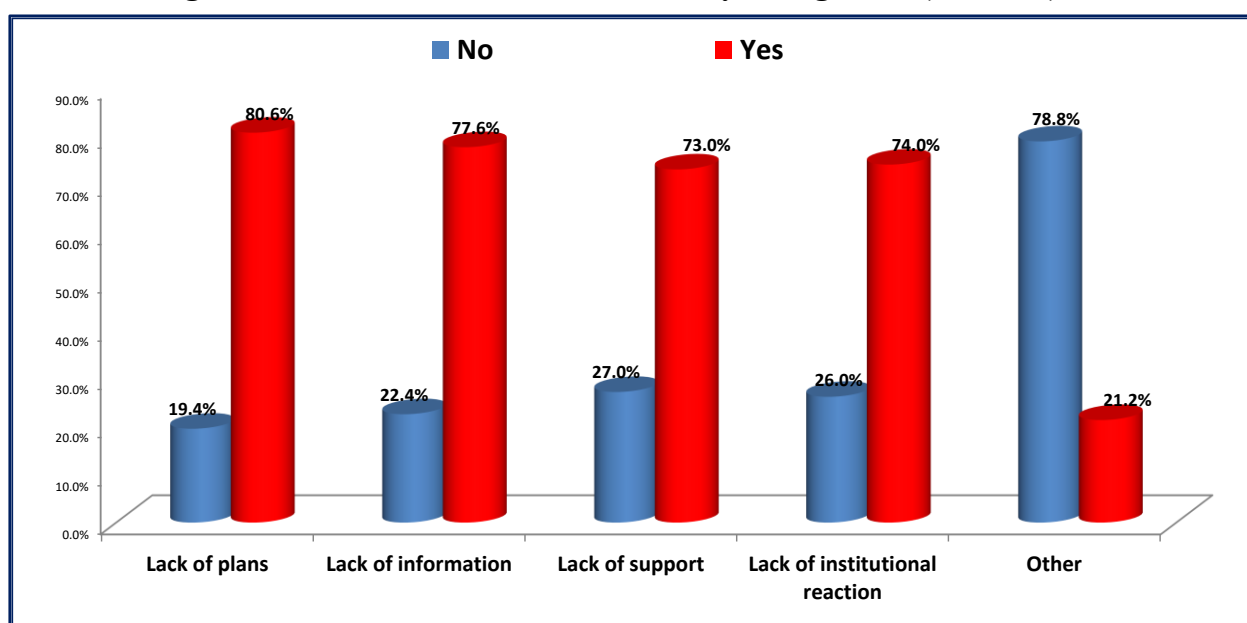


When asked about the self-perceived community impact in case of emergencies, about 18% of individuals perceived a high risk of negative impact at community level and further 58% of participants perceived risk of negative community impact. Conversely, about 4% did not perceive any risk at all, whereas 21% did not perceive any significant risk of negative impact at community level in case of emergencies (Figure 5).

When asked about the self-perceived own family impact in case of emergencies, about 21% of individuals perceived a high risk of negative impact on their own families and further 57% of participants perceived risk of negative family impact. On the other hand, about 3% of individuals did not perceive any risk at all, whereas 20% did not perceive any significant risk of negative impact on their own families in case of emergencies (Figure 5).

Next, participants who were concerned with the health emergencies at a community or society level were asked about selected aspects that made them worried/concerned about such events (Figure 6).

Figure 6. Main concerns about community emergencies (disasters)



Lack of local plans for preparation in case of emergencies was reported by almost 81% of participants, whereas the remaining 19% did not perceive this as a concern (Figure 6).

Lack of information about proper and prompt preparation against emergencies was reported by about 78% of participants, whereas the remaining 22% of individuals did not perceive this as a serious issue (Figure 6).

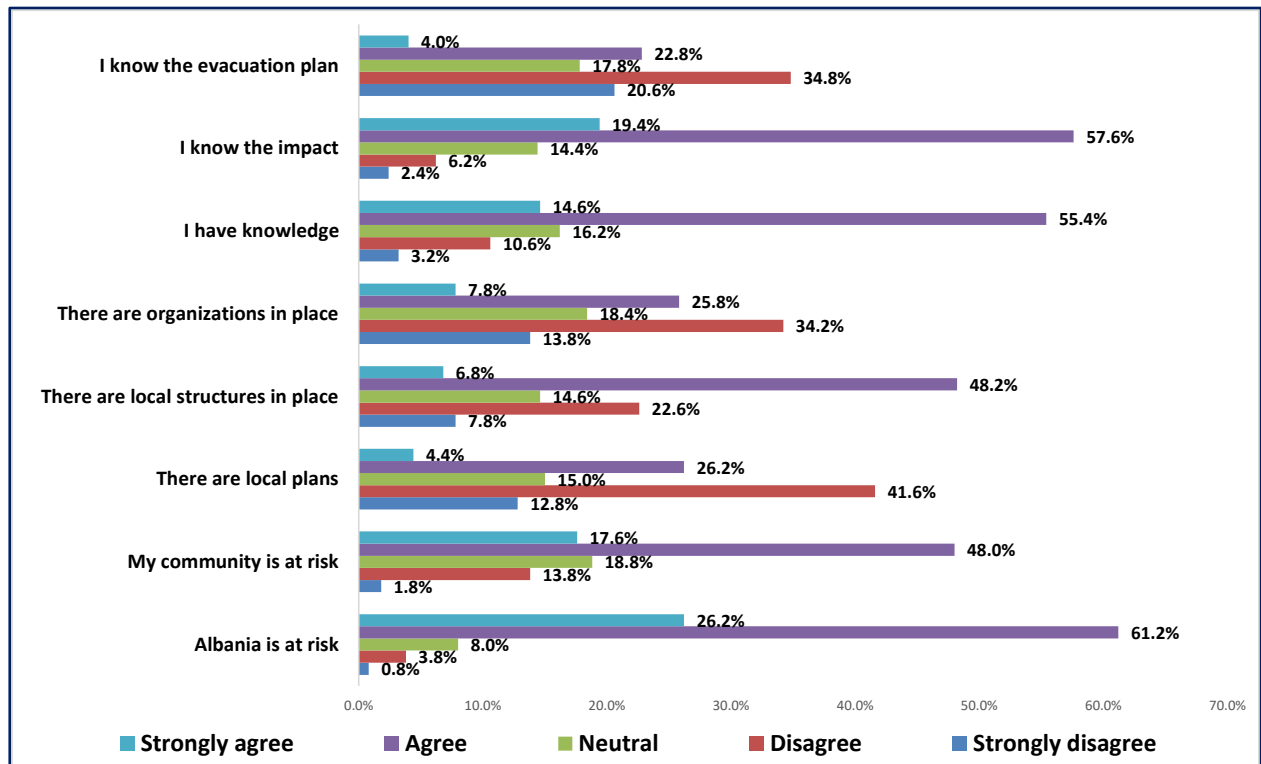
Lack of adequate support from local government in case of emergencies was reported by 73% of participants, whereas the remaining 27% of individuals did not perceive this as a challenge (Figure 6).

Lack of prompt institutional reaction in cases of emergencies was reported by 74% of participants, whereas 26% of individuals did not perceive this as a serious barrier (Figure 6).

Furthermore, about 21% of participants reported other concerns in cases of emergencies (Figure 6), including living alone, long distances, commuting difficulties, lack of community participation, lack of social cohesion, etc.

Next, participants were asked a series of questions assessing their level of knowledge and awareness about emergencies at community/societal level. More specifically, participants were asked about the following aspects (Figure 7): i) whether Albania is considered at risk for community emergencies; ii) whether participants considered that their communities are at risk for emergencies; iii) whether they knew about the existence of community plans supporting the management and control of emergencies; iv) whether they knew about the existence of municipal structures capable of responding in case of emergencies; v) whether they knew about the presence of organizations (including religious associations) informing about preparedness, management and control of emergencies; vi) whether they knew about the risks involved with emergencies; vii) whether they knew about the impact of emergencies; viii) and whether they knew about the existence of evacuation plans in case of community emergencies (Figure 7).

Figure 7. Knowledge and awareness about community emergencies (disasters)



Overall, about 26% of participants strongly agreed and further 61% agreed with the statement that “*Albania is at risk for emergencies*”. Conversely, 0.8% strongly disagreed and further 3.8% disagreed with this statement (Figure 7).

About 18% of participants strongly agreed and further 48% agreed with the statement that “*I know that the community I live in is at risk for emergencies*”. Conversely, 1.8% strongly disagreed and further 13.8% disagreed with this statement (Figure 7).

Around 4% of participants strongly agreed and further 26% agreed with the statement that “*I know that there are plans in my community which help facing the emergencies*”. Conversely, about 13% strongly disagreed and further 42% disagreed with this statement (Figure 7).

About 7% of participants strongly agreed and further 48% agreed with the statement that “*I know that there are municipal structures capable to support and respond in case of emergencies*”. Conversely, about 8% strongly disagreed and further 23% disagreed with this statement (Figure 7).

Around 8% of participants strongly agreed and further 26% agreed with the statement that “*I know that there are organizations which provide information on preparation and management of emergencies*”. Conversely, about 14% strongly disagreed and further 34% disagreed with this statement (Figure 7).

About 15% of participants strongly agreed and further 55% agreed with the statement that “*I have knowledge about risks involved with emergencies when they happen*”. Conversely, about 3% strongly disagreed and further 11% disagreed with this statement (Figure 7).

Approximately 19% of participants strongly agreed and further 58% agreed with the statement that “*I know the impact of emergencies when they happen*”. Conversely, 2.4% strongly disagreed and further 6.2% disagreed with this statement (Figure 7).

On the whole, 4% of participants strongly agreed and about 23% agreed with the statement that *“I am aware and informed about the evacuation plan in my area in case of emergencies”*. Conversely, about 21% strongly disagreed and further 35% disagreed with this statement (Figure 7).

Subsequently, all study participants were asked to report on their opinions regarding preparedness and response to emergency situations. More specifically, participants were asked the following (Figure 8): i) whether they had received instructions from experts about situations involving emergencies/disasters; ii) whether they had sought instructions about situations involving emergencies/disasters; iii) whether they had shown interest in the evacuation plans and shelters in cases of emergency; iv) whether they had gathered information about things they should do in emergency situations; and whether they had prepared an evacuation plan (or any other type of plan) for their families in cases of emergencies/disasters.

Only about 5% of participants strongly agreed and further 15% agreed with the statement that *“I have received instructions from experts of the field in cases of emergencies/disasters”*. Conversely, about 26% strongly disagreed and further 43% disagreed with this statement (Figure 8).

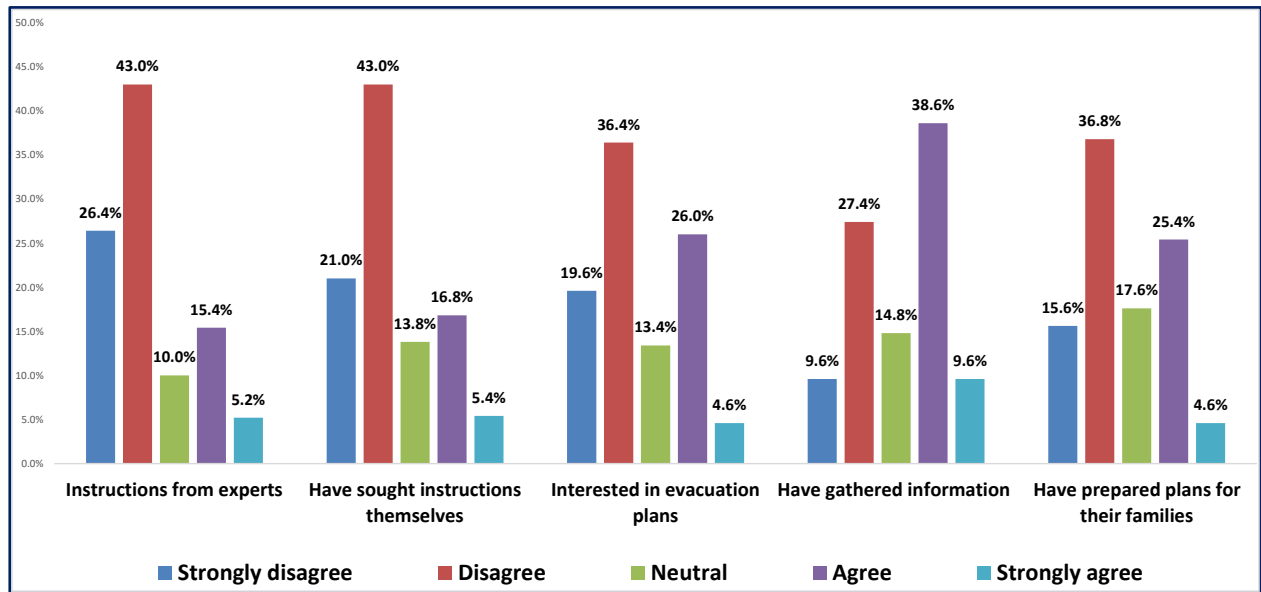
Similarly, only about 5% of participants strongly agreed and further 17% agreed with the statement that *“I have sought myself instructions about situations of emergencies/disasters”*. Conversely, 21% strongly disagreed and further 43% disagreed with this statement (Figure 8).

Furthermore, only about 5% of participants strongly agreed and further 26% agreed with the statement that *“I have been interested in the evacuation plans and sheltering in cases of emergencies/disasters”*. Conversely, 20% strongly disagreed and further 36% disagreed with this statement (Figure 8).

In addition, about 10% of participants strongly agreed and further 39% agreed with the statement that *“I have gathered information regarding things that I should do in situations of emergencies/disasters”*. Conversely, 10% strongly disagreed and further 27% disagreed with this statement (Figure 8).

Finally, about 5% of participants strongly agreed and further 25% agreed with the statement that *“I have prepared evacuation plans or other relevant plans for my family in case of emergencies/disasters”*. Conversely, 16% strongly disagreed and further 37% disagreed with this statement (Figure 8).

Figure 8. Attitudes about preparedness and response to community emergencies (disasters)



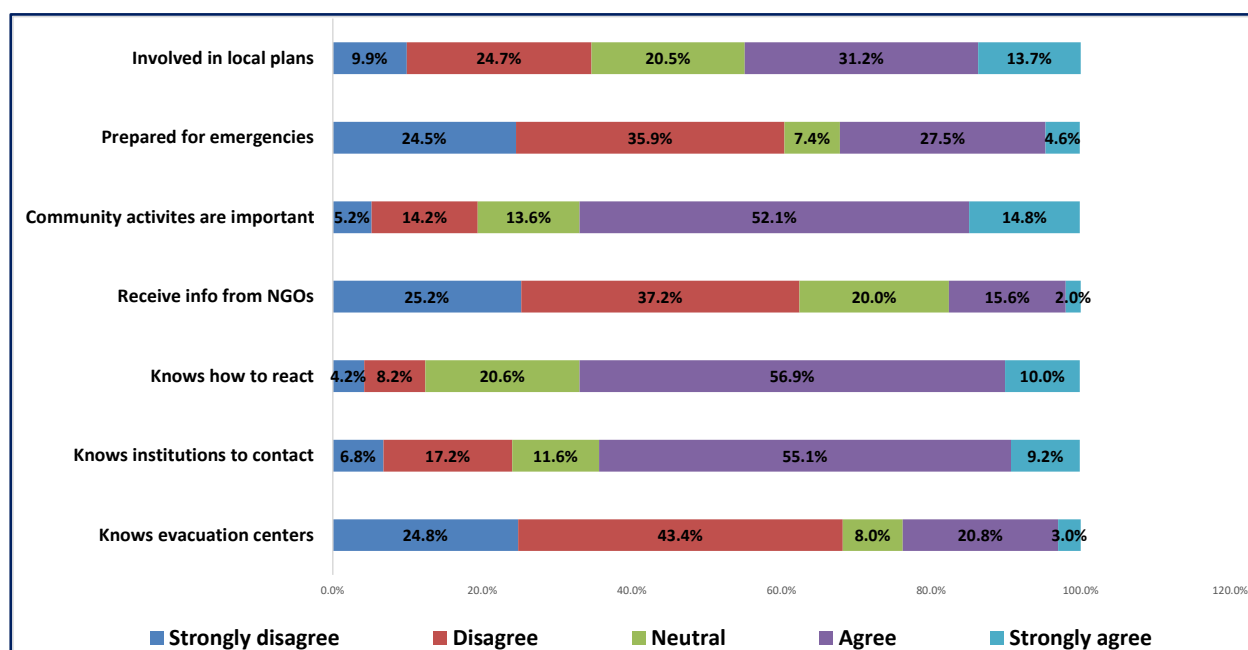
Next, participants were asked whether their families had ever been affected by any emergencies/disasters. Overall, slightly more than half of participants (about 51%) reported that their families had been affected by emergencies/disasters, whereas the remaining 49% had never been affected by any emergencies/disasters (Table 23).

Table 23. Has your family ever been affected by any emergencies/disasters?

Family affected by emergencies/disasters	Frequency	Percent	Cumulative Percent
No	243	49.0	49.0
Yes	253	51.0	100.0
Total	496	100.0	

Subsequently, participants were asked about their knowledge and attitude about adaptation and current practices for facing effectively potential emergencies/disasters. More specifically, participants were asked (Figure 9): i) whether they knew the location of shelters or evacuation centers in cases of emergencies/disasters; ii) whether they knew which governmental institutions to contact in emergency situations; iii) whether they knew how to react before, during and after situations involving emergencies/disasters; iv) whether they received from different NGOs the necessary information for adaptation measures in situations of emergencies/disasters; v) whether they were aware about the importance of community activities regarding risk reduction in emergency situations; vi) whether they were prepared (with kits or emergency bags containing essential medications, water and basic food items) in cases of emergencies/disasters; vii) and whether they had been involved in preparation of local plans for emergency response and preparedness.

Figure 9. Attitudes about adaptation and current practices for facing effectively potential emergencies/disasters



Only 3% of participants strongly agreed and further 21% agreed with the statement that “*I know the location of evacuation centers and shelters in cases of emergencies/disasters*”. Conversely, 25% strongly disagreed and further 43% disagreed with this statement (Figure 9). About 9% of participants strongly agreed and further 55% agreed with the statement that “*I know the governmental institutions that I should contact in situations of emergencies/disasters*”. Conversely, 7% strongly disagreed and further 17% disagreed with this statement (Figure 9).

Only 10% of participants strongly agreed and further 57% agreed with the statement that “*I know how to react before, during and after situations of emergencies/disasters*”. Conversely, 4% strongly disagreed and further 8% disagreed with this statement (Figure 9).

In addition, only 2% of participants strongly agreed and further 16% agreed with the statement that “*I have received information from NGOs regarding adaptation measures in situations of emergencies/disasters*”. Conversely, 25% strongly disagreed and further 37% disagreed with this statement (Figure 9).

About 15% of participants strongly agreed and further 52% agreed with the statement that “*I am aware about the importance of community activities regarding risk reduction in situations of emergencies/disasters*”. Conversely, 5% strongly disagreed and further 14% disagreed with this statement (Figure 9).

About 5% of participants strongly agreed and further 28% agreed with the statement that “*I am prepared (with kits or emergency bags containing essential medications, water and basic food supply) for situations involving emergencies/disasters*”. Conversely, 5% strongly disagreed and further 28% disagreed with this statement (Figure 9).

About 14% of participants strongly agreed and further 31% agreed with the statement that “*I am interested to be involved in development of local plans for preparedness and response to*

situations of emergencies/disasters”. Conversely, 10% strongly disagreed and further 25% disagreed with this statement (Figure 9).

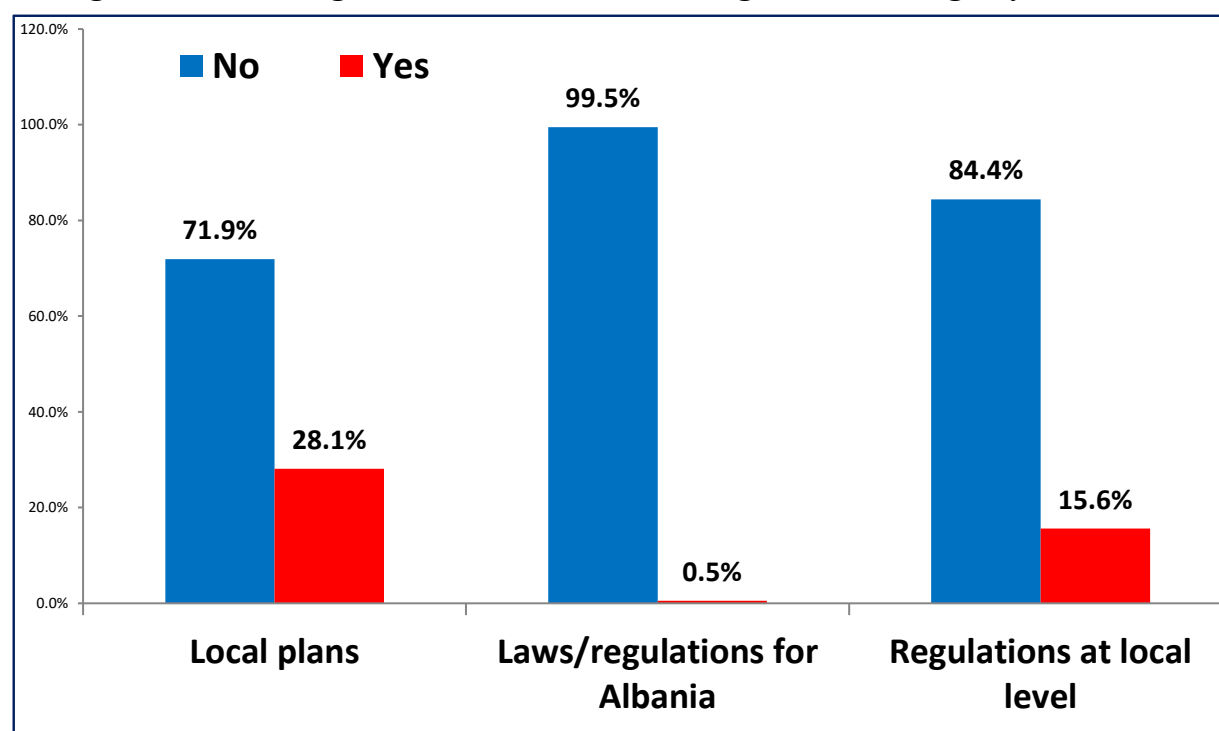
Afterwards, participants were asked about their level of knowledge and attitude toward management of emergency situations. More specifically, they were asked (Figure 10): i) whether they knew about emergency plans in their living areas; ii) whether they knew about existing laws and regulations for effective management of emergencies/disasters in Albania; iii) and whether they knew about regulations at their local communities for management of emergencies/disasters.

On the whole, only 28% of participants reported that they were aware of emergency plans in their living areas, whereas the remaining 72% did not know about the existence of any emergency plans in their respective living areas (Figure 10).

Even more importantly, only one participant (0.5% of valid responses) knew about the existing laws and regulations for effective management of emergencies/disasters in the Republic of Albania, whereas 99.5% of individuals were not aware of the existing laws and regulations about management of emergency situations (Figure 10). However, this question was answered by only 183 participants (36.6% of the total number of study participants).

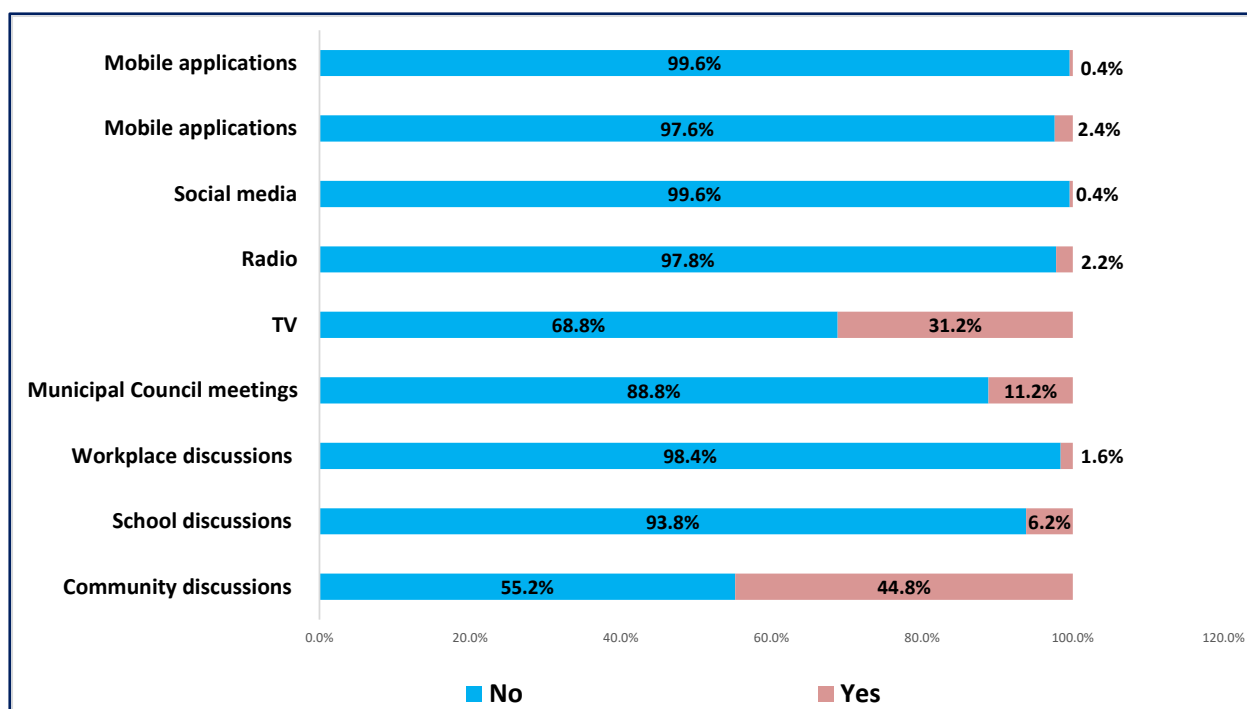
Lastly, only 16% of participants knew about the existence of local regulations for effective management of emergencies/disasters (Figure 10).

Figure 10. Knowledge and attitudes toward management of emergency situations



At the end, participants were asked about their preferred sources of information regarding the knowledge and awareness of emergency situations (Figure 11).

Figure 11. Preferred sources of information about emergency situations



Overall, the most preferred source of information consisted of community discussions, which was reported by about 45% of participants (Figure 11).

Television (national and/or local) was the second main preferred source of information which was reported by 31% of individuals (Figure 11).

Municipal Council meetings consisted of the third most preferred source of information, which was reported by 11% of individuals (Figure 11).

School discussions with pupils was the fourth most preferred source of information, which was reported by 6% of individuals (Figure 11).

On the other hand, the least preferred source of information consisted of mobile applications, which was reported by 0.4% of individuals (Figure 11).

5.3. Results of Qualitative Research

The qualitative component consisted of two parts: focus group discussions and key informant interviews.

5.3.1. Findings From Focus Group Discussions

The focus groups were conducted with individuals from vulnerable groups across 15 municipalities in four regions of the country (Table 23, Annex 2). These municipalities were selected to ensure representation of geographical distribution, encompassing both urban and remote rural areas.

The focus groups provided insights into various emergency and natural disaster situations that citizens have encountered, including earthquakes, floods, pandemics, fire risks, and landslides. Through these discussions, the aim was to assess the reaction and response of the health system, the coordination and interaction of health emergency services with other institutions, and the overall state of emergency health services in these situations.

A. Emergency health services (individual level)

a. Access in emergency health services

Access to emergency health services faces several barriers, particularly affecting vulnerable groups such as low-income individuals, disabled people, and rural communities. These barriers include demographic, geographic, economic, and cultural factors that hinder their ability to reach emergency health services. Ensuring access to healthcare is essential for upholding basic human rights, including safety, quality, and equity.

Participants generally reported having access to emergency health services when needed. Local emergency health services were preferred, as they offered ease of access, established contacts with doctors and nurses, and facilitated faster service provision. Patients usually sought assistance directly from the emergency department or contacted doctors to request ambulance services.

Yes, we called the emergency but they don't answer. It's good that we have nurses because we die for them until we go to Shkoder. The local primary care center is here. It's good that we have nurses. In case of emergency there is someone.

FDG 5, Dajç, Shkoder

However, some challenges were noted in accessing the National Center of Medical Emergencies (NCME) using the number 127. Delayed responses were attributed to traffic and limited address information, making it difficult for ambulances to locate patients promptly. Some participants were unaware of the national emergency service, leading them to seek emergency care independently.

Communication with the emergency service was generally satisfactory, though some reported receiving limited assistance and being redirected to more specialized care at hospitals.

However, participants felt that communication should be tailored to the patient's level of understanding.

"It works, but at night, for example a month ago there was an accident at two in the morning here in the neighborhood, it was raining and a big car hit a motorbike. A person was left lying down for over an hour, and we couldn't even grab him with our hands to give him first aid because there are some things that remain guilty for the rest of his life because we don't know how to help in such cases." FGD 10, Kamëz

"We use the services at the health center in Kamëz, but they don't give us a solution there and send us to the hospital". FGD 10, Kamëz

Participants expressed a preference for receiving all health services near their residences. The lack of comprehensive services in some areas forced citizens to seek private healthcare or neglect regular visits, potentially leading to emergency situations. Providing 24-hour emergency services near health centers in small towns was deemed essential by participants to improve access.

"I didn't know the number; I went to the emergency room with my car." FGD 6, Vore, Tirane

During the COVID-19 pandemic, citizens reported positive experiences with the health service, which remained available 24/7. Health personnel were responsive, providing guidance for managing mild COVID-19 symptoms at home through telephonic consultations. Some received in-home services during the pandemic.

"In the case of the pandemic, we had an excellent service. Thank you, head nurse. They were available day and night, responding promptly. I am very satisfied with them. We faced an emergency at home. Since we live far from the center and lack transportation, they were a great help." FGD, Shkodër

However, financial burdens were reported by some individuals, impacting their ability to afford treatment. Overall, citizens expressed high satisfaction with the willingness of family medicine service personnel to assist at any time.

"Another reason is that they say go to the private sector and do the medical tests. We cannot go to the private sector because we will pay the doctor, we will pay for the tests, and we have a pension. Now it's okay to say goodbye". FGD 7, Shijak

b. Use of traditional medicines

The study revealed that vulnerable individuals heavily rely on traditional medicines, particularly in emergency situations. Regardless of their socio-economic background, people turn to various traditional remedies, and only when the situation worsens do they consider seeking formal health care. Generally, participants tend to seek professional health services during critical moments, but initially, they try to manage the situation themselves.

Participants reported instances where family health care providers, such as family doctors or nurses, offered services within the home, and they expressed high satisfaction with such care.

In some cases, the doctor/nurse is called when the patient is unable to move or to obtain information about providing first aid during a health emergency or acute illness. However, there were also cases where the personnel providing home services lacked appropriate medications for first aid.

"We call them on the phone first, and then we try to arrange for them to provide health care at home. But sometimes, if they don't have the necessary medications, they refuse to come at all," as they feel there's nothing they can do. FGD 4, Gramsh

In certain situations, participants reported having to pay for in-home health services due to the need for immediate care and the inability to transport the sick to a health center.

Factors influencing the health status of the population include poverty, which reduces opportunities for accessing paid services, especially those located far from their residential areas. Poverty is often caused by limited access to income and can lead to adverse impacts on various aspects of life, such as living conditions, education, and health. The health impacts of poverty may manifest as hunger, malnutrition, stigma, discrimination, and lack of access to essential services. In remote areas and small towns, a significant portion of the population consists of elderly individuals with an increased need for health services. Some elderly individuals live alone, making it even more challenging for them to manage emergency cases.

Communities with low education or health literacy levels often experience poorer health outcomes. Specifically, individuals with limited education and/or health literacy skills are less likely to effectively manage chronic conditions, such as high blood pressure and diabetes. Moreover, they may neglect important preventive measures.

c. Barriers to access emergency health services

People living in rural and remote areas face greater risks due to physical and institutional barriers that impede their access to up-to-date health information, basic protective measures, and health-care facilities during emergencies. Access to health care is hindered for certain groups within the community, particularly low-income individuals, disabled people, and those residing in rural areas, due to demographic, geographic, economic, and cultural characteristics.

c1. Distance to the health facility. The distance to health facilities emerged as a significant barrier to accessing health care. Physical accessibility to facilities posed even more considerable challenges for those who are too ill to travel on their own or individuals living with disabilities.

"For example, I live an hour away. I have to come by horse. By the time I get there, I'm already in critical condition. Some parts of the road are impassable for cars, so we have to travel by horse. There are villages where ambulances cannot reach." FGD, Klos, Diber

Private vehicles, either owned by participants or their relatives, are often used as a means of transportation to access health services. However, for vulnerable groups, the additional burden

of funding transportation, such as taxis, to attend medical appointments can lead to delays in seeking treatment due to associated costs.

In some municipalities, especially remote areas like Belsh and Fushë Arrëz, accessing emergency services is challenging due to geographical isolation, compounded by a lack of road infrastructure in rural areas, leading to delays in emergency responses.

c2. Negligence. Many participants admitted that their negligence in seeking medical help constituted a significant barrier to receiving timely services. Lack of awareness about the importance of their health condition led them to believe that their health issues were transitory, resulting in delayed or avoided medical care.

"We know one who was sick and couldn't walk, she said it would pass, then when the ambulance came, she died." FGD 11, Ishem, Durres

c3. Delay to response. Delayed response times were reported as another significant barrier. Ambulances sometimes took a long time to arrive at the scene, and there were cases where ambulances did not arrive at all.

"There are cases where it takes two hours to reach the patient due to poor infrastructure. In some areas, part of the road is inaccessible by car, and patients need to be reached on foot." FGD 4, Gramsh

Participants preferred ambulances and health staff for transportation during health emergencies due to concerns about causing further injury during transport and the inability to provide immediate help in private vehicles.

Financial constraints were identified as a barrier to accessing emergency services in certain cases. Some participants could not afford immediate emergency care, resulting in delayed or deferred treatment.

*"If you don't pay the doctor, he won't touch you. I can also tell you their names".
FGD 1 Tirana*

While the emergency service number 127 is generally well-regarded, there were cases of delays due to traffic or nighttime issues in urban areas.

c4. Lack of information. Lack of knowledge to recognize danger signs and a preference for traditional approaches were mentioned as barriers by participants. The lack of community knowledge about medical emergencies could lead to the use of traditional remedies before seeking professional medical care, resulting in delays in seeking treatment and exacerbating the patient's condition.

Some participants were not aware of the existence of the emergency service (number 127), highlighting the need for better dissemination of information.

c5. Insufficient medicines and equipment. In some cases, the participants reported that they had to purchase some of the medications themselves due to their absence at the time they requested the service.

In some areas, ambulances lacked essential emergency supplies and medications and were not always staffed with a trained crew. Lack of necessary medical equipment prevented emergency responders from providing appropriate care to patients.

From the side of the emergency center here in Shëngjin, there are no complaints. One complaint is that there should be an ambulance available to the city of Shëngjin. How much does the ambulance do to come from Lezha, with all the traffic, neither the nurse nor the doctor does anything. FGD 12, Lezha

Our main request is that the emergency has all the medicines that it needs. We go there and don't find any kind of medicine, they tell us to go to buy it there (in a pharmacy they know) not in which pharmacy that we want. When we go to the emergency room, it is an urgent case and all the medicines should be there. FGD 10, Kamëz

We are in lack of a laboratory. So to do a urine analysis, a complete blood analysis, we are forced to go to Puke, or to Shkoder. This kills the pockets of the citizens of Fushë Arrëzi, it causes us financial problems. People here are in very difficult economic conditions. FGD 15, Fushë Arrëz

c6. Lack of human resources. Participants in the focus groups highlighted a significant barrier to accessing emergency health services, which is the lack of adequate health care providers and specialists, especially in small towns and rural areas. This shortage of medical professionals makes it challenging for individuals with chronic illnesses to access necessary healthcare services near their residences. Due to the limited availability of healthcare providers, patients may need to travel long distances to seek specialized care, leading to delays in receiving treatment and exacerbating their health conditions.

In some cases, health centers and clinics in these areas may only have one nurse or general practitioner covering multiple units, leading to an overwhelming workload for these healthcare professionals. This situation not only affects the quality of care provided but also impacts the ability of patients to access timely emergency services when needed.

c7. Quality of services. The public health system faces several challenges that directly impact the quality of services offered to citizens. One of the major issues reported by participants is the lack of health care providers and specialists in certain fields. Due to the scarcity of medical professionals, there may be long waiting times for appointments, delayed response to emergencies, and limited access to specialized medical care.

There is only one nurse in the health center. There is a shortage of doctors. One doctor covers two or three units. Village ambulances offer only the simplest serums, other medications are missing. FGD 4, Gramsh

Furthermore, the shortage of essential drugs in health facilities is a cause for concern among citizens. In some cases, patients have to purchase necessary medications privately, incurring additional financial burden, especially for vulnerable groups with limited resources.

Mismanagement within the public health system was also identified as a contributing factor to the perceived low quality of services. Poor coordination, inadequate resource allocation, and

administrative inefficiencies further hinder the delivery of efficient and effective emergency health services.

As a result of these challenges, some patients may opt to seek treatment in private clinics despite higher costs, as they perceive private facilities to offer better quality care and quicker access to services. This preference for private healthcare can exacerbate health inequities, as it may be unaffordable for vulnerable individuals and those from low-income backgrounds.

c8. Need to better equip Health Centers

Wider coverage with services from health centers will reduce the number of cases that are referred and require services in other facilities.

Citizens across all municipalities stressed the importance of equipping health centers and emergency services with necessary diagnostic tools and medical materials for providing first aid. The availability of various laboratory analysis types was also highlighted as a notable deficiency.

Main requirements according to administrative units/municipalities:

- Tirana: Increase the variety of tests that pensioners can perform at health centers
- Belsh: Establish a health service with 2 shifts and have a nurse available in the area during dinner time.
- Gramsh: Add a nurse (as there is currently only one); augment with more doctors (one doctor currently covers 2 units); equip the hospital with basic medications, including serum and essential medications.
- Shkodër: Acquire ultrasound equipment.
- Shijak: Address the lack of equipment and specialists, currently only having general practitioners.
- Klos: Establish a laboratory for analysis.
- Kamëz: Set up a hospital, improve ambulance services, increase the variety of tests, equip the hospital with basic first aid materials, and have specialist doctors available.
- Ishëm, Durrës: Employ a pediatrician and specialist doctors, provide state-of-the-art equipment, and establish a laboratory.
- Shengjin, Lezhë: Establish a 24-hour hospital throughout the year, equip with a laboratory and ambulance, and ensure the availability of basic medications in emergency situations.
- Këlcyrë: Establish a laboratory, employ a pediatrician, and ensure the availability of basic medications.
- Fushë Arrëz: Establish a laboratory for analysis and provide ultrasound services, maintain 24-hour service.

B. Health emergencies (population/community level)

The findings identified that communities, both in rural and urban areas, face various hazardous events, including disasters, that directly impact their health. As front-line health workers and first responders play a crucial role during emergencies, it is essential to involve them in all phases of emergency risk management. Coordinated efforts among community leaders and key stakeholders are necessary to identify and train the workforce, equip them with necessary resources, and build their capacity to cope with emergencies and reduce their impact.

During the COVID-19 pandemic, participants expressed high satisfaction with the commitment of health institutions, reporting that they were very responsive to the crisis. However, in other types of emergencies, such as earthquakes, floods, or landslides, the presence of health institutions seems to be less visible, with some participants reporting delays in their response.

*"In the earthquake situation, the health institutions arrived after 2-3 days."
FGD 10, Kamëz*

In civil emergency situations, such as non-pandemic emergencies, participants reported a lack of clear guidance and direction from health institutions. As a result, citizens often tried to manage the emergency themselves initially and later sought assistance from the municipality. To improve community disaster resilience, it is crucial for communities to receive adequate knowledge and skills through training and risk communication. Local stakeholders, including community leaders, play a vital role in identifying priorities and training the local workforce to respond efficiently to sudden disasters.

Citizens acknowledged the importance of civil society organizations, such as churches and the Red Cross, in providing crucial first aid and support during emergency situations. These organizations were perceived to respond faster than state institutions, highlighting the need for collaboration between government, partners, and local organizations to reinforce the community health workforce and strengthen existing health systems with resources like funding, technical support, human resources, and supplies.

However, during the experiences of the earthquake, participants reported that the response was not entirely positive. Families, especially those with chronically ill members, did not receive adequate follow-up and support. The lack of psycho-social services was a significant concern, as many individuals, including children and the elderly, faced trauma and fear after the earthquake. The absence of psychological help during the crisis impacted individuals' well-being in the long term, causing phobias and emotional distress.

Overall, improving emergency response and resilience at the community level requires better coordination among health institutions, community leaders, and civil society organizations. Providing comprehensive support during and after emergencies, including psycho-social services, is crucial to helping communities recover and cope with the aftermath of disasters.

"We had children and elders in the family. The children had an unprecedented phobia of earthquakes. My daughter was at the university and she used to say 'I don't go home anymore'. We had no psychological help. Young people and children, but also our parents experienced it very badly, my father cried for my house until the moment he died." FGD 2, Tirana

COVID-19 pandemic experiences

During the COVID-19 pandemic, citizens faced a challenging and unprecedented situation, and they relied on information from various sources to understand and cope with the emergency. However, the most preferred and trusted method of communication about emergencies and preparedness was through official channels and health authorities. This indicates that people valued receiving information from reliable sources and trusted the guidance provided by health experts and authorities.

One of the key emergency services during the pandemic was the national emergency service number 127. Participants generally reported positive experiences with this service, with quick response times in most cases. This efficient response from the emergency service was crucial in providing timely assistance to those in need during the pandemic.

The family medicine service and health personnel received high praise from citizens during the COVID-19 pandemic. Participants expressed maximum satisfaction with the willingness of health personnel to help at any time. This high evaluation of the health personnel reflects the dedication and commitment shown by healthcare providers in the face of the pandemic. Their readiness to respond to emergencies and provide care during the day and night was greatly appreciated by the citizens.

The positive experiences shared by citizens in different municipalities highlight that the health service's intensity and dedication were consistent across various regions. In smaller areas like Ishëm, participants expressed gratitude for the humanity and dedication of the doctors who put themselves at risk to help without expecting monetary compensation. This emphasizes the importance of local healthcare providers' role in supporting and caring for their communities during challenging times.

However, it's important to note that while citizens generally had positive experiences during the pandemic, there might still be some regional variations or specific challenges faced by vulnerable groups that warrant further attention and improvement in the healthcare system. Ensuring continued access to quality healthcare and support for all communities, especially during emergencies like the COVID-19 pandemic, remains a critical aspect of emergency preparedness and response planning.

a) Receiving Health Care at Home

The option of receiving health care at home was highly appreciated by citizens, especially during the COVID-19 pandemic. Doctors and nurses provided in-home services to patients who were unable to visit healthcare facilities, ensuring that medical attention was accessible and convenient. This approach proved beneficial for managing mild COVID-19 cases, with individuals receiving telephonic guidance from doctors and healthcare personnel demonstrating a willingness to provide in-home services.

However, there were instances where the health personnel conducting home visits lacked the necessary medications to provide first aid, leading to some concerns about the adequacy of resources for in-home care.

During the pandemic, citizens in small cities reported better health service experiences compared to large cities. In some large cities, access to health services became a challenge, with individuals having to pay for healthcare or manage their health situations themselves due to limited access to healthcare facilities. This disparity in access to health services had direct implications for patients, including postponed care, difficulties in obtaining follow-up visits, challenges reaching hospitals by ambulance due to resource constraints, and longer wait times.

One specific concern raised by a participant in Tirana was the limitation in the emergency service's capability to bring patients back home after hospital treatment. This issue posed challenges for patients and their families, particularly when there was a need for follow-up care or support after hospitalization. In this regard, the preference for the family doctor to answer

calls and provide assistance at home highlights the value of personalized care and continuity in health services.

The emergency service could come and pick you up but not bring you back home. Many people died in hospitals. I wanted the family doctor to answer me and bring the nurse home. FGD2, Tirana

b) Access to 24-Hour Emergency Service Near the Residence

Access to 24-hour emergency services near the residence was generally available, with many areas having 24-hour health centers to cater to the healthcare needs of the local population. However, some remote regions, like Belsh, faced challenges in providing 24-hour emergency services due to geographical barriers. Efforts were made to strengthen these services during the tourist season to meet the increased demand for health care.

Throughout the COVID-19 pandemic, the emergency service number 127 received positive feedback from citizens, with quick ambulance response times reported in most cases. However, delays were occasionally experienced due to difficulties in locating addresses, especially in areas with inadequate road infrastructure. This highlights the importance of improving address systems in remote and rural areas to ensure timely emergency responses.

While the emergency service efficiently transported patients to hospitals during the pandemic, there were limitations concerning transportation back home after hospital treatment. This lack of return transportation created difficulties for some individuals, especially those who needed follow-up care or support after hospitalization.

Unfortunately, the pandemic also led to unfortunate deaths occurring within hospitals, which might have been a result of various factors such as the severity of the cases, resource constraints, or other challenges faced by the healthcare system during the crisis.

c) Obstacles/Barriers to Accessing Health Care Services

During the COVID-19 pandemic, citizens faced several obstacles and barriers in accessing health care services, which impacted their health-seeking behaviors and overall well-being.

- #1 Financial Barriers: Participants reported spending significant amounts on health services for their families during the pandemic. This included expenses for buying oxygen bombs, medications, and healthy food. Although healthcare itself is typically free, the fear of incurring additional expenses, such as private laboratory tests and medications, deterred some individuals from seeking medical assistance. The financial burden of healthcare services was a major concern for many citizens during this time.
- #2 Negligence: Both citizens and medical personnel were suspected of showing negligence in seeking or providing medical help. Some citizens did not appreciate the importance of their health condition, delaying seeking medical care until their situation worsened. On the other hand, there were instances where medical personnel may have exhibited negligence in providing timely care or not having the appropriate medications to offer first aid during home visits.
- #3 Lack of Information and Awareness: Participants reported a lack of information and awareness about diseases, first aid measures, and when to seek medical help. This lack of knowledge could lead to delays in seeking medical assistance or attempting to manage health emergencies themselves with traditional remedies.

- #4 Infrastructural/Geographical Barriers: Remote and deep rural areas faced challenges in accessing healthcare services due to poorly maintained road infrastructure. Inadequate road networks hindered the timely arrival of emergency services, especially in cases where immediate medical attention was crucial.
- #5 Communication Challenges: Physical distancing, personal protective equipment, and limited time spent with doctors during the pandemic made communication challenging for some citizens. Some participants experienced postponement or withholding of regular care for chronic conditions, resulting in increased stress and anxiety.

d) Engagement of Health Institutions During Emergency Situations from Natural Disasters

During emergency situations, particularly natural disasters like fires, earthquakes, etc., citizens reported positive experiences with the formation of volunteer groups mobilized to help. These volunteer services were particularly beneficial for vulnerable groups with slower reaction and displacement times. However, there were some challenges faced by these volunteers, such as a lack of necessary clothing and tools to support their efforts during emergencies. Participants mentioned that volunteers sometimes had to enter emergency situations with their own clothes, highlighting the need for local institutions to provide proper support and resources to these volunteer groups.

In the case of fire situations, one of the problems that volunteers have is that they have no clothing. There were cases when they entered with their own clothes. I have asked for it many times and when there is a meeting with the prefect. FGD 4, Gramsh

While health institutions demonstrated maximum commitment and were highly visible during the COVID-19 pandemic, their presence seemed less apparent during other emergency situations like earthquakes, floods, or landslides. In such cases, local government institutions, particularly municipalities, were the immediate responders. The engagement of health institutions during natural disasters appeared to be more reactive, at the request of citizens when deemed necessary.

In fact, there is a lack of information. A few days ago, the house of a resident here was burnt. I received the information the next morning. So the information is missing a lot. The fireworks went off at the moment, while we went the next day. FGD 4, Gramsh

One issue highlighted by participants was the lack of timely information during emergencies. For instance, during a fire incident, a participant mentioned that they received information about the incident the next morning, despite the event occurring the previous night. This lack of timely information could hinder effective response efforts and calls for improved communication and coordination during emergency situations.

Another important aspect that citizens reported lacking during emergency situations, such as earthquakes, was psychosocial services. The presence of such services to address the emotional and mental well-being of affected individuals was not consistently reported, indicating a need for better planning and coordination to provide appropriate support and care during and after such emergencies.

e) Where Citizens Go in Case of Emergencies

During emergencies, citizens reported seeking help primarily from local government institutions such as the municipality, administrative units, municipalities, or village heads. These local authorities were often the first responders that citizens turned to for assistance. Additionally, the fire department was mentioned as another place where individuals sought help in case of emergencies.

In some cases, citizens considered approaching medical emergency services or their family doctor, but overall, healthcare facilities were not consistently mentioned as the first point of contact during emergencies. This suggests that in certain situations, citizens may not immediately think of healthcare facilities as their primary source of help during emergencies.

For disabled or chronically ill individuals, the movement during emergency situations, such as earthquakes or floods, posed significant difficulties. Family members often had to manage the challenges of relocating or evacuating disabled individuals on their own, as there were limited special support services available for this category of individuals during health emergencies.

f) Engagement of Organizations During Emergency Situations

During emergency situations, citizens in various municipalities reported limited engagement of civil society organizations in providing assistance. While some areas saw involvement from NGOs, such as the Red Cross, in providing aid and support to affected citizens, it was not consistently observed across all regions.

Religious institutions, particularly churches, were mentioned as being active in helping citizens during emergencies in certain regions. These institutions played a role in providing aid, such as clothing, food, and medicine, to those in need.

In some cases, external forces, such as teams from other countries like Turkey, assisted in addressing specific emergency situations and providing support to affected communities.

Overall, there was generally good cooperation among different local actors in managing emergency situations. However, in some instances, coordination and timely communication among relevant structures were lacking. Some service providers waited for citizens to contact them rather than proactively assessing the situation and offering immediate support.

To enhance the response of health institutions during emergencies, citizens expressed the need for more means of transportation and first aid equipment. These resources are vital in ensuring timely and effective assistance during emergency situations, enabling health institutions to provide prompt and appropriate care to those in need.

g) Reaction of Citizens in Emergency Situations

Despite facing various emergency situations, participants reported that they lacked information on how to react or provide first aid effectively. Past experiences did not adequately prepare them to handle emergencies, leaving them uncertain about the appropriate actions to take in critical situations.

However, there were some sporadic cases of training provided for specific emergencies. For instance, in Shkodër, the Church offered training for health emergencies, while schools in Kombinat conducted fire safety training. Moreover, some municipalities in Gramsh and Belsh trained volunteers to respond to fire situations.

While these training initiatives were beneficial, they were not consistently available across all regions, and comprehensive preparedness and response training for various emergency situations were lacking. Participants expressed the need for more widespread and continuous training programs to equip citizens with the knowledge and skills to respond effectively during emergencies.

h) The preferred way to receive information about emergencies, preparedness for responding to emergency situations

The most preferred method of obtaining information about emergencies and preparedness for responding to emergency situations was through community meetings organized by municipalities, local government institutions, and family doctors. These meetings provided a direct and interactive way for citizens to learn about emergency protocols, receive guidance on how to react in critical situations, and understand where to access health services during emergencies.

Educating and training children in schools was also viewed as an essential aspect of emergency preparedness. By imparting emergency response skills to the younger generation, communities can foster a culture of preparedness and ensure that future generations are better equipped to handle emergencies.

While television and phone-based programs were available sources of information, they were less preferred by participants. Some citizens highlighted that the elderly faced challenges in using phones, making such methods less accessible for this age group.

Overall, participants expressed a sense of lacking information about their rights regarding health emergencies. They emphasized the importance of having clear and accessible information on how to react in various emergency situations, provide first aid to themselves or family members, and know where to seek health services during emergencies.

5.3.2. Findings From Key Informant Interviews

“Key informant” was considered any professional engaged in health care service delivery, social services, local government, or members of non-governmental organizations (NGO) and/or other national or international agencies whose activity and field of operation may also include and concern various vulnerable groups of the Albanian population.

A total of 20 interviews were conducted, yielding valuable insights from individuals with expertise and in-depth knowledge of identifying and assessing hindrances and obstacles of vulnerable populations with respect to accessing and using emergency care. This inclusive approach facilitated a comprehensive exploration of perspectives and experiences, enriching the depth and breadth of the study's findings. To ensure a comprehensive representation of stakeholder perspectives, a maximum variation strategy was employed in selecting participants. The stakeholders included in the study were directors of health centers, family doctors, fire department managers, representatives of municipalities, representatives of state social services, representatives of non-governmental organizations (Save the Children, Together for Life, National Union of Pensioners). In total there were interviewed 20 key informants (12 men and 8 female). The age group ranged from 30-60 years old, most of the interviewees had a work experience of more than 10 years. The purpose of engaging stakeholders in interviews and consultations was to gather insights and feedback on the current

state of emergency health care services, and to identify barriers/obstacles to access and use emergency care, level of awareness and understanding of health rights, level of knowledge and attitudes toward civil society advocacy approaches, current and future usage of emergency services, access and perceived barriers to health services. Details about KI included in the report are presented in Table 24 in Appendix 3.

The main findings related to the KI interviews are summarized in the following section.

Vulnerable Groups and Patient Profile

During emergency situations, health centers and fire departments across different regions cater to various vulnerable groups with specific needs. In Belsh, the health center focuses on chronic patients, including those with diabetes, heart diseases, and mental health issues, indicating a recognition of the increasing prevalence of chronic conditions.

"In the area of Ishmi, chronic diseases are those with hypertension and diabetes." "Actually, I have 17 with mental illness." Family doctor, Ishem, Durres

In Gramsh, the Fire Department actively provides assistance to vulnerable groups, particularly those lacking social support, by collaborating with local administrators for economic aid. In Dajc, emergency services are available to all categories and the entire population, but during floods, patients unable to move or living far from the health center face challenges accessing emergency care due to transportation difficulties. Similarly, in Klos, Burrel, and Patos, Fier, chronic patients, especially those with hypertension and diabetes, are among the main groups accessing emergency services.

"We have a group of the Roma community that I would call a vulnerable group," "Another group I would call a group of people who do not have a collective decision or a decision to stay like the group above, but they are chronically sick people and people with economic difficulties." Director of Health Center, Novosele, Vlore

Fushe-Arrez, Puke, faces challenges with the Roma community's economic and geographical vulnerability during floods. Lezhe's Municipality recognizes the elderly, homeless individuals, the chronically ill, and the poor as vulnerable groups during emergencies, and Kucove highlights the elderly, chronically ill, disabled, and young populations, calling for education and awareness campaigns for the youth.

The Save the Children organization focuses on the poor, the Roma community, and the sick as vulnerable in emergency health services. Together for Life identifies chronic patients, people with disabilities, children, women, young people, and returnees as main vulnerable groups for emergency health services, while vulnerable groups for emergency medical services include those with urgent medical needs, such as chronic conditions, disabilities, the elderly, children, and abused women.

"We think that they are the group of chronic patients," "There are also people with disabilities, children, women, young people, but normal patients are the

first. There are approximately 420,000 chronic patients." Representative from Together for Life

During civil emergencies like earthquakes, floods, and pandemics, several organizations and representatives recognize financially disadvantaged families, marginalized communities, minorities, LGBTQ individuals, women, children, the elderly, and persons with disabilities as vulnerable groups.

Some findings mentioned the need for psycho-emotional support and counseling for vulnerable groups during emergencies, highlighting the importance of addressing the psychological well-being of these populations in times of crises.

The need for gender perspectives and inclusivity in disaster risk reduction projects is mentioned, emphasizing the importance of considering gender-specific vulnerabilities during emergencies.

Addressing the specific needs of these groups is crucial in providing effective emergency health services and support during civil emergencies. Collaboration between health centers, municipalities, and NGOs is essential to ensure the provision of timely and appropriate care for vulnerable populations.

Emergency Service Demand, Access, and Health Services

Accessing emergency services poses significant challenges for vulnerable groups, primarily due to distance, difficult road conditions, and limited access to transportation, especially for the elderly and disabled residents. In Patos, Fier, the national emergency number 127 may not work for certain mobile providers, further hindering access.

"Undoubtedly, in fact, the 127 culture does not exist, except for some people who abuse it." Director of Health Center, Fushe-Arrez, Puke

Lack of awareness, economic limitations, and limited physical access create barriers for vulnerable individuals seeking emergency care. Social problems, poverty, and limited access to information further increase their vulnerability, leading to difficulties in managing chronic conditions and accessing support resources. Negative past experiences with social assistance or doctors may deter some residents from seeking medical care during emergencies.

"Access to health services is the most difficult part of them for various reasons, of course economic impossibility is a reason." Director of Health Center, Novosele, Vlore

Moreover, during emergencies, vulnerable groups face difficulties in accessing and receiving health services, compounding their vulnerability. Factors contributing to these challenges include inappropriate living conditions, poor house construction, neglect of diseases over time, and inadequate preventive measures. Additionally, the limited operating hours of health centers in remote areas pose challenges. In regions with floods, transportation becomes severely restricted, making it difficult to provide timely assistance.

"For emergencies, the factors are inappropriate living conditions and house construction. For emergencies, factors are the long-term neglect of diseases,

the lack of prevention and early diagnosis." Representative from Save the Children

Furthermore, facility and infrastructure challenges include a lack of functioning ambulances, a shortage of medical personnel, and inadequate emergency medications. Proper infrastructure and transportation options are crucial to ensure timely care for vulnerable groups during emergencies, and home visits may be necessary for those unable to reach health centers. Training and preparedness efforts should focus on addressing the specific needs of vulnerable groups, including specialized training for handling chronic patients, dementia, and mental health disorders. Awareness campaigns targeting the younger population can improve emergency response.

"The village farthest from here is the village of Kelp, which is 2 hours away by car and the road is not good." "A problem that we have that maybe needs to be solved is the problem of cars, ambulances that are not able to be right because they need service." "We also have a problem with the number of personnel because we are few doctors and personnel. And when we have the ambulance in emergency situation we have to take a substitute doctor." Director of Health Center, Klos

Specifically, the following findings touch upon aspects related to access to emergency services and health services for vulnerable groups during emergencies:

1. Some patients might delay seeking care and go directly to larger cities like Elbasan due to perception and proximity. This is a challenge in accessing emergency services for vulnerable groups, particularly those living in remote areas.
2. The health center communicates with vulnerable groups through staff meetings, community meetings, and information provided by the administrator and village heads about flood-prone areas. This highlights efforts to improve access to emergency services for vulnerable groups by directly engaging with them through community meetings and awareness about potential hazards.
3. The health center encourages vulnerable groups, including the Roma community, to have continuous contact with doctors and emergency services. They attempt to increase contact through family visits and personal calls. This shows proactive efforts to ensure continuous access to health services for vulnerable groups during emergencies.
4. Vulnerable groups lack standardized information about their rights and access to health services. Efforts have been made to provide information through activities and training programs, but there is room for improvement. This emphasizes the importance of addressing barriers in accessing emergency health services faced by vulnerable groups.

Addressing the challenges in emergency service demand, access, and health services for vulnerable groups is essential to ensure their well-being during emergencies. Improving infrastructure, transportation, and communication, along with targeted training and awareness campaigns, can enhance the effectiveness of emergency response efforts. Cooperation between stakeholders and the provision of timely support and resources are crucial to meet the specific needs of vulnerable individuals and protect their health during crises.

Training and Preparedness

In terms of training and preparedness, several key findings have emerged. Education and awareness campaigns targeting different age groups are essential, as some individuals, particularly the younger population, lack sufficient knowledge about emergency response. The need for specific training in emergency care and first aid is emphasized across various regions, including training for handling emergencies like COVID-19, earthquakes, fires, and floods.

For emergency responders, such as the Fire Department's volunteers, proper clothing and specialized vehicles are essential for handling different scenarios, especially in rural areas with challenging road conditions.

"Yes, everyone is trained. The only problem is the infrastructure; you need a car that can handle these roads that are there." Fire Chief, Gramsh

"Normally we need clothes because we have to get into army trucks, so we need adequate clothes, for example, rubber clothes. There have been cases of entering knee-deep water to save people." Director of Health Center, Dajc

Additionally, there is a recognized need for trauma training to enable staff to effectively manage emergencies. Continuous training is deemed crucial, especially for young and newly graduated staff members, to keep them well-prepared for emergencies.

"I did trainings with the staff doing special trainings with vulnerable groups... Of course. The first thing is that I have a staff who are young in age. They just graduated from college. They are always moving, they are transferred, and I feel it necessary to train them from time to time." Director of Health Center, Dajc

Training efforts should also be tailored to address the unique needs of vulnerable groups, such as those with chronic illnesses, disabilities, and mental health conditions. Special attention should be given to vulnerable groups during disaster response, and health centers should be equipped with action plans to cater to specific responsibilities and risk groups.

"I personally trained in Turkey. For the military emergency, I graduated from military school." "Now our staff, nurses are young. 23-24 years old and she is capable. But other nurses are not capable. Few of them will soon retire." Family doctor, Ishem, Durres

Furthermore, specialized training for social workers and community center staff is essential to handle vulnerable groups effectively during emergencies. It is crucial to integrate gender perspectives and provide social support, counseling, and attention to health, nutrition, and hygiene during the rehabilitation phase.

"The social workers and staff in community centers need training for specific interventions they need to perform. So, we are at the strategic level of coordination, and the training at the technical level should be done by community centers for specific interventions they need to do." Representative of Municipality of Tirana

"It needs training," "The last training has been last years." Family doctor, Kelcyre, Permet

"Training has been done by 127 for the techniques of service availability, but not in the sense of vulnerable groups, I don't think it is something complete."
Director of Health Center, Novosele, Vlore

Findings suggest that involving community members and civil society representatives in training and preparedness efforts is essential and highlights the importance of community participation and cooperation in building disaster resilience and effective emergency responses.

"The key elements of preparedness are building and strengthening the capacities of the civil defense system and communities," "Building regenerative capacity in all parts of society requires the involvement and partnership of all sectors," "Having gender perspectives addressed in Disaster Risk Reduction projects enables better addressing of the needs of women and girls affected by disasters."
Representative from Civil Emergencies

The challenges faced by health centers in acquiring emergency drugs due to limited funds, as well as the need for proper training in emergency care and first aid for health center staff. These aspects are critical for preparedness and effective response during emergencies.

Concrete action plans, regular plan revisions, and simulation exercises are necessary for continuous improvement in disaster preparedness and response. To address the needs of vulnerable groups during health emergencies, the training should focus on providing first aid, handling chronic conditions, and coordinating with police and fire brigades. Training and preparedness efforts should be comprehensive, addressing the specific requirements of different communities and risk groups.

Information, Awareness, and Communication

The research findings highlight the significance of disseminating timely and accurate information about emergency health services to vulnerable groups. Efforts have been made through various channels, including mass media, health personnel, administrators, and village heads. However, there are challenges in reaching specific vulnerable populations, such as the elderly and people with disabilities, who may prefer face-to-face meetings and encounter difficulties with new technologies.

"For our age, it's a face-to-face meeting, because we don't understand new technologies," "To gather all the people and talk about the problems of diseases," "Someone listens to the TV, someone a doctor, even now a friend of ours is sick and I gave him a lot of advice on how he should act." *Representative of National Union of Old Age Pensioners*

While some vulnerable groups seem to be well-informed, others lack standardized information about their rights and access to health services, creating barriers in emergencies.

"There is no standardized way of giving the information," *Director of Health Center, Novosele, Vlore*

"I don't believe they have information, they can only take an example, but I believe there is someone else who helps them in this case because they are old."
Representative of Municipality of Kucova

Civil Society Organizations (CSOs) play a minimal role in informing vulnerable groups. In order to improve preparedness, awareness campaigns and sensitization projects have been effective in educating the community about emergency health services and their rights. Efforts have been made to raise awareness among specific interest groups, to protect property and health during emergencies. However, there is room for improvement, and continuous training and information sharing are needed to better serve vulnerable groups during crises.

"Vulnerable groups are mainly informed through the family doctor and the nurse of the respective health center," "The role of the CSO in this regard is almost non-existent." Representative from Save the Children

Raising public awareness about diseases and acute conditions through NGOs and information campaigns is crucial. Raising awareness among vulnerable groups about the importance of regular visits to the family doctor and vital parameter measurements to monitor their health, is essential.

"I make calls to people or try to get them to contact the doctor," Director of Health Center, Novosele, Vlore

"In addition to the leaflets, brochures, and informative meetings would be valuable... These are very important because it is known that citizens see these things." Representative of State Social Service

Television, radio, and distribution of flyers can be effective ways to inform the population about emergency preparedness and first aid.

There are specific challenges faced by vulnerable groups, such as people with disabilities and abused women, in receiving information about health services and emergencies. Understanding the information needs of vulnerable populations is crucial for addressing their unique challenges during emergencies.

Improving communication strategies and addressing the unique information needs of vulnerable populations will enhance their ability to access emergency services and make informed decisions during crises. Collaborative efforts between different stakeholders and channels can strengthen awareness campaigns and ensure that accurate information reaches all segments of the community, including those with specific vulnerabilities. By empowering vulnerable groups with knowledge, they can better protect their health and well-being during emergencies.

Facilities, Infrastructure and Resources

Adequate facilities and infrastructure are crucial for effectively responding to emergencies and supporting vulnerable groups during crises. For instance, the Ishem Hospital is a new center with good furniture but lacks essential medical equipment like oxygen machines, making access to emergency services challenging, especially during critical situations. The area's distance from well-equipped facilities further compounds the issue, hindering immediate medical attention when needed.

"There are no equipment. One, oxygen. The area is far. About an hour from the good areas. Oxygen apparatus are definitely needed." Family doctor, Ishem, Durres

"We are more or less coming together at the point I mentioned a little earlier. In setting up a health ambulance... Equipment I think. Not that we don't have it, but an oxygen cylinder would be good. It's a normal basic." Representative of Commune of Dajc, Shkoder

Proper infrastructure, resources, and equipment, such as fire extinguishers and ambulances, are vital for prompt and effective emergency response, and they play a critical role in supporting vulnerable groups during crises.

"... We will do even better, I hope we will do it with the presence of an ambulance, which has been issued to us by emigrant people living in Italy... it would be good to have a vehicle that is better, that vehicle can serve for the transport of not only sick people. So from areas that are at risk to areas that are not at risk." Director of Health Center, Dajc

Challenges in acquiring emergency drugs due to limited funds create a shortage of essential medications and supplies at health centers, placing additional strain on the already vulnerable population. Additionally, health centers that serve a significant number of chronic patients must consider expanding their facilities and infrastructure to handle the increased demand during emergencies. During crises, factors such as inappropriate living conditions, poor house construction, and long-term neglect of diseases exacerbate the vulnerability of certain groups.

"The fund is so truncated that there is no possibility to buy anything first: oil for the car, or to buy medicine," "The funds for emergency drugs are very low." Family doctor, Kelcyre, Permet

In Gramsh, the Fire Department faces challenges due to inadequate infrastructure and a lack of specialized vehicles for rural roads. Similarly, floods in Dajc pose difficulties in accessing emergency health services for vulnerable groups, underlining the need for improved transportation systems. The health center in Belsh serves an area with an average income and experiences emigration to England, indicating potential economic opportunities. However, the Fire Department in Gramsh struggles to secure funds to assist families affected by natural disasters, requiring attention to ensure sufficient resources during emergencies.

The Fire Department recommends more support from local authorities, NGOs, and infrastructure improvement to enhance emergency response. The director suggests improvements in equipment, such as having oxygen cylinders readily available, portable beds, and a dedicated vehicle for emergencies. Establishing a special service for chronic patients with dementia or psychotic disorders to ensure they receive appropriate care for their conditions. Acquiring additional equipment, will improve the quality of service in difficult terrain. Additional staffing, such as more drivers and specialists, is needed for improved service.

"Of course. I think that foremost the terrain indicates that we need to find a vehicle with some special features to cope with the terrain and the time and the difficult roads." Director of Health Center, Fushe-Arrez, Puke

The Health Center requires increased funding for emergency drugs, training programs, and essential medical equipment to improve emergency services. Increasing the number of medical staff, including specialized doctors, and improving their availability in remote areas would enhance the quality of emergency health services.

The various challenges faced by health centers and fire departments during natural disasters like earthquakes, floods, and landslides highlight the importance of investing in infrastructure and specialized vehicles to ensure efficient emergency response and support for vulnerable communities. Investment in medical equipment, transportation, and training for emergency personnel will contribute to better preparedness and resilience. Cooperation between authorities, NGOs, and other stakeholders is essential to address the challenges faced and ensure the availability of necessary resources during emergencies.

Collaboration and Cooperation

Collaboration and cooperation between various actors are essential for addressing the challenges faced by health centers and improving access to emergency services for vulnerable groups. Local and international organizations can play a vital role in providing training and medical resources to health centers, especially in areas with limited infrastructure. However, unmet infrastructure needs should be addressed to ensure efficient emergency response. Cooperation with the local government is crucial, and vulnerable groups should be encouraged to understand and cooperate during emergencies.

Civil society organizations (CSOs) are instrumental in providing aid and support during crises, supplying essential items, and raising awareness about emergency services. Their involvement can complement the efforts of local authorities, particularly in supporting vulnerable groups. Engaging citizens and encouraging them to seek timely medical attention is vital, as delays in seeking help can lead to critical situations.

"They can give more help to these groups, the categories we talked about or even in cases where there is a fixed civil emergency, they can give a lot of help; being it financial or health assistance." Representative of Municipality of Kucova

"Bringing civil society into awareness projects by staging emergency situations in the areas means to sensitize the community and the recipients of the service." Director of Health Center, Fushe-Arrez, Puke

"Raising awareness and informing vulnerable groups," "Training health personnel to focus on vulnerable groups," "Advocacy and 'pressure' on the government to increase support for vulnerable groups." Representative from Save the Children

International organizations' support, foreign aid, and cooperation with various actors, including NGOs, police, and healthcare providers, are instrumental in responding to emergencies effectively. Collaboration with civil defense institutions, advocacy, technical assistance, and capacity-building from NGOs further contribute to improved emergency response.

"The Red Cross, upon receiving the notification, offers to the home of the person with food, any blankets, and what are the possibilities. The Red Cross is always active for protection." Representative of Municipality of Lezha

"NGOs are among the first ones to approach us. Cooperation with them is significant." "Cooperation with them is very great, besides being powerful donors in those moments, they also offer capacities that are qualified social psychologists and are strong partners with the state..." Representative of State Social Service

Vulnerable groups themselves can play an active role in improving access to emergency health services by becoming active citizens, participating in decision-making processes, and organizing themselves to raise their voices collectively. Vulnerable groups can play an active role in influencing policies and programs that directly affect them. Their involvement can ensure that laws and programs are inclusive and applicable to their needs.

"These individuals themselves can be organized," "Of course they are a very large group. The strong point is that it is a very large target group. Their weakness is that they need to be organized" Representative from Together for Life

"Proactive approach, knowledge of relevant legislation and regulations. Knowledge of relevant structures and institutions," "Increasing awareness and health culture, information on health rights, etc." Representative from Save the Children

Volunteers and CSOs significantly contribute to emergency response efforts, offering material and psychological support to affected communities. NGOs and other organizations can also help by providing support, information dissemination, training, and advocacy for vulnerable communities.

Collaboration and cooperation among various stakeholders, including health centers, NGOs, local and international organizations, governments, and volunteers, are crucial for enhancing emergency response and improving access to quality health services for vulnerable groups. These partnerships enable the pooling of resources, expertise, and support, leading to more effective disaster management and better outcomes for the communities in need.

Recommendations for Improvement of Services

To help enhance emergency response efforts and provide better support to vulnerable populations during times of crises, a coordinated and comprehensive actions will lead to improved preparedness, accessibility, and inclusivity in emergency health services, safeguarding the well-being of vulnerable communities across the regions. Following are the recommendations for improvement of services:

Vulnerable Groups and Patient Profile:

- a. Conduct comprehensive assessments and data collection to identify vulnerable groups in each region, including those with chronic conditions, disabilities, mental health issues, and socio-economic vulnerabilities.
- b. Develop tailored emergency response plans and support services for specific vulnerable groups, addressing their unique needs and challenges during crises.

- c. Enhance cooperation and collaboration between health centers, municipalities, NGOs, and civil society organizations to provide comprehensive support to vulnerable populations during emergencies.
- d. Increase awareness campaigns targeting vulnerable groups, educating them about available emergency health services, rights, and resources.

Emergency Service Demand, Access, and Health Services:

- a. Improve transportation infrastructure in remote areas to ensure timely access to emergency care for vulnerable groups.
- b. Enhance communication during emergencies through mass media, community meetings, and traditional means to reach vulnerable populations who may face difficulties with new technologies.
- c. Invest in medical equipment, ambulances, and emergency medications to strengthen health centers' ability to handle increased demand during crises, especially for chronic patients.
- d. Provide specialized training for health center staff in handling emergencies, managing chronic conditions, and addressing the unique needs of vulnerable groups.
- e. Collaborate with civil defense systems, communities, and NGOs to build capacity and enhance emergency response skills.

Training and Preparedness:

- a. Conduct regular and comprehensive training for emergency responders, health center staff, social workers, and community center personnel to effectively handle emergencies and vulnerable groups' specific needs.
- b. Integrate gender perspectives and social support, including psycho-emotional care, into training programs to address the mental well-being of vulnerable populations during emergencies.
- c. Organize simulation exercises and concrete action plans to continuously improve disaster preparedness and response efforts.
- d. Involve community members and civil society representatives in training and preparedness initiatives to build disaster resilience and effective emergency responses.

Information, Awareness, and Communication:

- a. Implement targeted awareness campaigns for different age groups, including the younger population, to improve knowledge about emergency response and health services.
- b. Establish effective communication channels to inform vulnerable groups about available emergency health services, rights, and resources.

- c. Work closely with civil society organizations, religious institutions, and community centers to ensure comprehensive and inclusive information dissemination during emergencies.
- d. Address the specific information needs of vulnerable populations, such as people with disabilities and abused women, to overcome barriers in accessing health services and emergency information.

Facilities, Infrastructure, and Resources:

- a. Invest in essential medical equipment, including oxygen machines and emergency medications, for health centers to ensure proper care for vulnerable groups during crises.
- b. Improve transportation infrastructure in rural areas to enable timely access to emergency care for vulnerable populations residing far from health centers.
- c. Secure adequate funds and resources for the Fire Department and other emergency services to support vulnerable families affected by natural disasters.
- d. Expand health center facilities and infrastructure to accommodate the increased demand during emergencies, especially for regions with a significant number of chronic patients.

Coordination and Cooperation:

- a. Strengthen collaboration between local authorities, NGOs, health centers, and social services to ensure proper referrals and access to services during emergencies.
- b. Establish support mechanisms for vulnerable groups, including food, water, health monitoring, and psycho-emotional care during and after emergencies.
- c. Raise awareness about available assistance and rights among vulnerable families, supported by economic aid from municipalities, to mitigate barriers during crises.

6. CONCLUSIONS

This study identified and assessed hindrances and obstacles of vulnerable populations with respect to accessing and using emergency care services in order to inform effective and evidence-based policies for reducing the risk of vulnerable population groups in Albania. More specifically, this study explored and assessed in-depth the level of knowledge, attitudes and practices of vulnerable population groups regarding the access to emergency healthcare services.

All in all, the current study assessing access to and quality of health emergencies in Albania is of paramount importance for several reasons:

- *Improving Health Emergency Response:* the current study helps identify gaps and challenges in accessing timely and appropriate healthcare during emergencies in Albania. Understanding these issues should lead to targeted interventions and improvements in emergency response systems in Albania, ultimately saving lives and reducing the impact of health emergencies on individuals and communities.
- *Reducing Mortality and Morbidity:* access to quality healthcare during emergencies can significantly influence mortality and morbidity rates. Hence, the current study sheds light on factors that contribute to better health outcomes, allowing for evidence-based interventions to reduce the burden of disease and disability in the Albanian population.
- *Health Equity and Vulnerable Populations:* assessment of the access and quality during health emergencies highlights disparities in healthcare delivery in the Albanian context. Thus, the current study helps to identify vulnerable populations who might be disproportionately affected during crises, such as the elderly, low-income individuals, disabled individuals, or those with pre-existing health conditions. Addressing these disparities is crucial for promoting health equity in Albania.
- *Resource Allocation and Planning:* understanding the factors affecting access and quality should guide resource allocation during emergencies. The evidence generated from the current study should help policymakers and healthcare providers in Albania to prioritize the allocation of personnel, medical supplies, and infrastructure to areas with the greatest need, ensuring a more effective response.
- *Preparedness and Resilience:* findings from this study can inform preparedness efforts, ensuring that the Albanian health system is better equipped to handle future emergencies. By learning from past experiences and identifying areas for improvement, communities can build resilience and be better prepared for similar challenges.
- *Evaluation of Interventions:* the current study helps to evaluate the effectiveness of specific interventions or policies implemented to improve access and quality during emergencies. It provides a basis for refining strategies and replicating successful approaches in different settings.
- *International and Global Health:* assessing access and quality during health emergencies is crucial for understanding the global impact of outbreaks and pandemics. It allows the international community to collaborate and support countries such as Albania facing emergencies, fostering a cooperative and united response.
- *Data-Driven Decision Making:* data from the current study should form the foundation of evidence-based decision-making for policymakers, public health officials, and healthcare providers in Albania. Informed decision-making leads to more efficient and effective emergency responses.
- *Ethical Considerations:* evaluating access and quality during emergencies is essential from an ethical standpoint. It ensures that all individuals, regardless of their circumstances, have a fair chance to receive appropriate healthcare during critical situations. Therefore, the current study contributes to social fairness and social justice in Albania.

In summary, the current study assessing access to, and quality of individual and community health emergencies provides valuable evidence for guiding effective emergency responses, reducing disparities, and improving health outcomes for affected population groups in Albania. This study contributes to the development of a resilient and robust health system in Albania that can better withstand and respond to future emergencies.

7. RECOMMENDATIONS

Improving responses to individual and community health emergencies requires a comprehensive approach that involves various stakeholders, from government agencies to healthcare providers and the general public. Below are summarized some key recommendations for implementation in the Albanian context:

- *Enhance Emergency Preparedness:*
 - Develop and regularly update comprehensive emergency preparedness plans at local, regional, and national level.
 - Conduct drills and simulations to train healthcare providers and emergency responders for various emergency scenarios.
 - Establish communication protocols to ensure seamless information flow during emergencies.
- *Strengthen Healthcare Infrastructure:*
 - Invest in healthcare infrastructure to handle surges in demand during emergencies, including expanding hospital capacity and critical care facilities.
 - Maintain a strategic reserve of medical supplies and equipment to address sudden increases in demand.
 - Ensure the availability of essential medicines and vaccines for emergency situations.
- *Improve Early Detection and Surveillance:*
 - Establish robust disease surveillance systems to detect outbreaks and health emergencies early.
 - Enhance collaboration between healthcare facilities, public health authorities, and community-based organizations to monitor disease trends.
 - Invest in research and technology for early detection and rapid diagnostics.
- *Enhance Access to Healthcare Services:*
 - Ensure equitable access to healthcare services, particularly for vulnerable populations, during emergencies but also under “normal” circumstances.
 - Implement mobile medical units or telemedicine to reach remote or isolated communities.
 - Facilitate transportation options for individuals who need medical care during emergencies.
- *Community Engagement and Education:*
 - Conduct community education programs on emergency preparedness and response.
 - Empower community leaders and organizations to disseminate accurate information and promote preventive measures.
 - Involve the public in emergency response planning to address their specific needs and concerns.
- *Capacity Building for Healthcare Workers:*
 - Provide specialized training for healthcare professionals in emergency response techniques.

- Ensure healthcare workers have access to personal protective equipment (PPE) and training on its proper use.
- Establish mental health support programs for healthcare workers dealing with the stress of emergencies.
- *Coordination and Collaboration:*
 - Foster collaboration among different stakeholders, including government agencies, healthcare providers, non-governmental organizations, and international partners.
 - Create multi-sectoral task forces to coordinate emergency responses effectively.
 - Establish clear lines of communication and decision-making to avoid delays in critical decision-making.
- *Research and Innovation:*
 - Invest in research to understand the impact of health emergencies better and identify effective response strategies.
 - Encourage innovation in healthcare technologies and solutions to address emergency challenges.
- *Continuous Evaluation and Learning:*
 - Regularly evaluate the response to past emergencies to identify areas for improvement.
 - Use lessons learned to update emergency preparedness plans and response strategies.

By implementing these recommendations, Albanian communities can enhance their capacities to respond effectively to individual and community health emergencies, saving lives and reducing the impact on public health and well-being of the Albanian population.

ANNEX 1. INSTRUMENTS OF DATA COLLECTION

7.1. Interview Guide for Focus-Group Discussions

UDHËZUES PËR FOKUS-GRUPET (INDIVIDË VULNERABËL)

Prezantimi i moderatorit:

Unë quhem..... dhe jam specialist(e).....

Aktualisht, ne po punojmë për këtë vlerësim mbi “vulnerabilitetin në sektorin e shërbimeve të emergjencave dhe urgjencave shëndetësore” në kuadrin e një studimi të mbështetur nga projekti Kujdesi Shendetesor ne Emergjenca financuar nga Qeveria Zvicerane.

Koncepte kyç:

- **Emergjencë shëndetësore:** një situatë fatkeqësie natyrore dhe/ose njerëzore, apo situatë epidemie/pandemie (tërmet, zjarr, përmytje, aksidente masive, rrëshqitje dherash, shpërthim eksploziv, tufan, luftë civile, por edhe ndonjë shpërthim epidemik, d.m.th. infeksion masiv, etj.) që rrezikon seriozisht jetën e njerëzve. Për menaxhimin e emergjencave shëndetësore përfshihen institucione dhe aktorë të ndryshëm duke filluar nga Ministria e Mbrojtjes, Ministria e Brendshme, Ministria e Mjedisit, prefekturat, bashkitë, policia, zjarrfikësit, shoqëria civile dhe sistemi shëndetësor (Qendrat Shëndetësore të hapura 24 orë në ditë gjatë 7 ditëve të javës [pra, 24/7] dhe spitalet bashkiake, rajonale, terciare), etj.
- **Urgjencë mjekësore:** rast individual me një gjendje shëndetësore e cila perceptohet dhe/ose është objektivisht rrezik për jetën e pacientit në rast se nuk veprohet në mënyrë të menjëhershme përmes kujdesit shëndetësor të urgjencës. Kjo ndihmë ofrohet zakonisht në QSH-të 24/7, spitalet bashkiake, rajonale dhe terciare.

Prezantimi i qëllimit të vlerësimit:

Intervistuesi e fillon intervistën duke prezantuar veten, qëllimin e takimit dhe qëllimin e studimit. Intervistuesi i shpjegon informatorit kyç se ky informacion është konfidencial dhe nuk do të identifikohet me emër në raportin e vlerësimit.

Vlerësimi aktual do të ketë si qëllim final identifikimin e faktorëve kryesorë, barrierave dhe pengesave madhore të lidhura me përgatitjen e strukturave shëndetësore për t’ju përgjigjur nevojave të popullatës (kryesisht grupeve më të rriskuara) në raste fatkeqësive (zjarre, përmytje, tërmete, pandemi, epidemi, aksidente masive) si dhe me aksesin ndaj shërbimeve të urgjencës mjekësore të grupeve vulnerabël (të sëmurët kronikë, familjet në nevojë, gratë në nevojë, të moshuarit e vetmuar, pacientët me sëmundje kronike, etj.) në vendin tonë. Më konkretisht, qëllimi i këtij vlerësimi është që të identifikojë disa nga problematikat specifike, mundësitë dhe burimet për të përmirësuar përgatitjen dhe përgjigjen ndaj fatkeqësive si dhe aksesin dhe cilësinë e shërbimeve të urgjencës mjekësore, për disa grupe më në nevojë në fushën e shëndetit. Në të njëjtën kohë, ky vlerësim do të shërbejë si bazë e rëndësishme për të përmirësuar programet dhe aktivitetet e ardhshme në fushën e shëndetësisë të të gjitha institucioneve, organizatave dhe aktorëve të interesuar për të kontribuar në këtë fushë të rëndësishme.

Prezantimi i qëllimit të takimit dhe mënyra sesi do përdoret informacioni:

Moderatori prezanton qëllimin specifik të takimit (duke u mbështetur në objektivat e mësipërme, por në përputhje me audiencën, d.m.th. me llojin dhe përbërjen e grupeve vulnerabël (zona të thella, të moshuar, gra, të varfër, invalidë, pjesëtarë të komunitetit Rom/Egjiptian, etj.).

Ofrimi i stimulit financiar

Në kuadrin e këtij vlerësimi, pjesëmarrja juaj është shumë e çmuar dhe, prandaj, kontributi juaj në këtë studim vlerësohet shumë dhe shpërblehet edhe me një stimul financiar (për të mbuluar kohën/transportin tuaj), të cilin do ta shpërndajmë tek të gjithë pjesëmarrësit në përfundim të këtij takimi.

Numri i Pjesëmarrësve në Grup: 8- 10 persona

Kohëzgjatja: 1.00-1.30 orë

PYETJET E SUGJERUARA

(subjekt ndryshimi në varësi të dinamikës së grupit dhe përvojës së moderatorit):

Fillo me eksperiencat personale me COVID-19, duke qenë se të gjithë janë prekur nga kjo emergjencë.

Në lidhje me pandeminë COVID-19:

- Si e keni kaluar situatën me COVID-in? E keni kaluar vetë apo keni pasur të sëmurë në shtëpi?
- Cilat ishin burimet tuaja të informacionit lidhur me çfarë duhet të bënit, çfarë ishte e lejuar dhe çfarë nuk lejohej?
- A ishit konfuz apo të hutuar lidhur me çfarë duhet të bënit?
- A patët probleme me aksesin ndaj shërbimeve të kujdesit shëndetësor apo në shërbime të natyrave të tjera? Nëse po, çfarë problemesh kishit?
- Kë kontaktuat për problemet tuaja? A ju janë përgjigjur?
- Cfarë vështirësisht hasët në këtë drejtim?
- Kush ju ndihmoi në rast se kishit nevojë për ndihmë?
- A kishit nevojë për medikamente apo shërbime të caktuara? A mundët t'i merrni ato?
- Ku jeni drejtuar për të marrë mjekimin e nevojshëm? A erdhi personeli shëndetësor në banesën tuaj në rast se kishit nevojë? Si ju trajtoi mjeku/personi përkatës në atë rast?
- Cfarë problemesh të tjera kishit? (përmend vështirësinë për të siguruar ushqime, për transport, psh). Si i zgjidhët ato?
- A keni ndonjë mendim se çfarë mund të përmirësohej gjatë pandemisë në lidhje me shërbimin e kujdesit shëndetësor?

URGJENCAT MJEKËSORE

Pjesa e urgjencave mjekësore të zhvillohet shkurt, duke u përqendruar kryesisht tek aksesit ndaj shërbimeve, dhe problematikat e hasura në këtë drejtim.

1. Në përgjithësi, si e vlerësoni gjendjen tuaj shëndetësore? *(përpikuni të merrni informacion sa më konkret dhe specifik mbi sëmundjet akute dhe sidomos kronike ekzistuese, paafhtësitë apo kufizimet fizike të pranishme, si edhe problemet eventuale të shëndetit mendor)*

2. Me kë konsultoheni dhe/ose informoheni zakonisht kur sëmureni papritmas, ose kur keni nevojë të merrni mjekim urgjent, apo thjesht të bëni një vizitë shëndetësore urgjente? *(përpikuni të zbuloni nëse subjektet i referohen shërbimit të urgjencës në rast nevojë, personelit tjetër shëndetësor, apo i referohen personave të tjerë jashtë sistemit, si edhe burimeve të tilla të informacionit si media, Interneti, etj., si dhe identifikoni arsyet kryesore përkatëse)*

3. Mendoni një rast kur keni qenë sëmurë papritmas (ose, nuk jeni ndjerë mirë), ose një anëtar i familjes tuaj ka qenë sëmurë papritmas (ose, nuk është ndjerë mirë): Ku vajtët? Pse bëtë atë zgjedhje? *(përpikuni të merrni informacion sa më konkret dhe specifik për të kuptuar nëse subjektet i janë drejtuar shërbimit të urgjencës apo i janë drejtuar në mënyrë të drejtpërdrejtë shërbimit parësor, dytësor apo tretësor, si dhe arsyet përkatëse)*

4. A keni marrë ndonjë herë në telefon Shërbimin e Urgjencës Mjekësore Kombëtare (127)? *(shpjegojani këtë shërbim duke i kujtuar që bëhet fjalë për Qendrën Kombëtare të Urgjencës Mjekësore me “numrin 127” dhe përpikuni të dokumentoni përvojën e të intervistuarve me këtë shërbim përfshi*

kohën e ardhjes së personelit, automjetin, pajisjet/instrumentet në dispozicion, etapat e procesit, menaxhimin e detajuar të rastit, kohën e nevojshme të procedurave, etj. etj.)

5. Herën e fundit që keni vajtur tek qendra e urgjencës mjekësore në zonën tuaj (nëse keni vajtur ndonjëherë), na përshkruani me detaje çfarë ndodhi? Si vajtët? Kush ju referoi? (përpiquni të dokumentoni sekuencën e momenteve kryesore, për të kuptuar sa më shumë mbi elementet bazë që ndikojnë në aksesin ndaj shërbimeve të urgjencës përfshi njohjen e ekzistencës, disponueshmërisë dhe më pas vendndodhjes së qendrës së urgjencës, marrjen e lejes në punë, lënien/ndërprerjen e punës, transportin, distancën, kohën e nevojshme, etj. etj.)

6. Ju lutem, përshkruani me hollësi marrjen e shërbimit të urgjencës mjekësore gjatë vizitës tuaj të fundit nëse ka patur një të tillë (insistoni në detaje të tilla si: komunikimi me mjekun/personelin tjetër, hedhja e informacionit në kartelë dhe në librezë, pagesa eventuale, referimi nëse kanë patur nevojë, receta e ofruar, rimbursimi, etj. etj.)

7. A i keni kërkuar ndonjëherë mjekut ose infermieres t'ju vijnë për vizitë (urgjencë mjekësore) në shtëpi? (insistoni dhe përpiquni të kuptoni sa më shumë mbi: nevojën reale për vizita të tilla; nëse subjektet i kanë kërkuar personelit shëndetësor që t'i vizitojnë në shtëpi; nëse kanë patur nevojë për t'u vizituar në shtëpi por faktikisht nuk janë vizituar në shtëpi, insistoni që të kuptoni arsyet përkatëse dhe të dalloni qartë nëse i'a kanë drejtuar këtë kërkesë personelit apo jo)

8. Sipas mendimit apo perceptimit tuaj, cilat janë problemet urgjente mjekësore më tipike (kryesore) në pjesëtaret e komunitetit/grupit tuaj? Si mendoni, cilat janë shkaqet? Pse mendoni se prevalojnë këto probleme? (kjo pyetje ka nuanca të ndryshme në funksion të llojit të grupeve vulnerabël)

9. Çfarë shërbimesh të urgjencës mjekësore ka në komunitetin/lagjen/zonën/fshatin tuaj? Ku ndodhen? A keni qenë ndonjëherë (për të marrë shërbime shëndetësore)? A mund të na tregoni më shumë? (përpiquni të merrni sa më tepër informacion për grupe si fëmijët, gratë shtatzëna, të moshuarit, personat me aftësi të kufizuar, etj.)

10. Pyetje në lidhje me fëmijët: Nëse keni fëmijë, a mund të na shpjegoni cilat janë problemet më të hasura tek fëmijët lidhur me urgjencat mjekësore? Ku ndodhen dhe kush i ofron shërbimet urgjente mjekësore për fëmijët? Si është aksesin dhe cilësia e këtyre shërbimeve, në këndvështrimin tuaj? (përpiquni t'i listoni dhe t'i prioritetizoni problemet e urgjencës mjekësore tek fëmijët dhe më pas listoni në mënyrë shtrënguese qendrat/institucionet që i ofrojnë këto shërbime)

11. Cilat janë barrierat dhe pengesat kryesore për të marrë shërbimet e urgjencës mjekësore për ju dhe familjarët tuaj? (përpiquni t'i listoni dhe të shënoni të gjitha pengesat dhe barrierat)

12. Cfarë mendoni për cilësinë e kujdesit të urgjencës mjekësore që ofrohet për ju për ju dhe familjarët tuaj? A mund të na thoni disa problematika të lidhura me këtë (përpiquni t'i listoni dhe të shënoni të gjitha problemet që kanë të bëjnë me ofrimin e kujdesit të duhur, në kohën e duhur, me cilësi të lartë, trajtimi me respekt nga stafi, perceptimi për infrastrukturën dhe pajisjet e urgjencës mjekësore, etj.)

13. A keni besim në sistemin e kujdesit të urgjencës mjekësore? Cilat aspekte të këtij sistemi i konsideroni problematike? (shënoni çdo perceptim apo përgjigje që jepet.)

14. Cilat janë disa rekomandime për të përmirësuar aksesin dhe cilësinë e shërbimeve të urgjencës mjekësore për grupet apo kategoritë që ju përfaqësoni? (përpiquni t'i orientoni pjesëmarrësit dhe t'i nxisni që të shprehin pikëpamjet e tyre për përmirësimin e shërbimeve të urgjencës mjekësore)

15. Si mund të kontribuoni ju vetë dhe cili mund të jetë roli juaj konkret për të përmirësuar aksesin dhe cilësinë e shërbimeve të urgjencës mjekësore për grupet apo kategoritë që ju

përfaqësoni? (përpiquni t'i orientoni pjesëmarrësit dhe t'i nxisni që të shprehin pikëpamje/opinionë konkrete për rolin e tyre në përmirësimin e shërbimeve të urgjencës mjekësore, p.sh., përmes edukimit, informimit, angazhimit pro-aktiv në vendim-marrje, etj.)

EMERGJENCAT SHËNDETËSORE (në rast fatkeqësish)

Pyetjet për emergjencat të fokusohen dhe përshtaten sipas zonave të katastrofave, pra aty ku ka përmbajtje, fokusi do jetë tek kjo lloj katastrofe, etj.

1. Cfarë mendoni lidhur me rolin e institucioneve shëndetësore për ofrimin e shërbimeve të emergjencës shëndetësore në rast fatkeqësie? Cilët institucione janë më të rëndësishme në këtë rast? A keni besim në udhëzimet e tyre? A do i zbatoni udhëzimet e tyre? A mendoni se ka bashkëpunim të mirë mes tyre në rast fatkeqësie, me qëllim ofrimin e shërbimeve të duhura të emergjencës shëndetësore për popullatën në tërësi dhe ju në veçanti?

2. A ka organizata, shoqata, apo institucione të tjera që ofrojnë shërbime shëndetësore mbështetëse (emergjente) në raste fatkeqësie/urgjente për grupin që ju përfaqësoni, ose trajnime lidhur me këto situata? (përpiquni t'i listoni dhe të shënoni çfarë ofrojnë. Nëse ka Organizata të Shoqërisë Civile (CSO) të tilla, mundohuni të merrni informacion lidhur me rolin e tyre, çfarë ofrojnë (çfarë shërbimesh mbështetëse, cilat trajnime etj.), shpeshësinë e ofrimit të këtyre shërbimeve/trajnimeve, sa të kënaqur janë me to, etj.)

3. Si informoheni ju për të drejtat tuaja në lidhje me shërbimet e emergjencës shëndetësore?

4. Në rast të një emergjence, si për shembull, përmbajtje, zjarr, pandemi apo tërmet, a dini kujt t'i drejtoheni për ndihmë? Nëse po, përmendini ata dhe përshkruani procesin. Nëse nuk përmendet nga pjesëmarrësit, pyetini nëse ka ndonjë CSO të cilën mund të marrin në telefon në rast emergjence.

5. Në rast të një fatkeqësie, si i aksesoni (si do i aksesoni) ju shërbimet e emergjencës shëndetësore? (nxitini pjesëmarrësit që të mendojnë lidhur me çfarë do të bënin në rast të një fatkeqësie, cilin do merrnin në telefonin apo ke do kontaktonin? Në c'mënyrë do kontaktonin (telefon, email, radio, gazeta, rrjete sociale)? Çfarë do i kërkonin personave/institucioneve në këto raste?, etj.)

6. Cilat janë disa problematika tuaja në lidhje me aksesin e shërbimeve të emergjencës shëndetësore në tërësi në rast të një fatkeqësie? Po me cilësinë e këtyre shërbimeve? (përmendni dhe CSO-të, nëse pjesëmarrësit ndiejnë mungesën e CSO-ve të tilla dhe rolin e tyre, etj.)

7. Cilat janë barrierat dhe pengesat kryesore për të marrë shërbimet e emergjencës shëndetësore për ju, në rast të një fatkeqësie?

Më konkretisht:

Nga cilat katastrofa natyrore preket zakonisht kjo zonë?

8. Në lidhje me këtë fatkeqësi:

- Keni qënë ju vetë apo pjesëtarë të familjes suaj viktimë të kësaj fatkeqësie natyrore apo të tjera (tërmet, përmbajtje, zjarre, pandemi, etj)? Nëse po, çfarë pasojash patët?
- Keni pasur nevojë shëndetësore gjatë një fatkeqësie natyrore? (tërmet, përmbajtje, zjarr)?
- Cilat ishin burimet tuaj të informacionit lidhur me çfarë duhet të bënit, çfarë ishte e lejuar dhe çfarë nuk lejohet në rast të fatkeqësisë?
- A ishit konfuz apo të hutuar lidhur me çfarë duhet të bënit? Si vepruar konkretisht?

- A patët probleme me aksesin ndaj shërbimeve të kujdesit shëndetësor apo në shërbime të natyrave të tjera në rast të përmbytjeve? Nëse po, cfarë problemesh kishit? Dhe si i zgjidhët ato?
- Kë kontaktuat për problemet tuaja?
- Cfarë vështirësisht hasët në këtë drejtim?
- Kush ju ndihmoi në rast se kishit nevojë për ndihmë?
- Si ju trajtoi mjeku/personi përkatës në atë rast?
- A kishit nevojë për medikamente apo shërbime të caktuara? A mundët t'i merrni ato?
- Cili është opinionimi juaj për cilësinë dhe nivelin e mbështetjes që ju ofrua në këtë rast?
- Cfarë problemesh të tjera kishit? (përmend vështirësinë për të siguruar ushqime, për transport, psh). Si i zgjidhët ato?
- Cilat mendoni se janë pengesat kryesore në rast fatkeqësie natyrore për të marrë shërbimin shëndetësor apo mjekësor të nevojshëm?
- A jeni i interesuar të merrni më shumë informacion në lidhje me cfarë duhet të bëni ju në rast fatkeqësie, pra si të veproni në rast tërmeti, zjarri, përmbytje, etj?
- A jeni të interesuar të mërrni më shumë informacion lidhur me masat që janë në dispozicion nga qeveria apo shoqata të ndryshme për të përballuar një fatkeqësi të mundshme? Pse? Si do ju ndihmonte juve ky informacion?
- A keni ndonjë mendim se cfarë mund të përmirësohet në lidhje me shërbimet e emergjencës shëndetësore në rast fatkeqësie?

Ju falenderojmë shumë për pjesëmarrjen dhe e vlerësojmë pafund kontributin tuaj të çmuar!

7.2. Interview Guide for Key Informants

UDHËZUES PËR INFORMATORËT KYÇ

Prezantimi i moderatorit:

Unë quhem..... dhe jam specialist(e).....

Aktualisht, ne po punojmë për këtë vlerësim mbi “vulnerabilitetin në sektorin e shërbimeve të emergjencave dhe urgjencave shëndetësore” në kuadrin e një studimi të mbështetur nga projekti Kujdesi Shendetesor ne Emergjencat financuar nga Qeveria Zvicerane.

Koncepte kyç:

- **Emergjencë shëndetësore:** një situatë fatkeqësie (tërmet, zjarr, përmytje, aksidente masive, rrëshqitje dherash, tufan, etj.) që rrezikon seriozisht jetën e njerëzve. Për menaxhimin e emergjencave shëndetësore përfshihen institucione dhe aktore të ndryshme duke filluar nga prefektura, bashkitë, policia, zjarrfikësit, shoqëria civile dhe sistemi shendetesor (QSH 24/7 dhe spitalet bashkiake, rajonale, terciare), etj.
- **Urgjencë mjekësore:** rast individual me një gjendje shëndetësore e cila rrezikon jetën e pacientit në rast se nuk veprohet në mënyrë të menjëhershme përmes kujdesit shëndetësor të urgjencës. Kjo ndihmë ofrohet zakonisht në QSH-të 24/7, spitalet bashkiake, rajonale dhe terciare.

Prezantimi i qëllimit të vlerësimit:

Intervistuesi e fillon intervistën duke prezantuar veten, qëllimin e takimit dhe qëllimin e studimit. Intervistuesi i shpjegon informatorit kyç se ky informacion është konfidencial dhe nuk do të identifikohet me emër në raportin e vlerësimit.

Vlerësimi aktual do të ketë si qëllim final identifikimin e faktorëve kryesorë, barrierave dhe pengesave madhore të lidhura me përgatitjen e strukturave shëndetësore për t’ju përgjigjur nevojave të popullatës (kryesisht grupeve më të rriskuara) në raste fatkeqësish (zjarre, përmytje, tërmete, pandemi, epidemi, aksidente masive) si dhe me aksesin ndaj shërbimeve të urgjencës mjekësore të grupeve vulnerabël (të sëmurët kronikë, familjet në nevojë, gratë në nevojë, të moshuarit e vetmuar, pacientët me sëmundje kronike, etj.) në vendin tonë. Më konkretisht, qëllimi i këtij vlerësimi është që të identifikojë disa nga problematikat specifike, mundësitë dhe burimet për të përmirësuar përgatitjen dhe përgjigjen ndaj fatkeqësive si dhe aksesin dhe cilësinë e shërbimeve të urgjencës mjekësore, për disa grupe më në nevojë në fushën e shëndetit. Në të njëjtën kohë, ky vlerësim do të shërbejë si bazë e rëndësishme për të përmirësuar programet dhe aktivitetet e ardhshme në fushën e shëndetësisë të të gjitha institucioneve, organizatave dhe aktorëve të interesuar për të kontribuar në këtë fushë të rëndësishme.

Por, në mënyrë specifike, qëllimi i intervistave të thelluara është:

- Përfundimi i perspektivës/këndvështrimit të personelit (shëndetësor dhe social, si dhe titullarëve në nivele të ndryshme të shërbimeve, por kryesisht të personave me role kyç në emergjencat shëndetësore\urgjencën mjekësore) për shqetësimet/problematikat e ngritura nga vetë grupet vulnerabël, por edhe të perceptuara apo dokumentuara nga ana e tyre (personelit/titullarëve).
- Perceptimi dhe këndvështrimi i personelit dhe i titullarëve të aspekteve të barazisë, mosdiskriminimit, aksesit dhe cilësisë së shërbimeve të emergjencave\urgjencave shëndetësore nga grupet vulnerabël.

- Përftimi i rekomandimeve (nga këndvështrimi i personelit dhe i titullarëve) për përmirësimin e aksesit dhe cilësisë së shërbimeve të emergjencave\urgjencave shëndetësore për grupet vulnerabël.

Numri i Pjesëmarrësve: një (intervistë e thelluar individuale me secilin informator kyç)

Kohëzgjatja: 30-45 minuta

Niveli: shërbimi i urgjencës (kryesisht), por edhe shërbimi shëndetësor parësor, si dhe përfaqësues nga institucione tjera relevante në nivel lokal dhe qendror.

PYETJET E SUGJERUARA

(subjekt ndryshimi në varësi të dinamikës së intervistës me secilin informator kyç):

1.1 Sipas këndvështrimit tuaj, cilat janë grupet kryesore vulnerabël për shërbimet e emergjencave shëndetësore në komunitetin/zonën/qytetin/fshatin tuaj? (përpiquni t'i rendisni dhe t'i prioritzoni veçmas grupet e identifikuar sipas problematikave të urgjencave mjekësore)

1.2 Cilat janë grupet kryesore vulnerabël për shërbimet e urgjencës mjekësore në komunitetin/zonën/qytetin/fshatin tuaj? (përpiquni t'i rendisni dhe t'i prioritzoni veçmas grupet e identifikuar sipas problematikave të urgjencave mjekësore)

2.1 Cilat janë problematikat kryesore në lidhje me shërbimet e emergjencës shëndetësore për grupet vulnerabël me të cilat ndesheni gjatë punës tuaj? (përpiquni t'i rendisni sipas prioritetit dhe frekuencës përkatëse; përpiquni që informacioni të jetë sa më konkret dhe specifik për secilin nga grupet vulnerabël të identifikuar nga informatori kyç; nëse informatori kyç nuk përmend disa grupe të rëndësishme vulnerabël, përmendjani ju dhe drejtojini të njëjtën pyetje)

2.2 Cilat janë problematikat kryesore në lidhje me shërbimet e urgjencës mjekësore për grupet vulnerabël me të cilat ndesheni gjatë punës tuaj? (përpiquni t'i rendisni sipas prioritetit dhe frekuencës përkatëse; përpiquni që informacioni të jetë sa më konkret dhe specifik për secilin nga grupet vulnerabël të identifikuar nga informatori kyç; nëse informatori kyç nuk përmend disa grupe të rëndësishme vulnerabël, përmendjani ju dhe drejtojini të njëjtën pyetje)

3. Pse mendoni se këto probleme janë të pranishme tek grupet vulnerabël? Cilët janë disa faktorë kryesorë që ndikojnë? (përpiquni të përftoni informacion sa më konkret lidhur me faktorët kryesorë që ndikojnë në gjendjen shëndetësore dhe sidomos me shërbimet e urgjencës mjekësore të secilit grup vulnerabël specifik. Gjithashtu, përpiquni të merrni informacion veçmas për emergjencat shëndetësore dhe veçmas për urgjencat mjekësore).

4.1 Në dijeninë tuaj, si informohen grupet vulnerabël për të drejtat e tyre në lidhje me shërbimet e emergjencës shëndetësore? (përpiquni të eksploroni aspektet e lidhura me [mos]diskriminimin dhe [mos]barazinë për informimin dhe shërbimet e ofruara sipas specifikave të grupeve vulnerabil. Nëse nuk përmendet pyesni për rolin e Organizatave të

Shoqërisë Civile (CSO) në këtë drejtim - nëse kanë dijeni, sa CSO veprojnë në këtë zonë, çfarë aktiviteti kanë, etj.)

4.2 Në dijeninë tuaj, si informohen grupet vulnerabël për të drejtat e tyre në lidhje me shërbimet e urgjencës mjekësore? (përpiquni të eksploronit aspektet e lidhura me [mos]diskriminimin dhe [mos]barazinë për informimin dhe shërbimet e ofruara sipas specifikave të grupeve vulnerabil. Nëse nuk përmendet pyesni për rolin e Organizatave të Shoqërisë Civile (CSO) në këtë drejtim - nëse kanë dijeni, sa CSO veprojnë në këtë zonë, çfarë aktiviteti kanë, etj.)

5. Si e aksesojnë këto grupe shërbimet e emergjencës shëndetësore? A i informoni/nxisni ju që të marrin në telefon “numrin e emergjencave civile apo 127” në rast nevojë? (përpiquni të listoni barrierat dhe pengesat kryesore në aksesin ndaj shërbimeve të emergjencave shëndetësore dhe kërkonit shpjegime sa më të hollësishme; gjithashtu, përpiquni të kuptoni nëse personeli i nxit/informon individët për të kërkuar ndihmë pranë Shërbimit të Emergjencave Civile apo Qendrës Kombëtare të Urgjencës Mjekësore)

5.2 Si e aksesojnë këto grupe shërbimet urgjencës mjekësore? A i informoni/nxisni ju që të marrin në telefon “numrin 127” në rast nevojë? (përpiquni të listoni barrierat dhe pengesat kryesore në aksesin ndaj shërbimeve të urgjencave shëndetësore dhe kërkonit shpjegime sa më të hollësishme; gjithashtu, përpiquni të kuptoni nëse personeli i nxit/informon individët për të kërkuar ndihmë pranë Shërbimit Kombëtar të Urgjencës Mjekësore)

6.1 Cilat janë disa problematike në lidhje me aksesin e shërbimeve të emergjencës shëndetësore në tërësi? Po me cilësinë e shërbimeve? Si ndikohen grupet vulnerabël nga aksesit dhe cilësia e shërbimeve? (shpjegojini informatorit kyç se çfarë nënkuptohet me ‘cilësi’ dhe ‘akses’ ndaj shërbimeve të emergjencës shëndetësore)

6.2 Cilat janë disa problematike në lidhje me aksesin e shërbimeve të urgjencës mjekësore në tërësi? Po me cilësinë e shërbimeve? Si ndikohen grupet vulnerabël nga aksesit dhe cilësia e shërbimeve? (shpjegojini informatorit kyç se çfarë nënkuptohet me ‘cilësi’ dhe ‘akses’ ndaj shërbimeve të urgjencës mjekësore)

7. Si ndikojnë këto aspekte në mënyrë të veçantë tek grupet vulnerabël, ndryshe nga popullata e përgjithshme? (përpiquni të kuptoni faktorët konkretë që ndikojnë sipas specifikave përkatëse të secilit grup vulnerabil. Gjithashtu, përpiquni të merrni informacion veçmas për emergjencat shëndetësore dhe veçmas për urgjencat mjekësore)

8.1 Cilat janë barrierat dhe pengesat kryesore për të marrë shërbimet e emergjencës shëndetësore për grupet vulnerabël? (përpiquni t’i listoni dhe të shënoni të gjitha pengesat dhe barrierat sipas këndvështrimit të informatorëve kyç)

8.2 Cilat janë barrierat dhe pengesat kryesore për të marrë shërbimet e urgjencës mjekësore për grupet vulnerabël? (përpiquni t’i listoni dhe të shënoni të gjitha pengesat dhe barrierat sipas këndvështrimit të informatorëve kyç)

9. A keni bërë ndonjë trajnim të veçantë në lidhje me trajtimin e grupeve vulnerabël, në kontekstin e emergjencave shëndetësore? Nëse po, a mund të na tregoni qëllimin dhe si ju ka shërbyer në punën tuaj? Nëse jo, për çfarë do të donit të mësonit më tepër për grupet vulnerabël në mënyrë që t’i shërbenit më mirë dhe të përmbushni nevojat e tyre? (përpiquni të kuptoni boshllëqet konkrete në formimin profesional të informatorit kyç sipas

specifikave të grupeve të ndryshme vulnerabil. Nëse nuk përmendet pyesni për rolin e Organizatave të Shoqërisë Civile (CSO) në këtë drejtim - sa CSO veprojnë në këtë fushë, cfarë aktiviteti kanë, etj.)

10.1 Cilat janë disa rekomandime për të përmirësuar aksesin dhe cilësinë e shërbimeve të emergjencës shëndetësore për grupet vulnerabël? *(përpiquni t'i listoni sipas prioriteteve të raportuara dhe në përputhje me specifikat përkatëse të secilit grup vulnerabil. Nëse nuk përmendet, përmendni rolin që mund të kryejnë CSO-të në këtë drejtim)*

10.2 Cilat janë disa rekomandime për të përmirësuar aksesin dhe cilësinë e shërbimeve të urgjencës mjekësore për grupet vulnerabël? *(përpiquni t'i listoni sipas prioriteteve të raportuara dhe në përputhje me specifikat përkatëse të secilit grup vulnerabil. Nëse nuk përmendet, përmendni rolin që mund të kryejnë CSO-të në këtë drejtim)*

11.1 Cili mund të jetë roli juaj për përmirësimin e cilësisë dhe aksesit të shërbimeve të emergjencës shëndetësore të ofruara ndaj grupeve vulnerabël? *(përpiquni të përftoni informacion sa më konkret sipas specifikave të secilit grup vulnerabël)*

11.2 Cili mund të jetë roli juaj për përmirësimin e cilësisë dhe aksesit të shërbimeve të urgjencës mjekësore ofruara ndaj grupeve vulnerabël? *(përpiquni të përftoni informacion sa më konkret sipas specifikave të secilit grup vulnerabël)*

12.1 Cili mund të jetë roli i vetë grupeve vulnerabël për përmirësimin e aksesit dhe cilësisë së shërbimeve të emergjencës shëndetësore të ofruara aktualisht? *(përpiquni të përftoni informacion sa më konkret sipas specifikave të secilit grup vulnerabël)*

12.2 Cili mund të jetë roli i vetë grupeve vulnerabël për përmirësimin e aksesit dhe cilësisë së shërbimeve të urgjencës mjekësore të ofruara aktualisht? *(përpiquni të përftoni informacion sa më konkret sipas specifikave të secilit grup vulnerabël)*

13. Së fundmi, sipas jush, cili mund të jetë roli i organizatave të shoqërisë civile për përmirësimin e aksesit dhe cilësisë së shërbimeve të emergjencës shëndetësore dhe urgjencës mjekësore për grupet vulnerabël? *(përpiquni të përftoni informacion sa më konkret sipas specifikave të secilit grup vulnerabël)*

Ju falenderojmë shumë për pjesëmarrjen dhe e vlerësojmë pafund kontributin tuaj të çmuar!

7.3. Structured Questionnaire for the Quantitative Study

Qëllimi i studimit Prezantimi i moderatorit:

Ky studim mbi “vulnerabilitetin në sektorin e shërbimeve të urgjencave shëndetësore” zhvillohet në kuadrin e një projekti i cili financuar nga Qeveria Zvicerane dhe ka si qëllim final identifikimin e faktorëve kryesorë, barrierave dhe pengesave madhore të lidhura me aksesin ndaj shërbimeve të urgjencës shëndetësore të grupeve vulnerabël në vendin tonë. Ky studim do të shërbejë si bazë e rëndësishme për të përmirësuar programet dhe aktivitetet e ardhshme në fushën e shëndetësisë të të gjitha institucioneve, organizatave dhe aktorëve që punojnë në këtë fushë të rëndësishme.

Në kuadrin e këtij vlerësimi, pjesëmarrja juaj është shumë e çmuar dhe, prandaj, kontributi juaj në këtë studim vlerësohet shumë. Pyetësi është krejtësisht anonim dhe konfidencial. Pjesëmarrja juaj është tërësisht vullnetare dhe refuzimi nga ana juaj për t’u përgjigjur nuk ndikon aspak në cilësinë e shërbimeve që do t’ju ofrohen në të ardhmen.

Miratimi për pjesëmarrje në studim

A jeni dakord për të marrë pjesë në këtë studim? Po ☐ Jo ☐

PYETJE TË PËRGJITHSHME (TË DHËNA DEMOGRAFIKE DHE SOCIAL-EKONOMIKE)

Qarku/Bashkia: _____ Vendbanimi: ☐ Rural ☐ Periurban ☐ Urban

Datëlindja: _____ Gjinia: ☐ M ☐ F Edukimi: Sa vite shkollë keni kryer? _____

Profesioni: _____ Punësimi: ☐ Punësuar ☐ Papunë ☐ Pension

Gjendja civile: ☐ Beqar ☐ Martuar ☐ Divorcuar ☐ Ve ☐ Bashkëjetesë

Grupi etnik: ☐ Shqiptar ☐ Rom/Egjiptian ☐ Tjetër (specifikojeni) _____

1. Me kë jetoni? _____

2. Në një shkallë nga 1 (shumë i/e varfër) në 5 (jo i/e varfër), si e konsideroni vetveten?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

3. **Niveli ekonomik:** Krahasuar me mesataren e të ardhurave për frymë në Shqipëri, si e konsideroni nivelin ekonomik tuaj (ose të familjes tuaj):

☐ Shumë më të lartë ☐ Më të lartë ☐ Pothuajse njëloj ☐ Më të ulët ☐ Shumë më të ulët

4. **A merrni asistencë sociale/ndihmë ekonomike:** ☐ Po ☐ Jo

5. **Kategoria që ju përfaqësoni:**

☐ Varfër ☐ Sëmure ☐ Invalid ☐ Zonë e thellë ☐ Tjetër (speifikojeni): _____

6. **Si e vlerësoni gjendjen tuaj të përgjithshme shëndetësore?**

☐ Shumë keq ☐ Keq ☐ Mesatare ☐ Mirë ☐ Shumë mirë

7. **A keni ndonjë sëmundje, paaftësi apo çrregullim shëndetësor akut ose kronik?**

☐ Po ☐ Jo

7a. Nëse Po, listoni të gjitha sëmundjet tua kronike:

PYETJE MBI SHËRBIMET E URGJENCËS MJEKËSORE

8. A keni kërkuar/marrë ndonjëherë shërbim tek Qendra Kombëtare e Urgjencës Mjekësore?

☐ Po, shumë herë ☐ Po, të paktën një herë ☐ Jo ☐ Nuk e di

9. A keni telefonuar ndonjëherë numrin 127 (Qendra Kombëtare e Urgjencës Mjekësore)?

☐ Po, shumë herë ☐ Po, të paktën një herë ☐ Jo ☐ Nuk e di

a. Nëse “Po”, a keni marrë përgjigje nga numri 127?

☐ Po, gjithmonë ☐ Po, por jo gjithmonë ☐ Jo ☐ Nuk e di

b. Nëse “Po”, në tërësi, a jeni të kënaqur me këtë shërbim të ofruar nga Qendra Kombëtare e Urgjencës Mjekësore?

☐ Shumë ☐ Mjaftueshëm ☐ Mesatarisht ☐ Pak ☐ Aspak

c. Nëse “Po”, çfarë opinionini keni për komponentët e mëposhtëm të shërbimeve të ofruara nga Qendra Kombëtare e Urgjencës Mjekësore?

a. Autoambulanca vjen në kohë: ☐ Dakord ☐ S’e di/s’gjykoj dot ☐ S’jam dakord

b. Ka pajisjet e duhura në dispozicion: ☐ Dakord ☐ S’e di/s’gjykoj dot ☐ S’jam dakord

c. Personeli mjekësor është i aftë: ☐ Dakord ☐ S’e di/s’gjykoj dot ☐ S’jam dakord

d. Problemet mjekësore zgjidhen: ☐ Dakord ☐ S’e di/s’gjykoj dot ☐ S’jam dakord

10. Përtej marrjes në telefon, a keni marrë ndonjëherë shërbime të urgjencës mjekësore për veten ose familjarët tuaj pranë ndonjë qendre/institucioni? ☐ Po ☐ Jo ☐ S’e di

a. Nëse “Po”, ku jeni paraqitur për të marrë shërbime mjekësore në raste urgjencash?

☐ Shërbimi i Urgjencës në zonën e banimit ☐ Qendër Shëndetësore ☐ Spital

b. Nëse “Po”, në tërësi, a jeni të kënaqur me shërbimin e ofruar nga institucioni përkatës?

☐ Shumë ☐ Mjaftueshëm ☐ Mesatarisht ☐ Pak ☐ Aspak

c. Nëse “Po”, çfarë opinionini keni për komponentët e mëposhtëm të shërbimeve të ofruara nga qendra/institucioni përkatës?

a. Qendra është afër: ☐ Dakord ☐ S’e di/s’gjykoj dot ☐ S’jam dakord

- b. *Ka pajisjet e duhura në dipozicion:* ☐ Dakord ☐ S'e di/s'gjykoj dot ☐ S'jam dakord
c. *Personeli mjekësor është i mirë:* ☐ Dakord ☐ S'e di/s'gjykoj dot ☐ S'jam dakord
d. *Problemet mjekësore zgjidhen:* ☐ Dakord ☐ S'e di/s'gjykoj dot ☐ S'jam dakord
e. *Unë kam besim tek mjeku im i familjes:* ☐ Dakord ☐ S'e di/s'gjykoj dot ☐ S'jam dakord

11. A ka ndodhur **gjatë viteve të fundit** të keni pasur nevojë për shërbim mjekësor urgjent dhe të mos keni pasur mundësi ta merrni atë? ☐ Po ☐ Jo

a. Nëse “Po”, për çfarë arsyeje? (shënoni me numra të gjitha arsyet në rend prioritar nga 1-7):

- ☐ Shërbimin e kam larg dhe/ose transporti është i kushtueshëm (rendi___)
☐ Arsye shëndetësore (shumë i sëmurë për të shkuar) (rendi___)
☐ Pamundësi financiare (rendi___)
☐ Nuk kam besim tek sistemi shëndetësor (rendi___)
☐ Kam turp të paraqitem sepse stigmatizohem (rendi___)
☐ Neglizhencë personale (rendi___)
☐ Nuk di ku të paraqitem (rendi___)
☐ Arsye tjera (specifikojini të gjitha): _____

12. Nëse keni marrë ndonjëherë shërbime të urgjencës mjekësore (gjatë viteve të fundit), si e konsideroni komunikimin e personelit shëndetësor?

- ☐ Shumë të mirë ☐ Mirë ☐ Mesatar ☐ Jo të mirë ☐ Shumë të keq

PYETJE MBI SHËRBIMET E EMERGJENCËS SHËNDETËSORE

Ky seksion synon të vlerësojë njohuritë tuaja dhe përgatitjen tuaj në raste emergjencash shëndetësore (pra, një situatë fatkeqësie natyrore/njerëzore, apo situatë epidemie/pandemie). Në një shkallë nga 1 (aspak dakord) në 5 (shumë dakord), sa dakord jeni me pohimet e mëposhtme:

13. Perceptimi i rrezikut nga fatkeqësitë

	Aspak dakord	Jo dakord	Neutral	Dakord	Shumë dakord
a. Zona ku unë banoj është e sigurtë nga të gjitha llojet e fatkeqësive ose nuk mund të preket nga asnjë lloj fatkeqësie	1	2	3	4	5
b. Mendoj se pallati/banesa ku unë jetoj është i ndërtuar mirë dhe do e përballojë një tërmet apo fatkeqësi të mundshme	1	2	3	4	5
c. Jam shumë i/e shqetësuar se katastrofat/emergjencat mund të prekin komunitetin ku une jetoj	1	2	3	4	5

d. Jam shumë i/e shqetësuar se katastrofat/emergjencat mund të prekin familjen time	1	2	3	4	5
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13.1 Nëse jeni të shqetësuar për një nga pikat më sipër, për cilat aspekte jeni më të shqetësuar:

	Jo	Po
a. Mungesën e planeve lokale për përgatitjen ndaj emergjencave apo katastrofave	1	2
b. Mungesën e informacionit rreth përgatitjes për emergjencat/katastrofat	1	2
c. Mbështetjen e mjaftueshme nga qeveria lokale për përgjigjen ndaj emergjencave/katastrofave	1	2
d. Reagimin në kohë të institucioneve (Qeveria qendrore, Bashkia, institucione të tjera) në lidhje me emergjencat/ katastrofat	1	2
e. Tjetër (specifiko)		

14. Njohuritë lidhur me emergjencat/katastrofat

	Aspak dakord	Jo dakord	Neutral	Dakord	Shumë dakord
a. Unë e di se Shqipëria është e rrezikuar nga katastrofat natyrore	1	2	3	4	5
b. Unë e di se komuniteti ku unë jetoj është i rrezikuar nga katastrofat	1	2	3	4	5
c. Unë e di se ka plane lokale në komunitetin tim që ndihmojnë për përballimin e katastrofave natyrore	1	2	3	4	5
d. Unë e di se ka struktura të Bashkisë që ndihmojnë për t'ju përgjigjur katastrofave/emergjencave gjatë dhe pas tyre	1	2	3	4	5
e. Unë e di se ka organizata apo institucione fetare që na informojnë rreth përgatitjes para, gjatë dhe pas një katastrofe/emergjence	1	2	3	4	5
f. Unë kam njohuri për rreziqet e një fatkeqësie në rast se ajo ndodh	1	2	3	4	5
g. Unë e di (njoh) impaktin (efektin) e fatkeqësive kur ato ndodhin	1	2	3	4	5
h. Jam plotësisht i vetëdijshëm dhe i informuar për sistemin dhe planin e evakuimit në lagjen/zonën time	1	2	3	4	5

15. Përgatitja dhe gatishmëria në rast fatkeqësish

	Aspak dakord	Jo dakord	Neutral	Dakord	Shumë dakord
a. Kam marrë udhëzime nga ekspertë të fushës për situatat e emergjencave/katastrofave	1	2	3	4	5
b. Unë vetë kam kërkuar udhëzime për situatat e emergjencave/katastrofave	1	2	3	4	5
c. Unë jam interesuar për planet e evakuimit strehimit në komunitetin tim në situatat e emergjencave/ katastrofave	1	2	3	4	5
d. Kam mbledhur informacion lidhur me çfarë të bëj në rast të një fatkeqësie	1	2	3	4	5

e. Unë kam përgatitur një plan evakuimi (apo tjetër) për familjen time në rast katastrofe	1	2	3	4	5
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15.1 A është prekur familja tuaj nga ndonjë katastrofë/emergjencë? ☐ Po ☐ Jo

16. Përshtatja/reagimi/praktikat aktuale ndaj emergjencave/fatkeqësive

Në një shkallë nga 1 (aspak dakord) në 5 (shumë dakord), sa dakord jeni me pohimet e mëposhtme:

	Aspak dakord	Jo dakord	Neutral	Dakord	Shumë dakord
a. Unë e di se ku ka vend-strehime ose qendra evakuimi apo hapësira të mëdha në rast të një fatkeqësie	1	2	3	4	5
b. Unë e di se cilat institucione qeveritare duhet të kontaktoj pas ndodhjes së një emergjence/fatkeqësie	1	2	3	4	5
c. Unë di si të reagoj para, gjatë dhe pas një katastrofe/emergjence	1	2	3	4	5
d. Po marr informacionet e mjaftueshme lidhur me përshtatjen ndaj fatkeqësive nga NGO të ndryshme	1	2	3	4	5
e. Unë jam i ndërgjegjshëm për rëndësinë e aktiviteteve në komunitet lidhur me reduktimin e rrezikut nga fatkeqësitë	1	2	3	4	5
f. Unë jam i përgatitur (me kite ose çanta emergjence, që kanë medikamente kryesore, ujë dhe ushqim për 2-3 ditë) në rast të një fatkeqësie	1	2	3	4	5
g. Jam i/e interesuar për t'u përfshirë në formulimin e planeve lokale për përgjigjen ndaj emergjencave / katastrofave	1	2	3	4	5

17. Menaxhimi i fatkeqësive

	Po	Jo
a. A dini nëse ka një plan emergjence në zonën tuaj?	1	2
b. A e di nëse ka ligje apo rregullore për menaxhimin e fatkeqësive në Shqipëri?	1	2
c. A e di nëse komuniteti juaj a ka krijuar rregullore për menaxhimin e fatkeqësive?	1	2

18. Burimi i informacionit lidhur me ndërgjegjësimin rreth katastrofave/fatkeqësive

Nëse ju keni nevojë të ndërgjegjësoheni në lidhje me katastrofat dhe rreziqet e lidhura me to, si do të donit të informoheshit? Cili do ishte burimi i informacionit më i favorshëm për ju? Qarko një ose me shumë opsione të përshtatshme

a. ☐ Diskutimet në komunitet	e. ☐ Televizionet kombëtare apo lokale
b. ☐ Diskutimet në shkolla për fëmijët	f. ☐ Radio kombëtare ose lokale
c. ☐ Diskutime në vendin e punës	g. ☐ Rrjete sociale (Facebook, Instagram, Tik-Tok, Twitter)
d. ☐ Mbledhjet informuese të Këshillit Bashkiak/Prefekturë	h. ☐ Aplikacione në telefon

ANNEX 2: Detailed information on focus groups discussions

Table 23 presents a detailed information on focus groups discussions.

Table 23. Composition of focus groups

Nr.	Date	Zona	Grupi target
1	2.6.2023	Tirane, zona e Kinostudios	Të moshuar me sëmundje kronike
2	4.6.2023	Tirane, zona e Kombinatit	Komunitet i prekur nga tërmeti
3	5.6.2023	Belsh Rrasë, (Elbasan)	Përdorues të shërbimit në QSH 24 orëshe; Përdorues shërbimesh nga zona të largëta
4	7.6.2023	Gramsh	Përdorues të shërbimit nga zona të largëta dhe komunitet i varfër
5	8.6.2023	Dajç (Shkodër)	Përdorues shërbimesh nga zona me përmbytje
6	9.6.2023	Vorë (Tiranë)	Përdorues të shërbimit në QSH 24 orëshe; Familjarë të personave me aftësi të kufizuar; Persona të varfër; Përdorues që jetojnë në zonë të prekur nga tërmeti
7	10.6.2023	Shijak (Durrës)	Përdorues të shërbimit në QSH 24 orëshe Komunitet i prekur nga tërmeti
8	13.6.2023	Klos (Burrel)	Përdorues të shërbimit në QSH 24 orëshe; Përdorues shërbimesh nga zona të largëta Komunitet i varfër
9	13.6.2023	Patos (Fier)	Përdorues të shërbimit në QSH 24 orëshe; Të sëmurë kronikë dhe të moshuar; Komunitet nga zona të përmbytura dhe të ndotura nga produktet e naftës
10	14.6.2023	Valias, Tiranë	Përdorues të shërbimit në QSH 24 orëshe; Familjarë të personave me aftësi të kufizuar; Persona të moshuar
11	15.6.2023	Ishëm (Durrës)	Përdorues të shërbimit në QSH 24 orëshe; Përdorues shërbimesh nga zona të largëta Komunitet i varfër
12	15.6.2023	Shëngjin (Lezhë)	Përdorues shërbimi që jetojnë në zona të rrezikuara nga zjarri
13	16.6.2023	Kuçovë	Komunitet që jeton në zona të përmbytura Komunitet i varfër Të sëmurë kronikë
14	17.6.2023	Këlcyre, Përmet	Përdorues shërbimesh nga zona të largëta Familjarë të personave me aftësi të kufizuar
15	26.6.2023	Fushë-Arrëz	Përdorues shërbimesh nga zona të largëta Komunitet i varfër

ANNEX 3: Detailed information of Key Informants Interviews

Table 24 presents a summary of key informants contributing to the present survey.

Table 24. Summary of key informants interviewed

Nr.	Institution	Key informant	Region
1	Health Centre Belsh	Former director	Elbasan
2	Health Centre Dajç	Former director	Shkodër
3	Administrative Unit, Dajç	Head of Administrative Unit	Shkodër
4	Fire department	Director	Gramsh
5	Together for Life	Executive Director	Tirana
6	Health Centre Klos	Former director	Klos
7	Health Centre Fush-Arrëz	Former director	Pukë
8	Health Centre Këlcyrë	Emergency Doctor	Përmet
9	Kucov Municipality, Sector of Civil Emergencies	Specialist	Kuçovë
10	Health Centre Novoselë	Former director	Vlorë
11	Health Centre Patos	Former director	Fier
12	Health Centre Ishëm	Former director	Durrës
13	Institution of Prefecture Civil defense and crisis sector, Lezhe district	Head of Sector	Lezhë
14	Tirana Municipality	Specialist of Social Protection Sector and Civil Emergencies	Tirana
15	Institute of Public Health	Expert on Emergencies	Tirana
16	Institute of Public Health	General Director	Tirana
17	National Civil Defence Agency	Expert	Tirana
18	State Social Service	Head of Adult Social Service Sector	Tirana
19	Save the Children, “Shkollat për Shëndetin” project	Project Director	Tirana
20	National Union of Old Age Pensioners	Head of Association	Tirana

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Other useful websites:

- [Hazard Vulnerability/Risk Assessment | ASPR TRACIE \(hhs.gov\)](#).
- <https://publichealth.tulane.edu/blog/cultural-competence-in-health-care/#:~:text=What%20Is%20Cultural%20Competence%20in,attitudes%2C%20values%2C%20and%20behaviors>.
- <https://www.cdc.gov/about/sdoh/addressing-sdoh.html#:~:text=Addressing%20differences%20in%20SDOH%20makes,or%20access%20to%20healthcare%20services>.